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How Do We Define an Underserved PAH Patient?

Dr. Elwing:

Welcome. Thank you so much for joining me. My name is Dr. Jean Elwing, and I'm a Professor of Medicine and the Director of the Pulmonary Hypertension Program at the University of Cincinnati. We are going to be talking today about underserved PAH populations and how do we improve our connections. So, our learning objectives today are really to define this population, examine the use of remote monitoring in following these patients, discuss potential solutions to maintain access to these patients, and really hone in on the barriers and how to overcome them.

So, let's start with defining the problem. How do we define our underserved patient population? So, really, it's threefold. We have social barriers to care, medical barriers to care, and economic barriers to care. In those social barriers, we have physical remote populations, we have immigrant populations, non-English speakers, minority populations, innate prejudices, patient trepidations, and disbelief in medicine and science, which holds people back. We have the economic barriers to care: insurance issues, drug costs, care costs, lack of transportation, and lack of patient access to the tools for telemedicine. Then we have these very important medical barriers. And they may come in multiple forms: telemedicine and access issues, delays in referrals, physician awareness, patient disabilities, and access to primary cares.

Let's talk about social barriers to care. Native Hawaiians and other Pacific Islanders suffer a number of poor health outcomes such as high rate of overweight status, obesity, hypertension, and high rates of asthma and cancer mortality. This was actually recently looked at using Behavioral Risk Factor Surveillance System data, and they found that when all factors were taken into account, these patients were still 66% more likely to experience fair or poor health as compared to their Asian counterparts. Insured Native Hawaiians and other Pacific Islanders were more likely to experience a cost barrier than insured Asians, although there was no difference between the groups in regard to having a personal healthcare provider. If they were uninsured, they were less likely to receive an annual routine checkup as compared to uninsured Asians. So you see here, there are subgroups of the patient population that are not receiving the same level of care because of background and other issues.

So let's talk about the gorilla in the room. There are prejudicial attitudes that affect patient access, and we need to talk about these things so we're aware of them and we can adjust and adapt, so all patient populations are receiving similar levels of care. Racial discrimination is an emerging risk factor for disease and a contributor to racial disparities in health. According to a study from the Commonwealth Fund, about a quarter of Latinx and Black older adults reported facing racial discrimination at the doctor's office, making it harder for them to receive the care they needed. Patients of color 60 years or older were more likely to say they were treated unfairly or had health concerns dismissed by medical professionals. One in four Black or Latino older adults reported racial or ethnic discrimination when seeking healthcare, while fewer White older patients reported this. More than a quarter of US older adults who experienced discrimination based on their race or ethnicity felt they did not get the care they needed. So this is going hand in hand. They feel discriminated, and with that, they're not receiving the care they would like to receive from their care providers.

So what is also important about this? The older patients experienced discrimination also had more healthcare needs. The older patients experiencing this discrimination, they felt when they went into healthcare, are more likely to have feelings of social isolation and report material hardships and feel dissatisfied with their care than older adults who did not feel this discrimination. So not only did they not have

access, they felt more isolated that was in a negative experience in this setting.

Are there ways to address some of these issues and how is it affecting our PAH patients? So some of the things we can do is to improve literacy and low health literacy, especially, identify cost effective resources, expand care offerings, enhance the patient-provider relationship, and cultivate a culture of teamwork and customer service. Helping patients find the least expensive options for transportation, insurance, and medication was the most compelling patient-centered strategy that was reported. Appointment reminders and confirmation of patient plans for transportation to appointments also can reduce no-show rates, and this is extremely important in this vulnerable patient population.

Some other solutions. We need to promote transparency and accountability by identifying instances of discrimination and publicly reporting discrimination data. We need to develop medical school curricula to educate students about how the US healthcare system has interacted with patients of color and other historically marginalized communities. We need to reform policies that enable discrimination and address the lack of diversity in the US healthcare workforce. And very importantly, we need to provide culturally and contextually appropriate care to address patients' communication needs and their preferences.