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Geri Amori: Hello, everyone, and welcome to *Healthcare Perspectives 360*, a podcast dedicated to exploring contemporary health 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 treatment, 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 challenges to allocate resources to meet the mandate's requirements.

So let's start today with Rebekah. Rebekah, can you help us understand a bit of the impact on clinicians this mandate creates by painting a picture for our listeners of what, ideally, care coordination could look like in response to the data gathered on the patient healthcare disparities?

Rebekah Schiefer: Thanks for that question, Geri. The best coordination really looks like being able to pick up that phone and call someone directly along with the patient, or to be able to say to the patient, hey, I know Laura over at Community Action Team, and she's going to be in office on Tuesday at 1, and I want you to go in and tell her Rebekah sent you. I think that's ideal.

It's also really important to know exactly what accessing a particular resource looks like, which oftentimes is not the case in healthcare. So if you screen and then send a patient off to talk with someone about housing, and they have an entirely negative experience, they're going to trust you less, which I think we touched on a bit in our previous episode.

I think the issue with many healthcare providers [is that they] are implementing social determinants of health screening, and there hasn't been coordination with the other agencies in a meaningful way, so [there] are going to be times where these social service agencies are actually having significant staffing crisis, or they may be overwhelmed with requests and they can't respond.

I'll just give a simple example that I think a lot of our listeners would be able to identify with is just simply referring people to psychotherapy right now. People have to make literally dozens of phone calls and leave messages, and nobody calls them back, and no one's calling them back because the therapists on the other end are receiving 20, 30 messages a day, they can't possibly call back.

So what that would look like in an ideal situation is that that referral partner knows who's taking new patients, what is really happening on a week-to-week basis in those referral partner agencies. You actually know what that experience is going to look like for the patient, and you can help temper the expectation of what it will actually look like. That, I think, is ideal, and I

don't think that's oftentimes the reality of what actually occurs, because it takes a lot of planning and energy and time.

And additionally, it actually requires that the referring agencies have the appropriate resources, and oftentimes they don't. And so it starts to call into question where should the money be going; should it be going more into healthcare to do screening and help people with screening, or should we really be reallocating resources to the agencies that are actually delivering these services?

Amori: So what I'm hearing you say is that this new process is going to really give us some challenges in terms of managing expectations and what patients can expect when someone tries to help them; they may try to help them but not be able to as much.

Schiefer: Absolutely.

Amori: How does that affect you, Anthony? Can you talk with us about the resources you have available, truly available, for patients who have identified healthcare disparities needs?

Anthony Cheng, MD: That story about tempering expectations about resource access for patients—I have that conversation every day. I'd like you to have access to this thing. I know it's going to take a lot of work, and it's going to be frustrating for you to get that.

One of my patients, who is so depressed that he simply can't get out of bed, told me that he has been maintaining a spreadsheet of different mental health resources that he's reached out to, and the list just keeps getting longer and longer, and more and more resources that just are not available to him.

And then I think it taps into this larger social context. In Oregon, a worker making minimum wage would need to work 82 hours in order to afford a 2-bedroom apartment, and we have 250,000 families just in the state of Oregon making less than $33,000 and needing affordable housing, and there's only 140,000 units available to them.

So this housing crisis, which is writ large nationally, is just an example of how our whole country has underinvested in social services, and on a one-on-one basis with patients I experience that every day, that there's just not enough resources available.

Luckily, I work in a setting where Rebekah is a director of our behavioral health team, where we actually have someone in my clinic that can sit with patients as they go through this—very frustrating, sometime—journey accessing social services.

Amori: Wow, that's really sad when you're talking about somebody with that severe depression, especially, that really brings the picture home.

Josh, so here we are, it's like we're pulling the scab off a wound here. And what is the risk if these expectations and resources are not there to meet the needs that people have now identified?

Josh Hyatt: Yeah, that's a great question, because the question is is there an ethical duty to understand these things? Yes, there is an ethical duty. There's even potentially a legal obligation. If you know of something, and you don't do it, do you have liability? There's a possibility that that exists, for sure, and cases certainly can be made around that.

So the more you open up these, as you mentioned, "scabs," the more likely you're going to get an infection and something bad is going to come out of it. And so, for me, what I think more about is about instead of like these questionnaires and things like that, it's really how you develop relationships and build those relationships with patients. To me, that's the key component of it. It shouldn't be like a paper checklist thing.

Quick story. I had a urologist who had contacted me, and he had a 25-year-old healthy patient who came in and requested an orchiectomy. There was nothing wrong with him; there was nothing wrong with his testes, he just wanted an orchiectomy, he wanted the testes removed. And when the physician was trying to inquire why, he wasn't sure, and he didn't feel comfortable doing this. And this was in California where the laws favor protecting trans and sexual and gender minority individuals.

The provider said let me get back with you, set up a second appointment, and contacted us for help. When we tried to kind of go through what were the steps, what were the things that were happening, he didn't even know if the patient was trans, he didn't know what the other options were, he hadn't thought through that whole process. So that's what we were able to do is kind of think through it before you said no, that you didn't feel comfortable doing that and getting them to the right place.

Amori: Wow. Rebekah, what do you see as some options for clinicians and organizations to assemble those resources from the perspective of social work?

Schiefer: Well, I hate to just be playing one note here in this podcast, but to come back to the relationship. I actually wrote down something that Anthony had said earlier, which was that there's this process of disclosure at the pace of trust, which I thought was so accurate and beautiful. And I think that we have to consider that, at a larger level, there has to be trust between organizations, too, and there has to be communication and alignment.

And so I think as healthcare organizations are implementing these social determinants of health screening processes, it is really imperative they have relationships with and have cultivated some relationship with some of their most common referral partners, so that those people know, hey, you might be getting more referrals for food insecurity from us, and what do you need from us?

It has to be bidirectional. And I think some of the concern that's coming up right now is that the screening is going to be one-directional in many ways; the healthcare people are going to know what to do, and then they're going to send the person off to the right place. And I think this is a situation of we don't know what we don't know in healthcare a lot, and so there really has to be I think elevating the relationship between organizations, and prioritizing that is a piece of this process implementation.

Amori: Well, that leads to what I wanted to ask Anthony next, which is, you're going to be collecting a lot of data—I mean, tremendous amounts of information on your patient population in your catchment area, as Rebekah was just saying, and so you're going to have to prioritize based on what our colleagues here are saying. How do you see your practice analyzing and prioritizing what it is you can address and help patients with?

Cheng: Absolutely. And we have a human amount of capacity to develop relationships with partner organizations, and we have to recognize that there's humans on both ends, and that there's trust in relationships on both ends. And there's been a history of systematic disinvestment in social agencies, and so we need to approach that as healthcare organizations with that awareness and understanding. Ideally, take some actions to redistribute that power.

This is all going to be very intensive on a human level, so where the data can come in is that maybe on a population level we identify that this year we are going to focus on this priority area as defined by the data. Food insecurity for our clinic is number one, so let's build some relationships with agencies that can help us with that, and let's have those really robust conversations with them so that we can at least start somewhere.

And I think The Joint Commission's mandate recognizes that the status quo is not working, so we do have to change something. But the mandate to screen itself doesn't indicate the solution, but this thoughtful handling of the data, I think, could be helpful.

Amori: That makes a lot of sense. Josh, I wanted to ask you. You live in an urban area, and so do Anthony and Rebekah, and I live in a rural area. And I'm kind of scared, to be honest with you, I don't know how rural and underserved areas will be able to meet needs that are just—the stuff isn't there to meet them, the resources aren't there. How do you think that's going to take place from a risk management bioethicist's perspective?

Hyatt: That's a great question, and it's a huge unknown. Determinants of health obviously are often illustrated by increases in inequity in populations where there's poor people, and these communities often represent even in densely populated urban areas and areas where you have food deserts in the middle of cities. You have very significant disproportions in inequities around different things.

And I actually was born and lived a bit of my life in an extraordinarily rural community in eastern Tennessee, a very small group; those rural areas have both advantages and disadvantages, significant ones. And so, in my town, everybody knew everybody's business, and we all knew what was going on, and if somebody needed help, they got help: people were there. There was a community support program in place, and it was obviously very self-evident. What was interesting is, when I worked in downtown LA, I saw the very similar type of thing in their little regional areas. What I found was that these vulnerable populations were kind of linked by poverty and this kind of intersectional compounding different types of situations.

But I think, in reality, in the larger context of things, that this process and these outcomes will be impacted by the kind of institution and the affiliations that they have. Larger healthcare systems or those federal community health centers, they're going to have more resources to do this.

Freestanding rural and those densely urban institutions, they probably won't, and they're going to be at the most risk because they triage their time to take care of patients; they have very limited resources for these kind of outside endeavors.

Amori: Good. Okay, well thank you, more to think about there. So now it's time for my favorite question. And my favorite question is if you had the opportunity to leave one thought that you want our audience to think about particularly related to how we're going to allocate resources and the challenges to that. I'd like you each to share your thoughts. So I'd like to start with you, Rebekah. What would you say is your one thought, one thing you want the audience to remember?

Schiefer: I think going to the people in your organization who deal the most in resources, whether that is social workers or case managers, getting their input on who do you interface with the most, who do we refer to the most if you don't know the answer to that question. Inviting those folks to the table for a discussion about how this screening is going to impact those agencies and getting feedback from them would, I think, be my number one recommendation for how to think about resource allocation.

Amori: Okay. Thank you very much, that's very useful. Anthony, what is your number one thought for people to remember about resource allocation?

Cheng: I think that healthcare leaders will be tempted increasingly to invest in technological solutions to these problems, and I don't want people to think that technologies like referral hubs are not a part of the solution, but they are absolutely not the whole solution. We've touched on how resources, dollars of investment in social services agencies, human capital, and relationships are really essential to effectively addressing the needs that are uncovered with the screening. I just want everyone to be cautious about overinvesting in technology.

Amori: Okay, thank you. Remember not to trust technology in place of humans, that's important for us to all keep in mind. And Josh, finally, what would you like everyone to remember?

Hyatt: Kind of very similar to original, my first thought was around collaboration. There's not one way to do this, and I would recommend collaborating with like facilities to see what they're doing, and build those relationships with other facilities as well as within your communities.

Amori: Excellent, thank you very much. Well, this has been a very interesting and great conversation. And I want to thank our panelists very much, thank you for being with us today. And I also want to thank our listening audience. I hope our discussion has provided you with some new insights from a *Perspectives 360*. Thank you again for joining us, we'll see you next time.

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