Nursing Network Bias, Barriers and Breakthroughs in Care

CMEO Podcast Transcript

Monica E. Peek, MD, MPH, MSc:

Hello and welcome to a special program that I'm moderating that is part of a series on health access by CME Outfitters. This CMEO webcast is titled Nursing Network Bias, Barriers and Breakthroughs in Care. This program is supported by an independent medical educational grant from Johnson & Johnson. In support of improving patient care, CME Outfitters is jointly accredited by the Accreditation Council for Continuing Medical Education, the Accreditation Council for Pharmacy Education, and the American Nurses Credentialing Center to provide continuing education for the healthcare team.

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So my name is Dr. Monica Peek. I am the Ellen H. Block Professor of Health Equity at the University of Chicago, where I also serve as the associate vice chair for diversity, equity and inclusion. I'm thrilled to be joined today by my wonderful and esteemed colleagues and I'm going to have them introduce themselves.

Tiffany Gibson, MSN, RN, NPD-BC, CPN:

I just have lots of energy for tonight's conversation. My name is Tiffany Gibson. I am a pediatric primary care nurse manager. I'm a consultant, as well as the founder and CEO of New Nurse Academy and board certified in nursing professional development and also healthcare diversity, equity and inclusion. And I specialize in emotional intelligence, goal-led leadership, and professional development for nurses and healthcare team.

Monica E. Peek, MD, MPH, MSc:

Hooray, super excited. Thank you so much. Vicki, you go next.

Victoria Sherry, DNP, CRNP, ANP-BC, AOCNP:

Welcome everyone. I'm very excited to be here too tonight. My name is Vicki Sherry. I have a dual appointment as an oncology nurse practitioner where I practice at Penn Medicine Abramson Cancer Center. I've been there for 27 years. And for the past 17 years I've specialized in lung cancer. And I'm also on the faculty at the University of Penn School of Nursing, where I teach undergraduate and graduate nurses.

Monica E. Peek, MD, MPH, MSc:

Wonderful. Vicki, so thrilled to have you with us. Okay. So before we get started, I just want to acknowledge our disclosures. So here they are. All right. And so our first learning objective for today is to identify how unconscious bias affects nursing care and patient outcomes across diverse clinical settings. And then our second learning objective is going to be how to implement strategies to deliver care with cultural humility by leveraging the nursing profession's role in sharing best practices, amplifying the patient voice, and addressing education, health literacy, and the social drivers of health. So I want to start today's program with a brief video clip from a documentary called Everybody's Work. And so let's go ahead and watch.

Video:

So the way that I think about anti-racism is pretty simple, and that is we don't talk enough about how white people are harmed by racism in very distinct and specific ways. They are deprived of the excellence and brilliance of those of us around them who have to fight white supremacy all the time. The profession and discipline that we love so much, being in service to others, witnessing their life transitions, witnessing the most vulnerable periods of their time, it's a gift to be able to be in service to families and communities in the way that we are. To not want to share that gift is selfish, which is incongruent with nursing principles.

Monica E. Peek, MD, MPH, MSc:

So the thing that really struck me by that was that this is something that I experience all the time, the joy of patient care, particularly for marginalized patients who look like me, and understanding that we have the special connection because of some of our shared life experiences. But I hadn't really thought about it and that this is something that other providers who don't have that shared experience are being deprived of because they don't fully understand the way that racism impacts my life, that they're missing out on a chance to really more deeply connect with those patients. And so I think that that's a different angle on what racism is doing. Not just harming patients, but it's harming all of the people who could potentially care for them by missing out on that additional knowledge.

So I want to move forward, to move from the why to the how, and to help our learners see about what they can do. And so we're currently living in a very polarized, a very fractured country. And the quote from the very beginning about nurses are the people that could help lead us out of polarization, I think that's really, really powerful. And so Tiffany and Vicki, I want you to both sort of tell me what you think about that quote.

Tiffany Gibson, MSN, RN, NPD-BC, CPN:

Yeah, absolutely. This is one of my hands down favorite nursing documentaries ever. Because it's so honest, it's so real, and it definitely presents the truth in a different way, and it holds up a mirror to the nursing profession. And racism in nursing isn't just harmful, it's a collective loss, like you said. And it chips away at our excellence and our compassion and the outcomes where we're all here to protect. And we're in the business of healing, and we can't heal what we don't acknowledge. So that's a first start.

And it is polarizing because people have different point of views and their own bias and their lived experience. And just like that quote at the beginning of the clip said, I truly believe that nurses, more than any other profession, have the power to lead us out of this culture of division and polarization. We are the bridge and we just have to be willing to walk it.

Victoria Sherry, DNP, CRNP, ANP-BC, AOCNP:

Couldn't agree with you more, Tiffany. This quote to me means that we're really uniquely positioned to help lead society beyond division and racism by modeling equity and respect and healing in every space that we work. And our profession has the power to move us beyond polarization and racism. And that starts with each of us choosing to speak up, to listen, and to lead with compassion. And that's exactly what this program is about tonight. Exploring how that shared responsibility translates into practical steps we can take, whether it's at the bedside in an exam room or even during well visits. So every touch point matters.

Monica E. Peek, MD, MPH, MSc:

Excellent points. We've already had a question come in that asks how can we share this important video with others? And so I'll admit that I had not even seen this until we were preparing for this webinar. And so how might others who are watching fold this into their work spaces to share with others?

Tiffany Gibson, MSN, RN, NPD-BC, CPN:

Absolutely. SHIFT Nursing, S-H-I-F-T, is the organization that created this documentation. And if you contact them, SHIFT Nursing, Google, they may be able to come out to your organization and hold private screenings. I've been a part of that. And they also had panel discussion opportunity at the end of the screening, which is really important to allow people to process together, to think about strategy for moving forward together, but then also talk about some of the cases and instances that are going along in their organization. So SHIFT Nursing, you can find them on LinkedIn, you can find them on Google. They'll be able to help you out with getting access to the documentary.

Monica E. Peek, MD, MPH, MSc:

Great information already. So we know that, as very busy providers, we may not stop to always see patients in their full humanity. And so I want to share an audio clip from a patient about her personal experience and how it impacted her. So let's play that clip.

Colette Smith:

My name is Colette Smith, and I'm a proud ten-year lung cancer survivor. My story began in the Bronx, a community disproportionately impacted by lung cancer, and often overlooked in conversations about equity in care. When I first suspected that there was something out of the ordinary, I turned to my primary care physician, someone I trusted. He was supportive and referred me to a cardiothoracic surgeon within his network to further assess my scans.

I walked into the specialist office expecting a conversation. Instead, before any discussion, I was handed a referral for lung capacity testing, and asked which dates worked for me for surgery. I paused. I asked, "Why surgery? What's going on?" That's when I was told I had cancer in my upper left lung. Naturally, I asked, "What about the right lung?" The physician replied, "That's probably cancer too." I was stunned. I asked, "Why aren't we developing a plan that includes my complete care, including my right lung?" His response was chilling. He said, "We'll worry about that when the time comes."

In that moment, I knew this was not the right physician for me. I did not feel valued. I felt dismissed. I left his office with a script for the lung capacity testing, but I also left with a decision. I would find a care team that saw me as a whole person, not just a diagnosis. And I did. I found a practice that respected me, listened to me, and welcomed my questions. They never rushed me. They supported my decision to seek second and third opinions. They treated me like a partner in my care.

That difference being seen, heard, and valued was life-changing, and I believe it was life-saving. What happened in that first encounter, because it wasn't just poor communication, it was bias. Bias in healthcare can be conscious or unconscious. It can show up in assumptions, in tone, in decisions made without patient input. In my case, the assumption was that I would simply comply, that I didn't need to understand the plan, that my voice

didn't matter. But I'm a woman, I'm a person of color, and I'm from the Bronx. And those identities often shape how we are treated in medical spaces.

Monica E. Peek, MD, MPH, MSc:

So that was a very powerful clip. So we know that bias doesn't always show up like cruelty or calling someone a derogatory name. It sometimes shows up like indifference or rushing someone through the visit, or standing in the door and not coming all the way in, not answering people's questions or not even asking people all the questions. And it's one of the reasons that I study shared decision-making and shared power, and ways that we can help empower patients and help them feel seen. And it's one of the reasons that I always talk about, as healthcare providers, us wrapping our loving arms around patients. That's a figurative and literal thing that I do. And so this really, I think, is emblematic of how patients can experience care in a negative way. Vicki, what are your thoughts about this?

Victoria Sherry, DNP, CRNP, ANP-BC, AOCNP:

Well, I hope that this never occurs in my clinic, for one thing, right?

Monica E. Peek, MD, MPH, MSc:

A lung cancer patient. Exactly.

Victoria Sherry, DNP, CRNP, ANP-BC, AOCNP:

Yes. Yes. So this patient brings up such an important point, that bias, it's not always intense or overt like you said, it often shows up in those little moments like when we're rushed or we don't give the patient the time or the attention that they deserve. And those small lapses can tend to make patients feel unheard, and that directly impacts their trust in us and their willingness to follow through with their care and ultimately impacts their outcomes.

So even something as simple as sitting down when we're in a room with a patient changes how patients perceive the interaction. It makes them feel that we're present and not rushing, and I think that builds trust. And I always tell my students in class to practice the art of presence. We as nurses need to slow down.

Monica E. Peek, MD, MPH, MSc:

Everybody does.

Victoria Sherry, DNP, CRNP, ANP-BC, AOCNP:

We need to slow down enough to be fully present with our patient to ask questions and to really listen to them. So that awareness is what will help us move forward from just treating symptoms to truly care for the whole person.

Monica E. Peek, MD, MPH, MSc:

Absolutely. Tiffany, anything you want to add?

Tiffany Gibson, MSN, RN, NPD-BC, CPN:

Yes. Bias is more than just an emotional impact. It impacts trust, like Vicki said. It also directly impacts health outcomes, survival, someone wanting to come back to access healthcare because of the feeling that they received, which sticks more than the words that are said. And so we want to make sure that we're weighing out intent versus impact, which is very big in our area because we do a lot of talking, and in healthcare we have our own language. And sometimes we have metrics and things and other patients. And so our mind is going, and we don't realize the energy that we're giving off to patients and how that can be harmful.

And so one example that I like to share regarding intent versus impact is if I caused harm to someone unintentionally, if I rolled over your toes with my shopping cart at the supermarket, I caused you pain. I didn't mean to do that. I had no clue. I'm searching for the bread. Had no clue. However, it doesn't take away the fact that your toe hurts and I caused you pain. And so I have to acknowledge that, and make some sort of correction. And that's what happens when we operate from a lens of bias.

Monica E. Peek, MD, MPH, MSc:

Absolutely. Absolutely. One of the things that I tell my trainees is that when we're interacting with patients, apologies are free. I apologize multiple times a day for things I have no control over, things I didn't do. What does it cost us to try and make amends and heal wounds from... Because we are representing the entire healthcare enterprise every time we come into a room. And so we have the opportunity to apologize for someone whose shopping cart rolled over someone's foot, figuratively speaking, why not do that? Why not try and reestablish some trust along that patient care continuum? And so I'm always I am so sorry that happened to you. Let me hear about that. What can we do to make it up? So yes, perfect, perfect analogy.

All right, so it's time for us to get the audience involved. And so you're going to see a question on your screen, and so you can also vote right now. And so the question is, in your nursing experience, where have you most often witnessed cultural challenges or bias in patient care? All right. So the winner is the hospital setting, an acute care setting. And I'm not at all surprised by that. Tiffany and Vicki, do you have any comments on why you think that might be the case?

Tiffany Gibson, MSN, RN, NPD-BC, CPN:

One, out of all the other options here, in an acute care setting, one patients are probably at their worst. There's a lot happening unexpectedly in this moment in an acute care hospital setting. They're meeting a lot of different people around the same time. But for nurses, it's a high stress, high stage job where there's tons happening. Patients are even more acute now than ever. And the stress and pressure of treatment and the technology, but then also the art of nursing and the compassion behind it can definitely become misconstrued. And so I definitely can see how the hospital setting wins out of all the other places. I think patients are sicker, they spend more time there, and it's just a lot going on.

Victoria Sherry, DNP, CRNP, ANP-BC, AOCNP:

Couldn't agree with you more, Tiffany. These patients are at their sickest when they're hospitalized. Nurses are stressed, they're understaffed, and so communication might not be at its highest when they're in the inpatient setting as well.

Monica E. Peek, MD, MPH, MSc:

There have been studies that look at the environmental circumstances that make us most likely to use cognitive shortcuts or implicit bias. And those are ones that have time pressure, where there's a high cognitive burden, where there's uncertainty, and we have limited information. So they're coming from other places where we don't have their records, much easier now that we have sort of Epic everywhere, but not everybody's on Epic. And so these are some of the things that, we have a lot of complexity, we're trying to sort things out, we don't have a lot of time to make the decision. We don't have all the information. The patient may be attended. And so we fall back on these biases subconsciously to make clinical decisions, which can frequently not be the correct ones and treat people in ways that may not reflect our best selves. And so absolutely, yes, the hospital setting is a lot of times where things like that may come into play.

So implicit bias, for all of these reasons, can lead to disparities not only in healthcare, but as a consequence in health outcomes. And so there are clinical tools that can help us all in thinking about how we may address our own biases in care. And so Vicki, I want you to talk a little bit about some of those.

Victoria Sherry, DNP, CRNP, ANP-BC, AOCNP:

Sure, sure. So research shows that healthcare professionals display implicit racial and ethnic biases at rates very similar to the general population. A provider may consciously think and state that they are fair and supportive of all patients, but at the same time, unconscious biases may still influence how they listen and diagnose and prescribe and interact with their patients.

So the takeaway is that none of us in healthcare are immune to the biases that exist in society. One tool I often recommend to colleagues and to my students is the Implicit Association Test or the IAT, which is freely available online. And you can see the website at the bottom of the slide here. And it's really a valuable way to reflect on our own unconscious biases and begin thinking about they show up in our interactions with our patients.

Monica E. Peek, MD, MPH, MSc:

Excellent. Excellent. So let's see if our audience is familiar with the IAT or any other sort of bias tools. So we're going to move on to this next question. You can see it on your screen now. You can go ahead and vote. The question is, have you ever completed a self-assessment for bias? For example, the Implicit Association Test?

Interesting. All right. So this is fabulous. So the winner, I have not heard about these tests, which is great because we are here to all learn, constant learning. And so this is a wonderful opportunity for you all to learn about these. And so the Implicit Association Test was first created at Harvard. And it's fascinating. The tests were the speed of our short neurological pathways versus our long ones. And the biology of it is fascinating.

But it gets to how we have biased perceptions of a range of people based on their social identities as well as other health conditions like obesity. And so I think you'd be surprised by your own results. And so I encourage everyone to take that, and it just helps us have on our own radar things that we may not be aware of that's going on.

I want to now sort of because, and we can talk about that for hours, but we don't have hours, we have one hour to get through a lot of material. So I want to transition a little bit to think about how we can start changing behaviors, including our own. I want us to explore how we can stop playing the same old song over and over

again. And so Tiffany, I want you to talk to us about the golden rule versus the platinum rule. And we're going to be thinking about the golden oldies, thinking about music. Can you tell us the difference between those two?

Tiffany Gibson, MSN, RN, NPD-BC, CPN:

Absolutely. So you may have heard of the golden rule, maybe in pre-K or kindergarten, which state do unto others as you would like done unto you. And that really was rooted in be kind to people because you would want someone to be kind to you. But if we think about empathy, and if we're practicing from a lens of cultural humility, which is a fairly new term in our world of nursing, where it's a lifelong learning to want to integrate other people's cultural beliefs, practices, and attitudes in the work that we do, then you will refer to the platinum rule, which is do unto others as they would like done unto them. Because we are different people. We are not a monolith. We have different things, even within the same subgroup. You want to speak to people in their love languages, which may be different from yours. And so if we can get closer to the platinum role, we'll definitely shift some of the lenses that we're operating from and decrease bias.

Monica E. Peek, MD, MPH, MSc:

That's great. And that is so helpful for me because I read about the love languages, and I know my own love language and my kids' love languages aren't necessarily mine. And so that's a great analogy. Because I have to think, well, this is what I would like, but my son really needs this. And so learning to speak different languages, figuratively and literally, for our patients is really important to verbally and non-verbally express the kind of care and concern that they would like to have that you're trying to give them. You may be giving them something, but it may not be exactly what they want. So learning what they want is important as well. So Vicki, can you talk to us about some of the things that we might be hearing a lot about over and over again from our patients and talk to us about why we might be hearing them?

Victoria Sherry, DNP, CRNP, ANP-BC, AOCNP:

Sure. So actually, my friend and colleague, Dr. Mutale, recently published an editorial reflecting on the lack of progress in diversifying cancer clinical trials since 1993, the NIH Revitalization Act. And fast forward 30 years later and minorities still remain underrepresented. And it really limits how applicable trial findings are to real world patients. Dr. Mutale calls on advanced practitioners to help close those gaps through partnerships and recruitment and advocacy. And so today, we want to focus on practical strategies and real world steps nurses can take to address these barriers.

Monica E. Peek, MD, MPH, MSc:

Tiffany, do you want to tell us anything about the graphic?

Tiffany Gibson, MSN, RN, NPD-BC, CPN:

One, I love a good graphic because it helps put together very succinctly the point that we're trying to make. And so here we see different types of nurses holding keys, which is really important because we are the myth busters. It starts with us. We hold the key to changing this whole thing around. And so I appreciate the graphic. I think it helps to break up some of the slides. But it drives home the point that we own this. Nurses, it's in our hands. And so we have to use the tools that we have in order to make the change.

Monica E. Peek, MD, MPH, MSc:

Excellent. And so let's talk about some of the specific action steps that nurses can take to overcome the barriers to equitable care. So Tiffany, keep talking a little bit more about that kind of stuff.

Tiffany Gibson, MSN, RN, NPD-BC, CPN:

Well, one, addressing fears and bias directly. Even if trying to integrate, going from the mindset of the golden rule to the platinum rule, if we just think about what we do in healthcare and how we're patient centered, if we are asking the patient what they would like to see, what does treatment look like for them? How feasible is this to you? And we are involving the patient in the care, that within itself is practicing the platinum rule. So that's one.

So two, taking assessment tests like the IAT and other bias tests so that we are aware of what our biases are, that we're constantly asking and checking for feedback in how we're showing up. We have blinders, and bias is pervasive. We have bias. Everyone has bias. It's not about eliminating the bias, it's about making sure we're not treating people differently because of our bias, and what we need to do to just check ourselves in how we're showing up. And so asking for feedback is important as well.

And then making sure we're providing culturally tailored education. Again, someone may speak English, but if they have a primary language, are we making sure they have access to information in their primary language? Are we making sure that we are assessing for understanding instead of asking, "Do you get it? Do you understand?" And the patients nod, yes, and then we go about our way. So how do we know that they absorbed what we gave them? And so access to varying types of modified health literacy. And then checking in with resources outside of the primary networks of healthcare. So nurse coordinators, care coordinators, nurse navigators, and different resources that can check in with the patient after the point of initial visit.

Victoria Sherry, DNP, CRNP, ANP-BC, AOCNP:

Such a great point, Tiffany. I just want to add a few things there. I think it's important to engage, like you said, social workers, case managers, patient navigators who can help address these social determinants of health such as transportation, access to care. And I think nurses are amazing at doing that stuff. These supports can make a big difference in whether the patients are able to follow through with their treatment, stay on treatment. I also think we need to take the time to ask patients if they feel heard and to involve the caregivers. I don't think we do that enough in healthcare. And involve them in the conversation because this can both, it strengthens their trust in you and it improves their outcomes as well.

Monica E. Peek, MD, MPH, MSc:

Absolutely. And a lot of what we're talking about really has to do with relationship building and having people, like you said, just feel seen and heard, feeling validated in their experiences, knowing that they can rely on us, that we're going to be there for them, that we see them in all of their humanity and recognize the situations that they live in that we're willing to sort of walk with them along their journeys and try and help them fight all of the barriers that they have along the way to wellness. That we're someone who's there with them. So yeah, I think all of this is really important, and nurses are vital in that journey.

So one last video clip. We had a video, then an audio, one last video clip that highlights how bias can impact outcomes. And at the end of the day, that's really what we all want. We want lovely experiences, but also towards the end of having the best health outcomes for our patients. So let's play the clip.

Video:

When we have those wince moments, when someone says something that should not be said, or if you say something, it's never too late to correct that. When you have that heaviness in your chest that you can't get rid of, that you can't shake after you hear something, that's an indication to you in your soul that you have to take some action.

Until we can make that culture shift, I don't think we're going to move the needle.

Well, your IBIAS program is one step closer.

Monica E. Peek, MD, MPH, MSc:

So Tiffany and Vicki, what jumps out to you from that clip?

Victoria Sherry, DNP, CRNP, ANP-BC, AOCNP:

What jumps out at me is the reminder that bias isn't just abstract. We feel it in real time. Those wince moments that she was talking about or the heaviness in your chest, they're signals that we should not ignore. They're prompts for us to pause and reflect and to take action and to make things right, whether it means correcting ourselves or speaking up if we witness something that's harmful.

Tiffany Gibson, MSN, RN, NPD-BC, CPN:

Absolutely. Our intuition is strong. Our intuition actually speaks to us before our cognition does. And what we need to do as nurses is to trust that. Unfortunately, we're not taught to trust that in our fields. We're taught to look at the data. But if you feel something, you need to investigate that because it's a knowing, and a lot of times the knowing is correct. And so if anything feels uncomfortable, you feel a twinge, you feel something, check yourself and say, what is this? What could this be? What's going on? What's happening around me?

Monica E. Peek, MD, MPH, MSc:

Absolutely. Absolutely. So I want to talk a little bit about a program called IBIAS that I've heard you talk about before, Tiffany. Can you tell us about that and how it may apply to clinical practice?

Tiffany Gibson, MSN, RN, NPD-BC, CPN:

Yeah. So IBIAS is a framework that was created by Dr. Rebecca O'Connor, who was a nurse, and she created this with her colleagues to interrupt bias in the healthcare environment for student nurses. And I love that this is a framework that starts with students. I appreciate that so much. And so it's an evidence-based and pilot-tested implicit bias program with IBIAS being a framework. Basically I'm investigating myself, I'm doing assessments, I'm finding out what else could this be. But it's teaching students how to do the things we were just talking about, check themselves, ask for feedback, making sure that they are being mindful of other people's lived

experience and other cultures while in the healthcare setting that is so stressful and has lots going on at the same time.

And so the IBIAS framework is noted in the Everybody's Work documentary, and Dr. O'Connor talks about why she created this and how she created this. And so you definitely can find out more there. There are some nurses that are working behind the scenes to see how this framework tool can be modified for staff nurses, for experienced nurses, because the learning never stops. And we want to make sure that while we are catching future nurses before they get into the workforce, we also need to circle back to those that are in the workforce to make sure that we are educating them as well about bias and practical tools they can use in real life.

Monica E. Peek, MD, MPH, MSc:

Absolutely. Absolutely. It's lifelong learning. That's what you signed up for. That's why you're here. And that is, I think, things that draw people to the clinical professions is that we are curious, and that curiosity is something that we want to continue throughout our journey.

So I want to get back to the music theme, and talk about how culturally responsive care, having cultural humility is kind of like getting on the right track. And so a record needle needs to find its right groove, culturally responsive care aligns with each patient's values, their beliefs, and their lived experiences. And so we really need to have care that is patient centered. So having the patient sort of in the middle of our loving arms that we've wrapped around. And so that means that we are listening to what they're trying to tell us. We are focused on what their needs are, their preferences, and we are delivering care that is socioculturally tailored to the way that they want to learn, their love language.

That our care is equity driven. Means that we are specifically identifying their barriers to care, we need to be sort of fighting along with them. Is it bias? Is it literacy barriers, language barriers, other things? So that we can specifically adjust their care so that everyone has fair opportunities to equal outcomes. And so we can think about nurses, all providers, but in particular nurses as the DJs of care that are mixing evidence, empathy, cultural awareness to create this harmony between patient needs, health systems, and the community. And so yeah, that's this great analogy that I like to have. What do you all think about that?

Tiffany Gibson, MSN, RN, NPD-BC, CPN:

I love it. I think it's just fun and out of the box to think of nurses as DJs. If you've gone to a great party, it's probably because the music was amazing, and the DJ sets the tone, sets the pace, feels the crowd, is reading the room, and that's what emotional intelligence is, right? It's having that social awareness and relationship management. And the DJs know how to get the crowd going. And same thing with nurses. We can set the tone, we can set the pace. We literally are the crossing guards between the providers and the patient. So we can slow things down, we can speed things up, and we can use data that we're collecting from both parties to make change. And so I love this analogy so much.

Victoria Sherry, DNP, CRNP, ANP-BC, AOCNP:

Great. Love the music theme. I think we could also maybe do a cassette tape. Because as nurses, we're constantly adjusting the mix of the music depending on patients in front of us, turning on a dime. And sometimes we are turning up the volume on education. Sometimes we're tuning into social and cultural needs,

but the goal is always the same. It's creating that right rhythm of care so patients feel understood and secure at all times.

Monica E. Peek, MD, MPH, MSc:

Absolutely. And Tiffany, I like that you used the term emotional intelligence because that is what we're going to be talking about right now and the importance of that, particularly in nursing practice. And so what can you tell us about emotional intelligence? What is that?

Tiffany Gibson, MSN, RN, NPD-BC, CPN:

My favorite thing to talk about-

Monica E. Peek, MD, MPH, MSc:

Because you're an expert on intelligence.

Tiffany Gibson, MSN, RN, NPD-BC, CPN:

... that's what this is. Emotional intelligence is simply controlling yourself in the midst of the storm because you cannot control the storm. That's what it is in a nutshell. It is four domains that basically says, I first need to have some awareness of me. That's domain one. What am I feeling? Do I know that I'm feeling something? Do I recognize that I've been triggered? And if you are really self-aware, you may even ask yourself, where is this coming from and why is it bothering me?

Domain two of emotional intelligence is self-management. So now that I know that there's something going on internally, what am I going to do about it? I cannot continue to walk around with an attitude or this chip on my shoulder, and not actively do something with that because energy is contagious and other people around me are going to feel it and notice it either in my verbal or non-verbal cues.

The third domain of emotional intelligence is social awareness, like we mentioned with the DJ, I can pick up the energy of the people around me. I know that this patient is having a rough day. I know that my coworker is having an amazing day. You can feel the vibes when somebody is present. And then that leads to our fourth domain, which is social relationship management is what am I going to do with it? And so it makes you become a better team player. You have empathy, you're able to help people in their chaos because you're grounded and you're able to work together.

So that's emotional intelligence in a nutshell. And so when you use that to navigate bias and conflict, it just helps you with, one, not to take things personal, to two, to be open to feedback and to checking yourself. But most importantly, it's that empathy. To have an awareness to say, let me think about this through somebody else's point of view, and I can understand why they may feel this way.

Victoria Sherry, DNP, CRNP, ANP-BC, AOCNP:

I teach this to my students. It's just so important. To help, I try to teach them to respond with empathy rather than defensiveness when bias or conflict comes up in the environment. I try to get them to practice self-reflection. Because, and we've talked about this before, even their well-intended words can have a harmful

impact. And they just need to lean into that growth mindset and be willing, like you said, to feel uncomfortable if it means building trust and equity with our patients and colleagues.

Monica E. Peek, MD, MPH, MSc:

Growth is uncomfortable sometimes. You got to be willing to sit with that comfort in order to grow. And so I think that's really important. So I like that analogy. And also that anytime we're trying to do something, I'm telling my kids that you're building that muscle. My son's like, "My brain is not a muscle." I'm like, well, "Let's pretend it is because you want to work that muscle every day, Ezra." And so equity, addressing bias. This is something that requires a daily practice. And we're not ever going to be perfect, but we can be persistent and try and think about this every day. And so I also want to sort of explore, loop back to this idea of cultural humility and look at a model. Because we love models. And so Vicki, I'm going to have you walk us through this model about cultural humility and how we can use that to amplify the patient voice.

Victoria Sherry, DNP, CRNP, ANP-BC, AOCNP:

Sure. So here on this slide, we see a range of social drivers of health, and specific tips that may help in breaking through those barriers. Factors like income and housing, transportation, food access, and education, really all shape patient outcomes. And practicing cultural humility means acknowledging these realities. Asking patients what matters most to them seems to be a theme. And using practical strategies. So arranging an interpreter when a patient comes in who their first language is English or the language that you speak. Connecting families with meal or transportation programs, simplifying education materials to match their health literacy levels, and involving community health workers. This will help reduce barriers and really move us closer to health equity.

Monica E. Peek, MD, MPH, MSc:

Absolutely. And so I want to think about how we can tie the idea of emotional intelligence back to the social drivers of health. And so Tiffany, can you do that work for us?

Tiffany Gibson, MSN, RN, NPD-BC, CPN:

Absolutely. It really revolves around perspective taking and not centering yourself in other people's experiences. It's like we think about that video that we saw earlier today where the patient talked about her diagnoses. And we think also just about the different patient interactions that we have. I'm sure one of us can tell a story about how someone mentioned something, and we're thinking in our heads what we think it is immediately. One, it's the pressures of our job where we have to come to a conclusion quickly. We don't have all the time in the world. And so part of the bias that we have is also the pressures and the stresses of the job that we're in that we have to do things quickly.

But if we center emotional intelligence and look through that lens, it allows us to slow down a second, but also to not take things personal when patients are talking about their lived experience or how something made them feel. We don't like having negative feedback because we always want to think that we are putting our best selves forward. At least nurses, we try to think we're doing the best for our patients every time, all the time. That is absolutely the goal. But there's times when we mess it up, or there's times when we don't recognize our energy is speaking for us. So even though the words that we're saying may be one thing, but our energy is saying something different.

And so emotional intelligence is allowing us to be open to feedback. It's allowing us to apologize. It's allowing us to have empathy and compassion. And it's allowing ourselves to really reduce the burnout because we're eliminating some stress. And so there's tons of emotional intelligence tools that nurses can use to just check themselves. Again, another assessment tool. You can Google an array of them. There's emotional intelligence test out there. But we definitely want to be mindful about even how we talk to our colleagues about patients, and using emotional intelligence there. How we're giving reports to each other and the words that we're using, like frequent flier or pain seeking, non-compliant versus non-adherent. And so we want to just be mindful about the words we say and the narrative that we're creating. And that's where emotional intelligence comes in.

Monica E. Peek, MD, MPH, MSc:

Absolutely. Some of the work that I do looks at exactly those things, how biased language, negative descriptors, things that we use in handoffs, things that we use to document patients, to write about patients in the chart, how that impacts patient care delivery with other physicians. They see this, I'm like, ah, they don't deserve those pain medications. Or it affects how people feel about those patients and then subsequent care delivery. And so all of these things matter. Words matter. And so trying to check, not only how we feel, but how we're sharing those experiences or our feelings about patients with other nurses, other providers is really important.

And so I'm going to move us now to a slide that I think helps to bring all this together because we have been talking a lot about how equity is not an abstract idea, it's a practice. It's something that we can do every day. It's like a muscle that we can exercise. And it's the daily practice of ensuring that every patient's humanity, their dignity, their voice, are all at the center of the care that we're trying to deliver. And all care really now is team-based care, where there's all these different kinds of providers that are sort of rowing, I'm mixing metaphors now, rowing in the same direction to try and achieve a goal. And that goal is having patients feel respected, loved, and we're with them on their journey to wellness. And so they can have their best life, not just in society, but their best, most healthy life. And that's I think what we're here for.

Victoria Sherry, DNP, CRNP, ANP-BC, AOCNP:

Yeah, I'm going to add in here a little bit about nursing leadership because you think of leadership and they're just managing, they're doing tasks. And it's really more than that. It's about advocating for every patient and ensuring the patient's voice is heard, and keeping their dignity at the center of all decisions that are made. It also means educating the patients and families throughout their whole trajectory, helping them navigate barriers, and collaborating with colleagues across disciplines to improve, again, both outcomes and improve their quality of life.

And one great example is the use of a nurse navigator. A patient comes in, newly diagnosed lung cancer, and we're like, all right, you need to see pulmonology, radiation oncology, and surgery. And what we're not thinking is this patient doesn't have a ride. They're coming into the city, they're paying for parking. It's a nightmare. And so the nurse navigator really takes that, and they coordinate appointments and they keep the patients very patient centered and keeping them in mind when arranging all of this. So I feel like when nurses lead, like nurse navigators do, we really help turn equity from a concept into a lived reality at the bedside and beyond.

Monica E. Peek, MD, MPH, MSc:

Absolutely. And data backs that up.

Victoria Sherry, DNP, CRNP, ANP-BC, AOCNP:

Absolutely.

Tiffany Gibson, MSN, RN, NPD-BC, CPN:

I love this slide. Again, another great visual of what is the point of it all and who is at the center. And knowing that there is bridges and network between patients and systems in between culture and care. And I also want nurses to recognize that this network also goes amongst us ourselves. While we are being empathetic and having emotional intelligence to our patients, we also need to do it to ourselves. Because if nurses are not a cohesive team, then how can we be aware enough to put this patient in the center? It defeats the purpose. We all have to be on one accord because we're fighting the same mission and we're showing up for the same purpose, which is providing the best care ever. And so that's really going to work to help each other with our biases, and then to also help our patients feel psychologically safe.

Monica E. Peek, MD, MPH, MSc:

Absolutely. All right. We have one last audience response question. And the question is, how often do you believe patients perceive bias in their interactions with the healthcare system?

Basically 90% saying often or very often. And so that I think is really telling. And if we look at the, if we sort of asked everyone how often do you experience discrimination, or sort of just not very good care over your lifetime, the prevalence rate isn't 90%, but it's pretty high. And it varies with various populations. But I think that it is a call to action for all of us to continue to try and do better and do better every day. I know we're sort of running short of time and we want to take some questions, but anything in particular that you want to add, Tiffany or Vicki?

Victoria Sherry, DNP, CRNP, ANP-BC, AOCNP:

I just want to add that the results really just resonate with what the research shows, that many patients do feel bias very often.

Tiffany Gibson, MSN, RN, NPD-BC, CPN:

Same. What the research shows and what we see and feel in the hospital, it correlates.

Monica E. Peek, MD, MPH, MSc:

Yeah. So this has been a wonderful discussion. We've talked about the reality of bias in care, the need to check our own biases, and then some action steps that we can all take. And so always try and think about how we might summarize these with our SMART goals to highlight the bias barriers and how we can make a breakthrough in care. And so Tiffany, can you review our SMART goals, and then maybe Vicki talk about some commentary, recognizing that we have only four minutes?

Tiffany Gibson, MSN, RN, NPD-BC, CPN:

Absolutely. So the purpose of the smart goal is to turn an idea into action, and to map it all out so you can see it. So specifically, specific, measurable, achievable, relevant, and time-bound is the SMART in SMART goals. So

some examples here are within one month, I will incorporate at least two screening questions about social drivers of health. And then there's some examples there. Measurable. Within 90 days, I will refer at least five patients to community-based organizations. Achievable. Over the next six months, I will identify and collaborate with at least one community-based resource.

And then relevant, I will identify at least one patient per week whose care is impacted by a social driver of health, and document their barrier in the chart. And then time-bound. By the end of the calendar year, I'll develop and share a resource sheet listing at least five local community resources. This can be something that is shared with your leadership during your performance eval. Also, if you're looking for more continuing education like this, it's perfect to go to your HR business partner or your leader and wrap this up in your annual review.

Victoria Sherry, DNP, CRNP, ANP-BC, AOCNP:

And I'll just quickly add that, as nurses, I think we're all about SMART goals. If my students have heard it once from me, they've heard it 100 times. And what I appreciate is that they're concrete and doable. And like you said, adding things like screening questions or tracking referrals, building community partnership. When the goals are specific and time-bound, I think it pushes us from awareness into action.

Monica E. Peek, MD, MPH, MSc:

Excellent. Thank you all. So we have just a few minutes left and we have a couple questions. And so one is thinking about as we try and make that leap from gold to platinum, one of our audience members says it's going to be a big challenge. And so Tiffany, do you have any thoughts on how to make that happen happen? Besides repeating it as a mantra, I'm going from gold to platinum. I'm going from gold.

Tiffany Gibson, MSN, RN, NPD-BC, CPN:

Absolutely. Absolutely. You can just ask the patient what it is that they want. So this is my recommendation. How do you feel about it? Is there anything you want to add? You can start there. Thinking patient-centered, what the other person could appreciate in asking them what could you appreciate? That's how you can start utilizing the platinum rule.

Monica E. Peek, MD, MPH, MSc:

That sounds so simple. I love that. Just ask them what they want. Another person says, if my colleagues and I take the IAT, how should we talk about the results? Is that something that we take in our closet and keep the information to ourselves? Do we talk about it openly? What do we do when we get these results? What do we do with them?

Tiffany Gibson, MSN, RN, NPD-BC, CPN:

That's a good question. Well, one, if you both know that you're taking it, are you both committed to sharing your results? And then you have an accountability partner when you are making progress and improvement, someone to check you and give you feedback. So if you both know you're taking it, then I think sharing the results is kind of obvious. But again, I don't want to assume. But just to be open and objective. Everybody has bias. So you're being objective and the point is you're open to learning.

Monica E. Peek, MD, MPH, MSc:

Yeah. I think it depends on our comfort level. And I think your points are very well taken that we all have various biases. And so it's kind of like, I'll show you my scars if you show me yours. And so having a safe space I think is the most important thing where we can be vulnerable with one another and say, oh my gosh, I didn't think that I didn't like people with big hair, but apparently I do. And so if you see me, that a patient comes in who has big hair and I'm not being my best self, maybe you can pull me aside. And so I think having accountability partners in all of this. But everything in a loving space because we are all trying to do our best, but know that we are not always our best. And so having another set of eyes and ears on us I think is always helpful.

Victoria Sherry, DNP, CRNP, ANP-BC, AOCNP:

And I wasn't into the sharing with the IA. I was more of like a self-reflection. Yes. I went internal.

Monica E. Peek, MD, MPH, MSc:

Whatever, however you want to use it, as long as you're using it to grow.

Victoria Sherry, DNP, CRNP, ANP-BC, AOCNP:

Absolutely.

Monica E. Peek, MD, MPH, MSc:

All right. So thank you. Thank you so much, Tiffany and Vicki. I always learn from these, I have learned so much today. Want a wonderful conversation. The hub also offers tools to help you build skills for creating a welcoming and inclusive environment. And so all of that will always be available for you all.

So again, Tiffany and Vicki, thank you so much for sharing your insights, your expertise, your love for your patients, and just being great nurses. Thank you to the CME Outfitters team. You have worked so hard to create and help support this wonderful program. Thank you. And finally, thank you to our audience for joining us today. I had many wonderful questions come in. We only had time for a few. Thank you for those. And just together, I know that we can all strengthen nursing's impact and improve the care for all of our patients. So thank you everyone for this commitment. Have a wonderful evening, and thank you all again for joining us.