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The legal Role in Building Sustainable Public Health Systems- Keynote

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Tennessee Healthcare Hall of Fame 2019 Inductee

THE LEGAL ROLE IN BUILDING SUSTAINABLE PUBLIC HEALTH SYSTEMS

KEYNOTE SPEAKER:
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[edited for reading]

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Lauren Caverly-Pratt: Without further ado, it is my pleasure to introduce Dr. Mary Bufwack. Dr. Bufwack was a 2019 inductee into the Tennessee Health Care Hall of Fame. She served as a CEO of Neighborhood Health, formerly United Neighborhood Health Services, for 29 years. Her work has widely been recognized as having a positive impact on communities whose populations sometimes tend to fall through the cracks of traditional health systems. She earned her PhD in Anthropology from Washington University in St. Louis, and taught Sociology and Anthropology at Colgate University for seven years. Dr. Bufwack has also served on the board of directors and the president of the Tennessee Primary Care Association, as the director of the National Association of Community Health Centers, and as the chair of health care for the Homeless Committee. We are so excited to have her here with us at Belmont today. And so, with that, I'm going to have our symposium director, Grace Benitone who's behind the scenes, have her take control of the slides. And Dr. Bufwack, the floor is yours.

Dr. Mary Bufwack: Thank you so much, Lauren. And I want to welcome everybody today. And thank you so much for your interest in the safety net and in the underserved. When we have this kind of interest, we know that there's going to be some changes coming. Thank you to Deborah and all her crew for setting up this very timely topic for us to discuss today.

I am going to talk about the health care safety net. Which, as I will describe it, is neither safe nor secure at this time. And we're going to look at some legal issues that have an impact on the ability to sustain that safety net. Next slide please. So, first we're going to talk about what really is the safety net, so we're all kind of operating on the same page. Oftentimes the safety net is thought of as the last resort. It's failsafe. It's basic and minimal. But in reality, our definition of what's basic health care, minimum health care, changes. And that’s as it should be. The health care safety net is at best a patchwork. It's generally not really coordinated and oftentimes doesn't even do planning together. But it's usually defined as institutions, who generally have a mandate that relates to the public funding they receive, to actually serve the vulnerable populations. They usually also have a sustainable part of the patient mix that are vulnerable patients, a substantial part. That often includes public health departments, public hospitals, teaching medical centers, community health centers, and other faith-based groups. So you can see quite an autonomous patchwork.

We can also define the safety net by the vulnerable population served. And those populations vary with time and, again, are responsive to the needs of the community, and generally defined as uninsured and low income. But they also target many special populations: minorities, immigrants and refugees, migratory workers, LGBT, homeless, drug users, elderly… all those people who might be marginal, who might have insurance that is perhaps underinsured, marginal, or not accepted in the system, or they lack access to care for a variety of reasons on the frontier, they're rural. And, again, this definition changes based on changes in community needs.

Why talk about sustainability of the safety net now? There is a continuing number of folks… 9.2% of the population… higher in Tennessee… we're always generally higher of 12.1%, but over 600,000 people. Frighteningly, uninsured children have doubled over the last two years. Some of this is due to the problems of Medicaid disenrollment. Other parts of it are due to fear of the use of the system, and we'll talk about that. There's been a growth in the ranks of publicly funded insurance; Medicaid and Medicare now account for one in three Americans. And there are growing public resources used for insurance: the ACA and Medicaid expansion in those states fortunate enough to be serving their uninsured with that option. It's certainly led to a rising demand on the safety net, and this has put pressure on an already stressed-out system. And last, but not least, we have to talk about COVID's devastating impact on the poor and the uninsured, which has really shown many of the weaknesses in the safety net.

I'm going to digress a moment and talk about the COVID impact. Next slide. We know that there have been great racial and ethnic disparities among the many other impacts of COVID-19. Black, Hispanic, and Asian people have had substantially higher rates of infection, hospitalization, and death, in some cases more than double compared to Whites. This is because, obviously, for the lower economic status, crowded living conditions, certainly higher exposure to work… they didn't have the luxury of virtual work… they're oftentimes are essential workers… a higher number of chronic medical conditions… so the past is catching up with us… poor access to health care, is often limited English proficiency or health literacy. And many in these groups have a great distrust and fear, often justifiably, of the major health system.

If we look at COVID's toll… this is a map of Davidson County, and you can see the lower part of the map is Antioch. A

great number of Hispanic immigrants, refugees live in this area. The city core is the multi-population there, but it includes the homeless, public housing like J.C. Napier/Sudekum , and then some of the hotspots grade up into Madison area, kind of that northeast area, and that also is a growing area of low-income housing and ethnic groups. So, I want to make sure we emphasize that we still have people… 50 plus people dying a day in Tennessee. So, while we celebrate a lot of the fall in the rates of Omicron right now, we're still seeing a meaningful death rate that should be of concern to us all.

All of this, the importance of the safety net, COVID impact… we now have an unprecedented opportunity. Our eyes have been opened to address safety net adequacy and these disparities. It will take the clinicians, health systems, scientists, policymakers… and I want to point out, you. Wherever you are, I know you can do something to have an impact on this system.

What I want to focus on today… those community health centers, and that's going to be the safety net for our discussion, not just because I worked in a community health center for 29 years and continue to be affiliated with Neighborhood Health in some ways, but also because they're the critical primary care safety net provider. And I want to distinguish primary care from health department, hospitals, and specialties in many ways. Primary care is really your family doctor. Community health centers really are located in underserved areas. One, to assure the equity, but also to assure ease of access. And as the family doctor, the assumption is that these patients will be in continuous relationship with the community health center. The care at a health center is comprehensive. It includes preventive, chronic, integrated with behavioral health and dental, and serves many public health functions as well… doing family planning, STD testing, immunizations… so it really tries to cover many bases. It coordinates care with specialty and hospital, and, therefore, is looked to also to help cut the system cost so that we don't have unnecessary utilization of hospitals and emergency rooms. There's also a quality component in the goal of community health centers. It's not just to meet the needs of that visit, but to actually improve outcomes. So the point of continuous care is very central to the concept of this particular part of the safety net and should be very important to us as well.

Now, for those of you who don't know a lot about community health centers, and oftentimes you don't, just a little brief history. They were created over 50 years ago under LBJ. Hopefully some of you out there still remember LBJ and his War on Poverty… didn't win it, but we made some inroads. It was simultaneous with

Medicaid and Medicare with the idea of increasing access. But the CHC role was really to go directly to the communities and directly to the people, unlike the insurance models. Community boards composed 51% of consumers and they received funding, actually, directly from the government. I'm going to pick up my papers here. So these consumer boards received money from the federal government, so it didn't go through, unlike many other funding streams, it did not go through the state government or local government. Many of those reasons were because of what was happening in the South at this time. Oftentimes funds were diverted from African American communities and, as part of our systematic racial discrimination structure within the states, that funding wasn't getting where it needed to be. So, in this program, the federal government decided to actually directly fund consumer boards, and that continues to this day as part of the regulation. The community health centers are 51% consumers on their board… were limited to only about 25% who can actually make their living in the health care industry. The point is for community health centers not to be run by the health care system, but to be run by community consumers. So, the role of the CHC was actually supposed to fade with universal health coverage. Well, we know where universal health coverage is today, not… and so has continued to grow. Community health centers now number over 1,400, with over 14,000 clinics that serve over 30 million people annually. These are autonomous nonprofits that create a network across the US, held together loosely by funding streams and key requirements.

Before we move on to health issues within community health centers and among the medically underserved, I want to give a shout out to medical legal partnerships in primary care and many pro bono clinics, as well. These are really invaluable. Health outcomes can be influenced by laws, but they also can be influenced by the inconsistent enforcement or under enforcement of laws. And what both these programs do is embed civil legal expertise in the care team, oftentimes addressing what we call the social determinants of health. And what we find is up to 50 to 85% of patients in this low-income underserved bracket can oftentimes utilize these kinds of legal services. So, they address questions like substandard housing, denial of government supports, family violence, immigration status, and later today I think one of our presenters will be talking about food insecurity. That also is one of these social determinants of health that the legal profession has taken on as an important question to address. And we're extremely grateful for these much more personalistic, but important services, provided by many attorneys.

The impact of this legal system on community health centers and the underserved… I'm going to address basically five areas today. And when I talk about laws shorthand, I'm talking for everything broadly defined like statutes, regulations, executive orders, court decisions. These can be a barrier to care, but they also can be remediation. They can hinder access or help it. And we're going to talk about how they both hinder and help the underserved. So, we're going to look at policies to improve access and focus on the availability, particularly the supply of primary care clinicians, accessibility… bringing outpatient clinics into communities, alleviating structural barriers to care, removing financial burdens… and I'm not going to talk about financial burdens on the system because if we were to talk about the financing of public health and community health centers, we would be here all day. We're going to talk about it for the clients themselves. And we're going to talk about ensuring communication and trust, a very important element in this system.

I want to begin by talking about the supply of primary care clinicians. It's not enough to address just this underlying issue of funding. Much as we would like more of our citizens to be covered by Medicaid, we could get as much Medicaid out there as we could and still, if we didn't have the supply of primary care clinicians, we would have a clogged-up system. So, this is a very important issue of if we're going to have enough primary care clinicians going forward. We know now that medical school graduates are choosing primary care in declining numbers and sharply declining numbers. And that's primarily for two reasons, both very understandable. There's a significant gap in income and potential earning power between specialists and primary care, at least double and generally many times more. And many medical school graduates… most leave school with just an incredible debt burden. It's projected that in 10 years we'll actually have a shortfall from 20 to 50,000 primary care clinicians. So, it's really important that we look at ways to improve the flow of primary care clinicians.

We find two basic ways that work. One is to actually embed primary care residencies in underserved areas. And what we find is those trained in underserved areas are more likely to stay in underserved areas and serve the underserved. There are state efforts to do this. Texas, Georgia, and New Jersey have all had programs that do this very well. We wouldn't necessarily expect these in Texas and Georgia, but they've done a great job of putting the residencies right in the underserved areas. There are also many federal efforts to put medical residencies in community health centers. The other way we've found to get primary care physicians into underserved

areas is actually to diversify the physician workforce. Racial and ethnic minority physicians are more likely to practice in underserved areas, and they're more likely to do this in professional shortage areas. So, one way that there have been efforts to try to increase diversity in health professions is through school administration processes. That is admissions have changed their ways of admitting students so that they admit more diverse racial and ethnic minorities. There's very little evidence that this has worked. To the degree that those minorities have been admitted to many of these programs, they have, like those students in that program, continue to choose specialties. There are also pipeline programs that recruit students into the profession sort of downstream working with high school students, college students, to make these choices. And the University of Illinois has a particularly good program. But none do it quite as well as historically black colleges. Colleges… we have a gem in Meharry in our own community, where they have done just to superb job of recruiting minority providers and also exposing them to underserved populations and maintaining them in underserved populations. I also want to point to the Quillen College of Medicine in East Tennessee, which has a very long and respected tradition of doing this in rural areas. Their rural health program is one of the top ten in the country and also, again, really puts those residents into underserved areas, and those residents tend to want to serve in underserved areas. And also, people who live in rural areas tend to want to go to Quillen so they can stay in rural areas. So that's been just a very important resource for rural areas to draw on.

Other ways that this has been done is to use federal funds to bring primary care physicians to underserved areas. National Health Service Corp. is the stellar program that has done this. When I was with the community health center, I almost always had two to three providers who at any time were receiving loan repayment. Two years of service and they were able to pay off many of their loans. Four years of service and they could generally pay them all off. It's been very effective at keeping physicians in underserved areas and after two years after obligation, 85% are still serving. And after 10 years, over 50% are still serving. So, it's been one of the most effective programs. But currently with the funding available, only about 50% of applicants are actually funded. So, there's more potential there if we had more money upfront to actually do this program.

Another way to increase the supply of primary care clinicians has been the Conrad 30 Program, which is an incentive for foreign-trained clinicians. What we do find about foreign-trained clinicians is they also do tend to practice in underserved areas, and

they tend to remain in underserved areas. So, this has been a very important program because it avoids the J-1 visa issue of having to return to your home country, and the State Department of Health is actually allowed to grant 30 of these waivers a year to help effectively recruit foreign-trained physicians. If you look at the Tennessee state regulations, this program has been found to be very effective in urban areas. Tennessee actually only allows this Conrad 30 Program to be utilized in rural areas. That is because, as I was told on the QT, they don't want the competition in the urban areas where there's plenty of competition. Now I haven't seen competition in the urban areas to serve the underserved, but that's the state logic for keeping foreign-trained physicians using this special program from serving in the urban areas. These are one of the kind of areas where administrative law can certainly be changed to better open this up to other opportunities.

It does not really appear that these new and expanded residencies and these federal efforts are strong enough, big enough, there's enough effort in them, enough of them, to actually counter the market incentives. And so we do… it's important to keep all of those, but we do continue to actually experience this primary care provider shortage. One of the most controversial areas that has been attempted that I want to talk about a bit here, and states have used it, is the scope of practice. Now, as many of you know, these are the laws that detail the services that are allowed to be provided by health professionals. And of most concern here to us are nurse practitioners and physician assistants. Many states… and again scope of practice is very much controlled by the state, even though a nurse practitioner passes a national set of qualifying exams. Nonetheless, just as with licensing, the actual scope of practice is drawn up by the state. The legislature is heavily involved with this, as well as the nursing board and the medical board. So, these tend to vary by state and generally vary in terms of M.D. oversight. What has been found is that a scope that moves towards allowing practice of nurse practitioners to the full extent of their training and licensure has been very important at increasing, not only the numbers of nurse practitioners practicing in a clinic in underserved areas, but has also been very important in expanding care to the underserved, particularly in rural areas. So, this has been a very promising effort that has really encouraged team-based models of nurse practitioners and physicians working together in patient-centered medical homes. And later today, one of the presenters is going to talk more about team-based care.

But here in Tennessee, as many as you know, scope of practice has really generated some real heat down at the legislature with the nursing association and physicians really butting heads over

the last few years about changing the nurse practitioner scope of practice. The nurses' association would like to move towards much greater autonomy in terms of practice. The physician associations generally are not in support of this. And there was even kind of a truce for a couple of years when legislation along these lines wasn't introduced because of the amount of contention around this issue. Currently though, I will say that the legislature is starting to move in these areas. Community health centers, themselves, have a piece of legislation up at this time along these lines. Right now, the scope of practice in Tennessee requires that physicians sign off on 20% of a nurse practitioner charts, so nurse practitioners are paired up with a physician. That physician reviews at least 20% of their charts… generally the more complicated cases… cases with their controlled substances, things that might raise some bells or whistles, or where a physician can be of most use to a nurse practitioner in providing some consultation. That has become burdensome to the degree that it requires, up to now, oftentimes physical presence as well. Electronic health records were just a glint in someone's eye at the time many of these regulations were written. So, we have a piece of legislation at the legislature this year that is garnering a great deal of support that would allow the signing off on charts to be done electronically through the electronic health records. So, we can bring many of the statutes without actually changing the degree of autonomy, but changing the physical presence and making it, again, more attractive for physicians to work with nurse practitioners because of the ease of using electronic health records to review and sign off on charts. So, even within the context of maintaining a scope of practice that as it currently exists in Tennessee, which is quite conservative compared to many other states, changes are still necessary. And those are moving through the legislature, I'm happy to say, and hopefully will encourage more growth in the use of nurse practitioners by physicians to meet some of this uninsured need.

We're going to move on from primary care, and that contention, to accessibility. And that is bringing outpatient clinics into communities. 84 million people live in underserved areas and find it challenging to receive primary care. So, community health centers and rural health centers, which have been exceptionally effective at this, are actually embedded in underserved communities. Neighborhood Health, for instance, not only was downtown among the homeless with homeless health services, but here's a picture of Dr. Pete, who leads our street medicine team. And he's out there in encampments at least two to three times a week providing care directly to the homeless individuals who live in encampments. So, when we say embed in the community, we're talking about really embedding. Other places Neighborhood Health has worked is in

public housing, J.C. Napier/Sudekum. Also, a clinic was put up jointly in Casa Azafran to address the needs of immigrants and refugees. So again, embedded is… it really works. Oftentimes people have said: "Well why don't we bring retail clinics to underserved areas?" That's been tried and right now only about 10% of retail clinics are in underserved areas. Medicaid poses such a challenge. It's not an incentive to them to see the Medicaid recipients. And in many cases, we're not talking about urgent care. With the underserved need, it's not urgent care. What they need is an ongoing source of health care. So, bringing more clinics into these neighborhoods, more community health centers, is still very crucial.

Then there's the issue of alleviating structural barriers. There are structural barriers for the underserved who find it challenging to get primary care with long wait times for appointments. Transportation is one of the structural barriers that oftentimes needs to be addressed. Also, low-wage workers need hours outside of the 8:00 to 5:00, Monday through Friday, "bankers' hours" we used to call them. I'm not sure bankers even work eight to five. But they need those evening and Saturday hours.

Telehealth has become a very important way of delivering health care to challenged populations so that they have increasing access. And we've seen during COVID-19 that telehealth has been invaluable. It's helped us keep people safe. It's helped us keep people at home. And it's helped us address many issues that could not otherwise be addressed. But what we find is always with the underserved is that there are barriers and that it's very difficult, oftentimes, for the uninsured and the underserved to use telehealth. The populations that are low-economic status or limited English proficiency oftentimes have an absence of the technology, so they cannot utilize it. They oftentimes have limited digital literacy. I'm happy to say that our Nashville library system is doing a program now for the elderly in digital literacy, and it's specifically directed at getting the elderly so they can use telehealth, which is wonderful. And we also have unreliable Internet coverage in many areas, particularly rural areas, but also in many homes, making it very, very difficult for telehealth to be used and accessed.

There are also barriers for providers who serves the vulnerable to the use of telehealth. It's an investment in sophisticated and oftentimes expensive equipment. Funds that are oftentimes lacking or difficult to come by when you're serving the underserved. It oftentimes requires face-to-face visits every, say, 12 months or 16 months. This also is being addressed at the legislature because, to

the degree that you need a face-to-face visit to actually get reimbursement for telehealth, it again will limit services. And state laws have been really slow to keep up with those practice demands, and also with practice capabilities of things like telehealth. The other problem we're having right now is the reimbursement for audio only. This has been allowed during the emergency because it was recognized that many people do not have access to technology. So, if we allowed audio only to be used and reimburse that, we could create a lot more access. Now that the emergency is kind of going away, and we're returning to our current version of normal, there are efforts both at the state and federal level to actually make audio only continually reimbursable. So that is going on right now at the Tennessee legislature where there are efforts to build audio only into reimbursement structures that will continue to allow the uninsured and the underserved access to audio only where they are lacking video telehealth. There was a national survey just completed, actually February 1st of this year, that found that there were significant disparities among subgroups in terms of audio versus video telehealth. What it was found was that video telehealth users tended to be young adults 18 to 24, those making over $100,000, those with private insurance, and white individuals. The audio telehealth users tended to be those without a high school diploma, adults over 65, Latinos, Asians, and Blacks. So, you can see the disparity right there. Unless audio only is reimbursable and is approved for utilization of telehealth, we are really again having another discriminatory system in which those who are least served may be excluded from one of the greatest benefits we have had during the pandemic. That is, to use both video and audio telehealth to deliver healthcare. Very important pieces of legislation that we are very confident of actually at the state level, but are somewhat uncertain of it at the federal level whether there was enough commitment at the federal level for audio only to really move that piece of legislation the way it needs to move. But we hope again that that changes a bit and that we do get those federal legal mandates as well.

Alleviating more structural barriers, we talked about transportation. Obviously, the reasons for that is a structural barrier… are the people often without cars. Oftentimes those 65 and older don't have rides. Reliance on public transportation, which oftentimes doesn't exist or exists very poorly, really doesn't allow that much access. Medicaid transportation has suffered many issues too. It requires advance notice, there are issues with children riding along, long waits. Increasingly, Medicaid has tried to leverage ridesharing, and that has shown some promise to be used as emergency transportation. But we have a long way to go to assure

people have access to the transportation they need to actually use health care in a timely way that they would like to use it. We've talked about increasing medical office hours, which are generally 8-5, 7-4, Monday through Friday. North Carolina actually tried incentivizing outside of regular office hours care and found that they actually were able to reduce Medicaid child ER visits through that means. So, we know there are effective ways that we can utilize after-hours care. And CHCs also have a mandate and it's part of their mission. Limited staffing oftentimes limits their hours. But again, places like Neighborhood Health… Neighborhood Health has a clinic in Madison that is open until nine o'clock every night and on Saturdays. And that has provided, really, a lot of service for folks who need it during after-hours and on Saturday. Much more of that really needs to be done. We can learn a lot from urgent clinics on that end of things.

Affordability. There's a problem that uninsured often lack of source of care. They don't have a regular source of care because they are uninsured. Health insurance and other public benefits can have a significant impact on that and insured people tend to more generally have a regular source of care. And where there isn't a regular source of care, we know there is improper use of ERs and hospitals, which could greatly be reduced. The next slide, which you'll see, not right now but in a minute, shows many of the enrollment barriers. Health care benefits are a maze and it's very difficult for the consumer themselves to actually enroll, or move themselves through the enrollment process, because the requirements are different, the poverty level is different. So, navigators are very important in helping people actual get enrolled. That's one area that needs to be addressed.

Cost is another area. We've found that even $1 to $5 can reduce utilization of preventive care and primary care because of such limited income. That is in the light of the fact that health insurance deductibles and co-pays are continuing to increase. So, to the extent that that increases, it actually works to prevent people from getting the preventive and primary care they need. There are even states who want Medicaid plans to incorporate co-pays. There couldn't be anything more destructive for a Medicaid plan than to actually put in co-pays, which can ill be afforded by those receiving Medicaid. 25% of insured said they have put off care due to a copay. The mandates for zero co-pay preventative screenings are limited in their effectiveness, as patients oftentimes don't know the difference between what's preventative care and primary care. So unless this is spelled out, you might go to the doctor and go, am I going to be paid-

billed the copay, or am I not going to have to pay a copay? I don't know.

Value-based insurance designs - I think there's a panel that's going to address this - have oftentimes worked to eliminate copays. Some ACA plans, some Medicare plans, some state employee plans, and these have shown increased visits among their enrollees and do help to reduce hospitalizations and ER visits. So there is, again, a lot to be learned from these value-based designs that the panel will talk about later. I hope along the same lines that there are some very positive things happening in regards to these value based insurance plans.

This is the chart, it shows, if you just look at the household income limits for these different programs. For instance, in Tennessee, pregnant individuals, even those who are undocumented, can receive TennCare or CoverKids. That's less than or equal to 250% of poverty. You go down, and TennCare for parents with minor children is below 106% of the poverty level. For disabled, 135%. For other uninsured adults with things like CoverRx it's under 138%. Project Access is under 200%, Marketplace plans are 100-400%. So you can see this is very confusing. And if you were a person going like, what benefits am I eligible for, you need a navigator to help you around all of this, for it's very, very difficult for an individual to coordinate these, and the inconsistency among plans makes it very user unfriendly. So it's no wonder many people do not have the benefits that they actually could qualify for, because they actually can't navigate this system.

Now I want to talk about this issue of acceptability, that is, ensuring communication and trust. This is a very nuanced area. It's an area that, well, what in the world do we mean, and how in the world do you go about doing that?

Well, many vulnerable patients, and most vulnerable patients that we serve, have experienced some kind of discrimination, disrespect… they feel that they carry stigmas because of their prior contact with the medical system. Many low-income people feel disrespected. People of color, immigrants, LGBT feel exposed, drug users don't often times feel they can trust their providers to share what their drug issues may be. So it is very important that that trust be there to really address the problems and the service needed by these groups.

There are some policy solutions that do affect cultural competency. There are few, but they are very important. The

increased diversity of primary care physicians certainly is one of them. When you see people in the healthcare environment that look like you, talk like you - that's a system that you can feel more comfortable in. Limited English proficiency policies that ensure that languages are available is key.

Neighborhood Health was one of the first Spanish speaking clinics in Davidson County. We began to try to do this as we saw, many of you remember way back when - it's been, gosh, so many years ago now - when some of the first migrants and immigrants who were brought into town were brought into a motel out on, I'm not sure if it was Murfreesboro Road or Nolensville Road, and men were put up in a motel out there and were working on Opryland construction. It was one of the first waves of workers coming into Nashville. After that, of course, it wasn't long before families started coming and various construction booms, and everything continued to bring in immigrants and refugees - Nashville's always been a refugee resettlement area. It's a great way of diversifying the population in Nashville. But it was very difficult for folks to receive any kind of care at all in their first language. Offering languages in medical settings has been a very important part of encouraging people to get more care in the system.

Then, just a patient centered orientation… These are some quotes from our homeless about Doctor Pete and patient centered care. "I mean, he actually comes out to the camp… he's always on point, and he's there for you." Another quote, "there's no judgment and he's always willing to help. He's willing to go down the path that's easiest for me. He's listening, he's a friend, he's not just a doctor. He's helped people stay alive out here."

It's not that Dr. Pete has to be homeless. It is that he has to listen. He has to share their world. So that patient-centeredness is very important as we look to building the trust and communication that we need to be able to best serve those who are uninsured.

Discrimination in the medical system really still exists. There is a recent study that looked at, for instance, medical record charts and looked at the pejorative words that were used to describe client behavior. Words like "noncompliant", words like "difficult", words like "noncooperative" and these tended to be used much more for African American clients than for white clients, showing again a very disproportionate interpretation of behavior, not finding out why you couldn't take your medicine, could you afford it, could you get to the pharmacy, were there reasons that you have a barrier to your medication. But instead describing the behavior as noncompliant or

even the nicer word, nonadherent. These are all pejorative terms and often times used to brand low-income people of color and other populations who really have those structural barriers or economical barriers that we talked about, and so don't make their appointments, so don't take their medications, so don't go to the specialists, and there are structural reasons often times that interfere in actually receiving those services. So, the more we can understand those, the more we can address them, the better we can serve this population, and the better relationships we'll have when things like the pandemic come along.

I'm going to look at two specific populations here to talk about this idea that acceptability and ensuring communication and trust. First is the homeless population who we have discussed a bit. Across the United States there is about 1.3 million people, and it is uncertain who exactly the count of adult homeless at any one time, who is sleeping in the outdoors, who is sleeping in shelters, who is sleeping in cars. All of these are really variables. All we know is that you just need to drive into downtown Nashville, you know that we have a homeless problem. The homeless crisis is an affordable housing crisis. We know this, we talk about this a lot, it's been very slow and difficult to address this.

For women, homelessness is often an issue of domestic violence. For incarcerated people, it's of course the release from jail and inability to support themselves in many ways because of the prejudice directed at prior incarcerated folks.

The tactics to manage homelessness are often more about ridding the communities of their visible presence, so criminalizing homelessness. So we see criminalizing public camping and removing public camps, as this is happening at Jefferson Street, happening in West Nashville… laws that prohibit people from living in vehicles, loitering, even handing out food, reducing public services such as restrooms and bathrooms which are purposely done to keep them invisible, and reluctance for them on their part therefore to access COVID-19 assistance and services because of the issue of autonomy versus restrictions. That is, you remember when the positives were held at the fairgrounds, and one "escaped" there was efforts to bring them back - we don't do that with adults who are COVID positive, but we do it with the homeless.

Lauren Caverly-Pratt: Dr. Bufwack, we've gone over a little bit of time, and I think that we have to - I'm so sorry to cut you off and interject in here, but I think we have to continue moving on with the remainder of our program today. Thank you so much for being here.

Dr. Mary Bufwack: Yeah, I hope folks will get these slides and look at the rest of the points made.

Lauren Caverly-Pratt: Yes, yes absolutely, we will be sure to send those out. Again, thank you so much for being here with us today.