

## Prioritizing Equity video series: Advancing equity during COVID-19

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COVID-19 has highlighted the persistent health inequities that exist in the U.S. In this April 19, 2021, edition of AMA's Prioritizing Equity series, health leaders use the pandemic as a lens to examine how quality and safety can drive equitable health care and outcomes moving forward.

### Panel

- **Louis H. Hart, MD**—Director of equity, quality & safety, Office of Quality & Safety at NYC Health + Hospitals
- **Kedar Mate, MD**—President and CEO, Institute for Healthcare Improvement

### Guest Moderator

- **Karthik Sivashanker, MD, MPH, CPPS**—Vice president of equitable health systems and innovation, Center for Health Equity, American Medical Association; medical director for quality safety and equity, Brigham Health

### Transcript

April 19, 2021

**Dr. Sivashanker:** Welcome today to Prioritizing Equity. I'm Karthik Sivashanker. I'm a medical director at Brigham Health for quality, safety and equity, and also vice president of equitable health systems and innovation at the AMA Center for Health Equity. Filling in today for Dr. Aletha Maybank.

We're here today in the context of COVID-19. As we all know, today there have been over 30 million total cases, over half a million total deaths and over 168 million total vaccines that have been administered in the United States. In today's discussion, we'll explore how our quality and safety infrastructure is critical to advancing equity in health care through the lens of COVID-19 as a case example.

And with that, I'm really pleased to welcome Dr. Kedar Mate, who is president and chief executive officer at the Institute for Healthcare Improvement; and also Dr. Louis Hart, clinical assistant professor of pediatric hospital medicine and also director of equity, quality and safety at New York City Health and Hospitals.

So really excited to be here with both of you today. I've had the pleasure of working closely with both of you and together Brigham Health and IHS context under the leadership of Kedar have developed, tested, implemented a new model in the form of a five driver framework for advancing equity through quality and safety. And this approach has since been spread and further tested in New York City Health and Hospitals under your leadership, Lou.

So Kedar, I'd like to begin by getting your broad impressions around quality, safety and equity before diving deeper into the application and implementation at the health system level with Lou. So let's begin with Kedar. How are you today and can you just share your broad thoughts on the relationship that you see between quality, safety and equity?

**Dr. Mate:** Well, thank you, Karthik and Lou, it's great to be with you. Thanks to the AMA for having this series. I think it's really an amazing a series that we've all had the privilege of listening to, and thanks for having me on the program. I'm doing well today. Thank you Karthik for the question.

So you asked me to reflect on the relationship between quality and safety, and I've been on the record talking about now for a little while now, the fact that quality and equity are deeply tied together. We've done this for a long time. Equity has been in our shared consciousness around quality and what high-quality care looks like. At least since "Crossing the Quality Chasm" was written over 20 years ago now, and we have known even before then that inequities were prevalent in our health systems and in what our systems were producing.

We know that systems are designed to get the results that they get. And currently our systems are designed to produce the kinds of inequities that we're witnessing and that we're bearing witness to. We know that if we are to have a different result, if we want a different outcome, if we want fewer inequities, we have to actually change the underlying systems that are informed by significant years, hundreds of years of history and structural injustice, if we're ever going to make progress towards remediating these inequities.

There's another relationship, I think, between quality and equity, and that has to do with what's the fundamental underlying systems problem that an inequity belies, and that is a variation problem. All of our work in quality and reliability and systems science is aimed at essentially improving undesired variation in a system. Inequities are exactly that. Undesired, unjust, historically driven and structured variation in our systems.

And likewise, and this is something that we've worked on with Lou and yourself and others in systems across the country, which is that when you apply the methods of quality and improving system science and reliability, we can actually make a difference on some of the inequities that we see. So we see a lot of relationship between quality and equity, and there are some differences, and this is important. Inequities are not simply like every other quality challenge.

They have their root causes, stretched well back into history and structure in ways that may not be so apparent in how we think about, for example, a wrong site surgery or a nosocomial infection, like we're often working with or dealing with in our quality safety systems. So when you do a root cause analysis around an inequity, you reach back hundreds of years into history and structural injustice, which are part of the story around why we have the inequities that we have today.

So there are lots of things that are similar, lots of opportunity in the quality world to try to remediate these inequities. And there are some important differences which lead to, I think, a different way of applying quality science to the problems and the inequities that we see today.

**Dr. Sivashanker:** Thank you, Kedar. Couldn't agree more. I want to turn it over to Lou, asking once again, how are you today? And then we'd love to learn a little bit more about what led you to your current role as a medical director in quality, safety and equity, and just what your experience has been implementing this approach in a system.

**Dr. Hart:** Yeah. Karthik, thank you all so much for having me today. This is a real privilege and an honor to be here speaking in such esteemed company. I think that I've been so fortunate in life through hard work, perseverance, resilience and being blessed with having great mentorship and great opportunities that I now get to serve in this role. It's been the honor of a lifetime serving here in the city of New York at New York City Health and Hospitals.

We are the largest public safety net system in our country. We take care of a patient population that is less than 9% white non-Hispanic. And most of our patients come from lower socioeconomic backgrounds in terms of living below federal poverty lines, either not having health insurance or being insured under government subsidized or government supported insurance plans.

So in terms of dealing with inequities, injustice, disparities, this is kind of our bread and butter. This is what's in our DNA. This is our mission of service. This resonates from the top and is executed on the front lines by our heroes every day. In thinking about what drew me to this work, this was always

something that was a personal passion of mine. I was always an advocate for the underserved. I purposely chose to do my residency training at NYU and Bellevue to see the dichotomy and see the dynamic of how we have fragmented and segregated care in our country through historical reasons, often most unjust and how unfortunately, we're still haunted by those consequences of past decisions, how those things are still playing out today.

I think this was all made very unfortunately way too evident to all of us in COVID-19, when we saw that the types of patients that were coming in. Beyond just their racial demographics and as a fundamental non-believer of racial centralism or racial biology, I was quick to say it has nothing to do with their underlying racialization, unfortunately. And well, we all understand that genetics are extremely important. I think we're all at the point that race is a social construct and race is a poor proxy for universal understanding of genetics. I think we are getting closer and closer to personalized medicine where we will understand that certain genetic traits are inherited in different patterns, and I think we have that understanding.

But the ways in which the disease manifest themselves amongst racial groups, I think, speak more to the things that we've allowed to exist, as a society, the ways in which we've concentrated poverty, concentrated lack of opportunity, lack of access. The way we redlined housing and through that type of segregation gave different opportunities to kids in school. I know that hits close to home to me as a pediatric hospitalist, working at a trauma center here in East Flatbush, Brooklyn. It's a completely different patient population than even when I'm at another safety net hospital, Bellevue in Manhattan.

You look at the difference in terms of the public education and the opportunities we're giving our kids. Metal detectors, roaches, no air conditioning. Is this really the atmosphere that is promoting health or promoting wellness? And I think our system has unfortunately been so set up and really like a middle-class or higher income-class model, where you can take a day off work to come and get your primary care where you have childcare, so you can come in and do your free cancer screening.

This is not the case for most Americans. Most Americans, and definitely the patients that we serve here, aren't able to meet that traditional care model that was probably designed by affluent doctors for others. I think we're switching away from the paternalism and prescriptive nature that health care unfortunately continues to promote and more getting to this understanding of equitable care models, where we have to actually treat people differently based on the needs that they have, so that we can meet them where they are.

So in terms of how I got into this work, I was actually at IHI down in 2019, and I heard Karthik speaking on this topic. Some of the work he was leading up at the Brigham and really a very strategic approach to ingrain equity within quality and safety infrastructures. And it really resonated with me, because I was always afraid that if a system was to start health equity work, if it came from HR or if it came from a new shop that was about health equity, it might not have the same historical gravitas or the credence that well-robust, well-respected, usually well-funded and well-resourced quality and

safety departments have.

I think health care has gotten on board with the idea that quality and safety are hallmarks of an efficient system. And as referenced in Institute of Medicine, we talk about equity being a foundational pillar of quality, but unfortunately it's the sixth pillar if you read clockwise and for too long has become the forgotten pillar, forgotten aim. And I think after seeing everything that happened over the past year, we just cannot allow that to go on.

So unfortunate for us at Health and Hospitals, this is something that we were investigating and actually taking on prior to COVID and prior to the killing of George Floyd, the following social unrest really called to action. So we were in a very good position to be more responsive, as opposed to being reactive to these needs. And we really defined four clear areas where equity or an equity lens could be ingrained into quality and safety.

The first was performance improvement. We knew that we had a data problem. We knew that we did not have the most robust high-fidelity means of collecting patient self-reported demographic information efficiently and accurately. So that was literally step one. What's our current state, what's our percent rate of other, what are the trends that exist across our sites? Does that match up with the actual communities that we're serving in our catchment areas, looking at demographics such as payer type, such as race, ethnicity, preferred language. New York City does a great job of polling and surveying our residents here.

So we were able to look and see, are we actually serving our populations and in doing so, are we collecting their information. It was actually ironic, when you ask patients, is it important that a health system collects health information or demographic information, 60% say, yeah, sure. But 30% really say, no, I don't think it is. But when you ask the same question, but frame it, is it important for health systems to collect patient demographic information so that we can do analysis to ensure that all of our patients are benefiting equitably from our procedures? It jumps up to a 90% rate of people strongly agreeing with the statement.

So we had to inform our patients, inform our staff why this is important that we do, why we have to actually ask these questions, how we ask these questions in a culturally competent, congruent way so that we can then inform our performance improvement projects. Because the longest gripe is, "Oh, we don't have good data. We don't trust our data." Well A, you don't want perfect to be the enemy of the good. You have to actually start with the practice of stratifying data of looking at data amongst ages, amongst genders, amongst race, ethnicity and preferred language. And that's step one.

So once you have data or as you're concomitantly building your data infrastructure, which is probably the hallmark of any success in this field, is to ensure that our performance improvement teams start to look at the quality metrics, the same things they're doing everyday anyways, but with that equity lens. So hey, stratify that same CMS metric, that same NQF metric by a social identifier, such as sexual

orientation, gender identity. Race, ethnicity and language is where we started, because we've historically done age and sex or biological sex, but this was something that was a little bit of a cultural shift.

And I think to blanket all of this, so much of this, culture trumps strategy. Culture trumps structure. If you don't have from the top down and from the bottom up people, local champions and C-suite leaders who have prioritized this, who know that this is not only a strategic priority but a moral imperative that we do correctly, then no matter what beautiful design strategy or structures we exist, if the culture is not open to this, it will never be successful.

So it really is step one, looking at your mission and vision statement, looking at why you're doing what you're doing, what is the outcome that you're trying to achieve in the service of your patients? Making sure that everyone is in alignment there so that we can then actually start doing the work. So once we were able to set up a means of collecting high fidelity, robust patient self-reported information, we were then looking at the metrics that we report on anyways.

And we really did notice certain trends, which actually informed, unfortunately they fit a lot of the national inequities that exist across racial and social lines, but that actually informed some of the work that we've done in something called medically racism, which is work I'm leading around the removal of race-based cloud rhythms. We noticed that our patients, often African American, came to care later, came to care with higher or worse degrees of end stage kidney disease. Yet are the equations that we're using to measure their kidney function made them artificially appear healthier. So they came in later, they came in sicker, but yet our equations actually potentially made them look healthier, so as to refuse their referral to see a nephrologist or would put them later on a list to get dialysis, a very scarce resource, unfortunately still in our country, a country like the United States.

So it really was very important. Another thing we were looking at was maternal morbidity mortality. We noticed that there are vaginal birth equations that counsel obstetricians on whether they should tell their patients to pursue a vaginal birth after an earlier C-section or whether they should jump right to a C-section. And in the equation, it decreases a woman's success or likelihood of success of having a vaginal birth by 60 to 60, or sorry, 68 to 69% if their race is Black or Hispanic.

I don't believe that fundamentally the Black and Hispanic women have different reproductive organs or have different pelvis structures. Those are thoughts of eugenics and eugenesis, which is a pseudoscience that has long been disproven as fact, but unfortunately still permeates in the medical lexicon and the way in which we still teach, unfortunately, medical residents and medical students.

So we actually looked at ours. We had actually been fortunate at Health and Hospitals. We had gotten rid of that equation and we actually had lower rates of C-sections than the state and higher rates of feedback than the state average. The public health system has higher rates. So I think in terms of saying that these things don't matter, the insidious ways that unfortunately historical wrongs still exist

within the structural roots within health care, when you do start to get rid of them and start to reassess them, you do see differential outcomes. And you do realize that we are playing a part of this, unfortunately, but it's time to be accountable, acknowledge the past and move forward.

The other two key areas that we were able to ingrain an equity lens, where within the sphere, fields of patient safety and incident reporting. So the ways in which we would have disrespect, a miscommunication, someone not using an interpreter phone, someone maybe making an offhand comment. Those things are patient safety issues and concerns, and they need to be reported the same way we would a physical harm, like a wrong site surgery, a medication error, near harm. And we wanted to make sure that psychological safety, emotional safety and health justice, were key pillars that our residents, that our medical students, and that our attendings and all of clinicians, nursing, social workers, PCAs, were aware of.

So if they saw a physician not using the interpreter phone or rushing through an exam because they didn't feel like taking the time, that needed to be reported so that if unfortunately when untoward events came, we had earlier indications that hopefully would mitigate this. And hopefully it would allow. Perfect examples, we had a part of our hospital that had bad Wi-Fi. And we noticed that there was a report that was made about someone who was not speaking, not counseling on the patient, how to take a medicine right.

And everyone was quick to say, "Well, it's this pharmacist, it's really all this pharmacist's fault. They're just a bad apple." And I said, "Well let's look at the structural issues, where let's stay away from the interpersonal for now, let's see how the system allowed this to happen."

And we realized that in that part of the hospital, there was bad Wi-Fi. And the language access in that the hospital is an iPad that requires Wi-Fi. So we had set our clinician up for failure by not supporting them.

So I think if we can focus this on the structural things that exist within health systems, as opposed to the interpersonal approach, which is a lot scarier and a lot uglier, yes, that does exist. And yes, that can be handled by traditional HR mechanisms. But let's look at the ways, the holes in the Swiss cheese model that allow these inequities to persist. That's where we can actually make an impact. And that's where we can actually start to make a difference.

Finally, the last way that we looked into incorporating the equity lens was within the RCAs. We wanted to empower our risk investigators, our patient safety officers, our chief quality needs with a toolkit so that they can actually go through at various levels of bias, where bias can creep in, to ensure that bias didn't contribute to this event. This has been, from what started very scary to people and being like, "Oh, you know, the patient was white. The doctor was white, there was no bias." And we quickly would push back and say, "No, but that's your bias in thinking why we're asking." It's not all about race. It's about someone's ... whether they have a prior history of mental health issues, whether they have

issues with substance abuse or dependence, those are things, chronic homelessness.

Those are implicit biases that we all hold, unfortunately in America, that change the way we deliver care. So we looked at the explicit level of the interpersonal level, the human behavioral level, which is the implicit level, the policies and procedures, the structural level or the institutional level, I should say. And then at the structural level, things that exist outside of the four walls of the hospital, that unfortunately are contributing to these outcomes. Things like health literacy, things like medical mistrust, things like income and education. And we try to find ways at every level that we can intervene and mitigate.

And all those things actually get reported up to the board on a quarterly basis, so that senior leaders and executives are having these conversations. We're categorizing and cataloging these to ensure that no trends are noticed. And when they are, that corrective action plans are put in place to ensure that this never happens at any of our hospitals or any of our sites.

**Dr. Sivashanker:** That was a really full and rich response, and I am absorbing that. I think listeners are going to have to go through that again, because it was just so much useful information there. There's a couple of themes that I was picking up. There's many, many themes, but two that I want to pick up on are this idea of race as a social, non-biologic construct. So on the one hand, you're talking about collecting race and ethnicity data; on the other hand, you're talking about not misapplying it.

So, I just want to reframe that and then transition over to Kedar. So the idea I think that you're saying, Lou, is we should be collecting race data as a proxy for racism to understand how racism is leading to differential care and differential outcomes, as opposed to misapplying it as a biologic construct, as a proxy for ancestry, as we have been with our race-based calculations.

And then I'm also hearing you say that the advantage of this approach is that rather than trying to create an entirely new system or approach, we're taking our existing high-performance technologies, processes, infrastructure and enhancing it systematically with this equity lens. What's clear to me though, is that you have a ton of expertise here and that's not necessarily true across the country, that this is not systematically taught as part of our quality safety education or high reliability education, as part of our medical school residency curriculums.

So, I'm going to turn it over to Kedar because I know that that's part of the work that IHI is embarking on, is how do we spread this as a model? How do we develop that next generation of leaders? And just curious, what are your thoughts on that? What have you learned in starting to do this work in terms of spreading it? Which challenges, opportunities are you seeing there?

**Dr. Mate:** Thanks. Thanks for that. And Lou, wow. What an amazing set of experiences you just described that Health and Hospitals is executing on. It's absolutely brilliant, and I'm so glad that at least part of this started with some work that we did together on pursuing equity, which is an initiative



that we started some years ago now. But the fact that that body of work could in part contribute to some of the amazing things that you've done at Health and Hospitals is just really amazing to see, and thank you for sharing a lot of your experience. So much of what you said, we are in complete alignment. With all of what you said, we're in complete alignment with. There's this sense that I have in talking about this work around quality and safety and bringing attention to equity within the quality and safety circles, there's a bit of hesitancy around that.

It's interesting. Certainly, Lou, you represent someone who's become not only an implementer of quality, safety and equity altogether into one, but in fact, an advocate for it. But there's a lot of folks that don't see, actually, although it's in the definition of what we said, equality means, they didn't see it as the number one thing for them to work on. As you rightly said, it was the last of the six elements going around the STEEP dial, the safe, timely, efficient, effective, equitable was the last one of those dimensions. So one of the challenges that we've had is ensuring that the quality and safety community sees equity as part of their job and ensuring that we can apply the tools and methods and techniques that we all have, including root cause analysis event reporting, all the things we talked about, to the work, which when applied works, exactly as you described.

One of my mentors and an IHI board member, Mark Smith, is fond of asking audiences when he's talking about this issue about how many people in the audience that are working on health equity work, traditionally work with their diversity and inclusion councils or offices within their institutions. Everybody's hand goes up. And when he asked the same question, he says, how many of you are working with your quality and safety teams and committees? A handful of hands go up in the same room. And that testifies, I think, to a real need to bring attention in the quality and safety circles to the inclusion of equity formally in the work of those committees and the work of those teams. And as you rightly said, bringing the resources that are allocated to producing better quality and higher and safer care now into the work that they can do towards remediating the inequities that are present.

We also have to ensure, as both of you were describing, the idea that unless equity is described as one of the strategic initiatives of the organization, it has very little opportunity of being the focus of the organization's efforts. And I can testify to that from within IHI. Until we started to emphasize equity in our designs, in our quality improvement work, we didn't even know, for the most part, whether or not we were actually reducing inequities, having them stay the same, or whether they were widening on our watch, even as median performance assistance improved. So until a deliberate attention is paid to whether or not those disparities are getting worse, staying the same or improving, you won't necessarily allocate the necessary resources on data collection or on improvement activities to actually closing the gaps that we might see be present in our systems.

Once we identify equity as a strategic priority, once we commission the infrastructure of our organizations like the quality and safety shops of our systems to actually work on equity formally, then I think the question becomes, how do we do it? And that's a lot of what ... Lou, you just elaborated in

that four point strategy that you've been pursuing at Health and Hospitals exactly how to do this. Focus on the medical racism that we have and the biological constructs that we've been applying. Focus on event reporting, focus on the tools themselves. And then I would apply the capacity to reduce variation that's undesired in the system to the problem of the variation that's present and created by historical injustice and racism, frankly, in our systems. And then the last point I would add to that is we have to then marshal the resources and energies of our system to partner with community organizations to actually go further than what the health system alone can offer to try to tackle these inequities.

Because a lot of the reasons that these inequities are present, as all of us know very well, has to do with a systemic structured and certainly well beyond just what the health system can apply itself to some of the things that are built into our societies. And there we require a much wider coalition. Health care alone will not be able to solve all the problems that we see, the inequities that we see in our emergency rooms and in our hospital wards and our systems. We have to go well beyond that into education, public safety, criminal justice and a variety of other social factors that are contributing to the inequities that we eventually see in our hospitals and in our clinic environments.

And that requires partnership and marshaling ultimately the social economic and political clout of health care, which is powerful in almost every community that a hospital or health system is located, to actually bring around the table the necessary actors to tackle some of those deeply entrenched groundwater style problems that will ultimately change the environment in the milieu that is producing the inequities that we see.

**Dr. Sivashanker:** Great question. And I'm going to go off track in terms of our questions, because I want to follow some of the themes that are coming up here and also circle back to COVID-19. So the idea of embedding this in our reporting systems with safety and with patient complaints, et cetera, embedding equity in the processes and in the technology, so in our reporting solutions, in our trackers, et cetera. One of the things we saw at Brigham Health was that it was almost like an early detection system. That in real time, we were able to get reports from providers, from patients on inequities that were emerging through our safety reporting system and then apply our high-reliability tools to try to address them very quickly.

But this gets at the idea of what does progress look like and progress seems to look like things actually getting worse, in a way, when you start to do this work, because now you're systematically identifying inequities. Whereas many systems are currently operating in the blind and may not even realize the inequities that are there.

Lou, I want to ask you, what was your experience with that? Was this approach helpful in identifying inequities and then Kedar, I welcome your thoughts on this as well.

**Dr. Hart:** Yeah, I mean, I think our health system is so unique in terms of the patients that we serve. So many of our patients have so many similar variables that often confound the picture and then often differentiate their outcomes from counterparts who potentially get their care at academic medical centers or those who have private insurance. I think one thing that we did notice though, given the fact that 40% of our patient population has limited English proficiency and has a different language that they speak at home, and that reflects the beautiful amount of diversity that we have here in New York City, in terms of rich with different immigrants from various communities.

I think that we did notice that while we were very happy to see that patients who were fortunate enough to make it to the hospital and make it into our care, did actually have the same outcomes across race and ethnicity when socioeconomic class and our neighborhood deprivation was stratified for. So we were very proud to see that there was no genetic links here that was actually saying, well, even once they made it to the hospital, when you mitigated everything else, you still had worse outcomes that exist across race or ethnicity.

One thing we did notice, however, was that in certain key performance indicators, in terms of speed, to be able to talk to families, and in terms of how quick assessments were occurring. For patients that had a different language other than English, it was much more difficult for us to utilize interpretation services when most of our care was happening outside of the door, when most of the care was happening by the nurse quickly trying to change meds and then to quickly trying to get out of the room to decrease exposure to the virus.

And so I do think that having this infrastructure in place, being able to look at the numbers, being able to look at which patients were getting ICU beds, which patients were getting sent out to field hospitals. I know I spent a good month and a half at the Javits Center in the Billie Jean King Tennis Complex, helping coordinate our alternate care site transfers. This is the peak of COVID in New York City, March and April. And it was very interesting for us to see which patients were being made eligible for transfer to these alternate care sites. And we were very proud to see that there were no trends that noted that certain races, certain demographic criteria were predicting that, but like you say, Karthik, unless you're looking for things it's easy to overlook them.

And it's easy to assume that your interventions are benefiting all because the mean is going up. But then when you do the hard work, the brave work of actually stratifying and actually seeing, well, did all parties benefit? Are there certain social identifiers that actually might be speaking as an important proxy for something else? And once that is identified, then that can inform our PDSA cycle and looking at, okay, so now we've been no disparities exist.

Let's not be hard on ourselves. Let's be proud of the fact that we've actually acknowledged that it exists. Let's be transparent about it. Let's share the dashboard broadly. And then let's brainstorm around collaborative action. You know, a multidisciplinary group, to really come up with a collaborative correction plan. So I think the benefit of being able to do it in such a way is that it really can be difficult

and it can be scary.

Most people don't want to think that their systems perpetuating or continuing disparities. But I think the idea is unless we're looking for things, we're just going to be allow status quo to flourish. And I think we've all come to a collective understanding that status quo in America is not exceptional. And as a fundamental believer of American exceptionalism, this is unexceptional, and this is not where we need to be. This is far from where we will be, and it's going to take all health systems and all players, not just one health system, not just one race of people. It's going to take all of us, because at the end of the day, this affects all of us as our demographic shift. And we become to the end, we become a more racialized country. I think 51% of kids, less than 18 years-old come from a non-white or Hispanic background.

So the disparities are only potentially going to exist in a larger number of people. So all of your quality numbers will be going down if you'll allow disparities to exist on a larger sample size. So not only is this a financial imperative, we have to do this because this is going to change the way we're paid, but this is also a moral imperative and ethical imperative. because this is just what we came into health care to do, to cure illness, to promote health.

And really, I think we should do more of a job of actually actively promoting our patients' pursuit of health, as opposed to reacting to their sickness and trying to, once we're already behind the eight ball, pull them out of a hole. I think that's just a recipe for disaster. It's a great recipe for fee for service. But I think our country's got to a fundamental understanding that that is not the most efficient way to pay for health care because of the perverse incentives that it creates.

So I think doing the work as hard, I think that it's new for all of us at the start. You know, I might have some expertise in this, but I was still one person out of 70,000. This organization was much bigger than me. I was never going to be able to be successful on our own, but leveraging those already existing infrastructures and just tweaking what they do. The job role's not going to change that much, but they're going to look at the data a little differently. That's going to inform one of the PDSA cycles that they're already engaging on. Those are the ways in which you can implant and set this work.

And it doesn't feel like a big lift for a lot of the groups that are doing this. This feels like, "Oh yeah, this is just kind of what we do in Health and Hospitals. Of course, I would stratify the data." Of course, we would look for inequities at every level that it might exist, because we've made it part of the tradition, and we've made a part of the infrastructure. We've made it part of the culture.

**Dr. Sivashanker:** I'm hearing a call to action in that, Lou, which is that this is our work, another way to put it. And I know we've all said this in different ways, that there is no such thing as high quality and equitable care. So we need to really embed this as a core mission. Also, I'm hearing you say that this idea that equity is not a zero sum game. That when you improve care for our most historically oppressed populations, it makes care better for everyone because the system is more reliable and

resilient.

So this is really getting at why should we be doing this? Why should health systems and quality and safety leaders be thinking about this? I want to give the last couple of minutes to Kedar, any final comments in terms of a call to action that you might want to have to systems and leaders thinking about this.

**Dr. Mate:** Well, thanks for that opportunity. And I really appreciate this idea and I've come to appreciate the work of John Powell, a professor of law and ethics at University of California in Berkeley, who's promulgated this notion of targeted universalism. Which is a theory that we can get faster and better to universally held societal objectives through targeted strategies that approach the needs of different populations differently so that we can actually get exactly what you're describing.

And a really good example of that is some work that's happening right now in Alaska with vaccination. For a long time, our universally held goal is vaccine coverage, right? Herd immunity. And to get to that level of herd immunity requires us to undertake targeted strategies, to approach different populations in different matters that meet people where they are, meet communities where they are. And in Alaska, our colleagues there at South Central Foundation did exactly that, shaping the vaccination strategy around what Alaska Native and Native American populations needed in that environment, which has led to one of the fastest vaccination rates in a state that for a long time led the league table in the country as one of the fastest vaccinators in the country.

So that's just an example. If I think how this notion of a zero sum game is very deeply embedded in our psyche, in our consciousness. To undo that is going to require a deliberate understanding of how the zero sum game is a fallacy and how the notion that your gain is my loss or my gain is your loss, that that notion has to be significantly undone for us to see the broader narrative that actually ... I rise as you do too, and that notion is I think something that we have to help our leaders see as much as we do everyone else.

Well, one last thing I'll just say is that on the data score and on quality and equity in general, this is very similar in theme to other quality related topics that we've seen before. There's always a reaction to when data are presented and for the first time, stratified data or just data on any quality measure, which are, the data are not mine or the data are wrong in some way. And then at some point you come around through the stages of what we call data understanding, and it's, the data are right. The data are mine. And eventually I accept the burden of having to make a change to the system in which I am a member and a participant.

And I think that's my ask here for the community of health systems and health system leaders, that we look at that data with the same kind of honesty and integrity that we've looked at all quality data before this. And we actually undertake the challenge of working through those successive layers of understanding to eventually get to the place where we accept the burden of having to make a change

to the systems in which we live and act at work every day.

**Dr. Sivashanker:** This has been such a pleasure. I feel like we need another two hours to get through everything that we would want to talk about, but I thank you so much, Lou and Kedar, for your time. Really appreciate your expertise here today. I'm sure the audience can get a lot out of this. So just some closing remarks.

I want to remind folks who are listening that we do have a health equity resource center for COVID-19 on our AMA website. So you can take a look at that. And then we'd also like to remind everyone of our recent Medical Justice and Advocacy Fellowship, which is a training fellowship program designed for physicians that seek to advance health equity in their communities. Really exciting opportunity for folks in this space to learn and grow. So thank you so much everyone and wishing everyone a great day.

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