Family Medicine: Our Responsibility to Be Leaders in Health Equity and Social Accountability

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Kim Yu, MD, Lloyd Michener, MD
Jessica Lapinski, DO, Evelyn Figueroa, MD
Disclosures

• We are passionate about health equity
Goals and objectives

• Establish a curricular strategy for addressing health disparities
• Establish an advocacy strategy for decreasing health disparities, and make a business case for health equity
• Describe and plan social media and community engagement strategies
• Create a collaborative community
Health equity means that everyone has a fair and just opportunity to be as healthy as possible.
Health equity is the absence of unfair and avoidable or remediable differences in health among social groups.
Drawing “Equidad”, by Fernando Miguez, Argentina
When talking about health equity

We need to talk about social accountability
SOCIAL ACCOUNTABILITY

The World Health Organization (WHO) describes social accountability as, ‘the obligation [of physicians and medical institutions] to direct their education, research and service activities towards addressing the priority health concerns of the community, region, and/or nation they have a mandate to serve’ (Boelen & Heck 1995).

For care to be socially accountable, it must be equitably accessible to everyone and responsive to patient, community, and population health needs (Buchman et al 2016).
Social Accountability

Social accountability in health care intentionally targets health care education, research, and services and addresses social determinants of health towards the priority health concerns of the people and communities served, with the goal of health equity.
HEALTH EQUITY AND SOCIAL ACCOUNTABILITY

Community Engagement
Business Case
Social Media
Advocacy
Curricular Strategies

Join the conversation on Twitter: #STFM18
COMMUNITY ENGAGEMENT

Evelyn Figueroa, MD, MPH
Addressing Food Insecurity Through Community Engagement

Evelyn Figueroa, MD
Assistant Dean of Outpatient Clinical Affairs
Family Medicine Residency Program Director
UI Health Pilsen Food Pantry Director
Figueroa Wu Family Foundation Executive Co-Director
Associate Professor of Clinical Family Medicine
University of Illinois at Chicago Department of Family Medicine
Inspiration

1. **Intersectionality**
   - Realization that the biases and barriers my family planning patients faced were very similar to my trans/GNC patients

2. **Social accountability resolve**
   - Sept 2017 blog about my patient with housing insecurity → professional call to action
   - Although I come from a disadvantaged background in some ways, the physician privilege I enjoy affords me instant credibility
   - Assistant Dean role affords me access to health system executives

3. **Role models**
   - STFM May 2017 → UCSD medical food partnership presentation (Smith, Chang, Brownell)
Planning Steps

- Application to Greater Chicago Food Depository for membership (discounted bulk purchasing, delivery, some free items)
- Tour of local food pantries
- Food insecurity assessment – 60 days
- Space acquisition, signage, & promotion
- Food acquisition & donations
- Equipment acquisition
- Administrative: schedules, registration forms
- Discovery of community partners
Enlisting Community Support

- Posting & distributing fliers
- Notification of local social agencies via emails, calls, and visits
- Coordination with WIC office (also in building)
- Open house
- Street sign posted during operational hours
- Recruitment of community volunteers
Initial Impact

**Total Clients**

<table>
<thead>
<tr>
<th>Month</th>
<th>Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>310</td>
</tr>
<tr>
<td>February</td>
<td>351</td>
</tr>
<tr>
<td>March</td>
<td>470</td>
</tr>
<tr>
<td>April</td>
<td>552</td>
</tr>
</tbody>
</table>

**Food Distributed (pounds)**

<table>
<thead>
<tr>
<th>Month</th>
<th>Pounds</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>6200</td>
</tr>
<tr>
<td>February</td>
<td>8073</td>
</tr>
<tr>
<td>March</td>
<td>10810</td>
</tr>
<tr>
<td>April</td>
<td>12696</td>
</tr>
</tbody>
</table>

**Average Clients per Day**

<table>
<thead>
<tr>
<th>Month</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>January</td>
<td>14.8</td>
</tr>
<tr>
<td>February</td>
<td>17.6</td>
</tr>
<tr>
<td>March</td>
<td>20.4</td>
</tr>
<tr>
<td>April</td>
<td>26.3</td>
</tr>
</tbody>
</table>
Pitfalls & Obstacles

- Scale
- Sufficient storage
- Building access
- Institutional attitudes towards social accountability
- Inventory
- Funding
- Volunteer coordination
- Community collaboration
Testimonials

- “This is the best thing that has ever happened to Pilsen”
- “I eat all the vegetables that you give me”
- “I am returning and have brought a friend”
Sustainability

- Summer externs 2018
- Dominican Volunteer August 2018
- Blue Cross Blue Shield health grant
Next Steps

- Social outcome tracking
- Delivery services for home bound
- Health sciences advocacy rotation
- Integration into UI Health social action programming, including UI Health Housing First program

uihealthpilsenfoodpantry@gmail.com
What Makes Us Healthy

- Genetics: 20%
- Environment: 20%
- Healthy Behaviors: 50%
- Access to Care: 10%

What We Spend On Being Healthy

- Medical Services: 88%
- Healthy Behaviors: 4%
- Other: 8%
# Workplace Stress & Sickness

## The Rising Costs In Business

<table>
<thead>
<tr>
<th>Breakdown</th>
<th>Costs</th>
<th>Annual Cost for Businesses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Daily</strong></td>
<td>An estimated one million workers miss work each day because of stress. Absenteeism is to blame for 26 percent of health-related lost productivity in business.</td>
<td>$602 per/year per employee</td>
</tr>
<tr>
<td><strong>Yearly</strong></td>
<td>Presenteeism: making mistakes, more time spent on tasks, poor quality work, impaired social functioning, burnout, anger, resentment, and low morale.</td>
<td>$150 billion per year in lost productivity</td>
</tr>
<tr>
<td><strong>Long-term</strong></td>
<td>Left untreated, prolonged stress can raise the risk for developing chronic—and costly—diseases, for a vast amount of all healthcare costs.</td>
<td>$58 Billion of diabetes alone in indirect costs</td>
</tr>
</tbody>
</table>

From depression to heart disease, annual costs for businesses per year in lost productivity.
Table 2. Percent of Firms Using Specific Wellness Strategies

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Small Firm (3-199)</th>
<th>Large Firm (200 or more)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social media tools</td>
<td>15%</td>
<td>29%</td>
</tr>
<tr>
<td>Access to a benefits counselor</td>
<td>35%</td>
<td>39%</td>
</tr>
<tr>
<td>Team competition</td>
<td>5%</td>
<td>40%</td>
</tr>
<tr>
<td>Incentives</td>
<td>8%</td>
<td>40%</td>
</tr>
<tr>
<td>Assigning an employee to promote wellness</td>
<td>10%</td>
<td>45%</td>
</tr>
<tr>
<td>Personalized communication</td>
<td>37%</td>
<td>49%</td>
</tr>
</tbody>
</table>
What social and economic factors must be addressed on the continued path to achieving Health Equity?

Health Equity aims to ensure that all people have full and equal access to opportunities that enable them to lead healthy lives.
A BUSINESS CASE FOR HEALTH EQUITY

BRIAN FRANK MD, PROJECT LEAD
ASSISTANT PROFESSOR
DEPARTMENT OF FAMILY MEDICINE
OREGON HEALTH AND SCIENCE UNIVERSITY
PROJECT AIMS

Overall Aim: Understand the values, beliefs and perceived needs of businesses regarding the health equity of their employees and the impact on their business

- Identify drivers and barriers to existing projects in which businesses have seen a positive response from investing in employees’ health
- Summarize research demonstrating the impact of health equity on metrics that matter to businesses
- Create a set of individualized “executive summaries” tailored to individual businesses that combine data and stories to demonstrate how health equity interventions can yield a ROI that is meaningful to a specific business’s needs
ONGOING EFFORTS…

Review hiring and work practices.

Make targeted investments in people and communities.

Support public policies increasing ability for all to succeed.
There is also a business case to make at our institutions

- Support for faculty to do health equity work addressing most vulnerable in our communities
- Element of the CLER visit
- Health Equity research
- Think of Return on Investment!
SOCIAL MEDIA

Jay Lee, MD, MPH
@familydocwonk
#FMRevolution
Chief Medical Officer of Venice Family Clinic
Past Prez of CAFP

Join the conversation on Twitter: #STFM18
WELCOME:
THE FUTURE OF THE U.S. HEALTH CARE SYSTEM IS IN YOUR HANDS

“Do or do not. There is no try.”
- Master Yoda
G. Gayle Stephens Festschrift
John P. Geyman, MD

(Fam Med 2011;43(1):7-12.)

Gayle Stephens, MD, has long been, and remains today, a central figure in the emergence and evolution of family medicine as a specialty. He has participated in all phases of its development from general practice and has provided thoughtful guidance connecting us to the past and charting and proposed the establishment of a certifying Board in Family Practice. These reports and developments over the first 2 decades of our new specialty are well described in a chapter by Gayle titled “Developmental Assessment of Family Practice: An Insider’s View” that appeared in a 1987 book, Family Medicine: The Matur-Assistance Program and the Resid-idency Review Committee for Family Practice, as a reviewer of federal training grants, and as president of the Society of Teachers of Family Medicine (STFM) from 1973 to 1975. He was the editor of Continuing Education for the Family Physician from 1977 to 1986.
"Be there"
"Give a damn"
The Job vs The Work
HOW TO CHANGE THE WORLD

1. Realize yourself
2. Show up
3. Occupy the ground
4. Change the world
LAWS OF PHYSICS

Newton’s Second Law of Motion

FORCE = MASS \times ACCELERATION AMPLIFICATION
ADVOCACY

Christina Kelly, MD
Memorial Health
Savannah, GA
CURRICULAR STRATEGIES

Viviana Martinez-Bianchi, MD
Duke Family Medicine Residency
Chair-Health Equity Team

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ACGME now requires that institutions engage residents in the use of data and QI to improve systems of care, reduce health care disparities, and improve patient outcomes through experiential learning.
FM milestones include addressing SDOH and health equity.
Multiple frameworks for health equity and addressing social determinants of health in medical education
The 2016 IOM framework exhorts us to create -through education- highly competent professionals who understand and act on the social determinants of health in ways that advance communities and individuals toward greater health equity.
WHO provides a broad public health and systems context for impacting the social determinants of health.
CDC’s Tom Frieden’s framework shows us the largest impact for population health interventions to improve health is to address socioeconomic factors.
AAMC has developed curriculum for health equity and social justice
Population Health Milestones address health equity, social determinants of health

At Duke we have worked with the AAMC on a curriculum that links milestones in population health-
Our Purpose

- Create and support a culture of health equity to empower family physicians
- Collaboration with family physicians, their practice teams, chapters, and other partners
- Offer tools and resources to help educate family physicians
- Support research and policy development to support advocacy
- Encourage workforce diversity
Tools and Resources

**Topics**
- Impact of SDOH
- Screening for SDOH risks
- Referral to community resources
- Incorporating practice teams
- Advocacy
- Best practices
- Overcoming challenges and barriers
- SDOH Payment Principles

**Delivery Formats**
- In-person
- Webinars
- Issue briefs
- Policy statements
- Position papers
- Conference abstracts
- Workshops
- Journal submissions
Focuses on the Family Physician and Screening

- Overview of the social determinants of health
- Role of the primary care team
- Description of core social needs
- Screening tools for patients and providers
- List of resources
Experiential Learning as vital component (Kolb -1984)

“Exploration of one’s biases and positions needs to continue throughout life, reaching deeper levels as the health professional matures cognitively, personally, and professionally”

(El-Sayed and El-Sayed, 2014).
Disparities in Life Expectancy in the Triangle
Residency Curriculum

- Clinical rotations
- Lecture Series
- Professional Development
- Procedure Workshops
- Population Health
- Resident Education

- CFM Grand Rounds
- Noon conference
- M&M conference
- Clinic case review
- Blog posts
- Census management
- Billing & Coding
- Quality Improvement
- Conference participation
- Tues PM: Didactics
- Journal Club
- PHIT Project
- Pop health symposium
- Nexplanon, IUD
- Colposcopy
- Suturing
- Cyst removal
- Joint injections
- Ultrasound
- Simulation center

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Population Health Curriculum

- Journal Club (PGY1-3)
- Community Health Rotation (PGY1)
- Orientation including community-based introductions to Durham and the Duke-Durham relationship (PGY1)
- Population Management rotation with QI projects (PGY1-3)
- Population Health Symposium: 4 hour bi-monthly sessions (PGY1-3)
- Dedicated panel management & community engagement time (PGY1-3)
- Longitudinal, community clinic training sites (PGY2 & 3)
Durham County Community Health Assessment

Residents involved evaluating the Community health assessment,

Most Likely to be in Coverage Gap and Uninsured:
- Households with income below 133% of the Federal Poverty Level
- Workers in low-wage jobs without benefits
- People of color
- Ages 35-54
- Not a citizen

15.8% of Durham County adults are uninsured
Longitudinal continuity clinics in the community?

DFM Continuity Clinic

- PGY1: ½ day/week
- PGY2-3: 3 ½ days/week
- Centering Pregnancy groups

2nd Continuity Clinic (PGY 2-3) One half day a week

- VA PRIME clinic
- Duke Primary Care Oxford (rural)
- El Futuro
- Walltown, Lyon Park
- Southern High School
- Lincoln Community Health Center (FQHC)
- TROSA

Optional longitudinal tracks

- Leadership
- Research

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Why are you here?

WHAT IGNITES YOUR PASSION?
In the planning of their annual calendar we look at the activities and schedules of the organizations that they would like to be paired with: locally,
Family Medicine Leads Emerging Leader Institute

and nationally,
Barber Shop & Blood Pressure Project

What did we set out to do?

1.) Explore briefly the history of the role which barbershops play within Community Medicine

2.) Engagement of community partners in Oxford, NC (i.e. Barbershops, Barbershop patrons) in an effort to possibly implement screening of untreated hypertension (pilot study,) with a referral process in place (i.e. Vance-Granville Health Department Free Clinic, Duke Primary Care Oxford) in order to address a known health care disparity in minority and rural populations (i.e. chronic untreated hypertension.)

Jonathan Hedrick, MD
PGY 3, 2018
Incorporation of GIS mapping of social determinants of health into clinical practice

Alexa Mieses, MD, MPH PGY 2
Food Pantries Role in Poverty Reduction and Policy Implications

Kenetra M. Hix, MD-PGY3, MPH
Duke Family Medicine Residency

- Attended several meetings of the Chronic Care Initiative starting fall 2016 to early spring (2016-2017).
- To maintain funding for Chronic Care Initiative, DCDPH had to show effectiveness of programs.
- Logic Model created to identify the many activities implemented by the CCI.
Mental healthcare delivery for undocumented immigrants in North Carolina.
Tiffany Cagle, MD, Family Medicine Resident, PGY 2 2016
Audio documentary and establishing adherence to National Class Standards
Maria Portela Martinez, MD, Family Medicine Resident, worked during PGY-2 and PGY 3, class of 2013

Maria created a documentary sharing the social determinants related experiences of Latinos accessing healthcare during her 2nd year, and worked on improving all of the Duke Health System’s adherence to CLAS standards in her 3rd year

National Standards for Culturally and Linguistically Appropriate Services
Farhad worked every Tuesday morning on a respite program to improve health outcomes for Durham’s homeless.
Sam Fam’s project

https://vimeo.com/254381515/286cc13b2a
Video illustrates Social determinants of health through the patient experience

Patient Stories: Community Feedback
Access to Care Committee Meeting: Feb 8, 2018
Samuel Fam, DO
Duke Family Medicine Resident

Sam Fam, DO
Class of 2018
Tiffany and Jessica worked as residents, and are working now as a faculty and resident team on improving health care for the LGBTQ community.
AAFP Foundation Grant

$10,000 towards improving immunization rates in people 11-21 for vaccine-preventable diseases

- Make every adolescent visit an immunization opportunity
- Increase access to patient education materials regarding vaccination
- Increase awareness of immunization gap
- Reduce barriers to adolescent immunizations
- Change work flow to increased vaccination efficiency
- **Engage with community stakeholders to increase awareness regarding adolescent immunizations**
- Increase office awareness about adolescent vaccination rates
Family doctors and teams who can see the river of disease that flows into our clinics and hospitals and will go to identify what happens upstream
And now to our work together

Jennifer Edgoose, MD, MPH
University of Wisconsin- Madison
FMAH- Health Equity Team
Are we socially accountable?

Healthcare institutions are generally **socially responsible** (being aware of their duty to respond to society’s needs) and some can be seen being **socially responsive** (implementing interventions to address these needs). But few are wholly **SOCIALLY ACCOUNTABILITY**.

<table>
<thead>
<tr>
<th>Social needs identified</th>
<th>Responsibility</th>
<th>Responsiveness</th>
<th>Accountability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Institutional objectives</td>
<td>Defined by faculty</td>
<td>Inspired from data</td>
<td>Defined with society</td>
</tr>
<tr>
<td>Educational programs</td>
<td>Community-oriented</td>
<td>Community-based</td>
<td>Contextualized</td>
</tr>
<tr>
<td>Quality of graduates</td>
<td>«Good» practitioners</td>
<td>Meeting criteria of professionalism</td>
<td>Health system change agents</td>
</tr>
<tr>
<td>Focus of evaluation</td>
<td>Process</td>
<td>Outcome</td>
<td>Impact</td>
</tr>
<tr>
<td>Assessors</td>
<td>Internal</td>
<td>External</td>
<td>Health partners</td>
</tr>
</tbody>
</table>

Applying an Equity and Empowerment Lens

https://multco.us/diversity-equity/equity-and-empowerment-lens

Join the conversation on Twitter: #STFM18
Equity and Empowerment Lens

PEOPLE

Who is positively and negatively affected (by this issue) and how?

How are people differently situated in terms of the barriers they experience?

Consider physical, spiritual, emotional and contextual affects.
Equity and Empowerment Lens

PLACE

What kind of positive “place” are we creating?

What kind of negative “place” are we creating?

How are public resources and investments distributed geographically?

How are you considering environmental impacts as well as environmental justice?

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How are we meaningfully including or excluding people (communities of color) who are affected?

What policies, processes and social relationships contribute to the exclusion of communities most affected by inequities?

Are there empowering processes at every human touchpoint?

What processes are traumatizing and how do we improve them?
What are the barriers to doing equity and racial justice work?

What are the benefits and burdens that communities experience with this issue?

Who is accountable?

What is your decision-making structure?

How is the current issue, policy, or program shifting power dynamics to better integrate voices and priorities of communities of color?
SMALL GROUP ACTIVITY: Toward Health Equity

• **Purpose:** What is my purpose in recognizing, naming, and/or alleviating health inequities? *Propose a single intervention.*

• **People:** Which people or communities will be positively and negatively affected by my proposed intervention? Have I accounted for potential trauma to the people or communities I am trying to serve through this intervention?

• **Place:** How might my intervention account for the emotional and physical safety of people or communities and their need to be productive and feel valued?

• **Process:** Are there empowering processes at every human touchpoint of this intervention?

• **Power:** Who are the stakeholders who need to be involved in the proposed intervention? Describe the kind of power that they hold.
Go to

https://goo.gl/forms/7OoekkVrrjIzhsB23
Equity and Empowerment Lens

**PEOPLE**
- Who is positively and negatively affected (by this issue) and how?
- How are people differently situated in terms of the barriers they experience?
- Consider physical, spiritual, emotional and contextual affects.

**PLACE**
- What kind of positive “place” are we creating?
- What kind of negative “place” are we creating?
- How are public resources and investments distributed geographically?
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**PROCESS**
- How are we meaningfully including or excluding people (communities of color) who are affected?
- What policies, processes and social relationships contribute to the exclusion of communities most affected by inequities?
- Are there empowering processes at every human touchpoint?

**POWER**
- What are the barriers to doing equity and racial justice work?
- What are the benefits and burdens that communities experience with this (issue)?
- Who is accountable?

Source:

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Family doctors and teams who can see the river of disease that flows into our clinics and hospitals and will go to identify what happens upstream.
Thank you!

For more information about this project and other exciting FMAHealth news, visit:

www.FMAHealth.org
Please evaluate this presentation using the conference mobile app! Simply click on the "clipboard" icon on the presentation page.