# The Transformer: the UW Medicine Podcast
# Episode 6: Healthcare Equity: A Blueprint for Change

**Opening Soundbite:** I think I would make the distinction between treating everybody equally and equity. Equally assumes that we start from a level playing field, which we don't. So, we need to figure out how to give people what they need in order to achieve good health.

[Musical intro]

**Josh Kerns:** Greetings and welcome to another edition of The Transformer: the UW Medicine Care Transformation podcast. I'm your host, Josh Kerns. It's been quite a journey since we kicked off this series earlier this year. Our conversations have spanned all facets of the shifting healthcare landscape and the innovative care transformation work driving the changes in value-based care delivery here at UW Medicine. We've talked about the past, present and future, from changes to reimbursement to partnering with patients to deliver world-class care and improve outcomes. Also on the agenda has been standardized pathways to the dollars and cents of all of this as well as treating whole populations along with individual patients. But, there's one critical area we haven't really dug into deeply until now and that's making sure everyone has the same access and opportunities for the best possible health outcomes. A core belief of UW Medicine is that healthcare is a fundamental human right and this belief is very clearly tied to the mission to improve the health of the public overall. But it's important to acknowledge institutional racism has created inequities in society, even within our own healthcare system, and that results in health disparities. UW Medicine is committed to transforming the way care is provided to eliminate these inequities. So, in this edition of The Transformer, we sit down with two of the leaders of the effort to tackle healthcare equity head-on.

**Pat:** My name is Dr. Patricia Dawson. I am a former breast surgeon now retired from clinical practice and I have the honor of being the UW Medicine medical director for healthcare equity. In that role I work with Dr. Houston as my dyad partner and Keith Vensey who is our program operations specialist to achieve the goals of UW Medicine healthcare equity blueprint.

**Josh:** And Dr. Houston, introduce yourself and your role in this initiative.

**Paula:** Thank you. I am the director of healthcare equity for UW Medicine, so I am the administrative half of the partnership that is leading this effort. And previous to this I've been in leadership roles in health and human services organizations and non-profit and government organizations.

**Josh:** Well, first and foremost, let's talk about the need and the core mission proposition, if you will, for UW Medicine around healthcare equity. And as I started to dig into this, obviously, I as a privileged white male, have never experienced any of the things that I started to read about. And it saddens me, shocked, surprised me, any number of about just what a tremendous need there is and how much disparity there still is out there. And yet it is a core value of UW Medicine. So, tell me first of all, about just maybe the lay of the land and what it is now, what the blueprint looks like.

**Pat:** Well, UW Medicine's mission is to improve the health of the public, so it's our goal to promote health and wellness and to treat illness in an equitable fashion for everybody.

**Josh:** And that's a huge one, isn't it? Is that it's not just those that have insurance or just those that kind of can afford to pay or just live in Issaquah or in Seattle. It's everybody.

**Pat:** It's everybody. But I think I would also make the distinction between treating everybody equally and equity. Equally assumes that we start from a level playing field, which we don't. So we need to figure out how to give people what they need in order to achieve good health.

**Paula:** And the healthcare system has biases that are built into it. So you hear about institutional racism. And our healthcare system is certainly one of those institutions that unfortunately has racism and other inequities perpetuated in it. Going back in history, medicine was part of developing the construct of race which was first used to dehumanize blacks as a way of rationalizing slavery and from that the inequities and the racism and the disparate treatment, the substandard treatment, started there and has carried through and has led to the distrust in the healthcare system by African-Americans and other historically marginalized and oppressed populations.

[00:02:59] And give me some very specifics. I know in reading through a number of the materials out there in preparation, I know the historical, the experiments and things like that, but it can also be much more subtle and much more just at the at the foundation of the way that people interact with the system in general. For me again, and I think it's very important our audience understand, because I think a lot of our audience which are UW physicians, clinic providers, others that have never experienced that. So it's one thing to use those terms, but I think when you start to provide some tangible examples, then it becomes much different, much more real, if you will.

**Paula:** So we have the history which started out from, as I said, you know, dehumanizing blacks in the fact that there were physicians who actually said that blacks actually came from a different species and we're not actually human, to the experiments that were on slaves, to the use of Henrietta Lacks' and her cells, to the Tuskegee Experiment which didn't end until our lifetime in the early 70s.

**Josh:** That's terrible.

**Paula:** It is. It's an atrocity. And so those led to distrust in our healthcare system. And then you couple that with the implicit bias that people have about groups that are different than they are. That leads to what is, unfortunately, has become disparate treatment, things like there's a belief that African-Americans do not experience pain the same way that other groups do. And so here today, there are physicians that do not prescribe pain medication in the same level to African-Americans and so that's going to lead to poorer outcomes often.

**Josh:** And I would assume distrust as well amongst disadvantaged communities. You don't want to go to anybody in authority, whether it's physicians, police, if you have seen a history of ill treatment, of mistreatment, of disparate treatment.

**Pat:** Absolutely. You add to what Paula was talking about, the fact that African-Americans and Latinx patients may be stereotyped by physicians and also given less pain medicine on that basis. But about 15 years ago, the Institute of Medicine published a report that was called Unequal Treatment. And it discussed extensive research showing that U.S. racial and ethnic minorities are less likely to receive preventive medical care than whites and

often receive lower quality care. We know there are studies that show that people respond better to providers that look like them and they want to see them and that helps them to trust the system. At our community conversation in the south end, in Rainier Beach, we had a person there speak to us about their experiences trying to get care for a child with sickle cell and the difficulty they had finding doctors who even knew what it was.

**Josh:** Let's talk about the difference, one of the things we've talked about in the series, population health, and what is the difference between health equity and healthcare equity and you started to touch on this before, but maybe dig into that a little bit more.

**Paula:** Sure. So one of the things that the healthcare equity blueprint wanted to call out was that we are focusing on healthcare equity and that is that part of someone's health that we can control. So the actual health services that are being provided that is actually only 20 percent of someone's health status. The rest are those social determinants of health, so where they live, the type of food that they have access to, their education, housing. So we are part of certainly how someone's health status is affected, but only about 20 percent. And we wanted to make sure that we had the opportunity to make our services address people's needs so that they have the chance for a best outcome.

**Josh:** I know that the goal, the mission, is to become a national leader on this front. When we talk about these things, we've been talking about these issues for decades and decades and decades, you would hope we would be so much further down the road. Where are we actually at in terms of, is this just the beginning of a new initiative? Is this something that has been ongoing but now is accelerated, thanks in large part to your efforts, and the university's efforts?

**Pat:** I think that there have been pockets where this work has been happening over many years. Years ago, when I was at Group Health, we started doing this work in the mid 90s. But this blueprint and this whole effort at UW Medicine has allowed us to really put some resources behind it, coordinate it, find a way to look at it systematically and structurally, get some measures and some outcomes.

**Josh:** Can you impose strictly change from the top? How do you get everybody to buy in? It's one thing to issue edicts on anything in any organization…we're now going to be this kind of a company, with this kind of an organization. But how do you get the thousands and thousands of practitioners, clinicians, everybody else under you, to come along with you on this journey?

**Pat:** I don't think you can mandate change from the top but you certainly have commitment from the top. And that was one of the things that was so appealing about this role here is the demonstrated commitment that we've had from our top leadership. And then it's you percolate it through the institution in a variety of ways.

**Josh:** You know one of the things I find really interesting is the acknowledgement by the university, by UW Medicine, that you know what, we haven't done this great before. And, in fact, one of the things I read was that the university system acknowledges we have institutional racism. The fact that there is a willingness by the organization to acknowledge, even at the top here, you know what, yes, we have issues here. How important is that coming into this and over the last couple of years, to say, first and foremost, and to identify where are our weak spots?

**Paula:** I think it's, I mean it's extremely important. I mean it's one of the things that really

attracted me to this job as I was looking around for this type of a position, a director of diversity, equity and inclusion. I looked at a lot of different organizations and I can honestly say that none of them had already done the pre-work, as in, put together a group of leaders to then develop a blueprint so that when that director came in there was already a roadmap, they knew where their issues were, where some of the problems were and had actually started to put together some objectives and some strategies to try to address them. So to me, that tells me that this is this is real commitment. It's not just lip service. Not only do they put together the blueprint but this organization also signed on to the American Hospital Association's 123 for Equity Initiative which is a national initiative that many healthcare systems have signed on to. And our leadership immediately realized that, yes, we want to say upfront to the outside world, to the nation, that we're going to be one of these hospital systems that is making this a priority.

**Josh:** So how does that actually manifest then? I have a friend who is a practitioner at a UW Neighborhood Clinic who may have no awareness that's going on around them. Is it as simple as a doctor that doesn't speak just even in the vernacular in the language of a person who is not like them that comes in the door?

**Pat:** It's not that simple. And certainly people of color have racist tendencies because we grew up in a racist society. So, Paula has been doing a lot of training and I've been doing some training. We do a lot of communication with providers, leaders, clinic staff, about what is this whole healthcare equity deal, what's the blueprint about. And then further in-depth, we talk about microaggressions or implicit bias to try and help people understand where they need to improve, what they want to understand, what they don't know that they don't know, and to take that into consideration.

**Josh:** The blueprint itself. I don't think we've talked about that in the detail. Lay that out for us.

**Paula:** Sure. So, you talked about it a little at the top and the mission around it is to be a leader in healthcare equity and ultimately decrease health disparities. So it has three objectives. The first one is around our workforce, so diversifying the workforce, decreasing implicit bias, increasing cultural humility, really creating an inclusive environment and then working on our recruitment. We don't have a focused recruiting effort around recruiting diverse staff, particularly at our leadership. So that's one of the things that we're going to do in that area. Another big part of that is as Dr. Dawson was saying, is that we've gone out and done a lot of presentations and trainings or mini trainings really around, as you said, people just don't have the awareness. People are not aware of the history of medicine in constructing race and how medicine, the healthcare system, is a part of institutional racism and what that means. So really just building that awareness, the history of the atrocities, of the experiments on slaves. Most people know about the Tuskegee experiment but that kind of is the end of it, so really just building that awareness and then the third piece around that is then building some skills. So again, as Dr. Dawson said, we've kind of gone through some of the areas that people hear about, they hear about microaggressions, what does that mean. Let's have some skills so that people can understand and disrupt them. We've talked about intersectionality as well. What does that mean that people don't just live individual lives. We are very complicated. And so how does being African-American and part of LGBT and with a disability, how does that all intersect and what does that mean as you walk into the healthcare system to try to get care. So we're doing a lot of work around that. And one way that we intend to disseminate that is through Equity Diversity Inclusion committees that will be in each entity and also in some different departments. So that's kind of the bulk of the workforce work. The second

piece is our community engagement. UW Medicine has not had a presence really down on the ground engaging with communities and that's one of the things we've been doing with our Community Conversations on healthcare equity. We held our first one in August down in Rainier Beach and that's really an opportunity for us to come out and, first of all, just be present, hi, we're here, we're UW Medicine, we are a great healthcare system, we have clinics and we are here to serve you and we want to know how you're experiencing not only the healthcare system in general but specifically if you have had experience in UW Medicine, how has that experience been? What are the inequities that you're seeing? What are the disparities in your community, specifically if it's an ethnic specific community, Somali community, Latinx, any of the other specific communities that may have some disparities that we may not have data on but it's important to them, so we want to know about that and then how can you help us address those issues so that you're going to have the best outcomes possible. Then the third area really is around our clinical quality improvement in clinical innovation and so that's where we're looking at things like diabetes screening, retinopathy screening, hypertension, colorectal screening, breast cancer screening in specific groups. And then one of the biggest projects that's come out of that is our transgender gender non-binary work, where we're focusing on our transgender gender non-binary patients who we've been treating throughout our system for years but really not in any kind of a coordinated way, and so we now have a whole program around this patient population that will help them to have coordinated care and obviously lead to better outcomes for them specifically in that area.

**Josh:** I was surprised at the numbers. I just had no idea how many patients would fall in that category. And if there is no coordinated care I can understand where somebody would feel so marginalized and just not able to receive the kind of care that they need and deserve.

**Pat:** That's exactly right. I want to just add onto what Dr. Houston was saying about the trainings. I think that the workforce trainings have an additional benefit. They also make the workplace a more welcoming place for our diverse employees. And so that if you feel like you can bring yourself to work and not be discriminated against that allows for much more creativity and less stress at work. And it also provides a better environment for patients to receive care. So you have a happy, productive, creative workforce. Then you'll have happier patients.

**Josh:** You said something interesting before doctor, as well, which was simply you went out recently, did an event at the Rainier Beach Community Center. And so often we expect people to come to us. And simply going out into these communities and hearing from people, how powerful that is, and how much you can learn from these constituents you're trying to serve.

**Pat:** I think it gives the message that we are interested institutionally, we are interested in the communities, we want to do outreach to them and we want to hear from them. We want to know what their experiences have been and how we can make them better.

**Josh:** I'm curious how you overlay this against the overall vision of Care Transformation, value-based care. When we're facing cost restrictions in healthcare across the board, some of the limitations, things like that, how do we reconcile the desire to bring services to more people in more unique ways at a time when we're also trying to standardize care and cut costs?

**Paula:** Well, it's one of those areas that it is difficult to look at. I mean one of the things

that as the system is focusing on value-based care, we know that oftentimes focusing on value-based care actually will increase the disparities because you start focusing on those patients that can interact with the healthcare system in the way the system needs them to interact. And those often are not the people who are already marginalized. So people who maybe are not technologically savvy but you're focusing on, really you know, increasing your e-care and other ways, technological methods allow people to interact with it and not everybody has access to all those types of things.

**Josh:** Or locationally-based and I know that there's been a lot of talk of obviously trying to expand the reach into the communities where people are.

**Pat:** I think we're looking at lots of different creative ways about getting out into the community. We are certainly looking at expanding having retinal cameras at more clinics so that it's more accessible to patients. We already have mobile mammography vans that go around and provide mammography screening for patients. I think if you take the long view, this kind of preventative work actually is going to cut costs eventually because if you have people who don't get blind because of their diabetes or who have early diagnosis of breast cancer because of their screening. Ultimately that cuts the cost to the system. It's a long view though and it's sometimes harder to put that in your bottom line.

**Josh:** Oh, absolutely, so when we talk about the bottom line and obviously there is somebody who's going to be, you as the administrators of this, are going to be looking for tangible results. At some point, you have to show that we have made progress. Here's the field, there's the end zone. How do you measure that? What is progress, what is success and what are the metrics that you're using to quantify that?

**Paula:** Well, I mean we're really looking at the metrics that we use right now to look at our health disparities. And ultimately we want to close that gap. We want to see that there is no disparate treatment for any of the measures that we look at. So breast cancer screenings, colorectal screenings, hypertension, diabetes control, that eventually there would be no difference in those. So that's how we're where we're measuring those and that's going to be a result of all of the things that we're doing. If we have a more diverse workplace, if we have diverse leadership, who understands our communities, if we have become that employer of choice so that we're really getting the best and the brightest talent recruited into us. They’re gonna understand how to provide appropriate care and more effective care to all of our communities which again will lead to those better outcomes.

**Pat:** And I don't think it will take 10 years for us to be able to show improvement in the disparities. We have this great tool called the disparity index where it allows us to quantify differential care and by extension it allows us to quantify our move towards improving differential outcomes. So basically, the disparity index looks at how often a quality measure, like glucose control or breast cancer screening, doesn't get done in a minority group divided by how often it doesn't get done in the majority or white group. And so that gives us an index. Everything over one in that index shows a disparity. We can look at the disparity index across different screening protocols, across different patient populations and across different clinics, so you can really get a pretty good look at how we're doing across the system and then we'll be able to re measure that periodically.

**Josh:** And you're already seeing progress and you're already seeing gains whether it's engagement, whether it is the number of community meetings you're doing, things like that. I saw in some of my preparation in working with your colleagues, that we do have

some tangible already, we can see we are moving down the field here.

**Pat:** We definitely are.

**Josh:** When you go out and you begin to have these conversations and you're making these changes, how are your colleagues, how are folks in the trenches receiving this? What is your take on how the troops are doing so far?

**Paula:** The operationalization of this only started about eleven months ago. That's when I came on board and I can honestly say that most people have been very receptive. I think everybody wants to give better care. I will often open some of my talk saying, nobody wakes up in the morning and comes into work and saysn I'm going to provide disparate care today. No one no one is doing that. We know that we have very dedicated providers who want to make sure that everyone is going to have a good outcome. But it's just building the awareness. People didn't realize what was happening within our own system, certainly didn't understand the history of how we got here. So people are very happy that now there is a team that they can reach out to and say, you know, hey, how can I do better? Or we've even become sort of internal consultants, so individuals will say I've got this thing going on, you know, can you help me, too? How do I address this one particular thing with a patient or with another staff person? So I think people are very receptive to having us here and want to see this succeed.

Josh: And I would argue that while it may not be in the DNA of everybody here, because we talk about just the institutional biases that have built in over all those decades, but I know in working with so many physicians in my other role at the King County Medical Society, for example, there is an innate empathy and an innate desire to, as you say, provide the best care possible to everyone, regardless of their socioeconomic class, regardless of their race and everything and that it is as this educational effort continues, that it will become more a part of the DNA so that you all, everybody, is sort of sharing that it's not just simply, OK, we're going to go to this department to find that, but it just starts to seep in, if you will.

**Pat:** Yes, I think as Dr. Houston was saying, I mean we've just really assembled our team, so she started about a year ago, our program Operation specialists joined us in May and I joined in August. So it's really, it's two months for me.

**Josh:** Wow.

**Pat:** And it's a half time position.

**Josh:** I'm guessing that they pay you half time and you're not working only half time. I'm just guessing. [laughter]

**Pat:** There's some truth in that. So we are really just getting fully up to speed. But I have been incredibly pleased to find that people are reaching out to us and saying, can you come and talk to our group, can we meet with you? And then we're finding all these pockets of people who are already doing this kind of work but now they have somebody that they can come to to help them consolidate it. For example, we met with two social workers in the hospital who, on their own, have been doing anti-racism work for a couple of years easily. So now we can support them in the work that they're doing and get them plugged into a structure.

**Josh:** There's no manual for this, right? I mean you guys are making, I don't say I'm making this up, but you're having to aggregate just mentioned disparate pieces from academia, from your own experience, from your colleagues around the country. How do you create this program if it is going to be a fluid sort of morphing process as you learn things as well.

**Pat:** I think it is fluid. There are some blueprints, if you will, like the Institute for Health Improvement has a blueprint about healthcare equity, but you have to work within your system. So in some respects, we are making it up as we go. But there is an overarching structure to it. There is a committee structure. There's a reporting structure, there's a way that people can talk about things that they experience and we can look at them so that we can look not just at the individual but we can look at the structural issues in the institution.

**Paula:** And there are a lot of best practices out there. I've been doing this work for a long time and so I've had the opportunity to work with some of the best trainers and consultants in this work. And so, you know, I've brought some of them in for our Leadership Development Institutes, have consulted with them just personally on how to move this work forward. And I have to do it in a way that works for the UW Medicine system. And one of the things that I wanted to say when you were saying, you know, how do we get this across, get this in so that it becomes part of the fabric. One of the things we talk about is that, yes, we want to make this just part of the UW Medicine way. So it's the same thing as you wouldn't think, you don't have to think about when you do things that are around patient safety. We want it to be just that intuitive, that that's just the way I'm going to do it because that's going to address and enhance our healthcare equity work. But we have to make sure that we can do it in a way that fits this culture. So a lot of the best practices out there are you bring people together for two and three day trainings, a couple of times a year, and then you do a lot of follow up work. Well that may not necessarily work here. That's not the culture here. So I've been saying, you know what, we're gonna create a new best practice and that's where we do it in shorter bits and bite sized pieces but it's still going to be effective and it's still going to become part of the fabric and I actually think that's may be better because it's more frequent, people are going to talk about it all the time and that's how we infuse it to become part of that UW Medicine way.

**Josh:** And how important is the participation and the feedback of everyone in the system?

**Paula:** We're definitely learning as both of us, well all three of us, are brand new to the University of Washington system. We have to learn the culture here. And so we have to be flexible and fluid with our own personal styles, with, as I said, what's best practices to make it work here and that way is by asking people. But again people are very open. There's really a willingness to do this work. And they know that they are going to have to be part of the leadership to make this happen. That's why we're putting together Equity, Diversity, Inclusion teams, that each have an executive sponsor and an executive champion and leadership of the team. We're a mighty team of three for 30,000 people, so obviously we cannot go out and get in front of people…

**Pat:** That's just 10,000 each. [laughter]

**Josh:** It's like a 100 level class at the undergrad level, right?

**Paula:** It is. But you know it's exciting that we're going to be able to be creative and innovative right now. You know we have our equity, diversity, inclusion teams. So part of that will be a train the trainer. Once we bring in consultants so we'll have leadership at the

different sites and different departments who can do training and then we're looking at how do we use technology. We have a system here called learning management system which is online training. So we certainly hope that we will be able to use some of that resource and have online trainings and other ways to use technology. So it's really kind of exciting because we'll maybe get to do some cutting edge things that that other places haven't done. So one of the first ways we're using technology is with an online toolkit that we have developed and that was a way that we just wanted to make sure that those leaders who were going to be leading up our equity, diversity, inclusion committees at different entities in different departments had all of the resources that they needed at their fingertips. So we have an online toolkit that consists of a glossary of terms for equity and inclusion terms. It has a calendar of cultural celebrations and observances. It has a document on how to put together an equity, diversity and inclusion team. It has a list of resources that are video series and books and other podcasts that all address equity, diversity and inclusion issues. So people have been really excited about that and that will be online here in the next week or so. And we know we have diversity among our leadership who is going to be disseminating this work, so we want to make everything as accessible as possible.

**Pat:** There are different ways to get people engaged and what we're really looking for is engagement and trying to figure out what is that one piece that engages somebody. So, for someone it might be the fact that they have a daughter and their daughter is being discriminated against on the basis of her gender, so that that brings them into being interested about that, or somebody may have had an experience at work and they want to get interested and involved because of that, and so all these resources allow people to come in from where they are and to get engaged with us.

**Josh:** And I just have to underscore again, this is not just about race. You mentioned disabilities, a hearing impaired person faces all sorts of institutional discrimination which prevents them from getting the care they deserve. So I think it's just, this is based on my own shortcomings and growing aware, that it is so far beyond what I would, if you'd asked me 10 years ago, what I think about when I think discrimination, it might be solely on color.

**Pat:** Right.

**Josh:** But gender…

Pat: There are a number of elements about diversity that we're interested in. The hearing and deaf community is a particularly interesting one because at our Rainier Beach community conversation, there was great representation from the hearing and deaf community and they were telling us about how they're unhappy with the interpretive services that are provided to them for American Sign Language and how they want to partner with us to improve the care that they receive.

**Paula:** And that was something that we had not thought about, although we know disabilities is certainly a part of the marginalized populations. We hadn't called that out specifically in our blueprint. So we were thrilled to have that community come and tell us what they are experiencing and that they want to partner with us to help them to have a better experience. So we wouldn't have known that if we hadn't gone out to the community.

Josh: For the cynic out there who says, well, this doesn't affect me. I'm a physician. I've got a few more years left. I'm working here in the clinic and it just doesn't touch me. How does this affect the entire system? How does this benefit the entire system?

**Pat:** Well, as Dr. Houston said, people don't come to work saying I'm going to discriminate or I'm going to provide disparate care to people. Once they're aware of that, then we can work on providing more equitable care to everybody and more equitable care is going to result in better health outcomes, which ultimately is the goal of our system.

Josh: How does this benefit the system? When people say, well, what do you do, the work you do, what is the benefit for UW Medicine in general?

**Paula:** Well, one of the things that we're doing with our community engagement is just having a presence in the community and having a good reputation in the community for those communities that haven't historically engaged with us. And so it's hard to put a number or a benefit on that public relations piece and the community goodwill that you build, but we want to be able to be out in communities like Rainier Beach where we don't have a presence but people still know us and say, you know what, even though there's not a community clinic right here, I'm willing to travel down to Renton or up to downtown to Belltown or up to Harborview because I've heard such good things about the care that people are getting at UW Medicine, not just at one place in UW Medicine, but I know that I'm going to be able to walk in to any clinic and have a good experience there.

Josh: Well, and at the end of the day, that's ultimately what it's about, is delivering the best care to everyone possible, right?

**Pat:** I would just like to add to what Dr. Houston was saying that people sometimes have an assumption that when we say we're going out to the communities, we're going to end up with marginalized patients who don't have good insurance. But when we go to Rainier Beach, right next to Rainier Beach is Mt. Baker, is Seward Park. And I would make the point again, of the mission of UW Medicine, which is to improve the health of the public, and that includes people who have good insurance and people who don't have good insurance. It's not, we're going to improve the health of only those who are well insured. So we want to reach all the communities so everybody has good access and good care.

**Josh:** Such an interesting point. So where do we go from here? As we go down the road, what are the milestones, what are the goals that you would like to see as we go along this journey?

**Pat:** We continually look at what we're doing and measuring what we're doing in measuring our outcomes. So, for example, one of the projects that we recently had an intern work on for us, was looking at interpretive services across the system. And what she found is that there's quite a variety in how interpretive services are handled across the system and there are some places that are doing a stellar job and there's some places that are doing not a very good job at all. And so one of the goals would be to disseminate the information from that report and then to look at how we can get better at standardizing interpreter services across the entire system.

**Josh:** Doctor, milestones, goals over the next year, the next couple of years here.

**Paula:** Sure. One of the things that we did we did was a climate survey to understand how our workforce is experiencing their workplace based on demographics. So we really want to be able to use that information, that data. We'll do the survey again, not next year, but in two years, and hope that people start to have a better experience at running and being effective and being places where people are now actually talking about the issues rather

than having them just immediately go and become an H.R. issue, where people have decided that this can be a part of the conversation and that this is going to be a more inclusive and welcoming place for them to work and a more welcoming inclusive place for patients to come.

**Josh:** Based on what I've heard from you, though, and the passion and, I see joy in this work as well. It seems like we're off to a very good start here and the future looks very bright.

**Pat:** I think it definitely looks very bright. Again, I'm so impressed with the fact that UW Medicine has this blueprint, is putting the resources into it and is actually doing it.

**Josh:** Dr. Paula Houston is the UW Medicine director of healthcare equity and Dr. Pat Dawson is the medical director for healthcare equity. Doctors, thank you so much. Such a fabulous conversation and what I look forward to is continuing this conversation, much as the work you're doing, this is not just a one-off.

**Both:** Thank you very much.

[Musical outro]

Josh: And that’s going to do it for another edition of The Transformer. Over the course of this series, we’ve explored how care transformation is driving the necessary changes across the UW Medicine system to improve our delivery of patient care and support the wise use of healthcare dollars. You can call it the Quadruple AIM: improving the patient experience, achieving better health outcomes, controlling costs and addressing clinician satisfaction. If you haven’t had a chance to listen to our previous episodes, I encourage you to do so, as your colleagues from across the UW Medicine system detail the dramatic transformation in best practices taking place and integrating them into all aspects of locations of care. You can call this the end of Season1, if you will, but the journey really is just beginning. And we’ll be back with more in-depth conversations in the new year as we continue this journey along the UW Medicine Way. For now, though, I’m your host, Josh Kerns. Thanks so much for listening and we’ll talk to you again soon on The Transformer.

[Musical end]