Nourishing Communities Part III: Screening and Intervention to Improve Nutrition Equity in Underserved Communities

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 in the third in a series of our three-part CMEO Snack titled “Screening and Intervention to Improve Nutrition Equity in Underserved Communities.” This CMEO Snack is supported by an independent medical educational grant from CVS Health. My name is Dr. Monica Peek, and I'm the Ellen H. Block Professor of Health Justice at the Department of Medicine at the University of Chicago, where I also serve as the vice chair for diversity, equity and inclusion. I've been practicing medicine for more than 20 years on the south side of Chicago where I take care of patients who have a range of chronic diseases that are affected by the food that they eat. And so I'm really thrilled today to be joined by my distinguished colleague, Diana Mesa, who is an expert in many of these areas that we're going to be talking about today. She is a registered dietitian, she's also a certified diabetes educator. Diana, if you can introduce yourself today to our audience.

Diana Mesa, RDN, LDN, CDCES:

Yes, thank you so much. My name is Diana Mesa and I am a registered dietitian and certified diabetes care and education specialist. I'm also the founder of En La Mesa Nutrition. It is a private practice based in Miami, Florida, but serving 28 states virtually. And I help people from diverse backgrounds care for their diabetes, their PCOS, and disordered eating and eating disorders.

Monica E. Peek, MD, MPH, MSc:

I'm super excited to have you again for our third CMEO Snack. To frame our discussion today, let me start by reviewing our first learning objective, which is to identify the impact of culturally appropriate screening and intervention on food insecurity. And so I'll let you take it away.

Diana Mesa, RDN, LDN, CDCES:

Thank you so much. Yes, so food insecurity we know is so important when it comes to chronic disease management. It will impact it negatively, and we can really make a difference in connecting folks with food and resources to address their food insecurity. But how do we do this? How do we even start to ask questions about food security? Well, we can use formal screenings. There are some screening tools that we'll talk about in just a bit, but really the way that I do it in practice is I use that rapport that we've built and that curiosity and come from a place of empathy and no judgment when we talk about food security. I personally like to take a conversational approach, and I know that this may look different. I'm in private practice, I've got a little bit more flexibility. It may require a more formal screening depending on what facility you are at and where you're working. But I do like to take a more conversational approach when asking about whether people have access to food. And it can really just be simple questions.

It doesn't have to be something that is very involved. It can just take a minute or two to ask these questions. And now there is a screening tool that asks just two simple questions. It's called the Vital Signs, the Hunger Vital Sign screening tool. But really the questions are so easily incorporated into a conversation that it doesn't even

feel like a formal screening. Two questions that you can ask are, do you feel like you have enough food to make it through the week? And the other one is, do you worry about running out of food for yourself and your family? Those are two straightforward, simple questions that may open up a world of information. And so obviously depending on who you're asking, how they identify culturally, they may not feel comfortable just outright sharing this information, which is why it's so important to ask these questions so that you can get a better sense of if they're experiencing food insecurity. And then when we think about those screening tools, there are a few other screening tools that we might want to use if you have the time.

And then there are resources to connect you. For example, that hunger vital signs, those are those two validated questions that we can ask. There are also shorter six item questions that are available in other languages as well, like Spanish or Chinese. And that one is Map the Meal Gap. And so there are lots of resources out there for how to ask these questions in a session with a client. The USDA also provides estimates of food insecurity and food costs in individual counties across the US, so you may be in a county that is experiencing high levels of food insecurity. And it's important for you to know that because obviously if there's a client or a patient from a higher level income and not experiencing food insecurity, that is wonderful, but there are so many people out there who may not feel comfortable just outright saying it.

And so just getting to know your area, getting to know your county, getting to know if it's a county that experiences high levels of food insecurity is helpful because then you'll know that this is a screening I can't skip over. This is something that needs to be addressed.

Monica E. Peek, MD, MPH, MSc:

One thing I'll add to that is that we are having increasing rates of food insecurity and starting to see it in populations that are more atypical. And so I worked at the University of Chicago and we have patients from a range of socio-demographic backgrounds, and the rates, the prevalence of food insecurity was much higher than what we would've anticipated. And so with the cost of housing and the cost of lots of things going up, it's being harder for just everyday Americans to make ends meet. And so some people who may not have been food insecure 10 years ago may be finding themselves struggling and occasionally going to resources that they hadn't had to before. And so like with anything, you can never really fully judge a book by its cover.

Diana Mesa, RDN, LDN, CDCES:

Absolutely. That's such a great point that you bring up. I'm just recounting, I worked at a community clinic for many years and there were so many people that I worked with who were employed, had health insurance, but were living out of their cars because they couldn't afford housing. And these are people who are working full time, so just like that, they are likely experiencing some level of food insecurity as well. And thinking about not having housing, where are these folks cooking things and how are they nourishing themselves with foods that are nutritious but maybe they're more convenience foods, maybe they're already prepackaged, maybe they are already cooked? It's very important to get curious about that regardless of what they look like, how they're dressed when they come see you, that we can make many assumptions based on that, but it's important to ask those questions.

Monica E. Peek, MD, MPH, MSc:

Absolutely, absolutely.

Diana Mesa, RDN, LDN, CDCES:

One more thing I want to talk about, especially if you've flagged a person as experiencing food insecurity, is connecting them to a nutrition specialist. And if they have insurance, if they have insurance, most insurances now provide some level of nutrition service, most commercial insurances. I believe some Medicare Advantage plans also offer some level of nutrition service, but this is going to vary by plan by state. And so get familiar with what kinds of nutrition services are offered by the plans that you work with the most because we may be missing opportunities in referring individuals to nutrition specialists who can really help them bridge that gap between how to prepare foods that they are receiving in specific ways.

Or if you yourself don't have the time to refer to these food resources, the nutrition specialists, that's what we are here to do. And so many people just aren't aware that they do have these services as part of their plans, so just simply talking about that, letting people know that there are experts in that area, that if they have diabetes, they can go see a diabetes educator that's covered by insurance. They can go see a dietitian, they can talk about food for however long, 30 minutes an hour, just food, that can be really eye-opening and relieving to some people who are really in need of these services.

Monica E. Peek, MD, MPH, MSc:

Absolutely. There are professionals for just food and you get more time a lot of times than you would with the physician. And so all hands on deck.

Diana Mesa, RDN, LDN, CDCES:

Absolutely. I'll speak personally because this has been different across the board, but in my private practice I spent 90 minutes with an individual upon initial assessment and then follow-ups can be up to an hour. And so imagine having an hour to really work through all of the food concerns, whether it be food access, food safety, food preferences, managing chronic conditions, so on and so forth. And it's covered by insurance, so that's a great resource.

Monica E. Peek, MD, MPH, MSc:

That's just amazing. Amazing. I wish I had 90 minutes.

Diana Mesa, RDN, LDN, CDCES:

I know.

Monica E. Peek, MD, MPH, MSc:

And so how much ground you can cover for that initial consultation and the follow-up to really work with patients and say, this is foods you know and love, food is culture. We're not trying to change your culture. We're going to celebrate that. This is who we are, but let's figure out a way to optimize the way that we can do that in a way that's healthy. Let's make sure that you are not having to choose between food and medicine, your prescriptions. How can we do all of this so that you can be the best, most healthy person and live your best life? And so that takes a team approach, so thank you all for all of the stuff that you do.

Diana Mesa, RDN, LDN, CDCES:

Oh, no, thank you. We should all be thanked because this is hard work, and I know that I'm not the only one, I know that every practitioner feels this way. If we only had more time, if we only had the right resources, if only insurance covered this or that, and people are experiencing so many levels of social determinants that impact their health, and we're just one person, we can't do it all, so utilize that team so that we can all get a set of eyes on it.

Monica E. Peek, MD, MPH, MSc:

Tell me a little bit about how you do or how you approach culturally responsive, culturally sensitive nutrition education as an expert.

Diana Mesa, RDN, LDN, CDCES:

Sure. One thing I go in with is that I don't know it all. That is one thing that I start with. Again, leading with that curiosity is so important because we can't be expected to be the experts in every single food across every single culture, so getting better understanding. Clearly I am in a position where maybe I am serving Latinos. It is my culture for the most part. That doesn't mean that there's... And across Latin America, there are so many different food ways. There are so many different preferences. And so even across my own country of Cuba, you go to east Cuba, we cook and call things one way, and then we cook and call things a different way in western Cuba. So the nuances are-

Monica E. Peek, MD, MPH, MSc:

And the island is not that big.

Diana Mesa, RDN, LDN, CDCES:

It's not. It's not that big. Yes, there's a lot of differences even within the same island from region to region. We want to make sure that we go in knowing this, that we are not actually the expert here on their food. We may know a lot, but they need to bring their expertise into the session and it needs to be collaborative. That is one very big point that is an umbrella to the rest of how to approach it. I like to also think of how we can add instead of removing cultural foods. And I'll give this example about white rice. This is one of my favorite examples because it's one of the ones that I hear the most. And so many times people come and have a session with me and they say that they were told to stop eating their white rice to manage their diabetes. But the truth is that that is not necessary. Nowhere in our research does it say that white rice needs to be stopped in order to manage diabetes. And so how-

Monica E. Peek, MD, MPH, MSc:

We're counting carbs, so we just factoring that into the equation.

Diana Mesa, RDN, LDN, CDCES:

Exactly, factoring that into the equation, and also thinking about what else we can add to the plate instead of removing. If we're just having half a plate of rice and half a plate of protein, can we change the proportions a

little bit? Can we add some veggies? Maybe we can add some tomatoes, maybe we can add some beans. Maybe we can add these things that have more fiber. Maybe we can add a protein that's going to help manage that blood sugar better. It's going to extend digestion so that those carbs from the rice aren't as easily accessible to our blood sugar right away. That is a big tool that I use across my practice, what we can add instead of subtracting, because people already have that... Honestly, it's a trauma of having been told that your foods are bad for you, that your foods are too starchy, too greasy, too fattening, or any of those things that we hear so often about our cultural foods.

Monica E. Peek, MD, MPH, MSc:

And again, the way that we eat is a reflection of our culture and who we are. And so it's how we define ourselves as much as our cultural symbols, our dress, our anything else. And when we come together in community, we are always breaking bread literally and figuratively. And so we cannot say that we wanted a community to do better with their lifestyle and nutrition, but we're just going to toss out all the foods that they already eat. We have to be able to honor those foods, to lift them up and then figure out how we're going to make them healthier.

Diana Mesa, RDN, LDN, CDCES:

Absolutely. I love that. And we can really keep the integrity of our cultural dishes while making small adjustments. Can we use this kind of oil instead of this one? Can we use this cut of meat instead of this one? We're not substituting the pork necessarily, we're just maybe using a loin instead of a shoulder. And so thinking of honoring those flavors, thinking about those cooking methods that we're using, are there... Obviously making a lot of assumptions here, but say they have an air fryer, can we air fry it instead of deep-fry it? What a difference that could make in the nutritional profile of something, like a plantain, for example.

There's lots of ways to approach this, but I think the biggest takeaway on this subject is we don't want to make assumptions. We want to understand and we want to meet people where they are at and keep in mind what they have access to. We may not recommend the pork loin if it's the most costly kind of cut, so if they can't access it, if they don't have the finances to cover the groceries, well, it's not going to get done, and we're not going to make the impact we think we're making with our wonderful nutrition recommendations. Really just understanding that, and one analogy that I use a lot in sessions with people is that we want to focus on the forest instead of the tree. We want to focus on the overall eating pattern and not get too caught up on one or two or this or that ingredient, because ultimately it's the eating pattern that's going to make an impact. It might not be the pan dulce that they're having on a Sunday morning with their coffee, it's everything that they're doing.

Monica E. Peek, MD, MPH, MSc:

Exactly. Exactly. Big picture.

Diana Mesa, RDN, LDN, CDCES:

Big picture. Absolutely. Absolutely.

Monica E. Peek, MD, MPH, MSc:

Excellent. What a way to wrap up our first learning objective. That was fabulous. We're going to move on to our second learning objective, which is how to implement actionable strategies for the multidisciplinary care team to improve nutrition equity in underserved communities, so back to you.

Diana Mesa, RDN, LDN, CDCES:

Sure. I do want to talk about prescription food plans because I feel conflicted about some of these sometimes. And I'll tell you why. These prescription food plans are great in the sense that they provide these low cost or no cost produce, fresh access to fruits, vegetables, grains, to the person. That is definitely a pro. That is a highlight. The more free food we can get to people who are experiencing food insecurity, the better. And it encourages patients to incorporate those nutritious foods into their diet. But I'll put an asterisk on that because we might have to jump to the cons and do a little interchanging. But I like the fact that these prescription food plans really keep in mind the chronic conditions that people are living with and how those foods can be therapeutic for those chronic conditions. And moving to the cons, there are a few things that we want to be mindful of because prescribing is not person-centered necessarily when it comes to food.

And food is something that needs to be so person-centered because... We've been talking about it. It's their culture, it's the way that they celebrate things, it's comfort. It brings nostalgia, so on and so forth. Especially for an immigrant, for example, it really connects them to their country of origin, so these are really emotionally-tied charged emotions that relate to what we're prescribing. We don't want to remove the autonomy from the individual to be able to make choices because that's just not best practice. We want people to have that autonomy. And then when it comes to incorporating these nutritious foods in their day-to-day eating pattern, do they know how to prepare these foods? Are these foods that are from their culture or have they never seen it used before? One example that I think about often is dried beans versus canned beans. They're both beans, but people from Latin America may be so used to eating or using and cooking the dried beans that they might not necessarily know how to incorporate the canned beans.

And this is actually a question that I get often, well, how... I'm recommending canned beans. The question is, "Well, how do you prepare the canned beans? Do you just eat them out of the can?" And personally, no. I throw them on a pan, I add some spices on there, I heat it up, and then I make it like if I would've seasoned some dry beans. But if the individual receiving the prescription doesn't have the ability to ask these questions, or is just getting a box with no real instructions, no recipes, no association to their culture, it can be a con. It can be a con.

Monica E. Peek, MD, MPH, MSc:

Yes. And there's so much heterogeneity in the prescription box, what that would be if you can take this prescription to the farmer's market and get whatever you want, versus you're getting a delivered box that is preset, and then you have to work with what's in that box. And so I think that you're exactly right. We have to think about the pros and the cons. And what we know from the evidence is that interventions that are socioculturally tailored for an audience, which is what we've been talking about, are the most effective. They have the better chance of being used and being sustained because they align with that person's own lived experience, their cultural narrative, they know what to do with it, they feel empowered.

Diana Mesa, RDN, LDN, CDCES:

When we think about these things, there's already a power difference between the provider and the patient, and we want them to feel empowered to speak up and advocate for themselves, which can be hard, especially if you're coming from a culture who sees the provider as like, we have to respect... In my culture, the doctor knows best. You don't question a doctor. And so collaboration is really, really key. Engaging that person as much as possible in what their prescription food plan will include so that they enjoy it and they know it and they know how to use it, and it's not going to waste because all of that effort for something to go bad because we didn't know how to put it into practice, it's a sad thing to see happen, so absolutely.

Monica E. Peek, MD, MPH, MSc:

Talk about some of the lessons that we've learned from some of the produce prescription programs.

Diana Mesa, RDN, LDN, CDCES:

Sure, absolutely. There is the Navajo Fruit and Vegetable Prescription Program, and they partnered with local farmers to strengthen that local economy, so in a way, we were supporting the... Not we, because I wasn't part of it unfortunately, but they were supporting that local economy and also introducing those sustainable food sources to the population in that area. And then when combined with other programs designed to reinforce that healthy and mindful eating practice, it can really have some great outcomes, so that is a wonderful example. There's also the Mississippi Delta Produce Rx. With this one, it highlighted the great need for programs like this in rural areas because rural areas are likely experiencing some level of food insecurity when they're existing in food apartheid. And then similarly, combining that produce prescription with nutrition and cooking classes offers the greatest benefits because not only are individuals really understanding how these foods support their health, but also they're having that hands-on experience of actually doing it.

And so that really sticks to the mind, to the memory. You can take that back home and you can reproduce it time and time again, and you can make tweaks to it and make it really your own, so love the nutrition and cooking class component that the Mississippi Delta Produce Rx had. And then there's the Brown University 2020 Produce Prescription Pilot Program. And one thing I really liked is that they learned from people who did it before them. They looked at what's already out there and took what worked, took what didn't work, and implemented that. And then they partnered with policymakers to help identify stable sources of funding because pilot programs are great, but the funding needs to be there in order to bring it to fruition after the piloting. If the pilot program does so well, hopefully we get a lot of sources of funding for that.

Monica E. Peek, MD, MPH, MSc:

And that is always sort of the rub, is that unlike medications where there's already an infrastructure, like you have a great medication that comes on the market and it's going to cure this disease, or it has great efficacy for this chronic medical problem. There's already an infrastructure as far as pharmacies are available, the drug company has an advertising market. When we have new information about best practices for quality of care or something, there's not the infrastructure for scale and spread and the finances. And so a lot of times what we learn from smaller projects or pilots, never make it into the wider universe because there's not the infrastructure in place. There's not the financial incentives for improved healthcare quality like there are for

pharmaceuticals. And so that's something that is a reflection of how we finance our healthcare system and push things forward versus not.

Diana Mesa, RDN, LDN, CDCES:

Absolutely. Hoping to see some changes in that area, some more even distribution of interest and funding across the board and hoping to see in the future a shift toward prevention.

Monica E. Peek, MD, MPH, MSc:

And we already began to see that in some areas. And CMS has been a huge player in that thinking about these social drivers. And that is new for our healthcare system as far as payers and others, but we're still way behind how we think about prescription medicines, for example, but we're making progress.

Diana Mesa, RDN, LDN, CDCES:

Progress. Progress, something is better than nothing.

Monica E. Peek, MD, MPH, MSc:

It absolutely is. It absolutely is.

Diana Mesa, RDN, LDN, CDCES:

And then when we think about the impact of these prescription programs on health, there's one particular multi-site evaluation of nine different produce prescription programs across the United States. And what was found in that evaluation is that these programs can be very impactful. To put it simply, we can really see an increase in fruit and vegetable intake, so much so that people are actually increasing that to almost a cup a day, just shy of a cup a day. That's getting us closer to where we need to be as a country. Some drops in food insecurity, we're also seeing about a third of a drop in the odds of food insecurity.

Monica E. Peek, MD, MPH, MSc:

That's pretty-

Diana Mesa, RDN, LDN, CDCES:

That is pretty significant. A third, that's huge. And then an increase in patient-reported health status, which is always nice because we can have the records to show that, hey, your A1C got better. Hey, your cholesterol got better. But if that person isn't experiencing those benefits, it's going to be a lot harder to maintain and stay motivated, so when there's a patient-reported health status improvement, that is wonderful because they're the ones that really need to feel that improvement.

Monica E. Peek, MD, MPH, MSc:

Exactly. Exactly.

Diana Mesa, RDN, LDN, CDCES:

And then there were also some cardio metabolic outcomes that are noteworthy, like a decrease in systolic and diastolic blood pressure in adults with hypertension. And also a decrease in BMI in adults with obesity and a decline in hemoglobin A1C. All of these markers trending downward are nice to see. That's what we want, right?

Monica E. Peek, MD, MPH, MSc:

Right. Right. We see the association between chronic diseases and food insecurity. And so when we see interventions, we'd like to see these chronic diseases improve.

Diana Mesa, RDN, LDN, CDCES:

Exactly. It seems like the efficacy for these interventions is there, and we just need to really push forward, push that agenda forward so that we can do this on larger scales and across the country.

Monica E. Peek, MD, MPH, MSc:

Absolutely. You had talked a little bit before about the power imbalance between physicians and patients and making decisions around a lot of these issues and even discussing food insecurity. What are some of the suggestions you have for people that are watching to try and break down some of that power imbalances of trying to engage patients in talking about these really important issues?

Diana Mesa, RDN, LDN, CDCES:

That's such a great question. And one of the things I do... I'm not a doctor, so people don't call me doctor, but I like to normalize, "Hey, you can call me Diana. You don't have to use anything formal here." In Latin American cultures, the practitioner is always called doctor, whether they are a doctor or not, so a lot of my Latin American patients will call me doctor. And I'll immediately kind of, "Hey, I'm not a doctor and I appreciate that level of respect that you are showing me, but here you can call me Diana. I'm your partner. I am your teammate and I want to help you, rather than tell you what to do."

With dietitians specifically, there is this common misconception that we are going to tell you what to eat and how to eat it and when to eat it. And that is something that gives me a lot of power that I don't want, and I don't want that much power. I want you to have that power and I want you to tell me what you want to eat. And then we can work together to make it work for whatever chronic condition it is that you're managing. Seeking that participation is so, so important. Especially in Latin American cultures, the care that they might have received in their country is likely going to be more prescriptive, and so it's less collaborative. And so there is sometimes a level of discomfort, maybe a little bit of confusion like, "What do you mean you're asking me my opinion?"

Monica E. Peek, MD, MPH, MSc:

Like, "Weren't you the one who went to medical school?"

Diana Mesa, RDN, LDN, CDCES:

Exactly. Exactly. But really once they kind of feel comfortable, you can really see them just advocate for themselves and feel empowered and really call the shots. And there's nothing, at least for me, there's nothing

more satisfying than to see that with my clients. Because as we know... When I first became a dietician, meal plans, that was still kind of in our training, and it might still be in our training. You're going to make a meal plan with so many calories and these macronutrients. And really, I did that for many people, and I don't think any of those people ever came back and said, "Hey, I followed the meal plan."

Because really, if you're not making those decisions, how am I supposed to know what you like, what you have in your fridge, how many times you want to cook a week? There's just so much that goes into it, so helping them to meal plan rather than creating the meal plan on my own and then giving it to them became so much more effective in what both of us wanted out of the sessions. You want to give people options. You want to give them informed consent. You want to let them know, "Listen, this choice is going to have its pros and it's going to have its cons. And here they are laid out for you so that you can make the most informed decision for yourself because ultimately you're the one making the choice and you're the one having to live with it, so based off that, what do you want to do?"

Monica E. Peek, MD, MPH, MSc:

All right. I'm just going to note that for anyone who's interested in learning more about the SHARE model, which comes from AHRQ or more just about shared decision making in general, we did specifically do a CMEO Snack about that that I was thankful to moderate with Sheila Harmon, who is another certified diabetes educator. She's a nurse and just has a wealth of expertise in lots of ways. And so you can check that out. And so one of the things I know that we talk about a lot is the importance of an integrated healthcare team and team-based care and how we're always say wrapping our arms of love around the patient, and that includes for patients who have food insecurity. And so Diana, can you take us through what that might look like for a patient experiencing food insecurity, all the different kinds of team members that might need to be in play?

Diana Mesa, RDN, LDN, CDCES:

We've got so many teammates I'd like to call them because we all have our own specialties. We all have our own area of expertise, and we all have different resources that the next person might not be aware of, so really that interdisciplinary team approach is key for addressing food insecurity. Obviously, the physician, the nurse, maybe even the physician assistant might be doing some of that screening in their sessions, but that's where the referral comes in. We know that a lot of us are under a time constraint, and we don't have all of the time that we wish we did to address everything that this person needs, so refer. Referring out is so important. You can refer out to the dietitian to really address those food concerns, whether it be food insecurity or managing a chronic condition with food. And thinking about, we've talked about all sorts of different limitations that a person might experience when it comes to accessing food.

Also preparing food. Do they have a basic understanding of how to cook food? Is there something that the dietitian can do to support that, to provide education? Even outside of that one-on-one setting, are there group classes? We saw in some of these programs how these group classes focusing on nutrition and cooking can be so, so impactful. And then thinking about those community members that we can leverage to help us, community health workers, community leaders, those elders in the communities can really make a difference. And finding those community partners to really support the people that you work with is key in taking that food insecurity to food security. And even if the food security might be temporary due to circumstances, we can still move the needle a little bit. And a little bit is still something.

Monica E. Peek, MD, MPH, MSc:

Well, we've come to the end of our time. Thank you so much. You're just such an inspiration. What an excellent discussion. I really appreciate your time. I'm going to try and summarize our discussion with some smart goals. And smart goals are ones that are specific, measurable, attainable, relevant, and timely. And so that's what I hope that our audience will take away from our presentation and apply to their very own practice. And so first is to use simple conversational questions that incorporate validated screeners to ask patients about food insecurity. And number two, to provide nutrition advice and guidance that takes patient's culture, their background, their financial situation into consideration. Three, to participate in food prescription programs that are socioculturally tailored, that think about options, that are collaborative and that also increase patients' access to fresh and healthy foods. And then last is to empower patients to help them engage with you to make treatment decisions through education, culturally sensitive conversation and non-judgmental listening.

This CMEO Snack is one, it's the last of our three-part CME CE initiative, and we really hope that you'll take advantage and go back and participate in all of the activities of the series if you missed them, because they have been wonderful. The CMEO D and I Hub is huge now, and it has a number of resources that are available to help you further your own personal education on diversity, equity, and inclusivity. And so Diana, I just really want to thank you again for joining us for such a robust conversation. It's been really my honor and my privilege to actually share space with you today.

Diana Mesa, RDN, LDN, CDCES:

Thank you. Honestly, the honor and the privilege is mine. I have had such a wonderful conversation with you, and I hope that everyone watching this can really take some applicable things away.

Monica E. Peek, MD, MPH, MSc:

I know they will. I know I did. Thank you. To receive credit for today's activity, please complete the post-test and evaluation. We appreciate your feedback. We always want to hear from you. We want to know what you liked, how we ourselves can improve, and what additional topics you'd like to see us address in the future. And so I always want to thank you, our audience, for helping to keep this engine going for your own personal commitment to diversity, equity, and inclusivity education, because it's our ability to work together with you, our audience across this country, that we can provide the best and most equitable care to all of our patients, particularly those who are the most medically underserved. Thank you all so much and have a wonderful day.

