Welcome to the Partnership for Patient Care 2022 Leadership Summit

Live tweet your reflections to @hcifonline and use #PPC2022Summit
Thank You to Independence Blue Cross for their ongoing support of PPC
HCIF Board of Directors

Patricia Sullivan, PhD, RN (Chair)
Natalie Levkovich (Vice Chair)
Michelle Burroughs, EdD, MBA
Victor Caraballo, MD, MBA
Chaudron Carter-Short, EdD, MHA, MHEd, MSN, RN, NE-BC
Joanne Craig, MS
Allison Hess, MBA
Matthew Hurford, MD
Elaine Markezin, MBA
Sara McCullough
Mark Mullen, MD
Najja Orr, MBA
Vanessa Renee, MBA
Jonathan Stallkamp, MD
Richard Webster, RN, MSN, NE-BC
Norman Weinstein, Esq.
Daniel Wolfson, MHA
Stephanie Zarus, PharmD
Richard Webster, RN, MSN, NE-BC
President
Thomas Jefferson University Hospitals
HCF Clinical Advisory Committee

Jeremy Souder, MD (Chair)
Eileen Jaskuta, MSHA, BSN, RN (Vice Chair)
Victor Caraballo, MD, MBA
Mary Reich Cooper, MD, JD
Scott Cowan, MD, FACS
Shannon Davila, MSN, RN, CIC, CPHQ, FAPIC

Oren Guttman, MD, MBA
Christina Lauro, MSN
Charles Orellana, MD
Aileen Schast, PhD
Dharmini Shah Pandya, MD, FACP
Charles Wagner, MD
Summit Planning Team

Pam Braun, BSN, MSN  
Vice President  
Clinical Improvement

Liz Owens, MS  
Senior Project Manager  
Clinical Improvement

Cassidy Tarullo, MPP  
Project Coordinator
Brief Agenda

• Delaware Valley Patient and Safety Quality Awards
• Advancing Health Equity: Presenting HCIF Programs
• Break
• Keynote Speaker: Dr. Somava Saha
• Regional Speaker: Victor Murray, Camden Coalition
• Networking Reception for In-person Attendees
Why Health Equity?

“Health equity is achieved when every person has the opportunity to attain his or her full health potential and no one is disadvantaged from achieving this potential because of social position or other socially determined circumstances.”
Housekeeping for In-Person and Virtual Attendees

**In-Person Meeting**
- To pose questions during Q&A sessions, please use the stationary mic
- We encourage you to stop by storyboard displays during the break
- We welcome you to join us for a networking reception following closing remarks

**Virtual Meeting Features**
- To submit questions and comments throughout the meeting, please type them into the chat. These will be addressed during the Q&A sessions.
- Safety Award storyboards can be found on online platform
- We will be concluding the virtual conference shortly after closing remarks

**Reminders**
- Meeting is being recorded and all meeting materials, including slides will be circulated out to attendees after the meeting. Please be sure to fill out our evaluation.
Delaware Valley 2022
Patient Safety & Quality Awards

Wendy Nickel, MPH, President
Health Care Improvement Foundation
The Health Care Improvement Foundation is celebrating 20 years of the Delaware Valley Patient Safety and Quality Awards. This annual award program recognizes health care organization initiatives that demonstrate effective collaboration and innovation in advancing patient care.

Key Insights

- **Showcases & Inspires** Innovative Initiatives in Peer Organizations
- **Exposes** Organizations to Regional Best Practices
- **Advances** Health Care Quality, Patient Safety, & Health Equity

By the Numbers

- 600 total entries received
- $100,000+ total awarded
- 150+ total winners recognized
- All participating hospitals represented on judging panel
## Top 10 Winners

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Project Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doylestown Hospital</td>
<td>Solving Communication Gaps by Establishing a Family Advisory Council in Neonatal Intensive Care</td>
</tr>
<tr>
<td>Hospital of the University of Pennsylvania</td>
<td>Reducing Race-Based Disparities in Inpatient Access to Subspecialty Pulmonary Care</td>
</tr>
<tr>
<td>Main Line Health</td>
<td>Addressing Food Insecurity in Our Communities</td>
</tr>
<tr>
<td>Lankenau Medical Center</td>
<td>Early Sepsis Recognition and Improvement in Core Measure Bundle Compliance</td>
</tr>
<tr>
<td>Main Line Health</td>
<td>Inpatient and Ambulatory Care Collaboration to Decrease Readmissions of Patients with Congestive Heart Failure</td>
</tr>
<tr>
<td>Penn Medicine</td>
<td>Addressing Disparities in Colorectal Cancer Screening via Proactive Panel Management in Primary Care</td>
</tr>
</tbody>
</table>
Top 3 Winners

1\(^{st}\) Place
TEMPLE UNIVERSITY HOSPITAL
“Delivering Equitable Care Through a Community Health Worker Driven Multi-Visit Patient (MVP) Program”

2\(^{nd}\) Place
FOX CHASE CANCER CENTER
“Cart Smart - Reimagining the Emergency Code Cart Readiness Process”

3\(^{rd}\) Place
HOSPITAL OF THE UNIVERSITY OF PENNSYLVANIA
“QI Initiative to Address Inequities in Breastfeeding Initiation Rates in the Newborn Nursery: Work in Progress”
Click this link to view recognition videos for the Top 3 winners.
Panel Discussion
Delaware Valley Patient Safety & Quality Award

Moderated by: Pamela Braun, BSN, MSN
Vice President, Clinical Improvement, Health Care Improvement Foundation

Dharmini Shah Pandya, MD, FACP
Chair, Patient Safety Committee, Temple University Health System

James Helstrom, MD, MBA
Chief Medical Officer, Fox Chase Cancer Center

Jennifer Peterman, BSN, RN, IBCLC
Certified Lactation Consultant, Hospital of the University of Pennsylvania
For Questions

Please stop by storyboard displays during the break and networking reception and/or reach out to our panelists via email for questions.

Presenter’s Contact Information

• Dharmini Shah Pandya, Temple University Hospital
  Dharmini.ShahPandya@tuhs.temple.edu

• James Helstrom, Fox Chase Cancer Center
  James.Helstrom@fccc.edu

• Jennifer Peterman, Hospital of the University of Pennsylvania
  Jennifer.Peterman@pennmedicine.upenn.edu
Advancing Health Equity in HCIF Programs

Kelsey Salazar, MPH
Director, Population Health, Health Care Improvement Foundation

April Reilly, MSW
Director, Health Care Improvement Foundation
Collaborative Opportunities to Advance Community Health

OCTOBER 6, 2022

Kelsey Salazar, MPH | Director, Health Care Improvement Foundation
Community Health Needs Assessment + Community Benefit

• The Affordable Care Act (ACA) mandates tax-exempt hospitals to conduct a Community Health Needs Assessment (CHNA) every three years.
• Hospitals and health systems collaborated on a Southeastern Pennsylvania (SEPA) Regional CHNA (rCHNA) in 2019 and 2022.
• Hospitals identify a list of prioritized community health needs that emerge from the assessment.
• By better understanding service needs and gaps in a community, implementation plans can more effectively respond to high priority needs.
How do we **work together as a health care system** to address community health and social needs?

How do we **reach across sectors to develop partnerships** to address these needs?
The Nuts and Bolts

• Sponsored by the Hospital and Healthsystem Association of Pennsylvania
• Facilitated by the Health Care Improvement Foundation
• Founded in 2015
• Two focal implementation areas: Food Security and Trauma-Informed and Healing-Centered Practices
• Participants:
  • 8 health systems in the greater Philadelphia area
  • 18 multi-sector partners from community-based organizations, public health agencies, and insurers

COACH advances shared implementation strategies to address priority community health and social needs.
Supporting community

Food Security Workgroup:

- Implementation of needs identification and resource connection in clinical sites
- Partnership with community-based food access partners
- Shared learning and pilot testing of new strategies
- Shared goal of creating a trauma-informed, healing-centered experience that preserves agency and dignity
Supporting the community within hospital walls

Trauma-Informed and Healing-Centered Practices advance system-specific Action Plans to address:

- Training and awareness-building
- Healing-centered patient care
- Staff resilience and supportive resources
- Leadership and institutional engagement

“We are paying for trauma care already.”

“Just because covid has waned, does not mean the trauma has.”
Creating community, together

“I wonder how many patient’s nightmares I’m in. Sometimes I feel traumatized knowing I'm part of someone else's trauma.”

“We need to be partners in each other's self care practice.”

"I felt heartbroken, a lot.”

"I have often felt powerless in protecting my clients from the oppressive systems."

"I have felt grateful to be there for patients.”
What COACH brings to the table

- “Collaboratory”: testing & shared learning
- Rooted in community care & equity
- Reduce the “research to practice” gap; real-time implementation refinement
- Curate training resources and best practice presentations
- Leverage collaborative for accountability & case-making (“friendly competition”)
- Clinical-community partnership niche
- Build efficiencies into addressing needs of overlapping patient populations
- Relationship-building, community engagement, and inspiration
Thank you!

To learn more about what’s next for COACH, reach out to Kelsey Salazar (ksalazar@hcifonline.org).
Collaborative Background

- Multi-year collaborative funded through the signature HCIF program, Partnership for Patient Care (PPC)
- Topic endorsed by HCIF’s Clinical Advisory Committee
- Regional commitment and pledge to increase the collection and use of race, ethnicity, and language (REaL) and other socio-demographic data
- Officially launched in 2021
Collaborative Design

Aim Statement: To decrease disparities in health outcomes for patients

**WHO?** Advisory Group, HCIF-contributing organizations, and their multidisciplinary teams.

**WHAT?** Race, Ethnicity and Language (REaL) data collection, analysis, and utilization with a focus on centering patient and family voice.

**WHY?** To assess and understand the unique needs of the communities we serve and provide insight into strategies that eliminate disparities in care.

**HOW?** Baseline survey, interactive workshop sessions, recruit expert faculty, disseminate best practices, share resources and tools, pursue measurement and continue exploring partnership opportunities.
Year 1 Accomplishments

- Recruited 12 Advisors with diverse experience from 9 organizations
- Convened the region’s organizations in a formal launch
- Enrolled 8 Hospitals and Health Systems
- Baseline Survey assessment
  - Development, Administration, Analysis
  - Followed by disseminating public infographic aggregate report, and customized reports
- Hosted Webinar and Workshop Programs
Collaborative Priorities

- Alignment with state and national priorities
- Center Patient/Family Engagement
- Measurement/Benchmarking
- Continue to host interactive collaborative programming through webinars and workshops
- Disseminate supportive resources and tools to participants that highlight best practices
- Recruitment of new hospitals and advisors
Thank you to our Advisors!

Jason Aronovitz, DO **Director**, *Population Health Analytics*, Einstein Care Partners, Einstein Healthcare Network

Jaya Aysola, MD, MPH **Executive Director**, and Founder, *Penn Center for Health Equity and Advancement*; Chair of Penn Medicine’s *Health Equity Alliance*, Penn Medicine

Sandra Brooks, MD, MBA **Executive Vice President; Chief Community Health Equity Officer**, Thomas Jefferson University and Jefferson Health

Vic Caraballo, MD **Vice President, Quality Management**, Independence Blue Cross

Rosangely Cruz – Rojas, DrPH **Director**, *Performance Measurement, Improvement, & Analytics*, Main Line Health

Patrick O. Gee, Sr., PhD, JLC **Patient Advisor, Founder & CEHD**, iAdvocate, Inc.

Tara Hayden, MHSA **Vice President**, *Community Health Equity*, Philadelphia Collaborative for Community Health Equity, Jefferson Health

Eve J. Higginbotham SM, MD, ML **Vice Dean**, *Office of Inclusion and Diversity*; Senior Fellow, *Leonard Davis Institute for Health Economics*; Professor of Ophthalmology, *Perelman School of Medicine*, University of Pennsylvania and Penn Medicine

Sumesh John **Business Intelligence Developer**, Redeemer Health

Felice Le-Scherban, PhD, MPH **Assistant Professor**, *Epidemiology and Biostatistics*, Drexel University’s Dornsife School of Public Health

Shonalie Roberts, MHA, ARM **System Director**, *Health Equity*, Main Line Health

Lakisha Sturgis, RN, BSN, MPH, CPHQ **Director**, *Community Care Management*, Temple University Health System
We are taking a 10 minute break and will be back shortly
Somava Saha, MD, MS
Founder & Executive Lead
Well Being In the Nation (WIN) Network
WHAT CAN WE DO TOGETHER THAT WE COULDN’T DO ALONE?

ACHIEVING EQUITY THROUGH COMMUNITY PARTNERSHIP

SOMAVA SAHA, MD MS, FOUNDER AND EXECUTIVE LEAD, WELL-BEING AND EQUITY (WE) IN THE WORLD
A MOMENT THAT REDEFINED SAFETY IN THIS NATION
BRINGING IT HOME TO OUR SAFETY MOVEMENT IN HEALTH CARE
WHY WE NEED TO CHANGE OUR FRAME
CHRONIC PLACE-BASED INEQUITIES ARE NOT ACCIDENTAL – THERE IS A SYSTEM IN PLACE THAT PROPAGATES THEM

“Countering the Production of Health Inequities” Report from the Prevention Institute
A TALE OF TWO BOYS

The Impact of Legacies of Redlining (Chicago)

Risk Factors

Social Vulnerability Index

Risk scores by zip code
As of April 6, 2020

Locations of COVID-19 fatalities represented by green dots

-2.128570 - 0.728220
-0.728219 - 0.465970
-0.465969 - 0.385980
0.385981 - 1.015180
1.015181 - 1.871470

Social vulnerability index by zip code
As of April 6, 2020

-2.06303 - 0.83905
-0.83905 - 0.24714
-0.24714 - 0.37961
0.37961 - 0.96703
0.96703 - 2.45875

One of the reasons for such racial disparities is due to the fact that African American communities are disproportionately affected by multiple chronic diseases before the COVID-19 pandemic. Here, I created a risk factor score for the 77 Chicago Community Areas. The risk factor score includes the rates of heart-related death, stroke deaths, asthma, hypertension, diabetes, obesity and smoking. I utilized data from the Chicago Health Atlas.

Source: Chicago Health Atlas
Photo courtesy of Kaique Rocha. Metaphor courtesy of Natalie Burke.
WHAT CAN QUALITY AND SAFETY LEADERS DO?
HOW CAN WE TACKLE SYSTEMIC CHANGE IN PARTNERSHIP WITH COMMUNITIES?

1. Get ready: Deepen your literacy about equity and racial justice—both the problem and the solutions – become a helpful contributor to the solution.

2. Think about your own practices in quality and safety—and ask who they are leaving behind or where they may be creating harm.

3. Partner with people and communities experiencing inequities to prevent harm to address underlying social determinants and root causes of health inequities.
1. BUILD YOUR LITERACY ABOUT EQUITY AND RACIAL JUSTICE

Appendix #4: Structural violence and Black and/or African American community

This graphic was created by staff members at the AMA Center for Health Equity.
Root causes: “The –Isms” underlying culture, legacies, policies and systems (e.g., racism, sexism, classism, and the way they shape the configuration of communities)

Trunk and branches: Social Determinants
Configuration of determinants of health and well-being in communities

Leaves: Health and Social Outcomes
Individual health behaviors and illness, social needs

High levels of adverse childhood events, despair, asthma, diabetes, COVID
Lack of jobs, grocery store, high levels of stress, air pollution
Racism - Redlining and residential segregation
PATHWAYS TO POPULATION HEALTH EQUITY

• Developed with public health change agents and communities across the country at the request of the Centers for Disease Control and Prevention

• Adapts an existing framework for health equity that has already resonated with other sectors in health care, faith, and business, as well as with community residents to be used in public health

• Practical tools to take action, regardless of where you are on your population health and equity journey

• Connects you with the best available tools and strategies to take action

• Aligned with other tools and processes in public health – eg, PHAB standards
HOW CAN WE TACKLE SYSTEMIC CHANGE IN PARTNERSHIP WITH COMMUNITIES?

1. Get ready: Deepen your literacy about equity and racial justice—both the problem and the solutions – become a helpful contributor to the solution.

2. Think about your own practices in quality and safety—and ask who they are leaving behind or where they may be creating harm.

3. Partner with people and communities experiencing inequities to prevent harm to address underlying social determinants and root causes of health inequities.
2. THINK ABOUT YOUR OWN PRACTICES IN QUALITY AND SAFETY

1. Are you disaggregating based on race and ethnicity, place, etc and flipping the Pareto principle on its head to focus on those with the greatest risk of equity gaps—not just building supports for the 80%?

2. Are you building in additional supports for those who experience inequities to engage in new initiatives?

3. Are you measuring and improving what matters to patients and communities?
FLIPPING THE PARETO PRINCIPLE ON ITS HEAD

- Highest risk (5%)
- Medium/rising risk (20-40%)
- Everyone

Always disaggregate data based on common inequities in your area (e.g., race, place, language, etc).
THE NEW REDLINING – COVID CASES, PAYCHECK PROTECTION PROGRAM LOANS, AND VACCINATIONS IN CHICAGO
• The Well-Being In the Nation (WIN) Measurement Framework offers a set of common measures to assess and improve population and community health that was developed with contributors from each sector, federal agencies, and with communities across the country.

• The framework was developed by the National Committee on Vital and Health Statistics; measure development was facilitated by 100 Million Healthier Lives, with input from 100+ people and organizations.

• The National Quality Forum served on the Stewardship Group and NQF criteria was used in evaluating measures.
WIN Member recommended by NCQA and National Academies: Cantril’s ladder: People

Life evaluation

- % people thriving
- % people struggling
- % people suffering

Overall life eval index:
% thriving - % suffering

- Two simple questions
- Administered 2.7 million times, highly validated
- Relates to morbidity, mortality, cost
- Useful for risk stratification
- Works across sectors
- Recommended by OECD
- Recommended by National Academies as a Leading indicator for Healthy People 2030

www.winmeasures.org
New measures recommended by NCQA to CMS/Medicaid

Discrimination in Medical Settings33–3

Asks respondents to indicate whether the following events have happened to them in medical settings:

• Treated with less courtesy or respect than other people.
• Received poorer service than others.
• A doctor or nurse acts as if they think you are not smart, as if they are afraid of you, as if they are better than you or that they are not listening to what you were saying.

A follow-up question asks respondent to identify what they think is the main reason for these experiences. Response options include: Ancestry or National Origins, Gender, Race, Age, Religion, Height, Weight, Some other Aspect of Physical Appearance, Sexual Orientation, Education or Income Level.
Leading Indicators

- Demographics
- Community Vitality
- Economy
- Education
- Environment and Infrastructure
- Food and Agriculture
- Health
- Housing
- Equity
- Public Safety
- Transportation
- Well-being of People
Strong correlation between WIN measures and National Academies of Science, Engineering and Medicine recommendations for Leading Health Indicators of Healthy People 2030.
HOW CAN QUALITY AND SAFETY SPECIALISTS ADVANCE EQUITY AND RACIAL JUSTICE?

1. Get ready: Deepen your literacy about equity and racial justice
2. Think about your own practices in quality and safety—and ask who they are leaving behind or where they may be creating harm.
3. Partner with people and communities experiencing inequities to prevent harm to address underlying social determinants and root causes of health inequities.
3. CO-DESIGN WITH PATIENTS AND FAMILIES
The Continuum of Community Engagement

- Asking communities what they need or what they think of your solution
- Partnering with community members and organizations to co-design change
- Powering the vision and change ideas of community residents who experience historic racial and economic injustice

Community power and equity
“We asked ourselves, ‘Why keep perfecting the hospital if the key issues driving health equity are outside of it?’ Families and community leaders focused our attention on equity, racism and child well-being—they served as catalysts for more explicit antiracism work. Now we were talking about upstream drivers—social determinants of health, how we do what we do, and how we show up in the community. These intentional discussions led to explicit integration of equity and antiracism into measurement, our family and community-focused approach, and improving future child outcomes.”

- Uma Kotagal, Senior Fellow, Cincinnati Children’s Hospital Medical Center
It launched the All Children Thrive (ACT) collaborative in partnership with over 100 community groups and residents in 2015.

Created a community-based Capability University to assess what worked and what didn’t. CC utilized its renowned expertise in improvement science and capability development to help ACT train community residents and nonprofit leaders to use quality improvement methods to improve processes and outcomes. Additionally, CC provided administrative support and accompaniment to the community teams.

ACT set out to track and improve four primary outcomes -- infant mortality rate, third grade reading level, a Thrive at Five measure, and inpatient bed days.
**QI ENABLING WHAT COMMUNITIES CAN DO**

- Partnered with the Cincinnati Public Schools (CPS) to improve the third-grade reading level by 10% every year.
  
  - Over three years, the percent of third-grade students reading proficiently increased from about 40% to more than 70%. Results also indicate that equity gaps closed in schools where principals used quality improvement methods to improve student outcomes. \[3\]

- Health measures also improved.
  
  - The inpatient bed-day rate for the two target neighborhoods in Avondale and Price Hill, where 90% of the children were on Medicaid, decreased by 18% from baseline (July 2012-June 2015) to the improvement phase (July 2015-June 2018).

  - Hospitalizations decreased by 20%. \[4\]
CASE STUDY: USING THIS APPROACH TO RISK STRATIFICATION TO IMPROVE HEALTH EQUITY IN THE CONTEXT OF THE PANDEMIC IN DELAWARE

- Highest risk (5%) – 48,550 - SMI, homeless, incarcerated
- Medium/rising risk – 200,000-400,000 - people destabilized from supports, grief
- Everyone – 971,000
• One of only three states where overdose rates didn’t increase in 2020 (23% increase on average across nation)
• Reduced incarcerations (diversion)
• Reduced homelessness among the most vulnerable
• Data systems across sectors
• Improved access for everyone leveraging telehealth and online supports (Support Wall)
“The secret of quality is love.” Avedis Donabedian, Father of Quality Measurement

“Power without love is reckless and abusive, and love without power is sentimental and anemic. Power at its best is love implementing the demands of justice, and justice at its best is power correcting everything that stands against love.” Martin Luther King Jr
FOR MORE INFORMATION

Pathways to Population Health (health care) --
https://www.ihi.org/Topics/Population-Health/Pages/Pathways-to-Population-Health.aspx

Pathways to Population Health Equity (public health) –
www.publichealthequity.org

Well-being and Equity (WE) in the World - www.weintheworld.org

Well Being In the Nation Network – www.winnetwork.org

Well Being In the Nation Measures – www.winmeasures.org

Somava Saha – somava.saha@weintheworld.org
Victor Murray, MSW
Senior Director of Community Engagement & Capacity Building
Camden Coalition
Thank you for attending
the
Partnership for Patient Care
2022 Leadership Summit!