Josiah Macy Jr. Foundation
Vital Voices — Season 3, Episode 2
Interview with Rahul Vanjani

Holly J. Humphrey, MD, MACP (HJH):

Welcome back to Vital Voices, a podcast from the Josiah Macy Jr. Foundation. I am Dr. Holly Humphrey, president of the Foundation. Our third season of Vital Voices focuses on the 2023 cohort of Macy Faculty Scholars, six individuals chosen to participate in our two-year Macy Faculty Scholars career development program because of their demonstrated potential as future leaders in medical or nursing education. I am delighted to have the opportunity to share our Scholars' stories with you as I think you are going to find their work to advance health professions education and their own personal experiences and perspectives to be inspiring.

Today's conversation is with Dr. Rahul Vanjani, an Assistant Professor of Medicine at the Warren Alpert Medical School of Brown University. Dr. Vanjani also serves as Medical Director of Amos House, a Rhode Island nonprofit, providing social and healthcare services to individuals experiencing homelessness. In this role, he leads an interprofessional clinic at Amos House that integrates social care into the practice of medicine. As a Macy Faculty Scholar, Dr. Vanjani is promoting the integration of social care into the clinical environment via interprofessional collaboration. To do this, he is expanding the social medicine elective, which he launched in 2021 at Brown University, to professions beyond medicine, including nursing, pharmacy, social work, and law. In addition, he is directing a national learning collaborative on social medicine for health professionals at public hospitals. And now, here is my conversation with Dr. Rahul Vanjani.

Holly J. Humphrey, MD, MACP (HJH):

Thank you for joining me today Rahul. As we begin today's conversation about you and your work, I cannot help but be reminded of the virtual interview that you had for the Macy Faculty Scholars Program when you needed to make a last-minute adjustment and have your interview conducted from a booth in a restaurant. I hope you have not needed to go to such great lengths today to find a comfortable place for a conversation.

Rahul Vanjani, MD, MSc (RV):

Yes, I remember that. And no, I'm really comfortable. I'm in my office here at Amos House and yeah, I do remember that. I mean, I had planned out being in our hotel room, we were visiting Legoland, and it just so happened that the night before my daughter had gotten really sick and we spent the entire night in the hospital and my daughter needed to rest that day. And so I had to find another place in the hotel and in Legoland, which you can imagine is a really loud hotel. So the staff there were really kind and kind of put me in the corner of the restaurant and a lot of coffee and your all's kindness is what got me through that interview. And just as a quick anecdote, right after that interview, my son, who had been so wonderful and kind to my daughter, but was bored and hadn't really gotten to do anything because we had spent all night in the hospital, he said he wanted to go to Peppa Pig Land.

So right after the interview, we walked across the street to Peppa Pig Land. My son was so excited, and then Peppa Pig came out like the real life Peppa Pig and Papa Pig.

HJH:

Oh, my.

RV:

And he started crying and shrieking and then we walked back home. So that's a part you may or may not have known, but before we walked back home, I was able to capture this amazing picture of him crying, Papa Pig in the middle, and me on the other side. So that's what I remember from that day.

HJH:

Boy, life with children is always interesting in ways that you can never predict or expect. So I hope your daughter had a brief illness and is doing well.

RV:

Yes, she's doing just fine now. Thank you.

HJH:

Okay, well listen, you have such a fascinating background in terms of the work that you've done and the settings in which you've cared for patients. Let's begin with you talking about a few of the highlights of your path into medicine, to medical education, and specifically serving the underserved.

RV:

Sure. Well, I knew that I wanted to go into medicine toward the end of college, and the drive at that point was largely political and social. And that, combined with my interest in science, made medicine a natural fit. And after college, I spent a year doing a master's program in the UK where I was exposed to the National Health Service. That really cemented my desire to go into primary care. And so then I came back to the US and started med school. And when I started med school, I really had my sights set on the Montefiore Social Medicine residency program. And I never ended up making it there because during the fourth year of medical school, I did an away rotation there called research-based health activism, a really wonderful fourth-year rotation based in the Bronx taught by a brilliant educator and researcher named Dr. Aaron Fox.

And in that cohort of 10 people who were doing away rotations during their fourth year of med school, I met my wife and my wife, like me, had entered medical school wanting to go to Montefiore Social Medicine residency program. And so we ended up deciding to match together and we both matched to New York City, but we decided that residency program was too small for both of us. And so she ended up going there and I ended up going to Columbia. But what was really wonderful as I transitioned from med school into residency was that I was still exposed to that social medicine curriculum. So we'd come home from work and having spent the day at Columbia, I would talk to her about liver transplant physiology and EKGs and she would talk to me about the case studies of Frantz Fanon and the Black Panthers and what the social medicine curriculum at Monte did a really good job of as well was honoring the social medicine traditions of Latin America.

So we talk about Salvador Allende, who was a president of Chile at one point and Che Guevara. And so I really was able to absorb a lot of those teachings and ground my medical practice in that theory during residency. And after residency, we moved to California so my wife could pursue a palliative care fellowship, and I decided to join the San Quentin State Prison where I practiced primary care largely with people in the general population and also on death row. And what was interesting about practicing primary care at a California state prison at that time is that in 2005, so some years beforehand, the state's prison system had been placed in federal receivership because the state had found that one

person was dying a day due to medical negligence. And so the state had decided to place healthcare in federal receivership, invest all this money in it, and what it meant was it was the only correctional setting in the entire country where healthcare held priority over corrections. So if you had some sort of health related need, it had to be met. So I walked into a primary care environment where the nine other primary care physicians were really dedicated, really wonderful, really sort of aligned in terms of their political and social drive to provide care to people. And emerged from that experience sort of understanding that I wanted to continue to take care of people who had been exposed to the carceral system, but I also learned that I needed to move outside of the prison setting and care for people in the community. And the reason is because I don't know if you've seen pictures of the San Quentin State Prison, but, right outside its front doors is this beautiful scenery. You can see all of Marin.

And what was really hard is I had patients who were just inside the walls of San Quentin who never were able to see that landscape. And each day I'd walk out and there'd be this beautiful landscape and just that dichotomy of knowing it was right there, but it being deprived from people was hard. And so when we moved here to Rhode Island, I worked with a close colleague to set up a transitions clinic model, which is a model started in San Francisco where a clinic is set up, community health workers with lived experience are centered, and we support people as they transition out of prison into the community, really centering the social determinants of health. And in that work, I learned so much from the community health workers and social workers I was working with. And so in terms of medical education, my passion has really been immersing health professions learners in environments where they can learn from people with lived experience, in particular peer recovery specialists, community health workers, but importantly, also patients. And so that's a little bit about my journey.

HJH:

That is so interesting and a perfect segue into the opportunity for our listeners to hear more about your social medicine elective. I mentioned it in the introduction to today's episode, but I'd love to have you describe in a little bit more detail what you hope to achieve by expanding the social medicine elective that you originally developed. And now as part of your Macy Faculty Scholar project, you're expanding it to include other disciplines. Can you tell us a little bit about that?

RV:

Sure, so the social medicine elective is a one-month elective at Brown's Medical School that really emerged from my practice along with wonderful colleagues in the transitions clinic model, but also doing street outreach. So we talked a little bit about the transitions clinic and centering community health workers and their lived experience. But during street outreach, I had very similar experiences where in doing street medicine with social workers and peers, I learned that they are one of the only professions in society that really sees human beings in the various environments in which they live. And so the average case manager, social worker, or peer recovery specialist would meet someone on the street, they might take them to the DHS office, they'll accompany them to the clinic, and they may even be with them at home and do a home visit. And that felt really special to me and seemed to convey a particular type of learning and education. And thinking about where social medicine as a field was in the US., –we talked a little bit about social medicine in Latin America, which was very political and practice-based–as social medicine transitioned into the US, it became very theoretical and intellectual.

So most of the large social medicine organizations we have here in the US are heavily research-focused and education-focused. There's less of a practical component. And so I thought to myself, along with

some wonderful colleagues, again, what if we pair students — what if we train students to be case managers and pair them with patients so they can engage in this bidirectional learning and service where they're providing some case management and other services to patients in the form of filling out applications, accompanying them to appointments, but also trying to gain knowledge and learning from patients by seeing what life is like, learning from their experiences. And the social medicine elective was born out of that. And so the idea really was one, spend two full days training initially medical students to serve as case managers.

So that really entailed teaching them all about housing, food, transportation, how to navigate those challenges and secure social resources for patients. Two, linking them with one to two patients for the period of a month, full-time. And then three, grounding all that in theory by having a weekly social medicine reading group and just time to process since, as you can imagine, being paired with a patient, it can be existentially hard. And now the plan is to expand it so that the medical students are working in partnership with nursing students and law students. And we actually had our first cohort of nursing students two months ago, and it was really wonderful.

HJH:

Wow. Thank you for sharing that with us, and I'm really looking forward to learning with you as this develops over the course of the next year. I want to shift gears a little bit because you're about halfway through your experience of a first year in our Macy Faculty Scholars Program. You participated in our kickoff meeting, the Annual Meeting of Macy Faculty Scholar alumni, and you have connected, I believe, with your National Advisory Committee mentor as well as your peer mentor. I'd love to hear a little bit about your experience as a Scholar overall thus far into the program.

RV:

There's so much to say about that, and I really appreciate this question. I think I'll start with a little anecdote from, now, a week and a half ago. So one of the best parts about the Macy Faculty Scholarship is you come into it because you're dedicated to teaching and in particular this notion of sort of interprofessional education in health and medicine, but also you're in a cohort with many brilliant educators and then have these two mentors, one from the National Advisory Council, and then one peer mentor, so an alumnus of the program. And so there's also just so much to learn. There's so much room to continue to improve your teaching. And so our cohort over dinner, I think when we first met, had this idea where we would invite each other to our lectures and then kind of provide each other with coaching because we all talked about how we all go off into medicine and then there's no coaching, there's no support.

People never really see you practicing medicine again unless you're really deliberate about it. So none of us had volunteered this up, but about four weeks ago, I had a lecture scheduled for two weeks ago and I was like, "You know what? I'm going to ask everybody to come." So I asked my peer mentor to come. I asked the National Advisory mentor to come and all of my colleagues in the program in my cohort, and they all showed up, and I did this one-hour lecture. I was incredibly nervous. And then I got six emails afterwards.I got a ton of really productive and amazing and loving feedback and I was able to be vulnerable with all of these colleagues and mentors. As a result, I feel like I gained so much in terms of my teaching and educational abilities. I think that kind of summarizes the experience of the fellowship for me so far.

HJH:

Wow, that's a great example. So was the lecture that you were giving, was it to students?

RV:

So the lecture I was giving is actually part of my Macy Faculty Scholarship project. One of the three parts of the project, in addition to the social medicine elective, was creating a Project ECHO-type module that would provide education on integrating social care into the clinical environment. And the way in which I'm doing this is by working with about 10 public hospitals around the country where we have a monthly learning collaborative. Every month about 30 people get on the call and we talk about various subjects that lie at the intersection of social care and healthcare. And so this particular lecture was on the subject of disability income, so the concept of social security, so SSDI and SSI, what it is, why it's relevant to healthcare professionals. And then there were some practical aspects to it, like how to document for disability. So it was a lot of fun. And Dr. Kelly Skeff, who's a renowned expert in the field of education and medical education in particular, is also my faculty mentor. And he was there and then we were able to debrief a week later, which was really wonderful.

HJH:

Oh, that's terrific. What a wonderful and powerful example. So given what you've already shared, I think it's obvious to our audience that you model how to make a meaningful difference in addressing social determinants of health in your own professional practice and in your teaching and so forth. You have also contributed quite significantly to considering systems approaches that can be broadly adapted for others to use. Can you share with us some examples of some of those concrete steps that individuals working in their own systems can take in supporting our patients in the full context of their lives?

RV:

Sure. The reason this has become an area of focus for me is because we all know that there are incredibly high rates of burnout in medicine. And now more than ever, we're seeing a ton of attrition. And the data show that one reason that people in primary care in particular, but in all parts of medicine, leave medicine is when they're taking care of individuals who are plagued with a number of social risk factors; they can often feel disempowered like there's not much they can do for them. And when you pair that with the fact that we know that social and environmental conditions determine more of an individual's health and wellbeing than sort of are the medical care that we provide, which the data show probably makes up for about 20% of health and wellbeing, although it's not that precise obviously, then it sort of calls into question, well, how can we empower learners and attendings and other providers to be able to do something in the moment for their patients; one, so that their patients leave feeling like their agenda has been prioritized and met.

And two, so that our colleagues feel a little bit more empowered and hopeful. And what we see a lot in the literature is how to screen for social and structural risk factors and how to think about social health equity and racial and other disparities. And then we see a lot around high level policy structural change. There's less around what can be done in the moment in the clinical setting. And yet there was this great *New England Journal of Medicine* article a few years ago that talked about how physicians really, and all healthcare professionals, really can serve as street level bureaucrats.

And what that means is we have more power than we know in the clinical setting. So a quick example, somebody comes into your office and they are struggling because their utilities are about to be shut off. They just received a letter. Well, there are many things that the clinical team can do about that, but an important piece of law to know is that in most parts of the US utility companies are mandated to have a form that can be signed by a health professional saying that it would negatively impact someone's health if their utilities were shut off.

And so a quick Google search looking for that form with the local utility company and a signature can prevent that person's utilities from being shut off. And you can imagine how much of an impact that can make on a patient, how much it can improve that patient-physician relationship. And there are numerous examples of that. Most public housing authorities have a form like that. There's the HUD verification of disability letter, which can place individuals on the disabled subsidized housing list as opposed to the mainstream list, their form letters. So one thing we've done here is submit letters to judges talking about the impact that incarceration might have on someone's health, submit letters to landlords talking about the impact of poor housing conditions on health. There's a brilliant article from *JAMA* in 2021 that did just that and found that about 80% of the time, landlords resolve the housing issue in response to a letter from a doctor.

So the typical order of operations there is you refer that patient out to legal aid or to a medical-legal partnership, which are amazing, but can take six months. There can be a long wait list. And so to summarize, I think my kind of area of interest and focus is what are the ways in which our society, our state and federal governments have empowered us health professionals to unlock certain social resources for patients? And then what are the questions we ask to screen for those challenges and how do we quickly and efficiently in the context of a clinical setting overcome those challenges? And then does that improve our sense of efficacy?

HJH:

That was a really powerful example and a wonderful summary. And I'm wondering, would it be fair to say that that is the way you're hoping your work will ultimately impact both medical education and patient care?

RV:

Yes, that is what I'm hoping. Right now what we're seeing is that increasingly social services are being funded and pushed forward by Medicaid and Medicare. In fact, just this past month in November, the White House, HHS, and CMS simultaneously published documents about the social determinants of health. And starting in January of 2024, every inpatient facility that accepts patients with Medicare will be mandated to screen for social determinants and then do something about it. And so there are many forces pushing us in that direction, and one option is to simply screen and then refer people out to social service agencies. But like I said before, that can contribute to burnout. And many of our community-based organizations are already super full. And so it really makes sense to begin to integrate into medical education this principle of integrating social care into the clinical environment while of course, being really sensitive to our limitations and to time constraints. And so yes, that is my hope and the goal of my Macy Faculty project.

HJH:

Wow, that's very inspiring, Rahul. I could continue this conversation for a long time because there's so much to not only learn from you, but really be inspired by. But I do need to wrap up for today. You obviously bring great humanity to our conversations, which is something that all of us not only appreciate but admire. You have an appreciation for the nuance and complexity that are inherent to so many of these challenging topics, such as those that you grapple with on a regular basis when caring for patients whose experiences are quite unlike your own. We look forward to learning more about what you will discover as you study the impact of the social medicine elective. And personally, I can hardly wait to see what comes of all of this. So thank you for joining me today.

RV:

Likewise, thank you so much for having me.

HJH:

Thank you for listening, and we hope you'll share this conversation with others. You can find this and all episodes of the Vital Voices podcast on the Macy Foundation website. We hope you will subscribe to the series so that you won't miss my upcoming conversations with the 2023 Scholars. And finally, please be sure to sign up to receive email updates from the Macy Foundation, updates about our podcasts, webinars, funding opportunities, and other ways to connect with the Foundation.