The joys and challenges of urban underserved medicine:
Social determinants of health, solidarity and solutions

Andrew Smith, MD
Audra Williams, MD/MPH
Jonathan Lichkus, MD

OUTLINE

I. INTRODUCTIONS
II. SOCIAL DETERMINANTS OF HEALTH PRIMER
III. THE CITY OF LAWRENCE
IV. COMMUNITY BASED INTERVENTIONS
V. PRACTICAL POINTERS
VI. FEELING FULFILLED IN YOUR WORK

I. INTRODUCTIONS

Presenters

- Audra Williams (3rd Year Resident)
- Jonathan Lichkus (4th Year Resident)
- Andrew Smith (Attending)

ALTAGRACIA

- PICTURE TO BE ADDED

RAFAEL

- PICTURE TO BE ADDED

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JUANA

- PICTURE TO BE ADDED

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Who are you?

A. Medical student
B. Resident
C. Attending
D. Administrator
E. Other

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Which best describes you?

A. What are SDOH and underserved medicine all about?
B. Considering working in underserved community
C. Underserved medicine is my career focus
D. I'm in the wrong talk and waiting for the right moment to escape unnoticed

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My biggest hesitation about applying to residency in an underserved community is…

A. Financial issues and loan repayment
B. Relating to a culture different than my own
C. Lack of prestige
D. It seems really hard
E. Other

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My greatest motivation in considering working in an urban underserved community is…

A. Practicing complex, comprehensive medicine
B. Working in a culturally diverse community
C. Idealism / practicing with purpose
D. Interest in public health

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The 2017 federal poverty level for a family of 2 is

A. 12,000
B. 16,000
C. 26,000
D. 34,000
E. 42,000

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In 2015, what was the number of patients nationally who received care at a community health center

A. 1 in 12
B. 1 in 32
C. 1 in 65
D. 1 in 112

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In 2015, what percentage of CHC patients had income below the federal poverty level (i.e. <$16K for 2, 20K for 3, 24K for 4)

A. 25%
B. 49%
C. 62%
D. 71%

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OBJECTIVES

- Describe how SDOH affect patient outcomes
- Access resources to better understand how health is impacted by race and class
- Discuss realistic opportunities for community health interventions during residency
- Identify practical tools that can help with an urban underserved practice
- Appreciate the joy

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II. SOCIAL DETERMINANTS OF HEALTH

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SOCIAL DETERMINANTS OF HEALTH

Economic and social conditions → differences in health status

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SOCIAL DETERMINANTS OF HEALTH

- Risk factors in one's
  living and working conditions
  ….rather than individual factors

  that influence the risk for a disease

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SOCIAL DETERMINANTS OF HEALTH

- Not a "natural phenomenon".
- Due to :
  -- poor social policies,
  -- unfair economic arrangements
  -- bad politics."
  -World Health Organization

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FACTORS IN SDOH

- EARLY CHILDHOOD DEVELOPMENT
- EDUCATIONAL OPPORTUNITIES
- RACE AND GENDER
- SOCIAL EXCLUSION
- EMPLOYMENT OPPORTUNITIES
- SOCIAL SUPPORT NETWORKS
- STRESS
- EXPOSURE TO VIOLENCE
- ACCESS TO HEALTHY FOOD AND WATER
- ACCESS TO HEALTHCARE

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"Health starts where we live, learn, work and play."

– The Robert Wood Johnson Foundation (RWJF)

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Leaders in SDOH

- MICHAEL MARMOT
  - Chair of the WHO Commission on SDOH
  - **1980s/90s:** The Whitehall Study (I and II)
  - **2006**: Health in an unequal world (Lancet)
  - **2008**: Unnatural causes: Is inequality making us sick? (PBS Documentary and associated website)
- PAUL FARMER
  - Co-founder of Partners in Health
  - **2003**: Pathologies of Power (Univ of CA Press)
  - **2009**: Development: Creating Sustainable Justice (Joan B. Kroc Distinguished Lecture Series, USD)

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SUPPORTING EVIDENCE FOR SDOH

1) INEQUITIES BETWEEN COMMUNITIES
2) EDUCATION AND HEALTH
3) INCOME AND HEALTH
4) RACE AND HEALTH

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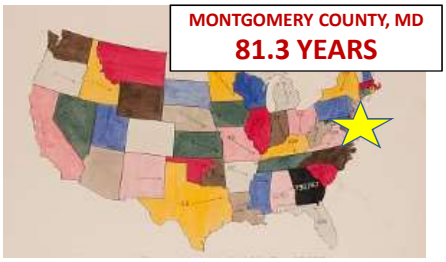
LIFE EXPECTANCY IN DIFFERENT COUNTIES ACROSS THE US



Source: RWJ Foundation: Commission to Build a Healthier America, 2008
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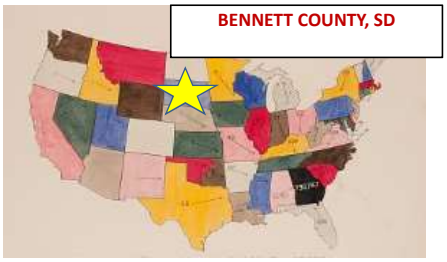

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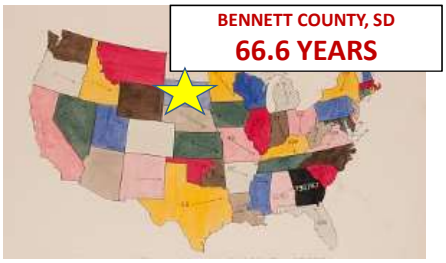

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A Short Distance to Large Disparities in Health:
Washington, D.C.

RWJ Foundation: A Healthier America

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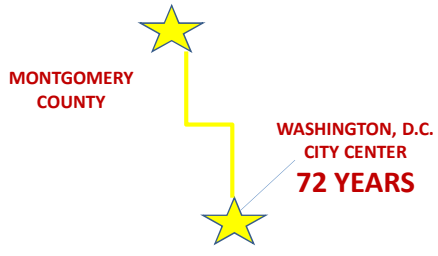

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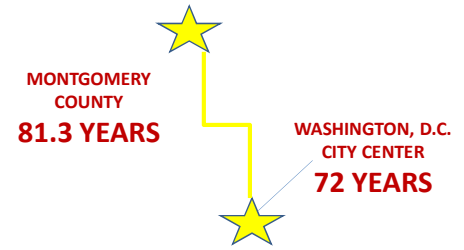

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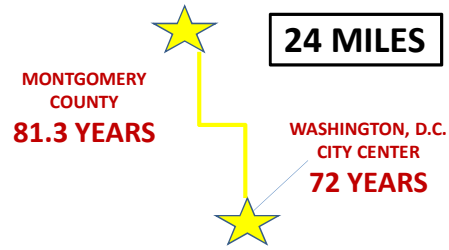

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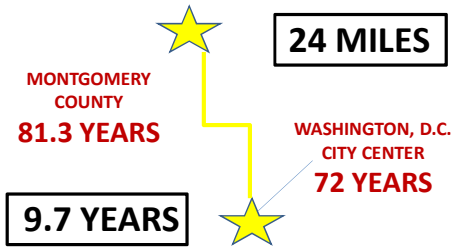

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SUPPORTING EVIDENCE FOR SDOH

1) INEQUITIES BETWEEN COMMUNITIES
2) EDUCATION AND HEALTH
3) INCOME AND HEALTH
4) RACE AND HEALTH

More education = Longer life

- College graduates live **5-7 years longer** than those who have not finished high school
  - Men and women

Source: National Longitudinal Mortality Study, 1988–1998.

More education = Longer life

- College graduates live **5-7 years longer** than those who have not finished high school
  - Men and women

EDUCATION (in years)	MEN	WOMEN
0-11	72.9	78.4
12	75.6	81.4
13-15	77.2	82.4
16 or more	79.7	83.2

Source: National Longitudinal Mortality Study, 1988–1998.

Education vs. Medical Advances

Giving everyone the health of the educated:
An examination of whether social change would save more lives than medical advances

–

Source: Woolf SH. AJPH April 2007.

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Education vs. Medical Advances

Giving everyone the health of the educated:
An examination of whether social change would save more lives than medical advances

– Impact of medical advances vs. estimated health impact of having every adult in the US have at least some college education. (1996 -2002)
  – Deaths averted by medical advances
    • **195,619**
  – Deaths averted by eliminating education-associated excess mortality
    • **1,369,335**

Source: Woolf SH. AJPH April 2007.

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Ratio of 8:1

Source: Woolf SH .AJPH April 2007.

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SUPPORTING EVIDENCE FOR SDOH

1) INEQUITIES BETWEEN COMMUNITIES
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Higher income = Longer life

- Life expectancy ↑↑ with increasing income
- Men and women in the highest income group live **6-8 years longer** than poor men and women

Source: National Longitudinal Mortality Study, 1988–1998.
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- Life expectancy ↑↑ with increasing income
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INCOME as % FPL	MEN	WOMEN
<100%	**70.5**	**76.5**
100-200%	72.7	79.5
200-400%	76.5	81.5
>400%	**78.5**	**83.2**

Source: National Longitudinal Mortality Study, 1988–1998.
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SUPPORTING EVIDENCE FOR SDOH

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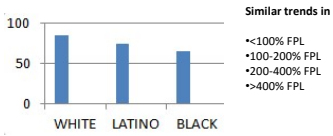
Racial / Ethnic Disparities

- Racial or ethnic disparities do not just reflect differences in income
- Racial or ethnic disparities are seen within each income group.



Source: National Health Interview Survey, 2001-5, Robert Wood Johnson Foundation, 2008.

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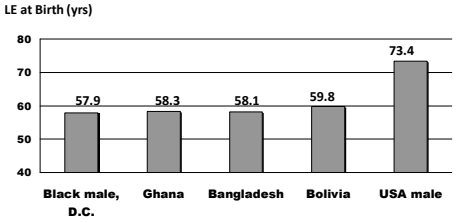
Male average life expectancies



Source: Harvard Global Burden of Disease Unit. Kawachi lecture notes; Society and Health, 2009.

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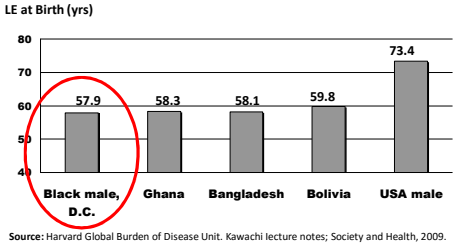
Male average life expectancies



Source: Harvard Global Burden of Disease Unit. Kawachi lecture notes; Society and Health, 2009.

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What accounts for racial and ethnic health disparities?

- Socio-economic status
- Genes
- Overt racism
- Systemic racial and class bias
- Implicit bias
- Access to healthcare

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Consideration for different levels of racism

- **Institutional racism** (segregation of resources)
- **Personally mediated racism** (explicit bias)
- **Internalized racism** (implicit bias)

Sources:

Jones, C.P., Levels of racism: a theoretic framework and a gardener's tale. Am J Public Health, 2000. 90(8): p. 1212-5

https://cultureandhealth.wordpress.com/2011/01/10/three-levels-of-racism/

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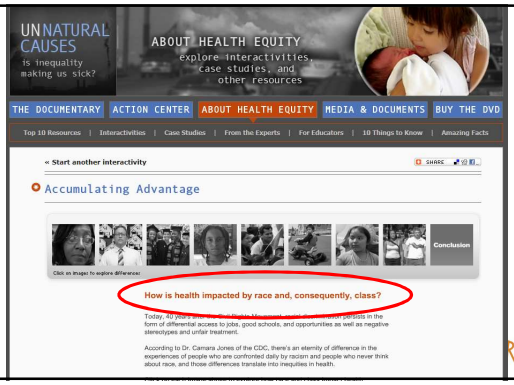

Resources addressing impact of race on health

- Unnatural causes (website and documentary)
  - http://www.unnaturalcauses.org/
- Accumulating advantage
  - http://www.unnaturalcauses.org/interactivities_08.php
- Dr. Camara Jones article on 3 levels of racism
  - https://cultureandhealth.wordpress.com/2011/01/10/three-levels-of-racism/
- 10 Things to know about health (pages 6-7)
  - http://www.unnaturalcauses.org/assets/uploads/file/UC_DiscussionGuide_All.pdf
- Implicit bias testing (Harvard)
  - https://implicit.harvard.edu/implicit/takeatest.html

SDOH take home points

- SDOH are not natural phenomena
- SDOH directly effect risk for disease and health outcomes
- Socio-economic and race status impact health
- Physicians need to be aware of the complex role that SDOH play in out patients' lives

"If medicine is to fulfill her great task, then she must enter the political and social life.

Do we not always find the diseases of the populace traceable to defects in society?

Since disease so often results from poverty then physicians are the natural attorneys of the poor, and social problems should largely be solved by them."

-Rudolf Virchow

III. THE CITY OF LAWRENCE

LAWRENCE

- Population 78,000
- Poorest, most Latino city in MA
  - 27% of population under federal poverty level
  - 74% Hispanic/Latino
  - 34% Foreign-born
  - 74% Speak a language other than English
  - Per capita income $17,295/year

Sources: Census Bureau Data, 2016, Citydata.com 2015, Boston Globe 2009

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EDUCATION IN LAWRENCE

–% of population with at least some college education

- United States 58%
- Massachusetts
- Andover
- Lawrence

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EDUCATION IN LAWRENCE

–% of population with at least some college education

- United States 58%
- Massachusetts 65%
- Andover
- Lawrence

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EDUCATION IN LAWRENCE

–% of population with at least some college education

- United States 58%
- Massachusetts 65%
- Andover 81.7%
- Lawrence

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EDUCATION IN LAWRENCE

–% of population with at least some college education

- United States 58%
- Massachusetts 65%
- Andover 81.7%
- Lawrence 32.2% (2009)

US Census Bureau, 2005-2009

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POVERTY IN LAWRENCE

- % of population below poverty level

–United States – 13%
–Massachusetts
–Lawrence
–Lawrence- single mother –

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POVERTY IN LAWRENCE

- % of population below poverty level
  - –United States – 13%
  - –Massachusetts – 10%
  - –Lawrence
  - –Lawrence- single mother –

Source: US Census Bureau 2005-2009

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POVERTY IN LAWRENCE

- % of population below poverty level
  - –United States – 13%
  - –Massachusetts – 10%
  - –Lawrence – 27%
  - –Lawrence- single mother –

Source: US Census Bureau 2005-2009

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POVERTY IN LAWRENCE

- % of population below poverty level
  - –United States – 13%
  - –Massachusetts – 10%
  - –Lawrence – 27%
  - –Lawrence- single mother – 38.4%

Source: US Census Bureau 2005-2009

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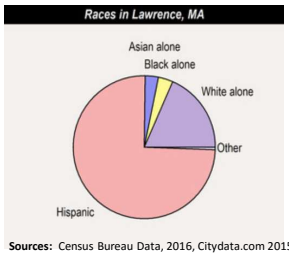
RACE IN LAWRENCE



Sources: Census Bureau Data, 2016, Citydata.com 2015

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LAWRENCE HEALTH MEASURES

- HIGHER THAN STATE AVERAGE IN
  - – OBESITY
  - – DIABETES
  - – SELF-RATED POOR HEALTH
  - – CV MORTALITY

Source: Kauffman, Social Determinants of Health in Lawrence, 2011

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INTERNALIZED EMOTIONAL IDENTITY

- LAWRENCE : **"CITY OF THE DAMNED"**
  - – Boston Globe – Boston Sunday Magazine feature
  - – "Crime is soaring, schools are failing, government has lost control, and Lawrence, the most godforsaken place in Massachusetts, has never been in worse shape."

Source: "City of the Damned, Jay Atkinson, Boston Magazine, March 2012

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LAWRENCE: Rewriting the script

https://www.youtube.com/watch?v=N3xLeDD04ZE

Source: Robert Woods Johnson Foundation, October, 2015

IV. COMMUNITY-BASED INTERVENTIONS

WHAT ARE THE NEEDS IN YOUR COMMUNITIES?

- What needs have you found where you work?
- How have you responded to them?
- What community health initiatives have you seen that have helped an individual patient's care?
- What individual interventions have you seen implemented that were not successful?

#1 THE IMPORTANCE OF A COMMUNITY NEEDS ASSESSMENTS

– "... there is a danger of a top-down approach to providing health services, which relies too heavily on what a few people perceive to be the needs of the population rather than what they actually are."

Source: Wright et al. Development and importance of health needs assessment. BMJ 1998. 316:1310.

#2 THE ROLE OF THE COMMUNITY HEALTH CENTER

- **CHC**: Private, non-profit, receive public funding.
- **1st CHC** opened in 1965 in Boston, now >1,200
- **MISSION**: to increase access to community-based primary health care services and improve the health status of medically vulnerable populations."

#2 THE ROLE OF THE COMMUNITY HEALTH CENTER

- **CHC**: Private, non-profit, receive public funding.
- **1st CHC** opened in 1965 in Boston, now >1,200
- **MISSION**: to increase access to community-based primary health care services and improve the health status of medically vulnerable populations."

"Health services… can change the cycle of poverty and ill health."

CHCs provide….

- Less expensive care
- More comprehensive care
- Care for poor /marginalized populations
- Some degree of social services /programs

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#3 ASK DIFFERENT QUESTIONS

- **CONVENTIONAL QUESTION:** How can we promote healthy behaviors?
- **HEALTH EQUITY PERSPECTIVE:** How can we target dangerous conditions and ensure healthy spaces and places?

- **CONVENTIONAL:** How can one protect themselves from health threats?
- **HEALTH EQUITY:** How can community organizing and alliance building help create policies that protect the public good?

- **CONVENTIONAL:** Which populations have the worst health?
- **HEALTH EQUITY:** What causes the unequal production and distribution of the conditions that promote and harm health?

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GREATER LAWRENCE FAMILY HEALTH CENTER

- Federally Qualified Health Center
- Opened in 1980
- First residency sponsored by a CHC 1994
- 60,000 patients
- 6 sites, 2 schools, shelters, community center
- 100+ physicians/PA's/NP's

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COMMUNITY-BASED INTERVENTIONS IN LAWRENCE

- **Can't recruit doctors** → Start a residency
- **Need spanish fluency** → Integrate into curriculum
- **Cultural education** → Send docs to the DR
- **Food insecurity** → Organize a food program
- **Patients depressed** → Run group visits
- **Losing pregnant patients** → Start an OB Fellowship
- **Opiate addiction** → Invest in a suboxone program
- **HIV patients with co-infection** → Viral hepatitis clinic
- **Underserved trans population** → Transgender clinic
- **Health cooking** → Offer cooking classes

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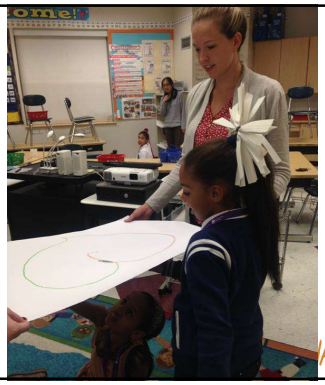

V. PRACTICAL POINTERS

#1 DO AN URBAN UNDERSERVED ROTATION

- EXPERIENCE FUELS INTEREST
  - Medical schools can foster interest in serving disadvantaged populations by providing students with training experiences in underserved settings.

Sources: Specialty and Geographic Distribution of the Physician Workforce: What Influences Medical Student and Resident Choices?", The Robert Graham Center: Policy Studies in Family Medicine and Primary Care; Robert L. Phillips, Jr., MD MSPH et al, March 2, 2009.

#2 FIND A GOOD MATCH (and a mentor)

- Be intentional about what your interests are
  - Working with a certain group / culture
  - Specific language
  - Refugee medicine
  - Substance abuse / addiction
  - Region of country

DO YOUR RESEARCH!!
INSPIRATION LOVES COMPANY

#3 LEARN A LANGUAGE

- Travelling = good option (think 4th year spring)
- Go by yourself (speaking English won't help)
- Don't need to go abroad
- Something is better than nothing
- BUT – don't overestimate your ability

#4 EMBRACE CULTURAL HUMILITY

- Learn about where people are from
- Share your genuine interests
- Read and inquire - Don't presume
  - Reframe your questions in the exam room:
    - http://www.ihi.org/communities/blogs/PublishingImages/mafvgnc4.goc.1e880535-d855-4727-a8c1-27ee672f115d.223.jpg

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In the Exam Room

Questions for first visit goal is to make the implicit, explicit:

1. "I don't want to assume anything about your identities. How do you identify racially, ethnically, culturally and what are your pronouns?"
2. "Many of my pts experience racism in their health care. Are there any experience you would like to share with me?"
3. What have been your experiences with the healthcare system?"
4. "Have there been any experiences that caused you to lose trust in the healthcare system?"
5. "It is my job to get you. You shouldn't have to work to get me. If I miss something important or say something that doesn't feel right please know you can tell me immediately and I will thank you for it."
6. "Put up more visible cues for safe space: BLM, Flag, etc.
7. acknowledging, honoring what pts are already doing – "wow, you're already doing so much"
8. "what's happened to you" vs. "what are you doing"
9. Curiosity can feel like colonizing language: Not, "can you explain to me why…." instead "there is something I don't know that I really need to understand…."

ERENCE

#5 APPRECIATE INFLUENCE OF SDOH

- Ten things to know about health
  - http://www.unnaturalcauses.org/assets/uploads/file/UC_DiscussionGuide_All.pdf
- Resources on culture and health
  - https://cultureandhealth.wordpress.com/about/
- Explore implicit bias
  - https://implicit.harvard.edu/implicit/takeatest.html

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#6 MANDATORY READING

- Pathologies of Power (Paul Farmer)
- The Spirit Catches You and You Fall Down (Anne Fadiman)
- Health in an Unequal World (Michael Marmot)
- Levels of Racism (Camara Jones)

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#7 CONSIDER THE MEDICINE
(and Family Medicine)

- **Family medicine**: a natural fit for those who work in disadvantaged communities.
- **Relevant topics to focus on:**
  - Global health and ID
  - Mental health
  - OB and Women's Health
  - HIV – Hep C
  - Homeless Medicine
  - Substance abuse / Addiction

Become a champion of a specific medical issue

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#8 CONSIDER THE FINANCES

- National health service corps
- Public service loan forgiveness
- Individual CHC loan repayment

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#9 MIND THE CHALLENGES

- **Daily frustrations** - lack of access, specialty services, "compliance"
- **Poor funding** - always working on bootstraps
- **Competing interests**: Balancing need for addressing major community health issues and need to learn how to be a doctor
- **Being an "outsider"** Providing care to a patient population that you are by definition not a part of
- **Stressful life trauma**: Facing trauma and violence daily through our patients' experience

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#10 DO ADVOCACY WORK

- Opportunities through the AAFP
- Attend the Family Medicine Advocacy Summit
- Organize a day at the state house
- Find inspiration from your local groups
  - **BSHAC: Boston Student Health Activist Community**
    - Various emails, promoting rallies, petitions, action
  - **Massachusetts Progressive Health Activists**
    - Monthly dinners to discuss local issues
  - **SURJ: Showing Up for Racial Justice**
    - Events, activities, campaigns

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IV. KEYS TO GETTING IT RIGHT

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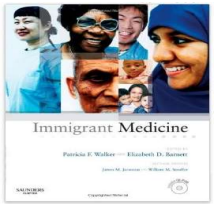
#1 DEVELOP YOUR COMPASSION

What do you need to maintain compassion amidst stress?



A medical textbook with a chapter on COMPASSION

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#2 UNDERSTAND SOLIDARITY

- Stages of working with the poor
  – Albert Nolan – Dominican priest

1) Compassion
2) Poverty = structural problem
3) Humility in service
   The poor know what they need – Listen to them
4) Solidarity –"We" vs. "us and them"

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#3 GET THE BEST TRAINING

- URBAN UNDERSERVED MEDICINE REQUIRES BREADTH OF TRAINING POSSIBLE
- Family medicine
- Family medicine
- Family medicine
- Family medicine

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#4 FIND THE RIGHT PLACE

For you……..and them

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#5 TAKE CARE OF YOURSELF

- –We drink from our own wells
- –Eat well, exercise as possible; reflect
- –Appreciate the beauty
- –Celebrate the victories

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CONCLUSION

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WHAT DO WE DO AS DOCS IN URBAN UNDERSERVED SETTINGS?

We become the doctors our patients and communities need.
We inspire, nourish, and support each other.
We dream big.
We partner with our community.
We practice evidence-based medicine.
We collaborate openly and recognize our own limits.
We never stop learning.
We challenge systems of injustice.

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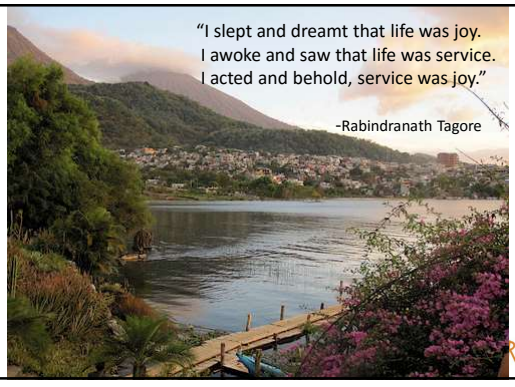

RENCE

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Good Social Determinants Websites

- http://www.commissiononhealth.org
- http://www.unnaturalcauses.org
- http://www.who.int/social_determinants/en/

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Q&A

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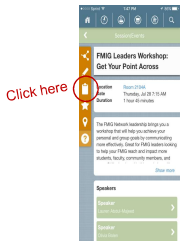
Let your voice be heard!

Evaluate workshops on the NC app



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