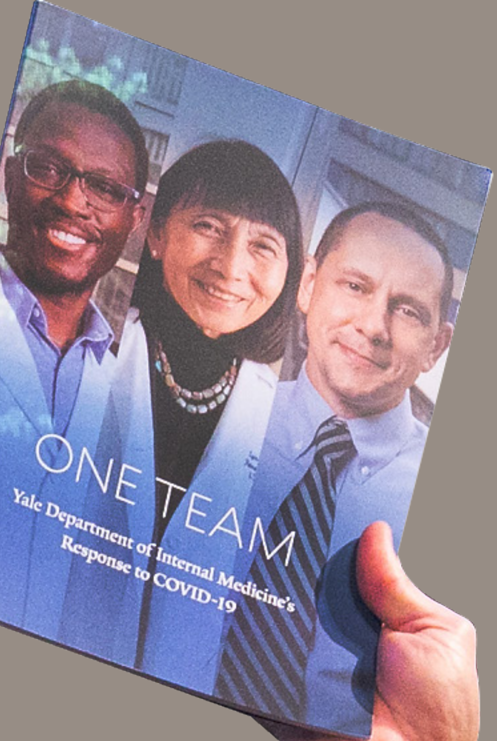
Post-Summit Report / 2024

Advancing Health Equity

Lessons from the COVID-19 Pandemic and Beyond

Yale SCHOOL OF MEDICINE
Department of Internal Medicine



"This event made a tremendous impact on me personally. I made some notes of all the takeaways from the event. In this booklet, we've written recaps of each panel presentation, as well as the list of participants, statistics about our media reach, and other support materials."

Yale Department of Internal Medicine Chair
Gary V. Désir, MD

Advancing Health Equity

Lessons from the COVID-19 Pandemic and Beyond

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Scan the QR code for complete coverage of the *Advancing Health Equity: Lessons from the COVID-19 Pandemic and Beyond* summit.

Advancing Health Equity

Lessons from the COVID-19 Pandemic and Beyond

"Disparities in both health and health care have existed for as long as we have had any system of health care delivery."

— Event Host and Facilitator, **Benjamin Mba**, MBBS

GREETINGS

On Wednesday, September 18, 2024, health care leaders from across the U.S. gathered for the *Advancing Health Equity: Lessons from the COVID-19 Pandemic and Beyond* event at Yale University's Greenberg Conference Center in New Haven.

Panelists and facilitators fostered discussions about health equity by highlighting strategies to increase health care access and reduce outcomes disparities and discussing how academic medical centers and health systems can achieve advanced health equity across the country.

Additionally, the Yale Department of Internal Medicine team shared learnings during the COVID-19 pandemic, which resulted in lower mortality rates, especially among patients from underrepresented populations.

This event made a tremendous impact on me personally. I made some notes of all the takeaways from the event. In this booklet, we've written recaps of each panel presentation, as well as the list of participants, statistics about our media reach, and other support materials. We hope that the strategies and ideas discussed during this event can be applied to your home institutions to improve health equity and outcomes.

Together I know that we can make a positive impact.

On behalf of Yale School of Medicine's Department of Internal Medicine, thank you for attending and participating in the event. Please stay in touch.

Gary V. Désir, MD

Yale University Chair, Department of Internal Medicine

Yale School of Medicine Paul B. Beeson Professor of Medicine

Affiliated Faculty, Yale Institute for Global Health

Chief, Internal Medicine, Yale New Haven Hospital

Health Equity Summit Celebrates Achievements, Plans Future Solutions

By Jenny Blair

Early in the COVID-19 pandemic, racial outcome disparities emerged. In the first year, for example, Black and Hispanic patients were far likelier to die than white patients were.

Yet a bright spot occurred at Yale. Not only was the mortality rate throughout Yale New Haven Health in the pandemic's first two years lower than the national average, but also no race-based survival differences occurred among discharged patients.

That was unusual, since health inequities in the United States have been documented across a vast range of diseases and outcomes. In fact, disparities in both health and health care "have existed for as long as we have had any system of health care delivery," said **Benjamin Mba, MBBS**, professor of medicine (general medicine) and vice chair of diversity, equity, and inclusion for Yale School of Medicine's Department of Internal Medicine, during the department's September 2024 summit, *Advancing Health Equity: Lessons from the COVID-19 Pandemic and Beyond*.

Hosted by **Gary V. Désir, MD,** department chair and Yale University's Vice Provost for Faculty Development and Diversity, the summit convened professionals from health systems around the East and Midwest. During panels, Q&A sessions, and a working lunch, they shared concrete lessons on what academic medical centers and health systems, including safety-net systems, can do to advance health equity.

Some takeaways: Health systems must broaden and reframe their responsibilities and pursue health equity, not just high-quality health care, as a strategic goal. Leaders must gather representative data and then set and pursue measurable community health goals. This can involve a range of tactics, including educating employees, building trust via community partnerships and direct investment, improving access by meeting people where they are, and engaging with law and policy. The pandemic demonstrated that with intentional strategies, health and health care disparities can be mitigated and health equity fostered.

Encouragingly, the participants concluded that such efforts are underway nationwide, and they can work.

Charged with achieving vaccination parity, for example, the Presidential COVID-19 Health Equity Task Force did so by prioritizing access, addressing structural barriers, and building trust, said **Marcella Nunez-Smith, MD, MHS,** associate dean for Health Equity Research and C.N.H Long Professor of Medicine, Public Health, and Management.

"In September of 2021, I briefed the president and the vice president on that historic achievement," said Nunez-Smith, who is also founding director of the Equity Research and Innovation Center (ERIC) in the Office for Health Equity Research at Yale School of Medicine. "The early racial [and] ethnic gaps in COVID-19 vaccination rates closed, and we observed subsequent narrowing and even some reversals in COVID-19 mortality disparities.

TWO ICUS, ONE STANDARD: A SUCCESS STORY

As Yale New Haven Health began to plan for the pandemic, leaders aimed to ensure equal treatment for inpatients. After calculating a need for 150 intensive-care beds at the system's flagship location, Yale New Haven Hospital (YNHH), they set out to standardize structures and processes across the health system, said **Jonathan M. Siner, MD,** associate professor at Yale School of Medicine, who chairs YNHH's Intensive Care Unit Committee.

To create capacity, they canceled elective surgeries, repurposed negative-pressure rooms on cancer wards, instituted tele-ICU, and expanded ICU staffing.

Then, to reduce cognitive load and risks of bias, they assembled a team that created a COVID care pathway—a standardized treatment protocol that was evidence-based, frequently updated, and integrated into the electronic health record, so it was available to all hospitals and clinics.

The health system had already partly laid the foundation of pro-equity structural change. After Yale New Haven Hospital acquired the Hospital of Saint Raphael, a nearby community hospital, in 2012, Siner decided both campuses' ICUs would come under the same banner. That meant making the same equipment and advanced techniques such as ECMO available at both units, as well as the same doctors and nurses.

"Everybody is treated the same," Siner said.

The practice was well established by the time the hospitals began to fill with COVID patients. Had Yale New Haven Hospital Saint Raphael Campus become overloaded, or if patients at that ICU had lacked access to advanced treatments and done poorly, the YNHH York Street Campus would have had to absorb them.

"The equalization of care really made a substantial impact," Siner said.

HEALTH CARE EQUITY: A STEP TOWARD HEALTH EQUITY

But achieving equity for critically ill COVID-19 inpatients, however laudable, is just the beginning.

"If you eliminate health care disparities, ...you won't eliminate health disparities—which is either unequal outcomes or unequal burden of disease, or disproportionate burden of disease—because of a myriad of factors outside our health system walls," said **Jaya Aysola, MD, MPH,** founder and executive director of Penn Medicine's Center for Health Equity Advancement.

Similarly, it is not enough to treat an inpatient with congestive heart failure, only to discharge them to the very milieu that made them sick in the first place, said **Harlan Krumholz, MD, SM,** Harold H. Hines, Jr. Professor of Medicine at Yale School of Medicine, and the founder and director of the Yale New Haven Hospital Center for Outcomes Research and Evaluation (CORE).

"We send [patients] out into an environment where right away, they can't get food, they can barely afford the medication, they don't necessarily understand the plan," Krumholz said. "Then they come back [for readmission], and we go, '...We did everything we were supposed to do.' "No, we didn't. No, we didn't, because we didn't address their risk factors for failing.

"Our job is to help people live healthy lives. Our job is to help people have successful recoveries," Krumholz concluded. (Putting it another way, Kaiser Permanente's **Israel Rocha, Jr., MPA,** said: "Our sole job is to give you back time.")

BEYOND THE HOSPITAL: COMMUNITY EQUITY

In Chicago, where life expectancy plummets in neighborhoods that are farthest west from Lake Michigan, Rush University System of Health (RUSH) has explicitly pursued community health equity for over a decade. The challenge: to eliminate life expectancy gaps in the West Side neighborhoods it serves.

"We had an accountability, if not a responsibility, for what's going on in the neighborhoods," said **David Ansell, MD, MPH,** RUSH's first leader of health equity. "If we're going to do something as a health system, we have to take on life expectancy. And to take

SUMMIT OVERVIEW

on life expectancy, we have to address racism and other forms of exclusion and oppression."

Tactics have included embedding anti-racist principles in all the hospital's actions, formal collaboration with other West Side hospitals, innovating care delivery and payment, and investing in local businesses like a laundry that serves the hospital while providing well-paid jobs with benefits for residents.

TRUST COMES FIRST

Health systems must also proactively build trust and help residents overcome barriers to care.

When the pandemic hit, **Manisha Juthani, MD,** professor of medicine (infectious diseases), began helping YNHH expand physicians' access to infectious disease expertise. In September 2021, she became commissioner of the Connecticut Department of Public Health, where she partnered with community organizations to help the state improve vaccination equity. For example, guided by trusted leaders, a vaccination van drove to gathering spots such as churches and barbershops.

Another way to build trust is via community health workers, who come from the communities they serve and can give culturally competent care. For **Ngozie Ezike, MD,** president and CEO of Sinai Chicago, building relationships with these workers has been a powerful tool.

"There are very few win-wins in society, but this is a win-win," Ezike said. "These people are now gainfully employed and now have insurance for themselves and their family, and they get to be a partner in the health system, in uplifting the health of the community.

"The health care systems of today can't stay in their beautiful buildings and say, 'Okay, come to us, and we'll do great when you get here,'" she added. "It's all about getting into the community, meeting people where [they are]."

EQUITY AMID INCARCERATION

What about people behind bars and the formerly incarcerated? The United States' 6,000 correctional facilities employ a half-million people and incarcerate some two million. This population faced much higher COVID-19 infection and mortality risks, said **Emily Wang, MD, MAS,** a Yale School of Medicine professor who directs the SEICHE Center for Health and Justice.

Yet these individuals were and continue to be largely overlooked by public health surveillance systems, Wang noted, and the CDC's early guidance around mitigating COVID-19 in correctional facilities did not take the realities of lockup into account. For example, a policy of sending sick inmates to solitary confinement for isolation discouraged many from reporting symptoms.

Far more effective at reducing infections and hospitalizations among inmates was decarceration, Wang found. The Transitions Clinic Network aims to meet their needs. During the pandemic, working with formerly incarcerated health workers and partner organizations, the network aided homegoers with essentials such as phones, a place to quarantine, and immediate access to primary care and substance use treatment.

"The transition of care is such a high-risk time period," Wang said.

DATA: THE BEDROCK OF HEALTH EQUITY

Whether they relate to lifespan, heart failure readmissions, or prison, all equity interventions depend on equitable data. "Without data equity, in a data-driven world, it would be very hard to even diagnose and prioritize on health equity issues," said **Bhramar Mukherjee, PhD,** the Anna M.R. Lauder Professor of Biostatistics and Professor of Chronic Disease Epidemiology at the Yale School of Public Health

(L-R) First Row: Celeste Philip, MD, MPH; Manisha Juthani, MD; Gary V. Désir, MD; Bhramar Mukherjee, PhD; Benjamin Mba, MBBS; *Second Row:* Ngozi Ezike, MD; Jaya Aysola, MD, MPH; Emily Wang, MD, MAS; Third Row: Suja Mathew, MD; Israel Rocha, Jr. MPA; Charles Dike, FRCPsych; MBChB, MPH; David A. Ansell, MD, MPH; Jonathan M. Siner, MD. *Not Pictured:* Harlan Krumholz, MD, SM; Marcella Nunez-Smith, MD, MHS.

and the school's inaugural senior associate dean of public health data science and data equity. She asked participants to think about who gets to contribute data to scientific studies and what the social determinants of data are.

Everyone, Mukherjee said, must have the same chance to benefit from data products. And as artificial intelligence (AI) trains on large datasets and offers results that may influence policy, the stakes rise higher.

"Even the best methods cannot rescue you if you're building your models in exclusionary cohorts," she said. "What goes into the input of these AI models really matters."

THINKING BIGGER

To achieve health equity, health systems and their employees must internalize that they are responsible for it in all that they do, panelists emphasized.

When **Suja Mathew, MD,** joined Atlantic Health System in 2022, she set about building a health equity initiative from scratch, starting with better data collection, stronger community collaborations, and systemic and shared accountability. During an educational campaign for employees aimed at conveying that equity is everyone's responsibility, she found that many had trouble believing inequities even existed within the health care system.

Celeste Philip, MD, MPH, invited the audience to think about political determinants of health.

"When we're thinking about what are the real root causes for the built-in racism into infrastructure, a lot of that is law and policy," said Philip, a professor of public health practice at Meharry School of Global Health. "What are the roles that health care facilities can help to make people understand that and to help change some of some of those policies and laws?" A key step, Philip said, is "building in belonging and civic muscle, which means that people feel like they are included, that they feel like their vote matters, and their rights are not being infringed upon."

Academic health centers, Ansell said, must strategically pursue the elimination of life expectancy gaps just as they pursue quality, safety, and research. That strategy, he added, includes public policy work.

"There's a countercurrent here between capitalism and the way we've organized our health systems, how we do margin work and equity," Ansell said. "We've got to somehow get them working in parallel." ■

Improving Health Equity:

Learning From Yale New Haven Health's COVID-19 Response

By Rachel Martin

HARLAN KRUMHOLZ, MD, SM
Yale School of Medicine

JONATHAN M. SINER, MD
Yale School of Medicine

EMILY WANG, MD, MAS
Yale School of Medicine

MARCELLA NUNEZ-SMITH, MD, MHS
Yale School of Medicine

Facilitator

MANISHA JUTHANI, MD
Yale School of Medicine / Connecticut Department of Public Health

PANEL 1

The first panel of Yale's health equity summit focused on how the Yale New Haven Health's decisions helped reduce health disparities and explored what could have been done differently to improve outcomes for all populations.

Manisha Juthani, MD, who moderated the panel, shared some of the state's efforts to partner with local and trusted organizations to expand vaccine access. The state mobilized vans that visited barbershops, churches, and community-based meetings, where people would feel comfortable learning more and getting vaccinated. Research later showed that Black and Hispanic individuals were much more likely to be vaccinated at mobile clinics vs. a stable office, which helped to increase equity in vaccination rates among different racial and ethnic groups. The state used that same network of trusted community organizations to distribute self-test kits to help reduce the spread of the virus.

"Our work highlights how you can use the principles we're going to hear today at the local level and then at a state level and far beyond," said Juthani.

> *"We must take the time to reflect on what we did and improve the next time,"* **Marcella Nunez-Smith, MD, MHS,** *said in a recorded message during the summit. "The lessons captured here today help make sure we don't return to our pre-pandemic normal."*

Facilitator
Manisha Juthani, MD

Standardizing Inpatient Care to Improve Health Equity

In February 2020, leaders within Yale realized that many patients were entering the health system with the same symptoms. They saw that hospitals in Italy and elsewhere were unprepared for the increase in patients and wanted to do everything possible to avoid that outcome. Yale quickly began to make preparations to free up beds and expand staffing in intensive care units (ICUs) in all the hospitals in the system.

During his presentation, **Jonathan Siner, MD,** shared that Yale created a dedicated team to review emerging literature and create a standard treatment protocol. They developed a rubric that clinicians used with each patient across the health system to establish goals of care.

"This made it very simple to determine what care an individual should get based on obvious, easily defined clinical parameters that are not subjective," Siner said. "That's particularly important when family members are no longer in the hospital, and we're talking to people by phone. That creates a huge psychological and emotional distance."

As a result of this preparation and commitment to uniformity, the average mortality rate of patients seen throughout Yale New Haven Health was much lower compared to similar U.S. health institutions. While there were disparities in who became sick and came into the hospital, patients from all races and ethnicities had similar outcomes once patients were in the hospital.

Panelist
Jonathan Siner, MD

Improving *Care* for Incarcerated Individuals

People who were incarcerated in jails or prisons had a higher rate of infection and mortality from COVID-19. **Emily Wang, MD, MAS,** also noted that federal and state guidance on social distancing was out of sync with the reality of incarceration facilities, which regularly experience overcrowding.

One of the policies that helped alleviate some of the burdens of the virus on this population was decarceration. However, community health systems were unprepared for the needs of recently released individuals, many of whom had no jobs, no insurance, and minimal transportation options. To help people transition home, Connecticut worked with community leaders with experience in the field to set up a special COVID-19 response line for individuals transitioning from jail or prison back into the community. The response line helped find quarantine housing and appointments for immediate health needs.

"Incarcerated people and correctional systems must be included in the public health infrastructure," Wang said. "If we do not incorporate them now when the next pandemic happens, this will again be a place that does not have the oversight."

Based on the experiences learned during the pandemic, Connecticut is piloting a program to systematically address this population's social and health needs, including triaging and coordinating social and health needs. Wang is hopeful this program will improve outcomes for people who were in prison but urged community health systems to better support those transitioning out of jails and prisons.

Panelist
Emily Wang, MD, MAS

PANEL 1

Using *Data* to Focus Action

Harlan Krumholz, MD, SM, noted that people from vulnerable populations were already in a precarious place before the pandemic. He shared new research showing that from 1999 – 2020, there were 1.5 million excess age-related deaths among Black Americans, resulting in 80 million years of life lost. These disparities multiplied when the coronavirus hit. Vulnerable communities who already had underlying disparities experienced even more significant inequality as a result of the pandemic.

“We’ve got to dismantle the structural racism that creates the gradients of barriers and obstacles and challenges that are faced by people as they’re trying to figure out how to live their lives,” Krumholz said.

Krumholz said that looking at this kind of data can help clinicians and health systems identify areas that need attention, set clear goals, and hold themselves accountable for progress.

He also called for clinicians to extend their reach beyond the hospital walls to advance health equity and ensure people can live healthy lives even after they are discharged.

Panelist
Harlan Krumholz, MD, SM

KEY TAKEAWAYS

- Standard treatment protocols can help eliminate health disparities. Health systems should develop standardized rubrics to minimize bias and ensure all patients get the same high-quality care.
- Data is essential to understand where inequities exist and if programs are helping—or hurting—specific populations. However, data must include all populations, including people who are incarcerated, to be truly useful.
- Providers must have the trust of the communities they serve. Leveraging trusted community health partners can help encourage the use of essential health services.
- Identify and address structural barriers to health care. To access care, patients may need childcare, transportation, economic assistance, or other support.
- Providers have a role in advocating for policy solutions, like expanding access to insurance and investing in communities, to advance health equity.

(L-R) Panel 1 included: Emily Wang, MD, MAS; Manisha Juthani, MD; Jonathan M. Siner, MD; Harlan Krumholz, MD, SM; and Marcella Nunez-Smith, MD, MHS *(not pictured)*.

Advancing Health Equity:

Synergistic Models for Health Systems and Academic Medical Centers

By Serena Crawford

DAVID A. ANSELL, MD, MPH
Rush University

SUJA MATHEW, MD
Atlantic Health System

BHRAMAR MUKHERJEE, PHD
Yale School of Public Health

Facilitator
JAYA AYSOLA, MD, MPH
University of Pennsylvania

PANEL 2

The second panel, Advancing Health Equity: Synergistic Models for Health Systems and Academic Medical Centers, focused on advancing equity in health systems. Moderator Jaya Aysola, MD, MPH, set the stage for the discussion by differentiating between health disparities and health care disparities, two distinct terms that she said are often conflated.

We systematically provide unequal care to minoritized patients in our health care system, and these health care disparities are separate from health disparities, she said. Health disparities, she added, are either unequal outcomes or a disproportionate burden of disease due to myriad factors outside of the health system, such as unequal access and unequal environments.

Facilitator
Jaya Aysola, MD, MPH

Equity Is Everyone's *Responsibility*

The first panelist, **Suja Mathew, MD,** discussed the idea behind establishing the Atlantic Equity Institute—to support optimal health for all people in every Atlantic community.

"We're well reputed for doing that at the global level, but if we opened our hood, would we find that our outcomes were the same across all those identifying factors and demographics?" she said.

She described the health equity index in the communities they serve as positive, except for certain areas in New Jersey with significant needs. To provide opportunities for these areas to achieve the same health outcomes, the institute focused on three areas of the American Hospital Association's Levers of Health Equity: systemic and shared accountability, collection and use of data to drive action, and community collaboration for solutions.

Systemic and shared accountability meant ensuring people understood that equity is everyone's responsibility. Mathew emphasized a rule they used in which the data they reported needed to be understood in ten seconds or less. The institute partnered with the government, not-for-profits, and others to target two key community health issues: diabetes and maternal health.

Panelist
Suja Mathew, MD

PANEL 2

Eliminating the Life *Expectancy* Gap

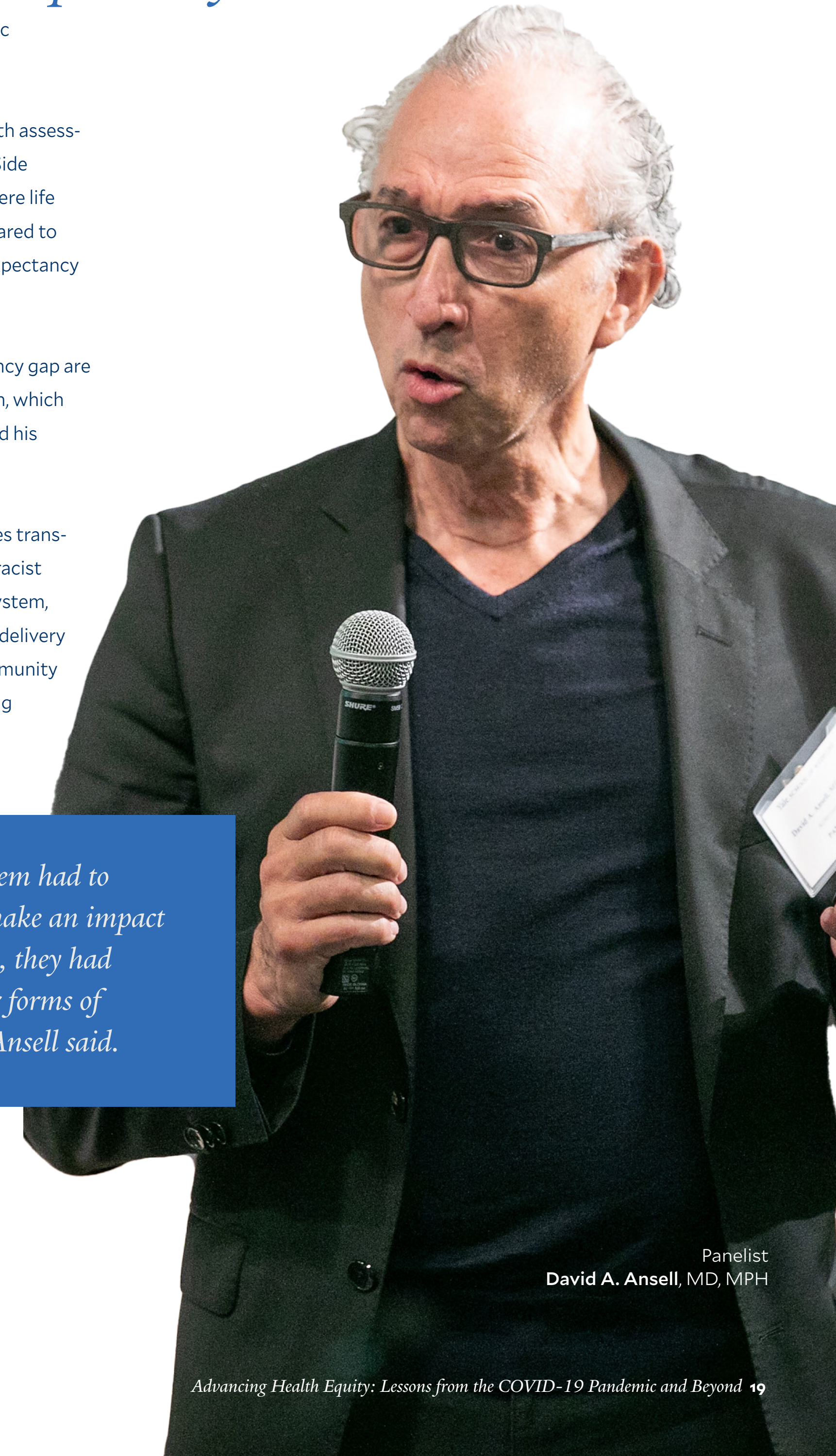
David Ansell, MD, MPH, turned to the topic of life expectancy.

He pointed to data from a community health assessment that showed two of Chicago's West Side neighborhoods, three stops past RUSH, where life expectancy plummeted to 66 and 67 compared to other Chicago neighborhoods where life expectancy was above 80.

Among the root causes of this life expectancy gap are structural racism and economic deprivation, which are causes, or vectors, of disease, Ansell told his board at the time.

RUSH's Health Equity Strategic Plan includes transforming culture and climate to embed antiracist principles, integrating actions across the system, leveraging data, innovating models of care delivery and payment, increasing diversity and community engagement and investment, and advancing the field of health equity through research, partnership, and ongoing learning.

Ansell knew the health system had to address life expectancy to make an impact as a health system. To do so, they had to address racism and other forms of exclusion and oppression, Ansell said.



Panelist
David A. Ansell, MD, MPH

PANEL 2

Seeing the Invisible Through Data

In the final presentation, **Bhramar Mukherjee, PhD,** spoke about advancing health equity through the lens of data.

She pointed out that AI is taking over our scholarship, lives, future, and health care decisions. She emphasized the need to consider the life cycle of data—who is in studies and who is left out—before developing an algorithm or tool.

"The stories of the unseen are never going to be told, and this vicious cycle is going to reinforce itself and increase inequity," she said.

Mukherjee stressed the difficulty of diagnosing or prioritizing health equity issues without data equity in a data-driven world. As an example, she showed a paper in *Nature Medicine* that tabulates all the genomes that have been genotyped worldwide. The South Asian population—where her parents live—was not represented in the genotype data even though it is a significant portion of the global population.

Panelist
Bhramer Mukherjee, PhD

KEY TAKEAWAYS

- Health disparities and health care disparities are two distinct terms.
- Equity is everyone's responsibility.
- The root causes of the life expectancy gap are structural racism and economic deprivation.
- Investing in communities through employment and other means reduces health inequities.
- Data that doesn't represent everyone increases inequity.

(L-R) Panel 2 included: David A. Ansell, MD, MPH; Suja Mathew, MD; Bhramar Mukherjee, PhD; Jaya Aysola, MD, MPH. Pictured with Gary V. Désir, MD, and Benjamin Mba, MBBS.

Trust comes first

Two ICUs, one standard: A ***success*** *story*

Health care equity: A step toward health equity

Equity amid incarceration

Data: The bedrock of health equity

Thinking ***bigger***

Beyond the hospital: *Community equity*

Safety Net System Models to Advance Health Equity

By Rachel Martin

NGOZI EZIKE, MD
Sinai Chicago

CELESTE PHILIP, MD
Meharry School of Global Health

ISRAEL ROCHA JR, MPA
Kaiser Permanete

Facilitator
BENJAMIN MBA, MBBS
Yale School of Medicine

Safety net health systems ensure access to care for all individuals, regardless of their ability to pay, delivering critical health services to those who are disproportionately uninsured, underinsured, or reliant on Medicaid.

The third panel of Yale's health equity summit spotlighted how these systems played a pivotal role in advancing health equity during the COVID-19 pandemic. Panelists offered strategic insights on how health care organizations can foster trust and effectively advocate for meaningful change within their communities.

Understand and *Support* Your Local Community

During her presentation, **Ngozi Ezike, MD,** highlighted the importance of understanding the local community's needs.

For example, when the COVID-19 vaccines became available, federal guidelines prioritized seniors over 75. Ezike and her colleagues pushed back on the guidelines because they knew that the average life expectancy in many of their local communities was in the 60s. Following federal guidelines would have exacerbated disparities.

"We can't follow this," she said. "You would have whole communities of people where many people in their community will not even have a chance to touch the vaccine. The data spoke for itself."

Ezike also urged health systems to get into the community to build trust and meet the unique needs of the communities they serve. She specifically highlighted how Mount Sinai Hospital in Chicago expanded the use of community health workers, which has helped improve trust and the quality of care while building up the local community.

Unfortunately, Ezike notes, safety net hospitals often lack the financial resources for capital improvements or program expansions that would help address health equity.

"Mission-driven work can often be at odds with the economics," Ezike said. "We need to find a way for these two things to work together in parallel and not against each other."

Panelist
Ngozi Ezike, MD

Partnership Models to Foster Health Equity

Health systems can build strong relationships in their communities, said **Celeste Philip, MD,** during her talk. However, trust must be earned over time. Health systems must continuously show they value the opinions of the community.

Philip pointed to her work in establishing a Health Equity Action team composed of 80% community members and 20% health department members. That group helped stop initiatives that they believed would threaten the health of the community and advocated for changes to improve health outcomes.

"In difficult situations, if people in the community have an opportunity to speak, they can be very influential and powerful," she said.

She challenged health leaders to include more voices from community members in their existing boards and organizations to involve the community, build trust, and ultimately address health equity.

Philip also highlighted the need to more fully integrate physical and mental health care and recommended health systems implement a "No Wrong Door" policy. This approach can create smooth transitions between hospitals and behavioral care facilities and help patients access social assistance programs more easily.

> *"If we are focused on closing gaps in life expectancy, we need to think about the whole person and the whole community through all of our actions and all of our planning," Philip said.*

Panelist
Celeste Philip, MD

Prioritize and Advocate for *Better* Care

Israel Rocha, Jr., MPA, noted that the problems leading to inequities have been well-established. He urged health care providers to avoid getting bogged down in the scale of the challenge and instead focus on what they can change immediately.

> *"Don't get blinded by the fact that it's an ocean," Rocha said. "If we could have a hundred spheres of influence, all tackling their part of the ocean, then we'll really start to see change."*

Especially in a resource-constrained environment, there is a need for policy changes to address some of these longstanding equity challenges. Advocating for policy changes requires buy-in from other stakeholders, including community organizations, foundations, policymakers, and other officials.

Rocha shared specific tactics that health care organizations should use to advocate for what they need. For example, he and his team improved care at the United States-Mexico border by sharing robust data and using messages specifically tailored to resonate with the decision-makers.

"Everyone has something that they care about," he said. "Your job is to figure out what drives them and then show them the data to help convince them. Align your goals with their goals."

Panelist
Israel Rocha, Jr., MPA

PANEL 3

(L-R) Panel 3 included: Israel Rocha Jr., MPA; Ngozi Ezike, MD; Celeste Philip, MD, MHS; Pictured with Gary V. Désir, MD; and Benjamin Mba, MBBS.

KEY TAKEAWAYS

- Community voices have value. Make sure all boards and programs include members from the community and truly listen to insights and guidance.
- Think about each patient's journey and identify problem areas. Try to improve transitions and create warm hand-offs.
- Stay encouraged despite the enormity of the challenge. Focus on the changes you an make in your own sphere.
- Health systems have a unique role in influencing their broader community. They can help advocate for investment and policy changes to improve political and social determinants of health.
- Doctors and other health care providers can be strong advocates for policy change. Training programs are available to help health care providers understand how to share stories and data to influence policymakers.

MEDIA METRICS & SUMMIT FEEDBACK

The summit received the following earned media because of Yale School of Medicine's Media Relations and Audience Develop teams' efforts:

WSHU RADIO STORY

LISTENERS

WTNH NEWS 8

- NEARLY HALF A BILLION **425,854,118** HITS ON THE YAHOO PIECE SYNDICATING WTNH'S COPY

FOX 61

VIEWERS TOTAL ACROSS THE FIRST TWO AIRINGS

OVER 4 AIRINGS

VIEWERS TOTAL ACROSS THE FIRST TWO AIRINGS

LOS VOS HISPANIA DE CONNECTICUT
**No data available as of publication date*

PRESS RELEASE

- Referenced or shared by **555** digital outlets nationwide
- Potential total audience of **210.4M** readers

FEEDBACK FROM POST-EVENT SURVEY

77% of most respondents expressed high satisfaction with the summit overall. They appreciated the opportunity to meetpeers (n=8) and learn about each others' experiences (n=7). Others felt inspired, hopeful, and empowered after the event (n=4).

100% of all respondents rated the quality of all sessions' panelists as **4** or **5**.

47% of respondents indicated the summit should be held every year, and **42%** indicated it should be held every two years.

Several respondents would have liked to have more opportunities for networking (n=6) and Q&A after each panel (n=4).

The Barthwell Group shared an anonymous feedback form with the **48** participants, panelists, and facilitators from the September 18, 2024 event.

During lunch, The Barthwell Group announced that the feedback form QR code could be found at each dining table. In addition, two emails were sent reminding individuals to complete the evaluation. **21** total responses were received.

PARTICIPANTS

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The Barthwell Group is the planning consultant for Yale Department of Internal Medicine's Health Equity Summit. The Barthwell Group, a Certified Woman-Owned, Minority, Small Business Enterprise, www.barthwellgroup.com, established in 2005, is a strategic management consultant firm with consultants and Subject MatterExperts in 17 states, Africa, and South America.

The Barthwell Group has extensive experience working with various healthcare organizations, more than 30 higher education institutions, and *Fortune 500* corporations throughout the United States.

For more information visit:
medicine.yale.edu/internal-medicine/

The Department of Internal Medicine's *Advancing Health Equity: Lessons from the COVID-19 Pandemic and Beyond* post-summit report is published by DIM Communications.

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Advancing Health Equity
Lessons from the COVID-19 Pandemic and Beyond

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