Community-based Teaching about Health Disparities: Combining Education, Scholarship, and Community Service

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The Institute of Medicine recommends that clinicians receive training to better understand and address disparities. While disparities in health status are primarily due to inequities in social determinants of health, current curricula largely focus on how to teach about disparities *within* the health care setting. Learners may more fully understand and appreciate how social contextual factors contribute to disparities through instruction about disparities in community settings. Community-based teaching about health disparities may be advantageous for learners, medical institutions, and participating communities. This manuscript aims to guide medical educators in teaching students and residents about health disparities through community-based activities, including service learning and research.

KEY WORDS: disparities education; community-based education; public health approach.

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IMPORTANCE OF TRAINING ABOUT HEALTH DISPARITIES

While the causes and consequences of health disparities are well known, this knowledge has not yet contributed to significant reductions in racial, ethnic, or socioeconomic disparities in health. Frameworks to study health disparities traditionally employ a health services approach, examining how factors within the health care system can exacerbate or ameliorate health disparities. More recently, there has been an emphasis on a public health approach,¹ acknowledging that individuals are embedded within broader systems that shape their behavior and influence their access to health-promoting resources. This approach focuses on multilevel determinants, including familial, cultural, community, social, economic, environmental, and policy factors.

The Institute of Medicine defines health disparities as differences in treatment provided to members of different racial or ethnic groups that are not justified by the underlying health conditions or treatment preferences of patients. This definition of disparities, which exemplifies the health services perspective, may contribute to the perception that disparities in *health care* are a major determinant of disparities in *health status*.² While disparities in health care are important and must be addressed, medical care is only responsible for about 10% of health status.³ Disparities in health status are primarily due to inequities in social determinants of health (e.g., education, employment, housing, political and economic arrangements), which have traditionally been outside the clinician's purview.

Many physicians participate in community service projects throughout their careers. Yet, they are largely unaware of the nature or full extent of health disparities both nationally and in their local communities,^{4–7} and medical trainees become more cynical and less concerned about social context as their training progresses.^{8,9} Despite the Institute of Medicine's recommendation that clinicians receive training about disparities,² few physicians receive any relevant teaching in this area. Academics who are the mainstay of medical education receive little community-based or disparities education.^{10–12} The few curricula or guidelines on how to teach about health disparities¹² largely focus on disparities *within* the health care setting. There is a paucity of instruction on teaching about health disparities in community settings, where learners can more fully understand and appreciate how social and contextual factors contribute to disparities. Yet, physicians who receive training in a given community domain have significantly greater involvement in that domain in their medical practice.¹¹

This paper is intended to serve as a "template" to guide medical educators in providing disparities education to medical learners (medical students and residents). The goal is not to explore clinical teaching in community-based medical practices. Rather, the focus is on employing community-based service learning or research to enhance knowledge, understanding, and experiences in addressing health disparities.

DOMAINS, FRAMEWORKS, AND BENEFITS OF HEALTH DISPARITIES EDUCATION IN THE COMMUNITY

The community is an ideal setting for health disparities education in four primary domains: (1) identifying and address-

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sing a community's health problems (e.g., conducting a community needs assessment, establishing student-led clinics for uninsured patients); (2) understanding and attending to sociocultural aspects of patient care (e.g., exploring barriers to care and partnering with academic and community partners to address these barriers, and establishing patient navigator programs); (3) coordinating local community health resources in the care of patients (e.g., having community advisory boards help improve aspects of clinical operations, developing and disseminating a community resource guide); (4) assimilating into the community and participating in its organizations (e.g., joining the board of the local YMCA or a coalition against lead poisoning). Community-based teaching might expose learners to these domains, provide opportunities to garner information about the health status of their local communities, and motivate learners to address disparities through education, service, and research initiatives with the community.

Two main frameworks in which such teaching can occur are service learning and community-based participatory research (CBPR). Service-learning is an experiential, community-based teaching and learning strategy that integrates carefully chosen and meaningful community service with instruction, reflection, scholarship, and research. The aims are to enrich the learning experience, teach civic responsibility, and strengthen communities.¹³ Learners are expected not only to provide direct community service, but also to learn about the context in which service is provided, the connection between the service and their coursework, and their roles as citizens.^{14–16}

In CBPR, clinicians and researchers partner with community organizations to conduct research. It can enhance student scholarship, make clinically important and socially meaningful contributions to scientific literature, and directly benefit the communities in which the research takes place.¹⁷ The process and products of CBPR have been extensively described in the literature and are beyond the scope of this manuscript.¹⁸ Community-based teaching through CBPR can directly benefit medical institutions through improved community relationships and increased institutional trust, particularly among communities of color. CBPR can also facilitate the establishment of critical community partnerships that form the basis for obtaining research funding in the expanding fields of disparities, and participatory and translational research.¹⁹

Community-based teaching about health disparities may benefit both clinicians and communities. It can shape physicians' cultural competency, ability to effectively communicate with patients from underserved communities, commitment to health advocacy, and understanding of both the challenges and assets within vulnerable communities.^{20,21} One example of an activity that would enable students to grasp connections among poverty, food availability and obesity involves the everyday act of grocery shopping. The activity would be set up with the temporal and spatial parameters that circumscribe the lives of low-income citizens living in public housing. Each student would be directed to use the average income of local residents to create a weekly grocery budget and use that budget to mock purchase a 1-week supply of healthy food for their family. The embodied challenge of the project is to travel from the housing complex to complete the tasks at local food stores within 1 hour. Such activities move learners beyond didactic teaching to critically engaging real-world problems through experiential learning.²²

Community-based teaching can benefit communities by increasing their understanding of resources within the medical

institution and enhancing their capacity to access these resources to address community-identified problems. This, in turn, can catalyze community empowerment and mobilization initiatives.²³ For example, working with multidisciplinary teams can also help improve community members' own knowledge of health topics, confidence, and leadership skills, so they can fill an educational role within their own communities.^{22,24} Finally, such teaching allows community members to actively contribute to the education of health professionals, lessening the power imbalance between the medical institution and the community.

PLANNING FOR COMMUNITY-BASED ACTIVITIES

To effectively teach about disparities in community settings, several steps must occur. First, select a community to work with and learn about its specific health needs and existing health disparities (see Table 1 for resources). With a specific community in mind, the next step is to assemble a team to carefully plan activities that are responsive to the needs of all involved. At a minimum, this team should include the faculty members involved, community representatives, and learners who will participate in the activity. Each individual should have clearly defined roles. The value of shared responsibility and clearly defined roles is illustrated in the example of a food festival in which health screenings were offered, and restaurants, who worked with nutritionists, gave out samples of healthy versions of their popular dishes.²⁵ A faculty member coordinated the activities and ensured the goals of all parties were effectively and collaboratively met. Community representatives conceptualized the idea and helped design, coordinate and implement the activity, the Executive Director of the Community-Based Organization (CBO) hosting the festival served as a "community gatekeeper," facilitating entry into the broader community,²⁶ and then used her influence to ensure ongoing organizational support. A "community preceptor" from another local organization helped problem-solve in real time and oversaw

Table 1. Resources for Learning about Health Disparities and Identifying Communities with Whom to Partner

Individual resources	Colleagues in other departments: public health, nursing, social work, preventive and/or family medicine, social medicine Researchers doing community-based participatory research Practicing physicians who are affiliated with the university Students from the local area Patients and their family members
Organizational resources	Health or social services community-based organizations or agencies Local city or county health departments
Institutional resources	Community relations department Clinical and translational science awards (CTSA) community advisory board
Media resources	Local radio, newspaper, or television Web-based resources (e.g., census data, website for state office of minority health) Published literature (particularly papers that feature projects using community academic partnerships or service learning paradigms)

the learners while they were in the community preparing for the event.

The team must identify the goals and objectives for conducting a community-based project. Each team member may have their own specific goals and objectives. For example, the institution may want to develop a formal curriculum that addresses social determinants of health or it may have a commitment or mandate to serve particular communities. Faculty members aiming to build a service-learning component with a tangible “end-product” (e.g., a paper or project) can use the Accreditation Council for Graduate Medical Education core competencies as a framework to select goals and objectives for the activity.²⁷ Learners might aim to enhance their clinical skills, work with an advocacy organization, engage in community outreach, establish relationships in preparation for more substantive work, or conduct research. Finally, CBOs may want to utilize the institution’s resources to increase their own capacity or access to health information and clinical services. As CBOs may have agendas and concerns that are not shared by the broader community, it may be useful to ask how they ensure that their work is responsive to self-identified needs of their target population and to ask colleagues familiar with the community about that CBO’s local reputation. Goals and objectives may evolve over time, and the team must be prepared to find common ground for achieving them.

The third step in planning involves identifying actual or potential resources available to facilitate community-based work. Such planning helps to assess the feasibility of the project and to identify and preemptively address potential challenges early in the process. Resources may include finances for the activity and human resources of learners, faculty members and community partners from health or social service organizations or local health centers. Interdisciplinary collaboration with colleagues from other disciplines (e.g., nursing, social work, education, urban planning) interested in a similar content area or target population can reinforce the value of engaging multiple points of view. Working across disciplines can also shed light on complex and multi-factorial topics, including health disparities.²¹ Developing new programs can be facilitated by faculty members with prior collaborations and therefore some trust and rapport with local CBOs.²⁸

In identifying resources, faculty should be mindful of the time commitment required to do a community-based activity, taking into consideration time constraints and competing priorities of all parties involved. For example, hosting a health fair may take as little as 1 month of planning and implementation, whereas establishing a free clinic may require up to a year of preparatory work and weekly involvement of trainees and faculty once established. In addition, one should consider whether activities are limited (e.g., writing an op-ed letter or giving a lecture in the community) or require a longer commitment (e.g., joining a coalition that meets monthly). Finally, geographic constraints should be considered if learners will be expected to travel to complete the activity. For example, to lessen the amount of travel by medical students working on one project with a CBO located several hours away, one group paired two students for carpooling and relied on regular conference calls, rather than in-person meetings, during the semester.

One way to minimize required resources while simultaneously providing learners with a meaningful experience might be to work with a local group on an existing project. Faculty should encourage CBOs to provide learners with an overview of

their mission and services (and the community resources with which they are connected) to facilitate learners’ understanding of the role of the organization within the broader context of the community it serves. Activities could range from developing and conducting a survey assessing the self-reported health needs of clients at a senior center, to developing a program for church leaders to use to screen for hypertension and ensure appropriate follow-up mechanisms for abnormal results. These examples have the advantage of having medical learners function in non-authoritative roles that allow them to experience the leadership and resources available within communities. However, they require that faculty negotiate the goals and objectives for the learners’ involvement with the leaders of those existing projects to ensure that the learners’ goals are met and the community partner is respected and treated equitably.

CHOOSING A SPECIFIC COMMUNITY ACTIVITY

In determining the specific type of community activity to pursue, there are three considerations. First, the team should decide on the *primary purpose* of the activity. This might include education, training, clinical or community service, advocacy, policy or community-based outreach or research. Many activities fulfill more than one purpose. Second, the teacher should determine the need for *individual* versus *group* involvement in the activity. Third, it is important to outline a *time frame* for conducting the activity. Activities could involve a one-time commitment (e.g., a health fair), be ongoing over a longer period of time (e.g., staffing a student-run health clinic), involve establishing a formal relationship with a community organization (e.g., a food pantry), or be recurrent (e.g., community tours for new faculty and trainees). Figure 1 provides an algorithm to assist with selection of a specific activity and examples of the type of activities that could be chosen, given these three considerations.

To make activities more meaningful, faculty should incorporate didactic exercises and required relevant readings. Topics may include minority, immigrant, prisoner, homeless and environmental health, poverty and health, social epidemiology, community organizing, health literacy, policy, CBPR, civic engagement by health professionals, and physicians as agents of change.

POTENTIAL TEACHING CHALLENGES

While teaching about disparities through community-based activities is rewarding, faculty should be aware of potential challenges involved in this type of work.²⁹ First, learners will likely have varying degrees of past exposure to and comfort with working in communities that might be culturally or racially dissimilar from their own. Stereotypes and biases of learners may emerge, and faculty should be prepared to help learners work through these issues. Physicians may have subconscious or implicit biases about patients from socially or racially discordant backgrounds.^{30,31} Such biases have been shown to influence health care processes^{31,32} and may affect the successful implementation of a community-based learning activity. Strategies to address these include identifying one’s implicit biases (using evidence-based tools), receiving training in cultural diversity and inclusion, having small group discussions about difficult issues before beginning the com-

Figure 1. Algorithm for determining specific types of community activities based on three parameters: (1) primary purpose of project; (2) need for group vs. individual (one) involvement; (3) time frame for conducting the activity—one-time commitment (1x) vs. ongoing or recurrent (>1x).

munity activity, and inviting community members to train with the learners.

Second, some learners become uncomfortable if they experience role reversals and associated shifts in power dynamics when they are expected to learn from community members. Medical learners may not readily identify the depth, breadth, and relevance of community-based knowledge to their medical training. Faculty should ensure that the learners become familiar with the community and be aware of its strengths and resources *before* the project begins.

Third, faculty and learners should be aware that community members may also have biases and challenges with working with health professionals. Community members may have skepticism about working with those in medical institutions, particularly if a given institution has been known to engage in negative or predatory practices that have adversely impacted local communities.³³ They might project this resentment onto learners,²⁴ potentially leaving both learners and community-members frustrated. Faculty members should know the history between the institution and the community prior to working in the community and be prepared to openly address issues that might impede the learning process. Faculty should ensure that the project is conducted in a way that respects the community's time and resources, and does not exacerbate any mistrust or enmity. Given this potential challenge, faculty should be flexible when working with communities. In addition, faculty need to provide learners a space for non-judgmental group discussions in which students can openly and safely discuss experiences and things they have seen in the community that they find thought provoking, especially if they find them disturbing.

Additionally, logistic and practical issues may arise. Faculty should address the actual safety of neighborhoods and students' *perception* of their safety and train learners in neighborhood safety prior to beginning any activity. The required time commitment should be outlined before activity begins to prepare learners and minimize the risk that promises made to community organizations will not be kept, thereby damaging current and future collaborations. Faculty should also ensure that the activities are appropriate for learners' skill

levels. For example, it may not be appropriate for medical students in the pre-clinical years to participate in the provision of certain clinical services.

Finally, faculty should recognize that despite their best efforts, some learners will remain skeptical about the value of community-based learning, the pervasiveness and impact of health disparities, and the ability of health professionals to impact health disparities. Faculty should pro-actively address these potential issues through assigned readings, small-group discussions, and exposure to experiences and individuals that challenge these beliefs. Many learners do find tremendous meaning and significance in community-based learning and service, and these activities can fill a need for them to give back that is not readily available through other channels.

INCORPORATING SOCIAL CONTEXT IN TEACHING

Student participation in community-based activities is an excellent method of educating learners about the larger policy issues that impact health disparities, such as substandard housing, environmental pollutants, safe recreational facilities and neighborhood parks, and educational inequities. Organizations can educate clinicians about non-clinical strategies to improve community health and reduce disparities such as media advocacy, legislative strategies (e.g., grassroots lobbying or writing letters to congress), or regulatory reform (e.g., changes in public health policy).

EVALUATION OF COMMUNITY-BASED ACTIVITIES

Evaluation of community-based activities should include quantitative and qualitative components, and capture the extent to which activities meet the goals and objectives of both learners and community members.²⁴ It is important that evaluations also capture the unexpected benefits and challenges involved in the activity (e.g., learners continuing to volunteer with the CBO after the project is complete or difficulty finding funding to help with specific activities), and

quantify the impact on learners' attitudes, knowledge, and behaviors.³⁴ Faculty might also consider taping the wrap up session that occurs at the end of the activity and having learners write anonymous reflection pieces to capture their experiences.

CONCLUSIONS

Health disparities are largely attributable to disparities in social determinants of health. Teaching about disparities in community settings allows learners to more fully understand and appreciate how social and contextual factors impact health and contribute to disparities in health and health care. However, medical educators receive little guidance in how to teach about disparities in non-clinical settings. This manuscript provides practical instructions on how to do that through community-based activities, using service-learning and research paradigms. When done effectively, this type of teaching can be beneficial to learners, the medical institution, and the community, and it offers the potential to produce a generation of physician leaders who are socially responsible, civically engaged, and better equipped to understand and address the inequalities that contribute to poorer health outcomes among vulnerable populations.

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