Analysis on Academic Medical Centers’ Directional Strategies for Health Equity

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Abstract

This objective of this paper is to analyze how U.S. AMCs include health equity in their directional strategy to close gaps in healthcare. The paper uses peer-reviewed publications discovered through Google Scholar and PubMed Central. The public health relevance section acknowledges the contributions of AMCs to the U.S. health system through research, education, and clinical practice. The literature review highlights frameworks such as quintuple aim, discusses relevant terminology, and describes practical ways to increase health equity. The case study reveals the complex reality of implementing health equity at AMCs, considering geographic and sociopolitical factors. Four major AMCs demonstrate patterns that might be reflective of their regions’ attitudes towards health equity. Overall, this paper demonstrates how AMCs can prioritize health equity in their directional strategy to close gaps in the U.S. healthcare system.
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1.0 Introduction

1.1 AMC Definition

An academic medical center (AMC) is a tertiary hospital that provides patient services, an institution advancing a scientific research agenda, and an allopathic or osteopathic medical school that trains health professionals.

Within AMCs, tertiary hospitals provide a wide variety of outpatient and inpatient services, including general, medical, surgical, pediatric, and maternal care. Mandatory specialty health departments such as mental health, internal medicine, and more, must be delivered for accreditation purposes. Emergency services support, specialized intensive care, and medical diagnostic services are a few of the other medical specialties also required. The diversity of specialty care at these facilities attempts to specifically address the unique illnesses of the populations they serve. Patients referred to tertiary hospitals from primary or secondary care providers require specialized expertise and equipment for their treatment plans. Within AMCs, tertiary hospitals often offer much needed comprehensive and multidisciplinary care.

In addition to providing optimal care, AMCs are expected to support the pursuit of medical and scientific advancements that will benefit their patients through research. Research may be represented in a multitude of ways, including in-vitro bench experiments, clinical human trials, medical device testing, and much more. The common goal of these experts is to examine and test the mechanisms of health and complex illness. In turn, researchers gain a better understanding of how to prevent, detect, and manage disease more effectively. These scientists develop and improve
technologies, such as vaccines and vital medical equipment and devices, which lead to safe and advanced health care.

Some of the key innovations that AMCs have helped to advance include the first general vaccine against polio and pneumonia, the introduction of total intravenous feeding, the development of magnetic resonance imaging (MRI), and many more. The discoveries of researchers within AMCs may be translated to improved bedside treatment plans, life-saving preventative health measures, and numerous other important medical advances that have yet to be discovered.

Incorporating the innovations provided by researchers and the exposure to complex cases at the hospital, AMCs create an ideal educational environment. AMC’s teaching methods and faculty demonstrate their commitment to nurturing the next generation of physicians and other health care professionals. Academic knowledge and experiential learning instruct upcoming medical professionals in the best ways to care for their patients.

The clinical, research, and educational branches in an AMC consolidate for mutually beneficial results between the branches and patients. An AMC is integrated as the hospital provides hands-on education for the medical trainees, researchers translate scientific discoveries to bedside treatment plans and beyond, while the hospital provide top-tier service and unmatched resources for their patients.

1.2 AMC Significance

Academic medical centers have proven to centralize specialized healthcare, support research for scientific discovery, and invest in the education of future healthcare professionals
within one entity. A[M]Cs graduate approximately half of U.S. medical residents, provide about 40% of the country’s hospital-based charity care despite representing only 6% of its hospitals, and account for nearly one-third of the nation’s health research funding (Park et al., “Health Equity and the Tripartite Mission”). The quantifiable effects of this small minority of healthcare have recently been investigated in studies by Harvard T.H. Chan School of Public Health, Massachusetts General Hospital Department of Medicine, and several other institutions.

The notable study “Association Between Teaching Status and Mortality in US Hospitals” discusses the significance and impact of AMCs on health outcomes. Specifically, the study aimed to examine risk-adjusted outcomes for patients admitted to teaching versus nonteaching hospitals across a broad range of medical and surgical conditions. Researchers focused on the following questions to arrive at their conclusion: “First, to what degree do overall outcomes differ in teaching hospitals compared with nonteaching hospitals? Second, are the benefits of receiving care at a teaching hospital, if any, focused on a small number of conditions or are they present more broadly across multiple types of conditions and procedures? Third, are differences present even among large hospitals, where high volume could potentially mitigate any advantage of being a teaching institution?” (Burke et al., “Association Between Teaching Status and Mortality in US Hospitals). This study found that major teaching hospital status was associated with lower mortality rates for common conditions compared with nonteaching hospitals. This result suggests that academic medical centers provide effective care as well as educational and research benefits to their patients. Highlighting the important role of AMCs allows for discussion of how these institutions have successfully executed these achievements, and plan to further improve through directional strategy.
1.3 Directional Strategy

Directional strategy is a plan of action to grow towards and achieve the overarching goals of an organization. An AMC’s mission, vision, and values are the most fundamental forms of directional strategy. As described by Bain and Company, a mission statement defines the organization’s business, who it serves, what it does, its objectives, and its approach to reaching those objectives (Purpose, Mission, and Vision Statements). It provides insight into the distinctness of the organization and what distinguishes it from all other organizations of its type. According to “Instructors’ Manual to Accompany Strategic Management of Health Care Organizations, Fifth Edition,” successful mission statements incorporate the following six components: target customers and markets, indicate principal services, specify geographic domain, identify an organizational philosophy, illustrate an organization’s desired self-image, and specify the desired public image (Swayne, Duncan, and Ginter, “Strategic Management of Health Care Organizations).

A vision statement is a description of the desired future state of the company. They account for the complex history of an organization, perceptions of the opportunities and threats present in the environment, as well as assess its strategic capacity to achieve goals. An effective vision inspires the team by helping them define and envision success. The vision statement is market-based and should reflect the overall direction desired for the AMC. Lastly, the values statement illustrates the hospital’s guiding philosophy, ideals, and planning principles as a desired state (Qin et al., “Learn from the Best Hospitals”).

The development and review of these statements requires the organization to communicate a message in deliberate, transparent, and precise language. Both statements explain the company’s motivations and reasons for being and function. They also encourage the organization to identify
and address how their objectives are measurable, how their approach is actionable, and how the vision is achievable. Internally, the statements help define performance standards, establish output standards, and inspire employees towards achieving a common goal. Considering the importance of directional strategy for an organization’s success and growth, AMCs must be willing to expand and revise their directional strategy to meet the ever-changing needs of healthcare.

1.4 Directional Strategies of AMCs

The tripartite mission of AMCs includes the goals of education, clinical care, and research. Within recent years, AMCs placed importance on a holistic view of healthcare. In doing so, AMCs see healthcare beyond the medical and clinical aspects. The growing significance of social determinants of health, population health, and community health reshape how these organizations goal-set, thus reimagining their directional strategy. The expansion of healthcare’s definition requires a revaluation of the scope of their mission, as well as reprioritizing funding and resources to best align with the unique needs of the communities they serve.

According to a study conducted by PwC Health Research Institute, AMCs are already expanding their clinical missions to incorporate wellness and the social determinants of health (PricewaterhouseCoopers, “Future Academic Medical Centers”). This clearly helps to broaden their research missions to include population health and personalized medicine and expand their educational missions to include these aspects of health.

The original clinical mission was predominantly focused on acute care and non-chronic conditions within siloed clinical practices. The expanded mission included holistic health and wellness care. Specifically, 73% of AMC executives plan to increase investments in extended care.
teams including nutritionist, clinical pharmacists, mental health professionals, and physical therapists.

The original research mission focused on obtaining grants to support internal research, overtime this caused limitation to vital external partnerships. With the expanded mission, executives are aligning their research pipeline with their clinical and business strategies. This supports 70% of AMCs that aim to improve the health of their entire patient population within five years through research.

The original education mission was to focus on providing clinical training for health professionals. The expanded mission aims to increase training in community health and build a workforce ready for the future of healthcare. Across the tripartite, the rapidly changing scope of AMCs’ directional strategy point towards holistic healthcare improvement. A common theme among these goals is health equity.

1.5 Health Equity

Healthy People 2030 defines health equity as “the attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and health care disparities” (“Health Equity in Healthy People 2030 - Healthy People 2030 | Health.Gov”).

The premise of health equity is bolstered in evidence that certain demographics receive and experience healthcare in unjust, unequal, and disadvantaged ways. Healthy people describe this discrepancy as a “health disparity,” further defined as “a particular type of health difference that
is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.”

Despite the seemingly new emergence of health equity, the topic has been historically highlighted by experts through multiple publications such as Institute of Medicine “Crossing the Quality Chasm.” This 2001 report describes the six elements of a high functioning health system, one of which is being equitable (Berwick, “A User’s Manual for the IOM’s ‘Quality Chasm’ Report”). This publication demonstrates the longstanding goal for health equity in healthcare, which has become increasingly important as health disparities have been magnified in recent years.

Statistics released by the Center of Disease Control and Prevention further illustrate the magnitude of health disparities among various groups. For example, a 2021 report reveals that the maternal mortality rate for non-Hispanic Black women was 69.9 deaths per 100,000 live births, 2.6 times the rate for non-Hispanic White women (“Maternal Mortality Rates in the United States, 2021”). Such issues can be addressed through allocating focus and resources towards these issues.

As AMCs acknowledge their influence on the future of healthcare, many organizations have already set the standard of incorporating health equity in their mission and vision. This shift in directional strategy will funnel AMCs research, education, and clinical services towards closing gaps in public health.
2.0 Public Health Relevance

Academic medical centers play a vital role in maintaining, advancing, and aligning medicine with public health. As discussed in the Burke journal, patients at AMCs have lower mortality rates than at nonteaching hospitals, allowing for access to optimal clinical care and better outcomes for sick individuals around the country (Burke et al., “Association Between Teaching Status and Mortality in US Hospitals). Furthermore, the educational component of AMCs prioritizes understanding diverse patients as accreditation bodies like the LCME and GMCE require curricula on health equity. With trainees understanding and advocating for health justice for their patients, the public benefits from their new care requirements and schools of thought.

One of the most notable ways that academic medical centers have contributed to public health is through research. An excellent example of which is the discovery of the Philadelphia Chromosome by Peter Nowell, who was a junior faculty member at the University of Pennsylvania School of Medicine, and graduate student David Hungerford. They discovered a chromosome in leukemia cells of 95% of patients with chronic myelogenous leukemia. This served as a hallmark of chronic myelogenous leukemia detection and provided evidence for a genetic link to cancer (Koretzky, “The Legacy of the Philadelphia Chromosome”). The legacy of this research, along with countless other projects at AMCs, serves as a paradigm for how research can lead to innovative treatment for human disease.

Many academic medical centers aim to adapt to the changing landscape of the current healthcare market to best serve diverse patients across the country. This is reflected in the expanding mission of including population health into AMCs tripartite mission, thus investing in
similar health equity initiatives. In fact, NYU School of Medicine launched an academic Department of Population Health with a strongly applied approach in 2012. Their research agenda prioritizes scalable initiatives to improve health and reduce inequities in populations defined by race, ethnicity, geography, and other factors. Their curriculum targets population-level thinking among employees and students. This major AMC exemplifies how modern institutions pioneer advancement in public health awareness and interventions.

The overall connection of AMCs to public health is well described by the article “Advancing Population Health at Academic Medical Centers: A Case Study and Framework for an Emerging Field.” Here, the cascading effects of the once Triple Aim help improve the individual experience of care, the health of populations, and reduce per capita costs of care for populations. The journal credits the creator of the idea, as they “sowed the seeds for making population health improvement a central tenet of health care transformation. Subsequently, this emphasis on populations has been construed both clinically, as connoting the roster of patients under care in each system, and more broadly, as a call for health care delivery to contribute to the health of all persons in an area or region” (Gourevitch and Thorpe, “Advancing Population Health at Academic Medical Centers”). The now quintuple aim further bolsters this comprehensive approach and promotes initiatives to better align primary care and public health. This is started by organizations recognizing health care delivery as an opportunity to identify social determinants that affect patients’ health. Meanwhile, helping patients meet needs in social domains and explore holistic health. Furthermore, this framework encourages hospitals to foster health improvement across all populations and strive towards equity. With health equitable goals incorporated in the vision, mission, and values of an AMC, the public will benefit from these advancements in healthcare
3.0 Literature Review

3.1 Methodology

This literature review intends to explore the emerging frameworks for health equity advancement, practical methods to reduce inequalities in healthcare, and key terms used in academic medicine surrounding the topic. To ensure reliable information, this paper references peer reviewed journals and respected publications that specialize in health policy and medical research such as JAMA Network, BMC Medical Educations, and Academic Medical Journal.

PubMed Central and Google Scholar served as primary search engines to gather literature as these platforms allowed for filtered English results. This setting allowed for results to focus on the recent publications based on the U.S. healthcare system. The original search on PubMed Central was “Health Equity Academic Medicine” which generated 159 results. Key words such as health disparities, health equity, mission, vision, social determinants of health, and academic medical center further matched results to the topic and excluded nonrelevant materials. Finally, the desired timeframe of 2019-2024 narrowed searches to reflect the emerging importance of health equity in the United States. Despite marginalized communities facing the detrimental effects of health inequities far before 2019, the larger context of the U.S. truly realized the issue’s magnitude through the COVID-19 pandemic and multiple media events. This condensed period of tragedy and immense disparities sparked conversations surrounding general injustices among demographics. Consequently, AMCs began to directly incorporate health equity into directional strategy to reflect the significance of the topic. The following recent publications evaluate health equity in U.S. academic medicine.
3.2 Tripartite Mission

“Health Equity and the Tripartite Mission: Moving from Academic Health Centers to Academic–Community Health Systems” begins by emphasizing the magnitude of health inequity and its negative impacts. The cascading affects are “… systemic prejudice perpetuates health disparities in a structure that advantages certain populations while disadvantaging others. The impacts of health inequities negatively affect us all, hampering our economy and national security by increasing financial waste in health care expenditures and decreasing the number of healthy individuals able to join the military and the workforce. By one estimate, health disparities cost the health care system $1.24 trillion between 2003 and 2006 alone” (Park et al., “Health Equity and the Tripartite Mission). The article explains well the severity of health inequity and how it affects individuals beyond marginalized groups, urging all citizens to prioritize the issue.

After describing why health equity is important, the article provides solutions by reviewing potential directional strategy of academic medicine to include social determinants of health. The article assesses gaps in current AMCs in inclusively defining the mission and vision of an organization. The article suggests that “A fully realized vision of an academic–community health system will demonstrate interdependence between A[M]Cs and the community.” This vision should be supported by shifting the identity of AMCs towards building academic–community health systems. This new identity supports an enhanced tripartite mission to a commitment to sharing power, resources, and goal alignment with the communities they serve to advance health equity. The authors further explain that “orienting each tripartite mission around community engagement will upgrade A[M]Cs from stand-alone institutions to a network of academic–community partnerships that values multisector community engagement, stays accountable to the community, and sustainably advances health equity.” This stance on clearly defining a new vision
and identity highlights the significance of community involvement to achieving health equity through collaboration, power sharing, and cocreation.

### 3.3 Quintuple Aim Expansion

Directional strategy ideals such as the quintuple aim allow for the expansion of tripartite missions for AMCs, thus allowing these organizations to equitably serve and promote health to patients across the U.S. The quintuple aim for advancing health care transformation, the latest expansion of the quadruple and triple aim, was coined by Dr. Shantanu Nundy in the opinion piece “The Quintuple Aim for Healthcare Improvement.” The model redefines healthcare’s role in society by highlighting health equity’s importance. The five pillars of the model include enhancing patience experience, reducing cost, prioritizing the well-being of providers, population health, and most recently health equity. Nundy defines health equity as “the state in which everyone has the opportunity to attain their full health potential, and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances” (Nundy, Cooper, and Mate, “The Quintuple Aim for Health Care Improvement”). The article well articulates the historical background that causes inequity, such as structural racism, employment, access to care, and networks. This background allows the reader to understand that health inequities are not a new issue but has not been highlighted due to challenges in high-level policy. Despite this barrier, Nundy addresses that health equity requires organizations to recognize the determinates of health and how they affect the wellness of patients. Nundy’s argument is that health equity should not be a consequence of the other aims, but rather, it deserves to be an explicit goal for health care leaders.
and professionals. To see advancement in this aim, Nundy suggests a multi-level approach to improving health equity.

The article advises healthcare professionals to identify disparities, design and implement evidence-based interventions to reduce them, invest in equity measurement, and incentivize the achievement of equity. Administrators should also provide practitioners the needed resources to measure and report quality and operational data stratified by the relevant social categories such as self-reported race, ethnicity, gender identity, preferred language, and physical or mental ability. On the bedside, clinical practitioners should be incentivized or required to collect data on social needs and barriers to care such as transportation, food insecurity, and housing.

On a government scale, the article argues that policy makers should set health equity standards and design effective economic supports to help achieve them. This should include accurate and timely collection of demographic identifiers and stratification of existing clinical measures and reporting through incentive programs.

Finally, the article suggests that in fee-for-service environments, evidence-based interventions designed to address underlying social needs that often underlie health inequities should be reimbursed. This promotes quality improvement efforts to address these needs through a financing model. Efforts should be made to accelerate value-based payment in under resourced communities in which payments reflect the greater social and medical needs of these populations.

Overall, the quintuple aim opinion piece highlights the significance of health equity and feasible methods of incorporating the idea into directional strategy. This concept encompasses AMCs newfound focus on holistic care. The quest for fair and just opportunity to reach patients’ highest level of health proves to be a pivotal goal for AMCs, making the health equity aim an upmost priority for directional strategy.
3.4 Vanderbilt University Medical Center

“Academic Medicine’s Journey Toward Racial Equity Must Be Grounded in History: Recommendations for Becoming an Antiracist Academic Medical Center” examines Vanderbilt University Medical Center’s (VUMC) commitment to racial equity in summer 2020. The institution created a task force that enforced 5 key strategic goals for academic medicine to dismantle structural racism: “(1) confront medicine’s racist past, which has embedded racial inequities in the U.S. health care system; (2) develop and require health care professionals to possess core competencies in the health impacts of structural racism; (3) recognize race as a sociocultural and political construct, and commit to debiologizing its use; (4) invest in benefits and resources for health care workers in lower-paid roles, in which racial and ethnic minorities are often overrepresented; and (5) commit to antiracism at all levels, including changing institutional policies, starting at the executive leadership level with a vision, metrics, and accountability” (Wilkins et al., “Academic Medicine’s Journey Toward Racial Equity Must Be Grounded in History”).

The fifth point directly challenges executives to address racial health disparities through directional strategy. The article comments “executive leaders must be actively involved in developing and communicating an antiracist vision and setting expectations for accountability.” This in turn will trickle down into the practices and beliefs of clinical and administrative employees at this organization. By executives setting the standard of anti-racist ideologies through mission and vision, this ideology will trickle down into the practices and beliefs of clinical and administrative employees at this organization. This approach can be replicated for other areas of equity in academic medicine across the country.
To best understand how AMCs can incorporate health equity in their directional strategy, common terms must be outlined. As described in “Towards a common lexicon for equity, diversity, and inclusion work in academic medicine,” “a shared language can provide opportunities for those who champion this work to pool resources for larger impacts across the institution. This article aims to catalog the terms used across academic medicine disciplines to establish a common language describing the inequities experienced by Black, Latinx, American Indian/Alaska Native … and other historically marginalized or excluded groups” (Rodríguez et al., “Towards a Common Lexicon for Equity, Diversity, and Inclusion Work in Academic Medicine”). The publication serves as a crucial glossary to define relevant terms to ensure a common meaning. Terms such as implicit bias, disparities, structural racism, microaggressions and more are explained in a manner that can be understood across academic medicine. The article highlights the importance of vernacular in academic medicine. This understanding of health equity terms is foundational to directional strategy of AMCs, as mission, vision, and values demand precise and shared knowledge of these terms to communicate the organization’s goals.

The language used in these statements convey the importance of the issue to the healthcare organization as described in “How Do We Define and Measure Health Equity? The State of Current Practice and Tools to Advance Health Equity.” Table 1 provides a basis for language surrounding the topic. The study did a scoping review revealing how peer-reviewed literature, web sites, and state health department plans express health equity in various terms.
Table 1: Health Equity Definitions

<table>
<thead>
<tr>
<th>Concepts</th>
<th>Example Verbatim Text From Definition</th>
</tr>
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| Highest level of health for all people | “Attainment of the highest level of health for all people”  
|                               | “Highest possible standard of health for all people”  
|                               | “Highest level of health”  
|                               | “His or her full health potential”  
|                               | “As healthy as possible”  
|                               | “Optimal health” |
| Opportunity                  | “When every person has the opportunity to attain...”  
|                               | “Everyone has a fair and just opportunity...”  
|                               | “When everyone has the opportunity to be...”  
|                               | “The equal opportunity for All Americans...” |
| Absence of disparities       | “Absence of unfair and avoidable or remediable difference in health...”  
|                               | “Absence of disparities or avoidable differences...” |

This article reiterates that “understanding common concepts and language used to define health equity can help advance efforts and collaborative action to improve health and well-being for all…one risk of ambiguity in definitions of health equity and health disparities is misdirection of limited resources away from the populations and groups that are disadvantaged” (Hoyer et al., “How Do We Define and Measure Health Equity?”). With an understanding of how health equity is defined in various forms, AMCs can adjust their directional strategy to include these terms in their mission, vision, and values.
4.0 Census Case Study

While the various ideologies and terms for health equity are straightforward, AMCs are affected geographic and socio-political influences that complicate health equity implementation. This case study focuses on major AMCs from the Midwest, Northeast, West, and South as shown in Figure 1. The inclusion of health equity, or lack thereof, in their mission, vision, and values may speak to the region's beliefs and health priorities. Ultimately, the case study demonstrates how major AMCs include health equity in their directional strategy to close gaps in the U.S. healthcare system.

Figure 1: Regional Map
4.1 Midwest

The example state for the Midwest is Minnesota. Despite Minnesota being ranked one of the healthiest states in the country, data reports reveal that marginalized populations lack opportunity and proper treatment for health. According to the 2022 United States Census, Minnesota is 86.6% white (“U.S. Census Bureau QuickFacts”). The Minnesota Department of Health released a report addressing the most pressing health inequities facing minorities, in which the following data was concluded: “African American and American Indian babies die in the first year of life at twice the rate of white babies. While infant mortality rates for all groups have declined, the disparity in rates has existed for over 20 years” (“Advancing Health Equity in Minnesota”)

This complex issue is being addressed at a prominent AMC in the Midwest region. Mayo Clinic Rochester is a single branch of the world renown leader in healthcare, serving as one of the most advanced and well-regarded AMCs in the United States. Their mission statement is “Inspiring hope and promoting health through integrated clinical practice, education and research.” Their vision is “Transforming medicine to connect and cure as the global authority in the care of serious or complex disease”(“Mayo Clinic Mission and Values”). While these statements do not directly highlight health equity is a goal for their directional strategy, their value of respect, defined as “[to] treat everyone in our diverse community, including patients, their families and colleagues, with dignity” clearly incorporates inclusive language suggesting their focus of health equity. This priority is again reflected in their strategic initiatives such as “Category of One” and “One Mayo,” which strive to better incorporate equity across research, education, and clinical practice within the organization. The push towards health equity is often associated in health organizations with liberal ideologies such as Mayo Clinic. This aligns with Minnesota’s consistent liberal voting
patterns during presidential elections. Interestingly, many Midwestern states do not share these political beliefs, as many states tend to vote conservatively. This may suggest that Mayo Clinic’s prominent health equity priorities may be siloed within Minnesota, as their political beliefs differ from surrounding states.

4.2 Northeast

The example state for the Northeast is New York. The state’s Department of Health demographic report revealed “Compared to the United States population, New York has a greater proportion of Black non-Hispanics (14% vs. 12%), Hispanics (19% vs. 18%) and Asian non-Hispanics (8% vs. 5%). Accordingly, the proportion of the population that is White non-Hispanic is lower in New York State than in the United States (56% vs. 61%)” (“Description of Population Demographics and General Health Status, New York State, 2018”). The same report found disparities such as “In 2015, the Black non-Hispanic infant mortality rate (9.1 per 1,000 births) was twice or more the rate of the other groups, except just under twice the rate among American Indian/ Alaskan Native”. This data reveals that despite having a higher percentage of racial minorities compared to the national average, New York state still faces health inequities among marginalized groups. This reality is reflected in the goals of healthcare in the region.

NYU Langone Health is a prominent AMC in the Northeast that prides itself on its health equity innovation and commitment. Their trifold mission is “to serve, teach, and discover is achieved daily through an integrated academic culture devoted to excellence in patient care, education, and research” (“Our Story”). The organization’s values are Performance, Respect, Integrity, Diversity, and Excellence. In the code of conduct, diversity is defined as “Create a
community of cultural competence and opportunity by embracing a wide breadth of resources, skills, ideas, and knowledge.” The inclusion of this language displays that NYU Langone is aware of the wide array of cultures within their patient population and aims to meet their unique needs through health equity. With New York representing a larger portion of minority patients compared to other major AMCs, as well as their strong liberal stances, NYU Langone certainly upholds a high standard for health equity. NYU shares similar health goals and political sentiments to other AMCs within the Northeast, likely making it representative of the region.

4.3 West

The state representing the west is California. The U.S. Census Bureau describes the state at 70.7% white, 16.3% Asian, 40.3 Latino/Hispanic, and 6.3% Black. The same report revealed:

“In California, the uninsured rate among Latinos in 2011-2012, 28 percent, was almost double that among the White population. From year to year, the largest disparities in access to care and quality of care nationally are for Spanish speaking Latinos, a fact that points to the critical importance of access to health insurance and linguistically and culturally appropriate care” (“U.S. Census Bureau QuickFacts”). Similar to New York, California’s large minority population still faces health disparities in accessing and affording care. California addresses this issue through its inclusive healthcare organizations.

Cedars-Sinai is a leading academic medical center in Los Angeles. Their mission statement reads “As a leading academic healthcare organization, our mission is to elevate the health status of the communities we serve. We deliver exceptional healthcare enhanced by research and education. We prioritize high-quality care for all with equity and compassion...” (“Our Mission,
Vision and Values | Cedars-Sinai”). Cedar Siani is the first organization that directly calls out equity within the mission statement in this case study, demonstrating their commitment to diminishing disparities.

The vision statement further defines their goals to be “trusted and respected worldwide, Cedars-Sinai will advance health and healthcare in Los Angeles and beyond.” The website also highlights their value in “Diversity, Equity, and Inclusion: We celebrate the richness of human diversity in an inclusive environment in which all stakeholders participate to build a better future.”

This organization spotlights health equity multiple times throughout their directional strategy. Considering the diverse community and liberal stances on social issues, it is no surprise this organization repeatedly acknowledges the topic in their directional strategy. These beliefs echo across the region in political and health spaces, indicating that Cedars-Sinai’s emphasis on health equity may be representative of the region.

4.4 South

The state representing the south is Texas. Due to lack of recent reports on statewide health disparities, which may reflect how the state prioritizes the issue, a Houston city report will be used in the case study. According to the latest Houston Health Department’s Health Equity Reports “African Americans in 2017 had the highest mortality-adjusted rates for heart disease compared to other racial and ethnic populations in Houston (185 per 100,000 population for African Americans, 157.1 per 100,000 population for non-Hispanic whites, and 83.3 per 100,000 population” (“Population Health Issues | Houston Health Department”). Additionally, data from
the 2018 Health of Houston Survey shows 48% of the Houston area Hispanic population remains uninsured (“HOUSTON HEALTH HIGHLIGHTS Sept 2019”).

Serving this population facing great disparities is Houston Methodist Academic Medical Center. Houston Methodist’s mission is “To provide high quality, cost-effective health care that delivers the best value to the people we serve in a spiritual environment of caring in association with internationally recognized teaching and research.” Their values are:

“Integrity-We are honest and ethical in all we say and do.

Compassion -We embrace the whole person and respond to emotional, ethical, and spiritual concerns as well as physical needs.

Accountability - We hold ourselves accountable for our actions.

Respect- We treat every individual as a person of worth, dignity and value.

Excellence - We strive to be the best at what we do and a model for others to emulate.”

Unique in comparison to previous AMCs, Houston Methodist has no mention of health equity or similar terminology found throughout the mission or values. This poses a question to whether the institution prioritizes health equity through their clinical, educational, and research goals. The lack of health equity goals at this organization and scare state reports on the topic may reflect the states beliefs. Considering the political climate of Texas and surrounding conservative states, this finding may reflect a regional attitude towards the significance of health equity.
5.0 Conclusion

This paper aimed to analyze AMCs’ directional strategies for health equity. Through this process, the paper acknowledges the contributions of AMCs to the U.S. health system and public health advancements. The literature review highlighted frameworks such as quintuple aim, discussed relevant terminology, and described practical ways to increase health equity. The case study revealed the complex reality of implementing health equity at AMCs, considering geographic and sociopolitical factors. The four organizations showed patterns that might be reflective of their regions’ attitudes towards health equity. Overall, this paper demonstrates how AMCs can prioritize health equity in their directional strategy to close gaps in the U.S. healthcare system.


“Description of Population Demographics and General Health Status, New York State, 2018,” n.d.


