

about primary care and the importance of keeping our health care workforce intact and safe like never before.

- *Receptivity to change.* New and familiar partners are being brought to the table to consider changes in health plans and optimal care of populations and communities, not just individual patients. COVID-19 has pinpointed the criticality, and shortcomings, of care of vulnerable populations.
- *Exposure of a broken system.* Related to the above point regarding receptivity to change is the way the pandemic has raised the stark, ugly reality of how broken our health care system is. At the root of the problem is how poorly aligned the US business model for health care is with the needs of our populations and communities. In addition to being part of the solution for change, physicians need to fully understand our hospital and procedure-centric business model for health care and why this has failed amidst COVID-19. Physicians need to receive training at all levels about the business of medicine in our country and to use their enhanced knowledge to work toward a more efficient and equitable model. COVID-19 has exposed this potentially critical gap in training and continuing medical education for all physicians.
- *Teamwork.* A hallmark of primary care, teamwork, has always been an aspirational goal. With COVID-19, teamwork is happening in organic and seamless ways as the altered universe of "normal" has dictated a new level of health professionals working together to care for patients and communities.
- *Family as care team member.* Through COVID-19, there is a newfound appreciation for the role of the family in the care of patients. With the need for strict policies keeping people away from inpatients during the COVID-19 pandemic, family members/support persons normally critical to care of patients in hospitals are not available to assist with care. This has led some physicians to write orders for a support person to be present in the care of patients.
- *Enhanced communication.* Communication has been enhanced on multiple levels as all of us respond to the reality of COVID-19. There is the patient-centered level of communication related to translating patient care materials for diverse populations; there is enhanced communication at the organizational level through active use of already existing list-serves and other communication platforms as leaders learn from one another about on-the-ground challenges and solutions; there is the enhanced ability for collaboration among professionals in organizational conversations through the onset of virtual meetings, with unprecedented frequency and utility.

A final and concluding point is that these conversations with public and private members took place

before there was subsequent heightened awareness of racial injustice in our country. Many of the "silver linings" touched on here are part and parcel with health equity. As Alexander and Perkins note, in this time of forced change, "why not create something better than normal?"⁴ The true realization of these "silver linings" will be the lasting change brought about by institutionalizing the ones which truly lead to a more just and equitable system of care and a safer world for all.

Ardis Davis, Amanda Weidner, Julie Moretz, Ned Holland, with acknowledgement of contributions from conversations with other family medicine public and patient members Beth Bortz and Arturo Martinez-Guijosa

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REFLECTIONS OF THREE HEALTH EQUITY FELLOWS

The Association of Family Medicine Residency Directors (AFMRD) is committed to delivering Health Equity education to residency directors and faculty. Over the past year, the AFMRD sponsored 3 individuals for the 2019-2020 AAFP Health Equity Fellowship. This yearlong fellowship develops family physicians into leaders with expertise in the social, institutional, and cultural influences that impact health. Fellows also complete a capstone project to demonstrate their achievement of the program's learning objectives.

The 3 fellows shared a brief summary of their experience in the fellowship.

Debra A. Rothenberg, MD

I came to medicine via the Peace Corps in Niger and then studying anthropology and have spent most of

my family medicine academic career teaching about and trying to address inequalities in the social determinants of health.

The goal of my capstone project was to design and implement an evidence-based, continuous evaluation plan for the community engagement-medical education project known as the Maine Medical Center-Preble Street Learning Collaborative (PSLC). The PSLC began in 2017 as a community-based site for low barrier access to both medical services and a coordination of complex care for people experiencing, or at risk of experiencing, homelessness. This evaluation plan included electronic health record data as well as narrative reports to regularly document whether or not we meet the goals to: (1) improve the care of homeless and at-risk clients, while learning about their health needs and how best to deliver their care; (2) demonstrate and evaluate the effectiveness of a population-focused approach to health care and medical education; and (3) design a culturally sensitive educational curriculum based on an understanding of health disparities, population health, and care of underserved and at-risk individuals.

The fellowship gave me permission to commit time and energy to both thinking about important issues and working on a project that will hopefully contribute to mitigating some of the disparities in my community.

Kristina G. Johnson, MD

Over the past few years, I have been developing a longitudinal health equity curriculum for our residency program. The impetus for the curriculum came from a combination of the Unite the Right Rally in Charlottesville, Virginia in August 11-12, 2017, and an inspirational panel of residents calling on graduate medical educators to explicitly include racism in curricula at the STFM Annual Spring Conference in 2019. Through working on this curriculum, I have become even more convinced that family medicine physicians can and should impact the health of patients and communities beyond the exam room.

My project focuses on expanding the advocacy portion of the University of Virginia Family Medicine Residency Program health equity curriculum. The health equity curriculum that I've developed lays a

strong foundation for residents to be aware of present-day health disparities and the social forces that created and continue to perpetuate those disparities (with racism being chief among them). However, the curriculum falls short of empowering residents to translate this knowledge into action in advocating for their patients. My hope was that this addition to the curriculum would not only improve the lives of our residents' patients and communities as they go out into practice, but also provide some protection for residents against burnout—as feeling powerless in the face of health disparities is certainly a driver of burnout.

Kate Kearns, MD

A passion for health equity was really the driver for me to choose medicine as a career and to choose family medicine as a specialty in the 90's before the concept of social determinants of health was popular. Family physicians, compared with other specialties, arguably have the closest vantage point and perspective on social justice. As a program director, I saw this as an opportunity to bring my residency culture up to date in this aspect, and to influence future cohorts of residents to approach their patient care through a health equity lens.

My project related to launching a new Friday afternoon specialized clinic within our family medicine center that serves LGBTQ+ patients in our community. I had previously learned how transgender patients from our local community had to travel 90-100 miles away to larger cities to receive care, and that they frequently faced discrimination when trying to seek care from local physicians who did not have the proper training. Previous research showed poorer physical and mental health outcomes for this patient group. So, I was very excited for our residency program to begin filling the gap of unmet need for this vulnerable and marginalized patient population. My project involved doing a needs assessment survey, training residents, faculty, and staff, and collaborating with community organizations to support a strong launch for the clinic.

Debra A. Rothenberg, MD

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