Community Organizing in Family Medicine Training

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Background

Social Determinants of Health (SDH) are increasingly recognized as potential root causes for health outcomes[1]. However, although medical education has easily adopted the language of SDH, there seems to be a gap between language and action[2], and a great deal of heterogeneity in the content and format of training regarding SDH during residency[1]. The United States has significant health inequities stemming from racist class structures that inequitably distributes power and opportunity. It is thus imperative that our medical training programs include specific SDH content, but also equips trainees with skills in organizing community powered change to better address root causes of healthy inequities[3]. Oregon Health and Science University's Department of Family Medicine (OHSU FM) has implemented a novel component of residency training to bridge the gap between theory and praxis. The fourth and final year of residency includes a formal, longitudinal Population Health and Leadership curriculum. Part of this curriculum includes a community organizing course, carried out in partnership with the Metropolitan Alliance for the Common Good (MACG), a local community-based organization, which aims to equip residents with skills to build community power to shift unjust structures.

In this mixed methods study, we are evaluating the community organizing component of the curriculum, focusing on the ways in which graduates of the OHSU FM residency program have carried the lessons learned forward, barriers to community engagement or organizing in the post-residency phase of their careers, overall experiences of the curriculum, and ways in which the curriculum impacted the graduates.

Aims

- Explore resident experiences of the community organizing curriculum and the impact post-residency
- Determine the extent of perceived behavior changes due to the curriculum
- Identify facilitators and barriers to participating in community organizing/engagement after graduating from residency training

Methodology

Quantitative

- Analysis of pre- and post-training questionnaires (n=32) for 2016, 2018, and 2019 OHSU FM graduates
  - Surveys were administered during residency prior to beginning the training and after its completion
  - Compared mean value of answers from 4 questions with a 7-point Likert scale between pre- and post-training using paired T-test
- All analyses carried out in Stata, version 13.1

Qualitative

- Focus group discussions with graduates of OHSU FM residency (ongoing) carried out between 2-5 years after graduation from residency
  - FGDs carried out remotely via Webex due to COVID-19 precautions. Recordings of FGDs were transcribed and analyzed.
  - Ongoing FGD recruitment. Two completed to date (n=6)
- Transcripts analyzed with qualitative content analysis[4] coded by two individual coders (AP and KT) with triangulation of codes and categories for increased credibility[5]
- Answers to pre- and post-training surveys analyzed using content analysis

Results

	Mean (SD) *n*		Mean Difference (95% CI)	t-statistic (df)	p-value[a]
	Pre	Post			
Q1: I am comfortable listening to and participating with patients in community settings	4.09 (1.53) *n=32*	5.38 (1.02) *n=26*	-1.31 -1.86, -0.75)	-4.84 (25)	0.0001**
Q2: My degree of knowledge about the problems affecting local residents is (low to high)	3.62 (1.10) *n=32*	4.69 (1.01) *n=26*	-1.00 (-1.69, -0.31)	-2.96 (25)	0.0066**
Q3: I feel capable of participating in a campaign on a community issue	3.59 (1.41) *n=32*	5.21 (0.87) *n=26*	-1.71 (-2.41, -1.01)	-5.04 (25)	0.00**
Q4a: I am confident that patients and clinic staff can bring about changes impacting the social determinants of health	4.58 (1.39) *n=19*	5.78 (0.79) *n=16*	-0.969 (-1.89, -0.043)	-2.23 (15)	0.0413*
Q4b: I believe community organizing campaigns can change resource accessibility for residents	5.46 (1.05) n=13	6.78 (0.44) n=9	-1.00 (-1.67, -0.33)	-3.46 (8)	0.0085**

Table 1 Mean responses with standard deviation and number of respondents pre- and post-training with p-values for paired T-test. Responses selected from a 7-point Likert scale. For each of the questions, the mean value of the answers for the post-training survey was significantly higher than the pre-training survey. * p-value < 0.05, ** p-value < 0.01, a) paired T-test

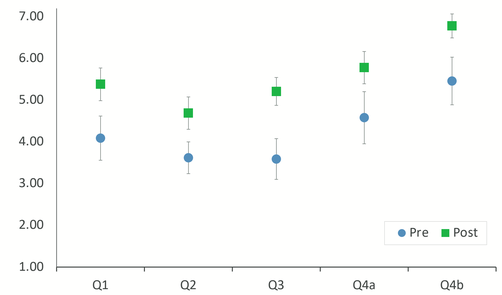

Figure 1 Comparison of pre- and post-training survey responses, with 95% confidence interval. For pre-training, n=32. For post-training, n=26.

	Pre (n=32)	**Post** (n=27)
Plans to engage in community organizing	9.4%	40.7%
Plans to engage in advocacy	46.9%	51.9%
Plans for clinic-based health equity/social justice efforts	28.1%	37.0%

Table 2 Content analysis of short-answer survey responses from cohorts 2015-2016, 2017-2018, 2018-2019

Emerging Categories	Well-being		Identity		Lasting impact			Barriers	
Sub-categories	Burnout Prevention	Community and Connection	Navigating complexity	Identity shaping	Relational one-on-ones	Stakeholder and power analyses	Knowledge of community resources	Constraints of professional role	Lack of institutional support

Table 3 Emerging categories and subcategories from preliminary analysis of focus group discussions

Focus Group Discussion Quotes:

Well-being

it helps us get outside of the bounds of our clinic and help the community... It feeds me"

"If you want to avoid burnout, help doctors do what they love"

Identity

"Understanding without centering myself"

"Added this kind of layer to my identity as a physician and as a community member"

Impact

"MACG was a really great example of... totally outside of medicine, totally outside of the public health world... having people organize to address something that they all particularly cared about, but then also turned out to be a huge social determinant of health."

Barriers

"much of SDH are not addressable in our one-to-one patient encounters"

"Your job is not going to offer you opportunities to make really big changes"

Discussion

Conclusions

The curriculum yielded shifts in perceived ability to engage with community, as well as increased comfort with community organizing as a tool to effect structural change which we have demonstrated both through quantitative analysis of the pre- and post-assessments, as well as through qualitative analysis of FGDs. Across each of the domains assessed in the pre- and post-training surveys, there were increases for all participants, with increased confidence in the ability of patient and clinic staff to bring about changes that impact SDH, and increased belief in the ability of community organizing campaigns to change resource accessibility for residents. Based on preliminary analyses of focus group discussion transcripts, the training had a lasting impact on graduates, and they continue to implement organizing techniques (relational one-to-one meetings, stakeholder analyses) in and out of clinical settings. Participants also indicated greater satisfaction when able to engage in community and organize, and described advocacy efforts, community organizing, and community meetings as ways to address social determinants of health.

Limitations

- Small sample size
- Varying level of response per cohort.
  - No survey data available for 2016-2017 graduates
- Slight difference in questions for one year of respondents (Q4a vs Q4b)
- Incomplete FGD data due to ongoing recruitment
- Sampling bias for FGD, e.g., those who enjoyed the curriculum may be more likely to participate
- FGD held remotely due to COVID-19 precautions

Next Steps

- Continue focus group discussions (goal is to reach ≥50% of the graduates)
- Bring suggestions for curriculum changes to the FM residency directors
- Disseminate findings with other institutions
- Maintain ongoing relationship with community organization MACG
- Addressing identified barriers to implementing community organizing post-residency

Acknowledgments

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References

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