Introduction

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This book seeks to provide an initial framework for promoting learning about health disparities and social determinants of health among health professionals. In 2012, we began to teach health disparities to primary care physicians as part of a faculty development program. During the delivery of the health disparities component of the program, we developed a range of teaching strategies, curricula, and associated resources for promoting learning about health disparities among medical professionals. In this chapter we provide an overview of possible goals and objectives for a health disparities curriculum and an introduction to our pedagogical approach.

Background

MetroHealth Medical Center is an urban, county-funded, safety net public hospital and a Level I trauma center in Cleveland, Ohio. Since its beginning in 1837, MetroHealth's constituents have disproportionately represented the poor, the elderly, people of many different races and ethnicities, and others from the City of Cleveland and Cuyahoga County who are in need of health care and often unable to pay. In addition, MetroHealth is known for a wide range of medical programs that treat patients with burns, kidney failure, tuberculosis, and HIV/AIDS and infants of addicted mothers, a physical medicine and rehabilitation department notable for care of spinal cord injury and traumatic brain injury and a bustling

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emergency room. MetroHealth is an affiliated Institution of Case Western Reserve University (CWRU). Narratives in this book draw upon decades of experience from clinicians caring for patients at MetroHealth and at many clinics, hospitals, and community locations in Cleveland and across Ohio and other areas.

The Department of Family Medicine at MetroHealth was the academic hub for educating three to four faculty scholars per year in an effort to develop basic knowledge, skills, and attitudes essential to medical scholarship. To this day, the overall curriculum of our training and faculty development programs consists of four primary courses including medical education, health disparities and social determinants, population health, and quality improvement. While this book relies primarily on narratives and innovations in health disparities education, we also experienced a synthesis from other collaborating educators in developing objectives, content, instructional methods, evaluation methods, and other features of the health disparities curriculum. Our work benefits most especially from the insights, writing, and ideas that come from faculty scholar learners themselves.

Goals of the Health Disparities Curriculum

The overall goals of the health disparities curriculum are similar to those typically found in undergraduate and graduate university coursework, and those are echoed here in this book. We review clinical cases together with social, political, economic, cultural, legal, and ethical theories related to health disparities in order to:

1. Develop a nuanced understanding of causes of health disparities.
2. Describe how health-care system and individual issues coalesce to create health disparities.
3. Connect health disparities encountered in clinical medicine to broader social problems.
4. Explore strategies for reducing/eliminating health disparities.
5. Encourage scholars to learn self-directed positive habits of the mind in writing a case narrative on a specific patient with a health disparity or a specific social situation, thereby challenging the scholar to develop knowledge proficiency.

Preparation of a Health Disparities Curriculum

Preparation of materials for a health disparities curriculum presents a unique set of challenges. Existing graduate-level courses on health disparities, including one co-taught by Dr. Perzynski at CWRU, are targeted to an audience of graduate student learners who more often than not have little firsthand knowledge of health disparities. The situation is drastically different at MetroHealth where clinical personnel are confronted on a daily basis with adverse circumstances, including patients who live in poverty, are homeless, do not have health insurance or a regular source of

income, and who come from a wide variety of diverse racial and ethnic backgrounds, many of whom do not speak English.

When planning our program in 2011, a search of the literature on teaching health disparities and social determinants of health to current and future health-care practitioners yielded few results. In the absence of a strong literature supporting educational strategies for health disparities in this audience, our approach was to rework the aforementioned graduate-level health disparities course by enlisting the input of the learners, the clinical faculty in the faculty development program.

Emergent Learning

Our emergent learning approach is adapted from the book, *We Are All Explorers,* which describes the *Reggio Amelia* approach to education that has been successful among young school children (Scheinfeld et al. 2008). According to the *Reggio Amelia* approach, people learn best when they explore a topic out of their own desire to know more about it. Thus, among our learners the curriculum is structured to elicit the scholars' own experiences and concerns about health disparities first and then select readings and craft a set of activities "on the fly." For example, in the introductory health disparities session it became clear that the seminar participants had a great deal to say about their direct experiences and frustrations with how broader social problems can become health disparities for their patients.

In response to this interest, participants were asked to draft case narratives of the social needs and disparities encountered by patients in their clinical practice. We designed a miniature curriculum that taught the scholars the principles of developing and writing case narratives with a focus on health disparities and social needs. The problem of not knowing the best ways to teach doctors about health disparities became the responsibility of the learners, and the process of learning about health disparities also became a process of collaborative learning of how to teach others.

In addition, the learners have gone on to develop and implement workshops and curricula for (1) teaching health disparities through narrative among Advanced Practice Registered Nurses via simple workshops; (2) promoting learning about health disparities among physician residents and trainees in a mini-course structure as part of residency; (3) developing curricula and materials for workshops at national health professional meetings, including one given at the 2014 Annual Meeting of the Society for Teachers of Family Medicine and another at The American Geriatrics Society Annual Meeting; (4) developing their own new health disparities courses in medical schools and clinical departments around the country; and (5) implementing dozens of new quality improvement and research projects focused on addressing social determinants of health in care processes and disease outcomes.

The case narrative approach provides opportunity for ongoing reflective critique and revisions. While the emergent learning approach has many advantages, on occasion the participants and the instructors struggled slightly with the loose, exploratory learning environment. For example, faculty scholars' feedback indicated that

they craved more structure in the curriculum, including a preference for more detailed and structured handouts. Thus, changes were made to supplement the open, seminar atmosphere with more detailed handouts and some other more structured activities including the viewing of videos on health disparities and visits by local health disparities experts.

The demands of health and medical training and the pace of work in clinical environments caused some participants to have difficulties fitting writing into their schedules. As instructors, we have found it challenging to provide timely feedback on the written cases prepared by participants. We worked to spend additional in-class time devoted to writing, and class time was occasionally "traded" to the scholars in order that they were able to spend additional time writing and revising their written case narratives. In all, the challenges of the emergent learning approach are more than outweighed by the benefits to the scholars' learning and changes in attitudes about health disparities. The broad enthusiasm among the scholars for sharing our work on health disparities with local and national audiences has been particularly encouraging.

Objectives from Health Disparities and Social Determinants Narrative Workshops

In exchange for the opportunity to participate in learning activities, participants are expected to:

1. Define and understand the nature of health disparities and social determinants of health as they affect patients and families of lower economic situations, patients of diverse racial and ethnic groups, and other disadvantaged populations.
2. Learn how to prepare a case narrative of a specific patient based upon oral and written feedback from faculty and fellow scholars.
3. Submit the case narrative for review and comment by the session leader.
4. Present the case narrative to the class for discussion, clarification, and feedback.
5. Revise the narrative and place it in his/her electronic portfolio.
6. Evaluate what s/he learned from the case narrative and the presentation to the class.
7. Commit to include the case narrative in future publications or presentations.

Evaluation and Outcomes for the Faculty Case Narratives Component

Over the last 6 years, hundreds of learners in our programs and courses have read, written, and/or presented a case narrative. Based on this writing, many have gone on to submit abstracts, give oral presentations, conduct workshops, redesign residency

curricula, conduct quality improvement or research projects, and even develop new clinical and academic programs.

Each time such an occasion has occurred, scholars have discussed the presentation as well as the results shared by each of the participants through their evaluations and feedback. As we continued to develop the program, we realized that many of these narratives were useful teaching tools and could be adapted for other health professionals, especially if we developed a collection that included an array of tools and learning experiences. Our overall goal is to eliminate health disparities. The pathway to that goal includes a critical awareness of the problem, a desire to improve the quality of care delivered to individuals of disadvantaged backgrounds, and the skills and resources to help team members understand their role in listening and empathizing with patients and families, as well as documenting and advocating for changes in social determinants of health.

At the outset, we did not realize that our work would become a model for teaching diverse learners in a variety of settings. True to form in the *Reggio* method, we are *all* explorers, and the process of learning about social determinants and discovering how to best promote awareness of health disparities continues through a shared sense of responsibility to sponsor health and social equity. We hope that the gentle minds of everyone who reads this book, from learners to workshop facilitators and faculty, experience growth in learning and passion that spreads throughout medical schools, health professions programs, and health institutions. We as professionals have a need to understand the social and cultural implications of disparities and determine a plan of action to effectively address social determinants and eliminate disparities in care and outcomes.

Reference

Scheinfeld DR, Haigh KM, Scheinfeld SJ (2008) We are all explorers: learning and teaching with Reggio principles in urban settings. Teachers College Press, New York