Health Inequities in Vaccine Optimization

CMEO Podcast Transcript

Monica Peek:

Hello, and welcome to a very special podcast that is part of a series I am leading on diversity, equity, and inclusivity with CME Outfitters. Today's CMEO cast is entitled Health Inequities in Vaccine Optimization. I'm Dr. Monica Peek, and I am the Ellen H. Block Professor of Medicine in the section of General Internal Medicine. I'm the Associate Director of the Chicago Center for Diabetes Translational Research, and the Director of Research at the MacLean Center for Clinical Medical Ethics, all at the University of Chicago here in Chicago, Illinois. I would now like to welcome my dear friend and colleague for many years, Dr. Monica Vela, none other. She's the Professor of Medicine at the University of Illinois Chicago College of Medicine, Director of the Hispanic Center of Excellence, and the Associate Editor for JAMA Network Open. Monica, I am so honored and just delighted to have you joining us today, and I'm excited for our discussion about a topic that has been near and dear to my heart since the pandemic started.

Monica Vela:

Absolutely, and I am so appreciative of the opportunity to discuss this with you, Dr. Peek. Thank you.

Monica Peek:

All right. I do want to remind our audience that this CMEO Podcast is really just a continuation of our initiative to address unconscious bias, health disparities, and racial inequities. This is not the first time. We are building a comprehensive library of educational activities addressing these important issues, and today's activity continues this discussion in vaccine optimization. On this slide are just some of the titles of activities in this series, with links to each of them. To view any of these programs, simply click on the activity title. If you participate in at least three of the programs in our D&I Hub, you will also be eligible to receive a digital badge demonstrating your commitment to education on diversity, equity and inclusivity. So, let's jump in with our learning objective for today's program, which is to analyze the influence of unconscious bias, health disparities, and health inequities on vaccine optimization.

As we begin to address disparities in vaccination, I do want to review some foundational points regarding historical racism that can help us all remember how we got here. We've done previous programs that cover these topics in depth, and those programs can also be found in our D&I Hub. But I want to recognize that we would be doing a disservice if we didn't take a moment in each of our programs to recognize that we have a groundwater issue that we have to address. And that is that, structural racism is really ingrained in everything that we do, every place that we work, live, and play, and that it affects so many things. So, it affects the social determinants of health that we are currently talking a lot about, as far as food insecurity, housing instability, all of those things. They're disproportionately determined by structural racism, which populations are more likely to have those things.

Structural inequity, structural racism, also impacts health care provider bias, which Dr. Vela is an expert in. It determines not just the social determinants of health, but the toxins and exposures and things that are in the environment that communities live in, which also directly impacts health. So, that gets to the indirect effects of systemic racism or structural racism, and how that leads to things like discrimination within the healthcare system, where there's deviation from what we call standards of care between populations based on race and ethnicity, where we start to see manifestations of disparities in health outcomes partly due to increased psychosocial stressors that cause pathophysiological changes, some of the mental health outcomes that happen. And then just because of the disparate care that happens, we start to see disparities in health outcomes from those as well.

And then the long-term effects of systemic racism impact patterns of behavior where we lead to decreased retention in healthcare systems, so that when we get specifically to things like vaccines, and we wonder why some communities are reticent to receive the vaccine are less likely to be retained in care or to seek care, we then have all of this historical backdrop that we're fighting against, that are issues that we have to address. So, to rebuild trust, to try and address these issues that have been going for a long time.

So, these are things that … So, how we got here is really important to the work that we're doing presently in trying to address these issues. So, Monica, let's focus now on racism and medicine to discuss the impact of structural racism on vaccination optimization. And can you talk us a bit about some of the reasons for disparities in vaccination coverage?

Monica Vela:

Absolutely. And I so appreciate that you start always, Dr. Peek, with providing the context for the conversation. I think it's very easy to skip over the context and go straight to action items, but it keeps us from reaching for higher goals, it keeps us from understanding how we got to where we are today. And so, I'm just going to highlight a couple of the things that you said. First, is that provider bias takes us a long way to creating disparities, in particular, in vaccination. How does that happen? While provider bias remains a really big concern in the United States and elsewhere, in particular because of the sociopolitical climate, in the rhetoric that we are hearing, and because we are facing, as a healthcare system, an inordinate amount of burnout and feelings of depersonalization, which always makes bias go on the rise. We also need to recognize that this bias comes from us teaching, within our profession, racialized medicine. All these algorithms that include race need to be gotten rid of.

Alongside of that, we recognize that there are significant disparities and inequities in the physician workforce. And so, we're not seeing enough of our patients' identities reflected in our providers. Alongside of that, I think it's important to recognize that insurance status is also driving disparities and vaccination status. We know that many states did not adopt the Affordable Care Act, and many more people remain uninsured in our southern states. It is also true that insurance remains highly dependent on occupation, and that there's significant occupational segregation in this country. That leads us to seeing whole swaths of our populations without primary care providers and without a primary care home. And so, it is very unlikely that patients will be able to develop trust with the profession with a single provider when they live in health professions shortage areas. All of this is driven by structural racism. And so, it becomes really important to recognize that this mistrust stems from our history and also our present day. And so, it is really incumbent upon us, it is our responsibility to become trustworthy.

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Monica Peek:

Absolutely. I think there's a …. What the pandemic has expanded the conversation to this idea of, why is there so much mistrust, to … there is a valid reason for that, and what are we doing to regain our ability to be trustworthy? And so, I think that is where a lot of the conversation is going right now, how can we try our best to rebuild that trust? What would that look like? What are the elements of trustworthiness? Because it's not only important for marginalized communities, but because we now have a better understanding that we're one ecosystem, it's in everybody's interest for Black people to have trust, Black and brown people to have trust in the healthcare system.

Monica Vela:

Absolutely. You know, I think it's so important, as providers, that we meet our patients and their communities where they live, where they work, on their own timeline, and also really understand what their experiences have been and where they share those experiences with each other, and where they get their information, their education, about diseases, about vaccinations, about how trustworthy we can be. And so, as providers and as physicians, we need to make sure that we partner with other healthcare workers, in particular, those healthcare workers that are most visible to our patients because they live in the same communities, they work alongside our patients. And so, who are those people? They are the nurses, they are the pharmacists, they are the dentists. They are really all those healthcare workers on our team that are the most visible, that spend the most time with our patients in their neighborhoods and communities.

And we can meet them there. We can meet them in community centers, we can meet them in places of worship, we can meet them at pharmacies and pop-up clinics, and really, where these vaccines are newly being administered, because the pandemic changed where people are accessing not only their vaccinations, but information about vaccinations, including social media.

Monica Peek:

Exactly. I talk a lot about trusted people, spaces, and places. And, one of the things … And so, that is exactly what you're talking about essentially, how can we use the existing infrastructure that we have and think about who, in this space, place, and what people, are trusted in the community and how can we maximize those. And one of the things I was mentioning some place in the last few days, is that there's already a racial gradient because of structural racism and inequities within any clinic, where the physicians tend to be white and the medical assistants tend to be Latin, Black, Asian, depending on what neighborhood you're in, that even if you can't afford to bring in additional community health workers, those are the people who are most like the patients that that community is serving.

And so, those are the people that likely know the patients because they're their neighbors, they're doing the same thing that the patients are doing. They may, because of their job, they may not be paid very highly. They may be suffering some of the same issues around social determinants of health and food insecurity, even though

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they're working in the hospital, that our patients are. And so, leveraging those connections is really important. So, thank you for bringing that up.

Monica Vela:

Those conversations that we have with our MAs, our LPNs, our RNs, the shared spaces that we have with them to communicate the language that we're using around vaccination, is so important because they're the first people patients see when they enter the clinic. And so, if they are brought into a room and they're discussing vitals and getting vitals, that is a golden opportunity to say, "You know what? I got my vaccine. And make sure you ask your doctor about the vaccinations that are available today." That way, the patient is prompted, they have some trust coming into the room as they come in to see us, and we can bridge that conversation.

Monica Peek:

One thing I also want to bring up is this tension between vaccine hesitancy and vaccine access. And the national conversation leaped into vaccine hesitancy before there was even vaccine access. And much of the issue was access before there was even hesitancy, people were clamoring to get the vaccine. And even now, we are still doing vaccine pop-ups with some of the work that I'm doing in community settings. And there are people who are extremely marginalized who are coming and they're saying, "Thank you. Thank you. I've been going to various Walgreens and places, and I'm having a hard time getting the vaccine." They're coming to the food pantry for food and, woo, and I can get a free vaccine too. And so, I still think even when there has access, it's still for people who have a challenge, who don't have a regular primary provider, like you were saying. Access is always relative depending on your financial situation and other resources that you have.

Monica Vela:

Right. Absolutely. I can't agree enough. The narrative surrounding vaccine hesitancy really was played up in a way that led so many people to point to individual decision making and to blame the people who did not have access for vaccinations for their lack of vaccinations. And it's the easiest out to say, "Well, that person doesn't want it. That person doesn't trust us. That person wouldn't take it if it was available to them." But we need to flip the script because the reality is, that both you and I know that every time we've entered a community, vaccinations in hand, people have lined up around the corner to get that vaccine and have been incredibly grateful that we've been there to deliver it. And so, I think that's what needs to be shouted from the rooftops is, let's make it available, and then let's talk about education, let's talk about trustworthiness, and when we've dealt with all of that, let's talk about individual choice. Because it's not an equitable choice if the vaccine's not available.

Monica Peek:

Right. Right. So, we take the most sociopolitical easy narrative for the far right, lift that as the top line, as opposed to addressing the real challenging issues that are more prevalent around access and sociopolitical reasons for mistrust, given all that the government has done and don't want to talk about those issues.

Monica Vela:

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Right. And in elevating that conversation and pushing the individual choice narrative, we are harming patients, and we are actually buying into structural racism, because we're ignoring everything else.

Monica Peek:

Absolutely. Absolutely. Monica, that's why I love you so much. So, as you noted, Monica, stemming from the pandemic, pharmacies are now regarded as a central location for vaccinations. While some pharmacies may be more accessible to some, disparities still remain. What are some inequities seen with specific vaccines?

Monica Vela:

So many. Starting with COVID, which we've been talking about now for two and a half years, we know that there are lower rates of vaccination amongst minoritized people in this country. We know that the impact is significant. So, we know that age adjusted mortality rates for Latinx people are much higher, 77% higher compared to white people in this country, 67% higher amongst Black people in this country compared to white people, and then even higher amongst Indigenous Americans in this country. We know that when it comes to the flu vaccine, the highest vaccinated group, so amongst white Americans, the vaccination rate only reaches about 50%. And then it drops from there for Black Americans, for Latinx people, and for indigenous peoples. And those are really big disparities that carry with them a significant amount of burden when patients do become infected with COVID and influenza. And so, we need to start normalizing adult vaccinations in this country across all populations, but in particular, those who have the lowest vaccination rates, because we just cannot take one more burden.

Monica Peek:

I will say that my medical assistant has taken this on as her personal mission. And so, I was in clinic last week, and every patient, because they have the ability, what we've done is given them, the medical assistants, the ability to put in the orders now for these vaccines, they don't have to just ask and then wait for me to put in the orders, they can put the orders in themselves. So, every patient I saw had already had their bivalent COVID booster and their flu shot. And so, I was like, "Oh, Stephanie already gave it to you." Stephanie gave every one of my patient their vaccinations. And I was like, "This is great." And so she's like, "Oh, already done. Already done."

Monica Vela:

Isn't it amazing how impactful she can be-

Monica Peek:

Yes, indeed.

Monica Vela:

... relative to other providers?

Monica Peek:

Yes. Because the flu shot is like, okay, flu season, I'm usually rolling up my arms, "Okay, here we go. Here we go. Done." And I had 100% flu vaccination rate and COVID booster rate last week.

Monica Vela:

In your clinic?

Monica Peek:

Yeah. And so, the idea of having our support staff working at the top of their game, gives them an increased sense of autonomy and purpose in the clinic, and it makes the whole team more effective. Works for our population. We have to be more creative in how we're thinking about addressing these issues in a real-time way.

Monica Vela:

Yes. I had a fascinating conversation with a patient just this week. I walked into the room and said, "I have some vaccinations for you. Guess what I have available? I have the bivalent COVID vaccine and I have the flu vaccine." He said, "I'll take the COVID vaccine. I don't want the flu vaccine. I never take it." And I thought, wow, what's going on here? And so, I took a step back and I said, "Tell me more. Teach me why you're so ready to take the COVID vaccine, but not the flu vaccine?" And what he said startled me.

So, he said, "You know, for years, I came to my doctor and I said, 'I don't want the flu vaccine because it makes me sick.' And my doctor would say to me, 'That's not true. The flu vaccine did not make you sick.' Period. When I came in to get the COVID vaccine, my physician said to me, 'You know what? It's going to make you sick for about a day or two.' And I felt like, yes, this person's telling me the truth. I know this to be true. Whereas when I came in with the flu vaccine, I was told I'm not telling the truth. And so, I feel like there's something funny going on with the flu vaccine and I don't want it." When we fail to validate our patient's concerns, when we don't listen to what their experiences are, or we invalidate them, we are creating mistrust.

Monica Peek:

Absolutely.

Monica Vela:

And so, I bet you a million dollars that when Stephanie, your MA, walks in and someone says, "The flu vaccine always makes me sick." She probably says, "Hey, me too, but then I'm better the day after." And that's what we need to do. We need to learn from our patients.

Monica Peek:

Absolutely. Absolutely. Can you talk more about the disparities and the disease burden?

Monica Vela:

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Absolutely. So, when we look at death rates, hospitalization rates, or rates of landing, unfortunately, in the ICU, we know that people who are Native American and Alaskan native are two times much more likely to die, unfortunately. To die, not just have a bad outcome, but to actually die. We know that death rate is also higher for Black people in this country, it's 1.7 times higher. And for Hispanics, it's 1.8 times higher. And we can talk about why, we can talk about the lower rates of vaccination, but we should place that in context with people who come from marginalized communities, live in communities that have much higher rates of pollution, much higher rates of asthma, are much more likely to live in crowded homes or in homes that are falling apart, and so the disease burden is going to be higher. We also know that these minoritized populations are much more likely to be essential workers.

And so, their exposure risk is much higher. I came into my office here at the University of Illinois and realized it had not been cleaned in a few weeks. And what I realized after asking was that, we lost many of our cleaning staff due to COVID. Same thing is true of influenza, the burden is much higher. And we can't just stop and think about hospitalization rates or even death rates. We got to think, what does that mean to the family if this person is the primary wage earner? And if this person is not well insured, what does that mean in terms of a financial burden for the family as well? So, the impacts just keep coming and it's up to us to say, "Stop."

Monica Peek:

Right. I think that's something that's really important to think about. When people are already marginalized, the financial impact of health is so much larger. It's not just, "Oh, I'm sick," but the loss of income, many people don't have sick days or family leave, and they may be, they're more likely to be supporting many other people in their family network, or social network. And so, the ripple effect for a much larger community is big. And then that community is more likely to be a marginalized population where there are many other people like them who are in the same situation. So, that's how COVID managed to just knock out entire communities.

Monica Vela:

Yes. And, you know, it's a lesson that we've learned before. We've learned it with influenza. So, COVID is now with us. We're on the third year. It's not going away anytime soon. It will be like the flu. And what have we learned from the flu? We've learned that over 10 seasons, from 2009 to 2019, Black American, Indian, Native American, and Hispanic patients were most affected by severe influenza, again, with higher rates of hospitalization, ICU admissions, and in-hospital, we're not even counting people who died outside of the hospital, higher rates of in-hospital death. And so, are we going to learn from those lessons? And are we going to recognize how important vaccinations truly are to our communities in stopping with COVID what has been going on for decades with influenza? And we've become so inured to the losses with influenza. I'm hoping we don't do that with COVID, right?

Monica Peek:

Yeah. I'm not sure, because the bulk of the losses are people who have, by definition, been invisible already. And so, that was my concern at the very beginning of the pandemic, that ultimately, it would be sort of ghettoized and concentrated in pockets of poverty, and then the rest of society would go on. We would open up, we would stop

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masking, it wouldn't be an issue. COVID would still be circulating in these areas, still killing people in these areas, and no one would really care.

Monica Vela:

Yeah. And not only killing them, we're keeping whole populations of people in poverty, oppressed. Look at what happened with education during COVID, and who was able to access the internet and who was not? And who were brought back into the classroom? Students in private education were brought back much sooner than students in public education. So, we are creating those very disparities that we are trying to put out. By providing disparate care and disparate vaccination accessibility, we are creating more poverty, and in the very same populations. We are driving this and we need to get out from behind the wheel and turn the car around.

Monica Peek:

Absolutely. So, what I'm interested in, because I'm not a pediatrician and I rarely think about RSV, except for when my kids were little, like, "Do they have it?" Are there … Tell me more about disparities in RSV and whether or not it has similar impacts to what you are just talking about related to COVID and education and some of the pediatric outcomes. Talk a little bit about RSV.

Monica Vela:

Yeah. So, sadly, it's the same story, different tune. So, we see the same disparities related to respiratory syncytial virus. And unfortunately we don't have a vaccine. We have only public health measures. The narrative around RSV is that it's a virus like the common cold. It is not. It causes much more of a burden, in particular to those populations that already, again, have higher rates of asthma, face higher rates of pollution, and are much more likely to experience respiratory distress with a virus like RSV that causes high degrees of inflammation in the respiratory system. So, Black children have a much higher RSV associated hospitalization rate than white children. They are, and … and Native American infants do as well, to the tune of 2.5 times the higher hospitalization rates, with severe consequences, including inflammation and bronchiolitis and then, subsequently, bacterial pneumonia. The season for RSV will also shock you, because the RSV season is greatest or longer in days that include disproportionately higher percentages of Black people. So, in states like Alabama, Georgia, Mississippi, North Carolina and South Carolina, RSV lasts for 23 days. And again, we need to look at the downstream cost of that.

Monica Peek:

That's wow … fascinating.

Monica Vela:

It is fascinating. the downstream cost of that burden to parents and lost sick days. The number one reason for a mom missing work in the United States is a child with an asthma exacerbation. So, if the child is missing school days, and mom is missing work, we are placing these families at risk for losing the very job that's providing the insurance, for loss of family income, and then loss of education. Because when a child misses a couple of days in a

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row, and you and I know this, they fall behind. They're often not ready to return when they do return. And then they don't feel like they're conquering the universe and doing their very best. And they end up not liking school if they're chronically ill.

Monica Peek:

My family has asthma. And I remember the stories of my uncle who had asthma really bad, growing up and him having to stay home and my family being concerned that he wouldn't live. And his best friend died of asthma. And my grandmother was a domestic worker and at the time, they didn't have a car. And so, she had to walk miles to work. And so, when she had to take days off, it was a huge thing, and she had to take so many days off. And so, all of the things that you're talking about are things that my family lived and I take for granted. My uncle, he retired recently as a dean from the business school. But his story could have been so very different.

Monica Vela:

Absolutely. And I appreciate so much you being vulnerable in sharing your personal stories, Monica, because the data doesn't tell us the stories of the individuals and their contributions to society. Your family, you yourself, have contributed so much to this American society, to the medical profession, to medical students, to research, but your stories tell us what you've had to overcome as a family because of structural racism, and yet how much you've contributed. What if we had removed all of these burdens for all the Black and brown people in this country? Where would we be as a society? Your stories, your individual stories matter, but I'm grateful that you are willing, still, to share them with us. I'm so appreciative.

Monica Peek:

Oh, thank you. Thank you. Well, let's move on to another joyful topic, HIV. Can you talk a bit about that? Because that's another disease that we know has really disproportionately affected marginalized communities, and talk about HIV prevention and outcomes.

Monica Vela:

Yeah. And again, we have to talk about HIV all the time and everywhere that we go. And we have to talk not about individual behavior, but what's available, because the treatment for HIV and the prevention for HIV are so different than when you and I were in our 20s and learning about HIV for the first time.

Monica Peek:

It's dramatically different.

Monica Vela:

We have PrEP now. We can prevent it. But guess what? Awareness of PrEP amongst white populations is twice as high as awareness amongst Black populations. It's 34% compared to 16%. We're doing something wrong. We can't talk about individual choice when there's not awareness, when there's not availability, when there's not accessibility. Let's not go there. We need to create equity first, before we allow that conversation again about

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hesitancy and about individual choice out into the ether. So, again, the data only carries us so far. We can sit here and talk about how Black men are six times more likely to acquire HIV in their lifetime, and Black women's HIV lifetime risk is 17 times greater than white women, but that doesn't tell us the story. When you walk into a patient's room and you have not discussed sexual practices, you can't begin to discuss PrEP.

And until we create a space where both patients but also providers, because how awkward are we, are comfortable enough discussing these issues, we're not going to get where we need to go, because one group of patients is going to come in and demand PrEP. The next group of people, who already feel marginalized for many, many more reasons, are not going to come in and be open about their sexual practices, and they're not going to come in demanding anything. We need to put it on the table. We need the topic on the table, and the medications on the table, and the vaccinations on the table. And we need to be open and say, "You know what? I am here to serve you. How can I be of service today?"

Monica Peek:

That is such an important point, that people's willingness to disclose their sexuality is going to keep us from providing the care that they need, and that is probably driving a lot of the reasons that they're unaware of these services because of what we are doing and not doing about creating safe spaces in the patient-provider relationship in the healthcare context.

Monica Vela:

And this gets right back to our own implicit bias. So, it's not even our awkwardness, or how, as Americans don't like to talk about sex. I read a paper recently that raised the hair on the back of my neck, because it demonstrated that patients are really smart at noting which providers carry implicit bias. They are as good as an implicit association test.

Monica Peek:

Yes.

Monica Vela:

And when you asked them, "How did you detect that implicit bias?" They're not going to say, "I detected that implicit bias because I ran my own test." No. It's the little things. The provider didn't sit down. The provider didn't look me in the eyes. The provider didn't wait for me to answer. The provider didn't believe me when I told them that I got sick from that influenza vaccination. The provider doesn't validate my concerns. We speak too quickly, we move too quickly, we don't lean in and listen. And when we don't do those things, we are showing ourselves. And so, it comes back to us, full circle. And we're going to keep seeing these disparities unless we address our own implicit bias and all of the structural racism that's in our systems.

Monica Peek:

And I'm just going to give a shout out to your review that you led, and the conceptual model that you created about addressing implicit bias and the need to not do so in a vacuum, that unless we are also thinking... Look, you just talk about it.

Monica Vela:

I have to say, Dr. Peek is on this paper as well. And so, what we co-created was a model demonstrating that, as we bring physicians up through the health professions education system and we train them, we train them in a system of very limited diversity. We don't have enough physicians who look like our patients. We train them in a system that teaches them racialized medicine. We teach them to put race into algorithms. We don't talk enough about disparities and implicit bias, and then we put time pressure on them. We have them carry a heavy cognitive load. And then when it comes to trainees and students, we're not very nice to them. We don't treat them well. And so, we put them in this environment where bias is allowed to just blossom and flourish. And then we have them see patients and they'll go in and they'll see a patient who has hypertension and they'll instruct the patient on everything we've taught.

They'll provide prescriptions for antihypertensives. They'll tell them to go out into their living space and seek out less stress, and seek out the green spaces, and lower the salt in their diet and give them many more directives. And the patient goes out and they take their medication. Some patients go out and they take their medication, they seek out the green spaces, they lower their stress at work, and they come back, and lo and behold, their blood pressure's well controlled. And so, we, as providers, pat ourselves on the back and we say, "I'm so fabulous. I improved this patient's blood pressure. I'm so good at my job. I love my patients." And then comes in a very different patient. And we fail to recognize that this patient's lived experience is very different than our prior patients. And we give them the exact same advice without taking that into account.

We give them the same prescription, not bothering to check whether the patient can afford the prescription. We send them out to reduce the salt load in their diet, not bothering to check in about what's available in their neighborhood and whether there are fresh fruits and vegetables available in their neighborhoods. We send them out to access green spaces and exercise without checking to recognize, are there green spaces in their neighborhoods? Are there places for them to exercise? And then they return, and lo and behold, their blood pressure's not well controlled. And so, what do we say to ourselves? Do we say, "Ooh, I didn't do a good job"? No. We say, "Well, I know I'm a good doctor because I took care of that other patient. Must be something wrong with this patient." And we compound our own bias. And so, we need to stop that.

And this is why it's so important to have conversations with our patients about their lived experiences, about the social determinants of health, and about what they live from day to day so that we can meet them where they live, with prescriptions that make sense, with recommendations that makes sense.

Monica Peek:

Absolutely. So, unless we can take into account the larger structural inequities, the individual things that we do are going to be less effective.

Monica Vela:

Absolutely.

Monica Peek:

So, I want to transition us into thinking about some positive things on the horizon.

Monica Vela:

Yes!

Monica Peek:

We talked about RSV and HIV. HIV has some positives and that we have PrEP now, but we are starting to have some vaccines that are in development for both of these viruses that we currently don't have available on the market. Can you talk a little bit about what's going on in vaccine development for both of those?

Monica Vela:

Yeah. So, the exciting thing is that there are vaccines being developed. And not only are they being developed, we're already in phase III of development.

Monica Peek:

That's like, write your name.

Monica Vela:

Right. For RSV and HIV. And again, we have to think about the context in which we roll out these vaccines and who we're enrolling in these studies. So, phase III means we're actually providing these vaccinations to humans. We want to make sure that those trials are being conducted in a diverse group of individuals so that when we actually have the vaccines available, we can say to our patients, "You know what? People from across this country use this vaccine and found it to be safe." And we have to make sure that the context in which we roll it out is one in which Americans have begun to recognize that vaccines are not only part of children's lives and part of their preventative healthcare, but also adult healthcare. We have to normalize vaccinations in adults, in new vaccinations in adults, not just as an emergency or an urgency, like during a pandemic, but as part of preventative healthcare. So, I'm super excited.

Monica Peek:

Me too. I mean, I remember when HIV first came out and they were, you know, it was like COVID. “Let's get a vaccine." And that was in the 1980s. It's 2022. And so, there have been so many failed attempts. So, the fact that

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we have a phase III HIV vaccine is miraculous. So, I'm super excited. So, let's talk more about what we can do to minimize disparities. You're an expert in disparities reduction. Tell me what we can do.

Monica Vela:

Right. So, I think it's everything from the individual provider level all the way out to these systems that we keep talking about. So, as an individual provider, I think it's really important to address those social determinants of health with our patients one on one. Have a conversation. What is your lived experience with each of these social determinants? How accessible are vaccines in your life? And what has your experience been with the flu vaccine and with the COVID vaccine? What can we expect to have happen? And I think having that conversation now is super important because when the RSV vaccine comes and the HIV vaccine comes, I want my patients to be ready.

Monica Peek:

Oh, my gosh. And that HIV vaccine is going to be a big sell.

Monica Vela:

Absolutely. So, I'm already talking to patients about how COVID vaccinations are going to be like flu vaccinations. Probably for the rest of our lives, we are going to be getting both the flu vaccine and the COVID vaccine seasonally.

Monica Peek:

Yes.

Monica Vela:

And that's what we need to expect. We can start talking about how other vaccines are being developed and they're going to come a lot quicker, and how lucky are we? Let's line up.

Monica Peek:

That's right.

Monica Vela:

Yeah, and I think …

Monica Peek:

Whoo-hoo!

Monica Vela:

So, beyond assessing our individual patients social determinants of health, reviewing with them what their experience has been with vaccines, where they can access them, how quickly they can access them, asking them about their experience with those vaccines and what the boosters have meant for them, and also what the disease has meant for them and their families. What has the impact been? I do that now with almost everyone I interview, not only in my patient rooms, but also when I'm interviewing medical students and healthcare workers that I plan to work alongside with. I ask them, "What has your experience with the pandemic meant?" Because it's a way to create trust, and a way for me to know what can I expect from this person, given what their experience has been. I think we need also as providers to be willing to go into maybe areas of education and avenues of education we haven't explored before. So, will we be willing to be on social media and address some of the misinformation that's been out there?

And patients will come in and they'll show me a YouTube video. I had a patient come in and show me a YouTube video with magnets. There was, for a while, this myth as how COVID would ...

Monica Peek:

I saw that.

Monica Vela:

And I had a young man, he was 17 years old, pull up the video and say, "Tell me what you think about this." And we talked about learning from social media. It was a really important appointment for both of us. Telehealth is another big area that we need to explore in terms of delivering education. It's a prime opportunity to climb into patients' homes.

And I learned so much more about my patients through Telehealth. I had one patient who introduced me to the dogs she had been talking to me about for 10 years. She said, "Now I get to show them to you." And it was fantastic. I'm a big dog lover. But to come into their homes and maybe educate more than the patient, meet their significant others and their loved ones, and have a family conversation about these issues, so much more fruitful than one-on-one, in a setting where they're already frightened.

And then integrate all of those avenues as part of our everyday routine and opportunity, recognize the opportunities as we move through our days to educate patients about vaccinations and the downstream impact of some of these diseases like long COVID. Very important, very important. So, I do my homework. So, I read as much as I could about what I need to tell my patients about getting the COVID vaccine and the flu vaccine on the same day. How will their immune systems be able to handle it? Will they have a day of downtime? "Everybody's a little bit different," is what I like to tell my patients, "And what you're experiencing is very much of a concern to me. And I will validate your experience. And it may be that you do get sick the day after. That's what we need to learn to expect."

Monica Peek:

Wonderful. Monica, all of this shows just what a wonderful clinician you are and how that impacts the work that you're able to do as a health equity leader and researcher. And I'm just so honored to be your colleague and friend.

Monica Vela:

Back at you.

Monica Peek:

So, we're going to put today's discussion into action that we can all do to provide more equitable vaccinations. So, we're going to talk about smart goals, and those are ones that are specific, measurable, attainable, relevant, and timely. So, little nuggets that we think that we can each do that aren't overwhelming. So, first, identify health disparities that may impact vaccination optimization for each patient, including prior healthcare experiences, social determinants of health, patient unconscious bias, and health literacy. Second, develop individualized treatment plans that consider health disparities screening, diversity, modes of education, healthcare accessibility, vaccination options, and social support needs. Third, educate patients and community members to minimize inequities in vaccination optimization. Patient and community education materials need to reflect diversity and learning preferences while considering health literacy. And finally, integrate all members of the healthcare team to develop holistic action plans with individualized smart goals for all patients. And to remind our audience that you can join me here for more CMEO Podcasts, live webinars, case discussions, and more, including an upcoming CMEO BriefCase in vaccination optimization.

You can find out all about upcoming live events and view previous ones on the D&I Hub link that's shown right here. Here are just some of the topics we've covered so far, and we'll be adding new content every month. Please remember to collect credit for the activity by using the apply for credit button that's currently on your screen. Again, thank you, Monica. Thank you. Thank you.

Monica Vela:

Thank you, Dr. Peek.

Monica Peek:

It was such a pleasure today. Oh, my gosh, I had so much fun. Thank you to our audience for all of your work in providing equitable and holistic care to all of the patients around the globe. Have a wonderful day.

Monica Vela:

Have a beautiful day.