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The Mount Sinai Health System targets bias through diversity, equity, and inclusion training

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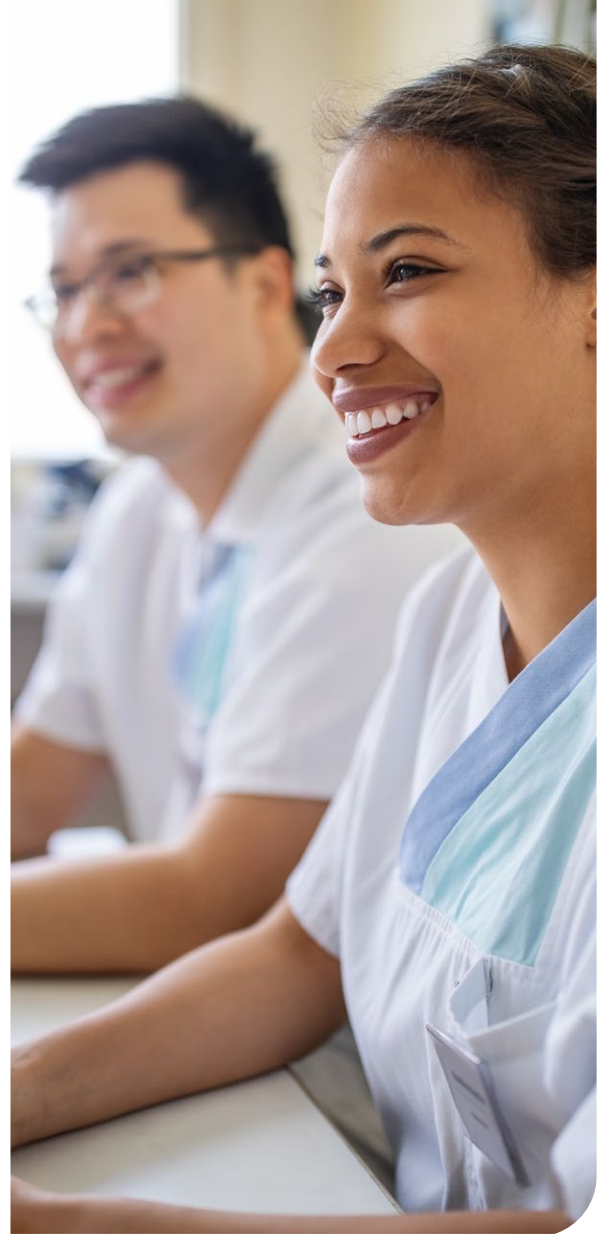

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At the Mount Sinai Health System, the principles of diversity, equity, and inclusion are driving excellence and innovation in the delivery of patient-centered care and medical and graduate school education.

By reinforcing these principles with systemwide training on how to practice self-awareness and recognize and mitigate unconscious bias, the organization is also improving the patient experience and advancing patient safety.

The Mount Sinai Health System (MSHS) was formed in 2013 as the result of a merger between the Mount Sinai Medical Center and Continuum Health Partners. Located in New York City, the system comprises eight hospital campuses, more than 45 ambulatory practices, and 13 freestanding endoscopy, ambulatory surgery, and urgent care centers, as well as two academic institutions: the Icahn School of Medicine at Mount Sinai and the Phillips School of Nursing at Mount Sinai Beth Israel.

AT A GLANCE

The Mount Sinai Health System has developed a series of sessions designed to educate leaders and staff on the impact of unconscious bias and the role that diversity, equity, and inclusion awareness plays in patient-centered care.

Among the various training modules are those that focus on specific topics of populations, such as LGBT Health, which teaches best practices for providing competent and sensitive care to patients who identify as lesbian, gay, bisexual, or transgender.

The health system is planning multiple events to support the diversity message, including a summit to discuss how inclusion can enhance the patient experience and improve outcomes, and a skill-building session designed to connect inclusive behaviors to the system's patient experience and culture change initiatives.

Prior to the merger, the Mount Sinai Medical Center and Continuum had well-established patient experience initiatives in place. A year after the merger, MSHS formed the Office for Diversity and Inclusion (ODI) to provide the system guidance and establish best practices and initiatives around diversity, equity, and inclusion. Integral to this was the introduction of customized unconscious bias education, which ODI began offering to the Medical Education department in early 2015 and systemwide soon thereafter.

As the largest private healthcare system in New York City, MSHS serves a patient population that's highly diverse in terms of race, ethnicity, age, religion, gender, sexual orientation, and gender identity/expression. So it was necessary that the system's leaders, staff, residents, faculty, and medical and graduate students not only exemplify but also support and embrace this diversity in order to provide culturally and socially effective patient care, according to Erica Rubinstein, MSHS vice president of Service Excellence and Patient Experience, and Pamela Abner, ODI vice president and chief administrative officer.

Recognizing that diversity, equity, and inclusion in healthcare can positively influence the patient experience and that unconscious bias can have the opposite effect, in 2017 Rubinstein, Abner, and other members of the leadership team brought together the patient experience and ODI teams to develop and implement a cultural alignment strategy. The goal, they said during a recent webinar in which they discussed their ongoing efforts, is to build on the foundational work around diversity, equity, inclusion, and unconscious bias that already exists and integrate it systemwide.

According to Rubinstein, focusing on diversity, equity, and inclusion as part of the cultural alignment strategy is important because it shows that MSHS embraces the diversity of its workforce as well as the people they serve. "Including unconscious bias is imperative," she added, "because most people don't know what unconscious biases are and how they impact the way we behave toward others."

As Rubinstein explained, unconscious biases, also known as implicit biases, are unintended, deeply ingrained attitudes and social stereotypes that can negatively affect people's perceptions of and interactions with others and the decisions they make, regardless of how well-intentioned they may be. Unlike conscious or explicit biases, which are attitudes and stereotypes that only some people have and that they know they have, unconscious biases are unwittingly held by everyone. As such, they can have an impact almost everywhere—from business, where they can influence how managers decide whom to hire, promote, and develop; to education, where they can affect how teachers interact with and grade their students; to society, where they can sway people's decisions about which neighborhood to live in and with whom to form friendships.

In healthcare, unconscious biases can be especially harmful, Abner noted, as they can lead to unintentional discrimination that can cause caregivers and clinicians to make poor decisions regarding the care of their patients. These decisions not only can negatively impact the patient experience, but also can compromise patient safety and result in poor outcomes.

"We may not like to admit it, but we'd be fooling ourselves if we didn't say that as human beings we have unconscious biases at play in every interaction we have with others, and as healthcare professionals we are just as susceptible as everyone else," Abner said. As an example, she recounted a case in which a patient in a dementia unit at an MSHS hospital was described to a surgeon during rounds as an elderly white woman with dementia. However, when the surgeon, who was from Jamaica, spoke with the patient, he realized immediately that the patient didn't have dementia; she was a Caucasian Jamaican and was speaking with a very heavy Jamaican Patois accent.

"When you see a person, there are things your brain does that cause you to automatically make assumptions and create a narrative about the person," Abner said. "This patient's physicians assumed she had dementia, because she was white and her spoken language did not align with their perception of her. Never did it click in their minds that she could be Jamaican. If it had, they likely would have treated her differently and not deemed her to have dementia."

In addition to racial/ethnic prejudices, sometimes biases can exist simply because the person is a patient and not a medical professional. As an example, Rubinstein detailed a case in which a resident discharged an ED patient even though the patient kept insisting she hadn't yet had a specific test performed. "If the resident's attending was the person insisting that the patient hadn't had the test yet, the resident probably would have listened. But it was the patient who was insisting, and to the resident, that wasn't enough to stop and double-check the results," Rubinstein said. "Although the patient wasn't physically harmed, she was psychologically harmed, and we can more than likely attribute this to there being some type of unconscious bias at play."

Training the workforce in diversity, equity, inclusion, and unconscious bias

To ensure that unconscious biases don't impede the system's efforts to develop and nurture a culture that celebrates diversity and inclusion, Rubinstein, Abner, and their teams developed training sessions and other tools that they use to educate leadership and staff on these issues.

To develop the training, the teams began by surveying all 38,000 employees to gauge their perceptions of patient experience, diversity, equity, and inclusion at MSHS. The survey asked employees to indicate whether they strongly agree, agree, disagree, or strongly disagree with statements regarding their understanding of how they contribute to the patient experience, whether their role is important to improving the patient experience, whether the patient experience is a top priority at MSHS, and whether their leaders, departments, and co-workers demonstrate a commitment to patient- and family-centered care.

The survey also asked whether they felt their co-workers treat all patients with respect regardless of race, color, national origin, age, religion, disability, sex, sexual orientation, gender identity, or gender expression. "We asked that question because it describes our commitment to nondiscrimination, and we wanted to see how employees thought we were doing," Rubinstein said.

Of the 18,000 respondents, 72.1% strongly agreed and 23.7% agreed with the nondiscrimination statement, while only 3.1% disagreed and 1.1% strongly disagreed with it. According to Rubinstein, those figures "showed us that employees were aware of the importance of appreciating people's differences and that we were ready to start our work toward cultural transformation and alignment across the health system."

A highlight of this work is the Mount Sinai Health System Experience, a four-hour foundational training session designed to show employees how everyone can help create an ideal patient-centered experience and how diversity, equity, and inclusion enhance the patient experience while unconscious biases can detract from it.

Recently piloted at Mount Sinai St. Luke's Hospital and now being rolled out systemwide, these sessions include in-depth discussions of MSHS's organizational values, and facilitator-led activities and conversations about diversity and bias. In addition, a graphic designed by a multidisciplinary group of leaders and staff as a visual representation of the organization'svalues and priorities is used to facilitate conversations around diversity, equity, and inclusion.

According to Rubinstein, an abbreviated version of the Experience sessions has been rolled out to the MSHS leadership team and board of trustees. "We've also developed a leadership readiness module that includes a section on teaching staff how to have robust conversations around diversity, equity, and inclusion," she said.

In addition, ODI offers a two-hour educational module focusing on unconscious bias. In one of the module's interactive exercises, the facilitator shows participants photos of people's faces, and asks them to describe the person depicted in each photo and rank them in terms of being "warm" or "competent," which is a manner in which people typically assess others. Then the facilitator reveals the identities of the people in the photos—along with their sometimes unexpected backgrounds. In addition to this exercise, the facilitators, and often the participants, share stories of when they exhibited bias toward others and explore the roots of those associations, Abner said, adding, "People are always surprised to learn how easy it is to misjudge someone."

ODI provides other systemwide educational sessions, including Cultural Awareness, which focuses on raising awareness of unconscious bias, enhancing the patient experience, and understanding people with disabilities; LGBT Health, which teaches best practices for providing competent and sensitive care to patients who identify as lesbian, gay, bisexual, or transgender; and Health Disparities, which focuses on how registration intake personnel can effectively collect data on patients' race, ethnicity, sexual orientation, and gender identity to eliminate avoidable differences in health that can result due to social disadvantages.

Initiatives focusing on inclusion have also been developed. For instance, ODI, in partnership with the Patient Experience department, will host a Healthcare Inclusion Summit next month. As part of the summit, which will feature a keynote address presented by a world-renowned inclusion expert, Rubinstein, a licensed social worker, will participate on a panel with the Dean of Medical Education at the Icahn School of Medicine and a chaplain from MSHS to share inclusion strategies that enhance the patient experience and improve patient outcomes.

"Inclusion isn't only about race and ethnicity. It's also about including other people's ideas and perspectives," Rubinstein said when describing the goal of the summit. "So, if only physicians are in a room making decisions for a patient, you're missing big pieces of that patient's care. Where's the social work perspective? The nursing perspective? The family's perspective? Moreover, what about the spiritual perspective—is anyone considering the patient's spirituality when making a medical decision about his or her care?

"When considering inclusion, you have to be holistic in your approach," Rubinstein said. "Shared decision making that also includes the patient's voice is a big part of that."

Also on the inclusion spectrum is a two-day interactive skill-building session that's designed to teach participants the meaning of inclusion and inclusive behaviors and how to connect those behaviors to the system's patient experience and culture change initiatives. This "Radical Inclusion" train-the-trainer session, which ODI will offer in June to a cadre of hospital leadership and representatives from ODI as well as the Medical Education and Patient Experience departments, will incorporate the system's core values, case studies, and interactive exercises that demonstrate inclusive behaviors. The goal is to build capacity for inclusive leadership.

At press time, the patient experience and ODI teams were continuing with the Experience rollout. And although it's too early to report measurable data showing improvements in patient experience and patient safety, Rubinstein and Abner feel their work so far has made a difference.

"We're making diversity, equity, and inclusion part of the organization's fabric," Abner concluded. "We have a long way to go, but we are headed in the right direction."

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