Family Medicine: Our Responsibility to Be Leaders in Health Equity and Social Accountability

Viviana Martinez-Bianchi, MD; Jennifer Edgoose, MD, MPH
Jewell Carr, MD;; Brian Frank, MD; Laura Gottlieb, MD, MPH;
Ronya Green, MD, MPH; Christina Kelly, MD; Jay Lee, MD, MPH;
Bonzo Reddick, MD, MPH; Karen Smith, MD; Jane Weida, MD;
Kim Yu, MD, Lloyd Michener, MD
Jessica Lapinski, DO, Evelyn Figueroa, MD

Disclosures

- We are passionate about health equity

Goals and objectives

- Establish a curricular strategy for addressing health disparities
- Establish an advocacy strategy for decreasing health disparities, and make a business case for health equity
- Describe and plan social media and community engagement strategies
- Create a collaborative community

Health equity

means that everyone has a fair and just opportunity to be as healthy as possible.

Health equity

is the absence of unfair and avoidable or remediable differences in health

among social groups.

Drawing “Equidad”, by Fernando Miguez, Argentina

When talking about health equity

We need to talk about

social accountability

Portland, Oregon – April 22-25, 2017

STARFIELD SUMMIT

SOCIAL ACCOUNTABILITY

The World Health Organization (WHO) describes social accountability as, ‘the obligation [of physicians and medical institutions] to direct their education, research and service activities towards addressing the priority health concerns of the community, region, and/or nation they have a mandate to serve’ (Boelen & Heck 1995).

For care to be socially accountable, it must be equitably accessible to everyone and responsive to patient, community, and population health needs (Buchman et al 2016).

Social Accountability

Social accountability in health care **intentionally targets** health care education, research, and services and addresses social determinants of health towards the priority health concerns of the people and communities served, with the goal of health equity.


HEALTH EQUITY AND SOCIAL ACCOUNTABILITY
Community Engage ment
Business case
Social Media
Advocacy
curricular strategies

COMMUNITY ENGAGEMENT

Evelyn Figueroa, MD, MPH

Addressing Food Insecurity Through Community Engagement

Evelyn Figueroa, MD
Assistant Dean of Outpatient Clinical Affairs
Family Medicine Residency Program Director
UI Health Pilsen Food Pantry Director
Figueroa Wu Family Foundation Executive Co-Director
Associate Professor of Clinical Family Medicine
University of Illinois at Chicago Department of Family Medicine

UIC

Inspiration


Contents lists available at ScienceDirect

Preventive Medicine Reports

journal homepage: http://ees.elsevier.com/pmedr

Implementation of a food insecurity screening and referral program in student-run free clinics in San Diego, California

Sunny Smith [a,b,c,*], David Malinak [b], Jinnie Chang [b], Maria Perez [c], Sandra Perez [c], Erica Settlecowski [c], Timothy Rodriggs [c], Ming Hsu [c], Alexandra Abrew [c], Sofia Aedo [c]

ARTICLE INFO

ABSTRACT

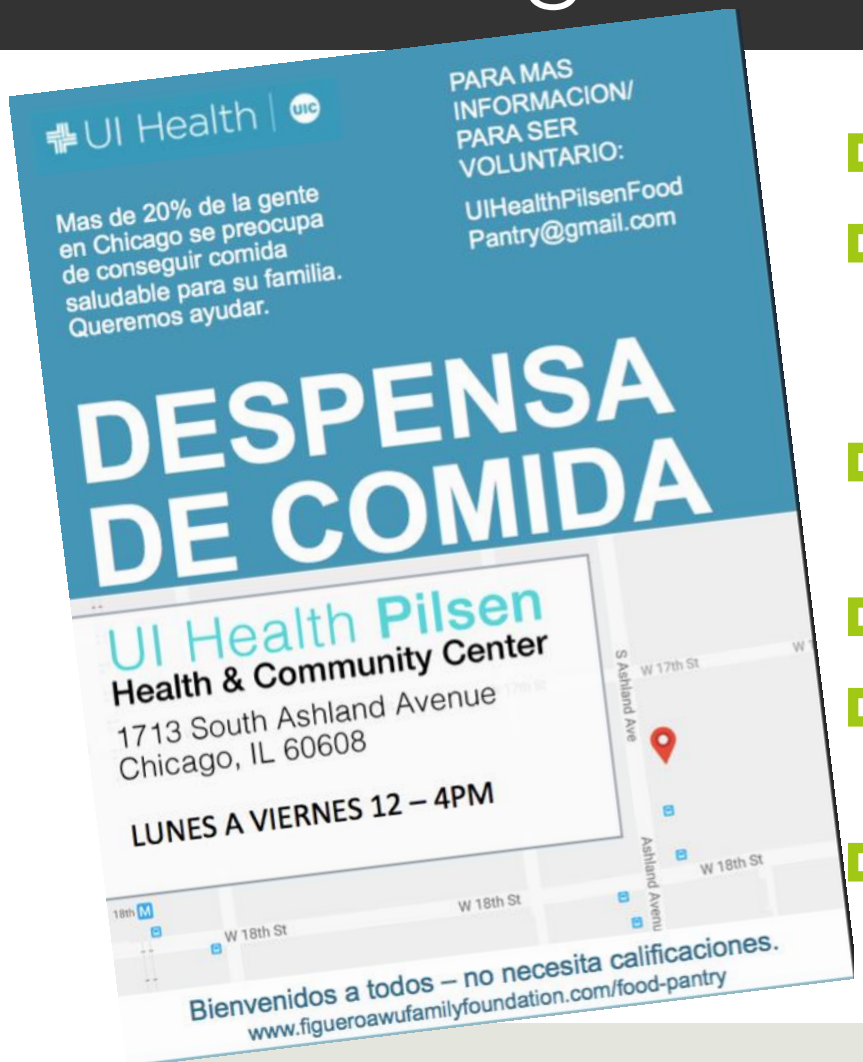
1. ***Intersectionality***
   - Realization that the biases and barriers my family planning patients faced were very similar to my trans/GNC patients
2. ***Social accountability resolve***
   - Sept 2017 blog about my patient with housing insecurity → professional call to action
   - Although I come from a disadvantaged background in some ways, the physician privilege I enjoy affords me instant credibility
     - Assistant Dean role affords me access to health system executives
3. ***Role models***
   - STFM May 2017 → UCSD medical food partnership presentation (Smith, Chang, Brownell)

UIC

Planning Steps

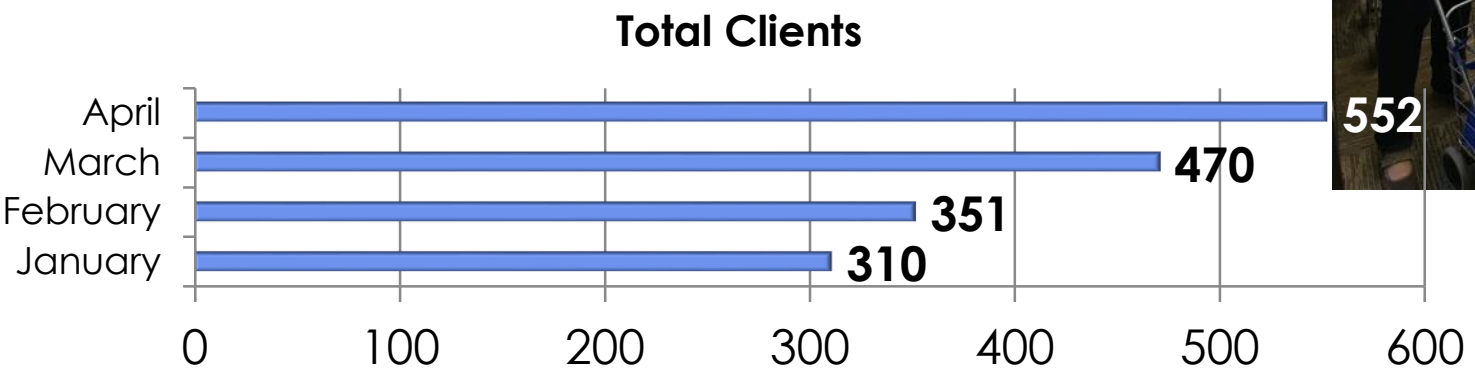
- Application to Greater Chicago Food Depository for membership (discounted bulk purchasing, delivery, some free items)
- Tour of local food pantries
- Food insecurity assessment – 60 days
- Space acquisition, signage, & promotion
- Food acquisition & donations
- Equipment acquisition
- Administrative: schedules, registration forms
- Discovery of community partners

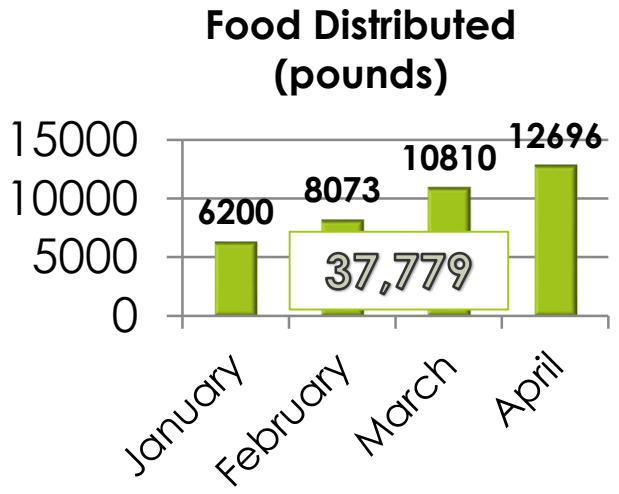
Enlisting Community Support

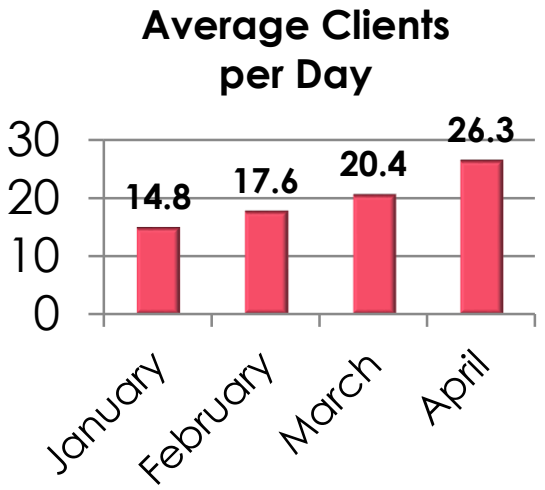


- Posting & distributing fliers
- Notification of local social agencies via emails, calls, and visits
- Coordination with WIC office (also in building)
- Open house
- Street sign posted during operational hours
- Recruitment of community volunteers

Initial Impact







Pitfalls & Obstacles

- Scale
- Sufficient storage
- Building access
- Institutional attitudes towards social accountability
- Inventory
- Funding
- Volunteer coordination
- Community collaboration

Testimonials

- "This is the best thing that has ever happened to Pilsen"
- "I eat all the vegetables that you give me"
- "I am returning and have brought a friend"

Sustainability

- Summer externs 2018
- Dominican Volunteer August 2018
- Blue Cross Blue Shield health grant

Next Steps

- Social outcome tracking
- Delivery services for home bound
- Health sciences advocacy rotation
- Integration into UI Health social action programming, including UI Health Housing First program

uihealthpilsenfoodpantry@gmail.com

MAKING THE BUSINESS CASE FOR HEALTH EQUITY

Brian Frank, MD
Oregon health sciences university

Jewell Carr, MD
Atrium Health, NC

What Makes Us Healthy

What We Spend On Being Healthy

STFM SOCIETY OF TEACHERS OF FAMILY MEDICINE

AAFP

Improve the Health and Wellness of Individuals

Improve the Health of Communities

Improve the Health Care System

FAMILY MEDICINE *for* AMERICA'S HEALTH


aetna
Bank of America
BlueCross BlueShield Association
Chan Soon-Shiong Institute for Advanced Health
Johnson & Johnson
McKinsey&Company
NANTHEALTH
The Coca-Cola Company
verizon
Walgreens

Workplace Stress & Sickness

& The Rising Costs In Business

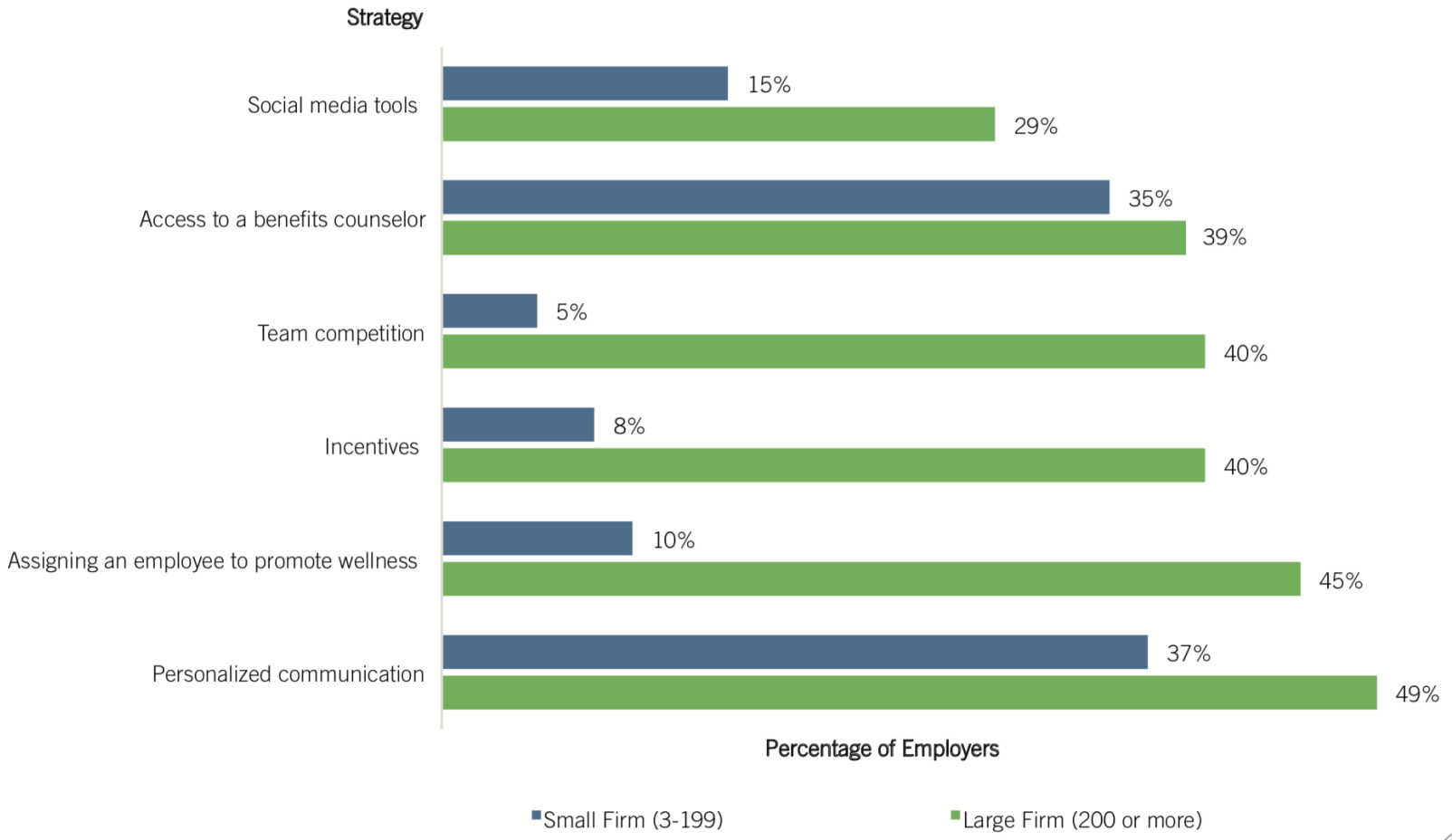
	BREAKDOWN	COSTS
DAILY	An estimated one million workers miss work each day because of stress. Absenteeism is to blame for 26 percent of health-related lost productivity in business	$602 per/yer per employee
YEARLY	Presenteeism: making mistakes, more time spent on tasks, poor quality work, impaired social functioning, burnout, anger, resentment, and low morale	$150 billion per year in lost productivity
LONG-TERM	Left untreated, prolonged stress can raise the risk for developing chronic—and costly—diseases, for a vast amount of all healthcare costs	$58 Billion of diabetes alone in indirect costs

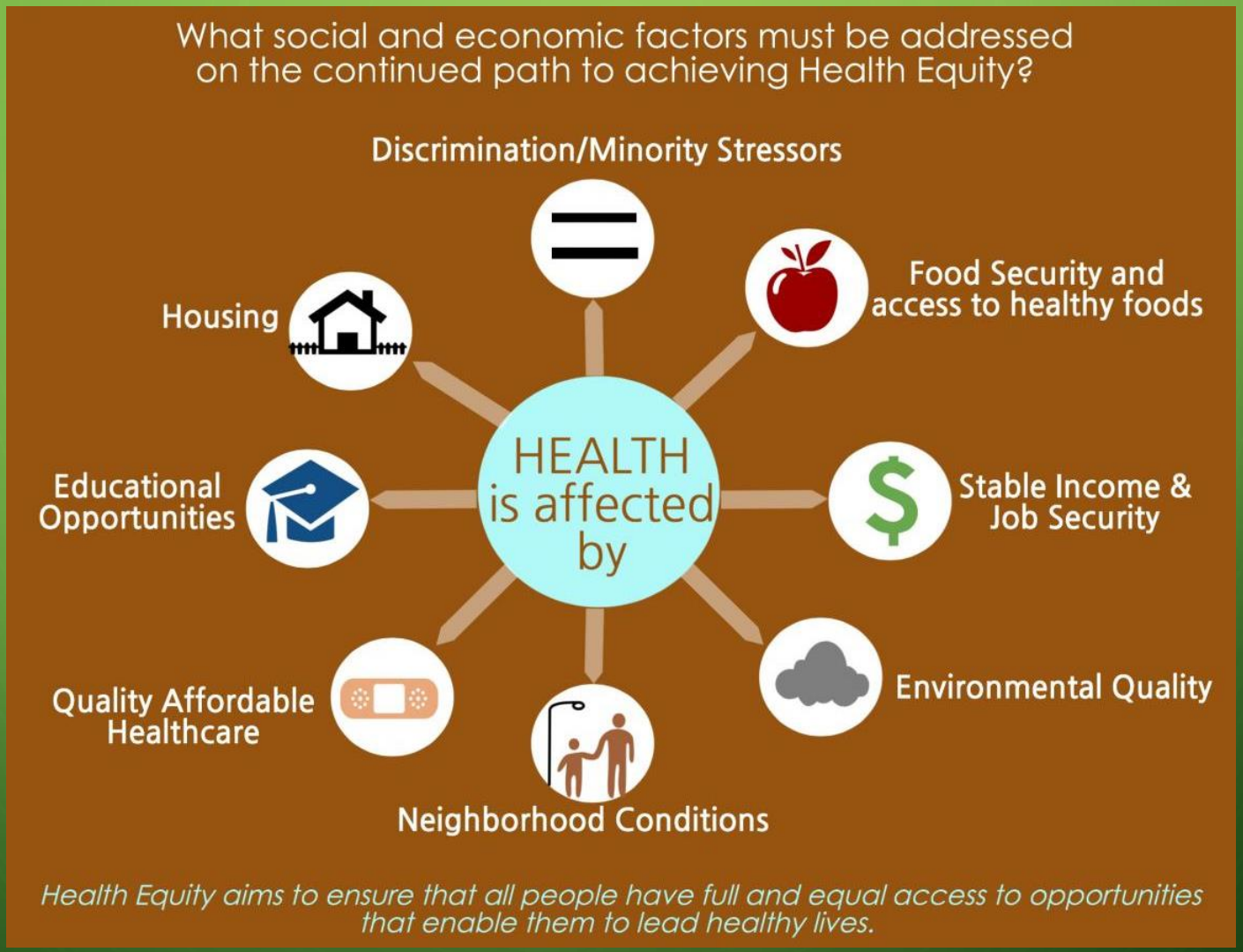
ANNUAL COST FOR BUSINESSES

$300 Billion

From depression to heart disease, annual costs for businesses per year in lost productivity

Table 2. Percent of Firms Using Specific Wellness Strategies




What social and economic factors must be addressed on the continued path to achieving Health Equity?
Discrimination/Minority Stressors
Housing
Food Security and access to healthy foods
HEALTH is affected by
Educational Opportunities
Stable Income & Job Security
Quality Affordable Healthcare
Environmental Quality
Neighborhood Conditions
Health Equity aims to ensure that all people have full and equal access to opportunities that enable them to lead healthy lives.

A BUSINESS CASE FOR *HEALTH EQUITY*

BRIAN FRANK MD, PROJECT LEAD

ASSISTANT PROFESSOR

DEPARTMENT OF FAMILY MEDICINE

OREGON HEALTH AND SCIENCE UNIVERSITY

PROJECT AIMS

Overall Aim: Understand the values, beliefs and perceived needs of businesses regarding the health equity of their employees *and the impact on their business*

- **Identify drivers and barriers to existing projects in which businesses have seen a positive response from investing in employees' health**
- **Summarize research demonstrating the impact of health equity on metrics that matter to businesses**
- **Create a set of individualized "executive summaries" tailored to individual businesses that combine data and stories to demonstrate how health equity interventions can yield a ROI that is meaningful to a specific business's needs**

ONGOING EFFORTS...

Review hiring and work practices.

Make targeted investments in people and communities.

Support public policies increasing ability for all to succeed.

There is also a business case to make at our institutions

- Support for faculty to do health equity work addressing most vulnerable in our communities
- Element of the CLER visit
- Health Equity research
- Think of Return on Investment!

SOCIAL MEDIA

Jay Lee, MD, MPH
@familydocwonk
#FMRevolution
Chief Medical Officer of Venice Family Clinic
Past Prez of CAFP


FAMILY MEDICINE™
REVOLUTION
THE EVOLUTION

WELCOME:

THE FUTURE OF THE U.S. HEALTH CARE SYSTEM IS IN YOUR HANDS

"Do or do not. There is no try."

- Master Yoda

FAMILY MEDICINE AS COUNTERCULTURE

ORIGINAL
ARTICLES

G. Gayle Stephens *Festschrift*

John P. Geyman, MD

(Fam Med 2011;43(1):7-12.)

Gayle Stephens, MD, has long been, and remains today, a central figure in the emergence and evolution of family medicine as a specialty. He has participated in all phases of its development from general practice and has provided thoughtful guidance connecting us to the past and charting and proposed the establishment of a certifying Board in Family Practice. These reports and developments over the first 2 decades of our new specialty are well described in a chapter by Gayle titled "Developmental Assessment of Family Practice: An Insider's View" that appeared in a 1987 book, *Family Medicine: The Matur-* Assistance Program and the Residency Review Committee for Family Practice, as a reviewer of federal training grants, and as president of the Society of Teachers of Family Medicine (STFM) from 1973 to 1975. He was the editor of *Continuing Education for the Family Physician* from 1977 to 1986.

DR. G. GAYLE STEPHENS

FAMILY MEDICINE REVOLUTION OG

"Be there"

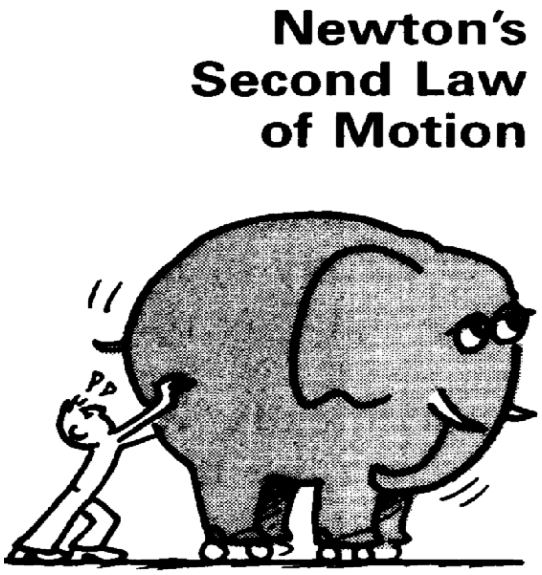
"Give a damn"

The Job vs The Work

HOW TO CHANGE THE WORLD

1. Realize yourself
2. Show up
3. Occupy the ground
4. Change the world

LAWS OF PHYSICS



FORCE

=

MASS

X

~~ACCELERATION~~

AMPLIFICATION

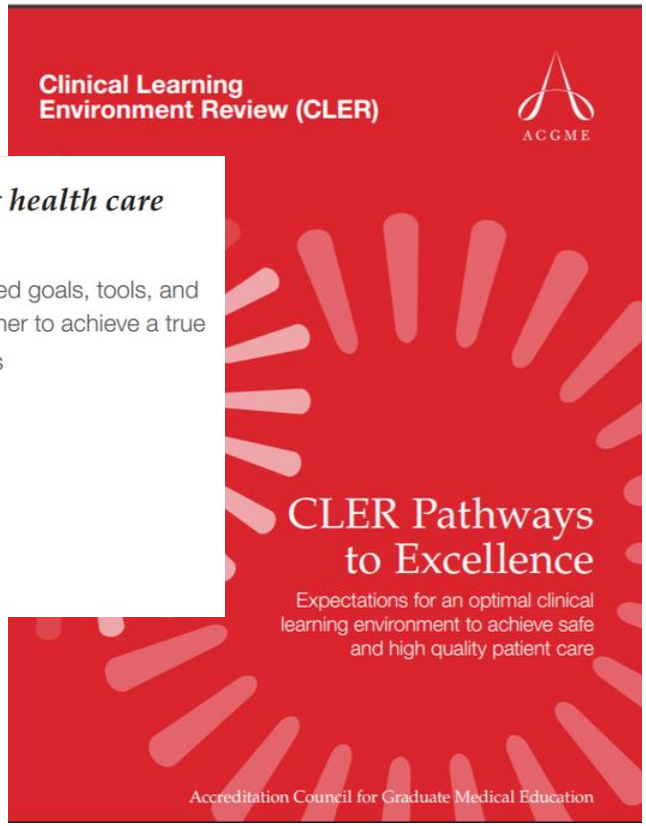
ADVOCACY

Christina Kelly, MD
Memorial Health
Savannah, GA

CURRICULAR STRATEGIES

Viviana Martinez-Bianchi, MD
Duke Family Medicine Residency
Chair-Health Equity Team

ACGME CLER visits



HQ Pathway 5: Resident/fellow and faculty member education on reducing health care disparities

Formal educational activities that create a shared mental model with regard to health care quality-related goals, tools, and techniques are necessary for health care professionals to consistently work in a well-coordinated manner to achieve a true patient-centered approach that considers the variety of circumstances and needs of individual patients

Properties include:

- Residents/fellows and faculty members receive education on identifying and reducing health care disparities relevant to the patient population served by the clinical site. *The focus will be on the extent to which individuals receive education on the clinical site's priorities and goals for addressing health care disparities in its patient population.*

Source ACGME CLER brochure accessed 4.10.17
https://www.acgme.org/Portals/0/PDFs/CLER/CLER_Brochure.pdf

ACGME now requires that institutions engage residents in the use of data and QI to improve systems of care, reduce health care disparities, and improve patient outcomes through experiential learning

The Family Medicine Milestone Project

A Joint Initiative of

The Accreditation Council for Graduate Medical Education

and

The American Board of Family Medicine

ACGME

October 2015

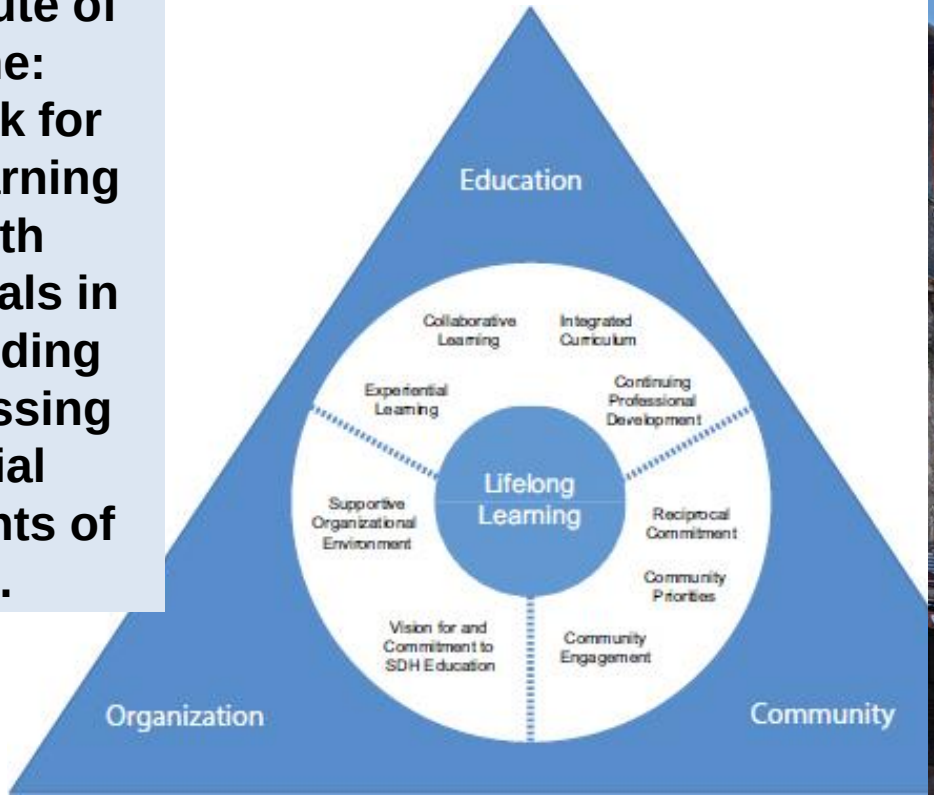
Version 10/2015

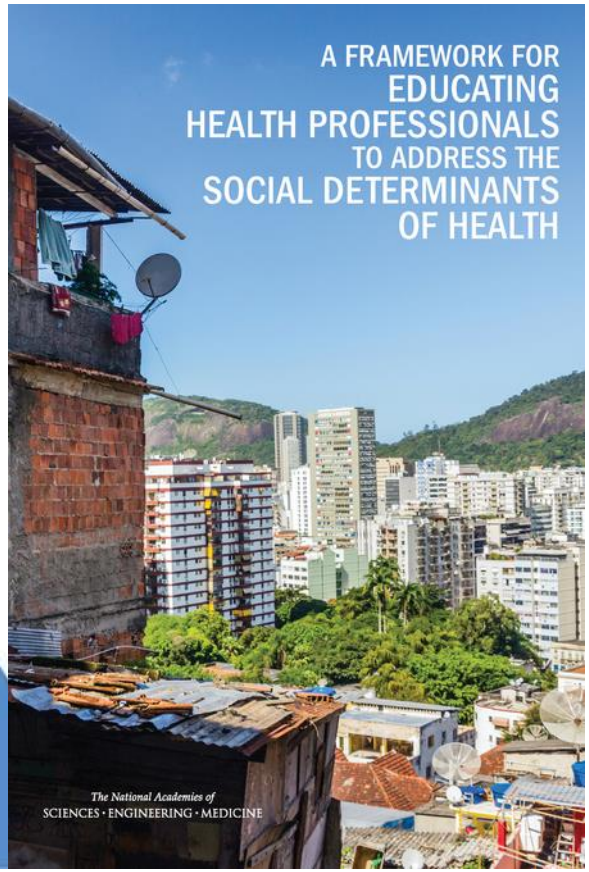
PROF-3 Demonstrates humanism and cultural proficiency					
Has not achieved Level 1	**Level 1**	**Level 2**	**Level 3**	**Level 4**	**Level 5**
	Consistently demonstrates compassion, respect, and empathy Recognizes impact of culture on health and health behaviors	Displays a consistent attitude and behavior that conveys acceptance of diverse individuals and groups, including diversity in gender, age, culture, race, religion, disabilities, sexual orientation, and gender identity Elicits cultural factors from patients and families that impact health and health behaviors in the context of the biopsychosocial model Identifies own cultural framework that may impact patient interactions and decision-making	Incorporates patients' beliefs, values, and cultural practices in patient care plans Identifies health inequities and social determinants of health and their impact on individual and family health	Anticipates and develops a shared understanding of needs and desires with patients and families; works in partnership to meet those needs	Demonstrates leadership in cultural proficiency, understanding of health disparities, and social determinants of health Develops organizational policies and education to support the application of these principles in the practice of medicine
Comments:					

FM milestones include addressing SDOH and health equity.

Multiple frameworks for health equity and addressing social determinants of health in medical education

2016 Institute of Medicine: Framework for lifelong learning for health professionals in understanding and addressing the social determinants of health.

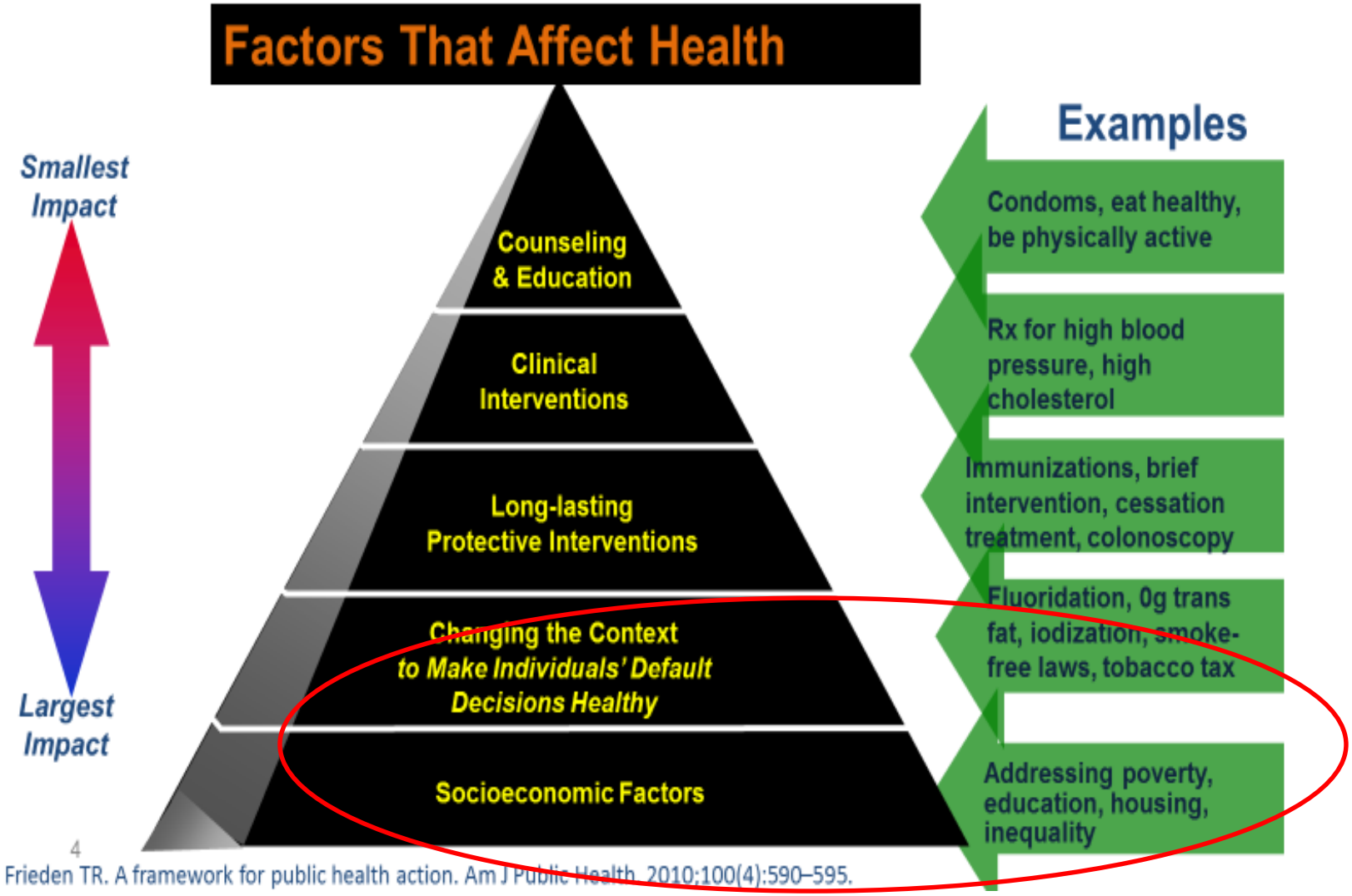




The 2016 IOM framework exhorts us to create -through education- highly competent professionals who understand and act on the social determinants of health in ways that advance communities and individuals toward greater health equity

A conceptual framework for action on the social determinants of health. Social Determinants of Health Discussion Paper 2 (Policy and Practice). Solar O, Irwin A.

WHO provides a broad public health and systems context for impacting the social determinants of health.



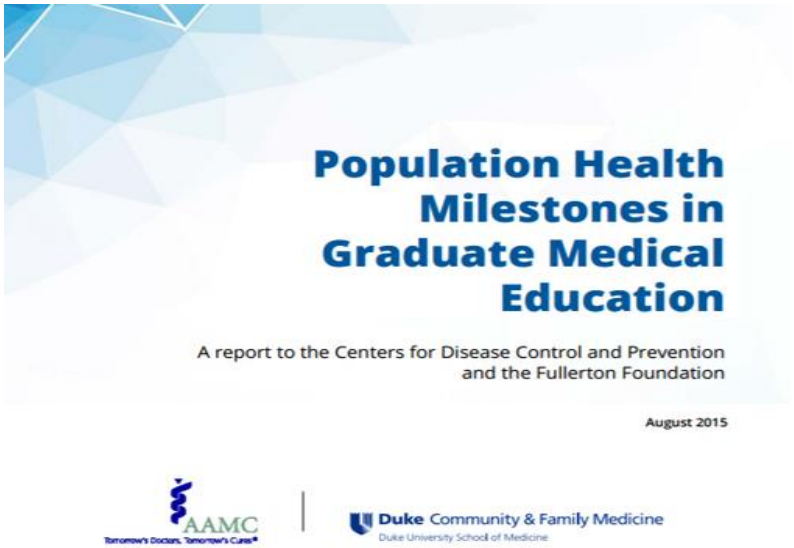
CDC's Tom Frieden's framework shows us the largest impact for population health interventions to improve health is to address socioeconomic factors.

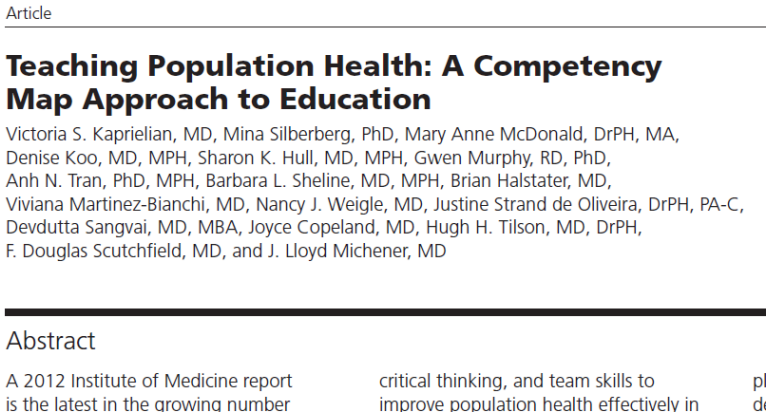
AAMC

AAMC has developed curriculum for health equity and social justice


PRACTICAL PLAYBOOK
PURCHASE THE PLAYBOOK
GET EMAIL UPDATES
ABOUT
BLOG
SEARCH
FIND A PARTNERSHIP
FUNDAMENTALS
BUILDING A PARTNERSHIP
EXPERT INSIGHTS
RESOURCES
SUCCESS STORIES
THE PRACTICAL PLAYBOOK
Helping Public Health and Primary Care Work Together to Improve Population Health.
GET STARTED
deBeaumont FOUNDATION
Duke Community & Family Medicine
Duke University School of Medicine
CDC
Diverse Partners Align to Cut Asthma Triggers by Curing Sick Buildings in
READ STORY
Medical-Legal Partnership helps align diverse partners to
READ STORY

Population Health Milestones address health equity, social determinants of health





At Duke we have worked with the AAMC on a curriculum that links milestones in population health-

The EveryONE Project

Advancing health equity in every community

Strategic Priorities

Workforce Development

We will increase diversity and pursue comprehensive representation in medical schools, residency programs, and the entire field of medicine.

Health in All Policies

We will advocate for policies and legislative efforts through a lens of seeking equal health for all communities, families, and individuals.

Interdisciplinary Collaboration

We will form key partnerships with organizations and groups that share our values and fortify our fight to eliminate health inequities.

Evidence-based Knowledge

We will develop tools and share research findings to fill knowledge gaps and raise awareness of issues surrounding social determinants of health.

Our Purpose

- Create and support a culture of health equity to empower family physicians
- Collaboration with family physicians, their practice teams, chapters, and other partners
- Offer tools and resources to help educate family physicians
- Support research and policy development to support advocacy
- Encourage workforce diversity

Tools and Resources

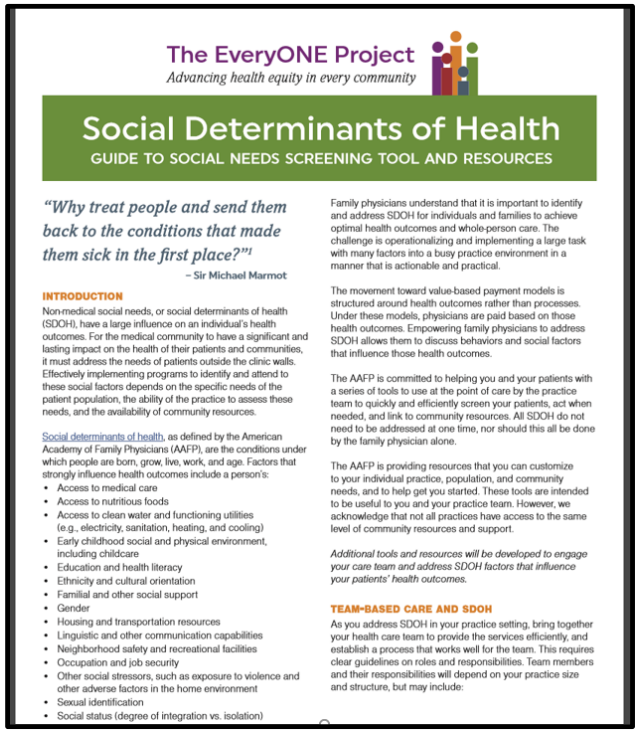
Topics

- Impact of SDOH
- Screening for SDOH risks
- Referral to community resources
- Incorporating practice teams
- Advocacy
- Best practices
- Overcoming challenges and barriers
- SDOH Payment Principles

Delivery Formats

- In-person
- Webinars
- Issue briefs
- Policy statements
- Position papers
- Conference abstracts
- Workshops
- Journal submissions

AAFP SDOH Toolkit Module 1



The EveryONE Project
Advancing health equity in every community

Social Determinants of Health
GUIDE TO SOCIAL NEEDS SCREENING TOOL AND RESOURCES

"Why treat people and send them back to the conditions that made them sick in the first place?"[1]
– Sir Michael Marmot

INTRODUCTION

Non-medical social needs, or social determinants of health (SDOH), have a large influence on an individual's health outcomes. For the medical community to have a significant and lasting impact on the health of their patients and communities, it must address the needs of patients outside the clinic walls. Effectively implementing programs to identify and attend to these social factors depends on the specific needs of the patient population, the ability of the practice to assess these needs, and the availability of community resources.

Social determinants of health, as defined by the American Academy of Family Physicians (AAFP), are the conditions under which people are born, grow, live, work, and age. Factors that strongly influence health outcomes include a person's:

- Access to medical care
- Access to nutritious foods
- Access to clean water and functioning utilities (e.g., electricity, sanitation, heating, and cooling)
- Early childhood social and physical environment, including childcare
- Education and health literacy
- Ethnicity and cultural orientation
- Familial and other social support
- Gender
- Housing and transportation resources
- Linguistic and other communication capabilities
- Neighborhood safety and recreational facilities
- Occupation and job security
- Other social stressors, such as exposure to violence and other adverse factors in the home environment
- Sexual identification
- Social status (degree of integration vs. isolation)

Family physicians understand that it is important to identify and address SDOH for individuals and families to achieve optimal health outcomes and whole-person care. The challenge is operationalizing and implementing a large task with many factors into a busy practice environment in a manner that is actionable and practical.

The movement toward value-based payment models is structured around health outcomes rather than processes. Under these models, physicians are paid based on those health outcomes. Empowering family physicians to address SDOH allows them to discuss behaviors and social factors that influence those health outcomes.

The AAFP is committed to helping you and your patients with a series of tools to use at the point of care by the practice team to quickly and efficiently screen your patients, act when needed, and link to community resources. All SDOH do not need to be addressed at one time, nor should this all be done by the family physician alone.

The AAFP is providing resources that you can customize to your individual practice, population, and community needs, and to help get you started. These tools are intended to be useful to you and your practice team. However, we acknowledge that not all practices have access to the same level of community resources and support.

Additional tools and resources will be developed to engage your care team and address SDOH factors that influence your patients' health outcomes.

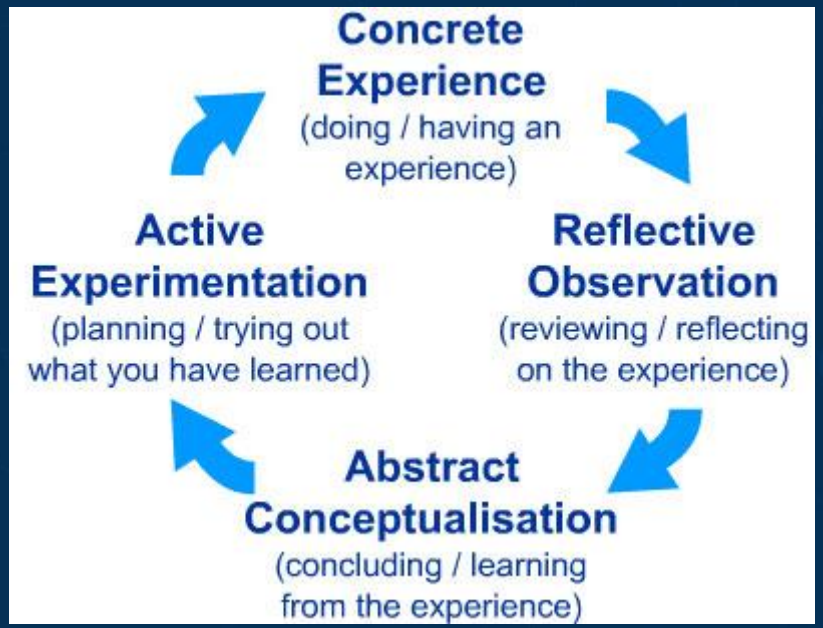
TEAM-BASED CARE AND SDOH

As you address SDOH in your practice setting, bring together your health care team to provide the services efficiently, and establish a process that works well for the team. This requires clear guidelines on roles and responsibilities. Team members and their responsibilities will depend on your practice size and structure, but may include:

Focuses on the Family Physician and Screening

- Overview of the social determinants of health
- Role of the primary care team
- Description of core social needs
- Screening tools for patients and providers
- List of resources

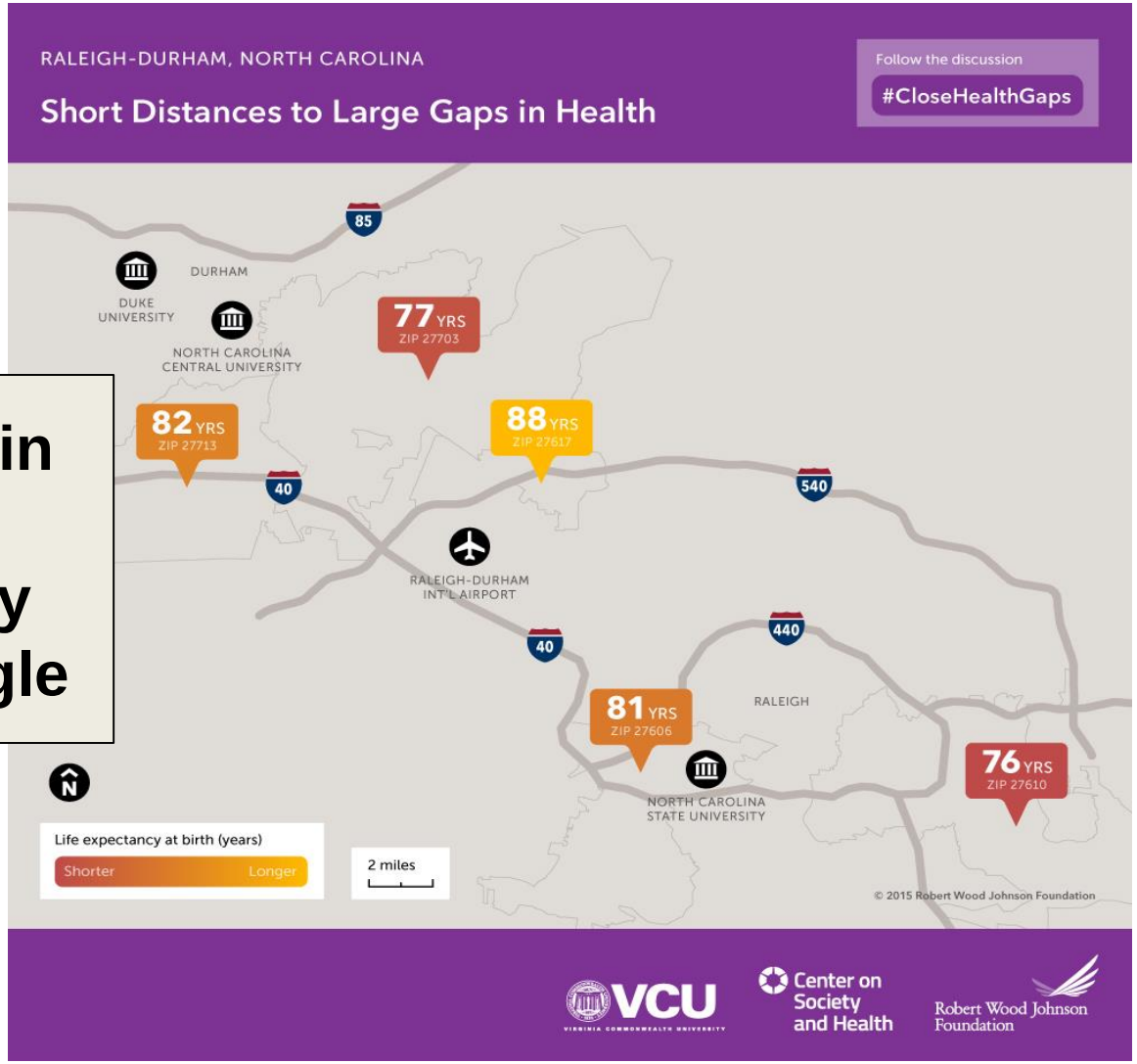
Experiential Learning as vital component (Kolb -1984)



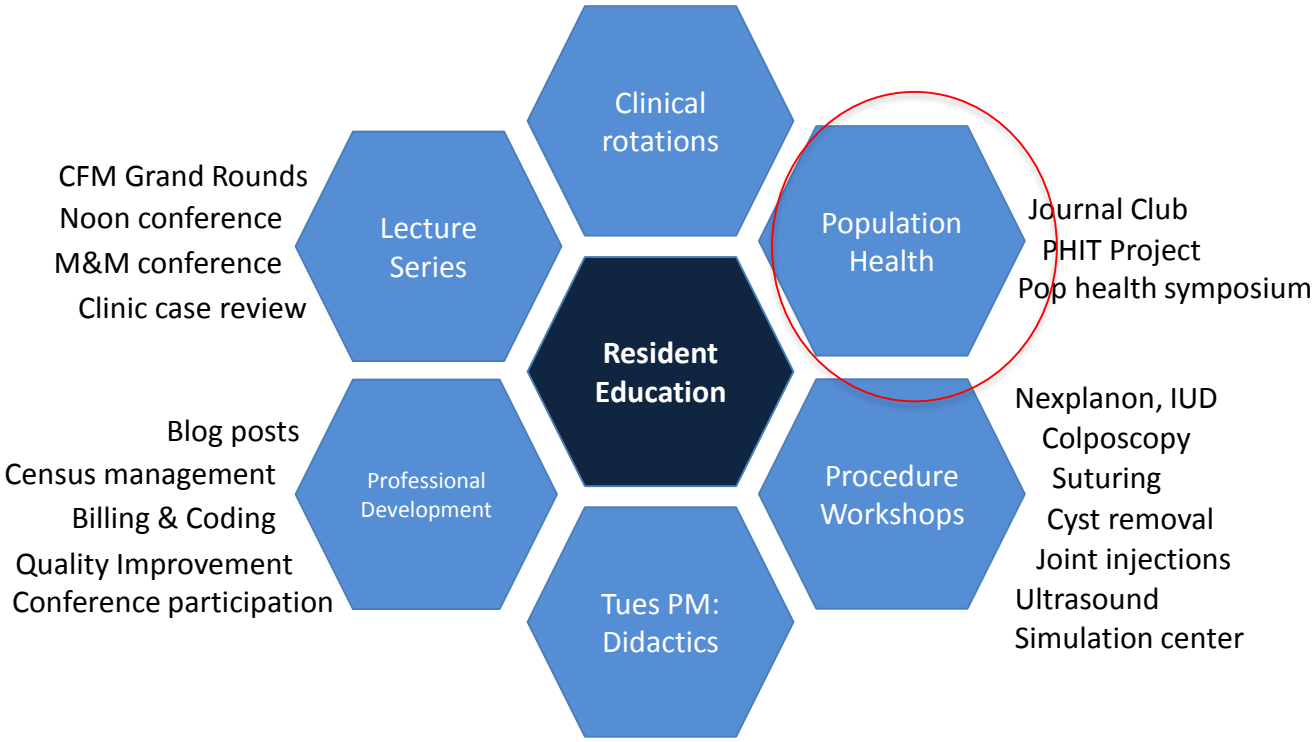
"Exploration of one's biases and positions needs to continue throughout life, reaching deeper levels as the health professional matures cognitively, personally, and professionally"

(El-Sayed and El-Sayed, 2014).

Disparities in Life Expectancy in the Triangle



Residency Curriculum



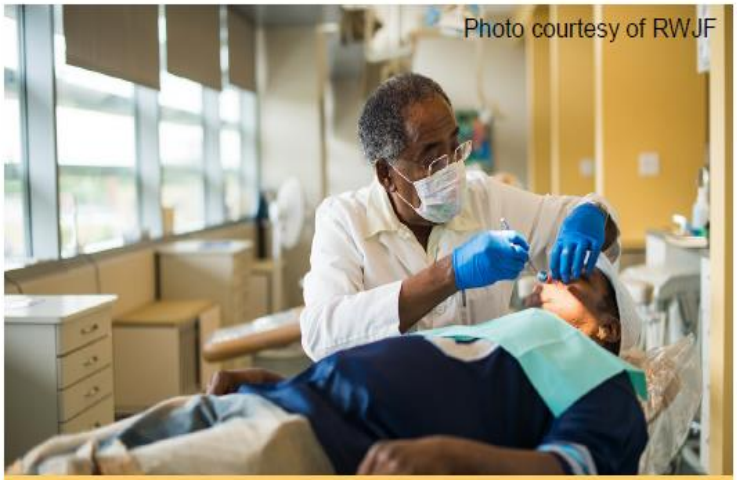
Population Health Curriculum

- Journal Club (PGY1-3)
- Community Health Rotation (PGY1)
- Orientation including community-based introductions to Durham and the Duke-Durham relationship (PGY1)
- Population Management rotation with QI projects (PGY1-3)
- Population Health Symposium: 4 hour bi-monthly sessions (PGY1-3)
- Dedicated panel management & community engagement time (PGY1-3)
- Longitudinal, community clinic training sites (PGY2 & 3)

Durham County Community Health Assessment

Most Likely to be in Coverage Gap and Uninsured[5]

- Households with income below 133% of the Federal Poverty Level
- Workers in low-wage jobs without benefits
- People of color
- Ages 35-54
- Not a citizen



15.8% of Durham County adults are uninsured[4]

Residents involved evaluating the Community health assessment,

Longitudinal continuity clinics in the community?

DFM Continuity Clinic

- PGY1: ½ day/week
- PGY2-3: 3 ½ days/week
- CenteringPregnancy groups

2nd Continuity Clinic (PGY 2-3) One half day a week

- VA PRIME clinic
- Duke Primary Care Oxford (rural)
- El Futuro
- Walltown, Lyon Park
- Southern High School
- Lincoln Community Health Center (FQHC)
- TROSA

Optional longitudinal tracks

- Leadership
- Research

Why are
you here?

WHAT IGNITES YOUR PASSION?

REFUGEE HEALTH INITIATIV

LGBTQ Center of Durham

Latino Health interest group

North Carolina Academy of Family Physicians INCORPORATED

In the planning of their annual calendar we look at the activities and schedules of the organizations that they would like to be paired with: locally,

STFM
SOCIETY OF TEACHERS OF
FAMILY MEDICINE

AAFP

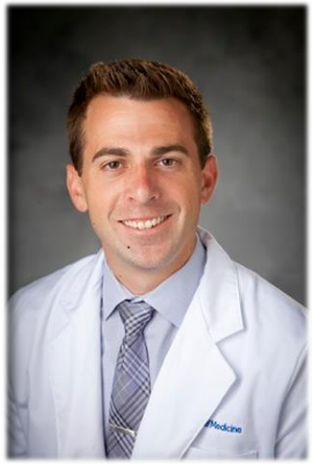
acofp | American College of Osteopathic Family Physicians

primarycare PROGRESS

and nationally,

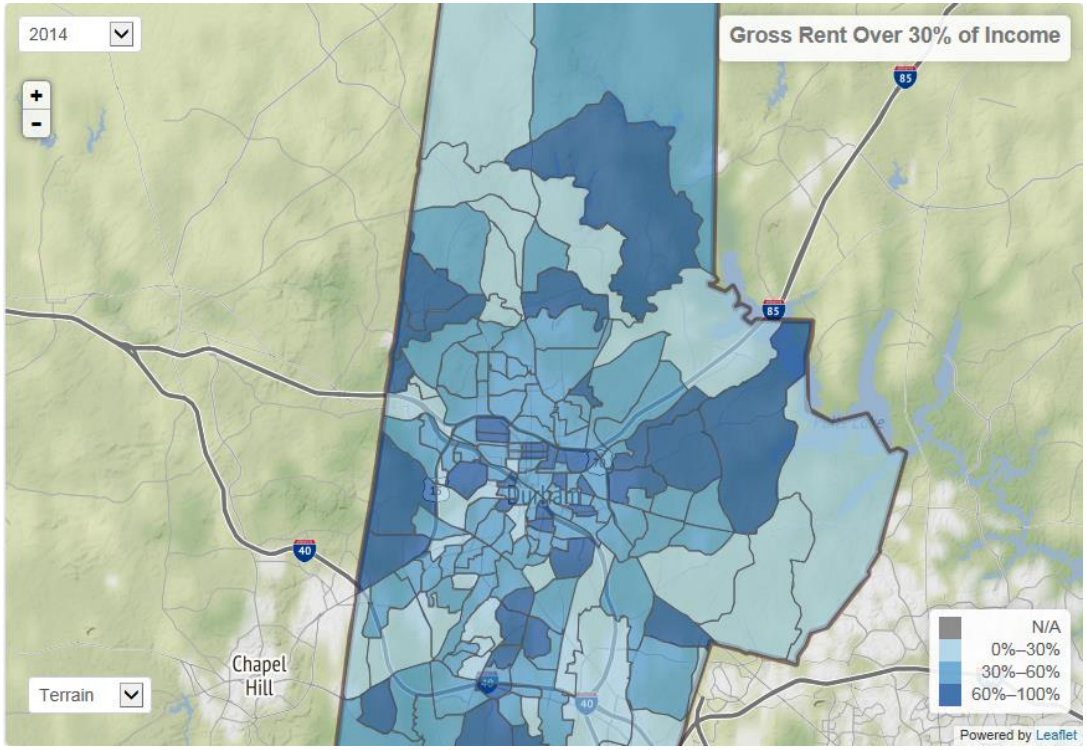
Barber Shop & Blood Pressure Project

- What did we set out to do?
- 1.) Explore briefly the history of the role which barbershops play within Community Medicine
- 2.) Engagement of community partners in Oxford, NC (i.e. Barbershops, Barbershop patrons) in an effort to possibly implement screening of untreated hypertension (pilot study,) with a referral process in place (i.e. Vance-Granville Health Department Free Clinic, Duke Primary Care Oxford) in order to address a known health care disparity in minority and rural populations (i.e. chronic untreated hypertension.)



Jonathan Hedrick, MD
PGY 3, 2018

GIS mapping interaction with the Electronic medical record



Incorporation of GIS mapping of social determinants of health into clinical practice

Alexa Mieses, MD, MPH PGY 2

Food Pantries Role in Poverty Reduction and Policy Implications

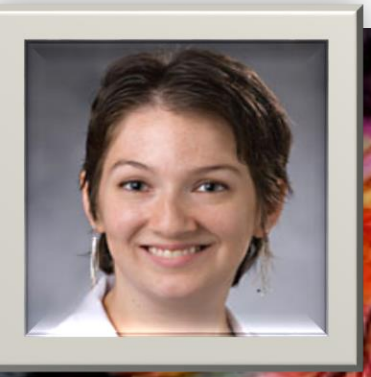
Kenetra M. Hix, MD-PGY3,MPH

Duke Family Medicine Residency

- Attended several meetings of the Chronic Care Initiative starting fall 2016 to early spring (2016-2017).
- To maintain funding for Chronic Care Initiative, DCDPH had to show effectiveness of programs.
- Logic Model created to identify the many activities implemented by the CCI.

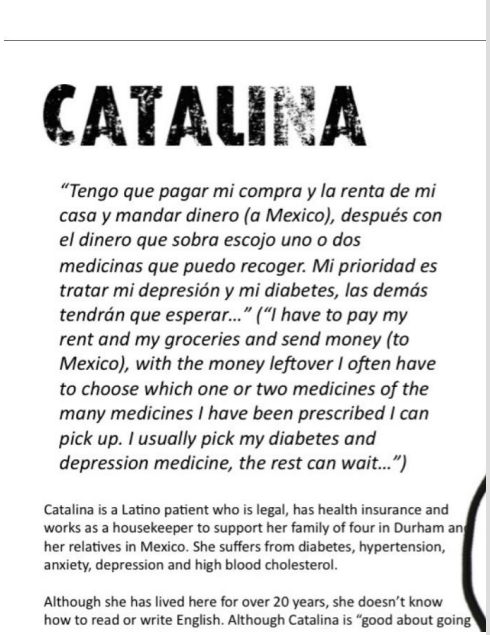
Mental healthcare delivery for undocumented immigrants in North Carolina.

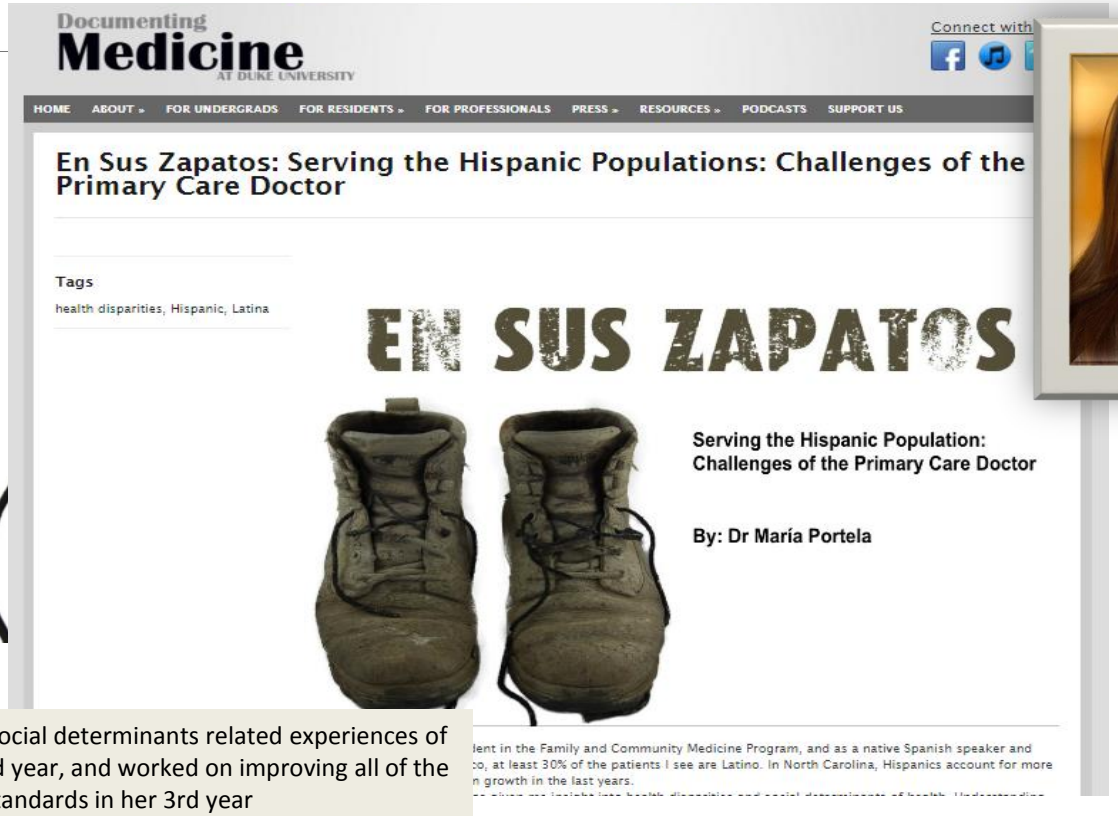
Tiffany Cagle, MD, Family Medicine Resident, PGY 2 2016



Audio documentary and establishing adherence to National Class Standards

Maria Portela Martinez, MD, Family Medicine Resident, worked during PGY-2 and PGY 3, class of 2013





Maria created a documentary sharing the social determinants related experiences of Latinos accessing healthcare during her 2nd year, and worked on improving all of the Duke Health System's adherence to CLAS standards in her 3rd year

National Standards for Culturally and Linguistically Appropriate Services

Nature and Scope of Homeless Medical Respite Needs

Farhad Modarai, DO, Family Medicine Resident, PGY-2 2015

Farhad worked every Tuesday morning on a respite program to improve health outcomes for Durham's homeless.

Sam Fam's project

https://vimeo.com/254381515/286cc13b2a
Video illustrates Social determinants of health through the patient experience

Patient Stories: Community Feedback

Access to Care Committee Meeting: Feb 8, 2018

Samuel Fam, DO
Duke Family Medicine Resident

Sam Fam, DO
Class of 2018

LGBTQ+ PCMH

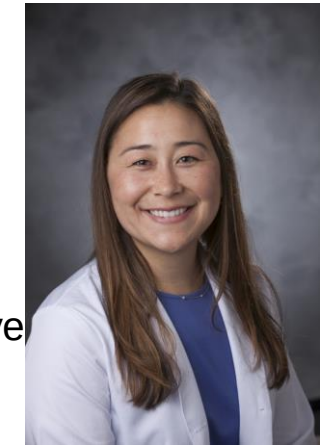
Tiffany Covas, MD, MPH, class of 2017

Jessica Lapinski, DO, PGY2 2019

Tiffany and Jessica worked as residents, and are working now as a faculty and resident team on improving health care for the LGBTQ community

Adolescent immunizations

AAFP Foundation Grant



$10,000 towards improving immunization rates in people 11-21 for vaccine-preve diseases

- Make every adolescent visit an immunization opportunity
- Increase access to patient education materials regarding vaccination
- Increase awareness of immunization gap
- Reduce barriers to adolescent immunizations
- Change work flow to increased vaccination efficiency
- **Engage with community stakeholders to increase awareness regarding adolescent immunizations**
- Increase office awareness about adolescent vaccination rates

Family doctors and teams who can see the river of disease that flows into our clinics and hospitals and will go to identify what happens upstream

And now to our work together

Jennifer Edgoose, MD, MPH
University of Wisconsin- Madison
FMAH- Health Equity Team

Are we socially accountable?

Healthcare institutions are generally **socially responsible** (being aware of their duty to respond to society's needs) and some can be seen being **socially responsive** (implementing interventions to address these needs). But few are wholly **SOCIALLY ACCOUNTABILITY**.

Table 1 The social obligation scale.

	Responsibility →	Responsiveness →	Accountability
Social needs identified	Implicitly	Explicitly	Anticipatively
Institutional objectives	Defined by faculty	Inspired from data	Defined with society
Educational programs	Community-oriented	Community-based	Contextualized
Quality of graduates	«Good» practitioners	Meeting criteria of professionalism	Health system change agents
Focus of evaluation	Process	Outcome	Impact
Assessors	Internal	External	Health partners

Boelen C. Why should social accountability be a benchmark for excellence in medical education? *Educ Med*.2016;17(3):101-105.

Applying an Equity and Empowerment Lens

https://multco.us/diversity-equity/equity-and-empowerment-lens

Equity and Empowerment Lens

PEOPLE

Who is positively and negatively affected (by this issue) and how?

How are people differently situated in terms of the barriers they experience?

Consider physical, spiritual, emotional and contextual affects.

Equity and Empowerment Lens

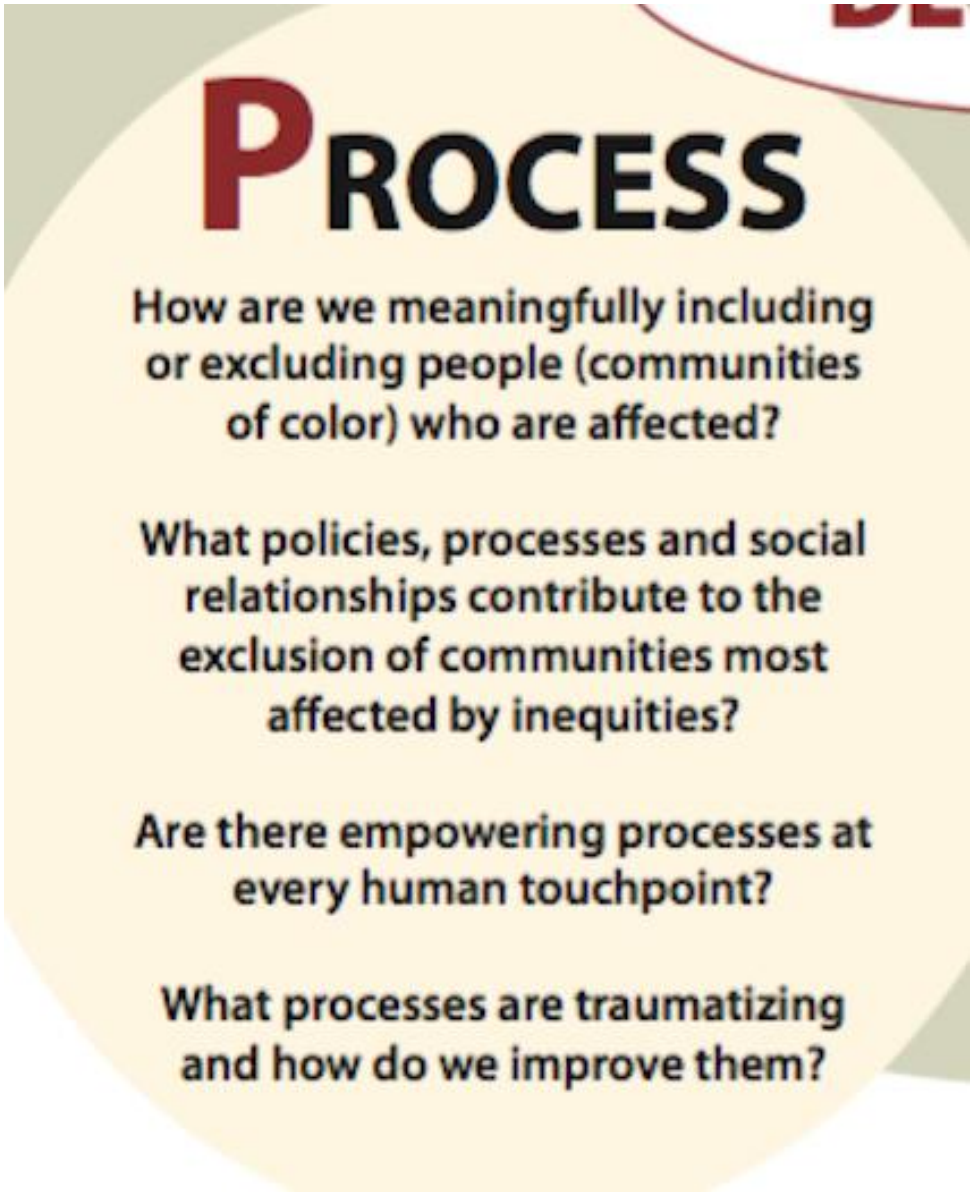
PLACE

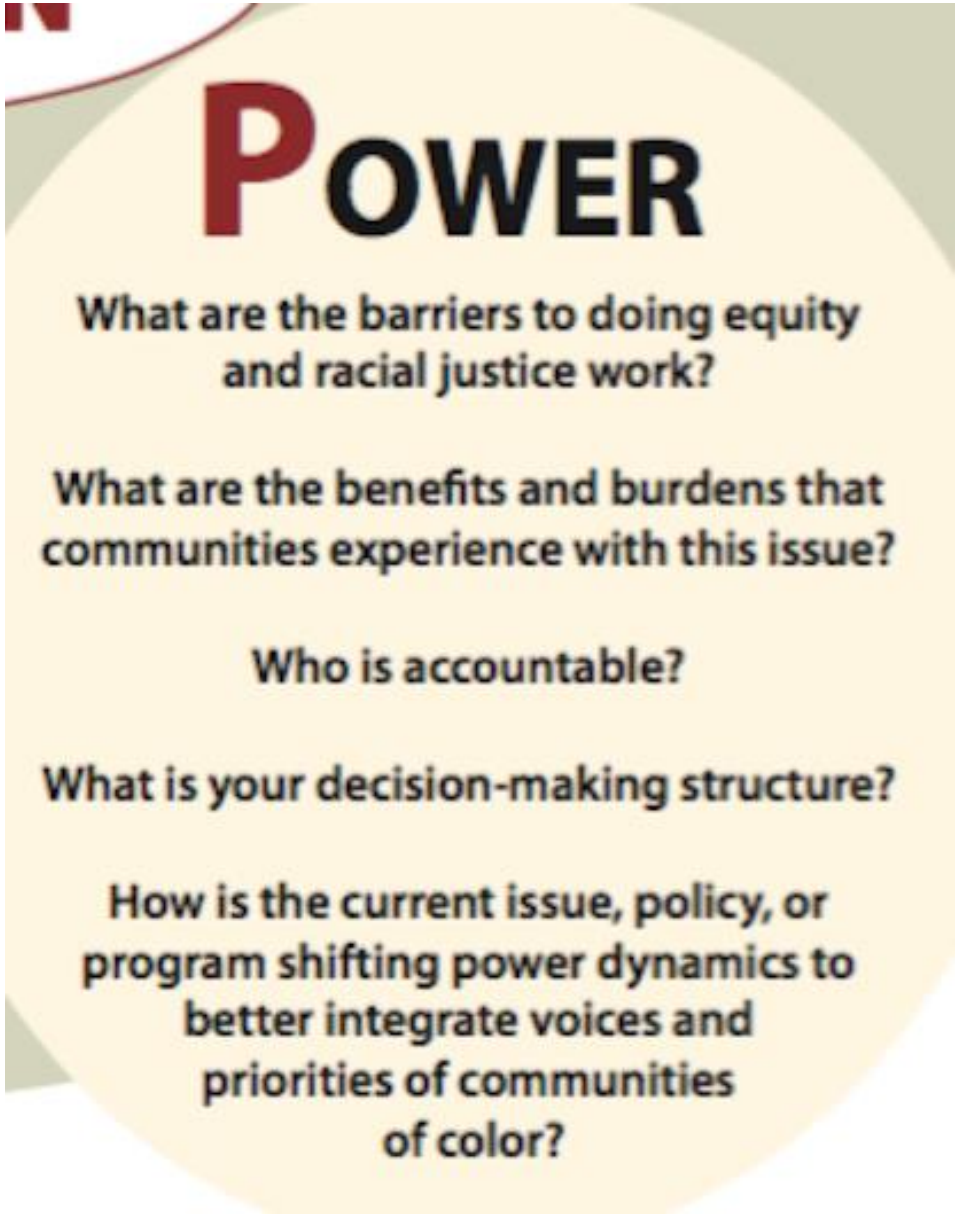
What kind of positive "place" are we creating?

What kind of negative "place" are we creating?

How are public resources and investments distributed geographically?

How are you considering environmental impacts as well as environmental justice?


PROCESS
How are we meaningfully including or excluding people (communities of color) who are affected?
What policies, processes and social relationships contribute to the exclusion of communities most affected by inequities?
Are there empowering processes at every human touchpoint?
What processes are traumatizing and how do we improve them?


POWER
What are the barriers to doing equity and racial justice work?
What are the benefits and burdens that communities experience with this issue?
Who is accountable?
What is your decision-making structure?
How is the current issue, policy, or program shifting power dynamics to better integrate voices and priorities of communities of color?

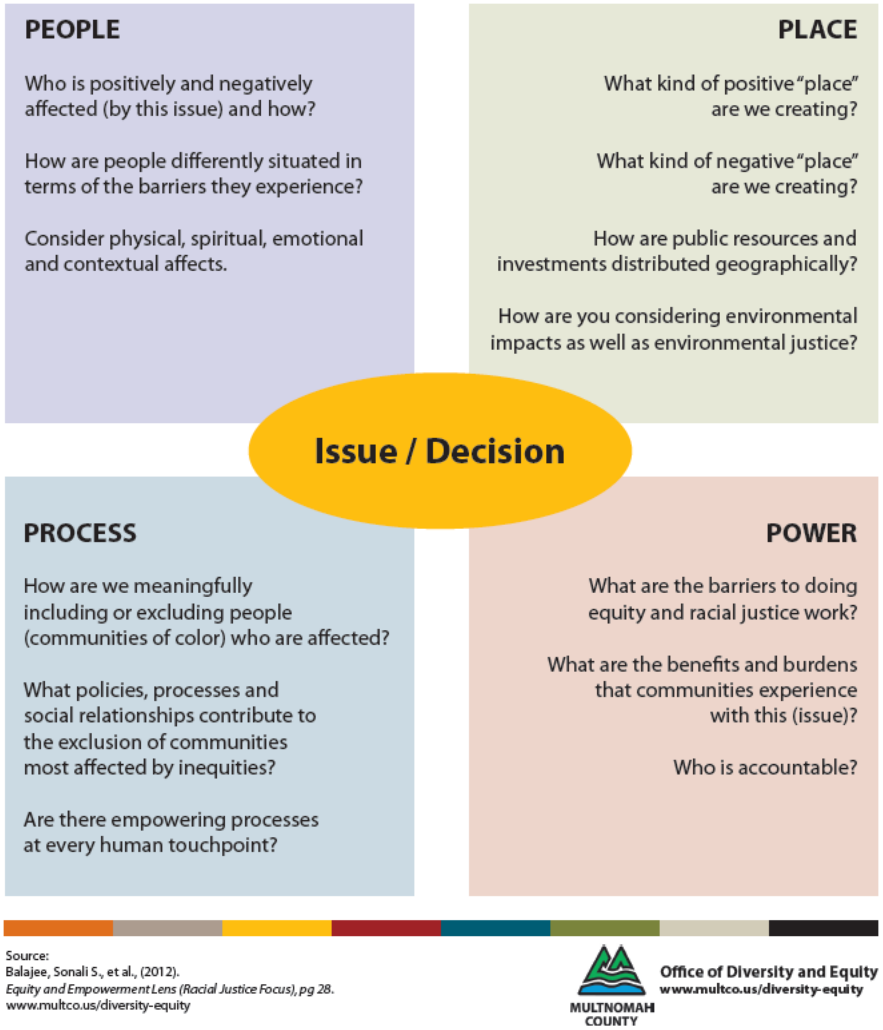
SMALL GROUP ACTIVITY: Toward Health Equity

- **Purpose:** What is my purpose in recognizing, naming, and/or alleviating health inequities? *Propose a single intervention.*
- **People:** Which people or communities will be positively and negatively affected by my proposed intervention? Have I accounted for potential trauma to the people or communities I am trying to serve through this intervention?
- **Place:** How might my intervention account for the emotional and physical safety of people or communities and their need to be productive and feel valued?
- **Process:** Are there empowering processes at every human touchpoint of this intervention?
- **Power:** Who are the stakeholders who need to be involved in the proposed intervention? Describe the kind of power that they hold.

Go to

https://goo.gl/forms/7OoekkVrrjIzhsB23

Equity and Empowerment Lens



Family doctors and teams who can see the river of disease that flows into our clinics and hospitals and will go to identify what happens upstream

FAMILY MEDICINE for AMERICA'S HEALTH

Thank you!

For more information about this project and other exciting FMAHealth news, visit:

www.FMAHealth.org

Please evaluate this presentation using the conference mobile app! Simply click on the "clipboard" icon  on the presentation page.