The Bernard J. Tyson National Award for Excellence in Pursuit of Healthcare Equity

2022 Tyson Award Ceremony
Introductions: Joint Commission and Kaiser Permanente

Jonathan B. Perlin, MD, PhD, MSHA, MACP, FACMI
President and Chief Executive Officer, The Joint Commission

David Baker, MD, MPH, FACP
Exec Vice President, Healthcare Quality Evaluation, Editor-in-Chief, Journal on Quality and Patient Safety, The Joint Commission

Ana McKee, MD
Exec Vice President, Chief Medical Officer, Chief Diversity, Equity and Inclusion Officer, The Joint Commission

Ronald L. Copeland, MD, FACS
Sr Vice President of National Diversity and Inclusion Strategy and Policy and Chief Equity, Inclusion, and Diversity Officer, Kaiser Permanente

Andrew B. Bindman, MD
Exec Vice President, Chief Medical Officer, Kaiser Permanente

Mark Smith, MD, MBA, Clinical Professor of Medicine, University of California, San Francisco
2022 Tyson Award Panel Chair
Introduction: New York Health + Hospitals Presenter

Jonathan Jiménez, MD, MPH
Executive Director, NYC Care
Introduction: Texas Children’s Pavilion for Women’s Presenter

Christina Davidson, MD
Associate Professor | Division of Maternal Fetal Medicine
Vice Chair of Quality, Patient Safety & Equity | Department of Obstetrics & Gynecology | Baylor College of Medicine
Chief Quality Officer, Obstetrics & Gynecology | Texas Children’s Hospital
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2022

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Making Healthcare a Human Right: Expanding Access to Healthcare to Undocumented New Yorkers

NYC HEALTH + HOSPITALS
NEW YORK, NY
two-thirds of undocumented residents in New York City have lived in the United States for more than a decade
NYC Care = Care for All
Program Pillars

- Primary care
- Pharmacy
- Patient experience
Membership Card

NYC Care provides you with affordable access to the healthcare you need. We want you to get healthy and stay healthy.

Use this member card to get care at NYC Health + Hospitals locations. Services are available in all languages. This card does not guarantee you care with any other medical providers or provide benefits outside New York City.

Copey/Fee
Primary Care Visits $0
Specialty Visits $0
Emergency Care $0
Pharmacy $2

For questions about NYC Care, medication refill, and to make an appointment please call the NYC Care Contact Center: 1-844-NYC-CARE (1-844-692-2273)

IF YOU HAVE A MEDICAL EMERGENCY, CALL 911

These copays only apply to care you get at NYC Health + Hospitals facilities.
Who is eligible?

Excluded from health insurance due to
- immigration status
- ability to pay

AND Live in New York City
How to Enroll

Become a member of NYC Care Today!
1-646-NYC-CARE
1-646-692-2273
Community Affairs

New York City Government

- Department of Health & Mental Hygiene
- Mayor’s Office of Immigrant Affairs
- GetCoveredNYC
- Mayor’s Public Engagement Unit

Community-based Organizations

- Twenty-two grant-funded CBOs across NYC
- Speak over 30 languages
- Direct enrollment pathway
- Trusted messengers
- Critical feedback
Outreach Overview
Public Awareness Campaign

NYC Health + Hospitals

Unlock Your Right to Health Care
1-646-NYC-CARE

Unlock Your Right to Health Care Before You Get Sick
1-646-NYC-CARE
Milestones

- **Launch in The Bronx**: Aug. 2019
  - 10,000 members

- **Launch in Brooklyn & Staten Island**: Dec. 2019

- **Launch in Manhattan & Queens**: Jan. 2020
  - 50,000 members

- **Launch in Manhattan & Queens**: Sep. 2020
  - 10,000 members

- **Launch in Manhattan & Queens**: Feb. 2021
  - 80,000 members

- **Launch in Manhattan & Queens**: July 2021
  - 100,000 members

- **Elimination of six-month requirement**: Apr. 2022
Improving health

- 50% of members are new to primary care
- 70% of members saw PCP in last year
- 53% of members with diabetes saw an improvement in hemoglobin a1c
- 40% of members with hypertension saw an improvement in blood pressure
Quality Improvement Initiatives on Decreasing Racial Disparities in Maternal Morbidity

Texas Children’s Pavilion for Women
Houston, TX
Examining the Effect of Quality Improvement Initiatives on Decreasing Racial Disparities in Maternal Morbidity

Christina Davidson, MD
Associate Professor | Division of Maternal Fetal Medicine
Vice Chair of Quality, Patient Safety & Equity | Department of Obstetrics & Gynecology | Baylor College of Medicine
Chief Quality Officer, Obstetrics & Gynecology | Texas Children’s Hospital
MATERNAL MORTALITY

Acute myocardial infarction
Acute renal failure
Adult respiratory distress syndrome
Air and thrombotic embolism
Amniotic fluid embolism
Aneurysm
Blood transfusion
Cardiac arrest/ventricular fibrillation or flutter
Conversion of cardiac rhythm
Disseminated intravascular coagulation
Eclampsia
Heart failure/arrest during surgery/procedure
Ventilation
Hysterectomy
Puerperal cerebrovascular disorders
Pulmonary edema / Acute heart failure
Sepsis
Severe anesthesia complications
Shock
Sickle cell disease with crisis
Temporary tracheostomy

SEVERE MATERNAL MORBIDITY
Severe Maternal Morbidity in Texas by Race and Ethnicity

Figure E2: Severe maternal morbidity due to obstetric hemorrhage per 10,000 delivery hospitalizations (estimated by blood transfusion procedures) by race/ethnicity, Texas, 2005-2014

Obstetric Hemorrhage Rates by Race/Ethnicity, 2005-2014
(Estimated by blood transfusion procedures)

Rate of Severe Maternal Morbidity (SMM) in Texas, 2010-2019

*Data transitioned to ICD-10-CM in the last quarter of 2015.
Source: 2009-2018 Texas Hospital Inpatient Public Use Data Files
Prepared by: Maternal & Child Health Epidemiology Unit
JAN 2019

Texas Maternal Mortality and Morbidity Review Committee and Department of State Health Services Joint Biennial Report, September 2020
TexasAIM

- Texas Department of State Health Services (DSHS) launched statewide initiative in 2018 to implement AIM Obstetric Hemorrhage patient safety bundle

- Goal: reduce SMM from hemorrhage by 25% by January 1, 2020
Texas Children’s Hospital Pavilion for Women

- Level IV Maternal and Neonatal hospital located in Texas Medical Center
- ~6500 deliveries/year
- 24/7 coverage by Ob/Gyn Hospitalists, Critical Care Medicine, and BCM Residents
- Patient demographics:
  - 38% Hispanic
  - 34% Non-Hispanic White
  - 20% Non-Hispanic Black
  - 8% Asian/Other
  - 40% Medicaid
  - 10% non-English preferred language
Data Presented at Texas Children’s Pavilion for Women Department Meeting: January 2019
SMM Rates October 2015 – January 2019
**Patient Safety Bundles - Improving Maternal Health**

**Council on Patient Safety (safehealthcareforeverywoman.org)**

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**READINESS**

Every health system:
- Establish systems to accurately document self-identified race, ethnicity, and primary language.
- Provide system-wide staff education and training on how to ask demographic intake questions.
- Ensure that patients understand why race, ethnicity, and language data are being collected.
- Ensure that race, ethnicity, and language data are accessible in the electronic medical record.
- Evaluate non-English language proficiency (e.g., Spanish proficiency) for providers who communicate with patients in languages other than English.
- Educate all staff (e.g., inpatient, outpatient, community-based) on interpreter services available within the healthcare system.
- Provide staff-wide education on:
  - Peripartum racial and ethnic disparities and their root causes.
  - Best practices for shared decision making.
- Engage diverse patient, family, and community advocates who can represent important community partnerships on quality and safety leadership teams.

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**RECOGNITION**

Every patient, family, and staff member:
- Provides staff-wide education on implicit bias.
- Provides convenient access to health records without delay (paper or electronic).
- Ensures information is clear and simple, format that is most pertinent to perinatal care and wellness.
- Establishes a mechanism for patients, families, and staff to report inequitable care and episodes of miscommunication or disrespect.

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**RESPONSE**

Every clinical encounter:
- Engage in best practices for shared decision making.
- Ensure a timely and tailored response to each report of inequity or disrespect.
- Address reproductive life plan and contraceptive options not only during or immediately after pregnancy, but at regular intervals throughout a woman's reproductive life.
- Establish discharge navigation and coordination systems post child birth to ensure that women have appropriate follow-up care and understand when it is necessary to return to their health care provider.
- Provide educational materials that include information about what danger or warning signs to look out for, whom to call, and where to go if they have a question or concern.
- Design discharge materials that meet patients' health literacy, language, and cultural needs.

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**REPORTING & SYSTEMS LEARNING**

Every clinical unit
- Build a culture of equity, including systems for reporting, response, and learning similar to ongoing efforts in safety culture.
- Develop a disparities dashboard that monitors process and outcome metrics stratified by race and ethnicity, with regular dissemination of the stratified performance data to staff and leadership.
- Implement quality improvement projects that target disparities in healthcare access, treatment, and outcomes.
- Consider the role of race, ethnicity, language, poverty, literacy, and other social determinants of health, including racism at the interpersonal and system level when conducting multidisciplinary reviews of severe maternal morbidity, mortality, and other clinically important metrics.
- Add as a checkbox on the review sheet: Did race/ethnicity (i.e., explicit bias), language barrier, or specific social determinants of health contribute to the morbidity (yes/no/maybe)? And if so, are there system changes that could be implemented that could alter the outcome?

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Data Presented at Texas Children’s Pavilion for Women Department Meeting: March 2019
Rate of Severe Maternal Morbidity from Hemorrhage by Race and Ethnicity
October 2015 - Feb 2019

Severe Maternal Morbidity from Hemorrhage Rate (%)

Numerator = delivery admissions *in Black women* with any SMM
Denominator = delivery admissions *in Black women* with a hemorrhage diagnosis

NH Asian
NH Black
Hispanic
NH White
Due to health disparities from unconscious bias, does not accept blood products.

### Obstetric Hemorrhage

#### READINESS
- Hemorrhage cart with supplies, checklist, and instruction cards for intrauterine balloons and compression stitches
- Immediate access to hemorrhage medications (kit or equivalent)
- Establish a response team - who to call when help is needed (blood bank, advanced gynecology surgery, other support and tertiary services)
- Establish massive and emergency release transfusion protocols (type-O negative/unmatched)
- Unit education on protocols, unit-based drills (with post-drill debriefs)

#### RECOGNITION & PREVENTION
- Assessment of hemorrhage risk (prenatal, on admission, and at other appropriate times)
- Measurement of cumulative blood loss (formal, as quantitative as possible)
- Active management of the 3rd stage of labor (department-wide protocol)

#### RESPONSE
- Standard, stage-based, obstetric hemorrhage emergency management plan with checklists
- Support program for patients, families, and staff for all significant hemorrhages

#### REPORTING/SYSTEMS LEARNING
- Establish a culture of huddles for high risk patients and post-event debriefs to identify successes and opportunities
- Multidisciplinary review of serious hemorrhages for systems issues
- Monitor outcomes and process metrics in perinatal quality improvement (QI) committee

### PPH Risk Assessment & Stratification

<table>
<thead>
<tr>
<th>Risk Factor</th>
<th>Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>BMI ≥ 40 kg/m²</td>
<td>TSG if indirect amniocentesis positive</td>
</tr>
<tr>
<td>2 or more prior cesarean OR 1 uterine incision (myomectomy)</td>
<td>TSG if indirect amniocentesis negative</td>
</tr>
<tr>
<td>History of PPH</td>
<td>TSG if indirect amniocentesis positive</td>
</tr>
<tr>
<td>EFW &gt; 4,000 g</td>
<td>Postpartum oxytocin for 4 hours</td>
</tr>
<tr>
<td>Multiple gestation</td>
<td>TSG if indirect amniocentesis positive</td>
</tr>
<tr>
<td>&gt;4 prior vaginal deliveries</td>
<td>TSG if indirect amniocentesis positive</td>
</tr>
<tr>
<td>Intervention magnesium sulfate administration (Antsopoulou, 2020)</td>
<td>TSG if indirect amniocentesis positive</td>
</tr>
<tr>
<td>Jehovah’s Witness or woman who refuses blood products</td>
<td>TSG if indirect amniocentesis positive</td>
</tr>
</tbody>
</table>

#### Low Risk
- No known bleeding disorder
- No history of PPH
- TSG if indirect amniocentesis negative
- TSG if indirect amniocentesis positive
- Postpartum oxytocin for 4 hours
**PATIENT SAFETY BUNDLE**

**Obstetric Hemorrhage**

**RECOGNITION & PREVENTION**
- Every patient
  - Assessment of hemorrhage risk (prenatal, on admission, and at other appropriate times)
  - Measurement of cumulative blood loss (formal, as quantitative as possible)
  - Active management of the 3rd stage of labor (department-wide protocol)

**RESPONSE**
- Every hemorrhage
  - Unit-standard, stage-based, obstetric hemorrhage emergency management plan with checklists
  - Support program for patients, families, and staff for all hemorrhage stages

**REPORTING/SYSTEMS LEARNING**
- Every unit
  - Establish a culture of huddles for high risk patients and post-event debriefs to identify successes and opportunities
  - Multidisciplinary review of various hemorrhages for systems issues
  - Monitor outcomes and process metrics in perinatal quality improvement (QI) committee

**RESPONSE**
- Every clinical encounter
  - Engage in best practices for shared decision making.
  - Ensure a timely and tailored response to each report of inequity or disrespect.
  - Address reproductive life plan and contraceptive options not only during or immediately after pregnancy, but at regular intervals throughout a woman's reproductive life.
  - Establish discharge navigation and coordination systems post childbirth to ensure that women have appropriate follow-up care and understand when it is necessary to return to their health care provider.
  - Provide discharge instructions that include information about what danger or warning signs to look out for, whom to call, and where to go if they have a question or concern.
  - Design discharge materials that meet patients' health literacy, language, and cultural needs.

**REPORTING & SYSTEMS LEARNING**
- Every clinical unit
  - Build a culture of equity, including systems for reporting, response, and learning similar to ongoing efforts in safety culture.
  - Develop a disparities dashboard that monitors process and outcome metrics stratified by race and ethnicity with regular dissemination of the stratified performance data to staff and leadership.
  - Implement quality improvement projects that target disparities in healthcare access, treatment, and outcomes.
  - Consider the role of race, ethnicity, language, poverty, literacy, and other social determinants of health, including racism at the interpersonal and system-level when conducting multidisciplinary reviews of severe maternal morbidity, mortality, and other clinically important metrics.
  - Add as a checkbox on the review sheet: Did race/ethnicity (i.e. implicit bias, language barrier, or specific social determinants of health contribute to the morbidity (yes/no/maybe)? And if so, are there system changes that could be implemented that could alter the outcomes?
Severe Maternal Morbidity from Hemorrhage (SMM-H) Rate decreased from 45.5% during the Pre-Intervention Phase to 31.6% during the Post-Intervention Phase \((p=.011)\)

Davidson C, et al. Examining the effect of quality improvement initiatives on decreasing racial disparities in maternal morbidity. BMJ Qual Saf. 2022 Apr 15
Rate of Severe Maternal Morbidity from Hemorrhage by Race and Ethnicity
October 2015 - June 2020

Pre-Intervention

Post-Intervention

11.11%
16.36%
26.98%
28.81%
26.56%
21.74%
33.33%
35.43%
41.88%
44.12%
36.05%
27.00%
33.83%
27.27%
20.93%
19.85%

Davidson C, et al. Examining the effect of quality improvement initiatives on decreasing racial disparities in maternal morbidity. BMJ Qual Saf. 2022 Apr 15
The Bernard J. Tyson National Award for Excellence in Pursuit of Healthcare Equity
# 2022 Applications – Top Finalists

(in alphabetical order by organization name; 2022 Co-Awardees denoted with * and bold text)

<table>
<thead>
<tr>
<th>Organization Name</th>
<th>City, State</th>
<th>Initiative Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Henry Ford Health</td>
<td>Detroit, Michigan</td>
<td>Reducing Hypertension Among African American Men</td>
</tr>
<tr>
<td>Mount Sinai Health System</td>
<td>New York, New York</td>
<td>Addressing digital health equity to improve cardiovascular health outcomes using pharmacist-led remote patient monitoring among New York City residents</td>
</tr>
<tr>
<td>Texas Children's Pavilion for Women *</td>
<td>Houston, Texas</td>
<td>Examining the effect of quality improvement initiatives on decreasing racial disparities in maternal morbidity</td>
</tr>
<tr>
<td>The MetroHealth System</td>
<td>Cleveland, Ohio</td>
<td>Partnering to improve childhood lead screening in high-risk urban communities: a community-based systems initiative</td>
</tr>
<tr>
<td>WellSpan Health</td>
<td>York, Pennsylvania</td>
<td>Reducing Disparities and Increasing Breast Cancer Screening Rates</td>
</tr>
</tbody>
</table>
2022 Applications – All Organizations that submitted applications  
(in alphabetical order by organization name; 2022 Co-Awardees noted with * and bold text)  
The full list, which includes the initiative titles, is available on The Joint Commission website.

| Atrium Health Navicent, Atrium Health Wake Forest Baptist Health, Atrium Health Floyd | Henry Ford Health | Texas Children's Pavilion for Women* |
| CarePoint Health-Hoboken University Medical Center | Jefferson Health | The Hospitals of Providence, El Paso, TX |
| Clever Care Health Plan | Meritus Health, Inc. | The Medical Clinics of the 501st Combat Support Wing: 422 Medical Squadron, RAF |
| County of Santa Clara Health System, Santa Clara Valley Medical Center | Mount Sinai Health System | Croughton & 423 Medical Squadron, RAF Alconbury |
| Erie County Medical Center Corporation | Northwell Health | The MetroHealth System |
| Eskenazi Health | Northwell Health, North Shore University Hospital | The Queen's Medical Center Queen's Care Coalition |
| | Novant Health | Therapeutic Play Foundation |
| | **NYC Health + Hospitals*** | WellSpan Health |
| | NYU Langone Health | |
| | Penn Medicine Princeton Medical Center | |
| | Robert Wood Johnson University Hospital | |
Congratulations to this year’s Awardees!

2022 Co-Awardees

NYC Health + Hospitals
Making Healthcare a Human Right: Expanding Access to Healthcare to Undocumented New Yorkers

Texas Children’s Pavilion for Women
Quality Improvement Initiatives on Decreasing Racial Disparities in Maternal Morbidity
Welcome, everyone, and thank you for joining us for the 2022 Bernard J. Tyson National Award for Excellence in Pursuit of Healthcare Equity Award Ceremony.

Allow me to introduce Joint Commission and Kaiser Permanente leaders that will be speaking today, including: Dr. Jonathan Perlin, President and Executive Officer, The Joint Commission.

Dr. David Baker, Executive Vice President, Healthcare Quality Evaluation, The Joint Commission.

Dr. Ana McKee, Executive Vice President and Chief Medical Officer and Chief Diversity, Equity and Inclusion Officer at The Joint Commission.

Dr. Andrew Bindman, the Executive Vice President and Chief Medical officer at Kaiser Permanente.

Dr. Ronald Copeland, Senior Vice President of National Diversity, and Inclusion strategy and Policy and Chief Equity, Inclusion and Diversity Officer at Kaiser Permanente; and

Dr. Mark Smith, the Clinical Professor of Medicine, University of California, San Francisco, who served as the Tyson Award panel chair.

I'm now going to turn over the proceedings to Dr. Perlin and Dr. Perlin. Please take it away.

Well, thank you. Good morning everyone. We're excited to be here with you all today. On behalf of The Joint Commission we're very pleased to co-sponsor the Bernard J. Tyson National Award for Excellence in Pursuit of Healthcare Equity with Kaiser Permanente for its second year.

This year, the award recognizes 2 healthcare organizations that achieved measurable, sustained reduction in one or more healthcare disparities. Under my direction, The Joint Commission is taking a leadership role to help ensure equitable healthcare for all. We believe that reducing healthcare disparities is not only a patient safety and quality imperative. But it's also our moral and ethical duty. As an organization, we were operating under the belief that equity must be the foundation for all that we do in healthcare. Without equity, the opportunity for safe care cannot and will not exist.
The Tyson Award provides national recognition for healthcare organizations that have joined this charge to provide safer and more equitable care. To get the ceremony underway, allow me to introduce my colleague, Dr. David Baker.

Thanks very much, Dr. Perlin. This year we had six really outstanding finalists for this award. The goal for the review panel was to select the best projects from these worthy submissions. However, there were two submissions that really stood out above the others. So we’re pleased to recognize 2 organizations that made achievements in healthcare equity worthy of receiving the Tyson Award. Joining us from New York City Health and Hospitals is Dr. Jonathan Jiménez, Executive Director of NYC Care and joining us from Texas Children's Pavilion for Women is Dr. Christina Davidson, Associate Professor, Division of Maternal Fetal Medicine and Vice Chair of Quality and Patient Safety at Baylor College of Medicine and Chief Quality Officer for OBGYN for Texas Children's Hospital, Dr. McKee. I'll turn things over to you at this point to discuss the genesis of the award.

Thanks, David. As the data have shown in the video, disparities abound in healthcare among many patient populations related to race, ethnicity, socioeconomic status, gender, sexual orientation, immigration status, and more.

In the past two and a half years, COVID-19 put a spotlight on these unacceptable disparities. In 2020, The Joint Commission committed itself to bringing positive change and improvement related to healthcare equity and made it a goal to provide incentives and best practices to improve in healthcare equity. We looked for leaders in healthcare equity and identify Bernard J. Tyson, the late chair and CEO of Kaiser Permanente, as he inspiring figure who would be the ideal namesake for this award program. We engaged Kaiser Permanente and worked with them to launch this award program. I'll turn things over now to Dr. Bindman and Copeland from Kaiser Permanente to say a few words about Bernard.

Well, thank you for the opportunity to be here today to recognize our 2022. Bernard J. Tyson National Award for Excellence in the Pursuit of Healthcare Equity co-awardees. As many of you know, Bernard's career with Kaiser Permanente spanned more than 30 years. He successfully managed nearly every part of our healthcare system. In hospital systems, serving in roles from hospital administrator and Division President to Chief Operating Officer before becoming Chairman and Chief Executive Officer. He was truly an exceptional leader and his untimely passing profoundly affected everyone at Kaiser Permanente and had ripple effects throughout the broader healthcare and broader business communities. Anybody who knew him or heard him talk knew how passionate he was about the work we do at Kaiser Permanente on behalf of our 12.6 million members. Bernard was particularly passionate about addressing inequities in the US healthcare system. He worked tirelessly to ensure that all Americans have access to high quality, affordable healthcare, regardless of their ZIP code or background.
In addition to the work to address inequities that we’re continuing, that we are continuing and Kaiser Permanente, this award provides a platform to celebrate other healthcare providers who are demonstrating that they are ready to join us in our efforts. The rigorous application and selection process ensures that the Tyson awardees are effecting change in ways that are measurable and sustainable over time. I'd like to turn to my colleague, Dr. Copeland, and maybe you could say a few additional words.

Thank you very much, Dr. Bindman. It's our honor at Kaiser Permanente to carry forward Bernard's vision by tackling some of our most pressing societal challenges, including healthcare equity. And for all of us, it is our shared duty to work together to put an end to health inequities that are preventable, unfair and unjust. We believe good health belongs to everybody.

Our commitment to advance healthcare equity has been institutionalized by declaring it an enterprise wide strategic priority and a formal quality of care standard. Through our efforts, we will drive equitable health outcomes and experiences for our Members, our patients, and improve the conditions of health in our communities. We aim to change the trajectory of care delivery, helping our Members and communities experience more healthy years.

The award provides an annual platform to recognize important achievements in addressing healthcare equity, and we hope it will inform and inspire other organizations to join us in these efforts. Bernard's vision was without limits. It was cross sector and cross industry. He knew good health happens together. Let’s continue to look for opportunities for partnership and collaboration to co-design and co-create the future of healthcare that is equitable and inclusive for all. I will now hand things back, hand things back to Dr. Baker to say a little bit about the selection process for this award. Dr. Baker.

Great. Thanks Dr. Copeland. For this award, only organizations providing direct healthcare services and their partners were eligible. Organizations submitted applications that described their efforts to address specific disparities in care processes or outcomes, implemented a well-defined intervention to address the disparity, and provided evidence of a sustained reduction in disparities. This award is intended to recognize an initiative that led to meaningful difference and proven results. Our goal is to honor organizations that have done outstanding work to inspire others and to take on ambitious projects to improve healthcare equity. To tell you a little more about the external award panels evaluation of the applications, we're delighted to have Dr. Smith here to represent the panel as its chair. Dr. Smith.

Thank you, David. So a diverse panel of national healthcare equity experts was assembled to review the submitted applications and select the award recipients. I want to first take a moment to thank them for their expertise and their time and their support for this program.
That was a tough job selecting 1 applicant, 1 recipient from a pool of so many excellent applicants.

The panel reviewed all the assigned applications, scored them and then met to discuss and deliberate. There were many excellent initiatives. So our discussions were quite robust. Overall, we were seeking initiatives that had a well-defined population of the data to show disparate outcomes and a specific intent to target efforts to that population to improve their outcomes. That targeted their intervention, and solutions to identified barriers that employed well described interventions or strategies included data to show that the strategy is indeed worked and improve the outcomes for the target population and lastly included plans for sustaining and sharing the lessons learned or strategies to replicate the improvement and inspire others.

So without further ado, I want to recognize this year's co-awardees. New York City Health and Hospitals Corporation and Texas Children's Pavilion for Women. New York City Health and Hospitals is recognized for its initiative and Making Healthcare a Human Right, Expanding Access to Healthcare to Undocumented New Yorkers, which includes the New York City Care program that provides health care access to those who are ineligible for or cannot afford health insurance, including the undocumented. We welcome representatives from NYC Health and Hospitals who tell you more about the interventions and results of that program, and we welcome Dr. Jiménez. Take it away.

Hello. Thank you. Thank you so much to The Joint Commission and to Kaiser Permanente for this recognition. We're just honored here at New York City Health and Hospitals. And thank you also to Dr. Ted Long, Senior Vice President of Ambulatory Care, Population Health, who's in the audience and Doctor Mitch Katz, the President, CEO of New York City Health and Hospitals, both of whom have been, you know, tremendous champions of access to healthcare and key to making sure this program happened. And I would be also remiss to thank The New York City Health and Hospitals team, which includes 10s of thousands of staff who really make it their mission every single day to make quality healthcare for all you know, the main value of the way they spend their time.

I'm Jonathan Jiménez. I'm a family physician and I'm also the Executive Director of the NYC Care Program and I'm excited to share with you the work that we've been doing.
So, NYC care really starts as an answer to New York cities, I think, profound health inequity, which is one that we all face. Many New Yorkers continue to lack access to health insurance, whether it's due to affordability or immigration status, despite the passing of the Affordable Care Act. And undocumented immigrants in particular are in are barred from accessing health insurance, and so they can have all the benefits. That means they lack access to regular sources of care, primary care increased then results in increased mobility and as we know decreased life possibilities. And as a child of a previously undocumented immigrants myself, I also have to emphasize that undocumented the label of undocumented immigrants really belies how long many residents that are in document have been here. As the slide shows, 2/3 of undocumented immigrants in New York City have been here over a decade. A vast majority live in mixed status households. Meaning they live with people with visas, people that are citizens. And so really the ramifications of lack of access to care for this population and people who continue to not afford health insurance are dramatic in our communities.

So we saw for example that that we estimated that there were about 300,000 uninsured New Yorkers in New York City. About half we estimated we're eligible for Medicaid. That's the symbol of Metro plus there. That's one of our managed care plans. The other half we thought were based on estimates ineligible because of their immigration status. And so how to make sure that this group really felt that they had access to not just the emergency room, not just inpatient setting or our delivery wards at New York City Health and Hospitals, which is the public healthcare system in New York City, but also primary care. You know, just all the things that come with the comfort of knowing you, you'll have a place to go.

And so we created the NYC Care Program, which is a healthcare access program designed to make sure that people who are ineligible for health insurance or cannot afford health insurance know that they have access to primary care and all of the other self services that New York City Health and Hospitals has to offer.

And really the key is to make sure that then we capture everyone and we can say you know healthcare in New York City is a human right. And so I'll go into a little bit more detail about the elements of the program, a basis for the program really was direct access to primary care. So we invested in primary care and expanding access through more hiring of physicians, definitely. And then we also wanted to facilitate that process of making the appointment. We know that the safety net clinics exist all over the country. Certainly they exist here in New York City, but there were so many different doors where you could access care. So we try to simplify the process, create one single program, the NYC Care Program where we would invite you, and offer you a primary care appointment if you're brand new to the system. The appointment we offer you an appointment within two weeks. And whether you know you're new to the system or not, we would offer you a primary care doctor to make an appointment for you with someone who spoke your language. If needed.
We also expanded pharmacy services so that you could the patients could. Access their medications right after clinic if need be or 24-hour access. So often our members couldn't access medications in the case under emergency let's say if they needed antibiotics late at night. We contracted with CVS's in all the different counties of that are part of New York City to make sure there was also a 24 hour access for in the case of an emergency.

And I think lastly the really I think most amazing part of the program that really means it. A great deal to our patients and our Members is the patient experience. So we created a 24/7 customer service line that was there both to help, folks who are interested in the program have their questions answered enrolled in the program. But also as a sort of front desk to the clinic, where they could ask for refills, they could make appointments, they could ask for a new membership card.

And then we had a membership card which is includes the name of the patient, the name of their primary care provider which would help facilitate you know assigning them. And then also I think really importantly for our Members, because so many are low income and there is tremendous fear of medical debt, we provided fees that they would expect to pay best on their federal poverty level on the back of the card, so there are no surprises. They know exactly what to expect when they come and visit us and visit any of our clinics.

With respect to eligibility, you know, the program is really designed for New Yorkers, those who live in New York City within the boundaries and then also, as I mentioned already, those who are ineligible for health insurance largely due to immigration status or are unable to pay or afford the insurance that they're eligible for by Affordable Care Act standards.

And this is where we really partnered with the Community and the process of how to enroll. We have the, as I mentioned the 24 hour customer service line and as a part of that process you know we engage folks in their language. We have over 200 languages available through telephonic interpretation. We also have multilingual staff at our call center.

People could also come to one of our facilities. We are the largest public healthcare system in New York City and so we have 11 hospitals across the city, over 57 local community clinics as well.

And then lastly and really exciting piece is the partnership with the Community, where it creates other doors where they can access their program. On the right side, you'll see here in the column that we partnered with community based organizations that were trusted in immigrant communities of diverse ethnic backgrounds across the city, 22 community based organizations currently the staff there speak over 30 different languages and we even
developed a direct enrollment pathway so that if they have a certified application counselor that can facilitate their application for health insurance.

20:24
They can directly enroll people into the NYC Care program and I think most importantly this, the community based organizations really serve as trusted messengers to relay the benefits of the program, the process for enrolling and have also really provided critical feedback so that we can continuously improve how we serve this Community. We also partnered closely with New York City government. There's the obviously the Department of Health and Mental Hygiene who also works to coordinate care across different health systems and providers. We work closely with the Mayor's office of Mayor Affairs, who really has maintained these relationships with immigrant communities since they opened earlier in the past decade.

21:07
And then other initiatives that aim to engage the public not just around health insurance, but just the benefits that New York City provides generally, like the Mayor’s Public Engagement Unit, like GetCoveredNYC.

21:21
These are the varied organizations that we currently work with, including the government agencies, and this is really again aphasia crucial part of the program because of the fear, I think that continues to persist in accessing benefits and certainly healthcare benefits.

21:46
Another piece has been a public awareness campaign, so part of that is of course, advertising. The safety net has always been here. That's always been our mission to serve everyone regardless of immigration status or ability to pay.

22:01
But people didn't always know and there was so there were so many doors and so many processes to access care across the safety net.

22:08
And so by creating one program and then one message, one phone number that people can call, it's really facilitated the access to care. And so we have a multilingual public awareness campaign with advertising subways. Social media. Ethnic media as well and many different languages and earned media as well to make sure we're out there and making sure that everyone knows in New York City that they have access to care and that it is a right.

22:42
Some of the key milestones. So we launched in 2019 and we launched borough by borough. By the end of 2020 we were citywide and of course that was accelerated in part due to the pandemic. Many people who are vulnerable because of they were essential workers ended up being NYC Care Members, but unfortunately when they had questions about the vaccine. They didn't know who to ask. Many people want to ask their primary care doctor or their primary care someone on the primary care team and didn't know where to go. And so it was important for us to accelerate that process of launching the program faster across the city to
make sure people knew where to go if they wanted to discuss their doubts or their questions about the vaccine with healthcare, healthcare team and the public responded dramatically.

23:35
We've seen that we're at over 100,000 members now, and I think it speaks to that, the fact that even despite fears about accessing healthcare benefits among the immigrant community at times because of persecution, I think in the public conversation, the overriding concern is to be healthy. And we've seen that in our clinics, in my, in my clinic, I see it among patients. We've seen patients who haven't seen a doctor in 40 years, didn't know they had access to one and because of our program they found out that they in fact do have access to primary care. And healthcare in New York City.

24:21
And we're beginning to look in detail at how the program is really affected our members. And we've seen, for example, that about half of the population is brand new to New York City Health and Hospitals. That means people and like I said, this is something we're seeing in our clinics, people that didn't know at all. They just thought they were locked out of health insurance. And so I'm seeing people who both had harbored a fear about their stomach ache. And, you know, we're treating that, but also someone who felt totally well came in to clinic for the first time in over a decade and turns out that they had a new diagnosis of diabetes. The data reflects, I think the need and the desire to engage in primary care. Over 70% of our members in the past year had a primary care appointment and over half had seen the primary care doctor more than twice.

25:11
And then among people with the diagnosis of diabetes, 50% have seen an improvement in their A1C, as I mentioned already, likely because of brand new diagnosis as well. And then access to medications which can be absolutely unaffordable if you don't have, if you're not part of a financial assistance program.

25:31
And then similarly, among patients with hypertension, we've seen a 40 percent, 40% of them have seen an improvement in their blood pressure since joining the program.

25:43
And so we're very excited hitting about, we've been about three years of the program existing and are really looking forward to new milestones and providing the highest quality care to all our Members and really thank you again it's an honor to receive this award.

26:03
Well, thanks very much for your work, Dr. Jiménez. And thanks to the entire team at New York City Health and Hospitals for the presentation about your initiative. Next up, we recognized Texas Children's Pavilion for Women for its Initiative Quality Improvement Initiatives on Decreasing Racial Disparities in Maternal Morbidity, which addressed severe maternal morbidity due to hemorrhage rate among Black mothers. We therefore welcome representatives from Texas Children's Hospital who tell you more about their interventions and the result of their program. Welcome, Dr. David.
Good morning. Thank you so much.

Thank you Kaiser and The Joint Commission for this award. And it's just an honor to be here to receive it and to be able to present our work. And if we go to the next slide, I would also like to give a very special thank you to the team members here at Texas Children's Hospital Pavilion for Women.

I mean, I could have probably put 100 more faces on this slide and it really has involved every single person who works here and takes care of our patients because it is. Truly been a team and collaborative effort. But these are just some of the people who have been absolutely instrumental in this work. And I would like to give a very special thank you to my Chairman, Doctor Michael Belfort, who is also on here with us right now. Without his support for this project and really just, you know, his, his belief and how important it was long before this was something that was being discussed on a regular basis, I really don't think we'd be where we are right now. And so before I get. Started with presenting the project, I'd just like to turn it over to Dr. Belfort to say a few words. I'm not sure if he's able to connect on camera. We saw him earlier. Well, I will just keep going then in the interest of time. So I will go on to the next slide.

Just to give a little bit of background about this project, you probably hear in the news quite a bit about maternal mortality and how the United States has one of the highest maternal mortality rates of any developed nation. And so when we're talking about maternal mortality, we're talking about deaths related to pregnancy.

According to the CDC, approximately 700 women die each year from pregnancy related deaths. And based off of reviews from different state maternal mortality and morbidity review committees, it has been identified that the majority of these deaths are actually preventable.

When we talk about maternal mortality however, it really does represent the tip of the iceberg and that there are a lot of different events that led up to a woman's death and those are referred to as severe maternal morbidity. And as you can see here, the different descriptors are the CDC's definition of severe maternal morbidity. There are 21 different indicators that can be obtained from ICD10 codes or administrative codes and these indications or factors that occurred during the labor and delivery admission represent the unintended consequences of labor and delivery. And a lot of these things, if unrecognized and untreated, are what ultimately leads to that maternal mortality.

So while any given hospital may have very few numbers of actual maternal deaths, for every one maternal death there are at least 100 cases of severe maternal morbidity. So morbidity
is something much easier to kind of look at and better understand. To better recognize and prevent as areas for opportunity to prevent not only morbidity but also long term mortality.

29:40
I'm I am a maternal fetal medicine physician who practices in Houston, Texas and in Texas, this is just sharing some Texas data. We see in the graph on the right that the rate of overall severe maternal morbidity. So any one of those indicators you saw in the previous slide is higher in our Non-Hispanic Black population which you see is represented in this blue line across the top. And then when you look specifically at rates from hemorrhage, so of those patients who experience a hemorrhage or have a risk factor for hemorrhage, when you look at the ones who experience a morbidity from it with a blood transfusion being the most common driver of morbidity, you see again in the top line that the rate for Black patients is much higher than any other race and ethnicity. And so we recognize this in Texas to be a problem and we recognize that at my hospital and similar to Dr. Jimenez. I think you know, this felt a little bit personal as well because I am a Black maternal fetal medicine physician who takes care of the most complicated patients. And it's difficult to recognize that within your own specialty you are seeing these huge disparities. And this is something that we have known was happening in our specialty for a while.

30:51
It's probably been in the last five to seven years that we've really been having a better understanding of some of those root causes. And when we look at maternal morbidity mortality, we know that, Black women are three to four times more likely than White women to have a pregnancy related death, and they're twice as likely to have morbidity. And all of this is independent of income, education and of comorbid conditions.

31:16
So it's not because Black patients are more likely to have medical complications of pregnancy, but some deeper factors like implicit bias, discrimination and potentially structurally structural racism and social drivers of health.

31:29
As a state The Texas Department of State Health Services launched a statewide initiative in 2018 to implement a patient safety bundle that had been published by the Alliance for Innovation on Maternal Safety or AIM, and the overall goal was for the state to reduce severe maternal morbidity from hemorrhage by 25%.

31:47
Just to give a little background about the hospital that I work in, we are in the Texas Medical Center in Houston, TX. We are a level 4 maternal and neonatal hospital and by Level 4 designation that means we have been designated to be able to provide care for the most complicated moms and babies, we have approximately 6,500 deliveries per year. We have 24/7 in house coverage by OBGYN hospitalist critical care medicine physicians and Baylor College of Medicine residents. And Houston is the most diverse city in the nation and our patient demographics are very representative of the demographic population of Houston.
So we take care of approximately 38% of patients who are Hispanic, 34% Non-Hispanic White, 20% Non-Hispanic Black and about 7% Asian, 1% other. Approximately 40% of our deliveries are Medicaid and approximately 10% of our patients speak a language other than English.

So as we entered into this statewide initiative, we decided as a hospital to start looking at our own severe maternal morbidity data. We had not been previously doing that, but because it is dated that you can get from administrative codes, we met with our coding department and felt confident that we had very robust data, so we decided to look at severe maternal morbidity overall from all conditions, and then as it relates to hemorrhage. And this is a slide that we presented in January of 2019 at our Department of OBGYN meeting. And it shows our overall severe maternal morbidity rate. And as it relates to transfusion and you can see that over the years 2015 to 19, we were holding pretty steady at around 3% to 5% year over year.

And as we started looking at this data we decided that we as an organization, wanted to apply a health equity lens to this project. There is another AIM patient safety bundle that is called Reduction of Peripartum Racial and Ethnic Disparities. And within it, it goes through a framework that you can really it was designed to overlay on all of the other bundles and those were framework of how to approach your QI efforts with a health equity lens.

So one of the things that we started with under the reporting and systems learning where you see this red arrow is to develop a disparities dashboard that monitors process and outcome metrics. Stratified by race and ethnicity with regular dissemination of this data to staff and leadership. So we decided we were going to look at our morbidity overall and from hemorrhage by race and ethnicity.

And the first time we presented this data was in March of 2019 and this is a slide from that month and when we got this data, when I got this data, I will, I have to admit it was was hard to look at it was pretty distressing to see that while our overall morbidity was holding pretty steady year over year when you break that down into race and ethnicity, we found it was because our Black patients were actually increasing and having a higher morbidity year over year, but our other patients were either decreasing or staying the same. And you can see in this graph from as it relates to hemorrhage, our Black patients were almost twice as likely to experience morbidity from hemorrhage as compared to our White patients. There was a significant disparity gap in the beginning of this project and the rate of Black women was increasing year over year.

And so, this was actually data that I presented at a department meeting, which we have on Friday mornings at 7:30 in the morning. And I wasn’t sure what conversation would develop from this presentation. But you know, I went into it just planning to present the data as it...
was. And then my Chairman, Dr. Belfort, followed up with a question of, so Christina, why do you think this is happening? And that really gave me the, the feeling that he had opened the door for me to really go into an open and honest discussion. He knew why this was happening. And I think again, because of his support and his understanding and belief of how important this work was, it's important to have that open dialogue about it as well. So we talked about things of lack of standardization of care and the potential for implicit biases to enter into care. And it really opened up an open conversation for everyone to recognize that we weren't bad people, but we had recognized that we had a problem in our hospital that we wanted to fix. And so we went into a hospital wide effort to try and identify these root causes and work to eliminate them.

36:12
This is one of the elements that we did within the OB hemorrhage bundle. It asks you to create an assessment of hemorrhage risk factor on admission and there are certain cause, there are certain OB factors that will increase the patients risk of experiencing a hemorrhage after delivery and then there are some factors that may not give you an increased risk of hemorrhage. But if you have a hemorrhage you're more likely to have a morbidity from them. For example, if you start out with a very low hemoglobin or hematocrit, well one of the things we decided to add to this risk factor stratification was Black or African American race. Not because there is any biological basis for why Black patients have a morbidity from hemorrhage, but just the recognition that in our own hospital they were experiencing higher morbidity. And we wanted to raise awareness to this so that it would really make people recognize and maybe think a little bit differently and approach things differently. And maybe remove some actions that could be driven by unconscious bias.

37:10
In fact, it was after a few months of having this implemented that we got some feedback that just having Black African American race on there, there was a concern that it was actually increasing. It was making people more likely to think that race was the reason for these disparities and not the potential consequences of racism.

37:29
So we actually changed the wording to say Black and African American due to health disparities from unconscious bias. And so usually you will hear our team members say that she is medium risk because of racial bias.

37:41
And one of the other things we also did an overlaying these two bundle side-by-side is within those reporting and systems learning, we developed and we completely redesigned our quality and patient Safety Review Committee where we had all of our severe hemorrhages reviewed by both a provider and a nurse to look for those opportunities for system level improvement And within it, we also considered the role of race, ethnicity, language and social determinants of health and talked about things like cognitive biases and implicit bias. We were actually even because of the work we were doing, Texas Children's gifted us with an Implicit Bias training course for 50 of our healthcare workers and we opened this to our Quality and Safety committee and then anyone else who was able to fill those spots and we
actually had a four hour live training on Implicit Bias; that also really helped us kind of think through these case reviews and a little bit different manner and after doing some reviews.

38:38
And recognizing the importance of social work involvement, we actually invited our social work colleagues onto the committee as well and so they participate in our committee as we identify these social drivers to make sure we are doing the right things to implement solutions to them.

38:54
So as a result of this, we went back and looked at our data and kind of did a before and after comparison using that time point to demarcate our before group from our after group as the month in which we started presenting our data stratified by race and ethnicity. Because we continue to present this data monthly. And we actually found that our, the morbidity in our Black patients was decreasing even before we had fully implemented all other elements of the bundle and we felt it was maybe just a result of recognition and awareness. And so when we looked at this before and after comparison, we found that before our intervention our morbidity rate and our Black patients was almost 46% and that actually decreased almost 32% after these interventions and that reduction was statistically significant.

39:42
We also looked at all of our races and ethnicities and found that that Black, White gap that existed that was statistically significant before interventions had been completely eliminated by the end of our study time period which ended in 2020. And we saw where we had been seeing our Black patients morbidity steadily increasing. It took a sharp dive and started to decrease. And on the next slide, the final slide, it just shows that we continue to look at these metrics. We continue to present them to the department and even here as where we are in 2022, we have maintained that reduction in morbidity in our Black patients and that elimination of the disparity gap.

40:19
So again, I want to thank you for the opportunity to present and thank you for this award.

40:26
Thank you to our presenters for doing such an excellent job in sharing the work, the hard work that they've done, and the enlightenment that they bring to so many subtle aspects of how disparities occur.

40:44
And now I would like to ask the audience members to please join me in congratulating the teams via messages in the chat. We will provide all of your comments to them following the ceremony.

40:58
We were extremely pleased to see many applications submitted and the quality of these submissions. This shows the breath of efforts to address the healthcare equity is steadily
increasing and we want to take a moment to recognize the top five finalists. We also want to acknowledge all the healthcare equity initiatives submitted for consideration for the award. We also have these lists available on The Joint Commission's web page, www.JointCommission.org/TysonAward We will also put the link in the chat.

41:31
With all this said, disparities continue to persist and we want to do more to encourage healthcare organizations to reduce these disparities and improve healthcare equity. To that end, The Joint Commission Journal on Quality and Patient Safety has issued a call for papers on addressing healthcare disparities and we have invited the finalists to submit to the Journal for an issue in 2023.

41:55
Also, we want to encourage organizations in the audience to be on the lookout early next year for information about the 2023 Tyson Award application from Joint Commission publications and on The Joint Commission website.

42:10
Congratulations one more time to the New York Health and Hospitals and Texas Children's Pavilion for Women.

42:19
Thank you all for to all our presenters and to our audience for your interest and participation. Have a great day!