

Prescription 1: Health Disparities

Facilitator Overview

Prescription:	<i>Health Disparities</i>
Content:	Covers definitions of health and disease; the model currently used to address health needs; health literacy and health disparities..
Lessons:	<ul style="list-style-type: none">• Lesson A: <i>Introduction to Community Health</i>• Lesson B: <i>Barriers to Health Care</i>• Lesson C: <i>Health Disparities</i>
Estimated Total Time:	5 hours 30 minutes max + tour of the health center + presentation by senior staff member
Methods / Media	<ul style="list-style-type: none">• “Reader”• Team discussion• Small-group activity• Brainstorming• All-Team activity• Health center tour• Senior staff as guest speaker
Assessment Method:	<ul style="list-style-type: none">• Pre- and Post-test• Worksheet• Report back

Facilitator Preparation

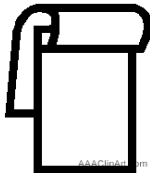


What You Will Need for All Lessons in this Module:

- easel
- flip pad
- large colored markers
-

Introduction to the Competency – 5 minutes

The Competency



Present the definition of this competency:

- Health Disparities defines a set of skills that enables you to work effectively with uninsured and underinsured people within their own community so that you can understand their needs and help them access the services that will meet those needs.



Point out the lesson(s) that you have selected for the Site Team to cover in this module, from the 4 lessons available to you.

If you will have other presenters or lessons separate from this curriculum, **review** the schedule with the team.

Lesson A: *Introduction to Community Health*

Lesson A



Introduction to Community Health -- 3 hours max



Direct members to Prescription 1: Health Disparities in the Participant Guide.

Lesson Objectives

Introduce the objectives of this lesson:



After completing this lesson, members will be able to:

- Define *community* and *health*.
- Describe their relationship.
- Discuss conditions and behaviors that influence the health of individuals, families, and communities.



Direct members to locate the “HealthCorps Reader” for this module and to read Part One: What Is Health?

Allow 10-15 minutes while observing individuals to gauge their reading comfort and speed.

Gaining an Understanding

2 hours max



Note: This first module will be exceptionally important to members. Their comprehension of this material and grasp of the competency will have a big impact on their overall understanding of the service they are doing throughout the year. Take the time now to ensure that high level of comprehension is met.

Bring up central issues from the “Reader” for discussion, such as:

- “Tell me about the World Health Organization’s definition of *health* and *disease* without simply quoting from the ‘Reader.’”
- “What does *biomedical* mean?”
- “How is that different from the *bio-psycho-social model* of health care?”
- “Let’s talk about the HIV–positive patient who is used as an example. Why does the ‘Reader’ include how she looks at her own condition and how others look at her condition?”
- “What is *primary* care and what is *secondary* care?”
- “I’d like to go around the table and have each one of us describe something that involves *health literacy*.”
- “Nobody is completely health literate — even a doctor! What is something you would like to be more literate about? For example, I would like to understand what is written on the prescription that I take to the pharmacy.”
- “If you are doing a *needs assessment* of me and my situation, what are some questions you might ask me?”
- “On the other hand, if you are *asset mapping* the neighborhood where I live, what would your questions be?”



Label a fresh flip page *Major Points about Community Health*.

Identify and **review** the four categories of information presented in the “Reader,” Part One as you **write** them on the flip page:

1. Definition of *health* and *disease*.
2. Current *model* or organization of information for working with disease.
3. People’s ability to access, understand, and use correctly the tools and services available to them related to their health.
4. Understanding both the needs and the assets of an individual or the entire community in which s/he lives.



Ask, “Does Part One of the ‘Reader’ define the term *community*?”

Allow members to look back at the “Reader” to check.

Answer: No, it does not.

Explain that the team will learn many aspects of this important term as they progress through Pre-Service Orientation, but for now they need only the following 2 pieces of information:

- *The community served equals* the people who use the health center plus the people in that geographical area who may need to use the center in the future.
- *Community health care* is care in which the people being served have a say in what health needs are addressed by the provider, which services are offered, and how they are offered.

Direct members to write out the two pieces of information as you read them aloud again slowly.

Point out that:

- The team will do some in-depth work with the term *health* before returning to the term *community*, and
- The strict definition of *health* in the “Reader” is simply the academic way of describing what it means to *be healthy*.

Ask 3-4 members at random, “In your own words, what does it mean to *be healthy*?”

Do not judge their responses — but **help** members clarify their responses where needed.

Explain that this question is at the center of the first activity.

Hand out the sticky notes (10-20 per member).

Direct members to:

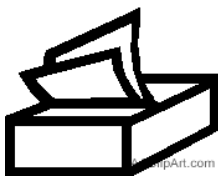
- Work individually, and
- Write a different answer to the question on each sticky note, until you call “Time!”

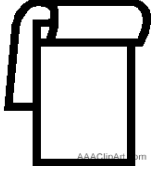
Allow 5-7 minutes.

Circulate to see how members are doing. **Help** as needed: some may find it a little difficult to get started.

Alert the Team when there is 1 minute remaining.

Call “Time!”





Display the prepared flip page labeled *HEALTH*.

Direct the team (or **call on** a member) to study the diagram and try putting into words what it's about.

Answer: The diagram shows 6 categories. Each one is a set of factors influencing a person's health. Each one has positive and negative possibilities.

Demonstrate the role of the categories by asking:

- For a volunteer to assign one of his/her sticky-note ideas to one of the categories, and
- For another volunteer to agree with that category assignment or suggest another possibility. If the second member suggests another category, **ask** him / her to explain why.

Point out that in some cases an idea will fit just as logically under one category as another.

Ask if members have any questions about:

- The categories, or
- Assigning their ideas to the categories.

Once you feel that the whole team understands the diagram and its relation to their sticky-note responses, **direct** all members to:

- Bring their notes up to the easel, and
- Post each one alongside the most appropriate category.

When all members are done, **ask for** 3 volunteers to:

- Return to the easel,
- Group identical ideas within each category,
- Place a good “version” of each idea as the top note of its pile, and
- Spread out the unique ideas so they can be read easily.

Allow up to 5 minutes.



Review aloud the unique ideas under each category, so everyone has the basic picture of the expanded diagram. Also:

- **Encourage** members to ask any questions they have,
- **Encourage** them to suggest alternative assignments and express their reasons, and
- If you come to an item which you know is more closely aligned to a different category, **reassign** the note and **explain** why.

Present the next stage of the activity:

- “You will work in a small group that is responsible for 1 of the categories;
- “For that category, you will brainstorm the characteristics of an 8-year-old child who is *healthy* in that particular way plus the characteristics of one who is *unhealthy* in that way;
- “You will start with the ideas that are on the flip-page diagram and go on from there;
- “For example, if your category is *social*, what are some ways that we recognize a healthy child?”

Answers will come from the flip-page diagram.

Then **ask** the opposite question, “What are some ways that we recognize a socially unhealthy child?”

Answers will come from the flip-page diagram.

Announce that their goal is to:

- Make the most complete description of each child they can, which will require them to add to the ideas on the flip-page diagram, and
- Present their lists to the team in 3 minutes or less.

Ask members if they have any questions about the activity.



Note:
If your Team is small, divide into 3 groups and assign each group 2 of the categories.

Divide the Team into 6 groups.

Calling on groups at random, **invite** the first 5 to select a category.

Allow 3 minutes for the groups to get organized.

Allow 7-10 minutes for the activity.

Circulate to see how the groups are doing and **help** as needed.

Alert the team when there is 1 minute remaining.

Call “Time!” **Let** the groups get down their last ideas.



Ask for a volunteer group to present first.

Note: It does not really matter which category is covered first, because they all relate equally to the concept of health. However, it may be better not to start with physical because doing so may reinforce many people’s perception that health is solely about medical treatment when a person’s body hurts.

Thank each group at the end of their presentation and **direct** them to select the next group.

When all 6 categories have been presented, **emphasize** that:

- All of us have characteristics from the healthy side and from the unhealthy side of the list.
- It is difficult to know how to recognize and help a person who is truly unhealthy until we have some image or definition of the *continuum* from extremely healthy to extremely unhealthy.

Ask if the team is ready to do its final work for the day with the 6 categories of the diagram.

Direct everyone to return to their original seats.

Introduce into the discussion a particular chronic disease so the team can further refine their knowledge of what is healthy vs. unhealthy.

Note: This lesson guide uses diabetes as the example. You may select any other chronic disease that fits your team and health center better. However, be aware that asthma is used in a similar activity in Module 9: Case Management, Lesson A: What Is Case Management?



Lead a Question & Answer session starting with these questions:

“Based on what you already happen to know about diabetes, tell us one healthy factor for a person with diabetes under the category *behavioral health*.”

Answer is likely to be one of these: Eat appropriate diet; lose weight or maintain healthy weight; follow doctor’s orders; test your own blood sugar level regularly; take your insulin; inspect your feet regularly.



“Now tell us one unhealthy factor for a person with diabetes under the category *behavioral health*.”

Answer is likely to be one of these: Eat lots of sugary or fatty foods; gain weight; ignore doctor’s orders; skip your blood testing sometimes; skip your insulin sometimes; assume your feet are healthy.

Continue the Q&A as you go around the diagram asking about each category.

Once the diagram Q&A is complete, **ask** members:

“Who remembers the 2 pieces of information I gave you about *community*? How much can you remember without looking at what you wrote?”

After members have come up with descriptions or definitions of both *the community served* and *community health*, **use** an example to help them relate these ideas with the *HEALTH* diagram:

“If I am a member of *the community served* and I have diabetes, what services am I likely to want the *community health center* to offer?”

Answer: Care for diabetes

“If I have children and I want them to avoid getting diabetes such as I have, what services am I likely to want the *community health center* to offer?”

Answer: Diabetes prevention

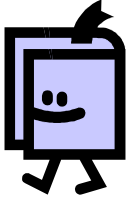
Tell the team that they will learn how members of *the community served* get involved in decision-making at the health center when _____ speaks to them about the history of the center.

Note: If this lesson is conducted after such a guest speaker, use this point in the lesson to review with the Team what was covered.

Lesson B: *Barriers to Health Care*

Building Skills

1 hour 30 min. max



Direct members to locate the “HealthCorps Reader” in the Participant Guide and review Part One.

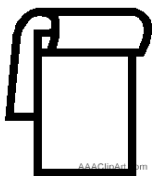
Allow **3 minutes**.



Introduce the activity by telling the team that they are going to bring the idea of *asset mapping* into this community and build a set of information that they can use throughout the year.

Emphasize:

1. “Even the best insured people in the country, who have no ‘brick wall’ stopping them, sometimes have trouble locating the right medical or social service resource to meet their needs.”
2. “Imagine, then, how much support the uninsured and underserved in our community will need your help to locate what they need!”



Label a new flip page *Physical Resources* and draw a line straight down the middle. **Label** one column “General” and the other, “Specific.”

Give the team an example of a *physical resource*, such as:

- A place where children can play safely, or

- A van owned by the community center that can be used occasionally by the health center for free.

Direct members to:

- Picture their own home town, “walk around” and “see” the various *physical assets* there are, and
- Picture this community and try to identify any *physical assets* they’ve seen so far.

Brainstorm with the team as many *physical resources* as possible.

Record responses under:

- “General” when they say “playground” or “school building” or “bus system,” and
- “Specific” when they name a park or building or transportation system in this community.



Label a new flip page *People Resources* and draw a line straight down the middle. **Label** one column “General” and the other, “Specific.”

Brainstorm with the team as many *people resources* as possible.

Record responses under:

- “General” when they say “school principal” or “lady who takes care of children in her home” and
- “Specific” when they identify people in this community.

Ask, “What type of resource have we not talked about yet?”

Answer: group/agencies/clubs/businesses = organizations

Label a new flip page *Organizational Resources* and draw a line straight down the middle. **Label** one column “General” and the other, “Specific.”

Brainstorm with the team as many *organizational resources* as possible.

Record responses under:

- “General” when they say “schools” or “Kiwanis Club” or “hardware store” and
- “Specific” when they identify actual organizations in this community.

Give a 10-15 minute break.





Welcome **members back to *Barriers to Health Care***.

Direct **them to locate the Worksheet: *Community Asset Map* in the Participant Guide and become familiar with it.**

Allow **5 minutes**.

Direct **members to write “Access to Health Care” as the Program Issue on the worksheet.**

Ask **if anyone can define or describe the word *stakeholder* for the team. If not, define the term yourself.**

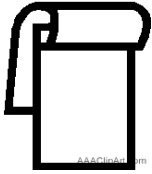
Answer: Someone with a personal interest in the issue

Ask, **“Who do you think has the biggest stake in whether the barriers to health care are removed?”**

Answer: The community served: the uninsured and underinsured

Direct **members to write “the community served” as the**

Primary Stakeholder on the worksheet.



Ask for a volunteer to be scribe for this next phase of the lesson — someone who likes color coding!

Point to all of the brainstormed lists around the walls and **explain** that the team will “test” what they see on the sample *asset map* against all of the ideas they’ve already had!

Emphasize the team should focus on “Specific” items, because they’re working to build a resource list for this community.

Announce that the team will begin with “Physical Resources.”

Direct:

- The scribe to pick a colored marker not used on the brainstormed lists and check off every *physical asset* listed.
- The members to jot key words from that list next to that box on the *asset map*.

When they’re almost done, **break in** suddenly, “Wait a minute! Wait a minute! What is ‘Parks & Public Areas’ doing way over on the other side of the *asset map*?!”

Whatever the team’s response, **lead** them to understand that the various categories on the map are not all mutually exclusive — there are bound to be overlaps no matter how you draw the map.

Allow them to complete their task — letting members link “Physical Resources” to “Parks & Public Areas” on the map in any way they wish.

Selecting members in sequence around the room, **inform** each that s/he can:

- Select a category box on the *asset map*,
- Tell the scribe what new color to use, and
- Direct the scribe to check off any brainstormed items that fall into that category.

Meanwhile, the rest of the team can jot down key words next to that box on the map.

As needed, **remind** members to focus on the “Specific” items listed — or to change something “General” to “Specific” by naming the actual person/place/organization in this community.

Continue around the room and around the map until all category



boxes have been covered. If there is a category box that has no corresponding items on the brainstormed lists, **encourage** members to think of one.

Announce that the final part of the lesson is to start making their own directory of specific resources for specific needs that are often requested by members of this community:

- “We are going to focus on key areas that are most critical to HealthCorps service and potential referral resources.”



Direct members to locate the Worksheet: *Where Do We Go to Find...?* in the Participant Guide and read all of it.

Allow **3 minutes**.

Ask **if members have any questions about the worksheet.**

Point out that:

- One of the ways that health center staff and HealthCorps members can be most useful to clients and patients is to be “information people,”
- ***But that is helpful only if the information you provide to them is up to date and relevant.***



Divide the team into new groups of 3-4.

Divide the items on the worksheet by the number of groups to find out how many items to assign to each group. (Try to give the groups an equal workload.)

Explain that:

- The worksheet will be a true work in progress, begun in this session but continued outside the training room;
- Groups will have _____ minutes today to start their list; and
- They will reconvene this activity on _____ for groups to report their findings.

Circulate to see how groups are doing, but **be more intrusive** than usual so that every group is given a strong start.

Note:

- *If a group is having trouble identifying how to start locating resources, suggest: patient literature distributed by the health center; the yellow pages; “gatekeepers” within their assigned departments; staff members of other organizations; community members they know.*
- *If you want members to interview people for this assignment whom they have not yet met, provide them with a letter of introduction so the staff member or community member will know this is a bone fide search for information.*



Suggested discussion questions:

- How is your presence in the community having an impact on the persons you serve?
- On the health center staff *amongst* whom you serve?
- On teammates *with* whom you serve?
- **Or are you having no impact at all? Why do you think that? If it’s true, what is the cause?**

Lesson B: *Barriers to Health Care*

Worksheet: *Community Asset Map*

Instructions:

- 1. Read the entire map so you feel familiar with it.*
- 2. Ask your facilitator to explain anything that is unclear to you about the map.*
- 3. Fill in the Program Issue and Primary Stakeholder as directed by your facilitator.*
- 4. Scan the flip pages mounted on the walls to find items from the brainstorming activity that match a category box on this map.*
- 5. During Team discussion of each category, jot down key words of the resources already listed during the brainstorming.*

Lesson B: *Barriers to Health Care*

Worksheet: *Where Do We Go to Find...?*

Instructions:

- 1. Meet with a few other members to discuss the items below that the facilitator has assigned to you.*
- 2. Your goal is to locate at least three actual community resources for each type of information.*
- 3. Brainstorm several ways to locate such resources. Which can you work with immediately? Which will take longer?*
- 4. As you locate such resources, write the people and/or organizations into the appropriate box and be prepared to present to the team (a) what the resources are, and (b) how and where you located them.*

HIV EDUCATION, TESTING, & COUNSELING:
ENROLLMENT IN WIC:
PRIMARY HEALTH CARE FOR CHILDREN:
LEGAL ASSISTANCE:

TRANSPORTATION AND FINANCIAL SUPPORT:

EDUCATION & SUPPORT FOR DOMESTIC VIOLENCE:

MEDICAID ENROLLMENT:

FINANCIAL & BUDGETING ASSISTANCE:

PARENTING EDUCATION:

UP-TO-DATE IMMUNIZATIONS FOR INFANTS:

FOOD & CLOTHING:

BREAST-FEEDING SUPPORT:

GED & LITERACY INFORMATION / ASSISTANCE:

FAMILY PLANNING INFORMATION & CLINICAL SUPPORT:

JOB TRAINING:

NUTRITION EDUCATION:

IMMIGRATION GUIDANCE:

CHILD DEVELOPMENT SCREENING:

HOUSING AVAILABILITY AND SIGN-UP:

MENTAL HEALTH COUNSELING:

PRENATAL CARE:

LEAD POISONING EDUCATION & SCREENING:

CHILD CARE:

SUBSTANCE ABUSE HELP:

SCHIP ENROLLMENT:

Lesson C: Health Disparities

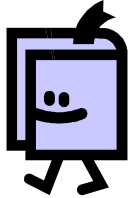
Lesson:	Health Disparities
Objectives:	<p><i>Note: this lesson should be included in Pre-Service Orientation.</i></p> <p>After completing this lesson, members will be able to:</p> <ul style="list-style-type: none"> List 5 examples of health disparities between ethnic, racial, and/or gender lines. Name 3 strategies for addressing those disparities.
You will need:	<ul style="list-style-type: none"> Prepared flip page labeled <i>Lesson Objectives</i> 1 poster for each population From Coordinator Sheet: <i>Health Statistics Revealing Disparities</i>, cut pieces of paper, each with 1 health statistic about one of the populations (enough for each member to have 2 or 3 statistics) Tape Worksheet: <i>Health Statistics Revealing Disparities</i>
Estimated Time:	<p>1 hour 15 minutes max</p> <p>+ <i>optional</i> activities after Gaining an Understanding</p>
Gaining an Understanding:	<ol style="list-style-type: none"> 1. Introduce the lesson objectives. 2. Members walk around the room to see posters. 3. Give each member an equal number of cut pieces of paper, each with 1 health statistic. 4. Members decide which populations their statistics go with and tape them to those posters. 5. Members check all posters for possible errors. 6. Members move any pieces they believe are wrongly assigned. 7. Hand out copies of the Worksheet: <i>Health Statistics Revealing Disparities</i>. 8. Members correct any errors on the posters. 9. Members add to their worksheet any statistics provided by the facilitator. 10. Debrief with questions. 11. <i>Optional: Hand out copies of “Healthy People 2010” and discuss its content.</i> 12. <i>Optional: Hand out copies of UDS information sheets and train members to read them.</i>

Building Skills:	<ol style="list-style-type: none"> 1. Divide the team into groups of 3-4. 2. Assign each group an ethnic, racial, or gender group found in your community served. 3. Focus attention on strategies within the capability of the health center. 4. Each group selects a recorder and a reporter. 5. Each group brainstorms likely barriers and possible strategies to reduce disparities for their group. 6. Groups report to the team.
Follow-up activities might include:	<ul style="list-style-type: none"> • Members go back to their service assignments and determine through observation if any of the strategies they brainstormed to address disparities are currently being used and/or other strategies. • Encourage your members to interview health center staff to learn about existing strategies to address health disparities. • Each member selects 1 health indicator or “Healthy People 2010” goal/objective and researches the issue a bit over several weeks, then reports to the team.

Lesson C



Health Disparities -- 1 hour 15 minutes max



Direct members to Prescription 1: Health Disparities in the Participant Guide.

Lesson Objectives

Introduce the objectives of the lesson:



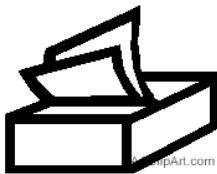
After completing this lesson, members will be able to:

1. List 5 examples of health disparities along ethnic, racial, and/or gender lines.
2. Name 3 strategies for addressing those disparities.

Gaining an Understanding

30 minutes max

Invite members to look around at the posters mounted on the walls, each with the name of a particular population/group.



Hand out to each member 2 or 3 cut pieces of paper, each with one health statistic.

Ask, “Is there any statement on your papers as to what group is being described?”

Answer: No

Direct members to:

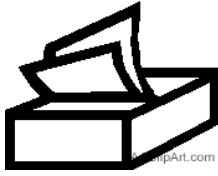
- Make their best effort to match each statistic to one group of people, and
- Tape the piece of paper to the corresponding poster.

Encourage members to work together and make use of any knowledge they already have in this area.

Once all members have posted all of their statistics, **direct** them to:

- Check all of the posters for accuracy, to the best of their ability, and
- Reach agreement on any changes that one or another member

recommends.



Once that process is complete, **inform** the team that you have a worksheet prepared which will allow them to know whether the statistics have been matched correctly.

Hand out Worksheet: *Health Statistics Revealing Disparities*.

Direct members to:

- Check every poster against the worksheet, and
- If they find an error, circle it with a marker.

Note: If you have added statistics to those on the worksheet, they will discover it at this point. If they ask, let them know where the “extras” came from and that you will correct any errors in their assignment.



Once that process is complete, **invite** everyone to sit down and guide you in correcting the errors they’ve identified.

For each statistic that has been circled on a poster, **call on** a member to direct you where to move it.

After the worksheet statistics are all correctly placed, **move** any of the “extra” statistics that were wrongly assigned and **explain** why.

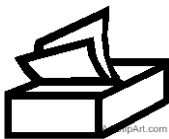
Ask, “Given how little guidance you had to work with, how well do you think the team did?”

Lead a discussion with such questions as:

- “What are your thoughts after this activity?”
- “Did anything particular jump out at you from the posters or the worksheet?”
- “Which of these are *target populations* for our health center? For our HealthCorps service?”

Going around the room, **ask** each member to share something s/he learned through this activity.

Optional
Activity #1



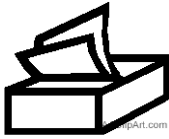
Hand out copies of or selections from “Healthy People 2010.”

Direct members to familiarize themselves with it a bit.

Allow 5-10 minutes.

Lead a discussion of its contents; perhaps:

Optional
Activity #2



- **Guide** members to find statistics similar to the ones they worked with today;
- **Direct** them to locate any information on particular populations; or
- **Encourage** them to locate any information on their own populations.

Hand out copies of the health center’s UDS demographic data from which you selected the “extra” statistics.

Direct members to scan a page or two to become familiar with the way data is presented.

Allow 5 minutes.

Teach the team how to read and interpret such information.

Building Skills

45 minutes max



Divide the team into groups of 3-4.

Either:

- **Assign** each group an ethnic, racial, gender, or age population that is served by the health center, or
- **Display** a list of these populations and **direct** the groups to choose among them.

Suggest that each group designate a recorder and a reporter.

Focusing the activity around barriers found in your community and strategies most likely to work in your community, **direct** the groups to:

- Identify these for their particular population, and
- Prepare a 3-minute presentation of that information.

For example: If the population is people with limited English proficiency (LEP), the barriers and strategies might be:

- ✓ *Language – bi-lingual education materials; interpreters*
- ✓ *Literacy – demonstrations; illustrated materials*
- ✓ *Fear related to immigration laws – education campaign about confidentiality*
- ✓ *Time conflicts – open the clinic on Saturdays and evenings*
- ✓ *Cultural barriers – culturally competent staff*
- ✓ *Finances – sliding fee scale, low or free screenings, enrollment in CHIP and Medicaid*

Allow 10-15 minutes.

Circulate to see how the groups are doing and **help** as needed.

Alert the team when there is 1 minute remaining.

Call “Time!”

Either **call on** the groups in a particular sequence based on the populations they worked with or **ask** for volunteers to present.

Encourage the audience to ask questions of each group. **Ask** a question yourself.

Lead a round of applause after each presentation.



Suggested discussion questions:

- Did you get any ideas today that would improve your service? This program? The world?
- What were some things you wanted to say today but did not?
- Now that you’re more aware of the health disparities in our community, is there any way that *you* can help, however small?

- Encourage your members to interview health center staff to determine what is happening to address health disparities. Assign each member a different health area (e.g. diabetes collaboratives).
- Have your members go back to their service assignments and determine if any of the suggestions/strategies they brainstormed to address disparities are being implemented.

Follow-up
Suggestions



*NOTE:
This page is intentionally left blank.*

Lesson C: *Health Disparities*

Coordinator Sheet: *Health Statistics Revealing Disparities*

Instructions:

- 1. Prepare one flip page or poster board for each population listed here (nine). You may add or substitute other populations for which you have data.*
- 2. Label each in large letters at the top or down the side with the name of the group.*
- 3. Do not put any further information on the posters.*
- 4. Mount them around the walls of the training room.*
- 5. Enlarge this page on a copier so each bulleted item will be easy to cut out and will look good on the poster.*
- 6. Using your health center's UDS reports, add more statistical data for the populations. The more information on each group, the more interesting the activity.*
- 7. Type up the UDS statements in large bold font also.*
- 8. Have members place the characteristics on the page for the group that they think it applies to.*

Women

- **Increased risk for Alzheimer's disease.**
- **Twice as likely to be affected by major depression.**

Men

- **Life expectancy is 6 years less.**
- **Higher death rate for the 10 leading causes of death.**

Gay, Lesbian, Bisexual, and Transgendered

- **This group is 2-3 times as likely to commit suicide.**
- **Higher rates of overweight, alcohol abuse, and stress.**

African Americans

- **Infant mortality is twice as high among this group.**
- **Heart disease rates are more than 40% higher.**
- **Death rate for cancers is 30% higher for this group.**
- **More than twice the rate for prostate cancer.**
- **Death rate from HIV/AIDS is more than 7 times higher.**
- **More than 6 times the rate for homicides.**
- **Higher rates of heart disease and obesity.**

Latino / Hispanic Americans

- **This group is twice as likely to die from diabetes.**
- **20% of all new cases of TB occur in this group.**
- **Higher rates of heart disease and obesity.**

Native Americans & Alaskan Natives

- **Infant death rate is almost double in this group.**
- **Twice the rate of diabetes.**
- **Disproportionately high rates from unintentional injuries and suicide are present in this group.**

Asian and Pacific Islanders

- **Considered one of the healthiest groups in the U.S.**
- **Cervical cancers are 5 times higher in this group.**
- **New cases of hepatitis and TB are higher.**

Low-income & low education

- **Can expect to live 3 years less than their age-appropriate counterparts.**
- **Three times as likely to report limitation in activity caused by chronic disease.**
- **Overall death rate is more than twice that of age-matched counterparts.**
- **Almost twice the Infant mortality rate.**

Rural Populations

- **Injury-related death rate is 40% higher.**
- **Higher heart disease, cancer, and diabetes rates.**
- **Less likely to use preventive health services.**
- **20% of this population is uninsured.**

Lesson C: Health Disparities

Worksheet: Health Statistics Revealing Disparities

Instructions:

- 1. Use this sheet to check the accuracy of everyone's guesses about which health statistics go with which population groups.*
- 2. If your facilitator added a statistic which does not appear on this sheet, write it in below.*

Women:

- Increased risk for Alzheimer's disease.
- Twice as likely to be affected by major depression.

Men:

- Life expectancy is 6 years less.
- Higher death rate for the 10 leading causes of death.

Gay, Lesbian, Bisexual, and Transgendered:

- This group is 2-3 times as likely to commit suicide.
- Higher rates of overweight, alcohol abuse, and stress.

Latino / Hispanic Americans:

- This group is twice as likely to die from diabetes.
- 20% of all new cases of TB occur in this group.
- Higher rates of heart disease and obesity.

Native Americans & Alaskan Natives:

- Infant death rate is almost double in this group.
- Twice the rate of diabetes.
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African Americans:

- Infant mortality is twice as high among this group.
- Heart disease rates are more than 40% higher.
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- More than twice the rate for prostate cancer.
- Death rate from HIV/AIDS is more than 7 times higher.
- More than 6 times the rate for homicides.
- Higher rates of heart disease and obesity.

Asian and Pacific Islanders:

- Considered one of the healthiest groups in the U.S.
- Cervical cancers are 5 times higher in this group.
- New cases of hepatitis and TB are higher.

Low-income & low education:

- This population can expect to live three years less than their age-appropriate counterparts.
- Three times as likely to report limitation in activity caused by chronic disease.
- Overall death rate is more than twice that of age-matched counterparts.
- Infant mortality rate is almost doubled.

Rural Populations:

- Injury-related death rate is 40% higher.
- Higher heart disease, cancer, and diabetes rates.
- Less likely to use preventive health services.
- 20% of this population is uninsured.

Prescription 1: Health Disparities

Health Disparities defines a set of skills that enables you to work effectively with uninsured and underinsured people within their own community so you can understand their needs and help them access the services that will meet those needs.



Lesson A: *Introduction to Community Health*

After completing this lesson, members will be able to:

- Define *community* and *health*.
- Describe their relationship.
- Discuss conditions and behaviors that influence the health of individuals, families, and communities.

Lesson B: *Barriers to Health Care*

After completing this lesson, members will be able to:

- List 5 barriers to service that patients/community members encounter.
- List 5 methods for overcoming those barriers.
- Match local resources to community needs in 3 key service areas.

Lesson C: *Health Disparities*

After completing this lesson, members will be able to:

- List 5 examples of health disparities between ethnic, racial, and/or gender lines.
- Name 3 strategies for addressing those disparities.

Part One: What Is Health?

There are countless definitions of *health*. Depending on how we look at it and what it encompasses, our definition will vary. For an especially well-written definition, we can turn to the World Health Organization (WHO) which defines health as “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (1).

Often, learning about the opposite of a term is useful, too. Consider WHO’s definition of *disease* as “a harmful, and undesirable situation ... associated with impairment or discomfort” (1).

For many years the dominant *model* or way of working with disease was strictly *biomedical*. In other words, it focused on the person’s physical condition and used the biology of molecules as its basic scientific discipline. This model assumed disease to be fully explained by measurable deviations from the normal variables of the human body. It did *not* include consideration of the social, psychological, spiritual, behavioral, or environmental dimensions of illness.

Today’s Model: The Bio-Psycho-Social Model

Today’s model for working with disease includes the biomedical factors but also takes into account much more of the patient’s world. The following example illustrates the difference between this and the older biomedical model:

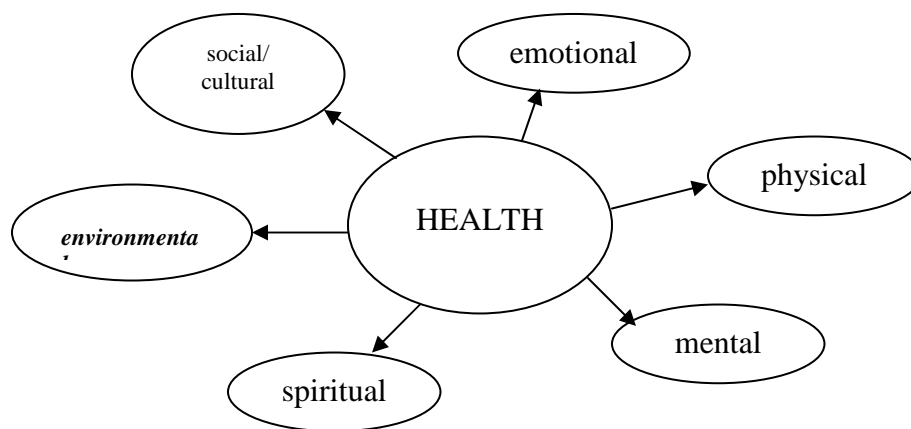
A patient gets a blood test done at her annual physical exam, and the test results show that she carries the human immunodeficiency virus, or HIV. The patient does not feel ill and did not report any unusual physical symptoms to the doctor that might indicate the onset of auto immune

deficiency syndrome, or AIDS, even though the virus that causes AIDS is present in her body.

When a health care provider orders lab tests for a patient to determine whether disease is present, the results may indicate only the *potential for disease*, not the actuality of that disease at that time. What determines when, if ever, the symptoms appear and how bad they are? What determines whether the patient considers herself to be ill and whether others look at her as being ill? To put it another way, does she believe she is “dying with AIDS” or “living with HIV”?

Like many diseases, the development and evidence of HIV/AIDS are affected by the person’s *living conditions* and *behavior choices*. They can affect the amount of time between the patient’s lab test showing the presence of HIV and when the patient begins to notice actual symptoms. They can have an impact on how fast the disease progresses and which symptoms appear when.

Psychological, social, cultural, and spiritual factors are also important in determining whether patients with HIV in their bodies come to view themselves as “sick,” if so when, and whether the people around them come to regard them as “sick.”



There are many clinical symptoms associated with HIV/AIDS — indications that a health care professional may identify or a lab test will show — but how any one patient *experiences* the symptoms and *reports* them to a health care provider all require consideration of physical, emotional, mental, spiritual, social/cultural, and environmental factors. *For example*, a patient’s language, religion, and cultural background help determine whether they will see HIV/AIDS as something shameful to hide as long as possible — believing it is an illness that they helped cause — or a disease like any other that can be treated.

Thus, understanding illness requires a basic understanding of the psychological, social and cultural determinants of how patients report their symptoms. One of the most important responsibilities of the provider is to elicit accurately and then analyze correctly the patient’s own account of the illness.

Community health centers focus on *primary* and *preventive* health care which include:

- Basic services provided at the health center: usually provided through departments of family medicine, obstetrics / gynecology, and pediatrics by a range of providers (such as physicians, nurse practitioners, physician assistants, lab technicians, dieticians), these services include physical examinations, diagnoses, and prescribing of medications.
- Services that are health center-based — as opposed to *secondary* care which is hospital-based;
- Screenings that identify health concerns early; and
- Services to promote overall well being of the individual before signs of disease are present.

Health Literacy

A vital part of understanding the full concept of *health* is to grasp the importance of *health literacy*. A person with health literacy skills is able to access, understand, and use correctly the health-related tools and services that are readily available to them. We use here the phrase “readily available” to underscore the fact that even the most health-

literate person, if uninsured or underinsured, will find it difficult to access good health care over time outside of the community health movement.

Some people may think of health literacy as simply the ability to read (decode) health-related text such as the label on a medicine bottle or a brochure about breast cancer. However this is a narrow definition; such a skill is only one part of the competency. Rather, health literacy involves the entire set of social and cultural practices that form a backdrop to individuals' and groups' relationship to health care.

Health literacy is contextual, that is, dependent on the position of individuals within a community. "Position" can refer to many factors of life. The following factors, and more, all impact our health literacy: Social status, age, gender, marital status, ethnicity, sexual orientation, ability status, family structure, number of children, the people we relate to, and the condition of the place where we live.

Out of hundreds of possible examples, here are a few that illustrate the impact of health literacy in everyday life:

- A child is sent to the store for toothpaste and must distinguish it from a tube of hemorrhoidal cream;
- A mother and father must get their child to the hospital emergency room quickly using public transit;
- A mother needs to read a medicine bottle, understanding both dosage and contraindications; and
- A man who neither hears nor walks well needs to find treatment for his specific condition by locating a specialist within a highly bureaucratic and complicated health care maze.

Some of these examples of health literacy needs are tied to people's ability to decode text — reading labels, advertising, or bus signs — while others are not. In fact, a person's ability to read text is *not* an indicator of his or her ability to access, use, and understand a particular health care tool or service.

Needs Assessments and Asset Mapping

Many community health centers use a *needs assessment* as a way of identifying problems, matching programs and interventions to those problems, and developing an action plan with the people they serve. This remains a common model for looking at community development and community health. There are four main steps to take while conducting a needs assessment:

1. Analyze the person's or population's existing situation;
2. Identify the varying importance of the factors in that situation and set priorities among them;
3. Identify causes of performance problems and/or opportunities; and
4. Identify possible solutions and growth opportunities (3).

Asset mapping, on the other hand, focuses primarily on the available resources — also called assets or strengths — that are available in a community, because they can be used by the residents and the health center together to address community-wide concerns. Looking at the community as a collection of strengths, we might see:

- Strong relationships among residents;
- Inclusiveness — the recognition that all people are valuable and able to contribute;
- Willingness to welcome and include newcomers;
- Desire on the part of many individuals to step forward and improve neighborhood conditions, instead of waiting for formal organizations to take action;
- Sustainability over time;
- Acceptance of risk (i.e., being able to proceed without knowing all of the answers and results in advance); and
- At least some transfer to residents of the power to act on their own behalf from various government agencies, professionals, and experts.

Citations

1. *Preamble to the Constitution of the World Health Organization* as adopted by the International Health Conference, New York, June 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of the World Health Organization, no. 2, p. 100) and entered into force on 7 April 1948.
2. *What is Health Literacy?* Muro, Andres. El Paso Community College/Community Education Program. <http://www.worlded.org/us/health/lincs/muro.htm>
3. *Needs Assessment: The First Step.* **Rouda, Robert and Kusy Jr., Mitchell E.** http://www.alumni.caltech.edu/~rouda/T2_NA.html

Part Two: Health Disparities

A *health disparity* is a difference in the presence of disease, health outcomes, or access to health care between two or more populations. How do such disparities come about? By looking at how people achieve health in the United States today, we begin to understand how some people are not in a position to “achieve health.”

Health requires high levels of social, economic, human, political, and cultural capital. This approach to disparities holds that the achievement of health is, at least in part, directly related to adequate living conditions, thriving neighborhoods, opportunities for education and employment, and freedom from environmental hazards. People whose participation in society is restricted, for instance, by segregation according to race and poverty have limits placed on their opportunities for a healthy life.

Health requires access to care through health insurance or the ability to obtain services free or through sliding-scale payment plans. Also involved are the location of health care services, the availability of transportation to those locations, the hours when such health care facilities are open, and the quality of care available there. This school of thought holds that the ability to secure access to high-quality, culturally competent care is what enables a person to achieve health. Those who face financial and cultural barriers — as well as differences in the quality of care — thus have worse health outcomes.

Health requires personal health decisions. This belief states that people achieve health through personal decisions about tobacco, illicit drugs, nutrition, exercise, stress, and the use of available health services. Such decisions can lead to improved behaviors: People stop smoking or chewing tobacco, start eating more green and yellow vegetables, get up off the couch for a daily walk, and so on. Varying barriers to making good personal health decisions exist for different groups of people. *For example:* Those who grow up in poor neighborhoods are likely to attend worse schools than other people in the same city or county. In turn, they generally learn less about how the human body functions, what causes disease, that we make good or bad decisions all the time that impact our own

health, how advertising affects that decision making, and so on. This is one of many scenarios that lead to differences in health outcomes.

Healthy People 2010

“Healthy People 2010” is a comprehensive, nationwide initiative of the Federal government involving health promotion and disease prevention. Sponsored by the Department of Health and Human Services (DHHS), “Healthy People 2010 challenges individuals, communities, and professionals—indeed, all of us— to take specific steps to ensure that good health, as well as long life, are enjoyed by all.” It is meant to serve as a roadmap for improving the health of *all* people in the U.S. during the first decade of the 21st century.

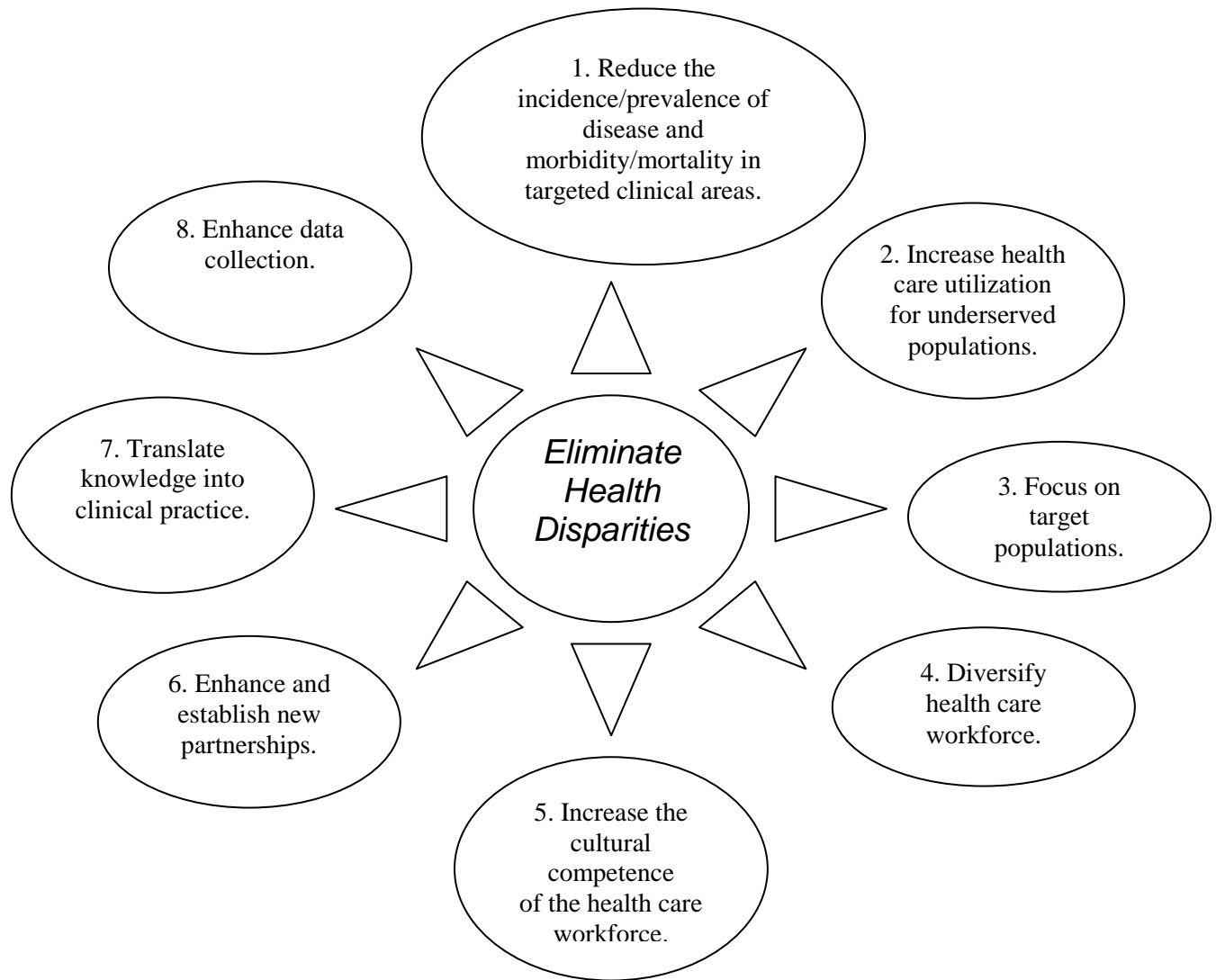
“Healthy People 2010” represents the ideas and expertise of a diverse range of individuals and organizations concerned about the nation’s health. It is designed to achieve two overarching goals:

- To increase quality and years of healthy life; and
- To eliminate health disparities.

Although significant advances have been made in the diagnosis and treatment of some diseases and conditions, there is still a long way to go. Diabetes and other chronic conditions continue to present a serious obstacle to public health. Many conditions now disproportionately affect women, communities of color, and low-income groups, that is, there are disparities in the presence of these conditions in certain populations within America.

These are addressed by the second goal of “Healthy People 2010.” DHHS seeks to eliminate health disparities, including those that occur by gender or sexual orientation, race or ethnicity, education level or income, physical or mental disability, or geographic location.

DHHS has developed a model with coordinated strategies for addressing health disparities, as shown in the following diagram:



Each of the eight strategies is detailed on the following pages.

Strategy 1: *Reduce the incidence/prevalence of disease and morbidity / mortality in targeted clinical areas.* The initiative focuses on:

- Physical Activity
- Overweight and Obesity
- Tobacco Use
- Substance Abuse
- Responsible Sexual Behavior
- Environmental Quality
- Immunization
- Mental health
- Injury and Violence
- Access to Health Care

Strategy 2: *Increase health care utilization for underserved populations.* This involves:

- Removing health care barriers;
- Establishing new health care access points; and
- Increasing employment of lay health workers.

Strategy 3: *Focus on target populations.* Specifically, the focus is on:

- Racial and ethnic minorities;
- Underserved males & females;
- People with low income;
- Rural and urban residents;
- Residents of the U.S. - Mexico border; and
- Lesbian, gay, bisexual and transgendered populations.

Strategy 4: *Diversify the health care workforce.* This strategy:

- Acknowledges that the patient-provider relationship is enhanced by ethnic, cultural and linguistic concordance; and
- Supports increased numbers of health care providers who are people of color and/or multilingual.

Strategy 5: *Increase the cultural competence of the health care workforce.* The initiative works to:

- Implement a plan to incorporate cultural competence principles throughout certain DHHS programs, practices and policies; and
- Enhance the cultural competence focus related to targeted clinical areas and populations.

Strategy 6: *Enhance and establish new partnerships.* This strategy:

- Acknowledges that communities with multidisciplinary partnerships are reducing health disparities; and
- Seeks new and enhanced partnerships that integrate primary health care and public health services.

Strategy 7: *Translate knowledge into clinical practice.* The initiative:

- Supports consistent utilization of evidence-based health care and population-specific health delivery practices; and
- Plans innovative strategies to bridge the gap between medical knowledge and clinical practice.

Strategy 8: *Enhance data collection.* This involves:

- Developing strategies for the collection of racial/ethnic, other demographic, and clinical data related to people using community health centers;
- Emphasizing data collection activities related to targeted clinical areas and population groups; and
- Identifying specific populations that suffer from health disparities in order to target future efforts accordingly.

To learn more about “Healthy People 2010,” you can visit www.healthypeople.gov.

Lesson B: Barriers to Health Care

Worksheet: Community Asset Map

Instructions:

6. *Read the entire map so you feel familiar with it.*
7. *Ask your facilitator to explain anything that is unclear to you about the map.*
8. *Fill in the Program Issue and Primary Stakeholder as directed by your facilitator.*
9. *Scan the flip pages mounted on the walls to find items from the brainstorming activity that match a category box on this map.*
10. *During Team discussion of each category, jot down key words of the resources already listed during the brainstorming.*

Lesson B: *Barriers to Health Care*

Worksheet: *Where Do We Go to Find...?*

Instructions:

- 1. Meet with a few other members to discuss the items below that the facilitator has assigned to you.*
- 2. Your goal is to locate at least three actual community resources for each type of information.*
- 3. Brainstorm several ways to locate such resources. Which can you work with immediately? Which will take longer?*
- 4. As you locate such resources, write the people and/or organizations into the appropriate box and be prepared to present to the team (a) what the resources are, and (b) how and where you located them.*

HIV EDUCATION, TESTING, & COUNSELING:
ENROLLMENT IN WIC:
PRIMARY HEALTH CARE FOR CHILDREN:
LEGAL ASSISTANCE:

TRANSPORTATION AND FINANCIAL SUPPORT:

EDUCATION & SUPPORT FOR DOMESTIC VIOLENCE:

MEDICAID ENROLLMENT:

FINANCIAL & BUDGETING ASSISTANCE:

PARENTING EDUCATION:

UP-TO-DATE IMMUNIZATIONS FOR INFANTS:

FOOD & CLOTHING:

BREAST-FEEDING SUPPORT:

GED & LITERACY INFORMATION / ASSISTANCE:

FAMILY PLANNING INFORMATION & CLINICAL SUPPORT:

JOB TRAINING:

NUTRITION EDUCATION:

IMMIGRATION GUIDANCE:

CHILD DEVELOPMENT SCREENING:

HOUSING AVAILABILITY AND SIGN-UP:

MENTAL HEALTH COUNSELING:

PRENATAL CARE:

LEAD POISONING EDUCATION & SCREENING:

CHILD CARE:

SUBSTANCE ABUSE HELP:

SCHIP ENROLLMENT: