June 26, 2026

Dear members of UConn Health community and community partners,

**Introduction:**

It is with pleasure that we submit our third annual report to you which provides an overview of our efforts to address health care disparities for CY 2025 in compliance with the standards set by The Joint Commission (TJC). This report specifically highlights the comprehensive efforts of a collaborative team from stakeholder groups across UConn Health and community partners. We are excited about this important work and the impact that it has on the communities we serve.

**Background:**

Effective January 1, 2023, new and revised requirements to reduce health care disparities were applied to organizations in The Joint Commission's ambulatory health care, behavioral health care and human services, critical access hospital, and hospital accreditation programs. John Dempsey Hospital and UConn Health leadership stood up a multidisciplinary and interprofessional team of stakeholders which was led by Jeffrey F. Hines MD, Vice President, Office for Inclusion and Civil Rights.

In 2023 and 2024, the team met bi-monthly, worked on implementing a health equity/DEI dashboard, and focused on food and transportation insecurity among all patients admitted to our OB unit. In 2023, the group identified disparities in a few selected postpartum complications in our Latine OB population. An action plan was developed, which we continued to implement in 2024, to address the disparity in postpartum infection (see the 2024 annual report for further details).

In 2025, we agreed to a refresh of the working group to a smaller, core group and extended invitations to new members based on the disparities and action plans identified by the group. The team is currently convened by the Interim Assistant Vice President for Diversity and Inclusion in the Office for Inclusion and Civil Rights, meets monthly, and includes representatives from the following administrative areas: John Dempsey Hospital, Clinical Effectiveness, Population Health, the Health Disparities Institute, and UConn Health Leaders (UCHL).

**Health Equity and Diversity Dashboard**

As noted in our 2024 report, we implemented a health equity/DEI dashboard using a national database from Vizient. This year themes that began to emerge from early analyses of the data were the readmission rate for Latine patients with Congestive Heart Failure (CHF) and an increased Length of Stay (LOS) for All Black patients.

In late 2025, we rolled out an update of our health care forms to include expanded options for race, ethnicity, and language (REL). This update went out as a “Serving You Better” announcement to patients through MyChart. This effort brought us into alignment with CT Gen Stat § 19a-754d. (2024) using the tools and best practices developed out of The REL Collaborative Network, a collaborative learning network for healthcare providers in CT.

As part of the review of the CHF patient outcomes data, differences emerged between the demographic data reports that were available to us through EPIC here at UConn and the reporting parameters available in the Vizient reports. As a result, we spent much of the year reviewing and aligning demographic classifications and data collection practices, as well as developing updated analyses of the CHF metrics data.

Analysis of readmission data from January 2024 until March 2026 identified race as the only demographic variable significantly associated with readmission risk. Compared with all other racial groups combined, Black patients demonstrated significantly greater odds of readmission (OR 1.49, 95% CI 1.19–1.87, $p<0.001$), while White patients demonstrated significantly lower odds of readmission (OR 0.71, 95% CI 0.59–0.86, $p<0.001$). This corresponds to a 49% higher likelihood of readmission among Black patients compared with non-Black patients and a 29% lower likelihood of readmission among White patients compared with non-White patients.

Examination of observed readmission rates demonstrated that Black patients experienced a 19.4% readmission rate during the study period (2004 through Q1 2026). This exceeded both the aggregate performance of surrounding hospitals (17.8%) and our institutional benchmark of approximately 14.5%. Notably, this was the only subgroup across analyses stratified by race, ethnicity, sex, and insurance status with a readmission rate exceeding 18%.

No statistically significant associations with readmission were identified for Asian or Other racial groups, sex, ethnicity (Hispanic versus non-Hispanic), or insurance payer status.

Simultaneously, an MPH student from UConn Health spent the 2025-2026 academic year exploring platforms to enhance the existing dashboard. This involved discussions with IT staff, as well as with key stakeholders to determine the variables and cadence of reports related to patient outcomes, patient experience, and the UConn Health workforce. The "refresh" of the dashboard now incorporates Power BI, in addition to Vizient, that allows for improved useability

**Culturally Relevant Congestive Heart Failure (CHF) Dietary Education**

In response to the difference in readmission rates for our Latine patients with CHF, our Heart Failure Program Coordinator and her team developed *Alimento Para Tu Corazón,* (*Food for Your Heart*). These educational materials include information on the impact of saturated and trans fats and salt intake, options for alternative seasonings, and healthcare tips. Our Director of the Health Disparities Institute (HDI) then facilitated a Community Advisory Board (CAB) Review session with members of the Pa'lante team, which is a collaboration between HDI and the Hispanic Health Council. Participants raised a range of questions and concerns related to nutrition, chronic disease, and the practical realities of maintaining a healthy diet. Specifically, concerns were raised about plastic, canned foods, and the quality of foods distributed by foodbanks. Participants noted that healthier options are often expired, and that cost and limited access to culturally relevant foods, especially Spanish foods, make healthy eating difficult. They emphasized that what is considered "healthy" is often unaffordable. Participants also discussed gender differences in heart disease, noting that symptoms in women are often misdiagnosed as anxiety. They expressed a need for more classes and education about healthy foods such as cooking demonstrations.

Participants expressed a strong desire for practical tools: quick and easy recipes, ingredient lists, culturally relevant options, and hands-on demonstrations.

**Screening for Social Determinants/Drivers of Health (SDoH)**

In 2025, the team focused on increasing screening efforts. After expanding the domains to include food insecurity, transportation, housing instability, utilities, and interpersonal safety, we expanded the scope to include all inpatient units in Feb of 2025. Inconsistent screening practices were observed, and screening rates varied unit by unit. With our nursing education department and nurse manager team, re-education efforts were launched to address the screening process, assure new hires were oriented appropriately and connect SDOH screening to our overall mission and the impact on patient care. The screening rates increased significantly from 65% in 2024 to 87% in 2025.

Here is a summary of the 2025 data for the collection of social determinants/drivers of health:

Reporting Period: 1/1/2025- 12/31/2025

| SDOH Domain | Screening Rate | Screened Positive |
|---|---|---|
| Food insecurity | 87.9% | 0.3% |
| Transportation needs | 87.3% | 4.6% |
| Housing Instability | 86.7% | 1.9% |
| Financial Resource Strain | 87.2% | 8% |
| Interpersonal Violence | 86.7% | 1% |

Referral to social work and distribution of appropriate resources was offered to patients who screened positive prior to discharge from the hospital.

**Postpartum complications in our Latine OB population**

As noted in last year's report, in 2023, we identified disparities in a few selected postpartum complications in our Latine OB population. In 2025, we continued to implement the action plan to address the disparity. OB-GYN developed a separate data dashboard to capture additional data within the population and are investigating additional disparities and opportunities for intervention, evaluation, and assessment to improve impact and outcomes. In addition, OB-GYN is now making referrals to the Hispanic Health Council prepartum and postpartum to address language concordance and continue to monitor disparities.

**Next Steps**

Moving forward, we will continue to build on the areas of focus outlined above.

Health Equity and Diversity Dashboard

- Finalize the "refresh" of the dashboard
- Identify a plan for granting access in concert with the data governance experts
- Develop an implementation plan for access and training needs

Culturally Relevant Congestive Heart Failure (CHF) Dietary Education.

- Finalize the handouts based on the feedback from the Pa'lante team
- Develop a distribution plan for the handouts
- Connect with CT AHEC to explore the possibility of collaborating on organizing and distributing healthy food bags to CHF patients
- Expand the collaboration with the Hispanic Health Council on nutrition programming to identify opportunities to collaborate and gaps UConn Health could fill
- Explore replicating this process for other populations, particularly Black patients

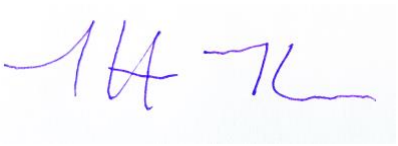
Screening for Social Determinants/Drivers of Health (SDoH)

- Explore continued options for education to enhance screening rates
- Connect with Case Management to explore options to address food quality as part of the food insecurity screening and referral process

Postpartum complications in our Latine OB population

- Continue to monitor the action plan quarterly to assess progress in addressing this identified disparity

Respectfully submitted,



Jeffrey F. Hines MD
Vice President for Diversity and Inclusion,
UConn/UConn Health

Kathleen Holgerson, MPA
Interim Assistant Vice President for
Diversity and Inclusion