Podcast Episode 33: Rural health disparities, and a checklist of solutions for addressing social determinants of health. Featuring Dr. Claire Pomeroy.

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Dr. Claire Pomeroy continues her discussion with Dr. Bonnie Simpson Mason, considering how extensive rural poverty underpins rural health disparities, and how these are being made worse by hospital closures. In designing and implementing policies, Dr. Pomeroy has a checklist of solutions that are implementable now, including the use of a social vulnerability index, screening for and integrating SDOH data into electronic medical records, linking to community resource directories, social assistance and reimbursement in payment models, and workforce diversity in the people providing healthcare. She also champions the idea of a Ryan White Act for conditions like diabetes. With Bonnie Simpson Mason.

Dr. Mason: Hello, once again, and welcome to our next episode of the Health Disparities podcast. 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 packed program of speakers and workshops at the annual Movement is Life Caucus. Today's podcast features Dr. Claire Pomeroy, who is the President and CEO of the Lasker Foundation in New York City. An infectious disease expert by training, Dr. Pomeroy held Professorships at the University of Minnesota, University of Kentucky and the University of California Davis, where she was also Dean of the School of Medicine. She is a long-time advocate for patients, especially those with

HIV and AIDS and in the public health arena. She has a special interest in Healthcare policy with a focus on the importance of the social determinants of health. Dr. Pomeroy, thank you so much for joining us today.

Dr. Pomeroy: Delighted to be with you.

Dr. Mason: Let's talk about another important point that you bring up is geography and its impact on health.

Dr. Pomeroy: There are huge disparities in our country on the basis of geography. People traditionally think that when we talk about geographic disparities, we're talking about urban disparities. Those are very real. There are also huge rural disparities and those different types of geographic disparities need to be addressed with different approaches. In the inner-city, we've already talked about, you know, many, many inner-city neighborhoods have more liquor stores than grocery stores, right? So, we also know that in the inner-city, a disproportionate number of hospitals are closing. They're making a business decision to close, and so we've even decreased the access to the clinical care piece of it. So, we have a lot of work to do there.

Sometimes more overlooked are the rural health disparities. Rural poverty runs very deep in this country. If you look at the parts of our country that have some of the lowest rates of education, family income, job opportunities, these are located in rural areas. We've just said, those are major drivers of health and look at where some of the worst indicators for chronic illness are. They are in rural communities. And then of course that's compounded by the fact that access to healthcare is particularly difficult in those settings, but, we need to make sure those people don't get lost, that we are talking about good school systems that we're talking about transportation. It can be very isolating in a rural area where there's no public transportation. Addressing rural disparities is a huge part of what we need to do in addressing the social determinants of health.

Now, one point I'd like to make is, that sounds like, well, everyone should just move to the suburbs, right? And social determinants have nothing to do with the suburbs. Not true. Look at how we build homes in the suburbs. We put the garages out front. So, we kind of turn our back to our neighbors. And we often take away the sidewalks and then we take kids to their soccer practice in the car, and they're not walking. They're not out working on the farm and those sorts of activities. So, no one should think that social determinants don't apply to all of us. They do apply to all of us. They disproportionately impact the poor and the vulnerable, but they need to be addressed for the good of all of us.

Dr. Mason: Absolutely. Well, I think that's a very important point that geographical lens to look through. Because I had not thought about it from the suburban perspective, but I live in the suburbs and we're going through a school redistricting issue, now. And they want to take some of the students from our neighborhood and move them to a neighborhood school where you have to drive to get there if the students are doing afterschool activities or not, and they're taking some of these. And so that means some of the students may not have access to afterschool activities because there's no bus route to take them home so they can't participate and stay after school cause they have to get on the actual school bus because there's no way to get home after school. So, we're not thinking about now the impact of their health and lack of access to additional activities, lack of community, how that will impact their feeling of community at this new school, where they're being bused to. I mean, you know, it, the parents need work and also be dependent on public transportation. If they can't get to the school for PTA meeting, then we have less engagement, right, and a lesser sense of community. So, this is, this is all overlapping here, Dr. Pomeroy.

Dr. Pomeroy: It's clearly all overlapping, it's clearly all complex, right? And we do need to understand that say we're redistricting for a good reason.

Dr. Mason: Sure.

Dr. Pomeroy: There are going to be unintended consequences that we have to understand, investigate and address. And in the example that you bring up, maybe they are addressable, but are they being addressed, right? That's the issue.

Dr. Mason: That is exactly the issue. And we are not so sure that the resources that are going to be used on the additional busing, right, meaning moving more students from A to B if they couldn't be best utilized in other areas.

Dr. Pomeroy: So, these are exactly the kind of discussions that we need to have that parents need to have that all the people in the community need to have. And so, we're asking all of them to think about health in that particular policy, right? So that's health in all policies, we all have to think about health in all policies.

Dr. Mason: And health from a holistic perspective, from the social determinants of health perspective. I hope everybody's getting this because this is like, this is good stuff, good information. So, I want to get a little bit more specific because you've done so much work in so many areas, you've thought through several processes. And so, we're talking about the solutions, but there's a question of not just designing it, but also implementing the solution in some key areas. So, I'd like to read off and then get your

response to some of these key areas and some of the suggested solutions that you've brought up in the past. So, we'll just go back and forth with this. Tell us about measuring a social vulnerability index and targeting high risk neighborhoods.

Dr. Pomeroy: When I went to medical school, no one taught me about trying to figure out the social determinants of health. I wasn't given a skillset. There were no classes on that.

Dr. Mason: Right.

Dr. Pomeroy: And when I started to be responsible for overseeing a hospital, no one told me how to figure out which communities need what and so, there are now, people starting to say as a health system, where do we want to direct our resources? If we are responsible for a whole population, which many of the new managed-care reimbursement systems make you responsible for a whole population, how do I figure out which neighborhoods that I serve need what kind of services to address the social determinants of health? So, some hospitals are calculating this social vulnerability index for their communities to sort out which communities they should put their facilities in, offer their special services for so that the whole population gets healthier. We can extend that from

the community-level down to the personal level, and we need to be screening every single individual for social determinants of health.

Dr. Mason: Well, that brings me to my next subject. So then, how do we integrate that into electronic health records and then help our developers understand why that's important and have them not turn around and charge the physician for the upgrade in the operating system, which is a particular pet peeve of mine?

Dr. Pomeroy: So, the electronic medical record, even though it's been a bit of a bumpy rollout for many physicians and they chafe against the electronic medical record, I believe that the electronic medical record can be an opportunity to get data that we didn't have before. And we are beginning to develop tools that can be modules in an electronic medical record that asks people about their housing, that asks people about whether there's violence in their life, that asks them if they have enough money to buy food, that asks them about transportation. These have been piloted in hospitals and clinics across the country from Boston to the OCHIN system. And you know what they work. The other amazing thing is that when you have those systems in the electronic medical record and they get used, they give you some pretty, amazing data.

Dr. Mason: Sure.

Dr. Pomeroy: In one of the reports, from a system of community health clinics, they found that three quarters of people had food insecurity at the end of the month. Half of them didn't have access to transportation to get to the places that they needed to get to. So, I think that that can be put into the electronic medical record. Now, how do we make this good for physicians? You as a physician want your patient to be healthier.

Dr. Mason: Absolutely.

Dr. Pomeroy: Physicians are, you know, that's why they work so hard. They want their patients to get healthier, but we often don't know, where is the food bank? Where is the transportation, you know, support system? And so, the electronic medical record could actually incorporate a list of resources that popped up just like the electronic medical record, now, if you order penicillin for someone with an allergy it pops up and it says, “Don’t do that,” right? Use this drug instead. What if it popped up and said, “Hey, did you know, that the food bank downtown can help your patient? Just push this button and we will reach out to them.” And so, I think that this could actually, in a very time efficient way, help physicians get the services to their patients that will address the social determinants of health. So again, this is another example where we have screening techniques, we have electronic medical record modules that we could use. It's a matter of

deciding to do it. We need to get done with demonstration projects. It was interesting, I was talking to one of the major vendors of electronic medical records systems and she told me that she is able to, she has a social determinant assessment model module for her electronic medical record, she says she's able to sell it quite easily in Europe. The health systems in the United States have not been as interested. And that goes back to the incentives that we were talking about earlier.

Dr. Mason: Exactly. Well, so, I'll have to have you speak with my husband, who is the Chief Medical Officer at the Office of the National Coordinator, who's working with all of the electronic health workers companies, but also with CMS and within the Department of Health and Human services. Dr. Thomas Mason, that's a plug, but you know, he by the nature of his practice in primary care at Cook County Hospital in Chicago, way back when we met, I mean, he's a number one proponent of this. So, I'm sure he would love to hear about the work that you're doing with Lasker, but also that integral component. I'm sure he's thought about it, but I'm sure he has with these systems

Dr. Pomeroy: I am sure he has too. He was smart enough to get married to you. I'm sure he's thought about this.

Dr. Mason: Hey my new friend, my new friend. No, that's really good. So, it sounds like the integration of the community resource directory is something you're referring to.

Dr. Pomeroy: Yeah. And, I do want to point out that, CMS, since they've created the accountable community approach actually developed a screening tool to be used. So, the government is stepping up and saying, we have a screening tool that we want you to use. So, I think this is getting picked up by more and more people, more and more organizations. One of the resistance points to gathering data about social determinants is the trust in how it will be used and the protections and the privacy. And understandably because we've been talking about a lot of vulnerable communities, and so we're already starting out at a trust deficit with the healthcare system.

Dr. Mason: Yes

Dr. Pomeroy: And I think that as we adopt these models, it's very important to make sure that we know how the data will be protected, who will have access to it. And we have HIPAA laws for a reason and there are private businesses getting into the social determinants of health area. And so, we just have to make sure that our approaches are protective of the patients, their data and their information

Dr. Mason: And inclusive of data being gathered from the most vulnerable populations with the recent algorithm. Oh, which company was it that's now been noted with their algorithm worsening the disparities for their African American patients.

Dr. Pomeroy: Right. Because they said that because African American patients had received less financial support for their clinical care in the past that they use that to predict.

Dr. Mason: Exactly.

Dr. Pomeroy: And so, any time you have data, you have to make sure that all our unconscious biases, all our conscious biases, don't allow it to be used in ways that will hurt rather than help the people that it's designed for.

Dr. Mason: Yeah, no, absolutely. So, just a couple other items, and then we'll wrap up and I just, I'm really relieved to hear that we're making some progress on this conversation at a national level, with both electronic health records vendors, but also at the level of CMS. So, this is a great conversation. So, I'm feeling better. This is great Dr. Pomeroy, but I'm curious to learn about the social assistance component that may be, or possibly could be added

to payment models. Tell us a little bit about that because that is just is very curious to me.

Dr. Pomeroy: So, health equity should be about giving people what they need, not making sure that everyone gets exactly the same thing.

Dr. Mason: Exactly.

Dr. Pomeroy: And if you are caring for vulnerable populations that have traditionally been discriminated against, haven't received the support that they need, at least in the beginning, they are going to be more expensive right? And so, what we want to do is make sure that our reimbursement systems, don't incentivize doctors and hospitals to cherry pick people who don't have social determinants of health, but rather incentivize them and give them the resources that they need to take care of the social determinants of health. And that may mean saying that people who have a large number of social determinants, that you have higher reimbursement rates or reimbursement rates that cover the full range of services that they need to get to a point of health equity.

One example of this that I learned early in my career, because I'm an HIV doc. I trained as an infectious disease physician and I took care of HIV patients and I'm old enough to know that when I first started taking care of

HIV patients, the stigma and the discrimination put them at great risk and the Ryan White Act was a phenomenal thing in our country, which provided wraparound services for HIV patients. It was one of the first recognitions that if we were going to adequately tackle something like the HIV epidemic that we needed to provide food and transportation, as well as treat their pneumonias and give them drugs.

So, I looked at my patients and I was able to prescribe those things upfront. It probably cost more money to give them transportation services and food, but if it prevented a hospitalization, it saved a lot of money, right? So, we have to change our reimbursement systems, so that we make sure those patients with greater needs, like my HIV patients at that time, have reimbursement, in this case, the Ryan White Act that allows us to get them the services that they need. Now, I have had many doctors come up to me and say, I wish there had been a Ryan White Act for my diabetes patients, so that I could give them healthier food and transportation and social support. Why can't we do that for every patient?

Dr. Mason: Exactly, exactly. And what I'm also hearing is that I'm hearing an opportunity for an infusion of the social determinants of health into how we educate our healthcare teams, right? Not just our physicians, but our teams overall, so that we're looking at this. So, this is another upstream intervention, right? So, I'm all on board, Dr. Pomeroy. So, then we're

infusing this at the undergraduate medical education level, at the GME level and reinforcing it with our faculty, saying, no, instead of looking at this patient, this patient doesn't have insurance. So that patient won't get this treatment. This is in an academic center. Then we're teaching that to our residents that we're actually flipping the paradigm, such that the social determinants of health become a driver of our education. And then that can play out in the larger healthcare community as well.

Dr. Pomeroy: And as you well know there was an important National Academy of Medicine study that called on us to incorporate the social determinants into the curriculum of all of the health professionals. And we do need to look at in our case, the medical school curriculum, but all of the health professions curriculum, and see if they're teaching about things like adverse childhood experiences and the long-term health impacts of that, if they're teaching about how do you identify the resources that these people need. But I would take it one step further. It's not adequate to just put that into the curriculum. We also have to look at who we're training. I believe more difficult for people who have never experienced adverse social determinants of health to truly connect with their patients. And so, when I look at medicine and I see that 50% of our medical students come from the top quintile of family income, I think it's going to be difficult for many of them to connect with the patients that we're talking about now. And I realized that they're only 227 black men who are African American

descendants of slaves out of 21,000 medical students right now, I think it's going to be difficult for us as a profession to connect with the patients that we need. So, we need to look at what education we're delivering. We need to look at who we're delivering it to.

Dr. Mason: Well, and we know when we have a diverse and inclusive learning environment that everyone benefits. So, to your exact point, if you have more students, residents, trainees from diverse backgrounds, then there's a cross education, there's a communication bridge that's built. And then we get a sensitivity there that happens innately in addition to the curriculum. So, I think that overlay is huge. My professional life stems around physician/workforce diversity and driving that entire arm of DE&I. So, you know, I think you're, you hit the nail on the head that that's yet another bung that we need to be more inclusive around making sure that we are driving the pipeline of physicians who are diverse, not just recruiting them, but retaining them because we know that attrition for these populations is significant. But I think that's also too, because there's a lack of awareness and support about what diverse student populations may need. Not that it's wrong or should be judged. It's to create that equitable, safe, and equitable learning.

Dr. Pomeroy: So, we know that diverse teams make better decisions. Lots of social science research that shows that. And we also know that, you

know, we cannot solve this exclusively at the medical student level. As you stated, we have to make sure that we move folks from all backgrounds into leadership positions, because they are the ones that inspire institutional culture. They're the ones that inspire the change that we need. And if I could just give you one example, there has been a coming together of some healthcare organizations to also say we have a responsibility to our community. So, once you get those people in leadership positions, they can say, where are we giving our contracts to? Okay, are they women in minority-owned businesses? Are they local businesses? You know, who are we hiring as employees, you know, are they from our community? So, I think that getting people into leadership positions so that we make different kinds of decisions will be critical to doing what you and I have been talking about, which is changing our healthcare systems to start truly thinking about health. And that means addressing social determinants.

Dr. Mason: Well, Dr. Pomeroy, it sounds like you and I could talk all day about these concepts. But I really would like to just summarize and appreciate your sharing some of these key elements with us. Number one, starting out earlier in our conversation that really only 10% of our health status is determined by the healthcare that we receive in a physician's office at the hospital, and urgent care center that the social determinants of health comprise the majority of that 90%. I hope that's an aha moment for many

of us in the audience, because that was huge. I really do see the future of solving our healthcare crisis in the US as being collaborative.

The point you made about intersectional collaboration is key. That's what we're doing here, at the Movement is Life Caucus, having this multidisciplinary approach and conversation to discussing healthcare disparities, race, and racism, and how it affects our, not just health equity, but our most vulnerable populations. You know, the health in all policies approach, looking at every policy that's made through a health lens. We talked yesterday, we were on Capitol Hill listening to how some of the value-based care decisions and regulations have actually exacerbated healthcare disparities, and we have not achieved health equity, but we widened the gap. So, I think that's a critical component that I'm sure with leaders such as yourself sounding the alarm on making sure we're using that health lens to influence policy and regulation at the local, state and federal levels. And that's the key to being successful. So, thank you so much for your time, Dr. Pomeroy. We squeezed every ounce out of you that we could. Thank you so much for being here.

Dr. Pomeroy: It was just fun. And it's an important message. So, thank you for sharing it.

Dr. Mason: Absolutely. So, thank you again for joining us for the health disparities podcast. You can follow us at movementislifecaucus.com and all leading podcast services. For more conversations around health disparities, with people who are working to eliminate them. These are the people who are passionate and we're happy to spend time with them and sharing them with you. I am Dr. Bonnie Simpson Mason, see you next time.

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