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

Tuesday, April 27

Hello all, and welcome to "The Road to Equity: Examining Structural Racism in Health Care" virtual forum hosted by the Centers for Medicare and Medicaid Services Office of Minority Health. Today's event will consist of 3 sessions, and there will be an opportunity for questions following speakers' presentations. To ask a question, you may submit questions via the chat box at any time to be read out loud. Alternatively, you may raise your hand by toggling the green hand icon on your Go-To menu to ask a question over the phone. Please note that members of the press should direct all questions to press@cms.hhs.gov. A recording of today's forum will be posted on the CMS OMH website following the event. A link to that page will be shared momentarily in the chat box. With that, we are pleased to introduce Dr. LaShawn McIver, Director of CMS OMH.

Thank you. Hello everyone, and welcome to "The Road to Equity: Examining Structural Racism in Health Care" virtual forum. I'm Dr. LaShawn McIver, Director of the Centers for Medicare and Medicaid Services Office of Minority Health, or CMS OMH. I want to thank all of you for attending our forum today. We are joined by several hundred people from across the country, including representatives from 100 different organizations, equity thought leaders, nurses, doctors, researchers, government and private industry representatives. We have people joining us from cities such as Seattle, New York and Chicago, to locations spanning across rural America, totaling 30 states represented today. Throughout these next 2 days, we will be joined by speakers from the federal government as well as private organizations to share their insights, experiences and solutions for addressing structural barriers within health care. We are excited to have this opportunity to meet with you all and deeply appreciate your tireless work in these unprecedented times. Next slide, please.

As you can see, we have a robust agenda for all of you today, and we'll be joined by representatives from various organizations including CMS, HHS, the American Medical Association, the American Hospital Association, the Commonwealth Fund and an entire team that's joining us today from the Jamaica Hospital Medical Center. We'd like to say a special thank you to all the speakers who will be participating in today's session. Our opening session will look at the current state of health disparities and current efforts to address health equity, while also taking a look at the barriers or at the broader picture of racism in health care. Session 2 will focus on increasing understanding and awareness of the value of collecting and analyzing standardized patient data, and session 3 will focus on increasing understanding of the impact CMS programs and policies have on health and health care disparities in minority and underserved communities. Throughout each session, we will also look to identify innovative ways health care systems and organizations can reduce disparities among those they serve. Next slide.

Before we get started with our presentation, I wanted to provide some additional information on CMS's renewed focus on health equity, the role of our Agency as an equity partner, and how we along with other federal agencies and partner organizations plan to address structural racism in health care to create a more equitable system for all Americans. Next slide.

CMS OMH serves as the principal advisor to the Agency on the needs of minority and underserved populations. We provide subject matter expertise to CMS on minority health and health disparities and give recommendations on how to address them. Our office ensures that minority health interests are represented by leading and/or coordinating minority health initiatives within CMS and engaging key internal and external stakeholders in this important work. Our mission is to ensure the advancement and integration of health equity in the development, evaluation and implementation of CMS's programs, policies and partnerships. Improving health equity will not be easy, and it will take all of us. Our office will continue working across health programs in our agency and with our colleagues in other federal health agencies and partner organizations to do all that we can to improve equity in health care. Next slide.

Drawing from the foundation of health equity, we've developed this overarching framework for pursuing equity at CMS. We utilize the health equity framework to guide the work within the Agency and with external partners. This framework consists of 3 core elements. 1st is increasing understanding and awareness of disparities. CMS OMH has expanding their collection, reporting and analysis of standardized data through publication of reports, public data sets, increased access to CMS data for researchers and data visualization products, and you will be hearing more about some of that work today. This increased understanding and awareness of disparities aids us in our second element, developing and disseminating solutions to achieve health equity. CMS OMH has evaluated disparities' impacts and integrated equity solutions across our programs. In addition, we've developed and disseminated promising approaches to support the health care workforce in addressing health disparities. This leads to the 3rd and final element: Implementing sustainable actions to achieve health equity. Since our inception over a decade ago, we've taken action and will continue to take action to improve policies and programs across the Agency to reduce disparities, while also mobilizing our partners to take action, like many of you gathered here today. Next slide.

CMS OMH understands the importance of equity and strives to provide equitable solutions to all of the populations that we serve. In recent executive orders on advancing racial equity and support for underserved communities through the federal government, the White House defined equity as the consistent and systematic fair, just and impartial treatment of all individuals, including individuals who belong to underserved communities that have been denied such treatment. Here at CMS, we are committed to working with local and federal partners and state partners to eliminate health disparities while improving the health of all minority populations, including our focus populations, which include racial and ethnic minorities, people with disabilities, members of the lesbian, gay, bisexual and transgender community, individuals with limited English proficiency and rural population. More specifically, our office focuses on health equity. That means allowing everyone to achieve their highest level of health. Minority and underserved populations routinely have worse health outcomes than their counterparts. This is seen across the board for many different health conditions, ages and geographies, and as an example, although we've made progress, the health status of the African American community is still disproportionately lagging behind other racial and ethnic groups. This includes higher rates of heart disease, diabetes and other chronic conditions. 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 these things influence a person's health. I'm sure you all are aware of the term "the social determinants of health," which are conditions in the environments where people are born, live, work, play, worship and age, and this all affects their health. It's estimated that between 70% to 90% of a person's health is determined by these social determinants of health. To put it simply, your zip code or education, for example, all affect your health status, which brings us to structural racism and discrimination, which refers to macro-level conditions, for example, residential segregation and/or institutional policies that would limit opportunities, resources, power and well-being of individuals in populations based on race, ethnicity and other statuses, including but not limited to gender, sexual orientation, gender identity, disability status, social class or socioeconomic status, religion, national origin, immigration status, limited English proficiency. So what does this all mean? This creates a negative and significant effect on the health of minority and underserved populations. Next slide.

This brings me to my final point that I'd like to make and the reason why we're all gathered here today, to highlight the impact racism has on our nation's health in an effort to address and eliminate structural racism and discrimination barriers. The COVID-19 pandemic has underscored the harsh realities of health disparities, especially for communities of color, and its effects have been felt across this country. In disproportionately impacting minority communities, COVID-19 has shed light on the health inequities that exist within our health care system, but these disparities are not new. Not only are we fighting the COVID-19 pandemic, but we are also fighting another crisis that is severely impacting public health, and that is racism. Structural racism and discrimination not only affects physical health but also the mental health of millions of people, preventing them from attaining their highest level of health and consequently affecting the health of our nation. This pandemic has presented us, though, with an opportunity for even greater action, a chance to achieve optimal health for all by addressing the longstanding social and racial injustices in our nation. To build a healthier nation, we must confront the systems and policies that have resulted in the generational injustices that has given rise to racial and ethnic health inequalities. We at CMS are committed to working towards a more equal and just health care system that will allow all people the opportunity to live a healthy life, and we look forward to continuing in our efforts to meet this goal. Again, thank you in advance to all the speakers and to those participating across the country today to examine these structural barriers impacting health care. My hope is this information will be informative and transformative as we collectively as the health care community work together to address this critical issue. Thank you so much, and now I'd like to turn it back over to Haley.

Thank you, Dr. McIver. We will now share a video from CMS’s Acting Administrator, Ms. Elizabeth Richter. Please note the video/audio will play through your computer speakers. You may need to adjust the volume on your computer speakers in order to listen.

Good afternoon. I'm Liz Richter, the Acting Administrator of CMS. It is my pleasure to welcome all of you to this virtual forum, "The Road to Equity: Examining Structural Racism in Health Care." I'm grateful to CMS's Office of Minority Health for planning this event and grateful to have people from across the health care spectrum join us for this important conversation. To begin, let me offer my appreciation and gratitude to all of the front-line clinicians and staff, facility administrators and personnel, state and local health officials, medical associations and other organizations and individuals working tirelessly in every community across the country for your dedication to protecting, supporting and caring for those impacted by COVID-19. We at CMS and the American people are profoundly grateful. We here at CMS continue to embrace opportunities to drive equitable care across all of our programs. We're critically examining our role in addressing structural racism in health care. This forum is an essential part of our efforts. As our country faces converging economic, health and climate crises that have exposed and exacerbated these inequities, advancing structural changes to promote equities is an urgent priority. The President's executive order entitled Advancing Racial Equity and Support for Underserved Communities Through the Federal Government makes this priority clear. This executive order lays out a comprehensive approach for the federal government to advance equity for all, including racial and ethnic minorities and others who have been historically underserved, marginalized and/or adversely affected by persistent poverty and inequality.

President Biden also issued a White House memorandum on Tribal Consultation and Strengthening Nation-to-Nation Relationships. This memo reaffirms the government's commitment to tribal sovereignty and self-governance, to fulfilling federal trust and treaty responsibilities to tribal nations, and to ensuring regular, meaningful and robust consultation. CMS is committed to supporting tribes and tribal health programs as they continue to respond to the pandemic. Working with HHS Intergovernmental and External Affairs, we have renewed our engagement with tribal leaders and look forward to hearing more from them on how CMS can improve its engagement to better assist the populations they serve.

CMS is committed to doing our part to ensure our programs facilitate equity and increased access to care. We seek to identify opportunities to advance equity through our policies and programs. Our approach will continue to use evidence to assess how the work of the agency impacts underserved communities. We'll gather, analyze and share data to inform our efforts to advance equity, even as we look for ways to strengthen our current data infrastructure so we can better understand disparities experienced by everyone we serve. Let me offer some recent examples of how we are putting this approach into action. We are currently holding a special enrollment period for our marketplace program. Thanks to the American Rescue Plan that Congress passed and President Biden signed into law, additional savings are available for consumers through healthcare.com. This SEP, as we call it, increases the access to coverage, and it's helping to reduce some of the structural barriers that people face when they need health care. The legislation is decreasing premiums for many, on average by $50 per person per month and $85 per policy per month. To date, more than 500,000 Americans have enrolled during this special enrollment period, and we've seen the largest enrollment increase in 2 years among Black consumers and among Americans near the poverty level. These results demonstrate that the SEP is reaching people who need it, but they also demonstrate that we have more work to do and that we need your help to do it. During this SEP, CMS is engaging with partners to host weeks of action focused on populations that may need affordable health care. Starting during this National Minority Health Month, these weeks of action will continue throughout the SEP. We'll have targeted materials in different languages with talking points, social media images and more to help partners amplify this important message. I hope all of you will continue to be our partners in removing structural barriers to coverage and increasing access to care.

Now, let me offer a different example of COVID-19 vaccination. I know this topic is on all of our minds. When it comes to the COVID-19 vaccines, we at CMS want to help smooth the path for providing the vaccines at no cost to our beneficiaries, especially those from underserved populations. We are doing this by addressing affordability, accessibility and vaccine confidence. In terms of affordability, our role is helping to ensure that anyone in Medicare, Medicaid and CHIP or those covered by group and individual health insurance through the Marketplace can get vaccinated at no cost. To help advance accessibility, we've made it as easy as possible for providers to enroll in Medicare to administrator the vaccine, and with Medicaid, we're working with states to expand their provider capacity to include certain pharmacists and pharmacy technicians and interns to help administer the COVID-19 vaccine. When it comes to addressing vaccine confidence, we're working in lock-step with the CDC and HHS to address questions and concerns around the COVID-19 vaccine. We've hosted a series of online fireside chats on vaccine safety and with nursing home staff, and our Medicare, Medicaid and Marketplace communication channels are engaging partners in educating their communities about vaccine safety and coverage. We're also working with state Medicaid agencies to ensure that individuals who are traditionally harder to reach are not left out or left behind. Additionally, we've held several listening sessions with minority health leaders to fully understand their needs and barriers in minority communities throughout the public health emergency.

Another example is from our Medicaid program. Medicaid covers 1 in 5 women of reproductive age and helps make prenatal and delivery care accessible for nearly half of women giving birth. A 3rd of maternal deaths occur between 1 week to a year after childbirth, and Black women are 2 times more likely to die from a pregnancy-related cause than white women. During Black Maternal Health Week a few weeks ago, CMS approved Illinois' request to test the effects of providing full Medicaid benefits to women for 12 months after they give birth. This significantly expanded coverage from the current 60-day postpartum period. This approval, which will last through 2025, addresses health equity by aiming to improve the health of low-income mothers and those with racial health disparities while reducing the rate of maternal morbidity and mortality. We've also approved postpartum tests in Georgia and Missouri. Providing this continued Medicaid coverage helps ensure women not only recover from birth, but that they have access to the ongoing care they need during and following the birth. As part of this approval, Illinois will undertake strong monitoring and evaluation. CMS plans to use these monitoring and evaluation results to determine if the demonstration benefits mothers in the Medicaid program.

These are just a few of many examples of our ongoing health equity work, but they are only the beginning. Going forward, we'll be redoubling our efforts to be responsive to what we're hearing from all of our stakeholder networks. Our work together must always be a dialogue, never a monologue. Weneed to not only work with one another, but to listen to one another, and my challenge to you today is to continue to be our partners in efforts to confront and eliminate structural racism in health care. I hope you enjoy a successful and thought-provoking forum. Thank you.

Great, thank you for that video, and with that, we will move to our first speaker, Mr. Figueroa, and Marvin Figueroa is the Director of the Office of Intergovernmental and External Affairs at the U.S. Department of Health and Human Services. And Mr. Figueroa, we will turn it over to you to begin.

Thank you. Hello everyone and thank you to the Center for Medicare and Medicaid Office of Minority Health for inviting me to the opening session of "The Road to Equity: Examining Structural Racism in Health Care" virtual forum. My name is Marvin Figueroa, and I serve as a Director of the Office of Intergovernmental and External Affairs at the Department of Health and Human Services. I was formerly the Deputy Secretary of Health for the Commonwealth of Virginia. I am grateful for the opportunity to speak with you all today about the Department of Health and Human Services Health equity efforts. We as a department look forward to partnering with you to advance our shared priority to address structural racism in health care. Marginalized communities know the consequences of social, structural, economic and environmental discrimination, conditions that determine people's risk of illness, access to care and life expectancy. They are the outcome of historical injustices, but in many ways, the past is not only not dead, it's not even the past. It is our collective work to disrupt these patterns, and the entire Biden-Harris Administration is dedicated to intentionally addressing these issues through policy, procedures and practice, which I will discuss in some detail in this presentation. Next slide.

Today I'm going to discuss with you the importance of health equity in our work, describe HHS's current Health Equity Infrastructure, including our leadership and recently established task force, and I will outline our ongoing and evolving strategies to address structural racism in health care. In the interest of time, I'm not going to filibuster. I won't go through everything, so please don't view this as comprehensive, but the beginning of a longer conversation. Next slide.

So first let me walk you at a high level through some of the drivers of health inequity. Next slide.

So let's start with COVID-19. The risk for COVID-19 infection, hospitalization and death are all significantly higher for historically marginalized communities compared to White, non-Hispanic communities, a fact that other presentations will cover more in-depth, but the same groups have lower rates of vaccination when compared with their total share of the population. While there's a lag in the date in front of you right now, it does point to a need to include vaccination rates in marginalized communities. Only 6.4% of Black individuals, 7.3% of Hispanic/Latinos and 4.3% of Asians have been vaccinated despite their higher total population percentages. As of Friday, there have been more than 286 million vaccine doses delivered and more than 222 million have been administered. 31.2% of the population have already received at least 1 dose, and the Biden Administration and Harris Administration have made tremendous efforts to reach minority communities with implementation of the Federal Retail Pharmacy Program, mobile vaccination pop-up clinics in high-risk communities and federal funds to jurisdictions for community health worker services to support COVID-19 prevention control as well as training and technical assistance and evaluation. As of last week, more than 90% of Americans now have a vaccine site within 5 miles of where they live. We recognize that access to easy, convenient and trusted vaccination venue is key for the communities that have been hardest hit. We're constantly innovating in this area. We will continue to meet people where they are while also intentionally addressing transportation and life barriers to vaccinations. Next slide.

It is important to acknowledge that these differential outcomes are not new. We know the pandemic took advantage of what our pre-existing and longstanding structural and cross-generational systematic realities that existed long before the pandemic. One of those realities, for example, is maternal health, as the Acting Administrator mentioned. This chart shows the multiple dimensions of equity, race intersecting with gender. As the Acting Administrator mentioned, pregnancy-related mortality for Black women is higher compared to White and Asian-Pacific women, and for American Indian and Alaska Native women, it is twice as likely compared to White and Asian-Pacific women. Black women are high in risk of pregnancy-related deaths and income and education level. Next slide.

One also observes similar patterns in looking at health insurance enrollment data. A recent ASPE, which is HHS's planning and evaluation arm, brief presented data on the racial disparities that exist in who remains uninsured. As you can see here, 28% of Black individuals and 25% percent of Hispanic individuals remain uninsured. Furthermore, insurance rates for Black and American Indian/Alaska Native individuals are significantly higher than their counterparts. As we collect data, whether it's maternal data or COVID data, the Administration is committed to partnering with you to fully understand the scale of these health and health care disparities the pandemic has laid bare, and to find correspondence in meaningful solutions. Part of our efforts have been, as the Acting Administrator had mentioned, special enrollment period for individuals affected by COVID-19 and ongoing efforts to expand Medicaid into states that have not expanded, and we again thank you for your partnership in those 2 areas. Next slide.

As we all know, this kind of work takes a village. Communication is key to all health care, whether it's about the COVID-19 pandemic or any other subtopic, communication is not only between a commission and a patient, but as a broader way of health messaging in the community. That's why we have partnered with various organizations in order to promote transparency and build trust for communities that have historically been treated unfairly. These health and communication partnerships include biweekly COVID-19 calls with Tribal leaders, collaboration with national faith organizations, a Community Corps program and cohosting a variety of helpful webinars. Communicating in a way that people will consume the information and ensuring that the communicator is someone the community trusts are just as important as the message itself. Next slide.

That is why we've been hosting a number of listening sessions to ensure that they are at the center of the sustainable effective policy change. At the center of the work and recognition that achieving equity is a hyper-local work, most successful when done in partnership and collaboration with those who are trusted community and faith leaders. Here are some examples, not a comprehensive list again, but here are some examples of kind of some of the conversations we've been having with trusted voices in the community, and Community Corps is now launched, with 8,000 partners to date armed with accurate information and resources. This is again an evolving process, but we are continuing to look for more engagement. On that note, I'd like to outline the current infrastructure we have in place to address and confront these issues of access and quality of care. Next slide.

All right. One more slide.

Our Health Disparity Council is led by the Assistant Secretary for Health and the Assistant Secretary for Planning and Evaluation, the council meets every other month with intervening equity learning sessions during intervening months. For example, CMS Health Equity Inventory as so far existing grant authority supporting the health equity, to name a few. Next slide.

The council alongside the steering committee and working groups confronts the health equity drivers, agency priority goals and presidential action. Subsequently, the monitor of the HHS response to the EL and other health equity efforts, provide recommendations to the secretary on existing asset utilization, and needs for advancing health equity and coordinating HHS's operation and task division efforts. Furthermore, while spreading HHS best practices while maintaining a high level of enthusiasm and success, the group outlined ways to communicate plans, strategies and new opportunities to reduce health disparities and advance health equity within different communities. Next slide.

Furthermore, due to the COVID-19 pandemic and in addition to the HHS Health Disparities Council, HHS established the COVID-19 Health Equity Task Force. The task force is part of the administration's government-wide effort to identify and eliminate health and social disparities that result in disproportionately higher rates of exposure, illness and hospitalization and death as a result of COVID-19. The president has asked the task force to make some recommendation on a range of issue, including equitably allocating COVID-19 resources and disburse relief funds, strategies for effective outreach and communications to minoritized populations in the hardest hit communities, and how to improve cultural, linguistic responsiveness within the federal government and on data collection. Data collection is a specific focus of the task force charge, particularly collecting data for the hardest hit communities and identifying data sources that will enable development of short-term targets for pandemic-related actions as well as addressing longer-term data shortfalls and challenges to better prepare and respond to future pandemics. This task force is not only critical for the current moment, but also fundamental to preventing such inequities in the future. Next slide.

This brings me to my final point of the day, the actions that HHS is currently and actively taking to address health disparities in the COVID-19 pandemic. As I mentioned previously, HHS has operationalized the health equity infrastructure, giving us the foundation and framework to launch sustainable and tangible changes. HHS has already released funding to communities to support equitable responses and is working on awarding even more financial support in the future. Next slide.

Furthermore, in this slide, HHS has and will continue to support federal COVID-19 vaccination efforts to meet populations where they are, to make the vaccine as accessible and convenient as possible. Next slide.

I want to take a moment to elaborate on our funding actions. "Through the Congressional appropriation and expanding scopes of eligibility in existing funds, the Department has provided funding intended to both explicitly and implicitly support equity in health care. We have received 250 million to issue grants for “Advancing Health Literacy to Enhance Equitable Community Responses to COVID-19.” The CDC has signed over 57 billion for response and recovery efforts related to COVID-19 that has been used to aid states, counties, cities and other entities in the overall COVID-19 response, including ensuring that resources reach all communities. Furthermore, we recently received 2 billion in national initiatives to address COVID-19 health disparities among populations at high risk and underserved including racial and ethnic minority populations and rural communities. There's also been almost 7 billion already provided to community health centers for service and infrastructure improvements. Next slide.

And a final point, the administration is working to ensure that vaccines are brought to the communities rather than just having communities come to us, and the federal government has set up a federally run community vaccination centers in hard-hit areas, provided vaccine supplies directly to community health centers and expanded eligibility and provided vaccine supply directly for local pharmacies that serve people of color, people living in rural areas and people struggling with poverty and launched hundreds of mobile clinics to meet people where they are in addition to vaccinating our country's dialysis patients. A commitment to equitable vaccine access means putting resources where they matter. The administration has also announced nearly $150 million to community-based health care providers to aid their COVID-19 response, another 12 million to address rural health disparity specifically. And we also launched a new partnership with dialysis clinics, as I mentioned, to vaccinate dialysis patients who often have severe health outcomes and are disproportionately racial and ethnic minorities. Next slide.

In closing, while I am proud of the department's work thus far, I'm even more excited about what we'll accomplish together. During this National Minority Health Month, I want to reiterate what Dr. Nunez just said about equity work. We have to show up. We have to listen. We have to learn, and we have to be humble. Communities are the experts in what they need to thrive. My gratitude to everyone for the transformational change that we'll be a part of, and the solutions that arise from this event will propel us all forward together with immediate and with sustainable strategy to root out structural racism and health care in the long-term. Have a terrific forum, and thank you again for the opportunity. Be well.

Great. Thank you so much, Mr. Figueroa. Our next speaker is Dr. Karthik Sivashanker, who is the Vice President of Equitable Health Systems and Innovation at the American Medical Association, and he's also the Medical Director for Quality, Safety and Equity at Brigham Health. Dr. Sivashanker, I will turn it over to you.

Thank you so much, and really great to be here, so, you know, as mentioned, my work is focused on operationalizing equity and quality and safety, and quality and safety is all about root causes, so I thought I'd actually begin by reinforcing some deeper framing and talking points around those root causes. I actually made some of these same points last week, so if you're in the audience, and you heard it last week, you'll get to hear it again, but I don't think these points can be overstated, and it really begins by zooming out to look at our larger health ecosystem and the fact that it's grounded ultimately in this hyper-racialized, quasi-capitalistic, increasingly global financial system that in the US, at least, traces back to our original sin and economic enterprise of US slavery. And in fact, when you think about slavery, it's been our most enduring and horrific legacy in innovation and health care and beyond in the way that it was carefully designed and curated, adopted and diffused, normalized, legitimized over time in culture. And we see the effects in health care as well, and it was especially uniquely operationalized in the US by justifying its existence through racist quasi-scientific and medical theories, and so these deeply entrenched myths and stereotypes are persistent to the present day, implicitly reinforcing a system of wealth and social inequality that's designed to benefit a privileged elite and ultimately to drive a wedge between poor white folks and people of color and other historically oppressed groups.

And we've seen an entire industry in health care as well as outside of health care grow out of and around slavery, and rather than correcting these historical injustices, innovation that we've seen in the US health care system has often reinforced or amplified existing inequities and led to a lot of unintended consequences for historically oppressed populations. And the example that I've given, Dr. Maybank has mentioned this example in the past as well is the classic example of Marion Sims, the father of modern gynecology who invented the vaginal speculum and tested it on enslaved women very painfully, literally using the womb of Black women as an engine of capitalism and innovation. And when I say this, it may feel shocking, but none of it really should be shocking when we think about our history as a country, so most of our history, most of our 400 years have been in a time of slavery or Jim Crow segregation, and in the modern era, we have the war on drugs. We have mass incarceration. We have felony disenfranchisement and so many other examples of oppression that we shouldn't be surprised by the pervasive, unjust, preventable differences in outcomes we're seeing across all these different categories, and when you look at our institutions, I was looking up CMS, founded in 1965, HHS, 1953, AMA, 1847. Most of our institutions were formed during or around the time of slavery and Jim Crow segregation, and so that legacy is there in our structures, in our systems and in the way we operate.

And concerningly is the fact that innovation across all these different sectors and also in health care is continuing in general a legacy of exploitation of natural resources and people, butcontinuing that theme of focusing on maximizing profit, usually for the benefit of a smaller group of people, and any efforts in the social justice arena have to contend with or answer to this racialized quasi-capitalistic system with the question, what's the return on investment? And so I think I'm raising all of this because we have to fundamentally reexamine some of what we're doing and start asking some really basic questions around motives and incentives and what's driving innovation in health care and beyond, and some of those questions are things like, who's benefitting, and who is not? Who's designing, and who's being left out? Are historically marginalized groups being recognized, elevated and centered? Have we thought about unintended consequences for historically marginalized groups in our work? How will we measure the impact, and will our efforts lead to equitable reallocation of wealth, power and resources?

And when we think about how organized medicine has responded to this social injustice, we've seen hundreds of reports in the literature describing the dangerous, potentially fatal undertreatment of Black, brown, indigenous, other populations, but the response has generally been passive academic descriptions or gestures or sentiments, expressions of concerns or euphemisms, rationalization by good intention, delaying tactics and half measures, usually framed in a colorblind way. And it's focused on bias, all the while acknowledging that, yes, Black and other historically oppressed patients are not getting treated as well as our White patients in American hospitals and clinics. So that framing I think is important when we start to think about, well, what can we do about this? And that really leads to my work which is on, how do we actually get to impact? How do we operationalize equity in our health care systems and make this a part of the fabric of the work that we do every single day? I'm going to try to share my slides now. We'll see if this works. I have a feeling it's not going to work, so you know what?

I'll continue talking through it. So once again, you know, when we think about the past, it's been a lot of ambivalence, euphemisms, passive academic descriptions, rationalizations by good intentions and generally a lack of accountability. The future needs to be urgent action, explicit conversations like the ones we're having right now, actions supported by resources and infrastructure. We need to get from good intentions to a comprehensive analysis of systems, performance and behavior leading to actual system improvement, and we need to go from a lack of accountability to an active embrace of equity as a core mission. Another way to say that is, we need to shift from this way of doing equity work siloed and fragmented, and it's all put on a couple of people of color to solve, and where we're now making this a part of our financial decision-making operations and our quality and safety work.

So when we think about quality and safety, the Institute of Medicine has actually defined quality with 6 dimensions. It's STEEP: safe, timely, efficient, effective, patient-centered. Equitable is a key dimension. It's just in the forgotten dimension, and there's a lot of reasons why we should very much consider safety, equity and quality as aligned. Safety and equity are both fundamental to high-quality care. Another way to say that is, there is no such thing as high-quality inequitable care, and yet we consistently deliver in this country highly inequitable care, so we're not delivering high-quality care if it's only to a small group of people, but they're both focused on system redesign, so when we think about safety, we want to design our systems to be resilient and reliable so that even if the individual makes a mistake, the system will catch it, and when we think about inequities, these inequities are not generally being driven by individual bad actors. They have a role, but they're being driven by systems and policies and practices and laws. That's what we mean when we say they're structural, so once again, both require systems-level redesign. We need to balance systems focused with individual accountability, so that's getting to address culture higher liability. Both involve cognitive biases whether it's anchoring biases with safety or implicit biases with equity, and both lead to unintentional harm.

And finally, with either safety or equity, you have to have psychological safety to have those difficult conversations around errors, bias, discrimination, et cetera, and so my work is really focused on that. It began at the Brigham Women's Hospital in partnership with IHI, and we developed and tested this 5 driver framework over 18 months, and the 5 drivers are really, number 1, integrate equity into quality, safety and risk analyses. Number 2, use equity-informed quality safety education to anchor that work. Number 3, use data to support equity improvement. Number 4, leadership awareness and engagement, and then number 5, organizational accountability, so I'll just give you one example. I'm not going to go through all the drivers for the sake of time, but one example would be, driver one, how do we integrate equity into all of our quality, safety and risk analyses? It can begin with a very simple question: Are there inequities contributing to this risk? So that's for patient safety reports, for patient complaints, for an HR report. It doesn't matter. We can apply the same equity-informed higher liability approach, and the question is, are there inequities, and if so, at what level? Is it implicit? Is it interpersonal, institutional or structural? And importantly, as we're doing this, we got to do it in an identity-conscious way, so the way we're mostly doing it in this country is 60-year-old woman has trouble getting her medication at the pharmacy. We're taking out all the identity factors, all the demographics because we think we're being less biased that way when in reality, the story is, 60-year-old non-English speaking woman from the DR with low vision has trouble getting her medication at the pharmacy. Let's compare those 2 and then think and ask yourself, can we really get to the right root causes with the first version? We're missing so much important and rich information, so doing this one simple thing, for example, at the Brigham Women’s, we went from identifying 0 inequities through our safety and quality structures in the year before to identifying hundreds in the year after, and many of those led to system-level improvements, policy changes, et cetera because we can apply our higher liability approach which is focused on what's the system-level intervention, what's the performance intervention and what's the behavior intervention? And to me, that's the beginning of what progress looks like because we're dealing with a complex historical trauma here.

You know, a lot of folks are so focused on action and getting straight to, how do we reduce that gap in hemoglobin A1c? And what we have to recognize is that this is a problem that's been going on for hundreds of years, and it's a trauma at its root, and so things usually look worse before they get better as with any trauma. It's almost like puncturing an abscess. The pus needs to come out, and so progress is more, not less, reporting of inequities. It's more discomfort as we acknowledge those inequities and get transparency around that. It's more complexity as we balance the concerns for liability and public perception or commitment to improvement, and so we can take this approach, this equity-informed higher liability approach for quality and safety, and we can apply that approach across the entire hospital, not just for safety and experience but human resources and what's happening with security and what's happening with residents and others, so I think I'm almost out of time if not out of time at this point. If anyone wants to learn more about the 5 driver framework, we can refer you to some articles there.

One thing I will get to real quick is just the idea of unintended consequences. Maybe I'll close on that, so this gets to metrics, and we do have an article that we can share about that as well which is to say there's a real tendency for health systems but also regulators and others to focus in on these downstream clinical measures, things like hemoglobin A1c or hypertension control, et cetera, and there's some real problems with that, so when we look at the Brigham, for example, let's use my home institution as a case example. Like a lot of affluent AMCs, academic medical centers, we chronically underserve our Black, Hispanic or Latinx, non-English speaking Medicaid patients. That's because of many factors. It could be because of contracting decisions. It could be because patients prefer to go to other institutions, but we're chronically underserving them, so if we were to incentivize on a downstream clinical measure like hemoglobin A1c, we as an affluent center can throw a lot of resources at a relatively small group of patients and look like we're doing well on that metric whereas our safety net hospital across the street, Boston Medical Center, which takes care of the vast majority of these disadvantaged patients, cannot do that, and so they might look like they're doing worse, so the point here is that a well-intentioned equity metric could actually lead to inequities or exacerbation of inequities at an institutional level.

It can also lead to exacerbation of inequities for individuals in communities, so for example, when you roll out an intervention focused on hemoglobin A1c, what inevitably happens is that the folks with privilege and resources are more likely to take advantage because they have the ability, and the folks who are really struggling don't. And so even then, you see this natural separation between the haves and the have-nots, so once again, without the right balancing metrics, a well-intentioned equity effort or set of metrics can actually exacerbate things, and that's not even getting at things like bad or predatory behavior, the tendency to pick too many metrics which can lead to data overload and analysis paralysis, et cetera.

So the framework that we've offered is very simple. Let's start with things like access and transitions of care. Access might be things like, are you taking care of a fair share of your Black, brown Medicaid patients, and transitions might be, are you equitably offering them services once they're in your care? And that gets to the heart failure studies at Brigham where we found that if you're Black with heart failure, you're more likely to get referred to general medicine, and if you're white, you're more likely to get referred to specialty cardiology care, so the take-home point here is, before we start working on the downstream clinical measures, can we restructure the system to incentivize and encourage institutions to compete for the patients that have been historically marginalized and oppressed? Because right now, they're competing for the folks with resources. Let's make sure that patients can get access to care, that we're equitably offering them services. Then, let's think about the clinical measures and making sure we're delivering the high-quality care, and then finally, of course, with community, making sure that we're operating as a responsible anchor organization, so I'm going to stop with that, and I really appreciate the time.

Great. Thank you so much, Dr. Sivashanker, and if you are able to share any of those links or articles with the audience via the chat, please feel free to do so, or we can disseminate those as well. All right. Great, and now we are pleased to invited Dr. Tekisha Everette who is the Executive Director of Health Equity Solutions and an Adjunct Assistant Professor at the Yale School of Public Health. Dr. Everette, you may begin.

Thank you, and thanks, everybody, for being here today, and thank you for the invitation to be with you today. I'm going to try to be as quick and as brief as possible, as I know time is edging out, and we definitely want to get to Q and A if there are questions, but as mentioned, my name is Tekisha Dwan Everette, and I am, of many things, the Executive Director of Health Equity Solutions, and that's the organization I'm using in this lens for today's conversation. You can go to the next slide.

Health Equity Solutions is a nonprofit organization, and we're located in Connecticut, but quickly, we are doing much more work outside of Connecticut and inside of Connecticut because we are one of the few organizations that are 100% all day and night focused on advancing health equity through policy and systems change. For us, we believe that achieving health equity needs to be and squarely has to focus on advancing and changing the disadvantages that individuals who are racially and ethnically minoritized in the United States have faced, as we know through research and experience that these are the groups who are the most disadvantaged as it comes to health and health care. Next slide.

It's already been talked about today, the definitions of racism, and exactly, but I want to take a step back and just talk one second about race and ethnicity because oftentimes, particularly in the United States, we get these confused. We don't understand and connect to the fact that race is a social construct, and why this is an important point to make is because a social construct means that humans created it. It is something that we have designed and thus we can dismantle. We have that power within us and around us. Now, none of us here today are the ones who created this notion of race, but as we continue to live in this Earth, if we don't address the connections between race, racism and health, then we are to blame just like the origin of the notion of racism in our country, but I'll go back to that. The reason I want to highlight this point about ethnicity being different from race is because we do not need -- One of the solutions you'll hear me advocate for or talk about in the context of advancing health equity and as others have said is the critical understanding of data. Do we have the data we need to be able to track what's happening, and do we have it in both ways that we can see people, racial identity but also ethnic identity and differences that may show up along those lines? And that's particularly important given the difficult immigration laws that we have as well as the different migration patterns people have within and around the United States. Next slide.

Now, race changes over time, but the real reason that this is really all important and connected is, it's connected to racism. We tend to make a mistake and think sometimes that the problems we see in health and health care are related to one's race. It's actually related to how their race is treated and connected to privilege, power and indifference in our country. Thus, it is related to racism, and racism is a complex social system. It is not something that is just easy enough to point out. It is something that we can see. It is something that we cannot see, but ultimately, it is the thing that is linking and really determining some of the outcomes that are happening, and we must address it, and racism is something that can be what I like to say invisible and baked in, and we don't even know that it is there, but also, it is the thing that we actually -- I'm sorry. It's one of these things that the famous Supreme Court said, and I'll say it a little differently. Racism is a thing that we know it when we see it. Sometimes, it's hard to define it. We can theoretically define this complex social system, talking about the ideology that places hierarchy on race, and we do this all back in a typical design, but sometimes, it's hard to really pinpoint and say, "That's exactly what racism is," but we have to be able to uncover racism wherever it is and however it shows up, and, again, it's rooted in history, social structures and culture. And I'm going to give a couple of examples after I talk about the forms of racism because often when we think of racism, we don't talk about all of the forms, and we talk about it without explaining those forms, and today, we're talking about structural racism specifically, but I do want to just go over quickly all 4 forms. Next slide.

So already mentioned, racism is a system that operates both at the macro and the micro level. If we're talking about macro level racism and the way it shows up there, we're thinking of structural and institutional, but on the micro level, just as important to health and health care are the interpersonal and internalized ones, and, again, I'm going to go through all 4, so the next slide.

Structural racism is the social and economic and/or political systems that produce culture, policies, practices and other norms that perpetuate race-based inequities. You've already heard this definition several times from the speakers before me. This is what our focal point is today, and I'm so excited about that because often when we talk about racism, we don't talk about the invisible hand, the unseen, baked in our laws and policies, systems and structures racism. We often talk about the interpersonal, that which we can see and know and can identify. Next slide.

If structural racism is about -- You'll have to click again apparently. These are animated. If structural racism is about the invisible hand, then institutional racism is the hand that makes it seen. It's the way our policies and practices are promoted within our institutions and across them that foster racial inequity. When we do trainings at Health Equity Solutions, we use everyday examples of how small things could be rooted in racial indifference and racial inequity. One quick example around policies is saying that you only see Medicaid patients on one certain day of the week rather than completely seeing them any day, or you don't see Medicaid patients at all, or you don't take health care insurance. There are a number of ways that you can unpack every day individual policies that may seem to have a business case to them but ultimately are rooted in inequity and creating and fostering different opportunities for people of color. Next slide.

Interpersonal racism is one that I don't have to go over too much. It's the thing that we most all think about when we talk about racism. We understand that racism is linked, and interpersonal racism is linked to the attitudes, behaviors, beliefs and exhibiting of those and discrimination and bigotry that is completely expressed and experienced by individuals. It is at that individual one-to-one level, so I'm not going to spend any more time on that. I'm going to go to internalized because it's the part that most people don't focus on, and it is so critical, particularly at the point of health and health care. Next slide.

So if structural is what our systems is built on, and institutional is how we see it, and interpersonal is about how each of us interact with one another based on racism, internalized is how all of those things together are put into the person or thought by the person that gives them either a sense of inferiority or superiority as it relates to their being in society. It's how we see ourselves. You can imagine that over and over and over again, if you don't see yourself in doctor's offices or hospitals, you don't see representation of yourself in those places, you don't see representation of yourself on television screens or people who look like you doing the things that you want to do, you internalize this unconscious or subconscious belief that that's not for you, that it cannot be done for you. There are also interesting ways that we internalize racism in our behaviors and mechanisms by not questioning a doctor or a nurse when they tell us something that we know is not right or accurate related to our body because of our instilled behavior that someone else has more knowledge, power or belief than what you have about your own care and what your needs are. This is a critical important place that a lot of people aren't spending time and focusing on how it all relates, but because we're talking about structural racism today, I'm going to keep moving because I just wanted to point out really quickly that structural racism is at its highest level the place that the government, our health care systems and our focus needs to be instead of just focusing on interpersonal, and I think internalized racism and its impact on health and health care is something we need to spend more time researching and understanding. Next slide.

So all of this is to say that when we think about the system of racism and how it functions in our society, we are all not starting at the same place, and I'm sure many of you have seen some version of these 2 images that are on this slide, and I'm not going to go into this full story as I would like to, but here is the bottom line. We are not all starting at the same place when it comes to accessing and improving and getting the best quality and outcomes from our health and health care, so if we continue down a path of one-size-fits-all health care, we are deepening the inequity that exists because we're not acknowledging the fact that people have different needs. I love this image because it just gives an opportunity to look at the fact that when we give each person the same resource, not accounting for their height differentials in the image on equality, there are still disadvantages there, and yet we treat everybody the same, but if we look on the other side and look at equity, and we think slightly differently about how we distribute those resources, we have the same resources, and in effect, each person here can get to the destination they need to, in this instance, looking over the fence and trying to see the game. If we put this into health, this instance is getting beyond any barriers that exist to get to their best health, and I always want to point out, nothing was taken away from anybody. We actually just wisely and effectively used our resources to ensure that we got everyone to the exact goal we need them to get to. That's equity. It is the understanding that structural racism has created barriers in communities and in people's lives that prevent them from getting to their best health. Thus, we need to do something different. We cannot do the status quo. We cannot remain using the same tools that got us to this place to undo the inequities and inequalities. Next slide.

So just a few quick examples of how we've gotten here today, and I'm going to not only talk about them in the historical context, but I'm going to bring them relevant to the contemporary context. Oftentimes people like to point out that these issues that I'm going to go over or these events that have happened in our country were in the past, but I want to give us a moment to reflect on how recent this past was and how it's connected to things we are seeing today. Everything on this slide, the Tuskegee Experiment, forced sterilization and eugenics movement and the story of Henrietta Lacks had either a combination of willingness by the government in funding it or the health care system involved in it explicitly, indirectly or both. When we talk about the Tuskegee Experiment, many of us have heard about this experiment and how people were unethically untreated -- were unethically treated and without their consent studied for untreated syphilis, but we often think about this as happening so many years ago, and I just want to contextualize this, that this period was 1932 to 1972. What happened in the time frame of 1932 to '72? I'll just speak for myself. My grandparents were not even teenagers yet. My mother was born. I was born shortly after that. Not going to give my age away, but these are people that just in my own n-of-one, all lived to understand and hear and experience what happened in Tuskegee. This isn't something that happened centuries ago that are so far removed from today's experiences of people who are living today. Descendants, family members, individuals within and throughout the United States are still connected and understand what happened in the experiment, but let's fast-forward today. Today we're now trying to understand, why is it that when we're trying to get the COVID-19 vaccine into communities that there is a resistance or lack of confidence in the vaccine? Well, it's directly related to the historical context of the Tuskegee Experiment and also some of these more recent things that have happened. So in order for us to address or provide confidence in the vaccine, we have to provide individuals agency in the process, not tell them that they have to get it, not mandate that they have to get it, but we have to fundamentally address the structural barriers that happened and the mistrust that happened in the government and the health care system in order to correct that issue.

The next thing I want to highlight is the forced sterilization of men and women in both North Carolina and Puerto Rico. Now there are other places where this has happened, and we could go on to those examples, but these 2 I just highlight because of how deep and widespread they were, and how, again, people want to think that this was so long ago, and it was state-sanctioned. And in fact, North Carolina has even begun to provide, if you will, reparations in relationship to its role in sterilizing the 7,600 men and women over the 50-year period that this forced sterilization process was in. Now if we fast-forward to the contemporary context, how does this relate to today? We've heard about individuals in border detainment centers, persons who are women in border detainment, detention centers who've been forcibly sterilized. These things, again, I just highlight are really not just connected to history. They're connected to the everyday lives that people are living now, and if we are committed to not only disrupting and dismantling the relationship between racism and health and health care in the United States, then we must acknowledge the history as well as what's happening right now, next slide.

So when I say we must acknowledge, we must fundamentally link our desire to correct the history that has connected structural racism and institutional racism to the health and health care outcomes of black, indigenous people of color in the United States. We need to know that. We need to understand it, but we have to put that knowledge into action, and this is what I'm excited about when I hear both the leadership from CMS OMH and the leadership from HHS and many, and the AMA and CDC and others who are actively acknowledging the relationship between racism and health and health care in the United States. But here is what my kind of call to action is today. We have to put that into action. We have to become antiracist in everything that we do with understanding and identifying these links and eliminating them actively, no matter where they show up, and this is really critically important. If we are not doing that, if we are sitting around or actively having a conversation, trying to debate if structural racism exists, if racism is the lynchpin or the thing that is creating the problem that we see. We're missing the entire point of why we're here today. We fundamentally need to acknowledge in everything that we do that racism exists, and it does play a part in every aspect of health and health care outcomes that we see, particularly for people of color. Once we have that acknowledgment, we must move that into action, next slide

And we must dismantle -- You can go to the next slide, and we must dismantle everything in every way that it shows up. So to foster that change, here is my charge. Here is what I think we have to do as a nation and how we do this collectively and individually. We have to deepen our learning, but we have to do this in a way that we understand the connection between racism and health, and that we're actively doing this consistently. We need to put that learning into action to dismantle racism, supremacy and privilege everywhere that it shows up. In doing that, we need to be committed to equity. We need to be committed to equity throughout our organizations from top to bottom. As I like to call it from C to C, meaning your CEO to the custodian must be engaged and embedded in advancing equity. This has to be central, and it has to be consistent. And lastly, we have to start today. If you're joining today, we've got to start now if you haven't already started, and in starting you have to be prepared to fail but also prepare to succeed beyond your wildest imagination. This all leads us to making sure that we have the system of health and health care that people need and deserve in order to get to their best outcomes. We have to use data. We have to use ourselves. We have to engage the people, and we have to constantly remind ourselves that the fight for racism didn't start yesterday, and that it's not going to end tomorrow. We have to be consistently committed. Thank you again for the opportunity today, and I turn it back to Haley.

Great. Thank you, Dr. Everette. I believe that concludes our presentation for Session 1, so we would again like to thank Mr. Figueroa, Dr. Sivashankar and Dr. Everette all for participating today. Our next session, "Collection, Reporting and Analysis of Standardized Data" will begin at 2:15, so we ask that you all please remain on the line. Thank you.

Session 2: Collection, Reporting, and Analysis of Standardized Data

Okay. We will now begin Session 2, and thank you to everyone who joined our opening session. And those of you who are joining now, we will begin our Collection, Reporting and Analysis of Standardized Data session. During the session, we are pleased to have Meagan Khau from CMS OMH, Dr. Dawn Alley from the CMS Innovation Center and Joy Lewis from the American Hospital Association provide their insights into the value and importance of collecting and examining standardized patient data. As a reminder, there will be time for questions following the presentation. We will address as many questions as time allows. You may submit 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 website following today's event. A link to that page will be shared with you all momentarily via the chat box. Now I will turn it over to Meagan Khau, who is the Director of the Data and Policy Analytics Groups at CMS. Meagan, you may begin.

Thank you, Haley. Can we go to the next slide, please? Next, thank you.

Good afternoon, everyone, and thank you so much for joining our session today. I just want to take a couple of minutes to emphasize the importance of data and the impact it has on health equities based on all the discussions we had in the first sections. For those of us who work with data, data is important to help us understand questions, answer questions, identifying gaps and provide evidence for decisions-making. At CMS OMH, we use what you see here as previously presented by Dr. McIver earlier, the CMS health equity framework, and this framework helps to drive our work, so we want to know, you know, how do we increase understanding and awareness of disparities? And how does data play a part of that? How do we develop and disseminate solutions, and how do we implement sustainable actions? And that's why I put that little box right there right in the middle between the first 2 arrows to identify that data plays a big part of this framework at CMS OMH. As discussed in our earlier session as well, structural racism has a long-term impact on individuals. It leads to health inequities, causing higher rate of morbidity, mortality, mental health issues, social problems just to name a few in mostly impacting the minority and underserved populations. In an article written Williams & Mohammed in 2009 titled "Discrimination and Racial Disparities in Health: Evidence and Needed Research," studies found that individuals who report experiencing racism exhibit worse health than people who do not report it. So what we want to achieve is health equity so individuals can have better health outcomes and better lifestyle. With the right data, we can use it to measure health inequities and to increase our understanding and awareness of disparities and also to use it to develop solutions and implement sustainable action. So what kind of data do we currently have? And what data do we need? So next slide.

Here is an overview of our Medicare beneficiary populations for 2019. With the breakdown of by race and ethnicity, as you can see here, the majority of our Medicare beneficiary are non-Hispanic Whites, and of course most of our beneficiaries are Medicare-only, approximately 81%, with 19% who are dual-eligibles, meaning that they qualify for both Medicare and Medicaid. And again, from a race and ethnicity perspective, following the non-Hispanic Whites, we have about approximately 11% Blacks or African-Americans followed by Hispanics, 54% female, 46% male and majority of our Medicare beneficiary falls in the age of 65 and 84. Next, please.

In looking at our Medicare population in rural areas, which is definitely very important, especially during the pandemic, we see approximately 14% of our beneficiary have Medicare only, and 3.5% are dual-eligibles. Again, they qualify for both Medicare and Medicaid. The breakdown of race and ethnicity, approximately 15% are non-Hispanic whites followed by Black or African-Americans in about 0.59% being Hispanic. Male and female very closely in percentage, 9.15$ female and 8.25% male. Then again, approximately 13% of the Medicare beneficiary fall between the age of 65 to 84, next, please.

And then in looking at our Marketplace consumers for the 2019 open enrollment period, we are able to see the majority of the consumers identify themselves as White or Caucasian. Approximately 30% identify as unknown, meaning that they did not make the selection in terms of what their race is during the open enrollment period followed by 7.27% black or African-American, and from an ethnicity perspective, approximately 12%, 12.26% identify as Hispanic or Latino, next, please.

We also look at the consumer's preferred spoken language, so as you can see here from the pie chart, approximately rounding up, 65% identify that their preferred spoken language is English followed by 27% unknown and 7.32% Spanish, next, please.

Looking at preferred written language, approximately 65% identify that their preferred written language is English followed by 27% unknown and 7.23% prefer Spanish as their written language, next, please.

And here is a look at our Medicare beneficiary as a whole and for Medicaid, and actually Medicaid and CHIP, and for those of you who are not familiar, CHIP means Children's Health Insurance Program. So approximately more than 78 million individuals are enrolled in Medicaid and CHIP, of which 72 millions are enrolled in Medicaid, and a little bit over 6 millions are enrolled in CHIP. So looking at the first 2 lines in the graph, we are looking at adult Medicaid enrollment, which is starting with October of 2019, and the public, the national public health emergency was declared in January of 2020, and then the announcement of the Families First Coronavirus Act in March of 2020. As you can see there starting from March 2020, the enrollment for adult Medicaid went up quite a bit as well as children who are enrolled in Medicaid and in CHIP as well. And then breaking down by children enrolling in Medicaid only and those enrolled in the CHIP program, there is definitely a slight increase. And, again, for those of you who are not familiar with CHIP, basically this is a health insurance coverage for children and families that earn too much to qualify for Medicaid but not enough to purchase private insurance, so it helps provide coverage for the children who are in that specific gap, next, please.

So I kind of want to slightly shift to the executive order, specifically the one issues on Advancing Racial Equity and Support for Underserved Communities through the Federal Government. I will not read through the slide because earlier on, Dr. McIver presented this slide, so we'll go to the next one.

I want to call out 2 sections in this executive order that focus on data, so the first being in section 4, "identify methods to assess equity." So we're looking at, how do we assess equity with respects to race, ethnicity, religion, income, geography, gender identify, sexual orientation and disability. So the executive order calls for the federal agencies to respond to collect demographic data in order to fully assess the impact of health equity responses and extent of existing health disparities. The second calling to establish a work group to gather the necessary data under section 9. The executive order pointed out that many federal data sets are not at the disaggregated level for race, ethnicity, gender, disability, income, veteran status and other key demographic variables. "This lack of data has cascading effects and impedes efforts to measure and advance equity," so there is definitely a need for us to gather data at the disaggregated level to promote equity, next, please.

So what are some of our data challenges? Next.

Sso let's talk about section 9 first. So we're talking about the federal data sets that are not collecting disaggregated level data based on these data elements. As most of us know, there are a lot of federal data sets available out there, but we don't know which federal data sets have all this information, some of this information or none of this information, the data elements that are listed in the title. And then what standards are these federal data sets using for collecting any of these data elements or all of them? So taking race and ethnicity as an example, we have 2 standards that we're using, the OMB 1997 standards, which has 5 categories of race and one category of ethnicity. And you can see that in the table to the right, and then the 2011 HHS data standards, which has 14 categories of race and 5 categories of ethnicity, and of course there are other standards out there, you know, that we may not be aware in other federal agencies or departments are using, so to the extent that there are different types of data standards across race and ethnicity, so it becomes a bit of a challenge for us when we analyze data because now we have to try to figure out, how do we roll the data up? And of course if it's not at the disaggregated level, we can't unroll it, looking at granular-level data. But I do want to call out that it is important for us to be able to collect race and ethnicity data at the disaggregated level, next slide.

So here is a quick example of why disaggregated-level data is important to us. So looking at the diabetes prevalence using ADA data for 2018, there's 10.8% of diabetes prevalence as part of the total populations as a whole, and then when we look at the middle pie chart there, this is the 97 standards. We're able to identify that individuals who are Native Hawaiian or other Pacific Islander has high diabetes prevalence, 15.5%. But if we stop there, we're only going to be able to see diabetes prevalence at that specific high-level category, but if we are to have disaggregated level, then we can go to the next pie chart, which breaks it down by 4 -- Sorry, go back, please. Thank you. So we can see the breakdown of the third pie chart there that shows that Samoan of 4 different categories broken down by, for Native Hawaiian and other Pacific Islander, Samoan has the highest numbers for diabetes, so having the data at disaggregated level or the granular level will help us target intervention pattern at a high level. Next, please.

And then in looking at assessing equity with respect to race, ethnicity, religion, income, geography, gender identify, sexual orientation and disabilities, we currently do not collect all of these data elements across CMS program or HHS program consistently. So we do have some information on some but not in others, so there may be some new data collection efforts for us if we were to collect all of these data elements. And with any new data collection effort, you know, what are the standards we're going to use to collect each of the data elements? And then once we're able to have the data, you know, what result will we get from the data collection? Will we be able to get a very good sample size once we analyze the data? So of course we have to analyze the data and assess the quality and the comprehensiveness of the data. What do the data say about race and ethnicity? We do collect it. You know, again, the end points of collecting disaggregated data, and then what questions can we ask from the data and understanding the impact of structured racism and health inequities from the data that we get? And lastly, how can we use the data to impact programs, policies, to assess and address health inequities? So we have to be able to interpret the data. How do we want to stratify the data? Use the data to measure health inequities and advance equity and then applying an equity lens across, you know, all of the data analysis, next, please.

Thanks. And so I just want to highlight some of the data analysis that CMS OMH has put out throughout the years, so the first being our Mapping Medicare Disparities tool, which was launched in March of 2016, It is an interactive map that allows users to identify areas of disparities between subgroups of Medicare beneficiary. It is user-friendly and visually appealing for those of us who are not data-savvy. The data currently reflect Medicare fee for service and was recently updated with 2019 preliminary data. The data and the map both are downloadable. It is available in

Spanish, and there are 2 views to it: The population view, which you look at the beneficiary data, and the hospital view, which allows you to compare hospital within a county, within a state and nationally, next, please.

And I'm not going to go into the details of the bullet points here, but I do want to highlight that, you know, as we do see, discuss, what do we do with the data? And one of them is, how do we stratify the data? So CMS OMH has put out this -- We call it the national stratify report, and what you see here is the official title. In the national stratify report, we have released this since 2016, so we have -- In 2016, we actually released 2 reports, so we have a report from 2015 to 2020, and it's looking at 2018 Medicare Advantage beneficiary data stratifying across race, ethnicity and gender and looking at clinical care and patient experience care using the CAPs and HEDIS measures. So this report itself help us, you know, identify where some of the strengths and when some of the gaps are when we look at stratification across race, ethnicity and gender, next, please.

We also have a system report comparing rural to urban areas of beneficiary, again, looking, this one looking at 2019 data for Medicare beneficiaries similarly using clinical care and patient experience care using CAPs and HEDIS measure to compare how are the experience for a beneficiary who lives in rural areas to those who live in urban areas, and in the general theme we have gotten so far is that individuals who live in rural areas tend to receive worse care than individuals living in urban areas, and the data are stratified by race and ethnicity in addition to geography.. Next, please.

And lastly we have a series of data highlights out there in the link to the data highlights and at the bottom. These data highlights varies across by topic, looking at CKD, chronic kidney disease, looking at opioid, looking at social determinants of health, looking at prevalence of sickle-cell disease, so definitely, you know, it presents both the national and regional-level data what our minority groups in the conditions that are relevant to them. Next, please.

And we do have a health equity TA resource mailbox out there in case you have any questions or need any assistance for any of the items that are listed here. We provide supports for quality improvements for our partners, providers and other CMS stakeholders, so please feel free to reach out to us if you need any assistance. Next, please.

And, Haley, I will turn it back to you.

Okay, thank you very much. Our next speaker is Dr. Dawn Alley, who is the Chief Strategy Officer of the CMS Innovation Center or CMMI. She's also the Director of the Prevention and Population Health Group at CMMI. Dr. Alley, you may begin.

Good afternoon, everyone, and thank you for the opportunity to talk with you today. The presenters this afternoon have emphasized the urgent need to address equity and structural racism, and Meagan just outlined the essential role that data plays in understanding who we serve at CMS and some of the opportunities and challenges in using data to achieve the vision of an equitable health care system, next.

At the CMS Innovation Center, we test innovative payment and service delivery models to improve quality and reduce costs. All right? So our goal is to drive value, a system that produces more health per health care dollar than we're spending, and data-driven learning is key to what we do because what we're doing at CMMI is testing, trying new things and evaluating them to see whether they work. Did a model reduce costs? Did it improve quality? And critically for whom? We can't have a high-value health system if we're not bringing high-quality care to all of our beneficiaries. So I encourage you to stay tuned for the next session where CMMI Director, Liz Fowler, is going to talk more about the innovation center and equity, but here I'm going to focus on data. Data underlies everything we do at CMMI. Just as critically, data informs what are model participants are doing. As we move away from a fee-for-service system, we are asking providers to take accountability for outpatients, and to do that, they really need to understand their populations. We have some critical data gaps in our systems related to race, ethnicity, language, disability and many of the characteristics that Meagan focused on, and we also have a great deal of work to do to determine how best to incorporate equity into quality measurement and payment models. And part of the purpose of this session is to show the promise of systematic data collection, so I'm going to start talking about a bright spot that shows the power of what we can do when we collect systematic data on health-related social needs. So I'm going to briefly describe the CMMI Accountable Health Communities Model, share a little bit about what we're finding in that model and then talk about where we might go from here, next slide.

All right. Accountable Health Communities Model or the AHC Model is a 5-year model test that is testing whether identifying and addressing Medicare and Medicaid beneficiaries' health-related social needs, improves quality, and reduces costs. Typical to the model is that every beneficiary that's accessing care at a participating clinical delivery states is screened for the 5 health-related social needs that you see here: housing, food insecurity, transportation problems, utility difficulties and interpersonal violence. This can also select a set of supplemental needs that they can screen on in addition, and depending on the sites and whether that site is participating in the assistance track or alignment track, beneficiaries are eligible for community service navigation to help connect them to resources in their community to address those needs. Our focus is really on beneficiaries' report of health-related social needs and have had 2 or more emergency department visits in the last year. That's the group eligible for community service navigation through the model. Next slide.

This shows you the sort of age ecosystem in our 29 participating sites where we have a set of clinical delivery sites that include hospitals, primary care, behavioral health and a set of community service providers. That those clinical delivery sites are working to connect beneficiaries who are navigation-eligible, too, all in partnership with Medicaid frequency, next slide.

And this gives you a sense of where we are, the 29 sites across the country that are participating in one of the 2 AHC tracks. Before we get to the really exciting part where I show you some of what we're actually learning, I want to just briefly acknowledge the incredible, Accountable Health Communities team, our evaluation partners and the critical work happening at each sites across the country. Now let's get to the data. What are we learning? What are our participants learning when we're collecting data like this on every beneficiary that walks through the door? I'm going to share a few findings today from our first evaluation report, which is up on our website, next slide.

Our focus today is on structural racism and health equity, so I wanted to start by highlighting what we're seeing related to race, which is that those who meet the AHC eligibility criteria are more likely to be racial and ethnic minorities, and you can see that in this slide broken down by Medicare and Medicaid. So of those that are screened in Medicare, 9% are Black or African American, but 26% of those who are navigation-eligible, meaning that they have a health-related social need in 2 or more ED visits are Black, African American. Also seeing about double the proportion of Hispanic or Latino in the navigation-eligible group in Medicare. The differences are not quite as large in Medicaid, where a larger proportion of beneficiaries have those health-related social needs, but what we're still seeing here across those programs and populations is that we're identifying beneficiaries with social needs. Those beneficiaries are more likely to be racial and ethnic minorities. We're really focused on, again, driving value, improving quality and reducing cost, so I think this slide shows that we're able to identify beneficiaries with social needs, but they're more likely to be racial and ethnic minorities, so we really want to know what all this has to do with outcomes and health care utilization.

The next slide shows that beneficiaries who were navigation-eligible are on a trajectory of increased cost and utilization. What you can see there is that the top bar are those that are navigation-eligible. Compared to those that either had similar numbers of emergency department visits without the health-related social needs or had health-related social needs without emergency department visits, that navigation-eligible group had higher expenditures and use of that emergency department. Of course, the question the model is focused on is whether we can change this trajectory by connecting these beneficiaries to services, and to answer that question, we're going to need more data. But we have some promising early findings in Medicare B for service beneficiaries. We've seen a 9% reduction in ED visits, emergency department visits in the group that received community service navigation relative to the randomized comparison group that just received a referral to those services. None of this would be possible if we hadn't systematically collected the data and next slide.

This slide shows the social needs in those Medicare and Medicaid beneficiaries who are navigation-eligible. If you're a data geek like me, this is really interesting. What you can see is that the most common need was food insecurity, but we are seeing a lot of needs for housing and transportation as well and many beneficiaries with multiple needs. But where we've seen this data's power is really in getting it into the hands of providers and local decision-makers. We heard from one state Medicaid agency that, you know, we really thought the biggest challenge that we were going to have in our population was housing. We were surprised to see the extent of food insecurity. We heard from a provider who said, "I've been working with this beneficiary on managing their diabetes, and we've been doing case management for a long time, and I didn't understand the extent of their health-related social needs. I had never asked. And we've heard from health systems that are seeing data like this for the first time and saying, well, this really goes down what I'm doing for a particular patient. I need to start figuring out what I can do in partnership with my communities to address upstream factors and make sure these needed services are more available. Hopefully this example shines a light on what we can do when we collect this kind of data systematically, next slide, please.

And I think systematically is the key here. We want this data to be useful at the point of care in a way that poses the least burden to patients and providers, and we know providers have a lot to do. We also don't want to ask patients to prove poverty every time they visit a provider by answering questions about food insecurity, and that's where we believe that looking at this data systematically can help us. We're currently collecting health-related social needs data or asking providers to collect systematic calculated social needs data for CMMI models and last December, CMMI published a request for information about accelerating the adoption of social risk data standards, and we got tremendous feedback. I think the resounding message from many of the respondents was that now is the time, and they highlighted the rapidly developing ecosystem of data standards we can use as well as opportunities to leverage Z codes to make sure that, that social risk data is really getting into the claims systems. But they also highlighted challenges such as the sensitivity of social risk data, the importance of patients being in control of this data and the importance of embedding data like this in the context of a relationship with a trusted provider. So we have a lot of work to do, but, again, hopefully this example shows the power of putting actionable data into providers' hands, and I look forward to the questions and discussion.

Great. Thank you. And finally, we are pleased to have Joy Lewis, the Senior Vice President of Health Equity Strategies and the Executive Director of the Institute for Diversity and Health Equity at the American Hospital Association present. Ms. Lewis, you may begin.

Thank you so much for the opportunity to present today on this very important topic to all of us. So to close out this panel, I will be discussing how hospitals are leveraging data to drive improvements in care, but before I jump into the topic, I wanted to briefly share a bit about the the AHA's commitment to health equity. In December of last year, the AHA announced a realignment to reflect the Association's increasing focus on health equity, and so this included the creation of my role, which is brand-new, and I transitioned into earlier this year, but a decision was also made at that time to fully integrate the Institute for Diversity and Health Equity into the AHA, which for over 2 decades had been an affiliate organization of the AHA. And so being fully integrated into the AHA means we're better able to maximize the assets and leverage the breadth and depth of the AHA team to really advance this work. Health equity is one of the Association's 3 strategic priorities along with workforce and behavioral health, next slide, please.

So given our experiences over the past year dealing with the fluctuating pandemic and its disproportionate impact on communities of color alongside the events of last summer following the murder of George Floyd and a renewed call to social justice, these set of circumstances really required us to think deeply about the ways our hospitals and health systems must advance actions and tactics around diversity, equity and inclusion in the communities that they serve. And so it's really opened up this window of opportunity, if you will, for us to engage in awkward, sometimes difficult but very necessary conversations around, how might we achieve transformative and sustained change to reduce health disparities? And so at the AHA, our job is to help our members understand the importance of this health equity work and meet them where they are on their journey. And so the mission and vision statement that you see on this slide from our Institute for Diversity and Health Equity really emphasized this commitment, next slide, please.

So ultimately we want our members to apply a health equity lens to all the work that they do and to ensure that they are equipped with the necessary resources and tools and the evidence-based information to do their part to dismantle structural racism and other -isms resulting in what we like to refer to as oppression-free health care systems. And so on this slide, you can see the 5 health equity goals we've crafted in order to meet this vision, and so for the purposes of today's conversation, we will be focusing on the second goal, which is the planning, the collecting, the stratifying of data that can then be used to drive care improvements because at the end of the day, it's all about, how do you make data actionable? To address disparities, hospitals and health systems have to first understand where the disparate outcomes are presenting across their different patient groups. And so this requires a multifaceted approach with the right processes, the right systems, the right people to identify and track disparities in care and outcomes, next slide, please.

So the first step in the process is to identify and define the types of data we want our members to collect, and so you can see 3 categories of data presented here. Real data allows our hospitals and health systems to gain a deeper understanding of the makeup of their communities and ultimately develop patient-centered plans to reduce health disparities. SOGI, or sexual orientation and gender identify data, really allows -- If you're systematically documenting these data, it helps to support a more whole-person approach to patient care. And social determinants of health, collecting these data we know help to provide deeper insights into the communities that are most at risk as well as enabling our hospitals and health systems to tend to the nonmedical needs or the social needs with which patients present because we know that health care in and of itself accounts for only up to 20% of one's overall well-being and one's health status. And so a great real-world example in application of real data to provide high-quality care is demonstrated by the Henry Ford Health System in Detroit, so I'm going to share with you a little bit about what they did in terms of their real data collection efforts.

Henry Ford Health System was actually the AHA's 2020 Carolyn Boone Lewis Equity of Care Award Honoree, so their challenge was to better understand the needs of their patient populations with a particular emphasis on patients from the Latinx and the Arab population. They've got a really high concentration of Arabs, and so they coordinated with a community partner, the Greater Detroit Area Health Council, to launch the We Ask Because We Care campaign, and through that campaign, the health system now collects real data from more than 90% of their patients. Before the campaign, nearly every patient in the Henry Ford Health System was counted but not in the most accurate way. What they had happening was that clinical services representatives would collect racial information just by looking at the patient through observation, which we know is a flawed approach, versus utilizing a standardized approach, so they established an interprofessional race, ethnicity and language task force to train frontline clerical and clinical staff on how to properly ask questions about race and ethnicity, and they specifically included clerical staff because when patients call to schedule an appointment, they used that as an opportunity to query them about how they identify along racial and ethnic lines. They then took the data, and they stratified it in an equity dashboard across 10 clinical services for which quality data are being measured. These include maternal and infant health, diabetes management and prevention as well as other areas, and their data exposed disparities in colonoscopy screening rates based on racial groups, and so what they were able to do was then implement programs to close those gaps and identified successful practices in reducing screening gaps for colorectal cancer screening to the tune of 13% across racial groups, next slide, please.

So let's move on to slide 6, which speaks to the data-driven care delivery dashboards because what Henry Ford System did was that they, as I just described, they created a dashboard that's frequently used in health care systems to provide leaders with the necessary information that they needed to monitor and track progress through a defined set of outcomes and metrics, and we know that measurement reporting and benchmarking are all critical to improving care and patient outcomes, next slide, please. Go to the next slide, please.

So as with all major strategic and operational objectives, there are challenges and barriers that hospitals must overcome in order to effectively collect, stratify and then use that data within their health systems to drive improvements. And so a significant number of these considerations are operational in nature, as you can see on this slide, which makes the case for emphasizing staff training and more standardized approaches and ultimately creating a culture of data collection. So the accountability and the resources needed to make data actionable must be supported from a system level, so whether the example we explained, I explained earlier around building out the infrastructure, whether it's within the EHR, for example, to allow for the collecting and the sharing of data across the organization or creating clinical processes that incorporate the stratification and the use of data at the point of care to identify disparities or establishing partnerships with community organizations who really understand the patients from their communities like we saw with the Henry Ford example. These are all necessary steps to collect the right data, and we know that we have to ask the right question in order to get to the right data but most importantly, leaders inside our health care organizations must be accountable to this work, and we at the AHA are really doubling down on this premise that accountability is going to be what moves the needle. That is going to be a key requirement for really making advancements in this work. It is important to remember that sustained systemic change entails both awareness and action, so stratifying patient data requires an organized comprehensive planning framework that promotes collaboration across many departments within a hospital and also across care settings, next slide, please.

So we reviewed the collection, stratification and use of data, but keep in mind that that's only one step in the larger organizational journey to achieving health equity. Unpacking patient data is important to pinpoint where resources should then be deployed to address gaps in access and quality, but the data also provided deeper understanding and insights for our leadership teams to implement strategies that support broader organizational strategic priorities. So I really want to make the case that understanding the data and identifying critical needs amongst patients will also lead to building sustainable equity practices in other parts of the organization that can then enhance and promote population-level health because at the end of the day, that's really what we're after is health, next slide, please.

Before I end my presentation, I want to share that the AHA launched a new health equity resource series last month really focused on advancing health equity strategies and actions, and the first tool kit released last month is on this topic that we're discussing today, data-driven care delivery. And it addresses the importance of segmenting and leveraging patient data to address disparate care outcomes and to drive improvements in care. The second installment in the series will be released next Wednesday, and that will focus on how to render care with cultural humility, and there are 2 others in the 4-part series. What you also see on this slide is the development of an equity road map that's currently underway with funding by the Robert Wood Johnson grant, so Robert Wood Johnson Foundation, so you should actually be on the lookout for more information later this fall in terms of our work to really drive the field in their efforts to become much more high-performing around high-quality and equitable care, next slide, please.

In closing, I hope my presentation really reinforced for you that the nation's hospitals and health systems are actively engaged in data collection, data stratification and then using those data, but that's only one foundational pillar to advance health equity. As you know all too well, the worth of health equity is iterative. It's the long game, and so the AHA really looks forward to working together with all of our partners to ensure that we're keeping diversity, equity and inclusion front and center and top of mind for our leaders and for our nation. Thank you so much.

Great. Thank you, Ms. Lewis, and now I will pass it back over to Meagan.

Thank you, Haley, and thank you so much, Dawn and Joy, for such an informative presentation. So as a wrap-up, you know, as we heard from all the presentation in this session today, the need for data is definitely important. Having more and better data help us with our analysis. Researchers, especially at the disaggregated level, the data will help us identify gaps in cares and assess the needs of the individuals that we serve by -- AHC social needs data elements. It is important for us to have that information, and the assessment can help us perform evaluations on the care and the services that are needed. And lastly, as we mentioned, data can can help address differential outcomes and identify areas for improvements to help the individuals that we serve to advance and achieve health equity. So I'm going to wrap this up with a quote. I'm not quite sure exactly from who, but it says, you know, "You cannot improve what you don't measure," and so data is definitely important for us. So, Haley, I will turn it over to you for a Q and A.

Great. Thank you very much. We will now move into the question and answer portion of this session. As a reminder, you may submit a question via the chat box, and we will read them aloud, and we will address as many questions as time allows, so we have about 15 minutes. Great, great, and then we will move into our first question, so I believe this one may be for you, Dr. Alley. And so they are asking, "What are your efforts to better understand the high percentage of unknown responses to race and ethnicity questions composing strategies for collecting this information?"

Well, I'd love to let Meagan weigh in on that because I think that is certainly an issue in many of our CMS data collection vehicles well beyond CMMI.

Yes. Unfortunately it is one of our, you know, data-collection barrier, as data collection isn't optional. Therefore it is up to the beneficiary, you know, to report the data or not, and if you recall from the 2019 Open Enrollment Period for the Marketplace consumer, we do have a 26 to 27% of unknown, meaning that the individual did not make a selection, either their race or ethnicity. It is even higher on the ethnicity side, so that is one of the challenges that we're trying to figure out how, you know, we could get the beneficiary or the consumers to provide better or data or report the data to us, but it is challenging when it is optional.

Great. Thank you. And our next question, "What role do members of the community have in identifying, prioritizing, planning and overseeing accountability for initiatives to address structural racism in hospitals?"

Thanks for that question. I mean at the end of the day, where we're trying to get our hospitals and health systems to focus on is codesigning the health equity solutions, so, you know, we don't see our role in communities as the party that basically parachutes in and tells a community what it is that they need to advance their own health. It's really this partnership that is going to be required and in a very intentional way. We've got to bring the patient voice to the table whether it's through patient advisory councils or other means. There is clearly a need and an emphasis on ensuring that the patient voice and the community voice is baked into whatever the solutions are that we're developing on behalf of the communities that we serve. So that's critical.

Great. Thank you. We will move on to our next question. "How do we ensure that data collection and stratification doesn't lead to more discrimination?"

So I'll start, and Dawn and Joy can definitely chime in. I think it is a very good question. You know, data can be good for us and bad for us, and as we've seen from the last year or so regarding, you know, biased algorithm and all the clinical algorithm discussions that are out there, so we definitely have to be careful in terms of when we stratify data to make sure that we do have a good, you know, sample size of the data for the stratification. What is it that we're stratifying? What outcomes that we're looking for and definitely, you know, to make sure that the analysis is valid, to check in with our experts, depending on what the companies are, but we definitely are considering, you know, in terms of, how do we -- As we try to collect more and better data, how would you really avoid that from happening?

Yeah, and I would just add that having diverse perspectives is really critical, right? So having diversity of thought, having diverse representation across all other dimensions of diversity that one might think of. Again, as a part of that process, it's going to be really important to ensure that there aren't these unintended consequences, that the question, right, is moving forward. The intent of collecting the data is obviously to put it to good use, but as Meagan just said, data can be used for good or for bad, and so at the end of the day, we want to make sure that the right voices and the right perspective are a part of that conversation.

And I would encourage anyone who is interested in the role of this kind of data in value-based payments to look at the compact reports from ASCII that -- and the work that they've done really trying to think very carefully about how we use that data in value-based payment and the idea that we want to make sure that we are not penalizing providers that are serving safety net populations, that we also don't want to accept lower bar for care for providers that are serving safety net populations and really being extraordinarily thoughtful about how we bring this data into our programs to accurately resource providers and then making sure that we are measuring the impact of those changes along the way so that if there are unintended consequences that we can identify them.

Okay. Thank you all. Moving on to our next question, we do have one that is specific for Ms. Lewis, and this person is asking, "How do patients feel about sharing their race and ethnicity when they are asked? Are they taken aback, or is it explained why this is being asked for?"

So that's a very good question, so it's a range, right, as in most surveys or data or questionnaires that are put out there, but the training component, in terms of how we standardize and how we ensure that the staff are appropriately trained to approach our patients, to ask for that information around race and ethnicity, is a key variable in terms of the response that we then get, so I think putting in the work up front to train the staff has actually resulted in better data collection from our patients and from our communities, so it's really -- The onus, I would say, is on us as the hospital and health system to prepare our staff appropriately to engage our patient populations and to help them understand why this data is meaningful and how we are going to make good use of it to inform and to ensure that the care is then patient-centric, and at the end of the day, moving the needle towards greater outcomes and better population health. So I would say that the response, historically, in the past, was varied and much lower than we would've liked, but we are seeing much better uptake, as we ourselves are better-prepared to ask the right questions.

Great. Thank you. We have been getting a few more questions, so one that we will move on to next is, "Would it be possible for CMS to consider a data collection process as outlined by AHA to disperse across states to ensure standardization in the process of data collection?"

I'm not quite sure I fully understand the question.

Sure. Yeah. I can go ahead and just read that one again and then also just ask for some clarity, so this attendee is asking, "Would it be possible for CMS to consider a data collection process to disburse across states to ensure standardization in the process of data collection?"

So it's -- and I want to take a shot, so it sounds like the person is asking if there is any standardization that CMS could set and that we could collect the data in sharing with the states, that the states could use the standards to collect the data in their own states? And if that happens to be the questions, I think, right now, from CMS's perspective, we are using the 2011 HHS data standards in terms of collection of data for race, ethnicity, disability, sex, and I want to say one more data element, but as we continue the conversation, you know, there is a lot of questions regarding, you know, what data elements we need to continue to standardize and, you know, at this aggregated level, what kind of standardization that is going to be. So, you know, whether CMS can do that or not, I simply cannot say that here on the call, but definitely something that we are having multiple discussions about.

And I do want to note, there are so many facets to that question, and sorry. I didn't want to cut Joy off if you were going to weigh in on, from your perspective, what this looks like, but I would also note that in addition to the standards that Meagan mentioned, the Office of the National Coordinator for Health IT also has a set of data standards for electronic health records, and we have, in some of the guidance that we've put out to state related to social determinants, suggests that where states are considering collecting data like this to make sure that they are using or encouraging providers of plans to use some of the standards that we've talked about here. So I think, you know, we, very much have an interest in ensuring that those standards are used to support the kinds of aggregations that I think the questioner is talking about.

Great. Thank you, and I believe we do have time for just one more question before we move into our third session of the day, and so this individual is asking, "Are there concerns that risk adjustments or stratification for paid-for performance can provide a loophole for institutions to not address racial and equity and health disparities? How do you suggest that reimbursement models address social determinants of health?"

I will say I'm not sure I totally follow the piece about the loophole per se, but I think that this is an issue that we are very conscious of and working with our colleagues around HHS, including ASQ, who I mentioned earlier, and the Center for Clinical Standards and Quality to think about, both in the CMS value-based purchasing programs and in CMMI models. We know that there is room for improved prediction in our risk adjustment frameworks and also opportunities to dig deeper on this. CCSQ, the Center For Clinical Standards and Quality, did ask the National Quality Forum to take a look at this, and they actually have some of the first work from that effort posted on their web site around best practices and risk adjustment related to social and functional risks, so I think this is an area where we are really trying to learn from experts that are looking at the opportunities to make sure we are capturing this kind of data in a way that will facilitate meaningful improvements through value-based payment.

Great. Thank you, Dr. Alley. All right. I believe that is all the time that we have for questions for this session, so again, we'd like to thank all of today's presenters for joining us. Our next session will begin at approximately 3:15.

Session 3: Integrating Equity Solutions Across Health Programs and Health Systems

Okay. Thanks, you all. We will now begin our third and final session for today, and this will be Integrating Equity Solutions Across Health Programs and Health Systems. During this session, we're pleased to have Jean Moody-Williams from CMS, Dr. Liz Fowler from CMMI, Dr. Laurie Zephyrin from the Commonwealth Fund and Dr. Sabiha Raoof and her team from the Jamaica Hospital Medical Center provide their insight. As a reminder, there will be time for questions following the presentation, and we will address as many questions as time allows. You may submit your questions via the chat box at any time. Please note that members of the press should direct all questions to press@cms.hhs.gov. The recording in the virtual form will be posted on the CMS OMH webinar and events page following this event. A link to that page will be shared momentarily in the chat box. If I could move to the next slide, please and next one, okay. So we will turn it over to our first presenter, Jean Moody-Williams, who is the Deputy Director of the Center for Clinical Standards and Quality at CMS. Ms. Moody-Williams, you may begin.

Great. Thank you so much, and if we could go to -- up to our next slide, please, so I would like to first thank Dr. LaShawn McIver for organizing this event. It's great to be on such a distinguished panel with Liz and Lori that have made tremendous strides in the field and with Dr. Sabiha Raoof, which I have had the wonderful opportunity, and her team. Let's say I can see them. Hello. I've had the wonderful opportunity to visit with Jamaica Hospital and spend some time with them learning from their tremendous operations, and so I can't wait to hear their presentation.

There was a disclaimer slide there that I think maybe I showed at the beginning, but my disclaimer is a little bit different than the ones that were on the slide in that it really is related to terminology and inclusiveness, and given that the focus of today is structural racism, most of my comments are specific to race and ethnicity but can, in most cases, be extended to people with disabilities, members of the lesbian, gay, bisexual, transgender and queer community, individuals who have limited English proficiency and rural providers, so I'm also going to focus on the part of the structure or system that we immediately influence within CCSQ with the clear understanding that only addressing structural elements in health care facilities or providers is not sufficient. You have to address all the social determinants of health when it comes to considering food, housing, education, wealth and all of the other factors.

So you have here -- I've included one data slide. We just had a complete data section, but just to quickly provide a basis for my comments because I don't plan to say much about this, as I don't really feel the need to make the case for addressing disparities and equity issues with this audience. The need is obvious, and they're obvious throughout the data that we'll focus on today. This quickly shows the difference in hospitalization during COVID-19 and the impact, as well, on nursing-home cases and mortality for some of the most vulnerable populations in this country, and I'll come back to this later. Next slide, please.

So I want to spend more of my time looking at the various levers of change that are available to us within the Center for Clinical Standards and Quality. As we look at the role of, really, reform and change in the country, for those of you that may not be aware, our center has responsibility for a full spectrum of possibilities for change, including regulations, providing guidance to implement regulations, executing oversight responsibility for each -- for more than 17 providers actually enrolling. We just got a new provider type that was one of the legislations that just passed. For laboratories that return results to patients and for payment assistance for value-based care, coverage determinations, quality improvement, technical assistance and learning and action networks, all of that, as you see on our slide, is within our portfolio, so this is a charge that we do not take lightly because all of those are mechanisms that really can make change in this country, and you will note that there's a question mark in the center, which I will explain in just a minute, if we could go to the next slide, please. While we have been on this equity journey for a while now, we have been giving a great deal of thought more recently on how to better-align these efforts and these levers to create more forward motion on the journey. We don't want to just spin around in circles but propel ourselves forward to meet the charge of the administration, really, to move to a world where good health and health care is available to us, so the question mark I mentioned is related to how I wanted to frame this discussion today and center around the 3 questions that you see here, and these are questions we address as policymakers on a daily basis as we try to balance the needs of many. They include pinpointing the issues. You know, exactly what is it that we're trying to address? What are we doing now?

And so we've gone through a couple examples today, but not an exhaustive list, and, more importantly, what are some of the outstanding policies and program questions that we still need to address? Because this last question is the one that helps us to continue to move forward so that we know our job is not done and to think, what else can we do? So the questions that have presented there are the ones we're thinking about, we're working on or what we hear from our stakeholders, you know, almost every day, and so looking at the leverage that we have, I want to start with the quality measurement and public reporting, so if we could go to the next slide.

So in our quality measure and reporting, we've heard all through the afternoon about the need and the quality measurement approaches that currently exist did not adequately identify issues for the equity of health care, the data, is still needed on inequality. It's not always available. It's not publicly reported, and it's people that really are involved are not adequately engaged in measure development, so what are we doing right now? Next slide, please. I'm hopeful that many of you have already participated in the presentations and listening sessions about the CMS Quality Measurement Action Plan, so I don't plan to really go into detail on this presentation, but I will call your attention to the focus area of promoting equity and closing gaps in care, is a major pillar in the action plan. Next slide, please.

As you can see from the objective here, as a matter of fact, we are already well underway with some of these. These are things that you could expect to see throughout the course of a year or over the coming years based on the things that we're working on or required by law, but expanding confidential feedback reports stratified by dual eligible in all of our CMS value-based incentive programs, right now, we do it in the readmissions reduction program, but by the -- We hope to get to this by the end of 2021, also introducing plans to close equity gaps through leveraging paid-for performance incentives by 2022 and sharing equity supported and measure development with socioeconomic status, SES measures and also working very closely with the Office of Minority Health on the HESS standards. So just one second here, so that and to develop multi-year plans to promote equity through equality measures, so those are some important things. Next slide, please.

So I've mentioned legislation a couple times. There were some really important ones I wanted to point out with the impact that -- of a 21st Century Cure, and we've taken steps to implement actions under the IMPACT Act and the 21st Century Cure. As was just mentioned in the last session, the IMPACT Act required the secretary, acting through the assistant secretary, obtaining an evaluation or asking to conduct research on issues related to social risk and Medicare value-based payment programs, so they have already published 2 reports on this. We are working very closely with them, and, in fact, we are actually meeting with ASQ and representatives from the secretary's office tomorrow to continue our discussions on it, so this is active work, and then this admission -- It also requires admission of standardized data across those those acute care settings, which we've been working on and implementing for long-term care hospitals, skilled nursing facilities, home health agencies and other post-acute care providers. Very important is that we are able to look across the continuum of care as we look for, where is the breakdown? When we start to talk about structural racism, we're talking about systems of care, and so we need to be able to look across some of those systems of care, and then in the 21st Century Cures Act, it requires assessment and imposition of penalties based on hospital readmission performance by comparing hospitals with similarly proportions of patients that are treating dual eligible populations, so we've already started to implement that program. Next slide, please.

So when I talk about the question, so what is it that's propelling us forward that we're working on, that we need to work on? So one of the most important things I wanted to make sure that you're aware of, this audience in particular, is that we are seeking comments on CMS's plan to address equity issues through a formal request for information published in our payment rules has gone out so far by looking at creation of reports for providers to share stratified information with the variables of race, ethnicity and the other variables that I mentioned earlier, use of imputation methodology for race in quality measurement where race data is not available and then the potential for using the HESS measures, so please look for that. Please submit your comments. We are earnestly seeking how we move forward here.

There are other questions that have already been brought up today about using this data in artificial intelligence and various algorithms to ensure that we are not disadvantaging racial and ethnic groups. That was a question that was just brought up in the last session, and we're very cognizant of that. How do we ensure that the voices of patients and families and diverse measure developers are further incorporated into the process? And what do we publicly display, and how do we incentivize the breakdown? Next slide, please.

So that was quality measurement. Now, I want to talk a little bit about conditions for participation and surveying oversight, and I'll just go right to some of the outstanding questions. You know, we're looking at, what changes should we make through the CoPs? Again, we have -- You heard about the executive orders that we have, so we're looking at all the levers. We're looking at best CoPs. What changes should be made? What type of enforcement is appropriate if regulations are changed? Because that’s what happens when you put things in CoP. You get regulations due to enforcement, and, you know, if you're instructing a surveyor to go on-site, what are you expecting the to look for when you're talking about evidence of structural racism or inequities or the various topics that they may be looking for? We have to be able to define that and look at variation across the country because inevitably when we do these types of things, we see differences in different parts of the country. Next slide, please.

Our coverage and analysis group, often women and members of racial, ethnic minorities are underrepresented in clinical research that's relied upon to make coverage decisions, so right now, if a researcher comes in and talks about study design, we ask them about their inclusiveness and how they plan to set up their studies. We talk to specialty societies and the like, and if we publish a coverage decision in which this information is available, we show it to include that, and, more importantly, we're working closely with the FDA, and they've made a commitment to eliminate disparities in clinical trials. Next slide, please.

And so going through the questions that we're looking at here, how do we address some of the mistrust issues? The literature suggests that racial and ethnic minorities would participate in trials if asked, but they're not always asked, and real-world evidence is becoming a way of looking at coverage, being sure that we are inclusive of populations as we look at them, and those that advise us in our Medicare Advisory Committees, how do we make sure that that is the first group that's actually advising us? Next slide, please.

Our quality improvement organizations, by statute, CMS contracts with QIOs and ESRD Networks, so we're working with over 25 Medicares and American Indian Health Quality Initiatives, hospitals in the Indian Health Services. We're working with hospitals, so this is just starting—the Hospital Quality Improvement Contracts, they help hospitals look at their data. How do they use their data as they start to stratify, producing disparities reports? What do you with it once you get it? And then spreading all of those interventions when we get an idea of, what's working? What's not? What are the best practices, promising practices? ESRD Networks, as well, are doing that same type of work as we start to see care expand more into the home, dialysis in the home, ensuring that we are doing what we need to do there, and so next slide, please.

Sticking to the questions we ask, we're already starting to look at our 13th Scope of Work with this launch not too along plus Scope of Work, but what goes into that next set of contracts as we work with QIOs? What are the best data sources to use? And we've already heard some of what CMS is looking at right now and the impact of our interventions, and how do we connect with that? I talked about connecting with that across programs where appropriate to use the data that we might be learning from the QIO programs to inform quality measurements and vice-versa. Next slide, please.

So I am going to end with a brief word on our COVID-19 activities. I'd be remiss if I didn't give a little bit of time on this after the events of the last year, and I know there is a panel that will address this tomorrow, but the data I shared at the beginning reflected that often who is hospitalized and what the outcomes were, good or bad, was associated with who you are, your financial status, your community situation, and also, as noted in the beginning slide, nursing-home residents were particularly vulnerable, and the slide revealed that the nursing home rate of infection closely matched that of the community rates. Now, nursing-home residents don't go in and out frequently, but community staff do, in and out daily, so you can see that the importance of making sure that staff are using appropriate precautions as well, including the vaccine, so recognizing there was a lack of vaccine confidence among staff, particularly as certified nursing assistants frequently are, of course, lower pay. They are members of ethnic and racial minority groups. We set out to answer questions and engage the staff through a series of fireside chats, and we had, I believe, 4 of these, and it was really peer-to-peer discussions. We were more the convener and the facilitator. We had, you know, 1,000 people or so joined in, listened to their peers and talked about some discussions that they had. What was it that they were concerned about? And not dismissing their concerns but really listening and then trying to address it with that. Next slide, please.

So what did we hear from them? That the vaccine was developed faster than other vaccines. Is this really safe? Long-term care staff often felt, "Well, we aren't usually prioritized for anything else. Why are you prioritizing us now for this emergency-use vaccine?" They asked us those questions, questions about infertility and many other things, so we had the opportunity to address those from a scientific perspective. We had CDC on, but also listening to what was important to them, so hot off the press today, a couple of hours ago, CDC released some guidelines, which, in turn, will impact our guidelines about fully vaccinated residents and staff in long-term care facilities and address visitation, congregation, if you can, if you need face coverings, source control, face masks when you are meeting, should you do physical distancing? You can find that information on the CDC website.

I said that was just released a couple hours ago, and really I think that we need to spread this information so that we can help to ensure safety of the very populations that we have dedicated this forum to. So I'm going to stop there. Next, last slide, please.

Oh, I'm sorry. I didn't show you the key questions, but I did mention those, and then the next slide.

I just want to say thank you, and, you know, the very essence of the term "structural racism" means that there is inherently systemic systems. You know, it includes many of our policies, looking to make sure that we're not contributing, but it usually means that change is not going to happen by one independent action, so it will take all of us working together, and we are committed to that change. So with that, I'll stop, and thank you very much for the opportunity.

Okay. Thank you so much, Ms. Moody-Williams. Next, we are pleased to introduce Dr. Liz Fowler, Deputy Administrator and Director of the CMS Innovation Center. Dr. Fowler, you may begin your presentation.

Thanks, and thanks to Jean for a really excellent presentation, and thanks to LaShawn and the Office of Minority Health for hosting this timely and important discussion, and also for their leadership within the agency and the department. I appreciate the opportunity to be part of this event, and specifically to be part of this panel, and in particular with my former Commonwealth Fund colleague and friend, Laurie Zephyrin. Hi, Laurie.

This week, it's 2 months since I became Director of the CMS Innovation Center, and I am very fortunate to step into this role. It's my third time working at CMS, and I have a very deep appreciation for the agency, the team and its powerful mission, and moreover, it's a crucial time for our health care system, and I'll use 2 somewhat disparate metaphors to explain why.

First, I believe we're at a crossroads in value-based care. We've been clearing a path to move the system toward value and away from volume, and now with 10 years of experience with the new models and alternative payment systems, the path is getting harder. It's not quite as clear or straightforward. We've lost a bit of focus in some respects, and recently it's become more comfortable to stay in fee for service. Taking the steps needed to move towards value requires effort and sacrifice. At this critical time, we face a choice at this crossroad, and it's a good time to take stock of where we're going and where we go next, and my second metaphor with regard to advancing health equity, I see us on a runway ready to take off.

For many years, we've been sitting on the runway waiting to take off, taxiing, waiting in line for other challenges in health care to be solved, like expanding coverage, addressing affordability, long-term care, which is still on the runway at the moment, but now it's time for health equity to embrace this moment and take off. COVID has exposed inequities that cannot be ignored, and with this increased visibility, the system is rushing towards solutions, and I for one am very heartened to see this movement.

In my short time with you this afternoon, I wanted to cover 2 areas, and granted, maybe a little bit bigger picture than some of the other presentations that you've heard from in the last panel and from Jean, and that's the role that CMS and HHS can play in setting a direction on health equity and CMMI's part in that story, and then considerations for other stakeholders in the health system as they take bold steps to advance health equity.

At the outset, let me say that health equity and racial justice are a cornerstone of the Biden-Harris agenda. One of President Biden's first executive orders signed on January 21st focused on ensuring an equitable pandemic response and recovery. Among other things, the executive order established the COVID-19 Health Equity Task Force within HHS that's charged with the broad mandate of making recommendations on mitigating the health inequities caused by or exacerbated by COVID-19 pandemic and preventing such inequities in the future. This includes consideration of how resources are allocated, data collection, how we communicate and how we reach different audiences.

Within the department, as we consider policy priorities, proposals and announcements, hiring decisions, messaging, a very clear signal has been sent that everything we need to do needs to be viewed through an equity lens, and at his confirmation hearing in February and describing his commitment to health equity, HHS Secretary Becerra said, "We will have a team at HHS that lives and breathes the desire to have health equity." That is proving to be true. In every meeting with the Secretary's office, his team asks, "What more can we do? Did you consider the impact of this policy on health equity?" And as Jean mentioned, we're meeting tomorrow to have this very discussion with the Secretary's office, and similarly in her confirmation hearing earlier this month, Chiquita Brooks-LaSure talked about the impact of COVID on her hometown, a predominately Black community where her parents still live. She also talked about the need to expand access to health care equality for all communities, and when she's confirmed, she will be the first Black woman to lead the agency.

CMS is a catalyst and a leader. Many payers follow CMS's lead, and as the single largest payer for medical services in the US, no other payer comes close to matching the influence wielded by our agency. This means that CMS has a unique position to be a health care disrupter and driver for change, and we take this responsibility very seriously.

On health equity specifically, we're focused on 3 core elements: Increasing understanding and awareness of disparities. Are we collecting and reporting equity in the same way? Developing and disseminating solutions to achieve health equity. Are we measuring progress in the same way? And implementing sustainable actions to achieve health equity. Achieving our goals and making progress in advancing health equity will take all of us, and that commitment and leadership will translate to what we do at CMMI. Just as it is with the rest of CMS, advancing health equity is part of everything we do, and will be even more so going forward.

The payment and delivery system models we test, develop and scale should reduce disparities. Starting with model development, consideration of equity should be part of every Innovation Center Investment Proposal, or ICIP, as it's called, the formal application that goes to the Office of Management and Budget. Recruitment of participants: Who is participating in our models, and what is the mix of patients they serve? Not all institutions or organizations have ready access to capital and technology that may be required to participate in our models, and we need to consider that. Similarly, our administrator requirements may be too high for some participants, again something we need to address, and overall we need to do a better job, and our model participants need to do a better job of forging relationships and working with community-based organizations.

And finally, model evaluation: We need to look more closely at the impact of our interventions by race and ethnicity and ensure that improvements to the health system benefit all patients. We need to be collecting, reporting and using data on race and ethnicity, and it should be a requirement of all providers that participate in our model. That also means including quality measures focused on social determinants of health, needs and outcomes as part of how we measure quality and outcomes.

You had a chance to listen to the session before this one, you heard my colleague Dawn Alley highlight CMS's accountable health communities model. We're going to continue to build on what we've learned from the AHC model, and we need to apply those concepts and elements back into our other models, for example, Direct Contracting, Primary Care First, so that we can continue to push toward equal care and better outcomes for everyone. CMMI will continue to explore ways to align our existing and new models as an opportunity to expand in the equities space and align with the agency's priorities for the CMS Equity Plan from 2021 to 2031, and we welcome your input as we forge this path and continue our journey towards health transformation.

And then, second, thinking about our monumental role that CMS plays in the health system, it's also important to recognize the leadership of so many organizations and stakeholders in the health system, and that leads to the second area I wanted to address: Considerations for other stakeholders as they take their bold steps to advance health equity. It's encouraging to see so many national organizations taking up the mantle. You heard already from Joy from the American Hospital Association. In November, the American Medical Association's House of Delegates adopted a resolution recognizing racism and the serious threat it represents to public health, to the advancement of health equity and a barrier to appropriate medical care. As part of its strategic plan, the AAMC, which represents medical colleges and academic medical centers, established a Center for Health Justice to focus on the intersection of population health, community health and the health equity for the nation's academic medical community, and last week the Blue Cross and Blue Shield Association announced its national health equity strategy, which includes collecting data to measure disparities, scaling of effective programs, working with providers to improve outcomes and address unconscious bias, leaning into partnerships at the community level and influencing policy decisions at the state and local level.

Not only are health care leaders across the country recognizing that racism impacts health and health care for marginalized communities and patients, but they're actively seeking and implementing solutions. It's really encouraging to see. So as we actively and collectively highlight and address the blight of racism in health care and advance health equity, a few lessons to keep in mind, and I think these are probably just repeating a lot of what's been said earlier in the panels and I'm sure on this panel. Defining health equity: Payers, providers, purchasers, and other stakeholders may have different responses to addressing equity, but we should adopt common definitions. Social determinants of health, health equity, and structural racism are not interchangeable, and I think we can all articulate the crisis that health care disparities represents. Is it possible to have a shared sense of what solutions might be and what success looks like? The role and importance of data: The last panel covered this issue extensively. Collecting data, measuring impact and reporting matters a lot, but there's a lot of lack of uniformity in data collection and analytic standards. We need to build a data infrastructure that will allow us to measure progress, and that's at a nascent stage right now, so how can we work together to build that infrastructure?

And then rollout of payment design: Some of the advice and recommendations given to CMS and CMMI about how to advance equity and payment model design are relevant to other stakeholders in the system. Consider the providers who are part of the network, the practice or system and the patients they serve, the types of insurance they carry, the ability to access services and their health needs. Consider services that are covered, paid for and delivered, and the patterns of care, the digital tools deployed and the potential biases they might inadvertently be promoting, and then the importance of engaging with community-based organizations. As I mentioned, this is a unique opportunity to identify strategies and solutions to address equity in the health system. I truly hope this momentum can keep going as we advance health equity and take off as a national priority and shared goal, so with that I’ll conclude and turn it back it over to our next speaker, and thank you again for your time, and thanks again to LaShawn for pulling together this event.

Okay. Thank you very much, Dr. Fowler. Our next speaker is Dr. Laurie Zephyrin, Vice President for Advancing Health Equity at the Commonwealth Fund. Dr. Zephyrin, I will now turn it over to you.

Great. Thank you, and thanks for having me, and thanks, Liz, for all of this work, and thanks, LaShawn, as well for hosting this event. We're in a really critical time now where there's just a significant opportunity to have an impact on health equity and intentionally address structural racism. If you'd go to the next slide, please.

So at the Commonwealth Fund, we've been thinking very deeply and engaging in work to address integrating health equity across programs and health systems, and as we recently launched our Advancing Health Equity program this January, we're focusing, you know, our goal was to really contribute to efforts to dismantle systemic racism in health care policy and practice and counter inequity and treatment experience and outcomes for Black people, Indigenous people and other people of color communities. In thinking through our key focus areas -- If you go to the next slide, please.

Our 3 focus areas address dismantling racism in care delivery, using policy to bring about equitable access and changing culture, beliefs and attitudes, and I'll describe some of the context in more detail in the next several slides in terms of, you know, what's within each of these areas and how we came to each of these areas.

If you go to the next slide, we do know that, as Liz had mentioned, a wide range of health systems have made strong commitments to address health equity, to develop effective anti-racism practices and, you know, are exploring a range of effective anti-racism practices within their systems, and we've had a number of conversations with a range of health systems to get a sense of what they're thinking about and what they're doing, and these strategies include what organizations can do internally, for example, for their workforce, whether it's promoting economic and educational opportunities and affordable health care or diversifying the health care workforce at all levels, particularly leadership levels or addressing health care systems' interaction with communities and addressing community partnerships, actively investing and engaging with community partners, and as we've heard throughout today, you know, data are central to these efforts, really efforts to not only collect data but also disaggregate the data and really act on that data as well, and financial and regulatory pressures, you know, from payers really can motivate health care leaders to examine their internal cultures and attitudes and beliefs and really take remedial action, and these financial and regulatory pressures can also promote collection and reporting of disaggregated data by race and ethnicity and other measures and created accreditation standards for measuring, tracking and reporting on comparative care experiences as well, and also even establishing regulatory requirements for inclusive community partnerships.

If you go to the next slide, please, we know that just policies, you know, whether we talk about big-P Policies or little-p policies are really critical to bring about systemic change. You know, as we think about the role of policies in entrenching systemic racism -- I think Jean had mentioned this earlier. Really, it's about the systems and the structures, and we really have to think about how to dismantle these systems, and we know the power of policies in dismantling systematic racism. Equity and racial equity has to be central to all policies, and just as we have a budget impact for policies, an equity impact for policies equally is critical, and, you know, having insurance is critical, that coverage, but we also know that alone does not guarantee equity and the provision and receipt of all health care services.

We're funding some work now with, for example, the Center for Antiracist Research, Dr. Kendi and his team, where to develop a racial policy tracker, which will help document and evaluate current health policies and their impacts on racial and ethnic minorities, and these trackers along with anti-racism policy toolkit will be provided to legislators, academics, community stakeholders and more to really support anti-racism in policy-making and implementation.

We also have some work that we funded with Dr. Jamila Michener where she's developing a framework that will provide a blueprint for assessing racial equity implications of a given policy, such as Medicaid for example, and so there's really a significant opportunity from a big-P Policy perspective to really address anti-racism and dismantle structural racism.

You know, we also have thought through strategies around changing culture, beliefs and attitudes, and people who work in health care are often really unaware of or ignore the ways in which, you know, institutional culture and personal attitudes contribute to racism, and so to foster anti-racism in health care, it's really essential to show how racism bias manifests within management or among members of the workforce or between patients and providers to really supporting research to inform and frame messaging and narratives around racism and health care is a critical part of our strategy, as well as thinking through and supporting metrics for the developing of metrics for assessing how racism manifests itself in health care. You know, and also -- Next slide, please.

Oops. And then I talked to this slide. Next slide, please.

And we recently had the Commonwealth Fund Task Force on Payment and Delivery System Reform and recommended 6 policy imperatives to improve quality, advance equity and increase affordability, and in terms of advancing racial equity in health care, some of these themes really resonated today around requiring that data stratified by race and ethnicity to be not only collected, but also publicly reported, developing and testing and scaling payment and delivery models that intentionally reduce disparities by race and ethnicity, expanding and diversifying and training the health care workforce as well as developing protections against racial bias, for example, in health care technology, so I wanted to dive a little deeper into a use case that -- If you can go to the next slide -- around maternal health equity and how maternal health equity and how maternal health equity can be integrated and central to payment and policy strategies, and this can really provide some additional examples based on some of the conversations that have happened earlier today.

If we go to the next slide, in terms of defining the problem, we know that we need to understand and address racial equity in maternal health. You know, there's significant data and anecdotal experience, sort of really addressing unequal treatment from data showing that Black-serving hospitals are more likely to perform worse in 12 of 15 delivery indicators and have higher severe maternal morbidity than white-serving hospitals, for example, or Black women are less likely to be screened for depression or access to mental health services or even receive health guidance in core maternal health concerns, to addressing unequal experience where we know that Black women, compared to white women, are more likely to report being treated unfairly and with disrespect by providers because of their race or not having decision or autonomy during labor and delivery, and, you know, this unequal treatment and unequal experience, you know, contributes to unequal outcomes, and the significant disparities that we see in maternal mortality and morbidity that are not remedied by having a college education or having a higher income.

And so if we go to the next slide please, you know, as we think about, you know, the drivers of health around maternal mortality, really incorporating and understanding the impacts of structural racism as well as the impacts of structural -- social determinants of health, and really think about that across the continuum of pregnancy care from before pregnancy, during pregnancy and birth and after pregnancy and birth, and that really also means thinking about supporting the interplay of primary health care and maternal health transitions and really being intentional about those transitions as we're thinking about maternal health models to address health inequities, and also as well as understanding that interventions that are required do not end with birth, and models of care have to take into account these postpartum interventions, particularly as we see that most of the majority of the maternal deaths occur after birth, and so this 1-year postpartum period is really critical in addressing these inequities. If we go to the next slide.

And so there are promising examples of strategies to improve maternal health, whether we're talking about payment and delivery system changes or public policy changes, and so for payment and delivery system changes, you know, whether we're talking about accelerated or advanced payments or greater access to things we know that work, for example, you know, coverage of birthing centers or coverage of perinatal team of providers that includes midwives and doulas, et cetera, and also focusing on the redesign of prenatal and postpartum care, and then the policy changes, you know, as we know, Medicaid coverage for birthing people, you know, continued to 1 year postpartum and really making sure that there's incentives for states to take that up, or coverage of low-income people to improve access for those who are not pregnant, or even allowing Medicaid coverage of doulas and lactation consultants and other perinatal health care workers that are part of the perinatal care team. If we go to the next slide, please.

And there's a range of several bills that are addressing many of these key areas, whether it's coverage or quality or addressing the social determinants of health, and really, you know, especially calling to attention just the interagency collaboration and integration that is going to be required to really bring these efforts to fruition to really see the impact we want to see to address maternal health equity. If you'd go to the next slide.

You know, there's a lot of data supporting key models, right, that work, whether we're talking about comprehensive health care across the life course, and Medicaid expansion can help cover that as well as extended Medicaid postpartum coverage, supporting the maternity care workforce, where if scope of practice changes that allow more universal coverage of midwifery care, for example, improved Medicaid reimbursement rates, supporting payment parity for midwives and birthing centers, reimbursing for social services, so all the conversations that we talk about, for example, in primary health care or drivers of health are very applicable to maternity care, federal and state partnerships to really help with technical assistance and guidance and implementation of these models of care, and again, data sharing, really better quality improvement measures and better accountability measures.

If we go to the next slide, and really integrating this culture of health equity throughout, intentionally addressing structural racism, incorporating interventions that incorporate structural competency and cultural humility and focus on patient and provider trust-building, workforce development and training as well as equity-focused quality and safety initiatives.

And, you know, the last thing I want to talk about is that there's also a lot of opportunity for -- Next slide -- for Title V and Medicaid synergies as well, and, you know, really thinking through the opportunity on the ground to really create those intersections in meaningful ways. For example, you know, can there be Title V and Medicaid partnerships that focus on equity through provider training and dissemination of the best practices that we know are out there, or work supporting equity and addressing of structural racism through perinatal quality initiatives, or greater use of Medicaid financing for home-visiting models that can improve both maternal and child health? So really there's a lot of opportunity to think through these synergies to really advance equity and address structural racism.

And I'd like to -- If we'd go to the next slide -- I'd like to end with, you know, as we think about opportunities for what next during this timely period and addressing maternal health equity, definitely state guidance on implementing the new postpartum option so that states can really advance that option and intentionally address maternal health equity, particularly in the postpartum period and address that postpartum integration of care. You know, really having -- including, you know, maternal health experts and community partnerships and CMS maternal health initiatives, right, and really have experts weigh in on recommendations to implement models.

Is there an opportunity to launch a maternal health demonstration model? Data, data, data: I think we can't -- You know, we have to continue to state how important it is to have data. I mean, just if we think about just the number of Medicaid-financed births, we really need to have and collect consistent data from states about Medicaid-financed births, and also I really think looking at quality of care through an equity and anti-racism lens is really critical beyond coverage, and CMS really can play a role in incentivizing that as well. Great. I'll turn it back to the moderator. Thank you.

Great, great. Thank you so much, Dr. Zephyrin, and finally we are pleased to have Dr. Sabiha Raoof, who is the Chief Medical Officer and Patient Safety Officer at Jamaica Hospital Medical Center, and her team join us. She is also joined by Trina Cornet, Eugene Clark and Stephanie Smith, so, Dr. Raoof, I will turn it over to you.

Good afternoon, everyone. I would like to start by thanking CMS and the Office of Minority Health for giving us this opportunity to be a part of this forum today. It is an honor to share this platform with our co-panelists, especially Jean. Jean, you've been an inspiration. The work that you have done to improve health care, especially your work on decreasing hospital-wide provision has been tremendous, so thank you for allowing me to be a co-panelist with her.

So today, we're going to be talking about what we have done in our safety net hospital system to advance health equity. Next slide, please.

Before I delve into the presentation, I would like to give an overview of who we are and where we are. Our 2 hospitals, Jamaica Hospital Medical Center and Flushing Hospital Medical Center, are 2 Safety Net hospitals in Queens, New York. We also have 10 community-based health centers and a nursing home associated with our Jamaica campus. Jamaica Hospital is also a level one trauma center. It is one of the busiest trauma centers in this area. We have 6,500 employees in our 2 hospitals. We see about 750,000 ambulatory care visits in our ambulatory care network, 165,000 ED visits in our 2 hospitals and about 5,000 deliveries in our 2 hospitals. We have also jumped both feet into value-based payments, so we take 100%risk for 160,000 lives, currently. Our payer mix: 80% of our patients are government-based, 60% Medicaid, 20% Medicare, 5% uninsured and 15% commercial. Next, please.

For those of you who do not know much about Queens, it is the most diverse county in the United States. People in Queens speak 138 languages. Our own team here at MediSys speak 60 different languages. Next, please.

So here at MediSys, we really feel that for us to provide equitable care, our own team needs to be diverse and reflective of the communities that we serve, so if you look at the breakdown of our team here at MediSys, 28% of our employees are Asians, 27% are African American, 19% are White and 17% are Hispanic/Latinx. It's very much the breakdown of these identities in Queens, so we are very, very reflective of the communities that we serve, and we believe that this diversity is our strength. It helps us understand the value sets of our patients. It helps us earn trust from our patients, and it helps us advance health equity. Next, please.

And, Dr. Zephron, to your point, this diversity extends all the way from our leadership down to the front-line staff, and it helps us build a culture where everyone has truly bought into the value of providing, advancing health equity and buying into the mission of our organization. We are safety net hospitals. We do not have much financial resources. Our biggest resource is our team resource. We are always trying to align our resources to serve our diverse patient population and providing resources based on individual patient needs. Next, please.

So today, what we are going to do is highlight 3 of the programs that we have within our organization, our care transitions program, patient navigation program and our language assistance program. Next, please.

We'll start with care transitions program that Stephanie is going to be talking about.

Hi, good afternoon. Thank you for having us. Our care management team manages our value-based risk patients in the community posthospitalization. The cornerstone of our care management programs are our care transition functions. We do assessments including assessments of psychosocial issues and social determinants of health. We formulate a person-centered care plan in partnership with the patient and their caregiver. Our goals and focus are to meet the patient where they are and build on small successes, reduce and avoid frequent and unnecessary hospitalizations, ensure PCP connectivity, provide education and address barriers to effective self-management. Next slide, please.

Our team is made up of a medical advisor, community care assistants, baccalaureate and master's-trained social workers, registered nurses, family nurse practitioners. We utilize a team approach incorporating all disciplines based on the patient's needs for our delivery of services. Our programs are based on each patient's individual risk for readmission, social determinants and other combined issues. Our lowest risk patients receive care transition services for 30 days along with an assessment of psychosocial and social determinants of health. Our medium-risk patients are managed telephonically by registered nurses in our complex case management program. Those patients determined to be at the highest risk or most clinically complex are managed directly in their homes more intensively and for longer periods of time. Next slide, please.

As previously mentioned, all patients regardless of determined risk or program is assessed for social determinants of health issues. Issues identified are addressed as part of the patient's person-centered care plan alongside with any concurrent medical needs. All care management staff are trained to perform the social determinants of health assessment and have been provided with an algorithmic decision tool to help determine if co-management with a social worker is necessary or if needs can be met through our community-based organization resource database. Next slide, please.

So what are some of the challenges we face? Our community and patient population are extremely culturally diverse, and while this adds to the richness of our exposure to so many wonderful cultures, it adds a layer of other steps that are needed to effectively communicate and ensure patient buy-in to interventions and goal achievement within the context of their cultural framework and preferences. In care management, we strive to make sure our department is representative of our community, and our team is currently made up of persons from Caribbean, Latinx, East Indian, Muslim, Albanian, African, Philippine, Black, white, brown, Asian and mixed-race personnel. Additional challenges include HIPAA regulations that impact care coordination efforts especially those related to behavioral health and substance use disorder. Shortages of housing and delays in rectifying immigration issues and thus eligibility for financial entitlements and access to some community-based organizational supports impact our abilities to effectively manage complex patients as well. Next slide, please.

The next 4 slides are examples of the high-level questions we ask as part of our social determinants of health screen. There are many more drill-down questions for each of these categories. We cover areas related to housing, food, transportation, next slide, please, utilities, childcare, next slide, please, employment, education, finances, next slide, please, and personal safety.

Our social determinants of health screen is adapted from the standardized screening for health-related social needs in clinical settings accountable care community screening tool identified in a CMS discussion paper May 30th, 2017. I'm happy to share this tool with anyone who needs it. In addition, I'd be happy to share with anyone the algorithmic decision tool we developed to support all team members with assessment, actions and resources related to addressing social determinants of health. Thank you for giving me this opportunity to present today. Next slide, please.

Good afternoon. My name is Eugene Clark. I'm the Administrator for the Patient Navigation department here at MediSys, so just to give you a little bit of history about our department, we started in 2012 under the New York state hospital medical loan grant where we focused on 4 of our outpatient sites to help improve our patient-centered medical care that we were delivering. Since then, we've had excellent results and then with the support and trust of our executive leadership, we expanded to all of our 9 outpatient sites where we currently see approximately 280,000 visits per year, so the department currently consists of 40 primary care navigators. We also have additional navigation resources that we utilize within the department of orthopedics, GI and oncology services. Next slide.

Okay. Oh! We got an extra slide, so next slide.

So we recruit our patient navigators mostly from the community. We seek bilingual and multicultural candidates as they play a role of cultural broker between the patients and healthcare system. Our training curriculum is developed through having them at the front line feeding us back information about what patients need, and they currently cover things like health disparities, health literacy, medication adherence and healthcare technology utilization. In addition, we outsource our training to all different areas. Some of the highlighted ones are Greater New York Cultural Competency Training. We also do training with the New York City Department of Health Motivational Interviewing. I highlight those 2 because they help us in working day-to-day with our patients. In addition, we train them with cancer prevention and control and the Conversation Project. Next slide.

So a big role that we have is connecting our patients to resources that they may or may not know are available. We do this by identifying the patient's needs, identifying their zip code and living situation, their primary language, and then we're able to help them through the system. We don't just give them a referral. We physically help the patient with their smartphone or whatever on sites like the Hyde site where they have access to different community resources. We help them with the Endoscopy Center of New York for free colonoscopies. We're fully versed in the food pantries, home shelters, substance abuse counseling, legal assistance, bereavement counseling and also financial assistance just to kind of bridge the gap for our patients. Next slide, please.

So being as though we've developed this close relationship with our patients, patient navigation, we've been utilizing them with our COVID-19 efforts. Currently our team is scheduling the appointments, making reminder calls. They handle the initial questions as they come up pertaining to the vaccine, and they also create medical charts so that when a patient does arrive, we're able to get them in and out relatively quickly.

Another big function is with the reassurance that we're providing patients as a lot of them are hesitant. This is for our patients, family members and other members of the community who are maybe reluctant about them. We are able to direct them to CDC literature, and this is especially true for people who are uninsured and undocumented. Additionally, we encourage the patients to direct any of their concerns to the clinical staff that we have available. Our staff is bilingual as I mentioned previously, so we're able to assist in these efforts in that matter as well, and believe to date we have completed 35,000 doses. Next slide.

I wanted to just close with a quick shout-out of our team just to kind of show you who we are and what we do, so thank you for having us today.

Good afternoon. My name is Trina Cornet, and I wear multiple hats for the organization including oversight for our language assistance program. The MediSys Health Network language assistance program provides support for all of the efforts we do around social determinants of health. We know that communication gaps can create a barrier to health equity, so we take pride in providing language assistance programs and services to our patients so that we can take an intentional path of advancing health equity. Next slide.

As Dr. Raoof indicated, we have the privilege and opportunity to serve a very unique patient population that reflects the rich cultural mosaic of the Queens communities. Our patients speak over 95 different languages. Across the network, the top languages spoken by our LAP patient population are Spanish, Chinese, and Bengali. Next slide.

We also serve a diverse deaf and hard of hearing patient population. Most of our deaf and hard of hearing population use American Sign Language or ASL to communicate. However, ASL is not a universal language, so patients who do not use ASL are provided another form of sign language, and deaf interpreters are used to help facilitate communication. When needed, we also provide communication resources and assistance to our patients' companions. Next slide.

Language diversity among our team members also reflect the diversity of the community that we serve. Across the network as Dr. Raoof indicated, our team members speak approximately 60 different languages. Spanish and Mandarin like our patient population are among the top languages spoken among our team members. Next slide.

We take measures to ensure that our LAP population have meaningful access to patient care services and can participate in their medical care. Our robust language assistance program coordinates various services for our patients. Next slide.

Our LAP team members coordinate translation, interpretation services. They also provide training and in-service to our team members so that they are aware and knowledgeable about all of the many services that we provide for our LAP patients. Of significant importance of all that our LAP team does is the work around team member training, as we believe that our team members, as many of my colleagues have said, make the most meaningful impact on patient experience, patient safety and overall care. Next slide.

Like many of you, we are really intentional about what we are doing in our efforts toward advancing health equity, and we're intentional in our efforts to hire team members from diverse cultural backgrounds who are able to relate to our patient population and are able to enhance cultural competency when serving our diverse patient population. Pre-hire, we start identifying what language skills our potential team members may possess. After employees are hired, using a language skills survey tool the LAP team dives deeper to gain more information about the language identified by our potential employees, now employees. The data is used to recruit employees to serve as qualified medical interpreters or QMIs. Next slide.

The QMI program is a 40-hour program designed to prepare team members who have demonstrated fluency in English and a language other than English to serve as medical interpreters. From 2017 to 2019, QMI training has been provided to approximately 96 multilingual employees. To further enhance the QMI program, the LAP team started a language coach initiative for QMIs who display exemplary interpreting skills. Language coaches are recruited to assist with QMI training so that we can expand the program and accept more QMI candidates into the program. The LAP team also coordinates with our patient navigation department so that we can provide yet more resources, in-house interpreters for our patients. As a safety net hospital, we fully recognize and appreciate the challenges and negative impact of limited resources and systemic inequities, and it's for this reason that we have had a long history of advocacy and service in this culturally diverse patient population. The LAP team, the patient navigation team and the care management team are representative of this long history of service and advocacy. Thank you for allowing me the opportunity to talk about the LAP program.

Great. Thank you, Dr. Raoof and team. That concludes our presentation for this session, and we will now move into a short question and answer session. As a reminder, you may submit a question via the chat box, and we will read them aloud.

Great, and then moving into our first question, and this is specific for Ms. Moody-Williams. This attendee is asking, "Please do speak a little about how CMS is modifying or expanding the socioeconomic status measure." And, Jean, your line may be on mute.

Yes, it is. Thanks for the question, and we really are in the expansion, exploratory stage here working to look at your comments that we'll receive from the Request For Information that we sent out and the various payment rules. You know, there's a lot of discussion as I'm sure you're aware of to risk adjust, to not ensuring that when -- stratification, so we're looking at those kinds of elements. If it is in fact risk adjustment that's necessary, the debate on making sure that we're not masking poor-quality care while at the same time recognizing as one of our presenters spoke earlier that we don't want to disadvantage facilities that are working and doing some of the marvelous things that we just heard about by removing resources. So as we look at these measures, we are looking to see how we balance those things working along with ASCII and others, so more to come on that. As mentioned, we work with NQS. Their report has also been published and posted, and we'll be over the next probably year doing more work in this area.

Great, thank you, and then moving onto our next question for the group, "What role does the community care assistant play in relationship to the care coordinator?"

Got it. Okay, hi. Thank you for the question. The community care assistant is a nonclinical support person who provides the care transition services to our lowest risk patients, so those services include, you know, connecting the patient with the PCP status posthospitalization, ensuring the patient is in receipt of the discharge instructions, ensuring that the PCP is in receipt of the discharge instructions, reviewing those instructions for understanding with the patient and ensuring that the patient is in receipt of all their discharge medications. If there's any further questions or issues about medications or medical conditions, the CCA would refer to her nurse on the team. The care coordinators are our baccalaureate-trained or our master's-trained social workers, so our baccalaureate-trained social workers generally work for care transitions and more complex issues with our substance use disorder patients, and our master's-trained nurses will work with our dual patients, those that have both significant medical issues and behavioral health or substance use issues. I hope that clarifies.

Great, thank you, and I believe we have time for maybe one or two more questions, so again, this question is for the group, so this attendee said, "For many of us who have been in this space for a significant portion of our careers, duration and attention often wanes when the work is hard. How do we hold each other accountable to this promise of racial justice?"

I can say great question, and I've been in this field for long while myself, and we have many frameworks and many action plans that have come about over the course of the year, but when an opportunity comes, I firmly believe you need to take advantage of it. There's a forward momentum. We have support of the administration as Liz said who has charged us and given us our marching orders, and so I am an eternal optimist that we can make a difference this time, and so as you noticed in my presentation, I kind of focused not so much on what we have done but what we are going to do and what we will do to move forward, so I think it's up to us to keep the momentum going and to make change.

Yeah, and I guess maybe I'll just say that, you know, leadership comes from the top, and I can't tell you what a message it sends for the secretary's office to ask in every single meeting, what more can we be doing, and for the administrator's office to ask, what more can we be doing? And so maybe as leaders of the organizations, we need to keep this on the radar and make sure that we're making progress. I do worry that because we lack data, because we lack some of the standard definitions, and, you know, we still have a lot of work to do in terms of how to measure progress, you know, that it will get hard at some point, but like I said, I feel like we're really at the precipice of really some big changes and hopefully a lot of progress, but I think it takes leadership to make sure that it stays front and center and doesn't fade.

Great, thank you all. Well, I do know we only have a few more minutes left before 4:30, so I think that that will conclude our Q and A for today which also concludes day one of the CMS OMH Road to Equity Examining Structural Racism and Healthcare Virtual Forum. Can I have the next slide, please?

And just to note that day 2 of the forum will begin tomorrow on April 28th at 1 p.m. Eastern Time, during which guest speakers from various federal and partner agencies will provide their thoughts on improving access to healthcare and COVID-19's impacts on disparities. We're also pleased to host a panel discussion on solutions to promoting equity. With that, we'll conclude day one, and we look forward to seeing you all tomorrow. Have a great afternoon.