Joint Health Care: Real-World Tactics to Address Health Inequities

Monica E. Peek, MD, MPH, MSc:

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 CMEO BriefCase is entitled *Joint Health Care: Real-World Tactics to Address Health Inequities*. Today's program is supported by an educational grant from Johnson & Johnson. I'm Dr. Monica Peek, and I'm the Ellen H. Block Professor of Medicine in the section of General Internal Medicine. I'm also the Associate Director of the Chicago Center for Diabetes Translation Research and the Director of Research for the McLean Center for Clinical Medical Ethics, all here at the University of Chicago in Chicago, Illinois. I am really delighted to be joined today by my distinguished colleague, Dr. Haydee C Brown. Haydée. Can you introduce yourself?

Haydée C. Brown, MD:

Hello and thank you, Dr. Peek. I'm Dr. Haydée Brown, and I'm an Attending Orthopedic Surgeon at New York City Health and Hospitals, Harlem Hospital. I am an Assistant Clinical Professor in the Department of Orthopaedic Surgery at Mount Sinai Health System. In addition, I am the Founder and President of Black Women Orthopaedic Surgeons here in New York, New York.

Monica Peek:

Haydée, I am so honored to have you joining us today, with all of your various hats that you wear. You're so busy. Thank you for making time for us. I'm really excited about our discussion. Our first learning objective for today is to identify the impact of health inequities on patients with joint health concerns. And I want to remind our audience that this CMEO 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 important issues, and today's activity continues the discussion in joint health care. On this slide are the titles of the activities in the series, with links to each of them. To view any of these programs, simply click on the activity title. If you participate in at least three of the programs in our D&I Hub, you will also be eligible to receive a digital badge, demonstrating your commitment to education on diversity, equity, and inclusivity. Before we jump into today's program, let's gauge our baseline understanding of disparities in joint health. Which the following do you think is true regarding joint health disparities in the United States?

As we begin to address joint health care disparities, I do want to review some foundational points regarding historical racism that remind us how we all got here. We've done previous programs that cover these topics in depth, and those programs can be found in our D&I Hub. We have a groundwater issue, and I encourage everyone to participate in our foundational program so we can learn and do better. What I want to start out with is just acknowledging that there's the existence of systemic or structural racism that affects so many things, such as the disproportionate distribution of the negative social determinants of health, like food insecurity, unstable housing, transportation barriers, etc., and also low educational opportunities, poverty, and crime. In addition, the structural racism and interpersonal racism affect health care provider bias within the healthcare system. And finally, structural racism determines not only what is happening inside the healthcare system but within communities. It determines who is exposed to things within the social and built environment, such as toxins and various pollutants, which we know have direct impacts on health.

All of these things cause indirect effects of systemic instructional racism, such that we begin to see things like differential care that's being delivered based on race, or deviations from standards of care. We begin to see elevations of stress levels for patients who are being exposed to racism, which we know causes pathophysiologic changes and epigenetic changes that impact their health negatively. We begin to see increased rates of mental health disorders such as anxiety, depression, and post-traumatic stress disorder (PTSD). And in the long term, we see things that cause distrust of the healthcare system, lower retention in care, and things that make it more difficult for marginalized populations to continue to receive the kind of care that they need in order to stay healthy. This is the backdrop or the context for which we are then going to be discussing many of the very specific clinical topics that we do on any given occasion, and today that is going to be joint health disparities. So Haydée, what I just discussed is applicable to many, if not most, specialties. Can you go into some of the specific disparities that are seen with joint health?

Haydée Brown:

In reference to joint health, we really are speaking about disabling osteoarthritis, in particular, and hip osteoarthritis. There's a similar prevalence of osteoarthritis in Black, Hispanic, and non-Hispanic White patients. However, there is a disparity in the amount or the number of African American and Latino patients as well as indigenous populations who access and obtain these total joints. It's been proven that there's a 35% longer wait between the first consultation with a primary care doctor and a joint replacement for Black patients. Overall, there's a lower rate of joint replacements in Black patients. When we start to talk about social determinants of health, if patients have commercial insurance versus something like Medicaid, those who have the better, more commercial insurance will most likely be able to see an orthopedic surgeon and have their care delivered effectively.

Monica Peek:

Absolutely. Thank you for that insight. We're going to switch gears to talk about a patient, but before we do, we're going to go back to that audience response question one more time and see if we can get more of the questions right. Which of the following do you think is true regarding joint health disparities in the United States? Now let's jump into our patient case. Haydée, can you tell us about Mary?

Haydée Brown:

Mary is a 52-year-old Indigenous/Native American female with chronic right hip osteoarthritis. Her past medical history is notable for hypertension and postpartum depression. Her BMI is 32.3. Mary has previously seen several clinicians for this severe right hip pain. Looking through her chart, clinical notes state that she's difficult and non-compliant. So that's already one thing to look at in terms of how we're labeling this patient. Note that the patient, Mary, does not work. She receives disability benefits, secondary to her hip pain and limited mobility. Mary also isolates herself from her family because she feels that she cannot contribute due to her hip pain and that she's unable to contribute in the house in terms of working in the home, outside of the home, cook, or help with chores without having significant pain over the next several days.

Mary has tried several creams and herbal remedies with little or no relief. She has occasionally used acetaminophen and nonsteroidal anti-inflammatory drugs (NSAIDs). There has not been a trial of physical therapy

or a home exercise regimen. Mary, at this point, is not interested in having surgery because a family member had struggled with opioid addiction following surgery. Mary states, "I just want to feel better so I can work. I don't have time to drive here for appointments every week." She misses cooking and working around the house and the yard and participating with her family.

Just a few things to highlight for her: number one is this label of a difficult and non-compliant patient. Sometimes those labels are applied to people of color more than non–people of color. And the question is, what has made her difficult? What has made her non-compliant? It could just be a reflection that it's difficult for her to get to appointments, as she points out in this slide. The other issues were that she's on disability because of this hip pain and the impact of that financially, but also that she's unable to contribute in her home, so there's a psychological impact as well.

Monica Peek:

Yes, absolutely. When there are so many additional burdens that poor people carry, just to get through the day, most people who aren't having to experience those things don't even know they exist and don't realize how difficult it may be to even get to the doctor, taking three buses, having to arrange for a ride when you don't have a car. Who's going to help you pay for gas? All of these things have to be coordinated. I have to wait until so-and-so gets off work. Are they running late? And there can be challenges for people who have limited resources. So, showing up late at the doctor's office just seems like, "Well, why didn't you just get in your car and drive here on time?" That is a privilege. People who have all of these resources have no idea what life is like when you don't have those resources. It's easy for us to label them as though patients are uninterested in their health, as opposed to they have a large stack of barriers to overcome when they finally do make it to their appointment.

Haydée Brown:

You make such a great point, especially about late arrivals, even when patients have access to some social supports such as Access-a-Ride or the ability to get a car service. That car service or access-a-ride may arrive much later than you have to arrive on time to your appointment. So, again, it’s so important to really look at the reasoning behind their difficulty.

Monica Peek:

Absolutely. So many things in this case. Well, we've talked about some of her issues and social determinants of health. Let me ask our second polling question, which is: In what percentage of your patients do you screen for social determinants of health during visits or as part of your preoperative screening? What we have discussed so far, I believe it's accurate to say that several social determinants of health may have impacted the care and treatment plan that Mary has previously received. Far too often, the responsibility is placed solely on the patient to raise and discuss life and societal factors that may be undermining the treatment and the outcomes. How can we do a better job of screening for these factors in our patient with joint health disparities?

Haydée Brown:

Well, we can use the screening tool that's noted in our slide for these social determinants of health. One being, do you or your family worry about whether your food will run out and you won't be able to get more? Number two is: are you worried about losing your home, losing your housing, or are you already homeless? Three: are you currently having issues at home relative to bills, utilities such as heat, electric, natural gas, water? And four: is there an issue with transportation? Has that kept you from making your medical appointments going to work or getting to things or activities that are needed for your daily living? Or are you worried that someone may hurt you or your family?

And these are important when evaluating a patient with joint pain, for multiple reasons. One is their diet, of course. Their intake is important. You want to have a healthy diet, or if the patient has comorbidities. If they have diabetes or high blood pressure or high cholesterol, those are all things that can impact their joint health, particularly their weight. Their home – are they domiciled? If they are domiciled, where do they live? Is that a stable home for them? It's very challenging to address your hip pain or knee pain if you're worried about where you're going to lay your head for that night. And then if you do have those items, if you do have a home, are you able to sustain that home? Are you able to be in your home and have heat and have electricity and have gas and have water? These are things that those with resources can very simply overlook. But those are all very key to someone being able to even come to an appointment or to follow a treatment plan. And that goes to transportation, which we discussed a little bit earlier. And then of course, being concerned that someone in the family can hurt them.

Monica Peek:

Yes. And they're also, as you were mentioning, interrelated to the pain itself. People who are obese are more likely to develop osteoarthritis. People who have transportation issues may be doing more walking on that joint that is disproportionately affected. So, all of these things may be causing flareups or exacerbating the very disease that they're coming to see you for.

Haydée Brown:

Absolutely. And sometimes if a patient has to take those three buses to get to the appointment, they are going to be in significantly more pain than they were when they first started. That may prevent them from wanting to come in the future or from wanting to go to physical therapy. So these do determine the way we can take best care of our patients.

Monica Peek:

One of the positive things is that we're seeing more and more screening tools that are being validated and getting shorter, become available and for use in routine clinical practice. So, Haydée, do you think it's realistic for orthopedic surgeons to screen for social determinants of health with their patients? And if so, are there key questions you focus on? And how does your care team do this in practice?

Haydée Brown:

I work in a city hospital. Most of these are asked before the patient sees us. They're screened but often in our conversation it's: What type of work do you do? If you're not working, what do you do with your time? How did you get here? How could you get home? And when you start to talk about the treatment plan, really asking the patient where they're at, would you be able to make this or not? So we're able to really go through the questions that are here on our slide about their housing situation, food, whether they live in a "food desert," and if they have significant responsibilities in the home, so they may not be able to make their physical therapy appointments or other appointments, and if they have enough support to really allow them to go through a treatment plan.

Monica Peek:

I really like this slide because it tracks those four questions and how they relate to these three key issues of outcomes, procedure planning, and ability to follow up with care. That is huge. And I think that would be hugely motivating for everyone who's watching this, which brings us, timely enough, to revisit that audience response question. So now that you've seen these data, what percentage of your patients will you screen for social determinants of health during visits, now that you may see how important it might be to take the time to ask those four questions during visits or as part of the preoperative screening? In addition to screening and assessing for social determinants of health, we should also provide and engage in culturally competent care. We know that Mary is an Indigenous/Native American female. Can you talk about how you provide culturally competent care and what you would consider specifically with Mary?

Haydée Brown:

The first thing is to meet the patient where they are and validate what other treatments she's used and even to ask more about them. Some patients use turmeric, for example. So again, just validate their current experience. And the second thing is to really speak to the patient while they're clothed, in their original clothes that they came to the appointment in, because then you are able to relate to the patient. They can perceive that as it's the same level, there's the same level of respect, and they have the dignity of having their clothes on. And of course speak to them and say, "All right, now that we've talked, I'm going to step out. If you can please put a gown on so that I can do the exam," and tell them what to expect.

Monica Peek:

I really like that you mentioned that, particularly as a surgeon, because sometimes people, when the nurse comes in, she wants the patient to be undressed so that when the doctor comes they're fully ready. The doctor meets patients naked and vulnerable. So the idea of saying when they're fully clothed, with all their dignity intact, when they feel like themselves, and to some degree there's always going to be a power imbalance, but they can meet you eye-to-eye and feel like they can at least have that kind of equal conversation. I think that is a huge thing. Thank you for saying that.

Haydée Brown:

It also builds trust, right?

Monica Peek:

Absolutely.

Haydée Brown:

As a surgeon, at some point, this patient may need surgery, whether it's hip arthritis, knee arthritis, or ankle arthritis. And yes, we're walking with this patient through their treatment course, but you need your patient to trust you. That's how they participate in their care. Before even beginning the exam, make sure that the patient's comfortable with that. And even while performing the exam check in with them often. For example, for a hip exam you are examining the patient's hip. So you're exposing near their genitalia. You need to internally and externally rotate their hip. They may be incredibly uncomfortable about that. So just check with them and say, "Okay, now we're going to range your hip." So be sure that you both are on the same page with what the next steps are. And again, once you're established, you've established this trust, so keep asking the patient, "Is this/that okay?" so that they can progress through the exam and give you a true physical exam and leave the exam with some dignity.

Monica Peek:

Absolutely. And one of the things that I always try to do is have an extra sheet that's handy that is covering any body part that I'm not needing to expose at that time. And even if I can't get everything covered, the patient knows that I'm trying. And I think that the efforts that we make go a long way to establishing trust, even if we don't get there. I think that's more important than whether or not there's a little bit that's showing, that they get that we're trying to respect their dignity.

Monica Peek:

With our patient case, it is clear that Mary is in need of better pain management. Mary's representative of patients we see every day, that I see every day, and they just, like Mary, may be impacted by deeply rooted disparities and pain management. And that can be a whole talk in and of itself. So, Haydée, what are some of the driving forces that are causing inequities and disparities in pain care?

Haydée Brown:

Well, it's the belief that there's a higher incidence of opiate abuse within Black and Brown communities and for that reason there's a resistance within certain clinicians to prescribe appropriate pain medication. Also, historically, if you even go back to, I think it was Anushka, the early exams and the speculum, it's believed that Black people, Black and Brown people experience pain differently, to such an extent that in the earlier medical history we did not receive anesthesia for procedures that require anesthesia. A lot of that is ingrained in our

dogma as clinicians, as in medicine and just as surgeons. And that's a problem because that's your implicit bias, where you would see a patient and make these assumptions and then inappropriately treat their pain.

Monica Peek:

We did a study not that long ago, of medical students and they're like, "Oh yeah, Black people have thicker skin and feel less pain." And who told you that? How is that? So yes, it's a challenge. It is a challenge.

Haydée Brown:

And it creates this level of distrust with patients. There are some data that show patients are more likely to get their total joint replacements once they are part of this care plan. And part of that is them thinking that you want them to get better, that you are believing that they're in pain, you're believing the limitations that they have. And then, that you will work with them to make them better, not just the surgery, but their recovery from surgery. And that's a challenge to do if you're carrying these implicit biases. But the first step is really to acknowledge that it exists and then to work on dismantling that.

Monica Peek:

Absolutely. Talk a little bit more about the lack of diversity in health care and what that might mean.

Haydée Brown:

Well, multiple studies have shown that patients get better care if they're cared for by people who look like them. It may just be that level of trust, a shared experience, but there is a huge disparity in terms of particularly Black and Brown physicians of all types. And we can even speak about orthopedic surgery. There are 1.9% of all orthopedic surgeons in the United States who are Black. It's about 575 people. Literally, 575 people.

Monica Peek:

You all could fit in one room.

Haydée Brown:

We have, I think, in our annual meeting. But that's an issue if the majority of orthopedic surgeons are overwhelmingly White and they're overwhelmingly male. Six percent of orthopedic surgeons are female. I think the number's now going up if you count some of the recent grads, to 12%. But that's still incredibly low, given that our population's about 50/50. So those create challenges for patients because they're not going to have access to a clinician who looks like them. However, it's incumbent upon all of us, regardless of color, race, gender, ethnicity, for us to be sensitive to these issues so that we can still provide quality care.

Monica Peek:

Absolutely. Piggybacking off of this provider bias and the lackluster diversity in our healthcare system, can you explore the relationships between race bias and opioid misuse?

Haydée Brown:

We hinted at this a little bit earlier, but this false biologic belief and superhumanization of Black bodies in our healthcare system directly correlates with undertreating or underrecognizing Black patients' pain. And that is historical, even if you think about how, I know I mentioned OBGYN before, but just the concept that people are exaggerating their pain from horrible arthritis to get drugs. That all plays into this perception that Black and Brown communities are at a higher risk of developing an addiction, and that Black patients are perceived as having a greater risk of opiate abuse or misuse than White patients, even though there's actual lower rates. And because of those implicit biases, there is a discrepancy in the prescription of opioid treatments in long term but also in terms of pain management for these simple musculoskeletal complaints. It's unfortunate and we all have to work incredibly hard at dismantling these biases so that we can take better care of our patients.

Monica Peek:

Absolutely. Let's go back to our patient, Mary, who has chronic osteoarthritis in her right hip. What are some of the nonsurgical interventions to manage her osteoarthritis?

Haydée Brown:

It's important to coach to patients that surgery is the end treatment. We want to partner with patients and help them manage this complaint until these treatments no longer work. It starts as minimally invasive as them taking a medication or applying a topical anti-inflammatory cream, so your nonsteroidal anti-inflammatories, ibuprofen, naproxen, meloxicam. Once those aren't as helpful and patients can try their different herbal medications, if that's part of their culture and something that they have found to be helpful, we then start to walk along with things a little bit more invasive. So that's where you talk about an intraarticular injection. We can inject the joint with a corticosteroid, we can inject it with stem cells, we can inject it with platelet-rich plasma, hyaluronic acid. A mix of two has shown to have good results as well. And these can all be paired with alternative therapies.

And that's your Ayurvedic therapy, your homeopathy, and even thinking about what patients are eating, their intake, using foods that are low in inflammatory mediators. And some patients do find relief just with supplements such as glucosamine or chondroitin or certain vitamins. And a big part of what, in my practice, is sending patients to physical therapy. Really strengthening the muscles around the joint as well as the core, can greatly diminish the pain that they're feeling. Using things such as a knee brace. And then, we can progress more in terms of invasive management, whether it's laser-assisted cardiogenesis, or then we really start to talk about surgical management depending on the type of arthritis. And that can range from things where we just stimulate cartilage healing within a certain part of the bone, and that's minimally invasive, to something such as a total knee replacement.

Monica Peek:

I have found that my patients love the joint injections, once they get past the idea of a long skinny needle, because they are so effective and it gives them several months of being pain free to be able to exercise and to try and lose some of the weight that is perpetuating that cycle; "I want to lose weight, but I can't move because of this pain. And so, how am I supposed to... What am I going to do here?"

Haydée Brown:

Right. Patients leave with a sheet of paper that says lose weight, go to physical therapy, take these medications, and see you in 6 months. How do they actually implement that? And that goes back to social determinants of health. What food do they have access to? Are they in “food deserts”? What transportation do they have? But joint injections are something that I use in my practice significantly because it does provide some immediate relief for the patient and then once that steroid kicks in, more prolonged response, more prolonged help.

Monica Peek:

Yes. Thank you for detailing some of those options for us. Now, as fantastic as it is to have an array of nonsurgical options to manage osteoarthritis, that doesn't mean that that array is applicable or possible for all patients. So how do we go about personalizing care for racial and ethnic underserved patients?

Haydée Brown:

One is recognizing what biases exist in medicine, thinking about the misperception of pain or that patients have had poor access to pain management. That's where you would just reintroduce the idea of the more conservative measures and be sure that they've used those conservative measures. Also, just thinking about any language barriers or cultural barriers. What if you prescribe physical therapy but the place closest to the patient's home is all men and if it's a female patient and she doesn't want to be treated by a man, then you've eliminated an entire really powerful treatment for this patient. So it's important, again, to meet patients where they are. And when you make these recommendations, talk about, "Well, how would you get there? How do you get to physical therapy? How would you get home? How would you pick up that medication? Is it easy for you to be able to change your diet and decrease certain high-fat foods?"

And another thing, really fortunate from the pandemic, is that we really think about telehealth, that patients can have physical therapy online. And that's really important, because now you're eliminating these barriers to care, whether it's that they can get the transportation or not, or if they're having so much discomfort that isn't well treated, that they can't get to therapy or move. So that's important, but then you have to think about whether they have the internet. Do they have access to consistent internet? So social determinants, all of these, you really, again, have to take the patient in their entirety and know their experience and validate that experience, and partner with them on how to take the best care of them.

And then it's very important to share to the patient that you both share the goal, that you do not want them to become addicted to an opiate. You do not want them to become dependent on opiates. And that we, particularly in orthopedic surgery, have made a lot of strides in using multimodal pain care to diminish the use of opiates to a very, very small window. And acetaminophen being something that we even use IV, intraoperatively to help folks, helps patients in their recovery from total joint replacements.

Monica Peek:

I didn't even know that that was possible. Look what I learned today. I'm trying to learn one new thing. Check that off. It was interesting, there was a clinic, I worked various kinds of federally qualified health centers (FQHCs) over

the years and one of them took over a space, I don't know what it used to be but they have a gym that's on site. And they have all kinds of classes that are available. They could pipe in this physical therapy and people could come to the clinic and get their physical therapy there, as opposed to wherever that was. I think there are a lot of creative ways when the community comes together. And that's what addressing these social determinants is about. It takes a village, putting all the pieces together to work for a certain person, to work for a certain population. What are the assets in this community and how can we piece them together to make this thing work? It's very fascinating.

Haydée Brown:

I often ask mid-level practitioners who are helping or trainees, "What would you do for your loved one?" For me it's, "What would you do for your grandmother?" And once you change that lens, it enables them to give more equitable care. But sometimes you have to personalize it for that provider so that they can begin to see the patient differently.

Monica Peek:

I remember when my grandmother, when she was still living, used the bank as her personal Kinkos. She would go to the bank and they would fax stuff to me and all this stuff, and I'm like, "Grandma, what are you doing?" But they just loved her so much. She was so sweet. I was like, "What is happening here?" But they knew she didn't know anything about any of that other stuff. So she was always going to the bank. Who pays with checks anymore? And my grandmother was always paying with checks and all that, so she was always in the bank asking, "Honey, can you just fax this to my granddaughter?" It's that sort of loving approach and seeing people's humanity, seeing them in need and realizing that they may not have the resources or the wherewithal to get this done, but you do. And it may not really be your job, but can you just lean into it a little bit more and make this happen. And that's what it takes.

Haydée Brown:

For these abuelitas, grandmothers here, I live in Harlem and work in Harlem, and rather than have a walker, they'll push a grocery cart, the little shopping cart, because it's more modest. You don't seem as old as if you're walking with a cane or with a walker. If you just push your cart as if you're going to and from the grocery store, you're still able to get out and about but without necessarily labeling yourself as someone who's becoming disabled.

Monica Peek:

We're going to have to move on to our second learning objective for today, which is to individualize treatment strategies that include assessment of social determinants of health for optimal outcomes in patients with joint pain. We're going to go back to Mary and learn more about her so that we can discuss how you would develop a treatment plan for her.

Haydée Brown:

So now looking at Mary, she's not in any distress. She does seem to have a flexion contracture of the right hip. The physical exam for most orthopedic patients actually starts with them walking in the room. You see their gait with advanced hip arthritis, and the fact that she's been in so much pain, she would have antalgic gait where she's favoring the less painful leg. You would look at the spine, and she has a normal spine exam. And again, just remember that someone can have lumbar spine complaints that maraud as hip pain and vice versa. It's important to examine both. And then, when we see her right hip exam, she's unable to really adduct or internally rotate. There's pain with the attempts of that and she has pain with external rotation. When you're doing that part of the exam, it's really important to be very gentle because you can feel sometimes the crepitus. You're feeling that inflammation in the hip and that's incredibly uncomfortable to the patient. You want to just do that once, but you need to be able to assess their range. You look at the rest of the body, the extremity, and note that there's no other numbness or tingling on that side. And again, we spoke a little bit about the gait itself, where that patient's going to have this antalgic gait, going to be walking at a slower pace, have a shortened stance phase on the affected hip, and that she's not using an assisted device.

Then we look at her imaging. This is normally when I can step out of the room. I'll go look at the imaging. After actually talking to the patient, step out, look at their imaging, then come back and examine them. That gives them the time to show change. Then we're looking at the imaging, the patient's x-rays with both the lumbar spine and the hip, that she has some moderate osteoarthritic changes of the hip, which means that the joints face is more narrow, that there's osteophyte formation, there are even some cysts, but the other hip as well as the lumbar spine aren't really significant. There are some mild degenerative changes in the lumbar spine at that L2, L3 level. How do we create a treatment plan that Mary can be a part of, and how do we partner with her in this plan? So first just ask, What do you currently use for pain control?

She was using some nonsteroidal anti-inflammatories as well as some herbal remedies. Did that work or did it stop working? And just be careful to be mindful that the patient may or may not be very sensitive to the implicit bias on our field of medicine, toward opiates and indigenous communities. And the other thing that's incredibly important is that her physical exam is coupled with what you see on her imaging. I have had some patients actually run marathons with pretty horrible knee arthritis. If you saw their knee films you would think that they need a total knee replacement. But you see them walk in and they just ran a marathon. You have to take the clinical picture, so what the patient actually looks like, together with what their radiographic findings are. And note that for a good amount of time, that conservative non-operative therapies help.

And again, with this discussion, you have to consider these social determinants of health. How does Mary get to and from physical therapy? How does she get to the pharmacy to get her medication? Does she need more social supports to help at the home? And is there a social work consult that needs to happen there? You want to partner, which is the important word there, with your patients so that they can participate in what your suggested treatment plan is. And it's also important not to have preconceived biases about other complimentary treatments, whether they be Ayurvedic therapy or certain herbal remedies or a low inflammatory diet. All of those elements are, if the patient's using them, therapies that they respect. And you as a clinician need to respect that as well.

Monica Peek:

I have a question. I would assume that if someone had just run a marathon and had horrible x-rays, my tendency would be to say, "Oh my gosh, you need to have a knee replacement because we need to get you back to running" as opposed to "Well, you seem to be doing fine" – so which one is it?"

Haydée Brown:

Well, they're not going to really run marathons on a total knee. They'll wear them out pretty quickly. But I think the point where you would start to suggest the surgery would be if they're no longer able of course to run that marathon or they're starting to get deformity, which would make it a much more complicated procedure.

Monica Peek:

Interesting. I've learned two things. This is great for me.

Haydée Brown:

It goes back to pain tolerance. For some patients, pain tolerance is different and you have to partner.

Monica Peek:

Yes. Let's talk about patients who may be candidates for hip replacement surgery. Are there factors that are specific to patients of color that may impact their decision-making with regard to arthroplasty?

Haydée Brown:

Well, it's really looking at the comorbidities. As we pointed out earlier in this presentation, Black and Brown patients actually present later with more advanced disease because they are referred at a later time for these. They may present with more comorbidities, making their perioperative course more difficult. And patients are interviewing surgeons depending on their area as well. It's also important to, again, partner with the patient where they are. Is this a patient who would want to have a faith worker, whether it's a priest or a natural healer around, who's in their social network who can help them go home? Will they need to go home? Will they need to go to a rehab facility? And walking them through their recovery process.

The American Academy of Orthopedic Surgeons actually has a small video on arthritis as well as on joint, different knee, or hip replacements. And if it's in the proper language, that's helpful for the patient as well. And that all allows you're setting your patient up and yourself up for the patient to have the best recovery they can have. But you really have to view them. Or surgeons, we love to do surgery, but our outcomes are impacted on how the patient's able to comply, how the patient's able to follow what our postoperative recommendations are. You do want to optimize them preoperatively, if you can get their blood glucose, if you can get their sugars under better control, or if they can lose some weight, so that they have a lower risk with surgery. But ultimately, postoperatively, it's very, very incumbent upon the surgeon to tailor the plan with the patient.

Monica Peek:

Yes, absolutely. That's when you're going to get the best outcomes, when that patient and the clinician are on board with what's actually going to happen. I do a lot of work in shared decision-making, so I say that all the time. I think that, often as clinicians, we do things in our practice that are based on medical voodoo, the way things just normally are implicit bias, and not necessarily evidence-based medicine. We're going to take a moment for another audience response question. And the question is, What strategy do you think health care institutions could use to most effectively reduce bias in pain management? Let's talk a bit about how we can provide more equitable pain care. Haydée, what can you tell us about that?

Haydée Brown:

Of course the first thing is to be aware of these biases. And that happens by using tools, such as this video, doing education for health care providers so that they understand the scientific history, the scientific racism that occurs within the Black community. And now that they are aware, we can start to tackle that and dismantle that, identify that bias. It's incredibly important to respect the history of Black and Brown communities in health. And with that, patients can have apprehension about interfacing with the health care environment. And that is a problem because if you interact with the physician who's unaware of these biases, they can traumatize the patient. It's not just that X study happened and people were tested or given diseases without their consent. It's an ongoing active process because structural racism exists. It's structural and patients are experiencing that in different ways.

And again, we need to partner with those patients in order to have them really be a part of that care, especially with pain management. Note that people have different interpretations of pain. We just talked about a patient who ran a marathon with horrible knee arthritis. Someone else can come in with not-that-bad knee arthritis who's having crippling pain, and know that patient should be treated differently than the one who just ran the marathon. That may be one that you're going to go through and think about more invasive, even such as a joint injection. We are in a world where there's evidence-based medicine.

It's not the science voodoo from way back in the day, where people just thought of things and wrote it down. We are able to actually use evidence to see how patients are experiencing pain, and we have techniques and multimodal processes that can help them improve their pain. It's really important to use those validated guidelines for their pain protocols or checklists so that we can be sure to treat patients for pain and not undertreat them. And of course there's a continuation of a collection of data for this pain management and communities of color.

Monica Peek:

Excellent. We're going to go back to our polling question. So now I'm going to ask again, What strategy do you think health care institutions could use to most effectively reduce bias in pain management? So, Haydée, let's individualize the treatment plan for Mary. Can you tell us how you treated Mary?

Haydée Brown:

I treated Mary by giving her acetaminophen anywhere from 650 to 1,000 milligrams, encouraging her to walk more, in that, some weight loss as well. And Mary, on the 60-day follow-up visit, is feeling better. She's able to start cooking again. She feels more valued at home; she's able to contribute. And although she has hip pain, it's not as limiting as it was before. Mary is doing well with our treatment plan, and given that she's having less pain, she will move more and she'll probably continue to lose weight. These are all positives for her.

Monica Peek:

One thing I also say that I've seen is the association between pain and mood. When people feel better about life and themselves, they seem to have less pain. They're less attuned to the pain that they're having and they're able to push past the pain that exists. For this patient case, when she's able to be back to herself, doing the things that she loves, feeling more engaged in her family, it's a patient that I would say would be having less pain even if she wasn't taking the acetaminophen. Do you know what I'm saying?

Haydée Brown:

Yes. There's that psychological component. If you're in this multi-generational family and you really love to cook and you can't do that, that's going to have an impact on you psychologically. And that, of course, would impact your pain as well. I would agree, it may not even be the acetaminophen; it's all of the treatment together, entirely.

Monica Peek:

Yes. Which gets back to this idea of thinking about people holistically, in their full humanity, and all the things that we can think about in our toolkit to help take care of them. In maintaining cultural competence, we can better connect with our patients and have conversations with them to determine the best treatment options for them. So, Haydée, how did you discuss treatment options with Mary? And what patient education tools do you use in practice that are culturally competent?

Haydée Brown:

Well, again, meeting the patient where they are. What are you currently using? What do you have access to? Being able to increase or change or combine, whether it's over-the-counter agents. Speaking to her about more movement and letting her know that the more weight you lose, that's less weight, that's less force on your joint, which can make you feel better. And asking what are her hindrances to doing more walking, beyond just the hip pain. Asking if she wants to continue with her current medications or if she's at a point where she wants to try something a bit more invasive. So something like an injection.

And if those have all failed, that's where we really start to talk about things such as a hip replacement. And again, patient education and partnering with patients is incredibly important. The American Academy of Orthopedic Surgeons, which is orthoinfo.org, has wonderful videos and articles, in English and Spanish, on exercise programs

for home, with photos and little diagrams. And those are things that can help a patient if they're unable to actually get to a physical therapist due to insurance or due to transportation or due to other barriers.

Monica Peek:

Excellent. This was such a wonderful discussion. I learned so much, including those two things that I had no idea about, IV acetaminophen, who knew? And I feel like we learned some great clinical pearls that we can use to provide more culturally competent care for our patients with pain. So let me summarize our discussion with SMART goals. And smart goals are those that are specific, measurable, attainable, relevant, and timely. So that's what I hope you'll take from this presentation and apply it to your practice, for everyone in the audience. Those were to identify inequitable processes and pathways in the prevalence, treatment, and pathophysiology of joint care in minority populations, and change outdated pathways or processes immediately. Two, incorporate solutions to address racial and ethnic disparities in joint disease diagnosis and management as well as access to care. Three, integrate simple tools that provide more culturally competent and empathetic care, which can be as simple as sitting down, looking the patient in the eye with their clothes on and asking about their goals. And last, develop personalized treatment plans for the management of patients with joint disease, with considerations for social determinants of health and patient preferences. Anything I've left out?

Haydée Brown:

No, I think you got them all.

Monica Peek:

All right. Well, here are just some of the topics we've covered so far and we will be adding new content every month. CME Outfitters also has the Diversity and Inclusion Hub with a number of excellent resources to share with your peers and your patients. To receive credit for today's activity, please complete the post test and evaluation online. You can then download your certificate immediately. Thank you again, Haydée, for joining me, and thank you to our audience for joining us. Be safe and take care of yourselves so you can provide the best care to your patients and especially our underserved patients.