-Thank you all for joining us, for our Healthcare Workforce and Health Equity Inclusion Virtual Forum. We are excited to host this forum in collaboration with the Centers for Disease Control and Prevention Office of Health Equity.

My name is Iris Allen. I am with the Centers for Medicare and Medicaid Services, The Office of Minority Health. I am an African American woman and today I'm wearing a silver headband and a blue and white striped shirt dress. Next slide, please.

Before we start, we want to note that closed captioning and ASL interpretation are both available. To access closed captioning, go to the menu at the bottom of the screen and click on "captions." This will display another menu where you can select "show captions." Selecting show captions will allow closed captioning to appear at the bottom of the screen. And for everyone on the call, the ASL interpreter is spotlighted for you. Next slide, please.

On this slide, we have listed the agenda for today's session. Following this welcome, our new permanent Director for CMS OMH and CMS' new Chief Health Equity Officer, Dr. Martin Mendoza, will provide a brief overview of the CMS Framework for Health Equity, which lists five priority areas. Followed by a focus on the framework's property area three. He'll conclude with highlights on hospital equity. We will then move onto the CDC Office of Health Equity portion, with opening remarks from Dr. Jeffrey Hall, who serves as their Deputy Director. A guest presentation will follow from Dr. Joel Weissman, Chief Scientific Officer for The Center for Surgery and Public Health at Brigham and Women's Hospital of Harvard University and Ms. Joy Lewis, Senior Vice President of Health Equity Strategies and Executive Director of the Institute for Diversity and Health Equity with the American Hospital Association, to discuss their work on the Equity Officers National Study, an early look at the experiences, challenges, and opportunities of hospital equity officers. Prior to concluding today's forum, there will be time for a moderated Q&A session where we will take questions from attendees, using the Q&A feature. Next slide, please.

I will now turn it over to Dr. Mendoza to provide opening remarks.

-Thank you, Iris, and good afternoon, everyone. My name is Dr. Martin Mendoza and I'm very pleased to be here with you all today. So, I proudly serve as new Chief Health Equity Officer for CMS, and Director of the CMS Office of Minority Health. I am wearing a blue and gray, white checkered shirt, with a bluish/gray blazer. So, I've been really looking forward to today's event, an opportunity to discuss the importance of enhancing the health care workforce, the role of health equity and inclusion, and what CMS OMH is really doing to address these challenges. So next slide, please.

So, to start out, let's take a look at the CMS Framework for Health Equity. So, as you can see from this slide, the framework consists of five priority areas, which are listed on this slide and they touch on standardized data, causes of disparities, the capacity of health care organizations, language access, and accessibility. And specifically, CMS OMH uses these priorities to guide our work within the next ten years, to really guide a couple things.

One, to design and put into practice policies and programs that support the health of all people served by our programs. Two, remove avoidable differences and health outcomes experienced by people who are disadvantaged or underserved. And three, provide the care and support our enrollees need to live a long, healthy life. So, each priority is really meant to illustrate where we need to take action to both advance health equity and reduce health disparities. And so, if you're interested, and I know you are, more information about these priority areas can be found on the CMS OMH website, at go.cms.gov/omh. Can we move to the next slide, please?

So, for today's forum, we want to focus on priority three of the CMS Framework for Health Equity, which is build capacity of health care organizations and the workforce to reduce health and health care disparities. As we really work to address this challenge, I want to affirm that CMS OMH is firmly committed to building capacity among health care providers, plans and other organizations. We feel very strongly that it is so critical that these groups have both the tools and the resources they need to support the communities they serve in order to tackle health disparities.

So, to get more specific here, among the advancements made by CMS in this area, are the CMS Innovation Models and demonstrations, including efforts like the Accountable Health Communities Model. So, this model, what it does, is it addresses whether identifying and addressing the health-related social needs of Medicare and Medicaid enrollees, through screening, referral and community navigation services, whether that will impact health care costs and reduce health care utilization. The CMS OMH Minority Grant Program. And so, the purpose of the grant program is to support researchers at minority serving institutions, where investigating and addressing health care disparities affecting people from all minority populations. And finally, the Community Health Access and Rural Transformation Model. So, this middle supports CMS' efforts to see how health care can be transformed and delivered to communities that are underserved to reduce disparities. Let's go to the next slide please.

So, CMS works to embed health equity across all programs and policies.

And CMS OMH works with our colleagues in the Center for Clinical Standards and Quality, the Innovation Center and across the three M's as we say, Medicare, Medicaid and the Marketplace, to really focus on health equity. So, we'll put a link the chat to our CMS Health Equity facts sheet that shows more details on all the work happening.

You'll also see notes in the fact sheet about graduate medical education allocations to enhance the health care workforce in underserved areas. And I'm sure many of you are familiar with hospital reporting requirements for screening of SDOH, or as I'm sure you also know, Social Determinants of Health. These efforts allow the people we need to be in place to see where enrollees have disparities or unmet needs and be able react to them. It's really a piece of the larger health equity work at CMS, but it also adds into what many of our hospital systems are working on directly themselves.

Furthermore, we also did want to include a note on hospital health equity work, given today's presentation. So specifically, CMS OMH plays a very critical role in advancing health equity in hospitals, by focusing on addressing and reducing disparities and health care access, quality, and outcomes among minority and underserved populations. So, CMS OMH achieves this through several avenues, but primarily by the following. One, development of targeted policies Two, providing technical assistance. And three, enhancing data collection and analysis to pinpoint and reduce health inequities.

Here, pictured on this slide are examples of CMS OMH tools developed to advance hospital equity, including the Hospital Improvement Innovation Networks. And so, to provide just a little more detail here, these networks are specifically charged with collaborating with hospitals to implement best practices for harm reduction and improving health equity and reducing health care disparities. In addition, we also have the Mapping Medicare Disparities Tool, also known as the MMD tool, which helps identify geographic areas of disparities and informs policy development.

As I said about our priority area three of our framework, we want to support our health care professionals, the work of many of you and CHEOs, and whether whole equity offices or single individuals, are doing in our health systems to improve health equity is vital. And we are here at CMS and our colleagues at HHS, understand that and we really want to support and learn from you. I'm glad we had this opportunity here today, to have this conversation. And we can move to the next slide, please.

So now, let me turn it over please, to Dr. Jeffrey Hall; Deputy Director for CDC's Office of Health Equity.

-Thank you, sir. Good morning colleagues. I am Jeff Hall, I serve as the Acting Deputy Director of CDC's Office of Health Equity. I am a black male, with loc'd hair, wearing glasses and a gray sport coat. My pronouns are he, him and his. I'm pleased to have this opportunity to engage with you today. Next slide, please.

OHE ensures health equity, via an all-of-public health approach, to overcoming health disparities and inequities. We see this across various population groups that disproportionately experience poor health outcomes. We champion health equity to achieve a world where all have fair and just opportunities to attain, as well as retain, their highest health possible.

What does OHE do specifically to pursue our strategic health equity goals? I'll answer this specific question using CDC's CORE Health Equity Science and Intervention Strategy. Next slide, please.

CDC's CORE Health Equity Strategy, challenges our centers, institutes and our offices, to address health equity is a foundation of our work. The C in CORE, is for cultivating comprehensive health equity science. CDC is expanding our approach to science, by identifying multi-level drivers of health disparities and inequities, as well as by standardizing data elements. Ultimately, what we see is the best evidence-based research on advancing health equity. O is for optimizing interventions. Alongside health equity science, what we do is support development of new, as well as scale up existing, evidence-based intervention. Next, the R in CORE, is for reinforcing and expanding robust partnerships. We seek greater collaborations with partners to change systems, to implement strategies, as well as to shift practices to advance health equity. Lastly, E is for enhancing capacity and workforce management. Next slide, please.

How is it that CDC serves in a broader context? Here, I'll start by highlighting last year's virtual summit with Chief Health Equity Officers in Health Systems. The summit was a collaboration between the CMS Office of Minority Health and CDC's OHE. Adding focused empowered leadership through positions such as Chief Health Equity Officers, or CHEOs, is a key means to dedicate attention to health equity goals.

Given the potential for health system CHEOs to assist with designing, implementing and operationalizing policies and programs that support health and health equity, for all served by CMS programs, we hosted a two-day virtual CHEO Summit. The summit, in brief, identified equity challenges in health care delivery, examined policies and other factors, creating barriers, to equity. And lastly, identify strategies for advancing health equity in health systems. It included three sessions on day one, findings thus far from the Commonwealth Fund study, understanding the who, what, and the why of hospital equity officers. It included a session on value based or alternative payment models. And lastly, the third and final session

for day one, focused on social determinants of health, as well as having conversations about opportunity partners.

Day two entailed just two sessions. The first focused on measurement and accreditation opportunities, whereas the second was about intra-system capacity-building opportunities. The possible benefits flowing from the summit are numerous. They include amplification and further spread of promising practices for promoting health equity, improved understanding of what can be achieved through structural competence, in modifying the health care environment for greater health equity. And lastly, a benefit stemming from the summit includes creation of connections in social capital, that could support more effective, systemic action post-event. Next slide, please.

CDC's Office of Health Equity, has a strong commitment to the health and health care workforce. OHE is pleased to provide an opportunity to strengthen the health workforce, through learning opportunities about health equity, with the foundations of health equity training plan.

This self-directed, on-demand, online training plan aligns six domains and 31 competencies, with 13 suggested trainings. Training domains include, organization policy, infrastructure, communication, community engagement, structural and social determinants of health and, lastly, anti-racism.

Learners may earn a certificate of completion by completing one training within each of the six domains. OHE is currently developing multiple trainings that will be uploaded to the training plan fairly soon. The training plan is hosted on CDC Train. If you don't have a CDC Train account, then you may create one from the training plan page in CDC Train. There is no fee to register for an account and all the trainings in the training plan are absolutely free. Access to the foundations of health equity training plan, through the OHE website, is possible and also, as soon as I finish this part of the webinar today, I'll drop a link into the chat to provide you easy access. Next slide, please.

Lastly, OHE supports the CDC John R. Lewis Undergraduate Public Health Scholars Program, as well as the Dr. James A. Ferguson Emerging Infectious Diseases Graduate Fellowship. These programs provide internship and fellowship opportunities for qualified undergraduate and graduate students, to gain meaningful experiences in public health settings.

OHE is pleased to partner with the following institutions to deliver the Lewis Scholars Program. Columbia University, Kennedy Krieger Institute, Morehouse College, Southern Plains Tribal Health Board, University of California Los Angeles, University of Michigan and the University of Pittsburgh.

The Lewis Scholars program introduces undergraduate students to topics in minority health and within health equity, as well as supports their career development. Each institution delivers a program with specific focus areas within public health and minority health. OHE is pleased to partner with the Kennedy Krieger Institute to deliver the Ferguson Fellowship, with additional support from CDC's Rapid Response Research and Surveillance Branch and the Division of Infectious Disease Readiness and Innovation of CDC's National Center for Emerging and Zoonotic Infectious Diseases, or NCEZID.

The Dr. James A. Ferguson Emerging Infectious Diseases Research Initiatives for Student Enhancement Fellowship Program, supports public health research and professional development in infectious diseases and health disparities, focusing specifically on increasing knowledge and interest in public health research careers, among students from underrepresented population.

OHE hopes and aims for the Lewis and Ferguson programs supported and described today, to be pathways into other CDC fellowship programs, led by other CDC centers. So, ladies and gentlemen, I've reached the end of my remarks and my time for presentation today. On behalf of CDC's Office of Health Equity, I thank you for listening, for your participation in today's webinar and for this opportunity to connect. Most importantly, I thank you for who you are and for all you are doing for health care as well as for health equity. Next up is the presentation by our presenters. I'll now pass the virtual podium to Dr. Weissman and to Ms. Lewis.

- Advance the slide. Fantastic. And I want to just check that my co-presenter, Joy, you want to turn off -- can you speak?

-Sure, I'm here. Can you hear me?

-Oh good, great, yeah, that's perfect. Okay.

-Okay, good.

-Alright. Next slide. Alright, I am really honored to be able to present today. The Equity Officers National Study, or EONS as we call it. It's an early look at the experiences, challenges, and opportunities of hospital equity officers. Next slide.

This shows our team, it's a big team. I want to give a special shout out to Dr. Joe Betancourt, who is the new President of The Commonwealth Fund and a big supporter of this work, as well as everybody else on this slide, were critical in making this happen. Next slide.

The project is funded by The Commonwealth Fund, next slide.

And here's the agenda today. So, I'm going to talk a little bit about background and aims, then I'm going to first talk about the National Survey of US Hospital Equity Officers, and then turn it over to Joy, who's going to talk about the results of our qualitative interviews and our conclusions. Next slide.

Alright, so you know, most people on this call, I'm sure, are aware of DEI Officers, Diversity Equity Inclusion and Belonging as well. And in the past most hospitals have addressed DEI, by focusing really on their internal HR processes. Like hiring and compensation and other sort of compliance matters. But, you know, along with COVID and some other events that happened in the U.S. something else started happening at U.S. hospitals and that is, the emergence of the Chief Health Equity Officer. I guess you could think about it as being the E part of the DEI. The D and I are more about the internal culture of the hospital, the E is more about reducing health disparities about both patients, their own patients, but also about the surrounding community which makes it kind of unique because we have these persons in a private entity, sort of responsible for public health responsibilities in their surrounding community.

The position of Equity Officers has gotten super charged. You already heard from the CMS folks, that they've been holding CHEO events and CHEO trainings in the last year, but also there have been new standards from the joint commission, which now essentially require a Chief Health Equity Officer to be present and there's new attestation based structural equity measures from CMS. So, our goal was like, this is happening, nobody knows what's going on. So, we wanted to try to get a road map or an early experience to find out what was happening to make sure that these Equity Officers had success. We conducted a survey of Equity Officers in U.S. community hospitals. Next slide.

And this is what we did. We first looked at over 5,000 U.S. community hospitals. And normally, you know, you want to have a real list of your sample, but we didn't have that, so we sort of excluded hospitals that we were pretty sure did not have one and we were left with about 1,179 hospitals that we thought potentially had Equity Officers. We reached out to all those hospitals, and we got 363 survey respondents. From among those survey respondents, we wanted to find out really sort of what made things tick and so we did 26 in-depth interviews as well. Next slide.

Alright, so now to get into some of the findings. So, first of all, many of the Equity Officers had only been in the position a short time, 35.8% less than one year. I also want to point out that the majority of our respondents were actually white, non-Hispanic, 58.25%. Although this matches really the demographics of the country. And only 10% were Hispanic or Latino. Next slide.

A lot of Equity Officers exist only at the system level. When we first started doing this, I got a call almost immediately from a friend of mine, who was -- who is an Equity Officer at a fairly large hospital system and he said, "Joel," he said, "My folks at the individual hospital can't answer these questions. Sometimes the Equity Officer only exists at the system level." This is important to know. And so, in fact, in our results about 57% were the multi-hospital system level for all U.S. community hospitals, just about 68%. So, we were pretty well represented there.

But this is, you know, important for a couple of reasons. One is the fact that, you know, if these Equity Officers only exist at the system level, then we have to make sure that the joint commission understands that when they start requiring things at the individual hospital level. And second of all, because of the community work that they do, I think more needs to be known about what happens to these, you know, how well the Equity Officers at the system level function in the surrounding communities of their satellite hospitals. Next slide.

Alright, then the first thing is we asked, you know, "How were you perceived?" And in particular, "Are you getting the support you need from hospital leaders?" And the good news is that hospital leaders are really very supportive. You know, you can see that from the CEO, 84% were very supportive. A little bit less so among clinical and operational leaders. Our interviews suggested that maybe they feel a little bit more threatened by some of these activities and so maybe they're a little less supportive of these results. But generally, these are very good. The one caveat I'd say is that, you know, we got respondents from people interested in the study and we may have gotten responses that were just kind of overly glowing. But I think this is really good news. Next slide.

And here we find that we really wanted to know, well, you're thrown into this role, you're relatively new, how prepared do you feel to carry out your key tasks in your current position? And you can see the green is well prepared and then everything else in the blue is less than well prepared. And hopefully you want to see that everybody's well prepared for all their tasks. And in fact, you can see from this case that in most cases, in fact in all cases it's less than 100%, right? You'd like to see it 100% are well prepared. But they did very well with collaborating with clinical leaders in their hospitals, performing project management, gaining the trust of the community. They do less so at the bottom about changing the culture in their

hospital or health care community or developing health programs in their community. So, this is really part of our road map for how we think training should proceed in the future to address these key tasks. Next slide.

Now we also wanted to find out about the obstacles that they faced and so we said, "Thinking about efforts to improve health equity in your hospital or health system or in your surrounding community, how much of an obstacle are any of the following?" And the thing that pops out, I know that the previous speakers have talked about resources, the first thing that pops out is lack of a sufficient health equity staff. And if you think about all those key tasks on the slide before and about all the things that people need to do, both internal and external in the hospital, they certainly need support. And so, this is something that we should keep an eye on in the future. The other thing that Joy's going to talk about is lack of a standardized way to record social determinants of health data.

A lot of hospitals, almost all hospitals collect the data, but they don't necessarily know what to do with it. And then you can see that there are also some issues around racism that have popped up, structural policies that perpetuate racisms or racist beliefs, by individuals who are in the hospital or health system, which, by the way, can go both ways. It can be discrimination against patients and discrimination by patients against providers. And then somewhat resistance from the community. And I hope everybody has access to these slides and welcome questions later, because I know I'm kind of zooming through some of the data that we can get to the interview results soon. Next slide.

And then, my last data slide is about, you know, we said, "Alright, let's say you were building a health equity office from scratch, how important are each of these attributes to achieve your health equity goals?" And here are the things that a new Health Equity Officer really needs to pay attention to and the thing, right at the top, is a good working relationship with the surrounding community. Again, this is a new type of task for an individual hospital. I mean, there have always been community benefits, but this is really sort of on steroids and reaching out to the community and working with the community. Access to the health system's health equity data. So those are the top two things. So community and internal health equity data. And then stratifying the health system by priority populations. And you know, and then control over the equity budget also was critically or very important. Although interestingly enough, not as much as sort of the first two at the left of this slide. Next slide.

So, for that, I'm going to turn over the interview results to Joy, who's going to talk about those and give the conclusions of our study. Thank you.

-Thanks, Joel. And I'm going to zip through as well. I'm actually going to focus just on two things here, from the interviews. The challenges that the Health Equity Officers called out for us and then advice that they actually had for their care, so can we move to the next slide please?

So, the qualitative interviews, as Joel stated earlier, were really designed to examine and do a deeper dive, probe a little bit deeper on the survey questions and so we followed up with selected respondents. So, what you see here is the first challenge is where do we start in this work? The work is voluminous and so many of the interview respondents were, as Joel mentioned, new to their roles. Over a third had been in their Equity Officer roles for less than one year and so they reported simply not knowing where to start. Next slide, please.

So, another challenge that they called out was this notion of building internal capacity to do the work. How do you educate your teammates within a hospital or health system? And then also pivoting to the community and we know how important trust is in terms of engaging community members.

So, we saw discussion both around needing to educate internally and the importance of advancing the health equity work with the community and most importantly, I think, what we heard was that internally, teammates would be more engaged in the health equity agenda if they had a better understanding of the why. Next slide, please.

So, they also wondered, these health equity officers also wondered, how can we advocate for policies that actually, and processes, that promote health equity? So, there's a recognition that many existing policies and processes have been in place for a long time and maybe actually perpetuating harms, whether intentionally or unintentionally, and so, there was an acknowledgement that policies, organizational policies, needed to be taken a second look at. Really re-examined through a health equity lens. Next slide, please.

So, Joel called out this whole concern about data collection and how to do that, the challenges, there were quite a number of challenges highlighted regarding data collection in a systematic and standardized way. And we talk a lot about the imperative to know your organizational story from a data perspective and how to then use those data to drive improvements, how do you make, essentially, how do you make data actionable? But it first starts with collecting data in a way that is standardized and systematic. Next slide, please.

And once you have those data, then the question becomes, if it's not collected in a really robust fashion, how do you move forward in confidence with that data? How do you know that it's valid? How do you know that it's accurate? And I'm sure that audience is well aware of the need to really utilize data that is accurate, not observed data, person reported data, to identify the disparities that exist, so that one can then plan the interventions and apply the right dosage of those interventions, to really reap the outcomes that we're after. So, we currently have data systems that don't talk to each other. And so, there's just a lot of work that needs to be done in the data space. Next slide, please.

So, we went a little deeper with our respondents and wanted to look at a possible pathway that a hospital might be charged with pursuing, in this work. So, when you think about the social drivers of health and the screening requirements around that, both from CMS regs and from the joint commission, there are actually some built in challenges there. And so, you have a clinical team member who, a provider, who screens for some social drivers of health whether it's housing, stability or one's transportation needs, food insecurity, education level.

And the question is always, okay, now that I've screened someone and they've screened positive, now what? And we hear all too often from the provider community that they are sometimes hesitant to screen if, and in fact, they don't have a solution to offer a patient. What is the hand-off that's going to occur? And so, if we drop down to that second lever, where we see that, well maybe some hospitals have strong, effective partnerships in place with community organizations that address these social drivers of health. And so again, the clinical team member makes that referral, if they exist.

But then what we are learning when we drop down to the community organizational level, that third bucket there, is that in fact, sometimes these hand-offs strain the resources at the community level, at the community organizational level, and their ability to be responsive and to meet the needs of the patients and those referrals that are being sent to them. And, oh by the way, are they able to then close the loop on those referrals and get back to the provider to let the care team know what the outcome of that referral was.

So, as you can see, even when a hospital screens for social drivers of health, it takes many more steps to -- and each step has its own set of challenges for the patients to actually receive the help that they're after. Next slide, please.

So, let's pivot and talk a little bit about the advice, those were the challenges.

The advice, let's hear a little bit what our Equity Officers had to say. First up was to focus on an organization -- knowing one's own values and vision for the work and how does that then tether to the organizational mission? And so, really owning the narrative, owning the work, knowing the space you're in, being creative and innovative. Think about the goals both personally and professionally. That was a key -- or the first-up advice. Second, next slide, please.

The second piece of advice we heard was to be sure to gain the buy-in up front and the sponsorship and support that's needed to move the needle in this space, because we know that in order to gain the traction that these Health Equity Officers need to create the culture that's necessary to drive change, you really do need sponsorship from the highest levels of the organization, and I'm talking about from the board level, the CEO, the C-suite and really all the way up and down inside an organization. Next slide, please.

Another bit of advice was to not reinvent the wheel. Look at what other hospitals and health systems are doing. I know at the AHA, through the Institute for Diversity and Health Equity, we issue equity of care awards to our hospitals and health systems. These are annual recognitions of those who are really leading the change.

And so, in addition to recognizing the good work that many hospitals are doing in this space, it's a great opportunity to spread the learnings and to really inspire others to take action. So, that is certainly a key piece of advice, is to not feel like you have to start from scratch in this work, but really to beg, borrow, and steal from others. Next slide, please.

Building relationships and working together. This refers to relationships both with colleagues in the hospital, as well as in the community. And this goes much -- the work of equity we know, goes much farther when you're able to do it in partnership. When you're able to do it coalition-style. I can't think of any movement in this country or even globally, that's achieved the results that we now look back today as history, right? And we might celebrate some of those results, that wasn't really done in partnership with other like-minded stakeholders. So, hospitals should not feel like they have to go this alone. And frankly, in many instances, we should not be in the driver's seat. So really leaning into the value of effective partnerships, is what we're getting at here. Next slide, please.

The next piece of advice is to be the squeaky wheel or what I would say, I like to harken back to the late Congressman John Lewis' words to get into "good trouble". And so, Equity Officers should feel empowered to speak up. They're often tasked with concrete responsibilities, like data stratification and

some of the more mundane aspects of the role, program development. But really want to call out the role that they play in speaking up and calling out injustices as they see them happening around them. And that, I really love this quote, for me it's really this recognition that things don't change on their own. The status quo is comfortable, so we really do have to be disruptors in our own right. Next slide, please.
And finally, it's this notion of playing the long game, right? We talk about this work as being generational work. And so, it's great to celebrate the wins, but we got to get right back at it. And so, this Equity Officer summed it up really well, when they said, you know, "You have to stay committed, stay focused, because it is indeed a long journey, it's not a sprint." This is a marathon.And these inequities as we know, have a very long tail. Next slide, please.

So, I just want to call out some of the limitations of the study that Joel already referenced, one being the low response rate. We did our best to identify those hospitals using the AHA's annual survey, as well as our DEI benchmarking survey that -- to tell us which hospitals had these roles already established and in place.

The other thing is we focused on really descriptive information around the experiences that folks were having, the challenges, the barriers, and the facilitators to their work. And less so on this being an evaluation of their work, leading to, well, what are the actual outcomes? So, it's too early. We don't have any data yet on whether or not the presence of a Health Equity Officer makes a difference. So, that's important work that -- and we like to say, good research begets more research. So, I know Joel's wheels are already spinning around what's the next study that we need to do here? Next slide, please.

We can forge ahead, next slide.

So, our work really represents an early glimpse into the state of these roles, the Hospital Health Equity Officer roles. We saw proliferation of these roles over the past two to three years, so they're relatively new roles.

Can we go back one slide, please?

We know that many exist at the system level, which really does raise questions around the tie-in to communities, right? We know that collaboration is key and really needing to co-design.
I think that's a miss from prior attempts in this space, is to not really bring in the community and to share power with our community partners, in a way that's really intentional. We recognize that it's a mixed bag in

terms of what Equity Officers are being asked to do. And so, having some clear uniform strategies to really start with the data. We know that that's a necessary first step in this work.

But then the training opportunities that exist, to build out that bench within a hospital, so that everyone begins to see him or herself as an equity influencer. And then also the coaching, again, around building those sustainable relationships. When we talk about this work at the AHA, we think that, from a sustainability standpoint, the solution really lies in the policy space.

So, whether it's federal policy, state policy, organizational policies, that's how we're going to embed these principles into the work that we're doing to achieve the outcomes that we're after. So, with that, I think Joel and I will hand it back to our esteemed moderators here. Thank you.

-And you can progress one more slide. Okay, so thank you Dr. Mendoza, Dr. Hall, Dr. Weissman, and Ms. Lewis, for your remarks and presentation. This work is critically important to increasing hospitality equity within our health care system. We will use the time left to transition to our moderated question and answer period. We will try to answer as many questions as we can from attendees. Please utilize the Q&A feature to ask your question.

So, I'm going to pull that up now. And one of the questions I see was, "Did the role have to be specifically the Chief Health Equity Officer or someone that is doing the work? i.e. Director of Diversity and Health Equity?

-I can answer that one. So, as I mentioned at the onset, you know, there is no listing of these Health Equity Officers. As a matter of fact, this is something maybe that CMS could do, to sort of develop this list of the universe. But what we did was we focused on the function of the Health Equity Officer, not the title. We actually asked about titles, we got over 150 different titles. So, the short answer to your question is, you know, we asked, who's doing this work in reducing health disparities in the hospital and in the community or the most senior level person? And that's who we tried to survey and interview.

-Next, did you find that CDO's or HEO's have responsibility for community health, benefit within their systems as well?

-Joy, you want to take this one?

-So, to Joel's point, the roles are really still under construction and so it's a mixed bag, as I mentioned earlier, in terms of what folks are being asked to deliver on. So yes, I would say that leveraging the community health needs assessment, which is as you know is now a requirement post ACA, is certainly one of the data points for the Chief Health Equity Officers to then build out what the agenda is going to be, in terms of moving the needle for the patients and families and communities that they serve. So, there's certainly import from the community health space, from the pop health space, into the functions and duties of this role.

-Thank you. I know from previous webinars and roundtables, a lot of the interested parties that attend our OMH events are worried about things like sustainability, as well as different policy changes and how they impact the work that they do. And so, one of the questions we've received was, "Do we have any information about how whether these positions have changed with the advent of these anti-DEI, anti-woke state policies that have been passed recently?

-Oof, that's a loaded question. I would tell you that interestingly enough we had some Equity Officers that were in relatively, you know, more liberal-thinking states, also had pockets of resistance in those states. I mean, think Wisconsin, right? So, you think of that being northwest, I mean Midwest and very advanced, but no, they had a lot of communities where they, they ran into resistance as well. And yet there were other places where we heard anecdotally that people weren't even allowed to use the word "equity". So, I think this is, you know, from my perspective, you know it's kind of like, "Who's not here? Raise your hand." We don't know about some of those places that may not be as active as others, and I think it's an unanswered question that I think could use some more looking into. Joy, do you want to add?

-No, I think that's right. We're certainly seeing more and more, you know, the political environment having an impact on the work that these folks are charged to lead. At the AHA we meet with our health equity leads at each of the states. So, we have a group of state hospital association health equity champions, and this is the number one topic, every month that we meet with them is, you know, the anti-DEI pushback, legislators across the country that are introducing legislation that would stifle or bridle their ability to even speak some of these works, but certainly do the work. Funding being withdrawn. So, this isn't going to go away. I do recall, you know, Joel, in the research, at least a few of our Equity Officers talking about their region's history, right? And doing really some self-reflection and I think that's what we're calling our hospitals and health systems to really do is that self-interrogation and self-reflection, to understand what their own history is in the communities that they're now serving. And is there an opportunity to engage in some work to really repair some of those relationships that might have gone sideways based on, whether historical or current context. So, this is ongoing work, I would say.

-And you know, I mean, the more I think about it, this is really an important issue and our research was done, you know, a year ago. And since then, I think it's really important for these positions not to be painted with that broad brush of DEI that's going on at universities, for example. I mean, this is different stuff, this is about health care disparities. This is about relationships with the community. I mean, there is overlap with the D and the I part, but it's a different environment now and I guess we have to do some more thinking about what that means for the positions, what they're called, what their functions and roles are.

-Okay, we will take a few more questions, because we have about four minutes left. Okay.So, it would be helpful to know what organizations who have been working on hospital and health system policies and processes that create the disparities, it would be nice to know what those policies and processes are that create the disparities and have those examples so that they could look within their own systems.Can Joy or Dr. Weissman, can you speak on any resources where someone could go to find those examples?

-So, we actually have a Health Equity Action library at the AHA, it is opensource, not a member benefit. So, I would encourage you -- and it is organized around our six levers of transformation, that exist in our Health Equity Transformation Model. And one of the levers is around equitable and inclusive organizational policies. And so, if you went to that lever and looked at the resources associated with how do you -- I mean it could be something as simple as, how do you create an organizational strat plan that has equity embedded in it? What does that look like? Right? And so, the tools and resources you'll find at the library are curated, vetted resources, that are really how-to guides. It's not the bright, shiny, "Oh, we've arrived, here is -- you know, case studies." It's really, how do you do this work? How do you create the outcome that you're after? What are those steps you can take? I mean, HR tends to be a common usual space. Again, more internal focused, not equity necessarily. But when I think about barriers to entry into the workforce for Black and Brown individuals that, you know, health care's a highly credentialed field. And so that is one space that I know a lot of our members are looking at their hiring policies and whether or not they're creating barriers to entry for -- because the requirements are just so onerous. And so that's certainly one place to start. But I would encourage folks to go access our library.

-And the final question we're going to take is, "one of the most common basic determinants for all socioeconomic growth groups is poverty. Poverty impacts every group that we are discussing. Would it be best to target poverty as a primary social determinant in order to make the most impact for goals?"

-I can start. I think, you know, the health care system can't solve poverty in the United States. And what I've learned in 40 years of doing this is that it's not necessarily the sort of the broad characteristics of the patient, it's specific kinds of interactions that they have with the health care system. What are their transportation challenges? What their language challenge is? What's their home situation like? And those can exist people in poverty or people not in poverty, those changes exist about the social determinants that might impact health. So, I think, you know, we can't boil the ocean, but we can impact some of the really important factors that led directly to some of these disparities that we're seeing.

-Yeah, and I'll just pile on. I think the questioner is really calling out some of those historical underpinnings that, you know, structures that -- systems that were intentionally created to disenfranchise some segments, some members of our society and that were sustained for hundreds of years. So, health care is not exempt. We're not immune to the impacts of those, you know, long-standing policies. And so, in order to really turn the tide, we're going to have to disrupt ourselves. And again, as a broader society, thinking about whether it's housing policy or in the finance field. All of those barriers that have been the system as Don Berwick said, is delivering the results it's designed to deliver.

So, we're going to have to dismantle some of those stuff and erect more just policies, if we want to see a just society where everyone has the opportunity to achieve their and pursue their health goals. So, I agree with Joel's point around, really looking also at the person in their broader environment and recognizing that, I like to talk to my team about, no one raises their hand at any point and says, "I want to be a patient". We don't do that. We find ourselves occupying that seat as a patient. And so, where else? What are the other attributes and assets that one brings to that care encounter that can be leveraged and tapped into? And how does a provider in the care team really think about the individual in front of them in that broader context? And then if you want to go further, think about the communities, rights? And then again, one concentric circle further out is thinking about these challenges at the societal level. So, these are big issues, big -- and challenges that have really existed for a long time. So, this is generational work, as we said earlier. We're not going to turn the tide overnight. But we have to be persistent and stay the course.

-So as we wrap up, I just want everyone to know that today's presentation and recording will be available on the CMS OMH website and please feel free to connect with us throughout different channels. We have several mailboxes listed on the slide here, with the main being OMH@cms.hhs.gov.

We encourage you to visit our website at go.cms.gov/omh and sign up for our listservs, so that you can stay up –to date on all our health equity related initiatives. Next slide, please.

Thank you all for joining us today. Sorry we ran like two minutes over, but I hope you all have a great afternoon and I hope that you found the information useful. And please sign up for the listserv so that you can become aware of other opportunities for us to engage. Thank you.