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Equitable HHealth for All: Improving Care for Underserved Populations and Their Unmet Needs

Announcer:

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Dr. Rahimi:

Hi, my name is Dr. Robert Rahimi. I'm from Baylor University Medical Center. And we're here to be talking about Equitable HHealth for All: Improving Care for Underserved Populations and Their Unmet Needs. And I'm here joined with Dr. Patty Bloom.

Dr. Bloom:

Hi, thanks for the introduction. So, I'm an Assistant Professor at University of Michigan, and a Transplant Hepatologist there. And we're excited to have this discussion today with all of you.

So, I'm going to start with the first question, which is Dr. Rahimi, what is equitable health?

Dr. Rahimi:

So, the way I look at it is, in essence, it means that everyone has to have a fair and just opportunity to achieve a high level of health and wellbeing. So, it's beyond this simple aspect of having access to healthcare. It goes deeper, where you actually have to have the underlying factors to create disparities and health outcomes. And the way I like to think about it is, for the key equitable health aspects, there are three things: fairness, justice, and the opportunity.

So, for fairness, as the word entails is that everyone, regardless of their background, obviously, in circumstances, really deserves equitable chance to live a healthy life. So obviously, removing barriers that prevent certain groups from accessing the quality of healthcare and healthy environments and the opportunity for wellbeing.

And then the justice part in general is addressing the historical and contemporary injustices that have contributed to the health disparities, which really becomes crucial. You have to recognize racism and discrimination, unfortunately, is in healthcare too, and there are other systematic inequalities, as contributors to the health problems that really if you actively work on it to dismantle them, will give more equitable health, but that's challenging.

And then opportunity, to create equitable access to with resources for these opportunities that really, overall lead to good health as being crucial. It includes things like eating healthy, healthy foods, safe housing, quality of education, social support, and networks.

But Dr. Bloom, I want to ask, well, what do you think?

Dr. Bloom:

I totally agree, I think you said it very well. And I don't have much to add. I think there's so much that contributes to health, and especially when it relates to hepatic encephalopathy. You know, people with hepatic encephalopathy have trouble working, trouble driving, trouble, you know, getting access to their doctors, to finances, to good food, to their medications. So, you know, HE really affects

a lot of people's lives and really, you know, a lot of aspects of people's lives and can kind of contribute or add to some of those disparities that already exist.

Dr. Rahimi:

Exactly. That's a great point. And so, I'd like to ask, so you kind of touched on this, but what disparities do you see in hepatic encephalopathy?

Dr. Bloom:

So, there are a lot of disparities in liver disease period. We know that especially black patients are less likely to be listed for liver transplant, are unfortunately less likely to get a liver transplant. And patients who are black with liver disease are more likely to die in the hospital also. And there have been several recent studies that show that in different settings and contexts in large, large, you know, database studies. So, we unfortunately know that disparities exist in liver disease.

We know that the disparities exist in hepatic encephalopathy specifically as well. There have been a couple of papers that have come out showing that rifaximin, which is one of the medications that we commonly use to treat hepatic encephalopathy, fewer black patients are getting that medication. So, there are definitely prescribing disparities and, you know, kind of access disparities to one of the main treatments we have for this condition. So, there are definitely big disparities to tackle.

What do you think about that?

Dr. Rahimi:

No, I agree. I would like to add also that, I believe also Hispanics, and in some Asian populations too, that can experience HE compared to the Caucasian patients. If you account for other risk factors, disparity might be linked to the social determinants of health. That gives them limited access to healthcare, as you mentioned. Unfortunately, sometimes the socioeconomic disadvantages and other environmental factors lead to these issues, right. So, that's where disparities in HE becomes complicated.

But that brings me to think about, you know, other diagnosis of access on care of the diagnosis of HE. Well, what do you think about that?

Dr. Bloom:

Right. Yeah, so I think, you know, unfortunately, you know, again, to focus on the data that exists out there, we know that black patients have less access to gastroenterology specialty care. That probably is true for other underserved minority groups as well. And specialists are really the people who get you connected with liver transplant, get you connected with some of that, you know, specialist expertise that helps treat things like hepatic encephalopathy in particular.

Also, I know being a specialist, I have access to a pharmacist who helps people to get their prescriptions for rifaximin, you know, fill out prior authorization paperwork, which is some of the like, you know, very unfun aspects of the practice of medicine but are necessary and so, actually get people that that access to those medications. And I've definitely had some patients from underserved populations where they had HE for years and they were being seen by you know, a very well-meaning generalist, who then finally when they came to me, I was able to give them access to rifaximin which they hadn't been able to get before seeing a specialist. So, unfortunately, I think that's one of the barriers to access of care.

I'm curious what barriers you see?

Dr. Rahimi:

Yeah, no, that's a great point. So, I think I agree with all that. And obviously, sometimes being, we have patients that come from rural populations, right, so that leads to their limited access to the specialist, as you talked about. But it also delayed the diagnosis and treatment of HE, right, which makes it more challenging. And that unfortunately, sometimes in the rural areas, there are underserved populations. And so, those patients can have worse outcomes. That's one of the types of disparities that we're talking about, right. So, although they might be able to have access, they're in a rural population, so it's also difficult to travel to some of the places like where we work. And depending on their overall situation, getting access to the medicines. I totally hear you with the prior auth, we have to deal with that all the time with rifaximin to try to get these patients the treatment they need if they've had a bout of overt encephalopathy and failed lactulose therapy, and that they need to be put on rifaximin to help decrease their readmission, as you know.

And so, I think the main thing for that, leading to sort of the treatment, besides the access or the financial part, which we also have pharmacists to help, there are some limitations like even the dietary counseling and lack of other resources that they can get. You know, we have to talk to them about titrating their lactulose, as you know, to have, you know, 2 to 4 bowel movements a day. It sounds simple to us because we do this all the time, but depending on their socioeconomic class and their education level, unfortunately, there is a disparity there. If their education level is different than some of our other patients, then it's sometimes hard to get them to understand the

reasoning behind some of these medicines, right? Like you take a blood pressure medicine, and you take it once and it's supposed to control your blood pressure, or twice a day, and that's it. Lactulose, I mean, it's a titratable medicine, it's challenging. So, I think it becomes difficult to sometimes portray that or have patients with different backgrounds to sometimes understand that. And unfortunately, that's a huge disparity there.

Dr. Bloom:

Yeah, absolutely. I totally agree. And then, you know, you mentioned also with rural populations, if you have someone with HE, and if, you know, it's significant, they can't drive. They can't come to that in-person visit with you, right?

And then also, not everyone has access to virtual visits. You know, as we're talking in early 2024, a lot of insurance carriers are covering virtual visits, but that is an ever-changing landscape of how much coverage we're going to get for virtual care. So, and then the additional challenge of virtual care is like, do they have internet? Do they have access to a computer or smartphone where they can actually have that virtual encounter? So, just even getting to the provider, like getting that face-to-face encounter may be a big challenge.

Dr. Rahimi:

No, that's a great point. I mean, it's hard to believe, you think everyone would have a phone, but again, in these rural areas, they might not have even internet access. They might not have TVs, they live on farms, they don't have a smartphone. So, we although we think everyone has that, some of the patients that we deal with, as you mentioned, they don't have the simple things that will allow them that greater access.

And that brings me to a point where you sort of were mentioning, you touched on the financial burden, right, caused by the diagnosis of HE. And we sort of touched on it, but is there anything else you can think of?

Dr. Bloom:

I just think that we can't understate it enough for the listeners that people with HE have a huge financial burden. They can't work. They have lots of medications, lots of medical visits, and hospitalizations that they need to pay for. A lot of them have kids and people who depend on them. And without being able to work, drive, and needing to pay for all these medical expenses, like it's just a huge burden for that individual, and then also for all their caregivers and family, you know, family and surrounding community. So, it is a huge burden.

But let's end with maybe some, like, next steps in, you know, maybe how our institutions are trying to mitigate some of that burden and mitigate some of these disparities. I'm curious what some of your thoughts are?

Dr. Rahimi:

Yeah, so, we have a free clinic that we offer, obviously, healthcare specific for patients with liver disease and hepatic encephalopathy. And so, we have, about once a week, obviously, it's very full because a lot of patients that are underserved and have a lot of disparities, and for access to care, so we usually offer that to them, as well we have a fellows clinic, the fellows in training, that see some of these patients in the GI clinic. Do you do something like that, too? Or do you guys have a different process?

Dr. Bloom:

Yeah, we have something similar. And I would also just add that we have a highly developed social work infrastructure at our institution that really tries to give all of our patients access to insurance, and also tries to get them transportation when they need it, help them with those virtual visits. Just really wherever these gaps in care are, they try to help fill some of those gaps. And I've definitely seen specific examples of that working out.

Dr. Rahimi:

That's great.

Dr. Bloom:

And then, you know, I think also there are some national societies as well that try to help. I know, the American Liver Foundation, for example, has some resources on their website, and especially for individuals who are trying to move forward to a liver transplant. Many patients with hepatic encephalopathy have a low MELD score, and need to look at options, like, for example, a living liver donor. And the American Liver Foundation has some really great resources to, you know, to help people find a living donor, to provide financial resources to that living donor, to try and, you know, be able to afford the financial burden that goes along with donating part of your liver. So, there are some resources out there, people are definitely trying to close this disparity gap.

Dr. Rahimi:

Well, I appreciate that. That's great. And Dr. Patty Bloom, it's obviously a pleasure and honor to be here on this call with you. I've learned some stuff from your system, maybe we can adapt some of what you have and you adapt what we have and then we can get

more patients to have more equitable health, I guess, and less disparities out there.

Dr. Bloom:

Sounds good. It's a plan.

Dr. Rahimi:

Alright. Very good. Well, thank you all.

Announcer:

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