**Health Equity Curriculum**

The Family Medicine Residency program at New Hanover Regional Medical Center (NHRMC) is committed to training its physicians to navigate the broad milieu of social and cultural backgrounds and environments they will face during their careers. The program is also passionate about instilling a sense of social justice in its physicians, with awareness to current problems of health equity across the nation. While the U.S. Department of Health and Human Services defines cultural competency as the “ability of health care providers and health care organizations to understand and respond to the cultural and linguistic needs brought in by patients to the health care encounter,” the NHRMC Family Medicine Residency reaches further to also explore sociocultural needs that are less evident, as well as trainees’ own implicit biases. Largely borrowed from a mix of other family medicine training approaches, NHRMC’s Family Medicine Health Equity curriculum designates a longitudinal set of training requirements with the goal of addressing multiple ACGME milestones, as well as basic cultural training principles, through innovative experiential learning.

NHRMC’s Family Medicine Residency expects its trainees to recognize how sociocultural determinants interplay in the socioecologic framework to affect health outcomes. While the Family Medicine Residency program believes that cultural awareness, competency, and respect are necessary for high quality and effective health care, these are insufficient without exploration of personal bias and application through \*cultural humility.

\*Cultural Humility Principles:

* Lifelong Learning and Critical Self-Reflection
* Recognize and Challenge Power Imbalances for Respectful Partnerships
* Institutional Accountability: Organizational life-long learning and reflection

[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].

**The following section describes the formal didactic touchpoints for this curriculum.**

A total of four formal didactic sessions, each one held every 3 months. These sessions will take place during resident educational conferences, and attendance is required as per usual conference standards. The session facilitator will be a neutral presenter, aiming to create a safe space for trainees to move through the sometimes challenging topics.

**The following sections describe longitudinal touchpoints for this curriculum, based on current physician rotation learning activities. These evaluation methods will all be reviewed with Dr Isaacs throughout the year.**

* **Community tour and Community Assessment [community medicine]**
  + **Goals**:
    - Provide trainees with a cultural immersion experience that highlights community assets and introduces the concept of community asset mapping and community health workers
      * <http://www.communityscience.com/knowledge4equity/AssetMappingToolkit.pdf>
      * <https://www.vistacampus.gov/what-asset-mapping>
      * <http://healthpolicy.ucla.edu/programs/health-data/trainings/Documents/tw_cba20.pdf>
    - Help trainees understand how physical and cultural environment is relevant to their patients’ health
    - Address trainees’ perceptions and stereotypes of the communities they serve
  + **Rationale**: Community entree and asset mapping activities enable trainees to understand the physical and cultural environments in which they will practice and how these environments are relevant to their patients’ health. This enables them to establish treatment plans that are in tune with the patients’ reality, maximizing patient adherence and positive health outcomes. From a public health perspective, community entree and asset mapping activities allow providers to design programs in partnership with the community, allowing for sustainable change. The purpose of the asset-based community tour is to introduce trainees to the local community’s resources, strengths and support systems, thereby informing any perceptions and stereotypes they may hold.
  + **Process**: interns engage in community tour during orientation block, and then also visit community based sites during community rotation block (including time with a community health worker), where they complete a community assessment that leads to a class project. Each of the sites visited can be completed in conjunction with a faculty member and community members. Sample talking points: demographics, economics (location of banks, check cashing stores), pressing health issues, obesity (lack of parks, safe play areas for children, overcrowding, food deserts), public transportation, educational centers, beauty shops, environments, other health related agencies. Debriefing after these activities is facilitated by a faculty member, with attention laid upon collective community asset mapping.
  + **Learning points**: community asset mapping, community health worker, health disparities, health equity, cultural competency, community based organizations
  + **Evaluation methods**: during community entree, residents will take a map of New Hanover county, and start to individually notate on the map various locations, services, and areas as “asset,” “need,” or “neutral”. Consideration of culture and health equity through this process should be given when determining the collective class project idea – which will be the primary deliverable.
* **Home visits [CFMC, BMED]**
  + **Goals**:
    - Help residents gain a deeper understanding of the impact of environment and culture on patients’ lives
    - Strengthen the trainee-patient relationship and faculty-trainee relationships
    - Improve trainees’ knowledge of the community
  + **Rationale**: Seeing a patient solely in the hospital or clinic limits a providers’ understanding of the patient’s reality. Through home visits, trainees can increase their awareness of the needs and assets of their patients’ environments. Trainees can witness non-medical issues that their patients face. This can improve quality of care and strengthen provider-patient relationships.
  + **Process**: There are 3 types of home visits during NHRMC Family Medicine Residency training:
    - **Community rotation home visits**: trainees select a continuity patient from the practice to visit. Trainees go in the visit in pairs, which allows trainees to observe each others’ visit, thereby introducing peer-earning and team-building aspects to their experience.
    - **Behavioral health home visits:**
    - **Standard CFM home visits:** trainees visit clinic patients whose social needs may interfere with timely clinic visits. These may include elderly and homebound, pregnant women with transportation difficulties, or small children
  + **Learning points**: Residents should seek direct or indirect information about family members, home dynamics, or general living environment that may contribute to the patient’s health. Trainees should also be prepared to consider non-medical services or referrals/recommendations that may benefit the patient during the home visit.
  + **Evaluation methods**: residents will document cultural and/or psychosocial elements specific to each patient that were observed during the visit, and link these observations to the patient’s health in either a negative, positive or neutral effect. This should be captured in the EMR, if the patient is a CFM patient.
* **Family Trees**: **[orientation]**
  + Goals: Help residents gain a deeper understanding and appreciation of their own family and cultural history, as well as that of their peers.
  + Rationale: Seeing colleagues solely in the work setting can limit one’s understanding of the each other’s reality. This exercise will help broaden understanding of one another, and strengthen relationships with each other, building the groundwork as a future form of social support.
  + Process: Led by the behavioral health specialist, interns will complete their family trees during the orientation period. They will be able to share their family trees with each other.
  + Learning points: Residents should recognize that we all have a cultural background, and began to appreciate the diversity within their residency class.
  + Evaluation/methods: residents will present their completed family trees to each other.
* **Balint groups**:
  + Goals: Provide a safe environment for residents to explore their feelings and emotions, when they may relate to differences with patients or colleagues/staff.
  + Rationale: Being a physician is often laden with stress, especially for residents in training who frequently experience new challenges with each patient encounter, some of which can be emotionally taxing if there are major cultural differences or misunderstandings.
  + Process: Residents take part in Balint group quarterly, to discuss and explore their feelings with work-related issues.
  + Learning points: Residents should start to grasp that it is expected to have differences with patients and other staff members. The Balint group can be a venue for seeing such encounters from a different cultural perspective, and help lay the groundwork for developing cultural humility.
  + Evaluation/methods: the behavioral medicine faculty member will create a safe space for culture to be considered during Balint discussions. These groups are confidential, and will not be shared outside the group.
* **Culturally and Linguistically Appropriate Services [orientation]**
  + Goals: introduce residents to federal requirements regarding non-discriminatory services for patients over various races and preferred languages.
  + Rationale: Residents will encounter a myriad of patients from various cultures and who speak limited English.
  + Process: A presentation will be delivered during orientation month on the CLAS (culturally and linguistically appropriate services) standards.
  + Learning points: Residents should understand what organizations who receive federal funds are required to offer in terms of translation services, and also what should be recommended for serving all persons in a health care setting.
  + Evaluation/methods: residents will complete interactive activities during the presentation, and will all know how to access translation services at NHRMC and CFM.
* **Behavioral Medicine Inpatient Rounds**: **[IPS]**
  + Goals: train residents to attain important psychosocial and cultural information that is pertinent to a patient’s presentation in the hospital.
  + Rationale: These rounds will help reinforce the importance of getting a full history on pertinent sociocultural histories (using SCREEM mnemonic).
  + Process: each Thursday morning on a resident’s inpatient rotation, he/she will prepare to share sociocultural information relevant to an assigned patient. The team will round together to review this information with the patient, under the supervision of the behavioral medicine faculty.
  + Learning points: residents will learn that patients in the hospital often have significant sociocultural histories that contribute both positively and negatively to their medical conditions.
  + Evaluation/methods: residents will document cultural and/or psychosocial elements specific to each patient that were observed during rounds within the patient’s daily progress note in the EMR chart, and link these observations to the patient’s health in either a negative, positive or neutral effect. The team can use the input to determine if there are any unmet psychosocial needs or barriers that can be addressed to further help the patient.
* **Video Encounters with Patients. [BMED, community medicine]**
  + Goals: residents will watch their videotaped encounters during Behavioral Medicine month, to self-assess one’s own cultural humility.
  + Rationale: this activity gives residents the opportunity to self-evaluate cultural skills utilized during a patient encounter.
  + Process: Residents have 1-2 encounters videotaped (with patient permission) weekly during Behavioral Medicine month. These video encounters are viewed in small groups with the Behavioral Medicine faculty to explore patient-physician dynamics.
  + Learning points: residents will have an opportunity to watch themselves and see if there were nuances they missed in person. Small group discussion will allow each resident the opportunity to see the encounter from a different perspective and help lay the groundwork for developing further cultural humility.
  + Evaluation/methods: completion of self-evaluation of “Intercultural Competency Observation Tool”, which will be reviewed with Dr Isaacs.
* **Service Learning opportunities:** 
  + Goals:
    - Help residents gain a deeper understanding of the impact of environment and culture on others’ lives
    - Improve resident’s knowledge of the community services
  + Rationale: residents will gain exposure through volunteer experiences, which can offer broader view on health care determinants in the community.
  + Process: each resident will have an opportunity to elect a service learning experience from any of the following:
    - St Mary’s
    - Migrant clinic
    - Youth Offender Program
    - Safe Zone Training
    - Other volunteer activity of one’s choosing
  + Learning points: residents will gain exposure to individuals outside of the traditional CFM or NHRMC setting, to provide a different lens for health.
  + Evaluation/methods: residents will write a brief reflective statement on an encounter during the activity which challenged a previous belief/understanding, and demonstrates an understanding of implicit bias.
* **Special populations month**: [**HSM, SPOP]**
  + Goals: allow residents to gain experience in thinking of a patient population from a systems and health equity/inequity perspective.
  + Rationale: residents need to gain the skills to evaluate health care delivery, and explore potential ideas for improvement in outcomes.
  + Process: a resident on this rotation (or during experiences with CFMC month, HIV clinic, hepatitis C treatment, etc) will choose a specific clinical population, and develop a question to test that is related to differences in outcomes. For example: is there a difference in rates of DM control between male and female patients at CFM? O,r is there a difference in completion of postpartum visits between races at CFM?
  + Learning points: residents will learn to look at population health and evaluate factors that may lead to various outcomes.
  + Evaluation/methods: residents will complete a brief QI project, and then write a reflective paragraph about their findings, which will be reviewed with Dr Isaacs.

**Definitions for Health Equity Curriculum**

Culture: Numerous definitions of culture exist from anthropology, psychology, and other disciplines. A frequently cited article by Kroeber and Kluckhohn in 1952 found 164 definitions of culture. Although there is not an agreed-on definition, a useful definition for purposes of examining culture and health is“a set of learned and shared beliefs and values that are applied to social interactions and to the interpretation of experiences. Individuals will often embrace more than one culture at the same time” (Mutha, Allen, & Welch, University of California, San Francisco (UCSF), 2002).

Culture: “Culture consists of patterns, explicit and implicit, of and for, behavior acquired and transmitted by symbols, constituting the distinctive achievement of human groups, including their embodiments in artifacts; the essential core of culture consists of traditional (i.e., historically derived and selected) ideas and especially their attached values; culture systems may, on the other hand, be considered as products of action, on the other as conditioning elements of further action.” (p. 181) of Kroeber, A. L., & Kluckhohn, C. (1952). Culture: A critical review of concepts and definitions. New York: Random House.

Concept of Culture: The understanding that culture plays a controlling role in shaping how people perceive reality, acquire a sense of self, think, feel, behave, and understand the behaviors of others. It includes an understanding that there is variation in the degree and extent of a shared culture among individuals in a cultural group.

Ethnocentrism: The assumption that the beliefs, values, norms, and behaviors of one’s own culture are the correct ones and that those of other cultures are inferior or misguided.

Cross-cultural: Action or understanding that involves a comparison of or action across more than one culture.

Acculturation: “Those phenomenon which result when groups of people having different cultures come into continuous first hand contact, with subsequent changes in the original pattern of either or both groups” (Redfield, Linton, & Herskovits, 1936). Given the significant historical and projected influx and growth of immigrant populations, acculturation is an important factor to consider in delivering services to multicultural populations and in leading a diverse workforce. Birman developed a two- factor model that described four types of acculturation to the culture of origin and new host culture (Birman, 1994). These included biculturalism, assimilation, marginalization, and separation/traditionalism. Health behavior, beliefs, and mediating factors such as social capital may be influenced by these factors. Therefore, they should be studied and considered for intervention. Acculturation changes over time and varies by the age of the individual or group. Health status may also change over time.

Culture and Health: Culture plays a critical role in an individual’s approach to health and healthy living. Cultures vary in perceptions of illness and their causes; beliefs with respect to health, healing, and wellness; adoption of health behaviors; and attitudes toward providers and the health care system (Goode & Dunne, 2003).  
  
Medical Pluralism: The use of treatments or healing from more than one medical system simultaneously or consecutively.

Multicultural: Characterized by two or more cultures.

Multicultural Health: Organizations and individuals interacting, communicating with, and/or delivering health services to individuals and populations representing multiple cultures. The focus in multicultural health care is on providing public health functions and/or health care services to individuals, groups, and communities representing multiple cultures and those representing specific individual cultures.

Cultural Competency and Proficiency: There are many definitions. Please refer to the extensive definitions in Section B, Cultural & Linguistic Competence: Rationale, Conceptual Frameworks, and Values.

Cultural Humility: A process of lifelong commitment to self-evaluation and self-critique, to readdressing the power imbalances in patient-physician and/or organization dynamics and to developing mutually beneficial and non-paternalistic clinical and advocacy partnerships with communities. The process involves active engagement in a lifelong process that individuals enter into with patients, communities, colleagues, and themselves. The process requires humility to develop and maintain mutually respectful and dynamic partnerships (Tervalon & Murray-Garcia, 1998).

Organizations and Individuals Responsible for Public Health: Because of the multitude of social, environmental, and behavioral factors that influence the health of multicultural populations, responsibility for public health includes but extends beyond health care and public health organizations and providers. This responsibility includes all individuals, systems, and institutions in a community or region.

Health Disparities: Differences in the incidence, prevalence, and burden of disease and other adverse conditions that exist among specific population groups. Many organizations are now using the term health inequities instead of disparities because it more accurately reflects that the root causes are related to societal, economic, and health care inequities.

Social Determinants: The social conditions in which people live daily including interactions with family, friends, community members, and institutions that have an influence on their health risks and behavior, lifestyle, and access to care and treatment.

Risk and Protective Factors: Factors that exist among communities and/or cultures that either increase or protect against health risk. Risk factors include racial and economic segregation, concentrated poverty, lack of social support, cultural practices, and lack of organizational and political power, etc. Protective factors include cohesion and sense of community, social support from friends and families, cultural practices, access to affordable high-quality housing, and civic engagement. Different cultural groups within the same physical community may have different risk and protective factors. Different cultural groups also have culturally driven behaviors that protect or cause risk for individuals within those groups.

Social Capital: Social capital can be a key protective factor: “Those features of social organization, such as the extent of interpersonal trust among citizens, norms of reciprocity, and destiny of civic associations that facilitate cooperation for mutual benefit” (Kawachi, Kennedy, Gupta, & Prothrow-Smith, 1997). An individual, group, or community’s level and nature of social capital are mediating factors , along with other risk and protective health factors.

Primary Prevention: Addressing the underlying causes of disease before poor health occurs. Taking action before a condition arises rather than when problems already exist. It focuses on changing conditions at the community level rather than at the individual or group level. It also focuses on system-level change (Eliminating Health Disparities: The Role of Primary Prevention, Prevention Institute, 2002). Upstream interventions are viewed as primary prevention.

Syndemics: Two or more afflictions interacting with each other (CDC, retrieved from Internet August 19, 2004). A syndemic orientation is primarily distinguished from other perspectives by its explicit emphasis on examining connections between health-related problems. With this concern, it offers a broader framework for understanding how multiple health problems interact in particular communities. A syndemic orientation elevates public health inquiry beyond its many individual categories to examine directly the conditions that create and sustain overall community health.

“The syndemic model provides an important intermediate model that frames the investigation of community level outcomes in terms of individual behavior, local processes, and higher level processes. The syndemic model raises difficult questions and challenges public health to address the root causes of health disparities. By introducing a multi-level, dynamic epidemiological perspective, it points toward the need to develop and evaluate systems- and community-level interventions that target linked processes” (MacQueen, in Breslow et al., 2002).

Whereas the usual public health approach begins by defining the disease in question, a syndemic orientation first defines the community in question. With this frame of reference, it goes on to identify links among the entire set of issues that create excess burden of disease among the community's members. In practice, a syndemic orientation follows a specific line of questioning: Who is sick, and with which diseases? Why those people? Why those diseases? What can be done to create (or restore) the conditions for optimal health? Under what circumstances do interventions contribute to improvements in health status and health equity? (CDC, 2004 see <http://www.cdc.gov/syndemics/>).

Built Environment: The man-made infrastructure of a community such as street design, public transportation, and permitted uses of buildings. Design and use influence behavior, including physical activity/nutrition, and tobacco and alcohol use. Design and use also affect such priority issues as mental health and trauma. This concept of built environment also includes the health care setting itself. Innovation in built environments is exemplified in the work of (1) Ulricht and Zimring of Georgia Tech University and the Center for Health Design (<http://www.healthdesign.org/>), bringing evidence-based design for hospitals, to decrease staff error; to decrease patient, family, and staff stress; and to enhance comfort; and (2) The Initiative on Active Living includes programs to stimulate and support research that will identify environmental factors and policies that influence physical activity ([http://www.rwjf.org](http://www.rwjf.org/)). These are funded and highlighted by the Robert Wood Johnson Foundation.

Social Structure: The overall arrangements and relationships, including power and resource differentials, among a society’s individuals, groups, and institutions. The ability of public health professionals to enact their roles in providing care to the population is heavily impacted by social structural variables. The health status of individuals or groups within a society is likewise dependent on social structural factors. When there are clear disparities in the health status of groups within a society, aspects of the social structure must be examined and, if necessary, changed through advocacy and action to achieve social justice in the health of the public.