Speaker 1:	00:01	Quality improvement in the time of COVID-19 is brought to you by the American Heart Association with support from Novartis Pharmaceuticals. As physicians, scientists, and researchers worldwide struggle to understand the COVID-19 pandemic, the American Heart Association has developed its COVID 19 CVD Registry powered by Get With the Guidelines, to aggregate data and aid research on the disease, treatment protocols, and risk factors tied to adverse cardiovascular outcomes. For more information, visit us at heart.org/covidregistry.
Sandeep Daas:	00:32	Hello and welcome to the American Heart Association Podcast series on quality improvement in the time of COVID-19. My name is Sandeep Daas, and I'm a cardiologist at the University of Texas Southwestern Medical Center in Dallas. In addition to clinical work, I spend a lot of my time thinking about systems approaches to improve quality of care. Today, we're going to talk about another aspect of quality of care in the time of COVID 19. I have the pleasure of hosting Dr. Brian Smith, an advanced heart failure and transplant cardiologist from the University of Chicago and an expert on healthcare disparities. Together, we'll talk about health equity in the care of COVID-19, but first I'll let Dr. Smith tell you a little about himself. Brian.
Brian Smith:	01:09	Thanks, Sandeep. Thanks so much for having me. I really appreciate it. Again, my name is Brian Smith. I am an advanced heart failure cardiologist at the University of Chicago. I'm also the director of our Advanced Heart Failure Hemodynamic Laboratory. I do research on health disparities, also interested in equity and inclusion at University of Chicago. And I'm on the board for the American Heart Association in Chicago. And I'm the co-chair of the American Heart Association Health Equity Advisory Committee here in Chicago. So thanks again for having me.
Sandeep Daas:	01:37	Wonderful. So I'm really excited to be talking about this issue today, because I think it's one that hasn't been historically emphasized, and we see the downstream effects of that very strongly today. So could you maybe start us off with a working definition of health equity?
Brian Smith:	01:51	Yeah. So health equity basically means that everyone has a fair and equal opportunity to be as healthy as possible. Even though that sounds very simple, it's not very simple because we all have different backgrounds and it requires us to take into account the social determinants of health. Those are the things that prevent people from being as healthy as possible. Meaning, thinking about things like poverty, things like discrimination,

things like access to care, fair and equal opportunities for education and housing and safety and those sort of things. So health equity really takes into account all of those things and try to equals the playing field so that our patients and everyone can be as healthy as possible.

Sandeep Daas: 02:35 Thanks. So with that definition in mind, how has health inequity manifested in our dealing with COVID-19?

Brian Smith: 02:43 So early on during the COVID-19 pandemic, it was very clear to us that a lot of the inequities that we know already exist in society and affect people of color, especially Black and Latinx communities, it was very clear to us that COVID-19 just unearthed and highlighted these inequities that we already know existed. So we think about COVID-19 and we think about the people who are most susceptible to it, it is people who are in communities of color, people who live in multi-generational housing, so kind of having the inability to social distance the way that they're supposed to. A lot of these people are also essential workers, so unable to work from home, and people who had to go out there and interact with other people. They were bringing COVID home to their families and their loved ones.

In addition to those things, we also think about the... What we know about COVID-19 is that certain people who have certain co-morbidities are susceptible to dying from it as well. So not only contracting it, but the people who are actually dying from COVID-19 are the same people that we're talking about. So mostly from Black and Latinx communities, we know that people have high incidents of comorbidities like obesity, high blood pressure, diabetes, coronary artery disease, heart failure, these are the patients who when they can track COVID-19 are dying at disproportionate rates. Across the board, we sort of saw that these are the patients who are getting it, and these are the patients who also are dying from it as well.

But then, in addition, things like access to care. So we saw limited access to testing for COVID-19 and these communities as well. So that's another reason why we saw disproportionate rates, lack of testing, and then delays in testing and diagnosis as well. And in terms of the treatment as well, we need to make sure these patients have access to medical centers where they can get the most cutting edge treatments for COVID-19. And we also saw that these are the same communities and people who didn't have access to those kinds of treatments as well. So truly, when talking about inequities of COVID-19, we can talk about it

forever, because really we see it at every level from diagnosis to testing, to management, to treatment.

Sandeep Daas: 04:46 Yeah. One thing that's interesting is in the early days of the pandemic, the cases that we started seeing in Dallas, the first cases we started seeing were in the affluent communities. And the thing that really, if you pause and think about it for a second, really, that's just where all the testing was. So in the low-risk-esque communities, they weren't getting tested and they were certainly having the disease, but it was undiagnosed. But the more affluent communities that were able to access the system, get these tests, at the time, were hard to get an expensive. So it was just interesting. It sort of strikes me, it still sticks in my head as an example of how inequity can manifest in visible ways.

Brian Smith: 05:24 We saw the same exact thing in Chicago, too, that... I remember at the beginning, we saw it was, exactly you're right, the affluent communities, and then didn't hear much about these communities of color. And then I remember it was one weekend where all of a sudden, all this data was coming in all at once that showed it was just rampant in these communities. And I think it is exactly what you mentioned. It's the lack of testing. And then people only knew they had it once they came to the hospital.

Sandeep Daas: 05:43 So one specific case example of health inequity relates to vaccinations. Now, a lot of people frame low vaccination rates, especially in communities such as you mentioned, such as Black and Latin X communities, as a patient problem. Without asking you too much of a leading question, I wonder if you agree with that framing.

Brian Smith: 06:03 That is a very complicated question, but no. So I think the short answer is no. I think I would not say that it is a patient problem. I think it's a society problem, honestly, and a problem that has to be addressed from a healthcare provider standpoint. So it is hard for us to break down the reasons why these patients are concerned and have a lot of vaccine hesitancy, but it goes back generations and decades. And we're talking about structural racism in the US and inequities and care and experimentation on these communities and lack of trust.

So that's not something that is a fault of the patient, but really the fault of society. And the onus is on all of us to look at the situation and see how can we improve trust? It's hard to do. We're in the middle of a pandemic and we need people to trust

and to take a vaccine. It's hard to do in an immediate basis. But I do think that we think of it more as a problem for healthcare providers and less of a problem that the patients are dealing with.

Sandeep Daas: 07:00 So what do patients tell you about why they may not be comfortable with the vaccine?

Brian Smith: 07:04 All kinds of things. I feel like most of my clinics, we discussed this, the most common things I hear are, number one, this vaccine came out too fast. I don't know where it came from. It came out too fast. I don't know what's in it. I'm not sure who made it. So I think for a lot of people, they think that they heard nothing about this vaccine, then all of a sudden, a few months ago, everyone was talking about it. So I think that's number one. Number two, I hear a lot of people say, "My family or my friend got COVID-19 after they got the vaccine. So why are people getting COVID-19 after they get the vaccine? Does the vaccine give you COVID?" And as we know that, especially with Pfizer and Moderna, we know that you have to get the second dose and wait about 10 days after that dose until it's maximally effective.

So it's probably likely that people might've gotten it in that interim period. So discussing that as well. I have a lot of patients who have religious objections to it, say that they're they're faithful. Well, they're depending on their faith to protect them. But a lot of what I hear too is just the misinformation that I think we all hear, that all kinds of things about, either it's too much information they're getting from multiple different sources they don't want to trust, or it's very little information.

And so what I'm hearing in my clinic, and I'd love to hear what you're hearing too, is that, patients will say, they'll be like, "Hey, doc, should I get this vaccine? What's the deal with the vaccine?" And I sort of discuss how long it's been tested, how many people have been tested, how safe it is. I discuss in basic terms how the vaccine works. And what I found is that on a case by case basis and on a one-on-one basis, that sort of the way you have to kind of break down this hesitancy, that I think if the information is coming from someone that patients trust, a trusted source or a trusted place, then I think they're more willing to trust it. So I'd love to hear what your experience is like with that as well.

Sandeep Daas: 08:44 Yeah. It's pretty darn similar. I think the vaccine coming online too fast is probably the most common thing that I hear. And the

one comment that you made really resonates with me, which is the preponderance of bad information that's out there now. And I feel like, maybe I'm just fooling myself, but it feels like it's been escalating in the last five years or so. It really feels like there's been a rise of these conspiracy theory type. At first, it was okay when it was just [inaudible 00:09:13] the statins and we had to fight a war every day to get people to take a statin. But now, it's like, this is even more obviously life-saving and it's super frustrating.

So let's really strikes to the heart of health equity, in my opinion, because an initial take some people may have, which is more process-related, is that if we just offer everybody the vaccine equally, that's fair. But if you think about it in terms of achieving equity and outcomes, are we really doing all we can by just offering the vaccine and ending the conversation there?

Brian Smith: 09:43 Yeah, I think we have to do more. I definitely think we have to do more than that. And the way I think about it, as I mentioned previously, in that I think when the information comes from a trusted source or when patients feel like they can trust the person who it's coming from, I think that makes a big difference. And so to that end also, it means that finding patients where they are, so meaning that these trusted sources for these patients that I'm speaking of can be a church, it can be local community centers. I often think that having mobile vaccine units that go into the community where these people are can make a difference as well. We're asking people who have been at home for a year who barely left their house at all to go out and get a vaccine.

A lot of people are crossing County lines and going into unfamiliar location to get this vaccine. So I really think that we have to kind of find people where they are and make sure the information is coming from a trusted source. What I noticed too is that over time, and studies are showing this in Chicago as well, that vaccine hesitancy is improving. People are starting to get it. But I think the more people start to get it, the more people discuss with their friends and family, the limited side effects and overall how they feel and how easy it was. I think it is definitely getting better. And I've noticed that too, in my clinic, and interactions with patients.

Sandeep Daas: 10:55 Yeah. And one of the points that I try to make to everybody is that myself, along with all my partners, we got the vaccine in January when it was first offered to us. We were eagerly busting down the door to get vaccinated. So if that's the kind of signal, if

all the doctors are lining up to get vaccinated, then that should be a signal that we don't think that this is some sort of evil concoction.

Brian Smith: 11:19 I think even things now, [inaudible 00:11:21] a pandemic, it's hard to reach people, but social media is great. There've been plenty of Facebook Live events and town halls and those sorts of things and social media campaigns and commercials. And I think the more and more people see people talking about it and getting it, including healthcare providers, I think that really makes a big difference too.

Sandeep Daas: 11:37 So to broaden it back up a level, what can we do as clinicians to improve health equity via our daily practice?

Brian Smith: 11:45 I think there are a number of things that we can do. So when even talking about the social determinants of health, I think it's important to understand what that is and what that when we're admitting patients. I think a lot of times as physicians, we sometimes admit a patient, we make a diagnosis, we come up with a treatment plan of care, we congratulate ourselves, and discharge patients. But so often, that's only half or even a quarter of the battle. The battle really has to do with the social determines that we're talking about. So I think just making sure that when we're admitting patients and we're talking to patients, we make sure we understand where the patients are coming from, what type of area they live, what kind of financial resources they have or education, all those sorts of things are just as important as a treatment plan.

Getting case managers and social workers involved really early makes a big difference as well. And I think just continuing to be educated on this. The one thing I always say is that I think we all have implicit biases about people and patients that we meet that we may not even be aware of. So I think just continuing to discuss these issues, making sure we have good cultural competency training, I think that the more and more we discuss this, I think the more it becomes second nature to us and the people that we're training to.

Sandeep Daas: 12:55 Yeah. I think that's a great point, that caring for people doesn't just end when they walk out the hospital door, that there's a lot of stuff that needs to go on after they leave. One thing, I realized that we haven't really defined social determinants. So maybe you could just give us a bird's eye view of what that means for the audience.

Brian Smith: 13:14 Yeah. Yeah. So social determinants are basically all the factors in your life, including where you live, how you live, the people you interact with, type of resources you have, education you have, that affect your ability to be healthy and affect your ability to be successful. And this directly relates to your ability to health equity as well. So I think health equity and the social determinants are really, really aligned with each other.

Sandeep Daas: 13:43 So to take an even step further, so we talked about what clinicians can do, what about health systems? What can health systems do to make care more equitable for all patients across races, ethnicities, cultural language, backgrounds?

Brian Smith: 13:56 So I think I'll come back to the point I made about cultural competency training, which I know a lot of hospitals have already implemented. But I think looking at the past year and a half and just seeing what's going on in our country, I think it's really important for all of us to make sure that we have good cultural competency training. Again, even though we think that we're always thinking about care in an equitable manner, we all do have these implicit biases that are important to discuss. Making sure that we have diversity, equity, and inclusion officers and people who are specifically focusing on these issues, both at the trainee level and faculty level as well, and making sure that the care that we give our patients as equitable.

And also something as simple as representation really matters. I think we have to make sure that we have diverse voices in every room of the hospital where decisions are being made, whether that be, this has to be made about patients, about applicants for physicians, about leadership roles. I think it really makes a huge difference because having different diverse voices at the table allows us to see patients in a different light and allows us to make sure that all of our patients are getting the best care possible.

Sandeep Daas: 15:01 Yeah. I feel like we could do another show just on the topics you raised in that last answer.

Brian Smith: 15:06 Yeah. I think I'm really proud of that I think a lot of hospitals and health centers have discussed this even more in the past year, just because we we're talking about how all the inequities we're seeing with COVID-19, a lot of the racial justice we've seen in our country the past year. So I think it's wonderful to see this happen, and I think that this could only make all of us better physicians.

Sandeep Daas:	15:25	Yeah, absolutely. I agree. So Brian, one of the things that I'm really struck by is the passion of the younger doctors coming out now. And people really seem committed to concepts such as diversity, equity, inclusion in a way that I think that, historically, we may have intellectually understood as important, but perhaps we didn't feel it as viscerally. I'm wondering if you're feeling the same thing in Chicago and if you have any thoughts on where we're going and what the future holds.
Brian Smith:	15:54	Thanks for asking that question. I think it's very, very relevant. And like you, I'm so impressed with this new generation of residents and fellows and trainees, because exactly as you said, they are... I think my generation questioned why we don't have as much diversity as we should, why we're not as inclusive as we should be. But this next generation is not only questioning it, they're demanding it, as they should. And they're making sure that if there are trainees are saying, "Why doesn't our training class look like the people that we serve? Why don't we have different voices at the table?" And I think that passion is really translating to real outcomes and it's holding all of us accountable. I think that's all we can really hope for is that making sure that we all feel that accountability and make sure that we are making the next generations of physicians, make sure that we continue to move equity and diversity and inclusion forward. Again, I'm just so impressed with them and impressed with how passionate they are about these issues. And I think we're only going to get better as a medical field, and I'm happy to part of that. I'm really happy to be part of this new movement.
Speaker 1:	16:55	Quality improvement in the time of COVID-19 is brought to you by the American Heart Association with support from Novartis Pharmaceuticals. The views expressed in this podcast do not necessarily reflect the official policy or position of the American Heart Association. For transcripts of this podcast and more information on the association's COVID-19 CVD registry powered by Get With the Guidelines, visit us at heart.org/covidregistry.