Hospitals & Health Equity: The importance of understanding patients' cultural backgrounds in healthcare

Every person brings their own cultural background into their encounters with the healthcare system.

But this doesn't mean that every healthcare provider needs to develop an encyclopedic knowledge of every culture in order to provide equitable, high-quality care to every patient.

"The truth of matter is: that could never be done, because every Latino patient. I'm Puerto Rican, Latino, and even among Puerto Ricans, there's a great difference in lived experience, exposure to health care and the like," says Dr. Joseph Betancourt, president of the Commonwealth Fund.

But there will be times when a person's cultural background affects their ability to access the health care they need. In those cases, Betancourt says it's important that providers be equipped with the right tools and resources to assess how those cultural factors may come into play.

Health Disparities podcast host Dr. Mary O'Connor speaks with Betancourt about the importance of culturally competent care — what it is, and what it's not. They also discuss the need for ongoing provider training to address cultural differences and structural barriers, and share about recent developments in health policy and health care that give them hope.

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

Dr. Joseph Betancourt: We need to fundamentally shift our thinking, to say every patient is an individual, one. Two, every patient brings their own culture to the encounter. Three, sometimes that may matter and sometimes it might not. And four, if I'm detecting that it might, then what are the series of questions that I'm going to ask to better assess how those cultural factors are going to play into our communication?

Dr. Mary O'Connor: You're listening to the Health Disparities podcast for Movement Is Life. I'm Dr. Mary O'Connor, Chair of the Board of Movement Is Life and cofounder and Chief Medical Officer at Vori Health.

Hospitals and health systems can play a big role in addressing healthcare disparities in our nation. And it's the focus of our latest podcast series. And today, we're going to talk about the topic of culturally competent care and the difference it can make in improving outcomes for patients and ultimately, in advancing health equity.

I am excited to welcome Dr. Joseph Betancourt as our guest today -- a friend of Movement Is Life and past speaker at our annual summit. Dr. Betancourt is the president of The Commonwealth Fund. The mission of The Commonwealth Fund is to promote a high-performing, equitable health care system that achieves better access, improved quality and greater efficiency, particularly for society's most vulnerable, including people of color, people with low income and those who are uninsured. He formerly served as the Senior Vice President for equity and community health at Massachusetts General Hospital. And as founding director of the Disparities Solutions Center. He's also an associate professor of medicine at Harvard Medical School. And he joins us now to talk about culturally competent care: what it is, what it's not, and why it's important for moving the needle on addressing health disparities. Dr. Betancourt, welcome to the Health Disparities podcast. Thank you so much for being here.

Betancourt: And thank you so much. My pleasure to be here with you and look forward to this conversation.

O'Connor: Great. All right. So let's start off with maybe some definitions. I think many, if not all, people who work in health care have at least heard of them, like culturally competent care. And, how do you define that?

Betancourt: You know, Mary, I think ultimately, what this boils down to is: every health care professional, every caregiver, and I'm one of them, I'm still a practicing primary care doctor, needs to have the skills, tools and abilities to care for anyone from anywhere at any time. So what does that mean? That certainly and absolutely means clinical competence. clinical competence, it is having a baseline set of skills for you to be able to execute on your healthcare and clinical responsibilities in a way that will promote the health and health care and well being of your patients. We call that clinical competence. We're tested on clinical competence in our boards, during medical school, during residency.

When we think about this concept of cultural competence, fundamentally, what we're saying is that in every care situation, there's a couple of things at play. We, as caregivers, need to be able to engage patients in such a way in which we can understand their symptoms, communicate with them in a way that they can understand, and negotiate a care plan that we all agree on. In those interactions, fundamentally, we have, first, two cultures that play: the medical culture where people like you and I learned very technical language for how to address these clinical concerns, and we have the patient's culture, which is, can be very different. The level of health literacy, clinical literacy could be a lot lower. And there could even be language barriers that play a role.

But the first set of cultures that I think we are needing to reconcile is the medical culture and the language we speak with the individual's culture as it relates to health care, which is the simple fact that they may not have the degree of health literacy that will allow us to communicate on the same plane. So you and I, in those instances, need to cross that first cultural divide by just speaking simply by providing information in ways that people can understand. That is the kind of first cultural bridge that we cross. The second one and the one that I think I've been working on for the better part of a quarter century now, over 25 years in this area of cultural competence, is this notion that individuals, no matter, again, who they are, where they're from Bryn their lived experience, their cultural background, driven by their race, ethnicity, where they were raised, you know, the experiences they've had in health care, their social context, a whole set of factors that makes up who they are as a person. Spiritual beliefs, it's, you know, there's a lot of different variables that define us. And I'd say that among those sorts of variables, we understand that there isn't any one culture, that you and I and people are part of multiple different facets that make up who they are culturally. And so as a caregiver, I also need to negotiate that. I need to have the tools and skills to understand how that cultural perspective impacts their health beliefs and behaviors and the communication that we are going to engage in. And thus allowing me with those sets of kind of tools and skills, to be able to bridge those cultural divides for the best possible outcome for a patient.

And so when I think about cultural competence, a term that some like, some don't understand, some don't like, there's a lot of different terms. For what I'm describing, I boil it down simply to a set of tools and skills that we have to cross both of those cultural divides: the medical cultural divide, and the individual patient's cultural divide, to get to high quality health care for everyone. That, to me, is being culturally competent.

O'Connor: Dr. Betancourt, that was fantastic. I think that's the best description I've ever heard. And it, as you know, it can be difficult to do the first task well, right?, bridge the

language barrier, because we will use language that a lot of patients don't understand. I mean, I'll take the term exacerbate. You know, I recently saw a little video clip of a physician just going on the street asking people if they understood what the term exacerbate needs. And it was amazing, right? I mean, we use this term so commonly in medicine, but we don't have to, right?, we could say, it makes it worse. And everybody understands that. So I actually think that is the easier of the two tasks, right? Because we can train ourselves to speak more plainly. And of course, then ask the patient to say back in your own words, what they're hearing the clinician share with them.

I think the harder task is the second one that you spoke about. Because, you know, how's it possible for any given clinician to really have as much understanding about different cultures and backgrounds? And so how do you see us moving forward with training the health care professionals of today and tomorrow to to learn more of those skills?

Betancourt: Absolutely. Look, I think they're not different, Mary, from what we do in clinical inquiry every day. So by that I mean this. There have been approaches in the past that aim to teach culture, individuals' cultural backgrounds -- the Latino patient, the African American patient, the Native American patient, and so on, so forth -- that quite frankly, although well-intentioned, or reductionist are maybe simplistic may lead to stereotypes. Just like if a patient came in and presented with a cough, I wouldn't make an assumption that every cough has pneumonia, I would then need to ask them a series of questions. We do this every day about: When the cough started? What makes it worse? What makes it better? Does it happen more in the day or at night? There's a series of questions I will ask to better ascertain the nature of that cough. Similarly, when we think about addressing the cultural divide, my caring for a patient who is different than me, who has a different lived experience, which by the way, health care givers have been doing this since the beginning of healthcare giving in the first place. So this is not new. I think what we've tried to evolve and try to say is that yes, our inability to understand the sets of cultural factors that you bring to the interaction limits our ability to communicate effectively and for you to get high quality care.

So back to your original question. That second part, I think, is harder, if we believe that we need to develop an encyclopedic knowledge of every culture. And the truth of matter is that could never be done because every Latino patient -- I'm Puerto Rican, Latino, you know -- even among Puerto Ricans, there's great difference in lived experience exposure to health care and the like. So we need to fundamentally shift our thinking, to say every patient is an individual, one. Two, every patient brings their own culture to the encounter. Three, sometimes that may matter, and sometimes it might not. And four, if

I'm detecting that it might, then what are the series of questions that I'm going to ask to better assess how those cultural factors are going to play into our communication?

So when we say, well, this is complicated, I would say, well, I don't think it's any more complicated than anything we do. I do think that we need to enter into interactions with curiosity, empathy, and respect. I think we need to have a framework a toolkit to figure out, hmm, if I have a patient in front of me, who has had difficulty taking medications that we've agreed are important for them to take, and they just continue to have challenges taking them, I need to then pull out a toolkit that allows me to understand are there some other factors: not being able to afford it, some cultural belief about a pill, some concern about the size of the pill, the color of the pill, I need to broaden my aperture to have questions at my disposal to figure out if there are cultural factors that are playing a role in that individual's decision making, and then negotiate from there, I am not making an assumption that, okay, you're a Latino patient, so maybe you're not adherent because of X, Y, or Z. I'm instead saying, I'm broadening my toolkit to assess whether there are socio-cultural factors that are limiting us from getting the best possible outcome. And that toolkit then allows me to shed a light on them and negotiate them.

So that's, I think, what we're aiming to do, and I would argue, again, that process of inquiry is something that we do all the time, we were taught how to do that. And I've been teaching healthcare providers for again, over 25 years, the toolkit and the set of questions they could ask to delve into those socio-cultural factors and manage them more effectively.

O'Connor: So, yes, you have been an amazing leader in this space. Tell us how and clinicians toolkit, how can they learn more about kinds of questions that they can ask? Because the more you do this, the easier it gets for you.

Betancourt: Yeah, you know, I began this journey. And I'll just say, because this is important, I began this journey myself as a resident back in the late 1990s, with two of my colleagues, Dr. Alexander Green, and my mentor Emilio Carrillo. And, you know, we were struck by the fact that we would have to see patients in a very short amount of time, these cultural factors came in, we didn't have the time or the skills to manage them, and poor outcomes, or health disparities were the result. And they particularly impacted those who are at a greater cultural distance from the Western medical model, right? So it was from that set of challenges that we were facing that we began to say, you know, can we create a framework, an approach that would allow us to, in an effective and time efficient way, really raise up the key factors that we thought were

important to manage those cross cultural challenges, and do it in a way that was practical and actionable, and realistic, right?

And again, to my earlier point, we felt it was not possible nor appropriate to be teaching cultures in, kind of, in a monolithic way, the museum-based approach to the patient from Country X or country Y. We fully understood the importance of learning about different cultures. That's excellent. But we said while we should learn, we shouldn't assume or stereotype that because the patient is from place X, that they believe or behave in certain ways that we've read about. We should have that as a backdrop. But instead, we should have a series of questions that we could use in a time effective way. So in 1997, we published a paper in Annals of Internal Medicine called Cross-cultural care, a patient-based approach. That, Mary, was our first -- and we use that in teaching, we study that process -- became our first framework for those sorts of questions. And that's available now. People could could find it on PubMed. It's been converted into a clinical decision support tool in UpToDate. So in UpToDate now, a very well-known used tool, our entire framework is there. And it teaches you how to basically deploy that framework in an as-needed basis, in almost a precise surgical way to get the information needed to manage encounter.

And so you know, we talked about the importance of curiosity, empathy, respect, we talked about assessing what we called core cross-cultural issues, getting at the patient's meaning of illness or treatment. And then identifying whether they were social factors have played a role and then negotiation. So it was really four components: assess cross-cultural issues, explore the meaning of illness or treatment for a patient, assess the social context and engage in cross-cultural negotiation. That framework became the springboard for, again, several decades worth of work, we converted that into e-learning, as well, an e-learning product that has been probably used to train more than half a million healthcare providers, doctors, nurses across the country. That is an effort called Quality Interactions. And Quality Interactions is an e-learning tool where people can leverage this set of skills. So a long answer to your question: Those tools and skills are readily available, we've published probably 40, 50 papers on, and evidence-based and we encourage people to, you know, who want to learn more to to delve in.

O'Connor: And Joe, we'll put some links for some of those on the end of the podcast on the profile there. Tell us more about your work with The Commonwealth Fund, and how that's evolved. And where you see that advancing us in terms of being able to provide more equitable care with a cultural competency focus, right? Because you're right, if we can focus on framing things in a way that resonates with the patient, and they're far

more likely to, basically engage in a treatment plan, and then far more likely to have a positive clinical outcome.

Betancourt: Yeah, absolutely. Mary, you know, I think the other point that's really important to make is that when we talk about, we always talked about cross-cultural care, cultural competence, per se, although again, I think part of this becomes a false debate. Is it cultural competence, cultural humility?, you know, there are all these terms, we spend a lot of time kind of, you know, debating these things, which I think isn't time well spent. At the end of the day, these are our first principles: high quality care for everyone, no matter who they are, where they're from, having the skills to do that. And so that's what we're aspiring to with the important, I think, addition, that every patient has their own culture. This isn't just a set of tools and skills that help you take care of somebody who's, you know, from a different country or from a specific group. You and I have our own lived experience that we bring to the clinical encounter. So I just want to close out that conversation there.

You know, The Commonwealth Fund is an incredible place. I'm the eighth president. This is a foundation that was founded by a woman in 1918, Anna Harkness, with the idea that we needed to improve the health and wellness of humankind, and $10 million set aside at that time to create a foundation that in its early days did some really incredible things funded the first public health departments the first rural hospitals, first medical schools in urban areas, funded the first advanced practice practitioner programs, then did a lot around health care policy, focusing on the Affordable Care Act.

Our mission is affordable, high quality, equitable health care for everyone. And as a foundation, we have both the capacity to do our internal research, which is the 'do' tank part of what we do in a think tank. So we're a 'think' and 'do.' We do some internal work and we deploy grants to advance different aspects around health care coverage, health care, and work around health care costs, and health equity. Health Equity is our biggest portfolio. And fundamentally, we're trying to work with organizations and on the policy side, to really address some of the health equity challenges that you and I are talking about. Some of them are around quality of care, some around communication and cross-cultural care, some of them around policies that we see. So you know, the health disparities and health equity challenges that have evolved over the history of this nation weren't developed overnight, didn't evolve overnight, and they won't be solved overnight. And so what we're trying to do with The Commonwealth Fund is chip away and get to a more equitable health care system.

And it's a blessing this, this foundation has meant a lot to me. It supported me very early in my career, I was a Commonwealth Fund Harvard University fellow in minority health

policy in 1997. I have gotten grants from the Commonwealth Fund over the years and now to come full circle and be the president. It's really amazing. So and health equity is a key part of my career. It's our largest program already, even when I joined, and will want to go deeper in the space. It's a key part of everything we do.

O'Connor: Yes. Congratulations. I was so excited when I saw that. And I thought, Wow, what a great new president. And I noticed that it was founded by a woman way back in the day. I mean, she must have just been, you know, to use my term, badass.

Betancourt: Completely, completely, you know, and it's one of these things that few people know about our foundation, but it's really, really important. I mean, two to $10 million, which you know, is the equivalent of several billion nowadays and set it aside for really a, you know, an incredible set of ideas, and just wonderful philanthropy. So I live in a lot of gratitude, I feel very blessed to be able to lead a foundation founded by a woman and carrying that, that, I think, that great work forward.

O'Connor: Exactly. You know, it's groups like the Commonwealth Fund, and leaders like you that actually give me hope that we're making progress. And, as you know, we're very committed at Movement Is Life, too, to moving the needle as well. So, so let me ask you, what do you see are some of the really positive policy changes that are occurring on the health equity front?

Betancourt: Yeah, that's a great question. I mean, I think the the good part about the health equity journey, over the last few years is that we've seen progress. You know, I break it up into a series of chapters, going back to 2003, when the Institute of Medicine report, Unequal Treatment, was released, you know, right around, then Mary, we had a lot of early adopters who did some work and responded to that Institute of Medicine report that found that there were disparities in health care, you know, over the following years of the Affordable Care Act really engaged more on the coverage side. And so equity lost a little bit of steam, but it was kind of part of the portfolio.

Then, I think the really exciting time happened where we started to talk about value in health care, and people understood that you couldn't deliver value if you weren't thinking about quality and equity. And certainly, our nation's reckoning on racism. Just a few years back, and the pandemic really catapulted a lot of efforts in the health equity space. So, you know, I think this has been an interesting journey in my career in the last 20, some odd years. And we have seen more health organizations collect data, monitor performance on how they're caring for patients with different backgrounds, and develop interventions to address them. That's been great.

What's been missing has been, I think, two things: financing and incentives to drive more sustainable and scalable change, and regulation, to move those who are reticent to move. And again, the good news today is that we're seeing health plans, trying to leverage some of their tools and levers to advance the field. We have some very exciting work going on at Blue Cross Blue Shield of Massachusetts, where they're developing a pay for equity program, I mean, a really exciting way to leverage equity into the healthcare payer space, we see the Center for Medicare and Medicaid Services that is really, really leveraging equity in almost everything they do in Medicare and Medicaid. The latest 1115 waivers in Medicaid really pushed the needle on health equity. I think that's been exciting. So I've talked a bit about the commercial space and what's happening with plans. Now I'm talking about CMS and what's happening in the public payer space. And we see a lot of hospitals to just on their own, trying to move the needle.

So policies and practices are evolving. And I would say certainly, the work of the Joint Commission, NCQA also, there is a confluence of activity here that is moving the needle forward. And we're trying to catalyze that with our resources, through convenings, through supporting white papers to supporting experiments. You know, I think that's our goal. And there's a lot of room for improvement, but we're trying to be a key player in that space.

O'Connor: Yes, that's very exciting. And, you know, I commend when, when private insurers like Blue Cross Blue Shield of Massachusetts, are really making a commitment to say that they're going to support health equity and address policies and procedures that will help drive that that's very meaningful. So you know, kudos to them for that great work. And, of course, as you said, CMS has has, you know, they've said this, but they're, they're really putting, I would say now, action two words. So the new bundle program that will come out in January of 26, for five very common surgical procedures, four of which are orthopedic. So a little bit, you know, closer to my turf, will include for the first time, some risk adjustment.

And that, of course, has been something that I and others for a long time have been, you know, calling out, like if we're going to have bundled payments to health care systems for certain procedures, and there's no risk adjustment, then we will see cherry picking of healthier patients and lemon dropping of unhealthier or socioeconomically less desirable patients who will require greater health care resources, thus driving up costs in the bundle and being a financial negative to that hospital. And we've seen this actually play out in the data. So CMS has now to their credit, recognized that this has occurred. And now with this new program, I'm optimistic that it's going to be a positive

step forward in providing some risk adjustment, the payments so that there will be less, you know, less negative incentive to provide the kind of care that every person needs.

Betancourt: Yeah, that's a great example, Mary, and, you know, I think ultimately, we see, what I've been really pleased about in my career is, we see healthcare, policymakers, healthcare leaders, really talking about equity, not as an afterthought. It's not where we want it to be, but the conversation has evolved significantly, you know, around risk adjustment around a whole series of different things. And I think that's what we've been driving for, for all these years. And so it's yet another step forward, but a significant one, it's, you know, health equity is no longer an afterthought. Again, not where we want it to be yet, but we're making progress.

O'Connor: Yes, and that is, I completely agree with you on that we're absolutely not where we want it to be or where we need it to be. But we are making progress. And people at least understand, I think the majority of people in the health care profession, that disparities are real, because it wasn't that long ago, that we actually had to like, convince people that there are health care disparities. So we've gotten past that. And so now there's general awareness and some education and a recognition that we need to advance health equity, and now moving into this action phase of how can we actually do it?

Betancourt: Right. That's right. I think that's exactly right. I mean, you know, the evidence is undeniable. The root causes are now well known, and they're multifactorial. And as such, no one solution, no one suspect, the interventions need to be multifactorial as well. And, but this is not impossible. And I think it is about will, it is about resources, it is about leadership. We've seen those organizations that have done well, combining those three things to improve health equity. And so with that formula, we believe we can make a difference. And so I do believe that policy, that financing, that regulation, will be the key things that get us to that last mile.

O'Connor: Yes, I agree. And you know, a lot of people are very committed to doing the work to help make the change. And that is, you know, gives me hope gives me a lot of hope. All right, one last question. I'd like you to share with us some of the most innovative approaches that you've seen any kind of health care provider or system take. So that those listening, watching the podcast might say, Wow, that's like something we could try or we could consider.

Betancourt: Yeah, it's interesting. I mean, I think there's always three that I've talked about, but I think we are scratching the surface on what is going to be possible with technology with artificial intelligence. You know, I think the ones that we've seen that

have been very effective, aren't particularly sexy, if you will, I mean, they're, you know, the leveraging of community health workers or health care navigators or coaches, high touch for high need patients in our team based approach that have really made a difference. Everybody's working at the top of their license. Individuals who need greater resources who have communication challenges, really deploying that team based care.

You know, we've seen improvements back when I was at Mass General in, for example, diabetes management, colorectal cancer, screening, flu shots, group B strep, prophylaxis, prophylactic antibiotics. I mean, we had a whole series of different successes using a series of those strategies. Now, I do believe that the, both science and data and technology revolution that we're seeing with genomics, genetics, precision medicine, big data and our ability to target care to individual patients, and artificial intelligence that will allow for clinical decision support, you know, democratization of information, language interpretation. I mean, I think we are on the cusp of doing some pretty amazing things in the health equity space. And I'd say that many people particularly you know, as they think about science, technology, virtual, you know, people who are tried and true health equity researchers, leaders, people who've been doing this for a while, are appropriately a bit skeptical out of the box, or a bit reluctant to jump right in. Because there's been a long history of kind of biases and stereotypes being built into those types of things one, and number two, there being a very, very long technological lag, when innovation happens, it gets vulnerable communities last. And so I think many in the health equity space are entering into these new revolutions with some trepidation.

That being said, I think we need to be forward-thinking, I think we need to be more on the offense than on the defense as it relates to leveraging data science, science technology, to improve disparities and address health equity challenges. So I think this answer to this question will be a lot more intriguing in about a year or two, because it's moving so fast, where you will see all types of, I think, very, very innovative strategies to address health equity that will leverage those components, the science revolution, the data revolution, and technology revolution. And it's going to be exciting. So I think the best is yet to come.

O'Connor: You know, Joe, that's a great comment. I'll do a follow up question-slash-comment. Because you already mentioned it, you know, the concern that bias will be built into algorithms. And I mean, we've already seen that with the Google tool, right. You know, kind of craziness coming out of that. And then I'm going to say, for communities that that have historically had mistrust of the healthcare system, right?, how do you see bridging that mistrust that could be accentuated if they think, Oh, I am just plugged into this, my doctors using this AI tool, and I don't trust the tool, the tool

could have inherent bias built in. And so, you know, playing on the fear of bias in the tool being accentuated in communities that historically have had had good reason to mistrust the system.

Betancourt: Yeah, no doubt. I mean, I think that mistrust is well earned. I think it will require a lot of what we did, quite frankly, during the pandemic, which is having, you know, clearly diversity and healthcare workforce adds value in a lot of different ways. But what we've learned, and particularly is that the ability for somebody who you might inherently trust because they share your lived experience, or share your language, have a cultural, similar cultural understanding. You know, the idea that health care providers can be messengers, trusted messengers, I think will be an essential ingredient to building that trust. But also those individuals will need to safeguard against all the things that you mentioned, assuring that, that we don't build those biases and stereotypes into algorithms.

We have a bunch of algorithms already that have been flawed that we're trying to pull out race and ethnicity out of out of clinical algorithms. So you know, we're trying to make progress there. So you know, back to my earlier point, I think this isn't that we don't play any defense, we need to play defense, need to play offense. And as we play offense, we need to build trust. And when we build trust, we need to do it with humility. I think we need to leverage a diverse set of providers to convey some of those messages. And we need to do it on the ground, oftentimes one on one with individuals. I didn't by saying that, one of the things that I think created a lot of mistrust. Just as an example, we've talked a lot about things like the Tuskegee syphilis study, and all those historical medical experimentation and in different committees. We've talked a lot about that.

But I think we have one recent lesson, Mary, that we need to we need to take into account. You know, during the pandemic, health care, a lot of scientists and health care providers spoke with a lot of certainty during different parts of the pandemic, about things that we didn't have certainty about quite yet. And that created more mistrust. So example. You know, in the early days of the vaccine development, we said, well, if you get the COVID vaccine, you're not going to get COVID You're you're not gonna get it. And we learned that, yeah, you're gonna get it, it's going to be more mild, and it's gonna prevent you from dying. And that was a great thing. But we had to go back and re explain that. And we had already, I think, by not being more honest and saying, Look, we believe that there's a strong chance that you might not get caught, but we can't guarantee it. But we could probably more strongly say that this won't put you in the hospital or won't kill you. If you get COVID new vaccine, right. My point here is that we need to to build trust, we need to have that humility and tell people exactly what we know when we know it and not overstep. Because when we overstep even despite our

best intentions, we're going backwards. We're chasing our tail. And we've created some mistrust. Does that makes sense? So I think we have a very recent example of, of greeting mistrust, among many people, not just people of color who said, Wait a minute, you said the vaccine this? No, wait a minute, you're changing your tune. And we need to say, we can only sing the tune we know now. And it may change based on science, because that's the way science is. And we have countless examples over history where we thought something worked, and it didn't. And we've learned, so we have to communicate with humility, not hubris. And I think that will be essential to building ongoing trust in the future.

O'Connor: Joe, you nailed it. I mean, I think what patients want most from us, and what I want, right from my own health care team is truth. Right? It's not that I expect my doctor to know everything, what I want is the truthful response. Here's the best knowledge that we have right now. Or, I'm not sure I'm going to find out, or I'm gonna, you know, call in someone else who knows more who might need to write is because, because that's how we build trust. And, and I was thinking about your comments earlier about, you know, cultural competence. And to me, if we distill it to one word, it's all trust. If we don't have trust between the clinician and the patient, we we're not going to be able to provide the care that they need, that we want them to have and that they're seeking. So, you know, to me, that's the essence of it. Trust.

Betancourt: I agree. I agree. Absolutely.

O'Connor: Okay. Well, Dr. Betancourt, it has just been such a pleasure to have you on the Health Disparities podcast. And we will post some some links on the site so that our listeners and viewers can learn more about the Commonwealth Fund. And I want to thank my guest, Dr. Joseph Betancourt president of the Commonwealth Fund for being with us today. It was really great speaking to you again, Joe, wishing you all the best, continued, great, great success with all the advances that you're making, because we need you, and the Commonwealth Fund, and everyone to be committed to advancing health equity.

Betancourt: Wonderful, thank you so much. I really enjoyed the conversation. Great to see you as well, and appreciate everybody's attention. And hopefully, everybody could take one or two things that they've heard today and incorporate them in what they do. That would be progress. And that would be a successful podcast. So thanks to all who listening.

O'Connor: Thank you, Joe. This brings us to the end of another episode of the Health Disparities podcast for Movement Is Life. If you like what you hear, be sure to subscribe

wherever you get your podcasts and take a moment to leave us a rating. It really does make a difference. Please mark your calendar for our upcoming annual summit. This year, we will be in Atlanta, Georgia ,on November 14, which is a Thursday and Friday, November 15, at the Whitley Hotel in the Buckhead area of Atlanta. You can go to our website for more information and to register. I'm Dr. Mary O'Connor. Until next time, thank you be safe and be well.