Data Informed Strategies to Advance Health Equity in Minnesota

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MN Community MEASUREMENT

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Utilizing a Community Co-Design Approach to Address Health Care Inequities

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ESSENTIA HEALTH

MN Community MEASUREMENT 2

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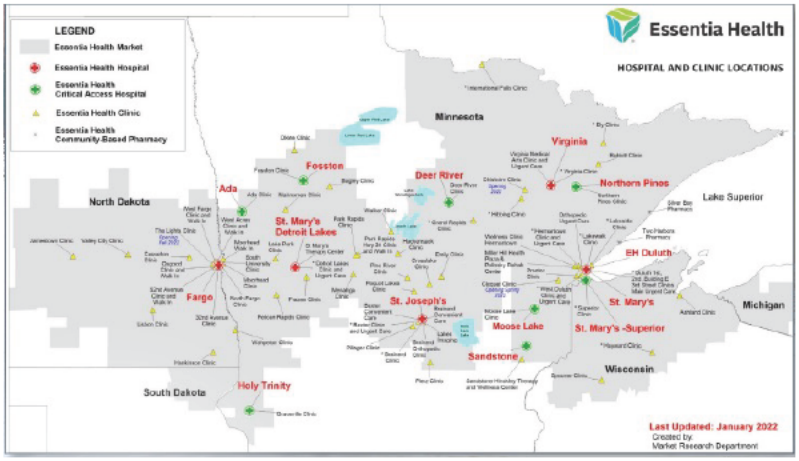
Essentia Health: At a Glance

- Nonprofit, integrated health care system headquartered in Duluth
- 15,000 employees
- 14 hospitals, 78 clinics
- Serving 560,000+ unique patients in Minnesota, Wisconsin, North Dakota



Health Equity Joint Commission Requirements

- The hospital designates an individual(s) to lead activities to reduce health care disparities for the organization's patients.
- The hospital assesses the patient's health-related social need and provides information about community resources and support services.
- The hospital identifies healthcare disparities in its patient population by stratifying quality and safety data using the sociodemographic characteristics of the hospital's patients.
- The hospital develops a written action plan that describes how it will address at least one of the health care disparities identified in its patient population.
- The hospital acts when it does not achieve or sustain the goal(s) in its action plan to reduce health care disparities.

Identifying Health Care Disparities

- Organizations choose which measures to stratify and which sociodemographic characteristics to use
  - Examples of sociodemographic characteristics include **age, gender, preferred language, race, and ethnicity**

Specific population(s) of focus

Organization's improvement goal

Strategies and resources to achieve the goal

Process to monitor and report progress

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Minnesota Community Measurement Data

COLORECTAL CANCER SCREENING

2022 measurement year

Data provided if medical group has at least 30 patients within the race group

	MEDICAL GROUP NAME		MEDICAL GROUP RATE	STATEWIDE AVERAGE	RATING (Comparison to Statewide Average)	RELC AVERAGE	RATING (Comparison to RELC Average)
Race	Essentia Health	Asian	60.8%	67.8%	Below	58.4%	Average
	Essentia Health	Black	47.7%	67.8%	Below	51.7%	Below
	Essentia Health	Indigenous/Native	52.8%	67.8%	Below	48.3%	Above
	Essentia Health	Multi Racial	53.4%	67.8%	Below	61.5%	Average
	Essentia Health	Native Hawaiian/Pacific Islander	51.9%	67.8%	Below	53.3%	Average
	Essentia Health	White	72.3%	67.8%	Above	70.0%	Above
	Essentia Health	Hispanic/Latinx	53.1%	67.8%	Below	50.5%	Average
Language	Essentia Health	English	71.6%	67.8%	Above	68.7%	Above
	Essentia Health	Somali	27.7%	67.8%	Below	30.1%	Average
	Essentia Health	Spanish	46.2%	67.8%	Below	45.4%	Average
	Essentia Health	Vietnamese	61.4%	67.8%	Average	67.2%	Average
Country	Essentia Health	Mexico	45.5%	67.8%	Below	47.5%	Average
	Essentia Health	Somalia	27.8%	67.8%	Below	31.3%	Average
	Essentia Health	United States	72.0%	67.8%	Above	69.5%	Above
	Essentia Health	Vietnam	64.4%	67.8%	Average	67.3%	Average

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Essentia Patient Data by Race

- *Equitable Care - Breast cancer screening*

Essentia Health	Total Patients (Overall)	Total Patients (w/o Exc)	Total Compliant Patients	Mammography Screening Compliance % (Overall)	Total Minority Patients (w/o Exc)	Total Compliant Minority Patients	% Compliant Minority Patients
CENTRAL REGION	8,952	8,799	7,432	84.46%	153	115	75.16%
EAST REGION	27,016	26,451	21,656	81.87%	777	525	67.57%
WEST REGION	16,464	16,254	13,754	84.62%	703	466	66.29%
Essentia Health Overall	52,432	51,504	42,842	83.18%	1,633	1,106	67.73%

- *Equitable Care - Colorectal cancer screening*

Essentia Health	Total Patients	Total Compliant Patients	% Compliant Patients	Total Minority Patients	Total Compliant Minority Patients	% Compliant Minority Patients
Central Region	20,274	14,803	73.01%	376	213	56.65%
East Region	63,164	46,295	73.29%	1,949	1,108	56.85%
West Region	39,526	29,127	73.69%	1,956	1,033	52.81%
Essentia Health Overall	122,964	90,225	73.38%	4,281	2,354	54.99%

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Colorectal Cancer Screening Compliance by Race

Population	% Compliant	Total Patients	Total Compliant Patients
Essentia Overall	73.27%	122,891	90,048
White, non-Hispanic	73.94%	118,603	87,698
Minority Overall	54.80%	4,288	2,350
Black, African American + Black, African Heritage or Carribean	47.01%	1,106	542
American Indian + American Indian/Alaskan Native	53.19%	1,675	891
Asian	65.27%	690	450
Hispanic	56.41%	523	295
Native Hawaiian/Pacific Islander	50.32%	157	79

This table does not include all race data

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Breast Cancer Screening Compliance by Race

Population	% Compliant	Total Patients	Total Compliant Patients
Essentia Overall	83.15%	51,459	42,787
White, non-Hispanic	83.65%	49,825	41,678
Minority Overall	67.87%	1,634	1,109
Black, African American + Black, African Heritage or Carribean	65.56%	299	199
American Indian + American Indian/Alaskan Native	60.68%	702	426
Asian	77.99%	317	247
Hispanic	77.32%	193	150
Native Hawaiian/Pacific Islander	67.11%	74	50

This table does not include all race data

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[redacted]

Dashboard Link: https://tabprd.essentiahealth.org/#/site/essentia/views/QualityDashboards/ClinicalQuality[illegible]id=1

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DEIB STRUCTURE & GOVERNANCE

Essentia Health Leadership Team

DEIB Executive Steering Committee

DEIB Resource Committee

10 DEIB Resource Committee Work Streams

- Health Equity
- Equitable Care
- Talent Management/ WFD
- Systems and Technology
- Learning and Engagement
- Employee and Labor Relations (policies)
- Community Health Partnerships
- Colleague Resource Groups
- Communications and Change Management
- Patient Experience & Spiritual Care

Diversity | Equity | Inclusion | Belonging (DEIB)

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co-design

Wicked and complex problems persist today because of a power imbalance in how solutions (policies, programs, and resources) are defined, developed, and implemented. **Co-design is a rigorous and meaningful opportunity for those disproportionately impacted by a problem to leverage their shared lived experiences and participate in more equitable decision-making structures.**

bydesign

Jess Roberts (He/Him) · 2nd
Co-Design Facilitator and Educator | Professional Un-expert & Founder | ByDesign LLC | by-design.org

University of Minnesota College of Design
University of Minnesota

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Proposed: Redesign Community Engagement

- **Directly invest and engage with the same communities experiencing these disparities most acutely.**
- **Community Co-Design approach:**
  - Avoids over-investing in assumptions
  - Reflects the realities of impacted communities
  - Complex issues – opportunity for fresh thinking and innovation
  - Community members integral to the process
  - Builds long-term relationship and community capacity

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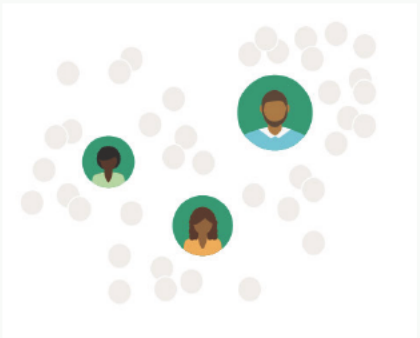
Traditional Community Engagement



Community Co-Design

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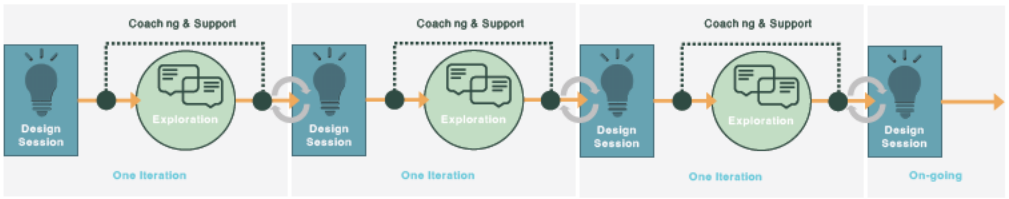
Community Co-Design: How it Works



- Best practice approach to equitable community engagement and action created by Culture of Health by Design LLC & University of MN.
- Involves an iterative sequence of 4 design sessions over roughly 3 months
- Community-co designers test concepts within the community between sessions
- Up to 8 compensated community co-designers
- Ensures diverse perspectives and active involvement in the initiative

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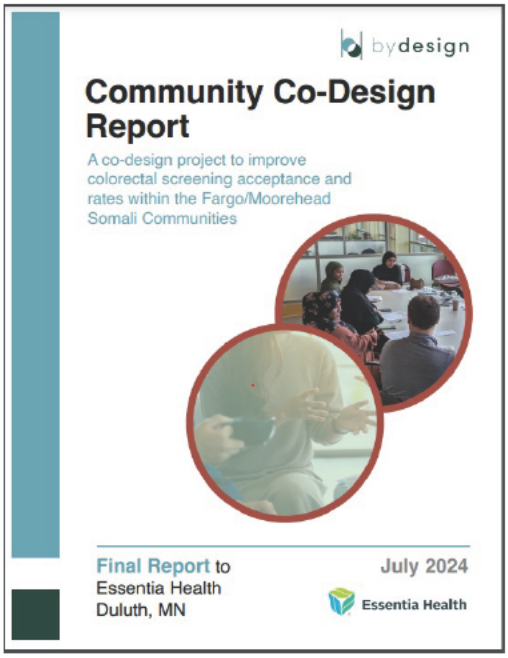
What we learned



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Theme #1

Community Navigator

Develop a care navigator role and structure to address difficulties like understanding preventive care, identifying available resources, and understanding complex insurance or referral requirements as well as increase comfort and advocate for Somali individuals and families in a clinical setting.

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Theme #2

Cultural Training Experiences for Providers & Leadership

Develop a narrative-based training for healthcare providers (who regularly see patients from the Somali community) and clinical leadership to better understand the complex lived experiences and cultural and/or faith traditions of their patients who are part of the Somali community.

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Theme #3

Prioritized Health Screening Guide and/or Discussion

Develop an approach and tool that helps individuals better understand and prioritize the health (and preventive health) issues that matter most (and are most practical to address) to an individual and/or their family.

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Next Steps: Initiative Ranking with Equitable Care Workstream Committee (10/24)

Goal: To reduce inequities in Colorectal and Breast Cancer screening rates among our BIPOC and Caucasian patients.

- Identify and develop RACI Model for 3 initiatives to try to move the needle on equitable care measures
- Set Targets/Improvement Goal for 2 equitable care measures on Primary Care Watchlist – CQD Dashboard (CY2025)

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	Difficulty to implement Easy (1) to Hard (5)	Payoff Low (1) to High (5)
System Initiatives		
Longer clinic visits for pts that require translation services *(mindful of impact on physician RVU's)*		
Develop an insurance navigation partnership through expansion of Resourceful incentivized network *(financial incentives to close the loop on referrals and increase pt outcomes)*		
Somali/Muslim specific cultural awareness training – Saba *(on demand)*		
Somali/Muslim specific cultural awareness training – Grand Rounds *(CME credit)*		
Design + Disseminate culturally tailored health education materials related to cancer prevention & screenings in multiple languages		
Replicate Community Co-Design process with Indigenous community		

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	Difficulty to implement Easy (1) to Hard (5)	Payoff Low (1) to High (5)
West Market Initiatives		
Expand Mobile Mammography to Tribal Clinics/Cultural Centers in West Market *(second unit, multiple hookups and technician required)* ***EXISTING INITIATIVE IN EAST***		
Targeted FitTest mailings to BIPOC pts with CRC or BC care gap in 8 F/M area clinics *(504 CRC BIPOC pt gap; 240 BC BIPOC pt gap)*		
FTE to support Cultural Navigation in the F/M area *(including CHW model in Moorhead Clinic)*		
Health Fair in partnership with community-based organizations tailored to New American community in F/M area		

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> "be persuaded, not persuasive"
>
> - Co-Designer

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Thank you!

?

QUESTIONS: Jill.Doberstein@EssentiaHealth.org

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Culturally Responsive Model of Psychiatric Care for Muslim Patients at Hennepin Healthcare

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Hennepin/Regions Psychiatry Residency Program Director
Assistant Professor of Psychiatry UMN Medical School

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Objectives

- Review the components of the Culturally Responsive Psychiatric Care Model for Muslim Patients at HHS
- Review quantitative baseline disparities and community relationship building that centered our care model
- Review quantitative and qualitative results of this intervention

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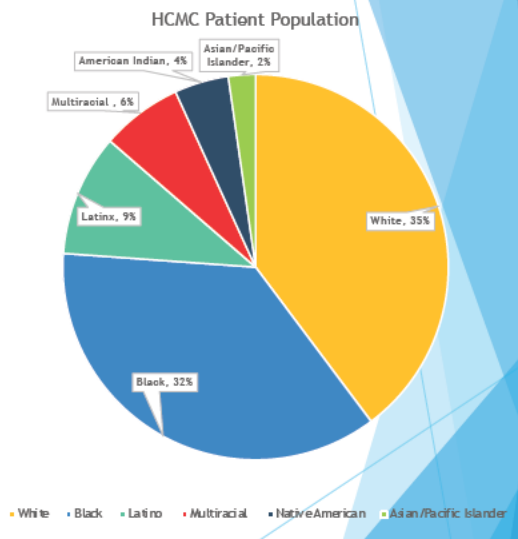
Who do we serve?

- Urban patient population at HCMC experience many social determinants
- Interpreter services uses 78 languages and is deployed 12,000 times per month.
  - Spanish, Somali, and Russian are the top three non-English spoken languages
- Poverty
  - 45.5 percent are 200 percent of FPL or below.



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Community Needs Assessment 2019

- The Somali community emphasized the importance of
  - integrating Muslim spirituality into health care delivery
  - inclusion of family centered care principles
  - barriers to accessing outpatient mental health care
  - role that mental illness stigma plays

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Culturally Responsive Model of Psychiatric Care for Muslim Patients

- Implemented in 2022
- Partnered with community (Open Path Resources) to integrate religious and cultural beliefs with medical understandings of mental illness in the treatment approach.
- **OPR leads climate creation among community-based systems to gain better support of patients and families dealing with mental illness and their treatments.**
- An essential component of the patient care model is the integration of three Muslim spiritual care providers (men and women) into the patients' care teams in the psychiatry units
- Followed-up by three to six months of sustained support once patients have been discharged.
- The spiritual care providers sustain the care plan and serve as a bridge for patient and family to a supportive community.
- 2024 MHA award for Innovation in Patient Care for **Culturally Responsive Model of Psychiatric Care**

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Model of Care

Inpatient support	Support after discharge	Community education & Capacity Building
Muslim spiritual care providers visit with/support patients throughout inpatient stay	Muslim spiritual care providers make outreach calls/visits to support patients after discharges	Community Advisory Team (CAT) and OPR meetsregularly for ongoing learning/training
Muslim spiritual care providers attend care conferences as a support and bridge	Outreach continues during first three months after discharge and is availabl to patients and familes	OPR, CAT, and HHS providers hold community forums and online & inperson programs on mental health

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Looking at the Data: Baseline Disparities

- Unique individuals with at least one psychiatric admission (n=6,324) over a 4-year period (2018-2021) at Hennepin County Medical Center.
- We found an association between Muslim self-identification and clinical outcomes, the majority of whom were Somali American (73.6%).
- Muslim patients had higher readmission rates to psychiatric units within 30 days after discharge.
- Muslim patients had higher rate of utilization of Acute Psychiatric Services (APS) within 30 days after discharges.
- Muslim patients admitted to inpatient psychiatry were less likely to be voluntary, and more likely to be on commitment.
- Muslim patients were more likely to have seclusion, restraint, and both seclusion and restraint.
- Muslim patients with a single psychiatric hospitalization were more likely to have a longer length of stay.

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	Muslim		Non-Muslim	
Race	N	%	N	%
American Indian	2	0.5	327	5.6
Asian	12	2.7	200	3.4
Native Hawaiian or Pacific Islander	0	0.0	17	0.3
Non-US born Black	356	81.1	240	4.1
Non-US born Hispanic	1	0.2	289	4.9
Other	10	2.3	12	0.2
Unknown	1	0.2	91	1.6
Blank	0	0.0	12	0.2
Us born Black	45	10.3	1482	25.2
US born Hispanic	0	0.0	51	0.9
White	12	2.7	3164	53.8
Total	439	100.0	5885	100.0
Gender				
Male	281	64.0	3347	56.9
Female	158	36.0	2538	43.1
	Median	IQR	Median	IQR
Age	32	13	36	23

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	Muslim		Non-Muslim		
	N	%	N	%	p-value
Medical readmission after index psychiatric discharge					
within 30 days	48	5.5	493	5.5	0.964
post 30 days until end of study time frame	193	22.3	1945	21.7	0.700
Psychiatric readmission after index psychiatric discharge					
within 30 days	138	16.0	928	10.4	<0.001
post 30 days until end of study time frame	429	49.6	3178	35.5	<0.001
Psychiatric Inpatient Legal Status during psychiatric hospitalization(s) at admission					
Voluntary	246	28.4	3973	44.4	<0.001
Non voluntary: includes 72 hour hold, Transport hold, commitment, admission by guardian	619	71.6	4971	55.6	

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Psychiatric Inpatient Legal Status during psychiatric hospitalization(s) at discharge					
Voluntary	324	37.5	4624	51.7	<0.001
Non voluntary: includes 72 hour hold, Transport hold, commitment, admission by guardian	541	62.5	4320	48.3	
Orders for restraint/seclusion during psychiatric inpatient stay (s)					
restraints	108	12.5	769	8.6	<0.001
seclusion	52	6.0	296	3.3	
both	119	13.8	588	6.6	
neither	586	67.7	7291	81.5	
Completed at least 1 outpatient visit after index psychiatric hospitalization	230	25.9	2313	25.9	0.641
	mean	SD	mean	SD	p-value
Length of stay for patients with one psychiatric hospitalization	12.6	17.1	10.2	13.0	0.036
Length of stay for psychiatric hospitalizations for patients with multiple admissions during study period	14.7	14.8	15.1	16.7	0.603

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Results from Intervention

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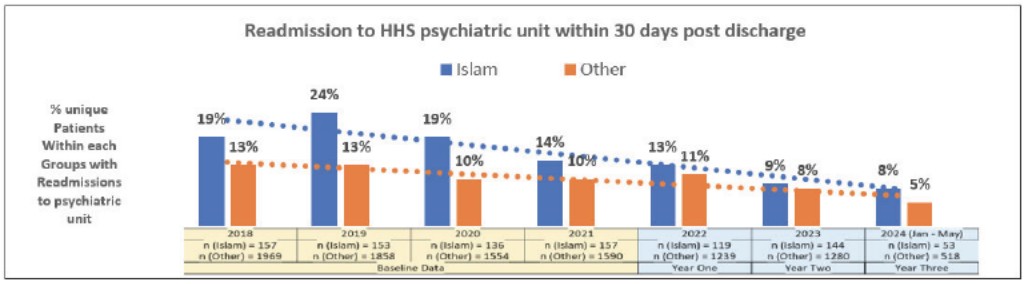

Comparing average rates of readmissions in baseline years with rates in years after program implementation, we found:

- 47% decrease in percent of Muslim patients with readmissions to psychiatric unit within 30 days post discharge.
- 75% reduction in gap between values for Muslim and non-Muslim patients.

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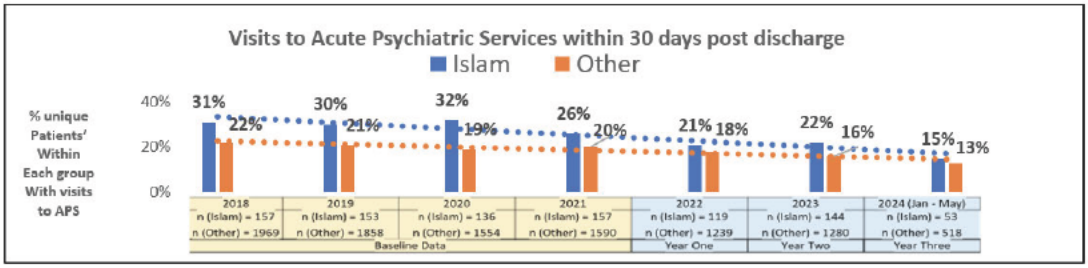

Comparing average rates of visits to APS in baseline years with rates in years after program was implemented, we found:

- 37% decrease in the percent of Muslim patients with visits to APS within 30 days post discharge.
- 56% reduction in gap between the values for Muslim and non-Muslim patients.

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Qualitative Results

"I no longer feel this illness is a punishment from God. It is like any other illness, and I have more understanding and ability to manage my situation. They make me feel more trust for my doctors. "

- ***Patient***

Families are dealing with stigma and may fear the psychiatric unit. They may not trust the providers and staff and work against them. When they meet with the Muslim spiritual care providers, we see their trust grow. I have witnessed families becoming more open to the diagnosis. It really changes how families respond to the staff. "
-- HHS Psych Social worker

"This model creates a climate where stigma is being reduced – education and awareness is good. This is how our community is going to find its way to meeting the needs of these individuals and families."
--Community Advisory Member

"When the Muslim spiritual care providers show up to talk with patients the patients are different. They show that they are feeling respected, not judged. They have so much more comfort."

-HHS psych provider

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Acknowledgments

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- Shukri Salah, Muslim Spiritual Care Provider
- Siham Gesey, Muslim Spiritual Care Provider
- Imam Abuturab, Muslim Spiritual Care Provider

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Assessing a Surge in Hmong Gestational Diabetes

ROBIN COUNCILMAN M.D. (SHE/HER/HERS)
FAMILY PHYSICIAN
NORTHPOINT HEALTH AND WELLNESS CENTER

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Introduction

- NorthPoint is an FQHC in North Minneapolis that serves approximately 12% Hmong patients.
- Hmong people are originally from the Yellow River region of China then living in the mountains of Vietnam, Laos, and Thailand and settled in the US after the Vietnam War.
- Resettlement primarily 1975-1996 with subsequent group 2004-2005
- 95,000 Hmong are living in the Minnesota based on 2020 census, making them the largest Asian group in MN
- Over the past 20 years, a marked increase in abnormal Glucose Challenge Tests (GCTs) during pregnancy has been noted in Hmong patients.

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Review of Literature

- Women from Asia are at very high risk of developing GDM and the increased insulin resistance is observed at much lower BMI (Li et al, 2022)
- On average, the risk of developing type 2 diabetes is 7.4 times greater for women with h/o GDM than for women without GDM (Bellamy et al, 2009)
- One study conducted in Wisconsin found that Hmong-Americans are three times more likely to have type II diabetes than non-Hispanic whites, 19.1% v.s. 7.78% (Thao 2015).
- Earlier literature indicates that in the 1980s Hmong women in the US had low rates of gestational diabetes.
- **Deaths due to diabetes represented the largest disparity in causes of death between SE Asian and non-SE Asian populations in Hennepin County, accounting for 7.1% of the deaths in the SE Asian population, which includes the Hmong community. By comparison, to just 2.6% of the non-SE Asian population.**

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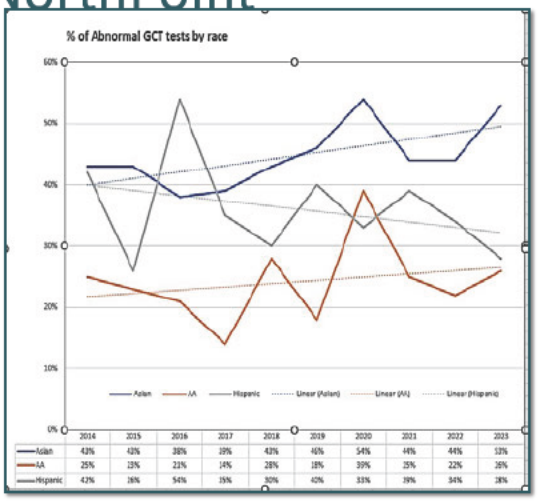
Gestational Diabetes Disparities at NorthPoint



	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Asian	43%	43%	38%	39%	43%	46%	54%	44%	44%	53%
AA	25%	19%	21%	14%	28%	18%	39%	25%	22%	35%
Hispanic	42%	36%	54%	35%	30%	40%	33%	39%	34%	38%

- In 2020 52.8% of our Hmong pregnant patients had a + GCT (≥135) compared to 38% of our pregnant patients as a whole
- In 2023 Hmong accounted for 17% of our pregnant patients and 72% of our GDM patients
- Review of Hmong pt with positive GCTs 2020
  - ❖25% of the Hmong patients have 2 or more of the results higher than normal on GTT (meeting dx of GDM)
  - ❖50% have one of the results higher than normal.

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"Deep Dive" into 2023 Data

- A group of healthcare providers and researchers, majority Hmong, brainstormed potential contributing factors other than diet that could be related to the surge in Hmong GDM
- Traditional risk factors: BMI, Age, Parity, FHx DM, previous GDM, weight gain in pregnancy, late presentation to care
- Measures of acculturation: Location of birth, requiring an interpreter, education
- Socioeconomic Factors: Employment, Multigenerational Households
- 44 charts reviewed for these factors

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Results

Characteristic	Abnl GCT	Normal GCT
Age years	30.4	28.6
English speaking	40	50
EGA intake wee	14.2	12
H/o GDM %	16.7	12.5
H/o LGA %	7	11
Parity	3.8	3.5
Multigene hous	48	55
Weight gain #	15.2	17.6
Foreign born %	71	67
BMI	24.4	25.7
Fhx GDM %	14.2	22
Employed %	64	44
Education %		
< 6	28	11
7-12	44	39
>12	29	44

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Traditional GDM Risk Factors

- No affect of BMI
- Increased abnormal GCT with prior GDM, increasing age, increasing parity, later presentation to care
- Decreased abnormal GCT with increased weight gain in pregnancy, Fam HxDM (clearly inaccurate)

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Measures of Acculturation

- Clear association with education: less education, more abnl GCT
- More abnormal GCT with requiring interpreter
- Very slight increase with being foreign borne

	Abnl	Nl
Education %		
< 6	28	11
7-12	44	39
>12	29	44

- So, more abnormal GCT with decreased acculturation but back in 1990s almost now abnormal GCTs

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Socioeconomic factors

- Increase in abnormal glucose with employment
- Decrease in abnormal glucose with multigenerational households

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Summary of Data

Realizing our data is too limited for statistical significance:

- Traditional risk factors for GDM of increased BMI and increased weight gain in pregnancy seem irrelevant for our Hmong patients
- Increased maternal age and increased parity seem to contribute risk
- Lower education seems to be a significant risk factor
- Not being employed and living in a multigenerational household seems protective.

Our picture: A non-English speaking, less educated, slightly older, Hmong woman with more children at home who works (likely low wage due to lower acculturation) and who does not have older relatives living in the home to share cooking and childcare responsibilities.

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Acting on the Data-2021

- We tried a Hmong GDM Prevention Program, that included 2 nutritional clinic visits with a Hmong speaking provider and a culturally specific tool kit to be used at home

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Results of PDSA #1 2021

- 7 Normal GCT
- 19 failed- moved on to 3 hrs. GTT
- 5 no test results
  - 1 too early
  - 2 Twin gestation- transfer of care
  - 1 lost to follow up
  - 1 moved out of state

Note, we did not have a control group to compare but data worse than our prePDSA data

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Acting on the Data 2024

- Interviews done by Hmong providers about education sessions 2021
- Started new PDSA June 2024
- Education material adjusted based on oral interviews with prior participants
- 2 **group** visits-hoping that the social connection can help with some of the non-nutrition related factors
- Results-TBD

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Summary of Journey to Address Surge in Hmong GDM at NorthPoint

- GDM has changed from a rarity to very common in the Hmong community over the past 25 years.
- There is minimal data available to determine when and why this change occurred.
- When providers realized this subjectively felt like a problem, we pulled the data and were shocked at the numbers
- Now we are trying to address it first based on our theory of diet changes, now combining diet with issues identified by deeper dive into charts and patient interviews
- However, intervening before this became such a problem would have been better.

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Relevancy for Other Clinics

- Are other clinics seeing the same surge but haven't reviewed the data in such a way that they can identify and address it?
- Will other immigrant and refugee groups (particularly Asians) see similar changes?
- What other problems are we missing because we are not collecting or reviewing the data or not evaluating the data by subgroups?

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Thank you!

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