HEALTHCARE EQUITY BLUEPRINT 2.0: THE PATH TO HEALTH JUSTICE

UW Medicine: Office of Healthcare Equity

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UW Medicine

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INTRODUCTION

In the fall of 2017 the UW Medicine Healthcare Equity Blueprint was operationalized by the newly formed healthcare equity team. The main focus of this team was to gather information about the current state of equity, diversity and inclusion (EDI) perspectives and activities, as well as to provide information, education and training to advance the principles and practices of EDI throughout the health system. The team launched its work guided by the blueprint objectives:

> **OBJECTIVE 1:** Increase diversity, increase cultural humility and reduce implicit bias in the healthcare workforce.
>
> **OBJECTIVE 2:** Engage the communities we serve as partners in assessing and addressing healthcare equity.
>
> **OBJECTIVE 3:** Deploy targeted quality improvement and healthcare services to meet the needs of marginalized populations.

We are pleased to report that the year one deliverables were met and, in several areas, exceeded, as the team engaged clinical and administrative leaders and staff throughout the system to raise awareness through training and to take actions through changes in policies and practices. Many of these accomplishments are highlighted in our annual reports.

The pandemic and concurrent focus on racial injustice highlighted by the national focus on police violence in spring 2020, reaffirmed the need for our commitment to anti-racism, healthcare equity and health justice within UW Medicine. Even prior to 2020, UW Medicine senior leadership realized the need for a more robust and integrated approach to infusing the principles of equity, diversity, and inclusion into the fabric of UW Medicine. This resulted in a reorganization that combined the healthcare equity team with the School of Medicine's Center for Equity Diversity and Inclusion, thus forming the Office of Healthcare Equity (OHCE), which launched July 1, 2020.

Much of the work of the Office of Healthcare Equity for 2020 through the first quarter of 2022 had focused on the response to the pandemic. Specifically, we worked towards creating equitable access to and distribution of COVID testing and vaccines in Black, indigenous and communities of color (BIPOC), along with limited English proficient (LEP) communities which were experiencing the greatest disproportionality of the disease and that even in the best of times, have poorer access to healthcare and other social determinants of health. This work highlighted the inequities in our healthcare system and motivated leaders throughout our organization to seek the resources and expertise of OHCE. This increase in demand resulted in the expansion of our work into 3 additional strategic focus areas. This document outlines these new areas of focus and is an update and extension to the original Healthcare Equity Blueprint objectives and strategies.

The 6 areas focus for this updated blueprint are:

1. Leadership and Strategic Visioning
2. Workforce Development
3. Community Engagement
4. Quality Improvement
5. Evaluation and Research
6. Learning Environments

The activities in these strategic focus areas will be delivered according to the OHCE vision, mission and values:

VISION:

To deliver on the UWM mission to improve the health of the public by ensuring that policies and practices focus on equity, social and health justice as we strive to become an anti-racist academic medical school and healthcare delivery system.

MISSION:

To reduce inequities in healthcare by training UW Medicine's workforce in the principles of diversity, equity, inclusion and justice;

To make UW Medicine and UW Medicine Centers a more equitable place to learn, work, provide and receive care by the critical examination of our policy and practices;

To provide local and national leadership in healthcare equity and be a national model for healthcare equity; and

VALUES:

Actively promote anti-racism in healthcare

Treat everyone with respect and compassion.

Embrace and model diversity, equity, inclusion and justice.

Practice and promote honest and transparent communication.

Facilitate collaboration and teamwork across disciplines, specialties and communities.

Engage in, promote and disseminate data-driven healthcare and health justice innovation.

GUIDING PRINCIPLES:

- Approach this work through a UW Medicine system lens.
- Develop and revise policies and practices in support of equity and justice across UW Medicine.
- Engage, partner and collaborate with all UW Medicine entities, health sciences, and UW schools as appropriate.
- Operate with explicit definitions of equity, racism, bias, diversity, and cultural humility.
- Acknowledge that patient safety, staff satisfaction, and health outcomes are crucially linked with diversity, equity, inclusion, and justice policies and practices.
- Ensure equity, diversity, and inclusion principles inform all system-wide quality improvement policies and practices.
- Identify where we have fallen short and commit with accountability to improving healthcare equity at all levels of the organization.
- Develop and sustain trust across the communities we serve through ongoing engagement, dialogue, advocacy and accountability. by being present to listen to and learn about those we serve, solicit ongoing feedback from them, and consistently report back.
- Advocate for and facilitate the formation of a workforce reflective of the diversity of the communities we serve.

Within this Blueprint, we offer deliverables be initiated in FY 22 - FY23, which will lay the foundation for the transformation of our learning, working, teaching and healing environment by upholding healthcare equity, establishing a culture of anti-

racism, including policies and practices and striving for health justice for our patients, faculty, staff, trainees, students and communities.

This is not a short-term project, but part of our dynamic journey as a leading healthcare system. There are no simple fixes to some of the barriers to equity, but we are confident we can make our system better by following this blueprint. Through our commitment to this work, OHCE will demonstrate that UW Medicine is willing to confront and tackle difficult issues and focus on outcomes that matter to those members of our internal and external communities who are most marginalized. To do this, work must be done across and outside of UW Medicine to broaden the perspectives and to imagine a future that looks different than today. This Blueprint is the next step in a long journey to creating a culture of health justice.

MEASURES OF SUCCESS:

- The ability to attract and retain diverse and inclusive leaders and workforce at all entities governed by UW Medicine.
- The development and implementation of anti-bias, anti-racist policies and practices that promote equity and reduce disparities for all staff regardless of age, race, ethnicity, language, religion, spiritual practice, sexual orientation, gender identity or expression and socioeconomic and mental/physical status.
- 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.
- Engagement of community stakeholders in planning and monitoring of quality improvement and healthcare services to meet their needs.

- The improvement of employee retention and performance metrics for UW Medicine staff.
- The improvement of quality metrics for OHCE patient populations of interest.
- Foster learning environments that are equitable and develop providers that further health equity and health justice in the care they provide to communities.

FOCUS AREA #1: LEADERSHIP AND STRATEGIC VISIONING

Goal: Position OHCE as the leading resource to internal colleagues and the external community, locally, regionally and nationally on advancing healthcare equity and health justice principles and practices.

Year 1 Deliverables:

1. Establish a robust social media presence. Track and monitor posts.
2. Create an OHCE newsletter/blog.
3. Cultivate 3 new prospective foundations for philanthropic support.
4. Host 2 speaker forums with local, regional or national thought leaders
5. Create a plan for a healthcare equity conference.

Recommendations:

1. Develop and implement broad outreach strategies to attract leaders from diverse sources to the organization through strategic partnerships.

2. Partner with local and national professional organizations for BIPOC health professionals such as the Association of American Indian Physicians and the National Association of Hispanic Healthcare Executives to support ongoing diversity recruitment for leadership and ecosystem development efforts.

3. Include EDI measures in all manager and executive performance plans.

4. Develop a communication strategy that provides information in a consistent, accessible way and regularly communicate about progress of DEI initiatives that continue to establish UW Medicine as an employer of choice and assist in business pursuits.

FOCUS AREA #2: WORKFORCE DEVELOPMENT

Goal: Acknowledge that patient safety, provider and staff satisfaction, and health outcomes are crucially linked with diversity, equity, inclusion, and justice practices.

Year 1 Deliverables:

1. Deliver a minimum 2,000 hours of training to at least 800 members of the UW Medicine workforce.
2. Launch EDI Climate Survey
3. Launch 2 LMS training modules.
4. Initiate the development of policy defining racism.
5. Launch formal administrative workforce equity consulting service.
6. Provide leadership to the restructure of the Committee for Minority Faculty Advancement (CMFA).

Recommendations:

1. Develop and implement policies and procedures that clearly define racism, racist behavior and state the consequences for those who engage in these actions.
2. Provide a culture of continuous improvement, innovation, and accountability by designing a learning infrastructure that provides high-quality, online learning opportunities around EDI.
3. Ensure that UW Medicine's values and progress in EDI are captured during the recruitment, onboarding and staff orientation processes.

4. Integrate EDI competencies into UW Medicine's performance expectations for all levels of our workforce.
5. Formalize individual and small cohort leadership coaching on EDI issues.
6. Provide consulting services to UW School of Medicine for curriculum review.
7. Maintain focus on capacity building for leaders to enable broad dissemination of EDI principles and activities.
8. Partner with the Office of Faculty Affairs to provide search committee training and ongoing leadership training.
9. Develop and implement policies and procedures that clearly state the consequences of inappropriate and/or abusive behaviors.
10. Create a safe forum for people to report injustice. Knowledge of this forum must be included in staff training.
11. UW Medicine must understand its current diversity baseline and break with its status quo recruitment efforts and set diversity standards for interview pools.
12. UW Medicine administrators and Board members must be held accountable for promoting the advancement, development, and retention of diverse leaders.
13. 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.

FOCUS AREA #3: COMMUNITY ENGAGEMENT

Goal: Develop and sustain a foundation of trust across our communities and build partnerships, by being present to listen to and learn about those we serve, solicit ongoing feedback and consistently report back.

Year 1 Deliverables:

1. Launch the OHCE Community Advisory Council
2. Hold a minimum of 2 in person community conversations
3. Initiate annual health fair with community partners

Recommendations:

1. Nurture and strengthen relationships with community stakeholders to establish an effective post COVID response presence.
2. Capture and analyze patient satisfaction/patient experience data across population groups to inform areas of focus for healthcare equity efforts.
3. Solicit feedback from marginalized and historically underserved communities to investigate problems and examine disparities specific to that community.
4. Sponsor events and enhance our public presence in partnership with CBOs serving marginalized and historically underrepresented communities.
5. Partner with legislators and local advocacy groups that focus on healthcare disparity and healthcare equity.

6. Create a discovery committee to explore the possibility of opening a community clinic between Seattle and Kent.
7. Continue to advocate for the establishment of a mammography clinic at Harborview.
8. Initiate exploration to establish a UW Medicine Community Center for Health Justice.

FOCUS AREA #4: RESEARCH AND EVALUATION: THE JUSTICE, EQUITY DIVERSITY AND INCLUSION CENTER FOR TRANSFORMATIVE RESEARCH (JEDI CENTER)

Goal: Conduct research and evaluation to develop specific knowledge that increases understanding of healthcare disparities and social determinants of health and improves the health of UW Medicine patients.

Mission Statement: To study and ultimately eliminate health disparities by promoting the principles of justice, equity, diversity and inclusion in the research of vulnerable populations, and by increasing the recruitment, retention and advancement of students, residents, fellows, and faculty from groups under-represented in medicine.

Vision Statement: To improve the health and wellbeing of the public and eliminate health disparities by justice and health equity driven research.

Year 1 Deliverables:

1. Fully launch The JEDI Center
2. Conduct health equity original research
    a. Telemedicine equity (focus groups)
    b. Emotional well-being in under-represented minority providers and students
    c. Social Determinants of Health
3. Support and stimulate our UW Medicine investigator community to engage in OHCE mission-relevant research; fostering research collaborations
4. Disseminate OHCE mission-relevant research findings
5. Promote diversity, equity, and inclusion in UW Medicine research endeavors

6. Community advisory board

Recommendations

1. Develop an OHCE Fellowship Program
2. Establish a community advisory committee for the JEDI Center

FOCUS AREA #5: QUALITY IMPROVEMENT

Goal: Ensure equity, diversity, and inclusion principles inform all system-wide quality improvement policies, processes and practices.

Year 1 Deliverables:

1. Develop and disseminate a short form of the Equity Impact Review Tool for use in day to day decision making.
2. Establish and launch a formal equity consult service.
3. Provide administrative leadership to the formal launch of the TGNB service line.
4. Partner with clinical operations leaders to improve access in scheduling, digital front door, telemedicine and language services.

Recommendations:

1. Ensure that quality improvement or clinical care standardization projects across UW Medicine incorporate healthcare equity as a measurable outcome of improvement or success.
2. Capture and analyze patient satisfaction/patient experience data across population groups to inform areas to target for healthcare equity efforts.
3. Propose and convene a system-wide committee sponsored by OHCE to coordinate collection, analysis and dashboard display of SDOH data.

FOCUS AREA #6: LEARNING ENVIRONMENTS

Goal: Reduce health inequities by educating healthcare professionals and research scientists informed by principles of equity, diversity, inclusion and justice, while fostering a learning and teaching environment that is welcoming and inclusive in which all members of our community thrive.

Year 1 Deliverables:

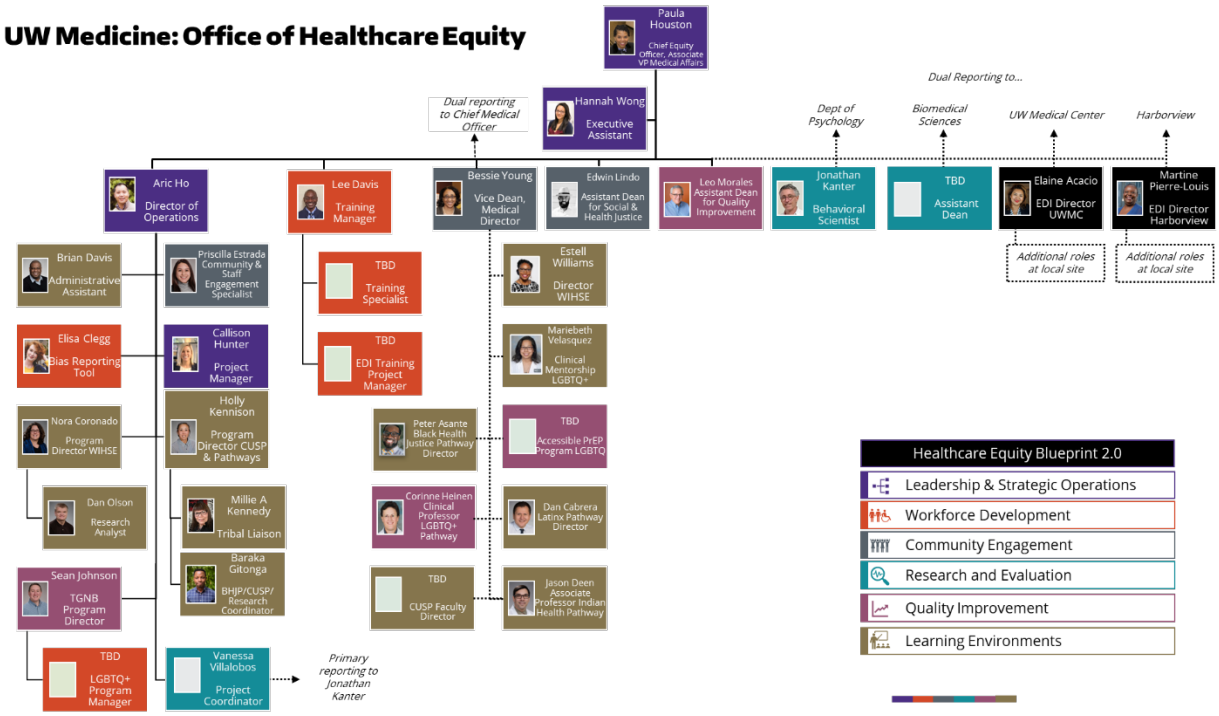
1. Establish and enroll students in Black Health Justice Pathway (BHJP)
2. Establish Research Graduate Education (RGE liaison position
3. Establish the Assistant Dean for Equity and Medical Student Engagement
4. Fully launch and promote the Center for Workforce Inclusion and Health System Equity (WIHSE)

Recommendations:

1. Provide a culture of continuous improvement, innovation, and accountability by designing or licensing a learning infrastructure that provides high-quality, online learning opportunities around EDI.
2. Develop health learning pathways and invest more in specific programs such as job shadowing and career-advancement scholarships.
3. Facilitate innovative research development and provide direction for instructional and curriculum development.
4. Create an OHCE Fellowship Program.
5. Lead, promote and support restorative justice and other forms of alternative dispute resolution practices.

6. Provide free medical school education to Black and Indigenous students.

APPENDIX A: OFFICE OF HEALTHCARE EQUITY ORGANIZATIONAL CHART



APPENDIX B: GLOSSARY OF TERMS

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-chroniccare/improve/coordination/caremanagement/index.htmlU)

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) UW MEDICINE | HEALTHCARE EQUITY Version Date 04.21.2017 Page 12 of 14

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, socioeconomic 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. UW MEDICINE | HEALTHCARE EQUITY Version Date 04.21.2017 Page 13 of 14 (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/)

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 | HEALTHCARE EQUITY Version Date 04.21.2017 Page 14 of 14

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)