NIH Public Access

Author Manuscript

Am J Prev Med. Author manuscript; available in PMC 2014 April 06.

Published in final edited form as:
Am J Prev Med. 2011 October ; 41(4 0 3): S283–S289. doi:10.1016/j.amepre.2011.05.028.

Faith-Based Partnerships in Graduate Medical Education:

The Experience of the Morehouse School of Medicine Public Health/Preventive Medicine Residency Program

Beverly D. Taylor, MD, **Ayanna V. Buckner, MD, MPH**, **Carla Durham Walker, MA**, and **Daniel S. Blumenthal, MD, MPH**
Department of Community Health and Preventive Medicine, Morehouse School of Medicine, Atlanta, Georgia

Abstract

Faith-based organizations can be strategic partners in addressing the needs of low-income and underserved individuals and communities. The Morehouse School of Medicine (MSM) Public Health/Preventive Medicine Residency Program (PH/PMR) collaborates with faith-based organizations for the purpose of resident education, community engagement, and service. These partners provide guidance for the program's community initiatives and health promotion activities designed to address health inequities. Residents complete a longitudinal community practicum experience with a faith-based organization over the 2-year training period. Residents conduct a community health needs assessment at the organization and design a health intervention that addresses the identified needs.

The faith-based community practicum also serves as a vehicle for achieving skills in all eight domains of the Public Health Competencies developed by the Council on Linkages and all six Accreditation Council for Graduate Medical Education (ACGME) Core Competencies. The MSM PH/PMR Program has engaged in faith-based partnerships for 7 years. This article discusses the structure of these partnerships, how partners are identified, funding sources for supporting resident projects, and examples of resident health needs assessment and intervention activities. The MSM PH/PMR Program may serve as a model to other residency and fellowship programs that may have an interest in developing partnerships with faith-based organizations.

In the past, preventive medicine physicians have been described as specialists who do not see patients.[1] However, in preventive medicine, the *patient* can be defined as an individual in clinical settings or a community in population-based settings. In 2002, the IOM found that academic and research institutions rarely engage in prevention and community-based collaborative research. To strengthen academia's role within the public health system through services, research, and teaching, providing integrated learning opportunities in public health training is recommended.[2] Preventive medicine residency programs provide an ideal environment for such integrated learning opportunities, particularly given the need to train clinicians who are equipped to address disparities that disproportionately affect vulnerable populations across the U.S.

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

© 2011 American Journal of Preventive Medicine

Address correspondence to: Beverly D. Taylor, MD, Public Health and Preventive Medicine Residency Program, Department of Community Health and Preventive Medicine, Morehouse School of Medicine, 720 Westview Drive SW, Atlanta GA 30310-1495. btaylor@msm.edu.

No financial disclosures were reported by the authors of this paper.

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

The Morehouse School of Medicine Public Health/Preventive Medicine Residency Program (MSM PH/PMR) is a community-based program that leverages the institution's substantial community partnerships into training opportunities for preventive medicine specialists. The program strives to support the mission of MSM by graduating physicians who are well trained in public health and preventive medicine, well prepared to meet the needs of medically underserved communities, and able to help eliminate health disparities across the country and globally. Faith-based organizations can be strategic partners in addressing the needs of under-served individuals and communities that are most disproportionately affected by health disparities.[3,4] Faith-based health promotion activities have become a widely recognized mechanism for addressing health disparities, and there is a natural fit for faith-based organizations in the training of physicians who are committed to population health competence.

Many academic, governmental, and nonprofit organizations complete health promotion and health education activities in tandem with faith-based organizations.[5,6] For example, the North Carolina State Health Department, in a study funded by the National Cancer Institute, collaborated with fifty area churches in a health promotion activity with the goal of increasing vegetable and fruit consumption.[7] Additionally, an increasing number of residency programs emphasize the importance of community-based education in addressing health needs of populations, particularly in the specialty of pediatrics.[8]

Such programs stress the importance of collaborating with communities to improve health outcomes. One such initiative is Communities and Physicians Together at the University of California, Davis Health System, a partnership between the pediatrics residency program and several local community and child advocacy groups. Residents learn to identify community assets, engage community members, and provide health education activities.[9] While other graduate medical education programs cooperatively work with faith-based institutions to further health goals, few programs require such activities to take place longitudinally throughout residency training or specifically with faith-based organizations.

Faith-based organizations are powerful resources in community development,[10] and public health practitioners can build collaborative relationships with faith-based partners for holistic strategies to improve the health of individuals and communities.[11] Consequently, faith-based communities provide a unique training environment for preventive medicine residents in community engagement and health promotion. The MSM PH/PMR has engaged in faith-based partnerships for 7 years. A discussion is presented on the structure of these partnerships; the associated assessments and health interventions; criteria for faith-based partners; and examples of, and funding sources for, resident health needs assessment and intervention activities. The authors explore how these partnerships help residents obtain the skills and competence required of public health and preventive medicine physicians. Additionally, lessons learned from the partnerships and training are discussed.

The Morehouse School of Medicine Mission and Public Health/Preventive Medicine Residency Program Structure

The MSM PH/PMR is fully accredited to provide training in the specialty of preventive medicine. Its mission is to train qualified physicians to promote healthy behaviors and prevent disease, injury, and premature death. The program teaches residents to understand the health risks associated with social, cultural, and behavioral factors; identify and address health needs in individuals and populations; understand and address the impact of health disparities among racial and ethnic groups; and recognize and eliminate behaviors that lead to injury and death. The specific program goal is to train minority physicians to assume

NIH-PA Author Manuscript NIH-PA Author Manuscript NIH-PA Author Manuscript

leadership positions in public health administration, public policy, academia, research, and the private sector.[12]

Faith-Based Community Partnership Rotation Design

One of the primary training objectives for the MSM PH/PMR is to train residents to collaborate with community-based organizations to achieve positive health outcomes through the completion of a health needs assessment and an intervention. The PH/PMR is structured to allow residents to complete a longitudinal, community-based, service–learning project with a faith-based organization during the 2-year residency training program. For the past 7 years, MSM PH/PMR residents have completed these longitudinal assignments within faith-based organizations, through the Faith-based Community Partnership Rotation (FCPR). Residents work at the faith-based organizations in groups of two or three. Each resident spends a minimum of 15 hours per quarter with the organizations, although some resident groups have exceeded the minimum requirement.

The goals of this community-based training have been to: (1) train residents to establish effective community partnerships, and (2) affect health outcomes through the related health promotion and education activities. A set of educational objectives, which could also be used in general community-based activities, drive the methods for the achievement of this project (Table 1). Churches are recruited to participate in this program through the medical school's affiliation with a local theological center and through referrals from faculty members and community leaders.

To be selected, each faith-based partner must have the support and engagement of its pastor. The church must also have regular community outreach activities (e.g., a soup kitchen, a community garden, activities for children or senior citizens), must be able to provide space for meetings and activities associated with the rotation, and must be located in the Atlanta metropolitan area to facilitate resident access to the church community.

The pastor is asked to identify a church leader involved in the health ministry, or other programs related to health, as the liaison for the partnership with the residents. A health ministry is a committee or unit within a church that oversees its health education and promotion activities. Typically, health ministries have at least three members, but the health ministries of large churches may have as many as 20 or 30 members. Health ministries frequently include nurses, physicians, and dentists. Membership may also include individuals who do not have health- related degrees but may serve as a caregiver in other capacities within the church. Partnering with churches can provide residents with experience collaborating with a multidisciplinary, community-based team with an existing focus on health.

Residents are introduced to the health ministry of the church by the pastor or health ministry leader(s). Orientation to the organization of the church, health ministry, and surrounding community occurs during the resident's initial meeting at the church. This meeting typically occurs shortly after the resident begins the residency program. Residents are also given a tour of the church buildings and grounds at this time.

Health Needs Assessment

The health needs assessment of the community consists of several components: (1) Windshield Survey; (2) Key Informant interview; (3) Focus groups; and (4) Surveys. The assessments usually begin with a **windshield survey** during which residents conduct a visual assessment while walking or driving through the community. The walk or drive allows residents to make subjective and objective evaluations that include descriptions of the

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

community and any evidence of trends, stability, or changes that may contribute to the health of the population. Key informant interviews are interviews with integral community stakeholders such as spiritual leaders (e.g., ministers, elders, and deacons), administrative staff, ministry leaders and members (e.g., health ministry, teen ministry, and recreation ministry), maintenance staff, nursery/day care providers, and food service providers or organizers.

The information from the key informant interviews is used to guide the composition of the focus groups. Focus groups may be composed of members of the general population or key informant interview participants. The information gathered in the focus groups is used to narrow the residents' focus and directs them to determine which members of the faith-based organization receive a survey. In some instances the entire congregation may receive one, or perhaps a targeted segment of the congregation may receive it. For example, if the focus group reveals an interest in youth-related health activities, then only the youth of the congregation may receive the survey. Surveys are reviewed by church leaders prior to distribution, and revisions are made with their input. Residents may also use public data sets and census tract data to inform their projects.

Residents, with the assistance of the health ministry, implement a combination of these assessment tools as appropriate for their faith-based community. The needs assessment is critical in identifying the community's health priorities. Residents analyze the needs assessment information to identify important health issues and potential interventions. The issues and interventions are reviewed with the church leadership, and together, health intervention goals, objectives, and plans are made. This process ensures that if sensitive issues (e.g., sexuality, substance abuse) are identified, the community's buy-in is inherent.

Types of Interventions

Intervention programs frequently focus on chronic disease prevention, cancer prevention, teen pregnancy prevention, men's health, and other related topics. Additionally, residents research the literature to identify best practices and models that could be applied to their faith-based community setting. Examples of interventions completed through this program include health seminars with a "Disease of the Month" focus, consistent with the topics identified through the assessment period. Residents have designed healthy-eating workshops and cooking demonstrations, coalition building activities such as assisting several small churches within the community to collaborate to plan health interventions for their combined congregation and the surrounding communities; walk-a-thons; health fairs; caregiver workshops; and men's health conferences.

Residents have also implemented evidence-based programs in the faith-based communities. For example, a group of residents conducted a train-the-trainer work-shop for the Body and Soul Program,[13] which is a nationwide, evidence-based health and wellness program tailored for African-American churches. Residents also evaluate the intervention's effectiveness, summarize the findings, and share the results with the health ministry and pastor. Table 2 provides a timeline for a sample needs assessment and intervention from the FCPR.

Funding Faith-Based Training Opportunities

Faith-based organizations participate in the FCPR without any direct financial cost extended to the organizations. Initially, resident projects were funded through the Morehouse School of Medicine Center for Community Health and Service-Learning, which received funding from the Corporation for National and Community Service. The residents received a budget of $1750 per project. More recently, the residency program began to use operational funds

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

to provide limited support to resident projects, as needed. Residents are encouraged to cultivate relationships and partnerships with other health and community organizations to secure resources, in-kind support, and technical assistance.

Faith-Based Community Partnerships: A Competency-Based Perspective

The FCPR serves as a vehicle for residents to achieve skills in all domains of Public Health Competencies developed by the Council on Linkages between Academia and Public Health Practice,[14] as well as each of the Accreditation Council for Graduate Medical Education (ACGME) Core Competencies.[15] The specific domains/competencies are listed in Table 3. The residents record their experiences quarterly in a learning portfolio.

Lessons Learned

Over the years, the program has learned valuable lessons that affect the effectiveness of its relationships with faith-based communities. Many of these lessons are essential to any community partnership and include working with a community liaison who has the authority to represent the church and has an interest in partnering with the training program; stating the mission, goals, objectives, and anticipated outcomes of the partnership early and clearly; working with community partners to revise and redesign these goals and objectives as needed; and sharing similar evidence-based interventions and strategies either from literature reviews or from other organizations with similar populations. Residents must also communicate progress and concerns consistently; maintain buy-in throughout the partnership; and create a reciprocal relationship that provides opportunities for training, technical assistance, and recognition for partners involved in all phases of the work.

In addition to the general guidelines above, some considerations are unique to faith-based collaborations. As an increasing number of churches take a more holistic approach to the well-being of their congregants, their health and wellness goals are more closely aligned with their spiritual goals. Therefore, these faith-based organizations are more likely to seek collaborations with partners in order to further their efforts. Likewise, institutions that desire to work with such communities must understand the importance of establishing mutual health goals and objectives from inception. Seeking partnerships with churches that have differing goals or that do not perceive a need for a health intervention is counterproductive.

To prepare residents for these partnerships, the MSM PH/PMR provides training experiences in cultural competence and sensitivity. This training is completed in the Community Health Promotion course offered through the MSM Master of Health Program, as well as in the residency didactic sessions. These experiences are designed to enable residents to better understand the relationship between spirituality/religion and health. Although residents may not subscribe to the faith or belief system of their assigned community partner, understanding this connection is important to their growth as physicians from a social, cultural, and behavioral aspect. In the program’s experience, church leaders have welcomed the inclusion of health professionals, regardless of their religious affiliations, in furthering the community’s health goals. Additionally, although this program’s partnerships have included Christian faith-based communities, the principles that have governed these collaborations can apply to other faith-based alliances.

The FCPR reinforces the principle that a public health professional’s perception of a community health need or concern does not justify the imposition of an intervention or treatment plan on that community. Without the community’s collaboration in the health-needs assessment process, the community may disagree with the assessment of its needs and the role of the health professional in the partnership. It is also important to note that while many faith-based organizations respect science and medicine, a totally evidence-based

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

approach may contradict the basic tenets of their beliefs, which are centered on faith. A better approach is to first engage the community to determine its health priorities and then proceed with health promotion activities that incorporate their spiritual sensibilities. For example, solely providing community members from a Christian church with evidence that a low-fat diet or increased physical activity improves health outcomes may not be as effective as also incorporating a Biblical reference regarding their spiritual responsibility to maintain their bodies. In order to positively affect the health of the community in both the short and long term, the language and beliefs of the community should prevail in all health-promotion efforts.

Lastly, in working with faith-based institutions, one must expect change. Personnel in faith-based organizations frequently change roles and responsibilities. Therefore, re-assessing and re-establishing priorities may be necessary.

Conclusion

Faith-based community partnerships can be a mechanism for training residents in the competencies that are expected of new medical and public health practitioners. The partnerships can provide longitudinal training experiences that incorporate public health into the continuum of medical education and can prepare residents for roles that they may assume within the numerous academic, governmental, and nonprofit organizations that conduct health promotion activities in tandem with faith-based organizations.

Although the FCPR may contribute to improving the education of PH/PM residents, further study is needed to assess resident and community perceptions of the rotation as well as its long-term effectiveness. Additional research is also needed to investigate the impact that the rotation has on the church’s health status, the sustainability of resident interventions, and the degree to which residents use the knowledge and skills gained from their FCPR experiences.

The model presented may be replicated in other general public health/preventive medicine residency training programs, and it may also serve as an example to residency and fellowship programs in other specialties. Through faith-based community partnerships, all residency and fellowship specialties may enhance the visibility and relevance of public health content in physician training. Interactive relationships between graduate medical education programs and faith-based community partners provide opportunities to develop and refine competencies related to interpersonal and communication skills, professionalism, and systems-based practice across all medical specialties. Health promotion activities may be designed to reflect specialty-specific medical knowledge. Through faith-based partnerships and the resultant health interventions, graduate medical education programs can train their residents and fellows to respond in a more coordinated and effective manner to societal health needs on relevant health topics.

Acknowledgments

The Morehouse School of Medicine Public Health/Preventive Medicine Residency Program receives funding from the Health Resources and Services Administration (HRSA)/DHHS, Georgia Board of Physician Workforce, and the American Cancer Society.

Publication of this article was supported by the CDC-AAMC (Association of American Medical Colleges) Cooperative Agreement number 5U36CD319276.

References

1. Ducatman AM, Vanderploeg JM, Johnson M, et al. Residency training in preventive medicine: challenges and opportunities. Am J Prev Med. 2005; 28(4):403–12. [PubMed: 15831349]

2. The future of the public's health in the 21st century. Washington DC: National Academies Press; Nov. 2002 Committee on Assuring the Health of the Public in the 21st Century.
3. Kaplan SA, Calman NS, Golub M, Ruddock C, Billings J. The role of faith-based institutions in addressing health disparities: a case study of an initiative in the southwest Bronx. J Health Care Poor Underserved. 2006; 17(2S):9–19. [PubMed: 16809872]
4. Campbell MK, Hudson MA, Resnicow K, et al. Church-based health promotion interventions: evidence and lessons learned. Annu Rev Public Health. 2007; 28:213–34. [PubMed: 17155879]
5. Corbie-Smith G, Goldmon M, Isler MR, et al. Partnerships in health disparities research and the roles of pastors of black churches: potential conflict, synergy, and expectations. J Natl Med Assoc. 2010; 102(9):823–31. [PubMed: 20922927]
6. Jackson RS, Reddick B. The African American church and university partnerships: establishing lasting collaborations. Health Educ Behav. 1999; 26(5):663–74. [PubMed: 10533171]
7. Denmark-Wahnefried W, McClelland JW, Jackson B, et al. Partnering with African American churches to achieve better health: lessons learned during the Black Churches United for Better Health 5 a day project. J Cancer Educ. 2000; 15(3):164–7. [PubMed: 11019765]
8. Meyer D, Armstrong-Coben A, Batista M. Incorporating community-academic partnerships into graduate medical education. Prog Community Health Partnersh. 2007; 1(3):207–8. [PubMed: 20208280]
9. Hufford L, West DC, Paterniti DA, Pan RJ. Community-based advocacy training: applying asset-based community development in resident education. Acad Med. 2009; 84(6):765–70. [PubMed: 19474556]
10. Vidal, AC. Faith-based organizations in community development. The Urban Institute; Aug 1. 1999 www.huduser.org/portal/publications/faithbased.pdf
11. Gunderson G. Backing onto sacred ground. Public Health Rep. 2000; 115(2–3):257–61. [PubMed: 10968765]
12. Morehouse School of Medicine. Public Health/General Preventive Medicine Residency Program. www.msm.edu/community_health/CHPM/CHPM_residency.aspx
13. Resnicow K, Campbell MK, Carr C, et al. Body and soul. A dietary intervention conducted through African-American churches. Am J Prev Med. 2004; 27(2):97–105. [PubMed: 15261895]
14. Council on Linkages: Prologue to the Core Competencies for Public Health Professionals. www.phf.org/link/prologue.htm
15. ACGME. Outcome Project: General Competencies. www.acgme.org/outcome/comp/compmin.asp

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript
NIH-PA Author Manuscript
NIH-PA Author Manuscript

Table 1

Faith-Based Community Partnership Rotation educational objectives

Objectives
Establish relationships with community representatives
Complete a health assessment of the assigned community
Present the project to a community meeting or community board, justify the assessment and its methods, and obtain community approval
Design a community intervention in conjunction with the community-based organization
Carry out the intervention in a culturally sensitive and appropriate fashion
Manage the project's budget
Design and utilize process objectives to assess the extent to which the project is consistent with the health goals
Analyze the results and prepare a final report to the organization
Prepare and submit a final report and presentation

NIH-PA Author Manuscript

NIH-PA Author Manuscript

NIH-PA Author Manuscript

Table 2

Sample needs assessment and intervention (Year 1 and Year 2)

	Year 1	Year 2
July–October	Residents are introduced to the community contact and ministry leaders to familiarize themselves with the organization and to plan the community assessment.	The following activities were completed: a cancer survivor assessment during the church's health awareness festival. The first application was submitted to the funding agency. Residents participate in the monthly health ministry meeting.
November–January	Residents complete community needs assessment: windshield survey of the church and the surrounding community; key informant interviews of stakeholders, and church survey of ministry leaders and congregants.	Residents continue to work on grant application based on comments provided by the funding agency. Residents participate in the monthly health ministry meeting.
February	Residents analyze the results of the community needs assessment. Residents begin participation in the monthly health ministry meeting.	Residents work with health ministry to plan upcoming health seminars and conferences. Residents participate in the monthly health ministry meeting.
March	Residents share results of needs assessments with community contact and key stakeholders. As a result, an intervention focused on cancer awareness is identified. Residents participate in the monthly health ministry meeting.	The church identifies March as "Cancer Education Month." A special dinner is held to highlight cancer awareness and education. Adult Sunday school classes collect pennies for leukemia patients during this month.
April	Residents work with health ministry to plan/develop health promotion activities. Residents participate in the monthly health ministry meeting.	Residents moderate a panel discussion with cancer survivors and representatives from the ACS. Residents participate in the monthly health ministry meeting.
May	Health ministry expresses desire to apply for grant to fund cancer-related activities. Residents are asked to participate in the development of a grant application. Residents participate in the monthly health ministry meeting.	The residents assist the health ministry in conducting a conference aimed at educating health professionals/ community members on the ACS screening guidelines. Residents participate in the monthly health ministry meeting.
June	Residents participate in the monthly health ministry meeting.	Residents participate in the monthly health ministry meeting. Graduating residents complete end of the year activities and provide a final summary to community contact.

ACS, American Cancer Society

NIH-PA Author Manuscript
NIH-PA Author Manuscript
NIH-PA Author Manuscript

Table 3

Domains and core competencies associated with the Faith-Based Community Partnership rotation

Council on Linkages Between Academia and Public Health Practice	**Accreditation Council on Graduate Medical Education core competencies**
Domain #1: Analytic Assessment Skills: Residents analyze and report the data from the health-needs assessments.	Medical Knowledge: Use medical knowledge to think through community problems
Domain #2: Policy Development/Program Planning Skills: Residents design and implement a health program from data compiled from the health-needs assessments conducted at faith-based partner sites.	Patient Care: Perform thorough assessments of population health problems, and develops intervention plans using clinical and scientific data and patient preferences
Domain #3: Communication Skills: Residents present the project to the organization's leadership and gain buy-in for conducting the assessment and intervention activities. Residents also develop a manuscript or final report at the project's end.	Systems-Based Practice: Work in interprofessional teams to enhance patient safety and improve patient care quality, and coordinate patient care/population care within the healthcare system relevant to preventive medicine
Domain #4: Cultural Competency Skills: Residents carry out the project in a low-income, underserved, largely African-American community.	Practice-Based Learning and Improvement: Critically appraise evidence about intervention effectiveness, and implement a method to assess the effectiveness of community health activities
Domain #5: Community Dimensions of Practice Skills: Residents collaborate with community partners to promote the health of the faith-based population.	Professionalism: Apply professional and ethical principles to practice of medicine and public health, and respond sensitively to an individual's and to a communities' culture, age, gender, and disabilities
Domain #6: Basic Public Health Sciences Skills: Residents retrieve current and relevant scientific evidence, apply the evidence to assessment and intervention activities, and identify the limitations of research and the importance of observations and inter-relationships.	Communication Skills: Collaborate and communicate effectively with patients, families, and communities
Domain #7: Financial Planning and Management Skills: Residents manage a modest budget for the programs that they implement.	
Domain #8: Leadership and Systems Thinking Skills: Residents' experience in project design and management develops and refines their leadership skills.	