A MANIFESTO FOR HOSPITALS

Actions towards holistic and equitable community health

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Given the current political climate in which progressive social goals feel increasingly under seige, we recognize that sectors driven by social missions must fortify their efforts and stand their own ground against the injustices and oppression being daily perpetuated by our federal administration. Hospitals are perfectly poised to be powerful change makers. Rooted permanently into place, hospitals are anchor institutions that have deep social and economic ties to the communities they serve. They are collaborators, investors and engagers, prominent community hubs and economic engines. Currently, there are approximately 5,500 hospitals in the United States, 3,000 of which are non-profits.1 As major employers, produces and consumers, hospitals support over 16 million jobs nationally and purchase nearly $852 billion in goods and services, contributing nearly $2.8 trillion in economic activity.2 Increasingly some hospitals have been cultivating their social capital, and expanding institutional capacity and transparency through relationship building and community engagement. Many are taking the lead as vital centers of community strength, compassion and resiliency in times of disaster. When hospitals strengthen and expand the role they play in their communities, they can start to impact community health in meaningful ways by caring for the factors that are at the root of wellbeing.

First introduced by the World Health Organization in 2003, it is now globally acknowledged that economic, social, and environmental conditions influence health outcomes.4 Social determinants of health are defined as “conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.”[5] The accessibility of affordable housing, public transit, quality education, green space, healthy food, and economic mobility determine an individuals’ health outcomes and wellbeing. The trauma, stress, and stigma experienced as a result of poverty, individual and systemic racism, discrimination, and structural oppression all affect health outcomes as well. Low-income communities and communities of color bear bigger burdens of inadequately distributed resources and suffer from worse health outcomes than their wealthier, white neighbors.[6]

Research shows that medical care accounts for only 10% of health outcomes, while social determinants of health account for roughly 70%. Yet, 96 % of our national health expenditures are focused on medical care, and only four percent are dedicated to preventative measures.[7]

Our nation’s healthcare system has been confronted with a triple threat in the past few years. Not only do we have the highest per-capita healthcare spending in the world, we have relatively poor health outcomes and persistent racial, ethnic, and socioeconomic disparities in health and healthcare.[8] The situation is only expected to worsen as the neoliberal, individualistic Trump administration turns its back against progressive public health policies. The planned Medicare and Medicaid reforms and budget cuts to social services and mental health programs are expected to decrease insurance rates and increase homelessness and incarceration.[9, 10]

These issues, coupled with the nation’s current opioid epidemic, exceedingly high rates of obesity and chronic disease, and the growing number of individuals experiencing anxiety from politics, climate change and the recent surge in mass shootings puts our healthcare system in crisis. As anchor institutions, hospitals have a moral and medical interest in curbing these massive public health threats. Recent changes in policies surrounding nonprofit hospitals’ community benefits standards have begun to aid this mission, pushing hospitals to the front lines of community change.

The passing of the Affordable Care Act in 2010 and recent reforms made to the IRS community benefit standard – which has required hospitals to declare their benefit to the community since the 1950s– freed up funds previously allocated for charity care, standardized federal requirements, and organized community benefit documenting.[11] As of 2011, tax-exempt hospitals have been encouraged to pursue community building initiatives that address “upstream” factors and social determinants of health like physical improvements, economic development, housing, coalition building and workforce development.[12] Regular community needs assessments and implementation plans are now required in order to encourage community partnerships and improve the impact of hospital community benefits spending. Furthermore, the department of health and human services has been moving Medicare towards alternative, value-based payment systems since 2015.[13] In 2016, the Center for Medicare and Medicaid Services debuted their Accountable Health Communities Model, a five year pilot project that enhances clinical-community partnerships in addressing health related social needs like violence intervention programs, food access and transportation to improve health outcomes and decrease costs.[14]

These advancements have opened the door for hospitals to work in collaboration with their surrounding communities to mitigate the impacts of the social determinants of health, and have given nonprofit hospitals the tools to embrace and strengthen their anchor missions. Though the revisions to the IRS’s community benefits standards increasingly focus on population health by addressing social needs charity care continues to be the major focus of community benefit spending overall.[15] In 2010, recorded community building activities (which includes physical improvements and housing, economic development activities, training in conflict resolution, civil, cultural, or language skills, safe removal or treatment of garbage and waste, etc) represented a mere 0.1% of community benefit spending overall.[12] We are at a critical juncture; despite continuing assaults against community health, we can see hope moving forward if hospitals are able to radically expand their approach to community building.

VISION

What you see before you is a guide for allies and advocates within hospitals who are dedicated to community health. The categories of oppression outlined are distinct, yet intersectional, and require multifaceted approaches. The stated directives call for action, advocacy, education, and policy changes across institutional, neighborhood, city, state, federal, and socio-cultural scales. They are ideas to bring to those in leadership positions, empower individuals to recognize the systems that perpetuate the inequalities highlighted here, and encourage initiatives to prioritize the most marginalized peoples interacting with the U.S. hospital industry. within the United States.

Examining hospitals' current community benefit practices, we believe that they must expand and deepen their understanding of community development. We encourage hospitals to break stagnant cycles of charity, extraction, and disproportionate investments in their communities that have been the status quo. We call upon hospitals to leverage their significant financial power and political voices as anchor institutions to eliminate the values and practices of capitalism, patriarchy, neoliberal individualism, colonialism and white supremacy embedded in the healthcare industry.

With the shifts in growth strategies and corporate values presented here, hospitals can center the needs of, elevate the voices of, and correct for the historical injustices and neglect imposed upon society's most vulnerable and marginalized groups, including persons of color, women, queer, trans, femmes, gender nonconforming, formerly and currently incarcerated, non-western religions, cash poor and working class, differently abled, mentally ill, undocumented, and immigrants.

Primum non nocere

RECOGNITION OF PAST INJUSTICES


The New York Times

Syphilis Victims in U.S. Study Went Untreated for 40 Years

By JEAN HELLER
The Associated Press

WASHINGTON, July 25—For 40 years the United States Public Health Service has conducted a study in which human beings with syphilis, who were have serious doubts about the morality of the study, also say that it is too late to treat the syphilis in any surviving participants.

Many of today's widespread disparities in health outcomes and accessibility to care can be traced to medicine's long and silenced history of racial and gender discrimination, exclusion, and exploitation. Legacies of the slave trade's commodification of black bodies and Jim Crow era laws are still plaguing the American healthcare system, yet these histories and inherited traumas are rarely acknowledged.

Advances in cancer research owes much to the cells of Henrietta Lacks, which were used without her consent or compensation. Though the industry has acknowledged the importance of her cells and the mishandling of her rights, her surviving family has still never received a penny for the decades of medical advancements that have been built upon the extraction from her body.[1] The horrific realities of Tuskegee Syphilis Experiment, where between 1932 and 1972, nearly 400 poor and mostly illiterate black sharecroppers were subjected to the longest human study in medicine's history without informed consent nor treatment when penicillin became the drug of choice for syphilis in 1947.[2] The study has long been seen as a root cause of mistrust and fear felt by communities of color towards the healthcare industry and has been cited as a reason for black patients refusing participating in clinical trials or organ donation.[3]

The LGBTQ community has been subjected manipulative and discriminatory attempts to pathologize of sexuality. Until 1973 homosexuality was listed as a disorder in the Diagnostic and Statistical Manual of Mental Disorders and LGBTQ individuals have been the victims of conversion therapies which have gone as far as electroshock treatments and castration.[4] To this day, conversion therapy is only formally banned in 10 states.

Hospitals have been and continue to be forces of urban displacement and gentrification. For example, in Portland, Oregon the Legacy Emanuel Hospital expansion plans in the 1960s leveraged urban renewal mechanisms that resulted in the razing of over 300 homes and businesses in the heart of the city's black business district.[5] Today, the neighborhood is one of the overwhelmingly white city's most gentrified.

Birth control, often placed on a pedestal as landmark victory of early feminism, is deeply linked to a history of violent exploitation of black bodies, including the forced sterilization of poor black women and experimental hysterectomies performed on black women without consent – a practice that in the was so prevalent in the American South that it garnered the nickname "Mississippi appendectomy."[6]

Acknowledgment of these past harms has occurred. Emanuel Hospital now has a permanent exhibition in its atrium detailing the neighborhood's history and the hospital's role in devastating it.[5] In 1997 President BIll Clinton, in the presence of the last five living survivors of the Tuskegee experiments issued a national apology.[2] However, for every injustice that has been acknowledged, hundreds go unremembered, and for every apology given, millions of Americans still live in a world where they are denied equal care or shoulder the disproportionate effects of chronic illnesses that are more the result of their zip code than anything.

Discussions of reparations must go beyond apologies for past injustices, including but not limited to inhumane medical experimentations, forced sterilization campaigns against poor women and black women, exclusion from medical schools and professional appointments, denial of care for people of color, colonization of tribal groups, conversion therapy, and mass displacement at the hands of institutional expansion efforts. These injustices have produced the very disparities in health outcomes and accessibility to care for that hospitals are now confronting through their community investment strategies. Hospitals must acknowledge and reconcile the fact that they played a major role in created these conditions from the onset and account for the healthcare industry's roots in white supremacy, colonialism, and misogyny if they are to appropriately fulfil their missions to provide exceptional care and improve the lives of patients.

RACIAL JUSTICE + CULTURAL COMPETENCY

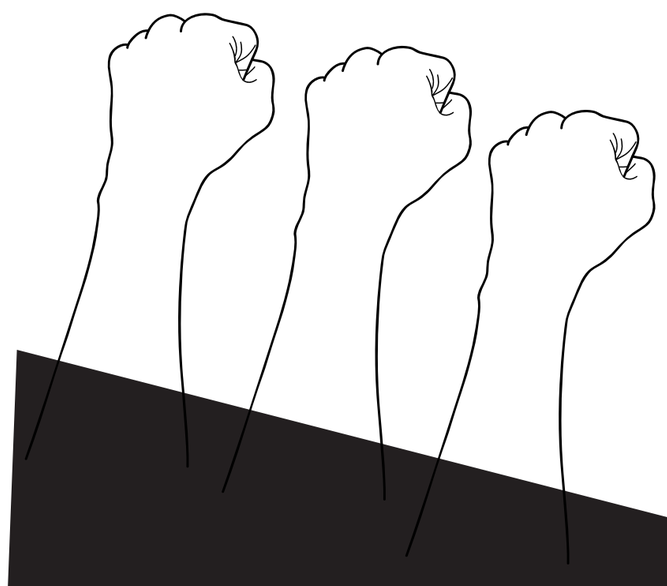
Fifteen years since the Institute of Medicine's landmark report, *Unequal Treatmen*t, racial and ethnic disparities continue to persist throughout hospital care[1]. The differences in access to and utilization of health services between racial and ethnic populations have been accepted as the status quo for far too long. The disparities in health outcomes between white and nonwhite patients are at essentially the same levels as 50 years ago even though overall American health has improved.[2,3,4]

Internal hospital goals and policies must explicitly aim to incorporate larger external fights against the oppression of marginalized people and recognize coinciding forces of prejudice and discrimination, from structural and institutional racism to implicit bias in treatment and diagnosis.

Factors influencing the differences in access to and utilization of care span from the availability of affordable transportation options, language barriers, mistrust between providers and patients, lack of provider diversity, inadequate cultural competency, and the unavailability of linguistically appropriate care options.[4a]

Once in the hospital, well documented disparities persist in quality of care. Studies have shown that even when they have the same type of insurance and the ability to pay, minority patients receive a lower quality of care that non-minorities.[5] According to the National Healthcare Disparities report, black patients were still receiving worse care than white patients for 40% of quality measures in 2012.[5] People of color receive unequal treatment for pain, asthma, heart disease, kidney disease, cancer, transplants, amputations and childbirth[1,4,6,7,8] black men are up to 30% less likely to receive diagnostic tests such as cardiac monitoring and chest x-rays than white men.[9] Black mothers in the U.S. die at three to four times the rate of white mothers.[7] Two-thirds of medical professionals display unconscious racial bias.[10]

Healthcare providers have a duty to not only recognize how these inequalities severely compromise their mission to provide exceptional medical care to all, but must acknowledge and deeply work to change their own roles as players in perpetuating these inequalities subconsciously.



DIRECTIVES

End racial disparities in quality of care received by patients of color and minority ethnic populations. Comprehensively educate medical students and practicing physicians about the racial biases in care engendered in medical school which persist throughout the industry. The American Medical Colleges and America's Essential Hospitals' 'national call to action' is an example of how those within healthcare industry are working to eliminate disparities and increase diversity throughout the system (*visit: www.equityofcare.org*).[11] The Implicit Association Test aims to make care providers understand and confront racial and ethnic biases (*visit implicit.harvard.edu/implicit*).

Ensure culturally appropriate healthcare that acknowledges all patients' agency to say what level and type of care their bodies need while validating concerns of individuals who are not accustomed to Western medical traditions.[4b] The Lowell Community Health Center in Lowell, MA has become a leader in culturally competent care since the opening of the Metta Health Center in 2000, one of the nation's first "east-meets-west healthcare facilities," offering culturally competent care for the city's large Cambodian population.[4c]

Enhance equity in physical access to and utilization of care. Fight to increase funding for the Community Health Center Fund from the Bipartisan Budget Act of 2018. As of 2016, 25.9 million relied on the 10,400 urban and rural community health centers for medical care, yet they are most at risk of suffering from a loss of funding or inadequate resources and the need for more is grave the unmet need is still enormous.[12] Financial restrictions limit the addition of new centers and capacity of existing ones.

Publicly stand against the substandard treatment allowed under the Federal Health Program for American Indians and Alaskan Natives. Actively campaign for a competent permanent director for the program. The Trump administration is advocating for a shift in Indian health programs which would result in the loss of millions of dollars to the Indian Health Services and destroy treaty rights. Hospital professionals within and beyond the Indian health programs must unite against this.[13]

GENDER EQUITY + REPRODUCTIVE RIGHTS

The widespread gender biases and discrimination experienced by female patients and medical staff undermine hospitals' missions and values. Despite the fact that he number of women matriculating in U.S. medical schools exceeded the number of men for the first time in 2017, female physicians and surgeons still earn 62¢ for every $1 earned by men.1 In an industry where eight out of ten support workers are women, nearly 9 out of 10 hospital CEOs are men. Not only are women working in hospitals paid less, they are treated worse in the workplace. One in three women physicians are harassed in their medical training or the workplace.[1]

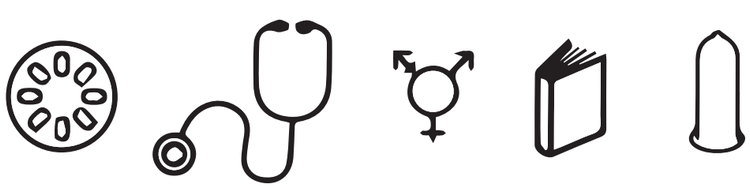
As patients, women face unequal insurance costs and coverage of medicine, gender bias and stereotypes in treatment and diagnoses, and exclusion from research and drug trials. While women overall report more severe levels of pain, more frequent incidences of pain, and pain of longer duration than men, they are treated for pain less aggressively until they "prove that they are as sick as male patients."[2] Implicit biases and gender stereotypes also impact the kinds of treatments recommended to female patients by their doctors. According to a study on patients with irritable bowel syndrome, male patients were more likely to be given X-rays while females were offered tranquilizers and lifestyle advice.[3]

Women of color, women living without shelter, and low-income mothers face exacerbated health challenges including menstrual care, childbirth complications, and discrimination from care providers. In a collection of over 200 stories from black mothers, ProPublica and NPR report that the feeling of being devalued and disrespected by medical providers as well as receiving worse care was prominent.[4] Black mothers die in childbirth at a rate three to four times higher than white women, even when controlling for income.[4] Black and low income women are also the most likely to report wanting but not being able to access doulas.[5]

Women have historically been excluded from toxicology and biomedical research which impacts how medical professionals understand the ways drugs and treatments will affect bodies differently. Cardiovascular disease is the number one killer of women in the U.S., yet research shows that only one third of cardiovascular clinical trial subjects are female and only 30% of clinical trials that do include women report the results by sex.[6]

Gender inequity in healthcare is also manifest in the war waged on women's reproductive rights at the local, state, and federal levels. Denying women the right to safe and legal abortions forces many to confront a wide range of health risks and personal dangers.

In order to uphold a commitment to practicing good medicine and saving and improving lives, medical professionals must unite to dismantle gender discrimination in pay, treatment, and medical care.[1]



DIRECTIVES

Eliminate the gender pay gap in hospitals. The discrepancy between female and male doctors has only been growing wider and this cannot be ignored nor tolerated.

Respond to the voices of the #MeTooInMedicine movement. Hospitals must join in this movement and declare zero tolerance for sexual harassment both publicly and within the walls of every department. Institute firm and transparent policies that elevate voices of victims and punish offenders.

Implement systems-wide gender bias trainings and mandatory procedural checklists. By requiring a simple gender bias checklist, John Hopkins Hospital was able to eliminate gender bias in blood clot treatment after recognizing that female trauma patients were disproportionately dying because they were under treated with preventative medication. If this kind of checklist could be applied to broader gender disparities in hospitals, massive structural change is within reach.

Guarantee that Doula and midwife care is equally accessible, billable to insurance, and covered by Medicaid. Recent findings have shown that doula care can reduce cesarean and preterm births and improve birth outcomes.[7] Access to lifesaving maternal care should not be accessible only to those with higher social and material capital.

Openly discuss and commit to action plans to address recent findings on the disparities in black infant and maternal mortality. The April 2018 New York Times report "Why America's Black Mothers and Babies Are in a Life-or-Death Crisis" details some of these findings.[8]

Ensure fair and appropriate inclusion of sexes and genders in all stages of clinical medical research. The Society for Women's Health Research (visit *SWHR.org*) is a national nonprofit dedicated to promoting research on biological differences in disease and advancing women's health. They provide resources and advocacy toolkits on furthering the inclusion of women in all phases of clinical trials, increasing funding for women's health research and advancing the study of biological and physiological differences between the sexes.

Demand reform on policies designed to attack women's right to a safe and legal abortion, including but not limited to the Global Gag Rule, H.R. 7, the Life at Conception Act of 2017 the fetal heartbeat law.

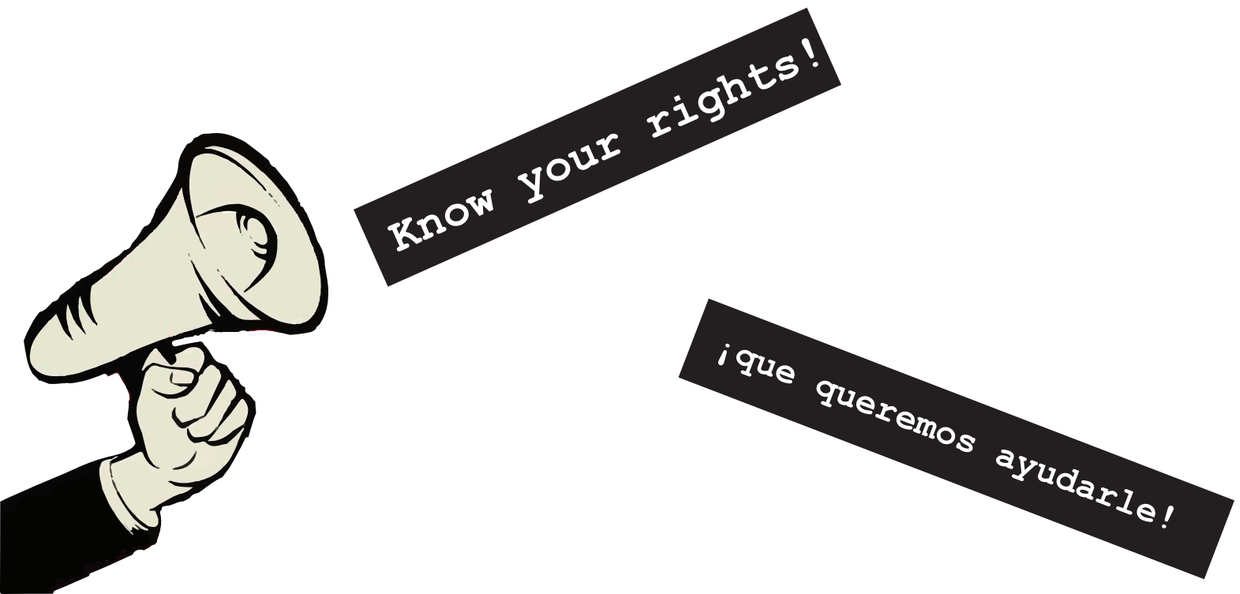
IMMIGRANT & REFUGEE RIGHTS

Although hospitals are by law required to treat any patient regardless of immigration status, and are prohibited from sharing personal health information patient information with enforcement officers under the Health Insurance Portability and Accountability Act of 1996, hospitals have become places of extreme fear for undocumented individuals living in America.[1] The Trump administration has threatened to roll back Obama era protections that prohibited arrests in sensitive locations including schools, hospitals and churches. Hospitals and health clinics have increasingly been targets of Immigration and Customs Enforcement (ICE) raids.[2]

Protecting patients from the risks of these enforcement tactics goes beyond a moral obligation, although it shouldn't have to. Creating a society where undocumented immigrants stop seeking the preventative and emergency care they need is a serious public health threat and could take a significant toll on taxpayers. This poses particular threats to the children of immigrants. In the past year, pediatricians have reported more children with sleep and eating disorders, anxiety, depression and stress. They have attributed this directly to Trump's policies and the federal administration's public attitude.[3] There is also an increased risk of children having critical appointments cancelled or going unvaccinated due to parents' fear of seeking care, posing a massive risk to wider community health.[3] Healthcare is a human right, yet people are forced to choose between the treatment they need or being deported.[4]

The integrity and quality of the medical profession and its ability to provide the best care is also threatened by these xenophobic policies. Most large hospitals are staffed by immigrant medical professionals from around the world. Trump's 2017 travel ban has already negatively impacted the medical profession in practice and research. About a 25% of all physicians in the U.S. have medical degrees from abroad and 18% of academic physicians were born abroad.[5] Foreign born physicians are also more likely to practice in rural areas and serve as geriatricians suggesting that if our country is unwelcoming to global practitioners, our rural and elderly populations risk losing care providers.[6] In light of the growing physician shortage, our hospitals need immigrant medical professionals and policies in place to support their permanent residency in the U.S.

Refugees and asylum seekers may also feel unsure of their protections and rights within the walls of a hospital, despite having arrived through a lengthy legal process including medical screenings. The bureaucratic nature of the American health system and the type of care provided can be culturally disorienting. Hospitals should be community anchors for refugees and asylum seekers to find care and support, yet often lack the cultural sensitivity, language services, and adequate understanding of different cultural traditions that may require specialized medical care (for example, female circumcision).[7]



DIRECTIVES

Refuse to stand for ICE raids within hospitals and community health centers, as well as on or near hospital property, including parking lots. All hospital staff should be trained to refuse to provide any patient information or grant access to any non-public areas to enforcement agents. See the National Immigration Law Center's resource page (visit *www.nilc.org*) and the Immigrant Defense Project's "#stopICEcold ICE Raids Toolkit" (visit *www.immigrantdefenseproject.org/raids-toolkit*). Both offer critical information regarding our country's detention and deportation system and guidance on how to prepare for ICE raids.

Conduct public awareness campaigns to inform patients of their rights and ensure them that their information will be protected and that they are safe seeking care or visiting loved ones at the hospital. Visibly display know your rights materials throughout hospitals and community health clinics in all languages representative of the community

Advocate for policies against immigration restrictions and travel bans that limit the ability of hospitals to staff international medical professionals and researchers that are crucial to the advancement of care for all.

Address a lack of cultural understanding that may compromise the health needs of recently resettled refugees. Partnership and coalitions that include hospitals and refugee resettlement agencies can provide a coordinated system of culturally and linguistically appropriate care for refugees. The Philadelphia Refugee Health Collaborative, formed in 2010, is a partnership between three resettlement agencies and eight refugee health clinics. As Dr. Marc Altshuler, director of one of the clinics states, "Everyone really put the competition aside to do what's right and what's best for our patients."[8]

REFORM NOT RAIDS

LGBTQ INCLUSION AND PROTECTIONS

Bias against LGBTQ individuals in hospitals continue to affect health-seeking behavior and access to care, causing multiple health disparities and exacerbating stigmas. Currently, LGBTQ populations suffer from higher rates of depression, suicide, substance abuse, depression, anxiety, homelessness, HIV and other STDs, hepatitis B, and lower rates of mammography and Pap smear screening than heterosexual populations.[1]

Expected and experienced discrimination deter LGBTQ persons from seeking routine care and care refusals leave individuals vulnerable to serious emotional, physical, and financial consequences. The U.S. Transgender Survey reported that one in four transgender people avoided seeking needed medical care in 2014 due to fear of discrimination or mistreatment due to their gender identity.[2] In 2017, a survey conducted by the Center for American Progress reported that 8% of LGBTQ respondents experienced care refusals from medical professionals due to their actual perceived or perceived sexual orientation, and 29% of transgender respondents reported this type of refusal.[3]

Dismissal of specific health issues and a lack of LGBTQ cultural competency within a hospital setting also impact patient-provider relationships. A JAMA study on 137 medical schools found that, on average, doctors receive a mere five hours of LGBTQ specific training throughout their medical education.[4] Special attention must be given to LGBTQ youth, who are 120% more likely to experience homelessness, exhibit higher rates of mental health and behavioral issues, and have a higher chance of engaging in substance abuse and survival sex than non-LGBTQ youth.[5,6,7]

Though recognition of and support for LGBTQ communities contintues to improve with the national legalization of same-sex marriage and the ending of Don't Ask/Don't Tell, there is much work to be done. For example, as of 2017, only 10 out of 50 states had laws banning conversion therapy for minors[13].

It is imperative that hospitals enhance their support of the LGBTQ community inside hospital walls by standardizing culturally-affirming and informed health care while standing in defiance to political threats against LGTBQ persons in the United States.

DIRECTIVES

Require all medical schools to incorporate LGBTQ and sexual minority specific health issues and cultural competency into their curricula in order to receive accreditation from the Accreditation from the Council for Graduate Medical Education. The Association of American Medical Colleges provides resources for "implementing curricular and institutional climate changes to improve healthcare for individuals who are LGBTQ, gender nonconforming, or born with DSD," and the Transgender Health ECHO Project trains healthcare teams to better support transgender and gender nonconforming patients.[8,9]

Demand the Joint Commission to require hospitals to have a written patient and employment non-discrimination policy outlining their non-discrimination standards that include both sexual orientation and gender identity.[10]

Provide access and assistance with social services that mitigate mental health and homelessness for LGBTQ populations with special attention to youth vulnerability.

Ensure hospitals are equipped to provide inclusive care that addresses behavioral health, HIV prevention and transgender medical needs. Collect more Sexual Orientation and Gender Identity (SOGI) data within hospital settings and require the inclusion of SOGI-targeted questions on surveys to increase nationally representative data on LGBTQ community members.

Advocate for federal funding to support the Human Rights Campaign's Healthcare Equality Index (visit *hrc.org/HEI*), a benchmark tool that evaluates policies and practices related to the equity and inclusion of their LGBTQ patients, visitors, and employees. The LGBTQ policies and practices of Mount Sinai Health System in NYC and others who have been named *Leaders in LGBT Healthcare Equality* serve as examples for successful strategies.[11]

Denounce the Trump administration's lawsuit against the U.S. Department of Health and Human Services challenging Section 1557 of the Patient Protection and Affordable Care Act, which prohibits discrimination on the basis of gender identity. Stand against the creation of the Conscience and Religious Freedom Division within the DHHS that imposes a broad religious refusal policy.[12]

Demand a federal ban on conversion therapy. As of 2017, only 10 out of 50 states have laws banning conversion therapy for minors. See the Movement Advancement Project's reports and maps on existing conversion therapy policies (visit *www.lgbtmap.org/conversion-therapy*).[13]

WORKFORCE DEVELOPMENT

Nationally, hospitals directly employ more than 5.7 million people and support 16 million jobs indirectly.[1] Although hospitals contribute significantly to the U.S. economy and workforce, labor shortages are threatening access to medical services and quality of care. Supply issues stemming from institutional barriers and retiring medical professionals cannot keep up with the demand for medical services from our growing and aging nation. The Association of American Medical Colleges warns of a nation-wide shortage topping upwards of 120,000 physicians by 2030.[2]

In addition to improving options within the professional educational pipeline, hospitals must address local employment concerns and capitalize on community assets. Often hospitals are one of the largest employers in their communities, making them uniquely positioned to transform neighborhoods by adopting inclusive local hiring and improved workforce development as central pillars in their plans. Workforce development requires attention to factors that include external stressors like housing and food insecurity as well as broad policy reforms that enhance financial security.

Diversity in hospital workforces needs to be prioritized. A 2013 survey found that even though minorities represent over 30% of patients in U.S. hospitals, they constitute 14% of board members, 12% of executive leadership positions and 17% of first- and mid-level management positions.[3] Five national health associations released a statement calling on hospitals to increase the diversity of their board members in 2011, yet board member diversity stayed the same or declined by 2014.[4] Diversity in hospital workforce is of the utmost importance for the advancement of population health and promoting environments that are less likely to suffer from racial bias.

Hospitals present myriad unique workplace hazards that affect workers throughout the system and create a deeply ironic environment of poor health. Hospital workers face risks including exposure to infectious diseases and toxic substances - including the chemicals that cleaning staff is regularly in contact with - physical and emotional stress, violence in the workplace, and unsuitable working hours. Many of these risks are disproportionately experienced by lower wage workers and nurses. The dangerous work culture perpetuated in the medical community "remains without parallel in the modern American economy."[5] Residents commonly work 80 hours a week and a single shift can span 28 hours. Despite a public opinion poll where "80 % of those surveyed said that they would request a new doctor if they knew their physician was on the tail end of a 24-hour shift" these practices are still the norm and this culture is still sanctioned by these powerful institutions.[5]

One third of the workforce in America's hospitals are non-medical positions. Although the average salary in hospitals is $48,013, top surgeons can make as much as $200,000 a year, while childcare workers, who are on average the lowest paid hospitas workers, make roughly a tenth of that at an average salary of $21,797.[6] Hospitals rely on a network of frontline workers and support staff including food service workers, technicians, janitorial staff, and home health aids who are often found struggling to afford even their own healthcare.[7] All hospital jobs should be living wage jobs. Hospitals have a stake in improving the economic outcomes and living wages for those outside of their own workforce as well. When patients don't have the financial ability to manage illnesses at home, afford prescriptions, or can't take time off of work to take themselves or their children to necessary medical appointments, public health suffers and hospitals end up spending more on emergency care services. Economic standing is arguably one the most prominent indicators of health in America. Since the 1970s, differences in lifespan after age fifty between the richest and the poorest individuals has more than doubled.[8]

DIRECTIVES

- **Commit to inclusive, local hiring practices and internal pipelines for upward mobility**. The Democracy Collaborative's Hospitals Aligned for Health Communities workforce resource page includes a robust toolkit for building better "outside in" and "inside up" hiring and retention processes that center the needs of the most vulnerable residents of hospital communities (visit *hospitaltoolkits.org/workforce*).

- **Provide advanced tuition** (not just tuition reimbursement) for lower wage employees for training and career advancement opportunities. For example, the program at Children's Hospital Boston provides a pre-payment for college tuition for entry level workers seeking advanced credentials. See the recent policy brief from the National Fund for Workforce Solutions, "Employer-paid Tuition Advancement for Low-income Workers" for information on how these programs advance frontline workers and help hospital develop a stable workforce.[9]

- **Decrease the financial barriers to medical school** and improve pathways into medical professions for students from diverse economic backgrounds. Demand that Congress increase federal funding towards residency training and protect Public Service Loan Forgiveness.

- **Enhance diversity across all salary levels**. Ensure that institutional staff, committees and leadership boards reflect the diversity of hospital service areas. The Health Professionals for Diversity Coalition recently issued a statement on addressing the need for diversity in the healthcare workforce that should be followed.[10]

- **Refuse to accept housing and food insecurity amongst hospital support staff**. Proactively monitor these metrics and provide layered social services for employees within standard care benefits packages. Hospitals in Seattle offer employee housing and ProMedica in Northwest Ohio and Southeast Michigan launched their employee food assistance program in 2016 available to all hospital employees system-wide.[11,12]

- **Build cultures of health within the walls of the institution** by reducing exposure to toxins which disproportionately affect low-wage support staff and insist on human hours and suitable working conditions. Healthier Hospitals has a list of resources for adopting safer practices (visit *healthierhospitals.org*).[13]

- **Fight for livable minimum wage for all**. Hospitals are increasingly recognizing the benefits of economic justice for staff and patients alike. In 2017 Midwest hospital workers participated in the nationwide Labor Day protests demanding a $15 minimum wage and unionization rights.[14]

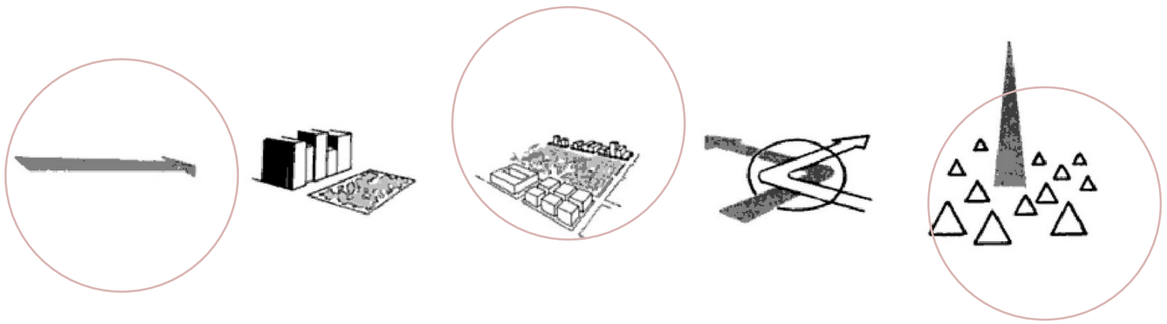
URBAN PLANNING DIRECTIVES

The relationship between the social determinants of health and the built environment is more widely understood now than ever before. Hospitals must partner in planning for these systems and move beyond the objective of their own institutional success. These planning efforts must involve dedication and collaboration across sectors that work on issues such as affordable housing and homelessness, access to schools and open spaces, access to unpolluted air to breath, fair transportation, planning for an aging population, and food systems. Further, as partners in the planning process, hospitals provide important connections to community members, insights into public health concerns and threats and an important channel of information to patients.

Gentrification is a public health issue. Studies show that gentrification leads to an increase in hospitalization for mental health related illnesses and, overall, residential instability has many detrimental effects on physical health.[1] Hospitals themselves are often major drivers of gentrification. They are major holders of land and capital and their constant expansion plans have a major economic and physical effect. Without careful involvement in planning processes, they are undermining their own mission to serve community health and improving the lives of their patients. For example, the Cleveland Clinic, touted as one of the greatest hospitals in the world, has consumed a 17-block stretch of its surrounding area while its neighbors continue to experience some of the most unjust living conditions and economic outcomes of the city.[2]

Even in the presence of available healthcare, many low income urban residents or people living in rural places do not receive the care they need due to a lack of transportation. Transportation investments and policies that privilege majority white, affluent communities leave society's marginalized groups vulnerable to negative externalities of infrastructure. The neighborhood of East Boston, for example, is exposed to the burdens of the city's most noxious transportation infrastructure and experiences a greater concentration of air pollution than other parts of the city.

Housing is a fundamental human right, yet about 11 million families — or about a quarter of all renters in the U.S .— spend more than half of their incomes on housing.[3] Conditions are only poised to worsen under Trump's proposed tax bill. A lack of affordable housing forces families to cut spending on healthy food, child care, transportation, and medical care, exacerbating the risks of eviction and cycles of homelessness. Shelterless individuals often have nowhere to turn for a place to sleep other than emergency rooms. Hospitals spend more on hospitals stays for patients without homes than they would if they simply provided them with free rent for a decent home.



Hospital strategic plans should guarantee that where you live does not determine how long you live. Create infrastructure that improves green spaces, safe streets, culturally relevant bike infrastructure, and better bus routes in all neighborhoods. In the early 2000s, Stamford Hospital began planning a major expansion. Through strategic cross sectoral partnerships, including with the local Housing Authority, they built an entire community, the Vita Health and Wellness District, centered on creating holistic conditions for community health (see *buildhealthyplaces.org* for a case study on Vita's impact).[4]

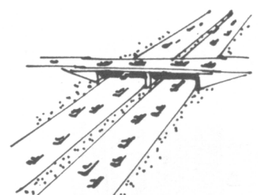
Housing is healthcare. Hospitals need to finance projects that build affordable housing and combat homelessness. If hospitals shifted to dedicating three percent of their annual community benefits spending to housing, it would equal the entire annual spending by the U.S. Housing and Urban Development agency on its homeless programs.[5]

Establish, support, and finance community land trusts for housing, farmland, and other land uses to protect against displacement and other negative externalities of growth, particularly that spurred by hospital expansion plans. Residents and planning activists from the Project for Public Good in Buffalo, NY outlined a plan for a community land trust in the Fruit Belt neighborhood where the major Buffalo Niagara Medical Campus expansions have brought increased burdens and pressures, but not many benefits to residents.[6]

Strengthen community food soverignty and food as medicine initiatives, including but not limited to VeggieRX prescriptions, on-property farmers markets, mobile markets, medically tailored meal deliveries for chronically ill patients. Wholesome Wave is a nonprofit with a national network comprised of over 1,400+ farmers markets, grocery stores, corner stores, farm stands, CSAs, hospitals and clinics that strive to create better integrated food systems planning and hospital healthcare (visit *wholesomewave.org*).

Advocate for policy that strengthens, not weakens, the federal Supplemental Nutrition Assistance Program (SNAP). Hospitals must pay careful attention to the Farm Bill.

Provide direct and free transportation services to urgent care and routine check ups. Lyft recently implemented a partnership giving doctors and hospitals the ability to arrange free rides for patients who cannot get to and from appointments.[7] This is a start, but better and more innovative strategies must be pursued that do not depend on a private corporation.



ENVIRONMENTAL JUSTICE

Climate change is one of the most pertinent public health concerns of the 21st century. It's estimated that the U.S. healthcare system was responsible for one tenth of all national greenhouse gas emissions in 2013.[1] As temperatures warm and climate patterns shift from rising CO2 levels in the atmosphere, the healthcare sector is bracing for inevitable health consequences from temperature related deaths, air quality impacts, extreme weather, vector-borne disease, water-related illness, food safety and nutrition, and mental health and well-being.[2] Unfortunately, these negative health impacts will disproportionately affect low-income populations, those already burdened the most by health disparities in the U.S..

Hospitals can recognize and decrease their contribution to climate change through infrastructure and systems improvements that reduce their carbon and water footprints and minimize solid waste. One study in the American Journal of Public Health estimated that the greenhouse emissions from the healthcare industry would be responsible for 123,000 to 381,000 years of healthy life in the future.[3]

Hospitals' contribution to carbon emissions and waste is not only driven by powering and sustaining services at their individual facilities but by additional industries they choose to support including medical supply producers, pharmaceutical manufacturers, industrial agricultural operations, and laundry facilities.

Hospitals are the most critical community resource in the face of climate-related disasters and must be adequately prepared to face increases in frequency and severity of storms. Grim reports from the days following the Hurricane Katrina detail power outages, failed generators, loss of running water and sewage, and failed communication that resulted in many patient deaths.[4] In just one case, at Memorial Medical Center as many as 300 patients and 1,500 others were stranded.[4] Hospitals house a communities most vulnerable, least mobile, and least self-sufficient populations and in the face of disaster, their duty to serve these populations is only heightened. Adequate planning, resource allocation, and federal funding for disaster resiliency must be a priority.

DIRECTIVES

Reduce greenhouse gas emissions in hospitals. Develop and commit to facility-specific sustainability goals and publicize emissions. Investigate equivalent alternatives options to desflurane, an expensive anesthetic gas that has 5-18 times the global warming potential than other anesthetic gases.[1]

Limit waste in hospitals. Practice Greenheath's Tracker is a tool that audits and tracks waste spending and volume by individual waste streams. (visit *www.practicesgreenhealth.org*). Put an end to the standard practice of incineration technologies for medical waste management which is contributing to toxic emissions.

Decrease the external environmental footprint of hospitals. Evaluate emissions along the supply chain and prioritize supporting products and companies that value safe substances, minimal pollution, energy efficiency, reusable materials, and limited packaging material.

Publicly support a global carbon pricing scheme and commit to the Paris Agreement Goal of limiting warming to 2 degrees Celsius.

Ensure disaster resilience plans prioritize access to care is ensured for all members of the community, particularly those most at threat of bearing the burden of environmental disasters. Hospitals must reduce their reliance on energy, and rethink their facilities design. For example, in the wake of Hurricane Katrina, Veteran Affairs hospital administrators redesigned the facilities so that the emergency room, electrical units, generators and kitchens are on the highest floors.[5]

INVESTMENT REFORM

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As economic engines in both urban and rural communities, hospitals have collective investment portfolios estimated at $400 billion.[1] They purchase over $850 billion in goods and services from other businesses and support over $2.8 trillion in economic activity.[2] Hospital investment presents an opportunity to address community health in a way that better aligns with the mission and values of the industry. Through values- and place-based investments and increased local procurement, hospitals can spur powerful environmental and social change. They have a moral, medical, and financial obligation to invest in building community wealth and to divest from the extractive and toxic industries that are contributing to today's pressing public health issues. Hospitals have an opportunity to take a more proactive approach to addressing the social determinants of health by investing upstream.

By planning to uproot the deepest economic injustices in their communities, hospitals can start to undermine gaps in health outcomes while also saving on healthcare costs in the long run. Health providers have proven before that they have the power to create cultural shifts through divestment as they did in the 1990s by taking a public stance against the tobacco industry.[3]

Hospitals are often one of the largest landowners in a community. Yet, 58% of all hospitals are nonprofits, meaning they do not pay property taxes. Tax exemption is based on the premise that charities are providing a value back to their communities, but a significant amount of nonprofit hospital revenue is consistently spent on executive salaries, hospital facilities improvement, and luxury services driven by competition for rankings.[4]

In order to claim tax-exempt status, non-profit hospitals are mandated by the IRS to provide a "community benefit." However, this is a loosely defined requirement that has historically been met through charity care for uninsured patients who lack the ability to pay out of pocket. With the passage of the Affordable Care Act, and an increasing number of patients expected to have coverage, additional community benefit-related standards were developed to encourage (yet not require) that they dedicate more funds to directly to community building efforts that address social determinants of health such as housing, food access, and the environment.

Presently, this type of spending amounts to a very small portion of a typical hospital's community benefits allocation, yet smaller when you consider the entirety of their assets and portfolio holdings. In 2014, the Cleveland Clinic reported expenses of $6,036,534,021 and $6,956,278,537 in revenue. The clinic claimed to dedicate 11% of spending to activities they qualified as "community benefits." Looking closer 4% of total expenses went to professional education and research for students and medical practitioners , while a less than 0.01% actually went to "community building" projects.[5]

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DIRECTIVES

- **Divest from all fossil fuel holdings and invest in clean energy sources.** Hospitals' financial ties should not be further exacerbating the risks associated with fossil fuel dependency. Hospitals should lead the movement for other anchor institutions to follow.[6]

- **Divest from portfolio holdings with ties to the gun industry**. Attempts to cut financial ties to gun industry can be deceiving and difficult but must be rigorously pursued if hospitals are to uphold a commitment to public health. As Reuters reports "U.S. investors who want to divest from firearms and ammunition makers may find it not so straightforward: They are hidden among the stocks and bonds of hospitals, toymakers and greeting card companies."[7]

- **Divest from companies that participate in advertising added sugar products**. As with divestment from the tobacco industry in the 1990s, this could lead to a culture shift in the way harmful products are advertised to consumers.[8]

- **Adopt institution-wide values-driven investment guidelines.** Bon Secours Health System in Baltimore has a Socially Responsible Investment Guideline document that can serve as an exemple for other hospitals looking to center the most vulnerable when making investment decisions. These guidelines apply to all of BSHSI's investment portfolios.[9]

- **Invest directly in community building projects by financing affordable housing development, community land trusts, and other infrastructure projects**. These investments not only strengthen community health outcomes, but create long-term solutions, addressing the social determinants of health and reduce patients' dependency on the E.R. for preventable chronic conditions.

- **Move assets into credit unions and community banks and minority-owned banks**. This simple investment strategy can serve as a major catalyst for economic development in local communities because credit unions and community banks lend more frequently and responsibly within underserved communities.[10] The Democracy Collaborative Hospitals Aligned for Community Health toolkit provides resources, templates, and case studies for place-based investment initiatives (visit *hospitaltoolkits.org/investment/*)

- **Provide micro grants and low barrier loans for community led projects** that help seed and scale local women- and minority-owned businesses. Dignity Health based in San Francisco has a community grant program funded through its member hospitals which contribute a percentage equal to the previous year's audited expenses. Financing goes to "projects to build affordable rental and assisted living homes for seniors, to expand food banks and day centers, to build shelters serving homeless individuals discharged from emergency rooms, and to fund healthy food projects and small business micro-loans in the communities."[11]

VIOLENCE REDUCTION

Hospitals must stand against all forms of violence that plague our nation inside and outside hospital walls. All violence is a threat to health and all communities suffer from the physical, social, psychological and economic tolls of violence, but women, LGBTQ populations, and low-income communities are particularly affected.[1,2] In 2016, there were nearly 65,000 documented deaths from physical violence across forty states in our nation with approximately 19,000 attributed to homicide and 45,000 attributed to suicide.[3] Direct and indirect impacts of violence increase the risk of other diseases, disrupts learning, and intensifies cyclical patterns of physical and emotional harm.

Healthcare workers currently endure the highest rates of assaults in U.S. workplaces every year, and the rates continue to rise. Between 2012 and 2014, workplace violence injuries rose 65% for all health care staff with a 55% increase among nurses.[4]

Outside of the hospital industry, the CDC reports that 55,000 people are killed, 2.5 million are injured from violent incidents each year.[5] These direct assaults and indirect behavioral and emotional consequences of community violence cost hospitals $2.6 billion in 2016.[6] Sources of community violence and aggression must be addressed with special attention to youth and vulnerable populations that are susceptible to gang pressures and activities, child abuse, street violence, unsafe gun behavior and human trafficking.

The severity of human trafficking in the United States has garnered increasing attention. According to the National Human Trafficking Hotline, reports of human trafficking increased 35.7% between 2015 and 2016.[7] It has been reported that over half of labor and sex trafficking survivors had interacted with healthcare workers at least once while being trafficked.[8] Hospital staff represent some of the few professionals to formally interact with victims of human trafficking, it is essential to ensure providers have the support, tools and training to identify and care for these individuals.

U.S. instances of gun violence rates continue to top the scales globally. When compared to other developed countries, American citizens are 25 times more likely to be killed with a gun.[9] Recently, the onslaught of mass shootings have sent the impact of violence rippling through every movie theater, concert and school in our nation. Every citizen seems to be aware of gun violence these days, but young, black males continue to be disproportionately affected targets. Currently, young, black men ages 10-25 are 20 times more likely to be murdered with guns than white males the same age.[6] With loose gun restrictions allowing for 13,000 firearm homicides and nearly twice as many injuries, hospitals must move beyond their traditional approaches of advocating for increased gun research and mental health funding.[10]

While the present narrative suggests that the solution to gun violence lies in increased attention to mental health, this will likely only address a small portion of the problem.[10] In fact, mass shootings by people with serious mental illness represent only 1% of all gun homicides and individuals with serious mental illnesses represent only 3% of all violent crime perpetrators.[11] Many large medical associations have spoken in favor of gun control, yet hospitals, who see the patients and feel the impacts have yet to take a firm stance (9). The political and financial power structures that perpetuate our country's gun culture must be addressed in seeking the solution.

DIRECTIVES

- **Strengthen partnerships to decrease the physical consequences and mitigate emotional and social impacts of community violence**.[2] Hospital-based violence prevention models and programs like the Prevention-Institute's Community-Centered Health Homes and Boston Medical's Violence Intervention Advocacy Program proactively layer clinical care and protocols with community prevention and trauma-informed recovery services and support.[10, 11]

- **Put an end to workplace violence through internal reporting and managing processes and external policy demands**. In 2017, National Nurses United petitioned OSHA to require mandatory comprehensive programs to prevent workplace violence.[12] Hospitals must stand by this mandate and ensure it is being implemented. Call for zero-tolerance reporting in the workplace that does not disregard verbal abuse or low-battery and create early warning systems that alert medical professionals of patient experiences.

- **Expand the hospital interventionist movement to create opportunities for those affected by gang and street violence**, building paths to conflict resolution and re-engagement in the community. Advocate for insurance companies to include hospital-based violence prevention programs. Train staff and provide screening to detect gang involvement. Partner with community organizations to continue prevention strategies through behavioral health and social support outside hospital walls with mentorship programs, guaranteed housing and food insecurity assistance. Reference The Center for Public Safety Initiative's Overview of Hospital-Based Violence Intervention Programs and the National Network of Hospital-based Violence Intervention Programs.

- **Improve measures and processes to identify victims of human trafficking that flow through health care settings**. Educate health care providers of the warning signs and train staff members in sensitive protocols involving victims. Dignity Health's' Human Trafficking Response program provide exemplary manuals that detail their programs and processes (visit: dignityhealth.org/).

- **Collectively stand in favor of strict gun control** by publicly declaring their stance on gun politics, divesting from gun manufacturers and sellers, and working to disconnect the association between mental health and gun homicides.

- **Demand the American Hospital Association support background checks and increased federal funding for gun research** and public health surveillance on firearm related injuries and deaths. Hospitals must join the 75 other public health, medical and research groups who have sent letters to Congress; one after the massacre in Los Vegas and another after the most recent shooting at Marjory Stonewall Douglas High School in Parkland, Florida.[9, 13]

CRIMINAL JUSTICE REFORM

The massive systems failures of the U.S criminal justice system mandates attention from the healthcare sector. The U.S. continues to have the world's highest incarceration rates. While the U.S. represents 5% of the world's population, accounts for 25% of its prisoners. Mental illness and addiction are criminalized in ways that have grossly neglected to treat these conditions for what they are: public health issues. For far too long correctional health has been viewed as a separate sphere from mainstream medical health.[1] Hospitals have a major opportunity as anchor institutions to become better partners in reforming the way that certain health conditions are criminalized and the ways that certain bodies are disproportionately punished by the justice system.[1]

In the wake of massive state hospital closures in the 1970s and 1980s, mental health care has been widely neglected and increasingly relegated to the prison system. Today, there are about ten times as many individuals with serious mental illnesses in jails and state prisons than there are in state medical treatment.[2] As an illustration of this point, Chicago's mental health specialty court handles approximately 300 people every year, while the Cook County Jail houses 3,000 people with mental illness every day, many of whom could be out of the criminal system if given adequate care.[2] The system is so hollowed out that medical providers are faced with the decision between putting a mentally ill patient back on the streets or in jail. Given our present system, medical professionals will often choose the latter because they see it as the safest choice.

Jails have become one of the largest providers of medication for mental health, yet this is managed by a system that is wholly ill-equipped to provide care. In fact, the medical community suggests that a correctional environment may only serve to exacerbate fear, worsen psychosis, and incite aggression for those struggling with mental illness.[2]

Sparked by the War on Drugs during the Nixon era, drug abuse has continuing been viewed under the lens criminal justice system rather than public health. Today's opioid addiction crisis continues this pattern and presents one of the most sustained and growing challenges to public health today. Heavy sentencing and mandatory minimums have contributed largely to the fact that, according to the Bureau of Prisons, there are 207,847 people incarcerated in federal prisons and roughly half of these are behind bars for drug offenses.[3] Substance abuse and addiction needs to be reframed as a disease not a crime and hospitals should leading the way in treatment, rather than correctional officers.

Female inmates face a host of exacerbated health issues while incarcerated. It has been reported that they are subjected to demoralizing and inhumane practices, including forced pregnancy tests, coerced sterilizations, barriers to safe abortions, denial of prenatal and postpartum care, lack of adequate menstrual hygiene products, and persistent sexual assault from within prisons themselves.4 These offenses demand reform immediately. The healthcare sector is obligated to unite to produce more just and humane health for female prisoners. The criminalization of sex work contributes to exacerbated health threats of these individuals when they enter a system that does not seek to care for them but rather punish them.

As a report from the Center for Prisoner Health and Human Rights states, "the broader health professions should leverage their traditional moral authority into civic engagement on behalf of their collective patient body, which includes prisoners."[1] Leaders in the hospital industry must take on the task of reframing the way mental health and substance abuse are handled and shift conversation from one that worships extreme and unwavering punishment to one that values treatment first. Hospitals can commit to replacing jail time with treatment time.

DIRECTIVES

- **Intervene in our country's inadequate ability to recognize and treat drug addiction and mental health**. Demands for increased federal funding for mental health care - which are under threat by Trump's current budget - must be unwavering.[5]

- **Recognize drug use as a disease not a crime**. Pursue meaningful steps to create major culture shifts in the way our society handles substance abuse. This year the cities of Philadelphia, Baltimore, Seattle and San Francisco have taken steps to allow for safe injection sites, however, the details of who will fund and house these facilities are all still up in the air.[6] Safe injection sites within hospitals could not only reduce risks for patients and providers but could better allow patients suffering from drug addiction better integration of high quality care and addiction treatment, a focus often lacking attention in hospitals.[7]

- **Support safe needle exchange programs.** According to research "Needle exchanges reduce the spread of bloodborne diseases like hepatitis C and H.I.V. and do not increase drug use. They've been shown to reduce overdose deaths, decrease the number of needles discarded in public places and make it more likely that drug users enter treatment. They also save money: One recent study estimated that $10 million spent on needle exchanges might save more than $70 million in averted H.I.V. treatment costs alone."[8]

- **Improve the pipeline from correctional health systems to community health systems**, particularly for inmates who are likely to return to homelessness upon release. The Jail Inreach project in Houston is a collaboration with the Harris Center for Mental Health and the Harris County Sheriff's Office and provides case management and pre-release planning for continuity of care for those who are homeless and incarcerated in Harris County Jail. The program's goal is to ensure that individuals do not face lapses in medical and mental treatment and reduce rearrest rates by providing treatment and continuity of care.[9]

- **Support legislation that protects female reproductive rights behind bars,** such as the Dignity for Incarcerated Women Act introduced last year by Senators Cory Booker, Elizabeth Warren, Kamala Harris, and Dick Durbin which among other things included explicit calls for menstrual equity provisions.[10]

- **Implement programs to identify incarcerated people eligible for ACA healthcare coverage** and help released prisoners complete the process of enrolling in a healthcare plan or in Medicaid.

- **Homelessness is not a crime**, commit to proving homes rather than ER beds or jail beds to persons living without shelter.

- **Ban the Box**: Reform hiring practices for formerly incarcerated individuals. The John Hopkins hospital system no longer runs criminal background checks until after an offer of employment is made. The hospital found that ex-offenders were more likely to stay in their jobs for more than three years than non-offenders.[11] The National Employment Law Project has released a guide that should be used by heath care employers to hire individuals with criminal records (visit www.nelp.org).[12]

INFORMATION DEMOCRACY

Universal access to information is essential for improving healthcare and health outcomes. Persistent calls for reforms and improvements in medical education and training programs by medical associations have been left unanswered. The current models of medical training does not adequately prepare physicians for today's public health needs and regulatory frameworks governing these systems make innovation and reform nearly impossible. The legacy of financial and structural barriers to the medical field, though improving, still contribute to inadequate representation of minority physicians. Hospitals are just beginning to breakdown the professional silos in their own facilities by creating integrated care models or "clinical microsystems," that provide interdisciplinary, patient-centered care.[1] Hospitals must embrace new technology and information sharing platforms to optimize the accuracy of, access to, and quality of care.

Currently, the fact that access to medical research prioritizes elite professionals is a direct threat to education, innovation, patient care, patients' rights, and global health equity.[2] Increasing the diversity of subjects in clinical trials has been on the National Institute of Health's (NIH) priority list for almost 30 years, yet women and people of color continue to be underrepresented.[3] Though black men die from prostate cancer at a rate twice as high as white men they comprise only 5% of participants in prostate cancer clinical trials.[4] Clinical trial participants that do not accurately represent the populations that the findings negatively impact health outcomes as a result of inappropriate diagnosis and treatment of disease.

Critical broadband infrastructure is also needed to guarantee information democracy. Almost 23 million rural Americans lack access to high-speed broadband.[5] Not only is the internet increasingly needed to schedule medical appointments and enroll in insurance programs, but will soon be used for telemedicine as the industry battles their physician shortage and barriers to rural medical access.[6] Currently, more than 60 million Americans don't have access or can't afford the internet. Today, internet access is necessary for job searching, voting, interpersonal connection, and education. To ensure equal treatment and justice, the barriers to broadband must be broken, yet at the root of inequality in the intersection of information and health is America's education crisis.

Early childhood education is the single most important determinant of health over a person's lifetime.[7] Preschool and childcare experiences dramatically influence a child's physical, social, emotional, and intellectual development, yet many families have been systematically excluded from these opportunities due to high costs and physically accessibility. In 2017, more than 60% of toddlers in the U.S. didn't have access to publicly funded preschool programs, with disparities in access predominantly affecting racial and ethnic minority children.[8] These disparities represent the foundation of our country's educational achievement gap. Further, early exposure to diverse environments is essential to eliminate disparities and prejudice of future generations.

DIRECTIVES

Urge medical researchers, practitioners and academics to boycott subscription-based research journals in favor of open access medical research for patients, physicians and society at large. Hospital research should follow the movement led by the many researchers that have created open access journals for a variety of disciplines.

Reform medical research design to be more representative of diverse communities. Clinical and drug trials need to be include people of all races, genders, and ages. Demand an increase in NIH budgets to decrease competition and encourage researchers to ensure subject diversity and request NIH to create minimum diversity requirements and increase gender, racial, and ethnic representation in their research review committees.[9]

Decrease the financial barriers into medical school. Demand that Congress increase federal funding towards residency training and protect Public Service Loan Forgiveness.

Advocate for policy on universal internet access. See Connect2HealthFCC on the intersection of broadband, advanced technology and health and further charting the broadband future of healthcare (visit *www.fcc.gov)*.

Demand that every toddler in the U.S has access to quality publicly funded preschool programs by advocating for universal preschool and protection of Preschool Development Grants. Petition for adequate pay for early childhood educators, equal to their K-12 counterparts, and the requirement that these educators have a Bachelor's degree.[10]

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