





# Engaging Minority Communities in Safer Healthcare

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MITSS ~ MEDICALLY INDUCED TRAUMA SUPPORT SERVICES



**MITSS**  
Medically Induced Trauma  
Support Services

## Medically Induced Trauma Support Services (MITSS), Inc.

MITSS is a nonprofit 501(c)(3) corporation founded in June 2002, and headquartered in Chestnut Hill, Mass., whose mission is “To Support Healing and Restore Hope” to patients, families, and clinicians following adverse medical events.

MITSS achieves its mission by:

- *Creating Awareness and Education.* Since 2002, MITSS has been educating the healthcare community on the uniqueness of medically induced trauma, the broad scope of its impact, and the crucial need for support services through participation in forums, local and national conferences, and through the media.
- *Direct Support Services to Patients, Families, and Clinicians.* MITSS provides educational support groups for patients and their families who have been affected by medical error or unanticipated outcomes led by a clinical psychologist. MITSS also provides support groups for nursing professionals finding themselves at the “sharp end” of an adverse medical event.
- *Advocacy for Action.* MITSS encourages and consults with healthcare institutions in developing infrastructures for clinician support systems. We also assist in developing a referral process to the MITSS program for patients and families.

### *Our Purpose*

To create awareness, promote open and honest communication, and to provide services to patients, families, and clinicians affected by medically induced trauma.

### *Our Vision*

Our vision is for all those involved in a medically induced trauma to have access to support services. We envision a more compassionate, people-centered healthcare system.

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## MITSS Board Members

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# Engaging Minority Communities in Safer Healthcare

*Sometimes the greatest challenge to change is not the question without an answer, but rather the question that has not been raised. The forum on medical errors is an important step that connects minority patients and families to the patient safety movement in ways that are distinct, specific, and meaningful.*

~ Deborah Washington, MS, RN

SINCE 2002, MITSS (MEDICALLY INDUCED TRAUMA SUPPORT SERVICES) has been pursuing its mission of *Supporting Healing and Restoring Hope* to those who have been emotionally impacted by a medical error or adverse medical event. The MITSS model is one of inclusion, built upon the belief that everyone involved in an adverse medical event – patients and their family members; doctors, nurses, pharmacists, and other frontline caregivers; hospital administrators and organizational leadership – may suffer varying degrees of emotional distress when something goes wrong in the healthcare process.

For the purpose of this discussion, it is important to describe medically induced trauma as MITSS defines it:

*Medically induced trauma is the emotional toll that results from an adverse medical event that occurs during medical and/or surgical care. An adverse medical event is an injury (physical, psychological, or both) that is due to a medical intervention. It may or may not be an error, but is an undesirable outcome that results from some aspect of diagnosis or treatment, not an underlying disease process. Most importantly, these events affect the emotional well being of the patient, family member, and/or clinician involved.*

MITSS is a small non-profit organization headquartered in Chestnut Hill, Mass., that enjoys a large reach. Over the years, patients, families, clinicians, and healthcare organizations have sought MITSS services, support, and counsel from throughout the state of Massachusetts, across the country, and around the globe. While data is not available regarding the ethnicity, race, or culture of those contacting MITSS outside of our geographic area, we can comfortably state that since 2002, the typical person who seeks our direct support services is white, female, and most often middle aged.

Given the enormous scope of the problem of medical errors and adverse events in the healthcare setting, and propelled by our observation that we have not been providing support services for a diverse population, we sought to investigate:

- How are medical errors/adverse medical events impacting the minority communities – people of different races, ethnicities, cultures, and those for whom English is a second language?
- Why are patients, families, and clinicians not routinely seeking MITSS support services following adverse events? Are there cultural barriers or issues that we need to understand in order to provide support to certain communities?
- How can we do a better job reaching out to minority communities and provide the education, support, and advocacy needed to address this important issue?

In order to try to answer these questions, MITSS held an all-day educational program, *Engaging Minority Communities in Safer Healthcare*, on August 28, 2010, in Boston, Mass. More than 70 people devoted the last Saturday in August to attend what we believe was the first-ever public dialogue about this topic of vital importance. MITSS sought to educate about patient safety topics, medically induced trauma, and the mission and vision of our organization. In turn, we sought to hear from healthcare representatives of some of the minority communities, as well as patients and their families, about their experiences, perceptions, and stories so that we could learn how best to serve and support a more diverse population.

## Background and Scope of the Problem

The overall numbers are astounding: 275 people die when a jumbo jet crashes, but 275 people die every day in the United States from preventable medical errors; 1,836 lives were lost during Hurricane Katrina, yet over 1,836 lives are lost every week to preventable medical errors. According to the famous Institute of Medicine (IOM) Report, *To Err Is Human*, it is estimated that 98,000 people each year die from medical error. Through the Institute of Healthcare Improvement's (IHI) *5 Million Lives Campaign*, it has been estimated that there are approximately 15 million adverse medical events each year, 6 million of which cause harm to the patient, resulting in a significant deviation in the patient care process.<sup>1</sup> In the hospital setting, this conservatively translates to 12 million affected family members and 12 million healthcare providers being emotionally impacted by these events each year.

Far less is known, however, about racial/ethnic disparities in patient safety. Neither race nor ethnicity was mentioned in the landmark IOM report. Linguistic issues were mentioned briefly in three sentences, and only in reference to access to care or general recommendations.<sup>2</sup> There is, as Johnstone and Kanitsaki found, "...a paucity of literature addressing the critical relationship that exists between culture, language, and patient safety, and the particular risk that patients from minority racial, ethno-cultural, and language backgrounds face when being cared for by healthcare professionals who do not know about, share, or understand either their culture or language."<sup>3</sup>

While the information available is not abundant, it does seem generally accepted that healthcare professionals provide different – and generally less – care to their minority patients. When in the hospital, African-Americans receive fewer surgical interventions, diagnostic tests, medical services, and less optimal interventions than Whites – even when their diagnoses, symptoms, and insurance status are the same. African-Americans get only three-quarters of the high technology interventions prescribed for Whites. Additionally, they are more likely to be discharged in an unstable condition and more likely to have longer hospital stays.<sup>4</sup> Chang et al. found that African-American patients were approximately 20% more likely than were White patients to experience a patient safety event. Flores and Ngui systematically reviewed racial/ethnic disparities in pediatric patient safety and found higher rates of newborn birth trauma and infections attributable to negligent medical care.<sup>5</sup>

*There is, as Johnstone and Kanitsaki found, "...a paucity of literature addressing the critical relationship that exists between culture, language, and patient safety, and the particular risk that patients from minority racial, ethno-cultural, and language backgrounds face when being cared for by healthcare professionals who do not know about, share, or understand either their culture or language."*

an emergency for bone fractures.<sup>7</sup> Hispanics are also more likely to have nursing-related patient safety events, while other non-Hispanic racial minorities are more likely to have failure to rescue and to die during hospitalization, compared with Whites.<sup>8</sup> These findings may be indicative of another important issue – errors that are due to racial prejudices and stereotyping. As Watson noted, bias, prejudice, class, and money all play a role, and differences based on race and ethnicity rather than medical needs are indeed medical mistakes.<sup>9</sup> In fact, for the African-Americans interviewed in one study, among the most important incidents were those in which racism or prejudice occurred. This would suggest that patients and families in some minority populations view breakdowns in the patient-physician relationship as more prominent medical errors than those related to technology or treatment.<sup>10</sup> It would seem, therefore, that when looking at patient safety through the lens of the minority community, the definition of medical error would need to be expanded to include differences in treatment due to prejudice and racial stereotyping.

Although there is limited research that states psychological trauma symptomatology may manifest differently among minority communities,<sup>11</sup> we could find no research that identified medical error or adverse medical events as a source of trauma among minority communities. In fact, in the body of research examining medical disparities due to race, ethnicity, and language, there was no discussion of the emotional impact on the patients. Although the issue of disparity in healthcare is a larger one and discussion varies on its root cause and contributing factors, including differences in socio-economic status and availability of healthcare resources,<sup>12</sup> MITSS's focus was limited to that of cultural barriers and to begin the discussion about emotional impact within minority communities following an adverse medical event.

The issue of patient safety and its impact on minority communities is certainly complex, with divergent approaches and points of view. There does seem to be some consensus, however, around the need for further research and more comprehensive data. There is also a fairly uniform call for improved cultural competence, the components of which would include:

- more diversity among staff and providers;
- system capacities, including data collection (to assess the needs of the patient population and track progress in improving health outcomes); and,
- cultural competence education for management, providers, and staff.<sup>13</sup>

It should be noted here that the Joint Commission has made several efforts to better understand individual patients' needs and provide guidance for organizations to address those needs. In 2010, they published a monograph, *Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals*, to help hospitals integrate communication, cultural competence, and patient- and family-centered care practices into their organizations.<sup>14</sup> Also, the Agency for Healthcare Research and Quality has published the

Additionally, a few studies indicate that language differences between the healthcare provider and patient lead to a higher risk of patient safety incidents. The use of family or friends as interpreters instead of professional interpreters may also lead to errors in medical interpretations, with potentially serious consequences.<sup>6</sup>

There is evidence that Hispanics are less likely to get treatment for cancer-related pain and are twice as likely as white patients to receive no pain medication when treated in

## Methodology

*National Healthcare Disparities Report* since 2003. The recently released 2010 report concludes that while healthcare quality in the United States is slowly improving, disparities and gaps in access to care persist, especially for minority and low-income groups.<sup>15</sup>

The goal of the conference was basically twofold: (1) to familiarize people from some of the minority communities about MITSS and its services; and (2) to learn about the impact of adverse events on minorities and explore what cultural barriers might prevent patients and families from seeking MITSS support services. Therefore, we sought to bring together a mix of minority healthcare leaders, frontline clinicians, and patients and their families representing various races, ethnicities, and cultures. To achieve this, MITSS:

- Partnered with professional associations – the New England Regional Black Nurses Association (NERBNA) and National Association of Hispanic Nurses (NAHN) – to get the word out to their memberships.
- Held the event at the Reggie Lewis Center, an urban location that is the site of a large number of community outreach activities in Boston.
- Developed and disseminated two brochures: one targeted toward healthcare providers, and the other to patients and their families.
- Contacted 26 community health centers (CHCs) throughout Greater Boston as well as the North and South Shore areas. MITSS staff called and spoke personally with CHC staff members. CHCs were additionally sent follow-up information about MITSS and the program.
- Utilized social media and websites. Posted notices and reminders to MITSS Facebook page, Twitter, and listservs (CLAS Listserv) as well as the MITSS website.
- Encouraged speakers, participants, and organizers of the program to reach out to their various constituencies.

## Engaging Minority Communities in Safer Healthcare



*Linda Kenney*

The conference attracted a highly diverse audience of more than 70 healthcare leaders, providers, and consumers. The day's agenda included five structured presentations followed by small group discussions to gather information and encourage feedback from conference participants.

### *Setting the stage through personal stories* \_\_\_\_\_

Linda Kenney, founder and president of MITSS, opened the program by presenting an overview of the day's goals and agenda and introduced the first speaker, Lucilia Prates, health consumer advocate, expert on the delivery of services to immigrant and refugee communities, and director of the Massachusetts Senior Medicare Patrol Program, a statewide multidisciplinary partnership that works to educate underserved, limited English proficient and other hard-to-reach, vulnerable populations. Ms. Prates told the story of her father, a 72-year-old Portuguese immigrant, whose death from both a medical error and a hospital-acquired staph infection, followed an increasingly dangerous cascade of events after surgery for removal of kidney stones. Ms. Prates' father, who had limited English proficiency, required two follow-up surgeries, multiple healthcare visits, and interactions with providers that he felt were belittling.



Deborah Washington

Ms. Prates emphasized the need for consumers' active engagement in their healthcare and in advocating for safer healthcare practices. She stressed that more minorities are urgently needed as healthcare professionals.

### *Patient safety in the minority community*

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Deb Washington, MS, RN, director of Massachusetts General Hospital's Patient Care Services Diversity Program, reaffirmed the importance of patients' and families' stories about the occurrence and impact of medical errors in minority communities. Embedded in these

stories are vital issues that must be addressed in order to assure patient safety. Ms. Washington described an 88-year-old Haitian woman who received regular procedures for her medical condition, requiring the use of sedation. During one visit, the medical staff had difficulty inserting the IV line but went ahead with the procedure without delivering the sedation. The patient's cries prompted her daughter to enter the treatment room and question the staff's performance. Ms. Washington stressed the need for patients, providers, and families to be honest and open about patients' experiences, especially among patients of color, so that all can learn and appropriate action can be taken. She noted that patient stories can inform new models of practice; identify opportunities for creating multicultural, multilingual, and multiethnic systems of care; and, uncover gaps in care and available support systems following adverse medical events.

### *The impact of culture on safety*

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Lin Wu, RN, Massachusetts General Hospital, offered important insight into the impact of Asian cultural beliefs and practices on medical care and patient safety. People of Asian backgrounds and traditions represent more than 13 percent of the U.S. population and are a fast-growing demographic. Asian children are taught from a young age to be agreeable and deferential, particularly with individuals they consider to be authoritative, such as physicians. Asians seek harmony, and so generally won't question their providers or indicate when they don't understand procedures or patient instructions. In the Asian culture, individuals call upon their inner stamina to tolerate crisis or pain and, therefore, may not report physical discomfort to their providers.

Ms. Wu provided an example of a new Asian mother who would not eat or drink or engage in daily care during her postpartum hospital stay. Concerned about her health and the health of her baby and assuming the problem was postpartum depression, the nurse prepared to call for a hospital social worker. Instead, Ms. Wu was able to explain that in traditional Chinese medicine, heat, which is lost during childbirth, must be restored through the consumption of certain "hot" foods which were not available to this young patient. Ms. Wu also stressed the importance of establishing communication with the patient's family, which acts as a collective decision maker and prioritizes protection of the patient from unnecessary stress or worry. Thus, Asian families may withhold what most Westerners would consider important medical information from the patient.

These issues are complex, and, while current hospital cultural sensitivity trainings programs are growing, they are typically insufficient, often operating on the assumption, for example, that one nurse's participation in training is adequate for raising cultural awareness and skills across the entire unit. Not surprisingly, research shows that Asians have reported challenges in their experiences with the healthcare system, including difficulty communicating with their doctors,<sup>16</sup> and they rate primary care provider performance lower than whites, African-Americans, and Latinos.<sup>17</sup>

### *Challenges of patient safety in an organization with diverse patient populations* \_\_\_\_\_

The conference's next speaker, Lisa O'Connor, RN, BSN, MS, vice president of nursing at Boston Medical Center, spoke about the strategies her organization, which has one of the most diverse workforces and patient populations in Massachusetts, has undertaken to improve patient safety. Core concepts supporting safety are communication, standard work processes (e.g., checking a patient's identification twice before administering medication), accountability, learning, competency, staff training, and reporting. At Boston Medical Center, clear, timely, and mutually understood communication is essential; reporting on patient outcomes must be transparent, as required by an increasing number of health insurers and consumers; and, training must be responsive to variable learning styles and perspectives.

While stressing the responsibility of healthcare leadership to begin the conversation, reach out to, engage, learn from its diverse patient population, and sustain the drive for change, Ms. O'Connor also emphasized the role of patients who can improve their health and safety by taking an active role at the center of their own healthcare team. At the same time, we must acknowledge that a patient who is sick and, therefore, vulnerable, or who doesn't speak English, is at a disadvantage and may not be comfortable asking questions such as whether the doctor has washed his or her hands. Ms. O'Connor addressed the need for high expectations for cultural competency in order to support patient safety, the resistance of medical and nursing professionals, many of whom are not accustomed to transparency about medical errors, and the importance of standardization of care to increase safety and reduce misinterpretations based on cultural practices or even tone of voice. Hospitals must be wary of risk or areas of exposure stemming from matters such as mistaken patient names for those from ethnic groups that use multiple names. Technology can reduce safety concerns, for example, through the use of biometric IDs. Patients as well as providers need to be open to novel approaches.

### *The role of medical interpreters in patient safety* \_\_\_\_\_

Lisa Morris, director of cross cultural initiatives at the University of Massachusetts Medical School, provided a clear and compelling picture of the role of medical interpreters in helping assure patient safety and how their understanding of culture strengthens overall care delivery and contributes to the reduction of medical errors. Though family members, including children, have long acted as interpreters in the healthcare setting, trained and experienced medical interpreters ensure the patient's right to understand and have equal access to healthcare by conveying complete and accurate medical information. In addition to their training, experience, and knowledge of medical terminology, medical interpreters develop other acuties that impact the healthcare experience, including sensitivities to the patient's pain, confusion, or anxiety, that can facilitate the patient-doctor relationship, contribute to rapport and trust in the system, and improve quality.

Medical interpreters can reduce the delivery of inappropriate care due to language differences or stereotyping. In one example, a 14-year-old Mexican girl who presented to the emergency room was assumed to be pregnant, resulting in a wrongful death from the actual cause of ill-



ness, a ruptured appendix. Medical interpreters prevent confusion or inappropriate care that results from family involvement, such as withholding information about medication side effects in order to increase the likelihood the patient will complete her or his medication regime. Medical interpreters can encourage the engagement in care of patients from other cultures, and they can clarify confusion; for example, the

English word *once* has a different meaning than Spanish word *once*, which means the number eleven. Interpreters can reduce missed appointments and improve health by communicating in the patient's language about follow-up appointments – when these involve complex and expensive tests such as an MRI or colonoscopy, the cost savings can be substantial. By fostering rapport with the patient, the medical interpreter can increase his or her trust in the hospital or health center, which may improve compliance with medical orders or reduce missed appointments, improving patient safety, and enhancing patient satisfaction.

### *Learning from consumers*

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Paramount to identifying and implementing sustainable improvements in patient safety in minority communities, and to providing culturally appropriate support to those affected by medical errors, is the design of deliberate and structured mechanisms for incorporating consumer voices in local and national discussions, creating new standards of care, and assessing their effectiveness. As an organization with a mission of responsiveness to families and providers affected by preventable medical errors, MITSS is positioned and committed to reach out to and gather feedback and suggestions from minority communities.

Toward that end, time at the *Engaging Minority Communities in Safer Healthcare* conference was devoted to hearing from participants. Small group sessions were held with trained facilitators using a structured format to assure engagement and consistency across groups. These lively sessions provided a wealth of information; in addition, follow-up surveys were sent to participants who were not able to participate in the small group sessions. The following represents the predominant themes expressed in the small group sessions and the surveys in the areas of barriers to patient safety and opportunities for improvement. These are not necessarily the opinions or positions of the MITSS organization.

### *Barriers to engaging minorities in patient safety*

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- Participants agreed that medical errors occur and are sometimes covered up.
- There are no proactive measures in place to prevent medical errors.
- There is a lack of open dialogue on the issue of patient safety.
- There is insufficient training and provider awareness of patients' experiences.
- Doctors take a defensive stance on the topic of preventable medical errors.
- Providers should be more humble, sensitive, respectful, and empathic, and they need to read the chart. They should listen more.

- Language barriers complicate care.
- Time constraints interfere with the delivery of safe and effective care.
- We have an egocentric healthcare system.
- Improving culturally sensitive healthcare and patient safety is a complex task on many levels: individual, cultural, community, healthcare leadership, and within local and national reform.

### *Opportunities for engaging minorities in patient safety and culturally competent care*

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- The conference was an important opportunity to learn new information about important matters.
- The theme most often expressed by participants centered on the need for greater understanding of cultural beliefs by healthcare providers and for more respectful, compassionate care of patients of all backgrounds. Provider training is essential.
- A number of providers conduct themselves professionally and communicate well with patients.
- Patients need more awareness about cultural issues, too.
- Patients must be more engaged in their healthcare and learn how they can help prevent medical errors. Patients should ask questions and demand answers.
- Mechanisms can be established to facilitate communication between patients and providers about patient safety issues. Both sides need to be heard, and all should participate in solutions.
- Minority groups can be part of efforts to improve patient safety and culturally competent care, including new immigrants, professional organizations, and churches.
- Outreach to these and other groups can take place through PSAs, cable, radio, and the ethnic media. Interpretation should be available at future discussions.
- We need accessible interpretation for patients in healthcare settings.
- There are successes to build from: interpretation for patients, escorts for seniors and disabled adults, advocates for rape victims, and resources for cancer patients.

### Where Do We Go from Here?

Outrage about the widespread and tragic occurrence of preventable medical errors has placed the issue squarely at the forefront of efforts to reform healthcare delivery at the state and national level. Increasingly, the healthcare literature documents the need for consumer engagement in identifying and implementing improvements in quality healthcare delivery. Positive trends are evident, including: (1) In 2001, the U.S Office of Minority Health created the Culturally and Linguistically Appropriate Services (CLAS) standards, to improve cultural competence in healthcare organizations and increase access to language services. CLAS standards are mandated for organizations that receive federal funds; (2) In 2006, the Harvard-affiliated hospitals adopted a joint error-disclosure policy; three of the policy's authors were MITSS board members, and the policy references the work of MITSS; (3) A new state law requires that a patient and family advisory council be established at each hospital in Massachusetts by October, 2010, offering new opportunities for patient engagement in safer healthcare, and more accountability in healthcare delivery. These Patient and Family Advisory Councils must include members of the diverse community where the hospital is situated; (4) The National Quality Forum's 34 Safe Practices stipulate timely and empathic communication, statements of regret and apology, full investigation, and emotional support for patients and families following an unanticipated medical event. For the caregivers involved, the standards stress treatment that is just, timely, compassionate, and free of blame, with the opportunity to participate in investigations.

The vibrant environment in which healthcare is delivered today has raised expectations and opened minds to the potential for change. The *Engaging Minority Communities in Safer Healthcare* conference was a pivotal opportunity for MITSS as we set our course for the coming year. The conference confirmed that increasing the engagement of minority communities in patient safety efforts, and assuring that anyone who needs or requests it receives emotional support in the wake of an adverse medical event, are complex matters requiring careful consideration. Further, MITSS realizes the necessity of an approach that is inclusive of people of all backgrounds, ages, incomes, sexual orientations, and physical and emotional abilities.

MITSS is committed to pursuing this area of work as a top priority. We will use our experience working across patient and provider groups to gather additional insight and information and then contribute this knowledge to new models for patient, family, and clinician support programs, provider training, and patient awareness efforts. During the coming year, MITSS will undertake work in the following areas:

- Carry out an assessment of our constituents in order to complement and add to the highly useful information that was gained at the conference. MITSS will seek feedback from our board members, healthcare partners, providers, and consumers about the role MITSS can play in engaging minority communities in safer healthcare and offering appropriate emotional support in the wake of a preventable medical error and/or adverse medical event.
- Develop further discussion and identify potential areas for collaboration with the Mass. League of Community Health Centers.
- Reach out to individual community health centers as providers of care for large numbers of minority patients to inform them about MITSS and seek their feedback about improving support for patients from minority communities who are involved in medical errors and/or adverse medical events.
- Strengthen our collaborative relationships with the New England Regional Black Nurses Association and the National Association of Hispanic Nurses.
- Seek out other partnerships with other stakeholders who may help to inform the work going forward (for example, the Joint Commission, Asia Pacific Nurses Association, etc.).
- Learn more about challenges faced by clinicians from minority communities and identify ways in which MITSS can provide support.
- Based on the data gathered from the previous items, create a long-range plan for MITSS to provide emotional support to minority groups impacted by medical errors/adverse medical events and encourage engagement by minority communities in improving patient safety.

## Conclusion

Medically Induced Trauma Support Services began as one woman's attempt to expose a serious problem in healthcare so that solutions can be identified; patients, families, and clinicians who have been affected by adverse medical events can receive emotional support; and, patient safety can be increased. MITSS is now an internationally recognized force that serves as a successful example of how consumers and the healthcare sector can work together to address the widespread occurrence of preventable medical errors. True to its mission, MITSS perceived a need to explore this issue in minority communities and swiftly responded. The *Engaging Minority Communities in Safer Healthcare* conference provided an unusual opportunity for frank and open discussion among consumers, providers, and healthcare leaders about issues that previously received little attention.

While the organizers of *Engaging Minority Communities in Safer Healthcare* initially envisioned gathering concrete information to move forward with its agenda of providing support for members of minority groups in cases of adverse events, the conference ultimately raised more questions than provided answers. The literature is clear that some minority groups routinely receive substandard medical care as compared with Whites. There are studies that have indicated this is true even when access to healthcare, insurance, and socio-economic status are adjusted for. However, we were unable to find any information in the literature regarding the emotional impact of medical errors/adverse medical events on members of minority groups. Conference presenters shared their personal and professional healthcare experiences and provided rich context in principles of patient safety and quality improvement. Work group participants imparted personal anecdotes, lessons learned at work, and recommended changes. It is upon these examples that we need to build our outreach efforts in order to provide support for a more diverse population.

The issues raised at this conference were complex and will require our deeper investigation by engaging in more discussion, providing education, and raising awareness; strengthening alliances with existing partners; and, expanding our scope by forging new relationships with representatives of various communities. MITSS's ultimate goal is providing emotional support to *people of all backgrounds* who experience the emotional toll following a medically induced trauma, and we are poised to take the next steps in order to do so.

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# Faculty

**Linda K. Kenney**  
Executive Director, MITSS



Linda Kenney founded MITSS in 2002 as the result of a personal experience with an adverse medical event, when she identified the need for support services in cases of adverse events and outlined an agenda for change. Since that time, she has been a tireless activist for patient, family, and clinician rights. She has become a nationally and internationally recognized leader in the patient safety movement and speaks regularly at healthcare conferences and forums. In 2006, Linda was the first consumer graduate of the prestigious HRET/AHA Patient Leadership Fellowship. That same year, she was the recipient of the National Patient Safety Foundation's esteemed

Socius Award, an annual award given in recognition of effective partnering in pursuit of patient safety. She has authored and contributed to a number of publications on topics including the emotional impact of adverse events on patients, families, and clinicians. Linda has served on countless local and national boards, task forces, and committees. She currently serves on the boards of the National Patient Safety Foundation and Planetree.

**Lisa M. Morris, Director, Cross Cultural Initiatives**  
University of Massachusetts Medical School



Ms. Morris is responsible for coordination and delivery of the Medical Interpreter Training Program disseminated throughout Massachusetts by the Mass-AHEC Network regional offices for bilingual/bicultural staff at MassHealth provider sites. In addition, she established a translation bureau to provide culturally responsive and sensitive written materials. Responsibilities also include development of policy and procedure recommendations and revisions of assessment tools and curriculum.

Ms. Morris works as an Adjunct Faculty member at two community colleges training medical interpreters. She has worked as a telephonic interpreter since 1994. She has been a medical interpreter since 1985. She serves as co-chair of the Organizational Development Committee of the National Council on Interpreting in Health Care. Ms. Morris earned a Masters in Training and Development from Lesley College. She received her BA in Romance Languages from Boston College. Most recently, she completed a fellowship in Cultural Competence Leadership with HRET in partnership with the American Hospital Association.

**Lisa O'Connor, RN, BSN, MS, NEA-BC**  
VP of Nursing, Boston Medical Center



Lisa O'Connor is the Vice President of Nursing at Boston Medical Center. In her role, she has a wide scope of responsibilities, including Nursing, Respiratory Care, Social Work, Patient Access, Rehabilitation Therapies, Care Management and Inpatient Operations. Ms. O'Connor is the only RN at the senior management level of the hospital and has the opportunity to bring the nursing perspective to organizational-wide initiatives as important decisions and policies are made to improve patient care.

Ms. O'Connor has 22 years of nursing experience in clinical and leadership positions. She started her career at the Dana-Farber Cancer Institute,

where she spent 10 years in direct patient care and management roles. For the past 12 years, she has held successful positions in both nursing management and hospital administration.

Ms. O'Connor graduated from the first Honors Program in Nursing at Salem State College, and received her bachelors in nursing in 1987. She received a Masters in Management from Lesley University in 2002. Lisa received her Green Belt in Six Sigma from GE in 2005. Ms. O'Connor is certified in Nursing Administration at the advanced level and is a 2009 Robert Wood Johnson Executive Nurse Fellow

### **Erin O'Donnell** **MITSS Support Team Member**



Erin O'Donnell is a 5th year student at the Massachusetts School of Professional Psychology working toward her Doctorate of Clinical Psychology (PsyD). She graduated from Indiana University-Bloomington in 2001 with a B.S. in Applied Health Sciences-Human Development/Family Studies. Prior to graduate school, she worked with children, adolescents, and their families in both day treatment and residential settings. Erin was a clinical psychology practicum student at MITSS in 2006 and stayed on as a Support Team Member. Other practicum and internship sites included: CMG Associates (an employee assistance program), Lexington High School, and Lynn Community Health Center. While at MITSS, she provides direct support to patients, family members, and clinicians; conducts research; and, co-facilitates the patient and family support groups with Susan LaFarge, PsyD.

### **Lucilia Prates** **Director, Massachusetts SMP Program** **Elder Services of Merrimack Valley**



Lucilia Prates-Ramos is the Director of the Massachusetts SMP (Senior Medicare Patrol) Program, a statewide multi-disciplinary partnership that works to reach and educate un-served, underserved, limited English proficient and other hard-to-reach, vulnerable populations across the state on the importance of taking an active role in their healthcare and detecting, preventing and reporting healthcare errors, fraud and abuse. Ms. Prates-Ramos has worked as a consultant with immigrant communities across the state in the area of program and organizational development. She has extensive experience in organizing and implementing workshops, trainings, conferences and summits to identify the challenges and the many contribution of multicultural and multilingual communities.

Ms. Prates-Ramos has served on the advisory boards of local foundations and is often consulted for her expert opinion on the delivery of an array of services to immigrant and refugee communities. She is recognized as a bridge builder when it comes to addressing the challenges of cultural and linguistic barriers.

*Faculty listing continues on following page*

**Winifred N. Tobin**  
**Communications Director, MITSS**



Winnie Tobin joined MITSS in the spring of 2003. Since that time, she has been responsible for strategic communications surrounding all of the organization's activities including annual event planning, web content, print media, social media, and community outreach efforts. Winnie received her BSBA in Marketing, Magna Cum Laude from the Suffolk University School of Management in Boston, Massachusetts. She is currently a member of Health Care for All's Consumer Quality Council's Advisory Group, and she was the consumer representative to the Massachusetts Board of Registration in Medicine's Med Spa Task Force from 2006 to 2008.

**Deborah Washington, MS, RN**  
**Director, Massachusetts General Hospital Diversity Patient Care**



Deb Washington has been Director of Diversity for Patient Care Services at Mass General for 16 years in addition to her time spent as a staff nurse for an additional 8 years at the hospital. Deb is a member of MITSS as well as the New England Regional Black Nurses' Association and Critical Mass, which is an organization focused on eliminating health disparities. Ms. Washington is a recent graduate of the Robert Wood Johnson Executive Nurse Fellowship where her project focus was the creation of community based collaborations formed to advance the health agenda of minority communities.

**Lin Wu, RN**  
**Massachusetts General Hospital**



Lin Wu received her nursing degrees in China and the United States and also obtained a Masters Degree in Healthcare Management in the United States. She worked for 10 years as Registered Nurse and Midwife in China before coming to America. Since that time, she has been employed in the hospital setting in the United States (approximately 10 years). Ms. Wu has had strong clinical experience in both China and America and has a broad knowledge of both healthcare delivery systems and management. She has a keen understanding of cultural values and background and their significant impact on the quality of healthcare.



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