Creating a Workforce to Address Health Equity

WPP Advancing Health Equity Conference
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Roadmap

• Making the case for health equity education
• Moving beyond cultural competency
• Defining health system science as a new core discipline
• Addressing workforce issues
  – Three examples
Addressing Health Equity to Achieve the Triple Aim

- US health outcomes
- Racial disparities
- Caucasian health declines
- Under spending on structural support
- “Death by Zip Code”
Moving Health Care Accountability from Individuals to Populations/Communities
Cultural Competency Education: Two Decades of Work

1990
• Cultural Competence

2000
• Cultural Humility

2010
• Structural and Social Determinants of Health
Cultural Competence Education is Required

- LCME (medical schools)
- ACGME (residencies)
- Core Competencies for Inter-Collaborative Practice
- State License Boards
- Joint Commission

- Cultural competence is defined as the ability of providers and organizations to effectively deliver health care services that meet the social, cultural, and linguistic needs of patients.

- A culturally competent health care system can help improve health outcomes and quality of care, and can contribute to the elimination of racial and ethnic health disparities.
Cultural Competence vs. Cultural Humility

- Builds an understanding of diverse cultures to better and more appropriately provide services
- Values knowledge & training
- Strengths: Promotes skill building.
- Shortcomings: Enforces the idea that there can be 'competence' in a culture other than one’s own. Can reinforce the myth that cultures are monolithic.

- Encourages personal reflection and growth around culture in order to increase awareness of caregivers
- Values introspection & co-learning
- Shortcomings: No defined end point. Can be ambiguous.
FIGURE S-2 Conceptual model for strengthening health professional education in the social determinants of health.
Workforce & Health Equity

![Graph showing trends in the proportion of underrepresented racial minorities (URMs) among medical school graduates and the U.S. general population.](image)

**FIGURE 2.2** Trends in the proportion of underrepresented racial minorities (URMs) among medical school graduates and the U.S. general population.

**SOURCE:** Sullivan, 2010 (AAMC).

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**Research Report**

**Latino Physicians in the United States, 1980–2010: A Thirty-Year Overview From the Censuses**

Gloria Sanchez MD, Theresa Neuman MD, MBA, Werner Schink MS, and David H. Hayre-Buckman PhD

**Abstract**

**Purpose**
To update and extend a 2009 study on the California Latino physician workforce, the authors examined the Latino physician workforce in the 30-year time frame spanning 1980 to 2010, comparing changes in the rate of physicians per 100,000 population for the Latino and non-Hispanic white (NHW) populations in the United States as a whole and in the five states with the largest Latino populations.

**Method**
The authors used detailed data from the U.S. Census Public Use Microdata Samples for 1980–2010 to identify total population, total number of physicians, and Spanish language ability for both the Latino and NHW populations. They examined separately for only Latinos.

**Results**
At the national level, the NHW physician rate per 100,000 of the NHW population increased from 211 in 1980 to 315 in 2010 while the Latino physician rate per 100,000 of the Latino population dropped over the same period from 136 to 109. With small variations, the same trend occurred in all five of the states examined. At the national and state levels, Latino physicians were far more likely to speak Spanish than NHW physicians. Over the 30-year period, the Latino physician population has worked from being primarily foreign born to being almost evenly split between foreign born and U.S. born.

**Conclusions**
The Latino physician shortage has worsened over the past 30 years. The authors recommend immediate action on the national and local level to increase the supply of Latino physicians.

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Addressing Workforce Diversity: Multi-factorial Needs

- Pipeline programs
- Post baccalaureate programs
- Health professions training
- Residency training
- Mentoring and role modeling
- Career transitions support
What if you could redesign medical education?
Accelerating Change in Medical Education Initiative

• RFP process: $13.5 million in grants to medical schools
  – 11 schools in 2013
  – 21 schools in 2015
  – 19,000 students ~ 33 million patient visits each year

• Consortium formed to jumpstart and speed dissemination of ideas
  – Meets twice a year (150 people)
  – Thematic meetings and focused interest groups

www.changemeded.org
Evolving Medical Education for New Models of Care

Moving care from:
- Acute
- One physician
- One patient
- Clinic

Moving care to:
- Chronic
- Teamwork
- Population health
- Community
Health System Science: A New Core Domain for Health Professions Education

Supporting the Triple Aim

Patient Centered, Culturally Sensitive Care
Patient Safety, Quality & Value Based Care
Population Medicine
Social Determinants of Health
Health Disparities and Health Equity
Health Care Structure, Policy and Financing
Leadership, Teams and Community

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Medical School of the Future

- Patient centered outcomes
- Health Equity
- Health care workforce
- Diversity
- Under-served populations
- Health care financing
- Patient safety
- Health systems science
- Quality improvement
- Competency-based assessment
- Team-based care
- Advanced technology
- Data analytics
- Teaching EMR

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UC-Davis SOM Holistic Admissions and ACE-PC Track
UC-Davis Accelerated Competency-based Education

- Admissions program designed for diversity goals (holistic, mini-interviews)
- Partnered with Kaiser Permanente Northern California to develop 6-year accelerated primary care track
- Medical school completed in 3 years; accepted into UC-Davis KP residency
- Begin clinical training in summer prior to medical school
- Clinical clerkships are longitudinal
- Community & health equity focus
Patient Navigator Program:
Penn State School of Medicine
Penn State SOM Patient Navigator Program

• Strong, evidence-based patient navigator programs in central PA
• First year students matched with clinical settings
• Nested within longitudinal Health Systems Science course
• Patients/families referred for care navigation
• Six weeks of training with patient navigator faculty & standardized patients
• Learn first hand about strengths and challenges of health care system
Lessons from Successful Models

**FACILITATORS**
- Individualized
- Experiential
- Workplace located
- Authentic
- Add value to care
- Assessed (graded & tested)
- Faculty resources

**BARRIERS**
- Structural
- Add-on
- Elective
- Weekends & evenings
- Competing priorities
- Disconnected from care
- Faculty development
Video of FIU NeighborhoodHELP program

• https://youtu.be/RftDn7mbmPc
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Thank you!

www.changemeded.org