Vivian Anugwom: Hello. Thank you all for joining, I'm Vivian Anugwom, Health Equity Program manager for Allina Health System and I am really excited to speak with you all today and I look forward to hearing your comments and questions at the end of the presentation. So what we'll do today is, really, I'll help you understand what Allina Health is doing around eliminating health disparities, also share an example of how analytics has helped us support eliminating health disparities in our system and share some of the results to date.

So, learning objectives for today. Well, like I said, understand how we're identifying disparities. And well, I really, really, really want to be able to hear what some of the things that are top of mind for you all. And then we'll talk about how bias can impact health disparities. So first, let's start with a poll question, I'm really curious to know where everyone's joining from? What setting do you work in?

Brooke MacCourtney: All right. I'm going to go ahead-

Vivian Anugwom: Let me turn it over to you.

Brooke MacCourtney: Yeah. Thanks Vivian. We'll launch this poll. So if everyone can just answer this really quickly, what setting do you work in? Have options; provider organization, payer, government, vendor, or other. We'll give you a few seconds to answer that, looks like we've got votes coming in and we will go ahead and close that poll and share the results.

So it looks like we're going to have a mix, a good percentage from provider organizations, lots of people in the other category, some government, so that hopefully gives you a little sense of our audience, Vivian, today.

Vivian Anugwom: Yeah. All right. It's really helpful to hear that, especially hearing that lots of folks are from provider organizations, so hopefully the information I share today will be helpful and also if you're interested, you could also, for those of you that said other, just try to type in the chat box where you're coming from, and I'd love to review that afterwards. So thank you.

All right. So let me tell you a little bit about Allina Health, first. So, Allina Health is a not-for-profit healthcare system that cares for patients from beginning of life to end of life through our 90 plus clinics, 12 hospitals and various specialty care services. Our mission is to serve our community through seamless connections and fluid care.

So, we have so many opportunities to connect with our patients and we want to ensure that anyone who seeks care at Allina Health receives quality care, that's tailored to their unique needs. So, any time I'm talking about this topic, or talking about health equity, I love to use this graphic, hopefully most of you have seen this before. But, what I would like to do is just talk about, what is

health equity and use this graphic to illustrate what equity is versus equality and use this relevant example to help us understand the difference.

So, I think as healthcare providers or in healthcare, we strive to provide quality care to everyone, and when we look at equality, so let's say, okay, right now we're dealing with COVID, right? And say, "We want to stand up a COVID testing, curbside testings site." I know we're talking about vaccines now, but let's stick with testing for now. And, you recognize that around the neighborhood, you want everyone to be able to get to the testing site, but transportation may be an issue or a barrier for folks.

And so you want to say, "Hey, we want our community to be able to get to our testing site, let's provide transportation and let's provide bikes to everyone so that they can get to the testing site." And so you give everyone the same bike that's equality, as you can see, giving everyone the same bike does not necessarily work for everyone needs and abilities. Equity is saying, "Hey, we recognize that transportation is a barrier and we're going to do the best that we can to provide the service, in this case the bike, that meets the individual's needs."

And so from an equity perspective, well, before we can really achieve equality for all, we need to make sure that we are able to adapt the way that we provide care, so that the folks who are starting at a deficit have the ability to step up to get to the point where they can achieve similar outcomes as others. So let's go to the next slide.

Also I want to just read the definition of health equity. So, at Allina right now, we've adopted the Robert Wood Johnson Foundation definition of health equity, and it reads, health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health, such as poverty discrimination and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments and healthcare.

And, I want to point out that, although healthcare is called out, healthcare is not the only factor in achieving health equity. And so it is crucial for all of us in different sectors and different parts of our communities to come together and do our part to support our communities in achieving health equity. And I'll read the definition for health disparities. So health disparities are differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States.

So for us at Allina as a healthcare system, know we're looking at the health disparities within our quality outcomes, but also looking at access to our facilities as well. I think a lot of us have probably heard that COVID-19 is disproportionately affecting our communities of color. This pandemic has really

magnified the disparities that we need to address immediately, but also as we plan for the immediate solutions, we have to also be ensuring that whatever solutions we're putting into place now are sustainable and will address the structural racism and health-related social needs that are among the root causes of these disparities.

So let's take it back to Allina. So as I mentioned, we're trying to address the health disparities at Allina, as you can imagine, because we're such a large healthcare system, there are lots of opportunities, but there are a few things that need to be done or ways that you need to... Things that you need to address or focus on before to ensure that whatever solutions that you develop are sustainable.

So for us, we've tied our health equity work to key strategic initiatives within our system. We have an executive sponsor of the work, this year, it's actually our CEO, Penny Wheeler, and really to be honest, for us to be able to really create lasting solutions to addressing disparities, we have to have executive leadership support and buy-in. And then as you uncover the different disparities and opportunities, there are ways to also prioritize what those disparities are. And I'll cover that a little bit later.

And then creating an infrastructure and support implementation is crucial, because like I said, there are probably lots opportunities for us, there are a lots of opportunities and we need to ensure that whatever solutions we create are sustainable.

All right. So, some of you probably have heard me speak at the HAS Conference earlier this year, and since then, we've actually made quite a bit of... Have had quite a bit of movement in terms of how we have looked at how we support our communities. And we have made some serious strides in really identifying who community is for us and want to just share what our definition of community is.

So for us community is patients, employees, and people who live in the communities we serve, who are of all races, ethnicities, gender identities, sexualities, abilities, and economic means. So trying to be as inclusive as possible. And for us, we are committed to improving the health of all people in our communities by leveraging the collective strength of Allina Health as a care provider, employer, purchaser, and community partner to eliminate systemic inequities and racism.

So really calling out racism as a root cause for the inequities we're seeing. Here I'll show you the commitment that we've made for diversity equity and inclusion, and some of the specific goals that we've set forth. So as the healthcare provider, and this is where health equity work lives, we are committed to improving access to experience with health care, making investments that create innovative solutions and building care models that support our patients' needs and eliminating disparities.

And for us, we really worked to identify, what are the goals that we are working towards under each role that we have as a healthcare system? So our role as a healthcare provider, our role as an employer, our role as a purchaser of goods and services, and our role as a community leader and partner. And so for us, this is our roadmap going forward to say, "As we've made this commitment to diversity equity inclusion, what is it that we're going to do? And what do we want our community to hold us accountable for?"

So pulling it back to health equity and our role as a healthcare provider, specifically, some key opportunities that have been identified as we continue on this journey to eliminating health disparities, we've identified some places for us to start as a system. So, we've seen that a lot of our leaders have the opportunity to learn more about our ability to pull a race at the same language from our dashboards to help them identify disparities in their quality outcomes and access.

And then, also there's an opportunity to develop tools to help leaders actually address the disparities once they've uncovered them. And then there's also an opportunity to normalize working with diverse patients and communities to co-create solutions to eliminate those disparities. We cannot continue to develop solutions within our office space or homes, we have to work with community and co-create with community to ensure that what we're doing is the right thing. And then, increasing visibility of disparities and the work that's being done across the system.

So, I think for one, you cannot address what you don't know. So once we've uncovered the disparities, we have to keep monitoring progress towards closing them, ensuring that our colleagues across our system, in our community understand what's being done so that we can learn together. Current State, we have a one health equity goal that we are tracking at the system level, and we will be expanding that in 2021. So today I'll be talking about the one goal that we have on our scorecards.

Let me also just talk a little bit about the strategy and the way that we're working towards achieving equitable care, or providing equitable care. So from our capacity and capability building piece, so, as I mentioned, there's lots of opportunities to get our leaders and my colleagues up to speed on first, how do we identify the disparities? And then how to actually address them.

So we'll be developing a health equity toolkit that will help bring my colleagues across or through the process of identifying disparities, addressing them, and then, also just understanding the root cause as well in that, so, looking at the literature, talking to stakeholders, which are frontline staff, and community members, and patients. So developing a health equity toolkit that will assist teams in actually doing that work.

And then we've developed something called culturally responsive care training, and it's really geared towards helping our frontline staff, our providers, understand how culture influences health, how it influences how people show up to the healthcare system, touches on cross-cultural communication, and also, just gives intro into bias as well.

And then we will also be embarking on race, ethnicity, and language, and SOGI which is sexual orientation, gender identity, data quality project, just really to ensure that our staff who are actually collecting the data, understand why it's important and feel comfortable in actually articulating that importance to patients so that folks understand that we need this data to be as accurate as possible, because it will be informing any improvement projects that are identified.

And then, from a value and accountability perspective, firstly, as we continue to identify disparities and address them, we want to ensure that our solutions are sustainable. And so, one example of that is we, as a system, have formed a partnership with Blue Cross Blue Shield, which is pretty unique. And within that work, we are identifying some health equity metrics and exploring how we can come together as a provider and a payer to understand what it really takes to create sustainable solutions.

And then, as we have identified our health equity goals for the next year, we are integrating those goals into various scorecards. So for example, our primary care group has identified colorectal cancer screening disparities for our African-American patient population as a focus area. And so, the goal that they've set will live on their scorecard and they will be held accountable to continue to monitor progress towards that goal as they implement their strategy.

And then, at the system level, we have several diversity equity and inclusion goals that will be monitored at the executive level. And then going up to the orange bubble really just, again, how do we address disparities differently? So, as we are building our capacity and capability internally, we're also learning how to work with diverse patients and community members to create solutions. So work in 2021 we'll be focused on really creating a process to help our teams do that. How do we integrate or how do we incorporate community voices into our improvement projects?

And then engaging departments in identifying the disparities, that's part of the work that we'll be doing. And then from a communication and transparency perspective, as I mentioned, it's important for us to share what's being done internally, but I think also from a transparency perspective, there's opportunity to share our opportunities, so the disparities and progress towards closing those gaps with community. So we have another level of accountability.

All right. So for us, just to talk a little bit more about how we use data to identify inequity, so right now it is standard practice for us to include the race, ethnicity,

and language filter on our dashboards. Like I said earlier, there is opportunity to increase awareness of that filter, but we do include it on our dashboards. And the filter really helps us to uncover the unique experiences of historically underserved populations and the opportunities to reduce those health inequities. Although the real filter is helpful for uncovering some of these opportunities, it's not complete. And so, it is crucial to still be able to understand how other factors influence health.

So, what are the patient values and beliefs that our patients and community members have around healthcare? What are some specific healthcare interventions that exist? Are they working? Are they not? And then talking about the social determinants of health, is housing instability a factor for a patient, financial resource strain, culture, gender identity, food insecurity. So, although it is helpful to really understand where disparities exist by race at the same language and also sexual orientation and gender identity, it does not replace the need to talk to people and really understand from the patient and the community perspective, what is contributing to those disparities.

So, I've spoken to this, but this is just a really high-level flow of how you address disparity. So, first identify the disparities. I think for us, we have the ability to do this through the filter, through our community health needs assessments, and talking to patients and community. But I think there are organizations that are probably in this category where you have to build in those systems, to be able to understand where your opportunities lie. And then getting into understanding the root causes, looking in the literature, talking to community. And then lastly, implementation and securing the resources that are needed to actually close those gaps.

I wanted to actually share this prioritization graphic here of how to prioritize the different disparities you might uncover. So, a couple of things that you would want to keep in mind is, what is your current sphere of influence? What programs do you already have in place? What communities do you serve? What partnerships do you already have in place and have built trust? And then if you've uncovered the disparity in your data, is it statistically significant? Is it clinically significant? And then, could the solutions drive value.

But I think for me, the most meaningful question to ask is, is there meaningful impact to community? Because we want to make sure that we are working out what matters most to our community members. So let's go a little bit into... Well, let me talk through an example of how we've addressed disparities at Allina. So after looking at data in 2018, one of the disparities we decided to start working on was around hospice care.

We found that minorities were disproportionately dying in the hospital setting versus hospice disparity in hospice length of stay for minority groups were uncovered and we saw that there are fewer minorities in the hospice program overall and lower hospice referral rates amongst minorities. And so, although

we uncovered all these different disparities, we decided on focusing on increasing referrals to hospice for our African-American patients.

There've been lots of studies exploring hospice utilization among African-American patients, and I just want to share a few key findings for a qualitative lens and to how many, but not all, African-Americans might approach hospice and end-of-life care in general. So the research says that, "African-American patients are more likely to prefer aggressive treatment than white patients. African-American patients are more likely, than white patients, to mistrust healthcare providers and African-American preferred to care for family members to the end of their lives." So, like I said, this is not everyone's belief, but this is what we see in the research.

So, our internal data showed us, though, that our African-American patients were less likely to receive referrals to hospice, but it was during our conversations with providers about the disparity data that we heard about their past experiences with making referrals to hospitals as for eligible African-American patients. And many of them were not surprised by the data. So, I think these conversations highlighted that bias could play a role in the referrals to hospice, we had one provider share, and we appreciate his vulnerability in saying this, but, he shared that, in his past experience his African-American patients have not typically wanted to even talk about hospice. And sometimes, because of that, he hasn't actually felt comfortable making those referrals, or even just bring up the topic.

And so, we decided to, instead of jumping to... After we've uncovered these disparities, instead of jumping to saying, "Well, we need to educate them and we need to help them engage in hospice." We decided that it made sense to hold a mirror to ourselves and take a step back and say, "What is it that we can change and improve on internally to get at some of these disparities?"

And so, what we did, it was to develop an implicit bias training specifically around hospice. So, in the training, we gave an overview of what hospice is, what implicit bias is, talked about the research that I shared earlier, but really open it up to create a safe space for the providers to talk about their experiences and really understand how, "Yes, even though they've had some of these experiences with African-American patients not engaging in hospice care, it does not mean that they should not still bring up the topic and try to meet the patients where they're at and give our patients, African-American patients, enough information for them to make informed decisions about hospice."

And so really quickly, I want to just read the definition of implicit bias. So, also known as unconscious bias. Implicit bias is, the bias and judgment and or behavior that results from subtle cognitive processes that often operate at a level below conscious awareness and without intentional control. So bias is automatically activated, it's often unintentional and it's a normal aspect of the human condition. I always like to just point out that we all have implicit biases,

it's just that people of color typically are the ones that are most affected by it, in patient care at least.

So how does implicit bias affect the patient experience? Providers who have a pro-white implicit bias might dominate the conversations with their patients, they might use slower speech, which can be offensive to folks and be less positive when compared to their interactions with white patients. Because of these biases, patients might be less involved in decisions about their care, they may be less satisfied overall and maybe less likely to return for follow-up visits, which can have a negative impact on their health outcomes.

So I just wanted to just give a high level overview of the learning objectives of the hospice implicit bias training that we developed. So we want to provide a perspective of African-American patients, perceptions of end of life care, so we shared the data, what we're seeing in the research, explore bias and its effects on communication related to hospice services, and provide resources for how to actually mitigate bias, but also how to communicate effectively around hospice services and end-of -life care.

We also gave them some mitigation strategies, so specifically things like, recognizing situations, that magnifying stereotyping bias, talked about the teach-back method, understanding how to individuate your patients, so, knowing what the research says about African-Americans and hospice, also knowing your experiences, and still having that in the background, recognizing that, "Yes, even though, that maybe I've had several patients who have turned down hospice, it doesn't mean that I cannot treat the current patient in front of me as an individual and understand what their knowledge of hospice is and where they're coming from."

So, this covers what I just shared. So in closing, I know this work is hard and even as we've uncovered other disparities with our system, once you have the infrastructure in place to pull the data and understand where the opportunities are, that actually is the easier part of the process, it's the next level of understanding the root cause, being comfortable with holding the mirror up to yourself and saying, "As a system, as a program, what is it that we may be doing unintentionally to contribute to these disparities? And what are we going to do about it?" I think that's the hard part. But I encourage everyone to continue to learn, continue to be open, continue to be comfortable with being uncomfortable in this space and ask questions.

So I shared one example of how we've addressed disparities within our system. We have many more opportunities to struggle through this, but doing something is better than nothing. So even if in 2021, the only thing you do is just uncover the disparities and sit with it and increase awareness within your system, that's a win. So, I would just say, "Be courageous in this work, support each other, ask questions, be okay with being uncomfortable, and just start

somewhere." Oh, actually, let me just show you real quick before we take questions.

So this is a just current update of where we're at with our hospice disparity goal. So last year we did train, I think, over a hundred of our providers in this work. The specific hospice disparity, or hospice implicit bias training, has actually morphed into a larger scale implicit bias training initiative. And so, internally we have developed three different bias training modules. So one is, just general foundations of bias training for all of our employees, and then another one is a more targeted bias training geared towards patient care. So, instead of focusing on one program and one population, we've expanded it and developed in partnership with some of our providers to be able to just increase awareness in general, around how bias can enter the patient care interaction.

So, we were doing pretty well in October, meeting our monthly goal, but this work is going to take a while to really, really see lasting impact, but we will continue to monitor our progress, and pivot, and implement other interventions to get at closing these gaps. So with that, I'll be able to take questions. Let me know if there's any piece of the presentation that you'd like clarity on. Yeah. Thank you all for your attention.

Brooke MacCourtney: Yeah. Thanks Vivian. It was a great presentation. As she mentioned, if you have questions, now's the time to submit them in the control panel and we'll begin our Q and A session in just a moment, we do have one more poll question for you, I'll go ahead and launch that, while today's presentation was focused on health equity, we'd like to know if you'd like to learn anything more about health catalyst. So if you'd like to learn more, please answer this poll question and we will leave that open for a few moments as we begin our Q and A session. So Vivian, we've got a lot of great questions coming in, so I'll just start at the top and we'll get through as many as we can.

Okay. So we had two people ask, they just wanted you to clarify what REAL stands for in your [crosstalk 00:34:21]?

Vivian Anugwom: Yeah REAL is race, ethnicity, and language.

Brooke MacCourtney: Perfect. Okay. Next question. Karen asks, does your toolkit include the use of the ACE score and use a trauma informed approach?

Vivian Anugwom: So the toolkit is still in development, I don't know what the ACE score is, but yes, there will be elements of trauma informed care perspective. That's critical, if we want to care for all of our patients in the way that makes sense.

Brooke MacCourtney: Perfect. Okay. Next question. This is coming from Starlet, how would you suggest incorporating this information education for future health providers and professionals? Is this something that should be addressed in every course or in a single source on inequities?

Vivian Anugwom: So I'll answer this two ways. So first, I believe that equity should be integrated in any course using examples, but so for us we have internal medicine residency program and we are actually working on developing. So the culturally responsive care training that I mentioned, we're rolling that out to them, rolling also the implicit bias training to them. So yes, they are receiving it in residency, but, I think that healthcare providers should be receiving it from the very beginning of their clinical education, but also even in the application process.

Having folks start to think about their own personal commitment to this work, and then also, it's one thing to integrate the training piece, but there's the experiential piece of it, and so, after the residents who've gone through the training, we'll also engage them in some of the specific health equity projects, so that they can start to see their role in closing those disparities and improving the quality outcomes that we are focusing on. Hopefully I answered your question.

Brooke MacCourtney: That's great. Our next question comes from Rebecca. When you engage your teams in discussions about implicit bias and hospice care, how did you prepare people to facilitate the conversation? We were wondering if our team leaders are ready to deal with the fragility and denial levels come up.

Vivian Anugwom: Yeah. So, it was three of us that actually led the training, so, I do recognize that it would take a little bit of work to get others, to be able to believe the training, but I think there's opportunity to focus on just normalizing the concept of bias for everyone, and everyone's on a different point and the journey of this type of work. And so, I think engaging the folks that maybe have a higher level of comfort and focusing on those folks to say, "Okay, we recognize that bias plays a role in patient care," for example, "How do we get ourselves to the point where we are comfortable, actually, having those conversations with our colleagues."

So I would start with the folks that have more comfort in this work, and don't jump to trying to change everyone's minds. You're going to have folks that'll feel more comfortable sitting back and going along the journey at a different pace.

Brooke MacCourtney: Awesome. Okay. Next question comes from Joe, what tools do you use for root cause analysis for impact? Who have you identified as key members to impact implicit bias change?

Vivian Anugwom: Mm-hmm (affirmative). So for the root cause piece, like I said, we're building our health equity toolkit but there are several factors to take into consideration. So in terms of root cause, you can look internally at workflow. It depends on what you're looking at, if it's a program or quality outcome. But looking at workflows, So, I'll give you an example with the hospice project. So we actually mapped out the process for making hospice referrals. And looked at, from the beginning, when a patient enters our system to when they received the referral, and identified very specific points and where some breakdown could happen.

And so, I think, mapping out workflows and identifying key issues or potential issues is one way, and then talking to people that are actually being affected by this. So patients, community, I think that helps. That is another way to address the root causes.

And then in terms of the bias piece, what was the question again? Was it, how do you engage...? What was the question?

Brooke MacCourtney: Have you identified key members to impact implicit bias change?

Vivian Anugwom: I think, like I said, for us, there were a few of us that were more comfortable with the conversation. So I think identifying the folks that are more comfortable with having these conversations and it depends on how large your institution is. So if you have a diversity and inclusion lead within your organization or a health equity lead, I would start with them because they've probably already had folks self-select and identify themselves. So for us, right? We've started out a health equities committee internally, and it's really made up of a group of folks that have raised their hand and said, "We're interested in addressing disparities, we're not really sure how, but we want to do this work."

And so, I would just find those folks that have an interest and a passion to start those conversations.

Brooke MacCourtney: Great. Thank you. Okay. Next question, Karen asks, did you include assessing the level of shared decision-making was used at the different sites?

Vivian Anugwom: Yeah, No. We didn't get to that point.

Brooke MacCourtney: Okay. Next one comes from Jacqueline. Do you find that hospice is not explained to patients as a benefit, not a death sentence among African-American patients?

Vivian Anugwom: Yeah. There's definitely opportunity to improve how we introduce hospice. And we did actually address that in the implicit bias training. So, for us, it's not introducing hospice as the last thing we have to offer you because, basically, we're giving up, it's rather flipping it and saying, "Hey, we have this hospice program and these are the benefits, and we think this is the best care that we can provide to you now."

So I think part of it is patients feel like we're giving up, and introducing hospice is not necessarily giving up, it's insuring that, if you are near the end of life, you are as comfortable as possible and your needs are being taken care of during that phase.

Brooke MacCourtney: Great. Okay. Next question, Kelsey asks, how did Allina providers get access to the anti-biased training?

Vivian Anugwom: The implicit bias training. So, fortunately for us, the hospitalist lead. So, we focused on hospitalist first, their lead was a champion for this work and he offered it as some continuing education class for the hospitalist. So I think year they have to complete a certain number of continuing education courses and the implicit bias training was one of those offerings for folks to choose from.

Brooke MacCourtney: Great. Okay. Next is Dorothea asks, "Have you received pushback from coworkers for this training?

Vivian Anugwom: Nope, luckily, at least not to us directly. And it's actually really interesting and encouraging at the end of each training, we actually, had an evaluation and asked the providers what they thought about the training, and most of them said that they would recommend it to their colleagues, most of them said that they prefer for the training to be in person versus some, online module that they could just click through, which was encouraging, so we had to get creative during these times.

And then we actually had a lot of folks at the end of the session say, "I didn't know I needed this training. And I wasn't really sure what I was coming to hear. But, this is the training that I didn't know I needed." So we actually got really good feedback. And to be honest, if providers are saying that your training is valuable, I think it's pretty successful.

Brooke MacCourtney: Yeah, that's really true. Okay. Next one, is from Hugh, hopefully I'm saying your name right, before you engage in equity work at Allina, did you go through an organizational self-assessment, if yes, what tool did you use?

Vivian Anugwom: Yeah. So, I believe there was a self-assessment few years back before I took this role, but as part of what we are, internally, we're calling community recovery. So it's really understanding from a diversity equity and inclusion perspective, what is it that we're doing to address these issues? And we did not use a specific tool per se, but what we did was just understand current state, understand our opportunities, and build a plan. So, to be honest, I think that there is opportunity to do a health equity specific assessment, which we plan to do.

And, IHI has a pretty good tool out there. There was a way to share links or if you contact me directly IHI has a pretty good tool that I would like to adopt. So it really takes you through the different parts of your... I think it's geared towards health systems, you could probably adapt it for your space, but really just understanding the opportunities from an infrastructure perspective, from education perspective, and I think community connections as well.

Brooke MacCourtney: That's great. Okay. Next question comes from Catherine, what is your organization doing to improve data collection, to be able to better understand other disparities in care that may exist?

Vivian Anugwom: Yeah. So, I think I had mentioned we're helping to improve the quality of the data we collect now, so, the race, ethnicity, and language data, and then also incorporate the sexual orientation, gender identity data by communicating with our registration staff, any staff that works to input that data, to just understand that... Make sure that they understand why we're collecting the data and to help give them maybe some scripting around, how to help patients understand why we collect the data.

And then, we have a community health needs assessment integrating the information that we collect from that process from community, but also looking at how we integrate patients and community into the actual projects. So for example, we've identified colorectal cancer screening for our African-American patient population as an opportunity, we want to ensure that there are patient and community voices throughout that process.

So first, we'll say, internally, you've seen this disparity, is this something that community also sees as an opportunity to work with us on? And then if so, how do we move forward together from a patient engagement and education perspective? But I think, regardless, there is work that we can do internally to ensure that the providers understand the different ways, different modalities for colorectal cancer screening and making sure that we have the proper workflows in place to trigger when to offer different options.

So, I think there's opportunity to increase understanding of what the disparities are and the root cause, and just ensuring that we're using the different tools that we have at our disposal.

Brooke MacCourtney: Perfect. Okay. Bill asks, "You mentioned that putting an infrastructure into place to pull the data and then base decisions on the data is the hard part, but I'm curious if you can offer a bit of detail on the infrastructure you put into place.

Vivian Anugwom: Yeah. So, there's a couple things. So, right now, our one health equity goal lives on our system scorecard, which is great, but there are many other metrics that we should be collecting from a health equity and from an overall diversity equity inclusion perspective, and so, working to build that separate scorecard to ensure that our system, our teams, can see what we're doing around diversity equity inclusion. So from a health equity perspective, what are the disparities we're looking at? How many of our colleagues are actually collecting this data?

So in 2021, we'll be focusing on normalizing the importance of collecting the data and putting out a survey to say, "Who is actually using these filters now? And as the tools roll out, we'll be monitoring how often people are using the filters in their dashboards, and then also from an infrastructure perspective, looking at, how are we building equity into the patient care policies that we have in place?

And so, next year we'll be looking at how many of our patient care policies we actually look at from a health equity perspective, so building out a toolkit or a guide to help folks review their policies from a health equity perspective, or if they're creating new policies, have that lens as they are developing. So, it's looking at, or anticipating any unintended cause issues that may disproportionately affect our equity populations, also ensuring that the language is as inclusive as possible.

And so, for us, yes, we have our one disparity that we've focused on, but there's so much opportunity for us to expand on that, and I think a lot of the next year we'll be normalizing and increasing awareness of the tools that we have, and then also some of the education that's needed.

Brooke MacCourtney: Perfect. Okay. Amber asked, "Do you recommend working with an external facilitator or trainer to ensure objectivity and reduce likelihood of awkwardness amongst staff in case of a small organization?

Vivian Anugwom: I'm battling with that. On the one hand I can understand. So, we have our bias training, but then we're also implementing something called the IDI, and now I'm forgetting what it stands for, but the IDI is essentially a tool to help folks understand where they're at in terms of acceptance of how differences actually contribute to our organization implementing an IDI tool to increase awareness and give people a plan to actually do some of that self-work around bias, I think can be done by an external facilitator because when it gets personal like that, it's awkward. But I think that the goal should be to work towards being able to have those conversations internally, because a lot of this is a culture shift, right?

And so, if you can't have vulnerable conversations with your colleagues and internally, I think it's difficult for you to be able to actually make the change needed. So, if you're a healthcare provider, make the change needed, in your culture, to be able to improve upon patient care and eliminate this disparity.

So, because you have to get to a point where you have to support each other, and actually implementing some of those mitigation strategies and as uncomfortable as it sounds, getting to a point where we can call each other out, in a respectful way and work through some of the awkwardness together.

Brooke MacCourtney: Yeah. Thank you. Okay. Next question. Let's see, Jessica asks, "How well, or how has your team addressed health equity and how community public safety trauma impacts one's physical and mental health?"

Vivian Anugwom: Yeah. So for those of you that are not in Minnesota or local, one of our hospitals is right in the community where George Floyd was killed, was murdered, and as we have reimagined, restated, recommitted to our community, we are committed to supporting the recovery of the Phillips neighborhood, and part of that is addressing the safety concerns. And so, we're in the midst of just understanding what the needs are of the community, and understanding how

we can support those safety concerns. And I think our learnings from that will inform how we support other communities, because, we're a large healthcare system, the communities we support look very different.

We have urban environments, and then we also have rural. But I think that just incorporating that mindset to say, "Although we are a healthcare system, there is opportunity for us to impact the different parts of what influences health, and I think we can apply that to any environment.

Brooke MacCourtney: Great. Thank you. Nadia asks, "Since starting to do health equity work, have you noticed any internal changes with regards to who's hired, who's promoted in positions of leadership within your organization?"

Vivian Anugwom: I have not noticed any specific hires, but I have noticed intentional efforts to ensure that there are diverse candidates coming to the table and being considered. So, I do think that internally, yes, there's increased level of awareness and different groups are working on, how to remove bias from the interview process, and so, I think with all this, it takes time, right? But, I think most importantly, yes, we are seeing increased awareness and action towards increasing the diversity in our hires.

Brooke MacCourtney: Perfect. Looks like Nadia had one other question, how did you train staff to ask about REAL demographic data?

Vivian Anugwom: So, I think that the initial rollout of that happened before I came into this role, and so, what I will be doing next year is understanding what folks know and what else they need to be able to ask that question or those ask for that information. So hopefully I can share that some other time.

Brooke MacCourtney: Yeah. Okay. Hope asks, "Do you think companies could benefit from having the implicit bias course as part of the list of corporate compliance competencies for employees annually rather than offering the course as an elective?"

Vivian Anugwom: So for us, the foundational bias training will be mandatory as we are replacing one of the trainings we've had to date. So I do think that there is a level of, yes, you should have the foundational training mandatory just to at least start to build some of that awareness for folks that maybe aren't as convinced, but I don't think it ends with just training. I think you have to integrate conversations and spaces for folks to be vulnerable and explore their own journey, talk about their experiences, ask questions with their colleagues I think it's a both and because training only does so much, you have to then start to think about how do we actually incorporate it into our operations.

So for example, I'm really interested in seeing how do we incorporate this concept of bias, or at least awareness of bias, into our huddle process? And also, looking at patient or visitor concerns or issues, doing a root cause analysis to say, "Did bias actually... Could bias have entered into this situation and how the

outcome or influenced the outcome." So, I think beyond training, there's opportunity to go the next level to say, "How do we actually increase or integrate the concept into the way we do our work.

Brooke MacCourtney: Perfect. We are at the top of the hour. I'm going to just see if we can get in one or two more questions, and then we'll go ahead and wrap up. Okay. Samar asks, "Thank you for the presentation, one of my questions is whether you have, before or now, worked with any urban city planners and health equity work? Plus was wondering what type of work people in urban planning professions can do and with an organization like yours.

Vivian Anugwom: So no, we have not, to my knowledge done any of that work and I would love to explore that with you. I'm always curious to see how we can collaborate with others. It's crucial. So feel free to send me an email. We can talk.

Brooke MacCourtney: Perfect. Okay. Let's do one more question. Maybe two more if we can get them in. Okay. Jessica asks, "What has been the biggest challenge or mistakes your team has learned from mistakes with such diverse populations in such a challenging time in our County?

Vivian Anugwom: I think I would just highlight the opportunity, I keep saying that, but the opportunity to authentically engage patients and community in the solution. So co-creating the solutions together. I think that, in the past we've done a lot of, "Okay, we have this issue, let's go ask them about it." And then we go back internally and fix it. I think there's an opportunity to say, "Hey, there's this issue that either community, patients have lifted up or, we've seen internally, let's talk about the issue. Let's, co-create the solution together." I think that that is one of the learnings that we have. And, it'll take time for our teams to get comfortable doing that in terms of just working outside of ourselves, but I think, it's crucial for us to see lasting change.

Brooke MacCourtney: Perfect. Okay. I think I'm going to make this, our last question, if you do have more questions, Vivian's email is up on the screen and you can go ahead and email her with your questions, but we'll try and just do one more live. So Charles asks, "How are you measuring the impact of the implicit bias training?"

Vivian Anugwom: Yeah. So, I think beyond, well the, let me see if I can go back. So we have this measure on our scorecard, so we are looking to see if the referral rates are improving, but I think going forward we'll continue to monitor changes, but we will also be in a better position respond to any... So, as we look monthly to see if we're not meeting goal a couple months in a row, we want to be able to pivot quickly and address the issue and say, "What changes do we need to make in our implementation to be able to be agile and respond to unfavorable outcome."