Addressing the Health Needs of the Underserved

by Ellen Beck

"Addressing the Health Needs of the Underserved" is a faculty development program for family physicians. The program, created by Dr. Ellen Beck, is sponsored by a federal grant from the Department of Health and Human Services. Of the initial group of twenty-four family physicians, six have decided to continue as part-time fellows, two are developing student-run free clinics in their own communities, and several are changing their residency's community medicine rotations. In addition, twenty-one of the twenty-one participants who completed the program decided to continue to meet on a yearly basis to further address the needs of the underserved.

Many individuals in the United States are underserved for a variety of reasons including poverty, lack of access to health care, cultural differences, illiteracy, and lack of transportation. Other barriers are hidden, as exemplified in a recent *New England Journal of Medicine* article indicating that physician management of patients with angina is independently influenced by the patient's race or sex (Schulman 1999).

Another population of the underserved includes those who are legally entitled to access but encounter so many constraining obstacles in their effort to seek care that the access exists in name only and not in action. Some are unaware that they have access or fear that it will affect their immigration status. Others do not know that they can appeal decisions denying them access.

Another underserved group comprises the undocumented who live in the United States without any official legal status. In 1996, forty-two million Americans were without health insurance (Daley 1998).

Underlying Premises

In developing a faculty program to address the health care needs of the underserved, I made a series of assumptions and held a certain set of beliefs about access to health care and the physician community. Among my assumptions were the following:

- To empower is to create an environment in which individuals, families, neighborhoods, or communities can take charge of their lives and achieve joy and well being.
- Health care is a right; universal true access to health care is a basic component of a mature responsible society, and a foundation for "life, liberty, and the pursuit of happiness."
- Our patients can be our greatest teachers; we can learn solutions from those in need.

And among my beliefs, four were crucial:

- There are primary care faculty physicians around the country who have a sustaining, deep, and ongoing interest in the underserved, who have a desire to develop or implement programs to work with the underserved, and who are willing to acquire the necessary tools.
- A sense of isolation may exist among these physicians. They need a sense of community.

- Currently, because of corporate pressures in managed care, physicians who believe in spending time to help patients transform their lives are under great stress. These primary care physicians need time for reflection and renewal.
- A renewal is needed in medical education to create learning environments for students and residents that will mirror, nurture, and sustain their compassion and desire to serve.

Program Development

To address these concerns at the University of California at San Diego, we wrote a faculty development grant proposal to the Department of Health and Human Services. This grant was funded in 1998 for three years to create a program that included a three-week core content institute followed by part-time fellowships. The three weeks were eventually separated into one-week blocks over the year. The part-time fellowships were for physicians who wanted to continue their studies but could not stop work long enough to complete a traditional fellowship.

Each fellow was expected to designate some time each week for a year, during which he or she would take on a specific project or do coursework toward a master's degree in public health. Each would receive funding and designate a local mentor to help with the project. The specific objectives of the program were consistent with the goals of the HHS grant program for faculty development in family medicine; each of the fellows would be able to

- design, implement, administer, and evaluate the community medicine component of a family medicine residency.
- design, implement, and evaluate a teaching intervention for medical students in community medicine/primary care of the underserved.
- integrate curricular components in the primary care of the underserved into an existing medical school curriculum.
- design, implement, and evaluate a research project in community medicine.
- design, implement, and administer a community service program.
- develop a working knowledge of resources that fund and support community medicine projects.

The core faculty of the planning group comprised individuals with experience in community organizing, research, medical education, occupational and environmental health, and administration. Two key individuals were a woman who had been homeless who is now the executive director of a program empowering the homeless, and an excellent facilitator, a teacher of administrative skills.

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We developed a brochure, which described a curriculum that was a balance of faculty development skills, community building skills, and community-oriented primary care (COPC) skills. COPC is a four-step process. It involves

- defining and characterizing a community,
- identifying and prioritizing the community's health problems,
- developing interventions to address the health problems, and
- monitoring the impact of the programs implemented (Donsky 1998 and Nutting 1990).

The curriculum ensured the inclusion of time for the group to build community, and to address some

of the limits and obstacles to individual professional growth. Each person would develop a project in his or her community that would reflect the values shared by the group.

First Group

Forty-two individuals applied to the first program. Thirty-five applied from around the country and seven from the San Diego area. Given the rapid turnaround time for the original application, we were gratified by the response, an indication to us that we had struck a chord of interest in the medical community. The applicant pool was outstanding, reflecting a depth of experience with the underserved that was impressive and a little intimidating.

Applicants were from all over the country. They worked in rural and urban settings, with residents, students, and patients, with few to many years' experience. Some were junior faculty in family medicine residency programs; one was a residency director; several were family medicine faculty who primarily taught medical students; and others were physicians and medical directors of community clinics. In addition, two had designed programs for the homeless; several worked with refugees and migrant workers; and two were faculty in military family medicine residency programs.

We selected seventeen from the thirty-five as well as the seven local individuals (since costs for their participation were small). The group came from fifteen states, including Montana, North Dakota, Oklahoma, Kentucky, Florida, New York, California, Iowa, Pennsylvania, Ohio, Colorado, Mississippi, and Maryland, and included three African Americans, and three Hispanics. Fifteen of the twenty-four were men; twenty-three were family physicians; and one was an internist. The bulk of the participants were family physicians because this program was funded through HHS Family Medicine funding.

Curriculum/Description of Sample Sessions

We met for three one-week periods, in February, May, and July. The focus of each week was a different theme. One week focused on homelessness; the next on environmental and occupational issues; and the third, on access to care. The format was similar each week and combined didactic, experiential, and reflective learning.

On Sunday we met to reconnect and share our personal and professional progress since the last meeting. Each subsequent day's session began with a brief check-in. On Monday, dynamic community members, who were making a difference, shared their experiences. In the afternoon, we explored an aspect of research or evaluation. On Tuesday morning, we learned a specific faculty development skill, and in the afternoon, we applied that skill. On Wednesday, we addressed a scholarly skill. The afternoon was free for personal renewal or self-directed learning. On Thursday, we would embark on a community visit or experience. On Thursday afternoon, an administrative or organizational skill was taught through experiential learning. And Friday morning was a time for personal reflection, renewal, and community building through a shared learning activity.

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Examples of sessions

Needs Assessment: This session focused on designing an assessment of the needs of the homeless; the group was divided into four small groups. Each small group had two experts, one was an epidemiologist, and the other was a homeless person.

Homeless Work Team: The physicians paired up with homeless men who were part of a local program that is helping them get back to work. These homeless men spend several mornings a week cleaning the streets of Pacific

Beach. Each physician was paired with a homeless man and spent the morning learning to clean the streets.

Designing a Community Medicine Curriculum: In a set of paired sessions, in the morning, the group learned how to design a course or curriculum; in the afternoon, they focused on designing a community medicine rotation for a family medicine residency program.

Environmental Health Sessions: The group visited a shipyard. They also met with a group of environmental health promoters who live and work in a poor Hispanic neighborhood to increase awareness of environmental risks and hazards and implement community-based programs for prevention and control.

Personal Renewal: In one session, they each drew a picture. In the center, they were asked to draw symbols of their lives back home and surround them with symbols for their sources of strength.

Learning Contracts

The participants were expected to design, complete and present a learning contract which was essentially a project relating to the underserved. For example, a family medicine residency faculty member in a large urban area decided that for her project she would learn about the history, needs, and resources in the zip code area of her residency program that had the lowest socioeconomic level. Her project presentation reflected a depth of understanding of the history and politics of the region. She is now in the process of helping her residents, as part of their community medicine rotation, to learn about and develop programs in this neighborhood. We hope that, over time, groups of family medicine residents will be able to maintain trust and collaboration with this particular community. By focusing on one neighborhood, these residents will have a greater possibility of affecting lasting change.

Another participant came from a military family medicine residency program. He reflected on who was underserved in the military community. He observed that young couples, with young children, are often separated from each other and their support systems as a result of military postings. He also observed that this situation can lead to domestic violence. His project attempted to assess the need in the military for a foster grandparent program for couples with young children as a possible intervention. Through a needs assessment survey, he identified that young couples would appreciate the presence of a foster grandparent. He is now in the process of implementing such a program.

Another participant was a faculty member in a medical school who was in the process of planning a day-long workshop on working with the homeless. After the first week of the faculty development program, this participant changed the design of the curriculum for his workshop, to involve the homeless as teachers and consultants for the providers. In addition, he developed a brief video, in which several homeless individuals eloquently articulate their needs and perceptions of the health care system. Finally, he is working with a group of students to create a student-run free clinic in his community.

Outcomes

Twenty-one of the twenty-four participants completed the program. Six chose to continue as part-time fellows, with projects including coursework for an MPH in public policy; development of a student-run free clinic; the creation of a community medicine rotation for a family medicine residency and writing a grant to support it; working with an existing clinic to better meet community needs, and studying tuberculosis epidemiology in an underserved community. Of the fellows, three are members of underserved minorities.

During the third week, the group discussed its future and made several decisions. Above all, the group wanted to continue to exist as physician teachers who advocate for the underserved. They formed a committee to develop a name, a mission statement, andto define underserved. The group also decided to meet on a yearly basis and planned

its first meeting to overlap with the second week of the faculty development's year 2000 program. They decided to meet for three days in San Diego next spring to report on projects and continue learning together, and each one agreed to sustain the cost of this meeting. When a show of hands was taken to poll how many would be willing to return if such a meeting were held, all twenty-one indicated a desire to return. The group developed an agenda for their next meeting and formed a planning committee.

A relationship has been developed with an existing organization, Association of Clinicians for the Underserved (ACU), and members of our group will organize informal meetings at Society of Teachers of Family Medicine and other organizations. Long-term outcomes will be measured (i.e., yearly cards will be sent out asking participants to indicate long-term benefits of the program). The group's desire for continuity is a meaningful outcome and quite moving for the originators of the program, who note that the same outcome was experienced several years ago. Then faculty from all the family medicine programs in the San Diego region had voted to continue their faculty development program, and recreated it as the San Diego Family Practice Consortium. It designs curricular offerings that bring together all the family medicine residents in the region, and hosts Surfnet, a family medicine research group. This consistent desire for continuity speaks to the need for community and empowerment among our physicians, and transforms their potential sense of isolation and frustration into the satisfaction of making a greater difference.

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