In this Nov. 2, 2022 edition of the Prioritizing Equity series, Karthik Sivashanker, MD, vice president at the AMA Center for Health Equity, speaks with participants from the Peer Network for Advancing Equity through Quality and Safety program on their strategies for operationalizing equity into their quality and safety operations.

Panel

- **Aderonke Akingbola, MD, MMM, AGAF**—CPE Vice President, Medical Affairs, Ochsner Health
- **Judy C. Washington, MD**—Associate Chief Medical Officer, Atlantic Medical Group

Moderator

- **Karthik Sivashanker, MD, MPH**—Vice President, Equitable Health Systems, AMA Center for Health Equity

Transcript

**Dr. Sivashanker:** Hello, everyone. Welcome to Prioritizing Equity, and I'm Dr. Karthik Sivashanker, vice president for equitable health systems at the American Medical Association. You're here with us for an episode of Prioritizing Equity today and really excited to have this episode because we're going to be hearing from participants in our AMA's Peer Network for advancing equity through quality and safety. This is a year-long program that was offered and is being offered by the Center for Health
Equity, the AMA, in collaboration with Brigham and Women's Hospital and The Joint Commission.

The program is designed to help health systems to apply an equity lens to all aspects of their quality and safety work and to improve their health outcomes for their historically marginalized patients and populations. Data and literature shows that there are systematic inequities in the quality and safety of patient care. And since we've launched this network, participants have been learning strategies for systematically identifying and addressing root causes of inequities via this integrated approach to quality, safety, equity and operations.

And this is a framework that we designed and implemented at Brigham and Women's Hospital in collaboration with the Institute for Healthcare Improvement and which we're now advancing as a national model in the country. We're going to be hearing from some of our pioneering systems who are applying this approach in their own work, in their own institutions, and really leading the way in terms of transforming systems, infrastructure, processes to reflect this equity informed high reliability approach.

Specifically, we'll get into roses and thorns. Not just what's going well, but what are the challenges and forms of resistance they've encountered in the work, and what approaches they've taken to overcome resistance, how are they building the case for the work with internal stakeholders, how are they operationalizing it on an everyday basis with their quality and safety teams, and also a little bit about their personal journeys that have led them to be a part of this network. With that, I'm really excited to introduce our special guests today, beginning with Dr. Aderonke Akingbola, who is vice president for medical affairs at Ochsner Health.

Dr. Akingbola currently serves as a physician executive, vice president of medical affairs and associate medical director at Ochsner Health in New Orleans. Obtained her Masters of Medical Management at Carnegie Mellon University and is a certified physician executive. She's also a practicing gastroenterologist. And then also very honored to introduce Dr. Judy Washington, who is the associate chief medical officer at Atlantic Medical Group, as well as being the coordinator for obstetrics and gynecology for Overlook Family Medicine. Her areas of focus include using data to identify and address disparities and patient outcomes and the number of underrepresented minority physicians in clinical care, academics and leadership.

She received her bachelor's from the University of Montevallo in Alabama, her medical degree from Meharry Medical College in Nashville, Tennessee, and completed her residency in family medicine at Mountainside Family Medicine in Verona, New Jersey.

With that, really excited to get the conversation started. I'll be referring to you as Judy and Ronke with your permission and want to begin by just opening this up to ask about your own personal journey. What led you to this work and what made you want to do this work in equity at the intersection of quality and safety? Maybe I'll open it up first to Judy, and then to Ronke.
Dr. Washington: Thank you. For me, it was a huge journey to get to where I am. In family medicine residency education, you're constantly teaching residents, inpatient, outpatient, and you're really talking about patient safety and really teaching them how to just write up a safety problem that they saw on the floors. As I was doing that and moving into this position, I had to reflect on my own residency and how we just weren't doing that and reporting clinical outcomes or errors which was just not, it was more punitive.

And so in this way, starting this journey, we were a high-reliability organization and doing that training, and then passing that on to residents. I really started to see this through a different lens; how we discharge patients, how we report even errors in vaccine, not using our interpreted devices for our patients. So for me, it was both personal, reflecting on my own journey and medicine, what's happened to my family in the past with personal experiences. And so this work became really a personal journey on how I could improve access and quality care for patients and even my own family by just communicating and advocating for them.

Dr. Sivashanker: Thank you, Judy. And Ronke?

Dr. Akingbola: Thank you for having me on this panel discussion, Karthik. My journey as a Nigerian American relocating here at United States in the 80s, my very first job here in America was working as a medical assistant in an underrepresented population area in Cleveland, Ohio. It quickly became very apparent to me that the quality of care that the population that I was working with was completely different from white America. And that was a very shocking revelation to me at that time. Through my residency training, none of my instructors, attending staff looked like me. And coming out of training, I also worked in another underrepresented area of New Orleans here for two years.

Again, the disparity in health care was overwhelming and I felt like something had to be done about this, but there was nothing that personally I thought I could do about it. But one decision that I did make to myself was that I had to get up the ladder somewhere where I could impact health care to people that look like me, and also be in a place where other African Americans can see me as a role model. That impacted what I did going forward. And I'm very blessed to work at the organization that I work at right now, that think the work on diversity and inclusion is a very important work in providing health care.

Being part of this organization has given me a platform to participate in this. And I was invited to join this work with the Peer Network group by our chief quality officer, and I'm very thankful to him for including me in this Peer Network.

Dr. Sivashanker: Thank you, Ronke. And Judy, you alluded to this idea of the impact on your family, and Ronke, you spoke to it a little bit more directly. Is there anything that is coming to mind for you? And as you were speaking, Ronke, I was thinking, who is health care actually designed for? What has the system been designed for and who is it currently designed to serve best?
I think we’re probably in agreement that it’s not designed to serve everybody in the ways that they need, and that’s not going to lead to high quality, safe care for every single patient and community that hasn’t been doing that. But I’m wondering if there’s anything else, Judy or Ronke, that is personally igniting your passion for this work?

**Dr. Washington:** It became really evident to me, Karthik, during the COVID epidemic. Even though I had worked in a rural community, had worked with a medical school in Tennessee, and then coming back to New Jersey, and then when we started this Peer Network, I was just starting my position as associate chief medical officer with Atlantic Medical Group. It was really apparent to me that after we were finishing our HRO journey and this opportunity was really presented to myself, Dr. Lauter, Scott, I’ll call him, that it was going to be new for me, it was going to be more work, but it was really the work that we agreed that we needed to do. Unlike being a hospital system, we are ambulatory. We have over 200 outpatient offices and we’re in 14 counties. Unlike a hospital, we’re so spread out. And so we needed to really address the inequities in our community day to day, taking care of our patients. And that was important to us as we started to really see inequities, inequities in care, and we were looking, starting to look at it through this lens of quality and safety reporting that was new to us, but we had been doing it so long, just looking at it with an equity lens was very eye-opening, especially for our team.

**Dr. Sivashanker:** And you’re leading us very naturally into the framework. So thank you for that. So maybe I’ll just share that with the audience. I think you’re all very comfortable with the framework now, but there’s really five components to the approach that we’re sharing and working on collectively. And that’s number one, integrating equity into all harm event reporting. So historically, we have done that in an identity-blind way, and that has led to us missing a lot of harms that are actually happening differentially to patients and populations. The second one is equipping staff with the knowledge, skills and tools to create safe spaces to actually learn about inequities and how to address it through high reliability practices. The third is collecting and using harm event data, segmented socioeconomic characteristics. Once again, if you don’t track the data, it’s hard to actually know who’s being impacted. Fourth is building will for urgent action, the senior leaders on the board. And then fifth is ensuring accountability to the communities that we’re seeking to serve.

So Judy, you were kind of starting to speak to that first element of what has it been like just to start asking systematically with every single harm event, is there an inequity associated and what work arises from that? So maybe Ronke, I’m going to hand it over to you to continue the thread of what’s that journey been like and what are you learning as you’re doing this work?

**Dr. Akingbola:** For right now, we are investigating on different things that we could do as it relates to reporting harm events, our harm event reporting tool. The conversation we are having at this point is what questions are we going to put there that will make people feel comfortable actually sharing with us what is going on and not being defensive. The work on doing equity work could be very sensitive in
the sense that you want to welcome people on the table. You want to be mindful of the fact that there may be some unconscious bias that people are not particularly consciously doing racist things, but allowing them to share things that are being perceived as unconscious bias. All of us have the element of unconscious bias in our interaction. And until we’re actually being made aware that this thing is not acceptable, it’s something that I can continue to do.

Here at the Ochsner Health, the conversation is about how do we not just collect the data. How do we make those data actionable items? If we have these questions embedded in our reporting tools, what are the things that we’re going to put in place to make sure that we address those things in a way that the person takes it as a learning opportunity and not an opportunity to get defensive?

And as we do this, the people answering the questions, the people investigating, we’re all learning together and improving on things that we’re not currently doing today. And we’re being mindful that our patients are also, we’re getting back to our patients who might have reported things that they feel this disparity or inequity we're getting back to them to let them know what measures that we are putting in place.

**Dr. Sivashanker:** That's excellent. And I think you're getting to this idea of just acknowledging that there are harms happening in our health systems and medicine in general, that those harms are sometimes from bias, sometimes from racism or sexism or classism or another ism or an intersection of them that they’re preventable. And then not only just acknowledging it, but doing more to identify it, actually take actions and then provide closure and the safety you need for that. So maybe we can spend a moment on the safety part of it, because that's the second component of the framework, which is actually educating staff in a way that they're able to facilitate these conversations and investigations where it's not about blaming individuals per se, but really about generating curiosity and a growth mindset and seeking ways of improving. And in some moments there might actually be a need for corrective action, but really how do we set that? How's it going in terms of that, creating that safe space and providing that education to staff? What has been going well, what's been challenging? I'll hand it over to you, Judy.

**Dr. Washington:** When we started our journey with the high reliability organization training HRO, we really spent a lot of time talking about safety reporting. Now that we're doing this and we have our small group, I think one of the things is to learn to be comfortable with each other and to honestly and openly talk about issues of racism, sexism and everything else. And I think it started first with, I was new to my role, Dr. Lauter, Scott, had been in his role for all over six years. And so we had to create a safe space. So the two of us get started to talk openly and honestly, and also to debrief when we had our first meeting. And then the second meeting, I think we both just had to sit down and move forward and we really had to do our homework. We had a reading list and we were trading off on books and articles.
Because if we couldn't be comfortable discussing this with each other, there was no way we could be comfortable forming this team and then moving forward, and now we're at this point where we have to invite others into the team. And so now we have to step back and go through that whole journey again so that the people that we bring in are really comfortable talking and listening the same way we are doing right now.

**Dr. Sivashanker:** That's great. And Ronke, do you want to add anything to that?

**Dr. Akingbola:** So it is important in this work that everybody feels safe, and by creating a cultural or psychological safety that whatever information we're gathering is not to actually address a person but the process. And so, in our root cause analysis, we make sure that we embed those questions to allow people to feel safe and not be judgmental. And that the questions that we are asking is out of genuine curiosity and that we're actually being very transparent in the work that we're doing. Because really it's a journey, and we have a department of diversity and inclusion that have done great work in this field for the entire organization.

And in our quality and safety department, Dr. Guthrie, who is our chief quality officer, has done a lot of work on psychological safety. Oschner Health West Bank, of which I'm one of the leaders, we embarked on a journey of psychological safety throughout our organization that every member from physician to nurses and EBS, we had to take a four-hour course on psychological safety and why psychological safety is important in health care.

So it's been almost a four-year journey. And also just building that culture that allow people to be able to speak openly and not speaking openly, not just on equity, on everything that has to do with safety. And I believe that equity is a very integral part of safety.

**Dr. Sivashanker:** So there you've just generated between the two of you, at least four or five other side questions that I want go explore a bit more. So maybe I'll name some of the things that I'm hearing and then we can decide where we want to go. One of them is just personal transformation that this work requires that historically this hasn't been viewed as a part of our work. It's oftentimes the work of the DE and I folks, and I don't think it's represented in this call because I think we all identify as people of color, but actually when you look at the full teams that are coming together in the Peer Network, it's a diverse group of people across roles. We have quality leaders, DE and I leaders, community and population health leaders and program managers.

So what we're seeing is that people are transforming as individuals in order to meet the need of this work. It also requires redefining what this work, what our work really is and how we do it. And so maybe we can start there. How has that been, how has it been in the personal journey? What have you seen for yourself, for others on the team? What has it been like to come together as a team across roles, across differences, to do this work? Maybe I'll let you start Ronke this time and then we'll go to Judy.
**Dr. Akingbola:** So it is important that the work is not just order to the quality team or to the DE and I team. Safety, it's a work that is everybody's work. And so, equity work also is one that is everybody's work, so the approach that we've had, it's not just to have a group of doctors, it's to have a group of cross-sectional people throughout the organization that have been having conversation around how do we address this?

Yes, we've done a lot of work on DE and I, and we've set a pace for the entire organization that this is where we want to be as an organization. And I'll share with you that here at Ochsner Health, we have a mandate that we put on ourselves that as the largest not for profit academic institution in Louisiana, that we owe it to this state to take quality care in Louisiana from the last that we're in now to number 40 by the year 2030. And in order to do that, we cannot ignore a segment of our society. Quality care, it's something that has to cut across the entire state, otherwise we have failed in that initiating. So that makes to us very important, the work on equity. And I personally consider it a boarding platform that it's got to be quality for all.

So what we've done here, we've had groups of administrators, non-clinical administrators, we've had groups of doctors and nurses having this conversation on how do we actually go about this journey? And we're welcoming everybody's input. On a leadership level, we've had to make presentation to our leaders to let them know the importance of what we are doing and getting input. It appears that Atlantic, you're far along in the journey of the data and data collection and implementation of what you're doing with the data that we are here at Ochsner. But we're gathering that data and we're making sure that the process that we are doing is a slow process that will be sustained because we're able to carry everybody along on the journey.

**Dr. Washington:** Well, we are a little different because we are the only group that's not a hospital-based group, even though we're part of Atlantic Health System and we have our hospitals, AMG itself is a little different. So it's been a little easier for us to put together our team. What we did was we were looking at people who were just, as we say, subject matter experts. So risk, we brought in our chief diversity officer who was somewhat new in his job just under two years. We had our quality team, we had some people from our integrative care, but more importantly, we brought in clinicians, internal medicine, family medicine. And one of the doctors is now our new health equity lead position, but we brought her on because of the work that she was doing around sickle cell and data collection. So that was important to us.

What we noticed is after we brought the group together, it was just a natural bit that we could all move toward this work. And it wasn't until a few months ago, we realized how we all had developed this culture and wanting to move this forward. So naturally, and I guess that was our diversity bonus because we certainly all are not from the same backgrounds. We don't look the same and our experiences are very different, but it's just really been very good for us.
I think the most important thing is that having everyone who was a leader, and namely our chief medical officer who sits in many rooms, take the lead in this rather than say myself who was new in my job, who sometimes you can get pseudo leadership where you walk into a room, no one knows you. With his six years of experience, he was able to push this forward because even though we were really ambulatory, we ran up against some of the systems within the hospital, like changing the whole safety reporting system did not just affect us. It would affect the hospital.

So having to negotiate, putting in questions or disaggregating data, putting in demographics was really important that we navigated that. And so it's really somewhat a little simpler being a hospital system and you're taking the lead because it's top down. We had to take the top where the medical group, but already our chief medical officer was part of that leadership team.

**Dr. Sivashanker:** So I think what you're both getting to in a way is how this work is leading organically in various ways to a reexamination of systems and processes and structures that need to be changed. And doing that takes time. So maybe we can actually talk about that a little bit. Maybe frame it as roses and thorns. So what is a thorn that you've encountered or a thorn or two that you've encountered? It could be in terms of trying to do the work and trying to make these systemic changes, or it could be in the form of resistance to why does this work matter to me, “I'm a safety person, what does equity have to do with anything?” So I'll keep it open-ended in terms of what the thorn is and ask you both. And then I would love to ask about the roses as well. So Judy, why don't we start with you and then we'll go to Ronke.

**Dr. Washington:** The thorn. I think for myself, I was somewhat impatient. And so really understanding the process and realizing that we were very lucky just as this work was starting, our chief clinical officer, Dr. Suja Matthew, joined us. And so she was able to take what would've been a roadblock and push that through for us. And I think she came to us just at a time when perhaps for us, it would've been a little bit harder. We also, another thorn could have been not having the support of our Atlantic Medical Group board because we have a board that governs the whole medical group, but we were able to really move them along because of some of the presentations that Dr. Lauter, Scott, had done. And so initially we thought, "Wow, this is going to be hard." But it started to really organically become one step at a time. But it took patience for us, I think.

**Dr. Akingbola:** So I will say that the thorn for me. You know there's a burden of work to be done. And there is a pressure that we got to do this yesterday, and you have to take a step backward because you know what you're trying to achieve. You want to be sustainable. So I consider it a thorn, the pace at which we're going, it could be a faster pace, but then it's intentional by the fact that it's not as fast as it is. So I'm calling that a thorn.

But then I'm going to flip to the rose part of it. At the pace that we're going right now, we're actually getting a lot of buy-in within the entire organization, which to me is a rose. People are really interested in this work. People really want to make sure that when they give care here, they're giving quality care.


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And so the how we get to where we need to be is what we are working on right now.

And Judy mentioned about talking to the board. In our board here at Ochsner Health, Dr. Guthrie, chief quality officer, and a couple of us that are in the Peer Network actually met with the physician board members and our medical advisory council, which are the top leadership in clinical care here at Ochsner. They were very, very supportive of the work that we are doing. They were very engaged in asking all the questions. We actually presented the case presentation that we presented the peer review to this board, and they were like, "Okay, how do we move this? What do we need to do to support the work that you're doing?" So I consider that as rose and as far as thorn is concerned, the pace could be better.

**Dr. Sivashanker:** And so the pace part of it is important and interesting because when we talk about this work, sometimes the first question is, well, what are you working on? What's the initiative? Is it about high blood pressure for a particular population or is it about diabetes management and care? And the answer is actually, it's bigger than that. It's actually about transforming the very way we do work and embedding it into the operations and the quality and the safety and the data. So it's literally changing the system itself, and that takes time.

And so I hear you on the impatience, and I think the opportunity then becomes, how are we transforming at the end of this? What's going to be different? I think, Judy, you alluded to that a little bit about how it's already starting to have some ripple effects, but both of you have mentioned the board and engagement. And I think I'd love to hear more about that.

We talk a lot about how do we use the stories, the actual harm events of individual providers or patients to drive change to build will. That's that fifth, fourth and fifth driver that we're talking about. So how has the actual events and the harms that you're starting to identify been helpful to start to build that will, make the case for the work? Well, maybe we'll do Ronke this time, and then we'll go to Judy.

**Dr. Akingbola:** Okay, thank you. A case that we had presented at the peer network was an OB case. Actually, when we joined the Peer Network, our intent was to limit the work to one of our hospitals and then whatever it is that we're learning to scale it and spread it through our entire organization. In the process of getting ready for our case, we had an OB case that was presented. And so based on all the things that we saw that the gaps that we have and things that we could be doing differently, we pivoted quickly and decided to do the work throughout our OB service line within the organization. So during that presentation of this particular case to the board, we shared the things, the gaps that we think we know we have. We shared those gaps with the board, we shared the gaps with our quality leaders in the entire organization.

And we started to put things into place. It was a care-experience inequity that this patient felt. And we're working diligently right now in our OB service line to know that every OB patient that comes in our building feels like they're getting quality care. We actually do have an internal survey that we are
using at my hospital, asking those questions, letting them know what we want to do, how we want to represent ourselves, and wanting to know if you fall short on that. So every patient that comes into the OB department already gets a survey to answer those questions. How are we doing? Were you respected? Are you participating in your care? Did we treat you with respect?

And we're working, getting those data and working on the data to make sure that we're spreading and scaling it through our entire organization. So those are the steps that we've taken in the area of OB as you're both aware, OB is an area that has marked disparity between people of color and white people. And we want to make sure that when a patient comes here to Ochsner and we look at those data, we can fully say that we're giving the same care to everybody that works in the building. And so we're putting those measures in place to make sure that that does happen.

**Dr. Sivashanker:** That's great. Judy, I'll hand it over to you.

**Dr. Washington:** So our case that we presented was along the lines of not using interpretive services appropriately. And so it really was an opportunity to revisit how we talked to our practices, how we onboard new practices, letting them know what services we have available. So we were able to do a root cause analysis of what happened in our case.

In doing the case though, and making the presentation to our board, and actually to not only the AMG board, but the Atlantic Health System Board, we've started now and I think pushed forward a program for training our team members who speak Spanish or other languages, getting them certified. We're starting with Spanish language first. But one of the other important things is that we started to look at our case study comments and we were realizing, one, that our response rate from our Hispanic patients was low, almost nonexistent.

And so we realized that the information in the offices was all in English, so we had to get everything printed, get them to the offices. And another problem we realized was there were comments by patients in their native language. And we were not using those, and we weren't even looking at those to see if patients were commenting about care, lack of care, or problems that they have perceived in our practices.

And now with using first just the office staff translating, but then if there's something of concern, making sure we have a certified interpreter, we're able now to use those comments for good, meaning the doctors, we put it in the patients' native language and they're there. But also we're able to now investigate problems and to really reach out to patients and make corrective actions and which is really important. We had not done that before.

**Dr. Sivashanker:** And I want to put an exclamation mark on what you just shared and the way you did it, because for the average listener to this episode, some of this might be surprising. “Oh, your system's not doing this.” But what's important to understand for those of us in the field is, and we know
this is a widespread problem, there are very few systems who are actually, if any, providing highly equitable, high-quality safe care. And so these problems are pervasive. And so what you're doing is you're sharing, you're acknowledging that the harms are happening, you're sharing transparently, that's actually what doing the work looks like. It's the beginning of the work because for decades we've been pretending like there is no problem, we haven't been looking. And so I just want to put that exclamation mark on that comment for any listener, because it takes courage to do this work.

You're basically lifting the rug on all sorts of things that have been happening in an institution that we weren't aware of or haven't been investing enough time and energy to, and we're doing it for the first time. And that's how the journey begins for all of us. But you're getting into roses now.

So let's talk about a rose. It could be a little rose, it could be a big rose, it could be a little moment between colleagues around this work. It could be something that you're excited about in terms of where you're going. But Judy, why don't we start with you? What's a rose that comes to mind?

Dr. Washington: Well, the one that just happened was, we are going to get pronouns on the Epic storyboard. That was a simple win. And as far to the IT team, a realization that when patients complete that information in MyChart, it wasn't translating and now it will be. And so that's a huge win for us around that. And also now we get to start on the next journey, which we've talked about a lot. And that is ensuring that the demographic data that we collect is accurate. And so that's a huge win for us.

Dr. Sivashanker: That's great. And Ronke?

Dr. Akingbola: And I'll also share that we have had the group of patient population that we are now paying more attention to LGBTQ in the sense that the appropriate pronoun that they would like to have used, we're making sure that it's posted and we're using those pronouns. We're also, we have a label on our Epic that tells us the preferred name that they would like to be called. Aderonke Akingbola but I like to go by Ronke. And so we have that label on our epic banner that allows us to do that. A big rose that I will say is that the ability to openly have a conversation on: this is where we need to be, we're not there today. And this is a plan to get there as it relates to the work on equity. The ability to be in the meeting and openly say that without having a pushback and knowing that your conversation is well received by everybody. Now that we're having more of those conversations is big news here for us.

Dr. Sivashanker: And that really reminds me of when we started at the very beginning. We have these teams coming together. Some of us know each other well on the team, some of us don't. And how far, just in nine months, the teams have come in their own relationships, leaning into the work, their safety with each other, and that has huge ripple effects.
And so I guess maybe the last question, and then I'll just let you all close this out here, is your systems are pioneers in joining this network. It's been a pilot. We're trying it for the first time. We want to know if what we tried in Boston can now work in other areas. And I think the answer is going to be a resounding yes. And that each system's different, has its own unique challenges, is in a different place, but the urgency for doing the work in this way is there and there's a need to do it.

But what would you say to health systems that are thinking about, should we be systematically thinking about equity in how we do our quality and safety work? And should we consider engaging in a program like this? What would you say to them or even to yourselves at the very beginning of the network when you were first joining and maybe had your own anxieties about it? I will go to Ronke and then we'll close out with Judy.

Dr. Akingbola: So the journey for me at participating in the Peer Network discussion is the wealth of information and knowledge that I've gained from just being in the same group with all these big health centers. Some are far along on the journey, and we have the opportunity to ask each other, “We're trying to develop X program, how did you do yours?” And we're borrowing and stealing ideas from each other and discussing openly. The case reviews that we discuss, the comments that come after those case reviews and what people are doing differently for the boarding of the work, it's just been great.

For hospitals that are coming in to do this work, it is very important that the members that present at the work should not just be the clinician; bring along your legal team, your DEI team, and maybe a leader, an administrative leader, so that when you know the volume of work that is going on, the requirements of and the need for the work, it'll be something that will be better received at the different institution. So I do encourage this to continue. You said it's going to continue because it's just been tremendous opportunity for us here at Ochsner Health and we hope to continue the journey.

Dr. Washington: I echo what you said. It was really important for us to have a diverse team and to have two senior leaders, our chief diversity officer from the hospital side and then also our chief medical officer from Atlantic Medical Group, leading the team. And I think it's really important that senior leadership buys in. We were really very fortunate that our CEO of Atlantic Health System had added diversity and equity as part of the mission. And so, as we were moving in this journey, I think in many ways we were saying to each other, all right, we can do this now because we have buy-in. And I can say, for any hospital system who, or even a medical group like ours, if you're going to do this work, you really have to first ensure that the team is diverse, meaning that the subject matter experts are leaders in each department.

Because I think that's important and then that everyone's willing to share and to be open and honest. And I think sharing your stories is real important. And as we've moved through that, I think for our team, certainly it's not perfect. Our data's not perfect right now, but we are now moving toward a goal of providing equitable care, safe care. And then now the next step is we've been working with our
board and now we are moving this out to our clinicians. That's every practice, every team member.

And then having the courage to develop this story. People have heard it; the one that we’ve shared, but now doing micro-learnings and identifying other stories that we can share so that our team members and our clinicians can learn from it, that is going to be a huge undertaking. But I think the people leading it are doing it in a way that I think everyone will see it as the next step in our journey from high reliability training to now this training. But I can say that if you’re going to do this, it’s just not as I’ve heard you say, Karthik, it's not just a half step. You have to be all in with this. And you have to be willing to just move it forward at a pace that, as we said, it's slow, but you have to be intentional with it.

**Dr. Sivashanker:** It makes me think that something we've talked about before, which is this is quality and safety work, it's operational work, but it's also spiritual work. It's emotional work. And it's just been remarkable to see how each of you and also the teams have evolved just in the short amount of time together and just knowing that you're going to be the future. You are the future leaders of this work, and we need a lot more of you. And hoping that the listeners for the episode today will join this movement to really make equity a part of everything that we do in our hospital. So with that, thank you both so much. It was an honor to have you here today, and we'll see you on the next network call. And yeah, it's just the beginning of the work.

**Disclaimer:** The viewpoints expressed in this video are those of the participants and/or do not necessarily reflect the views and policies of the AMA.