HEALTH EQUITY COMPETENCIES FOR HEALTH PROFESSIONS STUDENTS IN TENNESSEE

The Primary Prevention Clinical Advisory Committee

TENNESSEE DEPARTMENT OF HEALTH
HEALTH EQUITY COMPETENCIES
FOR HEALTH PROFESSIONS STUDENTS IN TENNESSEE

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INTRODUCTION

Tennessee is a state of unmatched beauty, rich with natural resources, including the 7 million people who call Tennessee home. Many Tennesseans are not able to fully reap the state's benefits because of poor health status and the social and behavioral factors that place even healthy Tennesseans at risk for suboptimal health in the future. The 2023 State of Health of Tennessee Report outlined multiple challenges and opportunities for improvement. For example, infant and pregnancy-related maternal mortality rates exceed national averages. Childhood obesity rates are twice the national average, and the average lifespan for adults in Tennessee is roughly 2 years shorter compared to adults in other US states.[1]

These factors and others lead to Tennessee's rank of 44 in the U.S. in overall health.[2] Health is not distributed equitably across our state. Members of minoritized communities and those who live in rural areas have worse outcomes than their non-minoritized and urban counterparts, creating unacceptable health inequities. [3-5]

"Social drivers of health" (SDOH), also known as the social determinants of health, are the non-biologic factors that influence a person's ability to be healthy. When they are negative, as in the case of housing insecurity, they become risk factors for poor health. These SDOH also are not distributed equitably across populations in our state, contributing to the documented health inequities.

SDOH are not often addressed in the traditional healthcare delivery model, and instead are viewed as the responsibility of local and state governments, community organizations, and individuals themselves. However, because of their profound effect on the patients and populations cared for by Tennessee's health professions workforce, foundational knowledge and skills related to SDOH and health equity must be considered an integral part of all health professions curricula and training.[6, 7] The importance of this foundation became even more apparent when the COVID-19 pandemic exposed and compounded pre-existing health inequities in many Tennessee communities.

The mission of the Tennessee Department of Health (TDH) is to "*Protect, promote, and improve the health and well-being of all people in Tennessee*." [8] Health equity is implied in this mission statement and is also an explicit cross-cutting theme in both the Tennessee State Health Plan and the TDH Strategic Plan.[1] This means that all Tennesseans should have the ability and resources to achieve optimal health, regardless of race, gender, sexual orientation, ethnicity, socioeconomic status, disability status, or geography.

With this mission in mind, the TDH Office of Primary Prevention (OPP) assembled the Primary Prevention Clinical Advisory Committee (PPCAC). PPCAC is a broadly representative group of clinicians, educators, and non-profit administrators who reviewed the national recommendations, curricular frameworks, and published competencies for population health, health equity, and SDOH. Their goal was to

establish and disseminate guidelines and competencies specific to training a workforce to address the needs of Tennesseans, with the aim of enhancing the capacity to carry out primary prevention work that actively supports the TDH mission. A list of the PPCAC membership is provided at the end of this document.

Based on a scan of the relevant literature, an initial draft was composed and was iteratively refined by the PPCAC over the months of July to September 2023. The draft was then reviewed by Tennessee Department of Health leadership and formally approved. The final framework includes five major competency domains and 29 sub-competencies. The five domains are:

- Population Health
- Core Concepts: Health Equity and Social Drivers of Health
- Whole Person Care
- Community Health
- Health Ecosystem

To the extent possible, these align with the accreditation standards of nursing, medicine, pharmacy, dentistry, social work, and public health professions education schools.

This competency framework references three essential areas for efforts aimed at achieving health equity:

- Interprofessional collaboration
- Community engagement
- Trauma-informed approaches and practices

Extensive scholarship supports the importance of each of these areas, and all three have their own published lists of competencies, principles, and practices. The sub-competencies we have listed for each are intentionally broad in scope and reflect a general overview of current literature.

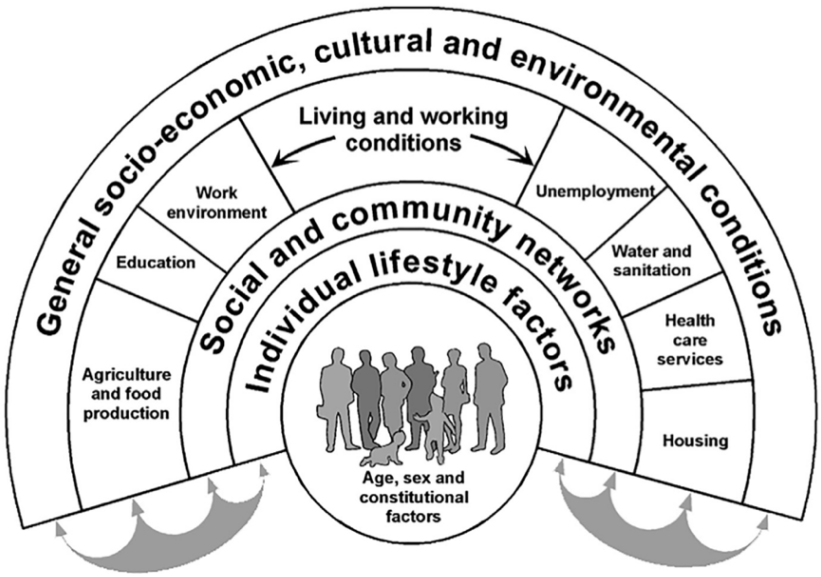
TDH offers this list of competencies to health professions educators and professional societies across the state. This document is meant to guide educators and administrators as they craft new curricular strategies or revise existing curricula using a health equity lens. It is not meant be a curricular mandate or to supplant other published frameworks. In the future, the PPCAC hopes to make available a repository of learning resources for faculty development as well as for student instruction and assessment.

HEALTH ECOSYSTEM

Our list of competencies highlights the importance of an “upstream perspective” for all health professionals. It reflects an understanding that while access to healthcare is considered a social driver of health, health across the lifespan begins and is sustained by many other factors outside of the healthcare delivery system, and that health and health care professionals should see their efforts within the larger context of a “health ecosystem.”

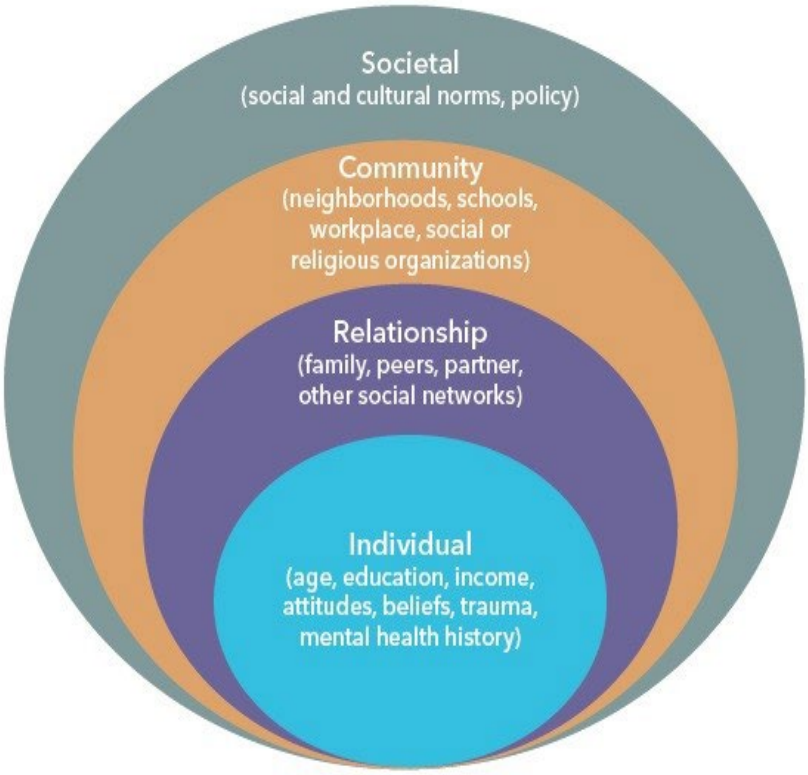
We adopted the term “health ecosystem” to communicate the idea that a highly complex system with multiple levels of interacting elements influences the ability of individuals and populations to achieve optimal health. While many published graphics depict a “*healthcare* ecosystem,” these are generally restricted to the factors that influence the cost, quality, and availability of healthcare delivery services and do not include all the elements that drive health. The graphics that more closely depict the idea of a health ecosystem are the socio-ecological model, the rainbow model, and the micro-meso-macro model (see below) and we recommend use of these models to illustrate the ecosystem concept.

Dahlgren and Whitehead Rainbow Model [9]

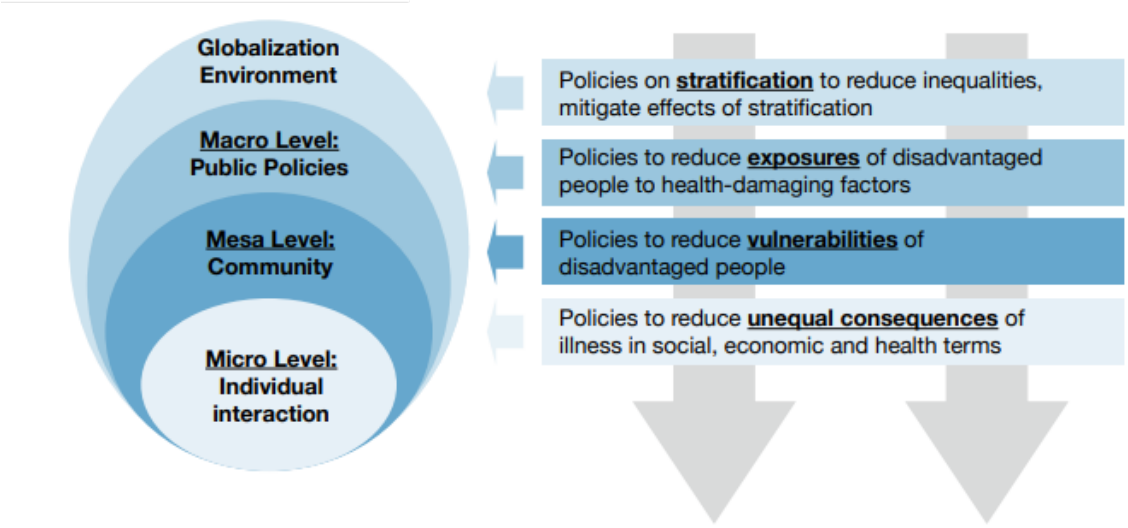


Source: adapted from Dahlgren and Whitehead, 1991

Socio-Ecological Framework [10]



Micro-Meso-Macro Framework [11]



DEFINITIONS

The terms below are used in the list of competencies, and we offer these definitions to promote clarity and shared understanding. *Many of the definitions are taken verbatim from the resources listed.*

Community engagement: The process of working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people.[15-17]

Community health: Community health is a multi-sector and multi-disciplinary collaborative enterprise that uses public health science, evidence-based strategies, and other approaches to engage and work with communities, in a culturally appropriate manner, to optimize the health and quality of life of all persons who live, work, or are otherwise active in a defined community or communities.[14]

Cultural humility: Cultural humility is described as a lifelong commitment to self-evaluation and critique, and to developing mutually beneficial partnerships with communities on behalf of individuals and defined populations. It requires reflection on one's own background, and an openness to learning from the lived experiences of others. Cultural humility is distinct from cultural competence, which focuses more on knowledge about cultures different from one's own, especially as related to health practices. [32-34]

Health: A state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity.[12]

Healthcare inequity: Differences in the quality of care received across groups of people, not related to preference, access, or clinical appropriateness. They occur proximate to health care outcomes, can be measured at the individual level, and can respond to actions taken at the health systems level. [21]

Health equity: The attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.[18]

Health inequities and health disparities: These terms are often used interchangeably to denote avoidable health differences across subgroups within the same population. Some experts distinguish between the two terms, with health disparities being differences that do not necessarily reflect unjust circumstances, and health inequities being those differences that are reasonably attributable to systemic factors such as policies, procedures, and structures that lead to unequal distribution of the resources needed to obtain optimal health.[19, 20]

Health related social risk and health related social needs: Health-related social risk factors are specific adverse social conditions identified at the individual level that are associated with poor health, such as housing or food insecurity. Social needs are not necessarily synonymous with social risk factors but also depend on people's individual preferences and priorities. Distinguishing between social risks and social needs emphasizes the patient's role in identifying and prioritizing social interventions. [31]

Interprofessional collaborative practice: Collaborative practice in healthcare occurs when multiple health workers from different professional backgrounds work together to provide comprehensive services by working with patients, their families, careers, and communities to deliver the highest quality of care across settings. [26, 27]

Interprofessional education: Occurs when two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes. [26, 27]

Intersectionality: The complex, cumulative way in which the effects of multiple forms of discrimination combine, overlap, or intersect especially in the experiences of marginalized individuals or groups. [29]

Marginalized populations: Groups that are excluded from mainstream social, economic, educational, and/or cultural life based on factors such as race, sexual orientation, age, physical ability, language, geography, and/or immigration status. [30]

Population health: The health outcomes of a group of individuals, including the distribution of such outcomes within the group.[13]

Social drivers of health: The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. While the term "social determinants" has been used more frequently in the past, we prefer the term "social drivers," as it conveys less finality and suggests that these factors can have variable impacts and are malleable. It has also been shown to be more accessible and acceptable to patients and community members. [22-24]

Structural drivers of health: The cultural norms, policies, institutions, and practices that define the distribution of resources across a population that in turn influence the distribution of the social drivers of health and lead to health inequities. [25]

Trauma informed approaches and practices: A program, organization, or system that is trauma-informed *realizes* the widespread impact of trauma on the overall health of individuals and communities, and understands potential paths for recovery; *recognizes* the signs and symptoms of trauma in clients, families, staff, communities, and others involved with the system; and *responds* by fully integrating knowledge about trauma into policies, procedures, and practices, and seeks to actively *resist re-traumatization*. The importance of trauma informed approaches extends to education, healthcare, social care, workplace, and community settings. [28]

HEALTH EQUITY COMPETENCIES FOR HEALTH PROFESSIONS STUDENTS IN TENNESSEE

1. Population Health: Learners will be able to define population health, discuss how it is assessed, and apply these principles in characterizing the health status within and across populations.

1.1 Discuss the definitions of population health.

1.2 Describe demographic and socio-economic data within and across populations of interest and discuss how they impact that population's health.

1.3 Explain the major indicators used to measure health within and across populations.

1.4 Use major health indicators to assess health within and across a population of interest.

1.5 Outline the major health disparities within and across populations of interest.

1.6 Discuss the landscape of insurance coverage in Tennessee and its impact on healthcare access.

2. Core Concepts - Health Equity and Social Drivers of Health: **Learners will be able to define and differentiate key terms related to health equity and social drivers of health and demonstrate understanding of the non-biological factors that affect an individual's ability to achieve optimal health potential.**

2.1 Define health equity, health disparities, health inequities, and healthcare inequities.

2.2 Describe the non-biological factors that influence an individual's ability to achieve optimal health, also known as the social drivers of health.

2.3 Discuss how structural factors, such as economics, policies, natural and built environment, and geography create challenges for achieving optimal health

across groups within a population, and how these factors may intersect with each other to compound or alter impacts.

2.4 Discuss the moral and ethical foundations for health equity.

3. Whole Person Care: **Learners will craft holistic care plans integrated with a person's values and cultural and community context that demonstrate the interrelationships between social, medical, behavioral, and mental health needs of individuals.**

3.1 Explain the importance of a trauma-informed approach to care and apply trauma-informed principles in interactions with individuals, families, and communities.

3.2 Elicit and prioritize a patient's goals and values in developing plans for integrated medical, social, mental, and behavioral health care.

3.3 Recognize one's own biases and their potential impact on patient care and collaborative practice.

3.4 Practice cultural sensitivity and cultural humility.

3.5 Effectively address communication challenges, such as health literacy, health numeracy, digital literacy, and non-English language skills.

3.6 Work within an interprofessional team to identify, document, and address a person's health related social needs across the continuum of care.

4. Community Health: Learners will demonstrate an understanding of the people, practices, organizations, and programs that promote health and prosperity for individuals within a defined community.

4.1 Explain how community assets, capacities, and needs positively or negatively influence community health.

4.2 Describe the importance of public agencies, community-based organizations, and community representatives in identifying and prioritizing community health needs.
4.3 Discuss the importance of cultural values and practices in planning, implementing, or evaluating programs that address community health needs.
4.4 Explain what community health needs assessments are and how they are carried out.
4.5 Explain what community health improvement plans are and ways in which they are developed.
4.6 Apply principles of community-engaged participation when working with community-based organizations to plan, implement, or evaluate programs that promote health, prevent illness, and address community health needs.

5. Health Ecosystem: Learners will demonstrate an understanding of the components of the health ecosystem and how they influence the ability of individuals and populations to achieve optimal health status.

5.1 Describe the components of a health ecosystem and place them within a tiered framework.
5.2 Explain the ways in which the components of a health ecosystem influence the ability of individuals, communities, and populations to achieve optimal health status.
5.3 Discuss the ways in which physical and psychological trauma are both caused by and experienced within all tiers of a health ecosystem and describe the effects this can have on the health and well-being of individuals and communities.
5.4 Use a tiered framework to suggest multi-level strategies aimed at modifying the social drivers of health or mitigating their effects on individuals.
5.5 Reflect on the primary role of one's profession within the health ecosystem and suggest ways in which individuals or professional organizations might influence other ecosystem components in efforts to achieve health equity.

5.6 Describe the healthcare safety net for a population of interest and discuss its role in efforts to achieve optimal individual and population health.
5.7 Advocate at the organizational, community, and state levels for policies and practices that address the sources of health disparities and unequal access to healthcare.

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