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Heart of Safety Coalition

Insights Huddle recap

May 2023

Health equity as quality

Our sincere gratitude to Lou Hart, MD, Medical Director of Health Equity, Yale New Haven Health System (YNHHS), for leading this Insights Huddle outlining how health equity can be part of mainstream quality systems and processes. Below is a summary of the discussion, including links to resources.

Key premise: Health equity is a pillar of quality that's often overlooked. Integrating health equity into quality efforts requires a strategic change management approach to educate, alter opinions, align data, engage cross-sector partners and hardwire equity into quality, safety and care experience systems. When health equity is integrated into mainstream quality initiatives and becomes a standardized approach, it helps create psychological and emotional safety for team members (especially minoritized team members) by showing that the organization is deeply committed to undoing structural inequity.

Lesson for leaders:

- Improve data collection and create awareness of the historical origins of inequities.
- Use improved data to identify variations in care – including variations caused by inappropriately race-based care guidelines.
- Build equity into quality, safety and care experience systems by including equity in adverse event analysis and quality improvement data analytics. Engage patients as consultants.
- Move quickly from pilot to organization-wide change by targeting areas that align with reimbursement and/or company goals (e.g. readmissions).
- Engage in cross-sector partnerships to address systemic social and environmental factors that contribute to inequities outside the health system.

Insights overview:

Equity is a quality approach to eliminate unwanted variance in the system. These systems were designed based on outdated notions of race as a biological construct, as well as other socially-constructed identity markers. This variance creates human pain and financial waste.

- The U.S. spends $320 billion annually on health inequities, more than the federal government spends on public housing and public education combined.
- Ties to external locus of accountability creates urgency (e.g., Centers for Medicare & Medicaid Services, The Joint Commission).

Change management approach: Create the climate for change; Engage and enable the organization; Implement and sustain change. (Kotter model of change)

- **Step 1: Shore up the data and engage with disbelievers [create the climate for change].** Two key questions: Do we have good data? Do we intentionally provide disparate care?
    - Identify barriers to collecting accurate, patient-led race-ethnicity and language (REAL) and sexual orientation and gender identity (SOGI) data from patients.

        - YNHHS simplified race and ethnicity collection by combining into a single question and adding new meaningful categories, reducing "other, unknown, patient refused, or blank" from 19% to 9%.
    - Make status quo uncomfortable by referencing overtly racist historical medical references and images.
        - Biological racism = the unscientific notion that races are meaningfully different in their biology and that these differences create a hierarchy of value.
        - Share examples of race-based medicine (e.g. eGFR for kidney function, neonatal jaundice, vaginal birth after cesarean (VBAC) success, kidney stones, pulmonary function testing).
        - Note: Changing the actual practice of medicine won allies to the office of health equity because it was viewed as a substantial corrective action.
    - Defuse discomfort around structural racism with language such as "failure to reject subjectivity" instead of "racial bias."

- **Step 2: Build equity into quality, safety and care experience systems [Engage and enable the organization].**
    - Implement equity in adverse event analysis.
        - Add equity-related elements to root cause analysis:
            - "What processes may have contributed to the event?"
            - "Which patient characteristics or social drivers of health may have precipitated or affected the outcome?"
    - Advance equity in QI data analytics.
        - Be as transparent as possible with quality variation.
        - Stratify key performance indicators by REAL and SOGI data (e.g. readmissions) – create equity dashboards within existing analytics systems.
        - Create relative risk scores for key groups by quantifying variability from the group with the most positive outcomes.
    - Engage patients as expert constituents.
        - Create wisdom councils to guide Healing ARC implementation (Acknowledgement, Redress, Closure).
        - Use relative risk scores to oversample patients with key demographic characteristics.

- **Step 3: Pursue cross-sector partnerships to address groundwater problems (structural inequities) [Implement and sustain change].** There is a structural groundwater problem, according to the Racial Equity Institute, that flows between multiple systems in our communities – healthcare, education, criminal justice, financial services, etc.
    - Leverage EHR data – gender, race, payer, ZIP code, etc. to ask better questions.
    - Communicate expectations transparently and directly with patients.
        - E.g., YNHHC reviewed newborn toxicology and discovered racial inequity in screening rates. They've implemented a new program based on patient feedback. It uses informed consent, recognizing that newborn tox screens are not required to refer to resources, but results have implications in multiple other systems (custody, social services, etc.). Pathways are available publicly on YNHHC's website.
    - Understand the two-way street of care experience (the intersection of patient and team member experience).
        - Stratify team member experience using identity data to uncover similar disparities in experience and use the data to make changes that protect team members from inequities, too.
        - Swiss cheese models should include patient and provider identity and trauma history.

Yale New Haven Health's org structure for health equity

- Health equity is integrated into safety and quality org structure (health equity, care signature, quality and safety – all reporting to the chief quality officer).
- 0.5 FTE medical director for health equity (Dr. Hart).
- 0.5 FTE co-director who covers administration, community health benefit, needs assessment, etc.
- Other members of the team pitch in on things such as analytics, care pathways, etc.
- Equity is discussed in daily safety huddles.
- The question of whether cognitive bias or social determinants of health contribute to a safety incident will be standard in YNHHS's new safety reporting system.

If you have topics you want to learn more about or best practices you want to share to help others protect the safety and wellbeing of healthcare team members, please email **HeartofSafetyCoalition@stryker.com**.

About the Heart of Safety Coalition

The Heart of Safety Coalition places care team member safety at the heart of healthcare. This national community of industry leaders, learners and advocates ensures that voices are heard, connections are made, and standards are raised to inspire systemic, team and individual change that improves working and healing environments. The Coalition's three pillars of care team safety advance the Heart of Safety Declaration, which intersects the essential wellbeing principles of dignity and inclusion, physical safety, and psychological and emotional safety. Driven by its mission to make healthcare better, Stryker supports and manages the Coalition. Learn more at www.HeartofSafetyCoalition.com.