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Who's in Our Neighborhood? Healthcare Disparities Experiential Education for Residents

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Background: Residents and fellows frequently care for patients from diverse populations but often have limited familiarity with the cultural preferences and social determinants that contribute to the health of their patients and communities. Faculty physicians at academic health centers are increasingly interested in incorporating the topics of cultural diversity and healthcare disparities into experiential education activities; however, examples have not been readily available. In this report, we describe a variety of experiential education models that were developed to improve resident and fellow physician understanding of cultural diversity and healthcare disparities.

Methods: Experiential education, an educational philosophy that infuses direct experience with the learning environment and content, is an effective adult learning method. This report summarizes the experiences of multiple sponsors of Accreditation Council for Graduate Medical Education–accredited residency and fellowship programs that used experiential education to inform residents about cultural diversity and healthcare disparities. The 9 innovative experiential education activities described were selected to demonstrate a wide range of complexity, resource requirements, and community engagement and to stimulate further creativity and innovation in educational design.

Results: Each of the 9 models is characterized by residents' active participation and varies in length from minutes to months. In general, the communities in which these models were deployed were urban centers with diverse populations. Various formats were used to introduce targeted learners to the populations and communities they serve. Measures of educational and clinical outcomes for these early innovations and pilot programs are not available.

Conclusion: The breadth of the types of activities described suggests that a wide latitude is available to organizations in creating experiential education programs that reflect their individual program and institutional needs and resources.

Keywords: *Cultural competency, healthcare disparities, internship and residency, problem-based learning*

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INTRODUCTION

Language, culture, and community can have a significant impact on the delivery of care to patients and on their clinical outcomes. For example, cultural preferences may influence patients' decisions about access to care, engagement with healthcare professionals, and receptiveness to the care that is recommended or provided. Cultural and linguistic preferences may influence patient willingness to comply with physician instructions.[1] Residents and fellows encounter patients from many cultures in their clinic and inpatient experiences. These healthcare professionals often have limited understanding of the cultural, racial, and ethnic communities in which their patients live. Furthermore, because of the residency matching process, residents may be selected to train in communities about which they have little personal knowledge.

Training available to residents and fellows in the specific cultural and community factors that might influence care is most often provided in the form of generic cultural competency modules.[2] Other formats, such as experiential education, offer additional means to enhance learner interest and knowledge.

Faculty physicians at academic medical centers are becoming increasingly aware of the importance of recog-

Table. Models for Healthcare Disparities Experiential Education

Model	Targeted Learners	Learning Objective(s)	Relative Complexity	Community Engagement
Simulation scenarios[a]	Residents, fellows	Clinical cultural awareness	Low	Yes, as advisory board
Treasure hunt[b]	Residents, fellows	Community awareness	Low	No
Community organizations[a]	Residents, fellows	Personal engagement with community	Low	Yes
Cultural sites[a]	Residents, fellows, faculty	Knowledge of community	Moderate	Yes
House calls[c]	Residents, fellows	Cultural awareness, clinical care	Moderate	Yes, individual patients
Geographers' tour[a]	Residents, fellows, faculty	Knowledge of community	Moderate	No
Cultural films[a]	All health professionals	Clinical cultural awareness	High	Yes, as actors, screenwriters
Community partnerships[d]	Residents, fellows	Health advocacy	High	Yes
Extended collaborative[a]	All health professionals, community members	Cultural understanding, clinical outcomes	High	Yes, as team members

[a]Developed by HealthPartners Institute for Education and Research, St. Paul, MN.
[b]Developed by Oregon Health and Science University, Portland, OR.
[c]Developed by University of Tennessee College of Medicine, Chattanooga, TN.
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nizing cultural preferences of the patient populations they serve and are interested in developing experiential education programs related to healthcare disparities for residents and fellows. However, limited information is available about the various formats that have been used for these activities. This report offers selected examples of innovative experiential education approaches designed to increase resident, fellow, and faculty physician understanding of cultural and community preferences for healthcare.

METHODS

We describe 9 examples of innovative experiential education activities, each characterized by the participation of residents in an activity that seeks to improve their understanding of patients from cultures and communities under their clinical care. The activities vary in length from minutes to months, in complexity, and in resource requirements.

The models presented are drawn from 4 sources. The HealthPartners Institute for Education and Research in St. Paul, MN, developed 6 of the models. The other 3 models are from educational programs at the Oregon Health and Science University in Portland, OR, University of Tennessee College of Medicine in Chattanooga, TN, and Emory University School of Medicine in Atlanta, GA. The models were presented at the Accreditation Council for Graduate Medical Education (ACGME) annual education conference in March 2014. In many cases, these models were included in larger educational constructs about patient and community culture that included additional didactic sessions and online learning.

The examples were selected based on faculty member and educational leadership reports of their effectiveness in familiarizing the target audience of residents, fellows, and faculty members with the demographics and health needs of the communities they serve. Characteristics of the communities in which these models were deployed varied widely but in general reflected urban centers with diverse populations. The selection purposefully represents a broad spectrum of potential educational formats to stimulate reflection, creativity, and innovation by faculty and administrators at academic medical centers and teaching hospitals who are considering implementing their own programs. The models were not selected with regard to similarities in objectives, resource requirements, outcome measures, or documented results. These efforts are early innovations or pilot programs, and, as such, are not presented to represent validated or optimal approaches to resident and fellow education on healthcare disparities.

EXPERIENTIAL EDUCATION MODELS

The 9 innovative experiential education models described here represent the efforts of multiple independent institutions to educate residents, fellows, and attending physicians about the population diversity and preferences for care in the communities they serve. The models are presented in a sequence of relative increasing complexity, with increasing resource requirements, preparation time, and administrative oversight (Table).

Simulation Scenarios

Clinical simulations (eg, rapid-response team training) can readily include care for a simulated patient from an ethnic community. In the model developed by HealthPartners Institute for Education and Research, the simulation mannequin is dressed with culturally appropriate clothing and made to verbalize or talk in a foreign language. Introducing a language barrier provides an immediate communication challenge for the responding health profes-

sionals in the training environment. Midway through the scenario, an additional challenge is presented: the patient's family, portrayed by community volunteers or by the simulation center staff, suddenly appears. The simulated family introduces additional challenges based on cultural preferences and linguistic barriers. The postsimulation debriefing includes cultural considerations such as decisionmaking by family proxy, preferences for resuscitation, and obtaining informed consent in another language. A simulation center community advisory council informs the content of the scenario to increase authenticity in the role-play and to guard against stereotyping.

Treasure Hunt

The family medicine program of Oregon Health and Science University challenged residents with a community treasure hunt. Serial clues led resident teams to historic, cultural, and other notable sites to familiarize them with the community, its cultural composition, and its relationship to the medical center and family medicine facilities.

Community Organizations

For residents and fellows interested in a longitudinal experience in cultural medicine, individual participation with community health organizations offers an in-depth opportunity. These organizations frequently are engaged in providing healthcare services, counseling, or health advocacy. Residents participate in organizational meetings and assist with health-related activities and mentoring. In the model developed by HealthPartners Institute for Education and Research, the length and depth of residents' interactions vary based on available time, interests, and opportunities for learning.

Cultural Sites

Residents and fellows in St. Paul, MN, were provided with an opportunity to better understand the Hmong culture through a visit to a Hmong market. The market's merchants sell ethnic foods, cultural goods, and traditional health remedies. Most merchants were Hmong women in traditional dress, speaking their native languages. Teams of 4 residents and an interpreter were transported to the market by bus and were asked to purchase traditional remedies for common medical conditions. The residents spent 1 hour in the market, talking with the Hmong salespeople through interpreters and purchasing herbs, roots, and other natural remedies. The learning activity exposed residents to a community located close to the hospital and the community members' preferences for traditional medicines. The visit also stimulated interest in potential toxic reactions to herbal medications that were discussed by an emergency department physician who is a toxicologist.[3]

House Calls

The University of Tennessee College of Medicine sponsored a resident house call experience, Bringing Back the Black Bag, in which residents cared for patients in their home environment. The patients were selected from ZIP codes close to the hospital and comprised a cohort that was diverse in many regards such as cultures, demographics, and beliefs. The initiative was part of a comprehensive diversity and disparities educational program of the internal medicine residency program.

Geographers' Tour

A mobile experience familiarized residents with communities near Regions Hospital in St. Paul, MN. Two geography professors were engaged to analyze racial and cultural demographic data and hospital admissions data for the communities surrounding the hospital. Residents and the geographers rode tour buses through those communities, identifying hot spots for emergency department admissions and familiarizing residents and fellows with areas of the city that have concentrations of ethnic populations. During the 3-hour bus tours, the geographers discussed the social determinants of health for the different neighborhoods. The tours were followed by a didactic presentation on the geography and social history of the city.

Cultural Films

Film or video is a durable educational format that can provide insights into the preferences of ethnic patients through narratives presented in an authentic cultural context. To highlight ethnic and cultural differences in access and use of the care system, the HealthPartners Institute for Education and Research produced 4 films, each based on a screenplay written by an author from 1 of 4 cultures: Hmong, African American, Latino, and Somali. Acted by professionals and talented amateurs under the guidance of a professional director, the plays were professionally filmed. Prior to viewing the films, resident audiences were informed that the stories were written from the perspective of 1 author about a fictional family and were intended for discussion. The films vary in length from 8-40 minutes and are available on the internet.[4]

Community Partnerships

At Emory University School of Medicine in Atlanta, GA, the Urban Health Initiative includes several sponsoring institutions, city government, hospitals, and community partners. Its goal is to improve health and decrease disparities of care in diverse and underserved populations in the city. An in-the-field learning experience for residents includes structured education regarding legislative and community advocacy, effects of social determinants on health, and improved familiarity with patients. Residents are paired with a mentor who guides them through the experience and assists them in completing a publishable project.

Extended Collaborative

Residents participated in a large-scale institutional quality-improvement collaborative to improve healthcare equity of preventive health services and learn about cultural influences and systems approaches to improving care. The year-long collaborative, called The EBAN Experience and developed by the HealthPartners Institute for Education and Research, included teams of residents; health professionals; and Hmong, African American, Somali, and Latino community members.[5] The teams studied preferences for care, access issues, and disparities in health outcomes for preventive health initiatives such as immunizations and cancer screenings. The teams demonstrated improved

clinical outcomes through serial quality improvement cycles.[6]

DISCUSSION

Experiential education—an educational philosophy that infuses direct experience with the learning environment and content—is particularly well suited for active learning, a modality that is preferred by the generation of learners currently in medical school and residency.[7] The wide variety of educational activities described here reflects the needs of learners, learning objectives, and available institutional resources. Faculty considering the use of experiential education are encouraged to select methods that meet their learning needs or to experiment with innovative formats that engage learners and communities, promote mutual understanding of the factors leading to healthcare disparities, and lead to possible solutions. The effectiveness of any of these methods may vary by location and institution. Clinical and educational outcomes are not available for these early innovations and pilot programs, and return on investment is not known.

These models are, in most cases, early efforts and may not represent the optimal means for addressing cultural awareness and healthcare disparities for a specific set of learners or a community. However, they offer preliminary insight into the scope of potential interventions that use experiential education to impart an understanding of communities and patients of diverse cultures. Methods to develop curricula and to evaluate the effectiveness of educational interventions for cultural competence were reviewed in 2015, including guidance in planning and evaluation of cultural competence educational programs.[8]

Faculty at academic medical centers and teaching hospitals who are considering implementing similar educational programs should take several factors into account when selecting or creating an educational approach. Some approaches are focused on individual learners, such as the community organizations model. Others are best integrated with resident and fellow orientation, such as the treasure hunt. And others have a potential broad reach, including penetration beyond the academic medical center into communities, such as the development of extended healthcare collaboratives and the use of films as educational modalities. Understanding the learning objective is critical when designing an intervention. Creating resident awareness of the preferences for care of a cultural group may require a relatively simple educational intervention with reinforcement, whereas engaging community members with health professionals to change clinical protocols to reflect cultural preferences requires significantly more administrative leadership, enlistment of community representatives, serial meetings, and a much longer timeline. Resource availability is also a consideration. Each of the 9 models has different resource requirements including preparation time, educator expertise, use of simulators or transportation resources, and length of participant involvement.

CONCLUSION

The experiential education models presented are examples of learning activities developed to improve resident understanding of patient and community cultural preferences for healthcare. The 9 models are the work of early innovators, and further studies are necessary to fully understand the appropriateness of individual models to meet educational outcomes, promote community engagement, and improve the effectiveness of clinical outcomes.

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