



*Celebrating
60 Years*

group practice journal

PUBLICATION OF THE AMERICAN MEDICAL GROUP ASSOCIATION®

**HealthPartners Medical Group:
Integrating the Equitable Care Aim**
2010 Acclaim Award Honoree



HealthPartners

Robert Lerman, M.D.
Center for International Health

HealthPartners Medical Group: Integrating the Equitable Care Aim

2010 Acclaim Award Honoree

Editor's Note: *In September 2010, HealthPartners Medical Group was named an honoree of the American Medical Group Foundation's 2010 Acclaim Award for its initiative "Integrating the Equitable Care Aim."*

healthPartners is one of Minnesota's largest medical groups with more than 700 physicians practicing in more than 35 medical and surgical specialties. The medical group is part of a family of nonprofit, consumer-governed, state healthcare organizations. HealthPartners and its related organizations provide healthcare services, insurance, and HMO coverage. More than 9,800 employees staff the various organizations. The family includes 25 primary care clinics, 9 specialty care clinics, 8 urgent care clinics, 17 pharmacies, an out of state clinic, a dental group and clinics, a hospital, a hospital foundation, a research foundation, and an institute for medical education.

Drivers of Change and Pursuit of the Six Aims

HealthPartners' mission and bottom line is *to improve the health of our members, patients, and the community*. Its vision is to transform health care through innovative solutions to achieve a triple aim: improving health and offering a consistently exceptional experience at an affordable cost. The group aspires to be the best and most trusted partner in health care, health promotion, and health plan services in the country.

Like many healthcare providers, the medical group uses the Institute of Medicine's (IOM's) six overarching aims as guideposts for achieving its vision. However, unlike many providers, HealthPartners successfully integrated the aim of equitable care into the organization's strategic plan. HealthPartners is at the forefront of the healthcare industry in its resolve to eliminate disparities; its efforts exist within a larger context of system redesign because of a belief that changing the deeply rooted inequalities cannot be done separately from the rest of its work. The six aims must be pursued simultaneously.

HealthPartners is at the forefront of the healthcare industry in its resolve to eliminate disparities.

The change that HealthPartners is focused on today builds upon foundational work that started nearly a decade ago, even before the landmark report from the IOM, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, called attention to the fact that minorities receive lower-quality health care compared to Caucasians. The executive leadership and governance recognized early on that cross-cultural care was a strategic issue and part of the mission because of changing patient populations. The

organization embraced the business, legal, and quality cases for providing cross-cultural care and service that meets the needs of all members and patients regardless of their race, creed, religion, color, age, sex, national origin or ancestry, sexual orientation, marital status, familial status, veteran status, or health insurance coverage. In the end, and in line with its mission, HealthPartners was driven to change by patients and members.

A number of factors influenced the evolution of the group's patient and member populations. The organization's health plan has a long history of providing coverage and HMO services to a large portion of the community residents on pre-paid medical assistance, and most of these patients receive their care through the medical group. The hospital also draws unique populations, many of whom are also served by the medical group. Before joining HealthPartners, the hospital was a government institution and then designated as a safety net as it converted to not-for-profit status. Later, in the 1980s, it began seeing an increasingly diverse population as waves of Hmong and Vietnamese immigrants established new lives in the hospital's catchment area. Subsequently, the hospital continued to observe changing patient demographics as Somali and other East African immigrants and refugees were welcomed into their community.

In response to the changes in its customer base, the medical group's executive team commissioned the Health Disparities and Cultural



Representatives from HealthPartners Medical Group accepting the 2010 Honoree Acclaim Award (left to right): Beth Averbek, M.D., associate medical director, primary care; David Johnson, primary care regional clinic director of the Central Region; and Anne Murray, M.P.H., senior quality coordinator of care innovation and measurement

Competence Task Force in 2001 to provide leadership across the family of organizations for providing culturally competent care for diverse populations. The establishment of this formal organizational structure started the trajectory that has brought the organization to its current standing as a national leader working in partnership with the community to eliminate disparities.

Becoming an Ideal Delivery System

HealthPartners' ability to achieve the equitable aim is dependent upon a number of complementary, high-level strategies, many of which embody the six attributes defined by the Commonwealth Fund's Commission on High Performance Health Systems. The organization's fully implemented electronic medical record (EMR) is the foundation of continuous improvement. Early in the phased implementation of the EMR, HealthPartners redesigned care delivery processes in synchrony

with electronic tool builds. The purpose of the standardization was to give patients a consistent clinical and service experience across the care continuum. Although the redesign occurred in 2005, the standardized workflows remain a stalwart vehicle for ongoing improvement work, as processes are enhanced and personalized to meet the individual needs of each unique patient.

Critical Changes

The work HealthPartners is doing today to address disparities in care outcomes and experience could not be done if it had not taken the initiative to collect patient demographic data starting in 2004. Sharing quality data summarized by race/ethnicity, language preference, and financial class (i.e., payer) with staff and providers was a necessary first step for increasing awareness of health disparities and engaging the workforce in addressing the issue.

Collecting demographic data has

been a sustained and long-term focus for the organization. Implementing the process took considerable planning, including the development of scripting and staff training on how to ask for this information; creation of printed materials, resources for the intranet; and building tools in the EMR. The efforts have paid off: in recent years the organization achieved its goals of 90% collection of race/ethnicity and 99% collection of language preference (see Figure 1).

Challenges

HealthPartners' most difficult challenge was deciding on the demographic data elements and associated categories to collect. The decision-making process began in 2003. At the time, there was no uniform direction from local stakeholders on which categories should be used, and HealthPartners was the first healthcare organization in the community to attempt to establish such standards. Realizing that collection of demographic data in a healthcare setting could potentially be viewed negatively by the public, a thorough and transparent outreach campaign was conducted in order to explain the organization's intentions, establish relationships with community leaders, and gain insight on how they could approach this process in a sensitive manner.

After much deliberation and community engagement, HealthPartners opted to collect race and ethnicity in unison, slightly adapting the Federal Office of Management and Budget's standard categories. HealthPartners' standard categories are: white, black or African-American, Asian, American Indian or Alaska Native, Hispanic or Latino, some other race, and choose not to answer. The third element that was added to data collection was country of origin, chosen as a key indicator based on two constructs:

1. **Unique barriers:** For many refugees arriving in Minnesota, the political turmoil and displace-

FIGURE 1
Demographic Data Collection

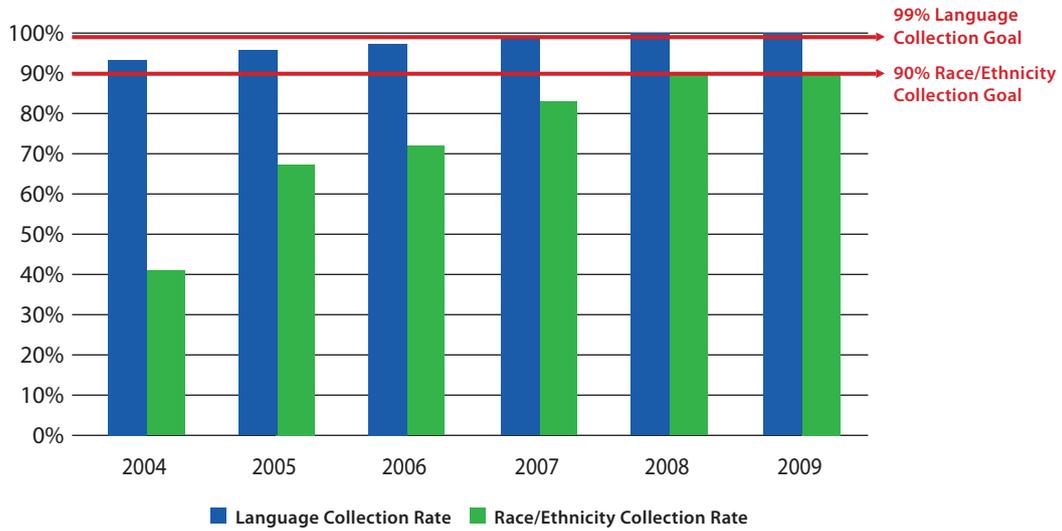
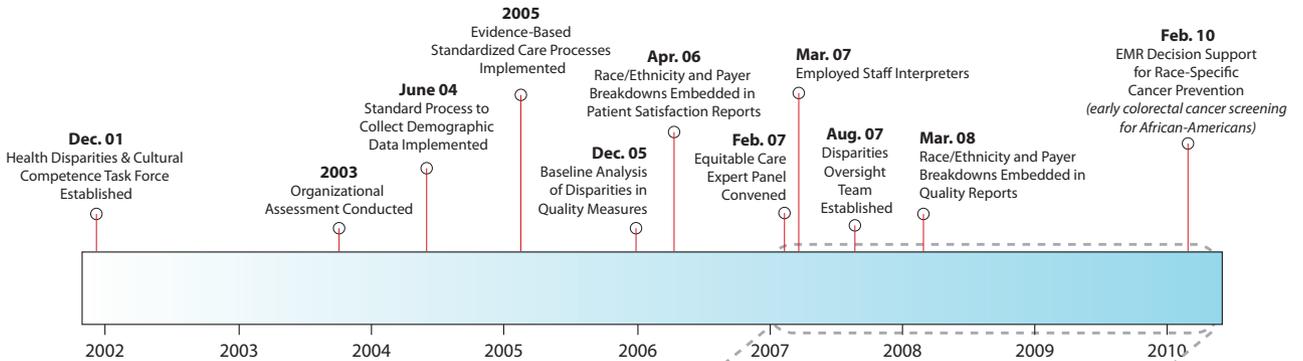


FIGURE 2
Equitable Care and Service Timeline



Disparities Oversight Team Interventions to Reduce Disparities	2007				2008				2009				2010	
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2
1 Reduce Barriers to Care	[Timeline bar]													
2 Free colonoscopy clinic for uninsured	[Timeline bar]													
3 Same-day mammography	[Timeline bar]													
4 Outreach phone calls to schedule mammograms	[Timeline bar]													
5 Implemented FIT test as alternative colorectal cancer screening	[Timeline bar]													
6 Documenting interpreter type	[Timeline bar]													
7 Patient Education and Empowerment	[Timeline bar]													
8 Culturally- and linguistically-tailored printed educational materials	[Timeline bar]													
9 EMR-based education message for visit summaries	[Timeline bar]													
10 Translated educational videos for exam rooms	[Timeline bar]													
11 Workforce Training	[Timeline bar]													
12 Equitable Care and Service intranet site	[Timeline bar]													
13 "Health in Any Language" training	[Timeline bar]													
14 Equitable Care Fellows program	[Timeline bar]													
15 Organizational site visits: "Every Encounter Is a Cultural Encounter"	[Timeline bar]													

ment they experienced for years meant exposure to many infectious diseases, mental health issues, lack of preventive services, and lack of access to care for chronic diseases. For those born in the United States, educational level and health literacy, as well as neighborhood of residence, are key determinants of health status among other social and economic factors.

2. **Clinical relevance:** Diseases endemic to certain countries correlate with risk for those diseases (TB, HIV, malaria, parasites, even hypertension and diabetes).

HealthPartners already found that country of origin is useful in analyzing opportunities. Most recently, the organization looked at breast cancer screening rates within the black or African-American population and discovered that US-born blacks tend to have screening rates similar to those of white women, while foreign-born blacks are much less likely to be up-to-date with mammography screening recommendations. HealthPartners communicated these findings to staff and providers to raise their awareness of populations that may be hesitant to seek preventive care such as mammograms.

Measuring Success

The most important measure of success is not whether a particular intervention or pilot produces a statistically significant improvement, but rather whether combined efforts produce sustained reductions in, or elimination of, the target disparity over time. With a number of initiatives occurring in tandem, the organization closely monitored quality and patient satisfaction results for improvements in specific subpopulations.

The Disparities Scorecard is just one vehicle for engaging leaders, staff, and providers in a dialogue about disparities and progress toward reducing these trends. Beginning in 2010, clinics became responsible

for reviewing their site-level data by race/ethnicity and by payer, which were new measures added to the 90-Day Plan process in 2010.

Overall Organizational Mission and Strategy

A key role of the board of directors is to understand, review, and approve actions that affect the strategic direction or fundamental character of the organization. Acknowledging health disparities exist and taking responsibility to address them has long been viewed as a key issue impacting strategic direction, and thus has evolved as an integral part of the organization's mission and vision.

Analysis of the group's baseline was used to establish immediate priorities.

The decision-making process began in 2003 when the Health Disparities and Cultural Competence Task Force commissioned a comprehensive, organization-wide assessment to establish a baseline of HealthPartners' Cross Cultural Care and Service (CCCS) status. The assessment tools were administered to the Board of Directors, as well as 138 various management staff, including leaders who were billable providers, with a 100% return rate. In addition, a survey was sent to 793 general billable providers with a 50% return rate.

Analysis of the group's baseline was used to establish immediate priorities for the task force's work plans, and to outline long-term strategic milestones for this work, some of which are yet to be achieved or represent work that continues today. In 2005 the board ensured alignment of these strategies within Health Goals 2010, a collaborative goal-setting process designed to help guide HealthPartners on the continuous journey to make the six aims a reality, and a set of commitments that would represent, to patients and

members, a transparent statement of the organization's aspirations for the following five years.

Health Goals 2010 was the first long-range set of goals that included aims for achieving equitable care in the patient population. The aspirations were also much broader in scope, covering the entire continuum of care including preventive, outpatient, inpatient, and end-of-life care, while focusing not only on quality but also on affordability and service (i.e., the "Triple Aim"). The goals specific to the equitable aim were:

1. By 2006, we will measure disparities in experience, preventive services, and diabetes by race and financial class.
2. By 2008, we will measure disparities in vascular disease care, pregnancy, and asthma by race and financial class.
3. By 2010, we will cut identified disparities by 75%.

HealthPartners was successful in achieving the first two goals, and has partially achieved the third.

Senior Leadership Accountability

The single greatest factor contributing to the success of this undertaking has been the full commitment of the organization's most senior leaders. To quote HealthPartners' chief executive officer, "Cross-cultural care is not about 'other' cultures, it's about recognizing the effect of cultural values—which we all have—on health." Reporting directly to the CEO is the senior vice president, who has been sponsoring this work since its inception in 2002.

Leadership in the medical group is structured in dyads at all levels. The senior vice president and medical director oversee the physician and administrative leader dyads of primary care, specialty care, behavioral health, home care, hospice, and geriatrics, as well as the directors of support divisions. Because this is an organization-wide strategic initiative, this high level of project sponsorship

FIGURE 3
Trended Mammography Disparities

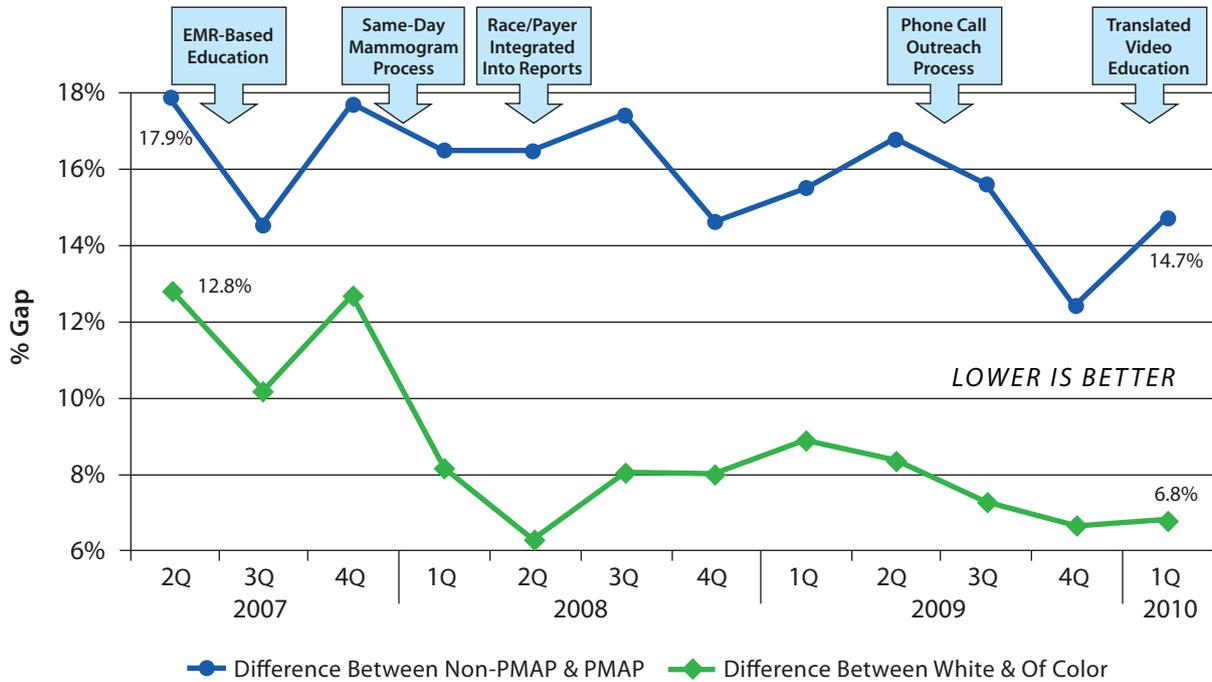
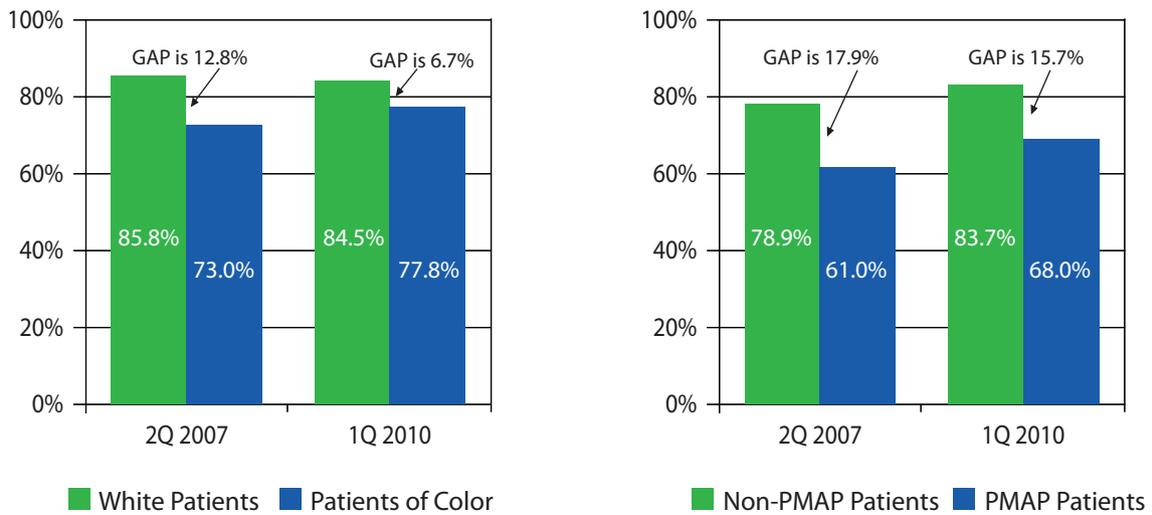


FIGURE 4
Mammogram Screening Rates by Race/Ethnicity and Payer



has been appropriate and effective.

Only a handful of individuals have been directly involved in this initiative throughout its lifespan, including the sponsor. Her sustained commitment provides continuity as teams evolve through modifications of project structures and membership, and also cultivates a culture within the organization where dedication to the most vulnerable populations is recognized and commended.

She was also instrumental in establishing leadership accountability for closing the gaps. Most recently, reducing breast cancer screening disparities was added to the Management Incentive Plan, which is a pay-for-performance program for managers and above. At the end of 2009, a portion of the payout was awarded for the progress made on closing the gap in breast cancer screening rates between patients of color and white patients. In 2010, the program is being expanded to include incentives for decreasing the mammography rate differences among payers (those with public insurance coverage compared to all others).

Leadership in the medical group is structured in dyads at all levels.

Directors have now begun to integrate front-line accountability for improving disparities by including four key measures in the clinic-level planning and reporting process called 90-Day Plans. Clinic dyad leaders are required to maintain a written 90-Day Plan that documents annual key measures and goals, baseline results and subsequent quarterly results, and specific action steps to achieve the goals. For 2010, the 90-Day Plans for primary care include breakouts for the optimal diabetes care measure and mammography screening rates for patients of color and patients with public insurance coverage.

Including these data on the

90-Day Plans will guarantee that the clinic dyad leaders have regular discussions with the regional clinic director and regional assistant medical director dyad teams about the site-level results for these specific populations. Although the data have been available since mid-2008, until 2010 there was not a structured process for reviewing local site data and discussing strategies for reversing the disparity trends.

It is important in establishing expectations that all levels of leadership are aware of the differences in the quality of care and service received among subpopulations.

Project Timeline

The timeline in Figure 2 represents key system milestones and details a series of Plan-Do-Study-Act (PDSA) interventions conducted during the past three years. Building HealthPartners' organizational capacity to provide equitable care has been a multi-year, long-term commitment. Acquiring data on race/ethnicity, language preference, and country of origin is a basic first step in addressing the disparities that was set into motion in 2004 when the medical group implemented standard processes for collecting patient self-reported demographic information. Leveraging these rich data, HealthPartners raised the collective awareness of disparities among staff and providers by embedding results by race/ethnicity and payer in its standard reporting process.

Two additional key structural milestones—the implementation of evidence-based standardized care processes and the development of a centralized interpreter services department—have provided the foundation for the project team to begin testing targeted interventions to reverse disparities trends. These interventions involve:

- Customizing processes in order to reduce barriers to care
- Empowering patients with culturally-tailored education

- Offering the workforce cross-cultural training

Project Team

HealthPartners' Disparities Oversight Team, whose mission is to develop and oversee the annual work plan to reduce disparities, is the group responsible for analyzing opportunities, generating ideas, and partnering with operational leaders to test and spread successful interventions. As one part of a larger, enterprise-wide strategy to close the gaps in health outcomes and experience of diverse populations, the Disparities Oversight Team reports up to the Equitable Care Sponsor Group, comprised of vice presidents and directors representing all areas of the organization.

Two additional teams report to the Equitable Care Sponsor group: the hospital's Equitable Care Oversight team and the enterprise-wide Interpreter Services Workgroup. The Equitable Care Sponsor Group ensures that initiatives across the enterprise are complementary, and that appropriate support and resources are dedicated to the operational teams. In addition, the Sponsor Group directs the strategy and approach for community and patient engagement.

1. Interventions to Reduce Barriers to Care

A number of interventions tested were designed to change the way HealthPartners offers care, so that patients have better access to services.

- Same-day mammography
- Outreach phone calls to schedule mammograms
- Documenting interpreter type

2. Patient Education and Empowerment

The IOM recommends that healthcare organizations promote practices that enhance patients' knowledge of how to best access care and participate in treatment decisions.

Research shows that patients are more likely to agree to cancer screening recommendations if they perceive their doctor's message to be "meant for me"—appropriate to their specific race/ethnic group, age, and gender.

Cross-Cultural Education for Staff and Providers

Integrating cross-cultural education into staff and provider training is another strategy recommended by the IOM for decreasing disparities. HealthPartners' greatest resource for developing the cross-cultural expertise of its workforce is the Equitable Care and Service intranet site. The site provides easy access to tools and information on how to arrange and use interpreters, links to translated materials, training programs, and population data, and much more. HealthPartners also offers a variety of educational forums for employees about social and cultural factors that affect health. A sample of these forums includes:

Health in Any Language

This series of trainings was delivered by staff interpreters in 2007 and 2008 at every care delivery site in the system. A total of 28 one-hour experiential and hands-on training sessions were offered, coinciding with the expansion of the organization's in-house interpreter staff.

Equitable Care Fellows Program

In 2009, HealthPartners established the Equitable Care Fellows program for staff members and providers who volunteer to receive expert training so that they can become advocates and serve as a local resource for their colleagues.

Organizational Site Visits

In 2009 senior leaders and trained facilitators conducted site visits that reached nearly all employees to build a baseline of cultural competence. Staff watched a video produced in house called "Every Encounter is a Cultural Encounter" and engaged in discussions about the issues raised.

Response to the site visits was overwhelmingly positive, as evidenced by the training evaluations.

Evaluating Success

HealthPartners' senior leaders and the Disparities Oversight Team evaluate the progress they're making to close the gaps using summary data available on the Disparities Scorecard. This document packages all clinical quality and patient experience data, displaying results by subpopulation, as well as trends in the differences between populations. Clinic managers and directors are also able to easily monitor local progress because these population-level results are included on the quality and service reports.

Closing the Gap

HealthPartners' greatest contribution to reversing disparities trends is its success in increasing the percentage of patients of color and publicly insured women who receive regular mammograms. The organization's mammography rate, based on data generated from the EMR, is the percentage of women aged 50-75 who have been screened by mammography in the 18 months prior to and including their most recent primary care or OB/GYN office visit.

In the beginning of 2007, HealthPartners' mammography rate for women of color was 73%, compared to 85.8% of white women. Even more concerning was the difference in these rates by payer: the rate for women with public insurance was 61.0% compared with 78.9% of those with all other payers. HealthPartners chose to discuss these data in terms of the disparity, or "gap," which is defined as the percentage point difference between two populations.

Demonstrated by the downward trend lines in Figure 3, the race/ethnicity gap decreased by 47% and the payer gap by 18% over the period 2007 to 2010. These improvements can be attributed to a number of converging and complementary initiatives (see graph's annotations) that changed

the organization's care delivery processes to minimize barriers, empowered patients with linguistically and culturally relevant health education resources, and increased staff and provider awareness of disparities and resources for developing culturally competent practices.

Had HealthPartners not decreased the trend observed in 2007, 165 fewer women of color, and 42 fewer patients on pre-paid medical assistance would have received a mammogram in the first quarter of 2010. HealthPartners celebrates these increases because research has shown that late diagnosis is major factor in the higher death rates from breast cancer observed in women of color and low-income women.

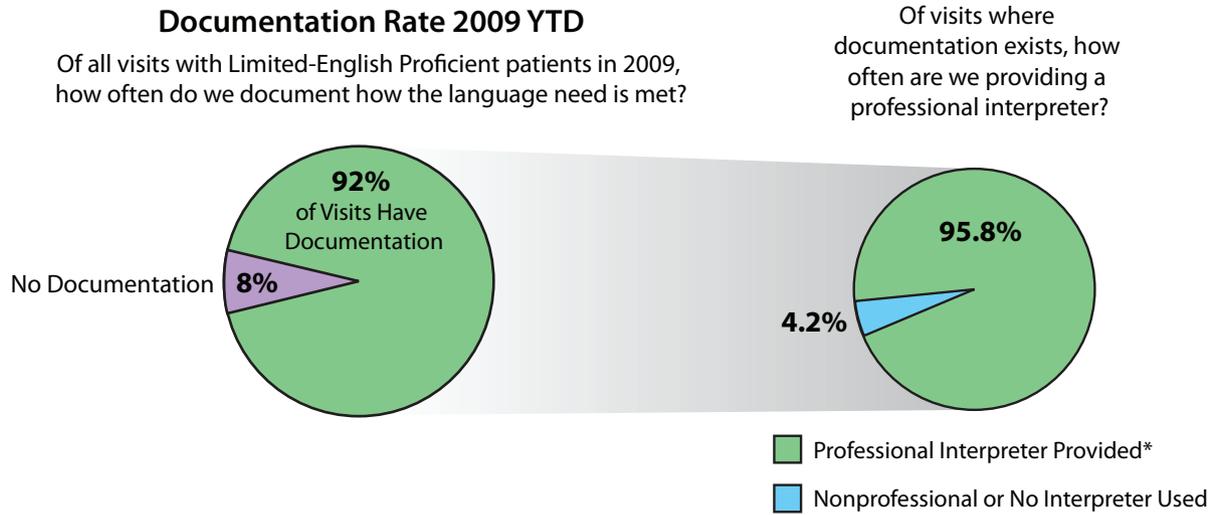
It is important to note that the decreases in the % gap are due to improvements in the mammogram screening rates for patients of color and for those insured by public programs, rather than lower rates for the comparison populations. These results are displayed in Figure 4.

Ensuring Access to Professional Interpreters

Patients' preferred language data are used to ensure interpreters are present when necessary. Figure 5 reflects the success of the process implemented at the pilot clinic to document in a discrete field of the organization's EMR the type of interpretive service provided for encounters with patients whose preferred language is something other than English. The process was implemented system-wide in 2010, and the organization plans to utilize the process measures to identify opportunities for focused trainings to increase the utilization of professional interpreters.

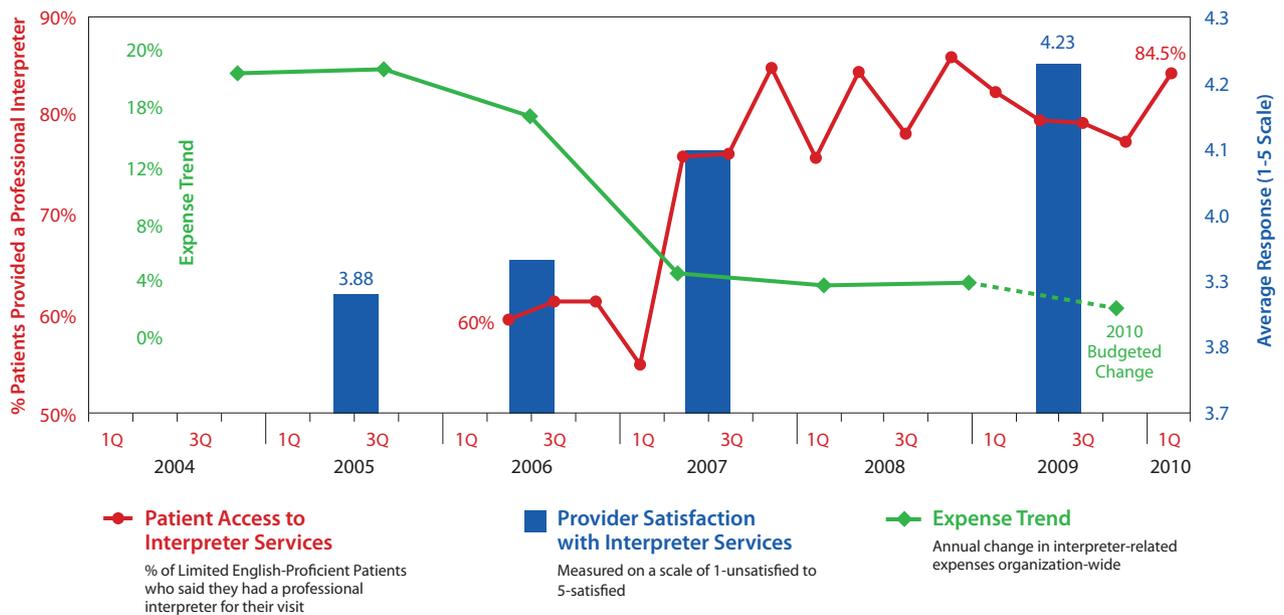
HealthPartners aims to reach a documentation rate of 100% and decrease to less than 2% the percentage of visits where nonprofessional or no interpreters were used. Ensuring patients receive the services of professional interpreters during their encounters in the system is not only

FIGURE 5
Pilot Clinic Results: Documenting How Language Need Is Met



*Professional interpreters include agency interpreter, phone interpreter, bilingual interpreter, and staff interpreter.

FIGURE 6
Language Services TRIPLE AIM: Improving Health, Experience, and Affordability



a method of providing equitable care but also a matter of safety. Without the ability to measure patients' receipt of interpreter services, HealthPartners would not be able set its sights on achieving reliability in these processes.

In addition to implementation of standard processes for documenting how a patient's language need is met, HealthPartners found it critical to increase the use of best practices for working with an interpreter. Efforts directed by the Interpreter Services Workgroup have aimed to equip the workforce with skills and knowledge to improve their ability to communicate with patients through interpreters in an efficient manner. HealthPartners sees "triple aim" results in evaluating these efforts as measured by patients' satisfaction, providers' experience with interpreter services, and success in reducing costs for providing interpreters (see Figure 6).

Healthcare leaders can leverage systems to support the notion of mass customization.

Future Plans

HealthPartners plans to build upon its success in decreasing disparities in breast cancer screening by applying the same strategies to address differences in colorectal cancer screening and diabetes care, with a focus on leveraging the EMR. In 2009, the organization launched an initiative aimed at saving lives by providing more timely colorectal cancer screenings for African-American patients. The initiative uses the EMR and race information to automatically generate reminders to African-American patients and their providers to have a colonoscopy when they turn 45 and then at regular intervals through age 80.

HealthPartners also incorporated this race-specific screening recommendation in its colorectal cancer screening measure, so patients are

eligible for the base population beginning at age 45 if their documented race in our EMR is black or African-American.

Lessons Learned

Reducing disparities is an important approach for raising a healthcare organization's overall performance. The ability to recognize populations that persistently have poorer-quality outcomes or are not as likely to access preventive care opens a new door for quality improvement strategies. As the US population becomes more diverse in the decades to come, patients will increasingly demand that their care align with personal preferences and cultural norms. A one-size-fits-all approach will be a thing of the past.

With innovations in health information technology, healthcare leaders can leverage systems to support the notion of mass customization. Although HealthPartners has only begun to develop knowledge and understanding of how to change practices and shift attitudes within the workforce; the group is an early adopter in an industry that tends to move as one.

Large-scale initiatives such as these may seem intimidating to care delivery organizations that are most likely already strapped for resources. The antidote is to realize that reducing disparities and becoming a culturally competent organization represents the value that will be generated by delivery systems that fully embrace the Commonwealth Fund's six attributes of high-performing organizations. As HealthPartners continues to make changes in pursuit of these attributes, it will look to the results on the Disparities Scorecard to judge its progress.

Adapted from the 2010 Acclaim Award Application of HealthPartners Medical Group submitted by Anne Murray, senior quality coordinator, care innovation and measurement.



Reach the Leaders of Every Medical Group in the Country

The *Group Practice Journal* is distributed to physician executives, physicians, and administrators at every medical group, IPA, and Integrated Delivery System in the country. With a circulation of over 70,000, the *Group Practice Journal* offers an unparalleled reach into the healthcare community. Advertising in the *Group Practice Journal* puts your message before the leaders of the largest and most prestigious medical groups in the U.S. These are the individuals who make the purchase decisions, choose vendors, and establish collaborative relationships.

**To advertise in the
Group Practice Journal,
contact David O'Leary at
The Sales Department
(301) 652-8862 or
david@salesdept.net**