



Advancing High Performance Health

Health Equity

*Quality and
Innovation Collective
(QuIC)*

Phase 3 Meeting Summary
August 5–7, 2024





AMGA Quality and Innovation Collective (QuIC) Health Equity



For the third phase of the Health Equity Quality and Innovation Collective (QuIC), Danielle Casanova, MBA, vice president of Population Health Initiatives and Health Equity for AMGA, welcomed participants back. “It’s an exciting day of learning, insights, sharing, and networking in our journey to advancing health equity.”

Physicians, nurses, quality experts, health equity professionals, and more gathered from a wide variety of healthcare organizations (HCOs) and practice areas—from diabetes and endocrinology to population health, ambulatory care, and beyond—as the QuIC launched its final set of sessions: Presentations from experts, peers, and a health equity advocate who’s been personally impacted by inequities and disparities, along with interactive breakout sessions, reflections on the activities of the past 12 months, and thoughts about what’s next.



Keynote Session: Mental Health in Vulnerable Populations

Rahn Kennedy Bailey, MD, DFAPA, ACP, Professor and Head Department of Psychiatry, LSUHSC

Bailey commenced his presentation by stating that LSUHSC has a clear understanding of the issue at hand. He emphasized that the primary challenge lies in addressing the issue in a manner that is both equitable and just. A nationally recognized expert on gun violence, intimate partner violence, and health disparities in minority populations, Bailey started off with an exploration of the connections across these areas.

Adolescents who live in poor neighborhoods with high levels of crime have the highest rates of gun-carrying and violence, he pointed out. Furthermore, adolescents who report high levels of exposure to violence are more likely than non-victimized peers to carry weapons in later adolescence as well as early adulthood.

This structural violence contributes to community trauma: Systematic and social injustices that prevent people and communities from meeting their basic needs. More and more, these effects can be seen in—and are exacerbated by—a lack of social capital and connections, a loss of structured activities and places that used to be safe, and a collective feeling of hopelessness. “How do we engage with this earlier as a society?” Bailey challenged.

He then talked about intimate partner violence, which includes physical, sexual, emotional, and economic abuse. Intimate partner violence hit a peak during the global COVID-19 pandemic and has recently increased in younger people, he shared, making it a critical condition to screen for at primary care and other medical settings. Yet when screenings are available, many women (64.7% in a recent study) refuse them. Telehealth is one alternative, but it poses risks and limitations, such as an abuser monitoring a victim’s phone.

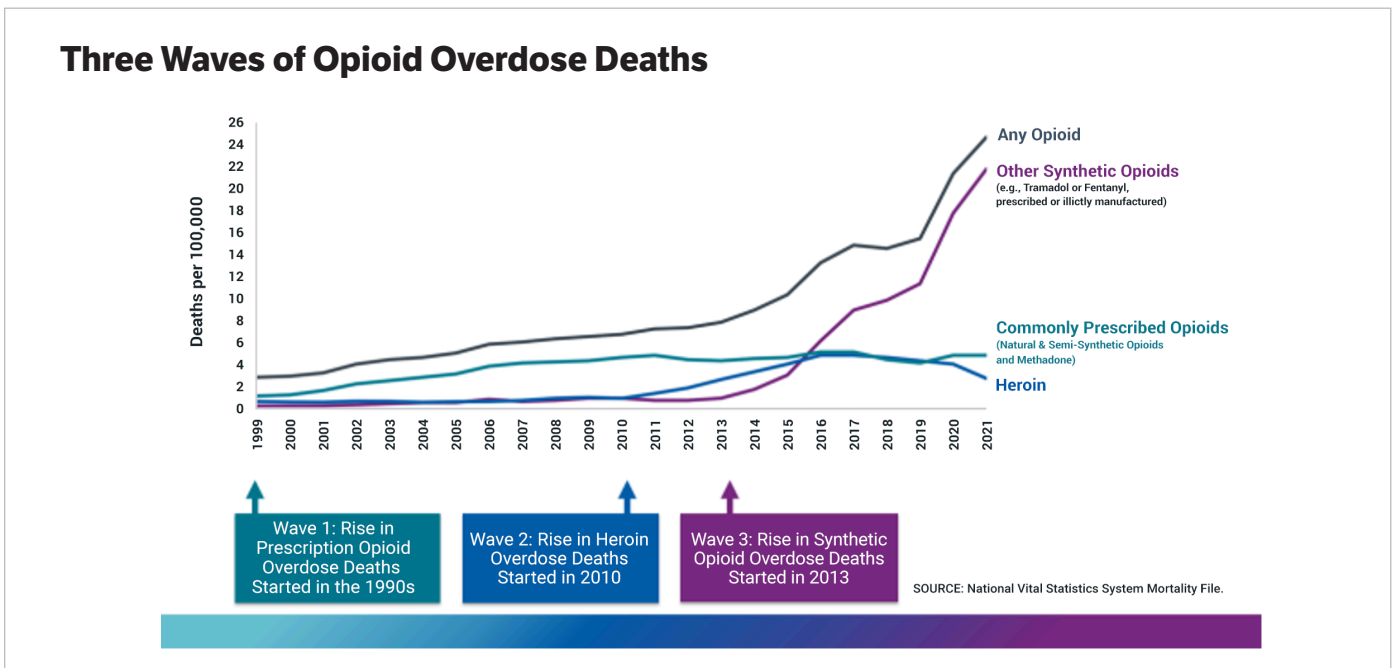
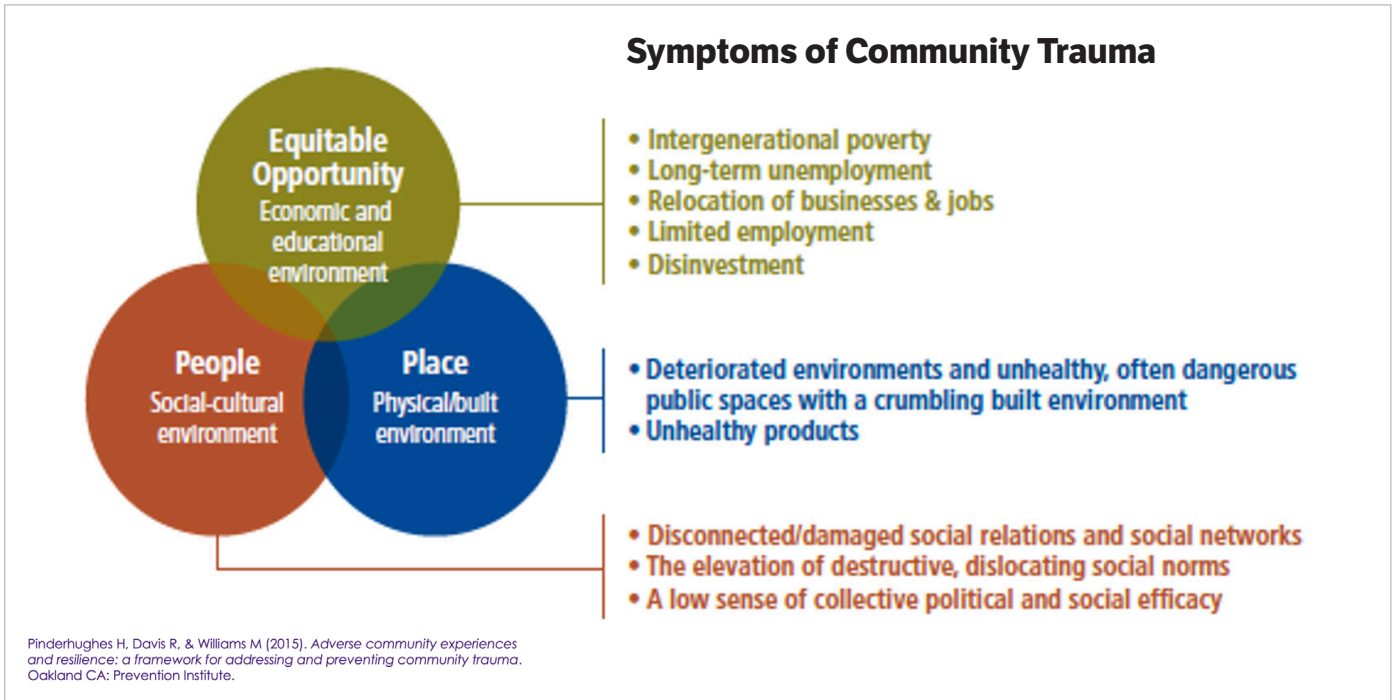


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These trends have a considerable effect on HCOs that prioritize health equity. Bailey observed that many individuals are feeling apprehensive, leading some to hesitate in seeking medical attention. This situation prompts critical reflections on the questions directed at patients and the ways in which they obtain care.

Bailey then talked about substance use disorder, specifically how opioid overdoses and deaths have skyrocketed in the past decade.





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Individuals in small towns typically visit a primary care physician, after which they are directed to a larger city for further assistance. When people with substance use disorder find themselves in difficult circumstances, they face arrest and social exclusion. This dilemma indicates a failure to effectively target and allocate resources at an earlier stage.

Resource allocation is rife with disparities as well, he continued, walking through medication-assisted treatment (MAT) as an example. While medications like buprenorphine have shown success in reducing or stopping opioid use and offer many benefits from a safety and access standpoint, whether or not a patient receives such a prescription often depends on race, income, geography, and care setting.

Bailey asserted that it is impossible to effectively tackle this crisis without considering health equity.

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Audience Q&A

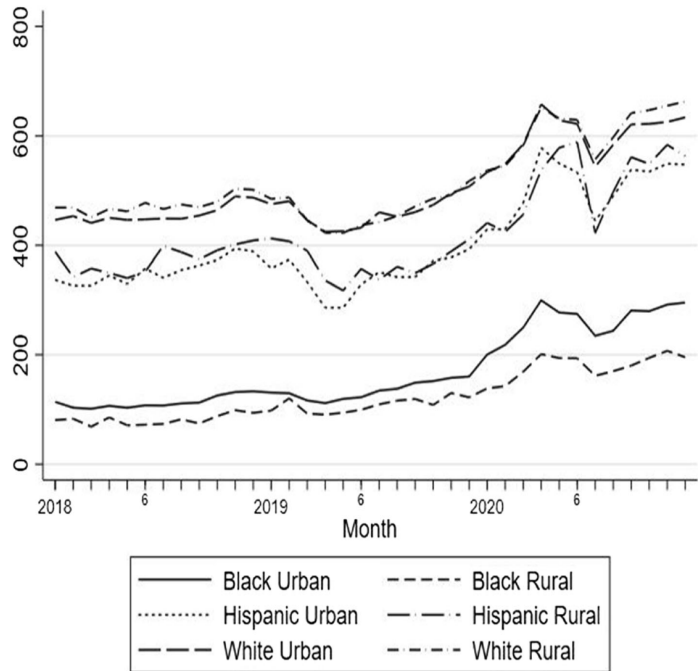
Considering today's lack of resources, especially in rural areas, what are your thoughts on giving nurse practitioners more ability to treat patients?

Bailey expressed a strong personal conviction regarding the matter. He highlighted the relevance of the discussion in light of current civil practice issues and the challenges surrounding the authority of physicians compared to nurse practitioners who provide similar care. He emphasized that the primary concern is to deliver effective care, which necessitates an increase in the volume of services offered. Initiatives such as the Substance Abuse and Mental Health Services Administration's (SAMHSA's) State Opioid Response project are contributing to this goal by providing substantial resources aimed at achieving optimal care levels. Bailey proposed that HCOs consider integrating nurse practitioners into their operations, suggesting weekly video conferences to exchange best practices, and described this collaborative approach as a promising model for future development.

What trends are you seeing related to mental health training and the police force, especially as recognition grows of the value of early intervention?

Bailey observed that numerous professions, such as law enforcement, subject individuals to excessive trauma and violence. He remarked that there is a limit to what people can witness before it affects them. He emphasized the necessity for continuous training across all professions that interact with the public.

Opioid Use Disorder



Anderson A, Walker B, Shao Y, LaVeist TA, Callison K. Racial and Ethnic Disparities in Medication-Assisted Treatment: Evidence from Louisiana Medicaid During the COVID-19 Pandemic. *Journal of general internal medicine*. 2023;38(1):266-268. doi:10.1007/s11606-022-07893-8



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Research just came out that patients do better when their doctor “looks like them” or shares cultural connectivity. Are you seeing this in psychiatry?

In every aspect of care, Bailey emphasized that trust in one’s provider enhances outcomes. This trust may stem from various sources, such as a shared racial or ethnic background or even mutual interests like football. It is essential to identify commonalities that foster connection, ensuring that patients do not perceive a gap and are more receptive to the information provided.

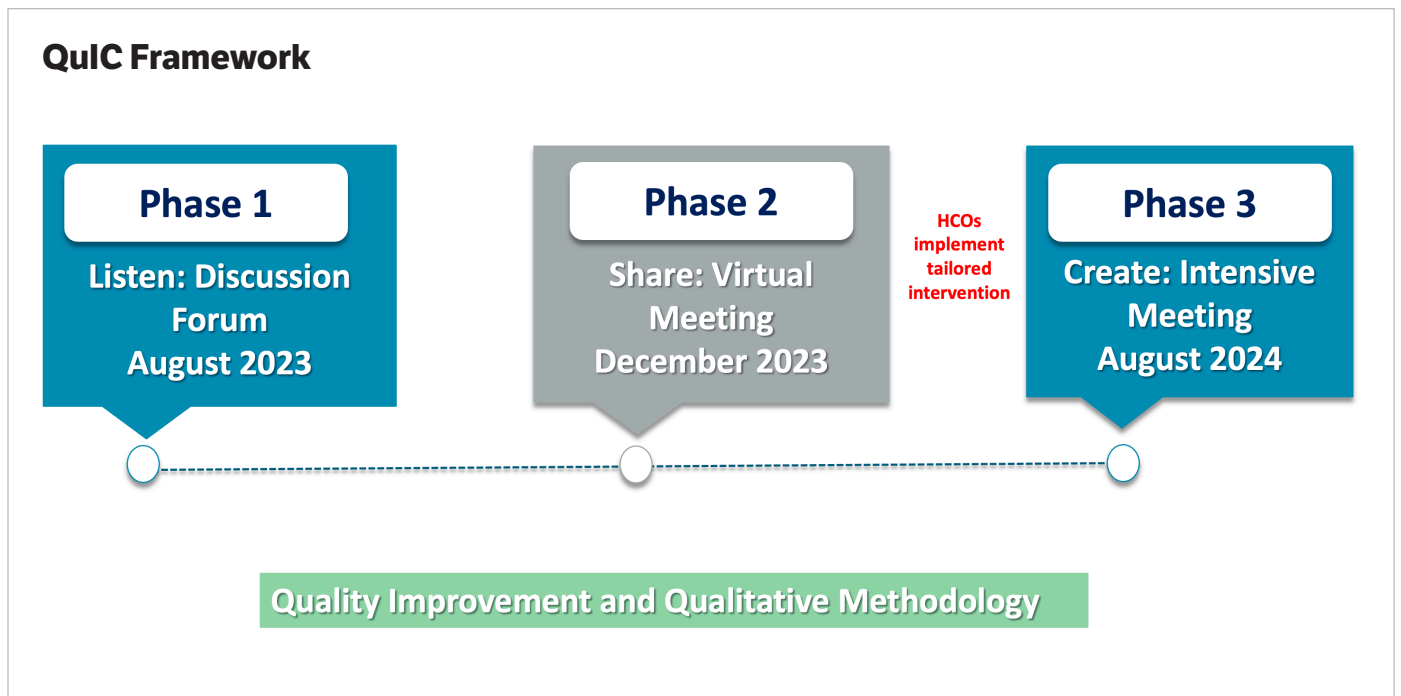
What role should a care delivery system play in addressing this problem, especially given that social isolation carries the same risk as smoking?

HCOs are facilitating support through the connections established in the physician-patient relationship. According to Bailey, individuals require a secure environment and a confidant to share their concerns. As the bond between physicians and patients deepens over time, patients are able to extend this trust to various facets of their lives.

Health Equity QuIC Quality Improvement Report

Earlean Chambers, RN, MS, CPHQ, Senior Director of Clinical and Quality, Population Health Initiatives, AMGA Foundation

“I want to take us back to where we started,” Chambers said to introduce this final quality improvement report of the QuIC. “What was the goal? To explore and make an impact in your organizations. You only had nine months, which was not a lot of time to do the work you did. But you were successful, and you did wonderful work.”





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She shared the many areas QuIC participants addressed through a health equity lens: Hypertension, vaccine management, peripheral artery disease, social drivers of health (SDOH) screening, maternal and neonatal health, pediatric obesity, mental/behavioral health, and breast cancer screening.

She noted a few pivots during the QuIC. Based on what they were hearing from the community, one group shifted its intervention from vaccine mobile delivery to providing education on navigating the health system, for example.

A common thread of food insecurity emerged across many interventions. “When I was reading your documents, I found it interesting that no one was targeting this, but it was coming out in the work you were doing,” she observed.

Learning from Experience and Sustaining Progress

In this final quality improvement overview, Chambers highlighted lessons learned. Participants recognized the importance of community health workers, especially for SDOH screening, and facilitating access to care—through health fairs, community partnerships, faith communities, and outreach channels such as text messages, phone calls, patient portals, and digital health monitoring.

Facilitating access to care was number one among HCOs’ motivating needs, with continuous provider education also ranking highly. Interventions revealed the importance of tactics such as addressing implicit bias, using a patient’s first language, and delivering culturally appropriate care to strengthen data collection and build patient engagement and trust.

Chambers shared additional motivating needs related to program sustainability. What data methodologies can organizations use for identifying and quantifying health disparities? What tactics could help them screen for SDOH and respond to positive screen results? And how can they more effectively navigate the landscape of reporting requirements and funding sources—especially when the programs communities need to thrive are typically not billable?

QuIC Tips Panel: Provider Education

Panelists: *Verlyn Warrington, MD, MS, Guthrie Medical Group, and Jennifer Hines, MD, HealthPartners*

Moderator: *Yeng Yang, MD, MBA, Regional Medical Director, Primary Care, Health Equity Medical Advisor, HealthPartners Care Group*

Guthrie Clinic, a participant in AMGA Foundation’s prior Obesity Care Model Collaborative, expanded that focus to include its pediatric population: How could the organization increase earlier obesity diagnoses? The need was there—too few eligible young patients were receiving diagnoses and referrals to the HCO’s weight management clinic—but provider discomfort and pushback stood in the way of progress.

Warrington’s team addressed this issue with information. They shared data with key provider groups and stories about the positive impact patients have seen in Guthrie’s Weight Loss Clinic. They also talked about barriers to obesity diagnosis and treatment. As engagement grew, the team worked with providers on education materials and group activities for their patients.

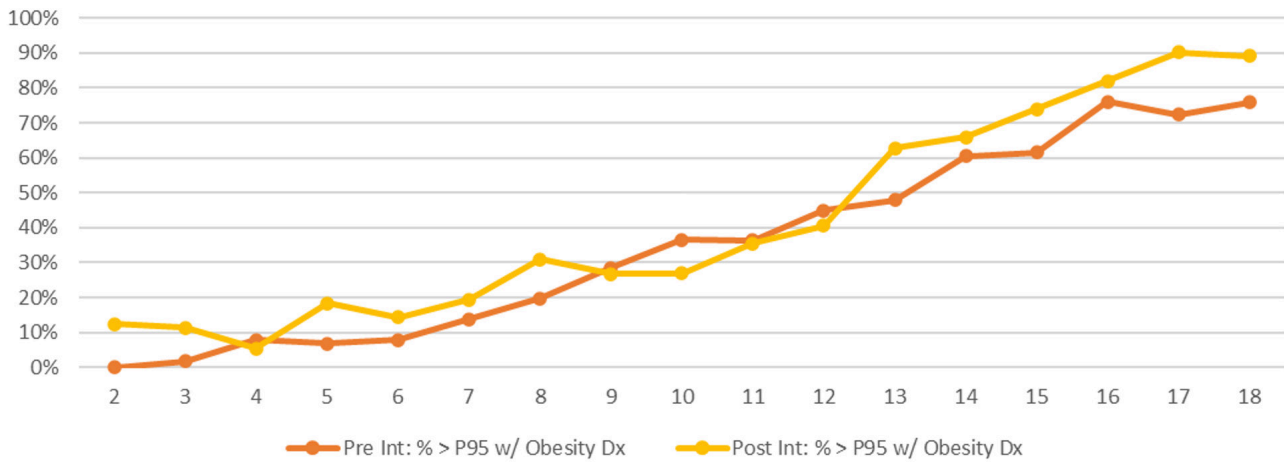
Guthrie observed a notable increase in diagnosis and referral rates, and according to Warrington, the newly appointed Pediatric Chair was significantly impressed by the data. This led to the initiation of pediatric grand rounds, while a new pediatric gastroenterologist has also shown interest in establishing a clinic.



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Pre- and Post-Intervention Obesity Dx Rate



Warrington stated that the compelling factor for their participation was the data, emphasizing that it was difficult to contest the validity of that information.

Hines talked about the challenge of reducing race- and payer-based disparities in hypertension management at **HealthPartners** and how the HCO was bringing in a wide range of tactics to tackle it, including educating nursing staff about food insecurity, developing hypertension champions, and focusing on SDOH barriers such as transportation.

They have also taken a close look at existing resources, from home cuffs for Medicaid patients to existing processes, according to Hines. “We have all these workflows and tools, but are we using them uniformly? Who’s using them?” she asked.

These collective efforts yielded improvements in a short amount of time, Hines reported.

The keys to success: Helping clinicians understand the power of their influence—in education, outreach, and outcomes—and bringing other care team members like nurses, social workers, and pharmacists along in the journey.

Hines stated that the essence of the village outweighs the significance of any single individual.

“What are you willing to do right now? How are you willing to build on that?”

— Jennifer Hines, MD, HealthPartners

Audience Q&A

How did you overcome physician hesitation to commit an obesity diagnosis to a patient’s chart?

Warrington stated that discussions are essential. She emphasized that the issue extends beyond a child’s weight, highlighting it as a significant health concern. She further noted that these discussions should also consider various social factors, such as the demanding schedules of parents.



What commonalities and trends are you seeing in the parents of children with obesity?

Financial limitations pose a significant challenge. Warrington emphasized the importance of discussing strategies to maximize financial resources, recognizing that each family's needs vary. She noted that solutions might be as straightforward as meal batching or exploring available support from schools. Her approach is to engage with families based on their specific circumstances.

What is a health system's obligation to go after root causes, especially when health plans don't always cover the things we're talking about?

When engaging with a patient, it is essential to consider all aspects that influence health, as noted by Warrington. Yang highlighted the tendency of the industry to operate in silos, emphasizing the importance of a holistic approach to patient care. Hines pointed out the necessity of collaboration with community organizations, stressing the need for education and relationship-building. The trio acknowledged the significance of advocacy at various levels, with Yang asserting the importance of being a vocal advocate and Warrington expressing that without active representation, meaningful change is unlikely to occur.

What goals, incentives, and compensation are involved in this work?

Hines talked about continuing education credits for participating clinicians and monthly quality measures across the organization so that clinicians know their data.

As of this year, over 50% of contracts at HealthPartners are value-based, Yang said. Next year will bring in hypertension as a clinic-based performance metric, with increasing impact on compensation.

"To enhance performance, particularly as no clinic has achieved the 2024 hypertension target, we are continuously introducing new resources aimed at empowering nursing staff to assist clinicians in addressing access challenges," Yang stated. "Furthermore, we plan to extend these opportunities to the broader primary care sector, expanding beyond the initial three clinics."

How do you deal with patient pushback about getting on the scale?

Warrington stated that the focus is on body mass composition, which resonates more with patients than merely a numerical value on the scale. She emphasized that discussions about weight are not part of her approach, as her patients primarily seek to achieve a sense of health and well-being.

QuIC Tips Panel: Community Partners

Panelists: *Insha Haque, DO, MPH, Concord Hospital; Kimberly Hailey-Fair, MPH, CPH, Johns Hopkins University; Natasha Smith, Sanford Health*

Moderator: *Leon Jerrels, MHA, MBA, RN, CPHQ, Former Director, Quality Improvement, Kelsey-Seybold Clinic*

Concord Hospital started addressing vaccination rates in its New American/refugee population as part of AMGA's Rise to Immunize® campaign. Through this work, the HCO saw an opportunity to look at health equity across its entire system. Through participation in the Health Equity QuIC, data led tactics in a new direction.



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Following analysis indicating that a successful intervention may not require additional vaccines or mobile units, the team opted to engage directly with the community for further insights. Haque emphasized the challenge of reaching the most vulnerable patients, noting that they often do not visit the hospital.

Through community leaders connected with the New American population, Concord Health was able to explore perceptions of healthcare experiences and identify the true barriers behind the vaccination rates, such as insufficient insurance coverage. This set the foundation for a grassroots-informed, health equity-centered vaccination strategy focused on increasing understanding and building trust.

In response to the recent Centers for Medicare and Medicaid Services (CMS) mandate for the collection of SDOH data, Johns Hopkins University utilized a Health Resources and Services Administration (HRSA) grant to enhance the training and skills of community health workers. This initiative was prompted by requests from

“Community health workers are able to meet people where they are and use their experience and training to identify and address clients’ foundational needs.”

— Kimberly Hailey-Fair, MPH, CPH, Johns Hopkins University

many who had previously engaged with the healthcare organization. Hailey-Fair noted that there was a desire to assist by gathering resources related to mental health and food insecurity, offering to conduct screenings directly.

These efforts have already yielded valuable insights, she said. Data collection revealed food insecurity in a significant number of patients and sepsis readmissions to be a top cause of re-hospitalization.

Community health workers are sharing feedback on an ongoing basis to guide efforts in areas from technology to cultural appropriateness.

Sanford Health also leveraged HRSA funding for its intervention, in this case to remove barriers to care for Native American patients in maternal and neonatal health.

The team prioritized the inclusion of indigenous perspectives from the beginning, according to Smith. She noted that while it is possible to establish Epic for tribal affiliation, the challenge of overcoming intergenerational mistrust remains significant, rooted in historical injustices such as genocide, land theft, and cultural erasure.

Interventions included training focused on bias and microaggressions to address these issues. Smith pointed out that individuals facing discrimination in the Midwest, whether they are employees or patients, often lack the knowledge or vocabulary to report their experiences. She acknowledged initial obstacles, such as unifying physician-led silos and

“Our system is pretty data rich. What isn’t as rich is the narrative behind the data.”

— Insha Haque, DO, MPH, Concord Hospital

“Purely doing SDOH screening isn’t health equity unless you’re targeting certain populations and can demonstrate movement.”

— Natasha Smith, Sanford Health



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integrating strategies such as remote patient monitoring into a cohesive initiative. However, she expressed optimism about the early signs of progress, emphasizing that while it is premature to analyze the data, the initiative has fostered increased empathy and understanding.

Audience Q&A

How has Johns Hopkins been making the case for hiring community health workers?

Hailey-Fair noted that following the death of Freddie Gray in 2015, Johns Hopkins employed community health workers to engage with individuals in their own environments. However, after these workers successfully connected patients to necessary care, their positions were eliminated, leading to public outcry and subsequent funding to reinstate the initiative. Since the grant's inception, which is set to conclude next year, Johns Hopkins has successfully facilitated access to free meals and Uber discounts, services that Hailey-Fair describes as directly addressing community needs, resulting in a reduction in hospitalizations. The organization is currently assessing the effectiveness of these efforts, which appear to be yielding positive outcomes.

What happens after the funding runs out?

Johns Hopkins has been actively seeking additional grants, collaborating with various organizations, and investigating opportunities for on-the-job training and apprenticeships. Hailey-Fair emphasized the significance of representation in healthcare, stating the substantial evidence indicating that patients benefit from interacting with individuals who share their appearance, language, and cultural background. She urged attendees to recognize the vital role of community health workers, noting that while HCOs have historically included these professionals in their initiatives, funding opportunities to support them are relatively recent.

What are your plans for collecting SDOH data? Are you expanding into ambulatory care and using community health workers to help?

The objective is to ensure that every individual who enters our facility is screened; however, current intake procedures are limited to hospitalization facilitated by tablets and community health workers, according to Hailey-Fair. She emphasized the necessity of gaining support for the recruitment of additional personnel.

A QuIC participant pointed out that certain states, such as Michigan, provide comprehensive coverage for both community health workers and doulas, although achieving this feat required significant advocacy efforts. Another participant lamented the ongoing need to repeatedly request funding, stating that the absence of allocated financial resources for this initiative is unacceptable.

Smith highlighted a major obstacle faced by Sanford in collecting SDOH data, which is the reluctance to pose these inquiries. She also celebrated a significant achievement of the healthcare organization: Collaborating with a community partner to address the needs identified through the data. Smith noted that transportation poses a considerable challenge for many patients, and thanks to Feeding America, a food pantry has been established within the hospital premises. This proximity makes it much easier to inquire if patients are concerned about their next meal.



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QuIC Tips Panel: Utilizing a Data-Driven Approach

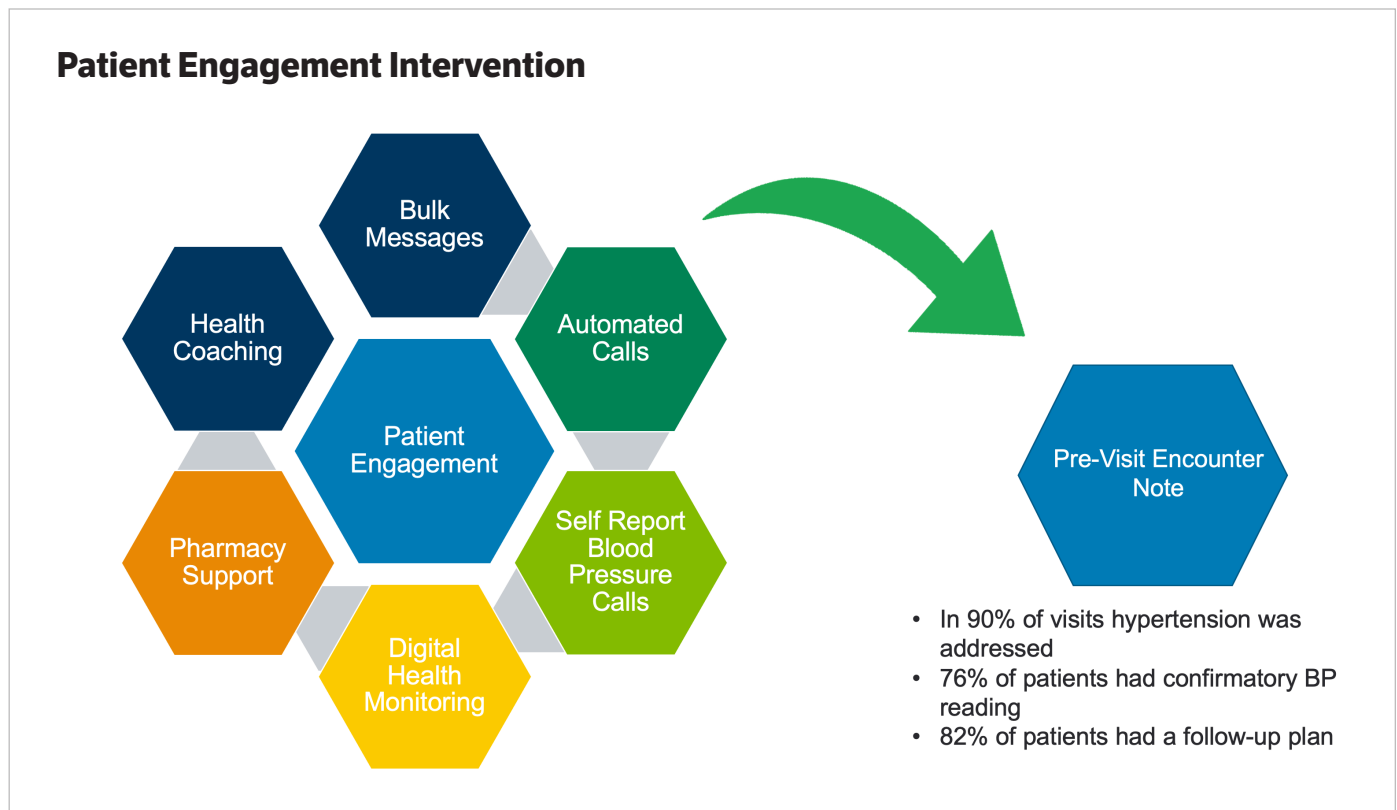
Panelists: **Victoria Harris, MPH, CPHQ, UC San Diego**; **Verlon Salley, University of Alabama Health Services Foundation**; **Gabriel Gomez, Scripps Health**

Moderator: **Leon Jerrels, MHA, MBA, RN, CPHQ, Former Director, Quality Improvement, Kelsey-Seybold Clinic**

The University of California San Diego system has identified disparities in hypertension control among the African American/Black population across its campuses, according to Harris. In response, UC San Diego has initiated efforts to address this issue by implementing a health equity dashboard that tracks hypertension management for primary care patients, categorized by division, clinic, and provider. This tool allows for filtering data by various demographics, including race, ethnicity, religion, language, payer, and ZIP code, to identify clinics with significant disparities.

The next phase of the team's comprehensive approach involves analyzing these data to connect patients with UC San Diego's extensive hypertension program during their existing office visits. Harris emphasized the importance of engaging patients in the doctor's office, where they are more receptive to addressing their health concerns.

UC San Diego effectively tackled hypertension by implementing minimal provider nudges to discuss blood pressure. It addressed hypertension in 9 out of 10 of visits, equipped 82% of patients with a follow-up plan, and reduced disparities in hypertension control disparity for African American/Black patients.





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The Results of Discovery

Utilization Data Review	Faith Alliance Church Assessments	Value Based Care Health Equity Metrics	Community Health Needs Assessment
Mental & Behavioral Health	Anxiety / Depression	Controlling High Blood Pressure	Mental & Behavioral Health
Maternity Health	Diabetes	Colon Cancer Screening	Access
ED Utilization	Overweight / Obesity	Diabetes HB A1C>9%	Diabetes
Diabetes	Affordable Healthcare / Health Information	Diabetes Care – Kidney Monitoring	
Cardiovascular Health	High Blood Pressure / Stroke	Breast Cancer Screening	
Oncology			

The University of Alabama Health Services Foundation directed its attention toward mental and behavioral health for African American patients based on utilization data, a community needs assessment, and a survey conducted among churches in under-resourced areas. Salley noted that although mental health was identified as a primary concern for people of color, it was not a significant factor in hospital admissions, indicating a gap where patients required services but were not receiving appropriate treatment.

His team turned these data into action with an initial focus on Jefferson County and an initial intervention aimed at identifying people in need of services, then connecting them to the appropriate resources.

Because the HCO’s mental health resources were limited, Salley’s team enlisted two community partners: The Jefferson County Health Department and the Confess Project of America, which trains local barbers and stylists to be mental health advocates. Through a train-the-trainer initiative, local barbers learned how to identify mental health issues among their clients and how to connect these clients to the appropriate community resources.


When **Scripps Health** assessed quality measures in ambulatory care through a health equity lens, it discovered a significant disparity in breast cancer screening: The gap to goal for Spanish-speaking patients was 7%, compared with only 1% for English-speaking patients.

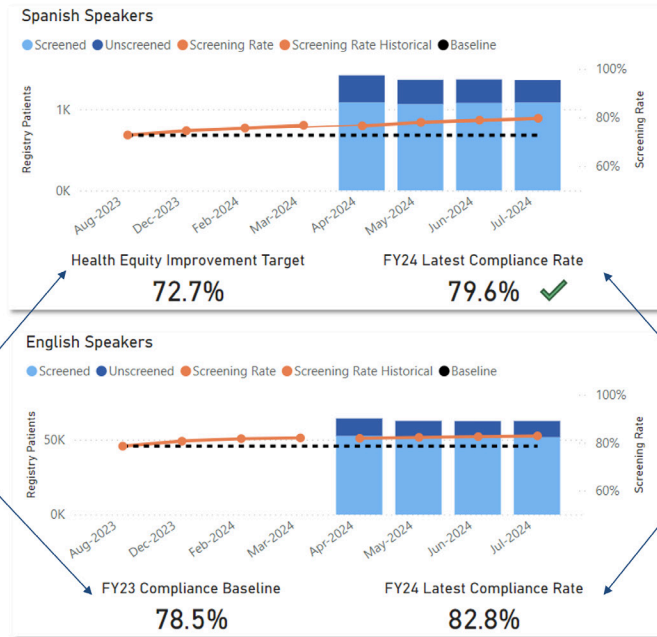
Guided by these data, the HCO leveraged a new tool in Epic to send Spanish-language messages and notifications about breast cancer screening through its patient portal, supplemented by text messages in Spanish. The goal was to improve the gap for Spanish-speaking patients, and the intervention surpassed it, with improvements for both Spanish- and English-speaking patients.



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Scripps Health AMGA QuIC Project: Impact

 **Goal**
Improve gap from Spanish baseline to Amb system goal by end of FY24



6%
Variance
at Baseline

3%
Variance
at Current

Gomez recommends that individuals incorporate a health equity perspective into their existing priorities and procedures. It is essential to pose fundamental questions and maintain simplicity when exploring new initiatives.

Audience Q&A

How did you decide which screening measures to focus on, and did you develop a tool or criteria for analyzing metrics across data sets?

Scripps prioritized established insights in selecting screening measures, as noted by Gomez, who highlighted this approach as a significant strength of their initiatives. Salley's team created a seven-domain index that specifically targets ZIP codes, while UC San Diego's dashboard incorporates various perspectives centered on justice, equity, and mission, according to Harris. Jackson stressed the necessity of standardization to effectively demonstrate impact beyond individual systems.

The panelists acknowledged the difficulties in conveying health equity data to providers, who frequently exhibit skepticism or resistance. Harris described this as a challenging endeavor that requires time, validation, and consistent presentations. Salley mentioned that he collaborates with a physician colleague to engage providers as equals, emphasizing that the data belong to them, interpreted through an equity perspective, and framing the conversation with the question, "How can we help you?"



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Leaders are often “happy to throw money at a fire.” How do you keep people focused when the urgency dissipates?

Gomez stated that a solution has yet to be determined, noting that Scripps is currently emphasizing financial performance and prioritizing initiatives with evident returns on investment. He mentioned that existing regulations mandating SDOH screening are beneficial.

Salley remarked that the approach has shifted from data-driven discussions to more conversational engagements. Harris highlighted the importance of regularly meeting with provider champions to gather their insights on challenges, frustrations, and desired changes.

Jackson summarized four essential insights for achieving success: Develop a strategy based on data, recognize potential partners, establish accountability through defined goals and metrics, and determine how to effectively allocate resources for operations—a challenge many are currently facing.

Breakout Session: Community Outreach and Engagement

Participants: *Concord Hospital, Henry Ford, Sanford Health, UAB Health Services Foundation*

Moderator: *Leon Jerrels, MHA, MBA, RN, CPHQ, Former Director, Quality Improvement, Kelsey-Seybold Clinic*

The session started with barriers and challenges, from effectively engaging providers in a patient handoff from a community partner to getting on a community leader’s schedule.

One participant observed that this may be a demographic that remains underserved, suggesting that organizations should be more inclusive. Jerrels recommended that efforts should focus on engaging individuals in their own environments, emphasizing the importance of investing time to cultivate relationships and enhance trust through consistent community presence. “Small steps translate to large impact,” one participant observed.

“Showing up is important,” another said, sharing how their HCO shifted its strict policy on co-sleeping for new parents based on community input on cultural norms.

Participants talked about how they’re measuring outcomes, including gaps in tools and tactics. Are there any health equity dashboards out there like the ones organizations are using to measure clinical measures like A1C? How are groups tracking data, from hours for community health workers to referrals to community organizations? And what metrics are organizations choosing to track in the first place?

Jerrels noted a strong emphasis on ZIP codes, suggesting that unexpected insights may emerge from the data. Another participant highlighted the importance of examining patient experience scores, recommending a comparison between quality data and patient experience data, as some individuals may be facing challenges in receiving adequate care.

In a region characterized by significant disparities between rural and urban populations, a healthcare organization is struggling to link resources, patients, and coverage effectively. Jerrels emphasized that food insecurity serves as a critical indicator of SDOH, which introduces another challenge: ensuring proper resource allocation and follow-up. A participant remarked on the difficulty of maintaining sustainability, stating that individuals seeking food assistance often return repeatedly, complicating the situation further.



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Finally, how are participants sustaining their health equity work? The answers included grants, relationships, advocacy, community partners like United Way, tech-based tactics like building a worksheet in Epic to track and document value-based metrics, and the ultimate goal of aligning health equity aims and initiatives with value-based incentive pay.

Jerrels recommended that the entire audience align their value-based care strategies with their specific needs. He suggested that by innovatively addressing community needs within their value-based care framework, organizations might successfully implement health equity initiatives discreetly, thereby maximizing their impact and efficiency.

Breakout Session: Provider and Staff Education

Participants: Guthrie Medical Group, HealthPartners, Johns Hopkins, Scripps, UC San Diego

Moderator: Yeng Yang, MD, MBA, Regional Medical Director, Primary Care, Health Equity Medical Advisor, HealthPartners Care Group

Provider and staff education today takes many forms: Mandated sensitivity training, ad hoc simulation exercises on microaggressions, sessions for leaders on unconscious bias, inclusive leadership, respectful and culturally appropriate terminology, and more. In this breakout session, participants shared the topics their organizations are focusing on, tactics, lessons learned, and tips for success.

“It’s easier to engage providers if you weave clinical issues besides just equity,” one participant remarked. The conversation touched on examples, such as weaving stigma and bias into conversations about obesity and incorporating SDOH and shared decision-making into hypertension workflows.

Another participant described “very beneficial” weekly calls with residents, nurses, community leaders, and “anyone who’s available at the time.” The purpose: Share perspectives and ask and answer questions—no slides allowed. “Everybody learns about issues together.”

Yet another organization brought in an outside agency to talk about bias—both their own and dealing with patient biases against staff. “We’re trying to teach and expose people to what it’s like on both sides, and we’ve had some really honest conversations about how we interact with each other and our patients.”

Common themes and recommendations emerged throughout the session—specifically to make training in-depth, multipronged, ongoing, and mandatory, supported by data. One participant suggested a report card, with the argument that nobody likes to be ranked at the bottom.

What’s needed to sustain health equity education? Participants talked about the need for more resources and a consistent approach. “There aren’t a lot of tools out there,” one observed.

Securing support from senior leadership is essential to ensure continuous funding and to prevent health equity education from becoming a temporary trend. Yang emphasized that engagement, advocacy, and sponsorship from the C-suite are crucial; without this commitment, such initiatives are likely to be neglected.

It is particularly crucial for HCOs to address workforce turnover and attrition, as training adoption and outcomes can differ significantly within the organization. Yang emphasized that continuous training for all staff and clinicians is essential, stating that it should not merely be a formality.



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For organizations facing resource constraints, she recommends initiating a focused educational approach on specific metrics while integrating health equity and diversity, equity, and inclusion (DEI) principles. Gradually expanding these efforts will facilitate meaningful discussions over time.

Show providers and staff how health equity is important, participants emphasized. Talk about how it relates to them, how current systems perpetuate inequities, and why health equity work is what an HCO needs to do in order to be relevant.

From ER to Advocacy: Overcoming Bias and Barriers in My Colorectal Cancer Journey

Paula Chambers Raney, *Colorectal Cancer Survivor and Hope Coordinator, Fight Colorectal Cancer*

“This is a room full of people who understand the barriers to care in marginalized communities,” Raney began as an introduction to her own story, which covers nearly a decade of colorectal cancer symptoms and increasingly severe health effects before a diagnosis—even as a member of two communities (Black, LGBTQIA+) with known disparities in healthcare access.

Her journey began in late 2011 with gas and pain. “It was embarrassing,” she recalled. “What did I eat? What did I do wrong? But the doctor said to take some medicine, and it would be fine.”

Even as new symptoms arose, like gastric reflux and trouble eating, no one suggested checking for colorectal cancer. “My doctor was trying to help me, but he really didn’t see a problem. He said it was probably something I was eating, or that I probably had the stomach flu.”

Raney’s challenges intensified when her doctor left the healthcare organization. “I loved this doctor. He knew I was gay. He knew my partner,” she said. Despite receiving care within a large institution, she never saw the same provider twice. By 2013–2014, she was regularly taking antibiotics and medication for her stomach, but no one even considered colorectal cancer screening, a critical missed opportunity in addressing the systemic gaps in care for marginalized communities.

“When some doctors noticed blood, they dismissed it as hemorrhoids,” she remembered. “One doctor told me I was too young for colorectal cancer. When I donated blood at a new job, they noticed my iron was very low. The advice I got? Eat more red meat. Eat more greens.”

Some encounters crossed into outright bigotry. “One time I went to urgent care because I had been seeing blood, and the doctor said: ‘Did you tell me you’re gay? You’re going to hell anyway, so it doesn’t matter what’s wrong with you,’” Raney recalled.





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In late 2014, Raney and her wife got married, traveling from Texas to New York where the marriage would be legally recognized. But even after the wedding, her health continued to worsen, and she faced ongoing obstacles to appropriate care.

“The day after our wedding, we were at the theater, and I was wondering: Is this play terrible, or am I about to pass out? In the emergency room, I was doubled over in pain. The doctor looked at my record and, seeing I’d been to the ER many times, accused me of being there to get drugs.”

“My wife stood up for me,” she said. “She yelled at him and demanded another doctor. It was the first time I realized that I could do that—advocate for myself.”

Despite this powerful moment of advocacy, Raney’s colorectal cancer still went undiagnosed. ER visits continued, and her health spiraled. Increasingly severe symptoms caused her to lose her job due to frequent illness, which led to the loss of insurance and fragmented care. “In Texas, there aren’t many options for the uninsured,” she explained, “especially for someone like me.” A deep depression followed.



“In 2014, I spent most of December in bed—30 pounds underweight, in pain, and unable to keep food down. My wife didn’t know what to do,” she recalled.

January 2015 brought a final trip to the ER. “I guess I looked bad enough this time,” Raney said. “They did scans, blood work, and I woke up in a pediatric room with eight doctors around me, two on their knees by the bed. They told me they tried to do a colonoscopy, but my colon was too swollen. When they did scans, they found a large mass on the right side of my abdomen.”

“I was half-dead,” she said.

Recovery was a long and difficult journey, both physically and mentally. “I was angry, depressed. What would have happened if just one person had offered me a FIT [fecal immunochemical test]?”

Raney’s anger transformed into advocacy. “I realized I could take that anger and turn it into something else.” She began sharing her story, urging others to do the same, and bringing her advocacy to Capitol Hill. She also began connecting with patients from queer, Black, and trans communities, focusing on the reasons why many have stopped seeking medical care and screening.

“If we catch colorectal cancer early, it’s treatable,” she said. “My experience—this nightmare—did not have to happen.”

She emphasized the importance of trust and care in the patient-provider relationship. “I encourage people to find doctors and caregivers who really see them for who they are, where they come from, and what they need.”

For healthcare providers, Raney stressed the necessity of Sexual Orientation and Gender Identity (SOGI) data, proper training on interpreting these data, addressing implicit biases, and providing compassionate, equitable care. “We need to ensure queer, Black, and trans people receive the same quality of care as everyone else.”

And she’s encouraged by the progress she’s seeing. Today’s healthcare providers, she said, “are starting to look at things differently. They’re coming in with a new perspective, and we’re learning.”



AMGA Quality and Innovation Collective (QuIC) Health Equity



Consultations with Advisors, Peers, and AMGA

Erin Leaver-Schmidt, MPH, Director, Population Health Initiatives, AMGA Foundation

Participants kept the discussion going and started new conversations in small-group and one-on-one “consultation” sessions. These covered a wide range of topics, including overcoming communication barriers like literacy with patients at discharge, tailoring messaging and outreach to African American patients, updating community needs assessments, and crafting a business case for community health workers.

Participants talked about tools and approaches to applying a health equity lens to their work, such as the Health Disparities Quality Improvement Framework and Evaluation, and emphasized the importance of—and challenges involved in—sharing data. “SOGI data are difficult because not everyone is doing it,” one participant observed. “People who need help have racial, language, and cultural differences. Some might not understand why SDOH questions are being asked,” another noted.

Alignment is key across community organizations, health systems, and social networks. “Clinicians don’t get feedback if the referral to transportation doesn’t work,” shared a participant whose HCO serves a community with access challenges. A variety of resources and models are out there for making these connections, but some are geared to health systems vs. individual patients. Others can be cost-prohibitive.

Hot Topics

Alisahah Jackson, MD, President, Lloyd H. Dean Institute for Humankindness & Health Justice, CommonSpirit Health

Throughout the phase 3 sessions, participants jotted down their most urgent priorities on a giant easel noteboard in the main conference room. In this final session, Jackson led a discussion of the “hot topics” that rose to the top: Sustainability, the relationship between DEI and health equity, and looking at care through a health equity lens.

Jackson inquired about the methods to sustain the significant progress being made. With government funding starting to evolve in this direction, one participant talked about advocating for—and successfully obtaining—Medicaid funding for community health workers. Participants also talked about how value-based care might follow in the footsteps of readmissions in terms of funding and reimbursement, as CMS shows an interest in this area.

In the meantime, Jackson suggested that participants look beyond grants to a “braided finance” approach, exploring potential revenue sources like county health departments, payer pilot programs and collaboratives, private funders, family foundations, corporate gifts, and more. Jackson stated that while they may not explicitly refer to it as health equity, much of the work they are financing aligns with that concept.

Jackson and Casanova talked about how the Society of Human Resource Management (SHRM) recently changed its DEI policy. SHRM received a lot of negative backlash, but in the overall environment right now, participants have felt the pressure to adjust their tactics, tracking legal activity, pausing activities like diversity surveys and DEI-related publicity, and separating DEI departments and programs from other initiatives—which comes with some risks. Jackson pointed out that a fragmented approach to this work will inevitably lead to a division of financial resources.



AMGA Quality and Innovation Collective (QulC) Health Equity



Participants are reexamining language related to equity. Jackson remarked that her organization has not encountered resistance regarding the concept of kindness in their initiatives, and she emphasized that current challenges compel them to be innovative, a practice they have consistently engaged in throughout their careers.

Finally, participants have been examining ways to look at care through a health equity lens, revisiting data collection (“How do you add ethnicity into Epic?”), language (“The word disparity can be disempowering.”), and the definition of equity itself. As one participant shared his organization’s journey toward finding a common definition, another pointed out that health equity “is not one size fits all.”

Wrapping Up

As the third and final meeting of the Health Equity QulC came to a close, Casanova addressed participants for final remarks, saying, “Thank you for being open and honest and vulnerable, sharing insights and strategies, talking about some of the challenges you’re experiencing, and being open to helping each other.

“This is the first program AMGA has designed, developed, and implemented solely focused on health equity—the first of many. Thank you for the work you and your organizations are doing.”

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