Optimizing Healthcare Efficiency, Equity, and Patient Experience: A Data-Driven Approach to Risk, Disparity, and Satisfaction

Executive Summary

This analysis identifies critical areas for improving healthcare delivery, focusing on expenditure efficiency, equity, and patient satisfaction. Key findings highlight disparities in healthcare spending across ethnic groups and conditions like ESRD and disabilities, emphasizing the need for targeted resource allocation. Preventive services and chronic condition management are pivotal for reducing avoidable hospitalizations and improving outcomes in underserved communities. Enhancing provider communication, care coordination, and resource stewardship are essential for increasing patient satisfaction. Actionable recommendations include optimizing preventive care, investing in chronic disease management, and addressing equity gaps through strategic policy initiatives, ensuring sustainable, high-quality healthcare for all populations.

Objective and Method Statement

Objective 1: To implement a risk model which fosters expenditure efficiency while maintaining safety scores.

In order to accomplish this goal, a scatter plot will be used to examine the correlation between CMS-HCC risk scores and per capita spending over a three-year period, providing information on trends and clusters. A bar chart that highlights gains or losses will compare the financial performance of the One-Sided and Two-Sided risk models. Lastly, a box plot will show the distribution of expenses and outliers for every risk model, highlighting inefficient locations and potential areas for cost reduction.

Objective 2: To address the disparity of healthcare expenditure over discharges and ethnic groups.

The association between inpatient discharges and associated costs will be analyzed using a scatter plot, which will show how utilization influences costs. To find inequities in the distribution of resources, expenditure differences between ethnic groups will be examined. Furthermore, by classifying data according to risk models, ethnic groupings, and service kinds, a treemap

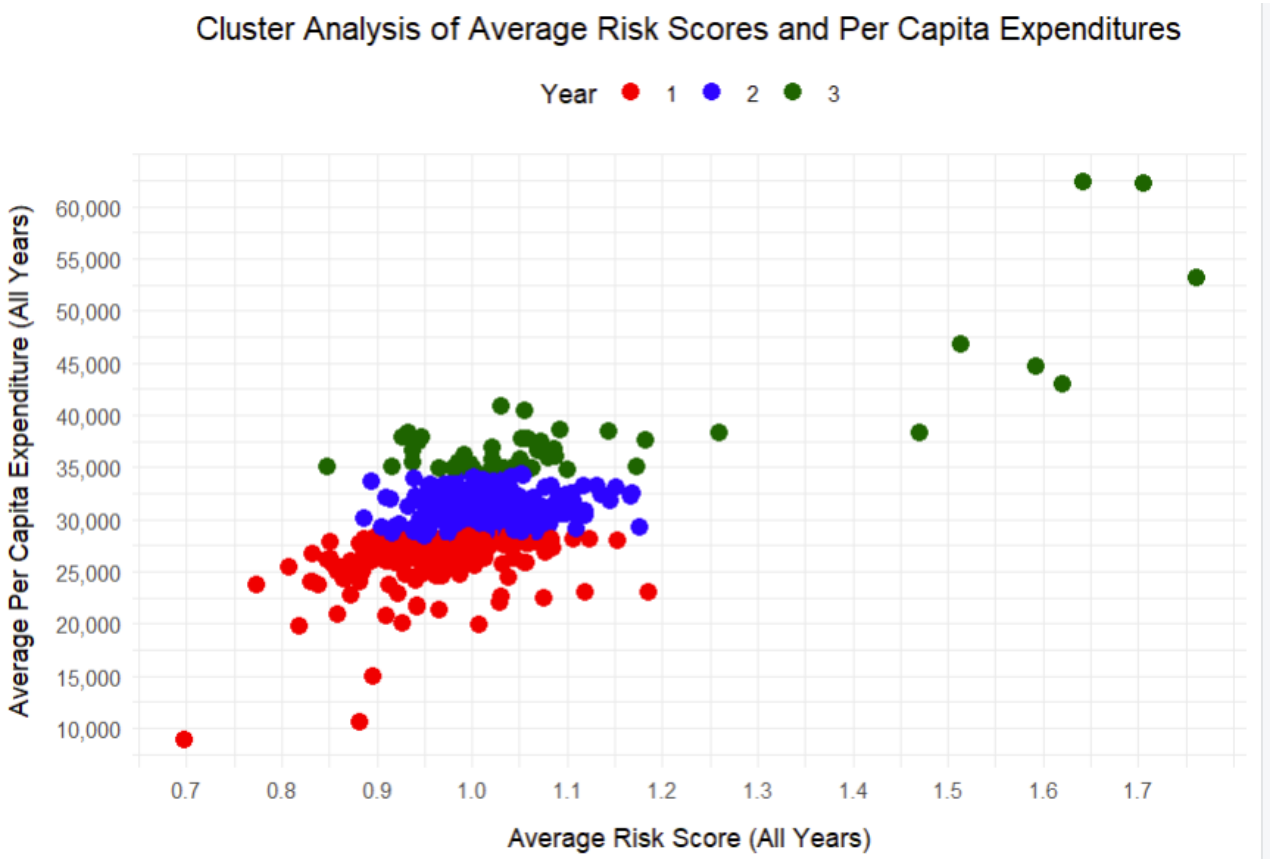
visualization will offer a thorough understanding of healthcare spending and reveal trends of disparities.

Objective 3: To systematically enhance customer satisfaction by addressing key drivers of patient experience and healthcare service delivery.

A radar graphic that highlights service delivery strengths and areas for development will provide average rating scores across important patient satisfaction measures. In order to guide focused measures for enhancing the patient experience, a correlation matrix will examine the correlations between satisfaction criteria such as provider communication, care coordination, and health outcomes.

Analysis

Objective 1: To implement a risk model which fosters expenditure efficiency while maintaining safety scores.



1.1 Understanding the Correlation

This graphic illustrates the relationship between the truncated and weighted mean total expenditures per assigned beneficiary person years over three years (y-axis) and the mean projected CMS-HCC risk scores (x-axis). This link is important for healthcare business models, especially when it comes to financial efficiency and risk management. Plotting these variables allows the chart to clearly show important clusters and patterns that can guide strategic decision-making.

Year 1 Insights (Red)

- **Risk Score Range:** 0.8 to 1.2
- **Expenditure Range:** $15,000 to $35,000 (average $26,000)
- **Implications:**
  Beneficiaries with lower to moderate risk scores and comparatively lower per capita spending are included in this cluster. It implies that members of this category are either in better health or have chronic illnesses that are under control. It is crucial to maintain these low spending levels by routine monitoring and preventive care. Costs can be kept down and preventable consequences can be avoided by taking steps like screening individuals 65 and older for fall risk in the future in which Ride (2023) and associates agree to the cost tactic.

Year 2 Insights (Blue)

- **Risk Score Range:** 0.9 to 1.3
- **Expenditure Range:** $20,000 to $40,000 (average $32,000)
- **Implications:**
  Patients with several chronic illnesses that need continuous care may be included in this group, which represents beneficiaries with moderate risk ratings and moderate per capita expenses. For this cluster to guarantee that patients receive coordinated treatment to avoid complications and control costs, effective integrated care management is essential. Chronic disease risks can be reduced by programs like regular tobacco use screening and help for patients who are 18 years of age or older to quit. This is also compelling to the study of Musich, Wang, Hawkins, and Klemes (2016).

Year 3 Insights (Green)

- **Risk Score Range:** 1.0 to 1.8
- **Expenditure Range:** $25,000 to $60,000 (average $35,000)

- **Implications:**
  Higher risk scores and higher per capita spending are among the beneficiaries in this cluster. These patients probably need special care and have complicated medical needs. To limit costs and manage chronic diseases, specialized care programs are required, including high-touch care management and cutting-edge treatment alternatives. It can be crucial to manage these complicated health demands by ensuring that patients 12 years of age and older receive routine mental health exams and follow-up treatment plans (CMS, 2022).

Implications for Healthcare Business Models

Healthcare practitioners can effectively customize their treatments to various patient groups by having a thorough understanding of these clusters. Significant resources must be allocated to high-risk, high-cost patients (Year 3) in order to manage their complex demands and possibly lower total costs through focused treatments. While low-risk patients (Year 1) can keep costs down with preventive care and health maintenance programs, moderate-risk patients (Year 2) benefit from integrated care models that treat chronic illnesses and prevent escalation.

By concentrating on the unique requirements of various patient groups, this cluster analysis provides a strategic framework for healthcare professionals to maximize care delivery and control costs. Making well-informed decisions that improve healthcare service and financial performance is made easier by recognizing and comprehending these spending trends. In order to efficiently manage overall expenses and reduce hospital admissions, for example, preventive treatments such as colorectal cancer screenings for individuals aged 50-75 years and influenza vaccinations for patients aged 6 months and older are essential. Similarly,

1.2 Risk Model and Savings

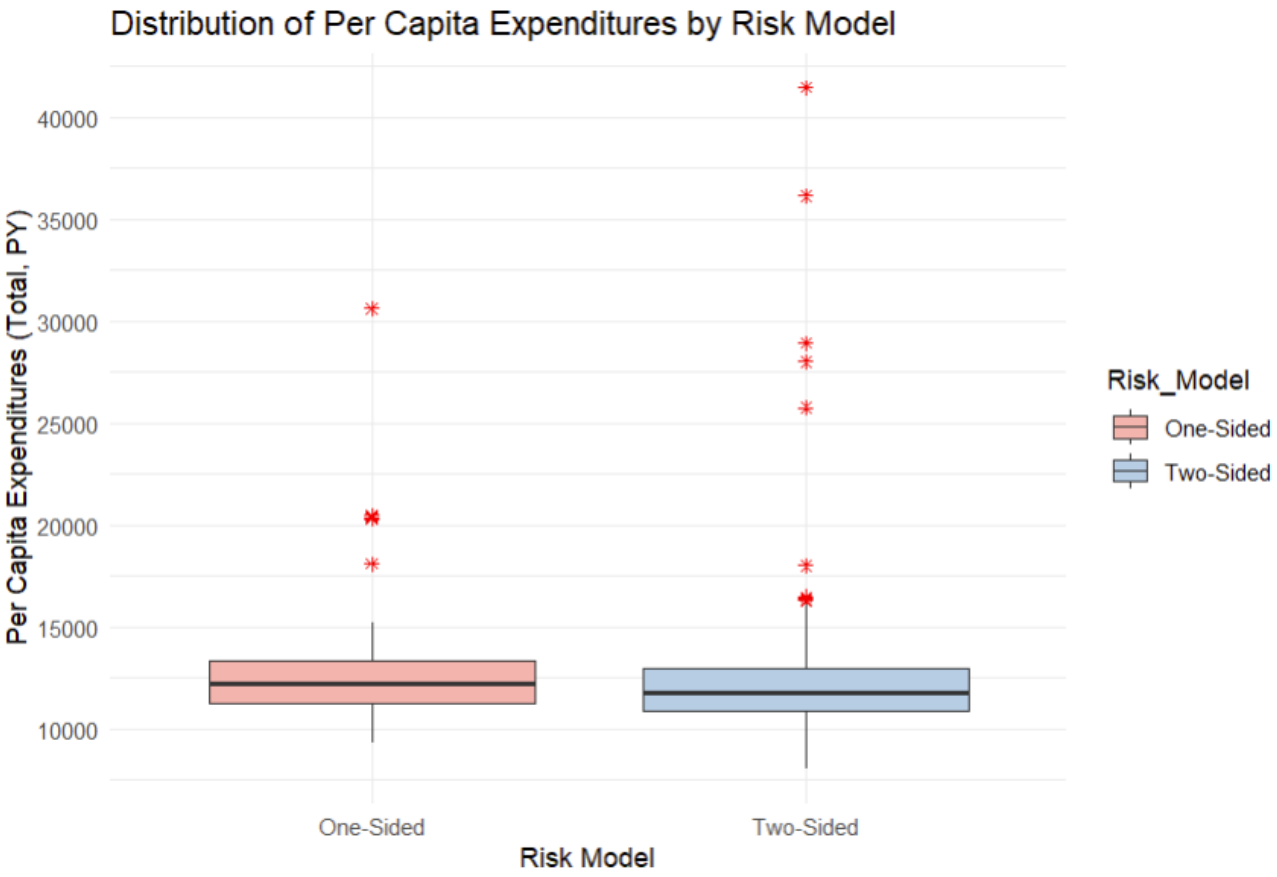
To be more granular on how the risk scores compel on financial goals, this graph illustrates remarkably well the dramatic difference in financial performances within ACOs, considering two sets of different risk models, One-Sided versus Two-Sided, and two assignment methodologies, Prospective versus Retrospective.

- One thing stands out: under whatever conditions of assignment methodology, savings generation is always higher with the Two-Sided model than with its counterpart, the One-Sided model. Where Prospective assignments yield savings of about $12 million in the Two-Sided model and approximately $5 million for the One-Sided model, for Retrospective assignments, the Two-Sided model yields close to $15 million in savings, whereas the One-Sided model yields about $7 million.

- This rather straightforward trend underlines the financial benefits of the Two-Sided risk model and could indicate that ACOs participating under this model have improved financial performance. The fact that the Two-Sided model has consistently outperformed the other models under both assignment methodologies suggests a very strong strategy toward maximizing savings.

- This will provide ACOs with valuable insight in making informed decisions about the selection of risk models that will, in turn, improve financial performance. From these dynamics shown in this chart, ACOs will strategically position their risk models and assignment methodologies to optimize their financial results, thus ensuring growth with sustainability and enhanced health delivery.

1.3 Risk Model Distribution by Per Capita Expenditures



Now, let us assess on the risk models effectively exercise their expenditures. The distribution of per capita expenditures shows that the majority of expenditures in the One-Sided risk model are concentrated between $10,000 and $15,000, with a median around $12,500. However, the presence of outliers, reaching up to nearly $30,000, indicates occasional high-cost cases that could skew overall financial performance.

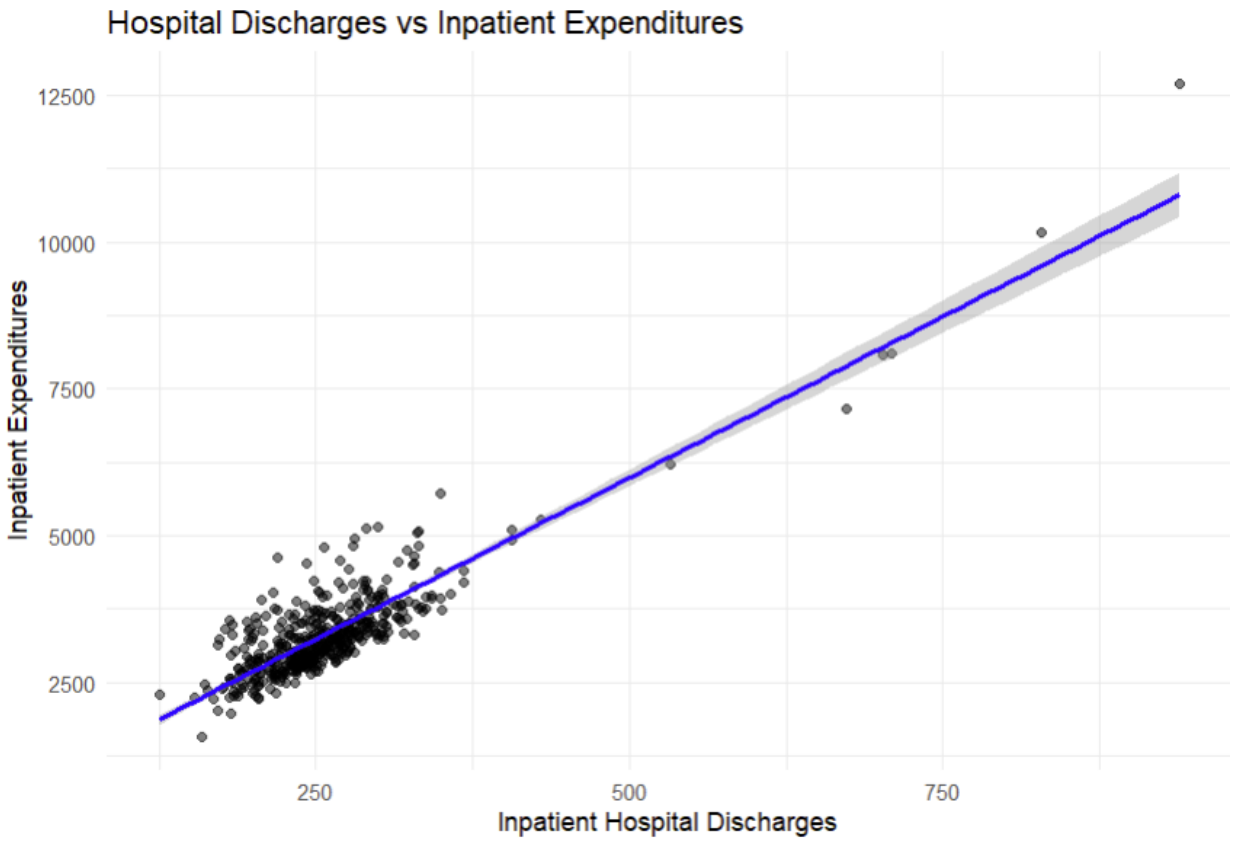
Variability: In contrast, the Two-Sided risk model exhibits a wider interquartile range, with expenditures primarily falling between $10,000 and $20,000 and a higher median of around $15,000. The outliers in this model are even more pronounced, extending up to $40,000, suggesting a greater variability in expenditures. This variability indicates a broader range of financial scenarios that ACOs might need to manage effectively.

Consistency: Relating this to the previous analysis, it becomes evident that while the Two-Sided risk model generates higher overall savings, it also involves handling a more diverse range of expenditure scenarios. This underscores the importance of robust financial management and strategic planning for ACOs adopting the Two-Sided model to leverage its potential savings while

mitigating the impact of high-cost outliers. By understanding these expenditure distributions, ACOs can tailor their strategies to optimize financial outcomes and enhance healthcare delivery.

Objective 2: To address the disparity of healthcare expenditure over discharges and ethnic groups.

2.1 Inpatient Discharges and Expenditures



The scatter plot shows that the number of inpatient hospital discharges and inpatient expenditures are positively correlated. It is the first step to investigate the indicators of disparities in the healthcare dimension. The plot indicates that hospital expenses rise in tandem with an increase in hospital discharges. While the data points clustered in the lower left show that most hospitals have lower expenditures and discharges, the higher values of the outliers demonstrate that some hospitals have much higher costs as discharges grow.

1. Disparities in Preventive Care and Screening Initiatives

The correlation between increased hospital expenses and higher discharge rates underscores the necessity of routine screenings and equitable preventive care. In underserved communities, quality metrics such as the "Percentage of adults 50–75 years of age who had appropriate

screening for colorectal cancer" and the "Percentage of patients aged six months and older who received an influenza immunization" can help reduce hospital admissions by preventing serious illnesses. This is also consistent with the work of Khoury, Maloyan, Conroy, and Epee-Bounya (2022), who emphasized the effectiveness of population management strategies in improving preventive care services.

2. Care Coordination and Follow-Up Plans

Disparities in care coordination can lead to increased expenses and readmissions. Metrics like the "Percentage of patients aged 12 years and older screened for depression with a documented follow-up plan" ensure continuous care and decrease the likelihood of recurrent hospitalizations, particularly for underserved populations with limited access to healthcare. This approach is also acknowledged by the medical study of Anderson, Mills, Willits, Lisk, Maksut, Khau, and Scholle (2022), which highlights the disparities in follow-up post-discharge, and by the intervention described by Bronstein, Gould, Berkowitz, James, and Marks (2015), which reduced readmissions through social work care coordination.

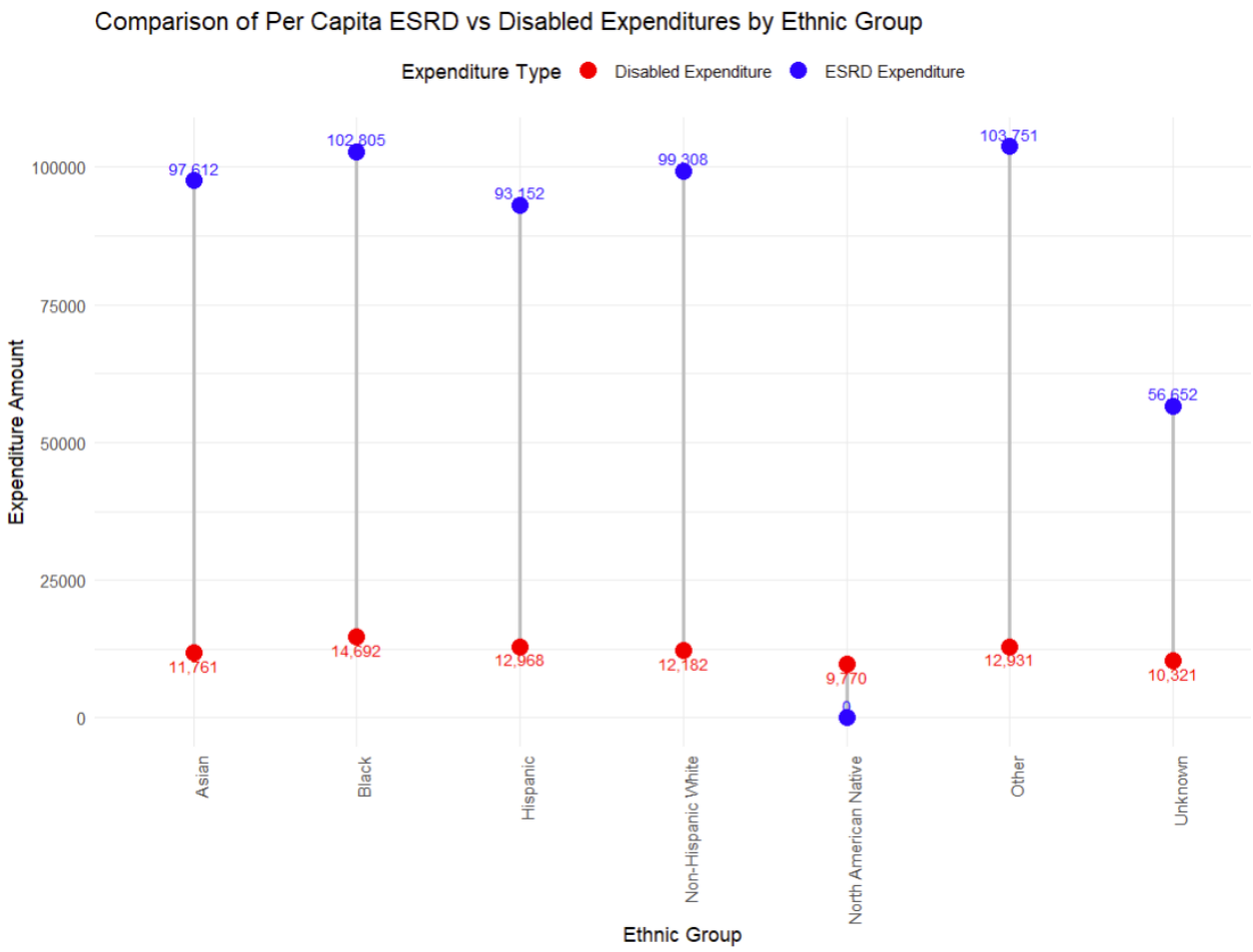
3. Resource Allocation in Acute Care

In acute care, addressing inequities in hospital discharges and expenses requires effective resource allocation. Adhering to policies such as the "Percentage of patients 65 years and older screened for future fall risk" can prevent fall-related readmissions, especially in populations lacking access to support services, thereby reducing overall inpatient costs. This aligns with recommendations from Health (2024) for reducing disparities in readmissions and is supported by the findings of Echere, Okobi, Iyun, Gyampoh, and Gill (2024), who analyzed disparities in rural versus urban hospital readmissions.

4. High-Risk Patient Interventions

Targeted interventions are essential for high-risk individuals facing disparities in healthcare quality and access. Quality metrics like the "Percentage of patients aged 18–85 years with controlled blood pressure" can aid in the effective management of chronic illnesses, reducing hospital discharges and associated expenses, particularly among ethnic groups with higher healthcare costs. This approach is reinforced by the findings of Borsky, Zhan, Miller, Ngo-Metzger, Bierman, and Meyers (2018), who identified gaps in preventive services, and Khullar and Chokshi (2018), who discussed the potential cost reductions through improved care coordination.

2.2 ESRD and Disabled Expenditure Comparison



Disparity

Second, let us see how this concerns the expenditure dimensions concern by ethnic groups. This bar chart provides a clear comparison of the average per capita expenditures for ESRD and disabilities among various ethnic groups. Black people and non-Hispanic white people had the greatest ESRD expenditures, at $102 and $99 thousand, respectively, according to the figure, highlighting the high costs of treating renal illness in these populations. Furthermore, at $14,692, the Black ethnic group has the greatest disabled expenditure compared to Non-Hispanic with the lowest Disabled expense among the first four groups, indicating a significant investment in healthcare for people with disabilities.

Asian and Hispanic are like the second recognized welfare lead spending between 11 and 97 thousand dollars range of healthcare expenses, except that Asian accounts for the wider range of expenditure to its counterpart making its ERSD ranking the third at $97 thousand while Hispanic's

is $93 thousand among the first four ethnics. Whereas, its Disabled expense is the fourth at $11 thousand while Hispanic's is just above a thousand dollar as the third among.

The expenditure levels of other ethnic groups, including Asian, Hispanic, Native American, and those classified as Other or Unknown, vary. The Unknown group has the lowest ESRD expenditure at $56,652, while the North American Native group has the lowest disabled expenditure at $9,770.

Implication

This chart's differences have significant ramifications for healthcare policy and resource distribution. In order to address underlying health issues and enhance healthcare outcomes for various populations, specialized interventions are necessary, as evidenced by the high per capita spending for specific ethnic groups. For instance, the high costs associated with disabilities for Black people point to the need for more resources and support to manage disabilities in this population.

In order to manage and lower the prevalence of ESRD in this community, it is also imperative to increase access to preventative care and early intervention measures, as evidenced by the high ESRD costs for North American Natives. In order to advance health equity and guarantee that all ethnic groups have access to the resources they require for healthcare, it is imperative that these inequities be addressed.

Connecting these insights to the implications of the scatter plot "Hospital Discharges vs Inpatient Expenditures," we can see that disparities in healthcare spending contribute to increased hospital discharges and higher overall costs. By focusing on equitable healthcare initiatives and targeted interventions, we can reduce hospital discharges and inpatient expenditures, ultimately improving health outcomes and achieving financial sustainability within the healthcare system.

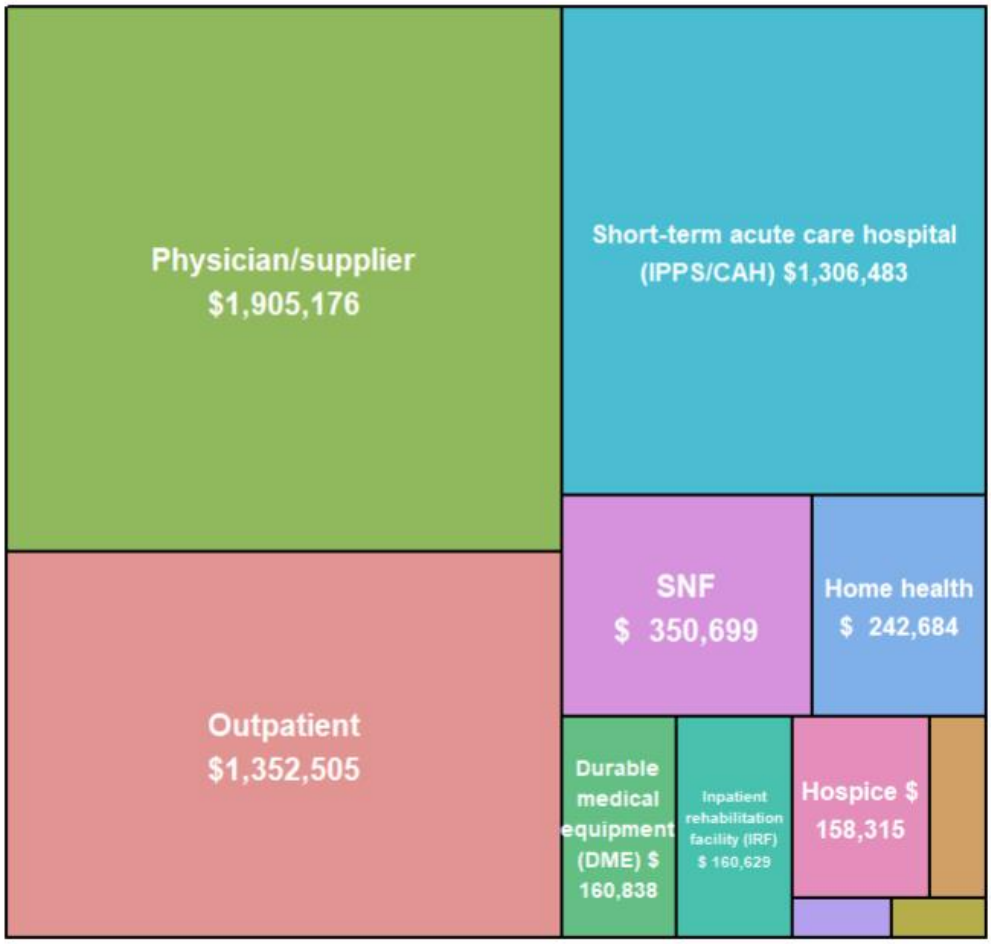
2.3 The Expenditure Treemap

Third, the expenditure treemap offers a graphic depiction of healthcare expenditures in a number of areas, including acute care hospitals, outpatient services, and physician/supplier expenses. This thorough analysis is essential for pinpointing places where ethnic healthcare disparities can be addressed. Policymakers and healthcare professionals can identify gaps and areas of disproportionate budget allocation by examining the treemap.

Key Areas for Reducing Disparities

The expenditure treemap offers a graphic depiction of healthcare expenditures in a number of areas, including acute care hospitals, outpatient services, and physician/supplier expenses. This thorough analysis is essential for pinpointing places where ethnic healthcare disparities can be addressed. Policymakers and healthcare professionals can identify gaps and areas of disproportionate budget allocation by examining the treemap.

Healthcare Expenditures Treemap



Key Areas for Reducing Disparities

1. Identifying High-Cost Areas

Important spending categories are highlighted in the treemap, including the $1,352,505 spent on outpatient services and the $1,905,176 spent on physician/supplier services. It is possible to guarantee that resources are fairly allocated to underprivileged ethnic groups that may not be receiving proper treatment by concentrating on these high-cost areas.

2. Enhancing Preventive Services

Improving access to screenings and immunizations is crucial for reducing avoidable hospitalizations, particularly among ethnic groups with higher health risks. This is also consistent with the findings of Black, O'Halloran, Hung, Srivastav, Lu, Garg, Jhung, Fry, Jatlaoui, Davenport,

Burns, and Influenza-Associated Hospitalization Surveillance Network (2022), who emphasized that increasing vaccination coverage, such as the "Percentage of patients aged six months and older who received an influenza immunization," can significantly lower hospitalization rates among racial and ethnic groups with historically lower vaccination uptake.

3. Allocating Resources for Chronic Conditions

Effective resource allocation is essential for managing chronic illnesses prevalent among specific ethnic groups. This approach is also acknowledged by Benavidez (2024), who highlighted the sociodemographic and geographic disparities in chronic disease prevalence, stressing the importance of targeted investments. For instance, allocating funds to home health services and skilled nursing facilities (SNFs) can enhance long-term care quality for elderly and chronically ill patients, especially in underserved areas.

4. Addressing Acute Care Needs

Acute care hospitals can optimize resource allocation, as demonstrated by the $1,306,483 spend, to guarantee that high-need areas receive sufficient assistance. For ethnic groups with greater healthcare expenses, this can lower overall inpatient spending and avoid frequent hospital readmissions. By leveraging the insights from the expenditure treemap, healthcare providers can strategically allocate resources to reduce disparities, enhance preventive care, and ensure equitable access to high-quality healthcare for all ethnic groups.

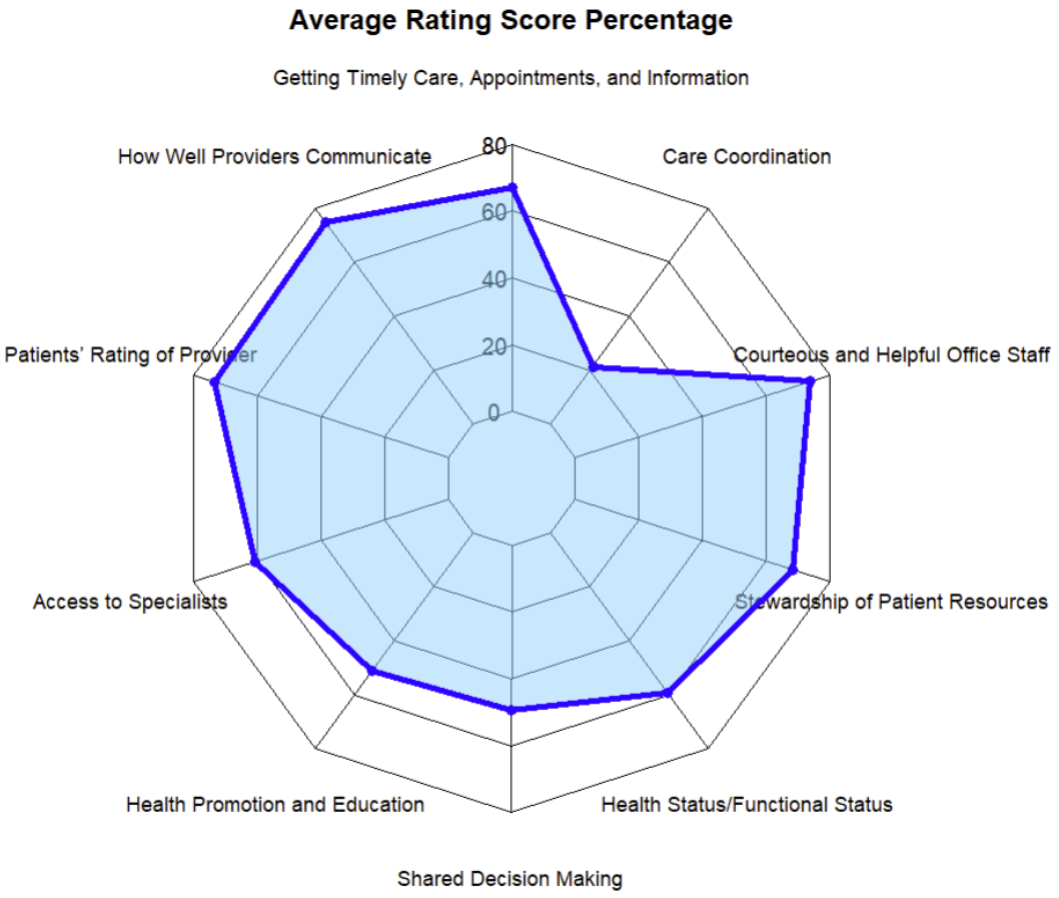
Objective 3: To systematically enhance customer satisfaction by addressing key drivers of patient experience and healthcare service delivery.

A clear picture of customer satisfaction across important healthcare service characteristics is provided by the "Average Rating Score Percentage" radar chart. The chart's clear peaks and troughs reveal information about the regions in which patients are most and least satisfied.

High ratings for provider quality and communication satisfaction suggest that these aspects are essential to the patient experience, favorably influencing encounters with medical professionals and their perceived level of competence. Patients seem to respect their healthcare providers and value clear, effective communication, which suggests that their relationships with them are based on trust and dependability.

The efficiency of organizational efforts to deliver smooth and amiable services is demonstrated by the comparatively good performance in areas like care coordination and interactions with support staff. These elements most likely have a beneficial impact on patient satisfaction, demonstrating effective interpersonal and logistical tactics used in healthcare institutions.

3.1 ACO Service Rating Score Percentage by Average

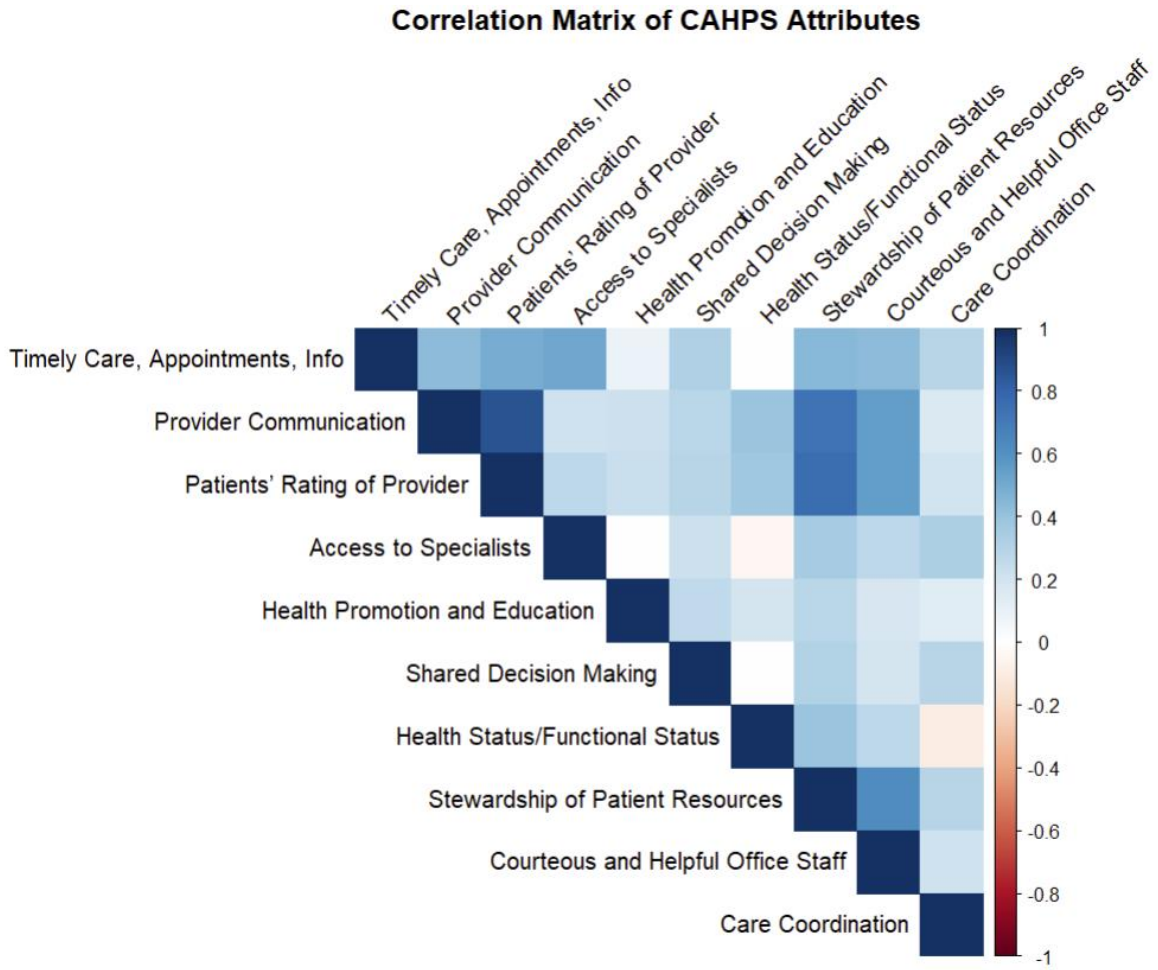


On the other hand, patients may feel less involved or knowledgeable about their treatment processes if they receive lower scores in resource management and decision-making. This could indicate areas in which healthcare professionals may need to improve patient involvement or transparency in order to better satisfy expectations.

There is potential for improvement in preventive treatment and continuing patient support, as indicated by the moderate satisfaction levels in health promotion and functional status. There is room for improvement in these areas since they are critical to patient involvement and long-term health outcomes.

Overall, the chart provides a comprehensive view of healthcare services' strengths and potential areas for improvement, making it a useful tool for assessing patient satisfaction and directing future developments.

3.2 Correlation Matrix of Service Provider Attributes by Score Percentage



Positive Correlations

1. **Provider Communication vs. Patient's Rating of Provider:**

Patients' evaluations of their doctors are strongly positively correlated with provider communication. This implies that patients are more likely to give doctors excellent ratings when they communicate well. Improving healthcare providers' communication abilities can result in improved ratings and increased patient satisfaction. Patient experiences can be greatly enhanced by training programs that emphasize empathy, active listening, and the delivery of clear information. This is also consistent with the work of Moslehpour, Shalehah, Rahman, and Lin (2022), who found that effective physician communication positively impacts inpatient satisfaction.

2. **Provider Communication vs. Stewardship of Patient Resources:**

Effective patient resource management is positively correlated with clinicians' communication skills. Effective communication is linked to improved resource management. The way that patient resources are perceived and managed may be improved by effective communication. Patients have greater faith in the care they receive when doctors are transparent about treatment plans, options, and resource consumption. Better patient outcomes and more effective use of resources may result from this. This approach is also acknowledged by Misra, Sedig, Dixon, and Sibbald (2020), who discuss the importance of prioritizing coordination in primary healthcare to enhance resource management.

3. **Stewardship of Patient Resources vs. Patient's Rating of Provider:**

Patients' evaluations of clinicians are positively correlated with the stewardship of patient resources. Patients are more likely to rate providers that effectively manage their resources. Increased patient satisfaction can result from the efficient and effective administration of patient resources. In order to guarantee that patients receive the right care without wasting any resources, providers should concentrate on using healthcare resources in a transparent, equitable, and prudent manner. This is also consistent with the work of Elliott, Adams, Klein, Haviland, Beckett, Hays, Gaillot, Edwards, Dembosky, and Schneider (2021), who found that patient-reported care coordination is associated with better performance on clinical care measures.

4. **Courteous and Helpful Office Staff vs. Stewardship of Patient Resources:**

The perceived stewardship of patient resources is positively correlated with office staff's politeness and helpfulness. Improved resource management is facilitated by amiable and helpful office personnel. The general impression of resource management can be enhanced by teaching office workers to be polite and helpful. Patients are more inclined to trust the healthcare system and believe that resources are used appropriately and effectively when they feel supported and welcomed by office workers. This can raise the standard of care and increase patient satisfaction in general. This approach is also acknowledged by Gao, Zhang, Zhou, Lei, Wei, and Shi (2024), who found that provider-patient communication skills impact primary healthcare quality and patient satisfaction.

Negative Correlation

1. **Access to Specialists vs. Health Status/Functional Status:**

Patients who need specialized treatment frequently have worse general health or functional status, as seen by the negative link found between access to specialists and these variables. In essence, people who require specialized care are typically in worse condition. This association emphasizes

how crucial early treatments and efficient primary care are. Specialist intervention is less necessary when primary care efficiently handles health issues early on. Health problems can be detected and treated by prompt, thorough basic care before they worsen and necessitate specialized treatment. The general health and functional status of patients can be improved by expanding access to early interventions and improving primary care services. By emphasizing preventative measures and regular screenings, medical professionals can identify health issues early, treat them successfully, and lessen the need for specialized treatment. In addition to improving patient outcomes, this strategy lowers healthcare expenses and lessens the demand on specialized services. This is also consistent with the work of Misra et al. (2020), who discuss the importance of prioritizing coordination in primary healthcare to enhance resource management.

2. **Care Coordination vs. Health Status/Functional Status:**

Ineffective care coordination has a negative impact on patients' health outcomes, as indicated by the negative association found between care coordination and health status/functional status. Ineffective provider coordination can result in gaps in care, which can lower patients' functional status and overall health. Effective care coordination ensures that all healthcare providers involved in a patient's care are well-informed and synchronized. This includes sharing patient information, planning follow-up care, and avoiding duplicated or conflicting treatments. Inefficient coordination leads to fragmented care, which can cause delays in treatment, missed follow-ups, and overall lower quality of care. Patient satisfaction and health outcomes can be greatly improved by better care coordination. To guarantee smooth provider communication, healthcare systems should leverage technology like Electronic Health Records (EHR) and integrate care plans. Effective care coordination enables medical professionals to give patients with more thorough and prompt care, avoiding problems and guaranteeing improved health and functional status. This strategy raises general satisfaction with the healthcare system in addition to improving patient outcomes. This is also consistent with the work of Elliott et al. (2021), who found that patient-reported care coordination is associated with better performance on clinical care measures.

Conclusion

ACOs should concentrate on the Two-Sided risk model in order to use a risk model that promotes spending economy while preserving safety ratings. Regardless of the assignment approach (prospective or retrospective), this model consistently produces better savings than the One-Sided model. Greater spending unpredictability is shown by the Two-Sided model, indicating the need for strong financial management techniques that let ACOs maximize savings without sacrificing patient safety. ACOs can strike a balance between cost effectiveness and treatment quality by carefully controlling spending scenarios, especially in acute and chronic care.

ACOs must give targeted interventions for populations with greater healthcare expenditures priority in order to alleviate differences in healthcare spending among discharges and ethnic

groups. End-stage renal disease (ESRD) and disability costs are higher in Black and non-Hispanic White populations, necessitating specialist care management. To manage these disparities, investments should be made in **preventive services** like screenings and immunizations, particularly for underserved communities. Enhancing follow-up plans and care coordination can cut down on avoidable hospital stays and discharges, which will eventually save healthcare expenditures and improve these groups' health outcomes. Enhancing follow-up plans and care coordination can also lower avoidable hospitalizations and expenses, especially in areas where access to treatment is limited.

To systematically enhance customer satisfaction, ACOs should address key drivers of patient experience such as provider communication, stewardship of patient resources, and care coordination. The analysis emphasizes the strong positive correlation between provider communication and patient satisfaction. Investing in training programs that enhance communication skills will likely improve patient ratings of providers and increase trust. Furthermore, improving care coordination and functional status will contribute to better long-term health outcomes and reduce avoidable hospital discharges, addressing patients' concerns and improving overall satisfaction.

Recommendations

To achieve expenditure efficiency while maintaining safety scores, the following steps are recommended:

1. **Adopt the Two-Sided Risk Model**

   Higher savings and shared accountability among providers are two benefits of the Two-Sided risk approach. Through the alignment of incentives with patient outcomes and financial performance, companies can manage the fluctuation of expenditures. It is important to execute routine audits and scenario studies in order to evaluate performance and guarantee financial stability.

   Actionable Item: Create simulation models for different patient demographics under the Two-Sided framework to predict financial and safety outcomes.

2. **Implement Optimal Risk Score**

   The cluster analysis captures a better and safer scale in year one for ACOs to execute which mostly concentrates at around 9.5 while increasing expenditure per capita. This shows year 3 a very unsolid projection of risk and spending wise, from which it can learn from its past metrics to ensure the average risk score is less than 1 while keeping up with resource utilization for healthcare science and business.

   Actionable Item: Limit the risk score to 9.5 on average and replicate the expenditure assignments, testing, and medical procedure metrics of year 1 to not just maintain efficiency but budget productivity while being safe and professional.

3. **Enhance Care Coordination**

Higher expenses are frequently the result of care coordination gaps. Digital tools like Electronic Health Records (EHRs) and structured care pathways facilitate better communication between care teams, improving patient outcomes and cutting down on duplication.

Actionable Item: Develop an integrated care coordination platform with real-time updates on patient status and provider actions.

Healthcare organizations must implement equitable resource allocation and preventive measures to reduce disparities:

1. **Invest in Preventive Care**

Avoidable hospitalizations are common among populations with higher spending, including as Black and non-Hispanic White patients. It is essential to implement programs like immunization drives and community-based screenings for chronic illnesses.

Actionable Item: Partner with local organizations to launch annual colorectal cancer screenings and influenza immunization programs in underserved areas.

2. **Standardize Care for Chronic Conditions**

Reducing the inequities in chronic illness can reduce emergency care expenses. Results can be enhanced by programs that target the management of hypertension and End-Stage Renal Disease (ESRD) among high-cost ethnic groups.

Actionable Item: Allocate resources to patient education and subsidize treatment adherence tools, such as home blood pressure monitoring kits for high-risk groups.

3. **Monitor Resource Stewardship**

Inefficient use of resources is shown by variations in hospital discharges. Disparities in care delivery can be minimized by matching spending to real healthcare needs..

Actionable Item: Use hospital discharge analytics to identify patterns among ethnic groups and implement discharge planning teams focused on equity.

4. **Integrate Cultural Competence Training**

Care providers need to be prepared to handle structural and cultural challenges. Trust and engagement are increased through customized communication and respect for different health perspectives.

Actionable Item: Conduct quarterly workshops for providers focusing on culturally sensitive care practices and communication techniques.

Improving patient satisfaction is critical for better health outcomes and service loyalty. Efforts should target specific drivers of satisfaction, such as communication, care coordination, and resource management:

1. **Enhance Provider Communication Skills**

Clear, compassionate interactions are crucial, as seen by the strong relationships found between patient ratings and physician communication. Patient impressions can be greatly enhanced by teaching medical staff to actively listen and provide clear, intelligible information.

Actionable Item: Introduce mandatory annual training on effective communication for all providers, including role-playing exercises and feedback sessions.

2. **Optimize Resource Management**

Trust and satisfaction are increased when patient resources are managed transparently. Patients are reassured about the appropriateness of care when treatment alternatives and related expenses are made clear.

Actionable Item: Develop resource utilization dashboards for patients, detailing treatment pathways and financial implications in a clear, accessible format.

3. **Improve Care Coordination**

Patient satisfaction and health outcomes are adversely affected by inadequate care coordination. Inefficiencies can be decreased by simplifying provider contacts and making sure that handoffs between specialists and primary care physicians go smoothly.

Actionable Item: Implement a centralized case manager system to oversee patient journeys and address coordination gaps promptly.

4. **Address Preventive and Long-Term Care Gaps**

There is potential for improvement in these areas, as seen by the modest level of satisfaction with health promotion and functional status programs. Engagement is increased by offering precise plans for follow-up services and preventive care.

Actionable Item: Launch targeted wellness programs, such as fall risk prevention for seniors and regular functional status assessments for chronic disease patients.

5. **Focus on Office Staff Training**

Their influence in patient satisfaction is highlighted by the favorable link found between resource management and polite office workers. Patient interactions are improved when front-line employees are equipped with interpersonal and problem-solving abilities.

Actionable Item: Establish a recognition program for exemplary office staff performance, coupled with regular skill-building workshops.

By implementing these targeted recommendations, healthcare organizations can create a robust framework for financial sustainability, equity in resource allocation, and superior patient satisfaction, ensuring long-term success in achieving the outlined objectives.

Reference

Anderson, A., Mills, C.W., Willits, J., Lisk, C., Maksut, J.L., Khau, M.T., Scholle, S.H. (2022). Follow-up Post-discharge and Readmission Disparities Among Medicare Fee-for-Service Beneficiaries, 2018. Journal of General Internal Medicine 37, 3020–3028.. https://doi.org/10.1007/s11606-022-07488-3

Borsky, A., Zhan, C., Miller,T., Ngo-Metzger, Q., Bierman, A.S., Meyers, D. (2018). Few Americans Receive All High-Priority, Appropriate Clinical Preventive Services. Health Affairs 37, 925–928.. https://doi.org/10.1377/hlthaff.2017.1248

Bronstein, L. R., Gould, P., Berkowitz, S. A., James, G. D., & Marks, K. (2015). Impact of a social work care coordination intervention on hospital readmission: A randomized controlled trial. *Social Work*, *60*(3), 248–255. https://doi.org/10.1093/sw/swv016

Black, C. L., O'Halloran, A., Hung, M. C., Srivastav, A., Lu, P. J., Garg, S., Jhung, M., Fry, A., Jatlaoui, T. C., Davenport, E., Burns, E., & Influenza-Associated Hospitalization Surveillance Network (2022). Vital Signs: Influenza Hospitalizations and Vaccination Coverage by Race and Ethnicity-United States, 2009-10Through 2021-22 Influenza Seasons. *MMWR. Morbidity and mortality weekly report*, *71*(43), 1366–1373. https://doi.org/10.15585/mmwr.mm7143e1

Benavidez, G. A. (2024). Chronic disease prevalence in the US: Sociodemographic and geographic variations by zip code tabulation area. *Preventing Chronic Disease*, *21*. https://doi.org/10.5888/pcd21.230267

Echere, J., Okobi, O., Iyun, O., Gyampoh, G., Gill, S. (2024). Health Disparities in Hospital Readmissions in Rural vs Urban Populations in the United States: A Comprehensive Review of Factors and Reduction Strategies. Medical Research Archives 12.. https://doi.org/10.18103/mra.v12i7.5699

Health, C. O. of M. (2024). *Guide for reducing disparities in readmissions*. https://www.cms.gov/about-cms/agency-information/omh/downloads/omh_readmissions_guide.pdf

Khoury, Z., Maloyan, M., Conroy, K., Epee-Bounya, A. (2022). Improving delivery of preventative care services using population management strategies. BMJ Open Quality 11, e001695.. https://doi.org/10.1136/bmjoq-2021-001695

Khullar, D., Chokshi, D.A. (2018). Can Better Care Coordination Lower Health Care Costs?. JAMA Network Open 1, e184295.. https://doi.org/10.1001/jamanetworkopen.2018.4295

CMS (2023). Performance Year Financial and Quality Result. https://data.cms.gov/medicare-shared-savings-program/performance-year-financial-and-quality-results

Elliott, M. N., Adams, J. L., Klein, D. J., Haviland, A. M., Beckett, M. K., Hays, R. D., Gaillot, S., Edwards, C. A., Dembosky, J. W., & Schneider, E. C. (2021). Patient-Reported Care Coordination is Associated with Better Performance on Clinical Care Measures. *Journal of general internal medicine*, *36*(12), 3665–3671. https://doi.org/10.1007/s11606-021-07122-8

Misra, V., Sedig, K., Dixon, D. R., & Sibbald, S. L. (2020). Prioritizing coordination of primary health care. *Canadian family physician Medecin de famille canadien*, *66*(6), 399–403.

Gao, Q., Zhang, B., Zhou, Q., Lei, C., Wei, X., Shi, Y., 2024. The impact of provider-patient communication skills on primary healthcare quality and patient satisfaction in rural China: insights from a standardized patient study. BMC Health Services Research 24.. https://doi.org/10.1186/s12913-024-11020-0

Moslehpour, M., Shalehah, A., Rahman, F. F., & Lin, H. (2022). The Effect of Physician Communication on Inpatient Satisfaction. *Healthcare*, *10*(3), 463. https://doi.org/10.3390/healthcare10030463

Ride, J., Kasteridis, P., Gutacker, N., Gravelle, H., Rice, N., Mason, A., Goddard, M., Doran, T., & Jacobs, R. (2023). Impact of prevention in primary care on costs in primary and secondary care for people with serious mental illness. *Health economics*, *32*(2), 343–355. https://doi.org/10.1002/hec.4623

CMS (2022). Risk Adjustment. https://www.cms.gov/priorities/innovation/key-concepts/risk-adjustment

Musich, S., Wang, S., Hawkins, K., & Klemes, A. (2016). The Impact of Personalized Preventive Care on Health Care Quality, Utilization, and Expenditures. *Population health management*, *19*(6), 389–397. https://doi.org/10.1089/pop.2015.0171