NAM Leadership Consortium Culture Inclusion & Equity Action Collaborative Webinar
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MICHAEL MCGINNIS
Good afternoon, everyone. I'm Michael McGinnis from the National Academy of Medicine and it's my great pleasure to welcome all of you to this webinar of our culture inclusiveness and equity action collaborative. This is an important element of our national academy of medicine activities in which we seek to provide the conditions that will help us move to health system which is effective efficient equitable and continuously learning.

My principal responsibility today besides providing the welcome and underscoring that welcome to each of you, where we have over 900 registrants on we've signed up for today's webinar. And we hope to use each of you as change agents working in partnership with us on behalf of better health for all Americans. My principal role is to give a little background on the National Academy of medicines leadership

evidence mobilization action collaborative, the value incentives and systems action collaborative in the culture inclusion and equity action collaborative.

We now move to the formal launch of today's meeting. Thank you for bearing with me and that background contextual overview, but it's a tremendous pleasure for me to turn the floor now to Mary

A real sense of how this engagement occurs, it occurs through community Coalition's multi Coalition's that very big investment in awareness standards and so on. So all of these efforts are going on

focus on funders health systems, community groups and assisting them in designing measures that will be useful to them.

And we expect that this final report will be achieved in December 2021 and it will be accompanied by an action oriented summary and dissemination aids, so that these measures can have the widest possible impact.

So what we're hoping and what I think you're getting a sense of through these efforts is that our work is to really capitalize on all of the experts in the field. The thought leaders, you're going to hear from many of them today.

But we're hoping that this overview gives you a brief sense of ways in which this collaborative is engaging in multiple topics to achieve and advanced inclusion and health equity. We're interested in using these opportunities, not just to produce papers about to produce action, as the name of our collaborative suggest positioning through webinars, such as this multiple stakeholders, with the knowledge and strategies and resources that they need to really advance conversations and ultimately action within and across organizations.

So now with that background I'm excited to introduce our first panel. This is a panel of outstanding leaders who have demonstrated extraordinary progress in improving Institutional Equity and will share with you today lessons that they've learned to identify best practices that healthcare organizations broadly defined how hospitals post acute care systems community care systems can use to track their progress towards internal equity.

We're interested in exploring this from the broadest perspective. So, gaining ideas and strategies from multiple sectors with the desired end user being health related organizations will begin with formal presentations and then move to a discussion with our panelists. Please feel free to type any questions that you have in the Q&A box at any time and will attempt to address as many of these as possible during the conversation, period.

So let me now take the opportunity to introduce all of our panelists who will who will then share their respective wisdoms from the work that they do.

First we'll hear from Dr. Ella, Washington, Dr. Washington is an organizational psychologist, the founder and CEO of elevate solutions and Professor of Practice at Georgetown University's McDonough School of Business, studying race strengths and other dimensions of diversity, equity inclusion in the workplace. Dr. Washington's in depth experience in this area stems, not just from her research on racial and gender disparities in corporate leadership positions, but her global consulting experiences with Fortune 100 government and nonprofit organizations.

Dr. Washington will be followed by Dr. JaNay Queen, who is the chief strategy officer at living cities. In this role, Dr. Queen convenes and leverages public, private, and philanthropic stakeholders in American cities, identifies and test innovative approaches to deploy millions in private and public capital for investing in people of color and harnesses and facilitates the power and resources of multibillion dollar foundations and financial institutions working collectively towards systems change. Throughout our throughout her career. Dr. Queen was air has worked across sectors at every level of government domestically and internationally to provide innovative, creative and solution focused leadership and strategy to address social economic challenges for children, adults, families, and communities.

Next we will hear from Dr. Ronald Copeland, who is the senior vice president of national diversity and inclusion strategy and policy and Chief equity inclusion and diversity officer for Kaiser foundations health plan and hospitals. A board certified general surgeon. He leads Kaiser Permanente his efforts to ensure their strategic vision for equity inclusion and diversity and is successfully implemented strategies to drive business and mission outcomes, resulting in Kaiser Permanente members achieving health and healthcare outcomes that are of high quality equitable and increasingly more affordable.

Mary Naylor: And finally we will hear from Dr. Yeng Yang, who practices primary care at Health Partners, which is a large consumer governed nonprofit healthcare organization based in Minnesota. Dr. Yang is medical Advisor of health equity and CO chairs the health equity and anti racism cabinet to provide medical leadership and oversight of activities to drive health equity and anti racism across this organization. She believes trusted patient clinician relationships and experiences are built upon and around multi mutual respect understanding and curiosity and believes all three are foundation to achieve foundational to achieving good clinical outcomes.

So we are absolutely delighted to have such amazing leaders with us today. Each presenter will speak for about seven to eight minutes. Speakers, if I can remind you to please only unmute when you it's your turn to present and the NAM staff will be controlling the slide deck. So please remember to indicate when to advance to the next slide. So let me now turn to Dr. Ella Washington to begin this conversation.

ELLA F. WASHINGTON
Thank you Mary Hello everyone, so excited to be here with you today. Thank you for tuning in to this important conversation. I'm an organizational psychologist, as Mary stated, and I study diversity, equity, and inclusion from both the micro lens of understanding leaders and teams and also the macro lens at the macro level I study the journeys that organizations are on and how they really work to create a better work environment for all. Next slide.

So as we start to unpack what this journey is all about. It's often helpful to begin with the end in mind. So imagine coming to work and not having to shrink any parts of yourself or hide any parts of who you really are. Working in an environment that allows you to thrive by using your best strengths being valued financially and working within a community of respected diverse colleagues. This for me would be the utopia of an inclusive workplace.

The terms diversity, equity, and inclusion are buzzwords we hear them a lot today. But let's start by qualifying what we're really talking about when we think about the ideal workplace in regards to DEI. So

So you think about the stages of the organizational DEI journey. The first stage is awareness. So when you and I first started becoming a buzzword in 1990s and back then it was just DEI diversity and inclusion not D&I. Many companies have chosen to be unaware of issues faced by marginalized communities.

As they came into higher levels of awareness, they started to ask themselves, you know, what is the point of DEI. See, I also see this happen unintentionally with newly formed organizations. That think about their human capital practices, kind of as an afterthought, they think, well, we're such a great organization, we have such a strong mission. We're at but they forget to intentionally focus on DEI.

And so those organizations would be considered at this stage one of awareness, what's the point of DEI and that's not necessarily a negative question I have many healthcare organizations that I've consulted with that truly believe in their mission and purpose to provide healthcare and humanity for all of their employees and all of their patients. However, they haven't intentionally focused on DEI and they're finding their self at this crossroads that, you know, just because we're good people. We have this good mission doesn't mean we're going to hit our diversity and inclusion goals.

So moving on stage one to stage two into the compliance stage, the second stage we see many organizations stuck in where they're focusing on maintaining ESC and other len7(15in why're finding

making sure that we're always remaining integrated in our efforts. I want to break down this stage for which is often the coveted stage. Next slide please.

Around the efforts and because I mentioned the organizational spheres of influence. And so here's a visual that just kind of shows for any organization. There are so many different spheres of influence, you have it by understanding how you can impact the world of diversity and inclusion for each of your spheres of influence. That is how you can move to a place where you're truly at a more integrated stage for your organization and so when I talked about Stage three, where organizations are strategic maybe they focused on their customers or their suppliers or maybe they have a very diverse workforce. But there are these other really important pieces of their sphere of influence that they haven't considered such as their industry influence that can have a really big impact.

When I'm working with organizational leaders we start to break down this sphere of influence. As you see here on the left side of the screen. And think about how does it adverse inclusive and equitable culture, help us achieve our greater purpose. Some critical questions that leaders have to answer from the outset, are you know what are our goals and objectives over the next one, three, maybe five years, it's important to have both short term and long term goals. The work of being is I'm sure all the panelists will share today. It doesn't happen overnight and there is no magic fix, unfortunately.

And so we do have to be very strategic in terms of the things we want to tackle from a short term and long term perspective. You also want to be thinking about how we're holding leadership accountable. For example, many organizations have moved to different models were compensation is tied in some ways to DEI. Our goals. And what happens when the organization doesn't hit these goals and so you know, many companies and organizations will say, well, DEI is really important to us. We're really committed to it. And everyone's kind of nodding their head yes saying it's important, but they don't take the time to kind of break down these specific silos of where these efforts are and to understand the success of these efforts throughout a whole organization or a whole system. Next slide please.

And finally, though, we're talking about the organizational journey around DEI, we have to acknowledge that each individual is going through their own journey, especially from a leadership perspective on understanding and being able to connect with the issues and challenges. And needs for change around diversity, equity, and inclusion and so one framework that I work leaders walk leaders through is trying to understand what's their goal. At their individual kind of leadership lens. So what's their bottom line for their department or business unit. Or what's most important to them in terms of patient outcomes for example with health care clients and understanding, you know, what is the goal, what changes are needed to meet that goal.

What skills are needed to activate on that goal and then connect that to how does this particular goals, support the organizations will organizations larger strategy. So oftentimes with DEI strategies, it will be the role of the Chief Diversity Officer or the head of human resources to activate on DEI but leaders don't see themselves in supporting that larger strategy. And so, breaking that down into smaller units in ways that you can understand how your individual efforts as a leader as a team, support the larger strategy are critically important. And then lastly, we want to think about how does this work specifically impact our business goals.

What are potential roadblocks that we might face were trade offs that we might have to make. For example, one of my health care clients day recently went through this process and they're doing a internal audit found that their health care providers were struggling with patients that were saying a lot of racist things in their care. And so of course we're struggling with how to deal with that. And so the organization itself had to grapple with. Okay, what are the roadblocks and what are the trade offs. What are we going to stand for and how do we serve our mission in terms of treating everyone with dignity and respect and providing the best care possible but also protecting our employees and letting them know that we don't want them working in a hostile work environment that allows racist comments to be made. And so it's important for us to think about these potential roadblocks and trade offs.

And you know, I want to end with every organization is at a different place on this journey, it's important to know kind of where you are starting and have some clear sense of direction of where you want to go. So that you can kind of track your progress and start to make intentional efforts. So thank you all for listening. I am really excited to hear the rest of the panelists and feel free to connect with me to continue to learn about my research on LinkedIn or Twitter at LF Washington. Thanks everyone. Mary, turn it back to you.

MARY NAYLOR
Thank you Ella that was terrific. A beautiful setting the stage for a wonderful conversation. And believe me, we have will have a lot of questions about how organizations at different parts of the journey move to the next steps. But thank you so much. So now let me turn it to Dr. Queen.

JANAY QUEEN
Thank you, folks. Hi, good afternoon. Dr. Washington, you set you set my talk up beautifully. So I actually want to start by telling you, our story and sort of humanize what you just heard from Dr. Washington and every on if you want to sort of put me on full screen you're welcome to and I can promise you when it's time to go to some of those slides. will skip through through the data.

So, you know, as was mentioned, I'm working at living cities and living cities is a collaborative organization, made up of foundations and financial institutions met several of the largest one so gates Rockefeller Ford any Casey Foundation, Bank of America Prudential and so forth. And we've been in existence. This is our 30th year and we exist to ensure that all people are economically secure building wealth and living abundant dignified and connected lives.

But we weren't always that we weren't always in that position. And so with Dr. Washington's what's beautiful about Dr. Washington's presentation is that we sort of went through that process that she laid out very, very beautifully. And our current strategies

And so what we did and with our staff is we try to do these whole staff convenience that didn't work. And

framework for are currently for our equity inclusion and diversity work. We've been on a long standing journey really that started you know 75 years ago when our founders took a stand against racial segregation of our patients in hospital systems and created our own system to make sure our values and commitment to diversity and inclusion could be honored without barriers and that was the beginning of this focus on integrating integration, but also recognizing the commune skills, the efficiency and, more importantly, the integration of clinical care practice research.

Making health care more affordable and benefit designed to optimize the improvement and health of an entire population. Taking full financial risk for that model and that foundational model, which has been modified and updated over a 75 year period is still core to how we operate in work today. But our vision is really around equity and inclusion for all, and our goal is to integrate practices and understanding across our enterprise influencing individuals our systems and communities, then enable the aspiration is to be achieved in a evidence base and measurable way over time. And so we, the three areas that you see highlighted here in terms of where our focus is regarding what we do in our work environment. What we do in the care delivery patient facing and patient interaction space and what we do, what our communities.

I'm going to give you just a quick flyby of a couple of initiatives that are underway currently in each of these areas to drive us forward and this work. Next slide please.

So this is a slide is highlighting some work we did in the beginning of 2000 sorely after the Institute of medicines report on equal treatment documenting the racial inequities and discrimination that drove racial and ethnic disparities across the country. We turned inward to ask ourselves, while we've had a long standing commitment to quality improvement both process and outcomes and experience. Do we have disparities within our work in our patient population and the conventional wisdom at that time was probably not, because all of our patients are cared for by the same physician care teams and systems and optimization of results and our population data shows that our patients are getting excellent care and having great improvements in health and so on.

But that was an assumption, as opposed to a documentation and validation, because we had not taken the time to appreciate the importance of dis aggregating our data based on race and ethnic identities by our members and patients to see if we in fact had disparity. So this slide is a reflection of one of the HEDIS measures that we were working on improving hyper tension control in African American patients. And so when we get our data along the identity groups you see listed here, what we found in the beginning of this slide back in 2009 was that African Americans by this scale. We're under treated in terms of hypertension control a variety of factors that are driving that.

But you can see the black dotted line is the 90th percentile, and our aspiration just on quality improvement was to make sure for all HEDIS measures all populations were at a minimum at or above the 90 percentile in terms of achieving those measures. So you can see by t

and while I won't go through all of these, there's a couple. I think are worth highlighting and given some of the discussions we've had earlier today.

One is the first one about holding leadership accountable. The value of stratified disaggregated data to see opportunities. And building this into individual and organizational performance goals to make sure that we had at scale, an aligned and collaborative approach to improvement holding everyone accountable for the role they played both in educating delivering effective practices and driving the results desire. And in a large decentralized system such as our as with as with so many physicians, nurses, hospitals across the country, it is imperative that the performance management system you have in place your quality improvement apparatus, but this work is fully integrated into that.

So that it's not a standalone it's not fighting you competing for resources, but it's fully integrated and people have that as part of their accountability that. The other thing I will point out near the bottom is the incorporating the voice of the patient. We discovered along this process that our interventions. while, well intended did not really hit the mark and have sustainability and create high trust between us, our patients and the communities we serve until we elevated appropriately so the voice of our patients by not just doing focus groups and surveys, but having patients sit side by side with us in co design interventions that they knew would work and incorporate all the nuances of culture, language belief systems etc that were necessary to drive results. And it was a different set of initiatives and nuances for different communities, different cultures.

But rather than guess at them, or some one size fits all having patients co design with us was really an important initiative that has served as well, even to today. And then the New England Journal article here is just a reminder that it's important to take your results in data and share it with third party reviewers to evaluate the science of what you're doing.

As well as the relevance to the to the issues at hand and to verify whether the work is sustainable transferable and could be used by other people across the country. So sharing it and participating bi directional learning as we're doing today is an important aspect of this work and ability to accelerate the pace of improvement. Next slide please.

And where we are on our, on our model of intervention beyond just recognizing disparities and the issues that that that are part of that we we've had in the last year or so have had a really dramatically increased focus in the model, you see here, which is really, really redefining what health is and what it consists of and rather than thinking about the traditional medical approach to physical health and wellness. We understand that physical health mental health and all that. That involves as well as social needs being met and social health is a set of constructs that in people's day to day live lives and lived experiences. is really all integrated and it's artificially just aggregated when people come into systems that only choose a recognized one aspect or another. So our, our evolving motto is to create new intervention approaches that integrate all three of these constructs and the one that is has a major focus right now is our social needs work.

And we've created a framework that is we call thrive local which is a social network arrangement across Kaiser Permanente geographic footprint and all the communities we serve. And it's a network of community providers that provide for social needs that have been on met and when we did surveys on a national basis through some research and then did it within our organization.

We found that over 25% of individuals identify that they had at least experienced one unmet social need that had a dramatic impact on your health, and we know for other underserved populations. This is further aggravated by additional unmet social needs. So incorporating this into our, our framework related to food insecurities homelessness financial strains social isolation intergenerational trauma racism and so on is now become a core construct for how we think about equity how we think about interventions and use our integrated model and our community presence to bring a comprehensive approach to this work. Next slide please.

And we are able to keep track using measurement to identify how are we achieving these results and what services are being identified so that we can intervene appropriately. Next slide please.

And we're also the last piece I want to highlight here is just what we're doing inside our organization, the core principle here is that we don't believe people can deliver services. And interventions to others that they don't experience themselves. So the work environment for all of our employees and physicians is critical to be an inclusive environment that is psychol

we've been going through it really initially started to achieve the triple aim in that equity piece and really just started with you know, collecting data race data, which was something that in the early 2000s, not a lot of the organizations in Minnesota were doing.

But then over the course of the last 10 years or so 10 to 12 years or so, we've been doing some work with just patient base, quality outcomes and identifying the gaps and then trying to close those gaps, but as you know that those gaps still persist across the country and in Minnesota we enjoy the status of having the best health in the country. But that's only if you're white. So if you're not white, then you have a huge gap in almost all of the preventative measures, as well as some chronic diseases as Dr. Washington and everybody talked about earlier. Next slide please.

So this slide just kind of shows you all of the efforts that our organization has been involved with and you can see it's a very busy slide and that highlights all the work that we've been doing since 2006 so we've been involved with patient quality outcome measures, we've been involved with community partnership in advocacy work in our community. We've been involved with the St. Paul anchor strategy which really anchors around one of our largest hospitals regions hospital and having business partnerships with the city of St. Paul, because we're one of the largest employers in St. Paul. And then lastly, and you know we've been working with our own internal work group was in the space of diversity and inclusion, however, because as you can see all of the little arrows and intersections on this graphic that there's a ton of work, but they're all kind of pretty siloed. And there's a lot of energy all throughout different parts of the organization, but up until last year. It wasn't very aligned or strategic there was just a lot of very interesting work and a lot of very excited people and passionate people in champions, but it wasn't an organizational approach to work. Next slide.

So one of the biggest incentives for us to really take another hard look at our organization and say, to ourselves, what are we doing, what are all the efforts that we've put in up to this point, getting us and are we getting to where we want to be, to the point of what Dr. Washington was talking about, about answering those crucial questions. And so during May of 2020 years. You remember the killing of George Floyd back right in my city of Minneapolis. That really shook us all in the city of Minneapolis and St. Paul. And we, you know, really took a deep breath and our CEO initiated a series of listening sessions. This is, you know, really was quite tremendous because almost all of our 26,000 employees either got to participate in it, or we're listening to recorded sessions. Thereafter, and what is taught us was that yes we've been doing a lot of work and within the organization, particularly in the patient outcomes phase. And somewhat in leadership space, but there was a lot of pent up demand for conversation and understanding and they need to have diversity and inclusion and equity. And really this first time that I've seen this introduced in our organization is the need for us to be an anti racist organization.

So this led us to really rethink the work that we're doing and really look at us along that journey and that Dr. Washington walked us through earlier and say, Where are we and where do we want to go. So that led us to the creation of the equity and Inclusion and anti racism cabinet, which I co chair with our CEO and another physician and what this does is that it created our vision of advancing health equity and eliminating racism which is big A, big deal because nobody has really spoken those words of eliminating racism before in our organization and perhaps not even in our city.

Our purpose of this cabinet is really to provide leadership and direction as well as oversight to the four cornerstones that we've chosen to organize our work around and just that if you remember that busy slide that I just showed you. All of those words now has been organized in the line within these four cornerstones many of those words you know crossover they intersect. They overlap but that allows us to kind of create some focus, as well as applied some, you know, specific leadership and resources to each of these cornerstones. So what we have learned is that yes we have had a lot of work, but they've all been done in silo. And we know that in order to make real improvements in equity.

We have to focus on culture and therefore we have to really break those silos down. So hopefully by organizing ourselves into this four cornerstones that we will do that. And, you know, one of the things that we've learned to is that in the past, there has not really been physician leadership and we really are a physician led organization. And so this edition sort of have been, you know, removed from this effort in

RONALD COPELAND
Yeah, I agree with what's been said, the only thing I would add was part of our journey is at the end of the day, this has a start and end with leadership setting the tone around declaring publicly inside the organization and how that these issues of discrimination in an equities and so forth are absolutely not aligned with our mission not align with our values or commitment and. And to the degree that it does not align with that making public statements and creating a movement within the organization.

That then goes into strategy and training and all the things that come from that but it starts with leadership. Making a state of putting a stake in the ground and saying that we're different, or we believe in something different. And we're going to drive our results and be a light to the communities we serve.

YENG YANG
Yes, thank you for that. I totally agree with you know my three panelists. What they've said. The other thing that I would add is that, you know, having listening sessions is really important. Because you want to hear the voices of the people and the lived experiences of the people that you know have some experience in various experience in various forms. I think that helps to inform you about, you know, who are the people that perhaps you can rely on to be champions that can help disseminate the work and who can help you know, create some of that energy out. You know, in the field and then the other. The I totally agree with having leadership really putting a stake in the ground because I remember when I was asked to be part of this cabinet. I'd asked our CEO Andrea. I'm like, if this is just going to be an initiative and we're just going to do this for six months. I'm not going to do that, you know, because I don't think that that's going to create a long lasting, you know, integrated change that is really going to take root in our culture so funny thing is that you know, our vision or organizational vision is really head and heart together and you know this is so poignant in that creating equity and becoming an anti racist organization really starts with hearts, right, because if you don't change your heart, you can go through checkbox trainings, all you want, but it doesn't change fundamentally who we are. So I think that’s something that's very important.

The other thing with that driving is that eventually you're going to be asking people to take personal journeys. Because this isn't just mandatory learning that you can do as an organization on a one year, you know, annual basis and then be done. Everybody is going to be at different places in that journey and you're going to take some organizational steps together, but you're going to ask people to do personal journeys, and this is a lot to ask for people really excellent advice. Um, maybe just an add on to this because there's been a from lead to lead Toshiba rouse this idea that maybe leaders get stuck and, you know, how do you move leaders as given the central role in this movement to from one step to another.

Yeah, I mean I would just add that I think that, you know, using the framework that Dr. Washington outline would actually be very helpful as a roadmap for an organization so that they can say kind of do an assessment along the way to say where are we, and you know, because when you're, you know, when you're still into it, you may just be in the thick of it and you may not see the forest for the tree. So having sort of a roadmap for you to periodically reassess yourself and say, Where are we, and are we getting you know making forward.

You know progress towards that next step that we want to be would be one way to kind of help leaders. The other way is that in, like I said before, instead of leaving this up completely. The to the DTD.0002 ehhelp .-2.x

you know I think out in the, the greater d i world.

And we've got to be actively practicing these competencies and skills daily because we, this has been we have been living a particular way for a very long time and we have to go through a reckoning, so that we can re imagine a world of society of healthcare system that will be to the benefit of us all. So it actually just starts.

RONALD COPELAND
Just add a second I think on this paradigm shift. Is right on point. But part of what I think has to happen as part of paradigm shift is the expansion and was included in the notion of health. So if your paradigm and world starts with health for us is transactional we would provide a service you pay for it into conversation and everything else you're on your own. But when you expand to say all of this is healthier social environment, your access to support your job poverty, etc, etc, when you expand it. So it's like the integration of medicine and pumped into traditional public health notions into one. Then the possibilities expand and your connection to those possibilities and your motivation to be involved. Changes because you see the world differently. So it is a belief system, but as a belief system, starting with your, your, your awareness and how you frame your, your competency effectiveness and your obligation.

MARY NAYLOR
I'm going to stay with you and both, both of you at all because so much of what we need in the integration of our health and social system is, you know, going well, way beyond our traditional internal boundaries. It's sharing data, it's sharing resources across to get to cross sector integration and so a question has been raised about how do we get breakdowns beyond our internal, break down the internal barriers to enable these kinds of changes to affect everyone?

RONALD COPELAND
I've had a now 32 year career with Kaiser Permanente in operations that I was involved with consulting advising and Cleveland, Ohio, when we had operations there. Around this question of what Kaiser Permanente health system was doing what the university system was doing what Cleveland Clinic was

just our, our how we engage with these notions of anti racist practice or racial equity, what is all of that mean and then look around and take in what's happening in the world just like sit in some silence for a little bit and don't necessarily rush to do something only because this does require a personal reckoning. And then as you are in partnership

ball and go home. When we get frustrated if something doesn't work the first time where it doesn't have the exact intended outcomes that we foresaw and so it's important for us to stay the course realize this is a long term journey. Um, and also, you know, celebrate the things that you can celebrate, celebrate the small wins celebrate those moments. Those interpersonal connections celebrate those moments of learning as everyone else has said, and so my advice would be to stay the course.

MARY NAYLOR
Terrific. So my final comment is, that I say this to my co chairs, all the time. I feel enormously privileged to have the opportunity to interact with such extraordinary thought leaders and learn from and you. This has been an outstanding panel. I'm very grateful for the time that you've taken and you've given us all a lot to start a new with so thanks to thanks to each of you. And now let me turn it to Bill Novelli who will continue this conversation.

BILL NOVELLI
Thank you Mary. I found that to be absolutely terrific. It was not just informative. That whole panel session was inspiring. Yes. And so now, it leads us naturally to this next session that we've got this afternoon, which is dashboard indicators to monitor national progress towards a culture of inclusion in equity. And so this is going to be background on a draft list of potential indicators, so that we can share progress made in identifying key measures that we can use to monitor progress towards a goal of ensuring a culture of inclusion and equity in the health system. And we have two reactors. One is Dr. Nicole Franks who's the chief quality officer at Emory University Hospital Midtown and the other is Dr. Apryl Brown, who is president elect of the Michigan Public Health Association. But first let me outline the background for this discussion.

So each of the four action collaborative says spec731.3iati77(iple thos5.8

in their life. Based on answers to two questions about where respondents see themselves in life. Now, and in five years, they can be categorized into thriving struggling or suffering.

The second potential indicator is asking more specifically about physical health has measured on the behavior. Risk Factor Surveillance survey. We've got good evidence that this measure corresponds strongly to someone's overall state of health and for a self reported measure it's reasonably reliable.

what information is not currently tracked that you think should be in first, I'm going to ask Dr. Franks to share her reaction. And then Dr. Brown.

NICOLE MARTIN FRANKS
Thank you very much for this opportunity to share a few thoughts and I really appreciate the work that's being done. I'm thoroughly enjoying participating in this conversation.

The first thing I'd like to say is considering the indicators that you all have presented. I do think that they do a wonderful job of trying to capture their respective categories that is intended. My first reaction is around the first two indicators related to overall satisfaction with well being versus adult self reporting excellent or very good general health and as you mentioned, I do my first reaction was that they're very similar but when I did take a step back and really focused on the word well being and how much it does need to incorporate the other factors that go into health. I think it's truly important to leverage an indicator that can be holistic and something tracked over time. So I do think that that particular indicator is on point. And then the drill down of the second one looking more specifically at a patient's self reporting of their general health is also important as well. I often wonder in these particular types of evaluations, the truth or how a patient's readiness to be healthy or readiness to do something about their well being plays into how they answer these questions.

And so I'll just offer that as something else to consider. When we look at some of these indicators and how they're reflecting our progress is also thinking about the readiness of the individuals answering the questions. Is that really giving us the information we have, or do we have another problem. We need to drill into.

The second thing that I'll give a little bit of feedback on is the health, the health care access indicator that's offered people who are unable to get or deleting getting needed medical care in the last 12 months and I'm really curious around how is this this particular indicator measured because I do think the spirit of it is directionally correct. I just I just am a little bit concerned around. Are we going to be able to measure that appropriately in how is it done. So someone who works on the frontline in the emergency department access to care, presents itself in so many different ways. So I just wonder how this particular indicator will be measured.

And finally, related to food insecurity. I think that that is also directionally correct. Food is fundamental to everything that we do, how we feel how we function at work. What is our health. So I do think that that is the right direction. And I also just wonder, again, that has so many components behind it related to just not just access or availability, but the quality of the food, the appropriateness. The variety and things like that. In terms of how we define security. So I'll just offer those few things as a reaction. Thank you very much.

APRYL BROWN
Okay, thank you for this opportunity to give my reaction. Today I'm enjoyed all the presenters and has been an awesome learning experience. I want to emphasize my reactions to that discussion, talking about food insecurity food insecurity is a significant social determinants of health. That should be analyzed in local communities, whether urban or rural to achieve health equity throughout our nation.

For example, according to the United States Department of Agriculture, the national food insecurity rate is 10.5%. A 2019 report by the Detroit Food Policy Council revealed that Detroit had an epidemic food insecurity rate of 39% Which has dramatically increased during the coven 19 pandemic due to loss of income and our families face with the difficult decision of choosing among critical bills like housing, transportation or medicine. The pandemic has may hunger in Detroit, Michigan, more widespread invisible. But major food banks, such as gleaners and forgotten harvests along with churches, schools and social services have worked to ensure that their people are able to eat. Detroit, Michigan, which is the 14th largest city in our nation as a demographic of almost 80% Black or African American Almost 7.7% Hispanic or Latino and almost 14% white still has rates of food insecurity higher than the national average for each demographic group.

In 2018 the Michigan Department of Agriculture discovered that there were 19 neighborhoods in the city of Detroit. That would classify as food deserts, which lack accessible grocery stores, providing a full range of healthy and nutritious food. The residents diet comprise the unhealthy foods located within their neighborhoods, often leading to preventable social disparities, such as obesity, diabetes mellitus type two and heart disease. Food Insecurity has demonstrated a direct relationship with a social economic status. That he tried meeting him household annual income is approximately $31,000 compared to the national average of almost $69,000 The average annual car insurance costs in Detroit is around 284% greater than the national average and also other communities in Michigan.

This high cost prevents many residents of Detroit proper from purchasing an automobile to travel to a grocery store in an area with affordable healthy food. There is a dual relationship between food security and food literacy whereby inadequate food literacy may contribute to food insecurity. And being food insecure may limit the ability to use food literacy behaviors to achieve an adequate healthy diet. The American Public Health Association provides public health policy statements to help influence federal legislation to protect the welfare or residents of community or communities throughout our nation elevating the health status of the United States involves achieving health equity in all communities that we are addressing the social determinants of health and each locality. Thank you.

BILL NOVELLI
Thank you very much. Appreciate that you both touched on food insecurity. So that sounds like that's an indicator that you both feel is im

APRYL BROWN
Like organizations like the American Public Health Association that represents people of diverse backgrounds in network with the different communities throughout our nation different partnerships with they have been doing National Public Health Week and just bringing a really strong community a nationwide community partnership indicating the need for health and really what healthy. Yes. As I still have to say even right now. People don't realize what they're doing is contributing to the welfare of their community. You know, they might say like I'm in ministry. You don't realize how that faith community can contribute to health or someone is the different dynamics. I think we have to come from the top and educate on down the importance of partnership in order to elevate the health status of our of our country.

NICOLE MARTIN FRANKS
Briefly, I would just add to that, if we're going to address power structures it. I think it has to be done at multiple levels. From the individual level, how can you influence your individual span of control up into any organization and that you belong to and that could be your homeowners association your school PTA that could be defined on any level and then moving up to the community and getting involved in local government, which is where real change from a system standpoint starts and then on up to full policy and that's at the higher levels of whether that is larger organizations, whether that is a federal government. So I think if we're going to get to the point of starting with and addressing the power structure certainly to

leadership around the culture of organizations Research and Action. The business case of health equity and then really, you know, kind of thinking about this challenge as we go forward. And I think some of the things that we heard today specifically around leadership.

Or how important that leadership is from the top. And so the leadership of the organization really needs to be invested and as much as folks as important as health equity and addressing health disparities. You know, needs to be a ground up movement. If you don't have that engagement from the topic. It's very difficult to get it to go somewhere and that leader needs to define the vision. Put support behind it and communicate that to the organization. And that really needs to be guided by principled leadership we heard this again and again today.

That is not only you know principled leadership, but it is guided and influenced by the voices of the people that they serve both within their own organization. But also within the community that they are serving, especially when we're thinking about health care and that leadership really needs to be willing to invest funds time and talent into the initiative. It's not just say good things. We're going to do better. We are going to work on it. There are people and there are resources that need to be invested to really be successful.

When we are thinking about leadership, you know, and who was sitting in that seat and who who's making that those decisions really making sure that that leadership is diverse and you know, when you're thinking institutionally about who's in that cabinet Yang mentioned this quite a bit. How is that diversity reflected in the leadership for that. And, you know, being very intentional about putting people in those positions. And giving them time and space to do that, you know, often, people are pulled into diversity conversations or diversity and inclusion groups because of interest and passion.

But it's not their day job. It's not what they're getting paid for. It's not their primary responsibility and so how do you support that and encourage that and make sure that they are given, you know, not just time to do that, you know, and then have it reflect badly on what they are. Their, their main job is. And so as we're thinking about leadership and having diverse leadership, making sure that there is a pipeline and that institutions have a program for pipe lighting people into leadership, you know,

As we've had this explosion. You know, I look across my friends and all of their organizations are trying to snatch them up, you know, can you do this. Can you be on our diversity and inclusion group can you be are, you know, address health disparities and so folks are getting elevated, making sure that they have the training and resources to sit in those seats and then now that you have taken them out of whatever position. They were in. You are backfilling that with more diverse folks as well. And so creating that pipeline of leadership, not just in the health equity space, but in all spaces. It's no good for an organization to have all of its people of color and the diversity and inclusion office. You want them in the Medical Affairs Office, you want them in the finance office. You want them in the human resources office. And so really being intentional about that and Yeng gave some great examples of how her organization has done that and looked at that.

You know also thinking about the culture of the organization. In healthcare, we do this a lot. We, we look at the field that's in front of us and we say there are so many health care disparities out there. In my neighborhood in my community, and I am going to give resources to address those health care disparities that are out there. Not stepping back and thinking about the health care disparities that are within our own organization and how are we Intentionally and specifically looking at our own biases. Looking at our own cultural competencies, looking at how we may be contributing to systemic racism within our own organization and really being intentional about how we do that work.

You know, I think something that came up again and again, especially when you're in health care if you are trying to address health disparities externally and haven't done that work internally, then it comes across as disingenuous. That you are not practicing what you preach and you know the community and the people that you are working with they see that and they recognize that and they will be less likely to engage because they you know there's a disconnect there, that is that is palpable. And so being very intentional that when we see disparity outside of our organization and we are working to correct it that we

were also doing that own work within our organizations we heard this again and again that you know process improvements. You can't just have process improvements, right, you need to have comprehensive cultural transformation as well. And so if you have you know, set up a process, but you haven't done the culture that's going to reinforce that, then, that process is going to fall apart right we hear this all the time culture eats strategy for breakfast. So how are we creating a culture that is inclusive that recognizes bias that is anti racist and then those processes that we put in place to address those things which are going to be more successful.

You know, we have to create space to learn and be vulnerable. In this country It is not comfortable to talk about race. And I think those of us who are in the field have a higher level of comfort than the folks who are in our organizations and there's often times when people because they don't feel like they have the right word, or they don't know what to say or they don't want to be embarrassed or perceived as racist. So they choose to say nothing. And then they squirrel off and have side conversations and if you're not

YENG YANG
So, you know, I mean, I agree that I think we get this image of the angry black woman, the angry Asian woman, you know, and I think, in my experience, it has been that it's easy to be brave. When you are in a room full of allies. It's not as easy to be brave. When you're in a room of people who are ambivalent or downright hostile and I think it is very important to, you know, bring your courage with you and to go ahead and speak up. But the importance of bringing what you know white allies along is it's so crucial I think because we obviously people of color. We can't move this fall on our own, you know, there's not enough of us who are in leadership, who are in positions of influence. And so having our white allies is super important. So one lesson I learned along the way, is that, you know, sometimes because I am the person of color, who's sitting in the room. My white allies may have lost to say, but they feel like they should defer to me and they don't want to say something. And so I think having those conversations ahead of time, perhaps privately to give them permission. In fact, encourage them to speak up is really important because you know their perspective is just as valid and you know the other thing that I said to my white allies a lot, including my husband who's white and have taken a very long journey to understand the issue of equity and racism in this country is, you don't have to keep apologizing for being white. What I need you to do is start doing something, you know, start changing your behavior and start doing something because I think that a lot of way people think that just by saying, yeah, I understand how you're feeling I am that could be hard that that's enough that that's the end of their responsibility and it isn't you know we all have a responsibility to acknowledge to learn acknowledge learn more and then do something and take action.

JANAY QUEEN
Please, for sure. A couple of I think tactical things you need white affinity groups just you do. You've got to create those safe spaces and it sort of came up in Dr Yang's comments. To the point of there's, you know, valuing being collected politically correct over wrestling with doing the work. If someone said you got to be uncomfortable. I think it was Dr. Washington, you got to be uncomfortable. That is really, really critical. And I'll and I'll name this notion of bringing white folks along black people and other people of color been bringing white folks along for a very long time. And so the thing to know is the emotional labor. That is associated with that. How do we actually compensate for that. How do we acknowledge that and so that's sort of a side note that folks should just consider because we still have to do the work. Because if you want everyone to be better off than those who are struggling need to join in. And so the last thing that I would say is in the People's Institute undoing racism, they asked, they go around the room and they asked the black people. What, what do you love about being black or Hispanic, what do you love about being Hispanic and they say as white people. What do you love about being white. And so I asked that question to you, what do you love about being white. And so if you just sit with that for a little bit and you start thinking about it. Just like, what is it, is it safety is it that you can get in and out of places with ease. Is it, like, what is it that you love about being white and so start to just wrestle with that and then that is a great way to do the mental and somatic work. That is necessary to even engage and take the risk in relationship to explore and interrogate. Why are we where we are and what do we need to do to undo it. That's how you can get into those affinity groups and begin to build white allies ship.

SANDRA HERNANDEZ
Dr. Copeland, we've talked here about humility and cultural humility and you lead and work in an organization with a lot of physicians who largely don't represent the demographics that they serve. Any observations that you would add for how as a workforce that is not yet representative of the population they serve. How do we bring cultural humility to physician groups.

RONALD COPELAND
Well, I think part of it is the same principles that that Jenny just brought up about the journey for Li ship finding common ground and part of the Common Ground is one coming to grips with the reality that there is some homework that you have to do, and you are accountable responsible for it. So if, if you're willing to do that and take that on that. That's part of the learning journey, the adoption journey. There is the issue of in a case of a of a care delivery system and people working on teams and so on creating us having a culture in the city in an environment where people can have appropriate conversations that may or may not need expert facilitation to engage around action feelings accountability, but where I found common ground among my physician colleagues over the years has really been around the shared

orientation of wanting to improve people's lives and the humanitarian aspects of serving others and understanding when something is getting in the way of that, whether it be your own belief systems, your own behaviors. Or other factors that that has to be accounted for and there has to be an account or responsibility for addressing those issues as well. So if the, if you can find the narrative that common ground where people rediscover, if you will. That's the right framework there humanitarianism and that's a common sharing, then the issue is how do we prevent barriers self created or external barriers from preventing us from doing that important work when it's a journey together and it requires a lot of grace in the in the evolution of it.

SANDRA HERNANDEZ

Right, like we got to grow the pie. And I think too often we buy into a zero sum game where it's like you have more. So I have less when in fact lots of folks got a whole bunch of credit and so they got some time, the opportunity to sort of just, like, hang on, while we figured this out so that everyone can be better off. So some of it again is just in our approach force working with marginalized folks solving for them so that we all benefit.

NICOLE MARTIN FRANKS
I may. The only other quick comment that I would add to that is as a review. Data and we talked about on indicators is again looking at the intersection of how how these indicators play out with a number of our vulnerable populations, because that will also be a way that we know that any change that we're putting forth is positively impacting all.

RONALD COPELAND
Yes, yes. Got the other thing I would just add is that you know voices around the table. So when our affinity groups to make sure our employee and our patient communities have active access to tables decision tables influence tables where their voices can be heard. And then, as we've heard over and over again during today's discussion, the role and importance of data and just aggregating data. Well, a lot of the journey in that space started around issues of race and ethnicity, because of the predominance of disparities in that space. We've expanded that orientation to desegregate our data first for our workforce and now increasingly beyond race and ethnicity for our patients as relates to communities with varying abilities to gender, sexual orientation, military veterans, etc. Because you don't know what you don't know. And what we just say is you can't manage what you can't measure and you can't measure what you can't see. So you have to create opportunity to become aware and then once you are aware then the conversation starts about how to best address that and share responsibility and accountability for owning that as part of the definitions of quality definitions of equity and so on, again, has to be part of the cultural

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other is you know, really measuring about patient, you know, employee engagement and asking those questions about racism, I think, you know, that was shared earlier. I think Jenny had shared some of those some of similar metrics. The other metrics is really around attitudinal change post training. So before, before and after training of, you know, unconscious bias training that's one of our big focus for this year.

So those are the kind of the beginning metrics. In addition to just sort of diversity, you know, dashboard metrics that we're looking to increase our diversity. So I we hope that you know obviously we're just sort of at the beginning stages of that because our you know bias training for the organization and leaders, I would say that has not necessarily been measured as vigorously as I would have liked. So this is a much more intentional, you know, start of building our metrics dashboard.

RONALD COPELAND
Well, we at Kaiser Permanente where we are, are, and have been for a long time believers in utilizes oh various scorecards and different ways of leveraging data and displaying data. Either for trending purposes for information purposes, but probably most importantly for action orientation. To identify effective opportunities for intervention and then to carry out those interventions and then documenting what you learn from them. But my point around the role of them in the space we're talking about today is, don't, don't be satisfied with a particular model or approach to a scorecard. That is that someone else may have created for in the context of the work they do or from some consulting organization, etc. They are good places to start. But what we found more selfless customization. And then standardization around the things that are really relevant important and then I would emphasize the importance of benchmarking. So you're not working in a vacuum and you're putting your information and results out for public display for others to evaluate and look at and comment on as well and all a we use it in all those different ways where our Process Improvement work and quality and regulatory requirements and so on and the efficiency of trying to do that, you know, large decentralized system is that was one of the drivers and reasons why we integrated our equity work into our quality improvement work. Has to be as relatively seamless as possible. So the analytics support the resources you need to provide those levels of information actual more information at the Governance level at the senior leadership level at the front line level and so forth that you can do it in an efficient way and effective way and sustain it.

Sandra Hernandez
Okay, so let me do this, then maybe just to summarize What we heard today is we before we give this over to Michael though, I would ask all of our meeting participants to do as our pan0 Tmshat uan0 g(p)e(an0 .ults o)ed,en to

Davis's reference to a cultural humility and in many ways that the dominant takeaways for me are humility