Social Drivers of Health Curriculum for Dermatology Residents: the UCSF Experience

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PRACTICE **POINTS**

- Integrating a formal curriculum on social drivers of health, including didactics on structural racism, cultural humility, communication, and practical strategies, can help residents learn to routinely assess social needs and develop feasible patient-centered care plans.
- Classroom learning paired with experiential rotations and community engagement in safety-net hospitals can help to build empathy, practical skills, and comfort managing real-world social barriers.
- Creation of trainee leadership roles and dedicated program support (eg, departmental funding) can sustain curriculum improvements, foster advocacy skills, and diversify the workforce pipeline.

Addressing social drivers of health (SDH) is essential to achieving health equity. These social and structural factors strongly influence patients' ability to access and benefit from care, but they often are omitted from formal dermatology residency training. We implemented a formal longitudinal SDH curriculum at a large academic dermatology program (University of California San Francisco [San Francisco, California]) that incorporated didactics, experiential rotations, community engagement, and trainee leadership to teach competencies such as assessing SDH; developing patient-centered plans; and practicing antiracist, culturally humble care. Residents reported increased awareness of the challenges faced by diverse populations, greater comfort addressing SDH in clinical scenarios, and perceived improvements in their ability to care for patients with complex social needs. Our results support broader incorporation of SDH and structural competency into dermatology training with continued refinement and community engagement.

Social drivers of health (SDH) describe the conditions in which an individual is born, grows, lives, works, and ages—all of which collectively influence their health. Examples of SDH include employment status, literacy level, education level, housing status, food access, income level, and social cohesion. Social drivers of health are critical catalysts to attaining health equity. Effectively applying an understanding of how SDH affect the care of all patients is an essential competency for physicians practicing in the modern era of rising income inequality and housing instability and increasing racial, ethnic, language, religious, and cultural diversity in the United States; however, in dermatology residency, this skill set often is developed by the hidden curriculum (ie, the informal curriculum that is based on what patient scenarios a resident happens to face) rather than one represented by formal educational objectives.[2]

Adding to this challenge of limited formal curricula is that caring for minoritized, marginalized, and other populations facing specific barriers can evoke feelings of frustration, helplessness, and even anger. These feelings can test the limits of a physician's identity as a healer, leading to burnout and self-protective attitudes such as distancing (emotionally, physically, or both) from these patients.[3] This is particularly relevant given that the majority (76%-79% each year from 2007-2019) of medical student matriculants

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The eTables are available in the Appendix online at www.mdedge.com/cutis.
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come from families with incomes in the top 2 quintiles nationwide, and fewer than 6% come from the lowest quintile earners.[4,5] These data indicate that most trainees have not experienced (and may even have a hard time imagining) the degree of economic and housing instability faced by many of their low-income patients, the care of whom disproportionately falls to large academic medical centers, which sponsor dermatology training programs.[6] Many trainees may feel uncomfortable communicating across the broad range of racial, socioeconomic, linguistic, and cultural differences they encounter during training and in practice. Structured opportunities to provide care in a supervised supportive environment combined with didactics that emphasize practical, evidence-based strategies can build empathy, improve attitudes toward patients from diverse backgrounds, and strengthen self-efficacy in challenging scenarios.[3]

In the past decade, there has been a push toward integrating our understanding of SDH into formal medical training.[7] Other specialty training programs—including psychiatry,[8] internal medicine,[9] pediatrics,[10] and family medicine[11]—have incorporated these elements into their curricula and competency evaluations. In dermatology, as in other specialties, making and implementing effective, patient-centered care plans requires attention to the various social and structural drivers that may influence outcomes. Dermatologists therefore should be educated about SDH during their training programs and empowered to address the ways they affect patient care.

At the University of California San Francisco (UCSF) (San Francisco, California), our dermatology trainees care for patients in several hospital systems citywide, including a tertiary academic medical center with multiple locations, a county hospital, and a Veterans Affairs medical center. Given the diversity of patient populations across our training sites—including many racially and ethnically minoritized individuals, immigrants, patients with limited English proficiency, people experiencing homelessness, and sexual and gender diverse individuals—we identified a critical opportunity to enhance our training through formal didactics and hands-on experiences that integrate SDH into existing curricula and strengthen trainees' ability to provide high-quality care to all patients.

Implementing an SDH Curriculum

In May 2020, UCSF dermatology faculty with an interest in SDH collaborated with departmental educational leadership to develop a formal SDH curriculum centered around 8 core learning objectives for residents (eTable 1). To achieve these objectives, we organized a 3-year didactic and experiential curriculum consisting of lectures (eTable 2), grand rounds sessions, journal clubs, and community engagement opportunities. Residents also spend 7 months during their training rotating at San Francisco's city and county hospital (Zuckerberg San Francisco General Hospital [San Francisco, California]) where all faculty are members of the core SDH curriculum development team and where residents can put into practice many of the skills learned in formal didactics to develop patient-centered care plans for low-income patients, approximately 40% of whom have limited English proficiency.

To further center the importance of SDH and health equity in our training program, we developed a Health Equity Chief leadership role for senior dermatology residents. Each year, 2 to 4 residents volunteer for and serve in this role, wherein they work with core faculty to review and improve SDH curriculum elements. They also work to enhance community engagement opportunities for residents (eg, pathway programs aimed at diversifying the dermatology workforce by introducing historically excluded local high school and college students to dermatology as a career path) and improve dermatology trainees' awareness of the history and health needs of the specific communities we serve in San Francisco. They also are prepared to become leaders in the field of health equity and to improve the care of diverse patient populations after residency. Our faculty curriculum leaders meet quarterly with our Health Equity Chiefs to review their individual and collective goals and strategize ways to improve learner and community engagement. Departmental funds are made available to support these efforts.

Leadership at our safety-net county hospital also developed a patient navigator position to improve our ability to care for patients with the most complex medical conditions and social needs. This role is held by a medical student taking a funded gap year and incorporates aspects of social work (eg, identifying barriers to care and connecting patients with resources such as transportation), quality improvement, and clinical research.[12]

Assessing Residents' Experience of a New SDH Curriculum

Prior to curriculum implementation, we surveyed graduating UCSF dermatology residents in June 2020 to assess their familiarity with SDH and the social and medical needs of various populations facing barriers to care, their comfort level with specific challenging clinical situations, and their desire for additional training. Responses were measured using a 5-part Likert scale, with additional options for free-text response. After initiating the SDH curriculum in July 2020, we sent the same survey each year to all senior residents immediately prior to their graduation, offering a small financial incentive ($15 cash gift card) to those who completed the survey. We obtained UCSF Institutional Review Board approval to utilize these survey data to better understand and to enhance residents' experience of the SDH curriculum.

All 8 residents invited in 2020 completed the survey assessing curriculum efficacy (100% response rate). For the 2023 and 2024 classes, data were analyzed in aggregate (n=14), with a 50% response rate. After implementation of the SDH curriculum, there was improvement in

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learners' awareness of challenges faced by every patient population, from a mean (SD) of 3.12 (0.66) to 4.52 (0.69) ($P<.05$). Learners were more comfortable handling hypothetical clinical scenarios requiring them to identify and address specific SDH after vs before implementation of the curriculum (mean [SD], 3.5 [1.06] before vs 4.0 [1.16] after)($P>.05$), though this difference was not statistically significant. Finally, many respondents expressed appreciation that our curriculum improved their ability to care for patients in complex social circumstances. Residents suggested in the free-text responses that learning more about the historical underpinnings of health disparities, opportunities for grassroots activism, and how to provide more culturally competent care of Native American populations could improve our curriculum.

Implications for Dermatology Training

Our survey results indicate that a formal SDH curriculum can improve dermatology residents' ability to care for populations with complex social needs. We advocate for implementing SDH curricula into dermatology training programs nationwide, as has been recommended by others.[13,14] We also propose that structural competency should eventually be a key dermatologic competency as determined by the Accreditation Council for Graduate Medical Education, in line with the American Medical Association's recommendation that structural competency is a learned skill required to end health inequity.[15] The Accreditation Council for Graduate Medical Education specialty program requirements currently are being revised; interested individuals can engage in this process by submitting this suggestion for public comment (https://www.acgme.org/programs-and-institutions/programs/review-and-comment/).

Limitations of a survey include the relatively small sample size (7-8 per year) and variable response rates. In addition, we did not survey each class of residents at the beginning and end of their training; our comparisons therefore were limited by comparing different individuals with distinct backgrounds and experiences. Furthermore, we acknowledge that the experience of developing this curriculum in San Francisco may be distinct from other communities, where access to dermatologic care may vary according to both the availability of public health insurance and the treatments covered by public insurers. In San Francisco, insurance coverage is near universal, such that residents in our training program regularly care for undocumented immigrants, persons experiencing homelessness, and other populations that might find it challenging to present to dermatology clinics in other settings nationwide.

Final Thoughts

Future directions of our curriculum include exploration of novel curriculum delivery methods (including a problem-based curriculum approach and other more experiential didactics), increased opportunities for community engagement, greater focus on advocacy with an emphasis on broader social and structural policies and their downstream effects, and focusing more specifically on the history and needs of specific low-income San Francisco neighborhoods and diverse patient populations.

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APPENDIX

eTABLE 1. Core Learning Objectives for UCSF Social Drivers of Health Curriculum Developed for Dermatology Residents

1. Evaluate SDH as relevant to the diagnosis and management of dermatologic conditions.
2. Describe dermatologic conditions seen in patients experiencing homelessness.
3. Develop patient-centered care plans that account for SDH.
4. Know how to assist patients with unmet health-related social needs through referrals to resources in the hospital and the community.
5. Understand US health care insurance systems, how patients access them, and how different contexts affect health care provision.
6. Develop cultural humility in caring for LGBTQIA+ patients, refugees, asylum seekers, and those with limited English proficiency.
7. Understand structural racism as a social driver of health and cultivate strategies for antiracist medical practice.
8. Exhibit humanism, empathy, and a capacity to build an effective therapeutic alliance when communicating across differences.

Abbreviations: SDH, social drivers of health; UCSF, University of California San Francisco (San Francisco, California).

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eTABLE 2. Social Drivers of Health Curricular Content Map

Residency year	Title of lecture (type[a])	Topics covered
1	Why assessing SDH improves dermatology care (GR)	Overview of SDH and skin diseases with strong social drivers; case-based examples showing how integrating SDH into patient care can improve outcomes
	Bridging differences through effective communication (GR)	Evidence-based and practical methods for improving communication in clinic visits; addressing microaggressions, language barriers, and agenda setting for complex visits
	HIV dermatology (RL)	History of HIV medicine and dermatologists' role; skin conditions more common in PLWH and evidence-based practices for treating them
	LGBTQ /sexual and gender minority dermatology (RL)	Taking a sexual history, LGBTQ/SGM demographics, skin conditions more common in gay men and lesbians, transgender terminology and approach to their unique skin care needs
	Dermatologic care of persons experiencing homelessness (GR)	Review of epidemiology for PEH in San Francisco and in the United States; review of conditions common in PEH and strategies for addressing lack of access to privacy, laundry facilities, running water, and refrigeration
2	Dermatologic care of immigrants (RL)	Definitional differences between immigrants, refugees, and asylum seekers; epidemiology of immigrant communities in the United States; skin conditions in migrants; tips for using interpreters in clinic
	Antiracist medical practice (RL)	Racial disparities in skin disease prevalence and outcomes, strategies for combatting racism in the medical encounter
	US health care systems, insurance, dermatology access and care (RL)	Distinction between public and private insurance types, how to incorporate knowledge of insurance into patient-centered care plans
3	Social drivers of health in pediatric dermatology (RL)	Adverse childhood experiences, pediatric skin conditions with strong social determinants, tips for addressing cost of over-the-counter products, health literacy, screening, and billing for SDH
	Ectoparasite infestation in persons experiencing barriers to care (RL)	Epidemiology of ectoparasite infestations, practical strategies for addressing infestation in persons with special barriers to care, including keeping extra clothing in clinics or using oral treatments

Abbreviations: GR, Grand Rounds; PEH, persons experiencing homelessness; PLWH, persons living with HIV; RL, Resident Lecture; SDH, social drivers of health; SGM, sexual and gender minorities.

[a]Grand Rounds has a duration of 1 h, and the entire department is present. Resident Lecture has a duration of 1 h and only residents and the involved faculty member are present.

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