

THE ROLE OF ESSENTIAL HOSPITALS IN COMBATING STRUCTURAL RACISM: *An Informational Brief*

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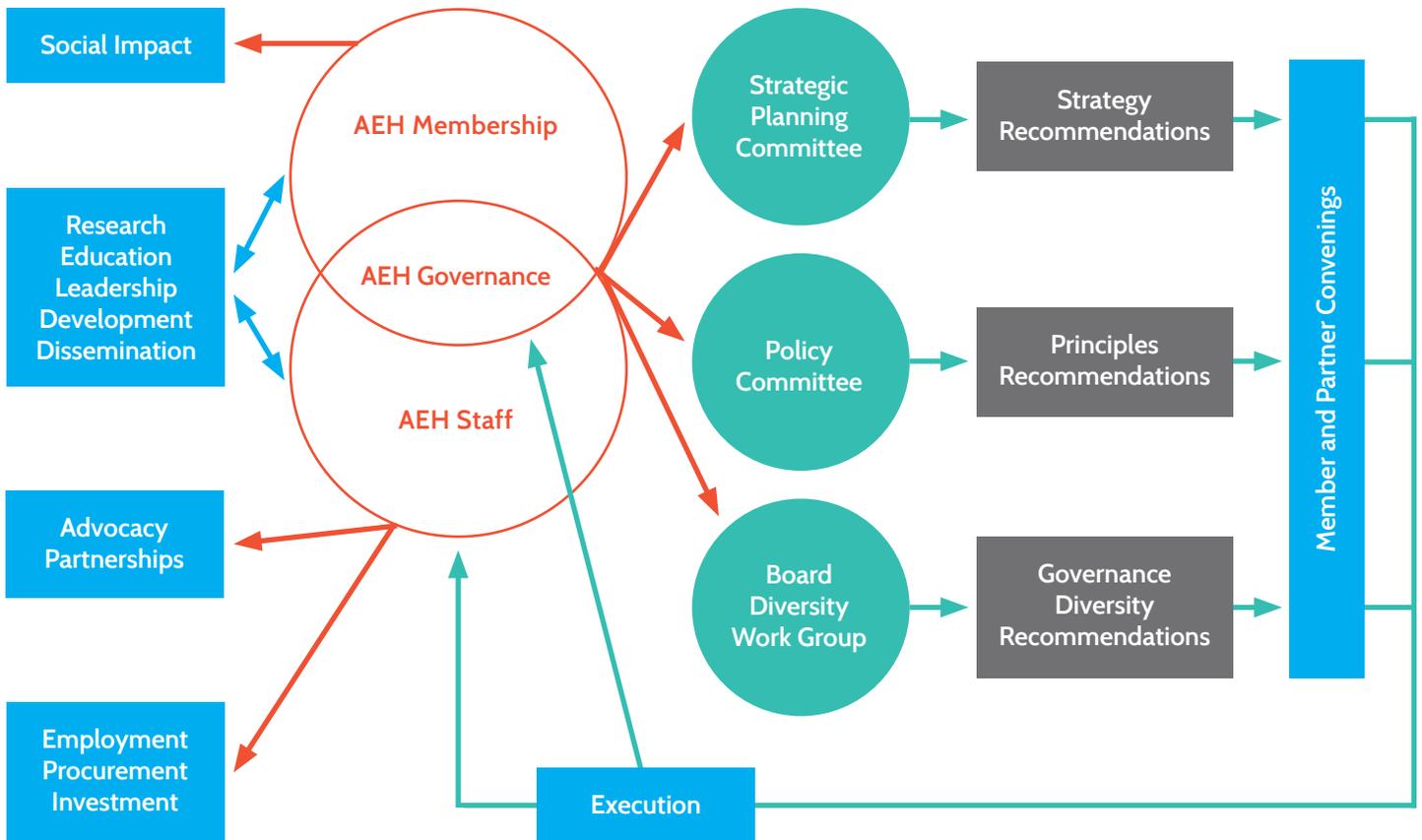
BACKGROUND

Many hospital systems grapple with their role in combating the history of racism to promote equity. The Black Lives Matter movement has prompted institutions to examine their organizational practices and policies to better understand how institutional racism impacts their work and make changes to promote diversity, equity, and inclusion. This work has become a focal point amid momentum across the nation demanding justice for the killings of George Floyd, Breonna Taylor, Ahmaud Arbery, and countless Black individuals who have died as a result of police violence and hate crimes.* The COVID-19 pandemic also places a national spotlight on health inequities that have existed for years—impacted, to an extent, by the United States’ history of structural racism. Black and Latino individuals are disproportionately affected by the COVID-19 pandemic, with higher rates of infection, hospitalizations, and mortality. While 12 percent of the population is Black, 20 percent of COVID-19 cases are in Black patients.^{1,2} Similarly, Latinos represent 18 percent of the population, but 31 percent of COVID-19 cases.^{1,2}

Thought leaders from the health care sector have expressed their views on how hospitals can support initiatives to address structural racism within their communities, as well as

* This informational brief uses these racial and ethnic categories unless otherwise specified by the literature: American Indian and Native American, Asian American/Pacific Islander (AAPI), Black to cover both Black and African American categories (many Black people in immigrant communities do not call themselves African American), white, and Latino rather than Hispanic (except when data sources specifically use “Hispanic”).

FIGURE 1: AMERICA’S ESSENTIAL HOSPITALS WORKSTREAM FOR COMBATING STRUCTURAL RACISM



institutional and individual racism within their system. This informational brief seeks to inform America's Essential Hospitals governance and leadership about how structural racism impacts health systems and the communities they serve. It is concluded with examples of actions by hospitals and other associations to address racial justice.

America's Essential Hospitals always has been guided by a vision of "equity in health and health care." The association's policy committee, strategic planning committee, and new board diversity work group will use this informational brief to inform the creation of strategy recommendations, advocacy principles, and diversity recommendations to combat structural racism. America's Essential Hospitals Board of Directors Chair Susan Ehrlich, MD, MPP, emphasizes that achieving equity requires dismantling a four-century-old system of structural racism.³ This initiative, spearheaded by the panels above, will include three prongs:

- identify and foster adoption of groundbreaking and transformative health system approaches to combat structural racism;
- build partnerships on social justice with other national organizations while clarifying and enhancing the association's policy principles regarding equity; and
- advance the ongoing work of America's Essential Hospitals to ensure diversity in its

Figure 2. Definitions

Structural racism, also called systemic racism, is the normalization and legitimization of historical, cultural, institutional, and interpersonal dynamics that routinely advantage white people while producing cumulative and chronic adverse outcomes for people of color.¹³

Institutional racism refers to the policies and practices within and across institutions that, intentionally or not, produce outcomes that chronically favor a racial group or put a racial group at a disadvantage—for example, the systematic undertreatment of Black patients for pain relative to white patients.^{14,15}

Individual racism is the attitude and behavior of individuals that support racism in both conscious and unconscious ways. For example, unconsciously, someone might not hire or promote a person of color because "something isn't quite right." Often, people focus on individual racism, failing to acknowledge or understand structural racism.¹⁶

Racial justice, or racial equity, is the systematic fair treatment of all people, resulting in equitable opportunities and outcomes for everyone. Racial justice, or racial equity, goes beyond anti-racism; it is not just the absence of discrimination, but also the presence of values and systems that ensure fairness and justice.¹⁷

Anti-racism is the active process of identifying and eliminating racism by changing systems, organizational structures, policies and practices, and attitudes so that power is redistributed and shared equitably.¹⁸

Note: Although other types of discrimination exist based on disability, age, status as a parent, sexual orientation, religious, national origin, race, sex, pregnancy, and retaliation/reprisal, this informational brief focuses on racism and how racism impacts the health system directly and indirectly. Intersectionality plays a role in everyone's experiences and individuals can experience different forms of discrimination simultaneously.¹⁹

board and other governance bodies.⁴

To this end, with guidance from the board, the association has drafted a workstream to combat structural racism for America's Essential Hospitals and its membership (see Figure 1). The strategic planning committee will identify how our association can best support member hospitals to combat racism effectively in their communities and implications this might have for the America's Essential Hospitals strategic plan. The policy committee will recommend principles to guide the association's policy and advocacy positions. Finally, the board diversity work group will develop recommendations to increase and maintain diversity for the association board, including whether to broaden the types of senior executive roles serving on the board. Members' and external partners' input will be solicited through two convenings in the fall.

IMPACT OF STRUCTURAL RACISM ON PATIENTS, PROVIDERS, AND THE COMMUNITY

Hospitals serving a safety-net role provide care for the most vulnerable in our communities, and 54 percent of member discharges were racial and ethnic minorities in 2018.⁵ Additionally, based on a recent report on community health investments, pay equity, and inclusivity, member hospitals have an average score in the 61st percentile on an inclusivity score. This score indicates members serve highly diverse patient populations compared with the demographics of their surrounding communities.⁶ These communities are significantly burdened by a system of oppression and structural racism that intertwines with social determinants of health and has implications for health outcomes. This section describes how structural racism impacts hospitals' patients, staff, and the communities they serve.

Impact of Racism On Patients

Individual racism impacts how patients are treated and cared for through subconscious prejudices or implicit bias. In a survey of 3,453 adults, all racial, ethnic, and sexual identity populations reported that discrimination exists today, and many respondents have had personal experiences with racial discrimination.⁷ Almost one-third of Black respondents reported experiencing racial discrimination when going to a doctor or a health clinic. In a different survey of patients and caregivers seen in member hospitals, Essential Hospitals Institute found that patients and caregivers from underrepresented groups trusted hospitals less compared with white patients.⁸ In addition, these patients were less likely to agree that hospitals treated patients the same regardless of race or ethnicity. These biases affect the care, treatment, and outcomes for people of color. A systematic review found that implicit bias was significantly related to patient-provider interactions, treatment decisions, treatment adherence, and patient health outcomes.⁹

Implicit bias also impacts access to care. In one study, almost a quarter of surveyed Black respondents reported avoiding seeking medical care out of concern for discrimination.⁶ Implicit attitudes were more often considerably related to patient-provider interactions and health outcomes than treatment processes. For example, one study found that doctors with a pro-white bias were less likely to recommend thrombolysis to Black patients than to white patients.¹⁰

Conversely, studies show that patients treated by a doctor of the same race achieve better health outcomes. In a randomized controlled trial, Black men assigned to a doctor of the same race sought more preventive care.¹¹ Further, investigators also estimated that racial concordance between physicians and patients could reduce the cardiovascular mortality gap between Black and white patients by 19 percent. Another randomized study found that Black patients who met with Black physicians sought more preventive and more invasive preventive care compared with seeing non-Black physicians.¹² In the Institute study, patients and caregivers of color at essential hospitals were less likely than white

Individual racism impacts how patients are treated and cared for through subconscious prejudices or implicit bias.

patients and caregivers to agree with the statement, “There are hospital staff that match my race or ethnicity.”⁷

Speaking a language that the patient can understand is another consideration. Improved communication might result in better outcomes, such as increased adherence to medications.¹¹ In the Institute study, patients and caregivers of color at essential hospitals were less likely than white patients and caregivers to agree with the statement, “Hospital staff provide services in my language and make sure I can understand what is being said.”⁷

While there is a critical need for more physicians from underrepresented groups to increase trust, patients would benefit from creating a more informed health care workforce through staff training.²⁰ This training needs to be accompanied by organizational policy and guidelines to address the racism, discrimination, microaggressions, or unconscious bias by providers. Health care organizations that have created an informed health care workforce find staff are motivated to provide nondiscriminatory care and are aware and sensitive to the dynamics of racism in different settings. These trained providers can hold difficult conversations with fellow providers. Organizational leadership and support are vital to supporting an anti-racist mission, and everyone within the institution has to be dedicated and committed to this mission.¹⁹

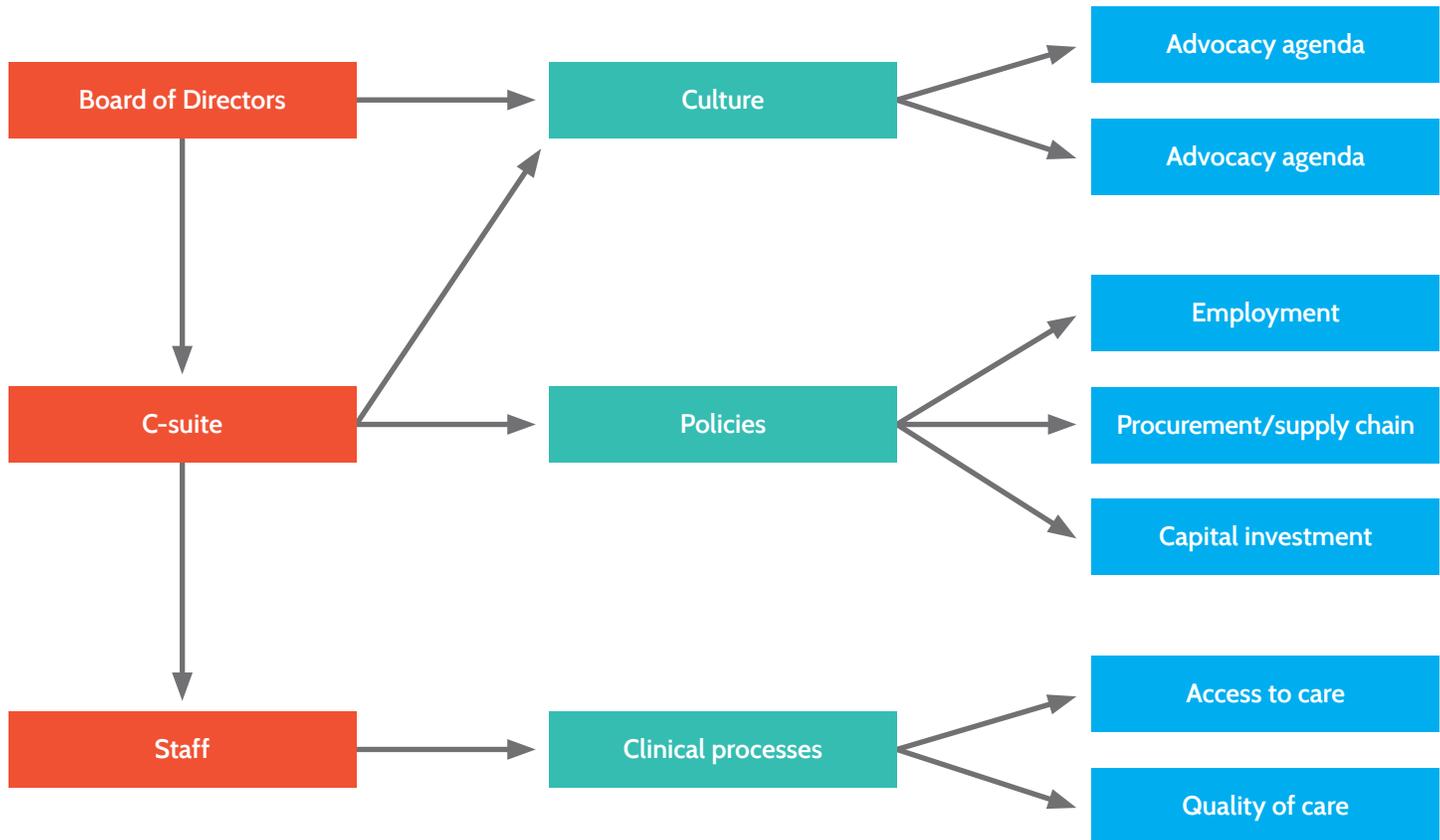
Impact of Racism on Providers

Structural racism produces disparities in employment and economic opportunities at the institutional, governance, leadership, and staff levels.²¹ Financially, at an organizational level, companies in the top quartile for racial and ethnic diversity are 35 percent more likely to have financial returns above their respective national industry medians.²² Both American Hospital Association (AHA) and Association of American Medical Colleges leadership point to the lack of diversity in hospital executive leadership and hospital boards as a problem, noting that only 14 percent of hospital board members and 11 percent of executive leadership in 2015 were people of color. An AHA study found that the percentage of executive leadership positions filled by people of color had remained flat since 2011, and chief diversity officers represented 77 percent of those positions.²³ Many hospitals have a chief diversity officer; however, a chief diversity officer’s role is not just to recruit and retain a diverse workforce. These leaders should be given a powerful voice in policy discussions to ensure the organization factors health equity into all their decisions.²²

Structural racism impacts employment at the clinician level, as well. According to a recent study on the physician workforce, some minority groups are underrepresented among physicians. In 2019, an estimated 68 percent of physicians were white, 23 percent were Asian American, 3 percent were Black, and 4 percent were Latino—in contrast, the U.S. population is 60 percent white, 6 percent Asian American, 12 percent Black, and 18 percent Latino.^{1,24} These statistics highlight the shortage of physicians that are Black and from other underrepresented groups.[†] As mentioned previously, there also is evidence that racial and ethnic concordance between patients and physicians could lead to improved trust, utilization, and adherence to medical advice. Given the diverse patient population member hospitals serve, it is particularly critical to correct this disparity by improving diversity among hospital physicians and staff.

Clinicians of color might be a target of bias and racism by patients.²⁵ Physicians of color regularly experienced racism at work. In one study, almost a quarter stated a patient had refused their care because of their race.²⁶ A majority of participants experienced significant racism from their patients, colleagues, and institutions. Creating organizational policies and guidelines to address racism can help combat discrimination, microaggressions, or actions

[†] *The brief uses underrepresented groups to reflect races and ethnicities that are not well represented in health care, including Black, American Indian and Native American, and Latino.*

FIGURE 3: HOSPITAL DOMAINS OF STRUCTURAL RACISM


by patients toward providers. For example, reassignment requests by patients based on their personal biases against nonwhite providers cause harm, but ways to effectively resolve these issues have not been well studied. In a recent article, a physician at a member hospital pointed out, “People might not realize you’re offended, but it’s like death by a thousand paper cuts. It can cause you to shrink.”²⁷ Training the workforce motivates staff to provide care as well as providing awareness and sensitivity to racism in multiple settings. Training also might support staff in engaging with patients regarding their organizations’ zero-tolerance policies. Leadership commitment, training, and policies support providers’ ability to manage racism directed against them.^{3,19}

Impact of Racism on the Community

Structural racism contributes to and exacerbates health inequities in communities. Perhaps the most recent and alarming example is how structural racism contributed to disparities in COVID-19, as noted earlier.^{1,2} As America’s Essential Hospitals President and CEO Bruce Siegel, MD, MPH, said in an April 2020 *Modern Healthcare* commentary, “Substandard housing and food insecurity thwart social distancing and exacerbate chronic conditions. Minorities who fill jobs in transportation and other critical infrastructure cannot stay home and, instead, are exposed to the virus. Those furloughed from hospitality and other ‘nonessential’ positions lose paychecks and insurance coverage and the health care access these bring.”²⁸

The impact of structural racism on the health of patients also is exemplified by the

number of deaths attributable to social factors. In a meta-analysis of 47 studies focusing on education, poverty, low social support, income equality, and racial segregation, 176,000 deaths in 2000 were attributable to racial segregation. An additional 245,000 deaths were attributable to low education, 162,000 to low social support, 133,000 to individual-level poverty, 119,000 to income inequality, and 39,000 to area-level poverty. These numbers are similar to what can be attributed to certain diseases. For example, the number of deaths attributable to racial segregation is comparable to the number from cerebrovascular disease (167,661), the third leading cause of death in 2000.²⁹

Structural racism also is embodied by the environment people live in, which contributes to poorer health outcomes and exacerbates health inequities. According to the American Lung Association, approximately 74 million people of color, or 5 percent, live in counties with at least one failing grade for ozone or particle pollution. Communities of color also are more likely to live near landfills and areas where toxic chemicals are dumped. Additionally, coal-fired power plants, incinerators, petrochemical facilities, and other polluters impact communities of color more than white communities due to geographical proximity to their neighborhoods and the pollution they create.³⁰ Pollution has been linked to higher rates of diabetes for Black people—an estimated 5,000 deaths—and increased asthma-related emergency department visits.³¹

Hospital and health system policies and decisions could perpetuate or mitigate structural racism in communities. A study that examined a commercial application used to allocate health care resources on predicted future health care costs found the application biased the outcomes.³² Of the patients identified by the algorithm as needing more care, 18 percent were Black, and 82 percent were white, although Black patients were identified as having 26 percent more chronic illnesses than white patients. However, the algorithm predicted health care costs rather than illness. If it predicted illness, the true proportions of both should have been 46 percent and 53 percent, respectively. Thus, the procurement choice to use this computer application would lead to profound disparities in health care.

Hiring is another example—in a study of 12 hospitals in a major metropolitan area, only two matched or exceeded the national average of 4.1 percent for their proportion of Black doctors.³³ However, these policies also might reflect the reality of structural racism: In a recent study, only 6 percent of physicians identified as Hispanic and 5 percent identified as Black or African American—thus making it more challenging to hire from these underrepresented groups.³⁴ The future does not appear to bring relief: In medical schools, there has been only a slight increase in the enrollment of Black men, from 2.4 percent during 2014–2015 to 2.9 percent in the 2019–2020 academic year.³⁵ One method to recruit more people of color, specifically Black physicians, is to recruit from historically black colleges and universities (HBCUs). For example, Howard University Hospital recruits from Howard University, an HBCU. Nashville General Hospital is Meharry Medical College's primary teaching site. Grady Memorial Hospital supports many residencies from Morehouse College. Finally, the Los Angeles County Department of Health Services is a training site for Charles R. Drew University of Medicine and Science. Thus, while hiring people of color can be difficult, hospitals can be effective in increasing their numbers through affiliations and recruiting practices.

Historically, hospitals supported segregated health care, and lingering effects of these policies continue to this day. Up until the application of Title VI of the Civil Rights Act to Medicare in 1965, which prohibited discrimination by race and ethnicity, many hospitals refused to provide care to people of color. In one study, 83 percent of general hospitals outside of the South reported offering integrated care in 1959.³⁶ In the South, only 6 percent of hospitals admitted African Americans without any restrictions; 33 percent refused to admit any African Americans; and the rest had segregated care or made other modifications. With the application of Title VI, hospitals no longer could segregate, and

Historically, hospitals supported segregated health care, and lingering effects of these policies continue to this day.

with Medicare, hospitals had a reason to integrate. Yet, in an examination of hospitals in a major city, only 11 percent of patients admitted to the city's largest hospital, which is in a white neighborhood, were Black.³² Among residents of the neighborhoods that surround this hospital, white patients were admitted to the hospital at twice the rate of Black patients. Looking at citywide data, Black patients are more than three times as likely to get care at a hospital that has been historically welcoming to Black people. The authors note that approximately 50 years ago, teaching hospitals divided up and supported community health centers based on geographic location. At the time, and to this day, there are racial disparities in whom the hospitals serve. In a written statement, the large academic medical center serving white patients stated that expanding operations to an area dominated by a hospital serving a predominantly Black population would be “destabilizing and disruptive to existing patient-provider relationships” and “quite disrespectful.”³² Similarly, in one of the largest cities in New England, Black patients are less likely than white patients to be hospitalized at private academic medical centers.³⁷

HOSPITAL STRATEGIES TO COMBAT STRUCTURAL RACISM

Many hospitals and hospital systems are reflecting on and have begun to combat structural racism and promote equity and social justice in their communities. Figure 3 presents potential domains in which hospitals might combat structural racism and who can influence specific activities.

Creating a Positive Culture

1. **Publicly commit to combating structural racism.**^{38,39,40} Multiple hospitals have public commitments to combat structural racism by working internally and taking actions to benefit and create community change. For example, one member of America's Essential Hospitals is developing an anti-racism statement and acknowledgment of racism as a social determinant of health.³⁹ The hospital is including an anti-racism statement as part of its mission, vision, and values statement. Public commitments can help ensure hospital employees work toward a common goal and share a bigger purpose.
2. **Convene committees to advise senior leadership to identify and remove discriminatory practices.**^{39,41,42,43} Several member hospitals are organizing committees or focus groups to determine the next steps related to combating racism. In some cases, these committees include internal staff and, in other cases, individuals outside the hospital. These committees or listening sessions are examining policies and methods to improve inclusiveness and identifying strengths of and growth opportunities for the system. This approach is a bottom-up approach to addressing health inequities that health systems can use to ensure they provide the right support to their communities.
3. **Partner with community organizations.**^{22,37,38,39} As noted earlier, member hospitals demonstrated high levels of contributions to community organizations and community building activities to improve community capacity to address health needs and social determinants.⁵ Multiple health care organizations, including many member hospitals, collaborate with community organizations to improve chronic conditions that impact communities of color.^{37,38,39} Some hospitals seek to act as a bridge between law enforcement and the community to improve relations and create trust, while others conduct community listening sessions to identify and address specific health concerns of residents and identify actions against racism.^{38,22}
4. **Gather data to identify and combat racism and inform culture change.**⁴³ Understanding the level and types of racism is a starting point in developing

strategies to combat racism. For example, one member hospital conducts employee surveys as part of a larger evaluation of the organization to identify the next steps for culture change.

Policies, Programs, and Initiatives to Combat Structural Racism

5. **Evaluate and revise institutional policies to support diversity and anti-racism in hiring and promotions.**^{37,38,39,44} Multiple members of America's Essential Hospitals are evaluating policies and procedures related to hiring and promotions because of the known disparities in pay. For every \$1 a white, non-Latino person makes, a Black person makes 76 cents, a Hispanic/Latino makes 73 cents, and a Native American makes 77 cents.⁴⁵ The goal is to create specific policies and procedures to ensure a more diverse pool of candidates. Another example is creating a pipeline for people of color to be hired into health care, such as reaching out to HBCUs.^{37,38} Similarly, hospitals can evaluate and revise policies related to promotions to identify and mitigate potentially biased selections. Finally, some hospitals are revising all antidiscrimination policies, protocols, and reporting.^{37,38,39,43}
6. **Gather data to identify and combat racism and inform policies.**^{41,43} While the Equal Pay Act of 1963 required equal pay for equal work, the current federal administration rolled back the previous administration's requirement to provide pay data with gender, race, and ethnicity, even though disparities have increased over the past 40 years.^{46,47,48} One member hospital is conducting an equity analysis to identify and mitigate disparities in income among employees.⁴⁴ In another example, a couple of member hospitals increased the minimum wage to a living wage after analyzing the cost of the competition and, in one case, turnover rates.^{49,50} To develop baseline data for recording discrimination, one member hospital is examining what data they already have in house that can be used.⁴¹
7. **Train and mentor to promote career advancement.** A couple of member hospitals are developing a training and mentoring program for employees of color to support upward mobility and career advancement, given the known widespread racial differences in hiring, performance ratings, promotions, and other outcomes.^{39,43}
8. **Educate and empower staff to educate other staff.**^{37,39,41,42} Multiple hospitals plan to regularly provide anti-racism or implicit bias training for their workforce.^{37,39} One academic medical center and member hospital is requesting input from residents, medical students, and trainees on learning climate and curriculum with respect to equity and racism.³⁷ This same hospital is developing a "stop-the-line" initiative to call out racism, similar to the one focused on patient safety, whereby anyone can call out issues regarding patient safety. Similarly, another member hospital is inviting people to volunteer to be "champions" to promote inclusion and combat racism within their department.⁴¹ However, it also was noted by one member hospital that annual implicit bias training for the workforce is not enough to bring about culture change.⁴²
9. **Support and engage in advocacy to improve racial equity.**^{37,39,51} Multiple hospitals seek to support legislation to increase access to health care and improve health equity.³⁷ For example, one hospital is focusing on advocating for Medicaid, the Children's Health Insurance Program, and the Supplemental Nutritional Assistance Program.⁵⁰ Other hospitals plan on advocating for more money for social needs, social services, and social justice programs and to support investments that create innovative solutions to improve access, quality, and health outcomes for their communities, which often have large proportions of people of color.^{37,50}
10. **Invest in Black and other underrepresented groups to overcome systemic**

economic disadvantage.^{22,37,38,43} Multiple health systems are working to buy locally, thereby supporting job creation and supplier diversity, and advocating for investments to improve access to care.^{35,36,41} Examples include relocating a hospital's headquarters to an economically disadvantaged area of their city, allowing the health system to address the area's health needs better and providing business loans and grants to businesses owned by Black and other underrepresented groups to overcome systemic economic disadvantages.^{22,43}

Enhancing Clinical Processes to Reduce Disparities

11. **Improve access to and quality of care.**^{37,38,39,52,53} Multiple hospital systems have committed to improving access to primary and specialty care and continuing to help communities overcome chronic conditions among people of color.^{37,38} As mentioned earlier, hospitals have committed to collecting data to improve referrals and support quality of care.^{35,36,37} Some hospitals also revised clinical decision models.⁵¹ For example, some hospitals once used the glomerular filtrate rate with different standards for Black and non-Black patients, stemming partly from a dated belief that Black people have more muscle mass. This faulty rate might mask potential health issues and prevent Black patients from being referred to specialists; thus, use was stopped. To alleviate racial disparities in COVID-19 testing, one hospital funded mobile units to test underserved people to alleviate the problem of transportation in these areas.⁵² In all of these cases, hospitals are taking strategic approaches to improve access to and quality of care for people of color.
12. **Gather data to improve quality outcomes.**^{38,39,42} One hospital asks each department to identify an issue, present data stratified by race and ethnicity, and identify a process to improve the outcomes.⁴² Finally, to improve health care outcomes, multiple hospitals have committed to collecting better data, such as race, ethnicity, language, and social determinants of health data.^{38,39}

STRATEGIES TO COMBAT STRUCTURAL RACISM BY OTHER ASSOCIATIONS

America's Essential Hospitals has always advocated for programs and policies that help ensure access to high-quality care for all, including the most vulnerable. Our longstanding work in health equity and social determinants of health has been a stepping stone to address structural racism. We already have begun reviewing and revising our procurement and hiring policies to ensure a continuing commitment to equal opportunity for all.

To help understand other associations' work in this area, we reviewed the websites of the American Heart Association, American Hospital Association, American Medical Association, Association of American Medical Colleges, Catholic Health Association of the United States, Children's Hospital Association, Healthcare Action Network, Institute for Healthcare Improvement, National Association of Community Health Centers, National Medical Association, and Society of Black Academic Surgeons. We summarize the themes below.

1. **Recognizing that structural racism is a root cause of health inequities.**^{54,55,56,57,58,59,60,61,62} Many, although not all, associations have made public statements regarding structural racism. Pledges are the most commonplace, likely because of the momentum around the nation demanding justice for the killing of countless Black individuals who have died as a result of police violence and hate crimes. It is unclear what strategies the associations will adopt to address these issues. Some associations were quite specific, including one that stated it would "actively work to dismantle racist and discriminatory policies and practices across all of health care."⁵³ In 2008, this same association "unequivocally apologized for our past behavior. We pledge to do everything in our power to right the wrongs that were

done by our organization to African-American physicians and their families and their patients.⁶³ Other associations are struggling; for example, one association recently retracted a paper arguing against affirmative action.^{64,65}

2. **Organizing learning activities and resources to support health care leadership related to diversity and equity.**^{34,66,67,68,69} Two organizations focused on creating leadership certificate courses, learning and action networks, and white papers. Two associations are collaborating to create an action collaborative to increase the number of Black people in medicine. Their associations then will engage a broader variety of partners in K-12 schools, higher education, academic medicine, community-based organizations, professional organizations and societies, and other key stakeholders to further refine the action agenda. The associations then will plan for the implementation and evaluation of system-level interventions.³⁴ All these activities focus on equity and diversity rather than combating structural racism.
3. **Using an anchor network strategy that seeks to improve community health and well-being by leveraging assets—such as hiring, purchasing, and investment—for equitable, local economic impact.**⁷⁰ This anchor network strategy recognizes that health care organizations are a major employer in the communities they serve and can make strategic decisions to hire, purchase, and invest locally and inclusively with a goal of benefiting people with low incomes and underrepresented groups. Fifty health systems across the United States have adopted this strategy and seek to establish the anchor mission as a health care sector priority. Although this strategy was not directly born out of an anti-racism mission, the principles of the anchor strategy apply to health systems seeking to form such a mission. For example, hospital systems can create positive change by making strategic business investments that promote equity and partnering with local businesses owned by people of color for hospitals' supply chain needs. Nineteen members of America's Essential Hospitals also are members of this 50-system Healthcare Anchor Network, and America's Essential Hospitals has been partnering with Healthcare Anchor Network on advocacy efforts.

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