Celebrating Diversity

Acceptance, Respect, Understanding, Inclusion

HSC Office of Diversity and Inclusion, in collaboration with the Belknap Office of Diversity and Equity

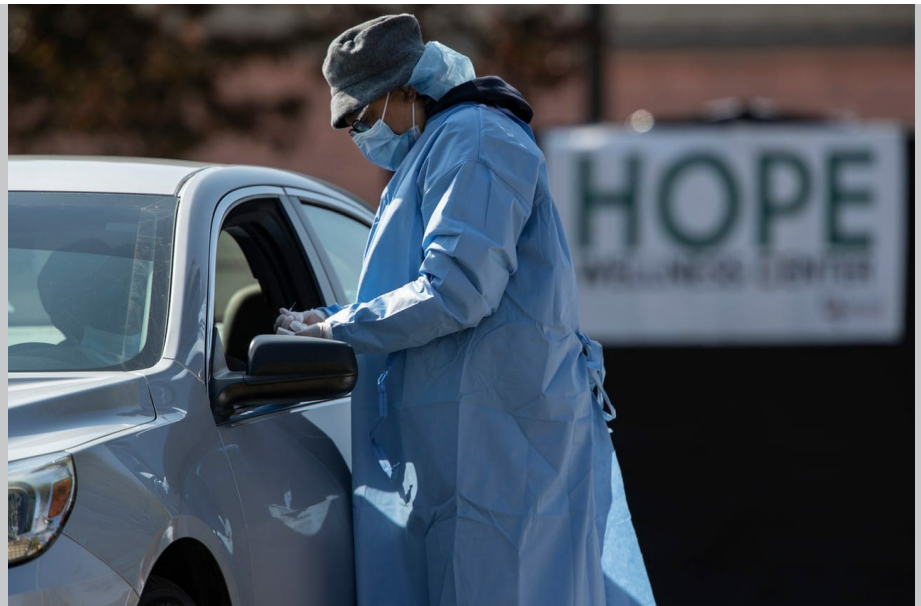## Covid 19 Shines a Spotlight on Health Disparities

by: V. Faye Jones, MD, Senior Associate Vice President for Diversity and Equity (Interim), Associate Vice President for Diversity/Health Initiatives, Professor and Vice Chair of Inclusive Excellence for Department of Pediatrics; and Vicki P. Hines-Martin PhD, PMHCNS, RN, FAAN, Professor and Assistant Dean to the School of Nursing, Director of Community Outreach Office of Community Engagement and Diversity and HSC Office of Diversity and Inclusion

Unidentified healthcare volunteer registers patient for Covid-19 drive-up testing at St. Stephen Church

In the US, over 1 million people have tested positive for COVID-19, with over 68,000 deaths reported. As of May 3rd, over 5,000 cases were confirmed in Kentucky, with more than 250 deaths. Although infection from COVID-19 does not care about race, ethnicity, gender, sexual orientation or geographic location, data suggests Black and Latino communities are disproportionally impacted from this disease. Data confirms an alarming trend – Black and Latino people are dying at higher rates than majority populations. Unfortunately, this trend is a continuation of the distressing rates within minority populations of individuals impacted by preexisting conditions such as diabetes, asthma, and heart disease, which increases the risk for more serious disease. The question is what role does the cycle of health disparities and structural inequalities play in this finding? The answer is a major role.

We know that where you live, work, and play affects your health and when you live in under resourced neighborhoods, it increases the possibility of a diagnosis of a chronic disease. Federal health officials have known for nearly a decade which communities are most likely to suffer devastating losses — both in lives and jobs — during a disease outbreak or other major disaster. In 2011, the CDC created the [Social Vulnerability Index](#) to rate all the nation's counties on factors such as poverty, housing and access to vehicles that predict their ability to prepare, cope and recover from disasters. The current COVID 19 pandemic brings attention to underlying inequities that place vulnerable groups at higher risk for disparities in health outcomes. Dr. Anthony Fauci, director of the National Institute of Allergy and Infectious Diseases, states, "…it really does, ultimately, shine a very bright light on some of the real weaknesses and foibles in our society."

In order to explore the interconnect-

Healthcare workers suit up and head out to test drive-up patients for Covid-19 at St. Stephen Church

edness of structural inequities and health disparities, we need to understand the role of structural racism. Structural racism is defined "as the macrolevel systems, social forces, institutions, ideologies, and processes that interact with one another to generate and reinforce inequities among racial and ethnic groups." It is the manifestation of the historical, cultural, political, and societal norms in place that continue to perpetuate racial group inequity. The documentary, *Unnatural Causes: Is inequality making us sick* (2008), brought into focus the body of evidence that clearly tied the role of social determinants of health in creating health inequalities/health disparities and explored how class and racism could have greater impact on one's health outcomes than genetics or personal behavior. Negative experiences and exposures over the life course of a population or community such as poor air/water quality and housing conditions,

Cars lineup as healthcare volunteers test patients for Covid-19 at a drive-up testing site, St. Stephen Church

food insecurity, limited employment opportunities and access to care are critical to the ability to respond to health crises such as COVID 19. Not only are socially and economically disadvantaged populations at risk for poorer health outcomes due to SDH and higher rates of predisposing health conditions, they are also disproportionately employed in jobs that are considered "essential services" –food service, entry level direct care, maintenance and environmental services which either increase their potential exposure or place them economically vulnerable to furlough.

On the surface, structural racism is insidious and appears to be neural in nature, making it harder to detect. However, it is historically rooted by our past. A past that reinforced privilege associated with the concept of "whiteness" and disadvantaged others centered on the perception of "color." Camara Phyllis Jones, an epidemiologist, family physician, and senior fellow at the Morehouse School of Medicine, states, "If you asked most white people in this country today, they would be in denial that racism exists and continues to have profound impacts on opportunities and exposures, resources and risks. But COVID-19 and the statistics about black excess deaths are pulling away that deniability." A scene that plays out every day as more states continue to report data based in demographics according to ProPublica on April 3, 2020. Although Kentucky has not experienced the same dramatic disparities in COVID morbidity and mortality, the *Courier Journal* reported on April 8, 2020 that "figures released by Mayor Greg Fischer's office on Wednesday show about 20% of the 27 people who have died from the virus in the city have been African American. That is slightly lower than their proportion of the population, which is 23.5%, according to census data. But black residents in Louisville have been infected at a slightly higher rate — 27% — among the 400 confirmed cases. Asian Americans are being hit the hardest, representing 9% of the cases and 4% of the fatalities while making up just 2% of Louisville's overall population"(https://www.courier-journal.com/story/news/2020/04/08/covid-19-hitting-louisville-african-americans-asians-harder/2970118001/).

Mobile advertising for the St. Stephen Church Driive-up Covid-19 test site.

Recognizing that disparity exists in COVID-19 health outcomes is only the beginning of addressing the problem. Utilizing what is known about the epidemiology of COVID and factors like poverty, housing, insurance coverage, language barriers, and the role of medical mistrust that place populations at higher risk are essential to stem the tide of the pandemic. We need to take this opportunity to be aggressive, ask questions, and demand accountability by reviewing existing policies and ensuring future policies and strategies have an equity-focused approach to address the root causes of health disparities.

Disparate Social Connections in Community and Medicine During Coronavirus Physical Isolation: Challenges to Telemedicine; a Month Long Adventure

by: Karen Krigger, MD, Med, FAAFP, AAHIVM(S), Professor Family and Geriatric Medicine, Director of Health Equity HSC Office of Diversity and Inclusion, Endowed Chair Urban Policy University of Louisville

Unequal community access between patients and medical providers is glaringly evident in our telecommunication exchanges involving disparate populations such as the poor, the aged, the foreign nationals, and the addicted. The context of these inequalities lies in barriers created by economics, locations, and optimal knowledge of computer systems. Providing physically isolated health care for the vulnerable has led to the rapid deployment of telehealth encounters, this is a good thing.

There are 4 different telehealth modalities, **real time** allows patients and providers to perform a medical visit in a "virtual exam room" in "synchronous real time." **Store and forward** is a modality allowing data, images, or sound to be transmitted from one care site to another for evaluation. Two examples of **store and forward** are EKGs and X-rays. **Remote patient monitoring** telehealth occurs at the patient's home, or another care site like a nursing home, sending information like blood pressure and heart rhythm to a medical office for monitoring and response. **Mobile health** is
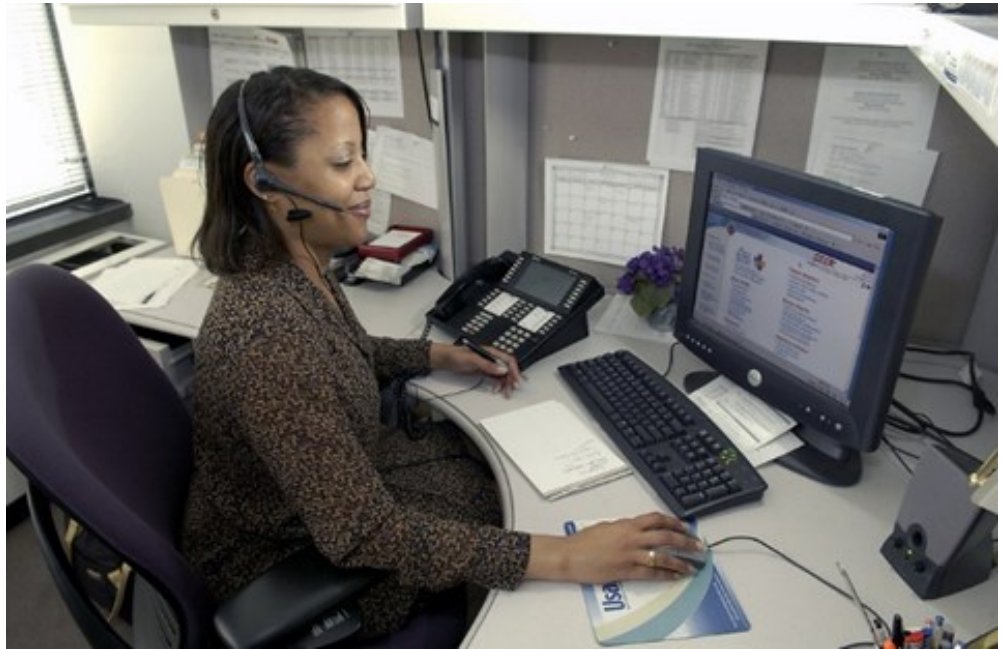
the 4th modality. It can provide access to health education, information, and other services through a phone line. (Enlund,2019)

Real-time communication is the most commonly applied modality applied during this crisis with the relaxation of federal rules for compliance and fiscal reimbursement. Video platforms such as Blue Jeans, Zoom, Adobe, and Doximity are just a few examples of commercial video platforms. The medical encounter is conducted virtually in "synchronous real time."

In this **real time** modality, using a video platform, a patient is provided an *emailed* link to their "virtual exam room" for their medical visit. Here lies the first barrier to a system functioning optimally in the business world or academia. Who has an email address? Or even more elementally, what is an email address?

While the review of internet access in Jefferson County, on first blush, indicates Louisville is well connected, unlike our rural brethren, this connectivity is dependent on location and economic resources - the patient has to pay for the service. The service has

to be available in their area. This is especially important during times when the sources of free internet access, i.e. libraries and coffee shops, are not accessible. Our community internet providers have been generous in providing free service for 2 months during this crisis. This service is extended to those not having prior service, however service accounts lost prior to the crisis due to inability to pay may not be included in this munificence.

Additionally, many people buy services for phone or cable and find internet "bundled" in. It looks like the county is well connected, from those numbers, but for many families they may not have access to laptops or computers, or the knowledge to use them. The "bundle" lowers the price of the desired services. Witness the thousands of computer devices given to Jefferson County School students for their on-line learning activities. While the contribution of the computer devices was intended to level the educational playing field, having access to those instruments will foster a multi- generational learning environment in computer skills. I discovered

this while conducting a telemedicine visit this month where the computer was borrowed from the eight- year old for the telemedicine visit. Neither the grandmother, mother, nor eight- year old daughter could navigate the access to the platform for real time visual and audio contact.

While there are more cell phones in this country than people, (Informory.com) quite a few of those are still flip phones or phones without cameras. Even if you are able to only conduct the visit via the phone number access on the video conferencing platforms, the patient is paying for the minutes used on their phones. This is a barrier for patients using "pre-paid" or not having "unlimited minutes" of usage. The provider should call the patient from phones connected to their offices to prevent patient expenditures.

Living spaces may influence the ability to make the connections. This is especially pertinent for patients living in mobile homes, because of metal interference. The quality of the **real-time exchange** can also be influenced by the slow or low internet band width. The patient needs to be reminded to be in a safe and secure environment, like the providers, to adequately ensure patient confidentially and HIPPA compliance. System overloads can cause delay, freezing, or dropped communications, even on the provider's end.

Patients needing interpreter services can have the interpreter call into the platform site during the visit. On a positive note, family members and patient advocates can remotely participate in patient/ provider exchanges via these video platforms, as well, if the provider site has knowledge of the possibilities. This is very important as family members are isolated from loved ones in hospitals, rehabilitation, subacute, and nursing home facilities and especially important for the disabled, youth or aged patients. Written medical support materials in the patient's own language should be made available through electronic means or mailings. Additionally, clinical summaries should be provided to the patients via mailings or electronically at the end of the visit for patient review.

Provision for virtual real-time medical encounters is also challenging for the medical office. As stated before, the patient must have an email account and know how to access it. Email invitations can find their way into the "trash or junk" mail folders of the patient's accounts. It is helpful to send a picture of the anticipated meeting screen with the emailed link. Providers should use a secure video/audio platform to avoid data mining. "If you don't pay for the product, you are the product." (Caudill 2020)

The medical office needs dedicated staff for patient scheduling with adequate interface with the medical provider to help match the patient encounter with the limitations of the telemedicine experience. Staff is needed to educate the patient about accessing the system *prior* to the encounter. Patients should be asked to have medications present for the encounter, as well as, any blood pressure measurements, glucose measurements, peak flow measurements, temperature readings, or symptom diaries. Optimally, a medical assistant should be available to ensure the connection is made between the patient and provider, to review medications and allergies similar to a "physical "office encounter. This is not a solo provider encounter, you still need office staff assistance. Medical office staff should be available in real time to complete the encounter needs   i.e. through texting by cell phone or by business landline text services like Zip Text. While this model is different from the provider, patient, and medical assistant being in the same physical spacing, virtual presence is achievable.

I believe this explosive support for telemedicine, and the subsequent learning curve for patients and providers, will help to decrease medical outcome gaps in disparate populations. Telemedicine has the potential to help mitigate barriers to medical care such as transportation, time lost from work, and the ability of family and patient advocates to participate in patient care. Greater access and knowledge of the technology, by both patients and providers, will be needed to fully embrace telemedicine's capabilities.

References

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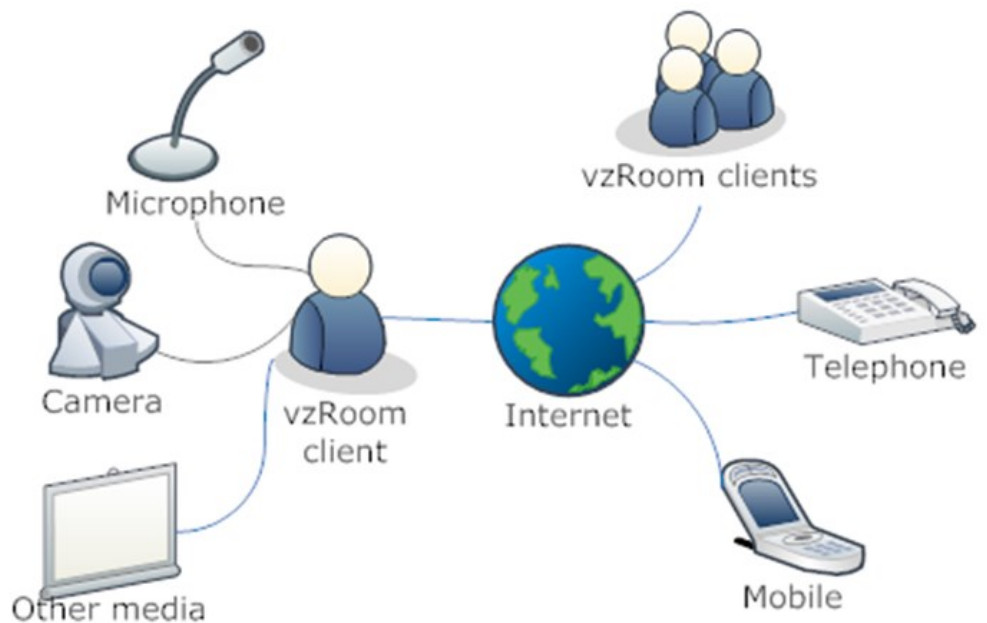- U.S. Census Bureau QuickFacts: Jefferson County, Kentucky. (2019). Retrieved April 29, 2020, from https://www.census.gov/quickfacts/fact/table/jeffersoncountykentucky/PST045219

Community Interfaces in the World of Physical Isolation

by: Karen Krigger, MD, Med, FAAFP, AAHIVM(S), Professor Family and Geriatric Medicine, Director of Health Equity HSC Office of Diversity and Inclusion, Endowed Chair Urban Policy University of Louisville

While the business world and academia readily embraces video platforms like Blue Jeans, Microsoft Teams, Face Book, Adobe, and others, during our coronavirus crisis, community cultural institutions and their participants were somewhat slower in adaptation and in many cases are unable to participate creating widening gaps in health disparities and outcomes. Health disparities in marginalized populations are not new. The COVID-19 crisis has highlighted technological and educational disparities in these communities.

The context of these contributing disparities are multifactorial. *Economic*, can you afford internet, laptops/computers or reliable smartphones? *Location-* do you have reliable internet services and adequate bandwidth? *Knowledge-* do you have basic computer skills to navigate and identify platforms for your needs? There is a correlation between employment requiring computer skills and increased comfort with virtual communication.

Religious organizations traditionally meeting in churches, synagogues, mosques, and temples for weekly services, bible studies, etc. require virtual replacements in a socially isolated mandated environment. Participation in these community institutions are important to many people in maintaining mental and spiritual health. Many congregations have adequate resources to participate in video platforms and have converted to online services via Facebook, Zoom, Doximity, Blue Jeans, Adobe, etc. Church leaders fearing the exclusion of their members from these venues hold services in their homes or unlawfully gather which fosters unintentional spread of the coronavirus to our most vulnerable citizens. One of my patients on a telehealth visit informed me four patients in his congregation had COVID-19. Many institutions may not know that group conference service utilizing telephones (Group Meet or Flock Notes) can make their institutional communications accessible to those not having smartphone, computer/ laptop or internet access. Flock Notes is free for congregations under forty people and includes both phone text and email features. Pricing starts at $7.00/ month for congregations greater than 40 people. Information about inexpensive alternative communication patterns should be communicated to religious institutions and other groups to help facilitate social distancing.

There are a plethora of peer led twelve step support groups facilitating recovery from addiction, compulsion, and behavioral problems. Such groups include AA (Alcoholics Anonymous) , NA (Narcotics Anonymous) , Ala-Anon/Ala Teen, CoDA (Codependency Anonymous) , GA (Gamblers Anonymous), and others; there are over 200 twelve step groups. Individuals attending these meetings may lack the equipment, internet, or computer skills to participate in virtual meeting spaces. This puts them at risk of relapse or mental health decline at a time when they are most vulnerable. Efforts should be made to convert community offerings to phone or virtual participation. Many of the twelve step groups have national on-line access points.

We are a social species. People may have physical, emotional, and mental needs to see the faces of friends, relatives and acquaintances. Many people need their unconscious interpretation of non-verbal communicative cues to have successful social exchanges. There will be those, however, who will be uncomfortable being seen through the live video format for a number of reasons – still in PJs, bad hair day, insecurity, etc. On one of my telemedi-

cine appointments, a patient took me on a tour of the renovations he had done on his apartment during lockdown. He, obviously, was very comfortable with me seeing his home. In another situation, an individual posts a different picture of herself in each weekly professional zoom meeting.

Community cultural institutions have already begun to embrace video platforms. Funeral directors facilitate video conferencing for funerals. In some places in the country, weddings have been officiated via video conference modalities. If social isolation continues there will probably be increasing inroads in the virtual world for family reunions, graduations, baptisms, births, and other culturally important celebrations. Museums, parks, and the arts have produced virtual exhibitions of their activities and offerings for the public free of charge in response to the COVID-19 crisis. People are offering virtual cooking classes, music classes, exercise classes, and mindfulness support in "real time" on the internet. Tutoring and homework support are not far behind if not already present in our community. With businesses deemed essential and non-essential financial consultation, legal meetings, and the like have all taken to cyber pathways. Who of our citizenry will be left behind?

A chain is only as strong as its weakest link. To facilitate a healthy, competitive, society we need to mandate computer skills education in our schools and for adults, in and out of the work place. This is the job for our community leaders to provide fiscal support. Recognition should be given to Jefferson Community and Technical College and University of Louisville for facilitating free computer certification classes this summer, and to The Louisville Free Public Library for their continued programming of adult computer education classes and computer availability. Internet access should be affordable and accessible with or without a coronavirus crisis in our communities. Those of us with computer skills and training must offer assistance to those in our respective professional and social circles. We should thrive to deliver such coaching with patience.

ATTENTION PLEASE

THE *2020* CULTURAL CENTER GRADUATION RECOGNITION

CONGRATULATIONS CLASS OF 2020

The Cultural Center will be recognizing all Class of 2020 graduates!

Virtual Graduation Recognition

MAY 7 @ 6pm EST. via Instagram Live @uoflculturalctr

Kente Cloth/Graduation Sash & Special Gift Distribution

Class of 2020 Video

Get more information at:
uofl.me/2020gradrecognition

you belong.

THEME: SUCCESS LOOKS LIKE ME

UofL Women's Center Celebrates Students Virtually

by: Phyllis M. Webb, Program Coordinator, UofL Women's Center

The Women's Center staff held its annual Awards Ceremony virtually on April 21, 2020 to celebrate the student groups, its members and graduating seniors over the past year.

Several students from various student groups such as The American Association of University Women at UofL, Student Parent Association, United Nations Association-Women at U of L, Women 4 Women, and various others participated in the 1st time virtual experience.

Jamieca Jones, a Program Coordinator in the Women's Center, read a prepared statement from Dr. Faye Jones, Senior Associate Vice President Diversity & Equity, Interim to start off the event:

"As we are all aware, this is not the ideal way we had hoped to celebrate the outstanding accomplishment of completing your college degree. If I had my way, we would be shaking hands, giving hugs, and celebrating you in-person. Your family, friends, and the entire University community are very, very proud of you. And as women, we know we have a history of demonstrating strength and resiliency in difficult times. Hopefully, years from now we will reflect on the year 2020 as a time when we banded together with renewed hope and a commitment to creating a revitalized sense of caring: for ourselves, our families and our future.

This strange time in our lives reminds me of lines from the poem "Choices" by Nikki Giovanni:

If I can't have what I want, then my job is to want what I've got and be satisfied that at least there is something more to want; Since I can't go where I need to go, then I must go where the signs point, through always understanding parallel movement isn't lateral.

My wish for you is a future of satisfaction in knowing there is something more to want, with signs that point you where you need to go. Thank you for spending this special time in your life with us. Louisville First, Cards FOREVER!"

Following her statement, a powerpoint was shown and included 'memories in photos' of the various student group events from 2019-2020.

Each student group's executive board, committees, programs, and members were recognized. Outstanding members are Kendra Stadford, AAUW; Amal Hassan, UNA; and Jasper Morris, W4W. In addition, graduating seniors from each group were recognized: Janet Dake, Samantha Matthew, Finn Depriest; Aisha Wilson, Michelle Leavell, Dajanea Coleman, Jessica Lahue; Emily Perkins, Victoria Dallas Ashley.

Federal work study students: Andreyah Crittenden, Rawan Saleh; Finn Depriest; Brittany Cross; Dajanea Coleman and Alexa Meza; and student events coordinator, Jessica Cox were also recognized. The outstanding student worker award went to Freshmen student, Rawan Saleh.

Students were given the opportunity to talk about their experiences in being a part of the Women's Center, some of their comments are below:

- "I am a graduating senior and being part of the United Nations Association-Women at UofL has been fun and a learning experience and I loved making new connections with people who are interested in making a huge impact on women and children in our communities and the world. I wish everyone the best of luck in their future and congratulations to fellow Spring graduates like myself."
- "I owe pretty much everything I have to the Women's Center. I made most, if not all, of my friends and my roommates through Women 4 Women Student Board and the American Association of University women at UofL. The Women's Center and these groups have given me so much. I don't even know what kind of student I would be if I didn't have these groups. I'm just really grateful to all the Women's Center staff and all of the members. It's been really fun and I'm looking forward to next year."
- "So thankful for the Women's Center! It was a place of positivity and affirmation during my journey going back to school and earning a degree while being a parent. Each and every person I've met through the Women's Center has been a ray of sunshine along my journey. Thank you!"

To view the awards ceremony in its entirety click here.

In Need of Scholarship Funds for School?!

by: Phyllis M. Webb, Program Coordinator, UofL Women's Center

Great news for U of L students!

In addition to the scholarships listed in the March 2020 Diversity Newsletter, the Women's Center has another scholarship of interest to students—the Minority Single Parent Scholarship provided by the Women's Club of the University of Louisville.

This scholarship is in the amount of $22,000. It is for two undergraduate students in the amount of $11,000 each for in-state tuition, books and fees.

Criteria, application forms and other information is available on the Women's Center web site at this link: https://louisville.edu/womenscenter/uofl-women-center-awards-and-scholarships/scholarships

The deadline to apply for this scholarship is **Friday, June 5** for the 2020 fall semester.

Other scholarships are also listed at the above link with deadlines set for May 15 and May 29.

For more details, email womenctr@louisville.edu or call 852-7715.

A Message from the Women's Center – We are STILL here for you!

For the health and safety of our staff and students, we are operating remotely per the University's response to COVID-19. *We are still here to support our UofL community.* To contact us, call 852-8976 or email womenctr@louisville.edu, Monday – Friday 9am-5pm. For specific staff members, visit our staff page. You can also connect with us virtually for group and/or one-on-one meetings! If you aren't a part of the Women's Center Engage page, join to receive our weekly emails with updates from the Women's Center and our student groups and fun activities.

Resources during COVID-19

The Women's Center has created a resource page on our website of campus, community and national resources, including fun activities to do from home. https://louisville.edu/womenscenter/resources/resources-during-covid-19

Resources for University of Louisville LGBTQ+ Students - You are not alone!

UofL Counseling Center: 502-852-6585
https://louisville.edu/counseling

- Beginning Tuesday, March 17, the Counseling Center will cease offering face-to-face services. Keep in mind that our operations may change if the University's precautions change.
- If you have an appointment scheduled in the coming weeks, your clinician will reach out to you to set up a brief check-in via phone.
- If you are in crisis, please call us at 852-6585 M-F between 8:30am and 4pm and we will assign a clinician to speak with you as soon as possible.
- For after hours or emergency services, contact one of the resources below, or visit: https://louisville.edu/counseling/emergencies/overview

Trans Lifeline: 877-565-8860
Trans Lifeline is a trans-led organization that connects trans people to the community, support, and resources they need to survive and thrive.

Trevor Project Lifeline: 866-488-7386
www.thetrevorproject.org/pages/get-help-now
The Trevor Project is the leading national organization providing crisis intervention and suicide prevention services to lesbian, gay, bisexual, transgender, queer & questioning (LGBTQ) young people under 25.

Trevor Space
Social networking site for lesbian, gay, bisexual, transgender and questioning youth ages 13 through 24 and their friends and allies. www.trevorspace.org

National Suicide Prevention Lifeline: 1-800-273-TALK (8255)
This 24/7 hotline is a national resource which connects you to the crisis center nearest to your location.

Crisis Text Line: Text HOME to 741741
Text from anywhere in the US to connect with a trained crisis counselor. Available 24/7.

Centerstone Adult Crisis Line: 502-589-4313 or 800-221-0446
This 24/7 hotline is a resource offered by a local Louisville agency, formerly Seven Counties Services. Individuals who are deaf or hard of hearing can call using KY Relay at 711.

Metro United Way: Dial 211
https://metrounitedway.org/get-help-now/
This site provides a wide range of information on services available in the Metro Louisville area

Emergency Services
University of Louisville Police: 852-6111
Or dial 911

Center for Behavioral Health is here to support you during these challenging times, with

TWO TELEHEALTH THERAPY GROUPS

Essential Support: Support group for Essential Workers
with Dr. Norah Chapman
Parent Process Group: For parents who need some extra support
with Dr. Steven Kniffley Jr.

WE'RE IN THIS TOGETHER.

ARE YOU INTERESTED?
Email us at
behavioralhealth@spalding.edu

These FREE therapy groups will start on Friday April 17, and will meet via Zoom. They are open to anyone living in KY or IN.

The Center for Behavioral Health is Open Via Telehealth!

Are you or someone you know looking for extra support while quarantining?

The Center for Behavioral Health at Spalding University is dedicated to providing compassionate, affordable, accessible, and high quality behavioral health services through videoconferencing (like Skype) or telephone, especially while we are closed for in-person services. Our clinicians are doctoral level graduate students under the supervision of a licensed psychologist and are well trained in the most innovative and science based approaches to treating a wide range of concerns.

If you are interested in scheduling a telepsychology appointment to address your individualized needs, please email at behavioralhealth@spalding.edu or visit our website below to learn more.