



The Hanley Center is deeply grateful to the **Maine Centers for Disease Control's Office of Health Equity** for its support in the development of this guide.



*Paul R. LePage, Governor*

*Mary C. Mayhew, Commissioner*

## IN ALL FAIRNESS Facilitator Discussion Guide

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## Letter from the Hanley Center for Health Leadership

Welcome to the Facilitator Guide for IN ALL FAIRNESS, a video series produced to heighten awareness about health and healthcare disparities and to improve our collective understanding of the scope of inequities that affect people’s health and the healthcare they receive. With it, we hope to catalyze collective action to address health and healthcare inequities in our state. Changing policies and practices can help improve outcomes and save lives.

Differential access to care results from social, economic and political forces that advantage some groups and individuals over others. In the clinical encounter, despite the best intentions of healthcare providers, administrators, and staff, everyone brings their personal background and unconscious, “implicit” biases against some groups or individuals who are seen as “different.” Bringing these biases into conscious awareness and mobilizing a personal goal to be mindful, compassionate, and empathetic can also positively impact the health and healthcare experience of vulnerable populations.

More than just an issue for the poor, we see imbalances in health care services with Native Americans, African Americans, and Hispanic Americans as compared to Caucasians. Even though the 2008 census data for Maine reports that we have a predominantly white state at 97.4%, we still have a problem. (Other races in residence include American Indian /Alaska Native (1.1%) and Black (1.4%), while Hispanics of any race comprised 1.3% of the state’s population.) We also have a growing number of immigrants and refugees, adding welcome diversity and cultural richness to Maine’s communities. In addition to racial and ethnic minorities and people living in poverty, other groups in our society face health disparities as well. Individuals with behavioral health disorders, physical or developmental disabilities, those who are homeless or homebound, rural and isolated elders and LGBT populations are have also been shown to be at higher risk for experiencing health and healthcare disparities.



Over the past five years, the Hanley Center for Health Leadership has assumed a growing statewide leadership role in the health disparities/equity arena by:

- Incorporating this issue into the curriculum for its interdisciplinary Health Leadership Development program and its Physician Executive Leadership Institute programs;
- Training and supporting a corps of 20 Health Disparities Ambassadors who are leading efforts aimed at addressing disparities in communities across Maine;

- Building a long -term public health workforce development plan that will include building competencies in health disparities; and
- Creating a Health Equity Advisory Council made up of alumni of Hanley Center programs to support the organization’s ongoing efforts to promote health equity and to serve as a resource for the health and healthcare system in Maine.



At the Hanley Center, we look forward to working with you to underscore the impact of social determinants of health – not just as a backdrop — but also as a cause of health disparities. We welcome your partnership in examining, understanding, and eliminating inequities in the delivery of healthcare.

**Kathryn Vezina, MSN, RN, JD, Esq.**  
Associate Executive Director

## Introduction

### Health Disparities: What are we talking about?

Health disparities are defined as differences in health outcomes that exist when we examine populations by certain characteristics such as socioeconomic status, sexual identity, race/ethnicity, and gender, to name a few. Examples can include the incidence, prevalence, morbidity or mortality for cardiovascular disease, diabetes, cancer, etc. in one population compared to another. In the case of health disparities in racial/ethnic minorities, for example, outcomes for conditions such as HIV/AIDS or asthma in this group are benchmarked against the majority population to identify if differences exist between them.

This issue gained prominence with the inclusion of goals to eliminate health disparities that were developed as part of our nation's [Healthy People 2010 blueprint](#), and more recently with the annual release of the [National Healthcare Disparities Report by the Agency for Healthcare Research and Quality](#). The causes of health disparities are multifactorial, and variations in the quality of care individuals receive within the health care system—known as health care disparities—play a significant contributing role. Health care disparities themselves are multifactorial as well.

### Reasons for Optimism

Although we have seen some progress in efforts to address health disparities, improve health care quality, and achieve equity, there is still a lot of work to be done. Here are some reasons to be optimistic:

- Progressive leaders and organizations are re-examining their founding missions and taking risks to be leaders the field.
- New and ongoing research highlights the important link between equity, quality, and cost.
- New quality measures and accreditation standards are being established to support efforts to achieve health equity,
- Innovative approaches to address the needs of all populations, whether through population management or health information technology, are emerging rapidly.

All of this is happening under the backdrop of healthcare payment reform and the realization that what will separate success from failure in healthcare going forward will be how well we care for all individuals, especially the most vulnerable.

## Overarching Framework

This facilitator discussion guide provides a framework for increasing understanding of health and healthcare disparities by highlighting six of the many populations in Maine that experience health inequity. We consider these and other questions:

- What disparities are they experiencing?
- How did these disparities develop?
- How are they measured?
- What are the 'root causes'?
- What does the evidence tell us?

- What are some key disparities to be familiar with in your community?
- How do these disparities occur locally?
- What key strategies can be addressed to eventually prevent them?

Ideally, presentations of IN ALL FAIRNESS should highlight both health and healthcare disparities, and also disparities of multiple types (socioeconomic, race/ethnicity, gender, age, etc.) reflected in Maine’s population.

Where possible and appropriate, a key component of the presentation should include how disparities in health and healthcare fit within the context of health care reform, payment reform, health care redesign, and health systems transformation.

## About the Videos

IN ALL FAIRNESS explores how population health is shaped by the social and economic conditions in which we are born, live, and work. Through sharing the personal stories of diverse Maine residents, the vignettes reveal some root causes of health inequities and how the healthcare system is challenged to provide equitable care.

The first 16-minute film contains three vignettes covering three distinct populations:

- Somali refugees
- Frail, housebound elderly, and
- Homeless teenagers



The second film contains another set of three vignettes covering three different populations:

- Mentally ill, homeless and/or addicted individuals
- Transgender people (and indirectly LGBT as a whole)
- Tribal/Native American communities

Each is located in a different Maine community and focused on a different set of circumstances. The films also offer insight into the perspectives of healthcare consumers and providers, community leaders, and family members who are partnering to reduce disparities and promote quality of life for the featured populations.

## How to Use This Guide

While this guide includes a wide range of questions and activities that can be used to engage many types of audiences in a dialogue, we focus in particular on those who work in health systems.

**Rather than cover all the questions, choose the ones that work best for you. Facilitators should be prepared to work with diverse discussion groups within a limited timeframe.**

## First, the Facts: Maine Disparities Data<sup>1</sup>

In Maine, about one person in 10 (10.2%) did not have health insurance in 2010. This is significantly lower than the US rate of 15%.

In 2010 10.4% of all Maine people reported that they had experienced cost related barriers to getting healthcare. This is similar to the number reporting such in 2000, but it is an increase from 2006, which was the lowest percentage (8.8%) reported over the last 10 years.

Eighty eight per cent (88%) of Maine residents reported in 2010 that they had one person they thought of as their personal physician or other health-care provider. This number has not changed significantly in the past 10 years.

### Also...

- In general, women in Maine have better access to care with lower uninsured rates (8.3% compared to 12.2% for men), and higher rates of reporting a primary care provider (93.1% versus 83.3% for men).
- The barriers to care due to cost are not significantly different between men and women.
- American Indians and Asians have higher uninsured rates (16.3% and 14.6% respectively) than other races, while white non-Hispanics are less likely to report barriers to health care due to cost (9.2%) than American Indians, Hispanics or multiracial non-Hispanics.
- Life expectancy rates are more than 20 years lower for members of the four Tribal nations in Maine compared to Maine residents, according to Maine CDC Office of Health Equity.
- Bisexuals were more likely to report cost related barriers to health care (17.8%) than heterosexuals (8.4%).
- More education and having an income of over \$50,000 is associated with higher rates of having health insurance, having a primary care provider, and having fewer cost related barriers to care.

Change in Population, by Race/Ethnicity	2000		% Change
	2000	2010	
White	1,236,014	1,264,971	2.3%
Black/African American	6,760	15,707	57.0%
American Indian /Alaska Native	7,098	8,568	17.2%
Asian	9,111	13,571	32.9%
Native Hawaiian /Pacific Islander	382	342	-11.7%
Some other Race	2,911	4,261	31.7%
Two or More Races	12,647	20,941	39.6%
Hispanic	9,360	16,935	44.7%
Non-Hispanic	1,265,563	1,311,426	3.5%
Total Population	1,274,923	1,328,361	4.0%



<sup>1</sup> Sources: 2012 Maine Health Assessment: <http://www.maine.gov/dhhs/mecdc/phdata/sha/index.shtml>; Healthy Maine 2020 Chapter 1: Health Equity: <http://www.maine.gov/dhhs/mecdc/healthy-maine/documents/HM2020-HealthEquity.pdf>

## Participant Learning Objectives

Facilitators should build the content to address 2-6 **selected** objectives from those listed below based on the 30-minute, 90-minute or 3-hour session time frame. After viewing the videos and engaging in the work sessions, participants will be able to:

1. Identify the most common health disparities affecting populations where the participant works and/or in the participant's community
2. Understand the potential impact of implicit bias.
3. List at least five populations in Maine that are affected by healthcare inequities, in addition to racial, ethnic, and language minorities.
4. Assess (or critically reflect on) how health disparities impact people in the healthcare professional's work and personal settings.
5. Identify innovative strategies that health and healthcare professionals can use to promote health equity and/or address health disparities in their healthcare environment and/or community.
6. Explain how promoting health equity enhances the overall quality of population health, health care services, and health outcomes.
7. Report increased confidence in talking with health professional colleagues and others about health equity and health disparities.
8. Identify a specific action step that the participant will take to address health disparities on an individual, organizational, and/or societal level.

### Suggested audiences for video

Hanley Center Programs

- Health Leadership Development
- Physician Executive Leadership Institute
- Public Health Workforce Project
- Health Professionals' Organizations
- Health Care Conferences
- Health Care Organizations
- Public health organizations
- Clinics
- Hospitals
- Home health agencies
- Mental health organizations
- Public Health Practitioners
- Educators

## Facilitator Objectives

1. Assure that participants can meet the above selected outcomes, as chosen by the facilitator.
2. Support participants in developing and/or building their awareness of health and healthcare disparities in Maine.
3. Support participants in developing and/or building their understanding and knowledge of strategies to lead change to improve health equity and reduce healthcare disparities.
4. Create safe opportunities for dialogue and engagement about how to improve health outcomes for persons affected by health and healthcare disparities.
5. Gather ideas and reflect back to participants about what more can be done to promote awareness of health disparities and to promote health equity.
6. Assist participants with understanding their role in promoting health equity.
7. Share tools, strategies, resources and information about innovative practices in Maine utilized for improving health equity.

## Facilitator Guidelines

Your job, as the facilitator, is to listen with compassion and provide coaching and guidance. The facilitator does not lecture but encourages participation and keeps the discussion focused and flowing, honoring the time limits allotted to the discussion. Be prepared to accept reactions to the film without judgment – stay neutral. If necessary, gently guide participants to consider how their personal experiences or concerns reflect larger systems, structures, and policies.

Use these as guidelines for working with your group, but don't allow the list below to thwart you from the conversation! Most professionals have good meeting skills, and the film is better shown than not shown – discussed than not discussed. In general, great facilitators have the following characteristics. They:

1. Create a safe environment in order for the group to open up and become actively engaged in the discussion.
2. Stimulate the interaction and the free sharing of thoughts and ideas.
3. Are masterful and engaging listeners.
4. Provide the structure for the discussion. Set the parameters and the intention, and guide the conversation.
5. Support the well-being of each participant as well as the group.
6. Utilize the art of the open-ended question to create and cultivate new possibilities that stimulate new thinking.
7. Tap into the wisdom of each person, as the value derived in each discussion is a result of the co-creation and wisdom of the group (vs. dominates the discussion.)
8. Are fluid and flexible vs. rigid.
9. Connect with the group, are authentic, and share themselves with others/are fully self-expressed.
10. Plan effectively, yet are fluid based on the atmosphere and needs of the audience.
11. Have fun and are passionate about the transformational process that occurs.

## Leading Discussion

Regardless of the topic, a successful film screening is one that allows participants to:

- watch purposefully and critically,
- reflect upon what they've seen, and consider new information and how it affirms/conflicts with preconceived ideas,
- then brings viewers' attention back to their own situation and how they might tackle inequities.

### How long should the video and the discussion take?

This facilitator's guide proposes a variety of content to choose from, and is designed to be presented in either a 30-minute, 90-minute or 3-hour segment. See Appendix for sample curricula.

## Components of the Session Design

1. **Before & After Video Discussion Starters** – These pre- and post-viewing suggestions help people become more aware of the pre-conceptions and beliefs they bring to these issues.

2. **Reflection and Comprehension Segment** – Use these to spark discussion and deepen understanding of key ideas and concepts from the video series.
3. **Focusing on What You Can Do Segment** – After viewing, these will help shift the group’s attention away from the screen and onto opportunities for action.

## Our Assumptions

It’s important to acknowledge existing ideas about health, healthcare, and patient “compliance” in order to examine our assumptions – especially those that make **us** resistant to new ways of thinking. The following **four** suggestions may be helpful:

### Understand Common Perceptions

People typically view and interpret health outcomes and social inequities through three dominant lenses that ultimately reinforce the status quo:

1. **Personal Responsibility.** Poor health stems from individuals making unhealthy choices.
2. **Unfortunate but not unjust.** Hierarchies are everywhere. Life isn’t fair, and differences in group health, like wealth disparities, will always be with us.
3. **Nothing can be done.** If health inequities do in fact arise from structural inequities in the rest of society, then what can be done short of a revolution?
4. **I am not biased against any sector.** I am well educated and have learned that all people deserve equal treatment.

### Discussion Question

How does this video affirm or contradict the status quo?

## Implicit Bias

Those who work within health systems can be proactive in addressing health disparities on individual and collective levels. Healthcare providers, even those who are trained to be culturally competent, often bring unconscious biases to their evaluation and treatment of some patients.



“**Implicit bias**” is that negative evaluation of one group relative to **another** that is activated quickly and unknowingly by situational cues such as skin color, accent, or physical appearance.

“Implicit bias” operates without the person’s intent or awareness and influences perception, memory, nonverbal communication, and other behaviors.

The impact of implicit bias is best documented for racial and ethnic minorities, but research also suggests other groups affected include the mentally ill, gay/lesbian/bisexual/transgender (LGBT), obese, drug-addicted, and low income individuals.

### **Discussion Questions**

Since we all have them, how can we learn more about our own personal biases?  
How can we employ what we learn to improve healthcare?

### **Ask a New Kind of Question**

We want to stimulate new dialog by shifting the types of questions we ask:

#### **Discussion Question:**

Instead of asking “What medication or procedure should be prescribed to improve this patient’s health outcomes?”

Try – “How can we target dangerous conditions and ensure better health outcomes?”

#### **Discussion Question**

Instead of asking “How can we improve patient compliance?”

Try – “What is different about Maine that makes it easier or more difficult to address health inequities?”

#### **Discussion Question**

Instead of asking “How can we get individual patients to change their behavior?”

Try— “How can community organizing and alliance building help create policies that protect the public good?”

Questions like these help redirect our attention away from blame and victimization towards larger structural conditions, collective problem solving, and policy change. Other useful questions might include: who benefits from particular actions and decisions, who bears the cost, and who has the power to make decisions about how resources are allocated?

### **Establish Common Ground for Action**

Finally, you can help attendees to leave feeling engaged and energized by encouraging them to look at how change happens and asking them to generate suggestions for action. Here are a few useful reminders:

- Ask what people think they can do on a personal or one-to-one level that will begin to help one or more of these populations.
- Note that because our health is shaped by public policies and larger socio-economic conditions, improving population health demands a collective (not just an individual) response.
- Talk about what people might do together that they would not be able to do working alone.
  - Who are natural allies?

- What other groups can be engaged—community residents, government agencies or elected officials, churches and other community-based organizations, the media, foundations?
- For those working in healthcare, what other individuals or groups within your own organization?
- Be prepared to assist with networking efforts
  - (e.g., collecting and distributing the names and contact information of attendees),
  - identifying local issues and priorities,
  - engaging potential allies, and
  - setting up future meetings and screenings (e.g., reserving a meeting site for the following week or distributing flyers announcing an event for a partner organization).

### **Other Considerations to explore**

- Consider how best to recommend practices that ensure representation of populations experiencing disparities in your organizations advisory council, board, leadership, staff, and client feedback mechanisms (*i.e.* satisfaction surveys).
- Consider how to recommend changes in your organizations data collection and analytic functions so as to better identify disparities in access, satisfaction, and outcomes.
- Consider incorporating the evidence based National Standards for Culturally and Linguistically Appropriate Services (CLAS) into your operating procedures, policies and communications to staff and communities served.
- Consider what public and organizational policies exist to guide staff in providing equitable care (examples: Language Access Policy, Confidentiality Policy).
- Consider what accrediting bodies require as proof of an organizations engagement and support of vulnerable populations.

### **Key concepts**

Using the examples provided in the three vignettes, identify:

- the difference between individual health and population health
- the social determinants of health
- how health care inequities impact health
- how social and economic conditions and structures affect health
- how the allocation of resources affects health and health care
- what policy changes in your organization might be envisioned to improve healthcare for the vulnerable populations you serve
- what more global policy changes might be envisioned to improve health

**The handout “Ten Things to Know about Health” (included in Appendix D and at [www.unnaturalcauses.org](http://www.unnaturalcauses.org)) may also help prompt discussion.**

Select a few points and ask: What did you see that supported this? Are you convinced that this is true? Why or why not? What questions do you still have and how might you find answers to those questions?

## Appendix A

### Sample Curricula

#### Sample 30-minute Curriculum

##### Target Audience

Individuals working in health care or public health who have an interest in learning more about health disparities in underserved populations in Maine.

##### Intro - 5 minutes

1. Some people start each viewing with a minute of pause / stillness or an opening quote. This minute facilitates a quieting of inner noise/hurriedness.
2. Introduction to health disparities in Maine- distinguish disparities from inequities---central role of values in decision-making
3. Opportunities for intervention –clinical encounter; community/public health; health systems; policy at every level
4. Focus for now on only 3 of many specific health disparities populations in Maine

##### Show video – 16 minutes

##### Discussion Q's: Pick 1-2 – 9 minutes

1. What response did you have to the film?
2. What's the burning question that's generated?
3. What resonates for you in your daily practice? What surprises you?
4. How well do these three scenarios reflect health disparities populations in Maine?
5. What other populations might we consider health disparities populations in the State?
6. Write down a single action item that you can take to respond to what you have learned here.

#### Sample 90-minute Curriculum

##### Target Audience

Individuals working in health care or public health who have an interest in learning more about health disparities in underserved populations in Maine.

##### Reflection & Comprehension – 10 minutes

Some people start each viewing with a minute of pause/stillness or an opening quote. This minute facilitates a quieting of inner noise/hurriedness.

Introductions around the table.

### Show video – 16 minutes

#### Personal reactions – 10 minutes (This is a critically important phase of the discussion.)

Have the participants write their answers to the first question. Ask for volunteers to share with class.

- ❖ How is this film similar to or different from other media you have seen, read, or heard on this issue or community? In what ways did it confirm or challenge ideas you held?
- ❖ What stood out as surprising or disturbing for you in the film? Describe a moment or scene that affected you and why.
- ❖ What questions / issues surfaced that you would like to know more about?

#### Further discussion – 20 minutes

Choose another question from above or from the discussion questions contained in the guide to have them talk about in pairs or threesomes.

#### Focusing on What You Can Do – 15-20 minutes

Have the group break into groups of 3-4. Ask them each to consider one of the following questions. Allow 20 minutes for the group to work together, then call them back to share highlights. Ask them to include in their thinking one element for addressing disparity that they can take back to their setting and begin to work on immediately.

1. **What elements depicted in this film reflect the health disparities populations with whom you work?** Which issues most affect health in those populations, for better and worse: housing, jobs, income, transportation, racism, schools, social exclusion or civic engagement, land use and development...? How?
2. **Who makes the decisions that affect the health and health care provided to these populations?** How can community members gain access to power? How might you change the ways in which the health system serves the needs of this group? What decisions would you make differently?
3. **What experience have you had as a patient?** Have you experienced situations where you were treated differently because of your status, background, or membership in a disadvantaged (or advantaged) group? How has this experience influenced your actions as a health/healthcare professional? How have you shared your experience??
4. **How can you work to improve the health systems environment for this population?** What are the greatest challenges? What additional resources are needed? Who are your natural allies and how will you begin creating alliances and partnerships? What are your priorities for action? What will you do about this when you leave this meeting?
5. **Brainstorm interventions to address health issues** for one (or all three, time permitting) of the populations in the video at three levels:
  - a. clinical encounter
  - b. community/public health
  - c. health systems
6. **Identify which of the proposed interventions are or could become policy interventions.**

**Wrap-up – 5-10 minutes:** Go around the table and ask each person for one specific takeaway from the learning experience.

## Sample A - 3-hour Curriculum

### Target Audience

Individuals working in health care or public health who have an interest in learning more about health disparities in underserved populations in Maine.

### Reflection & Comprehension – 10 minutes

Some people start each viewing with a minute of pause/stillness or an opening quote. This minute facilitates a quieting of inner noise/hurriedness.

Introductions around the table.

### Implicit Bias – 30 minutes

As a warm-up to considering health disparities, we're going to look inward at the possibility of implicit bias.

### Show PowerPoint (Appendix F)

### Johari Window (Appendix G)

Implicit bias can be understood another way using the grid of the Johari Window.

<b>Open</b> I know (about my biases) and you know	<b>Blind</b> You know, but I don't
<b>Hidden</b> I know, but you don't	<b>Unknown</b> Neither you nor I know

In which quadrant do you think biases live? [They live in all quadrants.]

### Show 1<sup>st</sup> video – 16 minutes

### Personal reactions – 10 minutes (This is a critically important phase of the discussion.)

Have the participants write their answers to the first question. Ask for volunteers to share with class.

- ❖ How is this film similar to or different from other media you have seen, read, or heard on this issue or community? In what ways did it confirm or challenge ideas you held?
- ❖ What stood out as surprising or disturbing for you in the film? Describe a moment or scene that affected you and why.
- ❖ What questions / issues surfaced that you would like to know more about?

### Further discussion – 15 minutes

Choose another question from above or from the discussion questions contained in the guide to have them talk about in pairs or threesomes.

### **Case study – 30 minutes**

Choose one of the case studies in Appendix B to have the class read and discuss. (Facilitator notes on case studies also in Appendix B.)

### **Show 2<sup>nd</sup> video – 15 minutes**

Personal reactions?

### **Focusing on What You Can Do – 30 minutes**

Have the group break into groups of 3-4. Ask them each to consider one of the following questions. Allow 20 minutes for the group to work together, then call them back to share highlights. Ask them to include in their thinking one element for addressing disparity that they can take back to their setting and begin to work on immediately.

7. **What elements depicted in this film reflect the health disparities populations with whom you work?** Which issues most affect health in those populations, for better and worse: housing, jobs, income, transportation, racism, schools, social exclusion or civic engagement, land use and development...? How?
8. **Who makes the decisions that affect the health and health care provided to these populations?** How can community members gain access to power? How might you change the ways in which the health system serves the needs of this group? What decisions would you make differently?
9. **What experience have you had as a patient?** Have you experienced situations where you were treated differently because of your status, background, or membership in a disadvantaged (or advantaged) group? How has this experience influenced your actions as a health/healthcare professional? How have you shared your experience??
10. **How can you work to improve the health systems environment for this population?** What are the greatest challenges? What additional resources are needed? Who are your natural allies and how will you begin creating alliances and partnerships? What are your priorities for action? What will you do about this when you leave this meeting?
11. **Brainstorm interventions to address health issues** for one (or all three, time permitting) of the populations in the video at three levels:
  - a. clinical encounter
  - b. community/public health
  - c. health systems
12. **Identify which of the proposed interventions are or could become policy interventions.**

### **Wrap-up – 15 minutes**

Go around the table and ask each person for one specific takeaway from the learning experience.

How was the learning experience for you?

Plus/Delta

Total time = 171 min

## Sample B - 3-hour Curriculum

### Target Audience

Individuals working in health care or public health who have an interest in learning more about health disparities in underserved populations in Maine.

### Opening 10 minutes

- Facilitator Introduces themselves
- Goals and Learning Objectives
- Reflection & Comprehension-Some people start each video viewing with:
  - a moment of pause/stillness or
  - an opening quote.
- This minute facilitates a quieting of inner noise/hurriedness.

### Introductions /Ice Breaker 15 minutes

- Each person around the table introduces themselves
  - Name
  - Where they work
  - Work Role
  - Why they are here today

### Group Guidelines for Engagement 5 minutes

#### *Transition Script*

### Show video 16 minutes

### Personal Reactions and Reflections 30 minutes

*(This is a critically important phase of the discussion.)*

- Have the participants reflect on and write their answers to this question. (2-3 min)
  - *How was that for you?*
  - Ask for volunteers to share with class. (10-12 min)
- What stood out for you in the film?
- In what ways did it confirm ideas you held about \_\_\_\_\_?
- In what ways did it challenge ideas you held about \_\_\_\_\_?
- Describe a moment or scene that affected you and why.
- **What experience have you had as a patient?**
  - Have you experienced situations where you were treated differently because of your status, background, or membership in a particular group (advantaged or disadvantaged)?
  - How has this experience influenced your actions as a health/healthcare professional?
  - How have you shared your experience?
- What questions / issues surfaced that you would like to know more about?

### Break 15 minutes

### Implicit Bias + Assumption Discussion 30 Minutes

### What You Can Do 40 minutes

- Have the group break into groups of 3-4. (5 minutes)
- Ask them each group to consider **2** of the following questions.
- Allow the group to work together for 20 minutes on each question (30 min)
- Then call them back into the large group to share highlights of their discussion.
- Ask them to include in their thinking one element for addressing disparity that they can take back to their setting and begin to work on immediately.

**13. What elements depicted in this film reflect the health disparities populations with whom you work?**

- Which issues most affect health in those populations, for better and worse:
  - housing,
  - jobs,
  - income,
  - transportation,
  - racism,
  - schools,
  - social exclusion or civic engagement,
  - land use and development...?
- How?

**14. Who makes the decisions that affect the health and health care provided to these populations?**

- How can community members gain access to power?
- How might you change the ways in which the health system serves the needs of this group?
- What decisions would you make differently?

**15. How can you work to improve the health systems environment for this population?**

- What are the greatest challenges?
- Who are your natural allies?
- What additional resources are needed?
- How will you begin creating alliances and partnerships?
- What are your priorities for action?
- What will you do about this when you leave this meeting?

**16. Brainstorm interventions to address health issues** for one (or all three, time permitting) of the populations in the video at three levels:

- a. clinical encounter
- b. community/public health
- c. health systems
- d. **Identify which of the proposed interventions are or could become policy interventions.**

**Wrap-up**

**15 minutes**

Go around the table and ask each person for one specific takeaway from the learning experience.

Total time = 176 min (2.93 hrs)

## Appendix B

### Racial and Ethnic Disparities in Health and Health Care: Cases for Analysis and Discussion

#### CASES ARE FOR POTENTIAL USE IN 90-MINUTE OR LONGER SESSION

##### Case #1

Mr. J is a 66 year-old African-American man who lives in the Bayside neighborhood of Portland, ME. He was born and raised in Louisiana (about two hours outside of New Orleans) and came up North when he was about 17 years old with his parents. They migrated to start a small grocery store in Portland with some old friends who had moved up a few years prior. His parents are since deceased. Mr. J lives in a small home he owns with his wife; his daughter is married and lives in Atlanta, and his only son was shot and killed about twenty years ago after moving back to New Orleans and getting caught up with some youth gangs.

Mr. J remembers that as a child he used to have to travel what seemed like hours to see the doctor because they lived out in the “country”. He has fond memories of those days, and still says his current bad eating habits stem from those days when they “fried everything they could and ate what they could afford”. Mr. J graduated from high school before he left Louisiana, and had just about gotten his Associate’s Degree at a community college and night school in Portland when his children were born, and he could no longer afford school. Mr. J still helps run a print shop, a job he considers extremely tough as there are always impending deadlines for contracts such as the monthly college newsletter, among others. He doesn’t want to retire because he loves being active, and his social security check “just won’t pay the bills”. A few years ago he was diagnosed with high blood pressure, which he said was probably caused by all the stress in his life, including the violence he’d seen as a young man in Louisiana and the violent death of his son, the stress of work, and the stress of “being a black man in a mostly white state”.

Mr. J was started on medications for his hypertension a year ago, but between the cost of the pills (he’s on Medicare) and the fact that he believes his pressure goes up when he’s stressed, he hasn’t been taking them regularly. He feels if he just relaxes, his blood pressure will come down, and his sense is that this strategy works because he never feels his pressure is high. He is able to do some walking, as someone suggested this was good for him, and tries to eat healthier (he felt fortunate living in Portland as he remembered talking to his cousin who lives in the Bronx and is afraid to go out walking because of crime, and who can’t get fresh vegetables in the neighborhood like he can). Mr. J doesn’t particularly like going to doctors because his old uncle in Louisiana used to complain about them and their “crazy ways.” As a result, Mr. J’s always tried to deal with health problems himself.

About a month ago, Mr. J started to feel some chest discomfort while he was carrying some boxes at the print shop. He thought this pain was due to the weight of the boxes, and started to take Tylenol for what he felt was just some muscle strains. He'd even started to get sweaty on occasion, and again attributed this to the hard work of moving the boxes around. He also thought the symptoms could be an acid stomach and reflux which he knew a close neighbor had in the past. After about three weeks when his discomfort persisted, a co-worker finally convinced him to get this checked out.

After searching around for a doctor, he finally secured an appointment at a group practice a friend recommended. He reluctantly went to his appointment at his wife's urging. Upon presenting to the physician, he described the pain as being related to his stomach. He also mentioned to the doctor, however, that he had heard that African-Americans suffered from a lot of conditions that whites didn't, and that in some cases they were actually treated differently. The doctor shrugged this off and said that he treated all his patients the same...and that he hadn't really read anything in the medical literature to support Mr. J's claims. He guaranteed Mr. J he'd get the best care possible, and started him on some acid-suppression therapy for a presumptive diagnosis of esophageal reflux (Mr. J wasn't a smoker or a diabetic, and didn't know much of his family history). The physical exam also revealed that Mr. J did indeed have high blood pressure, and so the doctor started him on a blood pressure medication from the ACE-Inhibitor class as well. Various blood tests were also done. An EKG was not significant for signs of heart damage.

About two weeks later, Mr. J returned to the doctor for follow-up. At this time, his blood pressure remained elevated, and his cholesterol was found to be high as well. He mentioned that his chest discomfort hadn't disappeared, despite no longer carrying boxes around at work. The doctor increased the acid-suppression medication and added another anti-hypertensive medication to Mr. J's regimen, saying that, "we should be able to handle this with medications...but we may want to do some other tests in the future if this continues".

Two days after his visit, Mr. J woke up at 6am with sharp chest pain that just wouldn't go away... and at noon he finally decided he should go to the Emergency Room. Upon arrival and work-up he was found to have suffered a small heart attack. He was admitted to the Cardiac Intensive Care Unit and an intern quickly explained he should get a cardiac catheterization in the next day or so to determine which arteries might be blocked...while simultaneously explaining that there was also a chance of heart attack, stroke, infection, bleeding, and arrhythmia as a result of the procedure. Mr. J didn't like the sound of this, and the intern acquiesced and suggested he may want a less invasive diagnostic procedure.

Mr. J agreed to a nuclear stress test, and was found to have two areas of the heart that might be suffering from limited blood flow. He was discharged on a medical regimen to control his symptoms, and was told to follow-up with a cardiologist for further consideration of catheterization in the future.

## Case #2

Mrs. L is a 33 year-old woman who lives with her husband and 7 year-old son, Hector in Biddeford, ME. Mr. and Mrs. L immigrated from the Dominican Republic (DR) about ten years ago. Both of them were raised in a little beach town on the northern coast of the DR named La Romana. While there, Mr. L worked as a gardener and Mrs. L worked as a housekeeper at a resort in Puerto Plata. Despite being employed, they had difficulty making ends meet, and there was no health care available to either of them (which wasn't necessarily a problem they had never been sick). After receiving word from their cousin that he'd gotten a good paying job in Biddeford and moved his entire family there, they decided to come to the United States to find work, save money to send to the family back home, and make better lives for themselves here.

Upon first arriving, Mr. and Mrs. L moved into a housing project that abutted a small incinerator and trash dump. Despite trying to get upgraded to a nicer apartment, they had been unsuccessful to this day. Lately though, there were renovations underway in their building, with placement of new dry wall. A few months ago, Hector started to develop wheezing at night associated with occasional difficulty breathing. He started to become tired while at school (he's in 2<sup>nd</sup> grade), and started missing classes fairly regularly. Several children in Hector's building were having similar problems.

Mr. and Mrs. L had gotten all of Hector's childhood immunizations at a school-based clinic that was defunded last year, and although they both worked here (Mr. L for a small local landscaping and snow clearing contractor and Mrs. L for a local restaurant), neither of them had health insurance. A neighbor of Mrs. L told her about a new insurance program for children called—she couldn't remember what—but she urged Mrs. L to look into it so she could get Hector some medical attention for his symptoms. Both Mr. and Mrs. L had limited English proficiency, although they both finished high school while in the DR.

Mrs. L was told she could both enroll in that special insurance program and get health care at a hospital in Portland, but it was difficult to get there because she didn't have transportation. Finally, Mrs. L found someone who could take her to Portland, and she got the insurance forms for Hector. After getting assistance filling out the forms, she was referred to the Pediatric Clinic to schedule an appointment for her son. Mrs. L had difficulty finding the Clinic, though, because all of the signs at the hospital were in English only. She finally arrived at the Clinic and asked if there were any Latino physicians, given that she only spoke Spanish—but there were none there on staff. She was given an appointment in six weeks.

In the meanwhile, Hector's condition persisted. Mr. and Mrs. L tried various home remedies to treat his symptoms, including herbal teas, steam baths in their bathroom (using the steam from the hot running water in the shower), and running a humidifier in his bedroom loaded with Vicks Vapo-Rub. One night they even had to bring Hector to the Emergency Room at the local community hospital when his wheezing got bad. After waiting 7 hours, Hector was treated with a nebulizer, and Mr. and Mrs. L were told their son likely had asthma and he should follow-up with the visit they had scheduled. The one on-call Spanish interpreter for the hospital was busy seeing other patients at the time of discharge, so the nurse gave the discharge instructions as best she could in English, instructing them to use an albuterol (beta-agonist) inhaler every four to six hours when Hector began wheezing. They understood this to

mean that Hector should use the inhaler *only* when his wheezing got bad, and that it should be used no more than twice a day, separated by four to six hours. They also understood that he would be better once he finished the inhaler they'd been given. This sounded okay to them, since they felt these symptoms would pass once the construction stopped in their building anyway. Either way, they never really understood how to coordinate the inhaler with the child's breathing.

Mrs. L took off work and pulled him out of school on the day of his appointment, and had to take a very expensive cab ride to get to the hospital. A Spanish-speaking clerk helped her fill out her intake paperwork upon arrival and she was promptly escorted in to see a doctor. Prior to going in, the clerk told her to make her points quickly, as the doctors in the clinic were compensated by how many patients they saw in a day and as such tended to rush and overbook.

Although there was supposed to be an interpreter for the encounter, there was none available at the time. The doctor knew a few words in Spanish, and Mrs. L knew some words in English, so between them they tried to communicate and get to the bottom of the Hector's case. Although Mrs. L explained that Hector still was getting bouts of wheezing while on albuterol, the doctor felt they weren't using it correctly and briefly reviewed how it should be taken. He reinforced the importance of taking this medication when Hector began to wheeze. He also gave her a "peak-flow" monitor so she could see how his breathing was at different times, and she was given instructions for a dust-free mattress cover for his bed (which she couldn't afford and wasn't concerned about since she kept the house in immaculate condition).

Mrs. L, and occasionally Mr. L, continued to follow-up with Hector when they could, but the clinical practice was only open during business hours and they couldn't afford to take off from work or the transportation to get there so they missed several scheduled visits over the course of a year. Hector's condition remained unchanged, and although he was a bit better on the albuterol, he would still get break-through wheezing. Mrs. L had recently seen that one of Hector's classmates used a different type of inhaler for his asthma—someone said something related to steroids—and he'd done very well. A few days ago Mrs. L brought Hector to the Emergency Room when he became markedly short of breath in the middle of the night.

### Case #3

Ms. S is a 28 year-old woman who has lived in Old Town, ME for the last six years. She was born and raised in Lisbon Falls, ME, an old industrial town that became socioeconomically downtrodden in the late 1970's with the closing of several large factories. Her parents had migrated from North Carolina to Lisbon Falls in the 1960's to secure promising work, but they both lost their jobs when the factory where they were employed closed down. Due to these difficult circumstances, Ms. S dropped out of school in 9<sup>th</sup> grade to help her family and siblings manage the crisis (which included doing spare jobs such as babysitting, etc.).

Although she received her childhood immunizations, she never had health insurance and her only experience with the health care system was visiting public health clinics about once every 3 years for anything major that arose, including two bouts of strep throat which required antibiotics.

Ms. S moved to Old Town when she was 22 years old to follow her boyfriend from Lisbon Falls who had a chance to start a job as a pizza delivery driver. They got a small apartment in a poor neighborhood as that was all they could afford, and were married about one year later. Ms. S, despite her limited formal education, was able to get a part-time job in local grocery store. This job didn't provide her with any health insurance. Fortunately, though, her spouse's job provided health insurance (through managed care) for both of them.

About four years ago, her spouse became addicted to drugs. She was never really sure what type, as he kept this very private (although she suspected oxycodone). According to him, stress from work and the closing of the community gym where he worked out were the "factors that tipped him over." He had trouble getting help initially as services weren't available locally, but some friends at their church pulled him through and he seemed to quit using shortly thereafter. Several months later he and Ms. S separated, although he kept her on his insurance.

Six months ago, Ms. S began to feel a little fatigued. Although she attributed her symptoms to long hours of work, her co-workers encouraged her to go to the doctor as there was a bad case of "flu" going around. She tried to make an appointment with several local doctors but was told she would have to wait 2 months for an initial visit. She ended up going to the outpatient center of a hospital about 15 miles away before her scheduled doctor's visit (she never had "appointments" when she went to the health center back in Lisbon Falls). Upon arriving, she was handed a set of intake forms to fill out. She went over to the secretary and said she didn't have her reading glasses with her, and asked if she could help her fill the forms out. Ms. S was then called in to see the physician, who did a complete history and physical and ordered a set of blood tests. One week later, Ms. S returned for a brief follow-up and found out she was HIV positive. She kept this completely secret given what she'd seen and heard about the way people with this disease were viewed in the community.

Ms. S was referred to an Infectious Disease specialist in one of the hospital practices, but again had to wait close to six weeks before she could be seen. Additionally, when she went for her visit, she was told she couldn't be seen because she didn't have her insurance card and authorization for the referral. Two weeks later when she arrived with the correct authorization and paperwork she began chatting with the secretary and asked, quietly, whether they saw many poor people at this practice. The secretary responded "I guess we see a good amount, but we don't collect that type of information here so I couldn't tell you exactly".

She was called in to see the doctor, and during the visit was told that her CD-4 count and viral load (both markers for disease progression) were low and high enough, respectively, so that she should begin HIV therapy. The doctor mentioned that there are many "complicated" treatments that may be hard to follow, so she should start on one medication, Retrovir, 300mg every 12 hours. Ms. S thought she understood most of what the doctor said, but many times she felt the language he used to describe the condition and treatment was too complex. She was given a booklet that explained HIV disease and a pamphlet on the side effects of her medication. Ms. S asked whether she could talk to someone in more detail about the medications, but she was told no one was available.

Ms. S continued to follow-up when she could, but the clinical practice was only open during business hours and she couldn't afford to take off from work so she missed several scheduled visits over the course of a year. Her condition continued to progress rapidly, and although she wasn't pleased with her ten minute visits with the doctor every few months, she didn't have many choices. A few days ago she presented to the Emergency Room with a few days of worsening cough and some shortness of breath with exertion.

## Case Review: Assignment and Instructions

1. Introduce yourselves to each other, and identify your particular areas of interest and expertise as it relates to public health and/or health care.
2. Based on these interests, divide your group into **three teams**:
  - Team One will focus on the **community health/public health aspects** of the case. This includes issues related to social determinants of health (housing, environment, socioeconomic status, employment, violence, education, transportation, etc.).
  - Team Two will focus on the **health systems aspects** of the case. This includes issues related to the way our health care system is designed, and financed, and the way health care is delivered at the national, local and institutional level (including access to care, data collection, structural processes and organization of care, health workforce issues, etc.).
  - Team Three will focus on the **clinical encounter aspects** of the case. This includes issues related to provider patient communication, clinical decision making, patient preferences, mistrust, health beliefs and behaviors, literacy, use of complementary and alternative medicine, etc.).
3. Each team will examine the case from their specific assigned perspective, and will report out regarding the following questions:
  - What are the potential root causes of the disparities presented? For example, from the community health/public health perspective, what are the key issues that arise (e.g. role of the environment on the disparity presented in the case, etc.)
  - What interventions could be developed to address the root causes of the disparities? (e.g. are there any interventions that can address the environmental issues identified, etc.)

### KEY ISSUES

- Although we are breaking the group into three teams to look at specific aspects of the case, collaboration and coordination between the teams is essential. If possible, we do not want three complete stand-alone presentations about the case—instead we'd like to see where recommendations are coordinated between the teams. This imitates real-life, team-based approaches to public health and health system interventions and design.
- The case provides several key issues and prompts for discussion and exploration, but do not feel limited by the information that is provided. As a team, you may identify other issues that might arise from the circumstances surrounding the case. Feel free to highlight these issues and present them.
- We encourage creativity and thinking creatively. In as much as you can, try to come up with interesting ways to address some of the problems you identify, and try to develop interesting ways to present your information. This can include pictorials, videos, examples of media campaigns, etc., etc., etc....let your imaginations run wild, and make it fun and engaging if you can (no need to stick with the standard-fare presentation styles).

## Appendix C

### Glossary of Terms

#### HEALTH DISPARITIES

A **Health disparity** is defined as a particular type of health difference that is closely linked with social or economic disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater social and/ or economic obstacles to health and/or a clean environment based on their racial or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation; geographic location; or other characteristics historically linked to discrimination or exclusion.

#### HEALTH CARE DISPARITIES

**Healthcare disparities** are differences among population groups in the availability, accessibility, and quality of healthcare services aimed at prevention, treatment, and management of diseases and their complications, including screening, diagnostic, treatment, management, and rehabilitation services.

#### HEALTH EQUITY

**Health equity** is attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities.

#### HEALTH INEQUITIES

**Health inequities** are those differences in health outcomes related to membership in a disadvantaged group and that are avoidable and the result of structural inequities in society.

#### IMPLICIT BIAS

**Implicit bias** is that negative evaluation of one group relative to another that is activated quickly and unknowingly by situational cues such as skin color, accent, or physical appearance. Implicit bias operates without the person's intent or awareness and influences perception, memory, nonverbal communication, and other behaviors. The impact of implicit bias is best documented among racial and ethnic minorities, but research also suggests other groups affected include the mentally ill, gay/lesbian/bisexual/transgender, obese, and low income individuals.

#### POPULATION HEALTH

**Population health** has been defined as the health outcomes of a group of individuals, including the distribution of such outcomes within the group. It is an approach to health that aims to improve the health of an entire human population.

#### RACISM

**Racism** consists of both prejudice and discrimination based in social perceptions of biological differences between peoples. It often takes the form of social actions, practices or beliefs, or political systems that consider different races to be ranked as inherently superior or inferior to each other, based on

presumed shared inheritable traits, abilities, or qualities. It may also hold that members of different races should be treated differently

### **SOCIAL DETERMINANTS OF HEALTH**

**Social determinants of health** are the economic and social conditions – and their distribution among the population – that influence individual and group differences in health status. They are risk factors found in one's living and working conditions (such as the distribution of income, wealth, influence, and power), rather than individual factors (such as behavioral risk factors or genetics) that influence the risk for a disease, or vulnerability to disease or injury

### **SOCIAL POLICY**

**Social policy** primarily refers to guidelines, principles, legislation and activities that affect the living conditions conducive to human welfare. Social Policy is focused on those aspects of the economy, society and policy that are necessary to human existence and the means by which they can be provided. These basic human needs include: water, food, and shelter, a sustainable and safe environment, the promotion of health and treatment of the sick, the care and support of those unable to live a fully independent life; and the education and training of individuals to a level that enables them fully to participate in their society

## Appendix D

### Ten Things to Know About Health

**1. Health is more than health care.** Doctors treat us when we're ill, but what makes us healthy or sick in the first place? Research shows that social conditions – the jobs we do, the money we're paid, the schools we attend, the neighborhoods we live in – are as important to health as our genes, our behaviors and even our medical care.

**2. Health is tied to the distribution of resources.** The single strongest predictor of our health is our position on the class pyramid. Whether measured by income, schooling or occupation, those at the top have the most power and resources and on average live longer and healthier lives. Those at the bottom are most disempowered and get sicker and die younger. The rest of us fall somewhere in between. On average people in the middle are twice as likely to die an early death compared to those at the top; those on the bottom, four times as likely. Even among people who smoke, poor smokers have a greater risk of premature death than rich ones.

**3. Racism imposes an added health burden.** Past and present discrimination in housing, jobs, and education means that today people of color are more likely to be lower on the class ladder. But even at the same level, African Americans typically have worse health and die sooner than their white counterparts. In many cases, so do other populations of color. Segregation, social exclusion, encounters with prejudice, people's degree of hope and optimism, as well as access and treatment by the health care system – all of these can impact health.

**4. The choices we make are shaped by the choices we have.** Individual behaviors – smoking, diet, drinking, and exercise – do matter for health. But making good choices isn't just about self-discipline. Some neighborhoods have easy access to fresh, affordable produce; others have only fast food, liquor joints and convenience stores. Some have nice homes, clean parks, safe places to exercise and play, and well-financed schools offering gym, art, music and after-school programs; others don't. What government and corporate practices can better ensure healthy spaces and places for everyone?

**5. High demand + low control = chronic stress.** It's not CEOs dying of heart attacks, it's their subordinates. People at the top certainly face pressure but they are more likely to have the power and resources to manage those pressures. The lower in the pecking order we are, the greater our exposure to forces that can upset our lives – e.g., insecure and low-paying jobs, uncontrolled debt, capricious supervisors, unreliable transportation, poor childcare, lack of health insurance, noisy and violent living conditions – and the less we have access to the money, power, knowledge, and social connections that can help us cope and gain control over those forces.

**6. Chronic stress can be deadly.** Exposure to fear and uncertainty trigger a stress response. Our bodies go on alert: the heart beats faster, blood pressure rises, glucose floods the bloodstream – all so we can hit harder or run faster until the threat passes. But when threats are constant and unrelenting, our physiological systems don't return to normal. Like gunning the engine of a car, this constant state of arousal, even if low-level, wears down our bodies over time, increasing our risk for disease.

**7. Inequality – economic and political** – is bad for our health. The United States has by far the most inequality in the industrialized world – and the worst health. The top 1% now owns more wealth than the bottom 90% combined. Tax breaks for the rich, deregulation, the decline of unions, racism, segregation, outsourcing, globalization and cuts in social programs destabilize communities and channel wealth, power and health to the few at the expense of the many. Economic inequality in the U.S. is now greater than at any time since the 1920s.

**8. Social policy is health policy.** Average U.S. life expectancy increased 30 years during the 20th century. Researchers attribute much of that increase not to drugs or medical technologies but to social reforms; for example, improved wages and work standards, sanitation, universal schooling, and civil rights laws. Social measures like living wage jobs, paid sick and family leave, guaranteed vacations, universal preschool and access to college, and guaranteed health care can further extend our lives by improving them. These are as much health issues as diet, smoking and exercise.

**9. Health inequities are neither natural nor inevitable.** *Inequities in health – arising from racial and class-based inequities – are the result of decisions that we as a society have made. Thus, we can make them differently.* Other industrialized nations already have, in two important ways: they make sure there's less inequality (e.g., in Sweden the relative child poverty rate is 4%, compared to 21% in the U.S.), and they enact policies that protect people from health threats regardless of personal resources (e.g., good schools and health care are available to everyone, not just the affluent). As a result, on average, citizens of those countries live healthier, longer lives than we do.

**10. We all pay the price for poor health.** It's not only the poor but also the middle classes whose health is suffering. We already spend \$2 trillion a year to patch up our bodies, more than twice per person the average of what other industrialized nations spend, and our health care system is strained to the breaking point. The U.S. lags behind 28 other countries in life expectancy, 29 other countries in infant mortality, and each year loses more than \$1 trillion in work productivity due to chronic illness.

*Ten Things to Know About Health* was adapted from the four-hour documentary series *UNNATURAL CAUSES: Is Inequality Making Us Sick?* as seen on PBS. Produced by California Newsreel with Vital Pictures.  
<http://www.unnaturalcauses.org/>

## Appendix E

### National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care

The National CLAS Standards are intended to advance health equity, improve quality, and help eliminate health care disparities by establishing a blueprint for health and health care organizations to:

#### **Principal Standard:**

1. Provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.

#### **Governance, Leadership, and Workforce:**

2. Advance and sustain organizational governance and leadership that promotes CLAS and health equity through policy, practices, and allocated resources.
3. Recruit, promote, and support a culturally and linguistically diverse governance, leadership, and workforce that are responsive to the population in the service area.
4. Educate and train governance, leadership, and workforce in culturally and linguistically appropriate policies and practices on an ongoing basis.

#### **Communication and Language Assistance:**

5. Offer language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all health care and services.
6. Inform all individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the populations in the service area.

#### **Engagement, Continuous Improvement, and Accountability:**

9. Establish culturally and linguistically appropriate goals, policies, and management accountability, and infuse them throughout the organization's planning and operations.
10. Conduct ongoing assessments of the organization's CLAS-related activities and integrate CLAS-related measures into measurement and continuous quality improvement activities.
11. Collect and maintain accurate and reliable demographic data to monitor and evaluate the impact of CLAS on health equity and outcomes and to inform service delivery.
12. Conduct regular assessments of community health assets and needs and use the results to plan and implement services that respond to the cultural and linguistic diversity of populations in the service area.
13. Partner with the community to design, implement, and evaluate policies, practices, and services to ensure cultural and linguistic appropriateness.
14. Create conflict and grievance resolution processes that are culturally and linguistically appropriate to identify, prevent, and resolve conflicts or complaints.
15. Communicate the organization's progress in implementing and sustaining CLAS to all stakeholders, constituents, and the general public.

## Appendix F

### PowerPoint: Implicit Bias



#### Learning Objectives

At the end of this session, participants will be able to:

Define Implicit bias

Identify the impact of implicit bias

Apply the concept of implicit bias in their own work experience

Describe at least one strategy s/he may apply to ameliorate implicit bias and its impact in healthcare

Page 2

What do we mean by implicit bias?



Page 3

#### Implicit Bias

Attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner



Page 4

#### Implicit Bias

Activated quickly and unknowingly by situational cues (e.g., a person's skin color or accent or other characteristics), silently exerting its influence on perception, memory, and behavior

Page 5

#### Bias

What experience have you had with what may have been implicit bias?



Page 6

How do you know if you're biased?

Do you feel queasy, anxious, angry or fearful when you come into contact with people who are:

- |                       |                    |
|-----------------------|--------------------|
| Frail elderly?        | Transgendered?     |
| Non-Caucasian?        | Native American?   |
| Homeless adolescents? | Substance abusers? |
| Mentally ill?         | Obese?             |

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## Discussion

What impact of health disparities do you see in your work situation?

What role does implicit bias play?

What could I do that might make a difference?

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## Strategies to Address Implicit Bias

Bring Unconscious Biases into Conscious Awareness

Take Implicit Bias Test:  
[www.projectimplicit.com](http://www.projectimplicit.com)



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## Strategies to Address Implicit Bias

Recognize that everyone has innate preferences and biases.

Expand your personal and social networks to include more people from groups that are diverse.

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## Strategies to Address Implicit Bias

Identify people you admire from a group that raises your biases. Spend time bringing more positive images into your habitual thinking.



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## Strategies to Address Implicit Bias

Negative emotions and stress may increase stereotyping, so take conscious steps to manage stress and to heighten awareness in these situations.

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## Strategies to Address Implicit Bias

Imagine yourself living in the situation of a difficult person from a group that triggers your biases.



Page 13

## Strategies to Address Implicit Bias

Approach each interaction with a person from a stereotyped and/or disadvantaged population as an opportunity to practice kindness, fairness and equitable treatment.

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## Strategies to Address Implicit Bias

Find common ground for partnership with persons from groups that activate your biases.



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## Strategies to Address Implicit Bias



Support more people from diverse communities within the health & healthcare workforce

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## Strategies to Address Unconscious Bias

Other ideas or questions?

Contact Kathy Vezina

[kathrynvezina@hanleyleadership.org](mailto:kathrynvezina@hanleyleadership.org)

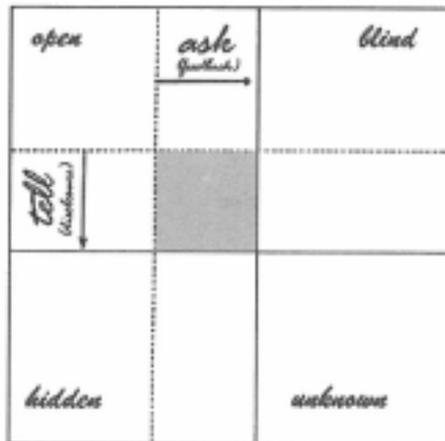
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## Appendix G

### Johari Window

#### The Johari Window Model

The Johari Window is a disclosure/feedback model of awareness, named after Joseph Luft & Ingham. It was first used in an information session at the Western Training Laboratory in G Development in 1955. The four panes of the window represent the following:



<p><b>Open:</b> The open area is that part of our conscious self - our attitudes, behavior, motivation, values, way of life - of which we are aware and which is known to others. We move within this area with freedom. We are "open books".</p> <p>It is through disclosure and feedback that our open pane is expanded and that we gain access to the potential within us represented by the unknown pane.</p>	<p><b>Blind:</b> There are things about ourselves which we do not know, but that others can see more clearly; or things we imagine to be true of ourselves for a variety of reasons but that others do not see at all. When others say what they see (feedback), in a supportive, responsible way, and we are able to hear it; in that way we are able to test the reality of who we are and are able to grow.</p>
<p><b>Hidden:</b> Our hidden area cannot be known to others unless we disclose it. There is that which we freely keep within ourselves, and that which we retain out of fear. The degree to which we share ourselves with others (disclosure) is the degree to which we can be known.</p>	<p><b>Unknown:</b> We are more rich and complex than that which we and others know, but from time to time something happens - is felt, read, heard, dreamed - something from our unconscious is revealed. Then we "know" what we have never "known" before.</p>

## Appendix H

### Selected Readings and Resources on Health Disparities

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Prevention Institute and the Strategic Alliance for Health: [www.preventioninstitute.org](http://www.preventioninstitute.org)

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## Selected Resources on Implicit Bias

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**Project Implicit:** <https://implicit.harvard.edu/implicit/>