ON THE FRONT LINES OF HEALTH EQUITY

PEOPLE WHO MAKE A DIFFERENCE

BY SUZY FRISCH

Physicians see stark disparities in health outcomes for different patient populations all the time. The diversity of causes mirrors the distinct efforts of Minnesota clinicians to tackle the complex roots of these disparities. Many physicians and public health experts aren't waiting for others to dive in and develop solutions for health equity. These six individuals are leading the way, from teaching future physicians about implicit bias to developing community-led health programs and advocating for policy changes.

MARY OWEN, MD

Family medicine physician for the Fond du Lac Band of Lake Superior Chippewa

Director of the Center of American Indian and Minority Health (CAIMH) at the University of Minnesota Medical School, Duluth campus

Assistant professor of medicine in the Department of Family Medicine and Biobehavioral Health

Mary Owen, MD, pursued a career in medicine to provide the kind of care to Native Americans that she rarely received herself. A member of the Tlingit nation, who grew up in Alaska, Owen earned her medical degree from the University of Minnesota. Then she returned to Juneau to practice medicine. When the CAIMH director position opened 11 years later, Owen was eager to perpetuate its mission. She helps other Native students become doctors while educating future physicians about her people, their history of trauma and health disparities.

Why did you get involved with health equity work?

We're addressing Native American health and, in doing so, we're addressing health disparities for other populations as well. We train people from Native communities and hope that they return to those communities to work. Within the Bemidji Area Region of the Indian Health Service, we have a 50 percent vacancy rate for physicians. We want to recruit people who will serve there, and we know that Native doctors are more likely to return to Native communities. We need a pipeline to increase the numbers of Native students who go to college and medical school. Only 20-40 Native American physicians graduate from medical school out of 20,000 people who graduate in this country each year.

How are you addressing health disparities?

I educate all of the medical students in Duluth about Native American health. Doctors who work in Minnesota will come across Native patients, and we have distinct needs and issues that they should understand. We have 10 hours of required curriculum around Native health. People in the United States are not aware of Native history. They don't know about the boarding schools and relocation of tribes and genocidal policies that were intended to wipe out our culture and the impact those acts had on the Native psyche and health.

We teach students about this historical trauma so that when they meet patients, they don't assume their health is the sum of poor choices. We have huge disparities, but if people don't know us, how can they attend to the disparities? We want them to recognize the impact of social determinants of health and meet patients where

they are with trauma-informed care and respect for what they might have gone through. Then they can use that information to guide their patients' health care and have patients lead them where they want to go with their care.

How do you feel about the future when it comes to health equity?
I'm really hopeful. I just taught those 10 hours and at the end, I asked for a reflection on what students learned about barriers to health care for Native American people and their role in the future. By far, most of the students were happy that they had learned this. They were interested in using this knowledge and applying it to patient care. The medical school's curriculum office is suggesting that maybe we need to have more than 10 hours and embracing the idea of making social determinants part of the curriculum. People seem on board with addressing the gross inequities we have in our country.

MICHAEL AYLWARD, MD

Internist and pediatrician who practices at the University of Minnesota Community University Health Care Center (CUHCC)

Associate professor of medicine and pediatrics and program director of the University's Medicine Pediatric Residency Program

President of Minnesota Doctors for Health Equity

From the start of his medical training, Michael Aylward, MD, has been motivated to care for underserved populations and to train medical students and residents to do the same. That work has been fulfilling. But Aylward concluded that physicians have a unique ability to advocate for changes to improve the macro issues affecting patients. He joined with other physicians to start Minnesota Doctors for Health Equity in 2017, aiming to train doctors how to promote changes that foster health equity.

Why did you get involved with health equity work?
Minnesota is an important place to be doing this work on equity because there are significant educational and health disparities here. When you start to pay attention to patients' stories and their struggles with getting medication and access to health care, housing and food, you begin to see that there are a lot of people struggling with a lot of different aspects that directly impact their health.

During the last three years, I've really gotten involved in advocacy efforts, specifically focused on health equity. I realized there was more work to do outside of the patient room. As physicians, we are privileged. We can walk into certain rooms and say things that other people cannot, and we should be doing that. When you juxtapose the feeling of powerlessness in the clinical environment with the things you can do outside of it, it drives you to do more.

How are you addressing health disparities?
Our focus at Minnesota Doctors for Health Equity is really on educating physicians to be effective advocates. We want to have as many health professionals' voices in Minnesota speaking about issues of health equity in whatever domain they are in. We want to educate lawmakers and community members about health policy and what it means when someone proposes a new law. How does that impact people? The thing that drives us is to get as many people using their voices to be change agents in whatever way they can.

There are a lot of issues that physicians can speak to from the perspective of health and public health. At the University, we're trying to increase awareness and collect data on health disparities so we can close the gaps. Also, the health systems of Minnesota are huge employers; what they do around family medical leave and making sure everyone working in the medical system has a living wage and good health insurance and housing—these are impactful decisions. We're also talking to lawmakers and testifying when they need more information about health issues.

How do you feel about the future when it comes to health equity?
In the last 10 years, we've recognized that there are health disparity issues in Minnesota. There is increasing realization that these health disparities affect everyone, they are costly and they weigh society down. There are many groups and physicians and health systems doing things to make changes both within the walls of the health system and beyond. There's a growing movement that these things are important, so it's promising.

LAPRINCESS BREWER, MD, MPH

Cardiologist at Mayo Clinic, Rochester

Assistant professor of medicine in the Mayo Clinic Division of Preventive Cardiology/Department of Cardiovascular Medicine

National Institutes of Health–funded researcher who focuses on cardiovascular health disparities

As a George Washington University medical student, LaPrincess Brewer, MD, MPH, was inspired to address the underlying causes of patients' health issues. She saw many patients referred to as "frequent flyers" whose health care providers didn't take time to investigate both the medical and the psychosocial factors behind their recurring problems. Brewer pursued a master's degree in public health from Johns Hopkins University, focusing on epidemiology and biostatistics to wield data against health disparities. Ultimately, she came to Mayo Clinic for a fellowship in cardiology. She is now a faculty member in the Department of Cardiovascular Medicine.

Why did you get involved with health equity work?

African Americans in Minnesota have a higher incidence of cardiovascular disease and they die earlier from cardiovascular disease than their white counterparts. That fuels me to address these disparities in Minnesota and on a national level. Some of the reasons African Americans die earlier include uncontrolled cardiovascular risk factors like high blood pressure, diabetes and poor health behaviors such as physical inactivity and unhealthy diets. African American women have worse cardiovascular health disparities than any other racial and ethnic group, influenced by unique psychosocial factors or social determinants of health such as high stress and stressors. We need to build a culture of health to prevent diseases and help people control them so that they can live healthier and longer.

How are you addressing health disparities?

During my public health program, we developed the Fostering African American Improvement in Total Health (FAITH!) program with an east Baltimore church. They wanted to learn more about how a healthy diet and nutrition can prevent chronic illnesses. We had a great relationship with the church that truly changed the culture of eating from within, with dissemination outside the church.

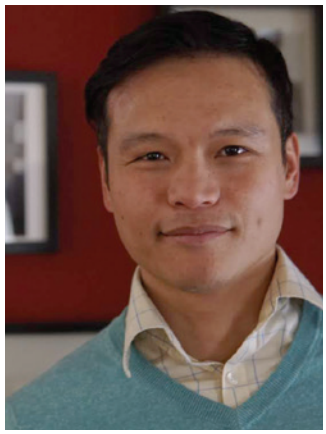
During my first year of cardiology fellowship at Mayo, I met with three pastors in Rochester who wanted to bring FAITH! to their churches. They saw the disparities in real life, with people suffering from hypertension, diabetes, heart attacks and strokes. We created a community-based research project and delivered a 16-weeks, face-to-face health education program centered on cardiovascular risk factors. We had activities that included cooking demonstrations, fitness classes, seminars by Mayo Clinic health professionals and support groups. We had several improvements in cardiovascular risk factors.

Participants provided us with insights that they really wanted a way to share this information with their families and communities to reinforce the concepts they had learned. With this feedback in mind, we used a participatory design process to develop a mobile app with African American community members. It includes culturally-tailored education modules on key cardiovascular risk factors, including those from the American Heart Association Life's Simple 7. It also has a social networking piece that truly builds a community of support. Participants in our app-based program had several improvements in cardiovascular health metrics of the Life's Simple 7, including blood pressure, diet and physical activity. This in turn works to prevent cardiovascular disease in this community.

How do you feel about the future when it comes to health equity?

I am extremely optimistic, not only because of the success of my work with FAITH!, but also because of efforts within our national societies of cardiovascular medicine. Just this year, the American Heart Association and the American College of Cardiology released guidelines for the prevention of cardiovascular disease. For the first time ever, they made a Class 1 recommendation that clinicians, including cardiologists, must address the social determinants of health. This is huge and groundbreaking! Diagnosis and management of disease with cutting-edge technology is central to our role as clinicians, but we also have to consider going to where people live, work, play and pray to better understand what influences their health. We have to think more broadly about how we are preventing people from getting ill in the first place, and what will truly help with eliminating cardiovascular health disparities. It will take leadership of hospitals, academic medical centers and health systems to recognize the importance of addressing the social determinants of health in order to improve health metrics and health outcomes. It's not something we can do overnight, but I am confident that we will accomplish this feat!

CUONG PHAM, MD



Internist and pediatrician at the University of Minnesota Medical Center and the Community University Health Care Center (CUHCC)

Assistant professor of medicine in the Division of General Internal Medicine

Treasurer of Minnesota Doctors for Health Equity

Cuong Pham, MD, came to Minnesota at age 2 as a refugee from Vietnam. He wanted to become a physician to give back some of the help he and his family received. With a personal understanding of the immigrant experience, he aims to provide medical care to other refugees and immigrants, many of whom experienced significant trauma. At CUHCC, Pham helps provide a one-stop shop for people with challenging conditions, aiming to serve as an access point and equalizer for the disparities they face.

How are you addressing health disparities?

Ryan Kelly, MD, and I got a grant from the Substance Abuse and Mental Health Services Administration for community-based research to find the best approach to reach out to patients in a culture-centered and family-centered way. We also received a clinical grant from the University, in collaboration with Fairview. If we as addiction specialists weren't on the medical service at the hospital and someone came in with endocarditis and addiction, it was a black hole to get treatment while they were hospitalized for IV antibiotics. We're starting an addiction consult service, with a care coordinator or social worker and a peer-support person. The team can help get the person with addiction into appropriate treatment and connect them to the community around the University itself.

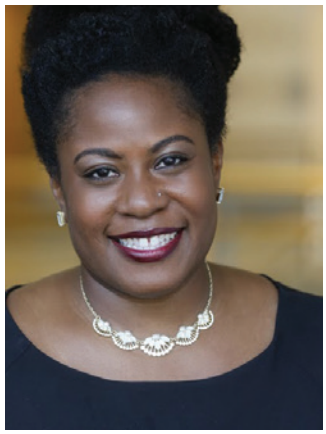
Why did you get involved with health equity work?

I have been a clinician for most of my career, but in the last three or four years, that has changed. We started having overdoses occurring frequently in our bathroom. As overdoses increased, we needed to do something about the epidemic. I became an addiction specialist. I was seeing what's happening in the Native American community, which faces more health inequities than any other community, around issues of addiction. They are dying in large rates from overdoses, family separation, interaction with the criminal justice system. I started thinking about how we're not talking to this community in a way that's helpful. When I started prescribing Suboxone, I saw that this was so complicated and that there were many social determinants of health. And then working with the immigrant population, there are so many barriers that stop someone from doing well with their health, like language, health literacy, being able to maneuver the health care system and understanding how insurance works.

How do you feel about the future when it comes to health equity?

We're holding steady. Physicians don't feel empowered most of the time to be part of the discussion. Until that happens, I think we'll be in this place for a long time. Physicians do have a viewpoint that others don't because we're on the ground seeing patients, but most of the discussion and work on equity happens with administration or people who work with policy because they have that time built into their work schedule. Health equity is not part of my job description, but it should be. If I'm not working on that part of my patient's life, I'm going to hit barriers left and right. We should expand what physicians do and incorporate health equity in our daily practice. There is so much we can do to train students and residents so they feel comfortable saying, "This change needs to happen in the system for our patients, and this is how we can do it."

RACHEL HARDEMAN, PHD, MPH



Assistant professor in the Division of Health Policy and Management at the University of Minnesota

National Institutes of Health–funded researcher who focuses on minority health, health disparities and equity

Member of the Minnesota Maternal Mortality Review Committee, the CDC Maternal Mortality Review Information Application Bias work group and the Planned Parenthood of the North Central States board.

Rachel Hardeman, PhD, MPH, knows that racism is a fundamental cause of the social determinants of health, and she uses her expertise in public health and population health science to analyze its effect on reproductive health. She covers a lot of ground, including developing a curriculum for medical students about racism in the health care system and researching the impacts of violence, mass incarceration and segregation on reproductive health.

Why did you get involved with health equity work?

I grew up here in Minneapolis, I'm African American, and I saw very clearly from a young age that not everyone in my community had the same opportunity to be healthy. That led me during my doctoral training to study health inequities. The more I learned about the history of our health care system and the history of our country, I saw that all lives weren't valued in the same way. It's not just an access issue or a health insurance issue. There are all these other complex pieces of the puzzle that make it really hard for people to be healthy. I study reproductive health becasue the start of life is critical for intervening and creating a level playing field. When an infant starts their life at a disadvantage, the cycle continues. We need to think about ways to do this better and to dismantle the systems of oppression that have allowed this to happen for so long.

How are you addressing health disparities?

Some of the work I've done in medical education is to develop and pilot test an antiracism curriculum for first-year medical students. We are not necessarily preparing our future health care workforce to equitably and authentically serve our changing communities and populations. We're the only industrialized nation with a rising maternal mortality rate, and black women are three to four times more likely to die in the first year after childbirth. I've been developing training and curricula that can provide a clearer understanding of the history of racism and implicit bias with respect to maternal mortality and other health outcomes.

There are steps we can take to address structural racism, like diversifying the workforce and supporting the development of community-led programs. We have done research on culturally-centered care with Roots Community Birth Center in Minneapolis. It's grounded in the idea of meeting people where they are and honoring their life experience and culture, approaching care from an asset-based model instead of a deficit-based model.

How do you feel about the future when it comes to health equity?

Some days I am super hopeful and some days I think we're in trouble. There is a lot more attention on these issues, certainly in the past two years, and often, with the attention comes resources. What frustrates me is that a lot of the work feels like we're trying to stop the bleeding versus an overhaul of the entire system. I think there are a lot of smart, motivated people doing this work and I get to mentor and advise students who are incredibly smart and motivated. That gives me hope. But a lot of the issues with health inequities require that we talk about power in a way that's really uncomfortable for people. These problems didn't happen overnight. I think it will take a fundamental shift in our values and beliefs as a society. We have to allow those closest to the pain to lead the work. This shift takes time and it takes effort and an intentional willingness for people with power to give it up.

CME credit

You can earn CME credit for reading the information in the three articles on health equity in this issue, then responding to a series of questions online.

To receive CME credit, complete and submit the online evaluation form http://mnmed.org/magCME. Upon successful completion, you will be emailed a certificate of completion within two weeks. You may contact the MMA with questions at cme@mnmed.org. Participants must complete all necessary activity components to be eligible to claim CME credit.

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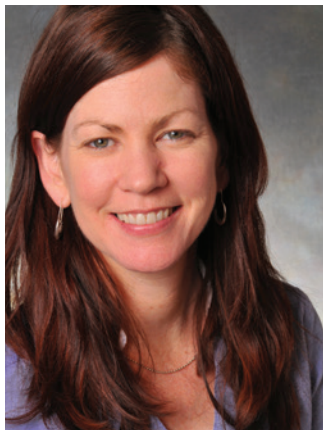
DANIELLE ROBERTSHAW, MD



Family medicine physician at Hennepin Healthcare

Senior medical director of the Hennepin Healthcare Community Connections Care Ring and medical director of Hennepin County Health Care for the Homeless

Assistant professor of medicine in the Division of General Internal Medicine at the University of Minnesota

When people are homeless, they often experience compounding health disparities. Danielle Robertshaw, MD, devotes her career to breaking down barriers to access and helping homeless patients get the care they need. Her work ranges from treating patients at low-barrier Hennepin Healthcare clinics and in homeless shelter clinics with Health Care for the Homeless, to making institutional changes to better serve this population. A staunch believer that health care is a human right, Robertshaw creates innovative care models and partnerships to better meet her patients' complex needs.

Why did you get involved with health equity work?

I never wanted to be a doctor. Then I did public health work in developing countries and realized that often things show up that require clinical expertise. So I returned to the United States to go to medical school. During school, I got involved locally with a homeless clinic and saw that we had essentially Third World needs in the United States. As a doctor I started out doing street outreach in Washington, DC, and focused on developing different models for meeting the unique needs of the homeless population. I've always loved that and continue to do that work at Hennepin. My patients often have had negative interactions with the health care system and are hesitant to approach it. If I can approach them with dignity and respect so that we can better understand and address their needs, it's an amazing way to think about how you can impact the health of the individual patient and a population.

How are you addressing health disparities?

Think of health conditions in the overall population such as diabetes and heart diseases, and adults who are homeless will have the same conditions. But they are frequently diagnosed in a crisis situation, for example presenting to the Emergency Department in a diabetic coma. They are often disconnected from health services where they would get routine health screenings. Competing priorities of daily survival—where they will get their next meal or sleep that night—make it more challenging to follow up on chronic health conditions. People experiencing homelessness are often sicker than their housed counterparts and die much earlier. The average age of death for a chronically homeless adult is around 47 years, despite an average life expectancy in the United States closer to 80 years.

Race, ethnicity and language are commonly collected data points through the health care system, but housing status isn't. As a health care system, we are working on processes to consistently identify and understand our patients' social needs, including housing status. If you don't know patients are homeless, you can't change the way you provide care to better address the unique challenges of being medically ill without a home. We also do individual care plans that acknowledge and incorporate the lack of housing so that we can approach things differently, including around discharge planning when leaving the hospital. Sometimes they may go to a homeless medical respite program where they can recuperate and get connected to social services, housing resources and primary care.

We also have an Accountable Care Organization through a partnership of Hennepin Healthcare, Hennepin Health Insurance, Hennepin County and NorthPoint to innovate and work together on patients' complex needs. For example, we have mobile social service navigators working in the community to assist patients in connecting to services for mental health, substance abuse, housing and other needs to help address gaps in the traditional health system.

How do you feel about the future when it comes to health equity?

I am hopeful. I think we are always worrying about the political climate that influences policy in a way that may not support public benefits for those who need them most, like Medicaid expansion. I worry about policy decisions that could backtrack on progress. I'm fortunate to work in a place that gives me hope through its mission and an unwavering commitment to serving vulnerable populations. I'm also seeing broader community interest to solve these problems. The way we approach health and social needs has shifted quite a bit. Health systems see a role for themselves, and want to partner with others in the community to be part of the solution It would be hard to do my work if I didn't have hope. MM

Suzy Frisch is a Twin Cities freelance writer.