Disparities (assuring health equity)

- **HQ Pathway 5:** Resident/fellow and faculty member education on reducing healthcare disparities
  - Education on the organization’s priorities and goals for addressing disparities in it's populations
  - Training in cultural competencies
  - Describe priorities and progress to date

- **HQ Pathway 6:** Resident/fellow engagement in clinical site initiatives to address health care disparities
  - Involve residents in projects to reduce disparities
Current state and bright spots

- Program, project, faculty specific
- Existing “partnerships”
- Triple Aim
- Population Health
- Focus for today:
  - Framework
  - Example – IHI’s Joint Replacement Community
  - Discussion- Actions

What is health care equity?

- “Health Inequity: A difference or disparity in health outcomes that is systematic, avoidable, and unjust.” – CDC
- Lower quality of care not justified by differential access, health status, or preferences of groups.
  - Racial and ethnic minorities
  - Women, children, elderly
  - People with disabilities
  - Rural residents
  - Low SES
  - Sexual orientation
  - Gender identity

Frameworks for equity

- Detection of disparities, understanding causes and mechanisms, develop, test & evaluate interventions
- Data driven:
  - Collect R/E/L data
  - Analyze performance by R/E/L data
  - With patients, identify & evaluate QI interventions targeted to specific populations
- Roadmap to reduce disparities:
  1. Link quality and equity
  2. Create a culture of equity
  3. Diagnose the disparity
  4. Design the activity
  5. Secure buy-in
  6. Implement change


Joint Replacement & Health Equity

- Health equity definitions and frameworks
- Joint replacement and health equity: the state of the evidence

“The lack of a reduction in disparities in either usage or outcomes [for TJR] over an 18-year period is sobering.”
- Jasvinder A Singh & colleagues

Joint Replacement & Equity

Detection
- 1991: TKA 36% lower for Blacks; 30-day readmission X% lower/higher
- 2008: TKA 40% lower for Blacks; 30-day readmission Y% lower/higher

Joint Replacement & Equity

Causes
- **Patient level**: differing patient preferences, KAB about outcomes and benefits, physician trust issues, less likely to have friends/family who have undergone, less likely to have heard of TKR; disease severity
- **Interpersonal level**: provider relationship building and communication
- **System level**: blacks less likely to be treated in high volume centers/providers, and treated more often in facilities where adverse outcomes more common; less likely to be referred for TJR, care processes
- **Community level**: lack of social support for Blacks (SDOH)


Actions– Table Discussion

- Inventory of current activities
- Linking with clinical site – population, priorities, data

**Table Discussion**:
- How are you educating residents/fellows on disparities?
- How are residents/fellows participating in activities to reduce disparities?
Healthcare Quality

Quality and Safety in a Clinical Learning Environment

Katharine Luther, RN, MPM, IHI
Andrew R. Buchert, MD, UPMC

Education on Quality Improvement
• Resident /fellow engagement
• Receive and use data
• Engaged in planning

Education on reducing disparities
• Engagement in activities to reduce disparities
ACGME- Logic Model

Source: IHI R & D 90-day cycle. Approaches to Training Faculty at Academic Medical Centers to Ensure That Clinical Trainees Become Effective Improvers August-October 2011

Outputs

<table>
<thead>
<tr>
<th>Vital Behaviors</th>
<th>Specific Example Activities</th>
<th>Audiences</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capacity Building Programs</td>
<td>Quality Academy, faculty training programs</td>
<td>Faculty, staff, trainees</td>
</tr>
<tr>
<td>Championing</td>
<td>Chiefs participate in Q&amp;S activities</td>
<td>Chiefs, chairs</td>
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<td></td>
<td>Faculty Promotions Pathway; Resident award</td>
<td>Faculty, Residents</td>
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<td>Routine experiential activity</td>
<td>Resident Q&amp;S daily walk rounds</td>
<td>Residents, faculty</td>
</tr>
<tr>
<td>Participation in institutional Q&amp;S activities</td>
<td>Residents on safety committees</td>
<td>Residents, faculty</td>
</tr>
</tbody>
</table>

Source: IHI R & D 90-day cycle. Approaches to Training Faculty at Academic Medical Centers to Ensure That Clinical Trainees Become Effective Improvers August-October 2011
Andrew R. Buchert, MD
Co-Chair, Patient Safety and Quality Improvement
UPMC Medical Education

Medical Director, Education Outreach and Clinical Resource Management
Children’s Hospital of Pittsburgh of UPMC

Assistant Professor of Pediatrics
University of Pittsburgh School of Medicine

UPMC Medical Education

~1800 residents and fellows
120 ACGME-accredited programs

10 teaching hospitals
  Tertiary care
  Community
  Women’s
  Children’s
  Psychiatric

More than 62,000 employees
Our patient safety and quality improvement mission

- Engagement and active involvement of trainees in patient safety and quality improvement at all levels
- Increased safety event and error reporting by trainees
- Integration of trainees into hospital and institutional/system-wide safety and quality structures

Strategy

Building relationships…

Breaking down silos
Strategy – Setting the wheels in motion

PSQI Committee – Multidisciplinary Representation

Resident/fellow representation at PSQI:
- Internal Medicine
- Pediatrics
- OB/Gyn
- Radiology
- General Surgery
- Urology
- Emergency Medicine
- Neurosurgery
- Orthopaedic Surgery
- PM&R

Faculty representation at PSQI:
- Internal Medicine
- Emergency Medicine
- Radiology
- PM&R
- Family Medicine
- Pediatrics
- OB/Gyn
- General Surgery
- Anesthesia
- ENT
Resident and Fellow Culture of Safety Survey

- 71% Response Rate
- 1,456 Trainees Surveyed
- 1,027 Total Respondents

- 76 Programs
  - 73 Primarily Inpatient
  - 3 Primarily Outpatient

Respondent PGY Level

- % PGY6: 13%
- % PGY5: 14%
- % PGY4: 14%
- % PGY3: 19%
- % PGY2: 20%
- % PGY1: 22%

Resident vs. Fellow

- 72% Residents
- 28% Fellows

All Facilities by Domain

- Teamwork Within Units
- Organizational Learning
- Management of Patient Safety
- Overall Perceptions of Patient Safety
- Feedback and Communication about Errors
- Frequency of Events Reported
- Communication Openness
- Teamwork Across Units
- Handoffs & Transitions
- Nonpunitive Response to Error
Providing Data Helps Open Doors

• By presenting data to leadership, many began to recognize a missed opportunity.
  
  – All hospitals engage in quality improvement.
  – We don’t label QI work well. Residents and fellows do not recognize the ways that hospitals are working to make things better.
  – Residents and fellows miss the opportunity to make QI an integral part of their training and their careers.

• Based on results many committees now have resident and fellow participation:
  

Program Report Card Example
Trainee Report Cards – Ask trainees what these results mean

Trainee Patient Safety Leadership Committee
Trainee Patient Safety Leadership Committee

• Peer selected trainees

• Hospital President, VP Medical Affairs, Risk Management, Infection Control, Pharmacy and Therapeutics, Patient Relations, Information Technology, Nursing Administration, Patient Safety Officer.

• Trainees set the agenda

• Opportunity for hospital leadership to capitalize on fresh ideas and perspectives from the front line.

• Opportunity for residents to shape practice.

• Residents disseminate practice changes to their colleagues. Work with residency programs to disseminate solutions.

Our multifaceted approach at Children’s Hospital

• Didactics to provide the foundation
  – Orientation
  – Intern Boot Camp
  – Noon Conference
  – Leadership Workshop for rising PGY-2s

• Innovative Morning Report Sessions
  – Intern To Err is Human
  – Senior Safety Rounds

• Integration of PSQI into daily activities, “setting the tone”
  – Chief Resident for Patient Safety and QI
  – Start morning sign-in and rounds with patient safety
Our multifaceted approach - continued

• Involvement in institutionally-supported QI work
  – Hand hygiene
  – Pediatric Septic Shock Collaborative
  – Solutions for Patient Safety
  – Joint projects with industrial engineering students
    • Family-centered rounds, Handoffs, ED physician work-flow
  – Joint projects with health care policy and management graduate students

• Opportunities to present QI work
  – Health Care Quality Week, Patient Safety Week
  – Annual Three Rivers Conference
  – UPMC Annual GME Leadership Conference

• Dedicated PSQI time during the PGY-2 year

Our Challenges:

• Engaging the institution/hospital(s), as well as programs, faculty, and residents/fellows is key
  – Hospitals are reaching out to include residents and fellows in safety and QI work
  – Trainees value this exposure
  – Trainees are ambassadors/liaisons

• CHALLENGE: TIME
  – Meaningful QI work is longitudinal
  – Program and faculty support for small chunks of time over a longer time period, i.e. not just an elective month
  – Keeping the energy going when results are not quick, process gets worse before it gets better

• CHALLENGE: FACULTY ENGAGEMENT
  – Hospital leaders and program directors are champions.
  – Reaching and engaging core faculty
  – Disruptive factors: Traditional thinking, negative role-modeling, disparate day-to-day messages from faculty
World Café -- Challenges

How are you engaging faculty in this work?
- Hospital leaders and program directors are champions.
- Reaching and engaging core faculty
- Disruptive factors: Traditional thinking, negative role-modeling, disparate day-to-day messages from faculty

How are you designing resident-driven projects?
- Meaningful QI work is longitudinal
- Program and faculty support for small chunks of time over a longer time period, i.e. not just an elective month
- Keeping the energy going when results are not quick, process gets worse before it gets better