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Urban Health: A Practical Application for Clinical Based Learning

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A Practical Application for Clinical Based Learning

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URBAN HEALTH:
A PRACTICAL APPLICATION FOR CLINICAL BASED LEARNING

CYNTHERA MCNEILL
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Foreword by LAURIE M. LAUZON CLABO

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Cynthera McNeill, Umeika Stephens and Tara Walker
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ABOUT THE BOOK

Drs. Cynthera McNeill, Umeika Stephens and Tara Walker

Urban populations demonstrate some of the world's most prominent health disparities and are key targets for health disparities research. The majority of the world's population lives in cities and urban development is expanding in all regions of the world. The creation of solutions to improve health and address health disparities in these complex, concentrated, and diverse urban environments is essential. It is well known that health disparities exist on both an individual and community level. People living in the same zip code can have a difference in life expectancy of more than 20 years due to factors such as economic stability, education preparation, employability, race and health care insurance access. Poor health outcomes for urban underserved patients related to these health disparities are well documented. The Health Resources and Services Administration (HRSA), Substance Abuse and Mental Health Services Administration (SAMHSA), and other organizations have spent billions of dollars supporting clinical practicum internships and incentivized employment opportunities across all health specialties with the hope of luring new providers into underserved areas to help improve poor health outcomes. While trainingships and employment opportunities provide clinical exposure to urban populations, these initiatives have not translated to a better understanding or improved health outcomes for the urban patient population. All healthcare specialties offer foundational graduate level courses that expose students to the concept of health disparities. Unfortunately, there exist fundamental gaps in comprehension and application of practical knowledge when preparing the student to actively engage urban patients. It is imperative that we train students to take a holistic approach to patient care, acknowledging that the patient is more than just their physical or mental illness. Urban providers need to recognize how social determinants of health, policy, perceptions, disparities, and lack of resources impact health outcomes of underserved populations. In acknowledging the lived experience of urban patients and how disparities impact their daily lives, we can begin to build more effective patient-provider relationships. This textbook aids in providing a platform for readers to have open discourse about urban health, healthcare disparities and interprofessional collaboration to achieve better patient outcomes.

The main goals of this textbook are:

- to explore how an individual's experiences, implicit biases, interpersonal skills and urban expectations impact healthcare delivery and patient engagement
- to develop a flipped consciousness that will engage and create awareness of the lived experience of urban patients and urban healthcare providers
- to explore how disparities impact personal health choices and health outcomes
- to explore available resources in the urban community and engage interprofessional collaborative practice to improve patient care
- to provide an educational tool that will be utilized by and adapted to all healthcare disciplines to provide a consistent approach to understanding urban health disparities in the United States

PEDAGOGY

This textbook goes beyond cursory evaluations of statistics related to disparities in underserved, urban environments and empowers the reader to actively engage in a deeper understanding of the impact of disparities on the lives of patients, moving the reader towards a more solution-driven, team-based care approach. This textbook can easily be utilized throughout the entire clinical/practicum program for the graduate student pursuing a health-related career and will serve as a much-needed toolkit as the student begins to merge theoretical concepts and practical application. A unique professional training guide and resource, this textbook seeks to challenge learners to evaluate their personal role in urban health delivery through a better understanding of the lived experience of the patient.

The intent of this textbook is to bring forward the perspective of urban communities, urban patients, and urban healthcare providers. The foundation of this textbook stems from the lived experience of patients and healthcare providers in the urban city of Detroit, Michigan. It is the hope of the authors that the content presented in this textbook and the themes identified will be relatable to urban communities like Detroit that have a high population of minority constituents and are disproportionately impacted by healthcare disparities. The perspective of this textbook speaks heavily to the lived experience of African Americans, as they make up greater than 82% of the population in Detroit; however, it is the authors' hope that the identified themes in this manuscript will initiate conversations and provide a platform to explore perspectives of other urban cities and minority groups with similar lived experiences.

The authors offer decades of knowledge, wisdom, and real-life experiences as both urban health providers and urban health educators. By compiling clinical practice, evidence-based knowledge and practical application of the science, the authors have created a space that allows the reader to expand their knowledge of urban health beyond the traditional urban health pedagogy. This textbook allows the instructor to assign additional readings, explore resources specific to their area of study or local demographic and expound on the learning activities to complement the themes identified in the chapters.

Each chapter begins with an introduction which highlights the main themes of the chapter followed by a list of learning objectives unique to that chapter. There are also learning exercises threaded throughout the chapters to reinforce learning and promote practical application of concepts.

KEY LEARNING FEATURES

Learning Activities are available in select chapters and include links to important resources with accompanying exercises to facilitate critical thinking and allow the reader to synthesize new knowledge. As opposed to restating or summarizing content, the learning activities include access to websites, manuscripts and videos that allow that reader to dive deeper into the content allowing for meaningful and practical application of knowledge.

Exemplars are found in Chapters 1, 2, 3 and 4. Exemplars highlight approaches that have been identified as best practice to improve the living conditions of urban residents. These exemplars allow the reader to explore strategies locally and internationally that have been employed to address disparities in urban communities. Reflection questions appear after the exemplar to give the reader a broader perspective of disparities in urban communities.

Case Studies are provided in Chapters 5, 6 and 7. Case studies allow the reader to explore the lived experiences of urban residents while conceptualizing how multiple factors contribute to poor health outcomes. Through the lived experience of urban patients, the reader receives an insight into the daily life and complex situational disparities that impact health. Open-ended questions are at the end of each case study to facilitate discussions about disparities and prompt the reader to identify practical solutions based on the available resources.

Each chapter ends with a number of **Exercises** (Learning activities, Exemplars and/or case studies) accompanied by thought provoking questions to give the reader an opportunity to review and apply their new urban health perspective. A **Bibliography** of material relevant to the chapter follows the learning exercises.

CHAPTER COMPOSITION

Chapter 1 lays the foundation for understanding rural, urban and inner city communities. The concept of urban health is explored, and the impact of the Urban Health penalty is discussed. The reader will explore the impact of philanthropic foundations within the urban communities and explore how philanthropic foundations assist in addressing health equity. The reader is also given the opportunity to explore a global perspective regarding urban health by examining urban communities around the world.

Chapter 2 highlights the role of the urban health provider and approaches the speciality of urban health as a unique subset to healthcare requiring special training considerations and a consistent educational tool to ensure all trainees have exposure to common themes present in urban health. Chapter 2 examines the current modalities in urban health training, including didactic and practicum preparation, and highlights the variations in urban health training which are dependent on the instructor's experience and knowledge of urban populations and the availability of practicum experiences in urban environment. The purpose of this chapter is to explore clinician preparation for urban health practice, taking a closer look at internal factors and external factors that impact readiness to practice in the urban environment.

Chapter 3 explores the five domains of social determinants of health (SDOH)—Education, Economics, Environment, Access to Care and Social Factors—in the context of disparities in urban communities. This chapter will also highlight specific healthcare barriers that are present in urban environments and the impact of barriers on health outcomes, and will provide insight into how healthcare providers can provide meaningful care taking into consideration the lived experience of the urban patient.

Chapter 4 provides a comprehensive discussion of the role of primary care in the current healthcare system and further dissects the impact of primary care in the urban community. The reader will examine how social determinants of health (SDOH) impact primary care and ways to navigate barriers for improved patient outcomes. This chapter explores the perspectives of both urban health providers and urban patients to address disparities in primary care and improve patient-provider communication.

Chapter 5 explores the impact of urban living and health disparities on mental health. The reader will understand the multifactorial impact of mental health in urban communities. This chapter explores the reciprocal relationship between mental health and physical comorbid conditions. This chapter will highlight the implicit factors that impact the mental health of urban residents and offer insights for clinicians to examine secondary causes of mental distress in these patients.

Chapter 6 focuses on urban consideration for hospitalized patients and highlights unique barriers in providing care to patients living in urban environments. The reader will understand the importance of interprofessional collaboration for addressing the needs of patients seeking care in the acute inpatient environment and develop strategies to mitigate barriers during the inpatient visit. This chapter will highlight the management considerations, factors that impact discharge, and gaps in continuity of care for patients living in urban environments.

Chapter 7 highlights the interconnectedness of disparities and insurmountable barriers in urban communities through the lens of the COVID 19 pandemic. Readers will have a better understanding of how the COVID pandemic compounded the poor health outcomes that plague urban communities and further exposed the 400-plus years of an oppressive system that has perpetuatually provided limited opportunities for individuals to live healthily in urban environments. In this chapter, we will discuss the emerging data surrounding the COVID pandemic and the impact this pandemic has had in the inner city

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Dr. Umeika Stephens is a dual-certified family and psychiatric nurse practitioner focused on the provision of holistic patient-centered mental health care. As a Detroit native she is acutely aware of healthcare needs in the community and the disparities impacting patients' access to culturally sensitive services. Dr. Stephens has worked as a nurse practitioner for over 25 years providing for psychopharmacologic management and supportive therapy. Her areas of expertise are integrated care, substance abuse, mental health issues secondary to chronic medical illness, caregiver role stress/ coping, and women's mental health issues. Dr. Stephens is also a clinical assistant professor at Wayne State University where she oversees the psychiatric nurse practitioner program.

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Dr. Tara Walker is an assistant clinical professor at Wayne State University College of Nursing and a board-certified acute care nurse practitioner in internal medicine at a local Detroit hospital. Dr. Walker holds a Doctor of Nursing Practice degree from Wayne State University. Dr. Walker's 24 years of nursing experience includes medical, surgical, emergency, administration, cardiology, and internal medicine. Her areas of expertise include reduction strategies in length of stay, improvement in throughput, nursing professional development, and nurse mentoring. Dr. Walker incorporates her administrative and clinical experience to combat barriers to implementing evidence-based practice in urban environments. Her foundational principle for every project starts with patient-centered, high-quality, cost-effective care. She belongs to the American Association of Nurse Practitioners, Michigan Council of Nurse Practitioners, and Sigma Theta Tau.

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Dr. Angela Allen is certified by the American Nurses Credentialing Center as a family nurse practitioner. She has practiced as a registered nurse in a level one trauma center for 22 years and later graduated with honors in 2014 from the University of Detroit Mercy with her Doctorate of Nursing Practice. She has worked for 11 years as a family nurse practitioner with a focus on the care of underserved and vulnerable populations in an urban setting.

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Katrina Belcher-Hobson has been a nurse practitioner for 17 years, and graduated with her Masters of Science in Nursing Practice from Wayne State University. She is pursuing her Doctorate of Nursing Practice at the University of Michigan with a matriculation date of August 2022.

She is also a member of Sigma Theta Tau Nursing Honor Society. As a nurse practitioner her experiences include sub-acute care, hospitalist medicine, primary care, and clinical services management of a nurse practitioner-lead community health program. Her career focus has been on chronic disease management, care of the community, and reducing healthcare disparities for underserved populations through health education, health promotion, and preventative services.

ANGELA BOWMAN, MSN, APRN, ANP-BC

Angela Bowman is a board-certified nurse practitioner who obtained her Bachelor of Nursing degree (BSN) in May 2004 and Master of Nursing degree (MSN) from Wayne State University in May 2012. Prior to transitioning into the role of nurse practitioner, Angela worked in Henry Ford Hospital's Neurosurgical ICU as a registered nurse for 9.5 years. During that time, Angela was promoted to assistant clinical manager and served in that role throughout her graduate studies at Wayne State University until completing and successfully passing the ANCC (American Nurse Credentialing Center) nurse practitioner certification boards. Currently, Angela has been working as a nocturnal hospitalist nurse practitioner for the past 9 years at DMC-Tenet Harper University Hospital in Detroit, Michigan. In addition to her current practice, Angela is pursuing her Doctorate of Nursing Practice (DNP) degree at the University of Michigan-Flint, with a potential matriculation date of Fall 2022; her future goal is to transition into academia as an instructor of nursing. Angela is a proud member of Sigma Theta Tau Nursing Honor Society and an active member of Chi Eta Phi, Lambda Chi Chapter, a professional nursing sorority.

LAURIE M. LAUZON CLABO, PHD, RN, FAAN

Dr. Laurie Lauzon Clabo was appointed the eighth dean of the College of Nursing at Wayne State University in April 2015. Dean Clabo has a strong background in academic leadership, including ten years of experience as a successful dean. From August 2020 until July 2021, she served as Wayne State University's interim provost and vice president for academic affairs. In addition to her role as dean, Dr. Clabo also serves as Wayne State University's inaugural chief health and wellness officer. In this role, Dean Clabo assumes primary focus for major health-related policies and services on campus, including policy development and implementation, campus health-related surveillance and planning, regulatory compliance, support for health-related research and education, response to health-related issues and crises, and efficient use of resources and the promotion of health and wellness.

Dean Clabo is recognized for her national leadership in innovation regarding education for advanced practice registered nurses (APRNs). From 2013 to 2015, Dr. Clabo served as the chair of the American Association of Colleges of Nursing (AACN) APRN Clinical Training Task Force. She led the Competency-Based Education for Doctorally-Prepared APRNs Work Group, a multi-stakeholder work group coordinated by AACN that produced the nation's first set of consensus-based competencies for doctorally-prepared APRNs. She has also chaired the Commission on Collegiate Nursing Education (CCNE) Standards Committee for Nurse Practitioner Residency Programs.

Dean Clabo received her baccalaureate degree in nursing from the University of Windsor, her master's in Nursing Administration from Dalhousie University in Halifax, Nova Scotia and her PhD in nursing from the University of Rhode Island.

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Dr. Gibson-Scipio is an associate professor (clinical) at Wayne State University. Both her research and clinical practice are directed towards improving the health and health care access of vulnerable populations that experience or are at risk for health disparities. In her research she has primarily focused on development of M-Health interventions for African American adolescents and young adults with asthma. She has been funded by the National Institutes of Health National Heart & Lung Institute among other foundations. She has practiced in primary care Federally Qualified Health Centers for over 20 years, providing care to persons at all stages of life. She also served as co-program director for the Michigan Area Health Education Center. In this role she worked with academic institutions across Michigan to increase the number of healthcare providers from diverse backgrounds.

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Raenita Glover is a clinical operation administrator working on research at the community level, including focus groups and evidence-based interventions for health disparities. She currently works with National Marrow Donor Program transplant centers in Michigan to help bring resources and workability to oncology/hematology research projects and other program initiatives. As a healthcare administrative professional with over 19 years of combined experience in project management, clinical operations, leadership and community outreach, she has been credited with the creation and sustainability of multiple clinical and community related initiatives in the Metropolitan Detroit area. She received her Master of Public Health (MPH) from Wayne State University with a concentration in Public Health Practice. Ms. Glover has worked closely with senior executives and providers in various healthcare organizations and academic institutions on value-based care initiatives including patient-centered medical home managed care models. As a native Detroiter, Raenita considers the experiences of people and examines multiple aspects of healthcare equity, from mistrust to communication of health priorities to underserved and underrepresented communities.

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Dr. Lauren Krist is a board-certified psychiatric mental health nurse practitioner with specialty experiences in emergency psychiatry, forensic nursing, substance abuse and intensive outpatient treatment and neurocritical care nursing. Dr. Krist earned her Bachelor's of Science in Nursing with a minor in Psychology, with honors, from the University of Detroit Mercy in 2011. Prior to earning her Doctor of Nursing Practice degree from Wayne State University in 2016, Dr. Krist obtained a graduate certificate in forensic nursing science through the University of Florida. She completed specialized training as a sexual assault nurse examiner (SANE) through Macomb County, Michigan and briefly worked as a SANE nurse through Wayne County, Michigan. Dr. Krist has continued to provide care to patients while teaching both undergraduate and graduate nursing courses at Wayne State University and the Detroit Medical Center. Dr. Krist is certified across the lifespan and treats all ages including children, adolescents, and adults with mood and anxiety disorders, PTSD, psychotic disorders, impulse and addictive disorders and ADHD.

ROSZETTA MCNEILL

Mrs. McNeill is the founder of Women and Youth Endeavors and has authored numerous books highlighting disparities in urban communities. She has spent her career working with pre and post adjudicated urban youth, is an advocate for fair and equal treatment, and has her finger on the pulse of the urban community. Her commitment to improving the conditions of urban communities and addressing disparities can be seen through her leadership and service to the Detroit community. Mrs. McNeill is the Executive Director of the non-profit organization S.A.V.E.T.H.E.M (Stomping Away Various Epidemics by Teaching Health Education and Mentoring) in Detroit, Michigan. She has been integral to leveraging community resources and engaging community-based organizations to facilitate a collaborative approach in addressing health disparities that impact the lives of Detroit residents, their families, and the surrounding communities.

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Ms. Roman is a hospital and community-based macro-practice social worker with more than 35 years experience in professional social work. Her social work practice includes urban emergency medical social work, inpatient and outpatient case management and insurance utilization, and case management in the following concentrations: persistent mental illness, neuroscience, pulmonary medicine, kidney and liver organ transplantation. Her current practice engages clients, patients, and colleagues from a servant leadership perspective. She is an integral part of social work education and leadership at Henry Ford Hospital and several private home-care-based agencies. She actively facilitates support groups for patients to encourage self-advocacy and education in health care.

FOREWORD

Cities were once the most helpless and devastated victims of disease, but they became great disease conquerors.

–Jane Jacobs, *The Death and Life of Great American Cities*

The proportion of individuals living in urban communities continues to increase around the globe. Currently over 55% of the world's population live in urban settings, and this is anticipated to reach as much as 65% by 2050 (World Health Organization, 2022). To promote health and provide appropriate health care for this proportion of the population requires an understanding of the impact of urbanization and a knowledge of strategies to mitigate its negative effects. To achieve this, health care providers who will practice in urban settings require preparation that focuses specifically on the needs and the strengths of urban communities.

The complex relationship between urbanization and health has been demonstrated for years and has been highlighted even further during the COVID-19 pandemic, during which we have seen this connection play out dramatically in the disproportionate impact of the coronavirus, including its incidence and mortality in urban settings. The nature of the relationships between social determinants of health is also dramatically displayed in urban settings in the United States and across the globe on a daily basis. More recently, we have come to have a deeper understanding of the long-term impact of urban stressors that may have demonstrated generational impact on the health of families and communities.

The authors of this important text, Drs. McNeill, Stephens, and Walker, are uniquely situated to share their expertise in the preparation of health professionals for practice in urban settings. As faculty members in the College of Nursing at Wayne State University, they are part of a community where we believe that urban health is in our DNA. The vision of the College of Nursing is to be a leader in nursing research and education, known for our commitment to and impact on urban health. Wayne State University and its College of Nursing are located in the heart of Detroit, Michigan—a city that has for decades experienced the variety of challenges and opportunities presented in an urban environment. The College is deeply engaged in the city and in the preparation of providers who will contribute to improving the health of urban communities in our neighborhoods and beyond.

Beyond their roles as educators, Drs. McNeill, Stephens, and Walker are each engaged in clinical practice as advanced practice registered nurses. Their dual roles as clinicians and educators reinforce the assertion that "nurses live and work at the intersection of health, education, and communities" (National Academies of Sciences, Engineering, and Medicine, 2021). Their practice is informed by their scholarship, and their scholarship is directed by the nature of the issues that present themselves in engaged, urban clinical practice.

This text makes several unique contributions to the preparation of health professionals for contemporary practice in urban environments. First, the authors present a thorough review of current knowledge of the relationships between social determinants of health, health equity, and health outcomes in urban settings. Next, while most texts centered on urban health and health care focus almost solely on the challenges that urban environments present to the health and wellness of individuals, families, and communities, the authors of this text place equal emphasis on the unique strengths existent in urban communities and thoughtfully explore strategies to leverage these strengths to promote health equity and improved health outcomes.

The text also supports faculty and students engaged in interprofessional education, recognizing that contemporary health care in urban settings requires maximizing the contributions of a variety of professionals, including those outside what are traditionally considered the health professions. In particular, the use of innovative learning activities, exemplars, and case studies supports the use of this text as a practical guide and launchpad for faculty and students engaged in preparation for interprofessional collaborative practice.

Finally, and perhaps most importantly, the authors approach this work with a focus on incorporating the voice of individuals, families, and communities experiencing life in an urban setting. This recognition of the critical importance of those served as equal members of their health care team supports the education of professionals designed to be true partners with their communities in improving health, reducing the burden of disease, supporting wellness, and reducing the impact of existing health disparities. This collaborative approach is essential to efforts to make substantive and sustainable changes in the health of urban communities.

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CHAPTER 1. DEFINING URBAN HEALTH IN THE INNER CITY

INTRODUCTION

Rural and urban areas, by designation, are geographically different and can be considered polar opposites in terms of population size, predominant occupations, and landscape. In many instances, the definition of *rural* is used in contrast to describe *urban*, and vice versa.

Urban areas are characterized by predominantly nonagricultural jobs, building and road congestion, and high population density (i.e., increased population per unit area, such as per square mile). In contrast, rural areas are known for having large amounts of undeveloped land, low population density, and high concentrations of agricultural occupations such as farming. Despite these differences, health inequity and disparity are common issues for both urban and rural communities. As it relates specifically to health, rural and urban communities are often compared to each other in terms of health care access, health care utilization, geographic distribution of providers, and availability of health services. Both urban and rural areas face their own unique disparities related to health care that have been well documented. The main focus of this text revolves around gaining a better understanding of urban communities and the factors that affect urban health. This chapter discusses how urban and rural areas are defined in the United States and gives specific focus to urban communities, urban health, and aspects that influence health in urban communities.

LEARNING OBJECTIVES

1. Discuss the similarities and differences between urban and rural communities
2. Explain the characteristics of the inner city
3. Explore the factors that influence urban health
4. Describe the "urban health penalty" and its impact on health

RURAL VS. URBAN

The US Census Bureau defines *rural* as any population, housing, or territory not in the urban area. Traditionally, rural populations have resided on farms or land producing food and other goods for local distribution as well as disbursement to larger urban cities. The economic stability of rural areas typically relies on topography, climate, and dependence on agriculture. In the 1900s, most of human civilization lived in rural settings and during that time the rural population was estimated to be approximately 60.4%. The most up-to-date calculation, from 2020, has estimated that currently approximately 17% of the US population—which is approximately 57 million people—live in rural areas.

As a result of industrialization and immigration, urban areas have grown quickly while rural populations have declined. Now, approximately 83% of the US population live in urban areas. The term *urban* was first defined in census reports in the early 1880s. At that time, urban areas were defined using population criteria thresholds of 4,000 or 8,000 to identify urban cities and towns.

The definition of *urban* has evolved since then, and in the mid-1900s the first official definition of *urban* was established to include places with populations of 2,500 or more. In the 1950s the definition was further expanded to include urbanized areas with populations of 50,000 or more and urban places with populations of 2,500 or more outside urbanized areas. The most recent change to the definition occurred in 2000 to recognize densely settled areas adjacent to small towns, called "urban clusters"; this change extended the urbanized area concept to smaller concentrations of population. There are currently over 3,573 urban areas in the United States with an urban population totaling over 272.3 million.

Urbanization, or the mass movement of populations from rural to urban settings, has long been associated with technological development and economic growth while simultaneously serving as an incubator for poverty, inequality, environmental hazards, and health disparities. The impact of urbanization on health is multifactorial, but data have directly linked poor health outcomes to living in urbanized areas. The changing demographics of the defined urban areas and the density of the population that comes with that urban designation also come with changing health care issues. An example of this is mental health. It has been well documented that high rates of mood disorders (~40% increase) and schizophrenia (at least a twofold increase) are present in urban areas. Inclusion of more urban clusters also changes what primary health care looks like. People who live in these areas adjacent to small towns, known as urban clusters, are more likely to have residents who are less well off than those in urban areas; however, often they are also less healthy, tend to smoke, and consume more alcohol, and like many inner city residents they are less likely to be screened for chronic conditions.

Health disparities are defined as a type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities are prevalent in urban communities and account for poorer health outcomes in the urban setting. It is important to recognize that there are many dimensions to health disparities that affect health outcomes. There are economic (e.g., poverty), social (e.g., race), geographic and environmental, and proximal (e.g., gender, sexual identity, age) factors that can have individual and synergistic consequences on the ability of an individual to achieve good health. We as health care providers must recognize, understand, and attempt to mitigate the impact these health disparities have on health outcomes.

Health disparities such as drug addiction, mental illness, chronic disease, and violence are evident in both rural and urban communities. These health-related issues are further compounded by racial and ethnic disparities. The synergistic impact of multiple health disparities is a unique contributing factor for both rural and urban environments; however, each geographic designation, whether rural or urban, has unique barriers directly related to whether residents have adequate quality, access, and utilization of health care. Efforts to address disparities in either rural or urban communities require unique approaches to address the complexities of each demographic. The geographical makeup of urban communities is distinctly different from that of rural communities, yet individuals living in the inner cities as well as those in the rural communities are more likely to be impoverished, have increased rates of death, lack necessary resources, and have poorer health outcomes than those living elsewhere. One of the major risk factors for poor health is poverty. In 2018, 16.1% of rural Americans lived in poverty compared to 12.6% of urban Americans. Individuals with lower socioeconomic status and lower levels of education will likely report unmet health needs, are unlikely to have health insurance, and are more likely not to receive preventative care. These disparities act in concert to create a situation that results in increased mortality regardless of where you live, whether in urban or rural communities. As the population becomes more dense in these already strained urban communities, health concerns arise that differentiate urban from rural areas. Consider communicable diseases, such as COVID-19, flu, and tuberculosis, and then think about the preexisting conditions that perpetuate the spread of disease. Dense populations, close living quarters, and poor air quality are examples of compounding risk factors that are unique to the urban environment and have direct correlation to the transmission of communicable diseases. When we look at resource allocation in relation to urban versus rural environments, urban environments possess unique challenges. One may argue that urban environments have access to higher quality health care, greater access to health providers, and more social service resources. However, the density of urban communities means that the need for services often outweighs current availability and access to care. The Health Resources and Services Administration (HRSA) has acknowledged these issues and created designations of medically underserved areas (MUAs) and health professional shortage areas (HPSAs). The HRSA applies the MUA designation to areas or populations that have too few primary care providers, high infant mortality, high poverty, or a dense elderly population. In addition, the agency applies the HPSA designation where there exists a shortage of primary care, mental health care, and dental care providers in a geographic location or population. Finally, there are designations for medically underserved populations (MUPs) that are designated for a specific population subset within a geographic area that may have economic, cultural, or language barriers to health care. Many urban health communities often have all three of these designations. Constraints related to resource allocation and other competing disparities hamper the urban health care system, which struggles to manage the increased need related to population growth.

INNER CITY

With the majority of urban growth taking place in developing cities, it is imperative to address not only health promotion and disease prevention but also the social determinants of health (SDOH) that influence health outcomes for individuals, families, and communities. Social determinants of health represent the nonmedical factors that directly or indirectly affect health. *Healthy People 2030* defines *social determinants of health* as “the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks.” From this definition have arisen five domains of SDOH: (1) Education Access and Quality, (2) Economic Stability, (3) Neighborhoods and Built Environments, (4) Health Care Access and Quality, and (5) Social and Community Context. Examples of the social determinants that directly affect health outcomes include housing insecurity, socioeconomic status, public transportation, and the educational system. The issues surrounding disparities in SDOH are embedded in societal structures that perpetuate discrimination and health inequities. In the United States the discussion of social determinants often focuses on racial and ethnic differences in health or health care. In Chapter 3 of this text we explore in great detail the five main SDOH domains and the impact these determinants have on urban patients living in the inner city.

When you hear the term *inner city*, what thoughts come to mind? For many, “crime burden,” “drug addiction,” “debilitated,” and “poor” are some unfortunate descriptors that many individuals associate with the inner city. This negative depiction of the inner city fails to highlight resilience, tenacity, and potential for growth and change. From the lens of the urban experience, the city can represent a multitude of human experiences and diverse conditions in which people live, despite barriers and disparities. Most formal definitions for *inner city*, especially in the United States, highlight disparity, socioeconomic problems, densely populated and deteriorating areas inhabited mostly by minority groups, violence and crime, and illness. These descriptions represent a very narrow perspective of inner cities and fail to tell the whole story. This text will serve as a guide to assist urban health care providers in broadening their perspectives in order to better understand the urban patient's "lived experience."

WHAT IS URBAN HEALTH?

The term *urban health* is used frequently in describing the health and living conditions of subsets of the population, but is there a clear-cut definition? A broad definition is "the study of the health of urban populations." Individuals who study urban health are charged with the responsibility of being able to describe the health of urban populations (as a whole and for specific subgroups) and strive to understand the determinants of population health in the cities, while focusing on how characteristics of cities themselves may affect the health of the urban populations. There are a multitude of factors that contribute to the health of urban individuals, families, and communities. Regardless of where you live, factors such as access to health care, quality of the environment, education, socioeconomic status, and economic resources are directly related to overall health status. The focus on urban health is of specific concern because urban populations are projected to grow. According to the World Health Organization (WHO), two thirds of all people will live in urban areas by 2050. With the anticipated population growth in urban areas and the current health disparities, improving the health status of the urban population needs to be a priority.

Exploration into the complexities of urban health leads only to further questions. For example, what are social determinants of health, and why are they important? What is considered an urban environment, and how does that environment affect health? What health outcomes are being evaluated in urban communities? What factors affect social determinants of health? The complicated and robust subject of urban health, embedded in the larger context of public health, has led to a unique area of study that includes evaluating how urban planning and policy, social constructs, and political influence affect the urban environment and the health of individuals who reside in urban communities.

The Urban Health Penalty

The term *urban health penalty* is defined as the price that low-income urban populations pay for living in impoverished communities. The urban health penalty is a concept that attempts to explore the interconnectedness of physical and economic deterioration that contributes to the vicious cycle of poor urban health. This penalty represents the disparities that exist or are exacerbated when the more financially stable, healthier individuals move away from the city. Individuals who are unable to leave the city are usually those who are financially insecure and/or in poor health. Considering city economics, the tax base shrinks when affluent individuals leave the city, the physical environment tends to deteriorate due to lack of resources, businesses struggle and are at greater risk of closing, and there are more vacant, dilapidated buildings. The degradation of these urban communities makes them unattractive to large corporations and businesses that could bring resources to the community. "Food deserts" are a good example of how the urban health penalty affects health. Large chain grocery stores are rarely seen in impoverished communities. Residents living in the inner city have less access to quality, large chain supermarkets and are forced to depend on corner stores, liquor stores, gas stations, or lower quality food markets for their nutritional needs. Lack of access to quality fresh fruits and vegetables, greater pressure to consume unhealthy products such as fast food, stronger marketing campaigns for cigarettes and alcohol in the inner city, and reliance on canned foods lead to lower levels of nutrition that directly affect health outcomes. For urban communities, the deterioration of housing, increased homelessness, higher incidence of violence, increased infant mortality, poor nutrition, poverty, and unemployment are just a few of the characteristics tied to the urban health penalty that result in higher incidences of adverse health conditions.

Improving health in urban communities will require a holistic approach that addresses not only the prevalent health behaviors and health conditions in the urban communities but also the social determinants of health that perpetuate these conditions. Solutions will require residents of the inner city, health care providers, governments, community organizations, and all stakeholders, among them health care systems, to coordinate and work collaboratively in rectifying the inequities that are at the foundation of the disparities that exist in urban communities. We challenge you to gain a deeper understanding of both the barriers and the facilitators that affect the health of urban residents. Work interprofessionally with colleagues from different specialties to explore practical solutions to overcome barriers and be cognizant of the “lived” experience of urban patients. Look beyond the current disparities to leverage the strengths within the urban communities and tap into the resilience of urban residents to optimize the health status of urban patients, families, and communities.

EXEMPLAR: LONG-TERM APPROACHES TO URBAN HEALTH IN DETROIT, MICHIGAN

The disparities that plague urban communities are systemic, chronic, and burdensome and thereby affect the quality of life of individuals and families living in urban environments. Despite what seem like insurmountable barriers, people in urban communities continue to persevere while striving to obtain health equity. Historically, solutions to achieving health equity have included the mobilization of philanthropic organizations. Philanthropic organizations are typically independent entities that have the capacity to take a long-term approach in responding to chronic and emergent needs of the community. These foundations allocate resources and provide services that can affect communities over generations, and their impact can be measured over long periods of time. In April 2021, Impact on Urban Health released a report entitled *Global Perspectives on Urban Health*. Through this report, Impact on Urban Health sought to discuss health equity in the context of cities. The report evaluated 10 urban communities around the world to obtain a better understanding of urban health equity and disparities related to health access. Detroit, Michigan, was one of the 10 cities evaluated in this report, in which the role of philanthropic entities was highlighted as being integral to addressing health equity.

Visit https://urbanhealth.org.uk/insights/reports/long-term-approaches-in-detroit-us to access the full 35-page report from Impact on Urban Health entitled *Global Perspectives on Urban Health*, which was released in April 2021.

Read the section of *Global Perspectives on Urban Health* that discusses Detroit, Michigan. What is the impact of philanthropic foundations on urban health in Detroit?

LEARNING ACTIVITIES

Take this opportunity to explore urban health from a global perspective. Read the full 35-page report entitled *Global Perspectives on Urban Health* (https://urbanhealth.org.uk/wp-content/uploads/2021/04/Global-perspectives-on-urban-health.pdf). Explore strategies, highlighted in the report, to address health equity that are used in urban communities around the world. Compare and contrast strategies utilized in other urban cities discussed in the report to those highlighted for Detroit, Michigan.

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CHAPTER 2. CLINICIAN PREPARATION FOR URBAN HEALTH PRACTICE

INTRODUCTION

Clinician training is the foundation that prepares providers to effectively provide care for individuals, families, and communities. If we approach urban populations as a unique population subset for which health care providers require special training considerations, we must acknowledge that individuals interested in working in urban environments would benefit from having within their training programs specific exposure to urban populations. Unfortunately, educational training, including didactic and practicum preparation, varies depending on the training program, the instructor's experience, the instructor's knowledge of urban populations, and the availability of practicum experiences in urban environments. The purpose of this section is to explore the role of the urban health care provider, assess clinician preparation for urban health care practice, and take a closer look at internal factors and external factors that affect readiness to practice in the urban environment.

LEARNING OBJECTIVES

1. Describe the role of the urban health care provider
2. Explore barriers to the recruitment and retention of urban health care providers
3. Discuss federal initiatives to recruit health care providers to work in underserved communities
4. Explore how implicit bias affects health care

ROLE OF URBAN HEALTH CARE PROVIDERS

We have alluded to the complex and convoluted nature of urban health and the many factors that affect health outcomes, specifically as related to living in the inner city. Health care providers working in the urban environment will need to possess unique experience and a specific skill set to better manage patients in light of the compounding factors that affect their health. Providers seeking to work in urban environments with the expectation of making a genuine impact in the health outcomes of their patient population must understand all the factors that play a role in their patients' lives. The urban health care provider must understand the importance of interdisciplinary care and collaborative practice in order to align necessary resources to meet patient needs. It is injudicious to work in the urban environment and not acknowledge the role that social determinants of health play in your patient's ability to adhere to treatment regimens, make lifestyle modifications, and reach health goals. The urban health care provider's role has to go beyond treating the patient for specific disease processes or screening for preventable diseases and must encompass practical application of evidence-based guidelines relevant to the patient's "lived experience" and available resources.

MEDICAL MISTRUST (TRUST IS EARNED, NOT GIVEN)

One unfortunate reality embedded in health care is medical mistrust. For many urban, minority patients, mistrust of "systems," including health care, is a part of their daily reality. The roots of racism in health care are deeply entrenched in the founding core ideas of our medical and political systems. Today we still see the cumulative negative effects of this painful history in how it continues to affect individuals and communities of color in the United States. For the clinician preparing to practice in urban communities, it is imperative to understand how racism, sexism, and other systemic health inequities influence the trust of minority patients seeking health care. In 1999 the National Academy of Medicine convened a group of clinical experts to complete a report that would examine racial inequities in US health care. The report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care,* was completed in 2002 and found that Blacks and other ethnic minorities received poorer medical treatment across all spectrums and levels of health care engagement even when factors such as income, age, insurance, and health conditions are similar. In addition, the report revealed that real or perceived discrimination by the medical system and society in general is the root cause of minority patients' mistrust in health care providers. The concept of medical mistrust goes far beyond a simple lack of confidence in the medical system. For many minority patients, it is the core belief that the medical system/government will purposefully act with detrimental intent or neglect toward marginalized individuals or groups. This chapter discusses the origins of medical mistrust, the impact of mistrust on health inequities and research, and how to address mistrust to build rapport in the patient–clinician relationship.

The origins of medical mistrust in the United States can be connected back to slavery. Physicians were employed by slave traders and plantation owners to ensure that the slave assets survived transportation, were healthy enough to work, and could be sold or traded on the auction block. The relationship with the physician was focused on slaves as a means of financial success. With the beginning of the slave trade came the beginning of the discussion regarding the concept of race. Much of the foundational basis for racism began with the concept of the hierarchy of humanity, with Africans being associated with innate overall inferiority, lower intelligence, and proneness to laziness. This doctrine would become the support for the institute of slavery and the root of the superiority of White culture. Once on plantations, slaves who became ill preferred the homeopathic remedies of other slaves rather than the treatment by owners and physicians in makeshift slave hospitals that offered little chance of survival. Mistrust in the White medical establishment had taken root and would become more pervasive as people of color were treated as lab specimens.

There is a long history of people of color being used by physicians in medical experiments. One of the most well-known experimenters is J. Marion Sims, who is considered the father of modern gynecology and was the founder of the New York Women's Hospital. He openly conducted experiments on Black women and their infants, doing so without anesthesia to develop vaginal repair procedures and to investigate surgically the impact of tetanus on newborns. A statue of him graced Central Park until 2018, when it was removed after his experimentation on slaves was highlighted in the book *Medical Apartheid*. The use of people in medical experiments without consent continued for most of the 20th century.

The Tuskegee Study is characterized as "the longest non-therapeutic experiment on human beings in medical history." This experiment is one of the most recognized and foundational supports for medical mistrust and was conducted by the US Public Health Services (USPHS) from 1932 to 1972 in Alabama. It was designed to be a short epidemiological study of the range of pathology associated with syphilis. At the time, it was postulated that the effects of syphilis depended on the race of the patients and that syphilis had a more pronounced cardiovascular effect in Blacks. The study total of 600 impoverished, African American male sharecroppers. Nearly 400 participants had latent syphilis, and the others were a control group of unaffected males. The USPHS blatantly lied to the participants, telling them they would receive free medical treatment. Nor were the participants ever informed of their diagnosis, potential health complications, or their ability to spread the disease to their sexual partners. They were told instead that the treatments were for "bad blood," which was a local term for a variety of illnesses such as syphilis and anemia. It is important to note that "bad blood" was the leading cause of death within the southern Black community at the time the experiment commenced. Initially, subjects were studied for 6–8 months and then treated with contemporary methods. Placebos were administered, and patients underwent unnecessary diagnostic procedures. The USPHS could have decided at any time to end the study and treat all participants with penicillin, which the facilitators knew was effective. Clinicians remained steadfast to the goal of observing the natural course of untreated syphilis. The UPHS reasoned that the knowledge gained would benefit humankind, and this reasoning was maintained even after the cure was found in 1943. Many of the participants died from syphilis, but the secondary victims were their wives who were infected and the children born with congenital syphilis.

It was also discovered in 2010 that the USPHS ran another study of a sexually transmitted infection, this time in Guatemala from 1946 to 1948. The USPHS conducted studies funded by the National Institutes of Health, with the cooperation of Guatemalan authorities. The study involved at least 5,128 vulnerable people, including children, orphans, child and adult sex workers, Guatemalan Indians, leprosy patients, mental patients, prisoners, and soldiers. The USPHS intentionally infected at least 1,308 of these people with syphilis, gonorrhea, and chancroid and also completed serology tests on others. The intent of the study was to test the value of different medications, including the antibiotic penicillin and other treatments in the prevention of sexually transmitted diseases and to evaluate diagnostic testing to refine STD-screening techniques for treating US military personnel. Researchers knew that many in the United States would consider the intentional exposure experiments in Guatemala to be unethical, and so great extremes were taken to hide these barbaric practices. The study was discovered in 2003 in papers by Dr. Susan Reverby after Dr. John Cutler, the lead investigator in the Guatemalan study and late investigator in the Tuskegee Study, donated his records to the University of Pittsburgh School of Public Health, where he had served as faculty later in life. The papers included research notes, laboratory and medical records of the Guatemalan subjects, photographs, and correspondence between the investigators. The findings about the Guatemala experiments were presented at an academic conference in 2010. President Barack Obama apologized for the US role in these experiments and issued a formal apology to the Guatemalan government.

These are but a few examples of how medical mistrust originated and developed in US health care. There are many other studies during the early 20th century that have generated the doubt or suspicion felt by minority patients. Experimentation on people of color without proper consent led to the implementation of the 1974 National Research Act, which was signed into law by Richard Nixon. The law created the National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research. In addition, it required researchers to get voluntary informed consent from all persons taking part in studies done or funded by the Department of Health, Education, and Welfare (DHEW). The act also required that all DHEW-supported studies using human subjects be reviewed by institutional review boards, which read study protocols and decided whether they meet ethical standards. While this law has significantly increased patients' protections, the medical mistrust created by these blatant abuses continues to be seen in the health inequities experienced by minority patients.

An effective health care system that truly cares for patients must be built on trust between providers, patients, and the medical system. Medical mistrust in health care can have repercussions that negatively affect health outcomes and can perpetuate ongoing health inequities. Medical mistrust has been linked to lower health care utilization, lower adherence to medical treatment, lower participation in health research, and poor patient–provider relationship and has a negative impact on preventive health services and chronic disease management. These issues directly influence health disparities and grow the health inequities for people of color. The impact of medical mistrust manifests in rates of maternal and infant mortality, diabetes, stroke, and hypertension that are 2–3 times higher in minority patients than in their White counterparts.

Over the last 3 decades there has been a concerted effort in the United States to increase the representation of minorities in clinical trials. As already discussed, there are significant historical barriers and mistrust that continue to affect clinical research involving minorities. A recent report indicates that minority participation has increased to almost 30% of those enrolled in clinical trials sponsored by the National Institutes of Health, but vast improvement is still needed to guarantee representation of minorities. Increasing minority representation is critical to producing evidence-based data that will improve generalizability of medical research. The inclusion of minority participants in clinical research is a public health imperative because inclusive representation helps to address issues of health equality and elevates the access to new, innovative treatments for minority patients that can improve health outcomes and management of disease. The research community must continue to actively work to establish trust and develop recruitment strategies that acknowledge the historical damage minority patients have experienced and foster connections on a personal and community level that can provide education and resources.

How do we begin to address medical mistrust in clinical practice? Communication and trust between the patient and the provider are essential for developing meaningful relationships and optimizing health outcomes. Without effective provider–patient communication, interactions remain superficial and lack the ability to substantially affect health. Barriers exist for both the patient and the provider that affect crucial conversations regarding health and can lead the patient to mistrust medical care provider. Strengthening relationships between patients and their health care providers may be a means of building trust, as some studies have found that people have more confidence in their health providers than in “the health care system” or pharmaceutical companies. The patient-centered provider relationship must start with the health care provider asking open questions and allowing the patient to help the provider understand the patient's “lived experience,” which includes doubts, fears, and the patient’s priorities for health. This approach also entails acknowledging that the patient needs to be an active participant in shared decision-making to achieve improved health outcomes.

MEDICALLY UNDERSERVED AREAS AND HEALTH CARE PROVIDER SHORTAGE AREAS

Medically underserved areas/populations MUA/Ps) are areas designated by the Health Resources and Services Administration (HRSA) as having too few primary care providers, high infant mortality, high poverty, or high elderly population. The MUA designation guides the allocation of resources and personnel to the areas of greatest need. Health professional shortage areas (HPSAs) are used to identify areas, population groups, or facilities within the United States that are experiencing a shortage of health care professionals. There are three categories of HPSA; these are based on health discipline and include primary care, dental health, and mental health.

Disparities in access to health care services and health care utilization have been a chronic issue in the inner city. According to the HRSA, there were approximately 4,128 MUA/Ps in the United States. There are also 7,302 designated primary care HPSAs servicing 83 million individuals (2,331 in urban areas), 6,567 dental HPSAs servicing 61 million people (2,059 in urban areas), and 5,828 mental health HPSAs servicing 122 million people nationwide (1,947 in urban areas), with 15,257 practitioners needed for primary care, 10,877 needed for dental health, and 6,456 needed for mental health to address the shortages.

Poverty, lack of health care access, and insurance issues contribute to the urban health care disparity. The clear shortage of primary care providers in urban neighborhoods and the inability of some providers to relate to and effectively communicate with their patients also exacerbate the problem. Without the continuity of services from primary care, urban residents find themselves traumatized by the health care system, encountering the health care system only through episodic, traumatic, and fragmented care, which results in the misutilization of hospitals for primary care.

Urban communities entice a high number of health care professionals. Despite the heightened desire of some health care providers to work in urban settings, the quantity of providers does not guarantee equal distribution or equal access. Health care providers do not stay in the primary care sector because of low insurance reimbursement and lower income earning potential. Many of the providers who practice in urban areas tend to specialize. Their desire to seek income higher than is possible for them if they stay in an urban area will take them away from communities with the highest needs. Another factor that contributes to the decrease of providers in the most underserved areas is the oversaturation of specialist providers in comparison to the primary care practitioner. Salaries for primary care providers tend to be on the lower end and can be unattractive to some providers. Additional factors that deter primary care providers from working in the inner city include difficult social conditions such as drug use, violence, and socioeconomic barriers. The inner city population tends to have more complex patients with multiple comorbidities; cultural and language differences; limited resources to address social determinants of health, which affect health outcomes; and increased incidents of no-shows and noncompliance. An obvious barrier for providers working in the inner city is the low socioeconomic status of the patient population. The low socioeconomic status of individuals living in the inner city increases the propensity for individuals to rely on Medicaid, which means the provider receives a lower reimbursement compared to payments from privately insured patients. The lack of minority providers can also be seen as a critical issue for the patient–provider relationship, since the majority of the inner city population are minorities. All these barriers contribute to the health care provider shortage for inner city residents and highlight the need for recruitment and retention of providers who will specialize in primary care for the urban underserved.

Given inner city residents' limited access to primary care providers and their low socioeconomic status, where do patients seek health care? According to the literature, inner city hospitals represent the largest provider of health services for the urban community. The emergency departments of these inner city hospitals have the highest demographic of patients with low socioeconomic status and minorities seeking care. Limited resources, inability to pay for health care, and lack of access to health care outside of the emergency department or inner city hospital lead to the increased use of hospitals and emergency rooms for primary care or urgent care issues. This increased use of the emergency room for nonemergency health care needs (e.g., medication refills) can stem from lack of community-based health resources; however, patients also have the perception that emergency department care will be faster care in a doctor's office, or they fail to see the value in a primary care relationship.

In addition to barriers related to social determinants of health, urban communities face barriers to better health outcomes directly related to population density and lack of accessible resources. Even though many urban areas house some of the largest and advanced health care institutions and entice some of the best health care providers, access to these resources for the urban community is limited and disproportionately allocated. Urban health care providers should be aware of the unique challenges in addressing health disparities in the urban community and understand how urban communities utilizes the health care system.

Urban Health Care Provider Recruitment: Federal Initiatives

The continued growth of the urban population and the well-documented health disparities for urban communities fuel incentives to recruit and retain urban health care professionals. As discussed earlier in this chapter, medically underserved areas and provider shortage areas are persistent in urban communities because there are not enough urban health care providers to meet the ever-growing and complex health care needs of urban residents. The federal government has acknowledged the disparity related to having sufficient urban health care providers and has developed programs and incentives to recruit more providers to urban communities. The National Health Service Corps (NHSC) and Area Health Education Centers (AHECs) are two long-standing programs sponsored by the federal government to focus efforts on recruiting providers for underserved areas.

Area Health Education Centers are a federally funded program developed by Congress in 1971 with the purpose of "recruiting, training and retaining health professions workforce committed to underserved populations." This program leverages relationships between academic institutions, health care institutions, and community-based organizations with the mission to "enhance access to Quality Health Care by improving the supply and distribution of health care professionals." The program has a network of more than 300 offices and centers that serve over 85% of US counties. Through programs such as AHEC Scholars, which exposes participants to additional didactic and experiential knowledge, individuals interested in working with the underserved are given the opportunity to work with these populations while in their health care training program and the potential opportunity to receive stipends for their participation. Participation in the AHEC program is available for students majoring in nursing, medicine, physician assistant, public health, social work, and other relevant specialties. The six core topics addressed in the AHEC Scholars program include behavioral health integration, social determinants of health, cultural competency, practice transformation, and current and emerging health issues. The AHEC program increases exposure of select students to underserved populations; however, the program cannot guarantee sustained service to this community once a participant graduates.

The NHSC is the most relevant program for health care providers and awards scholarships and enables loan repayment for primary care providers practicing in underserved rural and urban areas. Since 1972, the NHSC has pursued its mission to build healthy communities by supporting qualified health care providers who are dedicated to working in areas of the United States that have limited access to care. Through scholarships and loan repayment programs, NHSC offers incentives for providers to work in underserved communities; in return, providers commit to a specific time frame to provide services in that community. The NHSC scholarship pays tuition and fees and provides a living stipend to the health care students selected to participate in the program. Upon graduation, the scholarship recipient agrees to serve at least 2 years in an approved health professional shortage area. The NHSC loan repayment program offers fully trained primary care providers up to $50,000 to repay student loans in exchange for 2 years of full-time service (also available are part-time options). Once the initial service contract is completed, the applicant may reapply for additional loan repayment funds through 1-year continuation service contracts; however, the availability of these additional funds is not guaranteed. There are additional federal opportunities for financial incentive–based programs for health care providers through other entities such as the US Armed Forces Health Professions Scholarship and Loan Repayment Program and the Nurse Corps Loan

Repayment Program. On the surface, these programs have proved to be an effective way to initially attract providers to underserved rural and urban communities. NHSC has a strong network of current providers and a pipeline of health care professional students who will be entering the workforce. According to the Health Resources and Services Administration, 17 million people received care from more than 16,000 clinicians serving through NHSC-approved sites in urban, rural, and tribal communities. Despite the initial success of these programs to recruit providers to the areas of greatest need, long-term retention of these providers dwindles once the incentives cease. Many providers, once their contract with NHSC is over, will leave the despaired communities for better working conditions, increased salary, and better benefits.

We have reviewed two of the oldest and most well-known incentive-based programs for the recruitment of providers for underserved populations. There are also incentive programs administered at the state level, such as the State Loan Repayment Program (SLRP), which is intended to help employers recruit and retain primary medical, dental, and mental health care providers by providing loan repayment to those entering into service obligations (similar to the NHSC Loan Repayment Program). Through grant funding provided by the HRSA's Bureau of Health Workforce, participating states are given funding to support the SLRP for their state. The SLRP is administered at the state level, and each state decides the application process and submission cycle. As with the NHSC Loan Repayment Program, the SLRP is competitive and approvals are based on the availability of funds (https://nhsc.hrsa.gov/loan-repayment/state-loan-repayment-program/index.html).

In addition to government-sponsored scholarships and loan repayment, other efforts to recruit providers for underserved communities can be seen in the form of academic training grants and other funding opportunities that health care training programs can apply for. Academic institutions often partner with health care entities in the community to submit grant proposals that incorporate clinician training and address health disparities in both rural and urban communities. Government entities such as the US Department of Health and Human Services (HHS, https://www.hhs.gov/grants/grants/index.html) and Health Resources and Services Administration (HRSA; https://www.hrsa.gov/grants/index.html) are two well-known government entities that provide grant funding to academic training programs.

OVERARCHING THEMES IN URBAN HEALTH

Given the complexities of the urban environment, which include economic, political, and social factors that affect the health of individuals, families, and communities, *urban health care providers must be able to acknowledge and evaluate these complexities while implementing interventions that are appropriate and realistic for the patient to address the root causes and health consequences of these complex factors.*

In addition to being complex, urban populations are very diverse, having high populations of minorities and immigrants with different ethnic and lifestyle preferences. Disparities in socioeconomic status further add complexities requiring *urban health care providers to have cultural competency, effective communication skills, knowledge of anthropological factors affecting the health of the communities they serve and an understanding of how genetics, cultural practices, belief systems, biology, environment, and other factors can affect health outcomes.*

Living in the city, in and of itself, regardless of any other determinants, poses distinct barriers but also offers facilitators to health. For example, living in the city exposes individuals to a greater selection of social services, health care entities, and community-based resources. In some aspects, urban residents are healthier than their rural counterparts. For example, individuals in rural communities report less access to sidewalks, streetlights, workout facilities and less instances of seeing neighbors exercising in their communities, than urban residents. Disparities in this built environment in rural communities contribute to barriers to regular exercise, leading to sedentary lifestyles which often serve as a precursor to adverse health outcomes such as obesity. The impact of less developed built environments in the rural community, therefore, is correlated to data that supports that women in the United States who live in rural environments tend to be more sedentary than urban women.

Even though living in the city offers some benefits, the disparities that affect health are overwhelming. Increased incidence of illness and increased exposure to dangerous elements such as drugs, violence, and pollution, in addition to higher proportions of individuals with economic instability, which is directly associated with poor health, are factors that outweigh the benefits of inner city living. *An effective urban health care provider will need to be able to identify facilitators as well as barriers within the patient's community and leverage the available resources in the urban environment to address health disparities.*

The abilities of the urban health care provider will need to be robust and encompass knowledge in areas such as science (e.g., how variables interact within the city to influence health and disease), organizational practice (e.g., how to influence policy and practice change within the health organization), political influence (e.g., how to advocate to improve legislation and mobilize resources), and technical skill (e.g., how to implement evidence-based practice and evaluate processes and outcomes). *To accomplish the best health outcomes, urban health care providers will need to anticipate the needs of their patient population and embrace interdisciplinary approaches to meet the needs of their complex urban patients.*

One of the most important skills an urban health care provider can possess is the ability to acknowledge the impact of social determinants of health on the patient's ability to achieve health goals. The urban health provider will need to work with patients in the midst of their disparities, to achieve the best possible health outcomes. It is important for the health care provider to continually assess available resources and support systems available to the patient. Providing care for patients living in urban environments who have numerous health disparities will require the health care provider to go beyond the textbook and be innovative in finding ways to help patients navigate the disparities to reach the intended health outcome.

PEDAGOGICAL PERSPECTIVES IN URBAN HEALTH TEACHING

Improving the health of urban populations must begin with engaging a workforce of practitioners from all disciplines who possess unique knowledge, skills and the genuine desire to manage patients' health needs in the midst of their disparities. Clinician training, both didactic and practical, is the foundation that prepares individuals to effectively provide care to individuals, families, and communities. Unfortunately, the variability in how urban health is taught leads to inconsistent preparation of urban health care providers, and pedagogical approaches in teaching urban health depend heavily on the experience of educators and the availability of quality urban health experience before practitioners' entry into practice. This textbook aims to complement the foundational courses taken by health care providers by adding an urban patient and urban provider perspective to readers' didactic and clinical learning. As part of the foundational training for all health care workers, there should be (a) specific education related to their chosen discipline, be it nursing, medicine, social work, public health, or some other; (b) content that explores the history, current structure, and different aspects of the health care delivery system; (c) education on health disparities and their impact on health outcomes; (d) evidence-based practice, including the evaluation of evidence and the translation of evidence into practice; and (e) a broad understanding of social and natural sciences.

Pedagogy includes academic settings, learners, students, teaching methods, didactic content, and experiential learning. To prepare health professionals with the skills necessary to practice in urban communities, there must be distinct pedagogical methods with a specific focus on exposing the learner to the reality in which urban patients live. In this section, we review knowledge gaps related to urban health, external factors that affect readiness for providers to practice in urban health, and the perceptions of the prospective urban health care providers that could affect the care they provide for patients.

Gaps in Knowledge-Related Urban Health: Real World vs. Didactic Learning

Traditionally, urban health care providers are taught about health disparities in the context of outcomes or consequences. Providers are trained to use evidence-based interventions supported by randomized controlled trials to improve health outcomes. However, randomized controlled trials rarely take into account the impact of social determinants of health on patients in urban communities and the impact that disparities have on health outcomes (e.g., compliance with health care recommendations). Furthermore, the skills necessary to navigate the health care barriers in the urban community and the unique considerations for guiding patients through their health care disparities are seldom discussed or demonstrated in provider preparation programs.

Urban living conditions directly affect health and are influenced by multiple systems, including health care, education, the legal system, the environment, employment, and education. Urban communities consist of dense multicultural communities that require urban health care professionals who have the capacity to perform the appropriate assessments and implement the most effective interventions for the unique needs of the population and that take into consideration the disparities patients have to endure. Mindset shifts are needed to practice effectively in urban environments. We must realize that our reality is not the patient's reality. You must ask yourself, "What is the patient's reality?" and "How does that reality affect the patient's health care decisions?"

Urban health care provider programs rarely provide students with practical skills that will help them manage their patients' health conditions while taking into consideration their barriers and health disparities. Textbooks and evidence-based guidelines do not take into account social determinants of health, leaving novice providers feeling frustrated and helpless when they are trying to achieve positive health outcomes but the patient lacks the resources to meet the expectations. Being able to assess not only your patients' health conditions but also the availability of resources and consequently modifying plans of care, making them more realistic for patients with disparities, are skills not often taught in formal programs.

External Factors That Affect Urban Health

Student Recruitment

As discussed earlier, trust and communication are major factors when working with urban patients, especially minorities. The content taught in urban health training programs is not the only factor affecting the health of urban communities. We must also take into consideration who is being trained in urban health, as these individuals have the power to influence practice and research.

Research has shown that patients prefer health care providers from the same ethnic and racial background. Recent studies have found that patients are more likely to rate their health care provider higher when they see a provider of their own race or ethnicity. Substantial evidence supports recruitment and training of urban health care providers who represent the patient population being served. Students from underserved urban communities are more likely to return to urban communities to practice; they understand the life circumstances of their patients and communicate effectively with patients and communities. Health care provider programs have acknowledged the importance of having providers who look like the population being served, and some institutions have made special efforts to recruit students who better represent the underserved population. There are, however, disparities in the number of minority health care providers available to care for underrepresented communities. Furthermore, barriers to recruiting minority providers include some of the same socioeconomic disparities that affect urban patients, such as limited access to affordable higher education, low socioeconomic status, and income constraints.

For example, African Americans are the second largest minority population in the United States, representing 12.8% of the total population. Although African Americans made up 12.3% of the labor force, they are shown in single-digit percentages in the health care professions. African Americans make up just 5% of active physicians, 5.2% of advanced practice registered nurses, 8% of physician assistants, and 5% of pharmacists. What does this mean for access to care for African American patients who feel most comfortable with African American providers?

Teachers

Another important component to teaching urban health is hiring faculty who reflect the diversity of their students and the population the students are expected to serve upon graduation. Having experienced faculty who have worked with urban populations and/or represent the underserved population may increase the likelihood that the students will develop the cultural and communication skills necessary to engage the urban community. Selecting faculty with experience in providing care for urban communities can provide students with mentors and role models not only in the classroom but also in professional networks that can help students become acclimated to working in the urban community. Experienced faculty can provide real-life experiences and practical application to enable students to better understand the impact of social determinants of health on health outcomes. Unfortunately, research suggests that many health professional training programs (e.g., nursing, medicine, public health) do not have a diverse faculty pool that represents the underserved population. This dearth also applies to faculty that are research focused. A large proportion of research regarding health disparities occurs in underserved populations; however, the researcher is very rarely representative of the patient population that is being asked to participate in the study. Again, as a consequence of medical mistrust, patients are wary of participating in studies, and this wariness accounts for the decreased number of minorities that participate in medical research. The consequent lack of minority participation in research contributes to lack of understanding of how some of these medications and treatment regimens really affect communities of color.

Practicum Experience

Having the opportunity to practice skills and apply concepts to real-life work settings will increase the likelihood that learning can be reinforced for students once they get into practice. Many urban health programs, regardless of specialty, provide some type of internship, field work, or practicums to provide students with hands-on experience working with underserved populations. These practical experiences are typically a result of partnerships with the community-based clinics, hospitals, and organizations that serve the urban community. Those who are exposed to urban health experiences during their health care training have an opportunity to appreciate the complexity of the urban community and can see firsthand how providers with urban health experience navigate disparities. Although this is best practice, it cannot be guaranteed that every student will, while in their health care program, have a specific opportunity to engage the underserved population, nor can faculty predict the quality of a student's exposure while in the program. It is because some students face such inconsistent exposure to urban health that this textbook was created. This textbook provides a forum where perspectives from both urban health providers and urban patients can be explored. Other approaches to studying urban health come from the pursuit of special courses, from certificates or degree programs that specifically focus on urban health, or from continuing education in urban health–related topics.

Internal Factors (The Learner)

In the previous section we discussed recruitment of urban health students, the need to hire faculty that have experience working in urban health, and approaches to reinforcing the textbook knowledge related to urban health. In addition to the external influences affecting urban health care education, there exist internal belief systems and biases that also unconsciously affect health care delivery.

The Super Helper: White Saviorism/White Savior Industrial Complex

Why did you choose your area of study (e.g., nursing, social work, medicine)? What motivates you to work with the urban community? Usually health care providers and students are quick to answer, "I want to help!" or "I want to make a difference." These responses definitely sound like the right answers, but what does "help" or "make a difference" really mean? Do you believe you have *all* the answers? Do you believe you know what is "best" for the communities you serve? Be careful not to buy into the "White saviorism/White savior industrial complex."

White saviorism is birthed from deeply imbedded social constructs which disguise egotism and elitism as philanthropic effort and self-less service. It allows for "privileged" health care workers, philanthropists, public health workers and the like to justify making decisions on behalf of the underserved, low-income individuals whom the government has deemed in need of help. Typically, this help is provided without listening to the wants or needs of the population being served. White saviorism is more about seeking "a big emotional experience that validates privilege" than about truly caring for the patient. It perpetuates the belief that poor, despairing individuals and communities are inherently helpless, illiterate, and weak and need saving. These belief systems are fueled by superficial and out-of-context statistics that highlight disparities in social determinants of health but neglect to examine and address the root cause of the disparities. In the case of health care, the White saviorism/White savior industrial complex concept centers around health care providers who use their status to impose a paternal, "I know best" undertone to the patient–provider relationship.

Do not be misled by the title "White saviorism" or "White savior industrial complex." The term *White savior*, is defined as any person or group—regardless of race—possessing an imbalance of power or privilege. The fact that you are pursuing higher education, that you may have come from a higher socioeconomic status than your patients, or that to be successful you may have overcome obstacles similar to those faced by your patient population might encourage feelings of power or privilege. What are the motives behind your service to the urban community? Are you seeking an experience that makes you feel better about yourself, or are you genuinely serving the underserved? Have your patients openly expressed their needs? What type of support have your patients or the community asked for? Are you, as the health care provider, giving the help your patients want, or are you operating from your own assumptions of what they need?

Implicit Bias

The negative evaluation of one group and its members in comparison to another is known as *bias*. Bias can be expressed directly (e.g., "People who smoke clearly don't care about their health, and I prefer to take care of nonsmokers"), or bias can be indirect (e.g., providing less pain medication to African American patients than you prescribe to Whites because you believe African Americans have a higher pain tolerance). Being aware of one's own evaluation of a group, believing that evaluation to be correct, and having the opportunity to act on the belief to deprive the group—this is known as *explicit bias* and is considered unacceptable in general society today.

Implicit bias occurs in a manner that is unintentional and unconscious. Implicit bias is activated by situational cues and influences memory, perception, and behavior. In health care, implicit biases can have severe effects on patient care. Unconscious biases can be triggered by a patient's characteristics, such as the patient's clothes, race, sexuality, socioeconomic status, first language, color of skin, and insurance status. These biases can influence how a health care provider perceives the patient and the kind of care that is delivered. Examples of how biases can affect health care include these:

- New research shows that African American patients in the United States receive lower doses of pain relief medications than do their White counterparts. Previous surveys of health care providers have shown that providers believe African Americans have higher pain tolerance. A recent study found that 90% of US primary care practitioners offer lower pain relief doses to African American patients.
- Physicians' attitude toward patients with disabilities affect the care that people with disabilities receive. When physicians were surveyed, more than 80% believed that people with significant disabilities have a worse quality of life than people without disabilities.
- As a result of long-standing negative perceptions and attitudes toward people who are obese, obese patients may experience poor interactions with their health care providers, leading to poor health outcomes and decreased patient satisfaction. Health care providers view obesity as a preventable risk factor and may blame the patient for having poor health habits that contribute to preventable diseases. This bias is a stigma that can affect the patient–provider relationship and may lead to obese patients feeling judged about their weight, reduce their efforts to lose weight, and increase their feelings of shame.

Because of the unintentional nature of implicit bias, self-reporting is unreliable. Sophisticated instruments have been developed to specifically assess for implicit bias. The tool that is most commonly used to assess for implicit bias is the Implicit Association Test (IAT). The IAT has been used in many studies and across numerous disciplines, including psychology, political science, and health, to assess for implicit bias. The IAT is a computer-based measure that assesses differences in response latency to reveal implicit bias. Examples of different IAT assessments can be found at https://implicit.harvard.edu.

Cultural Competence

The desire and ability to understand, interact with, and effectively communicate with people across cultures is commonly referred to as *cultural competence*. Cultural competence in health care requires providers to be able to deliver health care services that meet the social, cultural, and linguistic needs of their patients. To truly embrace cultural competence, individuals need to be aware of their own beliefs and cultural worldviews, assess their attitudes toward cultural differences, and be open to gaining knowledge about different cultures, their practices, and their lived experiences. Cultural competence is a skill, and just like any other skill it requires training and constant practice for proficiency.

The massive disparities in health care utilization, access, treatment, and outcomes have warranted investigation into the underlying causes related to these disparities. It is well documented in the literature that specific races and cultures have poorer experiences and worse outcomes as related to health and health care than do other groups. Efforts to improve the health care experience for patients of all races and cultural backgrounds have fueled increased awareness of cultural competence. You can find cultural competence being addressed in the training of many specialties that interact with individuals, families, and communities. Cultural competence has gained momentum over the years, and consequently content related to cultural competency can, to some degree, be found embedded in many educational programs that train health care providers. Unfortunately, given the great variability in how cultural competence is taught, lessons in cultural competence can vary greatly not only in teaching method but also in content. Cultural competence is not gained in one course or a 3-hour lecture. It is best to think of cultural competence as a continuous process that builds upon the health care provider's previous knowledge and experience in hopes of improving the quality of health care for all patients.

Developing Expertise in Providing Care in the Inner City

Patricia Benner, a well known nursing theorist, studied the differences in clinical judgment as it relates to experience. According to Benner (1982), some health care providers, even those who have years of experience working in various specialties and with various patient populations, find it distressing to enter into a new clinical situation that makes them feel like a novice again. The underlying premise of this textbook is that providers of urban health care, specifically health care in the inner city, require specialized training to circumvent some of the misconceptions and barriers that affect the patient–provider relationship in the inner city. Even using basic skills, such as applying evidence-based guidelines for a patient newly diagnosed with hypertension, for example—something that on the surface seems pretty straightforward—could feel awkward and potentially be unsuccessful when providers try to apply conventional health care standards to the despaired inner city patient population. Standard evidence-based health care recommendations rarely take into account the barriers that exist for individuals who lack access to resources such as fresh fruits and vegetables, consistent health care, or money for medications. Without the knowledge and resources to help patients navigate the health care barriers caused by social determinants of health, providers could experience feelings of helplessness and frustration as their efforts fail to have their intended impact on the health status of their patients. Benner (1982). goes on to explain five skill levels: novice, advanced beginner, competent, proficient, and expert. Providers transitioning between different clinical environments or clinical specialties tend to focus on their own ability to perform skills more than on the patient's situation, and they have a difficult time "thinking outside the box." To create a smooth transition into urban health and the care of inner city patients, Benner et al. argue, specific exposure during the clinical practicum would enable students to gain skills putting them at the level of advanced beginner before graduation. Features of diagnostic reasoning used in the various stages of expertise are applied to urban health. These features are summarized in Table 1.

Skill Level	Clinical Judgment
Novice	Lacks context, inflexible (i.e., regurgitation of evidence based guidelines without practical application to patient's situation)
Advanced Beginner	Sensitive to the patient situation, Has knowledge base, lack in-depth experience (i.e., Can draw correlations to the patient disparities and the impact on health, but lacks experience to navigate disparities)
Competent	More experience with specific patient population has led to confidence in abilities to identify patterns and nature of clinical situations, can align some resources to assist in goal attainment (i.e., Has identified resources to assist with common psychosocial barriers that are recurrent in their patient population)
Proficient	Has anticipatory thinking, sees "whole" patient situation, not just parts (i.e., Understands and anticipating patient's barriers related to social determinants of health and utilizes resources to minimize delay in care and facilitate health goals)
Expert	Transcends the rules, uses creative approaches taking into consideration patient situation to meet practice guidelines

Table 1. Skill Acquisition in the Inner City Provider (adapted from the Benner model, 1982)

Burnout and Self-Care

In professions that require us to constantly care for others (e.g., nursing, medicine, social work), rarely are we taught to care for ourselves. Currently health care providers are experiencing higher rates of burnout than seen in previous years. The rates of burnout among health care providers vary depending on the profession (nursing, social work, medicine, etc.) and the specialty (primary care, oncology, acute care, etc.); however, it is clear that burnout, especially among health professionals, has become one of the largest health concerns among health providers. *Burnout* is an occupational phenomenon defined as "a syndrome conceptualized as resulting from chronic workplace stress that has not been successfully managed. It is characterized by three dimensions, feelings of energy depletion or exhaustion; increased mental distance from one's job, or feelings of negativism or cynicism related to one's job; and reduced professional efficacy". Emotional exhaustion, depersonalization, feelings of inadequate performance, and decreased sense of personal accomplishment are classic symptoms of burnout syndrome.

Stress- and work-related burnout affects more than just the daily work lives of providers and their families; it takes a toll on their quality of life as well. Burnout contributes to high rates of depression, drug and alcohol use, posttraumatic stress disorder, and suicide among health care providers. Burnout also has a major impact on the quality of care that patients receive and on patient safety. Burnout has been associated with increased medical errors, incomplete documentation, malpractice suits, health care provider turnover, low patient satisfaction, and increased patient mortality. Causes of work-related stress and burnout for health care providers include increased patient loads, long hours, lack of support, and emotional strain from patient care. Health provider–related stress is compounded when you have to constantly navigate health care barriers and address disparities in social determinants of health for the underserved, low-income, chronically ill patient.

Many studies have provided guidance on ways to mitigate work-related stress and burnout. No single strategy can eliminate stress or burnout; however, there are techniques that have been proved to be effective in helping people navigate through times that are filled with immense stress and anxiety. Being aware of your stress level, setting boundaries, and practicing self-care are individual strategies that can help you deal with work-related burnout. It has also been made clear in the literature that individuals should not be held solely responsible for mitigating work-related burnout. Employers need to take some accountability for the well-being of their employees. To address the root cause of burnout, employers need to use organization- and system-level approaches to address their employees' work-related burnout.

Taking breaks from work, having an optimistic attitude, forming and utilizing support systems, getting rest, using your vacation time, and practicing self-care are just a few ways to minimize burnout on an individual level. On an organizational level, interventions to address burnout should include healthy working environments (e.g., improved communication, collaboration, appropriate staffing) and encouraging interprofessional, team-based care. It is up to health providers to apply pressure to organizations they work for to advocate for an environment that minimize stress and burnout.

EXEMPLAR: AFRICAN AMERICAN MEN AND THE HEALTH CARE PROVIDER

Wilfred M. Allen, PhD, RN, ANP-BC

African American men in the United States succumb to the leading causes of morbidity and mortality more than any other racial group. The life expectancy at birth in 2018 was recorded as 76.2 years for men of all origins; however, this figure is nearly 5 years lower for African American men. Comparatively, the life expectancy for White men at 76.2 and Latinx men at 79.1 surpasses the 71.3 life expectancy of African American men. Although researchers have acknowledged a variety of factors that contribute to the ethnic differences that affect health and longevity, chronic illnesses such as cardiovascular disease, diabetes, and cancer are more likely to result in mortality for African American men than for White men.

Although a variety of influential factors have been noted to affect health outcomes, experts have cited health behaviors as having a substantial influence. The actions individuals take to improve and maintain their health play a significant role in their morbidity and mortality. Since active engagement in self-care practices is important for the promotion of a healthy lifestyle and may decrease mortality rates, we need to consider factors that affect a person's engagement in self-care, particularly factors that pertain to African American men.

Self-care can be a challenging responsibility for individuals, especially those living in an urban environment. Although earlier research findings indicate that African American men often fail to seek help from medical professionals, follow treatment regimens, or practice a healthy lifestyle, that may be only part of the story for African American men living in an urban environment. To understand how to help improve the health and health outcomes of African American men, we must explore some of the underlying reasons that may contribute to deficiencies in self-care practices.

African American Men in America

Statements made by racially and ethnically diverse people worldwide over the past year have echoed what African Americans have known for more than 400 years: Black lives matter. However, the golden age for African Americans has never been realized in the United States. Too often the assumption is made that the Civil Rights Act of 1964, which prohibits discrimination on the basis of race, color, religion, sex, and national origin, has leveled the playing field for all. Unfortunately, that was not the case in 1964 and it is not the case today, particularly for African American men.

Research that intersects race and gender in the United States shows that higher levels of education and income reduce the risk of discrimination for both male and female Whites and African American women, but this does not hold true for African American men. Further studies suggest that African American men are more than likely to be labeled as dangerous, threatening, and worse, yet they are also labeled as inferior. According to a study by Curry (2017), African American men experience racism, extreme levels of dehumanization, and violence. The most recent example of this is the aggressive (violent) and dehumanizing interaction between a police officer—an authority figure—and George Floyd that resulted in George Floyd's death. This is not to say that all authority figures participate in egregious behavior when interacting with men in racially and ethnically diverse communities; however, this incident heightens our awareness of what the possibilities are.

Given such awareness, African American boys growing up in America, particularly those in urban environments, receive "the talk." A common and necessary conversation that takes place in African American homes across the country, "the talk" is an ongoing conversation that parents, grandparents, uncles, and aunts have with African American children. Children are taught about the history of African Americans from their origins in Africa, the forced and difficult journey to America, and the treatment of African Americans throughout the years in America. They also learn about the long-term racial discrimination and abuse African Americans have endured, a history that has had a profound effect on the worldview of African Americans.

Cultural lessons within African American households include ways to respond to authority figures, especially law enforcement, and how to handle confrontations with other ethnic groups. Also among these lessons is discussion of the trust factor: how much to trust medical professionals, remembering historical events and the possibilities of their recurrences (e.g., mental and physical abuse by non–African American authority figures, the Tuskegee Study, misdiagnosis of health conditions, undertreatment or nontreatment of treatable illnesses). This is the type of information that should be considered and further explored by non–African Americans before, during, and after interactions. Understanding the history and the state of current affairs that pertain to African Americans will help health care providers to have more positive and productive interactions with African Americans.

Health care providers, in particular, should have some knowledge of the history and current challenges that patients of diverse ethnic groups face. Without such knowledge, it is easy for providers to project their own values, expectations, and worldviews on others. When this happens, there's a potential for misperceiving intentions, lines of communication may become fragmented, and attitudes may become resistant.

Closing the Communication Gap in Health Care

Effective communication is one of the most important components in any relationship. Communication is what enables us to exchange information with others and understand what others are saying. Although verbal communication is what is most commonly thought of when two or more people interact, communication can also be nonverbal: Think of gestures, tone and pitch of voice, and posture. Being able to clearly communicate accurate information as intended to diverse individuals can be challenging for some. Poorly communicated verbal and nonverbal messages can ruin current relationships and inhibit new relationships from being formed. This can be particularly true in health care interactions, where relationships between medical professionals and those seeking medical care and advice are paramount. Health care providers who understand that each individual is unique and who can recognize individual differences will have the ability to generate the strong lines of communication needed to establish trusting relationships. Unfortunately, not all health care providers invest time in learning about the basic beliefs and experiences of the diverse population with whom they work. Providers must do so to develop an understanding of the people they serve. Without this basic understanding, health care providers can unintentionally contribute to prejudice and discrimination that negatively affect the professional relationship and, ultimately, the health and health outcomes of the individuals seeking help from the health care provider. Prejudice and discrimination has been an ongoing concern among African Americans, especially African American men, as it pertains to their medical care and treatment and health outcomes.

African Americans have experienced a long history of medical mistreatment that ranges from egregious experiments to forced sterilizations and even to the infamous Tuskegee Study that withheld treatment from African American men for decades. So, it is not surprising that African American men lack trust in their health care provider and the health care systems that employ them. Studies have shown that the mistrust in health care providers is not related just to the long history of mistreatment; it has a lot to do with the ongoing discrimination in health care from the inequities in access to facilities and treatment to the interactions with providers when treatment is accessible. The lack of trust in the health care system and its providers has discouraged many individuals from seeking health care or following the recommendations offered to improve and maintain their health. As a result, African Americans who suffer from treatable chronic illness have been labeled as noncompliant and blamed for their poor health outcomes when they are resistant to seeking health care or fail to follow through with follow-up care after an acute incident.

Understanding Diversity and Building Trust

How should the problem of health care mistrust among African American men be addressed? The first step is for health care providers to perform a self-assessment to gain insight into their basic knowledge and understanding of diverse populations. Having a basic knowledge and understanding of the beliefs and experiences of various ethnic groups can enhance relationship building and trust. Gaining cultural competence through an appreciation for cultural differences can be the game changer needed to bridge the gap between African American men, their health care providers, and health outcomes.

After you gain fundamental cultural competence, the next step toward building trust is to develop and establish clear, accurate, and respectful lines of communication. The words you choose to communicate with your patient can be the defining factor that makes or breaks the relationship. For example, a health care provider is communicating with an African American man who says that he has not taken the COVID-19 vaccine. The provider responds by telling the man that he needs to get the vaccine and that he is putting the public at risk by being unvaccinated. This response by the provider can be interpreted as “You need to do what I say, I’m the educated one here.” This response insinuates that the patient is not educated enough to make decisions regarding his own health and that because of his choice, he is putting society at risk. The more appropriate response is to ask the patient why he was not getting the vaccine. In addition, the provider could offer information regarding COVID-19 vaccines while leaving lines of communication open for questions.

In an important last step, health care providers can facilitate positive relationships by becoming aware of their nonverbal messages. The gestures, facial expressions, body language, tone of voice, and even appearance of the health care provider can contribute to relationship building. Direct eye contact, listening with an attentive posture, and taking notes at well-timed intervals demonstrate focused engagement in the moment.

Implications

The willingness of health care providers to acknowledge, respect, and appreciate culturally diverse populations is a step in the right direction to gaining the trust of not only African American men but all diverse populations. Ultimately, the goal is to establish trusting professional relationships between health care providers and people of all racial and ethnic groups. In addition, increasing the trust in health care providers has the potential to significantly improve rates of compliance with self-care practices, medical treatment regimens, and health outcomes among African American men.

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LEARNING ACTIVITIES

1. Medically Underserved Area/Population (MUA/P)

Visit https://data.hrsa.gov/tools/shortage-area/mua-find to examine the Index of Medical Underservice (IMU). The IMU score is used to rank MUA/Ps. The lowest score (highest need) is 0; the highest score (lowest need) is 100. To qualify as an MUA/P per HRSA standards, an area needs to have a score less than or equal to 62. Explore MUA/Ps in your area: where you live, where you are going to school, or where you plan to practice.

2. **Health Care Provider Shortage Area (HPSA)**

Explore HPSAs near you: https://data.hrsa.gov/tools/shortage-area/hpsa-find to assess for the number of urban (nonrural) HSPAs in your state. Pay close attention to the number of primary care, mental health, and dental health sites with the greatest need (highest HPSA score).

3. **Area Health Education Center (AHEC)**

Locate the AHEC near you by visiting https://www.nationalahec.org/ and then explore the AHEC program in your area. Examine the resources that your local AHEC provides for its participants, identify key partnerships leveraged by the local AHEC, and locate the communities that benefit from your local AHEC.

4. **National Health Service Corps (NHSC)**

Visit the NHSC website at https://nhsc.hrsa.gov/ and then explore the requirements and incentives for the scholarship and loan repayment programs. These programs have had success in recruiting providers to underserved areas. What more can be done to retain providers in these underserved areas?

5. **White Saviorism**

Watch *The White Savior Trope, Explained* at https://www.youtube.com/watch?v=w1vuhrFfEkE to consider how White saviorism has been depicted in many facets of life, among them health care, movies, and philanthropy. After watching the YouTube video, which is focused on the White saviorism depicted in film, expand this example of White saviorism to discuss how it negatively affects urban health care.

6. **Implicit Bias**

Visit Project Implicit at https://implicit.harvard.edu/implicit/takeatouchtest.html to access your personal biases. Select up to five assessment categories (e.g., Asian IAT, Race IAT, Gender IAT). What did you think about the results? Were they what you expected? How could your results affect the health care you deliver? What can you do to be more conscious of your biases, and how can you limit bias from affecting care?

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CHAPTER 3. SOCIAL DETERMINANTS OF HEALTH IN URBAN COMMUNITIES

INTRODUCTION

For many low-income, urban individuals, health disparities are inherited from generation to generation. Financial barriers, poor health habits, intergenerational poverty, and normalization of risky behaviors such as substance abuse and poor eating habits are often ingrained in communities within urban environments and are fueled by disparities related to social determinants of health (SDOH). This chapter discusses the impact of education, economics, environment, access to care, and social factors on health outcomes for individuals and families living in the inner city. This chapter will also highlight specific health care barriers that are present in urban environments and provide insight into how a health care provider can provide holistic care taking into consideration barriers that disadvantaged communities are faced with.

LEARNING OBJECTIVES

1. Understand the collective impact of social determinants of health (SDOH) in the urban community
2. Develop an understanding of how education affects health
3. Discuss disparities in economics and the impact on health
4. Develop an understanding of how environment affects health
5. Describe lack of access to care for urban communities and discuss the impact on health
6. Explain how social context in urban communities affects health
7. Consider how social determinants influence how urban health care providers approach their patients

Social determinants of health are commonly defined as “the environment where people are born, live, learn, work, play, worship and age that affect a wide range of health functioning and quality of life outcomes and risks.” They are powerful social factors that occur in clusters that reciprocally interact with one another to influence the health and well-being of individuals and populations. Common SDOH are represented across five domains: (1) Education Access and Quality, (2) Economic Stability, (3) Neighborhood and Built Environment, (4) Health Care Access and Quality, and (5) Social and Community Context. These social determinants contribute significantly to the ongoing burden of health disparities most often experienced by those who live in poverty, are poorly educated, and have inadequate access to quality health care. Populations that overwhelmingly experience health disparities are minorities, with a predominance among urban-dwelling African Americans and Latinxs. Geographically health disparities often occur in impoverished urban environments but can occur in rural environments as well.

Initiated in 1979 and updated every decade starting in 1980, the “Healthy People” initiative releases quantifiable, data-driven objectives to facilitate national health promotion and disease prevention targets for the United States. An overarching goal of Healthy People 2030 is to reduce negative SDOH as a part of a national approach to improve population health across vulnerable communities such as those individuals who live in urban environments. This is a hearty goal considering that the Healthy People 2020 objectives were rarely met across low-income minority populations and especially in African American populations, where only 5 out of 24 objectives were met. In this chapter we explore some of the challenges that urban communities face related to SDOH, highlighting the five domains outlined in the Healthy People 2030 initiative.

EDUCATION ACCESS AND QUALITY

Individuals are exposed to educational systems early in childhood, and despite the fact that this textbook is focused on the lived experience of adults in the inner city, we would be remiss not to acknowledge that early childhood education and development sets the path for educational attainment throughout adulthood. Furthermore, future generations are exposed to the cyclic disparity of poor-quality education as products of despaired communities with lower quality educational systems raise children of their own in the same despaired community with lower quality and less access to education.

In the United States education is considered as the great equalizer that allows individuals in poverty to gain economic stability and a healthy and long life. Yet, the US educational system in has been labeled as "one of the most unequal in the industrialized world" as a result of disparate opportunities resulting from socioeconomic status. Basic K–12 education begins at a young age, and youth who demonstrate poor performance in cognitive and noncognitive skills when entering school rarely catch up (Garcia, E. and Weiss, E., 2017). These findings have implications at the individual and societal level. Individuals with low educational achievement are (1) likely to work in jobs that provide low wages and less stable income and health insurance, (2) less likely to gain social mobility later in life, and (3) more likely to live with unmet personal and health-related needs compared to persons with greater educational achievement

Across the country urban impoverished school settings repeatedly fail to provide students with an environment conducive to obtaining a constitutionally guaranteed basic education. Recently a landmark ruling was made in favor of students who attended Detroit Public Schools. The lawsuit brought by students from five Detroit schools alleged that a lack of basic educational resources such as textbooks, teachers, working bathrooms, and heating and cooling systems contributed to their inability to learn. Students also reported that infestations of insects and rodents in classrooms as commonplace. These findings placed healthy students and those with chronic diseases such as asthma at risk for exacerbations and missed school days. Even students who had no known health problems experienced ill effects of the environment such as fainting on days when the temperature in the buildings was extremely high because of a lack of a working cooling system. Unfortunately, these types of complaints are consistently voiced by students and parents who have encountered the public school system in the inner city communities.

Finding teachers credentialed to teach classes such as math and science in urban, high-poverty schools can be difficult. Despite the contribution of these subjects to a student's competitiveness on standardized college entrance exams and future STEM career options, high-poverty schools often fail to adequately educate students in math and science. Schools in urban environments such as Detroit's often find that they are unable to hire and/or retain an adequate number of teachers. Being short staffed has implications in the daily function of a school in that teacher absences or temporary leaves (e.g., maternity leave) further compromise student learning, as replacements are not found easily. In response to teacher shortages, students have sometimes been asked to fill this void. In one situation, for example, a student who was performing above average in math was designated to teach this subject for both seventh- and eighth-grade peers for a significant portion of the academic school year. When there are insufficient substitutes and more than one teacher is absent, students in Detroit reported being corralled into large rooms such as gymnasiums and left unsupervised to watch animated children's movies such as *Frozen*. The challenges students reported in Detroit public schools have been theorized using stress and coping theories. Using this model, the inadequacies of the school system undermine student performance on tasks that require concentration and motivation and instead contribute to learning disengagement.

High Poverty and Education

A large majority of African American students living in the inner city rely on the public school system for their educational needs. Given such factors as poverty and racial, residential, and economic segregation, in addition to inadequate allocation of financial resources and poor environmental conditions, minority students attending public inner city schools have many barriers to success. In 2020, the National Center for Education Statistics published a report entitled *Condition of Education 2020* with the intent of providing data on the educational progress of all students, prekindergarten through postsecondary education, to help monitor student progress and guide policy. Sadly, this report highlighted multiple educational disparities disproportionately affecting African American students. Of the 50.7 million students enrolled in either public elementary or secondary schools, 7.7 million were African American. Considering the high percentage of African Americans located in urban areas and inner cities and dependent on the public school system, the fact that 45% of African American students attended high-poverty schools when compared to 8% of White students is concerning. Poverty rates remain the highest among African American students, and in 2018, nearly 32% of African American students lived in poverty and 64% of them have parents with less than a high school education. As discussed earlier in the text, poverty affects every aspect of an individual's life, and education is no exception. Think about this: In 2020, in the midst of a global pandemic, the already despaired public school system had to pivot to virtual instruction, thereby compounding the aforementioned multitude of disparities with the traditional public school structure. However, lack of Internet access at home was noted as a huge barrier to learning for African American students in 2018. Ninety percent of African American students had internet access (compared to 98% of Asian and 96% of White), and 11% reported their smartphones were their only access to home internet. The cost of internet for families that are struggling financially is a barrier, and 39% of African American students without home internet access stated that internet was too expensive, indicating that the cost of internet service would have been a financial strain for their families. Furthermore, having internet access does not mean that other necessary components for virtual learning are available. A computer or similar device is needed to fully engage in virtual learning activities, and potentially multiple computers are needed if more than one child and/or a working parent who needs computer access are in the same household. In 2018, roughly 10% of US children ages 5 to 17 did not have a computer (desktop, laptop, or tablet) at home, and more than one third of African American and Latinx children lacked computers or had free internet at home. These are just some examples of how having low income affects access to education. Considering these and other barriers to education for inner city minority students, it is not surprising that there exists a significant and persistent disparity in academic performance between different racial groups of students, otherwise known as an *achievement gap*. The achievement gap between African American students and White students becomes even clearer when we consider that two thirds of all fourth-graders scored below proficient level in reading and two thirds of eighth-graders scored below proficient level in math. When we break these data down by racial and ethnic groups, there is higher disparity seen in minority groups with high levels of poverty who receive Supplemental Nutrition Assistance Program benefits (i.e., food stamps). Among African American and American Indian/Alaska Native students, at least 80% of fourth-graders scored below proficient reading level and 85% or more eighth-graders scored below the proficient level in math. These achievement gaps in reading and math are just a snapshot of the larger, long-term cumulative disparity that ignites concerns for the future and the capability of today's children to have the basic reading and math skills necessary to become productive adults in a globally competitive society.

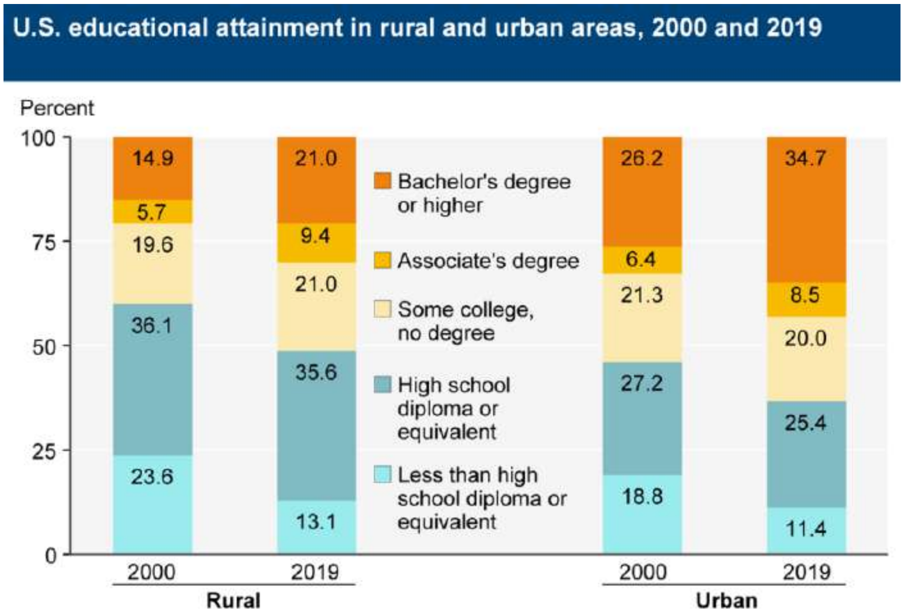
We have discussed disparities in early education for urban, inner city minorities that present barriers for educational attainment. High school graduation is another educational benchmark that further highlights disparities among minority students. The high school dropout rate nationally for African American students is 6.4% compared to White students at 4.2%. As we look closer at state data, in Michigan that high school dropout rate is higher than the national average at 8.36%, with Detroit having a 75.84% graduation rate in 2019. Furthermore, 20% of African American young adults aged 18 to 24 were neither enrolled in school nor working, a rate much higher than the national average of 14%.

Millions of families living in urban communities rely on the public school system to help position their children for success. The disparities that exist, especially for low-income urban communities, are strongly influenced by social determinants.

Educational Attainment

Identifying educational attainment (the highest level of education completed) as one of the major outcomes associated with social determinants of health speaks volumes to the importance of quality education during the formative years. Arguably, the level of educational attainment is a social determinant of future employability, economic stability, access to health care benefits, and neighborhoods that are safe and resource rich. Higher educational attainment exposes individuals to more employment opportunities, but it can also positively affect the ability of individuals to make better decisions regarding their health and the health of their families. In today's society, completion of postsecondary education, which includes graduating from universities and colleges, as well as trade and vocational schools, is quickly becoming the minimum requirement to obtain employment opportunities that could position an individual for personal, economic, and social capital needed to facilitate a healthy lifestyle. According to the US Department of Commerce (2021), the proportion of urban adults 25 and over who had completed some form of postsecondary education (associate’s or bachelor's degree) was 43.2% in 2019. This leaves over 50% of the urban population with some college but no degree (20%), a high school diploma or its equivalent (25.4%), or less than a high school diploma (11.4%) (Figure 1).

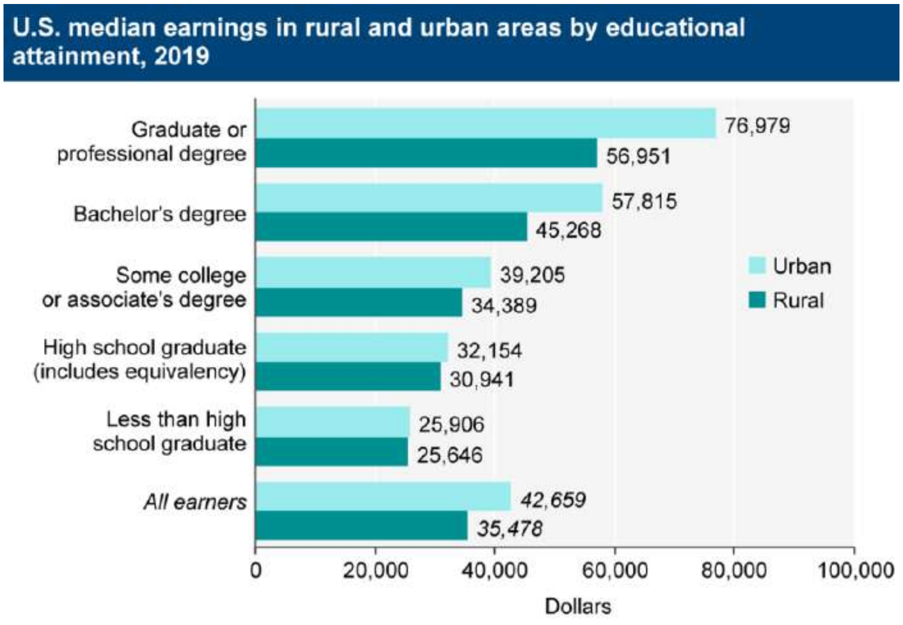
As stated earlier, education affects earning potential, and in Figure 2, we can clearly see how higher education is associated with higher earnings. In 2019 the median earned income for urban working adults with a high school diploma was $32,154, which was $6,248 more than the median earnings for urban working adults without a high school diploma or equivalent.



Note: Educational attainment for adults 25 and older. Urban and rural status is determined by Office of Management and Budget's 2018 metropolitan area definitions.
Source: USDA, Economic Research Service using data from U.S. Department of Commerce, Bureau of the Census, Census 2000 and 2019 American Community Survey.

Source: Economic Research Service, US Department of Agriculture, https://www.ers.usda.gov/topics/rural-economy-population/employment-education/rural-education.

Figure 1. U.S. educational attainment in rural and urban areas, 2000 and 2019 (Farrigan, 2021).



Note: Median earnings in 2019 dollars for all earners 25 and older. Urban and rural status is determined by Office of Management and Budget's 2018 metropolitan area definitions.
Source: USDA, Economic Research Service using data from the U.S. Department of Commerce, Bureau of the Census, 2019 American Community Survey.

Source: Economic Research Service, US Department of Agriculture, https://www.ers.usda.gov/topics/rural-economy-population/employment-education/rural-education.

Figure 2. U.S. median earnings in rural and urban areas by educational attainment, 2019 (Farrigan, 2021).

Literacy

The capacity to obtain, process, and understand basic health information is referred to as *health literacy*. The overall capability to read and comprehend (literacy) has been linked to disparities in health; however, individuals with high overall literacy may still have low health literacy if they do not understand the medical information regarding their health. Health literacy is integral for individuals to engage with health professionals and to make informed and appropriate health decisions. Whether it is reading discharge instructions, comprehending information provided by the health care provider, or understanding prescription directions and dosage, the basic ability to read, write, and comprehend are fundamental skills that contribute to how well and how safely patients can participate in their own health care. Health literacy is affected by numerous factors, including poverty, education, race, age, and disability. As discussed earlier, disparities in the educational system can impede an individual's ability to gain adequate literacy skills early in life, which in turn creates barriers in the individual's adult life. A national study found that low health literacy characterized almost half of adults who did not graduate from high school. Adults living below the poverty level, uninsured adults, and those with state insurance, such as Medicaid, are at high risk for having low literacy. As with other social determinants, disparities related to health literacy disproportionately characterize minorities. According to the National Assessment of Adult Literacy, Latinx and African Americans have the lowest average health literacy scores of all racial and ethnic group.

Impact of Education on Health

Education and health are embedded throughout the life span and across generations. Shorter life expectancy, worse health outcomes, more risk factors, and greater disability have been associated with lower educational status. The life expectancy gap between the most and least educated individuals is approximately 14 years for males and 10 years for females. Since the 1960s this life expectancy gap between the most and least educated has continued to widen. Major diseases such as diabetes and heart disease are more likely to occur in people with less education. According to the Centers for Disease Control and Prevention (2020), 13.3% of adults with less than a high school education had been diagnosed with diabetes versus 9.7% of those with a high school education and 7.5% of those with more than a high school education.

The skills needed to make informed health care decisions and to navigate the complexities of the health system are heavily reliant on an individual's literacy, numeracy, and technology capabilities. The complexities in the health care system and the need to comprehend essential health-related materials demand that individuals have a clear understanding of the information received and how it will affect their health. Providing patients with information they cannot comprehend is ineffective and has been linked to poor health outcomes. Furthermore, some patients may have a high level of verbal fluency that could mask their inability to understand health-related information. Patients with low health literacy tend to use emergency departments more often and have frequent readmissions, have difficulty complying with treatment regimens, and decrease compliance with appropriate medication usage. Older adults with low health literacy receiving Medicare benefits were found to have increased ER visits and hospitalization, higher medical cost, and decreased access to care.

Urban Provider Considerations: Education

Disparities in the urban educational system have been well documented to have long-lasting impacts on individuals throughout their lifetime. Poor education affects many other aspects of SDOH and impedes opportunities related to economics and health. Health care communication is essential to the patient–provider relationship, and acknowledging that disparities exist related to literacy, numeracy, and technology usage is the first step to improving health care communication.

Effective patient–provider communication is a key component to reaching desired health outcomes. To reduce disparities in health outcomes related to low health literacy, providers should assume all patients and caregivers may have difficulty understanding health information and should make a habit of communicating in a way that everyone will understand. Simplifying communication, confirming comprehension for all patients, incorporating "teach back" methods to ensure information is understood, making the health care system easier to navigate, utilizing infographics and empowering patients to ask questions, these are just a few suggestions to minimize the risk of health care miscommunication.

ECONOMIC DISPARITIES IN URBAN COMMUNITIES

Social determinants of health include economic stability, which concerns the association between a patient's financial income and its impacts on the patient’s health. Economic stability encompasses an analysis of income, employment, food security, and housing stability and examines how these factors affect health. A primary goal for Healthy People 2030 is for people to have adequate income to meet their health needs.

Poverty

Poverty is defined as the income level of an individual or family that is too low to consistently meet basic human needs such as food and shelter. According to the US Census Bureau (2020), “When a family’s threshold exceeds the total amount of income, then that family and every member of that family is in poverty.” In 2019 there were 34 million people in the United States living below the federal poverty level. *Federal poverty level* is defined as the minimal annual income used to pay for essentials (housing, transportation, and clothing), and under this definition a family of four has an average annual income of $26,000. The federal poverty level is used to determine benefit eligibility for many assistance programs. The poverty rate for African Americans in 2019 was 18.8% compared to non-Latinx Whites 7.3%. To put this into greater perspective, African Americans constitute 13.8% of the population yet experience almost twice the rate of poverty in the United States. This statistic alone causes the health provider a challenge in helping African Americans who live in poverty to meet optimal health outcomes and does not take into consideration factors that exacerbate chronic illnesses such as (a) toxic housing units infested with mold, rodents, and or insects; (b) unsafe neighborhoods that are prohibitive to outdoor exercise; (c) food deserts, where communities lack access to fresh nutritious food options; and (d) lack of reliable, timely public transportation. Living near or below the poverty line can also contribute to mental and emotional instability, chronic stress, and the development or exacerbation of chronic illnesses. (see Chapter 5, Mental Health Disparities in Urban Communities.)

Deep Poverty

As if living in poverty were not distressing enough, in 2018 the US Census Bureau estimated that over 17 million people lived in "deep poverty." *Deep poverty* is defined as a household with a total cash income below 50% of the property threshold. In 2018, individuals living in deep poverty represented 5.8% of all Americans and accounted for 45.4% of those individuals in poverty. Minorities were more likely to live in deep poverty, with African Americans having a 10.8% poverty rate and Latinxs having a 7.8% poverty rate. In contrast, Whites were less likely to live in deep poverty, with poverty rates of 4.1%. Deep poverty in and of itself is a chronic situation that persists through generations, creating a cycle of despair from which most individuals never recover.

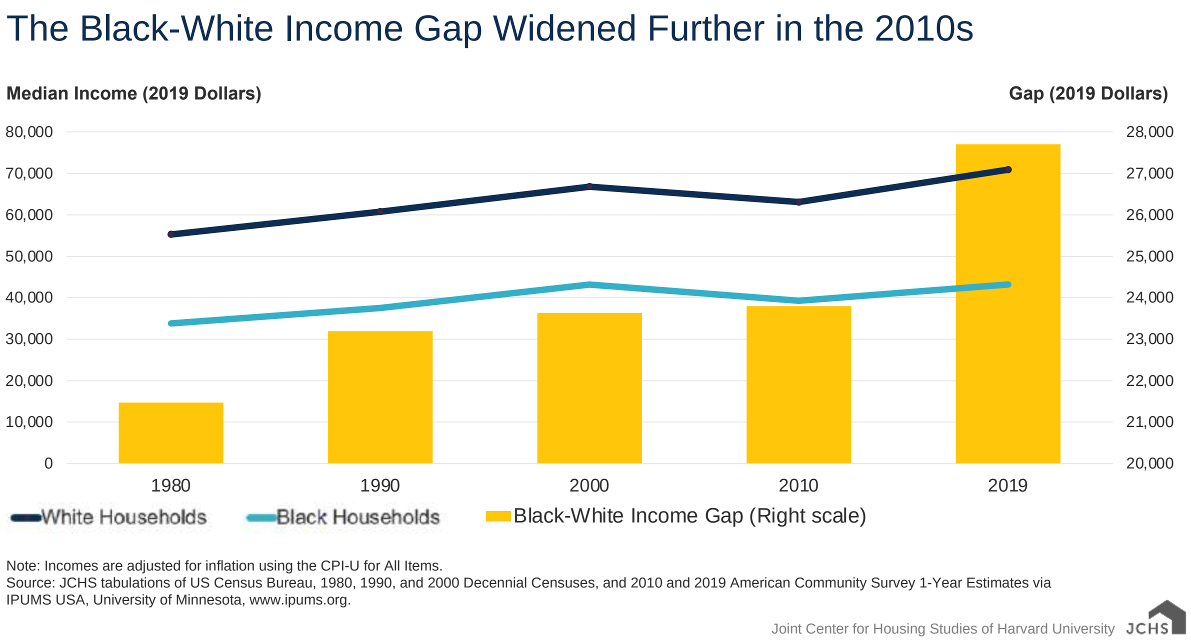
Brady and Parolin (2020) examined the levels and trends of deep poverty in the United States, spanning 1993 to 2016, using the leading standards in international income research, improved measurement tools, and high-quality data sets. Brady and Parolin concluded that deep poverty in the United States has increased in recent decades as high as 93%. The researchers also highlighted that deep and extreme poverty were concentrated in households without children. As a result of the expansion of state benefits such as food assistance for households with children, there has been a decline of deep and extreme poverty within child-rearing households.

Living Wage and the Working Poor

Living wage is the income needed for economic sufficiency, basically allowing individuals to meet their basic needs and the needs of their family. The living wage calculation takes into consideration the cost of living in relation to the earned income of individuals and families. Food, childcare, taxes, medical expenses, and transportation are some of the components included in the living wage estimates. A resource available to help you understand the living wage amounts for different cities in the United States can be found using the living wage calculator (http://www.livingwage.mit.edu). For example, using the living wage calculator, the living wage for Wayne County, Michigan, for one adult with no children is $13.78. This means that singles individuals with no children will need to make $13.78 an hour in order to support themselves while living in Wayne County, Michigan, whereas one adult with one child will need to make $32.87 per hour. Keep in mind that in 2021, the Michigan minimum wage was still $9.65, remaining the same as 2020, and that unemployment rates for 2020 exceeded 8.5%. It is clear that at minimum wage, individuals would be unable to meet their basic needs and would fall below the living wage. Tragically, families constantly struggle to earn enough money to afford housing, food, health care, and other basic necessities. Imagine working over 40-plus hours per week yet still being unable to provide necessities for yourself and/ your family on a continuous basis. We are talking about necessities such as food, water, medicine, and shelter and have not even considered emergency funds or saving money. Close to 30% of the population (96.3 million) live very close to poverty levels with incomes less than twice the poverty thresholds. These individuals can face substantial financial setbacks and easily fall into the poverty cycle if they encounter any type of financial distress such as a change in income or unforeseen expenses such as medical bills or car repair.

Income Inequality/Income Gap

With a disproportionate number of minorities residing in the inner city and those who are suffering from poverty concentrated in urban environments, the racial inequities related to income are more alarming. There has been a worsening of income inequality among African American households, especially when compared to White households. The median income for African American households was $43,200 compared to $70,900 median for White households. The median income for African Americans was roughly 60% of that of their White counterparts. Even when one compares African American households to other minority households such as those of Latinxs, Asians, and other races and ethnicities, the median income for African Americans remained significantly lower. Latinxs, Asians, and other races and ethnicities had higher median incomes of $55,000, $93,000, and $57,300, respectively—incomes significantly higher than the African American median income of $43,200 in 2019. When looking at the median income by race, we can clearly see that the income gap for African American households is wider now than it has been in decades (Figure 3).



Note: Incomes are adjusted for inflation using the CPI-U for All Items.
Source: JCHS tabulations of US Census Bureau, 1980, 1990, and 2000 Decennial Censuses, and 2010 and 2019 American Community Survey 1-Year Estimates via IPUMS USA, University of Minnesota, www.ipums.org.

Source: Harvard Joint Center for Housing Studies, The State of the Nation's Housing 2020, www.jchs.harvard.edu. All rights reserved.

Figure 3. The Black-White Income Gap Widened Further in the 2010s

Employment

The lack of high-paying jobs and sustainable businesses in inner cities not only contributes to the cycle of poverty seen in the inner cities but also serves to fuel social issues such as drug abuse and crime. The employment opportunities available for poorly educated and low-skilled individuals in the inner city typically offer inadequate wages, provide minimal benefits if any, and are stagnant positions offering no real advancement. Ironically, many "essential workers"—food service works, bus drivers, janitorial staff, certified nursing assistants, truck drivers, grocery store employees, and the like—are individuals usually considered low income and living in the inner city. Of the approximate 34 million people living below the official poverty level, close to 7 million individuals are considered the working poor. People who spend at least 27 weeks in the labor force either working or looking for work but whose income still falls below the official poverty level are considered the working poor. These individuals typically live paycheck to paycheck, and any slight miscalculation or unexpected expense can propel these individuals into deeper poverty. To make a living wage, many individuals travel outside the city, but this venture is often complicated by disparities in SDOH such as lack of transportation, childcare issues, and extended commute times.

In urban settings, specifically in areas of extreme poverty, high levels of joblessness exist. Low skills among potential workers, poor infrastructure, racial discrimination in hiring, and crime are just a few of the challenges that present barriers related to employment for urban communities. Extremely impoverished neighborhoods are also more likely to have low education levels, which are associated with low levels of employment and low wages. Jobs that require low skill levels are typically those that are more physically laborious, entailing long hours and hazardous conditions and requiring a lot of physical manipulation, among other difficulties.

Food Insecurity

Another disparity related to economic instability is food insecurity. Food insecurity involves many interconnected facets that make it a complex issue for patients. *Food insecurity* is defined as interruption of food consumption or eating patterns because of reduced financial resources or support systems, which can be temporary or lifelong. The US Department of Agriculture defines the ranges of food security and insecurity:

High food security: no reported indications of food-access problems or limitations.

Marginal food security: one or two reported indications—typically of anxiety over food sufficiency or shortage of food in the house. Little or no indication of changes in diets or food intake.

Low food security: reports of reduced quality, variety, or desirability of diet. Little or no indication of reduced food intake.

Very low food security: reports of multiple indications of disrupted eating patterns and reduced food intake.

Food insecurity can be caused by many things, such as limited income, unemployment, disability from a chronic disease or work injury, race or ethnicity, and single-parent household, as well as two-parent households with children. The greatest cause for food insecurity is limited finances. The rate of food insecurity in the United States makes up 10.5% of the population. However, the rate of food insecurity affecting African Americans is double at 19.1% compared to non-Latinx Whites at 7.3%. Most people who experience food insecurity live in urban areas (4.9%) and rural environments (4.6%). Food insecurities can cause increased rates of depression and anxiety, iron deficiencies, insomnia, and high rates of obesity, diabetes, and hypertension, all of which can lead to chronic disease and poor health outcomes. Food insecurities exacerbate chronic illnesses, making them more difficult to manage because food becomes the primary focus and takes precedence over spending money on prescriptions to manage the comorbidities or spending copays to see the primary care provider. Food insecurities also contribute to the selection of poor choices and the availability of food high in salt, sugar, and fat, which contribute to generations of chronic disease and poor health.

The reality is that eating healthily is costly and when income is sparse competes with local fast-food establishments offering low-cost meals that are not nutritionally dense. Minimum income forces low-income patients to contemplate how to use their resources—whether to buy food or pay bills and rent or to allocate funds for health care needs or transportation. Patients' agonizing over this type of decision is yet another barrier to your plan of care for optimal patient outcomes. What good is it to prescribe antiglycemic or antihypertensive medications when your patient is forced to purchase the $3 combo meal versus the $10 salad? As a health care provider assessing the types of food your patient can access, consider how close to grocery stores your patients live, as well as your patients' ability to afford their groceries. Doing this will help you in developing a treatment plan for your patients.

Knowing the following best practice interventions will help you as an urban health care provider to improve the health of urban populations. Start by conducting a food and security screening to identify hunger as a health need. The Food Research and Action Center offers numerous screening tools that can easily be incorporated as part of the patient assessment (https://frac.org/screen-intervene). However, screening for food insecurity is not enough. A second intervention would involve developing a database of community resources to provide for your patients once they are identified with having food insecurity. A third intervention is providing patients with referrals for support groups. Fourth, inquire about any potential barriers regarding housing and transportation. Last, remember that food has not only a nutritional component to it but also a cultural and religious aspect to it, so be sure to address all religious and cultural barriers.

Housing Insecurity

Traditionally, when we think of homelessness, we envision an individual living on the streets, disheveled, lacking shelter, with the inability to afford basic needs. Commonly, this vision of homelessness is associated with an individual asking for help at the local gas station or on the street corner. As a health care provider, it is important for you to understand that there are multiple levels to housing instability, with chronic homelessness being the most extreme situation.

The disparities related to housing stability can include individuals who may have a "home" but are burdened with a high housing cost—meaning that they are spending a large share of their income on housing—and extend to situations in which individuals experience a complete lack of shelter, also known as homelessness. Even the term *homelessness* in the sense of lacking shelter is in itself a transient state, and there can be individuals who experience episodic homelessness or chronic homelessness.

In the literature, housing insecurity is described in a variety of different extremes. *Housing insecurity* can be defined by many terms: housing cost burden, residential instability, multiple moves, evictions, constantly having to live with others (family or friends), and living in overcrowded, substandard conditions.

Urban Unaffordability

As discussed earlier, disparities in economic stability place limits on the available resources accessible to individuals. Housing is a basic necessity that millions of families struggle to afford. Decent homes in suitable living environments for all individuals was the goal established in the mid-20th century with the Housing Act of 1949. However, to date the nation has not even come close to meeting the objectives of the Housing Act, and millions of Americans still lack decent homes and/or suitable living environments. Low-income individuals spend large proportions of their income on housing and struggle to stay afloat. The US Department of Housing and Urban Development has defined households paying more than 30% of their income on living expenses as having a *housing cost burden*. Individuals paying 30% to 50% of their income on housing are considered as having a *moderate cost burden*, and households where the housing costs exceeds 50% of the income is considered to have a *severe cost burden*. As the cost of living increases and individuals have to decide on prioritizing resources, other necessities such as food and medications are sometimes neglected. In 2019 over 37 million households were designated as "housing costs burdened," and 17.6 million of them had a "severe cost burden." Despite the clear disparity related to housing cost burden, federal funding is being diverted away from this issue (Figure 4).

In theory, households with very low income would be eligible for federal rent subsidies, but these subsidies are not guaranteed. Housing subsidies are usually awarded on a first come, first served basis, and these initiatives are extremely underfunded, with three out of every four very low-income households unable to obtain housing benefits.

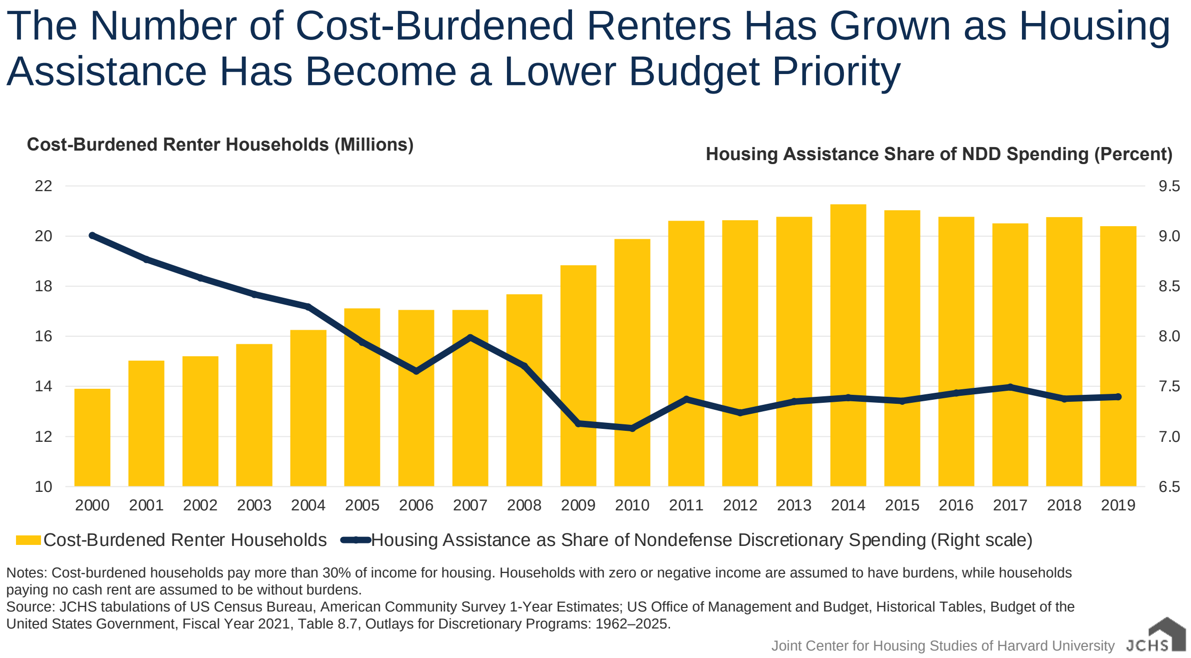
Families that are renting have been shown to be more cost burdened than homeowners, with 46% of renters cost burdened compared to 21% of homeowners in 2019. Also, 24% of renters and 9% of homeowners reported being severely cost burdened. Low-income households held the greatest disparity related to housing cost burden. In households earning less than $30,000, over 80% of renters and 64% of homeowners reported a cost burden. Severe cost burden was noted in 57% of renters and 43% of homeowners (Figure 5).

Consider what happened in 2008. The foreclosure crisis rendered millions of homeowners without homes and diminished their economic capacity to elevate their current financial status. This foreclosure crisis led to another disparity, which is referred to as the *affordable housing crisis*. The availability of affordable housing declined drastically, which led to many middle- and upper income individuals seeking affordable housing and moving to lower income communities. This trend has been repeated throughout history and is known as *gentrification*, a process in which a poor area experiences an influx of affluent people who renovate and rebuild homes and businesses, which often results in an increase in property values and the displacement of earlier, usually poorer residents. Gentrification adds further strain to the limited resources in low-income communities. As a result, diminishing housing affordability and stagnant wages during the crisis in 2008 caused many families distress, as they could no longer pay rent and found themselves in the category of housing insecurity or homelessness. The rental affordability crisis, specifically for low-income individuals, was amplified by the COVID-19 pandemic. In late September 2020 the US Census Bureau's household public survey indicated that renters earning less than $25,000 a year were much more likely to report lost income since the March 2020 pandemic shutdown. One in five renters earning less than $25,000 also reported being behind on rent.

Social inequalities have been identified as both the cause and the consequence of racial disparities in the housing market. As a result of these disparities and social inequalities, people of color have fewer opportunities to live in neighborhoods with higher quality schools and to have access to community resources. Instead, people of color are disproportionately situated in environments that expose them to crime, along with pollutants and other environmental hazards. Home ownership has been identified as one significant way to build wealth; however, discrimination in the housing and mortgage market and lack of affordable rental and homeownership options in more affluent communities have prevented generations of minorities from buying homes and establishing wealth. Because of these discriminatory practices and disparities related to the SDOH that affect economics, people of color have higher housing cost burden rates and lower homeownership rates than do White households, and they represent a large proportion of the homeless and housing insecure population. Although African Americans make up around 13% of the US population, in 2019 African Americans were nearly 40% of people experiencing homelessness. The racial disparities in housing have shown persistent growth over the decades, with the racial gap in home ownership being one of the main outcomes. The gap between households of color and White households related to home ownership is now more than 30%, and it is the largest it has been since 1983 (Figure 6). In 2019 the African American household home ownership rate was 42.8% compared to White household home ownership, which was 73.3%. Disparities in home ownership also exist for Latinx and Asian households, with 46.3% and 57.3% home ownership rates, respectively.

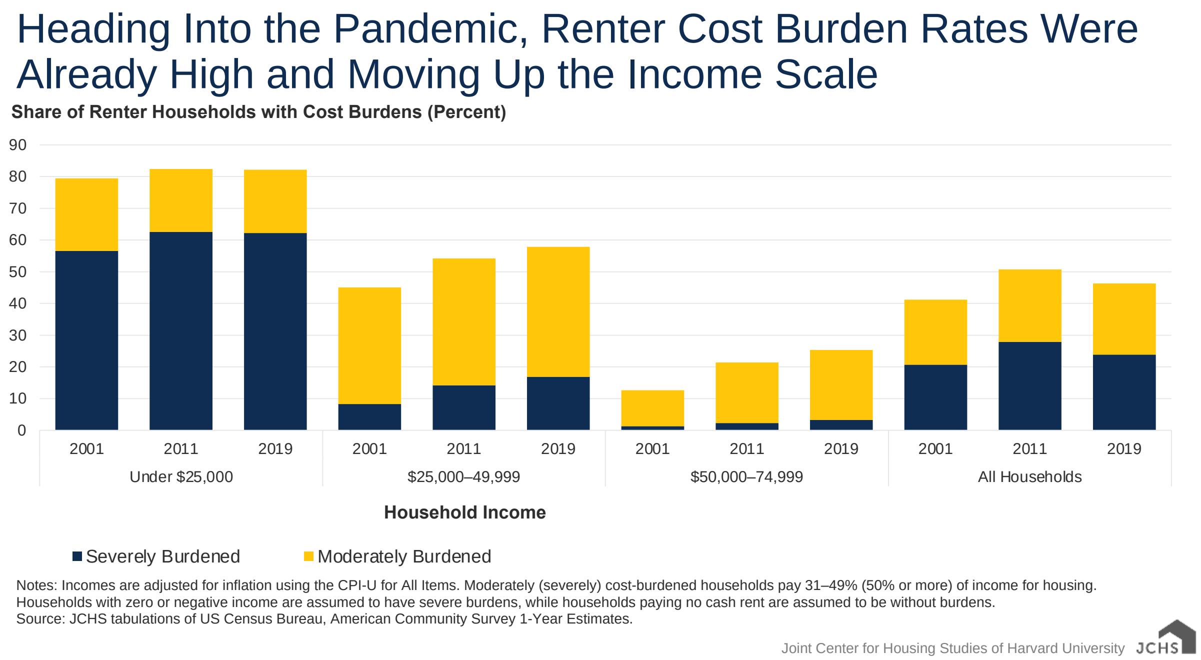
The compounded economic disparity related to home ownership can clearly be seen when we look at the process to obtain a mortgage loan. As discussed earlier in this section, minorities and low-income individuals living in the inner city experience disparities related to economics that make them poor candidates for home mortgages. The process to qualify for a mortgage requires the applicant to have strong income history, good credit, and a down payment. For those minorities and individuals living in the inner city that are low income, these goals are difficult to obtain, thus putting them at a disadvantage for home ownership. Close to 16% of African American mortgage applicants are denied, and inadequate credit history is among the most common reasons (Figure 7).

Among renters, minorities have a greater housing cost burden. In 2020, for example, 53.7% of African American renters and 51.9% of Latinx renters had high housing cost burdens in comparison to 41.9% of White renters. Low income, exclusionary credit requirements, competing financial demands, and prejudicial housing policies are barriers that plague minorities and low-income individuals seeking a better housing situation. Given their financial constraints, low-income individuals struggle to save for down payments, and even low-income workers who own their own homes may be threatened by foreclosure at any unforeseen financial crisis (e.g., pandemic, loss of employment, health care expenses).



Source: Harvard Joint Center for Housing Studies, The State of the Nation's Housing 2020, www.jchs.harvard.edu. All rights reserved.

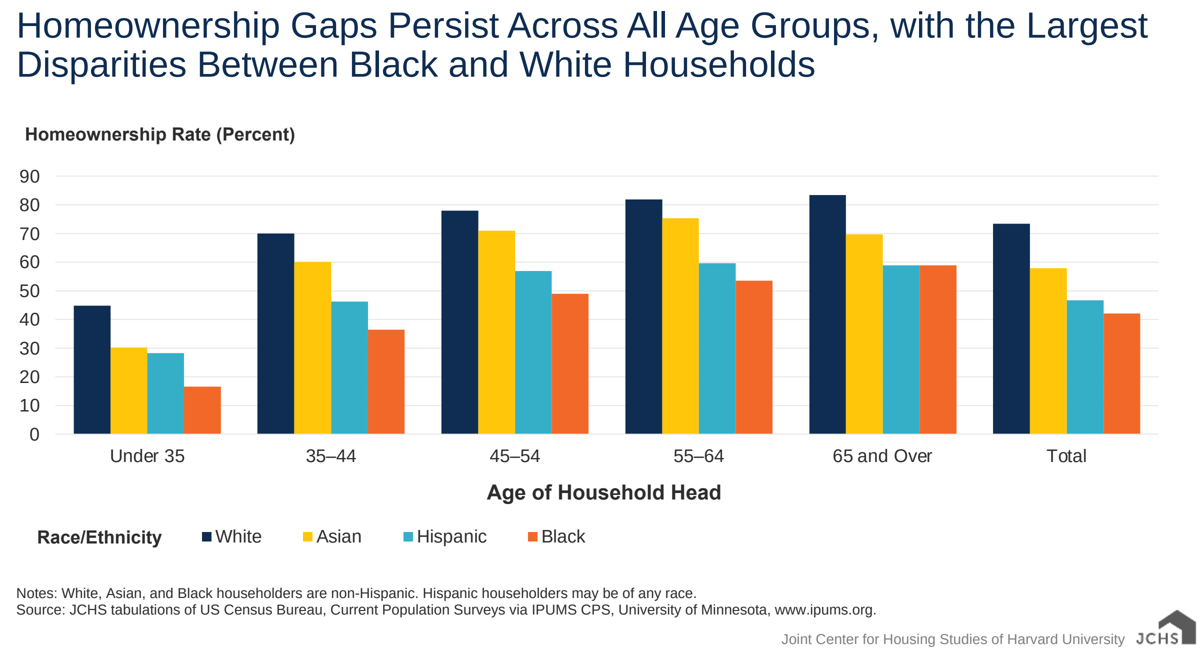
Figure 4. The Number of Cost-Burdened Renters Has Grown as Housing Assistance Has Become a Lower Budget Priority



Notes: Incomes are adjusted for inflation using the CPI-U for All Items. Moderately (severely) cost-burdened households pay 31–49% (50% or more) of income for housing. Households with zero or negative income are assumed to have severe burdens, while households paying no cash rent are assumed to be without burdens.
Source: JCHS tabulations of US Census Bureau, American Community Survey 1-Year Estimates.

Source: Harvard Joint Center for Housing Studies, The State of the Nation's Housing 2020, www.jchs.harvard.edu. All rights reserved.

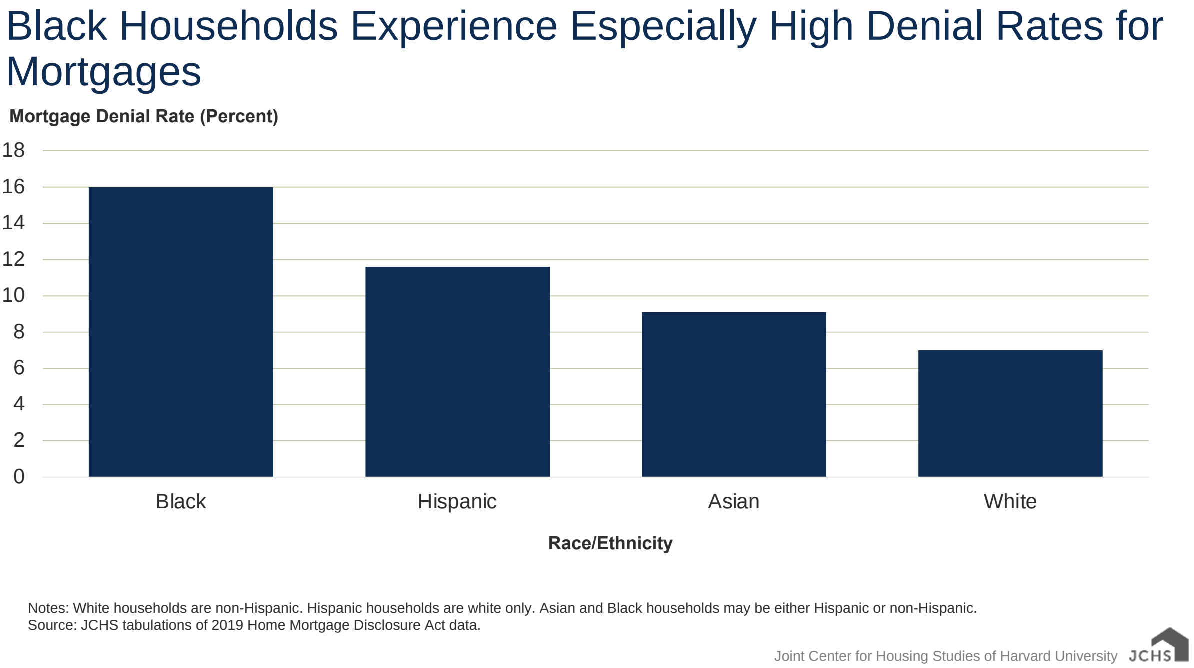
Figure 5. Heading Into the Pandemic, Renter Cost Burden Rates Were Already High and Moving Up the Income Scale



Notes: White, Asian, and Black householders are non-Hispanic. Hispanic householders may be of any race.
Source: JCHS tabulations of US Census Bureau, Current Population Surveys via IPUMS CPS, University of Minnesota, www.ipums.org.

Source: Harvard Joint Center for Housing Studies, The State of the Nation's Housing 2020, www.jchs.harvard.edu. All rights reserved.

Figure 6. Homeownership Gaps Persist Across All Age Groups, with the Largest Disparities Between Black and White Households



Source: Harvard Joint Center for Housing Studies, The State of the Nation's Housing 2020, www.jchs.harvard.edu. All rights reserved.

Figure 7. Black Households Experience Especially High Denial Rates for Mortgages

Impact of Economic Disparities on Health

Numerous research studies link low-income inner city living to increased health disparities and mortality. Hypertension, heart disease, asthma, stress, diabetes, obesity, COVID-19 infections, stroke, and maternal mortality are some examples of health conditions where increased morbidity and mortality have been disproportionately observed in minority, economically disadvantaged, urban populations. For example, heart disease and kidney disease often result in end organ disease and can be the result of underlying chronic diseases such as hypertension, diabetes, high cholesterol, and obesity. Social behaviors such as smoking, poor dietary habits, and inactivity are precursors to many chronic diseases and are present in higher rates among urban minorities. Each of these diseases is most prevalent among urban African Americans and Latinx populations, contributing to the high burden of disease mortality and morbidity among these populations. Preexisting health conditions are further exacerbated in urban populations because of lack of access to care, an inability to afford medication and medical supplies, not being poor enough to qualify for Medicaid but not making enough to afford private insurance, difficulty completing health appointments because of lack of transportation or geographical location, and limited social support systems.

Chronic homelessness has also been associated with poor health outcomes. An article published by Zlotnick et al. (2004) evaluated the association between chronic homelessness and adverse childhood events. The study concluded that individuals who suffered chronic homelessness or housing insecurity on a regular basis were susceptible to more adverse childhood events and had high rates of health disparities. It is also well documented in the literature that substandard housing or lack of stable housing is associated with poor mental and physical health. High rates of allergies, as well as tuberculosis and other respiratory infections, have been associated with poor housing conditions and overcrowded living conditions. Also, chronic diseases like asthma, along with cancer, have been linked to environmental causes related to housing. Individuals experiencing chronic homelessness also have higher rates of substance abuse and mental illness and higher health care costs, including increased acute care visits. Homelessness is also associated with higher rates of uncontrolled chronic disease linked to unstable housing, which makes detection treatment and management of chronic illness difficult.

There is a reciprocal relationship between homelessness and mental health. The state of being homeless or housing insecure exacerbates feelings of failure, embarrassment, and stress, which could lead to anxiety, substance abuse, inadequate sleep, and depression. For individuals with a preexisting mental illness such as schizophrenia or posttraumatic stress disorder, homelessness further compounds health care disparities and exposes the patient to mental health stigma; it results in lack of access to care and causes difficulty adhering to health care recommendation. Individuals with mental illness who experience homelessness are typically disconnected from family, friends, and other support systems and experience extended periods of homelessness.

When we take a look at a large urban city such as Detroit, which has an African American population of 78.3%, health disparities can often be seen in death rates that are unequally distributed within poor urban populations compared to communities with higher socioeconomic tiers. The life span of Detroit's poorest residents has been cited as shorter than comparable to that of residents in other big cities, and death rates are up to 16 years sooner than for residents of surrounding suburban communities. Exact reasons for disparities in life span for Detroit residents are unclear but are potentially related to chronic stressors and diseases common within this environment as well as inadequacies in access to health care, food, and exercise. Detroit residents demonstrate a significant burden in terms of chronic disease rates. The brunt of the ongoing health disparities was compounded by the COVID-19 pandemic in 2020. This pandemic was overrepresented in urban minority communities such as Detroit, where mortality rates were highest within African American communities. According to a report published in March 2021 by the Brookings Institution, African Americans were 2.1 times more likely than Whites to die from the virus during the COVID-19 pandemic. In Detroit, African Americans represented over 75% of known COVID-19 diagnoses by race and nearly 90% of deaths.

Urban Provider Considerations: Economic Stability

Economic stability is a significant and important contributor to health status and health outcomes. Income-based health disparities are greatest in the United States compared to other countries throughout the world. In the United States 1 in 10 persons live in poverty. The ongoing growth in economic inequalities is undisputedly a contributing factor to the level of poverty rates experienced by urban populations. These disparities often begin during the prenatal period and contribute to lifelong health disparities that can persist across generations. Consequences of living in poverty can include exposure to an unhealthy toxic environment, greater risks for chronic illness, and less access to quality health care, among other things. When evaluating an adult, health care providers often assess for factors that may have contributed to a health condition within the recent past. However, few consider early life health challenges common among persons living in poverty, challenges such as premature births or inadequacies in nutrition—the latter as a consequence of food deserts—that begin before birth when vital organs are being formed. The cumulative stress, environmental exposures, and lack of resources because of poverty each shape the health of the adult who presents with asthma, diabetes, or other chronic conditions.

Finances directly affect the health of your patients. Finances have been linked to longevity, access to care, the ability to buy prescriptions, healthier eating, and the ability to exercise, attend routine care visits, and take advantage of preventative care options. Limited finances inhibit the ability to pay for prescriptions, get preventative health care, or buy the appropriate food based on the patient's comorbidities, such as the right amount of carbohydrates for diabetes mellitus, low protein for patients with renal failure, or low-sodium foods for patients with heart failure or hypertension. Insufficient finances will often provoke hard choices of deciding to pay for utilities, rent, and food versus medications. Reduced amounts of disposable income can further exacerbate chronic illnesses, placing the patient at increased risk of hospital admission, hospital readmissions, and loss of employment secondary to lost workdays.

The inability to go to your primary care provider for routine visits because of office visit copays can lead to unexpectant trips to the emergency department, driving up expensive medical bills. After being discharged from the hospital, patients who are unable to follow up with their primary care doctor because they lack transportation or a support system are at high risk of being readmitted to the hospital, resulting in more hospital bills or loss of days from work. When chronic illnesses are not managed because a person's job does not grant sick time or taking off work means reducing income, the patient's priorities, be they obligatory or discretionary, will result in the choice that meets basic and immediate survival needs. We can clearly see that there is a reciprocal relationship between low economic status and poor health outcomes. Just as having low income adversely affects health, poor health will make it difficult to produce the income needed to "live," thus creating a vicious cycle of poor health outcomes and poverty. Even if patients have an income above the poverty level, that does not mean they are able to make ends meet. Incomes that exceed the poverty level may still fail to provide needed financial security or economic stability.

CONSIDER THIS . . .

Children who live in poverty offer a uniquely vulnerable population, as they experience the effects early and for extended periods. Although some children may live in poverty for shorter periods, this experience can result in negative mental and physical health outcomes that continue into adulthood. According to the American Academy of Pediatrics Council on Community Pediatrics, African American, Latinx, and American Indian/Alaska Native children are three times more likely to live in poverty. This council also reports that poverty rates for children in the United States are higher than in countries with comparable resources. Associations between poverty and birth weight, infant mortality, language development, chronic illness, nutrition, and injury have all been established. Children who live in poverty also tend to experience exposure to higher-than-average levels of toxic stress, which can influence brain development and increase risks for difficulties with self-regulation, executive functioning, inattention, impulsivity, defiance, and poor peer relationships. The impact of child poverty can be seen across the life span of a child who demonstrates gaps in educational achievement that contribute to low high school graduation rates and the risk for unemployment and incarceration. *Consider how disparities in SDOH affect childhood and the potential long-lasting effects throughout life.*

ENVIRONMENT

The Neighborhood

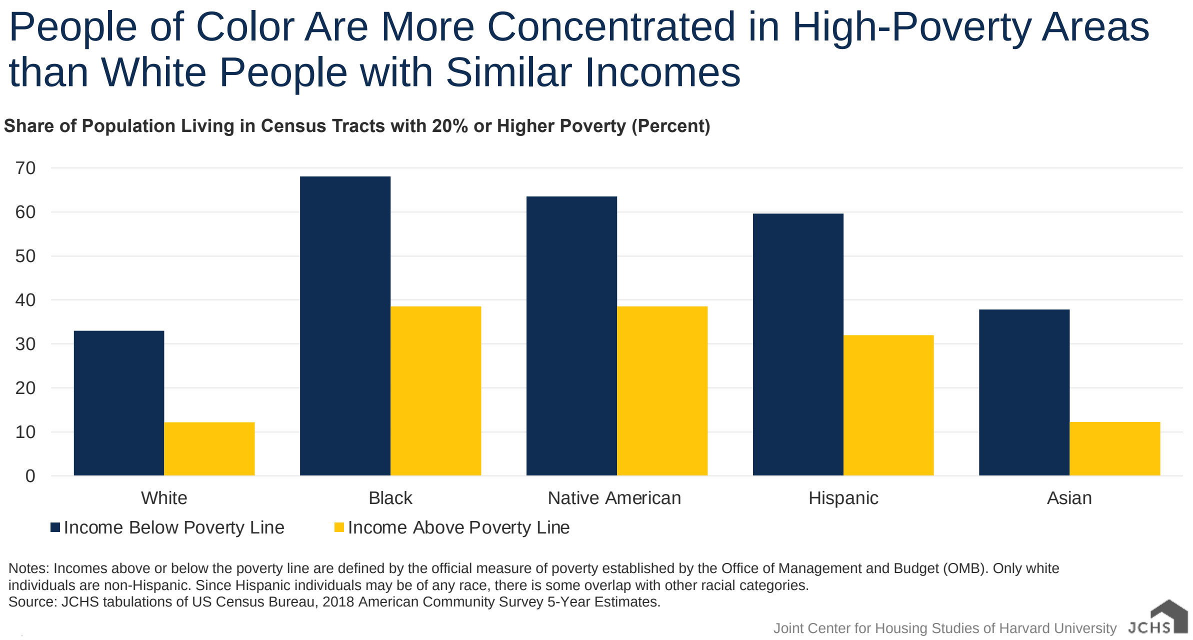
The urban environment and its impact on the health of individuals, families, and communities is multifactorial and requires evaluation of the different features of the urban community. The built environment includes housing, neighborhoods, transportation, and infrastructure that affect the ability of residents in the community to access and utilize resources effectively. Where one lives has been characterized as being an important determinant of health that may exceed the role of one's genetic code. Within the neighborhood or built environment many factors individually and collectively play a role in the health of residents as well as in the potential for early mortality.

Racial Residential Segregation

Racial residential segregation can be defined as "the sorting of people into particular neighborhoods and communities on the basis of race." Racial residential segregation benefits some while devastating others. Neighborhoods and communities are entities that connect residents to necessary amenities and services, including schools, grocery stores, employment, living environment, access to health care, and other critical resources. Recent research and empirical data undeniably demonstrate how racial residential segregation throughout the decades has left minority communities in despair, failing to connect them with the essential resources, especially when compared to the resource allocation for segregated White communities. As tax dollars, favorable financial opportunities, and community resources flow more readily to affluent nonminority communities, predatory financial institutions, food deserts, deteriorating infrastructure, unfairly allocated resources, poor-quality education, and toxic environments torment communities of color.

In June 2021 the Haas Institute released a highly anticipated study entitled *The Roots of Structural Racism*, which was a nationwide project that evaluated the level of segregation in the United States between 2000 and 2019. The study also compared the difference in economic determinants such as income and poverty levels, home values, rent prices, and health outcomes such as life expectancy between highly segregated communities of color, highly segregated White areas, and integrated areas. The study also unveiled an interactive map (https://belonging.gis-cdn.net/us_segregation_map/#2010) that highlights the extent of racial residential segregation in the United States. The study had many key findings, one of which was that out of every metropolitan region (i.e., an area with more than 200,000 residents) in the United States, 81% were more segregated in 2019 than in 1990, and segregated White regions had better SDOH outcomes, while segregated minority communities had worsening disparity. For example, individuals who grew up in segregated White neighborhoods had incomes higher than those of individuals who grew up in communities of color.

Findings from *The Roots of Structural Racism* provided further data supporting how segregation disproportionately disadvantages communities of color. Segregated communities of color have neighborhood poverty rates that are three times higher than in segregated White neighborhoods. Segregated communities of color have a neighborhood poverty rate of 21% in comparison to White neighborhoods, which have a poverty rate of 7%. The study also showed that neighborhoods also play a role in the annual earned income of adults. According to the study, Black children raised in integrated neighborhoods earned nearly $1,000 more annually and $4,000 more when raised in White neighborhoods compared to those individuals raised in highly segregated communities of color. The degree and impact of racial residential segregation becomes even more apparent when we look at the large percentage of minorities residing in the inner city and living in neighborhoods with deep and persistent poverty (Figure 8).



People of Color Are More Concentrated in High-Poverty Areas than White People with Similar Incomes

Share of Population Living in Census Tracts with 20% or Higher Poverty (Percent)

Notes: Incomes above or below the poverty line are defined by the official measure of poverty established by the Office of Management and Budget (OMB). Only white individuals are non-Hispanic. Since Hispanic individuals may be of any race, there is some overlap with other racial categories.
Source: JCHS tabulations of US Census Bureau, 2018 American Community Survey 5-Year Estimates.

Joint Center for Housing Studies of Harvard University JCHS

Source: Harvard Joint Center for Housing Studies, The State of the Nation's Housing 2020, www.jchs.harvard.edu. All rights reserved.

Figure 8. People of Color Are More Concentrated in High-Poverty Areas than White People with Similar Incomes

Quality of Housing in Urban Communities

The physical condition of a person's home, which includes the quality of the social and physical environment in which the home is located, is referred to as *housing quality*. Housing quality includes air quality, home safety, space per individual, and environmental factors such as the presence of mold, asbestos, or lead. Examples of poor quality housing include properties that are poorly designed (not handicap accessible, poorly constructed stairs, allow easy access for rodents, etc.), are poorly maintained (damaged appliances, leaking pipes, peeling paint, etc.), and allow exposure to the elements (underinsulated, lack adequate temperature control and are therefore either too cold or too hot, etc.). Low-income families are more likely to live in poor-quality housing that can have a negative impact on their health. Overcrowding, reliance on slum lords (i.e., absentee landlords who skimp on property maintenance to maximize profit), older homes, deteriorating neighborhoods, and poor infrastructure (e.g., houses prone to sewage backups and basement flooding) are unfortunate staples in low-income inner city neighborhoods.

Another phenomenon affiliated with inner city living is urban blight. *Urban blight* is described as deteriorating and abandoned homes and buildings as well as vacant lots covered in trash and vandalism rampant in neighborhoods. Blighted homes may result from lack of maintenance by absentee landlords, mortgage companies foreclosing on properties but not properly managing the property, and damage occurring in homes that is so severe that the homes are not worth fixing, such as when there is severe fire damage, vandalism, or mold. These situations leave vacant homes that attract squatters (i.e., individuals who move into homes illegally and do not pay rent) and criminal elements, including drug pushers and houses. These abandoned structures also create safety concerns. Furthermore, many low-income individuals who have lived in these neighborhoods for years have nowhere else to go and are stuck watching their neighborhood decline, crime increase, and property value decrease. As the criminal element increases, residents of the neighborhood may feel unsafe leaving their homes, nervous about walking at night, fear for the safety of their children, and even feel unsafe in their own home, worrying about people breaking in or arsonists starting fires in the abandoned homes, which could spread to theirs.

Yet another consideration related to neighborhoods and built environments is access to transportation. Transportation is essential to health care because if your patient cannot go to the hospital when needed, make follow-up visits for routine checkups or management of comorbidities, or even pick up prescriptions, then it is literally like riding a bike with no tires—a struggle to get nowhere fast while causing further damage. As a result of not having transportation, 3.6 million people do not have access to health care. Transportation barriers are not easy to fix because the problem is not just about not having a car, not knowing someone with a car, or not having access to public transportation. If patients do not have money, then they cannot pay for gas, parking, car repairs, or bus tickets to tend to their health care needs.

Natural Environment

The natural environment speaks to the quality of air, water, soil, and other organic components of the environment that affect the living conditions of individuals. These factors play an important role in health and disease prevention. Inequalities in environmental factors disproportionately affect individuals living in urban environments and directly contribute to the increased rates of environment-related disease.

Economically disadvantaged individuals and minorities in urban communities live in some of the most populated and polluted neighborhoods. It is well documented in the literature that low-income and minority communities are exposed to higher levels of pollution when compared to more affluent communities. Increased rates of lead poisoning in children, proximity to landfills, housing near entities that produce air pollutants such as industrial plants and incinerators, all tend to have high populations of low-income minorities. Toxins, water pollution, solid and hazardous waste, pesticide, air pollution, and lead and toxic debris from industries pose the greatest health risk for individuals living in low-income communities. This is evident when we look at the data related to lead levels in children. Regardless of income level, Black children were found to have more than twice the incidence of lead poisoning when compared to White children. The rates of cancer, asthma, and other environment-related diseases are higher in urban communities and difficult to manage when the environment is contributing to the presence and exacerbation of the conditions.

Poor water quality poses a huge public health concern. Essential life-sustaining practices such as drinking, cooking, cleaning, and taking care of one's hygiene are hindered without reliable water access. Without reliable water, basic disease prevention processes such as cleaning, which decreases transmission of contagious diseases, are hindered. Access to safe and reliable water is critical to sustaining and maintaining human health. Having access to clean and safe water is a basic human right. When you think of a country such as the United States, with its resource-rich infrastructure, it is hard to believe that there are some urban areas in the United States that suffer disparities when it comes to water access. From 2013 to 2017 there were an estimated 1,121,000 people in the United States without secure water access, and 47% of them were located in the 50 largest metropolitan areas. A nationwide study conducted by Meehan et al. (2020) found that those individuals more likely to suffer water insecurity were low-income non-White renters and immigrants.

Another well-documented environmental threat is air pollution. Air pollution has been linked to increased hospitalization, as it is a catalyst for respiratory disorders and a contributor to lung and heart disease. A positive relationship between outdoor pollution and asthma has been documented consistently through the literature. Furthermore, outdoor air pollution has been highlighted as a major contributor to ER visits related to respiratory disease, increased hospital admissions, and frequent readmissions. Air pollution is no different than poor water quality in that the burden of exposure to airborne pollutants is not equally shared and is more likely to exist in minority and communities having low socioeconomic status. In cases where people live, work, and go to school, exposures and health risk are higher. In Detroit, which is famously known as the motor city, cars contribute to the pollution of air. For decades Detroit was the site of innovation and development for the car industry. In fact, transportation and getting around the city was highly dependent on motor vehicles and was encouraged to help maintain this revenue-generating industry. The government built major highways that ran through and around the city. In doing so, the government exposed persons living along these highways to toxic output from cars in addition to pollutants spewed from car factories.

Minorities in urban environments, specifically African Americans and Latinxs, tend to have weaker political advocacy to fight environmental hazards in their communities, making them susceptible to living in areas with high levels of environmental contaminants. As a result of the social position of deprived minority groups living in urban environments, they are exposed to health-damaging environments and lack the political and legal support to combat entities that pose environmental threats.

Impact of Environment on Health

The environment, which includes the built as well as the natural environment, has a strong impact on a variety of health outcomes. It is estimated that we spend nearly 85%–95% of our time in our home environment, and if hazards are present in our homes, we are more susceptible to harm, injury, or even death. The leading preventable causes of death, disease, and disability in the United States related to the environment include asthma, lead poisoning, exposure to tobacco smoke (e.g., secondhand smoke), deaths by house fires, falls down the stairs and from windows, and drowning in bathtubs and pools (Office of the Surgeon General, 2019). In addition is indoor radon exposure, the second leading cause of lung cancer in the United States. Individuals in high-poverty areas display more negative effects from environmental causes. For example, poor neighborhood conditions and social inequalities have been correlated with high rates of asthma in minorities. Being low income, a minority, and living in substandard housing have all been correlated to higher rates of asthma and asthma-related hospitalizations. Living in poor neighborhoods from young adulthood has been associated with negative health outcomes throughout life. Studies have shown that African Americans' health status declined 30 years faster than the health status of Whites. These findings correlate to a study by Geronimus (1992) that found that African Americans experience earlier health deterioration because of repeated social disparity, economic adversity, and political marginalization. Poor mental health, chronic disease, and physical injury have also been linked to poor-quality housing, and as noted, these disparities are also more prevalent in low-income neighborhoods. Racial segregation, population density, income disparities, and concentrated poverty are only a few neighborhood-based factors that contribute to these disparities and negatively affect health outcomes of urban residents.

There has been extensive research on the negative health outcomes related to racial residential segregation as it pertains to despaired communities. Despaired segregated communities, specifically communities of color, are deprived of ample access to grocery stores (e.g., food deserts), healthy food options, and lack of access to quality health care services such as resource-rich clinics and hospitals. Segregated communities of color are typically located in environments with increased noise pollution and situated in proximity to industrial plants, which increase exposure to air pollution. They experience higher rates of violence than do other communities, resulting in unsafe neighborhoods, and they also lack important neighborhood resources. As a result of these and other health hazards that are typically found in segregated communities of color, incidences of infant mortality, heart disease, diabetes, obesity, and other health conditions are much higher in these segregated communities than elsewhere.

Urban Provider Consideration: Environment

Acknowledging that environmental disparities exist and that segregated communities of color suffer inequalities is the first step in understanding the impact these environmental barriers have on patients. A simple task such as making a follow-up appointment can become convoluted if the patient has no form of transportation and the clinic is not located on a bus route. Or what if the insurance copay would put the patient in a financial bind? Patients changing their diet because of a new diagnosis of hypertension or diabetes might turn out to be doing so because of more than just a required behavior change. What if their neighborhood lacks grocery stores and affordable health food options? Recommending a patient to add 30 minutes of exercise, 3 days a week seems like a routine evidence-based recommendation, but without safe neighborhoods to walk in or access to recreational spaces, what creative suggestions do you provide to help patients meet their health goals in the midst of their disparities? We as health care providers must understand that the community where our patients resides is an important influence on their health. Involving patients in the plan of care, assessing their current resources and environmental conditions, and working with patients to set realistic expectations are important steps urban health care providers can take to help their patients.

A "one-stop shop" approach—that is, clustering visits and services so that patients need to see their health care provider just one time rather than several times—or increasing use of telehealth visits to circumvent some of the barriers related to environment might be viable options. Also, check to see if your organization has a specialist community advocate to help coordinate health appointments and identify community support. Last, engage community leaders to change policy that gives funding to improve infrastructure of the despaired community.

HEALTH ACCESS

Health Access and Quality Health Care

Access to care encompasses physical/geographical availability, acceptance of insurance, and ability to provide culturally competent care. Adding to this definition, access is much broader and is uniquely defined by the needs of the population served. Access to care also involves the need of health systems, clinics, and offices to evaluate their services in relation to the delivery of quality care and the achievement of desirable health outcomes.

The inequalities in death rates are considered a marker of ongoing racial injustice. In the United States inequities in access to health care and quality health care are considered moral and ethical dilemmas. The United States is a leader in the world in advanced health care knowledge, technological resources, health care facilities, and pharmacotherapeutics, but the distribution and access to these resources is not equitably available to the general population. Low-income families often present with more complex needs that are unique compared to the needs of higher income families. This uniqueness is in part the effect of exposure to a chronically stressful natural environment and the constant chaos low-income individuals live in as they try to navigate life in general, as well as the impact of these factors have on their health care needs, warranting a comprehensive approach to care that cannot always be managed in a 15-minute visit or by health care providers who are insensitive or untrained in how to provide culturally sensitive care. African Americans from low-income communities describe non-race-related factors that create barriers to care. Providers scheduling multiple visits for a specific time (double booking) or showing up well after most patients are scheduled—doing so to ensure that patients have arrived—are concerns expressed by patient. Although these provider strategies are deployed to address high rates of no-shows from a clinic operations perspective, they are unfair and inconvenient to the patient who arrives on time.

Failure to engage in basic social amenities with patients as a part of their medical care has also been highlighted in the literature. Basic social amenities are described as greetings and exchanges about family members and family achievement (high school graduations, marriages, etc.) and non-health-related inquiries. Patients have voiced frustrations with provider biases, seeing their lives, not as "unique," but as a compilation of social and textbook stereotypes—that poor persons are noncompliant with care recommendations, are lazy, and are drug seeking. Some patients have described how various members of their health care team treated them with disrespect, often calling them by their first name without permission or familiarity. Patients perceived other disrespectful staff behaviors when privacy was not provided or when care members failed to take "enough time" to listen to their concern and address it in a way that was mutually agreed upon.

Lack of knowledge can also be a barrier to accessing care. Persons with public health insurance or who are uninsured rarely know of their health care insurance options, how to navigate the completion of forms, or how to select or find a health care setting or a provider. Furthermore, it is not uncommon for persons to have difficulty obtaining prescriptions from a local pharmacy because of inadequacies in what is stocked and available for distribution. Added difficulties are flaws in electronic systems that may not transmit a prescription as intended or pharmacy records that may not accurately reflect refill status or availability of a prescription. Persons from low-income communities do not often seek help when they encounter these barriers but instead just wait for weeks or months before they return to their health care provider and report the problem. Even when engaged in care with a provider they may have a "good relationship" with, patients will state they do not want to be a bother, consequently placing their health care needs as low on the provider's list of things to manage.

Transportation

Urban populations are denied access to care in many ways. Geographic location of care can be problematic for families that do not have personal transportation to medical care, especially if sites are not along public bus routes. In Michigan, Medicaid provides transportation services to and from health care visits. Unfortunately, this system is mostly unregulated and not monitored for quality of services. Patients experience long days when using this service in that they are often dropped off to a clinic hours before their scheduled appointments and may remain in the office for hours after an appointment. Transportation services may also cancel services to or from an appointment for no specific reason given by the driver. The long day for those who use the transportation service can affect diabetics, who have limited options for food availability while waiting for health services and/or transportation services. Also, mothers of infants and small children must prepare for a long wait in a setting that is not designed for a toddler or infant that needs space for play, naps, or meals. Transportation services can also contribute to late arrivals for appointments that may subsequently have been canceled due to office policies. In contrast, because they need to get to work, persons who have personal transportation or use public transportation may have to leave before completing an appointment if the health care provider is running behind schedule. Also, lack of transportation has been cited as a primary reason for poor use of primary health care services.

Coverage and Cost of Care

One of the largest barriers to health care access is inadequate health care coverage. In the beginning of 2020, over 40% of individuals 19 to 64 were inadequately insured. For low-income individuals, the uninsured and underinsured, needed health care services are often avoided because of high out-of-pocket medical costs and fear of incurring debts related to medical bills. Cost of care is a significant barrier to accessing care. In addition to the cost associated with buying health insurance, the cost to maintain health care is significant and includes paying for monthly insurance premiums, transportation expenses, missed work, prescriptions, copays, and all out-of-pocket expenses related to medical care. Hours of operation can increase the cost of care to an individual if services are not available after traditional 9-to-5 work hours or on weekends. Persons in low-income entry-level jobs often do not have work schedules that allow them flexibility in time off to accommodate a workday health visit. Other barriers include lack of pay for time away from work, which would not allow for a health visit that may in itself cost money. Individuals often balance decisions to seek health care by comparing the use of unpaid time off or paid time off and losing pay with the cost of covering office copays or office visit fees, prescription fees or prescription copays, and transportation fees. Consideration of all health care costs falls within the context of other personal expenses that must be managed within a given pay period. Factors such as having or not having insurance weigh into decisions on accessing health care. Federally Qualified Health Centers (FQHCs) provide sliding scale fees for care and often accept various Medicaid vendors for insurance. FQHCs do not seek legal routes to obtain pay for delinquent accounts from those who have accounts that are past due. However, some clients will delay care because they do not wish to have a bill or because they do not have the funds to bring accounts from the arrears.

Impact of Health Access and Health Quality

Lack of health insurance has been associated with negative health outcomes and is one of the largest barriers to health care access. Individuals who are struggling financially or are uninsured are less likely to receive health promotion, necessary health screenings (early detection of hypertension, diabetes screening, mammograms, etc.), or appropriate management of chronic diseases. The delay in care caused by lack of access contributes to increased health care cost is affiliated with increased ER visits, and individuals who do not have primary care because they lack health care access are more frequently admitted to the hospital for chronic diseases such as diabetes and hypertension and have overall worse prognosis. Nearly 20% of US households reported that household members were unable to get or were delayed in getting medical care for serious medical issues, and 57% of these individuals experienced negative health consequences as a result of the delay in care.

Urban Provider Consideration: Health Care Access

Barriers to access to care comes in many forms. A patient's negative experience with the health care system, financial constraints, competing responsibilities, lack of insurance, and the patient's fear of diagnosis and treatment regimens are just a few factors that can contribute to delays in care. Health care providers should be familiar with these barriers and align resources to assist their patients by providing information regarding insurance options, offering sliding scales if possible, including a social worker in their practice to help navigate barriers, and taking other such measures.

Embracing interprofessional practice and leveraging the expertise of other specialties (e.g., social work) can help you manage your patients' psychosocial needs. Furthermore, research has shown the evidence-based approaches such as behavioral health integration or on-site interprofessional practice, such as offering access to a mental health care provider on-site in a primary care clinic, yields greater success in patient management and improves access to care.

Considering your patient population when you set up your practice is important to anticipating how disparities could affect access to care. For example, if your practice caters to working adults, then having evening hours and weekend appointments may make it easier for your patients to meet their health care needs while still balancing their other responsibilities. Assessing for health care barriers related to follow-up appointments, medication compliance, and so on, could reveal simple solutions for your patient and potential compromises that can lead to better health outcomes.

SOCIAL AND COMMUNITY CONTEXT

Social and community context refers to a sense of cohesion and connectedness found where people live and work. Social community context also includes relationships between people, as well as connections between members of institutions (religious, social, occupational, and cultural). The quality of our relationships—our connections and interactions with family, friends, coworkers, and community members—is integral to health and well-being (CDC, 2021). The social support system individuals are born into and the one they build throughout their lifetime has a direct impact on their quality of life and on their growth and development; it affects every aspect of the SDOH. For this reason, social and community context is listed as a major domain of social determinants of health.

It can be overwhelming when you think of the cumulative weight of all the disparities that low-income inner city communities are faced with. As an urban health care provider, you never know what someone is going through or what that person had to overcome just to make it to the appointment. We understand that people are the sum of their experiences and lived reality, but hope and support systems can make this reality better. Yes, there are elements of life that people cannot control: being born into poverty, living in unsafe neighborhoods, facing discrimination, or lacking the income to afford basic necessities like healthy food and clean water. And yes, with prolonged exposure these disparities can have a negative impact on health. So how do people make it through?

As difficult as life can be, individuals, families, and communities have proved to be resilient, typically by pulling resources together. Having this resiliency and support system does not erase the disparities and barriers that are constantly and unfairly imposed on despaired populations but does provide assistance in "making it through." Positive relationships at home, at work, and in the community can lessen the negative impact of disparities on health.

Impact of Social Context on Health

Family Matters

The impact that family units have on health behavior is intuitively substantial when one considers learned behaviors modeled by adults within the family and early impressions made on the younger generations. Despite our knowing that familial influence is instrumental in setting the foundations for behaviors and belief systems, when we look at social determinants of health, families (chosen and unchosen) receive very little attention regarding their direct and long-term impression on individuals' health maintenance behaviors.

The family's role in modeling health behaviors makes the family an important focal point and hub for health interventions at the individual, family, and community levels. Positive or negative influences of the home environment can resonate as contributing factors to the health status of patients and communities. There is a reciprocal relationship between issues that affect populations and the issues that affect the family unit. When we look at health disparities such as chronic disease, substance abuse, depression, and violence, we can find a linkage to the family unit either directly through the family's influence on health outcomes and behaviors or through the impact of the health outcome on the family.

A support system that is caring and loving is correlated with better health outcomes, whereas a relationship burdened with stress and lacking support can contribute to negative health outcomes such as elevated blood pressure, stress, and depression. When we look at health, disease, and even recovery from illness, the impact of the physical, emotional, and economic support system of family has been associated with positive health outcomes. Given the diverse definitions of family, the literature has not been able to directly capture specific influences, as *family* is a general term that can have multiple configurations. Intimate partners, children, parents, and biological as well as chosen family members can either improve or undermine mental and physical health.

The perspective of this textbook focuses on adults in urban environments. Nevertheless, it is important to understand that adverse childhood events create generational trauma that can contribute to poor coping mechanisms and even poorer health outcomes throughout life. Families contribute to the health of individuals not only through genetics but also through the lifestyles and environments the patient is exposed to growing up. Family values, belief systems, relationships, habits, and observed behaviors directly influence the health decisions of patients. Families play an important role in acclimating individuals to the health care system, providing the initial introduction to how to utilize health care; they also model behaviors such as when and where to seek care. Furthermore, health care experiences are shared among family members and influence perceptions related to the health care experience.

The ingrained concept of not disclosing "family business," compounded by medical mistrust, can inhibit patients from being completely forthcoming about their health and family history. Only after the health care provider establishes trust with the patient will pertinent information be disclosed. The provider should seek organic conversations and opportunities to discern information, rather than prying or forcing data disclosure when interacting with chronically marginalized populations who are suspicious of the motives of others, including providers. Health topics that patients fear being judged on, such as abortions or sexually transmitted diseases, may not be initially disclosed in their health history. Patients may withhold information on such other sensitive topics as substance abuse, violence, and even the health history of family members (if, for example, that history includes mental illness).

Furthermore, stress and disparities patients experience directly related to their family dynamics may be withheld from health care providers despite the impact their family experiences have on health outcomes. Domestic violence, depression, and poor coping mechanisms stemming from trauma experienced during childhood may also manifest in adulthood and contribute to negative health behaviors such as substance abuse or promiscuity.

In African American family systems, unconventional extended family involvement in the rearing of a child is not uncommon. This often involves an informal adoption of a child, usually by a grandparent or extended family member, in order to keep the child from being put up for adoption when the child's biological parents are unable to provide consistent nurturing or a wholesome environment. Although we are not talking about the impact in childhood that may arise from the variation of family dynamics, it is important to note that our adult patients may have additional roles and responsibilities in the family, such as a grandparent taking care of a grandchild or an adult child taking care of a sibling. These variations of roles can have an impact on resources related to health—for example, if grandparents on a fixed income are now responsible for caring for a young child, they may experience further stress and strain on their financial situation or concerning their own health care needs, which are put on the back burner as they become the caregivers for others.

These familial flexibilities and roles are often ignited in times of despair, illness, hospitalization, incarceration, or death. African American families, especially those in poor or working-class communities, are disproportionately affected by health disparities, chronic disease, high unemployment rates, and stress. Family units that are in states of constant stress can find themselves financially and emotionally overtaxed, which creates burnout, resulting in family members' distancing themselves despite their ability to provide assistance.

Health care providers are quick to assume that certain nontraditional family structures—for example, multigenerational families living under one roof or a single-parent household—are dysfunctional. Providers need to be cognizant of the fact that though some family structures may not resemble a traditional makeup, the important thing to assess is the unit's ability to function as a family to provide support, safety, and consistency.

Families residing in the inner city are often drowning in socioeconomic disparities that directly affect health, such as housing insecurity and inconsistent financial stability. The transition to healthier behavior is a challenge for those individuals raised in low-income families. When resources are limited and the main focus is putting food on the table, it is difficult to be selective. If families are the primary producers of health across the life course, then to make a positive impact relative to prevention, treatment, or rehabilitation programming, health care practitioners must strategically consider and include the family.

Community Connections

Health status is also affected by the community and social environment. Social relationships, including friendships, social interactions, and supportive networks, affect mental health, health behavior, physical health, and mortality risk. Racial discrimination, inequality, disparities in civic engagement, and injustices in the criminal justice system are a few factors that affect relationships between people.

When people share an emotional connection with each other and are moved to take action, this is referred to as *social cohesion*. The potential for social cohesion has been amplified with the increased utilization of social media and the ability to have constant interaction with people and communities beyond those in close proximity. Social cohesions that promote solidarity and strong relationships can have positive effects on health. In the urban environment these connections are very important. One of the most important elements of social cohesion is the presence of social capital. Social capital involves shared group resources and is an important indicator of social cohesion, which has a significant impact on health. In urban communities, social capital can present in many forms, among them emotional support (e.g., encouragement after a setback), instrumental support (e.g., a ride to a doctor's appointment), or economic support such as bartering resources instead of exchanging money (e.g., I will watch your kids while you are at work if you can do my hair for an upcoming event).

In communities with minimum resources and many disparities, social networks are instrumental to survival in the midst of adversity. Although there are positive attributes to concepts related to social engagement, negative health behaviors and outcomes can also be "spread" within social networks. This phenomenon is known as *social contagion*. Studies have shown how an individual's risk for a particular health behavior (smoking, drinking, becoming obese, etc.) is likely increased when a friend, sibling, or spouse engages in those behaviors.

Societal Trauma and Institutional Trauma

Consider the fear, anger, and stress that African American families have as the deaths of African American men (e.g., George Floyd) at the hands of police officers are highlighted and revisited in the media. For those families that have African American husbands, brothers, and sons, the constant display of brutality causes continued trauma. Furthermore, African American men, knowing they are targets for injustices like racial profiling and unfair judicial practices, live in a state of constant stress, fear, and anxiety further complicated by the societal norm that men are always suppose to be strong and not show emotion or discuss the psychological impact of this constant stress (e.g., depression, substance abuse) nor mention the physical consequence (e.g., lack of sleep). The heavy policing in urban low-income areas, the discrimination, and the racial profiling contribute to these stressors, and as health care providers know, being under continued stress has physiological ramifications that manifest in high blood pressure, irregular heartbeat, depression, anxiety, and other physical health conditions. Underserved urban communities also suffer structural discrimination, discussed earlier when we examined racial residential segregation. Recall that the impact of structural discrimination on health outcomes is well documented in the literature and involves a sustained disability related to education, economics, neighborhood, and environment.

Implementation of the criminal justice system has been highlighted as another example of structural discrimination. The rates of minorities arrested, convicted, and incarcerated for criminal offenses indicate a huge racial disparity, with 1 in 12 African American men incarcerated compared to 1 in 87 White men. Consider the recent marijuana legalization in many states, where even legal systems have begun to overturn convictions for possession of marijuana that disproportionately affected African American communities. But how do you erase the decades of criminalization of marijuana and the longitudinal impact that criminalization has had on individuals, families, and communities (criminal records leading to poor job opportunities for those convicted, families and children that have been without loved ones incarcerated because of marijuana-related drug convictions, etc.)?

Discrimination based on race (i.e., racism) has been linked to low birth weight, high blood pressure, and poor overall health status. According to the *National Healthcare Quality and Disparities* report, White patients receive better quality of care compared to 41.1% of African American patients, 36.7 of Latinx patients, and 32.4% of American Indian/Alaska Native patients. These disparities in care have been linked to racial discrimination.

Discrimination in and of itself causes poor health outcomes. Experiencing discrimination may be related to health behaviors such a smoking and alcohol abuse, which have been linked to increase rates of disease, including cancer. Discrimination, specifically in health care, has also been related to patients not participating in health promotion behaviors such as cancer screening and diabetes management.

Unfortunately, discrimination is a fairly common experience, with 31% of US adults reporting at least one discriminatory event in their lifetime and over 60% reporting experiencing discrimination daily. Discrimination occurs more frequently for minorities than for other populations and features strong physiological and psychological consequences that lead to poor health.

Community engagement is a major category under the SDOH domain of social and community context. Community engagement involves working collectively and collaboratively through shared interest to address issues that affect the well-being of individuals and communities. Activities such as volunteering, voting, and participating in group activities by joining fraternities or sororities or participating in block clubs are all examples of civic participation. Positive health benefits of community engagement include decreasing social isolation, expansion of social networks, increasing social capital, and helping individuals develop a sense of purpose. Participation in the electoral process (e.g., voting or registering others to vote) is another example of civic participation that affects health both directly and indirectly. According to a study conducted by Kim et al. (2015), voter participation was associated with better self-reported health in 44 countries, including the United States. Furthermore, community members' use of voting and the election process to advocate for fair legislation and equal allocation of resources to their urban communities could have enormous impact on what laws are passed and who is elected to represent the best interest of despaired communities. However, disparities in the basic right to vote for minority communities has been a long-standing issue; given the barriers to getting registered to vote, African Americans still face huge disparities and inequalities in accessing the right to vote 150 years after the passage of the Fifteenth Amendment.

Urban Health Care Provider Consideration: Social Context

We may not be able to change the status of our patient's SDOH. Unfortunately, many of these SDOH disparities have been in existence for decades and are embedded in policies, procedures, governmental structure, and societal infrastructure. Our goal as health care providers should be to advocate for policy changes to improve the allocation of resources to reduce disparities and increase access to care. The routine assessments of SDOH are needed to identify not only where the disparities are but also how they affect our patients, as well as to help identify the patient's available resources and positive support systems, to aid in reaching the most optimum health outcomes.

Providing care for this community truly starts with an objective self-assessment: being aware of your own financial privilege, the basic needs that you take for granted, and your implicit biases, subconscious thoughts, and attitudes regarding how you perceive patients in urban environments. It must be remembered that all patients living in an urban environment do not fit the stereotypes of single-parent households, drug abuse, low levels of income, low education levels, and lack of support systems. Taking a conscious approach to provide care in an objective manner is necessary for each patient encounter. This may be difficult at times as you listen to patient stories from your colleagues or as you start to encounter perceived patterns when caring for patients in urban environments, but failure to understand your patients for who they are as individuals will lead to their mistrust or resistance, leading to unsuccessful treatment plans and unmet clinical outcomes.

As a part of your assessment under social history, asking about employment status and sources of income will be beneficial because by doing so you will gain insight into what additional resources your patient will need to reach an attainable health outcome from your plan of care. It will also give you insight into what additional health care team members need to be consulted to provide for extra care needs. In addition to asking routine questions about tobacco, alcohol, and illicit drug use, documenting where the patient lives, whom the patient lives with, and what support systems they have will be helpful. Also remember to assess for access to grocery stores, accessibility to transportation, and ability to make health appointments. Keep in mind that questions about employment or sources of income may touch on a sensitive subject for some of your patients. This sensitivity may be attributed to the patients' embarrassment and thoughts of being judged about their occupation, being unemployed, their sources of income, or simply their not wanting you to know their business, which is well within their rights and not to be considered as guardedness or noncompliance. This is why it is important to build rapport and establish trust with patients, so that solutions to health care problems can be remedied. Providing explanations for your questions about income and employment gives patients the option to determine what they will share or choose not to share with you. Providing rationales to questions asked during health visits promotes transparency and leads to building a trusting relationship. This trust will further foster a collaborative relationship to provide patient-centered care tailored to the needs of your patients and will promote patient self-efficacy to help manage chronic illnesses.

EXEMPLAR 1: DETROIT, MICHIGAN

In June 2021 the segregation study released by University of California, Berkeley, identified Detroit, Michigan, as the most segregated city in the United States. According to this study, entitled *The Roots of Structural Racism Project: City Snapshot: Detroit*, Detroit has an African American population of 78%, which is the highest proportion of any city in the United States. These data regarding racial residential segregation came from a larger project entitled *The Roots of Structural Racism Project* (Menendian et al., 2021). The project studied the persistence of racial residential segregation in the United States. The project included (1) a national segregation report; (2) the development of an interactive mapping tool that demonstrated the level of segregation in every city, region, and neighborhood in the country; (3) data tables that list cities, measuring their segregation level and political polarization; (4) a compilation of nine city profiles, including Detroit, highlighting significant levels of segregation; and (5) a literature review documenting the history of select cities.

1. Read "City Snapshot: Detroit," included in The Roots of Structural Racism Project (Menendian et al., 2021) at https://belonging.berkeley.edu/city-snapshot-detroit and then discuss the historical and structural factors that have facilitated racial residential segregation in Detroit.
2. Visit https://belonging.berkeley.edu/roots-structural-racism and then using the navigation bar on the righthand side of the webpage, expand "City Snapshots," which will expose the names of the nine cities included in The Roots of Structural Racism Project. Compare and contrast two of the nine city snapshots presented (Menendian et al., 2021). What are the similarities and/or differences (historically, structurally, etc.) between the two chosen cities in relation to segregation level? How does the segregation level of your chosen cities affect the social determinants of health for minority residents?
3. Visit https://belonging.gis-cdn.net/us_segregation_map/?year=2020 and then using the navigation bar on the left, select the address search. Enter the address (1) where you grew

up, (2) where you work, and (3) where you currently go to school (if you cannot find the exact address, type in the zip code or city). Compare and contrast these areas in terms of level of segregation and resource allocation (proximity of grocery stores, condition of neighborhoods, safety, etc.).

EXEMPLAR 2: SCHOOL DAYS

The main focus of this textbook is to explore the "lived experience" of urban adult residents in relation to health disparities. However, the impact of the urban public school system during the formative years cannot be negated, as education directly affects the quality of the lived experience for urban adults. As many urban adults are products of the urban public school system and many families in urban communities have children that are part of the urban public school system, the authors felt that it was important to briefly discuss the role of the public school system in urban communities. This exemplar will briefly highlight disparities that individuals are exposed to during their formative years that could affect social determinants of health throughout their adult life.

Urban school systems have many issues to overcome to ensure student success, but the biggest challenges involve attempting to educate young minds while competing with unstable living conditions, transportation issues, poverty, and high crime rates and then attempt to create an environment that focuses on hard work and future aspirations for students fighting to make it to the end of the day. According to the State of America's Children 2020 report, over 11.9 million children nationwide live in poverty—that amounts to 1 in 6 children. Child poverty is directly correlated to both age and race/ethnicity, with the youngest children being the poorest and nearly 73% percent of children of color being poor. Child poverty is also a result of the geography lottery. The report found that in 35 US states, more than 25% of Black, Latinx, and American Indian/ Alaska Native children were poor.

Urban schools have become more than just places of learning. The core function of the school system is to impart academic knowledge, develop students' social skills to foster emotional growth, and provide recreational activities such as sports and clubs. In the urban environment, however, schools and school systems function as so much more. While all schools, whether urban, rural, or suburban, face similar issues, urban school systems must deal with the additional challenge of meeting these core functions to a significantly higher number of students in heavily populated areas with fewer financial resources. In addition, these school systems are servicing students who are experiencing high rates of poverty, have more family responsibilities, and have chronic health issues. They may also be newly immigrated.

Thus, many urban schools have morphed into community hubs or use a community school model. These hubs are tasked with providing the core functions but also with the expanded responsibility of providing health care services, basic physical care needs, assistance with activities of daily living, daily nutritional needs, extended childcare, food pantries, and job training for the students and their families. Exemplar #2 discusses the impact educational systems have on health disparities, their role in the physical and emotional health of their student and their families, and the importance of school-based health care programs.

Most people envision the role of schools as purely academic ventures. The common thought being that "school is where you go to learn." Learning that occurs in schools is academic, social, interpersonal, emotional, and experiential. These learning experiences help students to develop problem-solving, relationship-building skills, self-esteem/confidence, conflict resolution skills, understanding of social/moral norms, and expanded worldview through cross-cultural interactions. Educational and medical researchers all agree that creating an education system that supports "the whole child" is essential to successful learning. The positive outcomes on children's physical and emotional development are greatest when children are emotionally and physically safe and when they feel connected, supported, and engaged. These outcomes for urban students are often challenged by the competing effects of poverty, housing and food insecurity, and chronic health issues that create toxic stress that affects learning, behavior, and overall development. Financially limited urban school systems often attempt to employ innovative supports to address these student needs. They often use partnerships with community organizations to provide opportunities to support students' school success and provide for their physical health, mental health, and social services needs. These activities typically include before- and after-school programs, summer learning opportunities, and field trips. The establishment and utilization of these supports reflect a committed attempt to support the positive development of the whole child.

Each day there are millions of urban children and adolescents in the United States attending school while actively experiencing physical and mental health issues that directly affect their well-being and academic performance. The Centers for Disease Control and other government agencies have identified that children living in poor communities have higher rates of asthma, anxiety, depression, obesity, and substance use disorders, with their health risks being compounded by the fact that many are not receiving regular health maintenance visits. Health disparities are also related to inequities in education. Studies have shown that good physical and mental health are directly associated with academic success. Teenage pregnancy, poor nutritional intake, lack of physical activity, emotional stress, and housing instability are all risk factors that not only impede normal growth and development but also place urban students at increased risk for poor overall health and life outcomes.

The Healthy Schools Campaign (2022) defines the core elements of a healthy school environment: It must include access to health care, healthy food choices, physical activity, clean air and water, and education about making healthy choices, all provided in safe, clean, and secure surroundings. Providing these core elements, especially the physical environment and food choices, is a struggle for most urban school systems. The National Center on Safe Supportive Learning Environments (2022) explains physical school environment as the standard of upkeep, noise, lighting, indoor air quality, and/or thermal comfort of the school's physical building and its location within the community. A safe physical school environment nurtures students' learning ability and has been linked to improved achievement scores and better overall behaviors. The challenge is that urban school districts often receive drastically less annual financial support per pupil funding than they need to sustain safe and well- maintained school environments. An ongoing argument is that there is no overall funding shortage for urban schools, especially with specialty aids and grants considered. But much of this additional funding is allocated to specific programs and cannot be used for buildings or maintenance. Furthermore, many urban districts are inundated with buildings that are outdated and unsafe, with issues such as mold or poor heating that exacerbate medical conditions like asthma and end up making things worse for the most at-risk students.

The 2004 World Health Organization's Information Series on School Health addresses the role of the physical school environment and its direct impact on children's health. The report identifies three major points. First, the environment is one of the primary determinants of children's health. Consistent exposures to pollution, tainted water, or heavy metals during childhood can lead to worsening chronic health conditions or death in some cases. Second, children are more vulnerable to long-term adverse health effects when exposed to chemical, physical, and biological hazards. The continued exposure to these hazards during periods of growth can be seriously detrimental. Finally, children's behavioral patterns such as thumb-sucking or eating foreign items put them at risk from exposure to environmental threats that adults may not confront. This is especially concerning, since children and adolescents developmentally lack the insight to accurately judge dangers associated with their behavior.

Abundant research studies have highlighted the direct correlation between nutrition and academic success. The National School Lunch Program, established in 1946, is the second largest food and nutrition assistance program in the United States, providing lunches to 29.4 million children daily in 2019. It sets the required nutritional guidelines vendors must follow. By the early 1980s the National School Lunch Program repeatedly experienced budget cuts and as a result schools were forced to move to prepackaged meals delivered from a centralized location. While cost effective, these prepackaged meals contained high amounts of preservatives and additives and very little nutritional value. This change directly affects the nutritional health of urban school children, who often receive more than 50% of their nutritional intake in school settings. While provision of school lunches offers some help to poor students, it does not address the issue of food insecurity that urban school children are battling daily, especially those who reside in so-called food deserts, where fresh foods are impossible to come by. Poor children's food choices and preferences are dominated by cheap, high-calorie, low-nutrient food, which is usually what is readily available at the nearest fast-food joint. Per the US Department of Agriculture, food insecurity is a household-level economic and social condition of limited or uncertain access to adequate food choices. Researchers have found that food-insecure children experience more gastrointestinal symptoms, hospitalizations, mental health issues, respiratory issues, headaches, and viral infections compared to their peers. This data is supported by the National Center for Chronic Disease Prevention and Health Promotion's 2014 *Health and Academic Achievement* report that connected food insecurity with lower grades, inattention, absenteeism, and academic failure. The inequity in nutritional offerings came to the spotlight in the Let's Move Campaign in 2010 championed by Michelle Obama. The main campaign goal was to encourage healthier food in schools, better understanding of food choices, and more physical activity for school-age children. This campaign was partnered with the creation of the Task Force on Childhood Obesity, which was charged with reviewing current practice and implementing a national action plan. The task force's plan was to create change through a national action plan that would develop a healthy start plan and provide healthy food options in schools, create programs to increase physical activity, and help empowered parents through education and access to affordable healthy food choices. This initiative led the USDA (2021) to release new rules that represented the first major revision of school meal standards in more than 15 years and made sure kids' lunches and breakfasts were healthy fuel for their minds and bodies.

School health programs have a long history in the United States but have never been consistently actualized. This has often been because of a lack of consistent financial investment, no prominent voice in school reform, and no niche in the educational mission of school leadership at the local or federal level. Most urban school systems have attempted to implement programs or health policies. These activities often include physical education, food programs, health care programs, health-related counseling, and expanded health literacy programs that focus on high-risk behaviors. Many schools offer minimal health care services, whereas others offer more extensive on-site health care services provided by nurses and school-based clinics.

According to the National Association of School Nurses, only about 40% of all US schools have a full-time nurse, with 35% of schools having a part-time nurse, and 25% having no nurse at all. It is not surprising that most of the schools in the last category are in urban environments. School nurses are usually registered nurses and licensed practical nurses. In schools their main job functions are to address acute problems such as fevers, assist in the management of chronic illnesses, and provide services such as immunizations. Their role also entails educating students on healthy lifestyle choices and working with other school professionals on individualized education programs (IEPs) and 504 plans that include physical health conditions. School nurses can act as the first line of public health nursing to keep students healthy.

School-based health centers are another option to respond to underserved children's access-to-health-care issues. The centers help youth and their families overcome a significant access barrier because they do not have to worry about transportation, time, costs, and lack of continuity of care—all issues that inhibit them from receiving needed health care services. A plethora of research has documented the positive effects of school-based health centers on physical and mental health access and overall health outcomes for children and adolescents. The presence of a school-based health center is associated with overall improved health-related outcomes for prevention, screening, early intervention, and treatment of most common health issues. The major secondary gain is the association of better overall student achievement. Care is provided on-site during and after school hours. Many school-based health services have expanded services to provide health care to students' family members and to the community at large, a move that creates positive support and community connectedness. Consider this: Students spend at least 8 hours a day, 5 days a week in school. For many low-income students and families, the services that public schools offer beyond education (free or reduced lunch, latch key services, etc.) are integral to meeting the day-to-day needs of urban families.

1. When schools, particularly those in urban communities, closed their doors because of the COVID-19 pandemic in March 2020, how did this affect students and families? Consider such consequences as the lack of childcare during working hours, the pivot to virtual learning, and students potentially missing meals.
2. What did local governments, school systems, and businesses do to address some of the barriers the pandemic created for urban public school students and their families? Consider such responses as providing low-income families with food assistance (food boxes sent to home or food stamps) to ensure students received meals; offering students iPads, laptops, or computers; and offering reduced cost for internet services.
3. Students and families within the urban community required additional assistance when schools closed as a result of the COVID-19 pandemic to meet basic nutritional and educational needs. What does this tell you about the importance of schools as a resource hub in the urban community beyond education? What does this tell you about disparities within low-income urban communities?

LEARNING ACTIVITIES

Cost Burden

Cost-burdened households pay more than 30% of income for housing, and severely cost-burdened household pay more that 50% of income on housing. As we learned in this chapter, economic burden is a heavy barrier in urban communities.

Visit https://www.jchs.harvard.edu/son-2020-cost-burdens-map to complete the following activities:

1. Examine housing cost burden throughout the United States. Select three states and compare housing cost burden in urban areas in your selected states.
2. Compare housing cost burden between renters and homeowners in your three selected areas.

3. Discuss how housing cost burden varied between the areas you selected.
4. Discuss housing cost burden of renters and homeowners in your select areas.
5. How do chronic economic disparities and housing cost burden in urban communities perpetuate a vicious cycle of poverty?

Inner City Public School System

Read the article at https://www.npr.org/2020/04/27/845595380/court-rules-detroit-students-have-constitutional-right-to-an-education and then complete the following activities:

1. Review the allegations made by the Detroit students outlined in the above article and discuss the impact these conditions have on educational attainment.
2. List the potential consequences of the despaired educational experience related to the five domains of SDOH.

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CHAPTER 4. HEALTH CARE IN THE INNER CITY: PRIMARY CARE PERSPECTIVE

INTRODUCTION

When you think about the disparities in health care such as those described in Chapter 3 and the increased cost of health care associated with these disparities, such as the cost of preventable hospital admissions and elevated health care cost related to increased severity of disease at time of diagnosis, the brunt of these plights falls on the shoulders of primary care. Consider: *Who is your primary care provider? When was the last time you saw your primary care provider?* These questions are a few of the first questions patients are asked to establish the timeline, trajectory, and quality of the patient's health care experience. Improving access to primary care and increasing primary care utilization is at the foundation of every method to improve the overall health of the nation. In this chapter, we take a look at components of the overall health care system that affect primary care, explore perspectives of the health care providers who deliver primary care, and discuss the patient's perspective as the consumer of the primary care product.

LEARNING OBJECTIVES

1. Understand barriers that affect primary care delivery in urban communities
2. Discuss how disparities in the social determinants of health (SDOH) affect the domains of the Healthcare Effectiveness Data and Information Set (HEDIS) that pertain to primary care (Effectiveness of Care, Access/Availability of Care, Utilization and Risk Adjusted Utilization, and Measures Reported Using Electronic Clinical Data Systems)
3. Describe the role of the primary care provider in all levels of health care: primary, secondary, and tertiary
4. Understand the perspective of the primary care provider in urban communities
5. Understand the perspective of urban patients as it relates to their health care experience
6. Explore how the urban health care provider can improve the patient–provider relationship in primary care

CURRENT HEALTH CARE SYSTEM

The US health care system has set standards and matrices to monitor and measure the effectiveness of the health care system. The transition from a "fee-for-service" model to a more "outcomes-based" model puts more accountability on health care providers to meet optimal health benchmarks. Many institutions, such as primary care clinics and acute care hospitals, gather data that is monitored by the government and insurance companies to evaluate how effectively health care dollars are being used. Providers are held accountable and sometimes penalized if certain quality indicators are not met. However, health care is not Apples to Apples. The disparities in the urban community that cause barriers to achieving optimal health outcomes have been well documented in the literature. Is it fair to penalize urban health care providers for not meeting the same quality indicators as providers in more affluent communities must meet? The inequity related to social determinants of health (SDOH) and the adverse impact on the overall health status of individuals living in despaired urban environments especially in dense, impoverished environments such as the inner city, have been well highlighted. These disparities create insurmountable barriers to reaching optimal health outcomes. The perception of personal health status and health care utilization can be different in urban environments as a result of intrinsic factors for both the patient and provider such as belief systems and biases. Extrinsic factors such as health care provider training and the allocation of resources available to patients also affect health outcomes. Medical mistrust, poor health literacy, and the lack of knowledge regarding how to effectively navigate the health care system can present challenges for both the patient and the provider. Many times we as health care providers must overcome barriers of misconception and issues related to medical mistrust to develop a functional patient–provider relationship before seeing improvements in the patient's health status. The evidence-based guidelines we expect patients to follow to maintain health, such as eating a healthy diet, exercising daily, taking required medications, and attending follow-up visits, are all given under the premise that individuals have an equal allocation of resources and support to achieve these goals. As shown in Chapter 3, individuals in the inner city may experience SDOH barriers that make following evidence-based guidelines very difficult despite the patient's willingness and desire to be healthier. We must be cognizant of how these disparities affect the patient's ability to follow evidence-based guidelines. We must also be able to work with patients within their "lived experience" and in their current situation to enable them to be as healthy as possible. The fact that these barriers exist does not excuse patients from their part in adhering to health care recommendations. Patients should be held accountable for the things they can readily change or control, but at the same time providers should set realistic expectations and outcomes by taking into consideration the patients' disparities. Patients must have the desire to participate in behavioral change for better health outcomes, commit to live a healthier lifestyle, and make health and health care needs a priority in order to be an accountable member of their health care team, and we as providers must facilitate these efforts.

Primary, Secondary, and Tertiary Care

Within the health care delivery system, primary care plays a central role, and the primary care provider is responsible for coordination of care and maintaining continuity. It is also important to recognize that there are other essential levels of care that affect patients' health; these include secondary and tertiary care. These additional levels of care are consistently affected by primary care. Compared to primary care, secondary and tertiary services are more complex and specialized. Secondary care usually involves consultation with a specialist, following referral by the primary care provider. The specialist provides such services as advanced interventions, typically system specific (cardiac, respiratory, etc.) to manage a particular issue—for example, a patient may be referred to the nephrologist after the primary care provider has attempted to manage the patient's kidney disease but feels that this issue needs specialized attention. Although the primary care provider may refer the patient to the nephrologist, the primary care provider is ultimately responsible for managing the patient's other comorbidities as well as overseeing the specialist's recommendations. Secondary care includes specialty consultation like referring a patient to mental health for counseling or medication management or referring a patient to orthopedics for evaluation and to schedule knee replacement surgery with the orthopedic surgeon. The role of the primary care provider is to be in constant communication with the secondary care provider, receive progress notes, and coordinate the care provided by the secondary specialist. For example, a medically complicated patient with uncontrolled diabetes, hypertension, and end-stage renal disease will have a primary care provider but may also have an endocrinologist (specialist who focuses on endocrine glands and hormones), a nephrologist (kidney specialist) to manage the individual’s dialysis needs, and a cardiologist (heart specialist) as part of their health care team. It is the primary care provider’s responsibility to know what the specialists are recommending—that is, what medications the other providers have prescribed for the patient, what dialysis schedule has been arranged, and so on. Typically, when multiple specialists are involved in a patient's care, they rarely communicate with each other, which is why all information goes to the primary care provider, who serves as the gatekeeper and manages the patient's health care. The primary care provider sees the whole picture, whereas the specialists focus only on their particular area of expertise. This is why it is important for the primary care provider to know what is going on with every aspect of the patient's care.

The most complex level of care is tertiary care. Tertiary care is institution based, highly specialized, technology driven care that is usually rendered in large teaching hospitals. Services provided at the tertiary level include trauma care, emergency interventions, surgeries, and conditions that require hospitalization. The role of primary care providers at the tertiary level is to prevent unnecessary hospitalizations if possible; and if a patient needs to be hospitalized, the primary care provider will need to immediately follow up with the patient after discharge to ensure continuity of care and to provide the necessary follow-up to prevent unnecessary readmission to the hospital. It has been estimated that approximately 80% of people in the general population require only primary care services in a given year, while about 10% require referrals to short-term secondary care services and approximately 5%–10% need tertiary care specialist.

Unfortunately, we currently have a very fragmented health care system with multiple electronic medical records for each health care clinic that are not interchangeable or set with the same interoperability functions. Patients who choose to visit different health care systems that operate on different electronic medical records systems cause fragmented and poor information exchange among primary care practices, specialty practices, and hospital systems. Communication barriers impede continuity of care and are very difficult to navigate. This fragmentation of communication contributes to increased health care costs with labs, imaging, and services unnecessarily duplicated. The lag time between communication between multiple practices has been attributed to medication errors, hospital readmissions, and poorer health outcomes.

Insurance Coverage and Barriers

Ideally, everyone should have access to the insurance and health care system equally. Some may even say that in a utopian system, one could seek and receive care equitably. Unfortunately, we live in an imperfect world that is said to have inequitable and unfair accessibility to health care, including inadequate costs and reliability of care. Note that at least 30 million people were uninsured and in the first half of 2020, with 43.4% of adults underinsured. Underinsured individuals are those who were insured but experienced a lapse in insurance coverage in the past year or individuals who were insured continuously but had such high out-of-pocket deductibles or spend-downs relative to their income that they had to limit their use of insurance, thereby causing underutilization. The health care coverage in the United States, determined on the basis of enrollment in an insurance payer group, is detailed in Table 2.

Very few patients pay out of pocket for medical expenses, however; most patients rely on third-party payers such as Medicare, Medicaid, commercial indemnity insurers, managed care organizations, Workers Compensation, and the Veterans Administration (VA), as well as auto liability payouts, to meet their health care needs. Every billable encounter is composed of three participants: the patient, the provider, and the third-party payer. Each third-party payer has its own policies and fee schedule, and billing providers will need to keep abreast of changes that affect their practice.

Insurance Provider	Coverage
Private Health Insurance - Group Plan (grouped or employer sponsored contracts)	177 million (54.4%)
Private Health Insurance - Non-Group Plan (independent/individual contracts)	34 million (10.5%)
Medicare	60 million (18.4%)
Medicaid/CHIP	58 million (17.8%)
Military—TRICARE	9 million (2.8%)
Military—VA Care	3 million (0.9%)
Uninsured	28 million (8.6%)

Source: Congressional Research Service, "U.S. Health Care Coverage and Spending," April 2022.

Table 2. U.S. Healthcare Coverage Enrollment by Insurance Provider

Medicare

Through policies, rules, and regulations, Medicare has a strong influence on all the third-party insurance payers. Medicare is a federal program run by the Centers for Medicare and Medicaid Services and is administered locally by Medicare carrier agencies. Medicare provides health coverage for individuals over 65 who pay premiums and are enrolled in the program, as well as for disabled individuals who qualify for Social Security disability payments and benefits. Eligible members can have Parts A, B, C, and/or D. Each part entails different coverage options. Parts A (hospital services) and B (physician/provider and outpatient services) are covered for eligible patients. Part C is what is referred to commonly as Medicare Advantage, which bundles Medicare coverage into one plan (Parts A, B, and D). Part D is prescription drug coverage and also includes coverage for most of the recommended vaccinations. Patients with what is considered Straight Medicare (meaning they have only Medicare and no other supplemental insurance to cover the 20% that Medicare does not pay) must often have supplemental insurances to cover the portion not covered by Medicare.

Medicaid

Each state administers the federal program entitled Medicaid, which provides health care coverage to low-income families, women, children, and elderly who qualify based on poverty or age and those with short-term disabilities. Unlike Medicare, Medicaid is intended to be jointly funded by both federal and state agencies. Insurance companies such as Molina, Priority, Aetna, Meridian, Blue Cross Blue Shield, and the like, all have Medicaid-sponsored plans for qualified Medicaid participants. These plans tend to be more restrictive in terms of how patients are able to access care. Patients require approval from the insurance company to be seen by specialists; to receive treatment such as procedures, surgeries, or exams; and to receive certain types of medications. They also require approval to participate in clinical trials or treatments that are considered experimental. Insurance payers will require what is called a prior authorization (commonly referred to as “prior auth” or PA)—a process in which the billing provider must justify care that deviates from what is determined to be a standard or covered benefit (e.g., medications that are not covered, procedures, specialists, and out-of-network providers).

Commercial Insurance

Whereas government programs such as Medicare, Medicaid, and VA insurance are primarily funded through taxes and are designed to provide medical coverage without return of profit, commercial insurance policyholders pay a monthly premium that funds commercial policies and often provides revenue for the insurance company. Commercial insurance providers vary by state and can fall in multiple categories, among them health maintenance organizations and preferred provider organizations. Commercial insurance includes employer-sponsored insurance plans and individual policies. Purchasing a commercial health insurance policy will require purchasers to choose a plan that covers the services they need with an affordable monthly premium. As you can imagine, the more health services needed, the higher the premium. Consider how this affects low-income urban patients, who tend to have more comorbidities and higher health needs but lower income than other populations.

PRIMARY CARE

Primary health care is defined by the World Health Organization (WHO, 2022) as "a whole-of-society approach to health that aims at ensuring the highest possible level of health and well-being and their equitable distribution by focusing on people’s needs and as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation and palliative care, and as close as feasible to people’s everyday environment." The fundamental goals of primary care are highlighted using six internationally agreed upon domains, which include (1) Longitudinality, (2) Comprehensiveness, (3) Accessibility, (4) First Contact, (5) Person or Family Centeredness, and (6) Community Orientation (WHO, 2020). Effective primary care relies heavily on relationships (e.g., patient, provider, family, community), focuses on evidenced-based disease prevention and management, incorporates health advocacy, and facilitates partnerships (i.e., interdisciplinary practice to meet the health care needs of the patient) to sustain and improve the health status of the patient. In 1996, the Institute of Medicine defined *primary care* as "the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community."

Primary care is charged with delivering preventative care services; improving the health of individuals, families, and communities; and reducing health care costs. Increasing “access” to primary care is only one step toward promoting health and disease prevention. Consider this: Healthy People 2020 set four goals as it related to clinical preventive care: colorectal screening, blood pressure control, blood glucose control, and childhood immunizations. To facilitate accomplishing these preventative care goals, a law was enacted by the 2010 Affordable Care Act for preventative services to be covered by insurances at no cost to patients. Despite the enactment of the Affordable Care Act, the United States failed to reach these clinical preventive care goals, and even individuals with commercial insurance failed to receive the recommended preventative care. Clearly, having health insurance is not the only factor that affects access to and utilization of primary care.

Despite primary care being the cornerstone of the health care system and the consensus around the world that primary care is a critical component of health care, disparities in access to and utilization of primary care continue to exist especially in inner city communities. A major concern for the primary care sector is the shortage and decline of primary care providers. These providers consist of physicians, nurse practitioners, and physician assistants. Currently, primary care providers represent only one third of the overall physician workforce in the United States. The low number of physicians pursuing primary care as their chosen profession is attributed to physicians choosing specialty practices that offer higher pay and better incentives when compared to primary care. As the number of nurse practitioners and physician assistants has grown rapidly, these providers offer new hope for filling the gaps in access to primary care. Just 31.4% of physicians practice in primary care compared to 42.8% of nurse practitioners and 35.7% of physician assistants. A substantial increase in demand for primary care providers is anticipated as the US population grows larger and older, but getting providers to select primary care as their specialty and retaining current primary care providers have been and will continue to be a challenge. Currently there are 111.7 primary care providers per 100,000 persons in the United States. Another way to interpret these data is that there is approximately 1 primary care provider (physician, nurse practitioner, or physician assistant) for every 895 people in the United States, meaning providers will ultimately need to have the capacity to manage a patient panel too large to facilitate the required outcomes in utilization and quality for all their patients. The challenge of attracting and retaining providers in primary care is further complicated when you add the barriers and disparities found in urban and inner city communities. Disparities in the retention of urban health care providers in other specialties, such as social work, dentistry, mental health, or obstetrics/gynecology (OB/GYN), show a similar downward trend, which further impairs access to quality care.

Primary care providers are responsible for the coordination of the patient's health care and assume responsibility for initial, ongoing, and continuous care. Primary care providers lead interdisciplinary teams to meet the needs of the people they serve, improving the overall health and welfare of the patients. These providers routinely work with other specialties, among them social work, behavioral health, physical therapy, and clinical pharmacy, to provide a holistic approach to meeting the patient's health care needs. This model of care coordination has been provided by primary care providers for decades without formal recognition or a payment structure that acknowledges the amount of work put into this type of coordinated health care delivery. This type of care coordination in primary care is now formally referred to as the *patient-centered medical home* (PCMH). This approach was initially introduced by the American Academy of Pediatrics in 1967 and revitalized in 2008. The PCMH model specifically focuses on activities of care coordination, enhanced access, and payment reform and seems to be the model that ensures the best outcomes for the patient and more satisfaction for the primary care provider. Other approaches to collaborative practice can be found within accountable care organizations (ACOs). An ACO is a comprehensive health care delivery system that either virtually or in real time integrates individual caregivers and hospital-based systems. These systems are connected in a reimbursement system that uses performance measures to ensure accountability. An ACO has multiple levels (Levels A–E), each level having distinct requirements in regard to performance measures, information technology requirements, organizational structure, and payment models (https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ssp-aco-participation-options.pdf).

Including urban community clinics with ACOs creates disparity. Urban practice settings typically do not have the payer mix—that is, enough patients with the insurances that provide high provider reimbursements—to benefit from the value-based reimbursement programs that are structured around majority commercial insurance and Medicare payers. Lack of staff and time to invest in coordination, few financial incentives, a fragmented health care system, limited financial resources to invest in infrastructure, and the complexity of coordination for patients with higher levels of health needs are some of the documented barriers associated with sustaining designation as a PCMH practice in urban communities. It seems that resources are key to participating in programs like PCMH and contracting with ACOs that provide the best care for our patients, and having resources means being able to afford a highly integrative electronic medical records system that will monitor quality indicators for the patients. Entities that are financially stable have the capability to invest in information technology and provide more resources to ensure that health care benchmarks are met. In some health care models, the more successful you are with meeting quality indicators, the more money you receive in reimbursements. Health care providers learn evidence-based guidelines and health recommendations under the assumption that patients will be able to adhere to them—that they have the resources to eat healthily, for example. Very rarely are providers taught strategies or considerations for instances when barriers and disparities cause difficulty for urban patients to reach optimal health outcomes.

Primary Care in the Inner City

As patients in the urban community tend to have more comorbidities and are faced with greater health care disparities than other populations, the urban primary care provider's role has drastically expanded, with the provider caring for more complex, multimorbid patients in the outpatient and community settings. Chronic disease management of hypertension, diabetes, heart disease, asthma, and other conditions is one of the main staples of care. Chronic medical diseases such as diabetes and kidney disease are evident at higher rates among racial and ethnic minorities compared to White populations. Furthermore, minorities are more likely to live in urban communities with minimal resources. Urban minorities are less likely to afford consistent health care coverage and may have difficulty meeting eligibility requirements, which creates disparities in acquiring and maintaining a primary care relationship. Health care systems that support comprehensive primary care have better health outcomes and reduce health care costs. Primary care providers, especially those in urban communities, find themselves managing two or more chronic diseases in a patient while helping that patient navigate a multitude of health care barriers related to social determinants.

Social Determinants of Health and Health Outcomes in Primary Care

Numerous studies have evaluated the impact of social factors on health outcomes and have provided data that substantiates a direct relationship between SDOH and health status. The correlation between increased debility, morbidity, and mortality related to poor health and SDOH disparities such as decreased income, low socioeconomic status, lower education, and lack of social support have been clearly documented in the literature. A study conducted by Galea et al. (2011) found that in 2000 in the United States, approximately 245,000 deaths were attributed to low education; 176,000 deaths, to racial segregation; 162,000 deaths, to low social support; 133,000 deaths, to individual-level poverty; and 119,000 deaths, to income inequality. Braveman et al. (2011) and Stringhini et al. (2010) provided further evidence supporting that social factors such as employment, income, and education strongly influence health-related behaviors. These findings highlight how social determinants of health play a significant role in health and mortality.

Acknowledging that there are greater disparities within urban environments related to SDOH, as well as understanding the relationship between disparities in the social determinants and poor health outcomes for urban communities, sheds light on the complexities of health care in the inner city. The health maintenance barriers and poor health outcomes related to SDOH disparities strongly affect the primary care sector of the health care system. Primary care providers are seen as the entry point to the health care system and are held responsible for maintaining the long-term patient–provider relationship, ensuring health promotion, and advocating for disease prevention. Primary care providers working in the inner city are expected to achieve optimal health outcomes in the midst of suboptimal social conditions that directly affect health status. It is important for primary care providers to recognize that clinical disease is not the only factor affecting health and management of these complex urban individuals and will require skills that go beyond what is traditionally taught in textbooks or in health care provider training programs.

Primary Care and Health Care Cost

In 2020 US health care spending reached $4.1 trillion, or $12,530 per person (Centers for Medicare and Medicaid Services, 2022). Health promotion and disease prevention within the patient–primary care provider relationship is recognized as the best approach to improve health outcomes and to decrease health care spending. Despite this, the United States spends on average 5% to 7% of the total health care funding on primary care. Using the broadest definition of primary care services, which includes services provided by nurse practitioners, physician assistants, geriatricians, adolescent medicine specialists, physicians, and other primary care providers, primary care spending for commercial claims decreased nationally to 7.69% in 2019 from 7.8% in 2017. According to research conducted by the Patient Centered Primary Care Collaborative, an evaluation of state-specific data also indicates that primary care spending declined in 30 states in 2019. Investing more in primary care correlates to decreased hospitalizations, decreased mortality, higher patient satisfaction, and fewer emergency department visits and also promotes continuity of care. Primary care is responsible for 48% of office visits each year and has a potential to affect up to 90% of total health care costs when you take into consideration referrals, procedures, testing, and hospital admissions. The US investment in primary care falls short when compared to other similar industrialized nations that have achieved better health outcomes. The Organization for Economic Co-operation and Development (OECD) states that the average spending for primary care internationally is 14%, which towers over the 5%–7% primary care investment in the United States (Berchet and Guanais, 2019).

Types of Primary Care Access

Ambulatory clinics can generally be classified as one of two types: primary care provider/practice and specialist care provider/practice. Other types of practices include urgent care facilities, mobile clinics, freestanding emergency rooms, retail clinics (e.g., CVS Minute Clinic), and now telehealth/e-visit practices. With the variety of options for health care, many patients still forgo primary care provider clinics for the instant gratification of urgent cares, emergency departments, and minute clinics. These options often offer an immediate short-term solution to address a single issue and lack the comprehensive, long-term care relationship of traditional primary care. Although they come at a greater cost, patients who frequently utilize the "quick fix" clinics generally prefer the convenience of not having to schedule an appointment 2 or 3 weeks out, are currently uninsured, or rather avoid the wait associated with emergency departments. Patients' lack of knowledge about the importance of primary care, about the long-term positive impact that preventative services and the primary care relationship can have on overall health, contributes to some of the disparities related to utilization. Considering the coming generations and an instant-gratification society, what does this bode for the future of primary care practices?

Community Health Centers

A more comprehensive and cost-effective primary care option for the most underserved communities in America is the utilization of community health centers such as Federally Qualified Health Centers (FQHCs). Community health centers were established to increase the access of health care for underserved populations by providing consumer-driven and patient-centered care. Community health centers provide health education and management of high-prevalence conditions such as diabetes, hypertension, and cardiovascular disease. They also provide a safety net for patients to decrease use of more expensive health care options such as going to the emergency room. Community health centers increase access to health care and provide integrated services that address the unique needs of the communities they serve. These health centers are typically located in areas of high need that the federal government has designated as medically underserved areas. Services ranging from behavioral health to vision, dental, and other interdisciplinary practices usually accompany the medical care that is provided, further increasing the community's access to specialty services. Community health centers are open to everyone, regardless of the ability to pay, and usually offer sliding scale fee options for low-income and uninsured patients. To ensure the centers are addressing the needs of the community they serve, each community health center is required to have a governing board made up of at least 51% of patients from the community.

Community health centers have been shown to decrease health care spending. When compared to private practices, community health centers have shown lower spending on specialty care, fewer inpatient admissions, and lower spending on inpatient care. With emphasis on primary and preventative care, effectively managing chronic disease, utilizing a health care team, and reducing ER visits, the community health center can treat Medicaid patients at a lower cost than private practices and provides saving to the overall healthcare system. For example, in Michigan, health centers generate an estimated savings of $123.2 million per year to the Michigan Medicaid program (Michigan Primary Care Association, 2021).

The majority of community health centers that meet the necessary requirements (use health information technology, use key quality improvement practices, emphasize care management for patients, etc.) are eligible to receive health center program federal grant funding to improve the health of underserved and vulnerable populations. Most health center funds come from Medicaid, Medicare, private insurance, and patient fees, among other resources. There are also some community health centers that meet all the health center program requirements but do not receive federal funding; these centers are called Look-Alike health centers.

Community health centers are great resources in urban, underserved communities; however, there are not enough clinics to address the overwhelming need and disparity. These community health centers typically have high provider turnover and too few health care providers to serve the community, which leads to longer wait times to see the provider and appointments that are booked months out. Provider shortages, decreased Medicaid reimbursement rates, increased competition with retail clinics, and more uncompensated care are just a few of the challenges that community health centers face.

HEDIS Measures and Urban Care

State and federal governments are moving toward an outcome and quality driven pay-for-performance model that ensures costs can be controlled among the population of members holding their policies. To achieve this goal, there must be set standards or targets for quality and preventive services. The Healthcare Effectiveness Data and Information Set (HEDIS) is one of health care's most widely used performance tools, with over 191 million people enrolled in health plans reporting HEDIS results. The National Committee of Quality Assurance (NCQA, 2022) defines *HEDIS* as "a set of standardized performance measures developed by the National Committee for Quality Assurance to objectively measure, report, and compare Quality across health plans." NCQA develops HEDIS measures through a committee represented by purchasers, consumers, health plans, health care providers, and policy makers. This data and information set is the most used performance measure in the managed care industry, and these measures are used for commercial, Medicare, and Medicaid insurers. Furthermore, HEDIS is a tool used by more than 90% of America's health plans to measure the performance on important dimensions of care and service. Currently, HEDIS consists of more than 90 measures across six domains of care: (1) Effectiveness of Care, (2) Access and Availability of Care, (3) Experience of Care, (4) Utilization and Risk Adjusted Utilization, (5) Health Plan Descriptive Information, and (6) Measures Reported Using Electronic Clinical Data Systems. These measures cover care throughout the life span, covering maternal health, pediatrics, adolescents, adults and older adults. Looking specifically at the quality measures for the primary care of adults, HEDIS measures cover aspects such as prevention and screening (cervical cancer screening, colorectal screening, vaccinations, etc.), management of physical health (diabetic control, blood pressure control), mental health, older adult care, and transition of care. For the most up-to-date HEDIS measures and detailed descriptions of the quality indicators, visit the HEDIS Measures and Technical Resources webpage at https://www.ncqa.org/HEDIS/measures/.

Independent of the performance measures, each health care provider is evaluated on the basis of ability to reach or exceed the NCQA's HEDIS targets for preventive and quality outcomes. By meeting or exceeding the national targets providers/practices are eligible to receive incentives from payers that help build additional revenue for the practices above the standard billing from claims alone. Typically, many community practices are so focused on meeting the bottom line, they forget to ensure that they are meeting their quality and preventive goals with the credentialed payers. Whether participating in an ACO to gain incentives for these measures or going at it alone, providers can qualify for incentives from individual payers by meeting quality measures for each patient. In essence, practices that are not part of an ACO can act as their own quality managers and send information to the payers to ensure patients are counted in meeting certain quality measures. This is most effectively done with accurate and consistent billing and coding. If doing this is missed during the billing process, providers are able to send reports electronically to payers.

Provider barriers to meeting NCQA's HEDIS metrics for the urban population are not currently acknowledged within the standardized assessments of the health care provider's ability to meet quality indicators (e.g., holding providers accountable for the diabetic control of patients without considering access to healthy foods or referring patients to a dietician). Meeting these HEDIS measures in community practices is definitely not an easy task and is compounded by a multitude of disparities. Factors such as provider–patient relationships, variation in the types of benefits insurance company provide, and social determinants all play a part in meeting quality indicators. Consider this: The availability of health services that promote improved health outcomes and that could improve HEDIS measures varies from insurance to insurance, with some insurers providing transportation to medical appointments, for example, but others not. The more comprehensive insurance policies typically cost more and are thus financially inaccessible to low-income patients, who tend to be sicker and have more comorbidities that those with high income.

PROVIDER PERSPECTIVE

It takes great skill to be an urban primary care provider. Having book smarts, evidence-based guidelines, and the desire to help others will only get you so far. Those providers who have been practicing in urban communities for a long time will tell you that being a really effective, confident primary care provider will come with time, and that is true. However, being an urban primary care provider practicing in the inner city takes additional effort and understanding. The lucky few who in their training programs are exposed to the multifaceted complexities that are unique to urban communities and/or have professors who are themselves urban health care providers—and who can therefore teach their students how to navigate health care disparities—have taken one step in the right direction. Other providers, those who find themselves working in urban health without having had exposure in their training programs, typically discover how ill prepared they are to navigate all the psychosocial barriers affecting health, especially if their first job is in a practice environment with very little to no support. Preparing yourself to work in the urban community means truly understanding the disparities in resources, compliance, access, and more and how they affect your patients' health. You will be managing not only your patients' health maintenance and disease prevention needs but also their chronic diseases; you will be working with multiple specialists and specialist recommendations, prescribing medications, and dealing with acute illnesses. In all this you have to be resourceful and creative as you compose plans of care with consideration of your patients' many psychosocial needs and health care disparities. As health care providers, we would love for our patients to follow the evidence-based treatment regimens we have written, quickly changing to a healthier lifestyle by following a low-sodium diet, for example, and taking medications as prescribed. We want our patients to follow up with needed screenings such as colonoscopies and mammograms and to pursue specialist referrals in a timely manner. But sometimes, it is not that easy. How can urban health care providers manage the complexities of urban primary care?

Mentorship

Having a mentor, someone who has worked in urban health care for a long time either at your site or in the community, is a great asset. Urban health care providers become knowledgeable about community programs, community resources, and other ways to help the patient navigate the health care system. They develop relationships with local pharmacies that offer free or low-cost medications for the uninsured, with state-funded programs that assist with health promotion needs such as free mammograms and pap smears, and with health care groups that can provide free or low-cost medical supplies such as glucometers—all entities instrumental in supplementing the gaps that urban health patients have. Many experienced urban primary care providers rely on professional relationship they have built over time with colleagues, universities, and health care institutions to leverage resources for their patient population; for example, because of their community connections, experienced urban primary care providers are often asked by their colleagues to participate in grants and evidence-based projects that could bring funding and resources to the impoverished communities they serve.

Phone a friend! One of the key pieces of advice we can offer to all new providers caring for an urban population is to always have handy the phone number of a colleague who is well versed and trained in urban health. Urban health care is in fact a specialty, one that requires creativity, patience, and endurance. As a novice practitioner you will need someone you can call to collaborate with on an as-needed basis. Although many situations will be unique and you will have to become creative when caring for this population, you will find that being able to bounce ideas off someone with experience is very beneficial.

Lifestyle Changes and Disparities

You have just received your patient's abnormal labs, perhaps for cholesterol or HgbA1c, or your patient's blood pressure has been trending up or both. Evidence-based recommendations start with encouraging a dietary change (low sodium, low carb, etc.). In your 15-minute visit with your urban patient, simply stating that the patient needs a change of diet and then ushering the patient out of your office without truly assessing the person's ability to adhere to the recommendation will not assist the patient in achieving the goal. For individuals who suffer from food insecurity, live in areas where fast food is more accessible and more affordable than healthier food options, the issues are deeper than "just changing." Assessing the patient's current ability to meet dietary needs, the patient's current dietary habits, and even the food the patient currently has access to could assist you in developing a more realistic, stepwise approach to reaching the desired behavior change. For example, ask about the patient's typical food patterns. You may glean from this conversation that the patient eats six slices of bacon every morning (each slice of bacon has approximately 200 mg of sodium), has canned soups (which are quick and cheap but high in sodium) for lunch, and eats fried chicken and canned vegetables (high in cholesterol and sodium) for dinner. Telling a patient to stop eating bacon, eat fresh vegetables, and bake the chicken is an unrealistic expectation (despite alerting the patient that this diet could be contributing to the high sodium intake, which could be affecting the patient's blood pressure). This patient is accustomed to eating this way, not to mention that financially, eating unhealthily is cheaper. A better approach would be to meet patients where they are with their resources and offer a baby-step approach. Teach this patient about sodium, how to read nutritional labels, and the daily recommended intake of sodium. Recommend reducing the amount of bacon daily, considering lower sodium options and/or rinsing off canned vegetables, using more herbs instead of salt for seasonings, and baking chicken instead of frying. Teaching patients skills they can use to make informed decisions (reading nutritional labels, using apps to monitor sodium or caloric intake, etc.) in the midst of their disparities could prove to produce a more sustained behavioral change.

Managing Disease and Disparity

Evidence-based practice is the foundation for primary care. Implementing evidence-based guidelines and recommendations for the treatment and management of illnesses in the community setting provides a standardized approach to patient care. Evidence-based guidelines are approaches to health care that have been proved effective through rigorous research and examination; however, such guidelines are rarely formulated with the low-income patient in mind. Urban health care providers must be aware of the disparities their patient population faces and translate the standard evidence-based guidelines in a very meaningful and practical way for their patients. As mentioned before, many of these evidence-based guidelines are written from a middle-class mindset assuming that patients have the resources to successfully follow the guidelines. When composing plans of care for the urban patient, it is important to assess the resources necessary to follow the guideline and ask patients what is feasible in their current situation. Modifications and recommendations to increase feasibility of the evidence-based recommendation may be required for patients to feel as though what is being asked of them is an attainable goal. For example, when you think about the recommendation to exercise daily, most people envision treadmills and fitness coaches. For the patients living in an urban environment, simple luxuries like having a safe outdoor track to walk around or even being able to walk around the neighborhood may be unrealistic, given the debilitated neighborhoods, blight, and increased violence in the inner city. The urban provider may have to make suggestions to help patients "think outside the box" to reach their exercise goal—suggestions such as safe and appropriate exercises the patient could do at home (e.g., using appropriate exercise videos on YouTube) or explaining to the patient what the recommended amount of exercise is but helping the patient come up with a stepwise approach to reaching that goal (e.g., starting off with 30 minutes of exercise every other day, with the goal of increasing the frequency of physical activity).

Meeting HEDIS Measures for Urban Patients

The impact of SDOH on health outcomes cannot be ignored. Despite strong evidence that shows the correlation between resources and health, quality measures in health care are the same across the board. Currently quality measures are reported without adjusting for social determinants and other factors that could affect health outcomes. Without adjusting for the social determinants, clinics and providers that serve under resourced low-income areas are labeled as poor performing, while clinics in more affluent communities with more resources and better health outcomes are seen as good. Often, quality measures are linked to financial incentives; again, without adjustments for SDOH, the lower performing, low-income urban clinics will miss out on financial incentives because of barriers that are out of the control of the health care organization.

The topic of adjusting for SDOH in relation to quality indicators is controversial. Those who support the adjustment take the stand that providers should not be penalized for factors outside their control (e.g., a patient's inability to afford healthy food that could be affecting the patient's diabetic control) and that for quality measures to be fair and informative, a statistical adjustment is necessary. In contrast, those who oppose the adjustment argue that adjusting for SDOH could establish lower standards or expectations for providers serving low-income communities and thus affect quality of care. The real question is, if we adjust the quality indicators to take into account the social determinants that affect the health of low-income patient populations, would this adjustment perpetuate and/or exacerbate health disparities in the urban inner city communities? Is there a compromise that will take into consideration the impact the social determinants have on patient health outcomes while maintaining high standards and expectations for meeting quality indicators?

Urban Health Care Provider Deficit

Although many health care professionals are enticed to work in the urban community, the sheer increase in providers does not guarantee equitable distribution and access. Primary care providers practicing in the urban communities typically have lower salaries than are possible in other health care disciplines, and consequently many providers are lured away from primary care and into more specialty practices. This migration leaves serious shortages in the communities with greatest need. The literature clearly shows an oversupply of specialists in the urban communities and a distinct shortage of providers in primary care. The substantially lower salary that primary care providers receive in comparison to their specialty colleagues as well as the increased pressure to produce better health outcomes with fewer resources contributes to the primary care provider disparities.

In addition to salary are other documented reasons why inner cities are unattractive locations for primary care providers. Higher rates of noncompliance and missed appointments; a sicker, more medically complicated patient population; and unattractive social conditions such as drug use, violence, and poverty—in addition to lack of patients with disposable income—are all disincentives for providers seeking higher reimbursement and better working conditions. Another obvious hurdle for inner city health care providers is the economic situation in urban environments. Given the economic disparities concentrated in urban communities, a high percentage of urban patients rely on Medicaid to meet their health care needs. Since Medicaid pays providers substantially lower reimbursement when compared to private insurance rates, it is difficult to offset the lower reimbursement of Medicaid without limiting the availability of Medicaid slots and increasing the private insurance recipients in relation to payer mix.

Another important layer to consider when looking at the shortage of primary care providers in the urban community is the lack of minority providers representative of the patient population being served. As discussed earlier, a high proportion of minority patients live in urban communities, but the demographics of the available providers do not match those of the patient population.

Fifteen-Minute Patient Visits Are Not Enough

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Both patients and providers complain about the amount of time expected for health care visits. When you add the complexities seen in the urban patient, 15–20-minute visits are not enough time. How did we get here? Are "good," "cheap," and "fast" appropriate collective goals to have when managing someone's health? When third-party payers reduce compensation for providers, providers increase daily volumes to maintain stable incomes. The foundation of the 15-minute visit stems from the fee-for-service model, which basically leaves providers feeling as if they work on an assembly line, rushed and quantity focused, diminishing their ability to truly engage with their patients to address the complex health issues compounded by the patient's psychosocial barriers. Considering all the tasks that the primary care provider has to do in one visit—obtain the history of present illness, the medical history, the family history, and the social history; conduct a subjective interview and physical examination; provide diagnosis and treatment; place orders, make referrals, and so on—what is sacrificed to fit into a time constraint of 15–20 minutes? It is typical in primary care for 25 patients to be placed on a provider's schedule for the 8-hour shift. The 15-minute allocated time rarely takes into consideration charting, following up, reviewing labs, and consulting with specialists on the case. Health care providers who feel rushed respond by cutting corners on the history and physical examination or may not have time to ask the detailed questions, which will lead to ordering unnecessary tests and increasing health care costs. From the patient's perspective, patients feel rushed during their visit, which may jeopardize the patient–provider relationship. Fewer health care issues are addressed during the visit, and key pieces of information are omitted. Patients report decreased satisfaction, lack of understanding of and adherence to treatment plans, and excessive use of emergency rooms (Geraghty et al., 2007). Emotional exhaustion, fear of making clinical errors, and burnout are consequences for providers who consistently try to adhere to this time constraint (Linzer et al., 2015). Urban providers have to advocate for appointment times that correlate to their patient's needs. Some patients may require at least 30-minute visits because of their complexities, and it is up to the health care provider to advocate for what is best for the patient. Health care entities need to embrace models that include care management and provide resources for team-based care by colleagues on the health care team (nurses, social workers, pharmacists, etc.). Urban providers are instrumental in helping leadership of health care entities, third-party payers, and other stakeholders to understand how factors such as time constraints affect patient care.

The Medicaid Disadvantage

The high proportion of patients with public health insurance such as Medicaid can cause challenges to primary care provider access. Primary care providers may not accept Medicaid because of the great amount of time and expense required to work with complex urban patients. Working with urban patients who present with biopsychosocial morbidity and have high risk factors but also have far fewer resources at their disposal to cope with these problems can make providing health care difficult for the urban provider. Reimbursement from Medicaid is significantly lower than rates for other insurances, and for urban patients with Medicaid this results in decreased access to care. Medicaid recipients have more difficulty accessing and maintaining a usual source of care compared to those individuals with private coverage and on average use services such as emergency departments more frequently. Furthermore, patients with low health literacy require more time for the health care provider to explain disease and treatment. Missed appointments are significantly higher in practices with patients from low socioeconomic status; thus practices frequently compensate for missed appointments by overbooking patients, which results in long wait times. Research suggests that social needs such as transportation access, financial considerations, health literacy, insurance status, and language barriers have been associated with increased missed appointments in the primary care setting. Unmet social needs may contribute to missed appointments. Many primary care providers do not accept uninsured patients, and if they do accept uninsured patients, their urban patients tend not to have the financial ability to pay for treatment out of pocket. Uninsured patients may feel that going to an emergency room is their only option for treatment.

Insurance Gaps

Gaps in health insurance, similar to auto insurance, can be challenging and financially devastating to patients who find themselves either between jobs or lacking ability to pay for individualized coverage. Not everyone who has a job has employer-sponsored health insurance. Often urban patients have several part-time jobs or under-the-table jobs that do not offer health care benefits. For instance, many grocery store clerks, fast-food servers, retail clerks, and the like are not offered employer-sponsored insurance for a number of reasons:

- The employer does not contract with insurance payers in the local network.
- The employees do not meet the minimum requirements to participate in the employer-sponsored programs (i.e., they do not work more than 24 hours per week).
- The employees elect to forgo the employer-sponsored plans, as they are too costly for the employee to cover basic expenses. (Keep in mind that offering expensive insurance is not necessarily the fault of the employer. Simply put, employers may be unable to afford a contract that requires them to absorb the majority of the costs so that they can pass along savings to their employees.)

Lack of health insurance is strongly linked to lack of health care access and limited exposure to high-quality health care.

PATIENT PERSPECTIVES

The primary care relationship has been well documented in the literature as one of the mainstays for improved health outcomes. Barriers exist within the inner city communities that affect the patient's ability to initiate or sustain the primary care relationship. In Chapter 3 of this text, we discussed SDOH from the lens of extrinsic factors that affect health outcomes and present barriers for individuals in the inner city. It is also important to recognize that there are intrinsic factors that also affect a patient's access to primary care. Brown et al. (2020) interviewed low-income patients living in an inner city to identify why primary care appointments were being missed. In this qualitative study they identified three major themes: transportation issues, uncontrolled personal health needs, and obligations to employers and family members. Identified under transportation issues were limited transportation options and unreliable transportation. Personal health factors that contributed to missed appointments included mobility challenges such as pain, limited range of motion, and inability to stand at bus stops or walk long distances because of gait instability or chronic pain. Other competing obligations such as attendance at work or prioritizing family needs were also identified as contributors to missed primary care appointments. Health care providers are quick to label a patient noncompliant when appointments are missed and/or plans of care are not completely adhered to, but have you asked, "Does this patient have barriers to compliance?"

This section highlights the urban patient's perspective related to health maintenance, disease management, and the urban health care experience. Crafted from patient feedback over the years, each theme is preceded by a quote from the patient's viewpoint, followed by additional discussion related to the theme and strategies to help the patient and provider navigate the barriers associated with the identified theme.

An Oil Change vs. Health Maintenance

"When do you learn about health maintenance?"

Health promotion and disease prevention is one of the main objectives of primary care. Sometimes, explaining to a patient the importance of health maintenance can be a challenge. Some patients believe that because they "feel well," health maintenance is not necessary. Other patients do not see the necessity for a long-term, consistent relationship with the primary care provider that involves regular checkups, annual lab work, and screenings, among other things, and interactions with the health care system. For these patients, interactions with the health care system are typically episodic and occur only after health issues arise. Unfortunately, it sometimes seems easier to interact with the patients once they have already experienced negative effects of the lack of health maintenance (e.g., having headaches from uncontrolled high blood pressure, experiencing symptoms such as vision changes related to uncontrolled or undiagnosed Type 2 diabetes, feeling burning with urination related to having contracted a sexually transmitted infection). It seems very difficult at times to get patients to really understand and embrace the concept of preventative care. However, If you apply the concept of prevention to a different situation, such as maintaining your car, the connection seems to come a little easier for patients.

Imagine you are trying to maximize the life of your car. If someone told you that getting an oil change every 3 months will sustain your investment and help your car run better and last longer, you will make an appointment every 3 months, wait 45 minutes to an hour, and pay $45 or more every 3 months to ensure that your car will last for a long time. The thought of your car breaking down, of your being stranded, relying on others for rides, or catching the bus, is enough motivation for you to make this regular investment to keep your vehicle running. Not to mention that you see the value in paying your monthly car insurance, just in case you are in an accident or someone steals your vehicle, so that you can promptly replace your car or get your vehicle fixed if necessary. How is this different from health insurance and health maintenance? You could even argue that replacing a vehicle is easier and more feasible than getting a new heart, lung, or other essential body part, pointing out that good health is a person's greatest asset.

As health care providers we have to work with our patients to get them to normalize health maintenance and to see the value in the preservation of health versus managing a preventable disease. This task is easier said than done, for as with other health behaviors, the normalization of health maintenance is usually a learned behavior and is strongly influenced by what an individual has witnessed growing up regarding use of the health care system. Think about it, from prenatal care until you are in your late teens, someone else is responsible for your health care. A parent or guardian is responsible for taking you for your immunizations and well child visits. If you are part of the school system, immunizations, back-to-school physicals, sports physicals, and so much else are part of your annual routine. And in school you are constantly observed by parents, teachers, coaches, and other responsible adults for any health-related issues (chicken pox, ringworm, ear infection, asthma management, etc.). But what happens when we become young adults (at 16, 17 years old)? You start to be more accountable for your own health or, at minimum, you do not want adults (your parents) in "your business" (e.g., going into the exam room with you). If you did not grow up in an environment that normalized health maintenance, how are you expected to value disease prevention and health promotion? Typically, the health maintenance of the adults in your childhood (outside of a family member with a chronic disease) is not normally discussed or witnessed during the impressionable years (e.g., you do not hear your mother talking about her annual mammogram or physical). Because of this, the concept of health maintenance is not introduced until well into adulthood, after other health behaviors (negative or positive) have been adopted.

Clear Communication Is the Foundation of the Patient–Provider Relationship

"As someone who has multiple chronic illnesses, involving multiple doctors, it's a lot to keep up with. One thing in particular is when my providers change or move on with no notification. This is why the first question I have for my provider/specialist is, 'How long do you plan on staying at this location or network?' By the time I finally found a provider, I'd seen her twice and then she left. So by the third time I was going to see her, she was no longer taking patients. Which means I had to start all over finding a new doctor. This is a hassle! Apparently, I'm supposed to go through the insurance company and tell them I have to find a new provider. But that means looking through and seeing who was taking new patients, who's available and all that. It would've been nice if I could've gotten a notice saying that my provider would no longer be taking patients and that I would have to find a new one. Especially when you find that out when you need your prescriptions refilled."

–Sincerely, Please communicate!

Provider turnover is extremely high in underserved urban communities (reasons for high provider turnover and other barriers to patient–provider continuity in the urban community are further discussed in the "provider considerations" section of this chapter). Although provider training programs find urban clinics a great training opportunity for future health care providers, if managed incorrectly these training programs could leave patients feeling as though they are interacting with multiple providers who do not know them or do not have a genuine interest in working in their urban community. Patients may also feel a lack of connectedness to their primary care providers or feel they are getting suboptimal care because they constantly have to interact with trainees instead of getting to see the provider with whom they scheduled their appointment.

Imagine having multiple comorbidities, taking multiple medications, and seeing numerous specialists. At every primary care visit, you have to explain the barriers you face related to disparities pertaining to SDOH, and each time you must explain yet again the chronic issues you are having with maintaining your health. Imagine each time having trainees ask you questions that should have been clearly documented in your medical record—questions about what the plan of care was from the last visit, why you were switched to a new medication, when the last time you saw the specialist was, when your last mammogram was, and so on.

It is important to train urban primary care providers—that is the whole purpose of this textbook— but there is a better way to train providers that preserves the patient–provider relationship between the provider of record and the patient. This starts with the genuine relationship between the provider of record and the patient. Patients should not have to question who their primary care provider is or ask where that provider is during the visit. One strategy to address this issue of connectedness is for the provider of record to at least speak to the patient at the beginning of every visit, introduce the intern who will be assisting with the patient's care today, and let the patient know who is the provider of record. The patient should know that the provider of record will be accessible for any additional questions and can be reached directly, and that the provider of record will make time for that consultation during the visit. If possible, as provider of record you should accompany the trainee, at least for the first visit with the patient, to let the patient know that continuity exists and that you, as the provider of record, are constantly involved in patient care and accessible.

The Patient Is a Member of the Health Care Team

"I remember when I was going to see my new podiatrist and I didn't receive the appropriate care. I'm aware of the basic things that should happen when I go to the foot specialist, I've been going to foot specialist for

decades. I was having a pain in my foot, and as a diabetic (Type 1 diabetic since the age of 14), I took this serious! I got a referral to a podiatrist. When the appointment came, I went in the room and the resident came in. I really don't like talking to residents, because I still end up having to repeat myself to the doctor. The resident is asking all of these questions, but never looks at my foot. The attending comes in, and she agreed with the resident, touched my foot and that was it, and walked out. That was it. Now, I know from previous podiatrist, I was supposed to get my feet looked at, the sensation test, check the blood flow/pressure, and get my toenails clipped and trimmed. None of that happened! So, I got a universal referral to see someone else out of the network."

–Sincerely, Knowledgeable about my health care needs

None of us like feeling as though our health concerns are being dismissed when we are seeking help from our primary care provider or specialist. When patients have concerns, it is important to address them. For some patients, it takes a lot for them to even bring the issue to their primary care provider's attention by saying, for example, "This new blood pressure medication is causing issues with my erections and hindering my sexual performance" or "This medication is causing me to gain weight." That the patient is trying to talk to you as opposed to just stopping the medication or treatment regimen is commendable. Reassure patients that you are listening to them and investigating their concerns, even if doing so requires asking a few additional assessment questions, coming up with a plan to monitor the complaint, or compromising regarding the treatment strategy. Taking these approaches could promote better patient compliance. Think about it, if you took a medication that made you feel worse than before you started taking it, wouldn't you stop? Side effects do occur, but the key to addressing the issue is keeping communication open between patient and provider. Here are some things you might say to allay patient concerns:

- "We really want to get your blood pressure down. The last two visits your blood pressure has been above 152/90, and heart disease runs in your family."
- "I am prescribing you this medication for your blood pressure to take everyday."
- "If you have any issues with this medication, please let me know right away so we can explore other options."
- "There are many different types of blood pressure medications that we can choose."

Communication lets patients know that there are other options and that you want to work with them to find the best solution. Controlling the health issue is important; however, we do not want the patient to abruptly stop the treatment regimen or give up.

Patients with long-term, chronic diseases might not be medical professionals, but when it comes to their health care, they have been dealing with their disease and its complications sometimes for decades. Honestly, they may have more knowledge about the disease and the complications than you do as the health care provider because they have a lived experience. The patient has probably seen multiple specialists and is familiar with the health care routine, including frequency of labs and what procedures are needed. If we, as trained providers, are practicing evidence-based care, then patients should be confident that what their health care providers do for them is consistent, even if they have to get a new provider. For example, uncontrolled diabetics should have their HgbA1c evaluated approximately every 3 months, so the patients should be used to their routine and expect the same type of monitoring regardless of which primary care provider or endocrinologist they visit. Patients living with chronic disease need someone who is part of their team and not someone who will dismiss their concerns or experience because they have no formal health care training.

Health Care Can Be Overwhelming

"It would be nice to get some type of reminder that you haven't seen your doctor in a while. Not because you don't want to, but because life is also happening, and sometimes you forget. Or the fact that when you walk out of an appointment and try to make another one, you're told that the calendar doesn't go out that far, and to call back to make the appointment. This is when the reminder would be nice. A phone call, email, MyChart message, letter, etcetera."

–Sincerely, Overwhelmed!

Do not be quick to judge a patient who forgets an appointment, misunderstands health care instructions, or does not follow up with a referral in a timely manner. Sometimes people get so overwhelmed with what they have going on with their health, not to mention what is going on in their personal life, that things are just too much to handle at one time. Many of us without health issues have difficulty balancing our daily activities. Consider everyday activities and responsibilities compounded with having four or five chronic diseases; dealing with fluctuations in wellness related to the chronic diseases; taking up to 10 daily medications; seeing three or four specialists, including for follow-up appointments; keeping up with durable medical equipment needs, medication refills, and health maintenance needs; not to mention dealing with acute health issues such as the common cold. As if that is not enough, add the disparities found in the urban community that were discussed in Chapter 3. "Overwhelming" seems like an understatement. Offering support, helping the patient to align resources, assessing for health-related—this approach is more beneficial in the long run than penalizing the patient or making the patient feel like a failure.

General Mistrust or Fear of Diagnosis/Procedure

"It's not uncommon for a patient to ask a medical layperson, like a family member, spouse, or friend, their advice about a medical abnormality–a lump, pain, discharges, and so on–before going to a medical professional . . . Going to the medical professional is the last resort, not the main or initial source for help."

–Sincerely, Can I trust you?

Patients reach out to those they trust for help. The goal of the primary care provider is to be among the trusted counselors. Vicarious "health experiences" from hearsay or the comments and experiences of friends, family, even strangers, strongly influence a patient's health decisions. Unrealistic expectations of outcomes and fear of experiencing a medical procedure because of hearing about someone else's bad experience (e.g., hearing that someone died during a colonoscopy, but not knowing what other factors may have contributed to the death) are real concerns patients bring to the health care visit. When a patient seems reluctant or afraid of a health care recommendation, it is imperative to offer understanding and try to discern why the patient has concerns. You can say, for example, "I can see that you are visibly disturbed by my recommendation. Can I answer any questions for you?" or "Tell me what you have heard or read about this procedure." Opening a dialogue offers an opportunity to potentially dispel myths and give the patient factual information to make an informed decision.

When it comes to compliance with preventive screenings, consider the type of screening you are recommending for your urban patients. As patients well understand, the more invasive the recommendation, the more risks involved. Consequently patients' concerns are elevated. Consider colorectal screenings. Of course, with colorectal screenings the gold standard is a colonoscopy. This is so not only because of the accuracy and visibility enabled by using the colposcope but also because patients will likely have to repeat the screening only every 10 years. So, you may think, “Great! I can help you prevent colon cancer with the best screening method and you will likely be covered for up to 10 years depending on the results of the procedure.” However, the reality for patients is they may not have someone to take them to and from the procedure appointment or to stay with them for the remainder of the day, since colonoscopy patients are a fall risk from having had anesthesia for the procedure and therefore require in-person support. Again, while requiring your patient to undergo a colonoscopy may benefit you as a health care provider (e.g., incentives, longer time/coverage of completed screenings), doing so may not best serve a patient’s lifestyle or could cause the patient to be afraid. In this case, it may be best to present all options—the pros and cons—related to invasiveness, time, comfortability, and other relevant factors. A patient who lives alone with little to no support from a network of people would likely be better suited for a Cologuard or other alternative.

The best approach for health care providers to consider is to education patients by discussing not only the screening procedure but also the nature of the tests, alternatives, and the best fit for level of comfort. It helps to let the patient know that a Cologuard test requires being comfortable with handling your own feces to collect a specimen. While we may describe this alternative as simple, it does have a moderately high level of user error for most patients over 55. You want to avoid wasting the patient's time and yours with inconclusive results. Not only that, but you must ensure that your patients are fully informed that a positive result will require them to still complete a colonoscopy. Now we run into insurance issues where the patient will potentially incur out-of-pocket cost for a procedure that is no longer preventive but considered diagnostic by the insurance payers.

Patient-Centered Communication

“I might not have a health care background, but that doesn’t mean I lack understanding.”

Before patients come to you as the health care provider, they have already googled health outcomes, possibilities, and situations that could potentially go wrong. No, many patients do not have a medical degree or health care background, but that does not mean they cannot understand information that is accessible to them in books, through internet searches, by deducing information from previous experiences, or by talking to their family or friends. Providers should use individuals’ access to resources to help educate and inform the patients. Provide them with reliable websites to visit; explain that everyone is different and that just because someone they know had a bad or good experience does not mean it will be the same for them. Patients who are technology savvy can be empowered to use apps for the benefit of the patient–provider relationship; they could, for example, use an app to monitor menstrual periods, blood sugars, carb/calorie intake and exercise frequency for healthy weight loss, or sodium intake to better control hypertension. Encouraging them to use technology to be healthier and teaching patients what reliable resources look like rather than being dismissive or feeling frustrated as the urban health care provider will garner better results. Patients are going to seek advice from tech sources anyway, so why not make that effort work for the overall outcome of better health. However, for this to work, health care providers have to give positive reinforcement: “I am very glad to see you doing some research on the topic, so let me show you the most reliable resources for patients. Read this and let’s discuss it at our next visit, but please communicate with me before you finalize any decisions.”

Patients can gather information from different resources, but what they lack is discernment grounded on medical knowledge, evidence-based practice, and a big-picture perspective. Your patient comes to you telling you that a cousin ordered a weight loss pill off the internet and lost a lot of weight. Your patient wants to try this drug and mentions that she looked it up and everyone that took it had great results. Your role as the primary care provider is to look into the medication in the context of your patient's specific situation and provide evidence-based guidance specific for your patient. The provider can say, for instance, "I understand people you know have taken this medication; however, due to your congestive heart failure and uncontrolled blood pressure, this medication can cause you more harm and put you at risk for stroke or heart attack. I understand weight loss is important to you, so let me get you a referral to a dietitian and let's see if your insurance offers a weight management program that will help you lose weight in the healthiest way possible, without causing further harm." Still, working within the urban community does increase the propensity for encountering disparities related to health literacy. Making sure patients understand health care instructions, involving support systems in their care, and having patients "teach back" the health care instructions—that is, having patients show you how, for example, they would perform insulin injections at home—as well as providing health information in a way that is culturally appropriate and easy for the patient to understand, are important strategies to ensure comprehension and further facilitate compliance and better health outcomes.

Respecting the Patient

"I deserve to feel respected."

You are the provider, not the parent. "Because I said so" is not the way to approach those you want to be active participants in their own health. Respecting the patient but, what is more important, making the patient feel respected is integral to having a working relationship. Respect does work both ways, of course, and includes clear communication, honesty, and understanding. Involving patients in every aspect of their treatment plan, taking into consideration of SDOH and other barriers patients may face, and even asking patients, "How does this plan sound?" or "Do you feel that you can do this regimen until our next visit?" If a patient says no, then you work with the patient to find a compromise that is doable for that patient. Setting attainable and realistic goals for a patient allows the patient to feel as if the goal can be met. Explaining in terms the patient can understand why you as the health care provider are taking this approach—for example, "Because I am trying to preserve your kidney function and treat your diabetes, I am putting you on this medication that provides protection for your kidneys"—helps patients make an informed decision. At the end of the day, you can come up with the most beautiful plan in the world, but if that patient leaving your office cannot adhere to the plan or refuses to follow it, then no health care goal will be met.

Something as simple as how you address that patient can affect how the patient responds to you. Remember, these urban patients are matriarchs and patriarchs of their families, leaders in their communities, and elders in their churches. Something as simple as addressing patients by their first name without first asking permission could be considered disrespectful. Being courteous and respectful puts patients at ease and allows them to feel more comfortable having a conversation with you.

Working With Patients Who Fall Outside the System

"If you're not born rich, you hope that you're fortunate enough to fall into one of the criteria or agencies that promote and preserve our health, agencies such as schools, employment that offers medical benefits, jails,

armed forces, and so on. . . . If you don't qualify for one of these agencies, you have no medical. . . . A prisoner under the medical services of the Department of Corrections has more access to medical services than a young unemployed college graduate. If you're part of an agency or system, you at least get some kind of health care services. But what if you don't meet the criteria to be a part of a system that provides health access?

–Sincerely, Adults who are not a part of a system

Well, this definitely provides food for thought. Most individuals work hard to become part of a system that provides assistance with their health maintenance and disease prevention. The drive to go to college, get a degree, and get a good job with benefits means that you will be a part of an employment system that may require you to get a physical to qualify for the job, maybe have access to occupational health, and increase your access to health care by providing health insurance. Joining the military is another system that comes with some type of health care coverage, and having that coverage is seen as a valuable benefit for the enlisted and their families. Even incarceration, as negative as this system is, does provide some level of health screening, health maintenance, and disease prevention. There are also other systems similar to the ones mentioned, that provide some access to health care if you belong to them: If you are in college and under the age of 26, for example, you may be able to stay on your parents' health insurance. Patients who do not qualify for these systems may feel that they have no recourse for support in effectively and economically maintaining their own health. Among those who do not qualify for health insurance are persons between jobs, mothers who received prenatal care but have delivered their babies and now have no health care, college students over 26 years of age, recent college graduates having difficulty finding a job—the list goes on and on. People who fall into this health care void usually try to stay healthy the best way they can or may feel that they have done "just fine" without a primary care relationship.

Understanding Patients' Competing Priorities

"Yes, my health is a priority, but there are things that have higher priority. There are moms that have never missed taking their young children to their mandatory checkups, but the moms don't take the same stance on their health... The mom doesn't prioritize her own health care needs as a woman, to have regular medical routines to maintain her health... By the time this mom has sent her children off to college, she's diagnosed with breast cancer that has metastasized."

–Sincerely, I'm not a bad patient, just trying to be a Good mother

Balancing being a mother, a wife, a full-time employee, the matriarch of the family, a sister, a friend, a caregiver for an ailing parent, and an overall superwoman is just one example of how life and other priorities can get in the way of taking care of oneself. A man who is the provider for his family, works 12–16 hours a day, has an inflexible job, and is the sole breadwinner for the family could easily prioritize these many responsibilities before addressing his own ailments or health concerns. This does not mean that such patients do not care about their own health. It usually means that in their role as providers, their attempt to be good employees, being there for the people who immediately and consistently depend on them, and valuing their role of being a good parent, a good spouse or partner, a good child to their parents ,and a good provider weigh more heavily than taking care of themselves. Consider the complexities and the health implications of grandparents taking care of grandchildren, parents taking care of chronically ill children, adult children taking care of ailing parents, or single parents taking care of multiple children. In certain situations, the weight of responsibilities to others, especially loved ones, tends to be prioritized over the health care needs of the patient who serves as the caregiver. Sometimes it is beneficial to put the concept of health maintenance into the realm of self-care. Remind patients that there are people who depend on them and that if they are not here or become ill, especially from something that could have been prevented or treated early, they could hamstring their ability to fulfill the roles they are proud of. Telling patients to "schedule an uninterrupted hour a day of exercise or meditation as self-care to reduce stress" or "attend your regularly scheduled health care appointments to talk about your needs, and your health and have someone focus on taking care of you for a change" is a way to change the perception of health maintenance from something that is "not as important" or "selfish" to something that will preserve patient health, prolong patients' ability to take care of others, and address disease prevention and health promotion needs so patients can continue fulfilling their many roles.

What You Don't Know Can Kill You

"I feel fine" or "I'm not fat, I'm big boned."

Do not assume that you and the patient have the same definition of *health* or *good health* or *healthy*. Try to understand what the patient believes is healthy and use that information as an opportunity to further educate the patient. For example, when confronted with the mention of weight loss, many patients in an urban setting are often under the impression that their weight is not a health risk. Being called "thick," "big boned," or "phat" in this population is not considered an insult. These words are viewed as terms of endearment or compliments among men and women. When faced with the issue of needing to lose weight to promote health, patients may not be receptive and often respond with "you're trying to make me weak" or "I'll look sick." The patient may, for example, be concerned about losing "curves" and not understand the effects of obesity on blood pressure, blood sugar, or heart health. Understanding the patient's feelings and being prepared for this discussion will be helpful for any health care provider in an urban setting working with patients to set health goals.

Many patients view "healthy" as the absence of illness—for example, no headache, muscle aches, or vomiting—and do not realize that though they may feel fine now, by the time some diseases show signs, the damage has already been done, as is the case with hypertension. Understand that health promotion and disease prevention are not normalized behaviors in some families. The patient may have experienced only episodic health care or seen family and friends encounter the health care system only for emergencies, which could give the patient a trauma-informed perspective of health care. Many patients do not value or understand the purpose of the primary care relationship. Trying to get your patient to embrace preventative care such as screenings, regular medical visits, and annual labs may require educating the patient on why these screenings are necessary or why you are concerned about the patient's risk factors. You could say, "I notice that you have a strong family history of breast cancer. Given your age and risk factors, it is important for us to schedule you for a mammogram."

Consider why we refer to hypertension as the silent killer. Many patients live with elevated blood pressures and have no symptoms or ignore the subtle symptoms they do have (e.g., headaches). By the time these patients with uncontrolled blood pressure seek medical treatment, it is because the elevated blood pressure has now begun to cause end organ damage such as chest pain, EKG changes, or vision changes. When these patients finally come in for medical treatment and you ask them if they have ever been diagnosed with high blood pressure or hypertension, they may say "no." Your next question should be, "When was the last time you saw a health care provider?"

Unfortunately, some patients believe that because they feel fine or because they do not go for regular checkups they are healthy.

Working With Home Remedies

"Big Ma said..."

As we urban health care providers encounter patients in an urban setting, we have to understand that we are encountering not only that patient but also all the cultural traditions and health-related experiences that person brings into the room. Previous health care encounters, what WebMD said, old wives' tales or remedies from family/friends, information accessed from other sources, all have preceded the patient's visit with you. Whether from general medical mistrust or simply because they do not know you and sought guidance from sources they know and trust, most patients have tried to address the issue themselves before coming to you; they may have tried over-the-counter medications, calling a family member, or asking a friend for advice.

Knowledge of health and wellness for most patients comes from what they learned and experienced during their upbringing. What "Big Mama," "Mama," "Auntie," or "Abuela" taught them while growing up sticks with them throughout their lifetime and is passed down from generation to generation. "If you have a cough, rub your chest with Vicks," "Drink baking soda and cornstarch or eat mustard for an upset stomach," "Drink Apple cider vinegar for your blood pressure," and "Eat some cinnamon to lower your sugar [i.e. ,high blood sugar]"—these are just some of the advice offered today, methods used back in the day that are still being used today because poor people lack finances and resources. It is considerably hard to compete with the advice of "Big Ma" or loved ones without seeming to look down on the patient's family and how the patient was raised. The discussion has to center on what prescription medications can do to control the patient's conditions and prevent the adverse effects of not treating chronic illness. As primary care providers we can encourage the patient to continue to be informed about nonpharmaceutical options like lifestyle changes involving weight loss and exercise, Do not be judgmental, condescending, or offensive regarding the patient's belief system. Create an atmosphere that encourages patients to be open to share these home remedies with you so that you will at least know what the patients is doing that could affect their health Doing so will also give you the opportunity to interject facts and evidence-based research.

HEALTH CARE ACCESS AND UTILIZATION

Consider the hours of operations in which the majority of community primary care practices are open. With the same operating hours as the average business and same work day for employees, the hours of available appointment do not correspond to the hours of availability for most of your patients. As much as the health care system has tried to normalize taking time off work for health care appointments, most people are less likely to take time off work to commit to a primary care visit. There are some exceptions, which include patients with chronic conditions that affect their daily lives. Likewise, patients receiving disability benefits are more likely to remain flexible with scheduling during work hours, and they typically prioritize their health as needed.

Not all working adults have the ability or the privilege to manage their own time during a work day, however. Most working adults cannot make a health care appointment without putting in a request for time off or simply calling in sick for the day. More than likely, the people with the freedom to come and go autonomously are those who work in corporate white-collar jobs. People with corporate jobs most frequently have the ability to take an appointment without a looming penalty involving corrective action or waiting for approval from supervisors. Think about someone who works at a grocery store, factory, or even a hospital. Depending on their role, title, and seniority, the majority of those employees do not have the liberty to take an appointment during work hours, and usually their leisure activities, which may involve attending extracurricular activities for their children or just spending off time relaxing and socializing, are prioritized for off-days.

One-Stop Shop

Considering all the barriers that urban patients face, as discussed in this textbook, it would seem very convenient for a patient to be able to get multiple health care needs addressed at the same location and, even better, on the same visit. Primary care facilities that offer interdisciplinary practice under one roof provide better access to multiple specialists for their patients. Consider how a clinic that offers primary care, mental health care, dentistry, gynecological services, and a social worker to assist with health care barriers (e.g., enrolling patients for insurance) and helping patients with social needs (e.g., helping patients identify community resources) provides a holistic approach to health care and improves access for the patient. Another great example of interdisciplinary practice is integrating behavioral health into primary care sites. Primary care clinics that have a mental health provider on site have been shown to increase patient access and decrease mental health stigma.

ROLE OF COMMUNITY IN HEALTH CARE

It is nearly impossible to manage the health care of complex urban patients without addressing their psychosocial disparities. A successful primary care practice will need to align with community resources. Many clinics have a community resource book that is often thought to be the magical book to solve everyone's problems or to make you as a health care provider feel better knowing that because of your knowledge and ability, you gave a patient the resources the patient needed. Indeed, your clinic should at minimum have a book of local and/or regional resources that covers areas of unmet need (food, housing, medication, disability, clothing, jobs, insurance, etc.). Not only should this magical book exist, whether electronically or on paper, but the best thing is knowing how to approach this conversation with patients and how to follow up with them. Asking patients if they could use some help with any of their basic needs may generally work for most. But many patients fear intervention from governmental agencies such as Child Protective Services, so they will not disclose to anyone (their medical provider included) that, for example, they do not have running water in their home. For these patients, lacking or needing assistance with basic necessities translates to being reported to the Department of Health and Human Services or to some other government agencies that offer assistance but also have the ability to take away assistance—or worse, their family. Sometimes being temporarily down on their luck can result in a domino effect of potentially bad outcomes.

As their primary care provider, your goal must be to ensure that your patients trust that you are there to help them and can offer a potential solution. Sometimes it is best to broach the conversation by acknowledging that many times people get down on their luck and telling them that the fortunate people are those who can receive help that will help eventually alleviate the temporary setbacks we all sometimes face in one way or another.

Build more trust not only by offering your patients the resources they need but also by asking them follow-up questions at their next visit or maybe during the phone call to relay test results: "Hey, how did that number work out for you? Did you get the help you needed? Do you think you'll need another resource to make sure everything is handled?"

Community Engagement

There are a number of approaches to building trust with patients in urban community practices. While not all-encompassing, here are some positive ways to develop a trust-based provider–patient relationship. Some health care providers may think that setting expectations and telling patients how you work (i.e., follow my rules) may be the best approach when first seeing a patient. It is not. As a provider in an urban community setting, it is incumbent on you to set a tone of listening and seeking to understand what limitations your patients face. Assuming that all patients in an urban community practice face the same barriers will cause patients to take offense and feel that you have judged not only them personally but also their circumstances before even getting to know them. So, simply listen and allow your patients to share what they want you to know about them personally. Undoubtedly many patients are coming to you with an immediate concern that needs to be met (yeast infections, medication refill, etc.). As important as it is to meet that need and solve the issue, it is important to offer patients an opportunity to prevent their encountering the same issue in the future.

Another opportunity to build trust is to allow patients to know you are willing to work with them through critical situations. Are you able to be a "call me first" type of health care provider? If resources are available, patients want to call their providers to see whether they need to come in to see them or go to the hospital. While most patients are compelled to go immediately to the emergency department, your goal is to provide the messaging of "call me first" to help patients trust you. Holding appointment slots to enable your patients to come in for same-day urgent appointments will help build trust of accessibility.

Think beyond just the patient in your exam room. Understanding that health is influenced by family, community, and social networks, consider opportunities to engage the larger community (e.g., hosting community health fairs or partnering with local churches to speak about health issues). Consider having an outreach person within your clinic who can forge relationships with community stakeholders to show that you are interested in promoting healthy communities, families, and individuals.

URBAN HEALTH CARE PROVIDER CONSIDERATIONS

Common solutions to address disparities related to the exacerbation of chronic disease, the eradication of preventable diseases, early detection of disease, or the need for immunizations that could ward off communicable diseases are expected to be initiated and sustained within ambulatory or primary care centers. Despite the huge responsibility that falls on primary care for maintaining the health of individuals, families, and communities across this nation, hospitalizations account for the bulk of health care spending. Recall, as discussed earlier, that traditionally providers see primary care as unattractive to because of low reimbursements and the multilayers of barriers to reach patients, let alone resources to truly address the health care disparities that exist. In addition to the ill prioritization of primary care on the national front is the unattractiveness of primary care to those providers looking for higher financial remuneration. Also unattractive is that low-income urban patients do not understand the importance of sustained long-term primary care relationships and preventative health care. These factors continue to be a hindrance to reaching the potential positive impact that primary care can have.

Primary care is indeed where the greatest impact on health promotion and disease prevention can occur. The primary care provider's role is complex and demanding but also very rewarding. The primary care provider is best positioned to profoundly affect the immediate and prolonged health outcomes of individuals, families, and communities. These providers working in the urban setting must solidify a reciprocal relationship with their patients, encouraging the exchange of ideas and identification of facilitators of health. To truly advocate for urban patients, we as health care providers must work collaboratively and intuitively to leverage all available resources to assist patients in overcoming barriers. Truly being with the patients, helping them navigate their disparities to achieve the most optimal health outcome, requires an interdisciplinary approach and a clear understanding and continued assessment of the disparities urban patients face.

EXEMPLARS

Exemplars for Chapter 4 are provided in the Provider Perspective and Patient Perspectives sections. The themes identified in these sections are derived from real situations and reflect the lived experiences of patients and health care providers. In small groups, discuss one provider perspective and one patient perspective. For each perspective, consider the provider's role and the patient's role in each situation. How would you feel if you were the provider or the patient in that scenario (e.g., discouraged, unappreciated, scared)? As you read the different perspectives, consider practical approaches to address the issues discussed in the exemplar. Share with your group your thoughts on how we can improve the patient–provider relationship.

LEARNING ACTIVITIES

Community Health Centers

Locate at least three community health centers (FQHCc or Look-Alikes) near you. Visit https://data.hrsa.gov/data/reports/datagrid?gridName=FQHCs and then visit the websites of the three community centers and discuss (1) the health care services they provide, (2) the demographic breakdown of the patients they serve, (3) their organizational structure, and (4) their reputation for providing quality care, then explore (5) what services are in place for low-income and uninsured patients (sliding scale, onsite social worker, etc.).

HEDIS Measures/Chronic Disease/Social Determinants of Health

Familiarize yourself with the HEDIS quality measures by visiting https://www.ncqa.org/hedis/measures/ and clicking on the plus sign after each domain to expand that category.

1. Reflect on the health care disparities discussed in Chapter 3. Then consider a patient with two or more uncontrolled chronic diseases (uncontrolled diabetes, uncontrolled hypertension, etc.), and select two or more HEDIS quality measures that pertain to your patient.

2. Discuss how you would meet these quality measures in the urban community in the context of the lived experience of the urban patient with multiple disparities to care (consider food deserts, unsafe neighborhoods, fixed income, etc.).

Prescription Assistance

Familiarize yourself with resources to assist the uninsured or underinsured patient with medications.

1. Major corporations and pharmacies like Target, Walmart, and CVS have prescription assistance programs. See, for example, the *Walmart Drug List* (https://www.walmart.com/cp/4-prescriptions/1078664). There are also apps and websites that help identify the best out-of-pocket prices available for prescriptions. See, for example, the GoodRx website (https://www.goodrx.com/). Explore these prescription assistance programs.
2. You are working with a patient or helping a family member who has recently lost prescription insurance. The person has been diagnosed with hyperlipidemia (currently taking Simvastatin 20 mg daily), hypertension (currently taking Amlodipine 10 mg daily), diabetes (currently taking Metformin 500 mg twice a day), and hyperthyroidism (currently taking Levothyroxine 75mg daily). The patient has up-to-date scripts for all these medications but having lost insurance cannot afford the prices at the old pharmacy. The patient has been stable on these medications and is willing to pay out of pocket but is on a fixed income and is trying to find the most cost-effective way to stay on the medications. Create a cost-effective prescription plan utilizing the prescription assistance resources provided (the patient is willing to go to multiple pharmacies as long as the price is low for the medications). What were the lowest prices you could find for these medications? Would the patient have to go to multiple pharmacies? What was the cheapest cost for a 30-day supply of all four medications?

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CHAPTER 5. MENTAL HEALTH DISPARITIES IN URBAN COMMUNITIES: IMPACT OF URBAN LIVING ON MENTAL HEALTH

The foundational premise for this chapter can be summed up in one statement: "There is no health without mental health." This chapter does not focus on the definitions or descriptions of specific mental health disorders but instead steps outside the clinic walls to examine the impact of certain facets of urban living and how they affect the mental health and well-being of urban residents who are under your care. The concepts presented in this chapter speak specifically to the care of underserved urban populations, but some concepts such as trauma and victimization are applicable to all. For the last century there has been a continuous migration from rural areas to urban cities. As discussed in Chapter 2, currently over 50% of the world's population are now urban dwellers and by 2060 the world will see this percentage grow to over 70%. This migration is driven by the desire for better economic and social opportunities, as well as distance from past negative traumatic experiences. The physical, emotional, and social environments of urban life have been shown to be both positively and negatively connected to the mental health and well-being of residents: positive, as urban living provides some residents with expanded access to health care, better employment opportunities, and diverse educational options. These benefits, however, come with the negative price of increased exposure to poverty, drugs, loneliness, homelessness, crowding, pollution, and crime. Urban living has been linked with higher rates of mental health issues, more specifically higher rates of depression, anxiety, schizophrenia, and stress. In this chapter we explore the social determinants of mental health, risk factors that affect urban residents' mental health outcomes, and the use of trauma-informed care.

LEARNING OBJECTIVES

1. Explore the risks factors that lead to poor mental health outcomes for urban residents
2. Provide an introductory overview of the social determinants of mental health
3. Discuss adverse childhood experiences (ACEs) and provide an overview of the ACE study
4. Develop an understanding of how substance use in urban environments is directly linked to the risk factors for poor mental health
5. Examine trauma-informed health care that can be implemented at the clinician and community levels to directly improve health outcomes of urban residents

MENTAL HEALTH VS. MENTAL ILLNESS

Before we move forward it is important to understand that mental health and mental illness are points on the same scale. *Mental illness* refers to the collection of diagnosable mental disorders. These disorders cause significant changes in thinking, emotions, and/or behavior and also create distress that affects successful functioning in educational, occupational, and social arenas that can lead to disability or functional impairments. In contrast, the American Psychological Association (APA) defines *mental health* as "a state of mind characterized by emotional well-being, good behavioral adjustment, relative freedom from anxiety and disabling symptoms, and a capacity to establish constructive relationships and cope with the ordinary demands and stresses of life" (APA, 2022). Good mental health improves patients' life satisfaction, relationships, educational and occupational achievements, housing, and earning potential. Good mental health also helps reduce physical health problems and social and health care costs. It is indispensable but is often devalued until mental health issues begin to manifest. Health professionals have been educated to understand that genetics and social risk factors are the core causes of mental illnesses and substance use disorders. This has been made evident by the emphasis on the biopsychosocial model in psychiatric treatment formulation. This new emphasis has created an awareness of the connection of biological, psychological, and social factors as impacts on development and progression of mental illnesses.

Adverse Childhood Experiences

The Centers for Disease Control and Prevention (CDC) and Kaiser Permanente developed the Childhood Adverse Experiences (ACE) scale in a study, conducted from 1995 through 1997, that was the largest collaboration between the CDC and Kaiser Permanente's San Diego health appraisal clinic (CDC, 2021). Since 1998 over 70 research papers have been published regarding the ACE study (ACEs Too High, 2022).

The ACE study examined three categories of traumatic experiences: childhood abuse (physical, sexual, and emotional), neglect (physical and emotional), and family/household challenges (growing up in violence, substance misuse, mental illness, incarceration of a family member, loss of a parent, abandonment, or separation/divorce. These categories can be directly correlated to negative effects on mental illness: childhood abuse (psychological), neglect (psychological), and family/household challenges (biological/social). Kaiser Permanente's nearly 17,000 study participants completed a detailed biopsychosocial (biomedical, psychological, and social) medical questionnaire and underwent a complete physical examination and extensive laboratory tests (Felitti, 1998). The participants were followed for 15 years using the original study as a baseline for everything published that drew back on these findings (ACEs Too High, 2022). The ACE questionnaire assessed 10 types of childhood trauma, with the scores calculated on the basis of exposure to adverse childhood experiences (ACEs), cumulatively. Being exposed to any adverse trauma is counted as 1 point, then these points are tallied for a final score, the maximum score being a 10. Each type of trauma counts as one, no matter how many times it occurs. There is a graded-dose relationship between ACEs and negative health and well-being outcomes: As the number of ACEs increases, so does the number of negative outcomes (CDC, 2021; Felitti, 1998). Therefore, the more experiences of childhood traumatic events, the greater the risk for negative physical and mental health outcomes.

COMMUNITY TRAUMA

Community and its environment significantly affect the quality of the mental health of residents. The discussion of ACEs would be incomplete without considering the community-level trauma and the direct correlation to individual ACEs. In 2016, with a grant funded by Kaiser Permanente, the Prevention Institute published the revolutionary *Adverse Community Experiences and Resilience (ACE|R): A Framework for Addressing and Preventing Community Trauma*, which has evolved to become the basis for understanding the impacts of community trauma. The research regarding individual-level trauma has made the effects abundantly clear. But when trauma exists as a community experience, the injury to community solidarity creates a compromised environment that negatively affects economic growth, social achievement, and health maintenance and decreases the life span of residents. The ACEs Tree (Figure 9) provides a clear depiction of the relationship between ACES and adverse community experiences.

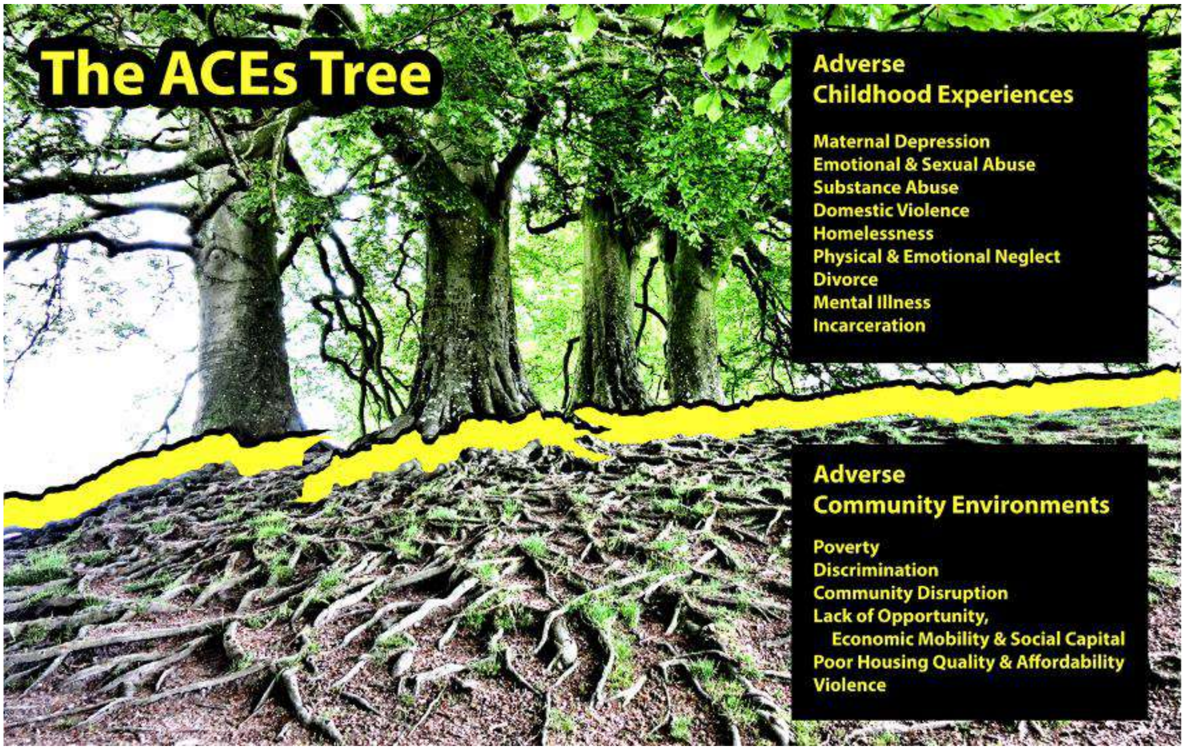


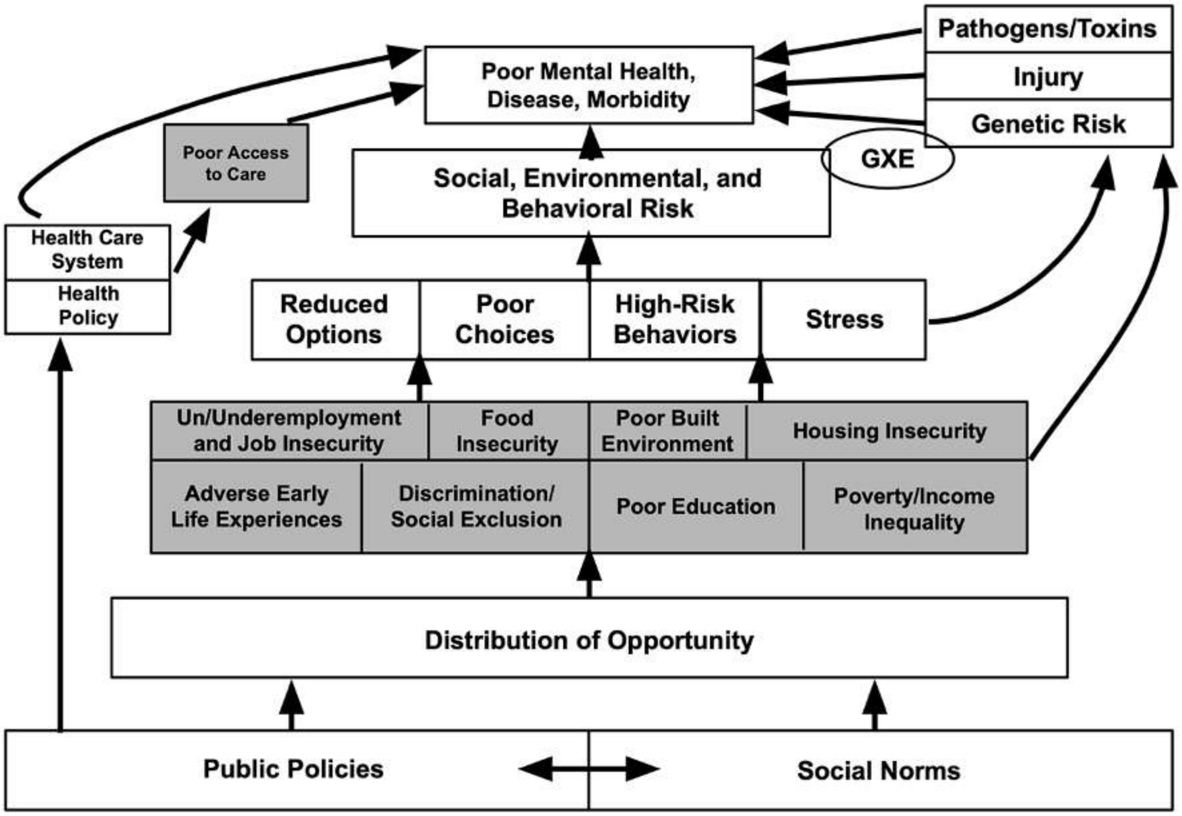
Figure 9. The ACEs Tree: Adverse Childhood Experiences and Adverse Community Environments

It is pivotal for health providers in urban settings to understand that adverse community experiences directly contribute to individual health outcomes. To truly help patients attain personal health and well-being, health care providers must not only see the tree but also consider the soil in which it was grown.

Social Determinants of Mental Health

As discussed earlier in this textbook, the World Health Organization (WHO) defines the *social determinants of health (SDOH)* as the conditions in which people “are born, grow, live, work, and age” and explains that these determinants are directly related to the allocation of money, power, and resources. The SDOH diagram created by Compton and Shim 2015 (Figure 10) illustrates the parallel between the social determinants of mental health and the social determinants of chronic physical health conditions. This diagram connects the influences of social, environmental, and behavioral risk factors for poor physical and mental health that lead to increased illness and death in communities around the world.

The concept of health can be connected to characteristics of individuals and households, but the purpose of our learning here must be viewed in a wider context that means examining the social, circumstantial, and environmental components of the cities where individuals live. This creates the connection for clinicians to understand how urban environments directly affect residents and have a relevant direct correlation to health outcomes. Each city has its own concentrations, diversities, and eclectic form of interactions that have meaningful and multifaceted effects on physical and mental health, effects that can be both negative and positive. In the 2016 report *Urban Sanity: Understanding Urban Mental Health Impacts and How to Create Saner, Happier Cities*, Todd Litman examined the processes by which urban living affects mental health and happiness. The population of urban cities is often highly concentrated with individuals from socially disadvantaged groups (e.g., the seriously mentally ill, the physically disabled, immigrants, and minorities) who have unique health needs that create high risk for mental illness. There exists a cycle of mental illness, poverty, and associated social disparities that are often attributed to urban living. Research shows, however, that people living with mental illness fare better overall in urban areas versus rural areas because of better access to mental health and supportive services. The *Urban Sanity* study found that mental health issues were related to risk factors that could be stratified into three main categories: individual (personal/self-selection), economic/social, and environmental (Litman, 2016). All these factors can be directly correlated to SDOH.



Source: Compton, M. T., & Shim, R. S. (2015). The social determinants of mental health. FOCUS 13(4), 419-425. Reprinted with permission from FOCUS, ©2015 American Psychiatric Association. All rights reserved.

Figure 10. The Social Determinants of Mental Health. From Compton and Shim (2015).

RISKS FACTORS FOR POOR MENTAL HEALTH OUTCOMES

Individual

Individual factors reveal the types of people that gravitate toward living in urban areas. People living with disabilities, poverty, addiction, and other personal crises, as well as immigrants, often choose to locate in cities because of access to jobs and supportive community resources. One of the biggest personal concerns regarding engagement in mental health treatment is stigma. Mental illness stigma is defined as devaluing of a person based on negative beliefs, attitudes, and perceptions about mental health conditions that results in loss of social status or discrimination. While stigma is not uncommon in many medical disorders, attitudes toward psychiatric illnesses tend to be far more negative and distressing for patients living with mental illness. Stigma can be categorized into three forms: public (community) stigma, self-stigma, and provider stigma.

Public stigma arises from the general focus on stereotypes and from prejudices related to mental illness, both attitudes that lead to discrimination. These views are often fostered by media representations or poorly understood symptomatology. The second facet of public stigma is community stigma, which is often represented by a patient's specific social or community circle and can directly affect self-stigma. For many people the decision to seek treatment for mental health is directly influenced by their cultural community. The cultural community instills in its members the norms for coping with distress and defines who is appropriate to rely on when the distress becomes too much. Each cultural community has its own understanding and beliefs regarding mental illness; for many there is shame about mental illness, and the fear of shame prevents people from seeking help. This community stigma can lead to individuals downplaying or ignoring their symptoms and suffering in silence without community support for fear of being ostracized.

Self-stigmatization is the process of adopting and internalizing the negative stereotypes about people with mental illness; this process leads to diminished self-esteem and value. This in turn leads to patients seeing themselves as socially unacceptable. Mentally ill persons may choose to conceal their illness from friends, relatives, and partners to avoid being rejected or labeled. Public stigma causes and worsen self-stigma because individuals adopt the stereotypes and prejudices of their communities. In addition, public and self-stigma can inhibit people from seeking mental health services when they most need them. Minorities also experience internalized racism, which refers to the acceptance of negative societal beliefs and stereotypes about their race or ethnicity as well as the characterization of superiority of White groups over non-White groups. This leads to low self-esteem and feelings of worthlessness, which can negatively affect mental health, health behaviors, and self-competence.

Provider stigma entails the health care provider's endorsement of common stereotypes about mental illness. These views can be conveyed by, for example, perceiving clients with schizophrenia as dangerous or telling patients to "get over" distressing events. In 2018, Wang et al. conducted a study to examine the relationship between provider stigma and its influence on internalized stigma. The researchers found that negative affective reactions and perceived social distance by providers were linked to client feelings of disempowerment (Wang et al., 2018). There were several other research studies that indicated that low-income mental health service consumers reported feeling demeaned by providers and frustrated by treatment regimens that resulted in limited improvement, which led to decreased use of mental health services. It is imperative for health care providers to be aware of their personal biases and judgments and how these manifest in the delivery of care. These behaviors create a toxic environment that propagates stigma for clients already experiencing emotional distress and pushes them away from engaging the services they need to improve their health and well-being.

Economic and Social Factors

Economic and social factors are a direct reflection of the geographic areas in which people labor, interact, and reside. In urban areas poor working conditions, violence, criminal victimization, neighborhood conditions, and poverty can exacerbate known and unknown mental illness. Earlier chapters have touched on many of these issues but have not addressed how they affect the mental health of urban residents. As already noted, people with elevated mental illness risk factors often concentrate in cities. People with preexisting risk factors, particularly poverty, minority status, or existing mental health problems, more often experience the negative effects of urban living. There is myriad research on the socioeconomic impacts of urban living. The most common mental health stressors have been linked to poverty, community violence, crime, and victimization.

Poverty

Poverty remains one of the major social determinants of both physical and mental health. It is directly interconnected with all the other social determinants and has a direct impact on their quality and availability of services. In the last two decades, most of the United States has become increasingly more urban, with high-poverty and poor urban neighborhoods more than doubling in size. This urban growth has left poor families stuck in neighborhoods inundated by poverty and social upheaval involving social challenges as individuals attempt to overcome feelings of injustice and hopelessness and experiences of discrimination. The risk for adverse negative mental and developmental health effects has been found to be dose dependent. People living in poverty starting early in life or for long periods experience long-term effects. Poverty in childhood has been linked to myriad negative outcomes: poor school performance, behavioral issues, poor cognitive functioning, development of depressive or anxiety disorders, and nearly all psychiatric disorders in adulthood. Poverty in adulthood is correlated to depressive disorders, anxiety disorders, psychological distress, and suicide. The impact of poverty on mental health is exhibited in numerous social and physical processes that affect society on individual, family, community, and national levels.

Crime, Violence, and Victimization

Crime and violence are, distressingly, a common part of urban life. Researchers have discovered that increased concentration of poverty leads to increased crime and violence. All people living in urban areas can experience violence in a variety of ways. They may be victimized directly or witness violence or property crimes in their community. Or they may be touched by crime through secondary means, perhaps by hearing about crime and violence from the media or from neighbors. *Victimization* is defined as being the object of deliberate harm initiated by another person or persons, such as being robbed, physically attacked, or being shot or stabbed. Residents of urban communities suffer higher rates of violent crime, rape and sexual assault, robbery, aggravated assault, battery, property damage, motor vehicle theft, and personal theft than do other communities. These victimizations leave people with physical pain, emotional suffering, and mental distress, all of which decrease engagement in life, especially if there are repeated exposures. Children and adolescents exposed to violence have more academic and mental health problems. These symptoms present as posttraumatic stress disorder (PTSD), anxiety disorder, depression, and aggression. High-crime and violent neighborhoods even affect parenting. Several studies have found that parents who reported living in dangerous neighborhoods also reported using more harsh control and verbal aggression with their children to protect them. The effects of exposure to violence in childhood may be seen in adulthood and can result in greater risk for substance use, risky sexual behavior, and poor physical health. These connections are discussed in the upcoming section on ACEs and their long-term consequences in adulthood.

The social organization of a neighborhood is reflected in processes such as social support and cohesion among neighbors, which lead to community solidarity and participation in community organizations. Research proposes that within poor urban neighborhoods, structural barriers often impede the development of neighborhood social organization and thus perpetuate the cycle that increases the risk for crime and violence. In urban areas poor working conditions, violence, criminal victimization, neighborhood conditions, and financial stress can exacerbate known and unknown mental illness. It has been reported that the frequency of police profiling of minorities has a negative effect on minority individuals as well as on the community. The frequency of traffic stops, intrusiveness of the encounters, and perception of injustice and disrespect during the encounters were positively associated with symptoms of PTSD and anxiety. Emerging evidence shows that witnessing violence and constantly being reminded in the media of violence and police brutality can become chronic stressors that adversely affect the mental health of the community at large.

Environmental Factors

The size, density, and configuration of the urban physical environment affect the psychological and social experiences and behaviors of urban dwellers. According to Litman (2016), the urban environment affects people in two major ways: overstimulation and removal of protective factors. Environmental factors reflect inherent urban factors such as more interactions with unfamiliar people, more cultural diversity, increased noise and air pollution exposure, and reduced interactions with nature. People who reside in urban areas battle daily with crowding, noise, urban decay, blight, and pollution. Every part of the urban environment triggers stimuli that can lead to an emotional or physical reaction. In small doses this would be fine, but this continual stimulation overworks the brain circuits. This stimulation leads to overload, which increases the body's baseline levels of arousal, stress, and preparedness, moving them into a state of constant hypervigilance and mental exhaustion. These mechanisms can lead to mental illness involving depression and anxiety, among other mental health disorders. The stress paradigm has been particularly applied to studies of crowding and noise, qualities associated with urban environments. Residential crowding is frequently accompanied by psychological distress, which may be more a function of the social withdrawal crowded households employ as a coping device rather than the direct consequence of arousal. The negative effects of residential crowding are more potent when they are combined with the other stressors typically experienced in low-income households. Like crowding, exposure to high levels of noise has been associated with destructive coping strategies, such as more smoking and learned helplessness.

Urban residents often have less access to the protective factors that are supportive for good mental health. This is especially true for low-income urban dwellers who often have diminished access to nature, have complex work schedules and commutes, and live in unsafe crowded areas with little to no privacy. As discussed in the previous section, urban residents may be reluctant to engage their community because of safety concerns. This disconnection increases feelings of isolation and makes people become more isolated and vulnerable to developing mental distress.

Urban Decay and Disorder

Deterioration of the physical infrastructure of cities, including abandoned housing, graffiti on subway trains, and the like, dominates many images of inner-city environments. Poorer, minority populations most often live in inner cities and also reside in areas characterized by deterioration and incivilities. Neighborhoods plagued with vacant or abandoned properties are linked to high rates of mental distress, chronic illnesses, smoking, and substance abuse. A plethora of research has shown that people who live in neighborhoods with a lot of graffiti, abandoned buildings, and other such attributes experience more mental health problems and are more likely to abuse drugs and alcohol than residents of other communities (see Burt et al., 2022; Garvin et al., 2013; Green et al., 2012; Hill et al., 2005).

Research on the psychological and social consequences of the physical form of urban areas most often focuses on threats to well-being associated with stress, urban decay, and disorder, and more recently urban sprawl. The importance of strong social networks cannot be overemphasized in terms of creating greater place attachment, which supports efforts to significantly improve the physical conditions and safety of individuals' homes. Despite a growing number of issues within the city that negatively affect safe and healthy outcomes, there are at-risk populations that experience such issues at a higher proportion than others. Individuals living in neighborhoods that are considered to have concentrated disadvantage are those with economic deprivation and are characterized as being low income, having low educational attainment, and having a high unemployment rate. Disordered environments are communities that are most often characterized by disadvantage, such as neighborhoods that have been negatively affected by a lack of social control, trash and blight, noise, and abandoned infrastructures; these neighborhoods have a very high presence of violence and crime. Individuals who reside in neighborhoods characterized by disadvantage and disorder are continuously exposed to chronic stress from economic struggles, violence, and crime. Substance use is often resorted to as a coping mechanism to deal with such chronic stress, and a number of studies have found that exposure to, and perceptions of, neighborhood disadvantage and disorder are associated with very high levels of stress and substance use, especially among adolescents.

Substance Use

Substance abuse has been a highly prevalent and destructive issue among persons living in urban environments and has continued to grow despite interventions and policies put in place to mitigate its spread. Those living in urban environments, especially those who have mental health issues, have been one of the most vulnerable populations to develop comorbid addiction. Substance abuse and addiction affect not only individuals but also families and communities on a variety of levels. Besides the health care system's concern about growing substance abuse, there have also been alarmingly increased rates of crime, domestic violence and interpartner violence, child abuse and neglect, motor vehicle–related accidents, homelessness, and HIV/AIDS, in addition to higher taxes and business costs. In many major cities across the United States, researchers have been able to apply this multidimensional and multifactorial concept to our study of environments to learn how its factors affect our physical, emotional, and psychosocial development. Multiple entities have been involved in developing interventions that address and prevent the process of addiction and prevent further instances of occurrence and expansion. Although substance abuse and addiction have been an increasingly prominent issue today, urban environments have been found to be the most highly affected area where these issues arise or continue. Coexisting demographic issues, stigmatization, and issues related to treatment, such as access, availability, and effectiveness, have all influenced the growing concern we have been faced with.

There are several notable reasons why substance abuse has continued to increase over the years among both rural and urban environments. Most notable among urban dwellers is the exposure and access to substances that puts individuals at very high risk of use and abuse. People living in urban environments already struggle with obtaining the essentials of living, as discussed at length in earlier chapters of this textbook. As a clinician caring for urban residents, you must think logistically. There are numerous settings that have increased the availability of nicotine, tobacco, and alcohol, among them gas stations, liquor stores, convenience and other stores, pharmacies, tobacco shops. Quite commonly many of these outlets are tasked with providing refreshments and basic groceries, yet they lack fresh produce and other goods that are necessary and beneficial to support health and wellness. Urban residents do, however, have an overwhelming ease of access to nicotine and tobacco products, alcohol, and illicit drugs, an ease of access promoted through direct advertising in urban areas. Such direct advertising not only glamorizes smoking and increases the intention to smoke among youth but also, as researchers have found, is a strong predictor of future smoking behavior. Similar effects on consumption have been found for alcohol advertising. Thus, the mechanism for smoking initiation stems not only from access to tobacco but also from exposure to tobacco ads, promotions, and marketing, which are often concentrated at the point-of-sale or near stores, especially in the United States, where there are restrictions on tobacco advertising on television and other media outlets.

Persons living with depression, anxiety, and schizophrenia often suffer from co-occurring substance use disorders, with higher rates of nicotine and alcohol use than persons not experiencing these types of mental distress. Individuals who are in close proximity, have regular exposure, and have ready access to acquiring such substances are highly likely to begin or continue use as a result of cravings brought about by environmental cues and triggers. Also shown is that the density of alcohol outlets in a community correlates to increased alcohol-related mortality and high rates of consumption in teenagers, college students, and adults in that community. Proximity to alcohol sales has also been found to be associated with other negative outcomes, including violence in the home and in the community. Research suggests that simply the exposure to the visual cues involved in seeing alcohol or tobacco outlets or other places associated with prior substance acquisition and use can activate craving for those substances among persons in recovery. Such environmental cues can have substantially negative consequences for those in treatment for substance use disorders as well as for those in long-term recovery who are attempting to maintain abstinence from substance use. This correlation is especially important to consider when clinicians are working with urban patients in active recovery. A simple trip to the local corner store may be the catalyst to relapse as a result of stimulation from ads.

Researchers have determined there are at-risk populations who are most subjected to and influenced by tobacco and alcohol sales and who may be inadvertently exposed because of racial and socioeconomic inequality. Numerous US-based studies at the state, metropolitan area, and county levels have found that stores selling tobacco are disproportionately located in neighborhoods with high percentages of minorities and low-income residents. Evidence indicates that racial and economic inequities are present not only in the selling of alcohol and tobacco but also in the advertising of these products. While the Master Settlement Agreement of 1999 drastically limited cigarette manufacturers from targeting youth, created restrictions for advertising/marketing, banned the use of cartoon characters in their advertising, and restricted advertising on billboards, it did not address storefront advertising in convenience stores, which are the major hub of most low-income urban areas. The Advancing Science and Practice in the Retail Environment (ASPIRE) study was conducted by the National Cancer Institute to examine the relationship of tobacco retailers' density and community demographics (ASPiRE, n.d.). The study isolated over 300,000 tobacco retailers across the United States. The findings show that the highest concentration of retailers was in areas with high concentrations of African Americans, people living in poverty, and women over 25 without a high school diploma. (Mills et al., 2022; ASPiRE, n.d.). The study findings were consistent with international studies that higher concentrations of tobacco retailers exist in areas of low-socioeconomic status as well. This is coupled with the fact that urban youths (ages 11–14) are exposed to three alcohol ads per day in their community. In addition, a growing number of legal marijuana-related facilities, such as dispensaries, have gained notoriety for marijuana distribution and sales after medicinal and recreational laws qualified individuals to attain such products. Although stores and dispensaries legally selling marijuana are still limited to certain states in the United States, preliminary evidence indicates a higher prevalence of legal marijuana outlets in minority and impoverished neighborhoods compared to other areas.

Stigma of Living With Addiction

The issue of stigma comes up when treating a wide range of health conditions from diabetes and HIV to most mental health disorders. While there have been major gains for many of these conditions, substance abuse remains an outlier. Patients who are known for a history of use or who are suspected of the potential for abuse are negatively affected by the stigma when they seek care for medical issues, but it worsens when narcotics medications are necessary in treatment. Without proper identification and acknowledgment of this specialized stigma, issues related to substance abuse will continue to interfere with proper care and treatment. It is imperative that persons with substance abuse history being treated in the community are given a plan that is individualized, compassionate, and tailored to their needs. Since the onset of the opioid epidemic, policies and procedures created by governing bodies and agencies have sought to avoid specific recommended pain treatment options for fear that they were not appropriate for those who suffer from substance use disorders or had the potential to lead to addictive patterns of use. Because of these regulations, individuals with pain-related issues stemming from chronic diseases and those suffering from disorders of anxiety have been affected by a combination of factors placing them at higher risk of treatment resistance, exacerbation of symptoms, and probability of developing a substance use issue if not treated properly. Despite a growing number of recommendations and guidelines for treating concurrent substance use and pain disorders issues safely, many clinicians use limited potential treatment options because they fear patients will develop a substance use disorder or the potential for overdose and death. Patients in turn have attempted to seek relief by their own means of accessing readily available and sought-after illicit drugs, which have caused their own inadvertent development of a substance use issue or recurrence of a once active addiction.

The lack of knowledge about options, coupled with a lack of access to care, has been another growing obstacle among individuals living in disadvantaged and low-income neighborhoods who suffer from a variety of health issues. As mentioned, individuals with mental health issues or already concurring substance use issues utilize nicotine, alcohol, or other illicit drugs as a means of coping. Individuals without awareness or knowledge of safe and effective treatment options cannot make potentially life-saving decisions to improve their health if no other possibilities are presented to them. This situation is further worsened for urban and poor residents by the lack of access to comprehensive substance abuse treatment centers. Recreation centers, libraries, and after-school programs can offer alternative leisure activities in structured social settings that act to discourage substance use, particularly for youth. It has been found that exposure to more green spaces has been an alleviating factor to reduce psychological stress and has a calming effect, thus countering, to a limited extent, the stressful conditions of disadvantaged neighborhoods and consequent substance use as a coping behavior.

Clinicians in urban environments must think holistically when caring for patients living with substance use issues. While it is imperative to educate the public and present current literature and data on the applicable treatment options, their effectiveness, and their feasibility, clinicians must keep in mind the community and population they are addressing. Thus they must also consider the stressors that lead to the use of substances as a coping mechanism, environmental factors affecting care, and the challenges of maintaining sobriety without causing additional stigmatizing trauma. These actions are counterproductive to the goal of preventing unwanted outcomes such as worsening dependency, exacerbation of current symptoms, and mortality. Clinicians should build rapport with their patients, which is crucial in the initiation of treatment because rapport will help you identify your patients' risks and needs so that you can address their individual concerns and set boundaries—all of which are important in maintaining a level of trust and consideration, promoting the quality and value of positive outcomes, and helping move patients toward improved health.

Trauma-Informed Care

Safety	Trustworthiness and Transparency	Peer Support
Staff and all patients feel physically and psychologically safe; the physical setting is safe and interpersonal interactions promote a sense of safety.	Organizational operations and decisions are conducted with transparency and the goal of building and maintaining trust among staff, clients, and family members of those receiving services.	Peers are facilitators of recovery rather than controllers; also referred to as "trauma survivors." These are integral to the organizational and service delivery approach and are understood as a key vehicle for building trust, establishing safety, and empowerment.

Collaboration and Mutuality	Empowerment, Voice and Choice	Cultural, Historical, Gender Issues
There is recognition that healing happens in relationships and in the meaningful sharing of power and decision-making. The organization recognizes that everyone has a role to play in a trauma-informed approach. One does not have to be a therapist to be therapeutic.	Organization aims to strengthen the staff, client, and family members' experience of choice and recognizes that every person's experience is unique and requires an individualized approach. This builds on what clients, staff, and communities have to offer, rather than responding to perceived deficits.	The organization actively acknowledges past cultural, gender, and historical stereotypes and biases, offers responsive services, leverages the healing value of traditional cultural connections, and recognizes and addresses historical trauma.

Figure 11. Six core principles of trauma—informed models in practice.

The Trauma Informed Care Implementation Resource Center, developed by the Center for Health Care Strategies with support from the Robert Wood Johnson Foundation, describes trauma-informed care as shift in looking at patients from a lens of "What is wrong with you?" to "What happened to you?" This simple consideration of the impact of patient's "lived experiences" changes how health care is delivered and moves toward true patient-centered care (Trauma Informed Care Implementation Resource Center, 2021). The research from ACEs lead to creation and adoption of numerous trauma-informed care models. Trauma-informed models of care have been utilized across all spectrums of health care. The adoption of trauma-informed practice models has been shown to improve patient engagement, patient–provider relationships, utilization of treatment, reduced health care costs, and overall health outcomes. It is important to note that for true success in a trauma-informed care delivery system, change must happen at both a clinical and an organization level. In 2014 the Substance Abuse and Mental Health Services Administration (SAMHSA) drafted the *Concept of Trauma and Guidance for Trauma-Informed Approach*, which provides the benchmarks needed to implement trauma-informed models in practice. The guideline is defined by four key elements and six core principles. The four key elements focus on realizing the impact of trauma and the paths for trauma recovery; recognizing the signs and symptoms of trauma in patients, families, and staff; responding by integrating knowledge about trauma into policies, procedures, and practices; and avoiding retraumatizing (SAMHSA, 2014). The six principles are defined in Figure 11.

A wealth of trauma-informed strategies are available to organizations interested addressing implementing trauma-informed care. These approaches can range from systemic staff education on the effects of trauma to full adoption of practices to address trauma at the clinical level. The positive benefits of trauma-informed health care are numerous and affect not only patients but providers and staff as well. For patients, trauma-informed care provides an opportunity for them to fully engage in their own health care, develop a trusting relationship with their health care provider, and improve their health. Trauma-informed care can help health care providers and staff develop better understanding of their patients and thereby reduce frustration and burnout.

CASE STUDY: TRAUMA-INFORMED CARE

Michael is a 37-year-old African American Male who has been a patient in Dr. Samantha Smith primary care clinic for the past 5 years. He has repeatedly stated that he prefers to see only female providers. His medical history includes hypertension, irritable bowel syndrome, gastroesophageal reflux disease (GERD), PTSD, and depression. He has reported a self-reported diagnosis of PTSD, but Dr. Smith has not asked specific details. Dr. Smith has been attempting to get Michael to see the local GI specialist (male) because of concerns about possible bleeding ulcers and ulcerative colitis. Each time the referral is discussed, he promises to follow up and make the appointment but has not followed through. He had been faithful in his follow-ups to Dr. Smith and had been consistent with other recommendations that she has made, but when Dr. Smith pressed him to see the GI doctor at this last visit, Michael did not return for several months.

During this time Dr. Smith began incorporating a trauma-informed care model into her primary care practices. Her practice services several domestic violence shelters, and she wanted to incorporate a trauma-informed model to make sure that her clinic was being more thoughtful in how it delivered care. The clinic implemented a workforce development model that trained all the staff about ACEs, the signs and symptoms of trauma response, and trauma-informed care. The clinic also implemented ACEs and mental health screening in addition to employing a social worker (Ms. Green) to provide on-site consults and resource referrals. In addition, Dr. Smith hired several new staff members, including a male receptionist and medical assistant.

Michael returns to the clinic for a follow-up because of worsening stomach pain. During his visit he becomes visibly upset and agitated when dealing with the new male receptionist. The receptionist then informs Dr. Smith that Michael is upset. Michael completes the ACEs screening with a score of 8. The screener shows childhood history of sexual and physical abuse, neglect, paternal incarceration, maternal mental illness, and parental substance abuse. Michael is taken into the exam room, and the new male medical assistant comes in to get his vitals. When the assistant takes Michael's arm to measure his blood pressure, Michael becomes upset and screams at the medical assistant to leave. Dr. Smith enters the room to find Michael sitting on the floor, rocking and crying inconsolably. She asks for Ms. Green to come assist while she plans to call to have Michael transported for psychiatric evaluation. Ms. Green enters the exam room and is able to calm Michael and gain more information. Her assessment discovers that Michael had been sexually and physically abused during his childhood, from age 3 until 16, by his older brother and cousin. He had told his parents, but no one believed him. He left home at 18 and was homeless for a time, from age 18 to 22, until he entered a youth training program and became a machinist. Michael is initially very vague about his life from age 18 to 22, stating that a lot of bad things happen when you're homeless. He eventually admits that he was robbed, beaten, and sexually assaulted several times when he was homeless but never told anyone. He had seen a therapist when he was in his training program but did not tell him about all the things that had happened to him and never followed up after that. He explains that he has been better since getting his life together and that he spends most of his time alone or with female friends. He informs Ms. Green that he had selected Dr. Smith's practice because it was an entirely female staff. He admits that he had not followed up with the GI referral because the doctor was male, and he did not want to explain to the doctor. He had considered going to the emergency room for the stomach pain but was afraid he would have to deal with a male provider there. The male receptionist and medical assistant had thrown him off guard, he says, but when the medical assistant grabbed his arm, it sent him into a panic. Ms. Green provides brief supportive therapy and assists with a referral to a female GI doctor and therapist. As a consequence of this experience with Michael, the clinic decides to also incorporate a patient questionnaire about gender preference for staff and provide additional training for addressing patients with history of trauma.

How Was the Trauma-Informed Practice?

- The clinic had incorporated a systems-wide approach to trauma-informed care; all staff had received core training.
- The implementation of ACEs screening provided background that helped health care providers better understand the specific issues that Michael had with the GI referral. This situation could be applied as well when sending female patients with history of sexual to trauma to gynecology.
- The social worker was included in the trauma-informed care team to have available a dedicated staff member to provide onsite intervention and referral to other organizations within the local community.
- There was reassessment of clinical practice and incorporation of changes in response to new information to avoid retraumatizing patients.

LEARNING ACTIVITIES

1. Take this opportunity to learn more about ACEs. Visit the following websites to complete training:
    - ACEs Aware: https://www.acesaware.org/learn-about-screening/training
    - CDC ACEs training modules: https://vetoviolence.cdc.gov/apps/aces-training
2. Review the Ted Talk by Dr. Nadine Burke-Harris to development further understanding of how ACEs affect individuals across the life span: https://www.ted.com/talks/nadine_burke_harris_how_childhood_trauma_affects_health_across_a_lifetime?language=en

3. Take this opportunity to examine your current organization's trauma-informed practice. Review SAMHSA's white paper on key ingredients to trauma-informed care practice: https://www.samhsa.gov/sites/default/files/programs_campaigns/childrens_mental_health/atc-whitepaper-040616.pdf
4. Review the World Health Organization report *The Social Determinants of Mental Health*:
5. https://apps.who.int/iris/bitstream/handle/10665/112828/9789241506809_eng.pdf
6. Take this opportunity to learn more about becoming a more culturally sensitive provider. Review https://store.samhsa.gov/sites/default/files/d7/priv/sma16-4931.pdf

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CHAPTER 6. TERTIARY PATIENT MANAGEMENT

COLLABORATIVE APPROACH IN URBAN HEALTH CARE: ACUTE CARE PERSPECTIVE

Providing care to patients living in urban environments requires unique considerations to help with decreasing health disparities. Access to care issues in urban environments contributes to increased use of emergency department (ED) services for primary care. Oftentimes patients entering the acute inpatient setting start with upfront social barriers that if not taken into consideration at the time of admission will lead to increased length of stays and possibilities of readmission rates. Acute care providers need to consider patients' physical health concerns and access to resources to help self-management of comorbidities after discharge. Addressing these barriers requires a health care team approach. Understanding the importance of interprofessional collaboration for addressing the needs of patients seeking care in the acute inpatient environment will help to mitigate issues during the inpatient visit. Interprofessional collaboration helps the acute care provider to increase access to care for patients living in urban settings. Case nurse management, social workers, pharmacies, physical therapy, occupational therapy, and life stress counselors provide patients with additional resources to help patients self-manage their comorbidities in an ambulatory setting or help patients to transition to a postdischarge facility (i.e., skilled nursing, nursing home, or long-term acute care facility). This chapter highlights the management considerations, factors that affect discharge, and gaps in continuity of care for patients living in urban environments.

LEARNING OBJECTIVES

1. Describe the impact of using the emergency department as primary care
2. Understand the cost of emergency department (ED) utilization
3. Describe the type of patients who utilize emergency care
4. Understand the components of an admission history
5. Describe several considerations the acute provider should consider for patients during the admission in the acute care setting, "starting with end in mind"
6. Describe how interprofessional collaboration can help overcome discharge barriers
7. Describe the impact of gaps in continuity of care and the importance of establishing care postdischarge
8. Describe end-of-life issues

USE OF THE EMERGENCY DEPARTMENT FOR PRIMARY CARE NEEDS

The American Hospital Association reports there are 6,090 hospitals in the United States, and according to the Centers for Disease Control (CDC), it is estimated that approximately 130 million people have visited an emergency department in 2018. In addition, in 2019 approximately 22% of adults 18 years and older visited an emergency department within the past 12 months. Many factors contribute to patients going to the emergency department instead of going to a primary care clinic for care. Some of those factors include

- lack of having an assigned primary care provider,
- lack of medical insurance or transportation,
- unwillingness to wait to schedule an appointment to see a primary care provider,
- misperceptions of appropriate usage of the emergency department, and
- psychosocial issues (e.g., homelessness, chronic mental illness).

Varying ideas of what is considered an emergent complaint versus an urgent complaint versus a stable complaint that requires prompt follow-up also contribute to patient health care behavior.

Emergent vs. Urgent: Similar but Distinctly Different

While the definition of *emergent* and *urgent* can seem synonymous, there is a distinct difference in their meaning when it comes to emergency department care and treatment. An emergent situation would be considered any situation that could be life-threatening in nature. In contrast, an urgent situation, while serious, would not necessarily (at that initial time) be considered life-threatening but does require prompt attention to avoid becoming an emergent situation. Unfortunately, and frequently, these terms are used interchangeably, and patients will default to going to the emergency department for situations that could potentially have been addressed and followed up in the primary care setting.

Cost of ED Utilization

According to the Agency for Healthcare Research and Quality (AHRQ), as of 2017, 13.3% of the US population has utilized an emergency department at least once (Moore and Liang, 2020). In addition, it was noted that 50% of patients admitted in the emergency department received previous ED services prior to admission. The aggregated costs of using the emergency department in 2017 totaled $76.3 billion, with adult patients ages 18 to 44 being the largest group that frequent the emergency department; adult patients age 65 years and older comprised the second largest group frequenting the emergency department. While many rationales explain why patients use ED services, it was noted that many patients felt ED care was higher quality health care than primary care. In addition, the realization that most emergency departments are open 24/7, 365 days per year and cannot refuse to treat a patient who cannot pay is also a driving factor for over usage and inappropriate use of the emergency department.

Characteristic of Frequent ED Users

Emergency department health care providers frequently encounter patients who come to their emergency department seeking medication refills. In addition, ED providers encounter patients who display “narcotic/opioid”-seeking behaviors. Oftentimes the patient will attempt to mask these behaviors under the guise of having true chronic health issues or chronic pain syndromes (old motor vehicle collision injuries, chronic low-back pain, fibromyalgia, sickle cell pain crisis, multiple sclerosis, etc.). Because every patient’s complaints of pain must be taken seriously, health care providers are challenged to use clinical judgment and discernment when providing treatment to these types of patients. Other types of patients the ED provider encounters are patients who are unwilling to comply with ED treatment modalities/interventions, patients who are unwilling to stay to complete the ED workup to accurately diagnose them, and patients who are displeased with the ED services provided—that is, they are not getting assigned a bed fast enough, not receiving IV pain medication, not receiving a hot dinner tray, and so on. These situations lead to patients leaving the hospital against medical advice. Usually when this happens costly ED services such as radiologic exams or initiation of IV medications/fluids have already been initiated. The ED provider can expect to experience the "revolving door or hospital hopping" phenomenon, which essentially involves a patient who will leave one hospital only to present at another local hospital's emergency department with the same complaints and the same behaviors. A major challenge ED providers face is to avoid taking personally any of the behaviors exhibited by these types of patients. When caring for this patient population, health care providers need to remain impartial and compassionate throughout the provision of care.

Why Do Patients Use the Emergency Department for Primary Care Services?

The urban health care provider is charged to recognize the causative factors that influence patients to inappropriately utilize the emergency department for primary care services. Urban health care providers must also take into consideration the patient population, mainly adults 18 years and older, who are accessing the emergency department and the disparities this population experiences when it comes to health care. Disparities faced by this age group include low socioeconomic status, high severity of illness, multiple chronic health conditions, previous negative health care experiences, lack of transportation, low health literacy, cultural considerations, and medical mistrust. Using the emergency room for nonacute issues is prevalent in the urban acute care hospital, as previously discussed in this chapter. Patients who say they go to a health care clinic complain that they never see the same provider, that they are unable to get timely appointments, or that there are long waits to see their provider; otherwise they claim that there are no providers in their area. Patients assume that by coming to the emergency room they will receive the best care quickly as opposed to going to their doctor's office. Often, however, the patients do not understand the benefit of having an established primary care provider or what the appropriate use of the emergency room is.

Many patients who frequent the emergency department again and again are seeking an immediate evaluation, a quick diagnosis; they want "on-the-spot" treatment with a swift resolution of their health concern. These patients often have frequented the emergency department multiple times; they have been treated before for their chief complaint and discharged home to follow up with their primary care provider within a specified period (typically within 1–2 weeks), only to return within 3–14 days with the same complaint; this pattern is known as the "treat'em and street'em" phenomenon seen mainly in emergency departments by ED personnel.

Emergency Department health care providers treat the patient's main problem but do not engage in health teaching; they do not assist with navigating the health care system, monitor health care needs over time, nor affect long-term health outcomes. In the acute care setting, however, any encounter with the patient is an opportunity to educate the patient about proper use of acute care versus nonacute care. Also, it should involve education about the benefits of having an established primary care provider. Although ED encounters with patients may be brief, educating patients according to their level of education and health literacy can positively affect their health care choices and ultimately their health outcomes. The ED provider must consider social issues and utilize the hospital's social work team for coordination of discharge and referral to community agencies. Given the increased disparities of the urban patient, community programs may be limited or able to offer only minimal assistance. For health care providers it can be hard to accept that the assistance they provide for the patients inadequately addresses their social determinants of health.

Decreases in Primary Care Services/Primary Care Physicians

It has been well established that when patients receive consistent primary care, they have better health outcomes. However, there continues to be a decrease in patients receiving primary care services. According to research from 2002–2015, there has been a steady decrease in individuals with an identified primary care provider. This decrease was specifically noted to involve younger Americans with few or no comorbidities, those of minority backgrounds, and those living in the southern regions. That in the United States there continues to be a shortage of physicians specializing in primary care remains an additional causative factor for why patients go to the emergency department instead of to a primary care clinic. According to the Association of American Medical Colleges (AAMC), it is estimated that by the year 2033, the United States could see a shortage of 21,400 to 55,200 primary care physicians (AAMC, 2020a). Because of this anticipated shortage, the medical community has implored legislators to enact full practice authority for advanced practice providers such as nurse practitioners to increase access to care to help improve patient care outcomes.

Knowledge Deficits and Lack of Disease Self-Management Skills

Patients who know little about their disease and how it may develop and who lack self-management skills often fail to adhere to their home medication regimens, and they subsequent go to the emergency department once their chronic condition has exacerbated. Many patients fail to understand that an emergency department is not equipped to refill home medications and can treat only the emergent situation. If unable to address and resolve that emergent situation, the ED physician will then discharge the patient home with instructions to follow up promptly with the patient's primary care provider, who can evaluate the patient's home medications and if appropriate ensure medication refills. When these patients present in the emergency department, having a member of the hospital's Utilization Review Team conduct a health insurance assessment would be helpful. If feasible, the team member should start a Medicaid application that if approved will help cover the patient's future hospital and primary care visits, medications, and certain diagnostic services.

Urban health care providers will also encounter patients who are labeled as and considered "frequent flyers," who "hospital hop/shop" to find an emergency department that fulfills their ideals or perceptions of what ED treatment should be. When approached with these situations, urban health care providers must remain cognizant of their own experiences while displaying compassion and empathy for the patient.

Challenges Posed to Urban Health Care Providers

When caring for patients who frequent the emergency department, urban health care providers will be posed with the challenge of recognizing their own unconscious and implicit biases and ensuring that these does not compromise care delivery. This challenge will be most urgent when caring for patients who repeatedly frequent the emergency department for "a quick fix." Providers must also be aware of how their own life experiences can affect the care they provide to their patients: Are they able to empathize with a patient or not? Various in-person and virtual courses designed for health care workers teach how implicit bias can hinder quality care delivery as well as how equitable focus can help improve clinical performance.

Higher Rates of Acute Care Admissions

Minority populations living in urban environments seeking care in urban hospitals are admitted to the hospital in rates higher than those of other population groups. On average, African Americans have a higher number of comorbidities than any other race and disproportionately lack health insurance. One reason for the higher rates of admission is lack of a primary care provider and lack of health care insurance. The average number of African Americans in urban environments with limited access to primary care is over 80%, resulting in few primary care visits to manage their chronic conditions and lack of access to preventative screenings. Because health care insurance is not affordable, 75.8% of African Americans are uninsured. Research shows that patients with multiple comorbidities have higher readmission rates and higher financial expenses than other populations. Currently, African Americans have more readmissions than Whites; this makes management of comorbidities challenging because their chronic conditions go unmanaged, so when the patients go to the hospital for treatment, their chronic illness is now in acute exacerbation, resulting in higher treatment costs. The financial burden of chronic conditions is $3.4 trillion annually, with a daily hospital admission now averaging $10,000 for 3 days. Inpatient admission of urban minority populations with increased social determinants requires an interprofessional approach from providers, nursing staff, pharmacy, physical therapy/occupational therapy, case nurse managers, and social workers to prevent readmissions. Optimizing patient health outcomes is not the only factor that prevents 30-day readmissions. Establishing primary care and assistance to overcome social determinants such as housing, transportation, financial support, and resources to access follow-up care will aid in decreasing readmission rates. Focus also needs to be on reducing barriers that may prohibit discharge to the appropriate setting in ambulatory care, subacute care, skilled nursing, or long-term care.

Inpatient Admission History

When urban minority population groups that lack insurance and/or primary care services require an admission to the hospital, a thorough admission history sets the foundation for the plan of care. Approach each patient encounter objectively and be cognizant of any implicit biases you may have as a provider when conducting the history and physical. *Implicit bias* is defined as the viewpoint on a particular matter that influence your decisions subconsciously. Implicit biases can hinder investigation of presenting symptoms and needed resources, resulting in increased health care disparities for minority groups. When taking the health history, listen to understand and convey your understanding of the patient's presenting problem to ensure it matches what the patient is explaining to you. Often patients feel that health care providers seem rushed when speaking with them or lack patience and hurry through the patient interview. The patients consequently feel dissatisfied, and if the patients become frustrated or appears irritated, they are sometimes labeled as being "difficult" to work with. This impression might be passed on to the rest of the health care team, potentially causing implicit bias toward the "difficult" patients and putting them at risk of having critical information overlooked that could delay care, prolong their hospital stay, cause a readmission, or lead to their death.

Obtaining the History and Physical

When gathering information on the chief complaint, at time of visit make sure you inquire about what led the patient to seeking medical attention. Ask about recurrence of the presenting problem, previous admissions, primary care and urgent care visits, and the patient's ability to obtain medications. Ask the patient about previous prescriptions used to treat the problem, and educate the patient to not take home medications while in the hospital to prevent adverse reactions. (Remember to review any previous clinic or treatment notes found in the electronic medical record.) Ask the patient about access to transportation for follow-up visits and the disposition goal (home versus facility) at discharge. Explain your level of questioning, as it may seem intrusive, especially if these questions have never been asked before because clinical practice varies among health care providers. It is hard to determine what a patient may deem as excessive questioning that could be viewed as intrusive, but this problem might be mitigated if you assure the patient that the goal is to provide comprehensive care and identify any barriers that will prohibit restoration of health and a safe discharge to an appropriate environment.

Be sure to ask if the patient has a primary care provider. If the patient does not, find out what type of health care provider the patient would be most comfortable with seeing. Remember to ask about location of the provider to ascertain that the patient is able to get to the provider's office for follow-up care. Patients living in an urban area may prefer seeing all their providers—primary care and specialists—at an associated hospital's professional medical building for care coordination and ease of accessibility. When the patient identifies a preferred provider, try to give the patient two choices and list the information in the discharge instructions so that the patient will be able to set up an appointment if the facility where you provide care does not have a nurse navigator team.

Health care providers serving urban patients may confront problems in communication and shared understanding that are related to differences in language, culture, and health literacy. So during the discussion of your patient's past medical and surgical history, use plain language and utilize clarifying questions to ensure accuracy of the history, realizing that patients may deny having medical diseases when medical terms such as *diabetes* and *hypertension* are used because the patient may refer to them as "sugar" or "pressure," depending on the patient's cultural background and level of health literacy. Also, be patient and sensitive with a patient's mispronunciation of medical diseases, as this is common. For example, *pneumonia* could be pronounced as "ammonia." When inquiring about surgical history, ask patients if anything on their body had to be repaired or if any organs were removed; then perform an assessment, noting any surgical scars the patient may have failed to mention. When completing the medication section, educate patients to use the "brown bag" method of bringing all medications with them to hospital visits. With electronic medical technology, many pharmacies have agreements with hospitals that allow providers to see what prescriptions the patient is using, the last date filled, and the quantity dispensed. When medications are unknown or left at home, use the chart review feature on your facility's electronic medical records system or call the patient's support person to gather the information when possible. Proper medical reconciliation decreases medication errors, reduces readmissions, and improves clinical patient outcomes.

Assessment of Social History and Social Needs

Health care providers need to know about patients' tobacco, alcohol, and illicit drug use. Under tobacco, ask about not only tobacco use but also cannabis use, both inhalation and edibles, noting if the patient uses regular marijuana cigarettes, known as "joints," or marijuana cigars, known as "blunts" (one of the latter could be the equivalent of two or three marijuana cigarettes). Does the patient smoke a cigar or use a pipe? Chew tobacco, or perhaps vape with electronic cigarettes, also known as e-cigarettes? This information will help you as a provider determine if the patient is ready to quit and what smoking cessations programs will be best for the patient—whether education on the sequelae of smoking such as stroke, heart attack, and cyclic nausea, or vomiting if cannabis products are used—and if the patient is vaping, the potential of acute lung failure. Because alcohol consumption can be a sensitive area to discuss, patients may be guarded about how much they actually consume. Differentiate the type of alcohol consumed (beer, wine, liquor), note how many ounces are consumed, and document the frequency of drinking. Also ask patients if they ever experienced withdrawal symptoms that caused hospitalization or admission to the intensive care unit. This detail will enable you to determine which preventive medications to order for the patient, what to communicate to the health care team regarding daily assessments that need monitoring, and which social work resources for substance abuse will be required at discharge. When asking about illicit drug use, once again health care providers must be nonjudgmental and explain their questioning. Faced with a person using cocaine, for example, providers will need to know whether cocaine is being actively used, so that they do not prescribe a beta-blocker, which could cause a coronary vasospasm potentially leading to decreased tissue perfusion and thereby leading to heart attack or death.

Social history is not limited to inquiries about tobacco, alcohol, and illicit drug use, of course. Social history also includes the patient's marital status, support system, and occupation. This information is helpful to know at time of admission so that the health care provider can initiate consults to the interprofessional team and assessments can be made to determine the courses of therapies and/or interventions needed for the patient to be safely discharged home and prevent readmissions. Determining social supports will give clues as to whether the patient will have help at home or will need a higher level of care at discharge, such as offered in a skilled nursing facility or nursing home. The provider should find out if the patient is a caregiver to children or an older relative and could help to ease the patient's concern by letting the family know the patient will not have an interruption in care. Inquiring about the patient's occupation will provide insight to any occupational work hazards that may have contributed to the presenting medical condition. Information about employment will reveal if the patient has the financial resources to pay for prescriptions or for transportation needs should a support person be unavailable. Another reason to know the patient's occupation is to find out if the patient is considered an "at will" employee. This information may help you understand why the patient displays any hesitancy in staying for treatment. For if the patient is an hourly worker and the job provides no compensation for time off, the patient could feel distressed, not wanting to miss earning a day's pay or being disciplined or even fired for missing work if the illness is not considered life-threatening.

In the acute care setting, health care providers may feel time constraints that can be a deterrent to performing an assessment of social needs. Hospitals may not have areas in the electronic medical records or tools for providers to quickly assess social needs. Providers may feel hesitant engaging in conversations regarding social needs because of the sensitive nature of the subject. Patients may feel ashamed about discussing their social needs or feel that a provider's questions are intrusive. Or patients may fear what providers will do with the information they obtain or feel they may be treated differently as a result of what they reveal. When speaking with patients, providers should not do so in an authoritarian manner but be active listeners who are empathetic and respectful, endeavoring to maintain a patient's dignity and be nonjudgmental. Active listening allows providers to listen to what patients are saying, identify any underlying hesitancy, and in return ask open-ended, clarifying, and reflective questions related to the patients' challenges to create a holistic picture of what the patients are experiencing socially. This approach will help patients gain a sense of trust in the provider, making it easier for providers to elicit information.

Family History

Taking a family history will give the provider insight on familial diseases, risk factors, and disease reduction; doing this will also provide an opportunity for the interprofessional team to provide the patient with education and educational resources. Keeping the patient and the patient's family informed about the plan of initial care and throughout the hospital admission makes the patient a partner on the team. Understanding the disparities patients may have may help you as the health care provider to establish baseline diagnostic care if the patient is new in your hospital system or you are unable to obtain medical records from previous hospital admissions outside your facility or if your facility's electronic medical records system is incompatible with the outside facility's system. Explaining the purpose of diagnostic exams and the medications prescribed, as well as clarifying why some medications may not be like the ones the patient takes at home, could potentially lead to greater cooperation, improved clinical outcomes, and improved customer service.

CONSIDERATIONS DURING ACUTE CARE INPATIENT ADMISSION

In the urban population there is a high percentage of noncompliance, poor chronic disease management, and lack of health care follow-up; so when urban dwellers present to the emergency room for admission, their health issues are poorly controlled or they are in advanced stages of their diseases. There are characteristics that can affect all aspects of the acute care admission. Awareness of these issues will assist health care providers in planning patient care and decreasing the impact these issues have on patient outcomes. Providers should ask their patients about their support network: Who are their third-party contacts (the persons providers are able to share information with)? Who helps the patient make decisions? Providers must accept that these persons may not be blood relatives. Issues can arise in the acute care setting during discharge planning—for instance, when an elderly patient is recommended to go to an extended care facility because of extensive care needs. Family members may refuse placement, which providers can perceive as being noncompliant or irrational. This decision may have to do with finances, however, such as an elderly patient's dependence on Social Security benefits to support the household.

Disparities in Continuity of Care and Discharge Summaries

Continuity of care is important to a patient's success in maintaining and managing health after discharge. In the acute care setting health care providers may have difficulty obtaining accurate health history from patients as a result of the patients' having knowledge deficits, having fragmented care, and receiving care from multiple health systems. This latter situation is problematic because health systems may not share the same electronic medical records, and the data may not be accessible to those outside a particular health care system. To obtain these records, written requests must be made with a signed authorization from the patient, but these records are usually fixed and may not arrive in a timely fashion. Furthermore, the process can be time consuming and cumbersome when a patient has visited multiple health systems. When a patient is admitted directly to the hospital from another hospital, hospital-based transfer teams coordinate the transfer. Most times these are nonclinical staff who may not know what pertinent information is needed. Prior to transfer there should be a phone conversation with the transferring provider, an accepting provider who discusses the reason for transfer, hospital course, and current patient status. These conversations are usually brief and do not cover in detail the hospital course or past medical history. For transfer patients, records may be sent but may be incomplete and not include pertinent information. Accepting providers should request that the medication list, lab results, radiologic testing, history and physical, and a discharge summary be sent.

Patients who have a primary care provider should have discharge summaries from their hospital stay sent to that doctor for continuity of care. Inpatient care may consist of changes to prior medication regimens, testing that reveals new findings, or new diagnoses as a result of the hospital admission that the patient's primary care provider should be made aware of. Patients who do not have a primary care provider or are unsatisfied with their current provider should be assisted in obtaining a new provider. For those patients without insurance, this may be difficult, but working with a social worker and case managers to find free or low-cost health clinics should be pursued.

If applicable, discharge summaries should also be sent to secondary care providers, home health care agencies, and post discharge facilities (i.e., subacute rehab, nursing home, or long-term acute care). When a patient is discharged, instructions are sent with the patient, but they may not be tailored to the health literacy of the patient. Instructions should include new information, new medications, and follow-up tasks such as scheduling appointments with primary care providers or specialists. Suboptimal transitions of care increase the risk of readmissions and adverse drug events after discharge. Discharge instructions are usually computer generated but can be modified. Providers should discuss instructions using their previous assessment of a patient's literacy and health literacy when wording information in the discharge instructions. Instructions that include follow-up appointments should include all contact information, the specialty of each provider, and reason for follow up in layperson's terms. Health care professionals may overestimate a patient's understanding of discharge instructions, and health care professionals and patients may use different wording to describe the same health-related terms; this vocabulary challenge can play a role in a patient's ability to state their diagnosis, name their medication, and identify indication. Up to half of patients instructed to make an appointment may not understand the reasons or mechanism for doing so, and therefore they do not make the appointment. Poor understanding or confusion about health care needs after discharge and lack of clear communication of the post discharge care plan puts patients at risk for poor outcomes and readmission. Just like discharge planning starts, discharge education should be provided throughout the hospitalization and then understanding confirmed throughout the course of the hospitalization, with a final educational assessment performed at discharge to confirm patient understanding. Use of tools such as Teach-Back, which assesses the key learner's understanding of the discharge instructions, helps facilitate discharge education. This tool helps to ensure that patients understand health information and education by checking their understanding. In this method, patients are asked to repeat in their own words what was discussed. This is not a test but does help to confirm that what was explained to the patient was understood.

Assessing Patients' Health Literacy

Health literacy is the ability of patients to obtain and comprehend information to make decisions about their health. Urban areas, recall, have a higher tendency than other areas to have patients with low educational proficiencies and health literacy. This can be attributed to patients having inadequate public education, not completing their education, or not having English as their primary language. Patients may be unaware of their low health literacy or, conversely, may feel embarrassed or ashamed and act as if they understand directions or information when they do not. This problem is important for providers to understand because health literacy can affect obtaining accurate history, relaying diagnosis, and accepting treatment. Low health literacy may also result from lack of health education from previous providers, health information that does not consider literacy level, or linguistically inappropriate health information. Numerous studies have demonstrated that health materials, such as discharge instructions, consent forms, and medical education brochures, are often written at levels that exceed patients' reading skills. This problem can be compounded when a patient has limited or no English. Efforts should be made to have written material in the patient's native language if possible, and the use of translation services is a must. Even with translation services, health education can be difficult because some dialects have no words or phrases that match English-language words. In addition, patients with low health literacy and chronic diseases have less knowledge of their disease and its treatment and fewer correct self-management skills than literate patients. These factors likely contribute to higher hospitalization rates among patients with poor functional health literacy compared to those with adequate health literacy. Quickly screening for literacy in the acute care setting using a tool such as the Rapid Assessment of Health Literacy in Medicine tool, available for free online through the Agency for Healthcare Research and Quality, will allow the provider to overcome literacy barriers. Using assessment of literacy to determine level of language and health literature can promote adherence and comprehension.

Familial Considerations

Care and treatment during an acute care stay should include an assessment of roles and characteristics of family members with such tasks as promoting medication adherence or making decisions about medical treatment. Patient characteristics such as age and current level of patient health are also likely to moderate the degree to which the family is involved in a patient's medical care. Consider, for instance, the structure of African American families. It often includes unrelated persons, and the term *family* is fluid and interchangeable in the African American community. During slavery, slaves were stolen from their families and country. When in America, slaves were sold and separated; consequently, for emotional and social support familial relationships were created with people unrelated by blood. In African American communities kinship can include family members, extended family, close friends, and neighbors who are involved in emotional and social support. A proverb in African American culture is "It takes a village to raise a child," which exemplifies how nonfamilial relationships are viewed. This blended idea of family is important in health care decisions, self-care reinforcement, and patient adherence to treatments.

Cultural and Religious Considerations

Cultural practices and beliefs can affect health care decisions. Some cultures have high regard for elders. In these cultures care is provided for by family. Many minority cultures such as African American, Asian, and Middle Eastern cultures have historically avoided institutionalizing their elders, with sons and daughters taking on the family caretaker role. Religion and religious practices can affect a patient's perceptions of diagnosis, care, and treatment. For example, the Latinx and Chaldean communities tend to be Catholic, and the last rites are usually given by a priest prior to death. For this reason, it is important to communicate prognosis and impending death to family as soon as possible. In the African American culture, the power of prayer and faith can be the basis of health care decisions. There is a strong belief that only God heals the incurable or can decide when a person dies. Families may ask for a chaplain or a priest from the hospital or from their congregation to see the patient to say prayers; this may influence whether a patient is placed in hospice, terminally weaned, or coded as "Do not resuscitate." Despite the belief that only God can decide who dies, there is also a strong belief life support should be used no matter what the prognosis. Often for extended family has a strong need to gather at the time of death; it is therefore important that that family be informed of impending death so out-of-state family members can arrive in time. Latinx and Asian families may want to avoid telling terminally ill family members their prognosis not only to shield them but also to avoid giving up hope. These examples are not all-inclusive and should not be used to generalize or stereotype any culture. Just remember that providers have the responsibility of learning about and understanding the religions, ethnicities, and cultures of the patients they care for.

DISCHARGE CHALLENGES WITH THE URBAN PATIENT

Health Systems and Length of Stay

During inpatient admission, hospitals focus on length of stay because they are paid on the basis of diagnosis-related groups, which are fixed amounts for each hospital stay. Spending less than the diagnosis-related payment means the hospital makes a profit; and when the hospital spends more, it takes a loss. Health care reimbursement is shifting toward value-based models in which physicians and hospitals are paid on the basis of the quality of services rendered, not the volume. Most hospitals receive no government financial support at all to provide this care to the uninsured or underinsured. Some hospitals owned by local governments, but not all public hospitals, receive tax subsidies from state or local governments to help offset some of the costs of care for patients with low socioeconomic status. Overall, these payments represent 10 cents per dollar of cost. With a higher incidence of Medicaid and Medicare patients in the urban health care facility, there is a strong push from upper management to have health care providers discharge patients in a specific amount of time. This can be difficult because of issues that arise during an admission. Patients are usually very sick and have very advanced disease, so they may need longer lengths of therapies, involvement of multiple specialists, increased time required to become medically stable, and care that warrants admission to a subacute facility for short-term or long-term care at discharge. Delayed discharge increases length of stay, puts patients at increased risk for nosocomial infection, and means the hospital loses money.

Psychosocial and Financial Barriers

In the acute care setting, discharge planning starts at the initial patient encounter. Assessments that include psychosocial factors can help identify patients at high risk for delayed discharge so that anticipatory discharge interventions can be initiated. Delayed hospital discharge once a patient is medically stable for discharge is often driven by functional dependence requiring increased assistance or alternative living arrangements (e.g., nursing home placement), patient or family disagreement with discharge plans, availability of community resources, and inadequate social support. Interdisciplinary care that utilizes life stress counselors and social care providers (social workers and case managers) is necessary to assist patients and mitigate barriers for discharge. It is common for people to experience stress, so utilizing life stress counselors can assist patients in identifying the stress, help them understand the causes of stress, and find steps to manage or reduce it. Social care providers help with obtaining supportive services, perform care planning, make referrals, and facilitate connection with community programs. In the hospital they assist with initiation of home health care, ordering durable medical equipment, obtaining authorizations for therapies like home oxygen, and identifying community resources for patients with and without insurance. Social care workers can assist with discharge to a long-term care or a subacute facility after a determination of need for such placement is made by ancillary services such as physical therapy, occupational therapy, and physical medicine rehabilitation doctors. Once need is determined, the social care team will work with insurance companies, families, and prospective facilities for placement. In cases of substance abuse or homelessness, they provide information to patients in treatment programs and shelters. When patients are discharged and unable to obtain durable medical equipment, medication, or outpatient treatments because these are not covered by their insurance, patients have financial constraints, or they lack of insurance, the social care team must find resources or alternatives. For instance, when lack of transportation is an issue for patients to keep follow-up appointments for dialysis treatment, the team will assist in finding low-cost transportation services or investigate if insurance will provide transportation. The social care team can assist with finding pharmaceutical programs for medication assistance, government agencies that offer assistance, and local community resources.

Refusal of Discharge

Refusal of discharge occurs when a patient or family member feels that the patient is not medically stable enough to be discharged. Health care providers must be proactive in communicating plans of care, progress, and prognosis with patients and their family members. It must also be stressed to families and patients that medical stability does not mean cured or back to the patient's previous baseline. Even when family members agree that a patient is medically stable for discharge, there can be issues with refusal of discharge to a subacute or long-term facility. As mentioned earlier, many cultures prefer to take care of their loved ones at home or there may be financial hardship if a patient is placed in a facility for an extended length of time. When subacute or long-term placement is needed but the patient does not have insurance, social care providers work with state agencies to try to obtain insurance coverage. This can be difficult and time consuming, so patients must stay admitted to the hospital until a temporary authorization for insurance is obtained.

For patients being discharged home, the social care team can provide information about how to apply for government insurance. Having a psychiatric illness or being cognitively impaired can delay treatments and discharge if a patient is deemed mentally incompetent. At this point the patient needs to have a guardian, and this involves going through the court system. There also must be a willing and competent family member who agrees to take over guardianship because that will be the person who makes decisions about care treatment and discharge. This can be problematic if family members do not agree or refuse to pursue guardianship. In these cases, social workers can refer temporary guardianship to a guardianship company, which also has to be approved by the court system. Another reason temporary guardianship may be sought prior to discharge is if it is found that a disabled or elderly patient will be discharging to a home that is not safe or there is suspected abuse. Reports are made to Adult Protective Services and alternative discharge placement is sought.

Discharging From an Acute Care Setting

Components of a Discharge

A safe discharge consists of several components health care providers need to be aware of. The first component of a patient discharge starts with determining where your patient will go after the inpatient stay. The disposition of discharges includes the ambulatory setting, ambulatory setting with home health care, skilled nursing facility, permanent nursing home placement, or long-term care facility. Final disposition of a patient starts on the day of admission so that any barriers to discharge can be identified and worked on throughout the patient's admission. If a patient is identified as having social barriers, a consult needs to be placed to the social worker or case nurse manager to facilitate discharge needs. The second component of a patient discharge is determined once the patient has returned to a stable state of health and is hemodynamically and mentally stable either to go home or to transfer to another facility to continue care. The health care provider should review vital signs, lab trends, and final results (i.e., blood, urine, sputum cultures, and available pathology reports), physical therapy/occupational therapy recommendations for home health care, skilled nursing facility, or acute rehab. Review results of ordered diagnostic testing and receive clearance from consultants along with their disposition recommendations so that care can be followed up as outpatient.

The discharge process also considers medication reconciliation, for as a health care provider you need to determine which medications you will have your patient continue or stop and what new prescriptions the patient will need. Considering the social determinants of health, for continuity of care try to have medications filled at the patient's home pharmacy unless you are prescribing a time-sensitive medication, such as an antibiotic; also consider having these medications filled in the outpatient pharmacy located in the hospital and brought up to the patient to ensure no doses are missed. Does the patient have reliable transportation? If not, try to be liberal when possible and provide refills, understanding the patient may have a 1-month or 2-month wait to see the primary care doctor or to establish new care. This is often challenging, as some new medications may require additional monitoring that is not available when the patient is not managed by a hospital system.

The third component of patient discharge includes follow-up care to all the consultants who helped manage the patient's care in the hospital. In the discharge section, give the names of the consultants and provide a brief summation of what items need to be followed up on (e.g., test results, diagnostic testing with time frame), along with the provider's address and telephone number and instructions on when to make an appointment.

END-OF-LIFE CARE

When approaching families about end-of-life decisions, it is important for the health care provider to identify who the head of the family is and who will be making decisions on behalf of the patient if no one has yet been identified. Patients who are terminally ill or suddenly face end-of-life decisions could cause overwhelming stress and emotional turmoil in families because of their relationship to the patient, family dynamics, or unresolved family issues. Because of the delicate nature of this sensitive subject, providers need to have patience and be prepared to fully explain everything that is happening to the patient. They need to use understandable language so that the family is fully informed of the patient's status. Oftentimes family members are asked to describe how the patient's health has been so that the family can reflect on the patient's failing health. Following this reflection the provider may state that the patient needs hospice care or that the patient's code status needs to be changed to "Do Not Resuscitate" (DNR). When families hear the terms *DNR* or *hospice*, what is often heard is that you are giving up on the patient. Given their mistrust of the health care system, members in the African American community in particular may believe that the health care team is giving up on their loved one and making no effort to save this patient because of the patient's race, socioeconomic status, or lack of insurance. Because of systemic racism in the United States, African Americans frequently feel that their lives truly do not matter and that one less Black life in society is somehow okay with health care providers, especially if societal norms label the patient's lifestyle as "less desirable."

Hospice care needs to be explained as an alternative terminal care that allows patients to live out their remaining days in peace and comfort and forgo the heroic life-saving efforts that would be futile in the last stages of a terminal illness. In the event imminent death is occurring in settings like the emergency department or ICU, thoroughly explain what is happening to the patient and describe all efforts that have been made. Sincerely express that everything is being done to save the person. Consider letting families know you have consulted with other experts to make sure that nothing is being overlooked for their loved one. The hope in these types of scenarios is to provide the families with reassurance that everything is being done to take care of their loved one and that race or socioeconomic status is not prohibiting the evidence-based care the patient deserves to have.

Another approach to the end-of-care discussion would be to tell the designated family member the status of the patient's health. Then explain to that person how the next 24–48 hours are critical and identify the markers that need to take place to show the patient is making progress. Doing this will start to prepare the family to know that though the end is near, care is not being stopped and all is being done to attempt to save the patient's life. If the patient is not meeting the identified markers, the family will be prepared and, one hopes, not feel that the doctors gave up on their loved one. At this stage acceptance of mortality begins. This approach is similar to what is traditionally taught but is just more "chunked out" compared to an "all at once" approach, which can be overwhelming.

CASE STUDY: ACUTE CARE

Robert Johnson is a 52-year-old African American man who was provided emergency care for approximately 1 year before getting linked to a primary care provider and before spending 12 consecutive months without a hospital admission.

Mr. Johnson lives with his 71-year-old mother, 73-year-old father, and one of his children, who is 19 years old. Mr. Johnson began working at Ford Motor Company at age 20, as he was starting a new family and living in a Detroit suburb. On his job, he had full-coverage health insurance with prescription drug coverage. He enjoyed reliable transportation and was married to the woman of his dreams. His wife was also working at Ford (it's where they met), and they had a healthy and prosperous lifestyle raising their three children in the burbs. After 28 years on the job, Mr. Johnson injured his back, and though he was fully prepared emotionally to retire, he left the job about 1.5 years short of retirement age, lost his health insurance and prescription coverage for at least another year and half until he could collect either his disability or his retirement benefits.

Mr. Johnson and his wife separated because she was angry that he could no longer work. He lost his connection to his primary care doctor at the local hospital because he could no longer be seen in his clinic without insurance. Although Mr. Johnson knew he would have insurance in the next year or two, he continued to show up in the emergency department to get help managing his back pain and his new onset symptoms of dry mouth and extreme thirst. He would later be diagnosed with diabetes mellitus Type II (DM Type II). On his last ED visit he was diagnosed with DM Type II, given a follow-up appointment with his primary care provider at the hospital, and told to also get an endocrinologist to assist with managing and controlling the symptoms of his diabetes.

Because Mr. Johnson was uninsured, he was unable to return to his own primary care provider though he had appointments made for him to do so. He and his wife were now estranged, and he and one of his sons decided to move in with his mother to conserve money and get additional help financially, emotionally, and with driving to the free community clinic, as he had begun to develop symptoms of decreased visual acuity and some numbness and tingling in his hands and feet. Mr. Johnson's elderly mother tried to supplement Mr. Johnson's medical expenses with her fixed income by purchasing his pain medicines and new diabetic medicine and supplies. His mother also tried to figure out how to help her son wait out the time while he had no insurance to get him medical help. Mr. Johnson was frequently sent from the community clinic to the emergency room because he was having such a difficult time managing his blood sugar and was often in excruciating pain. He began to get new hospital bills from the many monthly hospital ED visits and admissions trying to manage his medical issues. He still had no insurance, no income, no transportation, and no way to get in to see his regular primary care provider and the endocrinologist and pain physicians who had been recommended to him.

Mr. Johnson was often labeled as "drug seeking" or as a "frequent flyer" even with support from the ED social workers whom he now knew by name because of his frequent visits to the local hospital emergency department. After his last admission to the hospital, he informed the discharging case manager that he was uninsured and did not know where he was going to get a new blood glucose machine, testing strips, syringes, or any of the supplies that she was recommending for his discharge. The social worker reported Mr. Johnson's challenges to her manager to seek additional resources for him. Because of the number of his ED visits and inpatient admissions, Mr. Johnson finally qualified for the Safety Net Support program at the hospital. This program allowed the social worker to assist Mr. Johnson more directly with his own personal health needs. The safety net social worker was also able to assist with applying for speedy consideration for Medicaid, a 90-day supply of medications, community-based transportation to his previous primary care provider, and appointments with the endocrinologist and pain specialist. His safety net social worker also assisted him with his application for his retirement benefits and pension income and with initiating an application for possible disability benefits, since he was at risk for dialysis and possible transplant surgery. His new benefits and the ongoing work and contact of the safety net social worker reduced the ongoing and multiple admissions and successfully kept Mr. Johnson out of the hospital for 12 consecutive months.

1. What are three suggestions you might have offered this patient if you were his health care provider?
2. When you thought of the patient and his circumstances, did his socioeconomic status or financial situation affect your decision about what care he "deserved"?
3. What services would you have offered this patient to more quickly move him from at-risk to better health?
4. What gender or racial factors came to mind when you thought of how you might be able to help this patient?
5. What could the hospital have done to decrease this patient's use of its emergency department?
6. What are other considerations?

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CHAPTER 7. URBAN HEALTH DISPARITIES AND THE COVID 19 PANDEMIC: THE PERFECT STORM

The first case of COVID-19 in Michigan was on March 10, 2020. The next day, March 11, the World Health Organization (WHO) declared COVID-19 an official pandemic. As the pandemic began to spread, the disparities that have for decades been embedded in the fabric of the urban environment were exacerbated. The communities that chronically suffer from poor health outcomes were further crippled as the COVID-19 pandemic added another layer of despair, suffering, and death. Social determinants of health (SDOH) represent the conditions that affect the lives of every individual and are directly influenced by social power, economics, and access to basic resources at all levels. When these social determinants are diminished at baseline, adding another devastating event such as a global pandemic adds insult to an already gangrenous, chronic injury.

LEARNING OBJECTIVES

1. Recognize the chronic and cumulative impact of health disparities in urban communities and how these disparities were exacerbated by the COVID 19 pandemic
2. Understand the factors that contribute to urban African Americans being disproportionately infected and dying from COVID-19
3. Understand how COVID-19 has affected social determinants of health for urban communities
4. Explore the quantitative, qualitative, and demographic data gathered in Detroit, Michigan, during the first year of the COVID 19 pandemic

ACCUMULATION OF DISPARITIES IN URBAN COMMUNITIES

The COVID 19 pandemic refocused national attention on urban communities and the inequality that exists. We are living in a culture of inequity. Minorities encompass that majority of the despaired urban population in the United States, and historically, minority populations have inherent disparities stemming from their original indoctrination into what was "American" society, a country supporting slavery and experiencing waves of immigration. This textbook brings to light a unique perspective that exposes the barriers associated with consistent and compounded disparities experienced by patients in urban communities. **Chapter 1** has highlighted the unique characteristics of urban environments that set the stage for poor health outcomes (dense populations, close living quarters, etc.). **Chapter 2** has skimmed the surface of discriminatory medical practices in this country and explored the role that prejudice and bias play, both consciously and unconsciously, in the delivery of health care. **Chapter 3** has examined disparities in urban communities in the context of SDOH and introduces urban considerations to assist providers in understanding the "lived experience" of urban patients. **Chapters 4**, **5**, **and 6** have taken the reader through the current health care system, highlighting the disparities in primary care, mental health services, and hospital-based care for urban residents and have offered the reader a better understanding of how social determinants of health affect health outcomes.

URBAN COMMUNITIES AND COVID-19

This final chapter, **Chapter 7**, serves as a repository of urban disparities exposing what happens when the compounded injustices explored in Chapter 1 through Chapter 6 set the stage for the insurmountable obstacles revisited during the COVID-19 pandemic. Racial and ethnic minority groups continue to be disproportionately represented among COVID-19 cases and deaths. African American and Latinxs represented a disproportionate percentage of COVID-19 infections in many cities and states. The most highlighted urban community that suffered great travesties early during the COVID-19 pandemic was New York City. At the onset of the COVID-19 pandemic, In New York City, African Americans have accounted for 33% of deaths from COVID-19 despite making up 22% of the population, and Latinxs were dying at 1.6 times the rate of White deaths (New York City Health, 2020; New York State, 2020; Welli Cornell Medicine, 2020). Underlying health conditions further exacerbate the risk factors related to COVID-19 disparity and death. Health care systems in underserved areas tend to have fewer resources and decreased access to care for members of the community than do other areas. At the height of the pandemic, urban areas were hit with lack of access to care because of overcrowded facilities, health care providers refusing to see patients, and lack of access to testing and personal protective equipment, which was worsened by the inability to isolate as a result of overcrowded housing. People of color, who constitute the majority of the population in underserved urban environments, are more likely to have no insurance or have Medicaid, which unfortunately has lower reimbursement rates and is not as widely accepted as other insurances; in either case, both scenarios decrease access to care.

As the pandemic progressed, the nation shifted to virtual platforms that included telehealth, online learning for education, and worship service. The educational systems became strained as students faced with financial disparities experienced a disruption in receiving free meals, having access to technology, and working in a structured learning environment. Considering an already despaired community, access to home devices and high-speed internet, knowledge of virtual platforms, lack of proficiency with technology, and lack of access to computers and smartphones widened the preexisting barriers, especially during the time when health care providers quickly turned to technology to help them further manage patient care. The lack of in-person communication further strained an already tumultuous relationship between the chronically underserved patient population and medical providers. The history of medical mistrust, especially among African Americans, which is a direct consequence of the historical legacy of medical mistreatment, experimentation on the poor, and the underserving of minority populations, has resulted in a lack of confidence in the medical community.

For centuries African American churches have served a pivotal role in the physical and mental health well-being of African American communities. The COVID-19 pandemic forced the closure of houses of worship and left congregants without their main source of social, emotional, and spiritual support at a time of dire need. This situation was worsened by the deaths of many prominent African American spiritual who chose to forgo the pandemic restrictions and consequently died from COVID-19. The pandemic thus created a spiritual crisis as African Americans who were inundated with the deaths of family and friends were left to mourn the loss of pastors and spiritual leaders as well. Large-size centers of worship were able to shift to online formats, whereas many smaller churches were not technologically advantaged and struggled to leap the technology divide, leaving many people without the traditional foundational support of their church family.

One of the key strategies implemented to minimize the spread of disease during a pandemic is social distancing; however, doing that is a privilege not granted to everyone. Despaired urban communities typically house people of color. People of color are likely to have jobs as janitors, childcare workers, grocery store clerks, and public transit workers; these are the people otherwise designated as "essential workers," requiring them to interact with the public and thereby putting them at increased risk for disease transmission. But home is not safe either. Individuals living in urban environments are more likely to live in dense and lower income neighborhoods that are subjected to crowded conditions with multiple generations living under one roof.

DETROIT VS. COVID-19

For those individuals who did not recognize, acknowledge, or understand how disparities affect urban communities, the pandemic brought these disparities back to the mainstream. The COVID-19 pandemic did not create the health disparities observed during the initial phases of the pandemic, but it did further highlight the structural inequalities that have existed for centuries. In March 2021, Ray et al. published a report entitled *Examining and Addressing COVID-19 Racial Disparities in Detroit*. In this report, the authors analyzed quantitative, qualitative, and demographic data in Detroit, Michigan, to expose the disproportionate impact of the COVID-19 pandemic on urban communities and offer policy opportunities to address racial disparities in urban communities. This report provided empirical data that clearly exposed the disparities of African American residents in Detroit during the initial year of the COVID-19 pandemic. African American residents in Detroit were significantly more likely to contract and die from COVID-19 than their White counterparts. In fact, African Americans were 2.1 times more likely than Whites to die from the COVID-19 virus in 2020. According to the report, if African Americans had the same COVID-19 death rate as Whites, roughly 25,000 fewer African Americans would have died in Detroit in 2020. In addition to exposing the increased mortality associated with race and the COVID-19 pandemic, the report also exposed how the COVID-19 pandemic exacerbated historically embedded disparities related to social determinants of health. Over 75% Detroit residents earned under $50,000 annually, and African American residents were significantly more likely to report barriers in accessing food, water, and other household supplies. African Americans in Detroit were 7 times more likely to be concerned about eviction, 17 times more likely to need rental assistance, and 40% more likely to report running out of money than their White counterparts.

Examining and Addressing COVID-19 Racial Disparities in Detroit (Ray et al., 2021) proves to be a compelling exemplar highlighting how COVID-19 disproportionately affected urban communities, specifically communities of color. This report provides a comprehensive overview displaying how preexisting disparities in urban communities related to social determinants of health further exacerbated by the global pandemic.

CASE STUDY: EXAMINING AND ADDRESSING COVID-19 RACIAL DISPARITIES IN DETROIT

Read the full report by Ray et al. (2021) entitled *Examining and Addressing COVID-19 Racial Disparities in Detroit* and then complete the following activities:

1. Be prepared to discuss how the city of Detroit was affected physically, mentally, and emotionally by the devastation effects of COVID-19 using data gleaned from *Examining and Addressing COVID-19 Racial Disparities in Detroit*.

2. Examine the specialty that you are currently pursuing (e.g., nursing, medicine, social work, public health) and reflect on the role that your specialty has in providing care to patients in urban communities. After reading *Examining and Addressing COVID-19 Racial Disparities in Detroit*, imagine yourself caring for patients in Detroit at the onset of the COVID-19 pandemic. Using the skill set associated with the specialty you are pursuing, what strategies would you have employed to address some of the disparities that affected health highlighted in the report?
3. For most of us, the COVID 19 pandemic has been our first experience living through a global pandemic. Universal trauma inflicted by the pandemic has affected all our lives and will continue to have residual effects for years to come. After reading *Examining and Addressing COVID-19 Racial Disparities in Detroit*, try to imagine that the disparities highlighted in this manuscript were your "lived experience." How would you feel? Review the statistics presented in the report and explore realistic strategies to optimize health in the midst of disparities that are prevalent in urban communities.

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APPENDIX: EXAMINING AND ADDRESSING COVID-19 RACIAL DISPARITIES IN DETROIT

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THE BROOKINGS INSTITUTION, 2021

Examining and Addressing COVID-19 Racial Disparities in Detroit

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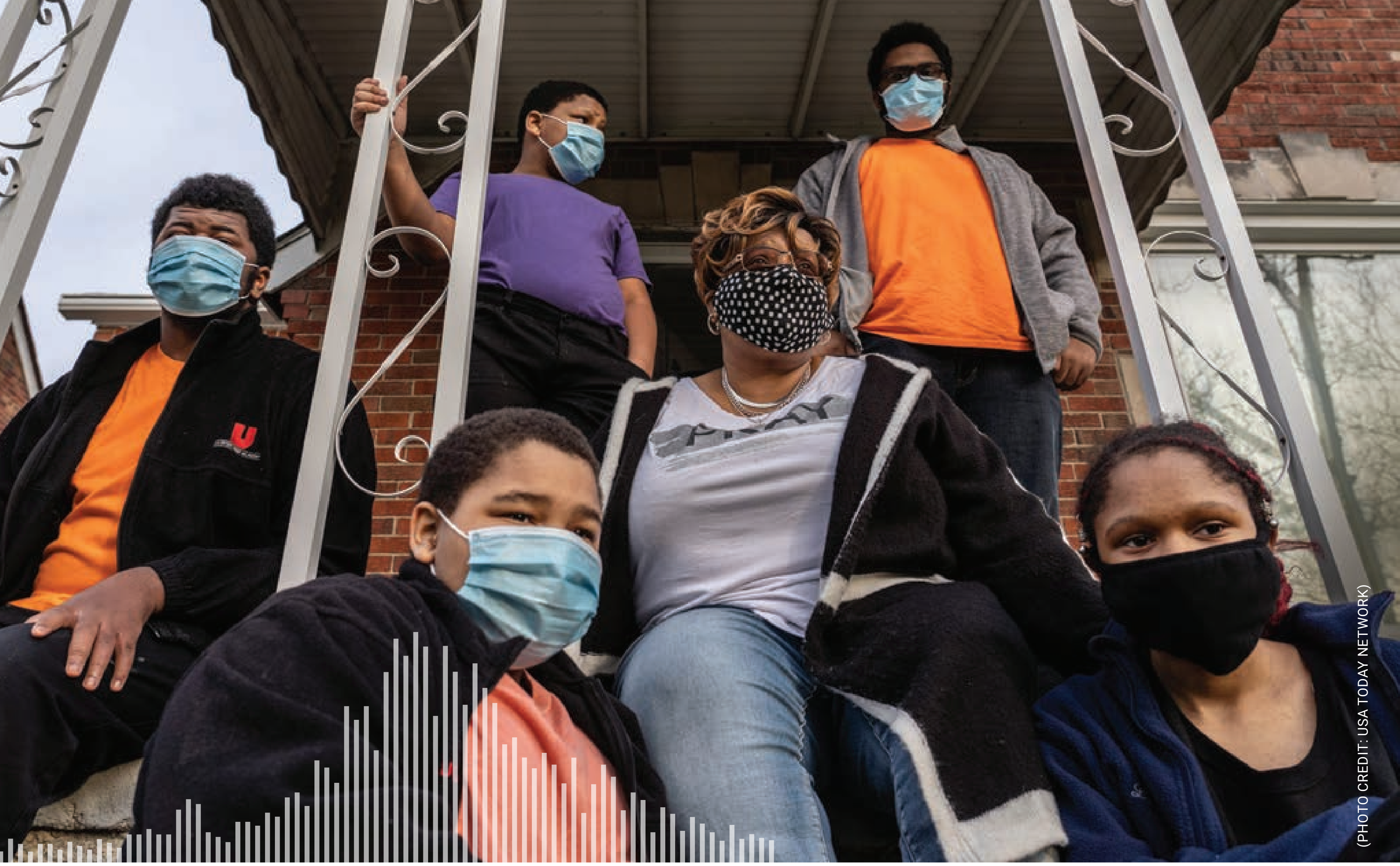
Lydia Wileden, Samantha Elizondo,
and Destiny Wiley-Yancy

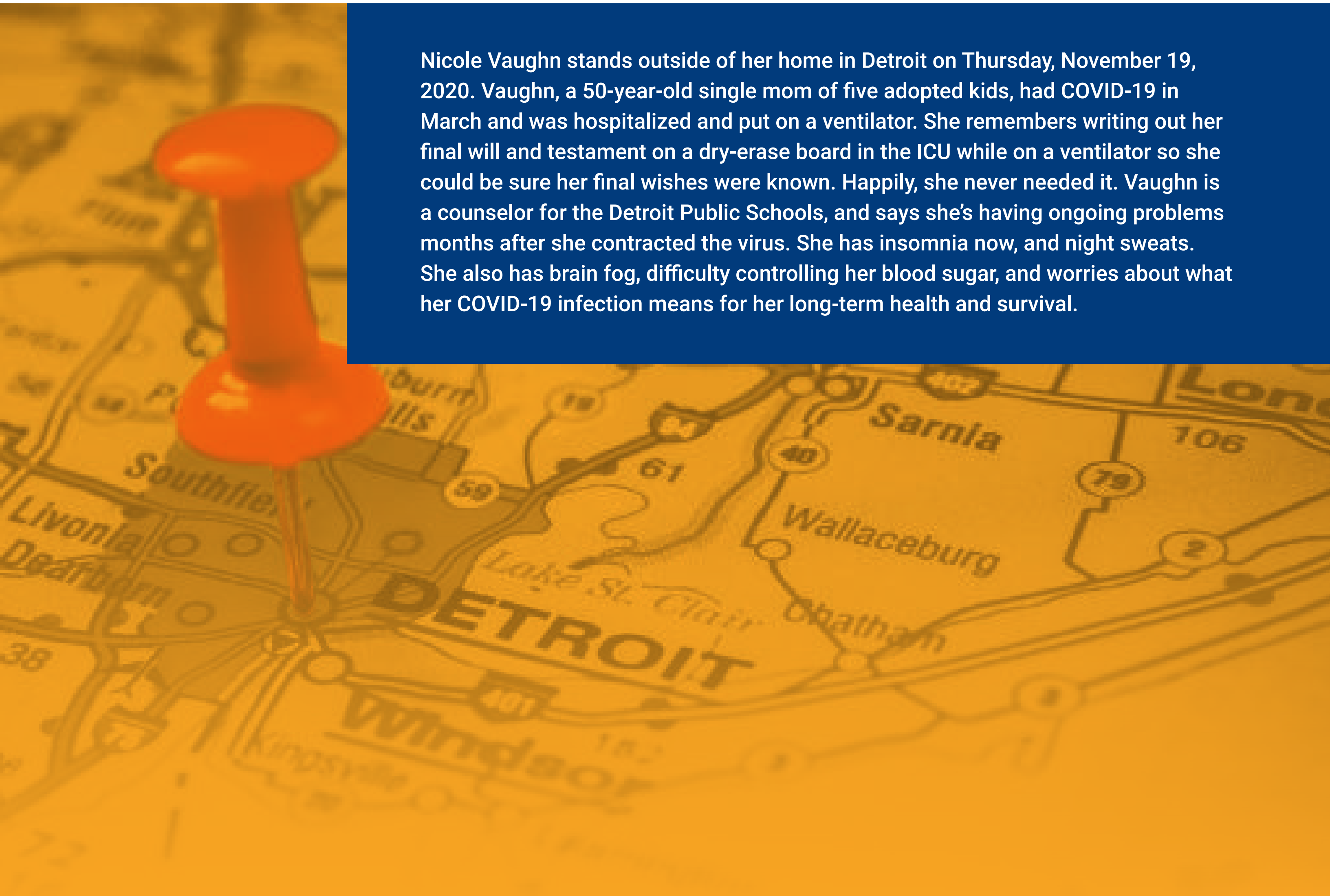
B | Governance Studies
at BROOKINGS

NEW DETROIT
A RACIAL JUSTICE ORGANIZATION



(PHOTO CREDIT: USA TODAY NETWORK)

Nicole Vaughn stands outside of her home in Detroit on Thursday, November 19, 2020. Vaughn, a 50-year-old single mom of five adopted kids, had COVID-19 in March and was hospitalized and put on a ventilator. She remembers writing out her final will and testament on a dry-erase board in the ICU while on a ventilator so she could be sure her final wishes were known. Happily, she never needed it. Vaughn is a counselor for the Detroit Public Schools, and says she's having ongoing problems months after she contracted the virus. She has insomnia now, and night sweats. She also has brain fog, difficulty controlling her blood sugar, and worries about what her COVID-19 infection means for her long-term health and survival.



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Introduction

One in every 645 Black people in the United States can expect to die from COVID-19.[1] Blacks are 2.1 times more likely than whites to die from the virus. In fact, if Blacks had the same death rate as whites from COVID-19, roughly 25,000 fewer Black people would have died in 2020.

Why are Blacks disproportionately infected and dying from COVID-19? And, what are the broader COVID-19 related challenges for Black families and communities? How does COVID-19 impact other health-related issues, employment, housing, food, education, and business ownership? These are the central research questions that our report aims to address.

> One in every 645 Black people in the United States can expect to die from COVID-19.

With racism being declared a public health issue in cities and states such as Michigan, we aim to examine the impact of COVID-19 through the experiences of Detroiters. The state of Michigan has the fourth highest COVID-19 mortality rate for Black Americans. Roughly 328 out of every 100,000 Black people have died from COVID-19 compared to about 122 out of every 100,000 white people living in Michigan. Wayne County has been most impacted by the virus. In Detroit, Black people represent over 75 percent of known COVID-19 diagnoses by race and nearly 90 percent of deaths. Considering there is a sizable percentage of missing data, the Black community may be even harder hit.

In light of these are sobering statistics, we assembled a formidable team of national, state, and local policy experts, practitioners, and researchers from The Brookings Institution, JFM Consulting Group, Data Driven Detroit, and the University of Michigan to better understand the factors related to racial disparities in COVID-19-related outcomes and the barriers to closing these gaps. Ultimately our findings will inform evidence-based solutions for government officials in the city of Detroit, Wayne County, and the state of Michigan when making policy decisions that can reduce the racial gap in COVID-19 and advance vaccine utilization.

Our extensive analysis of quantitative, qualitative, and demographic data reveals that COVID-19 has disproportionately impacted the Black community in Detroit. Not only are Black and Hispanic residents more likely to die from COVID-19 and know someone who died from COVID-19 relative to whites, but Black residents relative to white residents report more issues with housing, money, and food. A majority of parents report significant struggles with education for their children during the pandemic and report low levels of confidence in the school system to handle these challenges. Our report concludes with a series of policy recommendations for addressing racial disparities in COVID-19, COVID-related challenges, and racially-equitable vaccine dissemination.

While we focus acutely on Detroit and the Tri-County region in Michigan, our findings and policy recommendations are applicable to other localities that are attempting to employ racial equity in the midst of pervasive racial health disparities.

(PHOTO CREDIT: USA TODAY NETWORK)

Juliette Gilbert, 33, of Detroit and her sister Danielle Baldridge, 34, of East Pointe speak about losing their mother Monique Baldridge, 52, to COVID-19 while sitting on Gilbert's porch in Detroit's east side on Friday, December 11, 2020. Their mother fell ill in March 2020 and was hospitalized for about two weeks. Gilbert said her mother lived with her and her three kids.

METHODOLOGY

We gathered a diverse set of data to examine COVID-19 racial disparities. First, we compiled descriptive data from the APM Research Lab, U.S. Census American Community Survey, SBA Paycheck Protection Program Loan Level Data, City of Detroit Health Department, Michigan Department of Health and Human Services, Michigan Bureau of Labor Market Information and Strategic Initiatives, Wayne County Treasurer's Office, and Princeton Eviction Lab. Focusing on the city of Detroit and Tri-County area, these data detailed COVID-19 cases and deaths, racial demographics, household income, people living in poverty, labor participation, health insurance, internet broadband access, housing burden issues, foreclosures and evictions, household composition, and single-parent households. Though these data are presented in graphs and discussed throughout the report, we include the tables in a supplemental appendix.

Second, we conducted in-depth interviews with key stakeholders in Detroit to gain an on the ground perspective of how COVID-19 is impacting health care, families, education, employment and finances, and small businesses. We also obtained insights into reactions to the most significant factors contributing to racial disparities and solicited input on policy recommendations. JFM Consulting led the stakeholder interviews and the Brookings team participated in the interview sessions, conducted transcriptions, and helped with coding and analysis.

With consultation from New Detroit, we interviewed thirteen key stakeholders who represent health, housing, education, employment, small business, food security, and public policy sectors. With interviews ranging from 20 minutes to roughly one hour, these CEOs, Presidents, and Directors of local organizations, companies, and government agencies reflected on the sectors noted above. Each participant was asked the same eight broad questions that allowed them to discuss the challenges and barriers to racial equity, while addressing what a long-term and inclusive recovery looks like for Detroit and the state of Michigan. We provide quotes from these stakeholders throughout the report and include the interview guide and stakeholder list in the supplemental appendix.

Third, we analyzed data from Detroit Metro Area Communities Study (DMACS), a longitudinal panel survey conducted by the University of Michigan that gathers data on the experiences and opinions of a representative sample of 1,200 Detroit residents. Survey data includes a range of topics pertinent to COVID-19 including health and financial challenges, employment and health insurance changes, and views on race relations.

Particularly relevant to interrogating racial disparities in Detroit, the survey includes census tract-level data. Tract fixed effects control for differences across neighborhoods as well as additional controls (held at their means) for gender, age, income, education, marital status, and if the respondent has children. We focus on data from Wave 10 of the survey, which were collected during spring/summer 2020. The data were collected via an online survey, which respondents access by computer, tablet, or smart phone or via interviewer-assistance by telephone. After data collection, the data were cleaned, coded, and analyzed by University of Michigan researchers in close consultation and oversight from the Brookings team.

Sample weights are used to adjust the sample to the demographics of Detroit. Because of the small percentage of people who identified as multiracial or other race (1.75 percent of the weighted sample and seven percent of the raw sample), we limited the analysis to people who racially-identified as Black non-Hispanic, Hispanic, or white non-Hispanic. Nearly 93 percent of the raw sample and over 98 percent of the weighted sample were represented by these three racial groups. This sample is congruent to the percentages reported by the U.S. Census American Community Survey estimates for 2018. Throughout the report, we go back and forth between census data and DMACS data. We aim to specify accordingly. We include all tables from our analysis in the supplemental appendix including a table with the raw sample. In the report, we only present data from the weighted sample.

Ebone Jolly, registered nurse, prepares to administer a COVID-19 test to Shu Rice, 59, of Detroit in the parking lot at The Joseph Walker Williams Community Center, Friday, Nov. 13, 2020.

(PHOTO CREDIT: USA TODAY NETWORK)

Sample Demographics for the Detroit Metro Areas Communities Study

Table 1 shows weighted demographics for the DMACS sample. Roughly 55 percent of the sample is women relative to men. The average age tends to be younger with over 30 percent being 18–35 years of age. Nearly 20 percent of the sample is 65 years of age or older. Nearly 50 percent of the sample is 35–64 with a similar breakdown from 35–49 year-olds (22.8 percent) and 50–64 year-olds (25.6 percent). We mentioned the racial demographic previously. Similar to Detroit, nearly 80 percent of the sample is Black followed by whites at roughly 11 percent and Hispanics at about 8 percent. For education, over half of the sample has a high school degree or less, while about 16 percent have a bachelor's degree or advanced degree. The rest of the sample reports some college, meaning they either have an associate's, vocational, or technical degree or attended college for roughly two years.

For household income, slightly over 20 percent of the sample reports less than $10,000 in income, while 8 percent reports a household income over $100,000. Nearly 27 percent of the sample reports a household income of $10,000 to less than $30,000, about 22 percent reports $30,000 to under $50,000 and roughly 22 percent reports $50,000 to under $100,000. Only about 23 percent of the sample reports being married and roughly 40 percent report having children living in the house.

As seen in the supplemental appendix, people living in Detroit are substantially more likely to live in poverty than others living in the Tri-County region. In fact, over 50 percent of Detroit residents live below the poverty level. This is compared to 38 percent in the rest of Wayne County and 28 percent for people living more broadly in the Tri-County region. We provide more demographic details as the findings are discussed.

Table 1: DMACS Demographics

Category	Percentage	Percentage White	Percentage Black	Percentage Hispanic
Gender				
Male	45.1	64.5	42.5	42.9
Female	54.9	35.5	57.5	57.1
Age				
<35	32.4	47.0	27.5	61.3
35–49	22.7	23.9	22.7	21.3
50–64	25.8	15.1	28.7	11.3
65+	19.1	14.0	21.1	6.2
Race/Ethicity				
NH White	11.5			
NH Black	80.9			
Hispanic	7.7			
Education				
High School or less	51.9	30.3	53.1	72.0
Some College	32.2	25.6	34.1	21.9
BA+	15.9	44.2	12.8	6.1
Income				
<$10k	21.0	7.6	23.5	15.5
$10k–$29k	26.7	20.6	28.7	14.5
$30k–$50k	22.3	18.4	22.1	30.8
$50k–$100k	21.9	24.4	20.2	35.5
$100k+	8.1	29.0	5.5	3.7
Marrital Satus				
Unmarried	77.3	67.2	80.2	61.5
Married	22.7	32.9	19.8	38.5
Household Type				
No Kids	60.5	75.4	60.8	34.2
Kids	39.5	24.6	39.2	65.8

Major Research Findings

Our analysis indicates the toll that systemic racism has had on Black residents of Detroit and the Tri-County area. Because of the legacies of underinvestment, redlining, jobs without benefits, poor or nonexistent and culturally incompetent health care, Black residents are less likely to be able to transcend the challenges presented by COVID-19 and are more likely to contract and die from the virus. In the sections below, we provide further insights into these troubling outcomes.

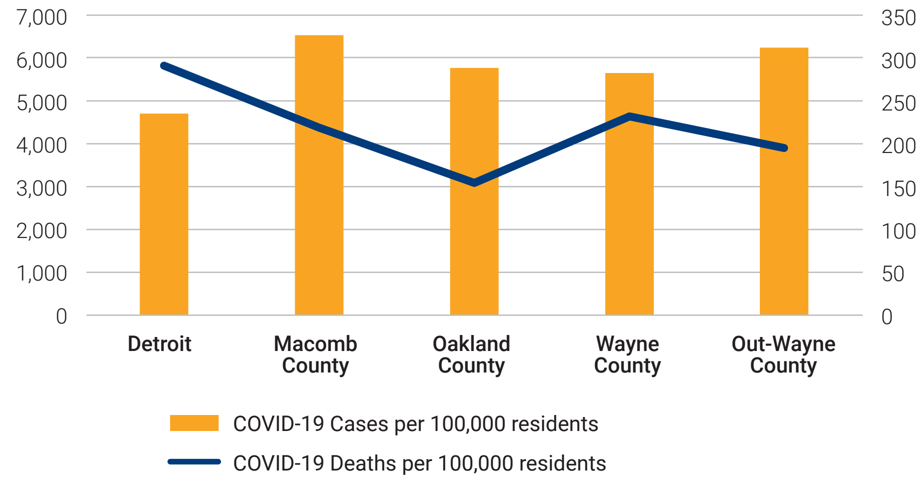
Racial Disparities in COVID-19 Infection and Death

Since the beginning of COVID-19, Black residents have died at a significantly greater rate than white residents. Additionally, Black residents are three times more likely than white residents to have family members or friends who have become ill from COVID-19 (this increases to five times as likely with census track-fixed effects) and ten times as likely to have friends or family members who have died from COVID-19 (this increases to twelve times as likely with census track-fixed effects). This is another way in which the Black community is disproportionately shouldering the burden of the pandemic.

> Black residents are three times more likely than white residents to have family members or friends who have become ill from COVID-19

Graph 1 shows the cases and deaths per 100,000 residents for Detroit, Wayne County, Macomb County, and Oakland County. While people living in Detroit are less likely to be diagnosed with COVID-19, they are significantly more likely to die from the virus. On a national level, the data indicate that COVID-19 is killing Hispanic, Black, and American Indian children and young people disproportionately. These groups account for 78 percent of COVID-associated deaths under the age of 21.[2]

Graph 1: COVID-19 Cases and Deaths Among Residents



Source: Data Driven Detroit, February 2021.

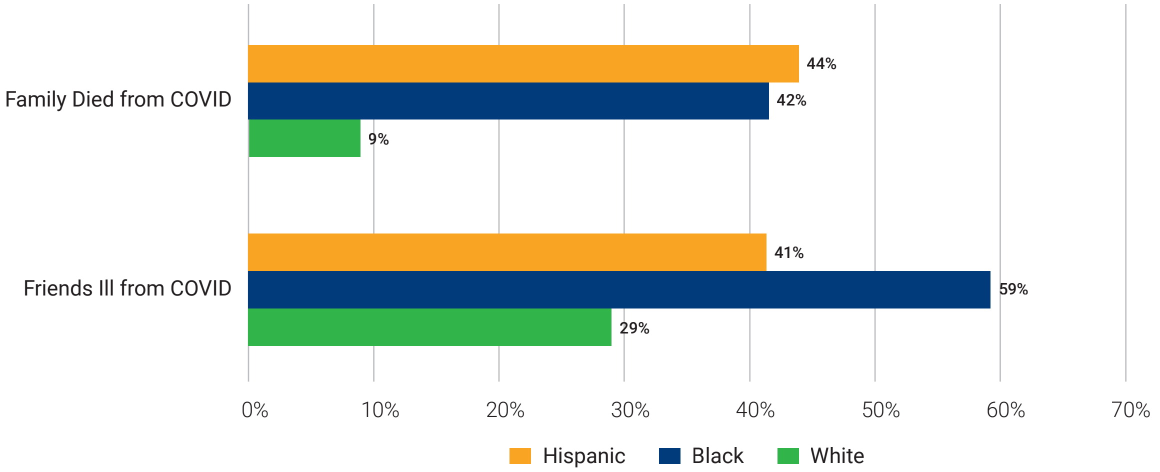
So, why this seemingly unparalleled pattern between cases and deaths? Well, one explanation is that people in Detroit are less likely to get tested for COVID-19 than people in other parts of the Tri-County region. However, recent trends suggest testing is adequate in Detroit relative to other parts of the Tri-County region. Another plausible explanation is that people in Detroit are less likely to obtain the health care necessary to decrease the likelihood of a severe case of COVID-19. Our analysis reveals the impact of racial disparities in health care and health care utilization.

Additionally, as illustrated in Graph 2 below, the experiences of Black Detroiters reveal why Black residents as well as Hispanic residents are much more likely to have a family member die or become very ill from COVID-19. While over 40 percent of Black and Hispanic residents report having a family member who has died from COVID-19, less than 10 percent of white residents say the same. Nearly 60 percent of Black residents and 41 percent of Hispanic residents also report having a family member who has become ill from COVID-19. This is compared to less than 30 percent for white residents.

These disparities highlight a tellingly dismal saying: “When America catches a cold, Black people get the flu. Well, when America catches coronavirus, Black people die.” Another stakeholder said the following about the ramifications of racism on health disparities:

> *“We still have not successfully addressed the historical consequences of racism and oppression in our society. As we’ve seen how COVID is impacting particular communities more than others… And I think the challenge now is that it’s sometimes harder to see. But one benefit, I guess I’ll say of COVID in the context of social unrest, is it forced a light on circumstances that, that we know were existing. So, what is the public will to acknowledge and do something about the fact that you knew it would impact the Black community more.”*

Graph 2: Predicted Probability of Detroit Resident Knowing Family or Friends Affected by COVID-19, by Race (Tract-Fixed Effects)



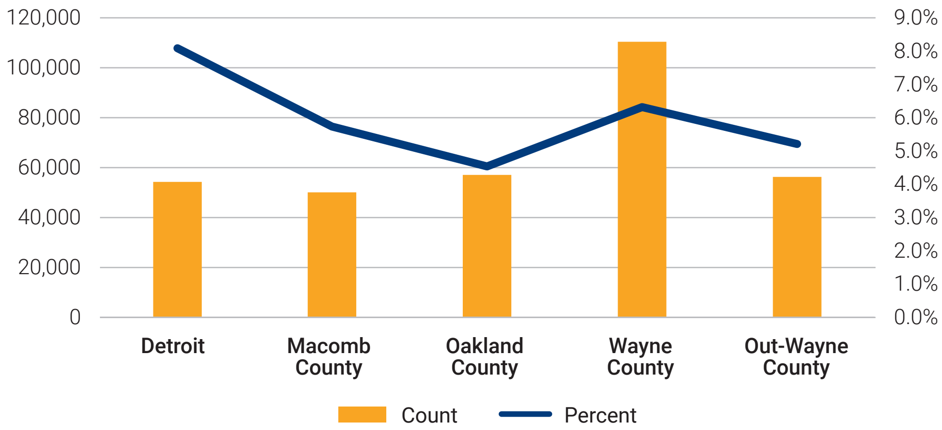
Source: Detroit Metropolitan Area Communities Study, February 2021.

Disparities in Health Insurance Coverage

When sick, Black people are about 30 percent more likely than white people to report not having a normal source of health care besides an emergency department.

While Blacks are more likely than whites to suffer from diseases that may exacerbate the impact of COVID-19, residents in Detroit are also less likely to have health care coverage.[3] People living in Detroit are 38 percent less likely to have health care coverage than others living in the Tri-County area. Though the Affordable Care Act helped to close the racial gap in health insurance coverage, Black people are about 35 percent more likely than white people to be uninsured throughout the country. Black people, compared to white people, are also roughly 25 percent more likely to report not seeing a doctor due to costs. When sick, Black people are about 30 percent more likely than white people to report not having a normal source of health care besides an emergency department.

Graph 3: Residents Without Health Insurance



Source: Data Driven Detroit, February 2021.

Structural Conditions Impact Health Care, Work, and Neighborhood Access

Micro-level factors further shape racial-health disparities including racial bias in medical treatment. Reports imply that Black people relative to white people are more likely to be turned away from COVID-19 testing and treatment, though research from the University of Michigan does not find disparate utilization of COVID-19 testing in Detroit. One stakeholder connected health disparities to access within neighborhoods:

> *"Our lifespan is a lot lower than many zip codes that are in the suburbs by 15 years. You can take a zip code in Southwest Detroit and also look in Northville. A person in Northville, I think will live to be 82. And for us, it's about 65. We already come to the table with a number of challenges and stress factors: living in food deserts and not having access to health care, clinics, and health insurance."*

Additionally, as compared to predominantly white neighborhoods, predominately Black neighborhoods are less likely to have hospitals, urgent care clinics, specialty doctors' offices, and pharmacies.[4] Another stakeholder from our interviews noted the following about health care access and utilization in Detroit:

> *"What does access look like…. just because there's a hospital or a health system in the neighborhood doesn't mean it's accessible. So, accessibility is not just geographic accessibility. What is the reputation of that health system? Will people of color go there? There are some health systems that have really bad reputations/historical experiences among communities."*

In addition to a lack of access to health care facilities, Blacks, relative to whites, are more likely to live in neighborhoods with a lack of healthy food options, green spaces, recreational facilities, lighting, and safety.[5] These subpar neighborhood amenities are rooted in the historical legacy of racial discrimination, housing discrimination, and redlining. One of the stakeholder respondents said it best:

> *"A place to start is let's acknowledge that there are structures and systems of racism that exist in this country, in this state, and in this city. Let's start with that because if you don't have an understanding of that, then it's really difficult to dismantle or to address issues because you're trying to solve a problem without actually addressing the root cause. Until the system changes, because sometimes that takes a long time… you have to work at changing structures of inequity, and you also have to work at helping people get to opportunity in the middle of the brokenness."*

Additionally, Blacks are more likely to live in densely populated areas further heightening their potential contact with other people. Nationally, Black people represent about one-quarter of all public transit users. Blacks commuting from Detroit to its surrounding suburbs rely on public transit to get to work, putting them at a greater risk of COVID-19 exposure. One respondent remarked on this dynamic:

> *"We have a very inadequate public transportation system that has always affected people who can't afford to buy cars, but it's even worse now. You don't want folks who have had historically to rely on public transportation to go on public transportation now, because they will be more at risk for getting sick. Unfortunately, many of the jobs that Black and brown residents are working in low wage jobs, or at least not making what they need to make."*

Blacks are also less likely to have equitable health care access—meaning hospitals are farther away and pharmacies are subpar leading to more days waiting for urgent prescriptions. So, health problems in the Black community manifest not because Blacks do not take care of themselves but because healthcare resources are woefully inadequate in their neighborhoods. The intersection of race and social class are highlighted in census tracts and zip codes. For example, analysis by Brookings fellows Makada Henry-Nickie and John Hudak reveal that zip code 48235, which is 97 percent Black with a median household income of less than $30,000, has one of the highest COVID-19 rates relative to the 48226 zip code, which is only 40 percent Black with a household income near $60,000, that has one of the lowest COVID-19 rates.[6] Environmental issues also create challenges in the Black community. Predominately Black neighborhoods are more likely to be exposed to pollutants and toxins. We simply have to look at the Flint to Detroit corridor where kids and families are overexposed to lead.

Health problems in the Black community manifest not because Blacks do not take care of themselves but because healthcare resources are woefully inadequate in their neighborhoods.

COVID-19 Spillover Effects

Our analysis underscores the health-related impacts of COVID-19 on Black and Hispanic Detroiters. However, the effects of the virus on people of color in Detroit are not limited to adverse health impacts. It is evident, for example, that COVID-19 is compounding existing racial disparities in the areas of economic security, employment, education, and housing. Further, the data also indicate that beyond health-related challenges, Black and Hispanic residents disproportionately experience difficulty meeting their essential needs due to COVID-19.

Essential Needs

In addition to being disproportionately more likely to contract and die from COVID-19, Black residents in Detroit also report a series of challenges and stressors that the pandemic has exacerbated. Our analysis suggests that structural conditions that inform pre-existing conditions and health disparities are the main culprit for the epidemic within the pandemic. Black residents in Detroit relative to white residents are significantly more likely to report challenges in securing and maintaining housing, obtaining medication, and getting essential needs. Blacks are nearly three times more likely than whites to say it has been a challenge having a place to live during COVID-19. Blacks are also three times more likely than whites to report having challenges getting food, water, and other household supplies (see supplemental appendix to see variations based on census track-fixed effects).

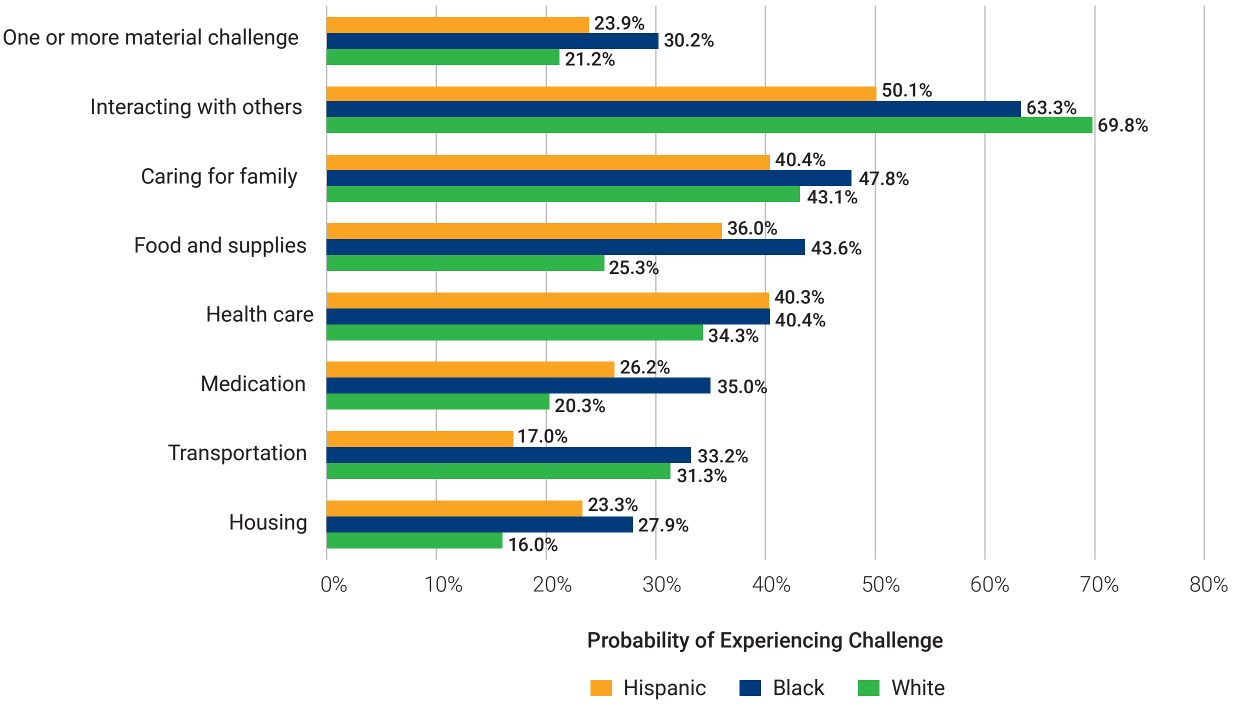
> Blacks are also three times more likely than whites to report having challenges getting food, water, and other household supplies.

Blacks relative to whites are two times more likely to report challenges with obtaining medication. While Blacks are not significantly more likely to report challenges with obtaining the health care they need relative to whites, medication clearly is an issue. Medications are costly and some medications may require the need to be shipped if not in stock. So, even if a neighborhood has a pharmacy, it may fall short of serving the needs of its residents.

We also analyzed the experiences of Hispanics. Hispanics relative to whites were more likely to report not having health insurance, while people 50 years of age or older reported being more likely to have health insurance than people under 35. One respondent connected lack of health insurance among Blacks to limited job opportunities:

> *"There's a link between poverty and health. It's a social determinant of health in some ways: lack of access to medical care to seek treatment and quality health insurance. Black folks tend to not have health insurance. They tend to have jobs that don't offer those types of benefits. They tend to lack access to healthy foods, housing, and clean water. These are all factors that kind of indirectly contribute to the heightened vulnerability and exposure to infection and lead to higher COVID outcomes."*

Graph 4: Predicted Probability of Detroit Residents Experiencing Material Challenges During COVID-19, by Race (Tract-Fixed Effects)



Source: Detroit Metropolitan Area Communities Study, February 2021.

Employment

Regarding work, Blacks across the country are hit with a double-whammy. On one hand, they are more likely to be laid off during COVID-19. Detroiters have a lower employment rate compared to others living in Wayne County and those in neighboring counties such as Macomb and Oakland. In July 2020, unemployment in Detroit reached nearly 40 percent.[7] This is much higher than The Great Depression nearly a century ago.

On the other hand, those who do continue to work are more likely to be part of the new COVID-19 "essential" workforce and overexposed to the virus. Nationally, Blacks represent nearly 30 percent of bus drivers and nearly 20 percent of all food service workers, janitors, cashiers, and stockers. A recent study in the state of California found that food/agriculture workers, transportation workers, facilities, and manufacture workers have experienced excessive increases in mortality rates during COVID-19.[8] Humanizing these dire statistics are people like Jason Hargrove, a bus driver in Detroit, who posted a viral video stating that a passenger coughed repeatedly on the bus without covering her mouth. He ultimately died from COVID-19.

In Detroit, our analysis reveals that 74 percent of Black workers are working outside of their home some or all of the time during COVID-19 compared to 51 percent of white workers. During a highly-contagious pandemic like COVID-19, Black workers, and consequently their families, are overexposed. In this regard, staying home during a quarantine is a privilege. As one respondent put it:

> *"By nature of employment opportunities, you see a disproportionate number of people of color who don't have the luxury of working at home. The majority of people of color have to do external work outside of their home, thus, making them have far greater exposure to the virus."*

Economic Insecurity

Black residents are significantly more likely to report not having enough money to pay their bills and are more likely to take out loans relative to whites. Black residents, on average, rate their likelihood of running out of money in the next three months due to COVID at 40 percent, significantly higher than white residents.

Over 75 percent of Detroiters make under $50,000 a year. One stakeholder stated, "We have to have policies that focus on equitable funding, and base it on the greatest need in our state." Blacks are over two times as likely as whites to say they cannot pay their phone, cable, loans, or credit cards on time. They are much more likely to say they are spending more money overall during the pandemic, which creates a greater risk of running out of money and potentially burning through any reserves, income, and/or public assistance funds faster. Consequently, Black residents report skipping or not paying a bill.

Accordingly, Black residents in Detroit are three times more likely than whites to report financial insecurity. Black residents relative to white residents are 2.5 times more likely to report receiving food from the local food bank. Black residents report spending more money on food and gas during the pandemic as well as obtaining food from local food banks. With children engaging mostly in remote learning, parents are concerned with having to provide more food with less money. Black Detroiters report being more likely to have children living in the home.

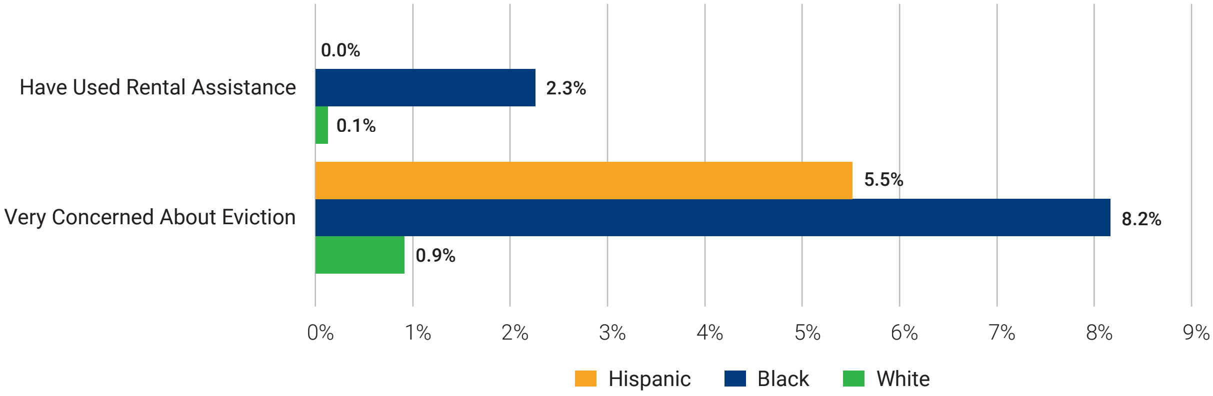
Black residents are significantly more likely to report not having enough money to pay their bills and are more likely to take out loans relative to whites.

Housing Instability

Affordable housing is an issue during non-pandemic times, but it is exacerbated under COVID-19. Black residents are more likely to be very concerned about being evicted and report utilizing rent assistance than whites. One respondent made the connections between housing, finances, and a failing service sector for employment:

> *"It's not just housing, but it's like the way that we've disinvested in schools and families for decades. When I think about the way that the unemployment rates have risen, our, our service sectors have been really, really decimated. And if those are the jobs that so many Detroiters were relying on, I think we can really expect a slow, painful recovery."*

Graph 5: Detroiter's Housing Instability, by Race



Source: Detroit Metropolitan Area Communities Study, February 2021.

Education

It is clear that COVID-19 has placed an undue amount of stress on families, particularly Black families who are more likely to work out of the home or poor families who have less access to broadband and technological devices. Nearly 70 percent of families with school-age children report having low confidence in schools' responses to COVID-19. On average, families with children in school gave the quality of their children's education in Fall 2020 a B- or C+. Considering the tumultuous time for parents and teachers alike, the school system might take this passing grade. Two-thirds of families say their children attend school entirely online, while 11 percent say they are homeschooling their children. More than half of families with school-age children (57 percent) say the quality of their children's education this year is worse than in previous years, while a quarter (26 percent) say the quality of their children's education this year is about the same.

> Nearly 70 percent of families with school-age children report having low confidence in schools' responses to COVID-19.

Due to the economic disparities described earlier, many families in Detroit, particularly Black families, do not have the same capacity to respond to the educational challenges created by the pandemic. These families appear to have limited options for meeting current COVID-related educational challenges.

> *"You've got this divide between what people think should be happening. When you dig down into it, some of the people who are demanding face to face learning, it's about an inconvenience of the children being at home while I'm trying to get my work done. Well, the fact of the matter is that's happening across all communities right now is people have to work from home. What we've seen in some of the wealthier communities is people decided to pool their money together and create educational pods. So, they could still go to work or be at home without their children. And, you have this disparity between families who have fewer means really feeling that they want face-to-face instruction… So I would say that's a space that has really shown a divide, and that comes back to economics."*

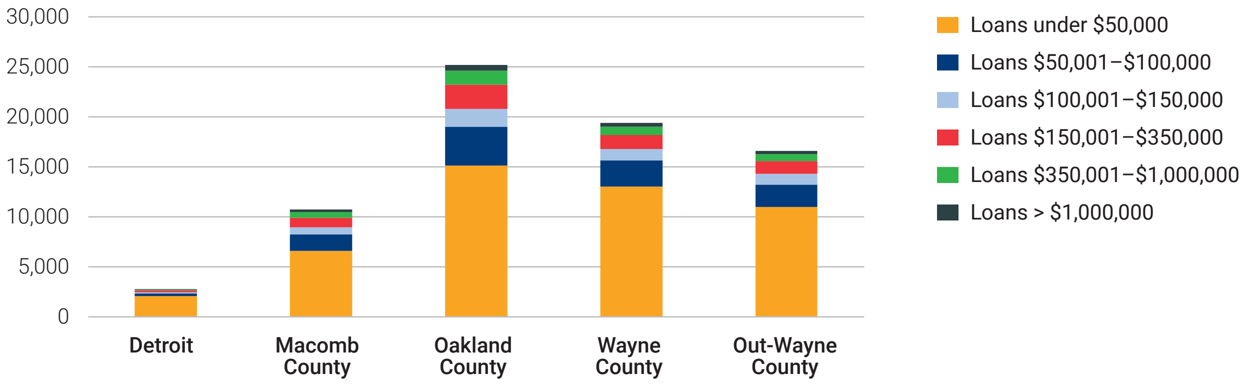
Small Businesses

We examined how many businesses in the Tri-County area received Paycheck Protection Program (PPP) funding during the first wave and how much funding they received. As the graph below shows, businesses in Detroit, compared to those in the Tri-County area, were much less likely to receive PPP funding. Even when receiving PPP funding, small businesses in Detroit were much more likely to receive $50,000 or less. In fact, over 75 percent of businesses in Detroit received less than $50,000 compared to 61 percent in Macomb County, 60 percent of Oakland, and 67 percent in Oakland County. Businesses in Detroit even received less money than businesses in other parts of Wayne County.

Businesses in Detroit, compared to those in the Tri-County area, were much less likely to receive PPP funding.

Regarding businesses, one respondent said, "Let's look at the data in the city. How many small businesses are owned by African-Americans? Who's getting the loans for starting a new business? Where are those businesses being allowed to open? And what other incentives are out there?" If Black small businesses are more likely to fade away during this pandemic due to the implementation of PPP funding, disparities in health care insurance, and subsequently health care access and utilization will also increase.

Graph 6: PPP Loans Issued as of 8/8/2020



Source: Data Driven Detroit, February 2021.

Policy and Practice Opportunities to Address Racial Disparities

Our analysis overwhelmingly reveals significant racial disparities in COVID-19, COVID-19-related challenges, and finances and housing. Highlighting these disparities with multiple forms of data present the opportunity to close racial gaps. We provide a list of recommendations for addressing COVID-19-related disparities broadly and implement a racially-equitable vaccine dissemination plan.

Racially-Equitable Health Care Access

Testing and treatment for COVID-19 have been inequitable. Racially-equitable health care access means that Black people and other racial/ethnic minorities have the same chances of being tested for COVID-19, receiving antibody tests, participating in clinical trials, and obtaining vaccines. Inconsistencies in vaccine risk communication and priority setting for vaccine qualification creates discrepancies in the process that leads to inequity. Therefore, it is important to be consistent. Part of consistency and being equitable is targeting the most vulnerable. While race cannot solely be used as a determinant for a vaccine, zip code may be an important alterative. Our analysis reveals that many of the differences among Detroiters are census-tract specific. Accordingly, access is about the ability for people to reach a location to get the care and treatment they deserve.

- **Universal Health Care**
  The COVID-19 pandemic highlights the importance of equitable health care and the flaws with the current system. The U.S. spends 25 percent more per capita on health care than any other country and over 100 percent more than Canada. Over the past 20 years, U.S. health care spending has doubled. If people have more equitable health care coverage, the number of people with untreatable pre-existing conditions will decline and health care costs will drop.[9] More health care equity also puts less strain on hospitals, emergency departments, and first responders who deal with people when their conditions have worsened rather than when they initially become ill.

- **Establish Testing and Triage Centers in Black Neighborhoods**
  People need to be tested, provided treatment, and vaccinated quicker. Failures in the health care pipeline fall on the bodies of Black and marginalized people. Leveraging community pillars like churches, barbershops, and hairstylists will not only be convenient locally but also will empower the community and provide resources as well as help overcome medical distrust. Local vaccine sites as well as mobile vaccine options are desirable for places with limited public transportation.

Comprehensive Collection of Demographic Data

Data on race, place, gender, and age should be readily available for social scientists, epidemiologists, and other public health researchers to formulate better preparedness plans for the upcoming waves of COVID-19. Data helps not only to direct resources, but it also helps to learn from places that seem not to have apparent disparities. Gilbert and Ray [10] note the importance using the Centers for Disease Control's Social Vulnerability Index, which "captures geographic-based vulnerability largely for emergency preparedness and natural disaster response." They also recommend using the Area Deprivation Index to examine neighborhood-level socioeconomic disadvantage using census tracts. Gilbert and Ray note: "These indices when combined with epidemiological data show areas hardest hit by COVID-19 morbidity and mortality to prioritize neighborhoods for vaccinations. Race does not become the primary factor but one of many."

Equitable Payment Protection Program Funding

Nationally, over 90 percent of Black-owned small businesses were denied Payment Protection Program funding in the first round. Because of this, over 40 percent of Black small businesses have closed during COVID-19. This has substantial implications for health care access since most people get insurance through their employers. For Black Detroiters, however, they are much less likely to be employed through work and more likely to be insured through Medicare or Medicaid relative to whites. In order to better protect and save Black-owned businesses, Community Development Financial Institutions can aim to focus more acutely on small businesses most in need to help with processes and access to funding. Mobile phone options to apply for loans and programs may be needed in areas with issues related to broadband access.

> Community Development Financial Institutions can aim to focus more acutely on small businesses most in need.

(PHOTO CREDIT: REUTERS/EMILY ELEONIN)

People join fast-food and nursing home workers during a "My Vote is Essential" rally before casting their early ballots, amid the coronavirus disease (COVID-19) concerns at Wayne County Community College in Detroit, Michigan, U.S., October 24, 2020.

Provide Hazard Pay to Essential Workers

Hazard pay is desperately needed for new "essential" frontline workers. The U.S. Department of Labor states: "Hazard pay means additional pay for performing hazardous duty or work involving physical hardship." The U.S. Department of Commerce notes, "Hazardous duty means duty performed under circumstances in which an accident could result in serious injury or death…." Being exposed to a deadly virus due to limited personal protective equipment and lack of training on using that equipment fits this criterion. Though it is nice for companies like Walmart to provide one-time $300 bonuses, this is not enough for a person risking their lives day after day, week after week. One stakeholder mentioned, "We have to have policies that focus on equitable funding, and base it on the greatest need in our state."

Provide a Living Wage

The newly minted "essential" workers need a living wage. The minimum wage varies by state based on cost of living differences. The problem, however, is that the minimum wage has not kept pace with inflation. One stakeholder said, "We need to establish an affordability benchmark that is more reflective of majority Detroit—majority-Black Detroit. And that's why we we've been working really hard to localize the area median income."

The minimum wage in Michigan is $9.65. The average rent in downtown Detroit is roughly $1,500. Before any other expenses, minimum wage workers could spend their entire gross pay on housing. A majority of Americans are in favor of a $15 minimum wage, including nearly 90 percent of Blacks. This is because the Black community is most impacted by low wages. Higher wages reduce dependency on federal and state aid and increases local investments.

Recommendations for Equitable Vaccine Dissemination

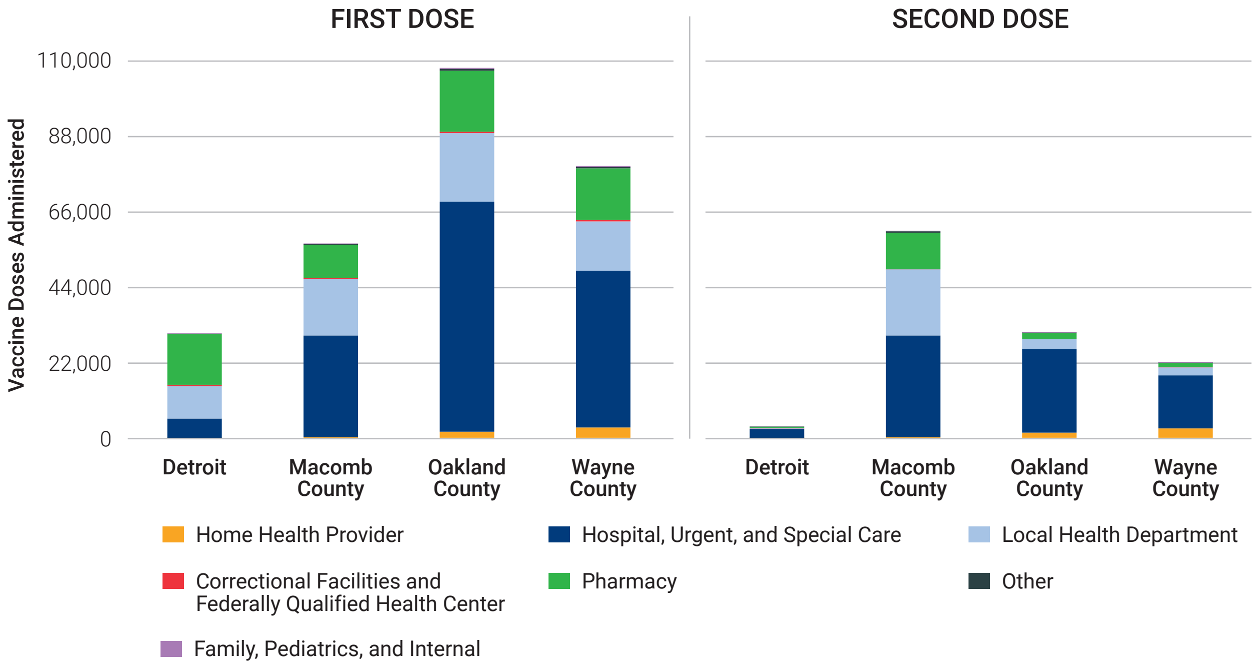
Blacks are 60 percent less likely than other racial groups to say they will definitely or probably take the COVID-19 vaccine.[11] According to DMACS data, over 60 percent of Detroiters say they are unlikely or very unlikely to get vaccinated with a government-approved COVID-19 vaccine when it becomes available. Among Black residents in Detroit, the percent who oppose getting a vaccine escalates to over 75 percent as opposed to only about 30 percent for white residents. Black Detroiters are therefore four times as likely as Whites to say they do not want to get the vaccine. Hispanics were twice as likely as Whites.[12]

> Over 60 percent of Detroiters say they are unlikely or very unlikely to get vaccinated with a government-approved COVID-19 vaccine when it becomes available.

Despite vaccine distrust, the availability of vaccines, uneven vaccination plans, and lack of access to broadband may play an even greater role. Macomb County Executive Mark Hackel said in January 2021 that the county health department's ability to administer more vaccinations "has been limited by the number of doses we're getting."[13] While Hackel asked for 50,000 doses of vaccine a week, the county health department was receiving an average of about 5,400 vaccines a week in January. In the last week of January, Macomb County received only 5,300 Moderna vaccines. During the same week, Macomb County received only 9,750 doses of the Pfizer vaccines. Health departments and hospital systems have said they don't have enough supply to meet the vaccine demand.[14] As bad as vaccine distribution is in Macomb County, the city of Detroit is even worse. Wayne County had to cancel about 1,400 vaccine appointments in mid-January when a shortage of Pfizer COVID-19 vaccines in Michigan amidst the shift to the Moderna vaccine meant that the county received fewer vaccines than expected. Those appointments were supposedly rescheduled.

Altogether, it is clear that vaccine distribution is a problem and reminiscent of the beginning of the COVID-19 pandemic when testing and treatment were unevenly distributed. We provide a series of recommendations for addressing this gap to properly ensure that the group hardest hit by COVID-19 gets the vaccine they so desperately deserve and need.

Graph 7: Number of Vaccine Doses Administered as of 2/1/2021



Source: The State of Michigan's COVID-19 Vaccine Dashboard, February 2021.

Acknowledge that Medical Distrust is Rational

Blacks have less trust in medical research, scientists, and doctors than other racial groups. This is a rational response that needs to continue to be acknowledged. One respondent said:

> *"A place to start is let's acknowledge that there are structures and systems of racism that exist in this country, in this state, and in this city. Let's start with that because if you don't have an understanding of that, then it's really difficult to dismantle or to address issues because you're trying to solve a problem without actually addressing the root cause."*

Knowledge about the Tuskegee Syphilis Study, where 400 Black male farmers were untreated after contracting syphilis, has a direct impact on lowering health care utilization among Black men. Though there was a financial settlement and a public presidential apology, its legacy lives on and drives medical mistrust. Similarly, the legacy of Henrietta Lacks lives on in the minds of Black people and the physical bodies of many of us. Lacks, whose cells were stolen from her without her knowledge died at 31 of cervical cancer. She would have turned 100 in 2020. Lacks' cells, commonly known as HeLa cells, are able to reproduce indefinitely and have been used to make historic discoveries in cancer, infectious disease, biotechnology, and immunology. Another respondent said, “Because of the history of medical malpractice against the Black community, there’s a valid distrust, right, in terms of vaccines and whether or not you should take it…These are valid viewpoints that are built in history and they are shared experience within the Black community.”

So, what has changed since the mid-1900s that should prevent the two incidents above, and other lesser known scientific atrocities like the Terre Haute prison experiments and Guatemala syphilis experiments from occurring? Well, transparency and policy regulation are key.

Continue Transparency about the Vaccine

Following the atrocities mentioned above, the federal government established the Office for Human Research Protections, which is housed in the U.S. Department of Health and Human Services (HHS) to provide ethical oversight for biomedical and behavioral research. Universities have Institutional Review Boards (IRBs) that ensure the protection and rights of research participants and prevent professors at universities such as Johns Hopkins and Tuskegee from conducting unethical and illegal research. Members of IRBs take their positions very seriously. There are a series of stringent protocols that must be followed and there are consequences for not doing so. However, these improved protocols alone will not earn the trust of the Black community—who have experienced abuse, discrimination, and benign neglect at the hands of researchers and medical professionals. Only transparency and equity can gain trust and not solely time. Collective memories of mistreatment must be disrupted to create trust.

Collective memories of mistreatment must be disrupted to create trust.

For COVID-19, a diverse group of scientists, medical doctors, and public health practitioners were assembled to ensure that the vaccine was efficacious across racial groups. In particular, Dr. Kizzmekia Corbett, who is a Black woman, is noted as one of the lead scientists at the National Institutes of Health in developing the Moderna vaccine. In Moderna and Pfizer/BioNTech clinical trials, Blacks represented about 10 percent of the more than 50,000 study participants. The percentage of Black participants provided a large enough sample to ensure similar effectiveness of the vaccines across racial groups.

Correspondingly, it is important to note that vaccines save lives. Smallpox, polio, measles, mumps, and rubella have decreased death rates over 90 percent over the past several decades because of vaccines. Receiving the flu shot reduces the likelihood of hospitalization by 80 percent. We should expect the COVID-19 vaccine to have a similar impact. Pfizer/BioNTech and Moderna vaccines are reporting over 90 percent effectiveness rate in preventing the contraction of COVID-19.

Ensure Effective Social Media Messaging

With COVID-19 restrictions, face-to-face communication is limited. The normal social interaction people have at work, church, or the gym is obsolete in many ways. This is coupled with an increasing group of people who do not watch cable or local news. They receive much of their information from social media. Ray, Sewell, Gilbert, and Roberts examined the role that mobile phone technology plays in health-seeking behavior among Blacks.[15] They found that Blacks with more technological devices are more likely to rely on the Internet as a go-to source of health information.

The same way people participated in Instagram Lives and social media collaborations to understand why racial disparities in COVID-19 and police brutality exist is the same approach that must be taken to level-up and level-set public knowledge about the vaccine. In addition to medical professionals and politicians, the public needs to see celebrities, entertainers, and athletes discussing the importance of the vaccine and actually taking the vaccine.

Lastly, critical to this outreach and messaging strategy is providing the organizations and businesses that provide this support, the necessary financial resources to undertake this effort. As a local media consultant stated, "In the Black and brown communities, you just can't send a letter," he said. "You can't just place an ad on TV and radio. You have to have direct contact with people. People want to hear information from people they know."[16] Efforts to encourage residents to wear masks and increased education around the vaccine are not only about the message but the messenger.

Leverage Black Community Gatekeepers and Pillars

It is important for community gatekeepers and trustees to be leveraged to establish trust in the vaccine. Politicians are important. However, there is a distrust of government. It is important to leverage prominent and local pastors and clergy, popular barbers and hairstylists, well-known small business owners, and hometown heroes like first responders, veterans, and athletes.

Officials should set up trusted locations in Black neighborhoods for testing and vaccination such as churches, community centers, barbershops, hair salons, schools, and senior centers. Even if a neighborhood has access to a hospital—some do not—Blacks may choose to avoid them due to previous mistreatment. Local trustees should be shown on local news and on social media discussing the vaccine and receiving their vaccine shots. Information will then be shared with congregations and clients.

It is also important to think deliberately about the location of vaccine dissemination. Hospitals may not be ideal in some communities. A stakeholder spoke to this point earlier in the report. Instead, Black churches can be leveraged to provide testing, triage, and vaccination. Sewell and Ray found that Black people who attend


(PHOTO CREDIT: USA TODAY NETWORK)

Academic Interventionist Michael Chieves (right) helps a student get his computer ready for online learning as students are released at the end of the day at Thirkell Elementary-Middle School in Detroit on Friday, November 13, 2020.

Black Protestant churches are more likely to utilize health care.[17] Black churches continue to be the glue that holds many Black communities together. During this crisis, they are proving essential for Black families by giving out food, laptops, and funds. Building on the proposed Health Empowerment Zone Act, Black churches can serve as "health action zones" to bridge federal, state, and local resources with community resources. Health action zones are popular in the United Kingdom and have some similar goals to former-President Obama's promise zones and the state of Maryland's Heath Enterprise Zones.

Additionally, Black churches can help to overcome trust issues related to health care and continue to be beacons of hope in the midst of perceived hopelessness. Nationally, Blacks relative to whites are less likely to trust health care, and for good reasons. The United States has a long and torrid history of abusing Black bodies for medical and financial gain. Led by Congressman Hakeem Jeffries and Governor Andrew Cuomo, New York rolled out a program to utilize churches in neighborhoods with less health care access. Other cities, counties, and states are following suit. Reid Temple African Methodist Episcopal Church in Prince George's County, Maryland is a vaccination site and serving an essential need for the predominately Black county.

Ray's research on physical activity found that places like barbershops and hair salons help to increase exercise because there is a level of comfort to be vulnerable.[18] These businesses and organizations are some of the first Black community pillars that operated as beacons of hope and provided Black people some forms of financial and cultural freedom. They are hubs of information, truth telling, and trust building. No matter where Black people live from Detroit to Washington D.C., they can normally find a Black church, barbershop, or hair salon. Community-based, participatory research projects such as The Barbershop Tour in St. Louis led by Dr. Keon Gilbert and 100 Black Men can be replicated to establish trust and inform the public. By relying on community trustees such as pastors, barbers, and hairstylists, this approach helps to center culturally-competent communication, dispel misinformation, and increase health care utilization.

Centering Racial Equity for a Long-Term Recovery

The racial gap in COVID-19 diagnoses is not only disproportionately killing Black people but killing Black communities. Stakeholders provided a series of insights about how to move Detroit and the Tri-County region forward in a way that centers racial equity in the process. The task force started by Governor Gretchen Whitmer is a good start. The stakeholders we interviewed recognize the importance of centering racial equity in all facets of life in order to properly build a long-term recovery for Black and the most marginalized Detroiters. One stated, "We've got to do something about getting policymakers and elected officials who are willing to challenge the status quo and look at moving public policy that is more progressive."

Another stakeholder does see some progress, noting that COVID-19, and broadly racial incidents in policing, have brought more people to the table:

> *"There is, uh, a renewed interest in trying to understand what has happened in this country where particularly African-Americans feel completely disenfranchised. And so, there is a group of people that I would say a year ago wasn't talking about any of this, and now there is conversation."*

Another stakeholder echoed these statements noting:

> *"So, I believe that in our city we have enough foundation folks and corporate sector folks who buy into equity and who are pushing it locally here in Detroit… So, I feel confident in our city that we're headed in the right direction. But it's going to take more than our city to get this right. So, to get right, we've got to move beyond the city and we've got to spread it throughout the state of Michigan and throughout the country."*

One stakeholder said there are unseen and undercover gems of Detroit that need resources and the financial backing to flourish.

> *"It's not visible, but just the hard work that everyday citizens are putting into wanting to make Detroit a place where everyone can succeed, particularly, average, income folks, and majority Black—that gives me a lot of encouragement. It says to me, people are still fighting to make this a great place to live."*

In conclusion, we have aimed to provide a comprehensive overview of the factors that contribute to racial gaps in COVID-19 as well as policy opportunities and recommendations to reduce these gaps. Implementing these evidence-based solutions will improve the lives of all Detroiters and empower families and local communities throughout the state of Michigan.

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