STRATEGIC FRAMEWORK FOR ADVANCING HEALTH EQUITY IN CHRONIC DISEASE MANAGEMENT & POPULATION HEALTH

"Engagement, Equity and Innovation in Changing Times"

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Disclosure

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)

Objectives

- Share HealthPartners' approach to advancing health equity in chronic disease management and population health management.
- Share outcome data from MN and HealthPartners
- Discuss HealthPartners' approach to community partnerships
- Lessons

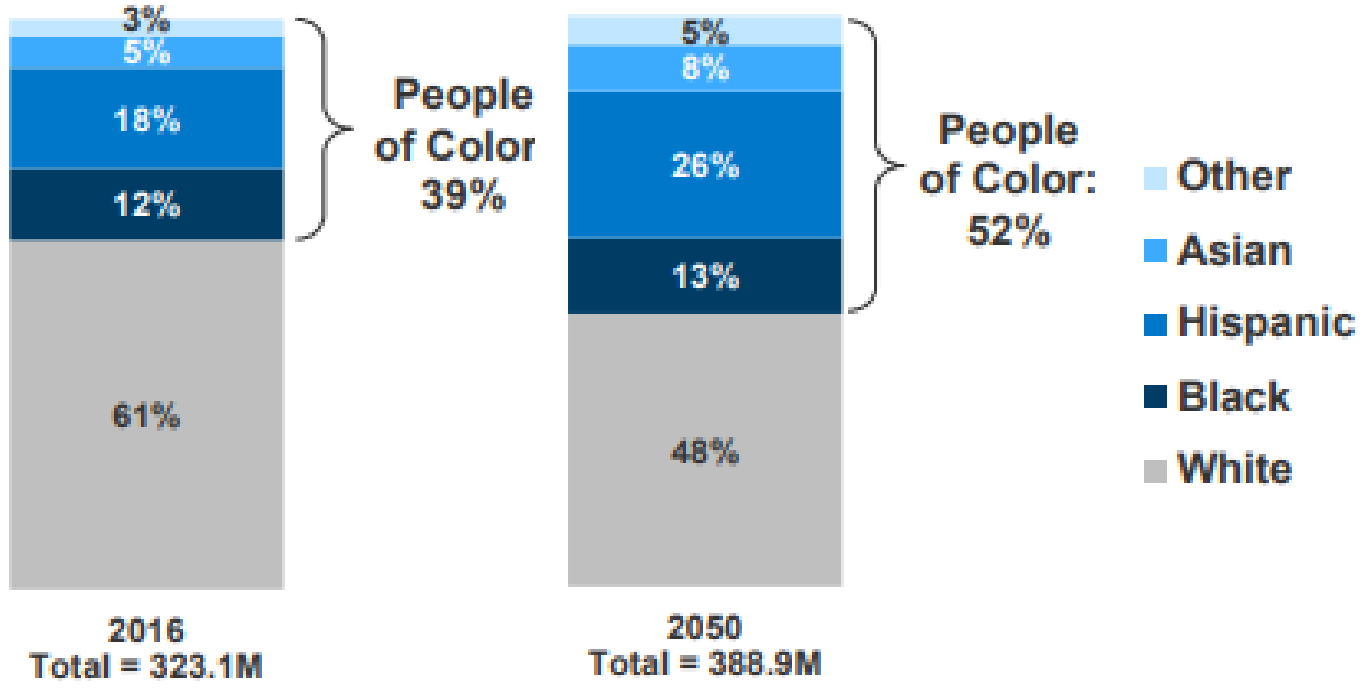
HealthPartners 2025 Strategic Roadmap

Excellence – Compassion – Integrity – Partnership

Why Does Health Care Disparity & Health Equity Matter?

- Adversely affects the affected groups
- Limits overall gains in quality of care of population at large
- Results in unnecessary costs due to disparity

Distribution of U.S. Population by Race/Ethnicity



KFF 3/2020; Disparities in Health and Health Care: Five Key Questions

Changing demographics

TwinCities PIONEER PRESS U.S. Census 2020: Minnesota grows more diverse,...

NEWS

U.S. Census 2020: Minnesota grows more diverse, white population declines

Ramsey County is among the state's most diverse.

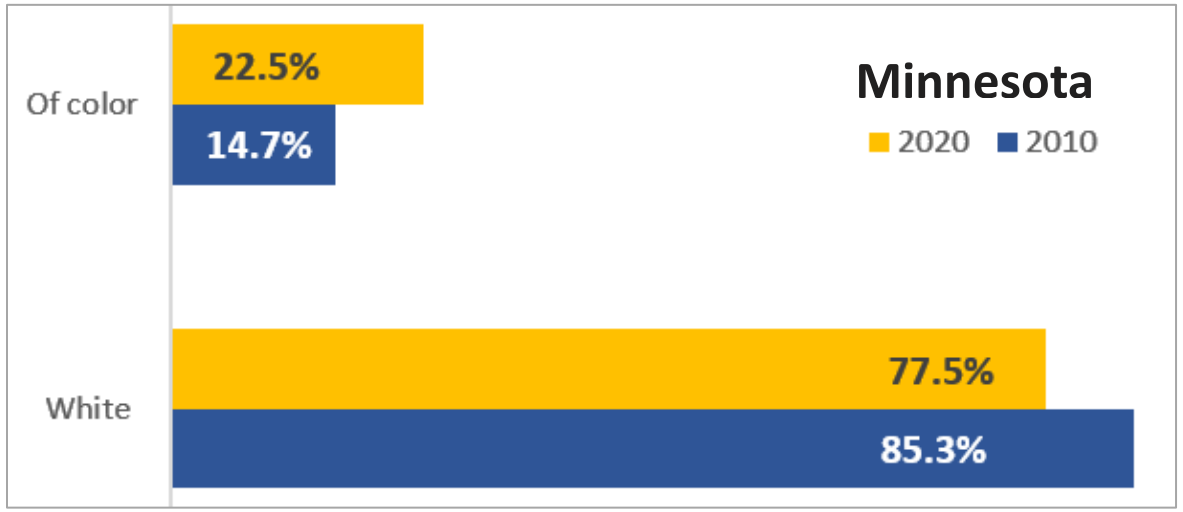
By CHRISTOPHER MAGAN | cmagan@pioneerpress.com | Pioneer Press
PUBLISHED: August 12, 2021 at 2:05 p.m. | UPDATED: August 12, 2021 at 11:55 p.m.

milwaukee journal sentinel

POLITICS

Wisconsin grows modestly and more diverse ...

Molly Beck Milwaukee Journal Sentinel
Published 3:26 p.m. CT Aug. 12, 2021 | Updated 12:42 p.m. CT Aug. 13, 2021



2020 MINNESOTA HEALTH CARE DISPARITIES

by Insurance Type

RELEASED MARCH 2021

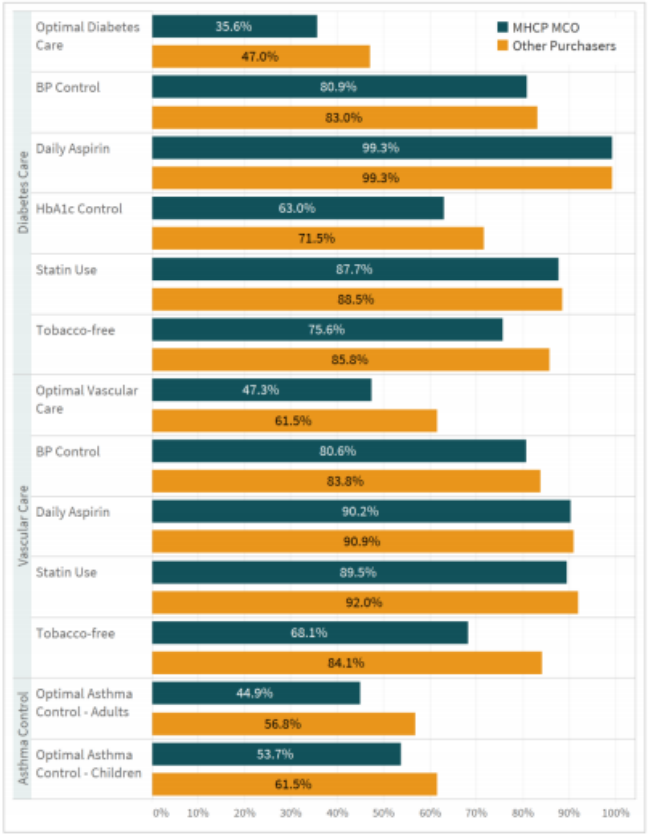
Largest Disparity Gap = 14.2 in Optimal Vascular Care

- **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.[4] 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. [4] Additionally, chronic diseases are not only the leading causes of death and disability in the nation but are also the leading drivers of the $3.8 trillion spent on annual health care costs. [4] 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 MHCP 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.

HealthPartners

MNCM 2020 Report: public health plan

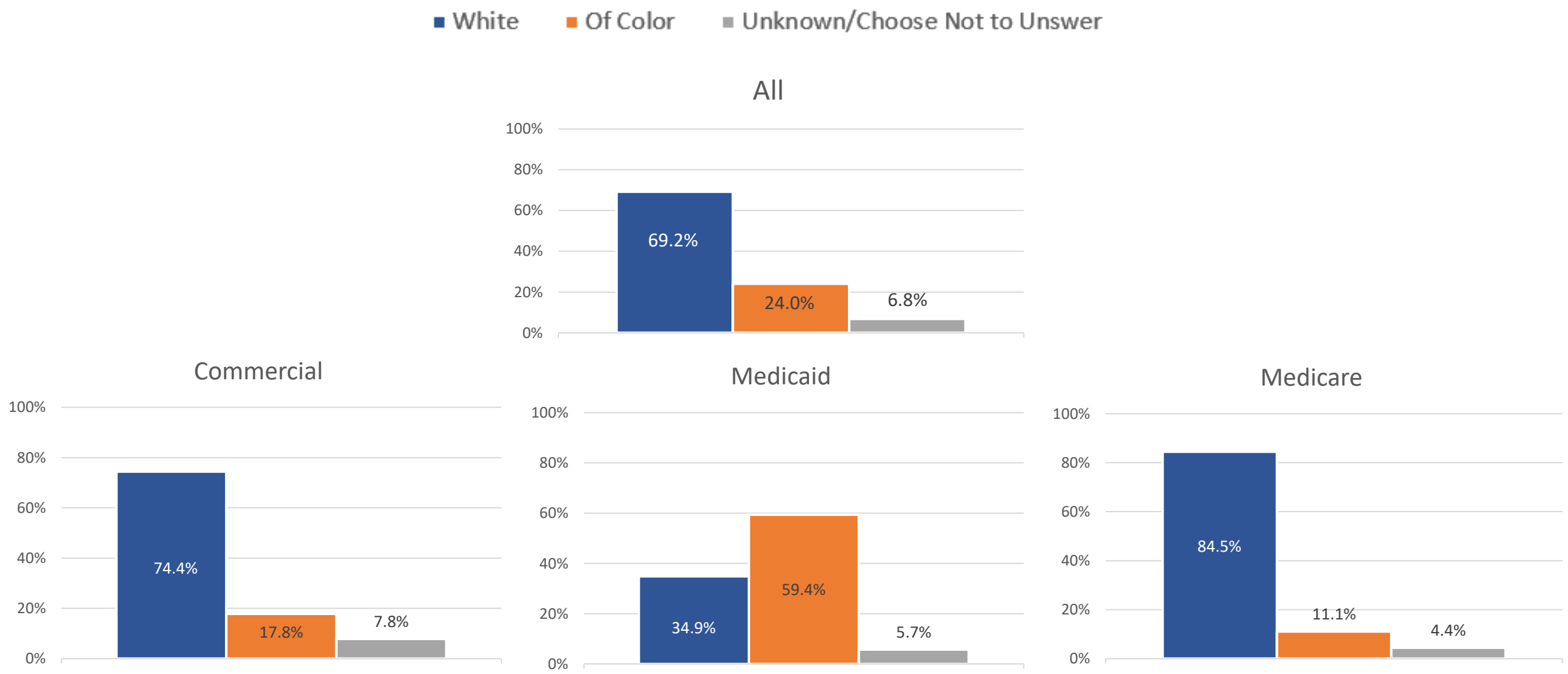
Statewide Summary by Race and Hispanic Ethnicity

QUALITY MEASURES	RACE												ETHNICITY			
	American Indian/ Alaskan Native		Asian		Black/ African American		Multi-Race		Native Hawaiian/ Other Pacific Islander		White		Hispanic		Not Hispanic	
	Rate	Rating	Rate	Rating	Rate	Rating	Rate	Rating	Rate	Rating	Rate	Rating	Rate	Rating	Rate	Rating
Colorectal Cancer Screening	54.0%	▼	62.9%	▼	58.3%	▼	61.2%	▼	59.1%	▼	72.9%	▲	56.2%	▼	71.9%	▲
Optimal Diabetes Care	25.7%	▼	47.6%	▲	33.8%	▼	32.0%	▼	43.1%	●	46.6%	▲	36.5%	▼	45.5%	●
Optimal Vascular Care	47.3%	▼	67.2%	▲	46.7%	▼	55.7%	▼	59.1%	●	61.8%	▲	57.4%	▼	61.3%	●
Optimal Asthma Control – Adults	34.1%	▼	53.5%	●	40.0%	▼	47.6%	▼	52.0%	●	55.6%	▲	44.2%	▼	53.8%	●
Optimal Asthma Control – Children	41.6%	▼	65.9%	▲	55.7%	▼	60.2%	●	58.3%	●	61.2%	▲	52.9%	▼	60.4%	●
Adolescent Mental Health and/or Depression Screening	69.0%	▼	88.7%	▲	84.8%	▼	88.1%	▲	85.0%	●	85.9%	●	80.7%	▼	86.1%	●
Adult Depression: Follow-up at Six Months	32.1%	▼	33.6%	●	27.1%	▼	26.9%	▼	29.7%	●	36.7%	▲	29.6%	▼	35.8%	●
Adult Depression: Response at Six Months	10.6%	▼	10.3%	▼	7.5%	▼	8.0%	▼	12.9%	●	15.5%	▲	11.2%	▼	14.8%	●
Adult Depression: Remission at Six Months	5.4%	▼	5.6%	▼	3.8%	▼	4.0%	▼	7.9%	●	9.3%	▲	6.5%	▼	8.8%	●
Adult Depression: Follow-up at 12 Months	25.2%	▼	29.4%	●	23.2%	▼	21.6%	▼	27.7%	●	32.1%	▲	21.4%	▼	31.3%	●
Adult Depression: Response at 12 Months	7.5%	▼	8.7%	▼	6.9%	▼	7.2%	▼	13.9%	●	13.9%	▲	8.5%	▼	13.2%	●
Adult Depression: Remission at 12 Months	4.1%	▼	4.4%	▼	3.5%	▼	3.5%	▼	5.9%	●	8.6%	▲	4.7%	▼	8.0%	●

▼ Below statewide average ● Average ▲ Above statewide average

Across all chronic disease and pop health screening measures, you do worse than state average if you are:
American Indian/Alaskan Native, Black/AA, Hispanic or Multi-Race

HealthPartners Patient Demographics by Race



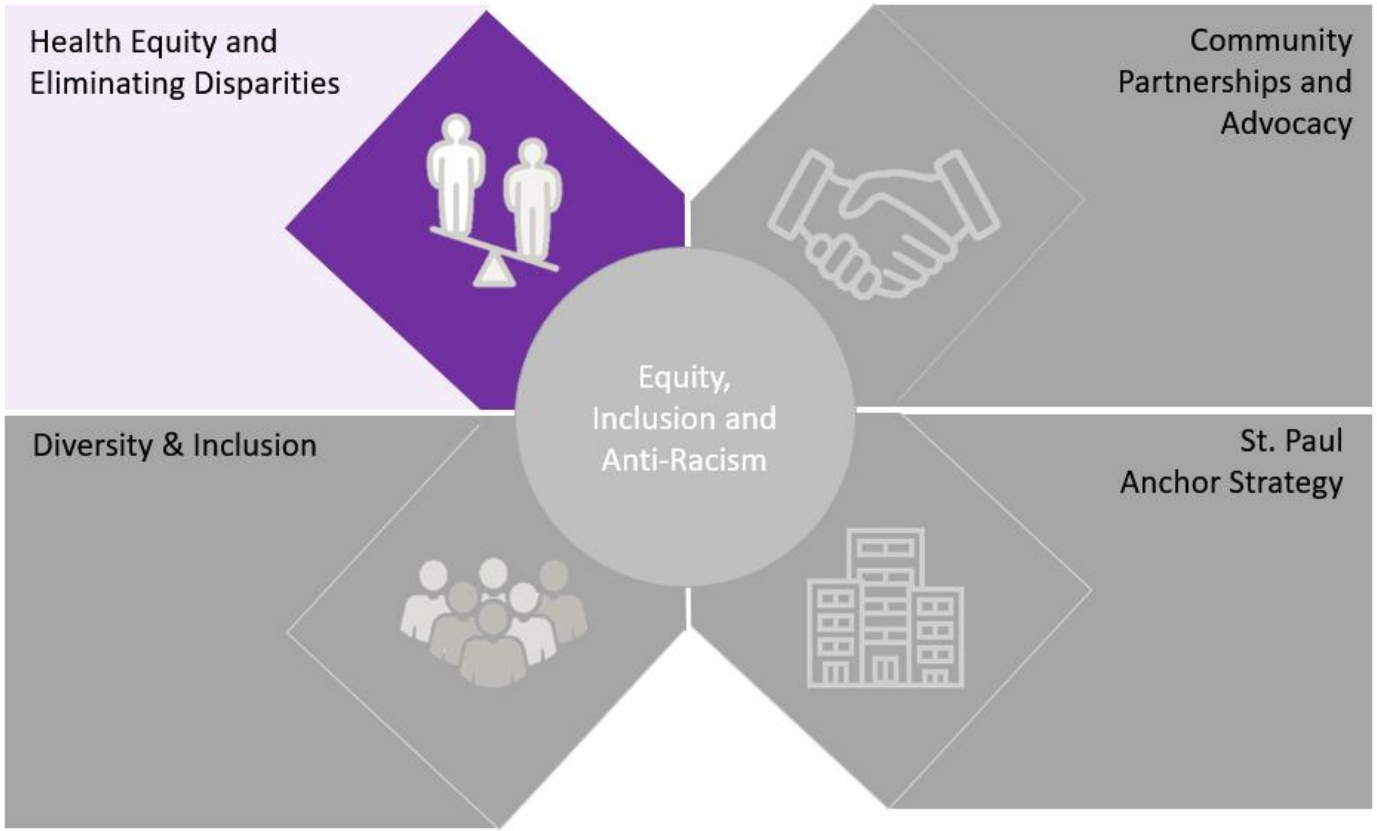
Equity, Inclusion & Anti-Racism

Co-Chairs:

Andrea Walsh
Cabinet Co-chair
HealthPartners President & CEO

Steven Jackson, MD
Cabinet Co-chair & Medical Advisor
Physician, Physical Medicine & Rehab

Yeng Yang, MD
Cabinet Co-chair & Medical Advisor
St. Paul Clinic Practice Medical Director



Health Equity and Eliminating Disparities

Advance health equity in our care and coverage

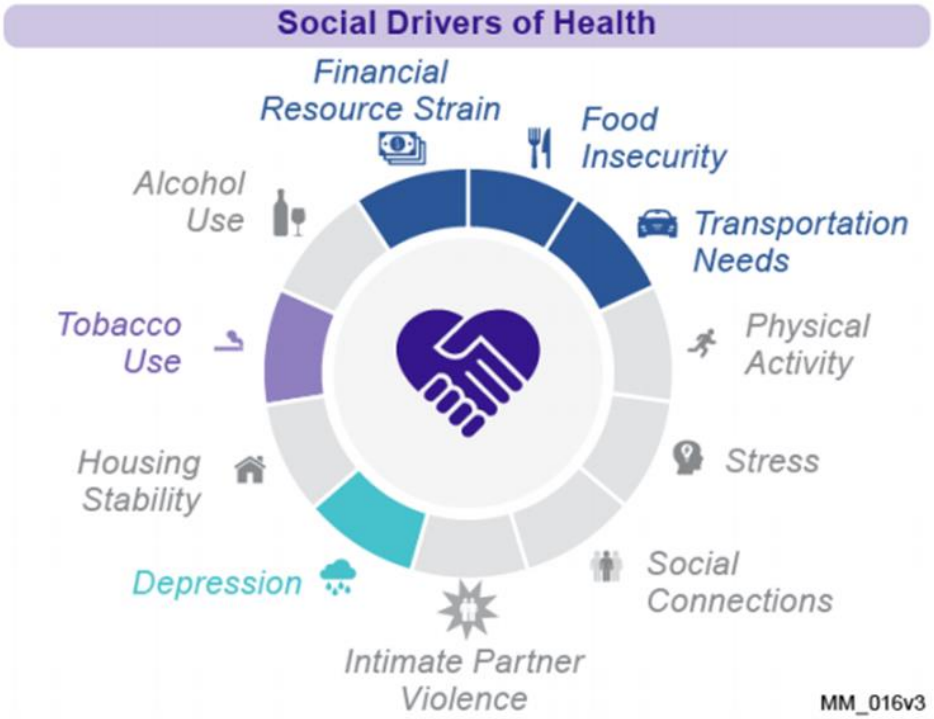
Equity Assessment Toolkit

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.

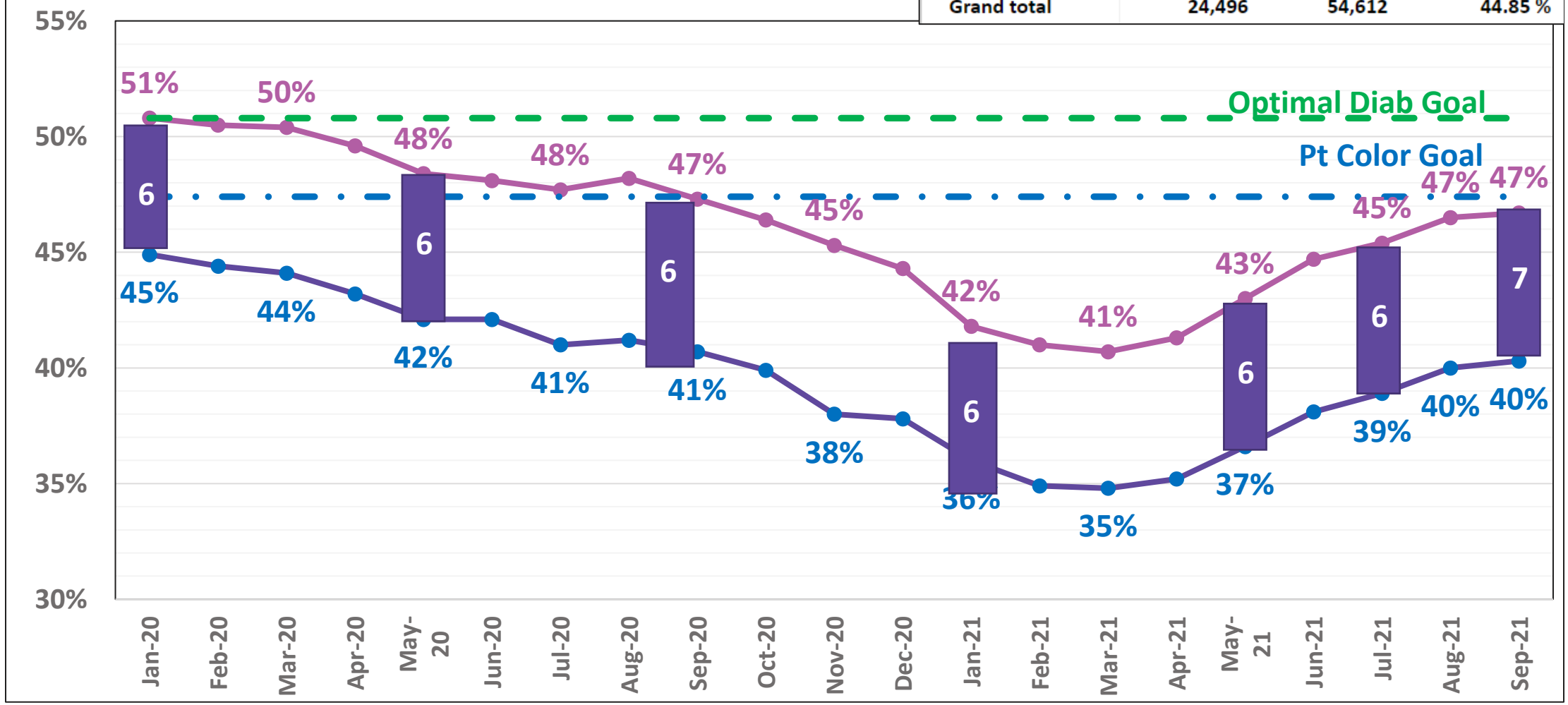
Screening for Social Determinants of Health

- 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



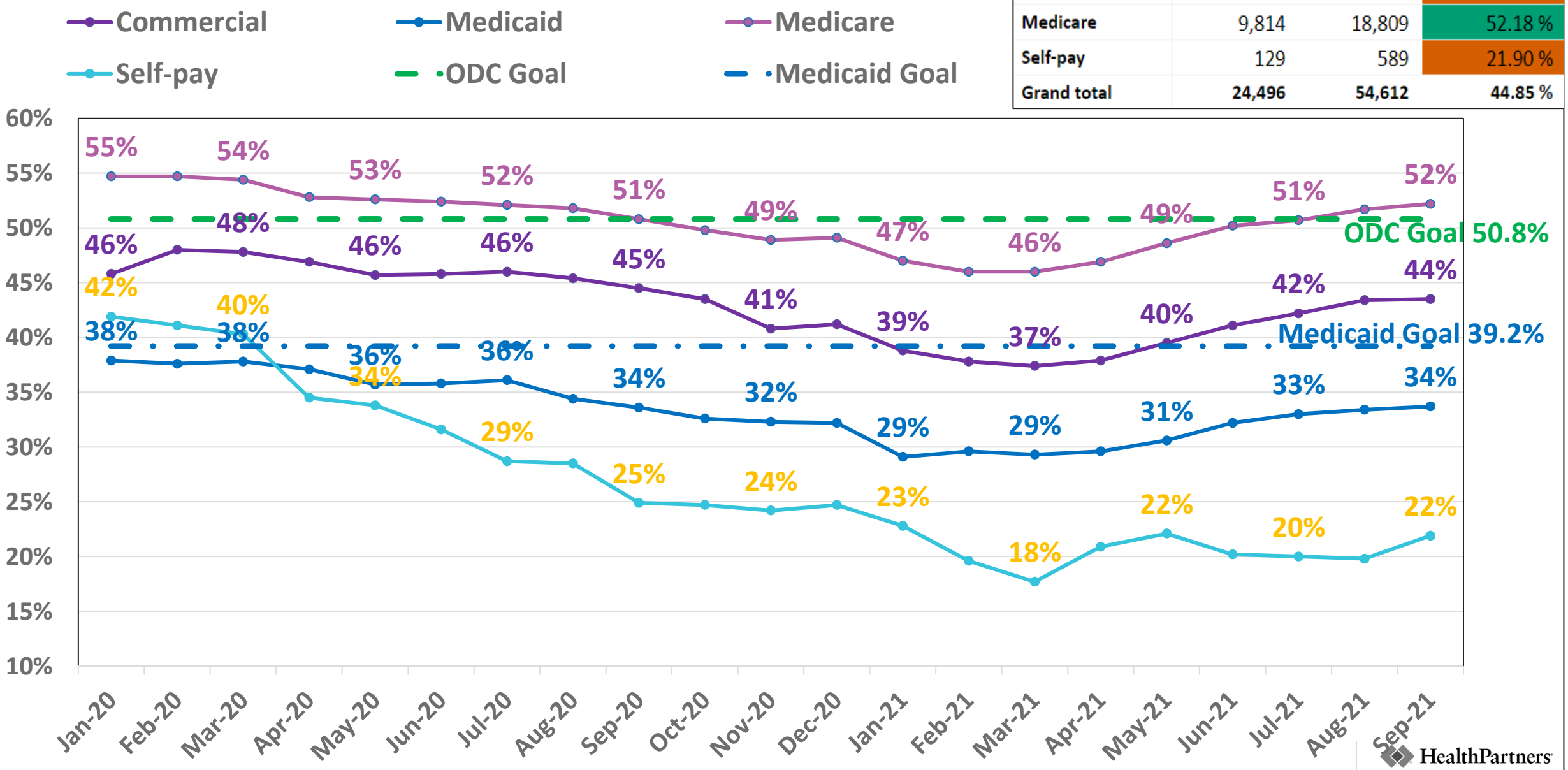
Diabetes Patients of Color

Race Group	Met ODC	# Eligible	% Met ODC
Of Color	5,979	14,854	40.25 %
Unknown	256	681	37.59 %
White	18,261	39,077	46.73 %
Grand total	**24,496**	**54,612**	**44.85 %**



Diabetes Payor

Payor Group	Met ODC	# Eligible	% Met ODC
Commercial	11,875	27,268	43.55 %
Medicaid	2,678	7,946	33.70 %
Medicare	9,814	18,809	52.18 %
Self-pay	129	589	21.90 %
Grand total	**24,496**	**54,612**	**44.85 %**



HealthPartners

Referral Use (Co-Management): % of Diabetes Pop being seen by:

Endocrinology: 15%

Diabetes Education: 14%

Medication Therapy Management: 5%

Care Coordination: 4%

Intervention strategies

HOME A1C TESTING – Lab Initiative

EXPANSION OF RAPID A1C TESTING - Fall 2021 (8 sites)

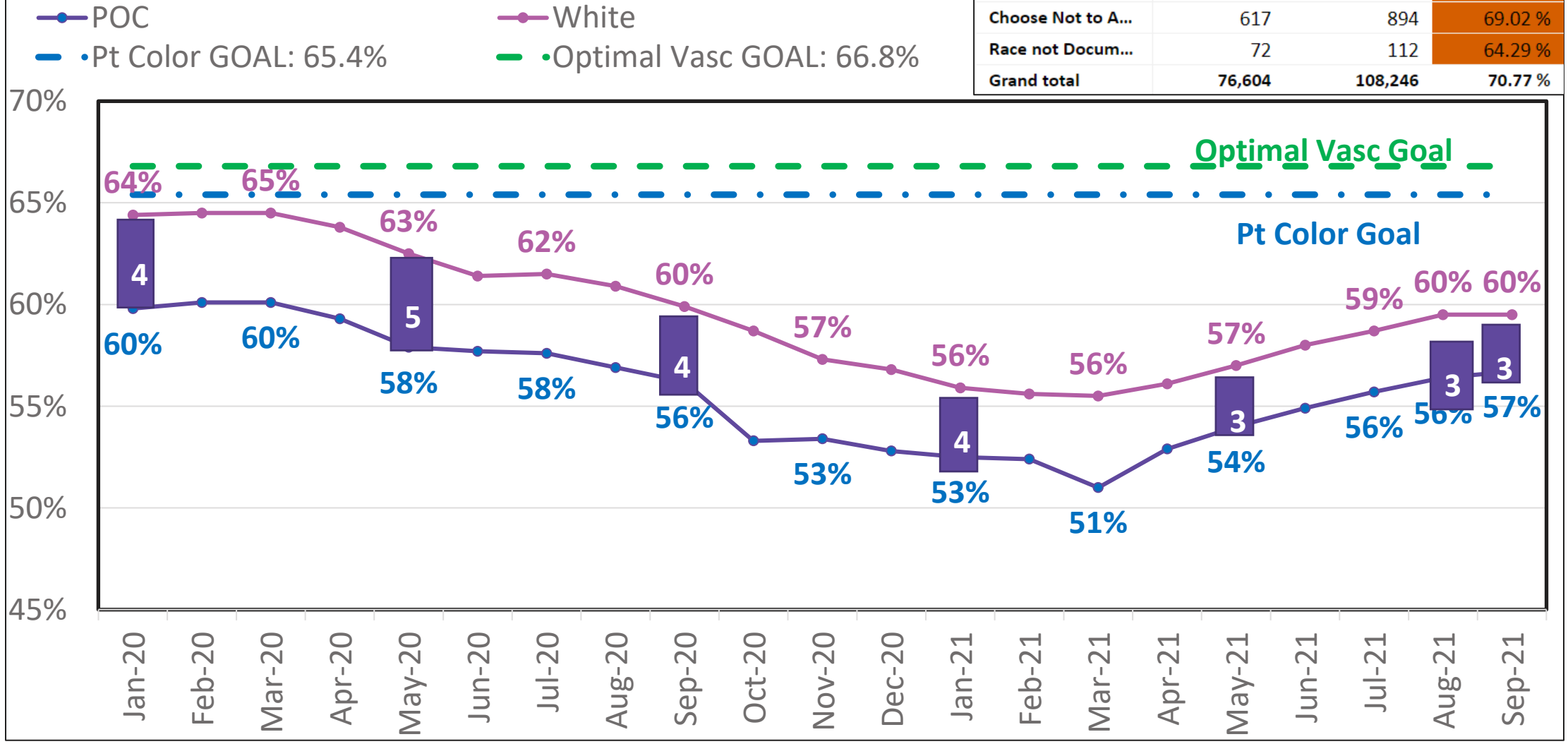
BATCH A1C ORDERS With Monthly Appt Reminders

HOME BLOOD PRESSURE MONITORING - Auto enters In Epic

BP HOME MONITORS FOR PATIENTS

PILOT DRIVE UP A1C & BLOOD PRESSURE - JUNE

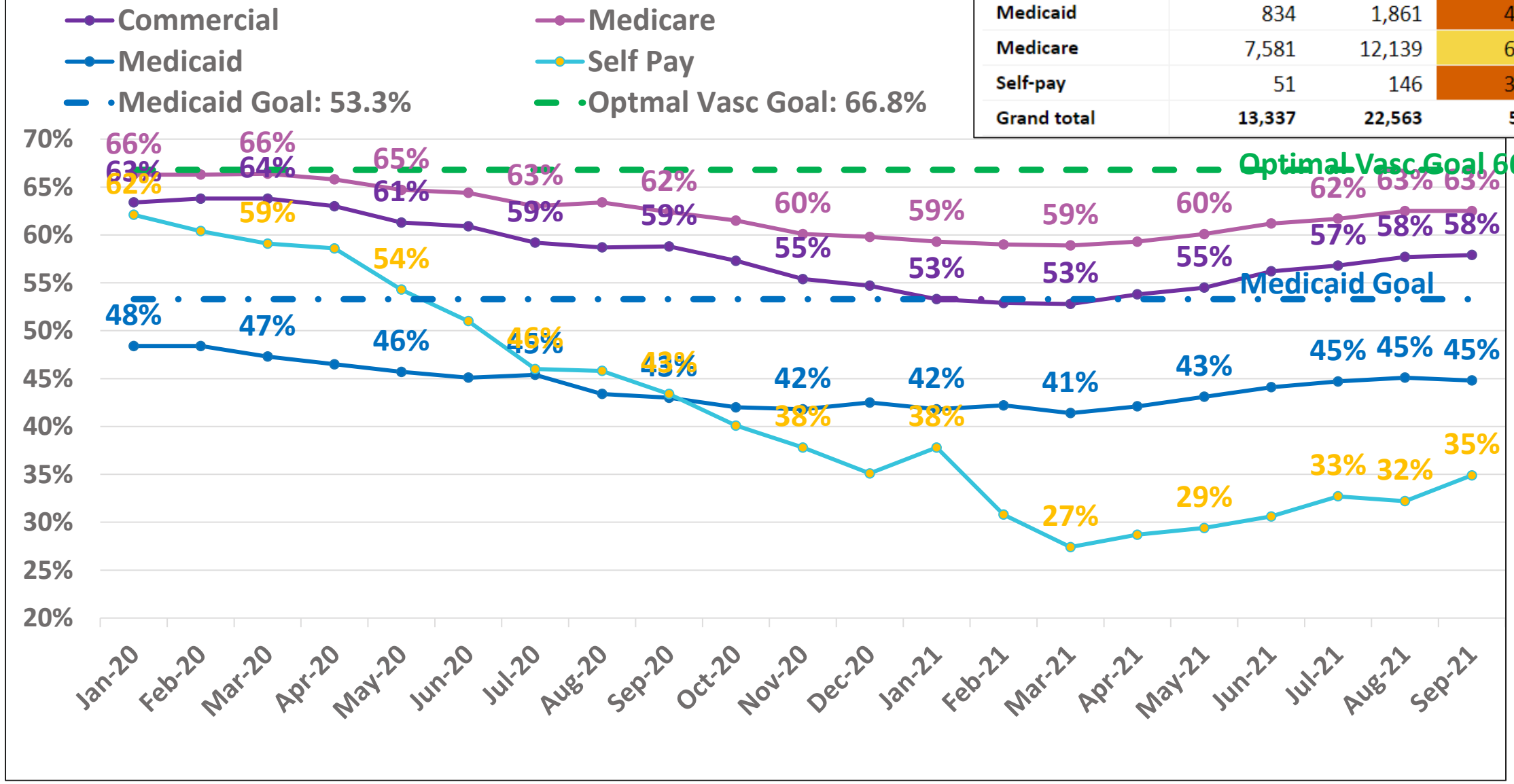
Vascular Patients of Color



Race Group	Met	# Eligible	% Met HTN
White	63,425	88,551	71.63 %
Of Color	12,490	18,689	66.83 %
Choose Not to A...	617	894	69.02 %
Race not Docum...	72	112	64.29 %
Grand total	**76,604**	**108,246**	**70.77 %**

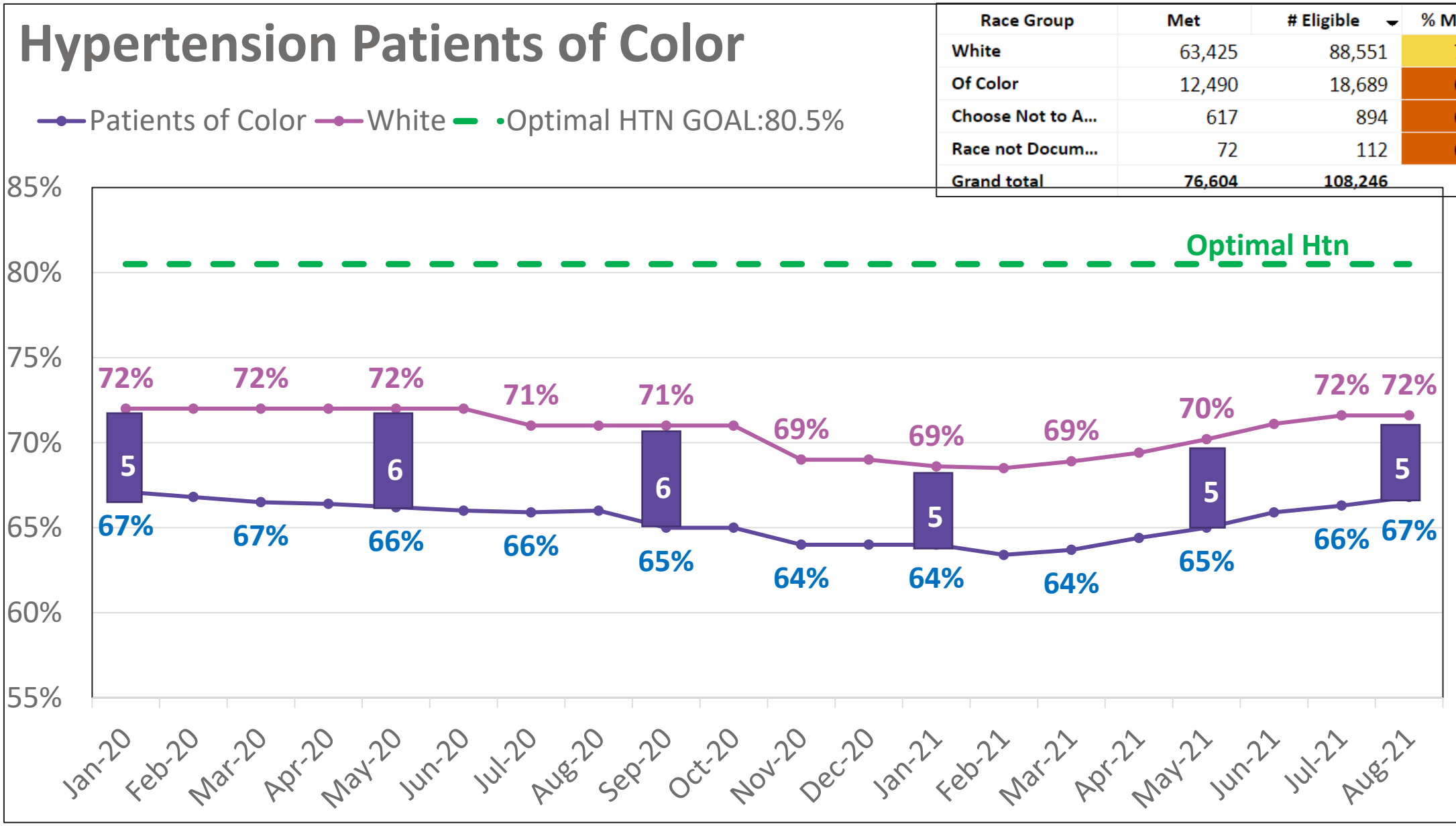
Vascular Payor

Payor Group	Met OVC	# Eligible	% Met OVC
Commercial	4,871	8,417	57.87 %
Medicaid	834	1,861	44.81 %
Medicare	7,581	12,139	62.45 %
Self-pay	51	146	34.93 %
Grand total	13,337	22,563	59.11 %



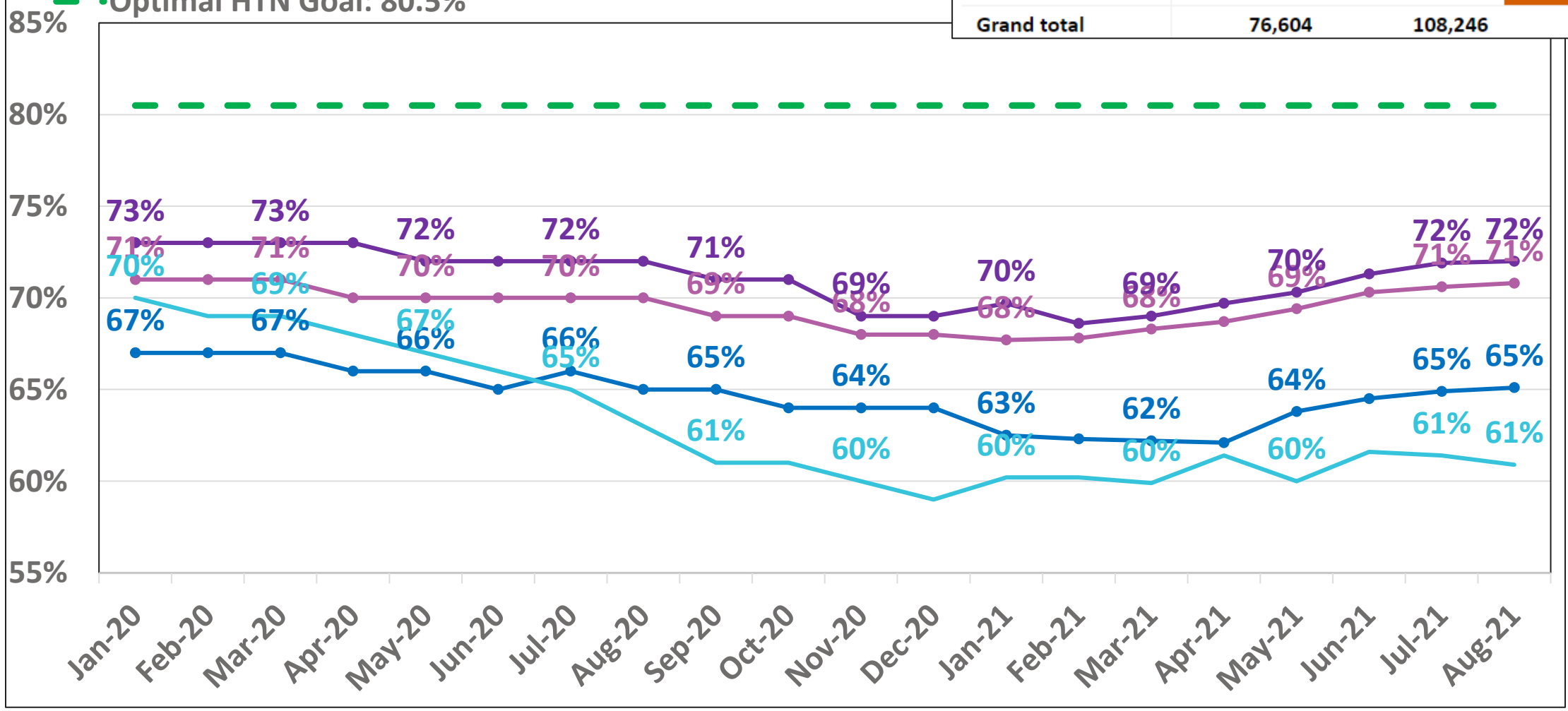
Hypertension Patients of Color

Race Group	Met	# Eligible	% Met HTN
White	63,425	88,551	71.63 %
Of Color	12,490	18,689	66.83 %
Choose Not to A...	617	894	69.02 %
Race not Docum...	72	112	64.29 %
Grand total	76,604	108,246	70.77 %



Hypertension Payor

Payor Group	Met	# Eligible	% Met HTN
Commercial	32,831	46,389	70.77 %
Medicaid	6,319	9,711	65.07 %
Medicare	37,022	51,437	71.98 %
Self-pay	432	709	60.93 %
Grand total	**76,604**	**108,246**	**70.77 %**



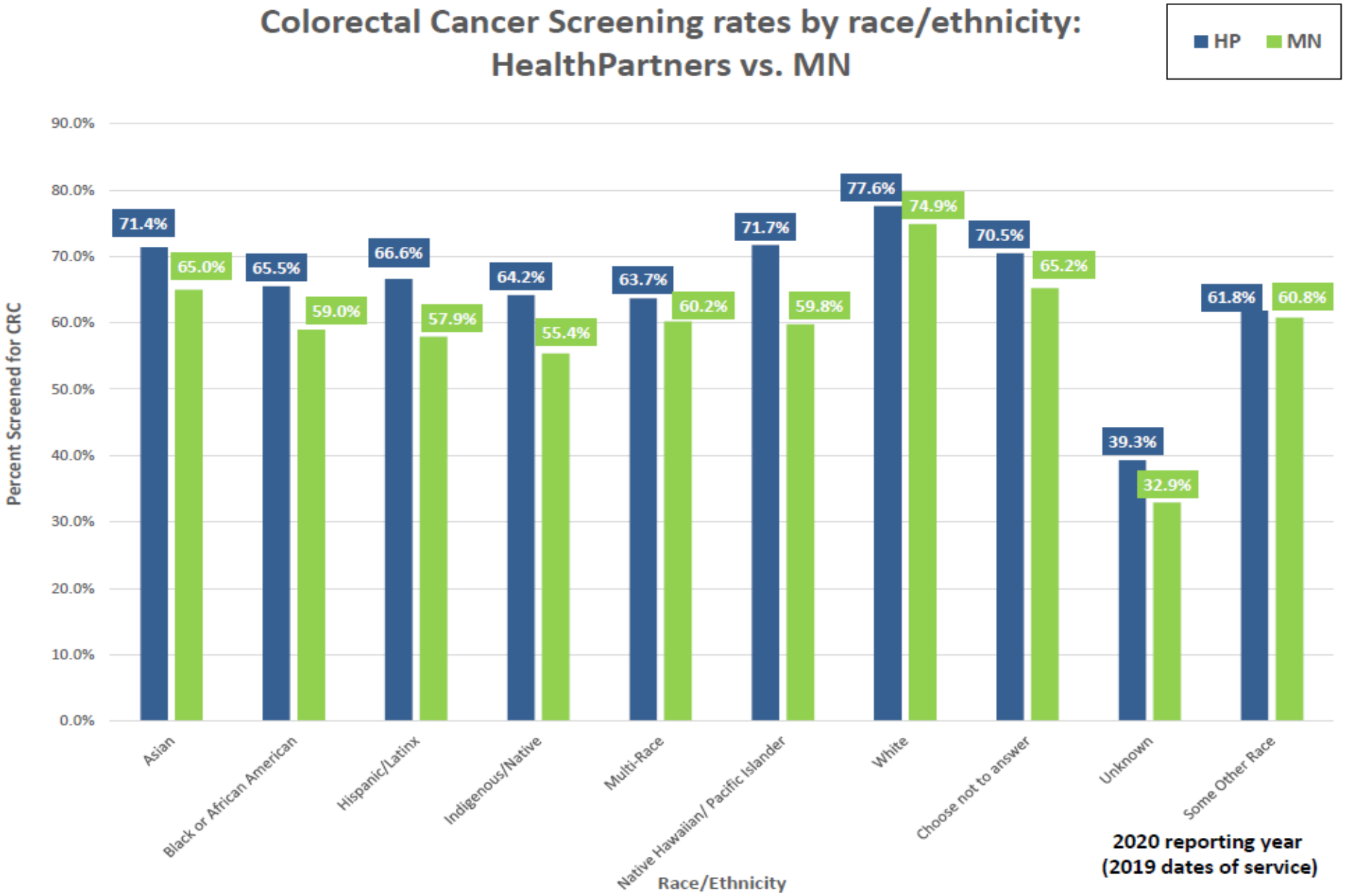
Hypertension Intervention Strategies

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

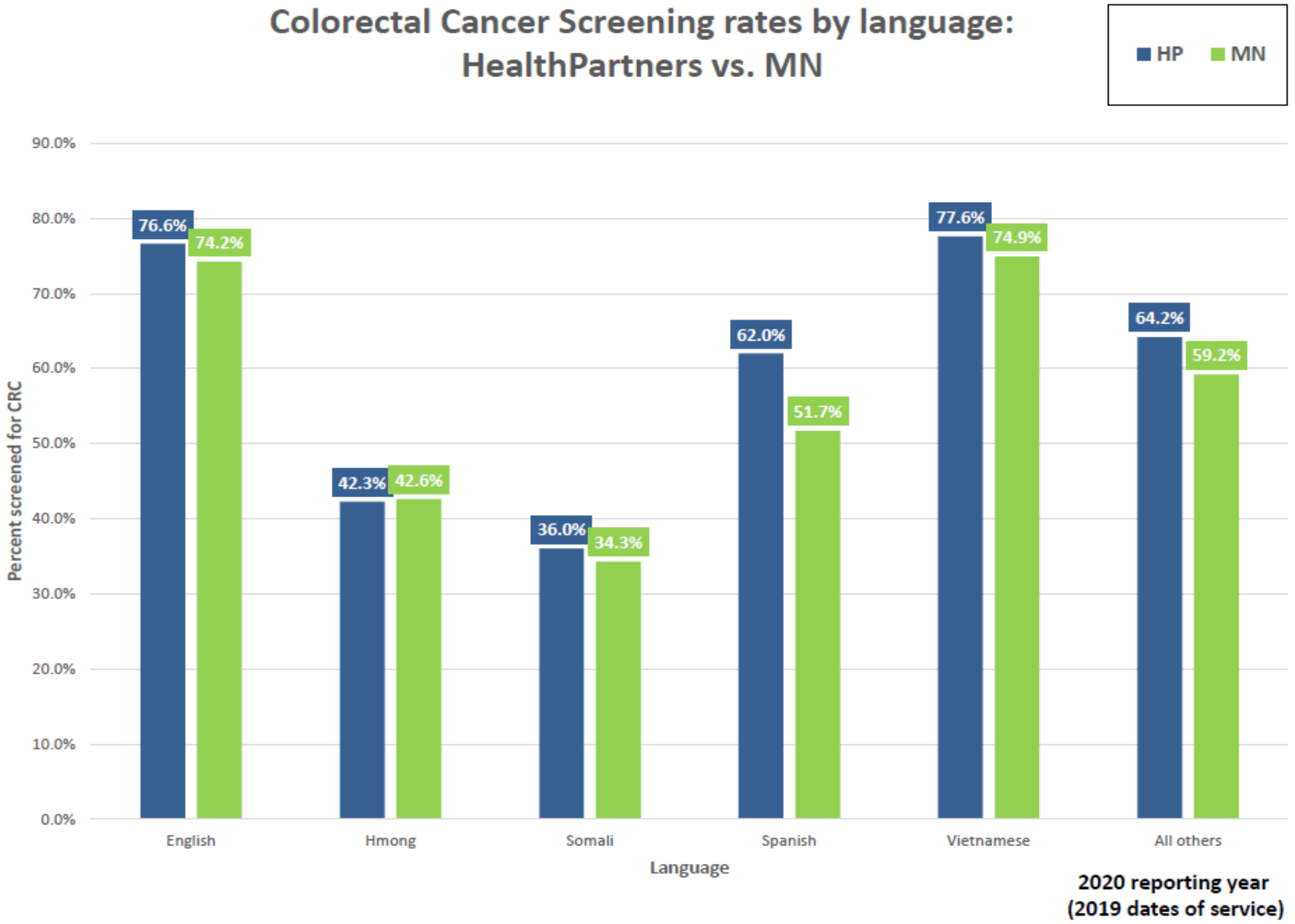
- MTM HTN Program

- Home Remote BP Monitoring/Measurement
  - ✓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*)

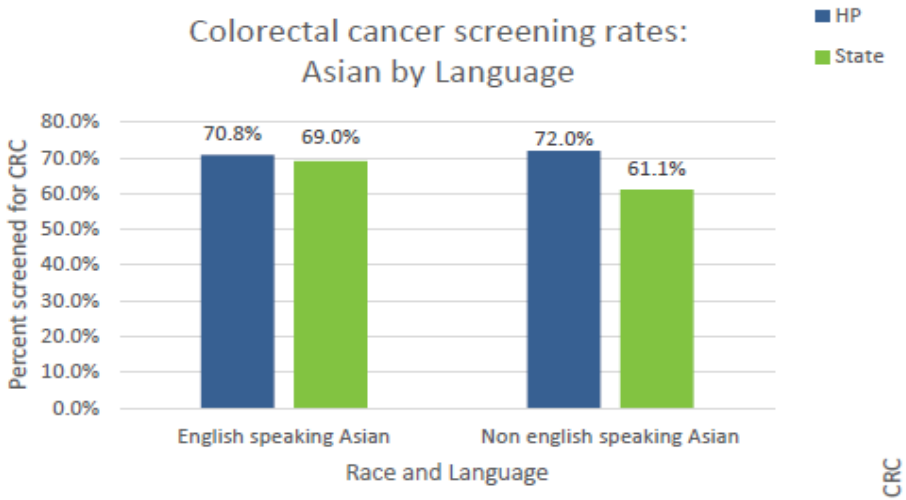
Colorectal Cancer Screening rates by race/ethnicity: HealthPartners vs. MN

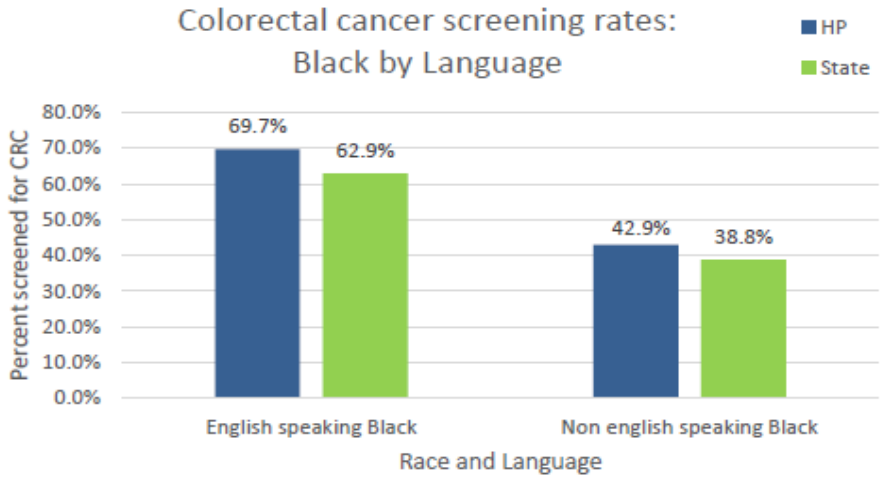


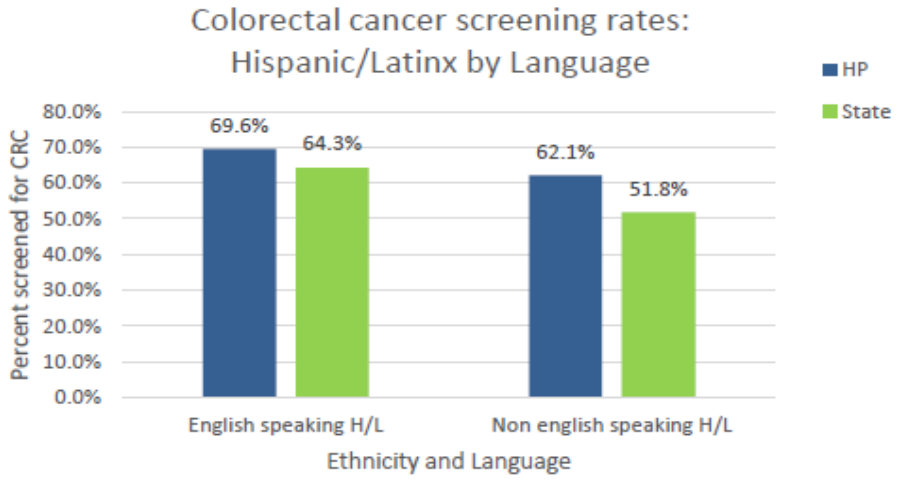
Colorectal Cancer Screening rates by language: HealthPartners vs. MN



Language in depth

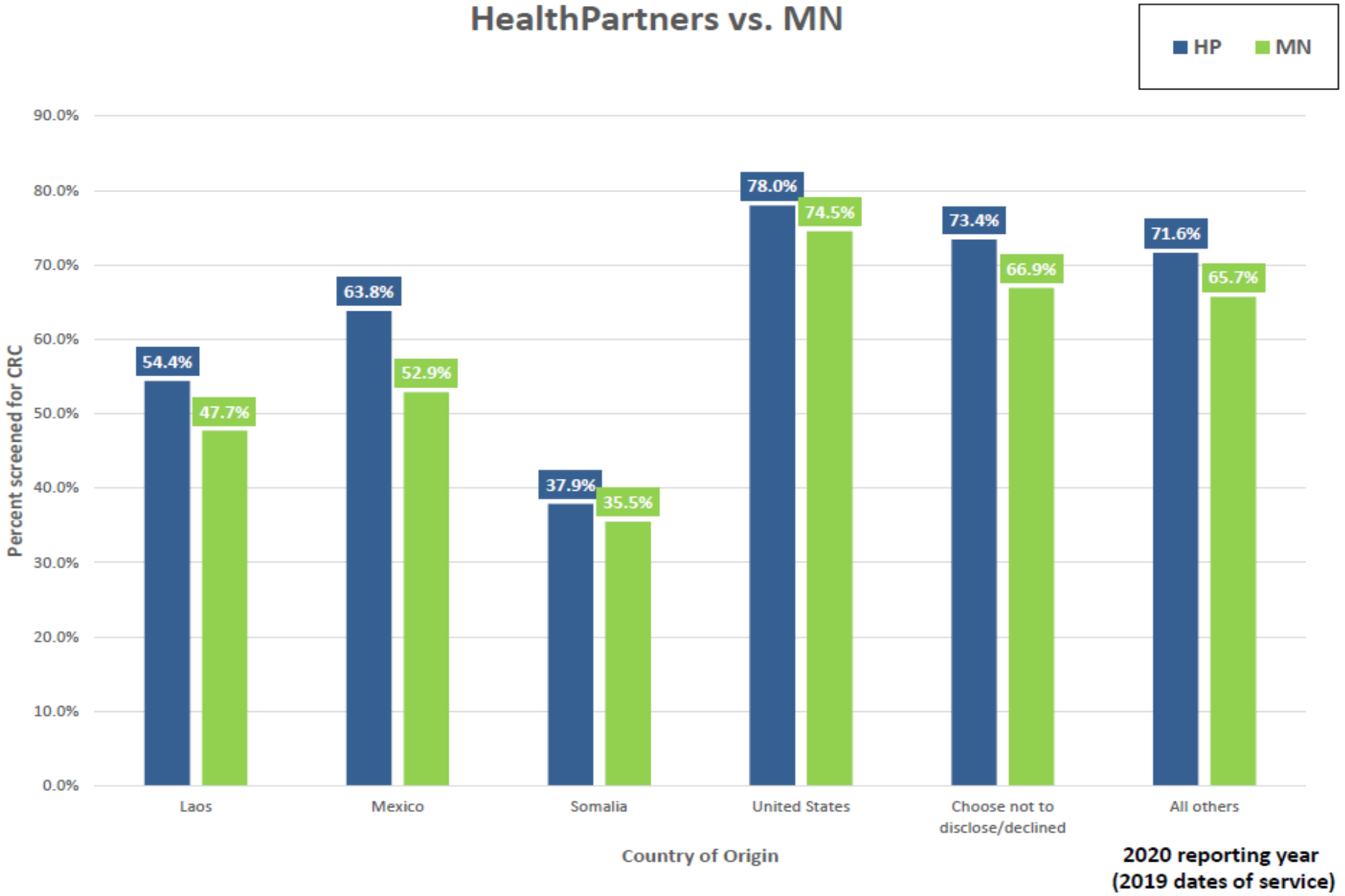




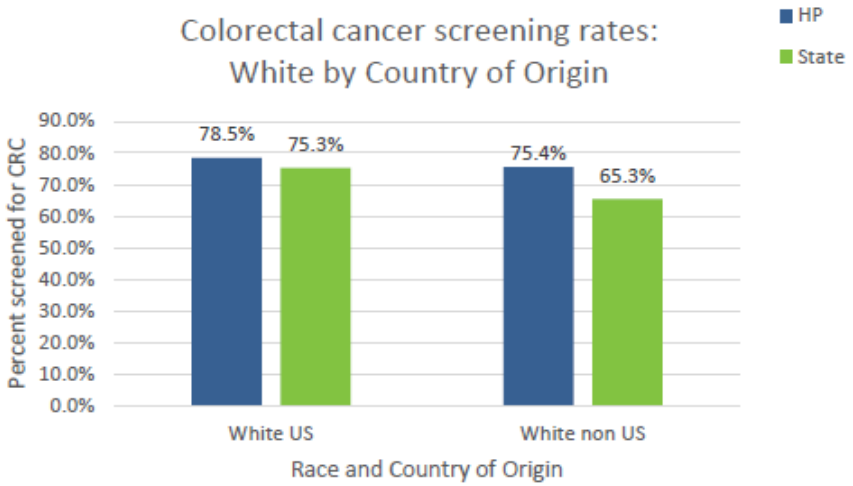


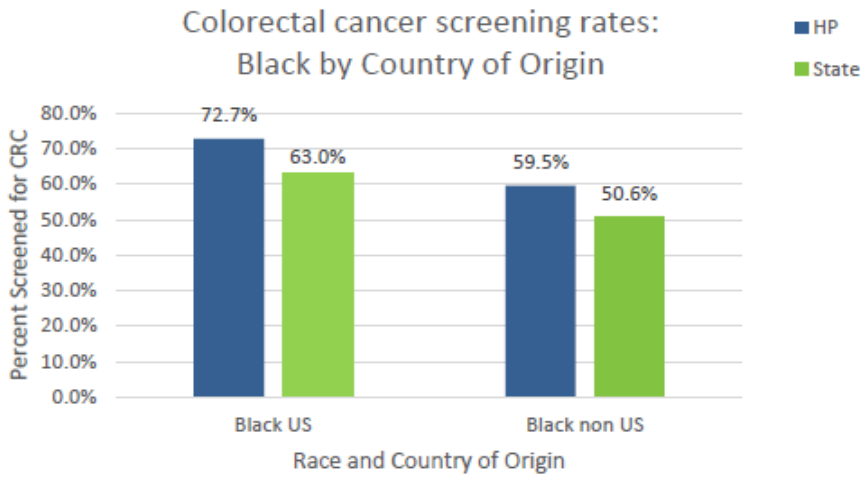
2020 reporting year
(2019 dates of service)

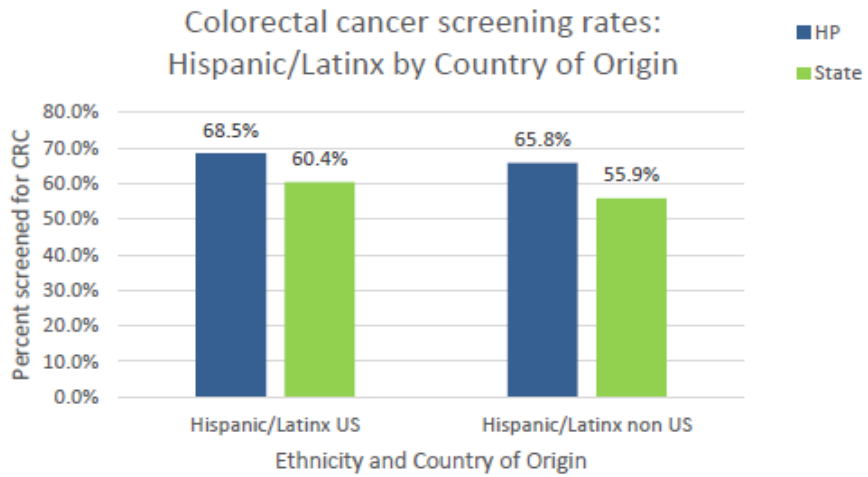
Colorectal Cancer Screening rates by country of origin: HealthPartners vs. MN



Country of Origin in depth







2020 reporting year
(2019 dates of service)

Health Disparities MOC Project update

MoC Cohort Summary

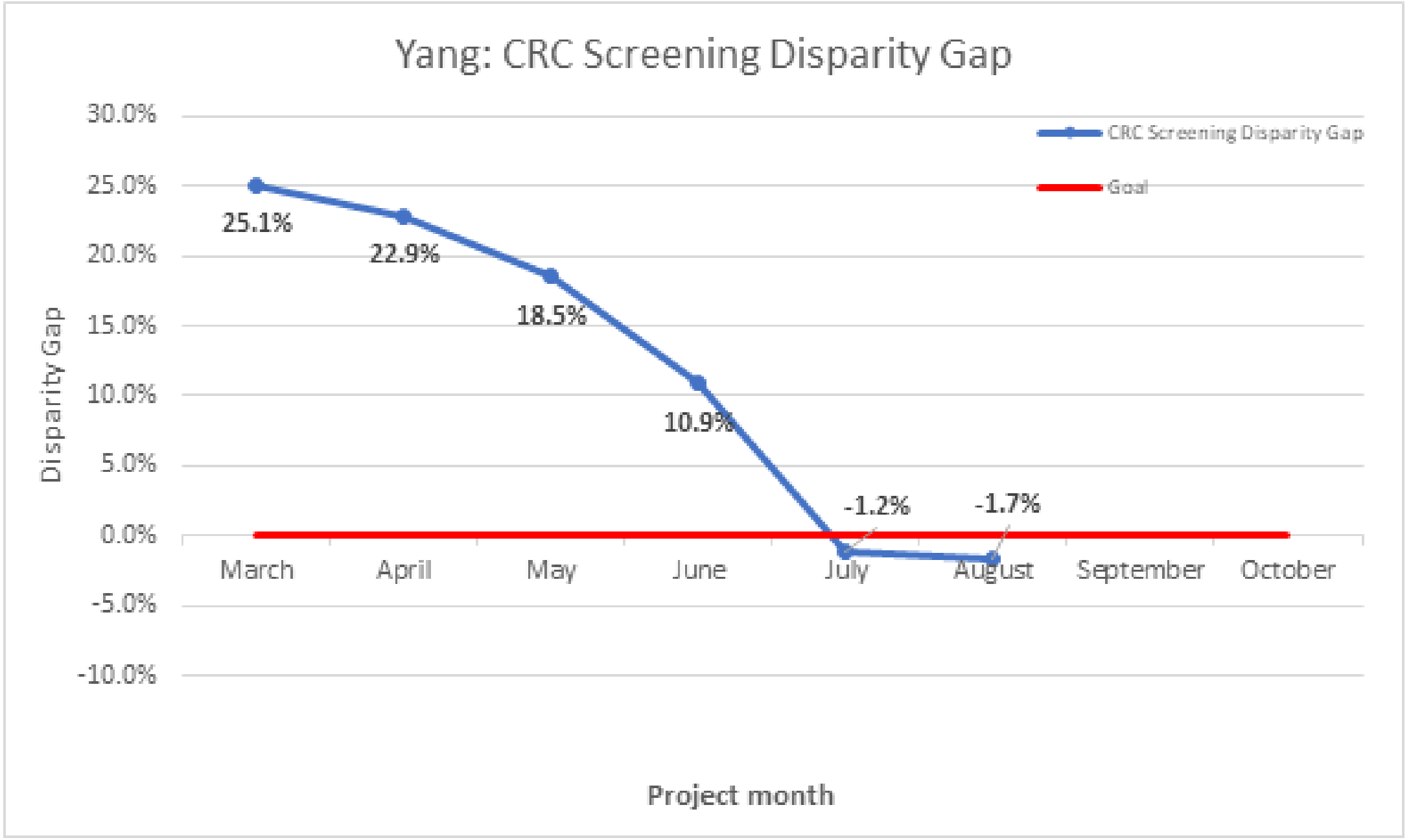
Cohort Summary - Race

	COLON - 2021 _1							
Report Date	# Eligible	% Met ALL	% Rate Change	# Eligible Pts Of Color	% Met - Pts Of Color	# Eligible - White	% Met - White	Race - Disparity Gap
3/1/2021	11,156	75.55 %		1,514	60.11 %	9,493	78.19 %	-18.09 %
4/1/2021	11,428	75.71 %	0.21 %	1,551	60.67 %	9,716	78.33 %	-17.66 %
5/1/2021	11,605	76.12 %	0.54 %	1,610	61.06 %	9,828	78.82 %	-17.76 %
6/1/2021	11,740	76.12 %	0.00 %	1,635	61.83 %	9,936	78.69 %	-16.86 %
7/1/2021	11,860	76.18 %	0.07 %	1,675	62.99 %	10,016	78.55 %	-15.57 %
8/1/2021	11,823	76.11 %	-0.10 %	1,680	63.33 %	9,977	78.40 %	-15.07 %

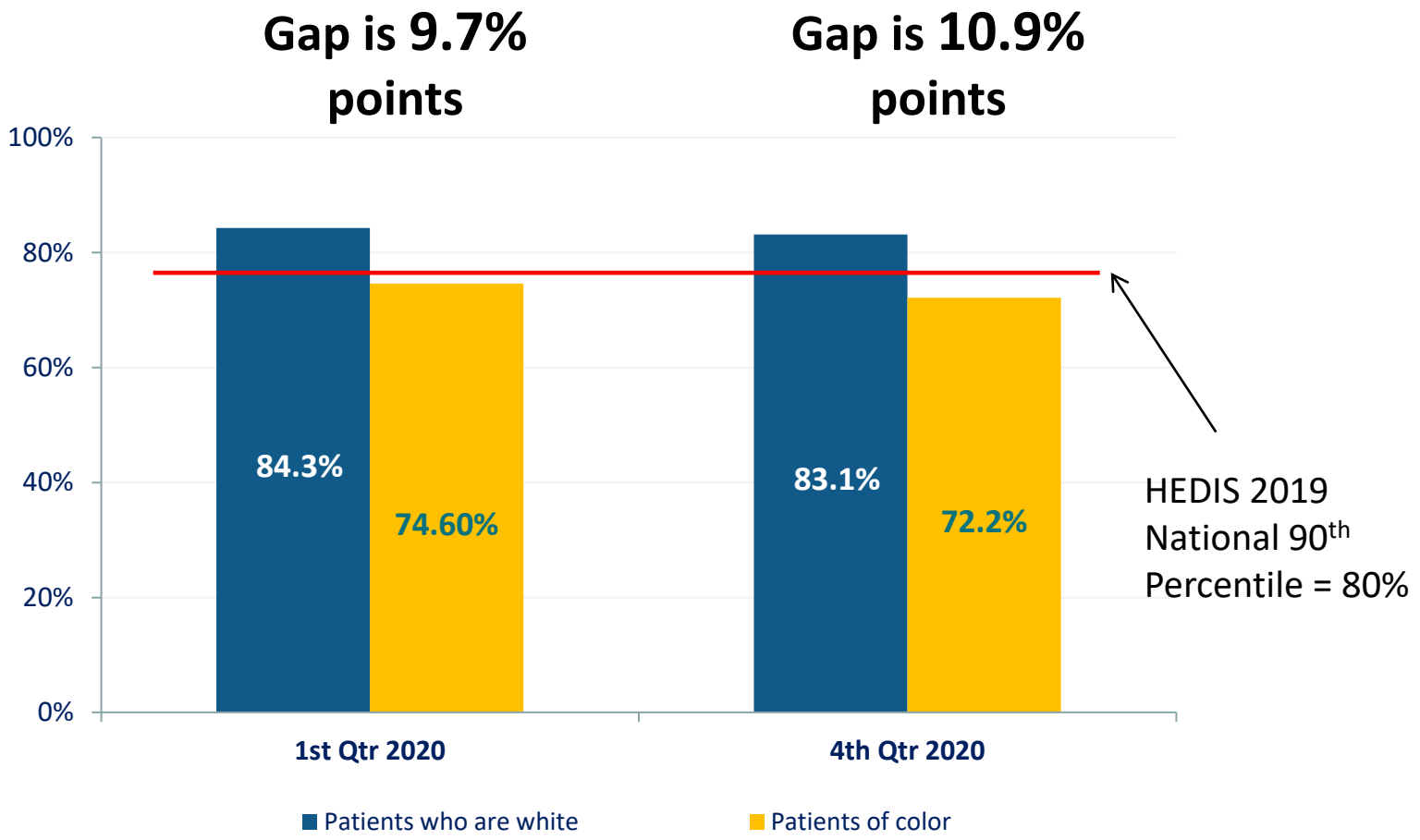
MoC Cohort Summary

Cohort Summary - Payor

	COLON - 2021 _1							
Report Date	# Eligible	% Met ALL	% Rate Change	# Eligible Gov't Programs	% Gov't Programs	# Eligible Commercial	% Commercial	Payor - Disparity Gap
3/1/2021	11,156	75.55 %		745	55.97 %	6,440	74.57 %	-18.59 %
4/1/2021	11,428	75.71 %	0.21 %	774	55.94 %	6,636	74.71 %	-18.77 %
5/1/2021	11,605	76.12 %	0.54 %	799	56.07 %	6,710	75.20 %	-19.13 %
6/1/2021	11,740	76.12 %	0.00 %	824	57.40 %	6,783	75.16 %	-17.76 %
7/1/2021	11,860	76.18 %	0.07 %	836	58.25 %	6,802	75.14 %	-16.89 %
8/1/2021	11,823	76.11 %	-0.10 %	822	58.88 %	6,803	74.98 %	-16.10 %


Yang: CRC Screening Disparity Gap
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
-5.0%
-10.0%
Disparity Gap
CRC Screening Disparity Gap
Goal
25.1%
22.9%
18.5%
10.9%
-1.2%
-1.7%
March
April
May
June
July
August
September
October
Project month

Breast Cancer Screening by Race

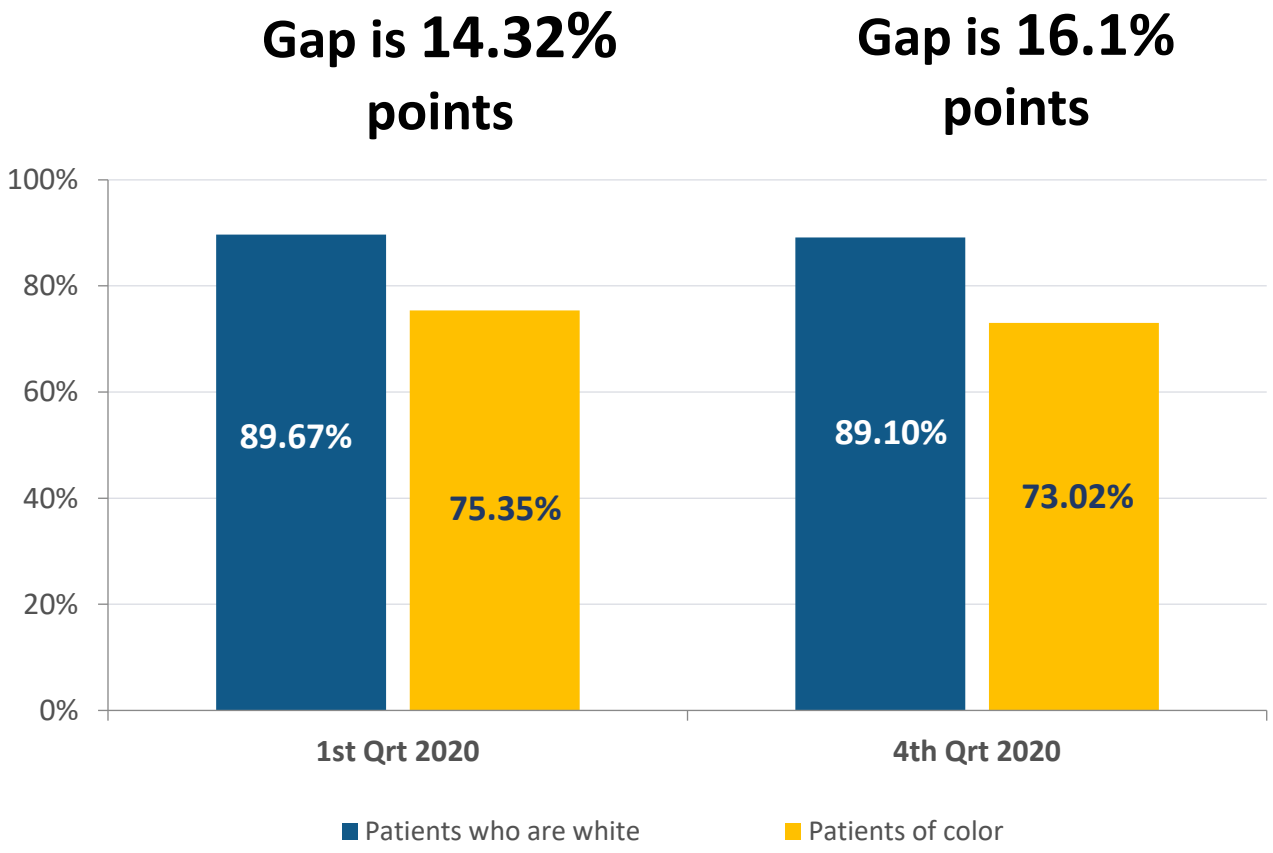


Interventions

- Same day access
- Customized messages based on consumer insights data
- Portable Mammography

Definition: *Percent of eligible women age 52-74 who have been screened for breast cancer by Mammogram in the past 2 years..*

Timely Prenatal Care by Race

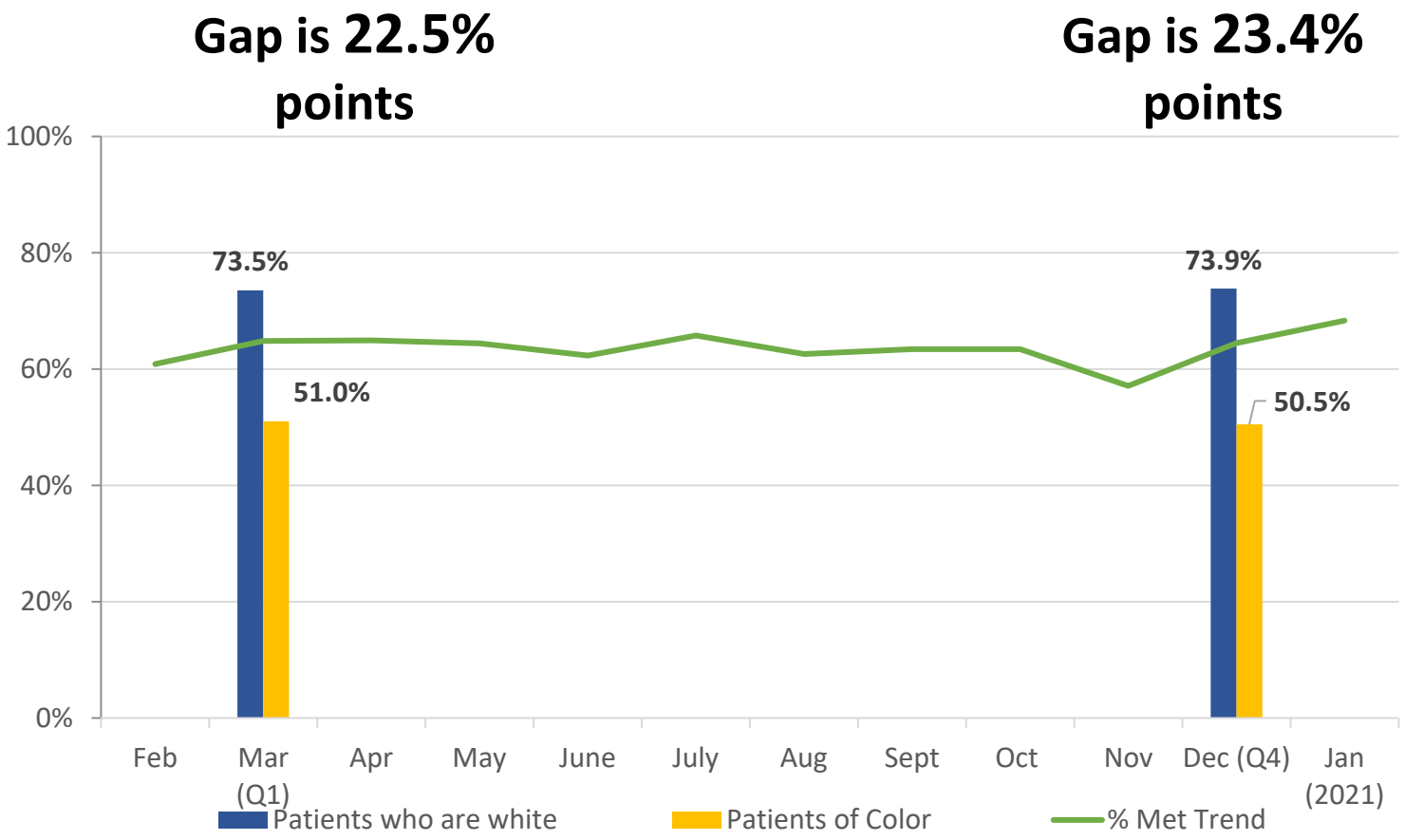


Interventions

- Remove barriers to schedule initial OB visit
- Utilize Healthy Beginnings Coordinators to assist patients with barriers
- Partner with community programs in identifying and removing barriers

Definition: *Percent of live birth deliveries where the mother received a prenatal care visit in the first trimester*

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)*

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

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:
  - Telephonic outreach with designated call back numbers
  - Vaccine sites
  - 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

COVID-19 Vaccine Equity

- “Clinician Speakers Bureau” to help us understand and address vaccine hesitancy in the communities we serve – trusted messengers

- COVID-19 Vaccine Trial

  ✓30% of HealthPartners participants are people of color

- Volunteers for community vaccination events

COVID-19 Vaccine Safety

“As a Hmong woman and doctor, I recognized months ago that my patients might be hesitant to get the vaccine. So I started talking with my patients of color well before the vaccine was available. Providing information in an empathetic and understanding way has been critical.”

-Yeng Yang, MD, Co-Chair of HealthPartners Equity, Inclusion + Anti-Racism Cabinet

“These vaccines are 30 years of research coming to fruition, put together by diverse teams. The clinical trials involved tens of thousands of people, including those of diverse backgrounds, races, ages, gender and those with other ailments. I see this as a way out of the pandemic. I trust the science and know that it will save lives. That’s why I got the COVID-19 vaccine.

-Benji Mathews, MD, HealthPartners Medical Director

COVID-19 Command Center Dashboard, Health Equity (Vaccination Progress)

Published at 9/23/2021 7:50:11 AM

HealthPartners

Health Equity metrics, by:
Race

This view includes patients only.

Administered within Care Group?
(●) Within Care Group
( ) Outside Care Group

This report includes all vaccination sites system-wide.
Note that some populations may be small, and that not all differences are statistically significant. See Appendix for details.

Values of "Unknown" are now excluded from the vaccination and population totals below - this applies to analysis by Race and Language. See appendix for details.

Age Band
All

Administered through Week of:
(week = Sunday to Saturday)
To 12/13/2020
and Null values
(controls the graph on left-hand side)

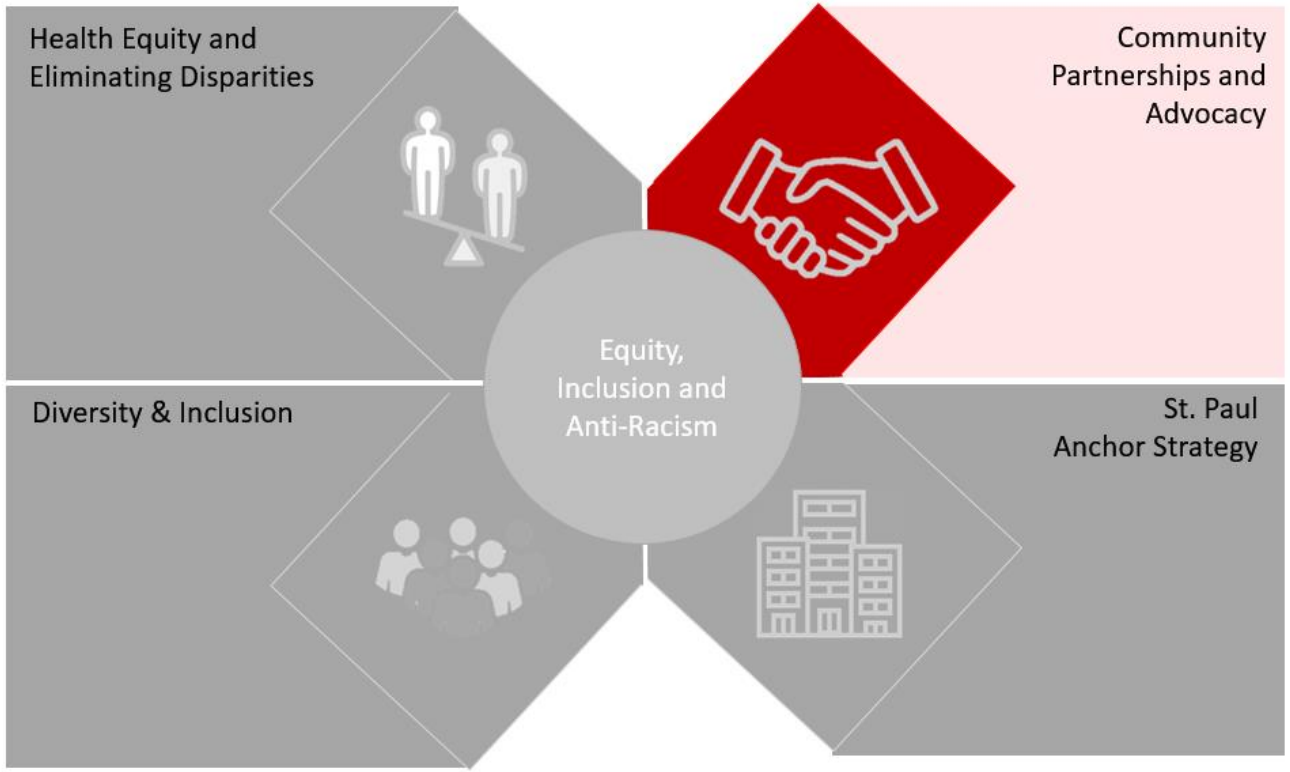
Vaccine health equity progress: 1st dose proportion by Race

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

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

Totals, for selected age bands: 179,351

Community Partnerships and Advocacy



Engage in community and advocacy to advance health, equity, education and economic development

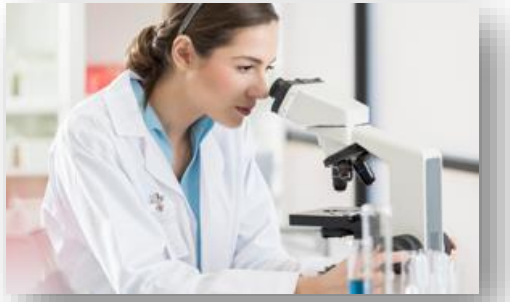
Approach to Community Partnerships

Healthy Children

Nutrition and Fitness

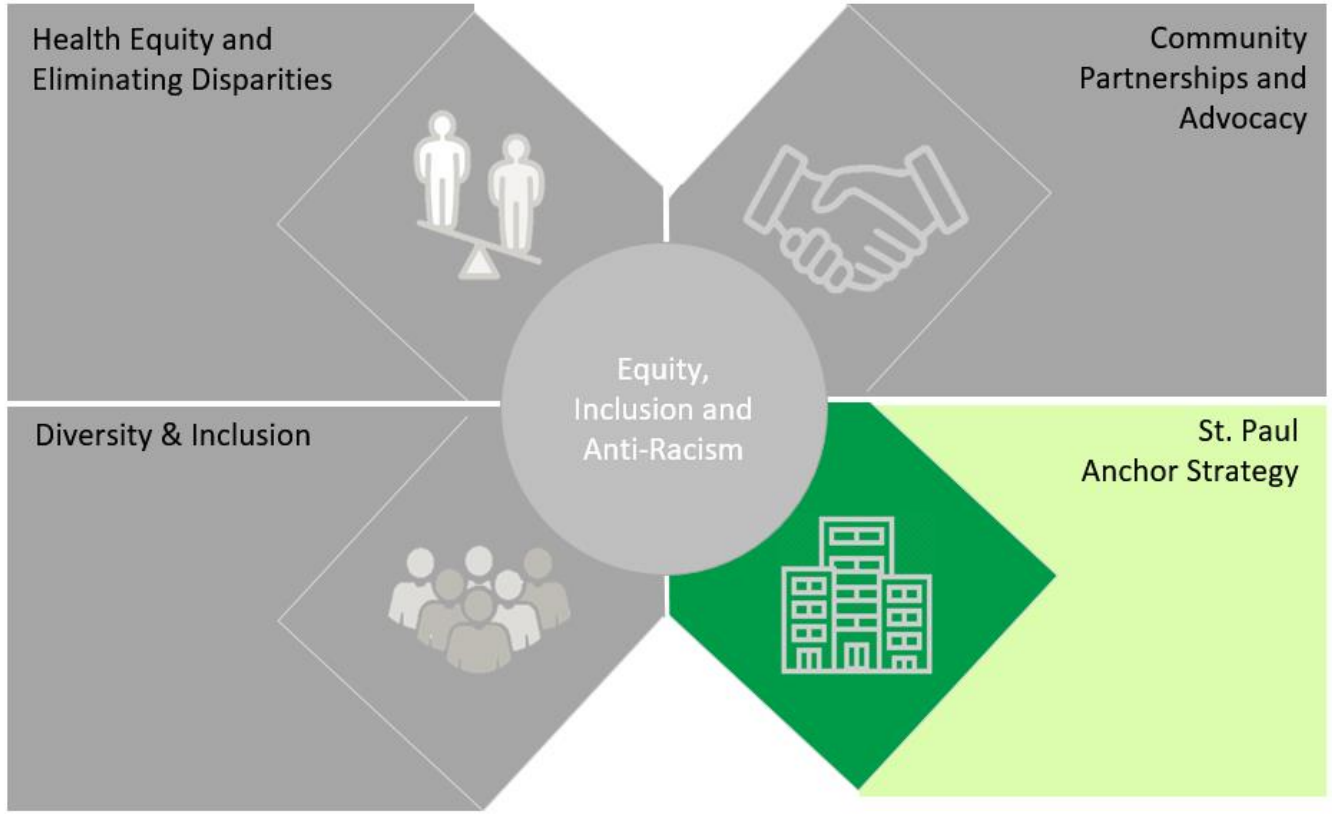
Mental Health

Wellness and Prevention



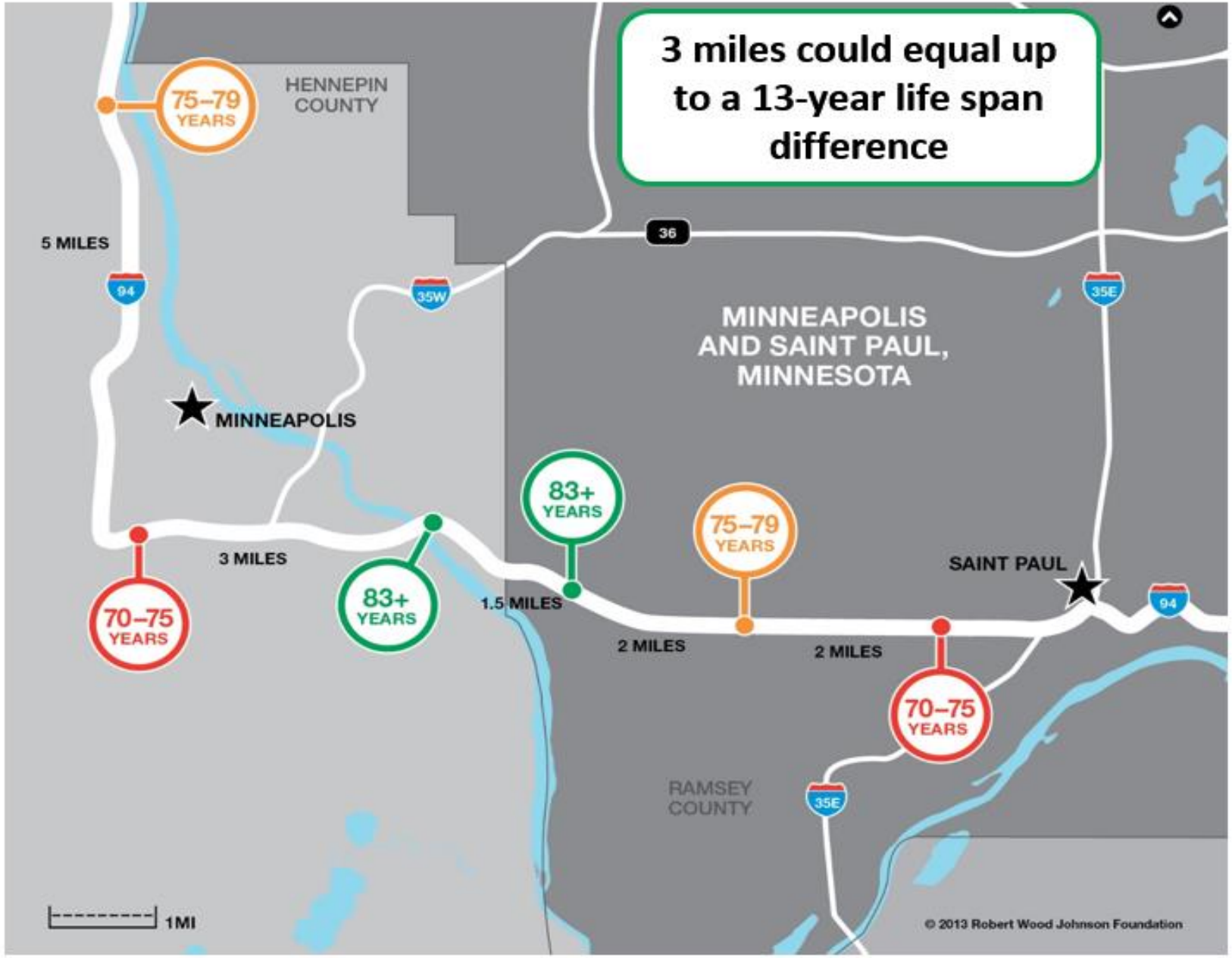
Research and Education

Federal, State and Local Policy



St. Paul Anchor Strategy

Lead health and economic development strategies to measurable impact community wellbeing


3 miles could equal up to a 13-year life span difference
HENNEPIN COUNTY
75–79 YEARS
5 MILES
94
35W
36
35E
MINNEAPOLIS AND SAINT PAUL, MINNESOTA
MINNEAPOLIS
83+ YEARS
75–79 YEARS
3 MILES
70–75 YEARS
83+ YEARS
1.5 MILES
SAINT PAUL
94
2 MILES
2 MILES
70–75 YEARS
RAMSEY COUNTY
35E
1MI
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Hire Locally and Develop Workforce

HealthPartners/Regions is the **largest private employer in St. Paul**

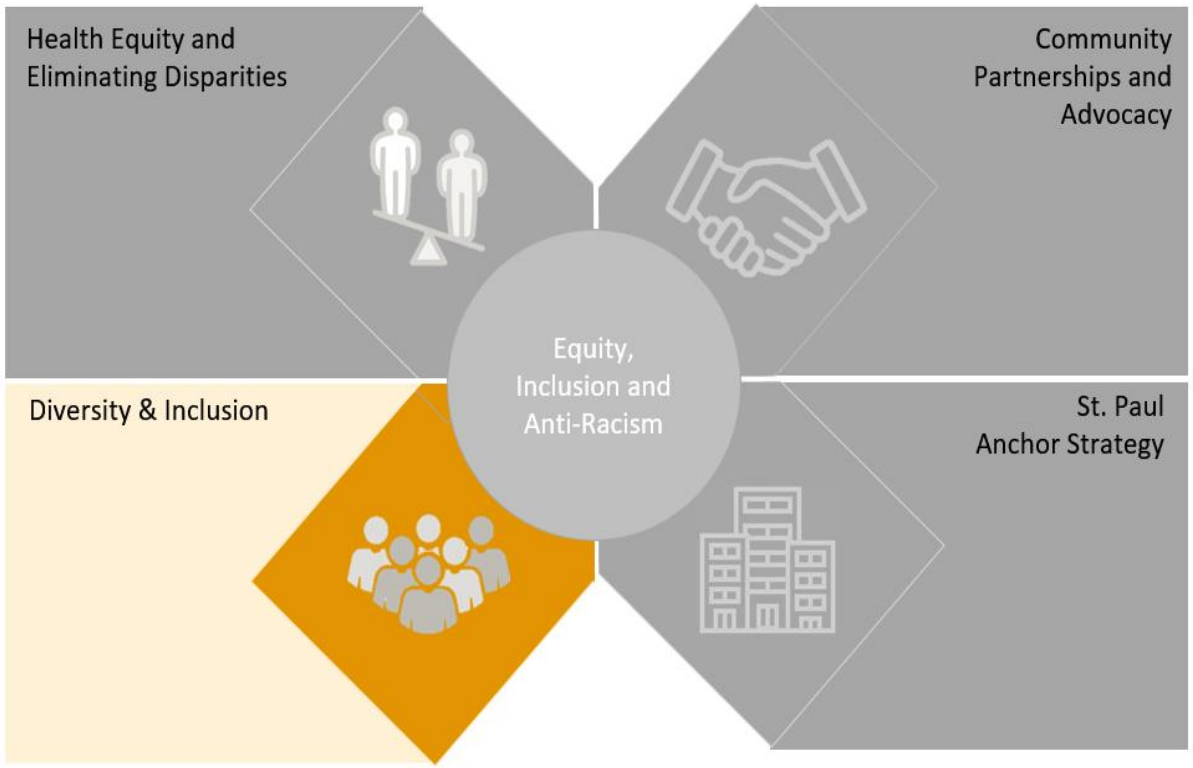
Market leading diversity

37% of 2018 new hires at Regions Hospital were diverse

Mentorship Programs

Leveraging community partnerships to create economic opportunities esidents of Ramsey county

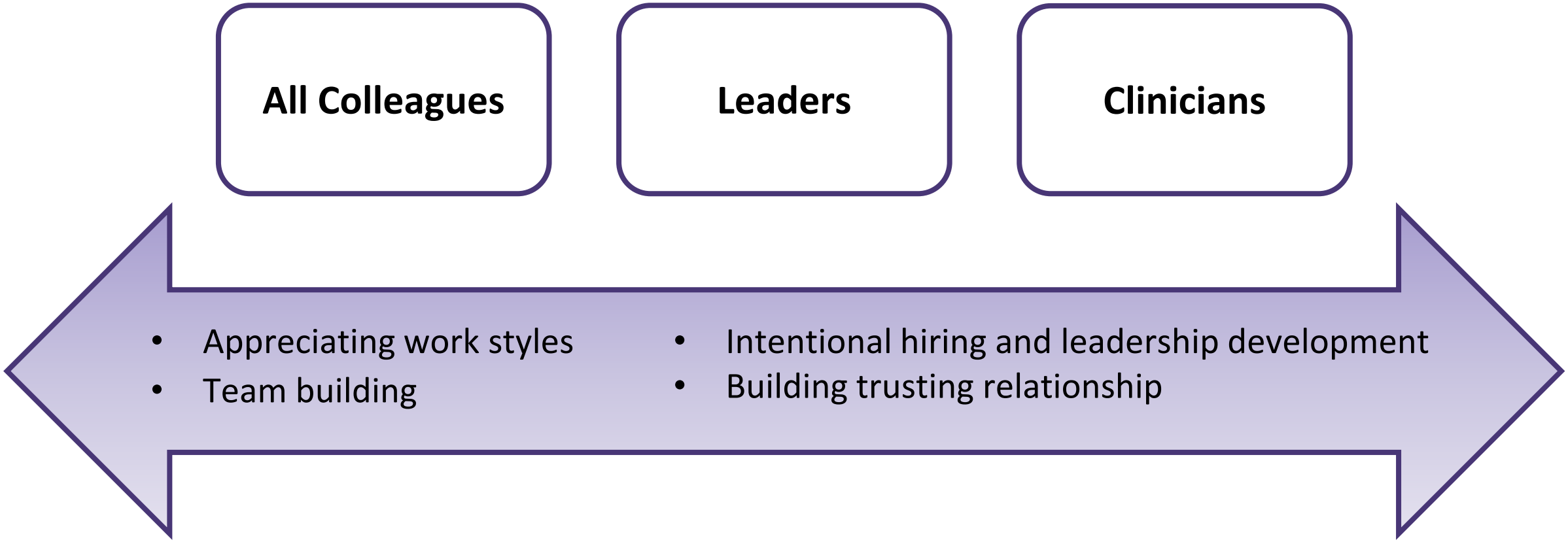
Diversity & Inclusion



Every person **welcome.**
Every person **included.**
Every person **valued.**

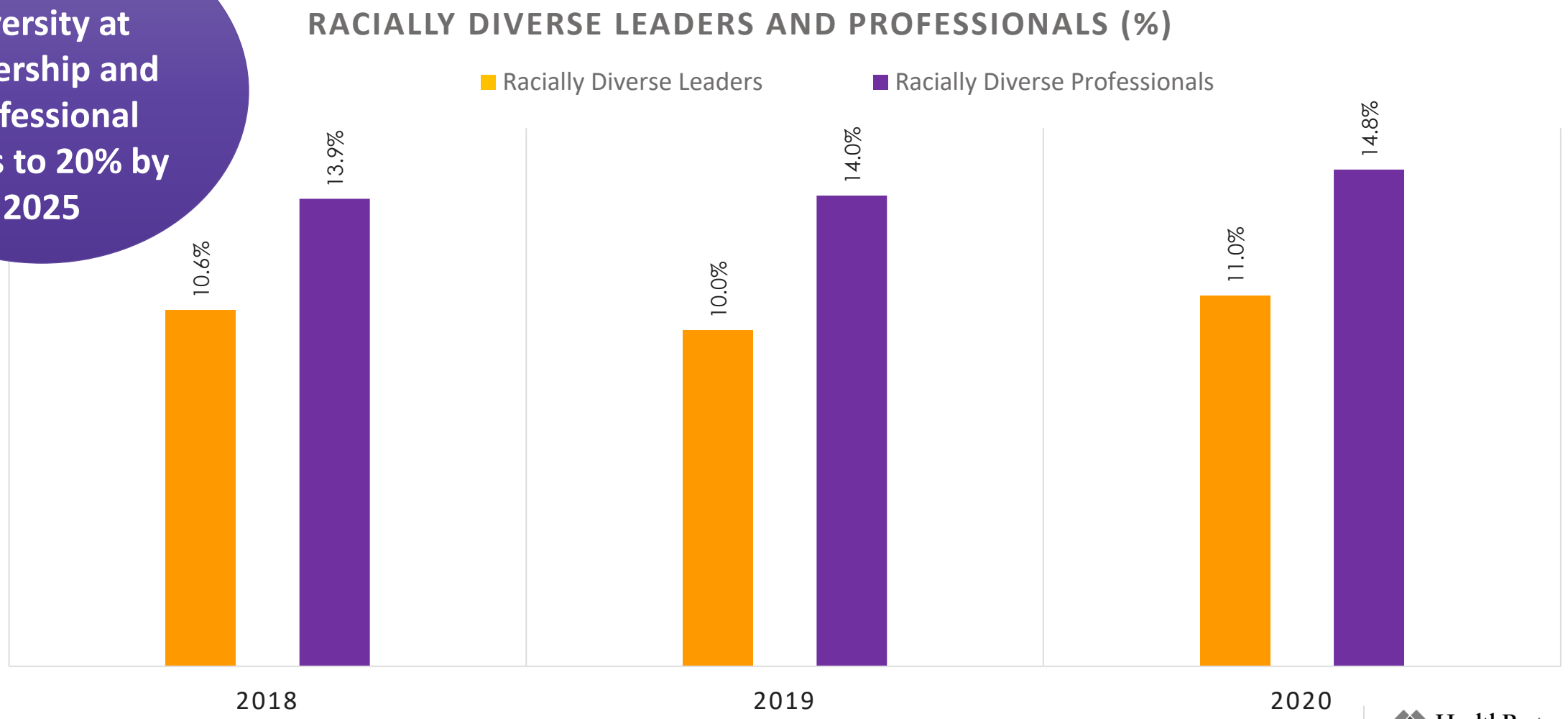
> *Health and high performing team of diverse leaders and team members*

Employee Development



Leader and Professional Demographics

Increase diversity at leadership and professional levels to 20% by 2025



HealthPartners

Diversity, Inclusion and Engagement

Health Equity Champions

Open to all colleagues across the organization

Provide adhoc feedback on various projects

Colleague Resource Groups (CRGs)

Open to all colleagues across the organization.

Standing up and supporting three CRGs:

- *African American/Black*
- *Leaders of Color*
- *LGBTQ*

Clinician Affinity Groups

Open to all clinicians across the organization

Two affinity groups have begun to form:

- *Black Clinicians*
- *Clinician Wellbeing*

Community Partnerships

TPT Racism Unveiled

Habitat for Humanity
Little Moments Count
Make it OK
NAMI Walk
Penumbra Theatre

Twin Cities Pride

St. Paul Bookmobile

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**