Nourishing Communities Part 2: Tackling Health Disparities Through Accessible Food Resources

CMEO Podcast Transcript

Monica E. Peek, MD, MPH, MSc:

Hello and welcome. On behalf of CME Outfitters, I'd like to welcome you and thank you for joining us on the second of our series in a three-part CME Snack titled "Tackling Health Disparities Through Accessible Food Resources." This CMEO Snack is supported by an independent medical education grant from CVS Health. My name is Dr. Monica Peek, and I'm the Ellen H. Block Professor of Health Justice at the University of Chicago, where I also serve as the vice chair for diversity, equity and inclusion. I've been a practicing internist for more than 20 years, and it really has been my pleasure to take care of a variety of patients who have chronic conditions like diabetes and hypertension, and other diseases that really are sensitive to nutrition and diet and other kinds of lifestyle changes. And food insecurity is a big part of how and why people make the dietary choices that they do. And so I'm really excited to talk about these issues, which is part of the research I do around health equity and diabetes.

So I'm thrilled to be joined by my distinguished colleague who has experience both in chronic diseases and in food and nutrition. She is a certified diabetes educator as well as a registered dietitian. And so she works in the same kinds of spaces and places with the same populations that I do. And so I'm really excited to have her with me today, Diana Mesa. Diana, would you mind introducing yourself to our audience today?

Diana Mesa, RDN, LDN, CDCES:

Yes, absolutely. Thank you so much. My name is Diana Mesa. I'm a registered dietitian and certified diabetes care and education specialist, and I'm also the founder of En La Mesa and Nutrition. It is a private practice that serves diverse populations in managing diabetes, conditions like PCOS, disordered eating, and eating disorders. And I'm now serving over 28 states virtually. I'm based in Miami, Florida. And I was born in Cuba. So I am bilingual and the populations that I serve the most are Hispanics and Latinos in Spanish as well as in English. And it is no secret that Hispanics and Latinos are impacted by diabetes and by food insecurity at very high rates. So I'm very excited to speak on this subject with you today.

Monica E. Peek, MD, MPH, MSc:

So this is our second program in our CMEO Snack series on Food Is Medicine. And in our last program we talked about what is "Food is Medicine," the latest on national initiatives. We had Dr. Seth Berkowitz, who is a national expert. And we talked about the impact of food insecurity on health. We introduced "Food is Medicine" as a topic, talked about policies that support "Food as medicine." And some of the ongoing pilot programs that are happening nationally that are being supported by CMS, particularly through Medicaid innovation grants. And we also specifically talked about some of the resources that might be available to try and integrate "Food is Medicine" programs into clinical practice.

And so today we want to frame our discussion a little bit differently. So I'm going to start by talking about our first learning objective, which is to identify the impact of food insecurity and nutritional inequity on health disparities in underserved communities. And so, Diana, I will turn it over to you to talk about how we think about food in the neighborhood and constructs around food apartheid versus food deserts.

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Diana Mesa, RDN, LDN, CDCES:

Thank you. Yes, so "food apartheid," this is a term that is relatively new. We hear about food deserts often, and we think of these food deserts as areas that are difficult to find nutritious options, affordable options for the people that live in those areas. But food desert describes this as almost a natural occurrence, as if these places where it is difficult to source these nutritious foods just happen. In reality, I think a more appropriate-

Monica E. Peek, MD, MPH, MSc:

Like a desert.

Diana Mesa, RDN, LDN, CDCES:

Right, like a desert. I think a more appropriate terminology for this might be "food apartheid," because food apartheid really highlights the underlying causes for why these food deserts exist.

Monica E. Peek, MD, MPH, MSc:

It brings in the structural inequities of it.

Diana Mesa, RDN, LDN, CDCES:

Exactly, the structural inequities. It highlights the structural racism experienced by the people that live in these areas. And historically, we need to better understand the reasonings why these places exist rather than just kind of chalking it up to nature. In fact, 17.4% of Americans live in food apartheid. That's a pretty jarring statistic there. And so it really is important to think about the language that we're using when we're describing these circumstances that don't just happen from thin air. There's a legacy of why the food apartheid exists.

Monica E. Peek, MD, MPH, MSc:

Absolutely.

Diana Mesa, RDN, LDN, CDCES:

And so when we think about food insecurity, just kind of segueing into how they are related to these chronic diseases, when we think about food insecurity it is quite impactful when we're talking about chronic diseases. Thinking about hypertension, diabetes, arthritis, asthma, COPD, all of these chronic conditions when we think about their nutrition interventions, what are some of the first things that we think about? We think about nutritious foods. We think about minimally processed whole foods, whole grains. Thinking about hypertension and the DASH diet, fruits, vegetables. We think about lean proteins, all of which are very difficult to source when we're living in food apartheid and when we're existing in food insecurity. So across the board we see that where there is food insecurity, there are higher rates of these chronic conditions. So to really, really make that difference and to really move the needle in how we're managing these chronic conditions, we need to address the food security piece without any question.

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Monica E. Peek, MD, MPH, MSc:

Absolutely. These are such important points that you're making, sort of helping to connect the dots for our audience on the why, not just the what. And as we think about these broader systems that create health inequities, that we put food into that same sort of conceptual framework.

Diana Mesa, RDN, LDN, CDCES:

Absolutely. And it's no secret that communities of color are disproportionately impacted by these chronic conditions. Similarly, food insecurity can be seen across the board too.

Monica E. Peek, MD, MPH, MSc:

And a lot of the times because you have to buy food with money, and so if you are a lower income person, then you have less money to purchase the food. And so it's a material need insecurity that manifests in your ability to cut the lights on, pay for rent, purchase your prescriptions or buy food, and people are making choices. And so people are insecure in multiple material needs, including their food. In addition to perhaps living in physical spaces where the community may have purposely had disinvestments around access to food, access to high quality food, access to nutritious food.

Diana Mesa, RDN, LDN, CDCES:

Absolutely. I was recently on a trip to a rural area where there are many peanut farms, and there were a few dieticians on this trip with me. And one of the biggest eye-opening things that we noticed was that there were no supermarkets for miles between the hotel and the peanut farms. There were bodegas, there were gas stations but no Walmart, none of these big super stores, no supermarkets that were easily accessible. So that's a great example of food apartheid happening there in a lower income rural community where there are farm workers, where there are immigrant workers who are coming in sometimes permanently, sometimes temporarily. But it can be seen across the board, not just in rural areas but also in urban areas. Living in Miami, it's a very urban place, and we have community fridges to kind of fill the gaps in where whole foods and minimally processed foods aren't readily accessible.

Monica E. Peek, MD, MPH, MSc:

Thanks. Absolutely. And I really like that you brought in the idea of food insecurity and food apartheid existing in areas where farming is happening because many of the staple crops that people are farming are single crops. They're growing corn for feed for animals or crops that are being shipped overseas, but not crops that are diverse that families are living on. And then there's not the infrastructure for the people to purchase the food. And so they're living where there's grass and ground and growing happening, but people are still not able to work that land for their own nutritional needs.

Diana Mesa, RDN, LDN, CDCES:

Yes, absolutely. And just thinking about juxtaposing the rural and the urban environments, thinking about how community gardens have come into place to kind of fill that need too, because while we may not have farmland

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here in an urban area, we still can't. It's not easy to grow food that you can eat from a balcony garden or even a backyard sometimes.

Monica E. Peek, MD, MPH, MSc:

So I want to sort of shift the conversation away from just the lack of food to thinking about eating disorders. Can you talk a little bit about that?

Diana Mesa, RDN, LDN, CDCES:

Absolutely. And eating disorders are one of my focuses in my practice, and it's not something that I sought out after I graduated. It's not like an interest that I had. It just happened to present itself among the people that I was working with. So among the Latinos with diabetes who I was working with on a day-to-day basis. And when we think about eating disorders, we might have an immediate image of what somebody with an eating disorder might look like. They are rarely in a larger body, they are rarely a person of color. It's usually thin, white women who we think experience eating disorders. But in reality, eating disorders don't have a look. Just like diabetes doesn't have a look, just like you can't look at a person and say, "Hey, you've got this type of diabetes." You can't do that with eating disorders either. So in practice, I've noticed that sometimes the screening may fall through the cracks.

But the link between eating disorders and food insecurity is so highly tied. It's very much hand in hand. And so food insecurity is linked to the development of eating disorders and it's associated with bulimic spectrum eating disorders in adults. But also for children and early adolescents, those ages who experience food insecurity, there's an increased risk of binge-eating disorder. Similarly, food insecurity is associated with higher rates of diabetes. And then we think about how one in four people with diabetes may also have an eating disorder. And it's almost like the Venn diagrams are a full circle.

Thinking about immigrant communities, myself as a person born in Cuba, there's food insecurity in Cuba. And watching my community here in Miami experience such high rates of diabetes, it's really easy to connect the dots when you see the relationship between not having enough to eat and then suddenly having an abundance of food. And then what happens? It's like a feast or famine mentality.

Monica E. Peek, MD, MPH, MSc:

Exactly. And your body responds in kind.

Diana Mesa, RDN, LDN, CDCES:

Absolutely. So I think in part, I think the biggest takeaway is if you aren't screening for eating disorders as is with people with food insecurity, I think it really needs to be a component that should be built in into the whole screening process, the whole conversation even if it's not a formal screening.

Monica E. Peek, MD, MPH, MSc:

Talking about our next topic, which is the cultural humility when sort of addressing this kind of food insecurity.

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Diana Mesa, RDN, LDN, CDCES:

Absolutely. And I'll speak to my culture in particular just because that's the culture that I'm most comfortable and most familiar with, but thinking about food insecurity among Latinos, we are a very proud people. So especially depending on what gender identity you're working with, there are some old school gender roles that we may fall into or may be expected to fall into societally. And the topic of food insecurity, as you've already mentioned, may be associated with trauma. And it may be associated with almost an inability to care for your family if you can't put food on the table. So it is a very sensitive subject. And for somebody who doesn't understand that about the Latino population, it may be a missed opportunity to connect. It may be even offensive to the person that you're speaking to. So understanding these cultural uniqueness sort of, is so important because it may not land well if you're asking things in a way that isn't culturally responsive.

And I like to use the phrase “responsive” because, with cultural competency, there's this assumption that we will at some point understand all cultures, but in reality--

Monica E. Peek, MD, MPH, MSc:

Check off.

Diana Mesa, RDN, LDN, CDCES:

Absolutely. Right, exactly. We've checked off the competency. But in reality cultures, even within my own culture there are so many differences, so much nuance there. And so you can't be expected to know everything about every culture, but we can respond to it with curiosity. We can respond to it without judgment. We can ask curious questions and better understand those cultural differences and address them. They don't have to be kind of swept under the rug. Sometimes these things can make us uncomfortable, especially if we don't understand them very well. But it is important to understand those nuances so that we can respond to them by being mindful when asking questions and offering help to where they're not feeling offended or overstepped.

And also consider the dietary differences among the cultures that we're serving. How many times have I had a patient come to my office and tell me that their provider may have told them to stop eating white rice or to stop eating tortillas? These foods are-

Monica E. Peek, MD, MPH, MSc:

Staples.

Diana Mesa, RDN, LDN, CDCES:

Exactly. If it were my father that they were counseling, he would get up and walk out of that door and never come back. He's a 72-year-old Cuban man with diabetes. Don't tell him not to have white rice or to replace it with brown rice. It's just not going to happen. And you're going to lose that rapport that you've built with them. So even though we know the nutritional benefits of brown rice, it's just not culturally responsive to recommend that most of the times, obviously people have preferences. So it's important to individualize the recommendations. But generally speaking, that could really lose that individual's attention and trust in you.

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Monica E. Peek, MD, MPH, MSc:

Yes. And one of the things that I really liked that you said at the beginning is that having an open mind and an open heart, and sort of asking questions and just being responsive because we can only be one person at one time. And at some point we're going to be culturally discordant, linguistically discordant, racially discordant with some patient that's in front of us. And I've been in practice for 20 plus years, and what I have found is that patients recognize when there's a difference between me and them. And they are more than willing to meet me more than halfway if they see that I'm trying, that I have found two or three words that are in their native language, that I am listening and asking questions and curious, trying to get it right. They want to help me help them. And if your heart is in the right place, people know it.

You don't have to always get it right, but people know when your heart is in the right place. And they will work with you on their journey to wellness. And so the cultural humility, trying your best to sort of share in these decisions and options with the patient, being on the journey together is what is most important. Rather than trying to become the expert in someone else's culture or having that keep you from engaging at all. I think we have the responsibility to try and do our best for all of our patients. And that means that we have to humble ourselves and recognize that they are going to be the experts in their lived experience. And that is an expertise that we need at the table to provide the best sort of treatment plan for them. And that means that we have two experts in the room, the clinician expert, and the patient expert.

Diana Mesa, RDN, LDN, CDCES:

I Love that.

Monica E. Peek, MD, MPH, MSc:

Yes,

Diana Mesa, RDN, LDN, CDCES:

I love that perspective, yes. And one more thing I think is worth mentioning when we think about that cultural humility, and how we might be able to first assess that and also connect those people to the right resources, is thinking about what our recommendations are when it comes to the socio-economic access. If we are already experiencing food insecurity, it's so important to be mindful of how those recommendations not only relate to their culture, but also what they have access to. What is at the food bank, if that is where they're getting their food? Is it brown rice or is it white rice? And how can we incorporate those recommendations into what they are already eating and what they enjoy to eat?

Monica E. Peek, MD, MPH, MSc:

Absolutely.

Diana Mesa, RDN, LDN, CDCES:

I do want to bring up one particular example of this in action. There is a culturally responsive food initiative from Food Bank of the Rockies, and they launched this culturally specific mobile pantry. And with that, they increased the availability of the top 15 culturally responsive foods by 80%, and that helped build trust in the community.

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Imagine people can go here and they know that they can get their cultural foods and they don't have to worry about whether that need is going to be met to some extent.

Monica E. Peek, MD, MPH, MSc:

Right. Foods that they know and love will be there as opposed to unfamiliar foods or foods that they're not as interested in.

Diana Mesa, RDN, LDN, CDCES:

Absolutely. And it'll engage the community more, which ultimately that's what we want. We want to engage the community. We want to be able to meet their needs, meet them where they're at.

Monica E. Peek, MD, MPH, MSc:

Exactly. You have to meet people where they're at, and that's where the conversation starts. So thank you so much, Diana. That brings us to our second learning objective, which is to implement actionable strategies. And we've been talking about them sort of all along, but these are actionable strategies for the multidisciplinary care team to address food insecurity and nutritional inequity. And so I'm going to have you take it away again.

Diana Mesa, RDN, LDN, CDCES:

Thank you. Yes, so there are plenty of resources to address food insecurity because this is not a new problem. This is a problem that's existed for a very long time. And so there are organizations like Find Help. It's a website where you can go in and plug in your zip code and get all sorts of resources there, not just for food security, but also for all sorts of things, medical things, the works. So you can really go there and find what resources exist in your community or in the communities you serve. For me for example, because I'm across 28 states working virtually with individuals, it's impossible for me to be acquainted with all of those communities. So these are resources that I use often. Feeding America is another very important resource for food security. We have a very robust feeding South Florida branch here that I volunteered with plenty in their packing house. It's separating food, and they are packing tens of thousands of meals a day in those facilities.

Monica E. Peek, MD, MPH, MSc:

They're busy.

Diana Mesa, RDN, LDN, CDCES:

They're very busy. And one of the... I'm not sure if this is different for other communities, but one of the things to consider is that some of the distribution sites do require that the individual has a car. So you can drive up, pop the trunk, they'll put the stuff in the trunk for you and you can drive away. That might not be feasible for everyone. So do your research and make sure that wherever you're located, there is a walk-up option for the individuals who don't have a car or who need to take public transportation. Religious centers are another very great hub of resources, not just for food distribution but for other things that are needed as part of our overall health, our spiritual health in particular. So I have volunteered as well with religious centers to do some food distribution and also do cooking demos in those centers. They often have meeting rooms. The community

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already trusts these places. And so it is very likely that if you contact a religious center or if you recommend that an individual goes to these religious centers, there will be resources there for them.

Monica E. Peek, MD, MPH, MSc:

Yes. They function sort of as community centers where there's all kinds of education and outreach and temporary housing and classes, there're just community hubs of vitality. Particularly for marginalized communities, that's where all this stuff is happening where we can sort of plug in. And frequently there is food distribution happening there as well.

Diana Mesa, RDN, LDN, CDCES:

Absolutely. Obviously we've got the social assistance programs like SNAP, TANF, and WIC. Now, I have met so many people who qualify for these programs who are not enrolled. So I think that's a big thing that we need to highlight because do they know these programs exist? Do they know they qualify for them and are they enrolled?

Monica E. Peek, MD, MPH, MSc:

Right. I think particularly within the Latino community, there is a lot of misinformation and fear about enrollment in government programs.

Diana Mesa, RDN, LDN, CDCES:

And stigma. We think about that mentality of I need to provide for my family and not being able to provide for them brings some level of shame. And so it's definitely tied to the under-enrollment in these programs among my community in particular. And then obviously food banks. Food banks are great. That's going to depend on your location, how many of them there are if there even are food banks in your location. But they are a resource out there. And then when we think about school-aged children, they do have access to that free and reduced-price breakfast and lunch. I enjoyed free school breakfast and lunch for pretty much all of my elementary, middle, and high school years. And I was well-fed, never hungry. And so it's a great resource to have. And some kids that might be their only meal for the day. So it's so important to support that.

Monica E. Peek, MD, MPH, MSc:

And it helps with their educational learning. And so it's a trajectory for so many things around health and well-being and their own course throughout life. Look at you now.

Diana Mesa, RDN, LDN, CDCES:

Exactly. I turned out fine.

Monica E. Peek, MD, MPH, MSc:

More than fine.

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Diana Mesa, RDN, LDN, CDCES:

Thank you. Yes, you can't expect a kid to learn or pass a standardized test if their bellies are grumbling. It's just not something we should expect of them at all.

Monica E. Peek, MD, MPH, MSc:

Of anyone.

Diana Mesa, RDN, LDN, CDCES:

And then when we think about how we can support food security as a team, there are so many touch points. From the second that patient checks into the clinic, there might be resources out in the lobby for them. There may be a community health worker that they can be connected to who can connect them to resources. Obviously the physician, the nurse, when we think about the pharmacist outside of the food security piece, medication access, which is also just as important to managing these chronic conditions as food is. The dietitian, can't forget the dietitian because the dietitian is truly trained in facilitating.

Monica E. Peek, MD, MPH, MSc:

Managing it.

Diana Mesa, RDN, LDN, CDCES:

Yes, absolutely. Everything from that cultural responsiveness to food to incorporating that into a recipe with whatever limited resources that person may have. Say they don't have a full kitchen, maybe they have a burner, how can we make that food nutritious? The dietitian is there for that. So use us. This is the shameless plug for dietitians everywhere, but please refer to us because I understand that there's just not enough time to get everything done in a visit, but we have that time. We are there to support you as physicians, as pharmacists, as nurses. And just working as that interdisciplinary team is so important because as you already mentioned, we can't possibly do it all ourselves. We all have our strengths, we all have our specialties, and so relying on one another and working as a team is really going to move that needle and make a difference.

And moving from the interdisciplinary care team into a more community-based approach, When we're thinking about the community health workers, when we're thinking about those religious centers, thinking about the partners in our community that can also support us. And that may look differently depending on what kind of community you're in. For example, in rural areas we talked about the farmers. We talked about maybe tapping into any unwanted or unused food. Maybe there is an opportunity to... Maybe this doesn't fall on your shoulders as a provider, as a practitioner, but maybe there are already some grassroots efforts to connect the people in the community with some of the extra food or the unused or the ugly produce as they like to call it. The things that aren't marketable because they may have a scar or a dent but are still very nutritious.

Monica E. Peek, MD, MPH, MSc:

And that can be an official program with the clinic. That doesn't have to be you yourself bringing in the vegetables every day. But if it becomes an official partnership, then we have that at my clinic. And so every time

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I pass through the door, I see there's a little shelf and I see various fruits and vegetables, and there's a little sign-in sheet. And it is great.

Diana Mesa, RDN, LDN, CDCES:

I love that. I love seeing these things put into action like that. There's so much opportunity.

Monica E. Peek, MD, MPH, MSc:

Absolutely.

Diana Mesa, RDN, LDN, CDCES:

Sometimes in small, more rural towns, there might be some sort of small town government officials, maybe the mayor of the town or some of these leaders in the town that we might be able to connect with to create these partnerships. Sometimes they are the first informed of the things that are happening in town. So having that open line of communication is so important.

Monica E. Peek, MD, MPH, MSc:

Absolutely. So while we've been talking about a lot of the positive aspects and the way that we can come together and really sort of wrap our love around patients, we also know that sometimes patients don't have optimal experiences within our healthcare system. And so can you talk a little bit about bias and just how we can be more mindful of implicit bias as we're trying to bring patients in and address these issues of food insecurity?

Diana Mesa, RDN, LDN, CDCES:

Absolutely. And I think we're all human beings. We will all have some level of implicit bias. That's just part of being a human and being conditioned to our environment. However, and I think it's important to also create a safe space around this discussion of implicit bias because people tend to feel more comfortable addressing it, even acknowledging their biases when there's less shame attached to that. So there is this one tool that I really like to use for not just myself, but whenever I'm talking to other providers, especially dieticians, obviously I'm a dietician so that's who I'm talking to the most, the Harvard Implicit Association Test. And this is an online test that you can take. And they have a library of all sorts of different biases that we may hold from racial bias to gender bias, to weight bias, to all sorts of biases that exist where we can get curious about where we fall on that scale of implicit bias.

And these biases are unconscious. They're unconscious attitudes. They are stereotypes that negatively impact our understanding of situations or the way that we make decisions based on these things. If we're assuming that somebody only likes white rice, for example, we're missing the opportunity to have the conversation around brown rice. So even in the attempt to be culturally responsive, we may have these implicit biases around those beliefs that we think, oh, all Latinos like rice, beans and tortillas. Maybe that's not the case for the Latino sitting in your office. And so just being aware of these things is number one. And then avoiding making those assumptions and just really getting curious. Again, curiosity and non-judgment are the themes I think, for these conversations because when we are making assumptions about people's circumstances, people's access, people's preferences, their motivations, it's often not what we think it is, rather. And so it's important to have

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these conversations and to just bring awareness to our own biases and how they show up in the way that we are caring for people.

Monica E. Peek, MD, MPH, MSc:

Absolutely. It's best to ask and find the facts, than assume and be wrong.

Diana Mesa, RDN, LDN, CDCES:

Absolutely. I think there's a saying around that.

Monica E. Peek, MD, MPH, MSc:

Yes, there is. All right, thank you so much. This was an excellent discussion. I really enjoyed just learning with you and from you. And so I'm going to try and summarize our discussion with some SMART goals. And so those are ones that are specific, measurable, attainable, relevant, and timely. And that's what I hope that our audience will take away from this presentation and apply to your very own practice. And so the first is to screen patients experiencing food insecurity for chronic diseases and signs of eating disorders in a way that has cultural humility and sort of within a safe space. Second, to adopt a culturally sensitive approach to discussing food and nutrition with patients that are experiencing food insecurity, which sort of flows nicely from the first one.

Third is to collaborate with the patient and to select appropriate resources to assist with food insecurity. And then last is to partner with other members of the healthcare team and local community experts to develop strategies that can increase access to food and nutrition, to support patients who are living in food apartheid. So this CMEO Snack is one of a three-part CME CE initiative, and we hope that you'll take advantage of and participate in all of the activities in the series. The CMEO D and I Hub also has a number of resources available to help further your education on diversity, equity, and inclusivity. Including activities that are dedicated to addressing implicit bias and improving cultural humility. And so Diana, I really just want to thank you again for joining us for such a robust conversation. It was really just a pleasure. Thank you so much.

Diana Mesa, RDN, LDN, CDCES:

Thank you so much for having me. This has been a very enriching conversation to have with you and to be able to learn together.

Monica E. Peek, MD, MPH, MSc:

Absolutely. It's always so much more fun when we do things as a village in community. So for our audience to receive credit for today's activity, please complete the post-test and evaluation. We really do look at your responses. We want to hear from you, we appreciate your feedback. We want to know what you liked, how we can improve and what additional topics you'd like for us to address. And so I just want to thank you our audience for your feedback, and also just your own commitment to diversity, equity, and inclusivity education. Because when we all are working together to provide the best and most equitable care to our patients, that's when we are able to reduce the healthcare inequities and the inequities in health outcomes. And sort of just lift all the boats, particularly for those who are most medically underserved. So thank you for joining us today, and I hope you have a wonderful day.

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