EMPRO INSURANCE

Welcome!

Annual Patient Safety Conference

Agenda:

8:30 AM – 9:00 AM
Registration & Continental Breakfast

9:00 AM – 9:15 AM
Welcome & Introduction
- Bruce Shulan, President & CEO, EmPRO
  Dawn Lewis, VP of Healthcare Facilities Underwriting, EmPRO*

9:15 AM – 10:15 AM
Pursuing Equity in Healthcare
- Ronald Wyatt, MD, Chief Science and Chief Medical Officer, The Society to Improve Diagnosis in Medicine

10:15 AM – 11:15 AM
Developing Partnerships with Patients, Residents in Long-Term Care, and Families: A Strategy to Enhance Safety, Quality, and Equity
- Beverley H. Johnson, FAAN, President and Chief Executive Officer, Institute for Patient- and Family-Centered Care (IPFCC)

11:15 AM – 11:30 AM
Break

11:30 AM – 12:30 PM
Improving Trust and Identifying Bias: Brooklyn Health Equity Index
- K. Torian Easterling, MD, Senior VP for Population and Community Health and Chief Strategic and Innovation Officer, One Brooklyn Health

12:30 PM – 1:30 PM
Lunch

1:30 PM –2:30 PM
Current Malpractice Climate
- Thomas J. Benvenuto, Esq., Senior Trial and Managing Attorney, Benvenuto & Gaujean

2:30 PM –3:30 PM
2-Second Decisions: The Secret Formula for Leading Change by Making Winning Choices
- Michelle Rozen, PhD, "The Change Doctor"

EMPRO INSURANCE Annual Patient Safety Conference

**PRIMMA LLC is the manager for EmPRO Insurance Company*

Annual Patient Safety Conference

EMPRO INSURANCE

Pursuing Equity in Health and Healthcare

Presenter:
Ronald Wyatt MD, MHA Senior Fellow IHI
Founder and President Achieving Healthcare Equity, LLC

Pursuing Equity in Health and Healthcare

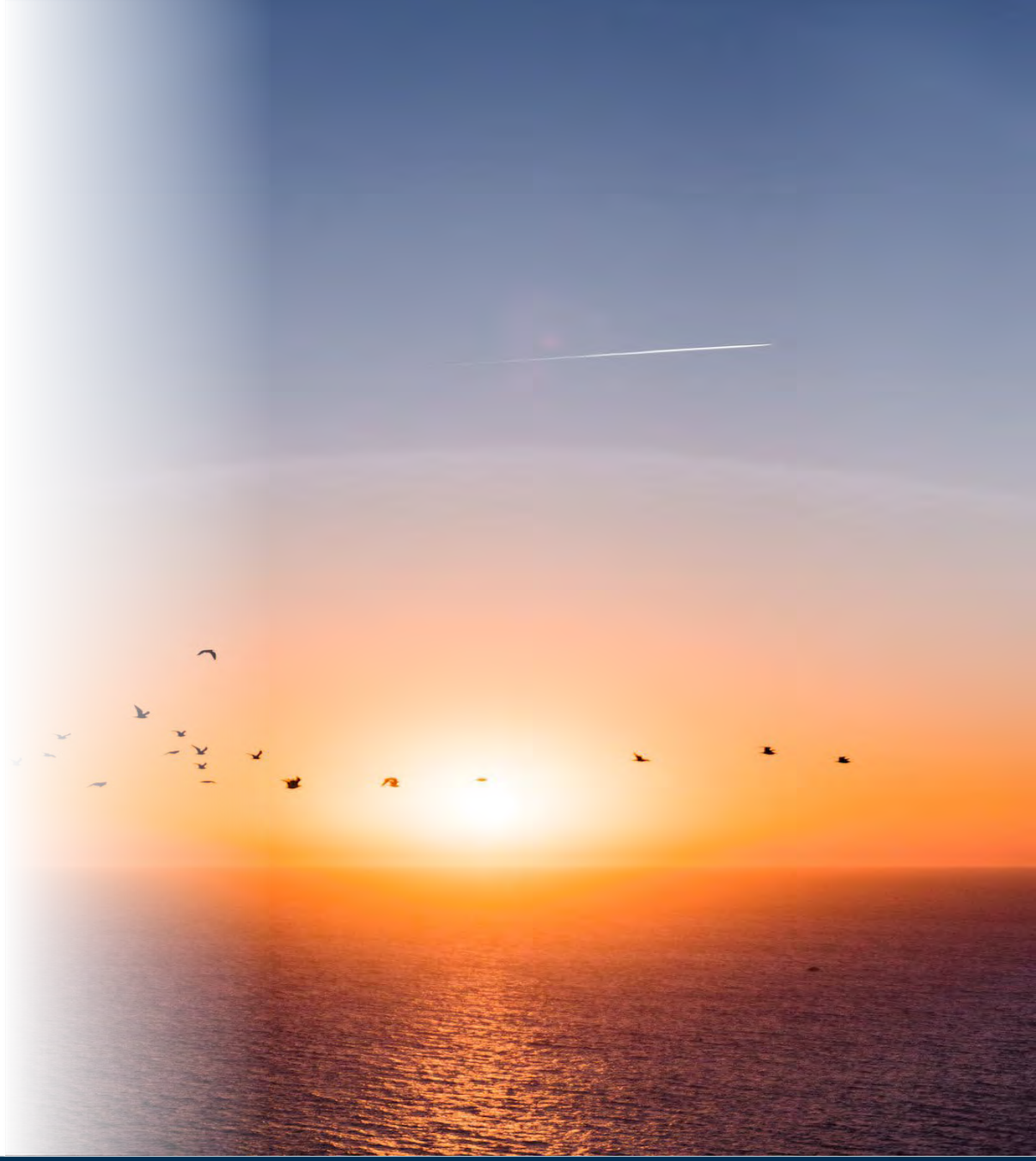
Presenter: Ron Wyatt MD, MHA Senior Fellow IHI

Founder and President Achieving Healthcare Equity, LLC

GRATITUDE

To all involved in advancing this work within EmPRO to advance Health Equity and through your efforts set the stage for the future.

Thank you.



Objectives

By the end of this session, we will:

- **Create a shared mental model for the definition of health equity**
- **Identify root causes of inequity in health and health care as a risk**
- **Become familiar with regulatory and accreditation requirements for health equity**
- **Understand actions to address health and health care inequity**

The Equity and Safety Connection

There is no Safety without Equity

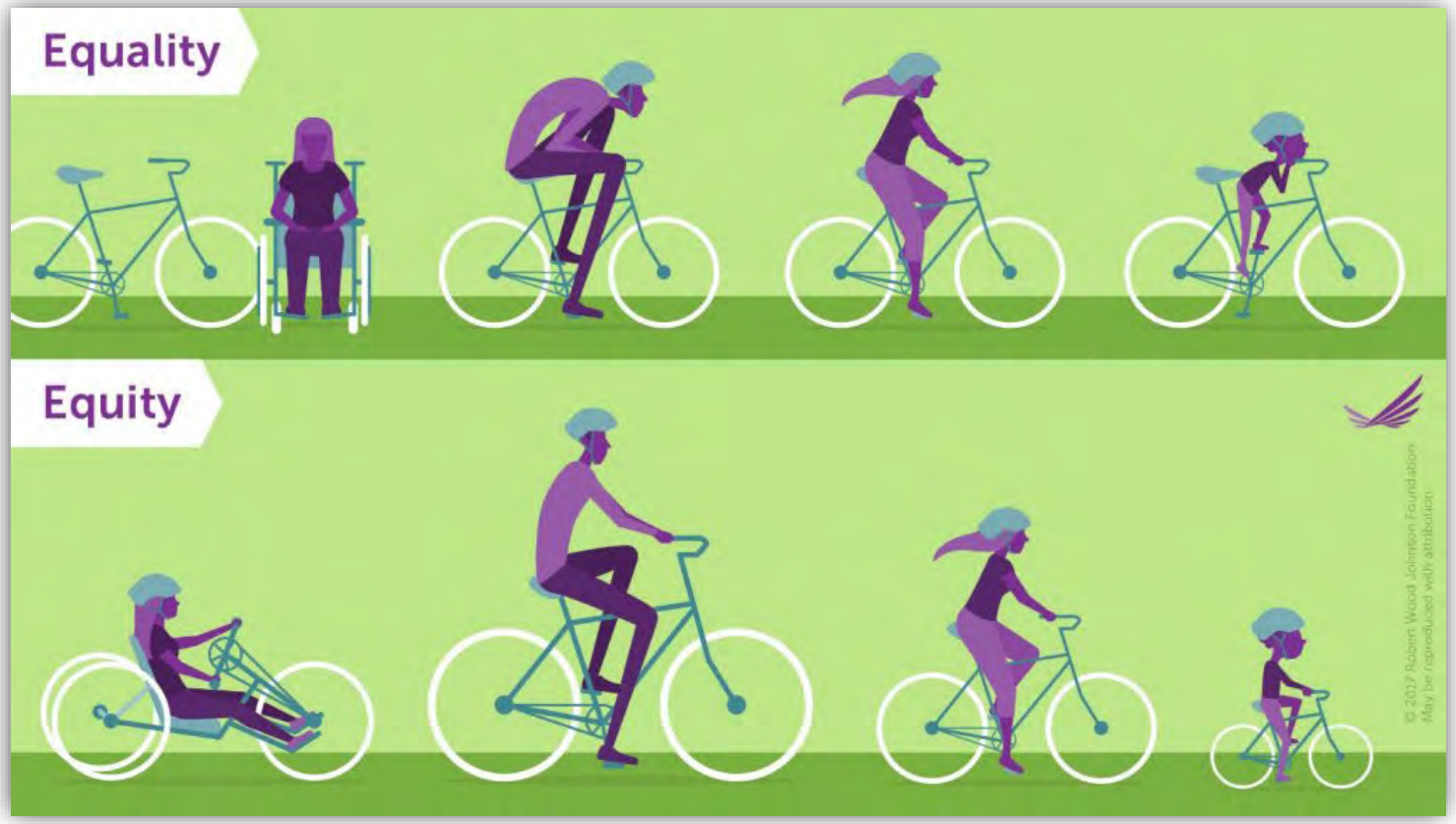
There is no Equity without Safety

Equity must not be assumed

What is Health Equity?

Why Health Equity?

We work in inequitable systems: As a result of how our economic, social, and health care systems are built, not everyone has a fair and just opportunity for health.



Defining Health Equity

Photo by Shane Rounce on Unsplash

Health equity:

The attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.

Retrieved from cms.gov

Commonly Used Definitions

Health inequity:

The difference in health outcomes between groups within a population

Health inequity simply denotes differences, whether unjust or not

We often look for disparities in health outcomes or health care experience data as a sign of health inequity

Photo by Ryoji Iwata on Unsplash

Commonly Used Definitions

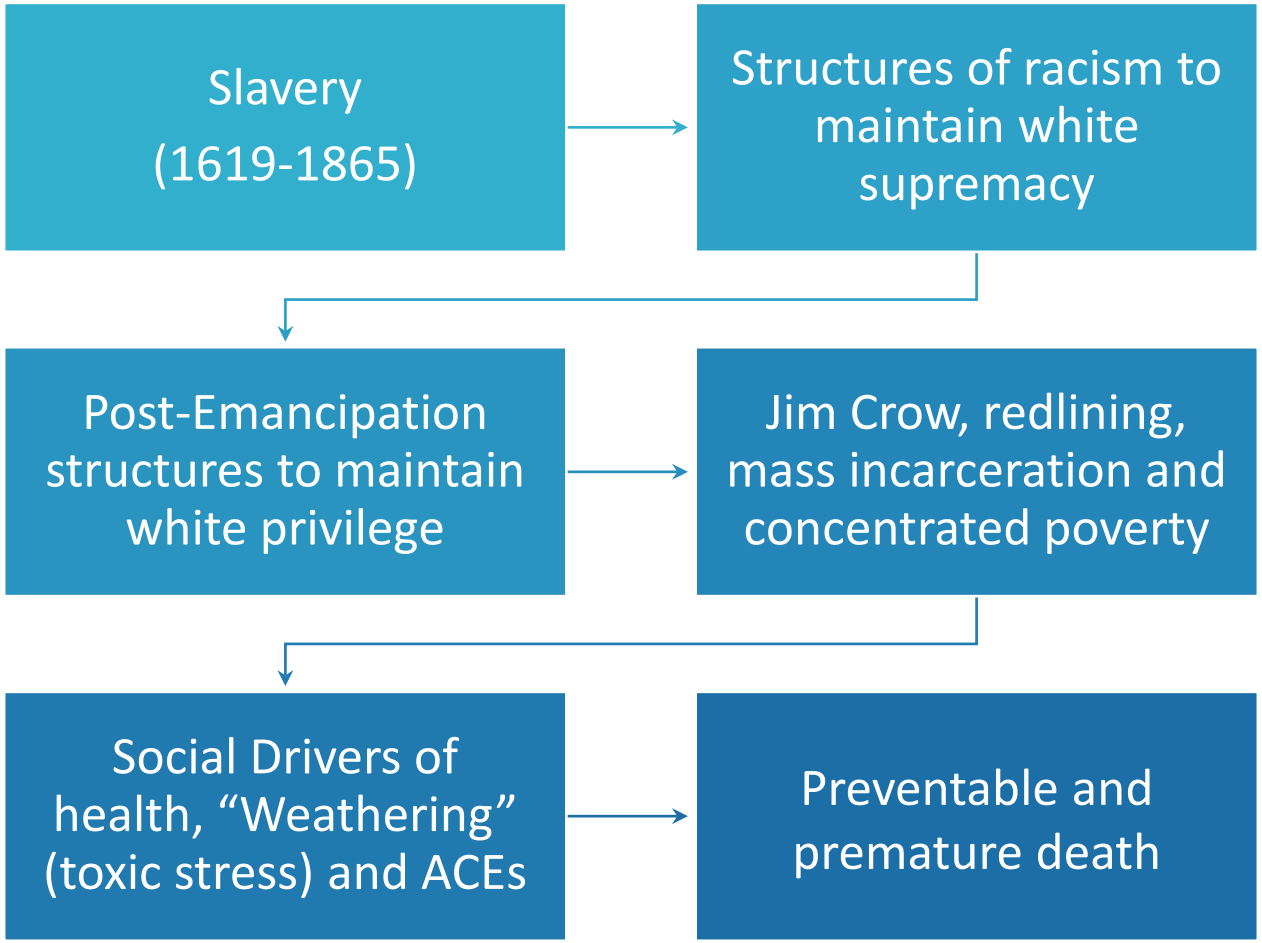
Multiple determinants of health:

The health care services, social factors, physical environment, and healthy behaviors that directly or indirectly determine health

This includes policy and advocacy activities that health care organizations can conduct to achieve health equity

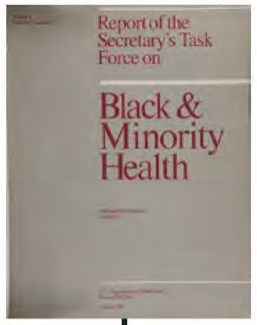
Photo by Hannah Busing on Unsplash

“Every system is perfectly designed to get the results that it gets”



Health Equity Timeline

1985:

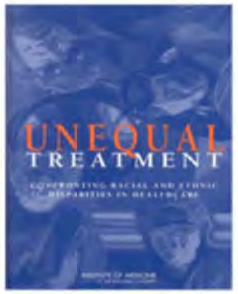


OMH U.S. Department of Health and Human Services Office of Minority Health

1999:

1999

2003:



2020:

2023:

The Joint Commission

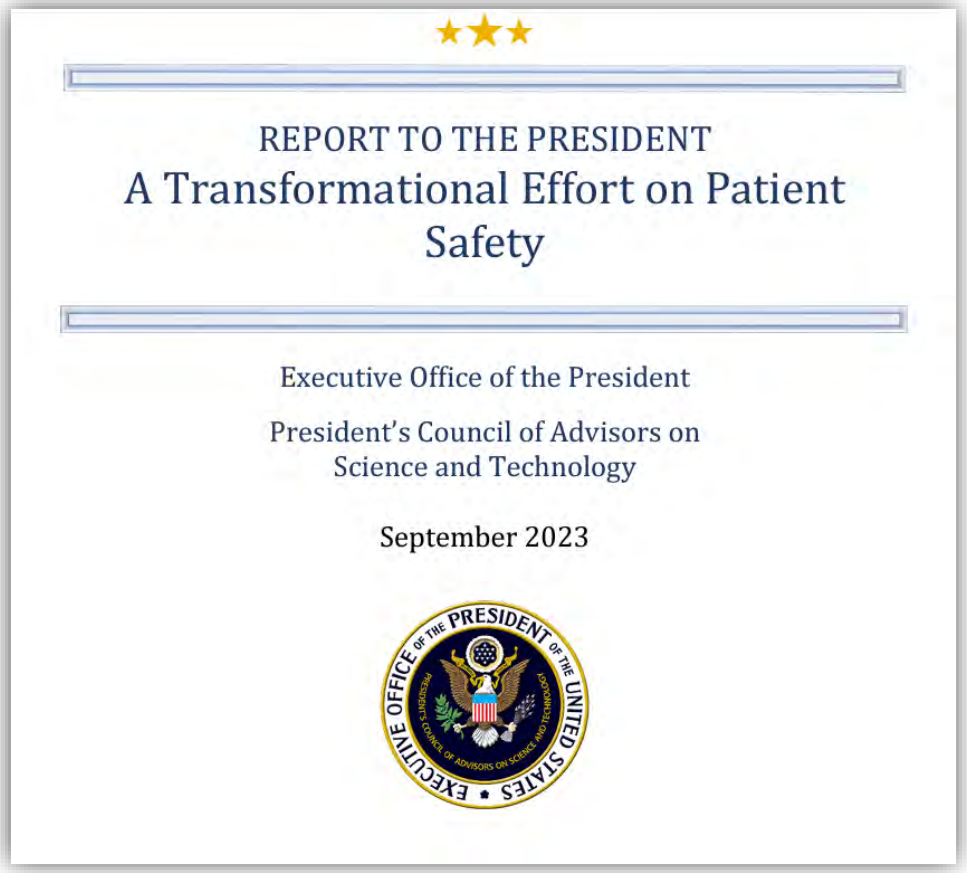
Prepublication Requirements

• Issued December 20, 2022 •

Health Care Equity Standard Elevated to National Patient Safety Goal

2023:

The President's Council of Advisors on Science and Technology (PCAST) and Equity



★★★

REPORT TO THE PRESIDENT

A Transformational Effort on Patient Safety

Executive Office of the President

President's Council of Advisors on Science and Technology

September 2023

"It is crucial to engage relevant stakeholders in the nation's effort to reduce harm from unsafe care. This should include partnering and collaborating with the patients, families, and communities ***most impacted by unsafe care.*** Implementing evidence-based solutions in healthcare settings should include patient-centered approaches and give special attention to collaborating with those communities that have experienced ***long-standing disparities."***

Disparities in Patient Safety Events


RESEARCH REPORT

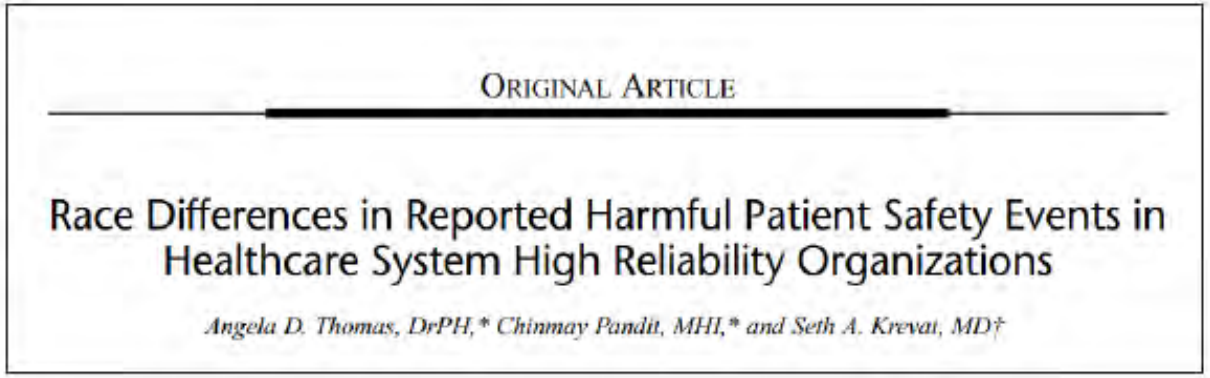
Do Black and White Patients Experience Similar Rates of Adverse Safety Events at the Same Hospital?

Anuj Gangopadhyaya

July 2021

URBAN INSTITUTE

Robert Wood Johnson Foundation


ORIGINAL ARTICLE

Race Differences in Reported Harmful Patient Safety Events in Healthcare System High Reliability Organizations

Angela D. Thomas, DrPH, Chinmay Pandit, MHI,* and Seth A. Krevat, MD†*


ORIGINAL RESEARCH

Inpatient patient safety events in vulnerable populations: a retrospective cohort study

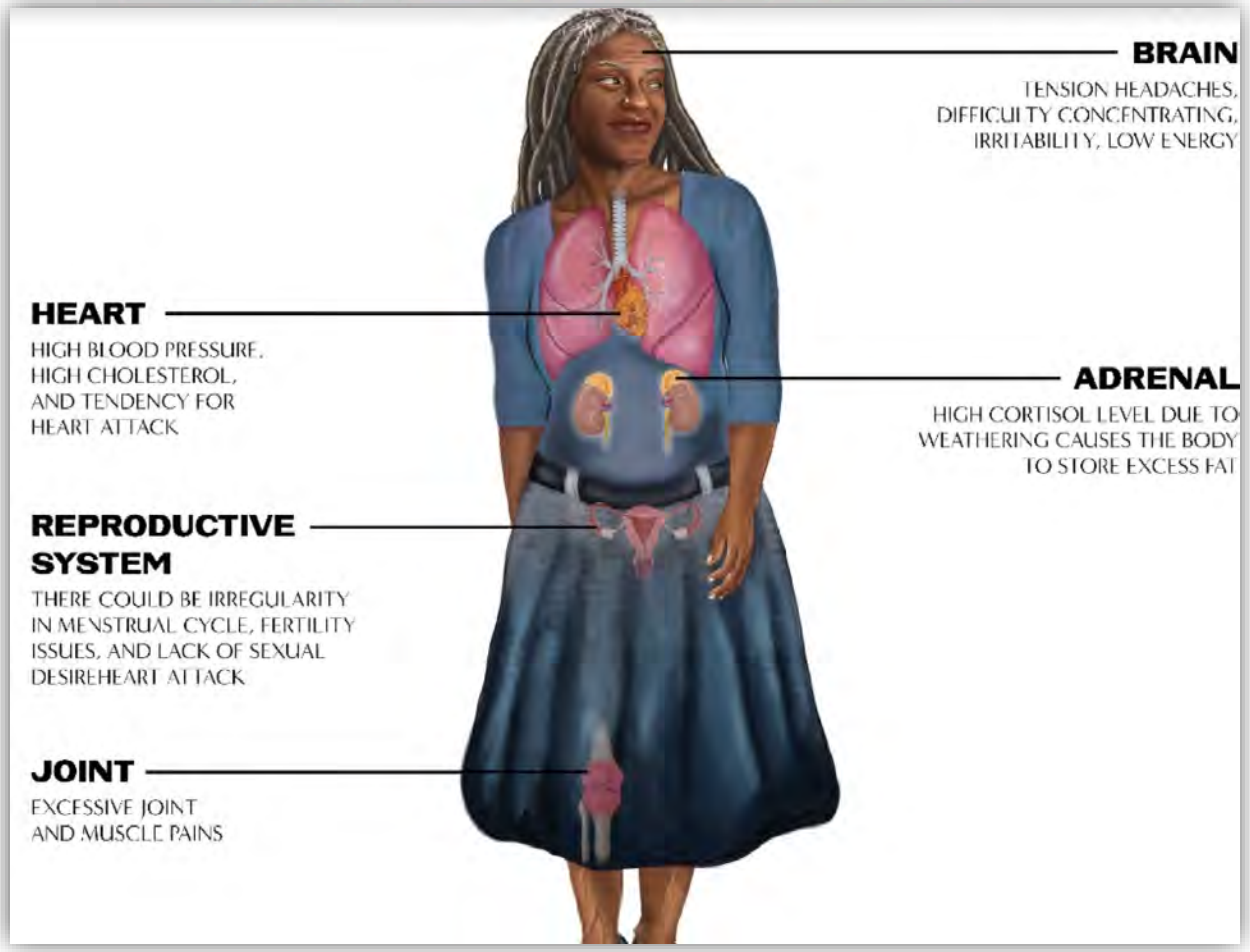
Lucy B Schulson [1,2] Victor Novack,[3,4] Patricia H Folcarelli,[5,6] Jennifer P Stevens,[3,7] Bruce E Landon[3,6,8]

ECRI

WHO DO YOU SERVE?

Age, disability, gender, marriage and civil partnership, pregnancy and maternity, race, religion , sexual orientation	• Protected Characteristics
Education, low income, occupation, unemployment, incarceration or formerly incarcerated	• Populations at high social risks
Built environment, social connectedness, rural, urban, coastal	• Geography
African American/Black, American Indian, Alaska Native, Pacific Islander	• Inclusiveness and vulnerable populations and communities

Who You Serve : Do You Know?



Afib/Stroke
- Facial droop/weakness
- Irregular heart rhythm
- Diagnostic error

“Weathering”
- HTN, High Cholesterol
- Irregular menstrual cycle
- High cortisol
- Low energy

Pre-Eclampsia
- HELLP Syndrome
- Pitting (leg swelling)
- Fetal growth restriction

Sickle Cell Crisis
- Under treatment of pain
- Stereotype bias (“drug seeking”)

Achieving Health Equity Requires Total System Safety

Culture, Leadership, Governance	• Declare equity a priority and create an action plan
People, Family, Community Activation	• Co-develop and test cultural and structural relevant communication
Learning System	• Support continuous learning and shared lessons to improve safety and quality of care and mitigate risk of harm
Workforce Safety	• Create a work culture of expression and inclusion

Culture, Leadership and Governance

Safety Strategy

Leadership	Bold and courageous leaders willing to do what is right, address harm and provide resources. Routinely share harm events at board level.
Build Awareness	"How is harm occurring here?" Build will with data and stories
Culture	Psychological safety for difficult conversations about error and move away from blame towards just culture
Transparency	Move from fear of litigation towards sharing, learning and improvement. Disclosure to patients and apologize
Aligning Incentives	TJC CMS

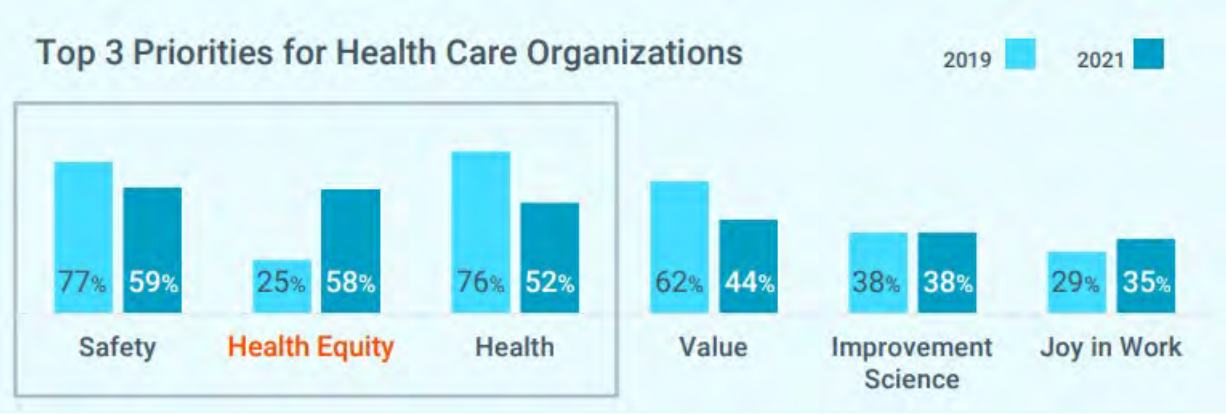
Parallel for Equity

Leadership	Bold and courageous leaders willing to do what is right, talk about systemic racism and invest in making improvements Routinely share harm events at board level.
Build Awareness	" How does racism operate here?" Build will with data and stories
Culture	Psychological safety for difficult conversations about racism and move away from blame towards accountability.
Transparency	Move from fear of litigation about inequities towards sharing, learning and improvement. Restorative justice: Bring people together to talk about incidents.
Aligning Incentives	TJC- Standards, NPSG, Certification CMS: COPS

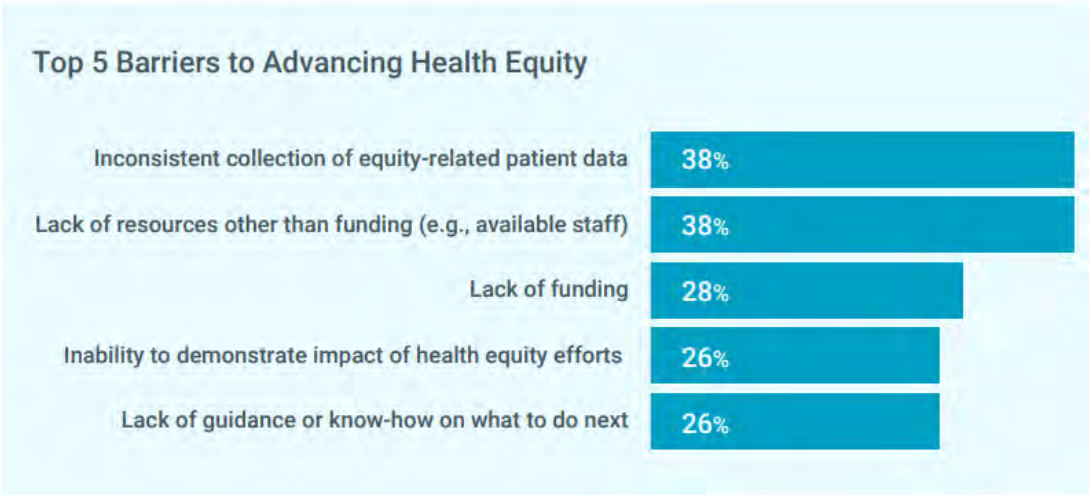
Adapted from: Sivashanker K, Gandhi T. "Advancing safety and equity together." *New England Journal of Medicine*. 2020 Jan 23;382:301-303

Health Equity is a Quality and Safety Priority

Top Three Priorities of Health Care Organizations



Barriers



https://www.ihi.org/Topics/Health-Equity/Documents/IHI-2021-Pulse-Report_Health-Equity-Prioritization-Perception-Progress.pdf

Contributory Factors Related to Increased Risk of Inequity Safety Events

System	Provider	Patient
• Segregated healthcare based on insurance status • Financial barriers to access • Low resourced systems • Race-based algorithms • Bias is education and training • Lack of culture of safety and psychological safety • Leadership failures • Overworked care teams • Lack of diverse workforce leadership	• Poor communication between care giver and people seeking care • Differences in language, gender, culture, social status • Care giver bias and stereotypes • Structural competence • Mistrust	• Social risks • Low health literacy • Language barriers • Comorbidities • Lived experience • Lack of empowerment • Earned mistrust

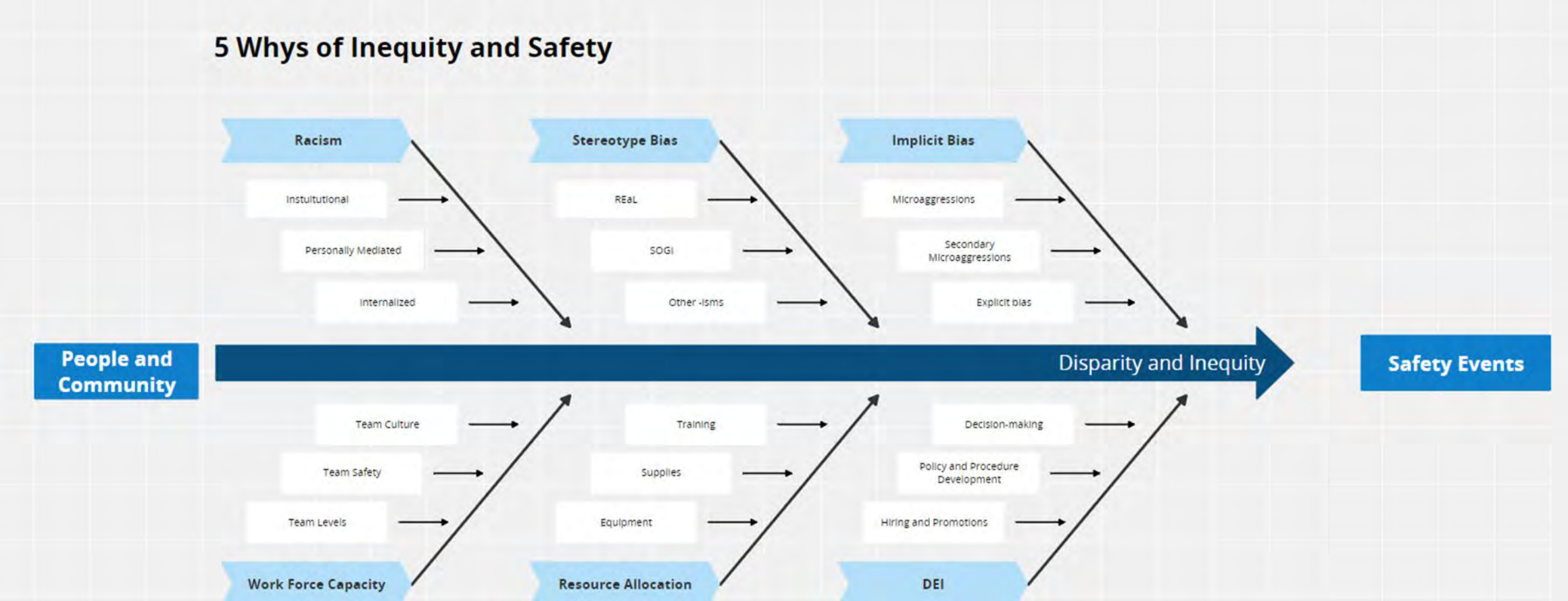
Source: Shulson, L et al RAND 2022

Root Causes of Inequity

- Bias
- Trust
- Structural Competency
- Racism

"I think unconscious bias is one of the hardest things to get at."
- Late Supreme Court Justice Ruth Bader Ginsburg

Inequity is an Unsafe Condition



Top 10 Patient Safety Concerns 2022

Bias and Racism in Addressing Patient Safety

Racial and ethnic disparities have been well documented in how they affect access to care and outcomes. What is less well publicized is that disparities can even affect how adverse events are reported and responded to.

To learn more about other aspects of racial and ethnic disparities in health and healthcare, see ECRI and the ISMP Deep Dive executive summary.

Although patients from racial and ethnic minority groups are more likely to experience an adverse event while in the hospital, providers are **significantly less likely to report harmful events for patients from minority groups** than for white patients.

In one study, the odds of reporting patient safety events in African American patients were only **0.65 times** the odds of reporting in white patients.

Sources: Thomas et al.; Thurtle et al.

Black adult patients experienced significantly worse patient safety events in 6 of 11 health indicators compared with white adult patients of the same gender, treated in the same hospital, and with similar insurance coverage.

Source: Gangopadhyaya

Patient Safety Event Analysis- Staff and Patient Interactions

- ECRI and the ISMP PSO analysts reviewed data on 503 relevant race- or ethnicity-related events submitted by healthcare organizations
- Timeframe July 1, 2019, and June 30, 2020

- Patient/family making inappropriate comments regarding race or ethnicity
- Patient saying that others are racist
- Patient/family report of disparate care because of patient/family race or ethnicity
- Staff making inappropriate comments regarding race or ethnicity
- Staff report of management or supervisor discrimination against them
- Patient request for other provider or staff member based on their current provider/staff member's race or ethnicity
- Interpretation or translation not provided (or suboptimal care because of language barrier)

Implicit Bias

A tendency of inclination that results in judgement without question

An automatic response

A shortcut to interact with our world

Implicit Bias

Judge rules racial bias present in misdiagnosed Seattle child abuse case

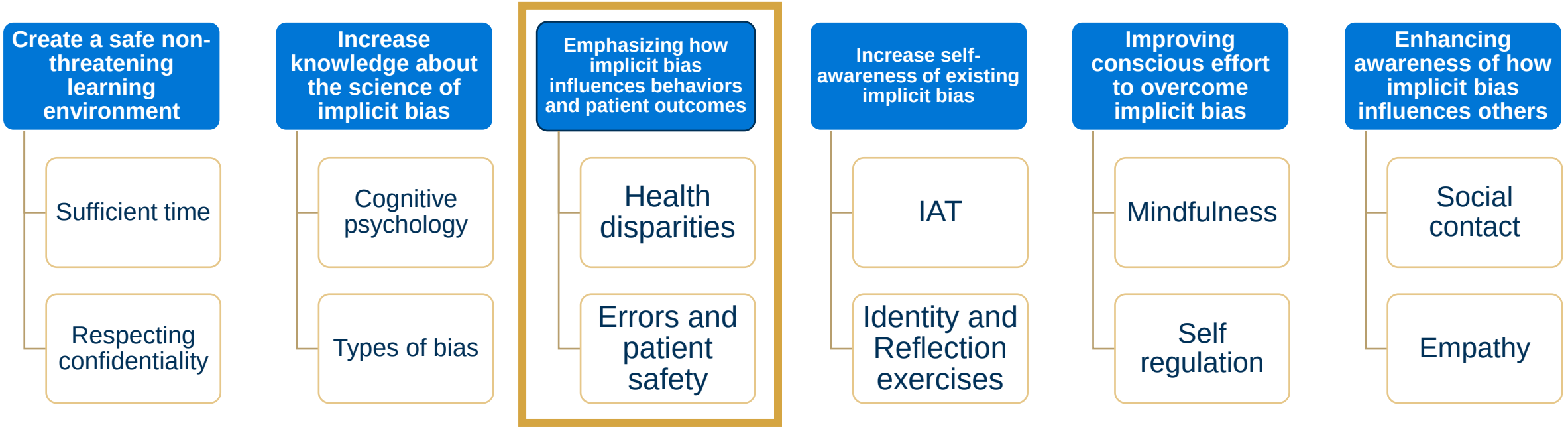
A couple dealt with terror triggered by a doctor at Seattle Children's, whose wrongful diagnosis of child abuse took their baby away from them.

SEATTLE - A couple dealt with terror triggered by a doctor at Seattle Children's, whose wrongful diagnosis of child abuse took their baby away from them.

What Purpose Does Bias Serve?

- Ensures our survival
- Part of automatic survival tendency
- Natural tendency to feel comfortable with people like us

Framework for integrating implicit bias awareness and management into health professional education



Adapted from Sukhera J, Watling C. *A framework for integrating implicit bias recognition into health professions education*. Acad Med. 2018;93(1):35-40

Actions to De-Bias

1. **Individual Level** – 1) Develop self-awareness about implicit biases and 2) Seek out strategies, such as perspective taking and emotional regulation training, to manage implicit biases that can negatively impact patient care.

2. **Institutional/Organizational Level** – 1) Develop a culture of open communication about implicit bias, 2) Encourage patient advocacy, 3) Enhance utilization of community resources to reduce access barriers, and 4) Invest in quality improvement to provide feedback on clinical interactions with consumers of care and family that may be susceptible to provider implicit bias.

3. **Educational Level** – 1) Provide hospital-wide implicit bias training for all employees who provide direct patient care, 2) Integrate perspective taking and empathy building trainings in medical school and clinical rotations, and 3) Reinforce implicit bias training for trainees during supervision.

4. **Scientific/Research Level** – 1) Use operationalized definitions and rigorously evaluate interventions for implicit bias, 2) Focus on implicit bias outcomes in the population served.


WHAT IS
RACISM?

Racism

A system of structuring opportunity and assigning value based on the social interpretation of how one looks (which is what we call “race”), that…

- Unfairly disadvantages some individuals and communities
- Unfairly advantages other individuals and communities
- Saps the strength of the whole society through the waste of human resources
- Creates unsafe conditions

Commonly Used Definition

Institutional (or institutionalized) racism:

The differential access to the goods, services, and opportunities of a society by race or skin color

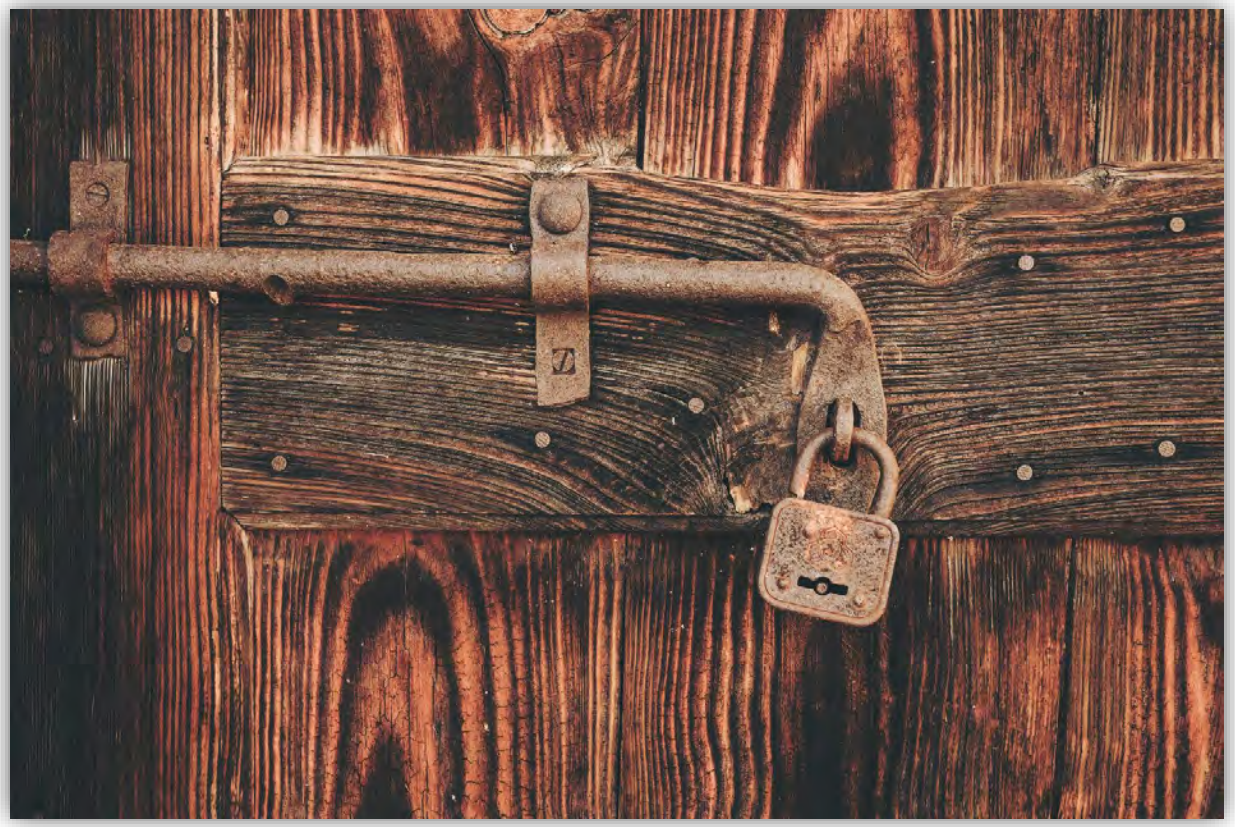


Photo by Cristina Gottardi on Unsplash

“

You cannot dismantle what you cannot see. You cannot challenge what you do not understand.

— Layla Saad

Structural Shifts: Confronting Racism

Lack of Accounting for Racist Past

Certain Bodies Cherished More

Current State

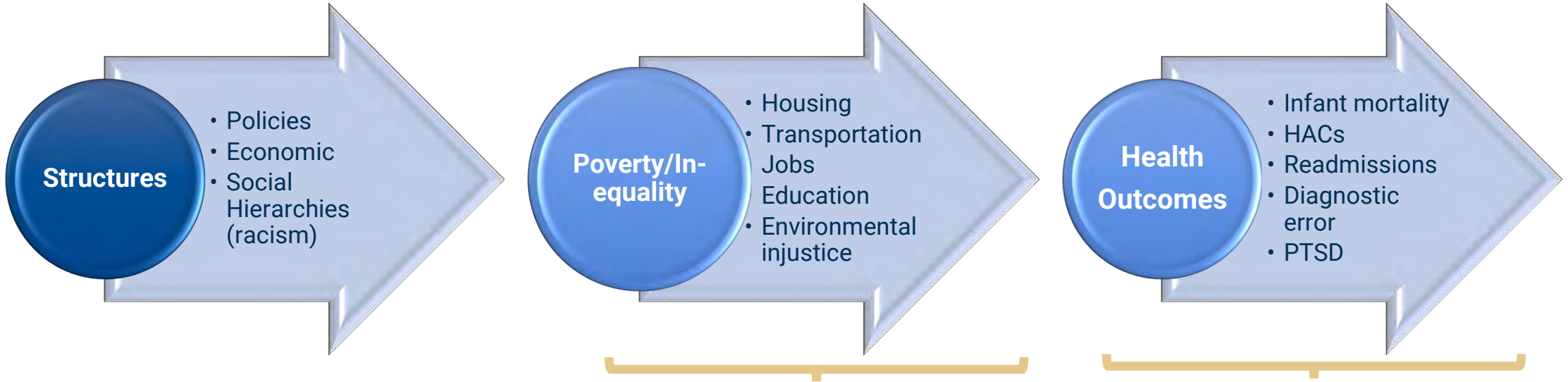
- We have not reconciled the deep racism that is still embedded in today's health care system
- White, male, cisgendered and nondisabled health and well-being are consistently valued over the lives of BIPOC, women, transgender, and disabled people

Future State

- Key institutions across the health system are actively engaged in a meaningful process of truth and reconciliation around past and present racism in their systems
- We have a shared culture in which all lives are valued equally

Structural Competency

Structural Determinants



Drivers of health

Health Disparity

Structural Competency

Volume 11, Issue 1, March 2023, 100675

A Matter of Trust: Commitment to Act for Health Equity

American Board of Internal Medicine®

ABIM FOUNDATION

UCSF

Institute for Healthcare Improvement

Parkland

scan HEALTH PLAN®

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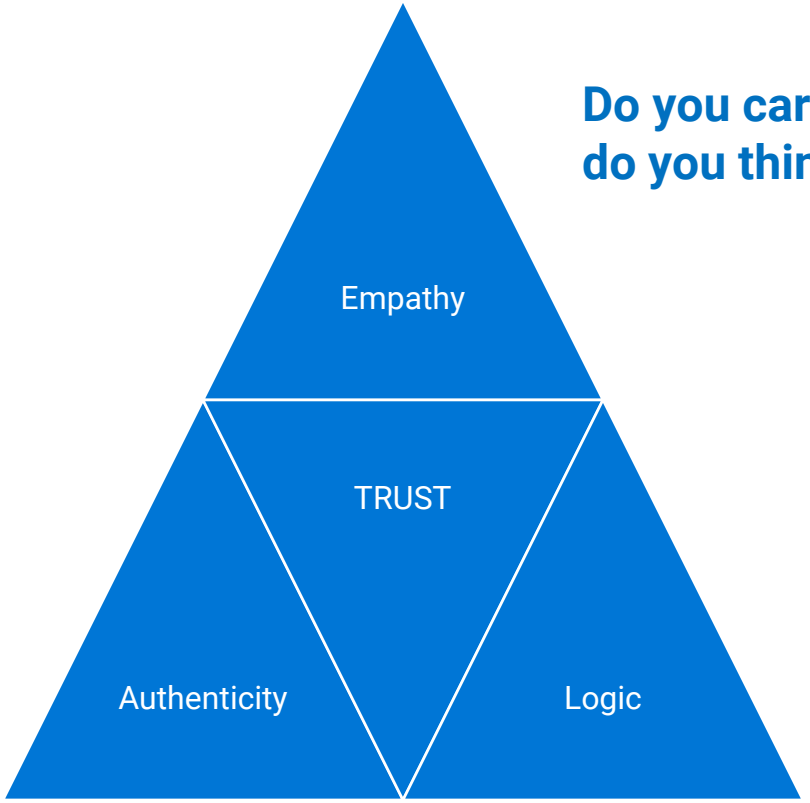
The Trust Triangle



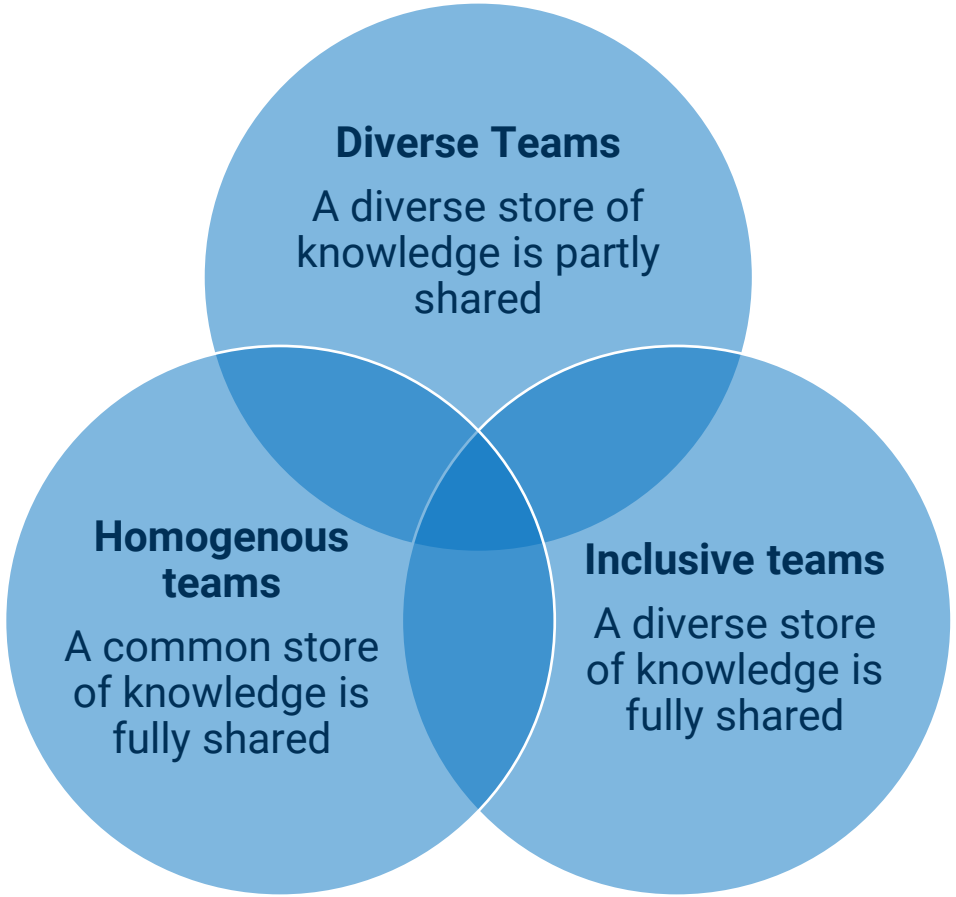
Do you care about me or do you think more about yourself?

Show me the real you and I will follow. How diverse is the team?

You have sound reasoning and judgement, so you can do it? If you don't trust your own judgement, why should I?

Adapted from: " Begin with Trust" by Frances Frie and Anne Morris, HBR May-June 2020.

Begin with Trust



"Begin with trust," Frei and Moriss, HBR 2020

A Matter of Trust

- Prioritizing racial and health equity by leadership/governance
- Leveraging payment to achieve racial and health equity
- Medical education and training
- Centering racial and health equity in health services research
- Accountability to communities most impacted by racial and other health inequities
- Measurement and reduction of racial and other health inequities
- Expanding and ensuring access to high-quality, patient- and family-centered, whole person health care

Trust Metric Domains and Indicators Are Community-Informed

Neighborhood-Level Trust (i.e., social cohesion)

Trust Metric Domains	Sample Indicators
Social connectedness and reliability	In general, people in my neighborhood are willing to help one another
Safety, peace, and crime	My neighbors respect others' property as if it were their own
Youth-focused safety and engagement	It is safe for my kids to play in this neighborhood
Solid infrastructure, cleanliness, and pride	There is frequent illegal dumping of trash or waste in my neighborhood
Opportunities to engage socially	My neighborhood has usable sidewalks

Institutional Trust

Trust Metric Domains	Sample Indicators
Reputation/track record	People in my community think **your system** is a safe place for people in my community to go
Offerings match needs/Listening begetting action	My community has influence over decisions that are made
Caring about people	Care teams truly care about people in my community
Opportunities for engagement/ accessibility	There are lots of barriers/red tape to getting services

The Health Management Academy and Spectrum Health Lakeland. 2022. "Health Equity in Action: Spectrum Health Lakeland's Trust Metrics"

Safety culture - segmented

	Ethnicity vs. Non-Hispanic or Latino	**Race** vs. White or Caucasian						**Sex** vs. Male
	Hispanic or Latino *(n = 12,236)*	American Indian or Alaska Native *(n = 665)*	Asian *(n = 9,035)*	Black or African American *(n = 16,007)*	Native Hawaiian or other Pacific Islander *(n = 383)*	Other *(n = 4,789)*	Two or more races *(n = 3,081)*	Female *(n = 113,660)*
Safety Culture-Prevention & Reporting	-0.01	0.01	**0.05**	**-0.04**	-0.06	**-0.05**	**-0.07**	**-0.05**
Mistakes lead to positive changes	0.01	0.01	**0.07**	**-0.04**	0.00	**-0.03**	**-0.07**	**-0.02**
Org is improving patient safety	0.00	0.01	**0.08**	-0.01	-0.02	**-0.03**	**-0.05**	**-0.03**
Mistake reporting is non-punitive	0.00	-0.02	**0.09**	**-0.08**	-0.04	**-0.05**	**-0.11**	**-0.02**
My team discusses error prevention	0.00	0.04	**0.05**	**-0.03**	-0.05	**-0.04**	**-0.04**	**-0.05**
Emp/Mgr work toward safe workplace	0.00	0.03	**0.09**	**-0.04**	-0.07	**-0.06**	**-0.07**	**-0.05**
Emp speak up re: poor patient care	-0.01	0.00	**0.02**	**-0.03**	-0.04	**-0.06**	**-0.06**	**-0.06**
Can report mistakes without fear	**-0.03**	0.00	-0.01	**-0.06**	**-0.15**	**-0.10**	**-0.08**	**-0.06**
Can raise workplace safety concerns	**-0.03**	-0.03	0.01	**-0.06**	**-0.10**	**-0.09**	**-0.09**	**-0.08**

Bold indicates statistically significant difference from comparison group.

Model controls for project. Prefer not to Answer responses excluded.

On average, employees who identify as **Hispanic or Latino** score 0.03 points lower on **"Can raise workplace safety concerns"** vs. employees who identify as Non-Hispanic or Latino in the same system and job category.

For a 50th percentile facility:

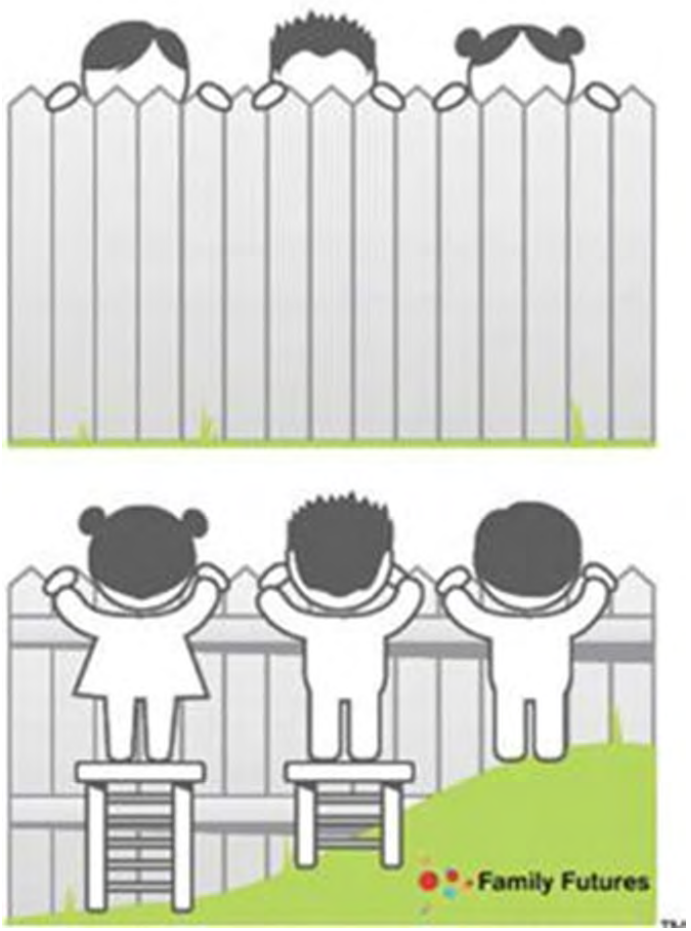
+ 0.05 = increase of 9-13 percentile ranks

- 0.05 = decrease of 8-10 percentile ranks

(2021 Nat'l Healthcare Avg)

PressGaney

Regulatory and Accreditation



OMH
U.S. Department of
Health and Human Services
Office of Minority Health

Partnership for
Quality Measurement

THELEAPFROGGROUP
Giant Leaps for Patient Safety

NCQA
Measuring quality.
Improving health care.

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

The Joint Commission

CMS

Commitment	**Establishing a Culture of Equity** • strategic planning, data collection, data analysis, quality improvement, and leadership engagement.
Drivers of health	**Screening for social needs** • food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.

CMS Maternal Morbidity Structural Measure

Participating in a structured state or national Perinatal Quality Improvement (QI) Collaborative; and

Implementing patient safety practices or bundles as part of these QI initiatives.

- **Answer choices: Yes, No, or N/A (does not provide inpt. L&D care)**

The Joint Commission

Make Health Care Equity a Leader-Driven Priority

Assess Health-Related Social Needs

Prioritize, Plan and Take Action

Use Data to Identify Disparities Across Patient Groups

Monitor Health Care Equity Progress

Inform Stakeholders About Progress

Evidence-based Interventions

National Patient Safety Goal to Improve Health Care Equity, Effective July 1, 2023

National Patient Safety Goal (NPSG), Goal 16:

Organizations will still be **required** to do the following:

- Identify an individual to lead activities to improve health care equity.
- Assess the patient's health-related social needs.
- Analyze quality and safety data to identify disparities.
- Develop an action plan to improve health care equity.
- Take action when the organization does not meet the goals in its action plan.
- Inform key stakeholders about progress to improve health care equity.

Continue Learning

1. **Total system safety cannot be accomplished with out achieving health equity**

2. Leaders must operationalize a health equity framework to strengthen and deepen their organization's quality alignment, engagement and improvement goals.

3. Health equity improvement is uncomfortable. Respect and humility must be integrated into the effort, learned and practiced in order to develop self reflective, inspiring, data driven and activating for leaders.

4. Ownership and leadership at all levels requires psychological safety, courage, and passion. Every organization has the power to act.

THE URGENCY OF NOW

A-historical Stance	• The present as disconnected from the past • Current distribution of advantage/disadvantage as happenstance • Systems and structures as givens and immutable
Myth of Meritocracy	• “If you work hard you will make it” • Denial of racism • Equal potential or equal opportunity?
Myth of the Zero-sum game	• “If you gain, I lose” • Fosters competition over cooperation • Masks the costs of inequity • Hinders efforts to grow the pie

Source: Camara Jones, 2021

Actions to Achieve Safety and Equity Together

- Evaluate and redesign systems that are more reliable and resilient.
- Reduce cognitive and unconscious bias that contribute to unintentional harm.
- Build a culture of safety that supports reporting of bias, prejudice, discrimination and racism.
- Focus on the process not the individual.
- Support respectful and professional behaviors

Adapted from: Sivashanker K, Gandhi T. Advancing safety and equity together. New England Journal of Medicine. 2020 Jan 23;382:301-303

I only ask that you care before it’s too late,
That you live aware and awake,
That you lead with love in hours of hate.
I challenge you to heed this call,
I dare you to shape our fate.
Above all, I dare you to do good
So that the world might be great

“An ode we owe”

Amanda Gorman 2022

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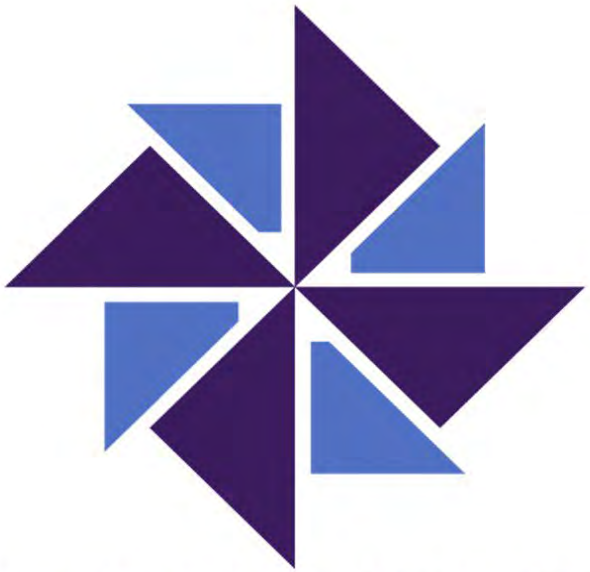
Developing Partnerships with Patients, Residents in Long-Term Care, and Families: A Strategy to Enhance Safety, Quality, and Equity

Presenter:
Beverley H Johnson, FAAN, President and Chief Executive Officer of the Institute for Patient- and Family-Centered Care (IPFCC)



INSTITUTE FOR PATIENT- AND FAMILY-CENTERED CARE

Developing Partnerships with Patients, Residents in Long-Term Care, and Families: A Strategy to Enhance Safety, Quality, and Equity

Beverley H. Johnson, FAAN
IPFCC President & CEO
EmPRO Annual Patient Safety Conference
New York Academy of Medicine
November 2, 2023

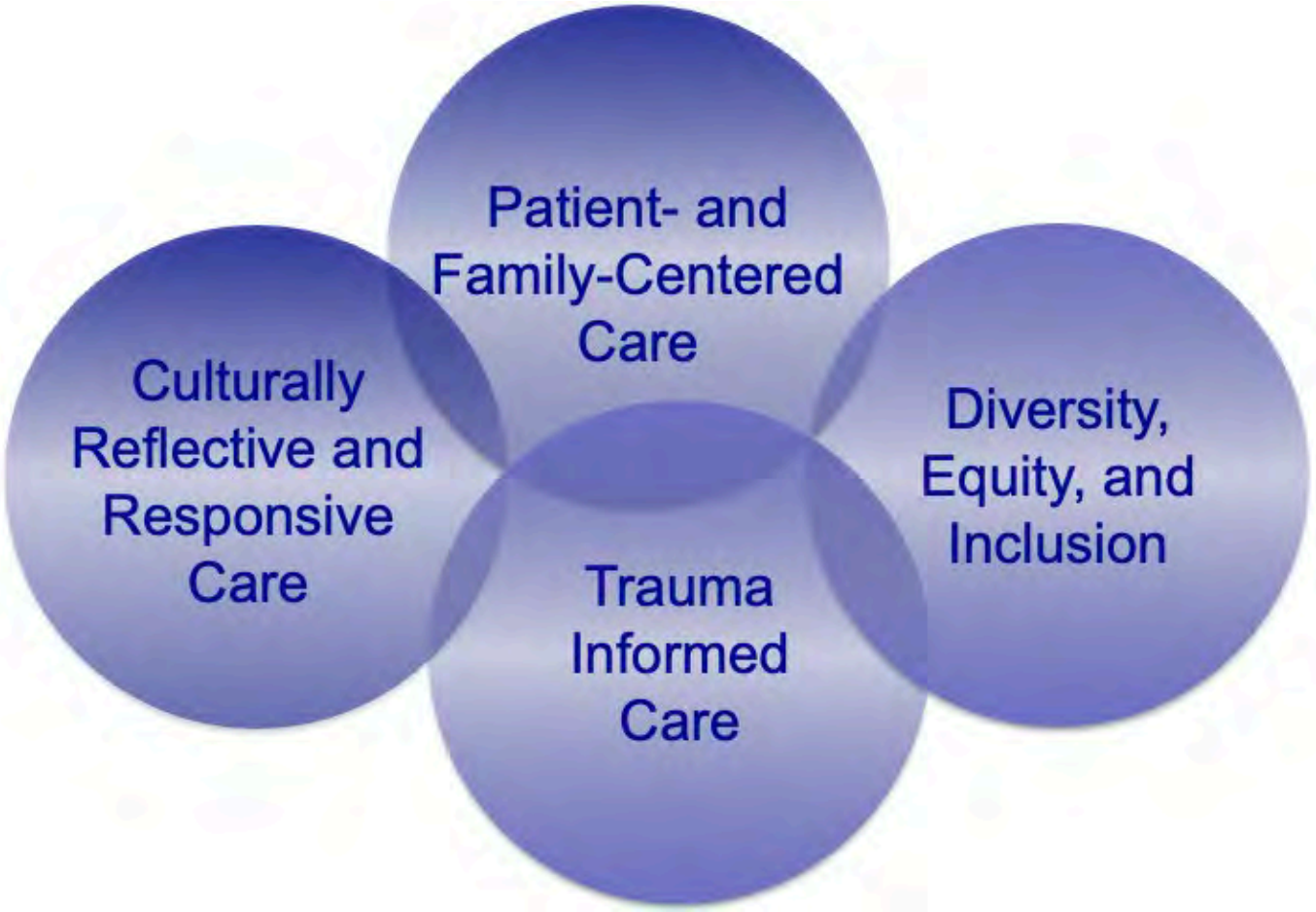
In our time together . . .

- Develop a shared understanding of patient- and family-centered care and how the core concepts are fundamental to improving safety, quality, and health equity.
- Discuss the strategies and benefits for developing meaningful partnerships with individuals and families served across the care continuum
- Describe emerging best practices following the pandemic and opportunities to reduce harm in the future.

Patient- and Family-Centered Core Concepts

- People are treated with **respect and dignity**.
- Health care providers communicate and share complete and unbiased **information** with patients and families in ways that are affirming and useful.
- Patients and families are encouraged and supported in **participating in care, care planning, and decision-making** at the level they choose.
- **Collaboration** among patients, families, and providers occurs in policy and program development, professional education, research, and innovation, as well as in the delivery of health care.

Inextricably Linked . . .



Transformational Change in Organizational Culture

Patient- and family-centered care provides the framework and strategies to **transform organizational culture** and improve the experience of care and enhance quality, safety, equity, and efficiency. It also can improve the work experience.

High Reliability Organizations

2014 . . . United States & Canada

Changing the Concept

From Families as "Visitors" to Families as Partners

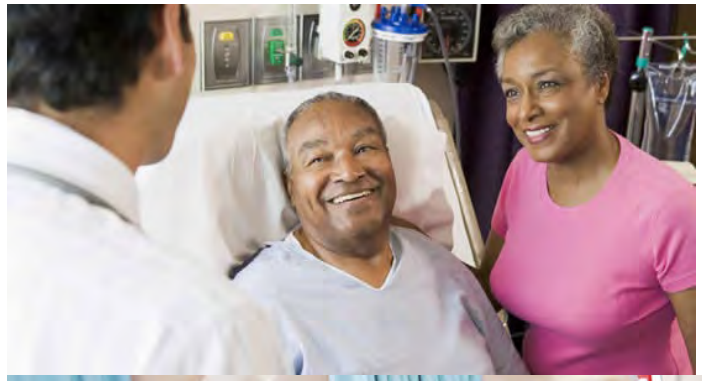
2014 American Society of Healthcare Risk Management

"Families of patients are not just visitors, they are a vital part of the team caring for the patient. ASHRM believes that changing the concept of families as 'visitors' to one of partnership is a **proactive approach to risk management."**

Jacque L. Mitchell, ASHRM President

Family Members/Designated Care Partners are NOT VISITORS

- Families/designated care partners are allies for quality and safety.
- Families are holders of vital information about the patient and are essential to transitions care.
- Families/designated care partners are the continuity for the patient.
- Families are contributors to mental health and well-being for all.



Evidence to Guide Practice . . .

Social Isolation is a risk factor . . .

Research is clear that isolating patients at their most vulnerable times from the people who know them best places them at risk for medical error, emotional harm, inconsistencies in care, and costly unnecessary care (Cacioppo & Hawkley, 2003; Clark, 2003).

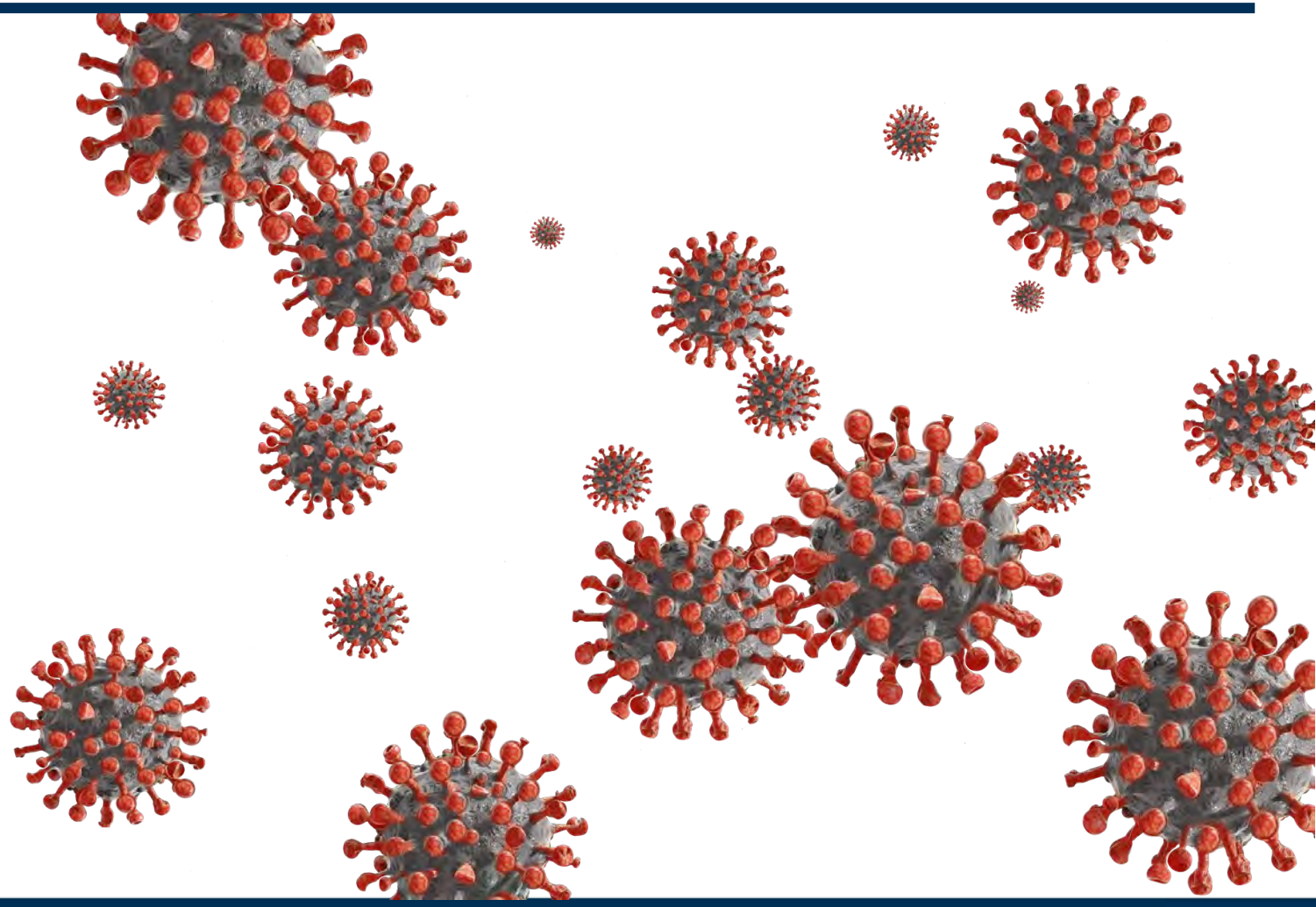
Evidence to Guide Practice . . .

Research indicates that for many older patients, hospitalization for acute or critical illness is associated with reduced cognitive function (Ehlenbach, 2010).

Families and other care partners are much more keenly aware of any change in cognitive function than hospital staff and therefore are a valuable resource during hospitalization.

2020 Response to COVID-19 . . .

Extreme Restrictions for Family Presence and Participation



Patient- and Family-Centered Care - True North

In a pandemic, the core concepts of patient- and family-centered care (PFCC) can serve as a North Star, to help inform decision-making, practices, and public health strategies.

Disruption of family connections has lifelong implications . . .

“The psychological impact of COVID-related separation on ICU families will reverberate for years and likely result in high numbers of people needing trauma-related services.”

Montauk & Kuhl, *Trauma Psychology,* 2020

Hospitals Separating Patients And Families Due To Covid-19 Causes Needless Suffering

"Restrictions on visitation made a little sense early in the Covid epidemic when hospitals and staff were overwhelmed, and we lacked a reliable supply of masks and personal protective equipment (PPE). It was cruel but could be justified . . .

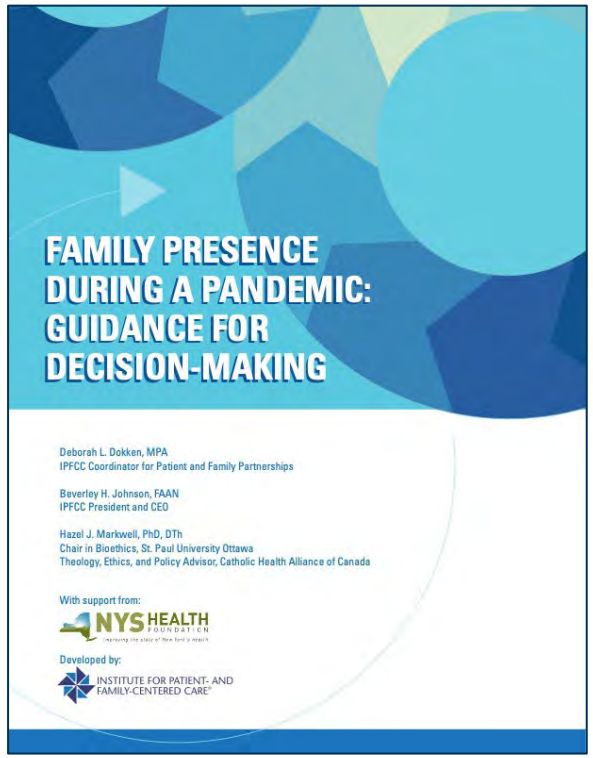
But this is no longer our reality. Now barring families from a patient's bedside is cruel and senseless."

Forbes, July 12, 2021

Well-Being of Staff and Clinicians

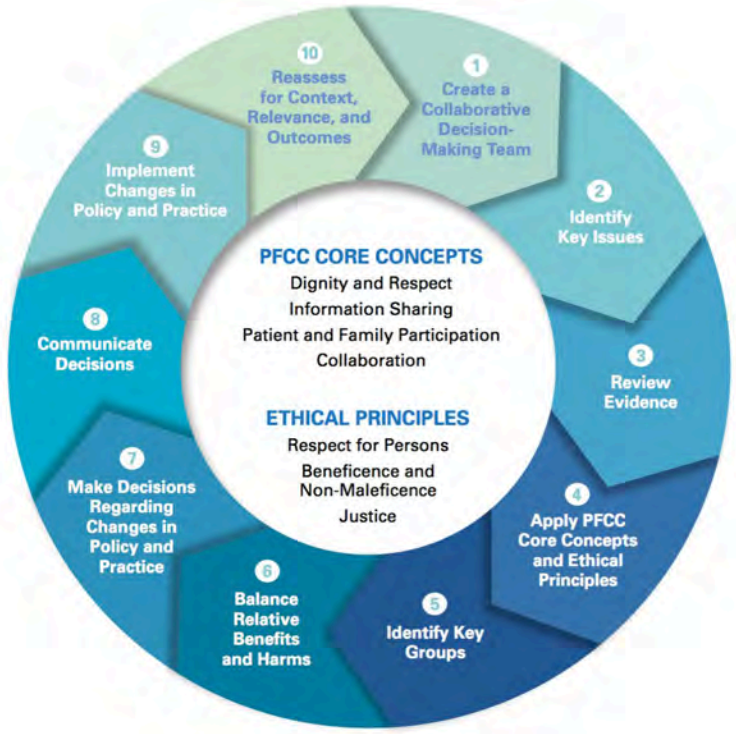
- Staff and clinicians missed the essential roles that families play.
- Staff and clinicians found it difficult to limit access to families.
- Staff and clinicians were distressed that they could not provide the quality of care they had before.
- Staff and clinicians could not provide clinical care, support for daily living, and emotional support typically provided by families.

Collaborative Process for Changing Family Presence Policies



A collaborative, deliberative process to develop family presence policies with a **better balance between benefits and harms**.

Available at: www.ipfcc.org/bestpractices/covid-19/index.html



"Family members provide an important safety net
for patients in the hospital, and
across the entire continuum of care."

Tejal K. Gandhi, MD, MPH, CPPS, Chief Safety and Transformation Officer, Press Ganey, Don't Go to the Hospital Alone: Ensuring Safe, Highly Reliable Patient Visitation, *Joint Commission Journal on Quality and Patient Safety*, 2021

www.jointcommissionjournal.com/article/S1553-7250(21)00270-1/fulltext

“We have concentrated our attention on the risks of visitation and lost sight of the benefits. When we close our facilities to visitors because we fear a few individuals, many are harmed.” For the future, she suggests returning to “the vision of family presence,” strategizing how to do it safely, and collecting data to measure the impact.

Tejal K. Gandhi, MD, MPH, CPPS, Press Ganey Chief Safety and Transformation Officer, in an interview by the Betsy Lehman Center for Patient Safety, *Patient Safety Beat*, February 2022.

https://betsylehmancenterma.gov/news/patient-safety-beat

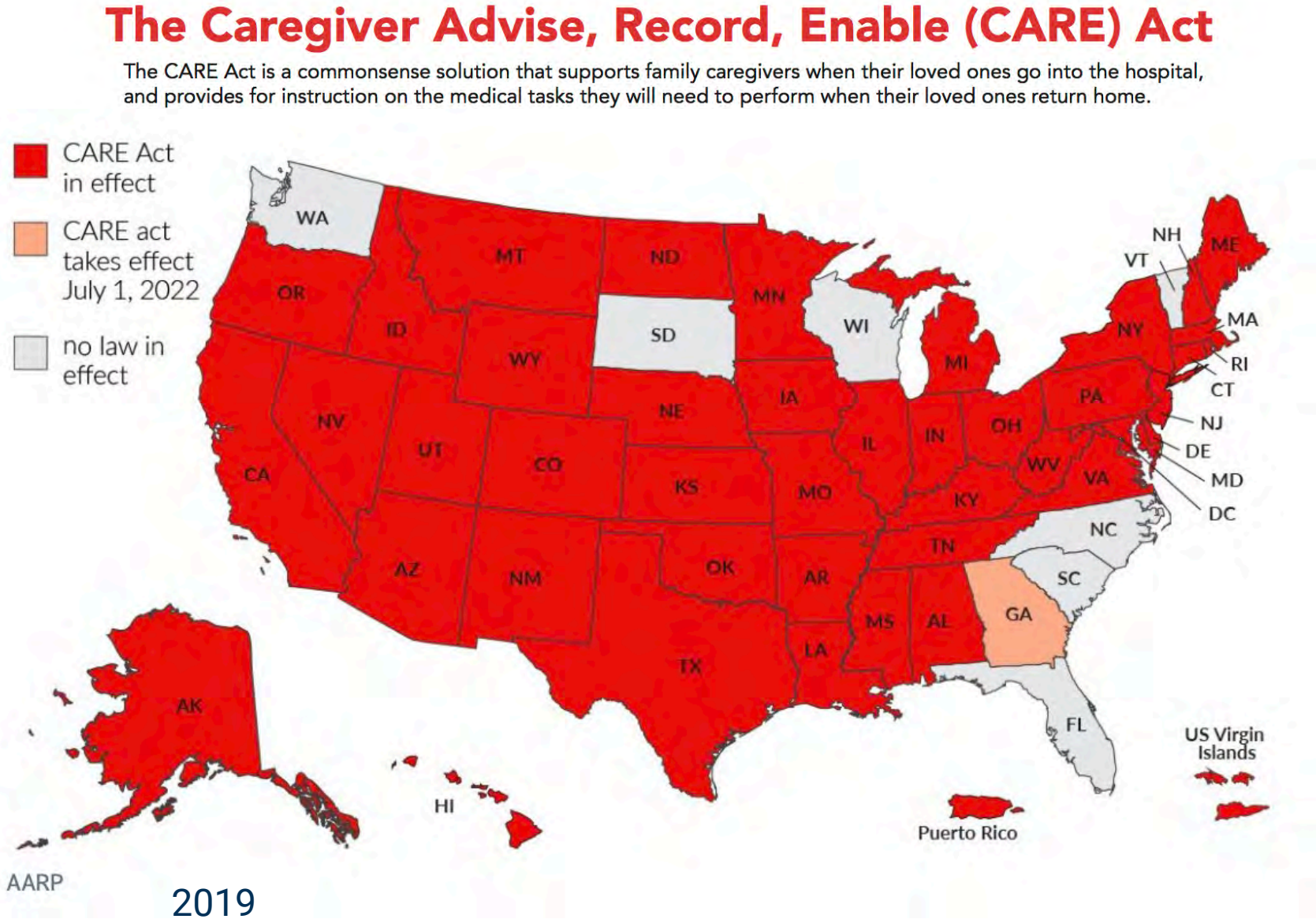
Leadership & Hospital Incident Command Structure

"The addition of family presence to our key objectives serves as an ongoing reminder of its importance and our commitment to stay true to its 'essence,' even in the midst of the pandemic."

Vice President of Nursing/CNO
Luminis Health Anne Arundel Medical Center, Annapolis, MD

NEJM Catalist

The Care Act: Partnering with the patient's family member or trusted friend



In a Care Partner Program . . .

In ambulatory care, inpatient care, emergency care, and long-term care, patients and residents are asked to designate a care partner(s) and how they will be involved in care and decision-making.

The designated care partner(s) name, role, and contact information are recorded in the chart and on the white board, and they are included meaningfully on the care team.

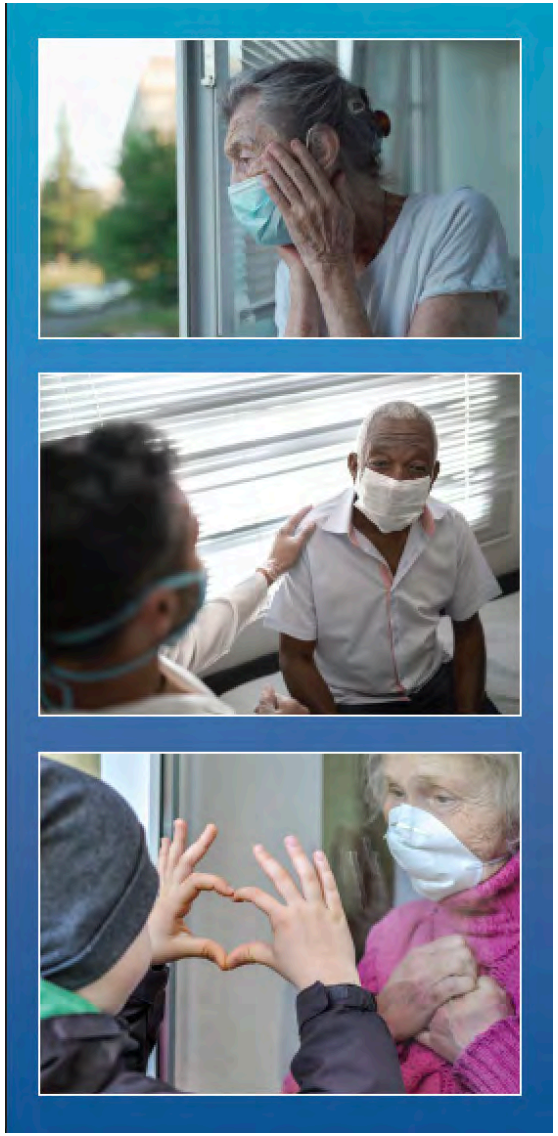
American Hospital Association
Quest for Quality Prize®

- Providing access to exceptional quality, safe and patient- and family-centered and affordable care that promotes individual and community well-being
- Partnering with other community organizations and agencies to improve the health status of their communities and address disparities
- Developing new and innovative models of care, services and collaboration to provide seamless care
- Partnering with patients and families to design the patient care experience and engage them fully in their health

www.aha.org/about/awards/quest-for-quality

Partnering with Residents for Health, Well-being, and Safety Brooksby Village, Erickson Senior Living, Peabody, MA

- Resident Advisory Committee (RAC) has nine resident members, elected for 2-year terms, and meets for 90-minutes monthly with Director and Associate Director attending.
- Health and Wellness is one of several RAC standing committees. It is co-chaired by a resident and the medical center's administrator. It meets monthly.
- This committee planned six-months of informational programs for independent living community on the various aspects of continuing care; developing a video with humor for fall prevention; and developing a volunteer program to connect independent living residents with continuing care residents.



Building Capacity for Long-Term Care Stakeholders in COVID-Related PCOR/CER

Ensure that future research addresses issues related to managing a pandemic, other infectious disease outbreaks, or disasters in ways important to residents in long-term care and their families while ensuring quality of life and safety for all.

Funded by a Patient-Centered Outcome Research Institute (PCORI) Eugene Washington Engagement Award

Small Group Conversations with Residents and Families — A Written Summary and Key Themes

Please do not distribute document beyond project participants

SUMMARY OF SMALL GROUP CONVERSATIONS WITH RESIDENTS AND FAMILIES

With additional family comments 7-17-22

INTRODUCTION

This summary of resident and family perceptions and experience during the COVID-19 pandemic was developed to create a better understanding of the root causes of social isolation and loneliness, highlighting the adverse impact on mental health and well-being. We are requesting the National Advisory Committee (NAC) to review this summary and share ideas about the root causes of social isolation and loneliness during the pandemic and possible topics and themes for future PCOR/CER.

BACKGROUND

The Resident and Family Small Group Conversations were conducted between April 22-May 6, 2022. All groups were held virtually via Zoom and were 60 minutes in length. The groups were facilitated by two trained moderators using the protocol developed with the advice of the NAC. Residents were gathered in a conference room at each respective site except for a resident who joined the call from out of state. Family members connected via Zoom individually from an off-site location, save for one group that convened at the long-term care community. Following each small group conversation, the team reviewed the moderator's guide and modified the questions, as appropriate.

Transcripts of these recorded conversations were developed and then reviewed by senior members of the project team. Quotes from the transcripts were coded and organized into themes. A summary of these themes is below.

SUMMARY OF THEMES

- **FAMILY CONNECTIONS AND SUPPORT: Both residents and families conveyed that the loss of family connections was amongst the hardest part of the pandemic experience. Although the modifications to in-person time with families and use of technology helped to ameliorate the sense of loneliness and social isolation for some elders, it had adverse consequences for others.**

For many residents living in long-term care communities, the loss of family connections was the hardest part of their experience during the pandemic. *"I couldn't see my sons. I had to stay away from them."* Some expressed it as an inability to communicate with family and friends. One resident commented on the loss of a significant celebration, her 90th birthday. Missed celebrations were a real loss to other residents, as well.

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KEY THEMES FROM THE SUMMARY OF SMALL GROUP CONVERSATIONS WITH RESIDENTS AND FAMILIES — August 30, 2022

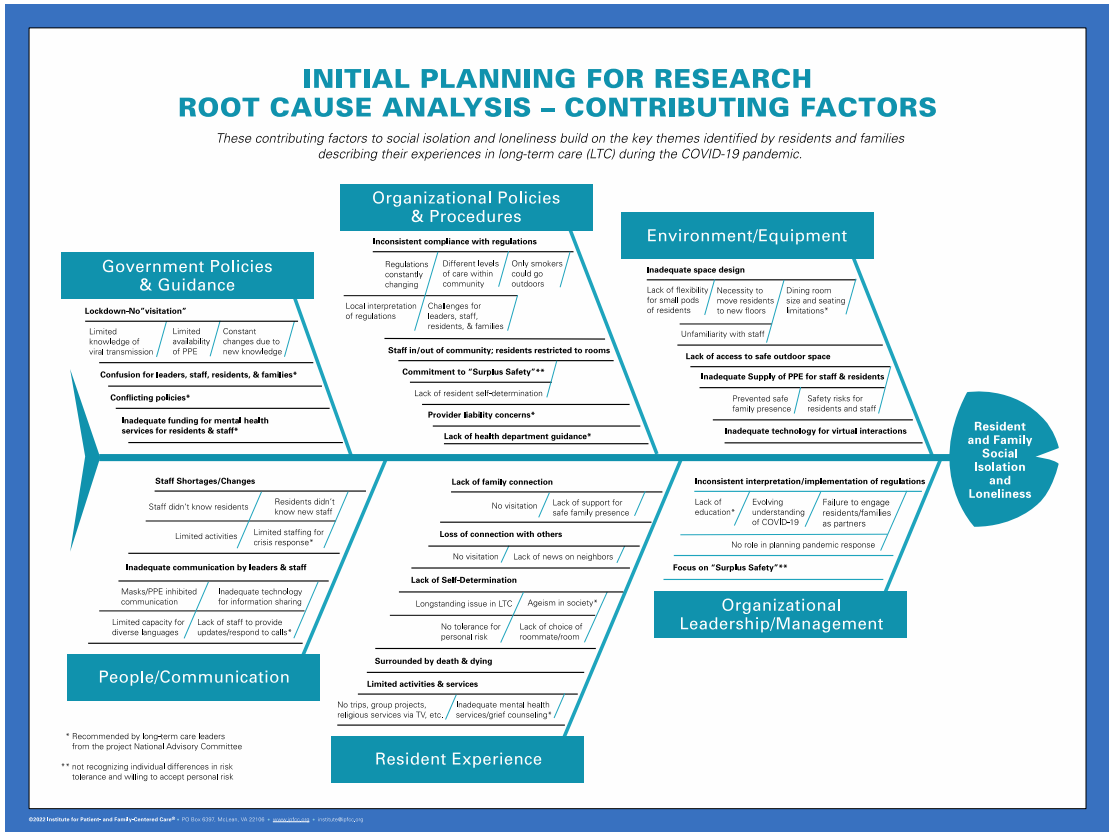
INTRODUCTION

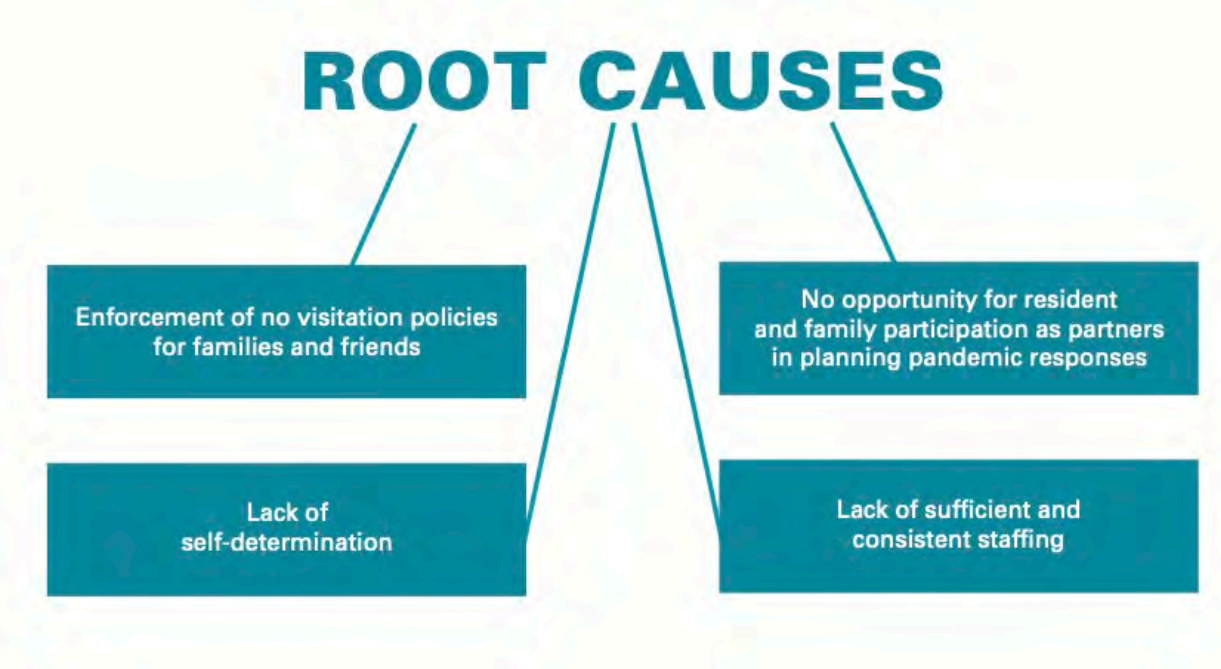
Resident and Family Small Group Conversations were conducted between April 22-May 6, 2022. This document lists the key themes drawn from these conversations. A separate document describes the summary of resident and family perceptions and experience during the COVID-19 pandemic. The key themes and summary have been developed to create a better understanding of the root causes of social isolation and loneliness during the pandemic that led to an adverse impact on mental health and well-being. They will be used in the September stakeholder meetings to generate topics and themes for future research.

KEY THEMES

- **LOSS OF FAMILY CONNECTIONS AND SUPPORT**: Both residents and families conveyed that the loss of family connections was amongst the hardest part of the pandemic experience. Although the modifications to in-person time with families and use of technology helped to ameliorate the sense of loneliness and social isolation for some elders, it had adverse consequences for others.
- **LACK OF SELF-DETERMINATION**: The loss of self-determination due to pandemic restrictions was a dramatic change for the everyday lives of residents, often with negative consequences. There appeared to be no opportunities for residents and families to serve as true partners in pandemic planning over the last 2 ½ years. There were almost no structures in place to support these effective partnerships.
- **LIVING ARRANGEMENTS**: Isolation in a room with or without roommate(s) and moving to new floors contributed significantly to feelings of loneliness, depression, loss of connection with staff and friends, and the lack of self-determination.
- **ACTIVITIES, MEALTIMES, AND LOSS OF CONNECTIONS WITHIN THE COMMUNITY**: Residents stated that interesting activities, some mealtime interactions, and informal connections and communication with friends and staff in the long-term care community contributed to their quality of life during the pandemic.
- **INTERACTIONS WITH STAFF**: Both residents and families praised staff and recognized the difficult working conditions created by the pandemic. However, staff shortages contributed to limited activities, ineffective communication, and impacted residents who now did not know their caregivers as they had previously. Similarly, these new caregivers were unfamiliar with residents and families.

A fishbone diagram was used to illustrate the Root Cause Analysis.





Comparative Effectiveness Research Topics and Themes

Government/Policy

Partnerships

Communication

Physical Spaces

Risk

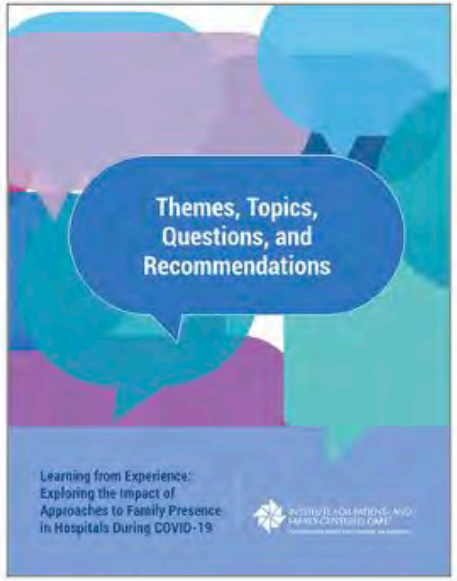
Staffing

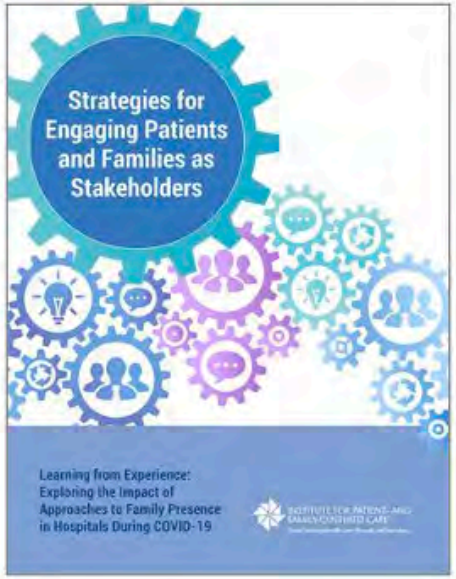
Examples of Topics for Further Research

Compare various approaches to inform/educate long-term care community leaders about the value of partnerships with residents and families in safety and quality improvement, and how to develop effective partnerships that can be sustained during a future pandemic, outbreak, or disaster.

Create and evaluate accessible, climate-controlled outdoor spaces that reduce the risk of infection with safe access for residents.

Better Together: Supporting Family Presence





ipfcc.org/bestpractices/supporting-family-presence/index.html

Long-term Care Partnerships

ipfcc.org/bestpractices/long-term-care-partnerships/index.html

Bev Johnson
bjohnson@ipfcc.org
www.ipfcc.org

EMPRO INSURANCE

Annual Patient Safety Conference

Annual Patient Safety Conference

EMPRO INSURANCE

Improving Trust and Identifying Bias: Brooklyn Health Equity Index

Presenter:
K. Torian Easterling, MD, Senior Vice President for Population and Community Health and Chief Strategic and Innovation Officer for One Brooklyn Health

Improving Trust and Identifying Bias: Central Brooklyn Health Equity Index

Torian Easterling MD, MPH One Brooklyn Health System

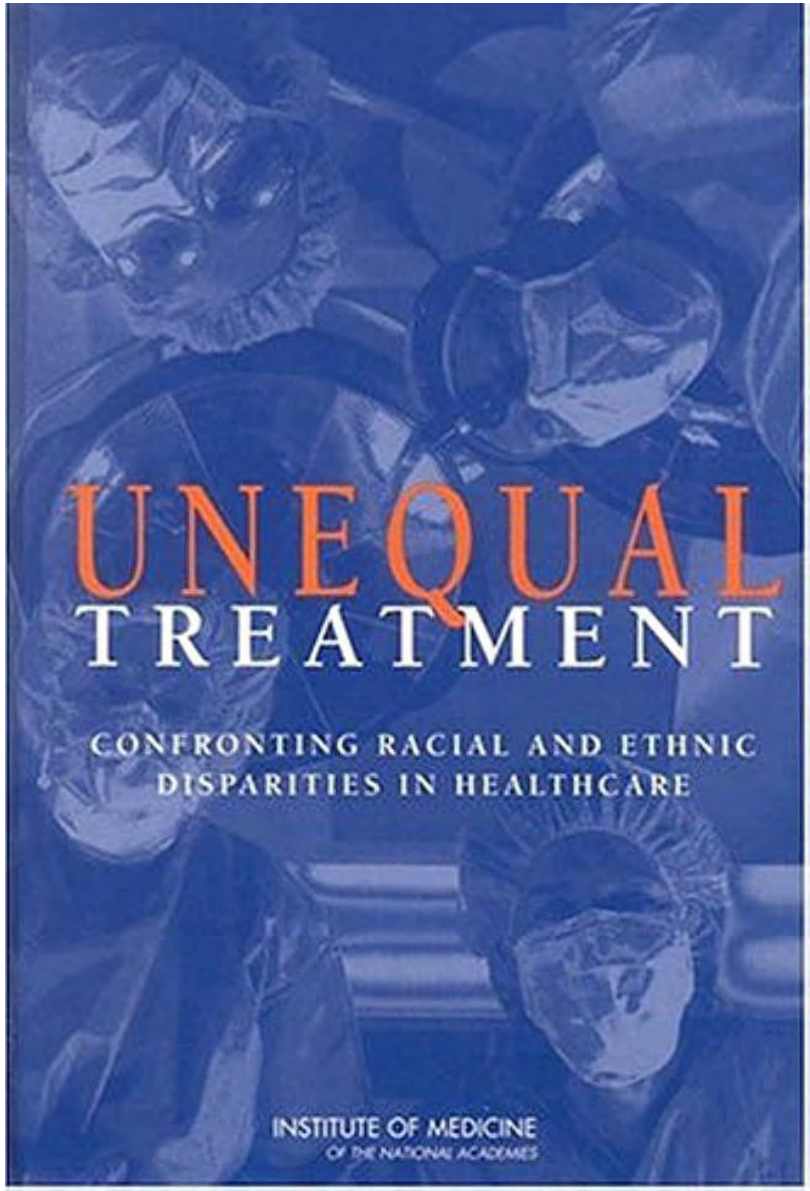
EmPRO Annual Patient Safety Conference November 2nd, 2023

Conflict of Interest Disclosure

No relevant financial relationships or relationships

Unequal Treatment

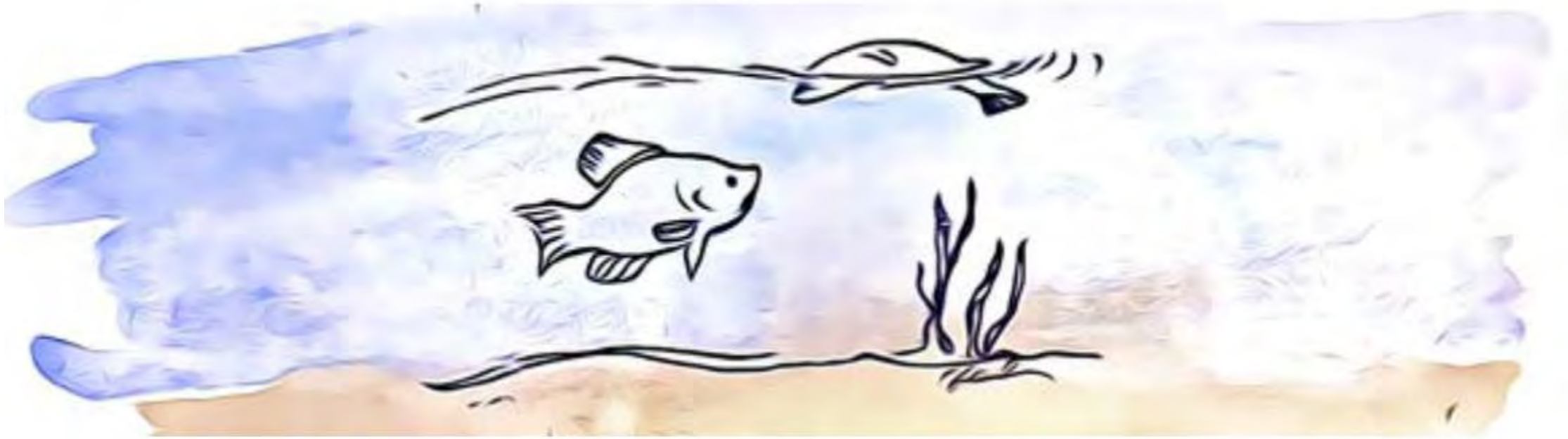
- Extent of Racial and Ethnic Difference in Healthcare
- Sources of Racial and Ethnic Disparities in healthcare
- Provide recommendations to eliminate healthcare disparities



Core Competencies for Advancing Health Equity

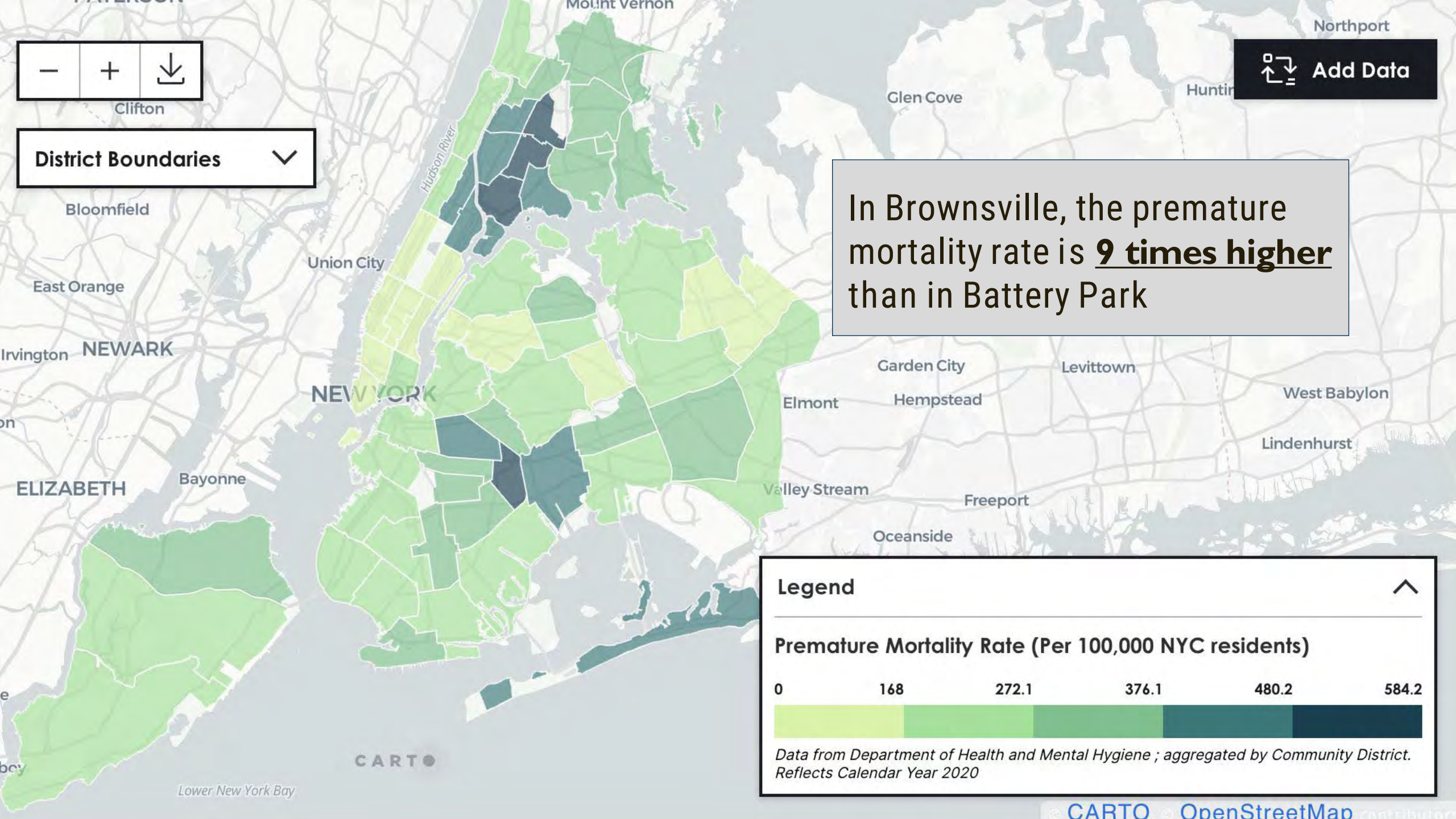
- Racial Equity approaches are the application of race-conscious and explicit investments in program, policy, and practice.
- Racial Equity is a continuous science seeking to address problem of inequity across policy, and practice which require a solution centering the well-being of the people most impacted by inequity and their corresponding community. Principles below provide a foundation for continuous equity practice
- Racial Equity is a discipline and emerging science. As anti-racist practitioners, it's important to center your practice on commitments that reflect your value and trust in the communities you serve.

The Lake, The Fish and The Groundwater

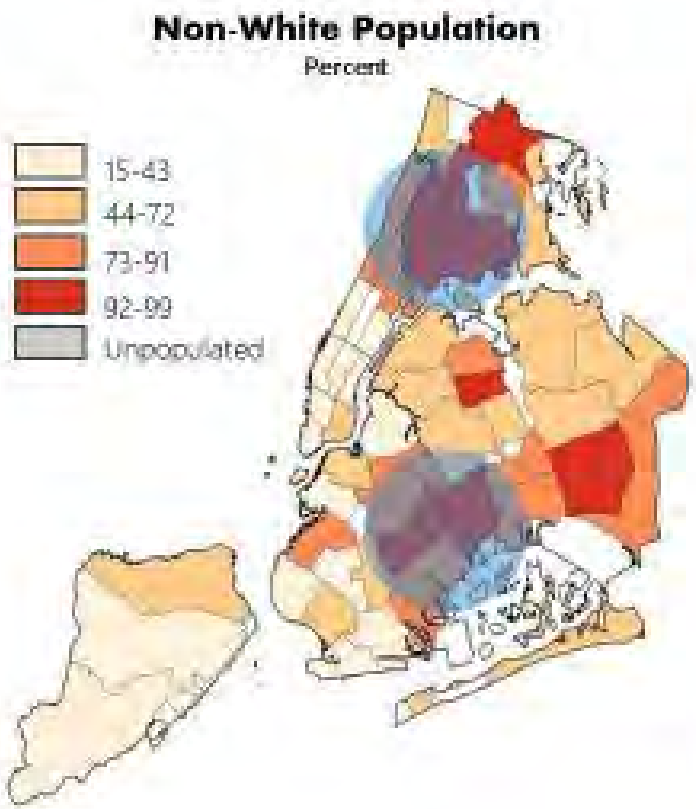


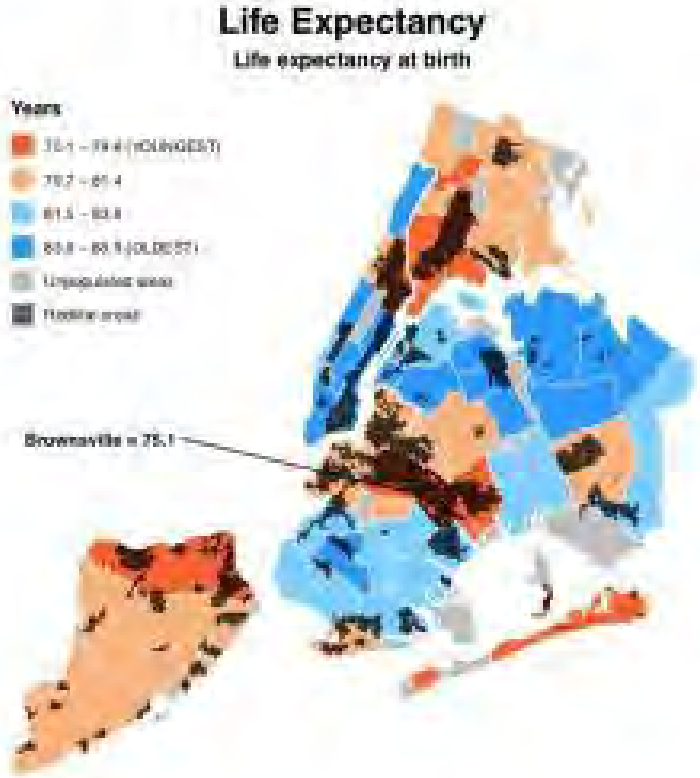
Artwork by Jojo Karlin (jojokarlin.com)

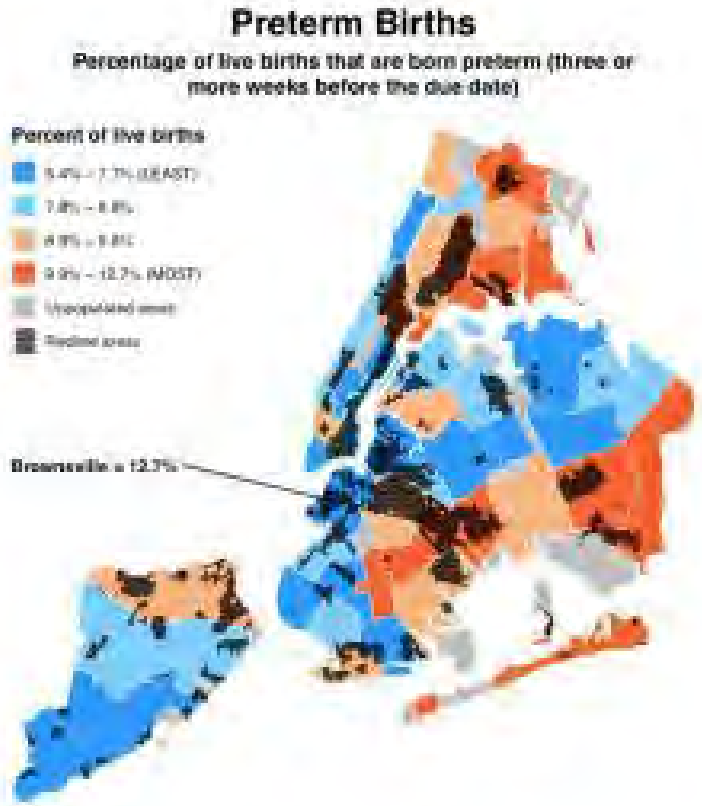
Dave G, Wolfe MK, Corbie-Smith G. Role of hospitals in addressing social determinants of health: A groundwater approach. Prev Med Rep. 2021 Jan 8;21:101315. doi: 10.1016/j.pmedr.2021.101315. PMID: 33505842; PMCID: PMC7814190.


Add Data
District Boundaries
In Brownsville, the premature mortality rate is 9 times higher than in Battery Park
Legend
Premature Mortality Rate (Per 100,000 NYC residents)
0
168
272.1
376.1
480.2
584.2
Data from Department of Health and Mental Hygiene ; aggregated by Community District. Reflects Calendar Year 2020
Mount Vernon
Northport
Glen Cove
Clifton
Bloomfield
Union City
East Orange
Irvington
NEWARK
NEW YORK
Hudson River
Garden City
Levittown
Elmont
Hempstead
West Babylon
Lindenhurst
ELIZABETH
Bayonne
Valley Stream
Freeport
Oceanside
Lower New York Bay
CARTO
CARTO © OpenStreetMap

Segregation Casts a Long Shadow on Health Outcomes

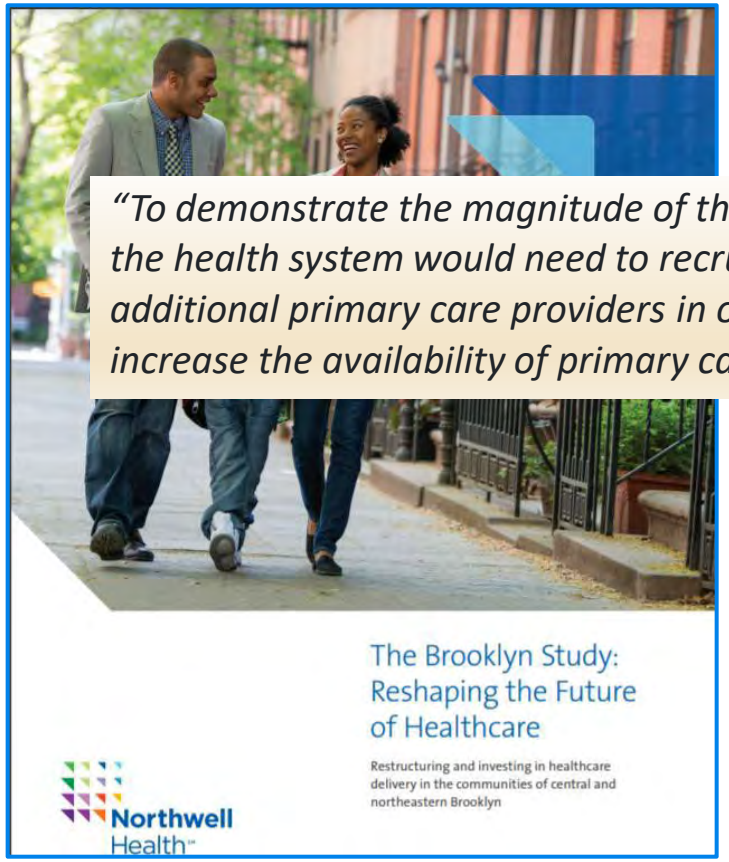






Source: NYC DOHMH population estimates, matched from US Census Bureau intercensal population estimates, 2010-2013, updated June 2014. U.S. Census Bureau, American Community Survey, 2013 3-year Estimates, Table S1701; generated using American Fact Finder (http://factfinder2.census.gov/)

The Problem We're Trying to Solve: Close the 11-Year Life Expectancy Gap in Our Community[1]



"To demonstrate the magnitude of this challenge, the health system would need to recruit 335 additional primary care providers in order to increase the availability of primary care providers"

RFA # 1701230306
Grants Gateway # DOH01-HCFTKC-2017

New York State Department of Health
Office of Primary Care and Health Systems Management
Request for Applications

Health Care Facility Transformation Program: Kings County

KEY DATES

Release Date:	**March 9, 2017**
Questions Due:	**March 24, 2017**
Questions, Answers and Updates Posted (on or about):	**April 7, 2017**

Applicatio

DOH Cont

Joan Cleary M
Director, Hea
Kings Cou
New York St
Office of Prim
1805 Corning Tower
Albany, NY 12237
e-mail: kingscounty@health.ny.gov

"..the extent that the proposed capital project furthers the development of primary care and other outpatient services;

[1] Source: Brownsville vs Battery Park: Link: https://societyhealth.vcu.edu/media/society-health/pdf/CSH-NewYorkMethods.pdf

Limited English Proficiency and Patient safety

- Adverse events affect LEP patients more frequently and severely than they affect English speaking patients.
- LEP patients are more likely to experience medical errors due to communication problems than English speaking patients.
- LEP patients are more likely to suffer from physical harm when errors occur

Divi C, Koss RG, Schmaltz SP, Loeb JM. Language proficiency and adverse events in US hospitals: a pilot study. Int J Qual Health Care. 2007

New Health Equity Measures: CMS & The Joint Commission

CMS FY23: CMS finalized three new health equity-related measures in the Inpatient Quality Reporting (IQR) program:

1. **Hospital Commitment to Health Equity (HCEC):** Looks across **five domains**: Equity is a Strategic Priority, Leadership Engagement, Data Collection, Data Analytics, and Quality Improvement
2. **Screening for Social Drivers of Health (SDH):** Screening domains include **food insecurity, housing instability, transportation problems, utility difficulties, and interpersonal safety**
3. **Screen Positive Rate for SDH:** This measure requires the reporting of the resulting screen positive rates for the above

Mandatory reporting in FY23 (HCEC) & FY24 (the SDH measures)

The Joint Commission New Standard: "Reducing health care disparities for the organization's patients is a quality and safety priority." Elements of Performance:

1. Designate an individual(s) to lead activities to reduce health care disparities
2. Assess the patient's health-related social needs and provide info about community resources and support services
3. Identify health care disparities by stratifying quality and safety data using patient sociodemographic data
4. Develop a written action plan that describes how it will address at least one of the identified health care disparities
5. Act when it does not achieve or sustain the goal(s) in its action plan to reduce health care disparities
6. Inform key stakeholders (i.e., leaders, licensed practitioners, and staff) at least annually about its progress to reduce identified health care disparities

The new standard became effective January 1, 2023

Brooklyn Health Equity Index

Tripartite Partnership to develop a tool to elevate patient and community voices in measuring and addressing inequities in the patient experience.

- To develop a health system metric that quantifies how systems are addressing health equity
- Elevate patient and community voices in health system governance and shared decision-making to foster systemic change
- To reverse history of systemic marginalization

BKHI Leadership

- **SUNY Downstate** is the only academic medical center in the Brooklyn and has served Central Brooklyn for over 150 years
- **Arthur Ashe Institute for Urban Health** founded in 1992 by Arthur Ashe , since its inception it has been a leading community force in addressing major urban health challenges.
- **One Brooklyn Health System E**stablished in 2016, one of Brooklyn's largest safety net healthcare systems serving a nearly 1.2 million mostly black and brown population.

Collective Action

- Impact: a multi-disciplinary team of SUNY Downstate, Arthur Ashe Institute for Urban Health and One Brooklyn Health System
- Engagement: Diverse Central Brooklyn stakeholders in the design and development of a new way of measuring patient experience
- Inclusiveness: Community-based participatory research and Community Change Committee ensures that community and patient voices are included in all aspects of the initiative

Phases of BKHI

- Phase 1: using Community-based Participatory Research, conduct focus groups and key informant interviews of diverse communities to ascertain information to add previously missing elements to our Patient Experience tools.

- Phase 2: Face Validity testing of the survey. Pilot-testing among a sample of 366 OBH patients in ambulatory, inpatient, ED and maternity care.

- Phase 3: deploy the prototype to 1000-1500 systemwide at OBH. Discuss the findings, develop solutions, plug into CQI

BKHI Phase 1: Community-Driven Data

- Qualitative study that used a purposive sampling method to recruit 62 participants from 10 focus groups (FGs) and 17 key informant interviews with stakeholders across Central Brooklyn.
  - Patients, healthcare leaders, staff, medical students, community activists
  - October 2021 through January 2022
- Core research team – 7 members diverse with regard to race/ethnic background, sexual orientation, life stage (medical students, faculty, experienced researchers)
- Maintained rigor and discipline throughout process, member-checking, verification of quotes
- Analytical strategy: phenomenology

BKHI Phase 2: Summary of findings

- Developed a survey that amplifies patients' voice, especially along health equity lines
- Pilot-testing on 366 patients revealed that this tool works well in assessing previously overlooked elements of Patient Experience, such as medical mistrust and discrimination
- Prototype was successfully Face Validity tested, meaning respondents correctly identified themes the items were meant to assess
- A 10-item version of the BKHI was created for future use.
- Data collection refined

BKHI Phase 3

- A total of 1,325 consumers of healthcare at OBHS facilities completed the BKHI (from 5/15/23 to 6/15/23)
- Patients were contacted via an automated phone call (Voice) and a text message (SMS) on day after discharge/visit date
- Second Voice and SMS requests were sent the second day following discharge/visit date
- A third set of Voice/SMS were sent the fourth day

Demographics of outreach group (n=11,425)

- A total of 11,425 received calls/texts, 1,325 complete the survey (response rate of 11.60%)
- Race: 82.4% were Black/African American
- Gender: 58.0% were female
- Age: Mean age = 50.58 years (SD=18.04 years)
- Employment status: 36% were unemployed, 13.5% full-time employment
- Insurance: 4.2% were self-pay, 95.8% some form of coverage
- Country of origin: 68.2% US born, 31.8% born outside US

Outreach efforts broken down by facility and unit (n=11,418)

	Facility		
Unit	Brookdale N (percentage by Unit)	Interfaith N (percentage by Unit)	Kingsbrook N (percentage by Unit)
Ambulatory Care	3,320 (61.7%)	745 (13.38%)	1,319 (24.5%)
Emergency Department	1,709 (37.7%)	1,979 (43.6%)	848 (18.7%)
Inpatient Unit	651 (61.4%)	360 (33.9%)	50 (4.7%)
Maternal Unit	437 (100%)	0	0

Areas of Strength and Opportunities to Improve

Item	Percent Agreed	Item (Theme)	Percent Agreed
Staff made me feel welcomed (Welcoming Atmosphere)	77.2%	The provider and care team asked about other aspects of my life, etc. (SDOH)	55.7%
I was happy with the way my provider/staff listened to me, etc. (Communication)	84.2%	There were times I felt shamed/blamed because of my physical condition (Stigma)	23.7%
I feel I can trust the provider and staff in this facility (Trust)	79.6%	I feel I was treated unfairly or disrespected because of my race, ethnicity, etc. (Discrimination)	19.0%
I participated as much as I wanted in making decisions regarding my heathcare (Empowerment)	84.4%	I felt dismissed or disregarded by the provider and/or staff about my medical condition (Dismissive Attitudes)	25.2%
My care team recognized how hard it can be to follow their medical advice in everyday life (Empathy)	48.0%	The state of the facility and medical equipment made me wonder whether I was getting the best possible care. (Resources)	38.3%

Culture Change

Embedding Racial and Gender Justice throughout the OBH enterprise system, culture, policies and practice.

- Creating a environment for learning and inquiry.
- Launching a systemwide engagement strategy.
- Collaboration with Institute of Healthcare Improvement to rebuild trustworthiness among patients with Sickle Cell Disease
- Develop an innovative curriculum for medicine residents and nursing staff to acquire community organizing skills and launch health equity campaigns.

Using Data for Advancing Equity

- Expand the Collection, Reporting, and Analysis of Standardized Data- Demographic Data (Race, ethnicity, Language)
  - Expand collection of racial subgroups
  - Data on individuals seeking asylum
  - Standardize collection of health-related social needs

Innovative and Equitable Care

- Supporting local food systems and addressing food insecurity.
- Strategic Partnerships and Data to improve maternal care.
- Ambulatory Practice Improvement approach with BKHI Tool
- Training on embedding equity in quality performance activities

In Closing

- To sustain health care transformation, all key stakeholders in the health care ecosystem must make racial health equity a priority, specifically advocate for payment restructuring to fully finance safety net systems.
- Innovative data tools and performance improvement approaches can be utilized to identify health inequities in populations.
- Systems must make intentional investments to both identify and find solutions to close and ultimately eliminate disparate care.

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Current Malpractice Climate

Presenter:
Thomas J. Benvenuto, Esq.,
Senior Trial Attorney/Managing
Attorney Benvenuto & Gaujean


BENVENUTO & GAUJEAN
Optimizing Outcomes in Litigation
Counsel, Claims Professionals and Risk Management *Combine* to enhance the Defensibility of Claims Against the Facility
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OUTLINE

I. General Game Plan

II. Facility Litigation
    a. Hospital suits
    b. Nursing Home suits
    c. Impact

III. Primary Goals
    a. Preparation prior to the filing of the claim
    b. Analysis of the claim
    c. Early motion practice to limit/dismiss claims
    d. Controlling the tempo of the litigation
    e. Choosing the path of resolution

IV. Optimizing Resolution
    a. Documentation
        i. Defensive
        ii. Offensive

V. Balance of Power

VI. Summation of Legal Strategies

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2-Second Decisions: The Secret Formula for Leading Change by Making Winning Choices

Presenter:
Michelle Rozen, PhD, "The Change Doctor"

Slides unavailable for download

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THANK YOU FOR ATTENDING!