MASSACHUSETTS Health & Hospital ASSOCIATION

Takeaways from MHA Webinar:

The Impact of COVID-19 on Health Disparities: Strategies for Addressing Health Equity

May 19, 2020

Overview

COVID-19 has disproportionately affected lower-income communities and people of color. The healthcare system has a role to play in addressing systemic disparities faced by these groups while providing access to critical healthcare services. The webinar features an in-depth discussion with Thea James, M.D., Vice President of Mission and Associate Chief Medical Officer at Boston Medical Center. The discussion includes how COVID-19 has amplified existing health inequities and an offering of specific strategies for healthcare systems and leaders to address structural barriers to health equity during this pandemic and beyond.

Interview

During the webinar, Dr. Thea James, M.D. was interviewed by Massachusetts Health & Hospital Association's Valerie Fleishman, Senior Vice President and Chief Innovation Officer.

1) **We've all seen the reports and the data that shows that the COVID-19 pandemic has had a devastating effect on communities of color. It is shining a clear spotlight on inequities that have existed for quite some time. Were you surprised about the reports of COVID-19 race & ethnicity data? If yes, why? If no, why not?**
    a. I was not surprised by the COVID-19 data actually, because I sort of live it every day of the week and have for many years. Maybe it's because I work in a safety net hospital and by definition that means that a majority of our patients and who we serve are in a certain level socio-economically. When you work in a safety net hospital grow to understand why these populations are here and what the root cause of it is. At the same time you know there's an opportunity to think about how can disrupt that. If you think about any data you see from slide presentations, to articles, to newspapers, and if it's categorized by race and ethnicity—you can predict that black and brown people will fare worse than everyone else, so it's predictable.
    b. As an ER doctor, I know that I only get one opportunity to get this right. In many cases, a patient's condition is tied to their socioeconomic status. My colleagues and I have learned working in a safety net hospital, that whatever you're doing for many patients, oftentimes you are just resetting them back to baseline. If a patient arrives unstable in their disease, you're going to reset them back to baseline only to discharge them back to

exactly what's driving it. We have started discussions on and started looking at how we can break these cycles. I've been reading a lot during the pandemic, and it reminds me of a lot of the 1929/1930s and the efforts to revive America at the end of the Great Depression of 1929. The most common pathways to rebuilding America were homeownership. However, at this time, redlining policies were established which stated that if you lived geographically behind certain redlines; you didn't have access to that wealth-building pathway. Due to this financial barrier, there was a creation of these two socio-economic populations being established which still resonates today.

2) **You talked a bit about the past, harkening back to the 1930s. What do you see as you look forward to the future? Do you think it's possible to break this cycle as you talked about, and if so, how?**
    a. I do think it's possible. From my experience, the most difficult thing is getting people to shift their mindset about what's possible. When someone finds a person in need of something, especially people who come from disinvested communities (say for example, they have food insecurity), oftentimes the immediate action that people want to do is to provide charity, such as food donations or vouchers. This is valuable, but to move forward and as part of that initial intervention & disruption, we must provide individuals with a pathway to financial stability. We must enable them to participate in the economy fully like the rest of us. This is often a tough mindset shift for people. I've even asked people, if you could imagine—even if it's hard for you, perhaps to try putting yourself in someone's place who is food insecure. Think about the options-- would you prefer food subsidies into perpetuity or would you like some subsidies to get back on your feet and then a pathway to eliminate your need for subsidies? If we can shift mindsets, I think this is the greatest pathway for creating financial independence for communities.
3) **Along those lines, what do you think healthcare organizations and healthcare leaders can do to support these efforts? I know hospitals like BMC have put a lot of focus on social determinants of health. What can hospitals do to address structural barriers?**
    a. Number 1: The creation of a Health Equity Assessment Tool. This can help to ensure that people you are trying to help end up being self-sufficient, on a healthy pathway, and don't fall victimized by a stressor such as COVID-19. Additionally, for every decision you make with that assessment considers equity.
    b. Number 2: Each time a hospital does construction of new buildings or facilities, say for example you are required to give 5% of the total cost to the community and for the first time we asked if we could contribute our obligation in multiple different Housing Initiative. We were granted permission to do that. The downstream consequences of this industry, which we call the "Healthy Neighborhood Equity Fund," is founded on certain criteria that developers have to meet, and are scored on before they can receive funding for development. For example, they must provide access to affordable housing, certain employment standards, and green walking space in the area. This ensures that we know what we are investing in and helps us to disrupt structural barriers. It is those

types of measurable development projects that you can take on and see what your impact actually is.

4) **Could you discuss the work you're doing as part of the City of Boston's COVID-19 Task Force? Is there data that we're not tracking today that we should be? What do you anticipate coming out of that as a Task Force?**
    a. It's been a fast-moving, action-oriented task force that has examined data and acted on everything that was seen immediately. For example, understanding which communities were not receiving information or supplies that they needed. Also, making sure that we had language-appropriate and culture appropriate trainings and webinars for communities where needed. We delivered safety kits and also very quickly set up an increasing number of testing sites in the communities. Simultaneously, examining policy and structural barriers. We also are discussing economic development, employment, and childcare needs. We are also looking at prevention on key healthcare issues and looking forward to ensure we are ready for the future.
5) **You spent some time working in the ED during COVID. Can you tell us what those experiences have been like and what you've learned from that?**
    a. I love Emergency Medicine and I love it so much because I love the people. Particularly, for the fact that a person comes, whether they are sick, depressed, angry, looking for help and you get to shift their perspective. I feel privileged to work at BMC. It has been challenging during COVID, with patients being tested positive, not being able to have family nearby. We have been faced with keeping a safe environment and to protect ourselves and our patients. From a humanity perspective, it is a complete privilege to be able to do it. I don't know if it's the nature of emergency physicians, but I know there's a lot of emotional toil and lately I've talked to colleagues and seen on webinars—all those amazing characteristics of humanity shine through.
6) **As an ED doctor, you are certainly accustomed to stressful conditions. Data has shown that stressful conditions that healthcare workers and many others have been operating under during this pandemic can exacerbate biased behaviors. Do you have thoughts as we look forward about how we can work to mitigate that?**
    a. I have told my residents before to start from a place of understanding. If someone presents with substance use disorder, a behavioral health condition, or other extenuating circumstances—you have to give them opportunities. People do not choose suffering and if someone presents themselves in the ED, they are asking for help. Growing up, I was never allowed to judge people—my father would always explicitly say "you have no idea what that person is going through, you have no right to judge them," and so I don't judge people. I just focus more on being able to relieve whatever it is they present with. Sometimes people do not understand life outside of the life they have, given their privilege. When you grow up in the world as a person of color, at least in America, it's impossible for you to not be aware of every part of that spectrum and I think this may help prevent some bias. We have started teaching about bias and determinants of health. Currently, this would be our fourth or fifth intern class going

through this learning as part of their hospital-wide orientation. This is an effective way to mitigate bias in hospitals system-wide.

7) **How can providers working within the hospital setting respond to racial bias and racial trauma as it presents itself in clinical care?**
    a. Mainly because there is a hierarchy in medicine, sometimes people feel at risk to speak up in the moment. There are avenues for individuals to articulate and if you don't feel comfortable doing so, there are some places that you can safely talk, but I think the hierarchy in medicine is what makes people feel so vulnerable. Oftentimes individuals may generally think twice before they speak up and speak out. I always try to seize the opportunity to help someone, especially my trainees, think differently about something, especially when they're on a learning curve. As a safety net hospital we have limited resources and our patients also have limited resources. We are working with a lot of healthcare systems in the city; it must be a joint effort and each hospital cannot do it alone. As a business model, we need to focus on business, foundations, philanthropy, community-based organizations, and government, and in bringing all of these organizations in we can have measurable impact and create a more innovative type of business model for effecting change. This will help us to change the paradigm so that we can see different outcomes.