Section of International and Domestic Health Equity and Leadership (IDHEAL)

http://idheal-ucla.org/

UCLA Department of Emergency Medicine

Social Emergency Medicine Teaching Modules

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This curriculum is a collaborative effort of the faculty, fellow, and resident members of the Section of International and Domestic Health Equity and Leadership (IDHEAL) of the Department of Emergency Medicine of the University of California Los Angeles (UCLA).

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Please visit our website for more information about our work.
UCLA Department of Emergency Medicine, IDHEAL Website: http://idheal-ucla.org/

Introduction

The emergency department (ED) is historically where one thinks of sick/unstable patients with myocardial infarction patients, those who present with gunshot wounds, or crashing septic patients. Although designed for medical emergencies, EDs have become a common place where patients seek help for various problems. EDs thus care for patients who present not only for heart attacks and strokes, but also for a variety of social ills, such as homelessness, poverty, and hunger.[1] In doing so, the ED has become the safety net for those who lack access to other resources for their care.

Every ED screens patients for life-threatening illnesses, no matter the chief complaint. However, EDs and emergency providers are often left frustrated, as they may be unable to address the root cause of the patient's visit. This is not surprising, given that experts estimate that only 20% of a patient's health is shaped by medical care, whereas social and economic factors account for 50% of health outcomes, highlighting the importance of concurrent medical and social interventions to advance patient health outcomes.[2] Social determinants of health thus impede healthcare by simultaneously creating barriers to healthcare access and resulting in non-adherence to medical interventions. Furthermore, left unaddressed, social determinants drive up both healthcare cost and utilization. Even for those with access to healthcare, competing social needs impede the ability of the individual to adhere to treatment plans. Social determinants thus place a strain on the physician-patient relationship.[3]

Few emergency departments take a population health approach to patient health by screening for and addressing social determinants. In part, this is because traditional medical education focuses on the biological aspects of disease while ignoring social determinants, resulting in healthcare providers and a healthcare system that are unprepared to ask about and address social determinants, such as housing and food. Previous studies have shown that providers are unable to address these social issues because of: 1) lack of time, 2) lack of understanding of the importance of these issues, 3) discomfort exploring these issues, 4) lack of knowledge of available community resources, and 5) failure to understand the relevance of these issues.[4] Thus, when social issues surface, healthcare providers depend on social workers to attend to patients' needs

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[1] Malecha PW, Williams JH, Kunzler NM, et al. Material Needs of Emergency Department Patients: A Systematic Review. Acad Emerg Med 2018 epub ahead of print.

[2] LA County Department of Public Health, Social Determinants of Health: How Social and Economic Factors Affect Health Fig.2 (2013).

[3] McGregor J, Mercer SW, Harris, FM. Health benefits of primary care social work for adults with complex health and social needs: a systematic review. Health and Social Care in the Community 2016; 26(1):1-13.

[4] Doran KM, Kirley K, Barnosky AR, et al. Developing a Novel Poverty in Healthcare Curriculum for Medical Students at the University of Michigan Medical School. Academic Medicine 2008; 83(1):5-13.
Schubert CJ, Volck B, Kiesler J, et al. Teaching Advocacy to Physicians in Multicultural Settings. The Open Medical Education Journal 2009; 7(2):36-43.
Klein MD, Kahn RS, Baker RC, et al. Training in Social Determinants of Health in Primary Care: Does it Change Resident Behavior? Academic Pediatrics 2011;11(5):387-393.
Fornari A, Anderson M, Simon S, Korin E, Swiderski D, Strelnick AH. Learning social medicine in the Bronx: an orientation for primary care residents. Teach Learn Med 2011;23:85–9

without fully understanding[5] or championing engagement.[6] Although some residencies have recognized this shortcoming and have implemented various programs to teach about the social determinants,[7] there is no standard curriculum.

These modules were created as a way for interested individuals who care for patients affected by issues such as homeless and hunger, but who are not experts in the social determinants of health, learn about the social determinants of health. These individuals can then use these modules to teach other members of the healthcare team, including, but not limited to, students, residents, nurses, advanced practice providers, social workers, case managers, pharmacists, and attending physicians about different social determinants of health.

Collectively, these modules serve as a primer to the social determinants of health that affect our patients. Each module, however, intended to stand alone on the social determinants it covers, can be used to teach during rounds or in small groups focused on introductory concepts and clinical "pearls" rather than an exhaustive review. It is our hope that using these modules will allow providers to recognize, discuss, and address the social determinants of health to improve the patient experience, patient outcomes, and clinician experience, and promote health equity while decreasing costs.

We welcome feedback and suggestions for improvement and would love to hear about your experience (s) using the modules, and thoughts on additional topics to cover.

Sincerely,

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[5] Hsieh D, Wang M, Losonczy L, et al. "Thinking Outside of the Box: How Well Do Emergency Department Providers Understand Their Patients?" Abstract presented as Poster at the SAEM National Meeting, May 15, 2014 in Dallas, TX.

[6] Bachrach D, Pfister H, Wallis K, et al. Addressing Patients' Social Needs: An Emerging Business Case for Provider Investment. Commonwealth Fund (2014).

[7] See, e.g., Hsieh D, Coates W. Poverty Simulation: An Experiential Learning Tool for Teaching Social Determinants of Health.
Fornari A, Anderson M, Simon S, Korin E, Swiderski D, Strelnick AH. Learning social medicine in the Bronx: an orientation for primary care residents. Teach Learn Med 2011;23:85–9.
Primary Care Pediatrics. Oakland, CA: Children's Hospital of Oakland, 2017. Available at: https://www.childrenshospitaloakland.org/main/pediatric-residency-departments.aspx. Accessed April 28, 2018.
Community Pediatrics and Advocacy Rotation. Los Angeles, CA: Children's Hospital of Los Angeles, 2017. Available at: https://www.chla.org/community-pediatrics-and-advocacy-rotation. Accessed April 28, 2018.

Objectives of the Curriculum

Every healthcare professional encounters patients with unmet social needs, however, medical training programs do not cover social determinants in a uniform way. The curriculum is designed to be an introduction to the social determinants of health, their impact, and how to identify and address unmet social needs in the clinical setting. Specifically, the curriculum has four main objectives:

1. To demonstrate the intersection of social determinants of health, unmet social needs and acute emergency department visits as they relate to emergency department care and to connect these concepts to the overarching theme of health equity;
2. To purvey this content in a case based-format that will be easily accessible to learners in healthcare;
3. To support faculty in medical training programs (medicine, nursing, allied health professionals) who may not be experts but wish to teach about social determinants;
4. To help the learner develop a process for identifying and addressing patients' challenges with social determinants of health.

We have included recommended screening questions for each domain. These questions are based on the recommendation of the Los Angeles County Health Agency's Social and Behavioral Determinants of Health workgroup (White Paper forthcoming).

Guide for Faculty

Thank you for your interest in the IDHEAL Social Emergency Medicine teaching modules. Here is how we suggested we use these modules with your learners. We are working on a more in-depth faculty teaching guide for each module that will be available by December, 2018.

Each Module consists of:

1. Objectives
2. A Clinical Case
3. Discussion Questions
4. Teaching Points
5. Practical Questions about Your Institution
6. Recommended Screening Question
7. A Paired Reading from the Literature
8. Discussion/Teaching Points from the Reading
9. Additional Reading Recommendations

For On-Shift Teaching (10-15 minutes)
Read the case aloud to the residents and medical students. Use the questions to stimulate a brief discussion. Use the discussion questions to stimulate discussion. Use the teaching points to summarize the discussion and take-home learning points. Finally, use the practical questions to make sure learners know how this case would be handled in your own institution (i.e. available local resources and how to access them).

For Small Group Teaching (30-45 minutes)
Distribute the Suggested Reading (s) in advance of the session with sufficient time for participants to read the paper. Initiate the session as above using the case and discussion questions.

Learners with a Strong Interest (Long term)
For those learners who approach the instructor after the session with the question, "how can I learn more about this?", we have prepared the **Additional Reading Recommendations** section. You can encourage them to look at the additional readings and to engage with the authors of the modules and/or the authors of the additional readings. You can also suggest that they connect with emergency physicians with similar interests by joining the ACEP or SAEM sections of Social Emergency Medicine or by applying to the IDHEAL UCLA Emergency Medicine fellowship in Health Equity.

Module 1. Language
Breena R. Taira, MD, MPH

Objectives:

1. Increase awareness of needs and rights of Limited English Proficiency (LEP) patients.
2. Improve knowledge of policies and laws regarding language assistance use and best practices for the care of LEP patients.
3. Demonstrate how underutilization of language assistance leads to inappropriate care and contributes to health disparities.

Case:

A 77-year-old male was sent from a skilled nursing facility for "continuous crying". The resident noted a diagnosis code for dementia in the records from the nursing facility. On interview, the patient seemed to stare blankly when asked questions. Given his Japanese surname, they thought he might speak Japanese. The medical student on the team said she studied Japanese in college and offered to try speaking with him. She reported back to her superiors that the patient gave answers but they were unintelligible. They assumed that his dementia must be advanced stage and decided to cast a broad diagnostic net, sending a variety of lab tests and a chest x-ray to check for pneumonia.

The diagnostic tests resulted but nothing was remarkable. He was admitted for a cardiac workup and had been boarding in the emergency department for 10 hours waiting for a bed in the hospital to become available. At morning sign out, the on-coming team heard his story. On rounds, the attending called a Japanese interpreter who asked him in Japanese how he was feeling. To everyone's surprise, he answered appropriately: "I'm in pain". "Why are you crying?" "Because my heel hurts." His right heel had a large decubitus ulcer that had not been noted previously. He recently suffered a broken hip and his nursing facility was not changing his position in the bed, therefore he developed the decubitus ulcer. In the 10 hours that he had been in the ED, this was the first attempt to communicate with him through an interpreter. He quickly disclosed that, not only was the source of his crying the intense heel pain, but also that he was suffering ongoing neglect at the skilled nursing facility. Further, he was having difficulty speaking clearly because his dentures were left in the rehab facility. His admission for cardiac workup was cancelled, the patient received wound care, and a social work consult was called to find a new rehabilitation facility.

Through social work, the initial rehabilitation facility was reported to the state ombudsman for the neglect the patient experienced. The patient's chart happened to be chosen for audit as the hospital prepared for a Joint Commission survey and was flagged for lack of documentation of language assistance during the initial history and physical. The team that initially evaluated the patient was made to repeat their training on a patient's right to language assistance under title VI of the 1964 Civil Rights Act.

Discussion Questions

1. What were some of the characteristics of this patient encounter that predisposed to a failure of communication?
2. What process failure must have occurred for this to happen?
3. How do you identify a patient's need for language assistance?

Teaching Points

1. All patient interactions should begin by ascertaining the patient's preferred language. The patient's preference for language assistance should be given priority over the practitioner's assessment of the patient's English language skills.
2. We, as health care practitioners, have not only an ethical obligation, but also a legal one based on Title VI of the Civil Rights Act to provide language assistance to limited English proficiency patients. Language assistance should be provided by someone who has verified credentials to do so, such as a certified healthcare interpreter (CHI). Use of family members to interpret is discouraged and the use of minors to interpret is expressly forbidden in many institutions.
3. Clinician use of non-English language skills when non-fluent (such as those who have taken "medical Spanish") leads to poor patient outcomes. A team member who states they have language skills, but are not certified by the hospital as bilingual may or may not have the ability to communicate clearly. Use of certified healthcare interpreters is recommended.

Practical Questions:

(The responses are intentionally excluded from the module because they meant to be specific to your own hospital environment.)

1. What options exist in your department for language assistance?
2. What type of certification is required before speaking a non-English language with patients at your institution?
3. Is there a specific policy regarding procedural consents for patients with Limited English proficiency?

Recommended Screening Question(s):

1. What is the language (spoken and written) in which you prefer to receive your healthcare? (List of languages)

2. Would you like the assistance of an interpreter during your visit? (Yes/No)

Paired reading:

Diamond LC "Let's Not Contribute to Disparities: The Best Methods for Teaching Clinicians How to Overcome Language Barriers to Health Care" J Gen Intern Med 25 (Suppl 2):189–93.

Discussion Points from the Reading

1. The persistent trend of underuse of interpreters by clinicians leads to poor quality of care and worse health outcomes for LEP patients that contribute to health disparities on the population level.
2. Short term language training programs such as "Medical Spanish" may contribute to disparities because interpreter use diminishes after these trainings, yet language fluency has not been achieved. A more inclusive curriculum about how to overcome language barriers including how to work with interpreters and how to identify problems in interpreted encounters is preferable to traditional "medical Spanish" classes.

Additional Readings

Basu G, Costa VP, Jain P. Clinicians' Obligations to Use Qualified Medical Interpreters When Caring for Patients with Limited English Proficiency. AMA J Ethics 2017;19:245-52.

Fernandez A, Quan J, Moffet H, Parker MM, Schillinger D, Karter AJ. Adherence to Newly Prescribed Diabetes Medications Among Insured Latino and White Patients With Diabetes. JAMA Intern Med 2017;177:371-9.

Price-Wise G. An Intoxicating Error: Mistranslation, Medical Malpractice, and Prejudice: Center for Cultural Competence, Inc.

Taira BR. Improving Communication With Patients with Limited English Proficiency. JAMA Intern Med 2018 Mar 19 (Epub ahead of print).

Module 2. Culture
Kian Preston-Suni, MD

Objectives
1. Understand the connections between culture and health care.
2. Learn to consider an approach to providing patient-centered and respectful care when differences exist between patients, families and their physicians.

Case:
A 64-year-old man originally from El Salvador presents to your Emergency Department complaining of fatigue, weakness and weight loss. You perform a history with the assistance of a Spanish interpreter, identifying, along with the above symptoms a vague, persistent abdominal pain and decreased appetite. You note a frail appearing man in no acute distress with scleral icterus. His daughter tells you in English that he's never been sick and previously worked long hours in a warehouse until two weeks ago when his fatigue and weakness began to prevent him from working. He thought his symptoms were from *empacho* and visited a *sobador* for the abdominal pain but found no relief from the treatments provided.

A CT of the abdomen and pelvis shows a pancreatic mass with liver lesions and peritoneal enhancement. When you are about to enter the room, the daughter requests that you explain the findings to her, but not to your patient. You engage the daughter in discussion outside the room. She explains that her father tends to be very fatalistic and think that disease is God's punishment. She is afraid that if you explain to her father that he has cancer that he will refuse treatment.

Notes:
Empacho is a culture-bound syndrome, or folk illness, in which it is believed that food becomes stuck to the stomach or intestines and causes an obstruction. Symptoms may include abdominal pain, bloating, diarrhea, vomiting, or anorexia. It is generally treated with massage, herbal remedies, or dietary changes.
A *sobador* is an alternative medical provider used in various Latin American cultures to address aches, pains and other complaints. They provide varying combinations of massage, manipulation, creams and herbal remedies.

Discussion Questions
1. Have you encountered patients that seek treatment from traditional healers?
2. How would you address the daughter's request to not inform the patient of the imaging findings?

Teaching Points
1. Recognizing cultural differences and providing care that is respectful of these differences is important in providing high quality medical care. This often requires humility on the part of the physician. Patient's attribution of the cause of the disease may lead them to make different choices about types of healers and treatments than a physician might recommend. Healthcare providers should strive to attain cultural humility in order to

create an atmosphere of open communication with patients of differing socio-cultural backgrounds.

2. Patient and family requests may differ from what you recognize as "appropriate". In this case, the family is asking the physician to withhold information from the patient. In the U.S., we tend to value autonomy and choice and believe that the patient's ability to make informed decisions trumps other priorities. This value may not be shared by patients and families. Some families may believe that shielding the family member from a bad diagnosis is more important to the patient's overall well-being. This can be difficult for the provider to navigate. Interpreters can aid health care professionals by acting as a "cultural clarifier" in situations like this.
3. Patients may seek care from a combination of formal medical providers and from traditional or alternative sources. Patients may gain some physical or mental relief from suffering from seeing a traditional healer. Health care professionals should encourage patients to share this information openly and receive the information in a way that is free from judgement. Only if the health care professional establishes and open and trusting relationship will they learn what other types of treatment the patient is seeking and then can also assess concerns for treatment interaction and be assured that treatment plans are based on the entire picture.

Practical Questions

1. What resources are available in your hospital when providing care for patients whose cultures are different than your own?
2. How can you approach a patient or family request which differs from you view as acceptable?

Recommended Screening Question(s):

The LA County Health Agency SBDOH workgroup recommends cultural humility and understanding when working with all patients.

Paired Reading

Teal CR, Street RL. Critical elements of culturally competent communication in the medical encounter: a review and model. Soc Sci Med 2009;68:533-43.

Discussion Points from the Reading

1. A culturally competent health care professional has the capacity to recognize and reconcile sociocultural differences between provider and patient to achieve a patient-centered approach to care.
2. The authors describe a model of culturally competent communication with four components: communication repertoire, situational awareness, adaptability, and knowledge of core cultural issues. When using this model, a health care professional whose communication is based in empathy, caring and respect can provide culturally competent care for any patient, regardless of the provider's specific knowledge of the

patient's culture. Invitation of the patient's perspective on their symptoms and illness with non-judgmental reactions and follow-up questions are key elements of culturally competent communication.

Additional Readings

1. Tervalon, M., & Murray-García, J. (1998). Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved*, *9*(2), 117–125.
2. Flores, G. (2000). Culture and the patient-physician relationship: Achieving cultural competency in health care. *The Journal of Pediatrics*, *136*(1), 14–23. https://doi.org/10.1016/S0022-3476(00)90043-X
3. Many in Boyle Heights Look to Sobadores for Relief from Pain. Available from: http://www.boyleheightsbeat.com/many-in-boyle-heights-look-to-sobadores-for-relief-from-pain-754/
4. Fadiman A. The Spirit Catches You and You Fall Down. A Hmong Child, Her American Doctors and the Collision of Two Cultures. New York: Farrar, Straus, and Giroux; 1997.

Module 3. Race

Breena R. Taira, MD, MPH

Objectives:

1. Discuss race as a social construct and understand the levels of racism.
2. Increase awareness of how racial bias contributes to health disparities.
3. To become aware of one's inherent biases and how these might impact your own behavior as a provider.

Case:

A 39 year- old English-speaking Black male presents to an inner-city emergency department. He had spent the day moving into a new apartment. This evening as he unpacked his boxes, he started to feel some shortness of breath. He had noted earlier that there was a significant amount of construction dust covering the floors of the new apartment and he had been sneezing all day. He had a history of childhood asthma and had memories of many nights in his childhood spent in the emergency department for breathing treatments, but had mostly outgrown the asthma as he became older. Tonight was different as he felt gradually progressive dyspnea - he felt as if the childhood asthma had returned with a vengeance. Patient waited, hoping it would go away. He was hesitant to go to the hospital because he remembered the disparaging looks given to his mother when he presented to the ED as a child. They always seemed to imply that his uncontrolled asthma was her fault. He carried this negative feeling about healthcare into adulthood and tried to avoid medical care unless absolutely necessary. Finally, the patient could barely breathe and started to think he might die, so he went to the nearest ED.

He walked into triage and said that he needed help and couldn't breathe. They told him to sit and wait his turn. He tried to explain repeatedly to the triage nurse that he could not breathe and was finally given a room in the ED. He was placed behind a curtain where he could not see anyone and no one came to evaluate him. He walked out of the curtain area to the desk and again said, "I can't breathe, can you help me?" to which the clerk responded, "You're walking so you must be breathing." Finally, a white male physician appeared to evaluate him. He took the patient's history and said," You are fine; it's a panic attack, I will order some Ativan." without listening to the patient's heart or lungs. The patient replied that he did not feel anxious. The patient thought about the traumatic experiences he had in the past - surviving 9/11, two motorcycle accidents - and never had a panic attack. Could he be having one now? And wouldn't it be a coincidence that it felt just like his asthma and occurred just after an environmental trigger? As the physician left the curtain area, he said to the nurse- "That guy looks fine, discharge him after the Ativan." The patient decided to leave the ED and took an Uber to a nearby university hospital emergency department where he was evaluated and treated immediately with nebulizers for an asthma exacerbation. The patient, being highly educated with two Ivy League degrees, filed a formal complaint to the CMO of the initial hospital for poor quality care and disputed his bill. The CMO is puzzled as this provider usually has excellent Press Ganey scores and is known to be a competent clinician. This patient, however, denies ever being given a Press Ganey evaluation to fill out. On further investigation, the CMO learns that the clerks choose which patients receive the Press Ganey cards and generally choose based on "who looks educated enough to follow the instructions."

Discussion Questions:

1. Was the care provided at the first hospital appropriate?
2. How did race impact care? Did it lead to different care? How did age play into the care?
3. How might this experience impact the patient's interactions with healthcare professionals in the future?

Teaching Points

1. Racism is not necessarily overt. Implicit bias describes the phenomenon of having a preference for or an aversion to a group of people without conscious awareness that the preference exists.
2. Health care professionals (just as all other individuals) are often unaware of their own implicit biases. In healthcare there is risk to the patient when a provider, unaware of his/her bias delivers a different type of care to a certain group based on his/her implicit bias. Often the discussion of implicit bias in the United States focuses on the negative implicit bias against Blacks harbored by other racial groups based on the years of racism that was normalized in our culture. This is an important example that is pervasive and has many societal and health repercussions. Implicit bias by definition, however, can be based on other group characteristics, not only skin color.
3. On the population level, the medical encounter is often cited as a potential source for persistent health disparities in the United States. Actions fueled by implicit bias on the part of the provider may be perceived as blatant racism by the patient. On the patient level, interactions like these contribute to continued mistrust of the healthcare system and worse patient outcomes for minority groups on the population level.

Practical Questions

1. Have you considered what your own implicit biases may be?
2. How can we become more cognizant of our own biases so that they do not influence medical decision making?

Consider recommending the Harvard Implicit Bias test that can be taken on-line free of charge:
https://implicit.harvard.edu/implicit/takeatest.html

Recommended Screening Question(s):

The LA County Health Agency SBDOH workgroup has not developed any recommended screening questions for implicit bias. To screen for patient's race and ethnicity, it recommends:

1. What is your racial and ethnic background?
   - ☐ American Indian or Alaska Native
   - ☐ Asian
   - ☐ Black or African American
   - ☐ Native Hawaiian or Other Pacific Islander
   - ☐ White
   - ☐ Hispanic, Latino, or Spanish Origin
     - Mexican, Mexican American, Chicano
     - Puerto Rican, Puerto Rican American, or of Puerto Rican descent

- Cuban, Cuban American, or of Cuban descent
- Another Hispanic, Latino, or Spanish origin

☐ Multiple Race, including Mestizo
☐ Other

Paired Reading
Jones CP. Levels of Racism: A Theoretical Framework and a Gardener's Tale. Am J Public Health 2000; 90:1212-1215.

Discussion Points from the Reading:

1. The three levels of racism discussed in this article include: internalized, personally mediated and institutionalized.

Level of Racism	Definition
Institutionalized	Differential Access to the goods, services and opportunities of society by race.
Personally Mediated	Prejudice and Discrimination where prejudice means differential assumptions about the abilities, motive and intentions of others according to their race.
Internalized	Acceptance by members of the stigmatized races of negative messages about their own abilities and intrinsic worth.

2. How do the three levels of racism described in the paper relate to the case above? Personally-mediated racism predominates in the interaction between the patient and provider. The provider provides substandard care, likely on the basis of his unconscious bias. Institutionalized racism exists in that the system of evaluating provider performance is limited to those who look "educated" according to the ward clerk, which very likely has a racial skew. This is an example of how an individual's (ward clerk's) implicit bias becomes institutionalized racism.
3. Can you think of examples of each from your own experience of the three levels of racism? How might they impact health outcomes?

Additional Readings

1. Hagiwara N, Slatcher RB, Eggly S, Penner LA. Physician Racial Bias and Word Use during Racially Discordant Medical Interactions. Health Commun 2017;32:401-8.
2. Black Man in a White Coat by Damon Tweedy, MD
3. Seeing Patients: Unconscious Bias in Health Care by Augustus A. White III, M.D.
4. The documentary **13th** by Ava DuVernay (http://www.avaduvernay.com/13th/)

Module 4. Gender Identity
Breena R. Taira, MD, MPH

Objectives:

1. To recognize that the transgender population may have concerns about disclosing their gender identity and to discuss strategies to approach the subject when relevant to the ED visit.
2. To learn how to incorporate gender identity into clinical care.

Case

A 44-year-old English-speaking Latina female presented to the emergency department with chronic indolent left lower quadrant abdominal pain for 3 months. Patient says she has waited this long because of some bad experiences with the healthcare system in the past but today the pain was so bad she finally decided to come in. She gave a history of progressively worsening pain, localized to one specific point in the left lower quadrant without any bowel complaints such as diarrhea, or constipation. She denied nausea, fevers, dysuria or any other associated symptoms. After a history and physical, the initial physician decided the patient was a "rule out diverticulitis" workup. Lab work was normal. The patient was signed out to a second physician pending a CT scan of the abdomen. When the second physician received the read from radiology, it read "Left sided undescended testicle" with no sign of diverticulitis. The CT scan shows male genitalia. On receiving the read, the second physician thinks maybe she had misunderstood her sign-out and looked at the initial note. On review of the documentation, the note consistently refers to the patient as female and makes no mention of an exam of the genitalia. The second physician ponders how to best approach the situation with the patient, whom she has not yet met.

Discussion Questions:

1. How would you approach this patient?
2. How do you typically initiate a discussion of gender identity?
3. Why is the second provider in the case uncomfortable about the pending discussion? What measures can she take to facilitate a smooth and respectful interaction?

Teaching Points

1. Transgender patients may be uncomfortable disclosing their gender identity and not offer the information freely. Even if the transgender patient tries to disclose their gender identity, there may be no appropriate way to record a trans-person's gender in the electronic record. Most electronic health records only allow for "male" or female", which can make an awkward situation/choice for both the patient and the registration worker.
2. Discussing gender identity is something that all health care professionals should feel comfortable with. For those who have less experience talking with trans patients, thinking through respectful language and having a planned script in advance of the interaction can be helpful. It is okay to ask about gender identity when it relates to the medical problem at hand and encouraged to ascertain the patient's preferred pronoun. Providers should be weary of using judgmental or demeaning wording when asking about gender identity. It is also preferable to use unassuming terminology when referring to partners such as "significant other" when appropriate.

3. Transgender people may avoid ED visits and sometimes healthcare in general because of concern for lack of respect and knowledge amongst healthcare workers regarding gender identity.

Practical Questions

1. Do you know how gender is recorded in your electronic health record and what the answer options are?
2. What practical improvements could be made to processes in your ED to help minimize repeated questioning about gender identity and to make communication about gender identity more private?
3. Are there local resources available for transgender patients to obtain primary care in a supportive environment with providers who are expert in transgender care?

Recommended Screening Question(s):

1. What is your gender identity? (Check all that apply)
   - ☐ Male
   - ☐ Female
   - ☐ Transgender male, trans man, female-to-male, trans-masculine
   - ☐ Transgender female, trans woman, male-to-female, trans-feminine
   - ☐ Genderqueer, neither exclusively male nor female, non-binary, or gender nonconforming
   - ☐ Additional gender category/Other (please specify): ____
   - ☐ Choose not to disclose
2. What is your identifying pronoun?
   - ☐ He
   - ☐ She
   - ☐ They
3. What sex were you assigned at birth, or was listed on your birth certificate?
   - ☐ Male
   - ☐ Female
   - ☐ Intersex
   - ☐ Other
   - ☐ Unknown
   - ☐ Choose not to disclose

Paired Reading

Samuels EA, Tape C, Garber N, Bowman S, Choo EK. "Sometimes You Feel Like the Freak Show": A Qualitative Assessment of Emergency Care Experiences Among Transgender and Gender-Nonconforming Patients. Ann Emerg Med 2017.

Discussion Points from the Reading:

1. Lack of privacy to disclose gender identity and repeated questioning from the healthcare team about gender identity is a source of distress and can produce a negative overall experience in the ED for transgender patients.
2. Basic education about trans patients is lacking in medical training curricula.
3. Clear communication about why sensitive questions and exams are necessary are helpful.

4. Binary gender documentation can be difficult to navigate for transgender patients and can cause confusion for the providers.

Additional Readings:

1. Chisolm-Straker M, Jardine L, Bennouna C, et al. Transgender and Gender Nonconforming in Emergency Departments: A Qualitative Report of Patient Experiences. Transgend Health 2017;2:8-16.
2. Jalali S, Sauer LM. Improving Care for Lesbian, Gay, Bisexual, and Transgender Patients in the Emergency Department. Ann Emerg Med 2015;66:417-23.
3. Maragh-Bass AC, Torain M, Adler R, et al. Is It Okay To Ask: Transgender Patient Perspectives on Sexual Orientation and Gender Identity Collection in Healthcare. Acad Emerg Med 2017;24:655-67.
4. Maragh-Bass AC, Torain M, Adler R, et al. Risks, Benefits, and Importance of Collecting Sexual Orientation and Gender Identity Data in Healthcare Settings: A Multi-Method Analysis of Patient and Provider Perspectives. LGBT Health 2017;4:141-52.

Module 5. Health Literacy
Mohsen Saidinejad, MD, MBA

Objectives:

1. To understand the importance of healthcare provider communication in improving health literacy for patients.
2. To understand the role of language fluency, education and culture in shaping health literacy.
3. To understand health literacy as a major contributor in medical decision-making.
4. To recognize the need to help patients find information and services needed to better care for their healthcare needs, including connecting the patients to their medical home.

Case:

A 6-year old Hispanic male is brought by emergency medical services (EMS) in respiratory distress. His mom, who only speaks Spanish, states that the child may have asthma and was treated in the emergency department (ED) several times for the same problem, including a visit 2 days ago. The grandmother, who is the main caregiver to the child, was the one that brought him last time, so she is not sure what instructions the grandmother received. The grandmother did tell the child's mother that a phone interpreter was used to communicate with her. The mother has an asthma inhaler for him, which was given to him a few months ago, and is now almost empty. She has a prescription for another asthma inhaler and another medication, which she has not had the time to fill. On arrival, the patient is in moderate respiratory distress, with tachypnea, and severe inspiratory and expiratory wheezing. He also has a persistent cough. His mother states that she is not sure who the child's primary care provider is, because she usually brings him to the ED when she has a medical concern. She also states that she was given a color-coded paper during a prior ED visit, that was supposed to help her understand how bad the child's asthma is, but she did not understand it, and she no longer has it. After a few rounds of treatment, the child is doing much better and is ready for discharge. Considering the history of this presentation, what can you do to help this family with their medical decision-making and disease outcome?

Discussion Questions:

1. Why did the child come back to the emergency department?
2. How does having mom and grandmother take care of the child affect his care?
3. What can be done to improve this child's care at home and prevent him from bouncing back to the ED?

Case Discussion:

Note: Health Literacy is defined in the Institute of Medicine report, Health Literacy: A Prescription to End Confusion as "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions."
This is a very common presentation to the ED, where health literacy directly influences health behavior and disease outcome. This child, who likely has asthma, needs to be connected to several resources. First, he does not have an identified primary care provider (medical home). Second, he has multiple caregivers, which may augment the impact of communication issues. Third, his mother does not understand the instructions which may have been given to her. Fourth, his mother is describing the color coordinated form to help diagnose his asthma severity. This is the asthma

action plan, which is an important resource for all asthmatics. Although she has the form, she does not understand it or know how to use it. This signals a failure of communication on the previous visit by the provider who gave her the sheet. Fifth, he is back in the ED within 2 days of his last visit, which suggests that the grandmother and mother likely were not able to follow the treatment plan. This could be due to a combination of provider communication (an essential component of patient health literacy) and lack of caregiver understanding (caregiver health literacy). When patients or their caregivers don't understand the medical problem due to limited health literacy, they are not well-positioned to engage in shared decision making.

Teaching points:

1. Healthcare providers should take care to ensure that patients (and caregivers in the case of a minor) understand their care instructions. The material should contain simple language, be at a proper reading level (~ 5th grade education level), and make use of graphics and simple illustrations when possible.
2. When a language barrier is present, use of a trained interpreter is essential. In-person interpreters may be more effective than phone interpreters. Interpreters are just as important at discharge as they are during the initial history and physical to help the patient and family understand and increase the potential for treatment adherence. It is important to ensure that discharge instructions and prescription labels are in the patient's preferred language.
3. An important factor related to limited health literacy is the lack of access to a medical home. If the patient does not have a long-term relationship with a primary care provider, they have less opportunity to ask questions and receive less anticipatory guidance. This may increase ED recidivism.

Practical Questions:

1. What are some practical things can you do at discharge to improve patient understanding?
2. Do you use pre-printed discharge instructions? If so, have you checked their reading level and their availability in other languages?

Recommended Screening Question(s):

1. How confident are you filling out medical forms by yourself?
   - ☐ Always
   - ☐ Often
   - ☐ Sometimes
   - ☐ Occasionally
   - ☐ Never

   *Please note that when working in settings with a high prevalence of patients with limited health literacy, the LA County SBDOH Workgroup recommends not screening for health literacy but instead taking universal precautions, meaning ensuring that all materials and discussions are accessible to those with limited health literacy.

Paired reading:

Griffey RT, Shin N, Jones S, et al. The impact of teach-back on comprehension of discharge instructions and satisfaction among emergency patients with limited health literacy: A randomized, controlled study. J Commun Health 2015;8:10-21.

Discussion Points from the Reading:

1. Discharge from the Emergency Department is recognized as a high-risk transition of care that has potential for miscommunication with patients. Because of language barriers, limited health literacy and cultural differences, patients may not feel empowered to question providers when they do not understand their diagnosis or treatment plan.
2. The "teach-back" technique is a method of improving patient provider communication. The patient is prompted to "teach-back" to a provider the information conveyed to confirm comprehension. In this study, patients who received a discharge that included a teach-back had improved comprehension of their post-ED care instructions.

Additional readings:

1. Institute of Medicine. 2004. *Health Literacy: A Prescription to End Confusion*. Washington, DC: The National Academies Press. https://doi.org/10.17226/10883.
2. U.S. Department of Health and Human Services. 2000. *Healthy People 2010*. Washington, DC: U.S. Government Printing Office. Originally developed for Ratzan SC, Parker RM. 2000. Introduction. In *National Library of Medicine Current Bibliographies in Medicine: Health Literacy*. Selden CR, Zorn M, Ratzan SC, Parker RM, Editors. NLM Pub. No. CBM 2000-1. Bethesda, MD: National Institutes of Health, U.S. Department of Health and Human Services.
3. Brabers AEM, Rademakers JJDJM, Groenewegen PP, van Dijk L, de Jong JD (2017) What role does health literacy play in patients' involvement in medical decision-making? PLoS ONE 12(3): e0173316. https://doi.org/10.1371/journal.pone.0173316
4. Agency for Health Care Research and Quality (AHRQ). 2011. Health Literacy Interventions and Outcomes: An Update of the Literacy and Health Outcomes Systematic Review of Literature, 2011
5. National Library of Medicine. Health Literacy. https://nnlm.gov/priorities/topics/health-literacy. Retrieved Jan 20, 2018.

Module 6. Debt

Shamsher Samra, MD, MPhil and Todd Schneberk, MD

Objectives:

1. T understand the burden of medical expenses and debt in the US population.
2. To recognize the possibility of "first doing (financial) harm" via medical care.
3. To be able to offer guidance to patients burdened by medical debt.

Case:

A 63-year-old Spanish-speaking female presents to the emergency department with abdominal pain for 6 months. She reports nausea, but no emesis, and no fevers. The pain is epigastric. She has no cardiac history. She had an evaluation of the same pain 2 months ago with a negative CT scan and a normal EKG. Labs and urine today are normal. On further discussion, the patient states that she has been trying to obtain a primary care doctor to further investigate her pain, but even the low-cost clinics charge something and she has no money. Her husband had an accident at work and hurt his shoulder 1 year ago and since then they have had no income. She has lived in the U.S. for thirty years but is undocumented and does not qualify for health insurance. On her last visit to the emergency department she was enrolled in the county government's "ability to pay" program. She receives monthly bills of $75 to pay off her last two visits. She cannot afford the bills, so she rotates paying the "Ability to Pay" program bill on each of 5 different credit cards. Now she is in overwhelming credit card debt because of her illness. The credit card companies have sent her bills to collection and the collections agencies are calling frequently. Each time the phone rings, she has palpitations and her abdominal pain worsens.

Discussion Questions:

1. How is this patient's medical care contributing to her debt?
2. What are some options for addressing this patient's medical debt?
3. How is the patient's debt affecting her health?

Teaching Points:

1. Practitioners should be aware that provision of care within the confines of the US medical system may impose significant financial burden on their patients. These costs may weigh heavily into patient decisions to seek care, adhere to treatment plans, and potentially increase mortality. How the emergency department visit translated into a patient bill is complex and often not transparent. It can be difficult to advise patients or even to know whether there is the potential for financial harm. Becoming familiar with financial workers in the department and learning about financial programs offered by the institution can help providers to recognize patients who need this type of assistance.
2. Providers should encourage patients to seek itemized bills and inquire into subsidized, "inability to pay," or charity care payment plans during that same visit. Plans may have time limits (for example "you must apply within 10 days of your visit to qualify") so if the patient waits until he or she is feeling better to act, it may be too late.
3. In advising patients faced with significant medical debt, providers may warn against the use of credit cards to pay for medical debt. Although this may seem like a good option for a temporizing measure, patients may not understand interest and may not realize the full implications of unpaid credit card debt.

4. Identification and referral of patients to local legal service agencies may limit debt burden. Legal services may be particularly helpful at helping patients who are harassed by collections agencies.
5. Bill forgiveness programs and financial hardship provisions often exist within the hospital billing system. There is often a limited window of opportunity, so patients must understand that they should talk with registration workers on that same visit and be sure to understand the instructions for which forms to fill out or offices to visit. Any misstep by the patient during the process could render them ineligible. There is also significant ability to negotiate with insurance companies and even collections agencies.
6. Local legal service agencies may be able to deploy legal representation to protect patients from predatory practices.

Practical Questions:

1. Does your hospital offer subsidies or bill forgiveness to those unable to afford their medical debt? If so are patients made aware of these plans when they receive their medical bills?
2. What local legal agencies may be able to offer legal aid to patients facing dangerous levels of medical debt?

Recommended Screening Question(s):

1. Do you have the resources to pay for the very basics like food, housing, medical care, and heating? (Yes/No)
2. Do you have any significant outstanding bills or debts? (Yes/No)

Paired Reading:

Himmelstein, David U., et al. "Medical bankruptcy in the United States, 2007: results of a national study." *The American Journal of Medicine* 122.8 (2009): 741-746.

Discussion Points from the Reading

1. Bankruptcies attributed to a medical cause comprise the majority of bankruptcies in the United States. These bankruptcies happen to educated, middle class people with health insurance.
2. People who have their health insurance through their employer may lose coverage when diagnosed with a serious illness if they are too sick to work. Especially in cases where the breadwinner of the house becomes ill, the financial implications of the illness may become quickly catastrophic for the family.

Additional Readings:

1. Hamel, Liz, et al. "The Burden of Medical Debt: Results from the Kaiser Family Foundation/New York Times Medical Bills Survey." *Kaiser Family Foundation, January* 5 (2016).
2. Street, Occupy Wall. "The Debt Resistors' Operations Manual." *New York, Strike Debt/Occupy Wall Street* (2012). (Section on Medical Debt p. 23)
3. RIP Medical Debt https://ripmedicaldebt.org/

Module 7. Food Insecurity

Hannah Janeway, MD, Adedamola Ogunniyi, MD, Kathleen Yip, MD

Objectives

1. To understand the concept of a food desert.
2. To understand how local food environment plays a role in residents' ability to purchase healthy, affordable and nutritious goods
3. To be able to connect patients with food security issues to appropriate services.

Case:

A 54-year-old male with a history of diabetes, hypertension, and congestive heart failure (ejection fraction 20-25%) presents to the emergency department with dyspnea on exertion, worsening lower extremity edema and orthopnea. The patient states he has been compliant with medications. His physical exam shows signs of volume overload. Labs demonstrate hyperglycemia of 450 mg/dL without an anion-gap, and a negative troponin. His EKG is non-ischemic and chest x-ray shows pulmonary edema. Upon review of prior visits, you find that the patient has been hospitalized 4 times this year with CHF exacerbations and his sugars have constantly been elevated. The patient states he always takes his medication but does admit difficulty with sticking to his cardiac diet. Since his wife died, he lives alone. She had always been the cook and now he eats a lot of prepared foods to make up for his lack of cooking knowledge and to stretch his budget. He has no car and walks to the closest store to purchase his food, a small grocery store about 3 blocks from his house (the furthest he can walk) that has a limited supply of vegetables. He notes that canned products are particularly cheap and saves his money by buying canned soups and beans.

Discussion Questions:

1. What are the barriers to eating healthy for this patient?
2. How does lack of access to healthy foods affect this patient's health?
3. What can be done to help this patient eat healthier?

Teaching Points

1. Practitioners should be aware of the effects of food deserts on patient's ability to comply with treatment plans and the contribution to overall poor health outcomes. In addition, those patients who are on a specific diet, such as those with diabetes or congestive heart failure, may find it even more difficult to adhere to the diet if they become homeless and rely on food banks or soup kitchens for their meals because of the lack of control over their food choices.
2. Studies have shown that poor and minority neighborhoods have increased exposure to unhealthy advertisements for tobacco and alcohol, fewer pharmacies with fewer medications, and fewer supermarkets that offer a larger variety of affordable and healthy foods compared to smaller convenience stores.
3. Food prices are higher and food quality is poorer in impoverished areas. There is both a smaller quantity of food and less variety offered at stores in these areas.
4. Identifying food insecurity with connection to social work and other services (WIC, etc.) can improve overall patient outcomes.

Practical Questions

1. What are the unique barriers to care encountered by patients at your hospital related to food insecurity?
2. What food deserts are in your hospital catchment area (bring up map below)
3. What resources are available at the hospital related to food security?
4. How can you connect a patient with the WIC program or food stamps?

Recommended Screening Question(s):

The LA County Health Agency SBDOH Workgroup recommends using both questions below. If only using one, we recommend using #1, as it is more sensitive than #2 alone.

1. Within the past 12 months, were you worried whether your food would run out before you got money to buy more?
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true
2. Within the past 12 months the food you bought just didn't last and you didn't have money to get more. Was this:
   - ☐ Often true
   - ☐ Sometimes true
   - ☐ Never true

Paired Reading:

Walker RE, Keane CR, Burke JG. Disparities and access to healthy food in the United States: A review of food deserts literature. Health Place 2010;16:876-84. Available at: https://www.ncbi.nlm.nih.gov/pubmed/20462784

Discussion Points from the Reading

1. Food deserts are poor, urban areas where residents cannot buy affordable, healthy food. In a food desert, residents have increased exposure to emptier calorie foods from convenience stores and fast food restaurants. People make food choices based on the food options available in their immediate vicinity, often out of necessity secondary to lack of transportation.
2. Access to supermarkets is critical and there are large areas of the country without supermarkets, and this is a way in which the built environment directly impacts health. There are racial disparities in the prevalence of food deserts, with Black neighborhoods having less supermarkets compared to White neighborhoods. Those stores that are present in economically depressed areas tend to be smaller and offer less variety of foods.

Additional Readings:

1. Food Desert Map: https://www.ers.usda.gov/data-products/food-access-research-atlas/
2. Chen D, Jaenicke EC, Volpe RJ. Food Environments and Obesity: Household Diet Expenditure Versus Food Deserts. Am J Public Health 2016;106:881-8.
3. Larson NI, Story MT. Food insecurity and weight status among U.S. children and families: a review of the literature. Am J Prev Med 2011;40:166-73.

Module 8. Homelessness

Hannah Janeway, MD, Adedamola Ogunniyi, MD, Kathleen Yip, MD

Objectives

1. Understand the connection between homelessness and poor health outcomes.
2. Understand the benefits of harm reduction and "housing first" in this patient population.
3. Understand the heterogeneity of the homeless population and the importance of the social history.
4. Enable providers to connect homeless patients to services that will address common social barriers to care.

Case:

A 60-year-old male with a history of diabetes and hypertension presenting to the emergency department for a lower leg wound with a new surrounding area of redness. Symptoms started 3 days ago when he scraped his leg against a piece of metal. There is no purulent drainage. He denies other medical problems. The patient drinks 1-2 beers per day and denies drug and tobacco use. Vital signs are within normal limits and the patient is in no apparent distress. On exam, he has a 4cm superficial laceration to his left leg with 6cm area of surrounding cellulitis. You prescribe him Bactrim and Keflex and discharge him home with wound care instructions. The patient returns 3 days later with worsening symptoms: the cellulitis has now spread to his thigh. He did not take the antibiotics. He is febrile and tachycardic and you admit him for IV antibiotics. During your encounter, you demand to know why he didn't take both antibiotics, frustrated that the patient did not follow your care plan. The pharmacy wanted a co-pay to fill the antibiotic prescription and he did not have the cash. The patient explains that he became homeless after losing his job, also is unable to afford his regular medications, and was denied a bed at a shelter secondary to drinking two 40oz beers per day. He has no way to care for his wound on the streets. You realize that you never asked him if he was homeless because he did not appear to match your image of homelessness and was not intoxicated at the time of encounter. You review the record and note that he has been to the ED at least 2 times a month in the last year for various issues stemming from his difficulty managing his chronic medical problems. You decide to bring this to the attention of the admitting team and they consult social work during his hospital stay.

You later follow up on his hospital course a few days later at which time you note that the social work note mentions that he has been placed in a "Housing for Health" program given his poorly controlled chronic conditions and high emergency department/hospitalization use. Over the next year, he has only 2 ED visits.

Discussion Questions

1. What factors contributed to the patient returning to the emergency department with worsening cellulitis?
2. How does lack of housing affect the patient's health?
3. What can be done to help this patient?
4. What is a "Housing for Health" program?

Teaching Points

1. Homeless individuals represent a heterogeneous group of individuals, many of whom can go unrecognized in the emergency department unless directly engaged in a conversation about housing. Homelessness, too, can represent varying states from living on the streets to couch surfing. Thus, critical social needs may go unaddressed during visits with homeless individuals.
2. Homeless individuals often use the emergency department as their primary source of care and the Emergency Department effectively becomes their only connection to the healthcare system.
3. The emergency department can serve as a community triage and coordinating entity for homeless individuals. Consider asking all ED patients if they have any trouble getting their prescriptions. The ability to obtain the medication prescribed is part of safe discharge and a key aspect of systems-based practice. Screening for homelessness in the ED can be quick and efficient; ask patients if they have stable housing or are concerned that they will not have stable housing in the next few months.
4. Connecting patients with housing has been shown to reduce overall ED visits and health spending. A harm reduction approach (housing without stipulations) can decrease healthcare utilization and improve outcomes in patients with mental illness and substance abuse problems.

Practical Questions:

1. What services are available to homeless patients in the emergency department?
2. What are immediate and long-term options for housing in your community?
3. It is 3am and you are discharging a homeless individual from the ED with a prescription for new medications. What do you need to do to assure maximal adherence with the treatment plan and safety for the individual?

Recommended Screening Question(s):

1. What is your housing situation today?
   - ☐ I have housing.
   - ☐ I have a place to live today, but I am worried about losing it in the future.
   - ☐ I do not have a steady place to live. (I am temporarily staying with others, in a hotel, living outside on the street, on a beach, in a car, abandoned building, bus or train station, or in a park)
   - ☐ Decline to answer

Paired Reading:

Raven MC, Tieu L, Lee CT, Ponath C, Guzman D, Kushel M. Emergency Department Use in a Cohort of Older Homeless Adults: Results From the HOPE HOME Study. Acad Emerg Med 2017;24:63-74.

Discussion Points from the Reading:

1. The median age of a homeless person in the U.S. is now greater than 50 years old. Older homeless have less problems with substance abuse and more issues with chronic medical needs.

2. Over half of the participants in the study rated their health as fair or poor and the majority had at least one chronic illness.
3. Historically homelessness has been defined in research as dichotomous. We recognize now that there are varying levels of homelessness and housing instability. Classifying individuals as homeless at a single point in time may be too simplistic. "Exposure to homelessness" over time may be a better concept to use to assess influence on health outcomes.

Additional Readings:

1. Fitzpatrick-Lewis D, Ganann R, Krishnaratne S, Ciliska D, Kouyoumdjian F, Hwang SW. Effectiveness of interventions to improve the health and housing status of homeless people: a rapid systematic review. BMC Public Health 2011;11:638.
2. Basu A, Kee R, Buchanan D, Sadowski LS. Comparative cost analysis of housing and case management program for chronically ill homeless adults compared to usual care. Health Serv Res 2012;47:523-43.
3. Morris DM. The Role of the Emergency Department in the Care of Homeless and Disadvantaged Populations. Emerg Med Clin N Am 24 (2006) 839-848. Available at: http://sbdww.org/wpcontent/uploads/2011/04/role_of_ed_in_treating_homeless_pt_emerg_med_clin_na_2006.pdf
4. Evicted: Poverty and Profit in the American City by Matthew Desmond

Module 9. Housing Conditions
Dennis Hsieh, MD, JD

Objectives:

1. To understand how housing conditions can affect health.
2. To understand what a tenant's rights are when it comes to substandard housing conditions.
3. To offer guidance for those patients facing substandard housing conditions.

Case:

A 65-year-old man, with a history of hypertension, type 2 diabetes mellitus and hyperlipidemia is brought in by ambulance because he is weak and short of breath. The patient has been feeling progressively unwell over the last week. Patient has also had nausea and vomiting. Paramedics note that his glucose read "HIGH." Vitals are as follows: BP 180/100, HR 110, RR 30, T 98.6°F, O_2 100% on 2L. The patient says that he has been out of his medications for one week because he didn't have the money for his co-pay. Until this past week, he had not missed any medications for several years. The patient is on fixed Supplemental Security Income (SSI) each month and has not been able to cook at home because his stove is broken. He called his landlord, but his landlord refused to fix the stove. As a result, patient has had to eat out instead of cooking at home, and thus has not been able to afford to pay the co-pay on his medications. His heater broke a year ago, but he has some extra blankets so this has not been an issue. You call social work. The social worker recommends that the patient call Code Enforcement because as a tenant, he has a right to safe housing with functional heating. The social worker also provides a template demand letter to sign that the patient can provide to his landlord.

Discussion Questions:

1. Why did this patient come to the ED?
2. How do you ask a patient about their housing conditions?
3. How did this patient's housing conditions affect his health?
4. How can you advocate for your client if you discover a poor housing condition?
5. What is a demand letter?

Teaching Points:

1. Housing conditions can impact health in multiple ways. The impact can be direct i.e. mold/roaches on asthma, or indirect, as you see in this case – the patient had to make an economic tradeoff leading to a lack of medications, leading to diabetic ketoacidosis.
2. Local jurisdictions all have habitability laws where a landlord has a legal duty to the tenant/renter of keeping a rental unit livable (habitable). This usually includes working heat (but not AC), working appliances, and cleanliness (pests/mold/rodents, etc.).
3. A tenant can request a housing inspection to document poor conditions. Each jurisdiction has a different office for this, but often it is either through the housing department (code enforcement) or the department of public health (environmental health).
4. A tenant can write a "demand letter" to a landlord asking that conditions be improved.

5. A healthcare professional can often help a client's case by documenting how housing conditions are poorly impacting health and writing a letter expressing their concern to the landlord.

Practical Questions:

1. What are the local agencies responsible for housing inspections and code enforcement and what is their contact information?
2. What are landlords in your community obligated to provide/ensure about the units they rent?
3. Are there local resources available to help the client enforce their rights?

Recommended Screening Question(s):

1. Think about the place you live. Do you have problems with any of the following? (CHOOSE ALL THAT APPLY)
   - ☐ Pests such as bugs, ants, or mice
   - ☐ Mold
   - ☐ Lead paint or pipes
   - ☐ Lack of heat
   - ☐ Oven or stove not working
   - ☐ Smoke detectors missing or not working
   - ☐ Water leaks
   - ☐ Other; Specify: _____
   - ☐ Not applicable
   - ☐ Satisfactory conditions

Paired Reading:

Oudin A, Richter JC, Taj T, Al-Nahar L, Jakobsson K. Poor housing conditions in association with child health in a disadvantaged immigrant population: a cross-sectional study in Rosengård, Malmö, Sweden. BMJ Open 2016; 6(1): e007979.

Discussion Points from the Reading:

1. Child health is especially vulnerable to environmental exposures. Poor housing conditions impact children as they spend more time in the home, have higher respiratory rates and are closer to the floor and more likely to put objects in their mouths. Exposure to poor housing conditions therefore may impact children to a greater extent. Poor housing conditions may also be a factor in the association between income inequality and child health.
2. In this cross-sectional study of child health in a disadvantaged, immigrant population in Sweden, there was an association between dampness and asthma, mold and headache and cockroaches and a variety of poor health outcomes.

Additional Readings:

1. Gibson M, Petticrew M, Bambra C, Sowden AJ, Wright KE, Whitehead M. Housing and health inequalities: a synthesis of systematic reviews of interventions aimed at different pathways linking housing and health. Health Place 2011; 17:175-84.

2. Jacobs DE, Brown MJ, Baeder A, Sucosky MS, Margolis S, Hershovitz J, Kolb L, Morley RL. A systematic review of housing interventions and health: introduction, methods, and summary findings. J Public Health Manag Pract. 2010; 16(5 Suppl):S5-10.
3. Krieger, J * Higgins DL. Housing and Health: Time Again for Public Health Action. Am J Public Health. 2002; 92(5): 758–768.
4. Thomson H, Thomas S, Sellstrom E, Petticrew M. Housing improvements for health and associated socio-economic outcomes. Cochrane Database Syste Rev 2013; 28(2):CD008657.

Module 10. Medical Legal Needs
Dennis Hsieh, MD, JD

Objectives:

1. Define a medical legal community partnership.
2. Understand what lawyers (as opposed to social workers, medical case workers, or health navigators) can do for patients to address the social determinants of health and thereby improve their health.
3. Become aware of the available local resources/referrals for patients with legal needs.
4. Be able to connect patients to legal resources when appropriate.

Case:

A 45-year-old female with a history of depression, hypertension, diabetes and hyperlipidemia is brought to the emergency department on a psychiatric hold (5150) from the Section 8 housing office. The woman was at the office and was told that she was going to lose her Section 8 voucher. She panicked and asked the housing office for help to prevent losing her voucher because she did not want to be homeless and had been on Section 8 for the last 25 years. Her son is graduating from high school in 2 weeks, and she cannot be homeless during this big event. The housing office told her there was nothing that they could do. The patient then threatened to kill herself by taking all her psychiatric medications. The housing office called the police who then placed her on a psychiatric hold (5150) and brought her to the emergency department. The patient tells you, the ED provider, that she doesn't want to kill herself, but that she had been at the housing office every day for the last three weeks trying to resolve this issue, but no one would help her, and she simply does not want to be homeless.

Psych sees the patient and tells you that the patient does not need a psychiatrist and drops the hold. Social work tells you that they can give your patient a shelter list, but also mention a new program they just heard about, a medical-legal partnership, that deals with all sorts of problems, including housing and public benefits. They advise the patients to call the local legal aid organization to find out more.

Discussion Questions:

1. What factors contributed to this patient ending up in the ED?
2. What is a medical legal partnership?
3. Why would you need a lawyer involved instead of a social worker or a case manager?
4. What are the range of challenges that patients face that legal services providers can assist with?

Teaching Points:

1. Legal issues (i.e. loss of Section 8 voucher/eviction) cause patients to present to the emergency department. The Section 8 program is financed by the U.S. Department of Housing and Urban Development (HUD) to provide rent subsidies in the form of housing assistance payments (HAP) to private landlords on behalf of low-income individuals/families, senior citizens, and persons with disabilities.
2. Legal issues affect health. From the National Center for Medical-Legal Partnership, the role of a medical-legal partnership is described by the following:

"The health care system needs the right workforce to tackle social problems once detected. As a result, patient navigators, social workers, and others have become fixtures on the health care team. However, many complex health-related social problems are entrenched in federal, state, and local policies and laws that require expertise in poverty law and administrative law. Attorneys in general—and poverty lawyers in particular—have an in-depth understanding of relevant policies, laws, and systems, and seek out solutions at the individual and policy levels to a range of health-related social and legal needs. When embedded as specialists in a health care setting, lawyers can directly resolve specific problems for individual patients, while also helping clinical and non-clinical staff navigate system and policy barriers and transform institutional practices. Using legal expertise and services, the health care system can disrupt the cycle of returning people to the unhealthy conditions that would otherwise bring them right back to the clinic or hospital."

3. Legal services are free for those who are low income from some publicly funded organizations.

Practical Questions:

1. Who are the local legal services providers locally available and what is their contact information?
2. What legal issues do your local legal services assist with?
3. Are there any medical legal partnerships in your local community?

Recommended Screening Question(s):

The LA County SBDOH Workgroup recommends that not all domains have to be asked – each clinical setting can customize the list to those domains they are have resources available for. The Workgroup recommends always including immigration as part of the list.

1. Would you like legal guidance/help with any of the following issues?

(The list may be modified to fit the clinical setting, however, we recommend always including immigration.)

- Immigration
- Trouble with your job
- Trouble at school
- Unpaid tickets
- Eviction
- Outstanding Warrants
- Clearing your record/expungement
- Child Custody
- Child Support
- Getting an ID/birth certificate
- Public Benefits (CalFresh/Food Stamps, SSI/Social Security, General Relief, CalWORKs, Medi-Cal, Medicare, etc.)

☐ **Yes**
☐ **No**

Paired Reading:
Sandel M *et al*. Medical-Legal Partnerships: Transforming Primary Care by Addressing the Legal Needs of Vulnerable Populations. *Health Affairs* 2010 29(9): 1697-1705.

Discussion Points from the Reading:

1. The role of the medical legal partnership includes legal advice and assistance, health system change, and advocacy. On the individual patient level, providing legal advice to help patient focuses on prevention of legal crisis and their subsequent health consequences. An example of health system improvements that could be implemented by medical legal partnerships would be the creation of clinic-based enrollment into social services such as food stamps. On the large scale, medical-legal partnerships can propose and support laws and regulations that benefit vulnerable populations.
2. Medical-legal partnerships can be a core component of a patient-centered medical home and can assist with many social determinants such as income/insurance, housing, education and employment, legal status and personal/family stability.

Additional Readings:

1. Hernandez, D. "Extra Oomph:" Addressing Housing Disparities through Medical Legal Partnership Interventions. *Hous Stud.* 2016 31(7):871-90.
2. Kenyon C, Sandel M, Silverstein M, Shakir A., Zuckerman, B. Revisiting the Social History for Child Health. *Pediatrics* 2007; 120;e734-38.
3. Murphy JS, Lawton EM, Sandel M. Legal Care as Part of Health Care: The Benefits of Medical-Legal Partnership. *Pediatr Clin N Am* 2015; 62(5):1263-71.
4. Zuckerman B., Sandel M., Smith L., Lawton E. Why pediatricians need lawyers to keep children healthy. *Pediatrics*. 2004 Jul;114(1): 224-8.

Module 11. Immigration
Todd Schneberk, MD and Shamsher Samra, MD, MPhil

Objectives:

1. Understand the ways in which immigration affects health.
2. Delineate the different barriers to health that immigrants face.
3. Identify methods of mitigating these barriers from the emergency department.

Case:

A 38-year-old female presented to the ED after a fall from a ladder. She could not ambulate at the scene and did nothing but scream when providers attempted to examine her and so she was "pan-scanned", i.e. received multiple CT scans in attempt to identify her injuries. The CT scans were negative. She is signed out to you, the on-coming ED attending, pending the radiology reading of her MRI of the spine. You enter the room to find a patient with a vacant stare. You attempt to engage her and she screams, "¡No me toca!" Her sister-in-law is at bedside and you decide to engage her in conversation.

She reveals the patient's unfortunate but common backstory. She is originally from El Salvador where she was being extorted for exceeding amounts of money by the "Maras" (MS13, a predominant gang). She feared for her life and, in attempt to escape their extortion and threats, she paid a coyote to smuggle her and her children into the United States. Midway through the journey, the coyote sold her to the Zetas (a Mexican drug cartel) who held her in captivity for 10 months. She was repeatedly sexually and physically assaulted until her family in the U.S. collected enough money to pay ransom. She was then freed and brought to Los Angeles. She has significant residual mental health issues from the experience, including intermittent episodes similar to today's presentation that resemble flashbacks. These episodes are increasingly affecting the patient's ability to function and especially to parent, so her children are often watched by other family members. The family has been trying to convince her to seek medical help and especially mental health care, but she is too afraid of deportation and the thought of returning to the nightmare she escaped.

She works cleaning houses to help support her family. Today's fall happened at work. She was asked by her employer to clean the windows on the outside of the house. Despite pleading that she didn't know how to use a ladder, the boss insisted. She complied for fear of losing her job, as work is difficult to find without documentation. Furthermore, if she lost her job, she was afraid that her new husband, a U.S. citizen, would beat her as he had in the past. She married him because he had promised her a green card but since their marriage, he had lost interest in helping her with immigration forms.

The MRI and complete trauma workup was negative. But since you spent the time to engage the sister-in-law, you were able to refer her for treatment of her psychiatric disease for which she now receives medication and therapy. She was referred to legal services and, with their help, submit a VAWA application.

Discussion Questions:

1. How has this patient's experiences contributed to her current presentation?
2. What is VAWA?
3. What is a green card and who can get one?
4. What are the different forms of immigration relief available for refugees, asylees, victims of domestic violence, trafficking, and other crimes?

Teaching Points:

1. Immigrants, especially those who emigrated within the last 10 years, are more likely to have experienced traumatic events in their country of origin, making them more likely refugees rather than economic migrants. (A Refugee is a person who has fled his/her home country and cannot return because of a well-founded fear of persecution due to race, religion, nationality or membership of a particular social group.)
2. Continued subjugation and mistreatment often continues to occur after arrival in the U.S. due to reduced status in society and lack of agency to fight back due to fear of deportation or other negative ramifications, often manifesting as fear of going to the police, or accessing social services or the healthcare system.
3. The ED is a pivotal touch-point for these populations so we need to equip our EDs to provide immigration-informed care, which includes explicit signage welcoming people of all backgrounds and documentation status to the ED, providing appropriate language services, training our providers in specific risks and reticence to fully disclose circumstances within this population, and create medico-legal partnerships from the ED to refer these patients to immigration legal advocates (more below).
4. Patients who are victims of a trafficking, domestic violence, any crime in the U.S. or who are fleeing their home country due to fear may be eligible for status adjustment and legal permanent residence; these, among other options, not only bring stability and security into their life but also provide eligibility for Medicaid and other social services. Asylum status is a form of protection for people who 1. meet the definition of refugee and 2. are already in the U.S. or are at a point of entry to the U.S.
5. Outside of these methods, there are very limited ways for someone to become a legal permanent resident or a U.S. citizen.

Practical Questions:

1. What are the immigrant demographics in your local population?
2. What resources are available for these patients locally?
3. What is the sanctuary status of your city and hospital?

Recommended Screening Question:

None: Given the current political environment, the LA County Health Agency SBDOH Workgroup has decided to not screen for immigration directly to minimize the risk to patients. It recommends instead that immigration be listed as an example of a potential legal need during the legal needs screener. In this way, the patient can say yes to "I have a legal need," and receive a referral with no further specifics recorded.

Paired Reading:

Saadi A, Ahmed S, Katz MH. Making a Case for Sanctuary Hospitals. JAMA 2017;318:2079-80.

Discussion Points from the Reading:

1. One of the ideals of medicine is that all patients should feel secure in seeking medical care, particularly the most vulnerable of our society.
2. The term "sanctuary" has been applied to cities and institutions that have established practices to protect their undocumented populations. Hospitals already adhere to HIPAA and state privacy laws to protect their patients. There are additional, specfic things that hospitals can do to further protect their undocumented patients. Hospitals can create clear policies regarding immigration officers who enter the institution. No hospital employee should provide information to ICE agents without a court-ordered warrant or subpoena. Hospitals can educate employees and patients about the policy so that patients know that their personal information will not be shared with ICE.

Additional Readings

1. Social Determinants of Migrant Health: https://www.iom.int/social-determinants-migrant-health
2. Castaneda H, Holmes SM, Madrigal DS, Young ME, Beyeler N, Quesada J. Immigration as a social determinant of health. Annu Rev Public Health 2015;36:375-92.
3. Holmes SM. An ethnographic study of the social context of migrant health in the United States. PLoS Med 2006;3:e448.

Module 12. Human Trafficking

Shamsher Samra, MD, MPhil and Todd Schneberk, MD

Objectives:

1. Understand the nature and scope of human trafficking.
2. Understand how the emergency department can be a unique venue to identify and address cases of human trafficking.
3. Learn how to assess for human trafficking and what resources are available to help victims of human trafficking.

Case:

JS is a 39-year-old woman who presents to the emergency department after a syncopal episode while picking fruit on a hot summer day. Her employer is at bedside and volunteers to interpret. She had been feeling lightheaded all day but tried to work through it. Lab work was sent at triage and her creatinine is slightly elevated. After intravenous fluids, the patient begins to feel better but still appears nervous. You try to delve farther into what has been going on in her life recently, but the employer interjects and answers your questions without interpreting them. You tell them that you are taking the patient to radiology for a chest x-ray and ask the employer to wait in the room. In radiology, you have an interpreter waiting and re-interview your patient far away from the employer. She divulges that she lives in a makeshift structure on the edge of the farm where she picks fruit. There isn't adequate water for all of the workers at the farm or sufficient breaks to access it. When asked if she wants to report this to local authorities, she is afraid of being fired and deported. She was brought into the country by her employer to work in what seemed to be a promise of economic stability so that she could send money back to her family. But when she arrived in the country, the employer confiscated her identification and had severely limited her contact with anyone outside the farm.

The social worker speaks with the patient and calls the police. In addition to referrals help with basic needs, the patient is referred to an immigration focused medical-legal partnership that helps her to obtain a T-Visa.

Discussion Questions:

1. What are the signs that this patient is a victim of trafficking?
2. What is a T-Visa?
3. What are the different forms of immigration relief available for refugees, asylees, victims of domestic violence, trafficking, and other crimes?
4. Does trafficking only happen to those from outside the U.S.?

Teaching Points:

1. Globally 12 million people live in conditions of forced labor or sexual servitude generating over 150 billion dollars in profit. According to the U.S. State Department, human trafficking is defined as the recruitment, harboring, transportation, provision, or obtaining of a person for 1 of 3 purposes: 1. Labor or services, through use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery

2. Commercial sex act through the use of force, fraud, or coercion 3. Any commercial sex act if the person is younger than 18 years old, regardless of whether coercion was involved.
2. Most labor trafficking victims (67%) and a large percentage of sex-trafficking victims (13%) are believed to be undocumented, contributing to higher barriers to exit.
3. While challenging, identification of trafficking victims in the emergency department can be a critical health intervention. There is no standard screener to identify victims of trafficking. Maintaining privacy during the interview and using a certified healthcare interpreter for limited English proficiency patients are critical.
4. Some victims of trafficking may be eligible for immigration relief and legal residence through the T-VISA or the U-VISA program.
5. Human trafficking can potentially include movement between countries but does not require movement to fit the definition. People can be considered trafficked that were born into servitude, were exploited in their own home town or were transported to the exploited situation which can be between within or outside of their own home country. The common denominator is the traffickers' aim to exploit the victim regardless of the location.

Immigration Relief	**Clinical Scenario**
U-Visa	Undocumented victims of certain serious crimes who are willing to assist authorities.
Violence Against Women Act (VAWA)	Survivors (male and female) of domestic violence by a U.S. Citizen or Lawful Permanent Resident spouse, parent or adult child.
T-visa	Survivors of human and labor trafficking
Special Immigrant Juvenile Status (SIJS)	Undocumented patients under age 21 who have been abandoned, abused or neglected by one or both parents including children in foster care, guardianship proceedings or on probation.
Asylum and Convention against Torture (CAT)	Undocumented patients who experienced persecution or torture in the country of origin.

Practical Questions:

1. Are your local social workers aware of the T-Visa and U-VISA programs?
2. Who are local legal organizations that can assist patients in cases of human trafficking?
3. What is local law enforcement's perspective on trafficking?

Recommended Screening Questions:

These are general physical safety questions recommended by the LA County Health Agency SBDOH Workgroup that may reveal labor or sex trafficking concerns. The Workgroup has not yet developed specific questions to screen for labor or sex trafficking.

1. Do you currently feel unsafe? (Yes/No)
2. Have you ever been slapped, kicked, hit or physically hurt by someone in the past year? (Yes/No)
3. Are you currently in or have you ever been in an abusive relationship? (Yes/No)
4. Have you ever been pressured or forced to have sex? (Yes/No)

Paired Reading:

Shandro, J., et al., *Human Trafficking: A Guide to Identification and Approach for the Emergency Physician.* Ann Emerg Med, 2016. **68**(4): p. 501-508.e1.

Discussion Points from the Reading:

1. Traffickers control their victims by coercion and maintain control by using fear, physical, sexual and emotional violence and manipulation. Patients who are trafficked rarely self-identify, and may have no obvious signs of abuse. This makes identifying potential victims even more difficult. Not all victims are ready to leave their exploitive situation or to acknowledge that they are being exploited. The most important focus of a provider is to create an environment of trust and respect so that those victims who are ready to disclose their situation feel comfortable to do so.
2. There is a national trafficking hotline available 24/7 which can be contacted at 1-888-373-7888. This resource can help victims, will accept tips regarding people being trafficked and has a directory of services available to trafficking victims.

Additional Reading:

1. Macias-Konstantopoulos, W., Human Trafficking: The Role of Medicine in Interrupting the Cycle of Abuse and Violence. Ann Intern Med, 2016. 165(8): p. 582-588.
2. Victims of Human Trafficking: T Nonimmigrant Status. (n.d.). Retrieved February 21, 2018, from https://www.uscis.gov/humanitarian/victims-human-trafficking-other-crimes/victims-human-trafficking-t-nonimmigrant-status

Module 13. Incarceration
Shamsher Samra, MD, MPhil

Objectives:

1. Understand the health implications of incarceration and the Prison Industrial Complex.
2. Understand the rights of detained patients in the emergency department.
3. Understand the right to access care for patients.

Case:

A 19-year-old man is brought into the ED with police after being arrested. Per police, he was arrested after running from police for presumed drug possession and resisting arrest, requiring a physical "takedown". The patient is dressed in street clothes and is in four-point restraints. He shows signs of craniofacial trauma and blood over his shirt and pants. He states he was assaulted by police. The patient, who appears coherent, is refusing medical examination. You formally run through each of the components of capacity assessment: understanding, expressing a choice, appreciation, and reasoning. According to your assessment, the patient has capacity. The police, however, are requesting the patient be "medically cleared" for booking.

You see the same patient 2 months later. This time he is coming in for left arm pain after being assaulted while in custody. The x-ray shows a healing fracture. The patient tells you this happened 2 weeks prior and he had been asking to see a doctor but the guards told him to suck it up. Patient wants to talk to you alone but the officer refuses to leave the room.

Discussion Questions:

1. What are some of the unique barriers to care encountered by prisoners?
2. What are the rights of an arrested patient?
3. What are the standards for access to care while in custody?

Teaching Points:

1. Patients affected by the prison industrial complex (PIC) may face significant structural, biopsychosocial, and institutional barriers to healthcare. The number of people in US prisons has tripled since 1987. As of 2014, almost 3% of the US population is under correctional supervision. Incarcerated patients are at increased risk of illness including injury, communicable disease, and poor mental health, a risk that continues following release.
2. Restriction on movement, skepticism towards incarcerated patients by correctional employees and medical staff concern regarding malingering, lack of confidentiality, and institutional constraints to medical care are just some of the many factors that may contribute to under-diagnosis and mismanagement of disease and/or decompensation of existing illness including substance dependence and mental illness.
3. Arrested patients are deprived of many constitutional rights but retain their eighth amendment rights, particularly protection against cruel and unusual punishment. Per court rulings, refusal of medical evaluation and treatment constitutes cruel and unusual punishment. As such, incarcerated individuals are entitled to medical care and provision of care recommended by health care providers.

4. Except for cases and conditions that endanger population health (e.g. possession of substances and weapons), providers should strive to maintain confidentiality in doctor-patient relationship. While this may be limited by constraints of detainment and proximity of correctional staff, providers may take certain measures to protect confidentiality and potentially promote patient openness in discussion. This may include asking correctional staff or law enforcement to move outside of earshot and sealing confidential patient information for transfer with law enforcement.

Practical Questions:

1. What are local policies to protect both healthcare staff and patient privacy?
2. What are local resources for patients who feel that their rights have been violated?
3. If you have a conflict with law enforcement, to whom to you raise the concern?

Recommended Screening Question(s):

The LA County Health Agency SBDOH workgroup has not developed any recommended screening questions for this domain. It recommends taking a thorough approach in investigating each patient's chief complaint.

Paired Reading:

Recognizing the Needs of Incarcerated Patients in the Emergency Department. *American College of Emergency Physicians 2006*.Available at: https://www.acep.org/Clinical---Practice-Management/Recognizing-the-Needs-of-Incarcerated-Patients-in-the-Emergency-Department/

Discussion Points from the Reading:

1. The National Commission on Correctional Healthcare publishes standards for the care of detainees. They have outlined basic rights of detained persons regarding healthcare and state that they maintain the right to access healthcare, the right to care that is ordered by providers, the right to a professional medical judgement, the right to have proper medical records, the right to confidentiality, and the right to refuse medical treatment.
2. All patients in shackles are not necessarily prisoners. Depending on the charges, the person may be brought to court and bail set. If they are able to post bail they may be released until a future court date. If they do not pay bail, they may be brought to a jail where they undergo an intake process. This intake process may bring to light medical issues, but also may fail to identify medical needs. Because of the uncertainty of what medical resources the detained patient may have access to at the next step in their process, it is important for the ED provider to take extra care that the patient receive any evaluation or medication that is critical during their visit rather than schedule outpatient follow up when possible.

Additional Reading:

1. Binswanger, I, Elmore, J. Care of Incarcerated Adults. In: UpToDate, Post, TW (Ed), UpToDate, Waltham, MA, 2016.
2. Institute of Medicine and National Research Council. 2013. Health and Incarceration: A Workshop Summary. Washington, DC: The National Academies Press. doi:https://doi.org/10.17226/18372. *Available at:* https://www.nap.edu/catalog/18372/health-and-incarceration-a-workshop-summary

Module 14. Violence Intervention
Shamsher Samra, MD, MPhil

Objectives:

1. Understand the scope of interpersonal violence and injury recidivism.
2. Understand how the acute care setting can be a unique setting to interrupt the downstream impacts of violent injury and re-injury.
3. Discuss what resources can be made available in the acute care setting for victims of violence.

Case:

MF is 23-year-old male presenting to the emergency department with a gun-shot wound to his left upper extremity. He has a past medical history significant for splenectomy in the setting of a previous gun-shot wound three years prior and a substance use disorder. He has a history of incarceration and has had a difficult time finding work since release from jail. While he is not affiliated with a gang, several of his friends and family members are. Today, his injury is determined to only involve superficial soft tissue. A plan is made to discharge him with supplies for wound care.

He tells you that he is scared to go home, because his neighborhood is not safe. The last time after he was shot, he had nightmares for a long time. You recently heard about a program at your institution aimed at preventing violence recidivism while providing support for the patient. Given the patient's concerns, you contact the new hospital-based violence intervention advocate to see him before he is discharged. The advocate educates him about the Victims of Crime program and arranges to follow up with him in the community.

Discussion Questions:

1. What can be done to break the cycle of violence?
2. What factors increase this patient's risk of recidivism?
3. What is a hospital-based violence intervention program?
4. What is the Victims of Crime program and what benefits does it provide?

Teaching Points:

1. Every year over fifty thousand deaths and 2.2 million injuries requiring medical attention are attributable to acts of violence between two individuals. The average non-fatal violent injury costs $24,000 for medical care and $1.3 million in lost productivity. This financial burden disproportionately affects already underserved communities.
2. For surviving victims, violence has long lasting psychological impact and a negative impact on life trajectory. Estimates of PTSD in urban victims of violence approach 40%.
3. Sustaining a violent injury increases one's risk for both committing violent acts and re-victimization. Exposure to firearm violence doubles a youth's likelihood of committing a violent act within two years. Estimates on re-injury suggest that between 5 and 45% of victims of violence will experience re-injury in five years.
4. Hospital-based violence intervention programs (HBVIP) can mitigate the downstream impact of interpersonal violence.

Practical Questions:

1. What services and support are offered to victims of trauma at your hospital?
2. Who are local community-based organizations that could be partners in assisting victims of violence?

Recommended Screening Questions:

The LA County SBDOH workgroup has not recommended screening questions to specifically identify those patients at risk for future violence after intentional injury, however, the paired reading below recommends the use of the Children's Hospital of Philadelphia Screening tool which includes the questions:

1. Do you know the person who hurt you?
2. Do you think the conflict that caused this incident is over?
3. Do you plan to hurt anyone because of what happened today?
4. Do you think that any of your friends or family members will hurt anyone because of what happened today?
5. Have you reported the incident to the police or any authority?

Paired Reading:

Cunningham R, Knox L, Fein J, et al. Before and after the trauma bay: the prevention of violent injury among youth. Ann Emerg Med 2009;53:490-500.

Discussion Points from the Reading:

1. Effective hospital-based violence prevention programs are based on strategies such as social skills training, positive youth development, mentoring, parent and family training and home visitation. Effective programs work to build resilience and help youth to face environmental and social stressors.
2. Preventing future violent injury is possible through HBVIP programs. When treating a youth after violent injury, consider whether the patient is at risk for retaliatory violence and potential re-injury. If so, consider counseling the patient briefly and referring to a local HBVIP. Initial contact post-discharge is much more difficult than an initial brief introduction face to face in the Emergency Department.

Additional Reading:

1. Medical Costs and Productivity Losses Due to Interpersonal and Self-Directed Violence in the United States. American Journal of Preventive Medicine Volume 32, Issue 6, June 2007, Pages 474-482.e2
2. Dicker, Rochelle. "Violence intervention programs: A primer for developing a comprehensive program for trauma centers." The Bulletin, American College of Surgeons, 4 Oct. 2017. Available at: bulletin.facs.org/2017/10/violence-intervention-programs-a-primer-for-developing-a-comprehensive-program-for-trauma-centers/#.WqSli-jwaM8.
3. James TL, Bibi S, Langlois BK, Dugan E, Mitchell PM. Boston Violence Intervention Advocacy Program: a qualitative study of client experiences and perceived effect. Acad Emerg Med 2014;21:742-51.

Module 15. Built Environment
Vanessa Kreger, MD, MPH

Objectives:

1. To consider the ways in which the built environment and urban design affect health outcomes and health care utilization.
2. To foster discussions of the role that emergency medicine providers play in addressing health disparities associated with the built environment.
3. To understand what resources are available to help patients with the built environment.

Case:

An 8-year-old boy with a history of asthma and allergic rhinitis is brought into the emergency department by his mother for persistent wheezing and increased work of breathing over the last hour despite strict medication compliance. This is the patient's third presentation to the ED over the last 8 months with one ICU admission in the last year. In addition to these ED visits and hospitalizations, the patient's mother expresses concern about her son's worsening school attendance due to frequent asthma exacerbations. The patient is up to date on all childhood vaccinations and lives in a non-smoking household. The patient and his family live about a quarter of a mile away from a major freeway interchange in a densely populated urban community. The patient's school is near dense urban traffic corridors as well. Both of the patient's siblings also have poorly controlled asthma despite optimal medical management and health education.

While in the ED, the patient's symptoms were appropriately medically managed with improved work of breathing and decreased wheezing throughout bilateral lung fields. Upon discharge, the patient's mother desperately inquired what more she could do to help prevent further such exacerbations in the future. The patient's physician acknowledged the mother's consistent work to control the patient's asthma. The provider described environmental and structural causes and triggers to asthma, including proximity to dense urban traffic corridors. The physician encouraged on-going strict medication compliance and offered new ideas to better control the patient's asthma, including avoiding outdoor-play during peak traffic hours. The practitioner explored the eventual possibility of the family relocating further to a neighborhood with less dense air pollutants and traffic. It is important for the provider to recognize frequent barriers to relocation including socioeconomic status, employment, family, transportation, etc.

Discussion Questions:

1. What is the built environment?
2. How does the built environment affect health?
3. What can ED do to address challenges with the built environment?

Teaching Points:

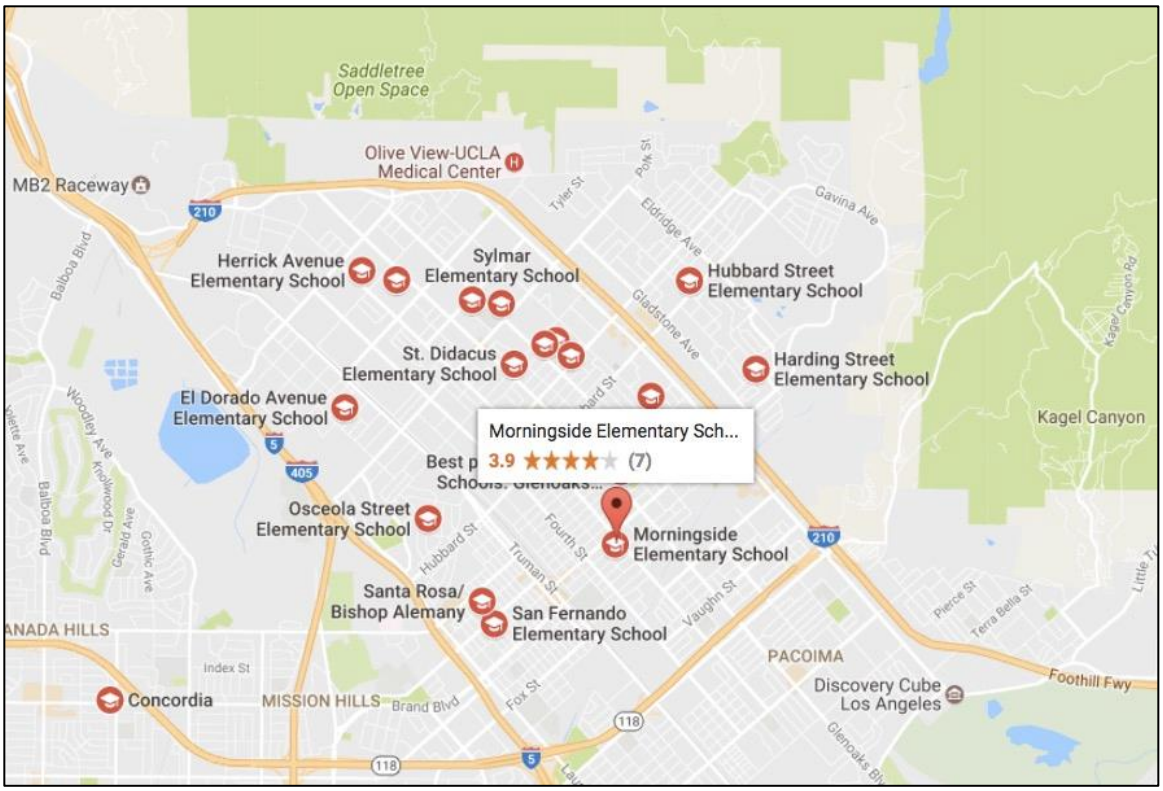
1. The built environment is described as the man-made, physical attributes of our surroundings, including structural conditions affecting walkability and recreation, availability of health-promoting resources (e.g. grocery stores, parks), undesirable amenities (e.g. fast-food restaurants, liquor stores, marijuana dispensaries) that influence individual and community health behaviors (physical, activity, diet).

2. A growing body of evidence points to the important role that poor built environment (ex. dense urban traffic corridors, food deserts, 'un-walkable' neighborhoods, poor, overcrowded, old housing structures, etc.) plays on a multitude of health outcomes including asthma, obesity, cardiovascular health, maternal and fetal health, and neurologic health. It is important to understand and acknowledge structural and systemic barriers to health that disproportionately burden certain neighborhoods, most frequently low-income communities.
3. The built environment has a direct impact not only on health outcomes but health care utilization as well. For example, studies indicate that individuals who reside in dense urban traffic corridors with high concentrations of air pollutants and small particulate matter have higher prevalence of poorly controlled asthma. As such, these individuals present to EDs and utilize healthcare at higher rates than their counterparts who lack this exposure.
4. On an individual level, ED physicians can acknowledge the challenges their patients face and offer creative solutions to mitigate the effects of the built environment. On a larger scale, it will require a multi-disciplinary approach involving health care providers, city planners, economists, health policy experts, environmental scientists, community advocates, etc. to advocate for policies that support healthy built environments and environmental justice.

Practical Questions:
(The responses may be modified to your own hospital/clinical environment. Example responses below refer to the UCLA-Olive View Medical Center Emergency Department.)

1. Think about communities surrounding your emergency department. Discuss the role of the built environment on community health (consider childhood asthma, for example). What other features of the built environment impact patient health?

Olive View-UCLA Medical Center is located within the densely-populated LA Basin, a region with some of the worst traffic congestion and air pollution in the world. OVMC is located at the base of the San Gabriel Mountains in a region of the LA Basin where air pollutants tend to accumulate in greater density as compared to other regions of Los Angeles. As such, the communities that make up the area around OVMC bear a substantial health burden of the poor regional air quality. As demonstrated by the map below, elementary schools in this region are surrounded by some the heavily driven highways. This contributes to a disproportionate health burden on young children and their lungs.



2. What are the local resources available for addressing the built environment?
3. Are there local groups one can partner with to advocate on behalf of improving the built environment?

Recommended Screening Question(s):

The LA County Health Agency SBDOH workgroup has not developed any recommended screening questions for this domain.

Paired Reading:

Brandt, Sylvia, Laura Perez, Nino Kunzli, Fred Lurmann, John Wilson, Manuel Pastor, Rob McConnell. "Cost of near-roadway and regional air pollution—attributable childhood asthma in Los Angeles County." *Journal of Allergy and Clinical Immunology* 134 (2014): 1028-1035.

Discussion Points from the Reading:

1. Near roadway air pollution can cause childhood asthma.
2. Costs of near roadway air pollution can be significant including direct costs for healthcare, and indirect costs such as lost wages.
3. Los Angeles County's rate of childhood asthma is particularly high and attributions have been made to dense traffic corridors, regional air pollutants such as ozone, nitrogen dioxide and particulate matter.

Additional Reading:

1. Delamater, Paul L., Andrew O. Finley, Sudipto Banerjee. "An analysis of asthma hospitalizations, air pollution, and weather conditions in Los Angeles County, California." *Science of the Total Environment* 425 (2012): 110-118.
2. Huynh, Peter, Muhammad T. Salam, Tricia Morphew, Kenny Y. C. Kwong and Lyne Scott. "Residential proximity to freeways is associated with uncontrolled asthma in inner-city Hispanic children and adolescents." *Journal of Allergy* (vol. 2010, Article ID 157249, 7 pages, 2010. doi:10.1155/2010/157249.
3. Koppel, Lianna S., Wanda Phipatanakul, Jonathan M. Gaffin. "Social Disadvantages and Asthma Control in Children." *Paediatric Respiratory Review* 15.3 (2014): 256-63.
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6. Mazenq, Julie, Jean-Christophe Dubus, Jean Gaudart, Denis Charpin, Antoine Nougairede, Gilles Viudes, Guilhem Noel. "Air pollution and children's asthma-related emergency hospital visits in southeastern France." *European Journal of Pediatrics* (2017). Doi 10.1007/s00431-017-2900-5.

Module 16. Employment
Dennis Hsieh, MD, JD

Objectives:

1. To understand how employment affects health.
2. To understand the rights of employees.
3. To learn how to advocate for a patient who is the victim of unfair employment practices.

Case:

A 28-year-old man comes complaining of shortness of breath and a full body rash. The patient has a history of asthma and uses an inhaler. He is otherwise healthy. He does not smoke or drink or use any substances. On exam, he is afebrile and his vital signs are as follows: BP 120/80, HR 90, RR 22, 94% oxygen saturation on room air. He appears uncomfortable, coughs throughout the interview, and is wheezing on exam. There is an urticarial rash on both arms and his face. The patient has avoided coming to the ED even though this has bothering him for a few days because he does not have health insurance through his job and he is worried about the bill. He is a painter. He recently started with a new company that does not provide facemasks or other protective equipment. He cannot afford to buy his own, because they pay him in cash at $7.00 per hour. He needs the money to pay for rent, food, and clothing for his two young kids, his wife, and himself. He knows this is less than minimum wage, but is afraid to complain, because he did so at his last job and they fired him without giving him his last paycheck.

He feels better after nebulizers and diphenhydramine. However, he is not sure what to do. Social work sees him and advises him to speak with an employment law attorney. You follow up with the patient one week later and he is doing better. The employment law attorney is in the process of getting him back wages and compensation for wrongful termination from his previous job. A demand letter to his new job resulted in the provision of protective equipment, back pay, and a raise to the market rate.

Discussion Questions:

1. How is the patient's job affecting his health?
2. What is a living wage as compared to a minimum wage?
3. What protections do workers have in terms of workplace safety protections?
4. What protections do workers have against unfair termination and unfair compensation/back wages?

Teaching Points

1. Employment conditions can affect health and is directly associated with healthcare coverage, health outcomes, and life span. Those with lower levels of control within their jobs also have poorer health outcomes which contributes to the social gradient in health.
2. Workers (regardless of documentation status) have rights when it comes to working conditions, minimum wage, unfair termination, and payment for completed work.

Practical Questions:

1. Who are the local attorneys who provide low-cost or free legal help with employment concerns?

2. What are the ways someone can find a job if they need one in your area?
3. What type of workplace issues do your patients face?
4. What are the different workplace protection laws that one should be aware of (OSHA, FMLA, etc.?)

Recommended Screening Question(s) (See also legal needs – trouble with your job)

1. Do you want help finding or keeping work or a job?
   - ☐ Yes, help finding work.
   - ☐ Yes, help keeping work.
   - ☐ I do not need or want help.

Paired Reading:

Robert Wood Johnson Foundation. "Issue Brief: How Does Employment – or Unemployment – Affect Health?" March 2013. *available at:* **https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf403360**

Discussion Points from the Reading:

1. A well-paying job allows for individuals to live in better neighborhoods, provide quality education for their children, and buy nutritious foods. Well-paying jobs also provide better benefits such as insurance. All of this leads to a longer lifespan. In contrast, those who are out of work face numerous health challenges, including being uninsured, being in poorer health, and developing a stress-related condition such as stroke, heart attack, heart disease, or arthritis. Those who are unemployed are also more likely to be depressed and report feeling sad and worried.
2. Workplace wellness programs consist of proactive steps that employers take to promote health and safety that result in improved employee well-being. Studies show that employers save an average of $6 for every $1 spent on workplace wellness programs by reducing sick leave, health plan costs, worker compensation, and disability costs.
3. The working poor (those with low paying jobs and limited access to healthcare) are less likely to have access to preventive care or insurance coverage through their jobs. This leads to more health challenges.

Additional Reading:

1. Robert Wood Johnson Foundation. "Issue Brief 4: Work and Health." December 2008. *Available at:* *https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf403360*
2. Robert Wood Johnson Foundation. "Policy Brief: How can wellness programs save employers money while making employees healthier and more productive?" August 2012. *Available at:* *https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf401183*
3. Benach J., Solar O., Vergara M. *et al.* Six employment conditions and health inequities: a descriptive overview. Int J Health Serv. 2010;40(2): 269-80.
4. Benach J., Vives A., Amable M. *et al*. Precarious employment: understanding an emerging social determinant of health. Annu Rev Public Health. 2014;35:229-53.
5. Marmot, M. The Health Gap: The Challenge of An Unequal World. Bloomsbury, London, 2015.

Module 17. Healthcare Coverage and Access to Healthcare
Dennis Hsieh, MD, JD

Objectives:
1. To learn what different types of healthcare coverage are available to patients
2. To learn the difference between healthcare coverage and access to care
3. To help patients figure out how to get the appropriate follow up.

Case:
A 68-year-old woman comes to the emergency department for a medication refill. She has a history of diabetes, hypertension, and hyperlipidemia. At triage, her glucose is 350 and her BP is 220/110 so the nurse rushes her back to see you.

She has been taking her medications everyday but cannot afford to refill them each month, so she carefully cuts each pill in half and takes half the recommended dose so that the prescriptions last twice as long. She worked for most of her life in the service industry and thus does not have much savings. She gets $885 from her supplemental security income (SSI) check each month and this goes towards food and housing. She assigned doctor through Medicaid is one hour away, so she comes to the emergency department to get her medications refilled.

The financial counselor educates her about the fact that she has both Medicare and Medicaid and that both are willing to change her assigned doctor if she calls the service center. She is given the phone number and is reassigned to a new primary care doctor who changes her medications to those that are on the $4 list at the local store.

Discussion Questions:
1. What is the difference between healthcare coverage and access to healthcare?
2. What are the different types of healthcare coverage available to patients?
3. What should a patient do when the patient cannot find a doctor who takes their insurance?

Teaching Points
1. Healthcare coverage doesn't guarantee access to care.
2. Medicaid is for individuals with low income. The income level depends on the state. Depending on if the state has chosen to expand Medicaid coverage under the Affordable Care Act, there may be additional requirements linked to Medicaid eligibility, such as age, disability status, and pregnancy status. Medicare is for individuals who are 65 or older. There is no income limit or requirement. However, to be eligible for Medicare, one must have worked 40 quarters or more in one's lifetime or be linked to someone who has worked at least 40 quarters.
3. Insurance companies will often assign a patient to a doctor if the patient does not select a doctor. One can change this assignment by calling the insurance company. Access to a medical home may decrease emergency department utilization.
4. All providers should inquire about the patient's ability to obtain the prescriptions when prescribing new medications. Patients may not volunteer that they cannot afford the medications unless asked.

Practical Questions:

1. Where can patients go to sign up for insurance at your institution?
2. What are the wait times for primary care and specialty care at your institution?
3. Does insurance limit whom patients can follow up with at your institution?

Recommended Screening Question(s):

The LA County Health Agency SBDOH Workgroup has not developed any questions on access to care. For assessing healthcare coverage, the Workgroup recommends:

1. What type of health insurance do you have?

☐ No health insurance
☐ Medi-Cal (Medicaid)
☐ Medi-Cal (Medicaid) pending
☐ Employer provided
☐ Medicare
☐ COBRA
☐ State children's health insurance
☐ Private health insurance
☐ VA medical services
☐ Indian health services
☐ Don't know or unsure
☐ Decline to disclose
☐ Data not collected
☐ Other

Paired Reading:

Sommers BD, Biendon RJ, Orav EJ *et al.* "Changes in Utilization and Health Among Low-Income Adults After Medicaid Expansion or Expanded Private Insurance." JAMA Intern. Med. 2016. 176(10):1501-1509.

Discussion Points from the Reading:

1. This paper compares 3 states: Arkansas, Kentucky, and Texas. They compared U.S. Citizens, age 19 to 64, in the three states. The populations had no differences in sex, income or marital status. The subjects in Texas, which did not expand Medicaid, was younger, more urban, and disproportionately Latino compared with the other two states. Kentucky expanded Medicaid. Arkansas used Medicaid funds to purchase private insurance for low-income adults.
2. Expansion of Medicaid coverage led to increased access to primary care, fewer skipped medications due to cost, reduced out-of-pocket spending, reduced likelihood of emergency department visits, and increased outpatient visits. Glucose testing among patients with diabetes, regular care for chronic conditions, quality of care ratings and the proportion of adults reporting excellent health all increased after Medicaid coverage expansion.
3. Increased healthcare coverage appeared to lead to improved health by improving access to care while decreasing emergency department utilization.

Additional Reading:

1. Kominski GF, Nonzee NJ, Sorensen A. "The Affordable Care Act's Impacts on Access to Insurance and Health Care for Low-Income Populations." Annu Reb Public Health. 2017 38:489-505.
2. Zallman L, Nardin, R, Malowney, M. "Affordability of health care under publicly subsidized insurance after Massachusetts health care reform: a qualitative study of safety net patients. In J Equity Health 2015;14:112
3. DoVoe JE, Marino M, Gold R. "Community Health Center Use After Oregon's Randomized Medicaid Experiment." Ann Fam Med 2015;13(4):312-20.

Module 18: Financial Strain/Instability
Dennis Hsieh, MD, JD

Objectives:
1. To understand the breadth of income support programs that exist for patients.
2. To understand how a lack of income affects health.
3. To learn how to help patients advocate for income support.

Case:
A 32-year-old woman comes into the ED with chief complaint of palpitations and chest pain. She has no past medical history and no past surgical history. This has never happened before. She has no leg swelling, no family or personal history of blood clots, no recent long trips, and no hemoptysis. Her vital signs are BP of 120/80, HR of 70, RR of 16, an oxygen saturation of 100% on room air with a temperature of 98.6°F. Her exam is unremarkable and her EKG is normal. She also has a negative urine pregnancy test and her chest x-ray is not concerning.

Upon further questioning, patient said this started after she got a notice from her power company that her electricity was going to be cut off because she is behind on her payments. She has 2 children and so it is difficult to work full time. They have not had enough to eat for the past two weeks since her savings ran out. She is also worried she may lose her housing if she cannot find money to pay the rent. Her phone has been shut off because she has not been able to pay the bills.

You call the social worker to talk with the patient. She educates the patient about cash aid, food stamps, utility assistance for gas and electric, and lifeline. Furthermore, they tell the patient that she can get emergency cash aid to help with the rent as well.

Discussion Questions:
1. Why did this patient come to the emergency department?
2. How does financial insecurity affect health?
3. Who is eligible for cash aid? For food assistance? For utility assistance? For lifeline?

Teaching Points:
1. Income insecurity affects health through factors such as increased stress, poor housing, poor diet, and poor access to care.
2. There are many programs available for low income individuals to assist with financial insecurity.
    a. Food Stamps/SNAP (CalFresh in California) is based on income.
    b. Cash Aid (CalWORKS in California) is based on income.
    c. Utility Assistance is based on income and varies by area. Usually there are assistance programs for heating (East Coast and colder climates), electricity and gas.
    d. Lifeline – cell phones for individuals on other programs such as Medicaid.
    e. Note that immigration status can be a barrier to these programs.
3. Providers can help educate patients about the availability of these resources.

Practical Questions:

1. What local income and utility support programs are available and what are the eligibility guidelines?
2. At your institution, how do you connect patients to these programs and how do they apply?

Recommended Screening Question(s):

1. Do you have the resources to pay for the very basics like food, housing, medical care, and heating? (Yes/No)

Paired Reading:

Chokshi D. Income, Poverty and Health Inequality. JAMA 2018;391(13):1312-1313.

Discussion Points from the Reading:

1. Income inequality leads to health disparities. This makes the steady increase in income inequality in the United States over the last 50 years very concerning. There is a well-documented association between income and life expectancy – 15 years for men and 10 years for women when comparing the most affluent 1% of individuals with the poorest 1%.
2. Factors that complicate the income-health relationship include wealth, educational attainment, sex, and race.
3. Healthcare spending can worsen income inequality; poorer individuals must spend a much greater proportion of their income on healthcare than richer people do. In 2014, healthcare spending lowered the median income of the poorest 10% by 47.6% vs 2.7% for the wealthiest 10% of the population.
4. Public health declines may be triggered by policies that theoretically have little to do with health directly, such as tax policy. This is because tax cuts may trigger cuts in governmental spending in programs such as Medicaid and Supplemental Nutrition Assistance Program (SNAP, aka food stamps), both of which play a crucial role when it comes to the health of low income individuals.

Additional Reading:

1. Urban Institute. Issue Brief: How Income and Wealth are Linked to Health and Longevity. April 2015. *Available at https://www.urban.org/research/publication/how-are-income-and-wealth-linked-health-and-longevity*.
2. Pickett KE, Wilkinson RG. Income inequality and health: a casual review. Soc Sci Med 2015;128:316-26.
3. Deaton, A. Health, Research Summary: Income, and Inequality. NBER Reporter 2003. *Available at http://www.nber.org/reporter/spring03/health.html*.
4. Sanger-Katz, M. *Income Inequality: It's also Bad for your Health.* NY Times Mar 30, 2015. *Available at:* https://www.nytimes.com/2015/03/31/upshot/income-inequality-its-also-bad-for-your-health.html.

Module 19. Transportation

Hannah Janeway, MD & Dennis Hsieh, MD, JD

Objectives:

1. To understand how geography and lack of transportation are barriers to accessing care and good health.
2. To understand the different resources available to help someone access care.
3. To learn to advocate for patients who need assistance to access care.

Case:

A 46-year-old man comes to the emergency department after being transferred from urgent care for a blood pressure 240/110. Patient denies any headache, chest pain, weakness, or any other symptoms. He had simply gone to urgent care to refill his medications.

When you ask the patient why he didn't go to his doctor, the patient explains that he doesn't have a car and the doctor assigned to him is 30 miles away, on the other side of town. It would take him 2-3 hours to get there on public transportation. He already must take 3 buses to work each day and works long hours. He cannot make it to his doctor without missing work. He has tried to ask Medicaid for help with transportation but was informed that, because he is not disabled, he cannot get the transportation services that Medicaid offers. He asks why he can't just keep coming to urgent care for medication refills. He also asks if you know whether any doctors participate in Uber Health – he would love to switch to them.

What do you do?

Discussion Questions:

1. How does transportation affect health and access to care?
2. What are the different options this patient has for being able to see his primary care doctor?
3. Who is eligible for Medicaid transportation services?
4. What is Uber Health?

Teaching Points:

1. People can change the doctors to whom they are assigned.
2. Transportation and geography are barriers to accessing care.
3. Local governments and Medicaid provide transportation options for those who have challenges accessing care.

Practical Questions:

1. What are the local resources available for transportation?
2. What are your state's policies around Medicaid non-emergent transportation?
3. What committees in your clinic/hospital should you approach to help improve access to care for patients?

Transportation Health Tool: Provides access to data that practitioners can use to examine the health impacts of transportation systems https://www.transportation.gov/transportation-health-tool

Recommended Screening Question(s):

1. Have you experienced difficulties getting needed services because you do not have transportation?

Paired Reading:

Aleccia J, de Marco H. "Medicaid Nation: No Car, No Care? Medicaid Transportation at Risk in Some States." Kaiser Health Network. Jan 30, 2018. *Available at:* https://khn.org/news/no-car-no-care-medicaid-transportation-at-risk-in-some-states/.

Discussion Points from the Reading:

1. Non-emergency medical transportation (NEMT) is a Medicaid benefit that transports people to and from medical services including mental health counseling sessions, substance abuse treatment, dialysis, physical therapy, adult day care and specialists.
2. The program covers almost 104 million trips each at a cost of nearly $3 billion (2013).
3. Lack of transportation is the third greatest barrier to care for adults with disabilities, with 12.2% of those patients reporting they couldn't get a ride to the doctor's office (2104) and about 3.6 million Americans miss or delay non-emergency medical care each year because of transportation problems (2005).
4. Currently, with states trying to cut costs, there are proposals to cut NEMT. Proponents say that data from Indiana shows that providing transportation does not increase access to appointments. However, opponents argue that NEMT is vital for those who do not have any other way of getting to the doctor – it is a program of last resort.

Additional Reading:

1. Chaiyachti KH, Hubbard RA, Yeager A *et al*. Rideshare-Based Medical Transportation for Medicaid Patients and Primary Care Show Rates: A Difference-in-Difference Analysis of a Pilot Program. J Gen Intern Med 2018 [Epub ahead of print].
2. Weber, C. Introducing Uber Health, Removing Transpiration as a Barrier to Care. Uber Newsroom. March 1, 2018. *Available at:* https://www.uber.com/newsroom/uber-health/
3. Smith ML, Prohaska TR, MacLeod KE, *et al.* Non-Emergency Medical Transpiration Needs of Middle-Aged and Older Adults: A Rural-Urban Comparison in Delaware, USA. Int J Environ Res Public Health 2017;14(2):174.
4. Thomas LV & Wedel KR. Nonemergency medical transportation and health care visits among chronically ill urban and rural Medicaid beneficiaries. Soc Work Public Health 2014;29(6):629-39.

Module 20. Education
Dennis Hsieh, MD, JD

Objectives:

1. To understand how education impacts health.
2. To learn about the right to educational accommodations and individualized education plans (IEPs) for children.
3. To discuss what resources are available for adults looking for additional educational resources.
4. To be able to help patients with resources for education.

Case:

A 7-year-old male is brought to the ED on a psychiatric hold from school. The patient has been having behavioral outbursts at school and has been diagnosed with mild autism. Dad tells you that he has been asking the school to provide an environment to help his son learn but the school says that they do not have the resources. Instead, when he acts out, he has been suspended, placed in detention, or placed on psychiatric holds. The dad says he wishes he could just put his son into private school but he doesn't have the money. The dad did not finish high school and works as a janitor. The dad is trying to find a way to go back to school and get his GED so that he can earn a more money. Right now, between his two jobs and caring for his son, he just doesn't have the time or resources to do so.

Discussion Questions:

1. How does this child's school environment affect his health?
2. What are the school's obligations to accommodate the child's autism?
3. How does father's education affect his health?

Teaching Points:

1. Lack of reasonable accommodations lead to many consequences such as suspension, expulsion, and psychiatric holds.
2. Schools have a legal obligation to accommodate health needs of children through the individualized education plan (IEP) process.
3. Educational attainment is directly correlated to a patient's health outcomes.

Practical Questions:

1. What are the local resources available to assist with educational challenges for children?
2. What are the local resources available to assist with continuing education and training for adults?
3. What resources are available in your clinic/hospital for education for children and adults?

Recommended Screening Question(s): (See also legal needs – trouble at school)

1. For how many years did you go to school? (Record answer in years: ____)
2. Do you want help with school or training? For example, starting or completing job training or getting a high school diploma, GED or equivalent. (Yes/No)

Paired Reading:
Robert Wood Johnson Foundation. Issue Brief: Why Does Education Matter So Much to Health? March 2013. *Available at:* https://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf403347.

Discussion Points from the Reading:

1. Education influences health in many ways. It leads to better jobs, higher income and reduced risk of illness.
2. College graduates live on average five years longer than individuals who have not finished high school. Better-educated individuals are less likely to have chronic diseases and have more positive health behaviors. They also have access to healthier foods and safer homes.
3. College graduates earn nearly twice as much as high school graduates over the course of a lifetime.
4. Education has inter-generational effects, with infant mortality rates of women who never graduated from high school (8.1%) being nearly double that of women with college degrees (4.2%). Furthermore, only 13.3% of children whose parents do not have at least a college degree earn a bachelor's degree, compared with nearly half of those whose parents are college graduates.
5. Current education trends pose a threat to the health of future Americans: nearly 46% of adults 25 and older have either not completed or pursued education beyond high school and 30% of high school freshman fail to graduate within four years.

Additional Readings:

1. Ng SL, Lingard L, Hibbert K, *et al*. Supporting children with disabilities at school: implications for the advocate role in professional practice and education. Disabil Rehabil 2015;37(24):2282-90.
2. Zimmerman EB, Woolf SH, Haley A. Understanding the Relationship Between Education and Health. AHRQ 2015. *Available at:* https://www.ahrq.gov/professionals/education/curriculum-tools/population-health/zimmerman.html.
3. Hahn RA & Truman BI. Education Improves Public Health and Promotes Equity. Int J Health Serv 2014;45(4):657-78.