are to be in in a conversation that we think will help position us to make a difference over the longer term and over the near term, I just want to make one other quick comment about work

MARY NAYLOR

Thank you Michael for setting such an eloquent and important stage for this conversation today on behalf of my co chairs bill and Sandra. I am delighted to join Michael and extending a warm welcome to those joining us online. There are over a 1100 people at leasa

applicable, who you are directing your question. We're going to set aside time at the end of the webinar to address as many of those possible although you may submit questions at any time during the presentations and finally a recording and copies of these presentations are going to be available to view after this event. So now let's go to the first session patient and family engagement during COVID-19.

The session is going to explore opportunities to engage patients and families in care settings during the pandemic, the discussion will focus on identifying solutions to the continued and existing gaps in engagement that are especially critical to address at this time. Our first speaker is Dr. Knitasha Washington. She is the founder and the president and CEO of ATW Health Solutions a management consulting and research firm based in Chicago and she's a board member for the national quality for Dr. Washington is a thought leader and advocate for researcher. She's worked with healthcare systems and US government agencies to ensure that patient centered inequitable approaches are at the heart of health care redesign.

And then we're going to hear from Beverly Johnson. She's the president and the CEO of the Institute for patient and family centered care in Bethesda, Maryland. Bev is provided technical assistance for advancing the practice of patient and family centered care and creating effective partnerships with patients and families to over 300 hospitals and health systems.

Now each of our two presenters, for seven to eight minutes. And please turn on your video when you're speaking, if at all possible, and our staff will be controlling the slide deck. So please remember to indicate when to advance to the next slide by saying next. We're going to have a feature where you'll be you'll be told when you have one minute remaining and also when your time is up.

So what, you know, where are we in all of this. COVID-19, I think, really opened up the eyes of many, but to be quite frank with you for someone who's worked in this space for many years, seeing the disparate numbers come out. As a result of COVID-19 in particular with the black community was not a surprise. As a matter of fact, for me personally, it was rather depressing to see because for the first time, I think in long time it was an opportunity to really evaluate the

And as you read to the very bottom where I've highlighted there. It talks about health equity. And so I think about the fact that, you know, there has been a lot of work done to improve the patient voice in a hospital in our health systems, yet many of the patient and family advisory council, so on and so forth. Lack of diversity and Inclusion. So we really have to ask ourselves the question why advances lessons.

Well, much of it goes back to, you know what I talked about a little bit earlier. And it's really that the infrastructure the structural inequities meaning the voices that have been at the table to really shape this agenda have Matt necessarily represented the diversity that we see in our American people, and I believe it is for that reason, we actually need to very critically examine our patient engagement strategies.

The theories, the concept and apply that equity lens to ensure that we are really representing all people. In other words, structural in equity is one of the ultimate reasons why you have not historically seen diverse voices or diverse representation at the table shaping what our patient engagement strategy. And so that has been one of the primary reasons that I had chosen to stay into this work because of the fact that we have lacked diversity at the very tail of who has dictated what patient engagement looks like how we defined it, how we executed and how we mentioned next blessings. And so really this is about how we're going to go about responding. The simplest is there cove it. You know, George, for now, you have many organizations institutions even cities legislation it dancing.

This understanding that racism is a public health issue. And so what will be our response. It's really predicated upon the choices that we make, to be honest with you, I sort of feel this slide deck, full of data, data that I've been sharing with organizations over the past two decades of my career. And yet we have moved very slowly and adopted almost in a minuscule way. What needs to be done in order to truly advanced equity in our health system. So this is really today about challenging connecting your heart with your head. And what my colleagues will present later in order to make the right choices so that we have the correct response. Because the data isn't new, the information isn't new. And actually, quite frankly, the conclusions aren't new. It's just what are we going to do different as a result of what we're experiencing today.

The couple of choices that we make should be making number one being intentional tokenism. We cannot any longer substantiating. What do I mean by that. I'll give you a great example. When I was asked to create the Board for a Cook County Health system here. One of the first things I did was I use data to help guys who should be on that board and as I looked at the population of patients that were being seen in the health system. It was clear the percentage of African American, the percentage of Hispanic, the percentage of Caucasian, so on and so forth. And as I went to make my recommendations for those for those board seats. I did that consistent with the patient population that that system has been seen. So a lot oftentimes what we do today is we pull in diversity at the end, and so I'm challenging you to use data and information. The other thing that I'll say in closing is being authentic about this because unraveling the systemic issues that we have, it will not happen overnight. This is going to be the overhaul. We're talking about dismantling many of the things that are embedded in our

infrastructure that to some degree. Most individuals are not even aware of that are discriminatory and so for that reason, we have to be authentic.

And then like I said earlier, applying the equity lens really means an internal and an external strategy. And so I've challenged all of the organizations that are represented today. Don't just think about your engagement strategy as it relates to purely your patients, but also your engagement strategy as it relates to your employees because those individuals are critically important to this and so that internal and external commitment to advancing engagement is going to be important.

BILL NOVELLI
And now let's hear from Bev Johnson.

BEVERLY JOHNSON
Thank you Bill and thank you Knitasha. I've been asked to talk about partnering with patients and families in really planning responses to COVID-19 but within an health equity framework and I want to urge folks on the webinar today. I hope that the Institute for patient and family centered care can be a resource to you as you expand your partner ships with diverse communities most affected by this pandemic. Next, please.

In early March, we felt we needed to be in touch with health systems to see how they were responding to the pandemic. We knew that they were restricting family presence significantly, and this was an important public health strategy, but how they were doing it and how they were communicating about it was really important we reach some leaders and health systems, who said, we don't have time to work with patient and family advisors and leaders. We just have to get on with doing it.

And we thought, this is a real missed opportunity that we need to hear from the community, particularly the diverse communities we serve. And what these are and these informal conversations where we could facilitate problem solving in groups. We reached out and we had published a paper in 2012 about SARS, and one of the lessons learned there was that rigid 0018 Tw8isy5gs

health systems. But we also wanted to track how the systems were partnering with patients and families in implementing these changes and in thinking about the impact on practice. We knew that to be safe, they were going to be changes, but we there ways that you can be consistent and provide respectful inclusive, equitable care today. We've had over 500 respondents from 24 different countries. The survey is going to close the end of July. So I hope everyone on the call will fill out for their hospital or health system.

that we are publishing the data every two weeks to sharing it so people can learn from the data as we go. Oh. Pleased to partner with nurse. Researchers at UCSF and the University of Washington. And Children's National they have partnered with their patient in visors to really have an opportunity several times a week, even to involve these voices that represent the diversity of the community in planning for COVID- 19 and in recovery. So shaping the website signage and scripts that staff are using to communicate to families.

One of the programs that they've modified is the wonderful parent navigator program that supports families caring for children with special health needs. These parents. They're the parent navigators were repositioned really to build on their role and to modify the way that they help families become zoom enabled and to see the benefit of what a tele health visit could do for their family and the kind of complexity of care, they interact through zoom and of course they were doing it in multiple languages as well.

I think one of the good things that have come out of this horrific pandemic is the forcing us to we look at transforming ambulatory care and to take finally advantage of the technology to build supportive respectful inclusive telehealth programs and Cambridge Health Alliance serves the gateway communities in Massachusetts multiple, multiple languages and they have partnered from the very beginning, they're committed to build their digital engagement committee response with their patient partners and they recently had a town hall that introduced the town hall.

They introduced Telehealth to their physician physicians and the patient partners were an integral part of that and helping them see what they were frightened about with coven and to help them see how they responded with support for tele health, they will be their partners from the beginning of this work.

And Jackson is a cancer survivor and an advisor at U Chicago medicine and she just serves as an example of listening to individual patient advisors in their perceptions of our healthcare system. She noticed because food had been an important part of her life and her family that there were people coming for cancer treatment, who were hungry, who didn't have access to nutritious food. So she partnered with the leadership of the Cancer Center to initiate a food pantry and help started and then with COVID-19 she's worked in partnering with social workers and with community equity for people living with chronic condition, a wonderful inspiring story and she has big plans for the future.
I think leadership in addressing the issues of health equity and for leadership commitment to building effective meaningful partnerships with patients and families is essential. We have

There's open, but we have to be intentional in

outcome. And lastly, I would also comment about our reliance lately, and it was discussed in fact we're relying upon it. Now for this conversation on digital technology. And I'm reminded

us to sort of think about the fact that there's diversity within these diverse communities that we keep talking about. So you know we can't just say, and I don't think that anybody meant to sort of to do that, but I want us to recognize that when we're talking about sort of an African American population recognize the diversity in there are more talking about a Hispanic population recognize that diversity and there and as we're collaborating as just as Bev was talked about in her work is we're collaborating with those social service organizations recognize that it's, it may be more than one because they're serving different types of populations have been the wreck racially and ethnically they might be the same.

I do think I so agree with that idea if you know one patient, you know, one patient every patient is unique in my world and social work as a social worker faculty and researcher, you know, we teach about listening. Patients and families are the experts in their lives. We may be the experts in the professionals, but they're the experts of their lives. So how do we truly listen and actually get them to figure out how they want to engage. Can we ask them, Have we ever had a conversation around what engagement strategy should we be using. How do we consider teaching them and getting information

Oftentimes for folks who don't look like them and have different experiences. And in thinking about equity we often look at racial disparity of racial disparities, understandably, to highlight those structural issues that we're facing and reflecting about your comment that racism is in fact a public health issue.

We here in Camden where I work at a community based nonprofit have been thinking a lot about reframing health issues of have racial disparities to not think of it around a race issue, but really around a racism issue and that this concept of structural inequity could also perhaps be reframed as Medical Apartheid and I would love to hear more about like your thoughts or comments on that and then what some of the other reactors. I've said to get more explicit around the impact of our direct patient engagement. If we change those cravings, like how would our strategy shifted. We think of it from a not a racial disparity, but a racism issue.

And then I also really appreciate that really is comments around radiative dudes to support workforce mental health and committing to that knowledge base and decreasing stigma, because I think right now. Everyone is living through so much trauma like acute trauma structural trauma generational trauma and I think we have a long way to go to support our workforce and to support the patients that we're serving. So I really just appreciate calling that out. We also talked about that a lot in Camden, and thank you for having me. And thanks for your time.

BILL NOVELLI
Thanks very much. There's a lot of food for thought in what you just said we received quite a number of questions, but we're virtually out of time. One of the big questions which we could probably spend another hour on is the need for better data. How are we going about utilizing data to improve the experiences as well as outcomes, rather than dwell on that which is a pretty complicated question.

I'm just going to turn to one very personal note, and this is from desire V Collins Bradley. She's a patient partner innovation community. And she wrote this to Dr. Washington, she said, when you spoke on the trust and tokenism it resonated with me as a black female patient partner. Oftentimes, I'm the only person of color at the table. How can a system, make it clear that equity is a priority.

Knitasha – do you want to comment on that?

KNITASHA WASHINGTON
Yeah, I really appreciate Desire's commentary and I'll just say this. It really requires some systems thinking. So this equity issue if we're really going to get a result we have to take a systems approach to doing it. And that's part and part two. What I meant by being intentional and the authenticity of the work. This is not a fad, meaning what we're dealing with, with COVID-19 what we're dealing with, with just the, you know, levels of racism and and just social unrest in in our country. This is not just a timeframe where we going to respond to equity and then we go back to doing what we were doing before. Organizations that I've been working

with in terms of helping them to develop their strategies I upfront ask. They are intentionality behind this and I do vetting of their authenticity to it because if you're not willing to look at your approach from soup to nuts from beginning to vary in and I'll give you this as an example. I guess better answered as an example, Bill had organization that I'm doing some coaching on developing an equity strategy within their quality improvement and the statement was made well you know I asked about diversity in their leadership it there is none. And that's quite popular. By the way, in health care. I'll just leave it there.

When I asked the question about who will lead this agenda. Right, so you can't take an agenda. You can't go and ask a whole bunch of black folks are Hispanic folks or Asian Americans to come to the table and help you develop an agenda and then you attempt to carry it forward. Right, that that intentionality and that authenticity means that you're going to take a systems approach, which means that we're going to shake it up. And that's what leaders do. That's what leaders do leaders make very hard decisions and they make hard decisions and critical times like today. And I think to Deseret point if we're really going to get at. You know, moving that needle two things. One is a systems approach and that requires both of pushing a pull strategy. The way in which you do that as the organization takes responsibilities and does what it needs to do. But also as an individual, and I'll use myself as an individual over the most recent couple decades in this work is that I'm always pulling someone else through. So Deseret is not new to me as is the other you know folks that look like me that might be listening on today's call. Because one singular individual can't do it. And this is not about me this about my granddaughter. It's about my future grandchildren. So I'm Hope that answers the question, but as a systems approach in, in summary. Thank you very much.

BILL NOVELLI
In order to stay on time. We're going to go on to the next session, but please continue to ask your questions and we've got some time at the end of the webinar to address more audience questions and we will online get to them all. This was a really good session, I think, from top to bottom. And I think that what Knitasha just said at the very end, there might be a rallying cry. This is not a fad. And now over to Mary Naylor to introduce the next session.

MARY NAYLOR
Thanks, Bill. What, what an outstanding beginning to this webinar and Knitasha, you just provided an excellent segue to the next session where I'm pleased to introduce the panel who will present on challenges and action steps ne

vice president for health equity at Vanderbilt University Medical Center. Dr. Wilkins is widely recognized for her work and stakeholder engagement and his principal investigator of a quarry Research Award focused on improving patient engagement and understanding its impact on research.

She will be followed by Dr. Tekisha Everett, executive director at health equity solutions. Dr. Everett served as managing director of federal government affairs with the American Diabetes Association, where she provided strategic leadership on policy and advocacy initiatives with the White House and several, several federal agencies and lastly we'll hear from Dr. Cara James, President and CEO, Grantmakers in Health. Prior to joining grantmakers in Health. Dr. James served as Director of the Office of Minority Health at the Centers for Medicare, Medicaid services, where she provided leadership vision and direction to advance the US Department of Health and Human Services and CMS is goals related to reducing disparities and achieving health equity for vulnerable populations.

Each of these presenters will speak for about 10 minutes. And just a reminder to each of them to unmute your line when it's time when it's your turn to present.

and inclusion. That's led by my colleague, Dr. Andrea churchwell and we thought it was very important to actually distinguish our work in health equity, which is truly focused on making sure that everyone has the best possible opportunity to be healthy looking at health outcomes that doesn't mean certainly that we don't care about the diversity of the workforce, or that we have an inclusive culture at UMC but that's not my primary goal. My goal is actually to focus on health outcomes, making sure that we are actually removing barriers, thinking about those social domains of health and how we actually prepare the enterprise to address those. So next slide.

One example of that is that in the last year, we've created this certificate in health equity for our medical students and this requires that the students actually have a foundations in health equity where they learn about power privilege race racism. The structural competencies that that really drive some of the health inequities that we see in our, in our course. That's the foundation. The first foundations of health equity. There are three full days of this only two week course. That are dedicated to dismantling racism and addressing white supremacy. So, so these are things that we've been working on and we need so much right now and are trying to determine how to best actually scale those to others who are realizing how important they are. Next slide.

So as it relates to COVID-19, when our COVID-19 command center was put together at Vanderbilt, like so many across the country. There were there was a focus on epidemiology and ICU beds and PPE and ventilators, and all of those things. And initially, we did not have a clear focus on health equity, but a couple of weeks in our CEO and our Deputy CEO asked me to join the COVID-19 Command Center to really make sure that we were integrating health equity into all of that work.

And so this slide actually shows those areas that we decided to focus on as part of our command center that is specific to health equity. So we and not just me. So I put together a team of physicians, nurses, social workers. Folks in in the business space and operations and research in different sectors of Medical Center to come together to try and decide what was most important for us to actually do to prevent as well as address health inequities related to COVID-19 so we came up with five areas to focus on effectively communicating risk about COVID-19 and I want to emphasize here that that wasn't just for our patients, but also for our employees.

Recognizing that some of our employees, especially those for whom their job title or their roles aren't actually direct patient care. But they're essential to the operations of the medical center so those who are responsible for environmental services maintenance, dietary services. These are individuals who are at the hospital, every day, but don't necessarily identify as a healthcare worker. And we wanted to make sure that the communications that were being created for

actually place these and wash them every day. So we wanted to make sure that we weren't leaving out our own employees because we see them as actually our first community.

We wanted to make sure there was equity and testing and surveillance and that meant connecting with the public health systems, but also community partners and looking specifically at how we are providing care or their differences and how we provide care based on race, ethnicity, social income status or pay or status and down at the bottom tiny is is research, but not because it's not important, especially for condition for which there's no proven effective treatment. But it's small here because there's another large stream of work focused on research. We also did focus on Telehealth and that acknowledges that not only are there known barriers to adoption of Telehealth. For some communities, but these are likely to be exacerbated doing during this pandemic. So next slide.

So the first thing that we needed to do is to just aggregate the data that we had. And so having access to all of the people who are making decisions. So at the end. The command center, all of the Presidents of the hospitals and the chief nursing officer and the chief communication officer, everybody is there. And so one of the great things about this was being able to actually get things done quickly, so I asked for dashboards to be created so that we could just aggregate the data by race, ethnicity, and language. And what you're seeing on this slide is the data.

For language so of our first about 46,000 people who've been tested for the novel coronavirus at Vanderbilt 48 different languages are spoken, other than English and for those in that group of people for whom English isn't their primary language they represented about 5% of people who were tested but in that group 26% positivity rate about 20% of the total cases. So we early on, saw some disparities among these groups these individuals for whom they had limited English proficiency and. Next slide. The other thing that we did.

In addition to looking at race, ethnicity, and language was we looked at zip code. And so we wanted to try and understand, you know, what's happening in the community and we identified that for the these two zip codes that had the highest percentages of cases, the highest number of cases, they actually were to adjacent zip codes in the south east part of Nashville and communities that are known to have higher percentages a refugee and immigrant populations and understanding not just what we could do as a health center, but how we needed to connect with community health centers and those areas community organizations who are serving those communities who are primarily you know, creating and developing information in multiple languages and so that actually led to not only making sure that we had information in multiple languages available within view MC, but that we were supporting community organizations who are communicating in Arabic and the poly and Spanish.

And as was mentioned earlier, it's important in this setting to also make sure that we are not thinking that we're the, the, the ones who have the most expertise. So we actually partnered with community organizations to have them actually lead the way and doing live streams on

Facebook in Arabic and Spanish and leveraging community organizations faith based communities to do this work.

So these are some of the things that we've been able to do because we actually have this enterprise wide focus and have resources that were already dedicated to health equity that we could then pivot to address this work. And then, next slide. So, that's an example of you know what we've been doing over the last few months as it relates to COVID-19 and as we've been seeing this increased you know focus and heightened awareness of racial inequities. We've also pivoted to make sure that we can provide more anti racism resources and tools so that our staff and teams can actually respond as needed. We've hosted a series of panels focused on race racism and healthcare and making sure that we could actually address those needs.

And then tomorrow will actually be releasing the initial steps for view MC as we begin a more systematic approach to confronting race one equities, which will include developing a task force that will gather data and develop a set of recommendations for our CEO and our board and anti racism training for all of our CC C suite leaders as well as our board and additional resources to make sure that we're embedding racism, anti racism into our medical education and curriculum and also building the tools to remove things from our from our curricula, as well as our operations, including also starting tomorrow. Vanderbilt will no longer report the

organization is the reality is that I'm a race scholar who has chosen the avenue of health care and health policy as the way to effectuate change because if we don't have our health. We have no ability to live the other. We have no ability to reach and live our full potential. If we don't have healthy lives. Additionally, my last point on this slide before I move on is that this is a personal, professional and passion for me. I have lost both of my parents to avoidable situations that did not have to happen way younger than they should have And this is the case that I could say for a number of people who are in my family. So at a very young age, I realized that there's something fundamentally unjust and problematic about the way we deliver care in our country and the process by which we do that. So this leads me to really being very clear about health equity. Next slide.

So often our discussions around advancing health equity centered around doing a lot more. I'm doing a lot around the social determinants of health, which in the last decade has become a very sexy term. When I'm pretty certain that everyone on this call knows what it is. So I'm not going to take time to define it. But we've spent a lot of time and focusing on that and literally what we've been thinking about is the factor of where the conversation is going is recognizing that health doesn't just exist within the four walls of care whether we're in a hospital or providers office. And that we're trying to get the health system to understand or leverage its power and position to really impact what's happening outside of the healthcare system and efforts to bring people to their best health actions.

What is missing when we only talk about the social determinants of health and talking about
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a little bit faster than I usually would and invite you, if I over effect gloss over something too quickly, if I say something too quickly to put a question in the Q & A so that we can address that.

But what this slide is showing is kind of on the left side, I'm going to go through five key ways that at a state level, we can address priorities around priorities for equity and then what you'll see on each side. And I'll come back to the end is how this aligns with the National Academy and medicines primary goals for health equity. So it's an opportunity to deceive that while you're not a body and many of the people who are listening may not be individuals who actively engaged in the level of state policymaking you can see how you can have key ways and key, key individual priorities and goals within yourself that you can mirror and use a your own level. So we'd like to talk about and health equity we like to talk about system change where where you set and how you can engage this and this is what this attempts to do and as I work through this, I realized something. I didn't say at the beginning, I want to take a moment and acknowledge the incredible staff and health equity solutions who were very helpful and putting this together a special shout out to Ashley, who I believe is also listening today.

So instead of going over the slide. I'm going to go to the next one. And each one of these and going into a little bit deeper. So the first one is institutionalizing inclusion and just as a reminder, are going through five key steps we can take today and help us in the pathway towards equity on institutionalizing inclusion and embedding an equity lens. So one of the things that I've heard a lot of the speakers who spoken so far and has been hearing a lot lately particularly given the environment we're in is that we need to make sure we have diverse representation. And I think diverse representation only takes us so far.

If we don't have an institutionalized way of including individuals who do not reflect our own positions, our own backgrounds, our own culture into the organization or into the process of the care that we're delivering or into the work that we do. So in addition to having those people. What has to happen is a fundamental way of doing the work that focuses on embedding an equity lens. It's asking some critical questions, no matter what we're trying to achieve, about how what we're doing impacts influences impacts and or influences health equity or an equity in general, particularly racial equity. So what we're saying here is that you need to have somebody in an advertising, they kind of call it a traffic cop somebody who's looking at all of the pieces and where they're going.

In this particular instance it mirrors it and saying you're looking for somebody, or a group of people who are looking at equity and equity and everything you do who's taking a moment to think if you change the hours in which you are open and deliver care are you doing the best thing for the patients. And how's that impacting equity if you're producing research and you're actually involving individuals in that research.

What have you done to make sure that you have the most representative policies, excuse me, the representative population is possible to reflect the people you are trying to address in the

long term. So again, business person or people who are consistently by routine stopping the process and asking the equity question. Next slide.

As I said in the beginning, and I'm going to say here again confronting racism is a super important. This is a super important thing in the first point in this is we have to start by naming it. I think one of the reactors to the earlier panel has made this key point about saying we talk about racial disparities and we talk about race, but we somehow divorce that conversation from the fundamental fact of looking at institutional interpersonal and individual race, excuse me, and in terms of internalized racism. What is very important here is that we need to recognize that nd roder our diversity and inclusion efforts haven't gotten as far as we would like them to go because we're fundamentally putting a quote unquote solution to a symptom without this really addressing the disease.

And so when we open this there was a conversation about saying we want to go deeper than tinkering around the edges. I'm going to say that this is probably the one thing that I'm offering of the five that doesn't tinker around the edges. It requires us to imagine how we deliver how we fundamentally reform and delive

MARY NAYLOR
Thank you. Keisha that was just terrific I learning about what's going on the state level priorities and there's nobody that left your presentation without knowing that we must confront and dismantle structural racism. So thank you. Now let me turn to Dr. James.

CARA JAMES
Thank you very good afternoon to all of you. Good morning. For those of you on the West Coast. It is a pleasure to be here and to be joining this conversation with such a great group of folks. 10 minutes really is not a lot of time. So I am going to move pretty quickly through what I have to say, so that we can get to the questions which have been great in the chat feature.

Grantmakers and health is a non profit educational organization that is dedicated to helping foundations and Corporate Giving programs, improve the health of all people we work with about 240 of health foundations, as well as going to be serving organizations and a variety of areas of health, including equity access, older adults for behavioral health and many others that are really coming to the forefront during the course of a COVID pandemic. We work to sustain better health through philosophy and as we go back to our greatest challenge to us as we were setting forth our conversation today to really think about, you know, what are the things that need to change for us to achieve health equity.

To think big and also that, you know, one of the questions we asked is, sort of, if we had an ideal world, what really does need to happen. And you heard earlier from Dr. Washington. Notice that this disparities that has been brought to the forefront excited during COVID-19 are not new. They really are not things that shouldn't be a surprise to us in 1985 Dr. Margaret heckler put out a report from HHS. That was the first report to really document in a very systemic way the racial disparities that we have in our health care system.

Since 2002 the Agency for Healthcare Research and Quality has been putting forth the national health care disparities national health care quality report that consistently show disparities and care, not just everything today, but also by closing economic status and we've had efforts all along the way, and even before that to try and address the disparities that we've seen. But one of the things that I would say that we really need to do is to really get serious about addressing health disparities and to make health equity a priority. Often when we think about who's working on health equity and trying to address health disparities. It's kind of a small group of people or maybe a single individual in an organization with limited resources that is trying to effect change. And when you think about the fact that individual may be in what is their ability to really affect change in a large organization or even in a small organization or large community.

It really does kind of begs the question, so I would encourage us, and particularly if we're talking about the leadership consortium and, you know, sort of, the ability to aim in foster prospector sharing and collaboration on a number of issues. I think elevating health equity as a priority. As it has already become but understanding that it took us over 400 years to get to

And after shine talks about humble inquiry, which is the fine art of drawing someone out of asking questions to which you do not already know the answer. Of building a relationship based on curiosity and interest in the other person applying that to a community based approach is we're engaging with our communities, as I said, can help to foster collaboration openness trust and lead to change. And one of the other things that we think about installed on the questions during the person and family. Engagement section is how we are engaged in this community and thinking about how we reduce those barriers to increase participation.

Oftentimes, we may have, you know, meetings that may like to coincide with schedules for those internal communities transportation may be an issue childcare may be an issue. Are we reimbursing them for their participation, I think, how we are reducing those barriers stroke, because the patient is important. One of the other things though is even within that we talked about diversity or the lack thereof in many places. You may have one or two people who are focusing on these issues like a lot of us who do health equity with phone is ringing off the hook or emails are coming through and we're getting a lot of requests and happy to fill those but also how are you engaging, or maybe reimbursing those individuals for their time.

Because this is part of their job, which is important that there are also other things that they may be working on. So again, reducing those barriers because With the limited number of people. They're getting probably probed multiple times with multiple requests. And so how can we foster that collaboration and support participation across all sectors to increase that engagement. Some the other pieces as you're engaging in communities and working with that humble in Aquarius to understand There's a lot of work that's probably already been done in that community.

And it's important before you step into that space to take a moment to understand and evaluate the environment, figure out who the key players are and to learn what's been done. often see that organizations and communities will come from come through with ideas and I would just encourage us to, you know, sort of reflect back on the statement in The disability community of nothing about us without us.

So engaging with those communities to understand and include them in the process to identify the areas that are most important to them where they see those opportunities. To engage them in solution building so that they understand how those solutions may or may not work in that community because there may be something we had a lot of interest of will barrier to engagement and participation.

The fourth thing is to really reflect back on something that you should focus on is data infrastructure. Data collection and analysis is not really sexy acceptor among some of them already or ones of us who get really excited about data. But without data, we cannot measure or monitor progress and we really can't even identify where we have gaps. She reflected on the data needs that we have within COVID-19. But if you look across again the national health care disparities and quality report or health us from the CDC, or any of the number of other works

on disparities in health equity. There's a lot we actually don't know. And we need to look at how we are prioritizing data collection so that we can do apples to apples comparison.

helping situation where we may be contributing to some of the challenges that we have. And if you're reflecting on how distribution resources, which is also something that we can have seen for a long time and historically in your country. And next is really, you know, making equity part of our standard operating procedures, I forgot who it was that said at the top of this. But as this is not a fad. I'm probably a little more cynical. I think that this is a window of opportunity where we are seeing a lot of attention that is focused on inequities and health equity.

But I think it is a window of opportunity and we have, if we look back historically at our issue and attention cycle. We have a lot of attention that paid. Then there's often a realization of what it takes to address these issues and we start to see people fade is the support of the And so during this time, I think it is critical that we think about how we get the chance to really make sure that when that window closes and we move on to the next thing. That arises and gathers our attention we get at least a beachhead and make some progress so that when the window opens. Again, we're able to move forward and we're not left Where we were or worse off. And so, helping to make that part of our standard operating procedures is critically important.

One of the ways in which we can do that is to think about and to borrow from something in The rural community that some countries have done, and that's called proofing and a way in which we think about How as we're developing programs and policies they may impact service delivery, the healthcare workforce Health Information System. As well as access to virtual treatments and in essence financing and budgeting and governance and leadership. asking ourselves these questions on the front end, whether or not the media disproportional impact to try and address those can help to mitigate some of the disparities that we may see And to help us develop more equitable policies and programs on the front end so adapting that from an equity standpoint to Senator equity into the work that we're doing.

But also embedding that focus on equity into our standard programs so that long after we've retired or moved on to our second career if it is Baking or whatever that may be the work continues. That is something that we want to make sure happens and that it is not reliant on special resources to fund equity initiatives or other programs that may come and go as attention wings and waxes. So that is another piece. The third is, I mean, the seventh one related to that is creating program and policy for sustainability. Something we always talk about with our grantees and others are how they're creating sustainability, so that when the grant is the program was able to continue Thinking, the same way in terms of our equity work. How is it sustainable over time, maybe, you know, with leadership changes, we may see differences in terms of Issues in areas of attention and priority. But how does that work continue and has a budget betters not depending on you know fluctuations in time or so forth.

And finally, to develop a robust pipeline. We talked about having diversity. We saw and the comment that was lifted up in the previous session by Desire in terms of being the only person of color at the table. It's not an uncommon experience for many people who are in this space. And so we need a more robust pipeline. We need to support the development of programs to

train Individuals starting in high

health policy. I'm going to steal an emphasis that Dr. James said about dark arts a presentation and this emphasis on data. I would note that the importance of just normalizing this conversation by measuring consistently performance based on race and ethnicity. The, the inability of Medicaid agencies across the country to systematically collective report on race, ethnicity, data is a clear example of where we could just simply operationalize this There's a line from quality improvement we improve what we measure we have to measure this stuff on a regular basis and Medicaid as a great, great starting place for that as as Medicare, because the data is in one place.

From Dr. James. I know we were cautioned about the hero leader, but I want to emphasize what she said about leadership in Dr Everett's National Map. I actually covered six states that were reporting testing rights by race and ethnicity by my count for those six states have public health officers who are African American, I maintain that's not by Accident that those are the states that are doing the measurement that is specific efforts that leaders have put in place.

They have to take that effort. And then that can be sustained into a regular pace is Dr. James encouraged us but leadership is really important. And we have to get a more diverse leadership, if we're going to make this a priority. Finally, it's a little bit outside the realm of the National Academy of Medicine, but since we're talking about enlist issues that are reinforced by science. I want to underscore the importance of the political process, we still have 13 states that have not expanded Medicaid. That is a result of political conflicts over competing values. If we are serious about racial equity. We have to engage the political process as well as the scientific process. The political processes where we work out competing values if racial equity is a value that we hold dear. We have to win that in the court of public opinion. So thanks for really stimulating conversations

MARY NAYLOR
Now move to Dr. Monica Bharel Commissioner and the Massachusetts Department of Public Health.

MONICA BHAREL
Hello. Thank you so much. Can you all hear me. Yes. Um, I think I can as, as Chris said, I think I could probably end by just saying, Wow, I mean, those were three just unbelievable presentations I spend a lot of time. Listening to and participating in groups, talking about how to concretely address the systematic issues and our three speakers just gave her such concrete practical advice. Dr. Wilkins speaking specifically about dis aggregating that data really key for us all. And I think one of the key takeaways from this conversation we're having today as well as setting up a task force and training. Including really important. We often talk about training individuals but training at the C suite and board level really critical pieces. Dr. Everett very concretely giving state level policy changes that can be made and I really would like to re emphasize what you said on, we must confront and dismantle structural racism to get to health equity and Dr. James again and you're enough is enough framework with eight different very concrete examples of issues that we can address. You know, I want to take that and I am here in Massachusetts, the Commissioner of our Department of Public Health. And I want to give

end right giving a really quick example that When you were speaking it really resonates with the work we're doing here. And so often I like to say Each one of us wherever we're sitting. What is the lever that we can individually, pull, and I hope that individuals listening to this will take all of the Structure that you gave in the concrete examples and use that in whatever setting there and whether it's in a clinical setting a systemic setting a healthcare setting. So here in a public health sitting at the Department of Public Health. Since We have been working on our health equity plan, which is about health equity and Health Access for All individuals across Massachusetts And as we started to do this. We took a precision public health view, if you will. And that was about looking at the existing data that we have. And highlighting the social determinants of health and then using our limited resources to target those areas where people need Our programs and policies, the most and looking for outcomes as we began to do this work to an office of population health. We actually found that unfortunately Almost every single one of the health inequities were, we were seeing or along racial lines. And so we then we structured and riveted the work that we were doing a couple of our speakers broke this up to have a focus on racism and specifically racial health equity and looking at institutional and Institutional individual and structural racism in our work both internally to the department and externally and we get began Training of our senior leaders as well as looking at all our work through our health equity lens, including how we gave out grounds, how we did hiring and how we did diversity training, etc. So really, along the lines of what you were speaking about, and I must say, as we did this work and put the data forward in many of our areas we found that these inequities. Were along racial lines, for example, during the opiate crisis.

We found the communities of color with one of the highest impact it and then diverted some of our federal and other funding to really focus in on those areas and what they needed. And then now with the COVID-19 pandemic, which the first surge of it hit Massachusetts really hard. We have seen that COVID-19 is a pandemic and racism is a public health problem and pandemic and the two are so intertwined and I'll have to get that reference from Dr. Everett because in Massachusetts. We do also Report on race and ethnicity related to COVID cases. So, um, I have to get that corrected, but I would I want to say one thing about the data just to be just to add this as people are thinking Initially we weren't reporting on race and ethnicity related to our COVID-19 cases because so many of you have heard this before we didn't have enough of the information. So as part of our public health emergency. We didn't stop there and as part of our public health emergency we put in an order under the Commissioner under my name so that we mandated reporting and we actually then we're able to increase our numbers to almost Hundred percent of deaths reported and doubling Recent misty reported in cases of hospitalization and it helped us form a health equity advisory group and a task force and now going through systematically looking at the changes we need to make as we continue to confront COVID-19 so an example of really To the principles you are all talking about making the racial equity work a priority centerfold and thinking about our policies and programming, because, as many of you alluded to in your time, you have Fantastic panel presentations. These policies and programs that will put in place that have caused this systemic structural racism. For centuries now they'll put in place by people, and it will take people just like all of us here to undo those policies and programming. Thank you very much. Mary

MARY NAYLOR
All right, I will then move to Dr. Melissa Simon Northwestern University Feinberg School of Medicine.

MELISSA SIMON
Hi everybody. Good to be here. Thank you so much for the panel is so good to actually have some of my friends and my heroes on that panel.

So again, enough is enough. I love that word I say it all the time. Time to take this seriously took us 400 years to get to where we are as Dr. James said this is a marathon and sustained efforts are needed. Equity needs to be woven in the fabric of everything we do. And that's the structural barriers and opportunities, need to be critically examined at every single level and I love how leadership was highlighted. And really trying to get towards that more star of racial justice and rooted and being anti racist and everything we do not just eliminating racism. Racism. And the familiarity part is essential humble inquiry and communication with deep listening and deep learning And being vulnerable and sitting in discomfort me for black and brown folks we've been sitting in the discomfort for a very long time, and it is very is very uncomfortable, admittedly, when you haven't felt that before.

And so really taking a moment to to listen and learn more than just a moment because again this is a marathon. And nothing about us without us is truly essential, we have to acknowledge all the dimensions of the work and a lot of a great examples were given Moving away from race ethnicity as a biological variable and how we calculate GSR or also in OB. I'm an obstetrician. The Vaginal Birth After Cesarean section calculator has two numbers in it ones for ethnicity Latina Latinx ethnicity and African American race. So can we reconfigure that calculator, which a lot of people use across this country.

There are many opportunities in terms of workforce and scientific development. In healthcare training as well that like what constitutes professional school rankings. For example, medical school does the cat score really have to be included. In professional in medical school rankings. So could we partner with us news. We're morals reports to try to rethink what actually is a ranking. And why do we need one because those are more indicators that are structural that n 18 Tw(anking. 5(w ne]nvestse again]TJ

and healthcare delivery and in our institutions of higher learning And that actually is a misnomer. I mean engagement should be the absolute floor the absolute minimum because we have to think about how we really center communities and everything we do. And we've in that racial justice framework and equity through everything we do. And the only way we can do that is actually centering communities and the word engagement. In an outreach implies other and if you continue to say other than you're not really centering and you're still, you're still making that separation. And so in for health and healthcare delivery. Regardless if you hear a nurse or a PA pharmacists or social worker phys

will acknowledge that's quite an order for you to have it in essence asked you to describe the central elements of the organization.

BEVERLY JOHNSON
Thanks Michael and I think one beginning point would be to select a group of leaders in the organization and some of your patient and family and community partners and listen to this webinar. That would be a great way to begin to help understand both the issues, but also key strategies. I think to support senior leaders also in having honest conversations and whether it's a town halls with experienced facilitators. So they really have an opportunity to hear directly

MICHAEL MCGINNIS
Thank you very much. Take a show. The next question says, having just been a year with my 15 year old a Children's National and Boston Children's I'm struck by the differences in patient centered care. And person centered care in just two institutions, there's really no place in most healthcare settings that allow for input unless you have a complaint and go through. But change in mindset is needed within hospital administration, how can patients, families and those of us in healthcare administration. Or health services research help administrators to see the value in improving care and practices and invest in metrics accountability structures to bring into fruition.

KNITASHA WASHINGTON
Thank you. I hope you can hear me clearly, clearly one. I'll just say this, that the question has been asked. Year over year. How do we create the business case, the business case exists. There's tons of research that is out there that support all of which has been shared by our panelists on today in specifically when it comes to patient family engagement. At UW Health Solutions and collaboration with our CMS partners busy and did some work to Scientifically measure PSP and clinical quality outcomes. And so, you know, the notion that the work that we do and patient engagement, does it or does it matter really impact. Outcomes. So there's research to support that work as well. So I think that what we have to do two things. And it goes back to, you know, Information that part on on the call today. Number one, the, the commitment is really over the long haul, and trust is definitely a factor. In developing relationships and other person that asked a similar question in the chat box I responded to a little bit earlier, and they were talking about th

CONSUELO H. WILKINS
Thank you for the question. It's obviously so important that we really hear from the communities that are most impacted or disproportionately impacted by this disease. We are. We're fortunate that we have long standing ties and relationships with many different communities in the Nashville area. So we are able to rely on them leverage them and work directly with community partners to actually convene those meetings. So our approach tends to be Not that we need to set the table and invite people but that we need to be able to be invited to tables and work with community organizations to talk about what would be the best approach to actually reaching those communities. So for example, we worked with Elmo Hava which is A Center here in Nashville that really has long standing ties to many immigrant refugee communities and we talked to them about the need for communicating with pregnant women who needed to come to the hospital, regardless of whether or not we're in a pandemic. And how to actually get information to them and languages that their primary languages and make sure they understood what was needed and necessary. And that center actually put together the platform told us the time of day that they could host it and made sure that the that all of the information was translated in available with, you know, an Arabic and had native speakers available so so that's typically our approach. And similarly, we did that with other communities. And we didn't just ask the questions or or tell them things but we wanted to hear from them and that's so important if we're really talking about engagement that there's this bi directional communication so that we are sharing information, but we're also hearing from them.

MICHAEL MCGINNIS
The next question goes I lead a healthcare supply chain and technology company. And I'm wondering whether I have health equity or disparities in our employee population which spans the country. We all have the same employee benefit plans and access to those benefits. But I'm wondering whether we still have health disparities and how we would most effectively measure that?

KNITASHA WASHINGTON
Yeah, absolutely. So one of the, one of the first ways to begin to level up is take a look at compensation across your organization across similar roles. Look at race. Race, ethnicity, also gender and see where those disparities exists. Most organizations that actually do go through the exercise five some pretty huge disparities in that So, warning, warning, as you decide to use that approach. The other thing is looking at employee satisfaction. So another Area to begin to use stratified data is employee satisfaction. So not only patient satisfaction also employee satisfaction and really understanding what you're hearing differently and understanding that in a deeper way. You know by those stratified groups as well. And so I think that the other piece of it is and it kind of goes back to the example that I talked about when I was working with Cook County Health system here in the Chicago area is really to look at who you're serving. Right. And when you look at who you're serving. Now, how does my staff.

How does the concordance of the staff align with who we're serving. And so let me let me give you a little bit of an example. So when, generally speaking, when we do community

engagement and we engage across a multitude of races and ethnicities meaning communities. And when doing that. It is important to have alignment or that concordance between that worker or the staff worker, along with the community in which they're serving. There's research to support it. And I would suggest that you also

We've already talked about some of the challenges at the state level in terms of data collection within the space of Medicaid and other public health infrastructure there are conversations that are beginning in terms of the need to improve all of the public health infrastructure that we have seen and kind of not paid attention to over the past few years. Making sure that actually is part of that conversation. And that is, we are building this out. It is they are centrally, I think the other thing I saw that in the chat box is what is the role for our Programs Medicare and Medicaid. I think there is a strong role for those programs in terms of where they from the incentives as well as helping with some of the data collection.

One of the areas we haven't talked about today, which I think is important is how are we actually looking at building equity into our quality measurement that is something that we look at a lot of quality measurement we have standard measures that we do across any healthcare setting nursing home. Home Health dialysis hospital. Where is equity in the measurements were are measured developers in terms of looking at building those building blocks to be able to measure and monitor quality. From an equitable standpoint and is that how we are building managing those programs. There's opportunity as we think about the supplemental benefits that are available Medicare Advantage who's receiving those benefits which plans are offering. Those are they going to those who are most in need of those services, or do we see differences and what's happening there. The conversation that happened last year in terms of, you know, the AI and artificial intelligence and United Healthcare Care model that had unintended consequences. Again, those we sort of stumbled on that because that model wasn't actually built to include race and it was only because there's researchers with during sort of racial ethnic disparities that we found that, but I think that, you know, creating that roadmap having concrete steps. Collaborating I think it's really important as we said, there are so many people that are pulling into this space at this point in time, there's a lot of energy. How do we focus that energy So that instead of having a million disparate projects we really have people sort of pushing and rolling in the same direction to have an impact and maximizing that effect across the time. And then, as Chris mentioned in his remarks policy, looking at those policies that are coming forth Out of congress out of our state legislators and others to really build those put those building blocks in to sustain those because We philanthropy communities. Actually, we all have a role to play and the government also has a role in this space. So tackling this from every level of our socio economic model. To ensure that we're building that in from the beginning. But again, for those who are in this for the long haul, know that you have a lot of support and there are a lot of us in the space and self care that you can preserve yourself like a long fight is important.

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CONSUELO H. WILKINS
I think it's really interesting. What we've seen

to support the expansion of telehealth, are some of the other areas. I think we also need to consider to make sure that Those who are disproportionately certain vertical communities also are able to provide those services. And lastly, I would say, is to make sure we're thinking about training and not assume that just because we're giving people Ideas, even on the provider side that they understand sort of how to use those and engage people in a way that is meaningful.

MICHAEL MCGINNIS

Thank you very much. We're going to go to one final question, but first I want to give a heads up to our last commenters and ask indicate that we're going to come back and ask you, each to give A maximum of 30 seconds on your key take home observation TIS

MICHAEL MCGINNIS
I think it was a splendid answer. Thank you very much to Kesha let's now go to our lightning round, as I think of the term of Our commenters to give their 30 seconds most important take home on culture and inclusiveness progress for the nation or for the National Academy of Medicine, as we move forward, Chris.

CHRIS KOLLER
Oh, you let me go first twice. Thank you, Michael. I'm, I'm going to steal Kara's line with apologies to all the other panelists, because you're all aware of it as well. But her line about humble inquiry sticks in my mind. I was having a side conversation. But as someone who's been the beneficiary of privilege myself. I think the framing of the approach is humble inquiry. Both encourages the persistence that we need the curiosity that we need and the respect that we need and also gives us some agency, regard