Advancing Health Equity-Moving From Intention to Action

Yeng M. Yang, MD, MBA
HealthPartners
I have no actual or potential conflict of interest in relation to this presentation
Who We Are

• Consumer-governed, non-profit

• Integrated health care delivery and financing
  – Clinics and hospitals
  – Health plan

• Twin Cities & surrounding communities (MN and Western WI)
Practical Steps towards Health Equity

**Leadership Commitment**
- **CEO Pledge**
  - Form committee with dedicated leadership/thought partners with diverse members

**Physician Leadership**
- **Identify Important Health Care Disparities**
- **Change Policies, Laws, Systems, Environment & Practices**
  - Integrate Equity lens into all aspect of organization including quality/safety
- **Dashboard**
  - Monitor Using Short- and Long-term
  - Reassess strategies in light of process and outcomes and plan next steps
- **Metrics with segmentation by race/ethnicity; payors**

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HealthPartners 2025 Strategic Roadmap

**ORGANIZATION**
Who Are We?

**MISSION**
What’s Our Purpose?

**VISION**
Where We’re Going?

**GOALS**
What do we need to achieve?

**STRATEGIES**
What we will do to achieve our goals?

- Operate as a System
- Digitize & Automate
- Innovate & Differentiate
- Deepen Consumer Affinity
- Evolve Culture; Transform Work
- Advance Health Equity

A value-driven health system people trust to improve health and well-being.

To improve the health and well-being of patients, members and our community.

Health as it could be, affordability as it must be, through relationships built on trust.

Excellence – Compassion – Integrity – Partnership
Equity, Inclusion & Anti-Racism

Co-Chairs:

Equity, Inclusion & Anti-Racism Cabinet

Health Equity and Eliminating Disparities

Diversity & Inclusion

Community Partnerships and Advocacy

St. Paul Anchor Strategy
Health Equity and Eliminating Disparities

Advance health equity in our care and coverage
Changing demographics

U.S. Census 2020: Minnesota grows more diverse, white population declines
Ramsey County is among the state's most diverse.

By CHRISTOPHER MAGAN | cmagan@pioneerpress.com | Pioneer Press
PUBLISHED: August 12, 2021 at 2:09 p.m. | UPDATED: August 12, 2021 at 11:50 p.m.

**Minnesota**

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<th>Of color</th>
<th>2020</th>
<th>2010</th>
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<td>77.5%</td>
<td>85.3%</td>
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<tr>
<td>Of color</td>
<td>22.5%</td>
<td>14.7%</td>
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**Wisconsin**

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<tr>
<td>White</td>
<td>80.4%</td>
<td>86.2%</td>
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<tr>
<td>Of color</td>
<td>19.6%</td>
<td>13.8%</td>
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</table>
Largest Disparity Gap = 14.2 in Optimal Vascular Care

- Most significant gap (16%) is Tobacco Free component

CHRONIC CONDITIONS MEASURES

This section of the report focuses on chronic condition measures segmented by insurance type. Chronic disease is defined as a condition that lasts one year or more and requires ongoing medical attention or limits activities of daily living or both. The Centers for Disease Control and Prevention (CDC) estimates that six in ten adults in the U.S. have a chronic disease and four in ten have two or more. Additionally, chronic diseases are not only the leading causes of death and disability in the nation but are also the leading drivers of the $3.3 trillion spent on annual health care costs. Chronic diseases are an important focus for measurement because of the large numbers of adults and children living with these conditions and known gaps in care related to optimal treatment.

In this report, we are focused on four chronic condition measures among MNCP managed care patients: 1) Optimal Diabetes Care, 2) Optimal Vascular Care, 3) Optimal Asthma Control – Adults, and 4) Optimal Asthma Control – Children. Additionally, the components of the Optimal Diabetes Care and Optimal Vascular Care measures have been added to this report as well.

For the four composite measures (i.e., Optimal Diabetes Care, Optimal Vascular Care, Optimal Asthma Control – Adults and Optimal Asthma Control – Children), there continues to be room for improvement, regardless of insurance type. However, there are significant differences in performance rates by insurance type. In particular, the Optimal Vascular Care measure has the largest gap between insurance types, with a difference of 14.2 percentage points.

Within the Optimal Diabetes Care measure, the largest gap between payers exists within the tobacco-free component with a significant difference of 10.2 percentage points.

Similarly, within the Optimal Vascular Care measure, the largest gap between payers exists within the tobacco-free component as well with a significant difference of 16 percentage points.
Care Group Demographics by Race

- **All**:
  - White: 69.2%
  - Of Color: 24.0%
  - Unknown/Choose Not to Answer: 6.8%

- **Commercial**:
  - White: 74.4%
  - Of Color: 17.8%
  - Unknown/Choose Not to Answer: 7.8%

- **Medicaid**:
  - White: 34.9%
  - Of Color: 59.4%
  - Unknown/Choose Not to Answer: 5.7%

- **Medicare**:
  - White: 84.5%
  - Of Color: 11.1%
  - Unknown/Choose Not to Answer: 4.4%
Quality Structure

Equity Cabinet → Quality Team → Senior Leaders (Sponsors)

Expert Panels → Clinical Care Teams (Primary Care & Specialty)
Channels for Quality Improvement

Central Outreach by Quality Team

Care Teams working Registries & POC work

Physician MOC Projects & Pilots
Equity Assessment Toolkit

Using this toolkit

As leaders, we have the responsibility and opportunity to take actions that bring our values to life and create a culture where every person is welcome, included, and valued. This toolkit will help you make more equitable decisions as a leader. In it, you will find an assessment you can apply to any decision-making process even if it appears to be ‘race neutral’ or otherwise fair. In this way, we as an organization can lead with integrity, continue to improve towards excellence through greater equity using a process that centers compassion and partnership across difference.
Screening for Social Determinants of Health

- Standardized screening questions that feed into centralized SDOH assessment tool
- Community Resource tool for easy reference to resources
- Direct, electronic referral to state anti-hunger organization that will connect patients to food resources, along with screening for other SDOH
Case Studies

- Chronic Disease – Diabetes/Vascular Disease/HTN
- Population Health
  – Childhood Immunization/COVID-19 Vaccines
  - CRC
Intervention strategies

- **HOME A1C TESTING** – Lab Initiative
- **EXPANSION OF RAPID A1C TESTING** - Fall 2021 (8 sites)
- **BATCH A1C ORDERS** With Monthly Appt Reminders
- **HOME BLOOD PRESSURE MONITORING** - Auto enters in Epic
- **BP HOME MONITORS FOR PATIENTS**
- **PILOT DRIVE UP A1C & BLOOD PRESSURE** - JUNE
Diabetes Patients of Color

- Patients of Color
- White
- Pt Color Goal: 45.7%
- Optimal Diab Goal: 50.8%

<table>
<thead>
<tr>
<th>Race Group</th>
<th>Met ODC</th>
<th># Eligible</th>
<th>% Met ODC</th>
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<tbody>
<tr>
<td>Of Color</td>
<td>5,979</td>
<td>14,854</td>
<td>40.25%</td>
</tr>
<tr>
<td>Unknown</td>
<td>256</td>
<td>681</td>
<td>37.59%</td>
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<tr>
<td>White</td>
<td>18,261</td>
<td>39,077</td>
<td>46.73%</td>
</tr>
<tr>
<td>Grand total</td>
<td>24,496</td>
<td>54,612</td>
<td>44.85%</td>
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2020-2021
Vascular Payor

- **Commercial**: Met OVC 4,871, # Eligible 8,417 (% Met OVC 57.87%)
- **Medicaid**: Met OVC 834, # Eligible 1,861 (% Met OVC 44.81%)
- **Medicare**: Met OVC 7,581, # Eligible 12,139 (% Met OVC 62.45%)
- **Self-pay**: Met OVC 51, # Eligible 146 (% Met OVC 34.93%)

**Grand total**: Met OVC 13,337, # Eligible 22,563 (% Met OVC 59.11%)

Medicaid Goal: 53.3%

Optimal Vasc Goal: 66.8%

### Monthly Breakdown

- **Jan-20**: Commercial 66%, Medicaid 48%
- **Feb-20**: Commercial 64%, Medicaid 47%
- **Mar-20**: Commercial 61%, Medicaid 46%
- **Apr-20**: Commercial 59%, Medicaid 43%
- **May-20**: Commercial 62%, Medicaid 42%
- **Jun-20**: Commercial 60%, Medicaid 38%
- **Jul-20**: Commercial 59%, Medicaid 27%
- **Aug-20**: Commercial 59%, Medicaid 29%
- **Sep-20**: Commercial 60%, Medicaid 33%
- **Oct-20**: Commercial 55%, Medicaid 32%
- **Nov-20**: Commercial 53%, Medicaid 35%
- **Dec-20**: Commercial 53%, Medicaid 32%
- **Jan-21**: Commercial 55%, Medicaid 33%
- **Feb-21**: Commercial 57%, Medicaid 32%
- **Mar-21**: Commercial 58%, Medicaid 32%
- **Apr-21**: Commercial 58%, Medicaid 35%
- **May-21**: Commercial 58%, Medicaid 35%
- **Jun-21**: Commercial 58%, Medicaid 35%
- **Jul-21**: Commercial 58%, Medicaid 35%
- **Aug-21**: Commercial 58%, Medicaid 35%
- **Sep-21**: Commercial 58%, Medicaid 35%
Hypertension Patients of Color

- Patients of Color
- White
- Optimal HTN Goal: 80.5%

<table>
<thead>
<tr>
<th>Race Group</th>
<th>Met</th>
<th># Eligible</th>
<th>% Met HTN</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>63,425</td>
<td>88,551</td>
<td>71.63 %</td>
</tr>
<tr>
<td>Of Color</td>
<td>12,490</td>
<td>18,689</td>
<td>66.83 %</td>
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<tr>
<td>Choose Not to A...</td>
<td>617</td>
<td>894</td>
<td>69.02 %</td>
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<tr>
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<td>72</td>
<td>112</td>
<td>54.29 %</td>
</tr>
<tr>
<td>Grand total</td>
<td>75,604</td>
<td>108,246</td>
<td>70.77 %</td>
</tr>
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</table>

Optimal HTN Goal: 80.5%
Hypertension Intervention Strategies

• Quick Schedule (EMR function) for RN BP follow up

• MTM HTN Program

• Home Remote BP Monitoring/Measurement QI/MOC
  ✓ Auto-input with EMR compatible BP monitors Piloting with Medicaid population with coverage for BP monitors
  ✓ Ensure we are not perpetuating or creating more disparities with process improvement and innovations (evaluating how to equitably distribute BP cuff when not all have coverage)
**Combo-10 Pediatric Immunizations – 2020**

**Definition:** Percent of children turning 2 years old during the reporting month who had a primary care visit in last 12 months who are up-to-date with the required HEDIS Combo 10 immunizations. (HEDIS combo 10 – DTaP - 4 doses, PCV7- 4 doses, IPV - 3 doses, Hib - 4 doses, HepA – 1 dose, HepB - 3 doses, MMR - 1 dose Varicella - 1 dose, Rotavirus 2 doses of Rotarix or 3 doses of RotaTeq, Influenza 2 doses)

- **Gap is 22.5% points**
  - February: 73.5%
  - March (Q1): 51.0%
- **Gap is 23.4% points**
  - November: 73.9%
  - December (Q4): 50.5%

**Interventions**

- Filter and prioritize outreach by patients of color, non-English speaking, and payor
- Well Child Visits only on Saturday mornings
- Every visit is an opportunity

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Systemic Racism, COVID-19 & Health Care Disparity

Syndemic Perspective:
This highlights how biosocial interactions move in both directions. Not only do social inequalities shape the risk for COVID-19; COVID-19 also is likely to exacerbate social inequities, further harming health:

- **Job loss Black>White**
  - Magnifies income & housing gap and income inequalities.

- **School moving to on-line learning:**
  - Threatens to widen the achievement gap
  - Unequal distribution of federally subsidized internet access (Rural vs inner cities)
Vaccine Equity: Reducing Disparities

• Using patients’ preferred method of communication (email/phone/text) and language
  Sending out text invitations translated into Spanish, Hmong, and Somali which has lead to a higher response rate
• Use of Interpreters:
  o Telephonic outreach with designated call back numbers
  o Vaccine sites
  o Translated vaccine education materials
• Holding vaccine slots for patients who require more time to make a decision to schedule
• Assistance with transportation
• Evening and weekend vaccine hours

120% increase in vaccination rates for patients of color
## Vaccine health equity progress: 1st dose proportion by Race

**Age Bands:** 0-14 15-24 25-34 35-44 45-54 55-64 65-74 75-84 85+  Unknown

<table>
<thead>
<tr>
<th>Race Category</th>
<th>Cumulative through Selected Week 1st dose administered</th>
<th>Latest Data (all, regardless of date) 1st dose administered &amp; future scheduled</th>
<th>Proportion of Patients within selected age bands</th>
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</thead>
<tbody>
<tr>
<td>American Indian or Alaska Native</td>
<td></td>
<td></td>
<td>0.2% 0.5%</td>
</tr>
<tr>
<td>Asian</td>
<td></td>
<td></td>
<td>6.2% 5.6%</td>
</tr>
<tr>
<td>Black or African-American</td>
<td></td>
<td></td>
<td>9.1% 10.8%</td>
</tr>
<tr>
<td>Hispanic or Latino</td>
<td></td>
<td></td>
<td>3.3% 4.1%</td>
</tr>
<tr>
<td>Native Hawaiian or Other Pacific Islander</td>
<td></td>
<td></td>
<td>0.1% 0.1%</td>
</tr>
<tr>
<td>White</td>
<td></td>
<td></td>
<td>78.4% 75.4%</td>
</tr>
<tr>
<td>Some Other Race</td>
<td></td>
<td></td>
<td>1.4% 1.9%</td>
</tr>
<tr>
<td>Choose Not To Answer</td>
<td></td>
<td></td>
<td>1.2% 1.6%</td>
</tr>
</tbody>
</table>

**Totals, for selected age bands:** 179,351
Colorectal Cancer Screening by Race

Definition:
All patients: Percent patients who have been screened for colorectal cancer by Colonoscopy in the last 10 years, Flexible Sigmoidoscopy in the last 5 years, and/or Fecal Occult Blood Test (FOBT) or Fecal Colorectal Screening (FIT) in the last 12 months.

Patients of color: Eligible patients of color, African Americans and Native Americans age 46-75, who have been screened for colorectal cancer by Colonoscopy in the last 10 years, Flex Sig in the last 5 years, or FOBT/FIT in the last 12 months.

Interventions
- Decision supports in the electronic record
- Shared decision making (FIT/colonoscopy)
- Addressing clinician unconscious bias
- Reminders for colonoscopy and FIT kit sending
- Outreach in patient’s native language

HEDIS 2019 National 90th Percentile = 72%

Gap is 13.8% points
Gap is 14.3% points

1st Qtr 2020

Patients who are white: 76.5%
Patients of color: 62.7%

4th Qtr 2020

Patients who are white: 74.4%
Patients of color: 60.1%
Colorectal Cancer Screening rates by race/ethnicity: HealthPartners vs. MN

- **Asian**: HP 71.4%, MN 65.0%
- **Black or African American**: HP 65.5%, MN 59.0%
- **Hispanic/Latino**: HP 66.6%, MN 57.9%
- **Indigenous/Native**: HP 64.2%, MN 55.4%
- **Mat-Hispanic/Latino**: HP 63.7%, MN 60.2%
- **Mat-Indigenous/Native**: HP 71.7%, MN 59.8%
- **White**: HP 77.6%, MN 74.9%
- **Choose not to answer**: HP 70.5%, MN 65.2%
- **Unknown**: HP 61.8%, MN 60.8%
- **Same Other Race**: HP 39.3%, MN 32.9%

*2020 reporting year (2019 dates of service)*

New Brand PPT Template
Colorectal Cancer Screening rates by language:
HealthPartners vs. MN

<table>
<thead>
<tr>
<th>Language</th>
<th>HP</th>
<th>MN</th>
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<tr>
<td>English</td>
<td>76.5%</td>
<td>74.2%</td>
</tr>
<tr>
<td>Hmong</td>
<td>42.3%</td>
<td>42.6%</td>
</tr>
<tr>
<td>Somali</td>
<td>36.0%</td>
<td>34.3%</td>
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<tr>
<td>Spanish</td>
<td>62.0%</td>
<td>51.7%</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>77.0%</td>
<td>74.9%</td>
</tr>
<tr>
<td>All others</td>
<td>64.2%</td>
<td>59.2%</td>
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2020 reporting year
(2019 dates of service)
Language in depth

2020 reporting year (2019 dates of service)
### MoC Cohort Summary - Race

<table>
<thead>
<tr>
<th>Report Date</th>
<th># Eligible</th>
<th>% Met ALL</th>
<th>% Rate Change</th>
<th># Eligible Pts Of Color</th>
<th>% Met - Pts Of Color</th>
<th># Eligible - White</th>
<th>% Met - White</th>
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<td></td>
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<td>1,680</td>
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<td>9,977</td>
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### MoC Cohort Summary - Payor

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<th>Report Date</th>
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<th>% Met ALL</th>
<th>% Rate Change</th>
<th># EligibleGov't Programs</th>
<th>% Gov't Programs</th>
<th># Eligible Commercial</th>
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<td>5/1/2021</td>
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<td>76.12 %</td>
<td>0.54 %</td>
<td>799</td>
<td>56.07 %</td>
<td>6,710</td>
<td>75.20 %</td>
<td>-19.13 %</td>
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<td>58.88 %</td>
<td>6,803</td>
<td>74.98 %</td>
<td>-16.10 %</td>
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Key Lessons

• Health equity isn’t a project, it’s a culture transformation (Head & Heart)

• Clear structure and alignment of the work across the organization

• Engage Board and senior leaders in the strategy

• Define concrete organizational goals on diversity, inclusion and equity – clinicians, leaders, and care teams reflect the communities we serve - define

• Collect data and regularly and transparently share results

• Intentionally apply an equity lens to all design processes from inception

• Involve care teams, patients and community in the interventions
  ✓ Employ best practices (MOC, Bias training, QI & Innovations, EMR Medical Decision Support tools)
  ✓ Pilot and spread
Q&A from live audience

• How did your organization build internal momentum to start your program?
  – The IHI reports that came out in 2001 outlining the 6 “aims”
  – HealthPartners has a rich tradition of being a quality improvement leader in our state being a founding member of many of our quality improvement org (MNCM and ICSI)
  – Led by senior leaders
CROSSING THE QUALITY CHASM
A New Health System for the 21st Century

UNEQUAL TREATMENT
CONFRONTING RACIAL AND ETHNIC DISPARITIES IN HEALTHCARE
Q&A from live audience

• How did you decide which community agencies to partner with, vs. others?
  – Partner organizations were chosen based on the communities of color we served (AA/Black, SE Asians, and Hispanic)

• How did you get the cost of your program approved by your health system?
  – We received some grants from some of our partnering organizations (example: Medtronic for Equity Champions)
  – Community workers who were essential advisers and liaisons for early engagement with communities of color (paid for by HP Health Plan)
Q&A from live audience

Do you anticipate you will be able to continue your program long term?

- Yes; we consider this work mission critical. We have not allocated a “separate” budget for this work. Our view and approach is that we are baking Equity, Diversity and Anti-Racism into all existing work and structure. When each service line leader(s) plans their budgets, strategic priorities and operations at all levels, we expect them to put those priorities through the equity lens and align them with our organizational goals.

For example:

1) Retention and recruitment requires a change in how leaders are posting positions in terms of education/experience of the candidate to cast a wider net for candidates.

2) Bias training as part of their individual professional development plan as well as mandatory education to help our leaders and workforce to recognize bias and how to mitigate bias in the workplace.

- The Equity, Inclusion and Anti-Racist Cabinet ensures that all work across the system align with organizational goals around defined equity, inclusion and anti-racism goals that are affirmed by the Board of Directors of HealthPartners.

- There is a business case to continue this work in order to remain viable and relevant
Q&A from live audience

• How long do you expect before you can see measurable improvements in health equity?
  
  – We have been monitoring measurements since the inception of our work over 18 years ago when we first started with just collecting the data.
  
  – We see that we have made progress in closing some gaps in our chronic diseases and population health screening, breast cancer screen, immunization and CRC screening rates and other areas like maternal/fetal work (timely prenatal and postpartum care).
  
  – We have plateaued and have much more work to do.
    • Clinician unconscious bias
    • Bias in the work-place training
    • Continue innovative work with an equity lens