HEALTHCARE EQUITY BLUEPRINT

VISION

Be a national model for healthcare equity and reduce disparities in healthcare delivery.

PREMISE

We will establish equity in healthcare delivery across UW Medicine because we value every human life. As a healthcare leader, it's incumbent upon us to "right the wrongs" in healthcare equity and improve consistency across our system. Through clear, consistent communications across UW Medicine and alignment with leadership, our workforce must increase their awareness of the healthcare disparities faced by the populations we serve and why achieving healthcare equity is a top priority. Through regular assessments and care transformation to address disparities, we will accomplish our vision.

OVERALL STRATEGY

- Establish training resources, programs, events and policies to create an environment that supports diversity, equity and inclusion across all aspects of the UW Medicine workforce.
- Work with the communities we serve to better learn their needs and engage them as partners in identifying and addressing care equity opportunities.
- Develop and implement strategies to promote healthcare equity for all patients regardless of age, race, ethnicity, language, religion, spiritual practice, sexual orientation, gender identity or expression and socioeconomic and mental/physical status.

MEASURES OF SUCCESS

- Our ability to attract and retain a diverse and inclusive workforce at all clinical sites governed by UW Medicine.
- Our engagement of community stakeholders in planning and monitoring of quality improvement and healthcare services to meet their needs.
- Our ability to provide standard, culturally-sensitive healthcare services to all patients.
- Our improvement of quality metrics for UW Medicine populations of interest.

GUIDING PRINCIPLES

- We will approach this multi-year work through a UW Medicine system lens.
- We will develop structures and processes to support healthcare equity work across the organization.
- We will engage, partner and collaborate with UW Medicine clinical sites of practice, UW School of Medicine and other UW schools, departments and offices to achieve our objectives.
- We will operate with explicit definitions of equity, racism, bias, diversity, and cultural humility.
- We will seek to understand where we've fallen short and demonstrate commitment and accountability to improving healthcare equity at all levels of the organization.
- We will develop and sustain a foundation of social trust across our communities by being present to listen to and learn about those we serve, soliciting ongoing feedback from them, and consistently reporting back.
- We will recognize that how and why people seek care is culturally variable.
- We will seek to build a workforce that reflects the populations we serve.
- We will include all healthcare professionals in diversity, cultural humility and implicit bias efforts.
- We will report annually on all of the ongoing efforts and outcomes under this initiative and distribute broadly across UW Medicine.

BLUEPRINT OBJECTIVE 1: Increase diversity, increase cultural humility and reduce implicit bias in the healthcare workforce.

Strategy 1-1: Increase diversity and inclusion at all clinical sites governed by UW Medicine.
Strategy 1-1 Priorities:

1. We must engage with the Equal Employment Opportunity (EEO) office to understand our current diversity baseline. We must break with our status quo recruitment efforts and set diversity standards for interview pools. UW staff must be held accountable for promoting the advancement, development and retention of diverse employees.
2. We must promote and celebrate our commitment to diversity and inclusion so people know these are key values. Diversity and inclusion must be visible and reflected at all levels of the workforce.
3. The communities we serve must be viewed as pools for potential employees, and we must support the appropriate education and skills acquisition for people from those communities who choose to work in the UW Medicine system.
4. We must invest more in specific programs that promote diversity and inclusion, and to eliminate barriers in our workforce such as job shadowing and career-advancement scholarships for staff.
5. We must partner with the UW Medicine Center for Diversity and Inclusion (CEDI) to support ongoing faculty and medical student workforce diversity and pipeline efforts.

Strategy 1-2: Increase cultural humility and respectful communications.
Strategy 1-2 Priorities:

1. We must use evidence-based strategies to integrate equitable practice and policies throughout UW Medicine.
2. We must provide training to the workforce regarding implicit bias, diversity, cultural humility and respectful conversations.
3. We must develop a safe forum for people to report injustice. Knowledge of this forum must be included in staff training.

Strategy 1-3: Implement policies, procedures and incentives to support desired behaviors.
Strategy 1-3 Priorities:

1. We must celebrate staff who exemplify a commitment to diversity, inclusion and cultural humility.
2. UW Medicine's healthcare equity values must be essential in staff orientation and onboarding.
3. We must integrate diversity, inclusion and cultural humility competencies into UW Medicine's performance expectations.

BLUEPRINT OBJECTIVE 2: Engage the communities we serve as partners in assessing and addressing healthcare equity.

Strategies:

1. We must conduct a community needs assessment and, when available, use existing data and resources.
2. We must create meaningful relationships with our community stakeholders (e.g., convene community based meetings) and explicitly address history with institutional racism.
3. We must sponsor events and have a public presence so diverse communities know we're invested in serving their needs.
4. We must partner with legislators and advocacy groups to enact change on a policy level.
5. We must educate ourselves about the diverse needs and cultural differences of the populations we serve and recognize there are existing resources and databases we can use (e.g., EthnoMed.org).

BLUEPRINT OBJECTIVE 3: Deploy targeted quality improvement and healthcare services to meet the needs of marginalized populations.

Strategy 3-1. Collect and analyze data to understand where disparities exist.
Strategy 3-1 Priorities:

1. We must make equity data and performance outcomes transparent and accessible to all clinicians and administrators through various formats and define thresholds from our metrics to identify when inequity is present or absent.
2. Using appropriate metrics, we must inventory UW Medicine data to understand what data is available and missing through the current REAL data collection.
3. We must add criteria to the Electronic Health Record (EHR) to capture fields that indicate social determinants of health and/or marginalization.
4. We must use the EHR to facilitate data collection and analysis.
5. We must design data and reporting methods that consider intersectionality to further identify and address inequities.
6. We must solicit feedback from departments and communities to inform areas of disparities or problems to provide data against.
7. We must capture and analyze patient satisfaction/patient experience data across population groups to inform areas to target for healthcare equity efforts.

Strategy 3-2. Targeted quality improvement (QI).
Strategy 3-2 Priorities:

1. We must have explicit, system-wide goals and performance reporting across all levels of governance throughout UW Medicine.
2. We must utilize data about UW Medicine patients (e.g., community assessments, REAL data, department and entity input) to determine areas of disparities. Based off our findings, we will direct quality improvement projects that harness and spread best practices from areas of strong performance.
3. We must incorporate the patient experience into quality improvement design.
4. We must ensure that quality improvement or clinical care standardization projects across UW Medicine incorporate healthcare equity as a measurable outcome of improvement or success.
5. We must provide resources for UW Medicine programs that focus on healthcare equity and healthcare disparity.

Strategy 3-3. Culturally sensitive healthcare services and programs.
Strategy 3-3 Prioritized Tactics:

1. We must develop and implement one standard for interpretive services across UW Medicine. To achieve this, we must first assess the current state of interpretive services across sites of practice and identify the ideal future state.
2. We aspire to deploy navigation and care management services for underserved patient populations in our community. To achieve this, we must first assess the current state of navigation and care management services across sites of practices and identify the ideal future state, and then deploy based on financial resources available.

MEASURES OF SUCCESS

The UW Medicine Healthcare Equity Blueprint submits key strategies and priorities for a multi-year approach to address healthcare equity and reduce healthcare disparities for the patients and communities we serve. We will measure our success through the achievement of the following:

1. Our ability to attract and retain a diverse and inclusive workforce at all clinical sites governed by UW Medicine.
2. Our engagement of community stakeholders in planning and monitoring of quality improvement and healthcare services to meet their needs.
3. Our ability to provide standard, culturally-sensitive healthcare services to all patients.
4. Our improvement of quality metrics for UW Medicine populations of interest.

Below, we offer potential deliverables to be achieved in the first year to lay the foundation for long-term success. We will also develop key performance indicators, or quantifiable measures to evaluate success in the first year. We will report annually on our progress toward success and on the ongoing efforts under this initiative and distribute broadly across UW Medicine.

PROPOSED DELIVERABLES – YEAR ONE

Objective 1: Increase diversity and inclusion, increase cultural humility and reduce implicit bias in the healthcare workforce.
- Gather and assess data to determine the "diversity baseline" of the current UW Medicine workforce at all clinical sites governed by UW Medicine. Set goals and metrics for diversity recruitment.
- Identify UW Medicine's workforce responsible for hiring of faculty, clinicians and staff and assess current state of diversity recruitment practices. Create an action plan to improve diversity recruitment practices.
- Assess existing training options for implicit bias, diversity, inclusion, cultural humility and respective conversations available to UW Medicine workforce members. Create an action plan to provide training to existing UW Medicine workforce and to insert training into new hire onboarding.

Objective 2: Engage the communities we serve as partners in assessing and addressing healthcare equity.
- Create an action plan for community engagement that identifies priority communities to engage, leverages existing UW, UW SOM, and/or UW Medicine forums and connections to the community, and specifies distinct needs to carryforward strategic work under this objective.

Objective 3: Deploy targeted quality improvement and healthcare services to meet the needs of marginalized populations.
- Complete Sexual Orientation and Gender Identify EHR data capture and report capabilities.
- Select 3 to 4 clinical improvement goals related to reducing healthcare disparities. Engage clinicians, teams, staff and patients/community in project efforts. Monitor and track clinical improvement and reduction in healthcare disparities.
- Assess the current state of interpreter, navigation and care management services across UW Medicine clinical sites. Perform a cost and personnel assessment, determine gaps and minimum necessary requirements, and identify ideal future state. Propose a plan to UW Medicine leadership on how to achieve one standard for interpretive services and optimal deployment of navigation and care management services.

ORGANIZATIONAL STRUCTURE

We propose a structure that establishes system-level goals and strategies for improvement and provides centralized, coordinated resources to support all UW Medicine clinical sites in addressing healthcare equity.

UW Medicine Strategic Leadership Council (SLC) will provide executive-level oversight of the initiative. The Chief Medical Officer and Chief Health System Officer will serve as co-Executive Sponsors. The Healthcare Equity Steering Committee will report into SLC's Clinical Strategic Planning Committee.

The Healthcare Equity Steering Committee will be responsible for establishing system-level goals and strategies for improving healthcare equity across UW Medicine clinical sites. The Committee will be comprised of 10-15 representatives appointed by the initiative Executive Sponsors. Members will serve one or two year appointments and provide representation from UW Medicine clinical sites of practice, UW School of Medicine and the patients and community UW Medicine serves.

The Clinician Director will be appointed by and report into the Office of the Chief Medical Officer. The Clinician Director will chair the Healthcare Equity Steering Committee, Healthcare Equity Advisory Council and participate in the Clinical Strategic Planning Committee and SLC when issues regarding healthcare equity are discussed. The Administrative Director will be appointed by and report into the Office of the Chief Health System Officer. The Administrative Director will staff the Healthcare Equity Steering Committee and Advisory Council, and chair operational workgroups and taskforces to achieve goals, objectives and deliverables.

The Healthcare Equity Advisory Council will provide insights and guidance on issues surrounding healthcare equity at UW Medicine clinical sites of practice and the community we serve. The Council will include perspectives from clinical care, teaching, research and advocacy. To attain a diversity of perspectives, the Council will include stakeholders from across UW Medicine clinical sites, UW School of Medicine, UW Health Sciences schools (e.g., Nursing, Social Work, Public Health) and the community.

Operational workgroups and collaborative taskforces will be convened by the Administrative Director as necessary to manage and fulfill action plans to achieve goals, objectives and deliverables. Potential operational workgroups may include workforce training, community relationships, measurement and reporting, and interpreter and navigator services. We will engage, partner and collaborate with UW Medicine clinical sites, UW Medicine administration offices, UW School of Medicine and other UW schools, departments and offices to design and implement strategies. Below, we have identified several internal collaborators that will be key to achieving success.

Strategic Leadership Council

Co-Executive Sponsor
Chief Medical Officer ← Clinical Strategic Planning Committee → Co-Executive Sponsor:
Chief Health System Officer

Healthcare Equity Steering Committee

Reports to Office of
Chief Medical Officer ← Clinician Director and Administrative Director → Reports to Office of
Chief Health System Officer

Clinical sites
Key internal collaborators { Operational workgroups and taskforces, convened as necessary   Healthcare Equity Advisory Council } Clinical sites
Key internal collaborators
Other UW stakeholders
Community stakeholders
Patients

KEY INTERNAL COLLABORATORS

- HMC Interpreter Services Department and Community House Calls Program
- HMC Refugee and Immigrant Health Promotion Program and International Medicine Clinic
- NWH Interpreter Services
- Seattle Children's Center for Diversity and Health Equity
- UW/UW Medicine/VMC/UWP/UWNC Human Resource offices
- UW Health Equity Circle
- UW Medicine Center for Diversity and Inclusion
- UW Medicine Director of Quality Metrics, and population health and quality improvement analysts
- UW Medicine Information Technology Services
- UW Medicine learning management system office
- UW Medicine Organization Development & Training
- UW Office of Equal Opportunity and Affirmative Action
- UW Population Health Initiative
- UW Professional & Organization Development
- UW Race & Equity Initiative
- UW research centers with specific population foci (e.g., Latino Center for Health)
- UWMC Patient and Family Education Services
- VMC Patient and Guest Services
- WWAMI Institute for Simulation in Healthcare

FIRST YEAR STRUCTURE DELIVERABLES

- Recruit and fill Clinician Director, Administrative Director and one central program staff positions. Identify designated operations leads and representatives from each UW Medicine clinical site.
- Charter, appoint and convene the Steering Committee. Organize and convene the Healthcare Equity Advisory Council. Convene workgroups and taskforces to fulfill first year deliverables across objectives.
- Develop an internal/external communications plan, working with UW Medicine Strategic Marketing and Communications to plan and execute.

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GLOSSARY

Bias — Inclination or prejudice for or against one person or group, especially in a way considered to be unfair.
(https://en.oxforddictionaries.com/definition/bias)

Care management services — Team-based, patient-centered approaches designed to assist patients and their support systems in managing medical conditions more effectively. It also encompasses care coordination activities needed to manage things like chronic illness.
(More information can be found here: https://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/caremanagement/index.html)

Community — A group of people that may or may not be spatially connected but share common interests, concerns and identities. Communities can be local, national or international with specific or broad interests. Members of a community are linked by social ties and gain their personal and social identity by sharing common beliefs, perspectives, values and norms that have been developed by the community in the past and may be modified in the future. They exhibit some awareness of their identity as a group, and share common needs and a commitment to meeting them. The UW Medicine community is embedded in the larger UW community, and includes all staff, faculty, students, healthcare providers, faith-based organizations, health centers, community centers, the array of other places where our patients are served, the organizations we collaborate with, and our patients themselves.
(http://www.who.int/healthpromotion/conferences/7gchp/track1/en/ and https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1446907/)

Community needs assessment — Provides community leaders with a snapshot of local policy, systems, and environmental change strategies currently in place and helps to identify areas for improvement. With this data, communities can map out a course for health improvement by creating strategies to make positive and sustainable changes in their communities.
(http://www.seattlechildrens.org/about/community-benefit/community-health-assessment/)

Cultural humility — Cultural humility in healthcare comprises three principles:

> 1. Cultural humility is a commitment and active engagement in a lifelong learning and critical self-reflection process whereby an individual not only learns about another's culture, but starts with an examination of her/his own beliefs and cultural identities.

> 2. Cultural humility requires recognizing and challenging power imbalances inherent in clinician-patient or service provider-community relationships.

> 3. The healthcare institution itself must model the first two principles of cultural humility.

(https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3834043/Vivian Chavez, "Cultural Humility: People, Principles, and Practices")

Culture — An integrated pattern of human behavior which includes but is not limited to thought, communication, languages, beliefs, values, practices, customs, courtesies, rituals, manners of interacting, roles, relationships, and expected behaviors of a racial, ethnic, religious, social or political group.
(https://nccc.georgetown.edu/documents/DVD%20Power%20point%20slides.pdf)

Determinants of health — Factors that contribute to a person's current state of health. Scientists generally recognize five determinants of health of a population: biology and genetics (sex and age), individual behavior (alcohol use, injection drug use, unprotected sex and smoking), social environment (discrimination, income and gender), physical environment (where a person lives and crowding conditions), and health services (access to quality health care/having or not having health insurance). (https://www.cdc.gov/nchhstp/socialdeterminants/faq.html)

Disparity threshold — We acknowledge that differences or disparities exist in care but since we are not able to act on every disparity, we need to identify a threshold to guide what we will act on. For example, what is the threshold for the difference, gap or disparity in care or health metrics that will result in our action? (https://www.ahrq.gov/research/findings/nhqrdr/nhdr13/chap11.html)

Diversity — Understanding that each individual is unique, and recognizing our individual differences. These differences can be along the dimensions of race, ethnicity, religion, gender, sexuality, socio-economic status, nationality and citizenship, parental status, body size and ability, age and experience. (http://www.inclusive.vcu.edu/media/inclusive-excellence/DiversityandInclusionDictionary.pdf)

Ethnicity — Refers to shared cultural practices, perspectives, and distinctions that set one group of people apart from another. (http://www.inclusive.vcu.edu/media/inclusive-excellence/DiversityandInclusionDictionary.pdf)

EthnoMed — Harborview Medical Center's ethnic medicine website containing medical and cultural information about immigrant and refugee groups. Information is specific to groups in the Seattle area, but much of the cultural and health information is of interest and applicable in other geographic areas. EthnoMed is a joint program of the UW Health Sciences Libraries and Harborview Medical Center's Interpreter Services Department/Community House Calls Program (ISD/CHC). (https://ethnomed.org/)

Health disparities — Health disparities indicate the difference in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exists among specific population groups. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion. (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1497467/pdf/12500958.pdf)

Health equity — A condition when all people have the opportunity to attain their full health potential and no one is disadvantaged from achieving this potential because of their social position or other socially determined circumstance. (https://www.cdc.gov/nchhstp/socialdeterminants/faq.html)

Health inequity — A difference or disparity in health outcomes that is systematic, avoidable and unjust. (https://www.cdc.gov/nchhstp/socialdeterminants/definitions.html)

Implicit Association Test (IAT) — Measures the strength of associations between concepts (e.g., black people, gay people) and evaluations (e.g., good, bad) or stereotypes (e.g., athletic, clumsy). Measures attitudes and beliefs that people may be unwilling or unable to report.

(https://implicit.harvard.edu/implicit/faqs.html)

Implicit bias — An unconsciously triggered belief in the inferiority of, or negative attitude toward, a group(s). Implicit biases can impact expectations and actions; unconscious negative beliefs and feelings about racial groups may not appear on a survey but may be revealed in everyday interpersonal interactions.
(https://scholar.harvard.edu/files/matthewclair/files/sociology_of_racism_clairandenis_2015.pdf)

Inclusion/Inclusive environment — An environment in which all individuals are treated fairly and respectfully, have equal access to opportunities and resources and can contribute fully to the organization's success.
(http://www.inclusive.vcu.edu/media/inclusive-excellence/DiversityandInclusionDictionary.pdf)

Institutional racism — Refers to particular and general instances of racial discrimination, inequality, exploitation and domination in organizational or institutional contexts. While institutional racism can be overt, it is more often used to explain cases of disparate impact, where organizations or societies distribute more resources to one group than another without overtly racist intent. The rules, processes and opportunity structures that enable such disparate impacts are what constitute institutional racism (and variants such as 'structural racism', 'systemic racism', etc.).
(https://scholar.harvard.edu/files/matthewclair/files/sociology_of_racism_clairandenis_2015.pdf)

Intersectionality — The interconnected nature of social categorizations such as race, age, health, ethnicity, class and gender as they apply to a given individual or group, regarded as creating overlapping and interdependent systems of discrimination or disadvantage.
(http://www.inclusive.vcu.edu/media/inclusive-excellence/DiversityandInclusionDictionary.pdf)

Navigation services — Navigation services, similar to care management services, bring together all necessary members of the care team to work on cases that are complicated by cultural, linguistic or social issues.
(https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4121958/)

Nurse Camp — A free, week-long day camp at the UW School of Nursing geared towards increasing access and opportunities in nursing to minority and low-income high school sophomores and juniors.
(https://nursing.uw.edu/community/uw-nurse-camp/)

Race — Refers to groups of people who have differences and similarities in biological traits deemed by society to be socially significant
(http://www.inclusive.vcu.edu/media/inclusive-excellence/DiversityandInclusionDictionary.pdf)

Racism — An ideology of racial domination in which the presumed biological or cultural superiority of one or more racial groups is used to justify or prescribe the inferior treatment or social position(s) of other racial groups.
(https://scholar.harvard.edu/files/matthewclair/files/sociology_of_racism_clairandenis_2015.pdf)

REAL data — Refers to Race, Ethnicity, and Language data. Real data categories include: Hispanic ethnicity, race, granular ethnicity, spoken English language proficiency and spoken language preferred for healthcare. Collecting and using REAL data in decision making can help insure that care provided is tailored to the individual needs of patients.
(https://www.ahrq.gov/research/findings/final-reports/iomracereport/index.html)

UW Medicine Center for Diversity and Inclusion (CEDI) — A department within UW Medicine whose mission is to build individual and institutional capacity to achieve excellence, foster innovation, and further health equity in our state and region by advancing diversity and inclusiveness throughout the UW School of Medicine's teaching, patient care and research programs. (http://depts.washington.edu/cedi/wp_cedi/)

UW Medicine Office of Organizational Development & Training (ODT) — A department within UW Medicine that exists to create a culture of learning and discovery that unifies UW Medicine, thereby creating the capacity to accomplish the strategic goals of the enterprise. (http://odt.uwmc.washington.edu/)

Vulnerable population — A group of people with certain characteristics that cause them to be at greater risk of having poor health outcomes. These characteristics include, but are not limited to, age, culture, disability, education, ethnicity, health insurance, housing status, income, mental health and race. (https://public.health.oregon.gov/About/TaskForce/Documents/public-health-terminology.pdf)