Weitzman Institute
2022 VIRTUAL
Symposium

Panel Presentation #1:
Building a Diverse Primary Care Workforce to Promote the Health and Human Rights of Marginalized Populations

Reimagining Primary Care through a Health Justice Lens **May 4, 2022**

PANEL PRESENTERS:

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Professor, Department of Family Medicine in School of Medicine, University of Washington (UW); Director of the UW Center for Health Workforce Studies; Deputy Director of the Primary Care Innovation Lab

Antonia M. Villarruel, PhD, RN, FAAN
Margaret Bond Simon Dean of Nursing, University Of Pennsylvania School of Nursing; Director, WHO Collaborating Center for Nursing and Midwifery Leadership

Wandy Hernandez-Gordon, AA, CD (DONA), BDT (DONA), CLC, CCE (ACBE), CHW
President, Founding Board of the National Association of Community Health Workers; Co- Founder, Vice President of the Illinois Community Health Workers Association

Christopher Cross, PhD
Managing Director and Founder, Cross River Strategies

PANEL CHAIR/MODERATOR:

Thomas Kenyon, MD, MPH
Chief Health Officer, Project HOPE

LEARNING OBJECTIVES:

By the end of this session, participants will be able to:

- **Examine the current sociodemographic makeup of the primary care workforce**
- **Understand the role of primary care in promoting the health and human rights of marginalized populations**
- **Identify approaches for training and educating health professionals to address health equity and social determinants of health**
- **Discuss shared challenges and potential solutions to recruiting and retaining a diverse primary care workforce**

Thomas Kenyon | Bianca Frogner | Antonia Villarruel | Wandy Hernandez-Gordon | Christopher Cross

I. Introduction

Tom Kenyon: Good day everyone, thank you for joining us. I am really looking forward to participating in this panel and doing my part with moderation.

First, let me introduce our panelists. First, we have **Bianca Frogner**, who is a Professor in the Department of Family Medicine in the School of Medicine at the University of Washington (UW). She is the Director of the UW Center for Health Workforce Studies and Deputy Director of the Primary Care Innovation Lab, which are housed in the Department of Family Medicine. Bianca is a health economist with expertise in health services delivery, health workforce, labor economics, health spending, health insurance coverage and reimbursement, and international health systems.

Our second panelist is **Antonia Villarruel**, who is the Margaret Bond Simon Dean of Nursing, and Director of the WHO Collaborating Center for Nursing and Midwifery Leadership at the University of Pennsylvania School of Nursing. As a bilingual and bicultural researcher, Antonia has extensive research and practice experience with Latino populations, health promotion, and disparities. She is an elected fellow of the American Academy of Nursing and an elected Member of the National Academy of Medicine, among others. She has received numerous honors and awards, including the 2021 Healthcare Leader Award from the American Academy of Nursing and the Sigma Theta Tau International Nurse Researcher Hall of Fame Award.

Our third panelist is **Wandy Hernandez-Gordon**, who has her degree in human service management and has been involved with Community Health Workers (CHWs) since she herself was a child growing up as a consumer of these services. She has been a CHW in the field and has implemented CHW programs regionally and nationally for more than 28 years. Wandy is an active speaker and advocate for CHWs locally, statewide, and nationally. Currently, she is the President of the founding board of the National Association of CHWs and a Co-Founder and Vice President of the Illinois CHW Association, where she brings vision, integrity and values to the table in support of unity in the CHW workforce.

Finally, our fourth panelist is **Christopher Cross**, who leads Cross River Strategies (CRS), a U.S. based boutique-consulting firm that uses community engagement and scientific research to power health equity strategies and services across biotech, pharma, and academic institutions. He completed his Bachelor's degree at the Georgia Institute of Technology, his Master's and PhD at Howard University, and a postdoctoral fellowship

at Yale University, where he currently serves as a Principal Investigator (PI) through CRS for the Center for Community Engagement and Health Equity within the Smilow Cancer Hospital and Yale Cancer Center. He has been interviewed by national leaders in the field of health equity, and was an official SXSW 2022 speaker on the panel titled, "Going Beyond Clinical Trials to Advance Health Equity".

My first question to the panel is: ***Can you discuss some of the shared challenges and potential solutions to recruiting and retaining a diverse primary care workforce?***

II. Laying the Groundwork for Understanding the Primary Care Workforce

Bianca Frogner: Thank you for those excellent introductions and thank you so much for having me here today. I am going to kick off the panel by trying to lay some groundwork about understanding who we are talking about in terms of the primary care workforce.

Defining the Primary Care Workforce

I am going to start with defining the primary care workforce, which is not a very straightforward thing to do. The first thing is to actually define primary care in order to understand who the workforce is. I know that many others throughout this session will be defining primary care, so I am not going to dig into that point too much. I am going to present this framework **(Figure 1)** provided by the Bree Collaborative here in Washington State. It builds from Barbara Starfield's fundamental work around primary care and **defines primary care as being a team-based activity where there is an accountable provider who often serves as that first point of contact for that patient, and helps lead patients through a larger healthcare system, coordinating across multiple services.** Patients engage in a number of activities in primary care where there might be a need for coordination of care across multiple settings, a need for doing both primary, secondary and tertiary prevention, as well as providing treatment and management for conditions.

When thinking about ***what*** primary care is and ***how*** to actually measure primary care, there are a number of data sources from which we are relying on. These include claims-based data, where oftentimes, we are thinking about the setting in which people are being provided care, as well as the providers actually delivering the care, so providers and the location of care are both important.

Recommendation Framework

The workgroup's goal is to foster a common understanding of primary care to increase primary care accessibility and availability.

Focus Area	Definition
Defining Primary Care	Team-based care led by an accountable provider that serves as a person's source of first contact with the larger healthcare system and coordinator of services that the person receives. Primary care includes a comprehensive array of appropriate, evidence-informed services to foster a continuous relationship over time. This array of services is coordinated by the accountable primary care provider but may exist in multiple care settings or be delivered in a variety of modes.
Components of Primary Care with Large Impact	• Care coordination • Integrated behavioral health • Disease prevention and screening • Chronic condition management • Medication management • Health promotion • Person-centered care that considers physical, emotional, and social needs
Measuring Primary Care	Based in claims, care delivered in an ambulatory setting by a predefined group of providers and team members as a proportion of total cost of care

Figure 1. Dr. Robert Bree Collaborative Recommendation Framework. Source: https://www.qualityhealth.org/bree/wp-content/uploads/sites/8/2021/01/Recommendations-Primary-Care-FINAL-2021.pdf

Challenges Defining the Primary Care Workforce

I am going to jump right into what the challenges are in terms of defining the primary care workforce, because defining primary care is already a challenge, but then digging into identifying the workforce is even another level of challenge. **There is just no one single source of primary care workforce data, so we rely on multiple sources, including claims data, as well as surveys, each of which provide only a part of the picture.** If you were to just list claims data, as an example, sometimes you have providers who say that they do primary care as their specialty work, but they may not work in a traditional primary care setting. As you might have a specialist who provides primary care, but is not necessarily thought of as a primary care provider, such as a cardiologist ordering a basic lab test.

The National Academies of Science, Engineering and Medicine recently put out a report about building a high-quality primary care team. In their work, they provided this framework **(Figure 2)** where they centered the patient and family and at the core, around them, are a primary care clinician, a nurse, office staff, and a medical assistant. But, as you can see here, there are a number of other types of providers that are part of that interprofessional team.

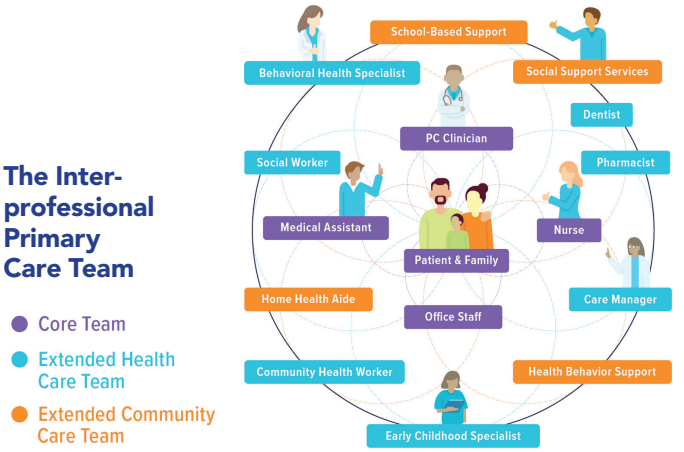

Figure 2. National Academies of Science, Engineering and Medicine Interprofessional Primary Care Team Framework. Source: National Academies of Sciences, Engineering, and Medicine 2021. Implementing High-Quality Primary Care: Rebuilding the Foundation of Health Care. Washington, DC: The National Academies Press. https://doi.org/10.17226/25983

Now, what does that actually mean in terms of numbers? **Data out of Health Resources and Services Administration (HRSA) shows that there are about a quarter of a million Full Time Employees (FTEs) that work in federally qualified health centers (FQHCs) across the country.** About 5 to 6% of those FTEs are physicians, another 17% or so are advanced practice nurses, who play a critical role in delivery of primary care in FQHCs, as well as registered nurses at 8%. However, you do see a number of other kinds of providers in these settings.

Another way to gauge primary care outside of FQHCs is working with the standard occupation codes that are then used to identify settings. The Bureau of Labor Statistics shows that in offices of physicians there are about 2.7 million people working in this setting and about 5 or 6% of that workforce are physicians. Again, there are considerable roles for advanced practice nurses, as well as registered nurses, but you also see about **15% of this workforce include medical assistants, and a number of other folks who are not providing direct patient care**. In outpatient centers, you see a little bit fewer primary care-oriented physicians, but there is a distribution of other kinds of providers in this setting, with another million people.

Sociodemographic Characteristics

Primary care settings, or thinking about it as office of physicians and outpatient centers, are female dominant. But, it's actually not a very diverse setting. In office of physicians, we have a workforce that has slightly less workers who are immigrants. People in this workforce tend to be a little less poor than people who work in other parts of the healthcare industry.

Looking at the education level of workers by setting, generally, office of physicians and outpatient care centers tend to have a more highly educated workforce.

The racial and ethnic distribution within office of physicians and outpatient care centers **(Figure 3)** are such that the percentage of Hispanic and other races and ethnicities tend to reflect what the rest of the healthcare workforce looks like. However, what is particularly notable or the orange bars, especially in **offices of physicians where we see significantly less representation of black healthcare workers in this setting** so there is a need for more diversity in this setting.

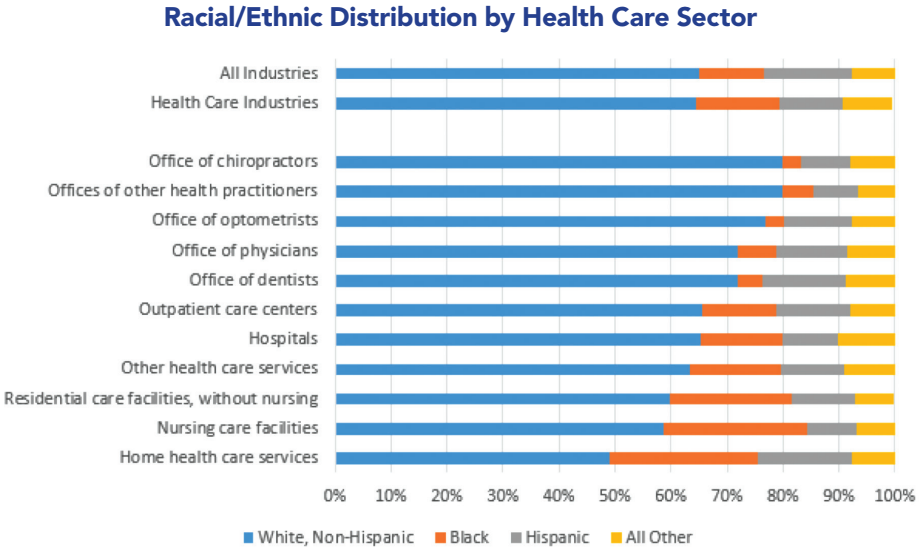

Figure 3. Workforce Racial/Ethnic Distribution by Health Care Sector. Source: Frogner BK, Spetz J, Parente ST, and Oberlin S (2015). "The Demand for Health Care Workers Post-ACA," International Journal of Health Economics and Management, 15(1): 139-151.

Workforce Barriers to Primary Care Access

Having a diverse workforce is quite important as a way to make sure that we provide high-quality healthcare. However, there are a number of barriers to making sure that we have the workforce that we need to provide primary care. One is the kind of array of scope of practice requirements around multiple occupations that work within the primary care environment. There really are variable allowances of our healthcare workers to provide care and this affects the available workforce available to provide primary care.

Another issue is that there is varied need across the country. Workforce needs across these areas really varies based on the level of vulnerability of populations across the country. From the same study, this group of researchers out of HRSA identified some of the markers of vulnerability. **There is a variety of needs that are not consistent across the country, so we cannot look at the country as a uniform place where everyone has the same needs and the same kinds of providers needed to provide the care.**

We need a workforce in the healthcare setting that also connects with the community settings. There's an increasing need of an overlap between these two that makes it even more difficult to monitor who is actually working in health in the primary care workforce, because this need to blend settings is critical.

Another area that makes identifying the primary care workforce a challenge is that we have new models of care that are coming about, such as the integration of primary care and behavioral health. The needs within the patient population really varies based on the severity of their physical health, as well as their behavioral health needs. Depending on the level of need of the patient, their primary care team really varies. You can go from just a few providers to having maybe seven or eight different kinds of providers on your primary care team.

Tom Kenyon: Thank you Bianca. I really appreciate that you have demonstrated that there is a science to the health workforce. There is the use of data. This is obviously very important if we set targets, we need to be able to measure progress and hold leaders accountable for achieving those targets. Thank you for pointing out the importance of measurement.

III. Perspectives from Nursing

Antonia Villarruel: Thank you and it is really a pleasure to be here to speak with you, and have a dialogue with you. I was asked specifically to talk about building a diverse primary care workforce from the perspective of nursing, but many of the lessons that I have for you, I think, are applicable to many health professions.

Implementing High-Quality Primary Care

As we think about building the workforce, we have to think about what we are building it for. There was a recent report from the National Academy of Medicine that talked about the implementation of high-quality primary care. One of the mantras that I think that is so important and can be transformative for the education of all health professionals is that **we have to pay for primary care *teams* to care for people, and not solely doctors or anybody else, to deliver services**. We have to assure high-quality primary care is available to every family, in every community, and we need to be able to train primary care teams where people live and work, and not just in academic health centers.

Nurses are essential to delivering high-quality primary care. First, just by sheer numbers, we are four million strong and nurses are natural leaders from bedsides to boardrooms. We know how to address social determinants of health and we are vital to leading interprofessional care teams, because of our holistic perspective. We bring those important perspectives to both management and policy discussions, and we amplify the voices of patients, family, and community advocates.

We also know that growing the ranks of primary care is cost effective and a viable solution to address primary care, specifically in underserved communities. If we were able to address care in communities, reductions in access could be as high as 70%.

Nurse practitioners are key because we **graduate from primary care programs at three times the rate of physicians** entering primary care residencies, and we are more likely to serve a majority of Medicare, charitable, or uncompensated patients.

Barriers to High-Quality Primary Care

We have barriers to high-quality primary care, and these are related to state regulations **(Figure 4)**. These apply not only to nursing, but to many other disciplines as well. **Our inability to practice to the full scope of license and education is absolutely a barrier in the delivery of high-quality primary care.** We have restrictive barriers to practice. For example, in Pennsylvania, you have to have two collaborative agreements with physicians and there is a whole industry that is taking advantage of nurse practitioners, especially when the physicians are not additive in terms of the care that is provided.

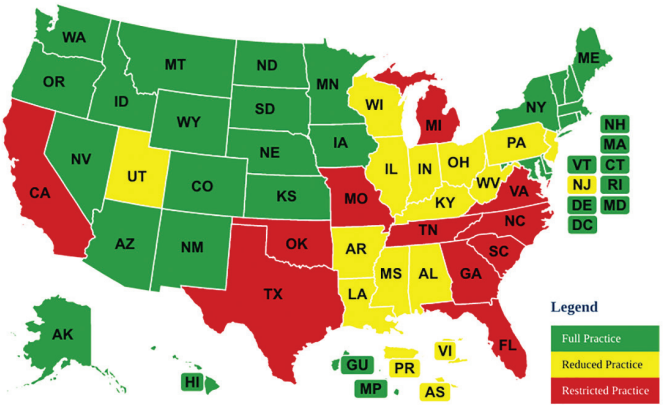

Figure 4. 2022 Nurse Practitioner State Practice Environment. Source: American Association of Nurse Practitioners. State Practice Environment. https://www.aanp.org/advocacy/state/state-practice-environment

A Framework for Educating Health Professionals to Address the Social Determinants of Health

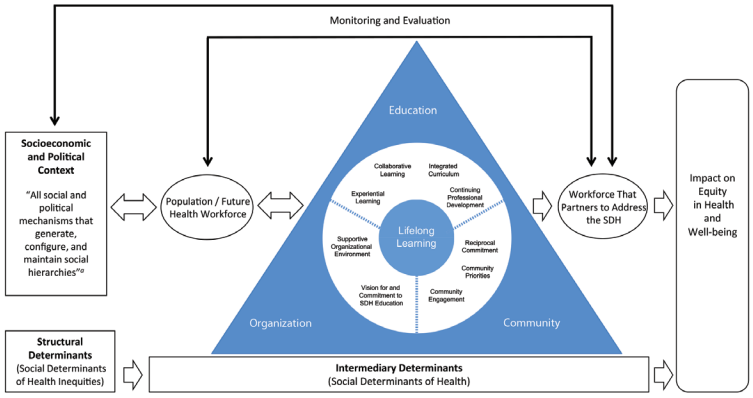

Figure 5. A Framework for Educating Health Professionals to Address SDOH. Source: National Academies of Sciences, Engineering, and Medicine. 2016. A Framework for Educating Health Professionals to Address the Social Determinants of Health. Washington, DC: The National Academies Press. https://doi.org/10.17226/21923

When thinking about education, I want to refer and talk to a framework that I was involved in developing in 2016, along with Bianca Frogner and others, for educating health professionals to address social determinants of health. While we were focused on the education mission, we wanted to situate education in the context of the where, the what, and the why. This is important because we live and are influenced by socioeconomic and political context and by the structural determinants of health. The education of health care professionals is so important because the ultimate goal is to impact equity, health, and wellbeing. **We want to prepare a workforce that addresses the social determinants of health, but we also want to ensure that we are recruiting potential health professionals from the communities in which we serve.**

There are three components to this triangle **(Figure 5)**. What is at the center of the circle is that we want to create practitioners who have a lifelong dedication to addressing social determinants of health, wherever they practice.

The first component is the organization. How supportive is the organizational environment in providing opportunities and relationships in order to address social determinants of health, which again if we were looking at this now, we would probably say health equity. Therefore, looking at the organization's commitment to health equity, we look at the important elements of education. You cannot teach anybody to deliver primary care in the settings in which we do, unless they are actually educated in those areas.

Collaborative learning is important. This is between the community and the educational institution, as well as interprofessional. We believe that the curriculum should be integrated throughout, including thinking about how social determinants of health are carried through. It is not just one class, one lecture, but has to be a thread. This leads to continuous professional development.

We cannot do this alone. We really need engagement with communities, which means is a reciprocal commitment. **What are we going to give our communities? How are communities going to be invested in the education of our health professionals? We need to be looking at, and considering community priorities, as well as community engagement.**

Leonard A. Lauder Community Care Nurse Practitioner Program

At Penn, we recently received an incredible, transformative gift to actually implement this model. This gift comes from Leonard A. Lauder, and the establishment of the Leonard A. Lauder Community Nurse Practitioner Program. The gift is $125 million, which will prepare a strong cadre of nurse practitioners dedicated to advancing health and health equity in underserved communities, in perpetuity.

We will be recruiting and investing in students committed to high-quality primary care access for all. We will partner with our communities and build capacity within those community-based health agencies. We will develop our own expertise and build on it in terms of leadership in primary care and health equity, and again, support lifelong learning through a robust fellow alumni network.

Our fellows, students, and alums will be looking for individuals who have a sustained investment in education and careers of primary care nurse practitioners. Fellows will be full time admitted students into a Penn nursing primary care program, and our students will demonstrate a commitment to nursing and promoting health equity by working in underserved communities. The fellowship will provide full time tuition and fees for the completion of the program, and we have funds to provide stipends for students with greater financial need. Within the program, we will provide cohort activities and, in return, students and alumni will be expected to commit to practice or service in underserved communities. We will support community placement and the development of a post-graduation plans, as well as yearly reporting or accountability. The alumni network will facilitate continued career support and social opportunities.

We will be partnering and investing in selected community partners. Our community partners will provide support for clinical training, and we will also work to address and improve health equity in those communities by bringing forward and integrating needs of the site into Penn nursing and to the university. We have support for our educational initiative to execute this program, and we will have an endowed professorship to provide leadership, an executive director, and a program manager. I am very excited that we are on our road here. We selected our first 10 students, so we are well on our way. Next year, we will be recruiting 20 students, so if you are interested, please check **our website** and encourage people to apply. This is open to everyone.

Final Thoughts

Primary care delivery needs to be team based and value based. Our education has to represent these initiatives moving forward. **Together, we need to work on policies that eliminate barriers that prevent primary care providers from working to their full scope of practice.**

Finally, we need sustained investment in developing the primary care workforce. Physicians are well supported through graduate medical education, but they are the only profession that are supported in terms of professional development, and even more so in primary care. We need continued government investment and, as Mr. Lauder has shown, we need private investments as well.

Tom Kenyon: Thank you, Antonia and congratulations on that donation. We need more people to believe in the U.S., including our leadership at the local, state, and federal level.

The importance of nursing and having worked alongside many nurses over many years, they are the backbone of the health system and globally, they are what makes it work. As you said, what are the services that we are trying to provide and then getting the right match with those services? I am sure we will come back to nursing as an all-important aspect of primary care and leadership.

IV. Community Health Workers

Wandy Hernandez-Gordon: Thank you so much, Tom. My name is Wandy Hernandez-Gordon and I am very pleased to be with you all.

I will be focusing on the local and national landscape surrounding Community Health Workers (CHWs), including defining what a CHW is, the history of CHWs, the Illinois CHW Association (ILCHWA), current ILCHWA activities, the National Association of CHWs (NACHW), and current NACHW activities.

Who Are Community Health Workers?

CHWs are mainly people of color. We share ethnicity, diagnoses, socioeconomic status, and geography with communities we serve. CHWs are disproportionately affected by inequalities, and often experience many of the same barriers to the social determinants of health (SDOH) and healthcare as marginalized communities. As a result, **CHWs are unique stakeholders in equity and systems transformation, who represent both provider and patient community members' voices**.

The American Public Health Association (APHA) defines CHWs as:

> *"A Community Health Worker (CHW) is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the CHW to serve as a liaison/link between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery. A CHW also builds individual and community capacity by increasing health knowledge and self-sufficiency through a range of activities such as outreach, community education, informal counseling, social support and advocacy."*

There are over 150 titles that fall under the CHW umbrella, including: community health advocates, promotor(a) de salud, street outreach workers, and most recently, contact tracers.

The concept of CHWs was born in the 1920s from barefoot doctors. In 2009, the APHA promoted the CHW definition that actually serves as the standard occupation of the category. In 2014, Illinois signed the first CHW legislation, which adopted the APHA standard definition, created the Illinois CHW Advisory Board, and created a recommendation for advancements of the CHW workforce.

CHWs work in different settings in healthcare, including mental health, community-based social services, faith-based, schools, and communities. In these settings, CHWs promote health and wellbeing, and address social determinants of health. **We advocate for ourselves, as well as for the communities that we live in, and that we serve.**

Local and National CHW Associations

ILCHWA has established a CHW curriculum comprised of community colleges, different federally qualified health centers, CHWs, State Representatives, among other stakeholders. We have developed workgroups to enhance our workforce efforts, which are comprised of the same audience listed above for ILCHWA's curriculum efforts. For ILCHWA's mapping project, we collaborated with the University of Illinois to identify current CHW work in Illinois, and what type of services they were providing. We are also currently revising our membership to include more opportunities to connect with our members.

I am also the Board Chair, as well as one of the cofounders of NACHW. NACHW was founded in April 2019 after years of planning and organizing by CHW allies. It launched as a 501C(3) driven organization with the mission to unify CHWs across geography, ethnicity, sector, and experience, to support communities to achieve health equity and social justice. Our values of self-determination and self-empowerment of our workforce, integrity of character, respect for every human being, social justice, and equity to ensure fair treatment across opportunities and outcomes for individuals and communities, guides our work. Executive Director Denise Smith, who was also a CHW, leads NACHW. The National Board of Directors is comprised of many CHWs and allies, who have decades of experience in research, CHW training, workforce development, community organizing and engagement, equity, social justice, advocacy, and policy.

Advancing Sustainable Financing of CHW Programs and Services

CHWs have an important role in improving health by addressing social conditions and social determinants of health. Social determinants of health are defined as the conditions in which people are born, grow, work, live, and age. **CHWs have proven effectiveness in reducing health disparities, containing costs, and improving outcomes across a range of diseases and conditions.** Yet, despite nearly 60 years of research and proven effectiveness, two decades of public health recognition, landmark workforce development studies, and a national labor classification, CHWs and allies are still building a national identity. Federal and state level policies and funding models have failed to reach CHWs, our associations, networks, and coalitions.

How do we transition into sustainable conversations? We broaden the definition to include financing, scope of work, training infrastructure, and career ladders. We cultivate and amplify CHW identity, policy leadership, and CHW network capacity. We center values and approaches that pursue racial equity, social justice, diversity, and inclusion. We promote policies that respect, protect and authenticity partner with CHWs and their networks and coalitions. We disseminate best practices from the workforce through playbooks, tools and webinars. We collect data on CHW workforce trends, experience, skills and opportunities. Lastly, we build a national feedback loop (database, communication, engagement) to activate members for future pandemic responses, and resiliency.

What are the barriers to the public and private financing of CHWs services and activities? Our first barrier is fragmentation, as services and activities tend to be disease-focused, silohed, short term, and limited in scope. Second, there is a lack of a consistent policy strategy. **There is inconsistent integration into Medicaid, no funding streams for SDOH, and lack of funding for community mobilization and advocacy.** The third barrier is that the funding is inequitably distributed. It cannot be directly/consistently accessed by community-based organizations where more CHWs work, which perpetuates barriers based on professional hierarchies, prevents the establishment of career pipelines, and limits the power of the workforce to self-determine.

CHWs need leadership, equity, and policy capacity building to realize their professional roles and impact systems change. We must integrate our unique services to address prevention, SDOH and racial equity in access to care based on a broad set of CHW roles. Currently, CHW organizations that are led/co-led by CHWs focused on membership development, training, career pathways and advocacy, as well as public and private actors, lack data, tools, and strategy to achieve sustainability. Further, federal agencies and national actors/payers lack policy and strategy to broadly describe CHW sustainability.

NACHW National CHW Policy Platform

In 2021, NACHW released a national CHW policy platform to provide evidenced-based policy recommendations to public and private institutions to respect, protect, and partner with our workforce. This document was created over the past year, with town hall calls with over 30 CHW Associations, three national CHW polls, numerous partner meetings, and member input on the Biden administration's national plan to Build Back Better. It centers many of the policies and best practices that are already nationally endorsed within our field and can be applied to COVID-19 response efforts as well as long-term policy development. We include ensuring all CHWs have access to personal protective equipment (PPE), a living wage, and the vaccine while we are on the frontlines. We promote hiring authentic CHWs who have established trust and shared life experience with the communities where they serve. We advance approaches to directly invest in and partner with our CHW networks, association and coalitions, to ensure that the rebuild and recovery from COVID is equitable.

Tom Kenyon: Thank you Wandy. It is encouraging to see that we have CHWs in this country. Having worked mostly overseas, they are really the crux of the primary health care system and they are the link with the community. We should not look at CHWs as somehow more economic approach, because like you said, they have to be compensated. We tried in the 80s and the 90s with Community Health Volunteers, and as you would expect, more and more responsibilities were piled on, and they could not sustain that level of effort.

Now, fortunately many countries are introducing CHWs into their workforce as part of the workforce. In the best-case examples, they are given a career structure, so they can move up from a CHW to another level, such as nursing assistant or nurse. They are backed up by policies that enable them to carry out their scope of practice, which has to be decided at the country level. I think in this country, what is so challenging is we have 50 states who have to decide all this, and we have 3,000 health departments. We are not like other countries with one health system. We do not have a health system with the ability to have a common approach. Other countries have a package of services that a CHW will deliver, a defined population that they will be asked to serve out in the community. CHWs are not sitting in a health facility in many cases. They are out going door to door, so they know the most vulnerable populations and are key to that linkage. We will not achieve primary health care without CHWs, we will not achieve universal health coverage and we will not achieve the United Nations sustainable development goals without primary healthcare.

Last but not least, Chris over to you. Then, we will go into some structured questions and answers.

V. Insights from Black and Brown Primary Care Staff and Patients to Advance Health Equity in the Healthcare System

Christopher Cross: The title of my talk is, "Insights from Black and Brown Primary Care Staff and Patients to Advance Health Equity in the Healthcare System." I chose this title because in the work of community engagement, we consistently hear that the voice and, in turn, the humanity of underrepresented patients' needs to be heard. In this talk, I advocate for them, and aim to show a replicable framework that researchers and health professionals could use to better incorporate their voices to inform their work.

Cross River Strategies (CRS) is a health equity boutique consulting firm. My business partner, Dr. Lu, and I own and run it, along with our awesome team members. We use a science-based method to help our clients achieve results that better the lives of those that need it most. For example, as of a couple months ago, the clinical trial sites that we added for our client resulted in over 240 African Americans completing a colorectal cancer clinical trial. Although, we do more than help redesign clinical trials, and you can visit our website **crossriverstrategies.com** to learn more.

We power our services with science and data, and one way we continue to evolve is remaining connected to our academic partners. We have an ongoing partnership with the Community Alliance for Research and Engagement and Yale Center for Community Engagement and Health Equity. This is where we, along with several other principal investigators and host sites, conduct primary research with community members. As a disclaimer, the scope of each of these organizations is much larger than depicted, but what is shown **(Figure 6)**, is for simplification and how it fits into our engagement model interacting with community members.

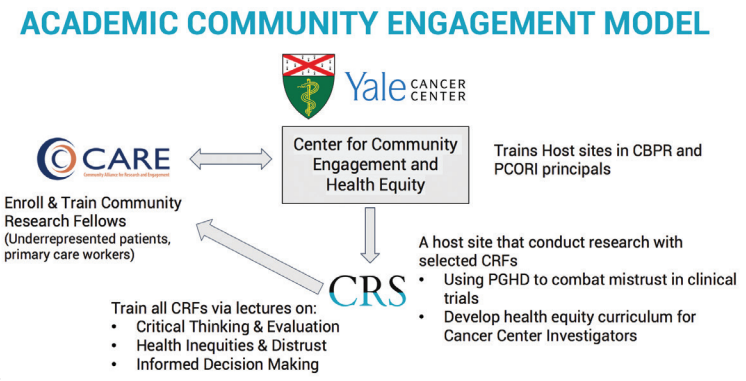

Figure 6. CRS Academic Community Engagement Model.
Source: Cross River Strategies

As a second year Principal Investigator, I have delivered a number of course topics, and teach them along with Dr. Lu, who is conducting health equity research with a couple fellows this year. Our Community Research Fellow (CRF) specific framework of how we interact with the fellows has been informed by CBPR, community-based participatory research, and Patient-Centered Outcomes Research Institute (PCORI) principles. **By using this framework with our fellows, I have implemented these five steps: engage, connect, design, challenge, and inform.** They lead to help sterilize the environment against white coat syndrome. That helps to create a space to discuss a myriad of topics, including scientific trustworthiness and some really vulnerable experiences.

Let's listen to a clip from a Community Research Fellow. To maintain her anonymity, we will call her Mary.

> *"OK, so my perspective came from both sides of the healthcare system. I remember working at the hospital when I was pregnant with my daughter, and I was working in a position called material services where I just dropped off the essentials needed to provide a certain level of care to certain departments. I just remember running into a doctor on the Labor and Delivery floor and she was so rude. I remember her just being so rude to me. So, fast forward to about six months later, I'm going into labor and she is the person that is helping me deliver my daughter. First, I already feel some kind of way because of how I was treated as an employee when I came on your floor, and now I have to trust you with birthing my child. It was the same thing I had been hearing where they don't listen. This time, at least I got the conversation and I got the smile, and I got the front that they put on for hospital protocol. I didn't get the listening part, so I ended up in Labor with my daughter for six days after I told her that my son was a C-section. She's trying to tell me that, you know, you can push naturally. I have a tilted cervix, so things aren't right for me to just push naturally. I sat in labor for six days with no food and she switching between Foley balloons and the shot they put inside to help you contract. I'm like you know, okay, this isn't going to work, you're going to have to cut me because I suffer from anxiety and I'll get depressed in this bed. You have to do something or I'm going to lose it in here. She finally decides to do a C-section. I'm telling her as they're starting cutting me that I can feel everything and it hurts. They kept cutting and I felt everything. Eventually, I lost all my color and I passed out. It took six blood transfusions and an additional six days after birth for me to even recover to where I was able to walk. It goes down from both sides of the pendulum, how we are employed by these hospitals that's in our communities and we go there to work and we're hit with the discrepancies that we are given as black and brown workers. Because our position might not have an MD or initials attached to the back of it, we're not seeing as a priority to these higher ups. Then, when you have to go back to the same place for your care and you get the stuff that you were hoping for it again as an employee you try to build that rapport. You end up not being heard and end up with trauma. That was just my time that I was just like, you know, don't trust, nobody."*

This is a harrowing experience of a Black woman, who is a healthcare worker in the United States, and who nearly died in child labor at the hands of a physician that she worked with and that she knew. Let that sink in. **This isn't Tuskegee, or Henrietta Lacks, or the era of medical apartheid.** This is right now. I know we are here to talk about how to avoid these scenarios, and this is a moment where each of you can listen to Mary's voice and think of a million ways her experience could have been better. **One of the takeaways here is respect healthcare workers, learn their names, engage them, and listen to them.**

Let us try to put ourselves in the mindset of Mary. How do you think she feels given her experience and now hearing about all of these statistics, especially the one about mortality rate, which is almost two times the national average for Black mothers? This is where science and data information can help change her internal narrative.

Let's briefly talk about insurance, one might think oh, it's because Black mothers have less insurance. **The data says Black Americans actually have more insurance than Hispanic Americans, yet, infant deaths are double theirs.** So, then we can start to use data to dispel myths and help generate a sense of agency in dignity.

Let us understand the greater context in which healthcare exist with more data **(Figure 7)**. **The U.S. had the most expensive health care system in the world and worst overall performance out of the top 11 income countries.** Mary might say, I thought I was getting bad care because my insurance was not the greatest, or because I do not have enough money. The data is starting to show an alternative.

Let us narrow in now on the primary care workforce. The number of support staff makeup about 7 million workers. But, the hourly wage isn't even $14, and it's disproportionately made up of women, Black and Hispanic individuals. One in five need the support of government assistance, just to make ends meet. Black Americans, American Indians, and Hispanic Americans are receiving worst care than white Americans. So, in summary, Mary can have a takeaway that the **U.S is failing the low wage healthcare workforce, both financially and in health**. It is not something she did something specifically wrong or related to her ancestry.

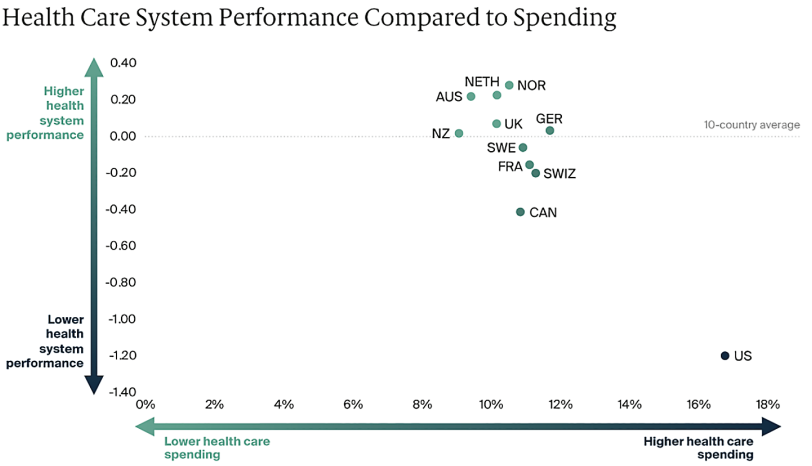

Figure 7. Health Care System Performance Compared to Spending. Source: Eric C. Schneider et al., Mirror, Mirror 2021—Reflecting Poorly: Health Care in the U.S. Compared to Other High-Income Countries (Commonwealth Fund, Aug. 2021). https://doi.org/10.26099/01DV-H208

Level at which to take action	Clinical care	Medical education	Research
Individual	• Read your hospital's community health needs assessment to increase awareness of community needs. • Develop a list of local resources and have it on hand to make referrals for patients. • Ask patients relevant questions about their health and social circumstances. • Develop patient centeredness and communication skills. • Be aware of the power dynamic that exists between patients and providers.	• Understand that you will not be 100% culturally competent about every patient and that each patient presents a new opportunity to learn. • Participate in community-engaged scholarship opportunities. • Increase empathy/patient centeredness/communication skills. • Be aware of the power dynamic that exists between patients and providers.	• Incorporate short-term, visible outcomes, even in longitudinal studies and report back to community participants. • Increase empathy/patient centeredness/communication skills. • Be aware of the power dynamic that exists between research participants and researchers. • Involve community members in all stages of the research process.
Hospital, teaching hospital, health system, and/or medical school	• Integrate non-medical services into the core medical team (e.g., social work, the housing department, legal services). • Create partnerships with local communities. • Incentivize community engagement in the merit and promotion process. • Provide interprofessional training on holistic patient care.	• Address institutionalized racism and discrimination at your institution. • Introduce cultural competency training earlier in education. • Include principles of community-based participatory research as a mainstream portion of medical education. • Incorporate community health needs assessment data and local community history into the curriculum. • Provide interprofessional training on holistic patient care.	• Integrate community-engaged research into medical education and clinical missions. • Incorporate community development as part of the research plan and align research priorities with the community priorities. • Create more opportunities for medical students and premed students to be involved in community-engaged research. • Ensure each research team consults with a community advisory board.
Association of American Medical Colleges	• Create a national taskforce that includes student affairs deans, researchers, information technology staff, business members, educators, etc. to come together and strategize about improving community health. • Develop tools and resources to teach physicians about community engagement. • Aid in advocacy efforts to demonstrate the value of community-engaged research.	• Bridge the divide between community and academic medicine. • Provide support for innovative educational programming like "hot spotting." • Work with member institutions to develop and evaluate curricula that address the social determinants of health.	• Create a toolkit or technical assistance to help replicate community-based participatory research and social justice work in local communities. • Provide a venue or resource which highlights the success stories of other institutions that are successfully addressing the social determinants of health. • Provide resources for community-engaged research funding opportunities.

Figure 8. Academic-Medical-Center-Derived Actions to Promote Health Equity and Justice. Source: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5628097/

Using our CRF engagement framework, we can help combat false narratives for marginalized people, and it empowers them to have more agency and dignity to use their voice to get the care that they deserve. As I close my talk, this table **(Figure 8)** is full of recommendations for all of us at different levels that are attending the talk. This box is actually highlighting what we are doing at CRF, but we are even augmenting what is in there, using a researcher's perspective. You can use a science-based approach to engage listen and learn and invite Community members to co-create your solutions to your science and your issues together and that actually has a much larger impact than you might think.

I just want to thank you for your time I know that's a lot, but you can visit our website for more information and I look forward to the Q&A. Thank you so much.

Tom Kenyon: And thank you, Chris and thank you for sharing that experience. As unfortunate as it was, it's helpful to hear the reality out there, we need to hear that.

VI. Question and Answer

Tom Kenyon: Wandy—I thought I would start with you about what can we do to motivate people to go into primary healthcare workforce professions, and your case, being a community health worker. ***What can we do to motivate professionals to go into this field?***

Wandy Hernandez-Gordon: The CHW field is not something that you are taught. It is street smarts. You have to actually understand the community that you come from. You have to understand the dynamics, the ins and outs, in order for you to be able to be a part of that community. Many CHWs actually live in the places that they serve. They have street smarts and they actually have a close relationship to the community so the community already trusts them. Those are the best people to be able to go back to being trained in different health issues, and go into these different settings, in a social setting or in a faith-based setting. As I stated earlier, there are different settings that CHWs are already a part of and can be mobilized to educate their people, promote the information, and provide resources. It is just really important for the person that is a CHW to understand what the culture is about. You can't just have a person who took the training become a CHW.

There are core competencies and skill sets that we actually look for before even becoming a CHW, if you're interested in becoming one. If anyone is interested, they can become a member through the National Association of Community Health Workers and can get the information. Right now, it's a hot topic, everyone wants to be a CHW, especially because there's a lot of money coming in. We need to be very careful in terms of who is a CHW and who is not.

Tom Kenyon: There is an interesting question from the audience about CHWs in incarceration environments. ***Do you know of any example of the incarcerated serving as a CHW within their population?***

Wandy Hernandez-Gordon: Yes, we do. In Illinois there is a program where they actually serve incarcerated women who are giving birth. The people providing the services actually went through the system themselves, so they know how it is to actually give birth while being incarcerated and they know the ins and outs. So yes, there are programs like that, that actually coincide with being incarcerated. There are also gang programs as well. There are CHWs that used to be gang members themselves who talk about life after being in a gang and try to become a role model for others who are interested in leaving that type of lifestyle and being able to be more productive in their lives. The CHWs have linkages with the police departments, just in case, if things do happen, the community is aware, as well as the police stations.

Tom Kenyon: Antonia—***what more can be done to train the healthcare workforce to address health equity? There were also some questions from the audience about preceptors and how they are not compensated, even though that is a vitally important area of training. So, any thoughts on what we can do to improve training and to more directly address health inequities and social determinants of health?***

Antonia Villarruel: I think the move to address social determinants of health at the point of care has received a lot of attention and has been accelerated as a result of the pandemic, the resulting inequities, both in COVID, as well as the injustices that we witnessed such as George Floyd and a number of others. I think everyone is aware of what we need to do to, as my students will say, decolonize the curriculum, to look at what we are doing, to look at where training is, and all of those particular components. I hope in this political environment that we do not lose the momentum and go back to burning books. I think we have a good framework, dedicated professionals, and students, who are holding everybody accountable.

In relation to preceptors, and I will say my nursing and primarily physician assistants, the issue of preceptor is huge. As I mentioned before, the only group that is compensated for clinical education are physicians. We don't pay for preceptors, although some of the schools, who are predatory, do pay people for preceptors, and it locks out many of the state schools and many others in getting the type of training that they're able to do. Someone referred to the graduate nursing education demonstration project of which Penn was a site, in which a small portion of Medicare dollars were used for clinical education, primarily in communities, but sponsored by a health system. That was extremely successful. What is needed now is a policy solution and the political will to move that forward. I know, for many of my physician colleagues, graduate medical education (GME) is sacred and there's many people that have their eye on those funds. I am sure my medical colleagues will say, well, we need more not less. But I think figuring out how to use those funds in order to support primary care education and other education in other areas that is something that's absolutely needed. It's going to be a heavy lift, a very heavy lift, but it's one that I think we're certainly up for the challenge. We have the evidence behind us and we have the needs of community saying that is what they need. As we're talking about community health workers, we need a funding stream for them, we needed a funding stream for dentists, we needed the funding stream for the workforce period so again, I think that is what needs to happen. That is going to turn the funding on its head.

Tom Kenyon: I think it is safe to describe the Global Health workforce as being in a crisis. It's been in a crisis. The World Health Organization projects that there will be some 18 million health workers short to reach the sustainable development goals by 2030, so there's a tremendous opportunity here if we're going to achieve these goals, to bring in the appropriate workforce, but it requires commitment. That's why I was describing the need for leaders to be on board with this. I would like to see more people engaged in primary healthcare run for office, whether it's local or state or national, we need more people in that environment because that's where these decisions are made.

Tom Kenyon: Bianca—I had a question about ***the sociodemographic makeup and you showed data that shows that the workforce doesn't necessarily match the population, we serve, and I wonder if you could elaborate. What can we do to change that and why is that important?***

Bianca Frogner: Thank you for that question, and I do actually want to also point out that. Dr. Cross really did a nice job pointing out the support staff and really the diversity that exists in among our support staff and figure out ways for us to leverage kind of who else is on the team, other than the physician and nurses, because there's so many important members of the team that bring important life experience.

It is important to also provide opportunities for those workers to move up a career ladder. However, **I think we need to be honest about what those career ladders look like, which is not clear, not straightforward, and expensive for many people to move up from a high school degree, all the way up to a bachelor's degree to be a nurse or a medical degree. We need to think carefully**

about how we do these things in parallel and how do we help provide career opportunities to increase diversity in some of our higher skilled jobs, while also making sure that the work of medical assistants and community health workers is valued and leveraged given that is where our diversity is currently. We need to also make sure that we reward them properly in terms of pay benefits, as well as providing them recognition as part of the team. I am hoping through this conversation, across all of our presentations that people walk away realizing the importance of understanding who is on their team and that everybody is an important member of that team.

> **Tom Kenyon:** Chris—I wonder if you can further ***elaborate on how primary health care actually addresses human rights issues and equity issues. What is it about primary health care that is that link to equity and addressing social justice?***

Christopher Cross: I think we are, because everybody's talking about how we have not got it right. There's a lot of issues with a lot of holes. I think it being the most expensive health care system in the world is really mind boggling. I go back to where I talked about that there's a link to in the sources. The measures they were taking into account to say that the U.S is the worst, and so that the measures they were looking at kind of fell into five buckets: access to care; the care process; administrative efficiency; equity; and healthcare outcomes. No top country did the best in all of those categories, but Norway, the Netherlands and Australia were the top performing countries overall. What they had in common was that they were providing universal coverage, removing cost barriers, investing in primary care systems to reduce inequities, minimizing administrative burdens, and investing in social services among children and working age adults. I would just add innovative approaches, I think a lot of times in these systems, people are so used to doing what they've been doing, but they need to be open to a different strategy because, clearly, what we are doing currently is not working.

Tom Kenyon: I want to thank all our panelists for a really rich discussion and presentations from a variety of perspectives and backgrounds.

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