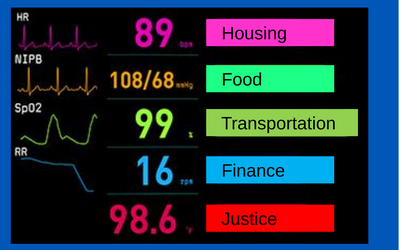
MAYO CLINIC

Social Determinants of Health and Justice are Vital Signs



Incorporating Social Justice into Residency Teaching as a Longitudinal Curriculum, Quality Improvement Project, and Social Justice Book Club

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INTRODUCTION

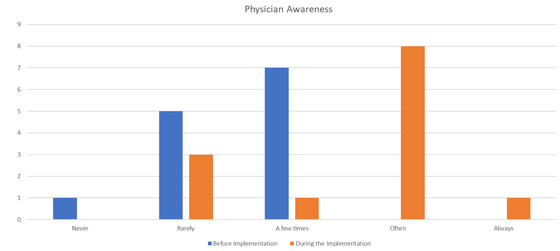
Social Justice in medicine is the idea that healthcare workers promote fair treatment in healthcare so that disparities are eliminated. Research has shown that cultural competence training improves the attitudes, knowledge, and skills of clinicians related to caring for diverse populations. Providing residents with the opportunity to explore social issues in health is the first step towards decreasing discrimination. This project was based on the model of three shields; education, engagement and implementation. Education was done with a monthly social justice talk, engaging in a quality improvement project and implementing the concepts into our monthly book club readings.

GOALS

To recognize that gross inequalities in health care are unacceptable for moral, political, social, and economic reasons, and to work toward a more equitable distribution of health care as part of health system change. To increase SDoH screening, increase provider awareness, increase personal model of care, and decrease the disparities gap. To advance, apply and practice social justice and health equity standards throughout our careers as physicians.

DESCRIPTION OF ACTIVITIES

- The longitudinal curriculum was focused on monthly discussion topics of social justice. The topics were based on the “precepting toward social justice” model of teaching from the University of Minnesota Department of Family Medicine and Community Health. The discussions provided knowledge, skills, and attitudes that helped residents and faculty build toward the competency.
- The QI project focused on any patient that came to the residency clinic. Nursing screened each patient for SDoH vital signs. If the SDoH questionnaire had not been updated in the EHR in the prior 6 months, the patient was provided with a paper copy of the questionnaire. If the screening was positive, nursing marked the SDoH vital signs for assistance on the encounter paper for provider awareness and action by referral to the residency health equity coordinator. Paper questionnaires were entered into the EHR after the visit by nursing. The goal for the QI project was to increase screening, increase provider awareness, and increase referrals to HEC.
- The Book Club goal was to practice engaging in challenging conversations in a safe and professional space, to learn about social justice issues impacting the health and well-being of our patients, and to become better physicians. Topics covered have included health equity, systemic racism, reproductive justice, abortion, LGBTQ+ health, health policy, sexism, implicit bias, weight bias, segregation and many more. Meetings were conducted by Dr. Nick DeVetter on the first Wednesday of every month.



Month	Number of Patients Referred to HEC
March 2022	20
April 2022	24
May 2022	11
June 2022	20
July 2022	18
August 2022	19
September 2022	18
October 2022	21
November 2022	15
December 2022	13
January 2023	16

RESULTS

The data for the QI project was collected from mid-Sept to mid-Oct 2022. The number of referrals to HEC, and the number of patients who were screened were counted. A survey was used to measure provider awareness before and after the project, as well as any challenges that were indicated as barriers to the project. During that timeframe, 700 patients were seen in residency clinics. 104 patients were given paper copies due to not having updated SDoH screening. This data reveals that with this process, SDoH screening was increased by 15%. The number of referrals to HEC was also obtained and compared to the previous month; this did not show any significant increase in referrals. Although the survey from providers showed an increase in awareness, it also identified challenges and barriers to the process such as a referral process to health equity coordinator, variability in nursing personal, nursing time to screen patients and provider's time to discuss issues with patient.

CONCLUSION

The focus of this project was to increase awareness, increase SDOH screening and identify the challenges that providers and patients are facing to decrease disparity gaps. Systemic changes might be beneficial to overcome some of the barriers identified. Further follow-ups with patients who were referred to HEC would be appropriate in order to study the impact of the referral on overall health.