Access deserts, Magnet designation, and comorbidity management centers in Boston. Featuring Sasha Dubois.

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Brigham and Women's nurse Sasha Dubois, MSN, RN discusses how racial segregation, gentrification, and displacement in her native Boston can create "healthcare access deserts" that fuel health disparities, even in an area where there are a number of high-quality hospitals. Establishing medical homes in the communities where patients are is one approach that Brigham and Women's is implementing, together with centers that focus on understanding and managing multiple co-morbidities by integrating factors such as social determinants into care plans and health records. Sasha is an expert in Magnet designation, a driver for excellence which raises standards of care and encourages a more patient centered approach. Magnet also emphasizes the importance of cultural competency, unconscious bias, and understanding disparities. With Dr Carla Harwell.

Dr. Harwell: You are listening to the Health Disparities Podcast from Movement is Life a series of conversations about health disparities with people who are working to eliminate them. Today, I'm discussing health disparities with Sasha DuBois. Ms. DuBois is the incoming National Black Nurses Association Secretary and the inaugural Mairead Hickey Leadership Fellow in the Department of Nursing at Brigham and Women's Hospital in Boston. Welcome, Sasha.

Sasha Dubois: Thank you for having me.

Dr. Harwell: Let me start by asking you this. We know that Boston is a quite racially segregated city. So, what types of health disparities are you aware of? And also do some citizens find it hard to access care services at Brigham and Women's Hospital?

Sasha Dubois: Yes, it is a racially segregated city and it's been that way for as long as I can remember. However, I think like most cities, most major cities in the country, we are experiencing gentrification. So, the access to healthcare really is harder because people are moving outside of the city so that they can afford quality housing. So, with people that normally lived in the city, the system was set up that we have four major level one trauma hospitals in the city that are literally within five miles of one another, and a lot of those hospitals have community health centers. And so, you could go maybe take a short bus ride or arrange a ride to go and get quality access to care. The same physicians and nurses that worked in those hospitals would also work in the community. Those are really accessible. However, if people are being displaced outside of the city, what does that mean for them? Then that's where the disparities come. So, it's almost like there's a healthcare access desert.

Dr. Harwell: Wow. In a city such as Boston with, like you said, so many options, but yet now people have been forced out and don't have that same easy access to that care.

Sasha Dubois: Yes. And as far as the Brigham, I will say they're expanding into a lot of the suburbs because they realized that people have a hard time coming into the city and honestly, it doesn't matter what color or what creed you're from. And I think they're really working to look into some of those cities, into some of those neighboring communities where it's harder to come into the city. I only live 10 miles out of the city, if I'm driving in the morning, it takes me an hour to get to work. So, imagine somebody that's ill, that's coming in to be seen, possibly have surgery, has multiple appointments, has to pay to park, even if it's discounted, even if it's free, then they have to find something to eat. Then they have to go back home. That's a lot, that's a lot on somebody that's already experiencing, an illness. I'm well, and I know I have to mentally prepare myself even for the ride, whether it's train or whether I'm driving. So, what they're really trying to do is establish medical homes. Really going out into the community locally in the Boston area and beyond. So, that way you can have surgery out in the community, you can have your primary care visit there. You can have physical therapy; you can basically get everything that you need and you don't have to come into the city or into the mothership hospital. And the thing is, if you really are acutely ill, then that's when you would end up

coming into the city. A lot of times people will say, and it's not even limited to Massachusetts, people that are snowbirds. When they know they're really sick, they say, "I'm flying back home, take me to Boston." Even if they're 30 miles away, they say, "We have to go into Boston." That's how they know that they're really sick. But a lot of times we really try to encourage people to stay in their communities.

Dr. Harwell: Wow. That sounds like at least one effort, the establishment of these medical homes to help eliminate some of those social determinants of health that are contributing to these healthcare disparities and you know, that's access. So, that sounds like a great thing.

Sasha Dubois: Yes. And we have an entire center that's dedicated to patients that have multiple comorbidities, multiple issues with access that also contribute to the social determinants of health and when a patient is admitted, that's under this program. If they have a flag in their system, they have acute care plans. So, that way, whenever a provider meets them, they know exactly how to care for this person. Especially if they have maybe some behavioral health needs because if you're seeing someone that comes in all the time, they're present all the time. If you're not familiar with them, you might be enabling their situation. And then they get upstairs and they're admitted and they get up to the nursing staff and they're like, "Oh, we know them. Why do they get this downstairs?" That

way the patient gets complete and direct care. That way they are at a lower risk for developing disparities and also, decreasing any kind of judgment and they already know they can come in and say, this is what my prescription is. This is what I know. And they know they have these acute care plans. It's not like they have to tell somebody their story all over again because that's part of the problem, especially when you have a chronic illness. These centers that we have are managed by care coordinators, social workers, nurses. So, that way they really understand what it means to take care of a patient and their job really is to keep patients out of the hospital, keep them from being admitted.

Dr. Harwell: That's great.

Sasha Dubois: And checking on them and making sure they're making their appointments and why not. And, reading their notes and seeing if they're not showing up for appointments, what else is going on? Are they able to make it to their appointments? Why not?

Dr. Harwell: Right. Those social determinants of health, that we always still have to be, very cognizant of. I understand one of your roles is to engage clinical nurses on the importance of magnet designation, something that only 8% of US hospitals currently earn. Could you talk a little bit about the magnet recognition program, and would you agree that this framework for nursing

excellence maybe could also contribute to the elimination of healthcare disparities?

Sasha Dubois: Yes. So, we actually already reached magnet status. We're very excited. We reached it last year, we're really just flying high on it. Our organization has over 3,000 nurses and it really was a wonderful undertaking. Obviously, it takes years to build the infrastructure, but once we knew we were on the magnet journey, everybody pretty much just pitched in.

Clinical nurses would go to forums that were just centered around magnet. And then they would take that information and that energy back to their units and basically like infect the other nurses and saying, "Look at all the wonderful work we're doing. Did you know this other unit, two floors up are doing this work, how can we show off all the great work we're doing?" Because every unit has a unit-based practice council that works on, initiatives that improve care on their specific unit because we tend to have service lines. So, if you work on an orthopedic unit, how can you get your patients out safer? How can you get them to walk? How can you get them to not have falls when they go home? How can you not have them to have falls when they're in the hospital? And these are some of the things that, you think about us as a nurse, because you always want to remember what does the patient need. So, a lot of times you'll have this practice council. Nurses from every shift will come together and talk about some of

the struggles that they have when they have to take care of patients. And then they find out what the common problem is. And then, they work towards fixing that. So, process improvement in name of patient care, just having it be a great collaborative place to work between all disciplines and really everyone being patient centered. It's fabulous. When I was an off-shift nurse administrator during this magnet journey, I would walk around with an associate chief. What we would do is, we would walk around, have a tray of cookies and have a theme that centered around our standards of practice. Our nursing practice model and highlighted something every month. And then we knew what units we were going to go to. And we would say, "Did you realize this is what you're doing?" This is actually in the magnet application.

So, then we would show the staff that the work they were doing was actually put into an application that other people were reading and seeing the great work that they were doing. That way they knew they were contributing to something. And it was really fabulous. We went to the Magnet Conference last year. We had, oh my goodness, maybe 130 nurses that went. People were like, who's working at the hospital if all of you are here, but it was our first designation. And the hospital was really, really supportive of us. And everybody just had a blast and was really proud to work there and really proud to be a nurse.

Dr. Harwell: Does that nursing excellence include things like cultural competency?

Sasha Dubois: Cultural competency, understanding disparities, the healthcare, understanding access, because we are literally in the middle of a city where a lot of folks use that as a community hospital. So, we have to understand some of the things that they are going to need. We have a lot of veterans that hang out around the hospital and a lot of times they seek a lot of emergency care. We also, on the other side are surrounded by some very affluent communities and what needs do they have? So, people have those different social determinants of health, but when they come in, they may look like they have one different package, but they have a whole host of needs. Unfortunately, because we do live in the city, there are violent things that patients experience. So, we have to understand what are the needs of those patients that need that acute care, whether it's while in life or if they don't survive their injuries. Also, considering too, we're a level one trauma center. So, we get burns, we get horrific car accidents, we get construction, mishaps, we get all kinds of things that people are rolling through those doors, and they're getting the worst news of their lives. And how, as a caregiver, as an administrator like myself, how are we caring for each other so that we can care for these patients? And how are we teaching people the right things to think, because people are going to have their unconscious bias, but how do we prevent that from, transferring over into how a patient is treated? We

actually have a great HR department that teaches a class on unconscious bias and they teach it like every month, this woman named Leanne Crossett, she's fabulous. And I don't know a single person that has said, I'm not really feeling this class because everybody realizes they have their own bias. Whether they like it or not. People say, "Oh, I'm not racist." But you may not like old people, and you don't realize it. So, everybody realizes that they have some kind of bias and realizing that is the first step.

Dr. Harwell: Yes, that unconscious bias is, so important for people to have that self-inner reflection and realize that we all bring some stereotypes and some, preconceived thoughts and notions about others that we're not even aware of that we bring to the table.

Sasha Dubois: People have their own experiences. And I can't knock somebody for the experience that they've had because they haven't walked a mile in my shoes. I can empathize with them, but if they're hardened based on an experience, maybe they had a bad experience or maybe they've gotten the same kind of patient and they've, they have caregiver fatigue from that. So how do I, as an administrator or as a nurse director say, okay, we need to understand where you're disengaged and how do we get you to be reengaged. Because the disengaged nurse is a very dangerous thing and the disengaged nurse really will impact how a patient receives their care and also what their caregiving experience is.

Dr. Harwell: I understand, right now, you're working on a research project to understand the experience of your colleagues at Brigham & Women's Hospitals, in relations to diversity and inclusion.

Sasha Dubois: Yes.

Dr. Harwell: What's your research telling you so far?

Sasha Dubois: We actually presented our work. We presented our work at our hospitals Brigham Research Day. Clinicians from across the hospital, doesn't matter what you are, physician, nurse, social worker, PT. It doesn't matter. We had digital posters posted up in public areas around the hospital, and we were able to do this research and then we're actually able to disseminate it here at the National Conference. Basically, what we found that is people loved and do love working there, but when you see certain hiring practices or when people don't have that unconscious bias training, or are unaware of their preconceived notions, for staff of all kinds, they just want to feel like they need to have a place to belong. And if you're a staff member of color or nurse of color, because we also interviewed aides like secretaries, like unit secretaries, if they feel like they're the only one on the unit, it's not that that's much of a surprise, but how are you feeling included?

Dr. Dawson always said that, diversity is being invited to the table and then inclusion is being asked to dance. And she says that and she also compares it to, a quilt versus a tapestry. A quilt is diversity and the tapestry because there are so many interwoven fabrics is inclusion. So, how do you really make a unit inclusive for everyone? Because you have competing preconceived notions, unconscious bias, then you have, the staff groups, the physicians versus the nurses, versus the aides, versus the unit coordinators. And really, we all need to lean on each other because the job won't get done.

Dr. Harwell: We have a few minutes remaining. So, for my last question, I'd like to ask you, how do you think we can get patients more involved in eliminating disparities?

Sasha Dubois: I think being paternalistic to patients is why patients don't become involved. My mom's a boomer and a lot of times I'll talk to her about healthcare and she'll say, "I'm just going to do whatever the physician says." And I said, "What if that's not the best thing for you?" That's a learned behavior and breaking that or unlearning that is the hardest thing I think for patients and for caregivers as well. I think for nurses, you know what your patient needs and yes, it's your responsibility to drive their care. So, that way they're in the hospital with you, because the longer they need

to be cared for that means the sicker they are. However, there are some ways that you can do it. When I was a clinical nurse, I started doing research with my unit-based practice group with Patti Dykes and there were couple of units that she did pilots on and we were interested in decreasing patient falls. So instead of saying, oh, go around every two hours and make sure the patient's toileted and check in on them. And then you trade off with the PCA and do all these things. In reality, that's not that realistic because something happens. There's an emergency. You get behind on your meds. Someone needs to go do a test and you really want to be able to speak to their practice and you want to be able to have some truth into it. So, Patti really worked on, it was basically like a laminate posterboard with the staff and what the patients and she did focus groups and the nurse would go have the board on the patient wall. So, the patient was laying in the bed. They wouldn't be able to see it. Every part of the board has a different color, and you circle it with a dry erase board and say, this is what you need to walk as a cane, please don't fall. Didn't have too many words on it. And you would talk to the patient and say, "What do you need in order to get out of bed?" Obviously, they couldn't speak for themselves, obviously we talk to their family member or you would use historical information, but that helped the patients stay involved in their care because then they would look at it and say, “Oh, wait, I need to call for the nurse or I need to call so, I don't fall.” It had great, great, great outcomes for patients, decrease falls, decrease falls with injury, and I think

being able to meet the patient where they're at is how we're going to start to decrease those disparities. And that research project, we were able to write a paper about it, actually get it published in the Joint Commission Journal. It really opened my eyes and helped me to understand you really have to meet people where they're at.

Dr. Harwell: You have to meet them where they're at. Absolutely.

Sasha Dubois: You really do.

Dr. Harwell: Well. Great work. Thank you so much. Thank you, Sasha.

Sasha Dubois: Thank you.

Dr. Harwell: Thank you all for listening to The Health Disparities Podcast from Movement is Life. Please join us for new installments every two weeks by subscribing at Apple Podcasts, Stitcher, Spotify, and Google. You can also find us@www.movementislifecaucus.com. Thank you and we'll see you again.

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