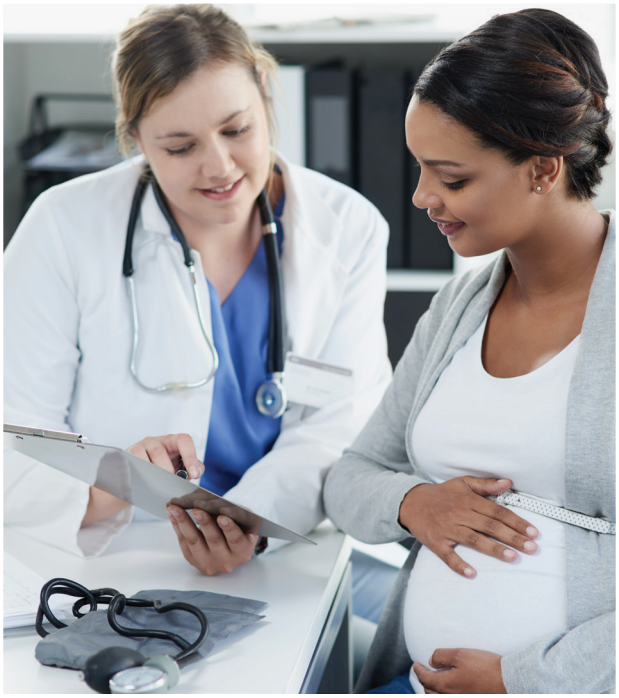


Economic Impact of Disparities in Health Outcomes Resource Guide

American Hospital Association™

Advancing Health in America

Table of Contents

American Hospital Association™
Advancing Health in America

Executive Summary

Disparities in health outcomes across populations impose a growing, substantial economic burden on communities and the hospitals and health systems that serve them. These disparities contribute to avoidable medical spending, reduced workforce participation and productivity, and premature death and disability — ultimately slowing economic growth and hampering prosperity across our communities.

For hospitals and health systems, the financial implications of health disparities can be long-term and significant. Disparities in health outcomes contribute to poorer health, leading to increased emergency department utilization, preventable admissions and readmissions, longer hospital stays and greater care complexity.[1] Unmet medical and nonmedical needs further amplify avoidable costs and utilization of preventable and uncompensated care.

The economic case for action is compelling. According to one estimate from 2022, disparities in health outcomes account for an estimated $320 billion in annual healthcare spending, with projections reaching $1 trillion or more by 2040 if left unaddressed.[2] Addressing the most significant disparities in health outcomes offers an opportunity to reduce costs, minimize strain on community organizations, healthcare organizations and public health, and improve outcomes for all.

This **Resource Guide** is intended to help leaders by offering potential approaches to quantifying and helping address the economic burden of disparities in health outcomes. Equipped with case studies and discussion questions, hospital and health system leaders can use this guide to assess the financial consequences of disparities within their communities, align strategic efforts with organizational and community priorities and identify data-driven strategies that address healthcare affordability, improve outcomes and support long-term financial resilience.

1 https://link.springer.com/article/10.1007/s11606-025-09491-w

2 This estimation model used specific high-cost diseases — breast cancer, diabetes, colorectal cancer, asthma and cardiovascular disease — where the proportion of spending could be attributed to health inequities. https://www.deloitte.com/us/en/insights/industry/health-care/economic-cost-of-health-disparities.html

Introduction

Defining Disparities in Health Outcomes

Disparities are measurable differences in health outcomes across populations, such as a higher burden of illness, injury, disability or mortality experienced by one group relative to another.[3] Health disparities can affect a broad range of chronic conditions, such as hypertension, asthma, diabetes, cancer, heart disease and mental health, among others.

Improving health outcomes for all people requires clearly identifying where gaps and differences in care exist and implementing actionable strategies to close them. When left unaddressed, disparities persist over time and, in many cases, widen.[4] One of the most striking examples is the significant variation in life expectancy across the United States, driven solely by where individuals are born or live. These differences are observed at the neighborhood or ZIP code level.[5] For hospitals and health systems, these enduring disparities in health outcomes represent a growing economic challenge, underscoring the importance of clearly defining and measuring disparities as a foundational step toward improving outcomes and managing financial impact.

Making the Financial Case for Reducing Disparities in Health Outcomes

Persistent disparities in health outcomes are not only a clinical concern; they also represent a significant and growing financial risk for hospitals and health systems, public health agencies, employers and the broader economy. According to 2022 data from the Agency for Healthcare Research and Quality, the costliest 5% of the population accounts for about half of all healthcare spending, and the most expensive 1% of the population is responsible for over 21% of costs.[6]

Understanding the economic consequences of disparities is essential to making the case for investments in data-informed strategies that reduce disparate health outcomes and improve financial performance over time. A 2023 review found that every dollar invested in interventions for populations experiencing health disparities generated an average of $3.20 in reduced healthcare costs, while also improving health outcomes.[7]

The costs of health disparities can be understood across three interconnected areas:

1. **The overall societal burden.**
2. **Excess healthcare expenditures borne by individuals and organizations.**
3. **The downstream impacts on the workforce and economy.**

3 https://www.kff.org/racial-equity-and-health-policy/disparities-in-health-and-health-care-5-key-question-and-answers/
4 Ibid
5 https://time.com/5608268/zip-code-health/
6 https://meps.ahrq.gov/data_files/publications/st560/stat560.shtml
7 https://wjarr.com/sites/default/files/fulltext_pdf/WJARR-2023-2490.pdf

Overview of the Financial Impact of Disparities in Health Outcomes

The financial impact of disparities in health outcomes has substantial macroeconomic consequences. National analyses estimate that disparities in health outcomes are associated with approximately $320 billion in excess healthcare spending each year, with projections indicating this figure could rise to $1 trillion annually by 2040 if disparities remain unaddressed.[8] These costs reflect higher utilization of healthcare services, avoidable complications and preventable disease progression across populations.

Mental health disparities alone contributed an estimated $278 billion in economic burden, consisting of cumulative excess medical, productivity and mortality-related costs between 2016 and 2020, underscoring the scale of impact when differences in care outcomes persist.[9] Additionally, certain conditions highlight the magnitude of avoidable spending for the economy: an estimated $15.6 billion in preventable costs related to diabetes and $2.4 billion related to asthma.[10] These macro-level costs can translate into sustained pressure on the long-term financials for hospitals and health systems.

Costs to Individuals and Associated Excess Medical Care Expenditures

At the patient level, disparities in health outcomes drive higher medical expenditures due to preventable, poorer outcomes. Annual medical expenditures per person include all direct payments for care, such as out-of-pocket spending, as well as payments by private insurance, Medicare, Medicaid and other sources.[11]

Drivers of excess costs include delayed or foregone care, missed or late diagnoses, limited access to preventive services and inadequate chronic condition management. These factors contribute to higher rates of emergency department (ED) use, longer hospital stays, avoidable readmissions, unnecessary or duplicative treatments, and greater reliance on high-intensity and high-cost services.

Additionally, patients who experience the greatest health disparities are also more likely to be uninsured or underinsured, which limits access to care and contributes to worse outcomes.[12] Uninsured and underinsured patients often generate uncompensated or under-reimbursed care, placing significant financial strain on providers. Most hospitals serve a large number of patients covered by Medicare and Medicaid, programs that have historically reimbursed below the cost of care.[13] Combined with tightening margins, this creates growing financial pressure and makes it harder for hospitals to absorb these losses.[14]

8 https://www.deloitte.com/us/en/insights/industry/health-care/economic-cost-of-health-disparities.html
9 https://www.deloitte.com/us/en/insights/industry/health-care/economic-burden-mental-health-inequities.html
10 https://www.deloitte.com/us/en/insights/industry/health-care/economic-cost-of-health-disparities.html
11 https://www.cdc.gov/pcd/issues/2025/25_0153.htm
12 https://www.urban.org/sites/default/files/2024-01/Guide%20to%20Equity%20for%20the%20Uninsured.pdf
13 https://pmc.ncbi.nlm.nih.gov/articles/PMC5769684
14 https://www.healthcarefinancenews.com/news/revenue-and-payer-mix-pressures-continue-weigh-long-term-sustainability

Overall Workforce Impacts of Disparities in Health Outcomes

Disparities in health outcomes generate significant economic losses through their impact on the workforce, affecting both employers and regional economies. Poor health outcomes can lead to prolonged illness, disability or premature death, reducing labor force participation and productivity.

Disparities in care are associated with an estimated $42 billion in lost productivity annually, driven by absenteeism, reduced performance at work (presenteeism) and unemployment.[15] Research has further shown that mental health and co-occurring physical health disparities alone cost employers billions each year due to missed work, reduced productivity and premature exit from the workforce.[16]

As employers, hospitals and health systems may also experience impacts on the workforce. These factors include higher turnover, increased caregiving burdens for employees and constrained talent pipelines. Reducing disparities in health outcomes has the potential to prevent millions of individuals from leaving the workforce prematurely due to disability or early death.[17]

Premature deaths associated with suicide, substance use disorders and untreated mental health conditions further amplify economic losses, reinforcing the need for data-driven interventions to reduce disparities in health outcomes.[18]

DISPARITY REDUCTION SPOTLIGHT

Alzheimer's Disease and Related Dementias

Alzheimer's disease and related dementias (ADRD) are among the costliest conditions in the United States and illustrate the economic impact of health disparities over time. Certain populations of older adults experience disproportionately higher rates of ADRD and often face barriers to early diagnosis, treatment and supportive services.[19] These disparities result in higher medical costs, increased emergency and inpatient utilization, and greater reliance on long-term care.

Beyond direct medical spending, ADRD imposes substantial indirect economic costs through unpaid caregiving, lost wages, reduced workforce participation and diminished tax revenue. Caregivers, often family members, experience lost income and productivity, further amplifying the economic burden. More than 11 million family members and other unpaid caregivers provided an estimated 18.4 billion hours of care to people with Alzheimer's or other dementias in 2023, and unpaid dementia caregiving was valued at $346.6 billion in 2023.[21] ADRD highlights how disparities across the care continuum generate far-reaching financial consequences that extend well beyond clinical settings.

15 https://www.deloitte.com/us/en/insights/industry/health-care/economic-cost-of-health-disparities.html
16 https://meharryglobal.org/research-scholarship/projected-cost-and-economic-impact-of-mental-health-inequities/
17 https://www.deloitte.com/us/en/insights/industry/health-care/health-equity-economic-impact.html
18 https://meharryglobal.org/research-scholarship/projected-cost-and-economic-impact-of-mental-health-inequities/
19 https://aspe.hhs.gov/sites/default/files/documents/5f3fc5aa6ae780f739265d40f20fc456/federal-racial-ethnic-disparities-adrd.pdf ("Older Black adults are twice as likely, and Hispanic adults are one and one-half times as likely, to have Alzheimer's disease (AD) compared to older White adults … Lack of access to timely and adequate healthcare is thought to also contribute to lower rates of participation in research by Black and Hispanic people: as a result of broader barriers to healthcare access, both groups are typically diagnosed later in their dementia progression than non-Hispanic White adults, making them ineligible for many clinical trials.").
20 https://www.alz.org/news/2024/new-alzheimers-association-report-reveals-top-stressors-caregivers

Examples of Economic Burdens by Disparity Type

Disparities in health outcomes vary depending on the underlying social, economic and demographic factors involved. Examining disparities by type, such as income, education and specific conditions, helps community leaders better understand how disparities in health outcomes translate into higher costs, avoidable utilization and broader economic losses. The examples below illustrate how disparities in health outcomes create measurable financial burdens for individuals, health systems and society at large.

The scale and breadth of social drivers' impact on health outcomes mean that hospitals and healthcare systems cannot address them alone. Patients experiencing unmet social needs often have higher ED utilization, more hospital admissions and readmissions, longer lengths of stay, and more complex and chronic medical needs. Identifying and addressing social needs benefits patient care and serves as an avenue to meet hospitals' strategic goals, including improving quality and health outcomes, reducing avoidable costs, achieving goals of value-based care payment arrangements, and building community engagement and trust.

Income-related Disparities

Lower-income individuals bear a disproportionate share of preventable illness and associated costs.[21] For hospitals and health systems, these income-related disparities in health outcomes can manifest as higher ED use and greater reliance on uncompensated or undercompensated care. Adults with lower or average incomes are more likely to delay or forgo necessary medical care, struggle to pay medical bills, and experience barriers to accessing preventive and specialty services.[22] These challenges contribute to higher rates of chronic conditions and more advanced diseases at the time of diagnosis.

Individuals and communities with lower incomes also face elevated levels of chronic stress, food and housing insecurity, job instability and mental health conditions. All these factors are linked to poorer health outcomes and higher mortality.[23] Moreover, lower-wage workers spend a larger share of their income on health coverage and out-of-pocket expenses, limiting earning potential and financial stability.[24]

DISPARITY REDUCTION SPOTLIGHT

Diabetes

In the United States, up to 15% of adults live with type 2 diabetes, and an additional 88 million people have prediabetes.[25] Lower-income adults with diabetes incur 15% to 22% higher medical expenditures than their higher-income counterparts, largely due to poorer physical health, higher rates of disability and reduced access to consistent, high-quality care.[26]

These costs are further concentrated among specific populations, individuals with lower levels of education and those who are uninsured or underinsured.[27] Delayed diagnosis, limited access to preventive services and challenges in managing chronic disease contribute to avoidable complications and higher-intensity care. Improving health outcomes among lower-income adults with diabetes represents a meaningful opportunity to lower medical spending while improving patients' quality of life.

21 https://www.cdc.gov/pcd/issues/2025/25_0153.htm
22 https://www.commonwealthfund.org/press-release/2023/new-international-research-us-adults-across-income-levels-more-likely-forgo
23 https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/poverty
24 https://www.rand.org/news/press/2020/01/27.html
25 https://www.ama-assn.org/press-center/ama-press-releases/88m-americans-risk-type-2-diabetes-change-your-outcome
26 https://www.cdc.gov/pcd/issues/2025/25_0153.htm
27 Ibid

Education-related Disparities

National estimates indicate that disparities in populations with different levels of educational attainment are primarily attributable to premature mortality, followed by lost labor market productivity and excess medical care costs totaling approximately $3,000 per person.[28] For hospitals and health systems, education-related disparities contribute to higher utilization of high-acuity-high-cost services, poorer health outcomes and greater long-term financial strain.

According to the National Institutes of Health, adults with less than a four-year college degree experienced the greatest economic burden among education groups. Additionally, although adults without a high school diploma represent only a small subset of those without a four-year college degree, they shoulder a disproportionately large share of the total economic burden.[29] This creates an imbalance where individuals with the least educational attainment bear an outsized share of economic and health-related costs, placing sustained pressure on hospitals and health systems.

Benefits of Reducing Disparities in Health Outcomes

Investing in efforts to reduce disparities in health outcomes delivers measurable benefits for hospitals, health systems and the communities they serve. Disparity reduction activities, particularly those focused on prevention, early intervention and increased access to care, can lower avoidable healthcare utilization, reduce overall spending and improve patient outcomes.[30]

By aligning clinical and community-based strategies, hospitals and health systems can support prevention, primary care access and care coordination, thereby preventing avoidable hospitalizations and readmissions.[31] Over time, proactively reducing disparities can mitigate the downstream costs associated with unmanaged chronic disease and premature mortality.

Reducing disparities in health outcomes also yields meaningful workforce and economic gains. A healthier population is more productive, with fewer missed workdays, lower disability rates, and improved cognitive and physical functioning.[32] For hospitals and health systems, these improvements translate into a more stable workforce, reduced turnover and stronger local economies.[33]

Beyond direct financial returns, efforts to reduce disparities in health outcomes can strengthen public trust in the healthcare system and reinforce hospitals' roles as anchor organizations in their communities.[34] Cross-sector collaboration helps connect the communities hospitals and health systems serve with the resources needed to address health disparities. Hospitals play a critical role in improving community health, but they cannot address complex social drivers of health alone. Strategic partnerships with community-based organizations, public agencies and local stakeholders create shared accountability, expand reach and strengthen community benefit efforts by aligning resources to address needs more effectively. For example, hospitals and health systems can leverage partnerships with state Medicaid agencies and local health departments to align initiatives with shared population health goals. These benefits underscore that disparity-reduction activities may be an underexplored strategic opportunity to improve patient outcomes and financial stability.

28 https://www.nimhd.nih.gov/research/publications/economic-burden-racial-ethnic-educational-health-disparities-us-2018
29 https://www.nih.gov/news-events/news-releases/nih-funded-study-highlights-financial-toll-health-disparities-united-states
30 https://milkeninstitute.org/content-hub/research-and-reports/reports/scaling-and-sustaining-better-health-outcomes-through-prevention
31 https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2812390
32 https://pmc.ncbi.nlm.nih.gov/articles/PMC10258929/
33 https://www.naco.org/sites/default/files/2024-07/01833%20DB_BYL_Economies%201P_V2.pdf
34 https://www.chcs.org/media/Shifting-the-Power-Balance-Creating-Health-System-Accountability-through-Trusted-Community-Partnerships_032323.pdf

Reducing Disparities as a Strategic Driver of Quality and Financial Performance

As anchor organizations, hospitals play a vital role in advancing health for all by working to improve outcomes across the communities they serve, drawing on a mission rooted in hope, health and healing, and building on local strengths and assets. Achieving this vision, however, requires more than community engagement; it depends on delivering consistently high-quality care.

Reducing disparities in care is deeply interconnected with broader quality improvement efforts. Evidence consistently shows that high-quality care is associated with better patient outcomes and stronger patient experience.[35] Performance on certain quality measures has also been associated with more favorable financial performance. By embedding disparity-focused initiatives within existing quality strategies, organizations can more effectively identify gaps, reduce unnecessary variation in care and prioritize improvements where they are needed most. Hospitals can use analytics to better understand differences across patient populations, prioritizing interventions that address those gaps and aligning organizational priorities across clinical, operational and financial domains.

Certainly, not all interventions that lead to improvement in performance and outcomes are solely within hospitals' control. However, when these elements come together, reducing disparities can improve quality and translate into lower costs and avoidable expenditures.

One example of a key quality metric that can be integrated into an organization's disparity reduction strategy is hospital readmissions.

Hospital readmissions, when patients are readmitted within a specified timeframe, are a key indicator of care quality and used in many quality measurement programs. Hospitals can use analytics to identify which parts of their community are experiencing more frequent readmissions and prioritize strategies to help close gaps. For example, some hospitals may find that their best opportunities for improvement are inside their four walls, and they may choose to take steps such as strengthening discharge instructions and improving patient education to help patients and families know what to do when they leave the hospital. Hospitals may also identify barriers outside the hospital setting, including limited access to transportation, unstable housing or difficulty accessing outpatient services. They could then use that information to help inform decisions about which community partners they work with to support patients downstream of the hospital.

It is true that efforts to reduce disparities in care often require significant upfront investment. Health systems would need to allocate resources to build data infrastructure, support care coordination and connect with community-based organizations. These investments can be challenging, particularly in today's complex environment with increasingly constrained resources. Hospitals and health systems could consider taking a long-term perspective, aligning early investments with mission priorities and developing mechanisms to measure impact.

Integrating disparity reduction into core quality strategies enables organizations to improve outcomes, reduce avoidable costs and build a more sustainable and high-performing health system.

35 https://www.researchgate.net/publication/397763196_Linking_Quality_Metrics_to_Financial_Outcomes_A_Quantitative_Study

Actionable Strategies for Hospitals and Health Systems

The actionable strategies and discussion guide below outline practical ways to identify and assess the financial impact of health disparities. They also provide clear, data-driven approaches to implement targeted interventions that reduce costs and improve health outcomes.

Establish Organizational Awareness

1 Adopt or reinforce an organization-wide mindset that addressing health disparities aligns with the mission.

Establishing organizational awareness begins with leadership prioritizing the improvement of health outcomes for all as a quality and business imperative. CEOs and senior leaders can set expectations that closing gaps in care, access and outcomes can improve the organization's functioning.

Leaders must begin by using data to understand where differences exist across patient populations, services and communities. Aligning this work with organizational goals helps drive meaningful changes across the system.

2 Strengthen workforce skillsets and commitment to disparity reduction efforts.

Organizational awareness depends on a connected and prepared workforce. Senior leaders can communicate to their team members how this work supports patient safety, quality improvement and long-term financial performance. Establishing workforce-wide expectations and equipping team members to deliver that core message reinforces that every role can contribute to reducing health disparities.

3 Develop an organizational reporting infrastructure inclusive of financial and outcomes-based metrics.

Disparities in health outcomes are associated with higher healthcare utilization, preventable complications, increased safety events and downstream financial strain, particularly in an increasingly value-based reimbursement environment tied to quality and financial performance metrics. Gaps in care and patient outcomes can directly impact performance on quality measures, accreditation standards and pay-for-performance programs, ultimately influencing reimbursement, public reporting and organizational reputation.

Consistently reviewing outcomes data alongside financial, quality and operational metrics can help organizations identify where disparities are driving variation in care, develop improvement efforts more effectively, and demonstrate how reducing disparities can simultaneously enhance clinical quality, patient safety and overall system performance.

DISCUSSION QUESTIONS FOR HOSPITAL LEADERS

1. How are accountability and ownership for reducing health disparities defined at the executive, leadership and governance levels of our organization?
2. Where do we see the most significant impact of health disparities across our patient populations and workforce, and how well do we understand their financial and operational influence?
3. Has the organization considered developing a structured approach to identifying the key financial metrics in relation to patient outcomes driven by health disparities?

American Hospital Association™
Advancing Health in America

Strengthen Data Collection and Analysis for Data-driven Decision-making

1 Build a standardized data-collection infrastructure.

Meaningful improvement in data collection relies on clear visibility into current data quality — identifying missing elements, inaccuracies and structural issues that affect analysis and decision-making. A deliberate data collection strategy can allow leaders to clearly see where outcomes vary among the patients and communities they serve, how large those differences are, and which populations are most affected. Hospital and health system leaders can assess their systems and workflows to support the collection of patient-reported demographic information and establish strong data governance to ensure data are accurate, consistent and actionable over time.

2 Use quantitative and qualitative data.

Integrating various data sources, such as measures of food security, housing stability, transportation access, spoken language and geography, alongside qualitative input from patients, employees and community partners, can provide critical context to healthcare utilization, quality and cost. Tools such as Community Health Needs Assessments, patient and family advisory councils, and workforce feedback help surface barriers that clinical and claims data alone often cannot explain. When combined, these quantitative and qualitative data can enable leaders to prioritize gaps in care, avoid one-size-fits-all interventions and direct resources toward strategies with the greatest operational and financial impact.

Applying a patient-level lens, such as tracking trends across individual patients over time, can highlight patterns in utilization and cost fluctuations, generating clearer insights to support more informed, data-driven decision-making. This approach can also assist with tracking key performance metrics — such as avoidable ED utilization, quality measures and length of stay (LOS) — helping organizations build a compelling, data-driven case with payers.

Hospital LOS highlights operational efficiency and care delivery effectiveness. Patients facing socioeconomic challenges or limited support systems often experience extended stays due to delays in securing post-discharge care. Improved care transitions, proactive discharge planning and stronger outpatient support can help improve outcomes and ease system strain by avoiding costs tied to preventable utilization and unnecessary readmissions.

Focusing on operational improvements, such as ED throughput and care coordination, can help drive efficiencies that better leverage fixed costs over time.

3 Stratify and analyze data to inform disparity reduction strategies.

Stratifying quality, safety, access and cost measures by key demographic factors can elevate disparities within overall performance reports and clarify where targeted interventions are needed. Linking these findings to associated costs helps support informed investment decisions. Transparent dashboards, regular executive and board review, and continuous monitoring can help organizations track progress and refine strategies.

DISCUSSION QUESTIONS FOR LEADERS

1. How well does our current data infrastructure capture differences in access, quality, safety and outcomes across patient populations? Are we collecting patient data in a standardized and systematic way?
2. Are we integrating community-level data, such as food security, housing, transportation, spoken language and community feedback, into our decision-making? If not, which data sources could we begin leveraging?
3. Which key measures could be stratified by demographic factors to guide targeted interventions, and how could these insights translate into continuous action and resource allocation?

Assess Financial and Operational Impact of Disparities in Health Outcomes Using Targeted Metrics

1 Integrate financial modeling early to inform disparity-reduction strategies.

Embedding cost and savings analysis into the earliest stages of data collection and analysis can be an important step toward assessing the financial impact of health disparities. Hospitals and health system financial leaders should consider assessing both the financial impacts (such as reductions in avoidable readmissions, ED use and LOS) and the longer-term benefits, including slower spending growth and improved performance in value-based contracts.

2 Use return-on-investment (ROI) frameworks to prioritize high-cost and chronic conditions.

Leveraging cost-estimation and ROI frameworks can help organizations generate strong economic evidence to guide disparity reduction efforts. This approach is especially useful for patients with multiple chronic conditions, individuals dually eligible for Medicare and Medicaid and other high-cost populations, who drive a disproportionate share of preventable spending. The costliest 5% of the population accounts for approximately half of healthcare spending and the costliest 1% accounts for over 21%.[36] By analyzing differences in disease prevalence, care utilization and health outcomes, leaders can pinpoint care gaps that directly contribute to unnecessary costs and operational strain.

3 Identify key disparity-related metrics and link them to financial and operational impact.

Effective financial analysis starts with selecting metrics that capture both operational and economic consequences of health disparities. Organizations could routinely stratify key performance indicators, such as quality, population health, patient experience and operational measures, by various social risk factors.

Priority areas often span clinical outcomes (i.e., mortality, ICU admissions, hospital-acquired complications), utilization and operational metrics (i.e., ED visits, LOS), preventive care, care transitions, patient experience and safety events, which provide a comprehensive view to guide targeted interventions.

Once stratified, linking these metrics to associated costs can help clarify which gaps drive unnecessary spending and operational strain. Presenting these data in clear and actionable formats for boards and clinical and operational leaders can align front-line teams, guide resource allocation, and demonstrate value to both internal and external partners.

DISCUSSION QUESTIONS FOR LEADERS

1. Having reviewed the data, which patient populations, conditions or service lines are most affected by health disparities, and do we have the right metrics to quantify the financial impact?
2. Are financial modeling and ROI analyses informing decisions early enough to shape strategy and resource allocation?
3. How can we better use stratified performance and cost data to prioritize initiatives, sustain funding and demonstrate measurable value to internal and external stakeholders?

36 https://meps.ahrq.gov/data_files/publications/st560/stat560.shtml

Implement Interventions in Pursuit of Sustainability and Innovation

1 Design targeted, data-driven interventions that translate insights into action.

Sustainable improvement relies on moving from data collection to strategic action. The use of stratified quantitative data alongside qualitative insights from patients, caregivers, staff and community partners is necessary to better understand root causes and design interventions that meet the needs of the patients that hospitals and health systems serve.

Many of the highest-impact opportunities may exist within current clinical and community-level data assets, such as emergency visits, admissions, missed appointments, intake information and Community Health Needs Assessments. However, these require intentional disaggregation and analysis to reveal where access barriers, health literacy challenges or other barriers exist. Once identified, further quantitative and qualitative analysis can provide insights into how these concerns lead to poorer health outcomes and higher costs.

Hospitals and health systems can convene community stakeholders to help design and implement collaborative solutions aimed at determining appropriate resource allocation among partners. Strategies may include tailored workforce training, improved access to preventive and social services, person-centered care models and expanded use of community health workers to support navigation and trust-building.

2 Apply quality improvement strategies to support sustained change.

To ensure durability and scalability, interventions could be designed using quality and performance improvement frameworks, with robust measurement and evaluation approaches to support adaptation and sustainability. Routine review of stratified performance data helps organizations refine interventions in real time, assess feasibility and unintended consequences, and ensure improvement efforts do not exacerbate existing inequities.

Continuous quality improvement strategies are central to improving key performance metrics, such as hospital readmissions and hospital LOS, which reflect both care quality and operational efficiency. These metrics should be monitored in real-time and analyzed to identify disparities in care transitions, discharge planning and post-acute access. Incorporate these insights into regular quality review processes to ensure disparities are addressed.

3 Build financial and operational sustainability across interventions.

Incorporating financial and operational sustainability into intervention design can help foster long-term success. Clear prioritization criteria, such as access to care based on insurance status (Medicaid, uninsured, and financially assisted populations) and patient comorbidities and severity of treatment, help leaders strategically direct resources where returns and impact are greatest. Upstream care should be viewed as proactive and prevention-focused, emphasizing investments that address root causes early to improve outcomes and reduce disparities over time.

Organizational policies help sustain improvements over time by defining expectations for data review, quality monitoring and resource allocation. These policies standardize workflows and reinforce accountability through effective practices that persist beyond individual projects or leadership changes.

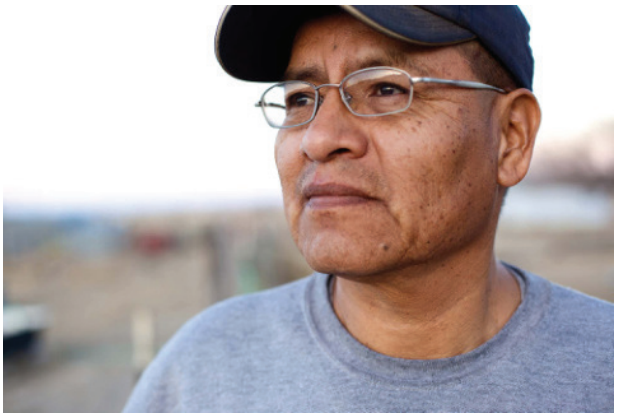
Transparent dashboards, routine monitoring tools and clearly defined accountability structures help reinforce momentum and trust, both internally and within local communities. Strategic partnerships with community organizations further strengthen this trust by aligning interventions with real-world needs, co-designing solutions and advancing community collaboration. Organizations should prioritize integrating community benefit initiatives into their strategic plans by aligning these efforts with quality and outcome goals. This will not only drive measurable improvements in care outcomes but also strengthen long-term relationships and community trust.

DISCUSSION QUESTIONS FOR LEADERS

1. Do our quality improvement and monitoring policies and processes allow us to adapt quickly, measure progress and sustain meaningful improvements over time?
2. Are we effectively turning stratified quantitative and qualitative data into targeted interventions that address the root causes of health disparities?
3. How are we reinvesting savings and communicating results to build accountability, trust and long-term financial impact?

Case Studies

Sanford Health



Background

Sanford Health, the nation's largest rural health system, serves more than 2 million patients across America's heartland and shares geography with 54 sovereign tribal nations. During tribal roundtables conducted by Sanford in 2023-2024, tribal leaders and healthcare professionals identified preventive healthcare — such as cancer screening — as a critical priority, citing geographic barriers and historical mistrust between tribal communities and traditional healthcare systems. In response, Sanford Health engaged tribal leaders and national partners, including the American Indian Cancer Foundation, to help address health disparities among tribal populations, particularly inequities in cancer screening.

Sanford Health's Colorectal Cancer Screening Campaign

Colorectal cancer (CRC) screening is an effective preventive strategy that identifies precancerous polyps or early-stage disease, significantly reducing both cancer incidence and mortality. Sanford Health faced a significant gap with CRC screenings in 2023, performing approximately 3,000 colonoscopies per month, falling short of the 8,000 total monthly procedures needed to meet population targets. In 2024, Sanford Health began implementing a large-scale CRC screening campaign centered on mailing at-home stool test kits to average-risk patients who were overdue for screening. Sanford mailed 50,241 test kits through the end of 2025, with over 11,000 completed and returned. As a result, organizational CRC screening rates increased from 68.7% in 2023 pre-campaign to 73.8% by the end of 2025, representing a meaningful improvement in preventive care and access across Sanford's footprint.

Through the initial screening campaign, 734 precancerous polyps were removed, and 29 colorectal cancers were detected (62% at early stages), improving estimated survival by 26% and preventing an estimated 55 additional cancer cases despite limited colonoscopy capacity. Beyond clinical benefits, the campaign generated substantial cost savings to the healthcare ecosystem, including patients, payers, communities and providers. Sanford's Enterprise Data and Analytics (EDA) team estimated a total of $5.8 million in avoided healthcare costs associated with early cancer treatment and polyp removal, as well as an additional $6.1 million in avoided payments linked to preventing advanced-stage cancer.

Looking Ahead

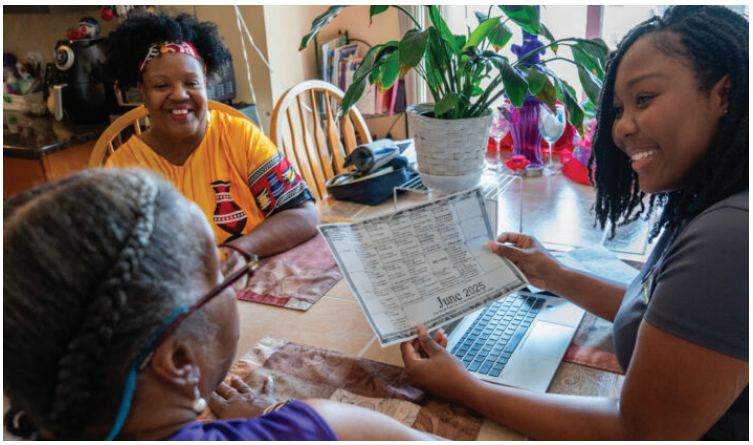
Analysis from Sanford's EDA team revealed persistently higher positivity rates among tribal or Alaska Native populations compared with other demographic groups. To address this gap, Sanford leadership approved a collaborative resource-based partnership model between Sanford, tribal nations and a screening kit partner. This partnership aims to jointly establish protected health information sharing agreements, co-design patient-centered materials, and tailor outreach and results management based upon tribal preferences and capacity. This approach reflects Sanford's commitment to reducing CRC mortality, improving quality-adjusted life years and reducing health disparities through direct tribal partnership.

An estimated 11,500 Native American adults in North Dakota and South Dakota are overdue for screening. The next phase of this screening campaign will activate the collaborative resource-based partnership model with tribal nations to address the tribal or Alaska Native patient populations. Based on historical claims data, Sanford estimates that achieving commensurate screening rates with the general population could lead to:

- Detection of an estimated nine additional cancers at their earliest and at more treatable stages.
- Prevention of an estimated 16 additional cancer diagnoses through pre-cancer polyp removal.
- Estimated $1.55 million in savings in healthcare costs related to polyp removal and early cancer treatment.
- Estimated $1.64 million in payment savings associated with preventing more advanced cancer cases.

Colorectal cancer is largely preventable and treatable when caught early. Sanford's screening campaign is proof that meeting patients where they are — starting with a simple at-home test — saves lives.

ChristianaCare



Background

ChristianaCare is a not-for-profit, integrated health system serving Delaware and the surrounding region. The organization's areas of strategic focus include population health, reducing health disparities and value-based care. ChristianaCare used validated clinical, utilization and administrative data to identify care gaps and establish a community health worker intervention within its primary care practices, targeting patients with high rates of ED visits, inpatient admissions and hospital readmissions, alongside unmet social needs.

The intervention addressed disparities in access to care for patients with uncontrolled chronic conditions. These disparities were selected because they reflected persistent patterns of potentially avoidable utilization and closely aligned with organizational priorities related to ambulatory-sensitive conditions and value-based contracts. Additionally, some of the patients were covered by public payers (Medicare and Medicaid) while others were uninsured — an indication that the disparities were driven by fragmented care and social barriers rather than clinical acuity alone. The economic impact of the intervention was assessed conservatively by converting statistically significant reductions in acute care utilization into estimated cost savings, while excluding nonsignificant metrics and revenue assumptions to avoid overstating results.

Reducing Acute Care Disparities Through the Primary Care Community Health Worker Program

ChristianaCare implemented the Primary Care Community Health Worker Program, embedding trusted community health workers within 11 primary care practices. While operationally integrated at the organizational level, the program functioned at the community-clinic interface, helping patients navigate social services, access community resources and coordinate care beyond the clinic walls. Successful execution required standardized eligibility criteria, defined caseload expectations, integration into care teams and alignment with clinic workflows. Data priorities focused on utilization outcomes (ED visits, admissions, readmissions), demographic and payer characteristics, and documented social needs. These data directly informed program design, performance monitoring and identification of standardization opportunities to stabilize outcomes across sites.

Results

Program effectiveness was evaluated using patient-level pre/post comparisons, symmetric measurement windows, annualization and nonparametric statistical testing to ensure rigor. The program achieved statistically significant reductions in acute care utilization, including annualized per-patient reductions of 1.19 ED visits, 0.54 inpatient admissions and 0.82 hospital readmissions. More than half of participants reduced ED utilization, and the majority experienced no inpatient admissions or readmissions following program completion.

Economic impact was quantified by monetizing only statistically significant reductions. The program generated an estimated $2.16 million in annual savings against $0.94 million in annual costs, yielding a net benefit of $1.22 million and a return on investment of $1.30 per dollar invested.

Key Takeaways

Hospitals and health systems can reduce disparities by investing in community-anchored, primary care-integrated infrastructure supported by standardized workflows, defined performance metrics and reliable data systems. Creating a business case requires: 1) identifying disparity-driven utilization, 2) implementing targeted interventions, 3) measuring patient-level impact with conservative methods, and 4) translating validated outcomes into financial value. This approach enables systems to reduce disparities while delivering sustainable economic returns.

Innovation Spotlight

Nantucket Cottage Hospital

Background

Nantucket Cottage Hospital (NCH) is a rural, community-based hospital located on the island of Nantucket, Mass., approximately 30 miles off the coast of Cape Cod. As the island's only acute care hospital, NCH plays an essential role in caring for a geographically isolated community where access to off-island services can be limited by weather, transportation, distance and the realities of island life.

NCH provides access to more than 38 specialties on the island and to approximately 97% of care locally, with only 3% of patients requiring airlift or transport to a mainland hospital. This level of local access is important given Nantucket's unique population, which ranges from approximately 7,000 year-round residents to more than 100,000 individuals during the summer months, including seasonal residents, visitors and temporary workers. The island welcomes more than one million visitors each year, creating a healthcare environment that not only must meet the routine healthcare needs of the community, but also respond quickly and effectively to sudden seasonal surges in patient volume and acuity. Transportation barriers remain a challenge, with a significant number of flight and ferry cancellations annually affecting access to mainland care, supplies and critical resources.

NCH TeleNewborn Medicine Program

As a member of the Mass General Brigham system, NCH uses technology to extend access to subspecialty expertise, support clinical decision-making and maintain continuity of care despite limited on-island resources. Through secure video consultation, Massachusetts General Hospital (Mass General) specialists support NCH clinicians with evaluation and stabilization of newborns, guidance on clinical management and determination of whether transfer to a higher level of care is necessary.

The TeleNewborn program is especially critical because NCH does not have an on-island NICU. The program helps ensure that newborns and families have timely access to expert neonatal care by providing real-time clinical support from Mass General specialists during moments when early assessment, stabilization and decision-making are essential. TeleNewborn strengthens local clinical capacity and helps NCH provide a higher level of neonatal care than would otherwise be possible in a small rural island hospital. It supports safer care, better coordination and more informed transfer decisions. When a transfer is needed, the program helps ensure the process is clinically appropriate and well coordinated. When it is safe for an infant to remain on the island, the program allows families to continue care close to home, which reduces family separation, missed work and travel costs, and mitigates both the financial and caregiver burden of arranging mainland care.

Reduced Costs for Patients

The program also improves affordability for patients and families by reducing the need for costly off-island care when local care is clinically appropriate. Round-trip travel to Boston typically costs approximately $400 to $600. These costs include approximately $90 by ferry or $450 by commercial flight, plus ground transportation, lodging and related expenses. Travel to neighboring Cape Cod is generally less costly, but still substantial, averaging approximately $200 to $250 per trip. Because ferry and flight schedules are limited and subject to disruption, families may also lose one to two days of work and wages.

Overall, the TeleNewborn program improves access, supports quality and safety, reduces avoidable off-island care, lowers the financial burden for families, and reinforces the hospital's ability to meet the needs of both year-round residents and Nantucket's large seasonal population.

Conclusion

Disparities in health outcomes have significant economic implications for communities and the hospitals and health systems that serve them. Avoidable utilization, higher costs of care and lost productivity place increasing pressure on organizations operating in constrained financial environments. Without targeted action, these gaps continue to drive unnecessary spending and poorer health outcomes.

Hospitals and health systems can help bring change. As anchor organizations in their communities and stewards of healthcare resources, they can help reduce disparities through intentional, evidence-based strategies and by leveraging community partnerships and collaboration. Clearly defined accountability structures, leadership engagement, disciplined use of data and strategic interventions can help bring about meaningful impact.

This **Resource Guide** highlights the critical role of actionable data in driving improvements in health outcomes. Strengthening data collection and stratification, while linking outcomes to financial metrics, enables organizations to identify high-priority populations and conditions that drive avoidable costs. By aligning data-informed initiatives to support the reduction of disparate health outcomes, hospitals and health systems can help impact local economies, improve outcomes for all patients and build a more resilient care delivery system.

Reducing health disparities can be a strategic investment in the future of health and well-being. Hospitals and health systems that prioritize reducing disparities in health outcomes may find success in value-based environments, support a healthier and more productive workforce and strengthen trust with the communities they serve. Reducing disparities in health outcomes is good for patients and it can bring significant economic benefits to the broader society, communities and the organizations that serve them.