

The Patient Journey: Eliminating Disparities at Every Step



CMEO Podcast Transcript

Monica Peek:

Hello and welcome to a very special webcast that is part of a series I am leading on diversity, equity, and inclusivity with CME Outfitters. I would like to welcome you to today's educational activity titled, *The Patient Journey, Eliminating Disparities at Every Step*. Today's program is supported by an educational grant from Johnson and Johnson. I'm Dr. Monica Peak, and I'm a professor of medicine and the Associate Director of 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 McLean Center for Clinical Medical Ethics at the University of Chicago here in Chicago, Illinois. I'm really excited to be joined today by my distinguished colleagues, Diane Bruessow, Dr. DeLon Canterbury, and Dr. Lisa Richardson, who we'll ask to introduce themselves individually.

Diane M. Bruessow:

Hi, I'm PA Diane Bruessow, and I'm the Director of Justice, Equity, Diversity, and Inclusion and an Assistant Professor Adjunct at the Yale School of Medicine PA Online program. We're located in New Haven, Connecticut, and I also practice clinically in transgender medicine.

DeLon Canterbury:

Hey everyone, my name is Dr. DeLon Canterbury. I am the founder of GeriatRx. We are a medication management and de-prescribing company led by a geriatric trained pharmacist, and I am based in Durham, North Carolina.

Lisa Richardson:

Hi everyone. I'm Dr. Lisa Richardson. I'm an Anishinaabe Physician, I'm a staff. I practice Internal Medicine at Toronto General Hospital in Toronto. I'm also an Associate Dean of Inclusion and Diversity at the Temerty Faculty of Medicine. In addition, I'm the Strategic Lead of Indigenous Health at Women's College Hospital, also in Toronto. I co-chair the Indigenous Health Committee of the Royal College of Physicians and Surgeons in Canada, and that college is located in Ottawa, Ontario. Miigwech [thank you].

Monica Peek:

All right, thank you so much. What a distinguished panel. I'm so excited to have you all here today. I'm really looking forward to the discussion. It's going to be fabulous. I want to start by asking our audience a quick polling question. I'm going to tell you in advance, we're going to have several of these throughout the hour. We're not going to actually give you the answers to the polls until the very end, because we're going to ask them to you again. So, the first question is asking the question about how equality and equity are different. How are they differentiated?

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Excellent. I want to make sure that we define equality and equity because these terms are often used interchangeably. If you look in the dictionary, they can semantically be used interchangeably, but they really are not the same. Within the world of disparities and equity, we think about them very, very differently.

Equality is when we think about giving everyone equal inputs, if we think about process measures, making sure that everyone has the same thing, whereas equity is thinking about outcomes and trying to have everyone have equal outcomes. It may require, and it often does, and that's what the evidence has shown us, is that we tailor differently the kind of the processes, the kind of inputs that we give different people, different communities based on the differential needs to get to the same outcome. This is a slide and we've seen this mocked up with different kinds of images to tell this story in different ways.

This is the most recent one that I've seen that I think tells it best, in that we could give everyone the same bicycle, but some people may be too tall, some people may be too short, some people may not be able to use their legs. That would be an example of equality. But what we really want is for everyone to be able to ride their way to the finish line. We can design different kinds of bicycles so that everyone can do that. Some bikes may be smaller, some are bigger, some allow people to use their hands. It's thinking about tailoring an instrument, tailoring the delivery of care, to meet individual needs of populations that may require more resources or different resources, to get to the same equal outcome. Equality is the same input, equity is the same finish line, the same output.

That's a really big difference. Now that we have at least that baseline level of understanding about the difference between equality and equity, we're going to try and talk about some other constructs that are challenging in the world that we want to make sure we have a level set for our conversation today. These are big ones. The next is around race. That's a whole lecture in and of itself, but we're going to try and just do that quickly here. Our main point, and the same applies to ethnicity, which is a different construct but interrelated to race. The point is that race itself is a social construct. It is not a biological or genetic construct. We know that because how we think about race has changed over time. If we think just within the United States, and we look at our US census over the past 100 years, how we have defined different racial groupings has changed over time.

We can think about how we define race over place in the current and in today. A given person can travel from this country to another country and their racial category would change depending on how that country would define their race. Some countries define it based on the race of the mother, some countries define it on different things. Here, historically in America, we have defined, for example, Black people based on whether or not there's any African ancestry based on the "one drop" rule. That is based on the economic history of slavery. So, trying to maximize the number of people that were kept enslaved, then the idea was that anyone who had any African ancestry was deemed to be African American, Black. That's how that definition came about in our country. But again, these definitions change over time and place and space. These are social constructs.

Now, it overlaps with the idea of genetics because many people who have brown skin and look like me, originate from Africa. There's a genetic component to that. But we have to also acknowledge that the continent that has the most genetic diversity is Africa. If we think about the North Africa and how people there look very much like Middle Eastern versus sub-Saharan Africa and think about all the genetic diversity within that continent. Africa is the continent that has the most genetic diversity. If we think, just about within this country, the people who may have some of the most genetic diversity are African Americans because almost by definition you could be anything as long as you have one drop of Black blood. There's so much diversity in how Black people look and

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kinds of genes that are mixed in together to make what are ultimately, people of the African diaspora that live in this country that define themselves as African Americans.

There's not a single thing that makes Black people "black," it's a social construct. When we are thinking about biology and genetics, we don't want to confuse that with the social construct of how we think about race. We want to be more precise in our language. If we're really looking to see if African Americans are going to be more sensitive to this medication or if there might be reasons for differences in health, then what we really need to be looking at are their genetic mutation. Are there certain biological markers within this group of people that may have, from an evolutionary standpoint, driven them to have developed this? We use malaria as the case where people in Africa and certain parts of the world were driven by the malaria and the mosquito to have sickle cell disease. That is not a function of brown skin. It's a function of being exposed to the mosquito and the malaria. There are more ways to be precise if we want to think about genetics than thinking about the color of someone's skin.

One thing that I do, two things that I want to note is that racial groups tend to have a shared cultural tradition. Part of that is how we define ethnicity. Where an ethnic group tends to share cultural traditions, a lot of times they share a nationhood. There are interrelated constructs about race and ethnicity, although they're different, but they're both social constructs and not biological ones. The most important thing is that race is a social construct, but race that has no biological meaning, but that racism is what can cause biological changes and epigenetic changes that lead to poor health. It's not race that is a predictor of poor health, it's racism that leads to poor health.

When we think about that, that's an important thing for us to keep in mind as we have our discussion today, and as you move about in your own work, and think about, are Black people at increased risk for this? What we really should be asking ourselves, are these people more at risk for exposure to structural inequities because of their race, like we learned with COVID? Then think about what those structural inequities are.

I hope that was somewhat useful, that background. Providing some clarity because we know that language matters and we want to be very clear about our language. We're going to move on to our second audience response question. You should now be able to see that on your screen and you can vote now. The question is, race is a biological risk factor for which of the following disease states?

Okay, so one of the unique components about our program today is the inclusion of the patient voice. With our partner, WEGO health, we reach a large cohort of patient leaders of color and ask them various questions. We'll be weaving their responses into our program. I want to start by sharing a patient response to the question, have you experienced racism, bias, or discrimination in your healthcare experiences?

Patient 1:

I do believe that there is inherent racial bias and discrimination rooted in the healthcare system. Many times going to the emergency room I experience delayed care, reduced dose in narcotic medication compared to a white patient. Sickle cell disease is primarily an African American disease, especially in the United States. Those are not the only patients who have it, those are usually the patients that are seen. I do feel like sickle cell patients are discriminated against, even though if you compare hematology patients, patients versus oncology patients,

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pain is a primary symptom of our disease process. You will see that they get prescribed higher levels, more frequent narcotics, more consistently than sickle cell patients do. I think it's a common occurrence and one that needs to be stopped because of course, we're not drug seeking, we're trying to get help for the disease process that we were born with.

Monica Peek:

Those patients are differential treated in general within our healthcare system. I'm going to turn it over to Lisa and see what your thoughts are regarding this patient's experience. Can you also elaborate on race and the negative impact of treating race as a biological risk factor?

Lisa Richardson:

Yes, thanks so much Dr. Peek. I think you did such a great job of outlining the difference between race and racism. Hearing the clip that we just heard, we clearly actually heard about the experience of racism within a healthcare encounter. Receiving waiting longer in the emergency department, getting lower doses of medication, being in pain and not having care providers respond to your pain needs. What is really important to understand is that when we, if we assumed, ... the problem with assuming that race is biological, which as you've explained it is not, is we overlook the fact that it is racism that is leading often to differential health outcomes. We must actually look at experiences of racism at the interpersonal level, such as what was described in that encounter by the patient. The experiences of prejudice, but also think about structural racism, which manifests with differential experiences, differential access to food, to housing, to economic opportunities, to educational opportunities.

Those are the social determinants of health that often will fall along, will be divided along, race and so, hence, leads to differential health outcomes. I think the second piece that's outlined on the slide that we have to think about is what does the chronic exposure to stress actually do, in terms of long-term health impacts? Well, I don't think anyone is going to be surprised to know that actually, research shows that chronic stress has impacts on long-term health. In that, because of these social determinants that I was speaking about earlier, it is more likely that people who are from racial and ethnic groups that are underserved, actually will carry more stress such as lower socioeconomic status, poor access to equitable healthcare, limited access to resources, the interpersonal and systemic discrimination that was highlighted so well in the clip that we heard. Exposure to unsafe environments, environmental hazards, social disadvantage in terms of opportunities in working in learning environments, et cetera.

So, really critical to understand that we must understand the social construction of race and the resultant racism, and its impact on social determinants of health, because that differential effect is related to structural and systemic racism, as causing the disparities. Of course, if we just said, "Oh, race is biological, can't do anything about it," then there's no impetus to act for change.

Monica Peek:

Thank you so much, Lisa, for that insight. One thing that I think is really important to discuss is how we got here? We're going to give an overview with this slide, but much of what we're going to be talking about today are details around this. The foundational points regarding historical and structural racism are so important. We've

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covered these topics in depth in prior programs. I'm going to summarize it here, but also recognize that we're going to hit some of these throughout the program here as well. When we're talking about systemic racism, what we mean by that are structural inequities that are due to race. These are how we think about the social determinants of health and how they're unequally distributed because of racism. Unequal access to stable housing, limited access to education and job opportunities, increased exposure to crime and poverty, all of those based on race. Decreased access to fresh food, basic things that we need that we consider to be human rights.

In addition to thinking about things that are part of the neighborhood, part of the social and built environment, as well as the natural environment. Things like toxins, we always think about the landfills, but other kinds of things that are in the water, in the air, that are more likely to be physically located next to racialized minority communities. That's outside of the healthcare system. Within the healthcare system, we think about disproportionate access to healthcare and healthcare provider bias. We then think about what are the impacts of these structural inequities? Of this systemic racism, we can think about deviations from standards of care or differential treatment or healthcare delivery by race. We can think about how the HPA access has been activated to elevate stress and cortisol, to increase things like autonomic dysregulation manifest in mental health disorders, cardiovascular disease, et cetera.

Ultimately, we find that healthcare spaces may not feel like safe spaces for persons of color. We see people disengaging or going way later than we know they should for care. We saw this, a lot of people predicted that this would happen with the pandemic. Much of the pandemic was about differential access, but ultimately there was some hesitancy because of the institutional mistrust, earned distrust with our healthcare systems. We think about the chronic inflammation, pro-inflammatory states from the result from chronic racism, as well as how people are interacting with the healthcare systems that are supposed to be treating all of this healthcare, these adverse health events. Structural racism is this thing that ultimately gets under people's skin and affects their health.

Then when we go to healthcare places for treatment, people may delay in getting there and have differential care once there. It's important that we have this pre-discussion about these very foundational topics. So, now I think we're ready for our first learning objective, which is to analyze racial and ethnic health disparities that result in health inequities in patient care. DeLon, I'm going to turn it over to you. If we look at health inequities as a whole, what is their impact on the monetary costs to this country and can you share some of that data with us?

DeLon Canterbury:

Thank you Dr. Richardson for that wonderful intro and the insights thus far. So, let's be honest, this is an ongoing problem. We have health inequities, unfortunately ingrained within our very own system and structurally. They cost almost about \$320 billion as we can see in annual healthcare spend. I work more in the geriatric world. Having the addition of housing crisis, of food deserts, food insecurities, we're seeing this hit all populations. But our seniors, more particularly in my world, are definitely being double affected to the impact where hospitals and health systems are turning into makeshift nursing homes. Again, this is costing that health system money. This is again, taking a bed away from someone who may be needing more urgent care. This issue of health inequity doesn't just touch healthcare, it touches housing, education, it touches your zip code, it touches literally everything within the system.

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This cost is compounded as we see and loses productivity per year about \$42 billion. We're seeing even on the slide as well, that Black people are two times as likely to have Alzheimer's disease with unfortunately, less diagnoses within this group. To even add to the points on the slide, that's not even highlighting the caregiver that's dedicating their time and their resources and their navigation of a system where they still feel perpetually unheard in that care. That is a stress, and you'd be surprised how many caregivers are being hospitalized before their loved ones, who are maybe dealing with a chronic condition, pass. It's becoming a generational strain of the inequity and it's not just, "Oh, the 1965 Voting Rights Act passed, so now it's all over." It's ingrained, it's in the laws. We as providers do have an onus to take charge of that and be aware of that. Also, see it's more than just what you may perceive as a phenotype or as a skin color. We're even still seeing, again, Black and Latino patients having less of that diagnosis, as I mentioned with dementia. That could probably translate to less of those resources that are, one, language friendly for such a demographic to manage and navigate that care.

But now we're even seeing more women of color who are becoming that caregiver and helping those with dementia. And so, they likely, in some cases, are still raising families while being a caregiver so these costs are there. Sure, we have the numbers that show that, but there's also this unperceived indirect cost. Whether it's absenteeism, chronic stress, and the tons of other -isms we can add to this. So, I just want to make sure we show the entire picture here outside of just a cost, but there is a cost and we need to start looking at ways to reinvest these wealth gaps and have establishments between community and private payers to really move the needle on this.

Monica Peek:

Absolutely, thank you so much. And unfortunately, there are many instances of disparities in medical care and our patient who spoke about sickle cell disease. Another one that comes to mind that isn't talked about enough is the HIV epidemic. So, Diane, as the clinical ambassador of the CDC Stop HIV Together Campaign, can you talk a little bit and shed some light on that for us?

Diane M. Bruessow:

Thank you, Dr. Peek. As this slide represents, there is a disproportionate burden of HIV incidents in Black and Hispanic communities. Forty-one percent of new HIV diagnoses were among Black patients, while the Black community represents less than 20% of the population. And 29% of new HIV diagnosis were among Hispanic and Latinx patients, and again, the community represents less than 20% of the population. Another example would be of the 18% of women who are diagnosed with HIV, 42% are Black women. And COVID really exacerbated this further, maybe you're familiar with the term syndemics, which is when the disparities in one epidemic really compound another with this exponential impact, and that's exactly what happened here over the last few years with COVID and HIV.

And in terms of prevalence, and I want to speak to the intersectionality for a moment, 42% of transgender women are living with HIV. Sixty-two percent are Black trans women, 35% are Latina. And I want you to contrast this with the 17% of White trans women who are living with HIV. So, while we're making tremendous progress in ending the HIV epidemic, the total number of HIV transmissions is going down year over year. But progress is not being delivered to all communities equally. And that downward trend, it's not happening fast enough to meet our goals of ending the HIV epidemic by 2030.

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I really appreciate this quote from Dr. Volko and it reminds me to recognize our responsibility to expand prevention and care to those who need it most, going back to equity and quality that Dr. Peek spoke to at the very beginning. So, to achieve this, stigma and structural racism and other forms of systemic barriers have to be mitigated. And in terms of HIV, healthcare professionals like us need to do a better job of creating that access to HIV prevention, testing, and treatment for those who need it most and are not accessing it currently.

Monica Peek:

Thank you. Dr. Canterbury, can you take us through some of the data regarding inequities in other chronic diseases and the patients that are impacted?

Lisa Richardson:

I think since I'm the internist, I'm going to do that. Is that right?

DeLon Canterbury:

Sounds good to me.

Lisa Richardson:

Okay. Because in fact, these represent a lot of the patients I see in my practice. So, I think it's really important, these slides are going to be heavy in data and I think it's important to see the numbers, but I also want us to remember that under, behind every number there is a patient, a family member, one of our own community members and to really be honing in on that. Of course, we need to see this data, but I think many of us in these communities are well aware of it.

So, to start with, for example, when we're speaking about diabetes, we know that Black adults are 60% more likely than White adults to be diagnosed with Type 2 diabetes and two to three times more likely to have complications from the diabetes. We know that White patients conversely account for 80 and 77% of hip and knee replacement surgeries in the US despite comprising only 62% of the total population. We also know that Black and Hispanic patients are three times more likely to be under medicated for cancer pain than patients in non underserved populations. And the risk of receiving no analgesic while in the emergency department was 66% greater for Black patients than for White patients.

A lot of data now emerging around the impact of homelessness on health. And just one example, thinking about those social determinants and intersectionality, as Diane was speaking about, people who are homeless have three times a greater risk of cardiovascular disease and an increased risk of cardiovascular disease mortality. And when we adjust for insurance, education level and income, Black patients are 20% less likely to receive a DOAC, so evidence-based treatment of anticoagulation for their atrial fibrillation. So, just a clear example of that racism at the interpersonal level that we all have a duty to interrupt in our practices as clinicians.

Some more slides here around the impacts of chronic disease, and in this case, the focus on maternal health. In the US, non-Hispanic Black women and birthing people die at rates of 2.9, so almost three times greater mortality than their non-Hispanic White counterparts. And maternal and infant mortality rates tend to be much worse in

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states with larger non-Hispanic Black populations. In terms of maternal morbidity, non-Hispanic Black, Hispanic, Asian American Pacific Islander, and American Indian and Alaskan native patients are at much greater risk of multiple comorbidities, multiple poor outcomes including DIC, shock, acute renal failure, hemorrhage and preeclampsia, eclampsia, and the HELLP syndrome. And non-Hispanic Black individuals have higher rates of maternal mental health conditions, including postpartum depression. So, what we're seeing here, because we heard the vignette around experience in the emergency department, we heard Dr. Canterbury speaking about some of the data in patients around dementia and caregivers, and Diane speaking about the impact in HIV, and then all of this data here around chronic illness and maternal health so just a broad range of data to support what many of us know.

Monica Peek:

Absolutely. And one of the things that you had mentioned that was so striking was about the DOACs. And so, all the disparities are horrible, some of them I think have so many larger implications because when we think about those versus Coumadin, which requires all the extra visits for the INRs and the medication adjustments, which means that there are extra prescription refills, multiple refills as opposed to staying on a stable dose for a period of time. And so, we think about the burden of managing Coumadin, but the real burden is for patients.

And so, to have an alternative medication, particularly ones that we now know can be covered at a lower rate, lower cost than when they first came out. And to have huge disparities in those, and to not be on those, and particularly when they're at risk for the disease being treated, strokes and atrial fibrillation which causes strokes are so high. It's really a travesty so I'm going to switch and move a little bit more from some of the data, and I'm going to ask you to share some of your thoughts about bias and medical mistrust what you think is going on there.

Lisa Richardson:

Yeah, thanks so much Dr. Peek, I think that what's really clear is when, as I said, as I was presenting the data, I said well, people in our communities know about this data because many, these people represent their families and either have experienced this themselves or are experiencing, are their family members have experienced it, so they're witnessing it. So, I think what we need to first talk about is implicit versus explicit bias, and then we're going to talk about the idea of mistrust at the healthcare system.

So, implicit bias impacts all aspects of care. And when we think about the fact that those patients, Black patients are not receiving DOACs, it's not being prescribed, what is the implicit bias in the provider that's actually causing them to actually omit the standard of care? So, that's an example of really having to, for those who are not aware of their biases to do the work of unearthing what your implicit biases are, it leads to the explicit or the conscious bias of actually not prescribing. And again, these are things that all of, many people, witness or have experienced.

And so, I think what's really important when we talk about medical mistrust is that you're likely to mistrust a system where you have seen your loved ones or where you have been excluded or mistreated. And so, although often, we talk about mistrust as lying with the patient or at the community level, I think what we have to understand is that it actually is due to a system that has been built up to be exclusive and that continues to enact these exclusive practices, discriminatory practices and racist practices. And I think the other piece to remember is

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that it's not historical. Commonly, people will hear, "Oh, get over it. That happened a long time ago, why haven't you gotten over it? Why is your community not able to recover?" Well, the abuse is ongoing.

Monica Peek:

Right, this is still today.

Lisa Richardson:

And the systemic discrimination and racism is ongoing, it's still happening. And for example, just back in 2003, members of the Havasupai tribe in Arizona found that their own genetic DNA, that genetic samples that had been collected for studies on diabetes were then being used for studies on schizophrenia, migration, inbreeding, all sorts of very sensitive topics that they had never consented to, so, that's a very recent finding. There are many others, we all have examples of what's happening daily in our hospitals and in our clinics. And this is why we really have to, when we talk about mistrust of the healthcare system, I shift it to well, what are we doing wrong in the healthcare system and how do we actually build that trust back?

Monica Peek:

Absolutely, and I think that a lot of the conversation since the pandemic has shifted to, how can we be trustworthy as providers and as healthcare institutions? As opposed to, why don't people want this vaccine? Why are they so hesitant and mistrustful? Because I think people are more interested now because we are recognizing the interconnectivity of all of us together and we're only as strong as the weakest link among us. And so, it's all going to come back to everyone unless we are all able to engage in the healthcare system. And so, how can that system have everyone's trust, not just a few people's trust? So, thank you so much, just really powerful points.

So, we have another audience response question, you should now see that on your screen and you can go ahead and answer that now. So, which of the following groups, there's so many groups that can experience disparities, but which of the following groups experience the greatest mental health-related disparities?

All right, so Diane, I'm going to turn this over to you. Just like we've been talking about racial and ethnic biases, there are also biases related to gender and sexual orientation. What can you tell us about that?

Diane M. Bruessow:

Thanks, Dr. Peek. So, there are many situations where biases occur related to sex and gender, and I'm just going to share two illustrations. One is how women generally aren't receiving the same access to cardiac care while being overtreated for mental health and specifically internalizing disorders like depression, anxiety, while men are having the opposite experience and being undertreated for depression. I don't know of another community more impacted by stigma than young Black transgender women, I've already spoken to how that plays out in HIV. The result though, of stigma, is associated with a lack of support and a lack of affirmation. And there's years of data that speaks to how this results in an increase in unhealthy behaviors including substance use disorder and suicidality, which we can resolve by resolving the stigma, right?

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Healthcare professionals, we're not immune to being influenced by stigma bias. Almost half of all transgender and non-binary patients report mistreatment and discrimination of the hands of their healthcare provider. One of the ways that stigma is experienced by sexual minorities is when sexual identity, specifically sexual minority identities like gay, lesbian, and bisexual, is seen as proxy for high-risk sexual behavior. And we know that sexual identity and sexual behavior are different constructs with incomplete concordance. So, to be explicit, we can't assume a patient's behavior just based on their identity.

There's a term, the transgender broken arm syndrome that was coined in the transgender community and it refers to a scenario that's all too common. And it's represented by a transgender person who tries to access medical care for a broken arm, and is advised by the healthcare provider that they can't help the transgender patient with their broken arm because they weren't trained in the care of transgender patients. In the situation, the patient's gender diversity has nothing to do with their broken arm or strep throat or whatever it is the patient's there for. But all the provider sees is that patient's gender identity. Assumptions and stigma are also experienced in the aging sexual and gender minority communities who are in assisted living and nursing facilities. And today there's similar stigma that's also playing out around the monkeypox epidemic that we're experiencing, where anyone who's experiencing or come down with monkeypox has been either assumed to be gay or ultimately stigmatized as a result of it. And I think we have a clip to illustrate this.

Patient 2:

A few years ago when I was living in Virginia, went to see a doctor about an issue on the back side, and my doctor sent me to a surgeon who was a specialty in that area. And he turns around, he basically insulted me, hurt my feelings, and all that, made me feel less of a human being because first of all I was gay and HIV positive. And he basically cross, examined me from across the room. It upset me deeply because I know he knew before he came in the room that I was HIV positive and yet he acted the way he did. I went back to my doctor and told him what happened and I told him he shouldn't refer anyone to this man because the way he acted, and what he did with me. I was very hurt on the issue. It was to the point where I cried because I was so hurt and so angry.

Monica Peek:

Diane, one of the questions that has come up, there's your primary care doctor who asked if there are specific resources or places that are specifically like safe homes, safe places where people can come for, who are LGBTQIA, to get safe care, maybe specializing in care for that population. I live in Chicago, so we do have those kinds of clinics, but not every city is large enough to have the bandwidth. What do you recommend?

Diane M. Bruessow:

So, I, I, ... I'm sure up there, there are federally qualified health centers that specialize in sexual and gender minorities are considered medically underserved populations, which is something I think that kind of goes under the radar sometimes. But I hope that the folks that are in this room with us will be able to reach the folks in their community without community members, sexual gender minority community members needing to go for specialized care. I think it's on all of us to be able to get this right.

Monica Peek:

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Absolutely. And then just one other question, or comment that someone said that some members of her team, it sounds like maybe some younger members, I'm not sure, said that some people have been very vocal about, "There are just too many terms these days," and I think maybe-

Diane M. Bruessow:

Yes.

Monica Peek:

How would you advise this person to talk to their team member who says, "I don't want to learn all these ... you know ..."?

Diane M. Bruessow:

Yeah, well, here's the thing. Language is changing, ever changing and what it is today is not how it's going to be tomorrow and I totally get it. So, I really appreciate the framework of cultural humility as opposed to cultural competence. So, our patient knows things about themselves that we don't know and we're going to have to ask them about it. So, we just have to ask our patients, "Hey, how would you like me to address you?" Use gender neutral terminology around spouses and partners until a patient advises us what their circumstance is. So, it's challenging, but it definitely has an outcome and as we heard from the audio clip, it makes a huge, huge difference when we can get this right for patients.

Monica Peek:

Exactly. Ultimately as providers, we should be concerned in patient outcomes. And we know that there are lots of ways to get to good health. Some of those are by addressing people's environment, those social determinants of health. Some of those are by helping patients feel like their full humanity and dignity is addressed as the last clip showed, I mean the poor man cried, how often do men cry? And so, when we can help people feel like they are seen by the healthcare system, and if that means taking on the burden of learning how people want to be addressed, then I think that that should be how... That we think about, although we learned a whole new language when we entered the healthcare system. We learned that this is not called the collarbone, it's called the clavicle. So, we took, and we figured, we didn't bat an eye about that burden. And so, I think the resistance to learn a few extra names really reflects a bias about wanting to embrace a way of addressing people's full humanity, because it's not that we aren't always having continuing education, that we're not averse to the idea of always having continual learning. I think there's something else that's underneath that, that is blocking that person. But we need to understand that this is ultimately for the best health for our patients and that's why we're showing up every day, so anyway.

Diane M. Bruessow:

Thank you for that.

Monica Peek:

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We can talk about any of these subjects all day long, but we don't have all day, so we are going to move. So, thank you for the great discussion. We're going to move to another audience question. Which of the following is not a social determinative health domain?

All right. The anticipation is building up for the answers. So, Dr. Canterbury, what can you tell us about the social determinants of health? And then before we start talking about those, it's just to sort of recognize they can be positive or negative and how they may impact health inequities. And then can you run us through the different kinds of social determinants of health?

DeLon Canterbury:

Oh, absolutely. As we can see here, pretty clearly stated, these social determinants of health are really what dictate the majority of our health outcomes, about 80 to 90%. And they range around from what church may be in your community, what type of social support do you have, education, food insecurity, the list can go on. And so, in talking about this, we know that this is where our outcomes will come from. So, how can we really truly try to hit and support people in need who may have some of these social insecurities. There are five domains around social determinants of health, but we can even see, again, based on your zip code, how differences in that zip code can impact, again, true quality care.

And so there is, of course, a bio-psychosocial feedback loop, when it comes to social barriers. I worked in the COVID Task Force here around the Durham, North Carolina area. We saw an immediate need for screening and testing for COVID, and unfortunately, it wasn't being addressed in those of most need. So, it took community stakeholders to truly have testing that's literally done 10 miles away to be put in the most communities, of course, that were lacking.

So again, touching on that social structure, that was what was needed in this example of COVID screening before there were vaccines. But again, trying to bridge where people are driving two hours away who had a little more time, a little more access, to have that ability to drive two hours to a low-income community to get screened. That again, I think is a poignant example of differences in some of those social determinants of health and barriers that lead to those outcomes.

So, as I overviewed cursorily, this can stem from anything from occupation, jobs. Of course, what you may have as assets financially, what kind of support you may have, what kind of community support you may have. So of course, the first tenant comes down to economics. What's around you? Is there opportunity for jobs? How can we address medical costs? If there's even medical debt? That's another issue as well. As well as the number of dependents you may have, and that may vary from culture to culture.

As another point, education plays a pretty huge role as well, especially when it comes to health literacy. And most importantly, I'd say language. How we're communicating in the language of the person we're trying to treat. We've seen it time and time again, how much your higher education can impact those outcomes.

Even access to internet became a huge issue. We can't just send people to go to school from home and assume everyone has the internet, you see. And that became... Essentially there were grant fundings to help put that

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internet into those rural communities to bridge those gaps. So technology, again, plays a role, along with this educational piece.

On another level, there's of course, simple access to just health, period. Who's the local provider that's nearby? How many patients-to-provider ratios are there? Is it a HRSA or low income... Sorry, zip code or region that's being treated, like we see most in our rural communities?

So again, trying to bridge those gaps. And I do see telehealth being a huge role in trying to do that, but we still have a long way to go in terms of infrastructure. As well as, again, access to just general basic health insurance.

Of course, neighborhood stability and safety can play a huge role. In my work with the COVID Task Force we had to build pretty strong partnerships with the Meals on Wheels and other food banks in hitting some of those social needs, while empowering about other ways to advocate for, in this case, vaccination against COVID.

But transportation, especially in our seniors, is a huge gap. There are patients who are missing dialysis clinics because they can't afford a bus ride to go downtown, or whatever the case may be. Or they may not have a loved one who's supporting them to give them a ride. So again, neighborhood safety plays a role. And with the pandemic we've seen spikes in abuse at home, domestic violence. All these may play a role. So, if you're worried about blood pressure, but they're worried about whether I'm going to make it home safely, that's a whole other context of a conversation we have to have. So, definitely keep that in perspective when it comes to just general, my day- to-day.

Monica Peek:

And I think we have an audio clip here.

Patient 3:

In the past, I have had limitations where lack of transportation definitely was a factor in me being able to get to the healthcare appointment. I live in an area where they do not really have bus service, so it was very hard to get back and forth to your healthcare providers.

My insurance did provide transportation, but a lot of times it was not on time. And some of these healthcare providers, if they're specialty providers, you can't get in until two or three months. Then you've made the appointment and you don't have the transportation, you don't have the resources to get there, or if the ride is late. They don't want you to come 15, 20 minutes late because they have other people to service that day.

So, I'm not really sure how the healthcare providers, how they feel about that. I've only been able to speak to the receptionist or the medical assistant who is handling that kind of thing. So, I've never known in any of my instances where a healthcare provider has tried to make any arrangements or accommodate any of my needs.

DeLon Canterbury:

Such a powerful testimony to the reality of our day-to-day. We know it's, sure, COVID, recession, all the blight we have on the news, but this is the day-to-day for someone and they're trying to get the care. This is someone

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motivated to get the care, and to not have that, what, \$3.00-\$5.00 cost one way, which again, may seem small to some, but a ton to others. That's again, the basis of why we're here today, is to bridge those gaps and show that empathy behind all of this.

Monica Peek:

Right. Right.

DeLon Canterbury:

So yes, yes. This is another great one as well, talking about just the lived history of social racism. And again, I appreciated someone mentioning earlier that this is not just ancient history. This is a very lived experience. Even during COVID there was a black doctor who died live, and filmed her Facebook testimony just to get the help she needed. And that's something I'll remember as a clinician, and that's what, guess what, my patients will remember because we live this every day. And so, having to address not just the elephant in the room, but take it head-on. Take it head-on as the conversation, because yes, you're going to hear, "Well, why should I get the shot?" I'm using COVID a lot because I worked on the COVID Task Force.

But referring to the example of the Tuskegee experiment. We have yet to really nationally apologize. It took Bill Clinton in the nineties to start talking about that. So, you can't expect people to just be bought in without having this, again, this elephant in the room conversation, I call it. And it's really just level-setting with coming to the fact this is a lived, ingrained experience. Unfortunately, maybe not going away as soon as I would like, but it's something that's happening now. From the person who's parking their car, and seeing an attendant, and walking in and saying hi to the front desk associate.

So, understanding that that discrimination is very real. And I, as you can tell, maybe... I'm a black pharmacist. I've gotten my own discrimination within my own schooling at a top school. And I can talk to countless doctors who say the same thing, within residency programs and within the didactic. Yes, Dr. Peek raised her hand. It's such reality. And so, it's never going to leave me. It's a part of my story. But again, that's how I'm able to empower others. And again, I think it just starts with having that understanding, just basic understanding that it's not going to be the same cookie-cutter story everyone else has.

And even further, when we talked about genetics, I look like a black man, but my family's from South America. My family's Guyanese. So, I got a genetic test just to see what kind of enzymes will do differently. And I'm an intermediate metabolizer for four different main cytochrome... I know we're getting to the weeds, but cytochrome pathways. So again, it's not a monolith. We have different cultures. And in fact, I could be speaking fluent Spanish and suddenly I'm Latino. You see what I'm saying? So, we can't go off what we see physically. And again, I wanted to just reiterate how that lived experience starts from the minute you walk into that clinical facility.

Monica Peek:

Great. And so, I think these are great examples of how it is not the fact that you have brown skin, but it's people's reaction to that brown skin. It's not race, but it's racism. That is the challenge. That is the social determinant of

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health that is driving, not just these poor health outcomes, but is a layer on top that is disproportionately distributing other existing things that we know to be social determinants of health. Like poverty and crime and access to basic human needs.

And so, one thing that I'll note is that we tend to think about social determinants of health in the negative because we're talking about what can impact health in a negative way. But there are also things within racialized minority communities that are protective, and that have allowed these very marginalized, oppressed communities to survive. It's how do we do it over time? How have we managed to stay together, to stay healthy, to not be crushed under the boot heel? And so, these are things that I think that we need to be also investigating the kinds of things that I think have made it livable over generations for communities to have survived.

And so, Dr. Richardson, I want you to talk a bit about how we can think about the protective effects of culture and community that help mitigate these negatives. And how we can frame that in terms of social determinants of health as well.

Lisa Richardson:

Yeah, thanks so much Dr. Peek. And I think it's really important to move from that deficit-based model to the strengths-based model. Because we need to speak about the health gaps and the disparities, and we need to understand that they're built into the systems that we're living within and working within. But we also need to understand the strength within all of our communities that actually do offer that protection.

And so, this slide really does speak to many different examples that support this idea that just as there are these social determinants that undermine our health, there are also these other factors that actually protect us. So, if First Nations, regardless of their living conditions, have social structure and physical traditional activities, land-based activities that go back to how we've lived traditionally, they are very protective actually. And so, some incredible examples, for example, of land-based treatment programs for people with diabetes, or poor people with substance use disorders. And a good body of evidence emerging around that. That Asian Indian patients benefit from social support interventions, such as a network of family and friends who are providing that instrumental support. And can actually, that can translate to support around medication adherence, and of course, the improvement in health based on that. That older Mexican Americans living in neighborhoods where there was a high density of people from within community had better self-rated health, which is called the Barrio Effect.

And some of the other potential mechanisms that may protect, again... Because we've talked about those negative social determinants of health. Those that undermine, such as low SES and economic distress, which present in the Mexican American neighborhoods based on this study, actually led to high levels of social cohesion, material and emotional resources, strong family structures and traditions, high involvement in the labor force, etc. So, even the response to those experiences of structural discrimination or the negative social determinants of health, demonstrate the resilience within communities that then becomes protective.

So, not that I'm suggesting that we need to actually always be resilient. We need to actually take away that need. But we also need to understand the strengths of culture, of community, of traditional activities, of family

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supports, community supports, etc., to actually protect the wellbeing of individuals. And really work from those community-based models, those strengths-based models that leverage that strength.

Monica Peek:

Absolutely. What a wonderful way to finish our first learning objective. Thank you, Dr. Richardson.

So, we're going to move on to our second learning objective, which is to develop a team-based approach to improve the patient experience during visits.

So, Dr. Canterbury, can you talk about the team-based approach to care and how important each member of the team is to optimizing care? And this slide has lots of different people, so it really gets to the heart of how many people can be part of the team, and how it's not just about the physician and the patient. So, talk to us about that.

DeLon Canterbury:

Yeah, I'd love to. And it's absolutely right. Honestly, we have to have a team-based care model. Regardless of what we're talking about in healthcare, it needs to be just done. We all have our own expertise and we all have a role to play together. And in doing this type of community work, it does truly take a village.

And I would say one of the most dependent upon, at least in terms of COVID outreach for us, was leveraging the power of community health workers and community health ambassadors. And upskilling them to have some of those ways to triage to mid-levels and higher-level practitioners.

And in my work, I serve as a pharmacist by trade, but a lot of the outreach I did was simply education at faith-based communities and town halls with nurse providers, with PAs, with other mental health specialists as we're dealing with a crisis. Because we're not just treating the arm if everyone's sick, we're treating the entire body. So, we need that mental health approach, we need that specialist. And we need a close-knit community of providers having eyes on the same patient, or in this case community.

So, I highly love... It just needs to be done, frankly, across the board. We may do it, it may be fragmented, but frankly, having that advocate, having that voice has been shown to be very effective in improving those outcomes.

Monica Peek:

Absolutely, absolutely. And not just for patients, but also for the staff themselves. When everyone is working together at the top of their license, people feel better and happier in the workplace. When they bring their best game to work and feel respected for their opinions, it's a happier place. You have lower turnover and that ultimately results in better patient care also. And so, it's just a win-win.

So, talk to me about community pharmacists. You're a pharmacist, so talk to me about community pharmacists.

DeLon Canterbury:

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Sure. Ninety percent of our country is within five miles of a pharmacy. And so, as we've seen in this pandemic, they have been critical in not only the vaccination of our people, but getting into those places that are hard to reach. And one thing I've been able to learn was how expansive and versatile the role of pharmacists can be. Whether it's going to someone's home, working in mobile clinics, working, again, in the faith-based communities, going where the people are. Using your access, of course, to reach others in a cohesive way.

And so, one of my loves is deprescribing. I'm a geriatric pharmacist by trade, and so I look for ways to teach, not just the patient, but the caregivers on how to advocate against maybe taking too many meds for maybe one condition. So, trying to start with simple things that maybe as, "Are you on more than 5 to 7 meds? How long have you been on it? Is it still working? Do you have any side effects? Are you comfortable with your body? What can you tell us so we can better advocate for you?"

And education's half the battle. And so, in order to get that potential medicine deprescribed in my world, it will start with someone saying, "You know what? Let's have a conversation about the meds. Let's talk about what we can do to get rid of this." And so, one mnemonic that can be used to help those who may be trying to become more culturally sensitive that I've learned about is the ethnics clinical tool. Essentially, in my world, I have a Caribbean background and my way of treating a cold is Vicks VapoRub and Tiger Balm, and put some stuff in your socks. Really old school and herbal based. But again, it's good to have. And I specifically look for providers that have a Caribbean background because they can relate to that. So, that's one method of using this ethnics tool, is trying to empathize where people are coming from. Whether they may resort to a healer or spiritual advisor or shaman, whatever their culture may be. Whether they're willing to collaborate. What do they think about that person's intervention in that person's case?

This could be a tool that may be helpful in at least becoming more aware of somebody's sensitivities and looking for a guideline to at least have a patient-centric model of addressing some of these differences that you may not be aware of.

Monica Peek:

Thank you so much. And I think that's really important because sometimes the pharmacists are not physically in the same building. Sometimes they are, sometimes they're not. Not everyone in the healthcare team thinks about how important that pharmacists can be for patient education for so many things. And I rely a lot on my pharmacists because you guys love to teach, rather than just filling meds. And that's important. But patient education at the point of sale, when they're actually picking up their medications. And everyone has to sign that little thing that says I was counseled by my pharmacist or not. We do that for a reason. You guys are trained to do that counseling. And so, when they're getting their inhaler, I'll say, "You're going to pick it up from the pharmacist. Have them show you how to use it. They can... Yes, they can. They know how to do this." And so, really thinking about all the members of the team who may ultimately touch my patient, even if they're not in the same building. So, thank you so much for that.

The other thing that I want to add is just how important all the team members are who may not typically be seen as a healthcare provider. So, the front desk staff, the people who work in the parking garage. Everyone who comes into contact with the patient before they get to see me will impact that patient experience.

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And I have had days where, by the time I get to see the patient... This actually happened last week. She looked so upset and I was like, "What is wrong?" And she's like, "I was about to turn around and leave." I'm like, "You just got here." And she's like, "Everyone who I have encountered before I saw you was so... I don't know if everyone's having a bad day, but I've still been living in a shell because of the pandemic. I've been frightened to leave my home." And so, all of that really impacts how people are perceiving their healthcare experience. It's not just about me. And so, if we can, again, have people at that front desk, have everyone be part of that team and educated on, "Hey, did you know that asking your doctor questions can help them know that you're interested in your care, and you're more likely to get extra, whatever?" All of that helps the patient, and again, it helps those team members. And so, really thinking about. And particularly because a lot of times cultural concordance and racial concordances between the medical assistant staff, the front desk staff, etc., and the patients that you're serving, no matter if you're in Chinatown or on the south side of Chicago, usually the physicians are more likely to be White heterosexual men and the patients may or may not be. And the patients will frequently reflect the staff that are serving them. And so, thinking about how to engage the staff in ways and the surrounding community that they're living in, how can we partner with those community-based organizations and the people that are in there? Because that's where they're going to be getting their food, shopping, navigating for all these things that we're telling them to do. Can we think about addressing those social determinants of health in ways that are above and beyond just a referral? And so, all of these things are really, really important as we think about how we're defining and redefining a team-based care.

So, I'm going to just ask one question because it doesn't quite fit exactly in this, but we've had a few questions that have come up just about care of transgender individuals. So Diane, I'm going to pull you back into the conversations before we move on to our next learning objective.

Diane M. Bruessow:

Of course.

Monica Peek:

And one is about identifying or asking about people's body parts and the kind of sex that people have when we're talking to trans women or men. How do we... Because a lot of time... How would you recommend engaging in those kinds of conversations?

Diane M. Bruessow:

Great question. I'm so glad it was asked. So, to the person who asked it, Thank you.

Monica Peek:

Those are two different people.

Diane M. Bruessow:

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There's a approach that's taken by folks and this approach is relevant not only in the trans community, but maybe for your patients who have had cancer, who may have a prosthesis, who may have had something removed due to cancer. We take an organ inventory and we want to understand, "Hey, what parts does this person have so that we know what parts we need to care for." And an organ inventory isn't a transgender health specific thing. It exists, like I said, it can help folks who've had cancer as well, but it really would be the way to approach that.

And as far as the question of what kind of sex someone's having, that goes back to, there's an illustration I like to share with my students. And that is that to remember that our patients are actually very different from us and they're going to be very different from each other. So, it's like the parable of the elephant and the blind men who each wanted to touch the elephant and one says, "Oh, it's a rope," and one says, "It's a tree." They're all right, but they're all wrong because of the assumptions that they were making. Sex is like that. You can't just assume what kind of sex your patients are having and what they're doing to be very different than what you're doing.

If your patient says it's sex, it is, right? So, it's about asking some of those open-ended questions at first, whether you're interested in exploring reproduction or sexual health or the mental health component of it. Really, you have to tailor your sexual health questions and your sexual activity questions based on really what your goal is. And like you said earlier, Dr. Peek, it's a whole other rabbit hole. It's a whole other lecture for another day. For sure.

Monica Peek:

Thank you so much for just ...

Diane M. Bruessow:

Getting us started.

Monica Peek:

Yes, exactly. Thank you.

Diane M. Bruessow:

My pleasure.

Monica Peek:

All right, so we're going to shift into our last learning objective, which is to determine treatment based on social determinants of health and improve accessibility and the success of patient care and outcomes.

So this, this is our final question. So, you should see the question on your screen, and you can vote now. And so this is, ... this may feel like our most challenging question, who knows because, but we're going to talk about these. And the question is, "In which of the following ways is cultural competence different from cultural humility?"

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Okay, Diane, back to you.

Diane M. Bruessow:

Thank you.

Monica Peek:

Can you talk to us about these two issues there? I think a lot of us are moving from this construct of cultural competence to cultural humility. And so, can you tell us the extra work that cultural humility does for us and where it gets us compared to competence and how they're different, how you can apply them to your clinical practice. Just tell us about it.

Diane M. Bruessow:

Absolutely. So, I think that the first thing to keep in mind is just that besides the fact that cultural competence is not an attainable goal, the reason for that is that no community is homogeneous. So no, community, members of a community are not all going to be similar. And this is really where cultural humility comes in. I've said it earlier that, and I'm glad to reinforce this, that our patients have information about themselves that we need to know and we can't possibly know just by looking at them or seeing a demographic, ... documentation. When we employ cultural humility, we avoid assumptions. And it does take a little more time and energy to make everything explicit. And as a result, cultural humility is a continuous process.

Monica Peek:

Sort of a mind shift and I think it actually can ease the burden of feeling like, "Oh my gosh, I have to know everything about everybody." And to thinking, "Well, it's really a state of mind and a sense of openness to trying to recognize that I have these limitations, but I can be open to exploring the individual in front of me."

Diane M. Bruessow:

It does really take the pressure off in that way.

Monica Peek:

Yeah, so Dr. Richardson, I'm going to pull you back in. And as we move to models of care where patients are truly empowered, we can think about cultural safety. And I'm super excited to talk about this. Many in our audience may not be familiar with our term, with this term, and how it applies to clinical practice. And so, what can you tell us about cultural safety?

Lisa Richardson:

Yeah, thanks so much, Dr. Peek, and similar to, ... the reason this is a paradigm shift is that when we're speaking about cultural sensitivity, awareness, competence, and even humility, which clearly is key as a practitioner, our goal of that continuous practice of humility, it's all about the provider whereas cultural safety is actually a shift to

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the experience of the patient or the client. And so, it actually is shifting the power to, how is the patient experiencing care? So, I often will say, "You could feel like you've done an incredible job, like high five, I just rocked that. That was awesome." And then someone might interview the patient as they're leaving your office or your clinic, and they'll say, "That was terrible. I felt completely ... Nobody, they didn't listen to me. I didn't feel seen as a person. My whole self, background was not considered and I felt disempowered." So, it really is about that shift.

We're using it a lot now in Canada in the care of indigenous peoples. But it works broadly, of course, for all communities who've been excluded structurally and experienced discrimination. It actually forces us to consider and gets us to consider the whole care of the patient, but also to really consider the power dynamic. So, who holds the power in that clinician-patient encounter? No matter how educated one might be, what one's background is coming into a care experience, into a hospital, into a clinic, getting a vaccine, you're nervous, you're anxious, and there's someone who is actually treating you caring for you. And so, inherently there's that power dynamic. It's heightened significantly when you're from a community that actually continues to experience exclusion, discrimination, racism. So, that's why it's such a key concept is, to actually shift to considering, how is the patient experiencing the care? We're seeing this a little bit when we talk about patient satisfaction surveys, but this is sort of an even more, I would say, a fulsome description of a patient's experience. Did they feel that they were being listened to? Did they feel cared for in that broad way? And this slide just really does describe many different examples.

And I do like the first point on this slide, which is really, what are unsafe practices? Those are practices, that any actions that diminish, demean or disempower the cultural identity and wellbeing of an individual. And going back to what you were talking about earlier, Dr. Peek, around like that humanity, the respectful engagement with the person whom we're treating or with whom we're entering into that treatment relationship. So, I think it's a helpful concept to actually shift the focus. And just as we were talking about shifting from the deficit-based model to a strengths-based model within our communities, shifting to, "Okay, what are the strengths with the patient and how do we really allow the patient to guide the care that we're providing?" obviously when that shared decision-making model, et cetera.

Monica Peek:

Exactly. And I think this is just a continuum. We, as medical students are trained to think about, Okay, we know we're going to be asking people very sensitive questions. We know we're going to be having difficult questions about the end of life, et cetera, asking about their sexual practices. And so, we need to create safe spaces, but it's extending this construct to things that we may not be accustomed to asking or talking about (racism, heterosexism), and to make space for people to feel safe about all aspects of who they are. And sometimes we have to explicitly say that and to understand that patients may not have that as a given, that our job is to make them feel safe.

And so, whenever I meet patients in the hospital for the first time, I always say things that seem very obvious. "My first job is to take the best care I can of your loved one." These things that 1, 2, 3, and a lot of times the student's like, "Yeah," but I'm like, "You know what? Nine times out of 10? I bet you the family was not aware of that. They may have thought that my first job was to make as much money as I could, to experiment on their family, to do whatever." And so, creating a sense of safety in time of vulnerability and stress, I think is really, really important,

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particularly for marginalized communities who frequently feel unsafe everywhere they go. So, thank you for introducing this construct for us.

So, Dr. Canterbury, I feel like I'm tossing the ball to each one of you, you each get a few minutes to rest. Talk about some of the tools that providers can use when we're thinking about the social determinants of health. What do we have? There are more things coming online, things that are now been validated. How can we integrate these tools to begin screening our patients for some of these social needs that they have to think about social determinants of health more broadly?

DeLon Canterbury:

Yeah, I'm grateful to see that more and more EHRs are actually integrating and tracking some of these social determinate needs assessments within their software. But as we can see here, we do have other tools at the PRAPARE Screening Tool, which comes from our NACHC, that's the National Association of Community Health Centers. And it's again, designed to engage patients and really look for some of those core needs we discussed earlier in social determinants. They use 15 core and five supplemental questions and the beauty about this is it actually comes with an implementation and action toolkit to help upscale the people using the assessments. And of course, it's translatable in a couple of 25 different languages. There's also the AHC-HRSN Screening Tool, which comes from our CMS. And this is again designed to help assess these needs and they use a short form, a 10-item short form and available in 10 languages as well. And lastly, we also have the Social Needs Screening Tool, which comes from our AAFP, and again, meant for a number of practice settings here. This is an 11 questionnaire, 11-point questionnaire. And again, this needs to be choosing based on a quality of evidence linking made to poor health outcomes and the ability to address real need overall.

So, I do want to also just highlight, sometimes these screening tools can kind of forget that a person's in front of you. And so, sometimes patients may be seen as, "Why are you asking me all this? What do you want from this? What are you going to do with this data?" So, I think I want to highlight the importance of at least connecting the why and not just probing into someone's business, but it may take some kind of reeducation around this and that they want to be sure that you're in it for the best of their interests and care, and not just as a way to say, "Hey, you know what? He has these needs. Let's defer to someone else and maybe cause trouble in their mind." And you don't know what people may think.

For instance, me working in the COVID task force, we learned heavily how much the Latino community wasn't sure they can go to these clinics because they may be fearing immigration or ICE around the corner just for getting something that was free and available to all, regardless of the education and people saying that what it is, there's still that intrinsic fear. And so, in that same vein, some of these screening tools may be seen with apprehension, but they are there and they need to be at least be seen repeatedly as a tool to help advocate and go beyond just the white coat syndrome we may have.

Monica Peek:

That was fabulous, thank you. Because as we are trying to help address these unmet needs that patients may have, we also need to be aware that people have a lived experience that may be wholly different than our own. And they may rightfully have apprehensions based on current and or historical experiences of the community that

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may make them question what may happen to the information, the data that they might share with them. And so, the onus is on us to provide culturally safe spaces, to provide the information so that people know that this is going to be used to help them directly and that will not be used to harm them and their families.

So, I'm going to jump now to talk about why, well, this is sort of obvious, but to the issue of diversity. And people frequently in their own minds equate them like equality and equity, those are different terms, disparities and diversity, different terms, but they're interrelated. It's because we need a diverse workforce to try and combat disparities. So, we're going to just do a quick sort of acknowledgement. And Diane, I'm going to ask you to talk a little bit about diversity and why that's important and to talk a little bit about your unique program in Yale and what some of the things are that you are doing there that can help us towards this goal.

Diane M. Bruessow:

That's great. So, just to share a couple of the actions that we've taken in the Yale online program, because this program is the first in the country for medicine anyway, that's online rather than residential for the didactic portion, our applicants don't have to be uprooted. And one of my favorite stories is of a student first, in our first cohort who lived on a reservation. It was either North or South Dakota, and has not gone more than 20 miles beyond their home. And they are training in their region. They're not going to be going off someplace and not coming back. They're going to stay in this region, they're going to stay in their area, they train there, and they're going to be providing primary care right there at home. And we're doing this in all 50 states, which is just, I love this part about the program. Because the program is online rather than residential, our applicants don't have to travel to the school for interviews. And that really helps applicants who are first gen and in low resource to cross that threshold to matriculation. During COVID, every school learned this lesson as well. And I certainly hope that many of them have continued for this very reason.

And the last thing I'll share is just that data on our applicant pool revealed that the GRE exam wasn't relevant to student success. So, we did away with it. And these just small changes resulted in a greater number of underrepresented minorities in medicine who are now matriculating in our program. This matters, high level summaries because we know that health outcomes and patient satisfaction are best when the provider represents and reflects their patients. And there's illustrations on the slide in front of you to give a little more detail on that.

Monica Peek:

Great. So, now we're going to go to the audience response questions and see how we did. So, the first is about equity and equality. So, we're going to do this, we're going to revisit. So the first question, "How do you differentiate equality and equity?" And so, Dr. Richardson, I'm going to ask you to actually talk about the results and see what...

Lisa Richardson:

So, what we're seeing in this is that after the results of after this session, 81% of people felt that equity allocates resources to account for individual differences to achieve equal outcomes for all. And that's amazing. That's the correct answer. And prior to this, at the beginning of the session, only 61% of people got that. So, that is actually a

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really cool and amazing result. And I love that there's been that evolution and growth in people's thinking through the course of this session. So, congratulations, everyone, for this learning and obviously to all the co-presenters.

Monica Peek:

Yay! Hooray! Okay, so as we come around the bend, we're going to ask the second question, "Race is a biological risk factor for which of the following disease states?"

DeLon Canterbury:

All right, so for our pre and post, it looks like we have 69% pre, now 65% post for sickle cell disease, regarding HIV infection, 2% pre, 7% post, 4% pre, 5% post for diabetes, and which we all want, none of the above for 23% post and 14% pre as race being a biological risk factor.

Monica Peek:

All right, so making some progress. Let's go to the third question, "After today's program, which of the following groups do you think experience the greatest mental health disparities?"

Diane M. Bruessow:

So, they're up and there's been a slight increase among the respondents. Start out with 74% saying pre and 81% post for identifying transgender persons as experienced great mental health related disparities. So, well done, attendees.

Monica Peek:

Well done. All right. Someone had thought that they're like, "So, you mean to tell me that non-Hispanic White males have the greatest "... " So, that 'wasn't the answer. Okay. Two last questions, After watching now, which of the following do you think is not a social determinant of health domain?" Four responses, go ahead and pick.

Lisa Richardson:

So, just interpreting the results. So, the correct answer to this question is, and the question was, "Which of them is not a social determinant, which is not a social determinant of health?" The correct answer is race and ethnicity. And once again, I'm lucking out here, we're showing the response that has massive growth. So prior to, at the beginning of this session, 44% of people got that question, were correct in that question. And at the end, we've got 67% of you who have got the answer right. So really, really cool to see, again, the educational impact of this session. So, congrats everyone.

Monica Peek:

Wonderful. All right. Now the last one, finally, "After today's program, so which do you think is the difference between cultural competence and cultural humility?"

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DeLon Canterbury:

Okay, so for the answer, cultural competence is an unachievable concept and cultural humility is a continuous practice. So glad that we've seen a huge growth: 54% post and before it was 18% pre. So, I think we've made some good ground in breaking that distinction.

Monica Peek:

Excellent. Excellent. Excellent. So happy, happy, happy that we're doing some good learning. All right. So, we're going to summarize our discussion, which has been long and interesting and great, and just juicy with our SMART goals which means, or stands for, specific, measurable, attainable, relevant, and timely. And so that is what I hope that you take from today's presentation and apply to your practice.

So first, recognize that disparities related to race, ethnicity, age, gender identity, and/or sexual orientation result in health inequities in your practice. Everyone's practice. Second, evaluate your personal implicit and explicit biases related to underserved populations in your care community. Additionally, screen patients for social determinants of health or unmet social needs to understand and accommodate circumstances that serve as barriers to healthcare access and quality. Importantly, collaborate with the entire care team from administrative staff to individual specialists, develop a team-based approach to care that seeks to remove barriers to health equity. And then finally, continually practice cultural humility and create culturally safe spaces during patient interactions to improve the patient experience.

To Diane, DeLon and Lisa, thank you so much for the work that you all do day in and day out to help empower your patients and to improve their care. It really, really has been an honor sharing this time with you tonight.

I also just want to remind our audience that CME Outfitters has a Diversity and Inclusion hub with several more educational activities and really excellent resources to share with your colleagues and patients.

Thank you again to everyone who participated in today's program. Thank you for sharing this space with me and for your continued commitment to improving the care for all of our patients.