The Joint Commission KAISER PERMANENTE

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

2022 Tyson Award Ceremony Transcript Text

[AD:] = audio descriptor text, explains on screen action for accessibility

0:00
[AD: contemplative/serious piano music starts]
[AD: Tyson award program logo appears in the left upper hand of the screen with the text below it reading: the Bernard J. Tyson National Award for Excellence in Pursuit of Healthcare Equity. There is a right-facing arrow in the middle of the screen, and on the left side of the screen is a photograph of a clinician wearing a mask with a patient chart in her hand and a young female patient in a reclining position.]

0:07
[AD: The screen changes to show a photograph of Bernard J. Tyson on the left side of the screen and on the upper right of the screen there is text that reads Bernard J Tyson. Below that is paragraph text that reads Bernard J. Tyson, the chairman and chief executive officer of Kaiser Permanente, worked tirelessly to address the healthcare disparities that plague the US healthcare system. There is a right facing arrow at the bottom right of the screen.]

0:16
[AD: A new screen fades in and has text in the upper left corner that reads infant mortality. Below that is a photograph of an African American mother, kissing a newborn baby that she is holding in her arms. On the right side of the screen, text reads babies born to black women in the United States die at more than double the rate of babies born to white women.]

0:27
[AD: At the left upper corner of the screen a header reads “life expectancy.” Underneath it is paragraph text reading: the average life expectancy among African Americans in the United States is four years lower than that of white people. American Indians and Alaska natives born today have a life expectancy that is 5 1/2 years lower than all US races. Below that is a right facing arrow, and on the right-hand side of the screen is an elderly African American man with a facemask partially covering his face.]

0:37
[AD: A title/header at the top left of the screen reads “cancer.” Below that is paragraph text that reads: people with lower incomes and education levels are more likely to get cancer and die from it compared to their more affluent peers, and that gap appears to be widening. Below that is a right facing arrow. At the bottom of the left side of the screen, there is a right facing arrow, and on the right-hand side of the screen is a photo of an individual obscured in the background, holding up a cancer ribbon, and below it an image of cancer cells is viewed from a microscope.]

0:47
[AD: On the left side of the screen is a photograph of a flag that has stripes of different gradations of gray. On the right-hand side is a title/header that reads: safety and security. Paragraph text underneath it reads: LGBTQ+ individuals are more likely to experience mental health issues, violence, HIV, and other STDs, poverty, substance, abuse, and food insecurity than non-LGBTQ+ individuals. Below that text is a right facing arrow.]

0:56
[AD: In the upper left hand of the screen is a header/title that reads: Covid – 19. Below that is paragraph text that reads: black and Hispanic individuals are less likely to receive the outpatient. COVID-19 treatment Paxlovid then white and non-Hispanic individuals.
To the right of that text is a photo displaying a microscopic image of a COVID-19 cell.]

1:07
[AD: Another screen appears, and the word healthcare access is shown as the title/header in the left hand of the screen. It is an image of a white male clinician with a stethoscope around his neck, holding a tablet in front of an African American woman. To the left of that image is a right facing arrow and to the left of that image is paragraph text that reads: people with lower incomes are often uninsured, and minority groups account for over half of the uninsured population.]

1:17
[AD: Another screen appears that shows an image on the left of the screen that includes an African American male wearing a facemask over his nose and mouth with eyeglasses over the mask. To the right center of the screen is a title/header that reads: colorectal screenings. Below that is paragraph text that reads: African Americans are approximately 20% more likely to get colorectal cancer, but are less likely to be screened and about 40% more likely to die from it than most other groups. Below that paragraph text is a right facing arrow.]

1:27
[AD: After another transition, the screen depicts a photo montage of Bernard J Tyson. The upper left is Dr Tyson with a group of construction workers in hard hats. To the right Tyson smiling and presenting to a group of people. Below that a second photo of Dr. Tyson speaking in front of a group and on the right side of the photo montage is a photo of Bernard as a child. Below are the words reading: Bernard Tyson strived for better," and in the right lower hand corner of the screen is a right facing arrow.]

1:30
[Susan Funk] Welcome, everyone, and thank you for joining us for the 2022 Bernard J. Tyson National Award for Excellence in Pursuit of Health Care 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 of the Joint Commission, Dr. David Baker, Executive Vice President, Health Care 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 Kaiser Permanente, and Dr. Mark Smith, the Clinical Professor of Medicine, University of California, San Francisco, who served as the Tyson Award Panel Chair.

2:33
I'm now going to turn over the proceedings to Dr. Perlin, and Dr. Perlin, please take it away.

[Jonathan Perlin] 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 two healthcare organizations that achieved a 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.

3:25
As an organization, we are 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.

3:55
[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 two 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 Jimenez, 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 OB-GYN for Texas Children's Hospital.

Dr. McKee, I'll turn things over to you at this point to discuss the genesis of the award.

4:55
[Ana McKee] 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 care equity and identify Bernard J. Tyson, the late chair and CEO of Kaiser Permanente, as the 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 Drs. Bindman and Copeland from Kaiser Permanente to say a few words about Bernard?

6:08
[Andrew Bindman] 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 Health Care 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 health care system and hospital system 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

health care 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 health care, regardless of their zip code or background. In addition to the work to address inequities that we are continuing at Kaiser Permanente, this award provides a platform to celebrate other health care 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 affecting 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.

8:11
[Ronald Copeland] 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 health care 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 to Dr. Baker to say a little bit about the selection process for this award. Dr. Baker.

9:43
[David 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 panel's evaluation of the applications, we're delighted to have Dr. Smith here to represent the panel as its chair.

Dr. Smith?

10:36
[Mark 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. It was a tough job selecting one applicant, one 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 and so our discussions were quite robust. Overall, we were seeking initiatives that had a well-defined population with 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 identify barriers, that employed well-described interventions or strategies, included data to show that the strategies 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.

11:44
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 in Making Health Care a Human Right, Expanding Access to Health Care 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 will tell you more about the interventions and results of that program, and we welcome Dr. Jimenez. Take it away.

12:33
[Jonathan Jimenez] Hello. 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 and Population Health, who's in the audience, and Dr. Mitch Katz, the President and CEO of New York City Health and Hospitals, both of whom have been, you know, tremendous champions of access to health care 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 tens of thousands of staff who really make it their mission every single day to make quality health care for all, you know, the main value of the way they spend their time.

13:22
I'm Jonathan Jimenez. 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. Next slide.

13:35
So, NYC care really starts as an answer to New York City's, 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 barred from accessing health insurance, and so they can't have all the benefits. That means they lack access to regular sources of care, primary care, increase then results in increased morbidity, and as we know, decreased life possibilities. And as a child of previously undocumented immigrants myself, I also have to emphasize that undocumented,

the label of undocumented immigrants really belies how long many residents that are undocumented have been here.

14:24
As the slide shows, two-thirds 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. Next slide.

14:52
So, we saw, for example, that we estimated there were about 300 ,000 uninsured New Yorkers in New York City. About half, we estimated, were eligible for Medicaid. That's the symbol of the 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 delivery wards at New York City Health and Hospitals, which is the public health care system in New York City, but also primary care, you know, just all the things that come with the comfort of knowing you'll have a place to go.

And so, we created the NYC Care Program, which is a health care 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. Next slide.

16:01
And really the key is to make sure that then we capture everyone, and we can say, 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 are 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, we'd offer you an appointment within two weeks.

Whether 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 of emergency, let's say that they needed antibiotics late at night.

We contracted with CVSs in all the different counties that are a part of New York City to make sure there was also 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 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, enroll 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. Next slide.

18:09
And then we had a membership card, which includes the name of the patient, the name of their primary care provider, which would facilitate 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 based 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. Next slide.

18:46
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. Next slide.

19:11
And this is where we really partnered with the community in 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.

19:32
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 or 57 local community clinics as well.

And then lastly, and really exciting piece is the partnership with the community, next line, where it creates other doors where they can access the 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, they can directly enroll people into the NYC care program.

And I think most importantly, 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 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 and Affairs, who really has maintained these relationships with immigrant communities since they opened earlier in the past decade.

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 Get Covered NYC.

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

Next slide. Another piece has been a public awareness campaign. So, part of that is, of course, advertising.

21:53
The safety net has always been here. That's always been our mission to serve everyone regardless of immigration status or ability to pay. 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. 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 in many different languages, and earned media as well to make sure we're out there and making sure that everyone knows in city that they have access to care and that it is a right.

Next slide. Some of the key milestones.

22:44
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 the primary care doctor or 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 a health care team.

And the public responded dramatically. We've seen that we're at over 100 ,000 members now. And I think it speaks to 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 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 health care in New York City. Next slide.

24:21
And we're beginning to look in detail at how the program has really affected our members. And we've seen, for example, that about half of the population is brand new to New York 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 were treating that, but also someone who felt totally well and came in the clinic for the first time in over a decade and turns out that they had a new diagnosis of diabetes. And 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. 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 diagnoses 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. And then similarly among patients with hypertension, we've seen a 40% of them have seen an improvement in their blood pressure since joining the program.

And so, we're very excited and 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
[Mark Smith] Well, thanks very much for your work, Dr. Jimenez, and thanks to the entire team at New York City Health and Hospitals for the presentation about your initiative.

26:12
Next up, we recognize 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 rates among black mothers.

We therefore welcome representatives from Texas Children's Hospital who tell you more about their interventions and the results of their program.

26:36
Welcome Dr. Davidson.

[Christina Davidson] 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 a hundred more faces on this slide, and it really has involved every single person who works here and takes care of our patients, because it has 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, Dr. Michael Belfort, who is also on here with us right now.

27:25
Without his support for this project and really just you know 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.

27:56
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.

28:33
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 lead 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 ICD-10 codes or administrative codes, and these indications or factors that occur 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.

29:26
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 a long-term mortality.

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 it at my hospital.

30:29
And similar to Dr. Jimenez, I think 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 happening in our specialty for a while. 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 structural racism, social drivers of health. 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%.

31:48
Just to give a little background about the hospital that I work in, we are in the Texas Medical Center in Houston, Texas. We are a level four maternal and neonatal hospital and by level four 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 seven in-house coverage by OB-GYN hospitalists, 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.

32:27
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 data that you can get from administrative codes, we met with our coding department. We felt confident that we had very robust data. So, we decided to look at our severe maternal morbidity overall from all conditions and then as it relates to hemorrhage.

33:09
And this is a slide that we presented in January of 2019 at our Department of OB-GYN 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 three 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 AEM 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 it goes through a framework of how to approach your QI efforts with a health equity lens.

33:55
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 have to admit it 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.

34:46
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.

34:56
There was a significant disparity gap in the beginning of this project. And the rate in 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 730 in the morning. And I wasn't sure what conversation would develop from this presentation, but 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?”

35:28
And that really gave me 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. 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 OB factors that will increase a patient's 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 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.

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.

And one of the other things we also did overlaying these two bundles 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.

38:12
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 in a little bit different manner.

And after doing some reviews 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 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.

39:25
And so, when we looked at this before and after comparison, we found that before our interventions, our morbidity rate in our black patients was almost 46 percent, and that actually decreased almost 32% after these interventions, and that reduction was statistically significant.

We also looked at all of our races and ethnicities and found that that black-white gap that existed that was statistically significant before our 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.

40:11
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. So again, I want to thank you for the opportunity to present and thank you for this award.

40:26 [AD: the Bernard J. Tyson Award logo appears back on screen as a transition before Dr. McKee speaks]
[Ana McKee] 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 in the following the ceremony.

40:58 [AD: On screen is shown a list of 2022 Tyson Award Applications considered as the top Finalists by the award panel. A table appears on screen with text reading:
Henry Ford Health, Detroit, Michigan, Reducing Hypertension Among African American Men; Mount Sinai Health System, New York, New York, Addressing digital health equity to improve cardiovascular health outcomes using pharmacist-led remote patient monitoring among New York City residents; NYC Health + Hospitals *, New York, New York, Making Healthcare a Human Right: Expanding Access to Healthcare to Undocumented New Yorkers; Texas Children's Pavilion for Women *, Houston, Texas, Examining the effect of quality improvement initiatives on decreasing racial disparities in maternal morbidity; The MetroHealth System, Cleveland, Ohio, Partnering to improve childhood lead screening in high-risk urban communities: a community-based systems initiative; WellSpan Health, York, Pennsylvania, Reducing Disparities and Increasing Breast Cancer Screening Rates.]

We were extremely pleased to see many applications submitted and the quality these submissions. This shows the breadth of efforts to address the health care equity is steadily increasing and we want to take a moment to recognize the top finalists.

41:13
We also want to acknowledge all the health care equity initiatives submitted for consideration for the award. [AD: list of all submitting organizations displays on screen and reads: Atrium Health Atrium Health Navicent Atrium Health Wake Forest Baptist Health atrium Health Floyd, Charlotte, North Carolina Winston-Salem, North Carolina, Macon, Georgia, Rome, Georgia, Expansion of School Based Virtual Clinic to improve access to high quality pediatric medical care; CarePoint Health-Hoboken University Medical Center, Hoboken, New Jersey, An Innovative Approach to Address HIV Care During Covid-19 Pandemic; Clever Care Health Plan, Southern California, Delivering culturally-sensitive, cost-effective Medicare coverage that honors and uplifts the traditions and values of underserved Asian American communities; County of Santa Clara Health System, Santa Clara Valley Medical Center, San Jose, CA, Cervical Cancer Screening Initiative: Removing barriers for Native Hawaiian and Pacific Islander Patients in a Safety-Net Setting; Erie County Medical Center Corporation, Buffalo, New York, Promoting Kidney Transplant Access Through Expanded Patient System Support and Donor Selectivity; Eskenazi Health, Indianapolis, Indiana, Access to COVID-19 monoclonal antibodies in high-risk, marginalized, ambulatory patients in a safety net health-system; Henry Ford Health, Detroit, Michigan, Reducing Hypertension Among African American Men; Jefferson Health, Philadelphia, Pennsylvania, Jefferson Health COVID-19 Mobile Vaccine Clinic; Meritus Health, Inc., Hagerstown, Maryland, Bold Elimination of Health Inequity in our Community; Mount Sinai Health System, New York, New York, Addressing digital health equity to improve cardiovascular health outcomes using pharmacist-led remote patient monitoring among New York City residents; Northwell Health, New Hyde Park, New York, Addressing Disparities in COVID Outreach, Testing & Vaccination; Northwell Health, North Shore University Hospital, Manhasset, New York, Implementation of a pre-pregnancy/early conception maternal morbidity risk assessment by a community based healthcare worker with chatbot navigation to improve pregnancy outcomes; Novant Health, Winston Salem North Carolina, Reimagining the System to Eliminate Disparities in Covid-19 Vaccinations; NYC Health + Hospitals *, New York, New York, Making Healthcare a Human Right: Expanding Access to Healthcare to Undocumented New Yorkers; NYU Langone Health, New York, New York, Equitable COVID care delivered through standardized clinical protocols, unbiased research trials, and adaptive, asynchronous, staff education; Penn Medicine Princeton Medical Center, Plainsboro, New Jersey, Reducing Major Maternal Morbidity and Mortality in BIPOC Women; Robert Wood Johnson University Hospital, New Brunswick, New Jersey, RWJUH Organizational Equity Model; Texas Children's Pavilion for Women *, Houston, Texas, Examining the effect of quality improvement initiatives on decreasing racial disparities in maternal morbidity; The Hospitals of Providence, El Paso, TX, El Paso, Texas, Vaccination and Monoclonal Antibody Administration Efforts in the Borderland – How a Healthcare

System Increased Access to COVID-19 Vaccinations and Monoclonal Antibody Therapy to a Vulnerable Population in a Border City; The Medical Clinics of the 501st Combat Support Wing: 422 Medical Squadron, RAF Croughton & 423 Medical Squadron, RAF Alconbury, United States Military Unit Stationed in: Brackley, Northamptonshire, UK & Huntingdon, Cambridgeshire, UK, Reducing Disparities in Developmental Outcomes for Military Connected Children in the Context of COVID-19; The MetroHealth System, Cleveland, Ohio, Partnering to improve childhood lead screening in high-risk urban communities: a community-based systems initiative, The Queen's Medical Center Queen's Care Coalition, Honolulu, Hawaii, Reducing hospital utilization by focusing on social determinants of health; Therapeutic Play Foundation, Pasadena, California, Mommy Matters program is a one-year wraparound, multidisciplinary outpatient maternal, infant and family support initiative. We provide mental and physical health care for pregnant Black women and their families; WellSpan Health, York, Pennsylvania, Reducing Disparities and Increasing Breast Cancer Screening Rates.]

We also have these lists available on the Joint Commission's webpage, www.jointcommission.org slash Tyson Award, 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.

41:54
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.

Congratulations one more time to the New York Health and Hospitals and Texas Children's Pavilion for Women. Thank you all to all our presenters and to our audience for your interest and participation. Have a great day.