

Paul Ravenna, MD Katherine Wright, MPH, PhD Elizabeth R. Ryan, EdD Deborah S. Clements, MD, FAAFP



in Family Medicine Residency

Financial Disclosures

National Collaborative for Education to Address the Social Determinants of Health

This project is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number UH1HP29963, Academic Units for Primary Care Training and Enhancement, \$3,691,515 total award amount.

This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.





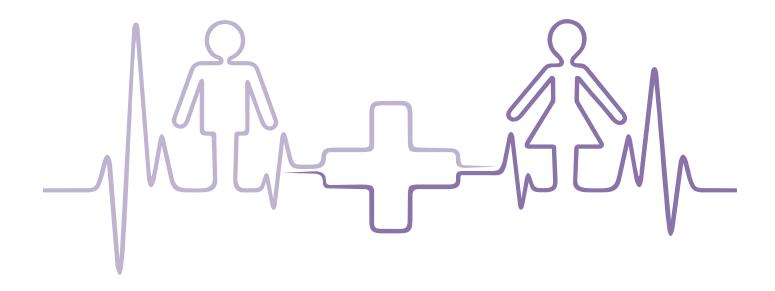


Agenda

- Overview of curriculum resources to teach SDOH
- Community Health Resource Navigator (CHRN) demonstration
- Northwestern Lake Forest Family Medicine Residency pilot curriculum development and evaluation
- Next steps for the National Collaborative for Education to Address the Social Determinants of Health

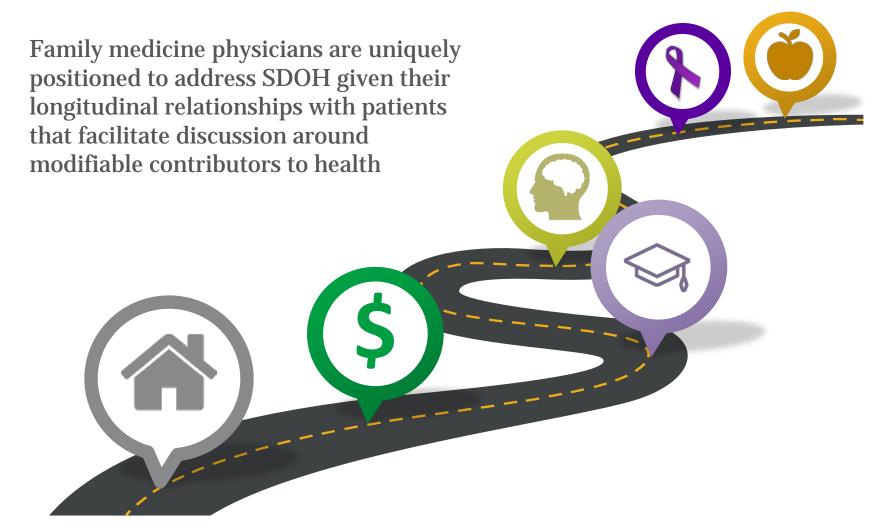
HealthyPeople 2020

"...defined as conditions in the social, physical, and economic environment in which people are born, live, work, and age. They consist of policies, programs, and institutions and other aspects of the social structure, including the government and private sectors, as well as community factors."





Roadmap





Survey Results; n=132 Family Medicine & Internal Medicine Residents

of residents stated they received previous training on SDOH in medical school

However, the following proportion of residents rated themselves as highly experienced or expert at the following skill-based competencies:

identifying SDH in their practice: 28%

discussing those challenges with patients: 14%



Family Medicine Milestones

as not achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	Consistently demonstrates compassion, respect, and empathy Recognizes impact of culture on health and health behaviors	Displays a consistent attitude and behavior that conveys acceptance of diverse individuals and groups, including diversit in gender, age, culture, race, religion, disabilities, sexual orientation, and gender identity Elicits cultural factors from patients and families that impact health and health behaviors in the context of the biopsychosocial model Identifies own cultural framework that may impact patient interactions and decision-making	Incorporates patients' heliefs, values, and cultural practices in patient care plans Identifies health inequities and social determinants of health and their impact on individual and family health	Anticipates and develops a shared understanding of needs and desires with latients and families; works in partnership to meet those needs	Demonstrates leadership in cultural proficiency, understanding of health disparities, and social determinants of health Develops organizational policies and education to support the application of these principles in the practice of medicine



Family Medicine Milestones

Has not achieved Level 1	Level 1	Level 2	Level 3	Level 4	Level 5
	Recognizes social context and environment, and how a community's public policy decisions affect individual and community health	Recognizes that family physicians can impact community health Lists ways in which community characteristics and resources affect the health of patients and communities	Identifies specific community characteristics that impact specific patients' health Understands the process of conducting a community strengths and needs assessment	Collaborates with other practices, public health, and community-based organizations to educate the public, guide policies, and implement and evaluate community initiatives Seeks to improve the health care systems in which he or she practices	Role-models active involvement in community education and policy change to improve the health of patients and communities



ACGME common requirements

VI.A.1.b) Quality Improvement

Residents must receive training and experience in quality improvement processes, including an understanding of health care disparities.

IV.A.5.f) Systems-based Practice:

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care.





Curriculum Resources

to teach social determinants of health



Curriculum Landscape

- Many undergraduate medical schools have incorporated this topic into training, but often focus on change in attitudes and knowledge, and not skill development.
- SDH training in residency is sparse and highly variable in content, delivery and evaluation
- As a consequence, physician residents enter the workforce without being equipped with the skills necessary to address SDH





National Collaborative for Education to Address Social Determinants of Health





Collection of Curriculum Resources

Review our collection or submit your own to contribute to our community of work.



Center for Primary Care Innovation

Search CPCI

About Us ▼

About Primary Care

Social Determinants Education <

Research ▼

Members

This collection of nationwide resources was created to address the knowledge gaps in best approaches for teaching social determinants of health to health professional trainees. By compiling and sharing information on innovative training being done nationwide, we hope to promote best practices and create a community of educators.

Are you interested in sharing what your program does to train learners about the social determinants of health? **Complete our survey here** and someone from our team will contact you.

Search by Keyword

Q SEARCH

Search by Type

Undergraduate Medical Education ▼

Undergraduate Medical Education

A.T. STILL UNIVERSITY SCHOOL OF OSTEOPATHIC MEDICINE IN ARIZONA

Description

Students assess patients during history taking and make resource connections. Students are taught to understand the connection between social determinants of health and disease management

Contact



Undergraduate Medical Education

BAYLOR COLLEGE OF MEDICINE

Description

M1-M2: Students complete a doctoring course focused on factors that impact health, barriers, education of patient, health literacy, communication models and elicit cultural interview style. Students break into small group lectures on healing traditions, beliefs and physician bias.

M3-M4: Students attend lectures on race and culture in

Undergraduate Medical Education

COLUMBIA UNIVERSITY COLLEGE OF PHYSICIANS & SURGEONS

Description

M1-M2: In the first few weeks of medical school, students have a 50-min lecture on social determinants of health followed by a 90-minute guided walking tour of the neighborhood (through Washington Heights), followed by an additional 1-hour discussion of what was observed and in what ways these observations might impact health. Students take photographs along the tour and then write to their

Q

Center for Primary Care Innovation

Search CPCI

About Us ▼

About Primary Care

Social Determinants Education -

Research -

Members

This collection of nationwide resources was created to address the knowledge gaps in best approaches for teaching social determinants of health to health professional trainees. By compiling and sharing information on innovative training being done nationwide, we hope to promote best practices and create a community of educators.

Are you interested in sharing what your program does to train learners about the social determinants of health? Complete our survey here and someone from our team will contact you.

Search by Keyword

Q SEARCH

Search by Type

Family Medicine Residency

Family Medicine Residency

NTIST LA GRANGE MEMORIAL HOSPITAL FAMILY MEDICINE RESIDENCY

Description

We review by "Health Disparities in the US" by Donald Barr, MD, PhD

Online Resources

Health Disparities in the United States

Contact



Family Medicine Residency

CHRIST HOSPITAL/UNIVERSITY OF CINCINNATI FAMILY MEDICINE RESIDENCY PROGRAM

Description

PGY1: During orientation there is an interactive session looking at population level data for Ohio, Hamilton County, and specific Cincinnati neighborhoods we serve. This serves as an introduction to the specific needs of our community and discussion of health disparities. Residents participate in an SDH Field Experience (M4's on family medicine elective also attend): which is a single day outing into the

Family Medicine Residency

KAISER PERMANENTE LOS ANGELES MEDICAL CENTER

Description

Our training includes a Monday morning lecture series to residents PGY1-3 and MS3-4 student learners. We discuss adverse childhood experiences in relationship to pediatric and adult health issues. We also have an afternoon workshop for PGY 1-3 residents to explore transportation and cost barriers to accessing appropriate levels of care. We explore food and housing insecurity during community

Q

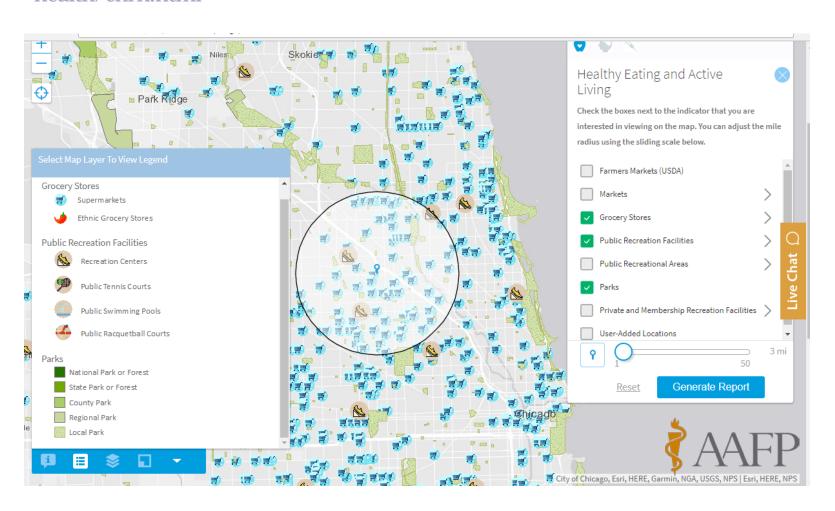
GIS Resources

to teach social determinants of health



Community Health Resource Navigator

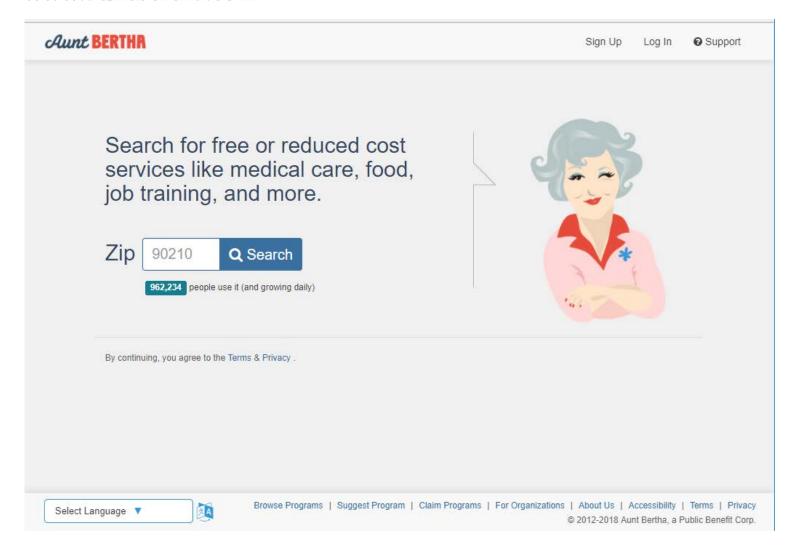
https://www.aafp.org/patient-care/social-determinants-of-health/chrn.html





Aunt Bertha

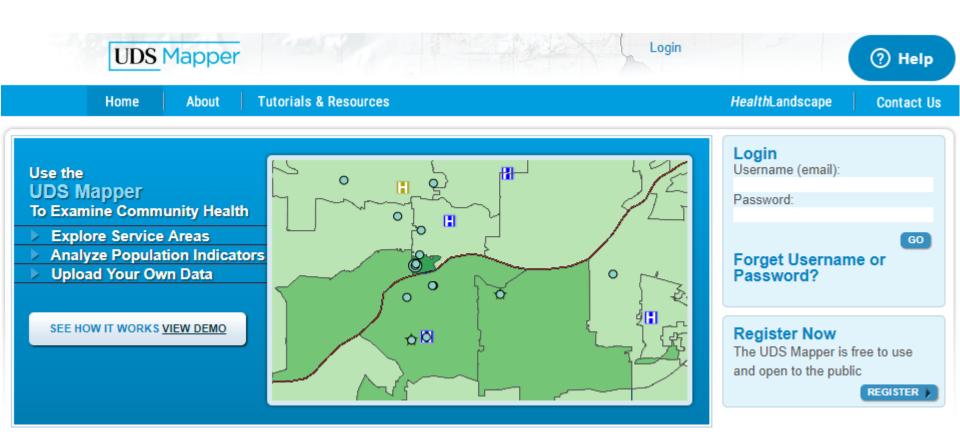
www.auntbertha.com





UDS Mapper

https://www.udsmapper.org/





Community Health Resource Navigator (CHRN) Demonstration



Primary+

Pay Dues Membership Join AAFP

Shop



Search



Sign In

Journals

Patient Care

Med School & Residency | Practice Management

Advocacy Events

AAFP News

PATIENT CARE

Clinical

Recommendations by Topic

Clinical. Recommendations by Type

Well-being and Prevention

Public Health Emergencies

Social Determinants of Health

Access to Health Care

Cultural Proficiency

Early Childhood Literacy

PTSD & TBI: Caring for Veterans

Community Health Resource Navigator

CHRN Interactive Mapping Tool

Community Health Resource Navigator



Social and environmental factors account for more than 50. percent of all health outcomes. Helping patients identify resources they can use to lead healthier lives is an important role family physicians can provide.

To assist our physicians, the AAFP developed the **Community** Health Resource Navigator (CHRN). The CHRN is an interactive mapping tool for AAFP members that locates community resources relevant to your patient's health needs. It generates a customized report that may be downloaded, printed, and shared during a patient visit.

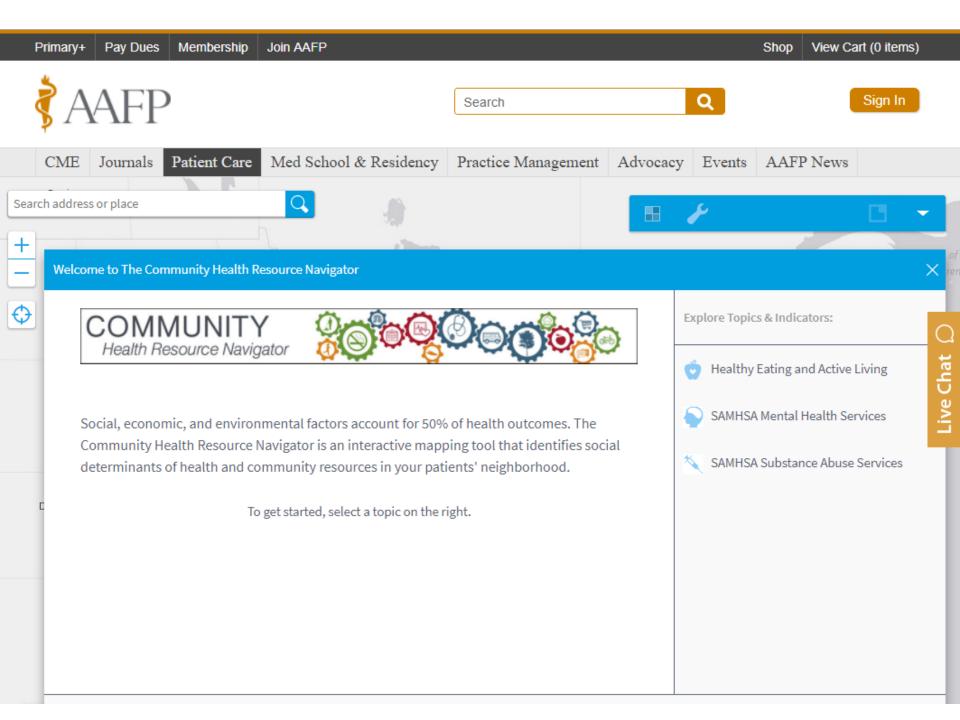
The purpose of the CHRN is to help family physicians personalize care by assessing patients' environment and barriers to healthy living. The tool provides resources in communities that can assist patients in achieving a healthy lifestyle. This may help shape counseling options and shared **Get Started**

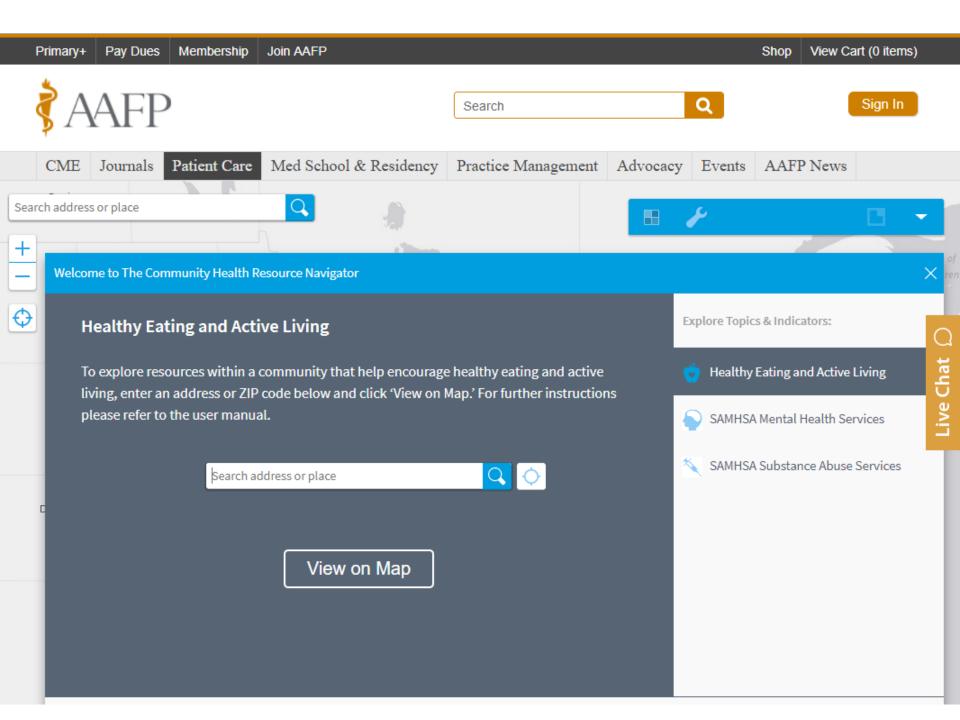
Use the CHRN to begin locating community resources for your patients.

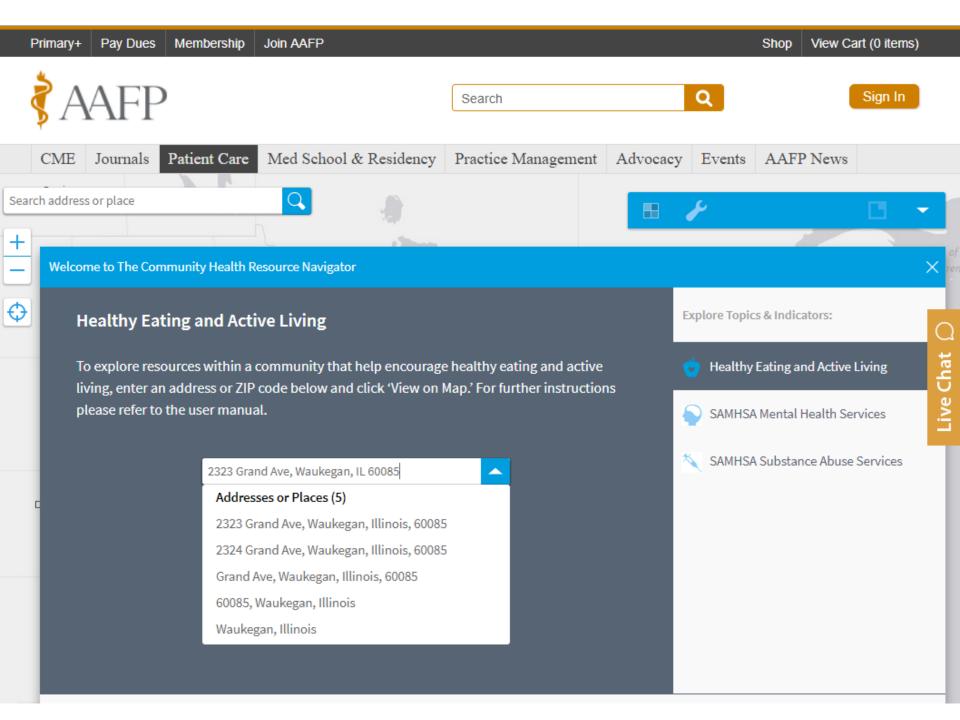
Access Resources

Supported in part by a grant from the AAFP Foundation.

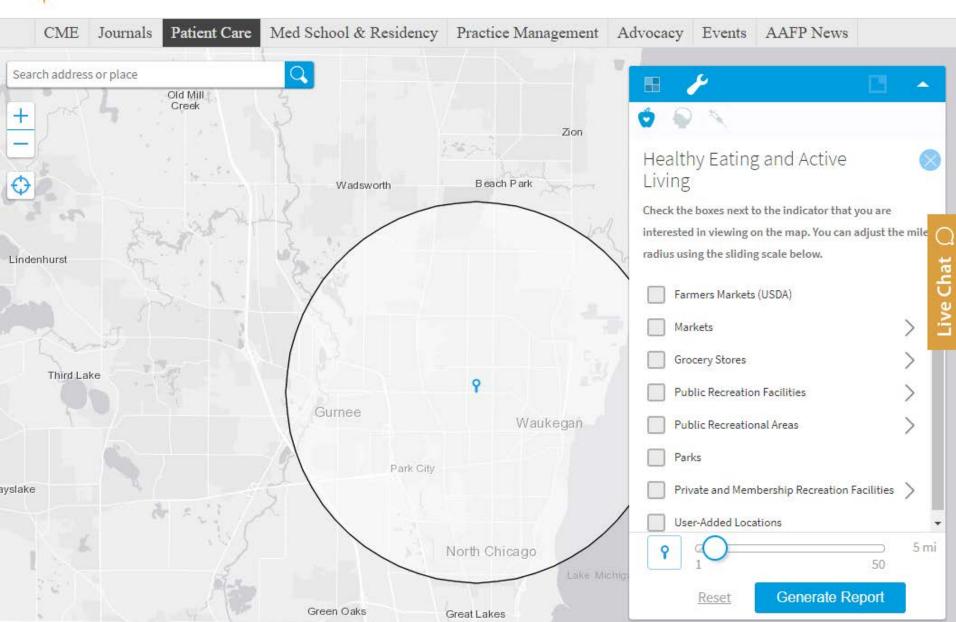


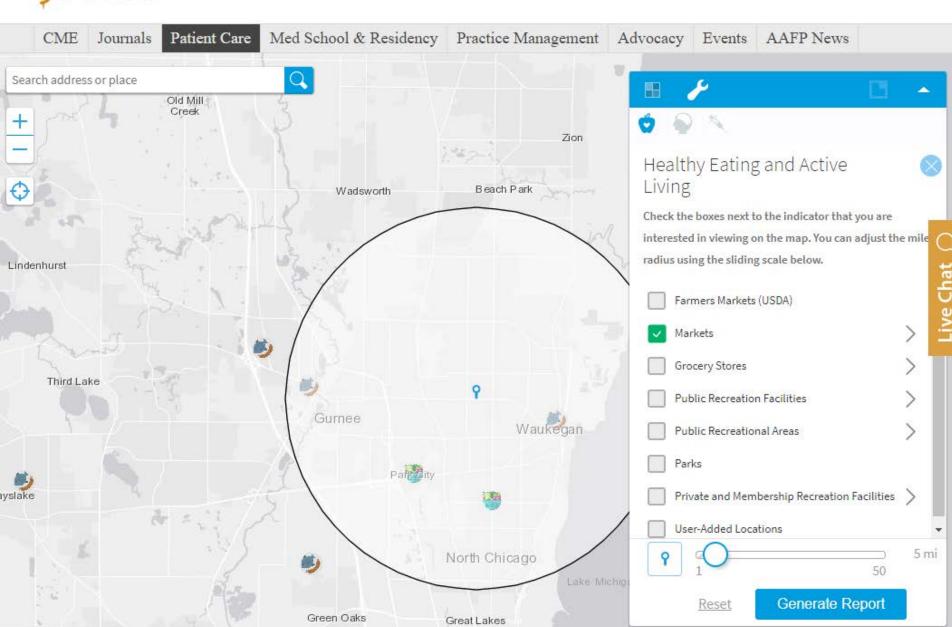




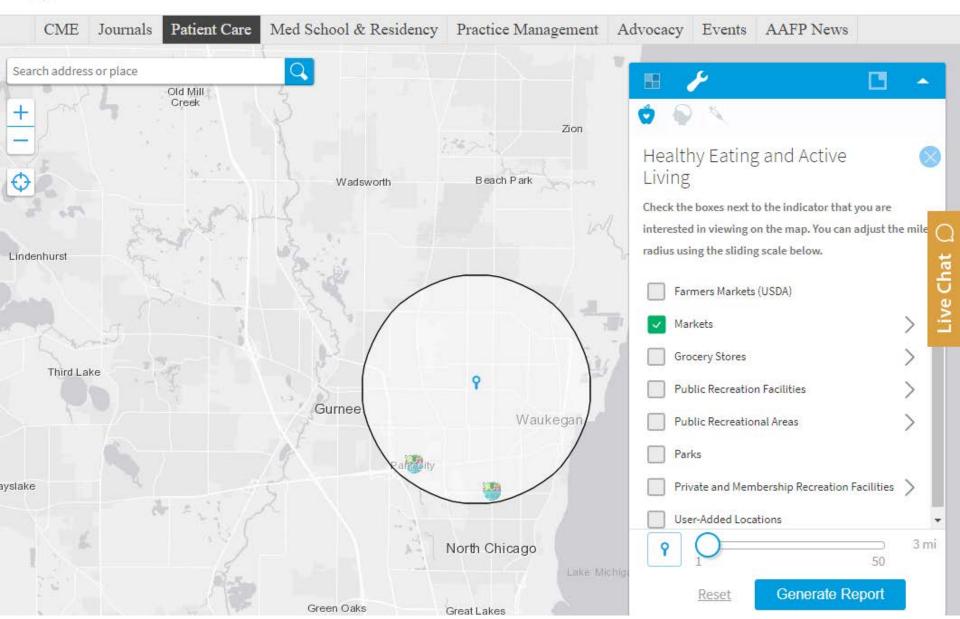




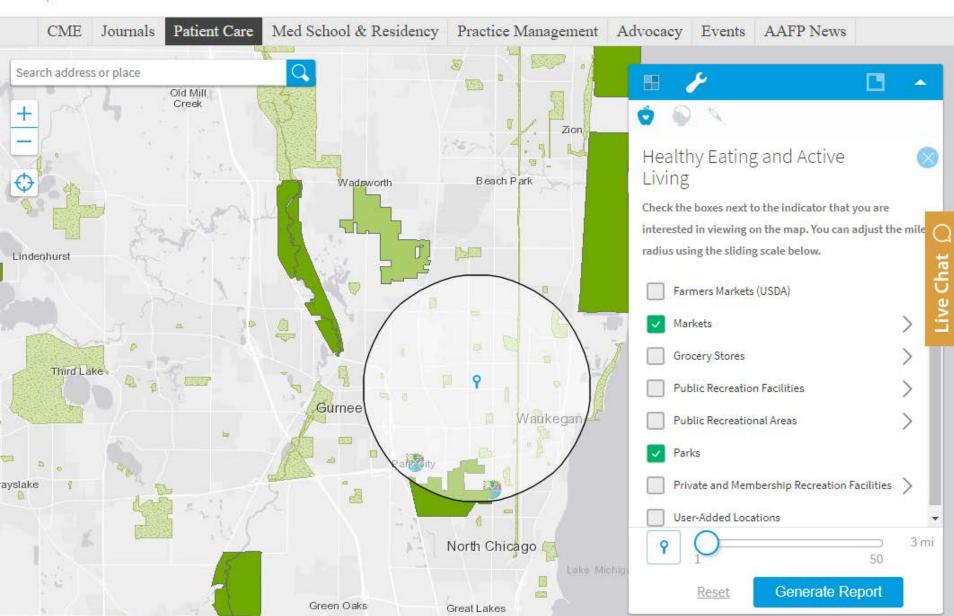




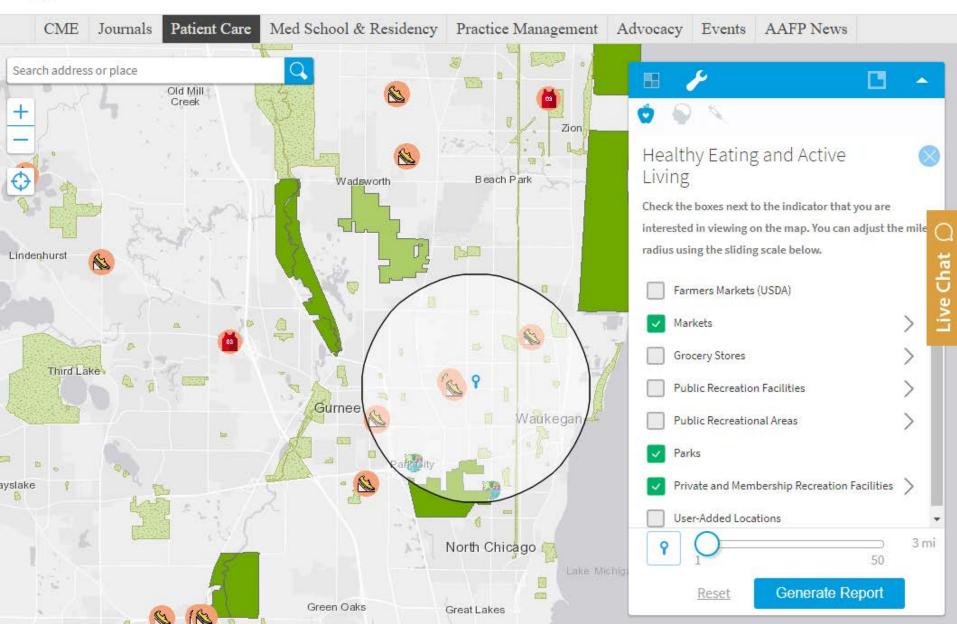












Old Mill

Old Mill



MARKETS

Marleens Fruit Market 3406 Kehm Blvd, Park City, Illinois, 60085

Waukegan Fruit Market Inc 951 S Lewis Ave, Waukegan, Illinois, 60085

PARKS

Chittenden Park

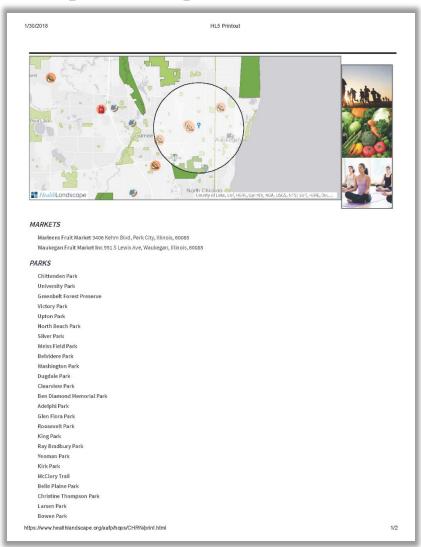
University Park

Greenbelt Forest Preserve

Victory Park

Community Health Resource Navigator

Report Example







NM Family Medicine Residency Pilot Curriculum Development & Evaluation



Our Residency Communities

Northwestern McGaw Family Medicine Residency at Lake Forest

We serve 3 Chicagoland communities close in proximity, but very different in terms of resources and health status





Our Residency Community

Northwestern McGaw Family Medicine Residency at Lake Forest

Median Income

Waukegan, IL •----• \$45,983

Grayslake, IL •----- \$87,967



Motivating Principles

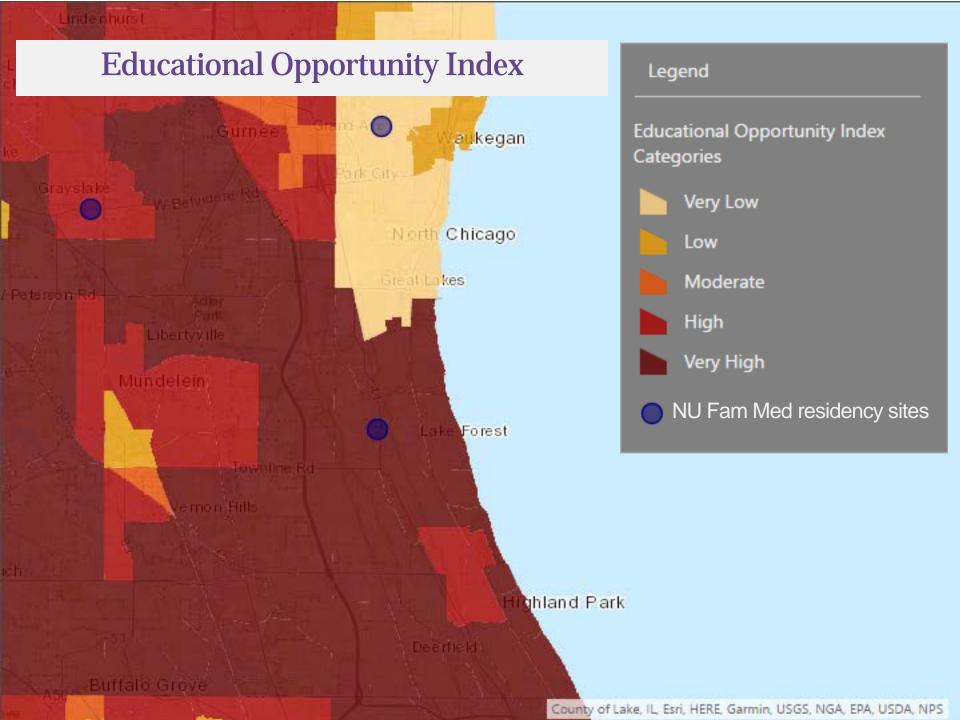
Pilot SDoH Curriculum Development



Geography matters.

Zip code can be more predictive of health status than genetic code in some contexts





Overall Child Opportunity Index Legend Overall Child Opportunity Index Categories Very Low aukegan Low ark City Moderate High North Chicago Very High Great Lakes NU Fam Med residency sites Mundelein Forest hland Park County of Lake, IL, Esri, HERE, Garmin, USGS, NGA, EPA, USDA, NPS

Motivating Principles

Pilot SDoH Curriculum Development

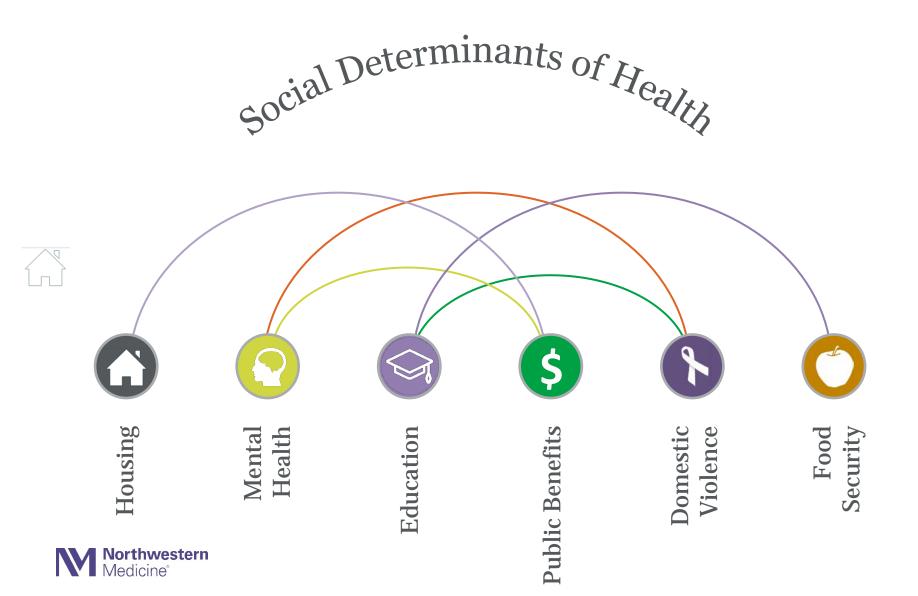


There are lots of moving parts.

As multiple systems operate simultaneously, we see complex interactions between social and contextual factors



Complex Interactions between Indicators



Motivating Principles

Pilot SDoH Curriculum Development



One size doesn't fit all.

The interaction between individual genes and environment is unique



Personalized Medicine



> No blueprint for each person's unique disease susceptibility



Personalized Medicine



- ➤ No blueprint for each person's unique disease susceptibility
- ➤ Highlights the need for individualized health promotion efforts



Motivating Principles

Pilot SDoH Curriculum Development

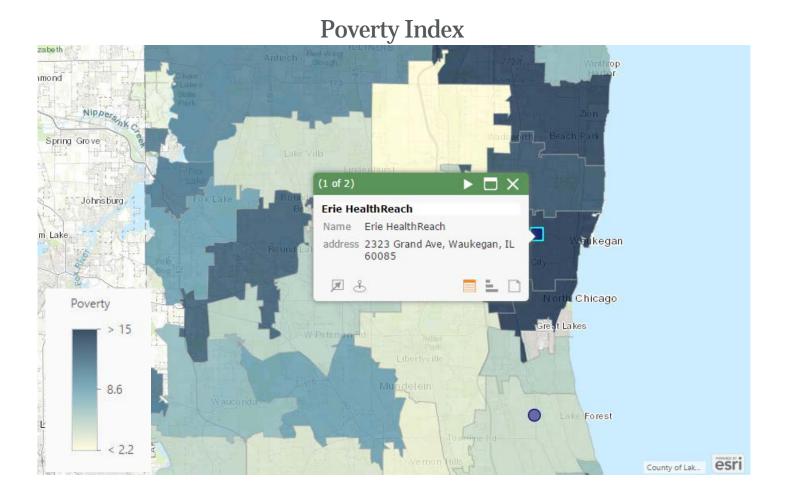


How can we enable students and residents to personalize care?

Geospatial analysis provides powerful information at the point of care

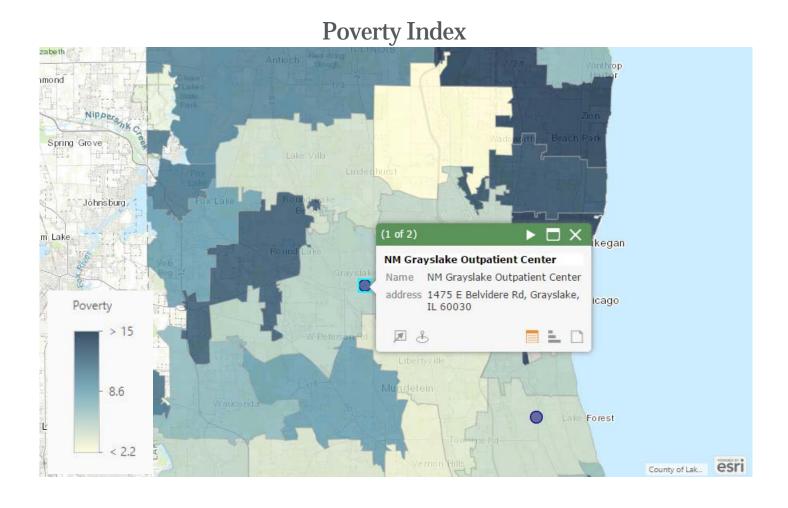


Erie HealthReach Waukegan



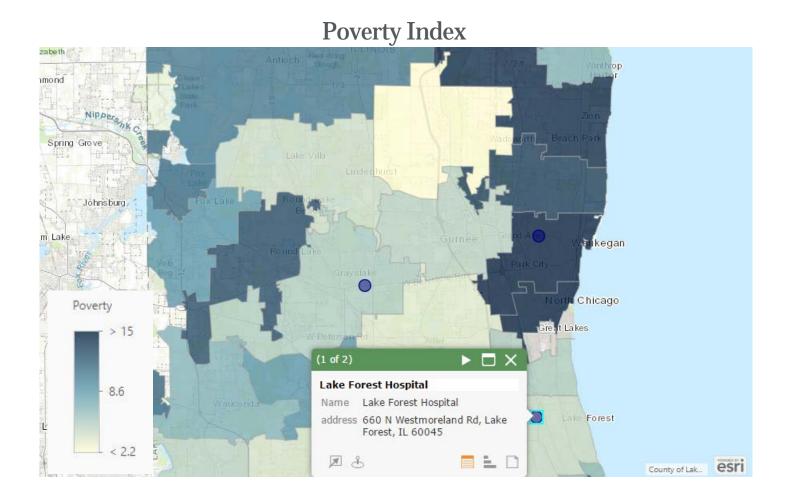


NM Grayslake Outpatient Center





Lake Forest Hospital





Curriculum Topic Areas

Pilot SDoH Curriculum Development





SDoH Skills Gap

Pre-Curriculum Survey Results, n=21 Family Medicine Residents

■ Engaging Conversation ■ Providing Resources (1=Novice to 5=Expert)



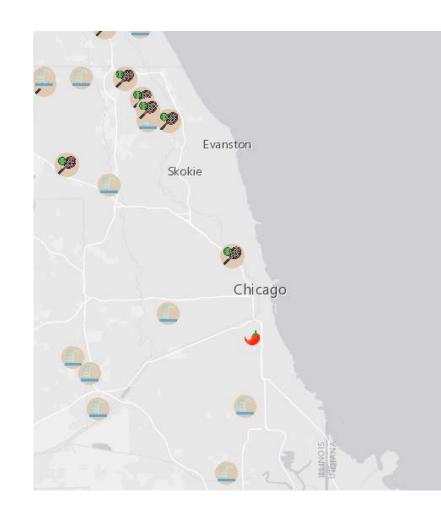


Resident Mapping Exercise

Pilot SDoH Curriculum Development

Use the CHRN tool to identify resources for patient panels at both clinics

- Inclusion criteria:
 - Hypertension diagnosis
 - Adult patients
- 195 patient addresses mapped
- Completed an evaluation survey at the end of the session





Resident Mapping Exercise

Pilot SDoH Curriculum Development

Residents completed a brief evaluation indicating the utility of the CHRN tool for each patient

- Yes, the tool is useful at point of care: 113/195 patients total= 57.9%
- Broken down further:
 - Erie (FQHC): **60.8**%
 - Grayslake Outpatient Center: 54.8%





Evaluation Survey

Example Items

 Which of the following, if any, do you wish you could write a prescription for? (check all that apply)

 Which of the following, if any, do you wish could be paid for through the health care system?
 (check all that apply)

Nutritional food
Housing assistance
Help with utility bills
Employment assistance
Transportation assistance
Household goods
Health insurance
Financial counseling or assistance
Fitness program
Legal aid
Child care
Adult education
Mental health assistance
Social work assistance
Assistance with accessing the social
 services listed above
None



Survey Results: Mental Health Assistance



WOULD WRITE A Rx FOR MENTAL HEALTH ASSISTANCE

69%

WISH MENTAL HEALTH ASSISTANCE WAS PAID FOR BY THE HEALTHCARE SYSTEM

62%





Survey Results: Housing Assistance



WANT TO WRITE A PRESCRIPTION FOR HOUSING

46%

WISH HOUSING WAS PAID FOR BY THE HEALTHCARE SYSTEM 23%





Survey Results: Adult Education



WOULD WRITE A Rx FOR ADULT EDUCATION ASSISTANCE

23%

WISH ADULT EDUCATION WAS PAID FOR BY THE HEALTHCARE SYSTEM

(8%)





Survey Results: Nutritional Food



WOULD WRITE A Rx FOR NUTRITIONAL FOOD

85%

WISH NUTRITIONAL FOOD WAS PAID FOR BY THE SYSTEM

85%





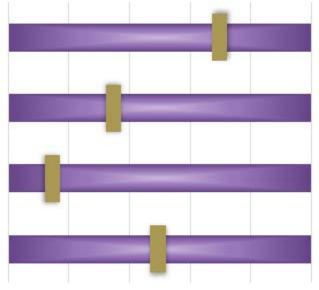
Survey Results, n=13 Family Medicine Residents

Food security is a medical issue

Food security is important enough that it's worth taking the time to screen

I am comfortable having a food security conversation with patients

I am confident I have the knowledge and tools to help patients with food security



Food security is a social problem

Actual food insecurity is rare

I am worried that asking about food security will feel awkward

I am worried about what I can actually do to help patients





How does mapping patient addresses change your understanding of each patient's community?

Survey Results, n=13 Family Medicine Residents

- Helps me see feasibility in my plan for their healthcare
- Even when the map identifies resources, it doesn't help with all the stuff people actually need in order to use those resources
- Being able to see what resources are available can help to adjust what suggestions to give patients
- It gives me better insight into why some of their screening measures are out of control



Describe one limitation of mapping clinical data

Survey Results, n=13 Family Medicine Residents

- Making sure that the maps are frequently updated with correct information
- Many pts without transportation--what resources are on bus-lines?
- Currently the only option is to locate resources that are around, would be nice to assess if pt's can actually access them based on certain parameters or offered services
- Limited information about listed resources



Describe one benefit of mapping clinical data

Survey Results, n=13 Family Medicine Residents

- Would be useful for community planning. In theory I would be able to identify resources my patients don't already know about and could use.
- Informing patients of nearby places to be active/get fresh produce
- Having point of care information to hand to patients regarding health and nutrition available to them
- Easily available resources for patients; recognizing resource poor areas





Next Steps:

- Next iteration of curriculum development
- Implementation at the point of care
- National Collaborative for Education to Address Social Determinants of Health

Questions?



Thank You

- @NUFSMFamMed
- MU_NCEAS

