Seven Pillars: A Safety, Quality and Health Equity Examination

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Abstract:

Limited research has been done to examine disparities in safety outcomes. As the United States continues to become more diverse in its racial, ethnic and social make-up the looming concern of health equity adds a challenging complexity to the national efforts to improve quality and safety. This research examines safety, quality and equity as parallel dimensions of improvement in health care and sheds insight on the perspectives of health care leaders about these issues. By aligning the elements of The University of Illinois Hospital and Health System Seven Pillars model and the national Safety Across the Board framework authors discover synergy that extends a pathway to ensure that both safety and equity are systematically integrated into hospital organization safety programming through the deployment of Seven Pillars. Use of the safety, quality and equity roadmap adds value to the daunting issue of addressing the impact of health disparities and adverse events among vulnerable populations.

Connecting the Heart with the Head

"Of all the forms of inequality, injustice in health care is the most shocking and inhumane."
— Martin Luther King Jr.

The lack of focus on vulnerable populations in patient safety discounts the significance of the many lives lost, all precious to those who love them. In a nation that seeks to recover from its horrid past of racism and remedy the harsh gap in opportunities for the haves versus the have nots, we have yet to place strategic emphasis on the need to protect all. A man's life lost to medical error then disguised as a heart attack, either intentionally or because of unconscious prejudice about the color of his skin, is more than a patient safety event. For the millions of Americans who have been exposed to racism, discrimination, limited access to resources and denial of equality in humanity, such an event adds insult to tragic injury.

We as a nation must connect the heart with the head in ridding our health system of all forms of inequality and ensuring that all people are protected from harm equally.

Introduction

The purpose of this report is to assess the deployment of the University of Illinois Hospital and Health Sciences System (UI Health) Seven Pillars model in its effort to advance justice, fairness and safety for all people in health care. Within the scope of this work, an examination is made of the two primary characteristics of Seven Pillars: (1) a commitment to measure, monitor and eliminate all hospital-acquired conditions and other forms of patient harm; and (2) a commitment to health equity as a systematic approach for inclusion of all stakeholders and the elimination of disparities.

This paper provides a framework for the eradication of safety disparities for vulnerable populations in a nation where minorities are becoming the majority. Ultimately, it is an urgent call to action to promote quality, safety and equity as the new national agenda.

Health service delivery stakeholders (physicians, clinicians, and institutions) are encouraged to use this guide to develop policies and to put into practice evidence-based measures that deploy quality improvement tools and work to identify and improve the care of minorities, eliminate disparities in outcomes and advance an organizational culture that is safe, compassionate and just.

Background

Adverse events and medical errors in health care delivery continue to be complex and a costly burden that significantly inhibits the achievement of high-quality care for all patients. The shift in reimbursement models to pay for performance and value-based purchasing indicate there has never been a time more than the present where greater pressures have mounted to improve quality and reduce overall health care costs. The issue of quality and patient safety first received attention in November 1999, when the Institute of Medicine (IOM) called for a national effort to

reduce medical errors in its first from a series of quality reports *To Err Is Human*. A subsequent and later phase of the IOM's quality reports produced *Crossing the Quality Chasm*; a publication that defined the six aims of quality health care (described as safe, effective, patient-centered, timely, efficient and equitable). While these calls to action prompted industry attention, now more than a decade later, care in the United States continues to be unsafe and inequitable.

It is widely accepted that medical error contributes to an estimated 98,000 preventable deaths from hospital harm annually, yet the most recent approximations suggest more accurately that the numbers have increased between 210,000 and 440,000.[1,2] Faced with rapid change, the nation's health care delivery system has fallen far short in its ability to translate knowledge into practice and to apply new technology safely and appropriately.[3] By 2042, it is projected the U.S. population will be minority-majority, with more than 51% of the total population represented by ethnic minorities.[4] Therefore, a more thoughtful discussion is needed to understand any relationship between disparities and safety outcomes.

As health disparities research has evolved, so has the definition of vulnerable populations. Due to our history of discrimination and unequal resources in health, social, education and economic opportunities, vulnerable populations traditionally were defined by race, ethnicity, socio-economic status, geographical, age, disability status, and risk status related to sex and gender.[5] More recent discussions have expanded the definition to distinct subpopulations which includes; racial or ethnic minorities; the uninsured; children; the elderly; the poor; the chronically ill; the physically disabled or handicapped; terminally ill; mentally ill; persons with acquired immunodeficiency syndrome (AIDS); alcohol or substance abusers; homeless individuals; rural communities; people who do not speak English or have other difficulties in communicating; and those who are poorly educated or illiterate to name just a few.[5, 6] When identifying disparities, evidence based practice supports stratifying data using these defining characteristics of vulnerable populations. Several studies that looked at safety outcomes used this methodology and found that ethnic minorities had more frequent exposure to certain types of adverse events.[7, 8, 9] The bulk of literature that looks at disparities commonly uses this data method for outcomes analysis' but has disregarded patient safety. Of the available research on disparities in patient safety findings conclude an increased risk for adverse events including adverse drug events, complications after surgery, infectious complications, pressure ulcers, and venous thromboembolism among hospitalized patients from racial and ethnic minorities.[10, 11, 12] Another study suggests that blacks have an increased risk of surgical complications largely due to differences in underlying comorbidities and hospital characteristics[11]. Other researchers, noted that blacks often receive care from lower quality hospitals and individual providers, there by suggesting that these factors may increase their risk of suffering an adverse event while hospitalized.[8, 10-12] For some drug events, genetic factors might play a role.[12] Concluding that more research is needed in this area.

The standardized collection and use of race, ethnicity and preferred language data (REAL) in clinical practice has not been widely adopted by hospitals.[13, 14] Therefore, this uncommon practice of identifying disparities in safety reinforces the seemingly nefarious market practices that reward and aid health care barriers through which health disparities flourish. Given the multiple reasons that influence disparities, vulnerable populations continue to grow in size and nature. Accordingly, the rate at which diversity is occurring across the United States builds a cogent platform to rigorously assess health disparities within our health systems and to measure

the relationship between quality, safety and equity. Essentially, to decrease the number of patient harms resulting in death, health care organizations must design systems that foster identification of disparities and put into practice processes that promote equity. [13, 14] The extensive evidence of health disparities has been well researched and validated in terms of medical care processes and outcomes. Yet, there continues to be limited investigation of disparities in patient safety. The growing concern that adverse events and medical error demonstrate, coupled with other phenomenon such as the catastrophic impact that health disparities has on an increasingly diverse population, signals the imploding of a nation.

Equity in Safety and Seven Pillars

In 2006, UI Health incorporated Seven Pillars into its business practice to improve patient care and reduce medical error. By design, this program intentionally forms linkages from the learning's of patient harm events to the necessary improvements in patient care.[14] Health equity is a central precept for the University of Illinois Health enterprise. Institutionalizing the Seven Pillars model put into action a methodology that improves safety and works to eliminate all harm for all people by intentionally surveying the environment for disparities in outcomes among vulnerable populations.

The UI Health journey to health equity marks the establishment of a safety aim where the organization researches, identifies and monitors health disparities while putting into practice strategies that produce more equitable safety outcomes. This framework hardwires a leadership philosophy that illuminates the consciousness to explore disparities and promotes the development of action plans to remedy all recognizable forms of preventable harm and inequity. With a shift toward a greater focus on personalized care and the patient experience, systems that strategically reengineer their programming to objectively measure differences in health outcomes have historically been relatively nonexistent.[13]

Engaging the patient voice in operations is one way to help organizations formulate patient-centered strategies for necessary change. This is evident in the Seven Pillars model. Examining disparate safety outcomes among vulnerable populations was a request originating from the Seven Pillars Safety Program Consumer Advisory Council. This council composed of a diverse panel of patient and family advocates, partners with hospital leaders to share information and provide input on systems change. Patient and family engagement (PFE) serves two primary aims. First, PFE is the socially responsible way to operate. Allowing patients to voice their perspectives on systems and outcomes can be a learning experience. [15, 16, 17] Secondly, patients and family actively engaged in health systems improvement work offers a strong catalyst for systems change. Through protocols established by patient and family engagement, UI Health in 2012 restructured its safety reporting and began using REAL data to identify disparities in safety.

The use of REAL data in recent studies reveal evidence that some types of adverse events are occurring more frequently in certain demographic subgroups of patients.[18, 19, 20] This national data suggests that disparities are not only an issue of access related to conditions such as asthma and heart failure but that inequalities may indeed exist because of unequal distributions of care and/or are embedded in our institutional systems such as stereotype and bias.[19, 20] Achieving more equitable outcomes includes identifying disparities, understanding the root-causes and

putting into action the practice of equitable strategies. Some evidence suggests that disparities are not only an issue of access related to conditions such as asthma and heart failure but that inequalities may indeed exist because of unequal distributions of care and/or are embedded in our institutional systems such as stereotype and bias. Flores and Ngui [19] systematically reviewed racial/ethnic disparities in pediatric patient safety and found higher rates of newborn birth trauma and infections attributable to negligent medical care. There are several studies that further support disparate safety outcomes for ethnic minority patients. One study measured outcomes and found that Black patients were approximately 20% more likely than were White patients to experience a patient safety event.[20] Dr. Suurmmond and colleagues conducted a qualitative study of disparities in patient safety and learned that patient safety adverse events occur more commonly among ethnic minorities because of three primary reasons: (1) inappropriate responses and practices by health care providers in relation to objective characteristics of immigrant patients, such as lack of language proficiency, lack of health insurance or genetic conditions; (2) misunderstandings between patient and health care professionals as a result of differences in illness perceptions and expectations about treatment and care; and (3) inappropriate treatment and care because of providers' prejudices against or stereotypical ideas about immigrant patients.[21] Considerable evidence also indicates that racial, ethnic, and linguistic diversity among health professionals is associated with better access to and quality of care for vulnerable populations.[22, 23, 24]

The UI Health institutionalized commitment to diversity within the academic training programs and its health care workforce well positions the organization to improve disparate outcomes.[25] Therefore, putting systems in place to measure, monitor and eliminate both avoidable harms and disparate outcomes ensures that outcomes are being improved for all people. The UI Health concept toward equitable outcomes in safety applies this three tiered approach: 1) inclusion and diversity in the patient and family engagement strategy; 2) use of standardized race, ethnicity and preferred language and income data to stratify outcomes by sub-group; and 3) development and implementation of strategies that produce more equitable outcomes.

Designing safe systems not only requires solid mechanics for managing safety but also a platform for continuous learning and improvement. In this evolving health care landscape, innovation has advanced toward the Safety Across the Board (SAB) also referred to as Harm Across the Board; a conceptual model which is rapidly being adopted by hospitals nationally and commonly referred to as the "new norm" in patient safety. Safety Across the Board provides a consolidated roadmap for hospital leaders to optimize safety programming by activating composite safety scoring, involving patients and families, ensuring diversity as a strategy and maintaining a culture of safety.[26] The UI Health model is in alignment with SAB, yet a further examination of how other hospitals review safety, quality and equity requires additional review.

Evaluating How Organizations Measure, Monitor and Eliminate All Harms

To further examine the business case of health disparities in safety and quality, a short-survey was administered to 250 health care executives to gain perspectives of these phenomena. 90 respondents returned completed surveys for a response rate of 36%. In addition to the survey, five independent semi-structured interviews were conducted with senior executive health care

leaders across the country. Table 1 provides the summary of descriptive statistics for both data capture methods:

Table 1. Descriptive Statistics for Study Respondents

	Survey Respondents	Semi-Structured Interviews
Professional Profile	7% (7) Chief executive officer (CEO) 5% (5) Chief operating officer (COO) 3% (3) Chief medical officer (CMO) 10% (10) Chief nursing officer (CNO) 12% (12) Executive director 7% (7) Nurse manager 22% (22) Health care consultant 20% (20) Medical faculty/division chair 14% (14) Other executive administrative role	(3) Health system chief executive officers - (2 physician CEOs and 1 non-physician CEO) (1) Chief of surgery (1) Association policy and physician leader
Race/Ethnicity	68% White, 26% Black or African American, 2% Asian, 1% Latino and 3% Bi-racial	40% White, 40% Black or African American and 20% Asian
Gender	64% female, 34% male, 1% preferred not to disclose	100% male
Type of Facility	31% Community hospital 23% Teaching hospital 22% Academic medical center 4% Veterans Administration Health System 2% Children's specialty hospital	60 % Integrated health delivery system (multi-hospital) 20% Academic medical center 20% National health association

The following summary lists the study findings on participant perceptions of safety and equity:

Perceptions of Just Culture and a Formal and Equitable Safety Program Widely Accepted

A just culture in hospital safety recognizes that competent professionals can make mistakes and develop unhealthy norms (.i.e., shortcuts, "routine rule violations", bias), but yet has a zero tolerance for reckless behavior.[25] Survey results support the wide acceptance of formal safety programs that practice just culture. 92% of the survey respondents and 100% of the in-depth interviewees all agreed that patient and worker safety is an organizational strategic imperative. 74% of these same respondents disclosed that their respective organizations practice just culture and 77% have a formal strategy for managing and improving outcomes for vulnerable populations. Board adoption of patient safety as standing agenda is on the rise (66%) but still not consistent with the number of formal safety programs. In-depth interview respondents also expressed the varied adoption at the Board level but how the increased need to achieve quality and cost goals as a means of margin management is a growing concern.

Vulnerable Populations Exposure to Increased Risk of Adverse Outcomes Inconclusive

When asked if vulnerable populations were exposed more frequently to adverse events, 80% of the interviewees and 46% of the survey respondents agreed that, yes, vulnerable populations were at more risk of being exposed to a safety or adverse event. The number of survey respondents who agreed increased to 54% when asked if vulnerable populations were more likely to experience patient safety events resulting from negligent care. Here we note that the most significant difference between the survey and interviewee demographics are that interviews were completed by a greater number of physician leaders (direct service providers). Interview participants further expanded on the topic. 80% stated that disparities are evident in patient safety and quality outcomes and that education, culture, language and bias are the dominating factors of influence. The remaining 20% did not feel as though race/ethnicity played a role in safety and that safety events are mostly acts of random happenings.

Perceptions of Equal Distribution of Care Among all Patient Populations Unfounded
Whether or not care is perceived to be equally distributed across all patient populations can be an indication as to whether certain populations receive less quality care. Standardization of care practices is a measure of highly reliable organizations for quality. Survey respondents (85%) believe that care is equally distributed across all patient populations. 80% of those persons interviewed disagreed and stated that care is not being equally distributed across varying classes or sects of people. One hospital CEO shared the experience where a patient brought to his attention (in the form of feedback) the fact that another neighboring patient had been receiving VIP treatment during their mutual days of hospitalization. The patient's comments were prefaced with all patient experiences should be VIP.

Perceptions that Culture, Bias and Education Influence Medical Error Varied
Fewer survey respondents agreed that medical errors occur because of prejudice, stereotype and bias (35%), although the same survey takers mostly agreed (68%) that misunderstandings between care providers and patients increase the risk of adverse events because of cultural beliefs and expectations about health and disease. Another 56% of survey respondents believe that medical error occurs due to misunderstandings between patients and providers as a result of differences of illness perceptions and expectations about treatment. 63% of the survey respondents cited that a formal process is in place for documenting observed discrimination or prejudice directed toward patients. Here, it is important to cite that while clearly the in-depth interviews revealed bias as a contender for causal factors of adverse events, the population of in-depth interviews were more heavily weighted with ethnic minority constituents as opposed to the survey respondents who were represented by 68% of non-minority individuals.

Perceptions of Race/Ethnicity and Language Data in Safety Signals Early Adoption
Although 60% of study interviewees felt there does not exist a positive correlation between race, ethnicity and safety, both the survey and in-depth interview participants agreed overwhelmingly (76%) that utilizing REAL data is useful when investigating the root cause of faults, problems or adverse events. Interestingly enough we found that 52% of the same survey respondents are developing standards for collecting REAL data, 64% are collecting REAL data, 38% utilize REAL data in clinical decision-making and24% utilize REAL data in patient safety. Accordingly, the survey found that of those institutions that do utilize REAL in patient safety also use this information to identify clinical and patient safety disparities.

Opening the safety discussion to include health disparities has proven to be enlightening. Vulnerable populations increase as diversity continues to be on the rise in the United States. Therefore, the national agenda to eliminate all harm requires additional research of the relationship between safety, quality and disparities. Historically, the issue of disparities has not been part of the national patient safety agenda. For this reason, reviewing the key findings from this examination builds the framework for development of a safety and equity roadmap.

The primary lessons learned are noted as follows:

A. **There is general acceptance among hospital leaders of *Safety Across the Board*, *Culture of Safety*, *Just Culture* and *Health Equity***. Regardless of where hospital organizations may be on the safety journey, Safety Across the Board, culture of safety, and just culture are concepts

that have become goals in which most all organizations strive to achieve. Health equity is another agreed upon precept, yet few facilities have implemented formal plans to ensure the elimination of disparities in safety.

B. **Defining vulnerable populations is necessary**. Consistently, study participants asked for a definition of vulnerable populations. When provided the traditional sub-group of ethnic minorities, persons impacted disproportionately by socio-economic status, geography, gender, age, and disability status, most all non-minority study participants stated that race and ethnicity are not factors in determining disparities in safety. One non-minority study respondent shared, "Safety events are random, and they can happen to anyone. Race and ethnicity is not a factor when considering the probability of a safety event happening to a patient." Minority leaders shared conversely different perspectives. One minority physician leader shared, "Yes, vulnerable populations including ethnic minorities are exposed to adverse events at increased rates. And it's usually competence of the staff and the poor practices that often exist in organizations. I don't think it's because people are bad, people are trying to do harm."

C. **Organizations must institutionalize more equitable practices and create a Culture of Safety and Equity**. There was a consensus among most group participants that disparate outcomes do exist in safety and quality (with an emphasis on quality). Both national and organizational level data revealed certain sub-populations (charts by race and income) with statistically significant different safety outcomes. This same data is supported by the research cited. What remains unclear is what variables are most appropriate to study disparities in safety. Disparities in outcomes are caused by a multitude of reasons where some are easily discoverable and others are not. The longstanding research on health disparities has provided guidance that supports best practice approaches toward eliminating disparities and achieving health equity. Therefore, equitable strategies such as workforce development, education/cultural competence, use of REAL data and inclusion/diversity can assist in ensuring the elimination of health disparities as well as all harm for all people.

D. **Workforce development**. Cultural competency isn't enough; the workforce must be developed to better align with the organization's patient population. Minority leaders were more sensitive to the deficiency in patient and provider concordance and stated unanimously that culture plays a role that impacts both safety and quality. As stated by a physician CEO, "Yes, our organization focuses on cultural competence but there is also a term called cultural disregard. So, this challenges us to look at, do you see me as a person the same way you might see someone of your same race or ethnicity? And I think that really does get to the level of physical fact, physical examination, thoroughness and time spent that will lead one to either see that these things exist around pressure ulcers or have a conversation long enough to be told." In organizations where a strategic focus has been placed on workforce development (the recruitment of more ethnic minorities), less concern was cited in this area. However, in institutions where there exists a focus on an extreme lack of alignment in terms of patient and provider concordance, poorer outcomes were noted.

E. **Education is necessary to eliminate bias and develop a more culturally sensitive workforce**. Similar to the approach used to train on customer service for patient satisfaction, practices such as cultural sensitivity, and health literacy must be taught across all levels of the organization in order to impact safety. Also, transparency about the patient population being cared for and community level issues should become part of the discussions occurring within the organization (across all disciplines). A recently developed Patient and Family Partnership Council in Chicago, Illinois, added gun violence to their 2014 safety agenda. While not historically seen on patient engagement agendas, patient safety and work safety have a direct correlation. Creating open forums for patient partners and staff to discuss safety is developing a growing audience.

F. **Use of standardized race, ethnicity and preferred language provides objectivity in measurement of disparities**. Whether or not race is a determinant that should be used as a variable in measuring disparities is a questionable debate for many. However, all indications reflect disparate outcomes within certain ethnic-minority sub populations. Safety has no room for "personal beliefs and perspectives" that hinder progress of discovery. Disparities in outcomes exist for a multitude of reasons. Based on the indication that race, ethnicity and language impact clinical disparities and the exposure rate to adverse events, REAL data should also be universally accepted as predictive variables to determine, identify and measure disparities in safety.

G. **Patient and family engagement remains obscure in the market**. During the in-depth interviews, 4 out of 5 participants required a full explanation of what was meant by patient and family engagement. Once defined, patient and family engagement was found to be another widely accepted theory. However, because most providers and leader participants asked for a clearer definition as to what was meant by patient and family engagement, it is understood that more education must occur in the field as a source of spread for best practice patient and family engagement activities. Most organizations represented had initiatives that responded to patient and family engagement at the point of care. Very few organizations were aware of Patient and Family Partnership Councils and only one facility of those studied had a robust agenda for patient and family engagement. A diabetic Hispanic male patron of a Wisconsin-based health system shared that the hospital closest to his home was not his facility of choice because "we don't feel welcome in that hospital". Meeting patients where they are and connecting the safety discussion into the agenda is optimal for increasing participation among ethnic-minority patients.

H. **Bias is a concern**. Here again, ethnic minorities were more inclined to believe that bias is a relevant issue that impacts safety. Bias, discrimination and stereotyping are difficult to measure. Non-minority participants believed that racial bias is not an issue and that economics is the true determinant to evaluate when assessing disparities. Training on these issues must take on a systems approach and become an expansion of the education received in medical school and in residency programs. Additionally, organizations that have implemented high reliability and have programming around population health were less fragile toward this subject matter.

I. **Diversity and inclusion must become a greater priority**. Two major findings are noted here. First, most organizations represented had diversity and inclusion strategies, but few had strategically integrated this into the fabric of the organization. Diversity and inclusion dramatically impacts patient and family engagement as it ensures representation of key stakeholders. This is also the case as seen with workforce development. Secondly, there were drastic differences between perceptions of ethnic-minority respondents and majority respondents. In most instances ethnic-minority respondents had increased sensitivities and greater awareness of issues related to equity (i.e., bias, distribution, unequal distribution of care, stereotype, etc.).

J. **Trust remains a long-standing issue that impacts outcomes**. Although the health reform vows to open access for many Americans, the pervasive health disparities among priority populations reveal the need to further explore interventions that improve health outcomes. Trust of health care organizations and preventative care resources remains a significant factor of influence among ethnic minorities' utilization of health services.[27] This was also found in the polling of hospital leaders in that most participants recognized the significant role trust plays in patient compliance and outcomes.

K. **The equal distribution of care lessens as transitions of care occur.** 85% of the survey respondents agreed that care is delivered equally across all patient populations. 3 out of 5 in-depth survey respondents also agreed that care is evenly provided to all patients. Here we found that most institutions are working toward developing improved systems through high reliability and are striving for increased standardization of care processes. Accordingly, we learned that as patients transition further away from the acute care setting, distribution of care becomes increasingly fragmented. Thus, hospital leaders expressed the need to continue working internally toward greater standardized care, but also the need to continue forging partnerships with providers, patients, families and community partners as a means of closing the gaps in care along the continuum while fostering learning and improving quality and care as a means of preventing harm.

L. **More research is needed to understand the causal factors of disparities in safety and quality**. The evidence of disparate outcomes in safety and quality are objectively shown in both national and local data analyses. Similar to the trajectory of health disparities, most people embrace the issue but the "*what next"* remains unanswered. More focused research on bias, education, culture, ethnicity and language as causal factors in safety and quality is necessary in order to achieve the elimination of all harm for all people.

Conclusion

The key findings of this report establish the basis for a more systematic approach toward safety, quality and equity. Of the IOM's six aims, equity is the one aim that has not been strategically integrated into the work of hospital organizations. To that end, the UI Health Seven Pillars model and the Safety Across the Board framework extend a pathway to ensure that both safety and equity are systematically integrated into hospital organization safety programming.

Eliminating all harm for all people should be the goal of every hospital organization. Designing safe systems require strong leadership and a systematic approach toward measuring, monitoring and eliminating all harm. Equity as defined by IOM remains the only one of the six aims used to define health care quality that has not been widely adopted in practice by hospitals. UI Health through implementation of the Seven Pillars model has institutionalized both safety and equity as organizational priorities. It is recommended other hospital leaders adopt similar methodologies through application of the safety and equity roadmap.

Because health disparities continue to plague the nation with excess financial burden, the looming concern of disparities in safety erodes profitability and adds to the evidence of increased exposure to adverse events for vulnerable populations. This epidemic if not managed places at risk the sustainability of our evolving and productive nation.

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Appendix

Eliminating Disparities in Quality and Patient Safety

Demographic Information						
I Identify My Gender As:						
□ Female	X Male	□ Transgender	□ Gender Queer/Androgynous	□ Prefer not to disclose		
I am a person of Hispanic, Latino, or Spanish origin:						
X□ No, not of Hispanic, Latino, or Spanish origin	□ Yes, Mexican, Mexican American, Chicano	□ Yes, Puerto Rican	□ Yes, Cuban	□ Yes, another Hispanic, Latino, or Spanish origin		
I identify racial as:						
X□ Caucasian or Non-Hispanic White	□ African American or Black	□ American Indian or Alaskan Native	□ Asian Indian	□ Asian including Chinese, Japanese, Korean, Vietnamese	□ Native Hawaiian, Guamanian or Chamorro, Samoan, or Pacific Islander	□ two or more races
My professional title or role within the organization is the:						
X□ Chief Executive Officer	□ Chief Operations Officer	□ Chief Diversity Officer	□ Chief Nurse Executive			
□ Executive Director	□ Nurse Manager	□ Chief Medical Officer	□ Director of Medical Affairs			
□ Healthcare Consultant	□ Medical Faculty/ Principal Investigator	□ Division Chief	□ Administrator			
□ Other _____						
I have had this title for:						
□ <1 year	□ 1 – 5 years	X□ 6 – 10 years	□ 11 – 15 years	□ > 16 years		
Which best describes your healthcare facility?						
□ Convenient Care Clinic	□ Urgent Care	□ Walk-in Clinic	□ Community Hospital			
□ Teaching Hospital	□ Hospice	□ Sexual Health Clinic	□ Doctor's Office			
□ Free/Sliding Scale Clinic	□ Academic Medical Center	□ Specialty Service Provider (ie, dialysis clinic)	□ Children's Hospital			
□ Cancer Center	□ Veteran's Hospital	X□ Other _adult day hhealth care, geriatric clinics, chronic disease mgt_____				

We are:				
□ Public/Government	□ Private/For-profit	□ Private or mixed	X□ Not-for-profit	□ Other
Number of beds: Licensed occupancy				
X□ < 200	□ 200 – 500	□ 500 – 700	□ 700 +	□ Not Applicable
Percentage of Patient Racial and/or Ethnic Mix (Please indicate in % who your patients' self-identified racial and/or ethnic background)				

Caucasian or Non-Hispanic White	African American or Black	American Indian or Alaskan Native	Asian Indian	Asian including Chinese, Japanese, Korean, Vietnamese	Native Hawaiian, Guamanian or Chamorro, Samoan, or Pacific Islander	Unknown
59%	24%	4%			4%	

Percentage of Patient payer coverage:				
40%			50%	10%
Medicaid	Medicare	Private Insurance	Uninsured	Out of Pocket

Patient Safety Assessment

Directions:
This questionnaire assesses your perceptions about patient safety and health inequity within the the current health care environment. Questions should be answered relative to your organization and/or the health system you access for care.

This questionnaire contains a series of statements about the patient safety issues, disparities in patient safety and patient safety events, which occur in some hospitals and doctor's offices.

Read each statement and then use the scale below to select the scale point that best reflects your personal degree of agreement with the statement.

Be sure to select only one response for each statement.

Scale:
Strongly Disagree (SD)
Disagree (D)
Neither Disagree nor Agree (N)
Agree (A)
Strongly Agree (SA)

STATEMENTS		SCALE				
	Leadership and Philosophy	**SD**	**D**	**N**	**A**	**SA**
1.	Patient and worker safety is a strategic priority for our organization.					
2	We provide an environment where customers are encouraged to share their concerns and satisfactions.					
3.	We have a formal strategy for improving the quality of care for vulnerable populations.					
4	Cultural knowledge and attitudes are valued attributes of our organization.					
5	Prejudging and stereotyping are addressed by our leadership staff.					
6	We have a formal plan for addressing diversity and inclusion.					
7.	Diversity and inclusion is evident within our organizational hospital board, hospital committees and staff members.					
8	Patient safety risks, hazards and opportunities are discussed and documented at every board meeting.					
9	Our medial team can relate personally to the cultural needs of our patients.					
10	Our support staff can relate personally to the cultural needs of our patients.					
11	The organization goes above standard to make all patients (minority and non-minority) feel valued.					
12	Our organization practices a just culture. Frontline personnel and patients feel comfortable reporting and disclosing patient and worker safety information.					
	Health Service Delivery	**SD**	**D**	**N**	**A**	**SA**
1	Care is delivered equally across all patient populations.					
2	Our organization evaluates care outcomes by type of patient population (race/ethnicity, age, gender, sexual orientation and language).					
3	We have a formal strategy for understanding the needs, expectations and desired outcomes of all patients.					
4	We follow a formal strategy or standard operating procedure for improving the quality of care for all patients.					
5	Our organization has an infrastructure capable of responding rapidly to patient harm.					
6	Cultural competency training is a component of the patient safety education and programming.					
7	There is a process for documenting observed discrimination or prejudice directed toward patients.					
8	Medical error can be the consequence of cultural incompetency.					
9	Health literacy is a big challenge resulting in medical harm.					

10	Culturally insensitive staff is evident within the care delivery teams.					
11	Medical errors occur due to misunderstandings between patient and health care providers as a result of differences in illness perceptions and expectations about treatment of care.					
12	Medical errors occur because of inappropriate treatment and care caused by provider prejudices or stereotypes					
13	Our organization evaluates utilization of interpreters.					
14	Misunderstanding between care providers and patients because of different cultural beliefs and expectations about health and disease increase the risk of patient safety events.					
15	Vulnerable populations are more likely to experience patient safety events resulting from negligent care.					
16	Vulnerable populations are exposed to more adverse and safety events.					
17	Little is known about the processes that contribute to ethnic disparities in in-hospital patient safety, as the potential contributions of organizational and individual care characteristics in the prevention of patient safety events.					
18	Ethnic minorities are equally likely to receive follow up care on treatment and recovery than their non-minority peers.					
19	Understanding patient background, race, ethnicity and language is key discovery for a root-cause analysis.					
20	Ethnic minorities are most likely to received inaccurate information regarding diagnosis, available resources and outcomes.					
	Healthcare Reporting	**SD**	**D**	**N**	**A**	**SA**
1	Developing a standardized approach to obtaining quality race, ethnicity and language data is an organizational priority.					
2	Our organization collects race, ethnicity and preferred language data.					
3	Our organization utilizes race, ethnicity and preferred language data in clinical decision-making.					
4	Our organization utilizes race, ethnicity and preferred language data in patient safety reporting.					
5	Our organization utilizes race, ethnicity and preferred language data in measuring clinical and quality performance.					
6	Variations in the quality outcomes among diverse populations is tracked, measured and reported.					
7	Disparities in adverse and safety events outcomes are easily detected through our standard reporting.					
8	Our organization has established goals and measureable targets for the reduction of health disparities.					
9	Our organization uses race, ethnicity and language data to identify patient safety event disparities.					

10	Our organization has a formal strategy for engaging patients and families in event analysis, investigations and complaints.					
	Legal and Disclosure	**SD**	**D**	**N**	**A**	**SA**
1	Claims and lawsuits are tracked and analyzed.					
2	Lawsuits associated with individual physicians are tracked within the organization.					
3	Disclosure includes emotional support for patients and families.					
4.	Malpractice suits often result when an unexpected adverse outcome is met with a lack of empathy from physicians and a perceived or actual withholding of essential information.					
5.	The current tort system does not promote open communication to improve patient safety.					
6.	Malpractice suits among vulnerable populations result when an unexpected adverse outcome is met with the lack of empathy from physicians and a withholding of essential information.					
7.	Hospitals and healthcare systems are reticent about discussing medical errors among vulnerable populations because they believe that they have no appropriate assurance of legal protection.					
8.	Families of diverse populations are equally compensated for legitimate medical injuries or death from hospital or health care providers.					
	Transparency of Information Sharing	**SD**	**D**	**N**	**A**	**SA**
1.	Follow up is provided for patients and families involved in harm events.					
2.	Follow up is provided for caregivers and clinical personnel involved in harm events.					
3.	Feedback is solicited from all care team members when harm has occurred.					
4.	There is a clear process for communication between staff in response to adverse events.					
5.	There is a clear process to assess and manage effective communication with patients and families in response to an adverse event.					
6.	Medical staff is encouraged to engage and alert patients when they believe medical error has occurred.					
7.	Legal counsel is sought before our medical team engages a patient who has experienced harm.					
8.	Transparency is encouraged and practiced at all levels of the organization.					
9.	Patients and families are encouraged to share perceptions of bias and discriminatory experiences.					
10.	Reporting of bias and discrimination are integrated into investigations and patient complaint research.					

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