To avoid racial bias, technology-based solutions need diverse voices at each stage of development. Featuring Adrienne White-Faines.

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Dr Mason: Welcome to a new episode of the Health Disparities Podcast, conversations about health disparities with people who are working to eliminate them across the country. I am Dr. Bonnie Simpson Mason and this week, we are recording our conversations at the National Harbor in Maryland, where we are enjoying a program of speakers and workshops, at the annual Movement Is Life Caucus. Today, I have the pleasure of interviewing Adrienne White Faines. She is a committed health strategist, who looks to achieve health equity for all in her numerous roles including being the immediate past-CEO at the American Osteopathic Association. She's also had a significant role at the American Cancer Society and is also, now, doing a lot of interesting work in tech with Innovaccer but also as an advisor to the Patient Center Primary Care Collaborative. Adrienne, thank you for being here with us today.

Adrienne: Absolutely, my pleasure. Thank you, Dr. Mason.

Dr Mason: So, you know, help frame for us your core mission to achieve health equity for all and how that's been a common thread woven throughout your career. That might be a big question to ask, but I'd like to get to your,

why. You know, what drives you? And then, we can get into some more details.

Adrienne: That's a wonderful way of framing it. The reality is like most that choose healthcare as their career, there is a passion and desire for change for humanistic empathy and touch and believe that individuals can be, at their best, with support through healthcare systems. And, I, too, grew up, actually, in Milwaukee, Wisconsin and my father was a dentist who practiced with other African American physicians as a group, and serviced the African American population in inner-city Milwaukee. What I did was observed, growing up, the dedication and commitment of these individuals who cared about the patient, the community, the whole person, the family, and their role was much more than just what happened in an exam room, but, at the same time, they also lived within a US system that was broken and fractured and they were marginalized from that system. And, as a result, you really saw and observed the incredible dysfunction of the healthcare system and how it played out on the inability to truly heal and preserve wellness within communities of color. So, with that, that was my driver. And so, my career, actually, took off. I, originally, was going to become a physician and decided that, actually, I would stay on the policy side and strategy side, and it has guided me through health and hospitals corporation, public hospital systems in New York City, to working with academic medical centers in Chicago, to working with the American

Cancer Society, looking at program delivery and patient service enhancements, so that everyone could have equal access to resources, to truly benefit from the science and technology of medicine. From ACS, American Cancer Society, I went and had the honor of serving as the CEO of the American Osteopathic Association, which was a beautiful and wonderful component to the career because osteopathic physician's deals are trained from Day One, to look at the whole person, to approach patient care from a mind, body and spirit perspective. So, it, actually, took all of my passion around health equity and, actually, brought it home to what does training look like for physicians and providers, when you are trying to get them to appreciate the importance of healing and providing wellness for the whole person. And with that work, I now have left it in continuing my work in health strategy, both working with tech companies, providing insight. I'm on the advisory council of Innovaccer, to provide insight on how do you design tools, not just building on the technology, but, truly, benefiting and taking the perspective of the realities of the community and building that in, so that it works for both the users, but, most importantly, surrounds and addresses the patient, the family, the community. So, that's, generally, how I'm approaching life. Still on a mission.

Dr Mason: Yes, it sounds like, even with this work with Innovaccer, you're looking at tech and how tech can support the whole person.

Adrienne: That's right.

Dr Mason: From that holistic perspective. Well, that's exciting, absolutely. In that evolving tech industry, I would imagine your voice, this voice, would be extremely needed and critical because I would imagine some of our tech developers, in some of these companies, might not, necessarily, have a lens directed towards our vulnerable populations.

Adrienne: I think, Dr Mason, that that's probably one of the most important messages to get out, particularly, to those in healthcare. And those who have seen and understand the issues around health equity, because, as observers, they, oftentimes, have come from marginalized communities or high-risk communities. The importance of lifting our voices. Many times, individuals, we will kind of diffuse or mute our own voices because we don't think that we have the appropriate pedigree or information or insight to be at the table. And, actually, it's for that reason that I believe that some of the work around health equity has taken so long. We need to get loud in those voices and be clear. The reality is a conversation can be happening around tech or development or data and because the voice wasn't there to provide perspective on the realities of what's happening or how it works, when you miss those pieces of insight, what happens is, on the other end, you end up with poor outcomes. Example, just two weeks ago, there was United Health Care is being challenged, now, by the New

York Department of Health because the algorithms they developed have a racial bias in them. Healthier white patients were getting access to more resources than sicker black patients because from a data perspective, they blinded out race. What happens is when you're designing those algorithms, if you have people of color at the table, or people that have worked in high-risk communities, every concept, every assumption should be checked and balanced and analyzed in a thoughtful way, so, you say, ah, missed that. Let's see what we can do to incorporate. And, it's going to be so much more important, as we start to develop and depend on technology, in our healthcare, that we don't lose that this really, is about the human experience. We will evolve as a healthcare system when we truly incorporate all of those components. It's those voices, at every step of the table, that is going to make the difference.

Dr Mason: And, we have to be intentional about that. We have to be intentional about encouraging our fellow healthcare providers, at every level, our physicians, our nurses, our techs, our community advocates and our patients, to seek out ways to have their voices heard.

Adrienne: To seek out ways and also to question. It's okay to question because it is only through those questions that we all evolve. If there's an answer to the question, we've all learned. If there's not, it's a moment to pause and say why, and together, with diverse input, we can find new solutions. I just

did last night, or two nights ago, a session with the tech designers from Innovaccer with a group of seven social workers, because they had designed a component of the social work arm, of the product that links to the electronic health system, the electronic health record, and I said it was designed from a perspective of a social worker working in an inpatient setting, but, the reality is, social workers work in a variety of settings. So, we brought individuals into the room and said, and will this tool apply if the social worker is working with DCFS or there's a child with trauma who was referred by an educational system? Is this going to work from an FQ8C? Is this going to work on behalf of someone in the school system? The reality is all of those touchpoints impact the health of that child and that family and, if you're truly going to design a system, then, design the system around the realities of what happens in the world.

Dr Mason: Absolutely. So, that sounds to me to be another common thread in your work focusing on the patient-centered medical home. Explain to our listeners what that is, what that means, and why it requires focus because we're thinking about healthcare and in my mind, it should be patient centered. So, what is the concept of the patient-centered medical home and, maybe, highlight what the patient-centered primary care collaborative, how they're supporting this particular work? Tell us about that concept.

Adrienne: Yes, so, you know, healthcare is evolving in such a way and there's both the academic approach, which always tries to label what everything is and what concepts are so, you can always have a multitude of titles and labels around what activities are, when, indeed, you are trying to achieve patient-centered care. The patient-centered medical home was actually developed, conceptually, and it's being really looked at from across the world to address the fact that as healthcare evolved in the '70's and '80's and really, building from the '60's, that we actually got so excited about the technology and precision of medicine, particularly, towards specialized and tertiary care that we started to lose where is the center and where is the focus of the care. That it's about prevention through and maintaining wellness, which really is not about the point of diagnosis and treatment, but how do you take and work with an individual, and their family, throughout their life and prevent disease but, also, ensure if you treat a disease, ensure wellness and enhance life expectancy of all individuals. So, the thought about the patient-centered medical home was how do you design care with a broader lens, but, also, setup the reimbursement structure to not just support let's pay the tertiary individuals the most money and make the most expensive components of the care based on the treatment. But how do we actually invest in the longer and broader continuum because in the long run, your return on investment is going to be greater. So, what you've seen is an evolution of how individuals, organizations, chronic disease management, as well as, academic

medical centers and the teaching curriculum is changing to keep that broader lens. So, they've used the terminology of the patient-centered medical home meaning how do you put the patient first and think about all the touchpoints that they may need throughout a healthcare continuum and design healthcare systems and reimbursement and structures and insurance, etc., around the concept that ambulatory care must be woven into inpatient care, must be woven into community care. After that long explanation, I would just say, we're not there. We're not there, yet, but it is something to strive for and the focus of putting the patient first is what is the reminder for every conversation around the table. So, the Primary Care Collaborative, their changing their title. They were PCPCC. They're changing it to PCC, which is good. It is a program that I've been working, it's a group that I've been working with for about the past seven years that brings together primary care associations, American Academy of Family Medicine, ACP, American College of Physicians, OB/GYN, Peds, and the osteopathic community. As we try to work on what policies need to change in this country to continue to support the movement towards patient-centered care, not physician-driven care, not hospital health system driven care, not science driven care but, patient-centered care and that's the lens by which we all hope to continue.

Dr Mason: I'm actually very happy to hear that all of the primary care associations are coming together to look to focus in on and achieve that goal of putting the

patient first, especially, in light of everything being so reimbursement driven and like you said tech driven that the patients get lost and I think everything I've heard you say today, it really, focuses on that holistic approach to supporting the patient and their family and I like the lens of looking at achieving health equity through wellness, as well. So, Adrienne, today, you're leading one of our workshops, which explores how extensively your neighborhood affects your health. You live in Chicago and we know that there've been some reports in publications about how zip code affects your life expectancy. What do you hope to share with the conference attendees, today, along those lines?

Adrienne: Yeah, it's a very appropriate topic. Our panel today is actually titled, "*What's Good in the Hood*," and the realities are it is based off of the NYU Public Health and School of Medicine studies that showed up to a 30-year gap between zip code areas within single cities. So, for example, in the city of Chicago in the middle of the Loop in Streeterville neighborhood, the average life expectancy is 90.2 years. If you just go six miles south, actually, about a mile away from my home on the southside, the average life expectancy from those community members is 59.9. How in the same city, when you have this is not an issue of access, if you have seven academic medical centers and resources galore, how do you have a 30-year life expectancy gap, and that is what it's about when you think about redefining what is health. It is the exposure and experiences and access

to all resources. What's happening with education, the criminal justice system, etc. So, today's conversation is a general discussion about how are we engaging all necessary parties in the healthcare conversation and reminding individuals of the importance of getting out of our siloes, if we are healthcare professionals. We also, then, must be invested in the continuum of education. We must be invested in advocacy policy and social justice, etc., because all of our work will never be resolved if you stay just in the space waiting for the patient to come to you.

With that, then, we'll go into some best practice review of some of the technology that's being developed to actually connect resources, community-based resources to providers, to physicians, nurse practitioners, social workers, etc., so that we can start to eliminate some of the redundancy and guesswork. So, that when everyone encounters the patient person family, they actually can get a broader lens to resources to support them. So, it'll be a great conversation, but it will also be a reality check to remind individuals to take their lens not just from when they show up for their shift or their 9:00 to 5:00, but their lens, as a person, and bring that global experience journey perspective to their work, each and every day.

Dr Mason: That will allow each one of us to look at every patient, every colleague as a whole person, not just through our own lens. I really, love, well, full

disclosure, Adrienne is one of my mentors. So, we have a relationship going way back.

Adrienne: It's quite an honor.

Dr Mason: Yes, but every conversation I have with you just continues to be this inspiriting and you always push myself and, of course, my husband, Dr. Mason, to do more, be more and to be our best selves for the sake of our patients and our communities. So, I want to thank you for your time today and for your insights. In my mind, what I found most interesting was essentially, how your entire career has spawned from the inspiration from your parents and that's been a similar story for me. Both of my parents were avid mentors and always giving back to the community. So, I just love to hear that common thread. So, something else I learned about you today. Then, also, too, that patient first perspective and how that can be and should be the common thread between any tech innovations, reimbursement innovations, as we know it, CMS, as they are looking at reimbursement models, and that evolution. Then, also, too, redefining health and access to resources for the patient, the person and the family, through all of our organizations working in sync and in collaboration, not in our siloes. So, I think that's great. I'm hoping that our audience understands the importance of each and every one of those aspects from our conversation today. So, thank you very much.

Adrienne: My pleasure. I would just close to remind you and everyone, we've seen what we've seen for a reason. We've experienced our journeys for a reason, and it is, therefore, our obligation to take that insight and share it to figure out how it can help inform new solutions, and that responsibility lies with all of us.

Dr Mason: That's right. A solution-driven mission, right?

Adrienne: That's right. Thank you.

Dr Mason: Thank you, Adrienne. And, we would like to thank our listeners for joining us for the Health Disparities Podcast. Join us, again, at MovementIsLifeCaucus.com or you can subscribe to the podcast at iTunes, Google, Spotify, Stitcher, with new episodes being posted every two weeks. Lookout for our special series featuring our thought leaders from our partner organizations, as well, and until next time, from Dr. Bonnie Simpson Mason and Adrienne White Faines thank you so much.

Adrienne: My pleasure.

(End of Podcast)