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The Development of Online Social Medicine Modules for Medical Students at the Emory University School of Medicine

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Abstract

The Development of Online Social Medicine Modules for Medical Students at the Emory School of Medicine

By Courtney Lane

Health inequities are associated with the social determinants of health. Though there is potential to impact inequities and social determinants through clinical patient-provider interactions, providers often feel ill equipped to address these non-clinical aspects of patient care and may even perpetuate inequities. The overarching goal of this project was to develop an online foundational level set of modules that could help Emory University medical students to develop and embed these skills prior to their practical post-graduate (residency and/or fellowship) training. Using an initial template from the existing social medicine course as the basic framework, modules were supplemented with skills development centered resources and translated into an interactive format. Three modules were developed, covering the social determinants of health, race and bias, and patient advocacy, respectively. These modules also included a set of pre-post test questions to evaluate short term knowledge acquisition. Further efforts should be made to pilot the program for refinement and to develop a long term evaluation plan.

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I) Introduction

The social determinants of health (SDH) are typically defined as major influences on health outcomes outside of genetic and clinical factors (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003). These include factors such as: socioeconomic status; race/ethnicity; accessibility to health care, transportation, and nutritious foods; and education level, among others (Brach & Fraser, 2000). Among these factors, minority status related to race or gender, poverty, or low education status is often associated with a higher likelihood of experiencing health disparities and poorer health outcomes. These range from conditions including cardiovascular disease, diabetes, infant mortality rates, obesity, asthma, and cancer (KFF, 2002; Murray et al., 2013; Murray et al., 2006).

Many, but not all, of these disparities can be linked to inaccessibility or under-utilization of healthcare services for these individuals. For instance, the differences in life expectancy within the United States between black race individuals and white race individuals have actually increased since Medicare was introduced (Gornick, 2008). Individual SDH are typically highly interrelated, which makes single, targeted interventions less effective.

Although there are clearly many systematic problems influencing health disparities, health care provider practices have some of the clearest impacts on quality of care, both positive and negative. A physician's clinical encounter with a patient has the potential to significantly affect the experience of that patient and even the eventual health outcomes. Strong communication, culturally appropriate interventions, and a bond of trust can help to ensure proper adherence and open dialogue about signs and symptoms. However, the absence of these qualities can result in negative patient experiences and potentially negative health outcomes.

Over the years, the gap in quality of care between whites and all other races has either remained constant or increased for a majority of the indicators (patient satisfaction, cultural acceptability etc.) being measured (Glasgow & Emmons, 2007). There is evidence of inconsistencies and variation in practice on the basis of race and income by physicians in both preventive and chronic care (Egede, 2006; Trivedi & Ayanian, 2006). It is likely that these practices are not the result of blatant prejudice and instead are the result of societal perceptions and subconscious biases of health care providers (Schulman et al., 1999).

In an effort to alter and possibly prevent these perceptions and biases, implementing a curriculum among physicians in training that focuses on exposure to the concepts of SDH and acquisition of cultural competency skills for use in the clinical setting has the potential to improve future patient encounters. Optimally, this curriculum would be concurrent with medical training prior to post-graduate medical training –which is in-practice training– so that translation into practice occurs as a package alongside all other clinical skills development early on.

Problem Statement

Physicians and patients historically cite loss of trust, miscommunication, non-compliance, and cultural barriers as the overarching influences on negative patient-physician relationships and subsequent health outcomes. Many of these issues could stem from a categorical misperception of people based on superficial characteristics such as race or income. To this end, adjusting these perceptions and providing skills for counteracting social biases during early medical training could impact the magnitude of health care disparities and inequities. Emory's School of Medicine (SOM) currently does not have any training modules to support development of these skills.

Purpose Statement

There is broad consensus among medical students at the Emory SOM that social medicine skills development during medical school could be helpful in reducing disparities in future medical care. In addition, revisions to the requirements of the Accreditation Council of Graduate Medical Education (ACGME) offer an opportunity for Emory University's SOM to add such a module to strengthen their current offerings on social medicine. This program emphasizes cross-cultural care, patient advocacy, and the benefits of experiential learning in a variety of clinical settings. The SOM has supported the development of an online, interactive, introductory course on key aspects of Social Medicine for use by first year medical students.

Research Objectives

To meet the needs of the Emory SOM, the following steps were proposed for this project:

1) Identify which key portions of Social Medicine are appropriate and necessary to cover in an introductory level course
2) Identify what the best platform for developing an online course would be
3) Identify what the best platform for delivering the course content would be
4) Develop the course content and format in such a way that it is engaging for the medical students

Significance Statement

The development of an online SDH course within Emory's SOM Social Medicine program will have multiple ramifications. From a public health perspective, the course will help close the knowledge gap on the SDH and improve Emory medical students' ability to provide high-quality medical care to their patients in the future. From an education perspective, this course will allow

students to become more competitive in graduate medical education programs (residency and fellowships) as they are fulfilling ACGME requirements. From an administrative perspective, the format of the course will provide a relatively self-sustaining platform in a program where faculty and staff are often pressed for time and have demanding schedules. The online component will also be more flexible with regard to students' schedules. Additionally, the course will serve as a model for potential use by other departments within the SOM, other schools at Emory University, or other universities altogether as a method for introducing subject matter in a flexible and interactive format.

Definition of Terms

Accessibility to health care- Having the ability to easily use a given service including, but not limited to, reasonable distance to the care facility, lack of language barriers, and financial feasibility.

Cross-cultural care- The sector of health care that focuses on the skills involved in communicating effectively with patients from a variety of socio-cultural backgrounds and using this communication to provide high quality of care.

Formative evaluation- Evaluation that is typically conducted during the developmental portion of an intervention. The results from formative evaluation are used to inform the intervention and increase the likelihood of uptake and success among the target population.

Graduate medical education- Formal in-practice medical training that is received after completing an MD (Doctor of Medicine) or DO (Doctor of Osteopathic Medicine) degree; other terms to describe this include "residency" and "fellowship."

The social determinants of health- Major influences on health outcomes outside of genetic and clinical factors.

Medical education- Formal medical training that is received before the completion of an MD or DO degree.

II. Literature Review

This literature review examines the following: the use of formative research and qualitative data in developing an intervention; the value of social medicine training; best practices among medical, social medical, and online medical training; issues in evaluating social medicine courses; and the current state of social medicine offerings at Emory University SOM.

1) Role of Formative Research in Developing a Course

The development of any intervention should take into account the context in which it will be applied. Satterfield's transdisciplinary model of evidence-based practice (EBP) (see Figure 1) describes a model which includes the environmental and organizational context of the intervention in addition to characteristics of the target audience (Satterfield et al., 2009). This context helps to maintain a balance between the primary intention of the intervention and the feasibility of uptake by the target population. Flexibility such as this is particularly important in the fields of education and public health, where the receptiveness of the audience is paramount to the aspired successful behavior change espoused by the intervention and those deploying it. Satterfield has predicted that using this new EBP model in the development of curricula would facilitate high quality uptake as well as a realistic depiction of an appropriate intervention.

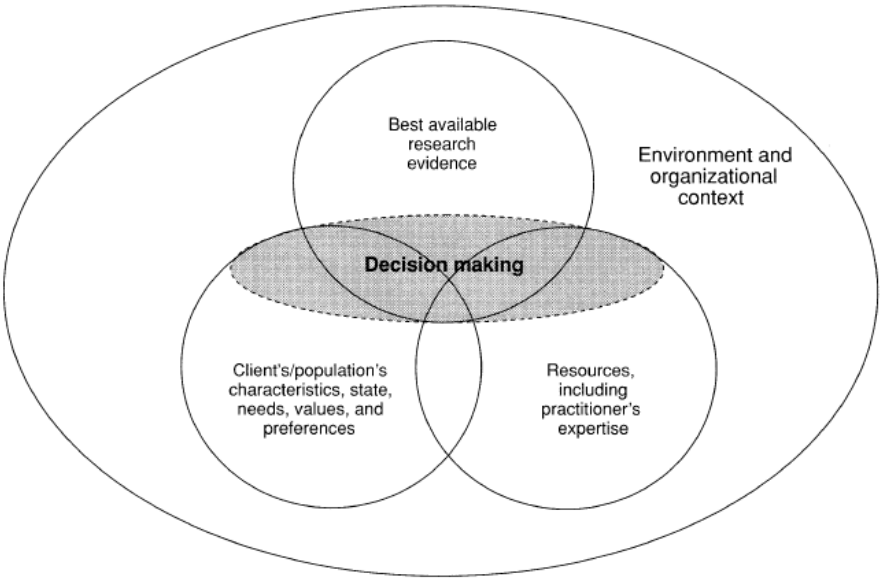

Figure 1 Satterfield, 2009

The data to better understand the context in which an intervention will be deployed are often gathered during a formative evaluation. The results of formative evaluation of an intervention are often used to ensure that the intervention is not only able to efficiently reach the intended audience but that it is also likely to be acceptable to and culturally appropriate for the target audience (Thompson N, 2006). In the specific case of medical education modules, this would mean generating buy-in from the students as well as other stakeholders and finding time for additional courses within the already-busy standard medical curriculum (Shah, Levy, Moriates, & Arora, 2015). Limited staff or student time and failure of staff and/or students to contextualize new knowledge are typically major barriers in implementing and gaining from training modules, particularly in the case of medical education (Glasgow & Emmons, 2007). Glanz recommends using a participatory program design and evaluation as methods to increase buy-in among participants (Glanz & Bishop, 2010).

Lomas also notes that dissemination of information should be tailored to the audience in order for implementation to become most effective and to promote buy-in (Lomas, 1993). Particularly, the format should be user friendly, readily accessible, originate from an influential body or organization, and the importance of the findings should be apparent from a variety of sources. Furthermore, Lomas argues that actively engaging training modules should be the preferred method of dissemination as opposed to pure didactics or readings. The sentiment of targeted strategies is echoed by Tinkle et al.-particularly when concerning dissemination of information (Tinkle, Kimball, Haozous, Shuster, & Meize-Grochowski, 2013).

Formative evaluation through the use of qualitative research methods offers strong potential to help inform project development and increase chances of success of an intervention by using data on participant beliefs, priorities, and opinions (Malterud, 2001; O'Donnell, Lutfey, Marceau, & McKinlay, 2007). Malterud argues that qualitative research methods have excellent applications in understanding social experience, communication, attitudes, and processes. She further posits that these methods can help lessen the distance between theory and practice in the medical field specifically. O'Donnell et al. followed a similar line of reasoning and used focus groups to refine a research project targeted at physicians. By including these focus groups, they increased instrument validity, streamlined the data collection protocols, and decreased the overall cost of the study. In sum, it can be argued that using qualitative data in the process of formative evaluations can lead to more tailored and acceptable interventions.

2) The Value of Social Medicine Training

Health disparities have been observed in the United States for a number of decades (Egede, 2006; IOM, 2002; Nelson, 2003). One of the major recommendations from the Institute of Medicine's 2002 report on health disparities was the need for training in cross cultural

competence and in the social determinants of health as tools to decrease racial and ethnic disparities that exist in health care The arguments for this appear to fall in one of three groupings: 1) that practitioners are unaware of the impact a patient's social and cultural circumstances can have on the status of their health and likelihood to adhere to prescribed health behaviors and treatments; 2) that practitioners may be contributing to health care disparities by making impartial diagnoses and recommendations; and 3) that practitioners feel unequipped to address issues that are outside of their clinical encounters with patients. Each of these is discussed in greater detail below.

A) The Patient's Social Context

Factors such as social stressors and support networks, changes in environment, life control, and literacy can be particularly influential on health status (Green, Betancourt, & Carrillo, 2002). Incorporating training for assessing a patient's understanding of their illness, strategies for bridging communication gaps, skills for negotiating and shared medical decisions, and tools for recognizing the complexity of non-clinical, non-genetic social issues could be of value in improving provider practices and care delivery (Betancourt & Green, 2010). Betancourt et al. find that such additions to medical school curricula result in practitioners feeling more confident in their ability to reach mutual decisions with their patients concerning adherence to treatment plans.

B) Provider Bias

The Institute of Medicine report highlights the following factors as responsible for racial and ethnic disparities in health care: bias or prejudice against minorities, greater clinical uncertainty when caring for minority patients, and beliefs or stereotypes on the part of the provider

concerning the behavior or lifestyle of minorities (IOM, 2001). Betancourt (2006) does note that these disparities could be due to conscious or subconscious judgements and biases of practitioners (Betancourt, 2006)

Variations and inconsistencies in practices based on race, gender, and SES in situations are abundant and may indeed affect health outcomes (Trivedi & Ayanian, 2006). Schulman et al. found that a patient's race and sex appeared to influence doctor's recommendations for cardiac catheterization in their randomized experimental study (Schulman et al., 1999). A majority of physicians surveyed by the Institute of Ethics in 2005 mirrored these sentiments, reporting that "minority patients generally receive lower quality care than white patients" and "close to 2/3 of the nation's physicians have reported seeing a patient receive a lower quality of health care because of the patient's race or ethnicity"(IOE, April 2005)

Van Ryn (2000) acknowledges that physicians are expected to be unaffected by social characteristics and to be objective (van Ryn & Burke, 2000). She argues that demographic characteristics such as age, race, and income influence the clinical encounter, diagnosis, treatment plans, and ultimately outcomes. Using medical record abstraction and surveys from 8 New York hospitals, she found that patients whom providers categorized as black were believed by the sampled providers to be at higher risk for substance abuse and less likely to desire an active lifestyle or to comply with physician recommendations. They were further rated as being less intelligent than white patients when income, education, patient age, and sex were accounted for. Through her model, physician response to the patient's demographic characteristics are at least somewhat impacted by the physician's perceptions and stereotypes about those characteristics.

In a subsequent paper, van Ryn refines this model with the inclusion of subtyping (van Ryn, Burgess, Malat, & Griffin, 2006). Social cognitive theory describes subtyping as breaking down gender and race into each of their subcategories such that black woman, white man, black man, and white woman each have different descriptors but generally remain homogenous within the subtype group (Moskowitz, 2005). This is an effort to simplify the information the brain processes on a daily basis so that critical decisions can be made as quickly as possible. Van Ryn (2007) finds that a majority of cultural competence programs focus only on the explicit prejudices an individual may have and thus may not improve the overall quality of care if the physician does not believe they are acting in a prejudiced manner.

C) Skills Development through Social Medicine Training

The Institute of Ethics suggests that education and training could help alleviate racial and ethnic health disparities if they concentrate on attitudes (cultural sensitivity), knowledge (multicultural/categorical approach), and skills development (IOE, April 2005). Many researchers have advocated the need for space within medical school curricula to expose students to the impacts of a multitude of social factors including race and ethnicity on health care (Betancourt et al., 2003; Haughton & Stang, 2012; Lim, Brown, & Justin Kim, 2014). Such an inclusion would promote the development of skills that some physicians feel they otherwise lack when attempting to address SDH.

As part of the 2007 update of the Accreditation Council for Graduate Medical Education (ACGME) General Competency, new competencies were included such as: “communicate effectively, demonstrate caring and respectful behavior”, “identify strengths, deficiencies and limits in one’s knowledge and experience”, “communicate effectively with patients, families, and the public”, “demonstrate sensitivity and responsiveness to diverse patient populations”,

"advocate for quality patient care and optimal health care or public health systems", and "awareness of the impact of race, ethnicity, and culture on clinical decision-making" (Swing, 2007).

Lim et al. found that practitioners with a more complete grasp of the social determinants of health garnered higher rates of patient satisfaction with health care among both racial and sexual minority patients (Lim et al., 2014). In a similar study utilizing nationally representative surveys, when perceived racism and medical mistrust were controlled for, race no longer became a significant predictor for the patient's satisfaction with a clinical encounter. (Kirby, Taliaferro, & Zuvekas, 2006)

Ultimately, social medicine courses aim to enrich the student's understanding of social context and the SDH, and to give them the tools necessary to address these issues.

3) Medical Education

A) General Medical Education

Typically, medical students are exposed to system specific courses (e.g., anatomy, physiology, pathology), a broad range of clinical scenarios-often times a combination of case studies and rotation experiences, and a few variants on medical ethics, professionalism, and communication. There are a multitude of important factors involved in creating a successful introductory level course in medical education. Chief among these is a mutual understanding of the importance of the subject matter between the instructors and the students (Betancourt & Cervantes, 2009). Betancourt (2009) suggests using a mixture of peer-reviewed literature and clinical case studies to increase buy-in among the students. This is based on his work integrating social medicine and cultural competency into the curriculum at Harvard University's SOM. This approach allows the

instructor to build a strong support system for the merit of the course which appeals to students, instructors, and funding sources alike among many of the courses examined by Betancourt et al.

Similarly, the randomized controlled trials performed by Schilling et al. suggest demonstrating how the knowledge and skills gained through the course will have application in real life situations to increase student buy-in (Schilling, Wiecha, Polineni, & Khalil, 2006). This would typically involve discussion and interaction among students and an emphasis on experiential learning. Programs that pair an introductory level course with experiential based learning are more likely to result in retention and practice of those ideas expressed within the course, while those without often resulted in inadequate development of the intended skills (Nasca, Weiss, & Bagian, 2014).

Finally, an introductory level course must be mandatory if it is to reach all students, regardless of their individual competence of the subject matter (Lum & Korenman, 1994). Methods for engaging students who already have some experience with the material include marketing it as a review or as an opportunity to learn the material from a new perspective. Nasca describes particular success when including these "expert students" as resources for the remainder of the students (Nasca et al., 2014). This has the added benefit of generating further student buy-in.

In summary, for general medical education, it is key that 1) buy-in is created by highlighting the potential usefulness of the knowledge or by peer feedback and support and 2) that introductory level courses be mandated.

B) Socio-Medical Education

The following section details the specific need for generating buy-in for socio-medical courses as well as best practices found in delivery format for these types of courses.

a) Student buy-in and socio-medical education

The themes of student buy in and practical skills-based learning surfaced multiple times in the literature specific to socio-medical education as well as general medical education. Many courses aimed to motivate their students by focusing on cultural competency as a tool to providing high quality care (Betancourt & Green, 2010; Park et al., 2006; van Ryn et al., 2006). This was typically accomplished through examining case studies and emphasizing clinical applications of the skills developed through the courses. This approach aims to overcome students' hesitancies about the clinical utility of their courses.

Furthermore, faculty and institutional support are necessary for the successful implementation and development of socio-cultural coursework (Rutherford, McIntyre, Daley, & Ross, 2012). As demonstrated in a survey of 176 medical schools in the United States and Canada, if trainers and medical school leaders within the academic institution show more interest and positive attitudes toward the content, students generally mimic these tendencies (Obedin-Maliver et al., 2011). Students have also reported feeling more prepared to have a clinical encounter with a patient with a different SES than themselves when there were major social medicine role models available to them during training, particularly in the form of instructors or mentors (Greer, Park, Green, Betancourt, & Weissman, 2007)

b) Delivery Format of Socio-Medical Education

Didactic, group learning, and problem based learning are all common formats for teaching social medicine (Flores, Gee, & Kastner, 2000). However, community based and experiential training consistently have been associated with higher levels of success than pure didactic courses (Brach & Fraser, 2000; Park et al., 2006). This is likely due to a combination of longer exposure to the

subject material as well as opportunities to actively implement and practice the skills being learned. Flores et al. and Betancourt et al. (2009) recommend a separate course or courses devoted specifically to social medicine rather than integrating the subject matter into the normal course load. Flores et al. postulate that integration could lead to a "dilution" of the potential behavior change and awareness that the course(s) are intended to elicit.

Social medicine courses should be taught in a developmental fashion in medical school and continued during post-graduate continuing medical education (Betancourt & Green, 2010). Systematic reviews of medical curricula reveal that such longitudinal designs permit the student to absorb basic knowledge and information in earlier courses and transition to skills acquisition and behavioral change through ongoing education and application (Price et al., 2005). Vignettes, videotaped interviews, discussion about personal beliefs or views, discussion of social context-SES, migration history, literacy, social networks, etc. are common methods to providing the foundational knowledge of social medicine (Carrillo, Green, & Betancourt, 1999). Ideally, future courses would include shadowing opportunities in a variety of settings to challenge and develop the skills of the student (Park et al., 2006). Park et al. notes that the longer the period of socio-cultural training the clinician undergoes, the more likely one is to see improvements in patient satisfaction.

c) Content within socio-medical courses

A potential downfall within social medicine courses is the antiquated approach of teaching students about cultural issues by isolating given combinations of race/ethnicity and SES and attributing certain factors or behaviors to those groups (Gornick, 2000; Kaplan & Greenfield, 2004). This category-based approach can lead to stereotyping of these populations even more

which in turn can potentially contribute to and/or worsen existing health disparities (Betancourt, 2006).

A more successful approach focuses on the students developing skill sets to identify major impediments to treating patients from a variety of backgrounds (Carrillo et al., 1999; Kaplan & Greenfield, 2004). These impediments can include language, lack of trust of authority figures or health professionals, conscious or unconscious judgement on the part of the clinician and/or the patient, and a lack of health literacy. Then, building communication skills, self-awareness and humility help to address the impediments students most often cite. Communication, self-awareness, and humility consistently rank among the most valuable skills when working among diverse patient population and acquisition of these skills should be a primary objective of any social medicine course (van Ryn et al., 2006).

C) Online approach

Tabak has suggested that creative approaches might be used in order to make dissemination of information more visually attractive. Social media, online applications, and smart phone applications were among the dissemination modalities listed (Tabak, Stamatakis, Jacobs, & Brownson, 2014).

Several schools of medicine, contemporaries of Emory University, have used these methods, particularly, web-based and online systems, for their curricula, and these are described further here.

University of Michigan's Medical School, as examined by Hammoud, uses a web-based system for student directed learning around evidence based research (Hammoud & Barclay, 2002). This includes multimedia tools in order to appeal to a wide variety of learning styles and an easy

system for monitoring use and student progress. Multi-media options were particularly sought after by the students at the University of Michigan based on post-testing feedback.

Boston University's School of Medicine (SOM) as examined by Wiecha in 2002 had developed the Heuristic for Electronic Asynchronous Learning (HEAL) model, which emphasizes a combination of didactic modules, case discussions, and practical experience in an evidence based medicine course for medical school students (J. M. Wiecha, Vanderschmidt, & Schilling, 2002). Pre- and post-testing showed increases in diabetes case management when compared to a control group with no online exposure. The students reported perceiving more flexibility in terms of managing their time with the course and better adoption of concepts due to the experiential component of the course.

Boston University's SOM also has used BlackBoard software as a platform for their continuing medical education program (J. Wiecha & Barrie, 2002). BlackBoard allows for participants to access modules posted to the website and discussion boards with both instructor and student contributions. Many of the participants noted that the course design and timing allowed for flexibility in terms of learning style and scheduling constraints when compared to traditional lecture formats. Furthermore, students can give feedback on any lacking resources, which the instructor can post easily to the platform.

The University of British Columbia Faculties of Medicine and Dentistry, as examined by Broudo, use the Medicine and Dentistry Integrated Curriculum Online (MEDICOL) as a supplement to their curricula (Broudo & Walsh, 2002). The course management system allows for easy tracking of student progress, student-directed learning components, weekly quizzes and immediate feedback, and easier structured communication between the students and instructors through email and bulletin board functions. Over 90% of their students used the MEDICOL sites

and believed them to be helpful as an adjunct to their learning experience. Instructors also reported finding the MEDICOL site useful as an environment for exchanging ideas, innovations, and data.

New York University's School of Medicine, as examined by Kalet, implemented a web-based interactive module on strategies for working with interpreters and navigating cultural issues amongst diverse patient populations. The course includes pre- and post-test questionnaires as well as videos and case studies. All first year medical students completed the course and on average, improved by 20% between the pre- and post-module questionnaires (Kalet, Gany, & Senter, 2002). They reported that 86% of the students were satisfied with the module, although many critiqued the technical difficulties that made completion of the module time consuming.

Online learning as a method within education has shown improvement in skills in the short term range (1 year post intervention) in randomized controlled trials, however longitudinal evaluation also needs to occur (Schilling et al., 2006). Furthermore, while small group discussions and constructive feedback have been identified as key in the successful development of new skills and behaviors (Tervalon & Murray-Garcia, 1998), many online courses do not emphasize these components or fail to pair the online course with an in-person component that does include them.

4) Evaluating Social Medicine Programs

In addition to the challenges in designing multicultural education and training curricula in the field of medicine, there is also substantial difficulty in evaluating the processes and outcomes of such an intervention. One of the most frequently described shortcomings in social medicine courses is the lack of a standardized evaluation system (Tervalon & Murray-Garcia, 1998). Tervalon posits that many institutions struggle with the evaluation of cross-cultural medical

courses because they do not lend themselves well to quantitative assessment. The courses are rarely objectively assessed, with progress typically being measured via self-report from clinicians (Brach & Fraser, 2000; Gozu et al., 2007; Park et al., 2006) and social desirability bias has been hypothesized to have a significant impact on these assessments.

Betancourt (2010) suggests that the reliability and credibility of socio-cultural interventions relies on results that are objective and systematically measured (Betancourt & Green, 2010). Betancourt reviews several possible systems for evaluation, but concludes that they are inconsistently applied in randomized controlled trials of social medicine courses. This further impedes the medical community's ability to assess the impact(s) of a social medicine course.

5) Emory University SOM's Social Medicine Offerings

The Emory SOM currently has two curricular options for medical students to participate in aspects of social medicine. One of these is the Social Medicine Grand Rounds which brings in a wide variety of speakers to discuss social medicine and its impacts on clinical practice. Since this is a grand rounds didactic style of exposure, it is not required to attend nor is it incentivized in any way. The second option is a social medicine elective course, which takes place during a medical student's third or fourth year. It is a month long course which is offered in both February and March (aligning with the state of Georgia's legislative sessions in Atlanta). This course offers students the opportunity to have both didactic and field-based experiences in learning about SDH and seeing first-hand how they can impact a clinical visit. Typically, 15-20 students out of an average medical school class of 135 take the course each time it is offered. Since it is open to third and fourth year students, this results in a total of around 35 students per year. It has historically received excellent evaluations from the students.

6) Conclusions

Based on the literature evaluated to date, a successful social medicine course should aim for the following qualities:

1) To be tailored to and easily accessible by the students, which can be accomplished through formative evaluation and use of qualitative methods
2) To impart both knowledge of the SDH and skills to address health disparities based on the SDH
3) Should be a mandatory and introductory level course given as early as possible with repeated "booster" doses during graduate training and continuing medical education so that skills can be integrated into clinical practice and reinforced regularly
4) To generate buy-in by emphasizing the usefulness of the information learned and by having strong role models and mentors within the SOM
5) To incorporate longitudinal evaluation into such a curriculum to demonstrate the impacts such a course might have

Such a course does not currently exist at the Emory SOM. The creation of this course as described in the following sections will endeavor to capture all of these qualities.

A large remaining gap, beyond the scope of this project, is the creation of an objective system for assessing impact of social medicine courses that can be applied to any course (medical school, graduate medical education, or continuing medical education) and in any setting (international, domestic, hospital, private practice etc.).

III. Methods

Introduction

A need was identified by Emory SOM faculty, staff, and students to strengthen the SOM medical student curriculum with regard to social medicine. It was requested that this take the form of a mandatory set of online modules, if possible. These were to be developed and pilot tested before May, 2016.

Since the use of formative evaluation data to increase student buy-in and program success is considered critical in these types of courses, previous data from focus group discussions and surveys implemented by faculty and students associated with the existing social medicine course in 2014 and 2015 were used to select the topics of the online modules. These topics were determined to be Social Determinants of Health, Race and Bias, and Patient Advocacy. The Emory SOM students and faculty who took the surveys or participated in the focus group discussions during this time period had been asked to focus on perceived usefulness in terms of knowledge base development and skills acquisition.

Since the combination of the three modules is intended to be a foundational course, the scope covered by each of them is limited to an overview of the subject matter and focuses on encouraging the students to think critically about the issues presented.

Target Audience

The students of this course are intended to be first year medical students attending the Emory SOM. The number of students within this cohort varies from year to year but is typically around 135. Every member of the cohort would be required to complete the course within their first year as registered students.

Anyone with an Emory email address and access to the Blackboard website will also have access to the modules, however at this point, it will not be mandated of anyone outside of first year medical students to participate in the course.

What follows is a detailed description of the tasks associated with developing the modules.

Procedures

A) Review of Existing Tools and Materials

Initial review included an assessment of PowerPoints, handouts, activities, and other materials associated with the Social Medicine elective course currently offered by the SOM. This elective course is a month long combination didactic and experiential course for third and fourth year medical students. Typically, only 35 students out of 260 elect to take this course in a given year. However, student feedback on the elective course has historically been very positive and the utilization of its materials, if valuable and possible, was deemed appropriate.

Furthermore, an assessment of other similar courses available online and at other institutions was performed to evaluate the usefulness of outside courses in providing an acceptable level of training in the subject matter. The list of those courses evaluated can be found in Appendix B. These courses were evaluated independently by both the author and by Dr. Bussey-Jones, Chief of General Medicine and Geriatrics at Grady Hospital and associate professor of medicine at the Emory SOM.

Criteria for potentially including materials from other sources into the Emory SOM Social Medicine course involved assessing:

1. value of information presented,

2. level of engagement provided to the user,
3. ability to track user progress, and
4. cost to utilize the modules such as access fees.

Evaluation of these criteria was based on professional opinions of the public health, medical, health care, and educational value of the materials. Findings were compared between the two evaluators and any discrepancies discussed. If necessary, courses were further evaluated by Dr. Maura George, assistant professor of medicine at the Emory SOM. None of the courses evaluated offered satisfactory results in all these categories and the decision was made to utilize portions of the PowerPoints from the currently-offered elective course as a framework for the mandatory modules.

B) PowerPoint, Voiceover, and Supplemental Material Development

Adobe Captivate was selected as the tool for use in module development since it could combine PowerPoint, voiceovers, and links to supplemental materials: the main sources of visual information, auditory information, and interactive components, respectively. PowerPoints from the elective courses were sorted for applicability within the scopes of the three topics to be conveyed (Social Determinants of Health, Race and Bias, and Patient Advocacy) and any excess material deleted to maintain focus within a given module. Supplemental material was then culled from a variety of sources with an emphasis on both student engagement and impact of information. A list of supplemental materials used and recommendations for utilization within the modules can be found in Appendix C. Once these materials had been integrated into the PowerPoint slide decks, voiceovers were performed by both Dr. Bussey-Jones and Dr. George, co-instructors of the Social Medicine elective course.

C) Module Development

The slide decks and voiceovers were combined in Adobe Captivate along with pre/post questions to assess understanding. Assistance in compiling the various components into a fully usable module was provided by Christopher Alspaugh, an information analyst at the SOM. Individual completed modules were then reviewed by the author, Dr. Bussey-Jones, and Dr. George for consistency, flow, appropriateness, and quality.

Institutional Review Board (IRB) Approval

As this project was focused on the development of course modules and did not involve de novo data collection, it was not considered human subjects research and Emory IRB approval was not required. The scope of work of this project consisted of utilizing previously-collected formative qualitative data to aid in the development of course modules.

IV. Results

The project resulted in the development of three modules (Social Determinants of Health, Race and Bias, and Patient Advocacy), each requiring approximately 30 minutes to complete. Several multiple choice questions are placed throughout each module to gauge knowledge uptake; explanations for correct answers are included after each question. What follows is a brief description of each module. Full visual content of modules can be found in Appendix A.

A) Module 1: Social Determinants of Health

This module begins with a set of pre-test questions. Following these questions is a description of the social determinants of heath (SDH) and how they can present during a clinic encounter. The advantages of addressing the SDH as a method to reduce tertiary care burdens are discussed. Education, income, and housing are then examined as they relate to health outcomes. At this point, an interactive activity from an outside website is presented for the students to explore. This activity, Playspent, allows the player to move through a short flash game wherein their character has a limited amount of funds with which to get through everyday activities. These include paying for health bills, utilities, tuition fees, and groceries whilst accounting for limited income. Several skill sets (motivational interviewing, strategies for harm reduction, and identification of high-risk patients) are then presented as options for navigating the SDH from a clinical perspective.

B) Module 2: Race and Bias

This module opens with asking the student to take the Implicit Association test (IAT) regarding race. The IAT is an online tool that is intended to evaluate a student's automatic responses to various stimuli. In the case of the race IAT, the students are presented with pictures and words

and asked to sort them as quickly as possible. Within the module, this tool is paired with a short article written by a medical student on the implicit biases surrounding race that are presented in medical curricula across schools. The association of race with other SDH such as housing, education, and income are then explored. These associations are accompanied by health outcomes and statistics from a variety of sources. The students are then given the opportunity to play an outside game called Fairplay where their character is a young black graduate student. The game purposefully has the player engage in situations where both overt and more subtle examples of racism and bias impact the character.

The module then focuses on the clinical impact of race including disparities in care, procedural allocation, and bias in curricula. The link between simplification of material and categorization based on superficial characteristics is discussed as are the impacts of this categorization. Finally, the students are presented with some options in terms of advocacy (attendance of legislative sessions, monitoring of QI reports, and personally prescribed treatment decisions) with which they can minimize disparities within their professional spheres.

C) Module 3: Patient Advocacy

The costs of health care are examined as is the issue of financing health care among disadvantaged populations. Health insurance coverage and income distribution are discussed as they relate to inequities within health. Georgia's Medicaid and Peach Care programs are examined as specific examples of health coverage programs. Medicaid expansion and the Affordable Care Act (ACA) are reviewed in terms of how they address gaps in coverage. The student is then walked through a case study focusing on health care coverage gaps.

Various types of policy that influence health care coverage are presented and the medical student's role in policy and advocacy is discussed. The skills needed are briefly discussed as are specific organizations which physicians can easily access given busy professional schedules. The third module concludes with the same set of questions posed at the beginning of the first module.

V. Discussion

Since social inequities can often have a multitude of impacts on health status and health outcomes, minimizing the presence of these inequities is an essential first step to improving health in the general population. Some of this inequity stems from poor communications between physicians and patients, physician's perceptions of their ability to address health disparities, or subconscious bias on the part of the physician or the patient. Providing physicians in-training with education and resources regarding these non-clinical aspects of care can result in both the increased awareness among physicians of the impact of SDH and increased patient satisfaction with regard to clinical encounters. Based on best practices described in the literature, to address the need for a stronger yet accessible foundational course on social medicine for Emory University medical students, we developed an online set of course modules. Using formative data collected in 2014 and 2015 by faculty, an in-depth literature review, the existing framework from the previous social medicine course, and tools and examples from Emory's contemporaries, the three online modules (social determinants of health, race and bias, and patient advocacy) were developed for use by first year medical students. These modules are now part of a mandatory course and aim to provide a foundational level of knowledge. Next steps include piloting the modules, making alterations based on this piloting, and the development and implementation of a monitoring and evaluation plan for the modules.

Strengths and Limitations of the Project

This project has resulted in the development of the first mandated course work for medical students at the Emory SOM which focuses specifically on the social determinants of health and their effect on health outcomes. The modules will require no additional maintenance from faculty or other staff outside of allowing student access or any updates or revisions based on new

research. This has the benefit of being a low time investment in the long term for faculty. This being said, the modules should be revised after the pilot study as well as the first few cycles of the course is first implemented to refine the way modules are conveyed to ensure they are as impactful as possible.

This project finds limitations in that it has yet to be implemented among the target audience. Delays in development resulted in an inability to pilot test the modules during the intended time frame. In addition, another limitation is that the course does not yet have a longitudinal evaluation plan developed. Simply having access to the modules or even requiring that they be completed does not ascribe any value of quality or usefulness to them, and it is difficult to estimate what value might be gained without evaluation.

Strengths and Limitations with Regard to the Literature

Flexibility of scheduling and ease of access were key concerns for the success of these modules and their integration was assured by designing online modules which could be completed at learner discretion within a set semester. Furthermore, focusing on the provision of skills within the modules satisfied the emphasis in the literature of providing less abstract and more applicable concepts to learners with this type of material. In addition to this, student buy-in and support was generated by utilizing previously-collected formative data to inform the framework of the modules.

The single largest limitation of this project is its failure to incorporate experiential opportunities for students. This could have hypothetically taken the form of a rotation in a clinic within a low income neighborhood or shadowing a social worker or clergy member in rounds at hospitals or clinics. Unfortunately, these were outside the intended scope of the course as laid out by the Emory SOM. Combining experiential opportunities with the online classroom didactic can

produce a stronger course offering and should be recommended to the course leadership to consider during implementation.

Additionally, an argument can be made for the benefit of in-person small group discussion and interaction with other learners while completing the course. Discourse and exposure to differing points of view can often trigger a more solid rooting of the concepts and theories presented. However, given the preference for online modules to accommodate already overburdened course loads, this was not feasible in this stage of development. Again, as a recommendation to the course leadership, this aspect can be built in as the course evolves in coming years and can be offered as elective opportunities to engage with classmates to discuss the course content.

Process development could been strengthened by using an objective method to assess which topics to include in the final modules. This could have resulted in topics that were more common in general clinical practice and therefore, potentially more useful. However, the topics selected do cover most of the more pressing issues related to social medicine and have the added benefit of being actively sought after by students.

Future Steps and Recommendations

Although the modules have been developed, neither pilot testing nor evaluation have been implemented to assess the quality or response to the material. Next steps would include pilot testing among a subset of students and focus group discussions to determine strengths and limitations of the modules from the learner point of view. Following any necessary modifications, the modules would become available to all first year medical undergraduate students to complete.

An evaluation plan should be developed to track student progress and completion rates as well as to compile any feedback from students who have finished the course. The pre- and post-module

questions embedded within the modules will serve to evaluate short-term goals of knowledge acquisition. The long term goal of this course is to give students the tools they need to effectively address health care disparities in their roles as physicians; also, as mentioned, reinforcing these concepts during graduate medical education and continued medical education is a desired goal. Evaluation of these goals could be assessed by tracking where students of the course choose to practice (hospitals in low-income neighborhoods, free clinics etc.) or how much advocacy work they engage in on behalf of their patients. Ideally, these could be assessed via survey or interview on a yearly basis. It should be noted that results from within the first few years of taking the course are more likely to be directly related to the course rather than results from several years out. Since a multitude of factors could influence the student's choice of where and how to practice, it is significantly more difficult to attribute this choice to the course as the time between them lengthens.

Should focus group discussion results or student feedback show a strong inclination toward more small group discussion, an effort should be made to incorporate a discussion board or some similar outlet using the Blackboard website to allow for this option.

Implications of Social Medicine

The impact of the social determinants of health on the clinical encounter and on health outcomes is constantly present and evolving. By introducing this material early in the educational career of medical students and then reinforced in clinical practice, more time can be given for the material to be absorbed and to be witnessed by the time the students become physicians managing their own clinical visits. Although an experiential component would assist dramatically in establishing a more concrete understanding of the SDH, these modules provide a step in the right

direction – toward focusing physicians on all aspects of patient care and health, not just the clinical and genetic aspects.

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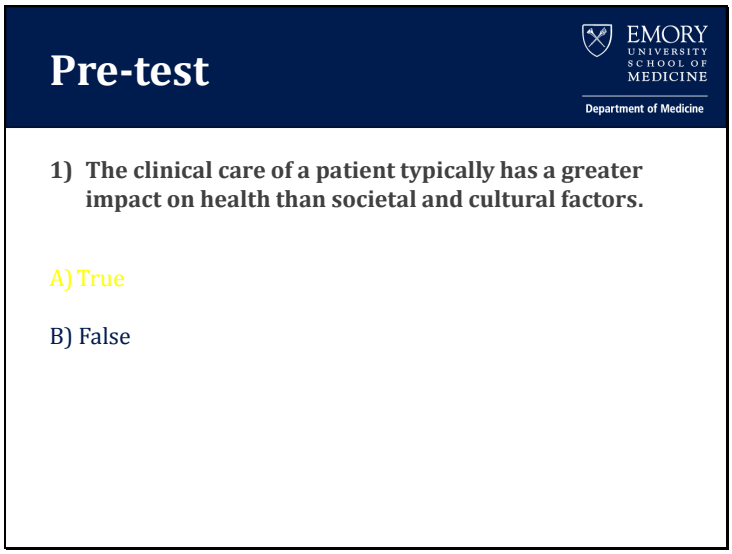
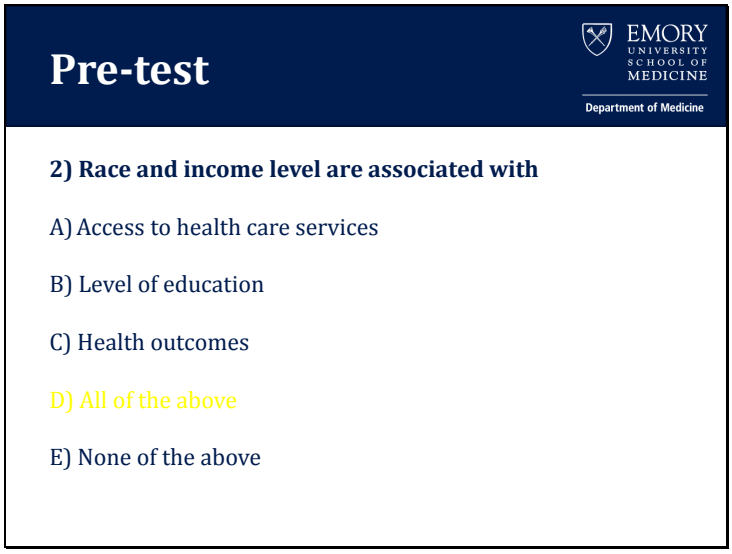
Appendix A
Module 1

Slide 1



Slide 2



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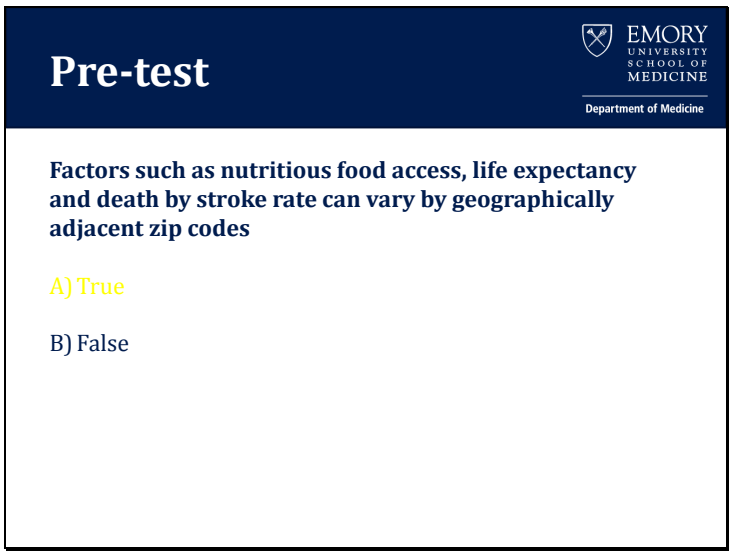

Slide 4

Slide 5

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The Social Determinants of Health and Equity

What you can do…

Slide 6

Objectives

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By the end of this session participants should be able to:

- Define the determinants of health disparities outside the clinical encounter
- List at least 2 ways physicians can explore and address social determinants in clinical care.

Slide 7

Social Determinants of health

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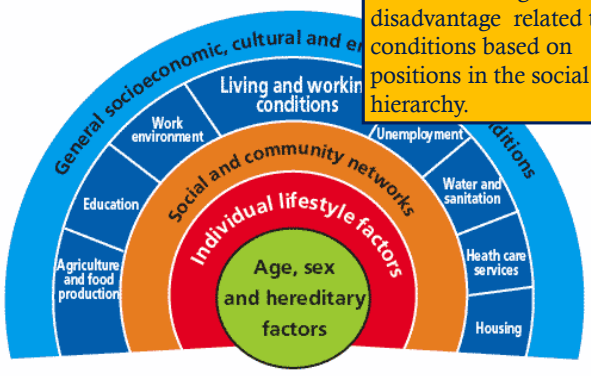
Department of Medicine

Defined as conditions in which people are born, grow, live, work and age that impact health

Items that impact health "beyond the office visit"

Slide 8

Social Determinants of Health Model



Social advantage/ disadvantage related to conditions based on positions in the social hierarchy.

Slide 9

Intern Case Presentation

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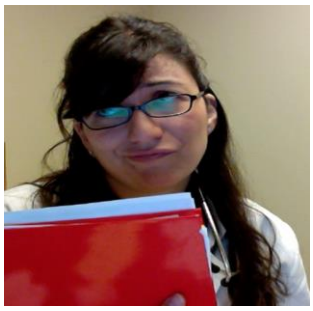
Department of Medicine

45 year old female with h/o CHF admitted for the 2nd time in 1 month with exacerbation.

The intern's frustration is evident.



Slide 10

What are the potential issues?

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- Afib with RVR
- Ischemia
- Hypothyroid
- Others medical causes…

This is how we are trained to think

Slide 11

What else could be going on?

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- Literacy
- Cost of treatment
- No transportation or copay for outpatient appt
- Inability to follow lifestyle modifications because of home situation (e.g neighborhood safety, food availability)
- Others…

Slide 12

"As physicians, most of our time in medical education and professional development is focused on getting the diagnosis and treatment plan right. All that work is meaningless without the dismount, which, in medicine, requires enabling the patient to understand and act in ways that maximize health outcomes."

Darren A. DeWalt, MD, MPH
JAMA 11/30/2010

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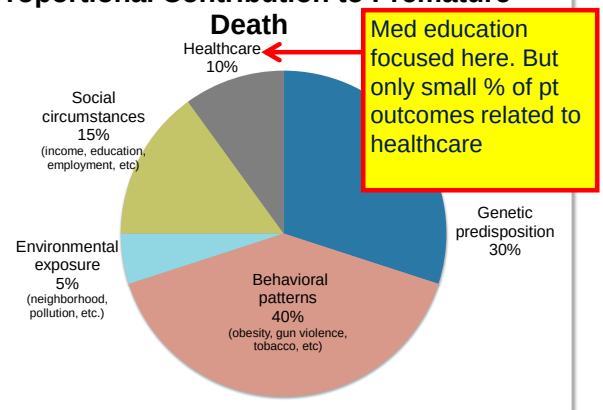
Slide 13

Many believe ***health*** is largely related to ***medical care***

but…

Slide 14

Proportional Contribution to Premature Death



Med education focused here. But only small % of pt outcomes related to healthcare

Adapted from: Schroeder S. "We Can Do Better — Improving the Health of the American People" *N Engl J Med* 2007; 357:1221-1228.

Slide 15

Multiple Choice 1

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Department of Medicine

Social determinants have the potential to greatly affect an individual's health status. Which of the following patients has the greatest number of identified negative social determinants of health?

a) An African American male college student who utilizes the collegiate Student Health Services for healthcare.
b) A Caucasian female who cannot afford supplemental dental coverage in addition to her current monthly health insurance premiums
c) A Caucasian single male who works part time in landscaping, has no insurance, and is currently staying on his friend's couch
d) An African American single female who has Medicaid and is pregnant with her first child.

Source: https://caringwithcompassion.org

Slide 16

Why?

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Department of Medicine

The negative social determinants in the previous examples included minority race/ethnicity, low socioeconomic status, lack of stable housing, and lack of access to affordable healthcare. Option C demonstrates two of these factors while the others involve one factor

Slide 17

Multiple Choice 2

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Department of Medicine

Which statement regarding social determinants of health is correct?

a) When controlled for insurance status and income, minorities receive care equivalent to the care received by majority Caucasians.
b) Low-income populations report worse health than middle-income populations, while middle and high-income populations report similar levels of health.
c) Behaviors, such as diet and exercise, are considered social determinants of health.
d) Social determinants of health include patient-generated and societal factors, genetic pre-disposition, and environmental exposure.

Slide 18

Why?

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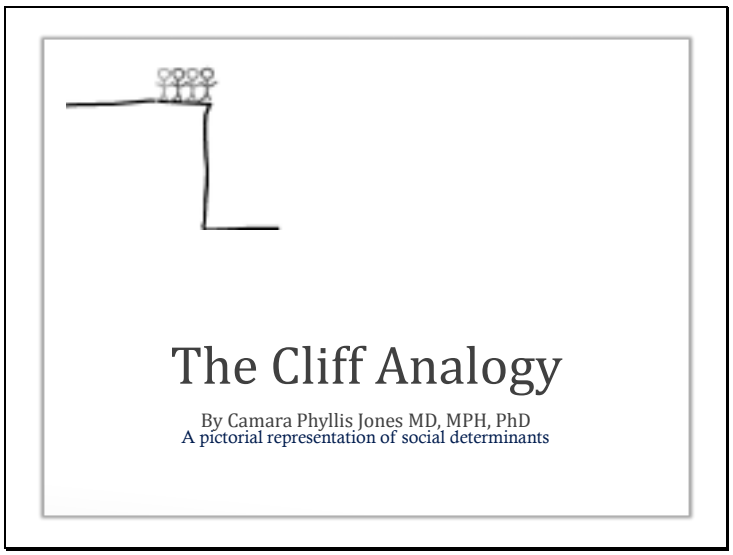
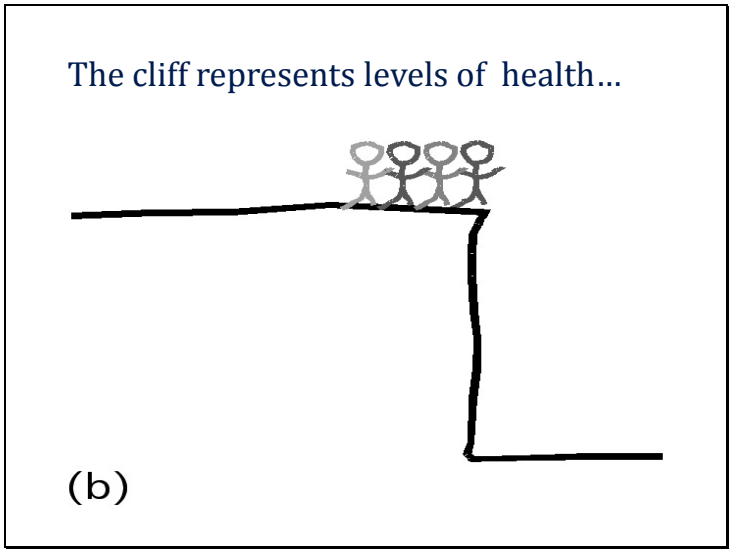
Department of Medicine

- Health related behaviors like diet and physical activity are heavily influenced by traditions, opportunities, education, environmental resources, and social environment
- The interaction of the social determinants of health is truly complex and interrelated

Slide 19

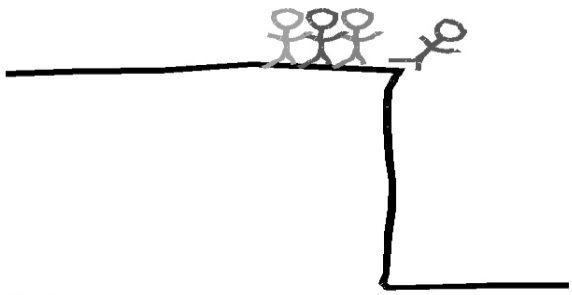


Slide 20



Slide 21

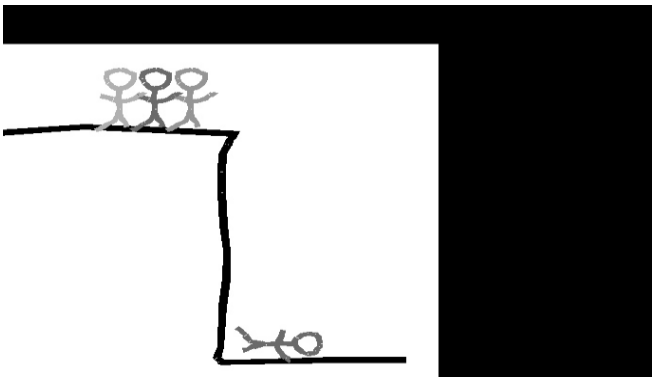
Patients occasionally fall…



(c)

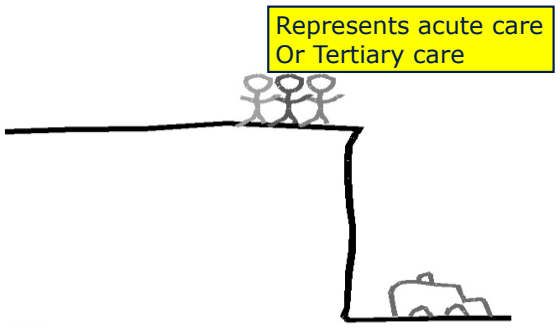
Slide 22

What's the solution?



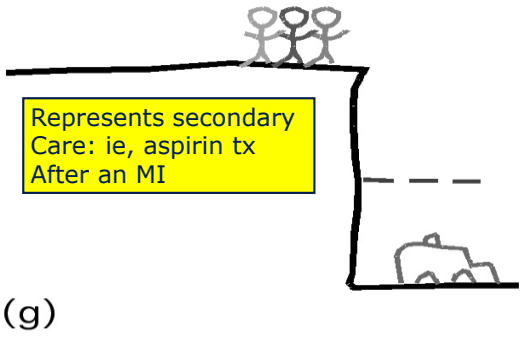
Slide 23

Ambulance at the bottom?



Slide 24

A net to catch them?



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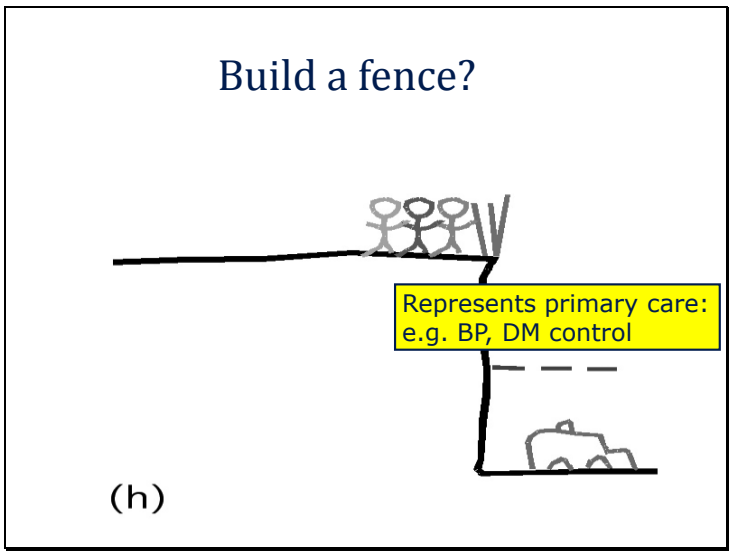

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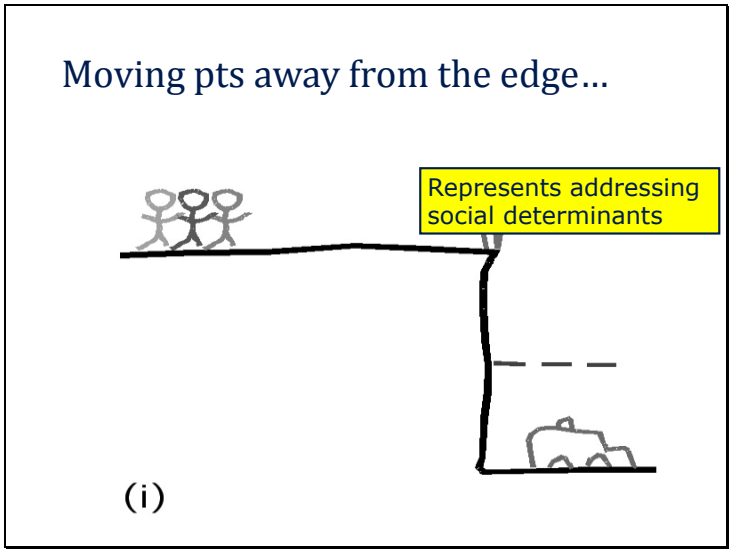
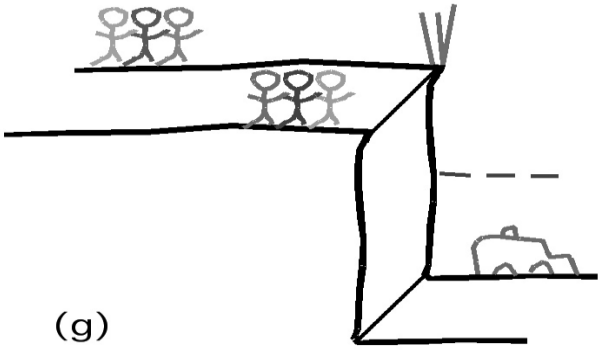


Slide 27

Is every cliff made equal?

Slide 28

Disparities: the cliff is three-dimensional



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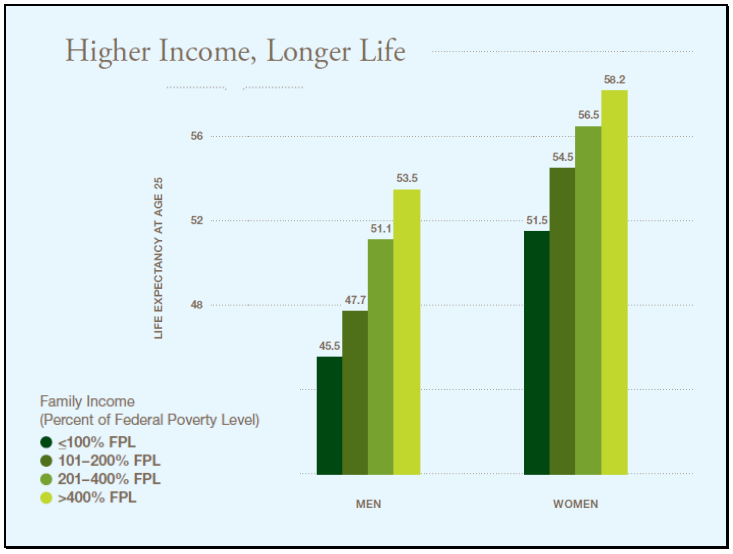
Examples of Social Determinants

Education
Income
Housing

Slide 30



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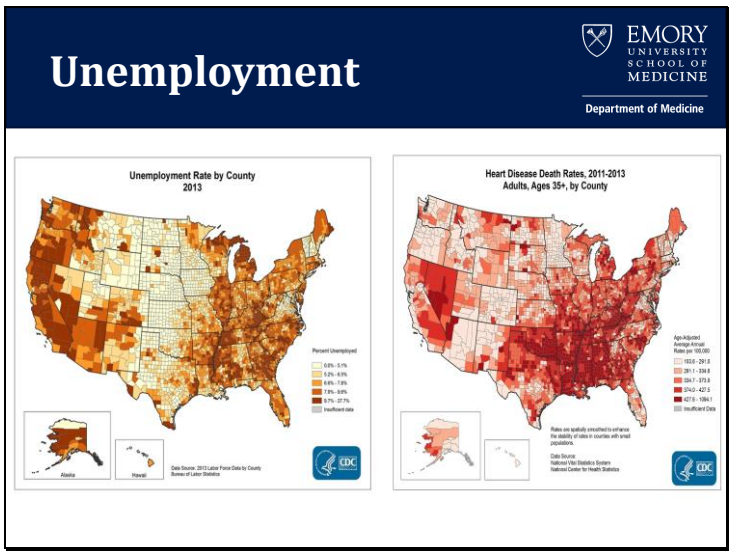

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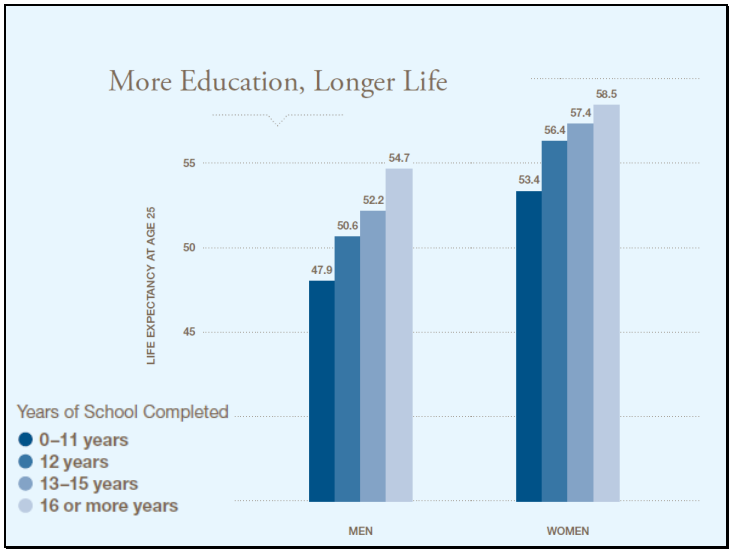

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Education

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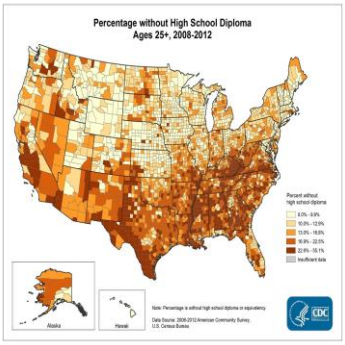
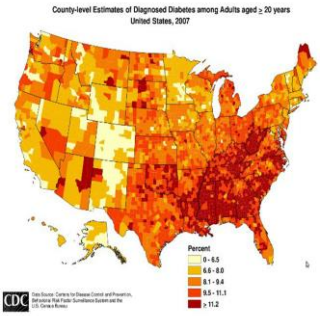
Department of Medicine





Slide 34

Home Ownership: why does it matter?

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- Relative to renters, homeowners have better physical health outcomes, lower child injury rates, higher, and more positive mental health, which is associated with lower blood pressure.

Macintyre S., J Epidiol Community Health. 1998, Shenassa E, Am J Public Health 2004, Cairney J, Boyle MH. Housing Stud. 2004, Rossi P, Housing Pol Debate. 1996

- Benefits of ownership independent of socioeconomic status, poor homeowners have better health outcomes than poor renters.

Cairney J, Housing Stud. 2004

- Children of homeowners more likely to graduate from high school and score higher on standardized tests.

Herbert C, A review and synthesis of the literature. Washington, DC: US Department of Housing and Urban Development, Office of Policy Development and Research; 2006. Available at: http://www.huduser.org/Publications/PDF/hisp_homeown9.pdf. Accessed July 7, 2009.

Slide 35

Whether you buy or rent…

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- Neighborhoods also matter

Slide 36

Impact of Segregation and concentrated poverty

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- ↓ Municipal services (transportation, police, fire, garbage)
- ↓ Purchasing power of income (poorer quality, higher prices, food deserts/ swamps).
- ↓ Access to Medical Care (primary care, hospitals, pharmacies)
- ↓ Poor performing schools

Slide 37

Neighborhood Segregation and Poverty

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- ↑ Personal and property crime
- ↑ Environmental toxins/ hazards(lead, pollutants, allergens)
- ↑ Abandoned buildings, commercial and industrial facilities

Slide 38

Multiple Choice 3

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You are seeing Mr. B, a 50 year-old man with diabetes, hypertension, hyperlipidemia, and obesity. He smokes ½ pack-per-day of tobacco, drinks 3-4 beers daily, and works as a janitor at your local hospital. He lives with his family in a low-income, racially segregated neighborhood. As you are finishing the encounter he says, "Doctor I need to ask your advice. My wife wants to move across town to a "better" neighborhood. My job won't change. What do you think?" In an effort to provide an evidence-based answer you reply, "moving may…"

a) Not improve your health unless your income increases
b) Not improve your health as access to alcohol is the same in both neighborhoods
c) Improve your health as fresh foods will be easier to get
d) Improve your health as tobacco ads will be bigger

Slide 39

Why?

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Residence in neighborhoods with concentrated poverty has been linked to all-cause mortality, poor health status, and high rates of chronic diseases. Several factors including higher-priced yet lower-quality foods, increased exposure to:

- tobacco and alcohol
- poor-quality housing
- limited transportation
- toxic environments

Winkleby MA, Cubbin C. Influence of individual and neighbourhood socioeconomic status on mortality among black, Mexican-American, and white women and men in the United States. J Epidemiol Community Health. 2003;57(6):444-52.
Patel KV, Eschbach K, Rudkin LL, Peek MK, Markides KS. Neighborhood context and self-rated health in older Mexican Americans. Ann Epidemiol. 2003;13(9):620-8.
Yen IH, Syme SL. The social environment and health: a discussion of the epidemiologic literature. Annu Rev Public Health. 1999;20:287-308.
Kwate NO, Lee TH. Ghettoizing outdoor advertising: disadvantage and ad panel density in black neighborhoods. J Urban Health. 2007;84(1):21-31.
Ludwig J, Sanbonmatsu L, Gennetian L, et al. Neighborhoods, obesity, and diabetes--a randomized social experiment. N Engl J Med. 2011;365(16):1509-19.

Slide 40

Healthcare Disparities-a visual

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- The below link will take you to an interactive map that is intended to highlight health disparities. Take some time to look at Atlanta or other areas that you may be familiar with

map

Slide 41

Further Disparities by Region

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This graphic shows the average life expectancy as of 2015 of individuals residing in these nearby zipcodes in the Atlanta area.

Source: http://www.societyhealth.vcu.edu/work/the-projects/mapping-life-expectancy.html

Slide 42

Social Determinants and health out comes – a visual

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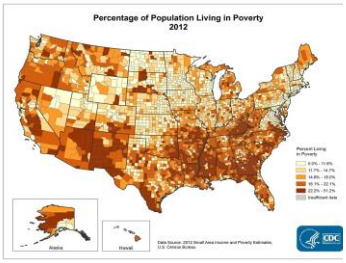
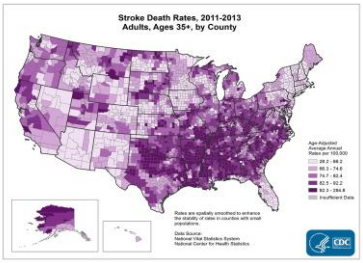
- The maps below highlight areas of poverty, employment, etc that closely "mirror" many negative health indicators.
- They also highlight issues in our southeast region.





Slide 43

Example: Photovoice Revealing Community Determinants of Health

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- Photovoice is a method where people enhance their community through photographs
- Emory students/residents learn from community members about lives of patients outside the clinical setting
- Community members learn about factors that impact health in their community

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Slide 45

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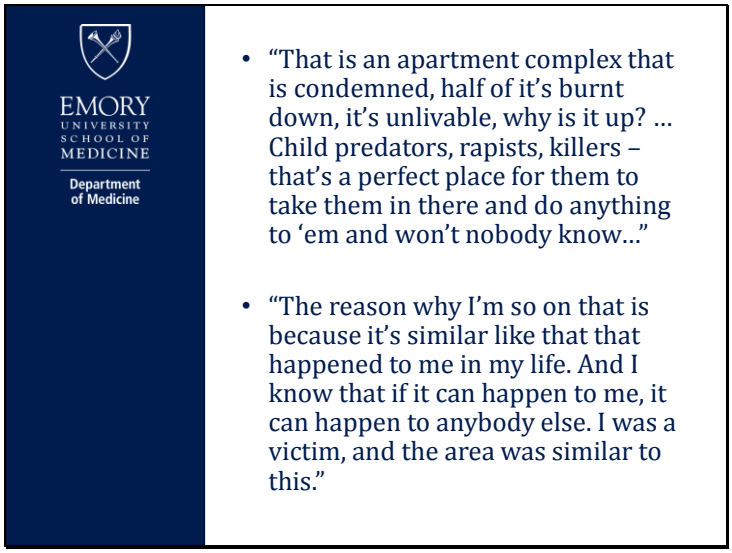
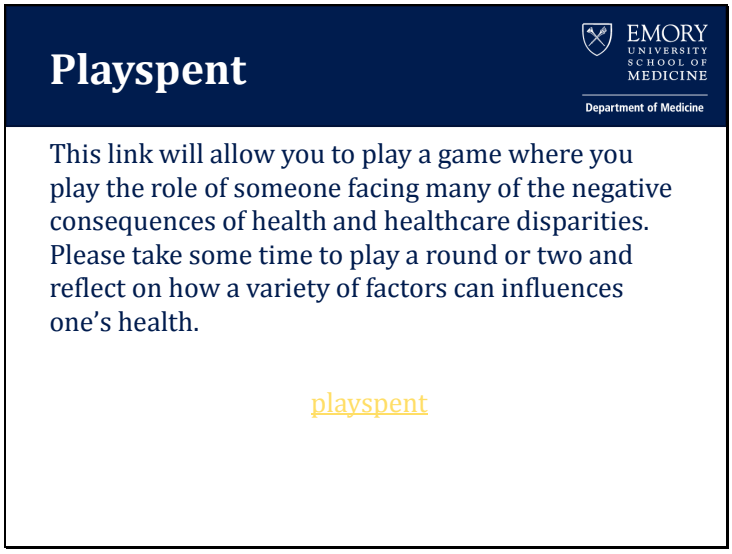
- "I don't know what that is. That's the whole point. I was raised in the country… I done seen some strange things. I *never* seen that before in my life. What is that? And then you stamp it with 99 cents on there. I might have 5 or 10 dollars to my name, and I need to find me some food over here to feed my family. Now that says 99 cents, I might not know what that is but, it's 99 cents. They put 99 cents on it and say 'Here you go, you can feed this to your children.' Ain't no way in the world."

Slide 50

Slide 51



Slide 52



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So what can you do?
EXPLORE DETERMINANTS OF HEALTH

Slide 54

S-E-L-F: An Approach to Social Barriers to Care

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S = Social Stressors and Sources of Support Sample questions

- "What is causing the most stress in your life?
- "Do you have friends or relatives that you can call on for help? Do they live with you or close by?"

E = Environment and Experiences of Medical Care

- "How safe would you say you feel doing activities in your neighborhood such as walking or shopping?"
- How easy is it for you to find the goods or services you want in your neighborhood (e.g. public transportation, banking, health care, exercise facilities, clothing, food, laundry or dry cleaning, etc.)?
- "What have your experiences with medical care been like for you?"

L = Life control and Literacy

- "Do you ever have trouble paying for food, medications, or other things you need?"
- "Do you have trouble reading your medication bottles, instructions, or other patient information?"

F = Faith in the facts and Family beliefs

Many people have thoughts about what has caused their symptoms and how to diagnose or treat them. What do you think is the cause or causes of your problem?

Green AR, Betancourt JR, and Carillo JE. Integrating social factors into cross-cultural medical education. *Academic Medicine* 2002; 77: 193-197.
Social Determinants of Health, 2nd Edition. Edited by Marmot M, Wilkinson. Oxford University Press 2006.

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For a practical exercise, follow the link below to see how the social determinants of health may present in a clinical situation

JGIM Example

Slide 56

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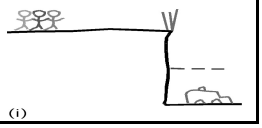
So what can you do?
ADDRESS DETERMINANTS OF HEALTH

How can we move them farther from the edge?



Slide 57

Some solutions…

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- Social workers, pharm Ds, diabetic educators
- Homeless resource list
- Low cost meds (e.g free amlodipine at Publix)
- Needymeds.org
- Pill counts, pill boxes, pill cards
- Language line
- Home visits
- Teach back
- Advocate
- Payees, relocation
- Think outside the box
- Involve families/friends

Slide 58

What skills will future physicians need?

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- Motivational interviewing
- Harm reduction
- Group visits
- Hotspotting

Slide 59

Motivational Interviewing

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- Simply giving patients advice to change is often unrewarding and ineffective
- MI incorporates:
  - Guiding rather than directing
  - Eliciting patient's own motivation
  - Refining your listening skills
  - Meeting the patient where they are

Slide 60

Useful MI Questions

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- What motivates you to control your diabetes?
- What changes would you most like to talk about?
- How many pills do you think you could take a day?

- *Caveat: Still important to be a doctor, educate patients, and make recommendations.*

Slide 61

Harm reduction

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- A range of public health policies designed to reduce the harmful consequences associated with various, sometimes illegal, human behaviors.
- Not enabling but supporting and engendering trust in the medical community

Slide 62

Harm reduction examples

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- Condoms to teenagers
- Housing first
- Methadone vs heroin
- Needle exchange program
- Starting 1 medication they'll take instead of 3 they won't.

Slide 63

Hot-spotting

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- Using data to find outliers and targeting them with interventions
- Tertiary prevention to address patient needs, improve care quality, and reduce cost
- 5% of Americans account for nearly 50% of costs
- 1% account for more than 20% of
- Focusing resources on these higher utilizers to decrease the cost curve and provide better care at lower cost for everyone

Slide 64

Multiple Choice 4

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In counseling a homeless smoker, which statement is correct?

a) Tobacco use reduction, rather than cessation, is an appropriate goal.
b) Homeless smokers are just as likely to quit smoking as other smokers.
c) Smokers with major depression report improved mood with smoking cessation.
d) Smokers with schizophrenia are more likely than other mentally ill smokers to successfully quit smoking.

Adapted from https://caringwithcompassion.org

Slide 65

Why?

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- Cessation of smoking among the homeless population is particularly difficult due to both a lack of structured support and access to health care.
- Furthermore, since smoking is much more prevalent among the homeless, there may be perceived social benefits to continue smoking.

Slide 66

In summary…

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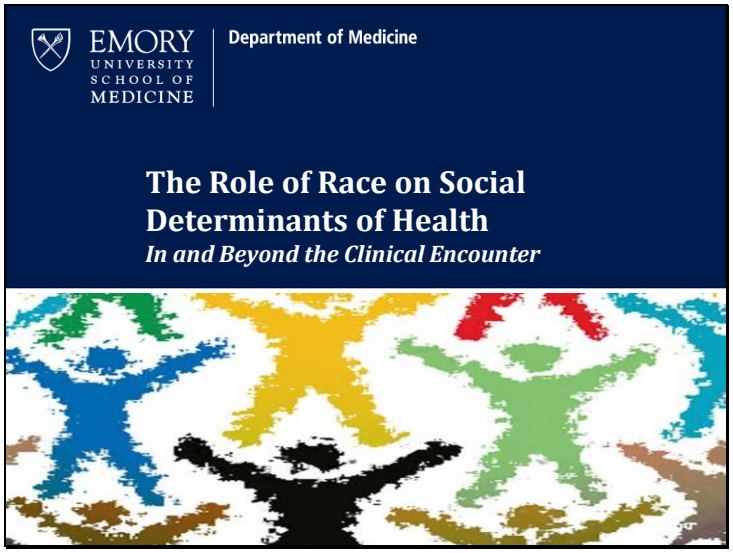
- Social determinants are the conditions in which people are born, grow, live, work and age that impact health.
  - Implications for life and health ***beyond*** medical care
- Physicians can explore determinants using the SELF model
- Once identified, a variety of interventions may be available

**Reasonable solutions may not always be available but exploring and understanding pt barriers leads to empathy rather than frustration.*

Slide 67

Module 2

Slide 1



Slide 2

Objectives

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By the end of this session participants should be able to:

1. Describe at least 2 ways race impacts on social determinants
2. Discuss implications of race/ bias on clinical encounter
3. List practical ways to improve equity and minimize impact of bias on clinical encounters

Slide 3

IAT

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- Here you will find a link to the implicit association test (IAT) website. Take the "race" test as well as any others that may have sparked your interest. Do take time to reflect on the experience afterward-was it what you expected?

IAT website

Slide 4

"Silent" Curriculum

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- Please read the short article linked here. It was written in 2015 by a medical student. You may find yourself asking many of the same questions as they did.

Slide 5

Disparities: the cliff is three-dimensional

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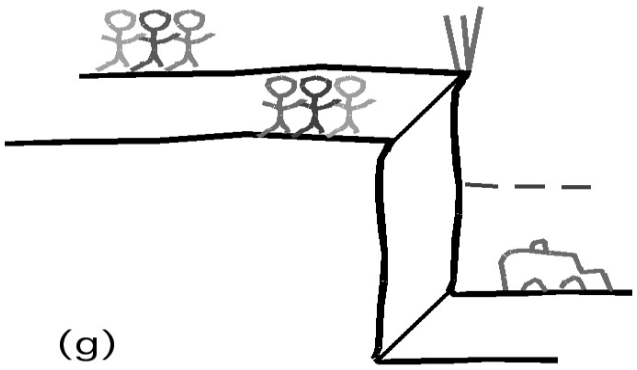

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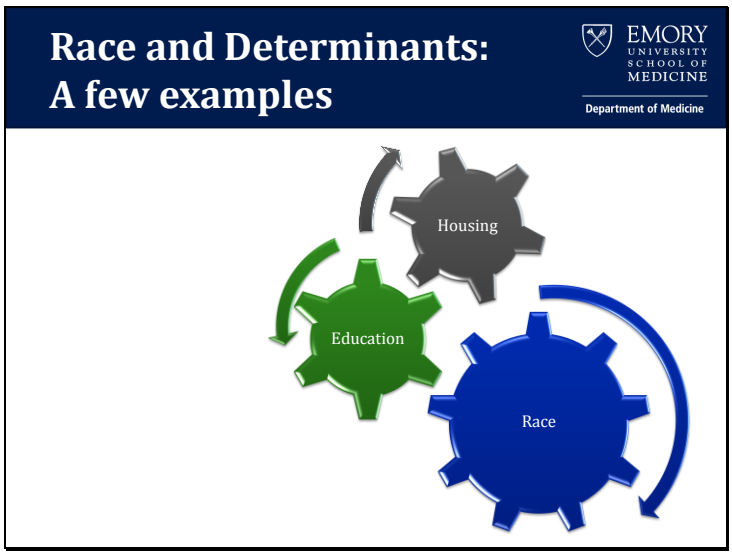

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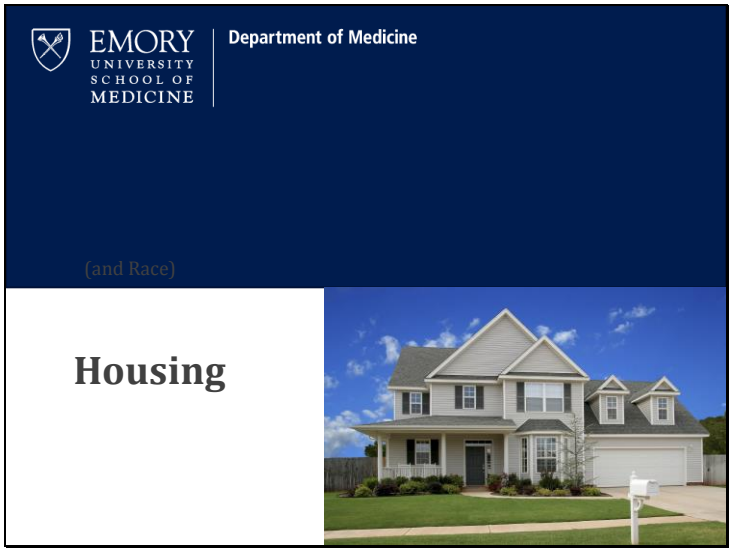

Slide 8

Home Ownership by Race

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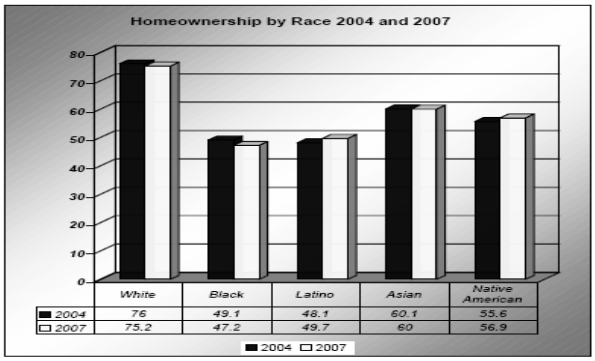

Source: Census Bureau

Slide 9

Disparities in Bank lending by relative income (1991)

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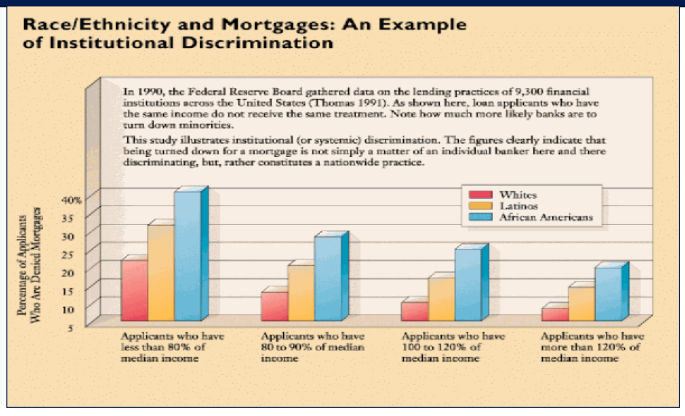

Slide 10

Minorities pay more for mortgage

from Center for Community Economic Development fact sheet 1998

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- African-Americans and Latinos more likely to get higher interest rates even with same credit scores
- In 1998, 51% of mortgages in Black neighborhoods subprime loans

Slide 11

Home Ownership: why does it matter?

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- Relative to renters, homeowners have better physical health outcomes, lower child injury rates, higher, and more positive mental health, which is associated with lower blood pressure.

Macintyre S,. J Epidiol Community Health. 1998, Shenassa E, Am J Public Health 2004, Cairney J, Boyle MH. Housing Stud. 2004, Rossi P, Housing Pol Debate. 1996

- Benefits of ownership independent of socioeconomic status, poor homeowners have better health outcomes than poor renters.

Cairney J, Housing Stud. 2004

- Children of homeowners more likely to graduate from high school and score higher on standardized tests.

Herbert C, A review and synthesis of the literature. Washington, DC: US Department of Housing and Urban Development, Office of Policy Development and Research; 2006. Available at: http://www.huduser.org/Publications/PDF/hisp_homeown9.pdf. Accessed July 7, 2009.

Slide 12

Whether you buy or rent…

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- Neighborhoods also matter

Slide 13

Impact of Segregation and concentrated poverty

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- Municipal services (transportation, police, fire, garbage)
- Purchasing power of income (poorer quality, higher prices, food deserts/ swamps).
- Access to Medical Care (primary care, hospitals, pharmacies)
- Poor performing schools

Slide 14

Neighborhood Segregation and health: The writings on the wall…

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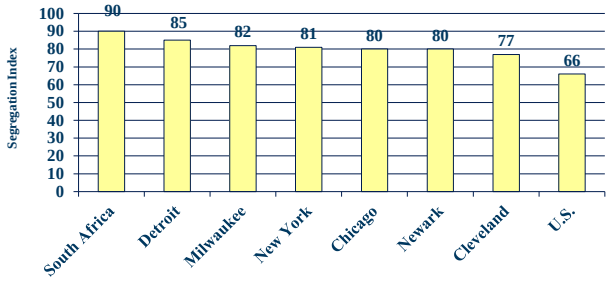
Slide 15

American Apartheid: South Africa in 1991 & U.S. in 2000



Source: Massey 2004; Iceland et al. 2002; Glaeser & Vigitor 2001

Slide 16

Neighborhood Segregation and health

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- Low-income/minority community (Seidenburg, Am J Health Prom 2010)
  - More tobacco retailers
  - Larger advertisements
  - Lower mean advertised price
  - Within 1000 feet of a school.
- Black neighborhoods (Kwate, J Urban Health, 2007)
  - more outdoor advertising space than white neighborhoods
  - Spaces disproportionately market alcohol and tobacco

Slide 17

How SDH and race interact

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This link will take you to a map depicting many aspects of the HIV/AIDS epidemic within the United States. Pay particular attention to what happens when you select the various SDH in conjunction with the available races

map

Slide 18

Neighborhoods, Obesity, and Diabetes — A Randomized Social Experiment

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1994 -1998, HUD randomly assigned 4498 women w/ children living in public housing in high-poverty to one of three groups:

- Housing vouchers redeemable in low-poverty census tract (where <10% of residents were poor)
- Unrestricted, traditional vouchers, with no special counseling on moving;
- Control group was offered neither

Slide 19

2008-2010 follow up

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Follow up data measuring health outcomes, including height, weight, and level of HbA_{1c}.

– *Assignment to the low-poverty–voucher group associated with a decreased risk of extreme obesity and diabetes.*

Slide 20

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Race and education

Slide 21

Percentage of College Grad by Race

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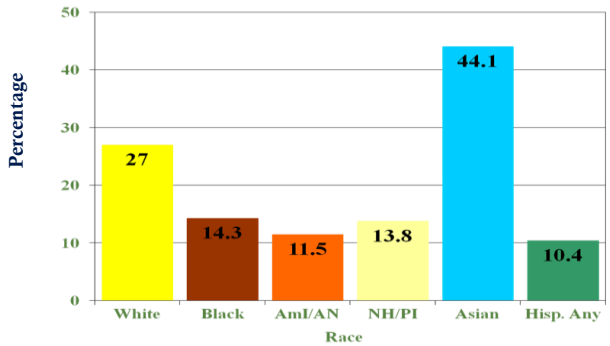

U.S. Census 2000

Slide 22

Education understandably linked to income

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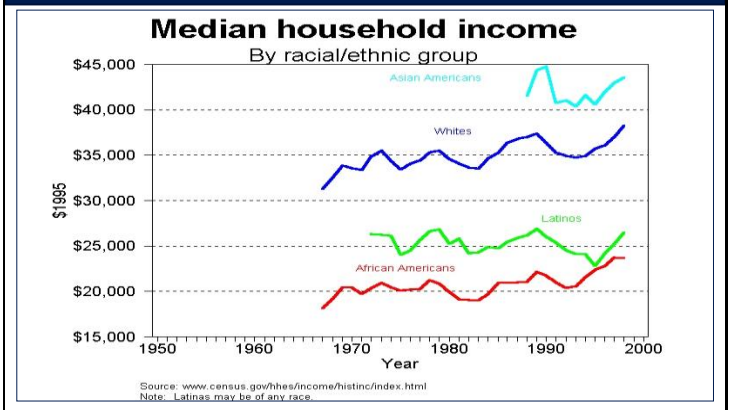

Slide 23

Even with Education: Bias in hiring…

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- Pairs of young, well-groomed, well-spoken college men with ***identical resumes*** apply for 350 advertised entry-level jobs in Milwaukee.
- 2 teams black and 2 white.
- In each team, one said that he had served an 18-month prison sentence for cocaine possession.

- Findings: Easier for a white male with a felony to get a job than a black male w/ clean record

Devah Pager; Am J Sociology, 2004

Slide 24

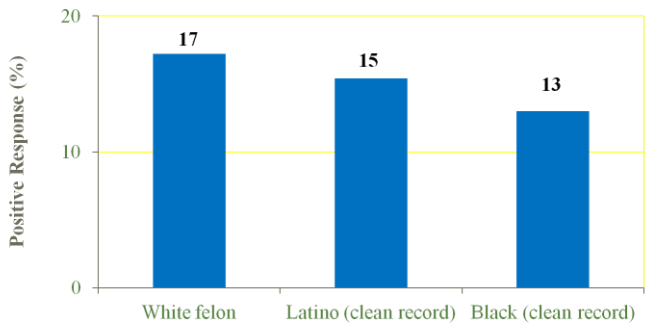
Percent of Applicants Receiving a Callback

Criminal Record	White	Black
No	34%	14%
Yes	17%	5%

Devah Pager; Am J Sociology, 2004

Slide 25

Race, Criminal Record, and Entry-level Jobs in NY, 2004



Devah Pager et al Am Soc Review, 2009; 169 employers

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Relevance to health…

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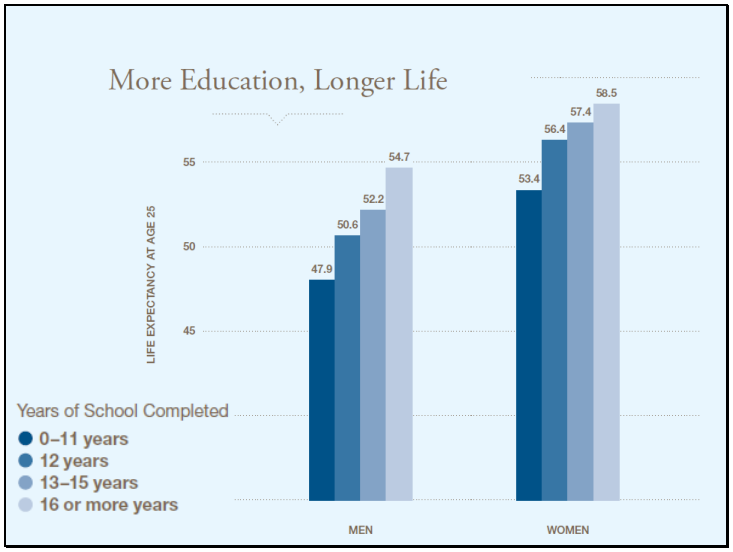

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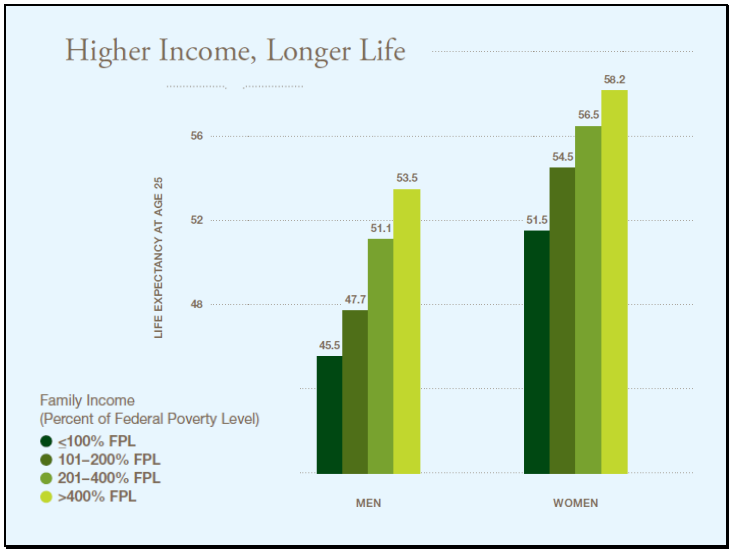

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Slide 30

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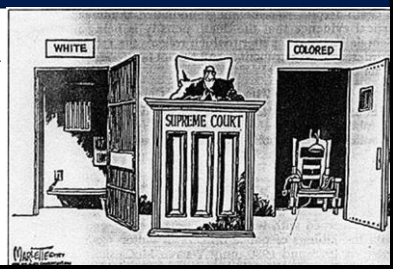
Race and criminal justice



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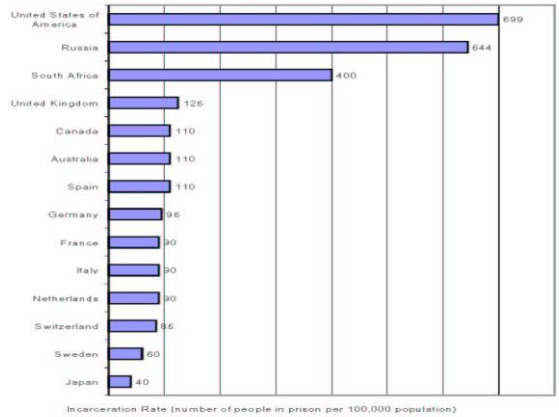
Comparing International Incarceration Rates



Source: Rate for Russia calculated from figures cited on previous page; for the US *Prisoners in 2000*: for all other nations, Roy Walmsley, *World Prison Population List* (2nd ed.), United Kingdom Home Office Research, Development and Statistics Directorate, July 2000.

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Incarceration rates by race

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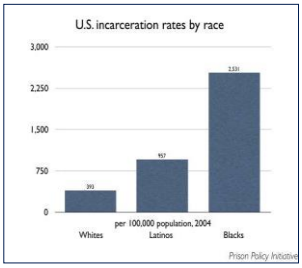

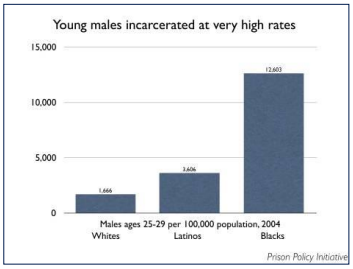

Source: Statistics as of June 30, 2004 from Prison and Jail Inmates at Midyear 2004, Tables 1, 14 and 15 and U.S. Census.

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Lifetime incarceration rates

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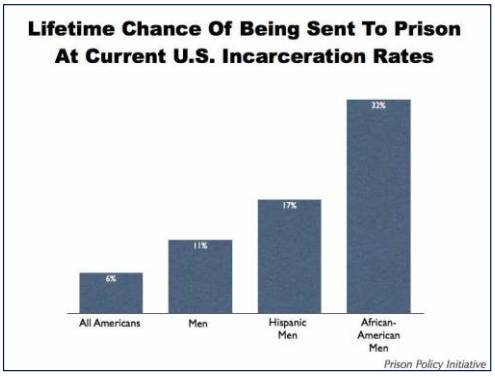

Source: Bureau of Justice Statistics, Prevalence of Imprisonment in the U.S. Population, 1974-2001.

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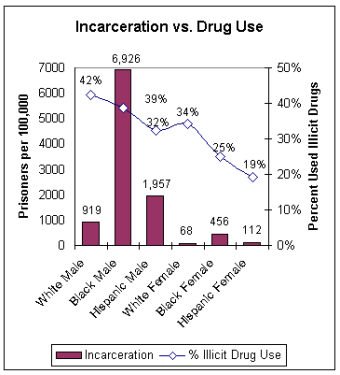
Incarceration vs Drug Use



- Black/ Latino drug use rates similar/ lower than White
- Rates of imprisonment for drugs are higher

Slide 35

Implications of being a felon?

Depending on the type of felony conviction, these are potential outcomes…

- Disbarment and limits on Business with the Government.
- Loss of Voting Rights and Jury Service.
- Ban on Firearms.
- Ineligible to enlist in Armed Forces.
- Limits on pilot's, private radio, and other federal licenses.
- Limits on Holding Federal Offices.
- Limits on Federal Employment.
- Limits on State Licenses and Occupational Restrictions.
- Loss of Federal Benefits.
- Travel Restrictions.

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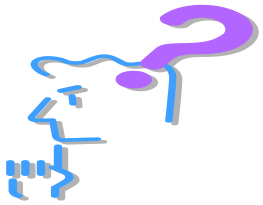
So race impacts social determinants…
Does it impact clinical care?



Are patients treated differently?
Does bias play a role?

Slide 37

We have heard about…
Tuskegee Syphilis Study

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"The Gradys"

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Black and White waiting rooms in the racially segregated wings of Grady Memorial Hospital

Slide 39

Okay, but what about today?

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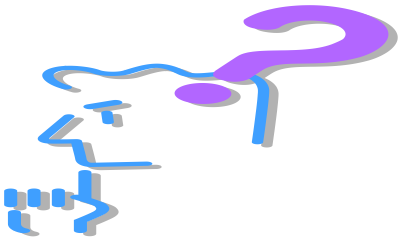

We have clearly made progress.
Do physicians treat patients differently?

Slide 40

Multiple Choice 1

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A colleague complains to you that he is upset about a patient who is switching to a competitor's practice. He notes that the patient is African American, as is the competitor, while your colleague is not. Aside from that, your colleague believes that the two practices are similar, and both are affiliated with the same insurers and health care systems. Which of the following is most likely outcome for the patient

a) His co-payments will decrease
b) His participation in decision making will decrease
c) His adherence to medication will increase
d) His access to specialists will increase

Slide 41

Why?

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- Patients given a choice of physicians are more likely to be in race concordant physician-patient relationships.
- Patients in race concordant physician-patient pairs reported greater satisfaction with their physician compared with respondents who were not.
- Satisfaction and perceptions of care have been associated with continuation of relationship and adherence.

Laveist TA, Nuru-jeter A. Is doctor-patient race concordance associated with greater satisfaction with care?. J Health Soc Behav. 2002;43(3):296-306.
Cooper-Patrick L, Gallo JJ, Gonzales JJ, et al. Race, gender, and partnership in the patient-physician relationship. JAMA. 1999;282(6):583-9.
Saha S, Komaromy M, Koepsell TD, Bindman AB. Patient-physician racial concordance and the perceived quality and use of health care. Arch Intern Med. 1999;159(9):997-1004.

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IOM: Race and Medical Care

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- Across healthcare
  - Minorities receive fewer procedures and poorer quality medical care than whites.
- Differences persist after controlling for
  - Insurance
  - SES
  - Stage and severity of disease, co-morbidity
  - Medical facility
- Persist in Medicare and the VA Health System
  - Differences in economic status and insurance coverage are expected to be minimized

Institute of Medicine, 2002

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Racial Disparity in Clinical Quality

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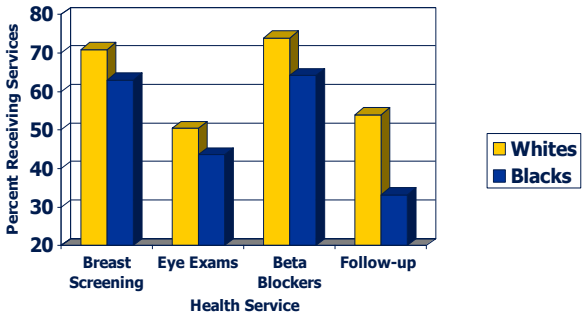

Schneider et al., JAMA, March 13, 2002

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Black / White Differences in Specialty Procedure Utilization Among Medicare Beneficiaries Age 65 and Older, 1993

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	Black	White	Black-to-White Ratio
Angioplasty (procedures per 1,000 beneficiaries per year)	2.5	5.4	0.46
Coronary Artery Bypass Graft Surgery (procedures per 1,000 beneficiaries per year)	1.9	4.8	0.40
Mammography (procedures per 100 women per year)	17.1	26.0	0.66
Hip Fracture Repair (procedures per 100 women per year)	2.9	7.0	0.42
Amputation of All or Part of Limb (procedures per 1,000 beneficiaries per year)	6.7	1.9	3.64
Bilateral Orchiectomy (procedures per 1,000 beneficiaries per year)	2.0	0.8	2.45

Source: Gornick et al., 1996

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Patients as Portrayed by Actors in Video Component of Survey

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Shulman KA. N Engl J Med 1999; 340: 618–626

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How does this happen?

- Van Ryn's evidence based conceptual framework of well-intentioned providers may provide differential treatment

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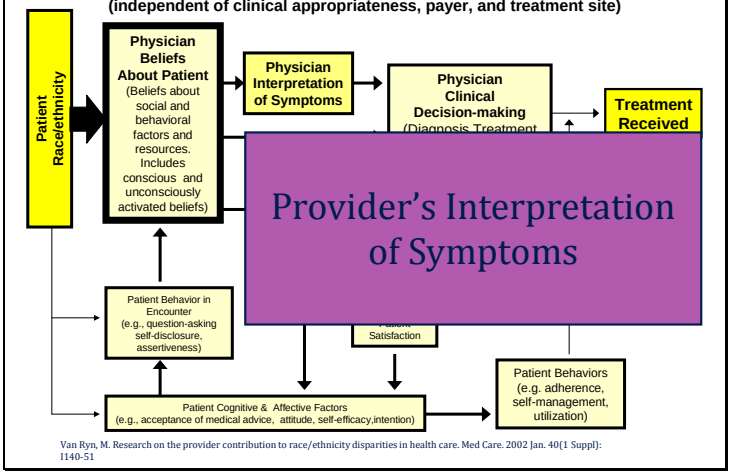
Figure 1
Hypothesized Mechanisms Through Which Provider Factors Influence Race/Ethnicity Disparities in Treatments Received
(independent of clinical appropriateness, payer, and treatment site)



Van Ryn, M. Research on the provider contribution to race/ethnicity disparities in health care. Med Care. 2002 Jan. 40(1 Suppl): I140-51

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Influenced by Beliefs about Patient

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Department of Medicine

- Mental health workers watched identical videos of an adolescent
  - Group 1: told **child of an alcoholic**
  - Group 2: told the **child was a social success**.
- Diagnoses varied even though based on the same adolescent exhibiting the same behavior

Burk JP, Sher KJ. Labeling the child of an alcoholic: negative stereotyping by mental health professionals and peers. J Study Alcohol. 1990 March;51(2):156-63

Slide 49

Figure 1
Hypothesized Mechanisms Through Which Provider Factors Influence Race/Ethnicity Disparities in Treatments Received
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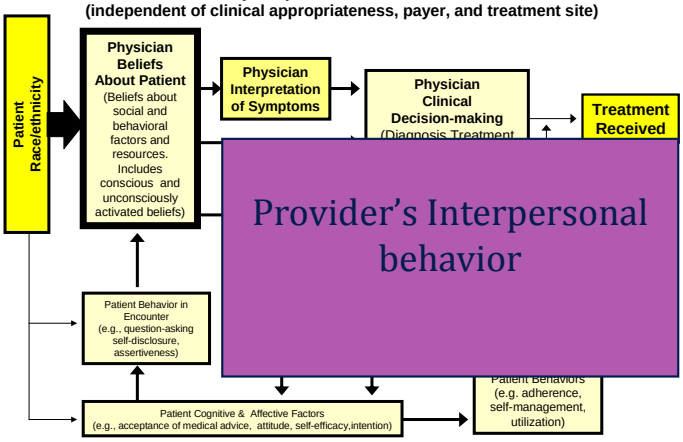

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Influenced by beliefs about patient

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- 150 physician-patient encounters observed
- Patient characteristics (ethnicity, sex, age, appearance) significantly influenced physician interpersonal behaviors
  - nonverbal attention,
  - empathy,
  - courtesy,
  - information giving

Hooper EM, Comstock LM, Goodwin JM, Goodwin JS. Patient characteristics that influence physician behavior. Med Care. 1982 Jun;20(6):630-8

Slide 51

Figure 1
Hypothesized Mechanisms Through Which Provider Factors Influence Race/Ethnicity Disparities in Treatments Received
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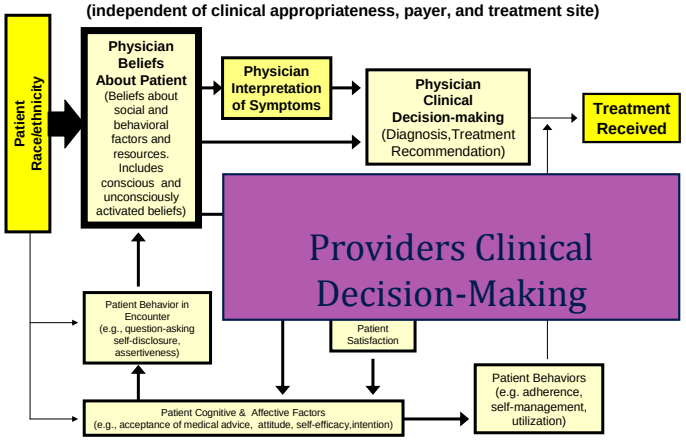

Van Ryn, M. Research on the provider contribution to race/ethnicity disparities in health care. Med Care. 2002 Jan. 40(1 Suppl): I140-51

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Influenced by beliefs about patient

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Opinions about appropriateness: Bogart Study

- HAART tx given to pts. perceived likely to adhere
- Examined characteristics assoc predictions of adherence
- Randomly assigned MDs to review patient vignettes varied by gender, disease severity, ethnicity, and risk group
- Black pts. more likely rated as non adherent compared to otherwise identical counterparts

Bogart. Med Decis Making 2001; 21: 28–36

Slide 53

Moral Rationing

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- Do we always make clinical decisions based on just the medical facts?
- Do we use non clinical descriptions of patients?
- Can you give examples of treatment that you have seen that was not based purely on objective findings?
  - "good guy", "solid citizen," "difficult"
  - Cardiac surgeon refusing valve repair b/c patient will **"just going to go out and do drugs**"

Slide 54

Overapplication of population statistics: Possible scenarios…

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- This person has difficulty with transportation and cannot keep their appt. so I won't refer them…
- This person has limited social support so I won't offer transplant…

Slide 55

Multiple Choice 2

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Which of the following is unlikely to influence the doctor–patient relationship?

a. The cleanliness of the office.

b. Physician's bias toward patients.

c. Past experiences of patients.

d. Personal prejudices of patients against certain ethnic groups.

Slide 56

Why?

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Although the level of office cleanliness can influence the clinical encounter, personal biases, past experiences, and other societal forces are much more likely to have an impact on the doctor-patient relationship.

Source: Hark, L; DeLisser, H. "Achieving Cultural Competency: A Case-Based Approach to Training Health Professionals

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So, what can we do?

Slide 58

Multiple Choice 3

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Which of the following approaches is most likely to address patients' and families' concerns about perceived racial disparities in clinical care and research?

a. Emphasize that race has no bearing on health care.
b. Assure patients that all medications and treatments have established safety and efficacy in all race/ethnic groups.
c. Openly discuss established differences among race/ethnic groups related to treatment and areas where differences may exist but remain unknown.
d. Limit opportunities for patients to speak to family members and friends about their concerns.

Source: Hark, L; DeLisser, H. "Achieving Cultural Competency: A Case-Based Approach to Training Health Professionals

Slide 59

Why?

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- Open dialogue between the doctor and the patient should always be the first priority
- Acknowledging disparities in research and in care is an important step in establishing this dialogue

Source: Hark, L; DeLisser, H. "Achieving Cultural Competency: A Case-Based Approach to Training Health Professionals

Slide 60

Enhance Motivation to Reduce Bias

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- Contemporary bias largely unintentional
- But those unaware have little motivation for change.
- Today's discussion meant to provide a social/ historical context of race and health
- Not meant to be "politically correct" or blame
- Rather to address the desire in all MDs to provide the best care

Slide 61

Enhance Understanding of the Psychological Basis of Bias

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- In past "pathologized"
- Research suggests this cognitive strategy that results in bias is a normal part of human cognition.
- Allows providers to approach biases in a more informed, open way.
- Not just for one type of provider
- While no blame needed, we must PUSH for solutions

Slide 62

Minimize disparities

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- When making tx decisions (esp. if differs from standard of care)
  - Consider pts perceived vs actual barriers
  - Explore and address social, cultural barriers when possible (prescription help, transportation, etc)
- QI works
  - Multiple reports of decreased disparities with ***guideline*** or ***protocol*** based care (renal transplant, DM, etc)
- Future leaders/ policy experts
  - ***Consider policies that address the social determinants of ill-health and disparities (eg education)***

Slide 63

Other Considerations

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- More bias/ stereotyping found during stress
  - Difficult to control stress during training
  - Work hour rules, etc. may help
- When making tx decisions
  - Consider pts perceived vs actual barriers
  - Explore and address social, cultural barriers when possible (prescription help, transportation, etc.)
- QI works
  - Multiple reports of decreased disparities with ***guideline*** or ***protocol*** based care (renal transplant, DM, etc.)

Slide 64

Other policy/ advocacy items…

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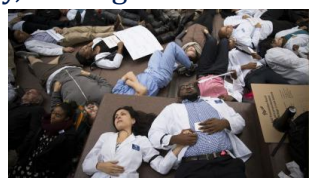
- Collecting race/ethnicity data
  - Review provider practice patterns & metrics/ compared by race
- Diverse work force
- Advocacy – clinical, health system, community, and legislative



Slide 65

Important: Not "their" problem but "our" problem

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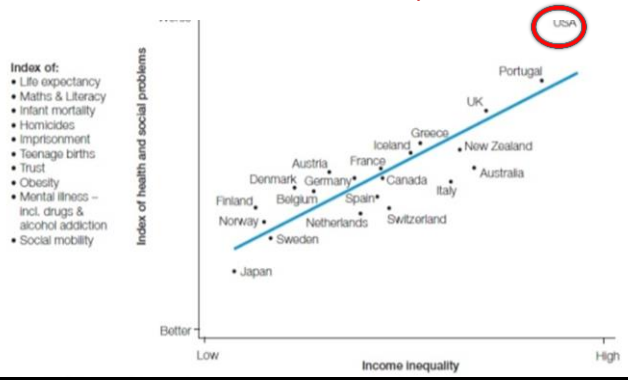
Health and Social Problems are Worse in More Unequal Countries



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Summary

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- Multiple determinants of health disparities outside the clinical encounter
- Determinants of health disparities in the clinical encounter
  - Subconscious bias may impact clinical encounter
  - Exploring/addressing determinants may improve care
- Physicians' role – determined by you
  - Impact individual pt encounters
    - Appreciation of pts' social context important and your own bias and system inequity
  - Community & political engagement/ advocacy not mandated
    - But potential impact great

Slide 67

"Of all the forms of inequality, injustice in health care is the most shocking and inhumane."

Dr. Martin Luther King, Jr

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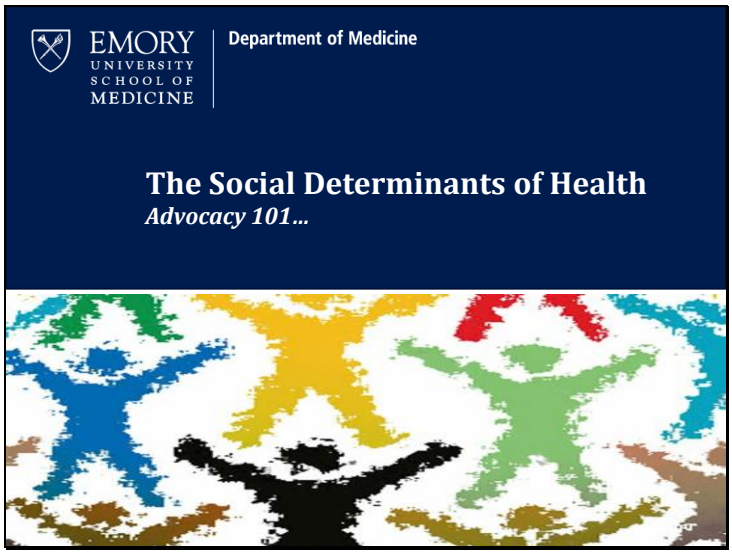
Module 3

Slide 1



Slide 2

Slide 3

Multiple Choice 1

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At a team meeting you discuss a new program in your community designed to reduce differences in colon cancer screening between different ethnic groups. Your nurse states that further efforts to reduce colon cancer screening disparities are no longer needed, and shares a google search on his smart phone that states more people are getting screening overall.

You respond that the best source for accurate and current information on US health disparities is:

a) Institute of Medicine
b) State Department of Vital Statistics
c) Center for Medicare and Medicaid services
d) Agency for Healthcare Research and Quality
e) United States Census

Slide 4

Why?

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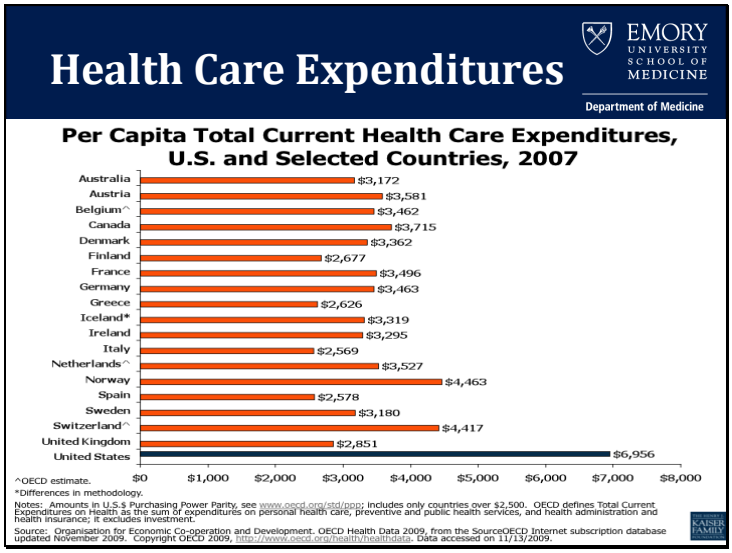
- The Agency for Healthcare Research and Quality (AHRQ) produces the *National Healthcare Quality Report* (NHQR) and the *National Healthcare Disparities Report* (NHDR).
- These reports provide an overview of national trends in the areas of patient-centered safe and equitable care by commenting on disparities and the opportunities for improvements.
- While reports from other organizations or state health records might also provide some of these data, the AHRQ reports are considered the most up-to-date.

http://www.ahrq.gov/research/findings/nhqrdr/nhdr12/nhdr12_prov.pdf

Slide 5



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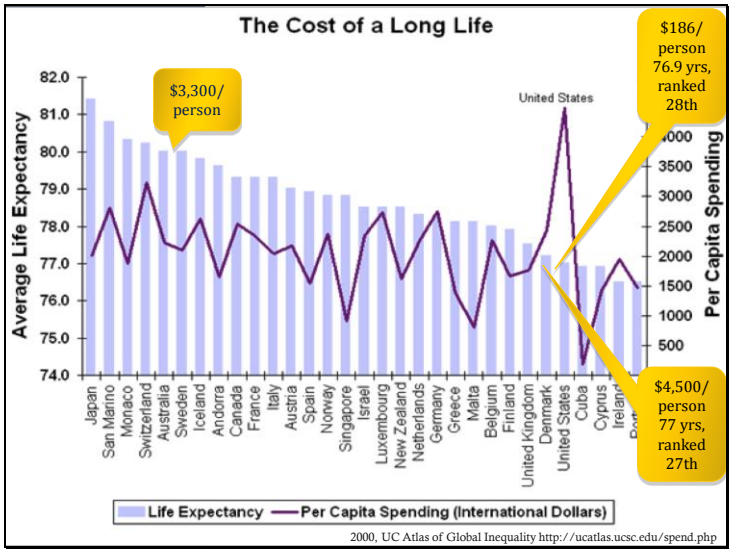

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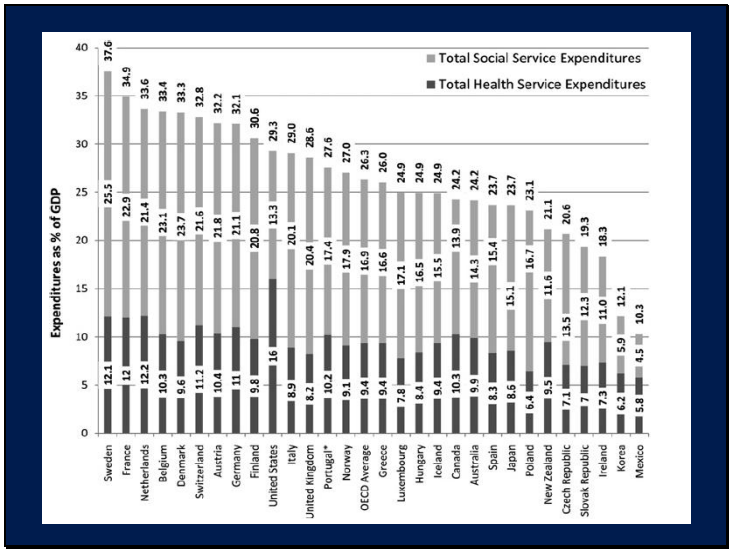

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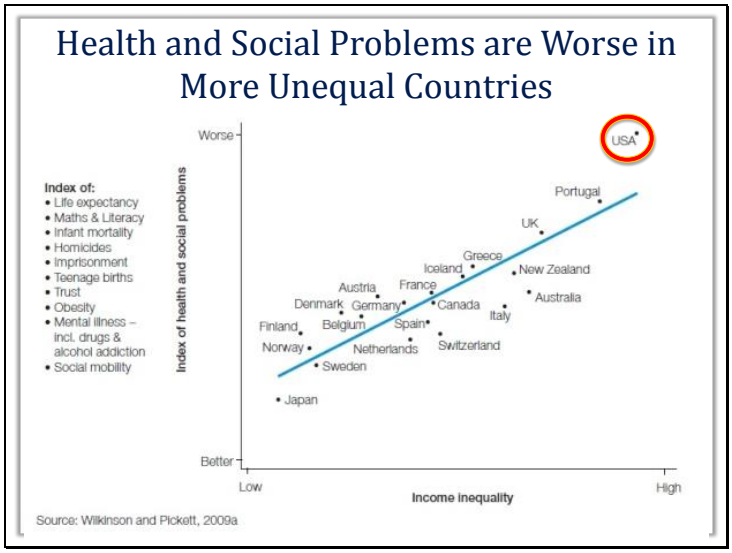

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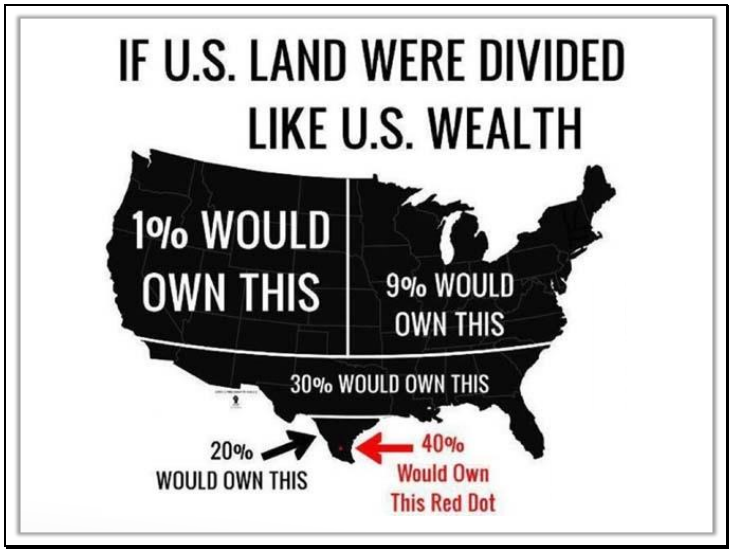

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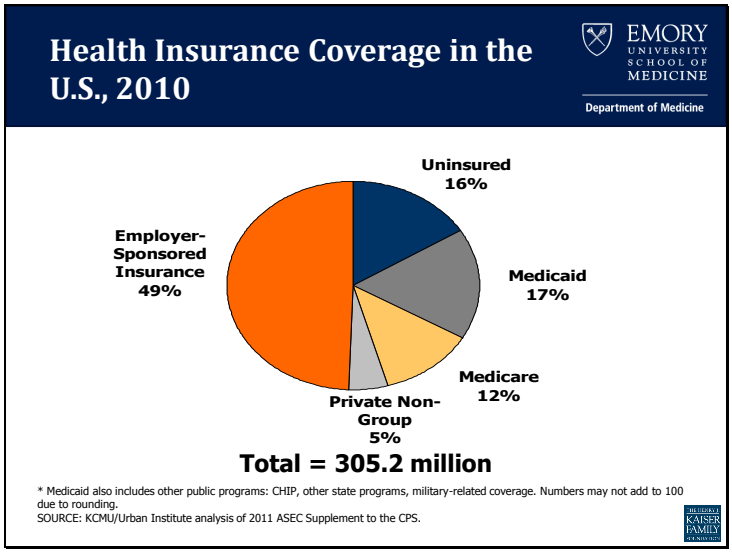

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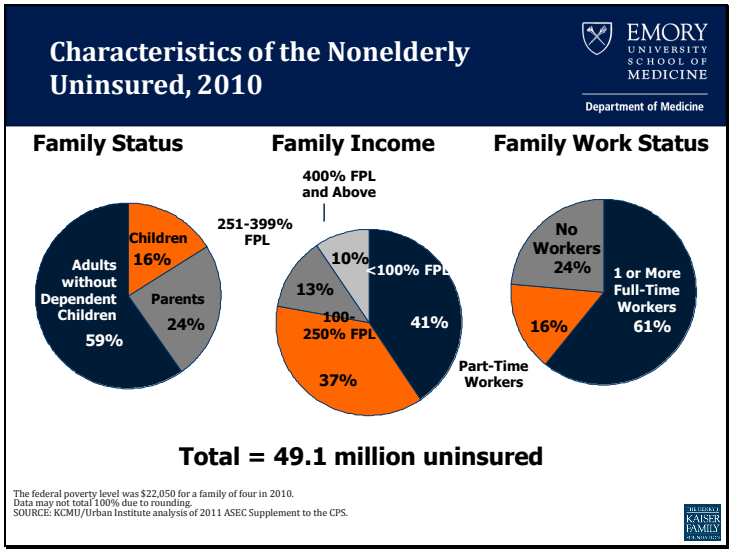

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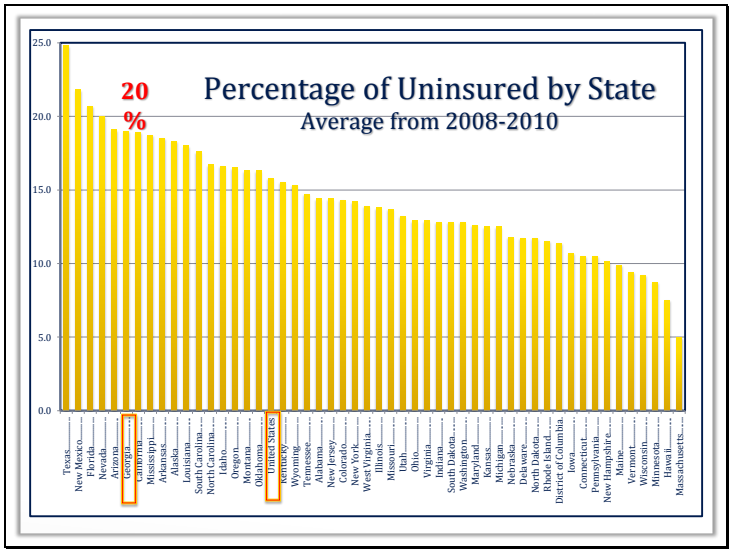

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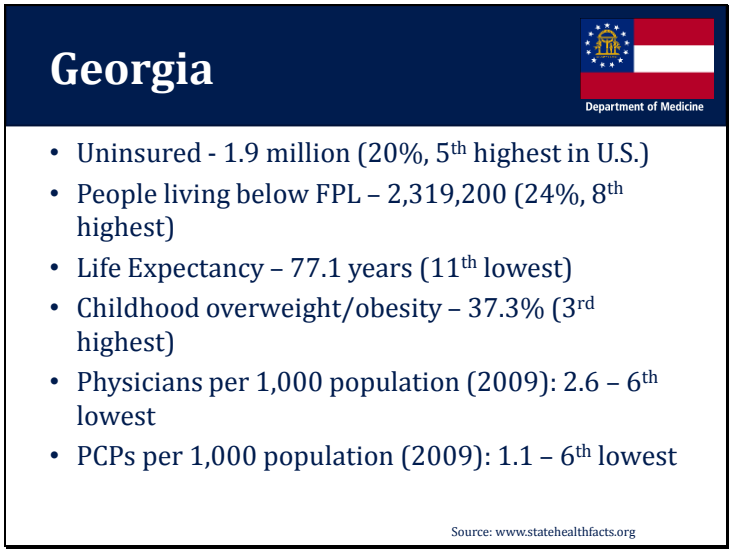

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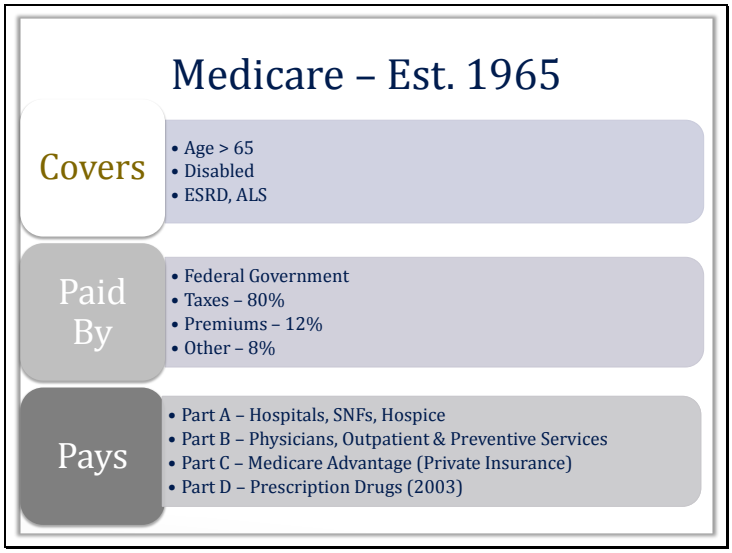

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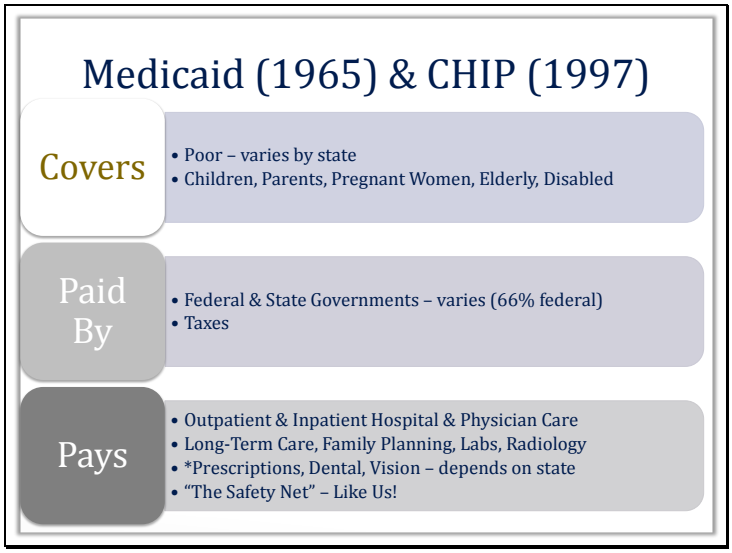

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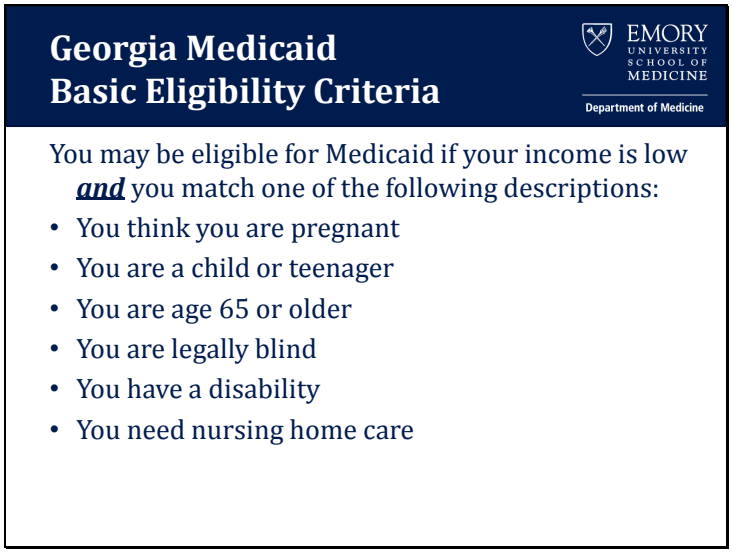

Slide 17

Medicaid and Peach Care Coverage

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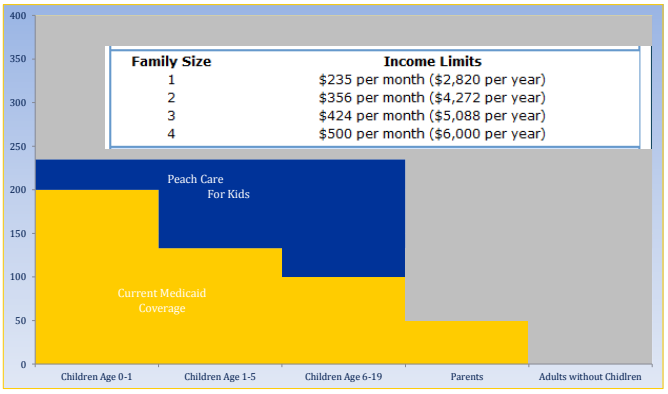

Slide 18

Health Reform Hits Main Street

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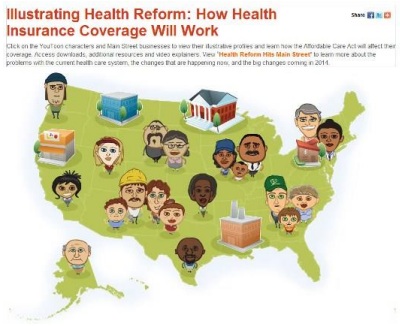

http://kff.org/health-reform/press-release/new-animation-explains-changes-coming-for-americans-under-obamacare/

Slide 19

Exploring the Uninsured

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The link below will take you to a tool that allows you to look more closely at the different types of uninsured populations and how the ACA affects them

Interactive Tool

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ACA Update

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- **8 million people signed up for private insurance through marketplace.**
- **3 million young adults gained coverage on their parents' plan.**
- **3 million more people enrolled in Medicaid and CHIP**
- **5 million people** are enrolled in plans that meet ACA standards **outside the Marketplace**. When insurers set premiums for next year, they are required to look at everyone who enrolled in plans that meet ACA standards, both on and off the Marketplace.
- **5.7 million people will be uninsured** in 2016 because 24 States have not expanded Medicaid.

http://www.whitehouse.gov/the-press-office/2014/04/17/fact-sheet-affordable-care-act-numbers

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ACA Update

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- Health care costs are growing at the slowest level on record
- CBO projects the deficit will shrink more and premiums will be lower than expected
- Medicare spending growth is down

http://www.whitehouse.gov/the-press-office/2014/04/17/fact-sheet-affordable-care-act-numbers

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What was supposed to happen… Everyone eligible for something

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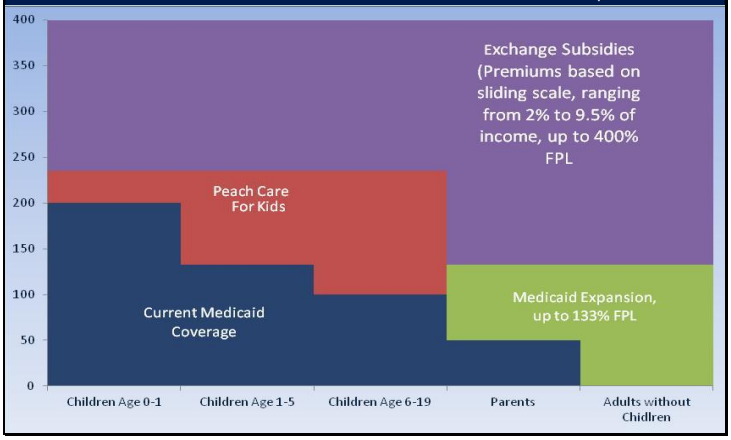

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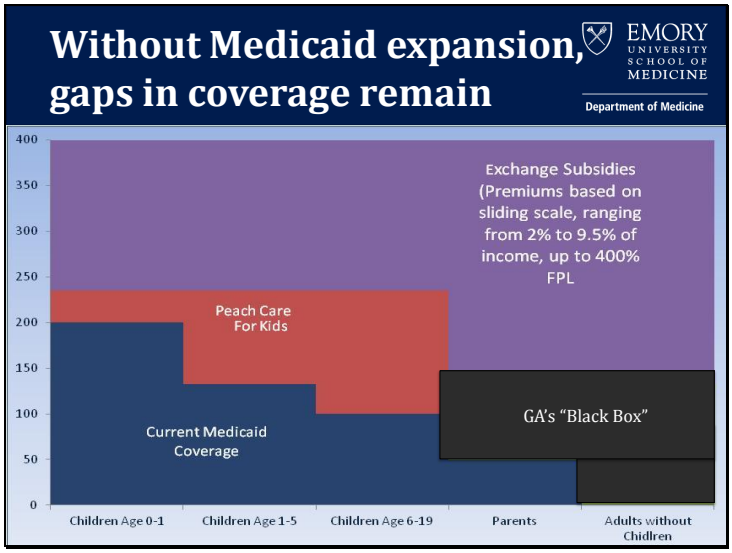

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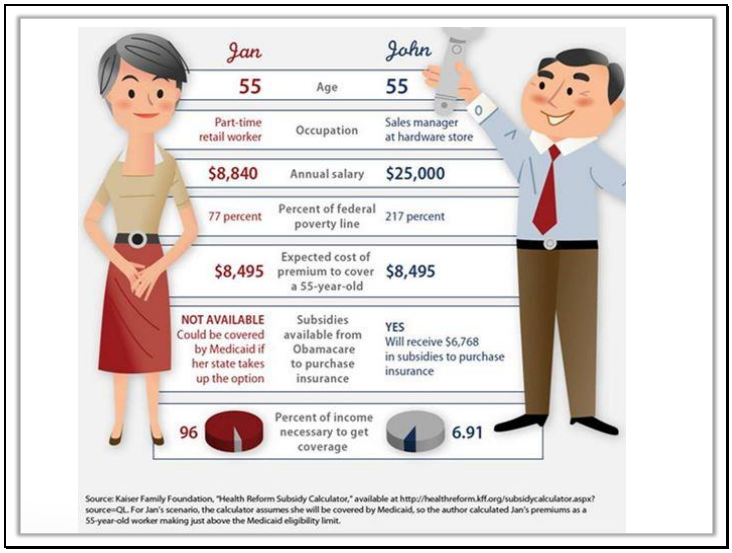

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From finance overview to a case…

Slide 26

A Case

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- Ms. Smith is a 45 yo woman with diabetes, hypertension, obesity & depression presents to you as a new patient
- She was last seen about 2 years ago
  - Hemoglobin A1c 9.6%
  - Blood Pressure 162/90
  - LDL 138
  - BMI 34
  - Creatinine 1.8
  - Previous provider noted “crying during visit,” “insomnia,” and “high stress level”
- 2 appts scheduled since then - both “DNKAs”

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You take a Good History In the last 2 years...

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- She was working for the first year, had insurance, and was seeing a private doctor
- When she lost her job, she lost her insurance, and couldn't afford her brand name meds.
- Her mother had a stroke, was in a rehab facility for a while, but after 30 days, it would have cost her $100/day to keep her in a SNF. Her mother could walk a little bit, but was unable to cook or bathe for herself. Ms. Smith decided to bring her home and care for her herself.

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A Real Good History

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- With the extra costs of her mother being home, she found a cheaper apartment in a different neighborhood.
- The nearest grocery was now 15 minutes away, and "didn't have many vegetables anyway"
- The nearest park is a few blocks away, but "filled with drug dealers and crazy people."
- With the stress of being unemployed and her mother being home. She wanted to see a psychiatrist, but didn't know how to get an appointment with one, or if she could afford it.
- She's happy to see you today. She only had to wait 2 months to get the appointment...

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What Health Policy issues arise in this case?

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Slide 30

Pocket Guide Tool

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The link below will take you to a sample "pocket guide" which can be used to help direct your future clinical encounters

Pocket guide

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Examples of Federal Policy?

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- Providing health insurance (Medicare)
- Providing health care (VA, IHS)
- Regulating health insurance (Affordable Care Act)
- Public Health (CDC)
- Regulation & Safety (FDA, Medicare)
- Research (NIH)
- Health Access (FQHCs)
- Medical Training (GME)

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Examples of State Policy

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- Providing health insurance (Medicaid)
- Health promotion (WIC)
- Taxes & Regulations (tobacco, food, guns)
- Public health
- Safety net (public hospitals, immigrants, elderly, long term care)
- Medical training (schools)
- Health providers (NPs, PAs, MDs)
- Mental health & substance abuse
- Implementation of federal health rules (ACA)

Slide 33

Examples of Community Policy

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- Public health
- Wellness promotion (community centers, parks, transportation)
- Access to care

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Examples of Institutional Policy

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- Medical centers
  - Access
  - Affordability
  - Coordination & integration
  - Culture
  - Protocols
  - Quality Improvement
- Employers (wellness, smoking, maternity & paternity leave, child care)
- Schools (nutrition, vending machines, PE)

Slide 35

Multiple Choice 2

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You work in a small community hospital that has recently experienced an influx of patients from a new immigrant community. Most of them speak limited English. You have been using a telephone interpreting service to communicate with them, but your administrator is telling you that you need to stop because it is too expensive.

Which would be the best response to the administrator?

a) "Yes, we can ask patients to bring family"
b) "Yes, they can speak English well enough for simple communication"
c) "Yes, I speak enough of their language to get by"
d) "No, this puts us at risk for Federal fines"
e) "No, this will increase malpractice premiums"

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Why?

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- Health care organizations that receive any federal assistance must provide equal access to patients who cannot speak English well or they will be in violation of Title VI of the Civil Rights Act of 1964 .
- Providing an interpreter is not the patient's responsibility, and family members should not be used.
- Communication in English by patients with limited English proficiency, or by clinicians with limited foreign language proficiency should be avoided.
- While language-concordant communication may decrease risk for malpractice litigation it is not generally used in determining malpractice premiums.

Chen AH, Youdelman MK, Brooks J. The legal framework for language access in healthcare settings: Title VI and beyond. J Gen Intern Med. 2007;22 Suppl 2:362-7.

Slide 37

Clinician, policy expert, or community activist?!

What's a physician's social responsibility to address health-related matters beyond providing care to individual patients?

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AAMC

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Students should demonstrate…

"knowledge of the important non-biological determinants of poor health and of the economic, psychological, social, and cultural factors that contribute to the development and/or continuation of maladies."

Slide 39

Medical education transforms learners in less desirable ways

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Medical students tend to become

- Less idealistic
- More cynical
- Less benevolent
- Less humanitarian
- Less tolerant of vulnerable patients

Eron, 1958; Gordon and Mensh, 1962; Gray et al., 1965; Kopelman, 1983; Merrill et al., 1994; Merrill et al., 1991; Merrill et al., 1995, 1996; Reinhardt and Gray, 1972; Rezler, 1974; Testerman et al., 1996

Slide 40

Med School Performance and Community Service

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Those with highest service (>18 hr)…

- Higher GPA
- Higher USMLE Step 2 scores
- Higher scores/rankings by their program directors
- Not associated with OSCE performance

Blue AV, Academic Medicine 2006 supp

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When we lobby, what are our issues?

Landes Arch Int Med. 2000.

Reports of 84 Health Legislative Assistants on How Much Physicians Lobby for the Following Issues*

Issue	Amount of Lobbying		
	"A Lot"	"Somewhat"	"A Little" or "Not at All"
Increasing or maintaining physician compensation	41 (49)	19 (23)	24 (29)
Increased funding for medical research	34 (40)	29 (35)	21 (25)
Improving the future viability of Medicare	33 (39)	27 (32)	24 (29)
Giving patients the right to sue their health maintenance organization	33 (39)	25 (30)	26 (31)
Increased funding of medical education	28 (33)	36 (43)	20 (24)
Malpractice tort reform	13 (15)	18 (22)	53 (63)
Better access to care for uninsured citizens	12 (14)	33 (39)	39 (46)
Tobacco control legislation	5 (6)	20 (24)	59 (70)
The right to have an abortion	0	6 (7)	78 (93)

*Data are given as the number (percentage) of legislative assistants.

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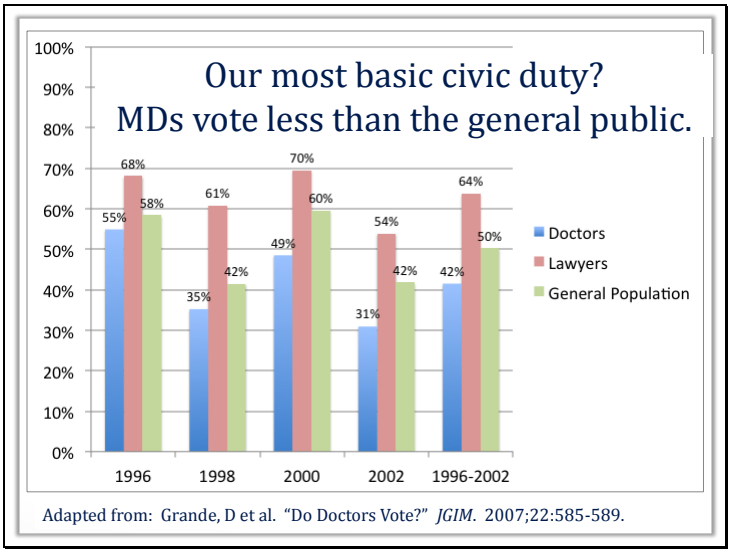

Adapted from: Grande, D et al. "Do Doctors Vote?" *JGIM*. 2007;22:585-589.

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Physicians are well-suited for this work…

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- Knowledgeable of medical aspects of issues
- Poised to delineate links between social factors and health
- Trusted by the public as a credible source of information
- Able to access policy makers and leaders because of social standing

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What's Your Issue?

- Why are YOU promoting it
- Who's your target?
- Who are your allies?
- What are your resources?
- What's the right campaign?
  - Legislative
  - Executive/Regulatory
  - Media
  - Institutional
  - Direct Action

CoverThe Uninsured

OUR FUTURE OUR CRISIS FIGHT GLOBAL AIDS

HOURS WATCH

Slide 45

What are the Basic Skills of Advocacy?

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- Writing
  - Elected officials
  - Media (local newspapers)
- Speaking
  - Elected officials (lobbying)
  - Media (TV, radio)
  - Community organizations

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But You're Busy

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- Work within organizations
  - Physician/Specialty (e.g. SGIM, ACP)
  - Physician/Advocacy (e.g. National Physicians Alliance, Doctors for America, Physicians for Social Responsibility)
  - Local (e.g. Georgians for a Healthy Future, HealthSTAT)
  - National
  - Political parties?
- Keep it related to you & your patients

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Can you make it a career?

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- Academic – scholarship, research
- Public health – local, state and national public health agencies
- Administrative – clinical leadership
- Politics - 19 physicians currently in Congress, many serve on staff

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Multiple Choice 3

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As the medical director of a hospital-based practice, a hospital administrator approaches you to discuss your practice's performance in diabetes care. She notes lower quality care for some minority groups and is particularly concerned because the data will soon be publicly reported.

The most appropriate next step would be to

a) Create a nurse-led care management team
b) Provide incentive payments for reduced disparities in care.
c) Allow physicians to preview the report and give them 60 days to improve
d) Institute cultural competency training

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Why?

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- Registered nurse case management via treatment algorithms resulted in significant improvements in process measures and outcomes in multiple studies.
- Additionally, culturally tailored programs that targeted patients also improved diabetes.
- While physician cultural competency training was included as part of a multitarget intervention, the independent effects of this training on outcomes has not been determined. Other approaches have not been studied.

Peek ME, Cargill A, Huang ES. Diabetes health disparities: a systematic review of health care interventions. Med Care Res Rev. 2007;64(5 Suppl):101S-56S.

Slide 50

In summary…

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- Learned the basics of health finance
- Physicians are well-suited but advocacy not mandated
  - Practice, Health system, community, legislative levels
  - Varied tools available (writing, speaking, engaging)
  - Select issues important to you and your patients
  - Working collaboratively with others decreases individual effort, broadens impact, and makes it more fun.

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What Motivates YOU?

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EMORY UNIVERSITY SCHOOL OF MEDICINE
Department of Medicine

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Post-test

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Department of Medicine

1) The clinical care of a patient typically has a greater impact on health than societal and cultural factors.

A) True

B) False

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Post-test

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Department of Medicine

2) Race and income level are associated with

A) Access to health care services

B) Level of education

C) Health outcomes

D) All of the above

E) None of the above

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Post-test

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Factors such as nutritious food access, life expectancy and death by stroke rate can vary by geographically adjacent zip codes

A) True

B) False

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Post-test

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What is the most important thing you, as a physician, can do about inequities in health?

A) Motivational interviewing of your patients

B) Practice harm reduction

C) Advocate during legislative sessions

D) Be mindful of different socio-economic backgrounds and challenges

E) All of the above

Appendix B

Coursera examples

https://www.coursera.org/course/publichealth

https://www.coursera.org/course/mentalhealth

Sick Kids Hospital in Toronto through the National Collaborating Centre for Determinants of Health (NCCDH)-2012

http://www.sickkids.ca/culturalcompetence/elearning-modules/eLearning-modules.html

Association of Academic Health Centers Toolkit

https://healthleadsusa.org/2013/07/association-of-academic-health-centers-releases-social-determinants-of-health-toolkit/

Society of Teachers of Family Medicine

http://www.stfm.org/Advocacy/AdvocacyCourses

Caring with Compassion

https://caringwithcompassion.org/

Appendix C

Resource name/location	Description	Recommendation
Maps		
AidsVu http://aidsvu.org/map/	• Depicts incident cases and rates of HIV in the United States • Can be targeted to specific cities etc.	Put in as link in the SDH module-supplementary materials for students to use at their leisure
Health Disparities Map (major cities) http://graphics.latimes.com/healthcare-disparity/	• Shows differences across the US (by marked city boundaries) in terms of health insurance, available doctors, poverty, preventable deaths, avoidable hospitalizations, and recommended care	Put in as link in the SDH module-main content for students to look through
Center of Society and Health age predictions http://www.societyhealth.vcu.edu/work/the-projects/mapping-life-expectancy.html	• Projections of life expectancies in various zipcodes of a selection of cities.	Put in as picture in as a picture near the introduction of the SDH module (Atlanta specific)
Games/Tests		
Playspent http://www.playspent.org	• Short game imitating choices made over the course of a month for someone starting at $1000 and unemployed	Put in as link the SDH module-main content for students to play
IAT https://implicit.harvard.edu/implicit/selectatest.html	• Large selection of tests aimed at recognizing unconscious biases. • Includes disabilities, age, race, weight, sexuality, religion, skin-tone, and gender	Put in just after introduction of race/bias module-encourage students to take at least one of the tests

Fairplay http://gameslearningsociety.org/fairplay_microsite/	• Role playing video game following a young black graduate student • Meant to expose implicit biases and allow the player to recognize these biases in everyday life	Put in as link in SDH module- supplementary materials to play at their leisure
SDH Fast Fact Series http://www.sgim.org/web-only (select Social Determinants of Health on left hand bar)	• 12+ short case studies with multiple choice options for how best to approach the patient's problem given the SDH's applicable in the situation.	
Tutorials		
Kaiser Family Foundation Interactive Tool http://kff.org/interactive/the-uninsured-an-interactive-tool/	• Tool using powerpoint type style that allows the user to select an uninsured sub group (pre-existing condition, self-employed, young adult, living in a rural area etc.) and gives statistics on amount of people within that sub group, why they may be uninsured, and how the ACA may affect them. • Resources are also given at the end for more information	Place in advocacy module under main content for the student to explore
Caring with Compassion Modules https://caringwithcompassion.org/	• 7 modules including Populations in Need, Insurance, Delivery Systems, Homelessness and Disease, Social Determinants of Health, Biopsychosocial Health, and Team Care which provide a significant amount of information on each topic and include multiple choice quiz questions relevant to available material • Interactive game which puts the player in the position of a clinician and gives options to find out more about a patient's background in order to provide a more effective visit.	

Caring with Compassion Pocket Guide https://caringwithcompassion.org/downloads/Pocket_Guide_A.pdf	• Provides general assessment plan including key SDH related domains (social history, community and environmental resources, behavioral or substance use or psychiatric disorders) • Also leaves space for user to fill in local members of the "care team" (social worker, case managers, clinical pharmacists, violence hotlines etc.)	Cite and use key elements and combine with aspects of the Advocacy module
Miscellaneous		
Social Medicine Pocket Guide Word Document	• Series of links for a variety of social services and options when caring for a non-insured or otherwise disadvantaged patient	Put in advocacy module??
Social Services Resource Card for Atlanta Word Document	• Provides example of the SELF approach (social stressor and sources of support, environment and experiences of medical care, life control and literacy, and faith in fact and family beliefs • Back page has the phone numbers for many organizations involved with providing resources to homeless and low income patients	Provide as supplementary material in advocacy module
A Silent Curriculum PDF	• Powerful writing on how lessons/thoughts/events impacted by race and social factors are "taught"	Use as mandatory reading in race/bias module