

**CMS OMH The Road to Equity: Examining Structural Racism in Health Care
Virtual Forum**

April 28, 2021

Hello, everyone, and welcome to day 2 of our forum, "The Road to Equity: Examining Structural Racism in Health Care Virtual Forum." Yesterday, we heard from CMS's Acting Administrator Liz Richter who underlined the importance of examining structural barrier across health programs and the work CMS touches. She spoke about opportunities to examine racism in healthcare through the intentions of recent White House executive orders, CMS orders around the special enrollment period, affordability and accessibility to COVID-19 vaccines for all Medicare population, maternal healthcare and Medicaid, and called upon us to not only work with one another but to listen to one another. She also challenged our forum attendees to continue in efforts to confront and eliminate structural racism in healthcare. Now we'll hear from Dr. LaShawn McIver, Director of the Centers for Medicare and Medicaid Services Office of Minority Health to welcome our participants and offer a recap of day 1. Please note this is a prerecorded video, and the video audio will play through your computer speakers. You may need to adjust the volume on your computers in order to listen.

Hello, everyone, and welcome to our forum today. I would like to thank you all for attending. I'm Dr. LaShawn McIver, Director of the Centers for Medicare and Medicaid Services Office of Minority Health for CMS. Today is the second day of our forum. Throughout these 2 days, we are joined by nearly 1,000 people across the country including representatives from 100 different organizations which includes equity thought leaders, nurses, doctors, researchers, government, and private industry representatives. We have people joining us again today from cities such as Seattle, New York, Chicago, across different parts of rural America totaling representation from 30 states.

CMS OMH understands the importance of equity and strives to provide equitable solutions to all of the populations that we serve. We know that structural barriers impact racial and ethnic groups differently and that these inequities can impact different aspects of life such as housing, education, wealth, employment, transportation. All of these things can influence a person's health. Yesterday and today, we have begun to address how we as a collective and we at CMS can continue to work to break down these barriers and to help everyone achieve their highest level of health.

Before we begin today's session, I wanted to provide a short recap of the first day of the forum. Yesterday, we heard from speakers of the U.S. Department of Health and Human Services, the American Medical Association, Health Equity Solutions, the Centers for Medicare and Medicaid Services, the American Hospital Association, the Commonwealth Fund and from an entire team at the Jamaica Hospital Medical Center.

In our first session, we discussed barriers to care and also talked about how COVID-19 has exacerbated existing disparity. We also had a session on the value and importance of collecting and examining standardized patient data. In our final session, we discussed how to integrate equity solutions across health program and health systems.

On day 1, our speakers outlined an urgent need to address structural barriers relating to racism in healthcare and achievable in an equitable healthcare system. Repeatedly, we see worse health outcomes, lower rates of care and vaccination whether COVID-19 rates, vaccination rates overall or patient experience outcome. We heard from HHS leadership that structural racism in healthcare is rooted in historical injustices, but it is not all in the past. We also heard that as a collective group, we have to show up. We have to listen, and we have to learn. Reducing structural barriers will take ongoing and evolving strategies. Dr. Everette from Health Equity Solutions echoed the sentiment as she called the path to eliminate racism an active process and practice.

Today, we're pleased to welcome speakers from the Centers for Medicare and Medicaid Services, the National Rural Health Association, BlackDoctors.org, the U.S. Department of Health and Human Services, the Black Coalition Against COVID-19, the Association of Asian Pacific Community Health Organizations, the US Food and Drug Administration, the National Institutes of Health, the CDC Foundation and the Kaiser Family Foundation. In our first session, we will discuss the accessibility of culturally and linguistically appropriate health-literate care as well as how to identify and eliminate barriers. Our second session will cover the disproportionate impact COVID-19 has had on disparities, and finally, our third session, we will host a panel to identify and implement solutions to promoting health equity. I look forward to today's discussions and would like to thank all of our presenters for their time and invaluable insights on this topic. Thank you.

Thank you, all. So now we will take a quick break until our first session begins, so our first session will be Implementing and Improving Access to Health Care Services for Coverage. We ask that you all please remain on the line, and we will begin session at around 1:15.

Session 1: Increasing and Improving Access to Health Care Services and Coverage

Thank you, all. We will now begin our first session for this afternoon, Increasing and Improving Access to Health Care Services and Coverage. During this session, we are pleased to have Darci Graves from the Office of Minority Health at CMS, Amy Elizondo from the National Rural Health Association, Reginald Ware from BlackDoctor.org and Dr. Nancy Fisher provide insights on the accessibility of culturally and linguistically appropriate health-literate care as well as how to identify and eliminate barriers.

As a reminder, there will be time for questions following the presentation. We will address as many questions as time allows. You may submit your questions via the chat box at any time to be read aloud. Please note that members of the press should direct all questions to press@cms.hhs.gov. A recording of the virtual forum will be posted on the CMS OMH All Webinar and Events web page following this event. A link to that web page will be shared momentarily via the chat box. Next slide, please.

Our first speaker is Darci Graves. Ms. Graves, you may begin.

Thank you so much. Good afternoon to everyone joining us here in the Eastern and Central time zones. Good morning to those who are joining us from further west, and happy tomorrow if anyone is daring enough to be joining us in the wee hours from our Pacific territories. My name is Darci Graves, and

I am with the CMS Office of Minority Health. It is an honor to be here with you today speaking to you all about the importance of increasing and improving access through CLAS, our culturally and linguistically appropriate services. However, before I get started, next slide, please, I feel that I would be remiss if in talking about CLAS and structural racism if I didn't first acknowledge that I am presenting from the tribal lands of the Susquehannock, Nentago and Piscataway lands. Next slide, please.

As noted in the title of this forum and the great presentations from yesterday, we are examining structural racism in healthcare. When we look through the lens of systemic oppression, we see the layers of oppression and racism and subsequently the places we need to intervene and make changes, individual, interpersonal, institutional and structural layers which make up these individual and systemic places where change must occur, and as we are intervening, we have questions we need to be asking.

How are people talking about the problem they are trying to solve? Who are the people affected by the current inequity being discussed, and are they at the table? What are the specific disparities and inequities we are seeking to eliminate? How do we understand the forces behind the inequity we see? What forces are perpetuating the disparities we seek to address? What barriers are in the way of achieving equitable outcomes, and how do we make room for different cultural constructions of leadership and problem-solving?

While we are focused on health and health care today, next slide, please, we know all too well that these levels of oppression and in this instance racism are also pervasive in other areas of what we frequently end up referring to as social determinants of health, including but not limited to banking, housing, criminal justice and education, and as we look onto the next slide, and we can look closer within another framework of the social determinants of health, and we see what pieces of the healthcare system we can influence.

We see health coverage, provider availability, quality of care and the provision of CLAS. In my remaining time today, I want to really focus on that CLAS and quality pieces and what we can do and what it might look like. Next slide, please.

I was happy to see Dr. Sivashanker yesterday bring this topic up and to underscore that we cannot have quality care that is inequitable. For those who may not have been able to join us yesterday, let me set these up a bit. These 6 domains of quality were first published by the then Institute of Medicine in their Crossing the Quality Chasm report 20 years ago, but I like to invoke these because these are the terms and values we talk about in health and healthcare every day: safety, effectiveness, efficiency, and I would argue that we're not able to achieve any of these without ensuring that they are culturally and linguistically appropriate.

Things cannot be safe nor effective if the patient and their family cannot understand their diagnosis or discharge instructions because they weren't provided in a language they understand. Things cannot be timely nor efficient if you don't have a process in place to provide services that are tailored to the populations you are serving, and things can certainly not be patient-centered nor equitable if cultural beliefs and practices are not taken into account. So when we talk about CLAS, what do we mean? Next slide, please.

This is the definition of CLAS used in the HHS Office of Minority Health's National Standards for Culturally and Linguistically Appropriate Services in health and health care, more commonly known as the National CLAS Standards, and I have a particular affinity for this definition because it discusses so many of the things that I think are important such as being respectful and responsive.

It takes into account individual cultural health beliefs and practices, preferred languages, health literacy levels and communication needs. It calls upon every member of an organization to play a part and that CLAS needs to be present at every point of contact, and I want to pause here for a minute because I think this is sometimes where the forest gets lost with the trees.

When we talk about CLAS or we think about CLAS, we frequently think about, you know, and we're simultaneously talking about the patient experience, we think about those 7 to 9 minutes in the exam room with the doctor that any of us who have been patients or caregivers know that the patient experience is so much more than that. You have to have health insurance. You have to find a provider on your insurance plan. You have to call and make an appointment. You have to drive or take public transportation to get to your appointment. You have to figure out where to park or where the bus stop is. You have to find the front door of the building, check in with security or figure out where your doctor's office is within the larger complex. Then you fill out, you know, a pile of paperwork or enter things into a tablet, and then you're checked in, and you have your vitals done, and then you see your doctor.

Then in all likelihood you get to do almost all of those things in reverse and possibly navigate a pharmacy, a laboratory, testing facility, therapy, and the list goes on, and all of those points of contact need to be culturally and linguistically appropriate for if the attendant in the parking lot doesn't know how to work with someone, you know, what to do when someone speaks ASL, that may be an issue. The security guard needs to know how to contact interpreter services, and a clinic and office needs to know if gender concordance is appropriate or necessary for particular patients and families. Next slide, please.

All of those examples happen to be at the individual and interpersonal levels of the socioecological model, but in order for there to be CLAS there, we also need CLAS to be present at the organizational, community and policy levels. CLAS needs to happen from the top down and the bottom up and not simply siloed with 1 or 2 individuals somewhere in the middle. CLAS by no means is a panacea for racism nor other types of oppression, but it is a tool to help us look at all of these areas and root out the oppression and identify ways to make things more inclusive and hopefully antiracist. Next slide, please.

So I've spoken quite a bit about culture and culturally and linguistically appropriate services, and typically when we talk about culture, you know, we ask questions like, well, what is it? What is your culture? How do you identify? And all of these questions are important because we know based on yesterday's data conversations that self-reported data is critical, but we have to be careful that we don't inadvertently 'other' the person or the

people that we're speaking to when we ask these questions, and we always have to remember that asking about culture isn't a box-checking exercise.

I want you to think about and consider how culture is an experience, how their culture is lived because as Dr. Everette said yesterday, one's race isn't the issue. Racism is the issue, and that is how that aspect of culture is sometimes experienced, and a lot of times when we're talking about culture, about all of the things in this Venn diagram, it is in terms of the other, but the fact is every one of us has all of these elements as part of our identity, and they aren't singular identities. I cannot tease apart the fact that I am a straight cisgendered woman from the fact that I am white from the fact that I grew up in the Midwest. All of those elements inform how I perceive and receive the world around me, and the same is true for our patients, our beneficiaries and their families and caregivers, and that is one of the many reasons why, next slide, please, that I am so happy to work in an office such as the CMS Office of Minority Health where our focus for priority populations include a number of the circles you saw in the previous slide's Venn diagram.

All of our focus populations face disproportionate burdens and health disparities which is why we focus our health equity lens there, but we want all individuals served by CMS and our partners to attain their highest level of health and wellbeing. Next slide, please.

This slide shows just a few of the many activities our office has undertaken to help achieve health equity including our From Coverage to Care initiative which is an initiative to help individuals understand their healthcare coverage and connect to primary care and the preventative services that right for them, many of the resources of which have been translated into multiple languages. Our Disparities Impact Statement which is a tool that can be used by all healthcare stakeholders to achieve health equity for racial and ethnic minorities, people with disabilities, sexual and gender minorities, individuals with limited English proficiency and rural population, and you'll see on this list a number of other resources that are intended to help organizations in more culturally and linguistically appropriate, more effective, accessible, safe, patient-centered and of course equitable.

How do we undertake this work? We follow the health equity framework Dr. McIver highlighted yesterday, identifying an increasing awareness of disparities because if you can't measure it, you can't make it better, and you can't see your progress. Develop and disseminate solutions to address the disparities and establish long-lasting, sustainable actions to mitigate them going forward. When we ask the questions that I raised earlier when we're talking about how do we address oppression, and how do we eliminate the disparities we're seeking to do? We seek to understand the forces behind the inequities we see. We strive to identify barriers that are in the way of achieving equitable outcomes. We think about our work as leaders for equity in cultivating new health equity champions and of course by always following the principle of nothing about us without us. Underserved communities are the experts on their communities, and we must listen before we plan, and we must engage before we act. Making things more culturally and linguistically appropriate will help us better serve our communities, empower them to make the decisions that are right for them and help us to set our sights on the undoing of so much structural racism. Thank you again for being here today, and with that, I will turn things back over to our moderator.

Great. Thank you so much, Ms. Graves. Can we have the next slide, please?

Great. Next, we are pleased to introduce by Amy Elizondo, Vice President of Program Services for the National Rural Health Association. Amy, you may begin.

Thank you for having me. My name is Amy Elizondo, and I do serve as the Vice President, as was mentioned, for the National Rural Health Association focusing on our programming and initiatives for the organization. Today I'd like to just give an overview of the rural health perspective, some challenges and opportunities as it relates to the topic at hand. Next slide.

A quick in brief who we are, we're a national membership organization with more than 21,000 members across the country with a mission to provide leadership on rural health issues through advocacy, communications, education, and research. Next slide.

We work to improve the health of the 62 million who choose to call rural America home, and we are nonprofit and nonpartisan. Next slide.

And this is just a quick snapshot of our membership around the country. We are mostly comprised of rural healthcare providers, critical access hospital representatives, rural health clinics, rural community health centers around the country, rural physicians, nurses, allied health professionals and other rural health stakeholders. We also have 43 state rural health associations around the country. Next slide.

Our priorities as an organization in terms of policy and what we advocate on is addressing rural declining life expectancy and trying to achieve rural health equity, working to reduce the rural healthcare workforce shortage that does plague rural America and investing in a strong rural safety net. Next slide.

Rural health challenges, next slide, to give you an overview sort of how rural America is currently combatting various issues, we do see a high rate of workforce shortages, a lack of primary care practicing professionals in rural areas, very vulnerable populations from issues related to chronic diseases as well as poverty also plaguing rural America. Next slide.

Workforce shortages, as I mentioned, there's primary care professional shortages across the country. 6,000 areas in the US are considered primary care shortage areas, and 4,300 areas are dental health shortage areas as you can see from the map here and another 3,500 are short of mental health shortage areas as well, so basic access to care is a challenge as well as some of the more specific care needed for rural areas. Next slide.

We do see a high prevalence of Medicare patients with 6 or more chronic diseases. This doesn't include the pandemic and the impact of that. As well, note that we do know that the pandemic exacerbated and made these folks more vulnerable to acquiring COVID-19 as well due to the vulnerability of having some of these chronic conditions. Next slide.

We do know from data that rural has an older, sicker and poorer population. The median age of adults living in rural areas is greater than those in urban at 51 years. 18.4% of rural residents are 65 and over compared to the

14.5% in urban, and rural areas have higher rates of several health risk factors as I indicated earlier related to obesity, diabetes and smoking. Next slide.

We also see high rural cancer death rates in rural areas compared to urban areas, and while overall cancer incidence rates were somewhat lower in rural areas, incidence rates were higher in rural areas for several cancers that are indicated there, such as lung cancer and those that can be prevented by screening.

While rural areas do have a lower incidence of cancer than urban areas, they also have higher cancer death rates, and the differences in death rates between rural and urban areas are increasing over time. We still don't know what impact the pandemic had, but we do know that folks delayed screening, so we do expect to see further increasing in this area. Next slide.

In rural mortality rates, we do see the death rate gap between urban and rural America continuing to get wider due to the leading causes of death listed here, and it is tied to income and geography. We do see for minorities, especially Native Americans, dying consistently prematurely nationwide, but more pronounced in rural areas, and then a startling increase in mortality of white rural women due to risky lifestyle for smoking, alcohol abuse, the opioid abuse and obesity as well as environmental cancer causes and suicide. Next slide.

And poverty in rural America is a striking feature here as well. You do see that nationally, rural households had lower medium household incomes as indicated here, and 14.7% of rural population is below the federal poverty line, further compromising much of their access to health care. Next slide.

For rural housing, here's some trends that we also see in terms of affordability issues, and I know Darcy alluded to this in one of her slides as well, just in terms of affordability and what we've seen over the last 40 years, just how this is increasing, especially for rural communities, and sort of where we see it vulnerable in Appalachia, the Delta South further highlighted there and how that has been exacerbated over the years. Next slide.

The opioid crisis, which did not go away in the middle of the pandemic, again still seeing highest in states with large rural populations as well as related overdose deaths in the non-metro counties, and it is 45% higher in rural areas than in urban areas. Next slide.

Overall, access to health care in rural America during COVID was further compromised with the pandemic, so just further brought out the vulnerability of the rural health safety net. We've seen that thousands of health care workers have been furloughed or laid off, and overall that rural providers are becoming increasingly financially vulnerable as the pandemic continues to impact rural communities, and we've been working hard with Congress and the administration to make sure that rural providers are not left behind. We've seen a lot of relief brought in recent legislation to help circumvent that, but obviously a lot of work continues to be needed to further continue addressing the crisis of the pandemic for rural communities. Next slide.

Prior to the pandemic, we did have sort of -- These are the numbers for the rural health safety net in terms of the total number of Federally Qualified

Community Health Centers, which serves 1 in 5 rural residents. We have 45 rural health clinics around the country, 1,300 critical access hospitals and 500 rural prospective payment hospitals. Next slide.

Again, with the workforce shortages, we've seen that only 9% of physicians practice in rural America. 77% of the over 2,000 rural counties again are health professional shortage areas, and more than 50% of rural patients have to go over 60 miles to receive specialty care. Next slide.

Pre-COVID-19, we were already seeing a rural hospital closure crisis, again further highlighting the vulnerability of many providers in rural communities. We saw 20 closures in 2020, and we've already seen some in this current year with the pandemic, and so again we were already working with a fragile infrastructure for rural America, and once COVID hit, we have had great concerns about how this is going to further impact them going forward. Next slide.

And then, just in summary, this graphic further highlights what I said about the overall characteristics and impacts that we're seeing for rural America that we have seen over time, just that they're older, less healthy, less affluent, and they do have limited access to multiple types of care. Next slide.

And with COVID, you know, there was a lot of, initially with the early warning signs of the pandemic hitting the United States, we did see it in some of the urban areas, so we knew that it wouldn't be long before it would make it to some of these rural communities around the country, and we did see that kind of snowballing rapidly as things began to increase around the country, and while rates have been holding steady, again we've seen some increases in someone rural areas, especially after the uptick after spring break. Next slide.

We're also currently working to deal with vaccine distribution, again trying to ensure equal distribution now that there is more availability and making it open to more of the population. We are seeing a lot of hesitancy and trying to address that specifically for rural America, working on a national strategy for the response and pandemic preparedness, but overall just working to protect those most at risk and trying to advance equity and ensure that it is across racial, ethnic and rural-urban lines, and we have been working closely with CDC to share the data that we have, what we're hearing from those boots on the ground and as well as by county on how it is playing out for rural areas, as well as working with the HHS COVID-19 Community Corps that was created. We've been working closely on those campaigns as well as various coalitions working to address vaccine uptake for rural communities. Next slide.

The NRHA strategy for rural vaccine uptake. We are working again with various groups to try to promote the benefit of the vaccine for rural America and increasing rural residents' confidence in the vaccine, and we believe that there are 3 key sectors for helping to address that. That includes rural health care leaders. We find that rural communities, as we know, it's very important to know your audience. We know that outsiders coming in, telling folks to get this vaccine, celebrities often times did not resonate with rural communities. They want to hear from people they know, people they grew up with, people they trust, so we're working with rural health care leaders to help with messaging for outreach to other folks

in the community, mainly looking at rural health care providers, those in rural health clinics, rural hospitals.

There's a heavy reliance on community health workers, as we know that they are very trusted members in their communities, and they are also helping with translation, with culturally appropriate education and information sharing, which is very key for these communities, and helping with things like access to a vaccine site and transportation, as well as just linkages to basic information. Another key sector are rural faith leaders. We have learned and we've heard from rural communities that the choice to get a vaccine is a personal and emotional one, and so with that, we are looking to continue to work and collaborate with rural faith-based organizations in rural communities to help with the outreach to congregations, especially with diversity of congregations to help further provide education and debunk myths around the vaccine.

And then lastly, another key sector are the rural agricultural leaders. We know that farmers and ranchers serve as an integral part of the rural economy, and they have been strong proponents of science around the vaccines, and so we are working with various groups to work with them as well to provide messaging to encourage rural communities to also get vaccinated to further help with circumventing the pandemic in these areas. Next slide.

So these are just some COVID resources that we have within our website for those that are interested later on and want to keep these in a slide, but we do have a COVID-19 Rural Technical Assistance Center with a list of information and resources by state for those that would like information on toolkits, other curriculum and the like and just basic contacts that are helpful. Next slide.

The opportunities: While I have highlighted a lot of challenges, there has been great opportunity, as with every great, you know, hurdle that we're trying to climb, we're looking for triumph and trying to use this opportunity to meet this moment, to make things better for rural America. Next slide.

We're working on a framework to achieve health equity that has long been in place with NRHA, but these are the 8 points that we've been working to highlight as an organization to further make health equity a priority for rural America, to have an equal, even playing field with other communities and urban counterparts, strengthening the role of leadership, engaging communities through humble inquiry and supporting data infrastructures, tackling the tough issues as an organization and making health equity part of our standard operating procedures, creating program and policy sustainability, and developing a robust pipeline. Next slide.

In addressing each of these points, we've had for more than 27 years, we've conducted the National Rural Health Equity Conference, the only one of its kind in the nation that focuses on health equity issues specific for rural America. We'll actually be hosting this conference next Tuesday virtually. I'm gearing up for that, but have a lot of content around various community organizations that are addressing health equity issues at the rural community level.

Strengthening the role of leadership is very key here for addressing health equity, we believe for rural areas. We launched several years ago the Rural Leadership Foundation to further help champion rural leadership resources and leaders within rural communities. This is one of the main areas that rural communities lack, is access to research, education, policies that would help them further elevate their leadership skills.

Engaging communities through humble inquiry: We don't just collaborate with the broad spectrum of rural health care interests. We are the broad spectrum. We represent every aspect of rural health care across the country. Next slide.

We also look and work hard to support data infrastructure and analysis. We quarterly publish the Journal of Rural Health, the only one of its kind, and we do partner on the All of Us Research Program collaboration that is funded by the National Institutes of Health to make sure that rural communities and rural subjects are included in rural research to further enhance access to care for rural communities, and we also work to tackle the tough issues.

We did issue a statement condemning racism last year, and over the years have again made sure that there are policy and legislations that again circumvent racism and try to, again, further decrease what is harming rural communities when it comes to barriers to infrastructure. Next slide.

And we have been working to make health equity part of our standard operating procedures. We've long had a track record of advancing policy and systems change through our Health Equity Council. That has been a longstanding part of our organization. They do develop policies and recommendations that work through our representatives in our Rural Health Congress that votes on these issues and includes representatives from all facets of rural health care. It establishes our overall health policies, and we've had a national policy on health disparities, on rural veterans' issues, border health issues through our Border Health Initiative that's been in place since 2008.

We have community health worker trainings specific for those working in rural areas since 2011 and access to rural maternity care, and we do have staffing practices that are also inclusive of a diverse representation so that we can better serve the members and the rural communities that we help, and we create programming and policy sustainability. You can find many of our rural health equity policies on our website through the link listed here. Next slide.

And finally, we are looking to launch this year the Faces of Rural campaign. This is a campaign that more accurately highlights the diversity of rural America through representation and best practices, to better showcase the true range of rural communities. I was going to ask if our organization only assists rural white America, and we actually obviously represent the broad spectrum and are working at better messaging on that. We do have the -- working with the Delta and the Appalachian regions. We work with Tribal nations to represent their needs and help with access to care issues, and so are looking to have a campaign that better resonates and showcases the increasing diversity of rural communities.

Again, we've said in the past, if you've seen one rural community, you've seen one rural community. They vary all around the country and within their

state, and we're working to better have that reflected from a national perspective and change the dialogue, change the stereotypes of what rural America is often viewed as, and to better highlight the great work that is being done when rural communities get together. We believe that innovation starts in rural America, and it leads to other areas following along, especially in urban communities, so we will be launching that this year. Next slide.

Thank you for the opportunity to present, and I look forward to answering questions later on.

Thank you, Ms. Elizondo. So our next speaker is Reginald Ware, Chief Executive Officer of BlackDoctor.Org. Mr. Ware, you may begin.

Mr. Ware, your line might be on mute.

Can you hear me now?

Yes, we can hear you.

Great. All right. Wonderful. I am following 2 great presentations, and I want to thank you all for allowing me to be a part of this presentation today, and what I want to talk about, my angle on health equity is the -- I want to do a case study, right? What does success look like when we get it right? And I want to address the health literacy, health communications and then also addressing cultural health policing practices, and the example we want to use is what we've been able to do this year, the past 12 months, with attacking COVID in the Black community.

So first of all, BlackDoctor.Org, which we affectionately call ourselves BDO, we're the number one health and wellness destination for Black Americans, and basically our tag line is, "Where wellness and culture connect," right? And so we leverage culture to make the connection so that we can get people motivated, empowered to make the decisions they need to make, so I'll begin. Next slide, please.

Okay. We've been around 15 years, and our audience ranges anywhere from 20 million to 30 million people per month, depending on what happens during that particular month, and one of the reasons for our success is, it's in the top-left corner here, you'll see that it says, "90% of Black Americans state that it's very important to get their information in a culturally relevant environment." We're one of the few resources that provide that environment for our audience, and they've rewarded us with their support, their engagement as well as their word-of-mouth referrals to other family members and so forth.

The other important stat on this page is that 93% -- the top-right corner here -- state that we are the most trusted health website for our audience, and that's higher than the CDC, which is number 2 by the way, and even stalwarts like WebMD. Next slide, please.

Great, and we're throwing out some big numbers here, so I'm going to show you numbers throughout the presentation, and they're all going to be third-party numbers. These won't be any numbers that we basically put together ourselves, and so when you look at our social media reach, we have basically 2 websites. One is BlackDoctor.Org, and then it's BlackDoctor Foundation,

and you can see with both of these websites, we're reaching over -- In the past 28 days, we've reached over 9 million people, so that's roughly, if you're doing the math here, roughly 19 million, and then there's also anywhere from 4 million to 5 million people coming to the website proper, so it's a pretty massive site with a lot of reach, and then you look at the engagement number for BlackDoctor, 2.4 million people engaged. Those are people that actually share the posts that we've done or commented on a post or liked something, so it's a really robust audience, and again all of our information is all about -- is all centered around healthy lifestyle. Next slide.

Good. And so what we're going to talk about today is how we were able to lower the vaccine hesitancy rate with Black Americans, and we talked -- I just showed you some numbers there, but our reach for just talking about COVID and the vaccine, we reached over 19 million people over the past 12 months, and there are 31 million black adults, so we reached the majority of US Black adults. Next slide.

Okay, perfect. So when COVID first started, you know, the big myth was, in the Black community, was that, "Oh, Black people don't get COVID," right? And so people were really comfortable. I mean, that was the prevailing sentiment in the Black community was, "Oh, no, this is an Asian disease. It's a white disease, but Blacks don't get it," and so back in March, so first one we did was on the right here, and we called it "Coronavirus and Black People," right? And we talked about, "Look, yeah, we need to really look at this because the way it's set up with the number of health disparities that we have and comorbidities, you know, when this thing comes, if it comes to the United States, when it comes to the United States, there's going to be an issue," and so we did the first one, and this is a Facebook Live that reached 72,000 people, so now most platforms that do Facebook Lives, they may reach 2,000 or 3,000. This reached 72,000, and so imagine an auditorium where you have a health talk, a conversation with Black Americans about health.

If you were to fill that auditorium with 1,000 people, man, that would be a major event. Well, 72,000 people, you can fit them in -- That's stadium. You're talking to a stadium full of people that are listening to this information, so it's an incredible opportunity to start talking about COVID, so we did this one on, I believe it's around March the 13th, and it did so well that we followed it up on March the 30th with "COVID-19: What's Next for Us?" Right, and trying to get people to understand that we've got to -- You know, we're going to have to protect ourselves from this virus and so forth, and all the things that we're going to need to do, and you saw that this, and you see that this Facebook Live did even better, reaching 189,000 people.

This is back in March 2020, and again, you know, the prevailing sentiment was that, you know, that Black people wouldn't even get the virus, and so, you know, when you're talking about communication needs and cultural and health beliefs, right, it's, you know, culture is interesting because it's more than a way -- It's the way people live, but it's also their perception, and a lot of times their perception is reality, so when you're trying to talk to people in culture, you can't just blow it off and say, "Hey, this is a foolish thought." You have to really address it, and those are some of the things that we started to do that you'll see later in this presentation. Next slide, please.

And so we started doing -- We partnered with the Black Coalition Against COVID, a great organization headed up by just an amazing leader, Dr. Reid Thompson, who is just a passionate, talented, smart individual that is truly committed to making sure everyone receives health equity, enjoys health equity, and so we were the engine behind the Black Coalition Against COVID's "Making it Plain," and the largest, most successful Facebook Plain that -- Making it Live -- I'm sorry, "Making it Plain" Facebook Live that we did reached over 622,000 -- had 622,000 views, which was actually part of our YouTube, so we would air it on Facebook, and we would air it on YouTube, but the genius of this, of the "Making it Plain" series is, we brought the top doctors in, right, and then we also married them with the top government officials, and so we had people like Dr. Fauci and, you know, the head of the CDC and head of Health and Human Services, and so it was just a really great opportunity for people to get the facts, and, you know, with the Black community, you know, the vaccine hesitancy rate was so high, not only was so high but people were really passionate about not taking it, so it wasn't like they just didn't take it. They were passionate about it, and so our strategy was, we're just going to give you the facts. We're going to educate you. We're not going to tell you what to do, but depending on what you want to do, we're going to give you all of the information that you need to be able to act in terms of what you feel is best for yourself and your family. Next slide.

And so we did a series of these. We had Dr. -- You can see in the middle here on the left slide, Dr. Kizzy Corbett, who was the Black woman that was also heavily involved in creating the Moderna vaccine, and just a number of other top experts, and then Dr. Fauci. We were the ones that hosted -- We introduced Dr. Fauci to the Black community, and that particular hour-long Facebook Live reached 335,000 people. Again, you know, when you're talking to people and culture, addressing their communication needs, you know, we're getting people that are really engaged, and not only are they're listening and watching, but they're sharing. They're reaching out to all their friends and telling them to tune in. Next slide.

And in addition to the Facebook Live, we create content. We've got the top doctors talking about what you should do, and then we have popular doctors that are talking about what you should do and their particular take on the vaccine, so this is, again, our 2 largest posts that went viral about the vaccine. This one here on the left, 8.9 million people were reached with this particular post, and then the second one, 2.6 million people were reached again. Had the right audience, talking to the right people on a trusted platform, and our audience knows that anything that we say is going to be, you know, they believe it's going to be true and it will be true, so we're authentic. It's an authentic truth. Next slide.

The other thing that we did really, really well during this time period is a series of polls, right? So we would poll to see, you know, to gauge sentiment to see what people were thinking, see what they needed, see where the opportunities were, and from the polls we would create the content that would allow us to be as relevant as possible, right? So we started polling. Remember that first Facebook Live you saw was in March. In April, we started polling people, asking them, "Will you take the vaccine as soon as it becomes available?" 58% in the first poll here, 58% said no. We hovered around 60% for most of the year, and then we started seeing some traction in late fall, and it was due to the number of the -- We started seeing traction

in terms of seeing people moving from saying, "No, I'm not going to get the vaccine," to, "Yes, I want the vaccine as soon as it becomes available."

And we started asking different types of questions, right? We started saying, "Well, what might boost your confidence about taking the vaccine?" And the responses were interesting because what fared worst in surveys like this was what the pastor said, what a celebrity said. Nobody really cared about that. They wanted to know, "What are the top Black doctors saying? What are trusted websites like BDO saying about the vaccine?"

Those were the things that were important, so we started feeding, feeding, feeding the audience information, content, addressing concerns, and since this is an audience of key stakeholders, we all know how big Tuskegee -- the huge role that Tuskegee played in really building an audience of -- an atmosphere of distrust in Black America, and, you know, it's not mistrust. I hear sometimes people say "mistrust," but it's not mistrust. It's distrust, and there's a difference, right? Mistrust is, "Eh, I got this hunch. It doesn't feel right, you know?" That's mistrust. Distrust is based on experience, based on history what happened, and so to overcome distrust is, it takes a much greater effort than to overcome mistrust, right?

And so we did that by creating the right content, listening to our audience, answering the questions over and over and over. There was never a dumb question. As much as you wanted to talk about it, we were able to give you the information.

So it took us to the next slide, so that over the course of the year we were able to show that -- Oh, and then the other thing about these polls, these aren't, you know, 100 people, 200 people. These pollings are always over 1,000 people. The first poll that we did was 1,500, roughly 1,500 people, and then this latest poll was 2,000 people, right? And so we went from 58% of people saying, "No, I'm not going to get the vaccine," to only dropping down to only 27%, so we've been able to essentially cut that number in half, right? And so now what that means is there's basically 31 million Black adults in America, so 27%, now it's only less than ... It went from 18 million people saying, "No, I don't want to get the vaccine," to roughly less than 9 million, right, so it's sort of a 10- million person differential.

47% are saying, "Yes, I want to get the vaccine as soon as it becomes available," so again, you know, we talk a lot about health equity and answering communication needs, addressing communication needs and addressing cultural health benefits, but it works. It really does work, and this is a great case in point here. Next slide, please.

And then we asked them, "How helpful was BlackDoctor.Org with your vaccination decision?" And we polled 1,500 people. 57%, just under 58% said BDO was very helpful, and the reason for that is, why? Again, being culturally -- You know, being services that are respectful and responsive to person's cultural health beliefs and practices, a platform that addresses their communication needs, a practice -- a platform that deals with health literacy, and what was interesting about the health literacy piece was that it actually was raised.

We had to go higher because people wanted to know, "Okay, so how does the vaccine work?" Okay, can't keep that at eighth grade level. You got to

really break some stuff down, right? And so we were able -- So we actually enjoyed being able to delve deeper into how things work, why it's safe, you know. "These are the things you should look for in terms of," you know, "These are things you could consider when you're trying to get a vaccine. This is how you keep yourself safe," and then again with all this communication, we also talked about -- If I go back to last March, you know when the mandate came down from up top that, "Okay, everybody work from home," right? Great strategy, right, because we've got to social distance and so forth, and I remember here in Chicago, that next morning there was a big full-page picture in the Chicago Tribune of a white woman sitting in her condo on Lake Michigan at her desk, floor-to-ceiling windows overlooking Lake Michigan with her laptop on her desk. She's working from home, beautiful picture.

The problem is only 10% of Blacks work from home, and so our content wasn't, everybody work from home. Our content was, how do you stay safe when you have to go to work every day still? How do you stay safe if you're living in a multigenerational home, and everybody is going to work, you know? So, again, being very, very relevant with our audience, but when you look at this number here, these numbers here, 57% say that we were very helpful, and that's pretty impressive.

The other thing is there's another 11% that's saying somewhat helpful. So you're looking at roughly just under 70%, two-thirds of Black America saying that, you know, this worked, this program worked. So, again, it's a testament to the importance of having a program that is centered around cultural health beliefs and practices that addresses the specific communication needs of an audience, and it's giving them everything they need: listening, which is the first thing, polling, getting information and then creating the content that helps people make the decisions that they need to make. Next slide.

So currently we have a COVID Resource Center. This slide is jumbled because it's just a long bevy of information, but I just threw these things together, just so you could see some of the things that's of this COVID Resource Center. So we drive so much traffic to our COVID resource center because the first thing that's there at the top is -- Right here on the left is a "find a vaccine in your area," and so we wanted to -- We were making it easy for our audience to find a vaccine close to them, and we could go into, you know, there are issues if the location is outside of a Black community and how certain people may feel about going outside their community to get it.

What I want to share with you today is that all of these resources are available on our site as we speak right now, and in the bottom left corner is the section that we have on the same -- within the same COVID resource center. It talks about the vaccine rollout, right? So we are a national website, but then now we're also doing local news in each city about different places to go, different things that are happening with the vaccine rollout. We have -- And then, in the middle section here, COVID-19 videos. This is a video here, we did a Facebook Live and we had the US Surgeon General come on and talk to college students.

Now, that last group, you know -- I talked about the 3 buckets: people that want to get the vaccine right now, people that need more information and then people that are just saying, "No, I'm not going to get the vaccine."

Most of that group are young people, and so we went to -- We got reps from college students, from HBCUs around the country, and then we put the US Surgeon General right in the middle of them and we let them have a conversation. So they were able to ask the U.S. Surgeon General, in a trusting environment, all the questions they wanted to ask. Again, just powerful ways -- Simple but powerful. It's not a celebrity doing some clever thing and trying to get people to do certain things. These are real conversations. They're genuine. They're authentic, with real people, and they're having a real -- And they're able to get the information they need.

COVID news, we have that, and then there's another piece that we have on this COVID resource page that's really important is my vaccine story, right? So for us, the finish line is not to get everybody vaccinated. The finish line is to get your vaccination, and then you go home and you tell everybody else how relieved you are, how good you feel because now you can go back to living your life, and that ignites other people to get the vaccine. Then perhaps -- We're trying to get people to, now that there's places where everybody can get vaccinated now, to, as a family, go in and let's get everybody vaccinated. If you have any older members of your family that still haven't gotten a vaccine yet, go pick them up. Let's take them to the vaccine center. Let's get them vaccinated. Let's get ourselves vaccinated and so forth, and so the my vaccine story, people are sharing their own personal stories in terms of what they did and why, how they got vaccinated and why they got vaccinated, and so that's a really important piece for us because that's the finish line for us.

And we're also doing a Facebook Live series called "When, Where and How?" where we're going into different cities, different states, different cities and we're talking specifically about that audience because we're seeing that there's still some hesitancy areas in the South, and so we're doing -- For example, we're doing Mississippi, you know? We got a popular doctor in Mississippi who's going to be breaking it down, and so -- Things of that nature, so it's a -- Again, addressing the communication needs of the audience, understanding that their cultural health beliefs and practices are different from mainstream populations, and that's okay, right? Let's address everybody -- Let's meet everybody where they are and give them what they need so that they can move forward, and that slide, I think that concludes my presentation. Okay, thank you.

Thank you so much, Mr. Ware. We are now pleased to invite Dr. Nancy Fisher, who is the Regional Chief Medical Officer for HHS Region 10, to present. Dr. Fisher, you may begin.

I wanted to thank you for inviting me to speak, and I want to -- I feel very privileged to be able to follow behind the great speakers we had already, and what I will do is build on what we have learned from them and from others that we've worked at to -- and CMS to address access to care, quality care and how we can do that, looking at racism and other barriers that have come up for health care. We've heard from the presenters yesterday and today, and so we're all, I hope, are on the same page about equity. It's giving people what they need, not what they want to, to have a healthy, as much life as possible. We're not talking about equality because we don't want to give everyone the same thing whether they need it or not, and what we now about this disparities is that when we look at various groups or populations, we're getting different outcomes, and they usually are not the good outcomes that we want, so we need to fix those.

CMS is the largest provider of health insurance in the nation, and in our Medicaid program we cover 50% of the children, and when we look at this and we look that we've really got to focus on patient-centered care, and we didn't say "some patients," we said "all patients," and so we need to look at all our policies for all segments of CMS to see what we can do, but we can't do it by ourselves, and so we partnered with other agencies to accomplish this, but, while we can't do it by ourselves, we need to know what we can and what we can't do.

So building on what the guest speaker said previously, I will provide some examples of what CMS has been doing on the road to equity. We know, when we look back, people will talk about the history of racism and discrimination in the country, culture is really the structure that we have. It's what we live under, and it's based on our history and experience, and they talked about the importance of that. They talked about the importance of what racism has done because it's about power, and it's about money, and if you think about it, if you have no accountability for doing anything wrong, then it's easy to do it again and again, and then nobody is calling you to task, so what you do is you broaden what you're doing.

So we went from indentured servants to slavery, and that was free labor. That gave money. That gave power, and this has been passed down to the point when we think about things that have happened. We know about Tuskegee and the trials there. We know about the Radium Girls. In 1917 to 1926, young white women were hired to paint luminous dials for the military, and the people that had them doing it knew that radium was in it and it would harm them, but they didn't do anything about it.

So when people go along with what's going on, what we're talking about is conformity bias, and we all have it. Short men don't like to date tall women. We have preferences for university training. We might not like people that have different accents. If people don't agree with us, we talk louder. It doesn't mean they're hard of hearing, they just didn't agree. So what we've learned is you can take any group of people, divide them into 2, give one less than the other, and what you've done is you've made it legally true for them to be separate, and then what happens is you have no relationships, and you can perpetuate anything good about or bad about the group that has less, and so this brings us to social determinants for health, not self-determinants.

Poverty is not a personal thing. It's not a failure. We've made it that way, and shameful, but our society is structured for capitalism, and this is one of the impacts. As we look down and we see what we cover and what we do and how we provide access to health care, we look also for social determinants of health that have been brought up. We know progress is killing us. What has happened is we don't walk as much because we have cars and buses, so then we don't get as much exercise, so then we put on weight, and that increases the incidence of diabetes, especially Type 2.

We now have lots and lots of cars, so we have emissions, and then that puts out -- and that emission is in the air, and then, when you think about it, we're an industrial nation, and we still have industries putting their waste and air pollution, and we've seen an increase of asthma.

We also see that there are other things that are going on about racism where we don't look like a majority, and it makes people feel tense, and so we want to stick together to provide safety, and even if you move into a neighborhood where you don't have the resources for protection, then you have to deal with other stresses. This all leads to depression, and we've also found out, when we look at infant mortality, Caribbean Woman that have come to the United States have a lower incidence of infant mortality than the Caribbean, but within 3 years of being here, their infant mortality rates have also raised up. This is stress, and this is something that we need to address because we cover 50% of the babies in America.

Progress, when we look at it, we think about telehealth because we just had COVID, and, wow, telehealth did a lot to help to fill the gaps when we couldn't go to the doctor's office, but, telehealth, we're now looking at data. There are 109 specialties, and not one size fits all, and telehealth is not available to everybody. There are wastelands of broadband under use in cities. There are places where you can't get broadbands because of mountains in the way. Few people can use it, and then you say, "Okay, we can use the phone." So some people have phones, but they only get so many precious minutes, and they can't be putting in more minutes because they can't afford it if they have a doctor's appointment.

So when we look at this, we can't fix everything, but we can learn from each other and we can learn from those that we want to serve. So the second thing I want to talk about is communication. Communication is the building of relationships. We live sometimes in isolated areas, and even when we're in a big city, we live in our neighborhoods, and we may have support, and we have access to a lot of resources, but we don't think about people where else could live.

In fact, there's a big difference living in east of the West Mississippi versus west of the Mississippi, and what we found out at CMS is, in order to serve our beneficiaries, we have to go out and outreach. We have to go to the individuals, not wait for them to come to us. We need to be proactive so we can learn what are their experiences, what problems are they having. Just because they have insurance doesn't mean they have access.

The other thing we have to learn is that words are powerful, and we have to think before we speak. Different words mean different things to different people, and so we can't just decide that, "Oh, we can avoid this language here and what we say." But we have to know what group we are going to speak with.

The diseases have been called by different names, and it's changed over the history. Patients speak about sugar, and doctors go, "What?" But these are usually elderly patients sometimes that are previously, when we talk about it, they were talking about sugar diabetes, and, like everything, we all make everything shorter to talk about. I mean, this is about a professional language. It's got lots of acronyms, and it doesn't mean that you're illiterate. We've got the generic names that are being used, and we can't pronounce some of them, and so that's when you refer to one of the monoclonal antibodies.

Doctors and health care people can't pronounce that long name. So they just call it Bam Bam, and so we have to look at, people do this, too. It's not always a literacy problem. You get generics, and they got tough names, and

then what else? They all look alike, and so we've got to be able to understand when people say, "Well, it's a white pill that's big, fat and it's round, or it's oblong. Oh, no, it's more rectangular."

Before we used to do that by pulling out the "Physician's Desk Reference" and looking up the pills and the colors, but now we don't have that because there's so many generics. We learned that, when we went out and did outreach, that people had not heard of CMS, but they know about Medicare and Medicaid, and so maybe this is an acronym we shouldn't be using when we talk to people, or we use both so they understand. We've learned to avoid emotionally charged language. Emotions get in the way of discussions. You're too busy trying to calm yourself down to listen to what's going on or to participate. So, what we learned about COVID is that we were told very quietly, "Don't use health literacy and get rid of vaccine hesitancy," because people aren't hesitant. They don't know, and you don't go out and buy things unless you know what they're worth to you. And so we needed more education. So, we talked about vaccine confidence, and some people have used health wisdom for increasing your health knowledge, but we want to get away from the emotional word.

The other thing that's been happening at CMS is we have an initiative that was going on for the last several years, and we learned that, from our providers of health care, all providers, they were having trouble with all the administrative paperwork. And as we listened, we put in an initiative for Patients over Paperwork. We spent more time listening to physicians about how they were spending too much time with the paperwork and what we needed to do to fix that. So, we didn't know what we didn't know, but we found out. We had to learn about what was the barrier to care because of duplications, the changes that have advanced in medical care but our policies hadn't advanced. And then we found out you should -- couldn't talk to physicians or the PAs or the nurses or the providers. You need to talk to the facilities. That meant that we were moving into a 360 view of the problem.

So, we had active listening sessions, and, let me tell you, it took a while for people to understand, when we were really actively listening. We weren't talking; they were, and we wanted to learn. So, we went to the multiple components of health care. We went to hospitals. We went to nursing homes. We went to dialysis centers. And we did that in rural areas. We did that in academic practices and also in private practices. What we did and what we learned from that is that we fixed or we streamlined the measures for quality, but we had to remember we have 109 specialties, and, for some specialties, they're not doing common things that, say, people in primary care are. But we've fixed them. We've honed them. We've decreased them, so that we can do the best. And we continue to look at what's going on so that we don't have unintended consequences, and we are reducing the time for paperwork.

And, so, for one measure where, where there was an unintended consequence, we have an opioid epidemic, and we wanted to address that, and we wanted to understand whether people were getting the information that they needed about opioids and the danger of opioids. And, so, the question was, are you satisfied with your pain management? And what we found out when we asked this in our hospital measures is that the doctors that were taking care of patients that were not satisfied, in some places this was used to penalize them or even lose their jobs. And when we found out about that, that measure

was changed. And, so, it's more about has someone spoke to you about pain management, which is really what we wanted to look at. We learned that we had to make exceptions for hardships when we put in the electronic health record. If you live on the East Coast, can you believe it, there are states with no broadband? There were big states, a lot of land, few people, big barriers like mountains, costly to put in broadband. So, they weren't doing an EHR, and if they don't have an EHR, they can't do any interoperability because we can't penalize them for that. We know that there are other things that we have to look at when we were talking about Quality Payment Program and MIPS, and this one thing is we had areas way out in the Pacific, and when you get out there and you look at it, some of the people there, they have weather like cyclones that interfere, and we had to make exceptions for looking at things like in cyclones and, yes, we do cover cyclones now.

We do rural road trips, and we invited leaders from headquarters to come and see real rural health, and what we found out is that there's a big gap in rural health, from sheer bush, like up in Alaska and geographically isolated communities. We had to do education so that people would understand about the size of states west of the Mississippi. We had to correct the idea about people to understand distance. New York to Atlanta equals El Paso to Houston, and when you go New York to Atlanta, you're crossing as many as 6 states. El Paso to Houston is one state, and you still have 6 more miles to the Gulf. We had to let people know that Alaska is our largest state. It's not a foreign country, that Washington is not attached to it, and that Alaska is not an island, as seen on some maps. Alaska is bigger than the next 3 states behind them, Texas, California, and Montana. We had to look and tell people there were no bus services in some of those states, and there's no train access for passengers in South Dakota. Did you know, to get care in Honolulu, many times you have to fly, and here we're complaining about driving 25 miles in bad traffic. And then, if you're in Guam, you have facilities, but you have a very limited resource for health care workforce.

We learned that in different cultures, they wanted to eat their food, and if the food chain became contaminated, what are we going to do? How are you going to get food up to St. Lawrence Island in Alaska if their food is contaminated by waste that's been left from military factions and tests. I mean, they're almost to Russia, and the thing is, how do you get food up there? We learned that, as we were missing what was going on and as we were learning about Pacific Islanders, that we now need them to keep telling us what we can improve, and they're now a vital member in our rural health comms.

Lastly, when we talk about taking care of people and coverage, we talk about caring and feeling, and we have to think about this, and we have to look at our unconscious biases in order to make things work and so we can look over our policies and see where we can make changes. We've already learned that when we have written handouts that go out, it's not just changing the brochure's pictures to make an appeal to different populations. But we also have to look at what is in the brochure and make sure we've taken care of any specifics to that group and make sure it's accurate. This is caring. We know that medications like insulin cost a lot. We know about people splitting pills. But when it comes to coverage about SUD drugs -- excuse me. When we talk about opioids and all the drugs that can be addictive, we covered methadone, but we didn't cover buprenorphine because of the price, and so people have to make a difference between "Am I going to pay for rent

or am I going to get my medicine?" We now cover buprenorphine, and there'll be announcements soon about how we're going to increase access to buprenorphine and to treatment. We've done a lot of education about rural and frontier areas in the United States. We've done a lot about looking at substance abuse in different groups. We've looked at people and gone out to reach them where we did not think that they would be. We were reaching out to Hispanics in Alaska. We now know that when we look at Asians, that we may be talking about 30 different groups, and we have to look and talk to the groups to see what they have in common, what they don't have in common and how we can address their needs for coverage. The solution is, remember, the definition of insanity is doing the same thing over and over again and expecting different results. We want to change. We know it's needed. It requires self-awareness and more knowledge, so we need to ask ourselves, "What am I willing to give up to get health care equity in our society?" I thank you for your time, and I'm really looking forward to answer any questions.

Great, thank you so much, Dr. Fisher. I believe that concludes our first session for the day. So, again, we'd like to thank all of our presenters, and we will now be moving into our second session of the day, and this will be the COVID Impacts on Disparities.

Session 2: COVID-19 Impacts on Disparities

And, before we begin, I did just want to do a quick sound check with our next presenter. So, Jeff Caballero, I just wanted to test.

Yes, here. Testing.

Great, and, Dr. Tuckson. ... Okay, and then we can also test RADM Araojo.

Hi, can you hear me?

Yes, I can hear you, great.

Great.

And then, Dr. Tuckson, are you able to hear us?

I hear you well.

Great.

Yes, I hear you.

Great, thank you, all. All right. So, now moving into session 2. Again, this is the COVID Impacts on Disparities section. During this section, we are pleased to have Dr. Reed Tuckson from the Black Coalition against COVID-19, Jeffrey Caballero from the Association of Asian and Pacific Community Health Organizations and RADM Richardae Araojo from FDA, and they will be providing our insights on the disproportionate impacts COVID-19 has had on health disparities. There will be time for questions following the presentations, and we will address as many questions as time allows. You may submit your questions via the chat box to be read aloud. Please note that members of the press should direct all questions to press@cms.hhs.gov. Just a quick reminder that a recording of today's virtual forum will be posted on the CMS

OMH website following this event. A link to that webpage will be shared momentarily in the chat box. Next slide, please.

So, first, I will turn it over to Dr. Reed Tuckson, Founder of the Black Coalition Against COVID-19.

Well, thank you very much. It's an honor to be here with all of you and with my co-presenters, especially Jeffrey, who we're working together tonight with the national town hall for the minor community, and, Dr. Araojo, great to see you. Let me quickly make 5 points in my few minutes. Number 1, this road to equity began a long time ago. I think it is very important that people do begin to understand what we mean when we say the structural racism issues that have affected and have such an important impact on this work. I don't like to use these kinds of terms easily because they become rhetorical often. They become inflammatory, and, a lot of times, when you talk about these things, it turns some people off, and they don't listen to you. That being said, this is a serious conversation among serious people, and we have to be serious about what we're talking about if we're going to try to save lives. Not winning this war means people die, and I am sick and tired of seeing people of color dying too soon from too many things, but especially from this pandemic.

And, so, understand that this road to equity began 400 years ago when my people were enslaved for 250 years. During that time, 10 to 15 generations of Whites grew well, owned land and began to prosper. One hundred and fifty years ago we were freed, although Jim Crow laws kept us enslaved, and in a revision to the past of 150 years ago, we still see the same things now that we did then with voter suppression, real challenges to the ownership of wealth, and back then Americans began to erect monuments to slavers, which has become a big issue. And that's important in our fight because 125 years ago, a statue of J. Marion Sims was erected for his work on unanesthetized slaves. He became famous as the father of modern OB-GYN because of the work that he did on unanesthetized slaves. During that time, those 125 years, another 5 to 10 more generations of Whites prospered while Black folks were kept down. 90 years ago, we had the infamous Tuskegee experiment. 60 years ago, we had somehow the right to vote legally. We were freed from discrimination. I was in junior high school when we got the right to vote legally, and now we see those being undercut every day all across our country, segregated schools and neighborhoods, denials of bank loans. Meanwhile, during that time, 2 to 3 more generations of Whites prospered.

50 years ago, there were 783 Black students enrolled in American medical schools, just 2.2% of the total. Today, after all of the work for affirmative action, only 5% of the doctors are Black. 40 years ago when we tried to fight the HIV/AIDS epidemic, the number-one dominant risk factor in overcoming that fight was the legacy of Tuskegee: distrust and conspiracy theories. Now, we then had recently Black Lives Matter, where thousands and thousands of people supported by millions of others at home took to the streets of their cities across this country to declare that our lives matter, that they have value, that there is meaning in our lives, that we have dignity. And we were protesting then for the suboptimal housing, food insecurity, and the fact that because of all of this, so many of us were working in these essential jobs.

So, my point is this: This road to equity is a long, long road, and all of the factors that I just mentioned are shaping the contemporary experience.

And so that means that, number 1, we've got to reestablish trust. This issue of distrust is essential. Distrust leads to death. It is not an emotion. It is a phenomenon that is real and leads to death, and so we have to do more, everything we can, to reestablish that, and that means every institution in our society from government to private business, philanthropy -- all of it has to work together.

Secondly, what we've got to help people to understand, that even as we have all of this upsetness, distrust, and the legacies of such a long period of time, we have got to help people to stop being, and when it comes to this pandemic, only myopic about what happens in America and look around and see what's going on in all the other countries in the world. That our distrust of the United States systems needs to also understand, though, that this is a worldwide phenomenon. This is not just about African Americans or other people of color's relationship with the United States institutions in society. This is worldwide phenomenon. We have to help people to do that.

Number 2, that we have to be very clear that if we've learned anything from this pandemic, it highlights a very bright light on the relationship between individuals and the people amongst whom we live, who we share our time and our space and our values. This sense that what I do affects you. That I, through my behavior, can kill you. That ought to have a very high and a much higher operative relationship that would cause me to behave in morally responsible, ethically responsible ways. Unfortunately, even within minority communities, we have too many people who are still self-absorbed with their own sense of narcissism, their own sense of following with miscommunication, misperceptions, false notions -- but a sense that somehow, too many people have gotten away from a shared sense of community, a sense that we are all in this together. That we are family. That we are community together, and we have a relationship to each other, and we have to learn to come back and love that more and more and more so that we become establishing a shared sense of community.

Number 3, we have learned clearly on this road to equity that we've got to do more in science education and literacy. We are living in a genetic era, yet hardly anybody that we talk to in our communities understands the concept of an mRNA vaccine. There is so much science that we don't get a chance to embrace so that the number-one question in our public town halls is almost always, how did you do it so fast? How did you do it so fast? We don't trust the speed of the process. Not knowing or not caring or not being able to embrace with enthusiasm and energy the genius of the human mind and how we have these fantastic new capabilities. We're looking always for reasons to find fault with, something to poke a hole at as opposed to being able to come at this with a sense of enthusiasm, and that's because our school systems don't teach science anymore. We don't put the money into our schools, particularly the schools for people of color. This has got to stop, and we need to have a much more assertive, aggressive posture when it comes to math educate and science education for those who now have to live in a genetic era, who have to make personally appropriate choices and decisions without that background.

That also means we have to be very clear about how science is introduced into society. Who regulates? Who decides? The challenge we had with the COVID vaccines was, who approved them? We always could go to 2 Black doctors who are on the committee that reports to the FDA, and we celebrated them every chance we could. Do you know how hard it is we have to

work to find Black scientists in positions of authority inside of our government apparatus? This is just disgraceful, and so we really have to decide now to get more and more of our scientists of color from across the minority communities to be involved.

Number 4, of course it means that the messages around vaccination have to then come from trusted messengers. Again, back to the fact that we have so few physicians of color who are in health care today and/or in positions of authority, but we have learned through the Black Coalition Against COVID, and I understand that Reggie Ware from BlackDoctor.org talked about the town halls we're doing. Jeffrey and I are doing one tonight, as I mentioned, and it is so important that we have these trusted messengers from the science and physician community and other health care professionals who can go out and be the carriers to overcome the social media distractions that we have. We need to have more social influencers, of faith leaders and others who are well-trained and well-prepared to carry the message.

And finally, to close exactly on time, I think we have to be very clear about the community infrastructure for engagement, access, and vaccine administration. It is maddening that when a crisis occurs, that the dollars flow through the already preexisting folks who have big mega contracts with government, and then the people of color go hat in hand having to beg, plead, and cajole to get dollars unleashed so that we can go ahead and do the work that we need to do. We need to have a much clearer infrastructure, a financial infrastructure that moves dollars and resources preexisting that are firm, well-established, and that we can tap into not only for the pandemic fight but for the health care disparities that existed before the pandemic, that exacerbated the pandemic, and will be there after it is over.

So, I was just going through 5 key things. I know that I was a little intense, maybe, in my presentation, and I did it for a reason. I'm not interested anymore in having meetings where we sit around and share nice stories with each other. I have seen too much death, and it has pissed me off. And I think that we now all need to have a level of upset, a level of anger, a level of urgency to get at these things and stop playing around on the edges and get down to the hard core of why our people were the ones who were the essential workers driving the buses and the ones exposed to this virus because they had nowhere to go. How we were the ones who live in these substandard housing developments with multifamilies in one bathroom, and we're telling people to quarantine. We cannot continue to be polite about these fundamental issues. We have work to do. I'm sick and tired of seeing how hard it is to get people of color and physicians of color. Meanwhile, 50% of all the students in med school today are women. Women were able to do it. We've got to learn. How did they do it? And how is it still that Black folk are still, and other people of color, are not in these schools? So, time for politeness is over. Time to get real because death is the consequence of failure.

Great. Thank you so much, Dr. Tuckson. Now we will move on to our next speaker, Jeffrey Caballero, who is the Executive Director of the Association of Asian Pacific Community Health Organizations.

Reed, I don't know how to follow you. That was incredible, and I completely agree. I mean, being pissed off is what we need to be, but I was asked by LaShawn to just share with you a specific perspective of where I'm coming from. And so I'm here this morning to use my time to share with you who

AAPCHO is, who I am, what we do, and a model that we feel is promising. But I will close with several examples of the barriers that we feel has been contributing to the continued inequitable distribution of the COVID vaccine for Asian Americans, Native Hawaiian, Pacific Islanders in particular. But a little bit of who I am first and foremost, and allow me to, again, thank CMS for the invitation, for this opportunity. You know, again, my name is Jeff Caballero, and I'm with the Association of Asian Pacific Community Health Organizations, AAPCHO for short. Who I am is that for nearly 30 works, I have been working at AAPCHO, advancing our mission, advocating and building partnerships with other communities of color. I'm a first-generation immigrant from the Philippines, naturalized and became a U.S. citizen prior to entering college. I came from a family committed to defending and serving this country for 3 generations, the first as a soldier in the Army and the last 2 generations as Navy physicians.

I've been at AAPCHO because I found it -- the community health center program has been an exemplary model for helping and assisting communities that are underrepresented and underserved. AAPCHO's mission is to promote collaboration, leadership, and advocacy that improves the health status of underserved Asian Americans and Native Hawaiians and Pacific Islander populations. We are a membership organization of 33 community health organizations, 29 of which are federally qualified health centers who serve predominantly Asian American and Native Hawaiian populations. And yearly we serve over 750,000 people in 14 states and 3 territories in the Pacific.

But for those of you who don't know about community health centers, just a little bit of facts. There are 30 million people that are served by the health center program. Almost all are nearly low-income, and about two-thirds are of people of color. By law, health centers serve all people regardless of the ability to pay, and patients are charged on a sliding fee scale based on their ability to pay. With regards to COVID testing at community health centers, health center patients who tested positive account -- so far, of all patients that have tested positive in the U.S., 4% of them have been tested at community health center programs. That's 1 in 25 of all COVID cases in the United States. Also, in line with other national research, racial and ethnic communities account disproportionately for the patients who have tested positive at community health center programs.

Let me share with you that for every week of reported data, and the data we started was collected by HRSA since last year, the share of patients who test positive who are racial and ethnic minority exceeds the share of patients that are tested who are racial and ethnic minority. Let me say that again. The share of patients who test positive who are racial and ethnic minority exceeds the share of patients that are being tested who are racial and ethnic minority. This means that given the socioeconomic demographic profile and known comorbidities of health center patients, health centers are finding the populations at greatest risk.

With regards to the COVID vaccine, in February, the Biden administration started to directly allocate vaccine supplies to health centers. This brought a lot of relief and hope to many health centers, including AAPCHO's member health centers throughout the country, and nearly half of all patients who had since initiated the vaccine program at health centers and 44% of all patients who completed the vaccine program at health centers are of racial and ethnic minority. However, you know, it is not a panacea. This program has not solved all the problems for health center programs because

we still have 45% of all health centers reporting that the vaccine supply is still their biggest challenge followed by vaccine availability at the health center program, though we have found promising in the last few weeks that vaccine confidence is reportedly down to 11%. Thus far of the 9 weeks of reported vaccine data that has been collected, of all patients that are eligible for the vaccine program at a health center, those that are over 16 years of age, 3.7% of the patients that are completed are of racial and ethnic minority population. So, let me just share that with you because there's still a lot and a long way to go.

What I want to emphasize, though, is that community health centers only serve 1.5 million Asian Americans, Native Hawaiians, and Pacific Islanders. That's part of a population of 23 million people, so there is a lot of care that is needed outside of the health center program, and this is what I -- these are the issues that I'm hearing from the communities that I work with and with allies that I collaborate with across the country both nationally and at the local level.

One of the things that is most underrecognized is that the Asian American population has been the fastest-growing population in the last 10 years. There has been 80% growth in the Asian population since 2010, and that, you know, and that is the most dramatic in states that have had lower numbers in the past, but even those states, like Texas and Nevada, have had growth rates that exceeded over 150%. However, the largest numbers have been, the largest growth has been in the traditional states, such as California, New York, and Washington. So, why that matters is that with this 80% growth, that means that this population is majority foreign-born, and what's associated with that foreign-born status in the last 10 years is that there is significant limited English proficiency in this community, around 40% in many of our health center programs. And in addition to that, this majority foreign population also has limited experience with the complex health care system in the United States and the role of technology in that.

So, there is a lot for a community to navigate, and this audience is an audience I really don't need to speak to with regards to the limited data in the Asian American and Native Hawaiian, Pacific Islander community. Well, at least I hope this is not that audience. But what limited data means is that we do not know how to resource for equity. Too much burden in being able to serve the most at-risk communities are being given to our community-based organizations, you know, such as translating the messages and providing the education without additional resources to various racial and ethnic communities and languages that exist in the Asian American and Pacific Islander communities. The burden of getting to the populations and the patients, but we need to be screened and vaccinated, it's based on the community organizations that have limited resources. And why do they need such -- why do we need such means to get to this population? You know, let us own up to what the country has done the last 4 years. There is -- with the anti-immigrant sentiment, if I can just say that, with the anti-immigrant policies and practices that this country, through the administration the last 4 years implemented, there is significant distrust with government, with government institutions, government representatives, and government systems.

That's why it's so critical to be partnering with those community organizations who these community representatives recognize and trust. It doesn't matter if you have a translated material. If the community doesn't

know you, they won't trust the information that you are sharing with them. And we know these trusted relationships, community-based organizations work. We saw it work during the voter registration and census campaigns where these community groups and networks were utilized to mobilize this population. So, we can do it again, but we need to invest in these community networks.

And let me just close by just summarizing several of these barrier issues that I just wanted to, that I've touched on. Historically there have been under-resourced community-based providers who we consistently go to as a nation whenever there is a crisis or disaster that hits our respective community. You know, in many Asian American, Native Hawaiian, Pacific Islander communities, these are usually the organizations of those leaders who can bridge the language or cultural gap that must be navigated during these difficult periods. We should be investing in these community organizations and leaders as part of the nation's equity infrastructure. Additionally, I want to just touch on the issue of Asian Americans being considered, you know, the perpetual foreigner. This has been an issue that has historically and has been a significant factor that has made it too easy for white supremacists to promote and to create a current environment where so much anti-Asian violence and discrimination is occurring. You know, it doesn't matter if Asian Americans have been in this country for 3, 4, 5 generations. They are always recognized as the perpetual foreigner, and this is an issue that must continually be addressed over and over again. And again, as I already noted about resourcing for equity, that until we can commit as a country and as government and as a community to collect granular racial, ethnicity data, we are never going to be able to identify the communities that must be reached when we have these crises like COVID. Again, let me emphasize: The lack of investment and recognition of community-based organizations in their fundamental roles to serve our most underserved communities is an area that I think as a country we need to look at and contribute more investments in, in the future. Thank you again for this opportunity, and I look forward to your questions.

Great. Thank you so much, Mr. Caballero, and finally we are pleased to have RADM Richardae Araojo, the Associate Commissioner for Minority Health and Director of the Office of Minority Health and Health Equity at the U.S. Food and Drug Administration present.

Thank you. Thank you so much. Good afternoon, everyone. I'm Rear Admiral Richardae Araojo. It's really a pleasure to be a part of this panel today, and, of course, definitely a hard act to follow from Dr. Tuckson and Jeffrey, and I've been asked to really kind of talk about our efforts at FDA related to COVID-19 vaccines, highlight the work that we do, and also highlight a number of the resources that we have available to our diverse communities. Next slide. Next slide.

And, of course, I think that our conversation today is very timely. We know that, of course, April being National Minority Health Month, very important thing this year, being vaccine-ready with the goal, of course, for us to continue to empower our communities to get vaccinated, make sure that you know the facts about COVID-19 vaccines, share accurate information, of course, get vaccinated when you are eligible. So, I thought before I'd jump into the work that we've been doing at FDA, I first want to take a step back and really set the stage to highlight, what does FDA do? What is our role? So, FDA is responsible for protecting public health by assuring the safety,

efficacy, and security of the range of products that we regulate, and, of course, critical to the conversation today, we regulate vaccines. Our Center for Biologics Evaluation and Research provides oversight for vaccines. They are responsible for authorizing a proven COVID-19 vaccine. So, I think it's important to know that FDA's authority is the authorizing, approving a COVID-19 vaccines for use within the United States. Next slide.

And, of course, the Office of Minority Health and Health Equity, we sit within the Office of the Commissioner at FDA. We work broadly across our agency as well as with a wide range of stakeholders, and our focus is working to protect and promote the health of diverse populations -- and when I say that, I mean racial and ethnic minority, underrepresented, and underserved populations by focusing our efforts on research and outreach and communication that works towards addressing health disparities. Of course, ensuring equity is a goal that we prioritize across all of our work, and we have been working hand in hand across our agency to support efforts in response to the pandemic, especially to address concerns about vaccines among diverse communities. Next slide.

So, I won't go into a lot of detail here. It's really just highlighting the work that we do across the office; our research and collaboration program, where we're focused on advancing minority health and health equity-focused research; and also our outreach and communication program, where we're focused on improving FDA's communications to the populations that we serve. And this is very important. We develop culturally and linguistically tailored programs, initiatives, and campaigns, and 2 of those programs became very important during the COVID-19 pandemic. One of those is, of course, diversity in clinical trials -- and Dr. Tuckson talked about that a little bit -- as well as our Language Access Program -- and we just also heard that from Jeffrey. It was critically important at the very beginning of the pandemic for us to make sure that our diverse communities, that our providers, and others had information available in multiple languages. Next slide.

So, we have heard, and we are all well aware -- as a Black African American woman, I see how COVID-19 has impacted our communities, that significant disproportionate impact on racial and ethnic minority and other diverse groups. We've also seen how COVID-19 has exacerbated those disparities in equities that have long plagued our diverse communities. We know that African Americans, American Indians, Alaskan Natives, and Hispanics and Latinos are more than 2 times as likely to die from COVID-19 than White Americans and have nearly 3 times the rate of hospitalizations. There are so many factors in these disparities, including in equities in health care access and utilization, housing, occupation, education, income, and wealth. Dr. Tuckson talked about a range of these inequities earlier, and one of the inequities that I want to talk a little bit about today is access to current and accurate information. Next slide.

So, when we talk about COVID-19 vaccines, I'm going to talk a little bit today about 3 key focus areas. One of those is vaccine safety and efficacy, clinical trial diversity, and addressing misinformation and disinformation related to COVID-19. I think one of the areas that has been really important, of course, is the issuance of the Emergency Use Authorizations for the 3 COVID-19 vaccines. Those were, of course, welcome milestones. Issuing these EUAs were major public health steps forward towards ending this pandemic, but we know that our minority communities, our diverse

communities have questions about the safety and efficacy of these vaccines. We also know that our diverse communities are targeted. They are targeted misinformation and disinformation related to COVID-19, so we have been working really hard to make sure that we are reaching out to our stakeholders, whether it be through providing communications to holding listening sessions to having direct conversations with specific organizations, making sure we are reaching out to providers and working with a wide range of stakeholders to make sure they understand the work that we are doing, that they have current and accurate information, and also highlighting how our authorized vaccines were tested in clinical trials that included thousands of participants from racial and ethnic minority, American Indian, Alaskan Native, and other diverse communities, so that's messaging that we've been working to make sure that we are communicating to our communities so that they are aware. The other message that we've been very focused on in making sure that we are highlighting for the public overall, and that is that FDA has not, and we will not sacrifice scientific integrity to bring a medical product to the market, and that the FDA will only approve and authorize a vaccine for emergency use if it meets our rigorous standards for safety and effectiveness. And that has been a theme that we have really been working to make sure that all of our communities are aware of. It's also important to make sure that we highlight the fact that we have a dedicated group of career scientists. These are career scientists that reflect our nation's diversity, that are reviewing the medical product applications to make sound scientific decisions about these vaccines. And, again, these are career staff that are globally recognized as experts in vaccine development, clinical trials, and data analysis. So, it's really important for us to make sure that we are hearing from those experts. And, of course, across all of the work that we are doing, FDA has taken, and we are continuing to take, active steps to make sure that we are providing access to the latest current and accurate information related to COVID-19 treatments and vaccines. And, so, this has been a message that we have been working throughout the pandemic to make sure that we are highlighting across all of our diverse communities so that we can continue to provide that accurate current information to address misinformation, distrust, and confidence. Next slide.

So, some of the activities that just -- can I just shift and talk a little bit now about some of the resources that we have available? And I think Jeffrey really highlighted this. One of the challenges that we have is, we want to make sure that our communities know the resources that we have available, where they can get this current and accurate information to really help address probably a range a questions that our communities may have. Some of the activities that we've had -- this is by far not all -- held a webinar with Dr. Peter Marks. He's the director for our Center for Biologics Evaluation and Research -- and as I mentioned, that's the center that has the oversight of vaccines -- and he spent time answering questions and answers related to COVID-19 vaccines, the approval process, and a range of other questions that we think were really important for our diverse communities to know. The other area that was very important when we think about COVID-19 is making sure that our populations are aware of the potential for health fraud. So, we also had a podcast where we had a conversation with our experts and our Health Fraud Branch at FDA. Another area that has been very important is making sure that everyone is aware of our review process. So, we have an infographic, as you see on this slide, that talks about the path to COVID-19 vaccine from research to Emergency Use Authorization. And this was really important to be able to highlight what is

the process that FDA follows so that we can make that process very clear, transparent, and public. And we have also gone so far as to also have a vaccine 101 webpage just to talk about the vaccine review and approval process as well as the importance of vaccines and the importance of getting vaccinated. Next slide.

Another area that is very important -- and we have long done work to work to address and to work to advance diversity in clinical trials. And we've continued to raise awareness, build awareness around the need for diverse participation during the COVID-19 pandemic. We, of course, know that there are significant barriers to enrolling diverse populations in clinical trials, so our office has an ongoing public education and outreach campaign that really works to help us try to raise awareness, educate to overcome some of those barriers. Oftentimes there's simply just a lack of awareness about what a clinical trial is, what it means to participate, and why it's important for us to have diverse participation. We also know that there are a range of other barriers from lack of access, lack of awareness, and a perception that minorities don't want to participate, and they aren't asked. So, our goal is to make sure that our communities are educated about clinical trials so they understand past historical abuses but also understand the protections that are in place now. And making sure that they have access to resources and educational materials that will hopefully prompt them to raise questions to learn more about this as they talk to their providers as well. So, we have videos. We have a webpage, podcasts, communications toolkits, a range of collaborations and partnerships that we continue to work to advance to raise awareness on the need for diverse participation in clinical trials, highlight the fact that we want enrollment in trials to reflect the diversity of the populations that are ultimately going to use those products so that we can, of course, review that data, analyze that data, and communicate meaningful information to the public. So, throughout the pandemic, we have continued to work to raise awareness around the need for diverse participation in clinical trials. Next slide.

And this was also highlighted in guidance documents that our agency put out that were specific to COVID-19. These are 2 guidance documents that came out last year. One was focused on development and licensure of vaccines to prevent COVID-19, and that guidance specifically states how FDA strongly encourages the enrollment of populations most affected by COVID-19, specifically racial and ethnic minorities. And then following that, we have a guidance focused on COVID-19, developing drugs and biological products for treatment or prevention, and this guidance also highlighted the importance and need for racial and ethnic minorities to be included in those trials. Next slide.

To support these efforts, we have also developed videos. We know that oftentimes resources where you can very quickly play and share these types of information can be helpful. We have 2 videos on COVID-19 vaccine safety and diversity, and, of course, these are our resources to help support and continue to build vaccine confidence. Next slide.

This is the other video that we have available. Next slide.

And the other area that has been really important throughout the pandemic is making sure that we're able to reach our diverse organizations so that they have -- there's just so much information, I think, coming at all of us related to COVID-19. We want to make sure not only are we disseminating our

FDA efforts and activities related to COVID-19, but that we're doing that on a regular basis and a consistent basis. So, every week, we send out our COVID-19 information to our listserv, and it includes the most recent updates related to FDA's COVID-19 activities. It links to all of the resources and the information and education materials that we may have developed and have available. And it also links to the most current and accurate information, including any recent press information, press releases, or other information that may be important. The other area that I'll highlight is that, of course -- and this is very consistent across many of our federal agencies -- we have a wealth of information on our webpage, and it's a matter of making sure that our communities are aware of where they can go to access information. So, for example, we had for the 3 vaccines that were authorized, we had advisory committee meetings. Anyone can go, and you can look at those prior advisory committee meetings. There are specific webpages across all 3 of the authorized COVID-19 vaccines, with frequently asked questions related to all of those vaccines. So, there is a lot of information that's available on the webpage. And, again, I think as Jeffrey highlighted it very well earlier, it's a matter of making sure that we can continue to get this information out there to the organizations, to community providers, so that they are aware. Next slide.

One of the other areas that I just want to spend some time talking about, and this is a priority for our office, which is our language access program and working to make sure that we have information tools and resources available in multiple languages. And during the pandemic, of course, we found out very early on the need for us to make sure that we had multilingual information, and really a dedicated multilingual resources webpage. And that's what you see here on the slide. And that webpage features a growing collection of educational materials, resources, and tools that are available in more than 20 languages including Spanish, simplified Chinese, Korean, Vietnamese, a range of other languages. And these are on educational materials that are on pertinent COVID-19 topics such as social distancing, diagnostic testing, vaccine development, fraudulent medical products, EUAs. So, there's a wealth of resources there, and I think it was very important for us to make sure that we had a dedicated multilingual resources page that has the catalog of all of our information and resources. And the other picture that you see on this slide is from our frequently asked questions, our COVID-19 FDA frequently asked questions, and that information is available in Spanish. Next slide.

So, we have also, especially, of course, in April being the theme of vaccine-ready, we've also been working to make sure that we are putting out our tools and resources related to vaccines to continue to work to build vaccine confidence and also to make sure that our communities have current and accurate information to dispel some of the misinformation and disinformation that's being communicated. We have a blog that was coauthored by myself and Dr. Peter Marks -- again, the director for our Center for Biologics Evaluation and Research -- and it has information related to the 3 vaccines that were authorized. It also links to a number of the activities that we've been doing to continue to work to build vaccine confidence. Next slide.

The other area that we know is that our health care providers have been, of course, tremendously hard-hit during the COVID-19 pandemic, and we've been working to make sure that we have ready-to-go resources that they can use to help educate their patients and their patient communities. And what you see

here are some that are related to, for example, vaccines but also a range of other toolkits that can be used for providers and others to be able to educate their patients, their stakeholders, their communities about different COVID-19 topics. There's one on monoclonal antibodies. There's another on hand sanitizers. On convalescent plasma. Again, I mentioned being vaccine-ready, so there's a range of toolkits that we have available so that hopefully our providers can have one-stop shop to be able to have some information that they know is accurate that they can share with their patients and their communities. Next slide.

This is an example also of other types of toolkits that we have available. We have our social media tool kit on, of course, being vaccine-ready and, of course, working to highlight the tools, resources, education that we have available and encourage folks to get vaccinated. Next slide.

This is our, again, I mentioned our vaccine 101 webpage that talks about that entire process of vaccine review, approval. There are infographics there. And this is also a already-prepared social media toolkit that can be used to continue to raise awareness. Next slide.

So I hope I have highlighted how we have, of course, worked across all of our stakeholders -- and this is by far not an inclusive list of everyone we have worked with to continue to raise awareness about FDA's COVID-19 activities to make sure that we are getting current and accurate information to our diverse communities. And the other area that I think has been really important throughout the pandemic is making sure that our diverse organizations, our communities, that patients are aware of the resources that we have available. Next slide.

So, thank you so much for the opportunity to share the work that we've been doing at FDA.

Great. Thank you so much, RADM Araojo. So, that concludes our presentation for this second session, and we will now move into the question-and-answer portion of this session. As a reminder, you may submit questions via the chat box, and we will address as many questions as time allows. And for our first question, and this is just for the group overall, so this attendee is asking, "Do the panelists have any recommendations regarding how to go beyond the social, economic and environmental determinants of health to address the political determinants of health? Especially in connecting with and convincing those who have a different political ideology. How do we develop both cultural competence and structural competence?"

Great question, and I think that what that really argues for here is the continuing willingness and commitment to talk to each other. I think that we still have to find a way to have dialogue with those who differ from us. That is, sounds a little Pollyanna-ish right now, I know, because we seem to be a country headed towards increasing polarization and fractionization away from each other. I think the political discourse is a challenging arena to do that, so I would probably reframe the thesis of the question and say, "How do people have a conversation with each other that starts to get us to a new place?" And, so, I would really sort of urge the-- and I'll just conclude my answer by sort of saying that, you know, when I -- the reason why I'm so happy to be with Jeffrey is, his community is different than my community. He was raised in a different way than I was, but the pain and heartache that I feel watching people from his community being beaten up and

attacked on city streets and accosted in restaurants, that fundamentally has changed my view of my world, and it has made me realize that Jeffrey and I are brothers in a way that I would not have known if I had just seen him walking down the street. I think we need to do that with our White brothers and sisters, Native American, and so forth. So, I think the conversation is more with people, and the political process will have to come behind it.

All right. Great, and then we can go ahead and move on to our next question, and this question is specifically for the rear admiral, and they're asking, "How could the FDA prepare a diverse community for the decisions to pause and resume offering the J&J vaccine? Any promising practices?"

So, there was a lot of, of course, preparation on our end. Of course, there was the press event that both CDC and FDA participated in and making sure that we knew that our stakeholders were aware that that was occurring, how to get to that, how to link to that. And then I think the other part is making sure that we were able to community that post that had been happening and making sure that, for example, we through social media, through email, through listservs, through direct communications where we reach out to organizations so that they know that those types of events are happening, but, more importantly, that once they've happened, that you have that because, you know, things are happening all the time. We're all in a virtual environment. You may not have been able to participate in that, but you want to know what has happened. So, all of that information is recorded, is actually on our website. We have actually repromoted it through both email, listserv, social media. So, and we also know that there's a big component of word of mouth. So, when we work with our stakeholders in making sure that they can get to that, we know that they're then going to be able to send that to their members, and their members are those providers in the community, and, so, it helps to get the information disseminated even further. But the one thing I will say is that we are always trying to find new ways to communicate information. There are new types of technology and advances that are coming up every day, so we are always trying to find new ways that we can extend our reach. We have a number of other types of programs where we work with directly individuals within the community that will help us also extend the reach of our information as we have those tools and resources available, so we're able to reach out to them. But I think that just to highlight the fact that we are always trying to find new ways to extend the reach of our information.

Excuse me. I'm sorry. I wanted to add, you know, just follow up on Dr. Tuckson's remark. Unfortunately I was talking but did not realize I was on mute. But I just wanted to just acknowledge as well that with regards to the political determinants issue. There are 2 practices or 2 things in particular that have a fine promising -- I'm trying to continue some development momentum across the country. In this last year I've seen much more of it in places like Atlanta and Oakland and Los Angeles, and that's the emergence of Black and Brown allyship, particularly among our youth and our most underrepresented community organizations. And I'm seeing allyship that I find very supportive as a community and inspirational as a community leader, and I'm really trying to learn much more about what is making this tick and how to be a agent of helping it spread. And the second issue, that area that I really wanted to highlight as well is that in the last 10 years, Asian American, Native Hawaiian, Pacific Islander community, we really learned so much more about civic engagement and what impact our community can make when we register to vote, get our community out to vote and get our

community counted in things like the census. Georgia has really helped us understand what community mobilization can do and what we can do with politicians who do not agree or see the benefit of some of the policies that our communities rightfully need.

Thank you so much, Jeff, and apologies for that earlier.

Well, no, it was -- the mute was on my side. It wasn't yours. It was me.

All right. Great, and we will stand by for our next question. ... Right, and we actually do have a question that was follow-up from our session 1, so I just wanted to check to see if Darcy Graves was still on the line with us. ... She may have had to drop off, so we can skip that question for now, but just as a quick reminder, if you would like to ask a question, please submit it to the questions box, and we will read that out loud.

While that question is going on, I think I want to come back to this issue that we've been sort of exploring about how do we work together. Tonight I alluded a couple of times to the fact that the Black Coalition Against COVID is sponsoring with the American Public Health Association, a webinar town hall for the 4 minority medical societies and their counterpart community activists and leaders like Jeffrey, and it's designed specifically for the very point that that question was getting to. To have the American Indian medical society, Hispanic American, Asian/Pacific Islander society, and the National Medical Association, the Black society, all working together with their counterpart groups and having a conversation about how do we work to come together. I think that what I'm getting at is, if we wait for governments and politics, and although we have to keep pushing for them. If we keep waiting for them to solve these things for us, it ain't going to happen, and it can only happen from the people themselves. And we've got to decide now that we've seen what fractionization really looks like. Now that we've seen what polarization really looks like. Now that we've seen what the efforts to disenfranchise all voters of color in Georgia looks like. When we see the bigotry and the hate on January, early January at the Congress. When we see these things, we now understand that the forces of good are going to have to be working overtime. And, so, I just hope that we will continue, especially for those of us on the health side of things, who are concerned with human survival, I really do hope that we continue to decide proactively. I've got to know Jeff. I've got to get to know Rear Admiral Araojo. I've got to get to know, you know, Dr. Anderson at the American Indian or Dr. Owen, who runs the American Indian. So we've just got to decide we're going to do those things and just self-appoint ourselves to be ambassadors to reach out and listen and learn, find common ground, and then move forward in a collaborative way. Then you can exercise political power, but we can't do it if we're fractionated.

Great. Thank you, Dr. Tuckson. And we will continue to stand by for our next question.

And by the way, if you want to come to our town hall tonight, you can go to facebook.com/blackdoctor.org. Oh, I'll say it again, facebook.com/blackdoctor.org, and you can do that, or you can go to YouTube.com, BlackDoctorOrg, YouTube.com, BlackDoctorOrg, no dot, either one, live tonight, 7 o'clock, be there.

Dr. Tuckson, now I need to make sure I promote the FDA webpage as well, so maybe I need to make sure I highlight our health equity webpage, FDA.gov/healthequity.

I'm sorry. I didn't hear that. You have to say it again; I didn't hear it.

I said -- Dr. Tuckson, you're making me -- now I have to promote that webpage. Can you hear me?

No, I want you to repeat the address again. I was giving you a little --

Oh, you wanted the address, FDA.gov/healthequity.

Great. Thank you both so much, and then, Dr. Tuckson, we actually have a follow-up question for you, and this attendee is asking, "So you mentioned women have been successful in breaking into science and medicine. What are the panelists' specific ideas for ensuring other minority populations are successful?"

Well, great question, and, number 1, it comes back to this fundamental of, we've got to deal with the education of science in all of our schools. And too many of our schools that are dealing with predominantly students of color are really suboptimal in terms of their infrastructure. The other thing is, if you go and talk with the associations for secondary science teachers and secondary math teachers, you listen to them, and I urge everybody to start to support them. They will tell you how hard it is to get the resources and the approval to be able to talk about genetics and those sorts of things in so many of our schools. So, I really think it starts there. And then, of course, if it is the pipeline. We have known for 60 years now that the only way to get this done is you've got to be able to start at the K through -- you know, the kindergarten, elementary school level to start giving these kids a sense of role models, possibilities. Then support it by education. Support it by mentoring and secondary supplemental science programs in the summer, after-school programs. It takes all of that. There's no magical solution here. I think for so many of the women that have been able to be successful, they to a large degree -- not exclusively but to a large degree -- they're also coming out of more resource-rich environments. Not exclusively by any means, but a great deal of them are out of resource-rich environments, and I think we've also recognized now this incredibly important social movement about the, just respecting the power, intelligence, and genius of women. And, so, those barriers are falling rapidly across every sector of our society. However, racism doesn't seem to fall as easily, and I think we've got to understand that there are still significant barriers there. But let's make sure that we support these junior high schools and high schools and teach the science. And by the way, just imagine what's going to happen when you're living in a genomic era where all of medicine is essentially founded on genetics. Where decisions are not going to be made on pathology data that say you have this or you don't have that, but you are giving back reports that say the probabalistic chances of such and such a thing occurring. How many people have an ability to participate in the modern world of probabalistic statistical-making decisions? It's just not there, and there's only about 6,000 registered genetic counselors in North America. So, physicians aren't going to have to time to do all of that. So, we've got to educate people to live in the modern world and be able to embrace it. So, I think it really starts at the elementary school, junior, and high school level.

Great. Thank you very much, and then just another question for the entire panel here. "Do you have any advice to offer reassurance to the minority communities that are currently being attacked or harassed due to rampant misinformation?"

Rampant misinformation?

Yes, and I can read that question once more. Let me just pull that back up. And this attendee was just asking for advice to offer as reassurance to the community, to the minority communities that are currently being attacked or harassed due to rampant misinformation.

Well, it's a tough issue that all Americans are facing, isn't it? And, so, unfortunately we're seeing it for everyone. As bad as it is for the Black community, the White Evangelical Republican community are getting it worse than we are, and, so, I think that this is a phenomenon that is now part of the modern world, and the only answer that I can think of -- and let's see what Jeff and Rear Admiral think -- but I think the only answer I can think of is, we're going to have to continue to make rational, intelligent, fact-based information easily acceptable to people in the way that they want it. One of the things that I am learning so much in my old age is I'm surrounding myself with very, very bright marketing people who are young, who are teaching me all kinds of ways of using social media that I would have never thought of. And, so, I -- you know, it has been interesting to me that I could do a YouTube show with a YouTube comedian and be able to reach more people through that one activity than a zillion press releases that will ever do it. And, so, I think that there are tools that we have available, but we're going to have to make sure that there are people who are trustworthy, and that's why I think it is so important that physicians of color from each of our minority communities are really out there. We have an extra -- and not only do we have to do our normal job, but we've got to go extra time and go out there and continue to put ourselves in front of our people and talk to them, not talk down to them, to be able to listen first then talk. That is essential: Listen first then talk. But then know that we have to be able to go at it over and over and over again and then do it in ways in which are convenient for the life that people are living so that it becomes -- that our messages are embedded in the normal life that people have.

And I'll just add to what Dr. Tuckson just mentioned. I think the "listen then talk" is so important. You know, I mentioned the listening session, stakeholder calls, other types of engagements we've had, so that way we knew the type of information also that we should put out there, that we needed to develop so that those resources were available to help to provide the education to work to dispel the myth and disinformation. So I think it's also making sure that our communities know where they can find that information and where they can find that accurate information and those resources.

And, you know, I just add to the complexity of that. I mean, always something to keep in mind when working with the Asian American and Pacific Islander communities in particular: People continue to look at community as a monolith. Remember, there are more than 50 racial, ethnic groups from different countries and different languages -- a hundred languages that are collected, at least recognized by the census, but we still do not have

enough information about all of those respective communities. Time and time again, even with the \$2 trillion relief for COVID, I hear government, both federal and at state level, "Jeff, which languages of the 100 languages do you want to prioritize." Because that's all we can do. But why do we hand that burden of communicating it and sharing the important education information -- we put a burden on our community-based organizations who have the least resources to do this type of additional outreach that must be done on the door-to-door level if needed. We've got to change our attitude about the collection of data and get our communities out of this invisible wall that they live behind because we are not selecting and committing to the collection of information about them as a country.

I would have to just also -- Jeffery's point is so important. I just want to put my arms around that one as well. One of the frustrations that so many community-based organizations have is that somehow there is the supposition that because their mission is to feed the poor and clothe the naked, that they're supposed to do that as a matter of course and that the money goes to other folks down town. The big contracts go to other people. The people that are on the ground trying to do it are oftentimes an afterthought. And, so, I just hope that we will continue to learn from this and realize that just because an organization has this beautiful saintly mission, thank god for them, doesn't mean they're supposed to continue always to have to do a catch-as-catch-can. That we need to invest and invest over the long-term in these things. If we go back and look at the resources that are given to organizations like Jeffery, if you look at the long arch of it, it's amazing how few of those organizations are still around or still strong. We move and lurch from disease to disease. Diabetes is big this year, okay, then AIDS was big one year, and now the pandemic. But when it's over, there's no oasis, there's no forest that grew. Just a few strands poking up through the cracks in the concrete. We need to invest in a long-term mature -- and these contracts and these grants, they can distract you because they're short-term. And we need to have the willingness to go the long haul and make sure that, 25 years from now, it's not just one flower planted but you have a whole garden. And that's the kind of work that we have to do. So, Jeff, you know, too often your organizations get taken for granted.

Thank you. I have nothing else to add to that. Thank you.

Great. I do want to be conscience of everyone's time. Rear Admiral, I know you may need to hop off the line, but we did have one final question for this session and this attendee did just ask, "How do you think we sustain these relationships after COVID is over?"

Well, I think you do it through -- first of all, I think now that we know -- I mean, look at India. Once you look at India and you realize the level of pain and suffering and hurt, and then we look back at our country and we look at the pain and suffering and hurt, I think we sustain these relationships based on compassion. Those of us who are still alive enough to care will continue to care. Now, there are some folks in this country who could care less. It's obvious. And we know that there's a whole bunch of them who have somehow or another equated wearing a mask or not wearing a mask as being some strange, weird political statement, which is absurd. And even some nut on TV I understand who's running around saying that you should confront negatively and attack people that are wearing masks. Other than those nut jobs, I think that the most of us now, our humanity is unlocked. And I really do believe -- I think if you have any sense of spirituality in

your life, any sense of optimism in your life, I think we'll find these relationships will sustain. I think we've learned a really important lesson, and I'm a heck of an optimist on this. I really do believe that our humanity will sustain us. There will always be negative nut jobs, but the overwhelming majority of us I think now will come together. And then let's remember also this, we had a heck of an agenda before the pandemic, so there's a whole lot of work waiting on us, you know, as soon as we get done. And there's a lot of us just chomping at the bit to get at it, so I think this will be good.

I'll just add one comment -- Oh, go ahead, Jeff.

No, no, please. Please.

I'll just add one comment quickly because, unfortunately, I do have to transition off, and really appreciate the opportunity to talk and participate on the panel. But the one thing that I would say is that COVID-19 has also with the relationships that we have -- we have new relationships and we will absolutely be working to maintain those relationships. So, I think that one of the areas that we've noticed with COVID-19, that it's brought us closer to the communities, the organizations that we should be working with, that we need to continue to work with. So, we will absolutely be continuing those relationships moving forward.

Yeah, and I just want to add that before COVID our organizations were focused on all the various health disparities that already existed in our communities. Now, we had our hepatitis B coalition, our tuberculosis coalition, our diabetes coalition. COVID popped in during all of that and we still have all of those disparities to address within our communities. Needless to say, all the other social injustices and inequities that still exist must be addressed for this country to ever meet that promise that we all want to see.

Hey, before we go, so I just want to make it again one more time, go to blackdoctor.org at 7:00 tonight and you will see the instructions for how to long into a live thing with all of our minority leaders. Lauren Smith from the CDC Foundation; Juliette Choy will be with us; Jeff Arsenio Lopez; Aaron Payment, Chairmen of the Chippewa Indian tribe. Anyway, thank you.

Great and thank you so much to all of today's presenters for joining us. I believe that concludes our second session. And our final session, which will be a panel discussion on solutions to promoting equity, will begin at 3:45. So, if everyone could please remain on the line, we will begin that session shortly.

Session 3: Solutions to Promoting Equity

All right. We will now begin our third and final session of the forum, entitled "Solutions to Promoting Equity." During this session, we're pleased to host a panel discussion to identify and implement solutions to promoting health equity as well as potential barriers. We're pleased to have Dr. Monica Webb Hooper from the NIH, Dr. Lauren Smith from the CDC Foundation, and Samantha Artiga from the Kaiser Family Foundation joining us as panelists. There will be time for audience questions following the panel discussion and we will address as many questions as time allows. Again, you may submit questions via the chat box at any time. Please note that members

of press should direct all questions to press@cms.hhs.gov. Just a final reminder that a recording of today's forum will be posted on the CMS OMH website following this event, and the link to that webpage will be shared momentarily. Can I have the next slide, please?

Great. Again, we'd like to invite our panelists to provide a brief overview of their organization's current work. And, first, we have Dr. Monica Webb Hooper who is the deputy director of the National Institute on Minority Health and Health Disparities at the National Institutes of Health. You may begin.

Thank you and good day, everyone. Actually, if we could stay on the first slide please for a moment. I'm delighted to be here participating in this important meeting, so thanks for the kind invitation. I do have the honor of serving as Deputy Director of NIMHD. And our mission is to work across NIH and the Department of Health and Human Services more generally to advantage the science of health disparities, to move us closer to meaningful progress, and also to promote health equity. Health equity is a term that we are hearing with increasing frequency, which is a good thing, yet conducting true equity work is quite the challenge. And as a biomedical research agency, the NIH and NIMHD approaches this from a scientific perspective. And advancing the science of health equity means that we are intentional about how we develop and train the next generation of scientists, how we engage with communities, how we develop and execute our science. It means that we plan at the outset how we will bake in equity as our primary ingredient in our science. Equity has to be baked in at the start of our efforts. It is an assurance and a process, not an outcome. It is the aspirational goal of health equity or that assurance of the level of highest level of health for all people that drives us in what we do every day, that assures that we value everyone equally, that we avoid inequities that can be avoided, that we provide support that are proportional to the needs, that we remove barriers to optimal health. Next slide, please.

So, I want to just give a couple of quick definitions to make sure we're all on the same page about this topic of structural racism, and we know it plays a role in health and other inequities. So, systemic racism, structural racism are synonymous and they can be used interchangeably. Structural racism refers to macro-level conditions, for example, laws and policies that limit opportunities, resources, and the well-being of less privileged groups. Two significant examples of structural racism are residential segregation and also the educational system, both designed to limit opportunities for less privileged groups. Structural racism is the most profound and pervasive form of racism. Other forms of racism, such as institutional, interpersonal, and internalized, emerge from structural racism. And then there is a distinguishing -- there's a difference between institutional racism and structural. So, institutional is more looking at the systematic distribution of resources, power, and opportunity to benefit people who are White and to the exclusion of people of color. And it results in discriminatory treatment, unfair policies within organizations and systems, and inequitable opportunities and impacts based on race that are perpetuated by institutions. And one example of that is how it has led to the inequitable access to funding, training, and workforce opportunities when you think about it within the biomedical research enterprise. Next slide, please.

This is the NIMHD research framework. It's important because it reflects an evolving conceptualization of how the science can examine factors relevant to the understanding and the promotion of minority health, and help us understand and reduce health disparities. And much of the biomedical research in this field has focused on individual-level biological mechanisms. So, the purple box here has an explanation for poor health among minoritized groups and for disparities. And as you can see, focusing there singularly on biology, genetics, or individual-level factors misses the great complexity of understanding and addressing health disparities. And it does not span the other domains of influence, such as behavioral, physical/built environment, sociocultural environment, or the health care system, or the other levels of influence -- interpersonal, community, societal -- within these domains. So, we have to think bigger and more holistically, and we have to study the same way to assure equity. Next slide, please.

So, we have to get to the root of the problems, and in recent months there is increasing recognition of the roles of structural racism and discrimination as root causes of health disparities. I want to mention just 2 specific ways in which NIH is working to address the root causes, recognizing that this is a marathon and not a sprint. Next slide, please.

So, on March 1st you may have seen this quote from NIH Director Dr. Collins, which is an apology to those individuals in the biomedical research enterprise who have endured disadvantages due to structural racism. This is an important statement and one that accompanied the launch of a new NIH initiative that you all have the opportunity to become involved in. It is called UNITE. Next slide.

NIH established the UNITE initiative to address structural racism in biomedical research with the goal of ending racial inequity. The primary goals of this initiative are described in the acronym. So, U, we are seeking to understand stakeholder experiences through listening and learning. N, we are supporting new research on health disparities, minority health, and health equity. I, we are seeking to improve the NIH culture and the structure as it relates to equity, inclusion, and excellence. T is our transparency focus looking at communication, accountability, with both internal and external stakeholders. And E is about changing policy, culture, and structure in the extramural research ecosystem. And there are multiple ways to be involved. We just closed a request for information on April 23rd, which sought wide-ranging stakeholder input and suggestions on new ways to support diversity, equity, and inclusion, and identifying and dismantling any policies or practices that may harm our workforce and our science. And we were delighted to have over 1,000 responses that we now have the great joy of analyzing. We'll also be conducting listening sessions and focus groups with internal and external stakeholders in the coming months to help advance these aspirational goals. Next slide, please.

The last thing I want to mention is NIH also has a new research funding opportunity lead by NIMHD that is entirely consistent with the goals of UNITE around structural racism, and its impact on minority health and health disparities. Next slide, please.

The goal of this opportunity is to promote inclusion of structural racism in health research. We know that racism and discrimination are documented social determinates of health and drivers of health disparities, but they're

not routinely included in human health research. So, we see need for this, research that examines and addresses structural racism at higher levels. And here are a few examples at the organizational, neighborhood or community, and societal level. We see this as an opportunity to not only think outside of the box to understand health, but to build a new one. And the purposes of this initiative are to support observational research to understand the role of structural racism in causing and sustaining health disparities; and, second, testing interventions that actually address structural racism to improve minority health or reduce health disparities. So, I encourage you to review these opportunities and I'll stop here. I thank you for your attention and look forward to the discussion.

Okay. Thank you, Dr. Webb Hooper. Next, we're pleased to introduce Dr. Lauren Smith, Chief Health Equity and Strategy Officer at the CDC Foundation.

Thank you very much. And it's a pleasure to be here and I am so thrilled to be on the panel with such distinguished colleagues. I want to take just a few minutes to tell you a little bit about how we're thinking about health equity and structural racism at the foundation. And we want to engage in that conversation with you. Next slide.

I wanted to start with this quote because I think this quote from Paula Braveman is so compelling and I think it really builds on what Dr. Hooper was just talking about, which is that health is something we create as a society and as communities, not something an individual can purchase or produce alone. And this goes counter to what is often a very individualistic approach to health and health care, that this is something we do on our own and make our own choices. If we're healthy it's because we tried harder and if we're unhealthy it's because we did something wrong. But I think as Dr. Hooper was pointing out, it's so important for us to remind each other and our colleagues outside of public health and health care that this is something we create as a community and you cannot get to health all by yourself. Next slide.

At the CDC Foundation, we are envisioning a time when we have vibrant, healthy, resilient, and prosperous communities where everyone can lead their healthiest lives and can contribute to the well-being of their families and communities. We see and I think we've been able to experience during the time of the pandemic what happens when this isn't the case. But when it is working, our country and the world benefit when all people can experience those conditions that allow them to be healthy and to thrive. It's really in our best interest. Next slide.

We have identified 6 key principles that we think are really important for underscoring and sort of building into all of work, which you see here. I won't go through all of them. I'll just mention, you know, a couple. Community inclusion, engagement, and partnership is essential; focusing on the building blocks and individual community health as we were just talking about is essential. But the piece that I wanted to talk about today is the understanding, communication, and reckoning with historic and current systemic racism, the level of racism that's structural or deep racism -- deep underpaintings that Monica was just talking about. Next slide.

One of the ways we've found it helpful to think about this is using the approach, the very helpful metaphor by the Racial Equity Institute has

developed called "The Groundwater Approach." And I want to give all props and shout-out to them because I think it provides a metaphor that is very easy for folks to understand and can then allow people to go deeper in their analysis of what's going on. Next slide.

So, their metaphor essentially starts with fish and the question they pose is: When you notice that there's a lake where fish are dying, what do you do? Initially the idea might be that you would focus on the fish and that there's something wrong with the fish. That there's some problem that they have because, you know, you're noticing that they're not doing well. Next, click. However, if you notice again -- next -- that in fact there are fish dying who are unwell in multiple ways. If you click again, then we see not just in health care but in education, in the criminal justice, those other systems that Dr. Webb was talking about -- next. Then they have to say, "Well, how is it that the fish in all of these different lakes are sick or not doing well?" And then that leads you to this idea of the groundwater. Next. And the idea is that the groundwater is the toxic or contamination that seeps into all of the lakes, i.e., the different domains or areas in which we live. And that we can't focus only the fish, what people start to call fish-fixing, because that doesn't get to those underlying causes, the root causes that in public health we're used to talking about, that's in the groundwater that seeps into all of these different areas. Next slide.

So, the foundation has identified 3 mutually reinforcing strategies that we believe will help us address that underlying groundwater, the structural racism that has been contaminating all of the different areas and ways in which we live our lives. The first is to support a strong, trusted, and diverse public health sector with the skills and capacities necessary to lead in the 21st century. And by that, we mean not only understanding the principles of public health, but understanding how to apply the equity principles, the community engagement, the partnership, the power sharing, the recognition of power dynamics, the recognition of history -- all those different ways of understanding our context that we want to make sure all of our public health infrastructure is adapted and prepared to do that. We also want to build the capacity of community-based organizations to promote that vibrant, healthy, and resilient vision of communities that we believe is so important because community-based organizations are trusted leaders in their communities. They know their communities well and they are important parts of the fabric, but in many times and many places they haven't necessarily had the connection to the rest of the public health infrastructure in a way that could be sustained in an ongoing way. And then, lastly, enhancing the integration of public health, health care, human services, and private sector to that cross-sector work that's necessary or essential to building a transformational community well-being movement. All of these with the principles that we talked about in this recognition of the importance of focusing on structural racism, that groundwater, we believe will help us get to the point of that vision of vibrant, healthy communities. Next slide.

And with that, I want to just pause and mention that we know that this is a difficult time because there's so much that we are confronting. We also know that people are weary -- emotionally, psychically, physically -- from this past year -- over a year -- but we're also feeling galvanized because of the energy and momentum that we see. And I would just say as an example, as a companion to what Monica mentioned, the CDC has -- as I'm sure many of you have seen -- made a very strong statement that the new director, Dr. Walensky, that racism is in fact a public health crisis. It is a public

health epidemic and one that we need to confront, and so we stand ready with NIH and all of our other partners to do that. Thank you.

Thank you, Dr. Smith. And our final panelist is Samantha Artiga, who is the Vice President and Director of Racial Equity and Health Policy Program at the Kaiser Family Foundation. Ms. Artiga, you may begin.

Thanks so much for having me here today. I'm really honored to present with these other distinguished panelists and look forward to the conversation that we'll be having. Next slide.

I wanted to start with just a little bit of background on who our organization is for those of you who may not be familiar with us. I'm with KFF, the Kaiser Family Foundation. We're a nonprofit organization that's dedicated to providing information and research to help inform on key health issues affecting the nation. I did want to clarify that we're not affiliated with Kaiser Permanente in any way. We really conduct a broad range of different types of work, including policy analysis, polling and survey research. We have a journalism arm called Kaiser Health News, and we have a team that engages in public health information campaigns, including a recent one focused on COVID. We really strive to reach a diverse array of audiences, as you can see on the slide there. Next slide.

Within KFF, I head up our work for the racial equity and health policy program, which is really focused on the intersection of racism and discrimination, social and economic inequities, and health as well as the health care and health care needs of underserved populations. We really strive to provide timely and reliable data and policy analysis to help inform on health and health care disparities. We try to provide education to increase awareness and understanding of disparities, conduct data analysis to provide better understanding into the status of disparities and how they're changing over time, and analyze the implications of emerging policy changes in terms of how they will influence efforts to advance equity. Next slide.

So, we have been focusing on disparities since long before the COVID-19 pandemic began, but when COVID started, a lot of our work across the organization really shifted to focus on COVID-19 impacts, and in particular the disproportionate toll the pandemic has taken on communities of color and underserved groups. At the outset of the pandemic, a lot of our work really focused on highlighting why these groups were facing disproportionate risks associated with the pandemic, including increased risks of exposure to the virus due to working and living situations, increased risk of experiencing serious illness if infected with the virus due to underlying health disparities, and increased barriers to accessing testing and treatment related to the virus due to underlying disparities in health and health care. As the pandemic progressed, a lot of our work has shifted to focus on the unequal impacts of the virus, both in terms of health outcomes but also in terms of the economic fallout that has been associated with the pandemic. And now that the vaccine effort is underway, much of our work is focused on tracking who is and who is not getting the vaccine, and as you can see from the slide here, we are seeing a lot of the same disparities that played out over the course of the pandemic now playing out in terms of who's getting the vaccine, where we're seeing persistent and widening gaps in vaccination rates, particularly for Black and Hispanic people. Next slide.

And we know from our strong base of work that existed prior to the pandemic that these disproportionate impacts we saw over the course of the pandemic are really reflective of underlying health disparities that were already in place. Here you see an example from some of the analysis we've conducted looking across federal data sets about how different racial/ethnic groups compare across a broad range of health measures. And you see in particular that Black and American Indian and Alaska Native people fare worse than their White counterparts across a broad range of health status measures, including infant and maternal mortality and overall physical and mental health and well-being. Next slide.

So, we know in part those disparities reflect differential access to health care, including disparities in health coverage. Here we see that, over time, people of color have been more likely than their White counterparts to lack health insurance coverage, which is a key component for accessing health care, and that while all groups have experienced gains in coverage as a result of the Affordable Care Act, that these disparities in coverage have persisted over time, leaving people of color facing increased barriers to health care. Next slide.

But as you've heard from our previous 2 speakers, our health and well-being is reflective and driven by many more factors that sit outside the health care system. So, while the health care system plays an integral role in shaping our health, it really is these broader social and economic factors that sit outside the health care system, which may in fact have an even more substantial role in terms of driving our health outcomes and our health and well-being. And it is those inequities across those broader factors that drive those disparities in health. And as mentioned by the previous 2 speakers, the inequities we see across these broader factors are rooted in racism and discrimination. Next slide.

So, I just want to close out with a few final thoughts. As you see here, I think everyone who's been working in this field knows that health and health care disparities have been a longstanding and persistent challenge, and that they are reflective of a broad array of underlying social and economic inequities that are rooted in racism. COVID-19 has really exacerbated and brought increased attention to disparities and may further widen health disparities going forward if the disproportionate impacts of the pandemic are not mitigated. I think we really are in a pivotal time now to advance equity, given the increased attention and focus on disparities and the risk of facing even widening health disparities into the future. And just some things to think about as we look ahead to advancing equity is really how to prioritize equity across sectors, so not only within health care, but across those other domains. And not only prioritize equity, but then direct the resources to help support efforts to advance equity across those sectors. How can we increase the availability of high-quality, disaggregated data that is so key for our understanding of disparities and for informing actions to address them? And then how can we support and build on the existing strengths we have in community resources and providers, who as the other speakers have mentioned really are already established, trusted resources within communities? And then, lastly, how can we establish measurable goals for health equity and build in incentives and accountability for meeting those goals? And with that, I'll close and look forward to our discussion.

Great. Thank you, Ms. Artiga. We'll now begin the panel discussion, which will be moderated by Dr. LaShawn McIver, who is the Director for the Centers for Medicare and Medicaid Services Office of Minority Health. Dr. McIver, I will now turn it over to you.

Okay, thank you. I'd like to start by saying thank you to our panelists who are joining us today. You are coming on the -- you're closing out a 2-day forum that has really shed some incredible insight on the complexities that we're addressing when we're looking at structural barriers in health care that are rooted in racism. And, you know, one of the things that I think is very unique about this time is we're seeing different stakeholders coming from different journeys and experiences, coming together to talk about this topic with the notion that we're looking to find solutions. And, so, this panel is focused on solutions, and just thank you to all of you for joining. So, I have a few questions just to start off about some of the things that you've covered and shared. So, Dr. Hooper, thank you for sharing what NIH is doing. I wanted to start with you, and, others, if there's insight that you have, this is -- you know, I do hope we can engage in a dialogue. You talked about the incredible work that you all are doing at NIH to address structural racism in the biomedical research area. As you all probably know, based on some of the recent executive orders that have come out over the last couple of months, the administration is asking for this whole-government approach of embedding equity into the work that we're doing. And, so, given the work that you all were -- actually, this sounds like it has been in the works for some time -- wanting to hear from you, what lessons did you learn and/or did the institute learn in this process of beginning this embedding of equity into the research in such a -- I mean, this is a pretty significant effort for NIH, so I'd love to hear if there are any insights that you'd like to share.

Sure, and thank you. It's nice to be on the panel with all of you. I think that -- so, this funding opportunity that I described to focus on structural racism and discrimination, you're correct, it's been in the works since 2017. So, for NIMHD, this is the work that we think about, but this is probably the first RFA -- or request for applications -- of this kind. And, specifically, there was a process undertaken by our amazing program officials who conceptualized the idea, brought it through our council, which consists of national experts and other stakeholders, and then engaged in a workshop and brought together stakeholders also from multiple sectors and disciplines and backgrounds to understand what the challenges are and to bring us to the place of being able to develop an RFA that would allow us to drive the science forward. And one of the major things, I think, about this FOA that is really important is that it's not only focused where typically see the work on racism and discrimination at the individual level or interpersonal racism experiences, which are important and are major drivers, but this is looking at racism at higher levels. So, encouraging science that looks at how we can address organizational factors such as, you know, workplace hiring, promotion, disciplinary practices, academic tracking -- things that along the pathway impact people's likelihoods, their opportunities, their experiences, and specifically tying those to a health outcome. They must be tied to a physical or mental health outcome. So, we think that hopefully we'll get great applications. This is an active funding opportunity that will hopefully lead us closer to understanding how we can address this and using actual interventions.

Thank you. I will see if any of our other panelists want to respond to this concept of, what does embedding equity into the federal government entail? Like, we saw this example with NIH. Maybe, Dr. Smith, you can speak to a little bit more about what the CDC recently described through their public health effort.

I think we're, you know, like what Dr. Hooper was saying, you know, thrilled to see a very explicit statement that acknowledges everything that the panelists have said, but to just really just put it out there in an explicit and intentional way, so the fact that the director really highlighted that for CDC, this is going to be a major focus and priority. And as a foundation and the work that we do to support CDC and to advance the overall efforts around, you know, building healthier communities, it has been part of the work that we've been doing, sort of like with what Monica was saying. It was there. Now we have, I think, the running room to really be able to be much bolder perhaps and much more explicit in our conversations around it because people are beginning to have language that they're increasing comfort in using about this.

Thank you. Ms. Artiga, did you have a comment related to that?

Well, you know, I come at it from a slightly different angle since we sit outside government, but I will say that I think the prioritization of racial equity from the federal government is a very strong statement, and to then see it being reflected through the agency actions and then through resources, I think a really important step forward in terms of moving forward toward advancing equity. As we've discussed, we can't start until we recognize the problem. And, so, I think as Dr. Smith has mentioned, naming what the root causes are, having an increasing level of comfort as naming those as a root cause is important. And then we also are now seeing these specific initiatives focused on addressing the issues at a systemic level as well as resources behind the prioritization of equity with the creation, for example, of the COVID-19 Health Equity Task Force with specific efforts focused on enhancing COVID-19 response directly to communities of color and underserved groups who have been disproportionately impacted by the pandemic, and then with the goal of continuing this lens and focus expanded beyond COVID-19 to help more broadly.

If I could just pick up on that one piece, I think that that's so essential. At the foundation, we are seeing the support for the response we're doing with community-based organizations as an example all across the country, focused on equitable, sort of, distribution and uptake and acceptance of vaccine. We see that as a both/and kind of proposition, that it's essential now to support these community-based organizations to do this work so that we can protect our communities. But it's also essential to just invest in them to help them to build to be part of that infrastructure that I was talking about because the very same issues and underlying root causes that led to the disparities, as Dr. Hooper pointed out, the disparities in COVID also cause all the other disparities that, you know, those of us who have been, you know, doing this work for a long time, have been documenting for, you know, years and years. So, we want to see this as both an opportunity to respond now to the pandemic that's in front of us, but to compare ourselves and our partners to sustain that momentum to address this long after the pandemic is hopefully over.

Thank you.

So, I want to start with - so, thank you for answering those based on your presentations. I want to start with something that we've seen as a solution, but I think COVID has kind of tested -- is this a good solution? Are there other things that we should consider? And it has to do with the digital divide that we've seen over time and has truly been tested during the pandemic. So, as we're thinking through solutions that are currently in place but more so solving around these things for the future, how can we address the digital divide and the impact that it's had on health disparities, and, you know, again, we saw, you know, what happened when we were forced to all -- I mean, we're having this virtual forum which informs. You're anticipating going up to the microphone and having your moment and engaging with the audience, but we're all in this new reality. But we've also seen, you know, we're seeing how that's playing out in the clinical area as well and how it's impacting people from different communities. So, how would you all speak to the digital divide and the health disparities that we're seeing and solutions towards that in the future?

I can start, and then if others want to jump in. I think one real lesson from the pandemic and the response efforts and the vaccine rollout is that our underlying systems and structures have inequities baked into them, and that when we turn and seek to build upon and rely on those existing systems and structures without an intentional focus on addressing equity, that we allow those underlying disparities to persist. And, so, I think a concrete example is when the vaccine rollout started, much of it was conditioned upon having online access to get an appointment. And that means people without online access, without high-speed internet, without ready access to a mobile device, were left behind in that process. So, that's an example of there where built-in inequities that then contribute to health disparities because we're relying on the existing systems. So, I think going forward, as we're increasingly looking at technology, and I think that the increased use of telehealth has helped to address some access barriers and disparities that were in place before, but we have to keep a very intentional focus on equity and account for, how do we address the needs of people who don't have those resources? And, so, ensuring that whatever policy or approach we are pursuing accounts for the wide range of resources that people have available and takes into consideration the fact that not everyone has ready access to a device, ready access to internet. So, for example, can you just use a phone call? How can we create broader types of platforms that provide broader access to people across a broader range of devices and connection systems. But I think it really comes back to starting with an intentional focus on equity and taking a very careful consideration of how any approach you are considering will affect people based on their differential access to resources and opportunities.

Well, I think that's spot-on, Samantha. I would add to that that we're aligned completely on the vaccine rollout and the dependence on internet access. I think that problem still is not completely resolved, and in addition to the access to the mobile or other technology, it's the ability to use it. So, the website, even for people who are technologically savvy and who use the internet on a regular basis also reported challenges with obtaining the appointments or even identifying an appropriate location for them to receive the vaccine as an example. And in my work before joining the government, I worked on behavioral interventions, and we looked at someone mobile health approaches just in what we thought was a simple text messaging intervention, and this was in the tobacco cessation world, and what we found

was that even just using text message for a significant number of primarily African American, primarily lower-income individuals was very challenging, and that many had pay-as-you-go phones, so they did not have data plans. And, so, you know, even utilizing their phones for this purpose was a challenge. So, unless you're providing the devices, that became a challenge for us to really have feasibility with regard to -- which was one of the questions with some of the work that we did. And I recall at the time having a hard time convincing grant reviewers of my work that this was an issue because it's sort of the idea that, you know, it's ubiquity. "Everyone has access. Everyone has access. This is not an issue." And I think that COVID, one of the kind of odd silver linings is that these things are on the surface now, and we do have this window of opportunity. Because otherwise I found it challenging to convince people that these are significant problems -- the access but then the ability to use the technology.

It's really almost as if you have to look across the entire life cycle or at each stage and ask yourself a set of questions. "Are there inherent barriers here?" So, even, you know, everything that Samantha and Monica said is 100% spot-on, and then there's the added piece of, who has time? Who has the disposable resource of time during the day when, you know, the websites are sort of, you know, functioning to be able to do this? Depending on the kind of job you work, you could potentially have all those other resources and just not have the time because you're working as a frontline worker in a nursing home; or you're working in a grocery store; or, you know, a meatpacking plant; or many other places where you literally just don't have the time. So, it's just, we have to ask ourselves at each step along the way, "Are there barriers that we're not accounting for?" And I think it's when we don't ask ourselves those questions that, you know, Monica, then you have that sense of that experience of people saying, "Well, how can this possibly be a problem?" It's like because they didn't interrogate the assumptions at each step along the way.

And if I can just pick up on that, I think that circles back to a lot of what we each spoke about in our comments about the important role of community-based organizations and using community-based organizations as a resource to learn from because a lot of times you can avoid some of those barriers and unanticipated impacts by seeking input from those community-based organizations who understand the needs and preferences of individuals best and can help shape approaches that will work to fit within those preferences and needs.

So, someone commented, I think it was you, Dr. Hooper, about -- so, we know that COVID demonstrated many barriers that people have worked in this space for decades were aware of, but did we learn anything new? Like -- this is for all of the panelists -- did we learn anything new during this pandemic that we should be thinking forward as we're looking at health equity solutions?

I would say there's -- I'm sure there's lots that we've learned, but I'll pick 2 things, one on the positive side and one on the less positive side. One is, in terms of delivery of health care, because I think this is what you were alluding to at the beginning, we -- health care was able to pivot in a lot of ways to be able to do things, either telephonically or in a telehealth way that, you know, as a, you know, recovering clinician, that we always said: "No, you couldn't possibly do that. There's no way you could do that." It's like: "Well, guess what? People figured out some ways, and they

figured out it worked, you know, pretty well." So, I think that that's -- there's that. Recognizing what we were just talking about, how there's not, you know, access to all this, but just getting over that hump of saying that, you know, "What's possible to do telephonically or in a telehealth way?" I think is important. The part that I guess is not necessarily new, but I think really was striking to me, is the degree to which misinformation and the just overflowing amount of mis- and disinformation that exists that we in health and public health are having to confront and sort of compete against, I think was something that was, you know -- I guess it's always been there, but it's really, I think, been really intensified during this pandemic.

And I think we've learned -- I agree with those. I was actually trying to think of what I've learned. What -- I think another thing that has -- that will be interesting to see as we go forward how things change is sort of the practice of medicine in general. Will these changes be institutionalized? Even kind of simple things that were sort of routine medical practice, will they change? So, for example, you know, taking your child to a pediatrician or even yourself going to see your internist, and the person comes into the room. They may wash their hands. They should wash their hands, but they're not wearing a mask, for instance, but they've been interacting with other people who have viruses. And now, with the way things have changed, you know, it stands to reason that these things will become standard practice in terms of medical providers, clinicians in general, wearing masks as part of what they do as they interact with people throughout the day -- because I think people have learned so much more about viral transmission, about behavioral mitigation. We've also learned, I think, about the need for public health and medicine to be more interlocked, because we saw lots of breakdowns because of those 2 systems not being as coordinated as they can be. That has improved, and I think we have an opportunity to sustain. I think that'll be the key, is, "Can we sustain the positive changes that have come from this experience with COVID-19?"

I don't think it's something that we learned new, but I think maybe there was increased understanding and awareness of how inextricably linked living and working situations are to health. And I think the pandemic just provided such a concrete example of how all the factors related to where you live, what your job is, can so directly influence your health, as we saw that play out in terms of who was at risk for getting infected from the virus, and who was at risk for getting sick and dying from it, and that just being so closely linked to those factors.

Thank you. So I have just maybe 1 or 2 more questions before, Haley, I'll turn to you to see if we have any from the audience. But, you know, one thing I used to talk about several years ago was health equity fatigue for people who had been doing this work for years and years, and, you know, we come through these mountaintops and these valleys in this experience, and we're right now at a mountaintop of opportunity. People, as you've said, they understand it in a different way. We're talking about something that I don't think, you know, 2 or 3 years ago we would have been able to have this type of forum, and people actually come to the table open to you, understanding what the problem is and what are potential solutions. So, my question for you is for many people who have been doing this work over a significant amount of time, how do we hold all of the stakeholders who are at the table now accountable for moving this moment forward? Like, how do we

come together and actually move beyond this moment and start to remove some of these structural barriers?

That's -- wow, that's a great question because essentially you're asking, "What comes next?" You know, you're asking, "How do you maintain the momentum, and how do you keep that door, that window from slamming shut now that it's been, you know, pried open, blown open, you know, people sticking their feet in to keep it open?" I think that there's issues around sort of transparency and recognizing our own roles in, even if unintentionally, in contributing to those inequities and having the stamina to be able to do that. I mean, I think we've seen that in organized medicine recently if people have been following some of the controversies, you know, with JAMA in terms of having to acknowledge its -- what's happened in terms of the, you know, structural racism at play. So, I think one of it is around sort of recognizing our own roles and then having that partnership with the trusted partners. I mean, to build on what Samantha was saying, now that we are developing -- or not now, but as we enhance the partnerships with community-based organizations and other community leaders and community activists, I think they are going to hold us accountable because, you know, they're going to continue to say: "Hey, you said this other thing. Now, you know, walk the walk."

I may be overly optimistic on this front, but I hope that we have crossed a line where we cannot turn back and shove this under the rug and ignore it because it has come under such a bright light in terms of understanding and because the disparate impacts have been so stark. So, I know a lot of us have concerns that this is just a moment in time, and, you know, how can we sustain it? I hope that we have reached a point where it is on the table and will stay on the table. I think it sounds very dry, but I do think increasing data collection and reporting is an important element because if we are measuring and showing disparities and showing potentially disparities persisting or widening, it's harder to ignore when the data tell us that picture. And even more than collecting and measuring it, building those equity-related measures into performance goals, quality outcome measures so that we are building a system that incentivizes and measures against equity so that we are more so embedding equity into our systems and goals, I think, is an important component of this.

Okay. So, Haley, I will just see if there are any questions in the chat for the panelists.

Sure. We can have one question that I think is pretty general for the group, so this attendee did ask: "How does the media help or hinder dealing with structural racism and health inequity? Any suggestions regarding how we can optimize the use of both quantitative and qualitative data to be positively impactful?"

Well, I mean, I think we use data all the time to try and tell the story of how people are being impacted, and the data can give a good overview and picture, but, obviously, the qualitative data and more anecdotal evidence can provide more context and nuance to understanding for the trends we see in the data. So, I certainly think both of those elements are important. I think the media has played a large role in terms of increasing the awareness and understanding of disparities, particularly over the course of the pandemic, and that it's important that the various factors be taken into account as we're considering disparities, and, for example, as Dr. Hooper

laid out at the beginning, how we move focus to systems and structures versus individuals. And I think that narrative is important going forward, as well.

Yeah, I agree that the media plays an important role in this. It's how the, you know, lay public receives information about this, and it can be very helpful especially when reporters do their due diligence, and they reach out to experts, and they're looking for multiple experts who can provide different context to address the same concerns so that the stories end up being, I think, more comprehensive and understandable for people who are in various stages of life and who may be engaged in various sectors. But it's important that we continue to work together. So, the media is an important component because they are often the deliverers of the messages. And for many people, it might be their local station where they find reliable news, but making sure that the news is accurate and helping people decipher the sort of infodemic that's in front of with us with this rapid spread of misinformation is really critical because the reliance on social media and other sort of word of mouth is, as we see here, very problematic, and the media has been helpful, I think, to help elucidate some of these challenging issues and questions people have.

Right. I'll give you an example of that. I was reading an article today about a school in Florida that has issued a decree that they will not hire, or they will not allow to be employed, any teachers who have received the vaccination for COVID. I know I'm looking at LaShawn's expression. And that's because they are following, you know, a debunked, you know, untrue idea that being exposed to people who received the vaccine has some reproductive -- you know, poses some reproductive threat. Now the article that I read about this I don't think did a good enough job at describing just how untrue that is and sort of laying that out. They sort of presented it as, you know, here was this thing, and, you know, maybe if you went further, you could find it. But that's an example where you can't just lob that out there, I don't think. I think that that's kind of irresponsible, frankly. I think if you're going to put an article out there, then you need to sort of have a whole section there about, like, why that's not true.

I think we are actually at time for this part of the panel. I have enjoyed the conversation, the information that you shared, and certainly the wonderful efforts that you all are doing to promote solutions to help address health equity. So, thank you, all, for joining us, and I'll just wrap up with just a few final thoughts. So, thank you, all.

Thank you.

Okay. So, just in these next few minutes, I wanted to say on behalf of the Office of Minority Health at CMS, thank you for those who have participated in our 2-day forum looking at this critical issue of addressing structural racism in health care. We've heard from a number of stakeholders, both federal -- you know, we talked about the span of people who joined us, so there were federal partners, community activists, health care systems, people from academia. We heard from a whole medical team from New York. Just different perspectives of, "What does this mean for the health care system?" But more importantly, "What are different solutions that we should be considering as a health care system as we're thinking through what happens next?" So, I appreciate the contributions of those who have expressed their opinions and views on these issues in a way to bring awareness of what this

means and how it impacts populations differently. At CMS, we're committed to addressing the needs of minority populations. And, so, we'll continue to, you know, deepen our knowledge and understanding of how things that we're doing as an agency, how we can help, you know, eliminate barriers so that people can receive optimal care. I'd like to thank also the Ketchum team who's helped to moderate this 2-day panel, and at this time, I will turn it over to Haley to tell you all how you can access things as we close out. But, again, thank you so much. I know that, you know, for some this might have been a difficult conversation at times, but understanding starts with - - you know, this is a part of understanding is gaining awareness of what the problem is and moving toward solutions. And, so, we at CMS are here working on behalf of the millions of people that we're responsible for delivering equitable care. We look forward to future collaboration and engagement with all of our stakeholders from every community, and, again, you know, thank you on behalf of our team. Thank you so much.

Thank you so much, Dr. McIver. This now concludes day 2 and therefore concludes The Road to Equity: Examining Structural Racism in Health Care Virtual Forum. As noted on the slide, the recording from the forum will be posted to the CMS OMH Webinar and Events page in the coming days. We thank you all for joining. Have a great afternoon.