# Education Session on Health Care Equity Certification

May 23, 2023

# Health Care Equity Certification: Introduction

Chad Larson
Executive Director, Hospital Business Development
Division of Business Development, Government & External Relations

The Joint Commission

# Today's Agenda

| Topic | Speaker | Time |
|---|---|---|
| **Introduction** | **Chad Larson**<br>Executive Director, Hospital Business Development<br>The Joint Commission | 9-9:05am |
| **Purpose of Health Care Equity Certification** | **David W. Baker, MD, MPH, FACP**<br>Executive Vice President, Health Care Quality Evaluation<br>The Joint Commission | 9:05-9:15am |
| **Embedding Equity Into Patient Quality, Safety, and Experience** | **Esteban Gershanik, MD, MPH, MMSc, FAAP, FHM**<br>Medical Director, Quality, Safety and Equity<br>Brigham Health<br>Instructor of Internal Medicine, Part-Time<br>Harvard Medical School | 9:15-9:45am |
| **Certification Standards & Resources** | **Christina Cordero, PhD, MPH**<br>Project Director<br>The Joint Commission | 9:45-10:15am |
| **Preparation and Application Process** | **Dave Eickemeyer**<br>Associate Director, Certification<br>The Joint Commission | 10:15-10:25am |
| **Overview of the Review** | **Doreen Donohue**<br>Field Director, Disease-Specific Care<br>The Joint Commission | 10:25-10:35 |
| **Wrap Up and Q&A** | **Chad Larson** | 10:35-10:50 |

# Health Care Equity Certification: Reaching for Excellence

David W. Baker, MD, MPH
Executive Vice President
Division of Healthcare Quality Evaluation and Improvement

The Joint Commission

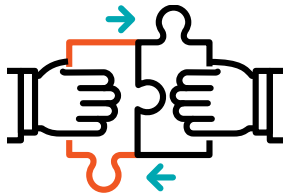
# Thanks to Our Amazing Team

- Amy Aliaga
- Stacey Barrett
- Tina Cordero
- Beth Ann Longo
- Jamie Patrianakos
- Kathryn Petrovic
- Haley Seaman
- Brette Tschurtz
- Tabitha Vieweg
- Scott Williams

# Our Journey to Advance Equity

**2003**

- ✓ Began **researching health care equity issues and alignment to Joint Commission requirements**



**2007**

- ✓ Released **public policy report** on improving health literacy

**2010**

- ✓ Released **Standards and resources** focused on improving patient-provider communication

**2011**

- ✓ Implemented **a requirement to prohibit discrimination** based on a variety of patient characteristics, including sexual orientation and gender identity or expression
- ✓ Released the **LGBT Field Guide**

**2016**

- ✓ Released ***Quick Safety* newsletter** addressed "Implicit bias in health care"

**2020**

- ✓ Issued ***Quick Safety* advisory**, "Understanding the needs of diverse populations in your community"

**2021**

- ✓ With Kaiser Permanente established **The Bernard J. Tyson Award for Excellence in Pursuing Health Care Equity**
- ✓ Announced **collaboration with the American College of Obstetricians and Gynecologists (ACOG)** to reduce maternal mortality and morbidity in the United States

**2022**

- ✓ ACOG and The Joint Commission launch **Maternal Levels of Care (MLC) Verification Program**
- ✓ Issued **Sentinel Event Alert** "Eliminating disparities for pregnant patients"
- ✓ New **health care equity standards** announced
- ✓ Accreditation Standards **Resource Center launched**
- ✓ Launched **Advanced Certification in Perinatal Care (ACPC)** in collaboration with ACOG to improve quality and safety for pregnant or postpartum patients and newborns

**2023**

- ✓ Elevate Leadership (LD) Standard LD.04.03.08, to a **new National Patient Safety Goal (NPSG)**
- ✓ Launch **Certification Resource Center**
- ✓ Launch **Health Care Equity Certification**

# Certification Program Domains

# Why HCE Certification?

To recognize those hospitals that have established a robust set of structures and processes designed to achieve equitable care

- Certification is a symbol of pride to share with their staff, leadership, patients, and community

To provide a road map that others can follow to advance equity

- Some may not be able to meet all requirements to be certified
- However, with the standards as goals and the resources as tools, they can slow and steadily move forward on this journey

Brigham and Women's Hospital
Founding Member, Mass General Brigham

# Embedding Equity Into Patient Quality, Safety, & Experience

Esteban Gershanik, MD, MPH, MMSc;
Medical Director of Quality, Safety, & Equity
Brigham and Women's Hospital

May 23, 2023

# Disclosures

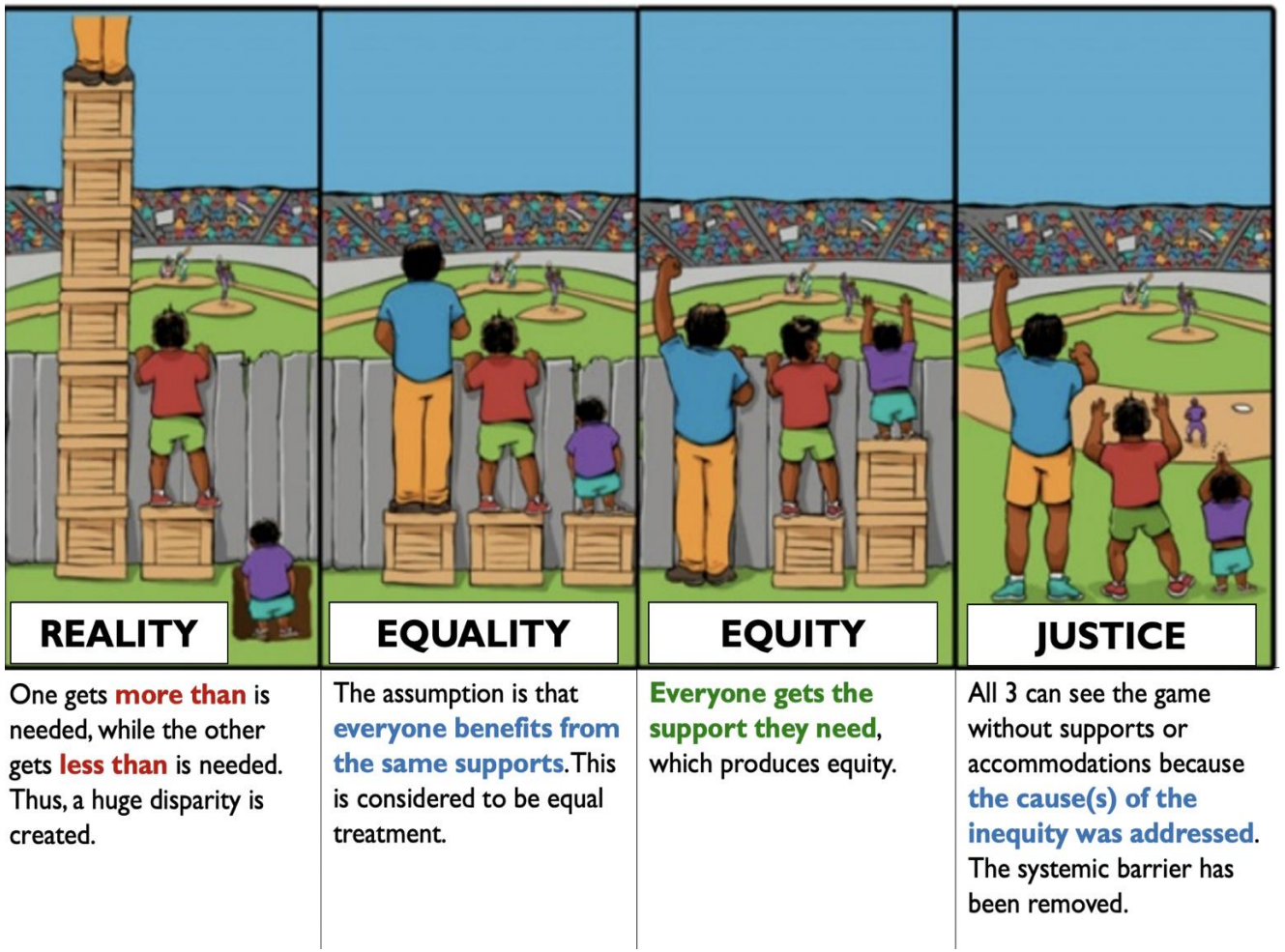
Esteban Gershanik in the last 24 months has consulted for Change Healthcare and Uzobi, Inc, and owns equity in Amgen, Eli Lilly Co, Johnson & Johnson, Pfizer.

None of these conflict with the presentation today.

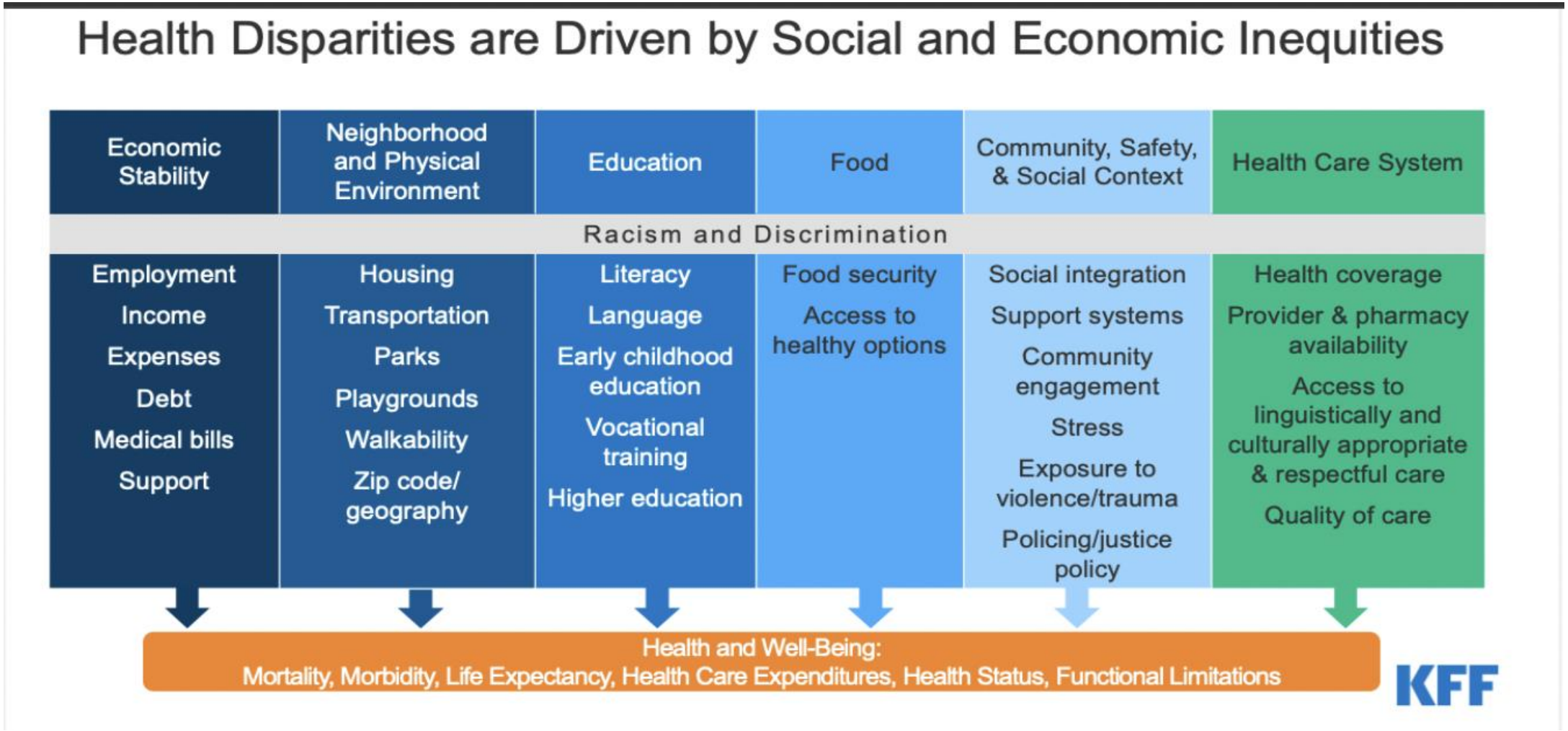
# Health Equity

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**.

**- Robert Wood Johnson Foundation**



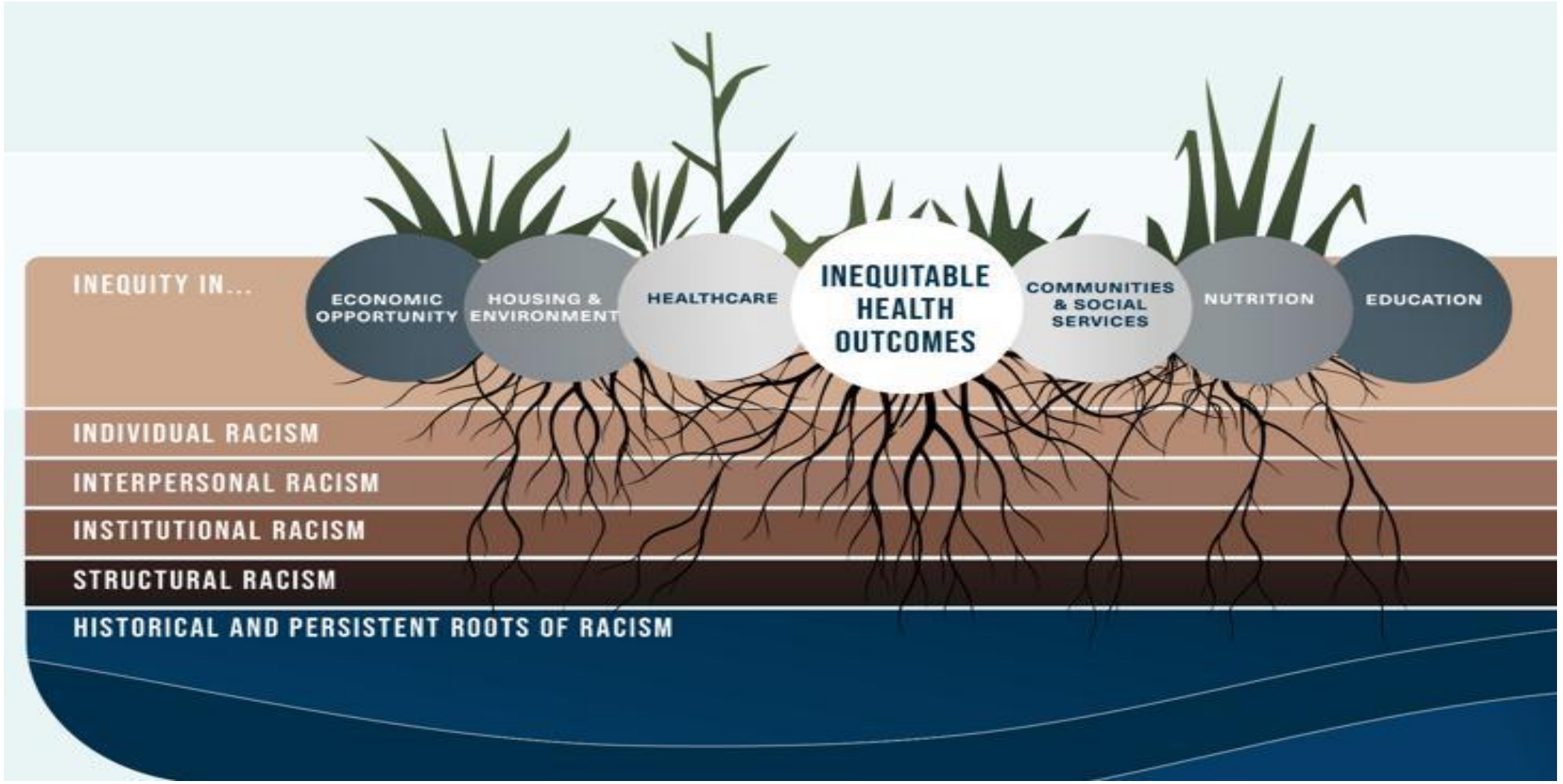
# Root Causes of Health Inequities






https://www.kff.org/policy-watch/health-disparities-symptom-broader-social-economic-inequities/

# Root Causes of Health Inequities

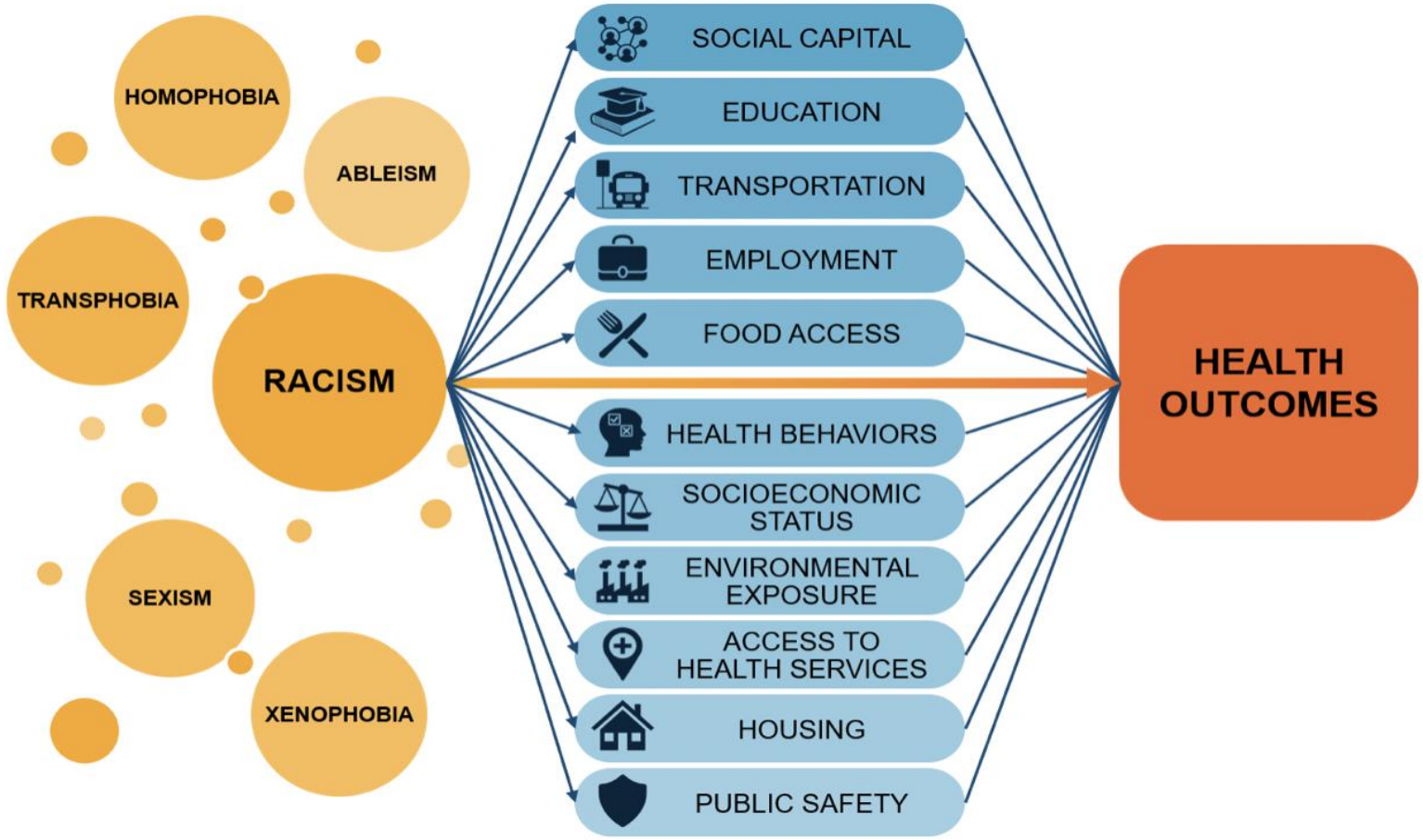



*Credit: MA BCBS*

# Racism + other -isms + SDOH *approach*

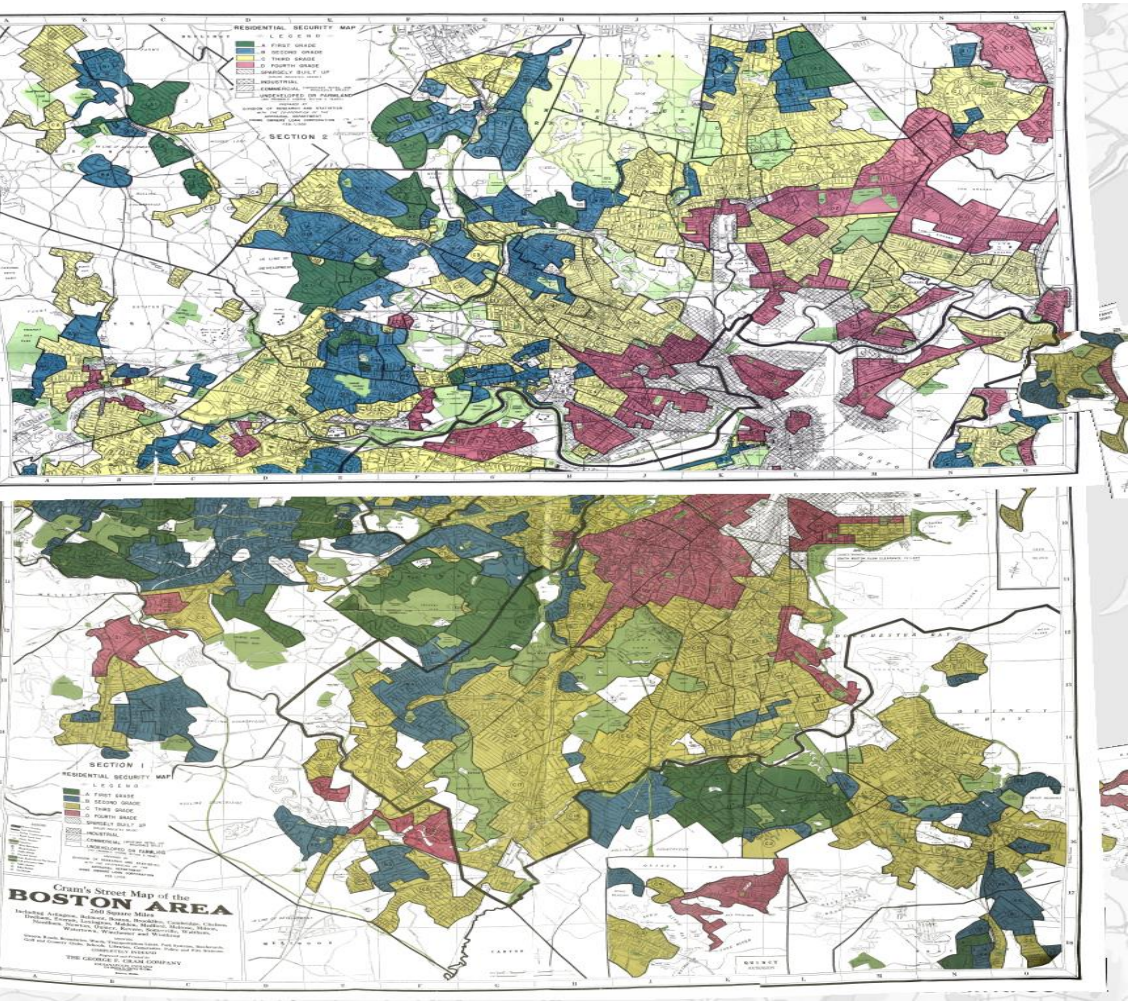
**Racism both influences social determinants and is an independent factor in health outcomes.**

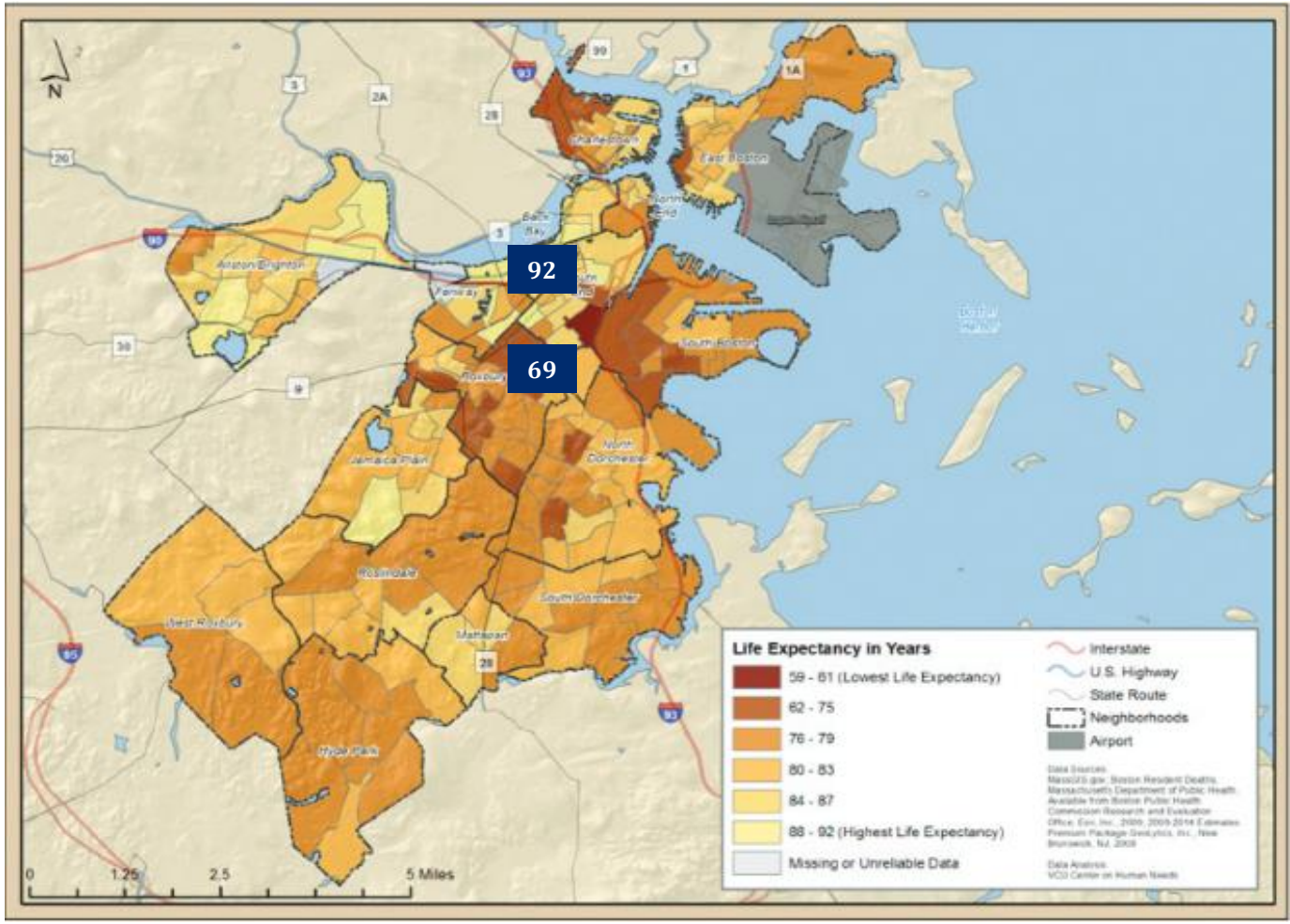
It is pivotal to acknowledge and address the impact of systemic racism as health equity work is implemented.




**Source: Boston Public Health Commission's Racial Justice and Health Equity Initiative; available: http://www.bphc.org/whatwedo/health-equity-social-justice/racial-justice-health-equity-initiative/Documents/RJHEI%202015%20Overview%20FINAL.pdf**

# Boston: Redlining and Current Life Expectancy




Boston, 1938 versus Boston, Present Day

What is the role of healthcare institutions?

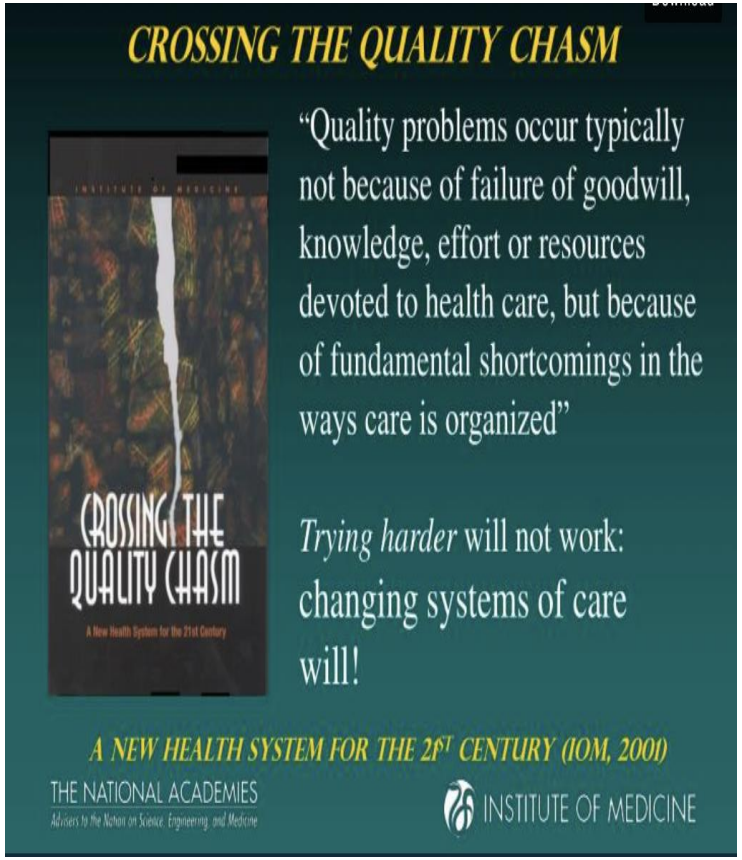
How do they take on these complex inequities?

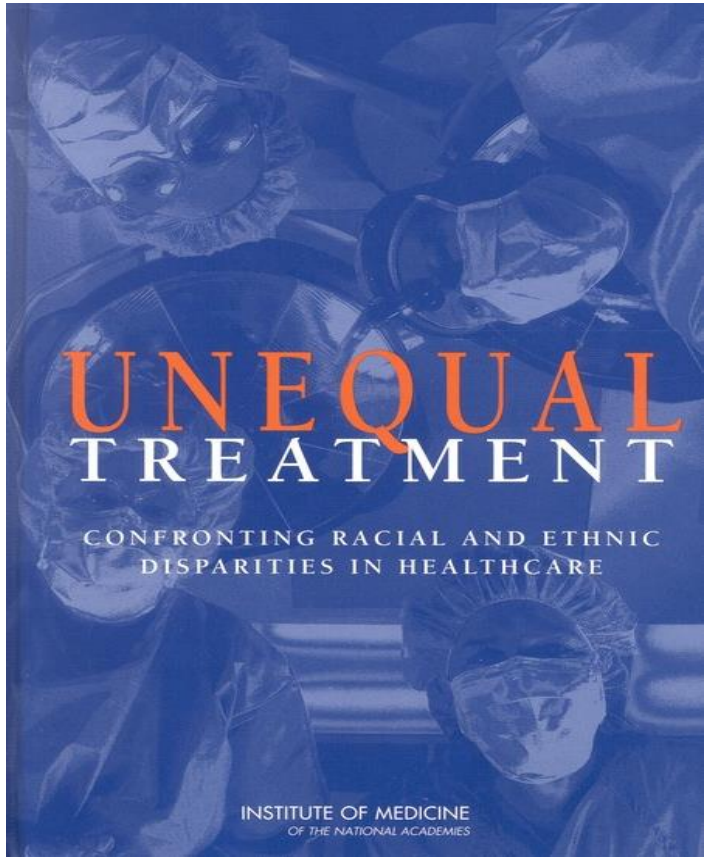
Where do they start?

# Early 2000 Quality in Healthcare

IOM's Six Quality Aims for Healthcare

- SAFE
- EFFECTIVE
- PATIENT-CENTERED
- TIMELY
- EFFICIENT
- EQUITABLE



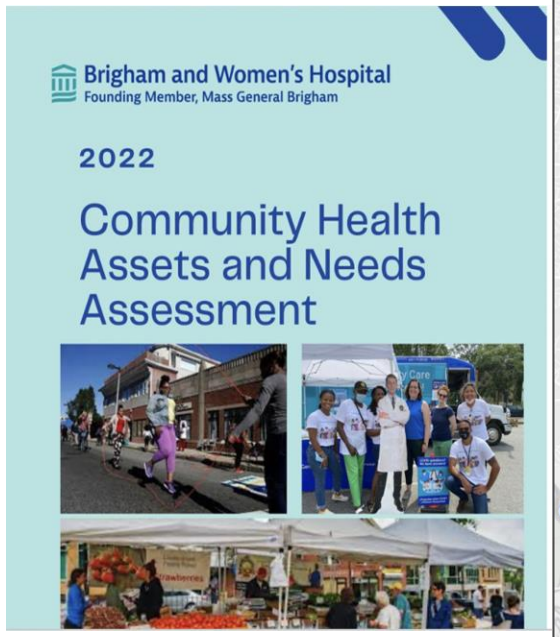



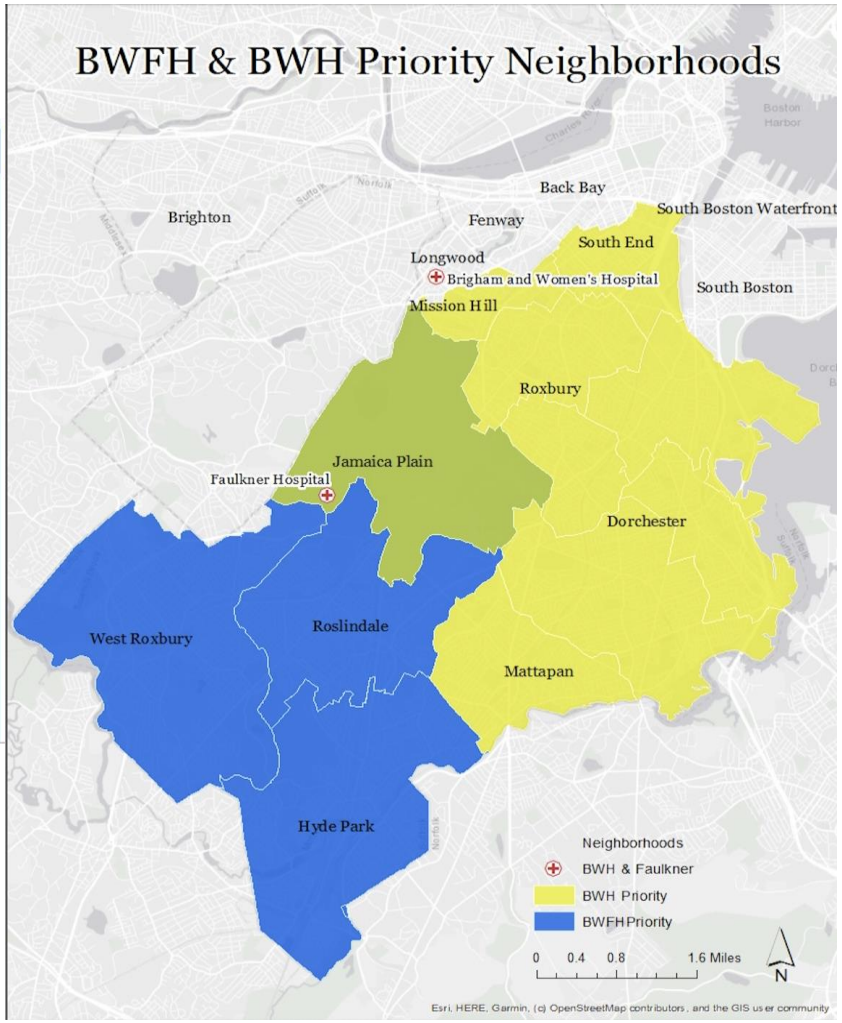
# 2010 Affordable Care Act – Community Health Needs Assessment

**Requires tax-exempt hospitals to create a CHNA every three years**

Includes

- Demographic Assessment identifying the community the hospital serves
- A community health needs assessment survey of perceived healthcare issues
- Quantitative analysis of actual health care issues
- Appraisal of current efforts to address the healthcare issues
- Formulate a 3-year plan - the community comes together to address those remaining issues collectively, towards growing a healthier community



The New York Times

Opinion

# Racism's Hidden Toll

In America, how long you live depends on the color of your skin.

By Gus Wezerek Aug. 11, 2020

# COVID-19 More Prevalent, Deadlier in U.S. Counties with Higher Black Populations

April 23, 2020 | Laurie Zephyrin, David C. Radley, Yaphet Getachew, Jesse C. Baumgartner, and Eric C. Schneider

PEW

TOPICS PROJECTS FEATURES ABOUT GET INVOLVED SEARCH

# Racism Is a Public Health Crisis, Say Cities and Counties

STATELINE ARTICLE June 15, 2020 By: Christine Vestal Topics: Demographics, Health & Social Issues Read time: 6 min

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AUTHORS

Christine Vestal
Staff Writer
Stateline

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U.S.

# As Covid-19 Cases Surge, Latino Communities Feel the Brunt

In heavily Hispanic neighborhoods of Los Angeles, crowded apartments and concerns about testing affecting immigration status are common

# 2022-2023 CMS and Joint Commission Prioritizing Health Equity


## PILLAR: HEALTH EQUITY

**2022 STRATEGY**

The first pillar of the Centers for Medicare & Medicaid Services' (CMS) Strategic Plan is health equity. CMS' strategy to advance health equity will address the health disparities that underlie our health system through stakeholder engagement and by building this pillar into the core functions of CMS. CMS' health equity strategy will build on the Biden-Harris Administration's commitment to advancing racial equity and support for underserved communities through the federal government, as described in President Biden's Executive Order 13985.

The Joint Commission

## Proposed Requirements for the Health Care Equity Advanced Certification Program Field Review

The Joint Commission is developing requirements for a new advanced certification program focused on improving health care equity. The advanced certification program requirements build upon The Joint Commission's long-standing accreditation standards supporting health care equity and the recently released requirements to reduce health care disparities. This voluntary program will recognize hospitals that strive for excellence in their efforts to provide equitable care, treatment, and services.

**Collect Accurate Self-Reported Patient Data on Age, Race, Ethnicity, Language, Ability, SOGI**


Established in 1980 with origins back to the Boston Lying-In Hospital, established in 1832, and Free Hospital for Women, established in 1875.

801-bed Academic Medical Center and partners with its 162-bed Faulkner Hospital in Boston, MA as part of Harvard Medical School.

Over 150 outpatient practices and 1,200 doctors throughout the New England area serving patients from New England, across the United States and from 120 countries around the world.

Mission: to provide high-quality, compassionate patient care, support groundbreaking research, train the next generation of health care professionals and cultivate healthier communities locally and globally.

Its values and guiding principles include integrity, collaboration, inclusion, professionalism and empathy which requires an inclusive environment that values differences including, but not limited to race, gender identity, ethnicity, language, sexual orientation, age, physical or mental ability, religion, income, and national origin.

To achieve their mission equity is embedded into its policies, practices, education, and strategic plan to support patients, families, employees, and the community..

**In 2019, a Medical Director of Quality, Safety, and Equity was established.**

**In 2021, expansion to 3 Medical Directors of Quality, Safety, and Equity.**

# 5 Key Drivers – Advancing Equity through Quality and Safety

**Driver 1**

Integrate Equity into all Operations / Quality / Safety Analyses

**Driver 2**

Use Equity-Informed Education

**Driver 3**

Use Data to Support Equity Improvement

**Driver 4**

Leadership Awareness and Engagement

**Driver 5**

Organizational Accountability

# Health Equity Priorities

Safety

Quality

Experience

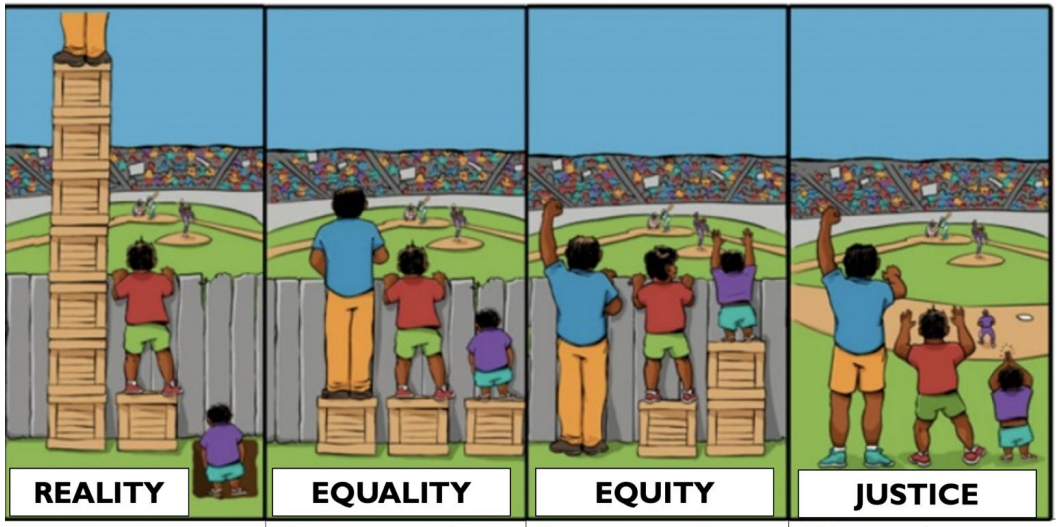
Data

Mass General Brigham

# Health Equity: Patient Safety

# Equity-Informed High Reliability Organization Framework to Patient Safety

## Equity Informed




| REALITY | EQUALITY | EQUITY | JUSTICE |
|---|---|---|---|
| One gets **more than** is needed, while the other gets **less than** is needed. Thus, a huge disparity is created. | The assumption is that **everyone benefits from the same supports**. This is considered to be equal treatment. | **Everyone gets the support they need**, which produces equity. | All 3 can see the game without supports or accommodations because **the cause(s) of the inequity was addressed**. The systemic barrier has been removed. |

+

## High Reliability Organizations

# Equity-Informed High Reliability Process

**Goal:** See and Understand **RISK** via Equity-Informed and High-Reliability Approach

## SYSTEMS Reliability

- Effective
- Resilient
- Examine Factors Influencing System Performance
- Test and Manage Potential System Performance.

## HUMANS Reliability

**(Interpersonal - Implicit/Explicit Bias)**

- Reliability
- Examine and Manage the Factors Influencing Human Performance (Systems/Personal)
- Examine and Manage Behaviors (Human Error, choices)

## ORGANIZATIONS Reliability

- Apply a balanced response to both System and Human Performance
- Does the organization See and Understand the risk?

**"Are inequities contributing to this risk?"**
**If so, at what level? Structural, Institutional, Interpersonal**

# Health Inequities: Levels of Discrimination and Bias

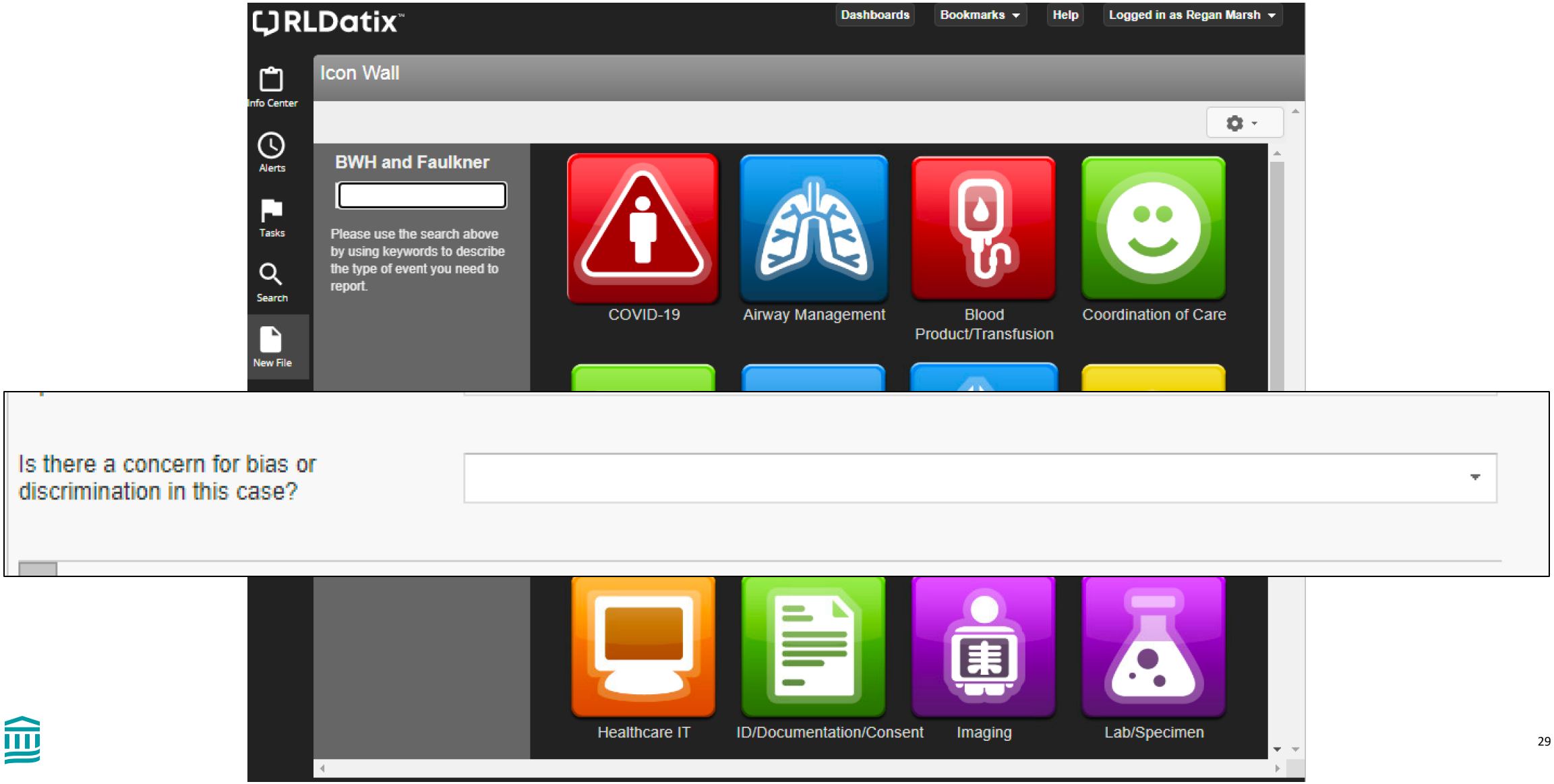
**Structural:** ***Structural drivers of health*** *refers to the macroeconomic social/health policies, and the systems of power that shape social hierarchy and gradient that contribute to patient harm. Often includes Social Determinants of Health.*

**Institutional:** ***Institutional or Systemic contributors*** *refers to the system in place to manage risk and any components of that system, including by not limited to policies, procedures, technology, etc.*

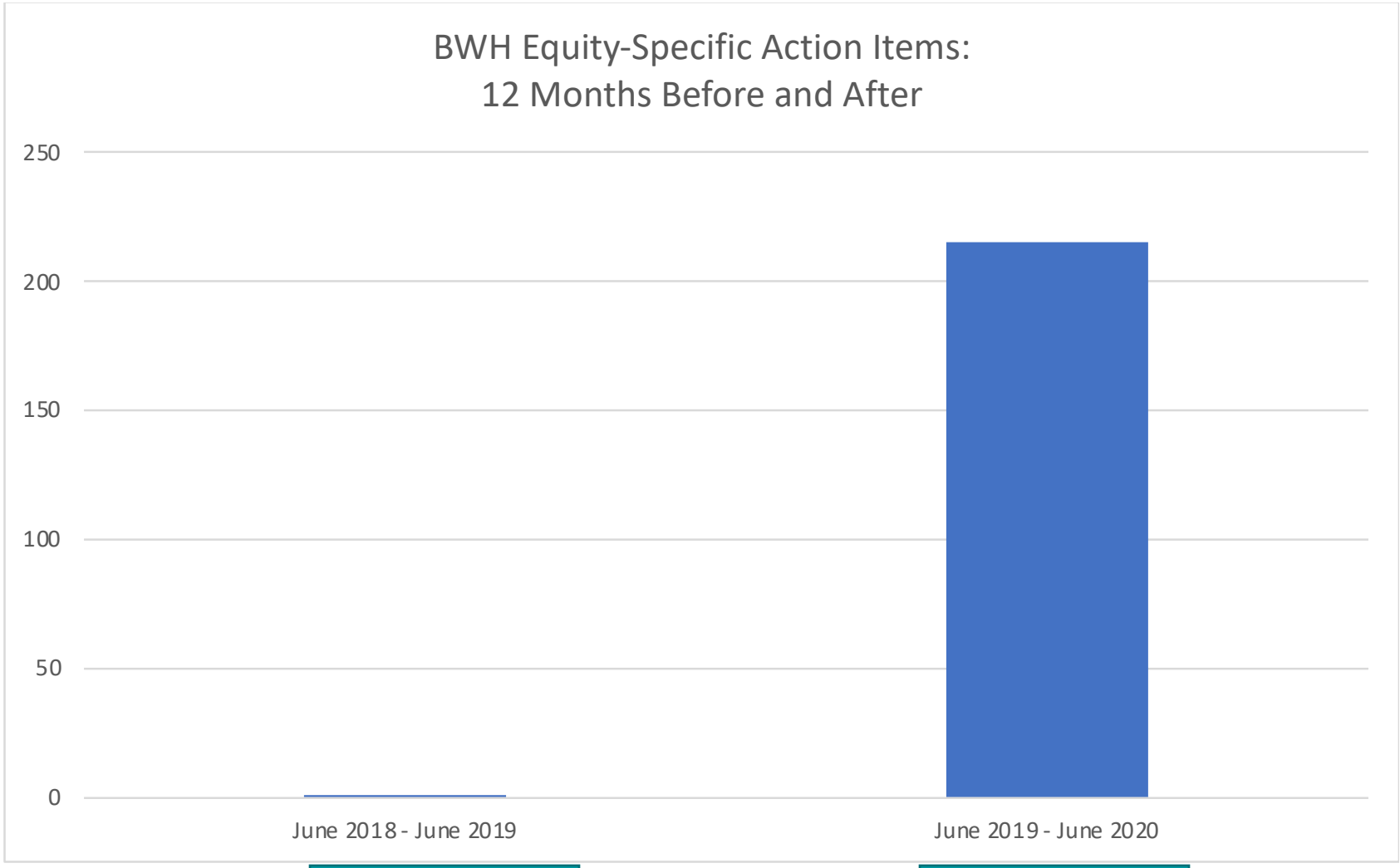
**Interpersonal (implicit):** ***Human performance contributors*** *refer to factors that affect cognition and can be both personal and system-related. For example, these contributors can include distraction, fatigue, training, and equipment.*

**Interpersonal (explicit):** ***Human behavior*** *refers to choices and errors made by humans.*

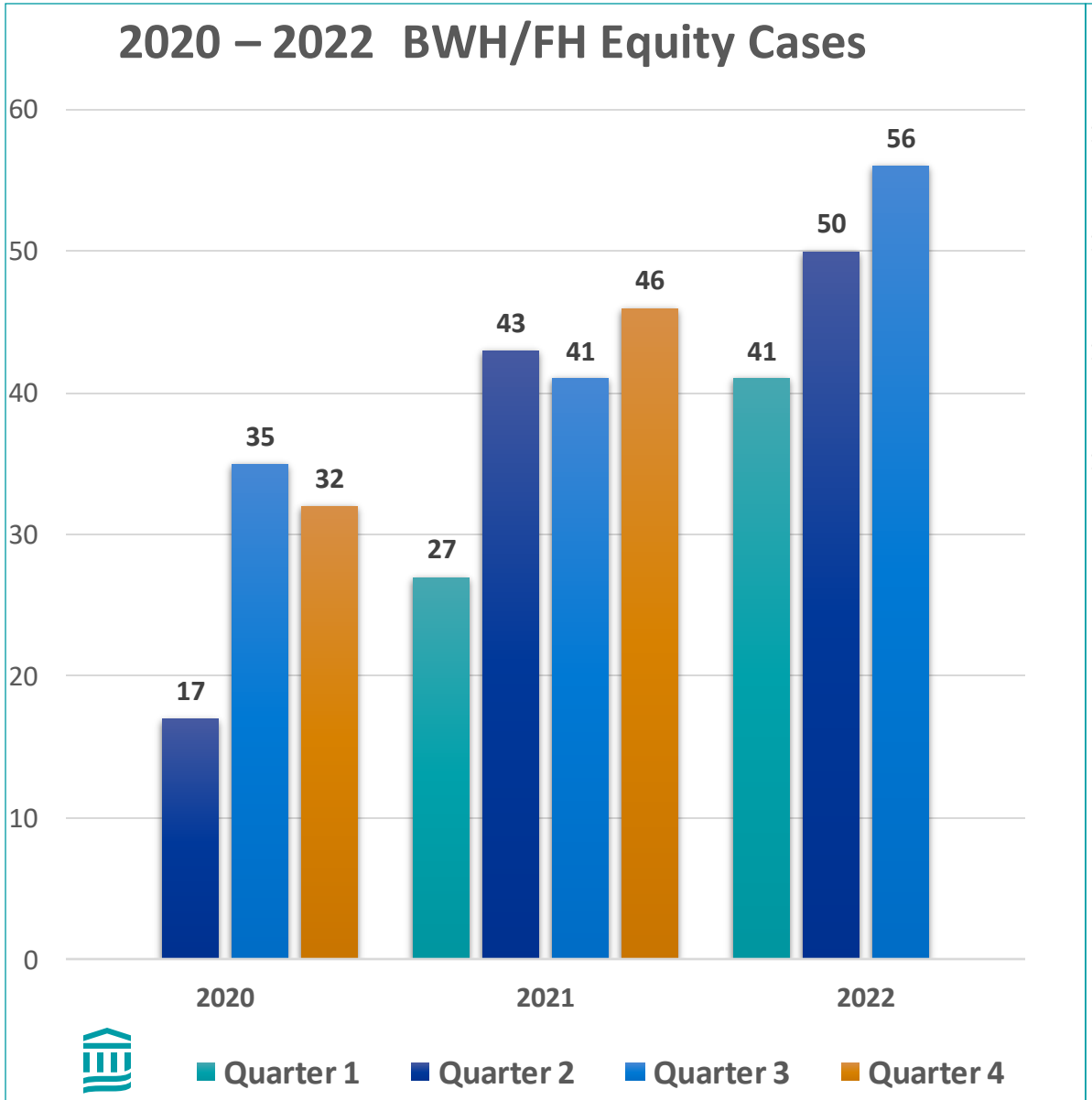
# Safety & Risk: Integration of Potential Inequities Reporting

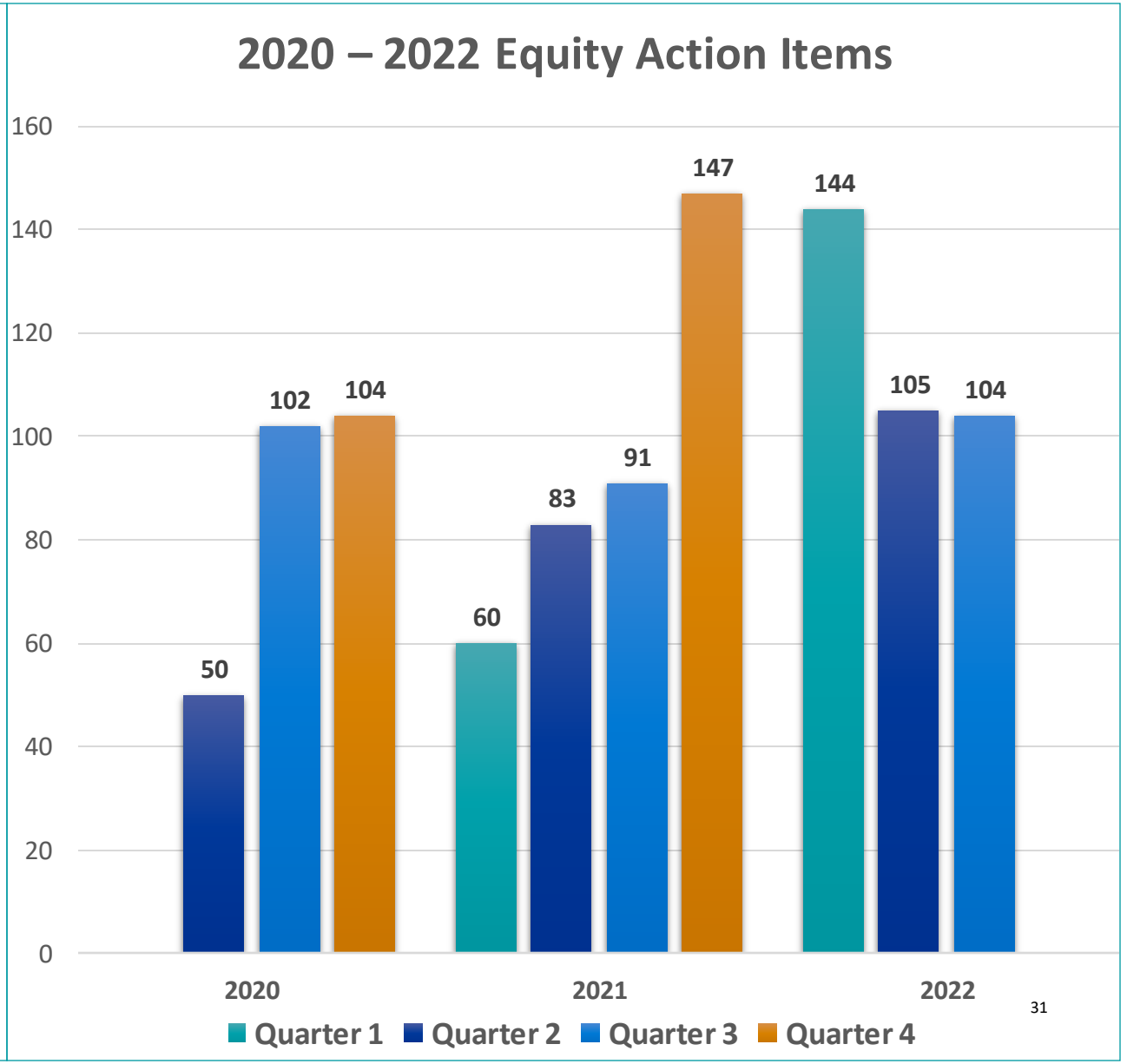


# Example: Equity Specific Action Items
# Pre- and Post- Launch of Equity-Informed HRO



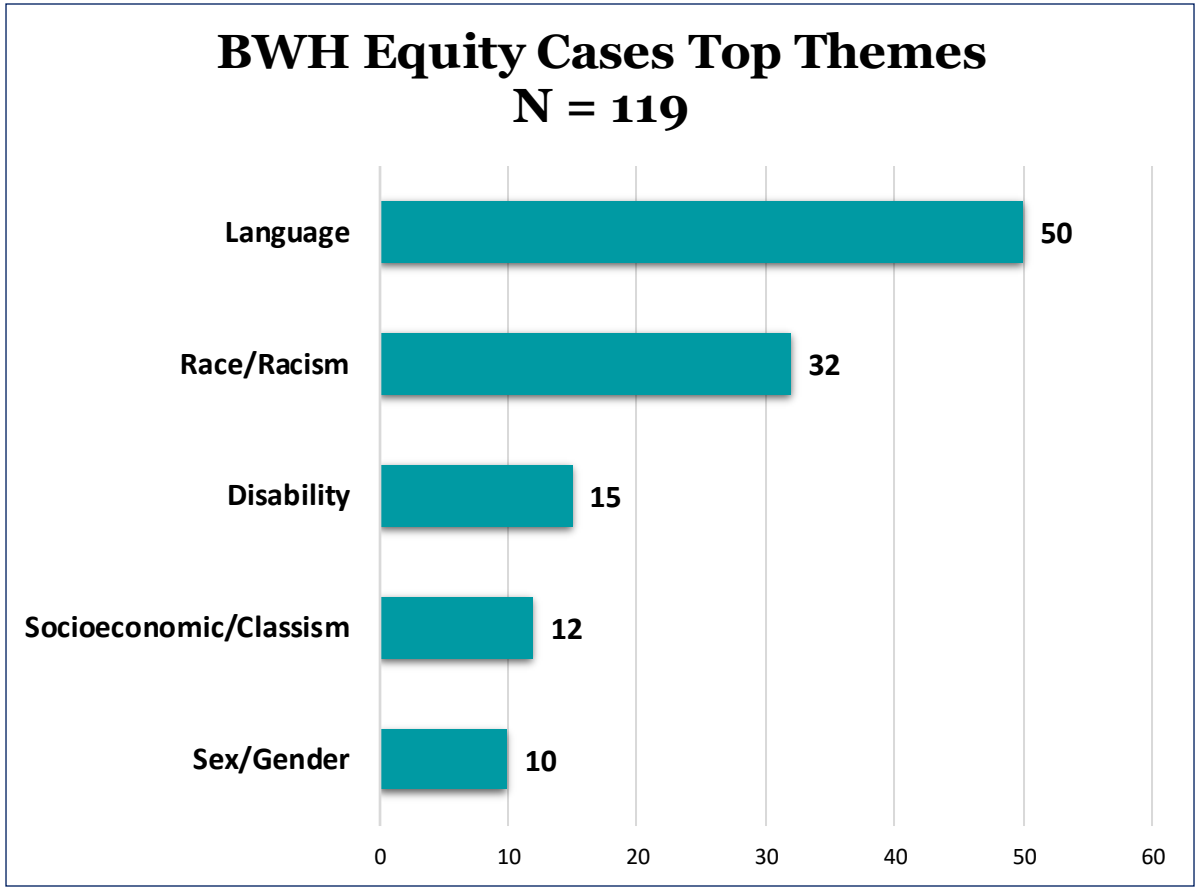
# BWH/FH Equity Tracker



# Building a Taxonomy & Capturing Themes

| Discrimination Type: | Subtype (optional) | Level | Modality |
|---|---|---|---|
| Ability/Ableism | Disability, mobility<br>Disability, visual<br>Disability, hearing<br>Neurodiversity<br>Other | **Structural**<br>**Institutional**<br>**Interpersonal** | **Explicit**<br><br>(e.g., clarity about beliefs and attitudes, and related behaviors or policies are made with intent) |
| On the basis of mental health/substance use issues | Behavioral health-related<br>Alcohol and substance use-related | | |
| Socioeconomic-related/Classism | Education-related<br>Poverty-related<br>Occupation-related<br>Neighborhood-related<br>Social status-related<br>Insurance-related | | |
| Language | Language-related | | |
| Race/Racism | Race-related<br>Ethnicity-related<br>Immigration-status related<br>Xenophobia related | | **Implicit**<br><br>(e.g., operating outside of individual or institutional awareness, and can be in contradiction to espoused beliefs) |
| Religious discrimination | Religious discrimination | | |
| Sex/Gender-based Discrimination | Sex related<br>Sexual orientation related<br>Gender Identity related | | |
| Age/Ageism | Age-related | | |
| Other | Veteran-related<br>Genetic-related<br>Pregnancy-related<br>Weight-related<br>Heritage & Tradition-related<br>Carceral status-related | | |
| No bias or discrimination identified | | | |



# Equity-Informed High Reliability Process

- Collaborative Case Reviews (CCR):
  - All CCRs begin with the patient's demographic information: *Name, Age, Gender, Race/Ethnicity, Language, Insurance*
  - Facilitates understanding of potential role of racism, discrimination and bias

- Comprehensive Review includes: *Systems, Human Performance, Human Behavior*
  - **Clinical Review**: Was standard of care met? Was care appropriate? Are there opportunities for improvement?
  - **Equity Review**: Did discrimination or bias affect care?

Standard Language

- The widespread inequities (and associated patient harm) seen in healthcare often arise from broken systems, policies, and practices.
- The intent of reporting is **not to blame the individual**, but rather to **re-design our systems** to advance high-quality, safe, and equitable care for every single patient.
- Equity at core of practice instead of forgotten in practice

# Tracking, Analysis, Improvement

**Equity Tracker:**

- Safety reports flagged for discrimination or bias by frontline care team
- PFR patient concerns
- Direct emails from local leaders and staff
- NRC patient satisfaction feedback

**Comprehensive case analysis:**

By multidisciplinary teams from quality, safety, equity, patient experience, diversity and inclusion and involved clinical services

**Identify trends:**

Opportunity to focus on high frequency themes that increase the risk of adverse events due to discrimination or bias

**Process improvements:**

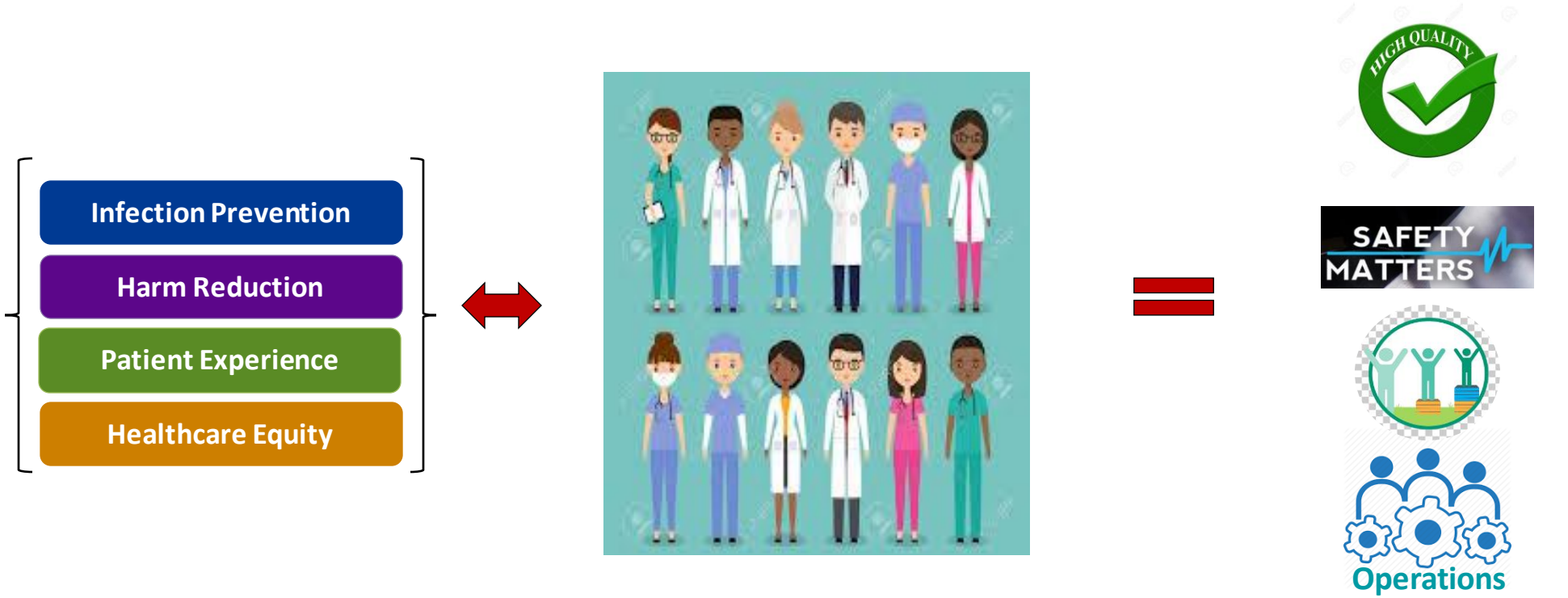
Support clinical teams and services to review their cases, data and develop processes to improve patient care and experience

Mass General Brigham

# Health Equity: Patient Quality

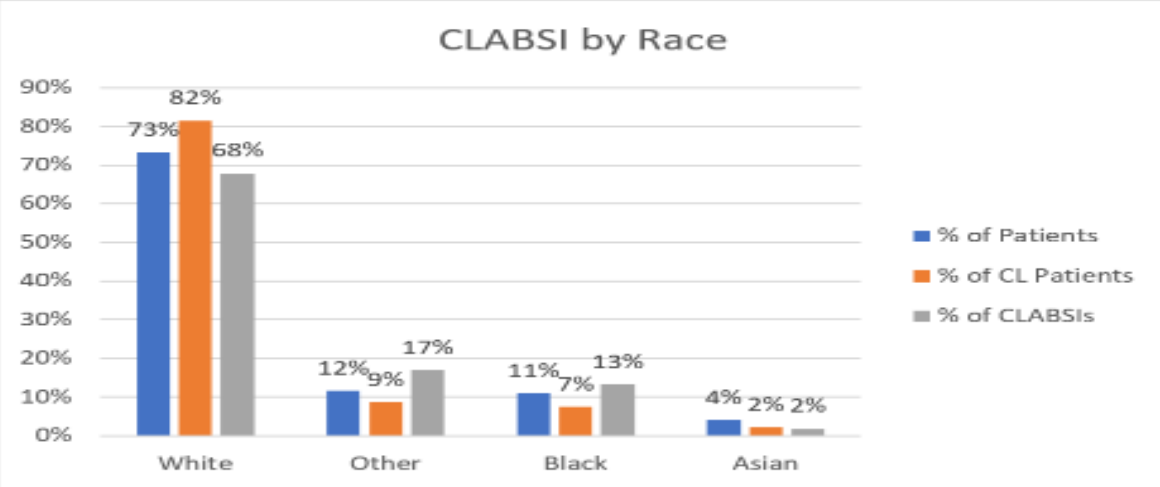
# BWH: Domain Teams

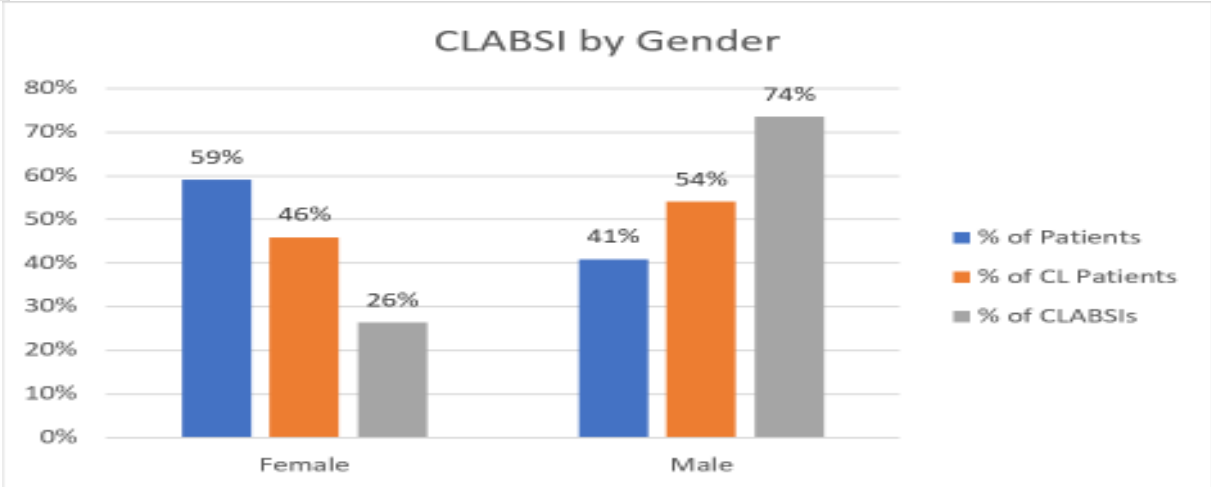
Domain Teams liaise with leadership to **inform goals** and **strategies, set priorities,** and **collaborate with UBTs** to help with **initiative development, design, workflow**, and **implementation**

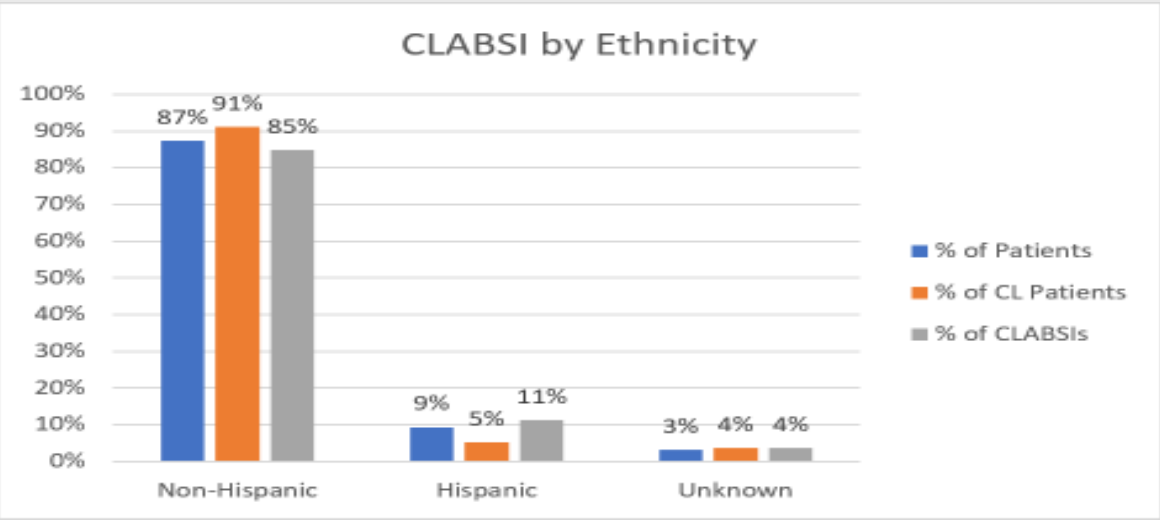


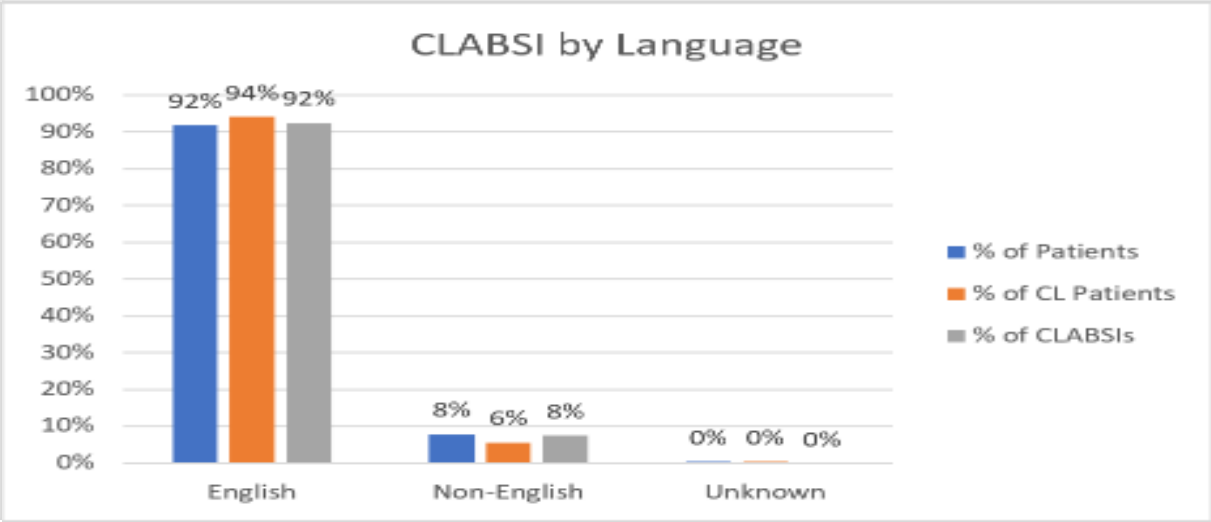

**Domain Teams** | **Unit Based Team** | **Clinical Outcomes**

# CLABSI by Race, Ethnicity, Gender, Language

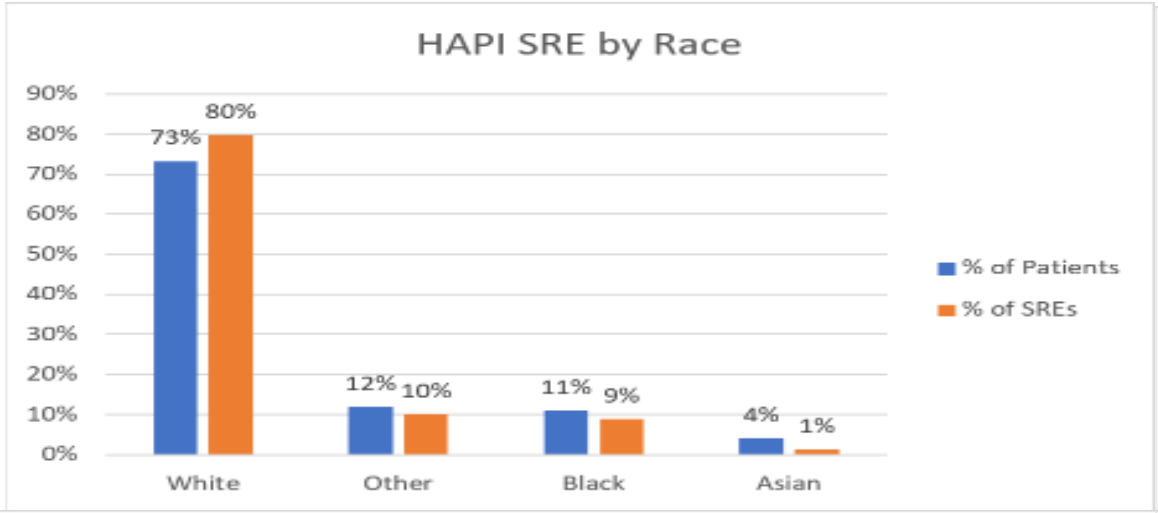


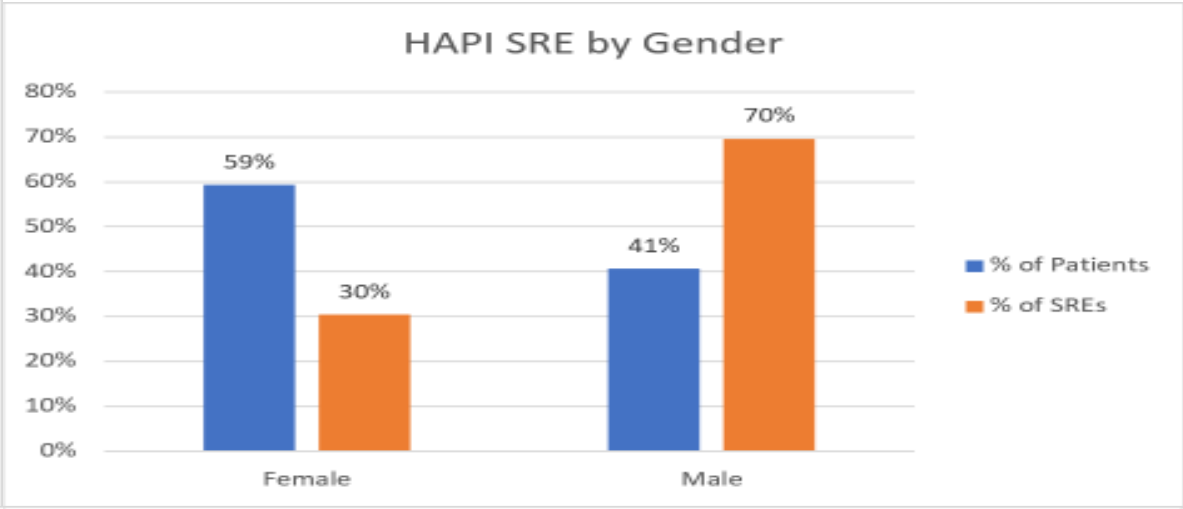



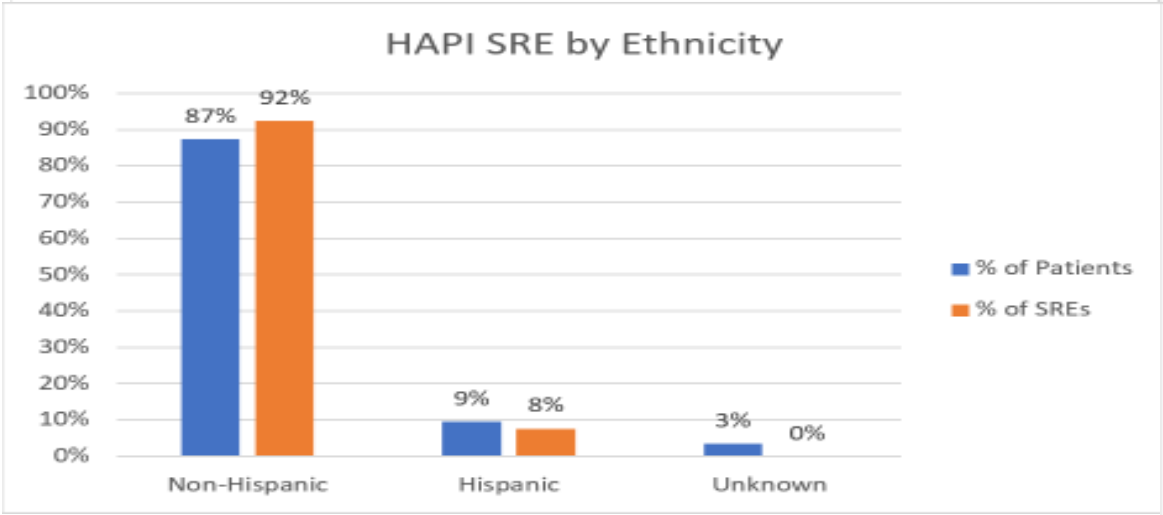



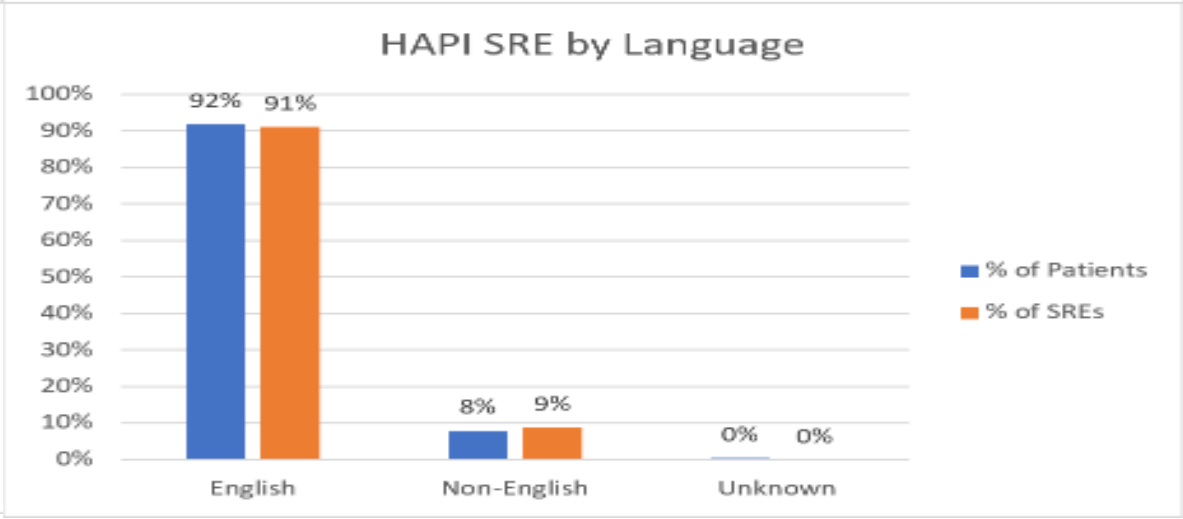



# HAPI by Race, Ethnicity, Gender, Language



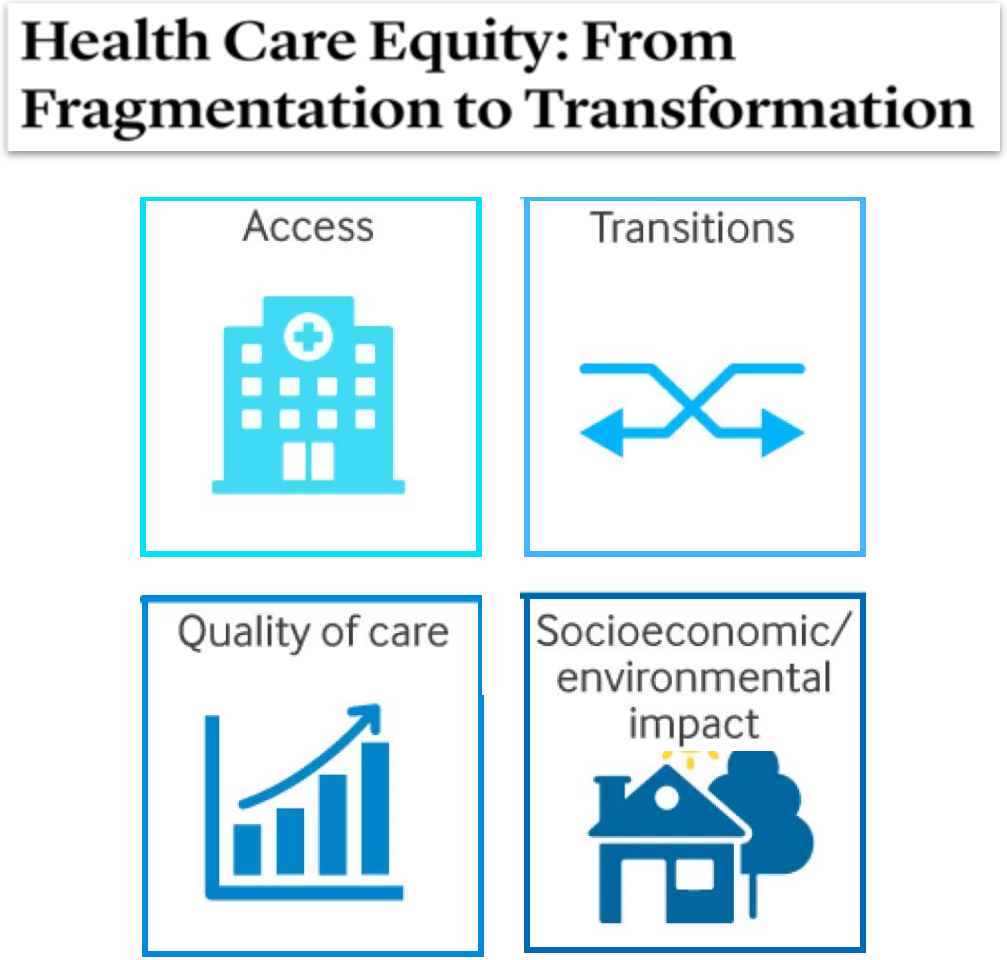



# Healthcare Equity Domain Team Aim and Framework

**AIM:** to systematically advance racial justice and equity in care delivery at Brigham Health, through high-performance quality and safety practices by:

- Defining equity-informed standard operating procedures
- Identifying and communicating evidence-based practices
- Working in collaboration with unit-based teams (UBTs) and departments, as well as service-line, hospital and enterprise leadership.






K. Sivashanker, T. Duong, A. Resnick, S. Eappen.
NEJM Catalyst. Sept 1, 2020

# BWH Equity Domain Approach

- **Build the Team**: leaders in equity and quality and safety
- **Collaborate**: across BWH and MGB groups
  - Board Committee on Diversity, Inclusion, Health Equity and Community Health
  - MGB United Against Racism
  - Center for Community Health and Health Equity
- **Standardize approach** to measurement:
  - REaL – race, ethnicity and language
  - SOGI – sexual orientation, gender identity
  - Geography and SES – priority neighborhoods, ADI and SVI
  - Payor

- **Perform a Landscape Analysis** of all Brigham health equity initiatives
- **Evaluate demographics** of the communities we serve – as an essential backdrop
- **Use NEJM Catalyst Framework** to harmonize, build efficiencies and expand equity work:
  - **Access**: understand our patient population at the inpatient, ED and outpatient levels
  - **Transitions**: identify differences in admission, transfer/triage and discharge
  - **Quality of Care**: support and highlight service-specific equity interventions
- **Disseminate** work to increase impact

# Healthcare Equity Domain Team Aim and Framework

**AIM:** to systematically advance racial justice and equity in care delivery at Brigham Health, through high-performance quality and safety practices by:

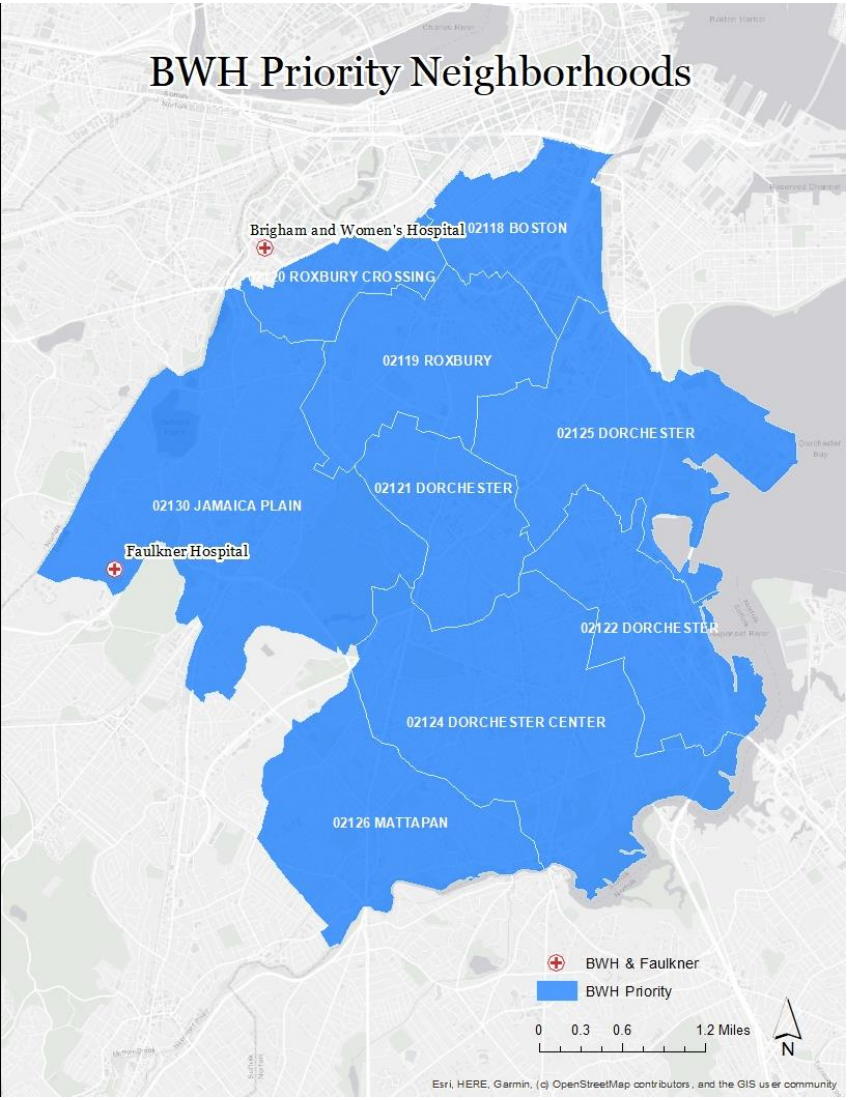
- Defining equity-informed standard operating procedures
- Identifying and communicating evidence-based practices
- Working in collaboration with unit-based teams (UBTs) and departments, as well as service-line, hospital and enterprise leadership.

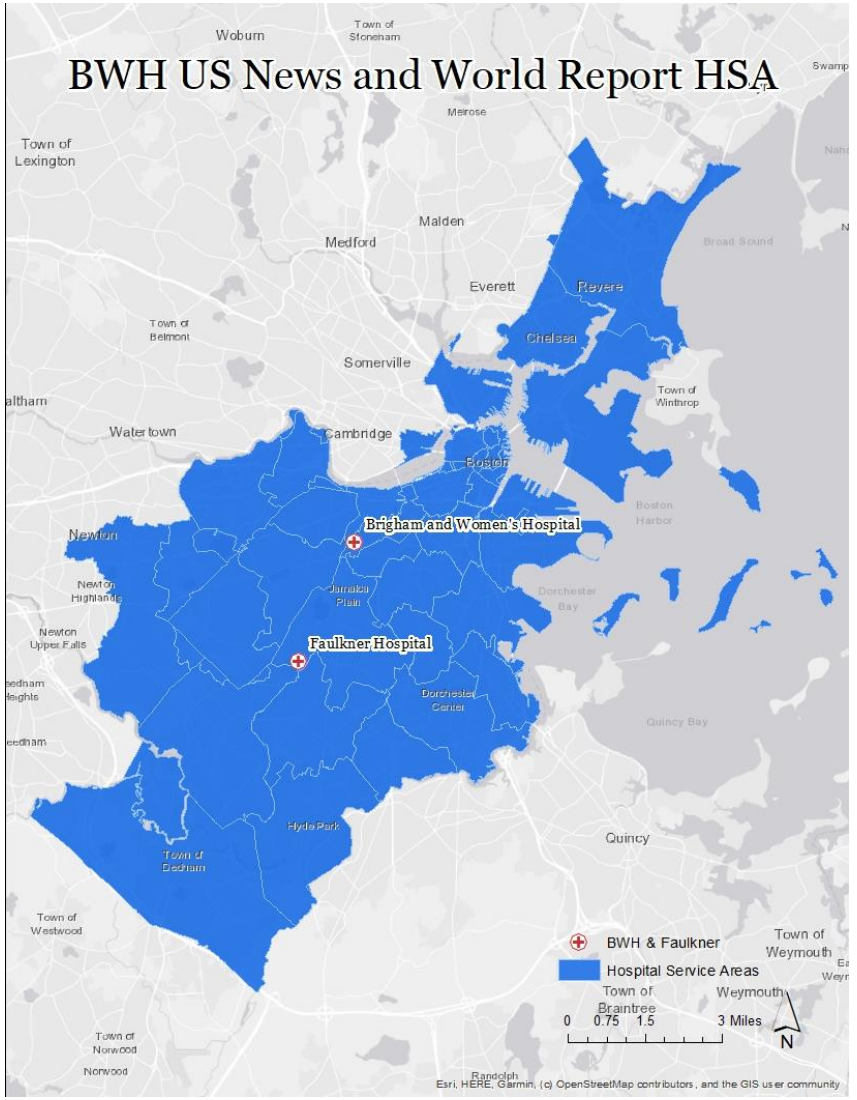
**Health Care Equity: From Fragmentation to Transformation**

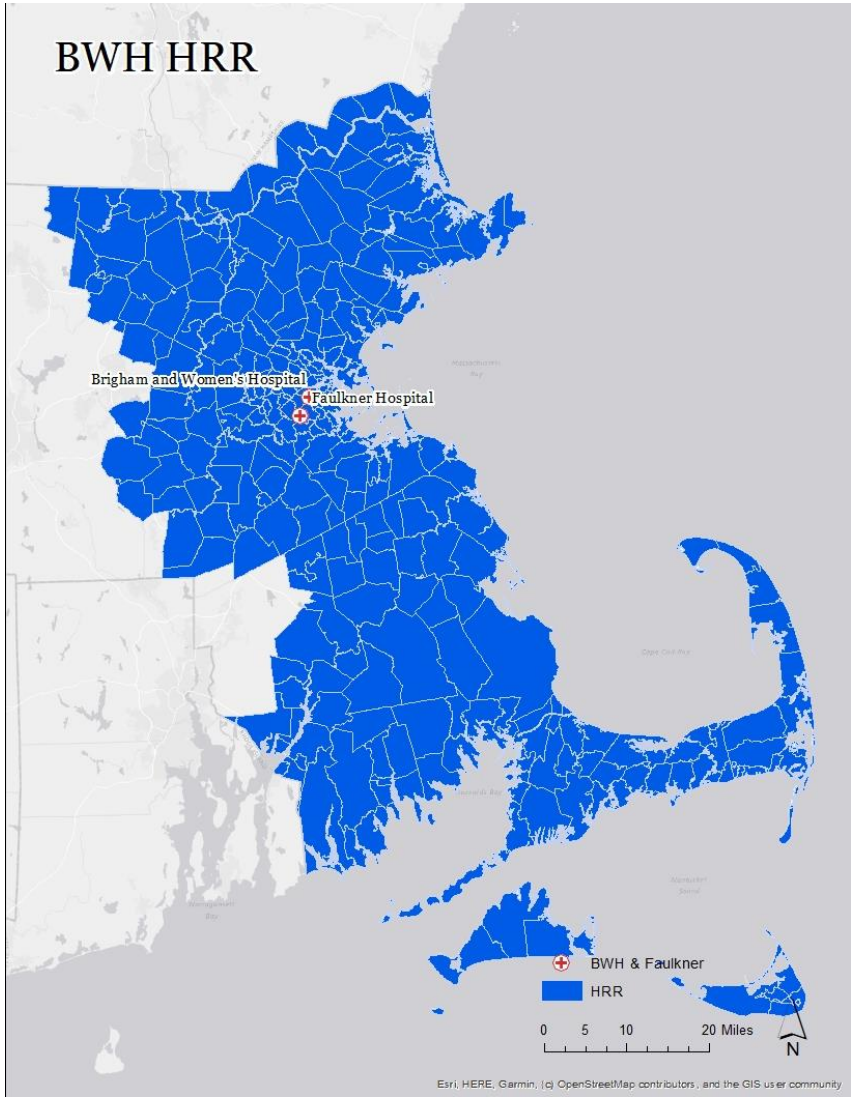



**K. Sivashanker, T. Duong, A. Resnick, S. Eappen.**
NEJM Catalyst. Sept 1, 2020

# Understanding our Catchment Area:
# *Priority Neighborhoods, HSA, HRR*



# Demographics: Community We Serve

| | BWH | BWH Priority Neighborhoods | HSA | HRR |
|---|---|---|---|---|
| Total Population | 202,495 | 287,777 | 893,984 | 5,157,971 |
| Sex | | | | |
| • Female | 61% | 53% | 52% | 52% |
| Race | | | | |
| • White | 66% | 33% | 57% | 79% |
| • Black | 10% | 45% | 20% | 10% |
| • Asian | 4% | 8% | 10% | 8% |
| • Other/unknown | 22% | 13% | 12% | 4% |
| Ethnicity | | | | |
| • Latino/Hispanic | 11% | 21% | 21% | 12% |
| Language | | | | |
| • English | 93% * | 54% | 60% | 74% |
| • Non-English | 7% * | 46% | 40% | 26% |
| • Spanish | - | (18%) | - | - |
| • Other | - | - | - | - |

Compared to our HSA and our Priority Neighborhoods population, a higher proportion of BWH patients are White and English speaking

# Patient Demographics: Ambulatory, ED and Inpatient

| | BWH | Ambulatory | ED | Inpatient |
|---|---|---|---|---|
| Total Population (Unique Pts) | 202,495 | 129,631 | 45,050 | 68,849 |
| Sex | | | | |
| • Female | 61% | 62% | 63% | 60% |
| Race | | | | |
| • White | 66% | 74% | 47% | 63% |
| • Black | 10% | 9% | 23% | 9% |
| • Asian | 4% | 4% | 5% | 4% |
| • Other/unknown | 22% | 13% | 25% | 24% |
| Ethnicity | | | | |
| • Latino/Hispanic | 11% | 11% | 23% | 12% |
| Payor | | | | |
| • Commercial | 54% | 56% | 43% | 51% |
| • Medicare | 28% | 31% | 22% | 33% |
| • Medicaid | 15% | 12% | 27% | 15% |
| • Uninsured, Military, Other | 3% | 2% | 9% | 2% |

Majority of patients seen in BWH ambulatory care are White and commercially insured.

Majority of patients seen in BWH ED are not White or commercially insured.

Least amount of "Other/unknown" race collected is in the ambulatory setting.

Brigham and Women's Hospital
Founding Member, Mass General Brigham

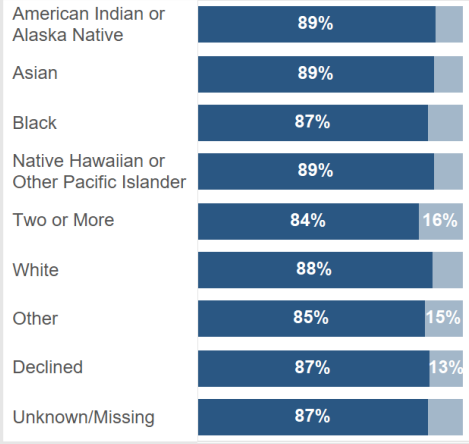
# Brigham Health Ambulatory Health Equity Dashboard

Completed Appointments | Date Period: **10/1/21 - 10/24/21**

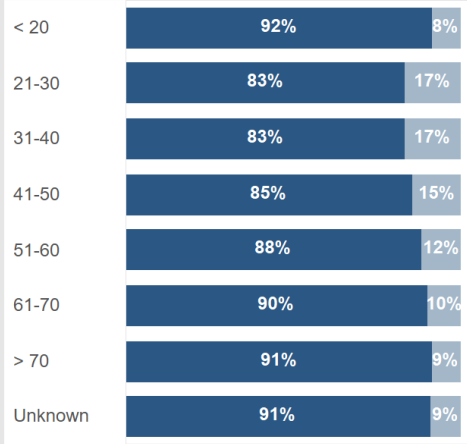
In Person  Virtual

| Metric | Period | Date Selection | Clinical Service | Sub Clinical Service | Division | Operational Cohort | Practice | Revenue Location |
|---|---|---|---|---|---|---|---|---|
| Completed Appointments | Month | 10/24/2021 | All | All | All | All | All | All |

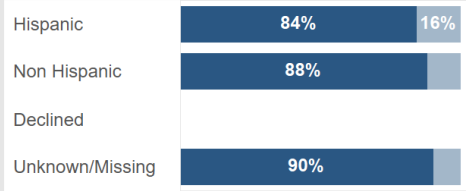
## Race



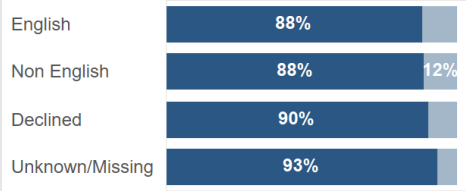

## Age



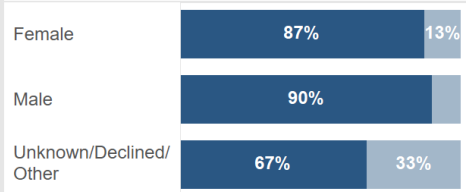

## Ethnicity



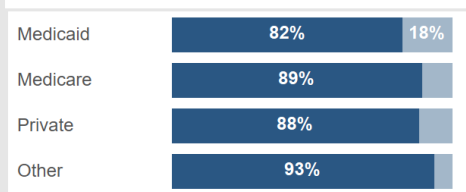

## Language




## Gender



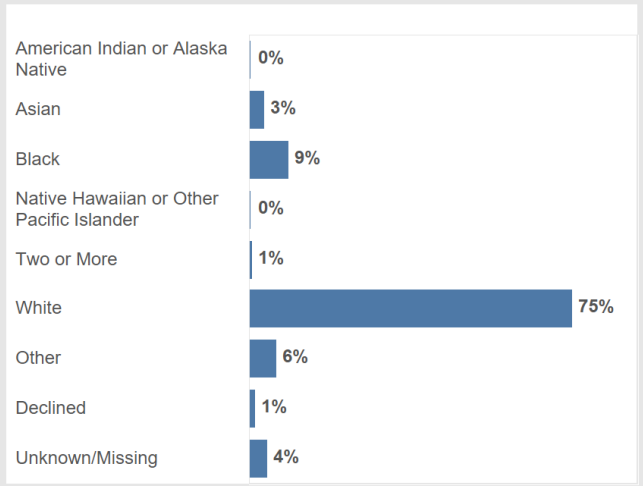

## Payor



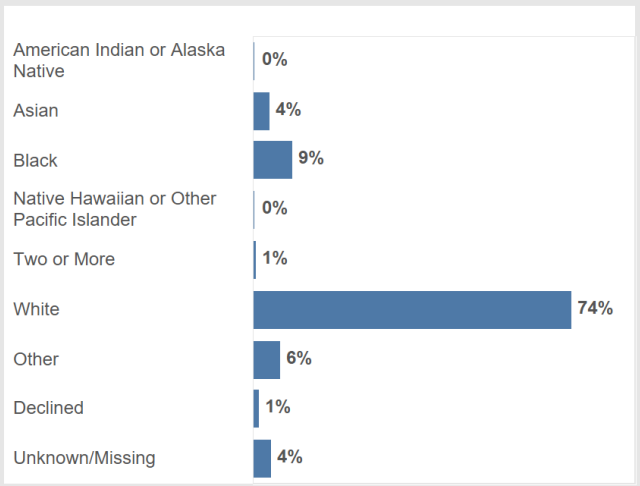

## Trend By Race

Select Group Race  Visit Method All  *Hover over the bars to view monthly trend*

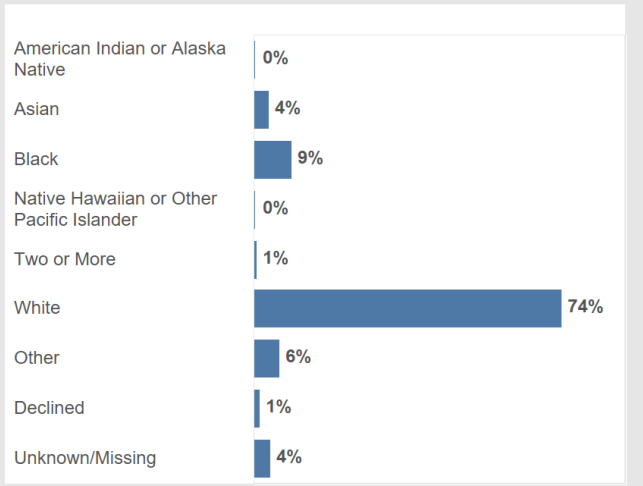
### FY 2020




### FY 2021




### FY 2022 YTD

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Prepared by ARI, APSI

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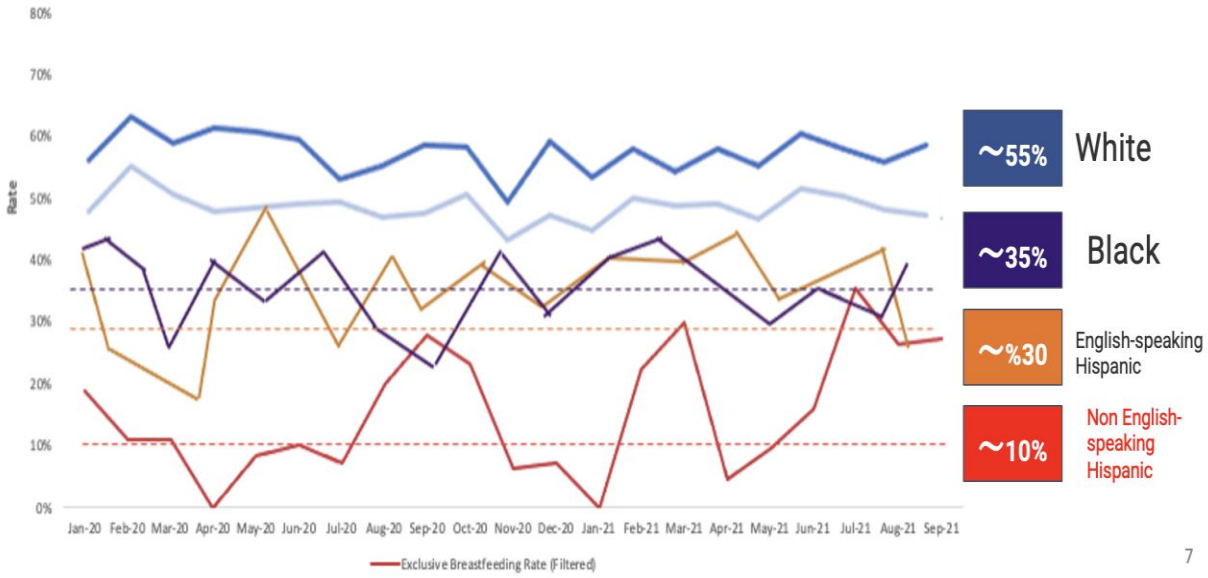
# Integrating Data to Quality Improvement Initiatives: Breastfeeding Example

## BWH: Exclusive breastfeeding rates at discharge

Lower rates among Black and Hispanic women than white.

Lowest rates of exclusive breastfeeding among Spanish speaking Hispanic women.

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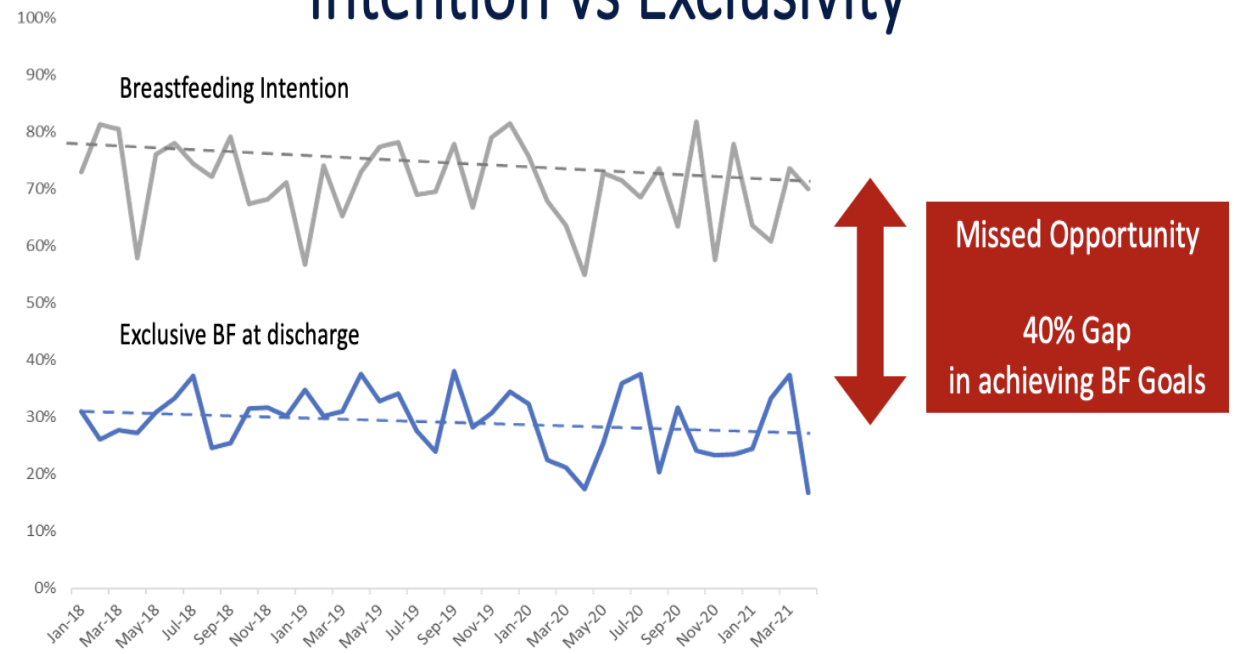
## BWH Breastfeeding Gap for Hispanic mothers: Intention vs Exclusivity



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# Aligning Patient-Centered Breastfeeding Resources



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# Healthcare Equity Domain Team Aim and Framework

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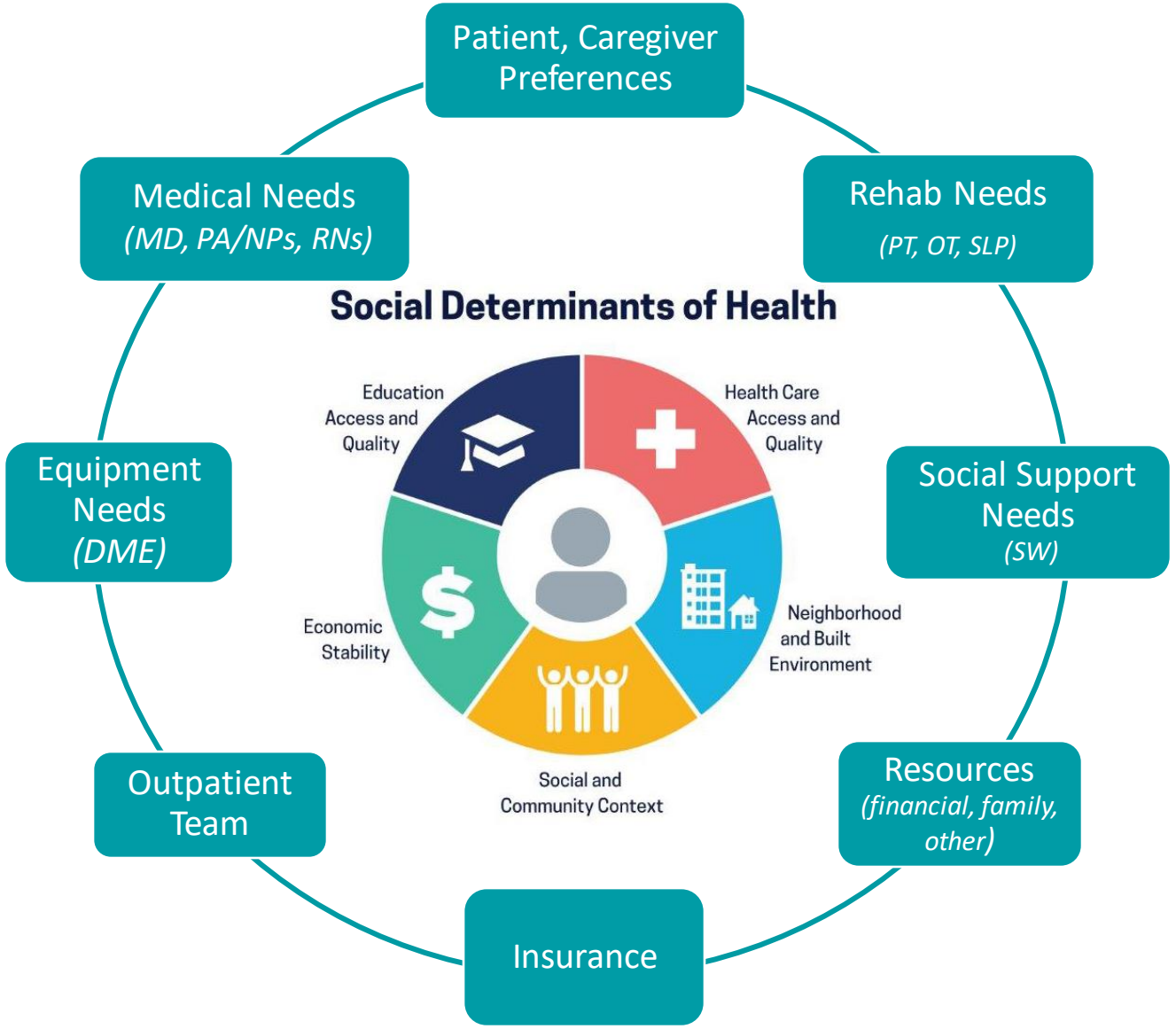
# Care Continuum Management aka “Case Management”

Multi-disciplinary division who uses **team approach** to ensure that the most appropriate & high-quality services are provided after discharge:

- Patient-centered
- Multi-disciplinary input and engagement
- Identify post-acute (after discharge) needs
- Create the optimal discharge plan
  - **Ideal vs feasible**

Division makeup:

- RN-Care Coordinators (RNCC)
- Social Workers
- Care Transition Specialists (CTS)
- Complex Care Team (CCT)
- iCMP
- Utilization Management



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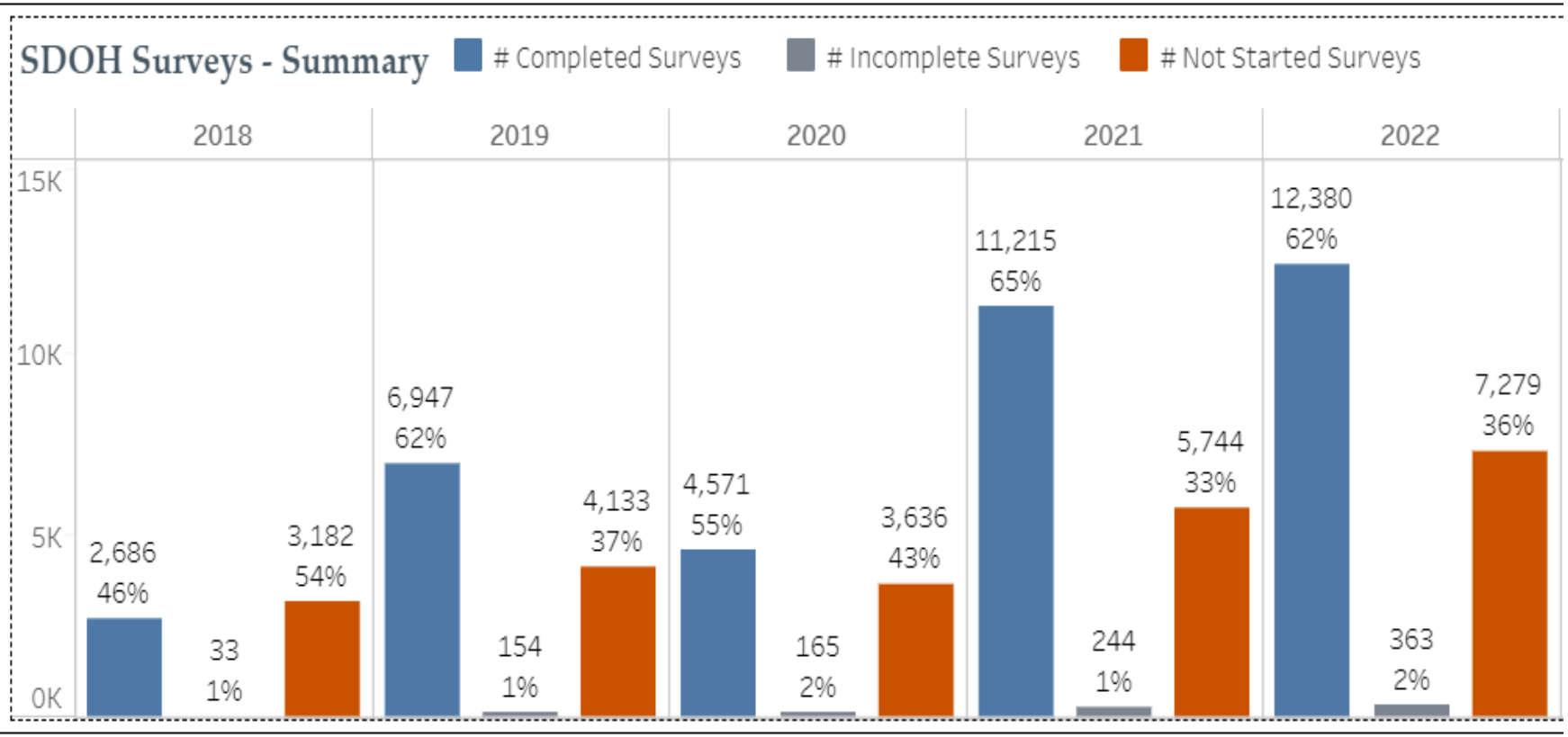
NEJM Catalyst. Sept 1, 2020

Mass General Brigham

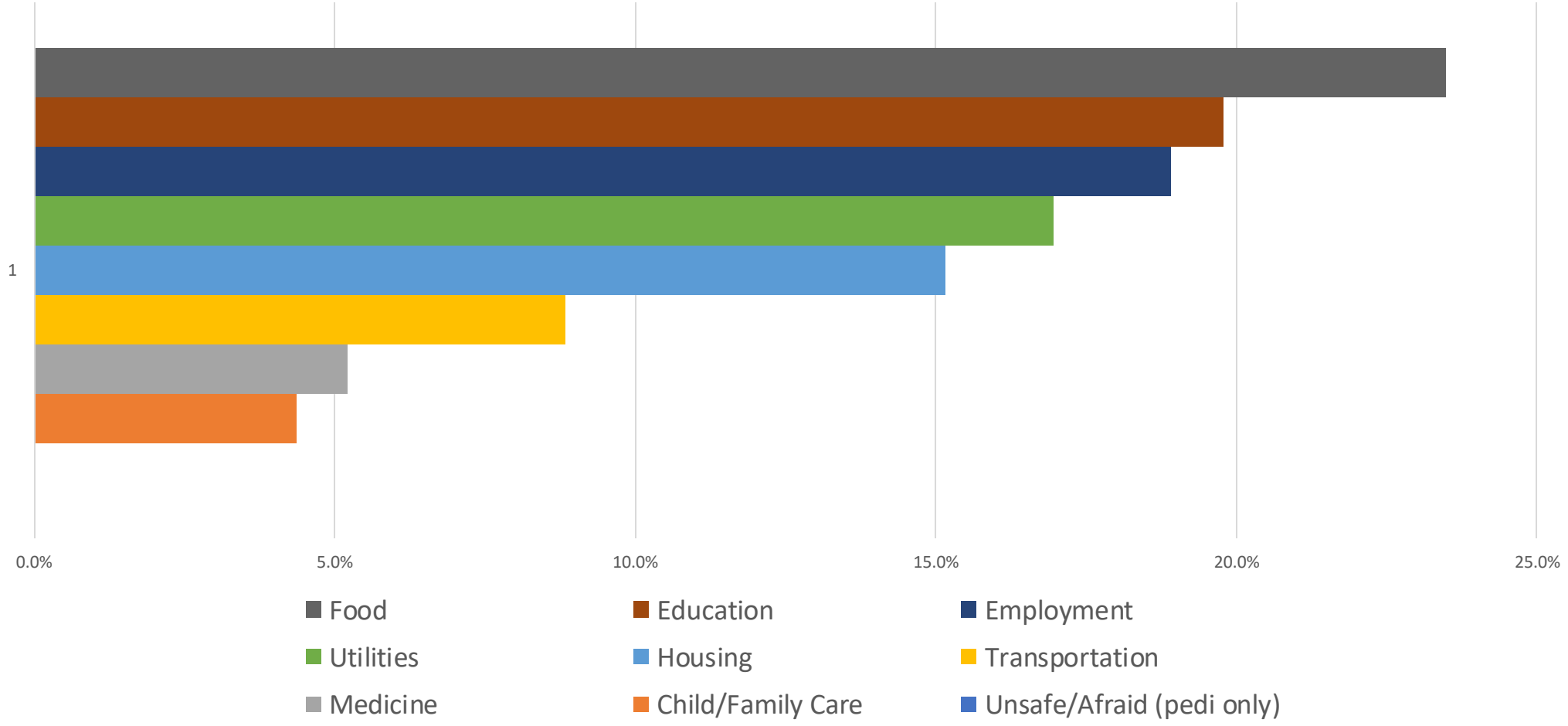
# Welcome to the SDOH Dashboard

## 2018 - 2023

| Number of Total Surveys | |
|---|---|
| 2018 | 5,901 |
| 2019 | 11,234 |
| 2020 | 8,372 |
| 2021 | 17,203 |
| 2022 | 20,022 |
| 2023 | 6,467 |



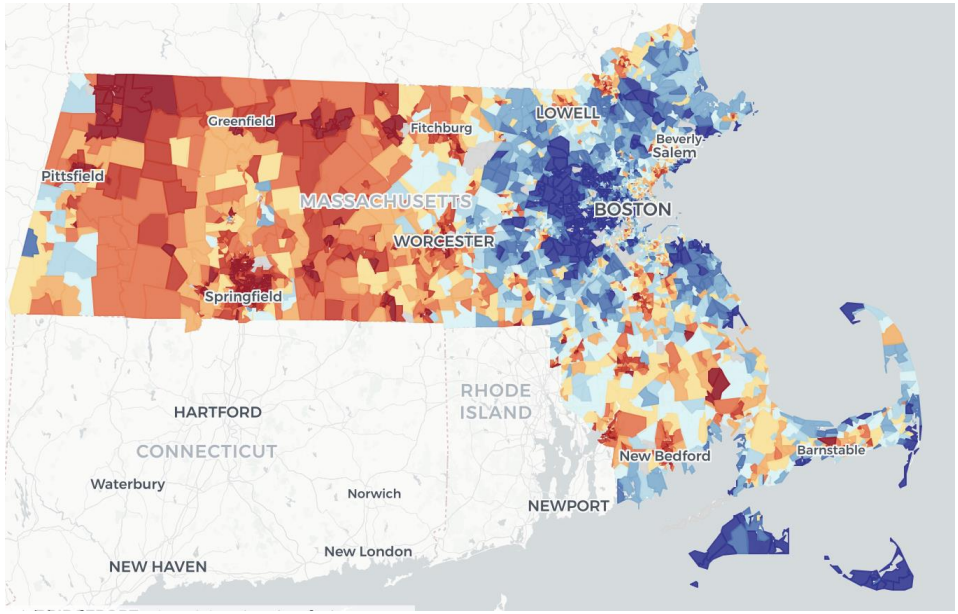
# Ambulatory SDOH Screening




~50% of Brigham Primary Care patients screen positive for 1 or more SDOH
13% have SDOH needs in 3 or more domains

# Measuring Other Data Neighborhood Risk/Vulnerability

| | Area Deprivation Index | Distressed Communities Index | Social Vulnerability Index |
|---|---|---|---|
| **Data granularity** | × County<br>× Zip Code<br>× Census Tract<br>✓ Block Group | ✓ County<br>✓ Zip Code<br>× Census Tract<br>× Block Group | ✓ County<br>• Zip Code possible<br>✓ Census Tract<br>• Block Group possible |
| **Timeliness** | Updated in 2015 and 2019 | Updated annually | Updated every two years |
| **Social Determinants of Health Domains** | ✓ Income & Wealth<br>✓ Employment<br>✓ Education<br>✓ Housing<br>× Health Systems<br>✓ Transportation<br>✓ Social Environment<br>× Physical Environment<br>× Public Safety | ✓ Income & Wealth<br>✓ Employment<br>✓ Education<br>✓ Housing<br>× Health Systems<br>× Transportation<br>× Social Environment<br>× Physical Environment<br>× Public Safety | ✓ Income & Wealth<br>✓ Employment<br>✓ Education<br>✓ Housing<br>× Health Systems<br>✓ Transportation<br>✓ Social Environment<br>× Physical Environment<br>× Public Safety |
| **Health Care Focus** | ✓ Life Expectancy / Mortality<br>× Chronic Disease Prevalence<br>✓ Readmissions<br>× ED utilization<br>× Maternal Health | × Life Expectancy/ Mortality<br>× Chronic Disease Prevalence<br>× Readmissions<br>× ED utilization<br>× Maternal Health | × Life Expectancy / Mortality<br>× Chronic Disease Prevalence<br>× Readmissions<br>× ED utilization<br>× Maternal Health |
| **Measurement Focus** | 17 components<br>2 components account for almost all of the variation (income and housing)<br><br>Intended to predict mortality, but a poor fit to life expectancy ($r^2$ 0.25) | 7 components<br>2 components account for almost all of the variation (income and housing)<br><br>Intended to describe economic differences; poor fit to life expectancy ($r^2$ 0.31) | 14 components in 4 domains, 2 components account for almost all of the variation (income and education)<br><br>Intended for disaster management planning; poor fit to life expectancy ($r^2$ 0.20) |
| **Geospatial Adjustments** | Single index algorithm for the whole country | Single index algorithm for the whole country.<br>Small zip codes excluded. | Single index algorithm for the whole country |



Mass General Brigham

# Health Equity: Patient Experience

# Demographics of Reporting:
## *Patient Family Relations & NRC compared to BWH Patients*

| | BWH | PFR | NRC |
|---|---|---|---|
| | 202,495 | 4628 Patients<br>8609 Concerns | 337,793 Responses<br>28% Response Rate |
| Sex | | | |
| • Female | 61% | 60% | 64% |
| Race | | | |
| • White | 66% | 74% | 82% |
| • Black | 10% | 13% | 7% |
| • Asian | 4% | 10% | 3% |
| • Other/unknown | 22% | 3% | 5% |
| Ethnicity | | | |
| • Latino/Hispanic | 11% | 6% | - |
| Language | | | |
| • English | 93% * | 94% | 97% |
| • Non-English | 7% * | - | - |
| • Spanish | - | 2% | 3% |
| • Other | - | 2% | <1% |

Compared to our overall patients, those who report via PFR and NRC are more likely to be White and less often Latino/Hispanic.

NRC reporters are more often English speaking.

# Patient and Family Relations: *specific types of patient concerns differ by race/ethnicity and language*

## BIPOC vs White Patients

**1017** Patients identified as BIPOC

**3402** Patients identified as White

PFR engaged **Patients of Color** more often for:

- Customer Service (8% vs 4%)
- Belongings (16% vs 14%)
- Behavioral & Patient Management (10% vs 7%)

PFR engaged **White patients** more often for:

- Billing (5% vs 4%)
- Pandemic concerns (6% vs 4%)
- Giving a compliment (3% vs 1%)

## Non-English Speaking vs English

**223** Patients Identified a non-English language

**4344** Patients Identified English as primary language

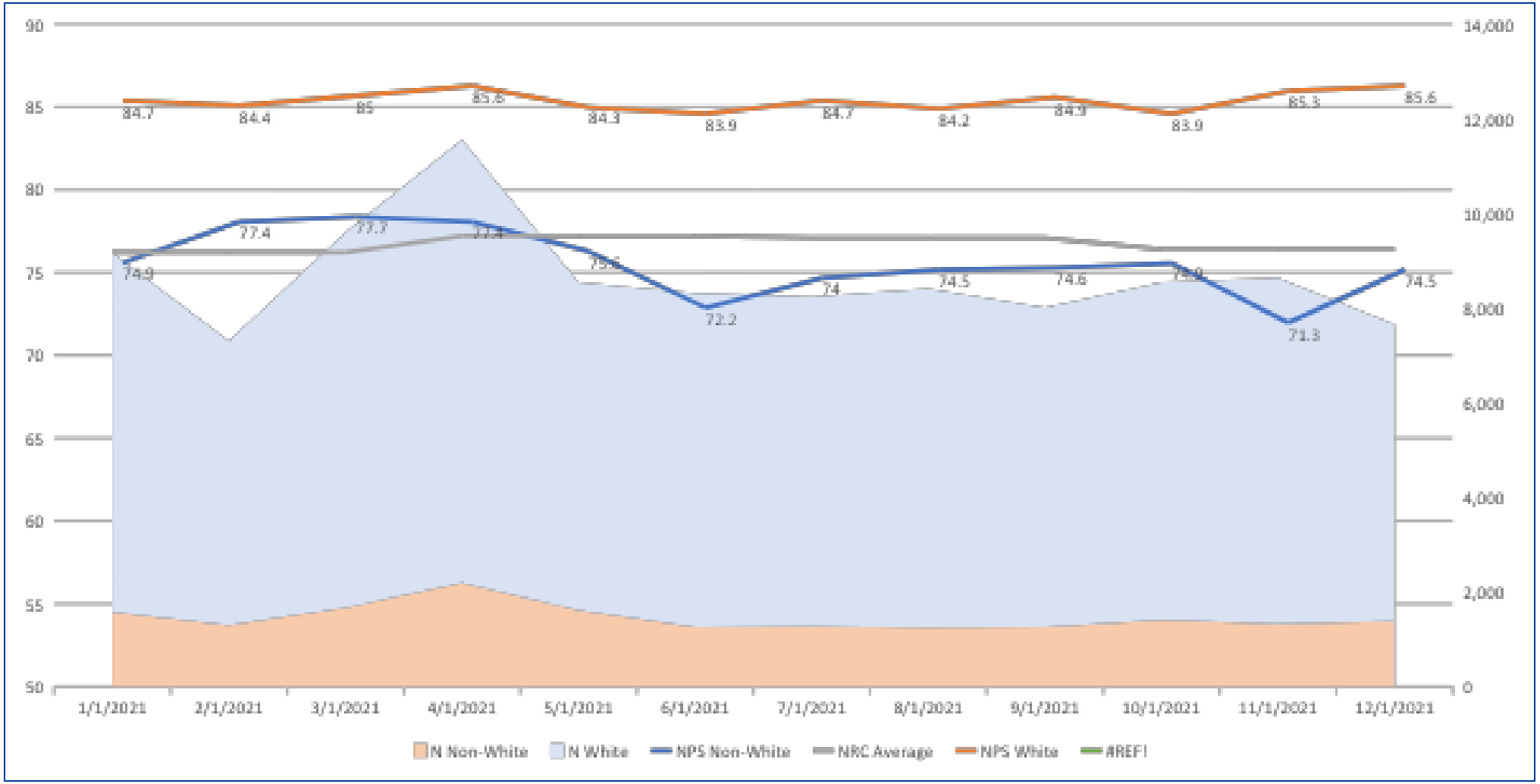
**Non-English speaking** engaged more often for:

- Customer Service (9% vs 4%)
- Belongings (18% vs 14%)
- Serious Reportable Events (4% vs 1%)

**English speaking** engaged more often for:

- Billing (5% vs 2%)
- Responsiveness (4% vs 1%)
- Giving a compliment (2.5% vs 0.5%)

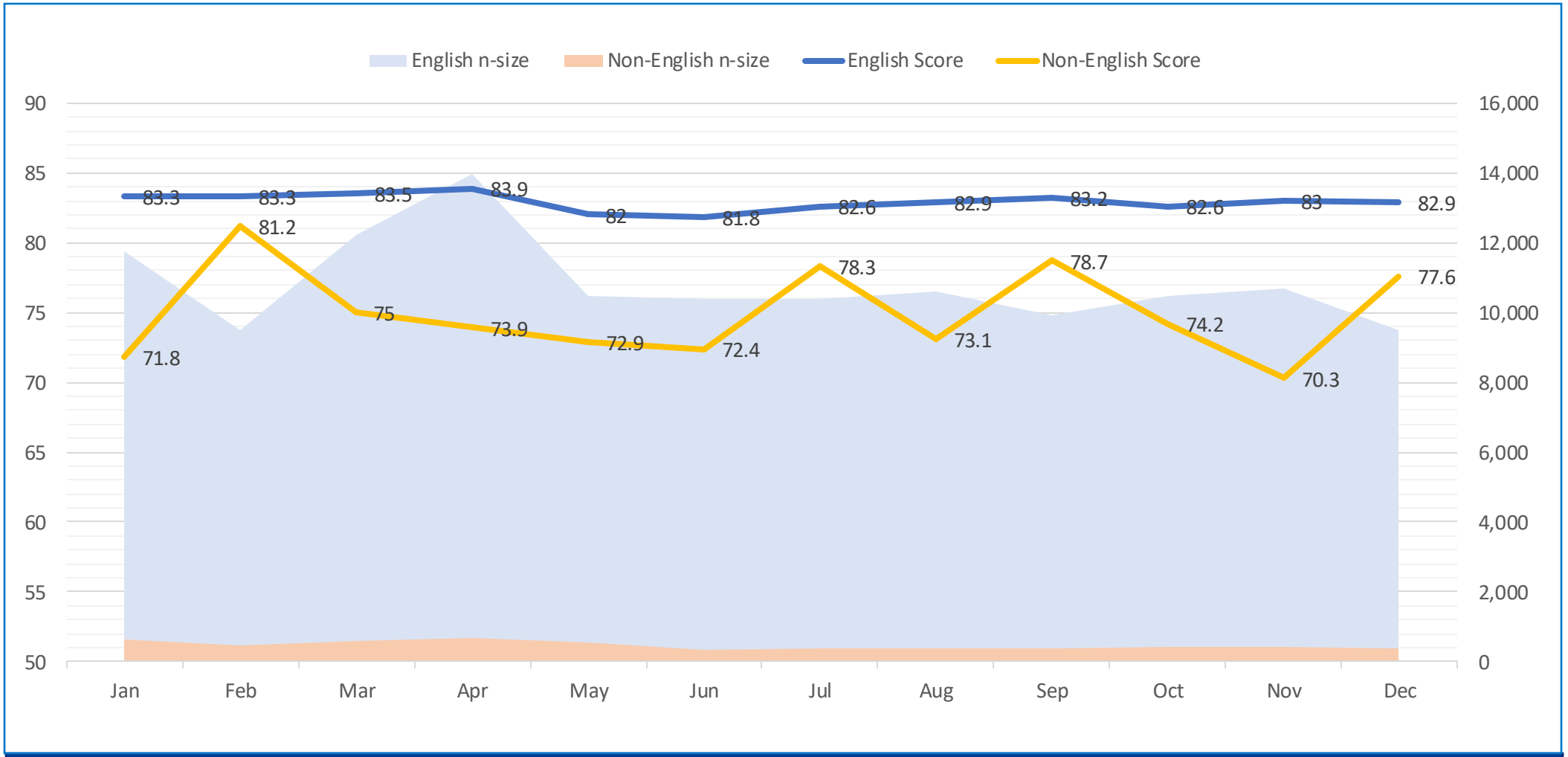
# NRC 2021: BWH Patient Satisfaction varies by Race




**White patients** express **higher satisfaction scores** (by ~10%) than **non-White patients**, who fall below the NRC average.

*Slide courtesy of **Aamer Ahmed**, Executive Director of Patient Experience*

# NRC 2021: BWH Patient Satisfaction varies by Language



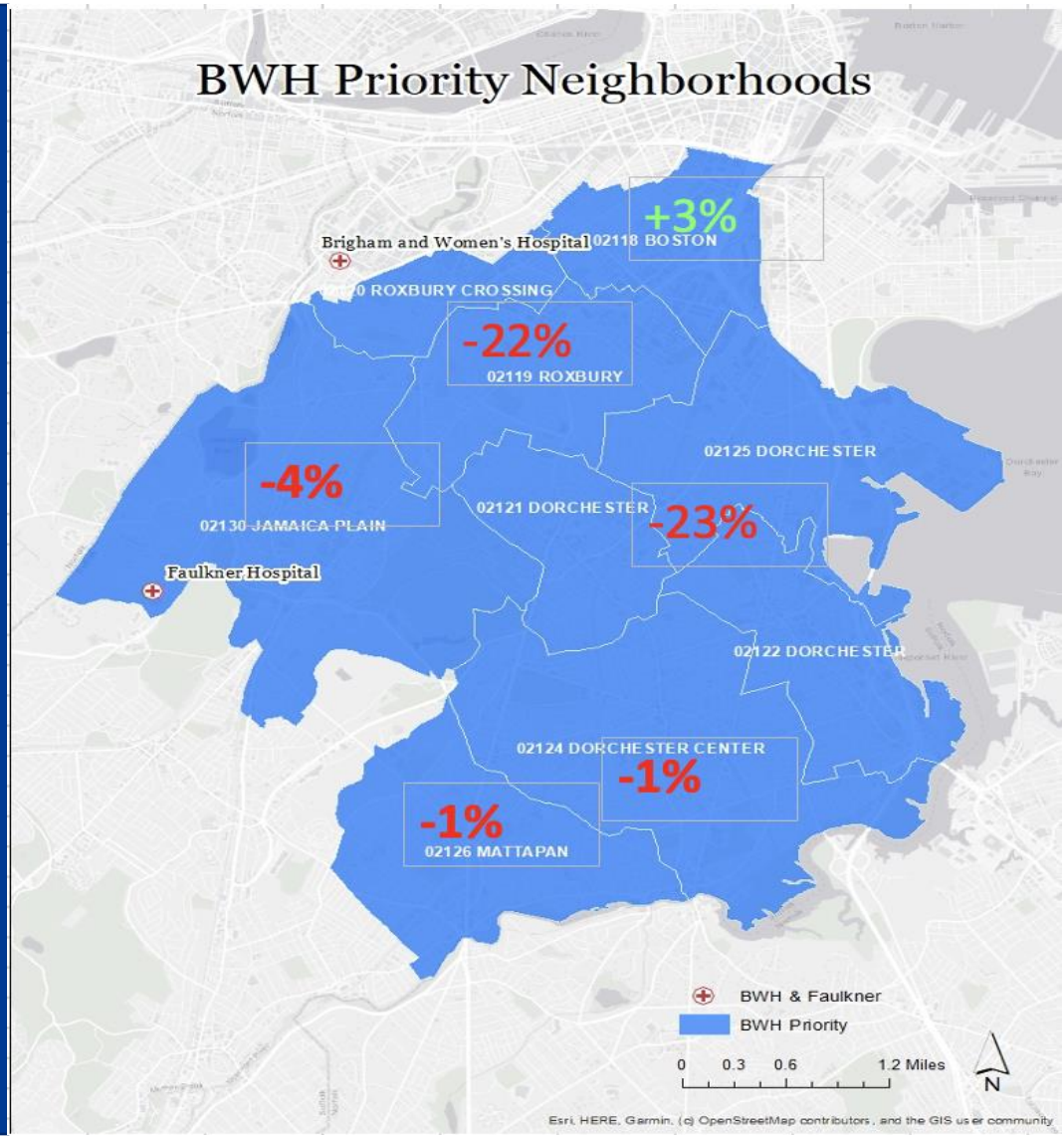

**English speaking patients** express **higher satisfaction scores** (by ~10%) than **non-English speaking patients**, who fall below the NRC average.



*Slide courtesy of **Aamer Ahmed**, MBA, BH Executive Director of Patient Experience*

# NRC: Patient Experience Differs by Neighborhood

Patients from **BWH Priority Neighborhoods have worse NRC scores/ patient experiences** than patients from other neighborhoods.






*Slide courtesy of Aamer Ahmed, Executive Director of Patient Experience*

# MGB Pilot Survey on Patients with Disabilities

NRC conducted an online survey of MGB patients who opted-in to the system's community insights survey panel and either self-identify as having a hearing, visual or physical/mobility disability or are age 65+.

- 2956 respondents
- 433 at BWH

## BWH Results:

- 13% felt always, most or sometimes devalued or discriminated in their experience
- BWH and FH consistently ranked low compared to other MGB hospitals
- Experiences worse for BIPOC patients with disabilities

| | Always | Most of the time | Sometimes | Rarely | Never |
|---|---|---|---|---|---|
| Cooley Dickinson Hospital (n=1) | 0% | 0% | 0% | 0% | 100% |
| Spaulding Nursing and Therapy Center Brighton (n=2) | 0% | 0% | 0% | 0% | 100% |
| Nantucket Cottage Hospital (n=30) | 0% | 0% | 3% | 10% | 87% |
| Community Physicians Organization (n=102) | 0% | 2% | 4% | 9% | 85% |
| North Shore Medical Center (n=56) | 0% | 2% | 5% | 16% | 77% |
| Spaulding Rehabilitation Hospital Cape Cod (n=41) | 0% | 2% | 5% | 7% | 85% |
| Massachusetts General Hospital (n=1,437) | 0% | 1% | 6% | 12% | 80% |
| Wentworth-Douglass Hospital (n=234) | 0% | 2% | 6% | 7% | 84% |
| Spaulding Rehabilitation Hospital (n=70) | 3% | 1% | 4% | 10% | 81% |
| Newton-Wellesley Hospital (n=248) | 0% | 2% | 9% | 14% | 75% |
| Massachusetts Eye and Ear (n=195) | 1% | 2% | 10% | 11% | 77% |
| Brigham and Women's Hospital (n=433) | 1% | 3% | 9% | 16% | 72% |
| Martha's Vineyard Hospital (n=66) | 0% | 6% | 8% | 18% | 68% |
| Brigham and Women's Faulkner Hospital (n=41) | 0% | 7% | 20% | 20% | 54% |

nrc HEALTH Q) How often have you felt devalued or discriminated against during your experiences with Mass General Brigham?

Courtesy of MGB, Caroline Pantridge and colleagues

# After Three Years: DQS Data-Driven Process Improvements Enhancing Health Equity Understanding and Action

## DQS Systems Data Capture

- **Patient Safety** (RL, Equity Tracker, EIHRO, Mortality)
- **Patient Quality** (Infection/Prevention, Harm Reduction, Core Measures, National Quality Measures, Access, Care Transitions)
- **Patient Experience** (PFR, NRC, CARe,

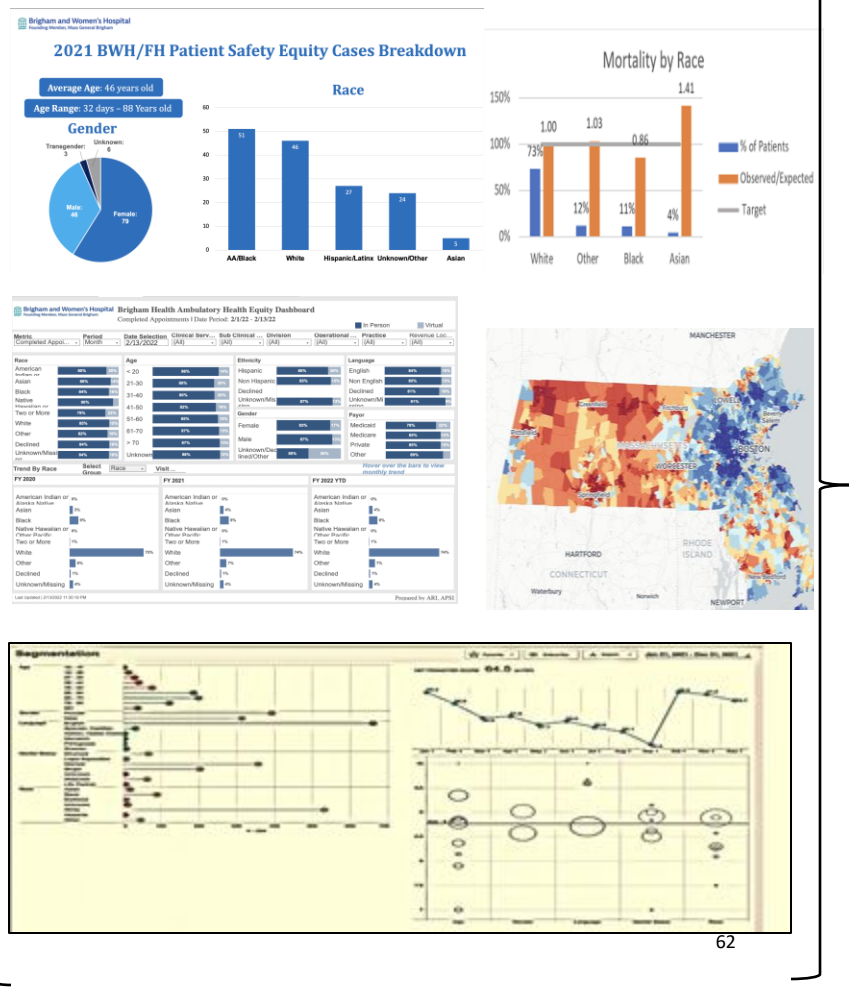
## Equity-Informed Data Processing & Standardization

**Hospital**
Equity Domain Team
REAL-SOGI+ Standards
+ Insurance
+ Disabilities + other Data taxonomy
+ Neighborhood
+ ADI/SVI

**System**
REAL-SOGI+ Standards
Data Equity Subcommittee Standardization

**State Standards**
REaL-SOGI+ Standards
Data Equity Subcommittee Standardization

## Data Analytics, Dashboards, & Visualization



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# We Measure what we Value, …and we Value what we Measure.

Establishing standards for quality, safety and operational analyses:

- Race, ethnicity, language
- Sexual orientation and Gender Identity
- Payor
- Geography: priority neighborhoods and social vulnerability index
- Ability

- Intersectionality
- Recognizing data ‘gaps’ in the EHR and our analyses

*What you measure affects what you do. If you don’t measure the right thing, you don’t do the right thing.*

– Joseph Stiglitz, 2001 Nobel Memorial Prize in Economic Sciences.

# DQS Lessons Learned, Next Steps, & Support

**Patient Safety**
- Continue to advocate for patient safety reporting, including around discrimination/bias.
- Advance education about and systems-based solutions for inequities in safety.

**Patient Quality:**
- Through Equity Domain Team, further understand access to care data disaggregated by REaL, ability, SOGI, payor, zip code, priority neighborhoods
- Identify at least one (1) inequity in an access, transitions in care, and quality-of-care metric and develop a clinical process improvement project for each service line.
- Continue to identify physician and nursing leaders in each service line.

**Patient Experience:**
- Provide PFR and NRC data disaggregated by REaL, SOGI, ability, zip code
- Develop Patient Experience Disparities QI Initiatives, including increasing response rates from marginalized populations, increasing availability of iPads for interpreting services, providing culturally appropriate hair/skin/hygiene products

**Patient Data, Engagement, and Policies:**
- Best Practices
- Advancement of ADI/SVI and other data initiatives
- Quality Improvements on Data Collection
- Community Outreach, Engagement, and Support

**_Collaborating_ together, we _<u>can</u>_ make a real difference in people's lives.**

# Acknowledgements

Chief Quality Officer: Sonali Desai
Vice President Safety Safety: Karen Fiumara
Medical Directors of Quality, Safety, and Equity: Regan Marsh and Nadia Huancahuari
Equity project coordinators: Jonathan Kong and Rosella Mastrocola
Patient Experience Executive Director: Aamer Ahmed
Executive Director, Diversity, Equity & Inclusion: Normella Walker
Patient Safety Specialist and Risk Managers
Patient Family Relations specialists
DEI Leaders throughout the departments and clinics
Prior Chief Quality Officer: Andrew Resnick
Prior VP of Quality: Jen Beloff
Prior Medical Director of Quality, Safety, and Equity: Karthik Sivashankar
Ambulatory Practice: Mary Catherine Arbour, Lisa Rotenstein


Mass General Brigham

# Health Care Equity Certification: Standards and Resources

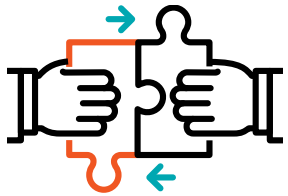
Christina L. Cordero, PhD, MPH
Senior Project Director, Healthcare Standards Development
Division of Healthcare Quality Evaluation and Improvement

The Joint Commission

# Our Journey to Advance Equity

**2003**

- ✓ Began **researching health care equity issues and alignment to Joint Commission requirements**



**2007**

- ✓ Released **public policy report** on improving health literacy

**2010**

- ✓ Released **Standards and resources** focused on improving patient-provider communication

**2011**

- ✓ Implemented **a requirement to prohibit discrimination** based on a variety of patient characteristics, including sexual orientation and gender identity or expression
- ✓ Released the **LGBT Field Guide**

**2016**

- ✓ Released ***Quick Safety* newsletter** addressed "Implicit bias in health care"

**2020**

- ✓ Issued ***Quick Safety* advisory**, "Understanding the needs of diverse populations in your community"

**2021**

- ✓ With Kaiser Permanente established **The Bernard J. Tyson Award for Excellence in Pursuing Health Care Equity**
- ✓ Announced **collaboration with the American College of Obstetricians and Gynecologists (ACOG)** to reduce maternal mortality and morbidity in the United States

**2022**

- ✓ ACOG and The Joint Commission launch **Maternal Levels of Care (MLC) Verification Program**
- ✓ Issued **Sentinel Event Alert** "Eliminating disparities for pregnant patients"
- ✓ New **health care equity standards** announced
- ✓ Accreditation Standards **Resource Center launched**
- ✓ Launched **Advanced Certification in Perinatal Care (ACPC)** in collaboration with ACOG to improve quality and safety for pregnant or postpartum patients and newborns

**2023**

- ✓ Elevate Leadership (LD) Standard LD.04.03.08, to a **new National Patient Safety Goal (NPSG)**
- ✓ Launch **Certification Resource Center**
- ✓ Launch **Health Care Equity Certification**

# New Advanced Certification Program

Builds upon on long-standing and recently released health care equity accreditation requirements

Recognizes organizations that strive for excellence in health care equity

Resource center to help implement requirements

Review Process Guide

The Joint Commission

# Certification Program Domains

# Resource Center

https://www.jointcommission.org/our-priorities/health-care-equity/certification-resource-center/

# Leadership

## Health care equity is a strategic priority for the organization.

- Describe in its strategic plan its goals for reducing health care disparities and providing equitable care to all patients
- Board review and approval of the strategic plan to address health care equity
- Allocate financial resources to achieve and sustain its goals to reduce health care disparities and provide equitable care, treatment, and services

# Collaborate with Patients and Community

HCECL.01 The organization collaborates with patients, families, caregivers, and community organizations to support health care equity.

- Identify patient-level needs
- Identify community-level needs

Intent and Implementation Strategies:

- Established relationships, opportunities to provide input
- Multiple options for feedback from patients and community members
- Engage a diverse group of patients and organizations

# Resources for Collaboration

## Engaging Patients and Communities in the Community Health Needs Assessment

This guide describes a process that involves engaging community members and patients throughout each step of the community health needs assessment process. (Source: HRET, ACHI)

## Community Partnerships: Strategies to Accelerate Health Equity

This toolkit focuses on developing community partnership strategies that can help expand health care services, eliminate inequities and improve health equity. (Source: AHA Institute for Diversity and Health Equity)

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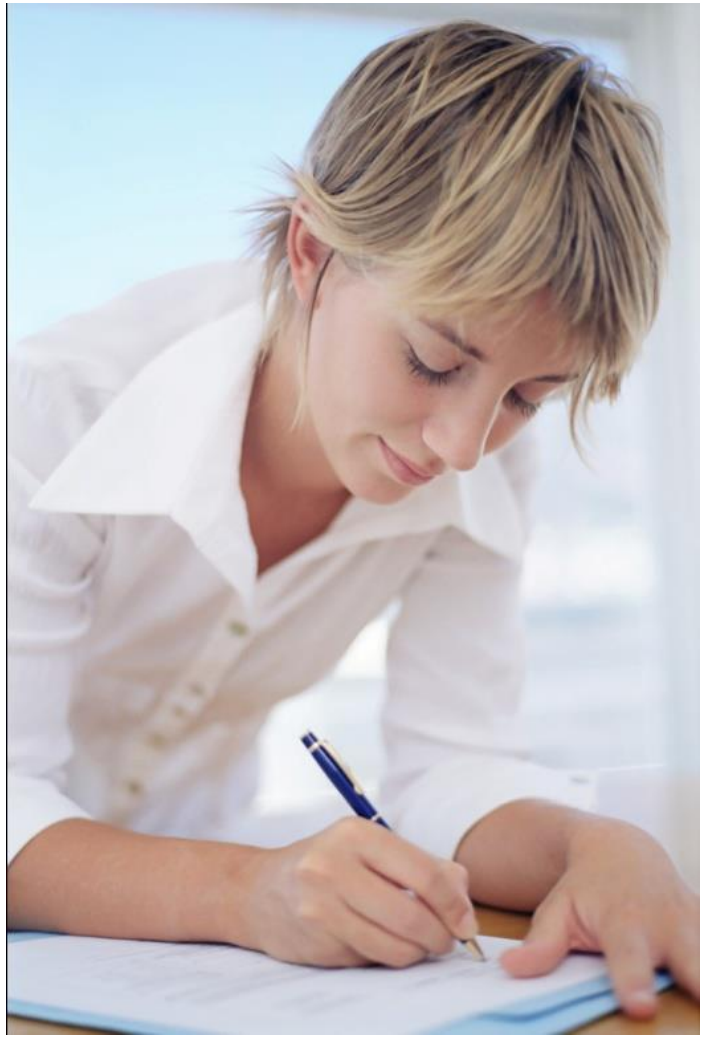
# Data Collection



## Three Areas

- Community – patients served or surrounding area
- Patient – self-reported
- Staff and Leaders – self-reported

# Data Collection: Community

**The organization reviews data about the community it serves to identify opportunities to improve health care equity.**

- Review data about the sociodemographic characteristics and health-related social needs of the individuals in its community
  - May review data from a community health needs assessment or other data sources, such as government datasets or state or local health departments.

# Data Collection: Patients

**The organization collects self-reported patient data to identify opportunities to improve health care equity.**

- Race and ethnicity
- Preferred language and need for a language interpreter
- Health-related social needs
- Physical, mental, communication, or cognitive disabilities that require accommodation and the accommodation needed
- Incidents and perceptions of discrimination and bias experienced by patients

# Data Collection: Patients (HRSN)

HCEDC.02, EP 3 Information about the patient's health-related social needs, includes (at a minimum):

- Difficulty paying for prescriptions or medical bills
- Food insecurity
- Housing instability
- Interpersonal safety
- Transportation needs
- Utility difficulties

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# Data Collection: Patients (Disabilities)

HCEDC.02, EP 4 Information about the patient's physical, mental, communication, or cognitive disabilities that require accommodation and the accommodation needed

Intent and Implementation Strategies:

- Identify disabilities and accommodations needed
- At every admission unless information available from prior admission/encounter
- Hospitals determine how information is collected

# Resources to Collect Disability Information

## Documenting Disability Status in Electronic Health Records

Shares learnings about implementing the collection of patients' disability status. The document should be regarded as guidelines that can be adapted to the local context. (Source: Disability Equity Collaborative)

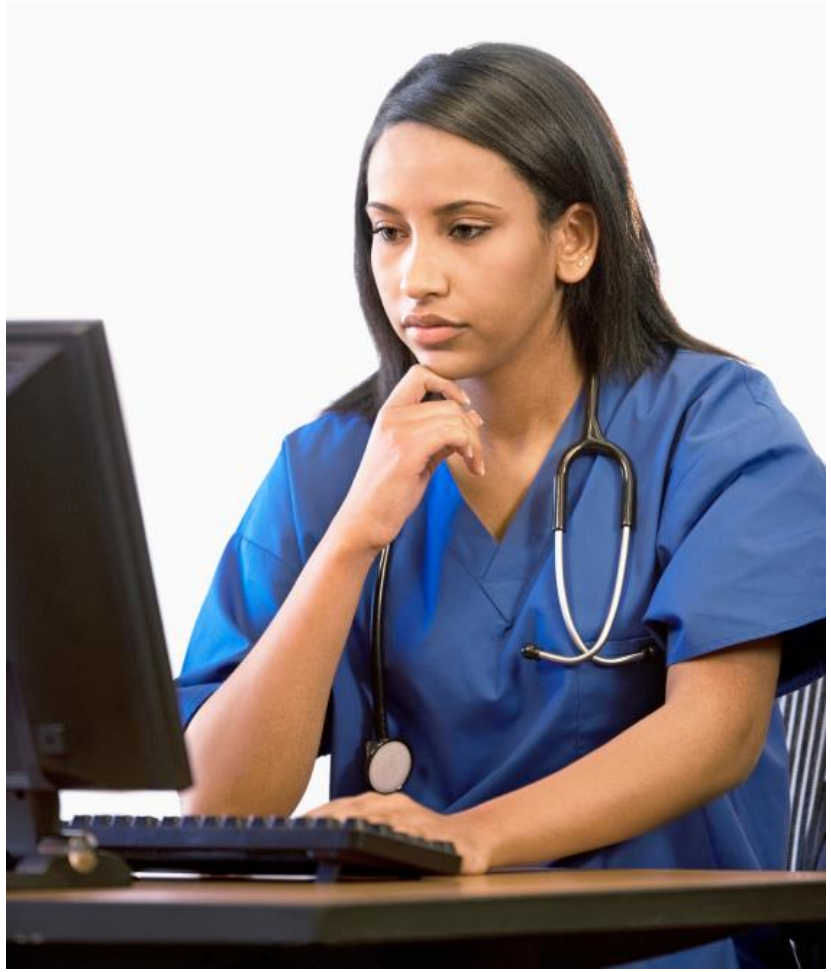
## Disability Equity Collaborative Healthcare Resources

This website provides a variety of disability-related resources, including links to training for front-line staff to collect disability status, guides for implementing accessibility initiatives, and more.

# Data Collection: Staff

**The organization collects self-reported data from its staff and leaders it identify opportunities to improve health care equity.**

- Race and ethnicity information
- Languages spoken
- Incidents and perceptions of discrimination and bias experienced by its staff and leaders



# Provision of Care

## Five Areas

- Workforce diversity
- Staff training
- Patient-provider communication
- Patients with disabilities
- Health-related social needs

# Provision of Care: Workforce Diversity

**The organization supports diversity, equity, and inclusion for its staff and leaders.**

- Prohibit discrimination against its staff and leaders
- Policies and procedures address the recruitment and retention of staff and leaders that reflect the diversity of the community and patient population
- Process to address incidents and perceptions of discrimination and bias experienced by its staff and leaders

# Provision of Care: Staff Training

**The organization provides staff with the education and training necessary to provide equitable care**

- Rationale for improving health care equity
- Collection of patient-level data
- Communication with patients and families
  - Accessing and working with interpreters
  - Using auxiliary aids

# Provision of Care: Patient-Provider Communication

HCEPC.03 The organization communicates effectively with patients and families.

- Assess qualifications for language interpreters
- Assess language proficiency of staff
- Address health literacy needs

Intent and Implementation Strategies:

- Effective communication with patients
- Hospitals implement a process (external or internal) for assessment
- Process to identify and address health literacy needs

# Provision of Care: Patients with Disabilities

**The organization accommodates the needs of patients with physical, mental, communication, or cognitive disabilities.**

- Provide care, treatment, and services in a manner that accommodates the needs of patients with physical, mental, or cognitive disabilities
- Provide auxiliary aids or services to address the needs of patients and families with communication disabilities
- Process to address the written communication needs of patients that have low vision

# Provision of Care: HRSNs

**The organization addresses the HRSNs of its patients.**

- Review the patient's HRSNs to determine whether modifications to the plan for care are necessary
- Collaborate with community and social service organizations to address the HRSNs of its patients

# Resources to Address HRSNs

## Food Insecurity and the Role of Hospitals

This guide describes the link between food insecurity and adverse health issues and outlines clinical and nonclinical approaches that hospitals and health systems can use. (Source: AHA)

## Find Help

Search and connect to support. Financial assistance, food pantries, medical care, and other free or reduced-cost. (Source: The Social Care Network)

# Performance Improvement: Services

**At least annually, the organization analyzes its data to identify opportunities to improve the provision of equitable care.**

- Review the sociodemographic data of its patients for missing or inaccurate information
- Review data from its complaint resolution process
- Stratify experience of care measures
- Monitor the use of language interpreters
- Stratify at least 3 quality and/or safety measures for priority clinical conditions
  - Examples will be available in the resource center, can also use any other measures identified in the health care equity strategic plan

# Resources for Performance Improvement

## Weaving Equity Into Every Step of Performance Improvement

Learn how NYC Health + Hospitals integrates a meaningful and impactful equity perspective right from the start of all performance improvement work. (Source: IHI)

## Using Data to Reduce Disparities and Improve Quality

This resource explores strategies that can assist organizations in organizing and interpreting data to improve health equity. (Source: Advancing Health Equity)

# Performance Improvement: Staff

**The organization identifies opportunities to improve its efforts to address diversity, equity, and inclusion for staff and leaders.**

- Compare the race, ethnicity, and the languages spoken by its staff and leaders to the race, ethnicity, and the languages spoken by its community
- Stratify culture of safety data or employee opinion surveys using the race, ethnicity, and language information for its staff and leaders

# Questions?

For more information, please contact the Department of Standards and Survey Methods (DSSM) using the form located at https://dssminquiries.jointcommission.org

# Health Care Equity Certification: Preparation and Application

Dave Eickemeyer
Associate Director, Hospital Certification
Division of Business Development, Government & External Relations

The Joint Commission

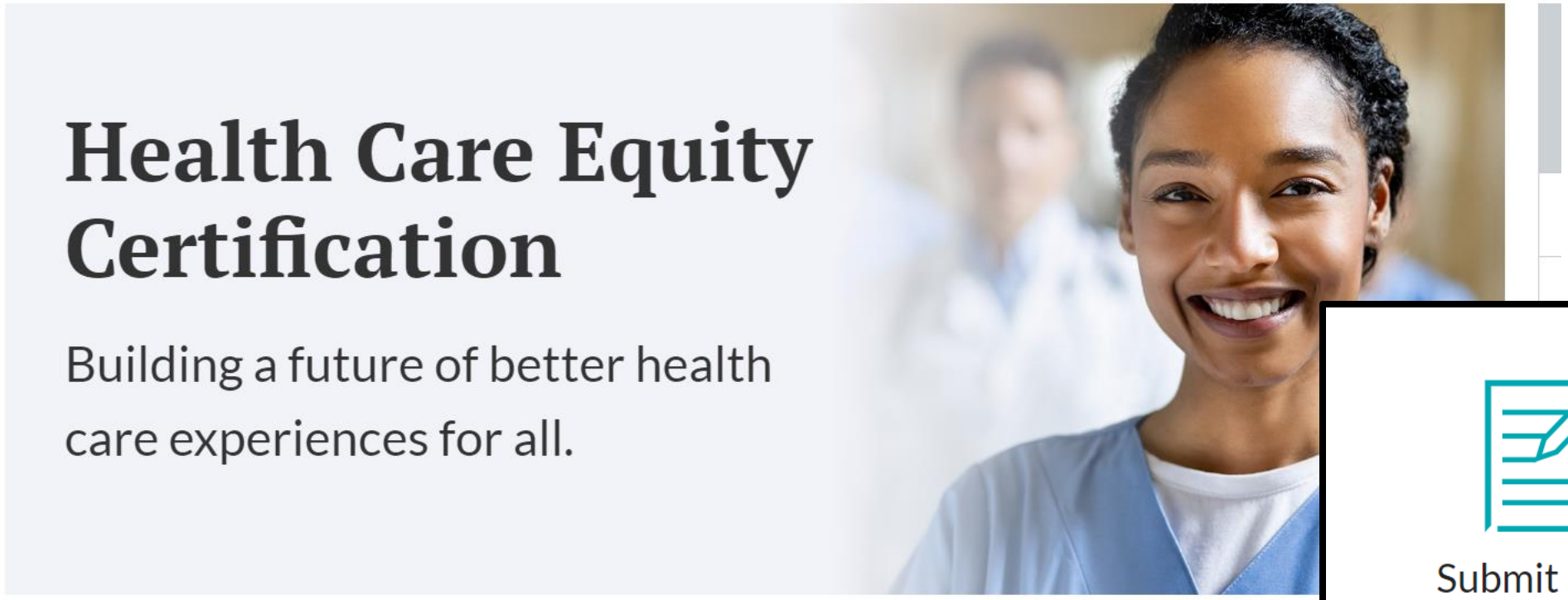
# Preparing for Certification

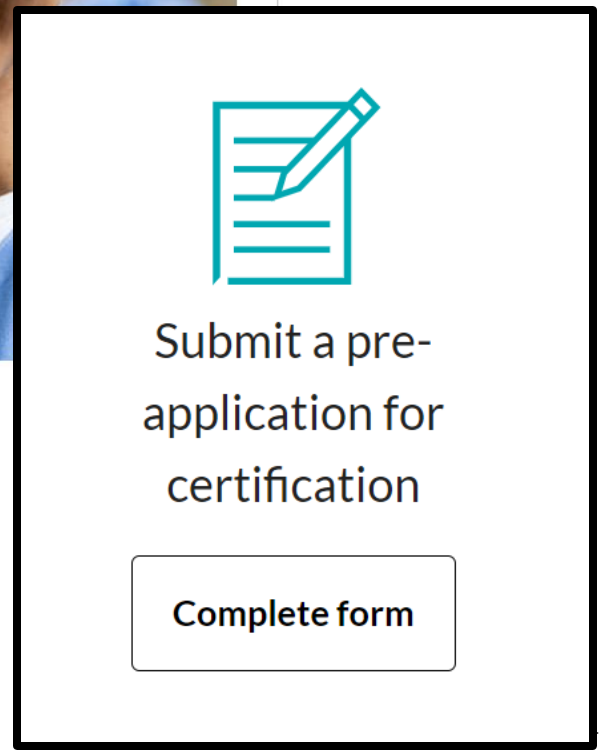
Your Business Development Associate Director will help you access what you need

- Standards
- Review Process Guide
- Pre-Application
- Full Application

- **certification@jointcommission.org**

Home > What We Offer > Certification > Certifications by Setting > Hospital Certificatior

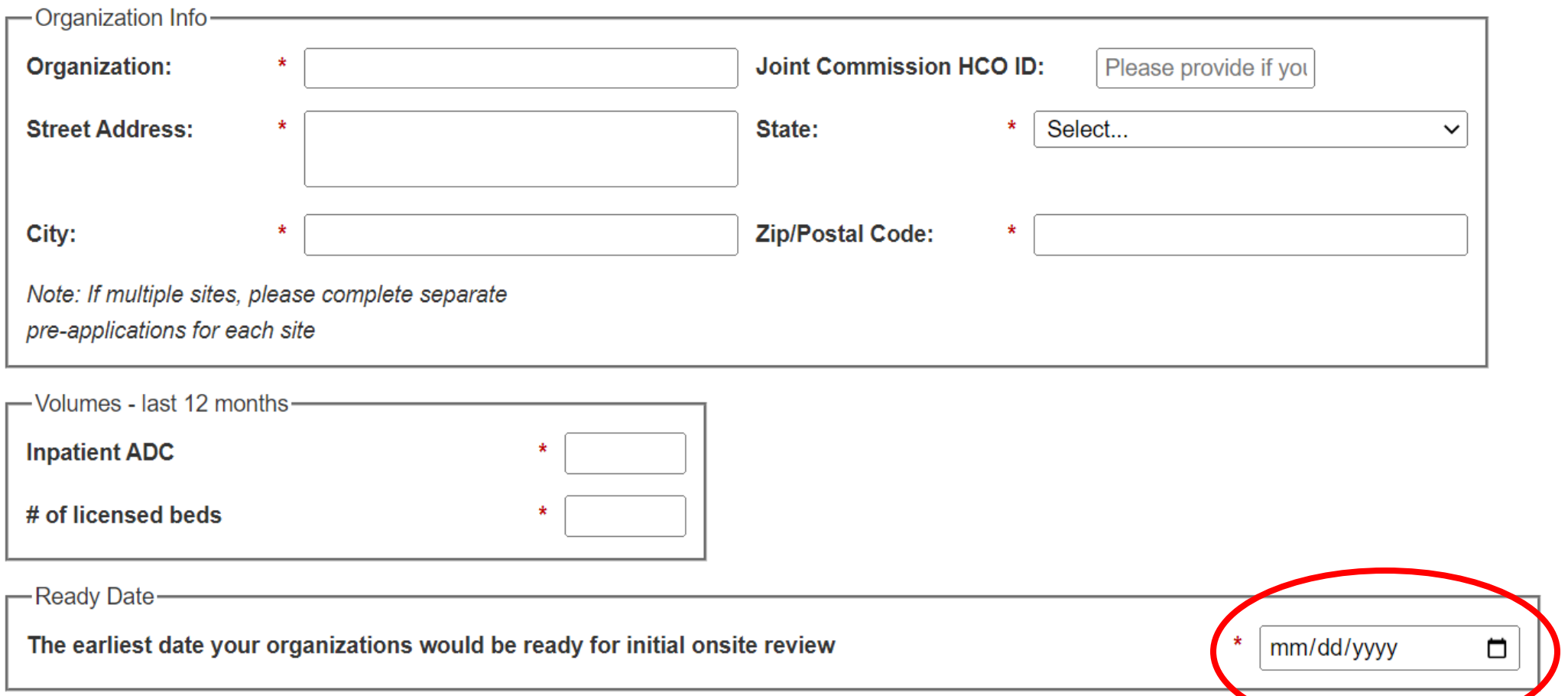


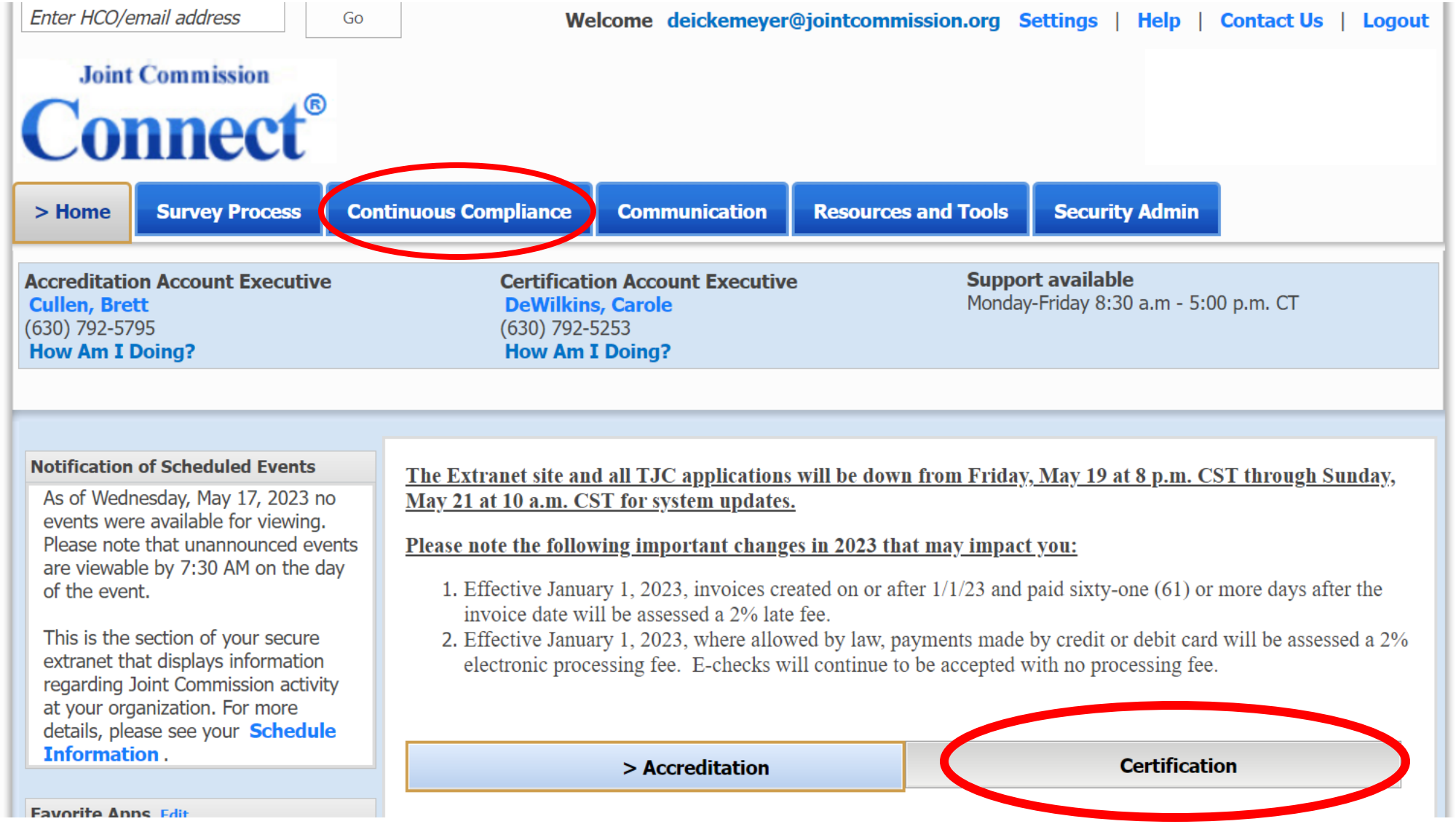

## The Pre-Application

If you are ready, apply now to secure a spot in line.
First in the country and every state is currently open!

# The Pre-Application



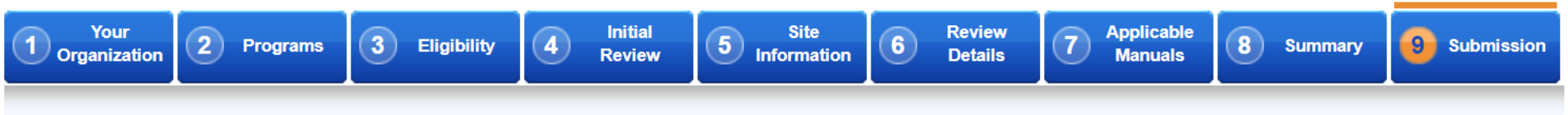
# The Full Application – July 1



# The Full Application – July 1

- We will guide you through the whole process
- Same information as the pre-application
- Identify the hospital's service lines
- Identify your readiness date


- No data is required
- Submit the application and get in the queue!



# Health Care Equity Certification: Review Process

Doreen Donohue, DNP, RN, NEA-BC, CPHQ
Field Director, Disease-Specific Care
Division of Accreditation & Certification Operations

The Joint Commission

# Pre-Review

- Review HCE standards and the Review Process Guide
- Utilize your Account Executive for any questions or concerns
- Notification 30 days in advance of Review
- SharePoint Site: upload documents including
  - Strategic Plan and Goals for HCE
  - Policies & Procedures
  - Education

# Opening Conference

- Include HCE leadership and other staff at discretion of organization
- Introductions
- Overview and Orientation to HCE program:
    - Strategic Plan and goals of program
    - Program Leadership and support
    - Patient Population and Demographics
    - Process to address health-related social needs (HRSNs)
    - Performance Improvement Process

# Planning Session

- Current list of Patients
- Patients discharged within the last 4 months
- Include: Name, age, race, diagnosis, identified disabilities.
- A minimum of 5 patients will be chosen to trace
- If active patients cannot be identified, closed charts will be reviewed.

# Tracer Activity

- Review of patients' course of care, treatment and service
- Will focus on:
    - HRSNs-how assessed and addressed
    - Accommodation of disabilities
    - Communication
    - Identifying and addressing patient incidents or perceptions of discrimination or bias

# Tracer Activity

- Review of chart with staff will determine where reviewer will go
- Discussion with staff and patients
- Observation of environment
- Review of procedures or other documents as needed

# Data System Tracer

- Include anyone involved in HCE performance improvement (PI) plan
- Data Reviewed:
    - HCE data and PI plan
    - Data from Community Needs Assessment
    - Incidents/Complaints related to HCE
    - Language Interpretation data

# Education and Competence Assessment

- Include anyone involved in orientation and education off staff and physicians that support HCE.
- Discussion regarding approach for education and competence
- Assessment of language interpreters
- Review of a minimum of 5 files for evidence of orientation, education and competence.

# Summary Discussion

- Small group of HCE key staff
- Opportunity to review any IOUs and any unresolved issues
- Review identified Requirements for Improvement (RFI)
- Determine if RFIs will be discussed in detail at Exit Conference

# Exit Conference

- Include HCE leaders and other staff at discretion of organization
- Review RFIs if determined during Summary Discussion
- Identified Best Practices
- Post-review process

# Keys to a Successful Review

- Ensure there are skilled individuals to review the Electronic Medical Record
- Power Points Presentations for Opening and Data Session
- Secure room for Reviewer
- Determine what your program would like to accomplish during review and share with reviewer
- Ask Questions
- RELAX and BREATHE

# Questions?