Solutions, success factors, & common mistakes. Round table.
(Systemic Bias & Systemic Racism in Healthcare 4/4)

Our guests are health equity practitioners Christin Zollicoffer and Dr. Bonnie Simpson Mason, who discuss programs and initiatives that are making headway in dismantling structural racism with episode host Claudia Zamora.

Together they explore a number of different examples and critical success factors that contribute to success – and mention some common mistakes that organizations may make when establishing initiatives.

This is the fourth and final episode in our mini-series focused on systemic bias and systemic racism, and we end with constructive forward steps and an optimistic outlook.

Christin Zollicoffer is Chief Belonging and Equity Officer at Lifespan Health System.

Dr. Bonnie Simpson Mason is the inaugural Medical Director of Diversity, Equity, and Inclusion at the American College of Surgeons.

Claudia Zamora is a consultant who serves on the Board of Directors for the National Hispanic Medical Association and the Board of Directors for Movement is Life.

0:01 Excepts | 2:30 Introductions | 5:30 Dr. Simpson Mason shares solution examples | 6:30 Different levels of experiencing oppression | 7:20 Increasing access via Nth Dimensions pathway programs | 9:30 Equity Matters ACGME | 10:45 Medical specialty societies education & communication | 11:45 Christin Zollicoffer shares solution examples | 12:15 Four levels of racism: internalized, interpersonal, institutional, structural | 12:15 Baking in DEI for patients & employees | 15:00 Employee resource groups role | 15:30 Workforce education and skills building | 16:30 Integration of equity practices | 20:15 Community based program Operation Change | 24:00 Importance of trauma informed lens | 29:00 Equity as the 6th domain of care (IOM) | 31:30 Addressing data collection to support equity | 34:00 Claudia Zamora shares examples including NHMA programs | 37:30 Critical success factors for programs e.g. change management & working with the “moveable middle” | 40:10 Definition of equity | 42:15 Common mistakes e.g. tokenism & placing DEI under HR | 46:00 Speaking the language of health equity | 49:00 Are things changing?

Full Transcript:

Claudia: You are listening to the Health Disparities Podcast. I am Claudia Zamora, your host for today's episode. I am the founder and CEO of Zamora Consulting Group. We provide healthcare and higher education and consulting services. I am also a

health equity advocate. I serve on the board of directors for the National Hispanic Medical Association and the board of directors for Movement Is Life.

This is the fourth and final episode in this miniseries of the Health Disparities podcast, in which we have been exploring the mechanisms of bias in medicine and decoding structural and systemic racism in healthcare. In today's episode, we'll be discussing some of the ways that health equity initiatives are helping to dismantle systemic bias and racism. These processes of systemic bias and racism are deeply embedded both within our health systems and as a major component of the social determinants of health. Because of this healthcare, public health and population health, policymakers are placing increasing emphasis on the importance of interdisciplinary solutions across healthcare that are designed to foster intergenerational change, and I am looking forward to discussing some examples with my guests today.

Firstly, I am so pleased to welcome back to the podcast Christin Zollicoffer. Christin is the Chief Belonging and Equity Officer at Lifespan Health System and has been involved with Movement Is Life for many years, including with the Movement Is Life community program, known as Operation Change. Welcome, Christin.

Christin: Thank you, Claudia. It's a pleasure to be here.

Claudia: I am also delighted to have with us today, Dr. Bonnie Simpson Mason. Dr. Simpson Mason has had a long association with Movement Is Life. She's the founder of Nth Dimensions, a former VP of DEI for the Accreditation Council for Graduate Medical Education, and she now serves as the inaugural Medical Director of Diversity, Equity, and Inclusion at the American College of Surgeons, where she leads the development and implementation of proactive anti-racism, diversity, equity, and inclusion initiative. Welcome, Dr. Bonnie Simpson Mason.

Dr. Simpson Mason: Thank you so much. Really, really happy to be here with everyone.

Claudia: And so, we are here to discuss solutions, how we're moving forward in terms of ending the systemic bias and systemic racism, not in theory, but in actual practice. Dr. Simpson Mason, can we start by asking you to talk about some of the ways that programs that you have been involved with in the past are steering in this direction?

Dr. Simpson Mason: Well, thank you so much. Of course, the scope of this problem is huge and historical nature. We know that the structures and systems that have supported racism and other forms of oppression have existed for hundreds of years. When it comes to thinking about solutions and the systems that have been in place and that are now in place to address them. We think in terms of really

addressing some levels of accountability for addressing issues of racism, sexism, and other forms of oppression. I like to think about it in terms of what's happening at a leadership level or leadership or governance level in medicine. I think about it in terms of what's happening at an institutional level, workforce level, and even at a patient care level. That's how I've been able to categorize the breadth of the issue to help it make sense for me. So, when it came to the early part of my career as an orthopedic surgeon transitioning out of clinical medicine due to an illness, I knew that it would be really important to make sure that we could address the inequities in healthcare by increasing access. And one way to increase access to care is to increase the numbers of physicians, and particularly in my case, orthopedic surgeons who were from minoritized backgrounds, helping them find their way into these highly competitive fields. So, Nth dimensions over the past 20 years now has become the premier formerly use the term pipeline program. Now, we use the word pathway program to help usher those from minoritized backgrounds, including from racial ethnic populations that are diverse as well as women into orthopedics. That work has been found to be extremely impactful over time. 30% of the graduates from the Inventions Pathway Program have national orthopedics as women. That's significant because 5% of practicing orthopedic surgeons are women, and so Nth dimensions has been able to 6x that number. And then also too, out of the 130 scholars from Nth dimensions that are now either in orthopedic surgery residency or are in practice, 80 of those 130 are African American. Also, significant because overall, only 1.5% of practicing orthopedic surgeons are African American. That equates to about 375 physicians who are African American in practice and Nth Dimensions is now contributing 80 to that number. So over time, we found that these pathway programs, which provide a longitudinal developmental pathway of support by way of mentoring, education, resources, and networking have found to be impactful at that workforce level of addressing inequities in healthcare. And then we can look at, I think Christin is going to address some of the institutional approaches that she's been instrumental in leading, but also from an institutional and maybe even leadership approach. Some of our accrediting bodies such as the ACGME where I worked previously, has developed a national GME educational platform called Equity Matters that I was truly honored to innovate and develop as a vice president there. And that work has now allowed a breadth of understanding and education to be digested across the spectrum of at least graduate medical education across the country. As the accreditor that's a big deal. It's the institution that accredits all residency training programs and institutions. So, for that organization to bring forth just a really comprehensive platform in order to educate our faculty and trainees in this space in order to address more equitable care, it's huge. It's huge.

And then also, and I'll just wrap up, medical specialty societies such as where I am now at the ACS, but also those who are under the umbrella of the Council for Medical Specialty Societies led by Dr. Helen Burstin, who is the current CEO.

Many of our medical specialty societies are proactively addressing issues regarding diversity, equity, inclusion, antiracism, anti-oppression with the basis of that understanding and increased knowledge base as to how to, number one, boldly acknowledge that structural racism is in fact not just a problem, but one that has to be addressed with action. As our colleague, Dr. Sunny Nakae says, we're tired of admiring the problem, but we know that these groups are galvanizing through education and communication their members across the spectrum of specialties to address the different impacts of structural racism across the board for those at the workforce level, but also and most importantly, their patients.

Claudia: Thank you, Dr. Simpson Mason. Now, Christin, could you answer the same question regarding ways that Lifespan Health System is addressing systemic bias and systemic racism?

Christin: I would just want to applaud Dr. Mason because the programs have done amazing work in pathway programs and just looking at her impact over the course of her career across industries, really impacting the physician space. So, phenomenal work, strong work as the surgeons say right? I'll speak to what we're doing at the institutional level, right, because there are four levels of racism, and those four levels, just to reiterate, and Dr. Mason spoke to these as well, is the internalized racism at the individual level, there's interpersonal racism that occurs between individuals. Then there's institutional racism that occurs within institutions and systems of power, and then there's structural racism, which is amongst institutions, between institutions and across society. So, it's helpful to know that there's four levels. A lot of folks, when they use the word racism, we really don't isolate those, and it occurs at every single level. So, I'll speak to an institutional level because we operate as a health system. We have multiple hospitals, most academic medical centers do have multiple locations, and just the same, we have community locations too. So, the image that I use for our work is a cake. So, before you bake the cake, you have the ingredients off to the side. You have your eggs, your sugar, your vanilla, your flour. But once you mix everything together and then you bake it, when you take a slice of it, you can't identify and separate out those individual ingredients. So, the cake represents diversity, equity, and inclusion at its best excellence where you can't parse it out, it's baked into the system. So, when I think of being baked in, my role is responsible for both the patient experience as well as our employee experience. So, when I think of system work, I think of both groups for all of our employees and usually at the health system, that's what you're thinking about. So, we have about 18,000 folks, and that's physicians, nurses, frontline, staff registration, literally our backend support when it comes to IS or IT and resources. So, when I think about that, we do our work in a few different categories and buckets, and we look at data, how clean is our data, how consistent is our data collection processes? And that's for collecting across race, ethnicity, and language

including sexual orientation, gender identity, disability status, veteran status, and gender. We also look at our community presence. How are we connecting and using equity practices to give us information, whether that's through a unified patient family advisory council, are we looking at community organizations such as employee resource groups internally where we're asking for folks who are impacted by our policies to give us information back, yes, we're doing a good job, no, we are not. But even before it becomes policy, we want to ask their opinion because if you're going to be impacted by the policy, you should have some say in how it reads and how it lands. That's a strong equity practice. And then we also look at how are we educating our workforce, skills building, and that has a variety of layers, right? We're looking at our recruitment and retention. How do we partner with organizations, the departments, I'm sorry, across our health system, whether it's compliance, policy, marketing, legal, right, our language interpreter services, our food nutrition services, how are we partnering with each one of those departments to embed and bake in diversity, equity and inclusion principles so that our employees and our patients not only feel safe, but are also we're creating health and we're creating care, delivering care. And then I would also say the last component is once again, creating that environment that's safe and healthy.

Dr. Simpson Mason: Claudia, could I weigh in just on a couple of commonalities that Christin shared that ring true to much of the work to address structural racism, even at institutional and association systemic levels, which we really love? What we're finding across this body of equity practitioners, so both Christin and myself consider ourselves to be equity practitioners in this space to address racism and all the forms of oppression is this concept of the integration, integration of our equitable practices such that, I love that analogy, Christin, that it becomes baked into what we do as opposed to being a set aside, an addition or a supplemental aspect of the work. It just becomes part of the fabric of who we are, how we conduct ourselves, and hopefully it becomes integrated into the culture such that it becomes part of the water we're breathing in. So, whereas this air and atmosphere of racism that has been part of the dominant culture for so long becomes infiltrated with equity practices that then our environments, which is the ultimate goal, then become inclusive. They become places where people from all backgrounds feel like they belong, where people are empowered to, number one, recognize and then mitigate the manifestations of any form of oppression, including racism, sexism, any type of discrimination, mistreatment or harassment because in that space, especially if we're talking in healthcare, whether you are teaching, whether you are providing care, you are in a space where you feel like you could show up authentically, where you can be yourself, where you feel like you belong to your point, right, Christin, so that then I can be my best self in this space and then my best self as a healthcare provider, physician, staff person, faculty, environmental services person, this allows me to deliver the best and most excellent care to every patient that I come in contact with. That's how we

overall hope that this work will begin to stem the inequities in the delivery and access to care and ultimately decrease the disparities that are the outcomes of hundreds of years of inequitable care, delivery and access. So, kind of like that overall overarching approach is just something that we're seeing across the board. And so, if anyone's organization is not highly invested in making sure that they are providing the resources, the finances, the strategic plan, putting that in place such that this becomes an integral part of what any organization is doing, that's the starting point. That's where we have to have leadership and governance buy-in and accountability because it's going to take that type of long-term human and financial investment to implement those practices, to create these environments such that everyone from all backgrounds can show up and perform authentically and deliver that excellent level of care that stem the disparities that are the result of the inequities over time. I know I probably repeated myself, but I get all charged up, right, Christin?

Christin: That's right. It's okay. Get charged up. We like the charged-up conversation. It's okay. And to say that when folks are listening to this, she mentioned the water, and there's a phenomenal, the groundwater theory, by all means, go ahead and look that up as a little bit of your homework. It'll give you some backstory to this. And I know we were talking about programs. Oh, there's so many programs within hospital systems. I will talk about Operation Change. Operation change is a little bit different. And that was really sponsored by Movement Is Life phenomenal, phenomenal program, community based. I was integral to our Chicago location. And let me just tell you, Operation Change was powerful. It was meant to target and attract women only who were 45 years and older in specific demographic groups. So, there's one specific to African American women, one that's specific to our Hispanic, Latinx women and another for our rural women. And what it did was it invited folks directly from the community. And so, I know we had probably 75 folks every summer for 18 weeks and for 18 weeks every single weekend, it was a grind y’all, every single weekend for three hours from 9:00 AM to noon, we had the first hour, which we would bring subject matter experts in, and the second hour we would move and then the third hour we would have motivational interviewing. I'll go into a little bit of detail for each one of those hours. So, for the first hour, for subject matter expertise experts, we would have every single week, whether there's financial literacy, your local pharmacist, and how are you talking to look at all, we would have a pharmacist come in and look at everyone's meds to see if there are any counter indications. We would have someone who would talk about how to eat differently. We would have someone who talked about Medicare plans in time for enrollment to prepare them. We would have folks who were talking about behavioral health and suicidal ideation or self-care. What does it look like? And I tell you, these women, phenomenal women, we're looking at literacy rates. Some of them may have had a third-grade education, they may even have a PhD, but we're all in one space. They've all either had children, lost children, or were in relationships single now

alone and I would tell you the commonality from these folks was that they needed community. They wanted to feel supported. I tell you, I get emotional, and Dr. Mason knows I'm a sap on the inside. So, if I get choked up, it's okay. But I tell you sometimes on that Saturday, when we would hug them, that would be the only time someone touched them all week. And you can't underestimate the power of a hug and human connection because we talk about trauma-informed responses that is so key and critical to doing this work. The answer to every single trauma-informed response is human connection. So, I'll leave that there because I know I…

Dr. Simpson Mason: No, I'd love that because I had the pleasure of was the first, probably first few years of Operation Change there in Chicago. I had the honor of delivering some of those first hour lectures just about self-care, about the importance of communicating with your physician. I remember one time we were in the basement of the local church and that was where the meetings were being held. So, we would do the first hour of lecture and then we would exercise and then commune afterwards. And you are absolutely right. I mean, those women made me feel loved as a part of that community. And I was there to give, and I certainly turned out receiving more than I gave in that space. But then to watch them over time reap the actual benefits and to know, to your point, Christin, just the absolute power of community, necessity of community, how isolation is like kryptonite when we're trying to manifest, move, change and actual transformation in the space. I mean, I think the formula that Operation Change has built, developed and proven is the formula for change. If you're going to ask me, I mean my husband came to lecture, colleagues, yourself and others, it takes that multidisciplinary, multi-level, longitudinal approach, but it can happen. And I think that's what they saw in each other, to your point, the vulnerabilities, but also it became an empowering experience, empowering, reinforcing, and positivity always emerged from that environment. And then they knew they could do it, and they knew they weren't alone. So, then it felt like a we, and not just a me or an I.

Christin: That's the truth.

Dr. Simpson Mason: And I've found that in all of the work in at any level between education and communication, that's how transformation takes place in this space. Like you said, through that trauma-informed lens and putting those two things together along with that longitudinal support, I think those are the critical keys. So, if you're going to change, move change at the community base level for patients outside of the traditional healthcare model, integrating and innovating the way Operation Change has, I think is critical.

Christin: Oh, it is completely critical. And the secret sauce was that you would have motivational interviewers and subject matter experts and folks who would come in and help you move a Zumba dance or aerobics instructor, yoga instructor.

They all looked and talked like they used the same language, the same dialect, the same dialogue. They knew your language. So, you had folks who looked like you race concordance, cultural concordance, language concordance, and you're meeting them where they are and you're providing information. And I think also this was a brilliant decision by Verona Brewton to design this course because women uplift communities. We're the ones who will nurture. We are the ones who will share. We are the ones, and I can tell you so many women were inspired to join a group, create a group, a support group, whether it was over knitting or cooking or going out or going to dance or doing yoga. What stemmed from Operation Change was information. So, you got them moving, but you also informed them and empowered them, and that was brilliant.

Dr. Simpson Mason: Brilliant. But women are the change agents before change agents were like a thing.

Claudia: Is there another program that you would mention that is having an impact and can you tell us why it's important?

Dr. Simpson Mason: Yeah, I think we can look at impacts from any number of levels and look at any number of communities that are involved. We have, we look at our Hispanic population, we have the National Hispanic Medical Association, we have the Latino Medical Student Association. We have Ben Gap that was founded and led by a good friend, John P. Sanchez, that has been working to increase the numbers of folks from diverse populations who stay in academic medicine to become the mentors, to encourage, influence and educate the next generation of medical students from diverse backgrounds. I mean, we have these organizations, I'll say, that have been doing this work for years. Right before DEI was a thing, before we were talking about anti-racism nationally or globally, this work has been going on for decades. And I'll even state that even two decades ago, the national, I think it was the Institute of Medicine at that point had even identified equity as being the sixth domain of delivering quality and safe care. So, they said, if you're not addressing equity in your policies or practices and healthcare delivery, you're not fully delivering quality and safe care. So, I think that's kind of one of the ways that people have been picking up on to say, listen, it's not new. It's not about a whole new ideology around being woke. It's not new. It's been around for decades and really just coming to the forefront. And then as we see folks, when we were talking about our Hispanic population, like the Latino Surgical Society, the American Association of Latino Orthopedic Surgeons, and I'm sure that there's a full scope of work and solutions in this space. We see them being identity-based. We see them being based on different cultural aspects, meaning the solutions being based on different cultural aspects by these organizations, which I'm really happy to say we are now doing way more collaborating than we may have done in the past. We recognize that we're better together. We are being able to, particularly in my current organization,

we're bringing different groups within the House of Surgery together to collaborate on best practices. Who's been doing work at the Pathway program level, who's been doing work at the residency medical education level in terms of building curriculum, who's been doing faculty development and leadership training when it comes to DEI and anti-racism. By convening all of these folks who have been conducting data-driven, research-based approaches, we hope soon to be able to impact the healthcare workforce in a way that continues to support their efforts and be able to move those work forward and integrating all of these efforts across the House of Surgery, but also the House of Medicine as well. I will also pick up on one last component. Christin, I think you mentioned this early on, and that was how your institution is addressing data. One important aspect that we found to be a commonality across associations, institutions, programs, and educational organizations hinges on the issue of data equity. We've not achieved that yet. We found that our institutions many times collect data in a disparate fashion. We're not collecting the same data even on the same populations and cohorts of not just patients, but when it comes to our workforce. So, there have been some efforts at the highest levels of the American Medical Association, the ACGME, as well as the AAMC to align and start to agree on some data equity efforts such that we can build a research infrastructure which is reflective of sound data collection practices such that that data can be analyzed more efficiently and with greater impact on the backend. We know that that has to happen at the patient level as well. That's been a huge kind of opportunity that has been recognized and is now being, I'll just say, reconciled across some of these major organizations that influence medical education and healthcare across the country. Without that, you can't change what you don't measure. So, if we don't have clean data in, you're not going to get clean data or conclusions out. So that's why the push towards data equity, including de-aggregation of many of our racial ethnic groups is really, really important. And the inclusion of other identity-based identifiers is also really important to add in. So, in addition to having these efforts as an integral part of your institutional organizational structure, achieving data equity or addressing the lack thereof in your particular arena is critically important.

Claudia: Thank you, Dr. Simpson Mason, these are all great examples of leadership in health equity. And actually, I was literally just thinking about what you said about how you worked in ACGME graduate medical education. In my work in consulting, I actually help accredit new allopathic medical schools. And one of the things I've seen, the first medical school that I worked on was Herbert Guam College of Medicine in Miami in 2007. Back in 2007, we were talking about how there was only 5% of Hispanic physicians in the US. Now we're in 2023, and I think the needle has moved maybe 1.5%. So, it's like we think we're progressing, but not really. So, one of the things that I thought was great that the LCME, Liaison Committee of Medical Education did was they reevaluated their standards. And one of them being diversity and saying, whoever you are

targeting as your matriculants, they also need to be reflected in the dean's suite, the faculty, how many number of faculty, the diversity has to be there. And that is great that the new medical schools are able to do that, where what I saw in some existing schools, because they've already been established, they were not compliant with that particular diversity standard. So, all of them had to then kind of regroup and say, how we're going to meet this standard to make sure we are really encompassing everything that we're saying. So, when you said about that, I thought, well, it's really, we all have the common goal of that's what we need to do in order to get a diverse healthcare workforce. In addition, I want to mention you did mention the National Hispanic Medical Association that the other board that I sit on, and their main mission is to empower Hispanic physicians to lead efforts to improve health of Hispanics and other underserved populations. And one of the things that we keep coming on is research keeps showing that health outcomes are driven by an array of factors including social, economic, environmental factors, significant racial and ethnic disparities that exist in Hispanic populations and other underserved populations. So, one of the things that NHMA does is we collaborate with Hispanic health, state medical societies, residents, medical students, and other public and private sector partners to help reduce the health equity act by tackling social determinants of health. And one of the ways, just an example that we do that is NHMA has 18 chapters across the us. So, each year we bring in health experts to educate congressional staff nationals and local stakeholders on policies and programs that can actually improve the health of our communities. And every year during an annual conference, we actually go to the Hill. We meet with Senate, we meet with the Congress to discuss the most pressing issues concerning our communities, not just Hispanics, but all underserved communities. And also, we're trying to increase scholarships to get more minorities in the healthcare workforce in order to help develop the next generation of culturally competent physicians, which seems to be what is missing in tackling this health equity app. So, I wanted to just give some examples how NHMA is working to tackle structural and systemic racism in healthcare. Now, I'm really interested to hear from both of you about what makes initiatives work. What are some critical success factors for initiatives aimed at ending systemic racism that you always include in the planning process?

Christin: So, immediately what comes to mind is change management. This is change management. And when you're looking at change management, you're looking at planning intentional communication and understanding your resistance. A lot of folks expect that when you're doing this work that you need everyone at the table, but I can tell you, and they're worried about those who are detractors or those who are on the extreme ends of being open-minded or being rigid, but there's that movable middle that is most powerful, and that movable middle is about 60 percent technically in general. And so, you're looking to influence them, educate them, and empower them to be able to make the change. You have to

bring them to the table. So, there's a level of collaboration that you always want to be able to increase. So, to me, it's two key components, change management and collaboration.

Dr. Simpson Mason: I agree wholeheartedly. When it comes to the change management piece, I encourage many of the physicians and executives that I had the pleasure of engaging with on the subject with routinely is that this is a process. So, change management requires time, and we let people know that this is a marathon, not a sprint. And that I highlight and have identified what I call the steps behind the science of DEI and anti-racism steps, which starts with making sure that we understand the scope of the problem within one's immediate community or environment. So really performing a needs assessment. Then you can build out or utilize some of the educational tools that have been put in place such as equity matters and the work, we're doing in the House of Surgery to address the fundamentals of DEI. Because having people understand the definition of equity, we like the definition of equity promoted by Dr. Kamara Jones, who is also a friend of Movement Is Life that achieving equity requires that we value all persons and populations equally, that we recognize and rectify historic and current injustices, and that we also provide resources according to need. And I add without judgment, that helps people understand why they're in the room. This problem can't be solved by just those who are from diverse or minoritized backgrounds. This has to be a solution set of solutions driven by everyone, but we have to let everyone know why they are part of the solution. Then we have to provide skills and training opportunities such that people can do this work, implement equity, build and implement equity practices in a way that's trauma-informed, meaning we don't cause more harm, although we intend to do good. So, we have to take this trauma aware and trauma-informed approach to building skills in order to do the work. And then we get to actually do the work, right? We put the steps towards change management in place through our programs, our efforts, our practices, and then we get to take a look back at it to see how we did. Evaluate and assess did we move the needle or not? Was that effective or not? If not, why not? And then we make some adjustments. We call it an equity morbidity and mortality review, an M&M, where we take a look back and see what we did. So, it's not just a one time, one touch approach. All of the programs, the work that Christin has been doing at the institutional level, the work of in dimensions, even equity matters and the work we're doing at the college, it's all longitudinally based. Operation Change over time. It is change management over time. And so, I don't know that we're going to solve it, but I know that we could effectively address it one step at a time. But that requires that people employ a level of patience and commitment in this space such that we can actually recognize the transformation which we hope will ultimately occur.

Claudia: And what are some of the common mistakes that initiatives make, however well-intentioned they are that our listeners can bear in mind.

Christin: You know what I would say? One of the common mistakes would be that they expect, and it's one of the dominant culture notes, tokenism. You're expecting those who represent a minoritized group to give you all the answers. And what that doesn't do is, one, it doesn't hold the majority accountable for doing their own learning. It puts an extra tax on those who are tokenized, and it absolves folks of their own responsibility. What I've learned at the institutional level is that most folks have the best of intentions, and they want to do this work, but our educational system in this country doesn't teach you how to share. It doesn't give you the truth. It doesn't tell you what you don't know. So, a lot of times when we present information in the skills building and we give them historical context, it is new information to them, and they are wowed. But not only is it new information, they don't have the tools to then understand how to mitigate and educate and rebuild. So, I spend a good amount of my time coaching folks and empowering them and giving them tools to teach them how to do the work. They don't know how to do the work. If we come from a minoritized group, we know it feels good. We know it feels good to be included. We know that if you have more people like us at the table, it's a better conversation. It feels great. There's some comradery, right? That's why you see affinity groups. But if you come from a space where you see yourself all the time, you really don't know how another person feels. So, when I think about this work, a common mistake would be one that you don't put folks at the table and hold them accountable, whether they're majority or in positions of power, it's accountability. So, once you set expectations, then how do you hold them accountable? So, if they didn't know you teach them, but then you hold them accountable. And then, when I also think about skills building, you bring other folks into this work. I would say a common mistake would be twofold for new institutions doing this work, they will place belonging equity or DEI work under HR. That's a huge rookie error, rookie mistake. And then they will focus it just on recruitment and retention. That is one sliver of how equity shows up within healthcare. One sliver, it does need work, but you have to hold those folks accountable who do the work in every single day. I call that the distributive method. So, when you are empowering folks in their scope of work to then become subject matter experts to move DEI forward, that's how you get accelerated growth. So, someone in compliance, someone in HR, someone in talent acquisition, someone in food nutrition services, someone in marketing, you skill them up and empower them. Go to their national professional resources and skill them up. How do you do DEI? How do you embed it in your scope of work? Our legal team, our everyone plays a part in doing this work. And if you don't teach them and empower them, they will think that they are absolved of their responsibility.

Dr. Simpson Mason: I mean, I just totally agree with everything you said, Christin. I mean, it is not and can't be on the shoulders of the people who are from the minoritized group. And just to make a point of clarification, here, we are using the word

minoritized because someone is not a minority. So that is not who a person is. They are part of a group that has been marginalized, that has been set on the margins, that has been deemed a minority, right? So, there is an action that has been placed on a particular group that has made them minoritized. But I am not a minority. I am a whole human being who belongs to a group. I identify as a woman and as a black woman. So, I am part of minoritized groups as it relates to the majority race and gender in this country, which forms an opportunity for groups to be minoritized or marginalized, moved. So, we want to speak to the systems of power and authority that have enacted these things on different groups that identify as diverse. Not that the group itself is a minority in and of itself. Christin might be able to explain it a little bit more eloquently than myself, but we want to focus on the root cause versus the downstream effect, right? So, we want to make sure that people know that inequities in access to care cause the outcomes, which are the disparities in morbidity and mortality for our minoritized groups in this country. It's not that someone set out to be a minority. This was part of and the result of the system of oppression over hundreds of years that has resulted in these outcomes.

Christin: You said it just perfectly, and if I were to add anything, it would just be a supplement, quite frankly the AMA, the American Medical Association put out a couple of years ago, a phenomenal resource that was really race-based, but it was a lexicon for language. And it really talks about equity practices and first-person language. So, speaking to the person, not the conditions that they're living under or against. So, a person with a disability or a person who's experiencing or with obesity or a person who is experiencing housing insecurity, that is not who they are. It is what they are experiencing.

Claudia: For my final question for the discussion, it's really about how optimistic can we be that things are changing. It seems that even in your respective job titles, we see evidence that organizations are being more intentional about ending systemic bias and racism and are also backing up that intention with actual resources. But at the same time, many health disparities continue to widen. So, to what extent will you say that a health equity ecosystem has become established and it's being effective?

Christin: It depends on the maturity of your organization. A lot of folks think it's a one size fits all approach, and it's not. So, this is a long, slow process. This is long, close, slow work, and you can't just jump into action at first. So, it really depends on where your organization is. If your organization has been doing this for 15, 20 years, you're at a seasoned level, you should be seeing transformational change. But for our organization, I just finished my first inaugural year as opening the belonging and equity department. So, we're still on the empathy stages where we're putting in the infrastructure. And so, I would say once again, it depends on the maturity of your organization. I am optimistic if we touch one person, that's a

huge deal. But we're touching thousands and thousands, and I have to marvel at Dr. Mason's work because she's touching physicians across the country, if not the world. And I'm pleased to say that when I come into my space that we're impacting change too. Our organization may only have about 18,000, but those 18,000 are going back home. We're giving them skills. They're going home and teaching their children, they're going to their community organizations and passing the messages along. So, I am optimistic that we are moving the needle.

Dr. Simpson Mason: I do think that we can be hopeful. We get to be realistic and recognized and strategically manage the pushback that we are getting. But I do think we're having far more conversations using accurate terminology and lexicon, using that education change management lens in this space and far more arenas and environments than we ever have before. And with that being said, we can only, even though I say hope is not a strategy, we can only hope that we are moving the needle sometimes one person at a times, particularly because DEI and anti-oppression work is relationship driven and requires individual reflection with outward impact. So, I would say, well, Christin and I have to hold on to hope if we're going to continue doing this work every day. So yes.

Claudia: Many thanks to my guests for a great discussion today. Thank you, Dr. Bonnie Simpson. Mason.

Dr. Simpson Mason: Absolutely. Christin, as always, I appreciate your leadership and your wisdom. Thank you for continuing to educate me and holding up the torch. Claudia, thank you also for guiding us through this session. Movement Is Life, Operation Change. Yay. Thank you.

Claudia: And thank you Christin Zollicoffer from Lifespan Health Systems.

Christin: Thank you, Dr. Mason. It was a pleasure to present with you. Thank you, Claudia, for such a robust conversation, and thank you, Movement Is Life.

Claudia: And I am Claudia Zamora saying thank you for listening, and please join us again soon when speakers from the upcoming Movement Is Live annual Summit will be joining us to share their perspectives on health disparities and health equity. Until then, be safe and be well.

(End of recording)