Structural Competency Pilot Training

WELCOME!

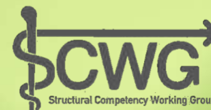
Health Outreach Partners

Northwest Regional Primary Care Association | Washington Association for Community Health

Friday, April 26th, 2019

8:30am – 4:30pm

Tacoma, WA



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Health Outreach Partners
SCWG Structural Competency Working Group

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WWW.OUTREACH-PARTNERS.ORG

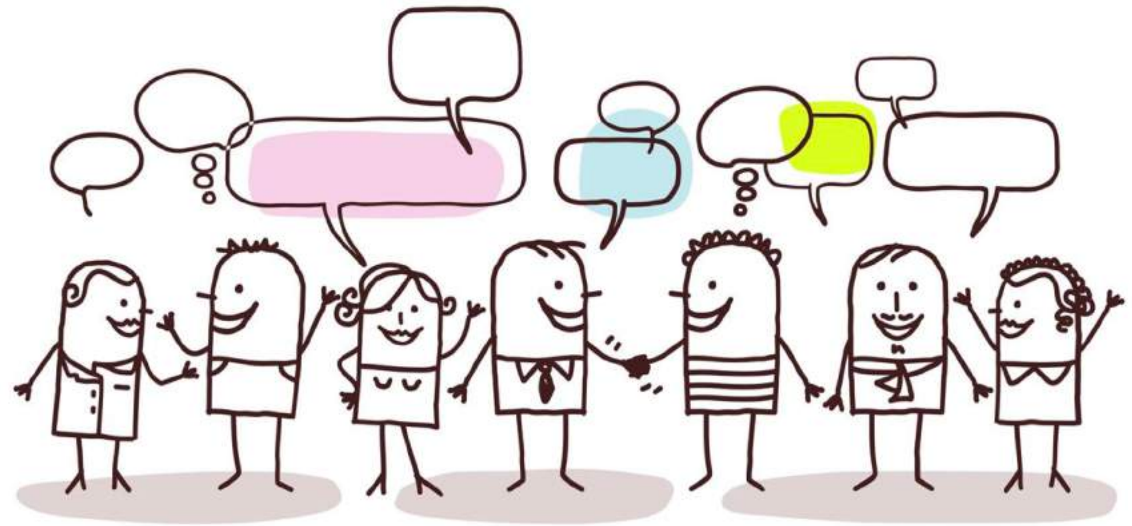
WE SUPPORT HEALTH OUTREACH PROGRAMS by providing training, consultation, and timely resources.

OUR MISSION IS TO BUILD STRONG, EFFECTIVE, AND SUSTAINABLE HEALTH OUTREACH MODELS by partnering with local community-based organizations across the country in order to improve the quality of life of low-income, vulnerable and underserved populations.

WE SERVE Community Health Centers, Primary Care Associations, and Safety-net Health Organization

Introductions

- Health center or organization
- Name
- What interests you in this training?



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SCWG

Structural Competency Working Group

Structural Competency Working Group

- Focused on integrating structural competency into training and practice of healthcare providers
- Comprised of nurses, physicians, scholars in the medical social sciences, health administrators, community health activists, and graduate and professional students in several disciplines
- HOP SC Curriculum adapted from the training developed by the Structural Competency Working Group

Piloting the Curriculum

Goal: Health centers actively participate in the pilot of the structural competency training curriculum in order to ensure that the training format, content, activities, and materials are substantive and relevant for health centers.

By agreeing to participate, health centers will:

- Engage fully in the training
- Participate with a critical eye
- Provide clear and constructive feedback
- Identify what works and areas for improvement

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Agenda

- Welcome and Introductions (30 min)
- Module 1: Structures and Patient Health (3 hrs)
  - Structures, Structural Violence, Racism, and Vulnerability, Naturalizing Inequality, Implicit Frameworks
- Lunch (45 min)
- Module 2: Origins and Definitions of Structural Competency (65 min)
- Module 3: Imagining Structural Interventions (50 min)
- Module 4: Beloved Community and Taking Action (60 min)
- Closing and Evaluation (10 min)

Learning Objectives

At the end of the training, participants will be able to:

1. Identify the influences of structures on patient health and healthcare
2. Generate strategies to respond to the influences of structures in and beyond the health center
3. Describe structural competency and humility as an approach to apply in and beyond the health center

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Group Agreements

We aim to create a safe space to learn and share with each other. To do so, we will:

- Respect the value of each other's opinions and experiences
- Maintain confidentiality
- Acknowledge its okay to disagree, respectfully and openly
- Remain present and engaged
- Listen to each other
- Seek to understand our blind spots
- Assume positive intent
- Honor the limitations of time, speak concisely
- Know when to *Step up* and *Step back*
- Be on time when returning from lunch and breaks
- Practice mindfulness and self-care
- Silence phones

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Positionality

- Privilege & blind spots
- Not experts
- Feedback

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Icebreaker

B I N G O

Module 1: Structures and Patient Health

Defining Structures

Why are people poor and sick?

"No one has a right to work with poor people unless they have a real analysis of why people are poor."

- Barbara Major
Former Director, St. Thomas Health Clinic

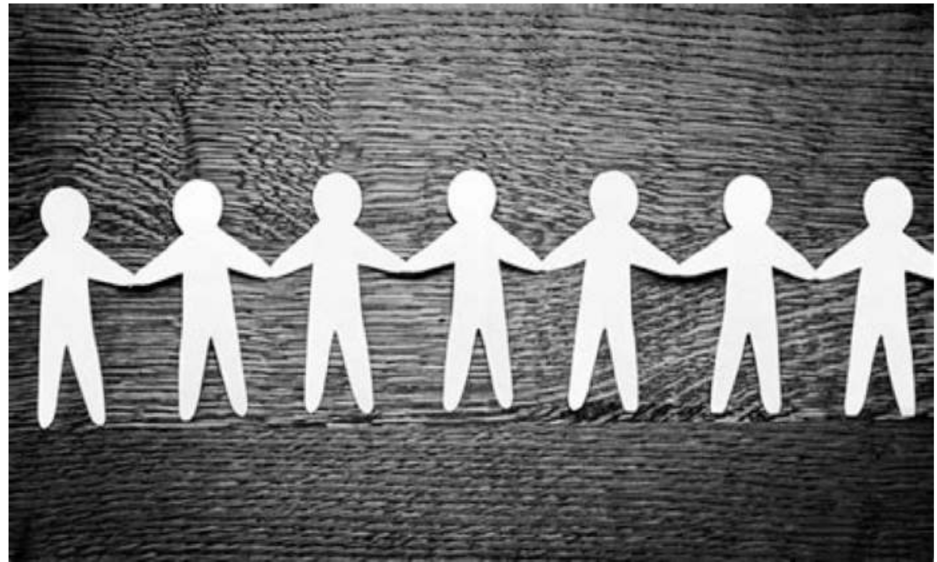

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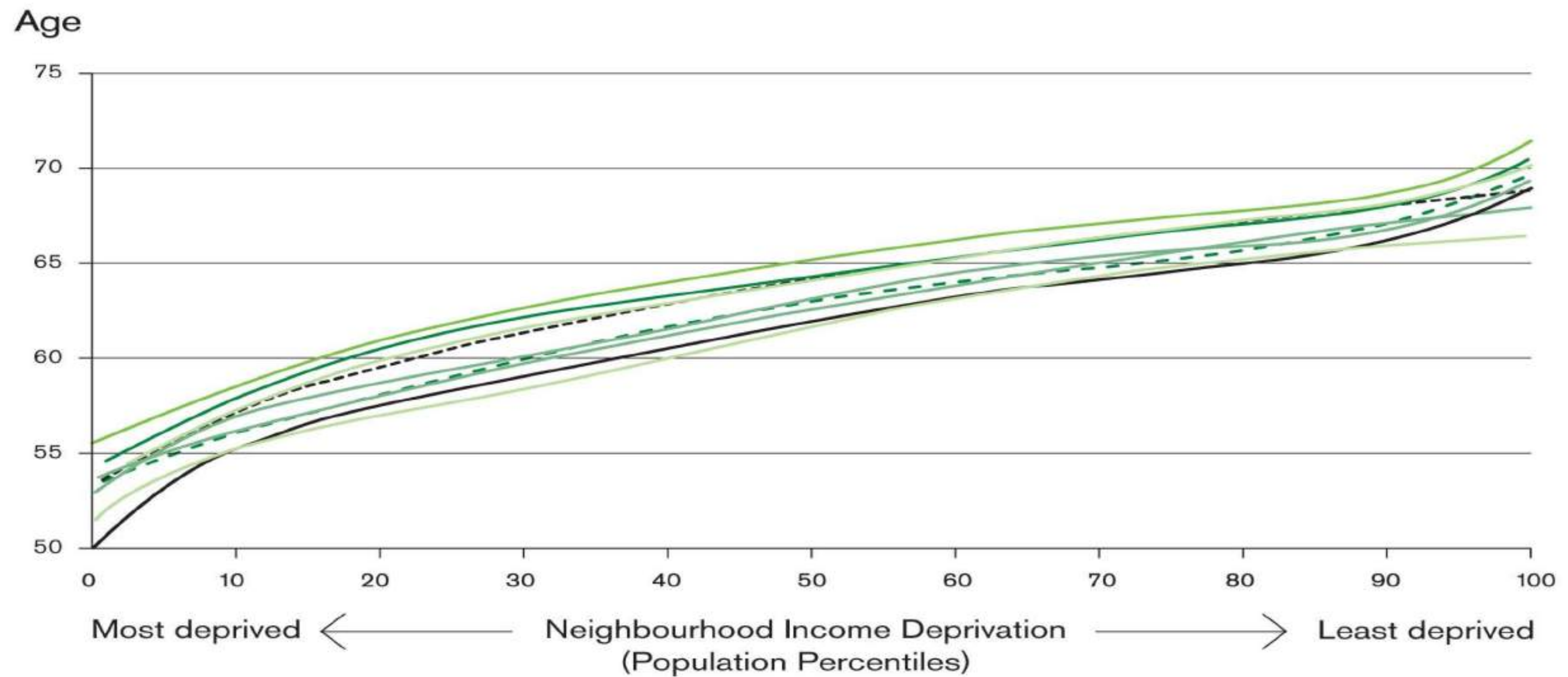
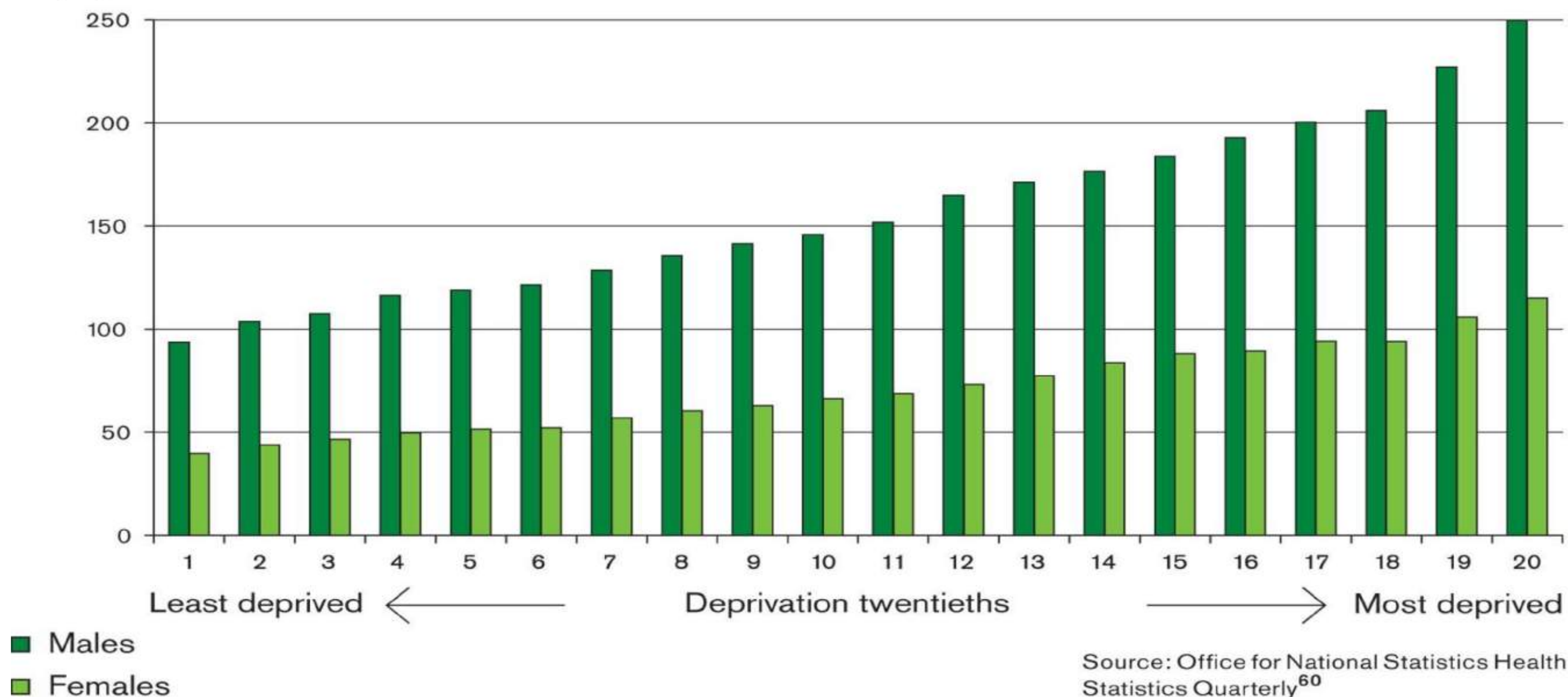
Figure 2.9 Disability-free life expectancy at birth, persons: regional averages at each neighbourhood income level, England, 1999–2003



- Yorkshire/Humber average
- South West average
- East of England average
- East Midlands average
- North West average
- West Midlands average
- South East average
- North East average
- London average

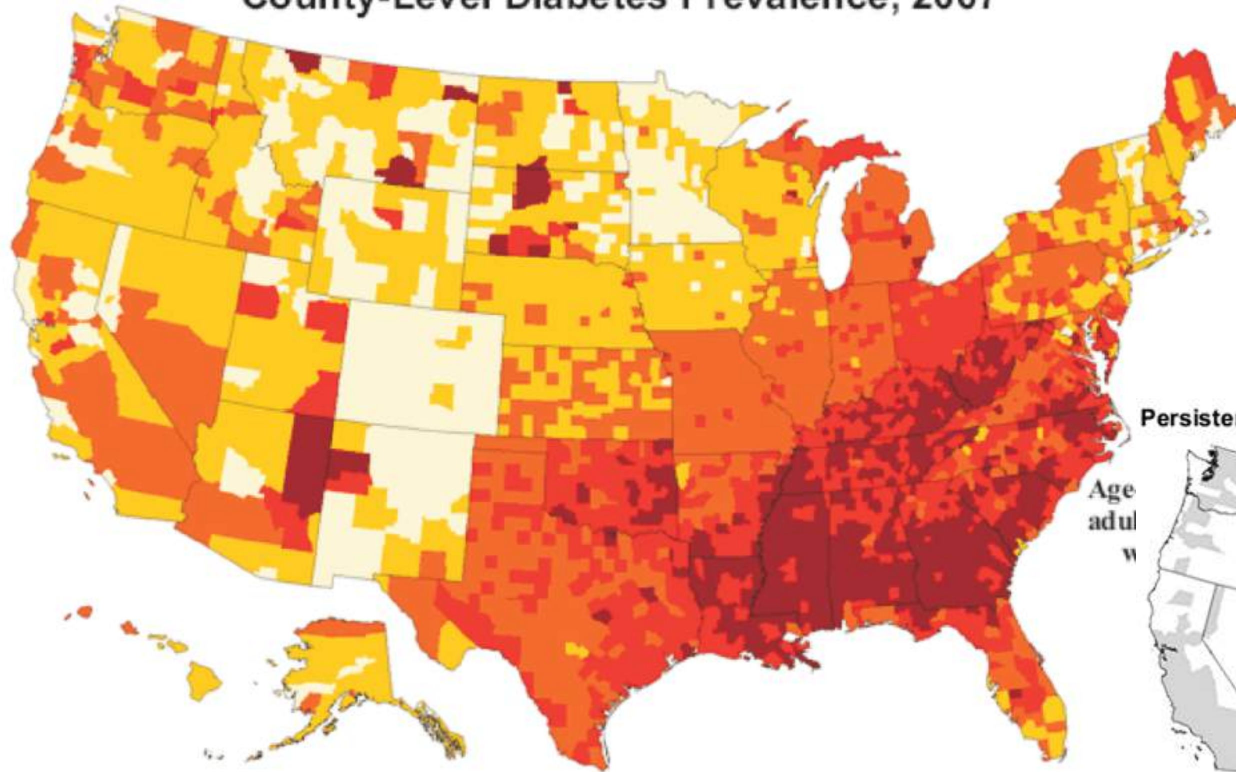
Source: Office for National Statistics[59]

Figure 2.10 Age standardised (a) circulatory disease and (b) cancer death rates at ages under 75, by local ward deprivation level, 1999 and 2001–2003



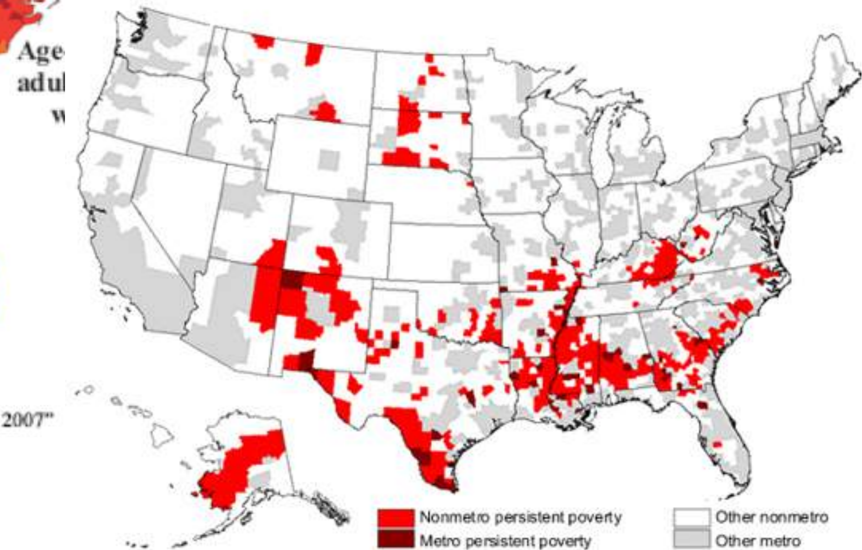
Source: Office for National Statistics Health Statistics Quarterly[60]

County-Level Diabetes Prevalence, 2007



Sources: Centers for Disease Control and Prevention, "Estimated County Level Prevalence of Diabetes and Obesity—United States, 2007" *Morbidity and Mortality Weekly Report* 58 No. 45 (Nov. 20, 2009):1259-1263.

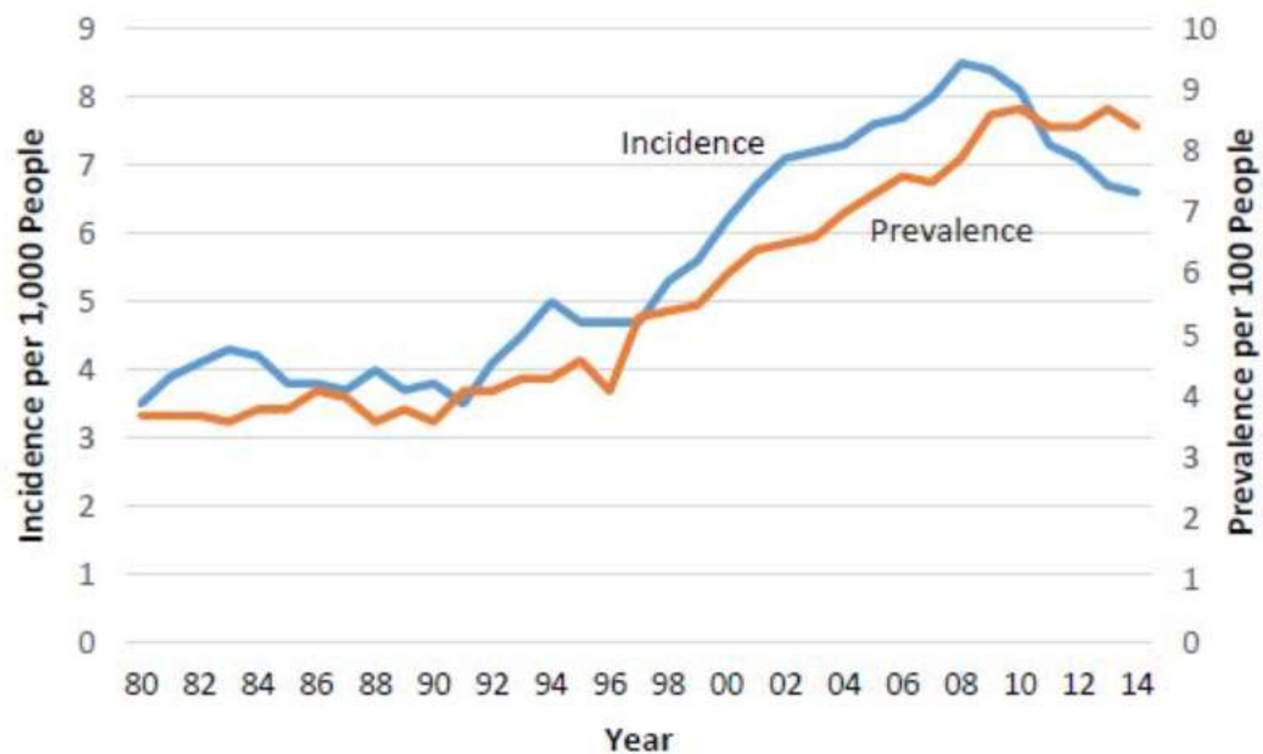
Persistent Poverty Counties, 1970-2000



Persistent poverty counties--20 percent or more residents were poor as measured by each of the last four censuses, 1970, 1980, 1990, and 2000.

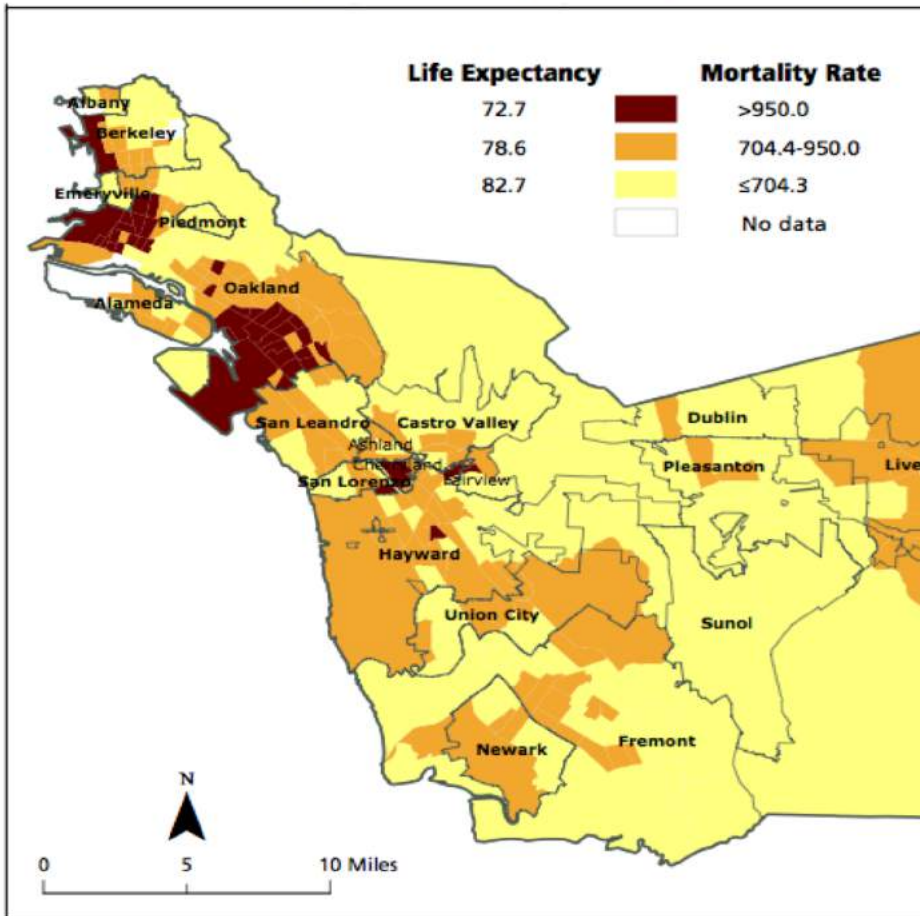
Source: Economic Research Service, USDA.

Trends in Incidence and Prevalence of Diagnosed Diabetes Among Adults Aged 20-79, United States, 1980-2014



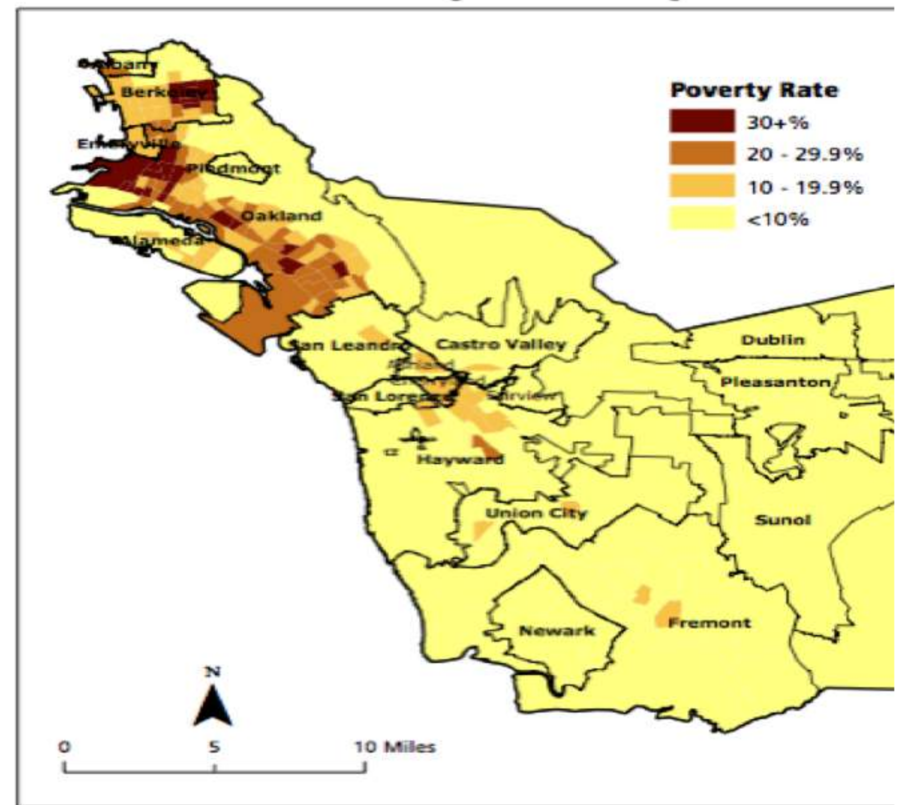
Source: National Diabetes Surveillance System, 2016.

Map 1: Mortality Rate by Census Tract, Alameda County



Source: Alameda County vital statistics files, 2001-2005.

Map 2: Neighborhood Poverty Rate

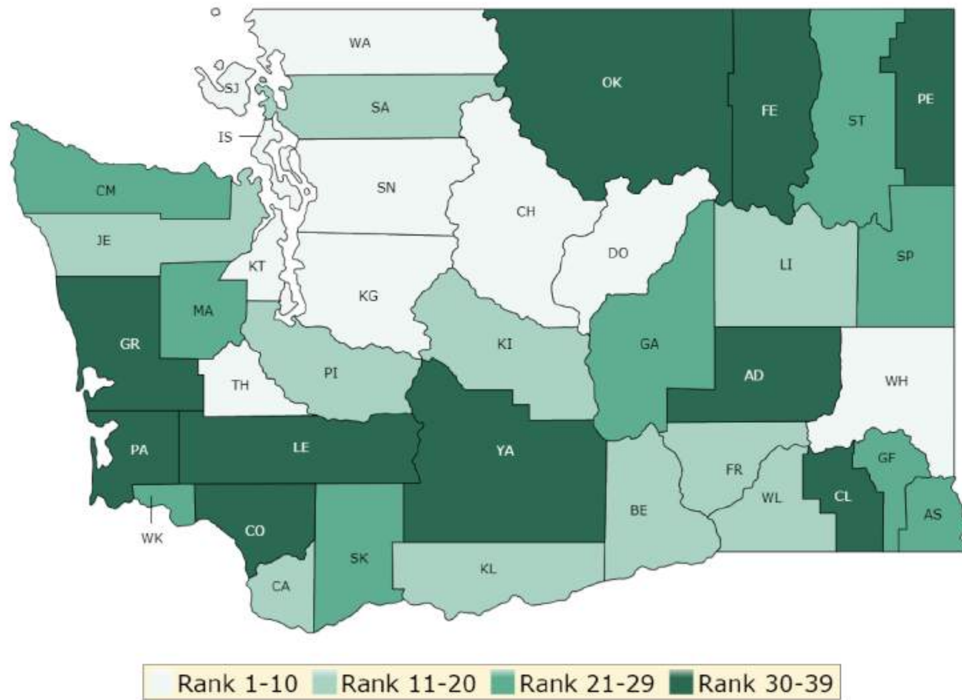


Source: Census 2000.

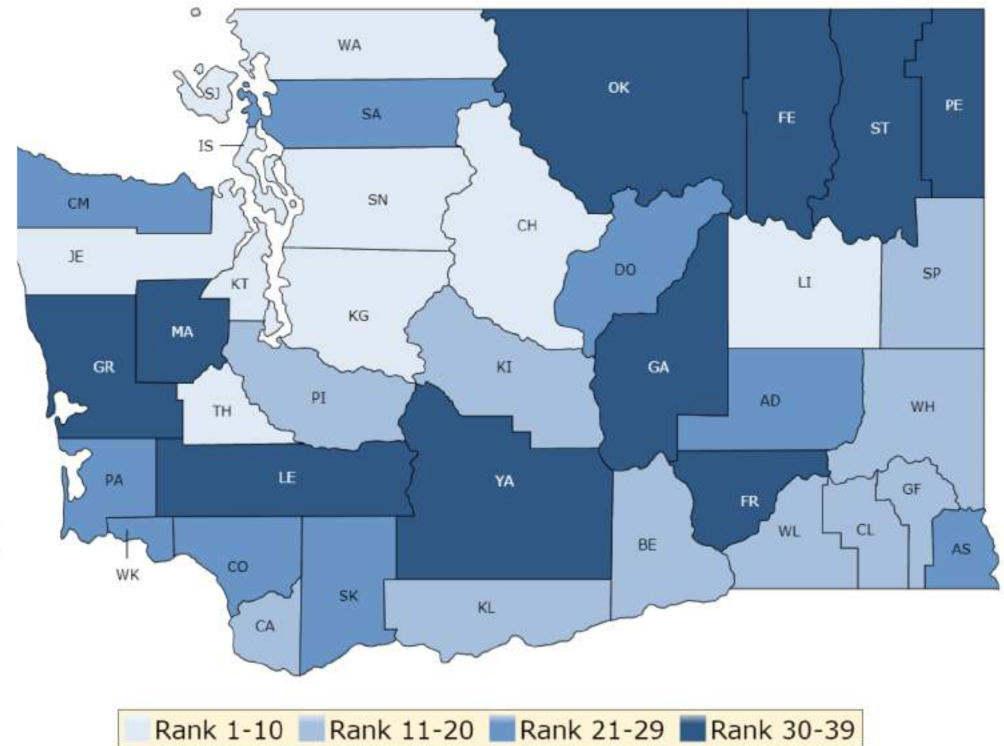
Life and Death from Unnatural Causes, 2010

2019 Washington Rankings Data

Health Outcomes



Health Factors



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Source: County Health Rankings & Roadmaps: http://www.countyhealthrankings.org/app/washington/2019/overview

Structures

The **policies**, **economic systems**, and other **institutions** (judicial system, schools, etc.) that have produced and maintain **modern social inequities** as well as **health disparities**, often along the lines of social categories such as **race**, **class**, **gender**, **sexuality**, and **ability**.

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HEALTH DISPARITIES

SDOH

POVERTY

INEQUALITY

POLICIES

ECONOMIC SYSTEMS

SOCIAL HIERARCHIES (e.g. RACISM)

Case

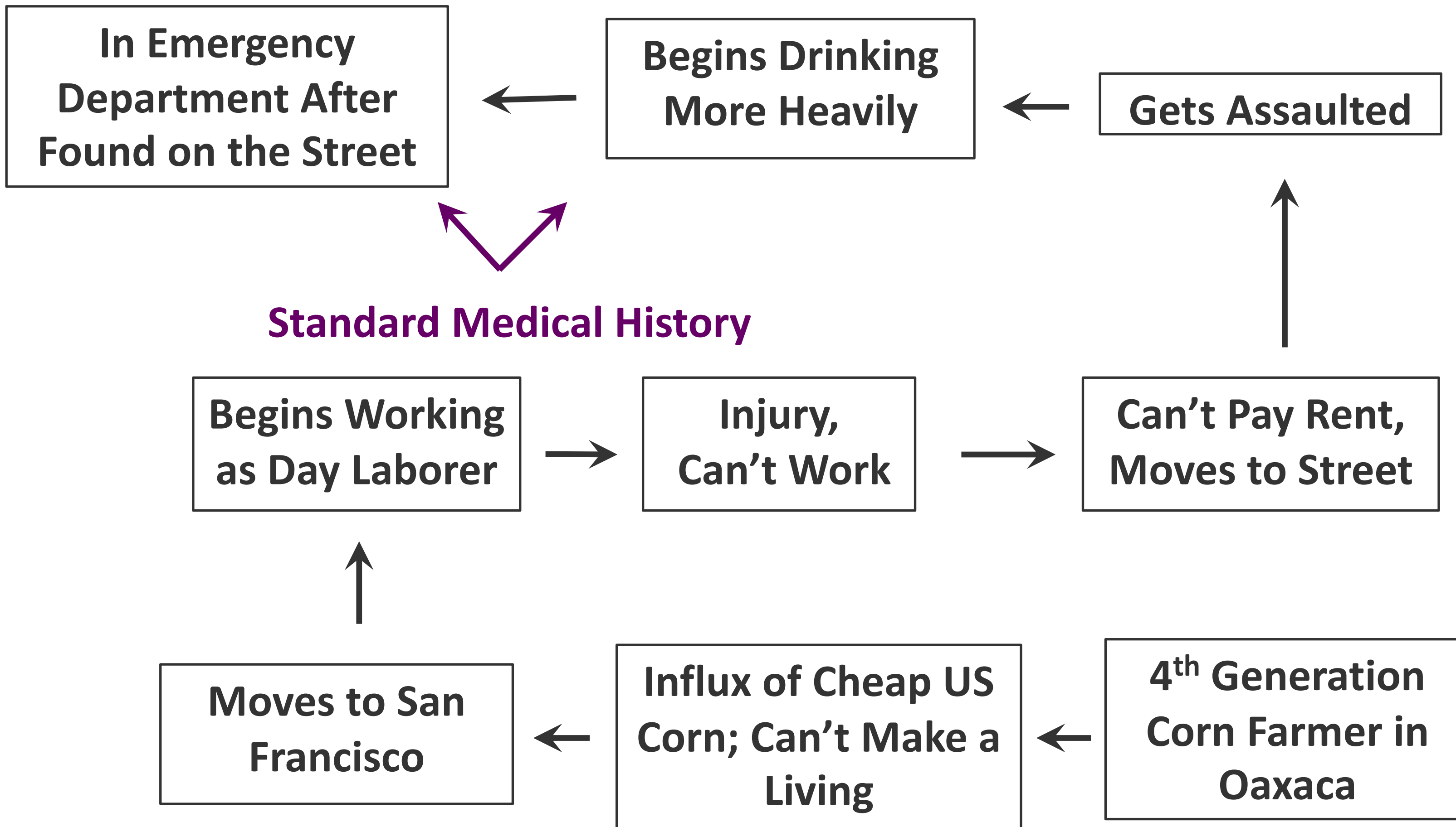
- **HPI:** Patient is a 37-year-old Spanish-speaking male found down with LOC
- **PMH**: Frequent flyer well known to the ED for EtOH-related trauma, withdrawal associated with seizures
- **PSH**: R orbital fracture 2/2 assault w/o operative intervention
- **SH**: Heavy EtOH use, other habits unknown. Apparently homeless
- **Meds**: currently noncompliant with all meds, D/C'ed after last hospitalization on folate, thiamine, multivitamin, and seizure prophylaxis
- **Neuro/Mental Status**: pt. muttering in incoherent Spanish, inconsistently able to answer "yes/no" and follow simple commands

Reflection Questions

- What questions do you have that might help you to better understand the patient's situation?

- What observations do you have about the language used in the medical note?

- What social, political, and economic structures might be contributing to the patient's health outcomes?



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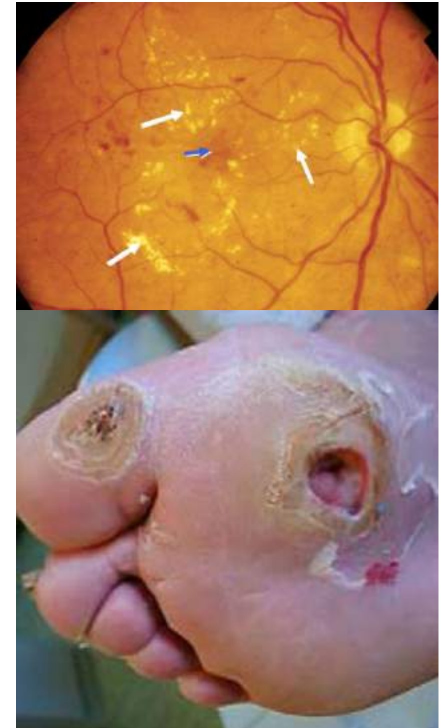
In Emergency Department after found on the street
Begins drinking more heavily
Gets assaulted
Racism/ racialized low-wage labor markets; US immigration policy
City & federal policies contributing to gentrification & displacement
Legacy of colonialism; Systematic marginalization & violence against indigenous communities in S. Mexico
Begins working as day laborer
Injury, can't work
Can't pay rent, Moves to street
US healthcare system (no access to care)
North American Free Trade Agreement (NAFTA)
Moves to San Francisco
Influx of cheap US corn; can't make a living
4th generation corn farmer in Oaxaca

Activity: Identify the structural factors of a patient

Case

- **HPI:** MS is an obese diabetic 56yo F admitted from ED after brought in by ambulance for altered mental status due to hyperosmolar hyperglycemic state (HHS – diabetes-related) with elevated creatinine. Pt reports “a couple months” of fatigue, blurry vision and “floaters”
- **PMH**: Pt reports hx of T2DM with lower extremity neuropathy, noncompliant with meds since moving to Tracy from Oakland 3 mos ago
- **PSH**: Cesarean 1995 (G3P2)
- **SH**: Former smoker, quit 1990. Pt denies alcohol or drug use
- **PEx**: Gen: obese, pleasant, looks older than stated age;
  - HEENT: periorbital edema, cotton wool spots and hard exudates on fundoscopy;
  - Back: + CVAT;
  - Extremity: multiple ulcerations on her feet bilaterally;
  - Neuro: Absent sensation to mid shins bilaterally, absent Achilles reflex, 1+ patellar reflex;
- All other findings/systems unremarkable



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Found to have stage 4 CKD, retinopathy, multiple ulcers on feet ← Taken to ED from Burger King for AMS due to HHS ← After 2 years gets housing in Tracy. No county health system. Overwhelmed by Medi-Cal, does not get new PCP

Standard Medical History

She becomes obese; develops type 2 DM. A1C well controlled on metformin → Husband dies from MI at age 53; she looks for work after 20 years out of workforce → Can't find work, can't pay rent, starts living in her car. Still sees PCP in county system but A1C climbs to 10.7 on multiple meds

They have 2 children; she stops working to care for them ← Works for 11 years as a veterinary tech after high school. Husband works as security guard ← 2nd generation born & raised in East Oakland (grandparents moved from Oklahoma)

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Exercise

1) What **social, political, and economic structures** might be contributing to the patient's health outcomes?

2) How are the social, political, and economic structures that you identified **causing harm** to the patient?

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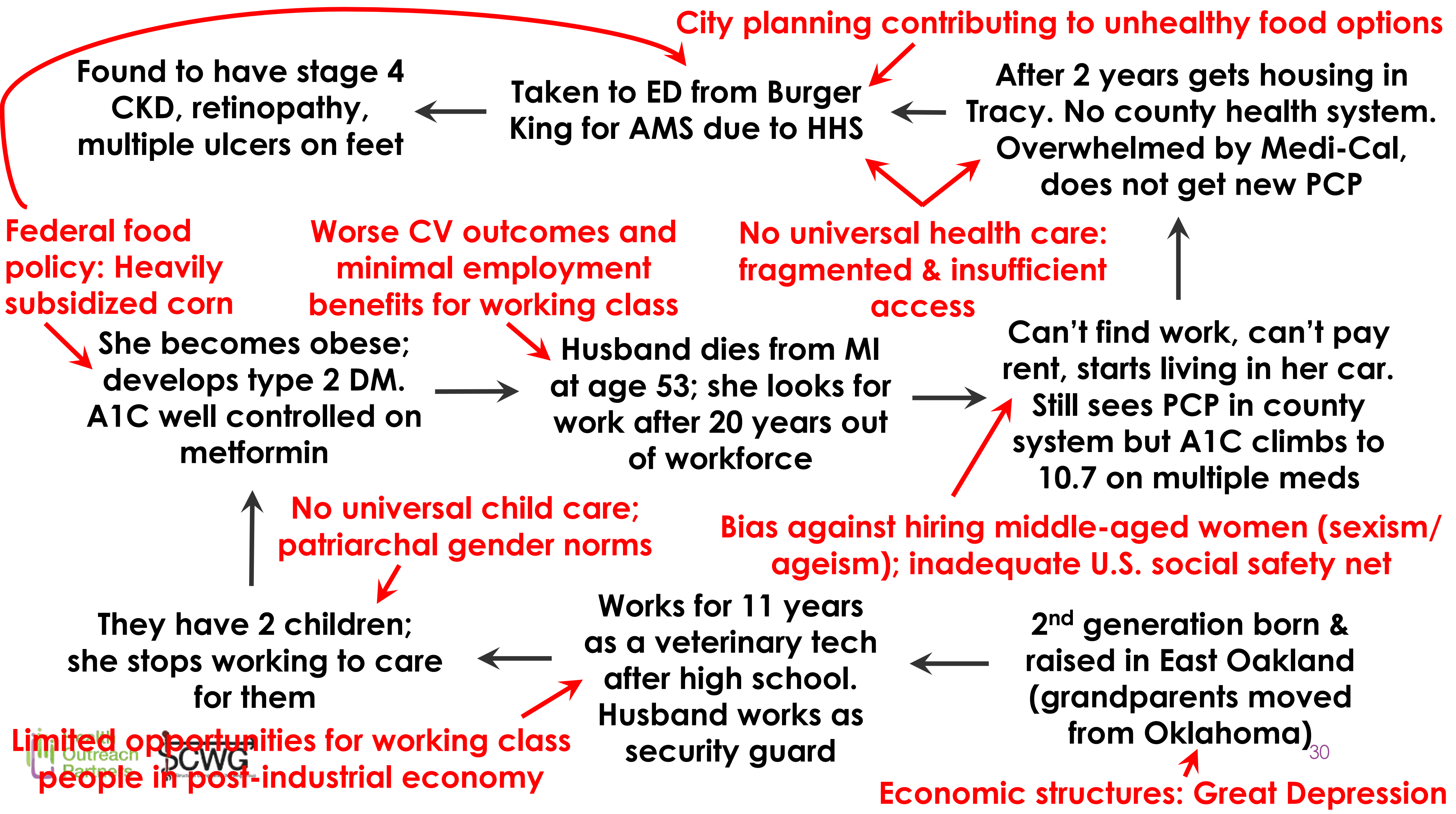
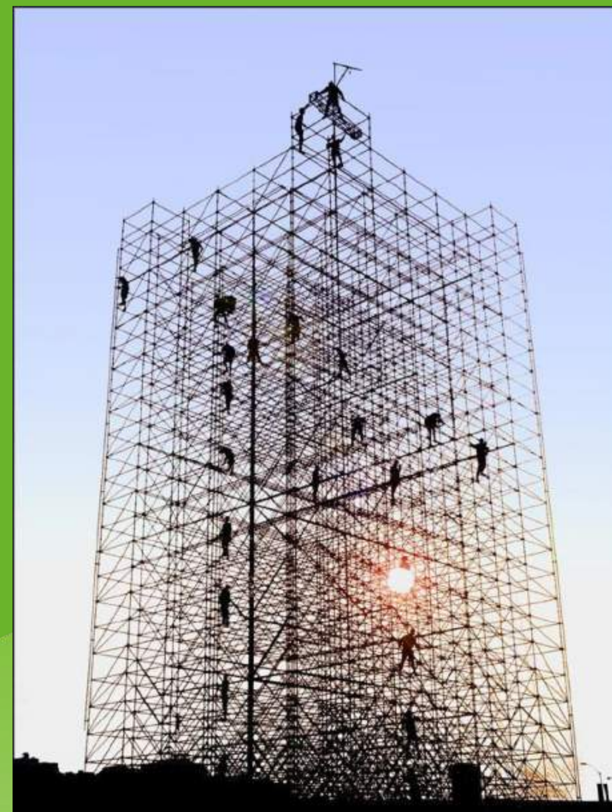

City planning contributing to unhealthy food options
Found to have stage 4 CKD, retinopathy, multiple ulcers on feet
Taken to ED from Burger King for AMS due to HHS
After 2 years gets housing in Tracy. No county health system. Overwhelmed by Medi-Cal, does not get new PCP
Federal food policy: Heavily subsidized corn
Worse CV outcomes and minimal employment benefits for working class
No universal health care: fragmented & insufficient access
She becomes obese; develops type 2 DM. A1C well controlled on metformin
Husband dies from MI at age 53; she looks for work after 20 years out of workforce
Can't find work, can't pay rent, starts living in her car. Still sees PCP in county system but A1C climbs to 10.7 on multiple meds
No universal child care; patriarchal gender norms
Bias against hiring middle-aged women (sexism/ ageism); inadequate U.S. social safety net
They have 2 children; she stops working to care for them
Works for 11 years as a veterinary tech after high school. Husband works as security guard
2nd generation born & raised in East Oakland (grandparents moved from Oklahoma)
Limited opportunities for working class people in post-industrial economy
Economic structures: Great Depression
SCWG

10 Minutes

Module 1: Structures and Patient Health

Structural Violence, Racism, and Vulnerability



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HEALTHY PEOPLE. EQUITABLE COMMUNITIES

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Structural Violence

"Structural violence is one way of describing social arrangements that put individuals and populations in harm's way... The arrangements are structural because they are **embedded in the political and economic organization** of our social world; they are violent because they **cause injury to people**."

– Farmer et al. 2006

In Emergency Department after found on the street
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4th generation corn farmer in Oaxaca

Structural Racism

"Racism is both overt and covert...we call these individual racism and institutional racism...The second type is less overt, far more subtle, less identifiable in terms of specific individuals committing the acts. But it is no less destructive of human life. The second type originates in the operation of **established and respected forces** in society, and thus receives far less public condemnation."

Institutional racism leaves individuals and communities "**destroyed and maimed physically, emotionally and intellectually** because of conditions of poverty and discrimination in the black community that is a function of institutional racism..."

- Kwame Ture (Stokely Carmichael)

Black Power: The Politics of Liberation

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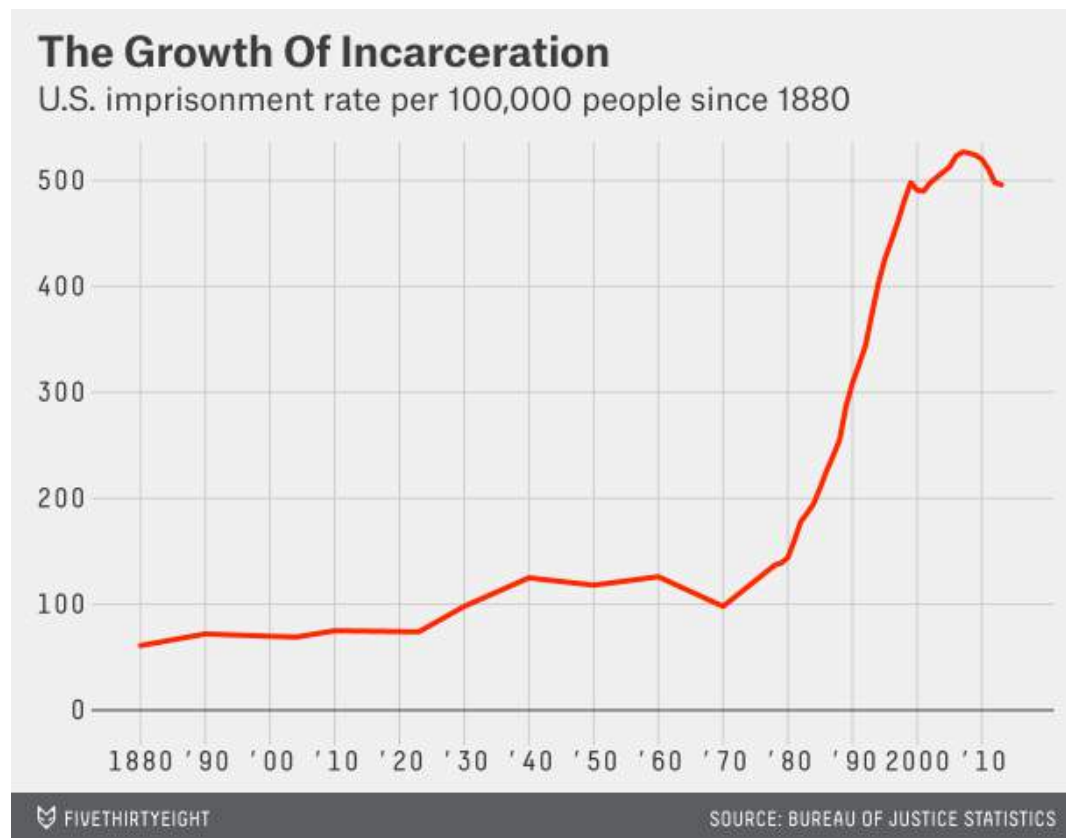
Mass Incarceration



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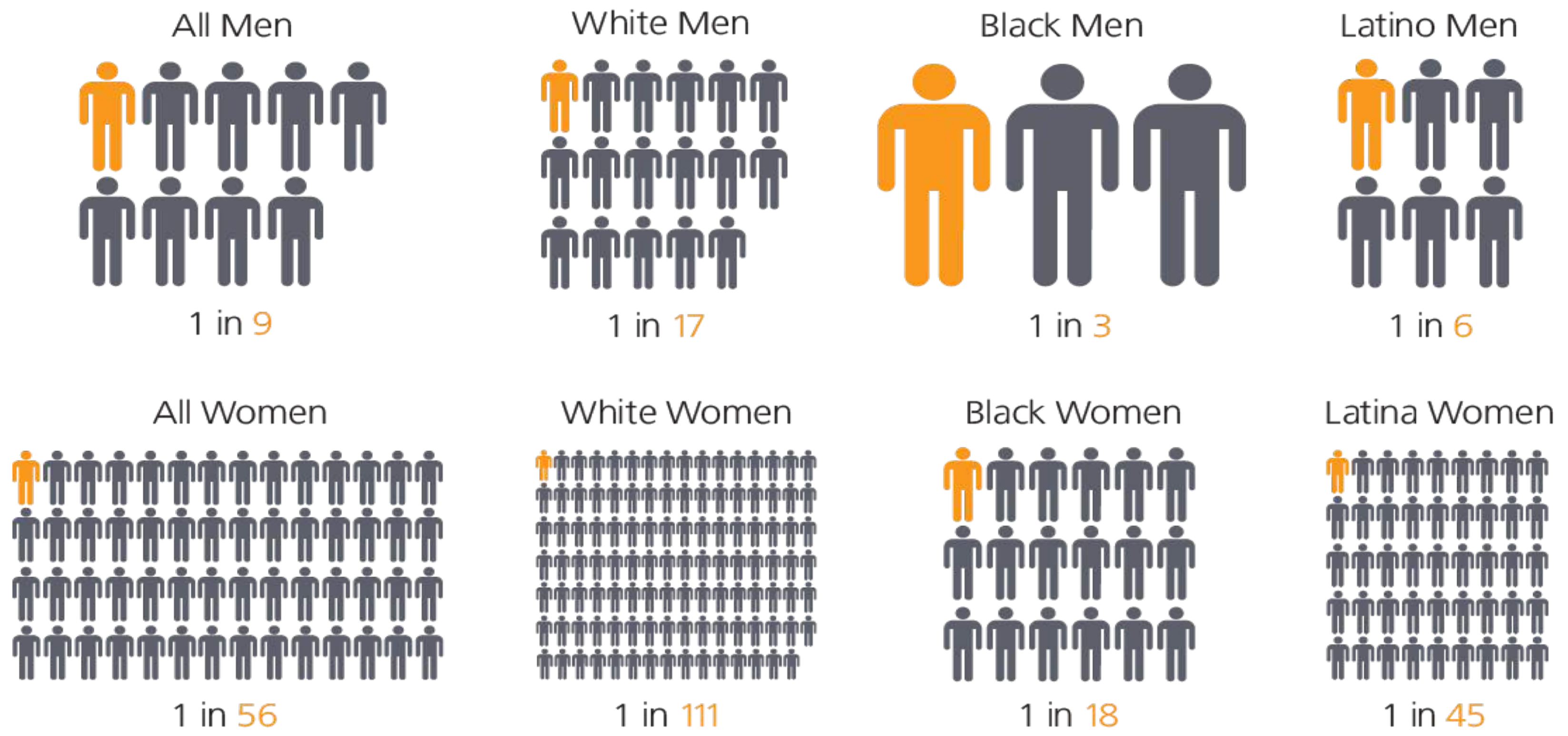
Lifetime Likelihood of Imprisonment of U.S. Residents Born in 2001



Source: Bonczar, T. (2003). *Prevalence of Imprisonment in the U.S. Population, 1974-2001*. Washington, DC: Bureau of Justice Statistics.

THE SENTENCING PROJECT

Mass Incarceration

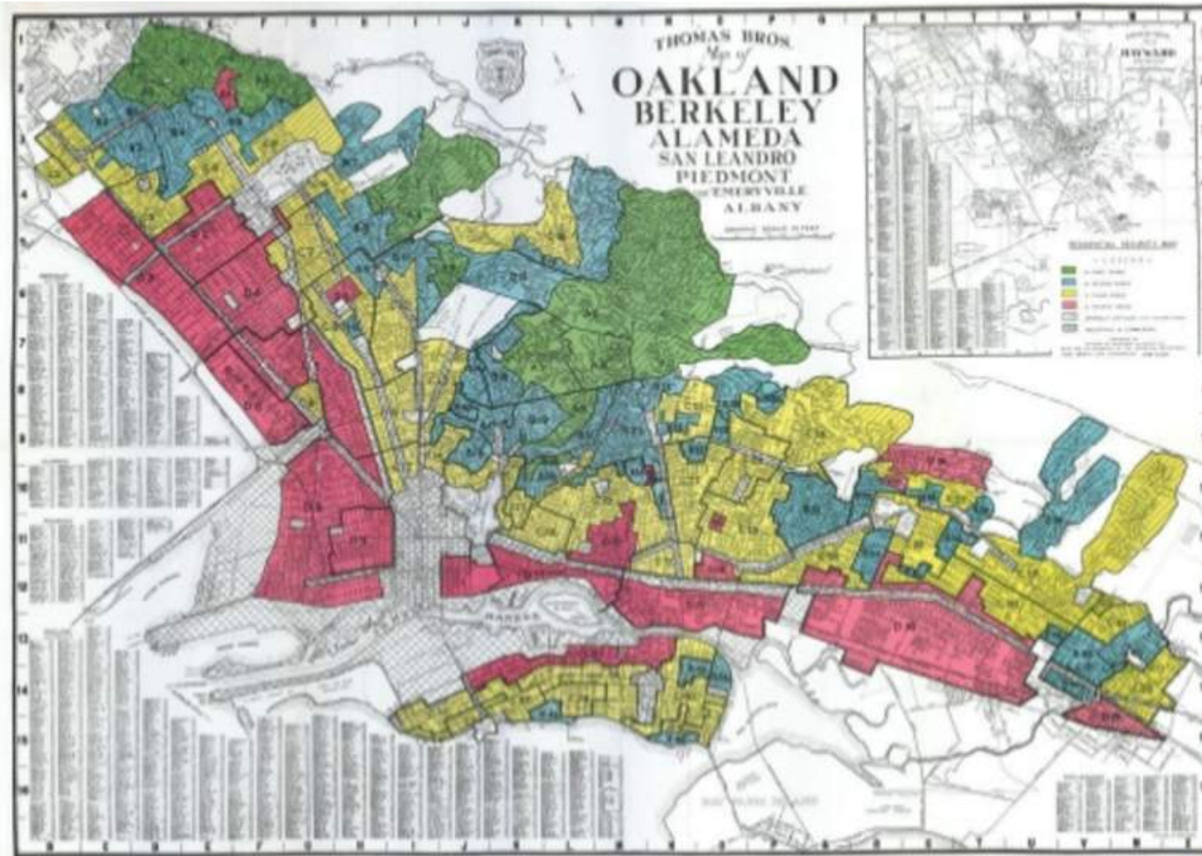
"The Nixon campaign in 1968, and the Nixon White House after that, had two enemies: the antiwar left and black people. You understand what I'm saying?

We knew we couldn't make it illegal to be either against the war or black, but by getting the public to associate the hippies with marijuana and blacks with heroin. And then **criminalizing** both heavily, we could disrupt those communities. We could arrest their leaders, raid their homes, break up their meetings, and vilify them night after night on the evening news.

Did we know we were lying about the drugs? Of course we did."

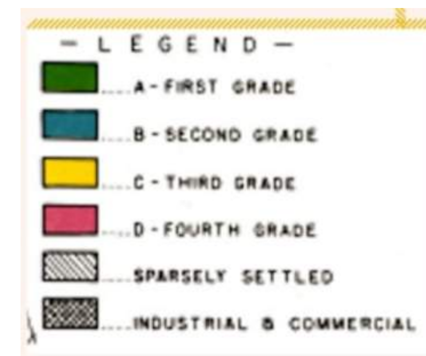
-John Ehrlichman (Nixon advisor)

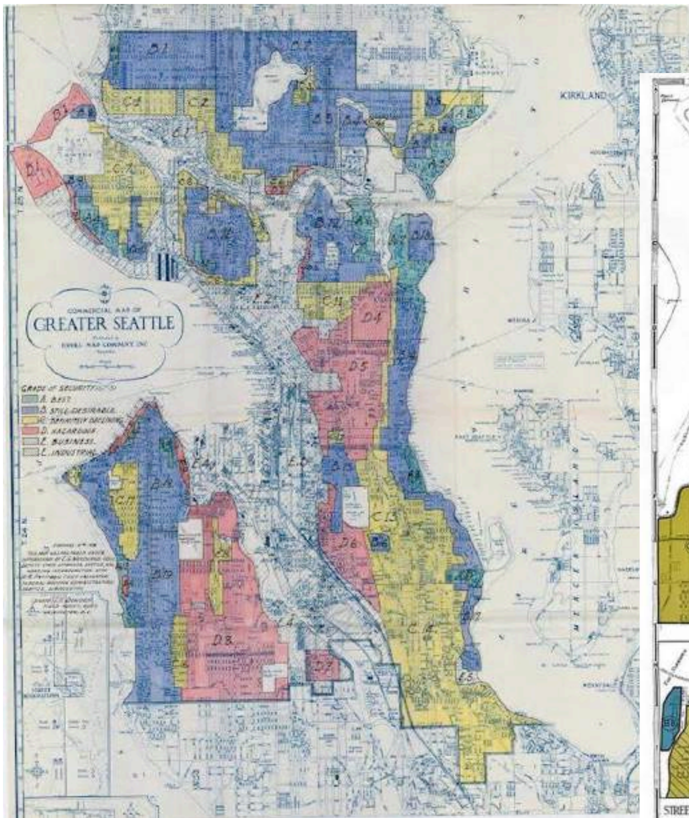
Redlining

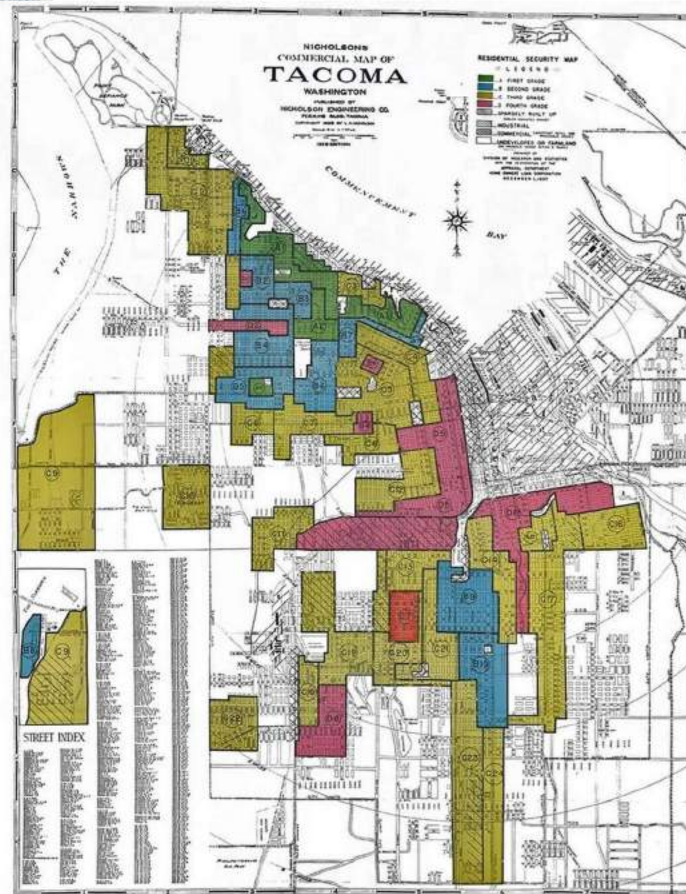


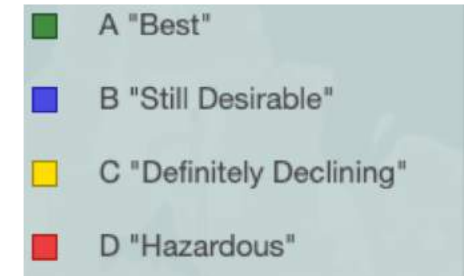
LEGEND
HOUSING INVENTORY
BEST
STILL DESIRABLE
DECLINING
HAZARDOUS
FUTURE DEVELOPMENT
BUSINESS & INDUSTRY

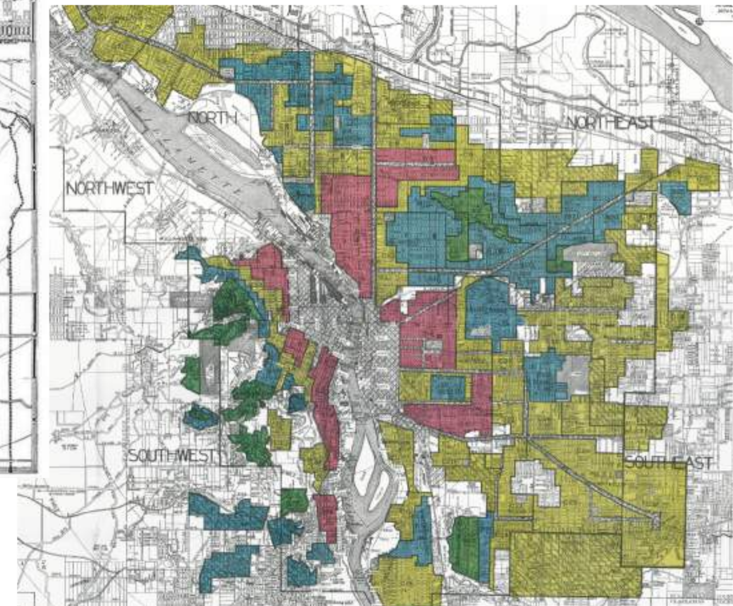
ABOVE *A legend from a map of Philadelphia showing language used to describe neighborhoods.*





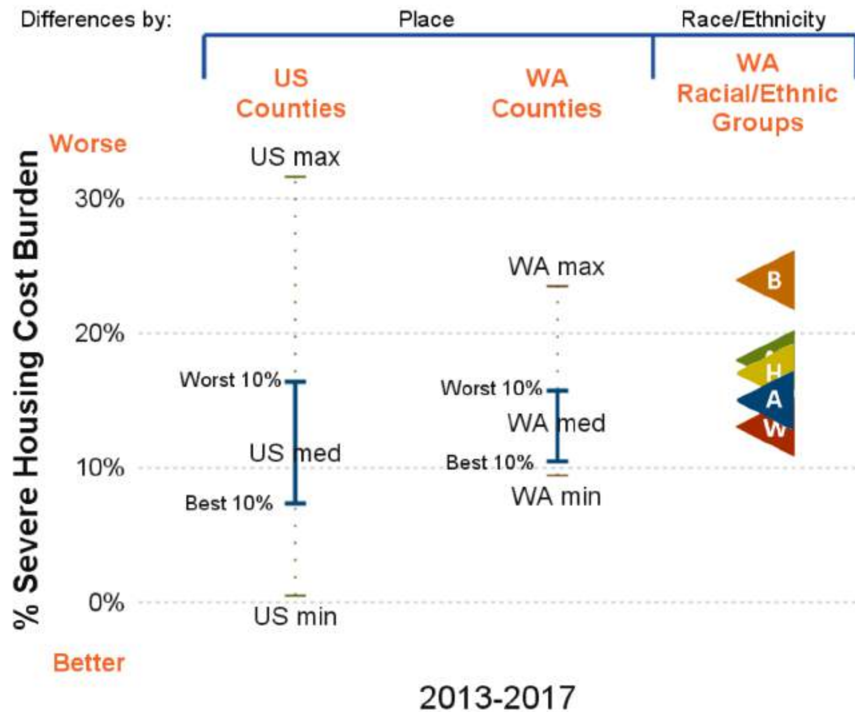


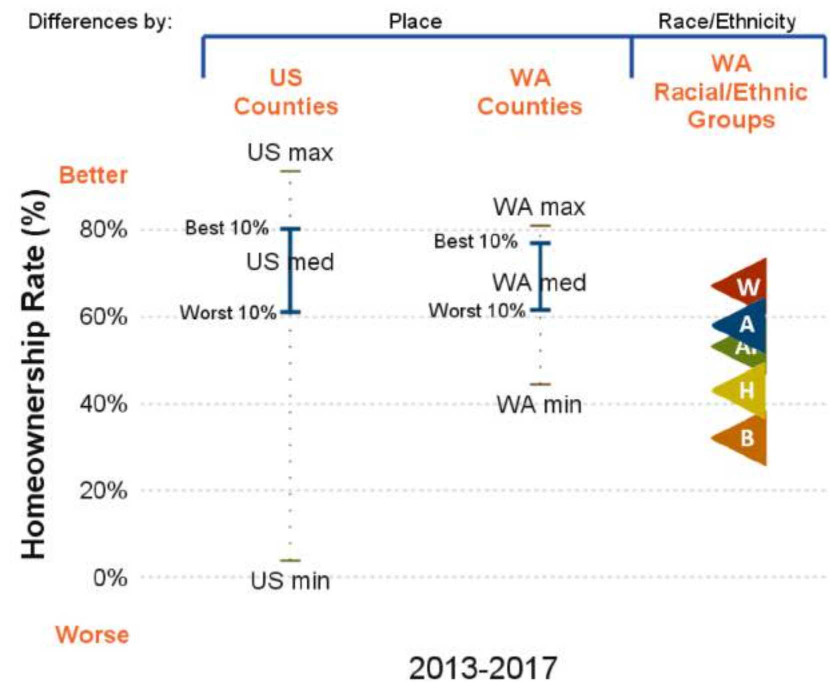




Source: *Mapping Inequality: Redlining in New Deal America*
https://dsl.richmond.edu/panorama/redlining/#loc=4/36.71/-96.93&opacity=0.8

2019 US County Health Rankings Report: Washington





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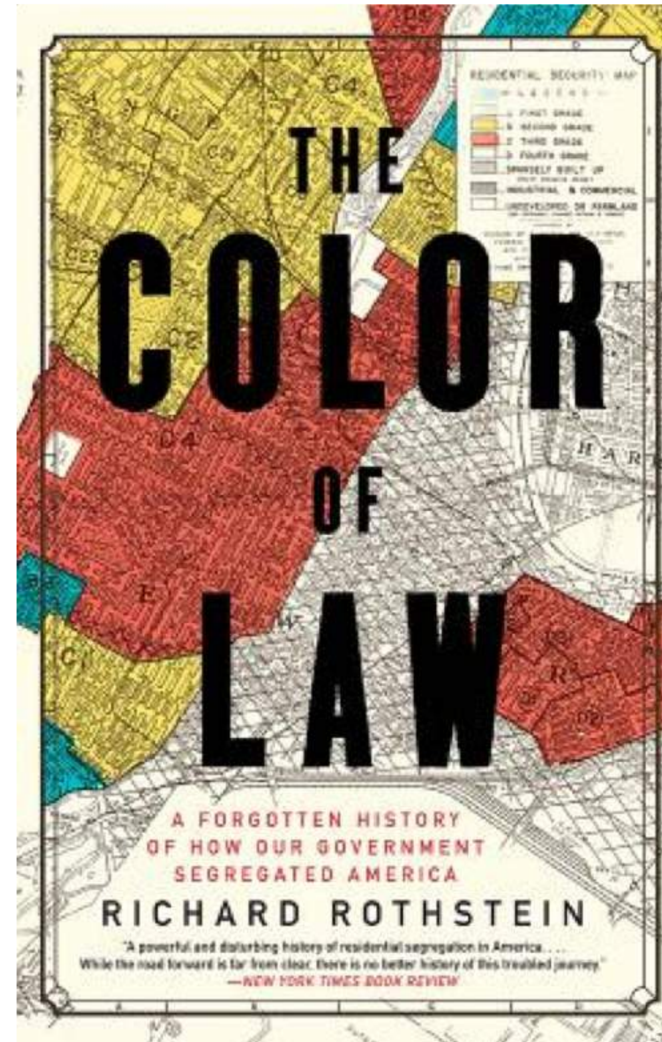
Source: http://www.countyhealthrankings.org/reports/state-reports/2019-washington-report

Segregated By Design



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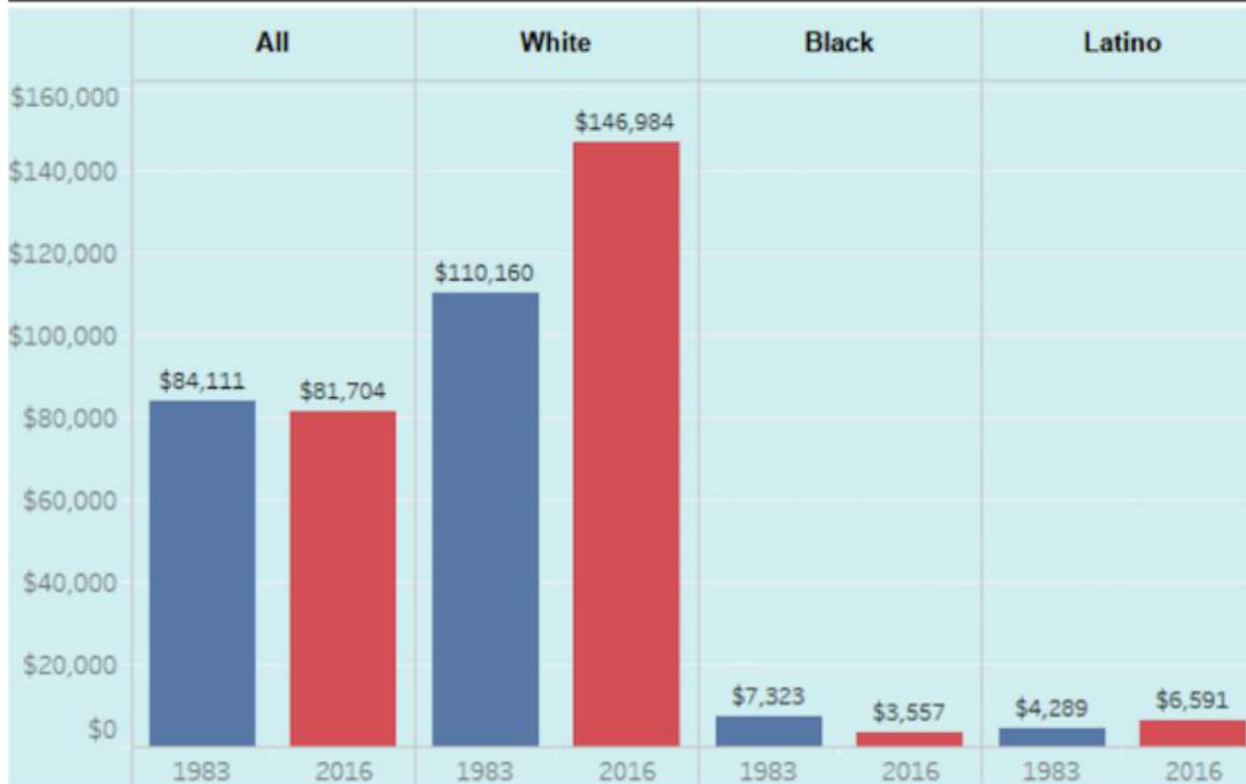

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Source: "Ten Solutions to Bridge the Racial Wealth Divide," by the Institute for Policy Studies, the Kirwan Institute for the Study of Race and Ethnicity and the National Community Reinvestment Committee.

Strategies to address structural forces

- Provide the down-payment for first-time homebuyers in historically segregated or red lined communities.
- Pass a Medicare For All Act that guarantees high quality health care and prevents bankruptcy resulting from the cost of medical expenses.
- Shift tax expenditures toward wealth-building programs for low-wealth people, especially people of color.
- Create a postal banking system to aid the disproportionately large number of people of color who lack bank accounts.
- Adopt a racial equity lens to address public policy to understand the impact of the racial wealth divide
- Create a direct and robust tax on ultra wealth, including inherited wealth and the expanding marginal income tax rates.
- Create a Congressional Committee on Reparations that studies and works toward a reparations plan or policy

Source: "Ten Solutions to Bridge the Racial Wealth Divide," by the Institute for Policy Studies, the Kirwan Institute for the Study of Race and Ethnicity and the National Community Reinvestment Committee.

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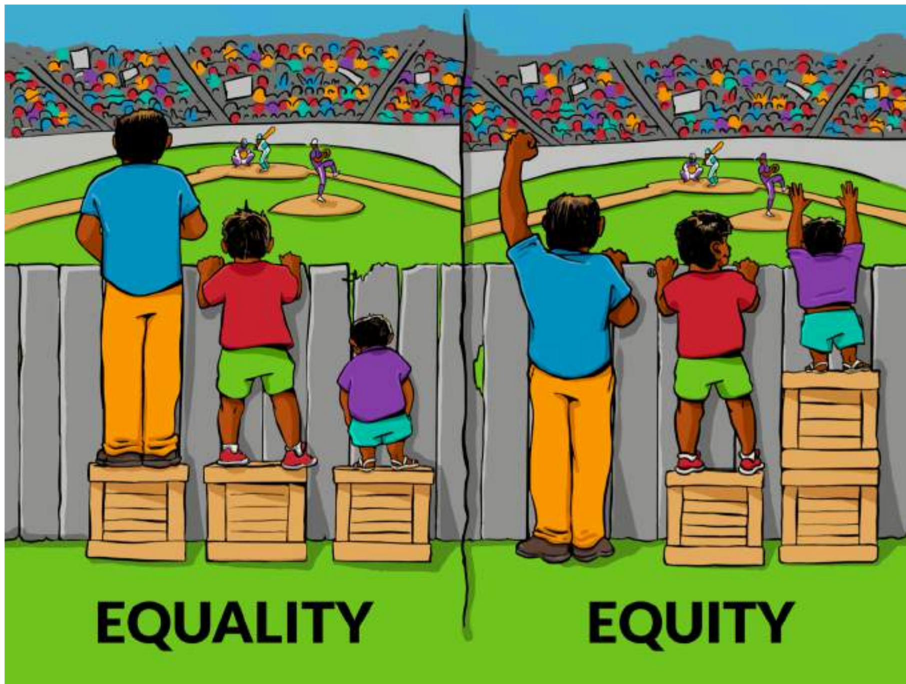
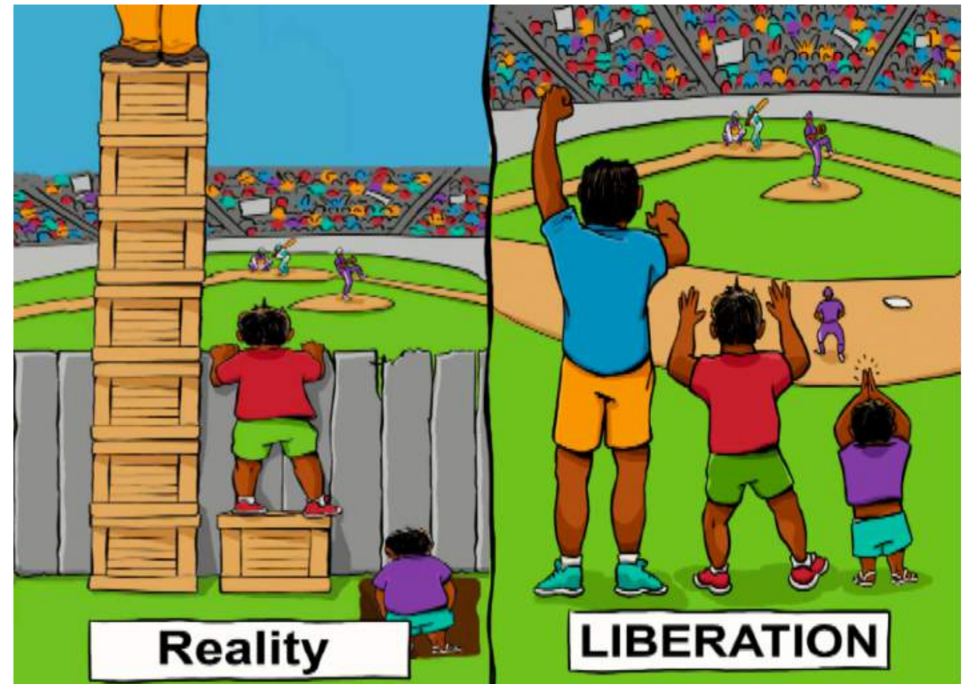

EQUALITY
EQUITY


Reality
LIBERATION

The Case for Reparations

Ta-Nehisi Coates

Discussion

Please share 1-2 reactions to the excerpt

Ta-Nehisi Coates is a national correspondent for *The Atlantic*, where he writes about culture, politics, and social issues. He is the author of *The Beautiful Struggle*, *Between the World and Me*, and *We Were Eight Years in Power*.

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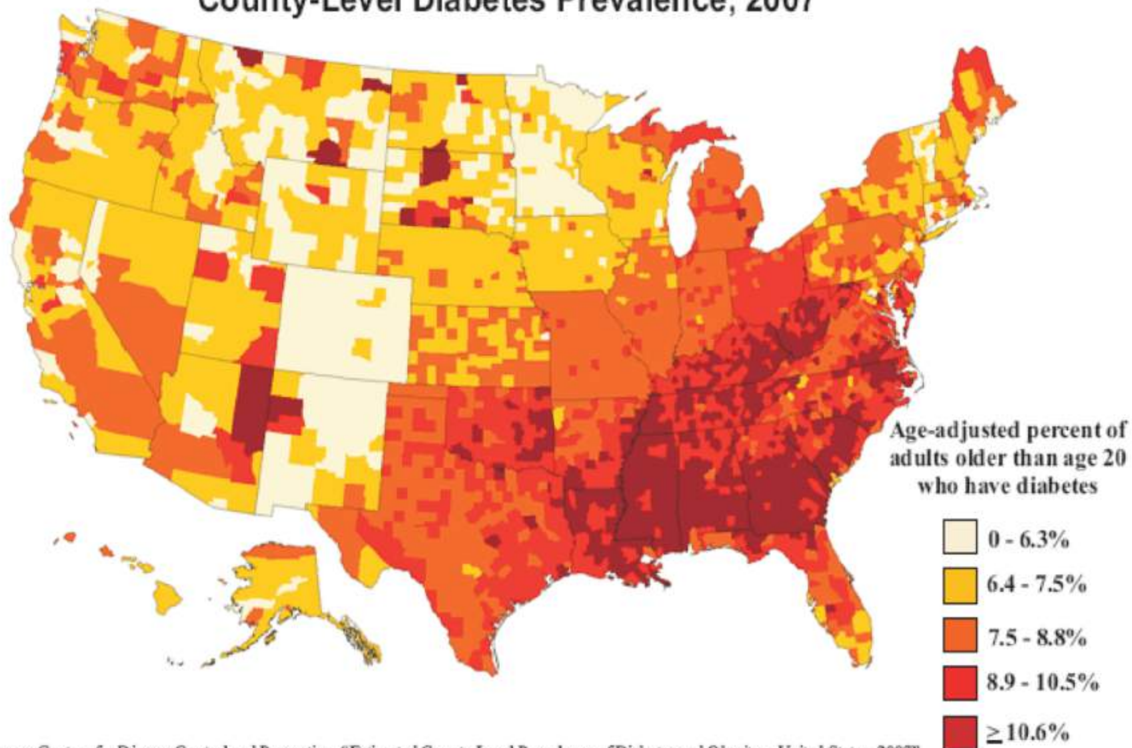
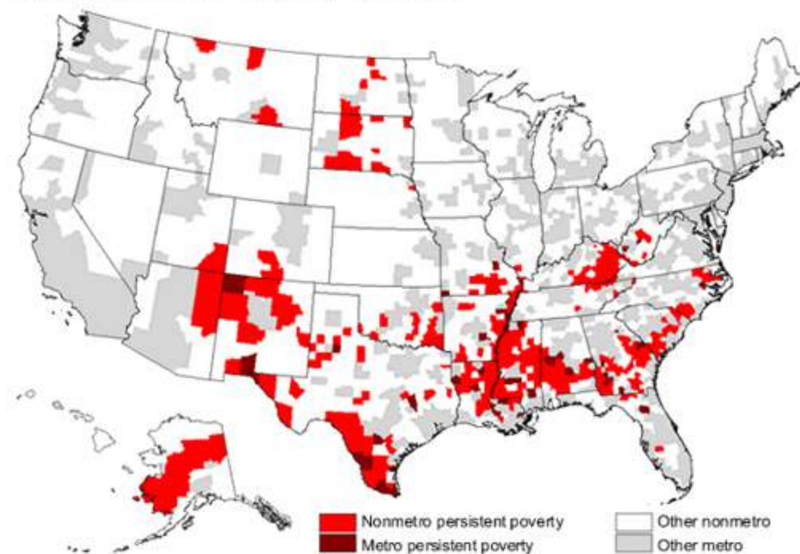


Sources: Centers for Disease Control and Prevention, "Estimated County Level Prevalence of Diabetes and Obesity—United States, 2007" *Morbidity and Mortality Weekly Report* 58 No. 45 (Nov. 20, 2009):1259-1263.



Persistent poverty counties--20 percent or more residents were poor as measured by each of the last four censuses, 1970, 1980, 1990, and 2000.

Source: Economic Research Service, USDA.

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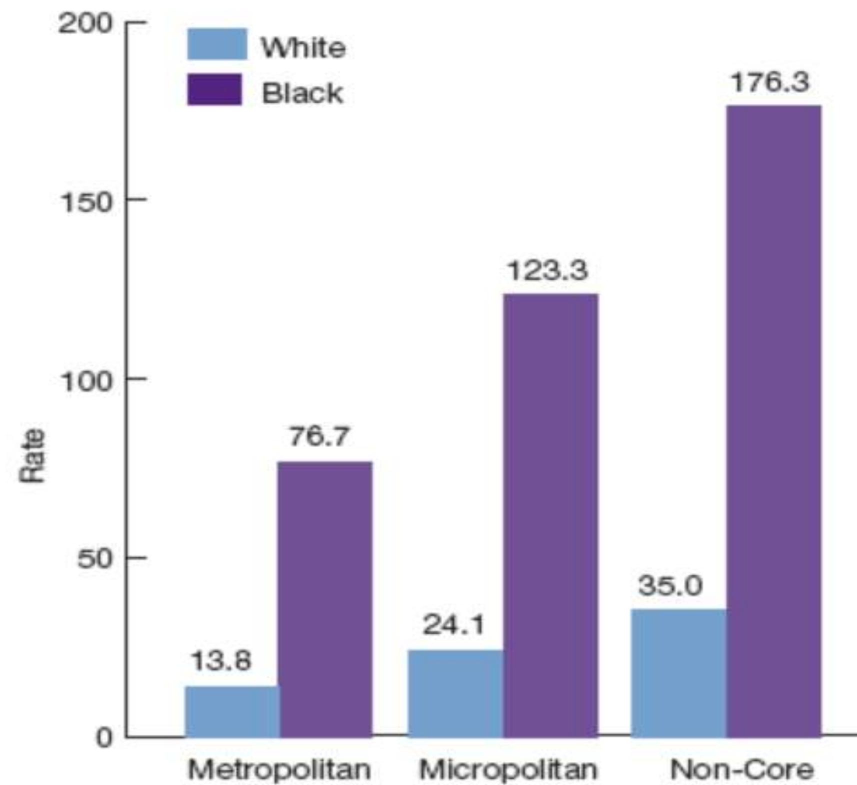
Figure 1. Adult Admissions for Uncontrolled Diabetes Without Complications per 100,000 Population, by Race



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Source: Healthcare Cost and Utilization Project, State Inpatient Databases disparities analysis file, 2001.
Key: Metropolitan = 50,000 or more inhabitants; micropolitan = 10,000 to 50,000 inhabitants; noncore = not metropolitan or micropolitan.

Structural Vulnerability

The risk that an individual experiences as a result of structural violence – including their location in multiple socioeconomic hierarchies.

Structural vulnerability is not caused by, nor can it be repaired solely by, individual agency or behaviors.

Perspective

Chart 1

Structural Vulnerability Assessment Tool[a]

Domain	Screening questions and assessment probes[b]
Financial security	**Do you have enough money to live comfortably—pay rent, get food, pay utilities/telephone?** • How do you make money? Do you have a hard time doing this work? • Do you run out of money at the end of the month/week? • Do you receive any forms of government assistance? • Are there other ways you make money? • Do you depend on anyone else for income? • Have you ever been unable to pay for medical care or for medicines at the pharmacy?
Residence	**Do you have a safe, stable place to sleep and store your possessions?** • How long have you lived/stayed there? • Is the place where you live/stay clean/private/quiet/protected by a lease?
Risk environments	**Do the places where you spend your time each day feel safe and healthy?** • Are you worried about being injured while working/trying to earn money? • Are you exposed to any toxins or chemicals in your day-to-day environment? • Are you exposed to violence? Are you exposed regularly to drug use and criminal activity? • Are you scared to walk around your neighborhood at night/day? • Have you been attacked/mugged/beaten/chased?
Food access	**Do you have adequate nutrition and access to healthy food?** • What do you eat on most days? • What did you eat yesterday? • What are your favorite foods? • Do you have cooking facilities?

Bourgois et al. Structural Vulnerability: Operationalizing the Concept to Address Health Disparities in Clinical Care. Acad Med. 2017 Mar; 92(3): 299–307.

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- **Maternal Mortality**

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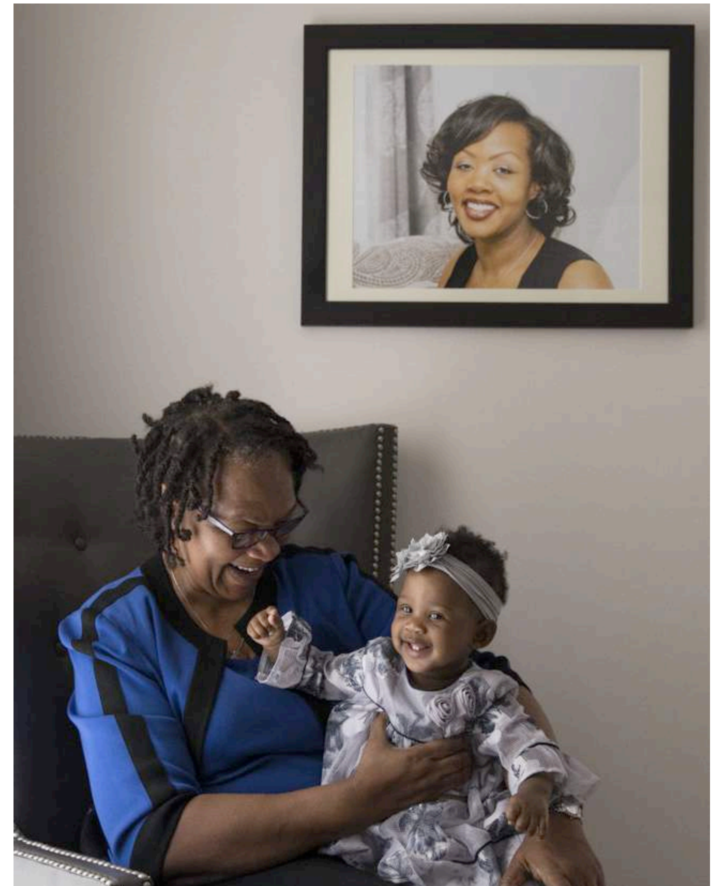
[NPR Story]

Shalon Irving, 1980-2017



Intersectionality

Term coined by Kimberlé Williams Crenshaw

"Holds that the classical conceptualizations of **oppression within society**—such as racism, sexism, classism, ableism, homophobia, transphobia, xenophobia and belief-based bigotry—**do not act independently of each other**. Instead, these forms of oppression interrelate, creating a system of oppression that reflects the **'intersection'** of multiple forms of discrimination."

Module 1: Structures and Patient Health

Naturalizing Inequality

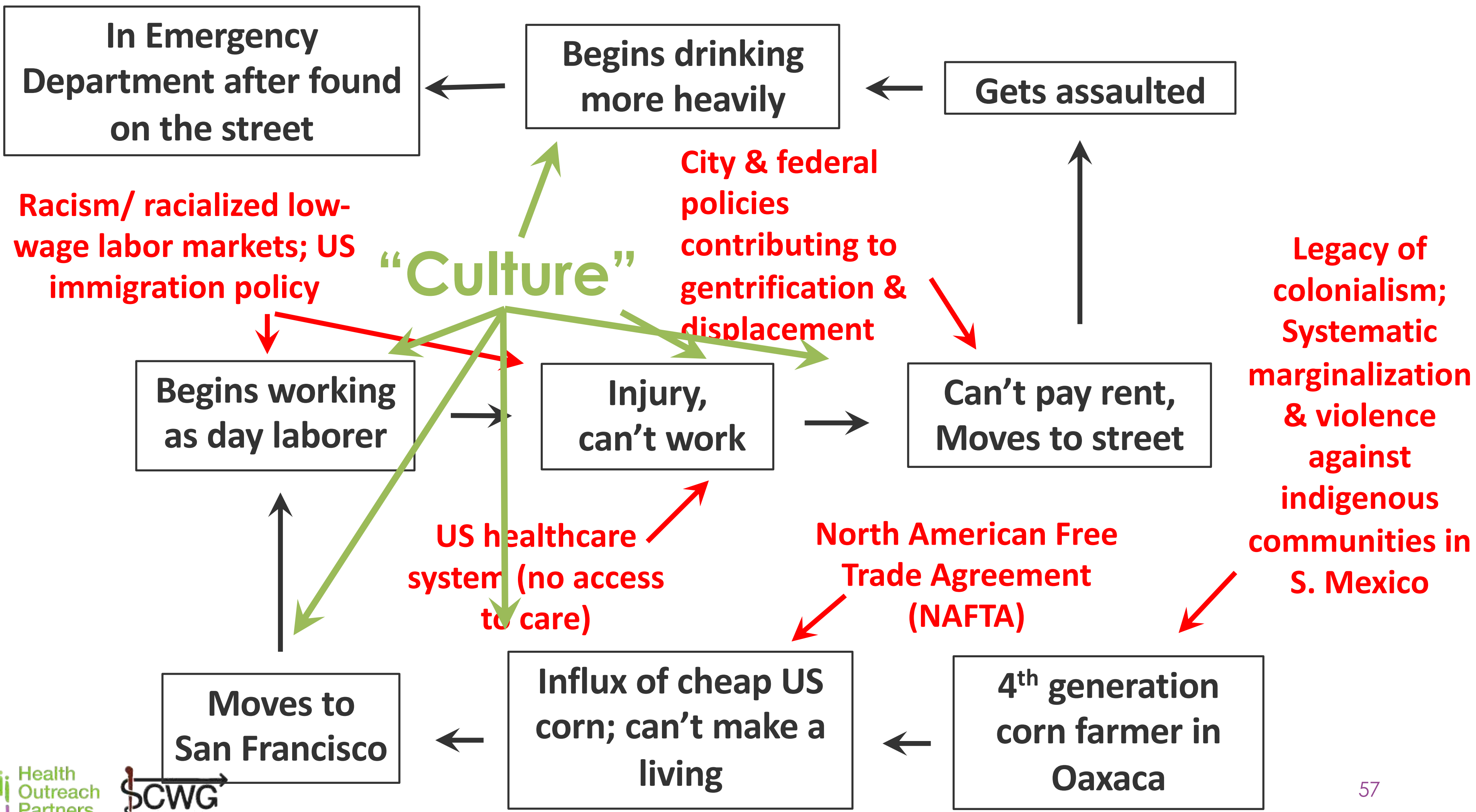
Why is there not more widespread discussion of structural violence and structural vulnerability in our society, and more specifically, in health and health care?

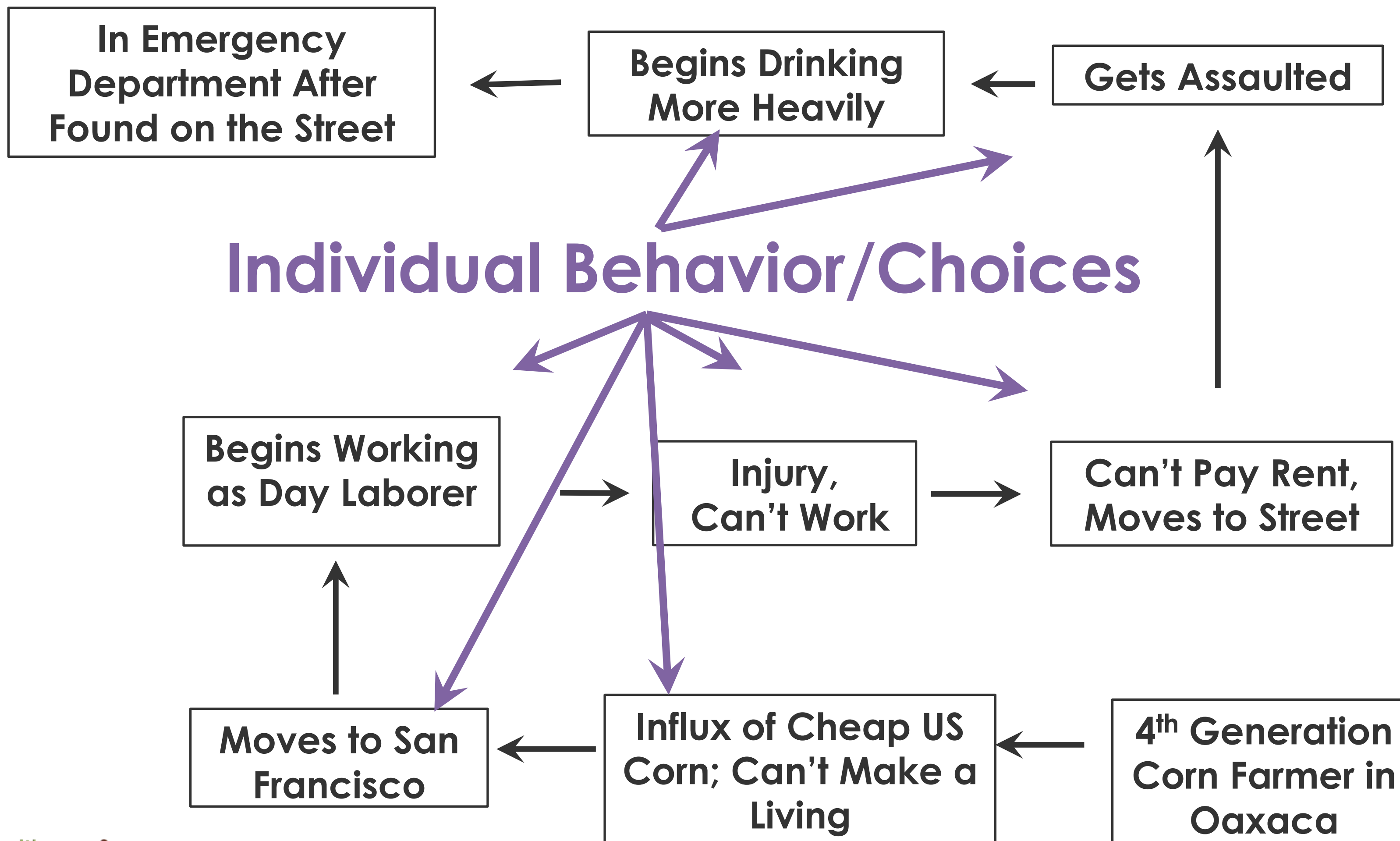
Naturalizing Inequality

- The sometimes subtle, sometimes explicit, ways that structural violence is overlooked
- Often through claims of cultural difference, behavioral shortcomings, or racial categories…
  - which distract from the structural causes of harm
- Operates through "Implicit Frameworks"

Implicit Frameworks

- "Taken-for-granted lenses through which health professionals and patients frequently understand health and wellness, including individualizing frameworks and "cultural" frameworks. Implicit as in "implicit bias." - SCWG
- Examples of Implicit Frameworks
  - Culture
  - Individual Behavior
  - Biology and Genetics


In Emergency Department after found on the street
Begins drinking more heavily
Gets assaulted
City & federal policies contributing to gentrification & displacement
Racism/ racialized low-wage labor markets; US immigration policy
"Culture"
Legacy of colonialism; Systematic marginalization & violence against indigenous communities in S. Mexico
Begins working as day laborer
Injury, can't work
Can't pay rent, Moves to street
US healthcare system (no access to care)
North American Free Trade Agreement (NAFTA)
Moves to San Francisco
Influx of cheap US corn; can't make a living
4th generation corn farmer in Oaxaca
Health Outreach Partners
SCWG



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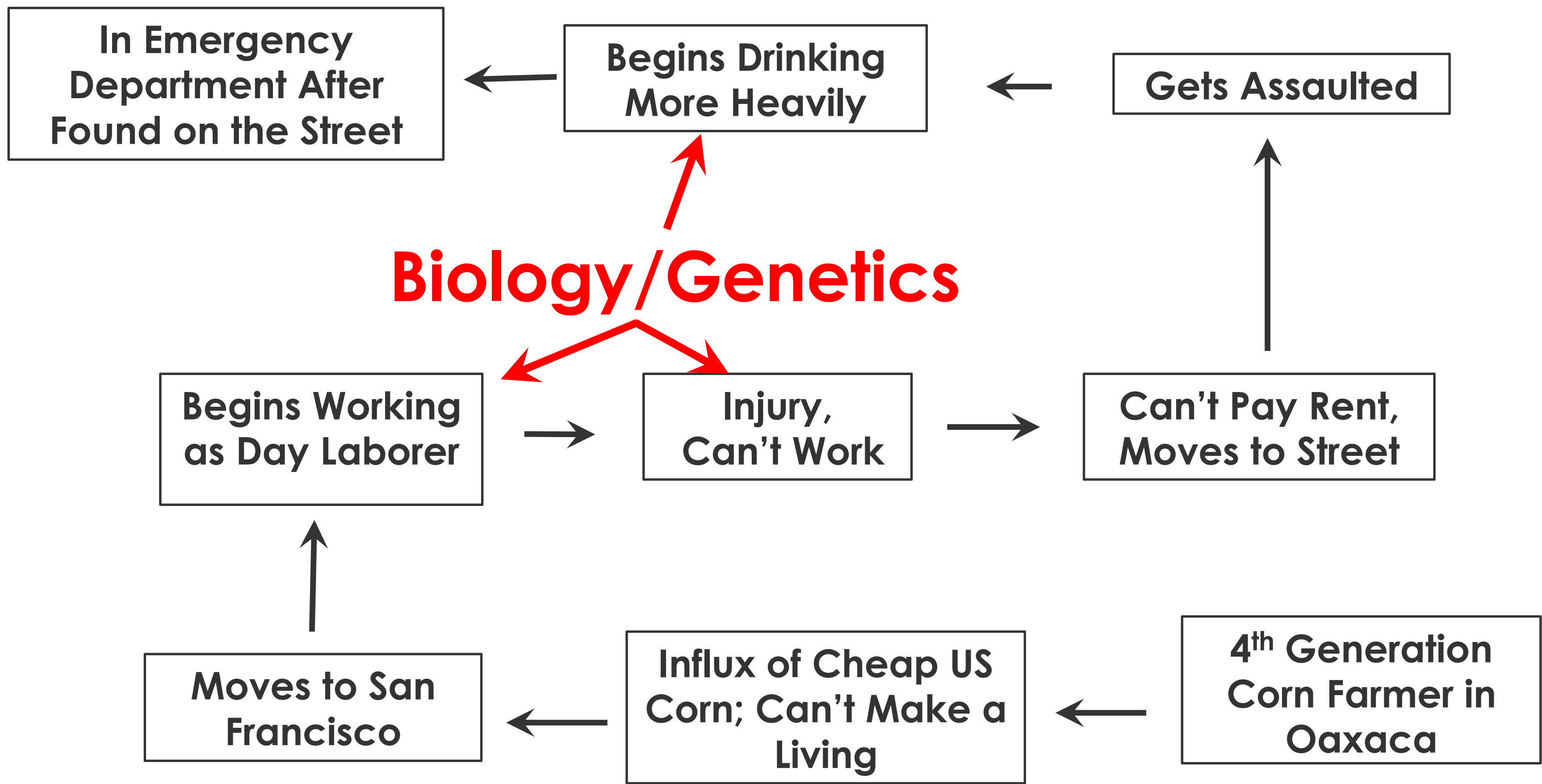

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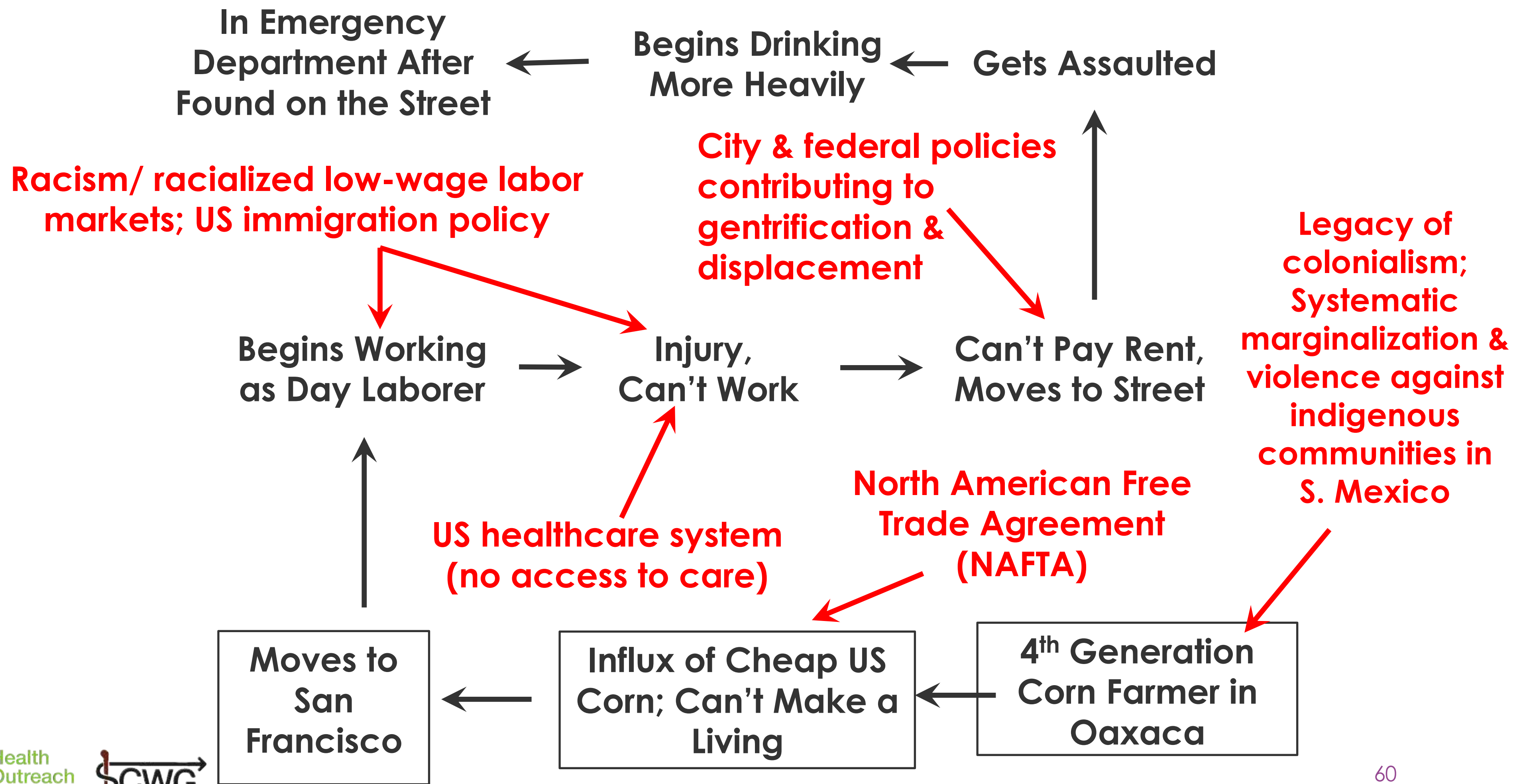
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US healthcare system (no access to care)
Moves to San Francisco
Influx of Cheap US Corn; Can't Make a Living
4th Generation Corn Farmer in Oaxaca
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Exercise #2: Implicit Frameworks

Spend the next 10 minutes reading through both passages. As you read through each passage, underline the parts where you see inequality or injustice naturalized through implicit frameworks:

- Cultural
- Individual behaviors or choices
- Biology or Genetics

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#1: When asked why very few Triqui people were harvesting apples, the field job known to pay the most, the Tanaka Farm's apple crop supervisor explained in detail that "they are too short to reach the apples, and, besides, they don't like ladders anyway." He continued that Triqui people are perfect for picking berries because they are "lower to the ground." When asked why Triqui people have only berry-picking jobs, a mestiza Mexican social worker in Washington state explained that "a los Oaxaquenos les gusta trabajar agachado [Oaxacans like to work bent over]," whereas, she told me, "Mexicanos [mestizo Mexicans] get too many pains if they work in the fields." In these examples and the many other responses they represent, perceived bodily difference along ethnic lines serves to **justify or** **naturalize inequalities**, **making them appear purely or primarily natural and not also social in origin**. Thus, each kind of ethnic body is understood to deserve its relative social position.

-Seth Holmes

"An Ethnographic Study of the Social Context of Migrant Health in the US," 2006

Biology/Genetics

Culture?

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#2: The urgent-care doctor he first saw explained that Abelino should not work, but should rest and let his knee recover. The occupational health doctor he saw the following week said Abelino could work but without bending, walking, or prolonged standing…. After a few weeks, the occupational health doctor passed Abelino to a reluctant physiatrist who told Abelino that he must work hard picking strawberries in order to make his knee better. She told Abelino that he had been picking incorrectly and hurt his knee because he "didn't know how to bend over correctly." Once Abelino had recovered, this doctor explained to the researcher that Abelino no longer felt pain, not because he got better, but because the picking season was over and he could no longer apply for worker's compensation…. Knee and back pain continue to be the most common health complaints among pickers on the Tanaka Farm.

-Seth Holmes

"An Ethnographic Study of the Social Context of Migrant Health in the US," 2006

Individual Behavior/Choices **Contextually Clueless**

Int.J. Behav. Med. (2011) 18:310–318
DOI 10.1007/s12529-010-9119-4

The Relevance of Fatalism in the Study of Latinas' Cancer Screening Behavior: A Systematic Review of the Literature

Karla Espinosa de los Monteros · Linda C. Gallo

"Fatalism has been identified as a dominant belief among Latinos and is believed to act as a barrier to cancer prevention."

"Culture"

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ELSEVIER

Social Science & Medicine 59 (2004) 973–986

MEDICINE

www.elsevier.com/locate/socscimed

Should "acculturation" be a variable in health research? A critical review of research on US Hispanics

Linda M. Hunt[a,b,*], Suzanne Schneider[a], Brendon Comer[b]

[a] *Department of Anthropology, Michigan State University, East Lansing, MI 48824, USA*
[b] *Julian Samora Research Institute, Michigan State University, East Lansing, MI 48824, USA*

"In the absence of a clear definition and an appropriate historical and socio-economic context, the concept of acculturation has come to function as an ideologically convenient black box, wherein **problems of unequal access to health posed by more material barriers, such as insurance, transportation, education, and language, are pushed from the foreground, and ethnic culture is made culpable for health inequalities."**

Naturalizing Inequality

In a survey of public health theory courses:

- 93% of frequently taught theories of disease distribution are behavior/lifestyle-focused
- Only 1 was structural (fundamental cause theory)

-Harvey and McGladrey, forthcoming

Individual Behavior/Choices

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Naturalizing Inequality

Journal of Hypertension. 18(11):1537-44, NOV 2000 Share Print

PMID: 11081764

MEDLINE Status: MEDLINE

Issn Print: 0263-6352

Is greater tissue activity of creatine kinase the genetic factor increasing hypertension risk in black people of sub-Saharan African descent?

L M Brewster; J F Clark; G A van Montfrans

"We postulate that the genetic factor increasing the propensity of black people of sub-Saharan African descent to develop high blood pressure is the relatively high activity of creatine kinase, predominantly in vascular and cardiac muscle tissue."

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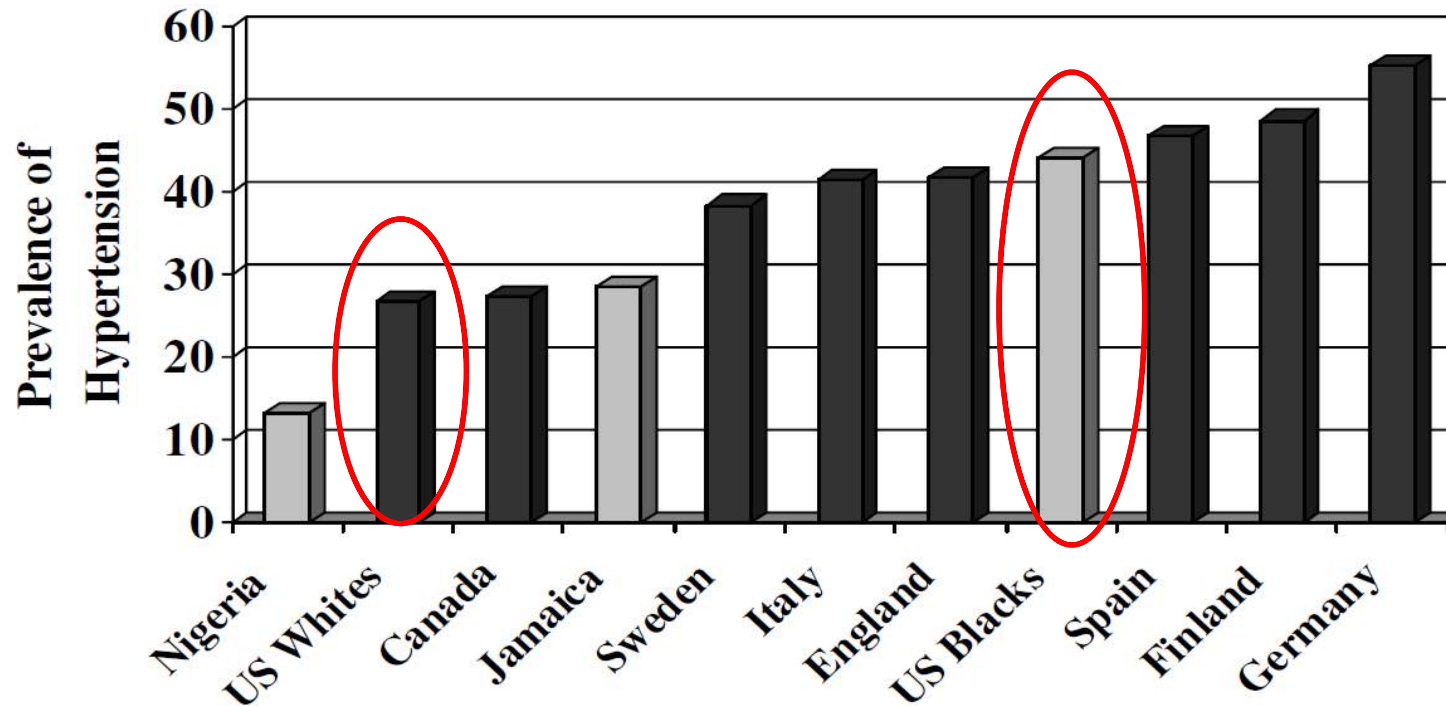
Biology/Genetics

Naturalizing Inequality



Naturalizing Inequality

ETHNIC ISSUES. Minority ethnic groups are increasing as a proportion of the total U.S. population, with Hispanics being the fastest growing group. Considerable evidence exists for differences in CVD epidemiology between whites and African Americans and Native Americans. African Americans have higher blood pressures and worse hypertensive outcomes than whites, and some Native American groups have a sharp excess of diabetes. Data also suggest excess obesity and diabetes in Hispanics and a high risk of insulin resistance and CVD among immigrants from the Indian Subcontinent.

Cecil *Medicine* 22nd Ed.

Biology/Genetics?

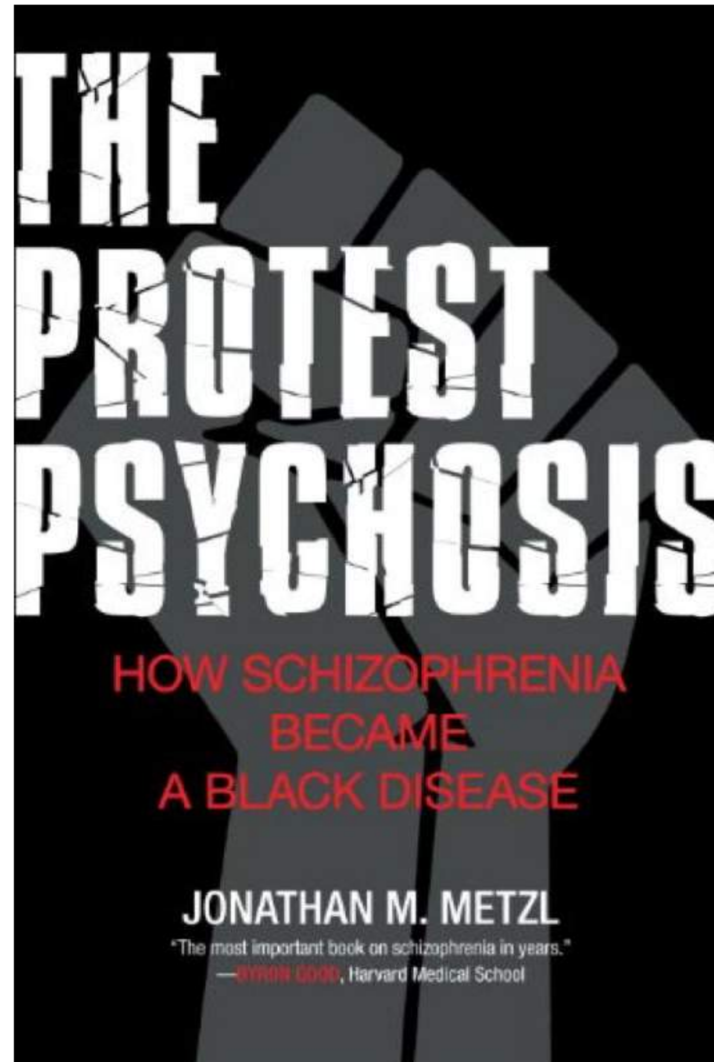
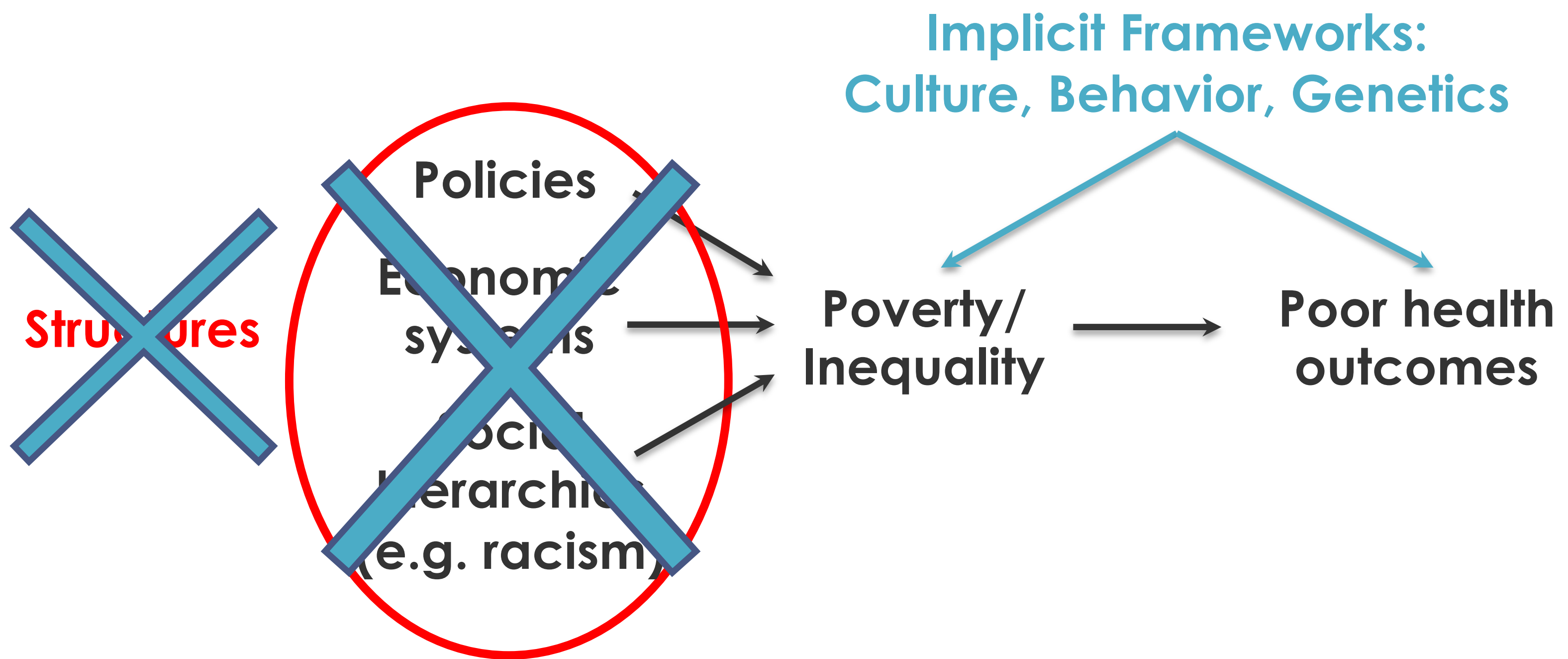
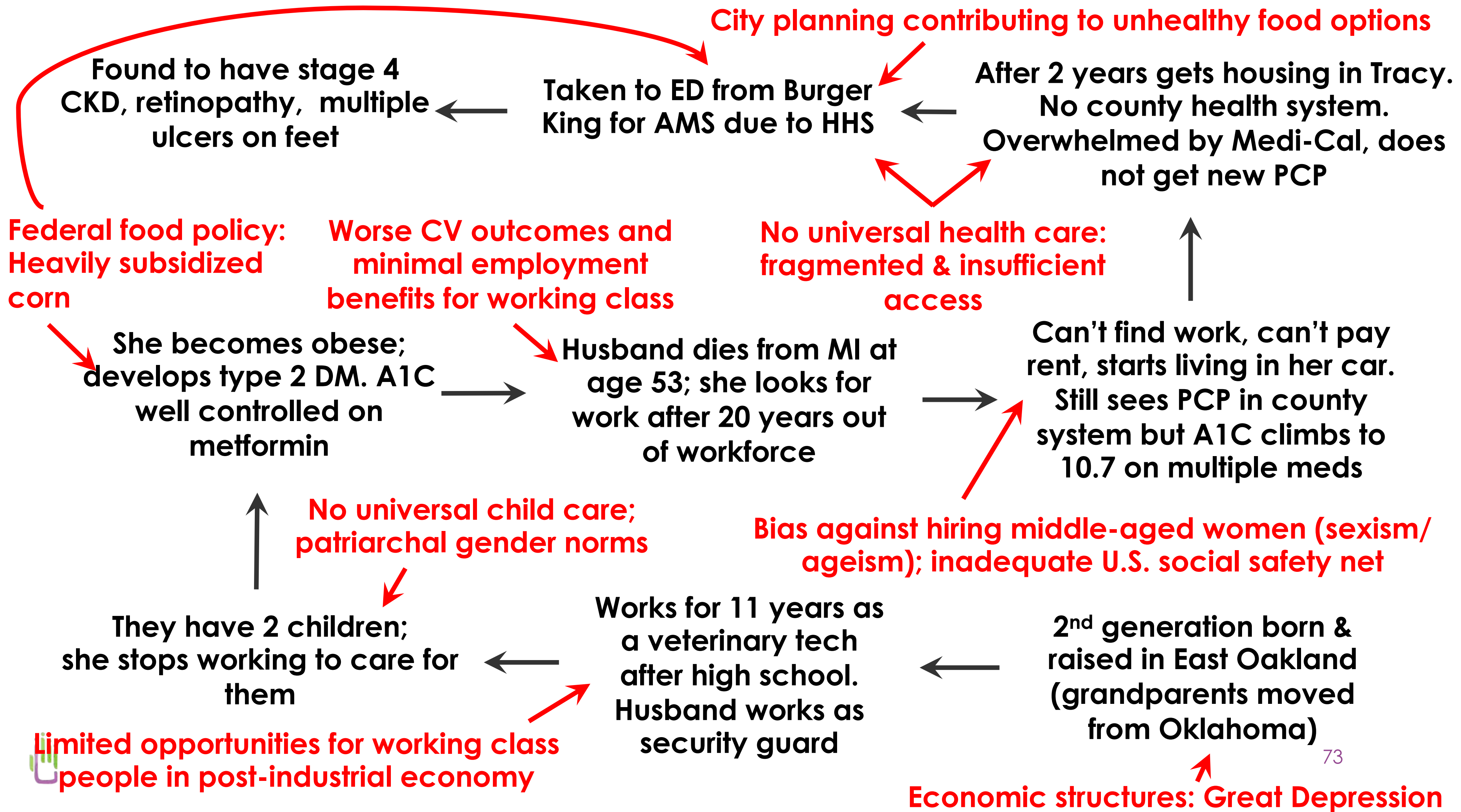
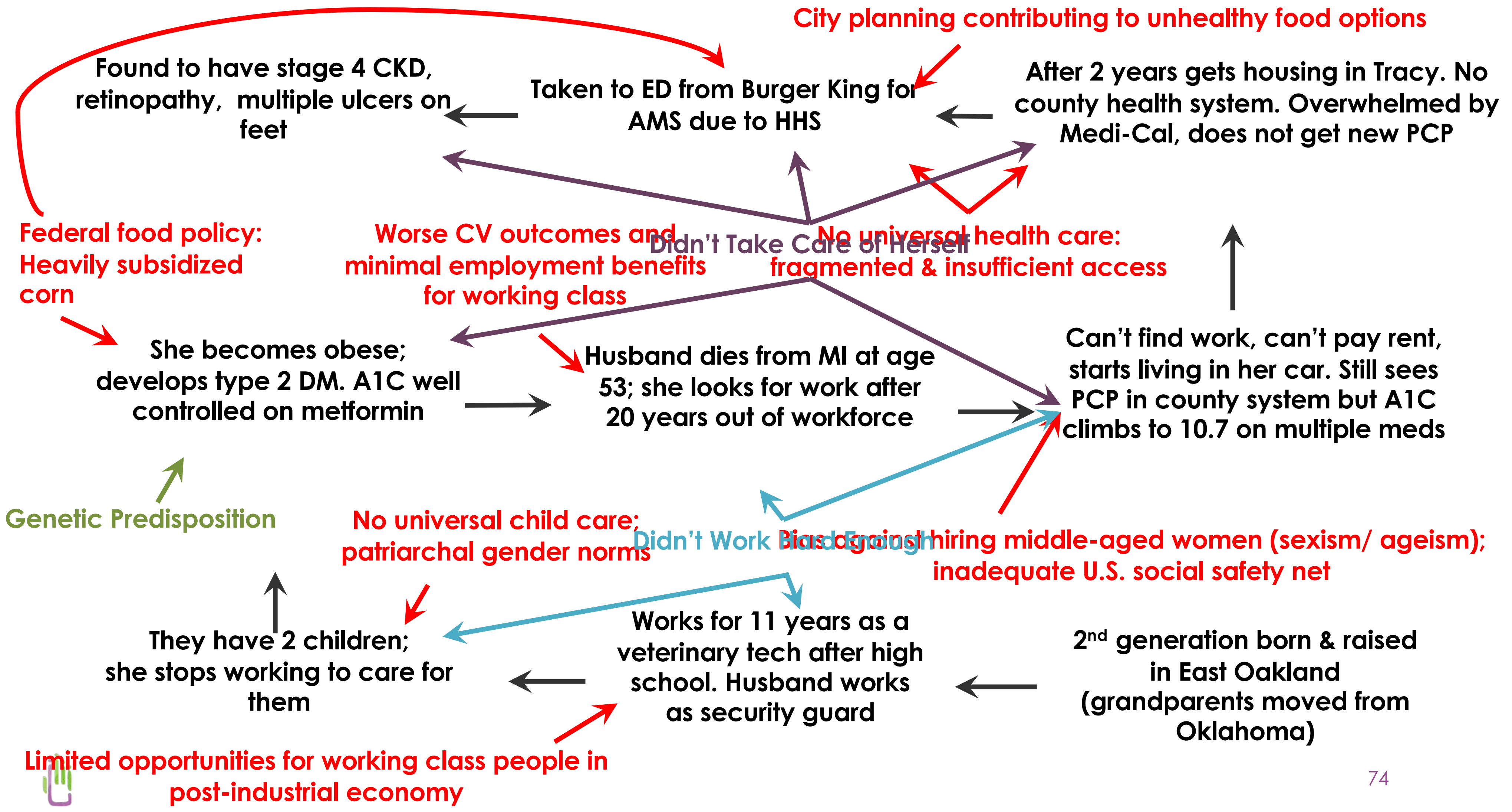

THE
PROTEST
PSYCHOSIS
HOW SCHIZOPHRENIA
BECAME
A BLACK DISEASE
JONATHAN M. METZL
"The most important book on schizophrenia in years."
Harvard Medical School

Figure 2. 1974 Haldol advertisement, *Archives of General Psychiatry* [41].



In what ways did naturalizing inequality play a role in the patient case study?


City planning contributing to unhealthy food options
Found to have stage 4 CKD, retinopathy, multiple ulcers on feet
Taken to ED from Burger King for AMS due to HHS
After 2 years gets housing in Tracy. No county health system. Overwhelmed by Medi-Cal, does not get new PCP
Federal food policy: Heavily subsidized corn
Worse CV outcomes and minimal employment benefits for working class
No universal health care: fragmented & insufficient access
She becomes obese; develops type 2 DM. A1C well controlled on metformin
Husband dies from MI at age 53; she looks for work after 20 years out of workforce
Can't find work, can't pay rent, starts living in her car. Still sees PCP in county system but A1C climbs to 10.7 on multiple meds
No universal child care; patriarchal gender norms
Bias against hiring middle-aged women (sexism/ ageism); inadequate U.S. social safety net
They have 2 children; she stops working to care for them
Works for 11 years as a veterinary tech after high school. Husband works as security guard
2nd generation born & raised in East Oakland (grandparents moved from Oklahoma)
Limited opportunities for working class people in post-industrial economy
Economic structures: Great Depression



City planning contributing to unhealthy food options
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Federal food policy: Heavily subsidized corn
Worse CV outcomes and minimal employment benefits for working class
Didn't Take Care of Herself
No universal health care: fragmented & insufficient access
She becomes obese; develops type 2 DM. A1C well controlled on metformin
Husband dies from MI at age 53; she looks for work after 20 years out of workforce
Can't find work, can't pay rent, starts living in her car. Still sees PCP in county system but A1C climbs to 10.7 on multiple meds
Genetic Predisposition
No universal child care; patriarchal gender norms
Didn't Work Hard Enough
Bias against hiring middle-aged women (sexism/ ageism); inadequate U.S. social safety net
They have 2 children; she stops working to care for them
Works for 11 years as a veterinary tech after high school. Husband works as security guard
2nd generation born & raised in East Oakland (grandparents moved from Oklahoma)
Limited opportunities for working class people in post-industrial economy

Exercise #3: Structural Violence

1. Write about examples of structural violence leading to poor health for patients you have encountered or other people you have known.

2. What are the **structures** involved, and how are they **violent** (how do they harm people)?

Feedback (Module 1)

- What parts of this morning's session worked well? What parts did you like or find most valuable? What expectations of yours did we meet or exceed?
- What should we change? How can we make this portion of the training more effective? Any parts that you felt were not helpful or worthwhile?
- Which parts of this morning's session are relevant for your organization? Which parts are not?

Structural Competency: Origins and Definition

What is culture?

Culture:
"Attitudes and behaviors, which are characteristic of a social group or community ."

Source: https://www.hrsa.gov/about/organization/bureaus/ohe/health-literacy/resources/index.html

Cultural Competency:
"A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations."

Source: Thackrah, R.D. and Thompson, S., "Refining the concept of cultural competence: building on decades of progress," *The Medical Journal of Australia 199* (1)(2013): 35-38.

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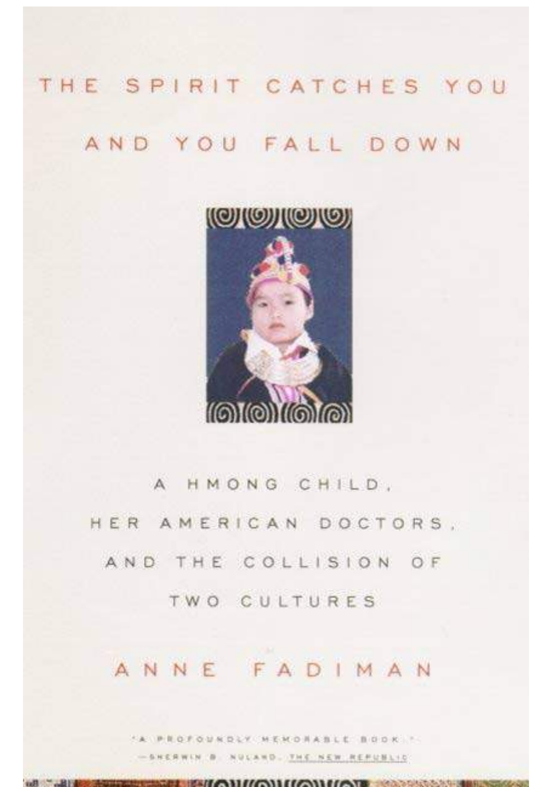
Cultural Competency

- Motivation: Providers and patients can misunderstand one another if they have different understandings of illness and health
- Cultural competency ideally helps providers to recognize that their own views are also culturally determined
- But it often became “list of traits” to memorize (not about white people though…)



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Focus on Diversity and Culture Cultural Differences in Response to Pain

A clients' culture influences their response to and beliefs about pain. Some common cultural differences related to pain are listed here.

Arabs/Muslims

- May not request pain medicine but instead thank Allah for pain if it is the result of a healing medical procedure.
- Pain is considered a test of faith. Therefore Muslim clients must endure pain as a sign of faith in return for forgiveness and mercy. However, Muslims must seek pain relief when necessary because needless pain and suffering are frowned upon.
- Arabs and Muslims prefer to be with family when in pain and may express pain more freely around family.

Asians

- Chinese clients may not ask for medication because they do not want to take the nurse away from a more important task.
- Clients from Asian cultures often value stoicism as a response to pain. A client who complains openly about pain is thought to have poor social skills.
- Filipino clients may not take pain medication because they view pain as being the will of God.
- Indians who follow Hindu practices believe that pain must be endured in preparation for a better life in the next cycle.

Blacks

- Blacks often report higher pain intensity than other cultures.
- They believe suffering and pain are inevitable.
- They believe in prayer and laying on of hands to heal pain and believe that relief is proportional to faith.

Jews

- Jews may be vocal and demanding of assistance.
- They believe that pain must be shared and validated by others.

Hispanics

- Hispanics may believe that pain is a form of punishment and that suffering must be endured if they are to enter heaven.
- They vary widely in their expression of pain: Some are stoic and some are expressive.
- Catholic Hispanics may turn to religious practices to help them endure the pain.

Native Americans

- Native Americans may prefer to receive medications that have been blessed by a tribal shaman. They believe such a blessing allows the client to be more at peace with the creator and makes the medicine stronger.
- They tend to be less expressive both verbally and nonverbally.
- They usually tolerate a high level of pain without requesting pain medication.
- They may pick a sacred number when asked to rate pain on a numerical pain scale.

Sources: Based on Munoz, C., & Luckmann, J. (2005). *Transcultural communication in nursing* (2nd ed.). Clifton Park, NY: Delmar Learning; Andrews, M. M., & Boyle, J. S. (2003). *Transcultural concepts in nursing care* (4th ed.). Philadelphia, PA: Lippincott Williams & Wilkins; Al-Atiyyat, N. M. H. (2009). Cultural diversity and cancer pain. *Journal of Hospice and Palliative Nursing, 11*(3), 154–164; Davidhizar, R., & Giger, J. N. (2004). A review of the literature on care of clients in pain who are culturally diverse. *International Nursing Review, 51*(1), 47–55.

Reflection Activity: I Am?

Cultural Humility

- Developed out of a concern that some approaches to cultural competency were lists of stereotypes

- "A commitment and active engagement in a lifelong process that individuals enter into on an ongoing basis with patients, communities, colleagues, and with themselves."

  —Tervalon and Murray-Garcia, 1998

- Emphasizes ongoing humility, self-reflection, self-critique, and lifelong learning

Conflating Culture

"In attempting to address racial and ethnic disparities in care through cultural competence training, **educators too often conflate these distinct concepts**. This leads to an inappropriate collapsing of many of the forces affecting racial and ethnic minority populations—such as poverty, violence, and racism—into the less threatening concept of culture."

—Gregg and Saha, 2006

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Dr. Jonathan Metzl

Structural Competency

"A shift in medical education … toward attention to forces that influence health outcomes at levels above individual interactions."

–Metzl and Hansen 2014

Dr. Helena Hansen

The capacity for health professionals to recognize and respond to health and illness as the downstream effects of broad social, political, and economic structures.

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Structural Competency

Develop capacity in the following five areas:

1. Recognizing the influences of structures on patient health
2. Recognizing the influences of structures on the practice of healthcare
3. Responding to the influences of structures in the clinic
4. Responding to the influences of structures beyond the clinic
5. Practice structural humility

Structural Humility

Structural humility cautions providers against making assumptions about the role of structures in patients' lives, instead encouraging collaboration with patients and communities in developing understanding of and responses to structural vulnerability.

—Based on talk by Helena Hansen, April 2015

“Structural” and “competency”

Structural:

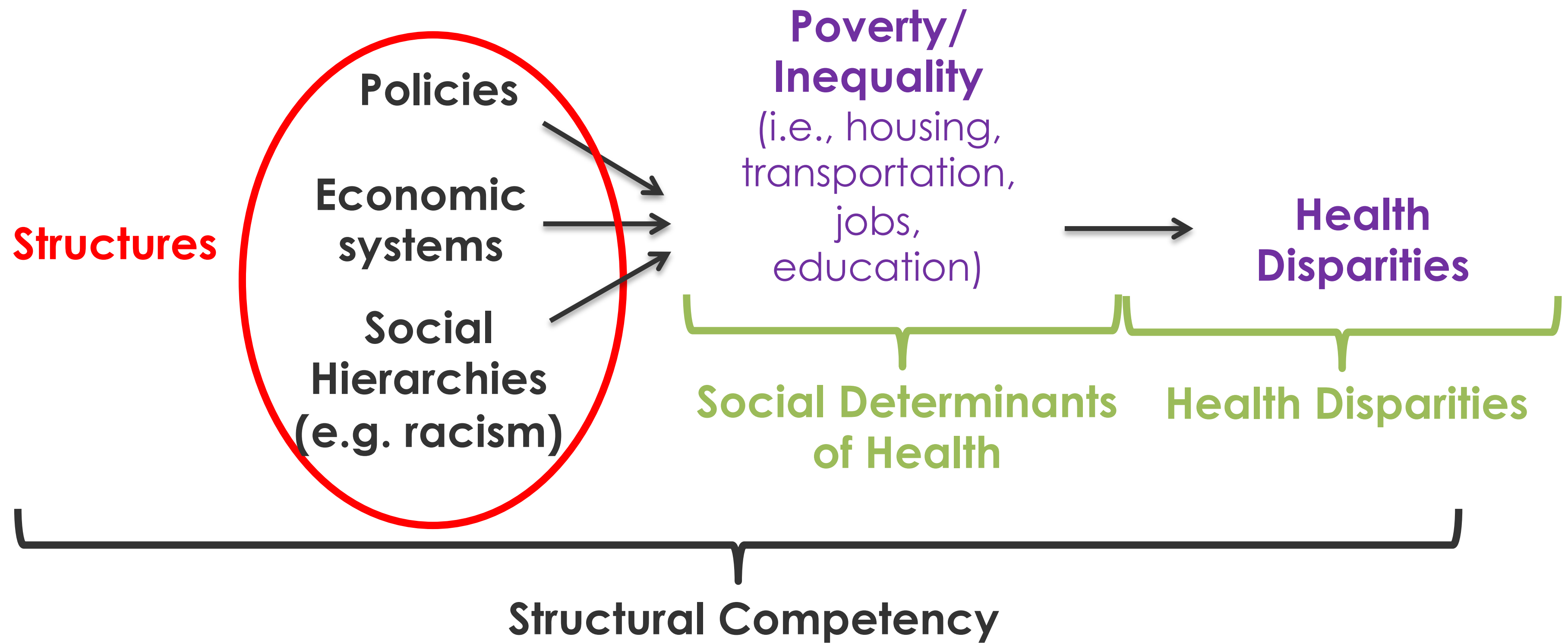
1. As used in “structural violence”
2. Maybe resistant to being watered down?

Competency:

1. As seen in “cultural competency”
2. US medical education framing
3. Suggests this content should be part of all providers’ training

Why not just call the whole thing “structural humility” like “cultural humility”?

1. We’re not trying to change culture, so it makes sense to center humility
2. Structures can and sometimes should be changed – so while humility is an important piece of the whole, it doesn’t capture the full spirit of the effort
3. Other terms we could consider using (if not for the advantages of the word “competency”) include structural “attentiveness” and/or “responsiveness”



"Structural determinants of the social determinants of health"

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Comparing Frameworks

Concept	Cultural Competency	Cultural Humility	SDOH
Strengths	Challenges assumptions of one "dominant culture"	Encourages the practice of self-reflection, humility, and lifelong learning	Attempts to understand and address social and economic conditions influencing health outcomes
Limitations	"List of traits" version of training	Does not attempt to address social, political, and economic factors influencing health outcomes	Focus on conditions rather than overarching structures

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But don't we already know this stuff?

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Teaching Structure

"I have been thinking about it constantly, in almost every one of my clinics and almost every day in the hospital, and it came up in conversation with my co-residents who are also really passionate about it. It has been on my mind constantly."

– Family medicine resident participant, 1 month after training

"I have a language and frameworks to use in something I have been teaching to residents for years without the language."

– Family medicine residency faculty participant, immediately post-training

"I want to emphasize how valuable I found it to have a shared vocabulary, to know [others] know the same terms that I do… it just lowers the barrier to having these conversations. It's a lot easier to talk about now."

– Family medicine resident participant, 1 month after training

Source: Neff et al, "Teaching Structure." Journal of Gen Internal Medicine, 2017

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Why is structural competency important for health and healthcare workers?

No neutral position – if you're not thinking structurally, you're thinking through some other (implicit) frame

"If you are neutral in situations of injustice, you have chosen the side of the oppressor. If an elephant has its foot on the tail of a mouse and you say that you are neutral, the mouse will not appreciate your neutrality."

—Desmond Tutu

Why is structural competency important for providers to learn?

- Good for patients – can improve the care patients receive
- Good for providers can help with burnout
- Providers are in a powerful position for advocacy

Flint Water Crisis

By Mona Hanna-Attisha
Feb. 11, 2017

FLINT, Mich. — Eighteen months ago, as a pediatrician here, I discovered that the untreated tap water corroding the city's plumbing was poisoning our children with lead. State officials called my science faulty and accused me of creating hysteria. But I was right and persisted, and with brave parents, pastors, journalists and scientists demanded answers until this continuing public health disaster was finally acknowledged. An entire city, with about 10,000 young children, was unnecessarily exposed to lead, a neurotoxin that causes irreversible brain damage. The corrosive water also likely caused the deaths of a dozen people from Legionnaires' disease. Flint remains traumatized.

Elevated Blood Lead Levels in Children Associated With the Flint Drinking Water Crisis: A Spatial Analysis of Risk and Public Health Response

Mona Hanna-Attisha, MD, MPH, Jenny LaChance, MS, Richard Casey Sadler, PhD, and Allison Champney Schnepp, MD

Objectives. We analyzed differences in pediatric elevated blood lead level incidence before and after Flint, Michigan, introduced a more corrosive water source into an aging water system without adequate corrosion control.

Methods. We reviewed blood lead levels for children younger than 5 years before (2013) and after (2015) water source change in Greater Flint, Michigan. We assessed the percentage of elevated blood lead levels in both time periods, and identified geographical locations through spatial analysis.

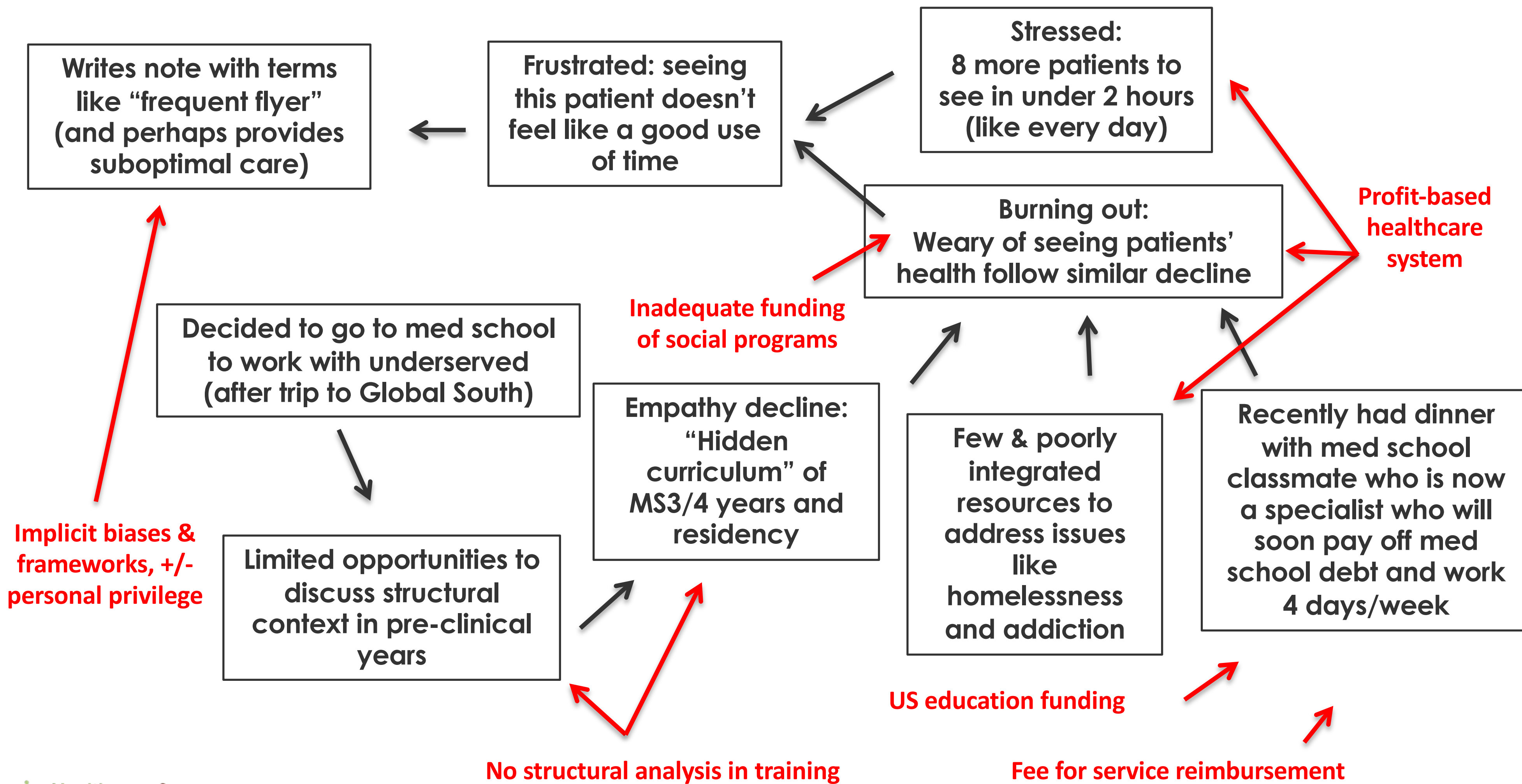
Results. Incidence of elevated blood lead levels increased from 2.4% to 4.9% ($P < .05$) after water source change, and neighborhoods with the highest water lead levels experienced a 6.6% increase. No significant change was seen outside the city. Geospatial analysis identified disadvantaged neighborhoods as having the greatest elevated blood lead level increases and informed response prioritization during the now-declared public health emergency.

Conclusions. The percentage of children with elevated blood lead levels increased after water source change, particularly in socioeconomically disadvantaged neighborhoods. Water is a growing source of childhood lead exposure because of aging infrastructure. (*Am J Public Health.* 2016;106:283–290. doi:10.2105/AJPH.2015.303003)

percentage of lead pipes and lead plumbing, with estimates of lead service lines ranging from 10% to 80%.[7] Researchers from Virginia Tech University reported increases in water lead levels (WLLs),[5] but changes in blood lead levels (BLLs) were unknown.

Lead is a potent neurotoxin, and childhood lead poisoning has an impact on many developmental and biological processes, most notably intelligence, behavior, and overall life achievement.[8] With estimated societal costs in the billions,[9–11] lead poisoning has a disproportionate impact on low-income and minority children.[12] When one considers the irreversible, life-altering, costly, and disparate impact of lead exposure, primary prevention is necessary to eliminate exposure.[13]

Historically, the industrial revolution's



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What is your arrow diagram?

- What social structures influenced your education and training?
- What social structures are present in your day-to-day work?
- How do they influence your interactions with your colleagues, with patients, and with the community?

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Why is structural competency important for communities and society as a whole?

"It [structural competency] has been very effective in helping to build a partnership with patients. Acknowledging that the system is failing all of us… helps to build that relationship in a different way."

"The blame went from here's this patient who makes poor choices to here we are as a society failing huge portions of our population."

– Family medicine residents, 1 month after training

Source: Neff et al, "Teaching Structure." Journal of Gen. Internal Medicine, 2017

Feedback (Module 2)

- What parts of this afternoon's session worked well? What parts did you like or find most valuable? What expectations of yours did we meet or exceed?
- What should we change? How can we make this portion of the training more effective? Any parts that you felt were not helpful or worthwhile?
- Which parts of this afternoon's session are relevant for your organization? Which parts are not?

10 Minutes

10 Minute Energizer

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HEALTHY PEOPLE. EQUITABLE COMMUNITIES.

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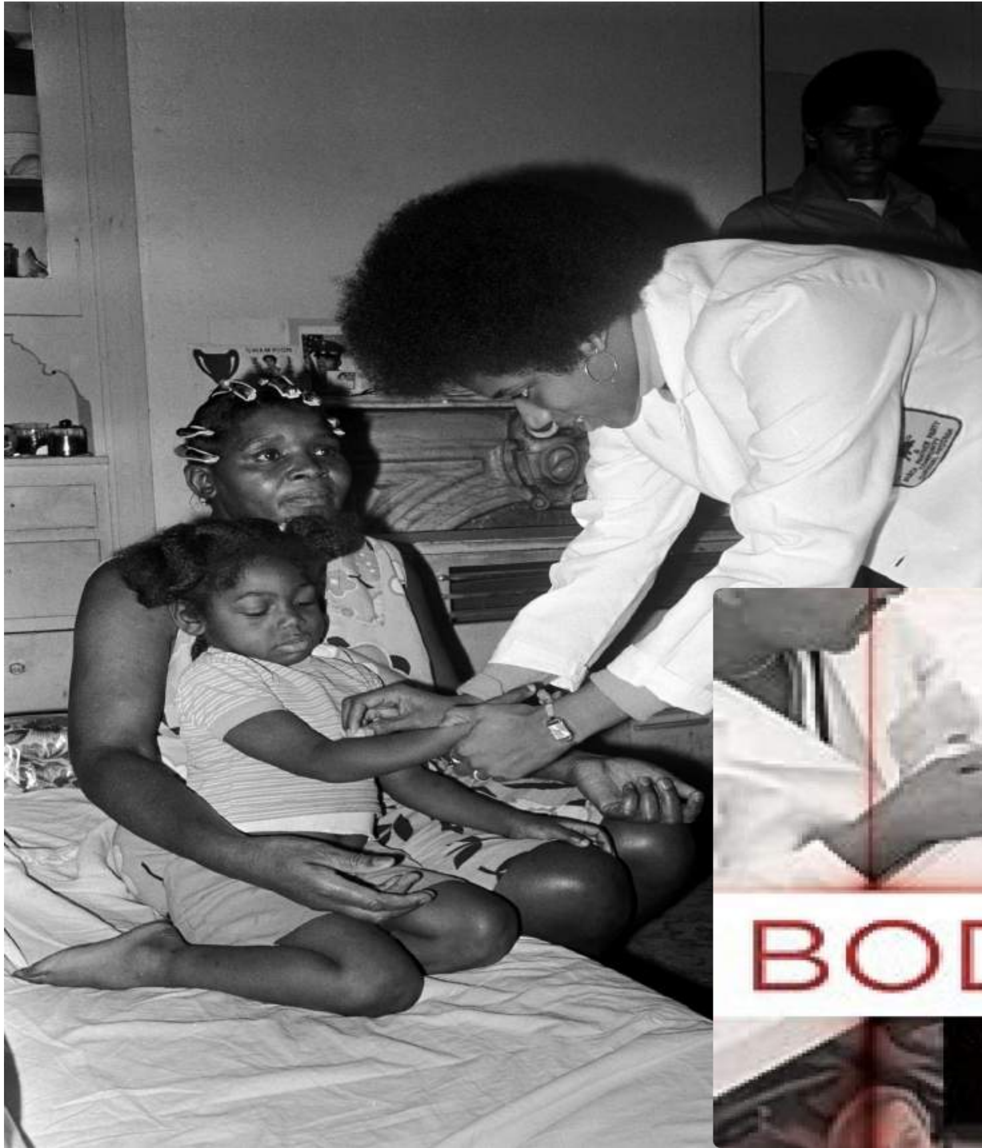
Module 3: Imagining Structural Interventions

The Integrated Soft Tissue Infection Service Clinic

"They prioritized pain management and recruited experienced clinicians committed to what they called 'compassionate' healthcare for injection drug-users."
– Messac et al.

The People’s Free Health Clinics of the Black Panther Party



The Federally-funded Community Health Center Movement

A stir of hope in Mound Bayou

ACT UP PHILADELPHIA

DYING FOR HOMES

HOW MAYOR NUTTER IS WASTING CITY MONEY AND FAILING PEOPLE WITH AIDS

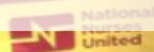
A report on the Philadelphia AIDS Housing Crisis

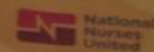
ACT UP

> "City policy was changed in accordance with ACT UP's housing first, harm reduction demands"
>
> – Messac et al.

California Nurses Association

- "CNA/NNOC sponsored the nation's foremost RN patient safety law, in California, requiring minimum RN-to-patient ratios…Other landmark laws sponsored by CNA/NNOC in California include whistleblower protections for caregivers who expose unsafe hospital conditions, a ban on inappropriate personnel providing telephone medical advice, and increased funding for nursing education programs." – CNA/NNOC





Levels of Intervention

- Intrapersonal
- Interpersonal
- Clinic
- Community
- Research
- Policy

In Emergency Department after found on the street
Begins drinking more heavily
Gets assaulted
Racism/ racialized low-wage labor markets; US immigration policy
City & federal policies contributing to gentrification & displacement
Legacy of colonialism; Systematic marginalization & violence against indigenous communities in S. Mexico
Begins working as day laborer
Injury, can't work
Can't pay rent, Moves to street
US healthcare system (no access to care)
North American Free Trade Agreement (NAFTA)
Moves to San Francisco
Influx of cheap US corn; can't make a living
4th generation corn farmer in Oaxaca

In Emergency Department After Found on Street

Begins Drinking More Heavily

Gets Assaulted

Can't Pay Rent, Moves to Street

Injury, Can't Work

Begins Working as Day Laborer

Moves to San Francisco

Influx of Cheap U.S. Corn

4th Generation Corn Farmer in Oaxaca

Educate yourself and work against implicit and explicit racism and other bias

Approach the patient without blame or judgment

Use an interpreter; diversify staff; provide structural competency training for all staff

Advocate for safe spaces and affordable housing for community members

Research the structural forces that affect the lives and health of migrants who work as day laborers, including policy and racism in your research questions and discussion

Advocate for more just housing policy;

Organize against trade agreements that contribute to the exploitation of foreign labor;

Organize for universal healthcare

Intrapersonal

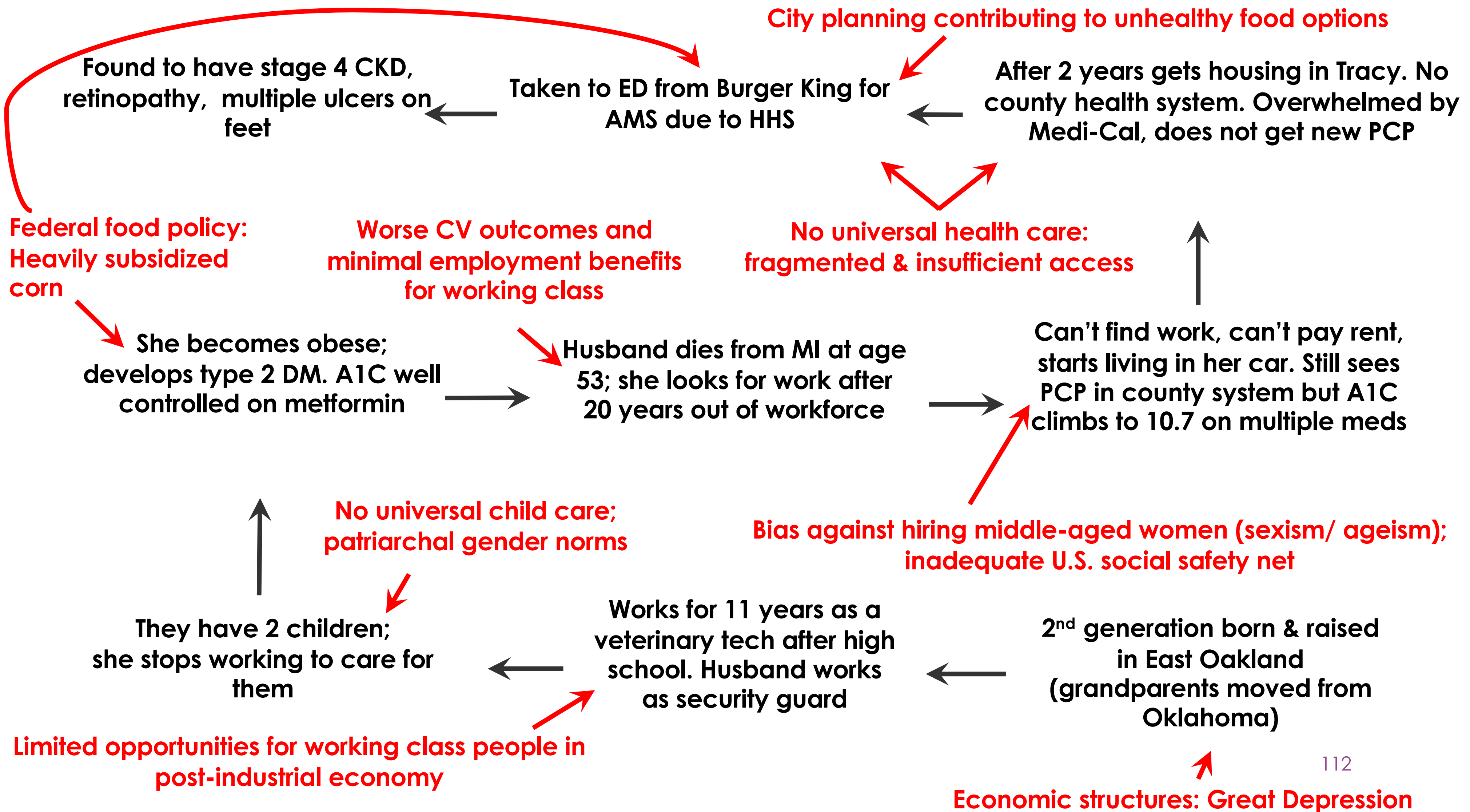
Interpersonal

Clinic

Community

Research

Policy


City planning contributing to unhealthy food options
Found to have stage 4 CKD, retinopathy, multiple ulcers on feet
Taken to ED from Burger King for AMS due to HHS
After 2 years gets housing in Tracy. No county health system. Overwhelmed by Medi-Cal, does not get new PCP
Federal food policy: Heavily subsidized corn
Worse CV outcomes and minimal employment benefits for working class
No universal health care: fragmented & insufficient access
She becomes obese; develops type 2 DM. A1C well controlled on metformin
Husband dies from MI at age 53; she looks for work after 20 years out of workforce
Can't find work, can't pay rent, starts living in her car. Still sees PCP in county system but A1C climbs to 10.7 on multiple meds
No universal child care; patriarchal gender norms
Bias against hiring middle-aged women (sexism/ ageism); inadequate U.S. social safety net
They have 2 children; she stops working to care for them
Works for 11 years as a veterinary tech after high school. Husband works as security guard
2nd generation born & raised in East Oakland (grandparents moved from Oklahoma)
Limited opportunities for working class people in post-industrial economy
Economic structures: Great Depression

Group Exercise

Each group will be assigned a level or levels at which to brainstorm interventions.

Write down at least one structurally competent intervention that is applicable in the case of the diabetic patient that is something you have either experienced or heard about happening.

Write down at least one structurally competent intervention that is applicable in the case of the diabetic patient that is something that you would do if you had a "magic wand" to address issues at your assigned level of intervention.

"It always seems impossible until it's done."
-Nelson Mandela

Health Outreach Partners SCWG Structural Competency Working Group

5 Minutes

Module 4: Beloved Community and Taking Action

Health Outreach Partners

SCWG

Source: In pictures, protesting racism in Washington. Al Jazeera, 2014.
https://www.aljazeera.com/indepth/inpictures/2014/12/pictures-protesting-racism-was-2014121584426203411.html

Working Definition of Beloved Community

- An inclusive, interconnected consciousness
- Based on love, justice, compassion, responsibility, shared power
- A deep respect for all people, places, and things
- Radically transforms individuals and restructures institutions

Shirley Strong, Chief Diversity Officer, Samuel Merritt Univeristy

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Three principles of action

(1) Improve the conditions of daily life

(2) Tackle the inequitable distribution of power, money, and resources

(3) Measure the problem, evaluate action, expand the knowledge base, develop a workforce trained in SDOH *(or structural competency).*

Marmot, M. et al. (2008). Closing the gap in a generation: health equity through social action on the social determinants of health. *Lancet, 372*, 1661-1669.

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Reflection Exercise

- Write down the levels of intervention that you have identified as areas where you can take action.
  - What are 1-2 specific actions that will you take?
  - What potential barriers can you identify for taking these action steps?
  - What will help you to navigate and address these potential barriers?

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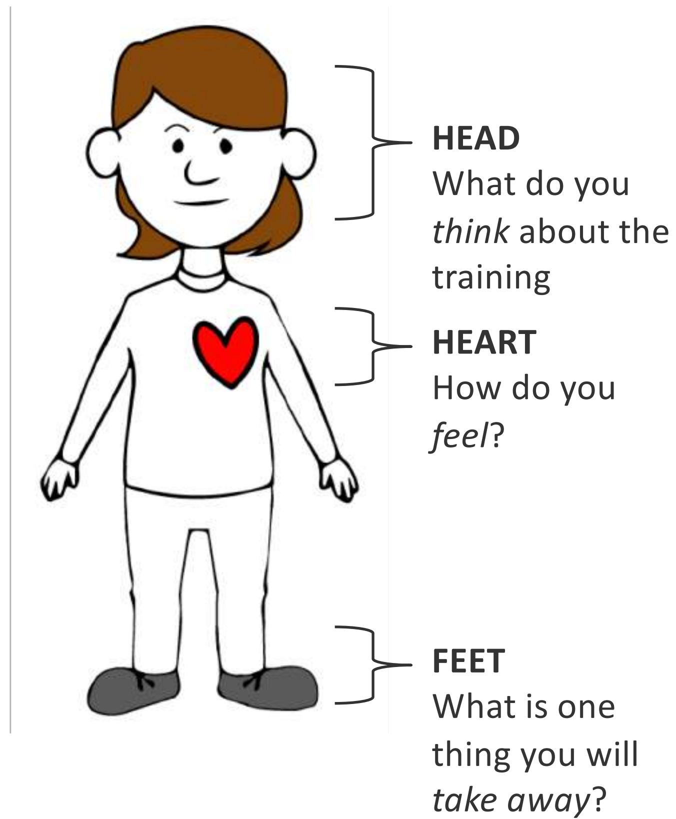
Feedback (Modules 3 and 4)

- What parts of this afternoon's session worked well? What parts did you like or find most valuable? What expectations of yours did we meet or exceed?
- What should we change? How can we make this portion of the training more effective? Any parts that you felt were not helpful or worthwhile?
- Which parts of this afternoon's session are relevant for your organization? Which parts are not?

CLOSING



Head, Heart, Feet

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thank you!