Dr. Mark Smith:
Imagine if COVID had hit 15 years ago, before broadband and Zoom and mRNA vaccines and all of the kinds of technologies and scientific advances that have allowed us to get as far as we've gotten in soldiering on, in work and health care, despite the kinds of pressures by the pandemic. Imagine if it had been 15 years earlier. In some ways, we're kind of lucky that this didn't happen in 1990.

Ellen Kelsay:
That was Dr. Mark Smith, Professor of Clinical Medicine at the University of California at San Francisco. As founding president and CEO of the California HealthCare Foundation, Mark helped build the Foundation into a recognized leader in delivery system, innovation, public reporting of quality and applications of new technology and health care. He published over 50 articles in peer-reviewed journals and chaired the Institute of Medicine's (IOM) committee, which produced the report, *Best Care at Lower Cost*. As a board-certified internist, he maintains an active clinical practice in HIV care at Zuckerberg San Francisco General Hospital.

I'm Ellen Kelsey, and this is a Business Group on Health podcast, conversations with experts on the most important health and well-being issues facing employers. My guest today is Mark Smith, and we'll be talking about health care quality through an equity lens and the connections between hybrid health and hybrid work.

Dr. Mark Smith:
Our health care system has largely been reactive for as long as there have been doctors and nurses. Basically, what we did was sit in our office or maybe in our hut and wait for people to come to us with something wrong and then try to do something about it. We're now moving much more towards a system that is proactive. Our system has been focused on being curative and we're now in a position, in large part thanks to the biomedical advances fueled in the last 50 years, to be much more preventative in our approach. Our system has largely been individually based, this kind of myth of the doctor. There are lots of things I hate to hear politicians say, but among the most despicable of them is between you and your doctor. Like your doctor has this huge brain that contains within it all of human knowledge.

Ellen Kelsay:
That's a clip from an interview Mark Smith did with the Mayo Clinic and the Center for Innovation and that theme about health care and how it's still transforming is something we'll be exploring in our conversation today. It is my pleasure to welcome him to the podcast now. Mark, we're delighted to have you here with us today.

Dr. Mark Smith:
Well, thanks. It's great to be with you.

Ellen Kelsay:
I know when you and I were chatting in the run-up to this conversation today, we were thinking about the things we wanted to talk about. I know a lot of our comments kind of sprung out of the six domains of health care quality that the Institute of Medicine devised. I thought maybe we could start there and have you explain for our audience, what are those six domains, just at a high level, and then we can springboard from there into more substantial parts of the conversation.

Dr. Mark Smith:
Well, 20 years ago now the Institute of Medicine developed a report, which I think is probably still the most authoritative in trying to describe what it is specifically we mean when we say health care quality. The six domains that they outlined are that it is safe, effective, efficient, timely, patient-centered, and equitable. Equitable is probably the one that is least often paid attention to, certainly least often mentioned, but it was, I thought, quite prescient of them to include it way back then before it became a thing, as it is clearly now. I think it's important really to center the conversation about health equity in the range of quality. It is not

something separate from quality. It is a part of quality. I also think it's probably worth pointing out to your listeners that it's not unusual for one of these domains to be intentioned with another.

I can see a circumstance in which one, in trying to be efficient, develops a process that is, however, not safe. Or if you're trying to be patient-centered, you might wind up giving therapies, say horse dewormer for COVID, that is not effective. It's not unusual for one domain of quality to have some sort of tension with another, which is why it's important to look at an issue from all those perspectives, to have a lens, if you will, from each of them. I'd submit that there are lots of things we do where equity is not the only consideration, but it ought to be a lens through which we view policy decisions, programmatic decisions, coverage decisions, etc. I always try to anchor this discussion about equity in the realm of quality in part to make sure that people understand it's not some separate discussion, it is actually an important part of that discussion.

Ellen Kelsay:
I love it and it's so important. As you said, these domains were identified over 20 years ago, but I think unfortunately for many, the aspect of equity has just really recently begun to enter into the vernacular. It's begun to become a primary area of focus in the past couple of years, certainly, but it is not new. And, as you said, it is not separate from quality, but yet I think many are late to the party of really framing their own thinking in a holistic manner in that way. As you said, these domains are interrelated, but yet I think for many years, they haven't always been actively viewed as that. I'm curious from your perspective of why is that, what are the barriers, and what are we able to do, perhaps differently, as we're in this current state and more actively focused on equity? How do we think more holistically and incorporate it more broadly into our view and work to address quality?

Dr. Mark Smith:
Well, let's talk about why now and then let's talk about barriers. I think the two principle reasons why this has come to the forefront now have to do with the kind of mass protests and national awakening to the equity issues in America that were stimulated and amplified after the murder of George Floyd and Ahmaud Arbery, and so many others, two years ago. In many parts of America where this had not been a front page item, people kind of woke up to the fact that there were these issues that have been bubbling along at the surface for some people for many, many years, and they were actually dramatically illustrated during that period. In addition, though, I think the COVID pandemic coming on the heels of that national conversation about inequality and racism really illustrated quite vividly the fact that these inequities in social standing, in income, the patterns left by residential segregation, by employment discrimination, and other inequities, manifested themselves in health and in particular to the degree to which people of color found themselves more likely to be infected, more likely to get sick, and ultimately more likely to die from a pandemic that has no particular biological reason to attack African-Americans or Latinx or Native American people anymore. I think those are the two reasons that this is really front and center for lots of providers and really for everybody in health care, as in other sectors of American society, including corporate America. Those two events coming on the heels of each other, I think, are part of why we're having this conversation now, as opposed to say 10 years ago.

What are the barriers? Well, one barrier clearly is kind of a logistical and data barrier, the extent to which we don't have this information broadly, we don't have it defined consistently, it's not collected universally, is one barrier. The other barrier, I think, is political. It's no secret to your listeners that the country is really deeply divided and struggles with issues of race as it has since its formation, so to the extent that people feel like they're walking on eggshells and don't want to touch this issue for fear of involving themselves in some controversy, I think that's another barrier to having frank and candid conversations about the extent to which the problem exists and how we go about trying to make progress on it.

Ellen Kelsay:
When I think on those points that you made is why now. It is definitely on everybody's radar. People are aware, they are very attuned to the need to address the situations and issues that you've just very clearly outlined, but those barriers are substantial and they're not easy to overcome. Do you see any glimpses of

promises when you think about the data barriers, political barriers, the willingness to have hard conversations to truly address these issues?

Dr. Mark Smith:
I do. I think the first thing that makes me hopeful is the fact that we're talking about it, the fact that we're talking about it on this podcast and really around the country, and not only in DEI committees and inequity committees, but in quality committees and in board rooms. I think that's the first step towards doing things. Secondly, I'd point you to a couple of things, actually, a couple of resources that may be helpful for your listeners. The Commonwealth Fund, full disclosure I serve on the board of the Fund, just published a report called, *Modernizing Race and Ethnicity Data in Our Federal Health Programs.* A report that was led by grantmakers in health and NCQA. You can find that on The Commonwealth Fund's website, which is https://www.commonwealthfund.org/. It's an attempt to look specifically about the extent to which, and the ways in which, this data is collected or not in different health programs, different health agencies, and make some really concrete recommendations about standardizing, and as they say, modernizing the collection of this data. I think your listeners and employers and others could learn a lot from it. A lot of the kind of modernization and standardization that has to happen has to be synchronized between government programs and private industry where a lot of the work of addressing these inequities happens. I think there are a number of things going on. Another resource, I think, comes from the Health Evolution Forum. Again, full disclosure, I've been involved in this, in which we try to develop an industry pledge to accelerate greater health equity by collecting, stratifying, and reviewing data on race, ethnicity, gender, language, sexual orientation where possible, across the top quality and access metrics.

I think an important point here is that if you want to get started on this issue, it's not like you have to invent a whole new set of quality measures. Every one of your listeners has a set of quality measures that are currently being reported to them by their health plans, by their vendors, their in-house clinics, their point solution vendors for diabetes or workers' comp or centers of excellence. So start with thinking about the most important quality measures that you're interested in and then ask for them to be reported in stratified fashion. This is also something that I think is important for health care providers and we ought to be asking our providers to do the same thing. A colleague of mine who's been involved in this work said, the magic is in trying to get every department, every line of service, to say what's the most important quality measure that you're looking at, and then let's look at it by race. Let's look at it by principal language or by gender. When you do that, there's an amazing kind of a revelation of places to go to work, hospital readmission rates, net promoter scores, revision rates for procedures, etc., etc. Almost anything that you think is important, if you start to look at it along the axes where we know inequities exist, I think you'll find not proof of inequities, but areas to investigate and places to get started.

Ellen Kelsay:
That's so great. There's so much that you just said that I wanted to kind of swing back around to, but certainly The Commonwealth fund, the Health Evolution Forum work that you all are doing. Those reports are wonderful examples. We'll make sure that we link to that for the listeners that they've got ready access to delve into those more deeply and no surprise that you are lending your fingerprints to that work. I think you had mentioned about awareness, and with awareness comes accountability, and having the data to measure and then to hold accountable, is so important. I do know that many often feel overwhelmed by where to start with the data, so I appreciate you breaking that down just to say what are the measures, what are the conditions, what are the populations that as an employer or as a system or as a provider, I want to understand better, and how do I then look at the data in a stratified way to have a better understanding of impacts on those various data elements? That's terrific. I do think sometimes people get just overwhelmed with the magnitude of that data and then they're paralyzed with where to start. So I think just breaking it down in some very incremental steps makes it feel less overwhelming. So those are great examples.

Dr. Mark Smith:
It's also, I think, again, part of this attitude which says look, we're not here to try to shame people or point fingers or accuse people of bad intent. We understand that these inequities are deep in our society. They go back literally hundreds of years. They're found ranging from infant mortality and maternal mortality to stage of diagnosis of cancer, to trust in the health care system from the beginning of life to the end of life. It's not like we don't know these things exist. Let's recognize that all of us have pledged to provide high quality care to everyone and equitable care is part of the definition of quality, so let's, as we do in other areas, be guided by the data. You can't manage this problem without measuring it any more than you can manage any other problem without measuring it. My approach is to take a pretty clearly data-led approach to finding inequities and then designing mitigation efforts.

Ellen Kelsay:
Absolutely. That makes great sense. I think we have this opportunity in this window of focus, attention, awareness, and now getting our arms around the data to devise strategy and start implementing some changes to really make some improvements in some of these areas. Again, that's where I come to now there's accountability, and we'll expect that whether you're a provider, a system, an employer, whomever you are and whatever role that you play, within some reasonable period of short time, we'll start to see some of the outcomes and benefits of this focus. I think that puts everybody on notice to take action as well.

Dr. Mark Smith:
You mentioned accountability. Accountability comes with targets. You have sales targets, you have return targets, you have revenue targets, you have hiring targets. We should have targets here too, and we should announce them, and so the only way you get held accountable is if there is some standard by which you can be judged. My friend, Don Berwick, says some is not a number and soon is not a time, right? So we're going to try to make some progress on this sometime soon, does not lead to accountability, right? We'd like to eliminate the disparities in infant mortality among our population by 2023, that provides a framework for accountability. I encourage people to be realistic, but aspirational about how far they're trying to get and how fast they're trying to get there.

Ellen Kelsay:
Okay with you if I transition to a different topic that you and I talked about in our prep call and that's the hybrid work and hybrid health topic?

Dr. Mark Smith:
Absolutely.

Ellen Kelsay:
Let's talk about that. I love your phrasing of hybrid work and hybrid health. Explain to our audience when you say that, what do you mean?

Dr. Mark Smith:
One of the things that I've been taught throughout my career, that turns out actually to be not true, is that health care inevitably and necessarily takes years and decades to change. Oh, we have to socialize this, we have to get everybody on board, we have to go slow. Well, the pandemic told us, actually, health care can change on a dime when it has to and it did. The numbers of virtual visits in virtually every hospital system and others in this country went from dozens to thousands in the course of a couple of weeks. Similarly, our workplaces have been absolutely transformed in the last year and a half, and everybody on this call knows that we're now working in ways that would have been unimaginable two years ago, and if you'd ask people, could they do it, they'd say no, and, in fact we have. Now we'll have to struggle with what the long-term impact of these changes has been, but in health care, I think it is now clear, doctors and patients learned, because they had to learn quickly, that we were wasting a lot of time and money, particularly patients' time in doing things in person that need not be done in person, and the two reasons that we did them in person were 1) because

we were used to doing it that way, and 2) because health care and education are the last two service industries in America where the business model requires that the customer show up for the provider to get paid. So health care from now on, I think, will be resolutely hybrid and every doctor in America three years from now will need to be able to take care of patients in person by asynchronous means, that is email and text and chatbots, on the phone and by video. And any provider who insists that their patients come in to see them in person and turn the turnstile in order to get care is going to find themselves in the same position that any bank that now require that you come into see a teller between nine and five, five days a week, would quickly be out of business.

Similarly, in our workplaces, the places where your listeners are working, they are now trying to adjust to a reality in which much of their workforce is working remote, some will probably be working remotely from now on, and the rest will be working in some hybrid fashion. We're all struggling with trying to figure out well, who needs to come into the office, do we need an office, how big an office do we need, when are they there, which of the people will benefit from that sort of storied, casual, coffee, water cooler interaction, which ones really will do just fine and zoom in five days a week. Both health care and the larger place of work have been transformed in the last year and a half, and while we will go back to some of the things that we did before, I don't think we're ever going to go back to doing things the way we did them before, out of both habit and kind of embedded investments in the old business model. In that way, I think we both learned we can change much more quickly than we thought we could when we're under duress, and we've certainly appreciated some of the advantages of working in a more convenient and certainly less-expensive way, in ways that we couldn't have imagined even two years ago.

Ellen Kelsay:
No doubt about it. Those are some seismic shifts and, like you said, they happened in an unbelievably accelerated timeframe and does give us promise for what we can sustain and endure and how quickly we can adapt and evolve when we have to, and for good reason. These are great changes that are here with us to stay. I know you've also spoken about this being really a window of empowerment for employers and that employers are more emboldened. I would love for you to elaborate a bit more there, as well.

Dr. Mark Smith:
I think employers had the advantage of seeing in their own internal operations that lots of stuff we were used to doing was simply unnecessary and wasteful, and I think they need to extend that same understanding to their health plans, to their contracted providers, to their entire perspective on health care. So when health care providers or others come to them and say, well, we've got to do it this way, I think employers will be asking why, we're now doing things that we didn't think were possible and our employees are demanding that we consider what actually has to be done in the old way and what kind of lessons and advances can we harvest from this horrible, terrible last year and a half. I think employers ought to be asking the same thing of every clinical trial that their employees are involved in, in every in-house clinic that they've invested in, in every arrangement between their contracted health plans and those health plans' contracted providers that wasted their employees time going in to do stuff on campus that we now know needs not to be done on campus.

I think employees, and I think there's very good evidence, are now emboldened to experiment with all sorts of radically virtual care, which is not to say that bricks and mortar medicine is going away, but I think it's really, really clear and employers have the greatest perspective on this in part from their own lessons of transforming work. They can insist that health care transform along with it and hopefully reap the benefits both in terms of presenteeism and expense for their employees and convenience for their employees, but also some of the cost saving benefits that come from virtualizing care that has the potential, at least, to dramatically reduce the capacity to extort monopoly pricing and all the other evils of the old way of doing things.

Ellen Kelsay:
Let's connect some dots between the virtual health topic that you just raised and our prior conversation on equity, where do you see those converging and how do we think about that as we move forward?

Dr. Mark Smith:
That's a great question. My own view is that virtual care is one of the most powerful ways in which we can address some, not all, but some of the problems of equity. If you are a Medicaid recipient in the Central Valley of California and you have diabetes, and you need someone to look at your retina to make sure that you're not getting diabetic retinopathy, let me tell you, it's almost impossible to find a private dermatologist who will see you, for all sorts of reasons. Your listeners will understand that well. Many of the equity problems that we have in America are related, at least in part, to the geographic mismatch between supply and demand. That's a problem that a virtual care can virtually eliminate. Let's be clear, it's not a panacea. There are lots of people in our country who don't have broadband or who don't feel comfortable with kind of advanced technology and fancy zoom things, but most people have phones and smartphones can do a lot. I think it's really important to think about the ways in which once care is divorced from the necessity of being in a certain place at a certain time, and that place and time, frankly being determined by the convenience and the business priorities of providers rather than patients, then you can make progress on a number of the equity challenges that we face. There are certainly challenges, and again, if you don't adopt an equity lens on virtual care, one runs the risk of making certain problems worse. But with apologies to Johnny Mercer, I think our task is to accentuate the positive and mitigate the negative. It is overwhelmingly, in my view, a good thing in terms of attacking equity problems. We need to be conscious of the fact that there may be special challenges for certain populations, and we need to always apply an equity lens to this, just as we should always apply an equity lens to everything else we do in health care.

Ellen Kelsay:
This is a tremendous period of opportunity, and also a tremendous period of necessity, to do things differently. You've pointed out, I think so well, that we no longer have the luxury of time, that there is an urgency, that there are employee expectations, we can't drag our feet on this, we can't deliberate for years and years and years, we need to be thoughtful, and we need to do things well and in the right way and for the right reasons, but we need to do it now and to move swiftly towards progress. I think those who defend the status quo or hope that things kind of pivot back to the way things used to be, are going to be left in the dust and see business move away from them if they don't also, kind of, get with the program and evolve. It is interesting because I do think, Mark, just to be honest, there are many who are very still entrenched in the status quo and who aren't really embracing this new reality.

Dr. Mark Smith:
Oh yeah. Look, if you think that the last year and a half has been a revolution, and it has, just remember every revolution is followed by a counterrevolution, right? After every revolution, there are people waiting in the wings to try to restore the king or the czar or the old fee-for-service, in-person medicine paradigm. So, yeah, there are a lot of people who are invested, heavily invested, both philosophically and financially in the old business model. There will be fights about scope of practice. There will be fights about cross state licensure. There will be fights about the requirements for establishing relationships before you can have virtual care. All the sorts of things that retarded the application of modern IT to health care for decades that got swept away because of the pandemic and now there'll be a bunch of policy fights about the extent to which they come back. Just like I suspect within many of your listeners companies, that people in the C-suite are really anxious to go back to in-person and think that employers should come into the office, and a lot of these younger folks just aren't having it, they're not going to do it. So, yeah, there's a counter revolution that's going to try to go back to the old way of doing things. As a colleague of mine put it several months ago, we still don't know the extent to which this is an elastic or a plastic moment. There was the extent to which we will snap back or actually emerge in a different configuration. I'm hopeful about that it's mainly the latter, but I'm not so naive as to think that there aren't powerful forces that benefited from this status quo, that would like to see us go back to that way of doing things.

Ellen Kelsay:
Well, I'm with you. I'm more optimistic it will be the latter as well. I think with steady, focused, deliberate pacing, unrelenting efforts in these areas, we'll see the progress that we so sorely need.

Dr. Mark Smith:
We don't have too much time left, but I want to end with what I think is maybe an optimistic note, which is to say as terrible as this pandemic has been and still is, and of course this is far from over, we don't know what the next chapter is, imagine if COVID had hit 15 years ago, before broadband and Zoom and mRNA vaccines and all of the kinds of technologies and scientific advances that have allowed us to get as far as we've gotten in soldiering on, in work and health care, despite the kinds of pressures by the pandemic. Imagine if it had been 15 years earlier. In some ways, we're kind of lucky that this didn't happen in 1990. I think it's really imperative that we take advantage of the amazing progress in vaccines and now antiviral therapies, and also the infrastructure of IT that allows us to communicate, to work, to deliver health care in a way that really was not possible 15 years ago and without which it's really hard to imagine how much more devastating this pandemic would have been. To the extent that there's a silver lining at all to this horrible cloud, it's that it emerged at a time where we had the necessary preparation and tools to be able to survive it. I think it's important that we keep that in mind and therefore adopt an attitude that says we need to lock into place the advances that we've made and prepare for the next inevitable challenges that will come.

Ellen Kelsay:
Here, here, and no better way to conclude our conversation. There is so much to be helpful about and a lot of promise and opportunity on the horizon. I have no doubt that with your leadership, your continued passion, and as I said, your fingerprints all over the industry, we have a good hope of achieving that optimistic future. Mark, thank you, again. It was delightful to speak with you.

Dr. Mark Smith:
My pleasure. It's great to be with you.

Ellen Kelsay:
I've been speaking with Dr. Mark Smith about the importance of equity as a measure of quality. Dr. Smith will be keynoting the Business Group on Health Employers' Summit on Health Care Costs and Delivery in January 2022.

I'm Ellen Kelsey. This podcast is produced by Business Group on Health, with Connected Social Media. If you're listening on Apple Podcasts and like what you heard, please rate us today and give us a review.

Articles mentioned in podcast:
The Commonwealth Fund - *Modernizing Race and Ethnicity Data in Our Federal Health Programs*
https://www.commonwealthfund.org/blog/2021/modernizing-race-and-ethnicity-data-our-federal-health-programs

Health Evolution Forum –
https://www.healthevolution.com/forum-health-equity-pledge-supporters/