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Drawing upon Interdisciplinary Medical-Social Sciences Partnerships to Address Racial and Ethnic Disparities in Healthcare

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Abstract: The determinants of health and well-being are complex, and social environmental factors play a pivotal role. Interdisciplinary approaches offer opportunities to address health concerns from a broader epistemological stance, one that provides a more holistic view for understanding this social phenomenon and for effective practice. This article describes a project that relied on interdisciplinary partnerships to address racial and ethnic disparities in healthcare in small cities in Northeast U.S.A. It drew upon two inter-related interdisciplinary partnerships: (1) between faculty and students from a local university and community colleges and (2) between academic institutions and local community stakeholders. Activities encouraged the development of a health related workforce from within local racial and ethnic communities, and helped future and existing health providers develop a deeper sensitivity and understanding of the influence of culture and social justice on effective healthcare. Successes and lessons learned from building and sustaining the interdisciplinary team and the development and implementation of selected project activities, including preliminary information on a research study, are offered.

Keywords: Interdisciplinary Team, Health Disparities, Education

THE REMARKABLE ADVANCES in biomedical sciences and healthcare interventions to improve life expectancy and overall health status have not equally benefited all societal members in the United States. Disparities in health outcomes and healthcare are prevalent among racial and ethnic minority groups (Balsa, Seiler, McGuire, & Bloche, 2003). Minority status, which is ascribed on the basis of racial ancestry, country of origin, and cultural distinctiveness, places certain subpopulations including those of African American and Latin American heritages in stratified positions where opportunities and privileges are unequally distributed (Pearlin, Mullan, Semple & Skaff, 1990; Scheafer, 1996).

Research consistently indicates that race and ethnicity correlate with persistent, and often increasing, health disparities, which remain apparent even when known factors such as income, education, and health insurance coverage are statistically controlled (Balsa et al., 2003). For example, compared to whites, for African Americans the rates of heart disease are more than 40% higher, the infant mortality rate is more than double, and the death rate from HIV/AIDS is seven times higher. Similarly, the rate of prostate cancer is more than double, the death rate from breast cancer is higher, and the death rate for all cancers is 30% higher. For persons of Latin American heritage, Latinos, the disparities are just as striking. Compared to whites, they have higher rates of high blood pressures and obesity and are nearly twice as likely to die from diabetes. Among some Latinos, the low birth weight rate is 50% higher than for whites (Office of Minority Health and Health Disparities, 2007). The determinants of health and well-being are complex, and, thus, explanations for health disparities must consider the interplay of a person's biological markers, health behaviors, and social and physical environments (Office of Minority Health and Health Disparities, 2007).

Of special relevance to this paper, factors associated with healthcare can, indeed, greatly contribute to these ethnic differences in health outcomes (Institute of Medicine, 2002b). African Americans and Latinos are also at a disadvantage with regard to healthcare utilization and the quality of the healthcare they receive. For instance, among older adults almost twice as many African Americans (9.6%) as whites (5.0%) delay receiving healthcare because of financial limitations, and fewer Latinos than whites report receiving preventive care such as mammography (Administration on Aging, 2002). For both minority groups, difficulties accessing information on preventive healthcare and disease management often result in greater disability and shorter life expectancy (Kim, Bramlett, Wright, & Poon, 1998; Kotchen, Shakoor-Abdullah, Walker, Chelius, Hoffman, & Kotchen, 1998). In a nationwide poll, 65% of African Americans and 41% of Latinos perceived that minority group members receive disparate healthcare, com-

pared to 22% of whites (Harvard Forums on Health, 2003). Further, a national report prepared for the Department of Health and Human Services found that quality healthcare is not a given and that racial and ethnic disparities affect healthcare at all points in the process, at all sites of care, and for all medical conditions (Agency for Healthcare Research and Quality, 2002).

Disparities in healthcare have been attributed to various personal and structural factors including financial, unequal access to health care, and language and cultural barriers (Dietz, 1997; Ramos, 2004; Tennstedt and Chang, 1998). Of utmost importance, racial and ethnic healthcare disparities occur "in the context of broader historic and contemporary social and economic inequality" (Institute of Medicine, 2002a, p. 6). For African Americans and Latinos, these disparities are linked to historical experiences of differential treatment, social disadvantages, disempowerment, and discrimination (Aguirre & Turner, 1995; Ramos, Jones & Toseland, 2005). When surveyed on perceived barriers to healthcare (Harvard Forums on Health, 2003), African American respondents often noted differential treatment by healthcare professionals, while Latino respondents frequently cited cultural and linguistic difficulties in patient-provider communications. Respondents from both minority groups reported distrust of the healthcare system and cultural differences as reasons for disregarding medical advice and/or forgoing treatment. At the same time, health advocacy in minority communities, ethnocultural sensitivity training for providers, use of interpreters, and a greater number of minority healthcare professionals were widely endorsed as necessary steps to improve responsiveness in the healthcare delivery system.

In sum, the elimination of minority healthcare disparities can be an essential step forward to effectively addressing the disturbing disparities in health status encountered in today's U.S. society. One strategy is to effect changes at the various levels of the healthcare delivery system in order to increase quality of services for and utilization by historically underserved populations. Interdisciplinary collaborations provide an optimal conduit to achieve these changes.

Interdisciplinary Collaboration

The notion of interdisciplinary collaboration is not new in academia, but its usefulness as an effective mode to approach curriculum, teaching, and scientific inquiry is increasingly becoming recognized. Such collaboration draws from a combined range of views, knowledge, methods, and practices that can help understand and address complex social phenomenon, such as health disparities, from a comprehensive, more holistic perspective (Dijkum, 2000; Stokols, Fuqua, Gress, Harvey, Phillips and Baezconde-Garbanati, 2003; Suarez-Balcazar, Hellwig, Kouba, Redmond et al., 2006).

Interdisciplinary collaborations that place faculty and students outside of university boundaries to work in tandem with community partners are also viewed as a powerful strategy for improving the health of the population (Levy, Baldyga & Jurkowski, 2003). Academic-community collaborations also foster innovation and bring together assets and resources which can help address the health needs and enhance the well-being of individuals and communities, particularly those who have historically experienced health disparities (Glasser, et al., 2005; Kahn & Prager, 1994; Rhoten & Parker, 2004; Rosenfield, 1992).

Organized efforts to foster and support this type of collaboration are illustrated by the Community-Campus Partnerships for Health (CCPH), a nonprofit organization that promotes health through partnerships between communities and higher educational institutions. CCPH is a growing network of over 1,800 communities and campuses across North America and increasingly the world (CCPH, 2007). It is based on the belief that communities must play an important role in their own well-being. Service learning, a carefully designed structured experience, is central to CCPH. Here, students provide direct community service and, at the same time, learn about the context in which the service is provided, the intersection between the service and academic course work, and about the students' roles as citizens, (Glasser, et al., 2005). A related initiative that highlights the importance of collaboration is provided by *Healthy People 2010* (U.S. Department of Health and Human Services, 2000). It establishes a set of national objectives for health promotion and disease prevention that enables diverse types of groups to combine their efforts and work as a team. As such, it fosters collaboration among local, State, and national government agencies; voluntary, nonprofit, and professional organizations; and individuals, businesses, and communities to improve the health of everyone in the U.S., eliminate health disparities, and improve years and quality of life

This paper describes the Health Disparities Education (HDE) project, which used interdisciplinary collaborations to address healthcare disparities in African American and Latino communities. The project focused on changes in the healthcare system at the level of the healthcare provider.

The Health Disparities Education Project

Background

HDE was funded by a three-year grant from the U.S. National Institutes of Health as part of a larger center

for the elimination of minority health disparities located at the University at Albany (UAlbany), a major research university in upstate New York. In this region, African American and Latino communities are dispersed throughout rural counties and small towns. Unlike in large metropolitan areas, here, these populations are nearly invisible in the political arenas and have even less access to resources and formal and informal supports (CEMHD, 2007).

The project focused its activities in the two geographic areas of Arbor Hill and Amsterdam. Arbor Hill is home to a large African American community (28% of the population), many of whom moved to the area during the 1960's seeking more affordable housing (U.S. Census Bureau, 2007). Amsterdam is an economically depressed rural area where 15% of its population are Latinos who migrated there attracted by rug factory jobs or to escape the dangers of big cities (Sperling's Bestplaces, 2007). Thus, HDE strategies to address disparities in healthcare had to take into account these distinct geographic and social disadvantages. These areas were deemed as ideal targets given a previous working history between these communities and the UAlbany's unit leading this project, the School of Social Welfare.

Goals and Objectives

The goals of HDE were (1) to strengthen the cultural competence of existing and future health service providers and (2) to encourage the development of a health related workforce from within the communities being targeted. Cultural and language barriers are likely contributors to healthcare avoidance, deferral, and/or patient deviations from treatment recommendations (White, 2003). Evidence also suggests that at least three provider factors may indirectly contribute to disparities in health care: biases and prejudices, racial attitudes and stereotypes, and clinical uncertainties with regard to minority clients (Balsa & McGuire, 2003; see also; Institute of Medicine**,** 2002a). Similarly, increasing numbers of racial and ethnic minorities in the health professions, where they are heavily underrepresented, may prove beneficial. Research indicates that healthcare providers from these groups are more likely to serve their own communities than their non-minority counterparts (Balsa, et al., 2003; Institute of Medicine, 2002a). Increased minority participation has been associated with improved access to care, greater patient choice and satisfaction, and enhanced experiences and outcomes (Institute of Medicine, 2004).

The HDE project had two primary objectives. The first was to convene an interdisciplinary collaborative team drawing from partnerships at two levels: (1) between faculty and students from UAlbany and local colleges and (2) between academic institutions and local community, government, and private healthcare providers. The second objective was to design and pilot test related project activities.

Interdisciplinary Team

HDE adapted a set of partnership principles which articulate partners' commitment to equity, collective decision making and action, an iterative process, community relevant high-quality ethical research and programming, optimizing opportunities for data-driven learning. Partners' commitment to challenging social inequalities in the partnership process and targeted communities, as well as to ensure that HDE activities lead to education, policy changes, and other actions leading to positive health and well-being, is also specified. These principles were adapted from those developed by Levy and colleagues (2003), who suggest using partnership principles to help define the ethics that will guide project development and to measure project objectives.

Academic Partnership

The academic partnership was comprised of researchers, educators, and graduate students from UAlbany, a private liberal arts college, the distance learning center of a state college, and three local community colleges. All in all, the disciplines of Anthropology, Sociology, Economics, Latin American Studies, Nursing, Public Health, Education, Medicine, and Social Welfare provided a multi-faceted capability for scholarly inquiry and practice. As noted earlier, this interdisciplinary approach offers opportunities to address healthcare disparities from a broader epistemological stance that provided a more holistic view for effective practice and social action (Dijkum, 2000; Stokols, Fuqua, Gress, et al., 2003; Suarez-Balcazar, Hellwig, Kouba, Redmond et al., 2006). Further, it facilitated bridging academics and scholarship with a real world social justice issue.

Academic-Community Partnership

The academic-community partnership included agencies and leaders, government representatives, and healthcare providers bringing the voice of those in the real world trenches to the table. Specific community partners included representatives from state and local health and human services, private healthcare providers, non-profit community agencies, professional organizations, and African American and Latino community advocates. As previously discussed, partnerships between higher education institutions and communities are increasingly viewed as essential in confronting the complex challenges associated with eliminating healthcare disparities (Scott, 2003).

Project Activities

The partnership drew upon theoretical principles of Participatory Action Research (PAR) as a framework for its processes and dynamics. These included ensuring that team members had a "level playing field," a truly participatory governance structure, and a clear goal of engaging in community capacity-building (Giachello, Arrom, Davis, Sayad, Ramirez, Nandie, & Ramos, 2003). For example, for time consuming challenges related to issues of power, trust, governance, and decision making, every effort was made to reach a balance between pure research and applied social action. This was achieved within a collaborative learning process that was inclusive, negotiable, and self-reflective (Minkler, 2000; Levy et al., 2003). Regular monthly meetings kept the group informed of the overall project activities. Here, team members shared current community information, reviewed the progress of initiatives underway and the status of pending proposals, and sought to keep the entire group engaged in forward momentum. Some of these meetings were held in sites located in the African American and Latino communities.

Following the PAR model, HDE activities were determined using an inclusive "ground-up" approach where all team members participated in decisions. Every effort was made to use open communication and shared-decision making to maintain trust, and commitment among members whose different strengths were continuously reinforced (Giachello et al., 2003). In the end, several project pilot activities that sought to emphasize community strengths were fully discussed and agreed upon. Consistent with HDE goals, some were geared to strengthen the cultural competence of existing and future health service providers, and others were designed to encourage the development of a health related workforce from within the African American and Latino communities. A brief overview of three project activities is provided below.

1. Culture Immersion for Future Healthcare Professionals

This activity was designed to promote cultural competence in the provision of services to African American and Latinos, with the ultimate goal of increasing healthcare utilization and positive health outcomes in these communities (Institute of Medicine, 2002a). One strategy to address cultural barriers is to immerse within a culturally different environment even if only for short periods of time. For example, this type of experiential activity has been found to be successful with nurses who lived and worked in areas with high immigrant populations (Kardon-Edgren, 2007). Similarly, studies of nursing faculty noted comfort in teaching or providing care to persons from other cultures was enhanced by "immersion and working in other cultures…and interactions with students from other cultures as helpful" (Kardong-Edgren, 2007, p.365).

Amsterdam Latino Community—This activity helped enhance the cultural competence of future healthcare providers by preparing them to overcome cultural barriers known to contribute to Latinos' healthcare underutilization, deferral, and low patient treatment compliance. Graduate students moved for a short time from their cities of residence to live with Latino families, visit healthcare organizations, and participate in community activities. Participants observed, learned, shared, and exchanged information focusing on what shapes Latinos health beliefs, practices, and help seeking preferences. Students had the opportunity to critically analyze their own biases, prejudices, stereotypes, and clinical uncertainties with regard to Latinos within the context of this population's ethnic reality. Pre- and post-questionnaires indicated personal and professional satisfaction through exposure to Latino language, family and social life, food, and customs. Participants developed a deeper understanding of Latino cultural traits such as familism, *simpatia*, and collectivism, becoming acutely aware of personal and systemic barriers underlying healthcare disparities.

Arbor Hill African American community —This activity was designed to raise student awareness of community environmental health, acknowledge community healthcare agencies and their employees, emphasize the importance of health advocacy, showcase local advocates, and facilitate cultural awareness and communication. High school and college students were brought together for three days to participate in this community immersion program. The group was transported by bus and adhered to a structured scheduled of events. Community leaders met the students and provided information about available healthcare services and the wide range of career paths available in the field of healthcare. Emphasis was placed on presenting the community and its resources from a strengths perspective, which highlighted its local knowledge and expertise. Pre- and post- immersion evaluations indicated participants found the experience increased their awareness about the strengths and resources of the Arbor Hill community, especially with regard to healthcare.

2. Minority Students in the Health Professions

A qualitative study was conducted to ascertain what helps and what hinders African American and Latinos' choice to pursue careers in the health professions. The literature underscores the role of universities and colleges in excluding persons from minority groups. Hurtado, Milem, Clayton-Pederson & Allen (1999) identified a number of factors that could limit minority representation in higher education. These include the presence of minority students, faculty and administrators; the psychological climate;

a history of discrimination; available support; and prevalent campus and classroom diversity.

Data were collected from Latino (N=41) and African American (N=42) middle and high school students using focus groups. Each group session was recorded and transcribed into PDF files professionally by AT&T services. Using a constant comparative approach, the resulting PDF files were then read by several members of the HDE partnership. The transcribed conversations were coded to determine emerging themes related to minority students' thoughts about choosing or not choosing the healthcare field as a potential career path. Preliminary results indicate participants had little and inaccurate information concerning healthcare professions. Most were not aware of the different career options available beyond those of medical doctor and nurse. Based on personal experiences with family and friends holding entry level jobs, some associated healthcare professions with low-paying jobs requiring demanding long hours and undesirable tasks. It appears that by 9th grade, most students already know what careers they would like to pursue. Family members have a strong influence on a youth's decision to pursue a given career or profession. The ultimate goal of this activity is to identify strategies for improving African American and Latino student recruitment and retention in the health professions.

3. Interdisciplinary Health Disparities Certificate

A long-term activity undertaken by HDE was the planning and curriculum development for an interdisciplinary certificate program. The curriculum is expected to mirror multiple determinants of health, with best practice offerings from several departments. Consistent, with Healthy People 2010 (U.S. Department of Health and Human Services, 2000), it will jointly address physical and social environments as well as individual behavior and biology within an overarching framework of policies and interventions to promote health care quality and access. Whereas stand-alone courses are quite common, widespread infusion like that of the proposed project is a unique and formidable task (Morey, 2000). Still, the project's attention to reducing disciplinary barriers, its common goals, and strong institutional support are key factors that make the distal outcomes of better health outreach and services realizable (Banks, 1993; Morey, 2000). The proposed end product will be an 18 credit cross-disciplinary certificate program. Discussions are underway to offer the certificate at UAlbany at both the undergraduate and graduate levels in collaboration with HDE partner higher education institutions.

Lessons Learned

As in any project, HDE encountered some challenges. When conducting the Latino community immersion activity, it became apparent that participants' exposure to healthcare organizations generated some overlap and repetition. This was due primarily to the small size of the city where the activity was conducted. Also, it became crucial to strongly stress confidentiality issues to student participants as well as the potential for them to make stereotypical conclusions based on their limited experiences with the healthcare agencies, staff, and community.

When conducting the study on minorities in the health profession, difficulties arose managing the logistics associated with the recruitment of participants and holding the focus groups. As can happen while undertaking research in bureaucratic, hierarchical institutions, communication within a school system needs to occur not only with high level administrators and teachers, but with everyone likely to come in contact with the research team. For example, some hall monitors and school staff had not been informed about the focus groups, which resulted in confusion and miscommunication at the time of data collection. Initially, decisions about tangible rewards for individual collaborators did not consider specific employment and situational contexts, failing to recognize preferred types of acknowledgement among team members. For example, differences between academic and community members emerged during discussions regarding conference presentations and journal publications. While academic collaborators welcomed the opportunities, some community partners voiced a preference for letters addressed to their employers highlighting their participation and contributions to HDE.

Employing an interdisciplinary, academic-community collaboration to address healthcare disparities was, at times, a bit daunting and even frustrating. This could be attributed, in part, to the complex logistics involved in assembling and sustaining it over time. Similarly, the design and prioritization of realistic project activities was not always a smooth, easy process. It required all partners to be receptive to each other's views, approaches, and preferences, which reflected the diverse constituencies they represented.

Evaluation

An independent evaluation consortium served as the evaluator for HDE as part of the broader center for the elimination of health disparities. Consortium personnel worked with the collaborative team to develop and implement formative and summative evaluations tailored to the specific goals and object-

ives of HDE. The formative evaluation activities utilized interviews, surveys, and focus group methodologies to document both academic and community-based stakeholders' perceptions of the project. Summative evaluation activities focused on documenting HDE's progress toward meeting its goals and objectives. Oral feedback on formative evaluation findings were shared with members of HDE at regular intervals. Written memorandums summarizing formative and summative evaluation findings were prepared on a biannual basis. An assessment tool was prepared to evaluate individual HDE partners' perceptions of whether or not the collaborative team adhered to the agreed upon principles of partnership. Data collection has taken longer than anticipated and is still underway.

Overall, some degree of success regarding the collaborative team can be inferred from the high level of enthusiasm, energy, and commitment reflected in the attendance and participation of team members throughout the three-year project. Individual partners have also consistently articulated positive oral comments within HDE meetings and beyond. Further, crossing disciplinary, school, department and campus borders fostered a community of scholars whose research and teaching has been greatly enriched and is more attuned to racial and ethnic healthcare disparities.

Future and Ongoing Activities

Although the original funding for HDE is approaching its final days, the partnership team eagerly continues with the planned activities for the project. Additional resources have been identified to facilitate their completion and future sustainability. For example, the completion and implementation of the interdisciplinary certificate in health disparities remains a top priority for the team. Similarly, transcriptions and analyses of the data on minorities in the health professions collected from high school students are being finalized. Additional data will be gathered at the college level. These data will then be compared and contrasted on a continuum from middle school through college, and bring to bear insights on how educational systems can better attract and retain African American and Latinos to the health professions.

Final Thoughts

The U.S. population is healthier and living longer than ever before. Yet, as a whole, the health status of racial and ethnic populations does not reflect these reported facts. Health and healthcare disparities in this country are serious, glaring problems. To reduce these disparities, the use of interdisciplinary collaboration is a timely scientific and social imperative (Kahn, & Prager, 1994). HDE illustrates a step forward in this direction. As such, a seed has been planted.

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