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

“Engagement, Equity and Innovation in Changing Times”

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Internal Medicine/Pediatrics
Medical Advisor, Co-Chair of Health Equity, Inclusion and Anti-Racist Cabinet HealthPartners
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

**ORGANIZATION**
Who Are We?

**MISSION**
What's Our Purpose?

**VISION**
Where We're Going?

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

- Healthy, High-Performing Teams
- Best Outcomes
- Grow & Diversify
- Competitive Costs

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

Ramsey County is among the state's most diverse.

By CHRISTOPHER MAGAN | cmagan@pioneernews.com | Pioneer Press
PUBLISHED: August 12, 2021 at 2:09 p.m. | UPDATED: August 12, 2021 at 11:55 p.m.

<table>
<thead>
<tr>
<th></th>
<th>Minnesota</th>
<th>Wisconsin</th>
</tr>
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<tbody>
<tr>
<td>Of color</td>
<td></td>
<td></td>
</tr>
<tr>
<td>22.5%</td>
<td>14.7%</td>
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<tr>
<td>14.7%</td>
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<tr>
<td>White</td>
<td>77.5%</td>
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</tr>
<tr>
<td>85.3%</td>
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<td>86.2%</td>
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</table>
Largest Disparity Gap = 14.2 in Optimal Vascular Care

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

**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%
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

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

Health Equity and Eliminating Disparities

Community Partnerships and Advocacy

Diversity & Inclusion

St. Paul Anchor Strategy
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

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

**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%

**Graph Details:**
- Measurements from Jan-20 to Sep-21
- Pt Color Goal and Optimal Diab Goal represented with dash lines
- Data points and trends shown for each month
## Diabetes Payor

<table>
<thead>
<tr>
<th>Payor Group</th>
<th>Met ODC</th>
<th># Eligible</th>
<th>% Met ODC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial</td>
<td>11,875</td>
<td>27,268</td>
<td>43.55%</td>
</tr>
<tr>
<td>Medicaid</td>
<td>2,678</td>
<td>7,946</td>
<td>33.70%</td>
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<tr>
<td>Medicare</td>
<td>9,814</td>
<td>18,809</td>
<td>52.18%</td>
</tr>
<tr>
<td>Self-pay</td>
<td>129</td>
<td>589</td>
<td>21.90%</td>
</tr>
</tbody>
</table>

**ODC Goal**
- Medicaid Goal: 39.2%
- ODC Goal: 50.8%

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**Graph**

- **Commercial**
- **Medicaid**
- **Medicare**
- **Self-pay**
- **ODC Goal**
- **Medicaid Goal**
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

- POC
- Pt Color GOAL: 65.4%
- Optimal Vasc GOAL: 66.8%

Race Group

<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>
</tr>
<tr>
<td>Choose Not to A...</td>
<td>617</td>
<td>894</td>
<td>69.02 %</td>
</tr>
<tr>
<td>Race not Docum...</td>
<td>72</td>
<td>112</td>
<td>64.29 %</td>
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</table>

Grand total: 76,604 / 108,246 = 70.77 %
<table>
<thead>
<tr>
<th>Payor Group</th>
<th>Met OVC</th>
<th># Eligible</th>
<th>% Met OVC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Commercial</td>
<td>4,871</td>
<td>8,417</td>
<td>57.87 %</td>
</tr>
<tr>
<td>Medicaid</td>
<td>834</td>
<td>1,861</td>
<td>44.81 %</td>
</tr>
<tr>
<td>Medicare</td>
<td>7,581</td>
<td>12,139</td>
<td>62.45 %</td>
</tr>
<tr>
<td>Self-pay</td>
<td>51</td>
<td>146</td>
<td>34.93 %</td>
</tr>
<tr>
<td>Grand total</td>
<td>13,337</td>
<td>22,563</td>
<td>59.11 %</td>
</tr>
</tbody>
</table>

**Vascular Payor**

- **Commercial**
- **Medicaid**
- **Self Pay**
- **Medicaid Goal: 53.3%**
- **Optimal Vasc Goal: 66.8%**

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**Graph**

- % of Met OVC over time for different payors.
- OPTIMAL VASC GOAL: 66.8%
- MEDICAID GOAL: 53.3%
Hypertension Patients of Color

Optimal HTN GOAL: 80.5%
### Hypertension Payor

- **Optimal HTN Goal:** 80.5%

<table>
<thead>
<tr>
<th>Payor Group</th>
<th>Met</th>
<th># Eligible</th>
<th>% Met HTN</th>
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</thead>
<tbody>
<tr>
<td>Commercial</td>
<td>32,831</td>
<td>46,389</td>
<td>70.77 %</td>
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<tr>
<td>Medicare</td>
<td>6,319</td>
<td>9,711</td>
<td>65.07 %</td>
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<tr>
<td>Medicaid</td>
<td>37,022</td>
<td>51,437</td>
<td>71.98 %</td>
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<tr>
<td>Self-pay</td>
<td>432</td>
<td>709</td>
<td>60.93 %</td>
</tr>
<tr>
<td><strong>Grand total</strong></td>
<td><strong>76,604</strong></td>
<td><strong>108,246</strong></td>
<td><strong>70.77 %</strong></td>
</tr>
</tbody>
</table>

*HealthPartners*
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

2020 reporting year
(2019 dates of service)
Colorectal Cancer Screening rates by language: HealthPartners vs. MN

<table>
<thead>
<tr>
<th>Language</th>
<th>HP</th>
<th>MN</th>
</tr>
</thead>
<tbody>
<tr>
<td>English</td>
<td>76.6%</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>
</tr>
<tr>
<td>Spanish</td>
<td>62.0%</td>
<td>51.7%</td>
</tr>
<tr>
<td>Vietnamese</td>
<td>77.8%</td>
<td>74.9%</td>
</tr>
<tr>
<td>All others</td>
<td>64.2%</td>
<td>59.2%</td>
</tr>
</tbody>
</table>

2020 reporting year (2019 dates of service)
Language in depth

Colorectal cancer screening rates:
Asian by Language

<table>
<thead>
<tr>
<th>Race and Language</th>
<th>HP</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>English speaking Asian</td>
<td>70.8%</td>
<td>69.0%</td>
</tr>
<tr>
<td>Non English speaking Asian</td>
<td>72.0%</td>
<td>61.1%</td>
</tr>
</tbody>
</table>

Colorectal cancer screening rates:
Black by Language

<table>
<thead>
<tr>
<th>Race and Language</th>
<th>HP</th>
<th>State</th>
</tr>
</thead>
<tbody>
<tr>
<td>English speaking Black</td>
<td>69.7%</td>
<td>62.9%</td>
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<tr>
<td>Non English speaking Black</td>
<td>42.9%</td>
<td>38.8%</td>
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</table>

Colorectal cancer screening rates:
Hispanic/Latinx by Language

<table>
<thead>
<tr>
<th>Ethnicity and Language</th>
<th>HP</th>
<th>State</th>
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</thead>
<tbody>
<tr>
<td>English speaking H/L</td>
<td>69.6%</td>
<td>64.3%</td>
</tr>
<tr>
<td>Non English speaking H/L</td>
<td>62.1%</td>
<td>51.8%</td>
</tr>
</tbody>
</table>

2020 reporting year
(2019 dates of service)
Colorectal Cancer Screening rates by country of origin:
HealthPartners vs. MN

<table>
<thead>
<tr>
<th>Country of Origin</th>
<th>HealthPartners (%)</th>
<th>Minnesota (%)</th>
</tr>
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<tbody>
<tr>
<td>Laos</td>
<td>54.4%</td>
<td>47.7%</td>
</tr>
<tr>
<td>Mexico</td>
<td>52.9%</td>
<td>47.7%</td>
</tr>
<tr>
<td>Somalia</td>
<td>37.9%</td>
<td>35.5%</td>
</tr>
<tr>
<td>United States</td>
<td>78.0%</td>
<td>74.5%</td>
</tr>
<tr>
<td>Choose not to disclose/declined</td>
<td>73.4%</td>
<td>66.9%</td>
</tr>
<tr>
<td>All others</td>
<td>71.6%</td>
<td>65.7%</td>
</tr>
</tbody>
</table>

2020 reporting year (2019 dates of service)
Country of Origin in depth

Colorectal cancer screening rates:
White by Country of Origin

Race and Country of Origin

Colorectal cancer screening rates:
Black by Country of Origin

Race and Country of Origin

Colorectal cancer screening rates:
Hispanic/Latinx by Country of Origin

Ethnicity and Country of Origin

2020 reporting year (2019 dates of service)
# Health Disparities MOC Project Update

## 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>% Met - White</th>
<th>Race - Disparity Gap</th>
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<td>3/1/2021</td>
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<td>75.55%</td>
<td></td>
<td>1,514</td>
<td>60.11%</td>
<td>78.19%</td>
<td>-18.09%</td>
</tr>
<tr>
<td>4/1/2021</td>
<td>11,428</td>
<td>75.71%</td>
<td>-0.21%</td>
<td>1,551</td>
<td>60.67%</td>
<td>78.33%</td>
<td>-17.66%</td>
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<tr>
<td>5/1/2021</td>
<td>11,605</td>
<td>76.12%</td>
<td>0.54%</td>
<td>1,610</td>
<td>61.06%</td>
<td>78.82%</td>
<td>-17.76%</td>
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<tr>
<td>6/1/2021</td>
<td>11,740</td>
<td>76.12%</td>
<td>0.00%</td>
<td>1,635</td>
<td>61.83%</td>
<td>78.69%</td>
<td>-16.86%</td>
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<tr>
<td>7/1/2021</td>
<td>11,860</td>
<td>76.18%</td>
<td>0.07%</td>
<td>1,675</td>
<td>62.99%</td>
<td>78.55%</td>
<td>-15.57%</td>
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<tr>
<td>8/1/2021</td>
<td>11,823</td>
<td>76.11%</td>
<td>-0.10%</td>
<td>1,680</td>
<td>63.33%</td>
<td>78.40%</td>
<td>-15.07%</td>
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## MoC Cohort Summary - Payor

<table>
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<th>% Met ALL</th>
<th>% Rate Change</th>
<th># Eligible Gov't Programs</th>
<th>% Gov't Programs</th>
<th># Eligible Commercial</th>
<th>% Commercial</th>
<th>Payor - Disparity Gap</th>
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<td>11,156</td>
<td>75.55%</td>
<td></td>
<td>745</td>
<td>55.97%</td>
<td>6,440</td>
<td>74.57%</td>
<td>-18.59%</td>
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<tr>
<td>4/1/2021</td>
<td>11,428</td>
<td>75.71%</td>
<td>-0.21%</td>
<td>774</td>
<td>55.94%</td>
<td>6,363</td>
<td>74.71%</td>
<td>-18.77%</td>
</tr>
<tr>
<td>5/1/2021</td>
<td>11,605</td>
<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>
</tr>
<tr>
<td>6/1/2021</td>
<td>11,740</td>
<td>76.12%</td>
<td>0.00%</td>
<td>824</td>
<td>57.40%</td>
<td>6,783</td>
<td>75.16%</td>
<td>-17.76%</td>
</tr>
<tr>
<td>7/1/2021</td>
<td>11,860</td>
<td>76.18%</td>
<td>0.07%</td>
<td>836</td>
<td>58.25%</td>
<td>6,802</td>
<td>75.14%</td>
<td>-16.89%</td>
</tr>
<tr>
<td>8/1/2021</td>
<td>11,823</td>
<td>76.11%</td>
<td>-0.10%</td>
<td>822</td>
<td>58.68%</td>
<td>6,803</td>
<td>74.98%</td>
<td>-16.10%</td>
</tr>
</tbody>
</table>
Breast Cancer Screening by Race

Interventions

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

**Gap is 9.7% points**

- 1st Qtr 2020: 84.3% (Patients who are white) vs. 74.60% (Patients of color)
- 4th Qtr 2020: 83.1% (Patients who are white) vs. 72.2% (Patients of color)

**Gap is 10.9% points**

- 1st Qtr 2020: 84.3% (Patients who are white) vs. 74.60% (Patients of color)
- 4th Qtr 2020: 83.1% (Patients who are white) vs. 72.2% (Patients of color)

**HEDIS 2019**

- National 90th Percentile = 80%

**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

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

**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

**Gap is 14.32% points**
- 89.67% (Patients who are white) vs. 75.35% (Patients of color)

**Gap is 16.1% points**
- 89.10% (Patients who are white) vs. 73.02% (Patients of color)
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:
  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
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 2/23/2021 7:59:11 AM

Health Equity metrics, by:
- Race
- Age Band

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

**Totals, for selected age bands:** 179,351

Administered through Week of:
- (week = Sunday to Saturday)
- To 2/13/2021

and Null values
- (controls the graph on left-hand side)
Engage in community and advocacy to advance health, equity, education and economic development
Approach to Community Partnerships

- Healthy Children
- Mental Health
- Research and Education
- Nutrition and Fitness
- Wellness and Prevention
- 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
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 for residents 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

- Appreciating work styles
- Team building

- Intentional hiring and leadership development
- Building trusting relationship
Leader and Professional Demographics

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

RACIALLY DIVERSE LEADERS AND PROFESSIONALS (%)

- Racially Diverse Leaders
- Racially Diverse Professionals

<table>
<thead>
<tr>
<th>Year</th>
<th>Racially Diverse Leaders</th>
<th>Racially Diverse Professionals</th>
</tr>
</thead>
<tbody>
<tr>
<td>2018</td>
<td>10.6%</td>
<td>13.9%</td>
</tr>
<tr>
<td>2019</td>
<td>10.0%</td>
<td>14.0%</td>
</tr>
<tr>
<td>2020</td>
<td>11.0%</td>
<td>14.8%</td>
</tr>
</tbody>
</table>
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

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

TPT Racism Unveiled

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