BREADTH

LOST TOUCH

Elisa Sottile, MD, FACP

Dr. Sottile (elisa.sottile@jax.ufl.edu) is clerkship director, associate program director of the internal medicine residency, and assistant professor of medicine at the University of Florida College of Medicine-Jacksonville.

My two college-aged children remind me daily of the various things that I have lost touch with—like recently, when I argued that Pearl Jam was new rock music, not classic. They laughed, knowing I still think Facebook is a hip social networking medium. Yet, there is part of my life that will never become outdated, and for which I will never lose touch—I will always be a physician. I have been practicing primary care for a quarter of a century in which I care for patients through all manners of personal turmoil and triumph. Certain aspects of my training as a young physician remain timeless and trusted:

- to look patients in the eye as they initially share their concerns, then, as time passes, they would share their life stories, not just their ailments;
- to listen, knowing that patients were allowing us a privileged view into their lives;
- to use touch, forming bonds, and deepening the human connection between two people, not just the sick and healer;
- to make ourselves present, both physically and mentally, so that we could respond to our patients' emotional needs.

After years of treating, crying, praying, and sharing with my patients, making connections had kept me fulfilled and was something that I looked forward to. I also had become a "hugger": if I forgot to provide at least one hug during our visit, patients would ask me what was wrong. Some have been patients for decades, noting "I love you" as often as "thank you". I had been fortunate to have such deeply positive patient relationships. Despite the countless hugs in that time, I don't think I ever fully appreciated personal touch. I had never imagined it would be lost.

Then COVID-19 struck.

These past months have been tumultuous, affecting all members of our communities. Some are fearful, some deniers, most anxious and many panicked; we likely have all recently interacted with patients in each of those groups. This pandemic has changed how you and I now care for all of those patients. We can no longer take touch and connections for granted. Our patient connections are possibly the most important factor in maintaining our resilience. It is ironic that during this stressful time in which strong patient relationships would help support us, we must separate ourselves from those same patients.

Lost touch is a phrase that one might use to describe someone living in the past. I wonder now if it is a phrase that will describe health care of the future. Human connections are deepened through our senses. Hence the challenges parents of a deaf or blind infant face while trying to build their family unit. On a different level, consider what we might miss when we consult with a patient through purely audio means. We might miss the downward glance the patient makes when not-

> This pandemic has changed how you and I now care for all of those patients. We can no longer take touch and connections for granted.

CONTENTS

AFFIRMATIONS FOR CHANGE

Tiffany I. Leung, MD, MPH, FACP, FAMIA, Editor in Chief, SGIM *Forum*

"Your voice is kind and you seem really knowledgeable," said a patient during a recent video visit for routine care. I felt like I was just doing my job, so his comment struck me as gratuitous; yet, it also affirmed the importance of clear communication by healthcare professionals at an individual level and more broadly. This year, we have experienced significant changes in our global and regional environments, culturally, politically, and interpersonally—with more major shifts on the horizon.

How we interact with patients has changed: remote visits have skyrocketed. How we interact with other professionals has shifted: videoconferencing for meetings and conferences are routine; social media engagement for professional networking and collaboration is commonplace. And how we interact with the general public has shifted: disinformation is widespread, where addressing it in patient-physician interactions and in public messaging and advocacy are becoming a part of our core competencies in professional interpersonal communications.

In this penultimate issue of 2020, Sottile reflects on "losing touch" with patients. Wilhite, et al, describe starting points for institutions to address social determinants of health to overcome inequities exacerbated by COVID-19, while Kuy, et al, provide an overview of communities affected during the pandemic, including children and rural communities. Systemic racism also remains an important aspect of these discussions, as Thomas, et al, explore differences in hypertension control by race among patients in resident and faculty clinics and Sgro offers the second part of a *Forum* essay collection on racism in medicine. Morales offers us a rapid-fire view of important issues to consider as the U.S. presidential election looms, while SGIM President Jean Kutner and CEO Eric Bass supply updates on the current state of SGIM advocacy and primary care research funding landscapes, respectively.

What we communicate has always been central to our work as physicians and changes in *how* we communicate call for continued development individually and especially institutionally. As we continue to practice, advocate, and research—and vote!—let's also remember to listen and compassionately receive and respond to others, especially patients. Even the seemingly smallest affirmations can seed change.

SGIM

TRANSFORMING VALUES INTO ACTION THROUGH ADVOCACY

Jean S. Kutner, MD, MSPH, President, SGIM

The importance of assuring that our voices are heard is especially timely. The Advocacy section of the SGIM website includes detailed information about SGIM's advocacy efforts as well as many valuable resources to inform advocacy efforts. I encourage you to familiarize yourself and leverage these resources to amplify your voice, and that of GIM as a field.

"So many things are possible when you don't know that they are impossible."

—Norton Juster, *The Phantom Tollbooth*

As we, as an organization and as individuals, seek to achieve the SGIM vision of "A just system of care in which all people can achieve optimal health",[1] it can at times be easy to become discouraged and frustrated regarding the pace of change. While we have made significant gains that should be celebrated, much work remains. We must maintain constant vigilance to avoid regressing.

Some recent personal experiences have reinforced this for me. For example, I celebrate the following observations:

- Primary care, hospital medicine, palliative care, women's health and geriatrics—core GIM content areas—have come to be seen as essential components of healthcare delivery by many healthcare systems and payers;
- We are paying attention to and acting in meaningful ways to address harassment in clinical settings;

- We are moving beyond giving lip service to healthcare disparities and equity, taking significant steps to collaborate with underserved communities to truly address identified health needs; and
- SGIM is has become a key partner and voice in national conversations and initiatives

At the same time, I have been distressed over the following:

- Persistence of use of wRVUs instead of patient outcomes to determine financial support for primary care and hospital medicine;
- There have been recent increases in situations in our clinical settings in which trainees, faculty, and staff were disrespected by patients due to the color of their skin or gender, despite policies outlining an institutional environment of mutual respect; and
- Significant health disparities persist in our commu-

ELECTION 2020: THE STAKES COULD NOT BE HIGHER

Susana Morales, MD

Dr. Morales (srm2001@med.cornell.edu) is associate professor of Clinical Medicine; vice chair, Diversity, in the Department of Medicine, Weill Cornell Medicine; and director, Diversity Center of Excellence, Cornell Center for Health Equity.

Over the past two weeks, I saw 11 COVID-19 survivors in my practice—all long-term patients in New York City—six Latino and five African American. Two were on ventilators, for over two months. One is still severely disabled and fears job loss. The other fears loss of a home. Most of these survivors continue to have symptoms months after their initial COVID-19 infection. Several of them are essential workers. Nearly all reside in multigenerational homes and had multiple family members who were also infected. All reside in low-income communities.

After a terrible spring, New York City was able to suppress COVID-19 due to a mandatory lockdown, aggressive testing, and masking. As of this writing, much of the United States is still in crisis, with thousands of deaths per week and more than 200,000 COVID-19 deaths cumulatively. Additionally, we are facing an economic toll not seen since the Great Depression with high levels of unemployment, loss of health insurance, and an imminent eviction calamity. The racial and ethnic health disparities seen in COVID-19 shocked because of the terrible death toll. Clear causative social, economic, and political determinants were all telescoped into nine months.

Additionally, the COVID-19 disaster has been exacerbated by a federal response characterized by deceit, political gamesmanship, disinformation, and dismembering of the nation's public health infrastructure. The mobilization of the Black Lives Matter movement against racist police brutality and murder via the largest political protests in United States history have added to our national sense of urgency. The extensive wildfires and other manifestations of climate change are yet more dire results of ignoring science.

For these reasons and more, the upcoming election will be crucial to all who are front line workers caring for Americans while risking our own lives to do so. Our experiences give us key insights into how politics affects all of our lives and how structural racism has affected politics.

In 2021, the new administration will have to think big—very big—and all policies should be approached with an anti-racist lens. Some priorities should include the following:

- *COVID-19:* The United States needs a national comprehensive testing strategy, universal masking, a fast and accurate data collection system, and vaccine development with exquisite attention to research ethics and scrupulously run clinical trials, and with a focus on poor and BIPOC (black, indigenous, and people of color) communities.
- *Health Care:* Millions lost their health insurance as they lost their jobs, and aggressive efforts to achieve universal health insurance coverage must move forward, especially as communities of color are disproportionately affected by lack of health insurance and poor access to care. The federal government should also expand programs that serve the underserved, including community health centers, migrant health centers, and workforce diversity programs.
- *Policing and Criminal Justice Reform:* The federal government should promote the redesign of policing that will redirect funds to appropriate social service, and mental health supports, especially as the mentally ill may be at extreme risk for fatal encounters with police. We must also reform drug laws to address mass incarceration, which has disproportionately affected men of color in particular, and promote the reentry of the formerly incarcerated into employment.
- *The Economy and the Environment:* The administration should immediately expand unemployment insurance due to our pandemic associated employment crisis, while expanding assistance for small businesses; and planning for infrastructure development, The administration should commit to anti-climate change initiatives that can also buttress economic development and create jobs, like the "Green New Deal." Infrastructure development should include affordable housing so that we can eliminate homelessness in the United States. Communities

nities, despite substantial efforts in outreach and community engagement.

These examples and experiences reinforce the importance of ongoing advocacy—individually, locally, and nationally. They also underscore the important role that SGIM plays in advocating for our field and for our core principles.

While SGIM has been active and visible in advocacy for some time, our advocacy activities have greatly accelerated this year. The unprecedented volume reflects both the opportunities that have emerged in the face of the pandemic, as well as ongoing issues relevant to SGIM in the clinical, educational, and research arenas. A complete list of SGIM endorsements is available in the Advocacy section of the SGIM website.[2] Some notable examples of advocacy actions undertaken by the Society of General Internal Medicine, its Health Policy Committee, and the three subcommittees during Spring and Summer 2020 include the following:

- SGIM provided an extensive comment letter to the Centers for Medicare and Medicaid Services (CMS) with regard to the Graduate Medical Education (GME) proposals that were included in the Inpatient Prospective Payment System (IPPS) proposed rule.
- In support of the patient and provider flexibilities implemented by the Department of Health and Human Services (HHS) and CMS during the public health emergency, SGIM sent a letter to HHS Secretary Alex Azar and CMS Administrator Seema Verma with recommendations on which of these policies could support the delivery of high-quality care, as well as economic recovery, once the public health emergency concludes.
- SGIM organized and led a sign-on letter addressed to Congressional Leadership

requesting that Congress include $50 million in the fourth COVID-19 relief legislation for the Agency for Healthcare Research and Quality (AHRQ) to generate the data needed to make an informed decision about which telehealth flexibilities Congress and the administration should make permanent.
- SGIM signed on to a letter in support of legislation introduced by Senate Finance Committee Chairman Charles Grassley to provide emergency support to nursing homes and other elder care facilities to address COVID-19 related impact.
- To ensure that patients have access to care through a robust physician workforce, and prepare for the next public health emergency, SGIM signed on to a letter asking Congressional Leadership to include the Resident Physician Shortage Reduction Act of 2019 in the fourth COVID-19 supplemental relief package.
- SGIM, through its Clinical Practice Subcommittee, is engaged in the 2020 Field Testing related to the Merit-based Incentive Payment System (MIPS).

The Health Policy Committee and its subcommittees have been essential voices in identifying, vetting, crafting, and speaking for SGIM and its members. The Committee has created an ambitious 2020-2021 Health Policy Agenda in the areas of Clinical Practice, Education and Research available on the SGIM website.[3] It is also exciting to see the engagement and leadership of the other SGIM Committees and Commissions in bringing forth important perspectives on many topical issues, through direct advocacy, position statements, publications, and presentations. We have encouraged collaboration across Committees and Commissions in these efforts to assure that all relevant perspectives are being included, and to further amplify the voice of our members. The "Communities" sec-

tion of the SGIM webpage provides information about the various SGIM Committees and Commissions as well as how to get involved.[5]

The importance of assuring that our voices are heard is especially timely. The Advocacy section of the SGIM website includes detailed information about SGIM's advocacy efforts as well as many valuable resources to inform advocacy efforts.[4] If you haven't reviewed these materials recently, I encourage you to familiarize yourself and leverage these resources to amplify your voice, and that of GIM as a field. Whether you express your voice by exercising your right to vote, by contacting your local, state, and Congressional representatives, by publishing in the peer-reviewed literature and other venues, or by advancing issues or positions through SGIM and supporting SGIM's advocacy efforts, we *must* continue to transform our values into action (to paraphrase the 2021 Annual Meeting theme) to effect important change, even if it may feel daunting at times, jointly striving for our envisioned future and achieving these possibilities even when others may say that they are impossible.

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SGIM

Q & A WITH SGIM'S CEO: IMPLICATIONS OF THE 2019 HEALTH SERVICES AND PRIMARY CARE RESEARCH STUDY

Eric B. Bass, MD, MPH

Dr. Bass (basse@sgim.org) is the CEO of SGIM.

What should SGIM members know about the 2019 Health Services and Primary Care Research Study?

In 2018, Congress directed the Agency for Healthcare Research and Quality (AHRQ) to perform a study of the breadth, scope, and impact of health services research (HSR) and primary care research (PCR) supported by the U.S. Department of Health and Human Services (DHHS) and the Department of Veterans Affairs (VA) since 2012.[1] The study was performed by the RAND Corporation, which interviewed stakeholders, assembled two panels of leaders in HSR and PCR, and analyzed the federal portfolio of funded HSR and PCR.[2] The analysis included projects funded by AHRQ, the Administration for Community Living (ACL), the Office of the Assistant Secretary for Planning and Evaluation (ASPE), the Centers for Disease Control and Prevention (CDC), the Centers for Medicare and Medicaid Services (CMS), the Health Resources and Services Administration (HRSA), the National Institutes of Health (NIH), and the VA. The most important findings are as follows:

1. Federal portfolios in HSR and PCR have distinct foci that reflect differing requirements of their congressional authorizations and missions. AHRQ has a unique focus on system-based outcomes and implementation of improvements across health care settings, and emphasizes patient safety, health information technology, and evidence synthesis. ACL concentrates on needs of community-living elderly and disabled people, with an emphasis on social factors. The CDC funds HSR and PCR focused on prevention and health promotion in community and health care settings. CMS supports HSR and PCR on needs of Medicare and Medicaid beneficiaries with an emphasis on cost, utilization, and financing of care. The VA focuses on needs of veterans. Last, but not least, the NIH supports HSR and PCR focused on specific diseases, body systems, or populations.

2. When agencies fund HSR and PCR on similar topics, the overlap is generally complementary, addressing different aspects of the topic. Nevertheless, the RAND team identified a need for more proactive coordination of the agencies' HSR and PCR portfolios.

3. Federally funded HSR and PCR have had significant impact in advancing science, improving patient outcomes, improving professional knowledge and practice, improving health care systems and services, influencing health policy, and addressing societal issues. The RAND team also noted barriers to determining the full impact of the HSR and PCR.

4. The analysis revealed cross-cutting gaps in federally funded HSR and PCR, including needs to: examine outcomes for a full range of populations and settings; follow changes in implementation and outcomes over time; communicate results that are actionable; produce timely results for improving health care delivery; use theory to advance knowledge; and leverage digital health and link new sources of data.

5. The report also called attention to specific gaps in both HSR and PCR on: healthcare workforce issues; burdens of health information technology on health care providers; the role of health care systems in addressing social determinants of health; effects of social factors on demand for care; integration of patient preferences into care; need to address misinformation about health issues; development of harmonized measures to assess quality of care; identification of root causes and solutions for overcoming barriers to health care access; and costs of new care therapies and delivery models. In addition, more HSR is needed on effects of evolving models of financing on outcomes in different populations, and ways to reduce costs and disparities across the health care system, while more PCR is needed to examine the core functions of primary care, and transform the role of primary care in the health care system, including its role in reducing disparities.

Based on these findings, the RAND team made numerous recommendations to improve the relevance and timeliness of HSR and PCR, encourage innovation in HSR and PCR, and improve translation of HSR and PCR into practice. To strengthen the impact of HSR and PCR, they recommended that federal agencies identify HSR and PCR priorities to more effectively allocate funding, proactively identify potential overlap in portfolios, maintain AHRQ as an independent agency serving as a hub of federal HSR, and fund an entity to serve as a hub for federal PCR.

What is SGIM doing to advocate for federal funding of HSR and PCR? Our Health Policy Committee (HPC) has had a long-standing commitment to advocating for "support of research consistent with the objectives of SGIM and for the types of research done by SGIM members."[3] For many years, the HPC has focused a lot of attention on HSR, with an implied but not explicitly stated commitment to PCR. The HPC's priorities for 2020-21 include active advocacy for the highest possible funding and a supportive policy environment for the National Institute for Minority Health and Health Disparities and for the NIH Clinical and Translational Science Awards, as well as coalition advocacy for the highest possible funding for HSR and PCR at AHRQ, NIH, VA, and the Patient Centered Outcomes Research Institute. The HPC's current priorities also emphasize the need for funding of research on healthcare disparities by AHRQ, CMS, CDC, and other relevant agencies, and the need for policies that allow members to conduct high quality research unencumbered by inappropriate restrictions.

In the past year, we have weighed in on many issues related to HSR and PCR. For example, we submitted a letter to Congress calling for increased funding of AHRQ to help generate the data needed to develop informed policies on telehealth flexibilities that the government should make permanent. We also submitted a letter to DHHS and CMS urging continuation and refinement of policies to facilitate use of telehealth, with a call for a data-driven approach to define and value telehealth services. We collaborated with the American College of Physicians on a letter to the Physician-Focused Payment Model Technical Advisory Committee, which included a call for more robust access to claims data from CMS to help develop more targeted evidence-based performance metrics and new payment models. We also have continued to urge the U.S. House and Senate to appropriate increased funding for research by AHRQ, NIH, and VA, and we have called for federal policies to be guided by science.

I believe the RAND report should help stimulate further advocacy for funding and policies that will help address the gaps in federal support of HSR and PCR. Although SGIM has consistently been a strong advocate for HSR, the report reminds us that we also need to strongly support PCR. To that end, I'm pleased to report that SGIM President Jean Kutner participated in a virtual Capitol Hill briefing about the need to invest in PCR. She explained the need for PCR and the differences between PCR and HSR, and she provided examples of PCR. We see this as a great opportunity to continue advocating for the research needed to achieve our vision for a just system of care in which all people can achieve optimal health.

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of color are disproportionately affected by unemployment and underemployment, and chronic homelessness is much more likely to be experienced by people of color.

• *Immigration:* The administration must proceed with a plan for comprehensive immigration reform; path to citizenship; permanent status for Deferred Action for Childhood Arrivals (DACA) recipients; and reversal of family refugee and immigrant policies that separate children and families.

SGIM members have been at the forefront of documenting health inequities and the impact of racism on health, educating young doctors, and caring for the most vulnerable. We will do our part to help the United States recover and shape the way forward. We must fight for scientific independence and the strengthening of public health, and advocate for the most vulnerable. The stakes could not be higher.

SGIM

RESIDENT AND FACULTY CLINICS: DOES OUR HEALTHCARE SYSTEM PERPETUATE HEALTHCARE DISPARITIES?

Meghan Thomas, MD, MS; Elisha Brownfield, MD; Sabra Slaughter, PhD; Elizabeth Kirkland, MD, MSCR

Dr. Thomas (andersmk@musc.edu; @MaggieT69807835) is an assistant professor in the Department of Medicine and academic fellow at the Medical University of South Carolina. Dr. Brownfield (brownfe@musc.edu; @ElishaBrownfie1) is an associate professor in the Department of Medicine and the director of Strategic Leadership Development at the Medical University of South Carolina. Dr. Slaughter (slaughsc@musc.edu) is interim director of the Center for Health Disparities Research, as well as a research associate professor in the Department of Medicine at the Medical University of South Carolina. Dr. Kirkland (kirklane@musc.edu; @LizKirkland15) is an assistant professor in the Department of Medicine and researcher within the Center for Health Disparities Research at the Medical University of South Carolina.

Despite medical advances and improved access to care over the last several decades, overwhelming ethnic and racial disparities in healthcare persist. The persistence of healthcare disparities demands attention and has prompted widespread efforts to address inequities in care. Unfortunately, these gaps are likely to widen further in the setting of a dwindling primary care physician (PCP) workforce and the rise of subscription-based primary care services; both are often inaccessible for those at the greatest risk of adverse health outcomes. A recent article in the *Journal of General Internal Medicine* reveals another disheartening blow to health equity in America[1]: patients of resident primary care clinics may receive a lower quality of care compared to similar patients of faculty physicians. We sought to identify disparate health outcomes across racial groups in our own Internal Medicine resident clinic when compared to our faculty practice.

Early studies of the quality of care delivered through resident clinics when compared to faculty clinics were promising[2]; however, Essien, et al,[1] show that resident patients were less likely to achieve chronic disease management goals or meet quality metrics for cancer screening when compared to faculty patients.

We similarly investigated the effect of resident versus faculty physician type on chronic disease control at our academic-affiliated primary care practice located in the Southeast. This was done in the context of a larger evaluation of Patient Centered Medical Home (PCMH) certification's effect on blood pressure (BP) control rates over time, with a focus on racial disparities. A previous analysis from our group revealed that while non-White patients started with a higher BP, all racial groups achieved similar BP reduction over time.[3] Based on those results, we hypothesized that there would be no difference in degree of BP reduction between resident and faculty physicians or patient race.

Our inception cohort included 1,702 patients with baseline quarterly systolic BP (SBP)≥140mmHg (63% Black, 36% White, 1% Asian or other based on self-report and electronic medical record (EMR) data) and served as their own historical controls. For this analysis, individuals identifying as Black, Asian, or other were grouped into a "non-White" group. Notably, within the inception cohort, most patients of resident physicians were non-White (87%) while the majority of faculty patients were White (62%). Mean SBP was calculated for the cohort on a quarterly basis in longitudinal fashion, averaging all recorded BPs during each quarter.

When we examined the association of physician group (resident or faculty) on BP reduction with subgroup analyses according to patient race, we discovered similar findings to Essien, et al,[1]; yet, the results were more pronounced. First, there were notable differences in patient distribution:

- 82% of resident patients were non-White in our clinic versus 37.7% in the work by Essien, et al.
- 62% of faculty patients were White in our clinic versus 78.4% in the work by Essien, et al.

Second, we found statistically significant differences in the mean SBP reduction between the two physician groups and between the two racial groups even within each physician group:

- White patients of resident physicians sustained a significantly greater SBP reduction than their non-White peers, also treated by resident physicians (p=0.0129).
- Non-White patients experienced a greater SBP reduction if cared for by a faculty physician rather than a resident physician (p=0.0477).

THE WAKE OF THE OUTBREAK: COVID-19 AND SOCIAL DETERMINANTS OF HEALTH

Jeffrey A. Wilhite, MPH; Harriet Fisher, BA; Sondra R. Zabar, MD

Mr. Wilhite (Jeffrey.Wilhite@nyulangone.org) is a researcher at NYU School of Medicine's Program for Medical Education Innovations and Research (PrMEIR). He manages the Unannounced Standardized Patient program. Ms. Fisher (Harriet.Fisher@ nyulangone.org) facilitates program implementation and coordination for PrMEIR. Dr. Zabar (Sondra.Zabar@nyulangone.org) is the director of the Division of General Internal Medicine and Clinical Innovation at NYU Grossman School of Medicine, director of PrMEIR, and a professor within the Department of Medicine.

News of the first confirmed case of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), more commonly referred to as COVID-19, in New York City (NYC) broke on March 1, 2020. By the end of March, the worldwide case rate had ballooned to nearly 800,000, with a directly-attributable-to-disease death rate above 40,000.[1] This number has grown exponentially since the early days of the outbreak. In mapping the spread, researchers identified an alarming trend: the most acutely impacted communities are located within low-income, minority areas.[2] Similar trends have since emerged across the United States, from large urban centers to smaller communities and towns. More concretely, emerging evidence suggests that Black and Hispanic individuals are as much as 3.5 and 2 times more likely to contract and face complications from COVID-19 than White individuals, respectively.[2] In this article, we describe how key SDoH have been exacerbated by the COVID-19 pandemic and how certain populations will face long-term implications hereafter. We use this information to make recommendations for health systems on how best to prepare care teams for the wake of COVID-19.

The COVID-19 pandemic has shed new light on the critical importance of the social determinants of health (SDoH), or the conditions in which people live, work, and grow. SDoH encompass a range of issues including income level, housing and insurance status, and distance from medical care, among others. A wealth of evidence says that SDoH directly impact a person's health status and mortality risk, and COVID-19's emergence has further affirmed the relationship between SDOH and health outcomes. As Americans shifted toward isolation when possible, lower-income and service industry workers whose work is considered essential have continuously faced exposure to the illness.[3] Additionally, lower-income workers, especially those living in households comprised of people of racial minorities and lower educational attainment, are also experiencing increasing rates of furlough and unemployment as the pandemic progresses.[1] Data trends show that those most directly impacted by job loss include minorities, women, and those with less than a college education.[4] Transition to telework has been reserved for those with a college degree, with 66% successfully switching compared to only 22% of those without a degree.[4] Lower-income minorities are also likely to be impacted by societal consequences of COVID-19, such as reduced healthcare access due to layoffs or lack of insurance status, and housing insecurity, long after the initial outbreak.[1]

The longer-term implications of the pandemic will more clearly unfold as the healthcare industry attempts to begin to return to normalcy in the next several months.[3] As communities begin returning to the "new" normal in the wake of COVID-19's declining numbers, we will likely see an increase in routine medical care and office visits for the general population, but those with existing and newly emerging SDoH will need multi-level care that addresses both present illness and underlying SDoH-related issues.

Addressing SDoH in the Wake of the Outbreak

Financial struggles and insurance issues are linked to decreased access of health services for treatment for long-term follow-up so systems must be prepared to address the immediate needs of patients as they return to seeking clinical care, especially in safety-net hospital systems.[1] Increasing awareness around processes and channels to mitigate the long-term repercussions of the relationship between COVID-19 and SDoH will be essential in protecting livelihoods in affected communities. How can we, or the larger health systems that care for this population, prepare to provide the high-quality services needed?

Step 1: Assess System Capacity to Engage with Patients Presenting with SDoH-Related Issues

Systems should begin with a needs assessment of their capacity to engage with patients presenting with under-

lying financial and housing insecurity, unemployment, and food access issues. A necessary first step is examining the care team's ability to link patients with community programs available through the hospital system. For example, when a patient presents without insurance or can't afford a copay, do clinical staff know best practices in referring them for low-cost or free services, whether that is testing for COVID-19 or routine medical testing? Or when a patient visits with concerns over affording rent due to job loss, do care teams know the referral and community resource networks available for homelessness prevention? Which free or low-cost counseling services exist for patients who have developed anxiety or trauma during the onset of the pandemic? Which practices (through EHR documentation/charting perhaps) are necessary to ensure long-term follow-up for these patients?

Understanding this capacity begins with taking an environmental scan of staff and care team member communication surrounding SDoH, and what knowledge exists on referral channels/resources available. This initial scan could be accomplished through simple methods like team efficacy surveys or interviews. Questions targeting provider efficacy and comfort in communicating with unique patient concerns is a critical first step in unpacking this capacity. Second, understanding precisely how providers communicate surrounding SDoH is a critical piece of the puzzle. Exploring what happens in the room between a patient and their provider can be accomplished through tools like unannounced standardized patients (USPs), or secret shoppers. These secret shoppers visit a clinic and collect data on health systems practices from intake to discharge. An examination of how providers elicit, acknowledge, and respond to patient SDoH is essential and tools like these provide the system with valuable knowledge and feedback

on gaps in knowledge and areas for necessary improvement.[5]

Step 2: Design Training Programs to Address Gaps in Capacity

Following a scan of the clinical environment, training that targets all levels of the care team, including front desk, clerical, physician assistant, nurses, and physicians, on identifying, referring, and documenting these patients SDoH should be introduced. Long-term care for those with financial instability/housing insecurity extends beyond initial identification and referral. We've been able to move the needle in our own hospital system on rate of provider willingness to engage with and provide resources to patients with underlying SDoH by as much as 21% through routine feedback and education.[5] Even with feedback, though, providers oftentimes struggle to know referral options available and fail to document these issues for follow-up. Training must focus on emphasizing both documentation for follow-up *and* utilization of established referral networks to ensure access to community services. Further, training that not only builds capacity and understanding, but increases *willingness* to engage with unique patient populations is essential. Preparing our clinical systems to handle these patients in the future begins with assessing and educating and concludes with patients accessing a social service as part of their long-term, integrated care plan.

The rapid spread of COVID-19 has implications for everyone, but those who are impacted most directly by financial, housing, employment and food insecurity will face longest ramifications in terms of healthcare access, follow-up, and decreased livelihood. These communities, while already impacted by a burden of being much more susceptible to rapid community spread now face long-term issues with finances and care access. Ensuring that teams are able to effectively communicate with patients about SDoH and refer

them to appropriate resources will prepare hospitals for the aftermath of the pandemic. Increasing the entire healthcare team's capacity to address SDoH will be essential for the recovery and future health of our communities.

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CARING FOR VULNERABLE POPULATIONS DURING THE COVID-19 PANDEMIC

SreyRam Kuy, MD; Raymond Tsai, MD; Tracey L. Henry, MD; and Ricardo Correa, MD, on behalf of Presidential Leadership Scholars & Aspen Institute Health Innovators group

Dr. Kuy (SreyRam.Kuy@va.gov) is an assistant professor of surgery at Baylor College of Medicine. Dr. Tsai (Raymond.c.tsai@gmail.com) is an assistant professor of family medicine at the University of California, San Francisco. Dr. Henry (traceylhenry@gmail.com) is an assistant professor of medicine at Emory University School of Medicine. Dr. Correa (ricardocorrea@arizona.edu) is the endocrine program director and director for diversity on Graduate Medical Education at The University of Arizona College of Medicine-Phoenix.

Introduction

Throughout the COVID-19 pandemic, the nation's healthcare systems have sprinted to develop interventions to improve the safety of our patients, frontline workers, and communities. Lessons learned from prior public health outbreaks and crises have demonstrated that the most vulnerable patients are at higher risk of presenting with more severe illness. We compiled expertise from a group of physician leaders who have worked on various projects to improve health disparities nationally and participated in the Aspen Institute's Global Leadership Network or the Presidential Leadership Scholars Program to provide diverse perspectives from current frontline medical staff. Our goal is to distill simple, yet impactful, actions clinicians can take to protect their most vulnerable patients.

Adults as a Vulnerable Population

Vulnerable populations include racial or ethnic minorities, elderly, immigrants or refugees, socioeconomically disadvantaged, people with disabilities, underinsured, those living in rural places, the incarcerated, LGBTQ+ individuals, and those with certain chronic conditions. These populations often face greater complications from stigmatization, affecting their physical, mental, emotional, and social health. In addition, vulnerable populations may have further barriers to participate in our healthcare system due to low literacy, language and cultural barriers, mobility challenges, and fear of seeking treatment due to immigration policies (i.e., Public Charge).

Among vulnerable populations, COVID-19 in the United States has been noted to disproportionately affect racial and ethnic minorities in many communities, but data on this issue is still missing universally. In Illinois and North Carolina, where statistics on COVID-19 include race, a disproportionate number of African Americans were infected. This data is mirrored in other communities such as Milwaukee County and Chicago, where 45-50% of cases and 70% of deaths occurred in African Americans. Although the reasons are multifaceted, one contributing factor is likely the higher rate of co-morbid chronic conditions amongst African Americans due to inequities that have caused health disparities to compound over generations. These co-morbid chronic conditions put patients at a higher risk of mortality from COVID-19.

During this pandemic, vulnerable patients who often require frequent healthcare system interactions may not be able to do so. While adhering to the guidelines of staying home, some patients present to the Emergency Departments (ED) later than they should, sicker and requiring higher levels of care. As clinicians, we *must* proactively find ways of outreach to vulnerable populations, many whom also lack reliable communication means, such as cell phones, landlines or the Internet, and often heavily rely on the ability to show up to clinic or the EDs for immediate care or to schedule visits.

Although virtual visits have already been utilized broadly throughout the healthcare system, some other interventions could assist vulnerable patients including advertising existing programs that provide internet services at reduced rates or free government phones (i.e., SafeLink wireless and Amerimex Mobile, which is designed specifically for Hispanics). Additionally, the re-implementation of house calls is an effective modality to ensure safe and timely patient care for our most vulnerable. Implementing a fully functioning Mobile Integrated Health unit consisting of a multidisciplinary group has proved most prudent. This team is fully equipped to triage, take vitals, examine the patient, do point-of-care testing, draw additional labs, start intravenous (IV) fluids, give IV diuretics or antibiotics, refill prescriptions, and check wounds. This team treats patients at their point of need, mitigating exposure to COVID-19 from in-person visits to clinics and hospitals, and reducing admission and readmission for common chronic medical conditions.

Children as a Vulnerable Population

Relatively, the pediatric population has been less impacted by COVID-19 and with lesser severity. A study of pediatric COVID-19 patients in China revealed that 5.9% of

pediatric cases were critical compared to 18.5% of adult cases. However, younger infants were more susceptible to more severe illness with 10.6% of infants younger than one year old being critical, compared to 7.3% of ages 1-5, 4.2% of ages 6-10, and 4.1% of ages 11-15.[1] In a study of U.S. cases, among those 19 years old or younger, between 1.6 and 2.5% were hospitalized versus 14.3-70.3% of those in other age categories with increasing age related to increasing hospitalizations and mortality.[2]

Clinically, children present in similar fashion as adults with complaints of fever, cough, and respiratory distress. It is important to note that co-infections with other respiratory pathogens, such as influenza and respiratory syncytial virus, have been described in the pediatric population.

Special consideration should also be made for women and children who are at higher risk for domestic violence and child abuse during a disaster. Outpatient clinics should consider sending a communication via e-mail and text to all active patients with domestic violence hotlines and resources. Additionally, children living in already financially stressed environments are particularly at risk for adverse childhood experiences. Every effort should be made to continue outreach to children.

Other special pediatric considerations include education and caregiver concerns. With stay-at-home orders for children, working parents are expected to ensure appropriate educational opportunities for their children. Quality educational and social experiences are not guaranteed, and there is a need for high-quality instructional materials delivered to homes or available online. In addition, these families may rely on other family members, particularly grandparents, who are themselves a vulnerable population, for childcare.

Rural Populations
Much of the attention of COVID-19 has been on metropolitan areas where population density has con-tributed to rapid spread of disease, however rural areas have also been affected. In the earlier part of this pandemic, according to national statistics on April 5, 2020, there were 13,591 cases and 382 deaths attributed to non-metropolitan counties in the United States, figures that represented 3.9% of cases and 3.6% of deaths nationally.[3] However, now rural counties, which have only 14% of the US population, account for 17.3% of new COVID-19 cases and 18.9% of COVID-19 related deaths, as of August 29. Rural communities now account for a disproportionate percentage of new cases and deaths.[4]

Forty-six million people live in rural communities in the United States. Even before COVID-19, people living in rural areas had higher risk of death than urban areas due to higher rates of obesity, high blood pressure, smoking, opioid overdoses, and motor vehicle accidents. Also, more uninsured and older adults live in rural areas.

During COVID-19, rural communities face new challenges while their health systems are struggling with finances and capacity; 117 rural hospitals have already closed since 2010. With hospital volumes down significantly and non-emergent procedures cancelled, the financial hit to certain systems could be nine figures in 90 days, raising concern of additional hospital closures. Rural hospitals also have limited capacity and are often at the end of supply chains, further exacerbating challenges in acquiring needed protection personal equipment (PPE) and other equipment. Out of 2,000 rural hospitals, 65% (1,300) have fewer than 25 beds and 32.5% (650) have one ventilator on site. Rural hospital systems are not optimized for additional capacity and are instead made to be efficient, leading to concerns about a potential COVID-19 surge.[5]

Despite the financial and capacity challenges, rural hospitals and providers are working to preserve healthcare through command centers with COVID-19 screening, cancelling elective surgeries to conserve PPE, telemedicine expansion where broadband allows and transfer agreements with larger hospitals that can handle acutely sick COVID-19 patients.

Conclusion
The COVID-19 pandemic has unveiled the uncomfortable truth about the existing socioeconomic inequities of our society. It has exposed the festering and often neglected problems facing our vulnerable population that are rooted in systemic racism. Given the indiscriminate transmission of COVID-19 and the interconnectedness of our society, it benefits our society to advance health equity among vulnerable populations and thereby protect the public welfare. Given the fact that health disparities are disproportionately killing black and brown daily, our nation must prioritize and be positioned to protect the health of vulnerable populations. Healthcare professionals, policymakers, and stakeholders must have the will and fortitude to confront and solve the socioeconomic challenges to protect vulnerable population from future insults.

Presidential Leadership Scholars & Aspen Institute Health Innovators group: Quyen Chu, Jay Bhatt, Pritesh Gandhi, Rohit Gupta, Reshma Gupta, Michael K. Hole, Benson Hsu, Lauren Hughes, Lenore Jarvis, Sunny Jha, Mansi Kotwal, Joseph Sakran, Sameer Vohra.

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Overall, this points to differential improvement in chronic disease control for patients of varying racial groups despite being managed by the same physician group.

Several factors may contribute to variability in chronic disease control among resident and faculty clinics: Variability in skills, disruption in continuity, complexity of residency continuity schedules, and resident patient-panel characteristics (containing higher proportion of underserved and complex patients) may contribute to the difference in care quality.[1] Weppner, et al,[4] further emphasize the role of continuity in care delivery as it relates to interpretation of value-based metrics. This is of particular concern as resident physicians are more likely than staff physicians to care for minority and publicly funded patients.[2]

The Role of Health Systems in Pursuit of Equitable Care

Our work suggests that disparities in chronic disease control persist and may be more pronounced in resident physician clinics. These inequities have complex origins and perpetuating factors. Previously published literature has suggested that implicit bias, therapeutic inertia, and unseen social and economic barriers all play a role. With this in mind, we must also recognize the role of systemic racism.

Like many clinics across the country, our faculty clinic was designed to promote financial sustainability through preferential selection of insured patients. An unintended consequence is the creation of resident ambulatory clinics as the primary resource for the medically complicated, underinsured, and socially vulnerable patients. The contrast in patient population seen in our clinic, in comparison to milder differences seen by Essien's group, may be further exacerbated by lack of uniform Medicaid service coverage or expansion in our state. Reimbursement considerations will likely continue to impact the partitioning of patient populations among faculty and resident clinics.

Consequences of our current healthcare structure expand also to future generations of patients. The higher density of medical and social challenges in the resident clinic population may lead to higher levels of primary care burnout, deter residents from choosing primary care, and further compound the issue of primary care workforce shortage.[5] Additionally, continued failure to meet quality metrics or disease control can lead to decreased attention and discouragement in treating chronic conditions, threatening the quality of care that already-vulnerable patients receive. Our current healthcare structure jeopardizes health equity not only through direct impact on patients but also through downstream consequences on our trainee and primary care workforce.

Risk of Perpetuation of Healthcare Disparities and Call to Action

We must pay attention to these alarming trends and appreciate the role that health policy has played in creating and perpetuating these disparities in our internal medicine residency clinics. As the U.S. healthcare system evolves, incentives for high value care may mitigate some of the effects of a fee-for-service arrangement. Together, we must address these systemic influences and fight for our patients and our future primary care workforce.

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ing "I feel fine." or the glistening of his eyes when he shares "The pain is still manageable." Having video may help to some degree, but still, touch is lost.

Direct eye contact is non-existent during a telephone visit and seemingly inconsequential when viewed as an image projected from my camera onto their smart phone. I can't look directly into the eyes of my 22-year-old patient and tell her that the graduation party she is planning is risky. I can't reach out to hold the hand of my middle-aged patient whose mother is sequestered in a local nursing home nor can I hold the husband who just lost his

> Lost Touch relates a clinician educator's reflections on how the absence of touch might impact our patient connections. By E.Sottile of @UFMedicineJax @ufjaxim

wife to the breast cancer she had been battling for the last six years.

Now, when we interact with patients directly, we are buffered by layers of barriers. I had one such face-to-face office visit last week. We both commented on how unnatural it felt. She in her mask and I in my mask and face shield. We did manage a laugh when my shield fogged over and I had as much trouble hearing as she often does; yet, this was a woman I had been treating for years. The barrier between me and my patient are miniscule compared to the emotional and physical obstacles between a hospital patient and staff who have never met, or for any new patient in the office. We stay at least six feet apart, the physician asking questions, moving closer only long enough to perform the minimally required physical examination. Masks, gloves, and gowns serve as a wall, blanketing out emotions.

I have colleagues who trained with me during the HIV epidemic who still wear gloves even for

contact with healthy patients; I also have many recent trainees who did the same even prior to the pandemic. How many practitioners will routinely don varying forms of PPE in the future? How many patients will expect it? Will we be able to maintain our skills as healers of both mind and spirit with these additional barriers between us?

In order to maintain connections with our patients despite this sensory deprivation created by a lack of touch, we must hone our verbal communication skills. Physicians will need to improve their active listening skills. When questioning the patient via a tablet in a different room, or through a camera at our desks, it will become more important for us to use summary to confirm we caught the patient's *thoughts*. We will need to watch the patient with intention as they speak and avoid the temptation to scan email or texts, so that we can ascertain the patient's *emotions*. Once our patient's feelings are revealed, the words we use to convey empathy will likely need to change. Some may find it simplest to say, "I wish I could show you my support," or "I wish I could hold your hand." Others might spell it out, "It must be terribly hard to go through what you are going through during this pandemic. Some find it hard to show you encouragement without an embrace or a handshake. Please know that I am here for you." Those who relied on the power of touch will now need to articulate their support.

How will the impact of lost touch affect students' and trainees' ability to be servant physicians? Students have already been impacted as their clinical rotations abruptly halted, after administrators removed them from harm's way. Many had been relegated to reading about patients, having small group discussions about diagnoses and diseases. They missed the opportunity to feel a pulse with their unsheathed fingertips or

the warmth of an elderly woman's hand as they squeezed it to provide comfort. Those students missed out on sitting close to their patients to listen to the stories that make each patient a unique individual, and not just a list of problems. As of July, many students resumed their clinical duties. How did they approach their face-to-face encounters with patients? I worry that even once the fear of contagion lessens, learners will hesitate to offer a hand in greeting, and will spend less time at their patient's side listening to their unique personal anecdotes. Some students and even trainees may look for specialties that don't require much direct patient contact. In addition to their own experiences providing direct patient care being affected, these learners have less exposure to the very activities that make some specialties so impactful. Due to distancing, they may not be there to witness the oncologist's careful discussion of treatment options, or they miss the surgeon giving the news of a successful cancer resection. We may see a decrease in the number of trainees seeking specialties in which such impactful communications may be the norm.

My concern is not only for Internal Medicine, or primary care, but also for all medical professionals. How will the loss of touch impact any physician's ability to escape burnout? While physical touch is not the only means clinicians use to convey compassion, it is an important method many use to build rapport with their patients. Yet, we can rally, and remind ourselves and our learners of the increased importance of listening to and empathizing with patients. Seasoned clinicians and learners alike, can still develop meaningful bonds with their patients, even in the face of a pandemic. In so doing, we can maintain our patient centered care, reduce the danger of physician burnout and mitigate the effects of lost touch.

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SGIM FORUM RACISM AND MEDICINE ESSAY COLLECTION: PART II

Dr. Sgro (Gaetan.Sgro@va.gov) is an academic hospitalist and clinical assistant professor of medicine, VA Pittsburgh Healthcare System and University of Pittsburgh School of Medicine. Dr. Leung is editor in chief of SGIM Forum.

In a recent issue of SGIM *Forum*, we presented the first five in a series of previously published *Forum* articles related to systemic racism and medicine. This month, we are featuring five more voices from SGIM who have called for the dismantling of systemic racism in American society and medicine.

"Race, Gender, and Quality of Healthcare"[1]
November 1999 | Giselle Corbie-Smith
True cultural competency requires a paradigm shift from a biomedical focus to a patient focus, one that elicits and incorporates each individual's experiences and values into the diagnostic and therapeutic plan.

"No Patient Left Behind: Ensuring Health Care Equity in Health IT"[2]
March 2012 | Mita Goel and Urmimala Sarkar
The "digital divide," or lack of access to technology, is known to exist at the level of health systems and among our patients, as low-income and racial/ethnic minority populations continue to lag behind in Internet access. Studies describing disparities in the uptake of portal technology suggest that providing universal access to high-speed Internet would not be sufficient to address current disparities.

"The Minorities in Medicine Interest Group: Helping to Promote and Sustain the Diversity of Academic Internists"[3]
December 2014 | Jessie Kimbrough Marshall and Marshall Fleurant
The Minorities in Medicine Interest Group was formed to address the challenges that minority faculty commonly encounter in academic medicine. Studies have shown that some underrepresented minority faculty perceive their respective institutions as having little commitment to sustaining diversity.

"The Cutting Edge for Achieving Health Equity"[4]
April 2016 | Marshall H. Chin
The health disparities field has moved beyond purely documenting disparities and explaining their causes. We are now immersed in the solutions phase.

"Mitigating Bias and Discrimination from Healthcare Leadership"[5]
November 2019 | Quaratulain Syed, Nicole Redmond, Jada Bussey-Jones, Eboni Price-Haywood, and Inginia Genao
African American, Hispanic/Latinx, and women physicians are under-represented at senior ranks levels in nearly all specialties and in leadership positions. Additionally, a pay gap exists across gender and race in U.S. health care as women and African-American physicians report lower incomes compared to peers.

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