
John Clymer: Turning now to our meeting theme, “Health Equity: Everyone Benefits”, our first panel will discuss the relatively new Vital Conditions for Health and Well-being framework, and how we might use it to advance the social determinants of health, and make policies, programs, and environmental changes that improve health equity more appealing to more people.

Leading the panel will be Celeste Philip, the founder of Unboxable Health Consulting. You may know Dr. Philip from her services at the Centers for Disease Control and Prevention, as Deputy Director for Non-Infectious Diseases until earlier this year, or her service as Florida Surgeon General and Secretary of Health, or as the Sonoma County Health Officer. She previously served as the National Forum’s Vice Chair.

Joining Dr. Phillip will be Rishi Manchanda, an internist, and pediatrician who is CEO of HealthBegins, a consulting firm focused on improving the social and structural drivers of health equity at all levels. You may be one of the millions of people who have watched Dr. Manchanda’s Ted Talk on upstream medicine.

You may have read the brilliant book, *The American Health Care Paradox*, we are joined by its coauthor Lauren Taylor, Assistant Professor of Population Health at the NYU Grossman School of Medicine. Her writing appears frequently in *Health Affairs*, *The Milbank Quarterly*, and other influential journals. Dr. Philip?

Celeste Philip: Hello, everyone. Thank you for joining this very important session and in discussion throughout the day on Vital Conditions for Well-being, and what that means for communities throughout the country. This session will articulate the case for investments and policies that lead to well-being for people throughout society. By focusing on the Vital Conditions, we can see how individual's needs form an interconnected web that helps people and places thrive collectively. When a vital condition goes unfulfilled, it can compound other existing conditions, including outcomes of individual health and well-being.

The federal plan for equitable long-term recovery and resilience or the federal plan for ELTRR, that’s a mouthful, leverages the Vital Conditions for health and well-being, which are grouped into seven categories, meaningful work and wealth, reliable transportation, lifelong learning, belonging and civic muscle, humane housing, basic needs for health and safety, and a thriving natural world. Identifying the Vital Conditions was an intentional shift to organize resources to adequately address the needs for long-term recovery and enhancing resilience. It’s an actionable approach to improving social determinants of health and addressing inequities. It fosters a

principle that places the needs of communities at the center of policies, programs, and resource allocation.

The framework identifies levers for community change and improvement and shows how the needs of individuals and communities define systemic approaches to foster well-being. It defines the interplay of one's life circumstances, choices, and resilience in that of their communities. We know that social determinants of health, or the conditions in the environments where people are born, live, learn, work, play, worship, and age, are not equally weighted and are not equally supportive of greater resilience.

So with that background, we're going to shift now into a discussion with our two guest speakers who have significant expertise in this space. And want to have an opportunity to hear about their great work up to this point. Their thoughts on this reframing of social determinants to health and to a somewhat broader context that does bring in, I think, particularly new focus on civic engagement, and hear their thoughts on how this resonates with the work that they are currently doing, and where they see the future as we shift to talking more broadly about health. And also understanding the importance of the connections between healthcare services and the communities in which people live, work, play, and learn.

So I will start with Rishi, if that's okay for you to share a little bit about your background, and maybe start with some initial reflections on what you think about this new approach focusing on Vital Conditions.

Rishi Manchanda: Thank you so much, Celeste. And good morning, and good afternoon. I'm Rishi Manchanda. I'm CEO at HealthBegins. I am, by profession, a primary care and public health-trained physician. I consider myself part of a social medicine lineage in western medicine that has long been interested in how to improve care for individuals while also understanding and improving the conditions in communities that can put people in harm's way. And so the work that I do at HealthBegins, in particular with our team is to help Medicaid-serving organizations, specifically Medicaid-managed care plans, health systems that primarily serve or especially serve Medicaid beneficiaries, and also the social sector, organizations at the national level as well as at the community level, that want to advance their social mission by partnering with and accessing some of the resources that Medicaid can provide.

In that context, a lot of our work is really informed by a focus on improving health equity, and especially helping the partners and clients we work with do so by addressing the social, institutional, and structural drivers of inequities, in ways that not only help meet emerging performance requirements and goals, and new regulatory

requirements and accreditation standards, but also to meet them in a way that addresses and provides long-term impact, especially for communities that have been most harmed by societal practices. So that's who I am.

And from that frame of reference, you know, I think the Vital Conditions Framework is interesting in a couple of ways. Let me talk about some of the things that immediately are cool about it to me. One is, as you rightly underscored, Celeste, the addition of civic belonging in the framework as well, and a framework that is analogous to some of the frameworks around social determinants of health and community conditions in general, in the past, it's nice to see civic engagement and civic belonging included so prominently. I think it recognizes the ways in which civic health and overall health, physical, mental, behavioral, and social health are interlinked. And so I think that's a welcomed addition.

I also appreciate that the stakeholders that the framework, the Vital Conditions Framework is trying to engage, are those at the federal government. It seems like it's an opportunity to engage perhaps agencies and individuals at the federal level, who may not have been as engaged, and see themselves as part of the social determinants or the health equity kind of language. If this allows them to come to the table, then I'm all for it. Because it means that more individuals, even if their day jobs aren't focused on equity and social determinants of health are not considering it. And so I do think that there's a strategic benefit in terms of creating a wider table to invite some folks at the federal level to join.

And there's some other advantages, you know, there's some specific recommendations, and list of seven, eight proposed recommendations from the federal report that I reviewed that I think are intriguing as well. I will say that I have some kind of – my reflections are really kind of grounded in this moment. And I'll go for about two minutes here. And then I'll pause because I really want to get, Celeste, your thoughts, but also, of course, Lauren's thoughts on this.

I think this moment helps frame my reflections. And this moment is one that's defined by great promise, but also great peril, and tremendous opportunity. The promise that we've seen, especially in the past three to four years at the federal, state, and local level, has been an increasing kind of focus and an understanding of equity, not just the presence of inequities, which are the unfair disparities, the unjust disparities between subgroups of populations, but also, of course, of the structural drivers that have created those inequities in the first place.

And because of that, I think there's been a lot of efforts that we've seen to help. There's been a lot of work now to place equity, especially in the healthcare

sector, health care equity, into performance requirements into accreditation standards like those from the Joint Commission, those from the NCQA, and into contracts like State Medicaid contracts, agency contracts between the state and managed care plans, for example. This is welcome. This is long overdue because at least in the sector of healthcare, which is where I spend a lot of my time, this lack of focus on equity, led to the persistence and the promulgation of inequities. Right? It was ignored, and therefore, they continued and ran them up.

So it's important to note that there's been a lot of promise and a lot of advances. That's also true for social needs, right, when we think about the ways in which social needs have become part of many standards, performance requirements, and contracts now, especially in healthcare and the ways in which healthcare and social care integration has been more discussed and acted upon in the past few years. There's a lot of learning. There's still a lot of things to learn about how to do it better, you know, what works, and what doesn't work.

But the very fact that we're in this space right now reveals, I think, a great deal of promise, especially compared to ten years ago when this idea of having healthcare move upstream, having healthcare perhaps in other sectors focus on equity was really a peripheral conversation, or more so than it is now. At the same time, there's been a lot of peril. We face a moment of great risk right now. And I would say that the risk that keeps me up at night, and a lot of the colleagues and partners that we work with across the country, is the risk that, that in the pursuit of, and I'm putting quotations around this "equity and social determinants" that we run the risk of whitewashing and perpetuating the various social arrangements that put people in harm's way.

There's a risk of doing equity in name only, without addressing the structural drivers that actually have been consistently, historically, over time putting groups of people in harm's way. And I don't mean only vulnerable, marginalized populations, racially-minoritized populations included. I also mean everybody, including White middle-class Americans, right, have been harmed as Heather McGee's book, "*The Sum of Us*" kind of talks about. Everyone's harmed by inequitable practices, especially, of course, those who are targeted, but not limited to them.

So I do wonder about the risks that we face right now of whitewashing perpetuating the arrangements that put people in harm's way. And at the same time, I think there's an opportunity here to really make sure that as we look at Vital Conditions, as we look at social determinants as we look at equity, and whatever framing resonates with folks, that we

have tremendous opportunity to make sure that while we're meeting performance requirements.

And closing inequities, and gaps for individuals through our services, that we're also thinking about ways to reallocate resources, and correct for historical patterns that have led to the accumulation of advantages for some groups, and the accumulation of disadvantages for other groups. We have to address those social drivers. And I think we have a tremendous opportunity to do so.

My reflections on the Vital Conditions are that it's a helpful framework to be able to bring people to the table, but it runs the risk, if we're not careful of actually whitewashing some of the structural arrangements that put people in harm's way. And I'm happy to go into that. That's a pretty heavy statement that I just made. I'm happy to go into that more. But with that said, Lauren, what do you think?

Lauren Taylor: Rishi, it's so good to be reunited. And thanks, Celeste, for trying to keep us trains on the track. My name is Lauren Taylor. I'm an assistant professor at NYU's Grossman School of Medicine. And so I am a scholar, and a researcher, and a writer. And so I do research still on a number of social determinants of health. Back in 2013, which is when I kind of started this journey, I coauthored a book called "*The American Healthcare Paradox*". And increasingly, I've been writing and thinking about the role of trust in public health and medicine, and issues of organizational ethics about what are permissible and impermissible ways for healthcare organizations to make money.

I'm really thrilled to be here thinking about kind of Vital Conditions as a new way of maybe thinking about, certainly talking about social determinants of health, and there's no one I'd rather be doing it with than my friend Rishi. I share a lot of his enthusiasm, and I might just tee up one comment, which is that in between writing *The American Healthcare Paradox* and now, I went to Divinity School, and I trained as a chaplain. I worked in an oncology unit, but Divinity School has a way of orienting one to issues like meaning, and certainly civic life.

And so I too, Rishi, picked up on the kind of infused moment of this framework with the ideas of civic muscle, meaningful work purpose, as really something that feels fresh. And I'm not sure I'm totally settled yet on whether it's the right direction or the wrong direction, but it certainly feels different from how we have, at least I have, historically talked about social determinants of health, which has really been trying to drive it into a more operational realm, like to take it out of the abstract and say, you know, we can really do something about this.

Because, historically, right, Rishi, we had gotten the critique, like, oh, you know, you social determinant of health people, you want us to solve poverty. Like, what do you want us to do about that? It was so big, and it felt like, just not an operational concern. And so my instinct for many years was to try and help people see that I wasn't asking healthcare, or other community partners, to boil the ocean. But like, look, we can really chunk this out into concrete, doable tasks. Find community-based organization partners. Start collecting data.

And yet this framework feels like it's taking us in a different direction. It's taking us more abstract. More conceptual. And in that sense, I think it has a lot going forward. It's more comprehensive. And it's like true in a form, that a lot of the ways that I have, at least, historically talked about social determinants of health, may have been under-nuanced. But I don't know, frankly, strategically, if that's the right or wrong direction. I think it also just really speaks to the moment in which it was born, right? It was born out of the pandemic, and the crisis that we were feeling, being literally physically isolated from one another. Like not, not going to work, and not going to school in the same way.

And so I think, just as a descriptive statement, that may account for some of the interest in civic life, civic muscle, purpose, meaning because we realized that like, in an atomic state, all disconnected from one another, life feels a bit empty. So I'll leave it there, and we can pick up on a conversation. But that's my introduction. Thanks, Celeste.

Celeste Philip: Yeah. No, thank you, to both of you. I jotted down a number of different statements or concepts to go back to. But Lauren, I wanted to start with your comment around trust. And you know, I spent several years working in county health departments, working with communities. And at that, in that setting, you can't do very much without trust. And as we saw through, across the country, through the different phases of the COVID-19 pandemic, when trust is not there, to begin with, or when it's eroded, because of the way information is shared, or the way information is perceived to be shared, that makes things very difficult.

So, coming out of that experience, and now recognizing, that we're hearing lots of conversation about the importance for governmental entities, but even I would say community-based organizations to really think about what it means to have a trusting, meaningful relationship with community members. And this idea also of shared power that we're hearing more and more about, as we're thinking about vital conditions, I would invite both of you to share any experiences you may have with how to do it. And it could be what worked really

well, or what didn't work well. Because oftentimes, what didn't work well tells us how we need to rethink our efforts.

But I, you know, as for me, and I should share that I was in a federal role during the development of the Vital Conditions Framework, and did have an opportunity to comment on it during different phases. I also was really happy to see the civic belonging piece, but I also know it's really difficult. And, Lauren, your comments about this moving to a more abstract space, where it may be more difficult to operationalize how we do it. I would just welcome your thoughts on the specifics around gaining and building trust.

Lauren Taylor: Yeah, I'm happy to maybe kick us off, Rishi, and then turn it back to you. But I think it's just important to remember that, like, the pandemic exacerbated trends that were already long in action. Right? It's not as if, oh, we had a, we had a horrific pandemic. And that just blew open, you know, a graft that was otherwise holding well. You look at historical trends of trust in certainly the federal government, but government in general, and, frankly, healthcare. And they had been on the decline since the late 1960s.

Certainly, COVID worsened it, and it accelerated the decline among certain parts of the population, but this is not a new challenge. I think it's really interesting to also think about what role the federal government has in building civic trust because what we know, empirically, about trust is that people always distrust things far away, and they're more likely to trust things near them.

So for instance, just in the healthcare space, if you ask people: "How much do you trust the US healthcare system?" The numbers are terrible. If you ask them: "How much do you trust your local hospital?" Better, not great. "How much do you trust your doctor?" Incredibly high. And it's been persistently high, even while different kinds of trust numbers have cratered, trust in your doctor has stayed pretty high.

So, it's kind of an interesting challenge for the federal government to figure out what to do about rebuilding trust from Washington D.C. for a nation of 330 million people who live in huge geographic diversity. So, you know, I think it's something where the federal government has to delegate that responsibility, and ideally has to delegate some financial resources to do some intentional reknitting, as the framework speaks to of like civic muscle and civic life. But trust is gonna get rebuilt to the extent that it's possible on a very local basis, and then you hope you can build with a virtuous cycle.

Okay. Can I get someone who's feeling mistrustful for probably, or potentially, very good reasons? Can I build a little bit of trust with a local pastor? Can I build a little trust with a local community-based

organization? Okay. Now, can I leverage that to build a little trust in the state government? Okay. Now, can we leverage that to build some trust back into the federal government? But it's a long road to home. Rishi?

Rishi Manchanda: I appreciate the comment about trust, especially the way in which it's inversely related to proximity, right, and – or directly related proximity, I should say, not inversely. So the more proximate you are to somebody, the more trust you feel with them, and the more distant something is. I think that really resonates, Lauren, as you're backing up with the research, as well as just the lived experience of a lot of individuals and communities. Right? That makes a lot of sense. I appreciate the kind of centering in the conversation around trust.

I also just want to underscore a couple of other things that I think are interesting, as I'm getting to become familiar with the Vital Conditions Framework. It may be more apparent in the version that has been used and voiced over by community partners. As I – Celeste, as you were educating me earlier, this document informs both the federal kind of efforts, but it also is something that has a parallel among community-based organizations and many non-governmental kinds of actors.

In the lateral one in particular, one of the things that I appreciate about it, overall, is it's, in some places, a bit more explicit, in some places, it's implicit. It's implied, this shift away from just looking at the presence or absence of a social need. There has long been, in the US, and I think in many parts of the world, a framework of looking at human development, rights, human health, of the health of communities, through the lens of whether there is the presence or absence of certain commodities. Right?

Do you have the presence of enough income or the absence of income? Do the presence of certain transportation, or the absence of things? And I think while there certainly are, it's important to be able to identify the presence or absence of basic needs, and how equitable that access is, and affordable that access is. And this Vital Conditions Framework does reference those basic needs, I think, in a clear way. It's also clear, as others have talked about it around the world, including the US, that only looking at the presence or absence of commodities doesn't really fully speak to the conditions, to use this language, for thriving and for freedom.

And so scholars have talked about the freedom of opportunity. Right? Amartya Sen and others from the late 90s. This idea of looking at human development, including poverty, is not just the absence or presence of income, but the presence or absence of the freedom of opportunity. And so there are some elements here in the Vital

Conditions Framework that go beyond that list basic needs, but go beyond that, to talk to Lauren, your point about meaningful work about lifelong learning, right, and civic belonging and engagement in those kinds of ways.

And I think that's really key. That represents a shift. Right? It may be seen, it may be happening subtly. And maybe some communities might lean into it head on, and some might slowly kind of come along into this. But this shift nonetheless is taking place, and it's what's implied by this framework, in a way that moves us beyond just looking at the presence or absence of basic needs, to going beyond that to talk about the conditions for thriving in the way that the Vital Conditions Framework is talking about.

And I think that's an important shift. And it aligns with the kinds of, these questions about, well, do we have the conditions to create not only to meet people's needs, but also to create an engender and earn trust? Do we have the conditions in place to be able to make sure that everyone has freedoms, and rights, in the Roosevelt kind of ways as well? Do we have access to these freedoms? And so I think that it creates a really nice touchstone or a springboard, right, for communities to come together in a way that's far more expansive than just the presence or absence of social needs.

And I will say in the healthcare community, that's been hyper-fixated late on closed-loop referrals, and making sure somebody's needs are screened for, and then addressed through a referral through a technology platform to social service. That very necessary kind of set of operational tactical questions, consent, if it's the only set of questions, it misses the point, right, which is whether or not that person has met social needs, but also do they have access to opportunity? Do they have freedom? Do they have the opportunities to thrive? So I just wanna underscore that. I'll pause there and see if that resonates with either of you.

Celeste Philip: Yeah. Thank you for bringing in, you know, what is required to be successful in gaining trust. Because if it's just words, and there's still a sense of not being valued, I think it's really difficult that we are able to move into a space of trusting transparent conversations, and then talking about, you know, from a community member perspective, where do we go from here.

And I wanted to shift Rishi back to something that you said in your opening comments about how equity matters for everyone. It's not just certain groups. If you live in this zip code versus this. I think, up until recently, there has not been enough data or understanding to show how, when certain parts of our communities, certain individuals, have less equity, it impacts everyone, and it affects the health and well-

being of everyone. So I would welcome you to dive into that a little bit more.

And if you have any examples of where you've seen, potentially more investment in certain communities, or individuals, how that is better for all because I think that's part of where we still may have some gaps in understanding. And even looking at vital conditions, you may have a number of folks that would look at the seven to eight measures, and say, oh, I have most of this in my community. And kind of, you know, go on from there rather than saying, okay, but what does this mean for me where I live, where my neighbors maybe don't?

o to process. Right? Think about the way you do your community health needs asses
Rishi Manchanda: Yeah. So I think this touches on one of the questions that arose for me as I was reading through the Vital Conditions Framework, both the federal one, as well as the non-governmental one, and that is, the question is will different communities apply this differentially? And is one of the ways in which that will happen dependent upon whether some communities have a structural kind of analysis to this work, versus not? Let me just underscore what I mean about structural analysis, and use that to answer your question really quickly.

A structural analysis says, for example, let's look at a really common adage, right, and give a man a fish, eats for a day. Teach a man to fish, he eats for a lifetime. That's such a common adage. Right? We take it for granted. Many of us can't recall exactly when we first heard it. It's something that's deeply ingrained in our collective consciousness. It's a narrative. It's a mental model that we all share. It makes sense, of course, what's missing about that is the structural analysis.

And there are slides that I have to kind of show this when we present this in different organizations that talk about structural competency, and how that's an area of competency that all of us, in any sector, I think have opportunities to improve and grow. A structural competency lens, a structural analysis, to that adage, would say, well, sure, you can give a man a fish, eats for a day. And yes, teach a man to fish for a lifetime. But why not teach a woman to fish? What if the pond close to home is polluted?

What if that family and other neighbors have been historically denied access to the resources to fish, like the rods, and the permits, and others, due to xenophobia, homophobia, transphobia, sexism, or racism? You get my gist. Structural analysis allows us to kind of look at the structures, right, and invites us into all things, including the Vital Conditions, right, to understand the ways in which, as you rightly pointed out at the top, Celeste, the ways in which these conditions

have clearly not been accumulated, distributed fairly and unfairly. Right?

It would be one thing if in every community in us, these Vital Conditions were not fairly – were not distributed to people, but that distribution was generally the same. But that’s not the case at all. Right? We know that because of what racism represents, right, in the US, in particular, what it’s represented from 1691, when the word “White” was first used in law, right, to be able to start a pattern of the accumulation of advantage for those who are labeled as “White” versus those who are not. Right? And if used, disadvantaged for those who are not.

We know that that pattern has persisted and created the unfair distribution and accumulation of the conditions for vital well-being for some communities, and disadvantaged other communities for a long time, including, of course, Black Americans, Latinos, Indigenous communities, and other people of color. That unfair distribution is something we have to acknowledge. Now, it’s not just about acknowledging it. It’s also about thinking from a thriving kind of perspective.

What does it mean then to address it? And to your point, Celeste, specifically, we know from the *American Healthcare Paradox* book that Lauren coauthored, and from other research that’s been done, that the US, every part of the US, every person in the US, suffers at a disadvantage in terms of our health outcomes. That includes White Americans, compared to peers in other countries. And so that doesn’t make sense in some cases. Right?

Well, if racism has been about the accumulation of advantages for White populations and the accumulation of disadvantages for racially-minoritized groups over generations, then why is it that White Americans are still having – suffering poor health compared to peers in other countries? And it’s because inequity harms everybody, especially those as targets, but not limited to those targets. When you close down, as Heather McGee talks about in *The Sum of Us*, when you close down the swimming pools, right, in Black neighborhoods, you’ve also taken away access to public swimming pools for everybody. Right?

So it’s a way to kind of when we use systems of oppression, as some communities rightly call it, when we look at structural violence, as Paul Farmer used to talk about it. Right? When we look at the ways in which, in other words, some groups of people have been put in harm’s way, we have to recognize that that harm, doesn’t only impact those communities, it disseminates and impacts everybody. And it’s to the – this is not just conceptual.

It's actually literally in the facts and the figures that define our health metrics, as we compare it to other countries. And especially when we look at the fact that we spend way much more money on quote/unquote, health or healthcare specifically, compared to other countries, we're not getting what we need. So I think a structural lens is an important one that can be added to this conversation, as the Vital Conditions Framework is put on a tabletop in various communities, at the federal level, and the non-governmental kind of sectors in different communities.

And then say, now, can we apply a structural lens to this work and understand the ways in which these Vital Conditions have been structurally distributed, or not? And how do we now apply conditions for thriving in a way that helps to make these conditions accessible for all, and that includes repairing the way, starting with the communities that have been denied these conditions most for generations?

Celeste Philip: Yeah, thank you so much. I think you helped to introduce information that maybe not everyone knows in terms of how we – because we often look at national data, as a whole, and we compare countries rather than saying, well, what if we start breaking down by different demographics, and race and ethnicity is always a telling one. So I think for folks maybe who are not familiar with what Rishi just talked about, a place to spend some time looking at how White Americans compare to other countries, I think that is very telling. Lauren, I'd like to get your thoughts on this as well.

Lauren Taylor: Yeah, perfect. I was going to ask if I could follow-up. So Rishi, I just wanted to add a little bit of nuance at the risk of being the skunk at the picnic, in the sense that there are definitely ways in which I can get behind the statement: "Health equity is good for everyone." And you've just outlined a lot of them. Because we all do suffer under the weight of inequity, and certainly certain kinds of health inequity. But I think we also do ourselves a disservice to think a little too rainbows and unicorns about this. Like there are some kinds of equity that we need to pursue, that are not everybody wins in equal measure.

And kind of a concrete example I'm thinking of is, and I think this goes back to something you were saying, when people ask me, like, where should we start if we're trying to put action behind, behind the words like, "We're committed to health equity," I often say like g sment, or think about process first. And, you know, it's not necessary that the outcomes will follow, but processes like tangible, and you can do it in the next quarter.

But to think about equity in various processes often means introducing new voices to the table, ceding power in ways that are really uncomfortable. You know, really letting community members, community-based organizations, make decisions that you may be in healthcare, or at a particular organization previously had full control over. And that can be uncomfortable. And that can mean like that on the net, you have less of a say because you're sharing the say, with a bunch of different folks.

And so I just wanted to kind of raise this point and get your reaction. Certainly, when we think about the pandemic, right, we all would have won, had there been more trust, had there been better access more uniformly distributed to vaccines and other life-saving measures. But there are some ways in which we have to be honest. And like the pursuit of health equity, while I think on the net, all boats will float higher, some people are going to have to give in order for others to get. And I just wonder what you think. I certainly agree and solicit that. I welcome your thoughts on this as well.

Rishi Manchanda: I certainly agree. And Celeste, I'd welcome your thoughts on this as well. I certainly agree. I think there's nothing, and if anybody misconstrued my comments, or in general, we talked about understanding the harms of inequities and how the nation suffers, as do the populations that are most impacted and targeted by inequities, primarily. That should not be therefore used or turned around to be able to say, well, therefore, let's create policies that serve everybody, right, and not have an equity focus on this. Right? We need an equity kind of focused aim.

And this is something in the Vital Conditions Framework, that's notable. You know, it's in the framework itself, thriving the conditions, certain conditions are listed. And yet the word "equity" isn't in the in the actual framework itself. It's there in the language that accompanies it. And then some of the recommendations that are there, but it's not front and center, right, in that kind of way. And it allows, therefore, for folks to potentially co-opt a framework, which is the real politic of what happens in a lot of this work.

Co-opt is to say, well, therefore, since there's a framework that says we should support everybody, therefore, we shouldn't kind of identify and prioritize through a targeted universalism approach, for example, those communities that are most impacted. So I think there are, it's absolutely right to focus in on where the harm is greatest. And that's maybe another thing I wanted to underscore here. One of the questions for today was how does this resonate with us and with the communities we work with?

You know, what I found increasingly important, especially to get to the questions of meaning, Lauren, that you're talking about earlier, and Celeste, what you're referencing, is more of these days than not, what we try to do to help people understand equity, social determinants of health, is to actually talk about what resonates with a lot of the healthcare community in particular, but I think people in general, which is notions of harm and healing. Inequities are experienced as harms. Right? They're not experienced as inequities. They're experienced by people as harm. Right?

And when those inequities persist when the data kind of tells us about inequities, the experience of that is actually harmful. Right? So the question really is like, how are we identifying those harms? Well, can we identify what's driving those harms? And then also, of course, can we not only prevent that harm but can we also then promote healing, that kind of way? And that exists, I think, at the levels of the specific healthcare inequities that healthcare is talking about. Still, it also exists as we, I think, take that lens and broaden it to talk about ways to identify harm, reduce harm, prevent harm, and of course, promote healing as well.

There is an approach here that I think could be helpful, as we think about ways to engage in communities to talk about harm and healing. And I do wonder, especially in some communities that have been most impacted by inequities, how the Vital Conditions Framework might resonate in ways if we start talking about healing and healing based on identified harms. And say, so how do we, and also the assets and the resources, the resilience, right, the wisdom, the expertise of the communities that we're mostly talking about here, framing in that way to say that the assets to be able to promote this are in this community, but they also need to exist elsewhere.

We can't, that's the other kind of issue over here as well, that's happens in these frameworks and as well as others. We need to have center community, but we can't burden community. Right? Communities need to be centered in this work, but communities don't have the burden of, therefore, fixing everything that has been an accumulation of disadvantage because of structural forces. We can't expect communities now to shoulder the burden of fixing problems that they themselves are, many communities especially or them are the victims of, right, have been harmed about. So those are my initial thoughts. But Celeste, I welcome your thoughts on this.

Celeste Philip: Yeah. Lauren, I appreciate your question. And, you know, it's not always obvious where – there are examples within the equity conversation to say, well, this is a space where everyone could potentially gain. And I think, Rishi, you mentioned Heather

McGee's *The Sum of Us*. I think her discussion on climate impacts and understanding that – and we're seeing this more and more, large portions of the country at any given time are experiencing different climate-related events.

And I think everyone would say, well, yes, this entire section, maybe a particular state, was hit with a hurricane or a wildfire, or whatever the example may be. I might be giving away my background by using those two examples.

Rishi Manchanda: [Laughter]

Celeste Philip: But you know, where you can start to see distinguishing characteristics in terms of how it's experienced and how recovery and resiliency, to borrow from the title of this plan, show up, I think that's part of where you can say, well, there are differences based on where people live. And you can look at who lives there, and start to see those trends as well. So saying we want to – and we are seeing more efforts to address climate change, and also encouraging that there might be different approaches in different communities.

Because of the disproportionate impacts that are being experienced, I think that is a space where there is more understanding and movement to say, okay, in an equity lens, this makes sense. I hope I will not regret these words down the road. But I think that is one area where a shift in the allocation of resources, people would see that there is a benefit to everyone if we're able to mitigate some of these impacts. So that would be a comment I'd like to share.

And as we're shifting into, what I think will be our last question before wrapping up with your final comments, Rishi, you talked about healthcare. And certainly that's a place where you have deep expertise. If you could – and Lauren, I would also welcome your comments here, but if we could talk about where social determinants and social needs, I would say, within a particular individual's experience, where you're seeing some of the advancement for how clinicians – because I think a lot of our participants will be clinicians, I'll be interested in hearing your perspective, you know, what is the role for clinicians and healthcare in this new framework?

And, you know, in thinking about how to show the multiple benefits of this approach, including some of the cost savings that could be experienced, I'd love to hear both of your thoughts on that. And I think I talked about this bridge between healthcare and public health, or the community if you could share your thoughts on what you've been doing, and how we build on that?

[Side conversation about being on mute]

Rishi Manchanda: So there's maybe one space here where I might share a screen just to show one slide to be able to kind of communicate the ways in which there's a bridge, perhaps, to the Vital Conditions Framework here, for those in the healthcare space. We do, I'll preface it by saying that we do a lot of work, working with people, I would term "courageous leaders", working within healthcare systems or health plans, often who come from public health backgrounds.

And are asking themselves questions like, well, how do I not only achieve some of the important metrics of success that I need for this health system, right, to be able to improve outcomes, but also to control costs, lower costs, if not – and improve patient satisfaction and keep all of our staff our team members thriving and happy? How do we do that, while also recognizing that I want to make sure our institution is playing a role in the community to be able to help support Vital Conditions, perhaps if that framing resonates?

And when we answer what we hear is a lot of folks, those courageous leaders, asking these questions. Very few people that we work with tend to be okay with just wearing one hat, leaving it on, and not taking – putting other hats on. Like, there are a lot of folks that we work with in healthcare, and I think this is true of other sectors as well, who are interested in doing their work, but also interested in how our work now influences a broader community, how can it advance Vital Conditions?

And so if I may, I'll show you an example just briefly about how we do that. This is an example. You can see my screen here of a way, we ask people to essentially how we take the social-ecological models that are very familiar to a lot of folks in public health, and adapt it actually to help leaders in healthcare start to identify where their aims are at the level of programs and care, the level of system work, the ecosystem level aims that they may have, and also whether they have aims to be able to help transform social policies and structures; societal aims.

What we recognize is that there are aims, many institutions, actually, leaders, institutions, and teams have aims that exist across these different levels, right, programs, systems, ecosystems, and societal kind of levels. The question really, and I use this as a frame of reference, is to say that this framing allows us to identify that a lot of folks in different sectors, and institutions, including healthcare, are not looking for whether this is my job, or not, but are just like we do with everything. Where can I lead, where can I partner, and where can I support? Right?

There are things that I can lead, for example, in healthcare, to be able to help advance healthcare equity, and address – and help better integrate with social services, so we can address the social needs of patients that are causing health problems. But there's also places that I can perhaps partner to be able to drive institutional change, and to drive ecosystem change. The Vital Conditions, to me is something that lives in the ecosystem kind of realm there, something that helped create Vital Conditions in the community.

And might be a helpful framework for those in healthcare that are saying, all right, in addition to doing what I need to do for my patients, and for my colleagues, in my system, as we transform our systems and advance equity here, perhaps we can use that as a way to align with what's happening in the ecosystem in the communities in which we work in. And the Vital Conditions framework may be a helpful touchstone for that conversation.

Celeste Philip: Great, thank you. Lauren, please, your thoughts?

Lauren Taylor: Yeah, I might just follow on Rishi's thread there, and add two other kinds of examples or suggestions for healthcare folks, who are inclined towards these conversations. One is I would just plug kind of the anchor institution, anchor hospital movement, because I think those hospitals that are stepping up and saying we our anchor institutions in our community, really have been working with this kind of Vital Conditions Framework, of course, not explicitly, but implicitly in mind. You know, they've been thinking about employment opportunities.

And beyond employment opportunities, what does meaningful work look like? How do we build a community that we, as a place, or we, as an institution, are permanently in? And I think that's really important because the thing about anchor institutions is that we think they can't leave. And therefore, they have a different kind of incentive to make sure that that community is healthy in all sorts of ways. I was recently at a talk by David Ansel, and some of his colleagues from Rush University Medical Center, that was so thought-provoking for me.

You know, they're doing a tremendous job really thinking about their relationship with Chicago, in particular communities and neighborhoods in Chicago, through a vehicle called West Side United, which is really driven largely by community-based organizations, and people who have grown up and lived in that part of Chicago. But they're just being very creative about how to leverage the resources of a huge medical center like Rush and deploy them in service of the community, true service of the community, through laundry

businesses, and all sorts of things that I'll leave it to you all to maybe go Google if you're interested.

But this stuff is happening. I would say it's not standard yet, but there are certainly bright spots where I think courageous leaders to borrow Rishi's language, have stepped up and really thought critically about how to pursue many of the things we've been talking about. So it's not impossible. It just takes some kind of managerial elbow grease, and I guess, courage of mind and heart as well.

Celeste Philip: Thank you both. I think those are excellent examples of what can be done with the patients, and then also at the institute, anchor institute level with the community. And I think we need all of it. So we're getting towards the end of our time here. I want to ask each of you to share one new thing you learned from either looking at the plan, or from our discussion that is like an aha moment of maybe a different direction to take some of your work.

And then also, because I think, you know, this is a new plan, but we're in a plan, do, check, act cycle. So as you've looked at this, is there one opportunity that maybe wasn't captured as well to just kind of help us all think about, you know, how else, if it's someone bringing someone else into the conversation, or a different strategy that should be elevated, if you could each answer those questions. And Lauren, I'll start with you if that's okay.

Lauren Taylor: Sure thing. The kind of aha moment, or the thing that I'm most gratified to see in the Vital Conditions, which we didn't talk about a lot, is the kind of natural world component. And I think it's a gesture towards bringing concerns about climate and climate change into the conversation about what we historically called social determinants of health. And it is high time. You know, the medical industry is incredibly wasteful and is really a long way from being a good citizen when it comes to climate change. And I feel like this cracks the door open to do some introspection about healthcare's role in that.

And there's great work going on at Hopkins. My colleague Cassandra Thiel at NYU Langone is laser-focused as an engineer on the relationship between healthcare, waste, and climate. And so while it's not my area of expertise, it's something that keeps me up at night as the mother of small children, who hopefully are going to live 80 years, 100 years from now. And so I'm really glad that that has at least started to be built in here.

The missed opportunity, if there is one, I think we had a long conversation about trust, I would have loved to see trust as a keyword at the fore, because I think as you said, Celeste, that is a necessary ingredient for

everything else we want to try and do. Without it, nothing really happens.

Celeste Philip: Thank you. Rishi, your thoughts, please?

Rishi Manchanda: Amen to Lauren's points, certainly about the natural world elements of it. It's a really welcome addition as well. I think, a structural lens, the ability to translate this framework into ways that individuals, institutions, and also movements can kind of relate to, I think is an intriguing next stage of opportunity. I think in and of that realm, this is where socially logic models and other frameworks that allow us to understand where these vital conditions show up, and how we can kind of influence them at the individual system, ecosystem and societal levels, I think becomes helpful.

Particularly, because right now, so much of what we've structured, in terms of, and normalized as opportunities for action, right, for a lot of individuals, especially those institutions, oftentimes is just constrained to what I can do for – in my – the ways we provide services and what we can do, maybe in our institutions. We don't have a lot of civic muscle to kind of extend that and build it out in the ecosystem and to structural kind of space. And so I think the more that the Vital Conditions Framework, and the way we socialize it, can enumerate ways in which individuals, and institutions, and movement, power building in organizations and others, can participate in understanding where their roles exist in this framework, that the more likely they are to adopt it, frankly, and to be able to engage in conversations around it.

I'm gonna make one last plug as well, which is for multiculturalism, as well, some of the discourse that happens in some communities these days, especially as we think about the benefits of certain frameworks versus others is, well, how will the sound to a White, you know, a White middle-class guy in the middle of the country. And then there's these, we have these identities. And I think part of what I want to kind of push for is that the version of America that I live in is one that, and that I've always lived in, has to be multicultural. Right?

And once all Americans have every kind of racial and ethnic kind of background, the more that more of us can kind of buy into a multicultural understanding of America, the better. And that would be something I'd love to kind of add into this; a multicultural multiracial America as a norm, rather than it's something that we're trying to struggle to, kind of, work ourselves around, is one that I bring I'm gonna put it front and center in the conversations, including the ones around this framework.

Celeste Philip: Thank you both. And I'll hold myself to the same standard, and answer my own questions and say, as a recovering civil servant, I just, it was so refreshing to hear your perspectives and to know that this work was not in vain. And yeah, I'm going to call this early success. And Rishi, to build on your comments about multiculturalism, I would say intersectionality of identities, and understanding that folks with disabilities, people who are members of LGBTQA communities, need special consideration.

Rishi Manchanda: Yes.

Celeste Philip: Thank you both.

Rishi Manchanda: Thank you both.

[End of audio]