Care New England

Advancing Excellence in Equity: 2024

Table of Contents

About Care New England Health System

Care New England Health System (CNE) is dedicated to prioritizing its patients and the community in all its endeavors. As an integrated healthcare organization, CNE is committed to advancing medical research, attracting top specialty-trained doctors, offering renowned services, and implementing innovative programs. It aims to improve the well-being of individuals and communities through comprehensive healthcare services and essential discussions about health and end-of-life preferences.

As a transformative force in healthcare, Care New England actively contributes to shaping the future of the field. The strengths of CNE emanate from the synergies of complementary programs and distinctive competencies embedded within its member organizations. With a substantial outreach footprint across southeastern New England, Care New England functions as a regional nexus for family health, ensuring seamless integration and delivery of a comprehensive spectrum of high-quality healthcare services.

Care New England Health System includes the following hospitals and organizations:

- **Butler Hospital** is Rhode Island's premier treatment, teaching, and research hospital for psychiatric, movement, and memory disorders.
- **Kent Hospital**, provides high-quality, compassionate, and personalized healthcare delivered in an interdisciplinary model that involves all members of the healthcare team.
- **Women & Infants Hospital** is the region's premier hospital for women and newborn children. It operates one of the nation's largest single-family room neonatal intensive care units.
- **The Providence Center** helps adults, adolescents, and children affected by psychiatric illnesses, emotional problems, and addictions by providing treatment and supportive services within a community setting.
- **The VNA of Care New England** provides a broad spectrum of home health and hospice services for adults and the terminally ill.
- **Care New England Medical Group** has over 500 physicians and advanced practitioners, offering primary care and specialty services in offices throughout Rhode Island and Southeastern Massachusetts.
- **Integra Community Care Network** is an Accountable Care Organization comprised of a community of doctors, nurses, social workers, pharmacists, community health workers, and patients working together to improve the health and well-being of the community.

Executive Summary

Advancing Excellence in Equity 2024 highlights Care New England Health System's (CNE) commitment to health equity and its progress in ensuring equitable access to high-quality care for all communities. This report is significant as the initial comprehensive document detailing the processes and outcomes of healthcare equity efforts made across the health system. These initiatives demonstrate a commitment, notable among health systems, to integrate the work of medicine, administration, and the communities served towards common goals. While extensive, this document is not exhaustive, acknowledging numerous other health equity efforts spanning policy, research, language access, and tailored clinical services. The intent of this report is not to catalog every action but rather to detail the system's approach as a work in progress and to share key connected initiatives. As Care New England continues to refine its methods for advancing health equity, the system remains committed to sharing this journey with stakeholders and collaborating to eliminate disparities, repair harm, and increase access to the highest quality care in Rhode Island.

CNE's health equity work in 2024 was driven by two primary approaches: targeted disparity reduction projects and universal screening for health-related social needs. Undertaking a strategic and collaborative approach, the Chief Health Equity Officer, in partnership with the Chief Diversity Officer, established a foundation for each Care New England Organization to analyze data and identify areas where disparities exist. This process enables each organization to examine its patient or client population and services and align its efforts to achieve meaningful impact. With leadership across each organization tasked with advancing equity, this framework allows CNE to address specific issues sequentially, building organizational capability for initiating change. Within a one-year timeframe, each organization identifies disparities, develops, and implements action plans, tracks progress, and makes necessary adjustments. This process for disparity reduction projects involves teams focusing on identified disparities and includes strategic leadership from the system level, with local executive sponsors, leads, and quality personnel monitoring data.

In 2024, while disparity reduction projects represented a large portion of the work, significant effort was also directed towards the implementation of universal screening for health-related social needs (HRSNs). Between 2021 and 2023, over 126,000 unique individuals had been screened in the ambulatory network across Care New England, led by Integra. Leveraging this foundation, inpatient screening was launched at the end of calendar year 2023, making 2024 the first full year with both ambulatory and inpatient processes fully operational. Data collection, stratified by race, ethnicity, gender, insurance type, socioeconomic status, and geographic location, facilitates the identification of patients' unmet social needs and potential disparities. Given the significant impact of social factors on health outcomes, these data provide a broader picture to inform the strategic targeting of interventions to maximize health improvement.

Care New England's advancements in health equity work in 2024 were also supported by shared learning opportunities. The DEI Summit, in its fourth year, provides a forum for equity-minded professionals to engage with community partners and enhance understanding of system-wide efforts. Reflecting expanding efforts to focus on community-centered equitable care, the inaugural Advancing Excellence in Equity Awards were established to recognize outstanding contributions to health equity. Two awards, one highlighting a leader and one highlighting a team, were presented.

Acknowledgements

Many people and organizations dedicate countless time, talent, and passion to advance health equity at Care New England. Most of these individuals work within the system, but this work would not be possible without dedicated partners who advocate for community wellness, fund initiatives and research, and hold the system accountable to a higher standard.

Butler Hospital

- Mary Marran, President, and Chief Operating Officer
- Carolyn Walsh, Director of Social Services and Care Management
- Diane Block, Director of Quality and Patient Experience
- Kevin Baill, Medical Director of Outpatient Services
- G. Mustafa Surti, Chief Medical Officer
- Diane Ferreira, Senior Vice President and Chief Nursing Officer

Women & Infants Hospital

- Method Tuuli, Chief of Obstetrics and Gynecology
- Heather Smith, Academic Generalist Division
- Denise Henry, Director of Quality Management
- Mariel Aleman, Health Equity Program Manager

Kent Hospital

- Jennifer La Luz, Executive Director of Operations
- Brydie Thomasian, Director of Behavioral Health & Clinical Social Work
- Sherri Sprague, Senior Vice President, and Chief Nursing Officer

Care New England Medial Group

- Roger Mitty, President, and Chief Operating Officer
- Claire Mathews, Executive Director Clinical Operations and Quality

The Providence Center

- Sandrine Fujah, Director of Clinical Services
- Donna Bagdasarian, Director, Quality Improvement
- Ben Isaiah, Chief Operating Officer
- Jillian Roy, Chief Nursing Officer, and Vice President of Clinical Services

Integra Community Care Network

- Matthew Harvey, Vice President of Operations and Executive Director
- Pam Costello, Senior Director of Quality and Primary Care
- Brady Dunklee, Manager of Community Health Strategy
- Joseph Diaz, Chief Health Equity Officer, Medical Director for Medicaid Accountable Entity program

VNA of Care New England

- Jane Pike-Benton, President
- Katie Ganusko, Director of Hospice and Palliative Care
- Lois Hamilton, Director of Home Health
- Kelley Munroe, Director of Organizational Excellence
- Paula Foster, Manager of Organizational Excellence

Care New England Corporate

- Joseph Diaz, Chief Health Equity Officer
- Kevin K. Martins, Vice President, and Chief Diversity Officer
- Robin Neale, Vice President for Quality and Clinical Effectiveness

A Letter from our President and CEO

Dear Colleagues and Community Partners,

At the heart of our mission as a healthcare system is the fundamental belief that access to high-quality care should be a universal right, not a privilege. Yet, we know that far too many individuals in our community face significant barriers to achieving this right. Obstacles such as lack of transportation, inadequate health insurance, and language differences create disparities that undermine our efforts to deliver equitable care.

In Rhode Island, the prevalence of unmet health-related social needs magnifies the importance of clinical intervention. We recognize that addressing these social determinants of health – such as food insecurity, housing instability, and lack of access to transportation – is paramount. If we can effectively address these needs, we can reduce the reliance on costly and often reactive clinical interventions and truly empower individuals to live healthier lives.

I am immensely proud of the dedicated individuals across our health system who tirelessly work to screen for health-related social needs and strive to reduce disparities among our patient and client populations. Their commitment to identifying and addressing these critical issues is making a tangible difference in the lives of those we serve.

While we have made significant progress in our journey towards health equity, we are keenly aware that we are still in the early stages. We are fortunate to have passionate and skilled teams throughout our organization who are deeply committed to doing more. We are determined to build upon our successes, learn from our challenges, and continue to innovate in our pursuit of equitable access to care for all Rhode Islanders.

Our commitment to health equity is not just a strategic imperative; it is a moral one. We will continue to work tirelessly to break down barriers, build bridges, and create a healthcare system that truly serves the needs of every individual in our community.

Sincerely,

Michael E. Wagner, MD
President & CEO
Care New England Health System

A Letter from our Chief Health Equity Officer

Dear Colleagues,

We are pleased to share the Advancing Excellence in Equity Report for 2024, which highlights both our progress and the ongoing work ahead in our commitment to providing high-quality, equitable care to all the communities we serve. This report reflects our collective dedication, and we extend our sincere gratitude to everyone involved in these efforts.

As the report details, we have made meaningful strides in key areas, demonstrating our ability to move from planning to action. This progress is a direct result of the foundational commitment developed several years ago. We are particularly grateful for the continued leadership of Care New England Health System CEO, Dr. Mike Wagner and partnership of Vice President Dr. Kevin Keith Martins in advancing this vision.

Our focus remains steadfast in the following areas:

- **Data-Driven Action:** We are committed to rigorous data collection and analysis to identify and address disparities across domains of care.
- **Strategic Implementation:** Our efforts are guided by clear, actionable plans at both the operational unit and system levels.
- **Community Engagement:** We recognize the importance of collaboration with community partners to address social drivers of health and advance health equity.

While we have made considerable progress, we acknowledge that there is still much work to be done. As we move forward, we will continue to:

- **Refine our approach:** Regularly evaluate and enhance our strategies for identifying and addressing disparities.
- **Expand our reach:** Extend our initiatives to encompass additional areas of care and populations we serve.
- **Strengthen partnerships:** Deepen our collaboration with community organizations to create a more equitable healthcare ecosystem.

We are confident that by staying true to our vision and working together, we can continue to make meaningful progress to improve healthcare quality, decrease disparities, and advance health equity for all the communities we serve.

Thank you for your ongoing commitment to this vital work.

Sincerely,

J.A. Diaz, MD, MPH
Chief Health Equity Officer
Care New England

Screening for Health-Related Social Needs

The Social Drivers of Health (SDoH)—the conditions in which individuals live, work, learn, and play—significantly shape health outcomes, often more so than healthcare or individual behaviors. Recognizing this profound impact, Care New England has increasingly implemented universal screenings to identify patients' unmet health-related social needs (HRSNs), such as food and housing insecurity, financial strain, transportation barriers, and safety concerns, across both inpatient and outpatient settings.

Initiated in 2021 by Integra Community Care Network within its primary care offices, including the Care New England Medical Group, this universal screening program expanded system-wide to inpatient units in 2023, with 2024 marking its first full year of implementation. By the end of 2023, over 126,000 unique individuals had been screened, resulting in more than 240,000 documented screenings in the EPIC electronic medical record system, representing a comprehensive dataset believed to be the largest of its kind in Rhode Island. The program's executive sponsor, Robin Neale, Vice President for Quality and Clinical Effectiveness, actively collaborates with key stakeholders to coordinate screening efforts at each inpatient site.

Inpatient Screening for Health-Related Social Needs: 2024
Butler Hospital, Kent Hospital, and Women & Infants Hospital

Screening and Positivity Rates FY2024	Butler	Kent	WIH
Unique Discharges	3972	8550	8749
Declined to answer	514	642	236
Numerator = Number screened for 5 required HRSNs	3122	6214	6553
Denominator = Number unique admissions choosing to respond	3458	7908	8513
% of unique discharges screened for all 5 HRSNs	**90%**	**79%**	**77%**
% of patients who screened positive for housing instability	36%	7%	8%
% of patients who screened positive for food insecurity	28%	7%	6%
% of patients who screened positive for trouble paying utilities	26%	5%	4%
% of patients who screened positive for lack of reliable transportation	29%	6%	5%
% of patients who screened positive for interpersonal violence	6%	< 1%	< 1%

Ambulatory Screening for Health-Related Social Needs: 2024
Care New England Medical Group

Health Related Social Needs Screenings	2024
Total Screenings	114,387
Positives	17,782
Overall Positive	15.36%

Domain	2024
Housing Positive	3.46%
Food Positive	3.90%
Financial Positive	8.95%
Activities of Daily Living Positive	5.20%
Transportation Positive	1.71%
Interpersonal Violence Positive	0.77%
Social Isolation Positive	3.54%

Patients who screen positive for health-related social needs (HRSNs) and express a willingness to accept support are connected with Social Work, Case Management, and/or Community Health Workers (CHWs). These teams facilitate referrals to essential resources such as safe housing, local food banks, and medical transportation. When a patient screens positive for Interpersonal Violence (IPV) in an outpatient practice setting, the electronic health record system, Epic, automatically flags this result. This flag presents as a Best Practice Advisory (BPA) that includes a hard stop, requiring the provider to address the identified concern. The BPA also provides the hotline number for the RI Coalition Against Domestic Violence as a resource. Providers are guided by established protocols to manage the concern in real time, with social work services engaged as indicated by these protocols or the patient's needs.

Care New England also utilizes FindHelp.org, a comprehensive database of local community resources, and includes this information in discharge paperwork. While these efforts provide a foundational approach to addressing identified social needs, the necessity of a more streamlined and proactive system is recognized. Analyzing the data collected since 2021 through Integra, combined with the 2024 findings, offers a significant opportunity to deepen the understanding of patient social needs and develop more targeted and efficient interventions. The ongoing, data-driven approach will involve benchmarking against innovative systems with exemplary community-centered care to optimize these critical processes, ultimately enabling the organization to work "upstream" and address the root causes of these needs before they escalate into acute health issues.

Identifying and Eliminating Disparities

Achieving health equity requires a nuanced understanding of the diverse factors influencing health outcomes across different population groups. This section demonstrates the crucial role of data collection stratified by variables such as race, ethnicity, gender, insurance type, socioeconomic status, and geographic location. By systematically collecting and analyzing these data, existing health disparities and their underlying causes can be identified.

Once disparities are identified, the next imperative step is to develop and implement targeted action plans aimed at closing gaps. This involves setting measurable goals, engaging stakeholders, and allocating resources effectively to ensure equitable health outcomes. The integration of data-driven insights with strategic intervention forms the backbone of efforts to promote health equity and foster a healthcare system where everyone has the opportunity to achieve optimal health, regardless of their background or circumstances.

In this section, each Care New England organization outlines an identified disparity and action plan to address and mitigate inequities. By doing so, the aim is to provide a comprehensive framework for understanding and tackling health disparities within the communities served.

"Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care."

— Paula Braverman, What is Health Equity 2017 Robert Wood Johnson Foundation."

Butler Hospital

Examination of Disparities in Care in 2024

In 2024, Butler Hospital identified three aspects of its care to examine for healthcare disparities. The areas selected were all evaluated by using patient characteristics such as race, ethnicity, and primary language. The areas examined were: the collection of accurate data during the registration process, the percentage of patients endorsing problems with specific social drivers of health, and assessing the use of (or access to) ambulatory services from nearby towns identified as having a population with high health needs.

Collection of Race, Ethnicity and Language Data (REaL)

In 2024, Butler had a goal to have 93% or more of patients self-identify their race, and 5% or less of patients have unknown or unavailable listed for race. As these goals have not yet been achieved, several areas of the registration process were identified for improvement.

The first step was to confirm that registrars were using the correct forms and processes for collecting personal demographic data. A change was made to change an optional field for reporting whether race data was "self-identified" to mandatory. During this time, education was provided to all the registration staff working in inpatient and partial hospital programs on the importance of their work, and how critical the collection of demographic patient data is in helping Butler identify disparities in care.

Once these improvements were made, it appeared that additional progress on this measure would require examining the multiple specialty outpatient programs located on the Butler and South County campuses. As the data from these programs were examined, there were inconsistencies noted between the workflow of registration staff and the data provided on the report. Currently, there is work underway to ensure that the data gathered during the registration process matches the workflow of the outpatient registrars. As of December 31, 2024, Butler achieved 91% of patients who self-identified their race, and 6% having unknown or unavailable as their race.

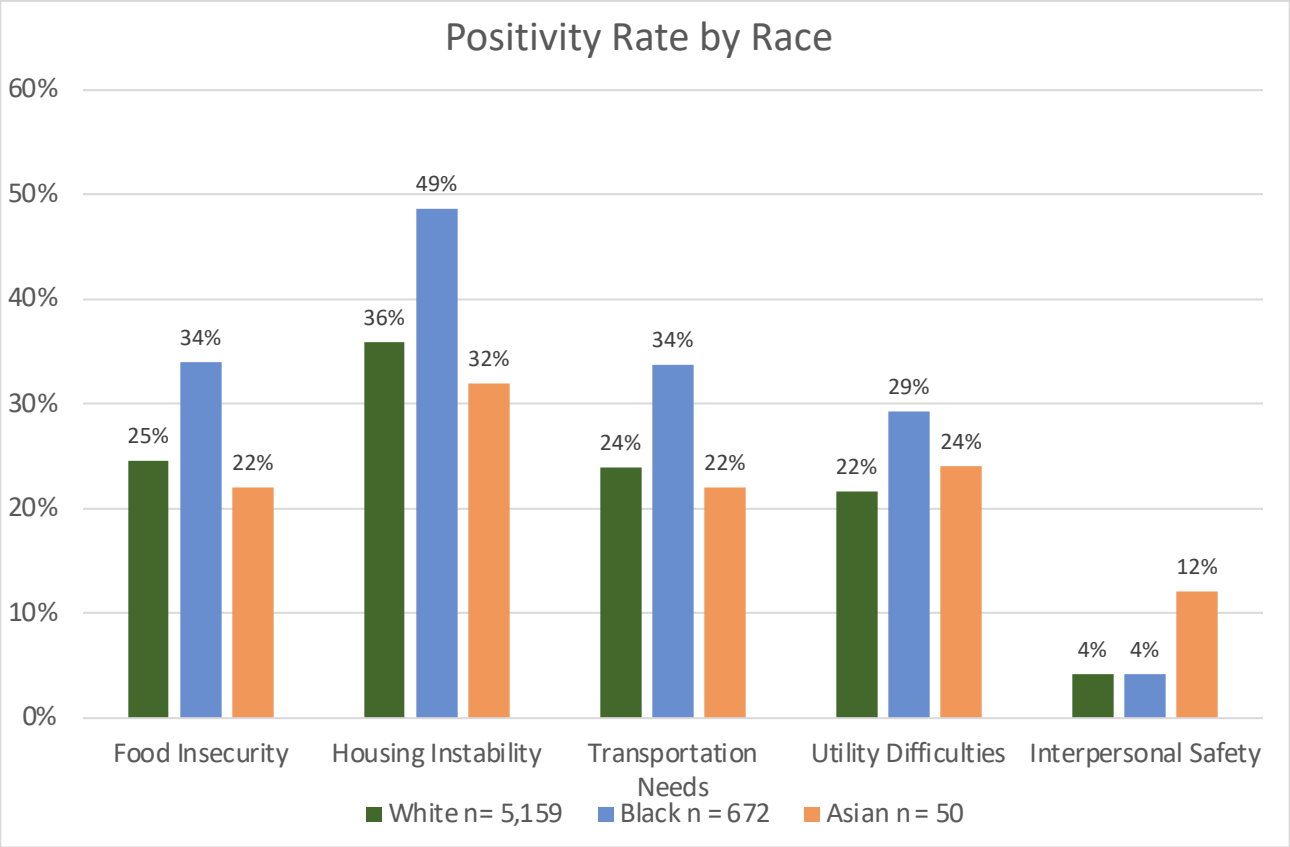
Health-Related Social Needs

In 2024, Butler Hospital instituted a new process of screening all patients aged 18 and over for five health-related social needs (HRSNs). These drivers include access to quality food, housing, transportation, utilities (electricity, gas, oil, etc.), and interpersonal safety. The initial phase of this project included identifying the staff responsible for this screening and creating the appropriate screening fields in the medical record. At Butler, this task is being consistently completed by Social Services clinicians on adult units. The overall screening rate for 2024 is 91%.

Patients may miss being screened if they refuse to meet with a social worker prior to discharge, or if an 18- or 19-year-old patient is treated on the adolescent unit. The screening is not done on this unit as patients are typically minors and have guardians responsible for their housing, food, etc.

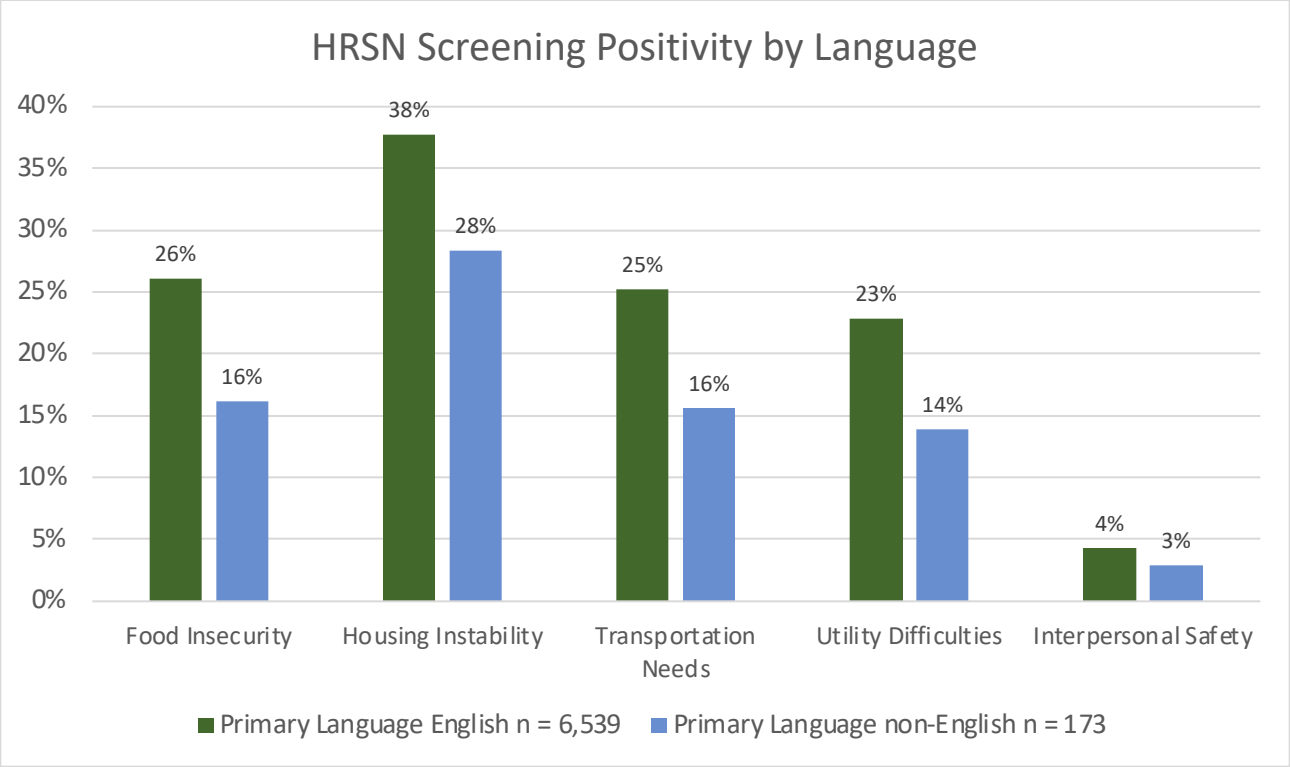
The driver that consistently has the highest positivity rate at Butler is housing instability. Roughly 40% of adult patients screen positive for this need. The next most common drivers are food insecurity (31%) and transportation needs (31%). Trouble paying for utilities was experienced by 30% of adults and interpersonal safety issues by 5%, respectively.

These positivity rates were examined by several characteristics including race, ethnicity, and health insurance type (commercial versus public). There was a difference in the number of patients identifying housing instability by race as shown in the table below. The low number of individuals in the Asian category prevents comparing this group to the groups of White and Black patients.

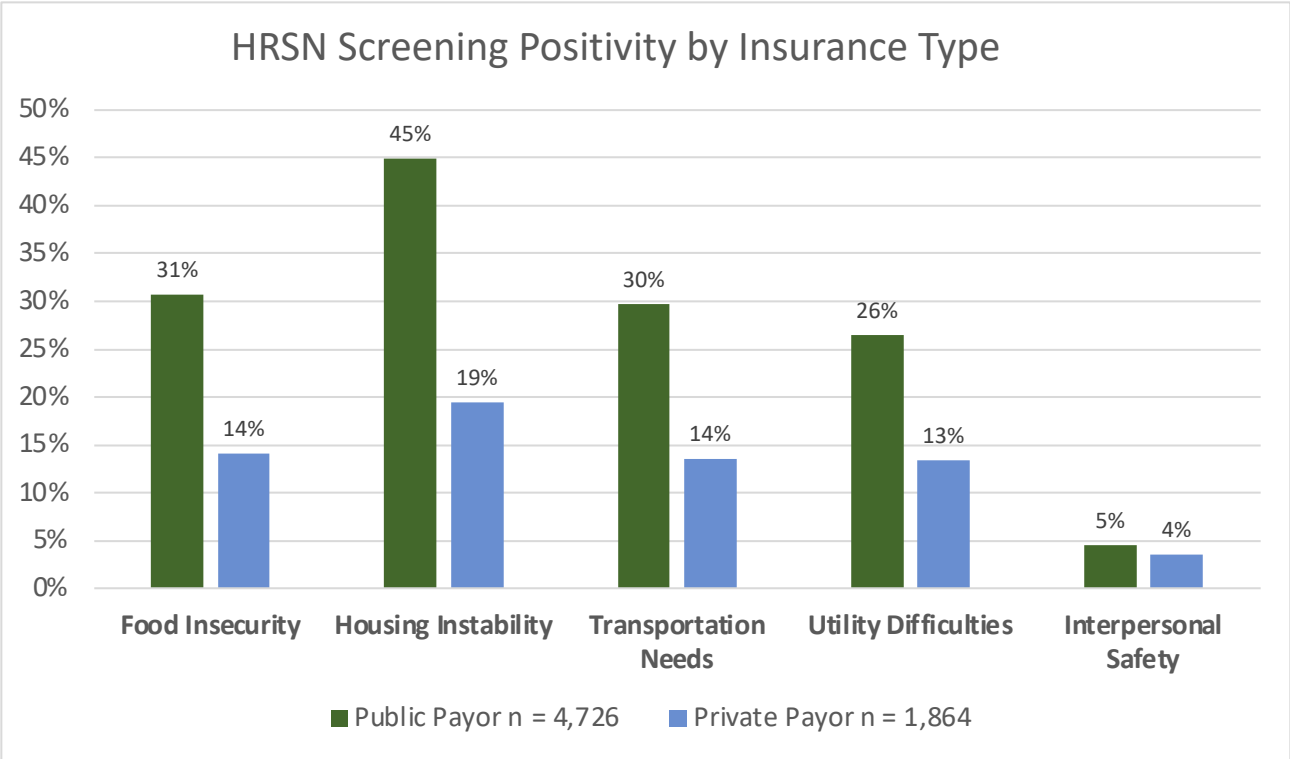


There were not significant differences between groups when examined by Ethnicity. The rates were very similar for all social drivers of heath for Hispanic (n = 911) and non-Hispanic (n = 5732). They varied by 1% or less for all five social drivers (not shown).

The characteristic of primary language showed differences across the social drivers (shown below). For each driver the positivity rate was higher for primary English speakers (n = 6,539) compared to individuals who did not report English as their primary language (n = 173).



The characteristic that had the most impact on revealing positivity rates for social drivers of health was insurance type. The positivity rates for 4 of the 5 drivers were substantially different when grouped by insurance status.



These data indicate that more than 35% of patients who are age 18 or older, and complete inpatient treatment at Butler Hospital have problems with secure housing. Roughly 25% have problems with food insecurity and transportation. More than 20% have difficulty paying for utilities. A smaller number, less than 5% acknowledge problems with interpersonal safety. These health-related social needs were concentrated in the group of individuals who rely on publicly funded insurance. Addressing these issues will require Butler to link patients whenever possible to CNE-based partners such as The Providence Center, Integra, and internal case management programs such as Health Path and the Transitional Outpatient Program.

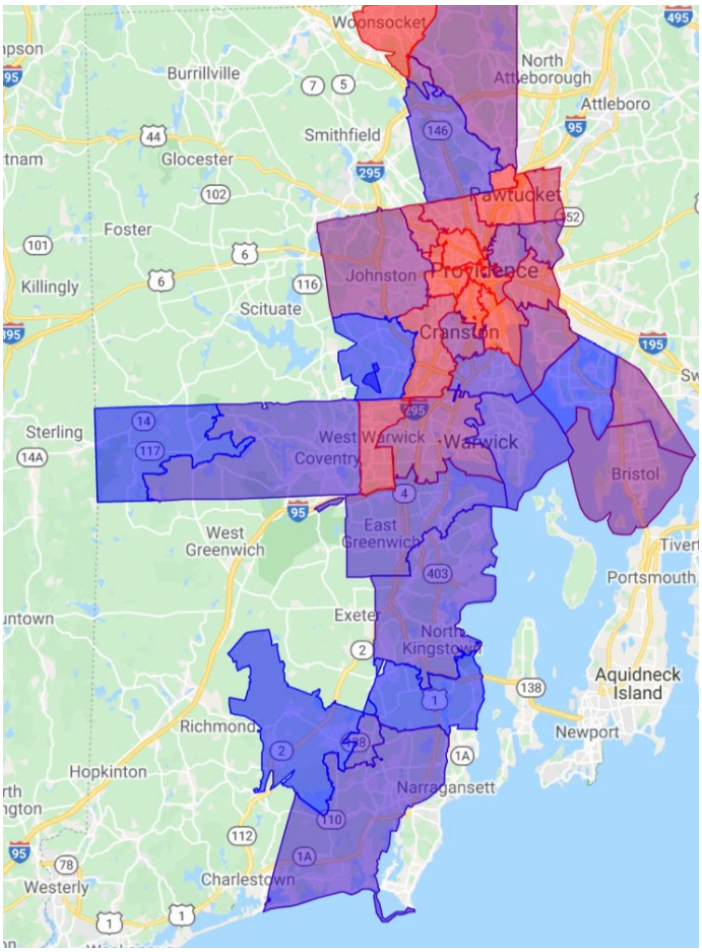
Ambulatory Services Usage

The 2022 Community Health Needs Assessment (CHNA) revealed important differences in the health needs of Rhode Island citizens based on the communities that they live in. This is summarized in the graphic below.

Butler explored whether its ambulatory services are being utilized by individuals living in the high need areas identified in CNHA report. There were eight (8) zip codes identified in the highest and second highest need areas. Butler decided to focus on two of these given their proximity to the Butler campus—Central Falls and Pawtucket.

The census data available for 2024 indicates that 65% of individuals in Central Falls identify as Hispanic and 35% as non-Hispanic. In Pawtucket, the ratios are reversed with 28% of individuals identifying as Hispanic and 72% as non-Hispanic. Butler served 131 individuals from Central Falls within ambulatory programs in FY 2024. Of the individuals served, 59% identified as Hispanic which is 6% less than expected given the proportion of Hispanic residents in Central Falls.

Butler served 241 individuals from Pawtucket, of which 33% were Hispanic. This is 5% less than might be expected given the percentage of Hispanics living in Pawtucket. The volume of individuals who identify as Hispanic that attended various ambulatory programs was examined to determine which programs might account for this disparity.



In evaluation-only services, there was no difference in use by individuals from Central Falls based on ethnicity. However, there were fewer Hispanic than non-Hispanic individuals coming in for evaluation only from Pawtucket. This suggested there may be room for improvement in making evaluation services more accessible to Hispanic individuals in Pawtucket. Evaluation services made up roughly one-third of the services used by individuals coming from Central Falls or Pawtucket.

In the partial hospital programs, more Hispanic than non-Hispanic individuals were seen from Central Falls. Fewer Hispanic individuals were seen compared to non-Hispanic individuals from Pawtucket. The various partial hospital programs offered were reviewed, and it was noted that the adolescent program may be responsible for this result from Pawtucket. Overall, this level of care accounted for less than one quarter of the individuals coming from either city.

Intensive Outpatient Services were used minimally by Hispanic and non-Hispanic individuals from either city. All other Outpatient programs (17 total) accounted for most individuals coming from these cities. These services accounted for 44% of individuals coming from Pawtucket and 38% of individuals coming from Central Falls. The only notable difference between Hispanic and non-Hispanic individuals was in the Cultural Psychiatry Clinic. This clinic serves individuals who are primarily Spanish or Portuguese speaking. The percentage of individuals who identified as Hispanic from Central Falls was 14%, and 8% from Pawtucket. The percentage for non-Hispanics was 1% and 0%, respectively.

This data suggested that the gap between the census of these high-need areas and the percentage that attend Butler Hospital ambulatory programs might reflect fewer than expected individuals from Pawtucket in evaluation and partial hospital programs. This observation was discussed among Operations leaders and felt to be inconclusive due to the presence of other providers that serve these communities—specifically The Providence Center and Gateway as Certified Community Behavioral Health Clinics (CCBHC) and Blackstone Valley Community Health Center. Absent data on the number of individuals from Pawtucket and Central Falls being served at these organizations, it is not clear that the low numbers seen at Butler reflect the adequacy of services provided through these other organizations. Importantly, the CCBHC's offer extensive services including 24/7 crisis support, family and individual counseling, case management services, and outpatient behavioral health and substance abuse services.

Goals for 2025

1. Complete improvements in gathering accurate race and ethnicity data at the time of registration by increasing the percentage of patients that self-identify their race and reduce the percentage in which unknown or other is entered in the medical record.
2. The 2022 Rhode Island Community Needs Health Assessment documented disparities in the use of medication-assisted treatment for opioid use disorders. Disparities existed for Black individuals and individuals living in certain areas of RI. There were also concerns about the use of medication-assisted treatment for individuals with alcohol use disorders. Butler will explore its use of medication-assisted treatment for individuals with opioid or alcohol use disorders, stratified by race, ethnicity, primary language, and town of residence. This analysis will apply to inpatient programs.
3. An additional area of study for inpatient programs will be the use of medications to treat severe agitation. Butler will examine all the medications that are offered when a patient is agitated and determine if there are differences noted based on a patient's race/ethnicity or primary language.
4. Lastly, Butler will embark on an analysis of the use of interpreter services for individuals who report a primary language that is not English. This analysis will examine how well information about a patient's preferred language is captured when discussing their health, and how effectively interpreter services are utilized during a patient's treatment in the hospital.

Women & Infants Hospital

Background

Throughout FY2023, the Women & Infants Hospital Health Equity Team focused on addressing the identified disparity in postpartum readmissions for Black patients. This led to the formation of the Postpartum Hypertension Equity Program, targeting hypertensive diseases of pregnancy (HDP) as the primary driver of these readmissions. This dedicated effort initiated in FY2023 continued into FY2024.

In FY2024, the Women & Infants Hospital Health Equity Team identified a further area of concern. Data from the Centers for Disease Control (CDC) indicates that hypertensive disorders in pregnancy affected at least 1 in 7 hospital deliveries nationally in 2019, with a higher prevalence of 1 in 5 for Black women. The Women & Infants Health Equity Team's analysis of data from the National Perinatal Information Center (NPIC) confirms this national trend within their patient population. Notably, Black patients at Women & Infants are experiencing higher rates of Severe Maternal Morbidity (SMM) among preeclampsia cases compared to White patients and the overall patient population.

Specifically, in CY2023 Q4, the Severe Maternal Morbidity Among Preeclampsia Cases rate for Black patients (15.1%) was statistically significantly higher than the rate for White patients (4.9%), approximately three times higher. Based on these data, the Health Equity Team established two primary priorities for FY2024, both centered on hypertension within their patient population.

Women & Infants Hospital recognizes the pivotal role of SISTA Fire in initiating and guiding the hospital's health equity journey. SISTA Fire is a community organization empowering women and nonbinary people of color to build collective power for social, economic, and political transformation. Their advocacy and leadership have been instrumental in shaping the hospital's understanding of systemic racism within healthcare and compelling the hospital to take concrete steps towards a more equitable and just system. This report reflects the hospital's ongoing commitment to the principles of equity and inclusion, building upon the foundational work initiated through accountability measures informed by SISTA Fire.

Postpartum Hypertension Equity Program

In FY2024, the Postpartum Hypertension Equity Program successfully enrolled 1,083 patients. The program Nurse Practitioner (NP) played a crucial role, initiating or adjusting medications for approximately 187 patients, resulting in approximately 223 medication interventions. Importantly, Black patients, who are known to have a higher chance of developing postpartum hypertension, made up 19% of the participants in this study. By including a greater proportion of individuals from this group, the program can gain more accurate insights into the factors affecting their health.

Recognizing the need to expand program capacity, program leaders actively sought additional resources. Through philanthropic support, an additional NP position was secured, with the new team member scheduled to join in January 2025.

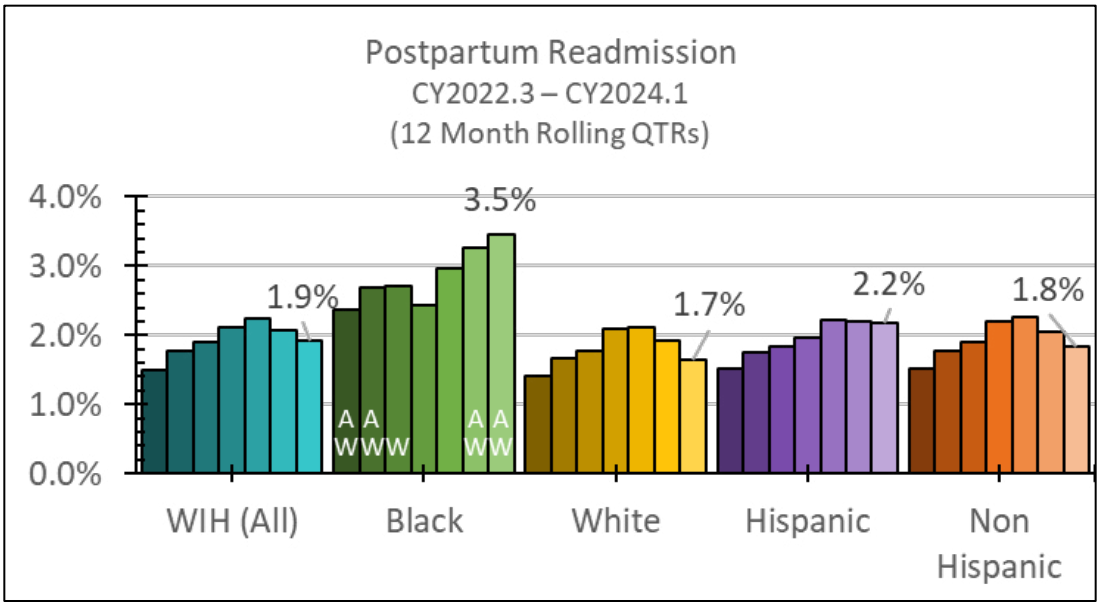
Postpartum Readmissions Task Force

In the latter half of FY2024, key stakeholders, including those involved with the Health Equity Team, formed a Postpartum Readmissions Task Force to better align efforts to investigate Postpartum Readmissions at Women & Infants Hospital. Key action items developed by this task force include:

- **Case Reviews.** 100% case review of postpartum readmissions that appear on the Daily Readmission Report. Cases are reviewed by an OBGYN provider as well as the NP from the Postpartum Hypertension Program. Each review helps to build a data set that provides valuable information to the Task Force.
- **Policy Review.** The Task force, in conjunction with the SMM Task Force, reviewed the current hospital policies and guidelines related to hypertension and blood pressure management in relation to standards of care and best practices. The Task Force found an opportunity for clarification in the Postpartum Hypertension Guidelines on Study of Women's Health Across the Nation (SWAN). The updated policy includes a visual algorithm for treatment recommendations as well as a handful of other minor updates. As of December 2024, the policy is on the path to approval.

Outcomes:

The overall rate of postpartum readmissions has gradually trended downward since quarter three of CY2023. However, the gap between the readmission rate for Black patients and the rate for White patients and WIH patients overall has persisted.



Severe Maternal Morbidity

The Health Equity Team initiated the development of an SMM Task Force by identifying key stakeholders from across the organization. This multidisciplinary team included representatives from Care New England Medical Group (CNEMG), Quality, Nursing, Maternal Fetal Medicine (MFM), and Obstetrics (OB) provider leadership.

To ensure thorough reviews of Severe Maternal Morbidity (SMM) cases, the Task Force adopted the Alliance for Innovation on Maternal Health (AIM) SMM Review Form as its main tool. Recognizing the need for more current data, the Task Force worked to improve its data sources. The previous source, NPIC, had a substantial delay of six months or more. The team identified a new resource that reduced this delay to about seven weeks. However, this improved timeliness requires monthly manual data processing.

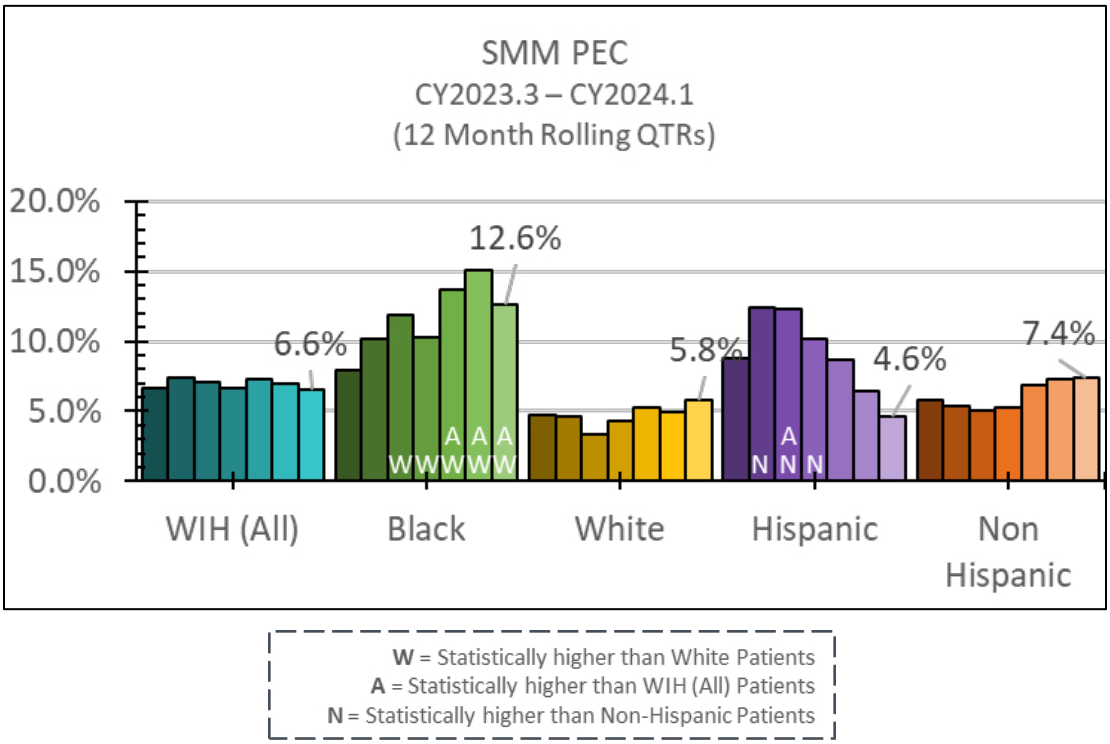
The Task Force created a dedicated Excel database to efficiently track and analyze SMM case review results using the AIM Review Form. Additionally, they recognized the importance of analyzing the time it takes to treat severely high blood pressure in all hospitalized obstetric patients. The team is currently refining a Cerner report within the inpatient electronic medical record to facilitate this crucial data analysis.

Finally, the Task Force conducted a comprehensive review of existing hospital policies and guidelines related to hypertension and blood pressure management. This review compared current practices to established standards of care and best practices. Based on this analysis, the Task Force identified areas for improvement and acted on these findings by updating the Postpartum Hypertension Guidelines, including the incorporation of Sequential Organ Failure Assessment (SOFA) scores and a visual algorithm for treatment recommendations.

Outcomes:

While the overall rate of postpartum readmissions has shown a gradual decline for three consecutive quarters, a concerning disparity persists. The rate of Severe Maternal Morbidity (SMM) for Black patients continues to be statistically higher than the rate for White patients and patients of other racial and ethnic groups.

Severe Maternal Morbidity Among Preeclampsia Cases (SMM PEC) by Race and Ethnicity



Community Engagement

Women & Infants participated in a three-part Rhode Island PBS series titled "The Risk of Giving Birth" that aired in January 2024. This platform provided an opportunity for clinicians to share the hospital's efforts to address racial disparities in maternal health. These efforts included highlighting valuable partnerships with community organizations such as SISTA Fire and local doula networks, as well as the successful implementation of the Hypertension Equity Program.

Furthermore, the Hypertension Equity Program Team actively engaged with the community by participating in the Women & Infants Trunk or Treat event in October 2024. This event provided a valuable opportunity to interact with community members and share essential information about the program. The team is eager to participate in more community events in the future to continue building strong relationships and raising awareness about the program's vital work. These community engagement initiatives are instrumental in strengthening outreach efforts and fostering meaningful connections within the community.

Staff Hiring and Training to Support Health Equity Initiatives

In FY2024, the team was strengthened by the addition of a new Community Health Worker (CHW). This addition, made possible through the generous support of The CVS Health Foundation grant, enhances the ability to connect with and support program participants. Furthermore, a Nurse Practitioner (NP) is scheduled to join the team in January 2025, also funded by the CVS Health Foundation grant. This grant funding directly addresses the growing needs of the Hypertension Program, enabling the program to expand its reach, deliver personalized care, and foster stronger community connections. The CHW will play a crucial role in community engagement and improving access to services, while the NP will bring valuable clinical expertise to enhance the quality of care provided for hypertension management and reduction. These staffing enhancements underscore the commitment to meeting the increasing demand for hypertension-related services and ultimately advancing better community health outcomes.

Community Health Workers (CHWs) are currently enrolled in the Rhode Island College (RIC) Community Health Worker Certification Program. This 12-week program provides specialized training for CHW professionals, enhancing their skills and knowledge to better serve patients. To further support CHWs' professional development, CHW supervisors also participated in supplementary training. This training provided valuable insights into the roles and responsibilities of CHWs and equipped supervisors with the necessary tools to effectively mentor and support their team members. This collaborative effort between CHWs, their supervisors, and Rhode Island College ensures that the workforce is well-prepared to meet the evolving needs of the community and effectively advance community health initiatives.

Plans for FY2025

In FY2024, Health Equity measures included postpartum readmissions and Severe Maternal Morbidity (SMM) among Preeclampsia (PEC) cases. While all these measures will continue to be monitored internally, efforts will focus on SMM and Hypertension for CNE's Health Equity reporting and initiatives in FY2025.

Equity Goal #1	Equity Goal #2
Number of Patients Enrolled in the Postpartum Hypertension Equity Program	**SMM PEC Full Interdisciplinary Chart Review**
Baseline (FY24): 1000 Threshold: 1170 Target: 1250 (about 75% of eligible patients)	Baseline (FY24): n/a Threshold: 90% Target: 100%
• Aligns with CNE Goal for FY2025	• Cases are obtained from Quality Analytics • Action planning will be completed for defects found in SMM PEC case reviews • Continue to report NPIC data for informational purposes – lagging data

This focus is driven by the significant disparity observed in SMM rates among Preeclampsia cases, particularly for Black patients. In CY2024 Q1, the SMM rate among Black patients with Preeclampsia was 12.6%, which is statistically higher than the rates for White patients (5.8%) and the overall rate for Women & Infants Hospital (6.6%).

These two goals create a focused effort on Hypertension/Preeclampsia in both the inpatient and outpatient settings.

Additional Health Equity Initiatives at Women & Infants Hospital

Women & Infants Hospital has implemented numerous equity-focused initiatives. This section highlights a selection of these initiatives, which aim to increase access to and equity in high-quality care for the communities served. The hospital is committed to sharing more about these and other impactful health equity initiatives throughout 2025.

Topical Estrogen: Brief Intervention to Improve Postoperative Experience for Transgender Men Undergoing Hysterectomy

Dr. Beth Cronin received a prestigious $50,000 award from the Constance A. Howes Women's Health Innovation Research Fund for her project, "Topical Estrogen: Brief Intervention to Improve Postoperative Experience for Transgender Men Undergoing Hysterectomy." This award, exclusively available to Women & Infants Hospital faculty, underscores the institution's commitment to addressing healthcare disparities and advancing research focused on underrepresented populations. Dr. Cronin's work exemplifies this commitment by focusing on improving care for transgender men, a population often underserved in both research and healthcare.

Rhode Island Community-based Maternal Support Services (RI COMSS)

The Rhode Island Community-Based Maternal Support Services (RI COMSS) project aims to improve perinatal health outcomes by integrating community-based support services into existing systems of care. In collaboration with the COMPASS+ initiative through the Hassenfeld Institute at Brown University, Women & Infants Hospital (WIH) has embarked on a collaborative care model that brings together physicians, Care Managers, Community Health Workers (CHWs), doulas, and community-based organizations. This participatory approach prioritizes care coordination and addresses the critical social determinants of health (SDoH) that impact maternal and child well-being. Beginning in February 2025, the WIH-led team will implement the COMSS model across six obstetric and gynecological sites,

including Care New England Medical Group in Warwick, Providence Community Health Centers, the Obstetrics and Gynecology Care Center (OGCC), Women's Care, and Brown University Health Women's Medicine Collaborative. This implementation will encompass care coordination, doula services, and referrals to community-based organizations that address critical SDoH such as food security, housing stability, and transportation. To facilitate these connections, the project will utilize a dedicated platform designed to streamline referrals for resources that address social needs.

RI Spheres Program: Regional Remote BP Monitoring

The RI Spheres program will offer a regional remote blood pressure (BP) monitoring service for patients with elevated blood pressure or a diagnosis of hypertension who receive care at hospitals outside of Women & Infants Hospital (WIH), including Landmark, Newport, and Kent hospitals. This collaborative initiative will expand reach beyond the WIH system, enabling the capture of a broader population of hypertensive patients, many of whom may also face significant social determinants of health (SDoH) challenges. By working collaboratively across these institutions, the program will provide more comprehensive and equitable care that addresses the full spectrum of patient needs. This innovative program has received funding from the National Institute of Child Health and Human Development.

Equity in Childbirth and Health Outcomes (ECHO)

In Rhode Island, severe maternal morbidity (SMM) impacts a significant number of birthing individuals, affecting approximately 1 in 36. Disparities in SMM rates are evident, with Black and Latinx patients experiencing significantly higher rates compared to White patients. Specifically, Black patients face a 48% increase in SMM rates, while Latinx patients experience a 32% increase. Recognizing that untreated peripartum hypertension and the "care cliff" following childbirth significantly contribute to these disparities, particularly for individuals facing unmet social needs such as transportation and childcare, Women & Infants Hospital (WIH) has developed the Equity in Childbirth and Health Outcomes (ECHO) project.

This project emphasizes empowering birthing individuals by shifting the narrative from viewing them as passive recipients of care to active participants in addressing the Black maternal mortality crisis. To achieve this, the ECHO project will implement several key strategies:

- Expand remote postpartum blood pressure monitoring and enhance care coordination to ensure timely intervention.
- Collaborate with the Irth App to foster a more equitable and patient-centered healthcare system by increasing patient and community engagement.
- Develop a mobile postpartum support program to bridge critical gaps in care and address the social determinants of health.

This initiative has been made possible through the generous support of the CVS Health Foundation.

Kent Hospital

Overview

Over the past year, Kent Hospital has expanded its health equity capacity and initiatives. Starting with the expansion of inpatient screening for health-related social needs (HRSNs), the hospital is now gathering data about patient needs beyond healthcare. 2024 marked the second year of data gathering on Primary C-Section Rates stratified by race and ethnicity. Analysis of these data, couple with process changes in partnership with the Premier Perinatal Collaborative

Primary Cesarean Section Rate by Race/Ethnicity

Nationally, disparities in birth outcomes based on race and ethnicity are well-documented. To address this, Kent Hospital partnered with the Premier Perinatal Improvement Collaborative to identify and implement strategies to improve birth outcomes for all patients. A critical first step was to understand the extent of these disparities within our own patient population.

Prior to 2024, Kent Hospital lacked comprehensive data on racial and ethnic disparities across several key areas. Recognizing this gap, the Health Equity Team initiated an analysis of the Primary Cesarean Section Rate (PC-02), a significant quality metric. PC-02, as defined by The Joint Commission, represents the rate of Cesarean sections for first-time mothers with a single, full-term baby in a head-down position. Given that Kent Hospital delivers approximately 500 babies annually, accounting for about 5% of all births in Rhode Island, understanding our PC-02 and any associated disparities is crucial for ensuring equitable care.

While Cesarean sections are sometimes medically necessary and may even be requested by a birthing person, elevated rates of primary cesarean sections (PC-02) are generally associated with increased risks. C-sections carry inherent risks for both the birthing patient and baby, including increased risk of infection, bleeding, and potential complications in future pregnancies.

High primary cesarean section rates may indicate that cesarean sections are being performed when vaginal birth might have been a safer option for the patient. While The Joint Commission (TJC) does not

set a target to avoid encouraging inappropriately low cesarean rates that may be unsafe to patients, rates under 30% are considered acceptable. The Leapfrog Group considers a rate of 24% a target for safe practice. Kent Hospital used both rates in the setting of the FY2024 target and threshold for performance.

Equity measure: Low-Risk Pregnancy C Section Rate by Race and Ethnicity
(First pregnancy, at term, one baby, head down position)

Measures	DD	Measurement Unit	Baseline (FY23)	Threshold	Target	FY24Q1 Oct-Dec	FY24Q2 Jan-Mar	FY24Q3 Apr-Jun	Jul, Aug	FYTD
PC-02: Primary C-Section rate		N: Patients with cesarean births D: Nulliparous patients delivered of a live term singleton newborn in vertex presentation	27% (47/177)	30%	24%	**27%** 13/49	**22%** 10/45	**37%** 15/41	**23%** 5/22	**27%** 43/157
Race Black			42% (5/12)			0% 0/2	67% 2/3	25% 1/4	0% 0/1	**30%** 3/10
White			24% (33/140)			33% 11/33	18% 6/33	38% 11/29	14% 2/14	**28%** 30/109
Asian			14% (1/7)			0% 0/1	100% 1/1	0% 0/3	NA	**20%** 1/5
Other								50% 1/2	33% 2/6	
Unavailable								67% 2/3	100% 1/1	
Ethnicity Hispanic			30% (8/27)			15% 2/13	14% 1/7	33% 3/9	28% 2/7	**22%** 8/36
Non-Hispanic			25% (36/142)			31% 11/35	25% 9/36	38% 12/32	20% 3/15	**30%** 35/118

Observations and Outcomes:

The Women's Care department worked throughout the fiscal year with the Premier Perinatal Improvement Collaborative, and successfully deployed all the best practices suggested for the Cesarean Section and Health Equity domains. Every case meeting the population definition for the Primary Cesarean Section Rate numerator was reviewed by the Kent medical director of women's care, as well as by the Women & Infants' Hospital provider liaison. These case reviews determined the clinical appropriateness of the decision to deliver by cesarean section.

National Healthcare Safety Network
2yr CSEC Rate by R/E
As of Decemeber 2, 2024 at 7:58 PM

	Black	White
Numerator (Number of Events)	9	64
Denominator (Number of Trials)	26	261
Number of Non-Events (Trials- Events)	17	197
Proportion (Events/ Trials x 100)	34.6%	24.5
Proportion p-valve	0.2742	

Kent Hospital successfully maintained a low Primary Cesarean Section Rate overall rate from the baseline; however, these decreases were not consistent across all racial and ethnic classifications. The largest gap observed was between Black and White patients as document in the table below, however, differences in outcomes across race were not statistically significant. This measure will continue to be monitored.

Emergency Patients Leaving Without Being Seen

"Left Without Being Seen" (LWBS) refers to a situation where a patient who presents to the Emergency Department (ED) for medical attention departs before being evaluated by a physician or other qualified healthcare provider. Hospitals aim to decrease this number to zero as the goal is to assess and care for all patients. Paying attention to this was particularly important in 2024 as Kent Hospital committed to "No ED Diversion" in June 2024. The state of Rhode Island followed with a no diversion policy in July 2024. This adjustment correlates to an increase in volume and LWBS rate during that timeframe.

Equity measure: Left Without Being Seen by Race, Ethnicity, & Language

Measures	DD	Measurement Unit	Baseline (FY23)	Threshold	Target	FY24Q1 Oct-Dec	FY24Q2 Jan-Mar	FY24Q3 Apr-Jun	FY24Q4 Jul-Sept	FY2024
ED Left Without Being Seen (OP-22)	↓	N: Count of patients who left the ED without being seen D: Count of patients registered in ED	**5.8%** (N=55,686)	3%	2%	**5.5%** (764/13,921)	2.8% (391/13,895)	**3.4%** (502/14,808)	**4.7%** (706/15,054)	**4.1%** (2,363/57,678)
Black			6.2% (N=2,286)			7.7% (44/548)	2.9% (16/549)	2.6% (16/606)	5.1% (30/593)	**4.6%** (106/2296)
White			5.3% (N=48,718)			4.7% (580/12,130)	2.5% (308/12,169)	3.1% (395/12,922)	4.3% (563/13,163)	**3.7%** (1846/50384)
Asian			5.3% (N=495)			2.2% (3/133)	3.2% (4/126)	0.6% (1/149)	1.5% (2/132)	**1.9%** (10/540)
Hispanic			6.0% (N=1828)			6.6% (33/498)	4.4% (22/499)	3.1% (16/524)	4.3% (25/577)	**4.6%** (96/2098)
Non-Hispanic			5.4% (N=49,897)			4.9% (621/12,399)	2.6% (316/12378)	3.0% (396/13,054)	4.4% (574/13,127)	**3.7%** (1,907/50,958)
English-speaking			5.7% (N=54,155)			5.2% (712/13,497)	2.7% (367/13447)	3.2% (460/14,289)	4.5% (658/14,576)	**3.9%** (2,197/55,809)
Limited English Proficiency			3.7%			2.7% (10/352)	1.5% (6/369)	1.6% (7/442)	3.0% (12/401)	**2.2%** (35/1,591)

Kent Hospital realized a 20% reduction in "left without being seen" overall in FY24 over the FY23 baseline, improving from 5.8% to 4.1%. Throughput initiatives in the Emergency Department as well as on the inpatient units to improve efficiencies supported this achievement, such as:

- Provider in Triage model
- Physical Therapy coverage improvements in the ED
- Surge planning mechanisms to decompress the ED and move boarding patients out of the ED to inpatient rooms by targeting resources to discharge patients from the floor efficiently.
- Daily cadence of discharge-focused interdisciplinary rounds
- Bi-weekly institution of complex-care rounds to address long length of stay patients.

FY2024 analysis shows that Black patients leave the Kent ED without being seen at statistically higher rates than White patients; Hispanic patients leave the Kent ED at higher rates than non-Hispanic patients, approaching statistical significance.

LWBS by Race and Ethnicity

As of Decemeber 2, 2024 at 7:19 PM

	Black	White
Numerator (Number of Events)	106	1846
Denominator (Number of Trials)	2296	50384
Number of Non-Events (Trials- Events)	2190	48538
Proportion (Events/ Trials x 100)	4.6%	3.7%
Proportion p-valve	0.0217	

Action Plan FY2025:

While FY2024 saw an overall improvement, the disparities persisted. The analysis this fiscal year will include a significance factor to each category to determine if there is a statistically significant trend. Simultaneously, the ED and hospital leadership are actively working on improvements in the ED waiting areas to enhance overall comfort and incorporate signs, posters, images, which are welcoming and inclusive.

LWBS by Ethnicity FY24
As of Decemeber 2, 2024 at 7:30 PM

	Hispanic	Non-Hispanic
Numerator (Number of Events)	96	1907
Denominator (Number of Trials)	2098	50958
Number of Non-Events (Trials- Events)	2002	49051
Proportion (Events/ Trials x 100)	4.6%	3.7%
Proportion p-valve	0.0552	

Data Analysis of Cancer Screening and Health Related Social Needs:

In FY2025, the Kent Hospital Health Equity Team will analyze data for two potential areas of intervention:

1. Lung Cancer Screening Rates: The rates of lung cancer screening in outpatient settings will be analyzed, stratifying the data by race, ethnicity, language, and insurance type to identify any disparities.
2. Prevalence of Health-Related Social Needs: The prevalence of health-related social needs among the patient population will be investigated, stratifying the data by race, ethnicity, language, and insurance type to identify any disparities.

The Providence Center

Overview

The Providence Center, located in Providence, Rhode Island, is a leading provider of mental health and substance use treatment services. Since its establishment in 1969, it has been dedicated to offering comprehensive care to housed and unhoused adults, adolescents, and children affected by psychiatric illnesses, emotional problems, and addictions.

The Center provides a wide range of services, including outpatient care, crisis stabilization, and community-based support. The Center also offers wraparound services such as food and housing assistance, job training, legal services, primary health care, and wellness activities. The Providence Center is committed to a recovery-oriented approach, helping individuals achieve their goals and improve their overall well-being.

In December 2014, The Providence Center became an affiliate of the Care New England Health System, further expanding its reach and resources. In October 2024, The Providence Center became a Certified Community Behavioral Healthcare Clinic (CCBHC) designed to serve anyone who walks through the doors, regardless of age, diagnosis, or insurance status with a goal to improve community health outcomes, reduce health disparities, and support providers in delivering higher quality, more sustainable services. These services are supported by the Centers for Medicare and Medicaid Services (CMS) and the Substance Abuse and Mental Health Services Administration (SAMHSA).

Client Population

In FY2024, The Providence Center served 8,752 individual clients. The following data provide additional context to the client population:

Diagnoses:

- 50% presented with a mental health diagnosis only.
- 33% had a co-occurring diagnosis of mental health and substance use.

- 1% presented with a substance use diagnosis only.
- 13% had no diagnosis recorded in the State's Behavioral Health On-Line Database (BHOLD) system.

Demographics:

- 41% identified as female, 39% as male, and 19% had an unknown gender.
- 43% were aged 41-65, 32% were aged 18-40, 14% were aged 6-17, 9% were aged 66-85, and 2% were aged 0-5. Sixteen clients (0.2%) were over the age of 86.
- 49% of clients identified as White, 21% as Hispanic/Latino, 19% as Black/African American, and 1% identified as Native American or Alaskan.
- 56% were non-Hispanic/Latino, 36% were Hispanic/Latino, and 8% had unknown ethnicity.
- 81% of clients preferred English, 17% preferred Spanish, and 1% preferred Cambodian.

Socioeconomic Factors:

- 57% of clients resided in Providence, 13% in Pawtucket, and 5% in Cranston.
- 35% of clients identified as disabled, 19% were unemployed, and 14% were students.
- 2% of clients were incarcerated.

Connecting Black Male Patients with a Primary Care Provider

In 2024, a disparity was identified within the TPC community: 37% of Black male clients (528 individuals) did not have a primary care provider (PCP). Recognizing the critical need to connect these individuals with healthcare services, an action plan was developed with several key steps.

First, the primary goal was to align Black male clients with a PCP. This process began with educating staff about the initiative's importance and ensuring staff could convey this information effectively to the clients. Educating clients on the importance of having a PCP was crucial in encouraging them to take steps towards securing one.

To facilitate this connection, the team sought out lists of PCPs accepting new patients from organizations such as the Care New England Medical Group and the Providence Community Health Center. Staff were provided with the contact information of these PCPs and assisted clients in making appointments.

Additionally, staff received updated lists of Black male clients who did not yet have a PCP, making it easier to identify and assist those in need. Metrics were tracked diligently, comparing the percentage of Black male TPC clients with a PCP to all TPC clients with a PCP. The rate of Black clients obtaining a PCP was monitored monthly.

Observations and Outcomes

Despite the availability of PCPs accepting new patients, a common challenge was that the first available appointments were often scheduled months in advance. Clients were not considered patients until they attended their first appointment, adding a delay to their healthcare access. Moreover, clients were generally reluctant to travel outside of Providence to see a PCP, presenting an additional barrier to care.

Staff performance improved significantly when they were provided with a list of clients needing a PCP, as opposed to having to check the care team independently. This streamlined approach allowed for more efficient alignment of clients with PCPs. With this initiative in place, the percentage of clients with a PCP increased from 62.7% to 75.4%. This percentage of clients with a PCP now aligns with comparative data overall for all clients at TPC, where the overall percentage of clients with a PCP is 74.5%.

Plans for 2025

Looking ahead to 2025, the initiative will continue with several ongoing efforts:

- Aligning Black male clients with a PCP: The primary goal remains to ensure every client has access to primary care.
- Updating staff with lists of clients needing a PCP: Continuously providing staff with current information will help maintain momentum.
- Seeking PCPs accepting new patients: Keeping an updated list of available PCPs is crucial for timely appointments.
- Staff education: Staff will be reminded that they can free-text a clinic name in the PCP field of the Care Team for flexibility and accuracy.

In addition to existing work to close primary care gaps, efforts will also seek to improve the collection rate of screening for health-related social needs to examine those data for potential inequities.

By continuing these efforts, TPC aims to improve healthcare access and outcomes for Black male clients, addressing disparities and promoting health equity in the community.

VNA of Care New England

Overview

In 2025, The VNA of Care New England enters its third year of focused health equity work. Each year, a specific area for investigation and action is selected. In 2023, the priority was improving data collection and analysis to better identify and address potential racial and ethnic disparities in the patient population. In 2024, the focus shifted to increasing diversity within the hospice program. Data analysis revealed a significant underrepresentation of racial and ethnic minorities among hospice patients. In 2025, recognizing the growing concern of food insecurity within the state, the prevalence of food insecurity among the adult day care population through Blackstone Health, Inc. will be investigated.

Home Health Data Improvement

In 2023, the VNA Health Equity Team prioritized improving the collection of race and ethnicity data. This enhancement was crucial for conducting analyses to better identify and address disparities in access to and quality of care.

Challenges were encountered in utilizing the Electronic Medical Record (EMR) to effectively capture this data. To overcome these challenges, processes were developed to enable clinicians to accurately document race and ethnicity information. Daily admission statistic reports were utilized for immediate follow-up and coaching by managers.

By the end of 2024, 100% compliance with race and ethnicity data collection was achieved by staff. To ensure long-term sustainability, the daily monitoring of admissions for missing data has transitioned to a weekly schedule. Work is currently underway with the Strategic Healthcare Programs vendor to explore cost-effective methods for generating these reports, aiming to minimize the need for extensive manual monitoring. This goal will continue to be monitored throughout 2025 to ensure consistent data collection and reporting.

Hospice Patient Diversification

In 2024, an analysis of current data revealed that most of the VNA's hospice patients were White, with a significant underrepresentation of patients from certain underserved communities. The Health Equity Team set a goal to increase the racial and ethnic diversity of the hospice patient population.

As a part of the action plan, the focus was on building strong relationships within these communities. This included increased community engagement through participation in various community events. Patient admission patterns by zip code were also analyzed, identifying five underserved communities in Providence (02904, 02907, and 02909), Pawtucket (02860), and Central Falls (02863), for targeted outreach and education efforts. Two physician offices were selected for initial outreach: Care New England Medical Group (CNEMG) Family Care Center (FCC) in Pawtucket and CNEMG Providence Primary Care. Two educational sessions were conducted at the FCC and one at the Providence practice. These efforts aim to improve the inclusivity and equity of hospice services, ensuring that all members of the community have access to quality end-of-life care.

Engagement within the communities the VNA seeks to serve is crucial to advancing the goal of increasing racial and ethnic diversity among hospice patients from underserved areas. In 2024, teams actively participated in several community events in the greater Providence area, including:

- American Cancer Society's Cancer Awareness Day at the RI State House
- Black Family Wellness Expo at the Community College of Rhode Island (CCRI)
- Providence Juneteenth Festival
- Alzheimer Association Walk to End Alzheimer's

These events provided valuable opportunities to connect with community members and raise awareness about hospice services. Opportunities for collaboration with organizations and agencies serving these communities will continue to be sought.

Plans for 2025

Home Health Data (Year 3). Data will continue to be collected, analyzed, and reported by race and ethnicity. These data will help to identify further potential disparities in access and care.

Hospice Patient Diversification (Year 2). To increase the number of patients from underserved communities receiving hospice care, the health equity team will implement several strategies. These include:

- Internal Education: Staff will be educated on cultural and religious nuances in hospice care.
- Community Partnerships: Partnerships with clinical partners and community-based organizations will be maintained and strengthened.
- Culturally Relevant Education: As knowledge of culturally diverse needs increases, culturally relevant education on hospice care will be provided to senior centers in underserved communities.

This multifaceted approach will focus on:

- Respecting Cultural Beliefs: It will be ensured that all aspects of care, including end-of-life decisions and symptom management, are delivered with respect for diverse cultural beliefs and practices.
- Building Trust: Efforts will strive to enhance communication and build trust between healthcare providers and patients/families from diverse backgrounds.

- Addressing Cultural Differences in Care: Cultural variations in symptom management preferences will be acknowledged and addressed, ensuring that pain relief and other interventions are aligned with individual and family needs.

By implementing these strategies, the VNA aims to improve access to and the quality of hospice care for all members of the community.

Food Insecurity (Year One). The VNA operates sixteen (16) meal sites serving over 120,000 meals per year to elderly community members through Blackstone Health. In 2025, the prevalence of food insecurities for community members attending Blackstone Health meal sites will be investigated. Kathleen Fisher, Director of Blackstone, Health Inc., will join the VNA Health Equity Team to lead this effort.

Integra Community Care Network

Equitable Population Health

Insurers measure the performance of Accountable Care Organizations (ACOs), like Integra, using quality measures for their populations. Insurers typically set lower quality goals for ACOs for their Medicaid patients than they do for their commercially insured patients. Patients insured with Medicaid are less likely than those who are commercially insured to meet population health milestones, such as the proportion of patients who are successfully managing their blood pressure or who are screened for breast cancer.

Integra, with its mission to deliver equitable population health, has set itself a higher bar. In 2023, the health equity goal was to meet or exceed the 4-star Commercial standard for Medicaid measures in at least 4 of the quality measures. In 2023, this goal was achieved, with 4 out of 6 quality measures in the Medicaid population reaching the Commercial 4-Star status. In 2024, Commercial 4-star targets increased, but Integra maintained the goal of achieving these quality measures for the Medicaid population. Specifically, these measures include rates of breast cancer screening, colon cancer screening, diabetes A1c management, diabetes eye exam, and hypertension blood pressure control.

Action Plan

Strategies to meet the health equity goal included partnering with HealthHelper, a tech-enabled outreach platform for patients who have gaps in care. HealthHelper went live in December 2023, and 2024 was the first full year of implementation. To date, HealthHelper has helped close a substantial portion of screening gaps, scheduling over 1,200 appointments for the Medicaid population, and providing reports broken down by payer that provide a baseline for identifying disparities in 2025.

In the 13 CNEMG primary care office locations, Integra's patient navigators and nurse navigators assisted patients by addressing barriers to care related to transportation, scheduling, and language access to close screening and care gaps.

Two CNEMG practices in Pawtucket with a high volume of Medicaid, uninsured, and underinsured patients and lower screening rates for diabetic eye exams were identified. These two practices were selected for point-of-care testing for diabetic eye exams, which went live in September 2024.

Community Engagement

Integra engages with the communities served in many ways, including a team of dedicated community health workers (CHWs) and an active Community Advisory Council. The Integra Social Partnerships Initiative for Community Engagement & Equity (I-SPICEE) engaged three community organizations in funded partnerships in 2024. The Green & Healthy Homes Initiative (GHHI) improves home environmental conditions that contribute to asthma and engages community members to advise on their approach. The Pawtucket/Central Falls Health Equity Zone, through the backbone organizations LISC and Progresso Latino, provides a Food Ambassador to help community members access nutritious, culturally appropriate food. The Refugee Dream Center worked with its clients and staff to conduct an extensive assessment of the healthcare needs of refugee communities and provided recommendations for equitable improvements to care.

Staff Training

Integra worked with community partners to deliver staff training related to health equity matters of concern in 2024. Expert trainers from The House of Hope CDC provided training in harm reduction and motivational interviewing to the care team, increasing the capacity to serve vulnerable populations. The founder and executive director of the Refugee Dream Center, Dr. Omar Bah, provided training to Integra staff and the broader Care New England community in cultural attunement and trauma-informed care.

Metrics

Integra tracks clinical quality measures using definitions established by standardized systems such as the Healthcare Effectiveness Data and Information Set (HEDIS) and specified by health insurers. Clinical quality measures were tracked in breast cancer screening, colon cancer screening, diabetes A1c management, diabetes eye exam, and hypertension blood pressure control. In 2024, Integra was able to compare the quality metric outcomes by payer. The 2023 target of having three (3) out of four (4) Medicaid population quality metrics meet the same standard as the commercial population was reached. Using the data from 2024, further disparities will be visible, allowing for the development of a plan to address these disparities.

Observations and Outcomes

HealthHelper's text messaging technology showed significant improvement in communication with patients with gaps in care and scheduled over 1,200 screening appointments for patients with Medicaid to close screening gaps. With a complete year of data from HealthHelper available, deeper analyses of disparities and progress towards closing them can now be conducted, improving the ability to drive population health equity in 2025 and beyond.

Integra will have a complete picture of its success at closing 2024 quality gaps for the Medicaid population in mid-2025, when insurance companies finalize their data. From preliminary gap-in-care reports, improvements are visible, leading to confidence that targets will be met or exceeded.

Plan for 2025

Care New England Medical Group (CNEMG) is committed to ensuring equitable access to cancer screenings for all patients. Currently, Medicaid beneficiaries experience a 17% lower screening rate for both mammography and colorectal cancer screening compared to commercially insured patients.

To address this disparity, Integra and CNEMG aim to reduce this gap by 50% in 2025 and achieve parity in screening rates by the end of 2026. This initiative will ensure that all eligible patients, regardless of insurance type, receive timely breast and colorectal cancer screenings.

A structured Plan-Do-Study-Act cycle will be utilized to guide these efforts:

- January-June 2025: Plan: Conduct a comprehensive analysis of the disparity, including data stratification, root cause analysis, and a review of best practices. Develop an action plan with measurable targets and establish data monitoring systems.
- July-December 2025: Do: Implement the action plan, focusing on interventions designed to increase screening rates among Medicaid beneficiaries.
- October-December 2025: Study: Evaluate the effectiveness of implemented interventions, analyze data trends, and identify areas for improvement.
- January-June 2026: Act: Refine the action plan based on learnings from the "Study" phase and continue implementation to eliminate the disparity in screening rates.

By employing this systematic approach, Integra is dedicated to achieving health equity and ensuring that all patients receive the preventive care necessary to promote early detection and improved health outcomes.

Care New England Medical Group

Closing Gaps in Diabetic Retinopathy Screening

Diabetic retinopathy is a serious eye condition that can cause vision loss in people with diabetes. The American Diabetes Association (ADA) recommends regular screening every 1-2 years for all diabetic patients to facilitate early detection and treatment. Unfortunately, screening rates for diabetic retinopathy are often suboptimal, and disparities exist among patient populations.

Analysis of CNEMG data reveals the following:

- **Overall low screening rates:** Only 23% of eligible diabetic patients underwent screening in 2023.
- **Racial disparities:** White patients have the highest screening rates, while Black patients are screened at statistically lower rates. Concerningly, race information is not recorded for approximately 10% of patients, highlighting a gap in data collection.
- **Ethnic and language disparities:** Hispanic patients and non-English speakers undergo screening at statistically lower rates than their counterparts.

These disparities underscore the need for targeted interventions to improve health equity and ensure that all diabetic patients have equal access to this essential preventive screening.

To address these disparities, CNEMG partnered with Verily to implement an innovative approach to retinal imaging. This technology involves a camera placed in the primary care office that, with the assistance of a trained Medical Assistant (MA), automatically captures retinal images. These images are then sent off-site for review by an eye care professional, and the results are relayed to the patient's primary care physician via the electronic medical record.

Interventions Implemented in 2024

In 2024, The Care New England Medical Group (CNEMG) prioritized health equity by focusing on closing the gap in diabetic retinopathy screening rates, particularly among Black and Hispanic patients.

CNEMG implemented a multi-faceted approach:

- **Education and Training:** Enhanced education for clinical teams on the importance of diabetic retinopathy screening and culturally sensitive communication strategies.
- **Patient Navigation:** Expanded the patient navigation team to provide personalized support and guidance to patients facing barriers to care.
- **Partnership:** Partnered with Health Helper to conduct patient outreach and education related to preventive health measures, including diabetic retinopathy screening.
- **On-Site Retinal Screening:** Implemented on-site retinal eye scanning at the Internal Medicine Care Center (IMC) and Family Care Center (FCC) in Pawtucket, locations serving a high volume of patients who may experience higher rates of unmet health-related social needs.

Outcomes and Observations

These interventions led to significant improvements in screening rates:

- **IMC:** Increased from 26% in 2023 to 40% in 2024.
- **FCC:** Increased from 7% in 2023 to 41% in 2024.
- **CNEMG Overall:** Increased from 23% in 2023 to 53% in 2024.

Plans for 2025

CNEMG will continue its focus on health equity and improving access to preventive care in 2025 by:

- **Expanding On-Site Screening:** Implementing retinal scanners in additional primary care offices.
- **Targeted Interventions:** Partnering with Integra Community Care Network to broaden the focus on screening disparities to include additional chronic conditions.

DEI summit 2024

ACCESS IN ACTION

DIVERSITY, EQUITY & INCLUSION at Care New England

DEI Summit 2024: Access in Action

In October 2024, Care New England hosted its annual DEI Summit, centered on the theme "Access in Action." This impactful conference, held at Women & Infants Hospital, brought together approximately 90 attendees and featured over 20 distinguished presenters, fostering a dynamic environment for learning and collaboration. The day was strategically designed to advance a collective understanding of health equity and strengthen engagement with key community partners.

Dr. Larry Warner (Opening Keynote Speaker)

The summit commenced with opening remarks from Care New England's CEO, Dr. Mike Wagner, Chief Health Equity Officer, Dr. Joe Diaz, and VP & Chief Diversity Officer, Dr. Kevin Martins, setting the stage for a day focused on tangible actions to improve access. The keynote address was delivered by Dr. Larry Warner, Chief Impact and Equity Officer at the United Way of Rhode Island, who provided insightful perspectives on leveraging access as a fundamental lever for achieving health equity. This address seamlessly transitioned into an opening panel discussion, moderated by Jai-Me Potter-Rutledge (Brown University School of Public Health) and featuring Dr. Diaz and Michelle Wilson (Rhode Island Department of Health), further exploring strategies to enhance access for equitable outcomes.

Attendees then participated in two sets of concurrent sessions, allowing for deeper dives into specific areas of focus. The morning sessions explored critical Social Drivers of Health, including economic disparities, housing, transportation, healthcare, and food and nutrition, with expertise shared by Nwando Ofokansi (RIDOH), Dr. Omar Bah (Refugee Dream Center), Peter Asen (Housing and Urban Development), and Channavy Chhay (Center for Southeast Asians), moderated by Brady Dunklee (Integra). The second morning session addressed the vital issue of Access to Safety, focusing on violence reduction and support for survivors and communities, featuring insights from Angela Kemp (RIDOH), Kelly Henry (Sojourner House), Naomi Tejada (Nonviolence Institute), and Commander Tim O'Hara (Providence Police), moderated by Dr. Kevin K. Martins.

The lunch break provided an opportunity for networking and featured engaging "Health Equity Innovation Presentations" from several Care New England teams, showcasing their internal projects aimed at advancing health equity.

The afternoon concurrent sessions continued the theme of actionable solutions. One session focused on Access to Behavioral and Mental Health Services, with expertise shared by Kinzel Thomas (Family Service RI), Akos Antwi (Revive Therapeutics), Courtney Johnson Threats (Butler Hospital), and Raymond Lambert (Whitmarsh House), moderated by Erin Ursillo (Butler Hospital). The other afternoon session highlighted The Role of Community Engagement in Advancing Healthcare Access, featuring Dr. Eugenio Fernandez (Asthenis), Dr. Silas Pinto (Providence Office of Equity), and Charles "Chachi" Carvalho (City of Pawtucket), moderated by Georgia Simpson (Health and Human Services).

The summit culminated in a powerful closing keynote address by Dr. Rahul Vanjani, an Internal Medicine Physician and founder/CEO of Docs for Health and Medical Director at Amos House. Dr. Vanjani delved into the critical Social Drivers of Health, emphasizing the importance of a more direct approach to addressing patient needs. He highlighted the limitations of current screening practices that primarily refer patients to resources, often simply providing a phone number. Looking ahead, he announced that a "screen and intervene" method will be piloted at Women & Infants Hospital in the spring of 2025, signaling a shift towards more proactive interventions.

Dr. Rahul Vanjani (closing Keynote Speaker)

The 2024 DEI Summit: Access in Action served as a vital platform for education, dialogue, and the forging of stronger connections between healthcare professionals and community partners. The diverse range of presentations and discussions provided attendees with valuable insights and a shared commitment to implementing effective strategies for advancing health equity within Care New England and the broader Rhode Island community.

Advancing Excellence in Equitable Care Awards

To cultivate a culture of success in advancing health equity, it is essential to establish clear expectations, foster trust, ensure accountability, and recognize achievements. In 2024, a key step in celebrating progress was the introduction of an inaugural award honoring one leader and one team for their exceptional contributions to equitable care. These awards were presented at a reception immediately following the DEI Summit. The distinguished recipients were Stephanie Czech, Director of Behavioral Health for Kent Hospital and CNEMG, and the Academic Midwifery Department at Women & Infants Hospital.

Kevin Martins and Stephanie Czech

Stephanie Czech, Ph.D.
Stephanie Czech, Director of Behavioral Health for Kent Hospital and CNEMG, is celebrated with the *Advancing Excellence in Equitable Care*, Leader Award for her impactful leadership in expanding access to vital behavioral health services for underserved populations.

Her key contributions include significantly increasing Integrated Behavioral Health (IBH) access within primary care settings, facilitating immediate warm hand-offs, and reducing the stigma associated with seeking mental healthcare. Recognizing the diverse community, Stephanie prioritized hiring Spanish-

speaking Community Health Workers (CHWs) to effectively connect with the substantial Spanish-speaking population and bridge gaps in accessing community resources.

Under her direction, access to pediatric behavioral health services has been enhanced, improving the identification of Attention-Deficit/Hyperactivity Disorder (ADHD) and Autism Spectrum Disorder (ASD) and linking children and families to crucial community support systems. Stephanie strategically grew the IBH practice, extending its reach to the Central Falls, Pawtucket, and Providence Medicaid population.

Since 2023, Stephanie's efforts have resulted in a substantial increase in weekly behavioral health appointments and the implementation of culturally relevant screeners in Portuguese and Spanish. She successfully secured funding to expand pediatric services and dedicate a CHW to this population. Furthermore, she recruited a Portuguese-speaking Psychologist and fostered a collaborative model integrating CHWs with IBH clinicians, leading to improved patient engagement and reduced wait times for essential assessments.

Stephanie Czech's visionary leadership and unwavering commitment to dismantling barriers to behavioral health care have demonstrably improved equitable access for vulnerable populations, making her a highly deserving recipient of this prestigious award.

Academic Midwifery Department, Women & Infants Hospital

Joe Diaz and Elizabeth Kettyle (Accepting on behalf of Academic Midwifery Department).

The Academic Midwifery Department at Women & Infants Hospital is recognized with the *Advancing Excellence in Equitable Care*, Team Award for their comprehensive commitment to health equity. Their multifaceted work spans research, implementation, advocacy, policy influence, and community engagement, all fostering a more equitable healthcare landscape.

Their dedication to health equity research is evident in studies on respectful maternity care (Knutson) and culturally appropriate transition to parenthood (Howard), alongside initiatives in trauma-informed communication, breastfeeding equity, and implicit bias training.

The department actively reduces health disparities. Howard secured funding for an Alongside Midwifery Unit, improving outcomes. Midwives engage in public health messaging and DEI committees. Barber De Brito is a voice on racial disparities in maternal health, with team participation in Black Maternal Health Week. Kleinman developed a national video series on respectful care, and the team contributes to state breastfeeding and perinatal quality improvement initiatives.

Their commitment extends to addressing social determinants of health through mentorship and advocating for underserved groups via conference participation and fellowships like the Centering Reproductive Justice project. Voytas' Safe Zone certification highlights their LGBTQ+ commitment.

The department influences policies for increased access, with Howard spearheading the WIH Doula Policy and securing funding for Community Health Workers and a Centering Pregnancy program (led by Barber De Brito with community partners).

They support inclusive practices, including Barber De Brito's trauma-informed pelvic care curriculum and Kettyle's role in medical school inclusion initiatives. The team conducts trauma-informed interprofessional simulations.

Community engagement is a strong emphasis. Providers volunteer at Clinica Esperanza, Barber De Brito promotes a Women's Community Health Fair and collaborates with community action boards, and the midwives developed an ongoing virtual community education series.

Individual contributions further their commitment. Hunter champions diversity in medical publishing. The midwives collectively published on equity and access, coordinate Trauma-Informed Care education for residents, provide extensive mentorship, and actively work to increase workforce diversity, as shown by Barber De Brito's involvement with the National Black Midwives Alliance and the Social Mission Alliance Advocacy Advisory Council.

The Academic Midwifery Department embodies a deep and sustained commitment to advancing health equity through impactful research, advocacy, education, and community engagement, making them a highly deserving recipient of the Advancing Excellence in Equity Award.

Appendix: Social Health Questionnaires

Inpatient Screening Tool

Social Health Questionnaire

"I have a few questions to ask you. You do not have to answer these questions, but they may help us take better care of you"

☐ **Patient incapacitated or otherwise unable to complete the screening and no caregiver able to do so on the patient's behalf**

1. What is your living situation today? Do you have a steady place to live?

- ◉ Reports having a steady place to live
- ○ Reports having a steady place to live today, but is worried about losing it in the future
- ○ Reports not having a steady place to live
- ○ Declined to answer

2. Over the last 6 months, have you worried about having enough money for food?

- ◉ No
- ○ Yes
- ○ Declined to answer

3. Summarize Plan of Care for Housing and Food

- ○ WANTS HELP with housing or food insecurity
- ◉ Does NOT want help with housing or food insecurity
- ○ No food or housing needs identified
- ○ Declined to answer
- ○ Patient unable to answer

When a patient wants help with housing or food, a social work consult will be triggered.

4. Over the last 12 months, have you had trouble paying your oil, gas, water or electricity bills?

- ◉ No
- ○ Yes
- ○ Declined to answer

5. In the past 12 months, has lack of reliable transportation kept you from medical appointments, meetings, work or from getting things needed for daily living?

- ◉ No
- ○ Yes
- ○ Declined to answer

"Information about how to get help with transportation or paying utility bills can be found within discharge instructions."

Additional Social Health Information

integra Social Health Questionnaire

Belong. Be Well.

Name Date of Birth ____/____/____

Where we live, work, learn and play affects our health. **You do not have to answer** these questions, but they help us take care of you by understanding more about you. You can skip any question you prefer not to answer.

1. Over the last 6 months, have you **worried that you may not have a steady place to live**? ☐ Yes ☐ No

2. What is your **living situation today?**

- ☐ I have a **steady place to live**
- ☐ I have a place to live today, but I **am worried about losing it** in the future
- ☐ I **do not have** a steady place to live (I am temporarily staying with others, in a hotel, in a shelter, living on the street, in a car, or abandoned building).

3. Over the last 6 months, have you **worried about having enough money for food**? ☐ Yes ☐ No

4. Over the last 6 months, have you had **trouble paying your heating or electricity bill?** ☐ Yes ☐ No

5. Do you **ever have problems being able to afford** everything you need? ☐ Yes ☐ No

6. Over the last 6 months, have you **needed help from another person or service animal** with any daily activities, such as bathing, dressing, eating, or doing household chores? ☐ Yes ☐ No

7. Do you ever **have problems easily and safely moving around** your home, or the place you live? ☐ Yes ☐ No

8. In the last 6 months, have you had **trouble getting transportation to medical appointments**? ☐ Yes ☐ No

9. In the last 6 months, have you been **afraid of someone close to you**? (Like a spouse, partner, ex, or family member) ☐ Yes ☐ No

10. Do you feel your **physical or emotional safety is at risk because of someone close to you?** ☐ Yes ☐ No

11. How often do you **see or talk to people that you care about and feel close to**? (Talking to friends on the phone or virtually, visiting friends/family, religious services, clubs)

- ☐ Less than once a week
- ☐ 1-2 times per week
- ☐ 3-5 times per week
- ☐ More than 5 times per week

12. Would you like **help** with any of these needs? ☐ Yes, I'd like written information on resources. ☐ Yes a team member can call me to discuss. ☐ No

Integra Social Health Questionnaire Revised 2022-03-03

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