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ReachMD

www.reachmd.com
info@reachmd.com
(866) 423-7849

Improving Inequities in Rheumatology Care

Announcer:

You're listening to ReachMD. This episode of *Living Rheum*, titled "Improving Inequities in Rheumatology Care" is sponsored by Novartis US Clinical Development and Medical Affairs. The host and speakers have been compensated for their time. This program is intended for health care professionals. Here's your host, Dr. Anisha Dua.

Dr. Dua:

Many factors contribute to disparities in rheumatology care, and these are largely centered around social determinants of health. A recent study found that patients living in low socioeconomic status areas were less likely to be prescribed biological disease-modifying anti-rheumatic drugs, if they were considered low income, male and African American.¹ These differences in care result in worse health outcomes for socioeconomically disadvantaged populations and the impact is felt across multiple disease states, further widening the gap in health disparities within rheumatology.

This is ReachMD and I am Dr. Anisha Dua. Joining me to explore strategies to improve inequities in rheumatology care are Dr. Grace Wright and Dr. Irene Blanco. Dr. Wright is a consultant rheumatologist in New York City and president of Association of Women in Rheumatology, AWIR. Dr. Wright, thanks for joining us.

Dr. Wright:

Thanks for having me.

Dr. Dua:

And Dr. Blanco is a professor and associate dean for diversity enhancement in the Department of Medicine at the Albert Einstein College of Medicine. Dr. Blanco, thank you also for being here today.

Dr. Blanco:

Thanks for having me.

Dr. Dua:

Of course. Let's dive right in here. Starting with you, Dr. Blanco, what are some of the key factors that drive poor outcomes in patients with rheumatic disease?

Dr. Blanco:

So, you know, I mean, I think that when we talk about patients that are from low socioeconomic status, we're really looking at the interplay between access of care, insurance, timely referrals, how aggressive physicians may be. And so it leads to then this spiral effect of, you know, if a patient doesn't necessarily have the right insurance, they may not necessarily get that timely referral and what are the biases on the provider's part where they think, "Well, they can't afford it, so I'm just not going to prescribe it anyway," right? So what are the biases of the patient of, "You know what, no, I'm going to see the doctor just yet, I can live with it because I don't have the money for the copay," and what are the biases on the physicians, where, I can't even start this med because the patient's "never going to get it".

So, we really need to think about how we build our structures and how we build what I like, what has been coined by Dr. Hansen and Dr. Metz, where they talk about structural competency. So, how structures within systems can be created to ensure equity for our patients. How do we really chip away at all of the barriers? And really how do we think about, well, if a Black male patient is doing worse, then we start to really ask ourselves, why, right? Because often times you'll hear, "Well, Black patients do worse," and people just seemingly are okay with that, right, as if that's just a given. We need to stop and say, "No, why is this happening?" What are the ways that we can intervene? And how do we start moving forward to ensure that we're creating equity in the care that we're delivering?

Dr. Wright:

And, you know, we have to recognize that not everybody has equal access to all of the good things. So, for instance, we'll tell our patients, you know, the importance of exercise. Not everybody lives in a secure neighborhood where it's okay for them to go out and just sort of walk the streets. There's lacks of safe green spaces.

What about eating healthy foods? They may not have access to that, or there's food insecurity. Is it my medication? Is it my child's food? Is it my food? These are all things in common that are part of the social structure, may not be something that we have in our charts, but it's going to impact our outcomes and our patient's ability to really access better therapies.

Dr. Dua:

Yeah, I think that is so important and getting that perspective and not just sort of coming in, in that paternalistic way, saying, "You know, you really need to diet and exercise and here's a list of foods you should shouldn't eat," but actually just asking the patient, you know, "What is your actual life and world and how are we going to maximize your health outcomes within that world because we can't necessarily change all of the pieces, right?" We can do what we can but try and understand what are their limitations, what's feeding into these health outcomes and what can we do to better understand and help them improve? Instead of just sort of shaming them and making them feel embarrassed about those limitations and their circumstances.

So we know that there's a lot of variability in clinical presentations, treatment responses to a lot of our rheumatic disease, right? So, moving to you, Dr. Wright, can you discuss sort of how communications barriers and unconscious bias might play a role in the care and the outcomes of our patients?

Dr. Wright:

Yeah, absolutely, because how we communicate really is sort of the underpinning, the cornerstone of what our patients understand. And how we communicate with individual 1 versus individual 2 should really be nuanced based on the cultural context of that person. What about their religious belief systems? How do we understand all of the various social cues that they give us? There are all of these things that we do as animals responsive to another animal that really sort of enhances that communication. Am I respectful? Am I demeaning to whatever their cultural or religious belief systems are? We really need to be mindful of communication being this bidirectional flow of information that we should deliver without judgment.

And it's also important in understanding some of the very key things that we need to know for our patients. So, for instance, anxiety and depression may be expressed, and experienced differently in different cultures. The person who is stoic may be as depressed as the person who is sort of effluvious, right? So, we really need to understand, number 1, the expression of depression and the terminology about how people express that so that we don't miss it as a comorbidity, don't miss it as a symptom, don't miss it as something that we can actually help them modify. And if we don't get it, then ask. We have to be humble enough to ask and not feel like, you know, I am the keeper of all knowledge and your just here to receive from me. I'm also here to learn from you because I'm going to be able to help my next patient because of the lessons I've learned with you. So, humility matters.

Dr. Blanco:

Humility definitely matters. And we're on the patient's team, right? So, the onus is on us to really understand our patients. So, for example, it's Ramadan right now, right? So, if I'm in an area where I have many Muslim patients, so the onus is on me to understand, are they going to be fasting? Are they not going to be fasting? How can I incorporate them taking their medicines into their fast, right? And so, can they take it when they break fast in the Iftar, should they take it in the morning before they settle in throughout the day? So, the onus is on me to really partner with the patients.

There's a paper by Ernest Vina that, you know, our patients are perceiving bias in clinical encounters, right?² Lupus patients of color are perceiving bias. And how does that then affect their adherence, right? So, if I think my physician is biased against me, how likely am I going to take any medicine that they prescribe for me, right? And it leads to higher rates of depression, lack of engagement, etc.

Dr. Dua:

Yeah, Dr. Wright, can you tell me some real-world examples that you've had of how, you know, race or ethnicity has impacted rheumatology care?

Dr. Wright:

Sure, say we look at for instance, psoriasis. Where, you know, when we trained I think almost all, if not 100% of the images that I was trained on were people of lighter skin tones. So, you know, we go to that image recall in our brains, and I see a rash, I think about it, I'm like, oh this is a dark skin, it's gray, it's not the typical and so I don't see the psoriasis. I don't make that diagnosis and so I don't connect that this person's complaints may actually be psoriatic arthritis in an early stage. And so, we don't initiate treatment early and so these

patients often, number 1, walk out with, as one person said to me, “I feel like I have post-traumatic stress disorder because I’ve seen 15 doctors and they all tell me I’m crazy and now you’re telling me that I wasn’t crazy. What happened for 15 years?” Right?

So, initiating early interventions is really hampered when we have this because they stop coming forward. And they’re not understanding the psychological impact of the scarring that can occur. So, we’ll say for instance, “Okay, your psoriasis is better. Your treatments are working, your arthritis feels better,” but what their experience is for them a huge ugly scar, a post hyperpigmented scar, and that affects their sense of well-being. And so, again very important for us to think about the patient’s perspective on that.

We think about organ transplant and the fact that we had glomerular filtrations rates that were based on a perception of race having this impact on renal clearance and so we missed early renal disease in those populations who were improperly misclassified.³ And so, this idea of having a window for early intervention disappears if we don’t recognize them when they’re early, whether it’s renal disease, musculoskeletal disease, skin disease, or cognitive disorders.

Dr. Blanco:

And it’s, you know, these biases are in so many different domains, right? So there’s racial and ethnic bias, there’s gender bias, so just going back to the example of like the psoriatic arthritis. I mean, the spondyloarthropathies have been anchored as this, like, white man’s disease for so long that women, particularly women of color are going undiagnosed for years with ankylosing spondylitis and psoriatic arthritis because there’s this misconception that, you know, these diseases just don’t happen in women.⁴ They just don’t happen in people of color and then, you know, what are the long-term ramifications and what is the disability that we see then subsequently?

Dr. Dua:

Thank you, guys for bringing up some of those very clearly real-world examples that that all of us have sort of come to face in our practices. And speaking of real world and social determinants of health with serious consequences, we know that COVID-19 is still a thing.

So with the pandemic, you know, this has really impacted some of the inequities in care and has brought to light some of the social determinants of health and some of the serious consequences that can happen as a result of it. So, can we talk a little bit about that? How do you think the global pandemic has impacted some of these pre-existing disparities that we’ve sort of touched on?

Dr. Wright:

Well, you know, we saw so much of this, sadly, in our frontline workers who tended to come from this sort of mixed grouping of multiple different demographics, and they were essential workers.⁵ Now that we’re sort of in the, you know, the next phase of the pandemic, we see that they’re low-skilled labor, and now they’re sort of being demeaned in many ways. So yes, we see how the social determinants really sort of play back and forth. They didn’t have the luxury of staying home and working remotely because they had to have hands on. So, what happened? They were essential, so they were exposed, they became ill, and they disproportionately died. So all of these minority individuals walking in with their comorbidities, whether it was hypertension, cardiovascular disease, obesity exposed at their jobs, resulting in deaths.

And then in that same community, because of the lack of trust that we see within our clinical trial programs, vaccine hesitancy was rampant to the very tools that we had to protect people, then were being shunned because of fear and distrust. So, we hurt them, and then we couldn’t help them. So, for me, that’s a double hit, right? And so this really plays through this idea of determinants of health really determined not just health care, but the ability to maintain life.

Dr. Blanco:

And it wasn’t only, you know, these laborers, right, these essential workers? It’s if they’re now living in multi-generational households and they’re bringing COVID home, right? And now the entire household was affected, and I know for us, in wave one, really the hospital was filled with the family members of these essential workers, right? So, it wasn’t just, you know, the truck driver, it wasn’t just the, um, supermarket worker, it was their entire family in certain instances, that were all in the hospital together.

Dr. Dua:

I really think that the pandemic clearly has, um, brought to light a lot of these stressors and inequities in our system. But it also has sort of shoved us into new pathways, right, in ways that we can try to address or bridge some of these major issues.

So, can you tell me a little bit, Dr. Wright, first about some ways that we have are trying to bridge this gap? And maybe how the pandemic, while it’s been miserable, maybe has had some other positive impacts or things that we can use to help address the inequities?

Dr. Wright:

Sure, I mean, you know, I always said that the pandemic jettisoned us into the future. It taught us that the things we thought were, you know, were carved in marble, were actually just floating in sand. So, for instance, the fact that we could use telehealth more widely was a huge boon for many of our patients. They could see us from the breakroom at work without having to leave, lose time off from work, or even expose themselves to environments. With patients who, themselves were quarantined, because they were so at high risk. And so, telehealth was this massive boon.

So, we could help our patients, we could also help them with their emotional well-being because we could reach them through a video call. They could, you know, contact us at their moments of greatest distress. But we have to also realize that this was not equitably distributed around the country and that there were many populations who had cell phones but not smart phones and so it was harder for them to do video calls. They didn't have broadband access and so when we look at our colleagues in more rural parts of the country or areas that didn't have adequate infrastructure, even within an urban environment, this level of care is not available to all people. So, yes, there are things that we can use to bridge the gap, but we have to make sure that as we bridge this gap, we do this in an equitable manner so that we don't also exclude those very people that we need to help.

Dr. Dua:

You guys, this is such an insightful and colorful and really amazing discussion. I think that was a great way to round it out honestly. And I just want to thank both of you for being here and helping us to better understand how we can try to improve some of these inequities in rheumatology care. And we've touched on so many different important pieces here in this conversation. So, Dr. Wright, Dr. Blanco, it was really great speaking with both of you today, thank you for being here.

Dr. Wright:

Thank you for having me.

Dr. Blanco:

Thanks so much.

Announcer:

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