



# Entrustable Professional Activities

## EPA 14 for General Pediatrics

### EPA 14: Use Population Health Strategies and Quality Improvement Methods to Promote Health and Address Racism, Discrimination, and Other Contributors to Inequities Among Pediatric Populations

#### Supervision Scale for This EPA

1. Trusted to observe only
2. Trusted to execute with direct supervision and coaching
3. Trusted to execute with supervisor occasionally present to provide advice
4. Trusted to execute without supervisor present but requires coaching to improve member and team performance
5. Trusted to execute without supervision to improve member and team performance
  - 5a. Not yet ready to also supervise others in the execution of this EPA\*
  - 5b. Also trusted to supervise other in the execution of this EPA\*

*\*Where supervision means: Ability to assess patient and learner needs ensuring safe, effective care and further trainee development by tailoring supervision level for this EPA*

#### Description of the Activity

All physicians engaged in the clinical practice of pediatrics should promote wellness, optimal health behaviors, anti-racism,<sup>1</sup> and equity<sup>2</sup> that lead to improved health outcomes for all pediatric populations. Populations can be defined by practice setting, demographics,<sup>3</sup> socioeconomic status,<sup>4</sup> geographic region, and/or medical conditions. It is the responsibility of every general and subspecialty pediatrician to understand the impact racism,<sup>5</sup> all forms of discrimination,<sup>6</sup> and other social determinants of health<sup>7</sup> on health outcomes, and leverage population health strategies<sup>8</sup> and quality improvement<sup>9</sup> methods to promote equity for infants, children, adolescents, and young adults (hereafter “children”).

The specific functions which define this EPA include:

- Recognizing one’s professional responsibility to populations, communities, and society at large
- Identifying populations placed at risk for poor health outcomes using statistical, epidemiological, public health, and community outreach measures
- Collaborating with diverse stakeholders in the development and implementation of initiatives to improve health outcomes
- Engaging in quality improvement initiatives to improve patient care delivery, outcomes and healthcare systems
- Utilizing data resources (e.g., electronic health record, patient registries, databases) to advance quality improvement and population health initiatives
- Dismantling processes/systems rooted in racism and/or discrimination to address inequities<sup>10</sup> and



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achieve optimal health outcomes for all children

### Judicious Mapping to Competencies Critical to Entrustment Decisions\*

SBP 1:	Patient Safety
SBP 2:	Quality Improvement
SBP 3:	System Navigation for Patient Centered Care – Coordination of Care
SBP 5:	Population and Community Health
PBLI 1:	Evidence-Based and Informed Practice
PBLI 2:	Reflective Practice and Commitment to Personal Growth
P 1:	Professional Behavior
ICS 2:	Interprofessional and Team Communication

\*Modified based on Pediatrics Milestones 2.0. ©2021 ACGME/ABP. All rights reserved.

### Context for the EPA

**Rationale:** Pediatricians are well trained to care for individual patient and family needs. As members of the community of physicians, pediatricians also have an obligation to contribute to, co-design,<sup>11</sup> and in some cases, lead health initiatives on behalf of populations of patients. Patient populations can be defined by practice settings, demographics, socioeconomic status, geographic region, and/or medical conditions. These populations must also include those in whom social determinants of health confer poor health outcomes via economic instability, diminished health care access, harmful environmental exposures, limited educational opportunity and attainment, and splintered social and community context. Furthermore, pediatricians' understanding of the impact of racism and all forms of discrimination on health outcomes for children, and specifically the widening of racial/ethnic health equity gaps, is key to this professional activity. Pediatricians should be knowledgeable about population health strategies, and quality improvement and should be entrusted to use these principles to improve the quality of care for patient populations they serve. These skills will equip pediatricians to identify populations placed at risk, improve screening and care, as well as enhance equitable healthcare delivery to all populations.

**Scope of Practice:** Engagement in population health initiatives is part of the professional commitment of pediatricians to the health and well-being of all children. All pediatricians should promote wellness, optimal health behaviors, and quality care delivery - of which equity is a core component as defined by the National Academy of Medicine. Importantly, general pediatricians and pediatric subspecialists should recognize and combat all forms of racism to improve child health. As part of their accountability to the public, all general pediatricians and pediatric subspecialists should be able to:

- disaggregate and interpret data (e.g. by race, ethnicity, language, geographic region, gender identify) about patient populations including those who are placed at high risk for poor health outcomes due to racism, all forms of discrimination, and social determinants of health;
- identify and actively partner with others to correct care practices and systems that contribute to inequities in care delivery and health outcomes;



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- apply population health strategies to critically appraise potential interventions;
- support, co-design, and/or lead initiatives in collaboration with other stakeholders (e.g., parents, community and nonprofit organizations/ leaders, schools, health professionals, health care administrators, and policymakers) to improve healthcare access, quality, delivery and outcomes for patients and populations; and
- advocate for policies and investments in upstream<sup>12</sup> community interventions that optimize health outcomes in all patient populations.

### Definitions

**<sup>1</sup>Anti-racism:** “The active process of identifying and eliminating racism by changing systems, organizational structures, policies, practices, and attitudes so that power is redistributed and shared equitably.”

*Source: National Action Committee on the Status of Women International Perspectives: Women and Global Solidarity*

**<sup>2</sup>Equity:** predicated on the ethical principle of distributive justice; one that requires our decisions regarding the allocation of resources, benefits, and burdens across society be informed by the social conditions of individuals and communities. Health equity in particular is the absence of socially unjust, unfair, and avoidable health disparities.

**<sup>3</sup>Demographics:** the statistical data regarding the characteristics of a given population (age, sex, race, income etc.)

**<sup>4</sup>Socioeconomic status:** an indicator of an individual’s social and economic standing in a given society; often determined by occupational status, income level, and education

**<sup>5</sup>Racism:** “an umbrella concept that encompasses specific mechanisms that operate at the **intrapersonal, interpersonal, institutional, and systemic levels** of a socioecological framework.”

*Source: National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Population Health and Public Health Practice; Committee on Community-Based Solutions to Promote Health Equity in the United States; Baciu A, Negussie Y, Geller A, et al., editors. Communities in Action: Pathways to Health Equity. Washington (DC): National Academies Press (US); 2017 Jan 11. 3, The Root Causes of Health Inequity. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK425845/>*

- **Intrapersonal (internalized) racism:** acceptance of negative messages about one’s self worth and abilities (e.g. self-devaluation, stereotype threat)
- **Interpersonal (personally mediated) racism:** prejudice, implicit/ explicit bias which are differential assumptions about the abilities, motives and intentions of others often rooted in stereotypes
- **Institutional racism:** differential access to goods services, and opportunities based on race that exists in specific institutional/ organizational policies/ practices
- **Systemic (or structural racism):** “ways in which societies foster racial discrimination, via mutually reinforcing inequitable systems (e.g., in housing, education, employment, earnings, benefits, credit, media, health care, criminal justice, etc.) that in turn reinforce discriminatory beliefs, values, and distribution of resources, reflected in history, culture, and interconnected institutions.”



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Source: Bailey ZD, Krieger N, Agénor M, Graves J, Linos N, Bassett MT. Structural racism and health inequities in the USA: evidence and interventions. *The Lancet*. 2017 Apr 8;389(10077):1453-63.

**6Discrimination:** unjust or prejudicial treatment of individual based on certain characteristics

**7Social determinants 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. SDH can be grouped into 5 domains: economic stability, education access and quality, healthcare access and quality, neighborhood and built environment, social and community context. While SDH are often framed in the negative, it is important to recognize that they are “social factors that confer health benefits to certain populations and cause harm in others” and are modifiable.

Source: <https://health.gov/healthypeople/objectives-and-data/social-determinants-health>

Source: Green K, Zook M. When talking about social determinants, precision matters. Washington: Health Care Transformation Task Force. 2019 Oct 29.)

**8Population health strategies:** Key strategies/ approaches include: a focus on health and wellness rather than illness, embracing a population rather than individual orientation, understanding needs and solutions through community outreach, addressing health disparities, addressing social determinants of health and inter-sector action and partnerships.

Source: Cohen D, Huynh T, Sebold A, Harvey J, Neudorf C, Brown A. The population health approach: a qualitative study of conceptual and operational definitions for leaders in Canadian healthcare. *SAGE open medicine*. 2014 Feb 7;2:2050312114522618.

**9Quality improvement:** Also called the science of improvement and refers to “an applied science that emphasizes innovation, rapid-cycle testing...and spread in order to generate learning about what changes, in which contexts, produce improvements. It is characterized by the combination of expert subject knowledge with improvement methods and tools.”

Source: Institute of Healthcare Improvement: <http://www.ihl.org/about/Pages/ScienceofImprovement.aspx>

**10Inequity:** A disparity or difference that is unfair, unjust and avoidable. More specifically, “health inequities are systematic differences in the opportunities groups have to achieve optimal health, leading to unfair and avoidable differences in health outcomes.”

Source: National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Population Health and Public Health Practice; Committee on Community-Based Solutions to Promote Health Equity in the United States; Baciu A, Negussie Y, Geller A, et al., editors. *Communities in Action: Pathways to Health Equity*. Washington (DC): National Academies Press (US); 2017 Jan 11. 3, The Root Causes of Health Inequity. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK425845/>

**11Co-design (in healthcare):** “involves the **equal partnership** of individuals who work within the system (healthcare staff), individuals who have lived experience of using the system [patients and their families] and the ‘designers’ of the new system [e.g.IT personnel, researchers). Co-design involves working together to design a new product, making full use of each other’s knowledge, resources and contributions, to achieve better outcomes or improved efficiency.”



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Source: Ward ME, De Brún A, Beirne D, et al. Using Co-Design to Develop a Collective Leadership Intervention for Healthcare Teams to Improve Safety Culture. *Int J Environ Res Public Health*. 2018;15(6):1182. Published 2018 Jun 5. doi:10.3390/ijerph15061182)

**<sup>12</sup>Upstream approach:** interventions that specifically target the social, economic and environmental origins of health inequities that manifest at the population level (e.g. addressing housing code violations etc. that triggers asthma in children who live in a building). The opposite of focusing on the downstream consequences or end effect of health problems (e.g. medication management for asthma symptoms)

### References

1. National Academies of Sciences, Engineering, and Medicine; Health and Medicine Division; Board on Population Health and Public Health Practice; Committee on Community-Based Solutions to Promote Health Equity in the United States; Baciu A, Negussie Y, Geller A, et al., editors. *Communities in Action: Pathways to Health Equity*. Washington (DC): National Academies Press (US); 2017 Jan 11. 3, The Root Causes of Health Inequity. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK425845/>
2. Bailey ZD, Krieger N, Agénor M, Graves J, Linos N, Bassett MT. Structural racism and health inequities in the USA: evidence and interventions. *The Lancet*. 2017 Apr 8;389(10077):1453-63.
3. Cerdeña JP, Plaisime MV, Tsai J. From race-based to race-conscious medicine: how anti-racist uprisings call us to act. *The Lancet*. 2020 Oct 10;396(10257):1125-8
4. Spencer N, Raman S, O'Hare B, Tamburlini G. Addressing inequities in child health and development: towards social justice. *BMJ Paediatr Open*. 2019;3(1):e000503.
5. Trent M, Dooley DG, Dougé J. The impact of racism on child and adolescent health. *Pediatrics*. 2019 Aug 1;144(2).
6. Lion KC, Raphael JL. Partnering health disparities research with quality improvement science in pediatrics. *Pediatrics*. 2015 Feb;135(2):354-61. doi: 10.1542/peds.2014-2982. Epub 2015 Jan 5.
7. Wagner R, Koh, N, Bagian, JP, Weiss, KB, for the CLER Program. CLER 2016 National Report of Findings. Issue Brief #4: Health Care Disparities. Chicago, Illinois USA.2016. ISBN: 13: 978-1-945365-07-2.