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PRESIDENT'S COLUMN

BUILDING A PHYSICIAN WORKFORCE TO ADDRESS THE SOCIAL DETERMINANTS OF HEALTH

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". . . to understand the context of our patient's health, not only their disease, is foundational for medicine and general internal medicine. It is even expected that we document a social history in notes recording encounters with our patients. Even without this, we all recognize the role of social needs in contributing to illness and disability as well as the impact of social needs on their ability to deliver effective health care. . . ."

Throughout this year, I plan to devote my column to cover some of the exciting work happening in the United States to address health beyond clinical excellence. I believe that understanding and addressing the social determinants of health (SDOH) to be a part of the core work we do as general internists, whether we consider ourselves predominantly clinicians, researchers, educators, policy makers, or leaders. We may address the social determinants directly or in partnership with others. It is essential because every one of our patients, and likely many members of our family and community, are impacted by the social determinants of health. This concept, that we need to have the capability and capacity to care for the whole person, inclusive of the understanding of their context, is not a new one for us. Whether our core site of work is in the inpatient environment, the outpatient environment, or someplace else, to understand all the drivers of health for our patients is critical.

In my first *Forum* column, I introduced the broad concepts about the social determinants of health. In that May 2019 issue, I indicated that health and wellbeing are foundational to economic vitality and business competitiveness, personal achievement, and prosperity. An increased level of health for all Americans is key to the promotion of thriving lives, economies, and communities. Healthy People 2020 defines the social determinants of health as the "conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks."[1] Health outcomes strongly relate to these upstream social determinants of health, which include a variety of non-medical factors such as food access and nutrition, transportation, housing, incarceration and recidivism, jobs/wages, safety, education, and other community-based, and environmental conditions. Intervening in these social determinants can improve health outcomes and lower cost.[2]

The notion that we should understand the context of our patient's health, not only their disease, is foundational for medicine *and* general internal medicine. It is even expected that we document a social history in notes recording our encounters with patients. Even without this documentation requirement, we all recognize the role of social needs in contributing to illness and disability as well as the impact of social needs on their ability to deliver effective health care whether because of experiencing social needs challenges in their own patients or having an opportunity to learn about the social determinants of health as part of their undergraduate or graduate medical educational experience.

Each of us can readily share a story of someone whose medical issues were not the reason they recurrently visited the emergency room, had prolonged hospital stays, or struggled to adhere to their care plans. I recall a Veteran with a diagnostically challenging series of episodic pulmonary infiltrates. It was not until I took a thorough social history that we were able to diagnose him with Farmer's Lung, from side work he picked up on weekends baling hay to supplement his income. Or the elderly man who visited our emergency room nearly weekly with chest pain, always ruled out for myocardial infarction and anything else we could include in the work-up. A conversation at the bedside revealed he was lonely, having lost his spouse and being estranged from his kids. Or the woman with refractory hypertension who became normotensive off medication when she was able to safely leave a physically and emotionally abusive relationship.

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Because of experiences like these, I have no doubt that general internists have an important role in understanding and supporting interventions to address the social needs of their patients. We are likely to have longitudinal or intense relationships with patients that support the development of trust and encourage our patients to share more insights about their social risks and social needs facilitating the implementation of supportive interventions as a component of care delivery. This is true no matter the predominant setting of our care—outpatient, inpatient, or in the community.

There is a growing recognition of the need to include formal education about the social determinants of health as part of physician training and some medical schools are calling for a dramatic rethinking of the social mission of medical schools more broadly, including the responsibility to focus on educational, research, clinical and community service efforts on the social determinants of health, particularly for the communities where they are located. A systematic review of the literature found rising interest in including social determinants of health as part of medical education.[3] Medical education leaders and experts are also supportive of increasing the exposure to the social determinants of health across the medical education curriculum but there is ongoing need to develop a shared curriculum, teaching methods and evaluation of impact.[4] The work in the area is still new however, especially for graduate medical education. When residency programs do include content on social determinants of health, it is largely didactic and provided in short or one-time sessions.[5] That said, there is evidence that even relatively simple educational interventions can enhance understanding of social needs and appropriate resources such as access to nutrition programs for those who are food insecure.

My home institution—the University of Texas at Austin Dell Medical School (Dell Med)—is a leader in developing curricula and experiences that help our medical students and residents understand the influence of the social determinants on health outcomes and build skills to help address them. Dell Med is a new school whose first class of medical students are only in their third year. They are experiencing an innovative curriculum preparing them for 21st-century health care and a core component is to ensure that they understand and feel more capable of addressing SDOH.

At Dell Med, the Department of Population Health, founded and led by former SGIM President Bill Tierney, has established a model undergraduate medical education experience for our students to introduce them to concepts around SDOH. The department is part of a newly emerging group that has established population health within U.S. medical schools to advance a broader and more holistic view of health that is purposefully inclusive of both medical and social determinants.[6]

The Dell Med's Department of Population Health's Primary Care, Family & Community Medicine Clerkship is a two-year longitudinal course that runs across the student's first two years and involves a continuity primary care clinic clerkship that they attend a half day a week. Our Dell Med curriculum is structured so that the students complete their clinical rotations by the end of second year and they undertake research and/or are pursuing a secondary degree, such as a certificate in value based care, in the third year. As such, this longitudinal clinical clerkship and ambulatory experience is their only clinical experience during their third year. The first year of the curriculum is constructed so that every fifth week, rather than their weekly half day of clinic, the students come together with faculty and have shared didactic experience on topics relevant to primary care. They split into small groups and walk through interactive clinical cases that are centered around a theme that focuses on common presentations in primary care. All the clinical cases have an SDOH challenge woven into the narrative to demonstrate how SDOH is integral to their care of *every* patient.

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Relationship of the Social Determinants of Health to Outcomes

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks			Discrimination	
Medical Bills	Playgrounds	Vocational training			Quality of care
Support	Walkability	Higher education			
Health Outcomes Mortality, Morbidity, Life Expectancy, Health Care Expenditures, Health Status, Functional Expectations					
READMISSION ↑		**NON-ADHERENCE ↑**		**COST ↑**	
OUTCOMES ↓		**SATISFACTION ↓**		**RISK ↑**	

Adapted from Kaiser Family Foundation

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If the work at Dell Med and the findings in the literature sparks your interest, I hope you will access some of the references and resources to learn more. If you are already engaged in undergraduate, graduate, or other health professional education in this area, I hope that you will submit your work for publication in JGIM, the SGIM *Forum*, or for the 2020 Annual Meeting. The data is clear, we will only be able to meaningful improve the health of our patients and communities if we understand and work to address all the determinants of health, including the social determinants. This matters not only for our own care, but for the next generation of physicians and health professionals we have the responsibility to train.

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