Health Inequities in Vision Care

CMEO Podcast Transcript

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

Hello and welcome to a very special podcast that is part of a series I'm leading on diversity, equity, and inclusivity with CME Outfitters. Today's CMEO podcast is entitled Health Inequities in Vision Care. Today's program is supported by an educational grant from Johnson & Johnson. I'm Dr. Monica Peek and I'm a professor of medicine at the University of Chicago and the Associate Director at the Chicago Center for Diabetes Translation 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.

I'd now like to welcome Dr. Adam Ramsey and Dr. Ruth Shoge. Dr. Ramsey is the Medical Director of Socialite Vision, the Co-founder of Health Focus South Florida, and the Co-founder of Black Eyecare Perspective in Palm Beach Gardens Florida. Dr. Shoge is an Associate Clinical Professor and the Director of Diversity, Equity, Inclusion, and Belonging at the University of California Berkeley Herbert Wertheim School of Optometry & Vision Science in Berkeley, California. Adam and Ruth, I'm really honored to have you joining us today and I'm excited for our discussion.

Adam Ramsey, OD:

Thanks for having us. I really appreciate it. I'm excited.

Ruth Shoge, OD, MPH, FAAO:

Yep. Thank you.

Monica Peek:

I want to remind our audience that this CMEO podcast 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 vision care. The titles of the activities in the series are on the slides and the links are in the images. Simply click on the images to review any of these 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. So let's get started.

Our first learning objective for today's program is to analyze the influence of unconscious bias, health disparities, and health inequities on vision care. Now, I'm going to say that it would really be a disservice if we didn't take a moment to discuss how we got here, and as I had mentioned before, this is part of a comprehensive library. So we've covered these issues in detail, but I did want to touch on some foundational points regarding historical racism. We've done previous programs that specifically cover these topics in depth and these programs, again, can be found on our DEI hub.

Monica Peek:

But to just make sure that we've summarized and that we're all level setting, we want to acknowledge that there are ingrained elements in our community around unequal access to housing, education, employment opportunities, what we call structural inequities, that really affect people's life trajectory and their health. Some of these things have to do with basic human rights like food, again, housing. Some of these issues have to do with what happens in the healthcare system, where health providers have a bias. Some of these are environmental issues like the increased access or exposure to environmental toxins that are more likely to be in marginalized neighborhoods.

All of these directly affects their access to healthcare. It affects their pathophysiology. It affects how healthcare providers may or may not deviate from what we consider standards of care, or SOC. And so we have to recognize that there's many, many levers that contribute to health disparities and have long term impacts on people's health, how they engage in the healthcare system, and how well we can or cannot retain them in not only self-management, but in healthcare delivery as well.

So Ruth, let's start by focusing on inequitable factors in vision care. How might these disparities be demonstrated in your field? And are there any of these factors that are particularly important with regard to patients that you see?

Ruth Shoge:

Yeah. Thanks so much, Monica. So what we think about as inequitable factors in vision care I think we could also term social determinants of health. I think that's maybe a terminology that people are more familiar with and hopefully more familiar with these days. And so it includes issues that you mentioned before as ingrained or structural elements, which include one's economic stability; the ability to pay for services, for example; one's environment... Is it safe? Is it healthy? Do they have good housing and transportation to meet their needs? Good education; literacy; access to different resources, updated and relevant resources; social access; and healthcare as well also being considered a determinant of health. And one that's new but an important factor is technology. And I think we're only going to see more of technology, not less of technology, particularly going through and still dealing with some of the ramifications of the pandemic really utilizing telemedicine as a way to access our patients and for them to access us and really being able to provide services in a more expedient manner.

So it's really hard to just pick one thing that's affecting eyecare. They all work in congruence in affecting eyecare and one's ability to access the healthcare system generally. And so probably top of mind for most people is, "Do I have insurance to cover my vision exams and to also cover my glasses?" Which sometimes is not always part of the insurance package or maybe you can get one pair of glasses every couple of years or so. So that's often a big hindrance.

But I think maintaining communication, especially when we're taking care of patients who have chronic illness that manifests in eyecare... Are we communicating with their primary care doctor? More importantly, is their primary care doctor communicating with us so that continuity of care isn't broken, the patients are getting eyecare needs in timely fashion, so disease processes and other things that are not reversible... Keep them from getting worse?

Ruth Shoge:

So again, there's a lot of aspects that come together that influence vision care: the healthcare system generally, technology. I think we need to see more technology in eyecare in my opinion. And I'm excited about conversations that are happening around that area as well as making sure that folks are getting the appropriate resources and education in a way that they can understand and value and know where their eye care needs fit into their general overall healthcare.

Monica Peek:

Yes. I think it's really interesting that you mentioned technology because we are almost always excited about new technologies and innovation. And for me, at an academic center, that is our bread and butter, trying to be innovative. And one of the things I always say is that whenever we have something new, that creates opportunities for disparities, because who is able to access these new technologies, this new innovation, are those who have all of the things that we were just talking about: more social capital, more economic opportunities. And so technology can move us forward, but it also can create worse disparities in any given disease. And so I'm glad to see that it's now being mentioned as a determinate of health. All of the things that you mentioned... One of the drivers is structural racism that differentiates populations as far as who is more likely to be affected by housing insecurity or lack of access to technology, et cetera. So thank you so much. Can you talk about vision loss and what that does to impact our patients and their quality of life?

Ruth Shoge:

I wanted to just if I could touch on one thing that you mentioned about technology. And you're absolutely right that we're going to continue to see disparities even with the use of technology if equity is not at the center of innovation. And so without that equity at the center and creating technology that can actually reach the masses and not just people who can already afford these services, then we're not really fixing the system. We're just continuing to add to a broken system. So I wanted to just respond to that technology piece specifically because we're all about innovation, but at the center of innovation has to be equity.

Monica Peek:

Absolutely. We have to plan for equity because if we're not deliberate in our planning what we'll have as an inequitable system. So Adam, do you want to talk a little bit about the relationships between vision loss and how that impacts patients and their quality of life?

Adam Ramsey:

Sure. I think this is a situation in which patients need to know that you care before they care what you know. And a lot of times doctors jump right into, "You need to do this. You need to do that. Make sure you go here. Make sure you go to this appointment. Go here, there, and the other." But they haven't gotten to know the patient, to understand it took them three buses to get to you. What you're asking is not on the same bus line as them. They watch their kids during the day. They watch their grandkids during the day. Different things like that that if the provider actually would ask those questions when you're making those referrals, the patient would understand that, "Hey, I took that into consideration and we looked at the bus routes. We found the place that is going to allow you to do this, is going to allow you to do that. This actual provider I'm sending you to has a van and they're willing to pick you up." That makes the patient really want to make that appointment and really want to do that follow up.

When you're talking to the patient, find out what their activities or daily livings are. What do they actually need? Because sometimes you can make... "Oh, I made it great for this and I made it great for that." But she's like, "Well, I don't really watch TV and I don't drive. I want to read my Bible and you haven't fixed that part." They're telling her, "Do you have a large print Bible? Do you have large print font? What if we got you an Audible subscription for $10 a month where you could listen to the books? Even though we can't do things to help you be able to see the books, what if you could actually listen to the content and now you're actually hearing the author? And you could hear Michelle Obama. Instead of just reading her book, you could listen to her voice." And that little lady would just light up and be like, "Oh, I could listen to Michelle? That would be so nice." And now she's stopped thinking about her vision loss and looked at it as a person and realized that I'm seeing you as a person.

And I think that's missing from our healthcare system is that personal care, that personal touch, that real connection that goes beyond the numbers and realizing what does this person actually need? What can I do to make their day better? What can I do to make their quality of living better? Even if we've done everything... Her pressure's as low as it's going to be. There's nothing I can do about that, but what if I could do this? What if I could do that? And then all of a sudden they realize the care and concern you have and the compassion you have and all the other stuff starts to work. All the other stuff they pay attention to because they show up to their appointments because, "Oh, that's my doctor. Oh, I love my doctor."

When you get a patient who says, "I love my doctor," that patient is going to follow what you're saying. When you ask the patient what your doctor's name is and they can't tell you their doctor's name, that's a patient that's probably going to miss their appointments. That's a patient that's probably not going to take their medication. That's a patient that's not going to be there. So I think the connection between vision loss and what's going on has to do with that personal touch. And once you get down to the root of those things, we can actually begin to solve the problems in minority communities.

Monica Peek:

That is so helpful to think about for several reasons. Addressing people's humanity and their specific circumstances... Not only does that show that you care and like you said help open up the space for more bonding with a patient and patient adherence to the treatment plan, but it actually allows you to address some of these social determinants of health that may be barriers to them accessing the care that you want them to have anyway. So it's like a two for. You're addressing the needs, but you're also by doing so showing that you care and helping to establish rapport. I think that was an excellent point that you made.

Adam Ramsey:

Thank you.

Monica Peek:

So, Ruth, this is excellent. You had mentioned something about missed opportunities. Can you tell us a little bit about populations that are more likely to have missed opportunities amongst kids?

Ruth Shoge:

Sure. So, research tells us that underrepresented populations, so Black children, Latinx children... They tend to have less access and therefore are not getting the care that they need as their peers are. And so we see in these populations they have three times the odds of reporting poor subjective visual function. They have two times the odds of presenting with visual acuity that's worse than 20/40. And for us, that now gets into amblyopia or some would call that lazy eye. And again, a lot of the times these things are fixable. We can remedy this situation with glasses, with patching, very low tech interventions, if you will.

And we also see the same statistics in low income households, which... There's often a crossover between minority households and low income households and these groups of people are also reporting poor visual function. So yeah, when I say missed opportunity, the numbers are there, the research is there that supports there are children, particularly children in specific populations, that require this care and intervention and we really have to do a better job of figuring out how to get it to them.

Monica Peek:

So Adam, what tools or treatments do we have? And what are our goals in optimal vision care for our patients?

Adam Ramsey:

Well, sometimes as optometrists we can sometimes overlook some simple things. So getting the patient the proper glasses and the proper prescription or contacts or referring them out for different surgeries, whether it be glaucoma surgery or cataract surgery, may be the first start at the new lease on life that they need for their health. But sometimes that's just not enough. So Dr. Ramsey turns into the IT director. So I will ask the patients, "Can I see your phone?" And I will enlarge their font. I will increase the brightness on their screen. And you'll be surprised. These patients are like, "I didn't know how to do that." And I'm like-

Monica Peek:

I don't know how to do that.

Adam Ramsey:

You just slide down and you can increase the brightness. Because they'll come in and say, "I can't see this and I can't see that." And I'll look at their phone and I'm like, "Well, you have it on 20% brightness. It's dark. Of course you're not going to see it." Without changing anything I just increase the brightness. "Oh, I can see it now." It's not a glasses issue. But sometimes those are the simple little things on getting down on the ground and getting with the patient and getting to their level and say, "Well, let me not just do it for you, but let me show you how to do it." And I get in there and say, "Click this and go to settings and you can make the font bigger." And you hit this little thing right here and all of a sudden the glasses that weren't working for them or their vision after cataract surgery that wasn't working for them with increased brightness, increased font size, all of a sudden they can see better.

So from a patient's perspective, finding out what they actually need, finding out where they are, and are they willing to wear the glasses? If they're not willing to wear the glasses and you gave them a great prescription, but when they walk out of your office, they won't put them on... This is where I asked the patients... I ask the kids and I say, "Does your dad wear the glasses?" "Oh, he never wears those glasses." So what he's talking about when he says he can't see is without the glasses. He's not talking about with the glasses on.

So asking the right questions and getting there. Sometimes I'll even go to a patient and say, "Can you buy your mom an iPad?" And then she's able to read on instead of a phone screen... Because some of them have those little cute small phones or a flip phone. And I'm like, "That's not going to work. I'm sorry. I'm not a magician. I can't do that. But could you get your mom an iPad?" I had a patient say, "Oh, well, the sisters will team up our money. We'll get her a tablet." And be able to then see appropriately... And now all of a sudden her world opens back up and her quality of life and her peace within her current health situation... It's not so stressful anymore.

And sometimes that's all it really takes, is meeting them where they are. What do you have? And asking the kids, "Do you have an iPad that you're not using or a tablet you're not using anymore?" "Well, yeah, I got one. I'm not using it." "Well, can your mom get it so that she can do X, Y, and Z?" And all of a sudden now their world is much better and we've actually met them at that disease state and we're actually treating them appropriately all the way through, not just prescribing the drops, not just putting them on vitamins, but figuring out what goes past that for that patient.

Monica Peek:

Now, I love that you have activated the entire family or social support system around this specific patient because we think about that for chronic diseases like diabetes, but asking the real truth tellers, the kids... My son is always telling way too much truth. And so bringing that same family based approach to eyecare I think is really important. So thank you for bringing that up too.

Both Adam and Ruth. Tools, treatment, and goals are important and I'm glad we have so many options, but they're not really useful for disparities prevention or our patients if we can't have access to them or utilize them. So I want us to shift our conversation to educating our audience on easy things that they can do to improve the care of our underserved patients and all patients. And Adam, you've been talking about that throughout our session today, but can we cover those areas a little bit more in detail for our audience?

Ruth Shoge:

Sure. So some small changes that clinicians can start making today is simply asking questions and asking about the social determinants of health that their patient might be experiencing in terms of accessibility. Do they have transportation to get to their provider easily or do they need some support in that way? Do they have social supports that can help them if they can't really do things on their own, such as obtaining the glasses or picking up medications and things of that nature?

So really just thinking about holistically all the factors that determine whether a patient is even able to get to your office and then subsequently able to manage the treatment plan that you've laid out for them. So don't be afraid to ask about these questions. Sometimes people think, "Well, it's not really any of my business what a patient's home life is," but it is our business because all of those factors are going to affect treatment outcomes and continuing these disparities that we're seeing.

We also want to consider comorbid factors. So is obesity an issue with your patient? Do they have autoimmune disorders? Do they smoke? Do they drink? Do they do recreational drugs? Are there things that we should be asking about as well as involving the appropriate providers in the care of these patients? So not only do we have to communicate with our patients better, but we also had to communicate with all the providers involved. And eyecare absolutely has to have a seat at the table because we really shouldn't see people going blind that are going blind because most of these things are preventable, sometimes even reversible with the proper care.

Adam Ramsey:

And I also feel like asking the right questions is important. I think of an example of... I had a patient that I was sharing with another provider and they came to me and they said, "I can't use this." And what it was was a heating mask, but it was something you put in the microwave. And I'm like, "Why can't you use it?" And the person was like, "I don't own a microwave." And I didn't think about it. And as a provider you may prescribe something or give them and tell them to warm it up or read the directions without going through it, but we may make assumptions. And the patient said, "Well, I don't own a microwave."

Adam Ramsey:

I had another patient in which we were like, "Okay, it's hard for you to get here. Let's set up a telehealth appointment and then we'll call you." This, that, and the other. But the patient did not have wifi or services at their home. And this is where asking the right questions... And we were able to set them up with... They had a local provider nonprofit that would provide wifi in people's homes at low or no cost to them, but this is where I got my whole office involved. So it went beyond just me. And I went to the front desk and I said, "Can you set them up with this service and can you find out about this?" And we passed their information along to get them wifi.

And then we found the other patient a dry eye mask that you could actually heat up in hot water instead of... And it was one that you just break and then you heat it up and you could put it in just hot water that you put on the stove to reengage the dry eye mask so they actually do the services that were prescribed to them.

But that's where you got to ask the right questions and go beyond. Telehealth and all that stuff is good if the person has access to a computer, has access to a phone that has those services on there. Do they have wifi that is dependable? So finding out where the patient is and let's say let's meet them where they are because we can add in all these telehealth, we can add in all this greatest technology, but if the technology's really expensive and they can't utilize it or if there is a barrier that they can't get over themself and they really sometimes are embarrassed to ask... Sometimes don't know the right questions to ask. Sometimes they make assumptions and you get home and they can't actually do it. And they're like, "Well, I came all the way over here. I bought this thing and I can't use it. It's too cumbersome."

I had a patient that they lived in a two story home. The microwave was downstairs, but we're telling them to do the dry eye mask before they go to bed. And the lady says, "Listen. It's a lot of work for me to get up my steps so by the time I get up my steps, I can't actually heat up the mask." So finding ways to get over those hurdles for the patient is really important. You just have to ask the right questions and then we're able to integrate it into their lifestyles.

Monica Peek:

I know that your patients love coming to see you. Sounds like you have really captured the ability to think about technology and innovation, but like you said, meeting people where they are and really understanding their barriers and being willing to address them in a way that is respectful and doesn't feel like it would be stigmatizing in any way. And that is really what we would want for all of our patients everywhere. So I just hat tip to you for all of the work that you do. Both of you. What are some other questions that maybe we should all be asking our patients to be able to get to issues that we need to resolve before they leave the office?

Ruth Shoge:

So great question. Some simple questions to add, either at the beginning of your appointment with the patient or towards the end, is one, do they have challenges even getting to your appointments? So that addresses transportation needs. That addresses social support needs. Do they have access to a pharmacy that they regularly see? Because again, we want to establish consistency and good continuity of care. So having these in our electronic health records (EHRs) or electronic medical records (EMRs) so that we know where a patient is going to get their medications or do they have a preferred provider on where to get their glasses if that's something that your office doesn't provide. Being able to provide care in a preferred language.

And now we're getting into a realm where maybe a practice has to put forth a little bit more effort to really be user friendly to the patient. Is your intake forms in a language that your patient can understand? Or do you have language access services, which is something that we should all really strive to have and through the use of technology? So that's one of the things that technology I think does really well, is provide language access services in a variety of languages that you can access either via phone or via video. Asking the patient if they are in safe housing. Do they have orientation and mobility issues? Do they use a cane or walker?

A lot of that can come from observations because they may very well say they don't need it. And we've all had perhaps elder people in our lives that say, "I don't need that cane." Nevertheless, they're bumping into both sides of the walls as they're walking down the hallway. So really being able to be a good observer and be a holistic clinician to really identify or ask more questions in order to see how we can intervene to really provide the best overall care for our patients starting with their vision. But vision is part of the whole ecosystem of health.

Monica Peek:

Yes, absolutely. So now we have some great questions that we can ask our patients. How do we as providers address this issue of access to treatment? What can we do differently? And maybe, Ruth, you can briefly cover this for us.

Ruth Shoge:

Sure. So I think I started to mention just putting a little bit more effort in. So some of the things that we had talked about earlier are a little bit more passive, maybe asking more questions, but really addressing some of the structural needs. Now we're getting into language access services. And really anybody who's taking federal dollars, and that's Medicare and Medicaid... You are actually required by law to provide language access services for your patients. And so just taking an inventory of the population that you serve, even just seeing what are the maybe common two or three languages outside of English that the population in your community speaks, and addressing those needs could be a great start. Having user friendly intake forms. Are you allowing people to identify by the pronouns that they want to be identified by, by the ethnicity that they prefer and race that they prefer to be identified by or not? Are you and your practice engaging in unconscious bias training so that we can learn these things that we have, these biases that we have, that do unfortunately trickle into our clinical care experience?

Ruth Shoge:

And it's ubiquitous. Not one person in practice can say that they're an unbiased individual, including myself. And so having that awareness and engaging in training and workshops... Even basic conversations, calling somebody and talking something through. Getting maybe over the initial embarrassment or shame you might have associated with some of those biases as you become aware of them can really make a difference in how you ultimately interact with your patients.

So just to summarize, language access services, creating a user friendly practice, having intake forms that are user friendly, having staff that's reflective of the community that you're serving that could maybe bridge the gaps with some of those languages, and ongoing bias awareness training I think are some of the structures that we can put in place to address these disparities.

Monica Peek:

Adam, when we were developing the activity, you said something that I believe is worth repeating. When discussing the current glasses market, you noted things that are made for everybody are made for nobody. Can you talk a little bit more about what that means?

Adam Ramsey:

Yeah, definitely. When my patients go out into the optical, I want them to feel like the glasses were designed for them with them in mind. The current eyewear market... They make it just universal. It's for everybody and then you have a global fit. So Asians have their own actual eyewear lines and then everybody else is supposed to fit in one box. And I think that's unfair. People that do not fit in the medium size frame are asked to extend the temples or widen out the temples of the frames or trying to adjust it, but it hits their face. It hits the sides of their temples. And I feel like that's not appropriate. We would never tell people to get clothes that are for men and women. Universal clothes. No, there are stuff that are for women and there's stuff for men. So there are stuff for people with larger eye sizes and there's stuff for petite eye sizes.

So we need to actually be more appropriate to the patients and their communities. And I think a lot of times minorities are left out because we need larger eye sizes. We need longer temples. Our cheeks stick out a little bit more so the glasses push into our face and we're not able to see clearly. And the glasses have to be affordable. They have to be able to meet the patients where they are. We can't say the ones that are for minority populations cost three times as much. That is not the answer. And we have to be able to find ways to meet patients where they are and be more specific to them and their communities.

Monica Peek:

Yes. Thank you so much for that. Ruth, as a clinical professor of optometry and vision science, you interact with students and faculty all the time. Where do things stand with provider education and vision care and what should we be focusing on moving forward?

Ruth Shoge:

Provider education. So educating our future providers... I'm assuming that's what you're getting to, so our students that are currently enrolled and our future students to come. I think taking a hard look at the curriculum, what we're teaching, and how we're teaching is really going to be what is a driving change in the education of our future providers. And so part of the things that I'm working on is infusing the curriculum with information about health disparities, information about oppression and what happens in marginalized communities, information about anti-racism and how to be an anti-racist, so that we can create this curriculum where students are now getting this information that they can use practically when they're in the clinic as students seeing patients as well as when they graduate, because it's something that's not been done before. It's either, "Figure it out yourself," or you continue with the practices that we've always learned, which are damaging and which is why we have these disparities in the first place. So really reforming the curriculum is a big part of what is needed to change in our education.

Monica Peek:

Absolutely. Absolutely. So you're both involved in some wonderful initiatives to promote equity and equality and vision care. Care to provide a little bit more information about the work that you're doing? Can you briefly talk about some examples?

Adam Ramsey:

Well, I co-founded Black Eyecare Perspective with Dr. Darryl Glover and one of our major initiatives is the 13% promise in which we're trying to get schools, institutions, corporate entities, individual practicing doctors to understand that we would like the percentage of black optometrists to reflect the US census. So from the information we saw on the previous slide, we are not there and we named the organization Black Eyecare Perspective because we needed a direct solution for a direct problem. And as you can see from the previous slide, if we just say we want to get minorities increased, well, that's not the problem because not all minorities are being underrepresented. So we needed to actually focus on saying, "What's going on in the black community and what can we do to alleviate those issues?" So the 13% promise was there to say 1% of the time we want to increase the numbers and create a pipeline for black students into the optometrist profession.

Monica Peek:

Excellent.

Ruth Shoge:

Yeah. And so for me, I currently serve as a chair of the Diversity and Cultural Competency Committee, which is part of ASCO, the Association of Schools And Colleges of Optometry. And so we have been working really hard recently to help promote racial and ethnic diversity and inclusion initiatives within our optometric institutions. And so this is aimed primarily at faculty and students in terms of increasing our application numbers, particularly the diversity of our applicants. And so over the past couple of years in particular we've hosted town halls. We are currently working on a speaker series, which is sponsored by Johnson & Johnson. And so we thank them for their sponsorship. And so we've just really been working to get this information into the hands of educators, including updating our cultural competency guidelines, including workshops that people will have access to, and creating a learning management system where all of this information will live and people can continue to access it over time.

Monica Peek:

Excellent. Thank you so much to both of you for the work that you're all doing to increase equity. And for this fantastic discussion let me put today's discussion into actions that we can all do to provide more equitable vision care and then you guys can let me know if I've missed anything.

First, identify potential cultural or language barriers. Second, ask patients if they foresee any barriers to accessing treatment, follow up appointments, medication and treatment adherence, et cetera. Third, assess each patient's potential disparities during the treatment planning process, including unconscious bias, prior healthcare experiences, social determinants of health, age of the onset of vision difficulties, their occupation, comorbidities, and health literacy as some examples. Fourth, educate patients to minimize inequities in vision healthcare and promote health literacy. And then finally, integrate all members of the care team to develop a holistic action plan with individualized smart goals for all patients. Anything else that I missed, Adam and Ruth, that you want to add?

Ruth Shoge:

No. I think that was a great summary. And just to explain SMART goals, which are important... And I like to add SMART-E so SMART being specific, measurable, attainable, relevant, timely. The E is addressing equity.

Monica Peek:

Thank you. I love that. I've not heard of it before, but SMART-E... That's perfect. Again, I really just want to thank you all, both Dr. Adam Ramsey and Dr. Ruth Shoge, for joining me today and for reminding our audience that you can join me here for more CME podcasts that are wonderful, just like this one, for live webinars, case discussions, and more, including an upcoming CMEO briefcase in vision care. You can find out about all of the upcoming live events and view previous ones on the DEI hub at the link here.

Monica Peek:

So here are just some of the topics that we've covered so far and we'll be adding new content every month. We really want to hear from you, our audience, on what we need so that 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 we read every email and we really do appreciate this feedback.

So please remember to collect credit for your activity today by using the apply for credit button that's on your screen. And again, thank you so much Dr. Ramsey, Dr. Shoge, for your input today. Thank you to our audience for all your work in providing equitable and holistic care to patients around the globe. Have a wonderful day.

