Structural Competency

Participant Workbook

Contents

Health Outreach Partners
HEALTHY PEOPLE. EQUITABLE COMMUNITIES.

Structural Competency Pilot Training

Friday, April 26, 2019 | 8:30-4:30pm

Place: Hilltop Regional Health Center, 1202 Martin Luther King Jr. Way, Tacoma, WA 98405
(Free parking is available on the 2nd floor of Hilltop's garage. First floor is reserved for patients.)

Agenda

8:15-8:30am	**Arrival and Sign-In (15 mins)**

8:30-9:00am	**Welcome and Introduction (30 mins)**
	• Objective: To set expectations and create a safe and productive learning environment that is engaging and enjoyable.
	  ○ HOP and Participant Introduction
	  ○ Agenda review and Learning Objectives
	  ○ Overview of Piloting
	  ○ Group Agreements and Positionality
	  ○ Icebreaker: People Bingo

9:00-10:05am	**Module 1: Structures and Patient Health (65 mins)** *Section 1: Social Structures and Health* • Objective: To identify examples of structures and understand the influence of these structures on patient health and the provision of care to the patient.
10:05-10:15am	**Break (10 min.)**
10:15-11:10am	**Module 1: Structures and Patient Health (55 mins)** *Section 2: Structural Violence, Racism, and Vulnerability* • Objective: To define structural violence, structural racism, and structural vulnerability and identify examples of how they influence patient health.
11:10-12:00pm	**Module 1: Structures and Patient Health (50 mins)** *Section 3: Naturalizing Inequality* • Objective: To understand the processes through which inequality is naturalized and examine three implicit frameworks.
12:00-12:15am	**Participant Feedback (15 min)** • Evaluation form • Semi-structured discussion
12:15-1:00pm	**Lunch (45 min)**
1:00-1:10pm	**Energizer (10 min)**

1:10-2:00pm	**Module 2: Origins and Definitions of Structural Competency (50 mins)** *Section 1: Cultural Competency and Cultural Humility - 30 min* • Objective: To reflect on the strengths and limitations of using the cultural competency and cultural humility approaches to explain disparities in health and health care. *Section 2: Structural Competency - 15 min* • Objective: To define structural competency and describe the five goals of the framework. *Section 3: Structural Competency and the Social Determinants of Health - 5 min* • Objective: To explain the association between structural competency and the social determinants of health
2:00-2:15pm	**Participant Feedback (15 min)** • Evaluation form • Semi-structured discussion
2:15-2:25pm	**Break (10 min)**
2:25-3:15pm	**Module 3: Levels of Intervention (50 mins)** *Section 1: Structurally Competent Interventions - 40 min* • Objective: To describe at least one historical or contemporary example of an intervention that addressed structural violence and vulnerability. *Section 2: Levels of Intervention - 10 min* • Objective: To define and understand the six levels of intervention for addressing harmful social structures.
3:15-3:20pm	**Break (5 min)**
3:20-4:05pm	**Module 4: Beloved Community and Taking Action (45 mins)** *Section 1: Beloved Community - 10 min* • Objective: To define "Beloved Community" and articulate its importance for structurally competent practice. *Section 2: Putting Theory into Practice - 35 min* • Objective: To identify at least one intervention strategy to implement to address structural causes of ill health.
4:05-4:20pm	**Participant Feedback (15 min)** • Semi-structured discussion, including prepared questions • Evaluation form
4:20-4:30pm	**Closing (10 minutes)**

Module 1: *Structures and Patient Health*

Case Study

Patient History

- **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

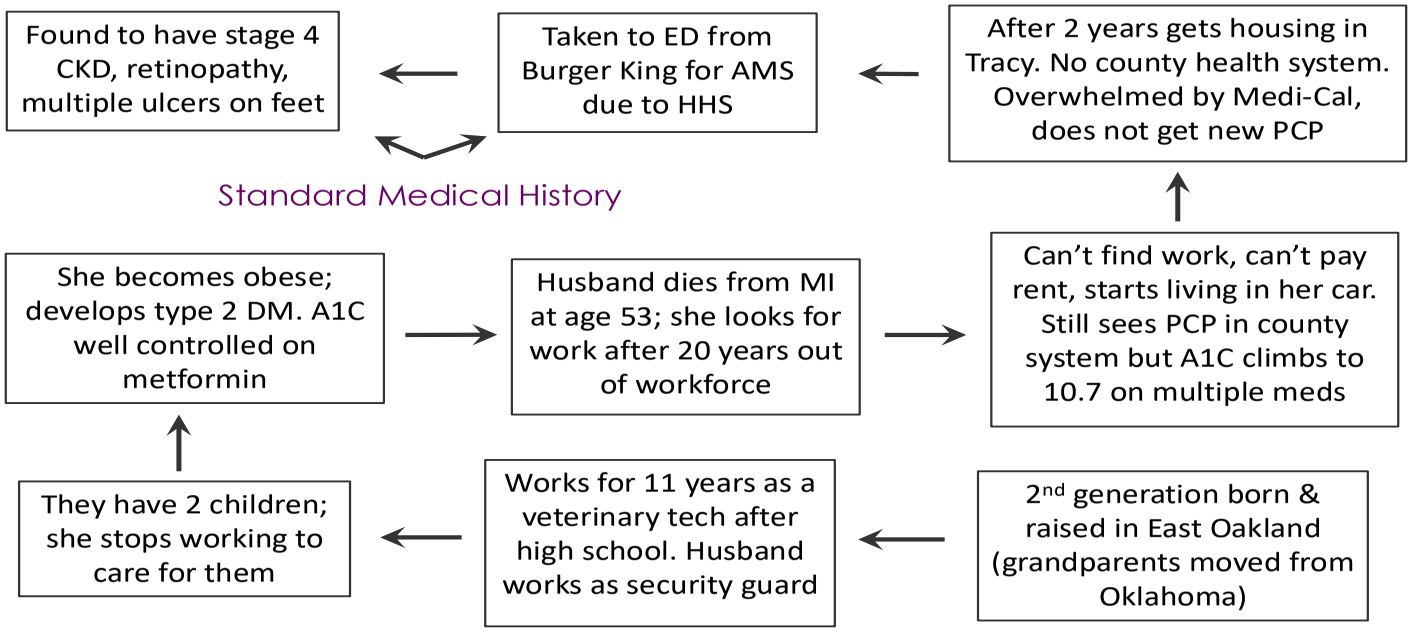
1. What questions do you have that might help you to better understand the patient's situation?

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

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

Module 1: *Structures and Patient Health*

Case Study #2



Questions

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?

Module 1: *Structural Violence, Structural Racism, and Structural Vulnerability*

Excerpt from **Ta-Nehisi Coates' "The Case for Reparations."** ***The Atlantic*****, June 2014.**

The men who peddled contracts in North Lawndale would sell homes at inflated prices and then evict families who could not pay—taking their down payment and their monthly installments as profit. Then they'd bring in another black family, rinse, and repeat. "He loads them up with payments they can't meet," an office secretary told The Chicago Daily News of her boss, the speculator Lou Fushanis, in 1963. "Then he takes the property away from them. He's sold some of the buildings three or four times."

Ross had tried to get a legitimate mortgage in another neighborhood, but was told by a loan officer that there was no financing available. The truth was that there was no financing for people like Clyde Ross. From the 1930s through the 1960s, black people across the country were largely cut out of the legitimate home-mortgage market through means both legal and extralegal. Chicago whites employed every measure, from "restrictive covenants" to bombings, to keep their neighborhoods segregated.

Their efforts were buttressed by the federal government. In 1934, Congress created the Federal Housing Administration. The FHA insured private mortgages, causing a drop in interest rates and a decline in the size of the down payment required to buy a house. But an insured mortgage was not a possibility for Clyde Ross. The FHA had adopted a system of maps that rated neighborhoods according to their perceived stability. On the maps, green areas, rated "A," indicated "in demand" neighborhoods that, as one appraiser put it, lacked "a single foreigner or Negro." These neighborhoods were considered excellent prospects for insurance. Neighborhoods where black people lived were rated "D" and were usually considered ineligible for FHA backing. They were colored in red. Neither the percentage of black people living there nor their social class mattered. Black people were viewed as a contagion. Redlining went beyond FHA-backed loans and spread to the entire mortgage industry, which was already rife with racism, excluding black people from most legitimate means of obtaining a mortgage.

"A government offering such bounty to builders and lenders could have required compliance with a nondiscrimination policy," Charles Abrams, the urban-studies expert who helped create the New York City Housing Authority, wrote in 1955. "Instead, the FHA adopted a racial policy that could well have been culled from the Nuremberg laws."

The devastating effects are cogently outlined by Melvin L. Oliver and Thomas M. Shapiro in their 1995 book, *Black Wealth/White Wealth*:

> *Locked out of the greatest mass-based opportunity for wealth accumulation in American history, African Americans who desired and were able to afford home ownership found themselves consigned to central-city communities where their investments were affected by the "self-fulfilling prophecies" of the FHA appraisers: cut off from sources of new*

investment[,] their homes and communities deteriorated and lost value in comparison to those homes and communities that FHA appraisers deemed desirable.

In Chicago and across the country, whites looking to achieve the American dream could rely on a legitimate credit system backed by the government. Blacks were herded into the sights of unscrupulous lenders who took them for money and for sport. “It was like people who like to go out and shoot lions in Africa. It was the same thrill,” a housing attorney told the historian Beryl Satter in her 2009 book, *Family Properties*. “The thrill of the chase and the kill.”

The kill was profitable. At the time of his death, Lou Fushanis owned more than 600 properties, many of them in North Lawndale, and his estate was estimated to be worth $3 million. He’d made much of this money by exploiting the frustrated hopes of black migrants like Clyde Ross. During this period, according to one estimate, 85 percent of all black home buyers who bought in Chicago bought on contract. “If anybody who is well established in this business in Chicago doesn’t earn $100,000 a year,” a contract seller told The Saturday Evening Post in 1962, “he is loafing.”

Contract sellers became rich. North Lawndale became a ghetto. Clyde Ross still lives there. He still owns his home. He is 91, and the emblems of survival are all around him—awards for service in his community, pictures of his children in cap and gown. But when I asked him about his home in North Lawndale, I heard only anarchy.

“We were ashamed. We did not want anyone to know that we were that ignorant,” Ross told me. He was sitting at his dining-room table. His glasses were as thick as his Clarksdale drawl. “I’d come out of Mississippi where there was one mess, and come up here and got in another mess. So how dumb am I? I didn’t want anyone to know how dumb I was.

“When I found myself caught up in it, I said, ‘How? I just left this mess. I just left no laws. And no regard. And then I come here and get cheated wide open.’ I would probably want to do some harm to some people, you know, if I had been violent like some of us. I thought, ‘Man, I got caught up in this stuff. I can’t even take care of my kids.’ I didn’t have enough for my kids. You could fall through the cracks easy fighting these white people. And no law.”

But fight Clyde Ross did…

Black Mothers Keep Dying After Giving Birth. Shalon Irving's Story Explains Why

(Excerpt)

December 7, 2017, All Things Considered

Link to full story: https://www.npr.org/2017/12/07/568948782/black-mothers-keep-dying-after-giving-birth-shalon-irvings-story-explains-why

Racial disparity across incomes

In recent years, as high rates of maternal mortality in the U.S. have alarmed researchers, one statistic has been especially concerning. According to the CDC, black mothers in the U.S. die at three to four times the rate of white mothers, one of the widest of all racial disparities in women's health. Put another way, a black woman is 22 percent more likely to die from heart disease than a white woman, 71 percent more likely to perish from cervical cancer, but 243 percent more likely to die from pregnancy- or childbirth-related causes. In a national study of five medical complications that are common causes of maternal death and injury, black women were two to three times more likely to die than white women who had the same condition.

That imbalance has persisted for decades, and in some places, it continues to grow. In New York City, for example, black mothers are 12 times more likely to die than white mothers, according to the most recent data; in 2001-2005, their risk of death was seven times higher. Researchers say that widening gap reflects a dramatic improvement for white women but not for blacks.

The disproportionate toll on African-Americans is the main reason the U.S. maternal mortality rate is so much higher than that of other affluent countries. Black expectant and new mothers in the U.S. die at about the same rate as women in countries such as Mexico and Uzbekistan, the World Health Organization estimates.

What's more, even relatively well-off black women like Shalon Irving die and nearly die at higher rates than whites. Again, New York City offers a startling example: A 2016 analysis of five years of data found that black, college-educated mothers who gave birth in local hospitals were more likely to suffer severe complications of pregnancy or childbirth than white women who never graduated from high school.

The fact that someone with Shalon's social and economic advantages is at higher risk highlights how profound the inequities really are, said Raegan McDonald-Mosley, the chief medical director for Planned Parenthood Federation of America, who met her in graduate school at Johns Hopkins University and was one of her closest friends. "It tells you that you can't educate your way out of this problem. You can't health care-access your way out of this problem. There's something inherently wrong with the system that's not valuing the lives of black women equally to white women."

For much of American history, these types of disparities were largely blamed on blacks' supposed susceptibility to illness — their "mass of imperfections," as one doctor wrote in 1903 — and their own behavior. But now many social scientists and medical researchers agree, the problem isn't race but racism.

The systemic problems start with the type of social inequities that Shalon studied — differing access to healthy food and safe drinking water, safe neighborhoods and good schools, decent jobs and reliable transportation.

Black women are more likely to be uninsured outside of pregnancy, when Medicaid kicks in, and thus more likely to start prenatal care later and to lose coverage in the postpartum period. They are more likely to have chronic conditions such as obesity, diabetes and hypertension that make having a baby more dangerous. The hospitals where they give birth are often the products of historical segregation, lower in quality than those where white mothers deliver, with significantly higher rates of life-threatening complications.

Those problems are amplified by unconscious biases that are embedded in the medical system, affecting quality of care in stark and subtle ways. In the more than 200 stories of African-American mothers that ProPublica and NPR have collected over the past year, the feeling of being devalued and disrespected by medical providers was a constant theme.

There was the new mother in Nebraska with a history of hypertension who couldn't get her doctors to believe she was having a heart attack until she had another one. The young Florida mother-to-be whose breathing problems were blamed on obesity when in fact her lungs were filling with fluid and her heart was failing. The Arizona mother whose anesthesiologist assumed she smoked marijuana because of the way she did her hair. The Chicago-area businesswoman with a high-risk pregnancy who was so upset at her doctor's attitude that she changed OB/GYNs in her seventh month, only to suffer a fatal postpartum stroke.

Over and over, black women told of medical providers who equated being African-American with being poor, uneducated, noncompliant and unworthy. "Sometimes you just know in your bones when someone feels contempt for you based on your race," said one Brooklyn, N.Y., woman who took to bringing her white husband or in-laws to every prenatal visit. Hakima Payne, a mother of nine in Kansas City, Mo., who used to be a labor and delivery nurse and still attends births as a midwife-doula, has seen this cultural divide as both patient and caregiver. "The nursing culture is white, middle-class and female, so is largely built around that identity. Anything that doesn't fit that identity is suspect," she said. Payne, who lectures on unconscious bias for professional organizations, recalled "the conversations that took place behind the nurse's station that just made assumptions; a lot of victim-blaming — 'If those people would only do blah, blah, blah, things would be different.' "

In a survey conducted this year by NPR, the Robert Wood Johnson Foundation and the Harvard T.H. Chan School of Public Health, 33 percent of black women said that they personally had been discriminated against because of their race when going to a doctor or health clinic, and 21 percent said they have avoided going to a doctor or seeking health care out of concern they would be racially discriminated against.
Black expectant and new mothers frequently said that doctors and nurses didn't take their pain seriously — a phenomenon borne out by numerous studies that show pain is often undertreated in black patients for conditions from appendicitis to cancer.

When Patrisse Cullors, a co-founder of the Black Lives Matter movement who has become an activist to improve black maternal care, had an emergency C-section in Los Angeles in March 2016, the surgeon "never explained what he was doing to me," she said. The pain medication didn't work: "My mother basically had to scream at the doctors to give me the proper pain meds."But it's the discrimination that black women experience in the rest of their lives — the double whammy of race and gender — that may ultimately be the most significant factor in poor maternal outcomes.

"It's chronic stress that just happens all the time — there is never a period where there's rest from it. It's everywhere; it's in the air; it's just affecting everything," said Fleda Mask Jackson, an Atlanta researcher who focuses on birth outcomes for middle-class black women.

It's a type of stress for which education and class provide no protection. "When you interview these doctors and lawyers and business executives, when you interview African-American college graduates, it's not like their lives have been a walk in the park," said Michael Lu, a longtime disparities researcher and former head of the Maternal and Child Health Bureau of the Health Resources and Services Administration, the main federal agency funding programs for mothers and infants. "It's the experience of having to work harder than anybody else just to get equal pay and equal respect. It's being followed around when you're shopping at a nice store, or being stopped by the police when you're driving in a nice neighborhood."
An expanding field of research shows that the stress of being a black woman in American society can take a physical toll during pregnancy and childbirth.
Chronic stress "puts the body into overdrive," Lu said. "It's the same idea as if you keep gunning the engine, that sooner or later you're going to wear out the engine."

As women get older, birth outcomes get worse. ... If that happens in the 40s for white women, it actually starts to happen for African-American women in their 30s, Michael Lu, a disparities researcher and former head of the Maternal and Child Health Bureau of the Health Resources and Services Administration.

Arline Geronimus, a professor at the University of Michigan School of Public Health, coined the term "weathering" for stress-induced wear and tear on the body. Weathering "causes a lot of different health vulnerabilities and increases susceptibility to infection," she said, "but also early onset of chronic diseases, in particular, hypertension and diabetes" — conditions that disproportionately affect blacks at much younger ages than whites. Her research even suggests it accelerates aging at the molecular level; in a 2010

study Geronimus and colleagues conducted, the telomeres (chromosomal markers of aging) of black women in their 40s and 50s appeared 7 1/2 years older on average than those of whites.

Weathering has profound implications for pregnancy, the most physiologically complex and emotionally vulnerable time in a woman's life. Stress has been linked to one of the most common and consequential pregnancy complications, preterm birth. Black women are 49 percent more likely than whites to deliver prematurely (and, closely related, black infants are twice as likely as white babies to die before their first birthday). Here again, income and education aren't protective.

The repercussions for the mother's health are also far-reaching. Maternal age is an important risk factor for many severe complications, including pre-eclampsia, or pregnancy-induced hypertension. "As women get older, birth outcomes get worse," Lu said. "If that happens in the 40s for white women, it actually starts to happen for African-American women in their 30s."

This means that for black women, the risks for pregnancy start at an earlier age than many clinicians — and women— realize, and the effects on their bodies may be much greater than for white women. In Geronimus' view, "a black woman of any social class, as early as her mid-20s should be attended to differently."

That's a concept that professional organizations and providers have barely begun to wrap their heads around. "There may be individual doctors or hospitals that are doing it [accounting for the higher risk of black women], but ... there's not much of that going on," Lu said. Should doctors and clinicians be taking into account this added layer of vulnerability? "Yeah," Lu said. "I truly think they should."

Other Suggested Reading/Podcasts:

YOU, ME AND THEM: EXPERIENCING DISCRIMINATION IN AMERICA
Racism Is Literally Bad For Your Health
Link: https://www.npr.org/2017/10/28/560444290/racism-is-literally-bad-for-your-health

SHOTS - HEALTH NEWS
Scientists Start To Tease Out The Subtler Ways Racism Hurts Health
Link: https://www.npr.org/sections/health-shots/2017/11/11/562623815/scientists-start-to-tease-out-the-subtler-ways-racism-hurts-health

KEY CONCEPTS:

"Language is never neutral." — Paulo Freire.

Social Structure: The policies, economic systems, and other institutions (policing and judicial systems, schools, etc.) that have produced and maintain social inequities and health disparities, often along the lines of social categories such as race, class, gender, and sexuality.

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

Structural Vulnerability: The risk that an individual experiences as a result of structural violence – including their location in socioeconomic hierarchies. It is not caused by, nor can it be repaired solely by, individual agency or behaviors.

Naturalizing Inequality: When social inequalities are preserved through the perception that the status quo is appropriate, deserved, and natural. Those at the top are seen as deserving their position at the top, and, especially, those at the bottom are seen to be at the bottom due to their own faults. Such perception is shaped by what we will call "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 (see below). Implicit as in "implicit bias."

Individualization: The common perception in healthcare that the most important causes of a patient's sickness lie in their individually chosen actions and habits and/or their individual biology (genetics, etc.). This leads to treatment plans focused primarily on education and incentive for individual level behavior change.

Cultural Frameworks: "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. It also leads to the misdirected application of cultural competence education as a solution to health care disparities for minority populations who are as familiar with mainstream American health care practices and institutions as the majority population, but who lack the resources and political clout to improve their health and health care." —Gregg and Saha

Structural Vulnerability Checklist

From: Bourgois P, Holmes SM, Sue K, Quesada J. "Structural Vulnerability: Operationalizing the Concept to Address Health Disparities in Clinical Care." *Academic Medicine*, 2017.

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?
Social network	**Do you have friends, family, or other people who help you when you need it?** • Who are the members of your social network, family and friends? Do you feel this network is helpful or unhelpful to you? In what ways? • Is anyone trying to hurt you? • Do you have a primary care provider/other health professionals?
Legal status	**Do you have any legal problems?** • Are you scared of getting in trouble because of your legal status? • Are you scared the police might find you? • Are you eligible for public services? Do you need help accessing these services? • Have you ever been arrested and/or incarcerated?
Education	**Can you read?** • In what language(s)? What level of education have you reached? • Do you understand the documents and papers you must read and submit to obtain the services and resources you need?
Discrimination	***[Ask the patient]* Have you experienced discrimination?** • Have you experienced discrimination based on your skin color, your accent, or where you are from? • Have you experienced discrimination based on your gender or sexual orientation? • Have you experienced discrimination for any other reason? ***[Ask yourself silently]* May some service providers (including me) find it difficult to work with this patient?** • Could the interactional style of this patient alienate some service providers, eliciting potential stigma, stereotypical biases, or negative moral judgments? • Could aspects of this patient's appearance, ethnicity, accent, etiquette, addiction status, personality, or behaviors cause some service providers to think this patient does not deserve/want or care about receiving top quality care? • Is this patient likely to elicit distrust because of his/her behavior or appearance? • May some service providers assume this patient deserves his/her plight in life because of his/her lifestyle or aspects of appearance?

Naturalizing Inequality Exercise

Underline the parts of the passages below where you see inequality/injustice being naturalized through "Implicit Frameworks." Implicit Frameworks we discussed include:

- ***Focusing on "culture" (instead of structures)***
- ***Focusing on individual level behavior or choices (instead of structures)***
- ***Focusing on biology/genetics (instead of structures)***

Excerpts from: Seth Holmes
"An Ethnographic Study of the Social Context of Migrant Health in the US,"
Social Science and Medicine 2006.

#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.

#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.

Structural Violence Exercise

Write about an example (or examples) of structural violence leading to poor health for patients you have worked with or for other people you have known. You can list examples from different cases in which structural violence has been a factor, or you may focus on one case in detail, pulling out themes of structural violence. Be sure to consider which structures are or may be involved, and in what way they led to harm (i.e. in which way they are violent).

Lesson Plan Four
Handout

I Am!

My Gender Is

_____

My Race/Ethnicity Is

_____

My Economic Background Is

_____

My Religion Is

_____

My Talents Include

_____

My Interests Include

_____

My Age Is

_____

My Sexual Orientation Is

_____

Other Social Groups to Which I Belong Include

_____

These are the social groups to which I belong!

Lesson Plan Four
Handout

Social Group Membership Profile

Use your answers on the *I Am* handout to respond to the questions below.

Of all of the social groups to which you belong:

1. Which ones are you most comfortable with? _____

_____

2. Which are you least comfortable with? _____

_____

3. Which do you think most about? _____

_____

4. Which do you think least about? _____

_____

5. Which groups give you the most privileges? _____

_____

6. Which groups limit your access, options, and/or rewards in society? _____

_____

7. Which have the greatest effect, positively or negatively, on how others see you? _____

_____

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

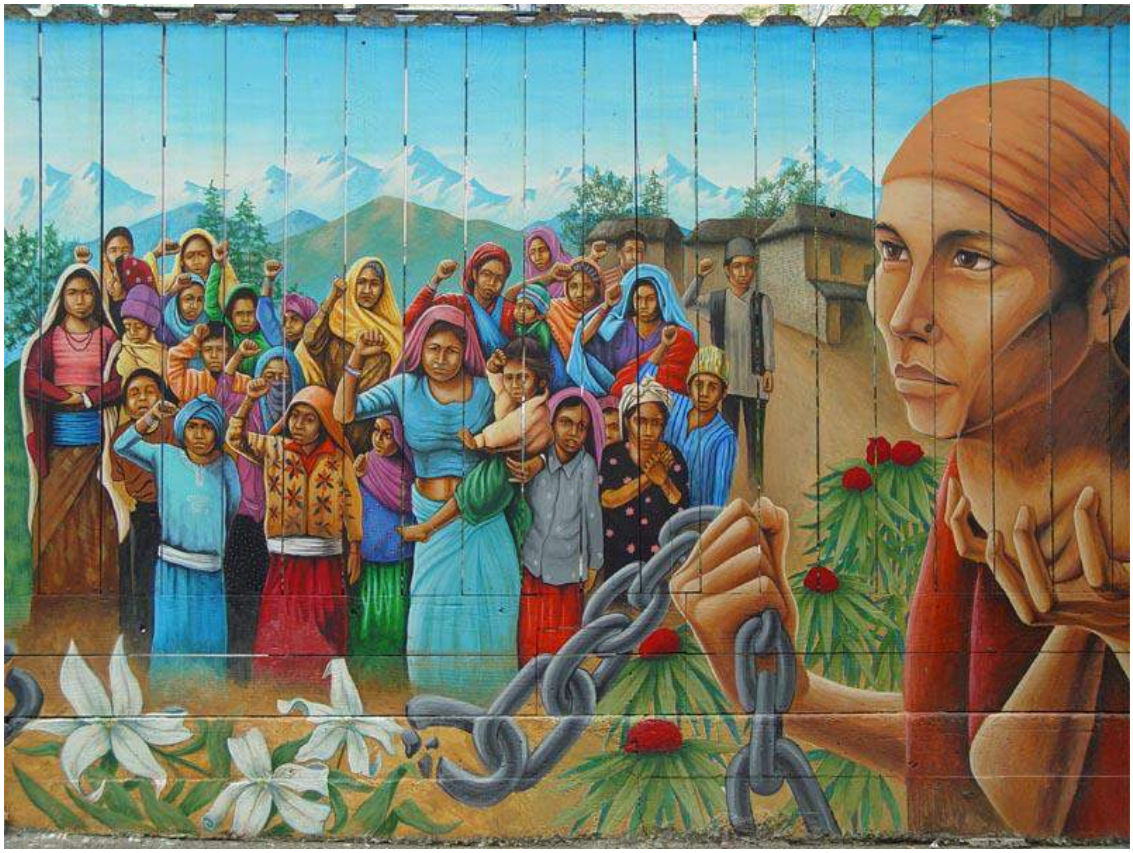
"A shift in medical education … toward attention to forces that influence health outcomes at levels above individual interactions." —Metzl and Hansen 2014

Components of Structural Competency:

1. Recognizing influences of structures on patient health
2. Recognizing influences of structures on the clinical encounter, including implicit frameworks common in healthcare
3. Responding to structures in the clinic
4. Responding to structures beyond the clinic
5. Structural humility

Structural Humility:

The orientation emphasizing collaboration with patients and populations in developing responses to structural vulnerability, rather than assuming that health professionals alone have all the answers. This includes awareness of interpersonal privilege and power hierarchies in healthcare.



Module 2: ***Origins and Definitions of Structural Competency***
Reflection Exercise

---

1. What social structures influenced your training?

2. What social structures are present in your day-to-day work?

3. How do they influence your interactions with your colleagues, with patients, and with the community?

Levels of Intervention

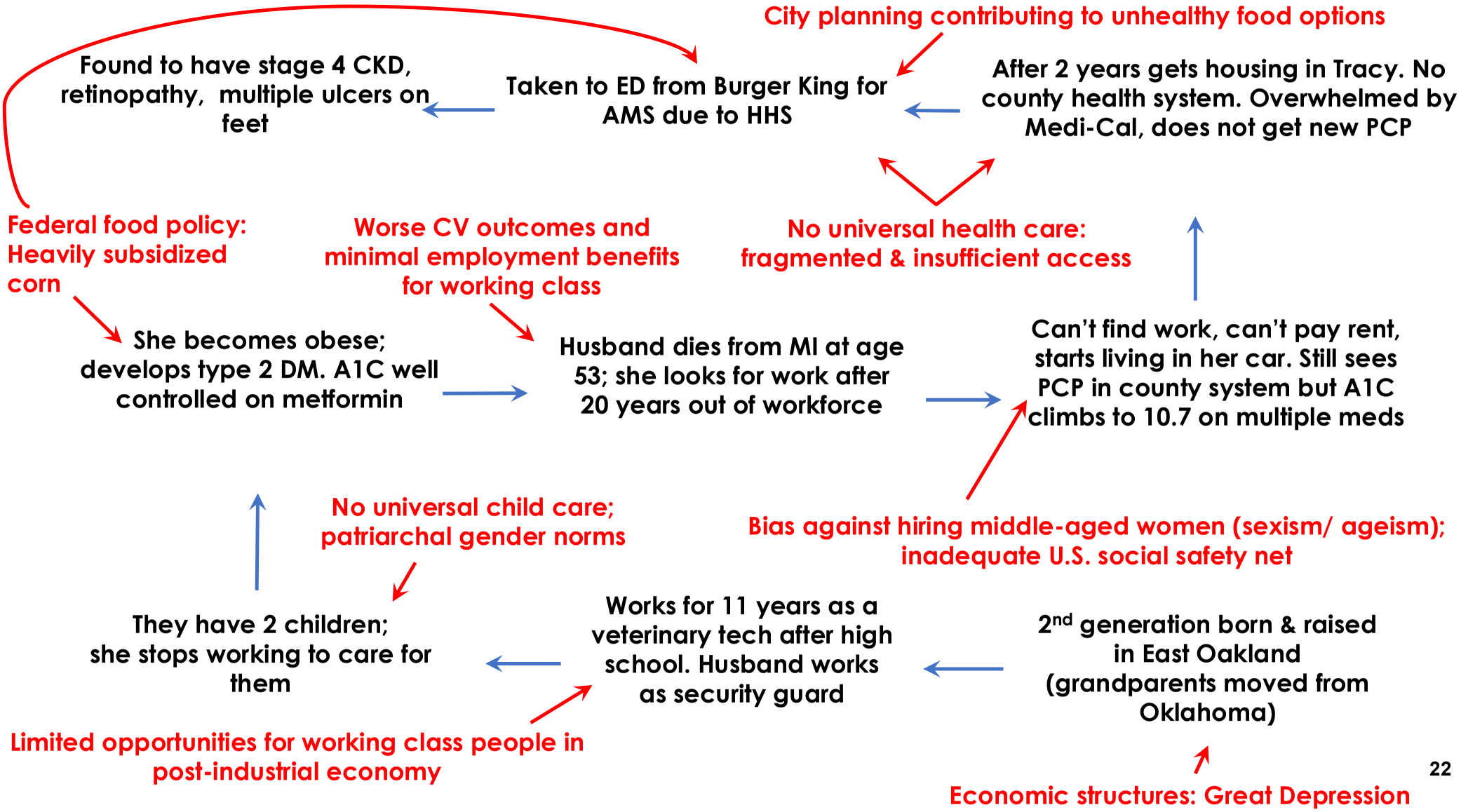
Listed below are potential structural challenges and interventions ranging from the micro to macro-level. You may note that many items could potentially fall under multiple headings. While presented in a static format, some of what makes these challenges so difficult to change or pinpoint, is the shared responsibility among many agents.

Level	Challenges	Strategies
Intrapersonal	- "Implicit Bias" - Discrimination: Racism, sexism, heteronormativity, ageism - Moral judgments of patient behavior - Negative/blaming language - Concern for medical education debt and choice of career path - Ignorance of structural problems and solutions/services	- Education - Find ways to hold one-self accountable - Use neutral language - Ask more questions of your patients. - Talk less, listen more. - Cultivate structural humility
Interpersonal	- Language Barriers (including complex medical jargon/terminology) - Power imbalance between patient and provider - Training and/or clinical team hierarchies - The "Hidden" Curriculum - Time constraints - Student needs (learning, performance) balanced with patient needs - Exploitation of patients (both historical and immediate) - Preference for biomedical interpretation over patient interpretation	- Use existing support services (interpreters, etc) and use real language - Recognize the hierarchies, practice humility, resist where you can, use your status for good where appropriate/possible (med students). - Understand that medical professionals have a culture as well. - Structural vulnerability checklist (as a tool to avoid assumptions, address patient needs)
Clinic	- Poor interpretation services - Inaccessible for families (hours of operation, location, etc) - Disorganized, chaotic care (different providers) - Unadapted to patient/community needs - Providers feeling overstretched, time pressures - Underfunding	- Restructure clinic within constraints to best meet patient needs, advocate to change the restraints - Community engagement –ask what they need - Case management - Integration of behavioral services with mental health services
Community	- Lack of community representation - Exploitation of communities - Community policing practices leading to violence and trauma - Poor access to clean water - Poor access to affordable gas and electricity and - Poor access to healthy food - High levels of toxicity, environmental racism/classism	- Create opportunities for community voices/leadership - Work to educate police about the health costs of policing/incarceration - Partner with CBOs working on structural issue outside of clinical settings - Affordable and safe ride share opportunities for lower income communities - Community food gardens - Community organizing for safe water, lower neighborhood toxicity

Levels of Intervention

Listed below are potential structural challenges and interventions ranging from the micro to macro-level. You may note that many items could potentially fall under multiple headings. While presented in a static format, some of what makes these challenges so difficult to change or pinpoint, is the shared responsibility among many agents.

		- Home/phone visits - Group visits - Use your white coat/title as symbolic capital
Research	- Emphasis on quantitative research that takes for granted social categories - Demand for particular kinds of evidence - Lack of funding for social science research relative to basic science - Publishing bias-research preferentially published from elite universities	- Engage patients in defining important research questions and aims - Situate research in a structural context - Use the accepted forms of evidence to point to structural causes for health disparities - Research the historical effects of policies - Advocate for better funding for qualitative research
Policy	- Immigration and housing policies - SSI benefits that require mental health diagnosis - Prison industrial complex and criminalization of drug use - Medicare value measurements that contribute to pressures - Access to/Cost of pharmaceuticals - Lack of diversity/inclusion in health professional education instructors - Lack of formal curriculum on structural determinants of health in health profession schools	- Refuse to report undocumented migrants - Contact media, seek out radio speaking opportunities - Write media article, editorials, and position statements demonstrating the relationship between policies and poor health - Challenge claims (e.g. based on genetics) that naturalize inequality - Research the historical effects of policies - Make pharmaceutical access inequity transparent through blog posts, social media, and formal media (e.g. Shkreli) - Activism - Be a medic or wear your white coat (with permission from organizers) at rallies, marches, etc. - #whitecoats4blacklives and other student movements to change admissions policies, national policies about policing and incarceration - Medical education reform


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

Module 4: *Beloved Community*
Reflection Exercise

The 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, and develop a workforce training in social determinants of health (or Structural Competency).

The Six Levels of Intervention (from Module 3): Intrapersonal, interpersonal, clinic, community, research, and policy.

Reflection Questions:

- **Write down the levels of intervention (find list above) that you have identified as areas where you can take action:**

    - **What are 1-2 specific actions that you will take?**

    - **What potential barriers can you identify for taking these action steps?**

    - **What will help you navigate and address these potential barriers?**