Podcast episode transcript: Melissa Clarke, Joy Lewis and Akin Demehin

Melissa Clarke: Hello, my name is Dr. Melissa Clarke. Welcome to the 3M Health Information Systems Inside Angle Podcast. I'm the co-host and chief population health officer for 3M Health Information Systems. We're going to have an incredible discussion today. And just to set it up, I wanted to mention that the landscape in health equity continues to evolve. There's been a lot of ground covered since the 2003 Landmark Institute of Medicine report, Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, which outline the evidence that the quality of health care received is unfairly influenced by race and ethnicity. And we have come all the way now to the recent embedding of health equity in all federal policies approach. The need for our hospitals and health systems to not only keep up in this evolution, but also to weigh in and lead on issues of equity becomes even more imperative.

So that leads us to the fact that today our 3M Inside Angle Podcast includes two leaders from the American Hospital Association who are going to help us walk through the role of hospitals and health systems in closing health equity gaps, help us understand recent related policy changes, as well as discussing equity-based best practices that hospital systems can pursue in their community and population health strategy. So I would love to bring into our discussion Joy Lewis, who is the Senior Vice President, Health Equity Strategies and she serves as the Executive Director of the Institute for Diversity and Health Equity all at the American Hospital Association, where she has brought oversight of functions related to diversity, health, equity and inclusion, all to support and build healthy communities.

Welcome, Joy. Thanks for joining us.

Joy Lewis: Happy to be here. Thanks so much for having me.

Melissa Clarke: Absolutely. And then I also would love to welcome Akin Demehin. He is the Senior Director of Quality and Safety Policy at the American Hospital Association. He leads public policy analysis, development and advocacy efforts related to quality and patient safety on behalf of AHA's nearly 5,000 member hospitals and health systems as well as AHA's regulatory policy work on national quality measurement and pay for performance programs, workforce and health equity that affect hospitals, physicians, as well as post-acute care providers. Welcome Akin. Again, thank you for being here.

Akin Demehin: A real pleasure. Thanks so much.

Melissa Clarke: So I'd love to start off with Akin. There have been several recent regulatory changes around health equity. Can you explain two or three of the ones that you think will have the most impact on hospital and health systems?

Akin Demehin: Absolutely. So let me focus on a couple of different buckets of regulatory activity. As you alluded to at the top of the podcast, Melissa, we have seen the embedding of health equity related regulation into a number of federal programs since the start of the Biden

administration. And it really started with an executive order issued on the first day of the Biden administration that instructed federal agencies to develop health equity and broader equity related plans to advance equity within their programs. The primary regulator for hospitals is the Centers for Medicare and Medicaid Services, CMS. And for its part, CMS has adopted several policies related to health equity that affect hospitals and health systems. First, there are new quality measures in CMS's inpatient quality reporting program. The agency adopted these measures in 2022 and hospitals are beginning to report the first of these measures this year in 2023 and the other two beginning next year.

The first measure is what CMS calls a structural measure. It's a measure intended to reflect whether hospitals are adopting certain practices related to health equity, such as having a health equity plan, having a plan for collecting certain health equity related data and training staff on it, a plan to share a progress on health equity with their boards and their senior management team. Those are really the foundational steps that CMS outlined in its structural measure. CMS is also very focused on data and improving the availability and use of data to identify and reduce disparities in care. And so they also adopted a measure that reflects whether hospitals are conducting screenings for certain health related social needs. And those two measures actually will begin to be reported starting next year. Those are the regulations that are in traditional Medicare. We have also seen a number of health equity related policies adopted as a part of Center for Medicare and Medicaid Innovation, or CMMI, programs that call for things like developing health equity plans, collecting equity related data and so forth.

So these are the steps that CMS has taken intended to encourage progress on health equity. I'll also point to another set of activities undertaken by the largest accrediting organization for hospitals and health systems, and that is the Joint Commission. Beginning this year, hospitals as a part of their routine, Joint Commission surveys are assessed on a set of new health equity related standards. And those standards actually look fairly similar to the hospital commitment to health equity structural measure that CMS adopted. So it calls for hospitals to have a plan to address health equity, a process for sharing progress and results with boards and with senior leadership teams and a process of really engaging their front line. So taken together, it's clear that over the past couple of years the amount of policymaker interest and activity with respect to health equity has really grown significantly.

Melissa Clarke: Thank you so much for that overview. I think it really also fortuitously works out that there is alignment as you mentioned, between CMS and the Joint Commission and potentially others. So Joy, what would you say has spurred the field to focus on health equity and put in place some of these metrics and benchmarks and certifications?

Joy Lewis: So that's a really good question, Melissa, and you pointed out earlier on that disparities are not new, right? The way in which health care is distributed across this country, there's a maldistribution of resources which leads to the disparities and the inequities that we see. But essentially, I would say on the heels of the COVID experience where we saw a disparate impact on Black and brown communities, whether it was from the testing phase to the vaccine administration phase and certainly in terms of poor health outcomes including deaths, it was just really hard for folks to turn a blind eye. So that certainly raised awareness and really catapulted this issue into the limelight. And then when you layer on what happened in the summer of 2020 or May of 2020 with George Floyd's murder in Minneapolis and the

renewed call for social justice and racial justice and health justice, it just became very hard for any health care leader to ignore what was happening in the broader society around us.

And certainly really the call for health care to do its part and to begin to address some of the inequities that we know exist in our system. So I would reflect on those two experiences. Some people refer to it, some experts call it the double pandemic, if you will. But really over the last three years or so, we've just seen a growing level of awareness and interest and actions from our members, from hospitals and health systems and other health care providing institutions to really begin to tackle these vexing challenges in our system.

Melissa Clarke: Yeah, I think you're exactly right. I wonder, as you support and represent your member hospital organizations and health systems, what are some of the member reactions or concerns that you're hearing with how this might affect just their normal hospital operations to now focus, have to focus on some of the CMS measures and certainly the Joint Commission standards? What's some of the feedback that you're getting?

Joy Lewis: So I can kick us off and then pitch to Akin because we actually worked together, my team with the policy team with Akin as the lead where we did a crosswalk between, or among I should say, three products that are out there. One being the AHA's Health Equity Roadmap, which I can share a little bit as to the details about that particular initiative. And we did a crosswalk with the elements of our roadmap against the Joint Commission standards and the CMS regs that Akin spoke about earlier. So what we are focused on at the end of the day is both clinical and operational improvement for our members. So the Health Equity Roadmap is around actions to eliminate disparities. We think commitments and pledges are a start. I mean, we won't knock those, but they can be performative at best if they're not then followed up by some meaningful action.

So you'll hear us at the AHA through the Institute for Diversity and Health Equity talk about mobilizing the field. And we provide the tools and the resources, not just case studies that really celebrate the wins that some of our members may have in terms of their experiences in their patient population to share writ large, but we want to get behind those wins and understand more importantly the how, how did you arrive at those outcomes? How did you achieve those wins? So that it can be instructive to others who might just be embarking on their journey. So the Health Equity Roadmap is something that we spent a year developing with some funding from the Robert Wood Johnson Foundation, and it's this national framework if you will. Really the model has six levers of transformation. So we say to our members, if and in fact you're serious about moving the needle in this space, here's where the evidence is pointing you toward, here are the six levers. And there are probably more out there, but these were the top six that we identified that our members needed to be paying close attention to.

And so we launched the roadmap last year and we've been on the road going to all nine regions similar to the CMS's nine regions across the country. We've spent much of this year, we will have hit all nine actually by November of this year where we're actually taking the national framework and then we're thinking about it within the context of a particular geography. Because as we said earlier, there are maldistribution of resources across this country. So how might one then take that framework and operationalize it within their

particular context? So it's been a great learning for the team to be on the road. And actually next year in 2024, we're looking to move these conversations to more of a state-focused convening. So moving from a region where you may have four or five or six states represented in that region to actually going to the state level and having these conversations. Akin.

Akin Demehin: Well, I think Joy laid out in great detail and precision how we're engaging members in this important process. And I think what we have heard with respect to the policy environment is an appreciation that so far the efforts of CMS, the Joint Commission, and our own AHA Health Equity Roadmap are well aligned with one another. I think so far the kinds of policies that we have seen come forth do have the recognition that the inequities and the communities that hospitals serve can look different. And so their responses are going to look different, but have some common elements like data collection and reporting and approaches for sharing progress with senior leadership and tracking and so forth. As we think about what the future landscape of policy might look like, I think there are a couple of things on our members' minds at this point. Number one, I think they want to see the policies remain as carefully aligned as they possibly can be.

This is a topic, health equity, that is of such importance to our members, to the communities that they serve and to our nation as a whole. And they feel very strongly that it's important that we're all rowing in the same direction. So one of the examples of how we can bring about that alignment is really around data. And I think we are at the beginning of the process of collecting and using data to identify inequities in care and track them over time. And I think what our members really want to see is for those data approaches to remain as carefully aligned and where possible as standardized as possible. We really should be looking at data that are very similar to one another, whether we're talking about a patient who may be covered by Medicare, by Medicaid, or by a private insurance product.

We really want to make sure that we are all focused on the same kinds of data to the maximum extent possible. The second thing that I think we hear is a desire to make sure that we are putting forward the evidence-based practices that are shown to be the most effective in driving health equity forward while leaving some room for hospitals and health systems to tailor their work to meet the needs of their communities. So that balance of making sure that we are standardizing where we should and providing flexibility where we should is I think where our members are really thinking about where future policy may head.

Melissa Clarke: Great, thanks so much. I think back to one of the things that Joy said, which is that they're these evidence-based six levers. So I would love to hear what are those six levers, maybe without going into a lot of detail, but just so that we know the broad categories and then talk a little bit about that customization piece. So maybe you can, Joy, share those with us.

Joy Lewis: Sure. Happy to do that, Melissa. So the six levers of transformation, as I mentioned, span both the clinical side of the house as well as operational efficiencies. And so the first is culturally appropriate patient care, how do we render care that has some humility, if you will, that's always a good word for me and a good place to start in terms of the provider-patient interaction. Then we talk about how do we ensure that the organizational policies are equitable and inclusive? So that's the second lever of transformation, equitable and inclusive

organizational policies. The third is the collection and use of data to drive action. And these are not listed in order of importance. I'm just sharing the six levers because I would argue that you've got to start with the data. And then there's a focus on diverse representation in leadership and governance because we know that you need to have a diverse set of voices at the table to inform decision-making.

We have better outcomes when you have diversity of thought, if you will. And then community collaboration for solutions. That's probably where I would say the field is spending a big chunk of its time. It's really thinking through how do you effectively partner with community, how do you bring community into the co-design and the co-development of these equitable solutions. And then last but not least is systemic and shared accountability, which speaks to this notion of once you've made a commitment to this work, then cascade that accountability to drive improvements throughout all that you do as a health care organization so that each person leads from wherever he or she sits and sees him or herself as an equity influencer. So those are the six levers of transformation. And as you might imagine with such a diverse membership, we see hospitals at all different stages of this work. So we have some exemplars and we have others that are just embarking on their journey and then we have everything in between. So that's the nature of association world. We represent nearly 5,000 hospitals and health care organizations.

Melissa Clarke: Sure. Which I would imagine also sets up a great learning lab because those that have more resources or have the ability to be more innovative can test out various workflows and then others that have less flexibility can still learn from them. It really strikes me that that accountability piece also goes back to data because you also have to understand the role that the interventions are playing in moving the needle, what works, what doesn't work. So I'm curious, can you give any examples of best practices thus far of seeing hospitals re-engineering their culture or their workflows that incorporate the six levers?

Joy Lewis: Absolutely. I mean, in terms of promising practices, I'd actually encourage our listeners to visit the IFDHE website, which is ifdhe.aha.org and read about our Equity of Care Awardees. Each year, the AHA through the institute recognizes hospitals or health systems that demonstrate a high level of success in advancing health equity, diversity and inclusion through the six levers that we just talked about. And so this year actually for 2023 was the first year that we expanded the awards to create three distinct awards, one at the transformational level, one at the emerging level. And then we also recognized a rural hospital. Last year's winner, they won because they actually developed a roadmap. This is a big system out of New York for an action framework which was created to address medical racism, which I mean, leaning into any work that is focused on racism I think is really bold and transformative.

And so these are tough issues to tackle because it requires that the health system interrogates itself. And so in order to do this work, they spent a lot of time starting out first with their data collection efforts, improving their data collection efforts, specifically real data, race, ethnicity and language data. Because you really need those data to identify the differences or the gaps in care as well as to also try to better understand how people are being treated as individuals. But maybe even more impactful is when you roll up those data at the aggregate or population level, what are the data telling you? So I just thought that was a really powerful intervention. And so they won the award because not only leaning into their data, which apparently they

had started a decade prior to the events I shared at the top of the call, but once following the George Floyd's murder and the COVID experience.

They really put things into overdrive and had just all hands on deck when it came to better trying to understand how they were performing across different patient types by demographics and by insurance status. They actually created, in addition to their focus on patient experience, they looked at their executive leadership team and the diversity that existed or didn't exist at that level and they created a dashboard to monitor and track the racial, the ethnic, the gender diversity at the top three levels inside their organization. And they were really proud and pleased to report that through this tracking mechanism, they actually saw an increased percentage of both women and individuals from underrepresented racial and ethnic groups, particularly Black and African American and Hispanic and Latino.

So I think having a leadership commitment to this work, putting the infrastructure and the mechanisms in place to track and monitor one's performance and being willing to do the hard work of looking at yourselves and probing and challenging yourselves around what the data are telling you, I mean that really does, it's really the formula and sets an organization up to really be leading edge, if you will, in this work and to really develop the muscle that's needed to do this hard work. So that's just one example. There are plenty of other hospitals and health systems out there who are really innovating in this way.

Melissa Clarke: So I think as you mentioned, self-examination, data, and then being willing to take action on the data seems to be some of the threads that you mentioned. You also mentioned too that community and the role of community collaboration in the design of the interventions is really critical. What are some of the innovative partnerships that you've seen and how do you really make those partnerships effective? Because I think that's a hard nut to crack, especially from hospitals or hospital systems that have not historically really tried to partner with the community. It might be hard getting started.

Joy Lewis: So I think this is probably going to be the game changer this time around because again, this is not our first foray into solving for health disparities. But I'm hearing much more from our members about reaching into the community and actually showing up as members of the communities that they serve. So as you might know, hospitals tend to be the anchor institutions, right? The largest employer in the communities they serve. And with that comes significant power. And we talk with our members about being aware of the power dynamics that might be at play when working with community partners. And so what I've observed over the past couple years is really an uptick in our members taking action. So doing things such as regularly attending community board meetings or reaching out to local businesses to find ways that they might work together around a particular initiative.

We certainly know that patient and family advisory councils are pretty common inside hospitals and health systems where you've got patient representatives on a committee advising the leadership around pick a topic, any topic, town hall meetings. That's also another strategy that we see some of our members employing. But the challenge with things like the patient family advisory council or the town hall meetings is that those tend to be on the hospital's turf. And what we are encouraging our members to do is to actually go out to the community and engage with them on their terms. And at times when we're actually not asking

for anything, right? We're just showing up as a community partner and being... We think that's one way to build goodwill and to build trust so that when you do have an ask, it is not perceived as really being beneficial to one party versus the other.

So I would say overall I see growing awareness from our members and hospitals and health systems really wanting to influence the economic, the social, the policy environment that they're working in. And they're doing that through making investments in communities, through building trust, sharing the power, centering the voices of those with lived experiences who can actually speak to what it means to be on the fringes of society. What does it mean to be marginalized and to hear from communities and community members who might be experiencing poor health outcomes. I think our members are really seeing that as an important part of the development of any solution set, if you will.

Melissa Clarke: And that makes perfect sense. If really the end goal is to improve health outcomes, again, we know that upwards of 50 to 80 percent of the factors that affect health outcomes are outside the walls of the hospital. So it only makes sense to engage communities where people work, live, play, pray, and eat. So I think it makes perfect sense to really encourage partnerships to move beyond the walls of the hospital and out into the community on their turf to change that power dynamic as you mentioned. So I want to bring Akin back in because Akin you mentioned at the very beginning, CMS and CMMI, and of course CMMI's goal is one of the things that they look at in innovation is the role of value-based care. How do you see the relationship between the strategies to promote health equity being related to value-based care in general?

Akin Demehin: It's a terrific question. I think that advancing health equity absolutely can go hand in hand with value-based care approaches. I think what we have heard from our members, and Joy alluded to this just a few moments ago, solving health inequities and addressing health related social needs is something that absolutely requires the engagement of hospitals and health systems. But to really get at the root causes and fully address them, we need the entire community engaged in some fashion. And what value-based care models can allow us to do is to interact with communities in different ways and have some of those interactions recognized in how we pay for health care. So for example, value-based approaches can be very useful in fostering the use of folks like community health workers and social workers who can be vital links to the rest of the community.

For those patients, for example, who have food insecurity. They can create those linkages with food pantries and other nutritional support institutions in a community to really create those kinds of linkages. Value-based care approaches also allow us to really make great use of data because we are often tracking outcomes and performance over an episode of care that could be a lot more longitudinal in nature than the limited amount of time that a hospital may have with a patient while they're inside our four walls. And so it can enable that broader lens that Joy was talking about, to really engage in the work that helps to identify what health related social needs patients may have and get them linked up with the resources that can be the most beneficial. The other part of this and where it'll be really interesting to see where CMMI's work continues to go in this space, I think that there has been a great deal of emphasis on the kinds of data that hospitals, physicians, and other health care providers themselves are collecting to identify these needs.

There will always be that need for providers to be engaged in that activity. I also think some of what our members have told us is if there are opportunities to help us get access to data that may be collected elsewhere, but that give us critical insights about the communities we're serving, the patients we're serving, and allow us to get that data with a little bit less effort than they have to expend now, that too could be a real game changer. And we know that the CMMI models have been focusing on health equity and using community oriented data to try to address some of these issues. I think the real opportunity in front of CMS and in front of other federal agencies is how do you create that infrastructure to ensure that we are exchanging data in some standardized fashion, in a timely fashion, in a way that helps people really address those underlying needs.

It is a complex process to build out. I don't want to understate just how complex it is to get there, but it's a terrific opportunity in front of us and one where given the amount of passion, momentum and engagement that we see on the part of hospitals and the communities that we serve around health equity, the opportunity to do that maybe now.

Melissa Clarke: Yeah, and I think that data piece, as you mentioned, it's complex. So it's not just the collection of data, it's the exchange of data as you mentioned before. And I know some places are a little bit ahead of the curve because their health information exchanges may be a little bit more mature than others, and it's also making sure that the data isn't biased, right? So there are multiple levels there. And speaking of technology, I'm wondering, so many solutions seem to focus around using technology to improve access to care as one of the ways of addressing equity. So for example, telehealth and patient portals. But one health system reported that 30 percent of its patients didn't have a smartphone or internet access. We certainly saw some of these barriers in the pandemic, at the height of the pandemic when it came to making vaccine appointments and how the lack of broadband access or a device might've disadvantaged certain populations.

So how can you start to address some of these issues for people who have low computer literacy, or don't have reliable access to broadband? How can you start to address some of these access issues for those populations?

Joy Lewis: So I think it's going to require a multi-stakeholder approach, right? No one entity has all the answers. And so I think when you talk about tech in particular, that holds a lot of promise as an enabler. To your point, we saw that during the pandemic to expand access and to bring people into care relationships with their providers with distance, with that barrier being removed. Or even in urban settings, right? I mean, I think a lot of times when we talk about broadband or mobile solutions, we're thinking about rural communities. But even within urban settings, there can be disparate impact. And technology, if not deployed in a responsible manner, has the potential to exacerbate disparities. But I think partnerships are going to be important in this space. I think we need to distinguish between those disruptors who are entering the space to really solve some of the vexing challenges you called out, like low health literacy or not having reliable access to technology versus those disruptors that are...

We remain a little skeptical of because they might be entering the health care space to cherry-

pick and are not necessarily interested in taking care of patients with a complex set of needs. So it is possible to partner and to get it done right. I just think it has to be the right partner where the motivations are aligned and where we have shared goals. And some of this may be public private partnerships. Again, I don't know, did you hear yesterday, Melissa, that Costco will now be offering virtual primary care visits for $29?

Melissa Clarke: No, that's hot off the presses.

Joy Lewis: Hot off the press. And $79, I think it was for mental health visits and some other discounts for medical services. I mean, when you think about Costco, that has the potential to be really impactful given their reach. But again, is that the right model or does that fragment patient's care even further? So I think Akin wanted to weigh in as well.

Akin Demehin: I did. Your answers were really spot on, Joy. I'll just note that there are a couple of policy dimensions to this as well that can be important enablers of really bridging that digital divide that you were just talking about. Number one, we have been longstanding supporters of rural broadband access that has been especially important for broadening access to the internet and to things like telehealth for parts of the country that have long been underserved by those modalities. So that is certainly one piece. The other thing that we can continue to pursue are some flexibilities around how we deliver remote services. So just to give you an example, during the pandemic, there was some flexibility given around whether visits could be done via, not just via basically visual means, like for example Zoom, Skype, or other visual telehealth platforms.

But there was also some flexibility around audio only services. And depending on the nature of the care that a particular patient needs, that kind of flexibility can be quite helpful in maintaining that linkage to care while reaching patients where they are. As Joy alluded to though, there's always an opportunity to support health literacy to really ensure that folks have the tools that they need to take full advantage of innovations like telehealth and that work will certainly need to continue.

Melissa Clarke: And just to round out the discussion, we can't leave without talking about our incredible health care workforce, which has weathered a pandemic and we're seeing the effects of workforce burnout. What effect is that burnout having as hospitals cope and hospital systems cope with staffing issues? What effect is that having on closing health equity gaps? And does this need to bring on new staff represent an opportunity or is it a setback to health equity efforts?

Akin Demehin: I'm happy to start, but I know Joy will have a lot of incredible insights here as well. I think that we view efforts to bolster our health care workforce as really complimentary to health equity related efforts. It is no secret that the health care workforce has been under a tremendous amount of strain for the past several years in light of the once in a century pandemic. I think what it has prompted hospitals and health systems to do is to be very intentional in how they align their health equity efforts with engaging their workforce and frankly, with any other strategic priority that they're undertaking at this time. We also consistently hear that there is a high level of interest among the workforce in understanding how they can serve their communities even more effectively. And at the heart of health equity

related efforts is really that work to help meet patients where they are and to meet their needs.

And I think that that kind of work for many in the health care workforce is actually incredibly energizing. So really I think that health care leaders are really trying to seek as much synergy as they possibly can between their efforts around the workforce and their efforts around health equity. The resourcing issues will always be a concern. It is part of the reason why when we look at things like public policy around health equity, we want to make sure that we're being as thoughtful as we can be in putting any new requirements in place. It's to make sure that hospitals can maintain that flexibility.

I think workforce is such a central question for hospitals these days. There are so many different strains on folks, and I think that getting more people into the workforce is going to take a lot of time and a lot of investment. And so at the same time, hospitals understand the importance of the work in front of them, including health equity. So I think they do the best they can to weave those things together. And we know that there are folks in the workforce who are really eager to engage on health equity related efforts, and in fact oftentimes help to shape the direction of those efforts inside their organization. So their leadership is always so critical in their engagement. We really can't do it without it.

Melissa Clarke: And Joy, would you like to comment on the effect that workforce burnout accelerated by the pandemic has had on the goal to move towards a more equitable health care system? Akin has given us his perspective. I wonder if you have anything to add to that association and helping us understand how the role of hospitals and health systems has been evolving as we seek to close health equity gaps and help us understand more about the policies and the best practices in this space.

Joy Lewis: Absolutely. So you've called out workforce is one. I would add onto that and say that the financial pressures that hospitals and health systems are facing today really create a challenging environment for them to continue to focus on health care transformation and innovation of which health equity is part and parcel of that work. And so earlier this year, the American Hospital Association, we released a cost of caring report, which was a refresh from prior year's work, but we looked at the three-year period of 2019 to 2022. What we found were significant increases in hospital expenses, somewhere close to 20 percent. And so think about that just in your personal life, if your expenses increased 20 percent and your income remained the same. So essentially where we find ourselves is in a resource constrained environment. And when one is in such an environment, you start to rethink your priorities.

And so that's true of our hospitals and health systems, having to think about their funding allocations and which programs they're prioritizing and the like. But interestingly enough, the institute did our biennial DEI survey, and what we found was that the data show that leadership commitment is actually not a barrier to advancing this work, but designing the roles for success so the individuals who are put in charge of leading the DEI or the health equity portfolio often don't have the proper allocation of resources. So there's a disconnect between the commitment and the resources that we see being put to bear on this issue. And so again, in an environment where there are real financial pressures, one of the concerns is that DEI will be put on the chopping block. And so there really are no quick solutions here. We're also very

cognizant of the fact that much of this work is what I like to refer to as generational work because you're trying to change mindsets.

And so there has to be just a broader societal acknowledgement, if you will, that we have those amongst us who are less privileged and we need to be willing to share space with these individuals. We need to wrap our minds around the fact that equity does not need to be a zero-sum game where you're taking resources from one in order to benefit another, that we actually all do better when you have a lift all boats strategy. So I think the debate that continues in this country around having access to high quality care is not over. And obviously there's a clear correlation between access and health outcomes. And so I would just argue that we want to continue to stay the course. There really continues to be enough work to move our interventions upstream. A, if health is really our goal after all, and where we see a world that there are opportunities for everyone to reach their highest potential for health. That is the AHA's vision is of a just society of healthy communities where all individuals reach their highest potential for health, and we have a long way to go to achieve that goal.

Melissa Clarke: Well, I think that's an excellent note to end on, that very positive vision. I want to thank you, Joy Lewis, and you, Akin Demehin from the American Hospital Association for helping us understand how hospitals and health systems are working towards closing health equity gaps, how their roles are changing, the policies that are driving that, and the best practices that are happening as a result. So thank you to you and thank you to our audience. My name is Dr. Melissa Clarke and this has been 3M Inside Angle Podcast.