

CULTURE AND INCLUSIVENESS ACTION COLLABORATIVE SUMMER WEBINAR – Unperfected Transcript

July 8, 2020

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MICHAEL MCGINNIS

I'd like to welcome you all to the meeting of culture and inclusiveness action collaborative. The collaborative is a key part of the National Academy medicines effort to foster health transformation health system transformation that leads us to a health system which is more efficient, more effective, more equitable and continuously learning the leadership Consortium has been operating for the last several years, focused and work in four domains.

The digital domain. The evidence development domain. The financing domain and the culture and inclusive domain and the important thing to underscore is that the collaborative is that represent our work and carry forward our work. And each of those domains are dependent upon the work in the culture and inclusiveness domain for their success.

We are, as a society, in a fashion that has been brought home pointedly, and in some respects painfully in the recent period dependent upon our success in effecting a national focus and national accomplishment of efforts to reduce health inequities.

The Achilles heel of our great society is the pervasive presence of an inequities in a society which is the most wealthy society in the history of the world. So our working culture and inclusiveness is fundamentally aimed at ensuring both the we are aware of the challenges before us and that we are positioned in a fashion to foster the changes that are necessary if we're going to ensure that the kind of progress that's possible for us as Americans is possible for every aspect of our society. So I want to thank again, each of you. I know that you've tuned into this conversation because you are sure you are leading in fundamental ways of the progress in your own in your own settings. And I want to thank you for that work that you have in play in your in your daily lives and in your communities.

I also want to thank our co leads. I have the privilege of my colleagues in the National Academy of Medicine. I have the privilege of working with three wonderful co chairs of this collaborative: Mary Naylor, Sandra Hernandez, and Bill Novelli. I want to offer a special welcome to Sandra Hernandez, as the President of the California Healthcare Foundation Center has long been involved in our work and as recently agreed to serve as chair of this collaborative along with Bill and Mary and so thank you very much. Sandra for joining us in this respect, and for the leadership that you provide for all of us, and the many activities to have led for for so long. We've got a very exciting agenda in store for us today. I won't go through it because I think I'll defer to our co chairs to do that. But I do want to emphasize how excited we

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 we have underway. That again is touched on quite directly by the work of this collaborative I mentioned the four domains.

What I didn't mention is that our leadership Consortium, the National Academy of Medicine leadership consortium is made up of leaders from nine different sectors of health and health care and those sectors range from the patient family and community sector, all the way through the health product manufacturing innovator sectors of the health care sector and on to the quality, safety and standards sector. With the other contributors that you might imagine. I won't go through all of them. But the point is that with that range of participation and leadership available to the National Academy of Medicine, we are taking advantage of our long standing relationship with the sector leaders to sponsor a series of sector assessments. So we have senior representatives from all nine sectors, who are working together to look at each of the individual sectors to assess the extent to which the COVID-19 pandemic has underscored again in painful ways. Often the fragilities in our system as a whole. The sharp relief of our systemic frailties has been clearly present and prominent in so many of the of the videos for that matter, and not to mention the reports of the challenges that we as a society have had in dealing with from the fact that the African American population has suffered four times the infection rates and the death rates as the rest of the population from the fact that previously successful and stable healthcare institutions have now found themselves on the one hand, burdened with overflowing emergency rooms and, on the other hand, empty wards because of the limitations on elective care and the economic challenges that go on with those circumstances to the fact that we've seen our ability to marshal the public health response that we need limited because not only because of the frayed nature of our public health infrastructure over the last few years, but also the result of lack of collaboration between agencies and organizations that have to collaborate in order to respond effectively to the fact that the economic consequences of the of the pandemic have hit most painfully on our most vulnerable population. So we have a great deal to learn from the lessons of COVID-19 for our health system and we will by February by fall have a pretty good sense, at least at that point in time of the kinds of broad systemic changes that are necessary in order to avoid these problems in the future, but more importantly in order to move our whole nation to a transformed health and health care system that is bringing to the population care that is effective, efficient equitable and continuously improving so we're looking forward to working with all of you on those counts as well and mean today of the culture and inclusiveness action collaborative is going to be an important start for us all on this journey to a dramatically improved health system. So again, thanks to every one of our participants. Special thanks to Dr. Mary Naylor who is the director of the new Cortland center for transitions and health of the University of Pennsylvania School of Nursing and co Chair of the collaborative. Dr. Sandra Hernandez, who I mentioned is president and CEO of the California Healthcare Foundation and CO Chair of the collaborative and Bill Novelli who's professor at the McDonough School of Business at Georgetown University co Chair of the coalition to transform advanced care see tech and also past CEO of the AARP, so thanks to each of you and Mary. Let me turn the floor over to you and your colleagues.

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 the more than 1100 people at least as a few hours ago who have joined us in the first public webinar sponsored by the culture and inclusiveness action collaborative. As reflected in our name and reinforced by Michael this collaborative is designed to promote a culture that prioritizes access to and delivery of equitable health care for individuals, for families and communities. At no time in our history has an intentional focus on equity and all of its inextricably linked dimensions, health, social and ethical been so critical. The collaborative seeks to advance an environment where policies and practices promote engagement of people in decisions about their health and ultimately positions all to have a fair and just opportunity to be healthy. We do so by engaging a broad range of key stakeholders. Some of them, you'll hear from today who have a deep understanding of the challenges contributing to inequities.

And as a collaborative committed to action work in small groups and as a collective to advanced evidence based solutions, a paper set to be released this Monday upcoming Monday, July 13, patient and Family engaged care and essential element of health equity is just one example of the outcomes of this collaborative and a link to this paper will be shared with all attendees when we least. So let me share with you now a brief overview of today's important session, we will begin the session hearing from leaders and patient engagement, exploring opportunities and challenges to equitable meaningful engagement of patients and families in care settings throughout the pandemic.

In the next session will focus on specific strategies to address health equity at system and policy levels. The speakers through our are sharing their experiences drawn from their work from health systems, state and federal policy making and funding organizations. Or they'll be conversations following their brief presentation that will also reflect on the short and long term opportunities to leverage the unique position of the leadership consortium National Academy of Medicine more broadly to scale and spread these approaches to systematically advanced health equity.

So now let me turn this session over to Bill, who's going to walk us through some logistics.

BILL NOVELLI

Welcome, everybody. I'm glad you're with us today. Thank you, Mary, Michael, I want to thank you for your leadership and now we're going to go over a series of presentations and we're going to have the opportunity for some discussion during each session so speakers. We ask that you turn your video on when you're speaking and please keep yourself muted when you're not talking. We're going to start by calling on a few people. And if time permits, we're going to answer some questions submitted by the webinar participants, if you're watching Please type your questions into the Q & A function located at to controls at the bottom of your screen on the zoom platform and please include your name, your organization. And if

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 told when you have one minute remaining and also when your time is up.

KNITASHA WASHINGTON

Thank you so much, Bill, Mary for the opportunity to speak on today, if we can advance the slide a little bit. I've been professionally trained, educated as a healthcare professional work in more than 20 years primarily as a consultant transforming healthcare and there has not been a time more critical in my career that I've seen where our need to transform healthcare is really predicated upon a couple of major drivers and that's both equity and engagement. If you can advance the slide please.

So the lens in which we see our healthcare system and that lens in which we bring our ideas innovation etc. to transform the system is really through the lens in which we see the system.

That is so critically important. And I say that because the lens in which I see our health system is the lens in losing my father to a preventable medical error, but being told that he had died of a heart attack. So I don't know if even, you know, if, here we are, you know, 11 years later, if the issue for me really is trust in the healthcare system or the lack thereof, and I'm talking a little bit about that. Moving forward, or is it truly the pervasiveness of medical errors advance the slide please.

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 fact that we have not made much progress at all. And to some degree it even prompted you know, me being emotionally sunken, to some degree, because I'm looking at the issue of a community in which I represent. And so here we are dealing with COVID-19 and then there is the issue or the death of George Floyd in his killing. And again, to be quite frank with you. You know, I clearly understand you know the voices in where we've been moving politically, but to be quite honest with you.

It's not the it's the pandemic that I've been living my entire life depends image that I've been living as a healthcare professional in an attempt to assert the fact that health equity has to be an important in our work that we do to transform our healthcare system and to improve quality.

So I you know I bring up the point of the six aims of healthcare merely to call out the fact that the equitable piece has been the least of those that we focused on. It has been noted as a priority decades. But yet we have continue to lack in asserting moving a meaningful and a real agenda as it relates to that one of the primary pieces of work that I have done over the years is to really integrate this concept of Health Equity into the work that we do in person and family engagement. And for me, which was, you know, very, it was very simple to conclude one patient isn't all patients.

And so how do we create frameworks or how do we create an engagement strategies when we create agendas that are very vanilla and that do not really bring into context, the beauty in all of the diversity that's represented in the patients in which we serve. I can go back to the case of my father and just pain management. And you can do the research for yourself. When you think about pain management and how pain management is even dealt with at the bedside, in particular with black patients in comparison to their white counterparts and I'm, you know, when I recall my father's case. Then I think about how does a very vanilla and bland approach to patient engagement. How does that now address my uncle. How does that address my neighbor. How does that really engage all patient. And so I think what we have to do is make certain that we get away from the notion that we can treat all patients to Spain.

And that, in order to activate patients the same amount of energy and the same amount of resources can go into activating every patient and bring the result in which we want to see because the truth of the matter is, is that ethical means that we are pushing to ensure that all patients that all patients can get to their most their most improved outcome for themselves advanced the cycling. And so that's exactly what we see here when it comes to the definition that CMS put on the table around patient person family engagement.

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 not 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 inequity 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 cover 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 restriction of family presence without supporting the mental health needs for staff conditions patients and families and even leaders.

Making these change had long term consequences. So we wanted to see some change and we helped show people what partnerships could look like, questions to consider in the webinar and they informal conversations, which we couldn't possibly answer in that short period of time probably like your webinar today. So we published frequently asked questions to respond to the field and give them the language of how they can partner with the diverse patients and families they serve in implementing and bringing about change in policies related to the COVID-19 pandemic.

We were also very eager to track what was actually in change in family President's policies in all clinical areas in maternity and pediatrics and adult I see us in ambulatory care all across a

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

support from the Lucile Packard chocolate foundation for children's health to do a national study on the effects in children's hospitals and in a series of interviews we learned from Seattle children's that the first month that held up perfect virtual meeting the emergency operation center met with the perfect and the lead founded so valuable that she came, he has come. Each month since that time. So this is frontline for planning for COVID-19, having a regular interaction with the patient and family advisors in South Carolina. They just moved into the new Children's Hospital in February in 2020 and the administrator of the USC children's health and the chief medical officer as to facilitate bi weekly unstructured offered at office hours with patient and family advisors didn't want an agenda. Just wanted to have an opportunity to address issues that emerged just in time and very successful again that shows commitment of leadership.

So, in the very beginning we reached out to a colleague, Sonia Ballantine who is a patient research leader at the Chicago health disparity center. We've worked with and learn from Sonia about how to build partnerships with very diverse community. She's worked and train 100 African American patient leaders with serious mental illness to engage in research, but she knew in the covert pandemic that there were real digital divide issues they had limited minutes on their phones, they any more had lost jobs they needed to have access to their payment on a very regular basis and she knew then we needed to use plain language. how we communicated the public health messages of COVID-19 planning. So she was an important person in shaping the work we were doing.

So again, I think leadership is so important for us to build a workforce that understands that COVID-19 may not be the most important thing in people's lives that for vulnerable populations and we learn this, and I work with HIV and AIDS. That immigration status or lack of access to food or housing or culture, language barriers are living with substance use disorder all can be major barriers to access to health care and participating effectively. So we need to build a workforce and we need leadership to understand this and to welcome these partnerships to build a knowledgeable committed workforce.

And some of the gaps. I think I hope we'll discuss further in the conversation is one of the communities most affected by COVID-19 with the long term care communities and they lack again back to committed leadership committed knowledgeable leadership of how to build and support effective partnerships with residents patients and families and also how to build an infrastructure in long term care communities in nursing homes assisted living for these kind of safety and quality partnerships.

And so really to build on and recognize that we do need greater diversity among our patient and family advisors and leaders. We've worked with a wonderful young doctoral student and helped develop recruiting tools that would ensure that the diverse individuals and families were recruited to this partnership work and I do see some encouraging it may sound strange we are signed up of attendance rates. There is more vigorous conversations that people from the diverse populations that often didn't have time to travel to a meeting on site in the hospital are now able to participate and participate in a robust way.

There's open, but we have to be intentional in the work we do. Thank you very much and I turn it back to you, Bill.

BILL NOVELLI

Thank you very much. Thank you both. Okay, now we're going to have invited participants make some brief remarks, some reflections on the speakers presentations. And these will be comments from a sec sector wide perspective, but also from their own experiences. So each of these reactors is going to speak for just two to three minutes and the first person speaking is Dr. Kathy Blake of the American Medical Association.

KATHY BLAKE

Thank you so much. And thank you also to our speakers and having read the materials and advanced but now hearing both of the presenters on there's much to be learned and match to be stimulus for conversation. So some of the things that I heard one is the importance of patient centeredness now more than ever. We've spent a long time working on this trying to advance it, but I think that if there is any silver lining to be found in that with the deprivation that patients have experienced of being away from their families, we now focus on that more than ever. The second thing that I heard and have replayed in my mind over and over again is the importance of humility and I heard Knitasha, say this is the pandemic that I have been living my entire life. And I think that we have to. Therefore, and it's true for the American Medical Association. It's true for many, many parts of America acknowledge our past not be paralyzed by our past, but to then say, what is it that we will commit to doing going forward. And I can't help but mention the Center for Health Equity established about a year ago at the AMA led by Dr Elisa Maybank and we are now in our organization applying the lens to everything that we do in terms of diversity, equity, and inclusion and recognizing that within organizations, you first have to understand yourself to then understand your gaps to then be able to start to advance and move forward.

I think we also, in addition to be humble to having humility about our past I think we also have to have humility about what it is that we know and don't know and as a physician, I will tell you that I know a lot about cardiovascular medicine. That's what I am trained to do however, for the person in front of me who I may be meeting for the first time, I don't know them as well as they know themselves. And I need to be humble about the fact that they or their family member speaking on their behalf, will be able to share that information with me as long as they think that I will listen and act accordingly. So it is not just knowing what you know it's knowing what you don't know.

The other thing that I was encouraged about is this conversation that is beginning within the profession, but also across health care about how challenging it can be to navigate these times, and that none of us should expect to do it alone. And I reminded of the comment that a system that depends constantly on heroes is destined to fail. And so if you start with that premise.

You then have to say in these challenging times, it really does take all of us that if we depend upon a system of heroes when it is a marathon, not a sprint that we will not reach our desired

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 of the disparities that we had in America back in the 1930s and the need for a rural electrification project and I would posit that this pandemic in addition to uncovering lots of disparities has also shown that we have a major disparity in terms of access to broadband. And that if we're going to reach a more equitable and inclusive health care system and society that we need to be investing in maybe what doesn't seem like healthcare infrastructure, but it really is and that everyone should have access to care, where they want it when they want it using the method of their choice. So thank you very much and I look forward to the ongoing discussion.

BILL NOVELLI

Thank you very much. The next is Stephen, who is with PFCC partners.

STEPHEN HOY

Yeah. Thanks, Bill. Bev and Dr. Dr. Washington, great to hear from you guys and terrific. As always, I couldn't agree more with Knitasha first comments about being intentional about this. I think we used to look at, or about just the handful, years ago, we look at P stack efforts and say, talk a bit about what Bev just demonstrated looking at data about the communities in which those engagement structures are intended to represent and more and more recently, I'm thinking I are believing that agenda a race neutral response may not be enough where we and we need to do even more intentional about tackling some of the inequity dilemmas in the health system that are so intertwined with education and other domains.

And in doing that, I, I've kind of now seen a real use for data and information and data transparency, you know, although race, age and demographic information and data, you know, maybe limited now is people are even less inclined to share you know, we it does have a powerful I think impact on highlight in those inequities. So to start efforts, driven by data that is transparent. I think would really mobilize some of that and even bring some of that information to those engagements structures we have in place.

I shared a lot of the concerns when the pandemic first arose. In that power taking all these steps backwards and patient family centered care and Shared. Shared Bev fear that All this great work we've been doing for a while. Have you know, been stalled by this somewhat militarized response to a novel virus and I can't help but think I haven't been around long all process with that but it seems as though these those plans were drawn up a little predated to our new understanding about engagement and i want i really want to hear from you than others in the group, how we might use this moment in time where we're starting to reflect on. Hey, how did we do, how did those plans go and weave in patient family engagement and community engagement to really learn how we tackle, not just the virus, but those competing priorities that live in people that are a part of people's lives and you know, can we in this moment when we're starting to look back and say, you know, how are those plans, what would we do better next time. How do we use and mobilize patient family engagement to, you know, improve those plans for the future.

STACY PALMER

Thank you, thank you so much for the opportunity to share reaction.

I'll start with Dr. Washington, I just want to say that I love and truly appreciate the passion that you clearly have for this and for your efforts to drive improvements. I think I'm especially inspired by your work of integrating health equity into the conversation on patient and family centered care. I think that is so, so important. And as you mentioned, how do we create strategies that acknowledge the beauty of diversity in those we serve and get away from that notion that we can treat all patients the same. You also address the lack of speed to respond to needs in our current healthcare climate. And I think that that's been one of the biggest AHA was from our community at the barrel Institute during that the current code and crisis. It's been the ability of their organizations to move swiftly they've been able to see policies updated they've been able to implement Tele health in a matter of days or weeks. And other services that had been on the drawing board for years, all of a sudden, we were able to make things happen. And so one challenge, I believe, is how do we keep that momentum going, and be able to address the important things with that type of speed.

And I always love hearing from my friend Bev and I love the work of IPFCC. I want to reiterate her comment about our need to hear from the communities that we serve. I think that's more important now than ever that we're enlisting patient and family advisors and we're finding from our community that they're finding more and more ways to do that virtually to do it in a safe way. But still, requesting and asking for that feedback.

And of course the visitation concerns have been huge for our patient experience community. It's a group that's been really long advocating for care of her and her presence. So how do we balance that with the unique needs within our organizations during this pandemic so bad. I just applaud you and your team for exploring best practices and sharing these stories so that others can learn and I couldn't agree more on the needs and opportunities to better support long term care and look forward to seeing more efforts in that area. Thank you for the opportunity.

TAMARA CADET

Hi there. How are you, thank you all for this opportunity. Thank you both to the presenters.

This stuff is sort of near and dear to my heart. Just a couple of points I wanted to make and reaction on I agree with sort of both panelists, this is nothing new. It's not a surprise, where we are. In yet. I'm still struck by the fact that it requires work, it requires a lot of work. It's not going to be easy. But I do think that we're in a position where we can step up in some ways I guess I've been thinking about all the change that's been happening.

As a result of George Floyd and all these other things. Can we take that energy. Can we take the data that we know and can we build sort of our protest in some ways to begin to think about engaging patients and families in a better way. I think that, you know, when we think about engagement strategies I think everything that we've heard has been so fabulous. I want

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 from them about how to engage in a way that we do and I'm doing some of that work in some of the research that I do.

And then, and then finally I think just sort of as we're doing this. Someone mentioned this idea of plain language and really recognizing that we all talk with these professional lenses. And that literacy is huge. It's huge amongst the entire population and there's certainly there are risk factors related to age and race and socio economic status. But I do think that, you know, some of the most recent research says that, you know, much, much of the US population in particular, you know, we're all at adequate health literacy levels. We're not all proficient. We're all at adequate in some way, shape, or form. And so really being conscious of that is we are starting to sort of develop these strategies, but all in all, how do we take those folks that we care so much about in truly engage them about what it means to have an engagement strategy because if we can get them on board.

Then they're going to talk to their neighbors and they're going to talk to their other community members about what works and be able to help us so that it truly is happening in a collaborative way versus us telling them or US inviting them. How about they invite us. So those are my quick thoughts. Thanks so much.

LAURA BUCKLEY

Hi, everyone. Thank you for having me. I for and I really agree very much so with the last reactor to as I was taking down notes that health literacy is also very much a part of this health equity conversation.

But really reflecting on Dr. Washington's comments and thank you so much for them. I really hear and appreciate your comments around our structural inequities in our healthcare system. And particularly, particularly in leadership and how often those folks are the people who help decide what patient engagement looks like.

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 or 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 needed to advance and spread system and policy level health equity strategies. The panelists have been asked to consider well known flaws, at least well known by scientists health system leaders clinicians in health and social systems which coven 19 has, as Mike McKenna said painfully brought to the public's attention as exemplified by front page story this past Sunday and the New York Times panelists have also been asked to reflect on wholesale change, not just tweaks around the margins that will be required, both in the short and longer term to address as Natasha described intentional and authentic system transformation.

So now it is my pleasure to introduce our panelists. First we'll hear from Dr. Consuela Wilkins,

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.

CONSUELO H. WILKINS

Thank you so much. Mary for the opportunity today. And thanks to Michael and Bill and others. It's my pleasure to share a little bit today about our approach to health equity at Vanderbilt and really thinking about the questions that were being asked is important because our approach here is to think about health equity at a systems level. So I'll start with my first slide, I believe it's just a title slide there.

Really though the, the goal is to make sure that we have health equity at the leadership level across the medical center. So I'll share a little bit about that on. So our Office of Health Equity at Vanderbilt was created at the beginning of when we after several years began to try and try and identify the best next steps for we have lots of opportunities to build on work in research and community engagement. As well as expand our, our focus in education and eventually decided that we wanted to take a different approach and have a more centralized structure that will that's the purpose. The intent was actually to to foster and catalyze health equity work across the enterprise.

So our community health needs assessment is a part of our Office of Health Equity and I think that's really important as we think about what priorities were responding to and how we actually organize, organize, organize, as an institution, and then we have work that's really falling into those traditional academic missions of clinical enterprise research and education. And so we have work that's spanning all of those areas, but it really important for me and take a leadership role in this office was to make sure that there was an institutional and leadership buy in. And so having actual metrics that are tied to incentives and at the leadership level.

As part of what's also baked into our, our office. I do want to make the distinction between health equity and diversity, equity, and inclusion. So we have a really robust Office of Diversity

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 them about you know how to Don and off their PPE what to do with their clothes when they got home took into account that not everyone had a garage that they pulled into and could take off their clothes and put them in a bag or had a washing machine at home so they could

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 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 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 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 race based GSR so the estimation of Romero rotation rate. So we're really excited about leveraging this systems wide approach and looking to learn from others.

MARY NAYLOR

Thank you Consuela for sharing what is amazing work going on at the Center for Health Equity at Vanderbilt. Now, let me turn to Tekisha for her presentation.

TEKISHA EVERETTE

Thank you so much, and good afternoon. We know that I'm here to talk about system and policy level strategies and I'm going to start off with a bit of storytelling, which is the way I try to address and talk to people about these very difficult and challenging issues. So I work in a nonprofit called health equity solutions and our vision and mission is right in our name.

Our daily activities are centered around advancing health equity, but specifically at the policy and system level. So our work is centered on promoting policies, programs and practices that will result in equitable health care access delivery and health outcomes for all people in Connecticut. And in doing that, we are unapologetically Race Forward, which means we focus very much on individuals who are considered people of color, which for us is inclusive of our Arab American Muslim American in Northern African individuals who are often considered or who are by definition considered by the CDC is white.

The reason I want to stop spending a little bit more time on this slide before I go on, is to highlight very quickly for everyone that this. Years ago I would come into this conversation introducing myself as an individual who is focused on health policy and has built a career there and chosen the lens of race. What I realized in the five years that I've been running this

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 equity or think of the social simply as solving or resolving SDI wage is that we're missing that by design. The healthcare system fosters and equity if we start historically and look at the evolution of the healthcare system how we've provided medicine for certain populations over others. The evolution of hospitals and clinics in our society, the fundamental premise is that it's all built on an equity.

So what you're going to hear from me is a consistent theme. That we have to and must, if we want to build equity confront structural racism and I'll talk a little bit about that in a moment. But I'm just gonna say that again. If we really want to get to the point of equity, we must confront and dismantle structural racism. So while our current focus when we talk about health equity has been around the social determinants help determinants of health as a way to link to better health care outcomes. It's totally fine. And I agree with that. But it's only one side of the equation. We have to do, or we need to really be in tune and having conversations that are centered on understanding the historical disadvantages that have existed in our healthcare system. The historical disadvantages around the power imbalance that happens in our healthcare system.

You have to really understand where these gaps have what the gaps are in terms of seeing and understanding the disparities, but really beyond that understanding the roots of them, and where they came from. So I'm going to go to the next slide. To do this, I'm going to go through a key. A few things very quickly and recognizing time because I will for one really appreciate when there is a question and answer period in a webinar. So I'm really going to talk

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 in order 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 deliver care and change our medical foundations in our society in a way that we've never seen before. So I'm going to pause for a second and say that again that we've never seen before.

None of us on this call have ever seen a state of equity. We've never seen a country or a place that does not exist or have within it, some bias related to race. We don't know what that looks like in the US. It's always been our foundation. So what we're fundamentally saying is, in order to create and dismantle racism and create health equity. We have to be acting towards a world we've never seen before. But that shouldn't scare us because we can definitely use things like health disparity gaps decreasing. We can use things like looking at our internal institutional policies, as well as our legislative and administrative state policies, how they have changed and what the impact are going to really understand if we are moving towards that world. We're hoping to see one of the activities that we are actively engaged in right now and Connecticut is getting every city in town in Connecticut to declare racism, a public health crisis or emergency that will mean something different at every particular at any level, but it's acknowledging the fundamental impact that racism is having on our public health structure.

In not acknowledging have a fundamental impact that racism is having on the individuals for whom public health is designed to serve. The next part to this is to ensure that even within the way that we are looking at reforming our health system. The research that we provide even in the convenience, we are having like today. It's making a point to pause and intentionally say we acknowledge that structural racism impacts everything we do. The moment of just making that statement changes the fundamental function of what we are next doing it. Knowledge is the power and difference. It acknowledges the problem and it forces us to really do something and action to it. I know what I'm saying right now is a really big concept and I'm spending a lot of time on this one because it is the most important one.

It is something that we created in our country and our society in our world and it is something we have the power to dismantle when I say we, I mean we as humans. I don't mean us on this call, or this new together, but we as humans created this construct. We can dismantle it. Next slide.

So now, what does it mean to say that it is important to look at disparities as an indicator of whether we are advancing towards health equity and whether we are in fact dismantling racism. It's really saying we do need data. Data is important and critical. We have to be looking at data in a way that clearly shows us who and where we have the problem. If we haven't, if you haven't ever heard of the idea of Targeted universalism. I encourage you to read about today universalism and read the work of John Powell, because this point about letting the data lead you to solutions that focus really squarely on the people who need or most disadvantaged in the process of whatever you're doing is really critical here.

What I'm going to point out on this slide is the image on the right. I think everybody may understand the concept of Graham Cooke collecting that data or the need to utilize the data and put into action. I think Dr Consuelo Wilkins made that very clear on her presentations. I'm just going to focus on these and this image on the right, because it should astonish everyone who's on this call and he sees this and who will also watch this later. The king part of this shows that when COVID-19 first started, and we started to release data. Everyone started to really make the do these maps. And this is from Johns Hopkins do these maps and start looking at who and how his data along racial and ethnic lines being collected

This top images shows you that there are only four states as a six days ago, only four states who are reporting out testing by race and ethnicity. So what that means is we have no real idea who and how the gaps and testing are showing up, except for in four states around the lines and racial and ethnic populations. We don't have, we have no clue. Unless you live in Nevada, Kansas, Nevada, Kansas, Illinois or Delaware. I think can't even see which one that fourth one is. It could be DC, but I can't tell.

And when we look at the death data we have way more information around the fact that there is more data is being collected on a race and ethnicity level across the States when it comes to death. So this is a huge gap that we should be looking at here and noticing. We can tell you who's died by racial and ethnic lines, but we can't really tell you our testing strategy and how that's working on racial and ethnic lines. So this is a really key relational thing here about this whole point is better data collecting it understanding it, and utilizing it to impact how we next act is really, really, really, really critical.

This is what can lead to the real change and how we act on what we do to help dismantle racism and to encourage health equity. Now the one point I want to make on a solidly is this is the one place where I'm going to pause for a second to call out. Principles around health equity and how this could have really been avoided this point about engaging and strengthening community capacity.

If anyone had engaged the community about asking what was necessary or needed pieces of information. This would have been one of the first things they would have highlighted, we need to understand race, gender, location, zip code. All of these things we need to be analyzing how we're doing our testing structures and how we're instituting in our testing across there that would have been something someone said, but this goes back to also having that equity person in place, who has that lens. Next slide.

The fourth part that I'm going to highlight in terms of a policy change are things that can happen that are really important around how into advanced health equity is this notion of fostering access. I'm only going to choose two things here to talk about. There are so many more that could have brought up, but I could have spent an entire time. I would like to highlight, I could spend an entire time that we have together on any one of these particular slot.

And particularly an entire day on dismantling racism timesteps health equity, but I digress fostering access to the two things I want to highlight here. That are critically important is that we need to do a better job of really engaging and building trust in communities to understanding the importance of clinical trials. And I am a person who has asthma and have had asthma for very long time. And there's a lot of research that has been done. That explains and shows that addressing asthma for black and for black and Latino kids, particularly is not though the medication that you use for the dominant population or the majority population doesn't always work or translate into for two populations of color.

So we all know that this is very important. But what does it mean to foster access to clinical trials. This is where it's much more important to focus on. And I think it was Dr. Washington who made this point, focusing on trust and building trust and the importance of that. In the context of being able to get individuals to wanting to be and understanding the need to be engaged involved in kind of clinical trials. This is where we cannot ignore the fundamental history. And the importance of history in the context of how racism has really driven people away from being interested in participating in clinical trials. The other side of this is we also need to increase access to medical services and COVID-19 has really highlighted the importance of increasing and making sure that we have The health insurance that is necessary for people. So I'm going to move on because I am getting the know I am noticing that I am really close to time so we can advance To science, please. And we'll go to the end. And I'll just say the following to wrap up.

One of the things that's important is if you look at what I've offered today. There's always an opportunity for you to align the work you do on a daily basis to what your goals are already as it relates to health equity, but if you don't have goals and this is the important part of why I added this on this. If you do not have goals around health equity that are specific and achievable and measurable. We can never achieve health equity and we can never really pair that work around understanding how we're achieving health equity in the process of dismantling racism, so I will you back the time or I don't have time to yield. I will turn back the conversation to Mary thank you and I look forward to the Q & A.

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

where we are. We're not going to undo things today. Or even next year and that it needs to be a sustained priority for us to really achieve equity and close those gaps.

So that would be one of the first thing is really to elevate back and in one of the things that I will just say that each of these elements that are going to reflect on Ethan find in the last GH bulletin letter that I wrote. On our GIS website which is G h.org and go through and talk about some of these tactical steps that we can take to really achieve health equity. And again, making equity a priority. Looking at our budgets, how does our equity works compared to other priority areas that we focus on Is this something that is significant risk or is it something that is comparable.

Who do the individuals that are leading the work report to within those organizations in the communities, again, is it on par with those of other areas or not. And when we have financially difficult times. What happens to our equity initiatives are they, some of the personas that we lose or the ones that we are able to sustain and focus on given the importance of them. I think if we look at these questions and sort of, if you see that there are discrepancies in the work that you're doing.

Making me to adjust to really ensure that equity as a priority. And if it's not, that is something also to have an honest conversation about the think about, is it something that can be looked it up and embedded in the rest of the work. The other roles and particularly as we're focusing on work at the leadership consortium is to strengthen the role of leadership. Leadership is so important, across all sectors in subtle and over wave leadership really does signal what's important. It can be things that are Polluted in conversation, both in public spaces as well as in private close to our communities and conversation. Things that are on our performance dashboard. What are we looking at and following as well as what are we investing our professional and financial capital in All of those things are important in terms of a leadership role in to signal how health equity could be something that can be sustained. And we need more leaders to think engaged in this space or to sustain that attention in this area.

Oftentimes when we look at what leadership does a sort of establish a program or set up an office and then maybe turn their attention to something else because they're getting pulled in any direction. But I think that we need that continued and sustain focus from leadership to help gather support for those who are working at other levels across organizations and communities to really emphasize the importance of to help drive change.

The third thing, and it goes back to our first session, the panel that we had on patient Person and family engagement is to really think about how we are engaging and approaching community and to make sure that we're doing that through humble inquiry. Working with communities can help to both identify what are the areas that we should be focusing on and not necessarily doing it from a top down approach. What are the areas where we can improve interactive working relationship building bridges, as well as fostering collaboration.

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.

Because even within the states we see a myriad of ways in which data on race and ethnicity is being captured. Whether or not, for example, is being captured in the owner of the Office of Management Budget data standards to have separation of systemic and race, ethnicity, Thinking about other factors such as language or the social determinants of health, which we've talked about, but really making sure that we have that ability to collect, Analyze and report out on the findings that we have to be able to track disparity. We can't have it on a dashboard. If we're not collecting it. And so I think that's one of the things that we really need to focus on the first thing is really tackling the tougher issues. Often when we develop strategic plan we focus on the low hanging fruit because it's something we can accomplish in six months, nine months or a year.

But again, the disparities and inequities that we see in our system have taken years and centuries to build and they're not things that we're going to cure and six or nine months. So we see look at the foundations. If we really want to improve health disparities and achieve health equity. We have to tackle those systemic issues, things that Are other speakers have talked about in terms of structural systemic racism. But also looking at how we have an equity in our coverage for example our health care system is largely built on a foundation of an equity, where we have differences in coverage. Based on income age military service or lack thereof, whether you're not you're a member of a federally recognized tribes, all of those have different access. Coverage in terms of what's provided payment rates to providers, creating incentives and disincentives for access and quality outcomes. And so, tackling some of those tougher issues of how we do that. We've also talked about the social determinants of health. And one of the things that I would note is that I'm you know this in situation that we've talked about in terms of the pandemic and all of the other social justice issues. Have really thought to before for the role of race and racism in our health and health care system in our society.

And what we had seen over the past few years as social determinants of health had become something that was much more recognized in the clinical world. And I say the clinical world because social sociologists medical anthropologist and others have talked about the social determinants of health for decades. And the World Health Organization kind of commission on social determinants of health, going back to 2002. But as we have seen much more conversation focus on the social determinants of health. We've seen a crowding out of race and health and racism. And fewer folks who are looking at this with the thinking that if we address income inequality, then we don't necessarily want to focus so much on race. And I would encourage us to continue to keep that because even as we address social determinants of health and look at Outcomes adjusted by the social determinants of health. We still see racial and ethnic disparities, they tend to shrink, but they do not necessarily disappear. And so it is important as we move forward to continue that focus and to keep that lens and to continue looking at our disparities. And the other piece that I would just say in terms of tackling those tough issues if it requires us to get outside of our comfort zone. To have some of those difficult conversations to shine an internal light on where we may be. Not necessarily

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 school and even before that, to some extent, to make sure that we have a pool of applicants. Getting into college graduating from college who can go on to be able to serve as doctors, lawyers, teachers, community leaders advocates and help policy. You know, reflecting even within the leadership consortium where there's an increase in diversity so that we're not ask them one or two people to serve in 2030 different roles, because we don't have a robust pool to choose from. Increasing the diversity at multiple tables increases the likelihood that we are able to have more policies and programs that are equitable And systems that are put in place that can bring up those issues and tackle those and understand them. So I would encourage us to really think about how we are focusing on that pipeline. Across our health and health care system to reflect the number of positions that public health government leadership and other spaces. To really address health equity and I think that if we can tackle some of these issues. Then we really can move a lot closer towards achieving health equity.

That again as I said at the beginning, this is a marathon and not a sprint and we need to make sure that we're supporting the development across all of these sectors to tackle those topics us and achieve health equity. Thank you.

MARY NAYLOR

Thank you, Dr. James, it is time to get serious and you have provided a thoughtful provocative pathway to do so. And thanks to all of our panelists for really More than meeting the expectation of offering strategies system and policy level strategies that move us toward long term systemic change. So now let's turn for some brief reflections on panelists presentations.

CHRIS KOLLER

Thank you. This is Chris Kohler with the Millbank Memorial Fund for those of you who aren't familiar with a fund. We're an operating foundation. Our mission is to improve population health by connecting leaders and decision makers with the best evidence and experience. We tend to focus most of that at the state level. So I'll be talking about state health policy really because policy creates the ecosystem in which these initiatives operate. I want to thank the members of this panel for what were three really interesting presentations I could just start end by saying Amen to all of them. But you won't let me do that. So I'm going to do kind of a greatest hits of what stood out to me. Um, first of all, from Dr. Wilkins, I want to highlight the surface systemic response that Vanderbilt is trying to put in place. I do want to do a shout out for the National Academy of Medicine and compare this to work. That I was privileged to be able to do on a committee on integrating social needs care. Into the delivery system social needs care is not the same as working on racial equity, but involves the same work at a systemic level, the five A's that the committee identified of becoming aware of adjustment of alignment. I'm sorry of assistance of alignment and advocacy. Think of those five increasing concentric circles. I also want to highlight What Dr. Watkins said about the community health needs assessment from an advocacy standpoint that's an unused tool that was created. In the Affordable Care Act to hold institutions accountable for the work that they do, to the point where I think we should start talking about the investments that these large institutions are making with the resource that they have. Dr. Everett went through a bunch of things, but stay

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 are based in structural racism. Then also with respect to data collection as it was said though all the left blank cases for COVID-19 it's remarkable across areas Texas about 50% or left blank for race, ethnicity, and in Chicago where I'm from about 20 to 25% are left blank and that really severely Causes black and brown communities, especially, we think Latin next communities and Native American communities from distant further disinvestment because that's how resources are allocated. Based on where the high levels of incidents are of code. So again, thinking about how we collect data is really important.

And again, appropriate acknowledgement of who is doing this work. Resource allocation. And then finally, I just want to close with words. Words matter. And so a lot of us use community engagement and community outreach. And a lot of things we say are mentioned and health

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 physician, whatever we are all in this on the same boat and we have to center community. And so the way we use those words community outreach and engagement need to change. Thank you.

MARY NAYLOR

Thank you, Melissa, and now we turn to Dr. Regina Davis Moss from the the American Public Health Association.

REGINA DAVIS MOSS

Well, good afternoon everyone and thanks so much to the presenters and giving me the opportunity to respond. I just wanted to say, on behalf of the American Public Health Association were 150 year old organization artists in the world. And if you say is doubling our efforts to advance racial equity. We have our own history and this work.

And we have invite you to partner with us on. You know what, it's different come last because I don't have a lot to offer. You know, other than to say you know definitely will say amen to all the presentations. They were excellent. But I would lift up that I didn't really appreciate. Dr. Watkins distinction between health equity and diversity and inclusion.

A lot of times when I get into D&I work, it, you know, it assumes you know existing and potential employees are they're going to be targeted by the programs have to change to fit into a workplace culture. And it's not always the best at embracing identity and sustaining it so I really like the notion of health equity being a true focus has been really good at this lack of resources and the opportunities. That's a disadvantage certain groups. That was a great job of outlining how you can incorporate equity across the institution and as part of your standard operating procedures, Dr. James alluded to, with regard to Dr. Evans and Dr. James I agree that you have to focus outside of healthcare system and puts it to be, you know, taking a population approach is really challenging because it requires targeting the resources where they're most needed. And that really requires accepting the role of institutional racism and structural racism and that is often where we brought up against the challenge, right, because we have to, you know, look at studies. I mean, there's a split on whether or not you think exist and who's to blame and how we approach we tackle that, but we know that education and income are major, major drivers of health.

We are still have a long ways to go in terms of the earning gap believe it's still been same as still in existence since the late 60s, 70s. So that's really where we have to actively want to see change. I would echo that. I think we are in a unique time. I think the reports that are now

saying that this is a larger movement in history. And so, you know, we think people try to meet the moment but I'm and I'm happy about that. But I really do agree that we have to commit to this and stay committed over time. And so you know when we're seeing these these people in and try to reform. We also have to tackle those core issues which goes back to racism.

I would ask that you know APHA is tracking the number of cities, states and counties that are naming racism as a determinant health or public health crisis or emergency I think that that those decorations are great. They're important first step and the movement to amass these issues. But they have to be followed by the allocation of resources and we have followed with strategic action. If you're interested in more learn more about that we have those all catalog on our website. And I just, you know, as I started encyclopedias underscoring what we already know. So the health inequities are dragging the cases to health disparities are driving the deaths. You know, so the lack of useful source of care insured. There are ways there are things that we can do now get advanced Medicaid We can open up the exchanges. So at the end of the day that we have to believe that health care is a human right. And once we get there, I feel that we can make change.

MARY NAYLOR

Thank you and everyone else on this call. Thanks, Dr. Wilkins, Dr. Everett and Dr. James and all the respondents for really an outstanding session helping us to understand how system changes policy changes.

In a course as all have described as a marathon can lead us to as, as was described. I think by Dr. Everett as a state. We don't know, but we need to get you so now remarkably on time, turning it over to Michael, for I know a number of really powerful questions to be addressed.

MICHAEL MCGINNIS

Thank you very much. Mary and Bill and each of you who have spoken and who have made comments and who have inspired by virtue of the knowledge, you've shared in the in the force of the issues with which you're dealing

We're now going to turn to questions from the audience. And we're pleased to have. Well actually it's unfortunate that we have so many because we won't be able to answer them all directly, but we do have a lot and it's a it's a treat to be able to put some before you. Let's start with what we'll do is we'll actually divide this into two general categories. The categories around which the collaborative meeting has been organized the patient engagement category and then system changes that are necessary to achieve health equity.

And so, beginning with the patient engagement group. We have a question for Beth Johnson from Lynn Walton Haines, who asks, says initially when I bring up equity and workplace. I'm often told yes it's a priority, but we don't have indicators to measure. So her question is, how do we move our organization beyond just reporting disparity by race, but to action, one of the top ways to include patients and communities and measure effectiveness that organizations

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 from the people that they serve in the community so they can build those off authentic collaboration, but they probably need to hold those kind of conversations with their staff as well. Me and I certainly agree with the impressive presentations of all the panelists today that we have to in a much more concerted direct way deal with front and center issues of racism. So to begin to create supportive ways to have those conversations and then have leader, saying, Okay, this is not just about talk. We have to start in develop true action plan and hold each other accountable.

MICHAEL MCGINNIS

So to Dr. Tekisha Everett if she might offer some related reflections.

The question is how basically can we move from reporting disparity by race, but to action and essentially, what are the ways in which that action can be undertaken in order to engage patients and communities and how can we measure effective in the results. Yes.

TEKISHA EVERETTE

So one of the things I used to sit on a board of the health care system. And the key thing that I said is, you know, measuring the data is very important, having the data is very important and understanding the difference in the data is really significant. It's what you do with it that matters. And so it really becomes a conversation about how do you engage individuals, both within the delivery of care. So, those who are within the organization as well as the people who are being served and understanding why that gap exists.

Asking that question five times as engineers do. Why, why, why. And do you kind of get to the root cause of that and then be able to put things into action to change it. Many of the things we already know that are the problem. Meeting. Again, we've already talked. I've already talked today about racism, being an issue there are things that you can still do in the near term, to really address the issues. To address the gaps that you see. So I think one point that I would make to this is, it's important to ask to not only have the data, but really put into action plan. Put into your plan, how do you make it actionable. And I think tying that actionable. Stage to that to performance. So when I say performance. Many of us have performance evaluations in the work that we do. How do you incorporate within that a real focus on making data actionable and actually moving into changing your performance evaluation process is very important. Those are the things that come top of mind.

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 the need that the fact that we need to make certain that we're paying Consumers or patient advocates to participate in these exercises so that we can actually get them and what I have found is in don't please, don't get me wrong. Payment does incentivize across the board. So, that is good, but what I have found in my own communities in working with disenfranchised Communities and hospitals within is that when you take the time to educate the community about what it is that we're trying to do and how it how we're going about doing it And you're able to substantiate that to point about performance measurement, not just indicators, but performance measurement is a game changer, because now you have a level of investment. That goes beyond what we might be able to incentivize one with financially. So I would say that, number one, it's really about focusing on that. On that trust factor and building the relationship. And then number two is really about, you know, making certain that we have an approach where we're taking the time to educate, not just the leaders, but the community as well so that we bridge that gap and bring everyone along the journey.

MICHAEL MCGINNIS

Thank you very much. This next question is how did you engage community members and community based organizations around your equitable COVID-19 response. And two other reactors. Have you seen any trends that suggest ways of engaging The tend to resonate most with non majority population. So the first is to Dr. Wilkins. And then if others from the commenters have comments will turn to them.

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 take a look at those percentages of just, you know, who you have as it relates to staff and who you're serving. And now, what are some of the strategies and some of the areas that you can begin to deploy to actually align some of those things. Because in order to really get to some of the solutions that my colleagues have talked about it again is really going to require having the right voices at the table. In order to nurture and to continue to challenge what the organization is doing in order to advance it forward that start with compensation applicant satisfaction and then of course I would look at that alignment across just staffing roles and the individuals that you have in place.

MICHAEL MCGINNIS

Thank you very much. Now moving to a broader system changes here. Here's a composite question from a number of individuals for Dr. James and it runs as follows. How can we take advantage of this window of opportunity to make durable structural and systemic transformations that last on the long term and how can we in that respect, develop and sustain partnerships as allies, for example, with historically black colleges and universities and not exhaust black indigenous or other people of color that may be very limited. In some rural areas, how do we avoid burnout or tokenism. For as we engage individuals and doing our work to combat health and equity.

CARA JAMES

So thank you for that there's a lot there. I think for those of us that are in the work. And for those of you who are facing burnout, because this is there's a lot at this time. Self care is important. Find their support groups and make sure that you are taking care of yourself, because this is this is America. And we have a long road ahead of us. I think that one of the things that we talked about a little bit air sort of my own circle is that I do feel like We do have a responsibility at this point in time to kind of push ourselves to help out and see what we can do, because there is so much engagement and opportunity in the space and I want to make sure that If and when that window does began to close there won't be a question of, could we have done more.

I think that in terms of what we need to do, looking forward, one of the things that we have talked about a little bit is developing a roadmap for an equitable recovery. So thinking sort of really strategically. What are those building blocks that we need to have, we've talked today about data. So how are we building data collection, analysis and reporting into our system to make sure that as we go forward. We don't have to ask questions about who got the vaccine. We don't have to ask questions about where are we in terms of providing the resources where those testing centers or other vaccine centers or however we're going to distribute that located. We don't have to ask questions about whether or not minority serving organizations, or those small businesses are getting the resources needed to keep going, I think. So how do we start to really push through the data.

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.

MICHAEL MCGINNIS

Thank you very much, Dr. James This next question is about Tele health. How does the role of Telehealth fit under the health equity umbrella. How can we structure this tool to reduce barriers to care and ensure that it does, does not exacerbate known disparities or allow a less robust quality of care for some populations.

CONSUELO H. WILKINS

I think it's really interesting. What we've seen during the pandemic where really the volume of Telehealth visits increased exponentially. And for some groups of people. They couldn't be more thrilled at how, you know, great. This was going and how many visits, they could actually have. And for other groups, not so much. And similar to what we saw with the COVID-19 data, we saw the most striking disparities among people for whom English was not their primary language and there were issues around getting interpreters actually to be part of the visit and accommodating them in that way. And certainly, there, there, there are other issues not specific to people with limited English proficiency, but to racial and ethnic minorities to people who live in rural communities, people who are who have limited resources that that are around both the device, you know, do they have devices that allow them to actually participate readily. Do they have actually, you know, Wi-Fi access to high speed internet. And so there's some access issues.

They're also cultural issues. They're also differences in how homes are set up. And so, you know, whether or not you have a place in your home that you can comfortably have a visit and private is something that we don't think a lot about from the standpoint of actually developing the technology and setting those things up. So, so there are issues that we actually have to address. At all those levels. I think one area that we've not quite, quite gotten a good understanding of is that, you know, the issue around touch and proprioception and what people can feel and the dynamics of a personal interaction where you're putting your life in someone else's hand that power imbalance. For people who've been historically marginalized and minorities and oppressed. That that is a barrier that relates to trust and whether or not we actually want to participate in the visit that has nothing to do with access and device. So, so I think there are lots of things that we can learn. During this process, we did take some specific steps during the pandemic to try and understand what barriers there were some of them were related to people, not having an email address to link to a portal and prefer to actually use text messages and what systems could accommodate those. I think in the long run, you know, use of Telehealth could actually extend care, it could make care more accessible to some. But there's certainly social, cultural and access issues that we will need to work through and be able to make sure that everybody has that opportunity to use it.

CARA JAMES

Sorry. Can I just add a couple of other things too that I think we've talked a lot about you know the challenges and how that can help on the patient side and we heard earlier about on the broadband issues. And the importance of making sure that people have that connection, I think we also need to think about the support for the providers, particularly who may be serving some of the vulnerable populations. So there are some changes. We still need to see that Telehealth technically is only reimbursed in Medicare through rural settings. And so, expanding that is a bit of something that we need some support from Congress to make permanent and those changes that have been put in place during Corbett. But also in a sort of barriers across providers and state licenses and some of those other issues to break down those barriers to increase access across the way. And for those organizations that may have low operating margins, the ability to purchase some of the equipment and technology needed

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 from the days of from the, from the conversation that we've had over the last couple of hours that is actionable for the nation. And if you want to be more specific for the National Academy of Medicine.

But first, while you're thinking about that. Let's go to the last question, which I believe was directed well it's we have a choice of many, many here, but the one that's flagged for me is for Dr. Everett. And it says, health and healthcare are not equal to medicine and medical care. How do these efforts, reaching include healthcare components beyond the triad of medicine nursing and pharmacy. How can we evolve community in these efforts.

TEKISHA EVERETTE

On. Thank you for the question to the part of my presentation that I kind of short changed because of time. Was talking about the importance of community based care and incorporating community health workers and other light workers in the community in the process of advancing health I think that what generally speaking, the social determinants of health or a lot of people are now saying social drivers of health or social influencers That in a word, you're using or phrase, you're using what a lot of that explains and helps us understand is that holistically. The process of getting to optimal health involves much more than just what's happening in the context of medical care. So involving and engaging the community understanding that policy level change needs to involve not only what's happening. Within our healthcare system. But broadly our healthcare ecosystem and looking at education, transportation and housing policies. As well as what's happening within the medical on the medical side is very critical and important. I think the last piece that I would add to this is that when thinking from my perspective when I usually talk I give this whole long discussion about how health is not just the medical piece of it, but it is the spiritual the social, the ability to Have well the homework, being part of it is kind of all of those things together. And so I think that in order to Move the dialogue forward, we need to concentrate wine in the spaces that we work well in and have the highest elevation to do So medical professionals need to be able to advance what's happening in the field of medicine as far as it can, but also in collaboration work with others to work where they are best suited to advance the conversation forward. I think that is the question that Michael. In fact, forgot any piece in it. I just calling you to call me out and asked me to respond to that piece.

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, regardless of where we are in the conversation so I think that's something I can take home for myself and I would hope everyone on the call could as well. So, and thanks to all the panelists again.

MICHAEL MCGINNIS

Thank you, Chris all certainly take it to heart as well. Monica.

MONICA BHAREL

Yes, thank you so much. My takeaways, this is nothing new. We have to confront structural racism. There is a formula that so many of our speakers spoke about the how is known. And the question is, when, and I say now. And specific things that all of us can think about from wherever we sit that we can start today. increasing awareness both our own and those people who work with us, increasing training at there's a lot that non can do in that area data collection and data criteria. Again, a lot to be done there. And then really thinking about the standard operating procedures and institutionalizing this week. So, it lives beyond this work, excuse me. So, it lives beyond any one of us health equity racial equity. It's about now. And thank you so much to all the speakers and for including me here.

MELISSA SIMON

I have nothing else to add, I think I summarized it and what I said and I did emphasize the humble inquiry and moving away from The words engagement because that should be the minimum amount we do to integrate community and really trying to center the more center community into everything we do with the goal, the North Star being racial justice.

REGINA DAVIS MOSS

I'm sure I would just add that the part of the privilege just not knowing. But once you know you have to act. And that's what an ally does such a challenge to systems that email about and so you know, we've taken that if you take the public health approach we've defined the problem we've identified the risk and protective factors, we've developed the strategies and now we need the widespread adoption.

MICHAEL MCGINNIS

Thank you very much. Thanks to each and all for an incredibly rich And I say, I said earlier, inspiring set of observations and an action opportunities. So we're going to turn now to our To our to co chairs bill Novelli and Mary Naylor for some wrap up comments and then I'll Make just a couple of additional thank yous.

BILL NOVELLI

Thank you, Michael. You know why I think you did a good job at the very outset of stating the problem. And we've got some big problems in this country we're facing big challenges. But you know what, I took away from today was a deep sense of optimism. This is, this is a really catalytic moment in American history. And in terms of our health and our healthcare and what we do now is critically important. And, and I think a big opportunity. and some other people talk about leadership. And I think leadership is the key to what we're trying to do here. leaders have courage leaders do things and one of the best things I ever learned about leadership was from Colin Powell. And what general Paul said was, you don't have to be the man or the woman at the top to be the leader. You can be the leader from the middle of the ranks. So, um, I think the cross cutting issues of today are optimism and the fact that we can all be leaders. Thank you.

MARY NAYLOR

So I want to let everyone on this call know that we began thinking about this webinar this agenda for today in January in February pre-COVID because we At the National Academy of Medicine, the leadership consortium and in this particularly in this collaborative believe that health equity is foundational its core to a culture of health that assures that Every human can enjoy the high quality of life that they deserve. We could not have imagined what happened or what transpired. And what is transpiring That made this seminar webinar so important, so timely and so let me just say that I feel very blessed today. I feel blessed that we have engaged the kind of stakeholders who are deeply committed to not just understanding the challenges, but who are activists who are passionate activist. very engaged in showing us a path of solutions. I think we've been blessed to have move this from a closed event to a public event. Because, as many have suggested I think this could have meaning and value to Students and clinicians and health system leaders, the conversation today is so central to understanding of the opportunities with optimism, as Bill said And I feel enormously blessed to be working with a staff at the National Academy of Medicine who pulled it all together. So while I join everyone I do or join everyone in saying Amen. Amen. Amen. I also think that this represents a new beginning a new beginning for us, perhaps as a collaborative And it is an action collaborative and we really want to hear from you about how we start On the path on that journey that everybody has been talking about today with all of the ideas sort of as a baseline to begin again to get us to As I will say again, a state. We don't know, but where we absolutely need to be so thank you all and thank you to the audience. Because you are as engaged as the rest of us, the presenters and respondents in helping us to and will be helping us to really move on very central agenda forward.

MICHAEL MCGINNIS

Yes, thank you, Mary, and let me actually just pick up where you let us to and left off with and that is the action component this we're called an action collaborative for a very specific reason and that is we We in the National Academy of Medicine feel obliged to facilitate action from all on the part of all you do everything we can to facilitate in that respect. We will be what you can expect and follow up from us is A note with a link to the webinar and the briefing materials. With background information on the topics that were discussed today and the presentation slides and also included in that I want to call this out in particular. A very short, easily accessible to page summary of the action collaborative strategy framework. And I call out that because you get a sense of the kinds of things that the collaborative can do with you and on your behalf to facilitate progress. And so we're in asking as part of our RS to you is that you Get back to us on the kinds of activities that you feel we can help steward that will do the most to achieve our collective vision. Of a of a nation and the world for that matter of health and health care, which is effective, efficient equitable and continuously learning. So please As you scan the materials that are sent to you. And as you reflect on the conversation today. Please do be in touch and I adult a nice a nice day has her Email address right here. Thanks to each of you both for being with us for what you're going to get back to us with in the way of comments and suggestions. Thanks to our wonderful Co chairs for their leadership to each of the speakers and the commenters and, again, from my perspective, especially to the staff. We look forward to working with you and we wish you Godspeed be well and be safe. Take care.