OO8 – EXEMPLARY PROFESSIONAL PRACTICE

Provide the policies, or equivalent evidence, that depict the organization's initiatives for patients and families, regarding the following issues:
- *Diversity, equity, and inclusion*
- *Cultural competence*

Diversity, Equity, and Inclusion

OO8.1	2022 Health Equity Report
	We Ask Because We Care (Equal Access)
	Epic Health Planning

OO8.2	Food Insecurity
	Housing Insecurity
	Utility Insecurity

OO8.3	Accommodations for People with Disabilities
	Interpreter Services
	Sexual Orientation and Gender Identity Training Resources
	Gender Identity Equity Guide for Healthcare Professionals

Cultural Competence

OO8.4	Increasing Cultural Competence Training
	Jewish Cultural Resources Webpage (Screenshot)
	Patient and Family Education Policy

NewYork-Presbyterian

2022 Health Equity Report

Overview

NewYork-Presbyterian is deeply committed to providing the highest quality care to our patients and supporting the health and well-being of the communities we serve. Affiliated with two top-tier academic institutions, Weill Cornell Medicine and Columbia University Irving Medical Center, NewYork-Presbyterian is a leader in medical education, groundbreaking research, and innovative clinical care. Our health system has extensive community health programming and a long history of working alongside with community partners to address the root causes of disease and reduce health inequities. NewYork-Presbyterian is one of the largest providers of care to Medicaid-insured New Yorkers in the state and over the past two years of the COVID-19 pandemic, has provided COVID-related care to and vaccinated hundreds of thousands of community members. Caring for all New Yorkers and advancing health justice is **essential** to our organization's mission and key part of our strategic framework.

Health Justice Goals

To advance our efforts in health justice, NewYork-Presbyterian is following a 7-point plan for health and structural equity, which includes efforts that impact our team members, our patients, and the communities we serve.

- **Staff Training:** We will continue to provide mandatory, enterprise-wide training addressing issues of equity, racism, and the intersections with health, including unconscious bias.
- **Recruitment & Retention**: We commit to diversity and equal representation in recruitment & retention. A diverse health care community is critical to providing high quality, equitable care.
- **Data Collection:** We commit to collecting structured, reportable sociodemographic information from patients, including self-reported race, ethnicity, sexual orientation, gender identity, and social determinants of health data, and training our staff in culturally-sensitive collection of this data.
- **Measurement & Action:** We commit to an equity measurement strategy that includes disaggregation of quality, access, and experience measures by sociodemographic factors to identify equity gaps and inform future work. We commit to take action when equity gaps are identified and participate in local and state quality improvement initiatives focused on reducing disparities.
- **Access:** We believe that all patients deserve access to unbiased, payer-agnostic care.
- **Community-Informed Programming:** We will take a community-led, data-informed approach to community programming, using the Community Health Needs Assessment (CHNA) process to gain an understanding of the needs, assets, and priorities of the communities the hospital serves, and to inform a robust Community Service Plan (CSP).
- **Community Partnerships:** We will continue building strong community partnerships to address health equity priorities.

In our first annual health equity report, we discuss the demographic profile of our inpatient discharges, emergency department visits, and outpatient visits, as well as highlight our health equity work in a key clinical area – maternal health. In 2020 NewYork-Presbyterian began its transition onto a new electronic medical record system. This report reflects data from 2022; the first time period when all of our locations (inpatient campuses and outpatient practices) are on a single uniform electronic medical record system. In future reports, we plan to provide updates on the demographic profile of our patients and highlight other areas of health equity in the enterprise. This health equity report is a first step in understanding patient representation within our health system and potential areas for improvement.

The Demographic section of this report contains measures of patient access; comparing the demographics of our patients to the demographics of the residents who live in our service area. Our main findings include:

- The racial and ethnic distribution of our **inpatient discharges** roughly matches racial and ethnic distribution of the population in our five-county primary service area.
- We see a higher percentage of Latino patients discharged from the **emergency department** (ED) (36%) compared to the percent of Latino people living in our five-county service area (29%). We also see a lower percentage of Asian American Pacific Islander (AAPI) ED discharges (7%) compared to the percent of AAPI people living in our service area (14%).
- We find that a majority of our **outpatients** are Latino or white, similar to the distribution of that population living in our five-county service area.
- The percentage of Black and Latino patients **giving birth at NewYork-Presbyterian** (12% and 26% respectively) is lower than the population represented in our five-county service area (21% and 29% respectively).

The Birthing Persons Programs section discusses the disparities in severe maternal morbidity (SMM) and what NewYork-Presbyterian, New York City, and New York State are doing to address those disparities, including expanding post-partum doula services to new mothers, extending the reach of our services through mobile medical units, and implementing quality improvement initiatives addressing maternal health. In a future report, we hope to address the key data and metrics for routine and advanced gynecologic care as they are critical to understand the full equity picture for this population of patients.

Contents

Background

NewYork-Presbyterian is one of the nation's most comprehensive, integrated academic healthcare systems, with services ranging from primary care to sophisticated specialties. In collaboration with two world renowned academic institutions, Weill Cornell Medicine and Columbia University Irving Medical Center, we are a leader in medical education, groundbreaking research, and innovative clinical care. Comprised of ten campuses and with over 4,000 beds and more than 10,000 affiliated physicians and 38,000 employees, NewYork-Presbyterian sees more than 2.6 million visits annually, including close to 26,000 infant births and more than 556,000 emergency department visits. Recognized nationally for quality and excellence, we are ranked as the #7 hospital in the nation by U.S. News & World Report.
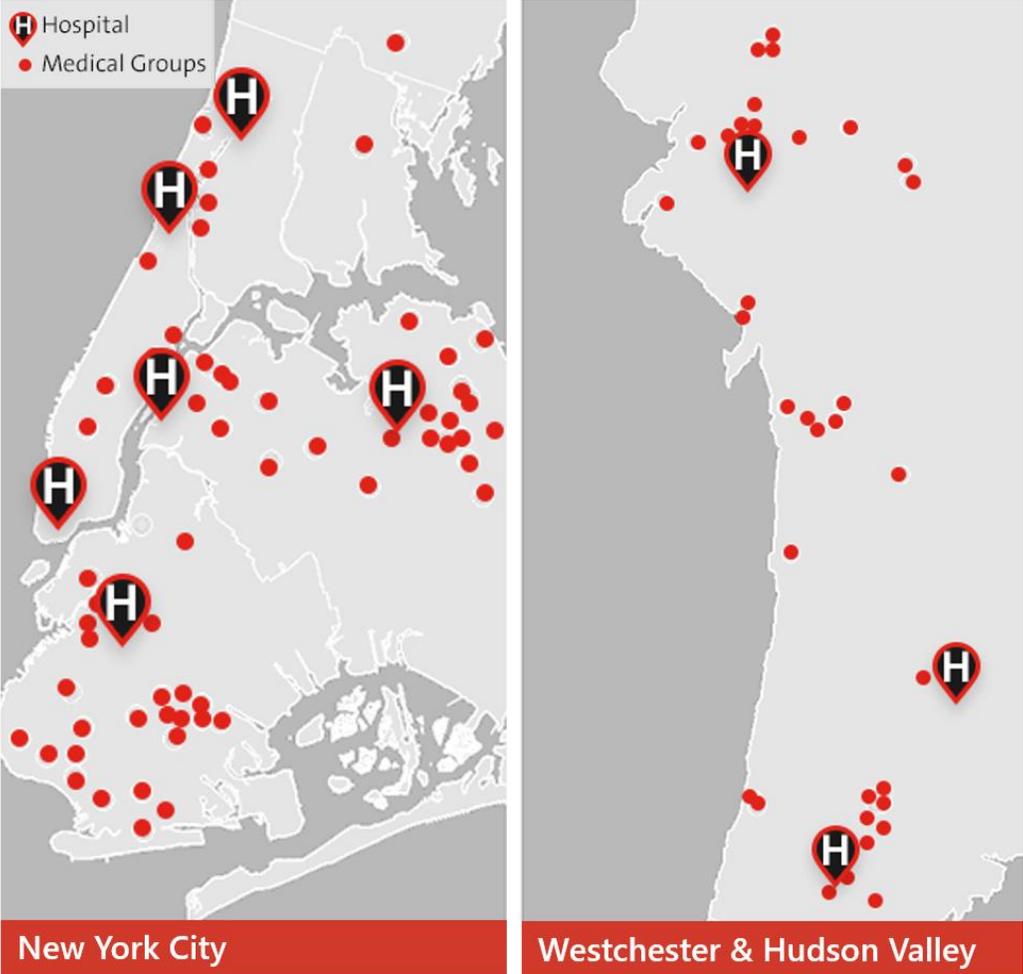
Now more than ever, health justice serves as the foundation for everything NewYork-Presbyterian does. All of our departments work together to provide the best comprehensive, compassionate care for our patients and communities. In this report, we highlight work towards health justice in the maternal health focus area, led by the Dalio Center for Health Justice, Division of Community and Population Health, Government and Community Affairs, Women's and Children's service lines, and the Department of Quality & Patient Safety.

Dalio Center for Health Justice

NewYork-Presbyterian founded the Dalio Center for Health Justice in October 2020 to understand and address the root causes of health inequities. Through the Dalio Center, we invest in research, education, and programing, and advocate for policy change to drive measurable improvements in health outcomes for all. Because 80% of health outcomes are driven by social, behavioral, and environmental causes, our work is not limited to addressing health care access and quality. We also support community initiatives, understanding and championing economic empowerment, social engagement, workforce development, neighborhood revitalization, and education.

The Dalio Center has organized its work into four key strategic areas illustrated in the depicted brownstone: Data & Infrastructure, Clinical & Community Strategy, Research & Implementation Science, and Leadership & Education.

As part of our Data & Infrastructure strategic goals, we aim to develop a robust health equity measurement strategy that includes an enterprise-wide effort to improve our underlying data, a suite of health equity measures, and a process to identify differences in health outcomes, target new initiatives, and measure ongoing impact. This first annual health equity report is an initial step at measuring our health equity impact and health outcomes. To read more about our other Data & Infrastructure work, as well as our work in the three other strategic areas, visit nyp.org/daliocenter or download our annual report here.

Division of Community and Population Health

The mission of NewYork-Presbyterian's Division of Community and Population Health is to collaborate across the community, hospital, and academic organizations to impact the health and well-being of children, adolescents, and adults in the communities we serve. In addition to providing education and training for residents, fellows and other trainees, the Division includes two key focus areas:

- **Ambulatory Care Network:** NewYork-Presbyterian's Division of Community and Population Health provides clinical services through its Ambulatory Care Network (ACN), which includes 14 primary care sites, seven school-based health centers, 10 mental health school-based programs, and over 35 specialty practices. We serve generations of families from across New York City who represent a wide array of nationalities and ethnic and religious backgrounds.
- **Community Programs & Services:** The Division connects community residents with medical and behavioral health care through a wide range of community health programs for children, adolescents, and adults - connecting NewYork-Presbyterian's expertise and programs with schools, faith-based organizations, and community organizations. We work with a number of community-based organizations on these programs and services. These programs and services address social determinants of health in our community to improve health outcomes.

To read more about the work of the Division, visit nyp.org/about/community-and-population-health or download our annual report here.

Government & Community Affairs

Our Government and Community Affairs department works to establish and maintain relationships and engagement with our local communities and government officials. The team leads advocacy efforts that benefit our communities and builds trust through ongoing communication, dialogue and support of community-based organizations.

- **Community Advisory Boards:** Our Community Advisory Boards include local representatives who meet regularly with NewYork-Presbyterian leaders to discuss issues affecting well-being in the communities we serve.
- **Community Service Plans:** Every three years the team conducts a comprehensive Community Health Needs Assessment (CHNA) to understand the needs of the hospital's local communities and the conditions that influence their well-being, and inform Community Service Plans to enhance community health.
- **Government Relations:** NewYork-Presbyterian works with local, state and federal officials to support the health and safety of the patients and communities we serve.

Women's & Children's Service Lines

NewYork-Presbyterian and our medical school partners, Weill Cornell Medicine and Columbia University Irving Medical Center, offer the full spectrum of care and services a birthing person and baby may need before, during, and after childbirth – including specialized prenatal care and high-level care for newborns in need of extra support. We provide coordinated comprehensive women's health care throughout the lifespan, including gynecology, heart health, cancer care, mental health, and bone health for quality of life.

Our team of nationally renowned pediatric specialists treats newborns through young adults with various conditions. With two major pediatric hospital campuses, dozens of medical group practices, and additional access to care through our telehealth services, we provide patients with exceptional care no matter where they live. Excellence in care does not stop once children reach adulthood. Our pediatric specialists work closely with our adult specialists to ensure a seamless transition of care, especially for children taking a more active role in managing their chronic illnesses.

Department of Quality & Patient Safety (QPS)

The mission of the Quality & Patient Safety (QPS) Department is to foster a highly reliable organization that promotes and supports quality and safety, optimal patient outcomes, research and innovation. The vision is to make NewYork-Presbyterian the best and safest academic hospital by promoting a culture of safety and zero preventable harm. The Pediatric & Obstetric QPS team takes a service-line approach to women's and children's quality, bringing clinical experience and expertise to performance improvement and event review for these populations. This team co-leads the enterprise-wide Perinatal Practice, Children's Practice and Neonatal Practice Committees and provides project management and leadership for annual obstetric and pediatric QPS goals. In 2020, the team created the enterprise-wide Severe Maternal Morbidity (SMM) review process. The SMM Committee works to identify and reduce the incidence of preventable maternal morbidity, with a particular focus on identification of disparities and developing performance improvement projects to address.

Demographics

In this section, we explore the demographics of our patient population. This includes the racial and ethnic distribution of patients seen in the hospital to assess how well that distribution matches the racial and ethnic distribution of the surrounding community.

In the report, we focus on the following access measures:

- Community Residents Who Accessed Inpatient Services at the Hospital
- Community Residents Who Accessed Emergency Department Services at the Hospital
- Community Residents Who Accessed Outpatient Services at the Hospital, with subdivisions for residents who used our Ambulatory Care Network Services

In this report, outpatient services include all ambulatory services provided at NewYork-Presbyterian sites, including ambulatory surgeries, outpatient procedures (like infusions or endoscopies), outpatient imaging and labs, and outpatient visits at our Ambulatory Care Network and Medical Group sites. NewYork-Presbyterian's Ambulatory Care Network is a network of community-based clinics that provide primary care, pediatrics, OB/GYN, mental health, and specialty care. NewYork-Presbyterian Medical Groups provide primary and specialty care across NYC and Westchester in over 125 locations.

About Our Service Area: For this report, our enterprise primary service area is defined as the large contiguous metro-area including five counties: Manhattan, Brooklyn, Queens, Bronx, and Westchester. Over 85% of our patients live in these five counties and all ten of our hospital campuses are located within this geography (Figure 1). Additionally, campus-specific service areas were calculated for each NewYork-Presbyterian campus to facilitate more granular analyses and evaluate geographic variation. Campus-specific service areas are defined using zip code-level patient origin data where the primary service area (PSA) represents the zip codes that comprise 50% of inpatient discharges and the secondary service area (SSA) includes the subsequent 25%.

NewYork-Presbyterian Service Area
▪ Manhattan
▪ Brooklyn
▪ Queens
▪ Bronx
▪ Westchester

About Our Race & Ethnicity Data: Throughout this report, self-reported race and ethnicity of NewYork-Presbyterian's patients is compared to 2020 Census data to assess representation of patients relative to our surrounding community. Race and ethnicity are collected and documented separately in our electronic medical record system and, in this report, the values are converted into a single combined variable that includes Latino, non-Latino Asian American/Pacific Islander, non-Latino Native American, non-Latino Black, non-Latino White, and Other. These analyses exclude patients that decline to provide a race or ethnicity value. (In the analysis time period this represents approximately ten percent of all patients.) In 2021, NewYork-Presbyterian launched an enterprise-wide initiative called *We Ask Because We Care* to improve race and ethnicity data collection and published our program in the New England Journal of Medicine Catalyst.[1] We continue to monitor these statistics over time.

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[1] Shapiro, A., Meyer, D., Riley, L., Kurz, B., & Barchi, D. (2021). Building the Foundations for Equitable Care. *New England Journal of Medicine Catalyst: Innovations in Care Delivery*. https://doi.org/https://catalyst.nejm.org/doi/full/10.1056/CAT.21.0256

Map of NewYork-Presbyterian
Five County Service Area

Figure 1: Five County Area with shading for patient volume
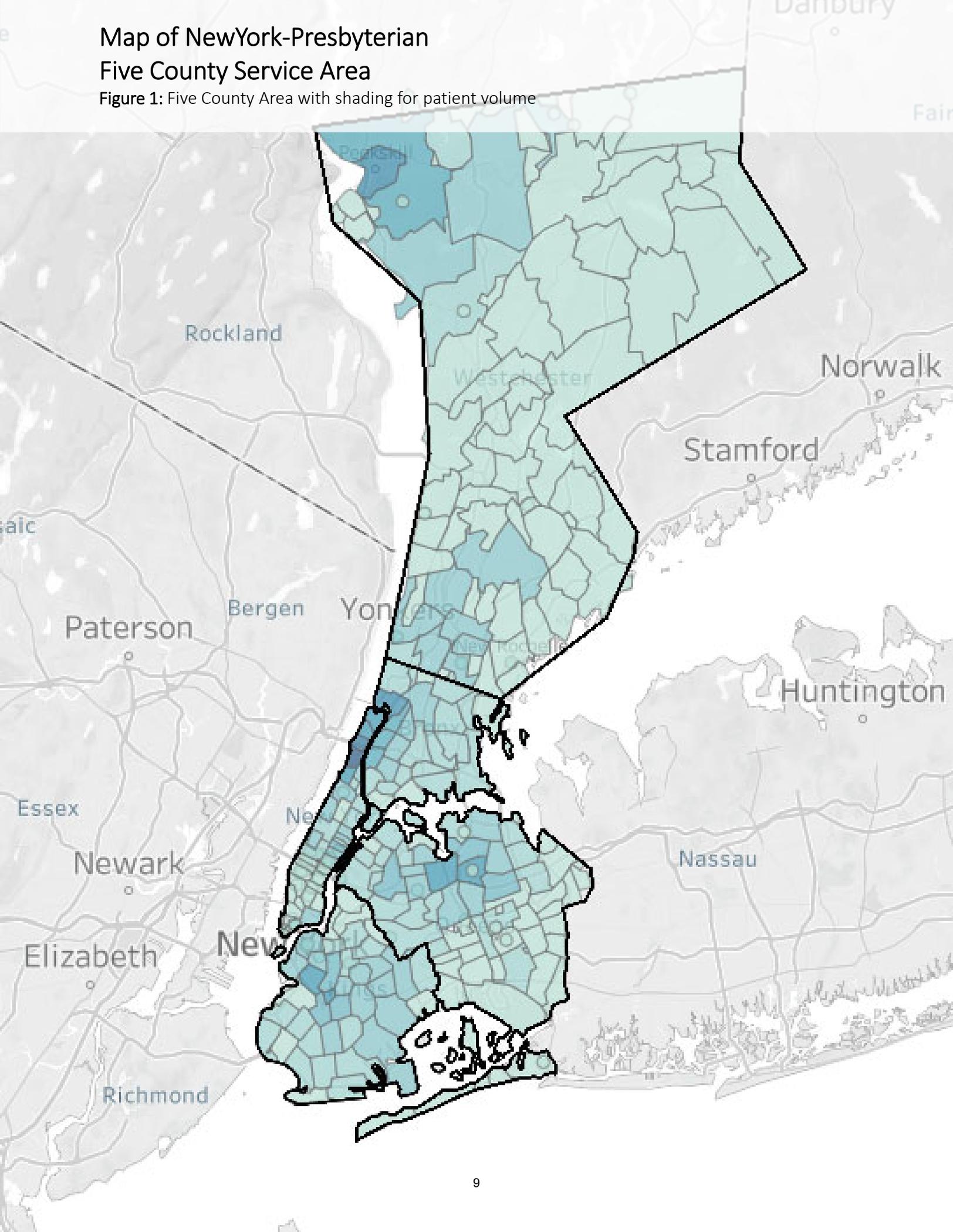
About the Hospital Data Covered in This Report: In this analysis, we evaluated inpatient discharges and emergency department and outpatient visits between January through June 2022. Future reports will evaluate a full year of retrospective data. However, from 2020-2021 the NewYork-Presbyterian enterprise underwent a transition onto a new electronic medical record system, so 2022 is the first time period when all of our locations (inpatient campuses and outpatient practices) are on a single uniform electronic system. In this report, we have included data representing patient encounters with the NewYork-Presbyterian campuses, including inpatient discharges and emergency department visits at one of our ten campuses and outpatient visits at our hospital campuses, within our ambulatory care network, and at our NewYork-Presbyterian Medical Group practices. Private physician visits with a Columbia Doctors or Weill Cornell Medicine physician are not included in this report.

About Terminology: Terminology evolves over time. NewYork-Presbyterian commits to continually apply an equity lens to our terminology, and conduct ongoing evaluation of our selected terminology for health equity work.

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[1] Shapiro, A., Meyer, D., Riley, L., Kurz, B., & Barchi, D. (2021). Building the Foundations for Equitable Care. *New England Journal of Medicine Catalyst: Innovations in Care Delivery*. https://doi.org/https://catalyst.nejm.org/doi/full/10.1056/CAT.21.0256

We evaluated the racial and ethnic distribution of our service area (using 2020 census data) compared to the racial and ethnic distribution NewYork-Presbyterian patients with an inpatient discharge or emergency department visit (using patient self-reported race and ethnicity). For example, in the first half of 2022, 25% of patients with an inpatient discharge self-identify as Latino compared to 29% of people living in our service area are Latino according to the 2020 census (Figure 2).
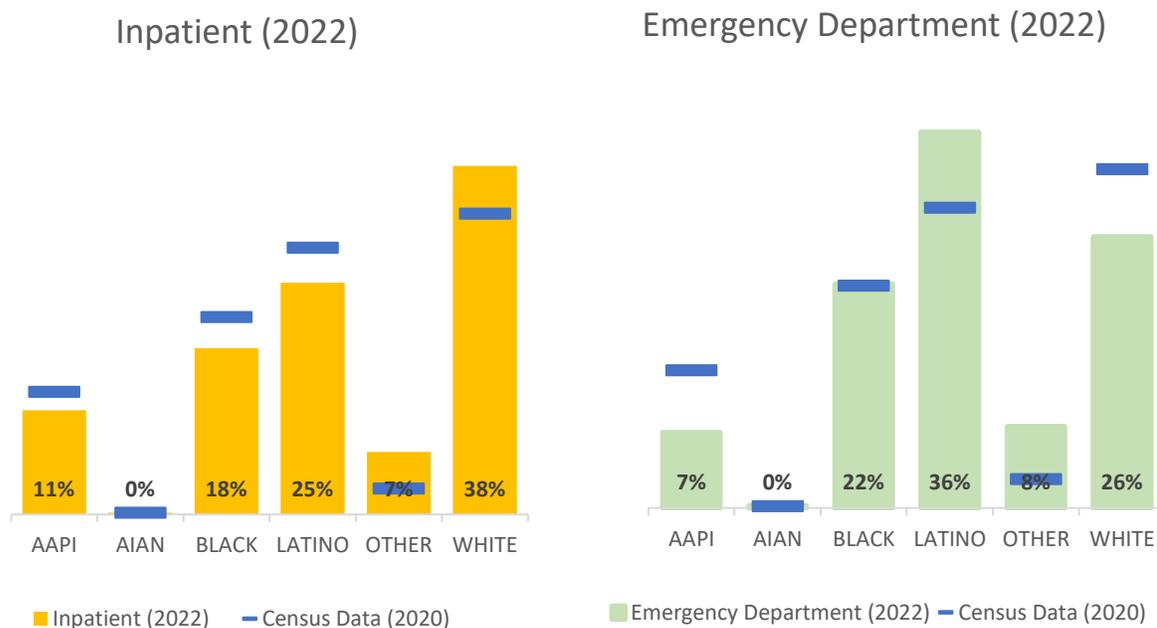
Inpatient (2022)

Figure 2: 2020 Census-based racial and ethnic distribution of population in the five-county service area versus racial and ethnic distribution of all patients with NewYork-Presbyterian inpatient discharges

Emergency Department (2022)

Figure 3: 2020 Census-based racial and ethnic distribution of population in the five-county service area versus racial and ethnic distribution of all patients with NewYork-Presbyterian emergency department visits

In all demographic charts (Figures 2-5), the blue lines indicate the race and ethnicity distribution determined by 2020 US Census data, while the bars indicate the self-identified race and ethnicity distribution of NewYork-Presbyterian patients.

AAPI: Non-Latino Asian American Pacific Islander; AIAN: Non-Latino Native American and Alaska Natives; BLACK: Non-Latino Black or African American; Latino: Latino/a/x or Hispanic; White: Non-Latino White; Other: Other not described.

When looking at our patient population (Figure 2), the racial and ethnic distribution of our inpatient discharges roughly matches racial and ethnic distribution of the population our five-county service area. However, we see that there are fewer AAPI, Black, and Latino patients with inpatient discharges compared to the those living in our service area and a higher percentage of white or Other-identifying patients than is reflected in our service area. In future reports, we will continue to monitor these statistics and see if results change, especially as we work to improve self-reported race and ethnicity documentation and capture informative information for patients that have previously declined. Additionally, we examined the race and ethnicity distribution of our inpatient discharges by service line (Appendix 02). In those exhibits, we see a similar distribution to the overall inpatient discharges distribution, with some variation among different NewYork-Presbyterian service lines.

In our emergency departments (EDs), we see a higher percentage of Latino patients (36%) compared to the racial and ethnic distribution of Latino people living in our five-county service area (29%) (Figure 3). This aligns with national experience[2] – Latino and Black ED patients reported higher ED utilization, lacked a usual source of care, and reported better experience with ED care than white patients. Results may be due to unmet need in these counties and lack of access to culturally sensitive primary care.

Data and Takeaways: Outpatient and Ambulatory Care Network

In our outpatient volume – including ambulatory surgeries, outpatient procedures, visits to our NewYork-Presbyterian Medical Group offices, and our Ambulatory Care Network (ACN) – we find that a majority of the patients seen in our outpatient locations are Latino or white, similar to the distribution of that population living in our five-county service area (Figure 4). In addition to measuring overall outpatient visits, we also evaluated the racial and ethnic profile of our ACN practices alone, which are located in Manhattan's Washington Heights and Upper East Side, Queens, and Brooklyn. For this measure, we chose to refine the census comparison group; instead of using the large five-county service area, we calculated an ACN-specific service area based on the catchment area of the ACN practices. In this measure, we find that the proportion of Latinos living in that service area from the 2020 census closely matches the proportion of Latino patients seen in our ACN locations (Figure 5).
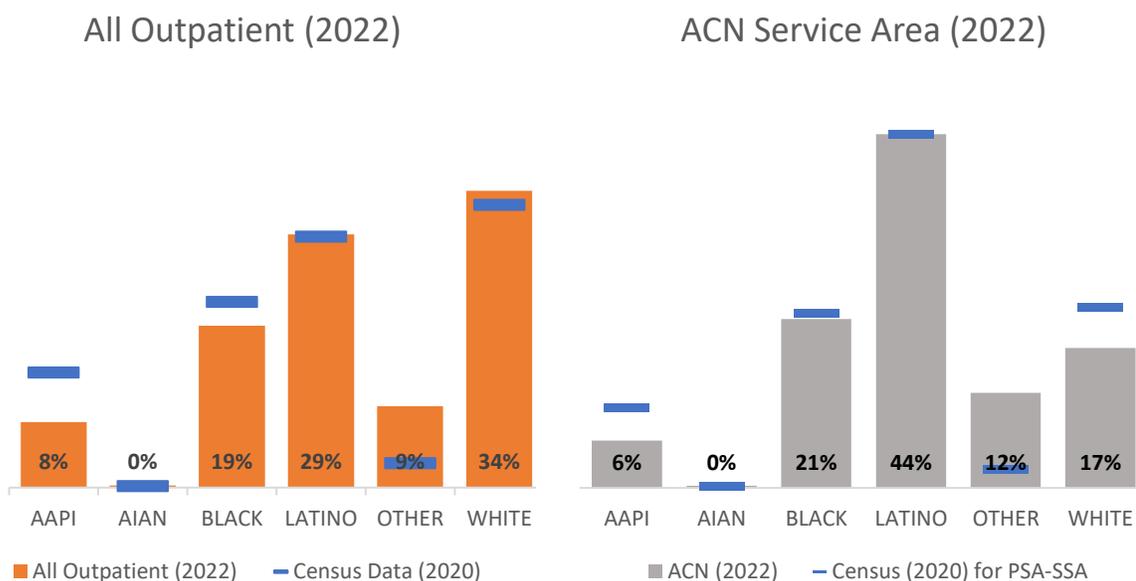
Figure 4: 2020 Census-based racial and ethnic distribution of population in our service area versus racial and ethnic distribution of patients that come to NewYork-Presbyterian outpatient locations

Figure 5: 2020 Census-based racial and ethnic distribution of population in the ACN PSA and SSA versus racial and ethnic distribution of patients that come to ACN locations

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[2] Cairns C, Ashman JJ, Kang K. Emergency department visit rates by selected characteristics: United States, 2019. NCHS Data Brief, no 434. Hyattsville, MD: National Center for Health Statistics. 2022. DOI: https://dx.doi.org/10.15620/cdc:114424external icon

NewYork-Presbyterian consistently delivers more babies in New York City and Westchester combined than any other hospital in New York.

Clinical	Facilities	Staff
24,000 births in 2021	**81** Labor & Delivery rooms	**275** attending physicians
	310 antepartum and postpartum beds	**83** Residents & Maternal Fetal Medicine (MFM) fellows
	54 OBGYN practice sites	**19** midwives

In this section, we explore the demographics of our births and alignment with the demographics of our five-county service area. By comparing these benchmarks, we can examine access and representation in our obstetric services.

When looking at the distribution of race and ethnicity of birthing persons, we find that more white patients give birth at NewYork-Presbyterian than is represented in our five-county service area (Figure 6). Meanwhile, the percentage of Black and Latino patients that give birth at NewYork-Presbyterian (12% and 26% respectively) is lower than the population represented in our five-county service area (21% and 29% respectively). In the following section on Birthing Persons Programs, we discuss initiatives we are implementing in our communities, such as EMBRACE and Obstetric Centering, to address this disparity and reach underserved populations.

Birthing Persons (2022)
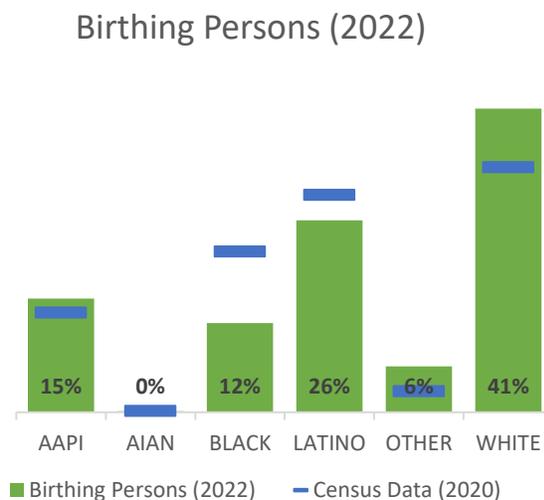
Figure 6: Racial and ethnic distribution of population in our service area versus racial and ethnic distribution of birthing persons at NewYork-Presbyterian

Birthing Persons Programs

Worldwide maternal deaths have decreased over the last century, but in the United States they continue to rise. The U.S. is the only developed country that has seen an increase in maternal mortality, from 17.5 deaths per 100,000 live births in 2000 to 26.4 in 2015. Additionally, there are significant racial and ethnic disparities in maternal morbidity and mortality across the U.S. In 2018, non-Hispanic Black birthing persons were three times more likely to die from pregnancy-related causes than non-Hispanic birthing persons. These disparities are worse in New York City, where Black birthing persons are eight times more likely than white birthing persons to die from pregnancy-related causes.[3]

In 2022, the New York State Department of Health (NYSDOH) released a new report on maternal mortality, "The New York State Report of Pregnancy-Associated Deaths in 2018", as part of the State's ongoing commitment to address systemic inequities and create safer birth experiences for mothers and families.[4] In the report, the New York State Maternal Mortality Review Board (MMRB) concluded that structural racism and its impact on birth outcomes must be addressed through an integrated approach that reaches the healthcare system across New York State. The NYSDOH review reported a rate of 18.2 pregnancy-related deaths per 100,000 live births and concluded that 78% of these deaths were preventable, and that 100% of the deaths caused by hemorrhage, mental health conditions, and cardiomyopathy were preventable.[5] The report recommended specific measures, including:

- Expanding postpartum Medicaid coverage for one year after birth
- Instituting home visiting programs to provide education and one-on-one support to families
- Integrating community-based resources, including doulas, visiting nurses, community health workers/patient navigators, telehealth visits, and remote monitoring
- Improving the continuity of care for pregnant New Yorkers who are treated by multiple doctors, both during and after the pregnancy

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[3] Landis-Shack, N. (2019, December 16). *Improving maternal care in NYC's Hospitals - FPHNYC*. Fund for Public Health in New York, Inc. Retrieved from https://fphnyc.org/blog/maternal-care-hospital-improvement/

[4] New York State Department of Health. (2022, April 13). *New York State Report on Pregnancy Associated Deaths in 2018*. New York State Department of Health. Retrieved from https://www.health.ny.gov/community/adults/women/docs/maternal_mortality_review_2018.pdf

[5] Ibid.

NewYork-Presbyterian has an ongoing commitment to address maternal morbidity and mortality and continues to establish and maintain partnerships across NYC and NYS to improve our maternal and child health outcomes. Over the past few years, there have been several federal, state, and city initiatives to address maternal mortality and morbidity, which are outlined below. The report highlights key efforts and programs at NewYork-Presbyterian that support birthing persons before, during, and after pregnancy.

Clinical Standardization and Perinatal Practice Committee/Quality and Patient Safety Goals

NewYork-Presbyterian has a robust structure for enterprise-wide clinical standardization and integration in Obstetrics. The Perinatal Practice Committee (PPC) is composed of representatives from Obstetrics, Nursing, Anesthesia, Pharmacy and Quality & Patient Safety from all eight campuses where babies are born. The PPC works to standardize clinical practice, and facilitate performance improvement work through the NewYork-Presbyterian Perinatal Practice Guidelines Manual. The PPC Guidelines apply to all campuses providing obstetric care and these guidelines comport with national standards, where standards exist. Where national standards are absent, the PPC creates novel internal standards, drawing on the vast clinical expertise at our organization.

Each year, NewYork-Presbyterian develops an enterprise-wide Quality & Patient Safety (QPS) goal specific to Obstetrics to address identified opportunities for performance improvement. Past goals have included:

- 2018: Standardization of Category II Fetal Heart Tracing Algorithm and Second Stage of Labor Management
- 2019: Gap analysis and optimization for Postpartum Hemorrhage Maternal Safety Bundle
- 2020: Creation of a novel Severe Maternal Morbidity (SMM) Review Committee and processes
- 2021: Implementation of the novel SMM prevention bundle based on identified opportunities from cases reviewed by the SMM Review Committee
- 2022: Implementation of a Maternal Sepsis Bundle

Severe Maternal Morbidity (SMM) Review

New York City became the first local jurisdiction in the United States to design a citywide Severe Maternal Morbidity (SMM) surveillance system. In 2020, NewYork-Presbyterian created a SMM review process to assess cases for preventability. Through the development of consensus case review criteria and local campus SMM review committees, cases where morbidity could have been prevented are escalated to the enterprise-wide committee. Common causes of preventable morbidity identified through the SMM review process are used to develop performance improvement projects, including the 2022 QPS goal to implement the maternal sepsis bundle. Using case review and analytics of SMM events across the enterprise, NewYork-Presbyterian strives to reduce preventable SMM rates and identify and close any disparities among patient populations.

Maternity Hospital Quality Improvement Network (MHQIN)

In July 2018, New York City announced an investment of $12.8 million over three years to support a comprehensive plan to reduce maternal deaths and life-threatening childbirth complications among people of color. This plan, known as the Maternity Hospital Quality Improvement Network (MHQIN) is led by the leadership of the Bureau of Maternal, Infant, and Reproductive Health at the Health Department. Additionally, it builds upon projects made possible by the Merck for Mothers grants as well as work implemented by the Sexual and Reproductive Justice Community Engagement Group.

MHQIN aimed to:

1) develop hospital quality improvement committees to review SMM cases,
2) conduct trauma-informed trainings to support systems and address implicit bias,
3) foster best health care practices through ongoing medical simulation trainings,
4) support hospital driven quality improvement projects,
5) support the implementation of the NYC Standards for Respectful Care at Birth, and
6) support resources and technical assistance for community engagement.

NewYork-Presbyterian Morgan Stanley Children's Hospital and NewYork-Presbyterian Allen Hospital participated in the first cohort of the MHQIN network and received grant funding to pilot the review of SMM cases. Subsequently, NewYork-Presbyterian expanded the case review enterprise-wide as part of our 2020 QPS Goal. In 2022, the MHQIN will be expanded to all 38 birthing facilities across the city in an effort to improve maternal care at local hospitals and birthing centers.

NYS Birth Equity Improvement (NYSBEIP) and NYC Respectful Care at Birth

NewYork-Presbyterian is an active participant in The New York State Perinatal Quality Collaborative (NYSPQC), an initiative led by the New York State Department of Health (NYSDOH) Division of Family Health (DFH). The NYSPQC aims to provide the best, safest, and most equitable care for birthing persons and infants in NYS. One of the current interventions within the collaborative is the New York State Birth Equity Improvement Project (NYSBEIP), which was launched in 2021. The project assists birthing facilities in identifying how individual and systemic racism impacts birth outcomes at their organizations and taking action to improve both the experience of care and perinatal outcomes for Black birthing people.

Figure 2: NewYork-Presbyterian standards for Respectful Care at Birth

Figure 3: New York City DOHMH standards for Respectful Care at Birth

Since the NYSBEIP began in 2021, NewYork-Presbyterian has implemented the Patient Reported Experience survey at all sites, which is offered to every birthing person before discharge. The anonymous survey provides an opportunity for birthing people to provide feedback on their experience of care during labor and delivery at our hospitals, for the purpose of improving care of birthing people. Additionally, the team has created NewYork-Presbyterian standards for Respectful Care at Birth (Figure 2), based on the NYC Respectful Care at Birth standards (Figure 3), which were created to inform, educate, and support birthing persons. These standards also help guide our teams to respect and be aware of patients' human rights during pregnancy, labor, and childbirth. Finally, the team is partnering with the Dalio Center for Health Justice to provide anti-racism training for our teams, which will focus on dignity in pregnancy and childbirth.

Vaginal Birth After Cesarean Section (VBAC) Calculator

In 2021, the NYC Department of Health and Mental Hygiene announced the formation of the Coalition to End Racism in Clinical Algorithms (CERCA) following the Board of Health's landmark resolution declaring racism a public health crisis. NewYork-Presbyterian is a member of CERCA, which aims to support health systems and providers in their efforts to eliminate race correction in clinical algorithms. The CERCA Project has chosen three algorithms to focus on for the first year: glomerular filtration rate (eGFR) equations, which measures kidney function, vaginal birth after cesarean section (VBAC), and pulmonary function testing (PFT).

NewYork-Presbyterian ended reporting of race-corrected eGFR years ago, and the VBAC calculator developed by the NICHD MFMU (National Institute of Child Health and Human Development's Maternal-Fetal Medicine Units Network) has not included race since 2021. As part of our CERCA work, we launched an in-depth analysis of practice patterns and physician attitudes towards use of tools to predict VBAC success. This program includes faculty and staff training and education, as well as a technical review of any clinical decision-making tools in use throughout our enterprise. This important work has been led by clinical leadership at Columbia University Irving Medical Center and Weill Cornell Medicine in collaboration with NewYork-Presbyterian's Information Technology Team and the Dalio Center. As part of our collaboration and participation in CERCA, we will be continuing our commitment to identifying and addressing algorithmic bias, and formally evaluating the impact of that work.

To learn more: [Health Department Launches Coalition to Confront Racism in Medical Algorithms](#)

Mother and Child Integrated Mental Health Program (MAC-IMP)

To improve obstetric and pediatric outcomes, strengthen support, and increase access, NewYork-Presbyterian implemented a two-generational, integrated approach to maternal-infant care. In April 2020, we launched a transformative collaboration, aligning interventions and metrics across obstetrics, pediatric, and behavioral health services across northern Manhattan community-based practices. Through this model, we set a trajectory to improve quality care through the continuum of a birthing person's and child's life.

Multiple programs exist within the Mother and Child Integrated Mental Health Program (MAC-IMP) collaborative. Each program is carefully designed to meet the unique needs of new caregivers at different stages of the early childhood period. MAC-IMP initiatives were first launched in partnership with the Columbia University Irving Medical Center campus, and are actively expanding across NewYork-Presbyterian campuses. Three programs within the MAC-IMP collaborative include Obstetric Centering, EMBRACE, and HealthySteps.

Obstetric Centering

Centering is an innovative, supportive, community-building model of healthcare and is a nationwide, evidence-based program developed by the Centering Healthcare Institute. As an alternative to individual routine prenatal care, expecting parents are given the option to participate in group-based healthcare visits expanding their social support network. With this model, expecting parents gain more time with providers, longer prenatal care visits, and the opportunity to build relationships with others in the same stage of pregnancy. As the Obstetric Centering program grows, pediatrics is developing plans to offer a similar model of care.

Empowering Mothers Birth Rights Through Advocacy, Community, and Education (EMBRACE)

In partnership with the Northern Manhattan Perinatal Partnership (NMPP), EMBRACE provides doulas that will serve 1,000 patients in northern Manhattan and the Bronx. During their second or third trimesters, patients are identified and referred to EMBRACE by either their OB provider or additional staff, such as nursing, a mental health provider, or social worker. Patients will be contacted within 48 hours of the referral. Patients are screened and services are offered through a Postpartum Doula and/or Community Health Worker (CHW). Assessments and services are provided through a hybrid model including virtual and in-person activities. Doula and CHW services are provided in partnership with NMPP. Currently, NewYork-Presbyterian is expanding this project to NewYork-Presbyterian Brooklyn Methodist in collaboration with Caribbean Women's Health Association, where EMBRACE is in the early stages of development. Since inception of EMBRACE in 2020, 323 patients completed the program. In 2022 year-to-date, EMBRACE has had 129 referrals to the program.

HealthySteps

HealthySteps is an evidence-based prevention model, aimed to build a foundation of health and strong social-emotional development for kids, beginning in early childhood. At NewYork-Presbyterian, we expanded this model to begin in the prenatal period, offering behavioral health support within both the obstetric and pediatric care environment. HealthySteps interventions provide targeted psychoeducation and skills-based coaching, covering a range of maternal mental health and child development issues. For high-need families, HealthySteps provides continuous support for psychological, developmental, medical, and psychosocial concerns, from pregnancy through early childhood. Since April 2020, HealthySteps has had 708 total referrals and 493 engaged in the program. Out of those engaged, 45% of those met their goals and 30% are still active.

Intended outcomes for MAC-IMP's implementation include:
- Decreasing no-show rate by 20% for postpartum checkups
- Increasing rate of screening (>70%), treatment, and follow up for maternal depression
- Increasing rate of contraception uptake (>75%) in postpartum visit
- Increasing rate of breastfeeding (>75%)
- Improving adherence (>75%) to well-child visits
- Increasing rate of developmental surveillance (>90%) at 9 months
- Establishing metrics to assess connection and reception of early intervention services (>65%)

Northern Manhattan Early Childhood Collaborative (NMECC)

To improve the lifelong trajectory of young children in the community, the Northern Manhattan Early Childhood Collaborative (NMECC) brings stakeholder families and over 14 child-facing community organizations together to share their expertise and experience and identify, collect, analyze and disseminate relevant data indicators. The Northern Manhattan Early Childhood Collaborative was launched by the NewYork-Presbyterian Division of Community and Population Health in 2022, with financial support from the Dalio Center for Health Justice and co-led by Literacy Inc. Citizens' Committee for Children is the partner organization for analysis of relevant data, gathering community input, and evaluation.

By the end of the first year, the Northern Manhattan Early Childhood Collaborative will be well positioned to seek external funding to focus on the execution of projects. While the projects are to be determined by the parent and direct service provider groups, projects could include:

- Facilitating enrollment in entitlement programs that can help lift families with young children out of poverty

- Working with families and service providers to improve pathways to essential early childhood services and new opportunities
- Strengthening parent-child relationships through training and workshops for parents and sessions for both parent and child that include child-directed play
- Redesigning public and program spaces from idle spaces into developmentally appropriate learning opportunities

Key accomplishments in 2022 include: launching a community survey to assess needs and resources, hosting 13 meetings with our stakeholders, and issuing a request for assistance to identify a lead agency for the project.

Community Conversations

The importance of sharing our own stories cannot be underestimated. Together with local community-based organizations including CAMBA, Caribbean Women's Health Association, YMCA, and Brooklyn Children's Museum, the Dalio Center for Health Justice collected and uplifted local stories about motherhood during the pandemic. These stories, called Community Conversations, are documented by video and were showcased at our Community Celebration and on NewYork-Presbyterian social media platforms. The Summer 2022 Community Celebration was an opportunity for the community to join together and hear stories from neighbors and friends. It was held at the Brooklyn Children's Museum in an outdoor space, with a screening area and entertainment – including music, food, art, and activities for children.

Crown Hair Care Project

In Black and African American cultures, hair is used to express mood, tastes, art, culture, and spiritual affiliations. This important connection between hair and cultural identity encouraged Nursing Leadership and the Dalio Center for Health Justice to develop the Crown Hair Care Project: an innovative patient care program that provides a wider array of hair care products to serve our diverse patient population. In collaboration with Carol's Daughter at L'Oréal, the first phases of the Crown Hair project are focused on pediatric and obstetric units across our health system. By providing a broader array of hair care products suitable for different hair textures, along with staff training on hair care, NewYork-Presbyterian has been able to better meet our patients' needs and improve the patient experience.

In July 2022, NewYork-Presbyterian joined Carol's Daughter at their annual Love Delivered Bump Day Block Party in Brooklyn, New York. Alongside many local Black-owned vendors with a focus on motherhood and children, NewYork-Presbyterian provided the Mother's Lounge, offering complimentary diapers and wipes, an area for feeding, and maternal health information and resources.

Baby Bus

The Baby Bus is a mobile medical unit, providing peer and expert support to pregnant persons and new parents. The Baby Bus aims to promote maternal health, child care practices, and mental well-being.

This program will provide family planning and prevention services, antenatal care, postpartum services, and newborn and pediatric care. These services include STI testing and education, STI treatment, contraception, folic acid supplements, referrals to OBGYN care, antenatal care linkages, supplements, mental health & health screenings, prenatal education, breastfeeding, safe sleep, immunizations, newborn education, and linkages to care.

Anticipated in 2023, the Baby Bus will serve the Jamaica/St. Albans, Queens Village, and Corona/Elmhurst neighborhoods in Queens, as well as several neighborhoods in Central Brooklyn including East Flatbush, Brownsville, East New York, Bedford-Stuyvesant, and Crown Heights.

Supporting Health and Reaching Equity (SHaRE)

Because 80% of health is driven by social determinants of health (SDoH), the Dalio Center's work is not limited to addressing health care access and quality. In addition to our clinical programs, our work in data infrastructure, and our investments in research and education, we plan to support targeted community initiatives – understanding and championing economic empowerment, social engagement, workforce development, neighborhood revitalization, and education.

We are launching this targeted community work with a program called SHaRE (Supporting Health and Reaching Equity) – a novel program designed to create a set of community-informed health programs focused on maternal and child health. These programs will focus on interventions to address social, behavioral, and environmental factors that influence health, alongside established clinical interventions, all driving towards a set of measurable health outcomes.

Lessons Learned

For our 2022 Health Equity Report, we reviewed the racial and ethnic profile of our inpatient discharges, emergency department visits, and outpatient visits, and highlighted our health equity work in one clinical area – maternal health. In creating this report, we identified key learnings:

- **Improving data accuracy is a continuous process:** Health equity analysis requires robust and reliable sociodemographic and socioeconomic data. NewYork-Presbyterian has committed to improving this data through our *We Ask Because We Care* program, but we are at the beginning of this journey. NewYork-Presbyterian will continue to invest resources into improving our underlying data and report on our progress in future health equity reports.

- **Hospitals are well positioned to conduct these analyses:** Several consumer reporting agencies that publish hospital measures and rankings have expressed interest in including health equity measures in their public reports. While we applaud these agencies for focusing on health equity, they often struggle with data constraints (e.g. including only Medicare Fee-for-Service data, including very lagged data, not reflecting hospital-specific catchment areas, etc.). Hospitals are able to evaluate health equity measures more holistically, with recency, and without data limitations based on payor. It is critical for NewYork-Presbyterian to actively engage in health equity measurement because we have access to complete, comprehensive, timely data about our patient profile and we have the expertise and experience to interpret the data.

- **Community engagement is critical for health equity:** To achieve true health equity, we need community engagement support and buy-in. Efforts to advance health equity need to be designed with the community and have community leadership and engagement. Many of our programs, such as EMBRACE, NMECC, and Community Conversations, were developed in collaboration with our community partners. NewYork-Presbyterian has an ongoing commitment to build and maintain our existing community connections, as well as form new relationships with the community in order to ensure that we are meeting our communities' needs.

- **Senior leadership commitment is key:** Many departments can impact health equity in an organization. Because of the connection between SDoH and health outcomes, every department at NewYork-Presbyterian can have a role in improving the lives of patients, employees, and people in the community. Improving health equity requires guidance and coordination at multiple levels of our organization. The board and senior leadership must be committed to health equity and must evidence that commitment in their work and actions.

- **These measures are only a first step:** We believe that comparing the racial and ethnic profile of our inpatient discharges, emergency department visits, and outpatient visits is an important first step in measuring disparities, but it can be challenging to interpret the differences we see and even more challenging to understand root causes of the differences. The observed racial and ethnic differences could be influenced by myriad factors, including but not limited to: the dense New York City hospital landscape with many hospital options, insurance limitations, lack of patient trust, and patient-doctor communication barriers.

Looking Ahead

As we work to understand and address the root causes of health inequities, it is critical to have widespread, reliable, and consistent sociodemographic and socioeconomic data about our patients. For that reason, we launched the *We Ask Because We Care* program in 2021, an enterprise-wide, coordinated campaign to improve the collection of self-reported race, ethnicity, and other demographic data. In 2022, NewYork-Presbyterian has been working to expand that program to include a robust social determinants of health (SDoH) screening program. In the first six months of the year, we collected SDoH responses from over 90,000 visits. For our next health equity report, we plan to include a deep dive into self-reported SDoH screening.

Health and wellness start in our homes, neighborhoods, and the communities in which we reside. Because 80% of health outcomes are driven by social, behavioral, and environmental factors, we need to address specific social aspects of health, as we work to address medical ones. We refer to these social needs – like food insecurity, inadequate or unstable housing, lack of access to transportation, and financial burdens – as the social determinants of health (SDoH). And the circumstances that create the SDoH are largely determined by the distribution of power, wealth, and resources. NewYork-Presbyterian is excited about our SDoH screening program and our comprehensive approach, which provides patients with the support they need, when they need it.

Appendix

01 Campus-specific Data

NewYork-Presbyterian Allen Hospital: Racial and ethnic distribution of population in the NYP Allen service area versus racial and ethnic distribution of all inpatients from January – June 2022

Blue bars represent the self-reported race/ethnicity distribution of all inpatients at NYP Allen

Orange lines represent the weighted-average race/ethnicity distribution from the 2020 US Census for people living in NYP Allen's primary and secondary service area, illustrated in the map.

	AAPI	AIAN	BLACK	LATINO	OTHER	WHITE
	0%	0%	14%	64%	5%	16%

■ NYP Allen   — Census for PSA-SSA

Map of NYP Allen Service Area

■ Primary Service Area (PSA); 50% of Jan – Jun 2022 discharges

□ Secondary Service Area (SSA); 75% of Jan – Jun 2022 discharges

01 Campus-specific Data

NewYork-Presbyterian Brooklyn Methodist Hospital: Racial and ethnic distribution of population in the NYP Brooklyn Methodist service area versus racial and ethnic distribution of all inpatients from January – June 2022

Blue bars represent the self-reported race/ethnicity distribution of all inpatients at NYP Brooklyn Methodist

Orange lines represent the weighted-average race/ethnicity distribution from the 2020 US Census for people living in NYP Brooklyn Methodist's primary and secondary service area, illustrated in the map.

	AAPI	AIAN	BLACK	LATINO	OTHER	WHITE
NYP Brooklyn Methodist	4%	0%	40%	10%	8%	38%

■ NYP Brooklyn Methodist — Census for PSA-SSA

Map of NYP Brooklyn Methodist Service Area

■ Primary Service Area (PSA); 50% of Jan – Jun 2022 discharges

□ Secondary Service Area (SSA); 75% of Jan – Jun 2022 discharges

01 Campus-specific Data

NewYork-Presbyterian/Columbia University Irving Medical Center: Racial and ethnic distribution of population in the NYP/Columbia service area versus racial and ethnic distribution of all inpatients from January – June 2022

Blue bars represent the self-reported race/ethnicity distribution of all inpatients at NYP/Columbia

Orange lines represent the weighted-average race/ethnicity distribution from the 2020 US Census for people living in NYP/Columbia's primary and secondary service area, illustrated in the map.

2%	0%	20%	41%	7%	31%
AAPI	AIAN	BLACK	LATINO	OTHER	WHITE

■ NYP/Columbia   — Census for PSA-SSA

Map of NYP/Columbia Service Area

■ Primary Service Area (PSA); 50% of Jan – Jun 2022 discharges
□ Secondary Service Area (SSA); 75% of Jan – Jun 2022 discharges

01 Campus-specific Data

NewYork-Presbyterian Hudson Valley Hospital: Racial and ethnic distribution of population in the NYP Hudson Valley service area versus racial and ethnic distribution of all inpatients from January – June 2022

Blue bars represent the self-reported race/ethnicity distribution of all inpatients at NYP Hudson Valley

Orange lines represent the weighted-average race/ethnicity distribution from the 2020 US Census for people living in NYP Hudson Valley's primary and secondary service area, illustrated in the map.

1%	0%	12%	15%	6%	66%
AAPI	AIAN	BLACK	LATINO	OTHER	WHITE

■ NYP Hudson Valley — Census for PSA-SSA
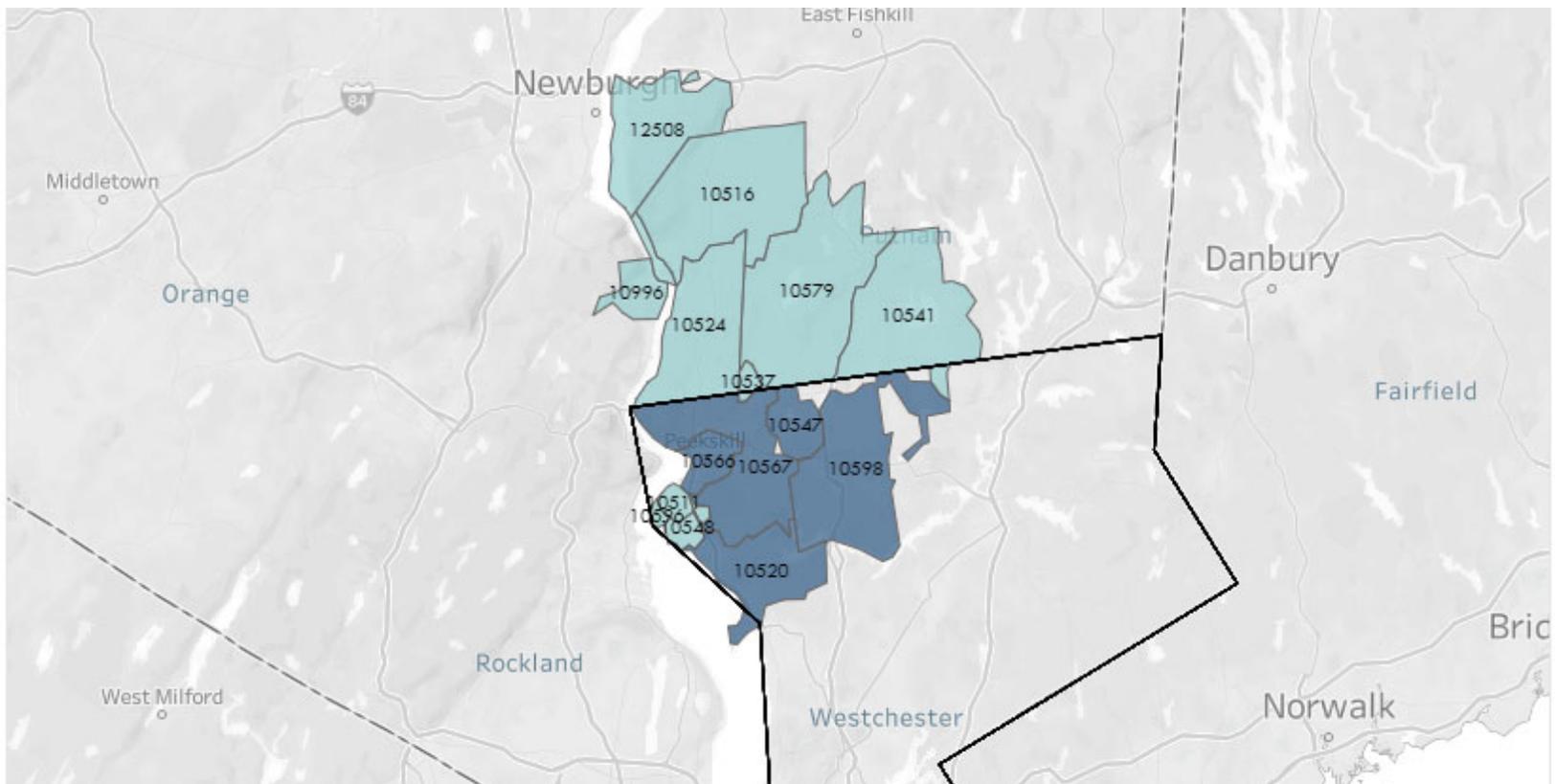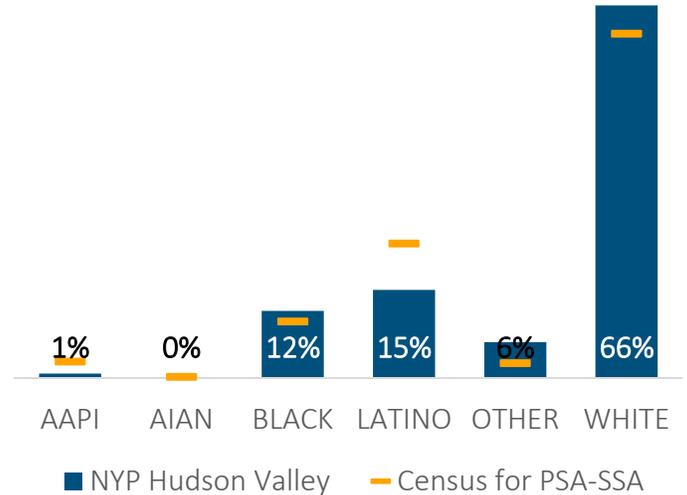
Map of NYP Hudson Valley Service Area

■ Primary Service Area (PSA); 50% of Jan – Jun 2022 discharges

☐ Secondary Service Area (SSA); 75% of Jan – Jun 2022 discharges

01 Campus-specific Data

NewYork-Presbyterian Westchester: Racial and ethnic distribution of population in the NYP Westchester service area versus racial and ethnic distribution of all inpatients from January – June 2022

Blue bars represent the self-reported race/ethnicity distribution of all inpatients at NYP Westchester

Orange lines represent the weighted-average race/ethnicity distribution from the 2020 US Census for people living in NYP Westchester's primary and secondary service area, illustrated in the map.

Bar chart values:
AAPI 1%, AIAN 0%, BLACK 25%, LATINO 19%, OTHER 10%, WHITE 45%

Legend: ■ NYP Westchester — Census for PSA-SSA

Map of NYP Westchester Service Area

■ Primary Service Area (PSA); 50% of Jan – Jun 2022 discharges
■ Secondary Service Area (SSA); 75% of Jan – Jun 2022 discharges

01 Campus-specific Data

NewYork-Presbyterian Lower Manhattan Hospital: Racial and ethnic distribution of population in the NYP Lower Manhattan service area versus racial and ethnic distribution of all inpatients from January – June 2022

Blue bars represent the self-reported race/ethnicity distribution of all inpatients at NYP Lower Manhattan

Orange lines represent the weighted-average race/ethnicity distribution from the 2020 US Census for people living in NYP Lower Manhattan's primary and secondary service area, illustrated in the map.

AAPI	AIAN	BLACK	LATINO	OTHER	WHITE
35%	0%	16%	18%	6%	25%

■ NYP Lower Manhattan — Census for PSA-SSA

Map of NYP Lower Manhattan Service Area

■ Primary Service Area (PSA); 50% of Jan – Jun 2022 discharges

□ Secondary Service Area (SSA); 75% of Jan – Jun 2022 discharges
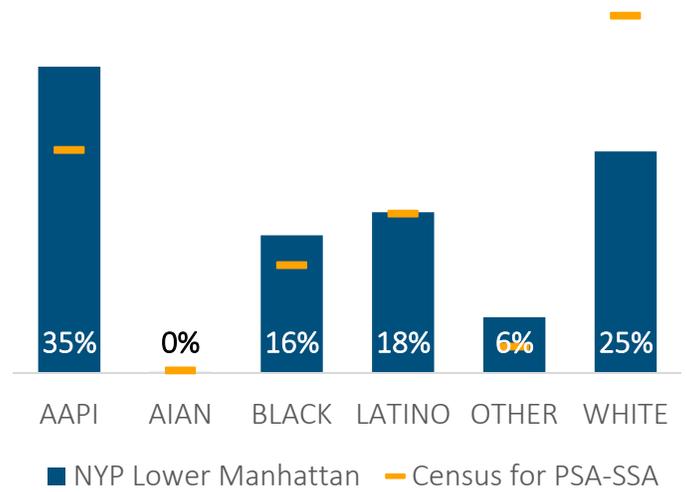
01 Campus-specific Data

NewYork-Presbyterian Morgan Stanley Children's Hospital: Racial and ethnic distribution of population in the NYP Morgan Stanley service area versus racial and ethnic distribution of all inpatients from January – June 2022

Blue bars represent the self-reported race/ethnicity distribution of all inpatients at NYP Morgan Stanley

Orange lines represent the weighted-average race/ethnicity distribution from the 2020 US Census for people living in NYP Morgan Stanley's primary and secondary service area, illustrated in the map.

Bar chart values:
- AAPI: 5%
- AIAN: 0%
- BLACK: 12%
- LATINO: 45%
- OTHER: 6%
- WHITE: 31%

Legend: ■ NYP Morgan Stanley — Census for PSA-SSA
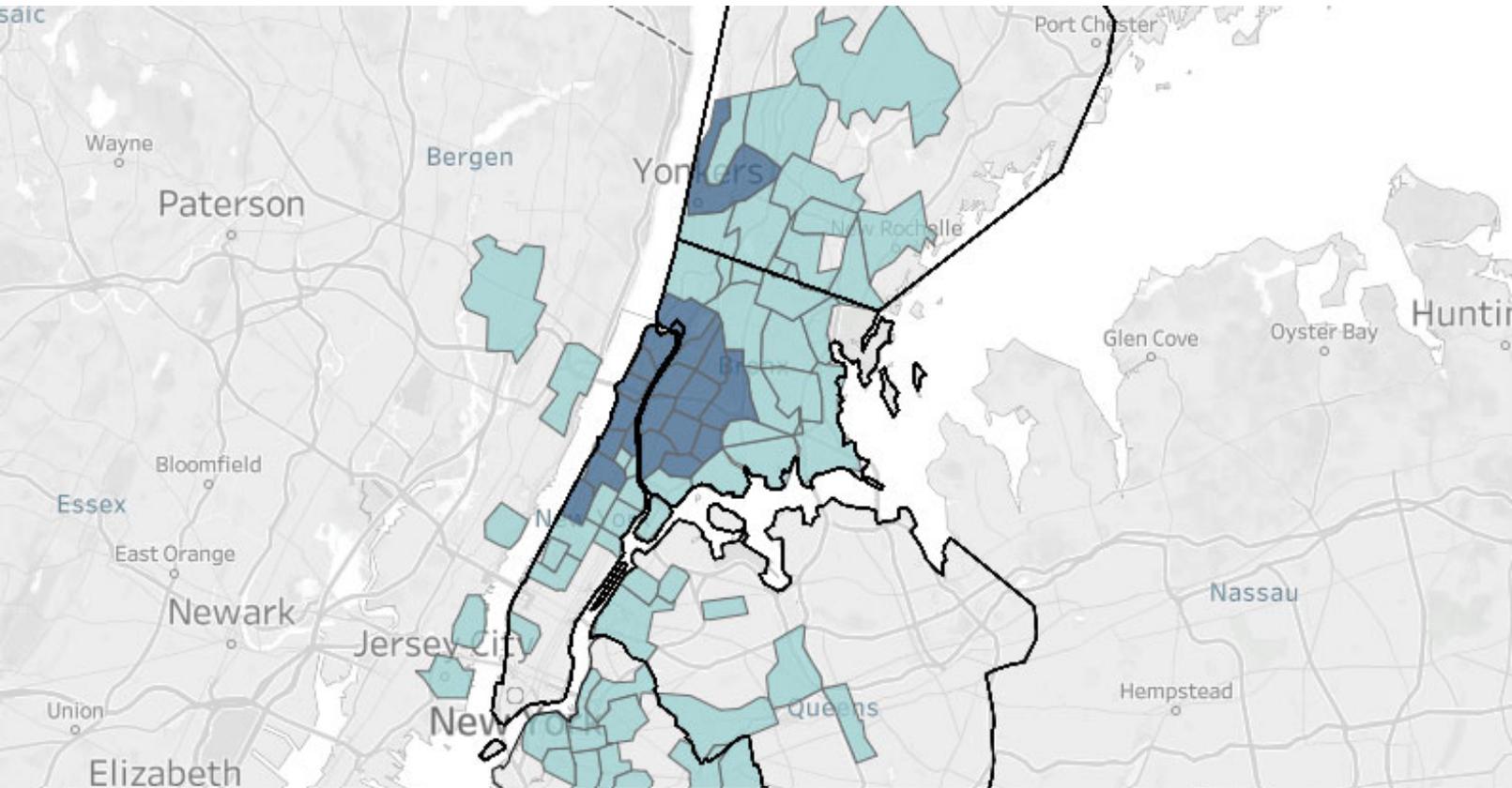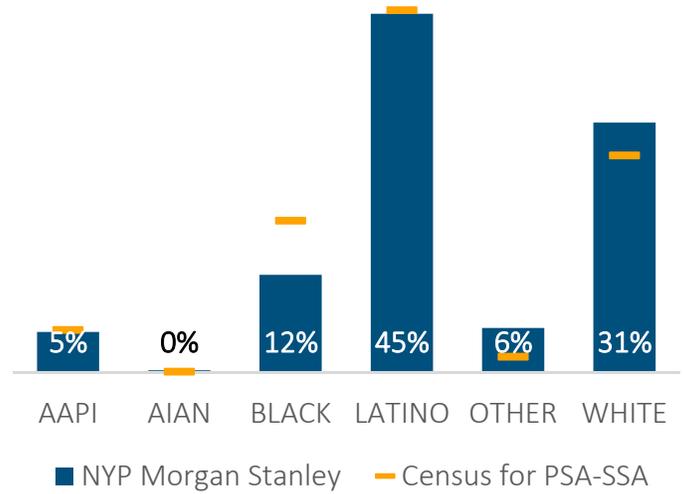
Map of NYP Morgan Stanley Service Area
■ Primary Service Area (PSA); 50% of Jan – Jun 2022 discharges
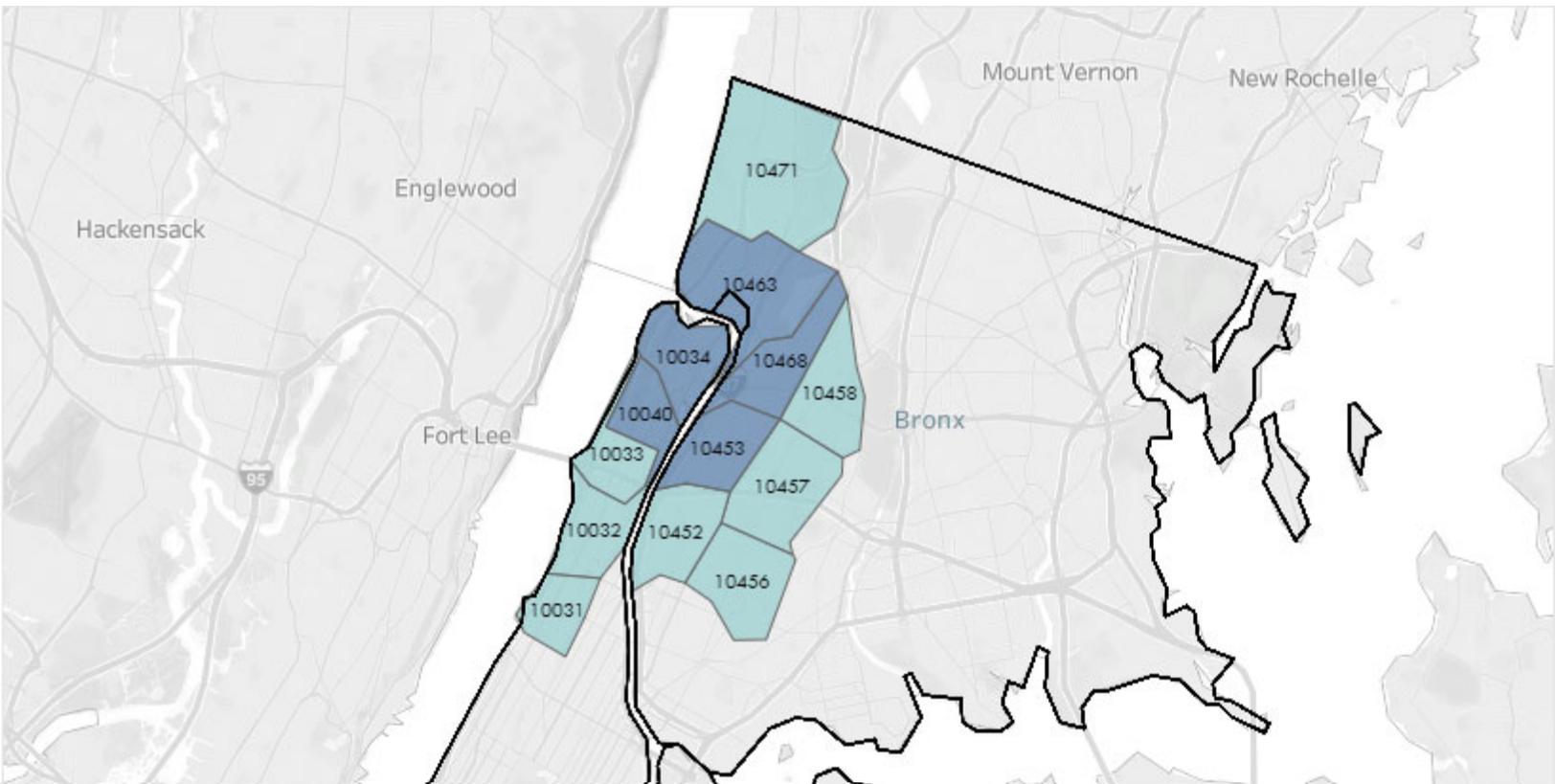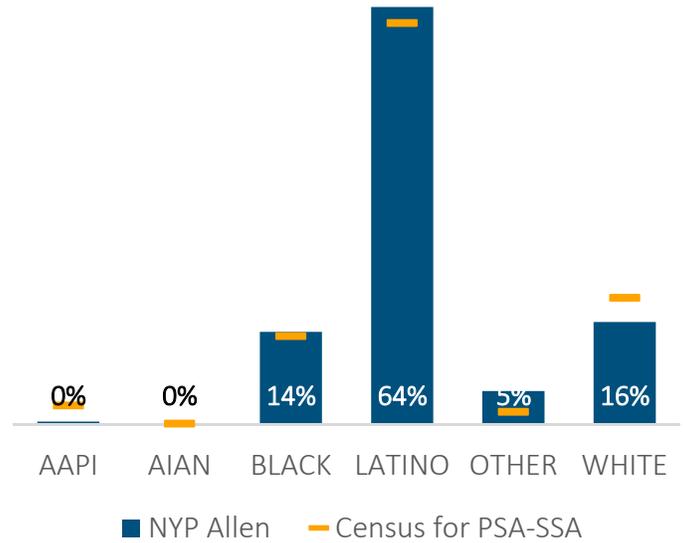□ Secondary Service Area (SSA); 75% of Jan – Jun 2022 discharges

01 Campus-specific Data

NewYork-Presbyterian Queens: Racial and ethnic distribution of population in the NYP Queens service area versus racial and ethnic distribution of all inpatients from January – June 2022

Blue bars represent the self-reported race/ethnicity distribution of all inpatients at NYP Queens

Orange lines represent the weighted-average race/ethnicity distribution from the 2020 US Census for people living in NYP Queens' primary and secondary service area, illustrated in the map.

AAPI	AIAN	BLACK	LATINO	OTHER	WHITE
35%	0%	11%	23%	7%	24%

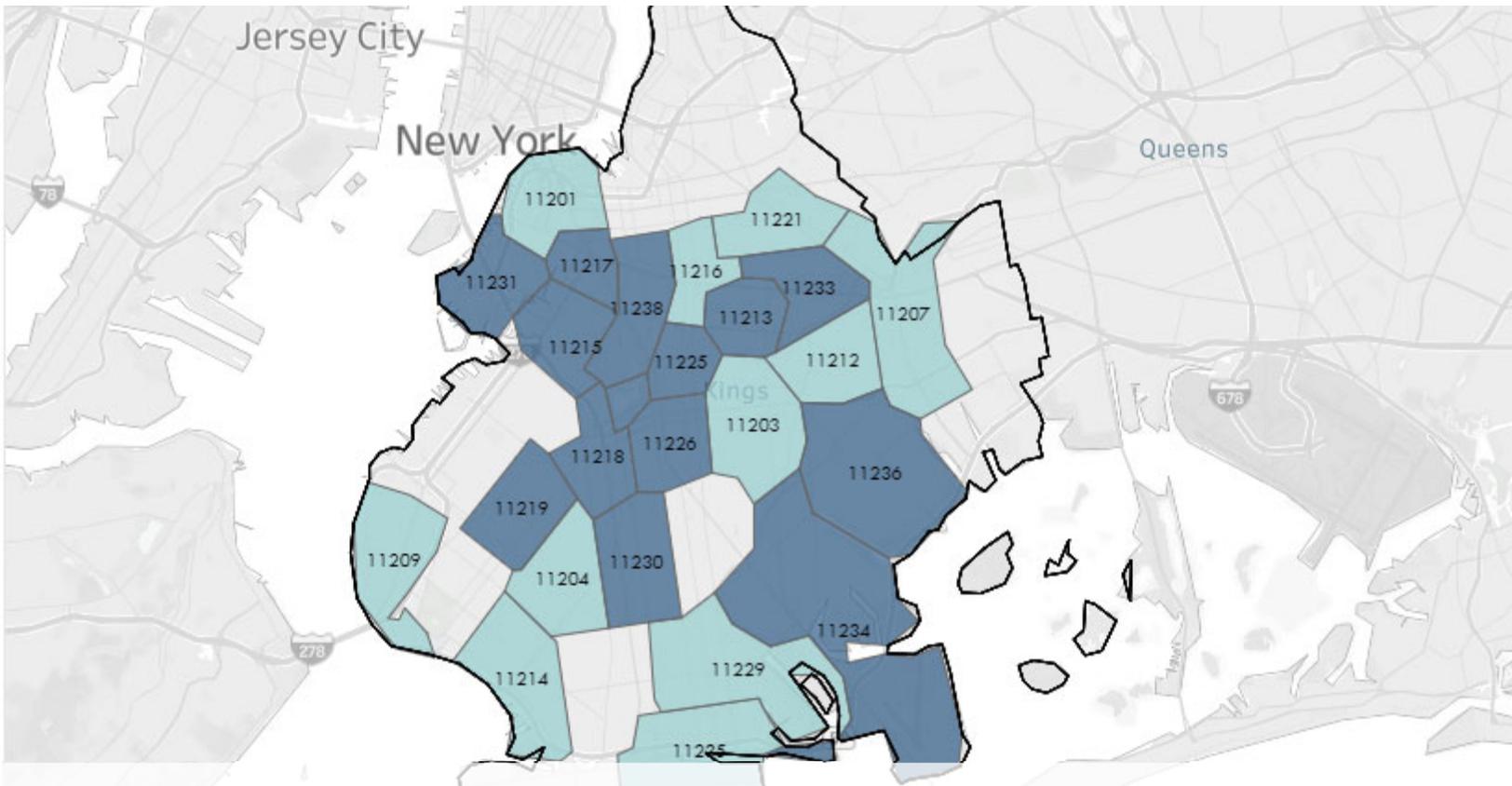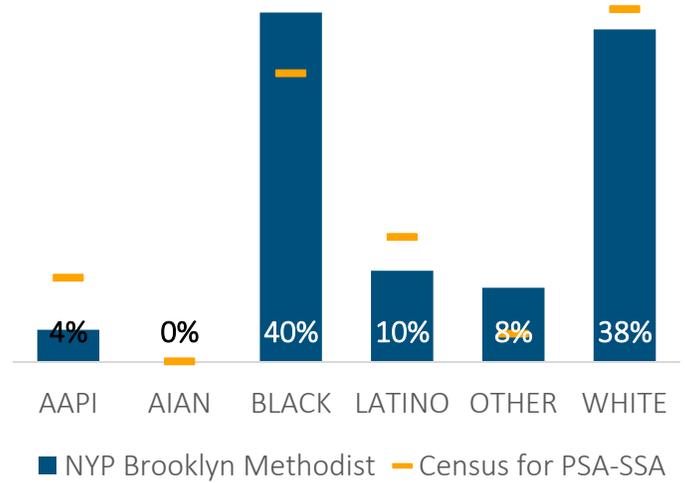■ NYP Queens — Census for PSA-SSA
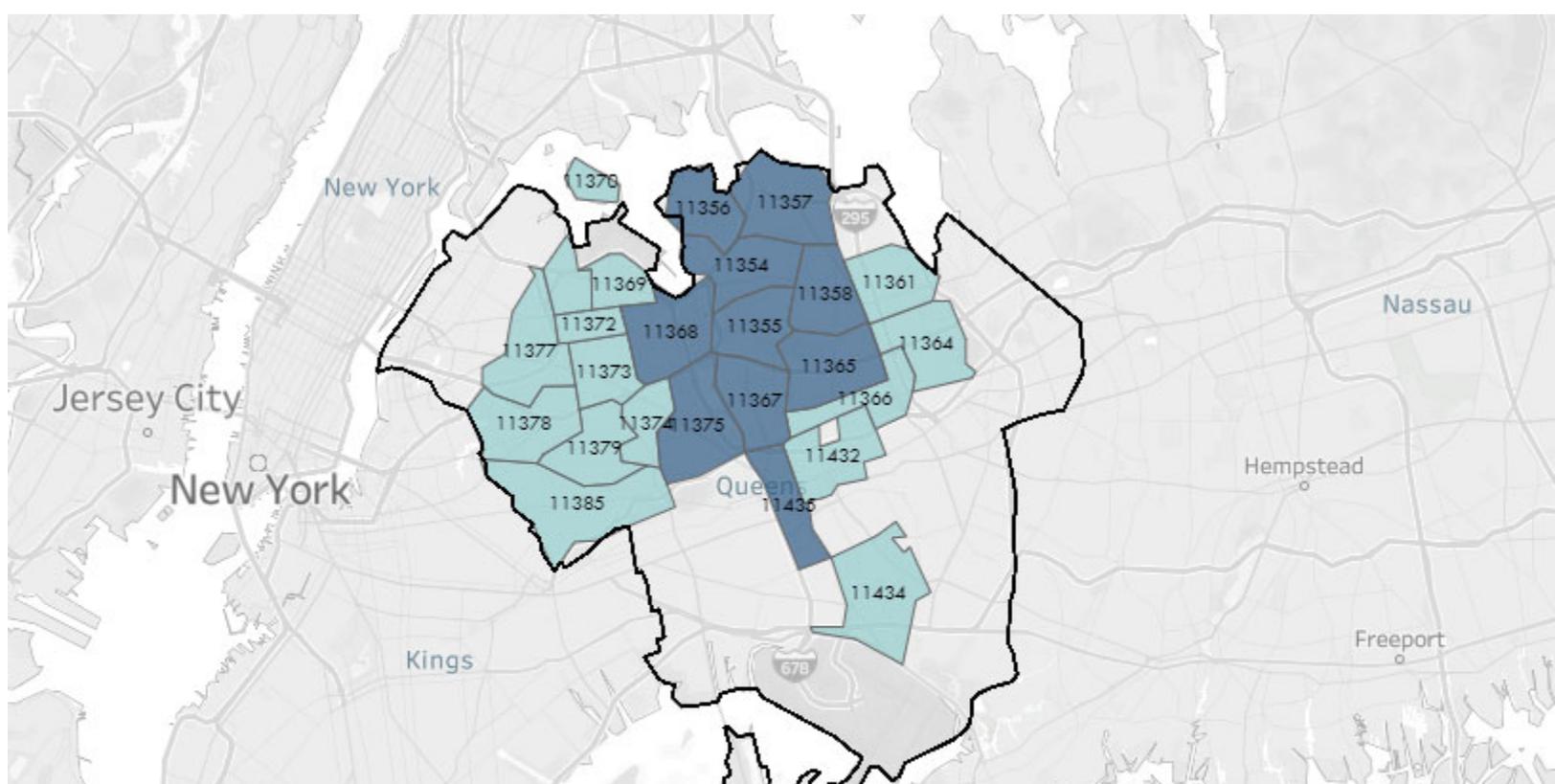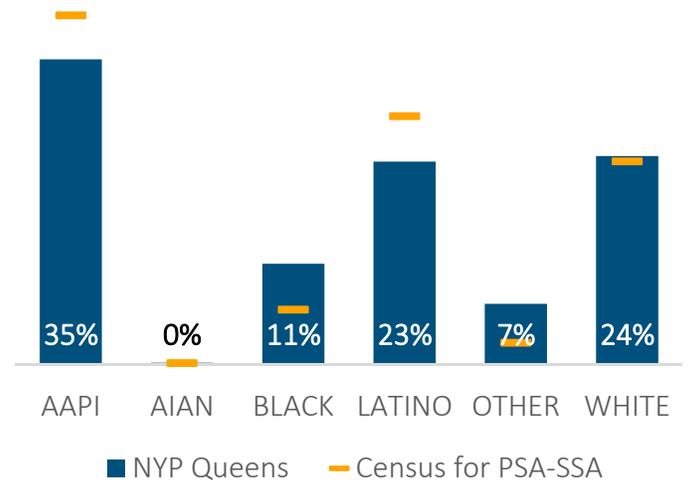
Map of NYP Queens Service Area

■ Primary Service Area (PSA); 50% of Jan – Jun 2022 discharges

□ Secondary Service Area (SSA); 75% of Jan – Jun 2022 discharges

01 Campus-specific Data

NewYork-Presbyterian/Weill Cornell Medical Center: Racial and ethnic distribution of population in the NYP/Weill Cornell service area versus racial and ethnic distribution of all inpatients from January – June 2022

Blue bars represent the self-reported race/ethnicity distribution of all inpatients at NYP/Weill Cornell

Orange lines represent the weighted-average race/ethnicity distribution from the 2020 US Census for people living in NYP/Weill Cornell's primary and secondary service area, illustrated in the map.

AAPI	AIAN	BLACK	LATINO	OTHER	WHITE
12%	0%	12%	13%	6%	57%

■ NYP/Weill Cornell   ━ Census for PSA-SSA

Map of NYP/Weill Cornell Service Area

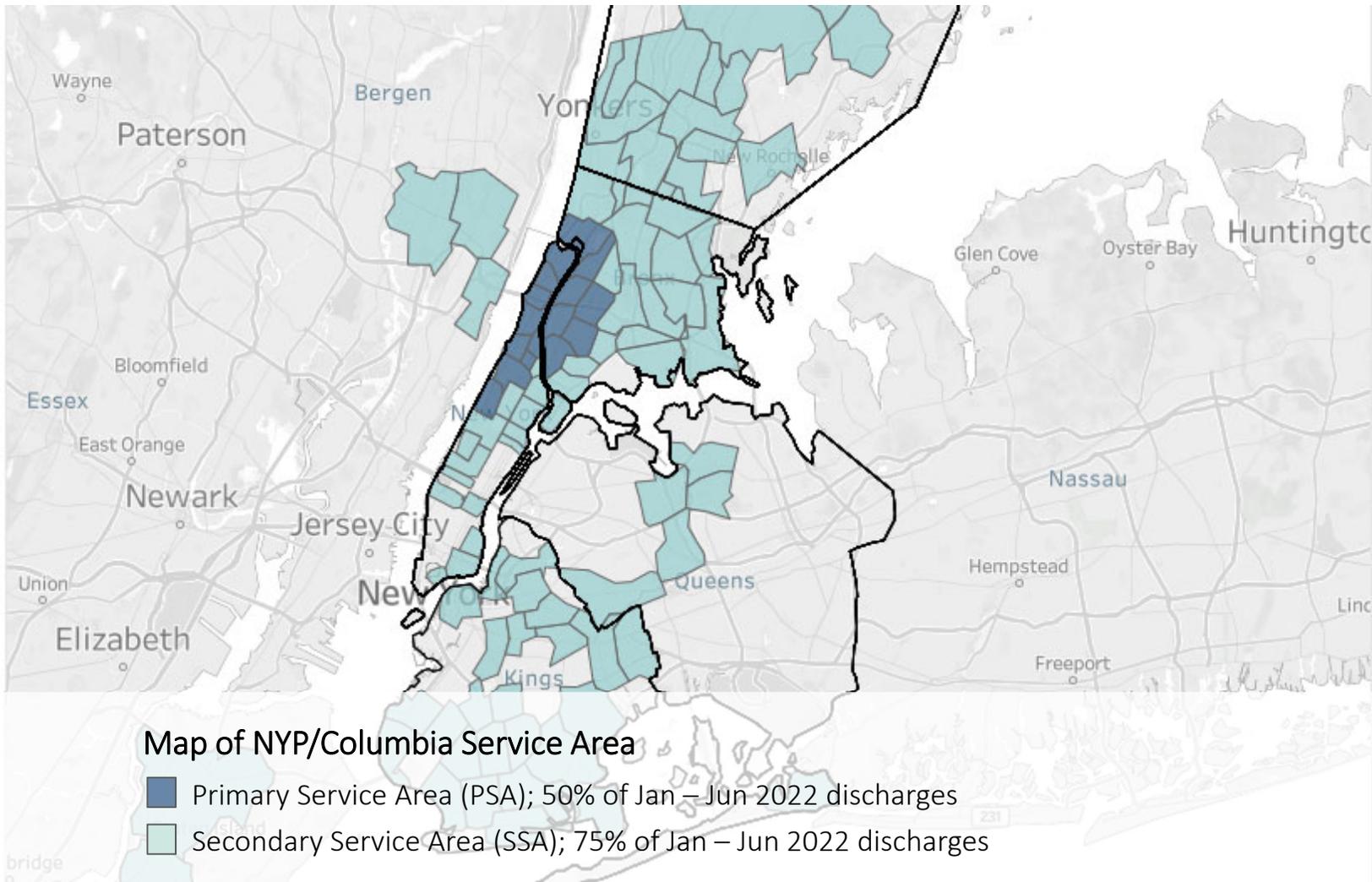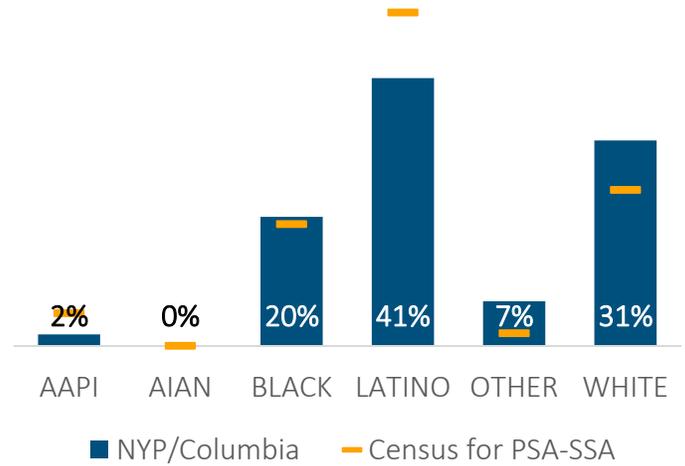■ Primary Service Area (PSA); 50% of Jan – Jun 2022 discharges
□ Secondary Service Area (SSA); 75% of Jan – Jun 2022 discharges
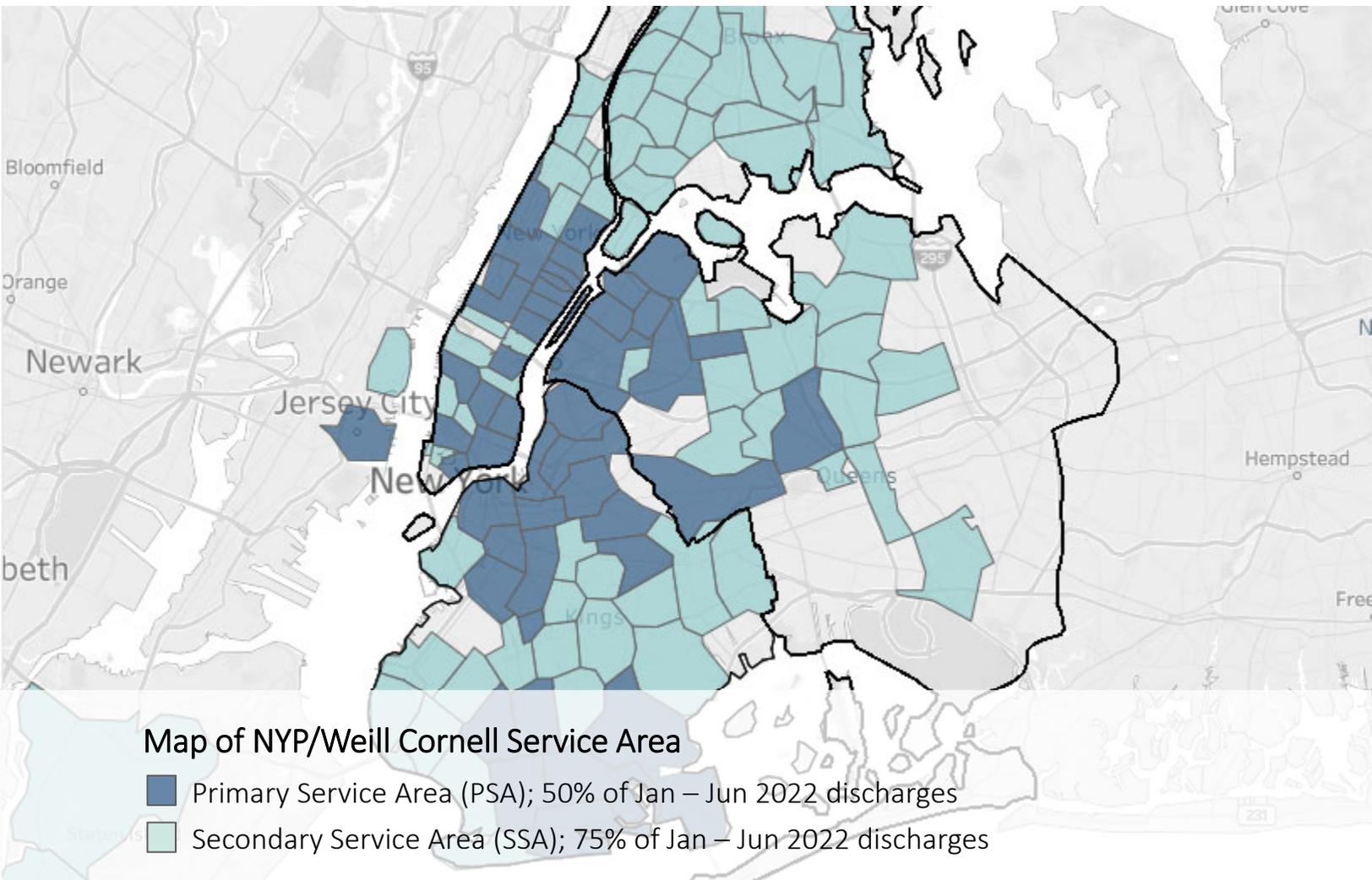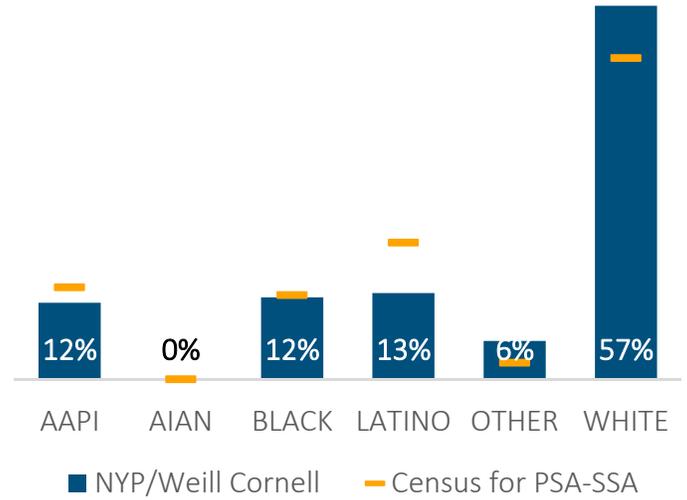
NewYork-Presbyterian Westchester Behavioral Health Center: Racial and ethnic distribution of population in the NYP Westchester Behavioral Health service area versus racial and ethnic distribution of all inpatients from January – June 2022

Blue bars represent the self-reported race/ethnicity distribution of all inpatients at NYP Westchester Behavioral Health

Orange lines represent the weighted-average race/ethnicity distribution from the 2020 US Census for people living in NYP Westchester Behavioral Health's primary and secondary service area, illustrated in the map.

Bar chart:

AAPI	AIAN	BLACK	LATINO	OTHER	WHITE
4%	0%	21%	23%	9%	42%

■ NYP Westchester Behavioral Health
— Census for PSA-SSA
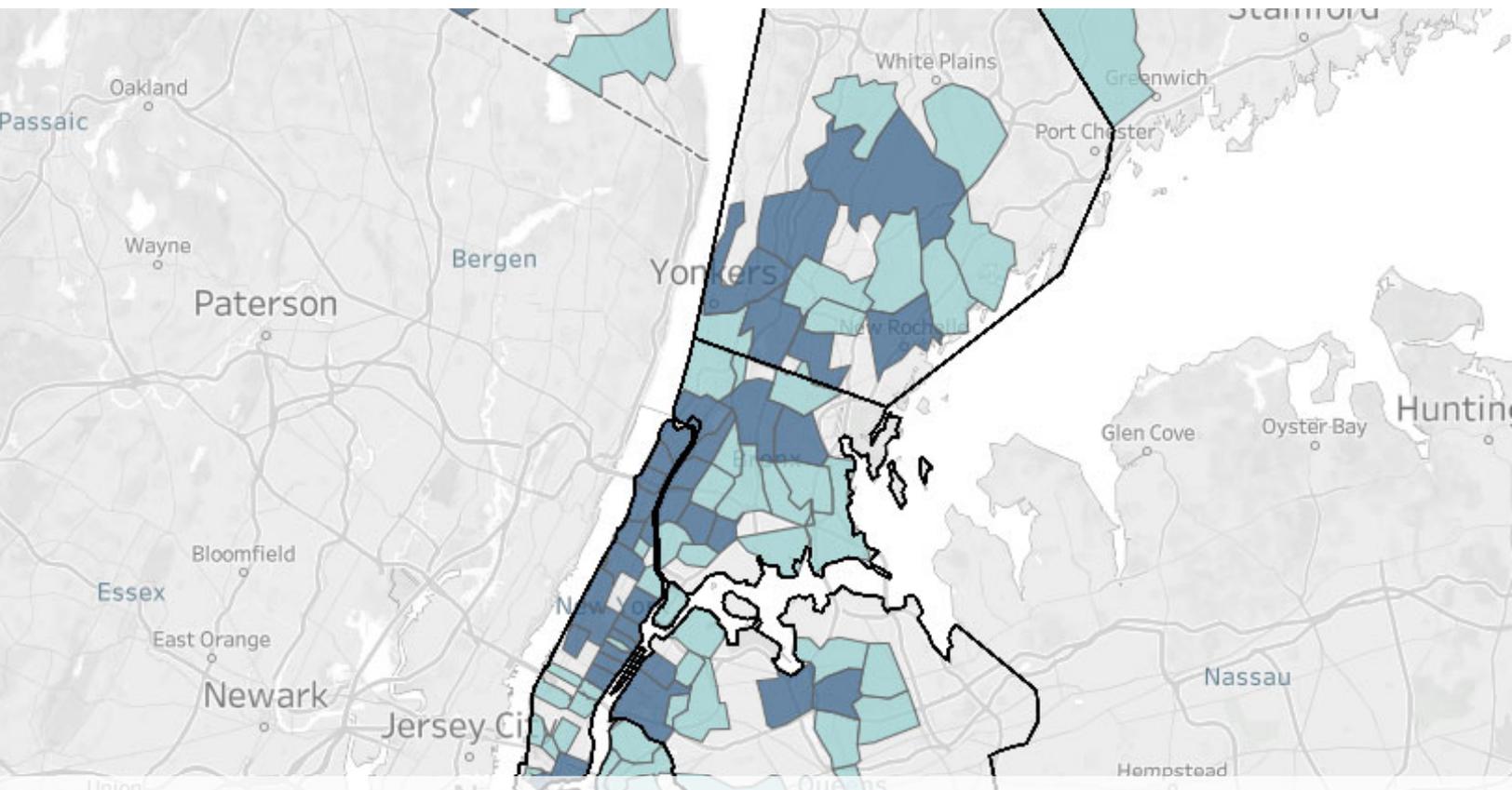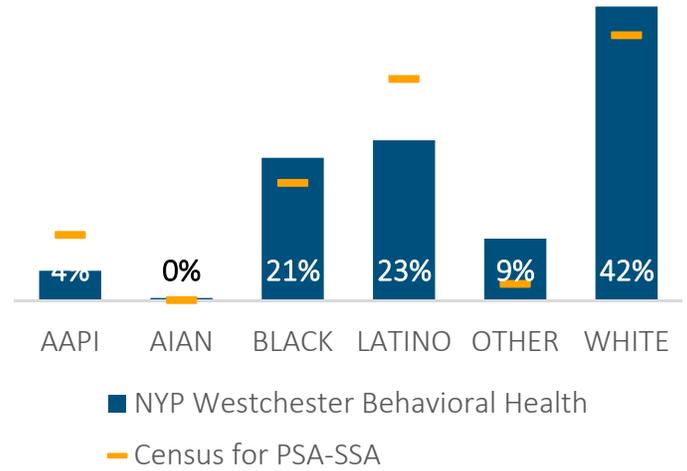
Map of NYP Westchester Behavioral Health Service Area

■ Primary Service Area (PSA); 50% of Jan – Jun 2022 discharges
☐ Secondary Service Area (SSA); 75% of Jan – Jun 2022 discharges

02 Service Line-specific Data
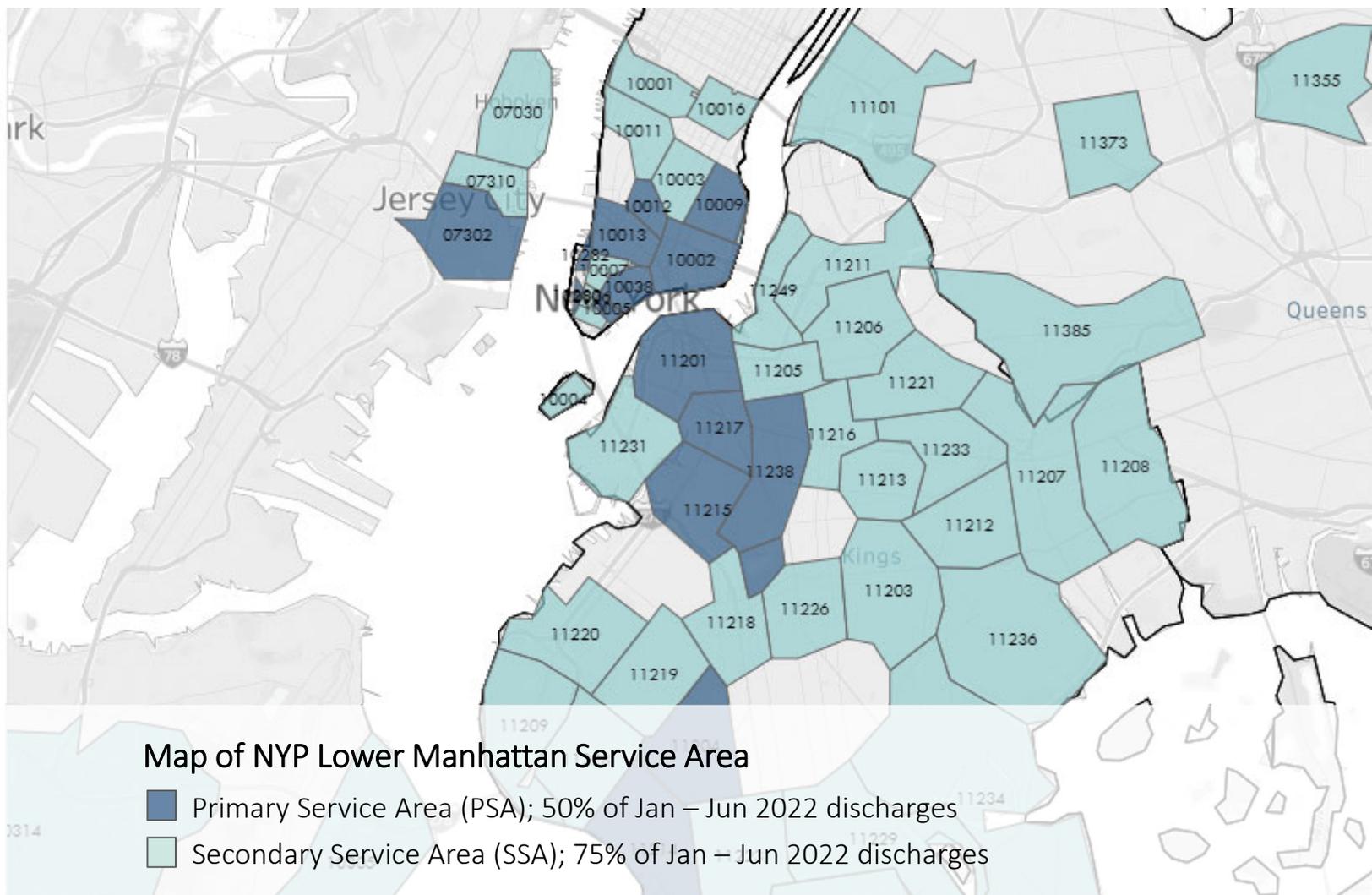
Charts show the racial and ethnic distribution of population in the five county service area versus racial and ethnic distribution of Jan - Jun 2022 NewYork-Presbyterian inpatients by service

Cardiovascular

AAPI	AIAN	BLACK	LATINO	OTHER	WHITE
9%	0%	24%	22%	7%	38%

■ Cardiovascular — Census Data

Children's

AAPI	AIAN	BLACK	LATINO	OTHER	WHITE
8%	0%	16%	35%	8%	34%

■ Children's — Census Data

Digestive

AAPI	AIAN	BLACK	LATINO	OTHER	WHITE
10%	0%	20%	29%	6%	35%

■ Digestive — Census Data

Medicine

AAPI	AIAN	BLACK	LATINO	OTHER	WHITE
10%	0%	22%	25%	6%	37%

■ Medicine — Census Data

Neurosciences

AAPI	AIAN	BLACK	LATINO	OTHER	WHITE
12%	0%	20%	21%	7%	39%

■ Neurosciences — Census Data

37
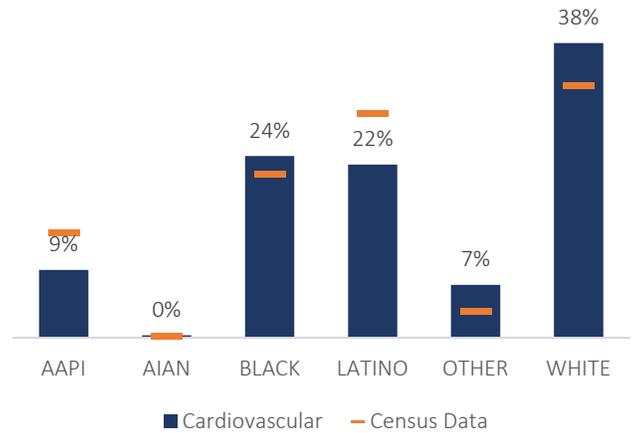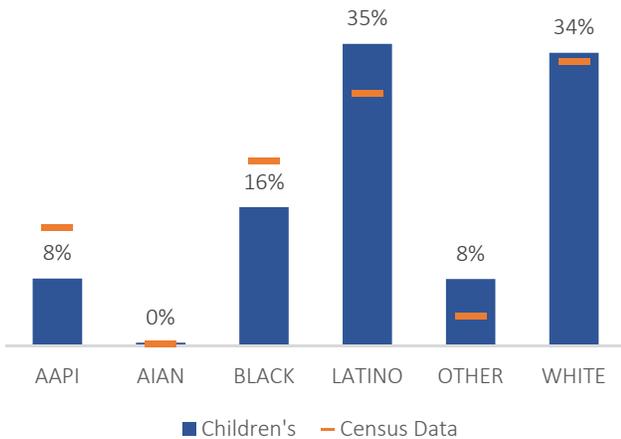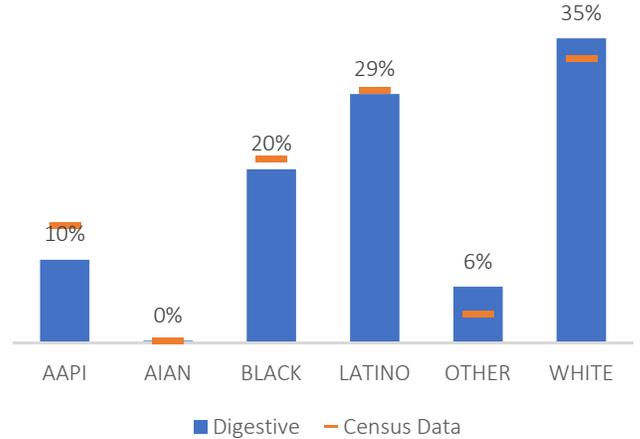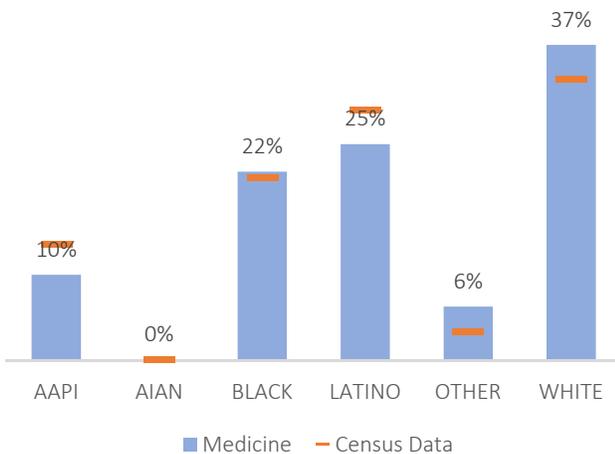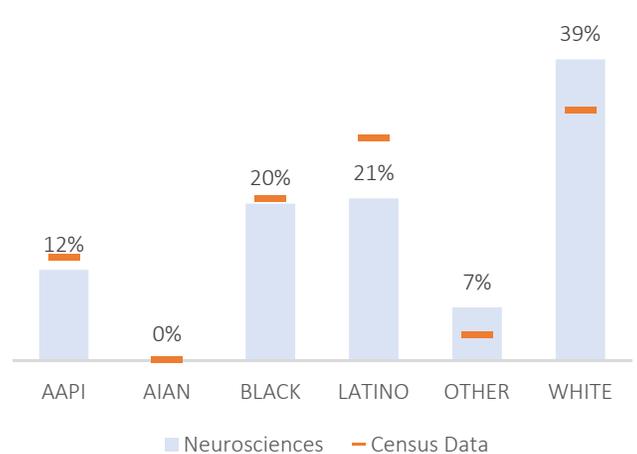
02 Service Line-specific Data

Oncology - Hematology
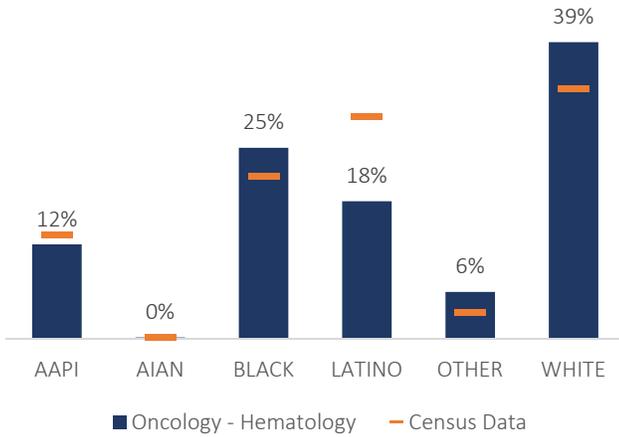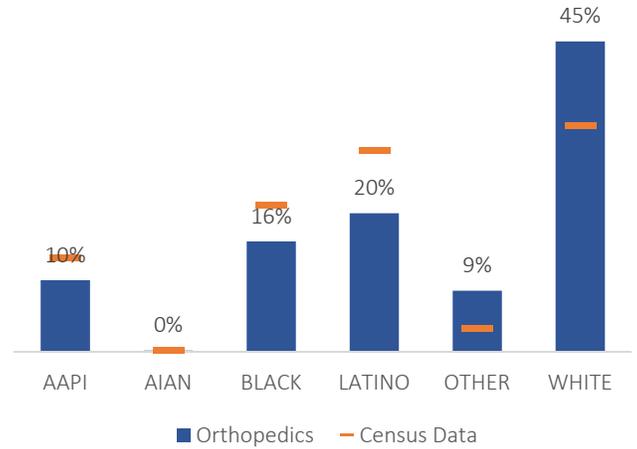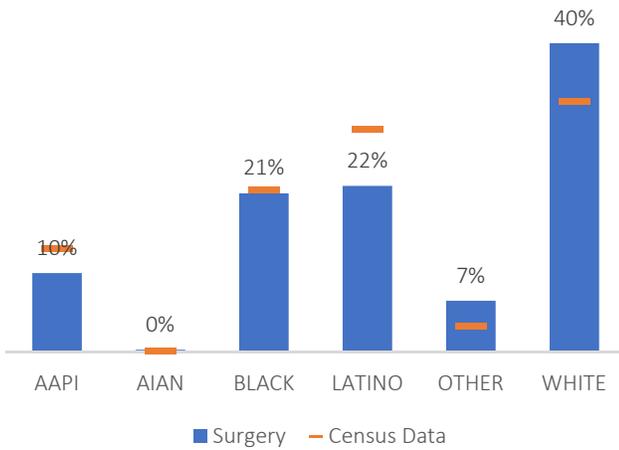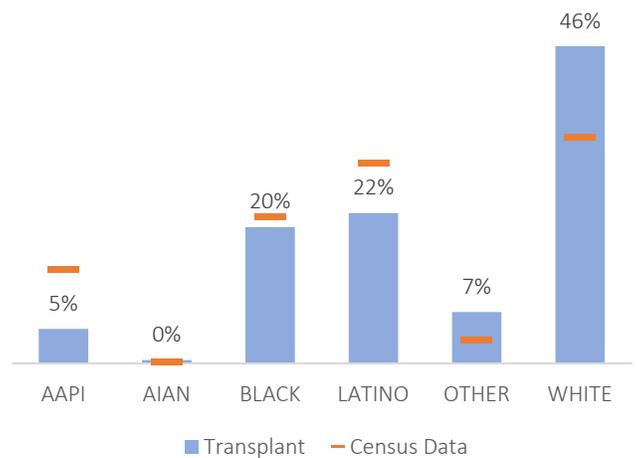
- AAPI 12%
- AIAN 0%
- BLACK 25%
- LATINO 18%
- OTHER 6%
- WHITE 39%

■ Oncology - Hematology — Census Data

Orthopedics

- AAPI 10%
- AIAN 0%
- BLACK 16%
- LATINO 20%
- OTHER 9%
- WHITE 45%

■ Orthopedics — Census Data

Surgery

- AAPI 10%
- AIAN 0%
- BLACK 21%
- LATINO 22%
- OTHER 7%
- WHITE 40%

■ Surgery — Census Data

Transplant

- AAPI 5%
- AIAN 0%
- BLACK 20%
- LATINO 22%
- OTHER 7%
- WHITE 46%

■ Transplant — Census Data

Gynecology, OB, & Newborns

- AAPI 16%
- AIAN 0%
- BLACK 12%
- LATINO 27%
- OTHER 6%
- WHITE 39%

■ Gynecology, OB, & Newborns — Census Data
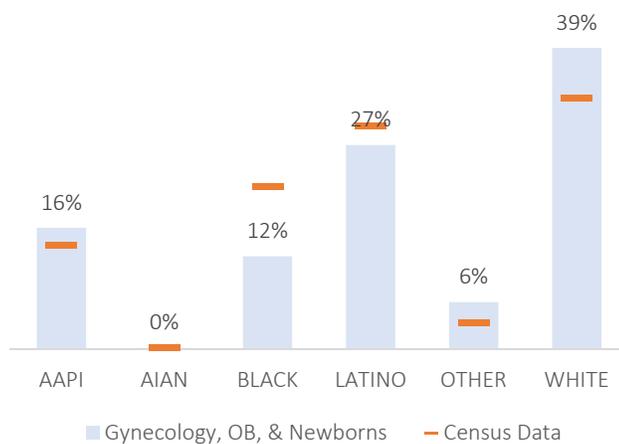
Blue bars represent the self-reported race/ethnicity distribution of all inpatients at NewYork-Presbyterian during January – June 2022, grouped by service line

Orange lines represent the weighted-average race/ethnicity distribution from the 2020 US Census for people living in NewYork-Presbyterian 5-county service area, including Manhattan, Brooklyn, Queens, Bronx, and Westchester.

Service lines associated with exempt units (e.g. Rehabilitation, Psych, and Burn are not shown)

AAPI: Non-Latino Asian American Pacific Islander; AIAN: Non-Latino Native American and Alaska Natives; BLACK: Non-Latino Black or African American; Latino: Latino/a/x or Hispanic; White: Non-Latino White; Other: Other not described.

03 Campus-specific Obstetric Data

Charts show the 2020 US Census racial and ethnic distribution of the population in each campus' service area versus the racial and ethnic distribution of Jan - Jun 2022 births for each NewYork-Presbyterian campus.

NYP Allen

Category	Value
AAPI	0%
AIAN	0%
BLACK	8%
LATINO	87%
OTHER	3%
WHITE	3%

Legend: ■ NYP Allen — Census for NYP Allen Service Area

NYP Brooklyn Methodist

Category	Value
AAPI	3%
AIAN	0%
BLACK	24%
LATINO	8%
OTHER	6%
WHITE	59%

Legend: ■ NYP Brooklyn Methodist — Census for NYP Brooklyn Methodist Service Area

NYP Hudson Valley

Category	Value
AAPI	1%
AIAN	0%
BLACK	10%
LATINO	37%
OTHER	8%
WHITE	45%

Legend: ■ NYP Hudson Valley — Census for NYP Hudson Valley Service Area

NYP Lower Manhattan

Category	Value
AAPI	43%
AIAN	0%
BLACK	8%
LATINO	9%
OTHER	5%
WHITE	35%

Legend: ■ NYP Lower Manhattan — Census for NYP Lower Manhattan Service Area

03 Campus-specific Obstetric Data

NYP Morgan Stanley

Race/Ethnicity	NYP Morgan Stanley
AAPI	6%
AIAN	0%
BLACK	12%
LATINO	44%
OTHER	6%
WHITE	32%

■ NYP Morgan Stanley   ▬ Census for NYP Morgan Stanley Service Area

NYP Queens

Race/Ethnicity	NYP Queens
AAPI	49%
AIAN	0%
BLACK	10%
LATINO	22%
OTHER	8%
WHITE	12%

■ NYP Queens   ▬ Census for NYP Queens Service Area

NYP/Weill Cornell

Race/Ethnicity	NYP/Weill Cornell
AAPI	16%
AIAN	0%
BLACK	7%
LATINO	11%
OTHER	6%
WHITE	61%

■ NYP/Weill Cornell   ▬ Census for NYP/Weill Cornell Service Area

NYP Westchester

Race/Ethnicity	NYP Westchester
AAPI	2%
AIAN	1%
BLACK	25%
LATINO	28%
OTHER	19%
WHITE	25%

■ NYP Westchester   ▬ Census for NYP Westchester Service Area

Blue bars represent the self-reported race/ethnicity distribution of birthing persons at each NewYork-Presbyterian campus during January – June 2022

Orange lines represent the weighted-average race/ethnicity distribution from the 2020 US Census for people living in the service area of each NewYork-Presbyterian campus.

Births defined by DRG.

AAPI: Non-Latino Asian American Pacific Islander; AIAN: Non-Latino Native American and Alaska Natives; BLACK: Non-Latino Black or African American; Latino: Latino/a/x or Hispanic; White: Non-Latino White; Other: Other not described.

Thank You

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We Ask Because We Care Initiative Overview

NewYork-Presbyterian and our academic partners at Columbia University Irving Medical Center and Weill Cornell Medicine celebrate the diverse people and communities we serve. We pledge to give every patient the best care possible regardless of race, ethnicity, age, gender identity or expression, sexual orientation, cultural background, or language. To support this mission, we have launched "We Ask Because We Care", an enterprise-wide approach to improve race, ethnicity, and language data, which includes five core elements:

- **Enterprise Commitment:** A workgroup, with leadership support and participation, dedicated to developing and implementing NYP-enterprise goals for improving data collection.
- **Technical Support:** A strong partnership with IT to ensure all aspects of data collection are seamless, convenient, and patient-friendly.
- **Staff Education:** A series of training sessions, resources, and regular communications to help staff understand our patients and their diverse needs.
- **Patient Communication:** A multi-pronged approach to raise patients' awareness about our efforts, encourage them to provide information about themselves, and build trust that this information is confidential and will help us internally identify and address disparities in care. Please see our "We Ask Because We Care" campaign at https://www.nyp.org/daliocenter/we-ask-because-we-care
- **Monitoring and Targeted Intervention:** An enterprise-wide strategy to measure, monitor, and assess improvement over time. Several monitoring tools have been developed, including dashboards and focused 'push' reports that help staff monitor progress.

We Ask Because We Care Resources

We have combined all of the resources developed in the program into a toolkit, which is available on the Dalio Center page of the NYP infonet. Key elements include:

1. **Program Overview:** An article published in NEJM Catalyst describing key elements of our program, along with recommendations for improving race and ethnicity data collection with more limited resources.
2. **Staff Education Materials:** Materials to support front-desk staff training, including a video on race, ethnicity, and language collection, a video on sexual orientation, name, and pronoun collection, powerpoint presentations based on our training video, a detailed tip-sheet for staff, and a short letter to staff about the initiative.
3. **Patient Communication:** Copies of patient-facing materials, which are also available translated on our external-facing website.

About the Dalio Center for Health Justice

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The Dalio Center for Health Justice at NewYork-Presbyterian (www.nyp.org/dalio-center) aims to understand and address the root causes of health inequities with the goal of setting a new standard of health justice for our patients, our team members, and the communities we serve. Through the Dalio Center, we invest in research, education, and programing, and advocate for policy change to drive measurable improvements in health outcomes for all. Because 80% of health outcomes are driven by social, behavioral, and environmental, our work is not limited to addressing health care access and quality. We will also support community initiatives, understanding and championing economic empowerment, social engagement, workforce development, neighborhood revitalization, and education.

In order to understand the health outcomes that are disproportionately affecting our communities, we are building on a network of ongoing projects and initiatives across NewYork-Presbyterian and our academic medical partners, Columbia University Vagelos College of Physicians and Surgeons and Weill Cornell Medicine. The Dalio Center will harness the power of our three institutions, expanding our capacity to create impact. In partnership with local community organizations and government agencies, we will make real progress in eliminating the health inequities that undermine our communities.

NewYork-Presbyterian
Dalio Center for Health Justice

We Ask Because We Care!

NewYork-Presbyterian, Columbia, and Weill Cornell Medicine celebrate the diverse people and communities we serve. We pledge to give **every** patient the best care possible regardless of race, ethnicity, gender identity, sexual orientation, cultural background, or language.

We will strive to make sure all patients have **equal access** to the highest quality of care. To support this mission, we will ask you questions about your background and preferred language. You can update your information today at **www.myconnectnyc.org**.

Your information is confidential. Sharing it is your choice. But **we ask because we care** about you and the health and wellbeing of all our patients.

At NewYork-Presbyterian, Columbia, and Weill Cornell Medicine, we put patients first.

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Dalio Center for Health Justice

The Validation of Race and Ethnicity Data at NYP

At NewYork-Presbyterian, Weill Cornell, and Columbia, we collect information on race and ethnicity to ensure that patients of all backgrounds receive equitable and quality healthcare. Documenting and analyzing the race and ethnicity of our patients allows us to identify health disparities within our healthcare system, which we can later address through targeted interventions. We acknowledge that race is a social construct and not a valid way to understand human difference; however, race shapes the lives, opportunities, and health of many. Collecting data on race and ethnicity is therefore fundamental to our ability to deliver the best care possible to the communities that we serve.

To maximize the efficiency and effectiveness of our health equity and justice projects, the race and ethnicity data we collect must be reliable, accurate, and as complete as possible. A thorough and valid understanding of the communities we serve allows us to create impactful intervention strategies and allocate resources where they are most needed. We employ several data validation strategies to maintain our race and ethnicity data at a high standard of quality, which include the following:

- Standardizing data collection fields in Epic
- Compiling multimodal race and ethnicity data
- Monitoring data collection rates
- Comparing Epic data to census and patient experience data
- Conducting targeted data reviews

Standardizing Data Collection Fields in Epic

At NYP, race and ethnicity are documented in patients' health records in Epic. Following the recommendation of the New York State Department of Health and in alignment with US Census standards, questions of race and ethnicity in Epic are presented as follows across our campuses:

We have standardized the order in which our questions of patient race and ethnicity are presented in the Epic system as research shows that asking ethnicity before race increases response rate, particularly within the Latino/a/x community. To minimize the number of "NULL," or missing values for race and ethnicity within our system, our race and ethnicity questions are required fields in Epic, and we provide patients with the option to decline to answer. We also train our staff how to appropriately ask for race and ethnicity and to remind patients that they can select more than one option under the race field. This has been a successful strategy to improve data capture, as it optimizes patient response rates and increases the completeness of our datasets.

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Compiling Multimodal Race and Ethnicity Data

There are several opportunities for patients to provide their race and ethnicity before, during, and after a visit and each of those data capture points happen within Epic workflows or the Epic patient portal. For example, a scheduler may enter a patient's race and ethnicity in Epic, but it is also possible that a patient may enter their own race and ethnicity through their Epic patient portal. Regardless of when race and ethnicity are documented, these data points are always stored in Epic, which is then accessible by the patient's care team and our data analysts. Further, historical values are accessible to data analysts.

Monitoring Data Collection Rates

We have developed several race and ethnicity dashboards through which we can monitor race and ethnicity documentation in Epic in real time. The dashboards, pictured below, provide a visual representation of combined race and ethnicity documentation rates by campus over time:

Combined Race and Ethnicity Documentation

Campus	%	%
NYP-AH	86%	5%
NYP-BMH	75%	9%
NYP-CU	79%	6%
NYP-HVH	79%	7%
NYP-LH	80%	9%
NYP-LMH	85%	6%
NYP-MSCH	83%	6%
NYP-Q	82%	11%
NYP-WC	77%	6%
NYP-WD	85%	8%
NYPMG-BMH	73%	7%
NYPMG-HV	64%	12%
NYPMG-Q	61%	19%
NYPMG-WD	64%	16%
WC-PO	70%	6%
CU-PO	70%	6%
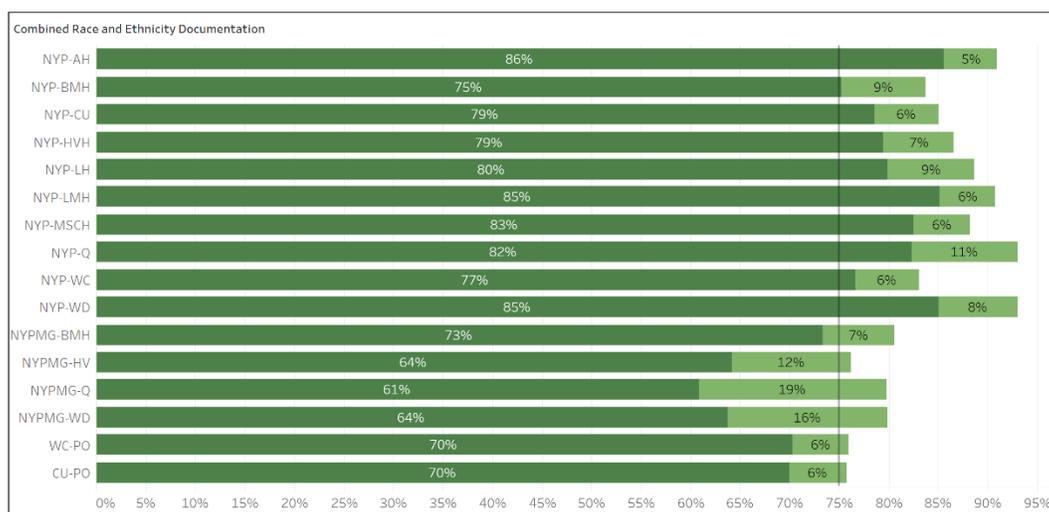
Through our dashboards, our team regularly monitors data completion rates on all campuses and aims to achieve a 90% race and ethnicity response rate. Our dashboards also allow us to monitor key statistics such as "Other / Not Specified" response rates. High "Other / Not Specified" response rates may indicate issues with existing data collection categories or methodologies and therefore compromise the validity of our data sets. These dashboards are also shared with our registration and access leaders for review.

In 2021 and 2022, we conducted a large-scale review of our database to identify departments and divisions with suboptimal race and ethnicity data capture rates. We then launched several focused initiatives to improve and monitor data collection in those identified departments to increase the completeness of our data set. For example, during our review, we found low rates of race and ethnicity capture among delivering persons and newborns. To address this finding, we developed procedures to increase documentation and now monitor capture rates through weekly emails sent to all clinical and administrative delivery teams at NYP. These emails detail the combined race and ethnicity data corresponding to the campuses of each

team. Staff are instructed to keep track of the demographic makeups of the populations that they serve as well as their overall data completion rates and alert the Dalio Center if they observe unusual or concerning trends.

Comparing Epic Data to Census Data

As a method of validating the accuracy of the data we collect, we annually compare our documented race and ethnicity percentages in Epic to census-derived population estimates based on the zip codes in which our patients reside. In comparing the racial and ethnic distributions of our patient populations with the predicted distributions according to census data, we can gauge if we are accurately documenting race and ethnicity throughout our campuses. When notable differences are identified between the real and predicted values, the campus is notified, and the cause of the discrepancy is investigated.

Comparing Epic Data to Patient Experience Survey Data

Beginning in 2023, we also validate the distribution of race and ethnicity data documented in Epic by comparing it to race and ethnicity data collected via the HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) survey. This survey measures patients' perceptions of their hospital experiences and includes questions regarding patients' racial and ethnic backgrounds. Since these surveys are completed by directly patients, without a staff intermediary, they are an excellent source of self-reported data. Our data analysts thoroughly compare race and ethnicity data stored in Epic to data from the HCAHPS survey every year to ensure that the values are consistent. In 2023, we found 88% concordance between combined race/ethnicity data documented in Epic and combined race/ethnicity from HCAHPS surveys.

Conducting Targeted Data Reviews

In 2023 several Columbia physicians, under the supervision of Dr. Joan Bregstein, conducted a targeted and focused review of our race and ethnicity data collected at NYP-MSCH in Epic. This work was part of an initiative led by Dr. Katherine Nash and the Columbia Pediatrics Equity Dashboard team, who were recently awarded a grant through the Columbia University Learning Health System initiative, which enables them to explore new technologies and practices that have the potential to reduce healthcare inequity. The Columbia Pediatrics Equity Dashboard Team reviewed the race and ethnicity documented in patient medical records and confirmed that information through one-on-one patient conversations with residents trained to explain why this data is collected and to solicit input from patients. The team conducted 101 reviews and found that 83.17% of Epic's combined race and ethnicity data align with responses solicited during the patient interviews. Of the 18 patients with discordance for the combined race/ethnicity category, 4 exhibited informative discordance (i.e., EMR and self-reported race/ethnicity listed specific but different race/ethnicities), 10 exhibited clarifying discordance (i.e., EMR listed other/declined/unknown and self-reported listed a specific race/ethnicity), and 2 exhibited non-informative disagreement (i.e., EMR and self-report listed unknown/declined and other respectively).

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Accessing Race and Ethnicity Data in Epic using SlicerDicer

At NYP we collect information on the race and ethnicity of our patients to make sure that patients of all backgrounds are receiving equitable healthcare. We acknowledge that race is a social construct and not a valid way to understand human difference. However, race continues to shape the lives, opportunities, and health of many, so we believe it is important to collect and analyze information on race and ethnicity across all our campuses.

Race and ethnicity are collected in two separate fields in Epic, but for reporting, we often group those two fields together. For more information about why we group those two fields together and the logic used to combine those fields, please read the "Race and Ethnicity Grouping, Visualization, and Reporting" white paper on the Dalio Center's Infonet site.

With the help of the Information Technology Team for Epic at NYP, combined race and ethnicity is now available for use in SlicerDicer. SlicerDicer is a useful tool within Epic that allows healthcare providers to design customized searches for data on patients that meet their selected inclusion and exclusion criteria. Adding the ability for users to disaggregate patient data by combined race and ethnicity within SlicerDicer is highly beneficial, as it allows Epic users to better understand the demographics of their patient populations and identify trends. This paper provides a brief overview of how to access combined race and ethnicity data in SlicerDicer.

Instructions

After accessing the SlicerDicer tool through Epic, the user should first select a **Data Model**.

Once the Data Model is chosen, a graph will appear showing the total count of patients within that group. On the right-hand side of the screen, users will find a section titled **"Slices"** and should select the green "+" button corresponding with that section. A pop-up will appear, and users should select **"Patient Demographics"** and then **"Combined Race and Ethnicity."**

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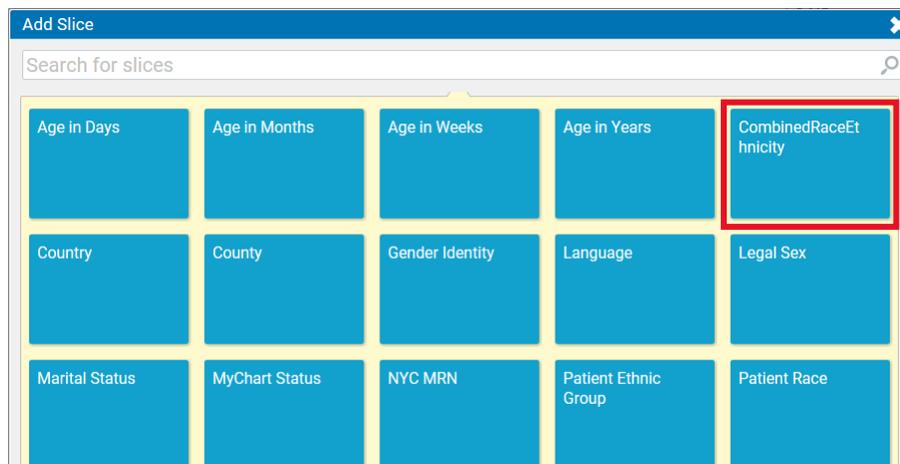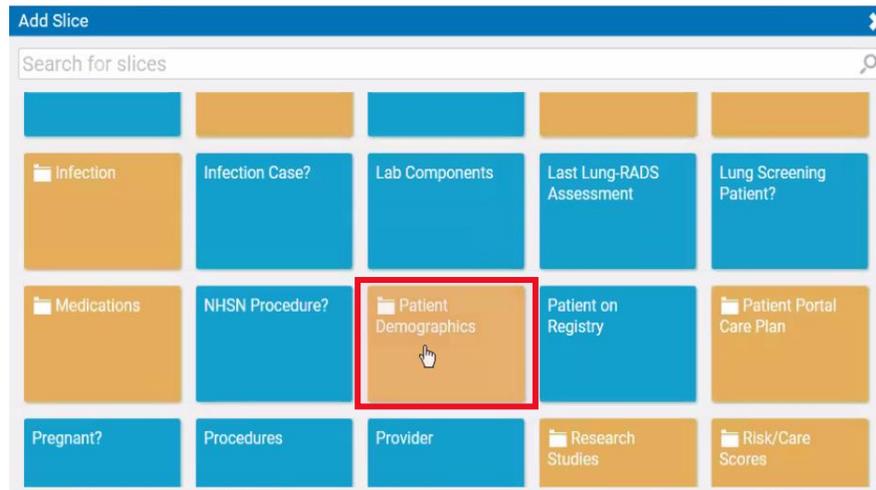
This will generate a graphical representation of the patients within the selected Data Model disaggregated by combined race and ethnicity. Users can then further adjust their search by adding exclusion or inclusion criteria through the **"Add Criteria"** function.

Resources

Additional information on how we collect, monitor, group, and validate race and ethnicity data at NYP is provided below.

- Improving Demographic Data Capture
- Race and Ethnicity Grouping, Visualization, and Reporting
- Measuring Health Equity at NYP
- The Validation of Race and Ethnicity Data at NYP

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Dalio Center for Health Justice

About Race & Ethnicity Grouping, Visualization, and Reporting

At NYP, Columbia, and Weill Cornell, we collect racial/ethnic background information so that we can review the treatment that all patients receive and make sure that everyone gets the highest quality of care. We acknowledge that race is a social construct and not a valid way to understand human difference. However, race continues to differentially shape the lives, opportunities, and health of many. Therefore, to ensure that we continue to provide the highest quality of care regardless of racial or ethnic background, collecting and analyzing race and ethnicity data continues to be important for NYP and our school partners Columbia and Weill Cornell.

As such, we have jointly developed standardized ways to present and report race & ethnicity data, which includes recommendations for "grouped" categories as well as best practices for visualization.

Overview of Race and Ethnicity Capture in Epic

Race and Ethnicity values are typically captured during registration and are found in four fields in Epic: Ethnicity, Granular Ethnicity, Race, and Granular Race. Epic allows users to enter multiple values for the Race fields. The values in these fields are standardized and match the NYS Department of Health reporting standards, which are based on the Office of Management and Budget (OMB) standards. Race and Ethnicity value options in Epic are:
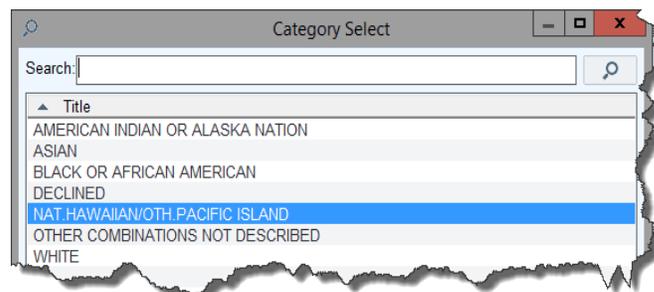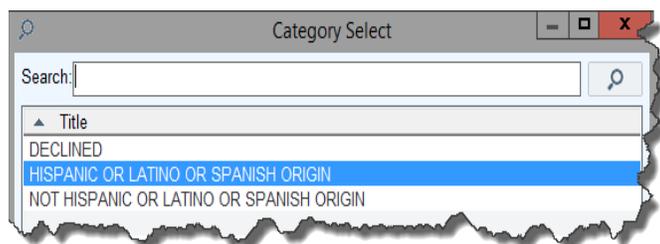
Best Practices for Reporting

Alignment of Race and Ethnicity Values

When Epic launched, historical patient data from legacy systems was imported and – for a small number of patients – the race or ethnicity values do not match the standard Epic options shown above. For example, a small subset of patients (<0.5%) have a Race value of "Asian Indian", "Sephardic Jewish", or "Ashkenazi Jewish". For Race or Ethnicity values that do not match the standard Epic options, a crosswalk has been developed to group those values to the standard options. This crosswalk is available on the Dalio Center infonet site and has been loaded into the NYP data analytics warehouse (Jupiter).

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Patients who Report Multiple Races

A small percentage (<2%) of patients report multiple races, where the second or third documented race is different from the first. Therefore, most reporting at NYP currently uses only the first documented race. We will monitor the number of patients reporting multiple races over time, and if the group grows, we may consider alternative approaches.

Reporting Race and Ethnicity together

In some instances, it is necessary to report Race and Ethnicity values together, in a combined category. Examples of this combined approach can be found in numerous government and public health reports, including reports produced by the CDC, NYSDOH, and NYCDOHMH.

When combining Race and Ethnicity values together, the recommended approach is:

- Group patients identifying as Latino (patients who select "Hispanic or Latino or Spanish Origin" in the Ethnicity field) to "Latino" and group all other patients by their race, with the sub-label "Non-Latino".
- Group patients identifying as Asian or Native Hawaii or Pacific Islander to a combined group of "AAPI" (Asian American Pacific Islander)
- Group patients identifying as American Indian or Alaska Nation under the label "AIAN"

The crosswalk summarizing these recommendations is available on the Dalio Center infonet site and has been loaded into the NYP data analytics warehouse (Jupiter). Below is a sample visualization. We recommend exhibits with combined Race and Ethnicity include the following footnote:

Race and Ethnicity (which are collected separately in Epic) have been combined in this exhibit. Patients identifying as "Latino", are grouped to Latino and may identify with any race. Patients identifying as "Non-Latino" are displayed with their identified Race. AAPI is Asian American Pacific Islander. AIAN is American Indian or Alaska Nation. Black is Black or African American.
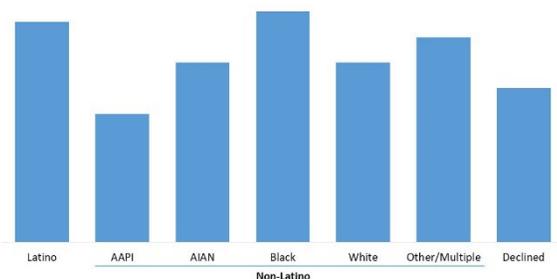
It is important to remember that this combined approach is only a way to report or visualize the data. No underlying patient data should ever be changed and not fields are merged in this process. All original data remains intact.

Epic Healthy Planet Wheel

What is the Epic Healthy Planet Wheel?

The Healthy Planet Wheel is a visual aide that allows the Care Team to see which social needs are documented in the chart.
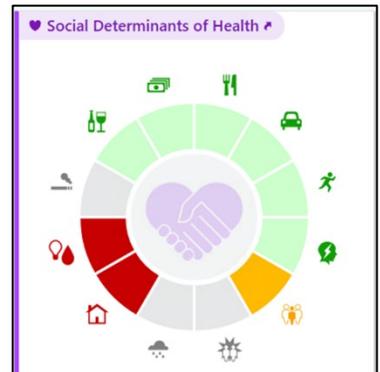
How do I know if Social Determinants of Health screening is complete?

- Check the healthy planet wheel:
  Chart Review > SnapShot > Plan of Care

- Data collected from our team members about Food, Housing, Transportation, Smoking, and Alcohol Use will population the wheel.
  At NYP, it is uncommon for other areas of the wheel to have data.

- Hover over any segment to see patient answers to individual questions.
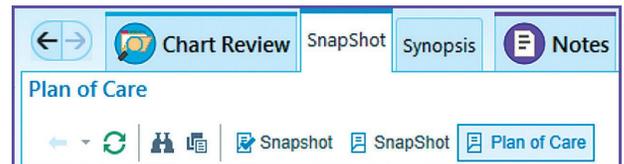
What do the colors on the wheel mean?

- The healthy planet segment will turn red if there is a patient need identified with any question in that domain.

- If the segment is grey, hover over the segment to see if individual questions were asked.

- The segment will turn green if every question in the domain is answered without patient need.

At NYP, our Care Teams often ask 1 question per social area. It is uncommon that every question is answered and, therefore, segments of the wheel are often grey or red, instead of green.

Food Insecurity

What is "Food Insecurity"?

Food Insecurity refers to a lack of consistent access to enough food for every person in a household to live an active and healthy life. People who are food insecure struggle to afford nutritious meals and are often forced to skip meals or rely on less expensive and less nutritious foods.
Source: Feeding America, Hunger and Food Insecurity

How does food insecurity affect health?

Food insecurity contributes to several chronic diseases including diabetes, high blood pressure, and heart disease. For example, food-insecure children are twice as likely to report being in poor or fair health compared to their food-secure counterparts. It may also force people to make difficult decisions, like choosing between food and rent, bills, transportation, or healthcare. One in seven NYC residents were food insecure in 2018–2020. One in 12 Westchester residents were food insecure in 2019.
Source: Feeding America, Hunger and Food Insecurity, Hunger Free America

How do we address this at NYP?

At NYP, questions about food insecurity are asked by inpatient social work and care management teams, as well as by emergency department Patient Navigation teams and Community Health Workers.

NYP supports food security through many programs. Two examples are:

- NYP's Food FARMacy program provides free, healthy groceries from West Side Campaign Against Hunger and Feeding Westchester by home delivery. Patients who are pregnant, 0-5 years old, or 65+ with 2+ ED visits in the past year are referred to the program by their healthcare providers after screening positive for food insecurity.

- Since 2020, NYP has provided $15M to local food pantries, allowing for the distribution of 4 million pounds of healthy food, including fresh fruits and vegetables, and reaching 13,000 households.

To learn more about food insecurity
and other social drivers of health, visit:
nyp.org/daliocenter/social-determinants-of-health-education

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Housing Insecurity

What is "Housing Insecurity"?

Housing Insecurity encompasses several housing challenges including homelessness, overcrowding, moving frequently, or spending a large portion of one's household income on housing.
Source: Office of Disease Prevention and Health Promotion, Housing Instability

How does housing insecurity affect health?

Housing insecurity can negatively affect a person's health in several ways including, exposure to health risks in poor housing conditions and chronic stress associated with homelessness. Being "rent burdened" (spending more than 30% of one's income on rent) can also impact a person's health, as they may not be able to afford other essentials such as food, transportation, and healthcare.

In 2021, 53% of NYC renters and 50% of Westchester renters were rent burdened, and being rent burdened was significantly more common in Black and Brown households.
Source: Office of Disease Prevention and Health Promotion, Housing Instability

How do we address this at NYP?

At NYP, questions about housing insecurity are asked by inpatient Social Work and Care Management Teams, as well as by emergency department Patient Navigation Teams and Community Health Workers. These team members are trained to utilize the NYC Home Base program, which provides New Yorkers experiencing housing instability with various homeless prevention services and helps families and individuals exiting NYC Department of Homeless Services shelters find permanent housing. Social Work teams may also help coordinate with supportive housing placements.

To learn more about housing and other social drivers of health, visit:
nyp.org/daliocenter/social-determinants-of-health-education

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Utility Insecurity

What is "Utility Insecurity"?

Utility insecurity refers to an inability to maintain basic household energy needs such as electricity, heat, and gas.
Source: Understanding 'energy insecurity' and why it matters to health. Soc Sci Med. 2016.

How does utility insecurity affect health?

Utility insecurity has been linked to several adverse health outcomes in mental health, respiratory health, sleep quality, and child health. Additionally, someone who is utility insecure may be forced to choose between paying their utility bills and other necessities like food and medicine. In the U.S., one in three households report facing a challenge in paying energy bills, and utility insecurity is most common in households of color, low-income households, and households with children.
Sources: (1) Energy insecurity and its ill health effects: A community perspective on the energy-health nexus in New York City. Energy Res Soc Sci. 2019. (2) Health City, Protecting Patients from Energy Insecurity Requires Universal Screening.

How do we address this at NYP?

At NYP, questions about utility insecurity are asked by inpatient social work and care management teams, as well as by emergency department Patient Navigation teams and Community Health Workers.

To assist our patients, we can connect them with community resources that address utility challenges, such as NYC's Home Energy Assistance Program, which helps low-income homeowners and renters pay for utility and heating bills.

To learn about other social drivers of health, visit:
nyp.org/daliocenter/social-determinants-of-health-education

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Accommodations for People with Disabilities

At NYP, we are committed to providing people with disabilities full and equal access to healthcare. A person with a disability is someone with a mobility or physical disability, sensory (vision or hearing) impairment, intellectual, psychiatric, or other mental disability. To make sure that we are delivering equitable care, it is important that we provide effective and easily understood means of communication for patients, family members, and hospital visitors, and ensure physical accessibility in our facilities. Providing accommodations upholds our institutional values and is required by law, under the Americans with Disabilities Act (ADA).

Low Vision, Blindness
- Provide materials in a larger font
- Use a larger call bell
- Remind patient of braille on the call bell
- Sight translation

> *Sight translation refers to the process of reading a document or piece of writing in the original language, and use interpreter services to interpret aloud in the target language.

Deaf or Hard of Hearing
- Use see through masks when available
- Use Video Remote Interpreting & On-Site ASL Interpreters
- Use visual aids, like pain scales
- Use communication boards
- Use notepads for written communication

Speech Challenges
- Use communication boards
- Use visual aids, like pain scales
- Use notepads for written communication

Physical Disability
- Have accessible entrances
- Install low elevator buttons
- Provide patient lifts

Interpreter Services

NYP policy is to provide access to effective communication for patients and their companions in their preferred language and mode of communication. Providing services is the right thing to do, and it's also a regulatory mandate.

What does NYP offer?	How to Request?
▪ Over-the-Phone (OPI) Audio Interpreting	▪ Contact Pacific, LanguageLine Solutions ▪ Use Language Line InSight App on NYP provisioned smartphone ▪ Use the Audio option on the Video Remote Interpreting (VRI) device
▪ Video Remote Interpreting (VRI)	▪ VRI information on the Infonet
▪ On-Site Medical Interpreter for Limited English Proficient & Deaf/Hard of Hearing Individuals	▪ Contact Interpreter Services ▪ During non-business hours, contact the Administrator on Call/Nursing Administrator through the page operator

Key Points:

- Identifying patient's preferred language is critical to ensuring that patients are active participants in their care.

- How you communicated with the Limited English Proficient and Deaf of Heard/Hearing Individual must be documented in Epic.

- Scheduling an interpreter in advance is recommended for languages of lesser diffusion.

- Only Staff who have passed the Linguistic Clinical Communicator (LCC) assessment can directly communicate medical information in language(s) other than English to their patient and may not serve as an interpreter for a colleague.

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Sexual Orientation & Gender Identity

To help all of us better care for the LGBTQ+ community, the following resources are available:

- **Caring for the LGBTQ+ Patient, Family, and Staff:** NYP Online Course
- **Dialogues in Diversity:** Celebrating Pride: A Conversation with Amber Hikes, Social Justice Advocate
- **Updates and Best Practices for Enhancing Patient Experience:** Names and Pronouns Training
- **Names & Pronouns Guide:** A guide for Health Care Professionals
- **Names & Pronouns Video:** A video training for asking patients about name and pronouns

For access to over 60 free, online, on-demand CME accredited LGBTQ+ training options, including interactive eLearning courses and recorded webinars:

- **The Center for Affiliated Learning (CAL):** View course descriptions and How to register*.
- **The National LGBTQIA+ Health Education Center:** View course descriptions and How to register*.

*When registering, you must provide an HEI Facility ID for **NYP/Weill Cornell:**
Facility ID: **55690**
Security Keyword: **HRC**

Gender Identity: Names & Pronouns
A guide for health care professionals

October 2021

We Ask Because We Care.

At NewYork-Presbyterian, Weill Cornell, and Columbia we are committed to celebrating the diversity of the patients and communities that we serve, and we are dedicated to ensuring that every patient receives the best care possible regardless of race, ethnicity, gender identity, sexual orientation, cultural background, or language proficiency.

In the healthcare setting, respecting a patient's gender identity and using their name and pronouns are critical elements of good clinical care.

When we understand and respect our patients, we can better personalize their experience and make sure that everyone gets the highest quality of care.

At NewYork-Presbyterian, we put patients first.

Respecting all Patients

In the United States, approximately 1.4 million adults are transgender and the percentage of Americans who are transgender is growing.[1,2] Sadly, many transgender people report poor health outcomes and unequal treatment in health care environments. In a large 2016 study[3]:

- **19%** of respondents reported being **refused medical care** due to their transgender / gender non-conforming status, with higher numbers among people of color.
- **28% postponed medical care** due to discrimination.
- **50%** reported having to **teach their providers about transgender care**.

A basic first step towards respecting a patient's gender identity is using their correct name and pronouns. Names are intimate and important. Using the right name is a simple way to make patients feel at ease and convey respect.

Understanding sex and gender

It's common for people to confuse sex and gender, but they're different.

sex

Sex is a label — male or female — that you're assigned by a doctor at birth. Factors determining sex include chromosomes, genes, hormones, and sex organs.

gender

Gender is much more complex: It's a social and legal status, and set of expectations from society, about behaviors, characteristics, and thoughts.

gender identity

Gender identity is the internal perception of one's gender. The gender with which a person identifies does not always align with the sex they are assigned at birth.

gender expression

Gender expression is how people express their gender through clothing, behavior, and personal appearance.

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[1] https://williamsinstitute.law.ucla.edu/wp-content/uploads/Trans-Adults-US-Aug-2016.pdf
[2] https://news.gallup.com/poll/329708/lgbt-identification-rises-latest-estimate.aspx
[3] Grant JM et al. Injustice at every turn: a report of the National Transgender Discrimination Survey. http://www.thetaskforce.org/static_html/downloads/reports/reports/ntds_full.pdf

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Asking for a Patient's Name

In order to respect a patient's gender identity, we must always use their chosen name and pronouns. Sometimes, a patient's chosen name will be different than the name on their insurance (their legal name). Epic allows us to record both the legal and chosen name.

There are several ways to ask a patient about their name that is respectful and allows us to differentiate between (chosen) name and legal name – for example:

> How is your name written on your insurance card?

You can explain that legal name is necessary for insurance purposes. Be sure to follow this with:

> Is there another name that we should call you?

or

> Is there a different name we should be using for you?

Once the patient provides their name, *use it* – whether or not they are present. Legal name should *only* be used when necessary, e.g. for tasks like verifying insurance or coordinating with a pharmacy.

Asking for a Patient's Pronouns

To ask about pronouns, you can simply ask, "What are your pronouns?" Another easy way to start the conversation is by sharing your pronouns:

> My name is Dr. Smith and my pronouns are she/her. What are your pronouns?

Use a person's pronouns regardless of whether they are present or not. Consistent, accurate use will help you and your team members remember the correct pronouns. It also demonstrates respect for patients, staff, and visitors.

Common Pronouns

There are many variations of pronouns used to express oneself. Below are a few commonly used pronouns. Information about additional pronouns is provided in the reference section. Some people may also use multiple pronouns (e.g. She/They).

She / Her / Hers

She went to the lab.
I gave the prescription to her.
She did the swab herself.

He / Him / His

He went to the lab.
I gave the prescription to him.
He did the swab himself.

They / Them / Theirs

They went to the lab.
I gave the prescription to them.
They did the swab theirself.

Ze/Zim/Zir

Ze went to the lab.
I gave the prescription to zim.
Ze did the swab zirself.

(Name only, no pro-noun)

Carlos went to the lab.
I gave the prescription to Carlos.
Carlos self-swabbed.

★ If a patient has a pronoun option not listed in Epic, you can select "Not listed" and make note of the patient's pronouns.

Addressing Mistakes

Mistakes can happen, and when do they do, apply the NewYork-Presbyterian service recovery AAA method: Acknowledge, Apologize, Amend. Keep it simple and sincere, and then move on to use the correct name and pronouns.

You might say something like:

> I apologize, I didn't use the correct pronouns for you. I'm going to try that again…"

Key Take-aways

Do treat all patients with empathy, respect, and dignity

Do ask patients for their name and pronouns, and use the correct pronouns each time you refer to them

Do use patient's name and pronouns, regardless of whether they are present

Do apologize and move on if you've made a mistake

Don't make assumptions about a person's pronouns

Don't assign nicknames to people because you don't know how to pronounce their names

Don't tell people that their names are too difficult to pronounce

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Frequently Asked Questions

How do I know which patients to ask about name and pronoun?

It's important not to make assumptions about our patients based on their appearance, so these questions should be asked of all patients.

We don't have transgender patients in our clinic, why do we have to ask these questions?

You may not be aware of transgender/non-binary/gender expansive patients, but there is a good chance that you have or will encounter staff, visitors, or patients at NYP that are gender expansive. Without options to disclose identity, some people may not share this part of themselves out of fear, shame, distrust, or other reasons. Asking these questions allows for a person to put their trust in us and allows us to provide better care. It demonstrates that we care and it contributes to an environment of RESPECT.

I am afraid of offending or confusing patients. Help!

You can always explain why you are asking a question. If you ask a patient what their pronoun is and they question you, you have an opportunity to demonstrate RESPECT.

> Staff Member: "What is your pronoun?"

> Patient: "What do you mean? Can't you see I am a man?"

> Staff Member: "We serve a lot of different people and our staff is diverse, too, so we ask all of our patients questions like this to help people feel comfortable and show respect. It also helps us provide better care. Shall I add he/him" to your chart?"

What if I notice a colleague using the wrong name for a patient?

Your colleague may not be aware that they are making a mistake and/or may not know where to look on the wristband and/or in Epic. You can simply correct your colleague- "Actually, her name is Orange," and show them where the information can be found and how it is displayed.

What if I can't pronounce the patient's name?

You may experience names that you do not know how to pronounce. Don't assign nicknames to people or tell people that their names are too difficult for you to pronounce. Do ask: "May I ask how to pronounce your name?" or "Am I saying your name correctly?" If you need to practice, that's fine! Asking and making an effort demonstrates respect and cultural competence.

Can patients enter (chosen) name and pronouns on Connect?

Yes, but they may not know this. It is best practice to ask patients directly.

Where is this information found in Epic?

Chosen name and pronouns are found in the Patient Storyboard. Detailed information on how to capture and record this information in Epic can be found in Epic training SGN100 "Documenting Gender, Sex, and Sexual Orientation (SOGI) in Epic".

Vocabulary

Agender: Person who identifies as genderless or outside the gender continuum

Cisgender: ("siss-jendur") Person whose gender identity corresponds with their biological sex assigned at birth (for example, assigned male at birth and identifies as a man). This term can be shortened to "cis," which is a Latin prefix that means "on the same side [as]" or "on this side [of]."

Cross dressing: Wearing of clothes typically associated with another gender; the term transvestite can be considered pejorative and should not be used.

Gender expression: External display of gender identity through appearance (e.g., clothing, hairstyle), behavior, voice, or interests

Genderfluid: People who have a gender or genders that change. Genderfluid people move between genders, experiencing their gender as something dynamic and changing, rather than static.

Gender identity: Internalized sense of self as being male, female, or elsewhere along or outside the gender continuum; some persons have complex identities and may identify as agender, gender nonbinary, genderqueer, or gender fluid

Intersex (noun) is a person whose combination of chromosomes, gonads, hormones, internal sex organs or genitals differs from the two "expected" patterns of male or female. Differences/ disorders/diversity of sex development, or "DSD," is also often used. Formerly known as "hermaphrodite" or "hermaphroditic", these terms are now considered outdated and derogatory. In the past, intersex was considered an emergency that doctors moved to "fix" right away in a newborn child by assigning a male or female sex. There has been increasing advocacy and awareness brought to this issue. Many individuals advocate that intersex individuals should be allowed to remain intersex past infancy and should not automatically be treated as a medical emergency.

LGBTQIA2S+: An acronym for Lesbian, Gay, Bisexual, Transgender, Queer and/or Questioning, Intersex, Asexual, Two-Spirit, and countless affirmative ways in which people choose to self-identify.

Non-binary and/or genderqueer: Terms used by some people who experience their gender identity and/or gender expression as falling outside the categories of man and woman. They may define their gender as falling somewhere in between man and woman, or they may define it as wholly different from these terms. The term is not a synonym for transgender or transsexual and should only be used if someone self-identifies as non-binary and/or genderqueer.

Queer (adj.) is generally used as an umbrella term to describe individuals who identify as non-straight or gender non-binary, and is sometimes used interchangeably with LGBTQ+ — "the queer community." Queer was historically a derogatory term, and some may still find this term offensive. Always respect an individual's own identity

labels and definitions, and only use this term if the person/group has indicated the term first. Many individuals identify as "queer" and do not to use other labels such as "gay" or "bi." If appropriate, you might ask someone what it means for them so you don't make any assumptions.

Sex: The classification of a person as male or female. At birth, infants are assigned a sex, usually based on the appearance of their external anatomy. (This is what is written on the birth certificate.) A person's sex, however, is actually a combination of bodily characteristics including: chromosomes, hormones, internal and external reproductive organs, and secondary sex characteristics. Often "biological sex" is seen as a binary but as there are many combinations of chromosomes, hormones, and primary/secondary sex characteristics. It is more accurate to view sex as a spectrum.

Sexual orientation: Term describing an enduring physical and emotional attraction to another group; sexual orientation is distinct from gender identity and is defined by the individual

Trans: Sometimes considered to be an umbrella term for people whose gender identity differs from the sex they were assigned at birth. Trans people may identify with a particular descriptive term (transgender, genderqueer, FTM/Female to Male, etc.) or identify simply as "trans." Though some non-binary individuals do not consider themselves under the "trans" umbrella and consider the term to be an abbreviation for transgender only. Always follow an individual's self-identified terms.

Transgender (adj.) typically indicates a person who is living or transitioning into living as a member of a gender other than what would be "expected" based on their sex assigned at birth. What this means can vary from person to person. For example, a person may or may not choose to have any medical interventions (e.g., surgery, hormones) and/or a person may or may not change their name and/or pronouns to affirm their gender.

Transsexual: A relatively outdated clinical term that you may encounter in medical literature used to refer to transgender people who are choosing to pursue medical interventions, but many people in the transgender community find this term offensive. Because sexuality labels (e.g., gay, straight, bi) are generally based on the relationship between the person's gender and the genders of individuals they are attracted to, a trans person's sexuality can be defined in a variety of ways. Take the person's lead on their own labels and definitions.

Sources:

aafp.org/afp/2018/1201/p645.html

genderspectrum.org/articles/language-of-gender

glaad.org/reference/transgender

childrenshospital.org/-/media/Centers-and-Services/Programs/F_N/Gender-Management-Service/GenderPronouns_Ebook.ashx?la=en&hash=7661BAFAC2B9FE662B65C931D7060597D90731F6

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Resources at NYP

NewYork-Presbyterian wants to create a welcoming, positive experience for every person who walks through our doors. To help all of us better care for the LGBTQ+ community, the following resources are available:

Through NYP's participation in the **Human Rights Campaign Foundation's Annual Healthcare Equality Index**, all NYP staff have access to over 60 free, online, on-demand CME accredited LGBTQ+ training options, including interactive eLearning courses and recorded webinars. Topics range from the basics of LGBTQ+ Patient-Centered Care to more specialized content for clinicians. Access the education through these two HEI-affiliated learning systems:

- The Center for Affiliated Learning (CAL): View course descriptions and How to register.
- The National LGBTQIA+ Health Education Center: View course descriptions and How to register.

*When registering, you must provide an HEI Facility ID for **NYP/Weill Cornell:**
Facility ID: **55690**
Security Keyword: **HRC**

Caring for the LGBTQ+ Patient, Family, and Staff at NYP Online Course

Whether you have taken this course or not, it's a great learning resource to refresh your knowledge. The purpose is to gain greater understanding of terminology and concepts that can help you better care for LGBTQ+ patients and their families, and foster understanding and respect among colleagues. Access the course here. Then click "Add to Plan" and "Launch" to start the course. The course includes a brief quiz that requires a passing score of 80%. If you don't pass, simply retake the quiz.

Managers can click here to run a report of completions for the course from the NYP Learning Center.

Dialogues in Diversity

These interactive sessions, featuring panels of NYP employees, or outside speakers, are designed to raise awareness and spark meaningful dialogues that nurture respect and trust across NYP. Visit the NYP Video Gallery on the Infonet to view recordings of previous seminars related to the LGBTQ+ experience, including the most recent event:

- Celebrating Pride: A Conversation with Amber Hikes, Social Justice Advocate

Please contact nypdiversity@nyp.org with any questions or for more information.

References

For more about **neutral pronouns**, including those in various languages visit:
https://nonbinary.wiki/wiki/Pronouns

For more information about **trans/non-binary/gender expansive people** visit:
https://prevention.ucsf.edu/sites/prevention.ucsf.edu/files/trans101/index.html#/

For a video addressing **questions about sex/gender**:
https://prevention.ucsf.edu/sites/prevention.ucsf.edu/files/trans101/video/index.html

Clinical References

AAFP: Caring for Transgender and Gender-Diverse Persons: What Clinicians Should Know:
www.aafp.org/afp/2018/1201/p645.html

Center of Excellence for Transgender Health: Guidelines for the Primary and Gender-Affirming Care of Transgender and Gender Nonbinary People, 2nd ed.; transhealth.ucsf.edu

Do Ask Do Tell: A Toolkit for Collecting Data on Sexual Orientation and Gender Identity in Clinical Settings www.doaskdotell.org/

National LGBT Health Education Center; www.lgbthealtheducation.org

World Professional Association for Transgender Health: Standards of Care for the Health of Transsexual, Transgender, and Gender-Nonconforming People, 7th ed.; www.wpath.org

For patients and family members

Colage (unites people with LGBTQ parents): www.colage.org

Parents, Families and Friends of Lesbians and Gays community.pflag.org/transgender

Human Rights Campaign (advocates for the LGBTQ community) www.hrc.org

National Center for Transgender Equality www.transequality.org

The Trevor Project (advocates for the LGBTQ community and hosts a call-in line for transgender youth in crisis) www.thetrevorproject.org

Trans Lifeline (hosts a call-in line for transgender persons in crisis) www.translifeline.org

TransYouth Family Allies (online resource for parents, youth, and health care professionals) www.imatyfa.org

AMAZING THINGS ARE HAPPENING HERE

Increasing Cultural Competence to Improve the Patient Experience

Using Zoom Today

- Please raise your hand via the zoom tool to engage with the facilitator.

- Self mute your audio.

- Please turn on video, if possible!

- Feel free to use the Chat function to ask questions, add your own responses, etc.

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Icebreaker: The Story of Your Name

Tell us the story of your name: first, middle, and last.

Feel free to include origins and meanings; plus nicknames from family and friends.

Each participant will take one (1) minute to share.

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Workshop Objectives

By the end of the session, participants will:

- Understand what culture is and why it is important in the patient experience and healthcare delivery

- Become more aware of one's own cultural background and how that influences communication with patients.

- Recognize the core cultural issues relevant to healthcare settings.

- Understand how NYP Service Expectations support cultural competence, humility and respect.

- Practice using case studies based on real NYP patient scenarios.

- Create a plan to build self-awareness and consistent use of skills.

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Today's Agenda

- Understanding of Culture and Identity

- Cultural Competence in Healthcare and The Culture of One

- Patient Experience, Cultural Competence and the Service Expectations

- Practice!!!!

- Personal Commitments and Next Steps

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CULTURE, HEALTHCARE, AND CULTURAL COMPETENCE

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What is Culture?

Culture is a shared system of values, beliefs, and learned patterns of behavior, not simply defined by race or ethnicity.

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What Factors Shape Culture & Identity?

- Race
- Ethnicity
- Age
- Education
- Income
- Religion
- Migration
- Geographic location

- Language and Accent
- Gender identity
- Sexual orientation
- Employment
- Marital status
- Family status
- Ability status
- Life experiences

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The Cultural Iceberg

VISIBLE
- Age
- Clothes
- Gender
- Language
- Behaviours
- Physical Characteristics

LESS VISIBLE
- Patterns of Speech
- Body Language
- Favourite Foods
- Festivals
- Musical Preferences
- Talents
- Family Traditions
- Religious Practices
- Social Skills
- Heritage
- Nationality
- Wealth
- Social Status
- Role in Family
- Skills
- Knowledge

NOT VISIBLE
- Political Views
- Life Experiences
- Attitudes
- Personal Values
- Sexual Identity
- Personal Beliefs
- World View
- Family Attitudes and Values
- Thought Patterns
- Assumptions

AKGTC 2018

Activity

Page 3 of handout.

Place your name in the center circle of the image.

Write different factors that are important parts of your identity in each of the circles.

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What is Cultural Competence?

Cultural competence in health care describes the ability to provide care to patients with diverse values, beliefs and behaviors, including tailoring healthcare delivery to meet patients' social, cultural and linguistic needs.

How to demonstrate?

- Knowledge
- Attitude
- Skills

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A Brief History of Cultural Competence

- Disparities in healthcare quality and outcomes

- Increasing racial, ethnic, and language diversity

- Unconscious bias and communication gaps with providers

A Brief History of Cultural Competence

- Title VI of the Civil Rights Act (1964)

- National Standards on Culturally and Linguistically Appropriate Services (CLAS) (2001)

- Hill-Burton Act

- Medicaid and Medicare

- Emergency Medical Treatment and Active Labor Act (EMTALA)

A Summary: Cultural Competence Models

- Develop awareness of one's cultural values, beliefs, and biases

- Acquire sufficient knowledge of the normative behavior and beliefs of the cultural group in which people claim membership

- Demonstrate ability to combine awareness and knowledge in professional practice

- Acknowledge diversity as normative and difference as resource, not problems to overcome

- Acknowledge culture as being fluid and dynamic

Reference:
Danso, R. Cultural competence and cultural humility: A critical reflection on key cultural diversity concepts. *Journal of Social Work.* 2016; Volume: 18 issue: 4, page(s): 410-430.

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What is Cultural Humility?

- Does not require mastery of lists of different cultures and peculiar health beliefs and behaviors

- Cultural humility requires continual commitment to learning, and relearning

- Cultural humility also requires continuous self-critique and analysis

  - Values, beliefs, goals

  - Understanding biases

  - Addressing one's own privilege

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A Summary: Cultural Humility Models

- Understand self and other

- Recognize one's prejudices and cultural misperceptions

- Engage in continuous self-critique

- Challenge power differentials in working relationships and in organizations

- Develop an attitude of not knowing and learn from the patient

Reference:
Danso, R. Cultural competence and cultural humility: A critical reflection on key cultural diversity concepts. *Journal of Social Work.* 2016; Volume: 18 issue: 4, page(s): 410-430.

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Patient-Centered Approach to Culture

When we focus on the patient experience, we do not focus on the culture of a population.

We focus on the **Culture of One**.

Cultural competence and cultural humility help us achieve that focus so we can create great experiences and outcomes for our patients.

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Explore the Culture of One

Consider issues that may be important to the patient for this healthcare experience:

- Communication Styles: *How does patient communicate? What is preference for formality, touch, eye contact?*

- Mistrust/Prejudice: *Does patient mistrust health care system?*

- Autonomy, Authority, Family Dynamics: *How does patient make decisions? Who is in charge?*

- Role of Physician/Caregiver: *What does patient expect? What is your role?*

- Traditions, Customs, Spirituality: *How do these factors influence patient?*

- Sex/Gender Issues: *How central are these to patient?*

Reference:
Carrillo JE, Green AR, Betancourt JR. Cross-cultural primary care: a patient-based approach. *Ann Intern Med.* 1999; 130(10):829-834.

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Recap and Reflection

- Definition of culture

- Culture and identity are multi-dimensional for every person

- Cultural competence vs. cultural humility >> RESPECT

- Ways to focus on the Culture of One

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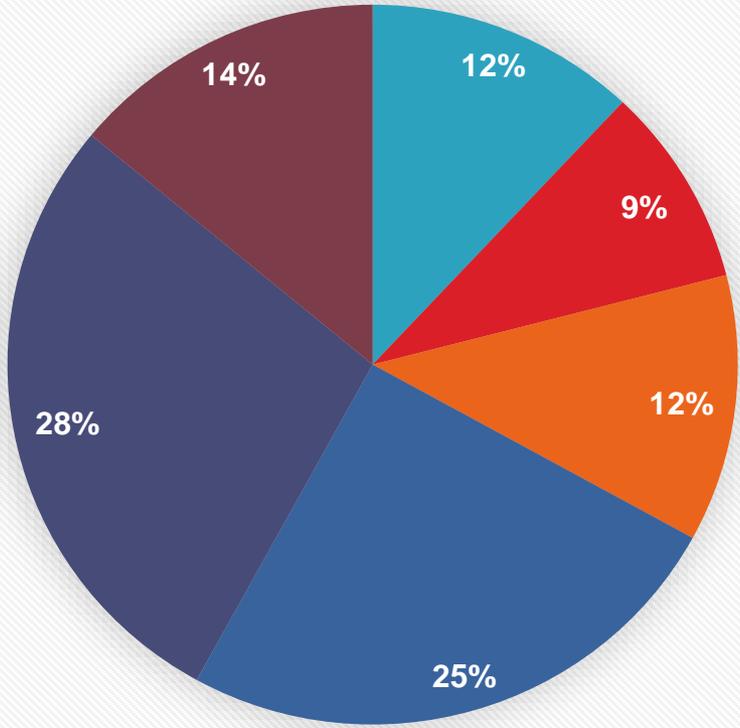# PATIENT EXPERIENCE AND CULTURAL COMPETENCE

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At NewYork-Presbyterian, we **work together as a team** and **partner with our patients and their families** to provide **compassionate, consistent, high quality, and safe care** that **instills confidence by creating connections** and **meeting our diverse patients' individual needs**.
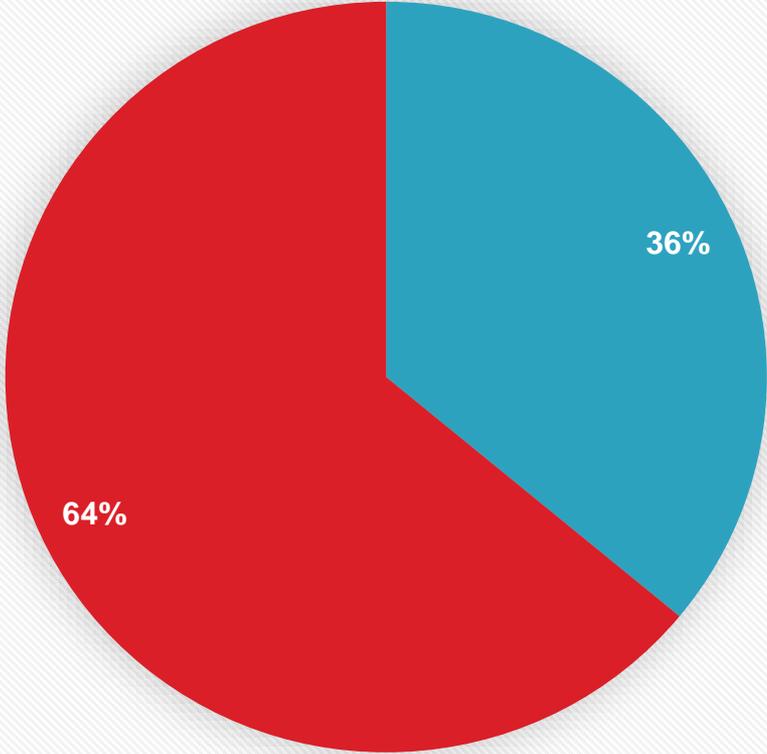
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Why Is This Information Important?

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THINGS
ARE
HAPPENING
HERE

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The Population We Serve

Age

- 12% — 0 - 17 Yrs'
- 9% — 18 - 34 Yrs'
- 12% — 35 - 49 Yrs'
- 25% — 50 - 64 Yrs'
- 28% — 65 - 79 Yrs'
- 14% — 80+ Yrs'

Gender

- 36% Male
- 64% Female

**Data obtained from the combined responses of the patient population of the ACN (CU & WC)

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The Population We Serve

Language

- English 71%
- Spanish 29%

Ethnic Background

- 48%
- 23%
- 5%
- 1%
- 22%
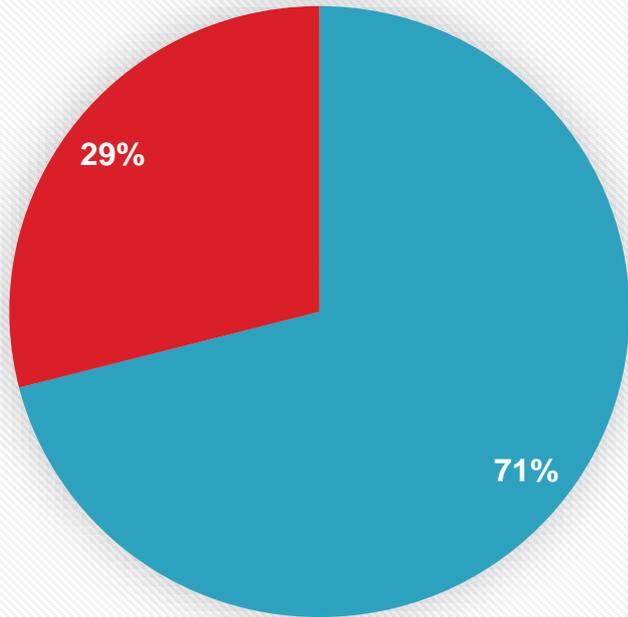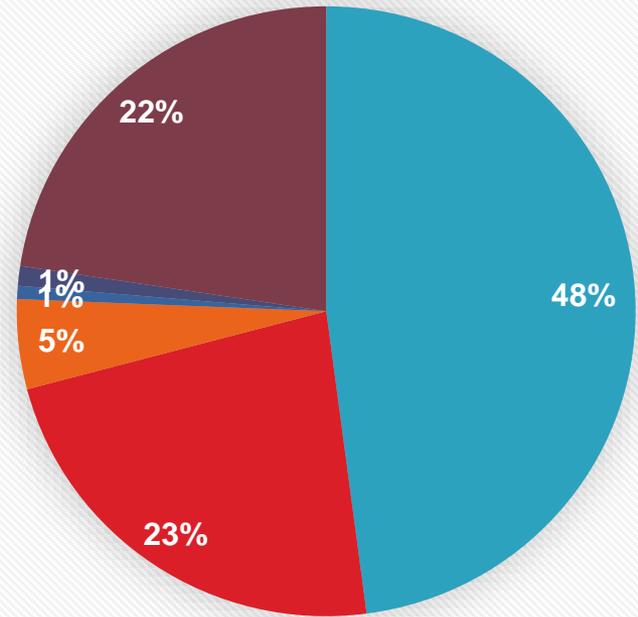
Legend:
- Race-White
- Race-Black/African-American
- Race-Asian
- Race-Hawaiian/Pacific Islander
- Race-Amer Indian/Alaska Native

**Data obtained from the combined responses of the patient population of the ACN (CU & WC)

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Diversity in Culture, Diversity in Values

- Patient Communication that makes a difference

- Impact of Culture On Patient Education

- Respect: Culture Goes Both Ways

- Citizenship

- Credo

Service Expectations

Patient Expectations → ← **Patient Service**

Best Practices

What is Service Recovery?

- Making right what went wrong

- There is a difference between just fixing a problem and restoring satisfaction

- When done right, Service Recovery restores confidence

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Service Recovery Best Practices

- **Triple A**
  - Acknowledge
  - Apologize
  - Amend

- **"Say this not that"**
  - Communication is key and what we say matters

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AMEND

I promptly act to resolve their concerns and keep the patient updated on progress until the issue is resolved to their satisfaction.

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THINGS
ARE
HAPPENING
HERE

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Say This, Not That

When we say or do this… (Please don't say this)	Our patients may hear and think this… (Please don't say this)	But when we say or do this… (Say This!)	Our patients should hear and think this… (Say This!)
This restroom is only for women/females. You can't use this bathroom because you are a man.	They are assuming gender and not respecting my privacy.	Hello, Do you need help locating the restrooms? We have gender specific restroom and gender neutral restrooms. Please feel free to use whichever you are most comfortable with.	I appreciate the staff not assuming my gender and sharing the different options I have. I can select what I am most comfortable with.
This patient is a frequent flyer in our Emergency Room. They are not really in need of anything.	They will not provide me proper care because I have a mental health issue.	Welcome to the Emergency Room. I see you have been a patient with us in the past. Is there anything specific you would like to address today?	I am confident I will be taken care of. It's reassuring they recognize me and want to help me with my visit to the ER.
I can't understand your language or accent. Please call when you have someone who can speak English.	They are not patient with me or helping me understand what is going on. I am not taken seriously because English is not my first language.	Hello, Thank you for calling. I want to better assist your needs and in order to do so what is the best language preference. Would you like me to provide a interpreter?	The staff answering the phone is being very patient with me and providing me resources to better assist me. This is helpful because I am able to understand important information.

Don't forget gestures and body language. If you roll your eyes, furrow your brow, sigh deeply, make grunting noises, mumble under your breath, or avoid eye contact, patients will lose confidence in our ability to care for them.

What Patients Expect

- Easy Access
- Human Interactions
- Prompt Service
- Clear Communication
- Empathy

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Service Expectations

- Hallways/elevators/public spaces
- Phone interactions
- Patient hospital/exam & treatment rooms
- Front desk/entrances/check in and out/retail

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Hallways, Elevators and Public Spaces

- Patients and family members will be acknowledged

- All staff will demonstrate awareness of patients and families in public spaces and offer assistance when needed

Phone Interactions

- All callers will be properly greeted

- Hold and transfer protocols will be followed

Informing Patients about Wait Times

Patients will be informed at arrival of any known wait times, and will be kept informed of status through the visit

Service Recovery Reminder

- When complaints or concerns are voiced by patients and families, we will act to resolve them

- Staff will use the "triple A" approach to communication during service recovery opportunities – "Acknowledge, Apologize and Amend"

Supportive Resources

- Patient Services

- Patient Bill of Rights

- Learning Center [Example: PX Academy, De-Escalating Aggressive Patient Behavior]

- NYP (Respect) Credo

- Report abuse or discrimination to your Manager or Director

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PATIENT SERVICES ADMINISTRATION

- A resource for patients, families, doctors, and staff to handle difficult situations involving patients' rights and other ethics issues

- Available 24/7

NYP/WC	**(914) 787-3074**
(212) 746- 4293	**NYP/HV**
NYP/CU & MSCH	**(914) 734-3671**
(212) 305-5904	**NYP/Queens**
NYP/Allen	**(718) 670-1110**
(212) 932-4321	**NYP/BMH**
NYP/LMH	**(718) 780-3375**
(212) 312-5034	
NYP/WD	
(212) 746-4293	
NYP/LW	

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Let's Practice!
-Case Studies-

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Case Study Directions

- Read the case study with your team

- As a group, discuss the situation

- Decide which service expectation applies to the case and what could have been done differently

- Choose spokesperson to represent and read-out for your team's response

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Case Study #1

The patient is a 39 year old transgender woman. She was newly diagnosed with HIV. The patient was immediately admitted in to receive the treatment. Upon her admission the patient reported that she was discriminated against by her Patient Navigators due to her gender and HIV status. The patient stated the Patient Navigator was using the wrong pronouns when speaking to her and continued to do so after being corrected. The patient felt that she was not going to get her proper support by the actions of the Patient Navigator.

- What could have been done differently?

- What service expectations apply to this patient's service case?

Case Study #2

The patient is a 29 year old man with autism. The patient needed help with setting up a follow-up visit and the mother asked the for the Community Health Worker for help. As the CHW tried to help the mother, the patient would not sit still. The CHW stated "the patient is not staying stable." and walks out the room.
The mother of the patient perceived "unstable" to mean mentally unstable and believed the CHW discriminated against her son.

- What could have been done differently?
- What service expectations apply to this patient service case?

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Case Study #3

Two women, Janice and Tonya, arrive with a baby for a 6 month check up and immunizations. A Patient Navigator introduces herself to Janice and says, "Oh, did you bring your sister? How nice!" Tonya and Janice both frown. Tonya says with exasperation, "Actually, I'm her wife and this is our baby.

- What could have been done differently?

- How can the Patient Navigator apologize?

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Case Study #4

A 30 year old woman went to her yearly routine check-up. Since she had not attended the clinic in a while, the patient did not remember where the new entrance was located. A Patient Navigator noticed the patient seemed lost and said "necesita ayuda señora?" The woman responded I do not speak Spanish. The Patient Navigator then asked the patient in English if she needed help.

- What could the Patient Navigator have said instead?
- What service expectations apply to this patient's service case?

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Personal Commitments & Next Steps

- What will you start doing?

- What will you stop doing?

- What will you do differently?

- What will you continue to do?

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Workshop Evaluation Survey

Scan this QR code using the QR Reader on your phone:

- iPhone: Go to Wallet > Scan Code

  - Or Open Camera & scan

- Samsung/Android: QR reader app

ANY QUESTIONS?

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Jewish Cultural Resources

Overview

Welcome to the Jewish Resources page of the Department of Pastoral Care & Education website! Your chaplains are developing resources so that all hospital staff can easily access information about the religious and cultural needs of our Jewish patients.

As with many religions and cultural needs, people have different levels of observance and concerns. Our intention is provide basic guidance with links for deeper exploration, and the reminder to contact your local department for additional details as relevant.

Two of the most familiar needs are for **kosher** diet options (which can be ordered through Food & Nutrition) and **Shabbat** (Sabbath) practices. In order to support the observance of Shabbat (Friday after sunset through Saturday after sunset), chaplains distribute Shabbat boxes with electric candles, grape juice, a special cup, spices, and a healing note.

Stay tuned for more information as we progress through the Jewish liturgical year.

L'Shana Tovah is a traditional greetings at this time of year, meaning Happy New Year !

Click here to return to Cultural Resources Page.

Resources

Purim 2023

High Holy Days 2023

Chanukah 2022

Holocaust Remembrance

Yizkor 9 2023

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TITLE: **PATIENT AND FAMILY EDUCATION**

PURPOSE:

To promote patient and family centered health education in an interdisciplinary, collaborative and interactive manner that meets education needs across the healthcare continuum.

PHILOSOPHY:

New York-Presbyterian recognizes that health education is an integral part of patient services throughout the continuum of care. New York-Presbyterian is committed to providing high-quality, compassionate and effective care to all patients.

Effective patient and family education promotes optimal health outcomes and health behaviors.

All patients and family members are provided the opportunity to acquire accurate, current, and comprehensible health information tailored to their needs.

The responsibility for providing education is shared by all disciplines who encourage individuals and family members to become active participants in healthcare processes and to help assume responsibility for managing their care to the best of their ability.

POLICY:

1. Effective educational delivery methods are based on the assessment of the patient and family's preferred language, current knowledge, skills and behaviors, and preferences in learning styles.

2. <mark>The patient and their family are also assessed for any barriers to learning such as: communication limitations, cognitive and physical barriers, health literacy level, cultural and religious beliefs, emotional state, and motivation and readiness to learn.</mark> With respect to patients and families who are not fluent in English, please contact Interpreter Service and refer to **Hospital Policy & Procedure I160, Communication Access for Patients/Families Having Limited English Proficiency (LEP)**.

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3. The professional patient care staff has the responsibility for assessing and documenting patient and family educational needs and incorporating relevant information into the plan of care.

4. The professional patient care staff assists patients and their families toward achieving educational goals by:
   a. Providing education specific to patient and family's needs.
   b. Facilitating the acquisition of knowledge and skills.
   c. Encouraging the development of attitudes and behaviors that promote the achievement of educational goals.
   d. Fostering patient and family participation in the continuing management of their health care.
   e. Supporting actions directed towards achieving a maximum level of wellness.
   f. Encouraging patients and families to ask questions.
   g. Working in collaboration with the health care team as needed.

5. The Teach-Back Process is to be used throughout the patient's hospitalization to evaluate a patient's comprehension and address any confusion or misunderstandings. Optimal learning outcomes are achieved in the continuum of care through interdisciplinary and collaborative processes. The Teach-Back Process includes:
   a. **Ask** the patient and/or family what they already know using their own words, or **Ask** them to perform demonstration of the task,
   b. **Tell** – continue teaching the patient and/or family and clarify their understanding as needed
   c. **Ask** – assess the patient and/or family's understanding of the information using the Teach-Back Process.

6. Information is provided to patients and their families in a manner that is understandable.
   Topics for teaching include, but are not limited to:
   - Disease/injury condition
   - Plan for care, treatment, procedures and services
   - Basic health practices and safety
   - Safe and effective use of medications
   - Safe and effective use of medical equipment or supplies when provided by New York Presbyterian
   - Nutrition interventions, modified diets and oral health
   - Drug-nutrient interactions
   - Potential side effects of medication
   - Pain management
   - Rehabilitation
   - Access to community resources
   - Access to pastoral care

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- Access to therapies such as physical and occupational therapy
- Information about how to access healthcare providers regarding any questions or concerns
- Safe discharge plans
- Follow up care

A. Patient and Family Education Review Committee

This New York Presbyterian Hospital-wide committee serves as the interdisciplinary planning, development and evaluation group for patient and family education policy, guidelines, programs and processes.

Meetings are held monthly. The committee is composed of representatives from clinical and administrative areas.
The committee reports to the Cross Campus Nursing Practice Council.

The Patient and Family Education Review Committee (**PFERC**) members serve in an advisory/consultant position to other committee(s) or clinical personnel and act as liaisons to their departments regarding patient education issues.

Some members are specialty consultants who provide direction, support and guidance to the committee, and actively participate in policy and program approval, but are not required to attend each meeting.

B. Divisional and/or Departmental Patient/Family Education

Each division and/or clinical department is responsible for identifying their patient and family education functions, consistent with New York Presbyterian policy. In order to accomplish this, a divisional or departmental patient education committee can be formed, or the departmental group can incorporate patient education issues into their regular department meeting agendas. Committee meetings are held at least quarterly.

Core membership can be interdisciplinary as identified by each division or department.

Reports from divisional and departmental groups are presented to PFERC.

C. Interdisciplinary ad-hoc committees for specific patient population education programs

Membership consists of individuals from those disciplines identified as having expertise in caring for the specific patient population identified. Ad-hoc committees may be formed by departmental committees or by PFERC.

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These committees are charged with the responsibility to plan and implement a specific patient education program.

PROCEDURES:

A. Development of resources
When the need for a resource is identified, the proposal is presented to the appropriate divisional or departmental committee. The resource is reviewed to determine whether a similar resource exists.

To initiate the development process, follow:
- The **Patient Education Template and Guidelines** located in the **Patient Education Handbook** on the **Patient Education** website on the Infonet.
- Refer to the **Lifecycle of Patient Education** for submitting educational requests.
- Complete an **Educational Content Request Form**. See section **E** for Approval of Resources.

Translation of the resource shall be arranged for patients and families if their preferred language is not English to ensure effective communication and cultural competence.

B. Procurement of resources
All resources obtained from outside sources must be evaluated and approved by PFERC.

C. Translation of resources
The information to be translated must be presented in a simple format, with clear short sentences and prepared at a 4th to 6th grade reading level as determined by the Flesch-Kincaid Formula. Every effort must be made to develop resources written at the 4th to 6th grade reading level to facilitate translation and understanding. The use of pictures and diagrams is encouraged to help promote understanding and different modes of learning by patients and families.

The initial translation should be done by a translation service approved by New York Presbyterian. The final translation must be approved by two persons fluent in both English and the translated language, and knowledgeable in medical terminology and medical treatment used in the material. **Refer to Hospital Policy & Procedure I160, Communication Access for Patients/Families Having Limited English Proficiency (LEP).**

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The translated resource and the completed document are forwarded to the Departmental representative responsible for patient and family education materials and Nursing Informatics for final storage on the Patient Education website.

D. Evaluation
Existing resources are reviewed at least every three years or as needed to verify that the content is current in accordance with New York Presbyterian and regulatory policies, standards and practices.

E. Approval of resources
All patient and family education resources including written, audiovisual, or websites must be reviewed and approved by PFERC

Specific information regarding process for creating and getting approval for educational material are located on the **Patient Education website.**

General requirements for approval include content review by at least three persons with expertise in the resource topic. More reviewers may be required as determined by the departmental or advisory committees. The proposed sponsor or designee must present the resource at the PFERC meeting for comment and review.

Internet websites may be approved sources of information for patient distribution only if the site is approved by PFERC for that purpose. Refer to **Patient and Family Education Guidelines for Internet Resources**. Complete the **Website Approval Form** prior to presenting to PFERC for approval of website. Approval applies only to the named site and not to links within that site.

DOCUMENTATION:
Documentation of patient and family education occurs initially on admission to inpatient areas and on entry to ambulatory care areas in the electronic medical record.

APPLICABILITY:

All licensed professional patient care staff.

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Reference:

Agency for Healthcare Research and Quality (AHRQ) (August 2022). Patient Engagement and Education. Accessed February 1, 2023 from Patient Engagement and Education | Agency for Healthcare Research and Quality (ahrq.gov).

Center for Disease Control and Prevention (CDC&P) (October 2019). Health Literacy. Accessed February 1, 2023 from Health Literacy Resources | Health Literacy | CDC.

Joint Commission 2023 - *Provision of Care Standards*
PC.02.03.01: The hospital provides patient education and training based on each patient's needs and abilities.

National Institutes of Health (NIH) (July 2021). Clear Communication. Health Literacy. Accessed February 1, 2023 from Health Literacy | National Institutes of Health (NIH).

RESPONSIBILITY:

Department of Nursing
Patient and Family Education Review Committee

POLICY DATES:

ISSUED: November 1998

Reviewed: September 2000; July 2001; March 2002; July 2005; October 2010;
Revised: December 2006; December 2008; August 2012; November 2013, August 2014,
Reviewed: November 2016; October 2018, August 2020

Revised: February 2023, **May 2023**

<u>**APPROVED:**</u>

Nursing Board: October 2010; September 2012, September 2014, November 2016, November 2018, August 2020, February 2023, May 2023

Medical Board: January 2011; November 2012; October 2014, January 2017, January 2019, October 2020, March 2023, May 2023