Announcer:

Next on Tim Talk. In recognition of National Minority Health Month, we sit down with a family well-versed in medical and social justice.

Tim Dentry:

Welcome back, loyal listeners, as we begin another discussion of Tim Talk, which is as a reminder, the health, equity, and diversity and inclusion part of our healthy, happy, and wise podcast series of Northern Light Health. Our intent is to heal, inspire, inform, and hopefully give us all something to think about and make us better persons.

My emphasis as CEO of Northern Light Health is to shine the light and open our minds on health matters as impacted by behaviors of diversity, equity, and inclusion. Good DEI helps with good health. Bad DEI leads to bad health. Yes, it is as simple as that. Our focus this month is on health for minorities. Joining us for this discussion is Dr. Judith Josiah-Martin from the University of Maine School of Social Work, Dr. Josiah-Martin. Hello.

Announcer:

Hello. Happy to be here and be a part of this conversation.

Tim Dentry:

And we're also very honored to have joining us today Dr. Josiah-Martin's two accomplished daughters, Dr. Lauren Bouchard OB/GYN physician in Cleveland, Ohio, and Dr. Nicole Kelm, public health practitioner based in Washington. D.C. Welcome, one and all.

Dr. Nicole Kelm:

Hello. Hello.

Dr. Lauren Bouchard:

Thank you.

Dr. Nicole Kelm:

Thank you for having us.

Dr. Lauren Bouchard:

Happy to be here.

Tim Dentry:

Thank you. Thank you, thank you. So let's get started. Dr. Josiah-Martin, can you provide us with your thoughts on medical justice and why it is significant, particularly in the context of minority health disparities?

Dr. Judith Josiah-Martin:

Certainly, would love to. So medical justice is the concept of ensuring fair and equitable access to healthcare for all individuals regardless of their race, ethnicity, socioeconomic status, and other identity factors. It involves addressing and working towards eliminating systemic barriers and biases that prevent certain populations from receiving proper healthcare services and achieving optimal health outcomes.

In the context of minority health disparities, medical justice holds significant importance. Minority populations such as black, Hispanic and indigenous communities often face greater barriers to accessing quality healthcare, mainly due to factors such as discrimination, lack of insurance, language barriers, and cultural differences. As a result, these populations are more likely to experience disparities in health outcomes such as higher rates of chronic disease, lower life expectancy, and overall poorer health outcomes.

And so this is a fantastic topic for us to be talking about today because it impacts service delivery across the United States pretty much in any city where there's a major hospital or health plan.

Dr. Nicole Kelm:

Yeah. And if I could jump in, Tim-

Tim Dentry:

Please.

Dr. Nicole Kelm:

I think when we talk about this issue, especially in the context of Minority Health Month and minority needs, a lot of the broader disparity categories get a little bit lost. And I think it's important for us to understand that health disparities and health inequities and these issues of medical justice impact all of us. So we are going to talk a lot about the impact on lives in terms of quality of life or lives lost in the worst case scenario, but really disparities come at a very concrete financial cost to us all. There's estimates that show that current disparities just based on race and ethnicity alone cost us about $320 billion each year in excess healthcare spend, and if we don't change the trajectory we're on, that those costs will rise to one trillion by 2040 based on our current demographics in this country.

So it really does matter very much in the context of minority health, but it also matters for other social identities and social groups. So think about our veterans communities, think about those who are living in rural versus urban communities, those who are impacted by disability or differences among people with gender or sexual orientation on minorities. And so there is something in health equity for everyone, and we should all care deeply about pursuing a more fair and just system for all of us.

Tim Dentry:

That's terrific. Thank you so much. You know, you both touched on so many key points that we try to emphasize as we engage in discussion. And by the way, we started this several years ago, this conversation. It's a Tim Talk, it's only followed by about 17 million people around the globe. No, just kidding. Don't know the exact number.

But we did this because we felt that... For example, Dr. Josiah-Martin, you mentioned optimal health outcomes. Well, many of our listeners are healthcare providers and especially I'm trying to really appeal to the healthcare providers within Northern Light because we're trying to provide a different level of care than any other health system, a different kind of sensitivity. And healthcare professionals are inquisitive and they want to improve the outcomes, so we should be about outcome orientation. And if this is something that detracts from the outcomes, we need to know. We need to know what we can do about it.

And Dr. Kelm, thank you for that idea as well. You mentioned concrete financial cost impact. And healthcare, especially now, has such a increasingly bad reputation as being high cost. Well, if we are creating a phenomenon of more cost in healthcare, shouldn't we all be doing something about that?

And you mentioned those that we serve, veterans, those in more of the rural settings, and gender identity, etc. Some of our podcast recordings were with individuals that really opened my eyes and hopefully a lot of people's eyes that I'll never forget. They were like, "Going through life being invisible is not good. It's

not healthy. It's not what life should be all about." And that's what they pointed to. So thank you both for those thoughts.

When I think of National Minority Health Month, so that's one reason why we're timing this right now, National Minority Health Month. If I could just take a step back and share a couple of personal thoughts and points in my life memories, number one is more recent, and that's the pandemic when the Northern Light health staff across the state stepped up to seek out those in need. And I think especially about our home care and hospice staff along with our ten hospital staff across the state and others who created pop-up clinics. One in the homeless shelters formed mass vaccination sites like the one in Portland, where I'll never forget walking in and seeing eight binders, folks were like, "Here's the binders for the patients." One was for each language spoken by the clientele that they served. And it was just going above and beyond just to explore ways to really reach out and make accessible and connect on their ground, whoever we were serving.

My number two thought isn't quite as pleasant, even though I've learned a lot from it and I think about it a lot. And it's more personal, and that is when I was growing up, I was one of eight kids, grew up in northern Maryland area, and people of color whom I grew up with, all the time I was thinking that they were treated equally. We're friends, we're on the same sports teams, all those kinds of things, only to find out literally years later at reunions and such that they had to wait until the end of the day to be seen by their doctor, and there were only two doctors in the county, and they saw my grandfather. And I thought we were the most progressive family in the world at that time. They had to wait until the end of the day because they were black.

So if I could ask, I think start with Dr. Bouchard, please. As we recognize National Minority Health Month, how are issues such as structural racism and implicit bias being successfully addressed in healthcare from your perspective?

Dr. Lauren Bouchard:

Yeah, thank you for sharing your stories. I think it's so important to understand our own life experiences that shape who we are as healthcare professionals and what we are bringing to our professional space and our care for our patients. I think that is so important.

So to do some reflection on your upbringing and on your story, I think, is so important to see what you're bringing to your patients as well. So I think it's great that you've had that reflection on your past experiences, too.

Some of the things that stand out from what you just mentioned are just reckoning with the history of structural racism and bias that's kind of baked into the systems in which we operate. And I think one of the things that I strive for is not necessarily blaming one individual, but kind of focusing on the system in which we exist, the society in which we exist, and how our history continues to impact our patients to this day.

So in my mind, it's not something that's in the distant past. It's something that continues to have rippling effects, and there are instances where patients are still experiencing racism at this time. It's not just that historic phenomenon.

But some of the successes I've had in my role as the co-chair of the Council on Diversity, Equity, and Inclusion for the OB/GYN Institute is really focusing on a culture shift. So a lot of the expectations in a lot of institutions has been really just having an annual or biannual anti-racism or anti-bias training that's mandatory. Sometimes it's an online module, sometimes it's in person, but similar to the way that we didn't train to do our jobs in a one-hour online module once a year like, that, unfortunately, in my estimation is insufficient in changing the course of the care that we give to patients.

So in my role, we try to make sure that anti-racism, anti-bias ideas and principles and best practices are percolated through all of the aspects of what we do, both for our professional staff and for our patients. So

that includes talking about it with our training programs, with our residents, which are with our PA and nurse NP and midwife students, talking about it at our journal clubs, really integrating these practices into all of our quality improvement protocols such as our peer review process, debriefs after adverse events, mortality and morbidity conferences with the questions of diversity, equity, and inclusion. Are there any social or cultural concerns that are contributing to adverse events for our patients? And I think really being honest about the data and sharing that data with people within our institution and outside.

So one of the things that we've also instituted is a community accountability panel. So we have panels of patients, people from our community who look at our data with us and try to get to solutions together and kind of eliminate the working in silos that happens in a lot of healthcare institutions.

So those are some of the things that I've found to be successful. And I think increasing the transparency for patients and for our healthcare professionals can help them realize that this is an ongoing issue that continues to impact our patients to this day.

Dr. Nicole Kelm:

Yeah, Dr. Bouchard, if I could just echo you, I think. Tim, I work on the other side of the spectrum here. So I work for a large consulting firm where we support organizations all across the healthcare industry in dealing with some of these issues around health disparities and medical justice. But I do think the key word that we all have to keep in mind is that desiloing, I think very often this work gets put on the desk of a DE&I officer or HR and talent leader or a community liaison or our social worker teams. And I think it's really important for us to really understand that health equity is a team sport and needs to be integrated across your organization.

So looking at what are you doing for your own staff? What are you doing for your patients? What are you doing in community and what are you doing as part of the ecosystem writ large to really advance these priorities at scale? Because we can talk about things that improve the individual patient experience, but we also need to be looking very closely at the structural components. How do we actually create a system that has accountability built in so it is easy for people to recognize bias, it is easy for people to recognize when disparities are occurring and address them in concrete ways?

And I think there are real opportunities when we talk about desiloing not just within our organization, but also within the way we think about the problem. Are there alliances that could be made across organizations or across industries? I think especially in healthcare, there's a risk that we just put more and more and more onto the plates of our providers by saying, "Okay, now you have to be someone's therapist. Now you have to connect them with community resources in addition to de-biasing yourself and examining your own past and own lived experience in order to be a better clinician."

But I think there's a lot of opportunity for partnership and collaboration that achieve the same outcomes. So looking at, for example what we see in our business, tech-enabled solutions. How can we put into place systems that maybe enable us to access patients that have historically been underserved? Can we use remote monitoring in new ways? Can we use wearables? Can we use the internet of things that enable us to do things differently? Are there ways for us to leverage the data that Dr. Bouchard mentioned to help us more specifically target areas of intervention? How can we then use that same data to measure progress and know what solutions work best versus kind of taking shots in the dark and presuming we know what works or presuming we know what communities need.

So there's tons of opportunity there. And I think we've seen, especially in the context of COVID, the rise of telehealth, and we've seen the rise of the empowered healthcare consumer through the use of telehealth and some of these more community-based solutions like the vaccination program you mentioned in Portland. So how can we take those lessons learned and integrate them into our systems going forward?

Tim Dentry:

Yeah, fabulous. Thank you, both of you. Desiloing, health equity as a team sport, and all the examples that both of you gave on measuring progress, whether it's through the quality improvement protocols and morbidity and mortality conferences, as you said, Dr. Bouchard as well.

What I'm taking away is that it's positive, constructive ways to see more clearly so that you can do something about it. I mean, I know you're the professionals in the field, so I'm boiling it down if you will, but it does come right back to focusing on a cultural shift, as you said, and it provides a better way, a more constructive, positive way to talk about it as an opportunity. It really does.

You're refilling my sails, not that they were getting empty. You truly are refilling my sails. Because you know what? Diversity, equity, and inclusion efforts sometimes can drain energy as opposed to give people energy, right? And when we're trying to create such a positive culture everywhere, but especially wherever we can influence that, and right now I'm talking Northern Light Health and I'm talking the culture for the citizens of Maine, and you are making, all three of you are making me feel just so much more positive and so much better about that.

So that's not a sign-off question. I got a couple more questions. And I was going to save that because it was forming in my mind, but as I'm listening to all three of you, I'm really getting even more motivated. So thank you. Thank you for that.

So back to a couple of questions if I could. Black maternal health and infant mortality rates are persistently high in the United States, and my goodness, we've heard examples of that most in the recent times. As you said earlier, Dr. Bouchard, this isn't a distant historic kind of phenomenon. These are current phenomena. So Dr. Bouchard and Dr. Kelm, could you shed light on the root causes behind these disparities and their historical context?

Dr. Nicole Kelm:

I can start. We know that about approximately 700 women die of maternity related causes with the new United States each year. That has increased, unfortunately between 2019 and 2021, and unfortunately because of the pandemic that has worsened in our country across all states, and unfortunately the rate of maternity or maternal related mortality and morbidity has increased, especially for black women. And it's about 2.6 times more likely to affect black women compared to white women in the United States. So that persists.

Similarly, the rates of infant mortality also reveal a disparity between our black and white patients and patients of other groups, including indigenous groups. I was looking for the data in Maine, and it seems like our Native American and indigenous population within Maine in particular is more affected compared to white population when it comes to infant mortality. And so those are things that persist to this day.

Some of the root sources, we already mentioned one, which is structural racism and bias that persists in the healthcare systems in which we work. Two, I think in thinking about maternal mortality, our pre-pregnancy health is very, very important to focus on. Across the United States, the number one contributor to maternal mortality is cardiovascular conditions and the second, sepsis and infection, the third, hemorrhage, third or fourth in the United States hemorrhage.

And so sometimes we can try to optimize health conditions prior to pregnancy in an effort to decrease maternal mortality. Unfortunately, there's some barriers to being able to do that, some of which includes the system of healthcare insurance. Like Dr. Josiah-Martin mentioned, sometimes people lack health insurance and the ability to optimize their health prior to getting pregnant. Sometimes the ability to choose when they do get pregnant and when they do not conceive a child, I think is also important in thinking about coming into the pregnancy at your best possible physical health.

The other thing that stands out to me in especially Ohio where I practice and in Maine is our numbers are slightly different than the national average when it comes to the conditions that lead to maternal mortality.

For our states, it's much more likely to be related to mental health conditions including suicide and drug overdose for both of our states. And so in thinking about, I'm sure Dr. Josiah Bouchard knows more about that topic, but in thinking about optimizing how people enter and exit pregnancy, we have to focus on mental health and their overall well-being.

Dr. Judith Josiah-Martin:

And I'd love to echo that because we know that particularly in the black female, black women experience a higher prevalence rate of maternal mental health conditions such as postpartum depression, anxiety, higher rates than what we see in the regular US population. And usually their symptoms are unreported and untreated and unaddressed. And we know structural and social determinants of health are usually risk factors that also contribute to what turns out to be the outcomes in the maternal situation or when they show up at hospitals. We know that prenatal care for many individuals, particularly at the poverty line, whether they have insurance or not, is also a contributing factor. And that's embedded in social discriminatory practices that do not engage them in prenatal services.

And when we're looking at the rural nature of Maine, having access to prenatal clinic services followups... And I'm really liking the rise of doulas and midwifery across the country. That's also a successful intervention to help in some of [inaudible 00:23:42] to address some of these disparities. But nonetheless, it's not the majority of people who are being able to access those types of interventions. And so I'm very much concerned about the mental health outcomes that are pre and post birth.

Tim Dentry:

Yes, absolutely. Thank you both. That was really excellent. I'm wondering, for all three of our great guests that we have today, with your extensive backgrounds, amazing backgrounds, could you share any successful interventions or programs aimed at addressing this that will help with the treatment of disease within minority communities?

Dr. Judith Josiah-Martin:

Well, I'd just like to highlight a couple that I've looked into, and those are services that actually originate out of women's own personal experiences with disparities and discrimination and racism and women who rose up as a collective to create services within their own communities as well as collaboratives that are happening on the national level and the international level.

We have the National Birth Equity Collaborative, which is focused on overhauling systems and structures that contribute to maternal death, and that's a national collaborative that all hospitals can access for resources to help their staff and their professionals address structural issues.

We have the SISTA Midwife Productions and the SISTA, S-I-S-T-A, midwife directory, which is an online, in-person doula training along with community events for people to learn about pregnancy, birth, and so much more.

So taking the education and the knowledge into the communities at the lay level and the paraprofessional level and the professional level. Because going back to what Dr. Kelm says, this is not a conversation that should only be held among practitioners, but this is a conversation that should be held at all levels of our society and across different populations, bringing it right into the family systems itself.

There's Black Mamas Matter Alliance, BMMA, I don't know if Dr. Kelm or Dr. Bouchard know about it, but it's an alliance that helps to advocate for better legislation to reduce black maternal mortality, highlights necessary areas of research, and spreads information about the social determinants of health that influence outcomes like traumatic birth or maternal and infant mortality.

Those are some, and I don't know if Dr. Kelm or Dr. Bouchard would like to mention a couple of others that are really out there helping us to look at this.

Dr. Nicole Kelm:

Well, if I could add, I would say, again, thinking through solutions that are aimed at different levels of the system. So within healthcare systems, we're seeing a lot of innovation in the space using virtual or augmented reality, for example, to train clinicians. Because we know that with the rise of DE&I interventions in large organizations that they're not always successful. It is not the silver bullet for solving for a lot of these things, but we are noticing through some of our work with our collaborators that to train in a virtual reality environment can lower the stress levels and sometimes produce a more effective training environment for some of these things. So there's a lot going on in that space that has potential to bear fruit and be a more effective model for how to change behavior on the clinician side of the house going forward.

I think, too, we see a lot of investment in community programs, so looking at providing what one might consider wraparound services. So looking at not just, to Dr. Bouchard's point, not just what happens during pregnancy with an individual, but what's their nutritional status? How can we get them access to the social services that might be needed, housing support, transportation support in order for them to have a successful birth experience and be healthy in all the areas that encompass that.

I think what we're also seeing is great organizations, for example, Grapevine Health that are working on health literacy in community, but really doing that at a grassroots level versus a top-down level.

And I think, too, there's a lot of thoughtfulness going into some of the structural components we mentioned. Infrastructure is a big thing. The way my organization thinks about some of the root causes of these issues, it's not just the structural racism and bias, but also flaws in the way our healthcare system was designed. So it is not by accident that hospitals exist in proximity to certain communities and further away from others, for example. And we see that here in Washington D.C., where we have a dearth of care, for example, in Ward 8, where mothers have to travel on average 1.5 hours by public transit to get to a birthing hospital here in the city of Washington D.C. And so how can we change our infrastructure and invest our capital differently in order to produce the outcome that we want to see for black mothers?

And lastly, of course, all these things relate to policy. So looking at our policies and procedures at the organizational level, we know what gets measured gets managed, so holding people accountable for delivering the outcome you want to see. And then at the higher social level, talking to our policymakers and holding them accountable for also creating a system that enables individuals to be successful.

So we know that 60 to 65% of black children born in the United States are born using Medicaid as their health insurance primarily. And so how do we make sure that really great initiatives like the expansion of coverage to one year postpartum versus 30 or 60 days postpartum becomes a national initiative? How can we ensure that when we see there are components of the system that work really well, that we scale those up rapidly if appropriate to do so? And engaging our policy makers and having our healthcare providers and clinicians and healthcare organizations going to bat on those issues is critical.

Dr. Judith Josiah-Martin:

I'd like to also add a couple of other programs. We have the Shades of Blue Project and we have Moms Rising, which is a nonpartisan organization pushing for cultural and legislative change around issues like gun safety, paid family leave, and maternal justice. And I think that those are just as important as all of the other issues that affect our families out there.

And I like what Dr. Kelm said because in a rural area like ours, we have to worry about travel distances for birthing families to care, not just for delivery services, but for follow-up services for postpartum services. And although we don't have a very large black population, we have a growing black population in the state of Maine. We have our indigenous populations in the state of Maine. We have our migrant health workers who are also birthing families that we need to look out for, who are sometimes away from our major birthing centers. And so we have populations here that we need to be very much concerned about.

Tim Dentry:

So true. Thank you very much, both of you. Cultural competency. So Dr. Bouchard mentioned earlier focus on a cultural shift, and cultural competency is obviously a critical part of that. So Dr. Josiah-Martin, we'll start with you, but also for Dr. Bouchard, Dr. Kelm, cultural competency is often cited as essential in providing equitable healthcare. What would you say to our listeners, again, many of which are healthcare providers, to improve their cultural competence to better serve minority patients?

Dr. Judith Josiah-Martin:

Well, you know, I'm not a fan of the term cultural competence because as a social worker, I have issue with thinking that we can ever get to that place where we are truly competent about all things cultural. So I'm going to put that as sort of a thought in there.

However, I appreciate the concept, and I think about culturally relevant and culturally effective healthcare system is one that acknowledges the importance of culture, incorporates the assessment of cross-cultural relationships, and recognizes the potential impact of cultural differences, linguistic differences, and expands intentionally our use of cultural knowledge in how we adapt and develop services to the populations that we're serving.

And when we use the word culture, we are recognizing that even for the individual family or patient that that could be defined very broadly. And so the practitioner, the service provider, has to walk into the space of delivering healthcare, not just bringing assumed knowledge of a culture, but allowing patients to inform the process about what is their culture, what are the norms that they hold in their systems, in their family systems as well.

Dr. Bouchard, what do you think about that?

Dr. Lauren Bouchard:

Yeah, I think it gets to the idea of treating the patient as a whole person that exists in the world outside of their interaction with you in the healthcare system. And to me, I try to educate myself on a professional level through programs in my institution or even outside, and I try and seek those out if there's a specific knowledge base that I'm trying to acquire. Sometimes on a personal level, trying to get outside of my bubble to learn about different communities around where I live, that can be helpful too. And then trying to bring some of that experience to a personalized, individualized care plan that I make with a specific patient.

So I think to me, this is why this conversation and this work is important yes, for Minority Health Month, but also is so beneficial for all the patients that we see. Because when you individualize care for a person of a specific culture, you change the way you communicate with everybody. I think that's so beautiful, and that's kind of what fills my cup up when it comes to the work within DEI, is it makes me a better physician when it comes to treating all of my patients. And it's not something that's just limited to one racial or ethnic group. It really is something that is applied to everyone, and I think we could all benefit from treating the patient more holistically.

Dr. Nicole Kelm:

That's such a great point. And I think that's exactly what bubbled up for me with this question is how do we really broaden this conversation? Because ultimately what we're talking about is not DE&I necessarily. It's not necessarily an issue that only impacts certain racial and ethnic minority groups. This is an issue that impacts all of us. All of us should want to A, as clinicians speaking as a clinician myself, want to provide high-quality, safe, fantastic patient care. None of us got into this business to harm individuals. And in order to do that, we have to do exactly what Dr. Bouchard is saying, really treating

that individual holistically, being humble in our approach to care, really taking that learning posture and that inquisitive posture into the work that we do every day.

And I think we do that so well as clinicians when we're thinking about continuing our clinical education, and this cultural learning is also a key component of that. And so how can we codify that in a meaningful way within our organizations as something for us all to think about?

I think the last thing I would add is, again, accountability. These issues around medical justice and health equity and closing the gaps in some of these health disparities are not a "nice to have", but are a necessity. They are a "need to have". I mentioned the cost of some of these disparities at the top of our conversation, but I do think we need to reckon with the real harms that occur in communities when we don't address these problems. The lack of trust in the healthcare system that we saw emerge during the pandemic or saw become more acute during the pandemic. The extreme cost burden of the healthcare system that communities and individuals bear. And so we can address some of these issues through a more careful management and intervention around these disparities, but it's something that we need to really think of from a systemic perspective in addition to looking at what we can do as individuals.

Dr. Judith Josiah-Martin:

And if I could just add, you all sound like social workers because at the root of all of this is enhancing human well-being, meeting the basic needs of all people by empowering them to have equal voice in their care by bringing in that humility, by bringing in that access, by allowing a mutuality, if you will, in the room where I can bring my knowledge as an expert, as a practitioner, but the client is the expert of their own story, of their culture, of their lived experience. And so together, if we're working in that collaborative way, wow, what a difference we could make in how services are delivered.

And even if we bring the patient voices and family voices into how we develop policies, how we design programs to really make them more effective, I think, wow, we could be really transformative in the work that we are doing.

Tim Dentry:

Fabulous. Now, I originally composed this last thought, this last question to listen and learn from this fabulous panel. For Dr. Kelm, but it really is for all three of you, please consider that. What actions can individuals, communities, and policymakers take to promote health equity among minority populations? And all populations, I would add, I've learned from all three of you already on that point, and you've also shared actually some examples, but there might be some further things, Dr. Kelm as well as then Dr. Bouchard and Dr. Josiah-Martin.

And as this is my last question, please feel welcome to share anything else that might be on your mind that really want to make sure you share with our listeners before we leave. But if we can start with that question then, Dr. Kelm.

Dr. Nicole Kelm:

So I think I will leave my better suited panelists to discuss the elements around individual actions. I'll leave that for Dr. Bouchard, and community actions for Dr. Josiah-Martin. But maybe I can speak more broadly at the organizational and policymaker level what could be done. I think really for organizational leaders, if you're a clinician working in a healthcare organization or any organization really, because as we like to say in my organization, health equity is everyone's business, that you really begin to explore across what we call four domains of action.

So looking initially at what is your organization doing? And that includes some of the actions we talked about earlier. So are you doing the training and the efforts to change actions around racism and bias within your system? Are you collecting adequate data, accurate data? Are you valuing patient lived

experience? And do you have accountability structures in place to ensure that patients have a high quality experience no matter what their background is?

So looking at within your organization, and then expanding that also to the people who work for your organization. So what are we doing for our staff to ensure they are well, to ensure that they are able and well-positioned to provide the type of care that we want to see them provide to our patients? So there's a lot just within that organizational bubble that you can think about and action around.

The next level out is really looking at the products and services we provide. So how can we leverage some of these new tools? I mentioned technology at the top of the call. How can we leverage some of the really innovative work that's happening in community that Dr. Josiah-Martin mentioned, some of the platforms that already exist, some of the forms that already exist, some of the tools or programs that we know work. How can we resource those programs more effectively and scale them up?

I think when we think about products and services, we don't always think of healthcare necessarily packaged that way, but that's an opportunity to do things differently and potentially do things better.

And then looking at the next layer out, so going beyond your organization, beyond what you're providing to your patients, now looking out into the broader ecosystem. Who can we partner with more effectively in order to drive the kind of outcome that we want to see? So for a healthcare organization, are we partnered effectively with organizations that provide transportation, organizations that provide access to affordable housing, organizations that provide access to nutritional or food services? How can we do a better job at engaging the community to build literacy around healthcare? How can we support the community to engage in healthier behaviors that happen outside of the four walls of our institution? How do we build a community that is more prosperous, writ large, not just in relation to health, though health is the foundation of that?

And who can we partner with to do that? Because that's a huge mission, right? Is to actually make a community healthy, not just treat illness when it arrives within our facilities, requires a big team and significant investment. So how are we thinking creatively about who we work with?

And I think there's tremendous potential. We see a lot of really interesting kind of alliances forming. The Food Is Medicine movement is one of my favorites to kind of talk about. But looking at partnerships between healthcare organizations and groups like Instacart, for example, who provide grocery delivery services for people who maybe have disabilities or who are mobility limited in some way. And then also couple that with education around meal preparation and healthy diets and do all of that within a budget, and it's AI-enabled and tech-enabled.

So how can we think more creatively about the possibilities and produce a radical re-imagining of what a healthy community looks like? So I'll pass it to Dr. Bouchard to talk more about what individuals can do.

Dr. Lauren Bouchard:

Yeah, thank you. I think it's great that you end on that like overall healthy lifestyle and wellness. For me, I think on the individual level in taking care of patients in my office, I try to do my best in listening to them, making sure that they feel like there's an empathetic ear in the room. Sometimes, as you probably know, we're not always going to come to a cure or solution to the issue that they're having, but what I can guarantee is that I can do my best to allow them to feel heard and to feel valued in my care. So that's what I try to do.

I find, going back to Dr. Kelm's point, I think as a healthcare professional, it's very challenging to do that when you're not taking care of yourself. And I think physician burnout and mental health issues are at an all time high, especially after the pandemic. And I think this is not unique to physicians, I think it's across all healthcare professionals. So I think making sure... The days that I feel really great about being a great listener and being a great provider are the days that I have been able to take care of myself, and I think that that is a part of providing the best care that I can to my patients.

I think sharing and amplifying their stories, so important as an individual. So sometimes I'll even journal, I'll write them down, and I'll just say, "This is what I talked to my patient about today." And trying to bring their stories to the forefront, both with their representation and also myself, to my institution, to the national level, lobbying through my professional organization at the state and national level. Those are some of the things I do as an individual to try and create change for this population. So I think that those are the first things that come to mind as an individual.

Dr. Judith Josiah-Martin:

That's awesome. And I would add from a social work lens, we need to confront through education. I believe that we need to speak the truth that there is implicit bias and there are disparities, and we need to not develop our services as if we are post-anything, that we need to hold the truth that this is the reality of where we are today and confront the reality through real education, through real conversations. Build collaborative community efforts is a very important part of what I... I don't want to reiterate what Dr. Kelm says because she said it so beautifully about all the different systemic levels that need to be a part of the conversation.

We're not saying that everybody needs to be in the same room. We need to have rooms of conversations where there are multiple community collaboratives looking at this question through the lens of honest, empowered integrity to break down this stuff. And we need to bring implicit bias trainings into all of our organizations because the nature of systemic racism or the nature of any systemic -ism is that it creates an invisibility, and to make that visible requires all of these conversations to really be out loud and not quietly behind doors. And so that's all I would add to this.

Tim Dentry:

Thank you all very, very much. Is there anything else that's on your mind before we say farewell? Anything anyone would like to share? Yeah, go ahead.

Dr. Judith Josiah-Martin:

I want to say thank you for having us be a part of this conversation. This is something that as a family we are very much passionate about. We could talk about this for hours on end. And as professionals in our own right in the organizations that inform how we come to these conversations, I am very passionate about the care of anybody that's disenfranchised by healthcare or education in this country. And I do think that we have the means, the opportunities now to make a difference. And having more and more of these conversations where the public can hear about the actions that they can join professionals in engaging with makes a change across our society that can only be for the good of the generations to come.

Dr. Nicole Kelm:

Yeah, I would echo the gratitude, Tim. You mentioned there's lots of good ideas in this conversation about what individuals can do, but I think honestly, it starts exactly where you have started, is sharing the position, sharing the privilege, sharing the power for us to have these conversations and for us to continue to platform all the wonderful action that's happening.

These are big, thorny, wicked, wicked problems. They're not going to go away overnight. And I think leaning into that occasional discomfort, leaning into that reality and continuing to wrestle until we find a solution that better serves us all is kind of the key to us continuing to move forward. So thank you for creating the time and creating the space.

Dr. Lauren Bouchard:

Thank you for having us. And I just want to especially thank my mom, Dr. Josiah-Martin, for being amazing and for providing so many great years of service in Maine.

Tim Dentry:

Wow, hear hear on that.

Dr. Nicole Kelm:

Hear, hear.

Tim Dentry:

Dr. Josiah-Martin. A couple of things in wrapping this up, you know when you just said, Dr. Kelm, leaning into the discomfort. Again, when we started this at Northern Light Health, literally three and a half years ago or so, I said, "I don't want to be comfortable. I don't want to find ourselves in a comfort zone when we talk about our culture of caring that starts with caring for one another, that cares about diversity, equity, and inclusion, and that's a part of us, what we do. I don't want to get comfortable with that."

So thank you so much. As excited as I am right now and really inspired by the three of you, I just wanted to share that. Thank you all for helping us get outside of our bubbles and fanning that passion that we share for the disenfranchised. You're right. That's why so many of us got into healthcare in the first place, and it isn't post anything.

And so let's create a better future. So I'm going to close with this, and that is, Dr. Bouchard, I might've jotted this down a little differently than you said it, so I apologize ahead of time, but you said, "The days I feel the greatest about my care for my patients are the days when I take care of myself." So on that note, listeners, I'm going to end on that note. Days I feel great about the care I provide for my patients are the days I take care of myself, and the ways that we do it even better and challenge ourselves in such a good way are all the many, many things that Dr. Kelm, Dr. Josiah-Martin, Dr. Bouchard shared with us today. This has been epic. Thank you so much.

And thank you, podcast listeners, as well. Until next time, I am Tim Dentry, humbly after this call encouraging you to listen and act to promote our culture of caring, diversity, and inclusion that starts with caring for one another. Thank you.

Announcer:

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