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Geri Amori: Hello, everyone, and welcome to *Healthcare Perspectives 360*, a podcast dedicated to exploring contemporary healthcare issues from multiple perspectives. I'm Geri Amori, and today I am joined by Rebekah Schiefer, a behavioral clinician and educator who focuses on the healing power of the patient-clinician relationship; Josh Hyatt, a healthcare risk manager, bioethicist, lecturer, professor, and author; and Anthony Cheng, MD, a full-spectrum family medicine physician with special interests in addictions treatments, gender-affirming care, digital health, and health equity. Welcome.

Today we're going to talk about The Joint Commission's mandate to collect data on patient healthcare disparities and the impact of this mandate on the wellness of healthcare clinicians. So let's start today's discussion with you, Anthony. You must hear about sad or difficult situations every day from your patients. Would you mind sharing with us how it feels when a patient has a need or has needs that you cannot help get met?

Anthony Cheng, MD: Yeah, Geri, that is a really poignant question. I mean, it creates a sense of rage, to be honest, right? Because you are seeing a broken system. You are seeing a system that is causing oppression. You're seeing a system that is breaking people's will, that's not providing the things that humans need to achieve their selves, their best versions of themselves. And that is my motivating principle in life as a physician and as a person. I seek to help people become the best version of themselves, enabling that through health. Enabling that through a trusting relationship with the clinician. And when you see that the system is preventing them from reaching that goal, it's deeply troubling as a professional. It creates anger as a citizen. And hopefully we can transfer that energy into something positive, but it really starts with anger.

Amori: It must be discouraging, as a human, too, to feel you can't really do a whole lot about a situation. Yeah. Rebekah, how do you think this information on disparities will impact the clinician-patient relationship if needs identified just aren't met?

Rebekah Schiefer, MSW, LCSW: I want to build on what Anthony said. I think this is happening already all the time, so I think some of the concern is that this screening would actually increase the experience of this for patients and providers. You know, and I think it could go in a lot of different directions. You know, sometimes it could actually create a situation where the provider and the patient sort of are bonded together in their frustration against the lack of a resource. I see that happen a lot. I also think especially if there isn't that relationship there between the provider and the patient that this could undermine the relationship a bit, especially just depending on how this kind of resource referral goes, and if the patient was really trusting that they were going to get something, they might blame the doctor, even though it's really not the medical provider's fault that the resource isn't available.

I think the other thing that can start to occur is that, as a person is unable to access a resource, the provider can start to just feel more responsible by default to try to solve the issue, even if it, you know, goes outside of their scope or their lane because they feel like, well, this person isn't going to get what they need and so I'll go ahead and try to do it. And I think that is oftentimes coming from a place of trying to do right by the patient. I do think it can sometimes open up the provider

to certain risks, maybe that fall into Josh's category even more around, could the provider get themselves into some ethical binds because they end up paying for something for the patient, you know. I mean, I've heard of many things happening like this where the provider gets frustrated and just goes ahead and does something that is sort of against the rules, but it's because the patient needs it. And I think that can create some…again, it could strengthen a relationship, but it could also create some risk there for the provider ethically, as well. So, it could go in many different directions.

Amori: So there could be some boundary issues that end up really coming to the forefront there. I can see that. Josh, in terms of quality, how do you think these unmet needs will affect healthcare quality? Both in the short term and long term?

Josh Hyatt DHS, MBE, MHL, DFASHRM, CPHRM, HEC-C, CPPS: You know, it's interesting, outside of or irrespective of these regulations, there are currently expectations from patients, staff, and the community that we meet these unmet needs, and when we as an industry fail a patient, it reflects back on us. And these unmet needs exacerbate the conflicts, the distress, and the moral distress that already are existing. So, I think in the short term, we see more conflict, more dissatisfaction from both the patients and the staff. And unfortunately, we often will end up with harm to the patient. For example, like in all emergency rooms have the "frequent flyer" patients, right?

Those are the…I've never seen studies on this, but I think it would be a fascinating research, but anecdotally in my career, many of these patients are from intersected vulnerable populations. They have significant determinants of health that are not met, and in several of the incidences that I've been involved with, these vulnerable patients received less and less care over time because of the perception of them being a frequent flyer. And then they end up with catastrophic outcomes because something was missed that shouldn't have been missed. And this is a good example of implicit bias kind of creeping into the provision of health servicing when we have significant determinants of health. In the long term, there's just this spur of the eroding of trust and burnout with our providers, and we have a record amount of people leaving the profession, which is going to impact us. And then we also see from the safety outcomes: litigation, accreditation issues, financial loss. So there are a lot of downstream impacts when we don't really think about this in the forefront.

Amori: Oh, thanks, Josh. You know, Anthony, I hope you don't mind I'm going to ask you kind of a personal question. You're a physician, you're a practicing physician. How do you plan to create the time and energy to actually embrace this new mandate and do it?

Cheng: Yeah, you know, it's interesting. I'm quite lucky in my practice. We have an integrated care model, and we have social workers and behavioral health resource specialists that work in my clinic. And so, when we identify as clinicians that there is a need for a connection to a social service agency, for example, I can do a one handoff. I can go down the hallway, make an introduction, describe what the needs are, and my teammate will kind of pick up the baton, and we'll continue to work as a team through that process. This is going to become incredibly important for us to standardize as healthcare because without that, I would be absolutely crushed. You know, it's just too much.

I do not have the time or expertise, frankly, to pick up the phone and have a conversation with social services agencies to, you know, and to help patients fill out complicated paperwork. And these are all things that are our jobs. They're functional roles that are part of completely caring for patients holistically. And so, we will have to allocate resources to that kind of need, but, absent that, it would just be incredibly frustrating and demoralizing. I have to, even with these resources, pace myself, right? Like I know that in a given day, I will dig deeper in a certain number of encounters, and there might be a certain time of the day where I reach, you know, this is just going to have to stay more superficial because I'm tapped out emotionally.

And unless, of course, if the patient goes there, then I'll go with them, but I'm not going to dig as hard. Sometimes if we're doing this every day, all the time, that could be really hard, especially if we're under-resourced.

Amori: Wow, thank you, Anthony. Thank you for being so honest with us. Rebekah, you know, I'm a risk management professional with a mental health background. Every day I talk to people all over the country, and I'm hearing about staffing issues and burnout issues, and I'm witnessing it when I teach communication skills. I'm sure you are, too. I want to ask you, I'm afraid…what are your thoughts about how this is going to impact burnout and all we're seeing?

Schiefer: I really want to try to end on a hopeful note, but I'm going to start darker first because I think it's important to acknowledge that, yes, this is happening right now already, right? So a huge part of my job is teaching residents, family medicine residents. I see the impact right now on our interns, who start out, coming out of medical school, very impassioned, really—I say idealistic in a good way, right? It's a good thing. And what they learn, you know, quite frankly just smacks them in the face in their first week on an inpatient service is that right now at least half the patients they see are there in the hospital, staying in the hospital because of a social issue—not a medical issue—a social issue that has not been addressed.

And that is what causes them to stress. You know, yeah, if they make a medical error, they don't know something and there's a knowledge concern, of course that creates distress. But the thing that they struggle with the most and the things they want to talk about the most are these cases that they have been…these patients, these people, these humans that they have been entrusted to take care of who they do not have the skills, resources, or ability to address, you know, the primary issues that are going on. And so, that's already happening. And, you know, I don't know that I have a good answer to how do we implement even further screening and not, you know, create further powerlessness because I do think that that is going to happen.

I think there are ways that we can do that that would lessen the impact, and I think that's one that we should not be relating to these screeners as a one-directional sort of thing. That, I think Josh had said it earlier, giving a form though and then responding to the form, that's not the way for these conversations to happen. And then I think we need to create a space for providers as we implement this to be able…it should be an iterative process. They should be able to give feedback about what's happening and what this is like. Do you need communication tools? Do you need more support from your team? Are there certain ways that you should be asking these questions that could really help with framing what your abilities are in your lane? I think that we

really have to be sending the message to our providers as we implement, you know, this screening process [that] they're not solely responsible for holding the bag here, and that it is okay for them to use their clinical judgement at times, you know, to determine whether this is the time for that conversation or not.

And the last thing I'll add is just that there's a lot of assumptions made also when people fill out a screener as to whether they want resources or not. And it's interesting because there are studies to indicate that, just for example, somebody might indicate that they experience food insecurity, but then when they're asked if they actually want help with getting more food, not everybody says yes to that. Again, we need to not make assumptions about what people want just based on what they might answer about, you know, their particular social determinant health situation.

Amori: That's kind of hard because those of us who want to take care of others, when we see a need, we want to jump in and take of it, right? But, you know, that gives me a little optimism, as you were saying. But, Josh, I want to ask you, you know, from the risk management perspective and the ethic perspective, are there options to like spread out this requirement so it doesn't all come and fall directly on, say, our physicians?

Hyatt: Yeah. And supporting what Rebekah said, and I appreciate the impassioned plea in that implicit conversation because it's real. And how I'll respond to this is aspirational. I think that this is more aspirational for me. I don't think of this as a delegation of a duty, of filling out a form or who does this or who does that. I would like to move from the idea that this is the responsibility of a person or a department, but a culture. And really, how do we change our culture, how do we build a culture that encompasses all of this as part of what we do in healthcare rather than be focused on the more task-driven things. How do we care for our patients, how do we care for our families, and how do we care for our providers? Everybody, in my opinion, should be aligned and aware of how these initiatives are developed and rolled out within their organization, how they are built within the culture, and the expectations.

And the topic should really be embedded into everything that the organization does, from their mission statement all the way down to creating forms and processes and what color you paint the hallways and everything. It should be a full, engrossed, comprehensive approach to both the practice and the art of medicine.

Amori: Thank you, Josh. Which leads me to my next to last question—for Rebekah here specifically. Do you see some ways we can include the patient in this discussion?

Schiefer: Yeah. I think we should. I think there's a lot of different ways that healthcare organizations do that. Some have patient advisory panels. If you're in FQHC, you may have a board. You know, collecting information just from patients in a particular clinical environment—because they can be so different, right? In our, me and Anthony's, healthcare organization we have like seven different family medicine clinics, and the culture there is really different. And so, I think being able to find out from people, how would you like us to ask about or find out this information, would be a really important step.

Amori: Great. And you're leading right into my last question, which is for each of you. If you had one thing you want our audience to take away today about this topic relating to, you know, how it's going to impact clinicians and what we need to do, what would that be? So I guess I'd like to start with you, Rebekah, since you just answered.

Schiefer: We can all have a value, which I think many of us do, for addressing the social determinants of health and simultaneously recognize that it is not without risk to the clinician. And so, the implementation of these screeners…I mean ideally it would be a culture shift and a change, but it is very important that we consider what is happening not just to the patient, but to the clinician and in the relationship.

Amori: Okay. Thank you. That's really good. Josh, would you share quickly your one thing for us to take away today?

Hyatt: Absolutely. I agree with Rebekah. This is a multifaceted issue. This is not a one thing, this is multifaceted, and it impacts everybody that's in the provision of care, from the patients, families, providers, all the way through to the community.

Amori: And, Anthony, please, from the physician's perspective what do you want people to remember today?

Cheng: So, physician and provider wellness is such an important thing to keep in the front of our minds. And yes, it is about systems. But if you're a clinician who's on the verge of burning out and quitting, or even if you're not, you can't wait for the system to change. So we, as clinicians, are going to have to get really good and stay really good at being wise about this. And what I mean about that is that we have to be okay with valuing those moments with patients that give meaning to our day with providing care to that person right there and that being enough while we're also tackling these big challenges that, from a day-to-day basis, feel unsolvable but eventually, as we stay engaged, will get better. But we need to be wise and regulate our energy and our emotional expenditures, so that we can stay in the game.

Amori: Anthony, thank you so much, Rebekah, Josh. Thank the three of you so much for joining us today and sharing your perspectives. And special thanks to our audience for joining us today, and we look forward to seeing you next time when we explore further *Perspectives 360*.

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