

Vision Care: Real-World Tactics to Address Health Inequities



Monica E. Peek, MD, MPH, MS, FACP:

Hello, and welcome to a very special briefcase that is part of the series I am leading on diversity, equity, and inclusivity with CME Outfitters. Today's CME briefcase is entitled, "Vision Care: Real World Tactics to Address Health Inequities." Today's program is sponsored by an educational grant from Johnson & Johnson. I'm Dr. Monica Peek, and I'm a professor of medicine and the associate director at the Chicago Center for Diabetes Translational Research. I'm also the Executive Medical Director of Community Health Innovation and the Director of Research at the MacLean Center for Clinical Medical Ethics at the University of Chicago here in Chicago, Illinois. I'm delighted to be joined today by my distinguished colleague, Dr. Ann Caroline Fisher.

Ann Caroline Fisher, MD:

Hi, I'm Dr. Ann Caroline Fisher, and I'm a Clinical Associate Professor at Stanford Byers Eye Institute. I'm also the Director of the Stanford Belize Vision Clinic, and the Director of Diversity, Equity, Inclusion within our department of ophthalmology at Byers Eye Institute.

Monica Peek:

Dr. Fisher, I'm so excited to have you with us today. Not only because I did my residency at Stanford, but because of all the amazing work that you're doing in diversity and inclusivity, and just bringing all of that together here with us today. I'm really excited about our discussion. Our learning objective for today is to recognize the impact of health inequities on vision care, which is just something that I deal with a lot. I focus a lot on diabetes, and so diabetes and eye disease is so very common, and so debilitating. So I'm so thankful to have you with us today. I want to remind our audience that this CME briefcase is a continuation of our initiative to address unconscious bias, health disparities, and racial inequities. We're building a comprehensive library of educational activities addressing these very important issues, and today's activity continues the discussion in the area of vision care.

The titles of the activities in this series are on the slides, and the links are in the images. You can simply click on the images to review any of those programs. If you participate in at least three of the programs in our DEI hub, you will also be eligible to receive a digital badge, demonstrating your commitment to education on diversity, equity and inclusivity. As we begin to address vision care disparities, I want to help us all remember how we got here. We've done previous programs that cover these topics in-depth, and those programs can also be found in our D&I hub, but I just want to make sure that we recognize that, and we'd be doing a disservice if we didn't take a moment to recognize that we have a ground water issue that we have to address. And that a sort of thinking about how systemic racism is underlying a lot of what we are commonly talking about in international conversation as the social determinants of health, and how they ultimately impact health outcomes.

And so when we about things like structural inequities in access to housing and education, how that can increase someone's exposure to poverty, crime discrimination, decreased access to fresh food, and impact coming from certain neighborhoods, the stigma that may be associated with that increased their risk of being exposed to healthcare bias, and increased exposure within their own neighborhoods to toxins and pollutants. Which we now have direct impacts on health, particularly for things like asthma. We're learning more about the relationship between toxins and diabetes. And so all of these things have indirect effects also, once people get into the

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healthcare system. So there is unequal care delivery between racialized minorities, and non-Hispanic Whites, along with other kinds of minoritized populations.

And there can be deviations in standards of quality of care, and that has been documented extensively for the past 20 years or more. And so we see that these mechanisms, along with some of the pathophysiology of racism, where people who are chronically exposed to discrimination, and poverty, and these other situations, begin to have biological changes in their body, changes in their epigenetics that put them at increased risk for chronic diseases, what I like to call the diseases of oppression, the things that I deal with every day as far as cardiovascular disease, hypertension, chronic lung disease, et cetera.

And so these long-term effects of systemic racism, really not only impact the morbidity and mortality, but also how well we're able to retain people in care in healthcare systems based on how we treat them. And so it's just a large sort of very complicated interwoven picture that we have discussed before, but that I always just want to give a hat tip to as we begin any discussion today. So let's start by meeting our first patient, Rodrigo.

Ann Caroline Fisher:

So our first patient is Rodrigo, he's a 78 year old cisgender male. He is about 5'8", weighs 212 pounds, so his BMI is about 32. He doesn't have any health insurance coverage, and he's been reporting that he is been having a lot of difficulty seeing, essentially blindness and vision distortion. And he's really struggling to enjoy his grandchildren, because he can't see their faces. He's also unable to use telehealth resources, because he doesn't have access to a computer at times, or proper wifi, and he's got poor eyesight. And so it makes it very difficult for him to use things even on a smartphone. He takes atorvastatin for hyperlipidemia, but he admits that he hasn't been taking some of his doses, because he feels fine, and he doesn't think that the medications are doing anything for him anyway. His blood pressure is moderately elevated, and he's been a lifelong smoker, he actually started smoking when he was about 10. And he occasionally drinks a beer, and he speaks very little English.

So previously he had seen an ophthalmologist, and he was labeled as a, "Difficult, difficult patient", and resistant because he declined to take any, to do any more eye examinations, and didn't want to take any medications. Since he felt that one, they weren't doing anything for him, and he also had limited access to funds, and so he was unable pay for his medications. In fact, he said that when he went to the pharmacy, he just wasn't able to get them, is what he told us. He hasn't gone to the eye doctor in about 11 years, and he states that the last time he saw a doctor, he was told to stop smoking and eating Mexican food, so that he could lose some weight and reduce heart cardiac risk, and it runs in the family. So he thinks that he meant it as a joke, but at the time he didn't think it was funny.

And so he also noted that his grandchildren really are his reason for living, since most of the time now he spends at home, and tries to watch the television, but he can't. And so he tries to play with his grandchildren, but is becoming increasingly difficult to recognize even their faces, and to interact with them. And so that's essentially the only reason he made his appointment, because now he can't recognize his own children and grandchildren at times when they come towards him. And so when you examine him, he appears to have the beginning of end stage macular degeneration.

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Monica Peek:

So, now it's time for our first audience response question.

And how can we go about individualizing equitable care for all patients, including patients like Rodrigo?

Ann Caroline Fisher:

So I think when we think about equitable care and patient access to care, I think we have to go back to what is most important to us as physicians, and that's treating each patient as an individual, even though disease processes may be similar. And also by the way disease processes affect different races and ethnicities at different prevalence with different prevalence, different rates, et cetera. And so being aware of those things is actually already helpful, because you're already kind of heightened and alerted to, "Okay, this patient is coming from this cultural background, and so we need to be aware of some of the disparities that they face that we know of." And so one of the first things is that empathy, that empathetic component, and being aware of the patient's cultural background, and just really listening to the patient. One of the things that I tell our residents in training is that the patient exam starts from the time you walk into the room and you are observing the patient.

Like for us as an ophthalmologist, you think, "Okay, I can diagnose things quickly, because I get to the slit lamp, I look in the eye and I can tell you if they have diabetes or not, just based on whether they have diabetic retinopathy on slit lamp examination." But what that examination doesn't tell you because you go straight to the microscope, is you don't look at a patient at how tired they look, whether their eyes are very, very red because they've had a night shift, and they haven't been sleeping, which may be a reason why they forget to take their medications. So there are many things that you can do just by entering a room, even before you jump into the actual examination with a patient.

Monica Peek:

I'm going to interject there and say that while we are examining patients in their environment, they're also examining us, and how we're treating them. And so just like you said, "It begins how we walk in the door, how we treat them, if we're going to look them in the eye, how we address them." And so as we're trying to size up how tired they may be, do they have their family there with them, all of these other things that may help us, they're also trying to get a sense of, "Are we there to support them ultimately or not?" And so we have to keep that in mind as well.

Ann Caroline Fisher:

... that is absolutely true. I think you start building a relationship with a patient from the time you walk in and introduce yourself-

Monica Peek:

Absolutely.

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Ann Caroline Fisher:

... and looking at them, oh go ahead, sorry.

Monica Peek:

No, I was just agreeing.

Ann Caroline Fisher:

Yeah, no, I mean that builds kind of a trust. And oftentimes we jump to the diagnosis and the problem, and, "I'm going to fix the problem", when what they want is to trust you, and you can't fix the problem. At least I have trouble with somebody helping me to fix a problem if I don't feel that I can tell them everything, And I don't build a relationship of trust. And especially in ophthalmology, oftentimes we think we can fix the cataract, we can put them on glaucoma drops, we can give an anti vascular endothelial growth factor (VEGF) injection. But if you really think about it, I am not going to allow a doctor to give me an injection just right off the bat. Usually it requires meeting with them, discussing with them, getting to know them, and then bringing them back even for another visit so that they've gained that comfort with you as their physician, and they've been given empowered to read over the information that you give to them, so that they can come back with a decision that they're not making for them, but you're making together.

Monica Peek:

Absolutely, and I will say as a primary care physician, I hear a lot about these visits before they get to the eye doctor, or after the initial consultation. Because it's such a simple procedure to you all, but to patients stabbing you in the eye sounds like the worst thing ever, people would almost rather have open heart surgery sometimes than eye surgery. And so it really does take, developing a relationship with people.

Ann Caroline Fisher:

And particularly also acknowledging other people in the room is very important, I think sometimes we jump into the patient and we are examining them. But especially culturally, I know growing up, I would always go to a doctor's visit with my mom or my dad to serve as kind of the translator. And so acknowledging, and also that kind of ties into not making assumptions also about the people accompanying them. Because that can also just to derail a PA doctor patient relationship because they think, "Oh, they're already making assumptions about who I'm bringing and who I'm with. This is my partner, not my daughter. This is my husband, not my son." Kind of those things.

So just knowing how to introduce yourself, "Hi, and I see you come with Mrs. or Mr. so and so, today", and then they usually volunteer. You can ask them, and they'll usually volunteer the information, "This is my daughter, this is my son." If you could just say something very simple, "Oh, and who do we have here with you today?" And that kind of is a very nice way of not making an assumption about who they're coming with, and their relationship status.

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Monica Peek:

And it also lets the patient and family know that you want to meet them. "Oh, great. I see you've brought a team of people here who all do we have here. And so you get the opportunity to shake everyone's hand, to introduce yourself. And so now everyone in the room feels seen and validated, that they're supposed to be there. And so then you start off, "This is going to be a team approach to this individual's care."

Ann Caroline Fisher:

Correct.

And then the other thing I would say about that, is it's also always important to bring it back to the patient after you've acknowledged everybody. Because sometimes what happens is then the patient defers to the other person, which can be helpful, because that may be just culturally how the family structure is. But you want to make sure when you're consenting somebody for a procedure or treatment that you tell them, "Okay, this is what we're going to do." And obviously discuss it with the family member if that's who they defer to, but ultimately say, "It's your choice, and your decision, so let's talk about how you want to proceed", and bring it back to them.

Monica Peek:

That's exactly right, "You're the patient, I'm here to help you. Everyone's here to make support the choices that you have made." So I think that is excellent. Thank you for this wonderful insight, Anne. I can tell you're just a wonderful clinician as well, technically as well as interpersonally. We're going to go back and revisit our first audience refer response question. I think we're ready to move on to our second learning objective today, which is to individualize treatment strategies that include assessment of social determinants of health to improve patient outcomes. So now we're going to go back to Rodrigo with that lens, and talk some more.

Ann Caroline Fisher:

So when we first encountered Rodrigo, we heard, we have to again realize how he's feeling. This is a man who's coming in. Obviously he hasn't come into the hospital, or come in to see a doctor's office in a while. So number one, it means that he really, as opposed to him being labeled as a resistant, reluctant, difficult patient, he really wants care. He's just not probably connecting with the physician to get the care that he needs. And he's clearly visibly anxious when he hears your diagnosis of late stage macular degeneration, or beginning of macular degeneration. Because oftentimes patients, they may hear these things on the radio or on TV, and they kind of have an awareness of it's a condition or a disease, but they don't often know that the gravity of it, right? There's a big difference between saying, "You have end stage macular degeneration, versus end stage glaucoma. Versus you have a very dense cataract that's going to require complex surgery, but we'll be able to bring the vision back."

So furthermore, with Rodrigo, when you mention surgery, you have to be cautious, and then this is just not culturally, but many people when they think of surgery on my eye, it's a tiny space. That's a very delicate surgery. "What are you going to do? What does this entail?" And they may not ask, but usually the first thing they ask about is pain. So the first thing they ask about is pain during the surgery, and second is it can be cost prohibitive to patients, because oftentimes, at least in the ophthalmology world, they'll hear about specialty lenses for

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cataract surgery. And they think, "Oh, my friends said that they had to pay X amount of money, and I don't have that kind of money for that treatment." Or in the case of macular degeneration that you might say, "You're going to need to have injections in your eye every six to eight weeks."

And they think, "Oh my gosh, Well, I don't have the money to pay for those injections, because I need that money to pay for my rent, or I need that money to eat, really." So it can be very devastating to a patient. And so the other thing that comes up, I would say in at academic centers is participation in clinical trials. When there are new devices, new technologies, new treatments obviously, patients are encouraged to participate, but oftentimes we don't think when we're screening for patients that we're already kind of an inequitable process, because patients may not be able to participate in clinical trials. One, because they're the primary provider, so they don't have time to take off of work and lose that income. Secondly, or if they're bringing an older family member, they may not be able to bring their family member in, because they have a job where they have to take care of kids.

So it's kind of this effect of already we're putting them at a disadvantage. In fact, sometimes I've heard people say, "Well, usually you prefer people who are retired, because they have nothing to do." And that's already a bias, right? Because in my family, at least growing up, my mom and my dad helped to take care of the grandchildren. So they couldn't-

Monica Peek:

Multi-generational family.

Ann Caroline Fisher:

... exactly, they weren't able to come in and they wouldn't have been able to participate in clinical trials, simply because of the logistics of, "I can't bring all the grandkids when my kids are at work, and I'm the care provider." And so in the case of Rodrigo, in this case, he doesn't understand, again, the medical terms used and you tell him, "Macular degeneration", and he says, "Oh, but I had a friend who had surgery, and the vision was better." And then you have to explain, "Well, that was cataract surgery." So lots of these questions and don't assume, and this is true for any patient, that they have your medical background and knowledge, and you really have to bring it to a level of conversation where they understand more than the medical terminology, but what their condition is, and the best treatment plan for that.

Monica Peek:

Yes, and I would say two things that responsibility really is on us. We forget as physicians that we have learned a whole new language when we went to medical school, that we speak to each other in this doctor speak, and that patients are not doctors. Sometimes they are, but most of the time they're not, and it's our responsibility to use common terms that everyone can understand. And if the patient leaves the office having no idea what just happened, that's our fault. No matter how literate or illiterate that patient is, that is our fault for not crossing that bridge, because we have to initially go back and back, translate everything that we've done and make sure that they understand. All right, so before continuing our discussion, let's see our next audience response question. So you talked a lot about cost, which is particularly in the area of vision care and dental care, something that people

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think about a lot. What are some of the other social determinants of health that we should keep in mind for patients like this?

Ann Caroline Fisher:

So environmental home situations, I think I briefly touched on that. We make that assumption, like I said, about people being retired, and they can just come to the doctor's office because this is their time to relax. And it's not always the case across different cultures, who are still actively working, maybe not where they're getting in a place where they're getting on a pension plan, or where they actually have a nine to five job, but they're the primary care providers for family members when their daughters and sons are at work, and so that's just one of many. The other thing is that oftentimes we're taught to be cost effective in medicine, but we're taught to reduce cost overall in healthcare. But really, at least in ophthalmology, there are ways to reduce cost of care also, in terms of treatment. For example, there was a light study, this is for the case of glaucoma management.

So it used to be that the treatment for glaucoma was you would start with eye drops to lower the eye pressure, because it's the only modifiable risk factor. And then subsequently you would administer laser, a laser treatment, specifically one called selective laser trabeculoplasty, if the medical management failed, or didn't help. And then ultimately you would move on to incisional surgery. Well, now it's changed quite a bit in terms of the treatment plan. So for example, if I'm going to tell a patient, "You're going to be on four glaucoma medications to reduce your intraocular pressure." Number one, it's very hard for them to take all those medications. And we're talking about-

Monica Peek:

For anybody.

Ann Caroline Fisher:

... oh, sorry, go ahead.

Monica Peek:

For anybody to take all of those medications.

Ann Caroline Fisher:

Right, and patients will say, "Oh, I'm putting drops all day in my eye." And not to mention the cost of the drop, each drop is about \$200 to \$400, so you can do the math very quickly there if you're using four different drops. And now if you've been diagnosed earlier, which is in the case of Black and Latinx patients, glaucoma actually affects them at higher rates at an earlier age. In fact, the American Glaucoma Society and the American Academy of Ophthalmology recommends screening instead. We used to teach the risk of glaucoma goes up in your fifties, but in fact, screening should start in your forties for people who are black and Latinx, because they're at higher risk for developing more aggressive glaucoma at an earlier age. So what happens is if you start taking those

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medications when you're 40, you can do the math one thing to start taking the medications in primary open angle glaucoma.

If you start at 70, and your life expectancy is obviously, even if it's in your eighties or nineties, that's 10 to 20 years of paying for those medications versus starting in your forties, and then paying that for the rest of your life.

And it's a huge commitment, and you're thinking, "Oh my gosh, I have all these expenses, and now I have to use these drops." So one, based on the light trial based, what they saw was the selective laser trabeculoplasty was it could be just as effective at lowering intraocular pressure, and it's a one shot laser deal right. It's not perfect all the time, but I offer that to my patients now. Or for example, if they have that night shift job, and they keep forgetting to take their medications, or if they work out in the field and it doesn't make sense for them to carry, we tell our patients, "Don't keep your eye drops out in above 90 degree weather."

Well, if their job requires them being outside, and they put their drops in their pocket to put them in, one, they're outside putting the drops in, and already the medication has been rendered ineffective, because it's the activated by the heat. So all of these things that we asking them, "What do you do? What's making it hard for you to get your medications? Would it make more sense to do a laser?" And again, that goes back to they say, "Whoa, a laser, that's surgery, right?" And then you explain to them, "Actually, this is a five minute procedure. Best case scenario, your pressure comes down and you don't have to take this drop. Worst case scenario, it doesn't work, and then you have to go back to the drop. But at least we've tried something that makes sense for you that's going to last longer and be more cost effective for you."

Monica Peek:

Yes, and that can address some of these issues you brought up when we have large populations that are marginalized, more likely to be day laborers, migrant farm workers, out construction workers, because of structural inequities, the kinds of work that people do may limit their ability to effectively take some of the medications, or adhere to the plans of care. So lots of things to think about, health literacy, how we're communicating with patients, costs, so many things. So we're going to do a second audience response question now. Okay, so now we're going to meet Muriel, a 48 year old cisgender black female meeting with her ophthalmologist. And so now I'll hand it over to you, Dr. Fisher.

Ann Caroline Fisher:

Okay, so Muriel is a 48 year old cisgender black female accompanied by Lori, her partner and caregiver. She's 5'6", weighs 195 pounds, BMI of 31.5. She's been having pain in both her eyes, and she says she's having some difficulty seeing. She was diagnosed with ankylosing spondylitis eight years ago, and resorted to drinking alcohol heavily to alleviate the pain. Currently she's taking infliximab, but only intermittently. She's not taking it all the time. And she's been seen by several other providers and labeled as a difficult patient because she's not always attending her follow up visits. And she says that he doesn't really trust doctors and hospitals, because they've really done nothing to help her. And in fact, she also uses a Crown Royal bag as a makeshift wallet, as she sits in your office explaining to you why she doesn't trust physicians.

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Monica Peek:

Okay, and then last but not least, here's our final audience response question. So as noted in Muriel's file, other providers have found her previously to be difficult, which is a common thing that we see in the medical records. And there have been several studies published in the past year about how minorities, particularly black patients, are more likely to be labeled as difficult or aggressive, or have these negative terms attached to them, even when you adjust for so many other sociodemographic and clinical characteristics. So why should we not strictly go by what a patient's file says?

Ann Caroline Fisher:

So again, this spans across all patients. I have had many patients who have been labeled or sent to me, because they're difficult patients and they're with their medications and they can be even as extreme as saying, "Oh, they can be aggressive with their providers." With medicine we're taught to treat, we treat all conditions, all diseases, all patients as people. And at the end of the day, we do no harm, and we advocate for our patients. So again, I teach the residences. I tell them, "Regardless of what anybody says, you need to make your own assessment." It's kind of like when I used to have a neurology attending who would say, "I know the radiologists look at the film and look at the scan, and they give me their assessment. But the first rule of medicine is, 'Don't trust what anybody else says and review it yourself.'" And it's the same principle here, because if you are reading off of what somebody else says, you're already putting in a bias there, right? For whatever-

Monica Peek:

Transmitting bias through their electronic record.

Ann Caroline Fisher:

... correct. So we're-

Monica Peek:

Stop those things ourselves.

Ann Caroline Fisher:

... yeah, exactly. And so you walk in and I don't walk in assuming, "Oh, this is going to be a difficult patient. It's going to be a rough visit, it's going to be a rough day." And certainly if I say that to the resident or the trainee with me, then they already are learning bad behavior. They're learning, "Oh, if somebody says they're difficult, they're difficult." We are taught to make our own assessments, and it starts with that patient interaction. So the first thing I do is I walk in and say, "Hey", and I'll acknowledge, I'll put it out there, I'll say, "I see that you've seen many different physicians, and I'd like to figure out if we can maybe come up with a plan to help you." And ask them again, don't just read the file, what the problem is, because what another provider writes as a, "Problem", may not be what that patient perceives as the problem.

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So it's just getting again, to know the patient, and asking them, "What is bothering you the most?" Because if I jump to the diagnosis and I say, "Oh, you have glaucoma, or you have macular degeneration." But they're telling me, "Well, my problem is that my eyes hurt." And in this case of Muriel, she had mentioned that her eyes hurt. And you're thinking, "She's not complaining about her vision, she's actually complaining of pain. But if I tell her I can do cataract surgery and fix your vision, but I'm not fixing her pain, then that's done nothing for the patient to address her. And I essentially ignored her concern. So-

Monica Peek:

Validate their feelings and concerns, yeah.

Ann Caroline Fisher:

... exactly, validation is a huge thing. And so I think that that begins with you, but you have to model that behavior for your staff, for your trainees, because it starts from when the technician comes in and says, "This is a difficult patient, she's already seen three doctors." Then I could say, "Ugh", and the same thing to the resident. But if I say, "Okay!" And I've had so many patients who have been labeled as difficult, and then I get to chatting with them, and trying to really get to the core of what their concern and problem is.

And then I realize, it's not that they're difficult, because I think the physician oftentimes can get taken aback and then say, "I just don't want to deal with this." But you have to realize that if you say you don't want to deal with this, then you're not fixing the problem, you're just pushing that problem along, and somebody eventually has to fix it. And I tell the residents that I say, "This is a patient who's been labeled as difficult, and really they actually do have a problem that we can-

Monica Peek:

And social care needs.

Ann Caroline Fisher:

... correct!

Monica Peek:

That need be addressed at the same time as medical care needs.

Ann Caroline Fisher:

Correct.

Monica Peek:

And that's where we're going now as a field, is integrating medical and social care at the same time at the visit. So these are excellent suggestions. When the exam was conducted, what did you notice?

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Ann Caroline Fisher:

Okay, so the first thing was that her intraocular pressure was 40 in both eyes. And so she had been diagnosed with uveitic glaucoma, but the first thing was, her concern was pain. And obviously with the pressure of 40, of course she's going to be in pain, right? And so the first thing that you would want to do as an ophthalmologist, "I got to take care of the eye pressure, because she's having pain from the eye pressure." But then you have to figure out, "Okay, well what is this pressure coming from?" And it turns out she has the uveitic or inflammatory glaucoma. So the first thing to do is to control the inflammation, because controlling the inflammation can actually bring the intraocular pressure down. And then that will alleviate some pain. But then the other thing that you notice is because the cataracts have gotten so thick, and they're kind of causing, and almost like a uveitic angle closure condition, that's also elevating the pressure.

So the next thing to do is to address taking the cataracts out, which by the way, I don't think you mentioned, but her vision was like, count fingers, hand motions in both eyes. So now you have somebody who's been labeled as, "Difficult", but really what it is, of course, if you can't see and you're in pain, you're going to be in a chronically frustrated condition. Again, so addressing the pain, addressing how to reduce the pain, but taking care of the clinical problem as well.

Monica Peek:

We're going to take a gander at the third audience response question one more time. So it's wonderful to hear that Muriel now has 20/20 vision with a need for further treatment, she's not quite out of the woods yet. And so what are some of the clinical challenges you see with patients like Muriel?

Ann Caroline Fisher:

Yeah, so in the case of Muriel, again, took out the cataract, achieved improved vision, pressure was lower, but she has a lot of scarring, and she has this chronic inflammation. So it's not just about even achieving the better vision, which now allows her to do the activities that she normally would've done if she had had that good vision, which she now has. But clearly there were other things that came up during the examination. She had resorted to drinking a lot of alcohol excessively as a result of the pain that she was having, as a result of just dealing with these issues. So now it's time to also get social work involved and address that, because also with her condition, you also saw in the prior slides that she wasn't taking her infliximab all the time. And part of it may have been because as a biologic agent, that interferes with her alcohol use.

And so first of all, address that. And now that you've gained that connection with that patient, because now she has better vision and she's not in pain and she's very thankful and grateful for that. But more than that, you've connected because you addressed the concern that she had. But now, it's time to have a deeper conversation of, "Okay, we have taken care of those problems. Long term, we have these other issues to deal with, and so involving social care to address the alcohol use, and coming up with a treatment plan perhaps.

And again, if she is unable to deal with her alcohol use, then you have to think, "Okay, what other treatments can I offer her that's not going to affect her liver function tests because of the medication she's taking with the concurrent infliximab? So thinking around the treatment plan for her, it's very specific. So again, this goes back to,

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"We can't just impose the same treatment plan on everybody. It has to be individualized care, addressing those social determinants of health, addressing the patient's personal needs." And so those are the things that we have to think about.

Monica Peek:

Excellent, there are some patient resources that can help offset some of the challenges that we've faced in our clinical cases today. Can you talk a little bit about those?

Ann Caroline Fisher:

Sure, I think one of the things that patients don't have is access to information. And they'll hear, like I say, especially in ophthalmology, "Glaucoma, cataracts, macular generation", and they kind of think they're all the same thing, but they're not. And obviously there are different levels of intervention, and results from surgeries and treatments from these very different conditions. And so oftentimes what can help is providing resources that patients can access to and feel comfortable with in their own environment. So lots of community screenings, I've actually done church screenings in the past, and given and done kind of little teaching sessions. A lot of the information out there is not necessarily written at a literacy level sometimes for some of these patients. In fact, recently at the AAO, American Academy of Ophthalmology, the new CEO, Steven McCloud, who's former chair at UCSF in ophthalmology, mentioned that a lot of the literature out there is written at a seventh grade level.

And which we would think, again, that's our bias, "Oh, of course you could read it at a seventh grade level." But oftentimes, especially in the southeast population, literacy can be in specific populations, black, Latinx can be at the fourth grade level. So it's not really written at a level of understanding that will allow patients to really get what's going on. So really interacting with patients through community resources, community screenings, even at religious locations, and institutions just to provide that information, and promoting that health literacy and education. So there are just many, many different support groups within the different societies. And this goes for ophthalmology, for ENT, usually for us, we have the American Glaucoma Society, and there are things that they can download off of the internet. And again, you have to remember, maybe they don't have wifi or maybe they don't have access to a computer, but you could say, "You can go to the public library if possible, and print some information." Or have some readily available in your office to give to the patient.

Monica Peek:

Exactly, wonderful. Okay, so we're going to summarize our discussion with our SMART goals, which are specific, measurable, attainable, relevant, and timely. And normally I do the SMART goals, but this time we're going to let Dr. Fisher cover our smart goals for us.

Ann Caroline Fisher:

One of the key things that we've discussed here, and I think Dr. Peek and I have really stressed, is to be an advocate for your patient. I think oftentimes we see patients, and that's how we're trained in medical school, we have a differential diagnosis, we go through that differential diagnosis, and then we also create an assessment and plan. And what we don't realize, and it's very hard as physicians because we talk about implicit bias and

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unconscious bias, but if you think about it, that's what we're doing as physicians. We're taught to put things, compartmentalize things, so that we can deal with them more easily when we come up with an assessment and plan. But I think we have to think outside of that, there is a role for that in the way we approach patient care, but we also have to think out about that, in order to be the best advocates for our patients.

So one thing is obviously addressing language barriers, having proper resources in the office, on the internet, like a list of things that they can access pretty easily. Or give to a family member, even if it's in English and oftentimes will, if I run out of my pamphlets, I will apologize to say, "I don't have these in Spanish anymore, but can you take this home, and go over it with your family members?" And that's also very helpful. And they come prepared and empowered to their next visit, so they're making the decisions with you, rather than you're saying, "This is what you're going to have done." So that's one thing, so providing resources. And really also trying to understand where patients are coming from, because that will help me formulate a plan. Like if I say to a patient, "Yeah, just take these drops, and I'll check your pressure in a month."

One, they think they may not take the drop, because they may think, "It's not doing anything for me, my vision is still the same." But be very clear like, "This isn't going to make your vision better, but it's going to treat your condition, your glaucoma, what have you. And so as a result the long term benefits will be there, even though you don't notice it immediately." And then with that, also finding a bit the best cost effective method for them, not for the medical system as a whole, but what's right for them in terms of cost, and what they can access easily, medication, laser, et cetera. And I think the most important thing, and I think we oftentimes forget why we went into medicine because we focus on that EMR system, and charting, and getting through the day. But at the end of the day, I tell my children, I tell my residents, I tell everybody who I train, "We will all get to a point where we need some form of medical care or treatment."

Age does not discriminate, and time doesn't discriminate. And as a result, I think we really need to treat our patients the way we would want, a loved one treated or the way we would want to be treated when we get to an age where we face these conditions that our patients are facing, and treat them essentially the way we would want to be treated." And I think when you start off with that, you're already going to say, "If somebody labeled me as difficult, because I ask a lot of questions because I'm a physician, and I know the lingo, of course I'm going to be labeled as difficult. But I wouldn't want somebody to have that bias against me from the get go." So I think those are the main things, the main takeaway points.

Monica Peek:

Yeah, there's the cultural competency, thinking about cost, engaging patients and their families, and thinking about treating patients as your future self. So those are all excellent points. So thank you so much Dr. Fisher, this has been a wonderful briefcase, we've really enjoyed having you today. Here are just some of the topics that we have covered so far, and we'll be adding new content every month, and we really want to hear from you, our audience, on what you need so we can make an impact on these important issues. So please email us at questions@cmeoutfitters.com with your comments and feedback. We assure you that we read every email, and we really appreciate your feedback. CME Outfitters also has a diversity and inclusion hub, with a number of excellent resources to share with your patients. So thank you again to everyone.

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To receive CME or CE credit for this activity, you must complete the post test, and the evaluation online, and you can download and print your certificate immediately among after completion. So thank you, Dr. Fisher for joining me today. Thank you for our audience for joining us. Please be safe, and take care of yourselves, and provide the best care that you can to your patients.

Ann Caroline Fisher:

Thank you, Dr. Peek. This has been wonderful.