

First Do No Harm

Quality and Patient Safety Division, Massachusetts Board of Registration in Medicine

Message from QPSD Leadership

Julian N. Robinson, MD
Chairperson, QPS Committee

Daniela Brown, MSN, RN, CIC
Director, QPS Division

Dear Colleagues,

As we navigate through a second surge of the pandemic, the disproportionate impact being experienced by minorities and people of color continues to be evident. Long-standing health and social inequities have put racial, ethnic, and LGBTQ minority groups at higher risk of serious illness and death related to Covid 19. In order to combat these inequities, barriers such as lack of access to care, poverty, food insecurity, and discrimination must be identified and acted upon.

The Quality and Patient Safety Division (QPSD) has asked several of the hospitals that report to us to share some of the programs that they have implemented to address the inequities in healthcare. Many organizations are attempting to close that gap by addressing the social, physical and economic conditions that impact health. We encourage all hospitals and ambulatory clinics to continue to share their efforts with us through their reporting. QPS Committee member, Dr. Ziad Alfarah also shares his thoughts on the changes that we individually can make in the fight against racism.

The QPSD is mindful of the ongoing toll the pandemic has taken on hospitals and ambulatory clinics in the Commonwealth. In 2020, we attempted to reduce the burden related to reporting by excusing the spring annual and semi-annual reports and making the fall semi-annual report and select SQRs optional. In 2021, we have made additional amendments to reporting including an extension for the spring 2021 annual and semi-annual reports as well as an option to submit modified reports in lieu of the standard annual and semi-annual reports. Details regarding these changes were emailed to PCA Coordinators in December and may also be found on page seven of this newsletter.

We would also like to announce additional changes to our division. In 2020, the Board's Quality and Patient Safety Committee was fortunate to welcome Dr. Yvonne Cheung from Mount Auburn Hospital and Dr. Leslie Selbovitz from Milford Regional Medical Center. We were also fortunate to add Dorothy Doweiko, MHA, BSN, RN to the QPSD. We are now pleased to announce the addition of another member of QPSD, Trinh Ly-Lucas, MSN, AGNP-BC. We are delighted to welcome Trinh as a valued member of our team.

There is no doubt that 2020 has challenged us in ways that we have never experienced before. The new year also presents challenges, but with the introduction of the new Covid 19 vaccine and with the knowledge of disease management and treatment options that were discovered during the first surge, the new year brings hope. We look forward to continuing to work with you and to a time when we can gather together again.

Best,

Julian N. Robinson, MD and Daniela Brown, RN

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Ziad Alfarah, MD

Associate CMO, Perfect Health Inc.
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Member, BORIM, Quality & Patient Safety
Committee

During the early stages of the state reopening this past June, one of my ambulatory patients presented for a routine exam. He was Hispanic, worked in the hospitality industry and was diagnosed with hypertension and hyperlipidemia. I soon came to find that, due to the Covid-19 pandemic, he had lost his job and health insurance. His diet and access to medications were now irregular. As I began to counsel him on the importance of a low salt diet, lifestyle changes, and adhering to his medication regimen, I felt the hollowness and futility of my words.

“Why treat people and send them back to the conditions that made them sick?” wondered Michael Marmot, the president of the World Medical Association in the first page of his book, *The Health Gap*. Health disparities, or inequities, are preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by socially disadvantaged populations.¹ Poverty, ethnicity, race, educational inequities, and environmental threats, are among the major social determinants leading to such disparities in health outcomes. While the social determinants of health are global themes, race has become a rough proxy for socioeconomic status in the United States given four centuries of slavery, racism and structural discrimination. Race has a profound influence on the daily lived experiences of African Americans.² The correlation between obesity and food insecurity,³ the link between a woman's level of education and infant mortality,⁴ and the disproportionate impact of the COVID-19 pandemic on Black Americans and other people of color are painfully striking examples.⁵

As providers, we encounter these inequities every day. They can be frustrating and impact our ability to do our jobs well. We often respond by calling the patient “non-compliant” or irresponsible. But we fail to ask: What choices are really available to them? And what are the social circumstances within which those choices are made? Inequities violate egalitarian roots as healthcare providers. They

leave us helpless, searching for ways to try and “get it right.” In this day and age, with healthcare cost skyrocketing, inequities are not only immoral; they are also expensive, and we are all paying the cost.

While addressing health inequities will require collective action, government intervention, and policy change, each of us can still play a role. We all witnessed a level of unprecedented activism among healthcare professionals after the brutal killing of George Floyd at the hands of the police. The mass protests on the streets were met with silent kneeling and vigils in many healthcare organizations. I am also encouraged by the actions taken in healthcare centers, large and small, all across the country to make fighting racism a healthcare issue.⁶

As new reimbursement models emerge, we must continue to push for reinvestment in our disadvantaged communities and removing social barriers to care. Empowering our patients to make healthy choices and live a healthy, dignified life should be incorporated in our everyday interactions with them. Isn't this, after all, the ultimate meaning of our roles as providers?

References

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- ²Jones C.P. Levels of Racism: A Theoretic Framework and a Gardener's Tale. *American Journal of Public Health*. August 2000; 90(8):1212-1215
- ³Morales ME, Berkowitz SA. The Relationship between Food Insecurity, Dietary Patterns, and Obesity. *Curr Nutr Rep*. 2016; 5(1):54-60
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- ⁵CDC. Health Equity Considerations and Racial and Ethnic Minority Groups. <https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html> July 24, 2020. Accessed September 21, 2020
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Cambridge Health Alliance Managing COVID in the Community: CHA Advances Health Equity

Maren K. Batalden, MD, MPH, Chief Quality Officer,
Jessamyn Blau, MD, Regional Medical Director

As COVID swept through Massachusetts in the spring, the Cambridge Health Alliance (CHA), a community-based academic safety net health system based in metro northeast Boston, was at the front line of the equity challenges exposed by the pandemic. CHA serves a panel of 140,000 patients -- the majority are publicly insured, including a large and diverse immigrant community; over 40% of our primary care panel speak a primary language other than English, and approximately two thirds identify themselves as belonging to a racial group other than white. Our patient population and the geographic communities we serve in Chelsea, Everett, and Revere were hit disproportionately hard by the COVID pandemic in the spring, obligating us early to nearly triple critical care capacity in our two small hospitals. Simultaneously under Governor Baker's order in the spring, we closed our ambulatory clinics and transitioned almost overnight to a telemedicine model of medical and behavioral health care. We stood up a portfolio of new ambulatory services to meet COVID-related demands: testing tents, a COVID-specific call center, a dedicated respiratory clinic, and COVID case management program. Approximately 75 staff were redeployed from other parts of the health system to staff these dedicated outpatient COVID services; teams tested up to 600 patients daily, triaged up to 900 calls, and provided in-person care for up to 100 patients with respiratory symptoms. Over several months, the team has provided case management services for a panel of more than 2,500 high risk COVID positive patients.

At the heart of our ambulatory COVID program is a commitment to rapidly evolving protocols in response to emerging clinical evidence, and an ever-deepening understanding of patient need. Using a population health mindset last spring, we identified individuals at high risk for COVID complications because of age, medical comorbidities, and sociodemographic variables including living conditions and access to transportation. Ever refining our understanding of "high risk," we began proactive outreach to these

patients to provide targeted education about preventing COVID and support for medication refills, scheduling tele-visits and helping people navigate disparate access to technology necessary for tele-visits. As some communities expressed concerns about hospitalization and treatment in the face of this novel disease, CHA staff and providers engaged with local community organizations and churches, including multilingual social media platforms, to provide information and education, and to learn about what we could do to help. When it became clear that we had a crisis of rising rates of infection in our facility-based geriatrics practices, we helped our nursing home colleagues develop protocols for testing and cohorting residents. Recognizing the special vulnerability facing people who are unhoused, we worked with the city of Cambridge to staff a dedicated temporary shelter in a neighborhood gymnasium to facilitate quarantine and isolation. When patients expressed concerns about getting enough to eat, we paved referral pathways to five local food pantries. Now, when members of the CHA team call patients with COVID test results, asking about food insecurity is part of the script; in the last several months, we have connected more than 3,500 people with groceries. Responding to the parallel pandemic of behavioral health needs, we have - among other things - expanded virtual mindfulness programming, offering scholarships for people of color.

Building on a strong patient-centered primary care orientation and deep pre-existing partnerships, CHA rose to the challenge of the COVID pandemic in service to our stated institutional mission to "improve the health of our communities." In a pandemic that has shone a bright light on health disparities, we have pursued a commitment to equity by keeping the needs of the most vulnerable in the center of our strategy.

For more information on CHA's efforts to advance health equity, please contact Maren K. Batalden, MD, MPH, Chief Quality Officer, at mbatalden@challiance.org or Jessamyn Blau, MD, Regional Medical Director, at jblau@challiance.org

Massachusetts General Hospital MGH Mobile Response Program for COVID-19

Avital DeSharone, MA, PMP

Stephen Dorner, MD, MPH, MSc

COVID-19 brought health equity to the forefront with unprecedented momentum this spring. During this time, MGH served many communities disproportionately impacted by COVID, including Boston, Chelsea, Revere, and Lynn. Many of these communities have higher populations of non-English speaking and racial or ethnic minority patients. With telemedicine emerging as the primary alternative mode of care in the early months of the pandemic, access to technology or internet further exacerbated existing disparities for already vulnerable groups in these communities.

In seeking to address the hospital's inpatient capacity constraints and avoid overcrowding in the Emergency Department, the Mobile Response Program (MRP) for COVID-19 launched in April. The MRP offered an alternative to patients that may have otherwise sought care in the Emergency Department for symptoms of COVID-19. Instead, patients received a visit at home from a specially trained paramedic who took vital signs and performed an evaluation with medical direction from a physician or advanced practice provider (NP/PA) participating in the visit by video. For non-English speaking patients, an interpreter joined the visit by telephone or video. Patients were assessed for clinical stability to remain at home to continue to self-isolate or come into the hospital to be seen in the Emergency Department and potentially be admitted.

Between April 16 and June 23, 2020, the program received 185 referrals, and performed 107 evaluations. Among patients evaluated, 43% spoke a primary language other than English, and 54% identified as non-white. Overall, 99 (92%) of patients evaluated could continue in-home isolation. There were no emergent transports to the Emergency Department.

By bringing care to patients' homes during this period, potential Emergency Department visits were avoided. At this time, we are unable to define the exact number of MRP visits that would have otherwise become an Emergency Department visit.

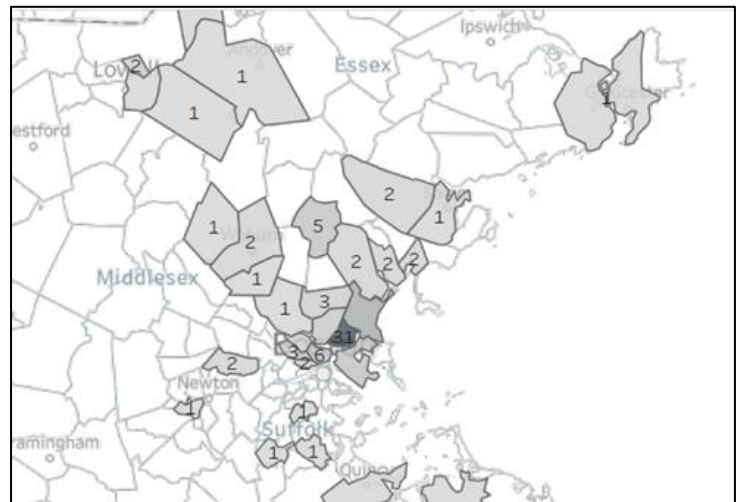
However, as a patient-centered model especially for vulnerable populations, this program served purposes beyond hospital capacity and Emergency Department avoidance.

With additional COVID surge planning underway, the MRP remains in place and will continue to support patients in the communities surrounding MGH, to improve access to care with special and ongoing attention towards maintaining equity among vulnerable populations.

Please contact Avital DeSharone, at avital.desharone@mgh.harvard.edu for additional information.

¹<https://pubmed.ncbi.nlm.nih.gov/32866264/>

Map of MIH Evaluations



McLean Hospital Equity and Health Care- Efforts to Close the Gap

Gail Tsimprea, Ph.D., RNPC
Chief Quality and Risk Management Officer

One of the important issues being considered today is equality in the setting of health care. In an effort to close the gap between the two, McLean Hospital has initiated the following two programs. These efforts are aligned with broader Health Equity efforts across MassGeneral Brigham.

PROGRAM 1-Anti-Racism, Justice, and Health Equity

McLean Hospital is committed to addressing racial injustice and inequity within its walls and more broadly across greater Boston and national communities. With these goals in mind, McLean appointed Stephanie Pinder-Amaker, PhD, as its first Chief Diversity, Equity, and Inclusion officer (CDEIO) in August 2020. "My overarching vision for advancing diversity, equity, and inclusion at McLean is really straightforward," said Pinder-Amaker upon accepting this new role. "I envision a McLean in which employees across all of our mission elements—across clinical, research, and training, wherever you sit within our organization—that you see yourself within these efforts and have a growing understanding of what your contributions can be."

Among her first milestones as CDEIO, Pinder-Amaker lead McLean's Anti-Racist, Justice, and Health Equity Oversight Committee to create McLean Hospital's Anti-Racist, Justice, and Health Equity Action Plan.

The plan includes a call to action to address long standing systemic and structural racism, injustice, and health inequities. These are a sample of the questions to be addressed:

- How do we continually improve our understanding of the need?
- How do we meet the need?
- What are the barriers?
- How do we change our culture from within to ensure that all members of our community feel seen, valued, respected, empowered, engaged, and included?
- How do we ensure that anti-racism and racial equity remain at the forefront of everything we do going forward?

- How do we integrate standards and practices for accountability system-wide?
- What strategies do we employ to establish a workforce reflective of the patient population we seek to serve?
- How do we improve clinical outcomes, reduce disparities, and promote equity in the care we provide?

The Advance the "Walls to Halls" project is an initiative aimed at diversifying the portraits of leaders that adorn the hospital halls and meeting rooms. This work includes gaining a more accurate and deeper understanding of the systemic racism and inequities experienced by Black, Indigenous, and people of color within the McLean community.

This fall, Pinder-Amaker and members of her team launched "The Anti-Racist, Justice, and Health Equity Listening Tour." The primary goal of the tour is to create space for members of our community to share—with a designated and trained senior McLean leader—their lived and observed experiences with racism and/or marginalization related to race or ethnicity at McLean.

In addition, as part of our organization's continued effort to educate and encourage open dialogue, the hospital assembled a library of Anti-Racist Education Resources. This curated list of educational resources is part of McLean Hospital's Anti-Racist, Justice, and Health Equity Action Plan. Members of our community can use these resources for self-education and support and to begin conversations with peers and within teams throughout the hospital.

PROGRAM 2-PRIDE

Building on McLean's core values, which include embracing diversity and promoting teamwork, the newly created Pride at McLean LGBTQ & Allies Employee Resource Group (ERG) provides McLean employees with forums for discussion, learning, mentoring, networking, and support. The Pride employee resource group is a vital partner with leadership to strengthen McLean as a welcoming and inclusive environment for employees who are LGBTQ and allies.

The Pride at McLean ERG ensures that the hospital is a workplace that is respectful, safe, and supportive of LGBTQ employees and allies and collaborates

with McLean Human Resources and the Partners Employee Assistance Program to provide educational programming focused on LGBTQ-specific needs and concerns, such as guidance on personal legal documents, taxes, name changes, and adoptions.

For the fourth consecutive year, McLean Hospital celebrated Pride Month. Throughout June, the McLean LGBTQ and Allies Employee Resource Group, also known as "Pride at McLean" or "Pride ERG," hosted and sponsored a wide variety of cultural, social, and educational events designed to celebrate and support McLean's LGBTQ staff, patients, and family members. McLean being involved in Pride month sends the message that employees are welcome to bring their whole selves to work. Diversity is one of McLean's core values. McLean Hospital's Grand Rounds have hosted lectures for the McLean community such as a presentation entitled: "Best Practices in Mental Health for Transgender and Gender Non-Conforming Patients;" and a presentation for McLean's Visiting Scholars Series entitled: "Transgender Youth and Families in Transition: Research Findings and Clinical Implications", A McLean physician, (who was also the PI of the following initiative) along with physicians from Boston Children's Hospital, MGH, Fenway, and Harvard University, received an award from the Harvard Mind, Brain and Behavior Interfaculty Initiative, entitled: Transgender and Gender Diverse (TGD) Youth Faculty Interest Group. This award will fund an initiative to unite faculty across Harvard University and to foster cross-disciplinary perspectives for understanding, treating and preventing mental health disparities associated with gender minority stress, which is associated with greater risk for adverse mental health and higher prevalence of suicidality and substance misuse.

In addition, a McLean researcher has analyzed data from McLean Hospital's Child and Adolescent Psychiatry Program, to assess mental health in transgender and gender diverse (TGD) patients enrolled in short-term treatment. Findings confirm significant mental health disparities in TGD youth compared to cisgender peers, including higher rates of suicidality and self-injurious behavior, as well as more severe depressive and anxiety symptoms. Importantly, both groups showed significant improvements in mental health following acute residential treatment. These data are in preparation for submission to a peer-reviewed journal.

To end, this is a quote from Maya Angelou: "We all should know that diversity makes for a rich tapestry, and we must understand that all the threads of the tapestry are equal in value no matter what their color."

For additional information, please contact Gail Tsimprea, Ph.D., RNPC at GTSIMPREA@PARTNERS.ORG

Tufts Medical Center Initiatives Aimed to Reduce Racial, Ethnic and LGBTQ Disparities

Beth Jackson, MS

Senior Risk Manager and PCA Coordinator

According to Wellforce President and CEO, Michael Dandorff, "the Wellforce Health System is influencing the future of health care and finding solutions to some of the toughest challenges faced by consumers and care teams. The goals we have for our system and our communities can only be achieved by creating a culture built on compassion, diversity, equity and inclusion". Over the past year, Tufts Medical Center, which is part of Wellforce, has made progress towards a culture that values diversity, equity and inclusion. Some of the actions taken include:

- The CEO of Tufts Medical Center signed the CEO Action for Diversity & Inclusion pledge which placed Tufts as one of the 1,200 organizations that are committed to advancing diversity and inclusion in the workplace.
- Participating in a system-wide Day of Understanding Learning Event with Dr. Camara Jones, a nationally recognized speaker on race, racism and healthcare disparities.
- Participating in town halls to support open dialogue for difficult conversations and allowing leaders to understand environmental issues we must address.
- Participating in a presentation with Julia Kajen, PT, DPT focusing on what providers should know about transgender health and non-surgical gender-affirming care.
- After a national search, hiring our first VP and Chief Diversity, Equity and Inclusion Officer, Rosa Colon-Kolacko.
- Organizing education and training sessions held in the Fall of 2020 for board members, executives, leaders, employees and physicians as we partner with Cook Ross, a global, Certified-Black Women-Owned consulting and training firm with 30

years of experience and a deep expertise in the role of unconscious bias and conscious inclusion in the workplace.

- Formed a Diversity and Inclusion Council which focused on ways to strengthen our welcoming of the LGBTQ patient, their families and colleagues. Some examples include providing LGBTQ specific clinical services, offering gender neutral restrooms in public areas, offering inclusive bereavement leave in the event of the death of an employee's partner or their immediate family, developing gender transition guidelines documenting supportive policies and practices on issues pertinent to a workplace gender transition and updating our Press Ganey employee engagement survey to allow employees to identify as LGBTQ and capture questions on LGBTQ concerns.

Please contact Beth Jackson, MS at bjackson4@tuftsmedicalcenter.org for additional information.

Update: Reporting to the QPS Division

The Board of Registration in Medicine would like to provide additional information regarding reporting to the Quality and Patient Safety (QPS) Division.

- The Annual and Semi-Annual Report submission due dates have been extended by one month. Healthcare facilities may also request an additional extension for Annual and Semi-Annual Reports by emailing Mali Gunaratne, Administrative Assistant, at mali.gunaratne@mass.gov after March 1, 2021.
- Healthcare facilities may also opt to submit modified semi-annual and annual reports if they are unable to submit the standard reports. Please contact the QPSD for further details.
- There is no change to the submission of Safety and Quality Review (SQR) reports. Please continue to submit SQR reports on a quarterly or rolling basis.
- The Q4 2020 Patient Falls and Pressure Injury Report submission due date has been extended to April 30, 2021. Both this report and the Q1 2021 report may be submitted as one report at that time.

Healthcare facilities who have questions or concerns regarding reporting requirements are urged to contact the QPS Division for additional support and guidance.

	Ambulatory Clinics	Non-Acute Care Hospitals
	Acute Care Hospitals with Inpatient Obstetrical Units	Acute Care Hospitals without Inpatient Obstetrical Units
Annual Report	Due April 30, 2021 For the period of March 1, 2020 to February 28, 2021	Due June 30, 2021 For the period of May 1, 2020 to April 30, 2021
Semi-Annual Report	Due April 30, 2021 For the period of September 1, 2020 to February 28, 2021	Due June 30, 2021 For the period of November 1, 2020 to April 30, 2021
Q4 2020 Patient Fall and Pressure Injury Report	Due April 30, 2021	Due April 30, 2021
Q1 2021 Patient Fall and Pressure Injury Report	Due April 30, 2021	Due April 30, 2021

Questions and comments may be directed to
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 Administrative Assistant

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