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

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

I'll tell you a little bit about it and try to give you a sense of the ways in which we're hoping to change the state of play in the nation on key dimensions. There's no question that we need change. The last year of experience with COVID has underscored that and almost every possible way and heightens the importance of what we're doing in particular, the importance of what we're doing in this particular action collaborative.

After I finish my remarks, I will turn it over to Bill Novelli,, who is a co Chair of the collaborative and he will give a preview of the agenda and work with his other two co chairs Mary Naylor and Sandra Fernandez. As we go through the very exciting programs, that's been assembled for today.

So if you see on the on this slide, that is showing at the moment. The NAM leadership consortium is focused on aligning forces for health system effectiveness, efficiency, equity, and continuous learning. I mentioned that in particular because so often much of our health system is fragmented into different components, whether their components related to fields in which organizations work or their components related to the organization's themselves. We are a relatively fragmented system and what's and with a system that is blessed with more financial resources than any other system in the world. We should be accomplishing a lot more and gaining a lot more value from our investments and so we in the National Academy of Medicine have formed the leadership consortium comprised of leaders from throughout the nation in many different sectors and I'll tell you a little bit more about that in in a minute.

But we all work together toward the notion of a learning health system which is one in which science informatics incentives and culture are aligned for continuous improvement innovation and equity with best practices and discovery seamlessly embedded in the delivery process. Individuals and family active participants in all elements and new knowledge generated as an integral byproduct of the delivery experience.

And as you see, our strategic action domains align with those don't with those issues that have been identified through our learning health system concepts that is we work in the digital arena. The evidence development and application arena, the economics arena. That is the incentives and health financing that are so important in ensuring that people get the care they need. And the socio cultural arena. I'm going to give you run through a few slides, very quickly to give you a sense of our operating model.

Yes, you see at the base of the operating model is are the strategic action domains and then moving right along to the next slide for each of the domains. We've developed action collaborative, which you see here displayed that counter that correspond to those domains. The Digital Health Action collaborative, the

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

You see also that those action collaborative have developed a set of common anchor principles around which their work is oriented and it provides a set of not one North Star, but a series of fundamental North stars that can be mapped on to each of the arenas and serve as an as a guiding set of principles moving forward.
Each of the action collaborative and the domains has a broad focus for emphasis in the digital domain, it's working to foster a virtual health data trust which in effect represents positioning health data as a core utility

In the evidence domain the focus is generating real world evidence and tremendously accelerating the pace of evidence development in application and we have some wonderful examples of how that can be done, although we're not going to review them today.

In the economics domain the focus is moving away from fee for service, which is generally acknowledged now as counterproductive, not only to efficiency, but to effectiveness as well and to a health financing system that's more focused on population health improvement.

In the social culture domain. Our focuses on ensuring that engagement involves everyone in the nation. To the extent possible, as part of the solution process.

In addition to the focused priorities of each of the action collaborative. There are networks that are being developed of organizations that are leading organizations around the nation in order to enable their ability to work together toward those anchor principles and progress in in the stated priorities of the domain.

Michael McGinnis: We you'll hear a little more today about the dashboard indicators of progress that are being developed for each of the domains of activity. The development of individual projects that are multi organizational in nature, collaborative in nature to fill key gaps that may be impeding progress at this point.

You see that the overall aim is for better health better value and equity for all throughout the system. So our approach is fairly systematic it's obviously bold in its vision and it will only work with the involvement and leadership of all of you who are on with us today and your colleagues throughout the nation.

We are involved right now in a series of fairly high profile assessments of the impact of the sectors, represented by the leadership consortium. These are assessments that are led by leaders in the field, including your three co chairs and the sectors that are in focus our patients, families, and communities. Obviously a major focus of today's discussion, clinicians and professional societies care delivery organizations. Digital health organizations, state and local public health, health payers health product manufacturers and innovators health and biomedical research and quality, safety and standards organizations, these represent the primary areas of activity and sectors involved in our health arena broadly and the work and I've seen the results today to have most of the sectors assessments, they're going to be extremely helpful moving forward in not only learning lessons for the next time we face a challenge like this, but even more importantly, identifying fragilities in our health system now in our social and health system now that we can make transformational changes in if we set ourselves as a nation to the test.

Each of the sector assessments as I've noted of the of the nine sectors that have been identified are developing whitepapers that lay out the challenges and the and the opportunities for broad health system change. They are being published individually as white papers by the National Academy of Medicine and collectively as a special publication. Together, which looks not only the individual sectors, but across the national sectors wide and finally lays this sets the stage for not only our collaborators, like the collaborative on culture inclusiveness and equity that's meeting today but for players around the nation to move forward with better information about the results of the challenges of the past year.

We now move to the formal launch of today's meeting. Thank you for bearing with me and that background contextual overview, but it's a tremendous pleasure for me to turn the floor now to Mary Naylor from the University of Pennsylvania School of Nursing, Bill Novelli from the Georgetown University coalition to advance and transform care, and Sandra Hernandez from the California Healthcare Foundation, each of them not only leaders of their organizations but national leaders of great importance.

BILL NOVELLI
Michael, thank you very much and Hello everybody, I'm Bill Novelli and on behalf of my fellow co chairs. Welcome to this meeting of our action collaborative. The overall goals of our collaborative are to promote equitable and evidence based health care practices. To implement strategies to ensure patient family and community engagement in health and healthcare decisions and to identify the social and cultural conditions, both inside and outside the health system that best meet individual needs.

My co chair Mary Naylor is going to share more details about our recent work shortly. And then we're going to hear from experts with a range of backgrounds both within and outside health and healthcare about strategies they and their organizations are using to address internal equity and how they're measuring progress.

After that will take a broader look at potential dashboard indicators of progress at a national level regarding a culture of health equity and engagement of patients and their communities. And we're going to wrap up with a session of reflection, where we're going to hear about where the field might go with our panelists having more opportunity to respond to questions.

And now just a word about logistics. Speakers, would you please turn your video on when you're speaking and please remember to keep yourself muted when you're not talking and after the presentations, the session moderator will start by posing a few questions to the panelists and if time permits will answer some questions submitted by the webinar participants.

If you're watching, please take your questions into the Q&A located in the controls at the bottom of your screen on the zoom platform. Please include your name and organization if that's applicable and who the question is directed to. We've got time set aside at the end of the webinar to address as many of those as possible. Although you may submit questions at any time during the presentations. And finally, a recording and copies of these presentations will be available to view after the event.

And now let me turn it over to Dr. Mary Naylor to begin the first section.

MARY NAYLOR
Thank you, Bill. And let me join you and Michael and Sandra and in welcoming our speakers and all of you to this session.

We know that many of you are new to the collaborative. This might be the first time that you're attending one of our webinars and thought it would be helpful to place into context, some of the work that has been done by the collaborative to date toward achieving our goals of an inclusive environment, a culture of equitable engagement in health. So most of our work is done by you. It's been done by members of the Collaborative who form work groups.

These are thought leaders in the field who helped to uncover where there are gaps and ways in which the National Academy can really advance this agenda. So let me just share with you a few examples of work that's been done in one prime example is a series of papers that have been produced or will be being are being produced in order to achieve this goal. So let's go to the first slide.

And this reminds us that our priority is to advance a culture of health that really places the needs of people and communities at its core. Next slide.

A real sense of how this engagement occurs, it occurs through community Coalition's multi Coalition's that very big investment in awareness standards and so on. So all of these efforts are going on simultaneously to arrive at full and equitable health engagement. Next slide.

So this first paper is a great example. This was released in July of this year. Patient and Family engaged care and essential element of health equity. Led by Melissa Simon, a group of authors thought leaders identified specific strategies that organizations can use to really promote family engagement patient engagement community engagement as a basis for as foundational to health equity, you know, this is really tough work. And I think that the panelists that will speak later today will describe how important but difficult this challenges to get people who were serving fully engaged.

This paper highlights a number of well evidence based strategies that might help us do better at this. Some of them are innovative strategies. Some of them are unconventional strategies, getting to this culture change will require a big shift in systems investments in this work. Maybe by paying closer attention to people's literacy levels. Maybe by better thinking about how we advanced already existing structures like patient and family caregiver councils, by promoting greater diversity within them. Certainly by thinking about more deliberately improving access to care or expanding our telehealth technologies that in a meaningful culturally meaningful way. And finally, by getting to a more diverse workforce, maybe more culturally humble workforce. So this paper helps to pull together those sets of strategies. Next slide.

As Michael mentioned a key focus of this collaborative and many authors on this sector assessment of patients, families, and communities come from this collaborative. This is an effort for us to think about lessons learned from the pandemic. About the effects of this pandemic, from the perspective of patients, families, and communities and what it is that we can do to transform care systems using these lessons learned now everyone in this audience knows that the challenges uncovered from COVID-19 are the result of long standing fractures in our healthcare system. Disparities Among people of color evidenced in higher rates of infections higher death rates, a real lack of trust in public health and healthcare systems. A proliferation of misinformation and tremendous confusion as a result of that on testing on treatment on vaccines unequal access to support among people who develop the disease.

Insufficient testing and all of these major factors uncovered not miss an exposed during the pandemic. Form, which we can learn major lessons and part of what we're trying to do in this paper is to come up with a series of recommendations. That call for a shift in focus to ensure that we effectively engage people in decision making around their health going forward. That we pay particular attention to home and community based services as a site of care to better meet the needs of individuals. And that ultimately we increase access to care and meaningfully include patients, families, and communities and all the decisions around their health. Next, next slide.

This is a paper that's currently underway. That is examining technologies to enhance patient family and community engagement. And really beginning to think about treatment of equity as the prime challenge. When we design technologies we need, first and foremost to think about how is it that those technologies will be accessible. To all yes it's important about thinking about quality and cost and efficiency but equity must be an underpin our design of future technologies.

This paper is outlining specific steps. That's policymakers technological companies health system leaders academic institutions and individual consumers can take to support this goal, and we hope that it will be timely and help to shape the way that we know major advances in technology are being accelerated that these unfold help to guide regulators providers consumers as more and more technologies. Enter the marketplace. Next slide.

In collaboration with the Robert Wood Johnson Foundation this collaborative has undertaken a multi year initiative convening a group of community partners, guided by a steering committee to assist in a project assessing community engagement. The report and associated materials are designed to be usable by a wide range of stakeholders, we recognize the critical importance of measuring Community Engagement in order to make sure that we get to health equity high quality. And so we're using this opportunity to

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The terms diversity, equity, and inclusion are buzzwords we hear them a lot today. But let's start by qualifying what we're really talking about when we think about the ideal workplace in regards to DEI. So first, we're talking about equal representation of demographic backgrounds experiences and perspectives. We're also talking about equity in terms of fairness and allocation of resources, access to opportunities. And we're talking about inclusive environments where all employees feel valued for their uniqueness well also feeling as if they belong.

So this is the ideal vision when organizations say they value DEI and when they want their employees that when they said they want their employees to bring their whole selves to work. However, this place of utopia that I'm describing it honestly rarely exists for all employees organizations have largely missed the mark when it comes to creating environments where all employees can thrive in an equal and equitable way. So this is the goal we're collectively working towards. So let's think about how we can actually get their next slide.

Over the past few years. The, the most common questions that I've been asked by organizational leaders CEOs and presidents. Are two things. The first thing they asked me is, where are we on the organizational journey for DEI and the second thing that comes up most frequently is how do we compare to other organizations. And the third question is how do we get to the quick wins.

And so because of those consistent questions that I get almost in every first meeting with an executive leadership team. I started doing this research to understand the systematic way, we can codified DEI organizational journeys, while also still acknowledging that each organization will have a unique journey and, you know, there is no one size fits all approach for DEI and so I love that the panel today here has such a diversity of experiences and organizations.

Because you want to understand that, you know, there are best practices, but really the best practices, the one that works for your organization and get you closer to your goal. So let's unpack this organizational journey. Just a little bit. Next slide please.

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

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

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

So moving on stage one to stage two into the compliance stage, the second stage we see many organizations stuck in where they're focusing on maintaining ESC and other legal standards, just in order to be able to essentially not be sued. Is how I describe it, it's often seen as just doing the bare minimum around diversity and inclusion and they're not thinking about it in a strategic way at all. And next place.

So in those organizations at stage two. They're really thinking about we do di because we have to next place as we move to stage three, we see organizations, thinking about where diversity and inclusion fits into their goals. They may be thinking about how it can help them strategically, for example, with their consumers or with their patients.

And it may link to initiatives that has specific business or bottom line outcomes. However, other organizations may be thinking about specific things they can be doing to be innovative. Such as, you know, how can we be in the frontline of health care in terms of how we're making sure to serve our patients more equitably than any other organization out there. So those are things that may be focused on innovation. All of these things kind of fit into the stage through bucket of being strategic you're thinking about how does DEI fit into our goals.

However, you're not thinking about it from a holistic perspective. Oftentimes these organizations have diversity and inclusion efforts that could be really successful in pockets, but you'll find that there the organization of pockets, don't talk to each other. There's a lack of consistency across the organization and even a lack of kind of overall strategy guiding these efforts. So while they might be great and well intention, there's often kind of missing the mark in terms of being incorporated throughout the whole organization. Next, please.

As we look at the next stage in this model Stage four, we're thinking about organizations that have DEI practices integrated throughout their entire business but more specifically organizations that have the eyes of part of every part of their sphere of influence from their employees to their patients to their stakeholders to their board of directors and to their larger communities. These are organizations that can honestly say that they have analyzed and can answer the question to say DEI is part of everything that we do in the next phase.

You moving beyond being integrated and you want to think about, you know, once even once you reach a place of integration, how can we make sure that we're creating systems and structural changes that outlive even our business cycles are changes and leadership's. We really need to understand that DEI efforts can remain strong over time throughout different organization or industry changes.

And then finally, you know, at in Stage six once the organization moves to all of these stages, their work, unfortunately, is not done. True commitment to DEI requires continuous improvement by reassessing the strategy and initiatives as the organization grows over time. And so we're continuously improving and

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

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

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

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

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

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

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

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

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

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

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

But we weren't always that we weren't always in that position. And so with Dr. Washington's what's beautiful about Dr. Washington's presentation is that we sort of went through that process that she laid out very, very beautifully. And our current strategies now are to start and grow business to leverage homeownership as a wealth building strategy to basically focus on closing ratio gaps and income and wealth. And so the way that we do this is by building people's and leaders capacity for centering racial equity and inclusion for operating in a collective impact way and for disrupting harmful narratives that have influenced our beliefs in ways that haven't been useful for our, our society in our community and we really work with leaders to create new ones that reflect equity inclusion and well being, for all.

And so as I mentioned, living cities wasn't always explicitly focused on closing ratio gaps. In fact, we found ourselves working on systems change across systems, Robert Wood Johnson is a member of ours. And so we were working across systems and education and health and so forth. And we didn't have a consideration for how the history and legacy of racism contributed to the problems we were trying to solve. And the systems that we needed to change, transportation, you know, sort of name a system name in which we all interact

And so, you know, we had to get real about that, but what did it take for us to get real about that. And those were stories and those were events, lots of externalities that was risk that people inside our organization took. So I want to go back to Trayvon Martin who was killed in Florida, and when that event took place some folks in our philanthropic and nonprofit community had sent some messages out they, you know, said we should say something about this. We should speak up. This is an injustice and you know we have always worked in cities and with low income people. But we never named race as a predictor of outcomes. And we sort of sanitized or in some language whitewashed our work, like many other philanthropies were doing at the time we use coded language urban low income, you know, so those are coded words.

For things that you know that we all sort of make assumptions about and we focused largely on equality and economic mobility and we bought into the narrative that if you just work harder if you have access, you'll succeed and we were the people working on supporting that access and a side note, I'll say is that access is not good enough. We need access, but we also need people to secure, what is necessary for them to be well.

So back to Trayvon Martin. When he was murdered staff could been concerned about our race neutral approach took tremendous personal risk to call this out to our CEO and leadership and force a conversation about how race and racial equity showed up in our work and to be frank, at that point, there was explicit rejection by our leadership that race was not a problem.

So, what do you do then when staff inside of your organization. So if you think about the trajectory that Dr. Washington just shared any weirdness right is a part of this process and there's rejection, especially if you're a junior staff person taking a risk and going to your CEO and other leaders to say, hey, we got to talk about this. While the conversation was fraught and challenging. I will say that the staff members who raised their voices around this allowed space to be created. So that we could grapple with how race showed up in our work and start making organizational changes around it.

And so just to note there was a contingency of staff who were brave and willing and working together to sort of try to do something different, but they didn't necessarily have the power. And they didn't have the formal authority as leaders in the organization. But folks, took risks to sort of challenge the status quo and really rethink what we were actually working towards. And so just a note about racial equity. Very much a part of our sort of lexicon in the way we work. Is it like we had to go through a process so that Trayvon Martin was a sort of an awareness process.

It kind of shook us up, but then fast forward a few years later, Freddie Gray was killed in Baltimore. Baltimore is a city home to one of our members the Ann Casey Foundation. Some of the leaders from our board and other institutions that we need to talk about this. We need, we need to do something because this can't keep happening in our cities in our places to people and so then we convened a group of our members a subgroup of our members who wanted to talk about race and racial equity and what was happening and could we do something as institutions and so you've got you sort of internally staff sort of moving and pushing to do more about race.

And we did some little things. We got a consultant. We had some conversations. And then, now you've got these externalities that keep popping up that are sort of forcing a conversation. And then you have leaders funders who were saying, hey, maybe we should like slow down a little bit. I give a lot of credit to Patrick McCarthy. Who was a major force to say we need to have some conversations and so number of our members got together and we started having conversations and we launched, which is typical a program, an initiative called racial equity here in cities.

But what was beautiful about the initiative. Is that right, that initiative that didn't focus on simply creating new programs and processes and things like that. It actually focused on, I'm conducting an audit of how cities worked and how it was impacting people in their communities and where they're sort of the things that are very noticeable like the obvious indiscretions and disparities and where were the things that weren't so obvious. And so we worked with five cities to do this work and it the outcomes. And it's all published on our website and it really made a difference for leaders in cities. But what was really critical about what happened was that the cedar that the leaders went through a reckoning of their own.

We introduced history, the notion of history because a lot of folks don't understand the history and legacy of structural racism, they don't understand what's happening. What has happened in government how government played a role. And because we work with local government. We needed to raise that they don't. They didn't understand how capital investments continue to create gaps in who had access to start, start and grow businesses or create jobs for people. And so the lack of awareness was just was largely was a huge problem. And so we went through that process and we launched the racial equity here.

Now what you're hearing me say is I'm talking about something that's happening outside your organization. So you've got parallel tracks. So you've got us with an initiative in cities working in partnership with our board and then sort of grappling with this internally but we had to get real with ourselves because we could not be out in the world talking about centering racial equity and not practicing in ourselves. And so, Ariana if you want to pull up the slides. I want to just share with you all. Some of the ways in which we start collecting and understanding how well you can go ahead and survey.

And so what we did and with our staff is we try to do these whole staff convenience that didn't work. And we created a group internally colleagues operationalize and racial equity or court that will lead to racial equity work and we put together a curriculum. And we gave people space to go and do what it was that they needed to do to sort of get a one on one, go do one on one. Just have a basic understanding so that we can all come to the table and be real and get and be clear about what it is and what it isn't. Our leadership signed on, they did it first and foremost, and they model behavior. So we had finally engaged leadership. Once we send to everyone and we empower staff to start on a journey. We then created lots of spaces and lots of opportunities for people to gather and to build their capacity and their competencies.

We also conducted our own racial equity audit the very same thing then thank you the very same thing that happened in in cities, when we created that. Next slide please. We asked the set of questions every year. Where we try to get a sense for how well we're doing across the board in terms of our racial equity culture, our practice. And how it showing up in our, in our work and it's like annual health checkup. And so what I have here to wrap up are just a few of the questions that we asked our staff to respond to so we understand what's working, what's not working. Why, and the weekend appropriately address it. And so here's the question. Next slide please.

They can identify instances of institutional individual structural racism. Next slide.

They have the tools to address it, because our responsibility to give them those tools. Next slide.

And they talk a little bit about their experience in the culture, they can, they feel like they can take risk and they feel like they are, they can't take risk or that their reputation is at risk because that's really important. Next slide.

And finally, we don't just collect quantitative data we collect qualitative data and there's lots of good things that staff, say, but we also want to know where the challenges are so that we can hopefully address them. And so that is what we've done at living cities to operationalize racial equity internally. So it's also showing up externally. Thank you.

MARY NAYLOR
Thank you JaNay for taking Ella's excellent framework and bringing it to life by an honest and open appraisal of your own journey. I really appreciate also the attention that you paid to the critical issue of engagement of all in including and especially leaders in that journey. So thank you very, very much.

And now we have the opportunity, Ron, to bring this down to healthcare system level as you talk about your work at Kaiser Permanente.

RONALD COPELAND
Well, thank you very much. Good afternoon, everyone. It's a pleasure to be here with you and be part of these very important and impactful conversations and the limited time that we each have a speakers today I would like to give you a little bit of insight about the care delivery system side of this discussion. And what we're doing, have been doing and aspire to do in the future to ensure that equity inclusion and diversity optimize for all of our employees, our patients and members and communities that we serve. So we'll go to the next slide please.

And I'm not sure how many of you know about Kaiser Permanente, so I want to spend a few seconds just orient you to our organization, we're viewed as the largest not for profit and fully integrated health system in the country Kaiser Permanente is 75 years old. We have a model where care hospitals and covered benefits purchased by employers or individuals is all really under one roof. And that's been a unique model that was created five years ago on the west coast and our current operations are in eight states and the District of Columbia.

Want to give you this view, just to help you appreciate kind of where we are on our journey, you know, Dr. Washington talked earlier about where people are on their journey. And this is the guiding strategic

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

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

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

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

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

But you can see the black dotted line is the 90th percentile, and our aspiration just on quality improvement was to make sure for all HEDIS measures all populations were at a minimum at or above the 90 percentile in terms of achieving those measures. So you can see by the graph, that the African American population was below that when this journey started, we put a formalized process together that I won't have the time to go through here today, but it involved really trying to understand root causes and all elements, and as a result of identifying those root causes, putting practices in place and driving that across our organization and measuring consistently.

We were able to demonstrate that we first moved the African American population above the 90th percentile. And then over time began to now the gap that existed among the different groups to the point where all we're achieving levels of quality and that was about at or above are intended measures and the gap, we're narrowing but we also learned that we could not close those gaps completely. And then the next phase of our work was really understanding what were the things that we were leaving out and I'll talk about those in a second. Next slide please.

So as we did our work and process this body of work and then went into other areas be beyond the hypertension. The example. We begin to understand some key lessons and took those lessons and develop them into evidence based practices, policies and approaches that that still inform our work today

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

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

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

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

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

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

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

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

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

And we're also the last piece I want to highlight here is just what we're doing inside our organization, the core principle here is that we don't believe people can deliver services. And interventions to others that they don't experience themselves. So the work environment for all of our employees and physicians is critical to be an inclusive environment that is psychologically safe and everyone is truly included and have a sense of belonging. That is work that is actively being deployed right now with a major initiative of being deployed across our entire enterprise over the next two years. Next.

And we are mapping the entire lifecycle of an employee in our organization and looking at all of our processes at a system level to determine where a discretionary decision making is disturbed by bias or racial discrimination and being able to disrupt that and integrate and implement fully inclusive practices and equitable practices, then follow up with appropriate measurement. Next slide.

And this is just an example of the type of things where we are measuring across our workforce. Indices that tells about how people are experiencing inclusion speaking up during engagement levels of trust levels and so forth, based on their own individual experiences to guide where we have further interventions to make. Next slide.

So I my last point here is that the urgency of now related to the pandemic and everything that's going on, as has been mentioned by previous speakers has just highlighted and put a spotlight on the fractures that exist in in all of our systems in the work we're trying to get done. So the framework we're going forward with the to our to our day to day work as well as in as urgent matter is really emphasizing the importance of unapologetic leadership.

That is principal and purpose base that challenges and says quote that data and transparency into the desegregation that data helps us see and identify who is being underserved and make sure that we then mitigate that harm by driving resources in an appropriate way. So that is equitable distribution, rather than cookie cutter approaches a one size fits all. So I thank you for your time and attention and look forward to further conversation.

MARY NAYLOR
And we thank you for this peek into what is a long journey. How you described 75 years of a history of commitment to this but also display very beautifully how this is a continued evolution guided by measurement guided by principles such as just culture and engagement of leaders and engagement of the voice of the people you serve so terrific exposure to what’s going on in an environment that has really made a continual investment in this work, though, so thank you. And now we'll turn to our last speaker, Dr. Yang. And thank you for joining us from Health Partners. We look forward to your opening remarks.

YENG YANG
Thank you Mary. It's a pleasure being here, good afternoon to everyone. Really enjoyed the speakers already. And I think that this is going to be a continued rich conversations this afternoon.

So I don't know how many people in the audience know about Health Partners. We're based in Minnesota. And so I'm just going to share a little bit with you today, more so specifically about the internal work that we're doing. We're doing a lot of work externally as well towards our patients and our members, but today I'm really going to focus a lot more about what we're doing internally next so here we are, we are an organization that is integrated. We have several hospitals many clinics, including primary care as well as specialty care and dental work.

And you know, we also have a plan. Much like Kaiser and a Research Institute and we are a teaching facility, as well as, you know, doing lots of research, even with COVID.

Just wanted to highlight a little bit of Dr. Washington spoke a little bit about the journey and health Partners has been going through this health equity journey since 2006 or not quite as long as Kaiser but

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

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

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

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

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

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

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

the past. So what has been changed with this creation of his cabinet too is that they've included myself and Dr. Steven Jackson, who the team and our submission into the leadership.

You know team and so that we could see things and bring that you know clinical practice lens into the, the leadership circle of to try to drive some of these changes going forward, because we know that it's not going to work. When we have just one side the administration driving this and the DEI team driving this alone.

So some of the strategies that we are really focusing on this year in terms of our internal work is really to address unconscious bias and really to cultivate that culture of inclusion. And taking some of those really meaningful steps to eliminate systemic racism in our organization and in the community. And then some of that work also spills over to our plan side by increasing our equity coverage, you know, in that plan space as well as continuing to build our community partners. Next slide.

So just a quick recap of our healthcare equity measure some of this. These are patient measures. And you know, we are really focusing on infant and maternal health and prenatal and in the discussion group. If you guys are interested can talk a lot about some of the collaborative in partnerships that we have been participating with our organization to really look at infinite maternal health and impact the outcome because we believe that doing equity work really and closing those gaps. If we can kind of move upstream, that that would impact so many things later on and then additionally, this will have a lot more me we have been doing a lot more work in the screening, you know, metrics that you can see that we've closed, some of the gaps, but the gaps continue to exist. And the reason for that is that I think we need to do some culture work. So if you want to go to the next slide please.

So just some baseline data for you. You can see that only roughly less than a quarter of our patient population or workforce are diverse and that is less than our patient population that we serve. We serve about roughly 25% of our patient populations is diverse, but what's most alarming about this is the level of diversity in our leadership team because those are the people who matter. They're the ones who are making decisions. Next slide.

So one of the first things that we're doing as part of our five year plan for this year is that we're going to really work on increasing the diversity of our leadership team as well as the rest of the team member but we have an ambitious goal of by 2025 we're going to increase that leadership diversity percentage by hundred percent and then work on increasing our team members as well. But one of the most important thing is to really increase cultural humility training in our leaders and our team, and that is to go through bias training because you know aswe have learned in the past that if you don't do the culture work. You can do process improvements, all you want, but you're going to continue to have gaps.

So hopefully by the end of this year 100% of our 26,000 employees will complete bias training and we will increase leadership skill acquisition currently only 30% of our leaders have gone through bias training and then you know as our previous speakers talked about. We really need to continue to integrate the equity lens into all aspects of our organization from the quality improvement design process and our quality and safety, you know, processes as well as recruitment, retention and onboarding then one specific area that we're really focusing on is clinicians specific recognition and mitigation of bias and we hope that by the end of 2025 that 100% of our clinicians will have experienced this.

So in. I know we probably don't have much time left. So I'm going to just go through some of the lessons that we've learned in our, in our journey that we've gone through. First is, like I said process improvement alone isn't enough to close the health care disparity gaps. And buys recognition and mitigation training for leaders alone isn't enough. We need to really train the rest of our organizations and we need to continue to have stains. Support and sustained learning and training ongoing in order to support the culture of equity and inclusion and we also then need to create a safe and inclusive and anti racist culture. When we don't have a safe culture, then you end up needing affinity groups to talk about race and it's not pervasive across the organization and this does not then allow you to move towards that next step in the journey. So really important to have an infrastructure to support the people and the work and so for example if you had a bias complaint against another team member, for example, for right now, we don't

really have a very strong infrastructure to be able to deal with that we've may send in the DEI team, but that's not really, you know, just the work of the DEI team, we feel that it's really the work of all of our leaders as well as our team members to be able to have these very tough conversations and sometimes very uncomfortable conversations.

And finally, you guys all know this, that this is really hard work and you're going to meet opposition's and if you meet opposition that usually means that we're probably on to something. Right. And that doesn't mean that we give up. It just means that we have to have more conversations. And lastly, there needs to be just talk leadership support and long term commitment to take this journey. I think that is all I have for now and I look forward to actually having more conversations with you with the rest of the panel. Thank you.

MARY NAYLOR
You are representing organization that is a little bit, you know, has about 10 years experience. But really, was willing to step back and when a major life event A cause you to change course and so thank you for sharing that the focus on culture, the focus on engagement and leadership. And continually this notion of this requires investment. It requires the hard work that you're describing, so really thanks to all of our panelists. I thought this was outstanding exposure to a framework for thinking about this work and a real set of important case studies that applied lessons to that framework. So I'm going to take prerogative of asking the first question, but I appreciate that there are a number of you that have asked questions, but we will absolutely get to as many as possible. You know, there are many in this audience who are listening who are at the beginning of this journey and there at the beginning of this journey in a very unusual time in our history.

With the challenges in terms of divisions racial divisions covid pandemic economic challenges, etc. So I'm interested if this goes to all of our presenters. If you could reflect on if you're taking what you know and organizations are just getting started. What is it that you would recommend in terms of first steps to kind of really make progress in this context.

ELLA F. WASHINGTON
Absolutely. So I think, you know, many other panelists may share stories of how they did some type of audit or assessment of where their organization was, I think, beyond that, though, what is really critical is that leadership is all on the same page and take a step back to really define the vision of where you want to go. And as I stated earlier, many leaders in many organizations will say, yeah, this is important to us, but they don't take the time to really define that strategic vision. And not that you have to have it perfectly because there will be some bumps and twists in the road. In your, your long term journey, but it's really important for us to be on the same pace as your leadership team of what we're actually trying to accomplish. And how we're trying to show up in this world. For example, you know, organizations now are using the term anti racist. That's a big deal. You know, just six months ago. Many organizations didn't even know what that meant, let alone, you know, have the courage to put that as part of their strategic plan. So I'd say kind of assess where you are, as well as define your, your, your move forward vision.

JANAY QUEEN
Yeah, so just ditto to what Dr. Washington said two things that were really helpful for us was taking the leadership team. And then ultimately the whole staff, but through a root cause analysis and we had a facilitator to come in and really do a deep dive and look at data look at experiences events and really dive in deeply to get to the source of the problem and understand that. So that was really critical. We also had lots of history lessons. There were different organizations we work with racial equity Institute who walked us through groundwater training and it was sort of very focused on data and showing us trends and patterns. So that we could sort of get through the get through the logic of it all and try to understand and grapple with some of the problems. And then we worked with a group out of New Orleans called the people's Institute for survival and beyond where we went through a two day undoing racism training. That, in my mind was like head and heart so the groundwater was head the undoing racism was hard and together those things connected sort of allowed us to connect have a holistic experience and understanding the history, the legacy and getting to the root cause.

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

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

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

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

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

You know progress towards that next step that we want to be would be one way to kind of help leaders. The other way is that in, like I said before, instead of leaving this up completely. The to the DEI team. Saying, you guys are the leaders and it will all your responsibilities we really need to integrate this into the entire culture that every leaders expectation is that they integrate this as part of the capabilities of their job as well.

MARY NAYLOR
Terrific. Have there been metrics identified for the different stages of this journey?

ELLA F. WASHINGTON
And yes, yes. So that's the part of the work that I do and I'm working with the competency model of understanding each phase and how that looks even different in different industry. So yes, there are some metrics and we're still working in the research phase of that. But there certainly are metrics and then also

you know I think out in the, the greater d i world. There's lots of kind of competency models out there and examples of organizations like the three that talk today that have, you know, found ways to put some teeth around some sometimes these really big concepts around diversity and inclusion.

MARY NAYLOR
Terrific. Dr. Copeland, can you talk about how your organization's thinking about expanding their frames external and internal frames to include justice restorative justice. you talk, you mentioned adjust culture in one of the principal lessons learned. So Dr. Copeland, any thoughts about that trajectory?

RONALD COPELAND
Well, yes, I think it's about the community engagement that I mentioned in our framework that is now fully integrated as opposed to just an activity going on for a specific purpose fully integrated into our notion of health and so we. What we don't want is people to have to get addressing competing priorities that to see this as seamless integration.

That if you want communities to be healthy and that's where our current patients. That's where our workforce and our future workforce comes from. And we want to be as long stream and for forthright and thinking about the future that all of the things all of the things that create barriers for people to achieve optimal health. The social needs their impact the impact of criminal justice social justice systems on their development economics, etc. All of that has to be accounted for and our model.

Because we are not for profit, and we have a long standing economic and financial commitments to communities we serve. But now we're shaping knows and being more specific in the portfolio, we create around how are these investments are these collaboration and financial support, are they driving these issues around justice in a different forms and take, whether it's in the social justice system related to health needs. And then how do we as a as a large organization in the country. How do we use our voice our policy influence voice. To make sure when wrongs are done or injustice is accommodated. How do we speak up and have our voice heard and how do we encourage other like minded organizations and leaders to do the same. So, some of that is done through collaboration is through networking through engagements directly with elements of the communities to help them achieve the resources and the issue they need or provide evidence and data of things that are going wrong by being a partner with them on those projects.

MARY NAYLOR
Terrific, thank you so much. A questioner wants to know your ideas about speeding up the movement of a social structures healthcare structures adopting diversity, equity, and inclusion policies in response to an increased recognition for such policies.

JANAY QUEEN
And so I was going to actually respond to something. Dr. Copeland said and try to connect the dots here. And so what it all boils down to. For me for us is a paradigm shift. And the question I would ask you all is what do you believe in. Why do you believe it because it comes down to people. Right. We the People make up the systems we all exist in no matter what. So when you talk about the voice that you talked about raising your voice. Dr. Copeland and speaking on behalf of policy. Well, who are the people in our systems. What do they believe. Right. And why do they believe it, and how does their belief or how do our beliefs turn into behaviors and then therefore influence policy, no matter the system healthcare policy education policy, whatever, whatever system you're working in, but we're in health here right and so you asked the question early on about what what does, what will it take for leaders to do this. It's going to take giving yourself permission. It's going to take getting personal. It's going to take being in relationship. It's going to take having resources that don't necessarily just look like dollars and cents, but it can be in community.

And to for too long we have sort of separated our personal selves from business. Oh, that's just business, but we are in the system of business and we are the people in the system of business. And so I think to the question about accelerating and advancing. I think it's been answered in terms of the leaders need to get involved. We need to create space for risk. People need permission to believe and behave differently.

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

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

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

RONALD COPELAND
I've had a now 32 year career with Kaiser Permanente in operations that I was involved with consulting advising and Cleveland, Ohio, when we had operations there. Around this question of what Kaiser Permanente health system was doing what the university system was doing what Cleveland Clinic was doing what the county hospital was doing but we came together using a model that allowed us to agree on how we could share data from an institutional level around the achievements of certain equitable practices cultural competency and so forth to elevate our community health systems patient population up to a level of effective outcomes and we created a process through trust through engagement of sharing data and then more importantly to join this group and be part of it. You had to agree from the very beginning to make your data public so we protected patient individual privacy, obviously, but our data as a population as a system.

We shared that and created a kind of a network of shared learning had regular seminars and engagements. Identified team leaders physician leaders to do this on our behalf so I point that out as at least one example I've had in my career time where like minded individuals who felt it was important to do something together at a community level leaders again driving in a green, we can break down barriers we can move past conventions share data and in a way that allows us to learn and engage share best practices. And create a friendly, if you will. Competition about achievement and whoever was getting really great results. What are you doing that we're not doing what can we learn from you and accelerate the pace of improvement so collaboration in that level at a scalable impacting communities is definitely doable. It has to be leaders who are enlightened and willing to take those things on. So again, courageous leadership is always part of the conversation.

MARY NAYLOR
During this last few minutes, I'm wonder if you could kind of reflect on this conversation and any key takeaway messages that you would want to share. Now that you've heard from your other colleagues on the panel.

JANAY QUEEN
So in reflection as folks go and start to do something I think everyone might be anxious to go do something and one of the things that I would offer and reflection is just like sit with it for a moment. Sit with the concepts that were brought to you today because there are multiple levels. We're talking about system change we're talking about practical ways to sort of start a process, but we're also talking about

just our, our how we engage with these notions of anti racist practice or racial equity, what is all of that mean and then look around and take in what's happening in the world just like sit in some silence for a little bit and don't necessarily rush to do something only because this does require a personal reckoning. And then as you are in partnership with others, you won't be able to solve it all my grandmother used to say in a messy room just pick a corner and start. And so you might have to pick a place to start. Pick a person to build a relationship with, take some risks, make some intentional decisions to move forward so that you don't feel stuck because this is overwhelming, y'all. This is not a 50 year solution of 50 year problem that we're solving this is a 400 year problem that we're solving, and it's going to take a heck of a long time to get it right. But we're on a path. So don't be discouraged. Take your time being relationship being community.

MARY NAYLOR
Brilliant.

YENG YANG
Yes, thank you for that. I think for me it's really about taking a moment as JaNay said to really think about what you're really wanting to do but really do a I know that Dr. Washington said, Well, many people kind of do an audit. I don't necessarily think an audit is necessary, but I think an assessment an honest assessment of where you are in the organization and then really kind of pick some low hanging fruits that are easy, particularly if you don't have great leadership support yet. But ultimately, it's really about getting to the leaders and making sure that they hear you and then having making that commitment. And then listening to the people for me would be the greatest thing and then, you know, having looking to other people like Dr. Washington and Dr. Copeland's example. Organizations that have done it. We've, we've made plenty of mistakes you know in our organization and learning from those mistakes that we've made. We've had to step back. I mean, we, I have a very innovative CEO and just really thoughtful CEO, but we've had to like really have some hard conversations and don't be afraid to have those hard conversations is uncomfortable. And if we're not uncomfortable, then we're not making progress. So go and be uncomfortable.

MARY NAYLOR
Love, love, love. Go to your corner and be uncomfortable in your corner. Terrific.

RONALD COPELAND
Well, just that I hope, as I've participated in many of these type of discussion and there's always some new learning that occurs and so I guess my point would be. It's a journey of continuous learning. continuous learning application and going forward and recognize, given the complexity and the challenges that have been outlined and highlighted here today. This is not something that any individual or any leadership team can do on their own. We have dramatic and tremendous demonstration of expertise around the small panel here today. But that's how the world in the field is constructed. There are experts and so many different areas that are part of this journey and available to folks. And so as you go on your maturation journey. As Dr. Washington highlighted and begin small and then build as you get more competency more understanding your needs and the complexity, you take on will change and Be aware that other folks that are have been on that journey they have something to share with you to make it available. So find the individuals find the communities of practice and become a part of them to accelerate your pace of learning and improvement.

MARY NAYLOR
Terrific, thank you so much. And now, Ella, you started us all with this I roadmap journey. I'm wondering if you now can reflect on what you've heard today, and any final words for our attendees.

ELLA F. WASHINGTON
Oh, absolutely. First, thank you to my co panelists for all that you share. I certainly learned some things today. So when I have my research hat on. It's very exciting to see all the different ways that this journey has manifested in your organization's you know what the other panelists have she has shared have been great in terms of kind of final thoughts on one thing I would say is stay the course. As Dr. Queen said, you know, this work is not a 50 year problem. It's a 400 year problem. And with that, we can't just pick up our

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

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

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

So each of the four action collaborative says specific principles that are organized around the 10 categories that you see listed here. The dashboard indicators, we're going to be discussing are going to help us understand how effective the broader field is in achieving the needed change and overall goal of the action collaborative these principles guide the overall work we do, and they're going to inform how we approach our projects in our partnerships and we hope that everyone who is involved in the collaborative and whose goals align with ours will share these principles in their work and we're going to work with organizations on implementation of these principles. Next slide.

Now each of the four action collaborative are in the process of identifying dashboard indicators and work is underway to determine how these measures will be disseminated and use by the field. The initial audience for all this is members of the leadership consortium national leaders in health in healthcare and biomedical science and we hope to have a wider audience in coming years. Now, one way to use these indicators is to publish the progress made from year to year identifying any changes or noting a lack of progress that might indicate a need for a more focused effort. At this point, we are not proposing any collection of new data.

So in this session, we're going to discuss ongoing efforts to identify three indicators that show progress towards the goal of our collaborative that is advancing a culture of health equity and engagement that places the needs of people and communities at its core. We're applying the following criteria to indicators drawn from nationally collected data again to identify three measures that are for the best indication of progress drawn from nationally collected data. Now, next slide please.

We pull together a panel of invited experts in state and national survey measurement in quality measurement policy change and patient and community engagement. The idea was to review a draft list of potential indicators and begin the process of narrowing down potential indicators to just three. We ultimately were able to narrow down a long list to the following four, which you see on the screen here, which we felt best met you identified criteria. Now the first two of these indicators were selected because we realized an individual self assessment of their own state of health and well being, is important. But we're split on how to best track that, which is why the first two indicators seem so similar. The first indicator goes beyond just physical health to tracking overall well being. And using a tool such as controls ladder from the well being in the nation report, we can get a more holistic sense of how someone is doing

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

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

The third indicator was selected because the group realized that access to health care is an important driver of overall health. And that there are deep disparities in who has that access. So we wanted to make sure there was more sensitive than simply tracking those with health insurance. And we think this major drawn from the National Health Service interview survey is a pretty good proxy.

And finally, the group felt it was important to track an indicator that allowed intervention on a short time span related to overall social needs and impact health. We talked about housing instability as well. But we settled on food insecurity as a good leading indicator of a health related social need that's already being tracked nationally.

The group discussed a number of factors to arrive at this short list of potential indicators. The first point was the value of state and local measurement versus only national level data. The real opportunity to make change can often come at a local level. But the goal of these dashboard indicators is to show progress nationally. The consensus was to pry prioritize indicators that can be rolled up to a national level, which would allow action at multiple levels.

If an indicator reveals why disparities, it could galvanize action at a federal policy making level that can help address some of these gaps and it could help community level, excuse me, community based organizations or other local groups take action at a state or local level. And given the available data about health disparities in the country. It seems important to be able to select indicators that would allow desegregation by race, ethnicity, gender citizenship status language spoken or other characteristics.

So, we discussed the relative value of leading versus lagging indicators for example and indicators such as differences in mortality rates between demographic groups is a good indication of the overall impact of all factors that impact health. However, it's also a clear example of a lagging indicator any reduction in premature death will take a long time to show up in this indicator compared with something like food insecurity, which might be solved relatively quickly. And finally, we realized that there are going to be some trade offs. No indicator is going to measure perfectly the exact thing.

For example, we decided not to suggest tracking health insurance status because having insurance is not necessarily the same thing. As having access to all recommended medical treatment other barriers like co pays lack of paid time off to receive care lack of transportation. Or the high cost of drugs could pose significant barriers that would not be captured by simply tracking percent of uninsured individuals. Next slide please.

So that background, we're going to turn into a brief discussion about these indicators and get participant reactions.

First, we're going to hear from Dr. Nicole Franks, chief quality, quality officer at Emory Emory University Hospital Midtown and an Associate Professor of Emergency Medicine at Emory School of Medicine and a practicing physician.

And then we're going to hear from Dr. Apryl Brown president elect of the Michigan Public Health Association and Associate Professor of Public Health biology at Wayne State Community College and then we're going to have a brief discussion and welcome input from the audience in the Q&A box.

And as you listen to the discussion, please consider the following questions to these measures seem to you to best track national progress towards the goal of the consortium. What are the considerations should we consider and choosing a set of indicators, how could you see these indicators being used and

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

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

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

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

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

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

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

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

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

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

BILL NOVELLI
Thank you very much. Appreciate that you both touched on food insecurity. So that sounds like that's an indicator that you both feel is important and you both also touched on getting a little bit deeper into it, whether it's the quality of food. Food literacy, or what have you. So thank you for that.

Some of these indicators that we have, or self reported. The idea of really needing a holistic indicator that we can track over time, but I wouldn't. I'd like to ask the first question, which is there anything that we're really missing here? Or is there anything that's not being tracked in these indicators that we need to add, and I'll go to Dr Franks first.

NICOLE MARTIN FRANKS
I'll just pivot back to what I mentioned before is really the readiness of the communities have to move towards change and how do we understand how what where they are in terms of empowerment in that is probably going to take drilling into a lot more related to trust experience certainly our history with racism instructional and systematic racism and the impact of those things. So I, I would say readiness is one of the things that we should consider because I think that there are a lot of well intended programs well intended people, but we have to really understand our folks really ready to accept where we need to go or where we'd like them to go and do they actually agree. So that's part of that engagement question.

BILL NOVELLI
Thank you. Thank you, if we can figure out how to do readiness. That's really a good leading indicator. Right.

APRYL BROWN
I must agree and also we have to allow our leaders to understand leaders from different, diverse professions that their field is directly related to the health status of the Community. So, for example, someone in transportation may not realize that task transportation is a public health issue or someone in housing doesn't realize that seem like right now everything is very fragmented. So we have to get our leaders together and educate them on the real definition of health. What is a healthy community. It's not just your hospital system. So we have to get our leaders together and educate them how the excellent performance helps to create a healthy, vibrant community.

BILL NOVELLI
Okay, thank you. We have a question. Power is something that matters to monitor the capacity to navigate and change power dynamics and imbalances is fundamental to advancing inclusive culture and equitable engagement and to achieving health equity goals. How could the collaborative advanced this capacity. Again, this compare this capacity to change power dynamics and how could it be reflected in our national monitoring concept.

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

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

BILL NOVELLI
Yeah. Well, said, You know, I'm really intrigued with this idea of community readiness and I think we're going to have to do some work on that. And I want to thank you both for terrific reactions to these again as a, as I say, these are drafts to be worked on to be made better. So thank you so much. And now I'm going to turn it over to Sandra Hernandez, to introduce the next session of our program.

SANDRA HERNANDEZ
Thank you very much to both of my co chairs for your leadership and putting together what really has been an extraordinary conversation this afternoon. I know all of us anxious to do is open the webinar participants up into this discussion to hear more about how they can partner with us as we move forward in this effort.

Before I introduce our final speaker of for the webinar. I do want to acknowledge our panel. Earlier today, just really how honest. They were and candid, they were about the organizational efforts. Some that are as old as 75 years in the case of Kaiser Permanente and other organizations that are really nascent in this journey. I know that from California Healthcare Foundation perspective, this is work as we work within the delivery system itself to achieve more equitable outcomes. The conversation that we had from the panelists was just profound and enlightening. And so I want to add my congratulations and appreciations for their leadership and for their work and for the conversation, thus far.

Now what I'd like to do is introduce our final speaker of the webinar today Dr Kisha Davis. Dr. Davis is a passionate primary care provider and a community health advocate. She's a family physician by training and she's the vice president of health equity at Aledade working to reduce health disparities in a physician led a CEO across multiple states. Prior to joining Aledade she served as a physician and medical director at CH AI healthcare an integrated Primary Care Center. She's also a Commissioner on the Medicaid and CHIP payment and access Commission. Dr. Davis is going to share some of her thoughts and the themes that have been addressed this far in the webinar. The overall direction in which the field might ought to move, and in particular how the collaborative and leadership as a whole, could begin to accelerate our action in this work. So with that, it's my distinct honor to give it over to Dr. Davis.

KISHA DAVIS
Thank you so much for that kind introduction. I am really just, it's an honor to be here and I want to thank all of the panelists that have gone before me the presentations were really just so insightful and enlightening and a lot of that I'll be taking back to my own organization, you know, and my comments today. I think we'll focus on a few themes. So leadership. I think what we heard a lot today around

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

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

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

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

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

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

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

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

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

You know, we have to create space to learn and be vulnerable. In this country It is not comfortable to talk about race. And I think those of us who are in the field have a higher level of comfort than the folks who are in our organizations and there's often times when people because they don't feel like they have the right word, or they don't know what to say or they don't want to be embarrassed or perceived as racist. So they choose to say nothing. And then they squirrel off and have side conversations and if you're not creating the opportunity and space to be vulnerable and share those perspectives then there's people who are working are going to be working against you because they haven't been included in the vision and to not everybody understands what's going on. And so you really need to, you know, create space for that learning and that vulnerability.

You know, making sure the right people are at the table, making sure that table is diverse and holding people accountable to deliver so often you see people become very passionate about health equity work. We want to do something we want to change the world and that passion doesn't translate into strategy and tactics and defined goals and outcomes and then it starts to fizzle because it feels like you're not getting anywhere and it feels like the problem is too big. And so really being intentional about that.

We heard today about the importance of physician leadership and making sure that they are engaged, especially when we're in healthcare. How are we engaging the clinicians in the care of their patients in the outreach that goes to the community and even, you know, setting the metrics and measures and goals that we are working to working to achieve and really from a high level addressing that bias and cultural competency and really cultural humility. You know, if there's one thing that you can get, you know, is cultural humility. If I can get my staff to understand, you know, my culture is different from your culture and I'm willing to learn what you know what is important to your culture that's the first step and that that really is where we want people to start from and integrating that health equity lens into all aspects of the of the organization.

I'll try to transition here to talk a little bit about research right so we heard a lot about research and you know dashboard goals and you know the collaborative is really this great kind of eating body to think about research and papers and where we where we go and we have a lot of research we have decades of it right. We know that health disparities are a problem. None of us were surprised. When that you know with COVID that it highlighted the disparities that we see between black and brown patients. None of us were surprised that there was increased morbidity and mortality right that could be predicted and yet with all the research that we have, we're still in a situation where we haven't seen meaningful progress. I will say, you know, I was really encouraged to see, you know, we have the things that Kaiser has done to really, you know, in the disparity and hypertension and other organizations have done. But why haven't we seen this across the country.

It takes time, you know, Kaiser said this is a 70 year process to get to this point. So we have the framework, we have the plans. We have the papers. We know it's important. So how do we get from the knowing the research to the doing and the action. And I think, you know, this committee in this collaborative really has the capacity and the capability to hold people accountable. You know, this is a group that convenes people together. And so not just convening them together to say what is the next thing that we are going to research, but what are the folks who are here listening to this, because this is important to you and to your organization. What are you going to commit to do based on the research that we have, you know, when we're thinking about these dashboard metrics which, you know, I think, are certainly the right direction to go. You're getting the right thing, you know, trying to get the leading indicators are they pushing us towards action.

What are we going to do now that we know the rates of food insecurity, what are we going to do now that we know that this population does not see that they have good health. What are the interventions that come from that and how do we make sure that we are addressing that. And not just being voyeurs in a community and saying, oh, wow, well, that it's bad in that community. Look, they don't have, you know, they don't have food their health is poor. What are we going to do with that information. And really using the research and the dashboard to be the thing that drives us forward on that. And I, the last thing I'll say about research is that when we are doing it, not forgetting the folks that we are conducting research on and making sure that they are part of the conversation so when we are looking at community based research and I know that I'm preaching to the choir here, what are the outcomes that are important to the community that we are serving and involving them in that and not just you know swooping in doing studies and leaving, but really I think when we're thinking about health equity and we're thinking about health disparities, the engagement is so much more important.

You know how we turn this this study into not just a, you know, we're going to do this, we're going to study it for a year and then leave. We're going to do this, we're going to study it for a year. We're going to implement it and we're going to change your community based on the results. We didn't talk about this as much today. But you know, I will just kind of bring this up a little bit is around the business case for health equity. You know, I'm not one who likes to talk about the return on investment. And what are the financial incentives for health equity. Because I think that they the return on investment is so much more than dollars and cents. But I also recognize that many of us are in organizations where that dollars and cents is important. And if we are going to invest those people time and talents that I mentioned before that leadership needs to do, then there needs to be some sort of return on investment in that.

And as we're making that case recognizing that that that return on investment does not come in six months a year, two years, that really is an ongoing effort. And so really being strategic and setting those short term and long term goals. On health equity, what can we do now, what can we do today that we are going to see improvements on what are the little things that we can chip away at while not losing sight of what's that big picture and making sure that while we're doing these little things. We are not losing sight of the big problem. It's really easy to get stuck on these, you know, I'm going to do these two, three things and spend my whole career, you know, chipping away at this and then, you know, we still have the whole iceberg. And so it's really and in health disparities, you really have to do both. And how does this small piece fit back into the hole and how are we pushing the whole field forward.

Again, not as much as our of our focus of our conversation today, but something that comes up a lot in my role. You know validated really thinking about value based care is how do we make sure that our care delivery models and the reimbursements that go with that are. Are they incentivizing or dis incentivizing work on equity and making sure that we that work is getting to vulnerable populations that we are not excluding providers that are caring for communities of color and caring for her vulnerable populations from the ability to participate in those programs that really can be beneficial in terms of reimbursements for them.

And, you know, wrap up with just a few kind of challenges to the group and I think, you know, this is a great time to really be having this conversation, you know, as we look at the, you know, events of the past year feels like you know the murders of George Floyd, Breonna Taylor, Ahmaud Arbery, all that happened this year, laid on top of the you know coronavirus pandemic really has just brought things to a head in a way that hasn't been that we haven't had before. And I think folks who have been in health disparity work and been doing it for years and years. It's kind of like, yeah, we knew that we've been here. We've been, you know, yelling into the wind for years to say this is important.

And now's the time that we have kind of the attention of the of the country to really move that forward and, you know, as we look the new administration, the Biden Harris administration, you know, they've appointed already Dr. Marcella Nunez Smith is the head of the task force and health equity. And so how can we, you know, work with that group. Hold that group accountable to really, you know, pushing the conversation forward on health equity. I think this collaborative this collective is really a base of accountability work should be a space of accountability.

Who was tackling this work you know i really challenge all of you that as your, you know, after listening to this conversation. And going back to your own organizations to sit down and you know as Dr. Queen mentioned, you know, sit with it. Don't just jump in and do something everybody wants to do something sit with it, reflect on it. And then say, Okay, what do we have the capacity to change. What is the most anti racist thing that we can do now in our, in our organization and Let's commit to some accountability, you know, can we send that back into the collaborative, what are the folks on this call going to commit to do to make a difference. What's that goal and make it measurable. Make it smart make it timely. And then I do want to address the question that we had at the end around, you know, the capacity to change power dynamics and I really appreciate the comments that were made at the end on, you know how to start at the bottom and whatever seat you are in, you know, whether that's your, you know, local PTA or church group, you know that you have the capacity to elevate the discussion.

You know, in working that up, you know, school boards and state legislators, I would also encourage the leaders on the call to think about your capacity to change the power dynamics. When you are thinking about who should be in the room or, you know, especially if you are someone who's Caucasian at the top and you are excited and interested in this work. Who are you pulling up so that they could be qualified to sit in your seat. You know, I will say, just thinking about my own career. There have been I have had several white men mentors who were very intentional about making sure I was in the right room for conversations so that that could elevate my career.

And, you know, as you are looking at the field of people who may come to succeed you is that a diverse field. And if it's not, why not and how can you make it that way. And with that, I you know I will wrap up, I just want to say this was really, you know, an awesome opportunity to be a part of. I think there's so many opportunities here and directions to take and really want to urge us forward to action. And so with that, I will hand it back over.

SANDRA HERNANDEZ
Thank you, Dr. Davis really appreciate your, your concluding thoughts here in summation, on struck that as we talk about changing culture that many of us hold the concept of culture in very different ways. Fundamentally, it's how people behave on a consistent basis and what are the programs and processes that support that and leadership has been a theme through the entire webinar. I think all of our speakers, thus far have mentioned it. And I wonder if any of you would like to talk about the importance of white allies. All of us on this panel as leaders recognize that, whether it's working to change governing structure of the board or whether it's diversifying a management team. That, in addition to voices absent. We have seen and heard today, we also need to be able to confront people who themselves are white and are in positions of power and maybe our ambivalent are, you know, guilt ridden whatever the terminology is. And I wonder if several of you would be willing to comment on examples how to bring a long white allies in this journey. As important as is to lift up all of these voices in the organizations that we are changing our people, whether they're in middle management or an executive leadership sweeps who by relationship need to be brought along. And I wonder if you Dr. Davis, or any of our panelists previously would like to comment on that.

KISHA DAVIS
Yeah, that's a great point. I just real quick and then hand it over a, you know, thinking about how to take some of the edge off. And I think the fear off from the folks who are sitting in that sweet so they I find are hesitant so often want to do something, but don't know what don't know what to say or, you know, some are just ambivalent and don't even realize that they that they have the blinders on. And I think it's that they're continuing to approach and engage and having conversations so that you are being seen as, oh yeah, they're qualified, they have this, I think, you know, being on the other side of that I think we always people of color feel that burden of trying to be the one who is educating people and being that non-threatening black person so that I can, you know, push the conversation along. And I think that's something that we probably just need to move past and get over and you just have to be the person in the room and be willing to, you know, call people out and saying, See me, I'm here. You know, let's have a conversation about it. And I think, you know, having some of those uncomfortable conversations are the only thing that's really going to move us forward.

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

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

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

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

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

SANDRA HERNANDEZ
Well said. Thank you. What I want to do now is turn to questions from our participants. How do we create establish and implement this work at the state and county level from a public health point of view. How do we advance public health in private partnerships and collaborative.

APRYL BROWN
Okay, um, she said, how it is episode first have patience, because it's going to be. It's going to take patience. I've been with the Michigan Public Health Association for about 10 years. And so I've seen things evolve. So I would have to say. Part one partnership at a time or either start with a few partnerships at a time, have a successful event or something that's showing partnership and showing health equity being promoted in the community and then just continuing to allow it to grow. So the partnerships that I have part of it took time for it to evolve. But yeah, just say one successful step at a time and then allow it to grow and then eventually, everybody wants to everybody, but many people will want to join us something that seems to be working.

YENG YANG
Yeah, you know, I, I would echo the same thing in that the work that we've done at Hill partners in Minneapolis and St. Paul here is that we've created a lot of different partnerships throughout the community and you want to find community partners that will continue to be with you for the long haul, rather than I wanted to do this for this year because there's equity, you know, initiative of the to we've partnered with both public and private organizations to form different organizations like the little moments counter example is an organization that promotes early brain development in children and that’s a collaborative between the state of Minnesota that the Minnesota Department of Health, as well as many other Oregon healthcare organization and you know, these partnerships, you really have to create rules right around what's the contribution for each of the organization. What is our goals and really kind of define it as a Chartered Organization to create some common metrics that you're going to work towards. So, you know, that's really how you can get that to out into the community and have a sustainable organization and community based partnership and then continue to grow from there. So we have like several partnerships with business collaborative across the city of St. Paul based on those shared goals and share commitment.

SANDRA HERNANDEZ
Great.

How will the culture of inclusion include individuals with disabilities.

JANAY QUEEN
I can. I'm happy to just start it. One. An activist says anti blackness is the fulcrum. That makes racism work. And when we start to deal with the route that some of the deepest, most severe issues. Everyone begins to benefit. Angela Glover black wall also has the curb cut effect and she's a beautiful story about disability justice and creating the carpets that we all sort of walk on. We like to think about it. But those were created. They didn't exist. And they were created to support people who didn't have access, but now we all use it. We don't even think about it benefited us all and that's why we have to get to the root cause. We have to. We got to talk about anti racist behavior, we have to talk about anti blackness. We have to talk about the isms that plague us because if we do we actually are all better off, but we have to believe that that's possible. And we can't buy into the zero sum game anymore.

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

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

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

SANDRA HERNANDEZ
Yeah, I think that's an important takeaway and your remarks earlier. Dr. Copeland in your example on hypertension. If you don't disaggregate data or you don't know what problems you are missing. And what opportunities for solving them might be. So I really appreciate that. And just to note on the example the generic gave the work on ADA and the Americans with Disability Act. Was an effort that came out of community activism and community participation with a number of philanthropic organizations supporting the work of organizations that ultimately pass that policy.

In this example, a question around disabilities. But in general, how important it is to support the work of community activism in creating policies that serve the benefit of folks who might not otherwise have a good access, whether it's to street corners or health care. Or maybe this is the last question, given the time we have left and I would ask me be everybody and take a shot at it because it really does speak to the heart of the conversation we've been having today.

Have you created a dashboard for measuring progress for healthcare organizations practitioners on the DEI front. For example, to what degree have healthcare organizations been trained on the class standards and what progress, are they making on adherence. So we're back to the question really of measurement.

YENG YANG
Sure. So that is a really great question. And I think that that has become you know the goal of much of, you know, many organizations. We're maturing in this journey. Right. So one of the things that you know, in addition to the patient outcome metrics that we have. We are developing this dashboard to measure our internal progress. Like, for example, we're going to be using, you know, patient experience as a kind of a proxy measurement for trust building relationship between patient and clinicians as an outcome of the clinician. Specific curriculum training that we are going to be deploying. And so that's one thing. The

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

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

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

Sandra Hernandez
Okay, so let me do this, then maybe just to summarize What we heard today is we before we give this over to Michael though, I would ask all of our meeting participants to do as our panelists have suggested, which is to stop step back, reflect on where you are and how your organization can take action on the things we discussed here today.

It's something that the NAM team will summarize and aggregate and I think it will help us think about our next steps as a leadership consortium and so we know that many of you are participating on the webinar are well into this journey and we want to make sure we are able to aggregate that information and understand it better. So I would invite you to do that what we heard today so important start with leadership, very important for everyone to take stock of where they are.

How important it is to start somewhere to recognize this is a very long journey and that to be uncomfortable means we're working in the place that is important to work. There are many, many, many disparities that exist in our community. And I think one of the takeaway messages here is that all of our organizations, regardless of where we stand with them. What kind of organizations they are have an important role to play in getting community participation and inclusiveness into a more equitable Health care system be in public health or health care delivery. So I going to hand it over to Michael I do want to thank all of our extraordinary panelists today. Again, an honest candid provocative. informative presentation. And again, appreciate my co chairs. So with that, I'll give it over to you, Michael.

Michael McGinnis
Thank you very much Sandra and thanks also to obviously to Bill and Mary for presenting over what an extraordinary and inspiring conversation we've been part of today. I will make my closing comments pretty brief, but I do have some things I'd like to touch on briefly. And I'll start in many ways, prompted by Dr.

Davis's reference to a cultural humility and in many ways that the dominant takeaways for me are humility and guilt and I mean that in the following sense humility because we've heard from such an extraordinarily insightful enlightened and wise set of commenters about the most important issue that's confronting our nation today.

That one can't be anything but humble in the presence of these kinds of observations in this inspiration, the guilt comes from the fact, not just because I have Irish Catholic roots in this household history there but it comes from the fact that we couldn't have 300 million people listening in and participating in this conversation Because, for obvious reasons The, the range of issues touched very constructively and very, very productively and again I'll use the word again inspirationally In a three hour period was simply phenomenal. So I feel it's a tremendous privilege and it's a privilege that I wish we could share and will try to share Over and over again in the, in the time ahead we heard important insights about our internal strategy. So within our own organizations clearly leadership was emphasized, time and time again listening as a fundamental obligation.

Bringing head and heart to the task. The notion of personal journeys and revealing personal journeys to each other as insight and inspiration and the issue of benchmarking benchmarks that will be particular to a particular organization, all of them themes that we will be taking to our own organizations to help advance our stretch strategies in that respect from an economic perspective. We heard similar things leadership again very important from all aspects of the leadership of society to place a priority, the importance of stories we need to do better in terms of making where we don't have the head and the heart at that’s prompted by our knowledge direct knowledge of individuals who are neighbors and coworkers.

We need to bring home the realities as effectively as we can and where we can't use stories we have to use measures and that's why, again, we're so appreciative of the kinds of measures that were discussed today. And that's an ongoing quest, obviously.

A couple of folks referenced the importance of accountability and for the National Academy medicine to be contributing on the accountability front and that's our aim in our work around measures where, oh, and there were interesting suggestions around social isolation around food insecurity around well being. Around housing insecurity. Also, the notion of readiness of individuals of organizations and communities as an important measurement challenge. All in all, we have a not only a strong foundation as a result of this conversation to move forward on.

But we have a new set of partnerships with each of you and with your colleagues around the country to move forward on we view this as an action oriented journey. And we're looking forward to your ongoing counsel in that respect. So I want to wrap up again with a note of thanks, not only two or three co chairs who've been extraordinary.

But to each of you who have been panelists and for your leadership to us today as well as the leadership that you're providing throughout the nation. Beyond Today and to those of you who tuned in. The 900 or so throughout the course of the meeting, who will be our ongoing ambassadors and change agents. This is a snowball effort that we have to take advantage of in any possible way. And finally, of course, I want to give special thanks to our staff. Meanwhile, enjoy. Stay safe and be well thank you