Improving Residency Program and Community-Based Organization Collaboration
A Guide to Developing Innovative Partnerships
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A Guide to Developing Innovative Partnerships

Greater New York Hospital Association
Collaboration between primary care providers and community-based organizations (CBOs) that provide social services is critical as the health care delivery system further addresses social determinants of health. Partnering with CBOs that provide services such as housing, food, and financial assistance has been a focus of New York's Delivery System Reform Incentive Payment (DSRIP) program and the shift to value-based payment within New York's Medicaid program. As primary care practices continue improving population health capabilities and their community focus, it is becoming more common to see referral relationships and more formal partnerships with CBOs.

In New York, primary care residents at teaching hospitals provide health care services to Medicaid consumers and other low-income individuals, many of whom have social needs that accompany complex health care conditions. Concurrently, the Accreditation Council for Graduate Medical Education (ACGME), which accredits residency programs, has increased its focus on addressing social determinants of health by adding new requirements that go into effect in 2019. These include requirements for residents to better understand their patient population and for residency programs to be more aligned with their communities' needs. While residents have begun to receive more education and experience in enhanced primary care models and population health management, they have limited education and experience collaborating with CBOs, an essential component to addressing social determinants of health.

With a grant from the New York State Health Foundation, Greater New York Hospital Association (GNYHA) conducted a two-year, multi-part project, Improving Collaborations between Primary Care Residency Programs and Community-Based Organizations, to incorporate social determinants of health into primary care residency training and raise awareness of the importance of integrating population health into the training of future physicians. GNYHA paired primary care residency programs throughout New York State with CBOs that provide a range of social services including housing assistance, culturally focused services, services that address food insecurity, and family support for the developmentally disabled. The partnerships created by the project yielded immersion training experiences in which primary care residents attended one- to two-day learning sessions at the CBO sites. During these training opportunities, residents learned about health disparities, the typical social needs of people living in the communities served by the CBO, and the importance of assessing community, environmental, and family influences on a patient's health.

While the project enhanced social determinants of health teaching within residency programs, participating CBO partners also benefitted from the collaborations. Through the residency program partnerships, CBOs had opportunities to work with hospitals and share their knowledge on the social needs they ad-
dress. CBOs were motivated to engage in hospital partnerships that provided their clients with more comprehensive care delivery.

This toolkit provides a roadmap for primary care residency programs to engage in mutually beneficial partnerships with CBOs to train residents on social determinants of health and better address the needs of the surrounding community. It details steps to engage in such a partnership and includes best practices, challenges, and lessons learned from the residency programs and CBOs that participated in the immersion training component of GNYHA’s project. The toolkit also includes didactic materials developed by participants in GNYHA’s project-sponsored immersion trainings. The information, tools, and materials were gathered from project participants.

GNYHA’s process to partner residency programs and CBOs included organizing discussions on how partners could mutually benefit from working together and launching resident immersion training. The steps are detailed below, providing a partnership roadmap for interested residency programs.

**TRAINING PROGRAM STEPS**

1. **Identify a CBO partner**
2. **Share goals for immersion training and discuss how a partnership can be mutually beneficial**
3. **Develop a training agenda, learning activities, and didactic materials**
4. **Select residents for immersion training and formulate a training schedule**
5. **Prepare residents and CBO staff for immersion training experience and host training**
6. **Evaluate residents’ experiences**
DEVELOPING PARTNERSHIPS BETWEEN RESIDENCY PROGRAMS AND CBOs

STEP ONE
Identify a CBO Partner
The first step in building a partnership between a residency program and a CBO is identifying the right partners based on community and patient needs, CBO interest and capacity, and social needs that are addressed. Because a large number of CBOs throughout New York address a variety of social needs, residency programs may need to first identify local CBOs. Residency program directors can use various resources to learn about CBOs in the surrounding communities. When seeking a CBO partner, having particular social needs in mind can help direct and focus the search. Below are some recommended sources:

- Hospital community affairs or population health departments may have a list of CBOs that they partner with for various initiatives
- DSRIP performing provider systems of which the hospital is a member may have a list of DSRIP-participating CBOs
- For New York City and Long Island, GNYHA’s Health Information Tool for Empowerment (www.hitesite.org) provides user-friendly, searchable listings of CBOs and the services they provide
- In many communities throughout New York State, 2-1-1 operates telephone and web-based (www.211.org) services that provide detailed service information on CBOs

Before starting partnership activities, residency programs are recommended to consult with their legal department to review whether an agreement needs to be in place. Documents may be required for legal/liability purposes before immersion training can begin. For instance, a memorandum of understanding and/or program letter agreement between the hospital and the CBO may be helpful (see Additional Resources for a sample program letter agreement). Residency programs should understand that some CBOs do not have legal departments or internal counsel, which may add to the time required to solidify the partnership.

STEP TWO
Share Goals for Immersion Training and Discuss How the Partnership Can Be Mutually Beneficial
Ensure that the residency programs and CBOs are satisfied with the partnership by discussing the overall goals of the immersion training and the factors important to each stakeholder. GNYHA facilitated these initial discussions with a structured meeting for the residency programs and CBOs to discuss resident learning needs and gaps, CBO programs and services, and shared goals and missions for immersion training.
After the initial meeting, residency programs and CBOs completed a collaborative worksheet that included the following:

- **Mutual Mission Statement:** Participants were asked to jointly develop one to two sentences that encompassed what both organizations hoped to achieve from their collaboration to educate the residents.
- **Learning Objectives:** Participants were asked to consider what they wanted residents to achieve through the immersion training, along with gaps in their current education related to social determinants of health. Participants were also encouraged to think about how the stated learning objectives could support improved referral relationships between residents and the partner CBO.
- **Learning Activities:** Participants were asked to consider learning activities that were well connected to the learning objectives, while also engaging residents in experiential opportunities. Activities that allowed residents to meet with both CBO staff and clients were particularly encouraged.
- **Scheduling and Logistics:** Participants were asked early on to consider start dates and potential logistical challenges for their immersion trainings. CBOs were specifically asked to think about who within their organizations would serve as a point person for the residency program. Partners were asked jointly to agree upon the best methods for communication. Additional details on scheduling and logistics are in Step Four.
- **Measures and Outcomes:** Participants were asked to consider how the success of the immersion training would be measured. Participants were encouraged to ensure that measures and outcomes were linked to the agreed-upon learning objectives for their respective programs. Additional information on evaluating residents’ experience is in Step Six.

CBO and program director representatives were asked to sign the worksheet and submit it to GNYHA to ensure mutual agreement (see Additional Resources section for the full worksheet).

Through these discussions, CBOs expressed how they could benefit from the experience. Participating CBOs found expanded involvement with hospitals through consultations and referrals to be a major potential benefit. Making the CBO staff active members of the care team creates a flow of communication between the hospital and the CBO, allowing both to view the complete picture of patient/client care. Emphasizing the need for a mutually beneficial partnership during project development will ensure dedication to the ultimate goal of better health outcomes for the patient/client and the long-term success of the partnership.

**STEP THREE**

**Develop Training Agenda, Learning Activities, and Materials**

Residents should participate in a variety of activities during immersion training, including interacting with the CBO staff and clients. For GNYHA’s project, residents engaged in activities including but not limited to:

- Tours of the CBO’s onsite/offsite client facilities
- Attending presentations from CBO staff
- Shadowing CBO staff as they provided services to clients
- Accompanying CBO staff on visits to homes and other community settings
- Working directly with CBO clients
- Providing education to CBO staff and/or clients on clinical issues
- Attending case lectures/conferences
- Practicing mock client intakes/client services with CBO staff
During some immersion trainings, residents had the opportunity to speak directly with CBO clients about their specific social needs and how they impact their interactions with health care providers. CBO staff first met with clients who agreed to meet with residents in order to ensure the residents could provide an experience aligned with the immersion training’s learning objectives.

To ensure residents have a valuable experience, residency program directors should work with participating CBOs to plan didactics and client-facing experiences that meet agreed-upon learning objectives. While planning time for CBOs involved in GNYHA’s project varied, depending on the CBO and planned resident experiences, participating CBOs agreed that it took between six and 10 hours to prepare. This included time spent meeting with residency program directors, creating materials, and preparing staff for the residents’ training experiences.

Each participating CBO created a structured agenda for residents that outlined the learning activities (see Appendix A for examples). For didactic materials, CBOs generally prepared presentations that detailed their mission, clientele, services, and surrounding communities. Elements of an introductory presentation from a CBO to residents may include:

- Organizational information
  - Mission and vision
  - Services provided, with detailed descriptions of each
- Community served
  - Community-level data on prevalence of social need
  - Relevant diagnoses
  - Related benefits (if applicable—e.g., Supplemental Nutrition Assistance Program, Medicaid, and Health Home)
- Effect of services on health care
- Case study, real-life example, or success story

See Additional Resources section for presentations from CBOs that participated in GNYHA-sponsored immersion training programs.

In a GNYHA survey of participating residents, many noted that having more time to interact with CBO clients would have been beneficial and that the most useful activities were home visits, community visits, and client intakes—each of which created better understanding of social determinants and a more defined care delivery role for residents. Leadership at both residency programs and CBOs should consider this when developing the immersion training.

**STEP FOUR**

Select Residents for Immersion Training and Identify a Training Schedule

Residency program directors must identify residents for training while taking into account complex resident schedules. There are several considerations for both organizations completing the process. Resident schedules sometimes have last-minute changes that can cause cancellations. Similarly, a CBO may experience a last-minute staffing issue that could impact its ability to offer immersion training as scheduled.
The resident’s post-graduate year (PGY) level and prior experiences are important factors in selecting residents. Some program directors said that PGY-1 (first-year) residents were the most enthusiastic and eager to participate in innovative rotations. One possible reason could be that, as social determinants of health are more integrated in medical school curricula, the immersion training provides opportunities to implement those concepts while still fresh in residents’ minds. One possible disadvantage of working with PGY-1 residents is that they do not have as much experience as more advanced residents at caring for patients with social challenges. PGY-1 residents also may be less familiar with how social challenges can complicate the process of meeting health care objectives.

While PGY-3 residents have the most experience and more flexibility with their schedules, some program directors found them to be less engaged in the project than expected because they were more focused on preparing for required board exams and/or fellowships.

The CBO’s specific activities may also be a consideration for determining the appropriate PGY level. For example, if the CBO provides home visits, a more senior-level resident may be more appropriate because they might be more comfortable in that type of setting or have prior experience with home visits. Completing a thorough review of the planned activities before selecting residents for training is recommended.

Several program directors also considered the extent of the resident’s interest in social determinants of health. While this kind of training is essential for all members of the future physician workforce, the training model is relatively new, and it may be beneficial to pilot such a training with residents who are interested in working with CBOs to address social needs. While some residency program participants in the GNYHA pilot selected residents based on their availability and existing schedules, others allowed residents to self-select and rearranged their schedules as needed. Some residency programs also incorporated this training into their primary care track programs since they focus inherently on community medicine.

**IMMERSION TRAINING TIMELINE**

<table>
<thead>
<tr>
<th>JULY 1:</th>
<th>SEPTEMBER:</th>
<th>MARCH:</th>
<th>MAY-JUNE:</th>
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<tbody>
<tr>
<td>Academic year begins</td>
<td>Identify CBOs</td>
<td>Begin immersion training</td>
<td>Evaluate training with resident surveys and feedback meetings with CBOs and use information gathered to make improvements to the program for the next academic year</td>
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</tbody>
</table>

**JULY-SEPTEMBER:** Identify resident participants

**SEPTEMBER-FEBRUARY:** Complete all program development
There are additional considerations for the timing of the immersion training experience. Program directors and CBOs must allow enough time for preparation, and must consider the resident's academic year, with preparation done in advance. A sample immersion training timeline is on the previous page. Residency program directors and CBOs should mutually agree on a timeline that meets their respective needs.

Residency programs also may want to consider the training's time of year. Unfavorable weather conditions could impact the schedule, particularly when travel is involved. For example, residency programs that partnered with CBOs that made home visits had cancellations of planned activities after a series of snowstorms.

**STEP FIVE**
Prepare Residents and CBO Staff for Immersion Training Experience and Host Training
Project participants learned of the importance of ensuring residents were prepared for the immersion training experience and the planned learning objectives for their time at the CBO site. Some participating residency programs used pre-training lectures on social determinants of health to tie an upcoming experience to previous learning. For a sample lecture on the context and theory of social determinants of health, please see GNYHA's *Training Primary Care Residents on Social Determinants of Health* curriculum (see Additional Resources section to download the full curriculum). Additionally, a sample lecture on biopsychosocial needs is available in the Additional Resources section.

Before sending residents for training, some program directors had one-on-one discussions with residents on the training goals and provided reading assignments to connect the training experience to larger educational goals. The reading assignments set the stage for residents’ appreciation of the relationship between health disparities and primary care. The Canadian Medical Association Journal’s *Taking action on the social determinants of health in clinical practice: a framework for health professionals* provides a comprehensive pre-training reading assignment for residents (see Additional Resources section for a link to the journal article).

Participating residency program directors also noted that residents from other cultural backgrounds may require additional preparation before the immersion training experience due to cultural and/or linguistic differences. Residents should be reminded of proper communication practices for visiting patients at home. GNYHA has resources on how to best train residents for conducting home visits (see Additional Resources section for information on home visits).

Project participants also noted that CBO staff should be prepared for immersion training. They should know about the residents’ role in the health care delivery system and why they are at the CBO site. This was particularly helpful with immersion trainings that included residents shadowing CBO staff. Ensuring CBO staff understood the reason for the immersion training made them more enthusiastic about the opportunity to highlight their services.
STEP SIX
Evaluate Residents’ Experience
Evaluation is an important component of resident training, and immersion training experiences should include their own evaluations of whether residents achieved stated learning objectives and modified behaviors by incorporating these objectives into their clinical practice. Evaluations can also be used to continuously improve the program. Immersion training programs should be adjusted based on feedback for subsequent academic years. For examples of how to measure the specific impact of these activities on resident practice, see the Evaluation and Measurement section in GNYHA’s Training Primary Care Residents on Social Determinants of Health resource.

As part of the GNYHA-sponsored immersion trainings, residency program directors and CBOs were asked to evaluate resident learning, which they did in several ways. Some project participants opted to survey residents pre- and post-immersion training. GNYHA also conducted a comprehensive evaluation of residents’ experience once immersion training was completed. These surveys, found in Appendix B, can help with crafting future immersion training opportunities and ensuring residents learn from their experience. Some program directors asked residents to write reflective papers about their experiences and the potential impact on clinical practice. The papers enabled residents to think about their interactions with CBO clients and share their perspectives on how the experience better prepared them as physicians. Sample reflections from GNYHA-sponsored immersion trainings can be found in Appendix C.

CONCLUSIONS AND ADDITIONAL RECOMMENDATIONS
Residents who participated in GNYHA’s project were much more likely to consider patients’ social needs than before immersion training. Further, immersion training made residents aware of the ability to respond to social needs by effectively leveraging resources outside the clinical practice, which ACGME also requires. Participating residents reported having a clear understanding of how collaborations between hospitals and CBOs can address social needs, further contributing to the ultimate goal of addressing these needs. Participating CBOs also agreed that the partnerships provided the CBO staff and clients with invaluable experience.
Implementing a successful, mutually beneficial immersion training program involves addressing many challenges. Below are final tips from GNYHA for ensuring a successful partnership:

• Discuss with the CBO beforehand whether any clearances or background checks need to be completed before the training begins. CBOs typically ensure confidentiality for their clients, and residents must follow CBO onboarding rules to interact with clients. Plan ahead for residents to be processed before immersion training begins.

• To the extent possible, the program director or associate program director sending the resident for training should be fully aware of the scheduling. Frequently, the scheduling responsibility resides with the program’s chief residents, so consider having them (in addition to the program leadership) involved in organizing the immersion training.

• Determine in advance the proper number of residents based on the CBO’s capacity. To make it a mutually beneficial experience, the CBO should have adequate staff and resources to support training the number of residents scheduled.

• To the extent possible, have residents interact with their own patients during home visits or at the CBO. This provides a lesson in continuity, as well as caring for the patient as a whole. A participating resident gained new insight after a home visit revealed why an elderly patient was periodically non-compliant with maintenance medication: the patient lived in a building with no elevators and had only limited, sporadic help from family members.
ADDITIONAL RESOURCES

ACGME Sample Program Letter of Agreement (PLA)
https://www.acgme.org/Portals/0/PDFs/Sample-PLAs.pdf

GNYHA Worksheet

CBO Orientation Presentations to Residents
AIDS Center of Queens County:

Arab American Family Support Center:

Young Adult Institute:

GNYHA Training Primary Care Residents on Social Determinants of Health Curriculum

Sample Lecture on Biopsychosocial Needs

Pre-Training Reading Assignment – Taking action on social determinants of health in clinical practice: a framework for health professionals
http://www.cmaj.ca/content/188/17-18/E474

Resources on Teaching Residents to Assess Social Needs through Home Visits
https://www.gnyha.org/event/teaching-residents-to-assess-social-needs-through-home-visits-webinar/
SIUH and PCCS Immersion Training Schedule

**Week 1:**
- Monday: 9am – 5pm Agency Orientation
- Tuesday: 9am – 5pm Agency Orientation
- Wednesday: 9am – 5pm Agency Orientation
- Thursday: 9am – 5pm Shadowing Department 1
- Friday: 9am - 5pm Shadowing Department 2

**Week 2:**
- Monday: 9am – 5pm Shadowing Department 3
- Tuesday: 9am – 5pm Shadowing Department 4
- Wednesday: 9am – 5pm Working with Training Department for Collaboration and Development
- Thursday: 9am – 5pm Outreach Implementation
- Friday: 9am-2pm Outreach Implementation, 2-5pm Follow-Up and Discussion of Experience
## Immersion Training for Primary Care Residents

**Funded by:** Greater New York Hospital Association

YAI & Premier HealthCare welcome SUNY Downstate Medical Center Pediatric Residents

### Schedule of Program:

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Activity</th>
<th>Location</th>
<th>Presenter(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Tuesday, March 13th:</strong></td>
<td>10 a - 12 p</td>
<td>Understanding I/DD; A Training Program on the Diversity and Inclusion of People with Developmental Disabilities</td>
<td>YAI Central Office&lt;br&gt;460 West 34th Street&lt;br&gt;New York, NY 10001</td>
<td>Anna Sheehy and Kathy Brown&lt;br&gt;12 p - 1 p</td>
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<td></td>
<td>12 p - 1 p</td>
<td>Resources and Supports: Navigating the Service System for People with Developmental Disabilities</td>
<td>YAI Central Office&lt;br&gt;460 West 34th Street&lt;br&gt;New York, NY 10001</td>
<td>Michelle Lang&lt;br&gt;1 p - 3 p</td>
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<td></td>
<td>1 p - 3 p</td>
<td>Tour of programs&lt;br&gt;YAI Day Habilitation Program&lt;br&gt;East 35th Street Residence</td>
<td>Premier HealthCare&lt;br&gt;175 Remsen Street&lt;br&gt;Brooklyn, NY 11201</td>
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<tr>
<td><strong>Tuesday, March 20th:</strong></td>
<td>10 a - 12 p</td>
<td>Nothing About Us, Without Us presented by members of “In My Shoes”; Car’Melo, Oscar, Harvey and Marty</td>
<td><strong>First Floor</strong>&lt;br&gt;YAI Central Office&lt;br&gt;460 West 34th Street&lt;br&gt;New York, NY 10001</td>
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<td></td>
<td>12 p - 1 p</td>
<td>Lunch (provided)</td>
<td><strong>Ninth Floor - 1 p</strong> YAI Central Office</td>
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<tr>
<td><strong>Tuesday, March 27th:</strong></td>
<td>10 a - 12 p</td>
<td>Tour of medical clinic with an opportunity to observe medical and/or dental visits.</td>
<td><strong>4th Floor</strong>&lt;br&gt;Premier HealthCare&lt;br&gt;175 Remsen Street&lt;br&gt;Brooklyn, NY 11201</td>
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<tr>
<td></td>
<td>12 p - 1 p</td>
<td>Lunch (provided)</td>
<td><strong>Ask for Dr. Thad Salido</strong></td>
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<td></td>
<td>1 p - 3 p</td>
<td>Wrap-Up Discussion and Program Feedback&lt;br&gt;(videographer present to capture reflections)</td>
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Resident's Orientation Schedule

9:00 AM - Meet and Greet – meeting all the key people in the Agency CEO and all of departmental and supervisors

Continental Breakfast will be provided

9:30 AM - Facility Tour – Robert Steptoe, MSW
10:00 AM - Lecture – Nat Liengsiriwat, LSMW
10:30 AM - Topic - What is a CBO? Why partner with CBO? Why collaborate?
11:00 AM - Lecture – Robert Steptoe
11:30 AM - Topic – AIDS Center of Queens County

<table>
<thead>
<tr>
<th>ACQC Services</th>
<th>Presenter</th>
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<tr>
<td>Case Management – Robert Steptoe, Site Director</td>
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<td>Mental Health – Laura Anhalt – Director of Mental Health</td>
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<tr>
<td>Harm Reduction – Laura Anhalt – Director of Mental Health</td>
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<tr>
<td>Syringe Exchange Program – Laura Anhalt – Director of Mental Health</td>
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<td>Legal Services – Kathryn Stein – Legal Director</td>
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<td>Education &amp; Prevention, HIV 101 – Shirley Bejarano</td>
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<td>Housing – Dawn Douglas</td>
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<td>Health Home – Norma Nunez</td>
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12:00 PM - Lunch (Provided by ViiV Healthcare)

1:00 PM - Open Forum with Care Managers

• Challenges that a CBO patient face when they go to the hospital
• Challenges that our care managers face when working with primary care physicians.

1:30 PM - Intake & Assessment (role play)
2:30 PM - Break
3:00 PM - Observation – Transitional living
3:30 PM - A tour of our transitional housing (Facilitated by Judy Pedraza, Housing Coordinator)

Interaction with clients that live in a transitional housing, challenges they face when meeting with their doctors

4:00 PM – Break
4:15 – 5:00 PM Summary & Evaluation
APPENDIX B
SAMPLE RESIDENT SURVEYS

Immersion Training/Pre-Survey

The Brooklyn Hospital Center worked with AAFSC to provide you with a foundation by which you can understand the unique health and cultural issues faced by the AMEMSA (Arab, Middle Eastern, Muslim, South Asian) communities native to Brooklyn.

Before beginning the training, please fill out the form below so we understand your level of understanding before beginning each session.

* Required

**Gender**
- Female
- Male
- Prefer not to say
- Other: __________________________________________________________

**Residency Year**
Your answer: _______________________________________________________

**Age**
Your answer: _______________________________________________________

**WHICH OF THESE GROUPS BEST REPRESENTS YOUR RACE?** (Choose all that apply.)
- White
- Black, Afro-Caribbean, or African American
- East Asian
- South Asian
- Native Hawaiian or other Pacific Islander
- American Indian or Alaskan Native
- North African
- Middle Eastern
- Arab
- Hispanic or Latino

FOR THE FOLLOWING, PLEASE RATE YOUR LEVEL OF UNDERSTANDING FOR EACH TOPIC BEFORE TODAY’S SESSION.

1 Being Lowest and 4 Being Highest
**GOAL 1:**
I can identify the following unique health issues faced by AMEMSA community.*

<table>
<thead>
<tr>
<th>AMEMSA community-specific health issues</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
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<tbody>
<tr>
<td>Physical Environment factors and their influence on patient’s health</td>
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<tr>
<td>AMEMSA cultural norms and taboos</td>
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<tr>
<td>AMEMSA holistic care needs or nuances</td>
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**GOAL 2:**
I can identify the social needs addressed and resources available at AAFSC or in the community.*

<table>
<thead>
<tr>
<th>Two-generation community service model</th>
<th>1</th>
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<td>AAFSC Health Program</td>
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<td>AAFSC Adult- Education Program</td>
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<td>AAFSC Legal Services Program</td>
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<tr>
<td>Our Community Partner</td>
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**GOAL 3:**
Become familiar with the unique challenge of collecting data on AMEMSA immigrants and refugees.*

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<thead>
<tr>
<th>Immigrant/Refugee process in the U.S.</th>
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<th>2</th>
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<tbody>
<tr>
<td>System Navigation of AMEMSA immigrants</td>
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<tr>
<td>Literacy Challenges</td>
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<td>Cultural sensitivity to personal information</td>
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<tr>
<td>Dealing with whole families (children answering for parents)</td>
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I understand that culture plays a role in my patients’ life and health outcomes.*
☐ True
☐ False
Immersion Training/Post-Survey

Thank you for attending the BHC/AAFSC Immersion Training Program!

The Brooklyn Hospital Center has required this training to provide you with a foundation by which you can understand the unique health and cultural issues faced by the AMEMSA (Arab, Middle Eastern, Muslim, South Asian) communities native to Brooklyn. The success of this program is rooted in how equipped you are with the knowledge needed to close the loop between client needs and community resources.

* Required

**GOAL 1:**
I can identify the following unique health issues faced by AMEMSA community. *

<table>
<thead>
<tr>
<th>AMEMSA community-specific health issues</th>
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<th>AMEMSA cultural norms and taboos</th>
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<th>AMEMSA holistic care needs or nuances</th>
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**GOAL 2:**
I can identify identify the social needs addressed and resources available at AAFSC or in the community *

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<th>Two-generation community service model</th>
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<th>AAFSC Health Program</th>
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<th>AAFSC Adult- Education Program</th>
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<th>AAFSC Legal Services Program</th>
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<th>Our Community Partner</th>
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**GOAL 3:**
Become familiar with the unique challenge of collecting data on AMEMSA immigrants and refugees*

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<tr>
<td>Immigrant/Refugee process in the U.S.</td>
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<td>System Navigation of AMEMSA immigrants</td>
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<td>Literacy Challenges</td>
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<td>Cultural sensitivity to personal information</td>
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<td>Dealing with whole families (children answering for parents)</td>
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I understand that culture plays a role in my patients’ life and health outcomes.*
☐ True
☐ False

The skills and knowledge I gained from this training will be useful to me.*
 ☐ Strongly Agree
 ☐ Agree
 ☐ Disagree
 ☐ Strongly Disagree

What aspects of the training were most effective?*

Your answer: ___________________________________________________________

What aspects of the training could be improved and how?*

Your answer: ___________________________________________________________
WellLife Network

IMMERSION TRAINING QUESTIONNAIRE
Pre-Test

Name: ____________________________ Date: ________________

I. What are the top three goals of your program for this brief rotation at WellLife Network?
   1. 
   2. 
   3. 

II. What are the top three personal goals for this brief rotation?
   1. 
   2. 
   3. 

III. What behavioral determinants serve as more serious obstacles, hampering care in your practice?

IV. What exposure/experience through this rotation could be of benefit to you?

V. Other interests or comments:
WellLife Network

IMMERSION TRAINING QUESTIONNAIRE
Post-Test

Name: ________________________________ Date: ________________

I. Please list three goals that were met.
   1.
   2.
   3.

II. What experience was more informative and helpful?
   1.
   2.
   3.

III. Please list three experiences that were not informative or helpful as an intern.
    1.
    2.
    3.

IV. What are three suggestions for future experiences?
   1.
   2.
   3.

V. Other comments:
GNYHA Resident Evaluation of Immersion Training

You are receiving this survey because you recently participated in an Immersion Training opportunity through your residency program which took place at a local community-based organization (CBO). This opportunity was a joint effort between your program director and the Greater New York Hospital Association (GNYHA), which provided support to develop the training. GNYHA is interested in collecting feedback on your experience to facilitate the development of similar training opportunities for other residency programs and for future planning/programming.

Q1. Please provide your name and contact information (identifying information will only be used by GNYHA).
   Name: ________________________________________________
   PGY Year:______________________________________________
   E-mail Address: ________________________________________
   Hospital:_______________________________________________
   CBO:__________________________________________________

Q2. Please think about the Learning Objectives for the Immersion Training. Did you…?
   Please select all that apply.
   [ ] Receive a written copy of your Learning Objectives prior to the Immersion Training
   [ ] Discuss the Learning Objectives with your residency program director prior to your Immersion Training
   [ ] Discuss the Learning Objectives at your Immersion Training
   [ ] Other (please specify): _________________________________
   [ ] I am not familiar with the Learning Objectives for my Immersion Training

Q3. What activities did you participate in while at the CBO? Please select all that apply.
   [ ] Attended presentations from CBO staff
   [ ] Attended case lectures/conferences
   [ ] Shadowed CBO staff as they provided services to clients
   [ ] Worked directly with clients
   [ ] Provided education to CBO staff and/or clients on clinical issues
   [ ] Practiced mock client intakes/client services with CBO staff
   [ ] Toured the organization’s on-site/off-site client facilities
   [ ] Accompanied CBO staff on home visits/community settings (met with clients outside of CBO offices)
   [ ] Other (please specify): _________________________________
### Q4. Please indicate whether you agree or disagree with the following statements about the Immersion Training.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly agree</th>
<th>Somewhat agree</th>
<th>Neither agree nor disagree</th>
<th>Somewhat disagree</th>
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<tr>
<td>I have a much better understanding of the social needs of the patients/clients served by this CBO</td>
<td>□</td>
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<td>I recognize that this CBO has resources and programs that address social needs</td>
<td>□</td>
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<tr>
<td>I understand how partnerships between health care organizations and CBOs can address social needs</td>
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<td>I am much more likely to consider the social needs of patients than I was before the Immersion Training</td>
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<td>I feel much more comfortable referring patients to CBOs to address a patient's social needs</td>
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<tr>
<td>My experience has improved my ability to work with social workers and other staff within my organization who specifically address social needs</td>
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APPENDIX C

RESIDENT REFLECTIONS

RESIDENT A REFLECTION

Week 1
To be completely honest, going over the material provided to us prior to the first YAI meeting, I had imagined that we would be discussing the impact that socioeconomic and racial prejudices have on the current health disparities experienced by members of our patient community. I had expected a thorough and discussion-driven discourse on exploring the health disparities that are prevalent in the POC, LGBTQ, and immigrant communities of New York. What I had come to find was a very different (yet very much in the same spirit) dialogue on the challenges and experiences of people living with intellectual and developmental disability. While a bit of a surprise at first, it now almost feels like the decision to learn more about this community was the obvious choice. It’s no secret that during this turbulent time, members of the POC, LGBTQ, and immigrant communities of the nation have raised their voices to demand change in a system that consistently counts them out. But what about the voices of the disabled/differently-abled community? These were voices from a community previously thought incapable of speaking on behalf of itself—voices from a community that is often ignored, and even historically shut away. As healthcare providers, we cannot become advocates for this group without understanding the real and lived experiences and challenges they face. A crash course into all this is of course, YAI. Here was now an opportunity to fully embrace the idea of intersectionality in medical practice—and I for one am all about it.

Week 2
Once again, I find myself in awe of what this community can accomplish. Today we had 4 members of their community speak about their experiences living with intellectual, developmental, and physical disability and how it has impacted their healthcare. They spoke with such articulation and dignity that I felt floored by their public speaking ability. Whatever assumptions I had regarding their capabilities and limitations continues to be challenged and shattered with every subsequent meeting. They spoke on a number of topics but what stood out to me was the relationship each of them had with their healthcare provider—both good and bad. As someone who hopes to one day become an advocate for my patients, I walked away with an important lesson today—and that is to be considerate. I learned that often this group of people are not given the dignity of choice, the comparative free will to go and do what we want, which is something we take for granted. They often end up with just any healthcare provider and often not given the opportunity to choose who that is. In reality, that is very much like the children we see in practice. They did not choose us to be their healthcare provider, but there they are in our office or in our hospital bed. I think it is important
to keep that in mind with every interaction we have with our patients whether in the clinic or in the hospital. The unfamiliar can be terrifying, disorienting, and in some cases in the disabled community, triggering. We have to be considerate of these feelings and it can be as simple as bending down to talk at their level, not demanding direct eye contact (which can be often feel confrontational), and speaking softly, clearly, and in language that they can understand. I know that this experience with the disabled community of NYC has already made an impact on how I’ll move forward in my career as a physician, and am excited to know that I am not done learning from them. Definitely a humbling and educating experience.

RESIDENT B REFLECTION

Week 1
I never realized how little I knew about the Intellectual Disability/Developmentally disabled population. We speak about the medical causes, the comorbidities, what some of them are at risk for medically, but I didn’t actually understand the community. For example, we spoke about how to speak with a patient with speech delay, or a patient who doesn’t communicate verbally. The most important thing is to always address the patients themselves. In Pediatrics, it is easy to always speak to the parent, because babies do not communicate verbally, but as our children grow up, we begin to involve them more and more in history taking, addressing questions, etc. Then why do I do such a poor job with my patients that have developmental delay? Just a couple days prior to starting YAI, I saw a 13-year-old patient in Endocrine clinic with significant global developmental delay. I said “hello, how are you” to her and her mother responded for her, explaining that she doesn’t speak. Now I know that even if she cannot respond, it doesn’t mean she can’t understand. I should always speak to my patient first, and the caregiver second. And instead of telling her I am going to examine her now and simply approaching her, I should wait for her to process this information. Because, in my encounter, she ended up pushing me to the floor. In reality, a little more patience and understand on my part would have made the entire encounter much more comforting for her.

I refer so many patients every day–some to Neurology, some to Early Intervention, OT/PT, etc. I know the process in Neurology clinic, because I have worked there. But I didn’t really think about the whole picture for “services,” other than they are in place. Someone in the Department of Education determined a certain amount of services. Is that enough? What about services outside of the home? I didn’t even understand that children qualify for services through OPWDD as well. These services are free, if they qualify, and are much more flexible than simply PT, OT, ST. There are people employed to help these families navigate the system.

Week 2
Our group was fortunate to meet a few members of “In my Shoes,” a group of men who have Intellectual Disabilities and/or Developmental Disabilities. Speaking candidly to them about their experiences with different forms of healthcare opened my eyes. Particularly Harvey, who is a middle aged gentleman with autism, spoke about his experience as a father navigating the healthcare system for his daughter. While I often think about literacy of my parents from a point of view of education completed or fluency in the En-
English language, I would not have done an adequate job explaining medical information to him, who openly struggles with social interactions and thinking very literally. I think it is so important to explain information multiple ways and truly gauge understanding. Another gentleman, who was diagnosed with Asperger’s, spoke about how he never had a provider explain to him what that diagnosis really meant. It was interesting to hear him speak about how as he was growing up, he had different questions that were never answered. And that as a Pediatrician, I should continue to provide age-appropriate information about a developmental or intellectual disability—just as I give advice on diet and changing social pressures.

Another theme discussed was our power and influence as Pediatricians. At Downstate, we often talk about advocacy for our patients—making sure they receive a specialist appointment, or that a school is honoring an IEP, or that WIC is giving appropriate formula, etc. But, I really feel that we have an even bigger responsibility to our patients to be role models in our community. For example, language is so powerful and we should always strive to use appropriate non-offensive terms. I already knew terms like retarded and stupid were offensive. But I did not realize that the terms handicap and nonverbal are also quite offensive. And as always, a patient is not a diagnosis, but rather a person with diabetes, or a person with autism.

Week 3
Today we spent time at Premier Health, a health clinic in Brooklyn catering to patients with ID/DD. It looks like any multidisciplinary clinic with multiple providers, administration, social work, but it really is an interesting concept. The Occupational Therapist there does a lot of desensitization work, especially around Dental care. This is easy because they have a dentist and the dental equipment in their clinic. This is so important because children have difficulty with the dentist but so do patients with ID/DD. Even if a patient makes a little extra noise, or even has an outburst, the staff are calming and used to these situations and are able to react accordingly. All of the different therapists and doctors have offices together, so lots of little conversations are happening about their patients. Some of these observations are similar to Suite D and likely because both are medical homes. Another difference is the waiting room—it is set up so one section has a TV, but the other section does not have a TV for patients that are sensitive to noise sensations. The lights are dim, and not fluorescent for people with autism who are sensitive to bright lights. It is all very well done.

Overall, it was an excellent experience, helping me to shed light on aspects of the ID/DD community. It forced me to think critically about the way I treat all patients, how much power I have by simply being a doctor, and the millions of ways to advocate for my patients on a daily basis. It also highlighted how underserved the ID/DD community is, how afraid some people are, and how with just a little bit of education and awareness I can make a huge difference.
RESIDENT C REFLECTION

So far, my experience with YAI immersion has been an eye opener. I always felt that my interaction and exposure to people with ID/DD has been limited, and to actually see that there are organizations out there like YAI, trying to include these people in the society was amazing. On my first day I learned that people with ID/DD always have a voice, they just want someone to listen.

On the second day we met some advocates from YAI. They shared their life stories and experiences with us. It was really great to see that these people were great public speakers, they actually motivated me to work harder for a better world. I think the best thing I learnt from the second day was that every person in this world has a unique strength even though sometimes we don’t realize that.

I feel lucky that I have been chosen to participate in YAI immersion program. I feel like I can help my patients more now. I think it would also be a nice idea if they came sometime to downstate and gave the rest of residents a brief overview of the program and its services. I am sure most of us will be happy to learn more.