

Dear UCSF Health colleagues—

We are thrilled to share our inaugural Health Equity report for UCSF Health. When we established our Health Equity Council last year, we set a vision for becoming a nationally recognized leader for how a health care delivery system achieves health equity. Actualizing this vision requires a data-driven approach to identifying and understanding the health care disparities that exist in our system, and building key partnerships within and outside the UCSF Health walls to eliminate those disparities.

The purpose of this report is to: 1) reinforce the "why" behind health equity, 2) share FY19 accomplishments of the Health Equity Council and our collaborating teams, and 3) highlight examples of our approach to examining and addressing performance metrics through an equity lens. Publishing this report signifies the commitment of UCSF Health leadership to openly and systematically assess equity in our care delivery system. This assessment will inform strategies to ensure that every patient cared for at UCSF Health, irrespective of race-ethnicity, socioeconomic status, gender identity, sexual orientation, ability/disability, and other factors, has an equal chance of benefiting from the best care possible.

During the initial phase of our Health Equity Council's work, we have been humbled and gratified by the widespread engagement and passion expressed by individuals throughout the organization to make health equity central to the work we do. It has been clear to us from this response that the UCSF Health community considers equity to be one of our core values, and finds meaning in striving to achieve equity in the care we deliver.

We hope that you find this report informative, and that it stimulates questions for how you might view the care provided in your own clinical setting through a similar equity lens. The report is just a starting point to build upon in the coming years. The work of achieving health equity is difficult, but we're excited about the journey ahead.

On behalf of the committed members of our Health Equity Council,



Niraj Sehgal, MD, MPH
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UCSF Health Equity Council

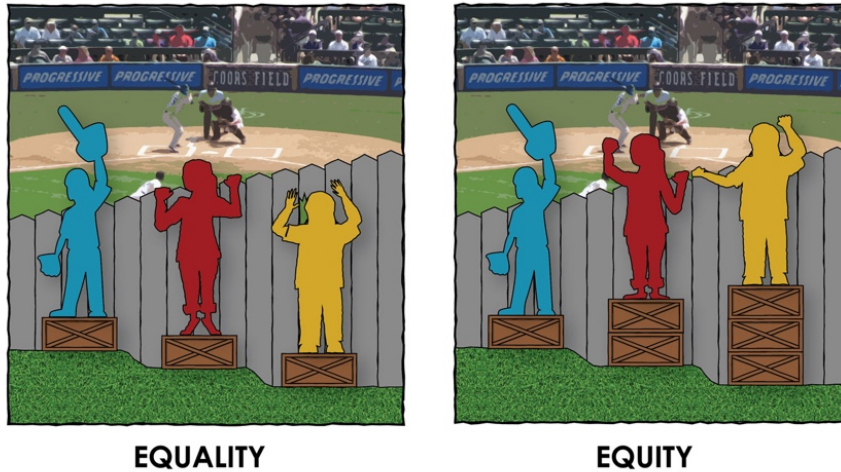
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What is the Difference between Equality & Equity?



The images above illustrate that people are all equal in ability/value/potential, but the fence and the ground give them unequal opportunity. “**Equality**” provides them all with the **same level of support**, whereas “**Equity**” assures they all achieve the **same outcome**.

Why is Health Equity Important?

Health equity is an essential element of health care quality as defined by the Institute of Medicine in 2000. Across the United States, extensive research has documented disparities in health and health care rooted in factors such as race, ethnicity, socioeconomic status, health insurance status, level of literacy, English proficiency, sexual orientation, gender and gender identity, and disability. Health care disparities are **preventable** and an important signal for potential gaps in care quality, and also compromise health system finances (e.g., readmission rate penalties, under/over-utilization of resources).

Why is Health Equity Important to UCSF?

UCSF Health is a leading public institution that proudly serves a diverse patient population, and we have a responsibility to promote **health care equity** (equitable access to care and quality of care) for our patients in an effort to achieve **health equity** (which is also influenced by social determinants that require community and civic partnerships outside of the delivery system). **Partnering to Achieve Health Equity** is one of three pillars highlighted in the Chancellor's Campaign that sets out "to solve some of the world's most intractable health challenges." The School of Medicine's **Differences Matter** Initiative is a multi-year, multifaceted effort designed to make UCSF the most diverse, equitable and inclusive academic system in the country.

How is UCSF Health trying to Achieve Health Equity?

UCSF Health established a **Health Equity Council** whose purpose is "to ensure health equity is a UCSF Health strategic and operational priority that is driven by systematically identifying and eliminating healthcare disparities." The Health Equity Council includes diverse representation from operational leadership (e.g., ambulatory, children's), support departments (e.g., informatics, patient experience, population health, quality), and School of Medicine Differences Matter content experts.

What are the Primary Roles and Key Functions of the Health Equity Council?

1. Culture & Awareness

- *Advocate and influence*: champion and socialize health equity as an institutional priority and advocate for the necessary investments and organizational change to achieve equity
- *Educate and inform*: educate the UCSF Health community about health care inequities broadly and specifically at UCSF Health, about the conceptual frameworks for understanding the nature of and solutions to health care disparities, and about progress on efforts to achieve health care equity at UCSF Health

FY19 Accomplishments:

- Established a formal Health Equity Council
- Focused on Equity as the theme for 2018 UCSF Health Improvement Leadership Retreat
- Shared vision and Health Equity work with key leadership groups
- Integrated Health Equity Council into medical staff committee reporting structure
- Advocated for Health Equity as a theme in the UCSF Health 2025 Strategic Plan
- Called out Health Equity as a theme for 2019 UCSF Health Improvement Poster Symposium
- Added "Health Equity Metric" to UCSF Medical Center and Benioff Children's Hospitals True North scorecards in FY19
- Developed an inaugural Health Equity report for UCSF Health

2. Data & Analytics

- *Establish and promulgate standards*: promote standard definitions of key concepts (diversity, inclusion, health equity, race-ethnicity, etc.) and consistent data definitions and data governance for patient demographics and other equity-related predictor variables
- *Integrate*: build data equity variables into existing (and new) data warehouses, dashboards, and other tools that create standards for understanding our disparities

FY19 Accomplishments:

- Established a taskforce to define UCSF Health standards for equity variable data definitions
- Established data standards for defining major race-ethnicity categories using the 34 ethnicities currently captured in APeX
- Implemented race-ethnicity categorization scheme in Clarity data warehouse and integrating into other data warehouses and dashboards in the coming months
- Working towards defining similar standard categorizations in data warehouses for language, sexual orientation, gender identify, and other variables

3. Disparity Improvement Work

- *Prioritize*: determine the health care sensitive disparities that are the most critical priorities for UCSF Health to address; identify disparities that require cross-cutting interventions and formulate integrated plans for these systemic interventions (e.g., interpreter use/language access)
- *Integrate*: include equity metrics in True North scorecards, build equity metrics into annual service-specific quality reporting, and foster adoption of improvement work into True North visibility boards
- *Facilitate*: guide incorporation of equity into standard improvement work, provide technical assistance and tools, and advise on best practices
- *Coordinate*: align and coordinate equity-related efforts with a bearing on UCSF Health (e.g., Office of Population Health, Differences Matter initiative, Center for Community Engagement anchor institution initiative, UCSF translational research on health disparities)
- *Enable and Convene*: leverage our incredible assets of clinicians, researchers, educators, and policymakers to generate big ideas and solutions

FY19 Accomplishments:

- All True North metric reports to Quality Improvement Executive Committee must now include an equity lens to create visibility for commonly seen metrics already spread within organization
- Developed a framework for approaching and prioritizing disparity improvement work (e.g., organizational metrics, disparity-sensitive metrics, clinical service-specific metrics, etc.)
- Collaborated on initial focused improvement work on racial-ethnic disparities in blood pressure control among hypertensive patients and Exclusive Breast-Feeding among new mothers
- Conducted an initial equity analysis of all True North metrics to begin understanding where we have differences, and where additional analyses are required to define disparities

Patient Care through an Equity Lens

What can we learn from our initial efforts?

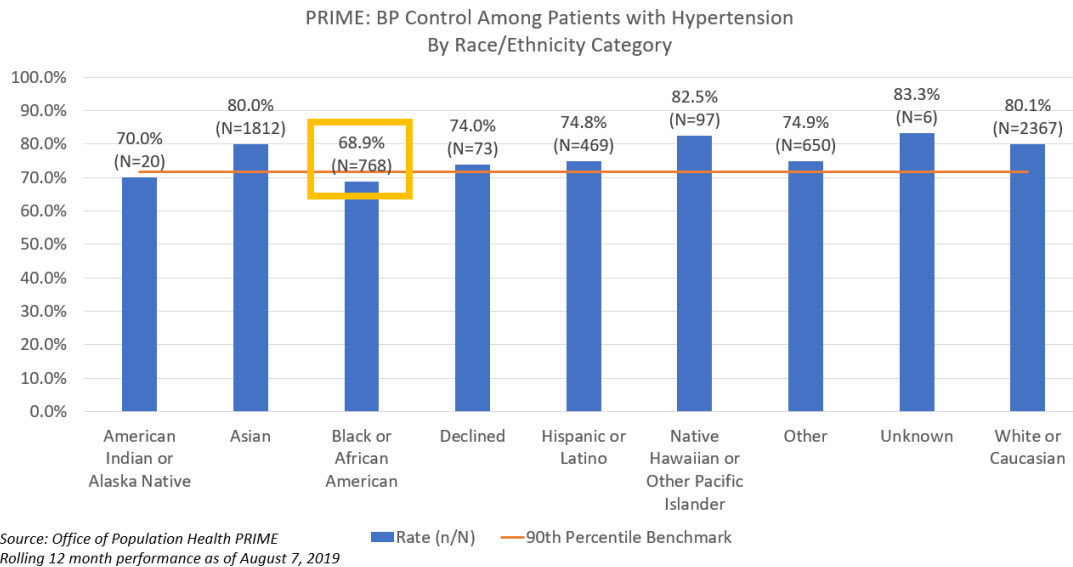
The data stories shared below represent an introduction to systematically evaluate performance across our True North metrics. A key limitation is a standard organizational approach for how we organize major patient populations through a race and ethnicity framework, which is being built into our data infrastructure over the next couple months. This approach will also extend to our approach for preferred language, sexual orientation, gender identity, and other important equity variables. We hope the examples and reflections below reinforce WHY it's so important to look at our performance this way, identify where we have differences (as well as where we do not), and ask whether these differences truly represent disparities that should be eliminated.

Section I: Disparity-sensitive metric examples: we're highlighting our FY19 performance around hypertension management, colorectal cancer screening, and exclusive breast feeding to illustrate how we

focus on nationally recognized disparities that are accompanied by evidence-based actions to eliminate them. As this list of metrics expand, it allows us to prioritize our disparity improvement work in specific conditions that warrant it.

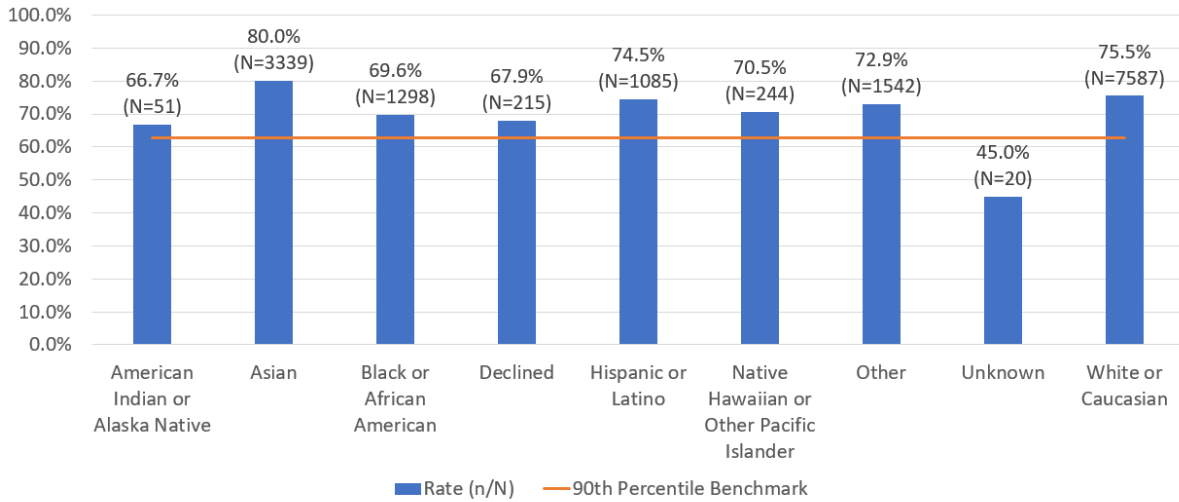
Section II: Organizational metric examples: we're highlighting our FY19 readmission rates and catheter-related urinary tract infections to illustrate how simply looking at differences across patient populations might lead to unintended conclusions, rather than raising a set of important hypothesis-generating questions. Whether it's patient experience or access to care, we want to develop a thoughtful approach to using our equity lens to better understand our improvement opportunities.

Section I: Disparity-sensitive Metrics



Key Points & Reflection: Among adults nationally with a diagnosis of hypertension, Black/African Americans, Asians, and Latinx are less likely than non-Latinx Whites to have their blood pressure under control. Uncontrolled hypertension is one of the risk factors contributing to national disparities in rates of stroke, heart failure, and end-stage kidney disease among African Americans. At UCSF Health, our Black/African American adults achieve poorer blood pressure control than other populations. This nationally known healthcare disparity is what led our primary care practices to adopt evidence-based interventions that demonstrated improvements over FY19, yet the disparity still requires additional work. What additional interventions might we deploy to close the persistent Black-White gap? How should we address gaps in other patient populations (e.g., American Indian, Latinx) that may be at or above national benchmarks, but still at lower rates than others?

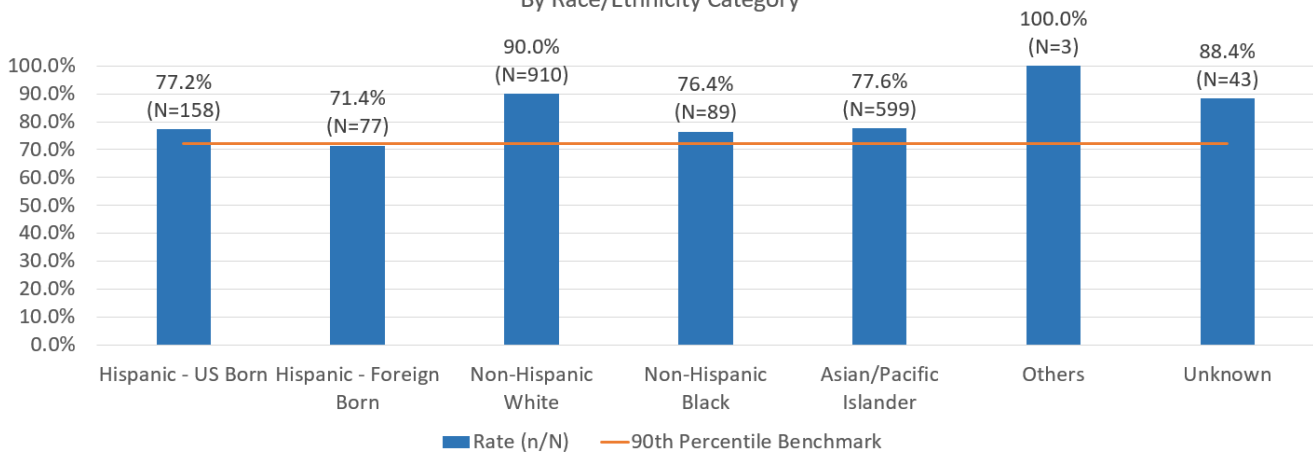
PRIME: Colorectal Cancer Screening (Adults 50-75, USPSTF Guidelines)
By Race/Ethnicity Category



Source: Office of Population Health PRIME
Rolling 12 month performance as of August 7, 2019

Key Points & Reflection: In the US overall, Whites and Blacks have similar rates of colorectal cancer screening, but screening rates among Latinx and Asians are more than 10% lower. At UCSF Health, all patient populations have screening rates above the 90th percentile national benchmark. Past interventions to promote improved screening proved effective in improving both overall screening rates, and rates across all patient populations. However, differences in screening rates still exist across groups. Should UCSF Health consider there to be a disparity in colorectal cancer screening rates if all groups surpass a national benchmark? If Asian patients can achieve an 80% screening rate, should that serve as our internal benchmark? Or should we focus our energy and resources on eliminating disparities in other clinical areas?

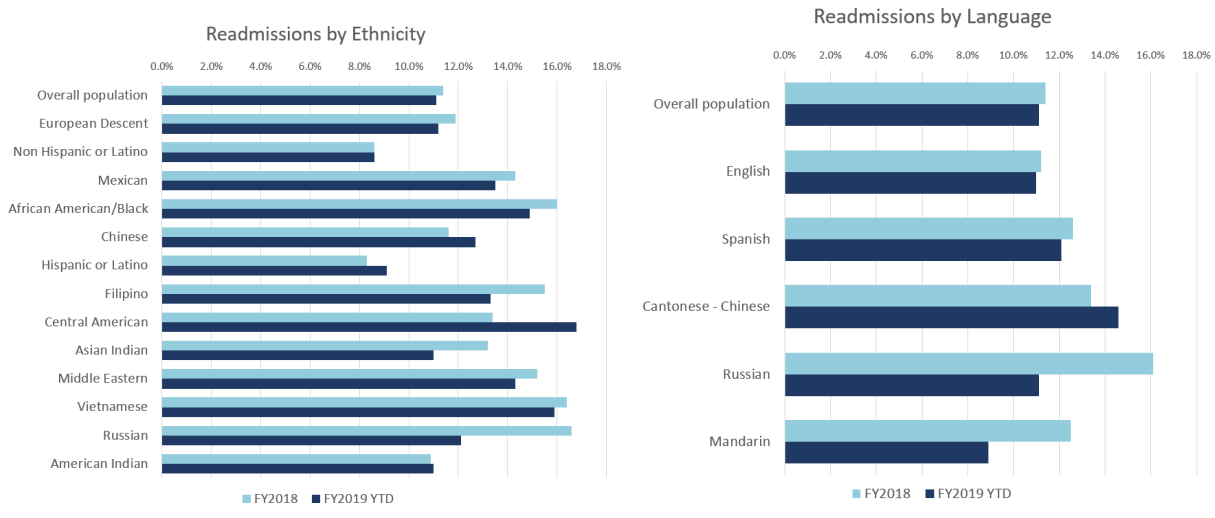
Exclusive Breastfeeding Among Newborns (PC-05)
By Race/Ethnicity Category



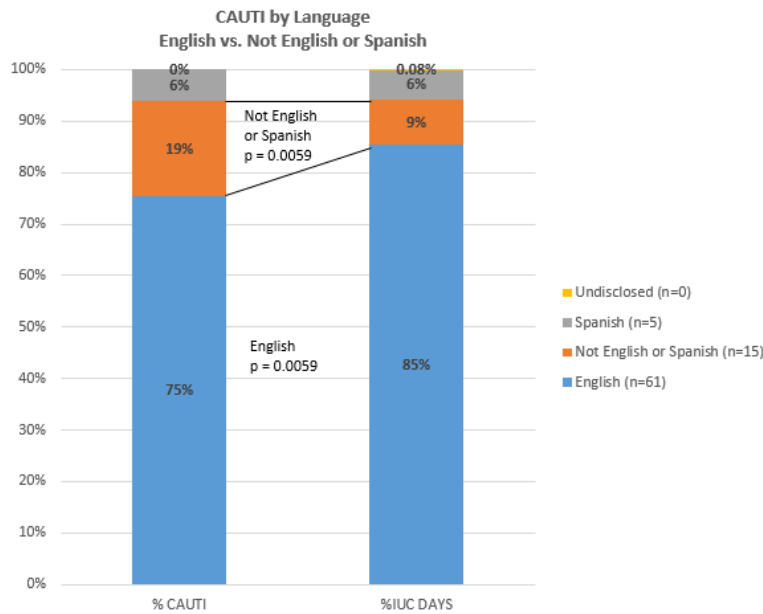
Source: CMQCC
July 2018 – June 2019

Key Points & Reflection: Similar to the colorectal cancer screening example, when looking at our exclusive breastfeeding rates among newborns, all racial-ethnic groups are now achieving rates above the 90th percentile. However, a prominent disparity identified with this metric was around payor mix. The overall rates were 86%, but only 63% in our Medi-Cal patient population. Significant improvement efforts the past year at BCH-SF improved the rate among Medi-Cal patients to 69%, but the improvement work continues into FY20 to address the disparity. How do we continue thinking broadly about equity with other metrics that may be influenced by variables such as payor mix or other social determinants, and not only by race-ethnicity, language, or gender identity?

Section II: Organizational metrics



Key Points & Reflection: On first glance, our readmissions data indicate higher rates among Black/African American and Asian patients, compared to White/Caucasian patients. The same could be concluded about the variation in rates across different ethnicities and language preferences. However, these differences are difficult to conclude as a true disparity with this analysis alone, because readmissions for all conditions and ages is a very broad metric. The analysis should raise important hypothesis-generating questions, such as: what if we looked at readmissions for certain conditions, such as congestive heart failure or for a mother following delivery of her baby? National evidence would suggest that disparities exist in these specific areas, so our analyses of organizational metrics (e.g., mortality, access, length of stay, etc.) should be the beginning of a deeper dive, rather than a conclusion based on very high-level data about whether a disparity is present.



Key Points & Reflection: As a proportion of adult patients with indwelling urinary catheters in FY19, those whose primary language was "Not English or Spanish" had more catheter-associated urinary tract infections. This type of analysis once again demonstrates an opportunity to generate hypotheses to explain the data: do we provide different level of interpreting services to limited English proficiency patients who speak a primary language other than Spanish? Does that contribute to our management of indwelling catheters? Will our recently implemented nurse-driven protocol for removal of catheters improve this difference, or worsen it?

Where do we go from here in the coming year(s)?

Meaningful data help us identify and understand problems. We hope the examples above begin to illustrate the necessary approaches to thoughtfully apply an equity lens to our performance metrics. In the coming months, your current ability to view performance through our existing dashboards and custom reports will be enhanced by also providing an equity lens. Our journey ahead will require examples that teach us how to embrace these approaches, and apply quality improvement frameworks to eliminate our healthcare disparities.

What's next for our Health Equity Council?

Future steps include: 1) a continued focus on disseminating equity data standards across the organization, 2) deeper planning into how we integrate the health equity work into our existing improvement infrastructure (e.g., True North Boards & Leader Rounds, Quality Committees), 3) deeper engagement of clinical services and practices to understand the equity metrics that impact their patient populations most, and 4) alignment and partnership with the health equity theme that will be a key component of the emerging UCSF Health 2025 Strategic Plan. We look forward to continuing this journey with you to help all our patients reach their highest level of health. **Together, we can eliminate health care disparities at UCSF Health.**