

TRAINING FOR BETTER CARE

A CULTURAL COMPETENCY CURRICULUM FOR THE HEALTH PROFESSIONS

Based on the successful cultural competency curriculum designed by the
Community Pediatrics program at Columbia University Medical Center



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and

The Columbia Center for the Health of Urban Minorities



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Introduction

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 importance of training health professions students in cultural competency is well-established.¹

This manual provides a train-the-trainer guide for integrating a cultural competency curriculum into the education of health professionals. It is based on the model developed at the Columbia University Medical Center’s (CUMC) Community Pediatrics program.

This curriculum presents a variety of teaching methods that can be used across many different professions, specialties and settings. It provides a complete and complementary set of educational methodologies that are straightforward, easy to implement, simple to adapt, and can be scaled up or down to meet the needs of a particular training program. These educational methodologies go beyond the traditional lecture or small-group methods used in many cultural competency curricula, thereby engaging students in more innovative experiential learning.

All the educational methodologies included fulfill multiple ACGME competencies, as well as standard cultural competencies. We don’t claim authorship of all the included ideas – many are adapted from similar programs. All educational methodologies have been evaluated and found to be successful in promoting cultural competency among participants and strengthening community-academic partnerships.

It is important to note that this is a work in progress; we are still developing further educational methodologies, especially those regarding health literacy and race and medicine.

We hope this guide will help health professionals to institute cultural competency curricula in their own training programs.

1 “Teaching Cultural Competence in Health Care,” Office of Minority Health, Department of Health and Human Services. March 2002. www.omhrc.gov/assets/pdf/checked/em01garcia1.pdf

**CORE COMPETENCIES FOR
CULTURALLY AND LINGUISTICALLY RESPONSIVE CARE**
*Developed by the Columbia University Medical Center
Curriculum Committee on Cultural Competency*

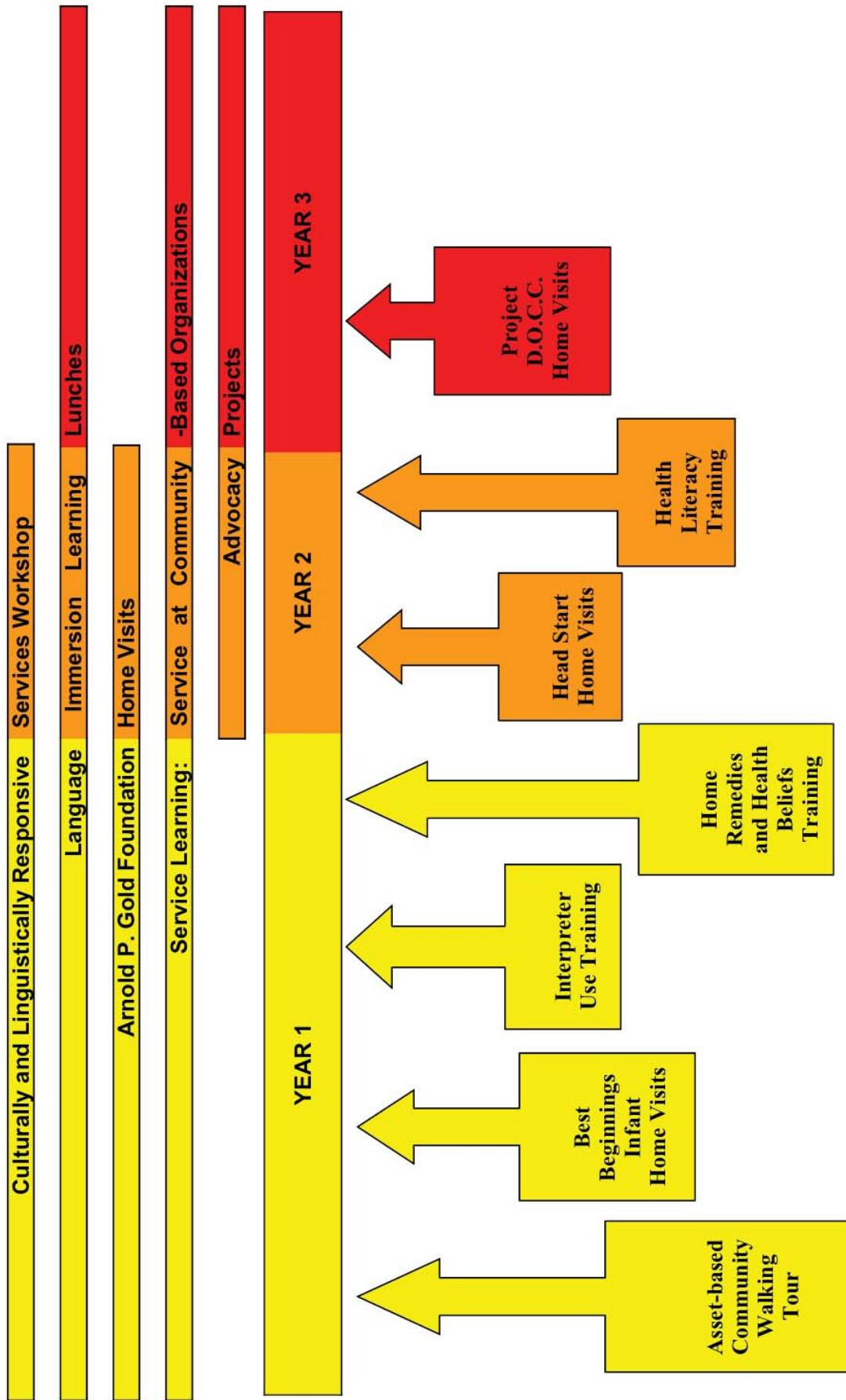
SELF-AWARENESS	Develop an understanding of one's own personal cultural values and beliefs and its impact on health and health care delivery.
CROSS-CULTURAL KNOWLEDGE	Develop an understanding of how beliefs, cultures and ethnic practices can influence health behavior and health status.
LANGUAGE DIVERSITY	Provide or advocate for the provision of information, referrals and services in the language appropriate to the client as well as the provision of interpreters when needed.
DELIVERY OF CARE	Provide culturally and linguistically appropriate and competent services, programs and interventions that meet the needs of the community of interest.
ADVOCACY	Advocate for public policies and programs that promote and support culturally and linguistically responsive services and the inclusion, representation and participation of individuals who reflect the diversity of our communities.

ACGME GENERAL COMPETENCIES

<p>1. PATIENT CARE Residents must be able to provide patient care that is compassionate, appropriate, and effective for the treatment of health problems and the promotion of health. Residents are expected to:</p>	<p>1a. communicate effectively and demonstrate caring and respectful behaviors when interacting with patients and their families 1b. gather essential and accurate information about their patients 1c. make informed decisions about diagnostic and therapeutic interventions based on patient information and preferences, up-to-date scientific evidence, and clinical judgment 1d. develop and carry out patient management plans 1e. counsel and educate patients and their families 1f. use information technology to support patient care decisions and patient education 1g. perform competently all medical and invasive procedures considered essential for the area of practice 1h. provide health care services aimed at preventing health problems or maintaining health 1i. work with health care professionals, including those from other disciplines, to provide patient-focused care</p>
<p>2. MEDICAL KNOWLEDGE Residents must demonstrate knowledge about established and evolving biomedical, clinical, and cognate (e.g. epidemiological and social-behavioral) sciences and the application of this knowledge to patient care. Residents are expected to:</p>	<p>2a. demonstrate an investigatory and analytic thinking approach to clinical situations 2b. know and apply the basic and clinically supportive sciences which are appropriate to their discipline</p>
<p>3. PRACTICE-BASED LEARNING AND IMPROVEMENT Residents must be able to investigate and evaluate their patient care practices, appraise and assimilate scientific evidence, and improve their patient care practices. Residents are expected to:</p>	<p>3a. analyze practice experience and perform practice-based improvement activities using a systematic methodology 3b. locate, appraise, and assimilate evidence from scientific studies related to their patients' health problems 3c. obtain and use information about their own population of patients and the larger population from which their patients are drawn 3d. apply knowledge of study designs and statistical methods to the appraisal of clinical studies and other information on diagnostic and therapeutic effectiveness 3e. use information technology to manage information, access on-line medical information; and support their own education 3f. facilitate the learning of students and other health care professionals</p>
<p>4. INTERPERSONAL AND COMMUNICATION SKILLS Residents must be able to demonstrate interpersonal and communication skills that result in effective information exchange and teaming with patients, their patients families, and professional associates. Residents are expected to:</p>	<p>4a. create and sustain a therapeutic and ethically sound relationship with patients 4b. use effective listening skills and elicit and provide information using effective nonverbal, explanatory, questioning, and writing skills 4c. work effectively with others as a member or leader of a health care team or other professional group</p>
<p>5. PROFESSIONALISM Residents must demonstrate a commitment to carrying out professional responsibilities, adherence to ethical principles, and sensitivity to a diverse patient population. Residents are expected to:</p>	<p>5a. demonstrate respect, compassion, and integrity; a responsiveness to the needs of patients and society that supercedes self-interest; accountability to patients, society, and the profession; and a commitment to excellence and on-going professional development 5b. demonstrate a commitment to ethical principles pertaining to provision or withholding of clinical care, confidentiality of patient information, informed consent, and business practices 5c. demonstrate sensitivity and responsiveness to patients' culture, age, gender, and disabilities</p>
<p>6. SYSTEMS-BASED PRACTICE Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care and the ability to effectively call on system resources to provide care that is of optimal value. Residents are expected to:</p>	<p>6a. understand how their patient care and other professional practices affect other health care professionals, the health care organization, and the larger society and how these elements of the system affect their own practice 6b. know how types of medical practice and delivery systems differ from one another, including methods of controlling health care costs and allocating resources 6c. practice cost-effective health care and resource allocation that does not compromise quality of care 6d. advocate for quality patient care and assist patients in dealing with system complexities 6e. know how to partner with health care managers and health care providers to assess, coordinate, and improve health care and know how these activities can affect system performance</p>

Cultural Competency Curricular Timeline

Residents



CROSS-CULTURAL KNOWLEDGE

Trainees will develop an understanding of how beliefs, cultures and ethnic practices can influence health behavior and health status.

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HOME VISITS	15
HOME REMEDIES AND HEALTH BELIEFS TRAINING	20
CULTURALLY AND LINGUISTICALLY RESPONSIVE CARE WORKSHOP	26

ASSET-BASED COMMUNITY WALKING TOUR

GOALS

- To provide trainees with a cultural immersion experience that highlights community assets and introduces the concept of community asset mapping
- To help trainees understand how physical and cultural environment is relevant to their patients' health
- To address trainees' perceptions and stereotypes of the communities they serve

RATIONALE

In order to properly address a community's needs and establish successful community-academic partnerships, trainees must view the communities in which they train and practice with an asset-based perspective. Cultural immersion 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, cultural immersion and asset mapping activities allow providers to design programs in partnership with the community, allowing for sustainable change. The asset-based community walking tour is based on the principles of Kretzmann and McKnight's Asset-Based Community Development (ABCD) model.¹

DESCRIPTION

The purpose of the asset-based community walking tour is to introduce trainees to the local community's resources, strengths and support systems, thereby informing any perceptions and stereotypes they may hold.

<u>CULTURAL COMPETENCIES</u>		<u>ACGME COMPETENCIES</u>	
<ul style="list-style-type: none"> • SELF-AWARENESS • CROSS-CULTURAL KNOWLEDGE • DELIVERY OF CARE 		PATIENT CARE: 1b PRACTICE-BASED LEARNING AND IMPROVEMENT: 3c PROFESSIONALISM: 5c SYSTEMS-BASED PRACTICE: 6a	
MATERIALS	<ul style="list-style-type: none"> • Tour folders (see below) • Lunch • Method of transportation (if a walking tour is not feasible) 	COST	<ul style="list-style-type: none"> • The approximate combined cost for the tour leader lunch, training materials, tour lunch and community resource folders is generally \$1,000. • Costs of tour leader faculty time will vary, but may be in-kind covered by grant funding. • Transportation costs may be a factor.
TIME FRAME	<ul style="list-style-type: none"> • Preparatory tour leader lunch and training: 60-100 minutes • Tour: 60-120 minutes • Post-tour lunch: 60 minutes <p><i>The activity takes half a day.</i></p>	STAFF	<ul style="list-style-type: none"> • Faculty and community leaders to serve as tour leaders. • Staff to copy and compile the community resource folders.

1 Kretzmann, John P. and McKnight, John L. *Building Communities from the Inside Out: A Path Toward Finding and Mobilizing a Community's Assets*, Evanston, IL: Institute for Policy Research, 1993.

PREPARATION AND PLANNING

BEFORE THE TOUR DAY:

1. Faculty and community leaders jointly determine which community sites will be visited and secure the consent and cooperation of staff at each site. Appropriate sites include any that are important contributors to the community's culture, such as community-based organizations (CBOs), cultural centers, senior centers, schools, child care centers, social service agencies, parks, houses of worship, stores, restaurants, arts organizations. For example, the tour at CUMC included visits to a public school, a home remedy shop ("botanica"), a community-based organization and a child care center. Once sites are determined, it is important to find a staff person at each site who will be able to meet each group of trainees as they visit.
2. Determine an appropriate route for the tour and create a clear map. Establish whether tour participants will be able to walk between the sites or will need other forms of transportation and make proper transportation arrangements.
3. Draft a logical tour schedule (see the sample provided in this section). The groups should be staggered, with different groups visiting different sites at different times so as to minimize congestion (a sample of this is provided in this section).
4. Compile the tour folders. Folders should include:
 - Tour map
 - A guide to each site visited (with location, contact person, history, description of services, pictures)
 - Demographic and standard health data for the community
 - Relevant literature on ABCD and community asset mapping¹
 - Guiding questions for the tour
 - An accurate up-to-date community resources brochure or manual
 - Any other material that would help trainees gain further understanding of the community
5. Recruit tour leaders; each group of students should be led by a faculty member and a community member. Community members may be recruited from tour sites or through other community channels such as neighborhood associations.
6. Organize a tour leader lunch. This is an opportunity for faculty and community site representatives to both learn how the tour will be organized and to strengthen community-academic partnerships. Establish an appropriate time, secure a location, and order catering services for the lunch; it is suggested that the lunch be held at the medical center. At the lunch, goals and objectives of each site visit need to be communicated to leaders. Community members also should partner with faculty in determining talking points for the walking tour (see the sample provided in this section). The importance of having community members serve as a part of physician training should be highlighted.

1 McKnight, John L. and Kretzmann, John P. "Mapping Community Capacity" pp. 157-172 of *Community Organizing and Community Building for Health*. New Brunswick, NJ: Rutgers University Press, 1997.

ON THE TOUR DAY:

1. Divide students into groups of 10-15 (the groups could be smaller, based on total group number) and assign each group two tour leaders: one community member and one faculty.
2. Before the groups leave, trainees are given an introductory lecture on some these topics: community asset mapping, health disparities, cultural competency and the importance of community-academic partnerships in addressing community needs. Sample slides are provided in this section
3. Visit all sites. It is recommended that groups stay at each site for about 20 minutes each. Encourage discussion at each site using guiding questions in the tour folders (see the sample guiding questions provided in this section).
4. Conclude the tour experience with a lunch with community members. This lunch can be held at a local restaurant or another community space. At CUMC, the residents' tour lunch was held at a CBO, however the medical students' tour lunch was held at the medical school due to space constraints. The lunch is an opportunity for debriefing and discussion among trainees and community members. Ideas for discussion include the roles of stereotyping in communities, particularly those that are underserved, and in patient encounters. Community members may share their experiences informally among small groups of trainees, or certain community members may make more formal presentations. For example, at CUMC's pediatric residents' tour lunch a few community members shared their stories of immigration.

EVALUATION METHODS

*A qualitative evaluation of the tour was done at CUMC. Before the tour, trainees wrote down a list of adjectives that they felt describe the community. After the tour, the trainees complete the adjective list exercise again. The pre- and post-tour adjectives were then coded either as "asset," "need" or "neutral" according to the needs and assets descriptions of Kretzmann and McKnight. These data were then analyzed, noting any changes.

SAMPLE TOUR TALKING POINTS FOR FACULTY

NOTE: *Talking points need to be geared to the particular demographics and characteristics of your community; this sample from CUMC is of the Washington Heights community in New York City.*

- Overview of demographics regarding ethnicity, immigration, age.
- *Economics:* one-third of GNP to the Dominican Republic comes from Washington Heights. Point to all the check-cashing and stores where one can wire money.
- *Pressing Health Issues:* Use examples from your own practice
- *Obesity:* address lack of parks, safe play areas for children, overcrowding, poor availability of low fat healthy food
- *Unintentional injuries:* point out fire hydrants and discuss how children use them as sprinklers in summer. (this then contributes to serious ICU injuries because of this, and deaths due to fire)
- *Day Care and Schools:* poor education system, overcrowding, long waiting lists
- *Beauty Shops:* center of social activities for women. Discuss high incidence of domestic violence in our community
- *Environment:* Bus terminals, old housing projects, high level of pollution, asthma, lead poisoning
- *Travel Agencies:* circular migration pattern, grandparents taking care of children, strength of families.
- Point out ambulatory care network sites

SAMPLE TOUR GUIDING QUESTIONS

The following is a list of questions to be answered at each stop in order to maximize your learning.

Community Based Organization

Who do they serve?

What services do they offer?

What is their source of funding?

Does the organization have any relationship with the university and/or hospital?

School

How many students do they have?

What are their biggest challenges?

What is the main reason for absenteeism?

What is the degree of parental involvement?

What is the food environment (cafeteria, vending machines)?

Senior Center

How many people do they serve?

What type of activities do they offer?

Who funds them?

Do they serve a recent immigrant population?

Home Remedy Shops (“Botanicas”)

Who do they serve?

What types of ailments do patients seek help for?

Do clients go there before or after seeing a doctor?

Do they share this info with their doctors?

Streets

What type of commerce do you see?

What types of transportation do you see?

What languages are being spoken?

What kind of conversations do you overhear?

Are there playgrounds? If so, what is their condition and use?

What are the foods sold on the streets (if any)?

Is there healthy and low fat food sold at the local corner stores/bodegas?

Do you feel safe or unsafe?

How does this environment compare to the one in which you grew up?

**PHOTOS OF THE COLUMBIA UNIVERSITY
PEDIATRICS RESIDENCY PROGRAM TOUR**



SAMPLE WALKING TOUR SCHEDULE

Group Number	Faculty Leader	Community Leader	Sites	Time
1			Site 1 Site 2 Site 3	10-10:20 AM 10:30-10:50AM 11-11:20 AM
2			Site 2 Site 3 Site 1	10-10:20 AM 10:30-10:50AM 11:30-11:50 AM
3			Site 3 Site 2 Site 1	10-10:20 AM 11-11:20 AM 11:30-11:50 AM
4			Site 2 Site 1 Site 3	10-10:20 AM 10:30-10:50AM 11-11:20 AM
5			Site 1 Site 2 Site 3	10:30-10:50AM 11-11:20 AM 11:30-11:50 AM
6			Site 3 Site 1 Site 2	10:30-10:50AM 11-11:20 AM 11:30-11:50 AM
7			Site 1 Site 2 Site 3	10-10:20 AM 10:30-10:50AM 11:30-11:50 AM

SAMPLE TOUR COMMUNITY PARTNERS THANK-YOU LETTER

[Date]

Dear [Community Partner]:

Thank you so much for helping to leading the walking tour for [trainees] on [date]. Your presence, insights and knowledge of the community helped make this a better educational activity for all.

If we are to improve the care that we give to our patients in [our community], we need to incorporate your knowledge into the training of future doctors. It is through community-academic partnerships that we can institute sustainable change, help reduce health disparities and train a better health work force.

Please feel free to give us your feedback of the tour and suggestions for future curricular activities. We look forward to continuing our work together,

With gratitude,

[Name]
Director, [Department]

[Name]
Community Liasion, [Department]

HOME VISITS

GOALS

- To help trainees gain a deeper understanding of the impact of environment and culture on patients' lives
- To strengthen the trainee-patient relationship and faculty-trainee relationships
- To improve trainees' knowledge of the community

RATIONALE

Home visits are a way to foster culturally-effective humanistic patient care. Seeing a patient solely in the hospital or clinic limits a provider's understanding of the patient's reality. Through home visits, trainees can increase their awareness of the needs and assets of their patients' environments. Home visits enable trainees to witness many of the non-medical issues their patients face. This in turn improves quality of care and strengthens provider-patient relationships. Incorporation of home visits in the training phase of providers' careers can help increase the likelihood of use of home visits in their future practice. Home visits also deepen community-academic partnerships.

<p><u>CULTURAL COMPETENCIES</u></p> <ul style="list-style-type: none"> • CROSS-CULTURAL KNOWLEDGE • DELIVERY OF CARE • ADVOCACY 		<p><u>ACGME COMPETENCIES</u></p> <p>PATIENT CARE: 1a , 1b, 1e, 1h PRACTICE-BASED LEARNING AND IMPROVEMENT: 3c INTERPERSONAL AND COMMUNICATION SKILLS: 4a 4b. PROFESSIONALISM: 5c SYSTEMS-BASED PRACTICE: 6d</p>	
<p>MATERIALS</p>	<ul style="list-style-type: none"> • Trainees bring the patient's chart, stethoscope, otoscope, ophthalmoscope, and any other tools need to perform a physical exam such as a scale for weight checks in infants 	<p>COSTS</p>	<ul style="list-style-type: none"> • Reimbursements for trainees' travel costs (i.e. subway card, cab fare) • Costs of meals during debriefing • Small stipend (\$50) for each parent participating in the Project DOCC home visits.
<p>TIME FRAME</p>	<ul style="list-style-type: none"> • Each visit lasts between 45 and 60 minutes. 	<p>STAFF</p>	<ul style="list-style-type: none"> • Faculty and community liaisons to supervise home visits • Parents to participate in the DOCC visit • Family support worker to participate in the infant visits

DESCRIPTION

Trainees may participate in four types of home visits throughout their training. Though the four types have many similarities, differences exist in each type's target populations and purposes.

Type 1: Home Visits sponsored by the Arnold P. Gold Foundation

For this type of visits, trainees select one of the patients from their practice to visit. Trainees go on the visits in pairs, conducting 2 different patient visits in one afternoon. Going in pairs allows trainees to observe

each other's visit, thereby introducing peer-learning and team-building aspects to the experience. Generally one faculty member and one community liaison accompany trainees on the home visits. The trainees take a history and do a physical exam, engage the patient and his or her family member(s) in a Reach Out and Read activity, and provide the family with a home safety box while reviewing the ways to child-proof the home. After the afternoon of visits, trainees, the faculty member and the community liaison should debrief and reflect upon the experience over a shared meal. Debriefing also occurs when trainees meet with a faculty member at the end of the month. Through a written reflection card, the faculty member prompts the resident to discuss challenges faced by the visit, lessons learned, and ways to apply those lessons to patient care. At CUMC, this type of visits occurs twice during the residents' training.

For more information, visit the Arnold P. Gold Foundation web site:
<http://humanism-in-medicine.org/>

Type 2: Project DOCC (Delivery of Chronic Care) Visits

Founded by parents of children with special health care needs, Project DOCC aims to improve "the quality of care for severely chronically ill children by educating pediatricians-in-training about their special needs from a parent's perspective." The project's integral method is a home visit with a chronically ill child and his or her family. The patient selected for this can be any child - not necessarily one of the trainee's patients. Trainees go on the home visit with a DOCC "parent teacher"; after the visit trainees complete a parent interview using the Chronic Illness History. The parent teacher and parent of the child being visited are each paid a small stipend for their participation. Faculty are not involved in these visits, however they do meet with the trainee before and after the visit occurs to introduce the program and then to debrief. This type of visit should occur at least once during training.

For more information, visit:
http://www.uhfnyc.org/pubs-stories3220/pubs-stories_list.htm?attrib_id=7687

Type 3: "Best Beginnings" Infant Visits

"Best Beginnings" is a home-visit based program designed to prevent child abuse and neglect, support young families and prepare children for school. For this type of visit, trainees select an infant that was born during their first year of training and follow the child throughout training. This involves going at least once a year to the child's home. These visits are accompanied by a family support worker from a community-based organization; at CUMC the family support workers come from a home-based prevention program called The goal of these visits is to strengthen the medical home and to understand how a family support worker helps a family. Faculty are not involved in these visits, however they do meet with the trainee before and after the visit occurs to introduce the program and then to debrief.

Type 4: Head Start Visits

This type of visit requires a partnership with a local Head Start center. The Head Start health coordinator identifies children with significant health needs who would benefit from a home visit. Trainees then accompany Head Start staff on a home visit, providing the child and his or her family with health education and/or clinical care. Again, faculty are not directly involved with these visits; they simply meet with trainees after the experience to debrief.

EVALUATION METHODS

- Trainees complete reflection cards (written or online – see examples in this manual)
- Community members and faculty evaluate trainee’s performance on the visits
- On the Gold Foundation visits, trainees observe each other and provide and feedback.

TIPS

- Trainees should be prepared to refer parents in need of services for any problems in the home, such as needed repairs, mold, lead, etc. Trainees should be taught to recognize such problems and provided with contact information of agencies to which parents can be referred.



*A Morgan Stanley Children’s Hospital of New York
pediatrics resident on a home visit*

SAMPLE TRAINEE REFLECTION CARD

Name:	
Site:	
PGY:	

Did you attend as scheduled?	Yes	No	
Did someone from the site expect you and orient you to the session's activities?	Yes	No	
Were activities done as scheduled (talks, classes)?	Yes	No	NA
If no, explain why:			
Describe one thing that you learned at the site:			
Describe one way you can apply the knowledge/skills learned into patient care:			

TRAINEE'S DESCRIPTION OF THE IMPACT OF A HOME VISIT

At their periodic debriefings with faculty members, Columbia University pediatrics residents are asked to present a narrative that is written in reaction to one of the experiences in their training. This narrative was written by a trainee in response to a home visit.

R.D. is similar to many of the toddlers I see in continuity clinic: he lives in the part of Manhattan known as Washington Heights, his parents are recent immigrants from the Dominican Republic, and his mother worries that he does not eat enough. When he was diagnosed with iron-deficiency anemia, I gave his mother, Lydia, a list of iron-rich foods, asked her to reduce the amount of milk she fed him, and recommended that she make an effort to gather the whole family at the table for meals. I thought that perhaps this would make mealtime more enjoyable and R.D. would eat more.

Lydia repeated my instructions back to me at each visit, but R.D.'s anemia persisted. Uncertain how to proceed, I prescribed him iron. Then, early in the summer, I had the opportunity to visit his home.

Walking out of the hospital and through the Heights is like walking through a street festival at any time of year, but in the summer the neighborhood is especially rich with activity. Vendors sell papayas, sorbet, and dulce de leche from their carts, and discount items sprawl across the sidewalk; kitchenware, children's toys, and lingerie are all piled high. Men on ladders shout into megaphones: "Se vende ropa! A mejor precio!" The neighborhood is its own world, a tropical island in the middle of New York City.

I have often wondered what life is like in this neighborhood of bodegas, cantinas, and envio businesses devoted solely to sending money home. I wondered what it would be like to live in a building like R.D.'s with a botanica next door and the apartment numbers handwritten onto the doors.

An elderly woman opened the door before I could knock. "Doctora?"

"Yes," I said.

She shooed me inside. "Can you imagine?" she said, over her shoulder. "This young girl is a doctor." She threw up her arms, as if to say, "what will they think of next?"

I had typed up a plan for Lydia, including my oft-repeated instructions ("sit at the table with the whole family at least once a day"), but when I entered the apartment, I shoved those instructions deep into my pocket. The apartment, roughly the size of my living room, had no table. There was a small, plastic table in the corner where 1 child sat eating cereal, but no place where a family of 5 might sit together and eat. The rest of the furniture was composed of a bunk bed, a bed for the parents, and a few chairs that the children rushed to set in place for us. R.D. sat in his mother's lap, a bottle of milk firmly applied to his lips. "His babysitter says he needs a lot," she explained with embarrassment. She gestured to the elderly woman, who had moved into the kitchen to prepare dinner.

Seated in a lawn chair in R.D.'s tiny apartment, leaning my notepad against the windowsill, I thought about my earlier conversations with Lydia. Of course, my advice to her was based on my own suburban preconceptions; a table was a large structure, big enough to seat a family. For that matter, a babysitter was a teenager who never gave parenting advice. Our ideas about very basic concepts were so different that it was as if, although I speak Spanish, we were not speaking the same language. It was as if I needed a translator to understand the inner workings of her life.

The truth is, every doctor must act as his or her own translator, and we do this every day. When we try to ascertain how well a child is truly feeding, or how often, we take emotional cues from parents and try to shape them into absolute facts. Similarly, to capture the sociocultural context of our encounters with patients can be an enormous challenge.

Walking into R.D.'s home, I saw him through a lens that I might never have accessed in the office. I understood Lydia's polite repetition of my instructions, and the impossibility of carrying them out. To understand was an enormous relief.

My frame of reference is worlds away from the bustle of Washington Heights, but it does not mean that I can't learn to speak to my patients on every level they will share with me. And now that R.D.'s family has let me into their home, I will listen more carefully for the things in which each family believes, the people in their lives, and the places they live, down to the very kitchen table that no good doctor can take for granted.

Sidelinger DE, Meyer D, Blaschke GS, Hametz P, Batista M, Salguero R, Reznik V. "Communities as teachers: learning to deliver culturally effective care in pediatrics." Pediatrics. 2005 Apr;115(4 Suppl):1160-4.

HOME REMEDIES AND HEALTH BELIEFS TRAINING

GOALS

- To educate trainees about the use of the most common home remedies and rituals used in their patient populations.
- To make trainees aware of health beliefs that may be held by patients of certain cultures and how those health beliefs impact delivery of care, patient-provider communication and treatment adherence.

RATIONALE

An increasing proportion of patients use home remedies and rituals to treat their symptoms, diseases and conditions.¹ These popular practices may have an impact on certain medical treatments. Patients from certain cultures may also have differing health belief systems that influence care-seeking behavior, communication and treatment adherence. Knowledge of both popular practices and health belief systems prevalent in the patient populations will help trainees take more complete histories, include local practices into treatment (when possible), and anticipate possible challenges to treatment. This will create an environment where patients are more comfortable disclosing their use of home remedies and rituals. Therefore, trainees will be able to provide patient care that is more culturally-sensitive, thorough and effective.

DESCRIPTION

The purpose of this training is to give trainees knowledge of both popular practices and health belief systems prevalent in the patient populations, so they may incorporate such knowledge into their own practice.

<u>CULTURAL COMPETENCIES</u>		<u>ACGME COMPETENCIES</u>	
<ul style="list-style-type: none"> • CROSS-CULTURAL KNOWLEDGE • DELIVERY OF CARE 		PATIENT CARE: 1b, 1i MEDICAL KNOWLEDGE: 2a PRACTICE-BASED LEARNING AND IMPROVEMENT: 3c PROFESSIONALISM: 5c SYSTEMS-BASED PRACTICE: 6a	
MATERIALS	<ul style="list-style-type: none"> • Equipment for a PowerPoint presentation (projector, etc.) • Samples of home remedies popular locally. • Copies of relevant literature • Copies of a guide to common home remedies and rituals (<i>optional</i>) 	COSTS	<ul style="list-style-type: none"> • Payment for community guest lecturer with expertise on commonly used home remedies • Samples of home remedies (the guest lecturer may provide samples to demonstrate) • Photocopying costs • Copies of guide to alternative medicines and traditional remedies (<i>optional</i>)
TIME FRAME	<ul style="list-style-type: none"> • One hour for the lecture 	STAFF	<ul style="list-style-type: none"> • Community guest lecturer • Staff to prepare a guide to common home remedies and rituals (this may be a resident project, or could be done in partnership with an outside organization)

1 Tindle HA, Davis RB, Phillips RS, Eisenberg DM. Trends in use of complementary and alternative medicine by US adults: 1997-2002. *Altern Ther Health Med*. 2005 Jan-Feb;11(1):42-9.

PREPARATION AND PLANNING

HOME REMEDIES AND HEALTH BELIEFS LECTURE

1. This portion of the training is a didactic session that provides an overview of health beliefs, home remedies and rituals commonly used in the different cultures represented in the patient population of the medical center. The training can focus on one particular culture or provide a survey of a few different cultures; at CUMC, this training has traditionally focused on the beliefs and practices from the Dominican Republic.
2. Invite a community member (or several) knowledgeable in the topic to give the lecture. The guest lecturer can be a staff member of a community-based organization and/or a member of the medical center staff; at CUMC the Community Pediatrics program's community liaison served in this role.
3. The guest lecturer should prepare a presentation; sample PowerPoint slides from the training at CUMC on Dominican beliefs and practices are included in this manual. Encourage the guest lecturer to bring samples of popular home remedies so trainees can see them.
4. Establish a schedule for the community guest lecturer to rotate through different clinical sites and departments in order to reach all trainees. This may require hiring multiple community guest lecturers.
5. Provide trainees with literature relevant to the cultures focused on in the training, as well as literature relevant to the uses of home remedies.

GUIDE TO HOME REMEDIES AND RITUALS

If possible, work with community members to create a guide to home remedies and rituals that can be a reference tool for trainees and other providers at the medical center. At CUMC, a brief guide was written as a resident project, with the help of local botanica owners, community members and pharmacists. This brief guide then inspired New York Botanical Garden staff members to create an extensive manual of medicinal plant profiles titled *Dominican Medicinal Plants: A Guide for Health Care Providers*. It contains the common names, scientific name, botanical description, medicinal uses, availability, safety and adverse reactions, contraindications, clinical and experimental data, and references for a variety of botanical home remedies. The manual also includes information about Dominican healing traditions and health beliefs drawn from ethnographic data. This manual has been distributed to all interested health care providers in the community

Developing such a manual can be an interesting project for trainees. They may begin by surveying the use of home remedies in the patient population, conducting surveys of patients (in waiting rooms or the emergency department, for example), and exploring what home remedies are popular in the community by visiting a home remedy shop. Once data on the common home remedies are gathered, trainees can work with staff at the medical center's Complementary Alternative Medicine department and/or staff at the local botanical garden to develop a local guide to home remedies.

HOME REMEDY SHOP VISITS

Another way to extend and deepen the home remedies training is to have trainees visit a home remedy shop (or "botanica"). This can be incorporated as part of the Walking Tour or done as a stand-alone visit. Some owners of home remedy shops may be reluctant to have medical professionals visit their shop; this can provide a teachable moment for the trainees, demonstrating how occasionally there is historical mistrust between local healers and western medicine. It is important that the community liaison provides entree for faculty and trainees to visit the home remedy shop.

EVALUATION METHODS

- The lecture may be evaluated using a brief satisfaction survey.
- Either focus groups or a more rigorous survey could be used to assess trainees' use of their knowledge of home remedies and health beliefs in their clinical practice.
- A survey and/or in-depth interviews with providers who received a home remedies manual could be used to determine the utility of such a tool.

Popular Cultural Practices and Beliefs: Home Remedies



- Presented by
Milagros Batista, MSW
Community Liaison
Dyson Initiative

1

Objective

- To increase the knowledge of
Dominican cultural practices and
beliefs as they relate to health

2

Why is it important for health
professionals to know about
the popular practices and
beliefs of their patient
population?

3

- Who are Dominicans?
- Where do they come from?
- Brief history of the Caribbean
- Ethnicity: Spanish/European,
African, indigenous influences

4

Popular Cultural Practices and Beliefs: Home Remedies



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Objective

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Why is it important for health professionals to know about the popular practices and beliefs of their patient population?

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- Where do they come from?
- Brief history of the Caribbean
- Ethnicity: Spanish/European, African, indigenous influences



Beliefs

- Health as an integrated vision
- The unity of physical, mental and spiritual health

Practices: Home Remedies

- Physical Health
 - Agua de Rosa
 - Aloe Vera
 - Anise
 - Bronquina
 - Chamomile (manzanilla)
 - Cordial de Monell
 - Higuerta (tree olive)
 - Honey
 - Lemon with salt

Practices: Home Remedies

- Physical Health (cont.)
 - Linden tree flowers (tilo)
 - Miel de Rosa (rose honey)
 - Rabano Yodado/Rabano con Berro (watercress)
 - Sancochito
 - Scott's Emulstion
 - Sebo de Flan (lambs' wool oil)
 - Siete Jarabes
 - Tussibron

Practices: Home Remedies

- Mental Health
 - Consultas
 - Fiestas
 - Reuniones Familiares
 - Relaciones Humanas

Practices: Home Remedies

- Spiritual
 - Altars
 - Hora Santa
 - Incense
 - Baths
 - Despojos (cleansing)
 - Clear Water
 - Reguardos (Mal de Ojo – Evil Eye)
 - Cintas en colores (Mujeres Embarazadas)

Cancion: El Yerbero Moderno

- Popular song by Celia Cruz and La Sonora Mantancera (1948)

CULTURALLY AND LINGUISTICALLY RESPONSIVE CARE WORKSHOP

GOALS

- To provide trainees with a basic understanding of definitions related to cultural competency, racial and ethnic health disparities, culturally and linguistically responsive services, and the Kleinman interviewing model.
- To give trainees an informational background in culturally and linguistically responsive services that they can use to improve the quality of their patient care.

RATIONALE

In order to provide optimal care to an increasingly diverse patient population, providers need to know how to deliver culturally and linguistically responsive services (CLRS). Though training in CLRS can occur through practical activities and experiences, it is important to convey the basic concepts of CLRS through some didactic training. Many trainees may not yet be aware of the facts, figures and theories surrounding CLRS. Therefore, conducting a general workshop that includes issues of CLRS, cultural competency, the Kleinman model and health disparities will provide trainees with a firm foundation for further training experiences.

DESCRIPTION

The purpose of this workshop is to present trainees with a basic overview of the terms, concepts, facts and theories surrounding cultural competency, racial and ethnic health disparities, Kleinman's model of clinical interviewing, intercultural communication and the health beliefs of some local cultures. Ideally, the workshop should be held early in training and repeated on a yearly basis.

<u>CULTURAL COMPETENCIES</u>		<u>ACGME COMPETENCIES</u>	
<ul style="list-style-type: none"> • SELF-AWARENESS • CROSS-CULTURAL KNOWLEDGE • DELIVERY OF CARE • ADVOCACY 		PATIENT CARE: 1a, 1b, 1e, MEDICAL KNOWLEDGE: 2a PRACTICE-BASED LEARNING AND IMPROVEMENT: 3c. INTERPERSONAL AND COMMUNICATION SKILLS: 4a, 4b PROFESSIONALISM: 5a, 5c	
MATERIALS	<ul style="list-style-type: none"> • PowerPoint presentation slides and supplies • Copies, of articles, newspaper clippings, etc. 	COSTS	<ul style="list-style-type: none"> • Faculty time in kind (1 hour for preparation, 4 hours for the workshop) • Food for lunch • Stipends for guest lecturers
TIME FRAME	<ul style="list-style-type: none"> • 4 hours annually per trainee 	STAFF	<ul style="list-style-type: none"> • Faculty to lead the workshop • Guest lecturers.

PREPARATION AND PLANNING

BEFORE THE WORKSHOP

- Find experienced interested faculty to teach the workshop. At CUMC, five teaching faculty were trained, since same workshop was held five different afternoons to accommodate trainees' schedules. At least one faculty member should serve as the leader of the faculty training and implementation of the workshop.
- Invite guest lecturers. It is important not to focus on learning about specific cultural norms of different populations, but rather to teach universal skills that can be applied to any given patient population and any given field of choice. To help achieve this, guest lecturers could include a patient (to describe experiences with physician culture) and a direct service provider (to address general issues of delivering culturally and linguistically responsive care). However, this being said, it is also important to spend some time providing knowledge about the norms and practices of specific cultural groups that are prevalent in the local patient population. Guest lecturers presenting such information could be, for example, a rabbi from a local Orthodox Jewish community, a director of a community-based organization for West African immigrants, or a social worker from a center for LGBTQ youth. Guest lecturers can speak individually, be on a panel, or even speak at different workshops if time does not allow for more than one lecturer.
- Schedule a convenient time, secure a space, and order food for the workshop. CUMC adopted a model used by Children's Hospital of Philadelphia in which afternoon continuity clinics were canceled for all first and second year residents for one week; the same workshop is then given Monday through Friday, with each day led by a different trained faculty member.
- Gather the necessary educational materials for workshop (samples are included in this section) and develop a PowerPoint presentation. Samples of two different PowerPoint presentations – one long and one short, with more case studies involved) are included in this manual and can be adapted to fit the local context.
- Invite trainees and ensure good attendance through, for example, reminder emails.

DURING THE WORKSHOP

- Open the workshop with an icebreaker relevant to culture (examples are included in this manual).
- The PowerPoint slides included in this manual provide a recommended structure, including time for lecture, role-playing, case studies and self-reflection using a sentence completion exercise, however the structure of the workshop can be adapted as needed. The workshop outline provided can also be split into sections (for example, "Patient Culture," "Physician Culture," "Culturally-sensitive Communication"), or simply kept as one longer workshop.

AFTER THE WORKSHOP

- Send thank-you letters to community guest lecturers; explore and suggest possibilities for further partnerships with them.
- Analyze the workshop satisfaction surveys trainees completed at the workshop and use data to inform planning of future workshops.

EVALUATION METHODS

- A short satisfaction survey for trainees (sample is included in this manual)
- A brief open-ended survey or informal conversational interview with community guest lecturers to assess their feelings, opinions and suggestions regarding their participation.

SAMPLE WORKSHOP INVITATION

[Date]

Dear [Trainees],

Next week you are scheduled to attend a workshop entitled **Delivering Cultural and Linguistic Responsive Services**. Please see the schedule below for the details of when you are scheduled to attend.

In advance of the workshop please write down both a difficult and a rewarding personal experience that you have had with a patient, student, or colleague that highlights issues of inter-cultural communication. Please bring this to the workshop.

Regards,

[Faculty name(s)]

SAMPLE WORKSHOP AGENDA

Introduction – 10 minutes

Definitions- 10 minutes

IOM interactive didactic – 30 minutes

Patient/provider perspectives– 30 minutes

Break – 15 minutes

Kleinman didactic -- 30 minutes

Local beliefs – 10 minutes

Summary and plan for future action – 15 minutes

SAMPLE ICE BREAKER

Have each member of the group explain the origin and significance of his or her first and last names. This is a nice way to both learn participants' names and illustrate the diversity within the group.

SAMPLE SENTENCE COMPLETION EXERCISE

Complete the following sentences in the space provided below:

1. I enjoy working with patients in this community when:
2. I wish my patients in the community would:
3. I get frustrated with my patients the most when:
4. I have the easiest time with patients in the community when:
5. I appreciate patients in the community because:
6. Cultural issues with patients become difficult when:
7. I am most comfortable with patients when:
8. Cultural issues that makes me the most uncomfortable are:
9. My values and experience affect my interaction with the community when:
10. Language barriers create problems when:

SAMPLE CULTURAL AND LINGUISTIC RESPONSIVE SERVICES EVALUATION

Please rate the following components of this workshop on a scale of 1 to 5 (with 1 being the least helpful and 5 being the most helpful.) Please do not write your name on this paper.

	not helpful ----> very helpful					
1. Introduction/ice breaker	1	2	3	4	5	NA
2. Background and definitions of race, ethnicity, culture, etc.	1	2	3	4	5	NA
3. Presentation of Institute of Medicine health disparities report	1	2	3	4	5	NA
4. Presentation of Kleinman model of interviewing	1	2	3	4	5	NA
5. Inter-cultural communication skills	1	2	3	4	5	NA
6. Local health beliefs discussion	1	2	3	4	5	NA
7. Local health beliefs guest lecturer	1	2	3	4	5	NA
8. Wrap-up and plan for the future	1	2	3	4	5	NA

Suggestions:

SAMPLE COMMUNITY PRESENTER THANK YOU LETTER

Rabbi []
[Synagogue]
[Address]

[Date]

Dear Rabbi [],

Thank you so much for taking the time to come and speak with the [Trainees] here at [Medical Center]. Although it has existed in less formal way in the past, the workshop in which you participated, entitled “Delivering Cultural and Linguistic Responsive Services,” started last year. It is part of a series of presentations, workshops and activities during which residents learn about and practice skills required to deliver healthcare across cultural gaps.

As you know, it was the [trainees] themselves who, last year, had asked to learn more about Orthodox Jewish culture. And, the response to your presentation was overwhelmingly positive! Although many of the residents are Jewish, their knowledge of Orthodox practices was, in many cases, quite limited. They really appreciated being able to ask their questions in a nonjudgmental and relaxed atmosphere. You have a wonderful, warm way of conveying information and encouraging discussion that was very effective with these groups of tired and stressed new doctors.

Some of my colleagues, on hearing the [Trainees] discuss their positive experience, have started talking about creating an educational session related to Orthodox Jewish beliefs for participation of the more senior faculty of the hospital. We have no concrete plan as of yet, but I may be contacting you in the future to see if you would be interested in joining that effort.

Once again, from all of us here at the [Department] at [Medical Center], thank you for your enthusiastic teaching and support of the development these [Trainees].

Sincerely yours,

[Name]
[Title]
[Medical Center]
[Contact information]

SAMPLE POWER POINT PRESENTATION VERSION 1

Delivering Cultural and Linguistic Responsive Services

GOALS AND OBJECTIVES

- Define terms and discuss rationale for workshop
- Discuss racial and ethnic health disparities
- Discuss Arthur Kleinman's model of clinical interviewing.
- Briefly discuss some health beliefs of local cultures.

COMMUNITY PEDIATRICS

COLUMBIA UNIVERSITY

COMMUNITY PEDIATRICS

COMMUNITY HEALTH	CULTURAL COMPETENCY	ADVOCACY
Explain major environmental, social, economic, and political factors affecting children's health	Explain how beliefs, cultures, and ethnic practices can influence health status and care for children of the community	Articulate the importance of the pediatrician's role as an advocate at every level (individual, community, national)
Describe the Washington Heights and Harlem communities and how their resources affect child health	Demonstrate an ability to form therapeutic alliances with patients from a variety of socio-cultural backgrounds	Use advocacy skills to develop a plan of action regarding relevant community health issues
Perform a community needs and assets analysis and discuss their influence on health care problems and outcomes	Recognize and manage the cultural attributes and biases that the provider brings into any clinical encounter	Help patients with complex medical problems negotiate the health care system
Apply basic epidemiological concepts and principles to health-related issues in the community	Develop skills to communicate and elicit information from the patient and family about their health belief system and socio-cultural background	
Describe how health insurance, entitlement programs and the health care system affect access to care for patients in the community		

Why this workshop?

- The US is becoming more diverse
- Provider-Patient communication is linked to:
 - Patient satisfaction
 - Adherence to medical instructions
 - Health outcomes
- Landmark IOM reports highlight the importance of patient-centered care and cultural competence on improving quality and eliminating racial and ethnic health disparities
- Increased provider satisfaction

Icebreaker

What's in a name?

- Tell the story of your name and its origins
 - Ethnicity
 - Family history
 - Place of birth

DEFINITIONS

- Race
- Ethnicity
- Culture

- **Race:** A group of people united or classified together on the basis of common history, nationality, or geographic distribution
- **Ethnicity:** A group of people who are classified according to common background, languages, traits, customs, or appearance.
- **Cultural Group:** People with common origins, customs, and styles of living; sense of identity and a shared language. No cultural group is homogenous, but contains diversity.

Define Cultural Competency

- or Culturally Effective Healthcare

“Culturally Effective Healthcare”

- Appropriate physician knowledge, understanding, and appreciation of cultural distinctions
- Takes into account the beliefs, values, actions, customs, and unique health care needs of distinct population groups
- Strengthens the physician-patient relationship and maximizes the health status of patients

IOM INTERACTIVE DIDACTIC

Objectives:

- Understand that health disparities exist
- Explore the psychology behind clinical decision making
- Focus on ways to decrease health disparities

Disparities in health exist

- Despite health promotion efforts which have increased the health of Americans overall, minority populations have been left behind.
- The Institute of Medicine – part of National Academy of Science. Private not-for-profit
 - Convened by Congress to look at this issue

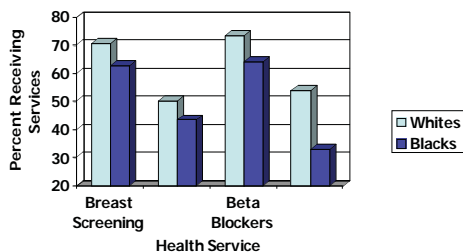
IOM Study Charge

- Assess the extent of racial and ethnic differences in healthcare that are not otherwise attributable to known factors such as access to care (e.g., ability to pay or insurance coverage);
- Evaluate potential sources of racial and ethnic disparities in healthcare, including the role of bias, discrimination, and stereotyping at the individual (provider and patient), institutional, and health system levels; and,
- Provide recommendations regarding interventions to eliminate healthcare disparities.

Evidence of Racial and Ethnic Disparities in Healthcare

- Disparities consistently found across a wide range of disease areas and clinical services
- Disparities are found even when clinical factors, such as stage of disease presentation, co-morbidities, age, and severity of disease are taken into account
- Disparities are found across a range of clinical settings, including public and private hospitals, teaching and non-teaching hospitals, etc.
- Disparities in care are associated with higher mortality among minorities (e.g., Bach et al., 1999; Peterson et al., 1997; Bennett et al., 1995)

Among Medicare Beneficiaries Enrolled in Managed Care Plans, African Americans Receive Poorer Quality of Care (Schneider et al., *JAMA*, March 13, 2002)



Disparities Among Medicare Recipients

- Mammography
- Influenza Vaccine
- Curative Lung Cancer Surgery
- Renal Transplant
- Cardiac Catheterization and angioplasty
- CABG
- Treatment of chest pain
- Referral to cardiology
- Pain management

Disparities in Pediatrics

- Decreased preventative visits
- Decreased referral to pulmonary and allergy specialists for children with asthma.

What factors are responsible for disparities in health?

Why?

- Social factors/determinants
 - Education
 - Environment – landfills, waste treatment, bus depots disproportionately placed in Latino and AA communities.
- Employment – Latinos well represented in the workforce, but in small firms and with poor or no health insurance.
- Access to care: 40% of Latinos are uninsured - higher than American average - even though many are working.

What are potential sources of disparities in care?

- Health systems-level factors – financing, structure of care, cultural and linguistic barriers
- Patient-level factors – patient preferences, refusal of treatment, poor adherence, biological differences
- Disparities arising from the clinical encounter

PATIENT/PROVIDER PERSPECTIVES

Factors That Influence Clinical Decision Making

- Patient characteristics
- Provider characteristics
- Features of the healthcare setting: incentives, physical surroundings, time

Patient Characteristics

- Patient preference
- Refusal of treatment
- Poor adherence
- Biological differences
- Patient may react to provider behavior with mistrust.

Provider Factors

- Bias
 - Least subtle
 - Prejudice against minorities
- Clinical Uncertainty
- Stereotyping

Clinical Uncertainty

- Baye's Rule: how a decision maker combines prior information and new information:
 - The relative weight placed behind the prior depends on the quality of the new information.

Clinical Decision =

“a prior” + information from the patient

Define Stereotyping

- The process by which people use social categories (race, sex, age, etc.) in acquiring, processing, and recalling information about other people.

Stereotyping

- Social Cognitive Theory
 - Automatic aspects: group to individual
 - Cognitive misers – cognitive shortcuts to save resources, principle of least effort
 - Primal: race, gender, age
 - *Activated most when:*
 - *stressed, under time constraints, multi-tasking*

Provider-Patient Encounter

- Conscious discrimination – rare in our profession
- Unconscious prejudice or bias
 - May be socially conditioned discomfort
 - Increased rate of blinking
 - Closed posture
 - Decreased eye contact

Evidence of unconscious prejudice or bias

- 2001 study of pain management (using vignettes)
 - Male physicians prescribed 2X more pain med to white than black patients.
 - Female MDs did the reverse
- 2000 study- MDs rate post-angiogram patients' intelligence, self-control, education level, rationality, responsibility.
 - AAs rated as less intelligent, less educated, more likely to abuse drugs and alcohol, less likely to comply with treatment.
 - 2/3 less likely to be "would be friends with"
 - Re: whites and AAs at lower SES – AAs rated as less pleasant, less rational

We all stereotype

- Can you think of an time when you gave poorer care to a patient because of a stereotype?
- Influenza vaccine example
 - If you offer the flu shot to 100 Dominican mothers and they all refuse, is the 101st mother going to get the same encouragement to get the vaccine as a mother from another ethnic group?
- What factors augment our tendency to stereotyping?
 - Fatigue
 - Time pressure
 - Multi-tasking

What can we do?

- Assess core cultural issues and explore the meaning of these issues. Be aware of issues in your community, you may have no clue - **ask!**
- Develop a differential diagnosis for non-adherence
- Determine the social context
 - Tension/stress
 - Life control
 - Literacy and Language
 - Immigration tensions

Role play: Generating a differential diagnosis for non-adherence

Mother's role

- You are very concerned about your child's speech delay and want help. You are unable to read and write, so when letters are sent, you can't read them and also have difficulty writing down instructions. Also, difficulty navigating new bus and subway routes due to illiteracy and inability to speak English to ask directions. You will not admit to illiteracy unless asked directly. You are also an illegal immigrant.

Doctor's Role

- You are seeing a 4 year-old with severe speech delay. You diagnosed the delay at age 2, and the child received EI for a while. But now you keep calling and setting up appointments with the Early Childhood Direction Center, and the family has missed all 3 appointments. When they return to you for the next appointment, it is always the same blank look.

What can we do?

- #1 Be Aware!
- Use interpreters
- Develop communication skills that emphasize negotiation and shared decision making
- Use evidence-based clinical guidelines
- Develop protocols – handouts

Physician Culture

To know others, we must first know ourselves
--- Adage

KLEINMAN DIDACTIC:

Culture, Illness, and Care

■ Disease

■ Illness

Problems

1978:

- Patient dissatisfaction with healthcare
- Inequity of access to healthcare
- Increasing health care costs

2004:

- All of the above plus...
- >28 million Americans are foreign born (up from 9.5 million in 1970 census)

Kleinman's Main Concepts

- Disease Vs. Illness
 - Disease: body malfunction
 - Illness: human experience of sickness
- Clinical reality is defined by culture
 - Biomedical culture of MD vs. patient's culture

The medical encounter is only one step in a more inclusive sequence.

- Personal awareness of change in body feeling
- Person and/or family action taken
 - Home Rx
 - Advice from extended family or community
 - Alternative, "marginal" practitioners
- May or may not lead to formal healthcare system

Illness ≠ Disease

- Similar organ pathology may generate different report of pain and distress
- Illness occurs in absence of disease

Accurate Dx and Rx of disease may not yield cure if ...

- Patient does not follow instructions because
 - a) Don't understand or
 - b) Don't agree with provider's rationale.

Two Ends of a Spectrum

- | | |
|---|--|
| ■ Patient → <i>Illness</i>
Difficulties in living resulting from sickness | ■ Doctor → <i>Disease</i>
Biological basis |
| ■ <u>Traditional healers</u> :
Meaningful and culturally appropriate explanation | ■ <u>Doctors</u> : recognize and treat disease |
| ■ Healing | ■ Curing |

How can we bridge this gap?

"Many physicians, without explicit knowledge of these concepts, treat both [illness and disease] superbly. We contend that by making explicit what is often merely tacit in good medical care, the yield of clinically competent graduates will be increased."

– Kleinman 1978

Clinical Reality: *Doctor*

- Describe the medical “explanatory model” for a cold.

Clinical Reality: *Patient*

- What questions would you use to elicit a patient’s “explanatory model” for cold?

Culturally Competent History

- What do you think caused your problem?
- Why do you think it started when it did?
- What do you think your sickness does to you? How does it work?
- How severe is your sickness? Will it have a short or long course?

-Arthur Kleinman et al.

Culturally Competent History

- What kind of treatment do you think you should receive?
- What are the most important results you hope to receive from this treatment?
- What are the chief problems your sickness has caused for you?
- What do you fear most about your sickness?

-Arthur Kleinman et al.

LOCAL HEALTH BELIEFS

Knowledge

- Local Demographics and Health Beliefs
 - Benefits:
 - May help to direct the clinical interview
 - May decrease misinterpretations and embarrassing moments
 - Limitations:
 - Stereotype vs. Generalization
 - It is impossible to be familiar with all relevant clinical practices
 - Each family is a unique cultural unit

Please see the Health Beliefs and Home Remedies PowerPoint Slides later in this manual for more information to use in this section.

PLAN FOR FUTURE ACTION

- What do we as an institution do well?
- What do you as residents do well?
- How can you continue doing these things?
- What can be improved upon?

WRAP UP

- Name game
- Definitions of Race, Ethnicity, Culture and Cultural Competence
- Health Disparities research and the universality of stereotyping
- Patient-Provider Perspectives Exercise
- Kleinman Model of Cross-Cultural Communication: Disease vs. Illness
- Local Beliefs
- Future Goals

SAMPLE POWERPOINT PRESENTATION VERSION 2

Cultural Competency

- Synonyms
 - Culturally Effective Health Care
 - Culturally Sensitive Health Care
 - Cross-Cultural Medicine
 - Multi-culturalism

DHHS National Standards for Culturally and Linguistically Appropriate Services in Health Care

Issued December 2000

- Primary aim is the elimination of racial and ethnic health disparities
- Standards focus on access to care in the patient's language.

Cultural Competency Techniques

- Interpreter services
- Recruitment and retention policies
- Training
- Coordination with traditional healers
- Use of community health workers
- Culturally competent health promotion
- Inclusion of family and/or community members
- Immersion into another culture
- Administrative and organizational accommodations

Iceberg Exercise

- Which characteristics of patients/people are visible?
- Which characteristics of patients/people are assumed/invisible?



Issues in Patient Culture

- Language
- Meaning of Illness
- Help-seeking Behavior
- Social and Historical Context
- Core Cultural Issues (gender, authority, physical contact, decision making, religion/spirituality)

Case Studies

- Case 1: You are seeing a Dominican-American girl for her one-year-old physical. She has dried and crusted lesions on her skin that her father says is "varicella" that she had 2 weeks ago. The parents did not seek medical care at that time because they knew they had this appointment coming up anyway. Although you try to focus on the nature of the rash (was it dewdrop on a rose petal?), the parents continue to ask you many questions about their daughter's milk intake. You ultimately realize that they have stopped her milk intake altogether.

Questions for Case Study 1

- What is this family's primary concern?
- What is your primary concern?
- How do you reconcile these two agendas?
- What are your primary educational goals with this family?
- How will you communicate these goals?

Case Studies

- Case 2: You are seeing an Arab-American family that you have seen multiple times in the past. On previous appointments, the mother would bring her 3 children. On this visit, the father is present as well. Although he speaks better English than his wife, he cuts her off repeatedly and undermines your pleasant relationship with the mother. He frequently erupts into Arabic, and appears to be yelling at the mother.

Questions for Case 2

- What is the family dynamic here?
- What issues should you be concerned about?
- How do you negotiate your relationship with this family?
- How might your age and gender be an issue here?

Case Studies

- Case Study 3: You are seeing the son of a recently immigrated Cambodian family who has transferred to your clinic after leaving another major medical center in the city. On examining the child, you realize the child has a dramatic murmur. The parents tell you that the child has “a bad heart” for which he is receiving treatments. You assume the child is receiving penicillin for rheumatic heart disease. However, the parents grow agitated when you suggest that this regimen be continued, and that the child should receive an echocardiogram.

Questions for Case 3

- What are your assumptions in this case?
- How can you clarify if they are correct?
- How might this child's cultural or political heritage impact the experience of illness?
- How should you proceed to ensure the best care for this child?

Meanings of Illness

- **Disease:** Abnormalities in the structure and function of body organs and systems.
- **Illnesses:** The human experience of sickness, which is shaped by cultural factors governing perception, labeling, explanation and valuation of the discomforting experience.

Perceptions of Disease and Illness

- Invasion of microorganisms
- Body imbalance
- Punishment by God
- Result of offending ancestors
- Caused by spirits or curses

Perceptions of Healing and Curing

- Fighting an intruder
- Putting the body back in balance
- Making an atonement to God for wrongdoing
- Purging the spirit or lifting the curse
- Making peace with ancestors

Perceptions of Doctors

- Healer
- Expert
- Miracle worker
- God's worker
- Shaman
- Confidant or family member
- Authority figure
- Someone who inflicts pain

Awareness

- Personal Backgrounds
- Potential Biases
- The need for culturally competent care
- The Anger Issue
- Aspects of medical culture, including the "hidden curriculum"

The **LEARN** Model

- **L**isten to your patient from his/her cultural perspective
- **E**xplain your concerns and your reasons for asking personal information
- **A**cknowledge your patient's concern
- **R**ecommend a course of action
- **N**egotiate a plan with your patient that takes into consideration his/her cultural norms and personal lifestyle

Workshop Exercise

- This exercise is designed to help you assess your own cultural heritage, including experiences that may influence your ability to work with patients from diverse backgrounds.
- There are no right or wrong answers.

Workshop Exercise

- What ethnic group, socioeconomic class, religion, age group and community(s) to you belong to?
- What is the first experience you had with people from an ethnic group, socioeconomic class, religion, age group or community not your own? What was that experience like? How did you feel about it?

Workshop Exercise

- What socio-cultural factors in your background might contribute to your being rejected by others? Have you experienced prejudice from others?
- What personal qualities do you have that will help you establish interpersonal relationships with people from other cultural groups? What personal qualities of yours may be detrimental?

Workshop Exercise Summary

- What were the assumptions you made about your partners before they spoke? Did you predict what they were going to say?
- Was anything difficult to discuss? Did anything make you uncomfortable?
- What did you learn?

Awareness

- Individual Cultural Heritage
 - Includes provider's own cultural family beliefs and upbringings regarding health etiology, treatments, and health beliefs and behaviors
- How does provider culture impact the health encounter?

Individual Health Beliefs Exercise

- What were some of the values in your family around health?
- What were some of the beliefs and healing methods used?

Awareness

- Biomedical Culture
 - Not value-neutral
 - Every** patient encounter is a “cross-cultural experience”

The Anger Issue

- What are patients' expectations of doctors?
- What are our expectations of patients?
- How do institutional policies increase this conflict?

Medical Culture

- What are the positive values of medical culture?
- What are the values of medical culture you would like to change?
- How are these values passed on?
- Have you ever been in an uncomfortable cultural situation among colleagues?

SELF-AWARENESS

Trainees will develop an understanding of one's own personal cultural values and beliefs and its impact on health and health care delivery.

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NARRATIVE LUNCH SERIES

GOALS

- To stimulate discussion of cultural issues, examine personal biases and expand points of view
- To improve empathy, communication and the quality of patient care
- To strengthen community-academic partnerships

RATIONALE

Narrative medicine, according to Rita Charon, its pioneer and director of Columbia University College of Physicians and Surgeons' Narrative Medicine Program, is "a medicine practiced with narrative competence and marked with an understanding of these highly complex narrative situations among doctors, patients, colleagues, and the public."¹ Lunchtime discussions of a literary text are a way to promote narrative medicine in the medical center and community. They provide a comfortable alternative environment where trainees and community members are all learners and power differentials are reduced. This allows for inter-professional and intercultural interactions that build community-academic partnerships. Qualitative evaluation has shown the narrative lunch experience improves self-reported understanding of cultural diversity, medical culture, and physicians' attitudes and behaviors in practice.

DESCRIPTION

In this activity, trainees, faculty and community members meet monthly to discuss a shared literary text in a way similar to a book group. Selected texts address issues of cultural difference, medical culture and relationships among patients, providers and communities. Discussion of these texts in an informal setting serves to increase knowledge and understanding between providers and community members.

<u>CULTURAL COMPETENCIES</u>		<u>ACGME COMPETENCIES</u>	
<ul style="list-style-type: none"> • SELF-AWARENESS • CROSS-CULTURAL KNOWLEDGE 		PATIENT CARE: 1a PRACTICE-BASED LEARNING AND IMPROVEMENT: 3c INTERPERSONAL AND COMMUNICATION SKILLS 4b; 4c PROFESSIONALISM: 5a; 5c	
MATERIALS	<ul style="list-style-type: none"> • Books or other texts • Food 	COSTS	<ul style="list-style-type: none"> • Books: Generally, participants buy the books themselves. If shorter texts are used, these could be provided to the participants. • Food: It is suggested that the lunches are catered, since this can be an incentive for attendance. If funding is unavailable, participants may bring their own lunches.
TIME FRAME	<ul style="list-style-type: none"> • Lunches: 60-90 minutes once per month 	STAFF	<ul style="list-style-type: none"> • A staff person to coordinate logistics (order food, distribute texts, and other administrative tasks) • Faculty and community leaders to take turns moderating sessions.

1 For more information on Narrative Medicine, visit the Columbia University College of Physicians and Surgeons Program in Narrative Medicine's Web site: <http://www.narrativemedicine.org/>.

PREPARATION AND PLANNING

BEFORE NARRATIVE LUNCH SERIES BEGINS:

1. School faculty and community-based organization leaders jointly select appropriate books or articles for the narrative lunches.
2. Invite community members to participate and secure their commitment and cooperation. If the medical center has partnerships with any community organizations, these can be key sources of participants. It is also possible to include participants from multiple community organizations; the participant structure should be tailored to the particular community situation.
3. Pick texts for the lunches. Selections should illustrate issues of patient, provider and/or institutional culture. The selected texts should allow for discussion of the complexities of interactions between members of the medical system and people with other culturally-informed health belief systems. If a book is chosen, it is then necessary to determine how much will be read for each session (e.g. one chapter per session). A list of some suggested texts is included in this section.
4. Determine a convenient location and time for the monthly lunches. It is suggested that the lunches happen outside the medical center, preferably at a community-based organization. Holding them in a community setting can help minimize power differentials that may exist between medical personnel and community participants. The time for the lunches should be consistent (e.g. the third Thursday of each month from noon to one p.m.). The time chosen should maximize participation of both medical and community participants, keeping in mind trainees' schedules particularly.
5. Determine food arrangements. It is preferable to provide the food through a catering service or local restaurant, since this is an incentive for participation. A staff person will need to order food monthly for each lunch. If funds are not available to provide food, participants may be asked to bring their own lunches.
6. Prepare a few discussion questions for each lunch. Some editions of certain books may already contain discussion guides organized by chapter that may be useful.

DURING THE NARRATIVE LUNCH:

1. At the first lunch, the participants should set ground rules and group norms for their discussions. It is important to emphasize respect for differing opinions, the importance of each participant's experience, and the need for confidentiality. These rules and norms should be reiterated at each subsequent lunch.
2. At the first lunch, create a rotating facilitator schedule that allows for all participants to take turns leading the discussion.
3. Emphasize that participants need to come to each lunch having read the text completely.
4. During each lunch, discuss that session's text using prepared discussion questions. The facilitator should make sure that all participants are included, the discussion flows, and issues from the text are connected to the experiences of the participants. The facilitator should also attempt to reduce power differentials, for example, by making sure participants' first names are used (instead of "Dr.").

EVALUATION METHODS

- Focus groups with community participants can be held at the end of the first series (or first year) of narrative lunches to evaluate their experiences. A sample focus group guide is included in this manual.
- Evaluation of the trainees' experiences at the lunches can be done using brief self-reported evaluation forms. At CUMC, each trainee completed these evaluations either online or in written format. Trainees' reflections on the experience can be discussed during their evaluations with faculty. Occasionally, a community liaison may be present at these sessions. The evaluation process is described in more detail in the following journal article: DasGupta S, Meyer D, Calero-Breckheimer A, Costley AW, Guillen S. Teaching cultural competency through narrative medicine: intersections of classroom and community. *Teach Learn Med.* 2006 Winter;18(1):14-7.

TIPS

- It is important to make sure that trainees, faculty and community participants are consistently able to attend the lunches. Picking a convenient time, canceling other obligations and/or reworking the trainees' schedules can help achieve this. It is key to set up the lunch at a time and place where community participants already meet so they don't see participation as a burden.
- If possible, order a lunch that coordinates with what the selected text (e.g. Mexican food when reading *How the Garcia Girls Lost Their Accents*).

SUGGESTED NARRATIVE LUNCH TEXTS

- Abraham, Laurie Kaye. Mama Might Be Better Off Dead: The Failure of Health Care in Urban America. Chicago: University of Chicago Press, 1994.
- Alvarez, Julia. How the Garcia Girls Lost Their Accents. New York: Plume, 1991.
- Berger, John. A Fortunate Man: The Story of a Country Doctor. New York: Vintage Books, 1997.
- Bulgakov, Mikhail. "Black as Egypt's Night" from A Country Doctor's Notebook. London: Harvill Press, 1995.
- Chekhov, Anton. Ward 6 and Other Stories. New York: New American Library, 1965.
- Cisneros, Sandra. The House On Mango Street. New York: Vintage Books, 1991.
- Crane, George T (Sam). Aidan's Way. Naperville, Ill.: Sourcebooks, Inc., 2003.
- Danticat, Edwidge. Breath, Eyes, Memory. New York: Vintage Books, 1998.
- Doerr, Harriet. Stones for Ibarra. New York: Penguin, 1985.
- Fadiman, Anne. 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.
- Franks, Lucinda. "Miracle Kid" from The Princeton Anthology of Writing. Princeton, N.J.: Princeton University Press, 2001.
- Gawande, Atul. Complications: A Surgeon's Notebook on an Imperfect Science. New York: Metropolitan Books, 2002.
- Grealy, Lucy. Autobiography of a Face. Boston: Houghton Mifflin, 1994.
- Hilfiker, David. Not All of Us Are Saints: A Doctor's Journey With the Poor. New York: Farrar, Straus and Giroux, 1994.
- Kidder, Tracy. Mountains Beyond Mountains: The Quest of Paul Farmer, A Man Who Would Cure the World. New York: Random House, 2003.
- Mates, Susan. The Good Doctor. John Simmons Short Fiction Award Series 1994. Iowa City, Iowa: University of Iowa Press, 1994.
- McCarthy-Brown, Karen. Mama Lola: A Voodoo Priestess in Brooklyn. Berkeley: University of California Press, 2001.
- Nigam, Sanjay. Transplanted Man. New York: William Morrow, 2002.
- Santiago, Esmerelda. When I Was Puerto Rican. New York: Vintage Books, 1994.
- Stinson, Robert and Peggy. "On the Death of a Baby." Journal of Medical Ethics 1981 Mar;7(1):5-18
- Tolstoy, Leo. The Death of Ivan Ilych. New York: Signet Classic, 2003.
- Vergese, Abraham. My Own Country: A Doctor's Story of a Town and Its People in the Age of AIDS. New York: Vintage Books, 1995.
- Vergese, Abraham. "Lives: Close Encounter of the Human Kind." The New York Times September 18, 2005.
- Williams, William Carlos. The Autobiography of William Carlos Williams. New York: New Directions, 1967.
- Williams, William Carlos. The Doctor Stories. New York: New Directions, 1984.

FURTHER RESOURCES

New York University's Literature, Art & Medicine Database: <http://mchip00.nyu.edu/lit-med/lit-med-db>

Bellevue Literary Review: <http://www.blreview.org/index.htm>

Literature and Medicine Journal: http://muse.jhu.edu/journals/literature_and_medicine

Columbia University College of Physicians and Surgeons Program in Narrative Medicine: <http://www.narrativemedicine.org/>

SAMPLE COMMUNITY MEMBER FOCUS GROUP GUIDE

General Questions

1. What do the narrative lunches mean to you?
2. Why do you attend the lunches?
3. Did you feel free to speak your mind during the lunches?
4. How is this sort of experience important for a community-based worker? For a physician?

Questions Regarding the Book

1. Have you enjoyed reading this book? Why?
2. What are the different skills/lesson/ideas that emerge from reading this sort of book?
3. Are these issues discussed in the book applicable to your life/work?

Questions Regarding Cultural Diversity

1. What are the benefits of reading a text about an unfamiliar culture? Is such an experience valuable for a community-based worker/physician in [location]?
2. Has reading this text helped you understand different perspectives?
3. Before coming to the lunches, what was your understanding of cultural diversity?

Questions About Points of View

1. Do the discussions during the lunches help you to better understand the physicians' points of view?
2. Do you believe these lunches have helped the physicians to better understand your points of view?
3. Did the discussions help you learn more about the medical system?
4. After attending the lunches, do you perceive the physicians differently? Do you think the physicians perceive you differently?
5. How has the lunch experience changed your working relationship with the physicians?

Communication Skills and Strategies

1. Have the lunches aided your communication skills?
2. What new strategies have you learned since attending the lunches?
3. Have the lunches helped you prepare clients to better engage with the clinicians?

Process Evaluation Issues

1. What worked best?
2. What could be improved?
3. If you want to change anything, what would it be?

SHARED READING EXPERIENCE

Another version of the Narrative Lunches activity is the Shared Reading Experience. This option is less structured, takes less time, and can be less expensive. However it does not include community members in the discussions of the texts and therefore does not serve to strengthen community-academic partnerships.

RATIONALE

Reading and discussing literature that is focused on cultural issues with a group of colleagues provides a forum for examining how beliefs systems and culture can influence delivery of care, health behavior, and health status. Such reflection can lead to more culturally competent clinical practice among participants. This shared reading experience can also help strengthen relationships among colleagues.

DESCRIPTION

This activity draws on the principles of narrative medicine¹, and it is based on a model used with medical students at CUMC. Students are sent a letter in the summer before their first year of medical school introducing the shared reading experience; all students are asked to read *The Spirit Catches You and You Fall Down* by Anne Fadiman (this text is described in the Narrative Lunches section). During their first-year orientation, the medical students then discuss their experience with the text in small groups facilitated by faculty members. In the transition period before their second year, the medical students then read *Mountains Beyond Mountains* by Tracy Kidder; this text is discussed during the students' Clinical Skills small group sessions.

MATERIALS	<ul style="list-style-type: none"> Letters to participants explaining the shared reading experience Copies of the selected texts Discussion guide for small groups 	COSTS	<ul style="list-style-type: none"> Mailing and printing costs for letters to participants Participants buy books themselves Faculty time (in-kind)
TIME FRAME	<ul style="list-style-type: none"> Reading of the selected text is completed over a specified time period (e.g. a summer, a semester, a month) Small group discussions of the reading are held periodically with participants 	STAFF	<ul style="list-style-type: none"> Faculty to lead small group discussions Staff to coordinate the logistics of arranging the periodic small group discussions.

PREPARATION AND PLANNING

- This model can be used as is with students, whose schedule lends itself to annual readings with small group discussion at the beginning of each school year. However this activity can be easily modified for other populations. For example, the faculty, trainees and staff of a certain department may participate in a shared reading experience to examine issues of cultural competency together, perhaps also serving to foster cohesion among department personnel.
- It is important to pick a text that deals with issues of culture, cultural competency, communication, and/or health disparities; for suggestions, see the bibliography and reference sources provided in the Narrative

¹ For more information on Narrative Medicine, visit the Columbia University College of Physicians and Surgeons Program in Narrative Medicine's Web site: <http://www.narrativemedicine.org/>.

Lunches section.

- The small group discussions could take place just once after everyone has finished reading the text, or they could be scheduled similarly to a book club with a regular schedule of meetings while participants are reading the selected text. Another option that may work better in some settings is to substitute small group discussions with a web-based chat room or discussion forum where people can post their reactions to the text. This type of online response method could be more convenient for participants and would reduce logistical issues related to having periodic in-person discussions.
- Depending on the text, it may be useful to develop a short discussion guide with a few key questions to stimulate discussion of the reading. Such a guide could also be used to structure an online discussion forum.

EVALUATION METHODS

- Participants may complete a brief survey assessing their satisfaction with the experience and how it may have changed their perceptions and beliefs.

SAMPLE INTRODUCTORY LETTER

Dear Class of [Year],

Welcome! The faculty for the [clinical practice course] is truly looking forward to meeting you all this fall. During this course, you will get some early clinical exposure and learn some of the fundamentals of clinical practice and medicine in the contemporary society.

As part of the educational experience at [medical school], you will be exposed to a curriculum addressing culturally and linguistically responsive medical care that will span all four years of your medical school experience. Minority populations are the fastest growing segment of the American population and medical providers face challenges in caring for patients from diverse cultures. Patients may have different languages, socioeconomic status, and unique ways of understanding illness and health care. Patient satisfaction and adherence with medical recommendations are related to effectiveness of communication and the provider's relationship with the patient. Recognition that cross-cultural communication is essential to providing the best medical care and helps to reduce health care disparities, it has become a requirement for graduate medical education.

As an introduction to this curriculum, we are requesting that all students read a book entitled, The Spirit Catches You and You Fall Down, by Anne Fadiman, **prior to the beginning of the school year**. Though required reading, students and faculty have found this book to be a thought-provoking yet enjoyable experience that has affected their approach to patient care. It is an account of a Hmong girl's epilepsy and her community's interactions with their local medical facility. As you read, consider the conception of illness from the family's perspective versus that of the medical team, where communication broke down, and how medical providers could have acted differently to improve communication and medical care.

This book can be found in any general bookstore, library, or ordered online. All students will participate in discussions about this book in small groups as part of the [clinical practice course] in September.

Have a wonderful summer and we look forward to partnering with you as you begin your medical school experience a few months from now.

[Faculty]

SAMPLE INTRODUCTORY LETTER

Dear Class of [Year],

We hope you are having a good summer. As part of the cultural competency curriculum that takes place within the [clinical practice] course, we are requesting that all students read the book Mountain Beyond Mountains by Tracy Kidder **prior to the beginning of the school year**. This book, depicting the life and work of Dr. Paul Farmer, serves as an inspiration and model for those in the health professions who strive for equitable care for all.

When trying to deliver cultural and linguistic responsive services to our patients, it is necessary to look at the local, national, and worldwide health care systems that affect the care we provide. We believe that the ability to advocate for the improvement of these systems and increased quality of care is an essential skill for every physician to possess.

As many of you are spending your summer providing care in different parts of the country and around the world, we hope you find this book to be thought provoking, enjoyable, and a relevant learning opportunity.

Mountain Beyond Mountains can be found in any general bookstore, library, or ordered online. Upon your return to class, you will have an opportunity to discuss this book in your small groups

Have a wonderful summer. We look forward to learning from you summer experience.

[Faculty]

SAMPLE DISCUSSION GUIDE: *The Spirit Catches You and You Fall Down*

Goal for debriefing:

- Explanatory model and multiple perspectives
- Framework of thinking for history-taking

Questions for the group:

- What went wrong?
- What would you do differently?

Talking points

Cultural Competency issues:

- Provider awareness: bias, stereotyping
- Patient perspective and health beliefs: explanatory model
- Negotiation
- Language
- Policies and institutional culture

Negative feelings that come up with cultural competency curriculum:

- Anger
- Tired of having to meet patients half way
- “We are not social workers.”
- This is not what medicine trained me to do

V.I.T.A.L. (Video Interaction for Teaching and Learning)

Developed by the Center for New Media Teaching and Learning of Teachers College at Columbia University¹ and Dr. Mary Jo Fink

GOALS

- To explore methods of communication in cross-cultural care and demonstrate essential components of linguistically and culturally responsive services
- To provide trainees with a distance learning multimedia format that helps them reflect on their own clinical practice
- To have trainees compare and contrast videos of patient-provider interactions with their own experiences of patient encounters in order to improve their clinical practice
- To help trainees examine the potential impact of both medical culture and patient culture on patient-provider interactions

RATIONALE

In developing cross-cultural communication skills, it is helpful to observe examples of patient-provider interactions that demonstrate varying levels of successful communication. Video clips from popular medical television dramas such as ER can be sources of such examples. Through analyzing these video clips, trainees can reflect upon their own communication skills, thereby realizing ways to improve their clinical practice so that it is more culturally-sensitive and empathetic. If video clips and reflective writing are done through a web-based program, this can be an effective tool for distance learning that is especially helpful for trainees who are spread out across multiple clinical sites.

DESCRIPTION

This activity involves a series of reflective exercises based on video clips of patient-provider interactions that highlight different styles, techniques and issues of cross-cultural communication. Trainees use these video clips to write reflective assignments relating the situations, themes or concepts in the video clip to their own clinical experiences and development as culturally-sensitive providers. At CUMC this is done through a web-based program called V.I.T.A.L., developed by the Center for New Media Teaching and Learning of Teacher's College at Columbia University and Dr. Mary Jo Fink at Columbia University's Department of Family Medicine. Since this technology is currently unique to Columbia, this activity can be carried out in several alternate ways that are described here.

<u>CULTURAL COMPETENCIES</u> <ul style="list-style-type: none">• SELF-AWARENESS• CROSS-CULTURAL KNOWLEDGE• DELIVERY OF CARE		<u>ACGME COMPETENCIES</u> PATIENT CARE: 1a, 1b, 1e MEDICAL KNOWLEDGE: 2a. INTERPERSONAL AND COMMUNICATION SKILLS: 4a, 4b, 4c PROFESSIONALISM: 5c	
MATERIALS	<ul style="list-style-type: none">• Video clips• Web-based program (this may not be available everywhere)	COSTS	<ul style="list-style-type: none">• Cost of obtaining video clips (will vary)• Cost of development of the web-based program/resources• Cost of help from the technology staff.

¹ For more information, visit <http://ccnmtl.columbia.edu/>

TIME FRAME	<ul style="list-style-type: none"> This is a web based module done throughout a course or clerkship. It is suggested that one question per week is posted for trainees to respond to. This is done on trainees' own time, taking about 30 minutes for each assignment. 	STAFF	<ul style="list-style-type: none"> Faculty to select video clips and read trainees' reflective writing assignments Assistance from the audiovisual, information technology and/or biomedical communications staff members at the medical center
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PREPARATION AND PLANNING

1. Faculty need to select video clips of patient-provider encounters that provide “teachable moments” regarding aspects of cross-cultural communication. These video clips need to be then provided to trainees in a suitable format (either DVD, VHS or online).
2. Trainees must then be introduced to the methodology of the VITAL exercises through a brief training with a faculty member.
3. Trainees can then watch these clips at a regularly-schedule pace (once a week is suggested), either at their clinical sites on DVD or VHS, or online. The video clips may be uploaded to a web site (the department’s web site, the residency program’s web site or a web-based curricular platform such as Blackboard) for trainees to view. This web site can also be used to post questions about the videos that trainees respond to weekly.
4. After watching each assigned video clip, trainees then reflect on it and relate it to their own experiences using a series of guiding questions. Trainees’ responses may be emailed to a faculty member, written in a journal, or completed online. A web-based format may also allow trainees to discuss video clips and reflections with each other through a common online bulletin board or discussion forum.
5. Faculty may respond to trainees’ reflective responses either in-person or through email.

EVALUATION METHODS

- Trainees can use the Bennett Model of Stages of Intercultural Sensitivity as a self evaluation tool before and after the series of V.I.T.A.L. assignments.

Bennett Model

Denial --> Defense --> Minimization --> Acceptance --> Adaptation --> Integration

Before the training begins, trainees place themselves on the Bennett continuum; they do this again at the end of the training. Data on the pre- and post-training continuum placements for each trainee can be gathered in order to assess the impact of the V.I.T.A.L. training. Also, a face to face debriefing session should occur with the faculty in charge.

*Trainees may also complete a basic satisfaction survey to determine their attitudes and experiences with the training.

TIPS

- The NYU Literature and Medicine database can serve as a good source of video ideas
- The web-based, self-directed format of this exercise is particularly well-suited to medical centers where trainees are spread across various clinical sites.

SAMPLE REFLECTIVE RESPONSE INSTRUCTIONS

Watch the two clips for this assignment and complete the following questions:

Miscommunication Encounter:

After reviewing the clips, choose a scene that portrays miscommunication.

How can this lead to stereotyping? How can this miscommunication be avoided?

How does the culture of medicine facilitate or impede communication with patients?

Please use examples of your experience with patients this week to further discuss the issue.

Teen Patient Encounter:

After reviewing the clips, choose a scene that shows the tension between parents and the medical team regarding patient confidentiality of teens.

How did the doctor connect with the teens?

What are the legal rights of teens in your site? Or state?

Please use examples of your experience with patients this week to further discuss the issue.

LANGUAGE DIVERSITY

Provide or advocate for the provision of information, referrals and services in the language appropriate to the client as well as the provision of interpreters when needed.

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INTERPRETER USE TRAINING

OBJECTIVES

- To improve health care delivery to Limited English Proficiency (LEP) patients.
- To teach trainees the correct use of different forms of interpreter services and increase service utilization.
- To show trainees how interpreter services can lead to more accurate patient-provider communication, which can then improve quality of care and patient satisfaction

RATIONALE

As of 2004, about 44 million Americans spoke at least one of 300 languages other than English at home.¹ Many of these people have Limited English Proficiency, which can be a significant barrier when seeking medical care. The negative impact of language barriers on utilization, satisfaction and adherence has been well documented; language barriers can result in the loss of important information, misunderstanding of instructions, and poor treatment adherence. The use of trained medical interpreters is an important method for reducing language barriers. Research supports the benefits of trained interpreter use, especially regarding improvements in the quality of patient care. Furthermore, the Department of Health and Human Services (DHHS), professional and training organizations, and various laws mandate the use of interpreter use by providers (such as the CLAS standards issued in 2001 by the DHHS Office of Minority Health). Through didactic instruction and workshops, trainees can gain the knowledge and skills needed to properly use interpreter services.

DESCRIPTION

The purpose of this training is to teach trainees how to properly use interpreter services in their clinical encounters, in order to improve patient-provider communication. This training consists of two sections: a lecture portion and an interactive workshop portion. These sections can be presented in one training session, or presented separately if timing and scheduling constraints are a concern.

<u>CULTURAL COMPETENCIES</u>		<u>ACGME COMPETENCIES</u>	
<ul style="list-style-type: none"> • LANGUAGE DIVERSITY • DELIVERY OF CARE • ADVOCACY 		PATIENT CARE: 1a, 1b, 1e PRACTICE-BASED LEARNING AND IMPROVEMENT: 3c INTERPERSONAL AND COMMUNICATION SKILLS: 4b PROFESSIONALISM: 5c	
MATERIALS	<ul style="list-style-type: none"> • Relevant literature • PowerPoint slides and related equipment • Interpreter use video • Laminated interpreter service cards • Role-play scenarios 	COSTS	<ul style="list-style-type: none"> • Interpreter services staff time (in-kind) • Faculty time (in-kind) • Payment for participating bilingual community members
TIME FRAME	<ul style="list-style-type: none"> • Up to 4 hours (1 hour for the lecture and 3 hours for the workshop) 	STAFF	<ul style="list-style-type: none"> • Faculty to supervise • Staff from the interpreter service • Bilingual community members

1 United States Census Bureau, 2000.

PREPARATION AND PLANNING

LECTURE PORTION

1. Before the presenting the lecture, invite staff from the medical center's interpreter services to attend the training and to speak about how to properly use the interpreter services. The interpreter services staff, with assistance from faculty members, can develop a relevant PowerPoint presentation (two different samples are included in this manual).
2. Have staff from the medical center's interpreter services present PowerPoint slides and discuss the proper use of medical interpreter services.
3. Then show the video "Communicating Effectively Through an Interpreter"² and provide time for interpreter services staff and faculty to lead a discussion of the video with trainees.
4. Provide trainees with a laminated interpreter service use card and other appropriate resource materials that the interpreter service staff and faculty may want to provide.

WORKSHOP PORTION³

BEFORE THE WORKSHOP

1. Determine which faculty will lead the training; the faculty should have experience and interest in use of medical interpreters. Multiple faculty members should be selected since trainees will be divided into small groups, each requiring a faculty member to supervise.
2. Establish appropriate times and locations for the workshops that are convenient for the participants.
3. Recruit bilingual community members who speak languages representative of the local patient population to serve as either "patients" or "interpreters" or both. Provide them with instructions on what their role will be in the training. At CUMC, 10 of the same bilingual community members who led the walking tour also participated in the interpreter use training. Each was paid a \$100 stipend.
4. Make laminated interpreter service use cards (see the sample in this manual) for trainees.

DURING THE WORKSHOP

1. Divide trainees into small groups. Have trainees role-play with the bilingual community members. The role-plays may have the bilingual community member as a patient or as an interpreter. Role-play scenarios may be found in interpreter use curricula, such as the materials developed by Jan Gottlieb for the Department of Family Medicine at the University of Medicine and Dentistry of New Jersey-Robert Wood Johnson Medical School. Also, trainees should be instructed to prepare interpreters beforehand, just as they would before a real clinical encounter. Faculty should observe trainees. Bilingual community members and faculty can then discuss the role-play experience with trainees, providing suggestions based on trainees' performances.
2. Give trainees the laminated interpreter use cards to take with them for their own reference.

After the training, send thank-you notes to the medical center's interpreter staff members for their assistance. Also, send payment and thank-you notes to the community bilingual members for their participation.

EVALUATION METHODS

- Evaluate trainees' knowledge, attitudes and satisfaction with the training using a survey. At CUMC we used the survey developed by Jan Gottlieb for the Department of Family Medicine at the University of Medicine and Dentistry of New Jersey-Robert Wood Johnson Medical School. Data from this survey could be used to inform the design of future interpreter use training. If possible, monitoring and evaluating the use of trained interpreters by trainees who attended the training sessions (lecture and workshop) could provide some data as to whether the training was successful.

2 "Communicating Effectively Through an Interpreter" Copyright © 1998 by Cross Cultural Health Care Program, PacMed Clinics, Seattle, WA.

3 This workshop is based on the model developed by Jan Gottlieb at UMDNJ.

SAMPLE LAMINATED INTERPRETER CARD

FRONT OF CARD

1. For an In-Person Interpreter call Interpreter Services Department at [EXTENSION].

2. To Access A Telephonic Interpreter from Pacific Interpreters:

Dial: 1-800-876-3059

Provide ACCESS CODE

Give the following information

Callers name (First name, Last Initial)

Department

Language

BACK OF CARD

The Pre-Visit

- Encourage the interpreter to meet with the patient before the interview; when possible meet with the interpreter your self ahead of time.
- Advise the interpreter where you want them to sit
- Establish the context and nature of the visit
- Ask the interpreter if they have any concerns that they want to share with you before the visit

The Visit

- Introduce the interpreter formally at the beginning of the interview.
- Direct questions to the patient, not to the interpreter unless they are meant for the interpreter.
- Speak in short phrases.
- Avoid technical terms, abbreviations, professional jargon, and idioms.
- Encourage the interpreter to translate the patient's own words rather than paraphrasing or omitting information.
- Watch the patient's nonverbal communication
- Be patient. An interpreted interview takes longer.

SAMPLE POWERPOINT PRESENTATION VERSION 1

Effective Interpreter Use

Hetty Cunningham, M.D.
Assistant Clinical Professor of
Pediatrics

Interpreter Use Training

- **Goals:**
 - Improved health care delivery to limited in proficiency English (LEP) patients and families
 - Improved provider satisfaction and fulfillment

Agenda

- Mandates for interpreter use
- Research supporting use
- Explore interpreter use skills -
Video
- Discuss interpreter service at CPMC
- And, what you can do...

*What the scalpel is to the surgeon, words are to the clinician...
the conversation between doctor and patient is the heart of the practice of medicine.*

Magnitude of need: census data

- >34 million Americans are foreign born
- >44 million Americans speak a language other than English at home
- Over 300 languages spoken
- Not only urban, many immigrants now live in suburban and rural areas throughout the country.

Mandates

- Professional and training organizations
- Department of Health and Human Services
- Laws

CLAS: National Standards for Culturally and Linguistically Appropriate Services in Health Care

- “Providing culturally and linguistically appropriate services (CLAS) to [diverse patients/consumers] has the potential to improve access to care, quality of care, and, ultimately, health outcomes.”
- Standards focus on access to care in the patient’s language.
 - Department of Health and Human Services
December 2000

Laws Pertaining to the Provision of Interpreter Services

- Title VI of the Civil Rights Act (1964)
- New York State Public Health Law 405.7

Hypotheses: how could a language barrier compromise care?

- Provider
 - less accurate medical histories
 - decreased discovery of home/folk remedies and other cultural information
 - increased unnecessary testing
 - decreased patient education
- Patient
 - decreased adherence to treatment regimens
 - change in patients’ healthcare-seeking behavior
 - limits patient choice and access to high quality clinicians

Data

- Well documented negative impact of language barriers on:
 - Utilization
 - Satisfaction
 - Adherence
 - Cost

Cost

- Prolonged length of stay in ER and higher diagnostic costs
 - L. Hampers, et al.
- Increased probability of hospital admission
 - M. Waxman et al.
- 3-fold increase in CT scans done for abdominal pain in LEP cohort in which 100% had interpreters, but 80% were “ad hoc” or untrained interpreters.
 - M. Waxman et al.

B: Satisfaction

- Effect of Spanish Interpretation Method on Patient Satisfaction in an Urban Walk-In Clinic
 - Satisfaction rates were as high with telephonic professional interpreters as with language concordant providers
 - Satisfaction rates are lower when family and ad-hoc interpreters were used
- Lee et al, 2002.

C: Outcomes

- LEP diabetic patients provided with trained interpreters vs. English-speaking diabetic patients:
- no difference between groups in glycohemoglobin, and other laboratory markers
 - no difference in ER and acute visits and hospitalizations

Source: T.M. Tocher and E. Larson, "Quality of Diabetes Care for Non-English-Speaking Patients: A Comparative Study," *Western Journal of Medicine* 168, no. 6 (1998)

Why this training??

- Karlinger et al, 2004: Previous training in interpreter use is associated with:
 - A. Increased use in professional interpreters
 - B. Increased satisfaction with medical care provided

Video: Communicating Effectively Through An Interpreter

"Communicating Effectively Through an Interpreter"
Copyright © 1998 by Cross Cultural Health Care Program,
PacMed Clinics, Seattle, WA.

Interpreter Services at New York Presbyterian Hospital

- Interpreter Services at NY Presbyterian Hospital: (212) 305-9607
- Service provides Sign Language, Spanish, and French interpreters in person and by phone.
- Pacific Interpreters
 - Professional interpreters, over 100 languages.
 - Phone number and access code printed on cards available all over the medical center. Simply identify yourself and give the site-specific access code.

What can you do?

- Ask for and advocate for interpreter services
- **Use** trained interpreters when available

SAMPLE POWERPOINT PRESENTATION VERSION 2

Why Use an Interpreter?

- Quality of care
- Health outcomes
- Legal ramifications
- Financial concerns

Laws Pertaining to the Provision of Interpreter Services

- The Americans with Disabilities Act (1991)
- Hill Burton Act (1946)
- Title VI of the Civil Rights Act (1964)
- New York State Public Health Law 405.7

Strategies for Working with Limited English Speaking or Low Literacy Skilled Patients

- Speak slowly
- Use a normal tone of voice
- Avoid jargon and slang
- A picture is worth a thousand words
- Use the “show me” approach when appropriate
- Limit visit goals

Strategies for Working with Limited- English Speaking of Low Literacy Skilled Patients

- Repeat instructions
- Attempt to verify understanding of important points
- Avoid invasive, not easily understood procedures at the first visit
- Avoid talking “down” to parents
- Demonstrate RESPECT

Challenges for Language Communication

- Non-primary vs. primary
- Slang
- Medical vs. lay terminology
- Literacy
- Speed
- Dialects
- Culturally appropriate
- Use and misuse of interpreters
- Family roles as interpreters
- Gender roles in communication

How to Choose an Interpreter

- Use a professionally trained interpreter (if possible).
- Avoid using hospital personnel who are bilingual if they have not had training as an interpreter.
- Avoid using family members as interpreters, especially those of a different age or gender from the patient.
- Do not use children as interpreters.
- Be sensitive to the patient's right to privacy and their choice of who should act as an interpreter.

The Pre-Visit

- Encourage the interpreter to meet with the patient before the interview; when possible meet with the interpreter yourself ahead of time.
- Advise the interpreter where you want them to sit.
- Establish the context and nature of the visit.
- Ask the interpreter if they have any concerns that they want to share with you before the visit.

The Visit

- Introduce the interpreter formally at the beginning of the interview.
- Direct questions to the patient, not to the interpreter unless they are meant for the interpreter.
- Speak in short phrases.
- Avoid technical terms, abbreviations, professional jargon and idioms.

The Visit

- Encourage the interpreter to translate the patient's own words rather than paraphrasing or omitting information.
- Watch the patient's nonverbal communication.
- Be patient. An interpreted interview takes longer.

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STUDENT MEDICAL INTERPRETING CLERKSHIP

GOALS

- To improve health care delivery to Limited English Proficiency (LEP) patients
- To increase the pool of medical interpreters available to trainees
- To provide medical students with experience in medical interpreting
- To provide medical students with the opportunity to observe care of LEP patients

RATIONALE

The benefits of use of trained medical interpreters in encounters with LEP patients are well established. Use of trained medical interpreters is also mandated by health professional and training organizations, the Department of Health and Human Services, and various state and federal laws. However medical centers may lack a robust supply of trained medical interpreters and not all trainees are skilled at using such services. Therefore, pairing bilingual medical students who have been trained as medical interpreters with trainees is a way to increase use of medical interpreting services, thus improving the quality of patient care. This is an educational experience for medical students as well as trainees. In their capacity as interpreters, medical students will be intimately involved with the medical visit from beginning to end, learning alongside the trainees as they present cases and receive instruction from supervisors.

DESCRIPTION

In this activity, bilingual medical students are trained in medical interpreting. They are then paired with a trainee, providing translation services during the trainee's continuity clinic.

CULTURAL COMPETENCIES <ul style="list-style-type: none"> • LANGUAGE DIVERSITY • DELIVERY OF CARE • ADVOCACY 		ACGME COMPETENCIES PATIENT CARE: 1a , 1b, 1e PRACTICE-BASED LEARNING AND IMPROVEMENT: 3c INTERPERSONAL AND COMMUNICATION SKILLS: 4b PROFESSIONALISM: 5c	
MATERIALS	<ul style="list-style-type: none"> • Fluency level evaluation forms (though this may be handled by the medical center's interpreter services) 	COSTS	<ul style="list-style-type: none"> • Faculty time (in-kind)
TIME FRAME	<ul style="list-style-type: none"> • Training of medical student interpreters: 8 hours • Length of clerkship: 9-13 weeks depending • Hours per week: At least 3 	STAFF	<ul style="list-style-type: none"> • The medical center's interpreter services staff to provide formal training for the student interpreters. • Faculty member(s) to serve as advisor(s) for the clerkship • Trainees to be paired with medical student interpreters

PREPARATION AND PLANNING

1. Recruit medical students to apply for the clerkship. This clerkship is open only to medical students who are bilingual in whichever languages are prevalent among the medical center's patient population. The number of clerkship spots available is dependent upon the language fluency of the medical students, the number of trainees who would like to be paired with a medical student interpreter, and the capacity of the interpreter service staff to provide training.
2. Establish fluency levels of medical students interested in the clerkship through screening. CUMC used a tool prepared for the Administrative Office of the United States Courts by the National Center for State Courts, Williamsburg, VA, and its collaborating partners CPS Human Resource Services and Second Language Testing, Inc.
3. Once the medical students are selected, they need to receive 8 hours of formal training in medical interpreting. Staff of the medical center's interpreter service may provide such training, just as they would for any other volunteer medical interpreters.
4. Pair the medical student interpreters with interested trainees. The medical students can work with residents in the outpatient clinics, in the hospital, or any other appropriate setting. At Columbia, students spend a half-day a week doing medical interpreting and shadowing the trainee during their continuity clinic.
5. Medical students must meet with the clerkship supervisor on a monthly basis to debrief regarding their experiences and to receive formal instruction in medical topics related to the clerkship.

EVALUATION METHODS

- Since this is a clerkship, it should be evaluated by faculty, just as any other clerkships offered at the medical school.

SAMPLE MEDICAL STUDENT CLERKSHIP PARTICIPATION LETTER

Dear [Medical Students],

Welcome to the Medical Interpreting Clerkship! I will be your clerkship supervisor and I look forward to meeting you all and working together. Please feel very free to contact me with any and all questions and concerns.

You have each been paired with a pediatric resident. In some cases I have given you two names. If the resident with whom you are paired is absent, or if they do not have a family who needs interpretation and the other resident does, you may go with the second resident. For that matter, you may be able to work with various residents who may request your services as an interpreter. If your resident does not have a case that needs interpretation, you will still shadow that resident. The residents and families really appreciate the valuable service you are providing, and I have many more than 4 residents who wanted to work with you.

After the resident does the interview, you will have the option of remaining in the room with the family and speaking further with them while the resident presents the case to the attending. Or you can follow the resident to learn with them the teaching points from the attending. You will then return to the room with the resident to complete the interview.

I want to point out that the residents will not be teaching you as they go. They too are in a situation to be learning and if they tried to teach it would confuse your role as interpreter. You will learn from watching the resident, from the families, from the attending, and from me when we meet.

Your responsibilities are to be at your respective sites from 2-5 pm. You are welcome, if you wish, to go early at 1:15 pm to hear the attending lecture. In addition, please email me a brief paragraph or so each week about your experience. You can write about anything that intrigued you or that you had questions about. We will use your comments as springboards for discussion when we meet.

Thank you,

[Faculty Member]

SAMPLE TRAINEE INVITATION LETTER

Dear Residents,

Some of you may recall, we have a Student Interpreter Clerkship that has been ongoing for a number of years. The project pairs a first-year medical student who is a trained Spanish Interpreter with a resident who does not speak Spanish. The response from past residents who have participated has been very positive. The residents have obviously benefited hugely from having a trained fluent interpreter in the exam room. The clerkship has been wonderful for the students, who have learned a great deal from actively observing the medical visit and from listening to the residents' case presentation and preceptor teaching. The experience will serve as the medical students' clinical selective.

I will be their selective supervisor and will debrief their experiences with them. You will not be expected to teach the students – they are first years and will learn a huge amount from merely being a part of the clinical encounter. In fact teaching them is discouraged because it adds confusion to the role of interpreter. The students have been screened and trained by the volunteer interpreter services in the hospital.

I am wondering how many of you would be interested in participating this year. The students are only available [number of times] per week for about [number] weeks

Please let me know as soon as possible if you are interested. I will need to assign students to their sites next week.

Thank you for your prompt response.

[Faculty Member]

SAMPLE TRAINEE PARTICIPANT LETTER

Dear Residents,

Welcome to the Student Interpreter project. A student will be matched with you to serve as a [Spanish] language interpreter in your continuity clinic for 9-13 weeks. The student will be fluent in [Spanish] and will have received formal training as a medical interpreter.

I would like to stress a few issues that came up in previous years.

You are not expected to teach the medical students. The role of the students is to adhere as closely as possible to the medical interpreter role. It is confusing, for them and for the patient, to do this if they are going in and out of a student role as well as an interpreter role. The previous students learned a tremendous amount from being an integral part of the medical team and from the presentations to and feedback from the attending preceptor. Remember, these are first year students; they have had minimal experience in the medical setting and have a very steep learning curve. In addition, I will be meeting regularly with the students to debrief their experience.

By signing up for this program, I would like your commitment to use the student interpreters whenever [Spanish] is needed during your visits – not just during the difficult moments. You will be sacrificing your opportunity to practice your [Spanish] during this time; however, I believe you can learn a great deal of [Spanish] by listening to how your phrases are translated correctly into [Spanish]. In the past, some students felt that their training and skills were wasted if the resident used [Spanish] while they were there to help.

The enthusiasm about the project has been great from both the student and resident sides, and I think it's a wonderful program. I have copied the students' schedule below. In addition to their medical school schedule, they will occasionally have to leave early to meet with me. The students will start the week of [date].

The match up of students and residents is as follows:

[Chart with medical student and resident pairings]

Please feel free to contact me with any and all questions and concerns.

All the best,

[Faculty Member]

LANGUAGE IMMERSION LEARNING LUNCHESES

GOALS

- To provide a venue for trainees, faculty and staff to practice their conversational skills in the language(s) prevalent among the patient populations they serve.
- To provide a regularly-scheduled, comfortable and enjoyable opportunity to practice language skills on topics relevant to patient care.
- To strengthen relationships among clinic staff and trainees.
- To provide an opportunity for staff development in relevant health care topics.

RATIONALE

In order to deliver culturally and linguistically appropriate patient care, providers need to be able to communicate effectively with an increasingly diverse patient population. Language barriers can result in the loss of important information, misunderstanding of instructions and poor treatment adherence. Although translator services are the preferred way of dealing with Limited English Proficiency (LEP) patients, they are not always readily available. Furthermore, developing abilities in languages other than English is one way for providers to improve the patient-provider relationship. Language immersion learning lunches present convenient, comfortable and routine venues for the practice needed to maintain fluency. In addition, the lunches provide time for staff development on various primary care topics, with language practice related to that topic.

<u>CULTURAL COMPETENCIES</u>		<u>ACGME COMPETENCIES</u>	
<ul style="list-style-type: none"> • LANGUAGE DIVERSITY • DELIVERY OF CARE 		PATIENT CARE : 1a, 1b, 1e INTERPERSONAL AND COMMUNICATION SKILLS: 4a, 4b	
MATERIALS	<ul style="list-style-type: none"> • Food • Informational material related to the topic to be discussed (ideally in both languages) 	COSTS	<ul style="list-style-type: none"> • Food (cost is dependent on the number of participants)
TIME FRAME	<ul style="list-style-type: none"> • One to two hours per month, though the lunches could be held more frequently 	STAFF	<ul style="list-style-type: none"> • Staff who speak the selected language(s) to facilitate discussion • Faculty members or other qualified professionals to present health care topics

DESCRIPTION

The purpose of the language immersion lunches is to provide trainees with a regularly-scheduled opportunity to practice their language skills, especially in topic areas related to health care.

PREPARATION AND PLANNING

1. Determine which language(s) would be most helpful to practice, based on what many patients speak and what trainees, faculty and staff are already familiar with. It is possible to have multiple language groups rotating each week (e.g. Spanish in the first week, Chinese in the second week, French in the third week, etc.), or multiple groups meeting at the same time but in different locations.
2. Recruit lunch leaders who are fluent speakers of the language(s). If no one in the medical center or clinic speaks the selected language(s) fluently, community members who speak fluently could be invited to join the group (either as volunteers or paid).
3. Find a convenient place (preferably where people already gather for lunch) and time (once a month, twice a month, or weekly - whichever is preferred).
4. The first half of the hour of the lunch should be spent discussing a relevant medical topic in English geared to trainees' and clinic staff's needs. Then, participants can role-play a patient encounter relevant to the topic in the other language(s). Medical literature as well as a list of relevant vocabulary and phrases used in the medical encounter should be distributed beforehand.
5. Food arrangements need to be made for each lunch. Depending on available finances, the lunches could be catered, just drinks and/or dessert could be provided, or people could bring bag lunches.

EVALUATION METHODS

- A brief participant satisfaction survey may be administered periodically during the lunch series to identify areas for improvement.

SAMPLE LANGUAGE PRACTICE SET

Common phrases used during a doctor/patient encounter where the patient has: A Cold

Physician's questions during history taking

Does she have a runny nose/cough/ fever?

Have you given any medicines for the cold?

Have you given her any home remedies?

When did it start?

What is bothering you the most about this illness?

Physician's statements regarding treatment

I think she has a cold.

A cold is caused by a virus.

Antibiotics won't cure a virus.

When a child has a cold, the fever usually lasts 3-5 days.

Call us back if the fever is not going away after 5 days, or if she looks sicker.

SAMPLE INVITATION

Memo: [Spanish] Language Lunches
To: Clinic Staff
From: [Faculty]
Date: [Date]

We are planning to start a series of [Spanish] Language Learning lunches. The primary purpose of these lunches will be to improve the [Spanish] language skills of the pediatric residents. The first part of the lunch will be a presentation of a medical (usually pediatric) topic. We will then have a discussion in [Spanish]. We plan to hold the lunches in the conference/lunch room from 1:00 PM – 2:00 PM on the dates below.

Everyone is invited to come and participate as much or as little they like. Lunch (Chinese food) will be provided.

We will meet on the following Tuesdays: [dates]

Attached please find a list of topics for discussion. Please rank the topics according to interest and return the paper to me. Thanks.

Please rank the topics below from 1-7. Use 1 for the topic that interests you most, and 7 for the topic that interests you least.

- _____ Benefits of Breastfeeding
- _____ Infant Formulas – how to choose
- _____ Cold/Gripe – how to treat
- _____ Emergency Contraception – what is it?
- _____ Diarrhea and Vomiting in Children
- _____ Ear Infections in Children
- _____ Lead Poisoning

Topic Suggestions _____

HEALTH LITERACY TRAINING

GOALS

- To increase trainees' awareness of the impact health literacy has on the quality of care.
- To teach trainees how to assess the literacy levels of health education materials and how to appropriately rewrite materials that are too complicated for most patients to understand.
- To teach trainees communication skills that include health literacy techniques

RATIONALE

The strong association between literacy skills and overall personal health has substantial impact on all aspects of health care, ranging from severe financial burdens inflicted on patients and health care facilities to limited patient comprehension and improper disease management. Studies have shown that people lacking adequate health literacy skills- defined as having literacy skills at National Adult Literacy Survey (NALS) level 3 or below- have more difficulty processing health information, receive less preventive care, and use emergency services with greater frequency. Literacy difficulties become even more significant when dealing with patients who are both at a lower literacy level and have Limited English Proficiency (LEP). Strong stigmas are associated with low literacy and patients are often reluctant to express their inability to read or understand written instructions concerning dosing information, consent forms, discharge instructions, or other written documents. In addition, health education materials used by providers are not always appropriate to patients' reading and comprehension levels. It is therefore important that health care providers be prepared to identify, screen, and follow-up with patients who have low literacy, as well as offer appropriate health education materials.

DESCRIPTION

This health literacy training takes place in three parts. In the first activity, trainees read pertinent literature and watch two videos – an AMA video on health literacy¹ and a communication skills video that is produced locally. In the second activity, trainees observe their peers during a patient encounter using a communication checklist and then conduct exit interviews with both the patient and the trainee who was observed. In the third activity, trainees review a health education material distributed at their clinics, test the materials' readability levels and then rewrite the materials to make their literacy level more appropriate.

<u>CULTURAL COMPETENCIES</u>		<u>ACGME COMPETENCIES</u>	
<ul style="list-style-type: none"> • LANGUAGE DIVERSITY • DELIVERY OF CARE • ADVOCACY 		PATIENT CARE: 1a, 1b, 1e PRACTICE-BASED LEARNING AND IMPROVEMENT: 3c INTERPERSONAL AND COMMUNICATION SKILLS: 4a, 4b PROFESSIONALISM: 5a, 5c	
MATERIALS	<ul style="list-style-type: none"> • AMA Health Literacy video • Communication Skills video • Relevant readings • Health literacy materials used at the medical center • Exit interview forms 	COSTS	<ul style="list-style-type: none"> • Purchase of the AMA Health Literacy video

1 Health Literacy: Help Your Patients Understand. American Medical Association Foundation. March 2003.

PREPARATION AND PLANNING

ACTIVITY 1: VIDEOS AND READINGS.

1. Purchase the AMA Health Literacy video and show a communication skills video
2. Select appropriate readings about health literacy for trainees. Suggested readings include:

Schwartzberg, Joanne G, VanGeest, Jonathan, and Wang, Claire. Understanding Health Literacy: Implications for Medicine and Public Health. Chicago: American Medical Association, 2005.

Mayer, Gloria G., and Villaire, Michael. Health Literacy in Primary Care: A Clinician's Guide. New York: Springer, 2007.

Sapphire. PUSH: A Novel. New York: Vintage Books, 1996.

For more resources, see the Harvard School of Public Health's Health Literacy Studies Web site: <http://www.hsph.harvard.edu/healthliteracy/>

3. Have the trainees do the readings, watch the videos and then discuss the issues these raise.

ACTIVITY 2: PEER OBSERVATION AND EXIT INTERVIEWS

1. Assign a trainee to observe a colleague in a clinical encounter. Have patients sign a written consent form.
2. Have the trainee observe the clinical encounter and fill out a communication checklist.
3. After the observed clinical encounter, trainees do a patient exit interview, (a sample is included in this manual). The interview should not occur in the exam room – the waiting room or a conference room is often suitable options. It is critical that trainees reassure the patients that their answers are entirely confidential and it will not impact their care. Trainees should emphasize that the patient's answers are critical to improving the quality of care.

Trainee then interviews their observed colleague, (a sample is included in this manual), and shares the findings of patient exit interview, focusing on addressing any communication gaps.

ACTIVITY 3: REVIEW AND REWRITE OF HEALTH EDUCATION MATERIALS

1. Trainees choose a health education materials distributed at their clinic site. Trainees review the materials using the SMOG (Simple Measure of Gobbledygook) Test of Readability.² This test is most suitable for texts with more than 30 sentences. The SMOG test may be done manually (see below) or online at <http://www.harrymclaughlin.com/SMOG.htm>

SMOG Index Calculations³

1. Count the number of complex words (words containing 3 or more syllables).
2. Multiply the number of complex words by a factor of (30/number of sentences).
3. Take the square root of the resultant number.
4. Add 3 to the resultant number.

$$\sqrt{\text{total complex words} \times \left(\frac{30}{\text{total sentences}} \right)} + 3$$

2 Doak, C., L. Doak, J. Root. 1995. Teaching Patients with Low Literacy Level Skills. New York: J.B. Lippincott Co.

3 http://en.wikipedia.org/wiki/SMOG_Index

2. Once the readability levels of the materials are determined, trainees rewrite them in a way that is appropriate for the educational level of their patient population. Trainees may use the “Clear and to the Point: Guidelines for Using Plain Language at NIH” handout to guide them in rewriting their selected materials.

EVALUATION METHODS

- Trainees self-reflect on the outcomes of their exit interview using the playback checklist. This checklist may be discussed during the trainee’s monthly debriefing with their faculty preceptors.

SAMPLE PATIENT EXIT INTERVIEW

1. Was this your first time meeting this doctor?
2. Why did you bring your child to the clinic?
3. What did the doctor tell you she/he had?
4. Did the doctor answer all the questions you had?
5. What instructions did the doctor give you?
 - a. Meds: dose, mode of administration, storage, duration
 - b. Anticipatory guidance
 - c. Referrals: who calls to get the appointment, where is it, and what it is for.
6. Did the doctor give you any written materials?
 - a. Can you read them?
 - b. Do you understand them?
 - c. Do you find them useful?

SAMPLE TRAINEE EXIT INTERVIEW

1. What was the reason for the visit?
2. What was your diagnosis/assessment?
3. What were instructions given?
 - a. Medications
 - b. Referrals
 - c. Anticipatory guidance
4. If you gave written materials, do you think the patient understood them and will use them?
5. How well do you think the parent understood the information given?

ADVOCACY

Trainees will advocate for public policies and programs that promote and support culturally and linguistically responsive services and the inclusion, representation and participation of individuals who reflect the diversity of our communities.

SERVICE LEARNING

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SERVICE LEARNING

Service at Community-Based Organizations and Resident Advocacy Projects

GOALS

- To involve trainees in service learning opportunities that contribute to their development as culturally-competent providers
- To engage trainees in the surrounding community by using the “community as teacher”
- To strengthen community-academic partnerships

RATIONALE

Service learning is a “structured learning experience that combines community service with preparation and reflection. Students engaged in service-learning provide community service in response to community-identified concerns and learn about the context in which service is provided, the connection between their service and their academic coursework, and their roles as citizens.” As trainees engage with the local cultures, community-based organizations and community leaders, they better understand the contexts in which the service is delivered. The collaboration with and deeper understanding of communities that comes through service learning is a key way to improve the cultural competency of trainees. Furthermore, service learning activities fortify community-academic partnerships. Community-academic partnerships provide a way to address health disparities; the university serves as a source of academic knowledge and research, while the community serves as a source of cultural knowledge. Community-academic partnerships help bridge the gap between these two types of knowledge.

DESCRIPTION

Service learning is a multi-step process. The steps are summarized in the following chart and described in more detail below.



<u>CULTURAL COMPETENCIES</u>		<u>ACGME COMPETENCIES</u>	
<ul style="list-style-type: none"> CROSS-CULTURAL KNOWLEDGE DELIVERY OF CARE ADVOCACY 		PATIENT CARE: 1b, 1h, 1i PRACTICE-BASED LEARNING AND IMPROVEMENT: 3c INTERPERSONAL AND COMMUNICATION SKILLS: 4c PROFESSIONALISM: 5a, 5c SYSTEMS-BASED PRACTICE: 6a, 6d, 6e	
PREPARATION	<ul style="list-style-type: none"> Build partnerships in order to set the stage for service learning to occur (see details below) 	COSTS	<ul style="list-style-type: none"> Annual community partners appreciation breakfast Salary support for CBO staff/community liaison Cost of curriculum materials for trainees
TIME FRAME	<ul style="list-style-type: none"> Service learning is longitudinal, with the time frame determined according to trainees' and community needs 	STAFF	<ul style="list-style-type: none"> Faculty to supervise trainees Participation of staff from community-based organizations Community liaison

PREPARATION AND PLANNING

- For a service learning (SL) program to be effective, community-academic partnerships must be established and trainees must be prepared for the experience:
 - Connections must first be established with community-based organizations (CBOs). Suitable CBOs need to be identified; possibilities include schools, social service agencies, domestic violence programs, mobile medical vans, Head Start centers, parenting groups, WIC, lactation support programs, after-school programs, youth services, etc. Developing partnerships with these CBOs takes significant time and effort; detailed methods for this process are described in the article from Academic Medicine included in this section.
 - Trainees must be prepared to participate in the service learning experiences. This may be achieved by providing trainees with some content (i.e. news articles about the community, profiles of CBOs, journal articles about health disparities and/or particular problems prevalent in the community, demographic and epidemiological data). It is also important to put the service learning within the context of the larger curriculum by explaining to trainees how service learning experiences are beneficial to their development as culturally-sensitive clinicians.
 - Just as you need to prepare trainees for service learning, you need to prepare the CBO staff to help with medical education of trainees. Participating CBO staff should be empowered to share relevant local health beliefs, their view of the medical culture, and the history between community and academic medical center.
- Once partnerships are established and both CBOs and trainees are prepared, service learning activities can

begin:

a. SL experience within a residency program:

Due to the schedule structure that exists in a residency program, it is very hard for trainees to have a longitudinal SL experience within one agency. At CUMC we created the following SL experiences:

- CBO Visits
 - a. Trainees visit various CBOs throughout their training. When possible, trainees return to the same CBO year after year. The schedule is established in such a way that the CBO knows that they will be having a trainee a specific day of the month throughout the year, even though the specific trainee changes block by block. Trainees make two visits to each CBO. On the first visit, trainees meet the staff and learn about what the CBO does and the services it provides. For example, at CUMC trainees' visit to Best Beginnings, a home-based child abuse and neglect prevention program, trainees meet with family support workers and participate in a case conference. During the first visit trainees and CBO staff jointly determine an appropriate activity for the trainee to do on the second visit, such as a health education presentation. Trainees then carry out the determined activity on their second visit. Trainees may make subsequent visits if it is so desired. It is important to debrief and reflect after each CBO visit. This can be done through one-on-one meetings with faculty, group sessions or through written or online evaluation forms.

- Group longitudinal and individual advocacy projects mentored by community members and faculty:
 - a. Group longitudinal projects: All trainees can participate in these communal projects, with faculty serving as the backbones of the projects. Trainees with the guidance of faculty and community liaisons select a problem or issue in the community that would be appropriate for an advocacy project. Examples include lobbying for legislation that would help combat obesity, advocating for increased services for mothers with post-partum depression, or establishing local programs for injury prevention. Projects should be culturally-competent and based upon needs assessments and epidemiological data of the community. Trainees are mandated to work a few half-days for a period of a month on the project. After his or her month is up, the trainee signs out the project to the next trainee, updating him or her on the status of the project and what next steps need to be taken. This "pass-it-along" method allows the project to be sustainable and tailored to community needs. However such a method can sacrifice trainee buy-in, and if it is not supervised well, could become logistically difficult or disjointed.

 - b. Individual projects: In this model, each trainee selects an advocacy project they will work on themselves throughout their training. Just like the group longitudinal projects, individual projects must be supervised by a faculty member and a community liaison and based on the needs and culture of the community. One example from CUMC was the development of a culturally-relevant cookbook of healthy recipes contributed by community members. Examples of successful individual advocacy projects can be found on the American Academy of Pediatrics' Community Pediatrics Training Initiative web site: <http://www.aap.org/commpeds/grantsdatabase/grantsdb.cfm>. The individual model may also be adapted so that trainees could work in pairs or small groups.

b. Short group community service experiences:

- These may be incorporated at any point during training as half or full-day service projects. At CUMC, medical students participate in such projects through a program called Team WoRx funded by the Arnold P. Gold Foundation, during their transition period between the second and third year. Appropriate projects in the community include housing repairs, painting, making a mural, rehabilitating a playground,

community gardening, reading to children in an after-school program, or volunteering in a preschool or daycare center. The community service sites can be at partner CBOs or can be sites completely different from those used for service learning visits. Nonetheless, sites should be selected by community liaisons and faculty

TIPS

- For more information on use of service learning in the health professions, visit <http://depts.washington.edu/ccph/servicelearningres.html>

EVALUATION METHODS

- Reflection cards (either written or completed online) are the primary evaluation tool for CBO visits.
- CBO staff members also evaluate trainees using a brief survey of trainee performance. Completed surveys are then given to the faculty.
- Community-academic partnerships are evaluated annually through a survey completed by CBO staff members at the annual community partner appreciation breakfast. A sample is included in this manual.

SAMPLE TRAINEE REFLECTION CARD

Name:

Site:

PGY:

Did you attend as scheduled? Yes No

Did someone from the site expect you and orient you to the session's activities? Yes No

Were activities done as scheduled (talks, classes)? Yes No NA

If no, explain why:

Describe one thing that you learned at the site:

Describe one way you can apply the knowledge/skills learned into patient care:

SAMPLE TRAINEE EVALUATION SURVEY QUESTIONNAIRE

COMMUNITY PARTNER RESIDENT EVALUATION

Name of Evaluator: _____

Name of Resident: _____

Instructions: On the scale below, please circle the number (1-5) that best describes your rating of the resident's performance for each item. Your answers will help the Community Pediatrics program to evaluate the resident's progress and to better understand the strengths and weaknesses of the Community Pediatrics residency training program overall.

Please rate the **Resident's Participation** in the following areas:

	Poor		Good		Excellent
1. Willingness to listen and learn from leaders/staff at your organization?	1	2	3	4	5
2. Interest in learning about your organization's goals, programs and services?	1	2	3	4	5
3. Interactions with the staff to meet the needs of your clients?	1	2	3	4	5
4. Interest in actively participating in group case discussion?	1	2	3	4	5
5. Overall contribution to your organization's service goals?	1	2	3	4	5
6. Open-mindedness, sensitivity and responsiveness to issues of culture and ethnicity?	1	2	3	4	5

Please rate the **Resident's Presentation** in the following areas:

Topic(s) of Talk or Discussion: _____

	Not at all		Somewhat		Very
7. How informative was the resident's presentation?	1	2	3	4	5
8. How easily understood was the presented material?	1	2	3	4	5
9. How useful was the presentation for the audience?	1	2	3	4	5
10. How well-organized was the presentation?	1	2	3	4	5
11. How well did the resident engage the audience and promote discussion?	1	2	3	4	5

Additional Comments (please continue on reverse if necessary):

SAMPLE COMMUNITY PARTNER SATISFACTION AND FEEDBACK SURVEY QUESTIONNAIRE

Name of Organization: _____ Date _____

Your Name: _____

Your Title or Job Description: _____

The Goals of the Community-Academic Partnerships Are:

1. To increase pediatric residents' knowledge of community resources and skills relevant to community pediatrics, and to foster a community-minded attitude through observation and interaction with community members and staff at your organization.
2. To provide a needed service at your agency (to your clients, staff, or others).
3. To create a working relationship between the Medical Center and the community (through the Community Pediatrics program and your organization).

Instructions: For each of the statements below, please indicate how much you agree or disagree by choosing the appropriate number based on the following scale:

Strongly Disagree 1	Disagree 2	Mixed Feelings 3	Agree 4	Strongly Agree 5	Not Applicable NA	Can't Answer/ Don't Know DK
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(Disagree)----->(Agree)

- | | | | | | |
|--|---|---|---|---|---|
| 1. In the past year, activities with the pediatric residents have usually happened as scheduled.
NA DK | 1 | 2 | 3 | 4 | 5 |
| 2. Scheduling and arranging for the residents' visits is usually easy to accomplish.
NA DK | 1 | 2 | 3 | 4 | 5 |
| 3. At our site, the staff teach residents knowledge and/or skills which are important for them to know as pediatricians.
NA DK | 1 | 2 | 3 | 4 | 5 |
| 4. The residents are interested in working with the staff.
NA DK | 1 | 2 | 3 | 4 | 5 |
| 5. The residents are interested in learning from the staff.
NA DK | 1 | 2 | 3 | 4 | 5 |
| 6. Our organization benefits from the residents' time at our site.
NA DK | 1 | 2 | 3 | 4 | 5 |
| 7. Working with the residents is worth our time and effort.
NA DK | 1 | 2 | 3 | 4 | 5 |

8. Our staff is interested in working with the residents. 1 2 3 4 5
NA DK
9. Our staff is interested in learning from the residents. 1 2 3 4 5
NA DK
10. Our organization has input into how the goals of the partnership (as above) are met at our site. 1 2 3 4 5
NA DK

11. Overall, does working with the residents help your program/organization? Yes No
If yes, how does it help? If no, why not?

12. Do you have other goals for the partnership that are not currently being addressed? Yes No
If yes, please describe:

13. Would you like to continue working with the Community Pediatrics program? Yes No
If yes, what else could we do to keep this partnership going? If no, why not?

Additional Comments:

THANK YOU!

If you have any questions about completing or returning this survey, please contact [Name], Community Pediatrics Program Coordinator at [phone number] or by e-mail at [email].

How a Community-Based Organization and an Academic Health Center Are Creating an Effective Partnership for Training and Service

Dodi Meyer, MD, Anne Armstrong-Coben, MD, and Milagros Batista, MSW

Abstract

Community-academic partnerships in the training of doctors offer unique learning opportunities of great importance. Such partnerships can induce a paradigm shift such that physicians view community as a teaching resource and partner rather than as a passive recipient of services or solely as a placement site.

The authors describe a model of a community-academic partnership in New York City, begun in 1995, in which, for training and service, pediatric residents are integrally involved in a community-based program. Principles adapted from the Community-Campus Partnerships for

Health's principles of partnership provide a framework for portraying the essential elements of developing and maintaining the partnership. The authors explain the clashes that may arise between partners and show how the principles of partnership guide partnership members in working and learning within a setting that by its nature entails conflict and inequality.

This report is based on the knowledge gained from the structured reflections of both members of this partnership: the residency program at a large academic health center and the community-based social service organization. Such partner-

ships provide the training ground for the development of physicians who understand the social and cultural determinants of health and constructively use community agencies' input in promoting child health and well-being. Within this framework, community-based organizations are not solely service providers but become educators of physicians-in-training who, with new knowledge gained through the partnership, more effectively contribute to the overall health of the communities they serve.

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The origin of pediatrics as a specialty began with practitioners training in community settings. However, over the years, education for practice shifted to the university and its teaching hospitals.¹ In the mid-20th century, community medicine was based on a concept of the community as a patient to be diagnosed and treated.² However, at that time, the idea of a partnership between a medical center and a community-based organization, by which both direct services and service-based learning could be mutually negotiated and ongoing, had yet to be developed, even though such a partnership would be beneficial for both the educa-

tion of professionals and the health of target populations.

The partnership concept emerged later. Numerous programs were—and continue to be—created to enhance the training of physicians in community settings.^{1,3-5} As stated in *Bright Futures: Guidelines for Health Supervision of Infants, Children, and Adolescents*, published by the National Center for Education in Maternal and Child Health, optimal health depends on a trusting relationship in which the health professional, the child, the family, and the community all become partners in health care practice.⁶ The development of community-academic partnerships in the training of doctors offers unique learning opportunities of great importance. Such partnerships can induce a shift to a paradigm in which physicians view a community as a teaching resource and partner rather than as a passive recipient of services or solely as a placement site. They also provide the training ground for the development of physicians who understand the social and cultural determinants of health and appreciate the input that community agencies can have in promoting child health and well-being. However, the partnerships between academic institutions and community-based

organizations can also give rise to tensions and conflicts that must be confronted.

In this article, we describe a model of a community-academic partnership in which, for training and service, pediatric residents are integrally involved in a community-based program. This partnership began in 1995. The partners are the pediatric residency program at a large academic health center—the Children's Hospital of New York Presbyterian at the Columbia University Medical Center (CHONY)—and Alianza Dominicana, a community-based social service organization, both located in Washington Heights in northern Manhattan, New York City. "We" are the director of the community pediatrics training program (DM), a Columbia faculty member with an expertise in curriculum development (AA-C), and the co-founder of Alianza Dominicana who is also the community liaison for the community pediatrics training program (MB). Our article's content represents both partners' perspectives. In developing this academic-community partnership, we have adapted the Community-Campus Partnerships for Health's principles of partnership⁷ and will refer to them in describing the partnership and its successes and chal-

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allenges. We will describe four of these principles whose applicability has been substantiated in the CHONY–Alianza Dominicana experience. These principles, in fact, have proved essential in creating a productive community–academic partnership. They are implemented within a context characterized by three dimensions of power and inequality: (1) the institutional dimension, extending between a large research university and a grassroots organization, (2) the professional dimension, spanning physicians at one end and community activists and workers at the other, and (3) the ethnic and socioeconomic class dimension, ranging from mostly white upper-class physicians to minority working-class community members.

We will portray the clashes that arose between the partners and show how the principles of partnership guide the members of this partnership in working and learning within a setting that by its very nature entails conflict and inequality. Residents' experiences in a true partnership, in which tensions and disagreements are openly probed and examined rather than ignored, as occurs typically in a hierarchical relationship, will be described as a critical part of the successful training of residents. Their exposure to such a partnership provides a basis for the development of knowledge, skills, and attitudes necessary to become a competent community pediatrician.

This report is based on the experiences accumulated during the past nine years since inception of the program and the knowledge gained from the structured reflections of all members of this partnership. Such reflections have been elicited at monthly debriefing sessions with the residents and biannual focus groups with community partners.

The Community and the Partners

Washington Heights

At the time of the 2000 census, 208,328 people lived in the New York City community of Washington Heights. Of this total, 74% were Latino, of whom 72% described themselves as Dominican.⁸

Most of this community's Latino immigrants come from rural areas and are working class. The community is economically disadvantaged, with 77.3% of children born into poverty, according to

1999 data; the comparable New York City average was 53.2%.⁹ Nevertheless, this is a vibrant community with multiple assets, including numerous community-based organizations (CBOs) addressing the diverse needs of the people in the community.

CHONY's pediatrics residency program

Community pediatrics has become a key part of the pediatric residency program at Children's Hospital of New York.

CHONY, a 256-bed pediatric hospital founded as Babies Hospital in 1887, is part of the Columbia University Medical Center, a large, highly ranked academic medical center. It trains an average of 60 residents, two chief residents, and 76 fellows each year. In 1998, the residency program was restructured to give greater emphasis to primary care. As a result, residents now spend 25% of their time delivering primary care in one of five hospital-affiliated, faculty-run, community-based practices. These practices are where residents' continuity clinic experiences occur. The community pediatrics program is mandatory for all residents and is integrated into all three years of training. Most of the community pediatrics training experiences take place outside of the clinical setting—they occur within the community under the auspices of the community agency and do not involve traditional clinical work. These experiences will be described later in detail. The general pediatrics faculty are the core teachers for the residency training program; 30% of them lead the efforts of the community pediatrics training program.

Alianza Dominicana

Alianza Dominicana, Inc., founded in 1982, is the largest nonprofit community development and social service organization in northern Manhattan and the Bronx, with an annual budget of over \$12 million and more than 350 full-time and part-time staff. Annually, Alianza serves more than 17,000 individuals throughout the City of New York. To address the community's multiple and complex needs, Alianza has developed dozens of innovative neighborhood-based initiatives. The organization currently provides services of more than 20 distinct types, including multidisciplinary cultural activities, neighborhood economic development projects, employment and training programs, family-focused and youth development projects, as well as health and

mental health services. Alianza has become the leading national authority on Dominican immigrant communities and is considered a pioneer in many program areas. It has served as a catalyst to the development and creation of many programs and initiatives of both local and national scope.

The Partnership

The relationship between the Department of Pediatrics and Alianza Dominicana began in 1994, when these two groups joined together with the New York Society for the Prevention of Cruelty to Children to create a service called Best Beginnings. Best Beginnings is a voluntary, home-based service for high-risk expectant families and new parents that employs community workers to promote optimal child health and development, prevent child abuse and neglect, support positive parent–child bonding and relationships, and enhance parental self-sufficiency.¹⁰ This program is based on the Healthy Families America model.¹¹ Best Beginnings provided the foundation for a partnership to be created between CHONY's pediatric residency program and Alianza Dominicana in 1995. Initially, Best Beginnings was physically based in Alianza Dominicana's community home, but to improve the model, the program decided a "medical home"¹² was needed for all enrolled babies and families. A community-based practice affiliated with CHONY was located two blocks from Alianza's headquarters and the pediatric faculty practicing at this site committed to providing the much-needed "medical home." Fifteen percent of the hospital's pediatrics residents received their primary care training at this site and became the primary care providers for babies enrolled in the program. Currently all 60 CHONY residents participate in various programs offered at Alianza Dominicana, where a productive partnership for service, education, and training has developed.

The Training Experience

The overall goal of the community pediatrics training program is to prepare pediatric residents, upon completion of their education and training, to relate to, be advocates for, and remain committed to the community and the children for whom they care. The curriculum organizes residents' educational and training

experiences to enable them to achieve competency in three categories: community health, cultural competency, and advocacy. The overarching methodology used to achieve these goals is service-learning. In service-learning, community partners are integrally involved in the design, implementation, and evaluation of the curriculum so that the academic goals are aligned with the service needs. The model stresses an approach that builds from the communities' self-perceived assets rather than from outsider-perceived deficits. It emphasizes the value of reciprocal learning between residents, community partners, and multidisciplinary academic faculty. Structured reflection on these experiences and on specific objectives ensures that the experience meets programmatic and educational goals for the residents.

A critical prerequisite of service-learning is a mature community-academic partnership, one in which the partners can resolve major differences for the sake of the program. Through the partnership, residents not only provide service but also learn about the context in which the service is provided, the connection between the service and their curriculum, and their roles as citizens.¹³ The critical elements of the partnership are the establishment of institutionalized mechanisms for interaction and dialogue between—in this case—the community pediatrics program and the community-based organization, significant community participation in program development and

implementation, and provision of an arena for changing stereotypes and misperceptions. The pediatrics residents are taught the skill of reflective practice whereby structured reflection on their experiences in the community-based organization facilitates the connection between practice and theory and fosters critical thinking. In addition, this program addresses community-identified needs through the integral involvement of community partners.

Initially the partnership's focus was on health care delivery, providing primary care for all children enrolled in Best Beginnings. Integrating a focus on residents' education and service came as a second step. All residents now provide service at Alianza Dominicana. During their first-year ambulatory block rotation, residents receive an introductory session from a community pediatrics faculty member where the purpose of the program and the residents' roles as teachers and learners in a community agency are described. Residents then go to the Best Beginnings facility to learn about the program's services, meet the family support workers, and participate in a case conference. Together with the family support workers, residents choose a health care topic to be discussed at their scheduled visit during their last week of the rotation. Throughout this block, residents join support workers in home visits of newborns enrolled in the program. During their second year, residents return to the program to teach prenatal classes to expectant

mothers. They also participate in monthly "narrative medicine" sessions with agency staff, which will be described later in detail.

Principles of Partnership

The four principles of partnership described below provide a framework for reflecting on our partnership. They portray the essential elements of developing and maintaining the community-academic partnership between the CHONY residency program and Alianza Dominicana. Each principle is based on critical concepts described below; see Table 1 for a summary of the principles and these concepts.

Principle 1: Build a relationship between partners characterized by mutual trust, respect, genuineness, and commitment.

Although most residency programs in pediatrics use many community sites as training grounds, we at CHONY decided to embrace the richness and depth that come with establishing a partnership with a single community agency. Our relationship with Alianza Dominicana took years to develop in an ongoing, labor-intensive process. It offers an incredible array of opportunities for all parties involved. Different areas of our curriculum are taught within this agency: domestic violence, cultural competence, and early childhood support. While enjoying the commitment to one partnership, we have had to struggle with the discontent that

Table 1
Principles of Partnership*

The principles	Critical concepts	Outcomes
Build a relationship between partners characterized by mutual trust, respect, genuineness, and commitment.	<ul style="list-style-type: none"> • Partner with one institution • Establish personal relationships between leaders • Foster awareness of stereotypes 	<ul style="list-style-type: none"> • Strong commitment • Reversal of stereotypes
Build agreement on mission, values, and goals for the partnership.	<ul style="list-style-type: none"> • Negotiate agendas • Embrace partners perspectives • Respond to community-identified needs 	<ul style="list-style-type: none"> • Awareness of shared mission • Integration of training and service
Balance power and share resources among partners.	<ul style="list-style-type: none"> • Exchange complementary resources between partners • Foster active participation of community in program development 	<ul style="list-style-type: none"> • Creation of a zero-sum situation • Ability to take advantage of community assets
Create an open, accessible communication between partners, and develop a common language	<ul style="list-style-type: none"> • Share knowledge about the other partner • Recognize and accept different perspectives 	<ul style="list-style-type: none"> • Clarification and redefinition of perceived roles of partners • Improved relationships

* These principles of partnership between community-based organizations and academic health centers, and the critical concepts upon which they are based, have been shown to foster positive outcomes, as described in the text.

this brings to other agencies in the community and to those individuals within the hospital system who for political reasons are not comfortable with our agency of choice.

Our relationship and perceptions of one another have evolved over time. Initially, the university faculty was perceived as the “Ivory Tower,” arrogant and all-knowing, as our community liaison reported. There was mistrust of the university’s intentions, the community seeing itself historically as being poorly served or having its members exploited as subjects of research. Faculty did not trust the community members’ ability to understand the culture of the medical center and its training methodology. They viewed the community as impoverished and lacking in resources and knowledge, and rarely acknowledged the community’s assets and strengths. As a first step there was a fundamental need to change these perceptions, for they created barriers to working together to improve children’s health.

Although the institutions in our partnership had a formal partnering relationship for the Best Beginnings program, it was of critical importance that a pediatrics faculty member committed to community child health and a leader at Alianza Dominicana involved in women’s and children’s issues were able to engage on a personal level and share the commitment to the educational endeavor. The latter leader, a social worker, became the community liaison for the community pediatrics training program and now has a faculty position within the Department of Pediatrics. As the partnership evolved, members of Alianza Dominicana have had to respond to the community’s hesitation and mistrust of having one of its leaders work within the medical center. Questions of loyalty arose that put the university and the community in opposite camps. Pediatrics faculty had to withstand criticism from within the university about their bringing outside agencies to participate in physicians’ training. For example, members of the hospital’s Department of Social Work expressed anger that one of their own staff was not fulfilling the role of community liaison. The faculty member and the community liaison conducted a painstaking, slow process of confronting both residents and community workers with their own biases and misperceptions and with the

negative consequences of holding to stereotypes.

An essential outcome of this personal relationship was its clear, emphatic message to all participants that a genuine collaboration would facilitate all participants’ work and maximize community health. This message was conveyed through workshops and with in-depth training led by the community liaison and a pediatrics faculty member.

Through this process community workers gradually took on leadership roles within the community pediatrics program, allowing them to share with residents their own health beliefs and perceptions of the medical center. For example, a dialogue about the prevalence of home remedies used in the community developed. Community workers encouraged patients to share with physicians their use of complementary and alternative medicine. As a result, pediatrics residents developed a booklet of the most common home remedies used in the community, their known efficacy, and their side effects. The booklet is now given to incoming interns during orientation week when interns visit a local “botanica” as part of their introduction to the community. The goal is to apply this knowledge in the patient–doctor encounter.

The residents now perceive community workers not only as service providers but also as their educators, whose input and beliefs they value. Our community liaison rotates through the continuity clinic and gives noon lectures to residents on topics related to community health. She then acts as a co-preceptor to whom residents can present cases for comment. Through such experiences residents come to understand the importance of the community context in child health. They become willing to leave the hospital walls not only for service but to enhance their own education. In turn, this has allowed community members to demystify physicians and value them as peers.

Principle 2: Build agreement on mission, values, and goals for the partnership.

The original individual mission of both the community pediatrics program and Alianza Dominicana was to serve the community in an integrated way, viewing the family in its totality and offering high-quality services. However, it was

necessary to bring both partners to a full awareness of their shared mission. This allowed the community pediatrics program to embrace the community’s perspective and Alianza Dominicana to incorporate physician training and medical services into their programs.

Best Beginnings, as noted, understood the importance of offering a “medical home” to all babies enrolled in the program. The medical practice located near Alianza Dominicana offered primary care services. Each resident assigned to continuity clinic at this site (nine out of 60 residents) was assigned a baby, performed a newborn home visit with the family support worker from Best Beginnings, and then followed this baby throughout the three years of training. Based on positive feedback from both partners, all 60 residents now go to Best Beginnings twice: once to learn about the program and participate in a case conference, and the second time to give a health education talk to the family support workers. This offered Best Beginnings a unique opportunity to enhance the medical knowledge of their workers and at the same time to allow the family support workers to share with the residents their local health beliefs and practices related to topics of interest. The goals and objectives both for residents and for the community workers at Best Beginnings evolved over time. The partners needed to negotiate agendas and be open to changing them, always giving preference to the community’s needs rather than those of the training program. Though fearful of overwhelming the practice, the practice administration committed to accepting all Best Beginnings’ babies and their siblings for primary care services because this fulfilled both partners’ missions. While the training program would have benefited greatly from having all residents at all practice sites partake in the medical home portion of Best Beginnings (i.e., newborn home visit and three years of continuity of care), this was not feasible for the Best Beginnings staff or the families involved in the program. However, the community pediatrics faculty recognized the educational value of this experience and therefore arranged for all residents practicing at the other hospital-based, community-based practices to perform a newborn home visit with a Best Beginnings family support worker without becoming the child’s primary care provider.

As we defined our goals, we realized that it is complicated to meet the inherent demands of each partner in terms of time and continuity of experience. Community needs are addressed over a long period of time, while an individual resident's training is a brief window within the community's life. Taking this into account, we came to define our goals as follows:

- To provide needed services—for the most part, health education and anticipatory guidance at the community site to maximize the health of participants and/or staff
- To enhance residents' knowledge and skills in working in community settings with diverse populations
- To foster and strengthen a working relationship between the medical center and the community
- To ensure and develop an informed, community-sensitive "medical home" for the Best Beginnings target population

Principle 3: Balance power and share resources among partners.

The balance of power is key to a thriving relationship free of resentment and misunderstanding. This is hard to establish in a situation in which structural imbalances of resources and power are inherent.¹⁴ Broadly speaking, the communities in which residents train often are underserved, impoverished, and culturally diverse. These factors add complexity to establishing partnerships, sharing decision making, and allocating resources. Elements that contribute to the academic health center's power and resources are physicians' salaries, which are almost double those of leaders in community-based organizations; power and prestige associated with faculty appointments; control over grants where the university is the leading agency; and control of local real estate. Elements that contribute to the community's resources and power include grassroots social service agencies; human resources; knowledge of the community's culture, strengths, and needs; and trust bestowed on the CBO by the community.

In our particular partnership, these varied resources allowed for an exchange between the partners. The partnership generated a zero-sum game, moderating the imbalance of resources and promoting a shift towards optimal use of the

partners' complementary assets to attain common goals. Seven years after Best Beginnings' creation, Alianza Dominicana became the lead funding agency for this initiative; a board of directors was created with equal representation of all parties involved.

Often universities approach CBOs for letters of support attesting to collaborations in order to obtain grant funding, frequently having no history of a partnership and having little intention of truly involving the CBO in the program design and implementation. As a result of the positive experience of the partnership with CHONY described here, Alianza Dominicana now does not get involved in any collaboration or partnership unless the benefits are clearly defined from the outset. Unfortunately, although much of the community pediatrics faculty feels they have come to understand this, the community liaison must continually teach them what community participation in this process should be.

In the community pediatrics training program, the community liaison was integrally involved in curriculum design, implementation, and evaluation. For example, it was the community liaison who initially advocated including training in domestic violence screening as part of our maternal child health curriculum unit. The community pediatrics faculty were reluctant at first, as it was an area where the faculty themselves lacked competency. The liaison's knowledge that our community had the highest rates of homicide due to domestic violence in New York City made the university partner realize the need to create a curriculum that incorporated both the community and the hospital perspectives on domestic violence and begin intensive faculty development in this area. Both a community member and a pediatrics faculty member are now part of a hospital-wide initiative to review our domestic violence screening and referral practices in all pediatric settings.

The family support workers benefit from a hospital ID and library access. Representatives of the CBO participate in scholarly activities, give lectures, participate as professional equals in workshop settings and national meetings, and share authorship on publications. Historically, the faculty had never considered including the community members in these

"academic" endeavors because of perceptions that the community members did not belong side by side with educators in these venues. The community partner's open and abundant sharing of knowledge about the culture and values of the patients from the community has helped make the faculty and residents more responsive to patients' and families' needs. The residents' exposure to family support workers has allowed them to gain an appreciation of their impact on children's health and well-being.

Principle 4: Create open, accessible communication between partners and develop a common language.

Community-based education takes the resident into someone else's territory. This experience can be humbling to residents, who are often struggling to develop an identity within a traditional model where doctors carry a sense of entitlement in the hospital setting. On the other hand, community members now empowered to participate in physicians' training need to be sensitive to the issue of "MD bashing," that is, anger sparked by the community's view of the medical center expressed in such a way as to make residents defensive and unwilling to participate in training. Furthermore, overworked and overcommitted residents may feel they are already giving everything they can in serving their patients. Asking them to learn about patients' culture and health beliefs may generate anger and frustration. Thus, the emphasis has to be on teaching them the skills to elicit patients' perspectives rather than on learning facts about practices of other populations.¹⁵

This principle has been key on many levels, and its importance recognized more and more over time. Our faculty, residents, and community members are often from markedly different backgrounds. Recognizing such differences from the onset of our partnership and reminding ourselves of our common goals prevented the demise of a potentially fruitful relationship.

Preparation for the encounter between all parties involved in the educational process is vital for success. To create a common language, we developed forums for doctors and community members to talk about cultural differences in an open and respectful dialogue. An example is our "Narrative Lunches" activity—a venue

where community workers, residents, and faculty discuss cultural clashes that occur in a medical narrative. In preparation for such meetings, all participants read a designated chapter from Anne Fadiman's book *The Spirit Catches You and You Fall Down*,¹⁶ that describes the colliding worlds of Western medicine and Hmong culture. With a community worker and a faculty member as moderators, participants are encouraged to describe real-life encounters involving cultural clashes. One of Fadiman's chapters focuses on the topic of the medical world's reporting the child's family to the state's child welfare system. Extensive, emotional discussions have occurred during the Narrative Lunches devoted to this chapter. The Best Beginnings staff felt that families from the community were often reported for unjustified reasons and spoke of instances where families suffered great burdens as a result of such reports. Residents explained their professional obligation and possible loss of medical license should they not report when appropriate. There is now a better understanding of this process—the roles and obligations of the medical staff on one side and the sequelae to a child and family should a report be unjustified. Residents now include the staff from Best Beginnings as a resource in helping to make decisions of when and when not to report a family, and the family support workers are more respectful of the medical staff's decision in such cases.

An early need was for community members to learn the hierarchy of who's who within medical training. For example, it was important that they understand that interns are recent medical school graduates and are unaware of the long-standing tensions between the community and the medical center. Lacking such awareness, interns at a community site might feel threatened and discouraged by the "MD bashing" to which they are exposed. Where residents were perceived as disinterested or bored at times, there is now more empathy from the CBO staff who recognize the residents' yawns and tired appearance as a possible byproduct of their schedules at the hospital.

Pediatricians in training need to know who the family support workers are—women from the community trained to work with, and be advocates for, the families the partners serve. Emphasis is placed on the role of agencies in maxi-

mizing the health and well-being of the patients we serve and on the learning value of spending time in community agencies in an educational rather than a clinical role. Without this understanding, residents question the value of community-based education, and often become angry when they feel that their "doctoring" skills are not being utilized.

Outcomes

To assess the impact of our program, four years ago we developed two qualitative instruments: biannual in-depth semistructured interviews with our community partners and monthly written "reflection cards" (described below) for evaluating the self-reported educational impact of community experiences on our residents.

Semistructured interview with community partner

When interviewed, the program directors at Best Beginnings agreed that all goals were being met by the ongoing activities; they wanted the partnership to continue and believed the program was benefiting from it. At Best Beginnings, residents' participation in the case discussions and monthly Narrative Lunches with the family support workers were regarded as important contributions to staff development. Staff education was seen as a way to improve service to clients. "Staff can now reinforce basic medical knowledge about child health care issues during the home visits made by the family support workers." For example, when discussing families' expectations versus actual medical practice in the treatment of upper respiratory infections, family support workers can explain to mothers why antibiotics are not effective, avoiding an emergency room visit or a visit to another provider. The personal relationships between medical providers and family support workers have changed over time. As a result of sharing their own personal stories regarding their childhood experiences and paths to becoming doctors, residents have become demystified as physicians and valued as colleagues and peers. This creates an atmosphere in which all parties can learn from one another. Reflecting on the Narrative Lunches and residents' role, a family support worker stated: "They had very good communication skills and delivery style. They were modeling how to discuss in a composed way. Not like us, all emo-

tional." The improved relations have a direct impact on patient care. As a CBO staff member said, "To treat me you need to know me." Family support workers have open access to medical providers, are familiar with the clinical setting, and can be advocates for improved services to meet families' needs. Although not predicted at the outset, each resident's involvement in Best Beginnings is fulfilling a state requirement for staff development and cultural competency training for home visiting programs.

Written reflection cards for residents

At the end of each block of community-based activities, residents completed preformatted "reflection cards" asking them to identify new lessons learned and ways they could apply this new knowledge to patient care. Major areas where residents described how they could apply the knowledge gleaned from their experiences included (1) paying more attention to social and home-life issues that affect family health, (2) improving the ways doctors communicate with patients, and (3) being knowledgeable about community resources that could help their patients and families. One resident stated, "Closer interactions between physicians and staff of such community programs may be an effective way to accomplish specific goals for families and also broad public health goals." Residents describe ways that they have changed their own patient care practice, such as utilizing community resources to help support their patients and their families or spending more time getting to know the families. One resident reflected, "Sometimes the personal support given by staff through programs like Best Beginnings can be more effective than the best medical advice we can offer." Residents found their home visits enlightening—"I realized that things I take for granted (for example, a steady source of income) can be a real obstacle in attaining medicine, food, and adequate supervision." As a result of this, residents are now incorporating into their medical history questions about source of income and housing status and making appropriate referrals.

For both the community partner and the residents, a major obstacle was the difficulty in scheduling. Community program directors reported that scheduling issues prevented residents from participating consistently in support groups, depriving

them of the “full experience.” Some residents expressed frustration that the CBO staff did not understand the residents’ schedules and their lack of flexibility.

For some residents, their training imposes a perspective that they are not willing to embrace. For example, as one resident reflected, “When I am told how important it is for me to learn more about the cultures of my patients (meet them half way, develop working relationships with them), the conspicuously *absent* corollary is that the patients need to do the same! In other words, I felt that I was being told that I have a responsibility to change my practices to be more appropriate, but never are patients expected to do the same. I do understand the learning value of this—our positions put us in a more adaptable and observed position, but I think it’s overdone.”

Over the years, as community pediatrics became ingrained in the culture of the pediatric residency program, the residents’ reflections have become more positive. There is less questioning of the value of community-based education, and a majority of residents embrace the opportunity to partner with community members.

What Partnerships Contribute

By attending to the principles of community–academic partnership and embracing the long-term relationship built on trust and common goals, the partnership we have described has been a fruitful and valued venture for all parties. We were able to achieve this partnership, despite the structural inequalities and tensions that typically characterize the relationships between academic institutions and

CBOs. Throughout the country, there are similar models of successful partnerships, such as those selected to be a part of the Anne E. Dyson Community Pediatrics Training Initiative.¹⁷ Community-based education provides residents with a comprehensive view of issues affecting our patient population and an understanding of the different disciplines and organizations that must be involved to improve the health of the children we serve. It empowers the CBO by giving it an active educational role within the health profession, thus enabling it to strive to equalize the power of the medical center and the community. Moreover, the partnership provides community workers with knowledge of health care topics, confidence, and cultural capital that allow them to fill an educational role in the community. These effects suggest the value of community–academic partnerships for serving all communities and for providing future physicians with the knowledge, skills, and attitudes necessary to become truly competent community pediatricians.

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