

Healthcare hurdles: Exploring disparities and solutions for underserved communities

For too many people in the U.S., health care is *unaffordable* and not accessible. Even patients who have health insurance coverage can be confronted with barriers that keep them from accessing the health care that they need.

And research shows health disparities are rampant, with health care access — and outcomes — worse for people of color and other marginalized groups.

The new [State of Patient Access](#) report from the [PAN Foundation](#) breaks down these disparities and highlights next steps for creating more equitable access to care.

“Our goal with the project was really to understand the challenges that adults living with chronic conditions every single day face accessing the care they need,” says [Amy Niles](#), the PAN Foundation’s health policy expert and Chief Mission Officer. “More importantly, our goal was to understand what disparities exist, and there were some significant disparities between various groups and communities.”

To learn more about the report, and what can be done to help overcome barriers to care for underserved communities, Health Disparities podcast host Dr. Ramon Jimenez spoke with Niles, along with [Adrianna Nava](#), president of the [National Association of Hispanic Nurses](#).

The transcript from today’s episode has been lightly edited for clarity.

Adrianna Nava: Once an individual is able to enroll or be enrolled in a health insurance plan, for example, being able to then have a provider that’s, you know, automatically assigned given where you’re at. We know that there’s not necessarily enough providers. So being able to have that initial assignment might reduce the burden of an individual having to navigate the healthcare system when they’re not familiar with that. So that could help with individuals accessing their provider more readily than having to do it on their own and kind of navigating it through a computer or making sure that they even have, you know, access to broadband or a computer to begin with, and being able to have the literacy to use technology might be reduced in terms of a barrier.

Dr. Ramon Jimenez: You’re listening to the Health Disparities podcast – from Movement Is Life.

I'm Dr. Ramon Jimenez – a Board member at Movement is Life, and Treasurer of this nonprofit organization. For too many people in the U.S., health care is unaffordable and not accessible. Even patients who have health insurance coverage can be confronted with barriers that keep them from accessing the health care that they need. And when you look at the data – disparities are rampant. Health care access – and outcomes — are worse for people of color and other marginalized groups.

A new report from the PAN Foundation breaks down these disparities and highlights next steps for creating more equitable access to care. To learn more, I'm joined now by the PAN Foundation's health policy expert and Chief Mission Officer – Amy Niles. Welcome to the Health Disparities podcast!

Amy Niles: Thank you so much. I'm glad to be here.

Jimenez: You're welcome. In addition, I'm also joined by Adrianna Nava – president of the National Association of Hispanic Nurses, which is an advocate for increasing access to care for underserved populations, non or at a genetic works to help people from communities have access to affordable, equitable health care. Adrianna, welcome to you as well!

Nava: Thank you so much.

Jimenez: So for particulars and more resources, you'll find at the end of the footnotes of this podcast, resource materials who you can go to about PAN Foundation's work. So Amy, I have some questions. Let's talk about the new report. The PAN Foundation worked with the Harris Poll to survey about 2,500 adults, which is a diverse populations across the country. What was your aim? What were you hoping to find out?

Niles: Yeah, thanks for your interest in the State of Patient Access report. This was a critical initiative under the auspices of PAN's newly developed center for patient research. And our goal with the project was really to understand the challenges that adults living with chronic conditions every single day face accessing the care they need. More importantly, our goal was to understand what disparities exist, and there were some significant disparities between various groups and communities. So you're right, we surveyed 2,500 individuals living with chronic conditions. On average, they had, individuals had about four chronic conditions, and we ensured that our population was diverse so that we would be able to compare findings.

And just a little bit about the report: we created a scorecard, which aggregated patient's responses to questions in five different areas using a pretty rigorous methodology. And

the questions were grouped into five categories overall access to care, relationship with health care providers, affordability of prescription medications, access to treatment through health care plans, and financial toxicity. And when we look at the overall study, patients across the country gave access to care, a grade C, which, in my opinion, is not very good. Wasn't terribly surprising, either. But when we dove into the various groups and communities that we surveyed, we found a lot of disparities and those grades often were much lower or even failing grades.

Jimenez: You know, I, I was surprised also to see in your report, it was very clearly demonstrated in that graphic that you had that nearly 1/3 of the people experienced a barrier when it comes to receiving health care. What kinds of health care disparities did you find when it comes to overall access?

Niles: There were a lot of them, and I'll go through some of them, but your listeners can read the report and in a whole lot more detail. But yes, there were challenges. In terms of accessing the care patients needed this could be in terms of getting appointments, or being able to afford their treatments or restrictions that were put on them by their health care plans. We found that overall, patients do trust their health care providers, but one in three indicated that there were certain circumstances that didn't create optimal and optimal effective partnership. And so they thought that, for example, that providers often don't take their concerns seriously, or they're critical of their lifestyle habits. One of our dimensions, which was access to, through health care plans got the worst grades. And, you know, overall, adults rated this dimension D-minus certain groups, like Hispanic patients gave this dimension a failing grade.

And we hear this all the time, there are tremendous health care planning challenges, medications are not covered on formularies, high out of pocket costs, high deductibles, and prior auth. Challenges getting the prior authorizations before proceeding. So a lot of disparities and you know, there's no shortage of issues faced by adults throughout the country accessing the care that's been prescribed by their health care professionals and care that they need.

Jimenez: Yes, you know, as, as a treating orthopedic surgeon, when I would write prescriptions for certain patients, I would just be mindful of the fact that they may go out and not even have the prescription filled because of a lack of resources to do so or they may have may get the prescription filled somewhat, but then take half the dose in order to make it last longer, and things like that which directly impact the effects of treatment and, and leads to more disparities, if you would, just by itself.

Niles: And that's exactly what we found in the report. That dimension that looked at prescription medications, overall, adults gave it a B-minus, but Hispanic patients, those identifying as LGBTQ gave it much lower grades. And some of the statistics were really disturbing to me, but again, not terribly surprising. One in five adults said that their medications were just not affordable, overwhelming majority of patients who thought that took some action. And those actions were: one in two decided not to fill their prescription, that's a high percentage; a third chose to go back to their health care provider to find a more affordable treatment, a third decided to ration their treatment, make the prescription last longer. And a quarter simply chose not to just stop taking their medication. And all these actions, as reported by the adults really had significant impact on their physical and mental health.

Jimenez: Sure, you know, some of our listeners may wonder about the fact that they could say that Hispanics, Native Americans may come from underserved areas, underserved communities, etc. But why does LGBTQ patients fall in that category?

Niles: You know, I think they feel disenfranchised. And you know, we saw it in the the questions relating to effective partnerships with their health care providers. There are many reasons and I'm probably not going to do this question justice. But I do feel that people in the LGBTQ community are concerned about the conversations that they're having with their their health care providers that they may not be taken seriously or they're being judged in terms of their lifestyle habits.

Jimenez: Another potential reason, may be true or not, is that maybe their partners are not recognized in, in drug coverage and in health care coverage, like the traditional heterosexuals. Adrianna, the National Association of Hispanic Nurses advocated for improvements to the healthcare system and access to care. Did any of the findings that have been articulated so far surprise you? And why or why not?

Nava: Yes, when I first read the report, I wasn't too surprised that there was dissatisfaction generally with accessibility and paying for medications. It was interesting that the Latino population did see and did, you know, note that there were additional challenges. But I think, you know, being focused on underserved populations, sometimes we don't give as much attention to individuals that are not necessarily those at the greatest need. But yet this report highlighted that even individuals who are insured are still having challenges paying for prescriptions, and how do we reach and address the needs of individuals that are also not necessarily always in the limelight of getting some advocacy, but also making sure that we address their needs as well from a health insurance or even access standpoint.

And one of the things I also thought was really interesting in this report was individuals feeling that some aspect of their identity would lead to less quality care or not being able to find that, you know, high quality care that they deserve. So, you know, even from us from a workforce standpoint, how do we better integrate, you know, trust and build that trust, so individuals feel safe to be their true, authentic selves and come to a place where they're going to receive high quality care?

Jimenez: Great. You know, it's easy to get bogged down in the numbers and forget that behind all the numbers are real people who cannot access healthcare and who suffer because of that. Are there any stories of patients that you can share about what this looks like on a very personal level in the Hispanic community?

Nava: Sure. So with our organization, I just want to provide a little bit of context. So we have over 40 chapters across the country within 24 states. And a lot of the work that our nurses do is they're volunteers within their community. So they're often hosting health fairs, providing information that's bilingual to patients that don't necessarily have access to care or may not have access to resources in their preferred language, such as an in Spanish. So oftentimes, we hear about individuals, not necessarily trusting going to a healthcare provider. So that might be one reason, but also the fact that a lot of them don't have access to care, especially if they're within a state that did not expand Medicaid. So then they're left in the coverage gap. So as an organization, we've been really focused on elevating the needs of, you know, increasing access to care, especially Medicaid expansion through our Hispanic Health Policy summit that we hold once a year.

So that has been some of the work that we've been doing. But even within our own membership, we do have nurses and students who are DACA recipients. So the recent move to have DACA individuals eligible for health insurance through an exchange was really helpful for this population, especially as they continue their education, making sure that they have access to care is really important.

Jimenez: Oh, great, you know, educate me a little bit more. As you were speaking, it made me wonder, does the National Association of Hispanic Nurses, do you collaborate with community health care workers, Promotoras?

Nava: So we don't have a formal national partnership at this point. But that's a very great idea for us to get in contact with. But at the local chapter level, our chapter leaders do a great job working locally with different partners to ensure that they're able to, you know, share resources, and expand their outreach to the Latino community, but even you know, others in their community that they serve.

Jimenez: Just as a note, I know that Texas is very much involved with Promotoras. And there's a, at San Francisco State College, there is a, I think it's a year course that they take for granted intermediate CHW or Promotoras, which was a lot of interest to me when I saw it. So, Amy, can we talk about why it's important to collect this kind of data and follow it year after year? In other words, I understand the first report is going to serve like a baseline.

Niles: Exactly. You know, it's while the data was not I got wonderful data to hear, I think, regardless, it's good to have this data because it does serve as a baseline. For for us at PAN, and I'm sure it's the same for NAHN and other groups, it really provides us with a roadmap, if you will, for the kinds of policy solutions we advocate for, and even the, you know, the education that may be needed by patients and providers. And it also encourages, I think, all of us to form those kinds of partnerships that you were just talking about, to better serve our patients. So we are going to conduct this survey year over a year, we're going out this August with our second poll. And you know, really, the goal is, are we moving the needle? Are we making a difference to improve access to care? Or are we not? And what can we do about it? And that's really the goal of this report?

Jimenez: Right, yeah, we need to find out, we're just spinning our wheels, right?

Niles: Hopefully not, hopefully not.

Jimenez: Adrianna, it can be very discouraging to learn about these kinds of health disparities, especially when they seem to be persistent. So talking about solutions, what does it take to address these health disparities, in particular for the Hispanic community?

Nava: So, what we've really been focused on at NAHN has been looking at increasing the pipeline of Latinos interested in the healthcare workforce and careers in the healthcare workforce, and even seeking leadership roles within their local community in order to be in places where they can make decisions about what's going on in the affairs of their local community, but also achieving higher levels of leadership as well within their organizations, and even at the state and national level. So we've been able to provide scholarships and mentoring to students who are interested in nursing and even nurses themselves, who are interested in that leadership development. We've also been focusing on making sure that we're getting a better, you know, doing a better job of translating some of our health documents. So any partners that we have when we're out in the community, making sure information is available in English and in Spanish.

And we've also been focused on addressing some of the misinformation that is really targeted towards Latinos, we saw during the COVID pandemic, a lot of the information in Spanish tended to be not accurate, and especially many Latinos tend to take a lot of information and through social media, so making sure that as an organization, we're able to meet our Latino population, where they're at in terms of where they're getting their information, but making sure that it's accurate, and represented by nursing professionals, which we know that nurses are a highly trusted profession within the US. So making sure that we can leverage that to make sure that information is accurate. And our community has a place where that they can go for trusted information.

Jimenez: Right. So this is directed to the "A.N." sisters. And when I say that, I mean Amy Niles and Adrianna Nava, so both of you. So in light of these findings, what's your message to policymakers? What changes do you feel are necessary at the policy level to move the needle on these health disparities?

Niles: You know, first and foremost, is making sure that any policy that is put forth or piece of legislation is truly patient centric, and is designed with the patients in mind. And I think all too often we find that the patient voices is simply not heard or patients are not, you know, at the table, as pieces of legislation are put together. So I think that is critically important. One of the reasons why PAN has an annual Hill day and NAHN has their Hill day to make sure we can bring these important voices to our elected officials. So that's at the very broad level. I think there are specific things that kind of came out through the State of Patient Access report that will help many patients, regardless of groups and communities. One is, we heard loud and clear through the report concerns around prior authorization and the tremendous delays and treatment that causes for everyone. And we know that Congress is very interested and intends to introduce legislation that will streamline the prior authorization process that will be a step in the right direction. Secondly, we know come January 1, there are important Medicare reforms that will significantly lower out of pocket costs for prescription medications for people on Medicare. That's great. But what about everyone else? Especially people, you know, on the exchanges, people who are commercially insured, they need that kind of relief as well. And so I'm, we're hoping that Congress can move in that direction.

Jimenez: Do you find that it's necessary sometimes to educate, clarify, either the Congress persons or their health, health policy advocate in our office, that the difference, the real difference between diversity and disparities? In other words, I think they get hung up sometimes, especially in this anti-DEI attitude or notions that are going on now, that's what are disparities? And do you find that it's necessary to clarify that?

Niles: I find that it's necessary to have conversations, just to introduce the notion to them and to discuss the disparities. When I'm on the Hill, I'm mostly speaking with staffers and not their elected officials. And oftentimes, the staffers themselves need a lot of education. This is not a criticism, they just need a lot of education around the particular health issues. And often, we simply don't get into the very important conversations around diversity and disparity, which is unfortunate. It needs to happen more. Adrianna, I don't know if you have anything to add?

Nava: Sure. And I think the challenge historically has also been and I know, Amy touched on this earlier about the need to collect accurate data. And for a long time, we weren't able to necessarily because it wasn't reported, or we didn't have the infrastructure in place to be able to collect the data at, for example, the level of race and ethnicity. And now with the recent changes in OMB to, you know, categorizing Hispanics, for example, under race that should help with collecting more accurate data, but there might be still opportunities for improving the way we identify specific groups or who's missing from that list. And then what do we do with that data once we're able to capture it, and then linking it back to like our quality indicators that we have in place as well.

Jimenez: I can only second what you're, you're both saying and you in particular Amy, about when you visit Congress is that even though I knew four or five more of our Congress, people here in California on their first name basis, I have a personal basis, also, I found that their staff, even their health care staff, really needed and really welcome education. They could then be the conduit to educate their member, if you would. And so I think that that's very important work when we when we go visit Congress. Adrianna, on the on the ground level at the clinical level, what kinds of changes are needed need to happen?

Nava: So we've noticed more recently now because there's been more quality measures that are focused on addressing the social determinants of health. We've been noticing a lot more systems and healthcare providers, asking patients about what their social needs are, because we know that your health is impacted by where you live, where your climate that you're surrounded by all these non clinical factors that impact your health. So being able to accurately capture that information and then link individuals to resources in their local community in a timely manner, is really important. And we've been seeing a move from, you know, the systems and even from healthcare providers in addressing individuals' social determinants of health.

Jimenez: Adrianna, in the Hispanic community that remains uninsured. There's been some talk about insurance enrollment, making it automated, what difference would that make?

Nava: There's already a lot of challenges to, you know, even just knowing where to go. So once an individual is able to enroll, or be enrolled in, in a health insurance plan, for example, being able to then have a provider that's, you know, automatically assigned, given where you're at, we know that there's not necessarily enough providers. So being able to have that initial assignment might reduce the burden of an individual having to navigate the healthcare system when they're not familiar with that. So that could help with individuals accessing their provider more readily than having to do it on their own and kind of navigating it through, you know, a computer or making sure that they even have, you know, access to broadband or a computer to begin with, and being able to have the literacy to use technology might be reduced in terms of a barrier if we're able to automatically enroll individuals.

Jimenez: This will be the last, sort of last question. So are there any bright spots that you share when it comes to addressing health, health disparities in communities of color, and other underserved groups? Are there clinics or hospitals have started to do some of the things you mentioned, like screening for social determinants? And on the other hand, are there any states that are considering considering automated enrollment into insurance plans?

Niles: You know, I don't, I don't want to end on a negative note, because there were lots of not so great data in the State of Patient Access. But if I step back and think broadly about where we've come, I do think that there's some bright spots. I think, overall, we are, the patient voice is being elevated. I think all of us in the the patient advocacy community, the professional community are working really hard to make sure the patients are seen heard listened to and that they feel empowered. You know, we we're doing all we can at the federal and state level on on policy to improve access. I think while we have a long way to go, there's tremendous interest in lowering prescription drug costs in this country. So again, many more steps to be taken. But we've Congress has taken some some important steps over the last few years.

I think there's growing interest in diversity and clinical trials. We haven't talked about that. But again, here too, a long way to go to build the trust within diverse communities. But it's really important and I think all of us are committed to to seeing that happen. Adrianna talked about social drivers of health, I think we're doing a better job. But yet there are, there's so much more to do. And I think it's it's difficult for the healthcare provider community, especially physicians to define the time within a 10 minute visit to

ask all the right questions of the patient. So we have to find ways to do a better job of supporting those patients. And then finally, I would say that we I think we're all trying to invest more in community work. You talked about community health workers earlier, but you know, health is is at the local level. And I know hospitals, I know NAHN and even the PAN Foundation, we are investing in communities to learn more to listen to the community to understand why they're having challenges accessing the care they need, and to figure out local solutions. We've been in metro Atlanta, we're moving to Dallas soon and hope to move to other communities as well.

Jimenez: Great. Let me just comment briefly on what you just said, Amy, and I really appreciate your remarks. Is that the American Association of Latino Orthopedic Surgeons, you know, we're, we're really pushing to try to get more orthopedic surgeons who, who are racial racially or ethnic concordant with with the exploding Latino population if you would, and but there is a big disparity gap. There's only at best 6% of orthopedic surgeons and 33,000 orthopedic surgeons are Hispanic Latino, where the population is up to about 20% and will be a 25% by another 10 years for sure. And, and so, what we've decided to do is to really have to include those physicians, primary care providers, orthopedic surgeons, etc, who, who are not Latino to and who serve as medical Latino communities so that they present a venue and their office if you would, that is Hispanic Latino friendly. I mean, that doesn't mean you gotta have serapes and sombreros in your in your waiting room but it means that if you have a receptionist, who's bilingual, medical assistants or whatever, patients will really accept that and feel more comfortable being able to explain what's going on with them. Because we all know, as providers that that history, the history you get from the patient leads to a better diagnosis and better treatment. So thank you for allowing me to go on my little harangue there for a minute or so. Adrianna?

Nava: No, I think that really resonated with me, Dr. Jimenez, especially you know, talking about the need to increase the number of Latino providers and even for nursing as a profession, we have 5 million nurses and but less than 10% are Hispanic. So we've been working a lot to increase that pipeline. And one of the bright spots that I would like to go back to is that we have seen that over the course of time that Latino Americans are continuing to increase the number of degrees that they're obtaining. So I think that's helpful in terms of their family being able to make better, you know, healthier choices or health behaviors for their families. But even professionally, we've noticed when we focus on self advocacy of not only ourselves in our family, but of those in our community, we tend to be able to increase our efforts to reduce health disparities. And even at the National Association of Hispanic Nurses, we've been really focused on being advocates for our community. And with this new lens that we've been bringing to our work, we've noticed a 53% increase in our membership over the last three years. So we've noticed

that we're gaining a voice professionally as nurses that are Latinos, but also more visibility in the larger community to address some of the pressing issues that our Latino families face every day. So happy to share that.

Jimenez: Great, you know, we held a surgical skills session for high schoolers. I happen to chair a board that owns three charter high schools in California, in San Jose 95 percent are Hispanic or Latino. And we encourage them, we hold the surgical skills so that, not so they can become orthopedic surgeons, but just to kind of stimulate their juices to, you know, to enter the health sciences as physical therapist assistants, medical assistants, nursing, community health care workers, etc. We really need that if we're going to provide the best care for our patients. Just one last one last question. Could either of you name any states that are considering automated enrollment into insurance plans?

Niles: I'm not familiar, but I do know this is maybe somewhat related when it comes to the Extra Help Program, which is a it's a federal program for low income individuals, you are auto enrolled into that program, which means you you'll probably pay no out of pocket costs for your prescription medications, or virtually none, but you're auto auto enrolled if you have both Medicare and Medicaid, so it's a little bit different. But I agree that sometimes having that auto enrollment opportunity goes a long way to improving access to care.

Jimenez: You can learn more about PAN Foundation's State of Patient Access report at the link, which is at the end of our show notes. And so coming to the end of another episode of the Health Disparities podcast from Movement Is Life. I'd like to thank my guest Amy Niles and Adrianna Nava. Thank you very much for being with us. You really have educated us, elucidated some issues for us and hopefully, move the needle so if you'd like to hear If you like what you hear, be sure to subscribe wherever, wherever you get your podcasts and take a moment to leave us a rating. It does make a difference.

And mark your calendar for our upcoming annual summit of Movement is Life. This year we have a change of venue in Washington, D.C., to Atlanta, Georgia. And so on Thursday, November 14 and Friday, November 15. We'll be at the Whitley Hotel, which is the Buckhead area in Atlanta. Please go to our website for more information and to register. I'm Dr. Ramon Jimenez, and until next time, be safe and be well.