



Advancing High Performance Health

Health Equity

*Quality and
Innovation Collective
(QuIC)*

Phase 2 Meeting Summary

December 4-5, 2023





AMGA Quality and Innovation Collective (QuIC) Health Equity



“Before we jump in, it’s important to take a step back and ask why we’re here today,” Danielle Casanova, MBA, vice president, population health initiatives and health equity, AMGA, said as she welcomed participants back to the Health Equity Quality and Innovation Collective (QuIC).

This virtual meeting was the second gathering in a three-part series enabling organizations to listen to high-level discussions, share current care practices, and create new models and care paths through interactive workshops.

Health inequities impact how long a person lives, their quality of life, their likelihood of disease and its severity, and their access to treatment. Improving health equity can improve the quality of health outcomes and reduce the cost of care.

Each year, Casanova said, \$320 billion is spent in the United States on health and healthcare disparities—and this figure will grow to over \$1 trillion by 2040 if not addressed. “Working toward health equity is both the right thing to do and good for business.”

It’s a complicated challenge. “Equal and equitable are two different things,” Casanova noted. But together, healthcare organizations can make an impact in reducing disparities and providing more equitable care. She concluded her remarks by reminding participants that health equity is one of AMGA’s strategic priorities. “We’re here to support you.”



Keynote: Enhancing Equity Through Population Health

Georgia McGlynn, RN, MSN-CNL, CPHQ, Administrative Manager, Office of Population Health and Accountable Care, and Reshma Gupta, MD, MSHPM, Chief of Population Health and Accountable Care, UC Davis Health

McGlynn oversees a team of project specialists and clinical informatics specialists to improve care outcomes and reduce costs for UC Davis Health’s patients, including populations with high and rising risk. Gupta oversees population health programs in quality improvement, affordability, care pathways, and social needs across the health system. They began the session by sharing highlights from their work, from how UC Davis Health has a standard approach to screening for food, housing, and transportation insecurity to how the organization works with six academic health centers to implement upstream interventions.

Data have been key to these efforts, McGlynn said, giving the example of initiatives to tackle food insecurity. When UC Davis Health discovered it only had data for 3% of the population, they used vendor-supplied data to grow this figure to 73%. Then they dove into the details to explore gaps and connections.



Approach to Improving Equity in Quality of Care



They discovered that older patients with multiple chronic conditions were 1.6 times more likely to have an acute care visit and 1.7 times more likely to be food insecure. These patients also were more likely to be Black, Hispanic, or Native American.

McGlynn and Gupta's team used these findings to target resources and customize care, connecting patients to services like a program offering months of medically tailored meals.

McGlynn also noted that some patient groups may be underrepresented in the data due to factors such as different outreach thresholds for different populations. When analyzing predicted resource use versus actual use at UC Davis Health, for example, her team found a 15% difference between Black and White patients.

An Audience Poll on Health Equity Maturity and Priorities

Throughout the keynote, participants responded to an interactive poll, starting with how mature they thought their organization was in the area of health equity.

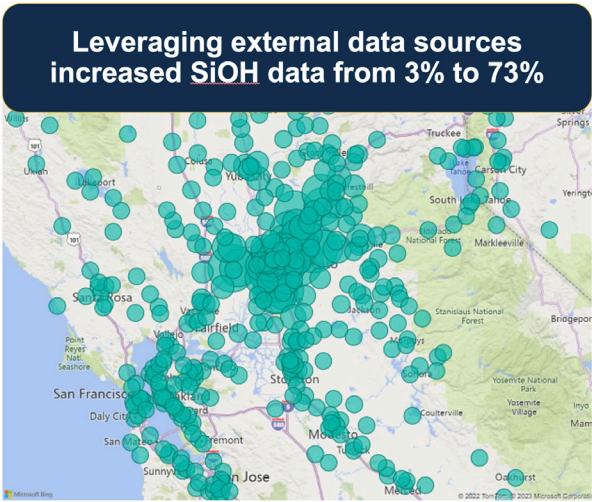
A vast majority of respondents ranked their maturity as "intermediate" (53%) or "advanced" (30%), showing that the needle has moved from thinking about health equity needs to addressing these needs through strategies and interventions.

Participants were also asked to identify their most pressing and relevant health equity concern from a list of three options. More than half (57%) checked "screening and addressing social needs," followed by "equity in quality of care" (42%). Casanova called these responses "unsurprising, given upcoming SDOH [social drivers of health] mandates."

"Reducing bias in how high-risk patients are identified," the third item in the list, received no responses. Gupta predicted that this will be health equity's "next new area of work," but infrastructure will be needed for data collection.



Food Insecurity Data at UC Davis Health



Our target population: 65+, higher risk zip codes and chronic conditions (chronic kidney, heart, liver disease; HTN, DM)

- Food insecure patients are 1.6x more likely to have a hospitalization or ED visit
- Patients 65 and older are 1.7x more likely to be food insecure
- Rates are particularly high among older Hispanic, Black, and American Indian patients

While risk stratification is a key component of population health—meeting the right patients at the right time and place with the right care team—risk models can perpetuate bias, she cautioned. UC Davis Health has developed a framework for models with built-in risk strategies to acknowledge and address potential bias.

McGlynn's other advice to participants in their health equity work, drawing from her team's lessons learned, is: Work with aligned data—this helps information be used more effectively across teams. Localize health equity efforts and consider the historical context. Different communities face different barriers. Building relationships is critical, and building trust in one's institution takes a lot of work.

“Leaders must be okay making mistakes and asking for help,” McGlynn said, “so they're not afraid to do this work.”

The keynote concluded with Casanova moderating a Q&A session.

How do you decide where to begin and what to focus on?

“You need data first, and we all have to work with what we can get,” McGlynn said. To evaluate a potential health disparity and assess organizational readiness for tackling it, she suggested:

- Looking at the size of the gap between populations
- Talking to subject matter experts within primary and specialty care and the community to see if the organization's data are in line with national and community trends
- Assessing the available infrastructure and resources for making a change



AMGA Quality and Innovation Collective (QuIC) Health Equity

McGlynn called this third point “one of the most crucial things, so you’re proposing something that people can get behind and actually do.”

And doing something—putting data into action—is critical in health equity work. “Even if the data’s not 100%, there’s probably a story there to dig into,” Gupta said.

What advice do you have for working with models?

Developing a risk model is its own specialized discipline in terms of technology, cleansing data, and so forth. That being said, population health teams are always implementing models even if they didn’t develop these complex tools themselves, Gupta reminded participants. The important thing is to know how well models are working and get input from experts and the community on the why behind the data.

How can organizations address gaps in data?

Data quality can differ depending on who collects it. What’s their comfort level with information that’s often sensitive and difficult to discuss? Do they know the questions to ask and how to respond to various types of answers?

Train staff to spend time with a patient in order to get their full history, Gupta advised, noting that sometimes medical conditions make it difficult for patients to communicate. She also noted that her team met with equity experts to shape these trainings. “Empowering staff is one of the main ways we’ve been addressing data of differing quality or missing data.”

OVERVIEW: Health Equity QuIC and Quality Improvement Report

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

In the Phase 1 virtual meeting in August 2023, QuIC participants discussed the topic of health equity and their organization’s top-ranked problems related to it, working from a list compiled by AMGA’s health equity team and advisors.

There were eight “motivating needs” in total: strengthening data collection and reporting, committing to leadership support and sponsorship, provider and staff education, and addressing implicit bias in healthcare, as well as educating patients about chronic disease management, building patient engagement and trust, working with the community to identify SDOH, and facilitating access to care.

Before this Phase 2 meeting, participants were asked to revisit the list and their top priorities.

“We noticed that these rankings had changed,” Chambers said. Facilitating access to care and patient engagement and trust now rank higher. Top priorities grew from four to five.

She then showed how these five motivating needs connected to specific objectives, such as establishing community relationships and using quality data.



Ranked Motivating Needs

Before VDF

- Address implicit bias in healthcare.
- Facilitate access to care.
- Patient engagement and trust
- Identify SDOH across patient populations with involvement of community members.

After VDF

- Facilitate access to care.
- Patient engagement and trust.
- Strengthen data collection and reporting.
- Provider and staff education and training about disparities in care.
- Address implicit bias in healthcare.

Top ranked

Motivating Need	Objectives
Facilitate access to care.	Services (availability of recommended screening and prevention services, transportation, housing, social support, financial security, etc.)
Patient engagement and trust with healthcare system.	Establish relationships with the community.
Strengthen data collection and reporting.	Use quality data to guide implementation and monitoring of patient care.
Provider and staff education and training about disparities in care as it relates to population health, such as cancer and other screenings, and chronic disease management.	Identify opportunities for provider and staff education/training (i.e. cultural humility concepts).
Address implicit bias in healthcare.	Provide education and training.



AMGA Quality and Innovation Collective (QuIC) Health Equity



Chambers concluded by sharing the chronic diseases and SDOHs participants chose for their targeted interventions:

- Concord Hospital: Improved vaccinations for new Americans
- Guthrie Medical Group: Obesity
- HealthPartners: Hypertension
- Henry Ford Health: Peripheral artery disease
- Sanford Health: Colorectal cancer
- UC Davis Health: Hypertension

She walked through the steps in the implementation process. “It is important for you to add these to the documentation you submit to AMGA,” she told participants. “We want to know what you are trying to accomplish, what interventions will be implemented, what happened, and what you learned, as well as whether you met your goal and how you concluded.”

As participants work toward the next deadline—submitting SMART goals and an implementation plan by January 26—Chambers encouraged them to share data throughout and take advantage of the many channels and resources available to QuIC participants: outreach calls and other forms of virtual engagement, a May 2024 webinar, and a community page for collaboration.

SPOTLIGHT: Using Data to Identify Opportunities for Improvement

John Cuddeback, MD, PhD, *Chief Medical Informatics Officer, AMGA*

Reducing data variability can play a big role in reducing disparities in health and care. Yet data standardization has typically been the exception, not the rule in health equity work. Race has typically been “poorly defined,” and even when organizations are able to expand their view beyond insurance claims, much of the information in electronic health records has not been collected “with sensitivity and nuance,” Cuddeback explained.

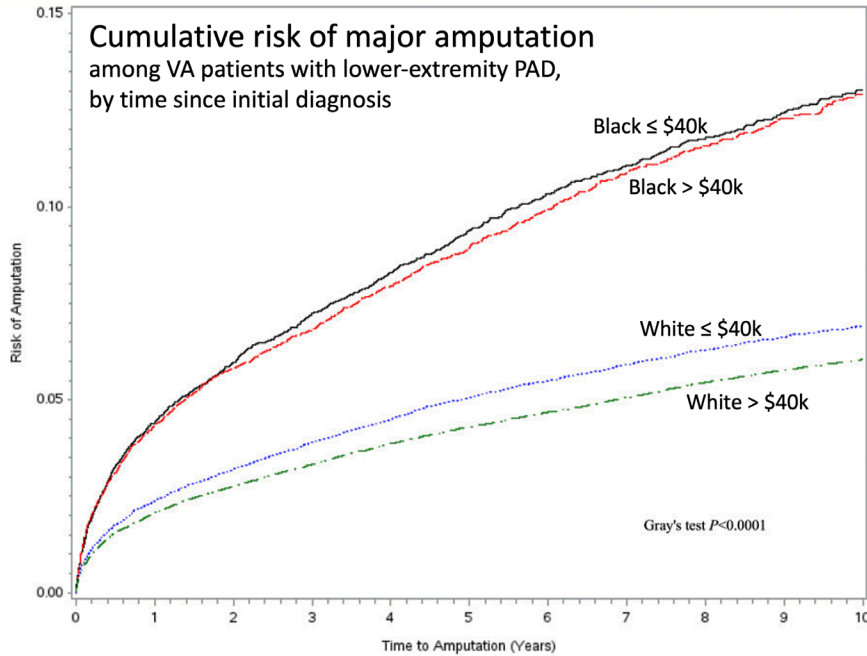
He talked through how government initiatives have been tackling the issue. The 2022 CMS framework for health equity is standardizing the collection of information related to food, housing, and transportation insecurity, and Cuddeback called it a “more usable, operable model.” The Office for Management and Budget is revising federal standards for race, and an interagency group is pursuing a similar goal. Yet with 21,000+ public comments and counting for the latter initiative, “this is going to take a while,” Cuddeback observed.

Healthcare organizations have been working with what they have in the meantime. Cuddeback shared a few powerful examples.

Lower extremity peripheral artery disease (PAD): When diagnosed and treated early on, prospects are favorable for delaying PAD or preventing its progression. At its most advanced state, however, the condition too often leads to gangrene and amputation—and too many patients (around 64%) are being diagnosed at the ulceration stage, “when it’s pretty far along,” Cuddeback said.



AMGA Quality and Innovation Collective (QuIC) Health Equity



Veterans Affairs data, 2003–2014
(n = 155,647)

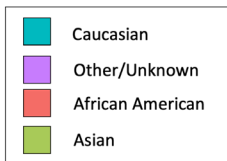
By race and household income (imputed based on zip code of residence)

Race and socioeconomic status independently affect risk of major amputation in peripheral artery disease.

Shipra Arya, MD, SM; Zachary Binney, MPH; Anjali Khakharia, MD, MS; Luke P. Brewster, MD, PhD; Phil Goodney, MD, MS; Rachel Patzer, MPH, PhD; Jason Hockenberry, PhD; Peter W. F. Wilson, MD.

J Am Heart Assoc. 2018;7:e007425.
DOI: 10.1161/JAHA.117.007425.
<https://www.ahajournals.org/doi/10.1161/JAHA.117.007425>

Time to follow-up colonoscopy, by race



- Follow up rates were significantly lower for Black/African American and Asian patients compared with White patients ($p < 0.05$).
- 180-day follow-up rates*
 - White 52.5%
 - Other 43.3%
 - Black/AA 42.9%
 - Asian 40.7%
 - Average 51.4%

* $p < 0.05$, after adjustment for age group, sex, race, ethnicity, insurance type, smoking status, recent SBT, year, SBT type, and CCI
SBT – stool-based test; CCI – Charlson Comorbidity Index



AMGA Quality and Innovation Collective (QuIC) Health Equity



He shared research on how race and other factors play a role in PAD outcomes—for example, after controlling for factors like comorbidities and medication use, Black patients had a higher risk of amputation than White patients.

Even in larger organizations, primary care teams may have difficulty finding suitable specialty clinics, Cuddeback explained, citing how one primary care physician “hand picked cardiologists” because people of color and low-resourced patients don’t want to visit a healthcare facility where they don’t feel heard.

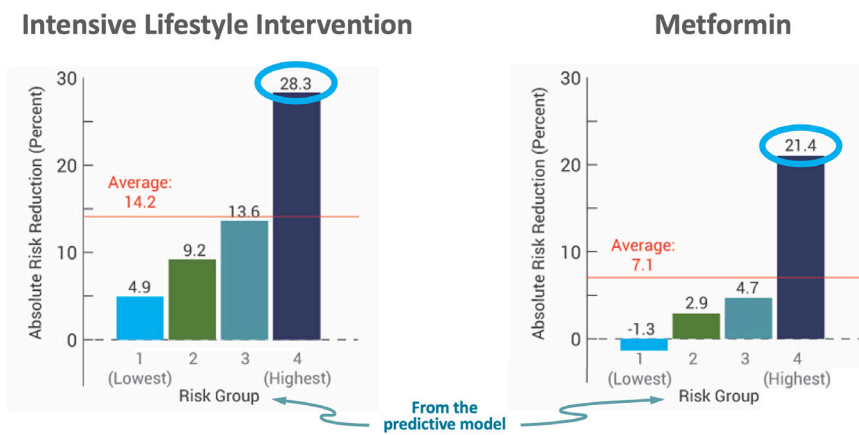
Colorectal cancer screening: After a positive reading on a stool test, time is of the essence for getting a patient in for a colonoscopy, and timely follow-up with patients is key to making this happen. Cuddeback shared an 18-month study across 41,000 patients in which such follow-ups differed by both race and payer type. “These are important disparities in a very important screening process,” he said.

New medications for type 2 diabetes: With SGLP2 inhibitors and GLP-1 agonists, diabetes patients and providers have powerful new tools in their treatment arsenals. With the American Diabetes Association and European Association for the Study of Diabetes issuing a consensus statement, “It’s a pretty big change,” Cuddeback noted.

How quickly have providers been adopting this approach, and has adoption varied?

Cuddeback shared AMGA’s own research into this question. Asian patients were 84% as likely as Whites to be offered SGLT-2 prescriptions, and Black patients 72% as likely. A “significant difference” was also found in prescriptions for GLP-1. Additionally, patients were up to three times more likely to get a GLP-1 prescription if they have a specialist visit—another area of potential inequity.

Absolute Risk Reduction Seen in DPP Study



<http://www.pcori.org/research-in-action/moving-beyond-averages>



AMGA Quality and Innovation Collective (QuIC) Health Equity

“If referrals are harder to get or less effective for minorities,” Cuddeback said, “the ultimate result is that people of color are less likely to get new drugs—drugs that are very valuable for dealing with major comorbidities and complications.”

Organ transplantation: One area in which the healthcare industry has both identified and addressed racial disparities is kidney transplants. Research revealed that creatinine tests had the potential to overestimate kidney function in Black patients by as much as 16%. In response, the Organ Procurement and Transplantation Network now requires that hospitals assess their transplant wait lists and backdate the waiting times for Black patients who were previously disadvantaged by this calculation.

Moving Forward

Cuddeback concluded the session with guidance on data use for health equity initiatives. How should organizations incorporate data on race into their efforts, given limitations and the ongoing process of standardization? Should they use these data with SDOH data, or use as a proxy if SDOH information is not available?

Cuddeback explained that all models use data from the past to predict future outcomes and that organizations should be aware that data collected in the past reflects systemic racism. But he cautioned against excluding race data from modeling entirely. “Leave race out and we risk leaving out at-risk groups, and this can perpetuate rather than solve barriers to access,” Cuddeback said.

The ideal scenario: Collect data on SDOH and incorporate the information directly into models. Cuddeback called this approach “more immediate and more directly useful than using the proxy of race data, which will only reflect incremental improvements in data standardization.”

Even in an imperfect state of standardization, data can be a powerful guide, with variations revealing opportunities for more informed resource allocation and more effective care.

“Analytics are key to identifying opportunities to target inequities and highlighting the areas of greatest opportunity,” he said, “And AMGA members are ideally positioned to use this approach.”

PANEL: Health Equity QuIC National Advisors

Panelists: *Alisahah Jackson, MD, President, Lloyd H. Dean Institute for Humankindness & Health Justice, CommonSpirit Health; Leon Jerrels, MHA, MBA, RN, CPHQ, Director, Quality Improvement, Kelsey-Seybold Clinic; Yeng Yang, MD, MBA, Regional Medical Director, Primary Care, Health Equity Medical Advisor, HealthPartners Care Group*

In this session connecting top motivating needs to work on the ground, panelists talked about their organizations’ approaches to health equity and their efforts.

“Health justice starts with human kindness,” Jackson declared before walking through a five-pillar blueprint for putting this philosophy into action. The first three pillars are tactical: transforming from within through staff and providers, using an analytics engine to turn data into actionable insight, and standardizing the delivery of equitable whole-person care.



AMGA Quality and Innovation Collective (QuIC) Health Equity

The final two pillars deal with advocating for meaningful change and partnering effectively for community impact. “We can’t do this alone,” Jackson said.

Jerrels highlighted Kelsey-Seybold’s efforts to increase pneumonia and flu vaccinations and colon cancer screening for African American and Hispanic patients through provider education, culturally specific recommendations, and focused, concentrated outreach. Partnerships with groups from the National Minority Quality Forum to local churches have been key. So has the organization’s needs assessment.

“We ask patients what services they need, and if we are fulfilling what they require,” Jerrels said. “This helps us gauge barriers like access to care or informational resources and bring an understanding of the community back to Kelsey-Seybold.”

From joining forces with community organizations to supporting Black and minority-owned businesses, partnerships have long been a priority at HealthPartners as well. Yang talked about the organization’s collaboration with the Institute for Health Improvement on a health equity lab and efforts with Minnesota’s Somali community to narrow gaps in chronic disease management and preventative care such as screening.

“We’re engaging members of the community to teach us what outreach and education and engagement looks like for their culture and community,” Yang said.

John W. Kennedy, MD, president, AMGA Foundation, and chief medical officer, AMGA, moderated the discussion.

How are you facilitating equitable access to care?

Kelsey-Seybold is addressing access for a growing patient population on two fronts: expanding physical facilities while concurrently promoting services like e-visits and video consultations. “If you can’t get into the office, virtual care can take care of a lot of things,” Jerrels explained. “Our Medicare Advantage and elder patients love virtual care.”

HealthPartners has augmented e-visits and e-consults with a virtualist program staffed by clinicians who only work remotely. Yang called it “a backbone” for Medicare and Medicaid patients. In fall 2024, a hybrid program will offer screenings, vaccinations, and other preventative care. “We’re really proud of our ability to reach specific populations with specific needs.”

Jackson noted that COVID and digital transformation in other industries, like banking, “are making us think about how and where care is delivered.” The organization has launched “national virtual command centers” for monitoring patients, with a focus on hypertensive pregnancies. “The U.S. is dead last in birth outcomes, and these discrepancies are even greater for Black and Brown patients.” In the Phoenix area, where the organization serves many undocumented patients, mobile vans provide prenatal and postnatal care.

Healthcare access also involves cultivating a next generation of providers “who look like the communities we serve,” Jackson said. Toward this end, the Institute is partnering with Morehouse School of Medicine to help the historically black college or university (HBCU) increase its class size and expanding its residency program to support these students in their professional development.

How are you developing an engaged population who trusts your care?

Yang calls trust “the quintessential ingredient for therapeutic relationships,” explaining that “we build that trust by showing up for patients every time.”



AMGA Quality and Innovation Collective (QuIC) Health Equity

This involves a partnership with Catholic Charities to connect patients to housing, which Yang calls a stepping-stone for job training and education, and HealthPartners' efforts to reach out to Hmong and Somali community centers and areas of worship "to help us define what health looks like for them."

Meanwhile, clinicians equipped with guidance and best practices from expert panels are engaging patients in areas like diabetes and hypertension management. "We can't just tell our patients what to do, because that doesn't work anymore," Yang said.

HealthPartners is also working on how it develops the workforce overall. "We want the people who serve our community to look like the community we serve, so there's that instant cultural connection," Yang said.

This means support at the educational level through scholarships, internship programs, and early-career opportunities for gaining work experience. "You can't expect traditional organizations to suddenly churn out more providers of color," Yang said. "We need to diversify everywhere in the organization, and developing the pipeline is where it's at."

Jackson elaborated how building trust comes down to actions—teaching care teams skills like eye contact and not interrupting a patient—and attitude. "Kindness has the power to heal, and there's decades and decades of science to back up that statement," she said.

"Accelerating the science" by providing caregivers with the infrastructure and environment to build a trusted relationship is the next step. Jackson talked about bringing a "human kindness curriculum" to training for the organization's patient experience team and carefully thinking through both the message to the community and who delivers it.

"It might not make sense for a CEO or CMO to go into a community that's been systematically excluded for generations," Jackson elaborated. "Maybe communications need to be from a community health worker from that community," adding that such an approach also gives staff with the opportunity to learn new skills and "be a force to carry out our message."

At Kelsey-Seybold, trust begins with a community needs assessment: looking at data, identifying trends, and asking patients about the services they need, Jerrels said. "Before you try to change a community you have to understand it and talk to it."

He detailed an example. Reaching out to African American and Hispanic patients about vaccinations—their fears, what they'd been hearing—led to Kelsey-Seybold's popular Mythbuster campaign. In a series of videos, African American and Hispanic providers related information that responded to patient input and feedback. Kelsey-Seybold used a similar approach for its pre-diabetes education workshops, "designing it based on what people knew and the questions they had."

Finally, having a care team that reflects the population it serves helps with trust and care delivery, Jerrels said. "Houston is one of most diverse cities in US, with a huge population of diverse providers. Having that good mix feeds into having information delivered in a way patients want."

How are you scaling your approach?

HealthPartners considers all projects, policies and workflows "within the lens of our equity framework," which is a formalized document, Yang said. Jerrels noted "little battles at a time," with a focus on getting new, high-risk patients into the Kelsey-Seybold system, and Jackson called sustainability "a four-legged stool" of strategy, operations, accountability, and outcomes, with a feedback loop for continuous improvement.



SPOTLIGHT: Sentara Community Care’s Partnership with the Union Mission Homeless Shelter

Michael G. Charles, MD, FAAFP, Executive Director Sentara Community Care Program, Sentara, and **William T. Crawley**, Director Program Development SCC/Health Equity (Former COO of Union Mission)


Treatment for chronic conditions like diabetes and heart disease is an important part of healthcare, but it’s just one part of many in the bigger picture, said Crawley. “Eighty percent involves social determinants, like financial factors and behaviors.”

Crawley previously served as COO of Norfolk’s Union Mission Ministries and now leads program development at Sentara Community Care—two organizations who are working together to address the many health care and life needs of individuals experiencing homelessness in Virginia.

“We’re looking at an individual’s total health and well-being,” he said and walked participants through the partnership’s multifaceted array of services.

“Traditional brick and mortar” offices cover areas with high emergency department usage and low numbers of patients with primary care providers. One clinic can be found on the ground floor of a Norfolk housing complex while another is embedded within the Union Mission shelter itself. Mobile care vans supplement these clinics by regularly traveling to high-need neighborhoods across the state. At both types of facilities, teams of primary care providers, nurse practitioners, and pediatricians provide traditional medical care while community health workers and medical assistants connect patients to a range of wraparound services, from counseling to programs for addiction.

A New Model
Uniquely Designed Services

 1. Primary Care & Behavioral Health Services	 2. Wraparound Services	 3. Community Partner Support
<ul style="list-style-type: none">➤ Comprehensive & preventative➤ Convenient times for those that work➤ Virtual options➤ Individualized care plans➤ Counseling & coaching➤ Frequent check-ins➤ Increased health education	<ul style="list-style-type: none">➤ SDOH support and connections➤ Insurance enrollment➤ Healthcare navigation➤ Transportation assistance➤ Food and nutrition assistance➤ And more...	<ul style="list-style-type: none">➤ Neighborhood community support system➤ Faith-based leaders➤ Food bank & food pantry organizations➤ Addiction medicine support➤ And more...



AMGA Quality and Innovation Collective (QuIC) Health Equity

“If you’re not looking at community health workers for your health equity initiatives, you should, and hire them from neighborhoods you’re serving,” Charles advised, calling these care team members “invaluable” for making contact with patients, following up on SDOH, and helping individuals who are struggling.

Throughout, Sentara and Union Mission prioritize patient trust. Crawley explained that people experiencing homelessness have often been dismissed by care providers in the past, so “it’s a natural inclination to be hesitant or apprehensive.”

Since the partnership has taken root, Sentara has seen an 80% decrease in emergency department referrals for patients experiencing homelessness and invaluable benefits for these individuals themselves. “The fabric of their lives has changed. They’ve come to the realization that their life matters—that a community sees their life of value,” Crawley said

Earlean Chambers moderated an audience Q&A.

Talk more about your approach.

Crawley called it human-centered co-design “based on people having regard for one another and being willing to help each other in time of need,” delivered through a medical home model. Union Mission delivered some services like acute care and vaccinations. Now through the partnership with Sentara, patients have access to a continuum of care on a regular basis. They also develop relationships with nurse practitioners and other members of the care team, which makes them more comfortable asking questions, Crawley noted.

How are you using data to track and improve the partnership’s effectiveness?

Charles talked about how the team uses a dashboard to track all patient encounters—with providers, community health workers, nurses, and beyond—and supplements these data with qualitative metrics such as vaccination and cancer screening rates and metrics for diabetes and hypertension control. Statewide “heat maps” provide insight into high emergency room utilization and mortality rates and areas with low resources and insurance coverage. “We can’t be everywhere, but we try to filter and go into the areas of greatest need,” he said.

What advice do you have for selecting community partners?

“Look at those who are really making a demonstrable difference in the life of the community and see how you can support them in their efforts,” Crawley said.

How do you work to build trust and help employees understand the Mission’s community and needs?

Staff receive specialized training in areas like confidentiality, trauma care, coping mechanisms, and implicit bias, but the underlying attitudes are most important. “People who are experiencing homelessness are the most vulnerable, so everyone should have a central focus on improving lives and affording our patients the dignity they deserve,” Crawley said. This includes cultural humility. “It’s more than just a phrase. It’s, ‘I am able to look outside of myself and my position and ask how I can best serve you.’”



AMGA Quality and Innovation Collective (QuIC) Health Equity



PANEL: Breaking Down Implicit Bias

Panelists: **Jennifer Hines, MD**, *Clinic Medical Director, HealthPartners*; **Panagis Galiatsatos, MD, MHS**, *Health Equity Faculty Lead, Office of Diversity, Inclusion, and Health Equity, Johns Hopkins University*; **Verlon E. Salley**, *Vice President of Community Health Equity, UAB Health System*

Panelists started the session by talking about their organizations' efforts to tackle implicit bias.

HealthPartners has been teaching physician leaders and “cascading that down” through e-learning—30-minute, off-the-shelf modules with facilitation guides the organization developed itself. Small group discussions are a critical element, Hines said. “It’s easier for people to be open and honest.”

Galiatsatos talked about the efforts he oversees at Johns Hopkins related to community health workers, who have become part of the organization’s workforce to meet Centers for Medicare & Medicaid Services (CMS) requirements. He deemed these professionals “destined to revolutionize healthcare” through their work on SDOH. As community health workers talk to patients from diverse communities and cultures about sensitive topics like domestic violence and food and home insecurity, finding ways to identify and mitigate implicit bias is vital to this work.

Salley said he sees orientation and onboarding as UAB’s biggest area of opportunity regarding implicit bias. “It’s the perfect time to outline the expectations of this health system.” Members of the medical school’s search committee are required to undertake implicit bias training, and UAB is looking at how data are entered into patient medical records. “Are we being objective or biased in the language we use? Different interpretations of the notes can cause differences in treatment.”

Jerrels began the moderated Q&A part of the session by asking about Project Implicit, a tool AMGA has shared with QuIC participants. What reactions and responses have panelists seen so far?

All noted experience with the tool, citing it as useful for gauging individual awareness of bias but merely a first step toward a larger overall effort. At Johns Hopkins, tools like Project Implicit evaluations are conversation-starters and an entry point into further education. “If people are interested, they can come in for more,” Galiatsatos said.

“We’re trying to develop curricula that we can use every day and find ways to talk about implicit bias as part of our workflow, making those conversations more organic and acceptable,” Hines said about HealthPartners’ efforts. Through daily interactions on multiple levels around areas like patient complaints, “we’ve been able to learn and do better,” she said.

Jerrels cited research that once a year is not enough for implicit bias training: “It needs to be ongoing.” And Salley commented that training itself may not be enough, saying, “I hear at conventions and conferences that implicit bias training doesn’t work, and I believe it’s because it doesn’t deal with the systemic issues.”

Organizations are tracking progress through patient comments, complaints, and patient satisfaction surveys—all measures that are vulnerable to bias themselves. “Even patient scores have their own bias in terms of who comments,” Galiatsatos pointed out. He suggested that insights from community health workers, who frequently have in-depth conversations with patients on sensitive topics, could serve as a proxy.



AMGA Quality and Innovation Collective (QuIC) Health Equity

Hines emphasized the need for patient education and trust in efforts to strengthen data collection. “We don’t get a lot of evaluations back if patients feel threatened, stressed, or don’t understand that their comments could change the system,” she said. “There’s a fear that if you speak up your care will change.”

Sharing data on implicit bias “hasn’t led to dramatic changes” at UAB, Salley said. “But when the conversation turns to health equity, there aren’t as many barriers as in the past,” he said. Galiatsatos noted short-term reactions at Johns Hopkins, especially when the subject intersected with economics. “We made a case for CMS compliance.”

As the session concluded with an audience Q&A, Hines talked about how HealthPartners is exploring the role of implicit bias in patient readmissions, and Galiatsatos talked about Johns Hopkins’ work with Baltimore churches and community partners to bring in Hispanic community health workers. All panelists shared initiatives to help LGBTQIA+ patients share information about themselves and access resources.

Have organizations experienced any staff hesitation or pushback on implicit bias efforts? All three panelists responded with a resounding “no,” with Galiatsatos commenting that “people realize the morality and ethics, and that it’s the right thing to do.”

BREAKOUT SESSION: Organizations selected their patient population for intervention implementation based on SDOH

Participants: Concord Hospital, Johns Hopkins, Sanford Health, UAB Health Services Foundation

As moderator, Yang began the session by asking about participants’ current activities related to SDOH.

One organization has been focusing on cancer screening, specifically for colorectal cancer. Right now, screening is “largely opportunistic,” and the organization hopes to reduce disparities by approaching it in a more programmatic way. Payer status is one of the main barriers, along with access, long wait times, and frontline teams who aren’t equipped to send patients to the right resources. Participants talked about these challenges through care navigation, from offering average-risk patients colonoscopy alternatives so higher-risk patients can get a slot to automating patient navigation through payment resources and processes.

Another organization, which is also a participant in AMGA’s Rise to Immunize® collaborative, is aiming to improve vaccination rates among refugees and other new Americans, building upon success with the Nepalese community and expanding this success with patients from Africa. Community partnerships and a human-centered co-design model have been central to this mission. How can the organization better understand barriers to care? How can they improve trust with community leaders?

Another participant in the breakout session talked about working across patient groups to prioritize screening for the five SDOH areas in the new CMS requirements: housing, safety, economic security, food security, and transportation. The organization is training patients to provide information themselves via digital means such as iPads and QR codes and community health workers on how to assist and ask questions in culturally sensitive ways.



AMGA Quality and Innovation Collective (QuIC) Health Equity



Participants noted that community health workers have been a valuable tool in learning to understand various patient neighborhoods and that community partnerships are vital in addressing patient needs that fall beyond the organization's purview as a healthcare provider.

In terms of best practices, participants noted the importance of "building trust in the background." One way is by educating providers about cultural differences and how past traumas can impact receptiveness to communications, treatment plans, and attitudes toward their organization and care overall.

One participant shared an anecdote about the importance of not making cultural assumptions. One outreach program for cancer screening encouraged patients to hassle their friends to get checked. This messaging didn't resonate with the Nepalese community, which is typically more private regarding health concerns. "I think we make a lot of assumptions about what we think is going on instead of having the humility to ask and listen and take the time to learn."

Another best practice is targeted communications. Yang shared an example from HealthPartners. The organization communicates with patients through a variety of channels, from its MyChart portal to text messages to letters. "But it's hard to receive a letter in the mail when you don't have a personal connection to anyone at the clinic."

Community health workers are one way to build trust. Tailored communications are another. Yang talked about HealthPartners' efforts to create videos of patients from different communities sharing their experiences and advice, then included links to the videos in text messages and emails. "That has been more powerful than anything the system has been able to do to make that connection," she said.

Creating such bridges and partnerships is critical to patient support. Participants talked about hiring community health workers from a specific patient community, like a local tribe, then training them on the specifics of the medical system. Federal health centers can also be valuable conduits, provide vital knowledge and connections for connecting patients to available resources.

Finally, it's important for health care organizations themselves to be engaged in discussions about SDOH concerns like food and housing security, transportation access, and domestic violence. When patients know their care providers are working on their behalf, they're more likely to be receptive to that text message, email, or letter in the mail. "A lot of advocacy takes place in the background," one participant noted.

Yang wrapped up the session with key takeaways related to SDOH. Meet patients where they are. Tailor outreach to different populations. And partner with organizations in the community. "We're not equipped to do it all."

BREAKOUT SESSION: Organizations selected their patient population for intervention implementation based on Chronic Disease

Participants: Guthrie Medical Group, HealthPartners, Henry Ford, Scripps Health, UC San Diego Health

Jackson launched the session by asking participants to talk more about specific chronic conditions they're focusing on.

For two organizations, the priority has been hypertension.

One participant talked about launching a home blood pressure monitoring program for African American patients after data revealed this group to be more at risk. After a referral to the digital health team, patients receive a blood pressure



AMGA Quality and Innovation Collective (QuIC) Health Equity

cuff that transmits data directly to their electronic health record. High readings trigger an alert and referral to their primary care physician. The program employs multiple challenges of outreach throughout to address SDOH and barriers to care. The challenge: sustain the program with current workflows and staffing.

Another organization has also been using home blood pressure monitoring as a hypertension management tactic, along with virtual visits and efforts related to care transitions and multiple chronic conditions. The current focus is to work through its four clinic locations to examine hypertension management overall, with a focus on race and payer disparities. One participant shared, “We’re looking at the barriers we know and identifying additional barriers related to access, education, language barriers, and building trust.” These efforts are expected to dovetail with targeted outreach and community-building efforts and forays into automation.

As discussed in previous sessions, PAD is a condition for which African Americans experience significant disparities in diagnoses, leading to more complications such as amputations. One participant talked about partnerships with churches, temples, synagogues, and other faith-based organizations to connect community members to healthcare resources and services. (“When they’re coming in for Bible study and prayer, they’re able to go to a private room and get screened.”) For PAD, these partnerships are expanding to educational toolkits and activities like healthy cooking demonstrations.

Pediatric obesity is another rising priority. One organization, which has an accredited bariatric surgery center and freestanding obesity medicine clinics, recently launched a weight loss center. Participants recalled children as young as 11 with multiple comorbidities, from sleep apnea to fatty liver disease, but only a third were being diagnosed with obesity. The participant shared, “Is it that our providers are uncomfortable speaking to parents about their children’s weight? Is it that parents themselves are resistant?”

The organization is addressing this challenge on multiple fronts, from programming that engages patients at multiple touch points to working with community partners like school districts for initiatives such as community gardens and other learning opportunities.

Another participant detailed efforts to “apply a health equity lens to the work that we’re already doing.” As one example, the organization noticed that its Hispanic population and Spanish-speaking patients had lower rates of breast cancer screening than other groups. The response: Use the Epic Campaigns tool to conduct automated, targeted outreach—and be sure to reach out in a patient’s primary language. “You’d think that would be a no-brainer that folks just do, but it wasn’t.” Participants from another group noted a similar experience. “We weren’t getting feedback to a campaign because it was sent in the wrong language—so they couldn’t respond.”

Jackson concluded the session with a discussion of the many challenges related to chronic disease management and health equity. How do you standardize workflows to accomplish more with the workers you already have? How do you educate providers about new developments and practices in areas like pediatric obesity?

Participants cited patient access as a common obstacle for monitoring and management programs. Online connectivity, and therefore digital monitoring and telehealth, might not be reliable in rural or mountainous regions. And this was just one of many obstacles, especially with Medicaid patients. “We had a lot of patients who would go on and off insurance. They didn’t have computers. They didn’t have smartphones, so they couldn’t download readings.”



AMGA Quality and Innovation Collective (QuIC) Health Equity

Patient education is another gap reflecting an urgent need. One participant offered the example of setting up and getting started with a glucose-monitoring device. “If you didn’t have a human intervening and really helping at that initial part, it was not going to be successful.” Home blood pressure monitoring was another example. Patients not only need to know how to get a good reading—keeping their feet on the ground while taking the measurement, for example—they also need to understand why such data are valuable in the first place.

Next Steps

Casanova concluded Phase 2 of the Health Equity QuIC with next steps: Take lessons learned back home and put them into action.

Before Phase 3, participants were charged to develop an intervention addressing a chronic condition or SDOH for a patient population with disparities. These activities will work toward a measurable, clearly stated goal over a specific length of time, with plans on how to accomplish the intervention and explanation of its relevance—the why now?—which was due January 26.

An implementation update is due April 5, and a full write-up June 3, recapping highlights, challenges, and lessons learned, as well as whether the organization plans to sustain the intervention over time—and how. Insights will be shared at the QuIC’s third and final meeting in August 2024, in person in Alexandria, VA.

AMGA Health Equity QulC Team

John W. Kennedy, MD, President, AMGA Foundation and Chief Medical Officer, AMGA

Danielle Casanova, MBA, Vice President, Population Health Initiatives & Health Equity, AMGA

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

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

AnnaMaria Sebastino, BS, Program Manager, Health Equity, AMGA



Advancing High Performance Health

One Prince Street
Alexandria, VA 22314-3318

amga.org/foundation