

# Health Equity

Perceptions, Knowledge, and Attitudes of Transforming Texas Sub-Grantees and Community Partners

TRANSFORMING TEXAS EVALUATION





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# EXECUTIVE SUMMARY

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This report analyzes perceptions and knowledge regarding health equity among health professionals who are implementing *Transforming Texas*, a 5-year Community Transformation Grant awarded to the Texas Department of State Health Services (DSHS), by the Centers for Disease Control and Prevention (CDC) from 2011 through 2016. Health equity is a core principle of the CTG program.

The perceptions and knowledge of Transforming Texas sub-grantees—18 in all—and their community partners were assessed with surveys immediately before and after completing a health equity training workshop. The training was conducted by the Centers for Elimination of Disparities and Disproportionalities (CEDD), an agency of the Texas Health and Human Services Commission. Analysis of the baseline and post-training surveys was conducted by the Transforming Texas evaluation team, led by the Center for Community Health, a part of the Texas Prevention Institute (TPI) at the University of North Texas (UNT) Health Science Center.

Before the training, the perceptions and knowledge of the sub-grantees regarding the existence and causes of racial disparities in health and health care were generally comparable to results from prior surveys of the public and physicians. After the training, there were changes in the perceptions and improvement in the knowledge of the sub-grantees regarding health equity and disparities.

Factors perceived to cause and perpetuate racial/ethnic disparities in health and health care in local

communities were also qualitatively analyzed using focus group data from Transforming Texas sub-grantees working in six counties selected for evaluation.

Qualitative analysis revealed that focus group participants cited socioeconomic differences, neighborhood characteristics, poor physician-patient interaction characterized by lack of cultural competence, low health literacy levels, and cultural norms, as well as poor community awareness of and engagement in addressing health disparities, as factors contributing to health disparities in the evaluation counties. Immigration-related problems and patronage of alternative care sources were also reported as contributing to health disparities in the border counties.

Specific recommendations to DSHS include conducting health equity training and evaluation of Transforming Texas sub-grantees at intervals throughout the duration of the grant. All activities of the sub-grantees should also be assessed for their health equity impacts during the planning and implementation phases, and also during the post-program evaluation. To ensure the long-term health equity impacts of the programs, the sub-grantees should increase their communities' awareness of health disparities, and actively engage them in addressing these through local health policies and programs. Pre-existing local programs aimed at reducing health disparities should also be leveraged by the sub-grantees.



# INTRODUCTION

*Transforming Texas* is one of 61 5-year Community Transformation Grants (CTGs) in the United States funded by the Affordable Care Act's Prevention and Public Health Fund, and awarded by the Centers for Disease Control and Prevention (CDC). CTG awardees include state and local government agencies, tribes and territories, and nonprofit organizations in 36 states. The CTG awards total \$103 million and *Transforming Texas*, at \$10 million per year, is the largest of these awards.<sup>1</sup>

The goal of the CTG program is to reduce chronic disease burden in the nation by addressing and improving such risk factors as diet, physical activity, tobacco use, weight, and the use of high-impact clinical preventive services.

The grant was awarded to the Texas Department of State Health Services (DSHS), which has subcontracted awards to 18 organizations working in 30 counties to implement its state-wide initiative. *Transforming Texas* will potentially reach 3.6 million Texans living in diverse sociogeographical environments, including urban, rural, frontier, and border counties.

The three core principles designated by the CDC to guide the implementation and evaluation of *Transforming Texas* and other CTGs are:

1. Maximize health impact through prevention
2. Advance health equity and reduce health disparities
3. Use and expand the evidence base

The in-depth, state-wide evaluation of *Transforming Texas* focuses on the activities of four sub-grantees working in six counties. These evaluation counties include those where the highest-impact strategies are being implemented, and where racial and ethnic minority populations are sufficiently large for samples to detect differences in the impact of these strategies. The mix of counties includes urban, border; rural, border; frontier; urban, non-border; and rural-non-border counties. This diverse cross-section of counties will provide ample opportunity to examine geographic factors that contribute to successes or challenges in achieving outcomes over the 5-year project period. These counties are listed in Table 1 below, with their racial/ethnic composition and population size. Figures 1 and 2 present the racial/ethnic compositions and geographical locations of these counties, respectively.



TABLE 1. COUNTIES FOR EVALUATION

| County    | Description          | White | Black | Hispanic | Other | Total Population | Transforming Texas Sub-Grantee  |
|-----------|----------------------|-------|-------|----------|-------|------------------|---|
| Lubbock   | Urban, Non-Border    | 57.3% | 7.5%  | 31.9%    | 3.3%  | 278,831          | Texas Tech Health Sciences Center   |
| Hale      | Frontier, Non-Border | 37.6% | 5.3%  | 55.9%    | 1.2%  | 36,273           | Texas Tech Health Sciences Center   |
| Jim Wells | Frontier, Non-Border | 19.7% | 0.6%  | 79.0%    | 0.7%  | 40,838           | Migrant Health Promotion (MHP)  |
| Willacy   | Rural, Border        | 10.1% | 2.1%  | 87.2%    | 0.6%  | 22,134           | Migrant Health Promotion (MHP)  |
| Webb      | Urban, Border        | 3.3%  | 0.5%  | 95.7%    | 0.5%  | 250,304          | Serving Children and Adolescents in Need (SCAN)   |
| McLennan  | Urban, Non-Border    | 58.9% | 14.8% | 23.6%    | 2.7%  | 234,906          | Waco-McLennan County Public Health District (by and through the City of Waco Health Department) |

FIGURE 1. RACIAL/ETHNIC COMPOSITION OF TRANSFORMING TEXAS EVALUATION COUNTIES

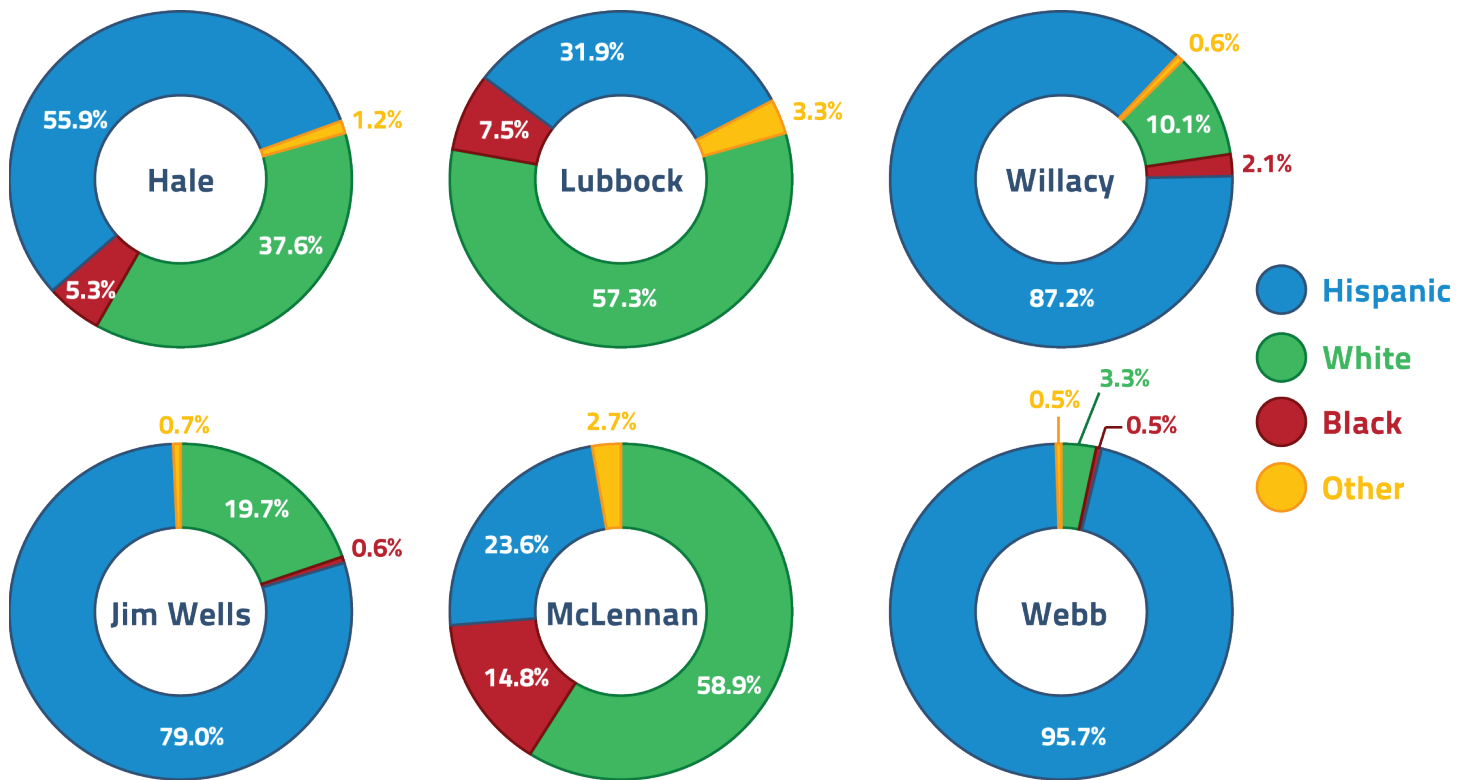
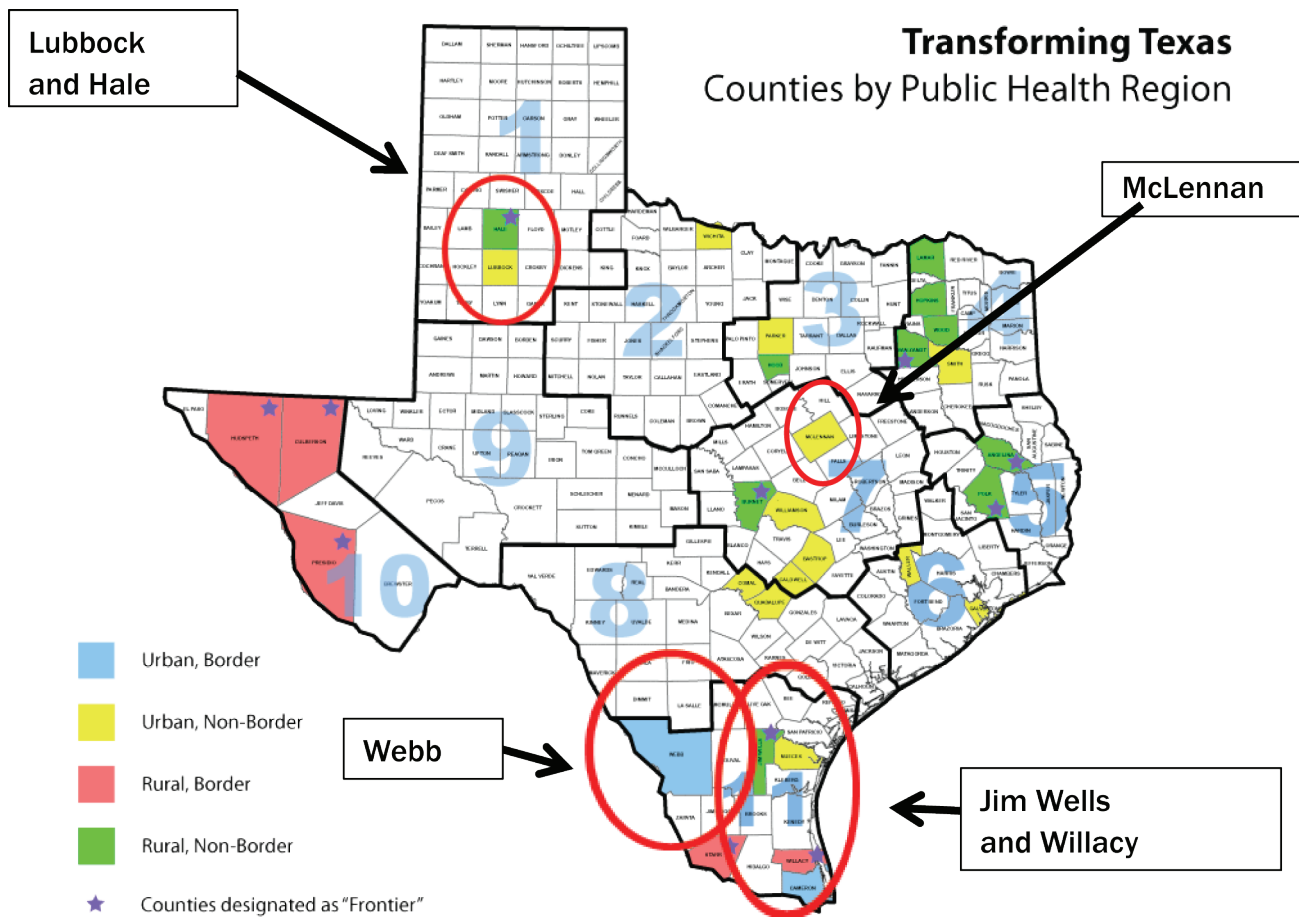


FIGURE 2. LOCATION OF TRANSFORMING TEXAS EVALUATION COUNTIES



As illustrated above, the counties selected for evaluation are geographically diverse. There is also a mix of rural vs. urban, and border vs. non-border counties, whose residents will provide a unique blend of health equity perceptions and knowledge.

While the primary goal of the evaluation is to add to the chronic disease reduction and prevention evidence base by determining which strategies produce successful outcomes in different environments in Texas, it will also provide an opportunity for a health equity analysis in these counties. Such analyses will involve an evaluation of the health equity foci of the processes that the sub-grantees employ while implementing their *Transforming Texas* interventions. It will also involve an evaluation of the program outcomes in the sub-grantee counties with regard to racial/ethnic disparities. It is, therefore, imperative to conduct a baseline evaluation of the perceptions, beliefs, and attitudes of the sub-grantee staff involved in *Transforming Texas* towards health disparities and health equity in the United States as well as in their local communities. Such an evaluation is informative in identifying areas where further training and guidance may be needed by the sub-grantees to address health disparities through their cross-cutting *Transforming Texas* interventions. An evaluation of the changes in these perceptions and attitudes after health equity training was also necessary in order to gauge the adequacy, relevance, and overall effectiveness of the workshops.

# HEALTH EQUITY, DISPARITIES, AND INEQUALITIES IN THE UNITED STATES

Health equity is the attainment of the highest level of health for all people. It involves addressing avoidable inequalities, historical and contemporary injustices, and disparities in health and health care.<sup>2</sup>

Disparities in health are differences in the incidence, prevalence, mortality, and burden of disease and other adverse health conditions that exist among specific population groups in the United States.<sup>2</sup>

Disparities in health care specifically refer to [group] differences in the quality of health care that are not due to access-related factors or clinical needs, preferences, or appropriateness of intervention.<sup>3</sup> Population groups can be defined by such socially-defined characteristics as race/ethnicity, socioeconomic status, gender, age, disability, and sexual orientation. These groups have typically been subjected to longstanding discrimination that systematically produces noticeable and often adverse differences in their health.<sup>2</sup>

Racial/ethnic disparities in health were brought to public attention on a national scale by the seminal Health and Human Services Secretary's Task Force Report on Black and Minority Health in 1985. This report documented racial/ethnic disparities in life expectancy, as well as overall and cause-specific age-adjusted death rates due to infant mortality, cancer, heart disease/stroke, diabetes, homicide/accidents, and liver cirrhosis.<sup>4</sup> While most of these disparities are still shown to exist, use of preventive health services, obesity, preterm births, HIV infection rates, the prevalence of hypertension, and preventable hospitalizations have also been documented.<sup>5,6,7,8</sup>

In 2002, the Institute of Medicine summarized the evidence for racial/ethnic disparities in health care for a wide range of conditions, including cardiovascular disease care, cancer diagnostic tests and treatments, HIV treatment and care, diabetes care, kidney disease care, pediatric care, maternal health, mental health care, nursing home and rehabilitative services, and surgical procedures, even after accounting for socioeconomic differences.<sup>3</sup> Racial/ethnic health care disparities have been shown to persist both over time and over the life course of Americans.<sup>5</sup>

Health inequalities were estimated to cost the U.S. economy \$1.24 trillion between 2003 and 2006 due to direct medical care expenditures and indirect costs. In the same period, as much as 30.6% (\$229.4 billion) of the direct medical care expenditures on racial/ethnic minorities would have been saved if there were no health inequalities.<sup>9</sup> Correction of health inequalities and achieving health equity might generate more gains in health than advances in medical treatment. For instance, it is estimated that for each life saved by biomedical advances, five lives would be saved just by eradicating the black-white mortality gap. Similarly, for every life saved by biomedical advances, eight will be saved by eliminating racial/ethnic disparities in education.<sup>5</sup>

Several explanations have been advanced for persistent disparities in health and health care. These include social determinants of health, such as differences in education, income, housing characteristics, and air quality. Other important reasons include residential segregation, lifetime exposure to social and economic adversity, personal histories of discrimination, and institutionalized racism.<sup>5,6</sup>

National efforts to address health disparities include provisions of the Medicare Improvements for Patients and Providers Act (MIPPA) of 2008 that seek to improve data collection to measure disparities, the Health Information Technology for Economic and Clinical Health Act (HITECH) of 2009, and provisions in the Patient Protection and Affordable Care Act (PPACA) of 2010.<sup>5</sup>

Ongoing federal initiatives to address health disparities in several communities across the country include the Racial and Ethnic Approaches to Community Health (REACH) and the Communities Putting Prevention to

Work (CPPW) programs of the CDC. Others include the National Institute of Minority Health and Health Disparities (NIMHD) Centers of Excellence (COE) and Community Based Participatory Research (CBPR) programs, the Agency for Healthcare Research and Quality (AHRQ) Excellence Centers to Eliminate Ethnic/Racial Disparities (EXCEED) program, and the Health Research and Services Administration (HRSA) Health Disparities Collaborative.<sup>5,10</sup>

Achieving equity in health and eliminating health disparities is one of the four overarching goals of the nation's health plan document, *Healthy People 2020*.<sup>11</sup> Achieving health equity in communities is also one of the underlying objectives of the *Transforming Texas* initiative.

## HEALTH EQUITY TRAINING FOR TRANSFORMING TEXAS SUB-GRANTEES

The Center for the Elimination of Disproportionality and Disparities (CEDD) of the Texas HHSC works with government, private, and community agencies in addressing the problems of health and health access disparities in Texas.

The CEDD organized 4-hour training workshops for the staff of *Transforming Texas* sub-grantees and their community partners, held from July through September 2012. Each participant was required to attend only one of these 4-hour sessions. The workshops were similar in content and methods and sought to improve the sub-grantees' awareness of health disparities and to encourage them to design and implement community activities using culturally-competent strategies built on the health equity principle of the CTG.

At the training, topics that were covered include:

- Terms used to describe racial inequity in outcomes in the health, education, child welfare, and juvenile justice systems
- Social, economic, and environmental factors that serve as determinants of health and equity across systems
- Major determinants of health inequity such as:
  - ♦ Institutional racism
  - ♦ Socioeconomic status (SES)
  - ♦ Health care access
- Disparities in selected health behaviors and outcomes:
  - ♦ Smoking prevalence
  - ♦ Tobacco-related cancer site mortality
  - ♦ Diabetes prevalence
  - ♦ Cardiovascular disease mortality rates
- Strategic approaches to addressing disparities in their communities:
  - ♦ Identification of disparities in local communities and health-disparate populations
  - ♦ Designing and adopting strategies that are tailored and adapted culturally to meet the needs of, and address the barriers faced by, the disparate and underserved populations
  - ♦ Community engagement
    - ▷ Community involvement at the earliest stages
    - ▷ Engaging community partners from different sectors
    - ▷ Community influence on projects
    - ▷ Ensuring that research processes and outcomes benefit the community
    - ▷ Hiring and training community members for tasks and projects addressing disparities

- ▷ Seeking community input into data interpretation
- ▷ Forming and forging lasting community partnerships targeted at addressing the contributing causes of health disparities
- ▷ Community empowerment to initiate their own projects
- ◆ 5-year targets for reduction of disparities

At the training workshops, pre- and post-training surveys were administered to assess the perceptions and knowledge of health disparities among the Transforming Texas sub-grantees.

Four focus groups were organized to better understand the perceptions, causes, and remedial strategies regarding health disparities within the local context of the communities served by the sub-grantees.

This report presents the results of the pre- and post-workshop surveys administered at the CEDD training, and also the findings from the focus groups. These quantitative and qualitative results are synthesized to gain insight into the health equity perceptions and attitudes of the sub-grantees. Recommendations are also proposed for future action.

## TRANSFORMING TEXAS EVALUATION TEAM

The evaluation of Transforming Texas is a collaborative effort led by Dr. Kathryn Cardarelli's team at the Center for Community Health. Other partners in the evaluation are 2M Research Services, LLC, and the Health and Disease Promotion Section of the Texas DSHS.

### **UNTHSC CENTER FOR COMMUNITY HEALTH**

The Center for Community Health (CCH) is a research center located in the Texas Prevention Institute at the UNT Health Science Center. Directed by Dr. Kathryn Cardarelli, CCH works to enhance community capacity for prevention and employs novel community-based participatory methods, along with traditional social and behavioral health science approaches, to enhance community-academic partnerships and develop replicable risk-reduction programs in underserved communities. CCH boasts more than 6 years' experience in working with vulnerable populations in the most underserved areas of Texas, and focuses on community-based approaches to reducing health disparities and translating epidemiologic evidence into health policy. Guided by a Community Advisory Board comprised of diverse community health representatives, CCH has a national reputation for excellence in addressing preventable illness in underserved populations.

More information about the Center can be found at: <http://www.hsc.unt.edu/Research/TPI/CCH/>

### **2M RESEARCH SERVICES, LLC**

A Texas-based, minority-owned health services research and program evaluation consulting firm, 2M Research Services has extensive experience with state and federally-funded program evaluations.

More information about 2M Research Services can be found at: <http://www.2mresearchservices.com/>

### **CENTER FOR ELIMINATION OF DISPROPORTIONALITY AND DISPARITIES (CEDD)**

The CEDD conducted the health equity training workshops and assisted with the distribution and collection of pre- and post-surveys. The CEDD is housed within the Texas Health and Human Services Commission. Its mission is to partner with Health and Human Service Commission agencies and external stakeholders to identify and eliminate disproportionality and disparities in the Texas Health and Human Services System as well as other systems that serve children, families, and vulnerable populations.



# OBJECTIVES

The objectives of this report are:

1. To assess the baseline perceptions and knowledge of *Transforming Texas* sub-grantees and community partners with regard to racial/ethnic disparities in health and health care in Texas and the United States.
2. To evaluate the changes in perceptions and knowledge of *Transforming Texas* sub-grantees and community partners regarding health disparities after completing the CEDD workshop.
3. To assess the understanding and attitudes of *Transforming Texas* sub-grantees and community partners with regard to health disparities in their local communities.
4. To identify, from the perspectives of *Transforming Texas* sub-grantees and community partners, the chief contributing causes of health disparities in their local communities.
5. To make recommendations to DSHS that will allow health equity to advance in *Transforming Texas* over time.





# SURVEY METHODS

## SURVEY DEVELOPMENT, ADMINISTRATION, AND ANALYSES

In order to assess baseline knowledge and beliefs of the sub-grantees and community partners with regard to racism and health disparities, a survey was developed by the evaluation team, comprised of staff from the University of North Texas Health Science Center (UNTHSC)'s Center for Community Health (CCH), 2M Research Services, and Texas DSHS. The draft survey contained items that were adapted and modified from other surveys that have been used in studies assessing attitudes, perceptions and knowledge of health disparities and health inequities.<sup>12,13,14,15,16,17</sup> This draft survey was shared with the CEDD staff for feedback on its relevance to their workshop curriculum, and for cultural appropriateness. The evaluation team finalized the instrument based on its review of the feedback. All of the survey items except one were constructed as closed-ended questions. The only open-ended question asked for the respondent's definition of health disparities. Approval for this study was obtained from the Institutional Review Board (IRB) of the UNTHSC.

The pre-training survey was administered to consenting workshop participants as a self-administered paper questionnaire prior to the start of the workshops. Informed consent was obtained from willing participants before completing the pre-training survey. After the workshop, the post survey was administered to reassess the participants' knowledge and beliefs about racism and health disparities. The survey participants are referred to as "respondents" in this report. The informed consent, pre-training and post-training surveys for each participant were sealed in an envelope, and all the envelopes from each training site were mailed together in a larger envelope to the evaluation team at the UNTHSC. All surveys were distributed and collected from the participants by the CEDD staff, all of whom were approved as study personnel by the UNTHSC IRB.

Responses from the pre-training and post-training surveys were entered by the evaluation team members into a Microsoft Access data base and then imported into a Microsoft Excel spread sheet and SAS for analysis.



The mean and range of the respondents' ages were calculated and presented. Frequencies and percentages were computed for the other demographic variables (gender, race, and education), and for the respondent's employment organization type.

Frequencies and percentages were computed for the pre- and post-training survey items on perceptions, knowledge, and attitudes toward health disparities, and the pre- and post-training percentages were graphed in adjacent histograms to facilitate comparisons of any differences resulting from the training. The open-ended question on the definition of health disparities was analyzed qualitatively, and the themes from the definitions were extracted and summarized.

To help ensure that the results are interpreted and understood within the context of actual data, data on disparities in health behaviors, health care quality, morbidity and mortality, and health outcomes are also presented with the study data where appropriate. Where available, results from similar studies or reports, are also presented with the findings.

## SURVEY LIMITATIONS

1. Not all respondents who completed the pre-training survey ( $N=106$ ) also completed the post-training survey ( $N=98$ ), and not every respondent answered every item on both surveys. The analysis for equivalent items on the pre-training and post-training surveys was conducted only for respondents who answered the items on both surveys. Only a few participants did not complete either survey, and these are not likely to have biased the reported findings.
2. Statistics for Asian Americans, Native Americans, and Others were not reported because these groups had too few respondents.
3. The post-training survey only assesses immediate changes in perceptions, knowledge and attitudes about race/ethnicity and health. The changes observed might not necessarily be sustained.
4. No scales were constructed to provide summary scores of the perceptions, knowledge, and attitudes of sub-grantees and community partners. Similarly, no single item was designed to capture their perceptions, knowledge, and attitudes as stand-alone items.
5. Comparisons of the study results with previous survey findings should be made with caution. An earlier nationwide study of physicians and medical students used a self-administered paper questionnaire, but one for the general public was administered as a telephone survey. Both were conducted, at the least, 10 years before the current survey, and a recent study showed that public awareness of health disparities might have improved over the last decade.<sup>5</sup> The rates from these prior surveys should therefore not be used for rigorous comparison with the current findings. They might, however, help place this study's findings in context.

# SURVEY RESULTS:

## PERCEPTIONS AND KNOWLEDGE OF HEALTH DISPARITIES

TABLE 2. BASELINE DEMOGRAPHIC CHARACTERISTICS OF SURVEY RESPONDENTS (N=106)

| DEMOGRAPHIC VARIABLE                           | n (%)    |
|--|----------|
| <b>Age</b>                                     |          |
| 18-24 years                                    | 14 (14%) |
| 25-34 years                                    | 42 (40%) |
| 35-44 years                                    | 22 (21%) |
| 45-54 years                                    | 19 (18%) |
| 55-64 years                                    | 7 (7%)   |
| <b>Gender</b>                                  |          |
| Female   | 85 (81%) |
| Male   | 20 (19%) |
| <b>Race</b>                                    |          |
| Asian/Asian American/Pacific islander          | 3 (3%)   |
| Black/African American                         | 18 (17%) |
| Hispanic/Latino                                | 35 (33%) |
| Native American/American Indian/Alaskan Native | 1 (1%)   |
| Other  | 1 (1%)   |
| White/Caucasian                                | 48 (45%) |
| <b>Type of Organization</b>                    |          |
| Academic Institution                           | 18 (17%) |
| City/County/Regional Health Department         | 40 (38%) |
| Nonprofit                                      | 36 (35%) |
| Other  | 10 (10%) |
| <b>Position</b>                                |          |
| Entry level                                    | 28 (26%) |
| Mid-level                                      | 43 (41%) |
| Senior level / manager                         | 25 (24%) |
| Other  | 10 (9%)  |
| <b>Education</b>                               |          |
| Doctorate degree                               | 4 (4%)   |
| Master's degree                                | 36 (34%) |
| College degree                                 | 44 (42%) |
| Some college or technical school               | 20 (19%) |
| High school graduate or GED                    | 2 (2%)   |

## SURVEY RESPONDENTS' DEMOGRAPHICS

Table 2 displays the demographic characteristics of survey respondents at baseline.

- A total of 106 respondents completed the pre-training surveys; the overwhelming majority (81%) was female.
- The average age of respondents was 36 years, with ages ranging from 21 to 64 years.
- Based on their self-identified race/ethnicity, White was the largest group, with 45% of the respondents. About one third of the respondents were Hispanic, one sixth were Black/African American, and the remainder reported other minority racial/ethnic groups.
- The majority of the respondents reported at least some college education. A total of 19% had some college or technical education, 42% had a college degree, 34% had a master's degree, and 4% had doctorate degrees, while 2% of the respondents had high school/GED as their highest educational attainment.
- Approximately 38% of the respondents were employed by City/County/Regional Health Departments, about a third (35%) worked in nonprofit organizations, 17% worked in Academic Institutions, while the others (10%) worked in other settings.
- Respondents who were in an entry level position in their organization accounted for 26% percent of the sample. Those in a mid-level position were 41% of the sample, and only 24% were in a senior level or managerial position. Additionally, 9% reported being in an "other" type of position.

## MAIN FINDINGS

### *PERCEPTIONS OF RACISM, RACE/ETHNICITY AND DISPARITIES IN HEALTH AND HEALTH CARE*

Before the training:

- More than half of the respondents reported that racism, as well as discrimination, were major problems in the health sector.
- However, less than half of the respondents thought that racism and discrimination were major problems in other areas of life such as the workplace, education, and housing.
- Less than half of the respondents thought skin color affected the quality of care received.
- Only a minority of respondents reported that race/ethnicity, gender, education, and money were very often the basis for unfair treatment by the healthcare system.
- Few respondents indicated that Hispanics and Blacks/African Americans were very likely to receive quality medical care.
- Personal behavior was most commonly cited as the underlying reason for observed disparities in life expectancy.
- The majority of the respondents agreed that reasons for the observed health disparities between different groups in the United States included healthcare coverage, the physical environment, health habits, biological makeup of individuals, and communities/neighborhood characteristics.

After the training, these perceptions changed considerably:

- More respondents thought that racism and discrimination were major problems in health and the other areas of life.
- More respondents also thought that skin color was a determinant of health care received, and more respondents indicated that the healthcare system treated people unfairly very often based on their race/ethnicity, gender, how much money they have, and their level of education.
- The majority of respondents reported that Whites were very likely to receive quality care.
- Prejudice and discrimination was the most often cited reason for disparities in life expectancy.

The baseline perceptions of respondents about the effect of race on health care quality varied by:

- *The respondents' organization type.* Those who worked at academic institutions were more likely to perceive that racism was problem in health, and that skin color was a determinant of the quality of health care received by in the general population.
- *Their self-identified race/ethnic group.* Black/African American respondents were the most likely to view skin color as a determinant of health care quality one receives.

- *Their perceptions about the likelihood of receiving quality medical care also varied by race/ethnicity.* No Black/African American respondents thought that African Americans or Hispanics were very likely to receive quality medical care.

## KNOWLEDGE OF RACIAL/ETHNIC DISPARITIES IN HEALTH AND HEALTH CARE

- Knowledge of disparities regarding health behaviors and access to care improved after the training.
- Blacks/African Americans and Hispanics were the groups that respondents thought were the least likely to
  - ♦ 1) Live healthy lifestyles;
  - ♦ 2) Receive preventive health care; and
  - ♦ 3) Have health insurance, at baseline (Hispanics followed by Blacks/African Americans).
- After the training, Blacks/African Americans were reported to fare worst in all these areas.
- Knowledge of disparities regarding health outcomes improved after the training.
  - ♦ The vast majority of respondents indicated that Whites were the most likely to have the healthiest birth outcomes, at baseline and after the training.
  - ♦ Blacks/African Americans were thought to be the group most likely to be diagnosed with HIV/AIDS and cardiovascular diseases, at baseline and after the training.
  - ♦ While Whites and Hispanics were thought to be more likely to be diagnosed with cancer and diabetes at baseline, after the training, Blacks/African Americans were thought to be more likely to be diagnosed with cancer and diabetes.
- A quarter of respondents had neither heard nor read anything about racial health disparities in the past year.
  - ♦ At baseline, a third had not heard of “Healthy People 2020,” a document that highlights health behaviors and develops guidelines for improving the nation’s overall health.

## PARTICIPANTS’ DEFINITION OF HEALTH DISPARITIES

An open-ended question, “what does the term health disparities mean to you?” was asked on the pre- and post- training surveys. Out of 97 baseline responses and 85 post responses, five major themes were noted. In the analysis of this question, certain statements, made by participants, were chosen to highlight the established themes.

- The first theme, “Access,” was mentioned 23 times in the pre-survey (24%) and 17 times in the post-survey (20%). “Access” was mentioned in both their pre- and post-survey by 11 participants. The term “access”

was used in a variety of ways in the pre-survey. Some comments referred to “access of resources” such as:

- ◆ “Those who do not have access to resources in which a healthy lifestyle can be lived. For example, food deserts where grocery stores are not located or unsafe neighborhoods which make exercise difficult.”

The term “access” was also used in reference to health care services for underserved populations:

- ◆ “Inequity in health care including access, health outcomes, risk factors based on race, ethnicity, gender, geography and social-economic status.”
- ◆ “Differences in overall health of different ethnic and socioeconomic groups in the society that can be tied to factors such as different lifestyles and cultures as well as different levels to access to health care.”

In the post-survey the term “access” was further used to identify limits to health care for certain populations. One comment illuminated this:

- ◆ “There are a disproportionate number of folks in our communities from specific ethnic/racial/ socioeconomic and geographic groups who have a greater burden of disease and lack access to preventative and interventions of health care. This stems from systemic causes which [have] impact.”
- The second theme, “Differences,” was mentioned 19 times in the pre-survey (20%) and 16 times (19%) in the post-survey. Six participants mentioned differences in both pre- and post-surveys. The term difference was used in reference to race, age, gender, certain population groups, social, economic status, ethnicity, access, education, lifestyle, health outcomes, institutionalized racism, health and insurance coverage, environment, medication, heredity, and cultural differences. The term “difference” was acknowledged as a decision maker to health care access. For example, one participant in the pre-survey said:
  - ◆ “Differences in health status and access in a community associated with racial, ethnic backgrounds, ages, residence status, and overall socioeconomic status.”

After the training one participant noted in a post-survey, “A preventable difference in one group versus another group compared to norm...”

- A third theme, “Inequality/Inequity, Unequal/Lack of Equity or Equality,” was mentioned 7 times in the pre-survey (7%) and 12 times in the post-survey (14%). Three participants mentioned this theme in both pre- and post-surveys. An important note here is that the second theme of “difference” is connected and sometimes used interchangeably with this third theme. Also, the terms “equal” and “equity” have two distinct meanings. According to the Merriam-Webster Online Dictionary, the first definition for the term “equal” is “of the same measure, quantity, amount, or number as another.” The first definition for the term “equity” is “justice according to natural law or right; specifically: freedom from bias or

favoritism” <http://www.meriam-webster.com/dictionary/>. Consideration for the definition differences should be noted. In the pre-survey, one participant stated:

- ♦ “[Health] disparities mean inequalities. Everyone should have the same opportunities to equal quality and availability of health care despite income/race.”

Another participant noted:

- ♦ “Unequal access to health care by certain groups which results in disproportionate health care issues.”

This theme appeared almost twice as much in the post-survey as the pre-survey. This result is indicative of the training emphasis on the inequities in health care access and resources and unequal treatment for certain groups of people discussed in the first two themes. In the post-survey, one participant, who clearly understood the differences in term definitions, said: “The lack of equity and equality in regard to those in different groups.” Another participant noted: “Unequal health outcomes/unequal opportunities to achieve good health outcomes due to institutionalized racism.”

- A fourth theme, “Barriers,” was mentioned 3 times in the pre-survey (3%) and 6 times in the post-survey (7%). Two participants mentioned “Barriers” in both pre- and post-surveys. The theme of barriers may be connected to the first theme of “access.” “Not having access” or “having barriers” are similar in definition. For example, in the pre-survey, one participant noted:

- ♦ “Barriers to healthcare including race, socioeconomic status, religion/beliefs, or others.”

In the post-survey a different participant noted: “Not having access to healthcare systems or experiencing healthy living because of barriers.”

- The final theme, “Opportunities” (lack of), was mentioned 2 times in the pre-survey (2%) and 9 times in the post-survey (11%). No participants mentioned “Opportunities” in both the pre- and post-surveys. The term “opportunity,” according to one participant in the pre survey, was stated as:
  - ♦ “Health disparities are the preventable differences in the burden of disease, disability, or opportunity to achieve optimal health that are experienced by socially disadvantaged populations.”

In the post-survey, one participant noted:

- ♦ “Racial, social, or economic standings that have an influence on the quality of care someone receives, the attitude toward them. Or the opportunities they get.”

It is interesting to note that the post-survey results showed a higher percentage increase in the themes of “Inequality, etc.” and “Opportunities,” than in other themes. This increase could possibly be due to the similarities in terminology used in the training. From the pre- and post-survey responses there seems to be a clear understanding that health disparities are closely linked to differences in groups of people. In the pre-survey, more statements acknowledged health disparities based on unequal and inequitable treatment of groups of people. In the post-survey, more statements specifically linked these disparities to systems that are in place.

# PERCEPTIONS AND EXPERIENCES OF RACISM AND DISCRIMINATION

## MEASURES

Perceptions of the influence of racism and discrimination were assessed by gauging the extent to which the respondents perceived these to be problems in each of five areas of life—health, workplace, education, housing, and government.

Perceptions were measured based on the responses to the following questions:

How big of a problem do you think racism is in the following areas of life?

- ◆ Health
- ◆ Workplace
- ◆ Education
- ◆ Housing
- ◆ Government

How big of a problem do you think discrimination is in the following areas of life?

- ◆ Health
- ◆ Workplace
- ◆ Education
- ◆ Housing
- ◆ Government

Further analyses of the baseline perceptions regarding the influence of racism and discrimination on health, based on the respondents' employer type, were conducted.



FIGURE 3. PERCEPTIONS OF RACISM AND DISCRIMINATION IN HEALTH

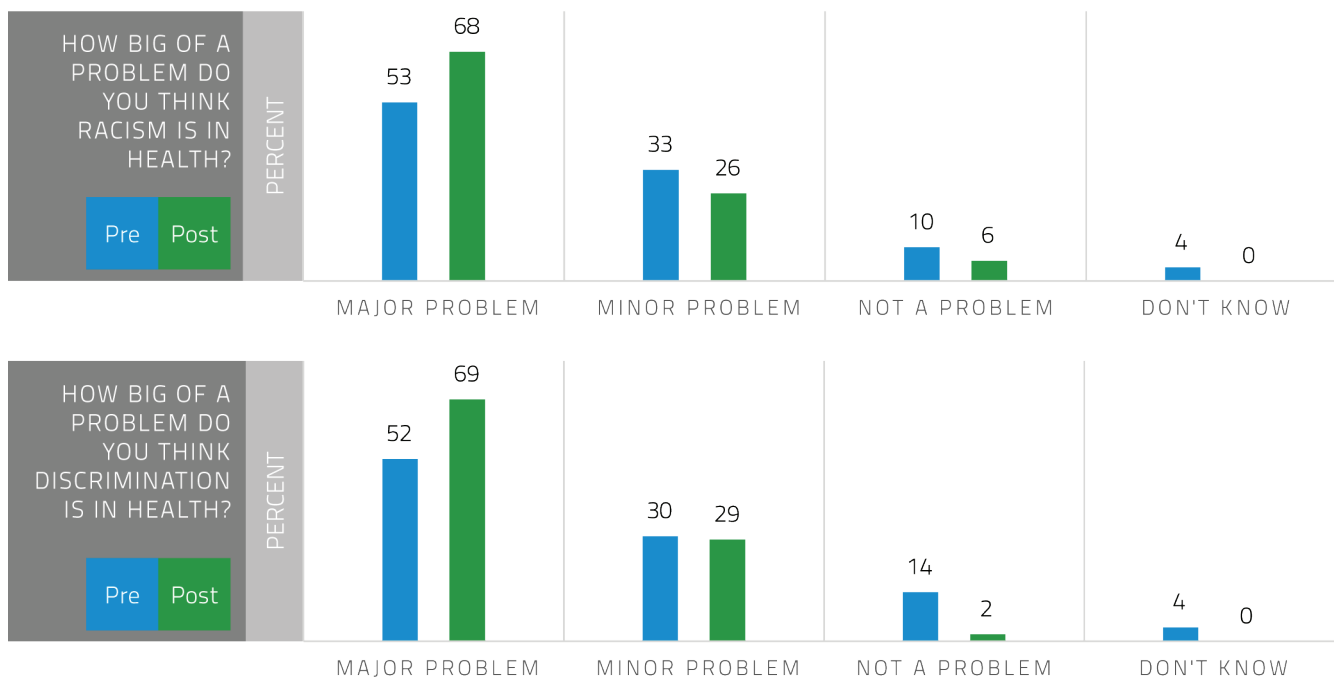
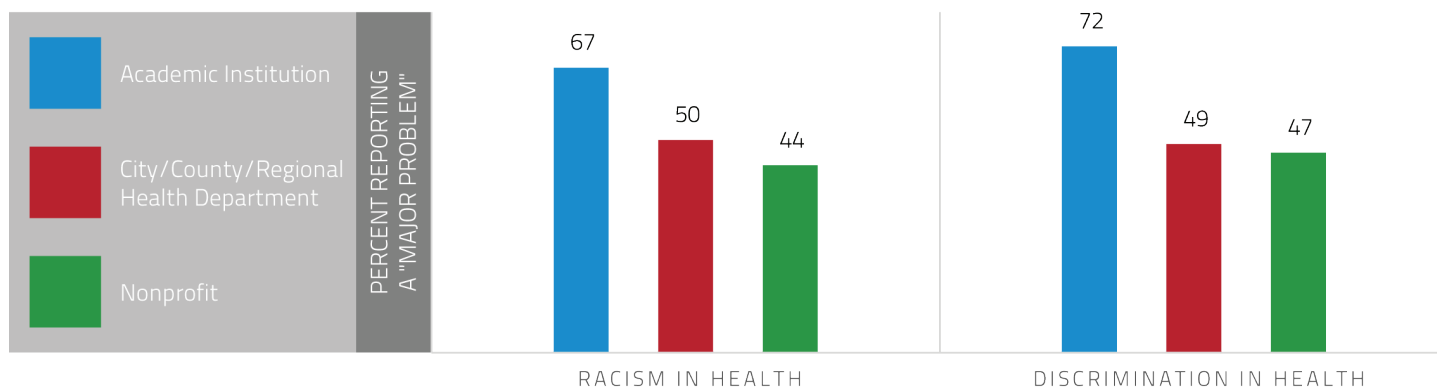


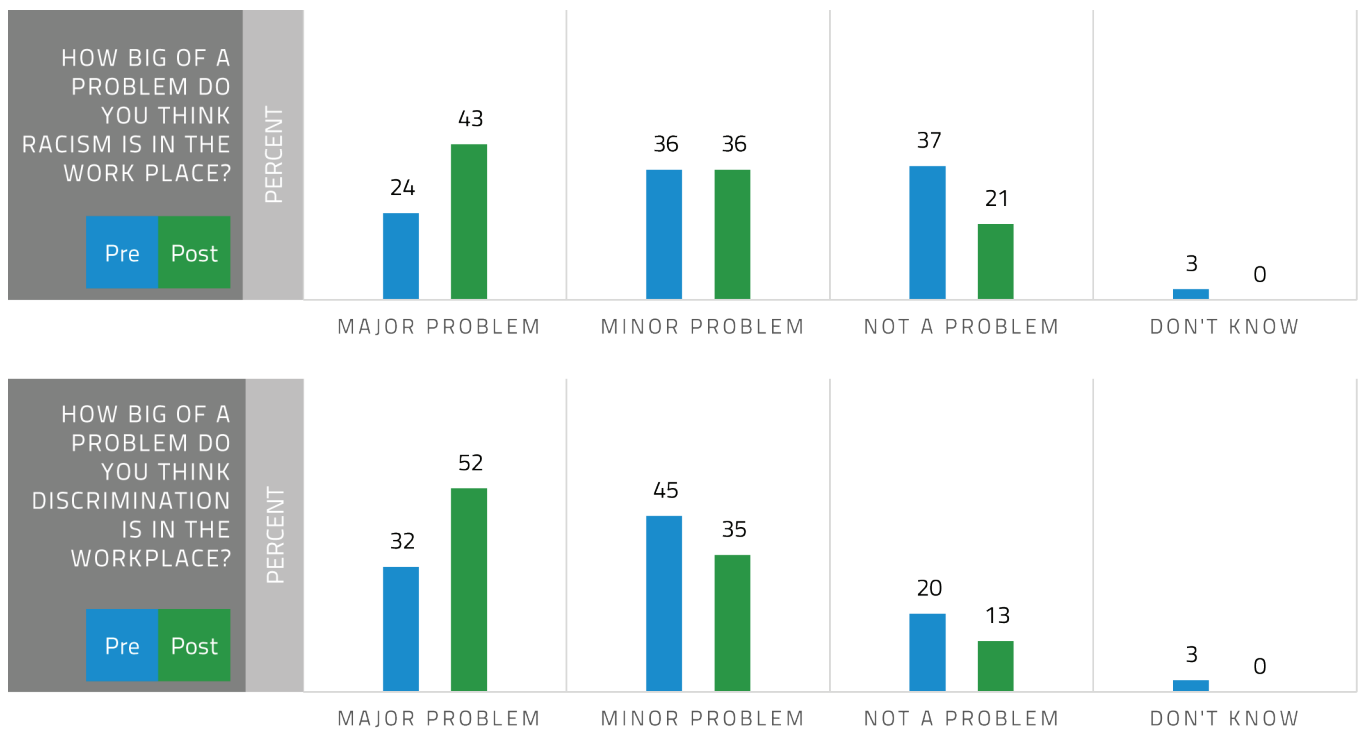
FIGURE 4. PERCEPTIONS OF RACISM AND DISCRIMINATION IN HEALTH, BY ORGANIZATION TYPE



- At baseline (pre-training), about half of the respondents thought that racism (53%) and discrimination (52%), were major problems in the health sector.
- There were substantial changes in these perceptions after the training, with two thirds of the respondents indicating that racism (68%) and discrimination (69%) were major problems in health. Conversely, there were reductions in the proportions of respondents who thought racism and discrimination were only minor problems or not problems at all in health.
- The majority of the respondents (62%) who thought racism was a minor problem at baseline thought it was major problem afterwards. Similarly, the majority (70%) of those who initially thought racism was not a problem in health thought it was at least a minor problem afterwards (*data not presented*).

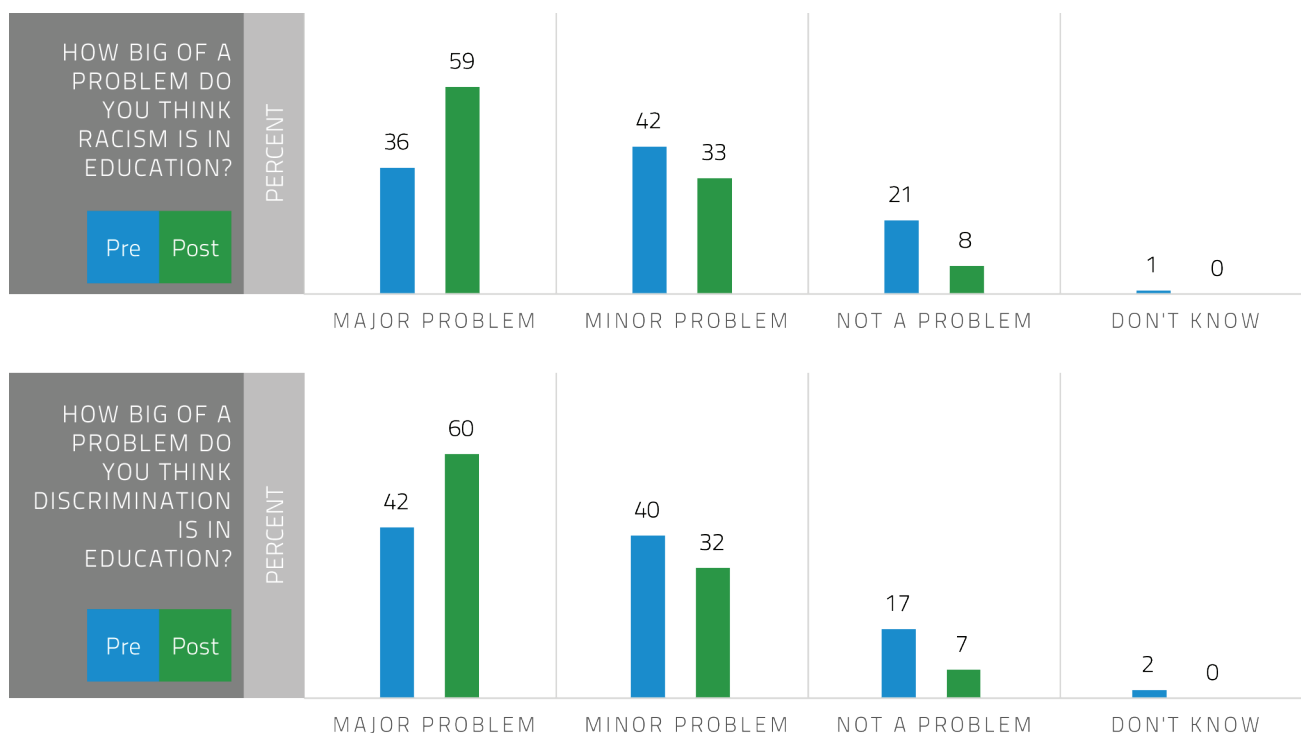
- Respondents working in academic institutions were the most likely to view racism and discrimination as major problems in health.
  - ♦ At least two thirds of such respondents viewed racism (67%) and discrimination (72%) as major problems in health, while about half of those working in city/county/health departments saw racism (50%) and discrimination (49%) as major problems in health.
  - ♦ Less than half of those who work for nonprofit organizations—44% and 47%, respectively—thought racism and discrimination were major problems in health.

FIGURE 5. PERCEPTIONS OF RACISM AND DISCRIMINATION IN THE WORKPLACE



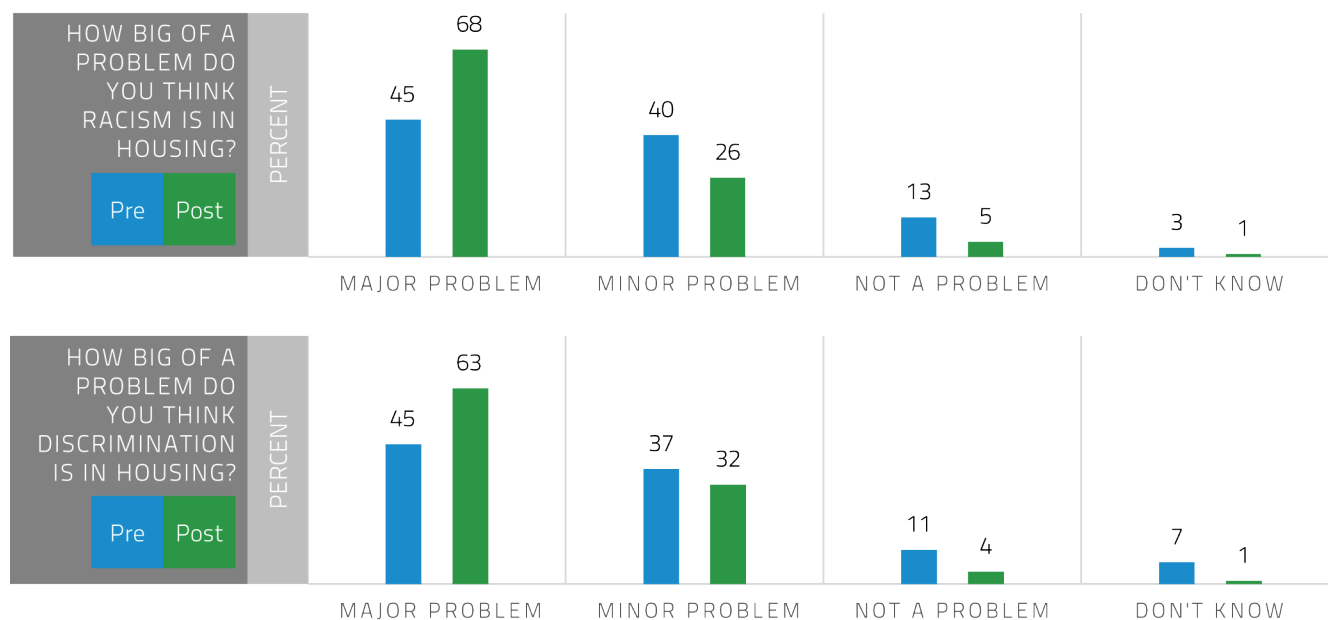
- At baseline, less than one quarter (24%) and one third (32%) of the respondents believed that racism and discrimination, respectively, were major problems in the workplace.
- After the training, more respondents indicated that racism (43%) and discrimination (52%) were major problems in the workplace, while fewer respondents indicated that these were either minor problems or were not problems at all.

FIGURE 6. PERCEPTIONS OF RACISM AND DISCRIMINATION IN EDUCATION



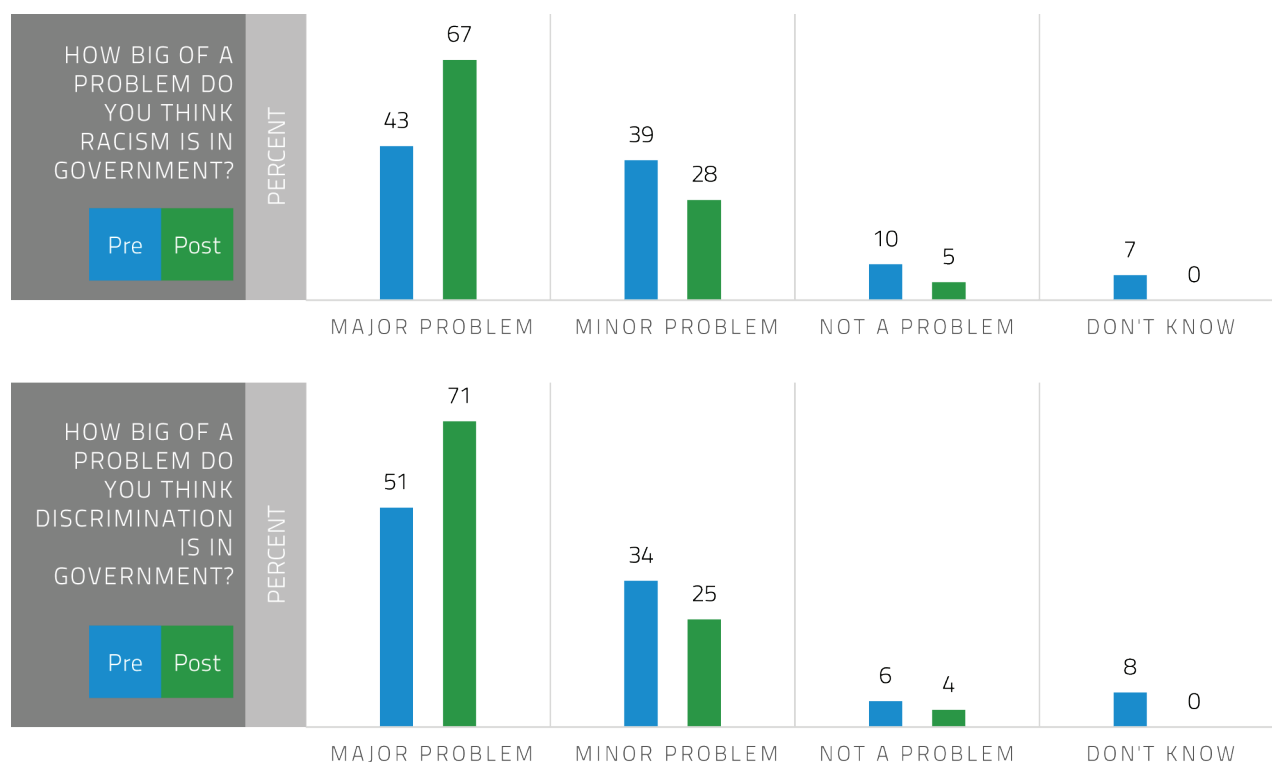
- Before the training, more than one third of respondents believed that racism (36%) and discrimination (42%) were major problems in the education.
- This response pattern changed after the training, with 59% and 60% indicating that racism and discrimination, respectively, were major problems in education.

FIGURE 7. PERCEPTIONS OF RACISM AND DISCRIMINATION IN HOUSING



- Before the training, 45% of participants thought that both racism and discrimination were major problems in housing. Again, these proportions grew considerably after the training, with 68% and 63% of the respondents indicating that racism and discrimination were major problems in housing.

**FIGURE 8. PERCEPTIONS OF RACISM AND DISCRIMINATION IN GOVERNMENT**



- Before the training, 43% and 51% of the respondents indicated that racism and discrimination, respectively, were major problems in government.
- After the training, these proportions increased to slightly more than two thirds (67% and 71%) of the respondents.

## **PERCEPTIONS OF THE INFLUENCE OF RACE/ETHNICITY ON HEALTH CARE QUALITY**

### **MEASURES**

Pre-training and post-training perceptions of the participants regarding the influence of race on the quality of health care received by the general public were assessed based on the responses to the following questions:

Do you think the color of one's skin determines the quality of health care they receive?

How likely do you think the:

- ◆ Average Black/African American is to receive Quality Medical Care in your community?
- ◆ Average White is to receive Quality Medical Care in your community?
- ◆ Average Hispanic/Latino is to receive Quality Medical Care in your community?
- ◆ Average Asian American or Pacific Islander is to receive Quality Medical Care in your community?

FIGURE 9. PERCEPTIONS ABOUT SKIN COLOR AND HEALTH CARE QUALITY

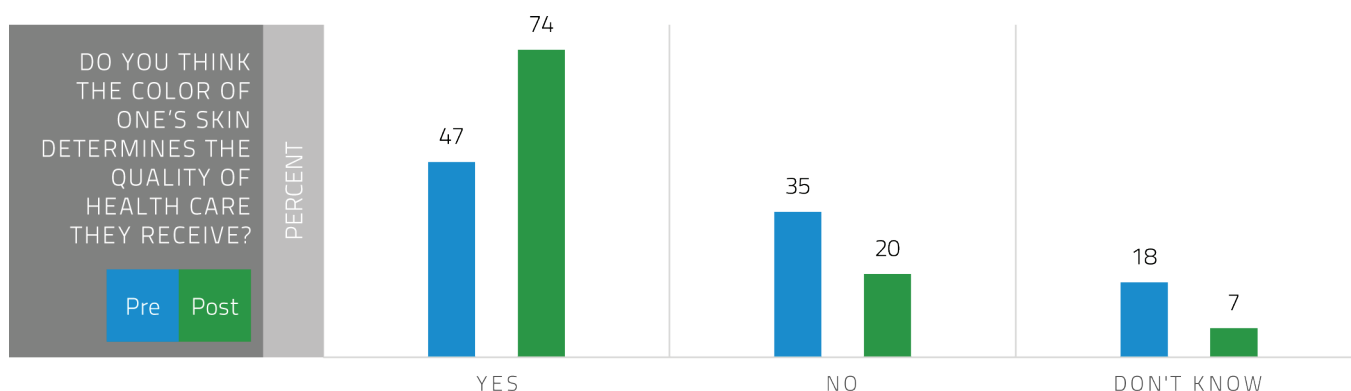
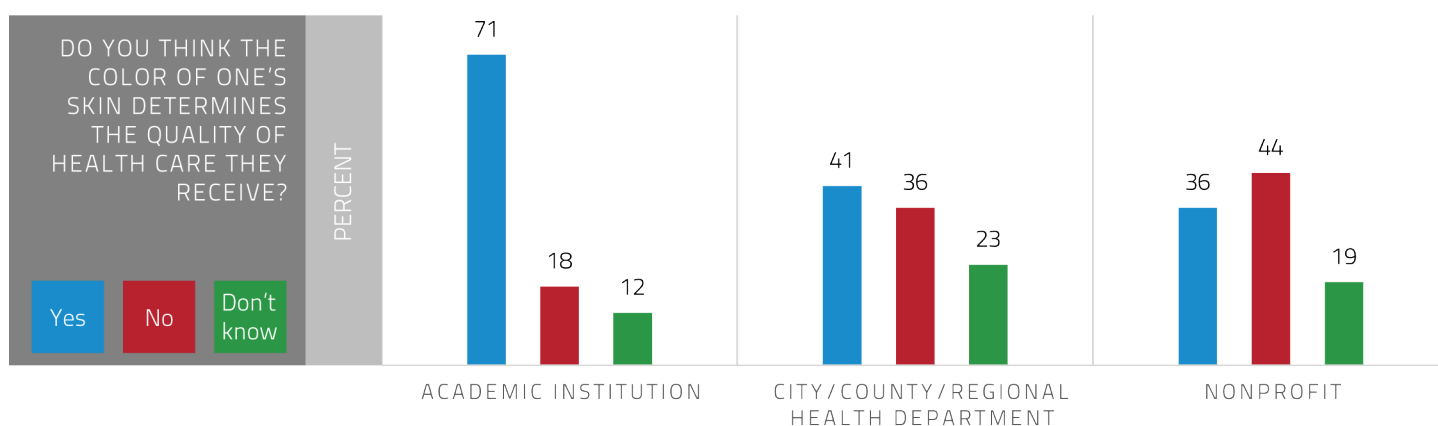


FIGURE 10. PERCEPTIONS ABOUT SKIN COLOR AND HEALTH CARE QUALITY, BY ORGANIZATION TYPE



- At baseline, less than half of the respondents (47%) thought that skin color was a determinant of health care quality. A little over one third (35%) of respondents thought it was not a determinant, and 18% did not know if it affected health care quality.
- After the training, however, the proportion of those who thought skin color affected health care increased to almost three quarters (74%) of the respondents.
- Among those who answered “no” at baseline, more than half (53%) changed their responses to “yes” after the training; about 41% still answered “no.” (Data not presented).
- Conversely, the proportion who thought that skin color was not a determinant of health care quality fell by over 15 percentage points to 20% of the respondents.
- Respondents working at academic institutions (71%) were much more likely to think that skin color was a determinant of health care quality than those working at city/county/health departments (41%) or at nonprofit organizations (36%).
- Over two thirds (68%) of the Black/African American respondents thought skin color was a determinant of health care quality, while less than half (47%) of the Hispanic respondents and just over one third (38%) of the White respondents thought so. (*data not presented*).

FIGURE 11. PERCEPTIONS ABOUT RACE AND MEDICAL CARE



- At baseline, just about 1 in 6 and 1 in 8 respondents indicated that Blacks/African Americans and Hispanics, respectively, were “very likely” to receive quality medical care. About 60% indicated that Whites were “very likely” to receive quality care, while over a quarter (27%) thought the same about Asian Americans/Pacific Islanders.
- After the training, approximately 10% of respondents indicated that African Americans and Hispanics were likely to receive quality care.
- No Black/African American, about 1 in 8 White respondents, and about one quarter of Hispanic respondents, thought Blacks/African Americans were “very likely” to receive quality medical care. There was a similar response pattern for the likelihood of Hispanics receiving quality medical care.
- Just about one quarter of the Black/African American and White respondents, and about one third of the Hispanic respondents, thought Asian Americans were “very likely” to receive quality medical care. On the other hand, more than half of the Black/African American, White, and Hispanic respondents thought that Whites were “very likely” to receive quality medical care.

## PERCEPTIONS OF SOCIODEMOGRAPHIC AXES OF DISCRIMINATION IN THE HEALTHCARE SYSTEM

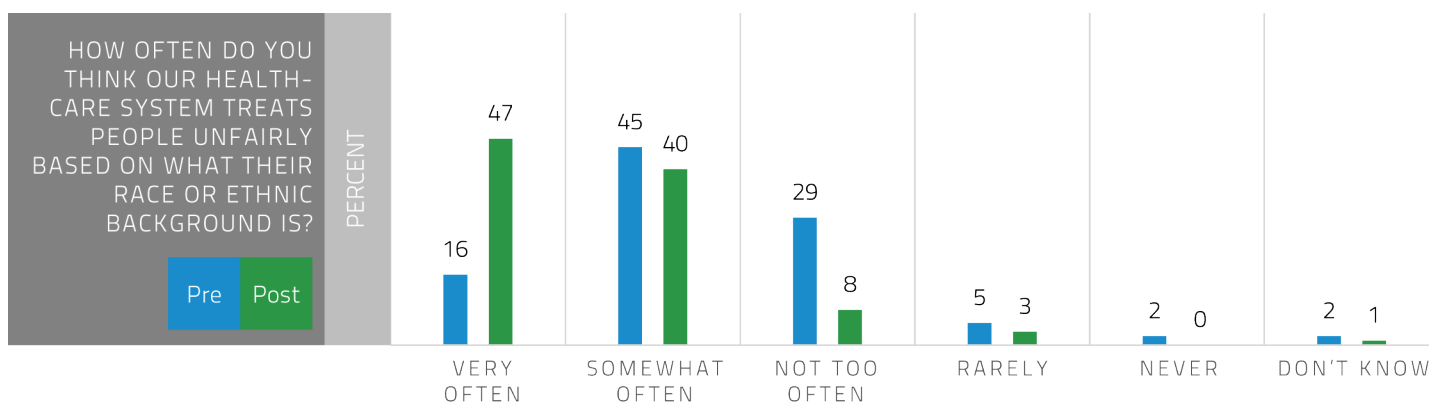
### MEASURES

The participants’ pre-training and post-training perceptions of discrimination in the healthcare system based on sociodemographic factors were assessed based on the responses to the following questions:

How often do you think our Healthcare System treats people unfairly based on:

- ◆ What their race or ethnic background is?
- ◆ Their gender?
- ◆ How much money they have?
- ◆ Whether or not they have health insurance?
- ◆ How educated they are?
- ◆ How well they speak English?

FIGURE 12. PERCEPTIONS ABOUT RACE AND THE HEALTHCARE SYSTEM



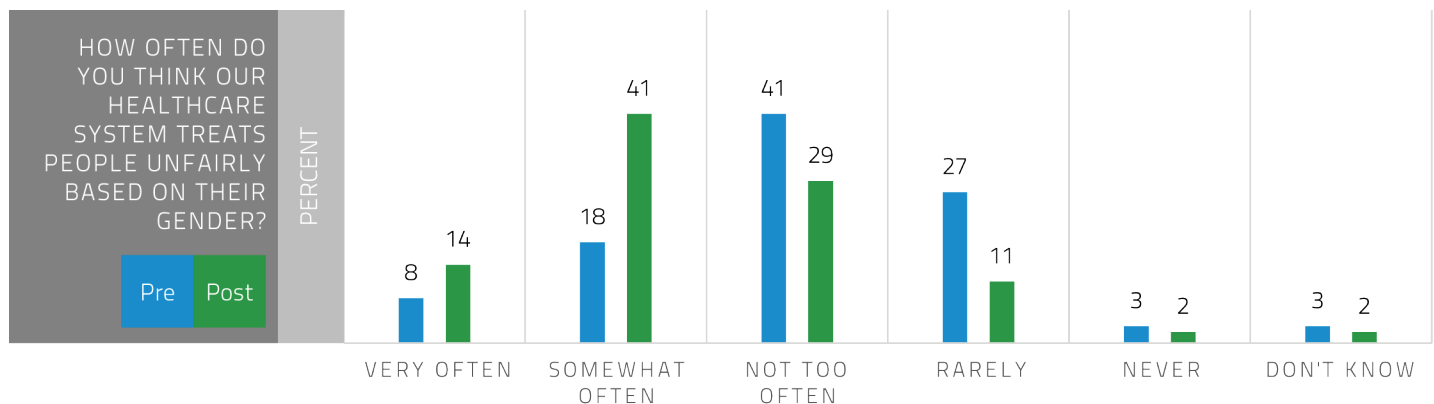


- At baseline, 16% of respondents indicated that the healthcare system treats people unfairly based on their race/ethnicity “very often,” while 45% thought this occurred “somewhat often,” 29% “not too often,” and 7% “rarely” or “never.”
- After the training, however, the proportion who reported that race/ethnicity was “very often” a basis for unfair treatment nearly tripled to 47%.
- Among the respondents who indicated “not too often” at baseline, almost one third (32%) and one half changed to “very often” and “somewhat often,” respectively, after the training, and 43% of those who thought this occurred “somewhat often” thought it occurred “very often” after the training (*data not presented*).

### COMPARISON WITH PREVIOUS SURVEY FINDINGS

- At baseline, 61% of respondents indicated that the healthcare system treats people unfairly based on their race/ethnicity, either “somewhat often” or “very often.”
- In previous surveys among medical students, physicians, and the public, similar responses were made by 52% of the public in 1999, 30% of physicians in 2001, and 57% of first and fourth year medical students in 2004.<sup>14,15,17</sup>

FIGURE 13. PERCEPTIONS ABOUT GENDER AND THE HEALTHCARE SYSTEM

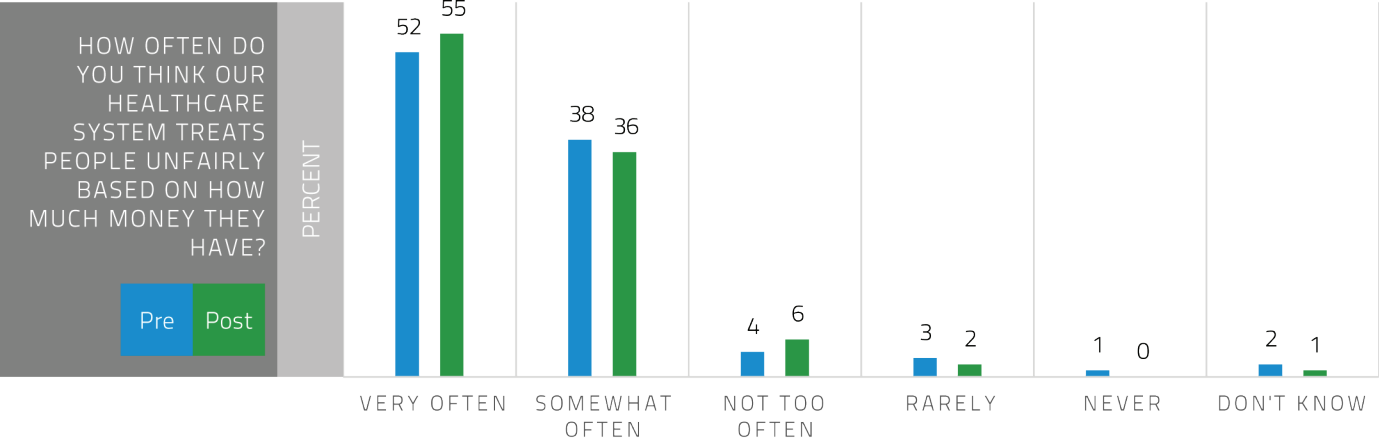


- At baseline, only 8% and 18% of respondents thought gender was a basis for unfair treatment “very often” and “somewhat often,” respectively, while most thought it was a basis “not too often” (41%) or “rarely” (27%).
- After the training, the combined percentage who thought gender was “very often” or “somewhat often” a basis for unfair treatment doubled, from 26% to 55%.

### COMPARISON WITH PREVIOUS SURVEY FINDINGS

- In this survey, 26% of the respondents indicated that people were treated unfairly based on their gender, either “somewhat often” or “very often,” compared to 27% of the public in 1999 and 15% of physicians in 2002.<sup>14,15,17</sup>

FIGURE 14. PERCEPTIONS ABOUT MONEY AND THE HEALTHCARE SYSTEM

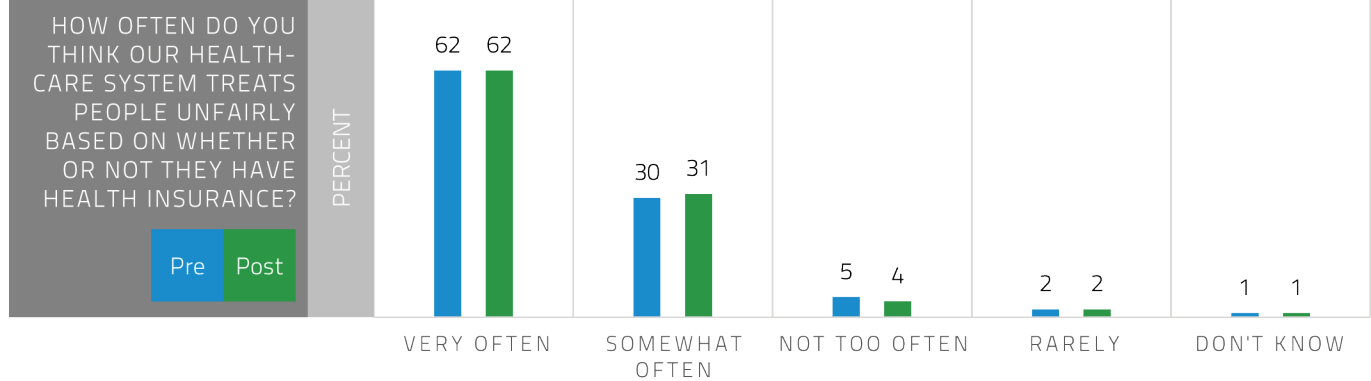


- More than half of the respondents (52%) reported that the healthcare system treats people unfairly based on how much money they have “very often,” and one third (38%) indicated “somewhat often” at baseline. This pattern did not change following the training.

COMPARISONS WITH PREVIOUS SURVEY FINDINGS

- While 90% of the respondents to this survey indicated, at baseline, that the healthcare system treats people unfairly based on how much money they have either “somewhat often” or “very often,” 73% of the public in 1999, 47% of physicians in 2001, and 71% of first and fourth year medical students in 2004 chose the same response.<sup>14,15,17</sup>

FIGURE 15. PERCEPTIONS ABOUT HEALTH INSURANCE AND THE HEALTHCARE SYSTEM

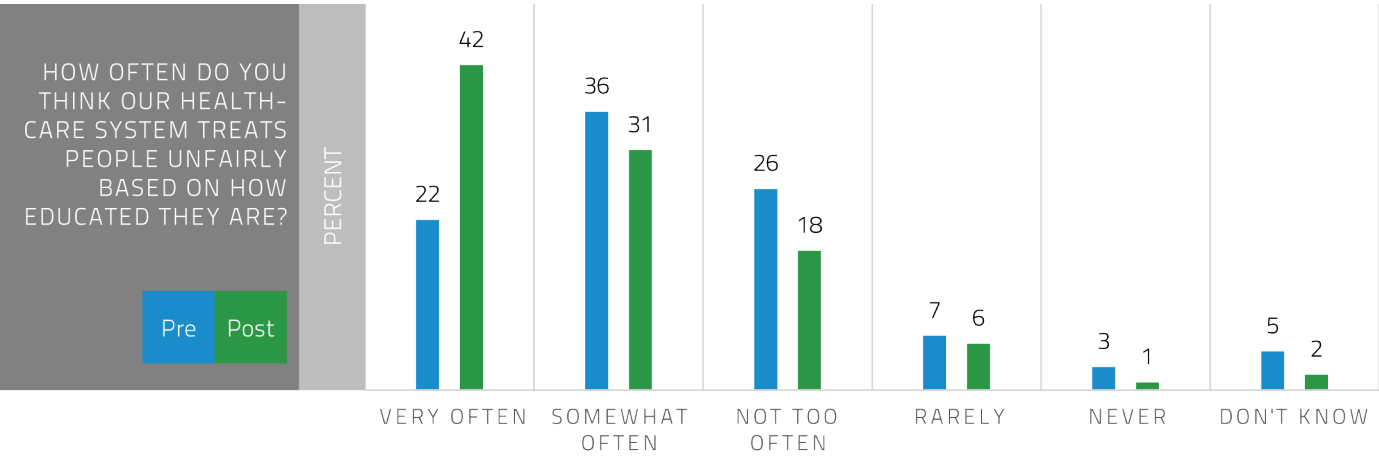


- At baseline, close to two thirds (62%) of the respondents thought that whether or not one had health insurance was “very often” a basis for unfair treatment by the healthcare system, and slightly less than one third (30%) indicated “somewhat often.”
- This response pattern did not change significantly after the training.

COMPARISONS WITH PREVIOUS SURVEY FINDINGS

- At baseline, 92% of respondents indicated that the healthcare system treats people unfairly based on whether or not they have health insurance, either “somewhat often” or “very often.”
- In previous surveys, similar responses were made by 74% of the public in 1999, 73% of physicians in 2001, and 82% of first and fourth year medical students in 2004.<sup>14,15,17</sup>

FIGURE 16. PERCEPTIONS ABOUT EDUCATION AND THE HEALTHCARE SYSTEM



- At baseline, less than one quarter (22%) of the respondents thought that one’s level of education was “very often” a basis for unfair treatment by the health sector, and about one third (36%) indicated “somewhat often.”
- The percentage of respondents who thought education was “very often” a basis for unfair treatment increased to about 42% after the training.

COMPARISONS WITH PREVIOUS SURVEY FINDINGS

- Over half (58%) of the respondents indicated that people were treated unfairly based on how educated they are, either “somewhat often” or “very often,” while 48% of the public in 1999 and 39% of physicians in 2002 had similar responses.<sup>14,15,17</sup>

PERSONAL EXPERIENCE OF DISCRIMINATION BY THE HEALTHCARE SYSTEM

MEASURE

The participants’ personal experiences of discrimination by the healthcare system were assessed by the responses to the following questions:

Have you ever felt you received poor medical treatment or health care in the past five years because of your ability to pay for care?

Have you ever felt you received poor medical treatment or health care in the past five years because of your race/ethnicity?

FIGURE 17. PAST EXPERIENCE OF DISCRIMINATION IN MEDICAL CARE BASED ON ABILITY TO PAY

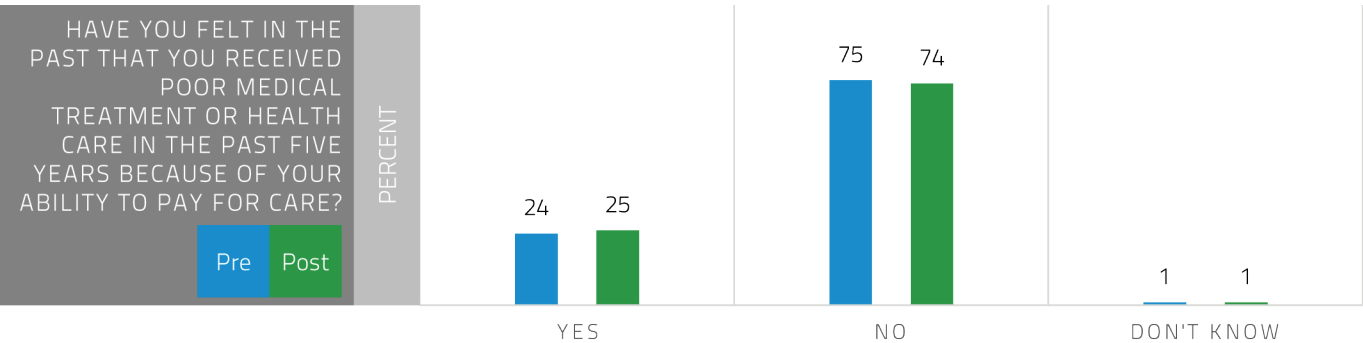
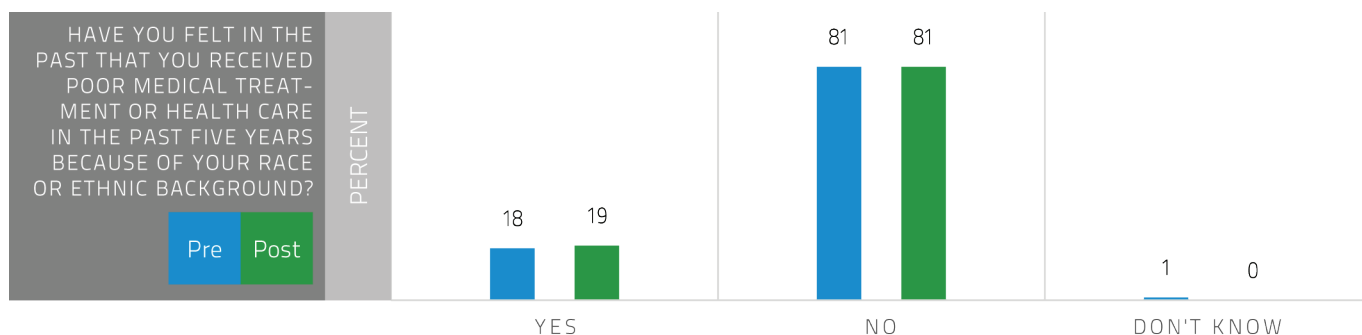


FIGURE 18. PAST EXPERIENCE OF DISCRIMINATION IN MEDICAL CARE BASED ON RACE/ETHNICITY



- At baseline, almost one quarter (24%) and 18% of the respondents reported having received poor medical treatment in the previous 5-year period based on ability to pay for care and on their racial/ethnic background, respectively.

## COMPARISON WITH PREVIOUS SURVEY FINDINGS

- In a 1999 survey of the public, 14% and 6% of the public reported poor medical treatment in the preceding 5-year period based on their inability to pay for care and on their racial/ethnic background, respectively.<sup>17</sup>

## KNOWLEDGE OF HEALTH DISPARITIES

### KNOWLEDGE OF DISPARITIES IN HEALTH BEHAVIOR

#### BACKGROUND

- The Centers for Disease Control and Prevention's (CDC's) Health Disparities report shows that Hispanics and Blacks were less likely to utilize preventive services such as receiving seasonal flu vaccines from 2000-2010, or undergoing screening for colorectal cancer during the period 2002-2008.<sup>6</sup>

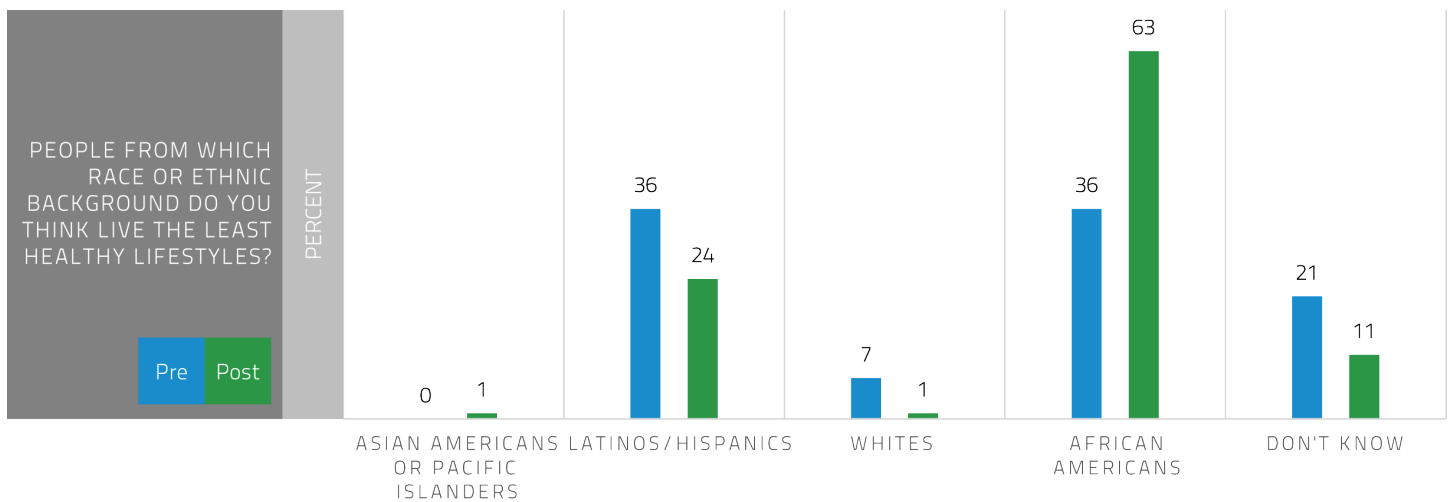
#### MEASURE

The participants' knowledge of disparities in healthy lifestyles and use of preventive services, based on race/ethnicity, was assessed based on the responses to the following questions:

People from which race or ethnic background do you think live the least healthy lifestyles?

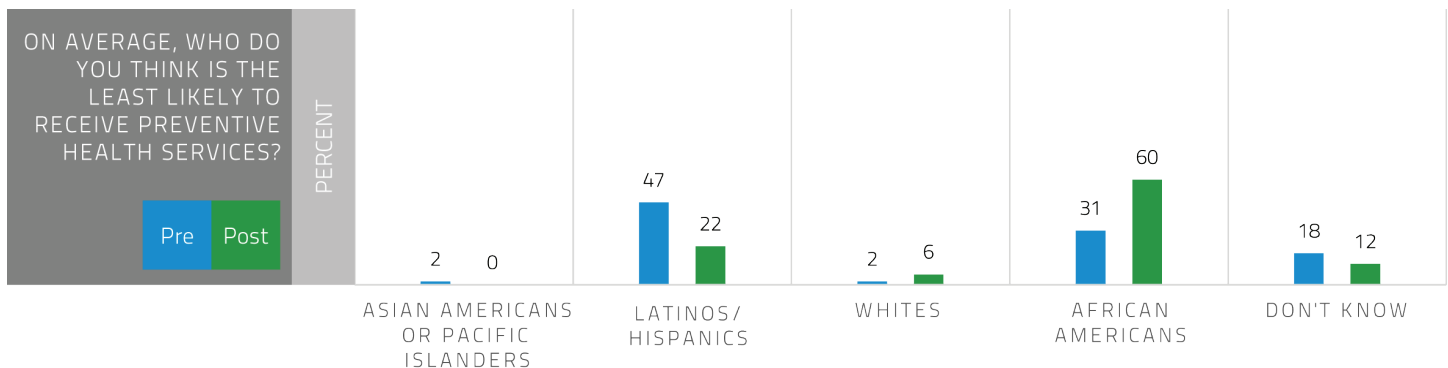
On average, who do you think is the least likely to receive preventive health services?

FIGURE 19. KNOWLEDGE ABOUT RACE AND UNHEALTHY LIFESTYLES



- At baseline, about 36% of respondents indicated Blacks/African Americans and Hispanics led the least healthy lifestyles, and 21% did not know the response to the question.
- After the training there was a shift to believe that Blacks/African Americans live the least healthy lifestyles compare to Hispanics, with 63% and 24%, respectively, indicating that Blacks/African Americans and Hispanics lead the least healthy lifestyles.

FIGURE 20. KNOWLEDGE ABOUT RACE AND RECEIPT OF PREVENTIVE HEALTH SERVICES



- Before the training, almost half of the respondents (47%) indicated that Hispanics were the least likely to receive preventive health care service, almost one third (31%) indicated that Blacks/African Americans were the least likely, while about 2% each said Whites and Asian Americans/Pacific Islanders were the least likely to receive preventive health services.
- The higher baseline percentages for Hispanics compared to Blacks/African Americans reversed after the training, with more than half (60%) indicating that African Americans, and less than one quarter (22%) reporting Hispanics, were the least likely to receive preventive care.

## KNOWLEDGE OF DISPARITIES IN HEALTH CARE ACCESS

### BACKGROUND

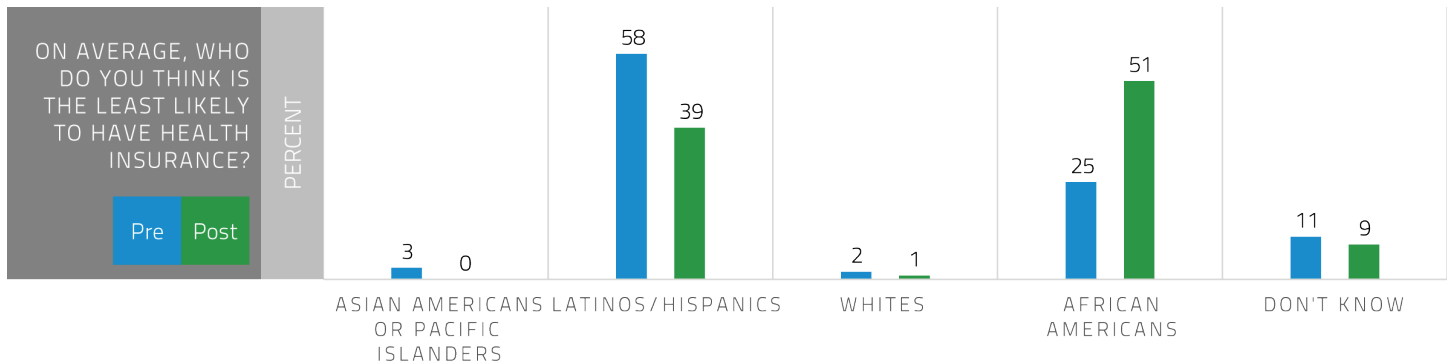
- According to the CDC, Hispanics and Blacks were 3 times and 2 times as likely, respectively, as non-Hispanic Whites to not have health insurance in 2004 and 2008.<sup>6</sup>

## MEASURE

The participants' knowledge of disparities in health care access was assessed based on the response to the following question:

On average, who do you think is the least likely to have health insurance?

FIGURE 21. KNOWLEDGE ABOUT RACE AND HEALTH INSURANCE



- At baseline, more than half of the respondents (58%) reported that Hispanics were the least likely to have health insurance, compared with one quarter (25%) who thought African Americans were the least likely.
- This pattern also changed and reversed somewhat after the training, with half of respondents (51%) indicating that African Americans were the least likely to have health insurance and 39% reporting Hispanics were the least likely to have health insurance, which indicates a shift to less knowledgeable responses.

## KNOWLEDGE OF DISPARITIES IN HEALTH OUTCOMES

### BACKGROUND

- National data shows that Blacks/African Americans had the highest rates of infant mortality, while Asian/Pacific Islanders had the lowest infant mortality.<sup>6,18</sup>
- Recent national data show that among Whites, Blacks and Hispanics, Blacks are the most likely to be diagnosed with HIV/AIDS.<sup>6,19</sup> The highest rates of new diagnosis of diabetes were seen in non-Hispanic Blacks, and Pacific Islanders/Native Hawaiians.<sup>6,20,21</sup> Blacks also have the highest incidence of cancer and hypertension.<sup>6,22,23</sup>

## MEASURE

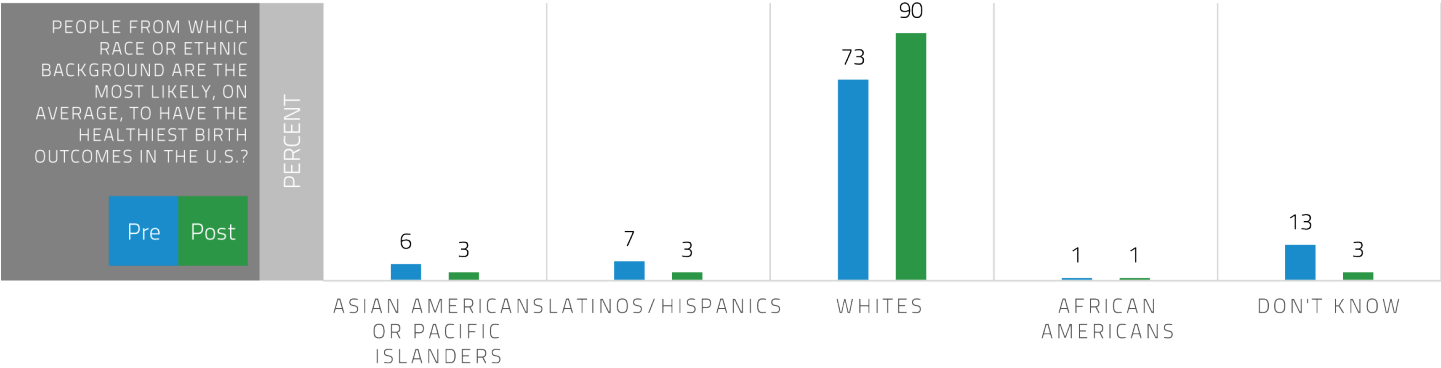
Knowledge of disparities in health outcomes was assessed based on the responses to the following questions:

People from which race or ethnic background are the most likely, on average, to have the healthiest birth outcomes in the U.S?

People from which race or ethnic background are the most likely, on average, to be diagnosed with:

- ◆ Acquired Immune Deficiency Syndrome (AIDS) or HIV virus?
- ◆ Cardiovascular disease?
- ◆ Diabetes?
- ◆ Cancer?

FIGURE 22. KNOWLEDGE ABOUT RACE AND BIRTH OUTCOMES



- At baseline, the majority of respondents (73%) identified Whites as having the healthiest birth outcomes, and this proportion increased to 90% after the training.
- Before and after the training, only 1% of respondents reported that African Americans are the most likely to have the healthiest birth outcomes.



FIGURE 23. KNOWLEDGE ABOUT RACE AND DISEASE DIAGNOSES



- At baseline, almost two thirds (66%) of the respondents indicated that Blacks/African Americans were the most likely to be diagnosed with the Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome (HIV/AIDS).
  - ◆ Blacks/African Americans were also thought to be more likely than any other race/ethnic group to be diagnosed with cardiovascular diseases.
  - ◆ On the other hand, more than half of the respondents indicated that Whites and Hispanics were the most likely to be diagnosed with cancer and diabetes, respectively.
- A notable change in these response patterns after the training was that 61% and 51% indicated afterward that Blacks/African Americans were the most likely to be diagnosed with diabetes and cancer, respectively.

## ATTITUDES TOWARD HEALTH DISPARITIES

### MEASURE

Attitudes towards, and explanations for, health disparities, were assessed based on the responses to the following questions:

In your opinion, how strongly do you agree or disagree with each of the reasons below as being causes of why some groups are healthier than others in the U.S.?

- ◆ Differences in their health habits such as healthy food, getting exercise, or not smoking, and managing stress
- ◆ Differences in the communities they live in such as having grocery stores selling healthy foods, having streets with sidewalks, having safe parks to play, and having supportive neighbors
- ◆ Differences in their healthcare coverage
- ◆ Differences in their physical environment such as the quality of air or water
- ◆ Differences in genes inherited from their parents
- ◆ In your opinion, what is the most important reason that different groups in the U.S may be expected to live shorter lives, on average, compared to the average American in the U.S?
- ◆ In your opinion, who should be responsible for making sure that health care is equitable for everyone in society?

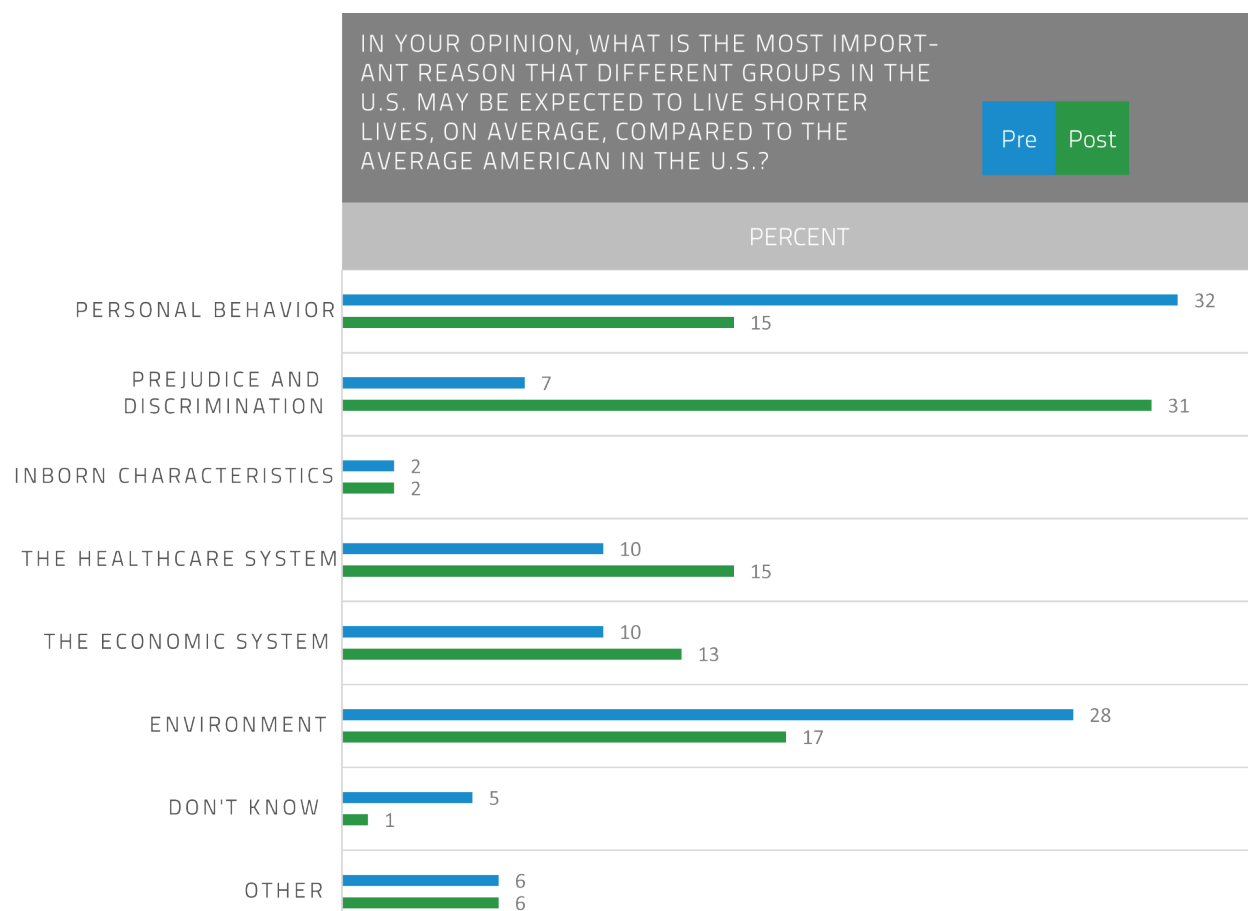
FIGURE 24. PERCEPTIONS ABOUT DETERMINANTS OF HEALTH DISPARITIES



In your opinion, how strongly do you agree or disagree with each of the reasons below as being causes of why some groups are healthier than others in the U.S.?

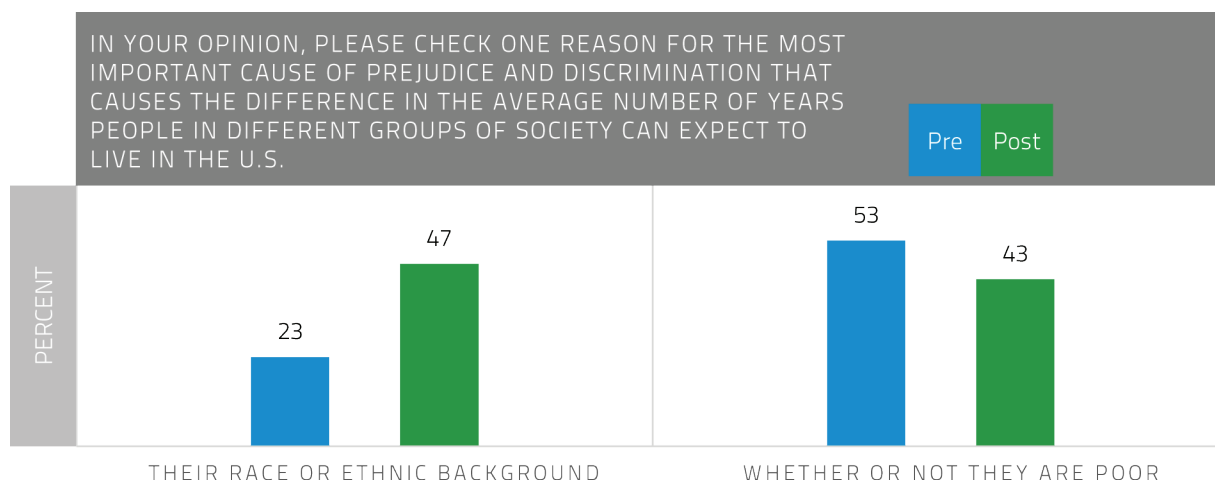
- At baseline, the majority of respondents either “agreed” or “strongly agreed” that differences in each of the following health determinants were reasons for health disparities: community/neighborhood characteristics, health habits, the physical environment, healthcare coverage, and inherited genes.
- The majority of respondents “strongly agreed” that health habits (77%) and communities (69%) were reasons for the disparities, while slightly less than half of respondents “strongly agreed” that differences in healthcare coverage or the physical environment were contributing factors. Only about one quarter “strongly agreed” with inherited genes as a reason.
- There were no notable changes in this response pattern after the training.

FIGURE 25. PERCEPTIONS ABOUT CAUSES OF DISPARITIES IN LIFE EXPECTANCY



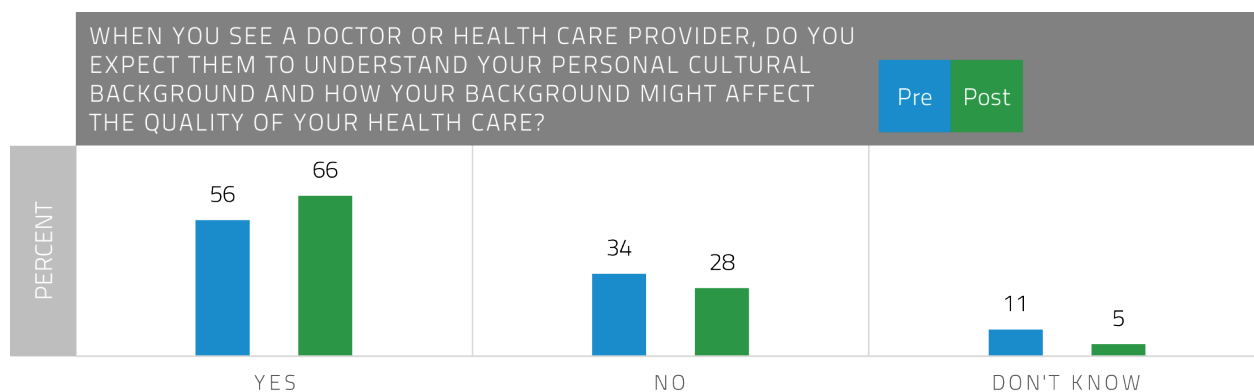
- At baseline, when respondents were asked to identify the most important reason for the differences in life expectancy for different groups in society, “personal behavior” was the cause most commonly identified by respondents (32%). The “environment” was cited by 28%, while about 1 in 10 (10%) respondents each reported “economic system” and “healthcare system.”
- This response pattern changed after the training, with “prejudice” as the most common reason reported by participants (31%), and the percent reporting “personal behavior” dropped by half, to 15% of respondents.

**FIGURE 26. PERCEPTIONS ABOUT PREJUDICE AND DISCRIMINATION THAT LEAD TO DISPARITIES IN LIFE EXPECTANCY**



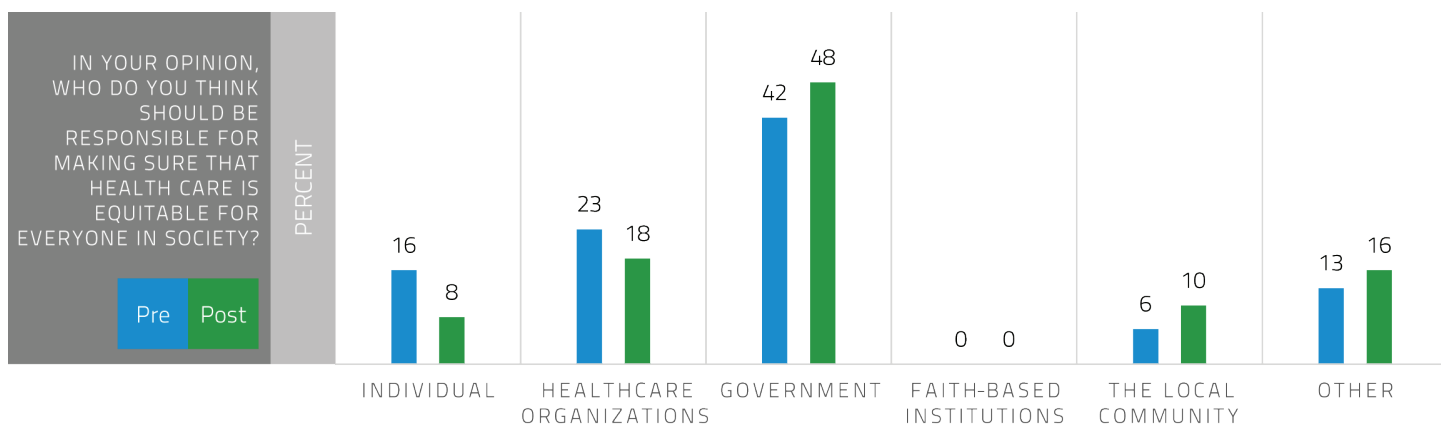
- Less than one quarter (23%) of the respondents thought race/ethnicity was the underlying reason for prejudice and discrimination leading to disparities in life expectancy, while more than half (53%) cited poverty as the underlying reason.
- After the training, almost half of the respondents (47%) attributed health disparities in life expectancy to prejudice and discrimination based on race/ethnicity, while 43% thought poverty was the underlying reason.

**FIGURE 27. EXPECTATIONS REGARDING CULTURAL COMPETENCY OF HEALTH PROVIDERS**



- At baseline and after the training, the majority of respondents (56% and 66% respectively) indicated that they expected their health providers to be culturally competent during their clinical encounters and interactions.

FIGURE 28. PERCEPTIONS ABOUT ENTITIES RESPONSIBLE FOR ENSURING HEALTH EQUITY



- When asked at baseline about who should be responsible for ensuring equity in health care, the government was the most commonly identified entity (42%), while 23% reported healthcare organizations, and 16% reported individuals.
- After the training, even fewer respondents (8% vs. 16%) reported individuals as being responsible for ensuring equity in health care. There was also a decrease in responsibility of healthcare organizations, and increase in government responsibility.

## EXPOSURE TO HEALTH DISPARITIES INFORMATION

### MEASURE

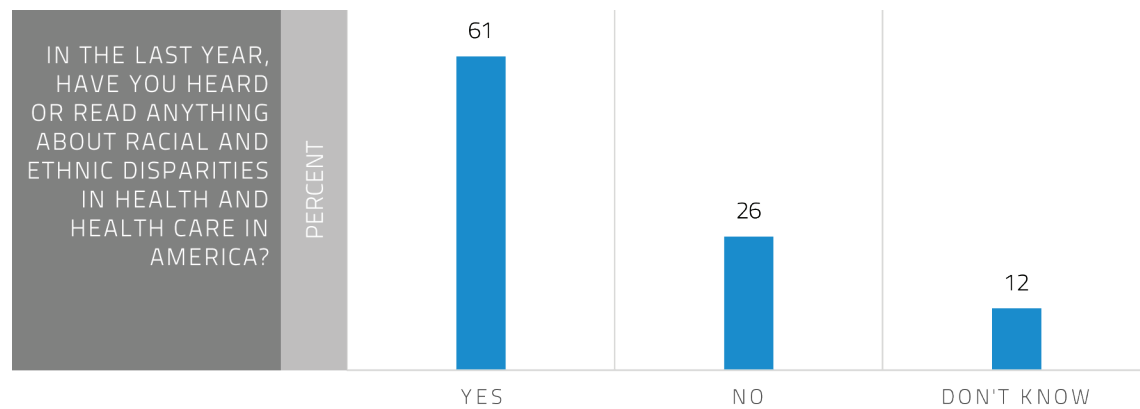
The participants' exposure to information on health disparities was assessed based on their responses to the following questions:

In the last year, have you heard of or read anything about racial and ethnic disparities in health and health care in America?

Have you ever heard of any of the following public health campaigns or read or seen any of the following publications or television series?

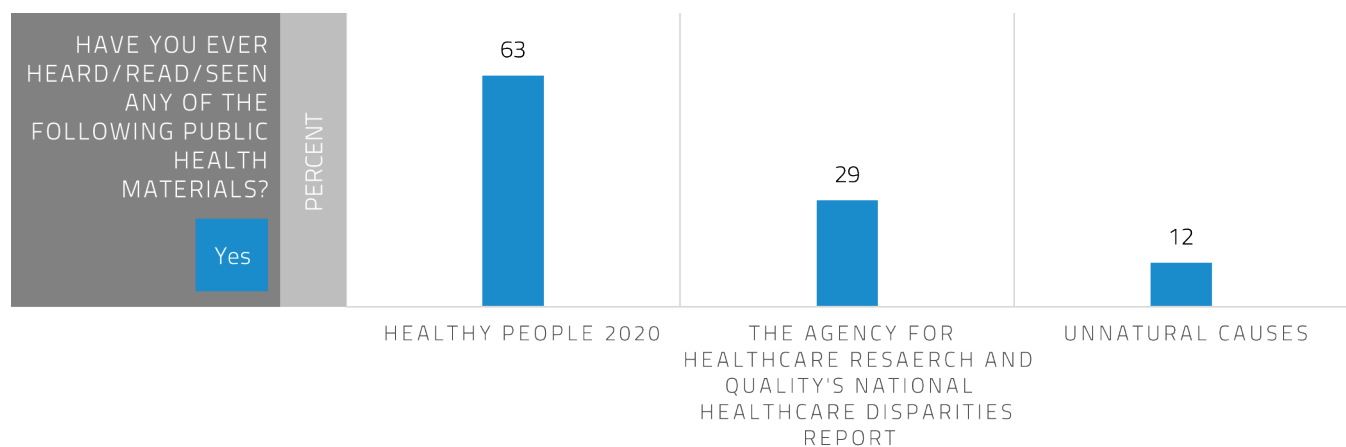
- ◆ The U.S. Department of Health and Human Services' Healthy People 2020
- ◆ The Agency for Healthcare Research and Quality's Healthcare Disparities Report
- ◆ Unnatural Causes

**FIGURE 29. BASELINE EXPOSURE TO INFORMATION ABOUT RACIAL DISPARITIES IN HEALTH IN THE PAST YEAR**



- About one quarter of respondents (26%) indicated having not heard or read anything about racial health disparities in the past year.
- On the other hand, 61% had heard or read about health disparities based on race in the past year.

**FIGURE 30. BASELINE EXPOSURE TO MAJOR DOCUMENTS/DOCUMENTARY HIGHLIGHTING RACIAL DISPARITIES IN HEALTH**



- The majority of participants had heard of at least one of two major national documents that highlight racial disparities in health—“Healthy People 2020” and the Agency for Healthcare Research and Quality’s (AHRQ) National Healthcare Disparities Report.
- Only 12% could recall having seen the documentary “*Unnatural Causes*.”



# FOCUS GROUP METHODS

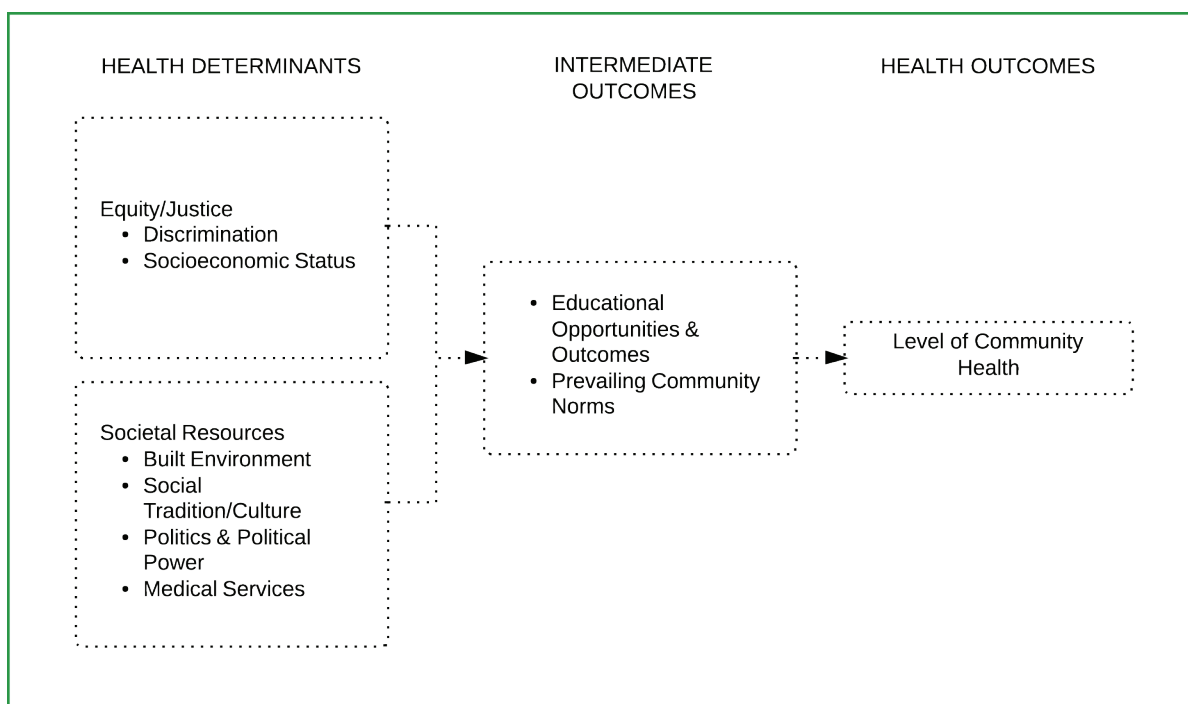
Four focus groups were conducted with selected *Transforming Texas* sub-grantees and community partners.

The aim of the focus groups was to gather insight from the sub-grantees and community partners about their knowledge, awareness, perceptions, and beliefs about health disparities and health inequities in their local communities. Approval for the focus groups was obtained from the UNTHSC IRB.

A pre-established focus group moderator guide was employed to create a conversation among participants on health disparities and health inequities in the participants' local communities. The conversations were documented by a digital audio recording device and a note taker, which were the same for all four focus groups. The focus groups were conducted in English. Prior to beginning the focus groups, participants were asked to complete a demographic survey.

The focus group audio recordings were then transcribed by a trained qualitative research analyst. Transcriptions were assessed for themes using inductive methods. After a preliminary set of themes was identified, a team of four selected the most salient themes, emphasizing those most relevant to the study. Within each broad theme, several subthemes were developed. Themes were input into NVivo, a qualitative data analysis software tool, using a parent/child node structure, and a summary of each site was developed. Another researcher looked for commonalities in the themes and cleaned the document, leaving 60 unique themes. The new themes were applied to a revised version of the CDC Community Guide framework,<sup>24</sup> which left a final total of 57 themes.

FIGURE 31. REVISED CDC COMMUNITY GUIDE FRAMEWORK



Each focus group transcript was recoded in NVivo by the qualitative researcher using a parent/child theme and subtheme structure. Following the CDC Community Guide Framework, which we adapted and revised for our analysis (see Figure 31), the main themes were organized into categories representing “Equity and Justice,” “Societal Resources,” and “Intermediate Outcomes.” Finally, a codebook was created to illustrate how themes and subthemes fit together.

The Equity and Justice theme included two main subthemes (parent nodes):

- Discrimination, which focuses on discussion of various forms of discrimination cited by focus group participants; and
- Socioeconomic Status, which reflects the ability of community members to afford a healthy lifestyle, as well as the local economy's ability to provide a living wage.

The Societal Resources theme included four main subthemes (parent nodes):

- Built Environment, which features local infrastructure, recreational options, and access/ability to access healthy choices;
- Medical Services, which focuses on the ability to access local health care providers and effective communication;
- Politics and Political Power, which reflects participants' perceptions of who is responsible for addressing health disparities, as well as using politics as a tool to promote health equity; and
- Social Tradition and Culture, which addresses social trends in technology and physical activity.

The Equity and Justice and Societal Resources themes both influence the Intermediate Outcomes theme, which includes two main subthemes (parent nodes):

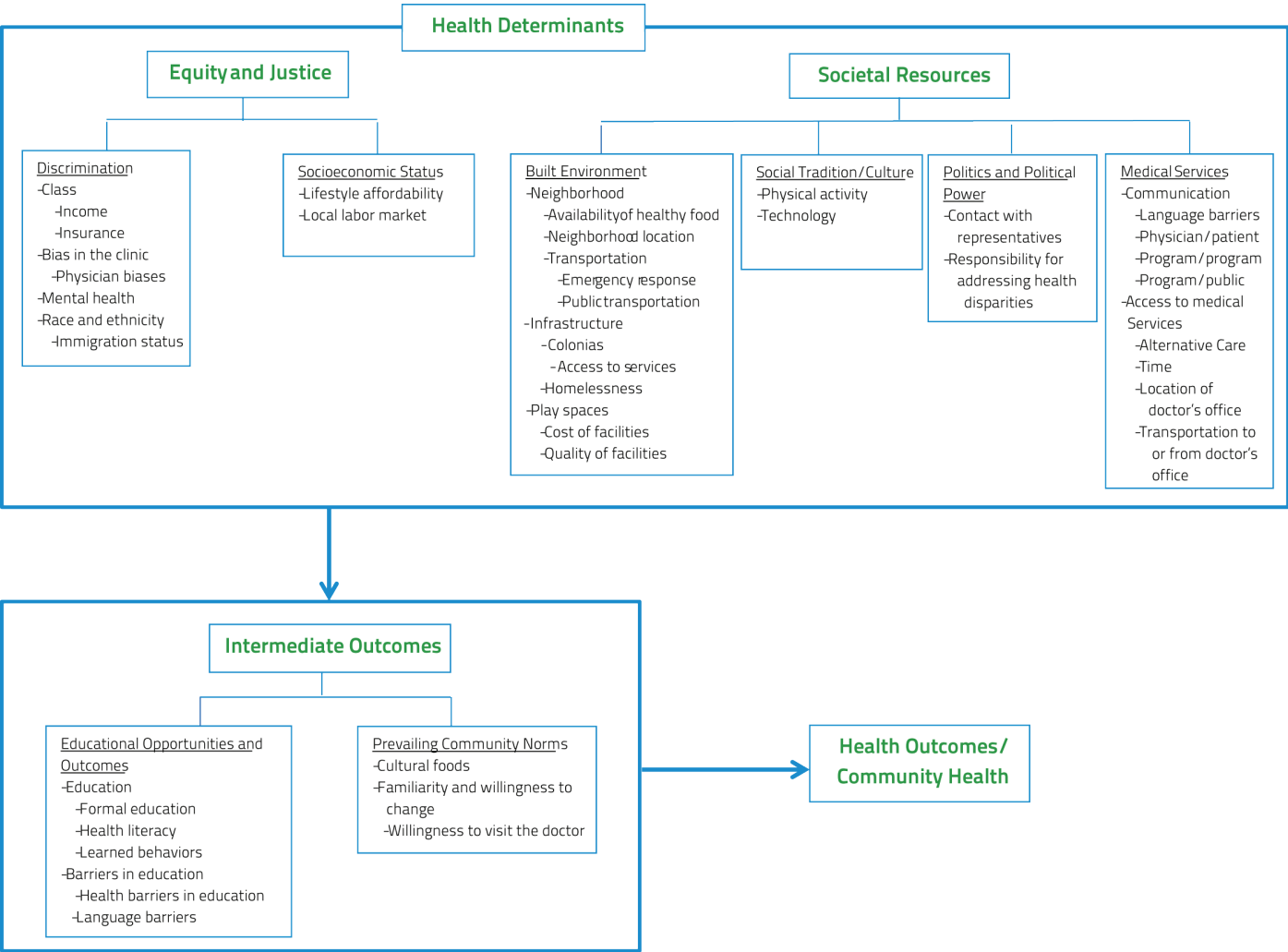
- Educational Opportunities and Outcomes, which features discussions of the relationship between health and education; and
- Prevailing Community Norms, which focuses on comments regarding local dietary practices, cultural beliefs, and community members' willingness to change their behavior.

Responses to the brief demographic survey were compiled and entered into a Microsoft Excel spreadsheet. Descriptive statistics were computed to assess the demographic characteristics of the focus group participants.

## LIMITATIONS

Given the nature of qualitative methods, participants' responses cannot be assumed to be generalizable. Some consensus was reached across the sites about causes and effects of health disparities in highly diverse communities, and focus group responses were often reflected in responses on CEDD survey results discussed earlier in the report. Still, future focus group sessions will reveal the extent to which participants' responses were representative of community attitudes.

FIGURE 32. REVISED CDC COMMUNITY FRAMEWORK WITH THEMES AND SUBTHEMES



The study was exploratory in nature, and was designed to fill a gap in our knowledge of how health disparities are perceived by health professionals in CDC-funded sub-grantee counties. The focus group questions were therefore necessarily broad in nature and limited in scope. The term “community” was not explicitly defined at each focus group session, thus the interpretation was solely up to the individual participant. All themes were not discussed in the same depth at each site, which limits the ability to make comparisons across all sites. In addition, there is always the possibility that, while creating the thematic analysis, the research team may miss nuanced data.

# FOCUS GROUP RESULTS:

## CONTEXTUAL/COMMUNITY-LEVEL ANALYSIS IN SELECTED EVALUATION COUNTIES

TABLE 3. FOCUS GROUP PARTICIPANT CHARACTERISTICS (N=38)

| Characteristic                  | Jim Wells/<br>Willacy County | Webb County | Lubbock<br>County | McLennan<br>County |
|---------------------------------|------------------------------|-------------|-------------------|--------------------|
|                                 | n (%)                        | n (%)       | n (%)             | n (%)              |
| <b>Gender</b>                   |                              |             |                   |                    |
| Female                          | 6 (75)                       | 7 (78)      | 8 (67)            | 8 (89)             |
| Male                            | 2 (25)                       | 2 (22)      | 4 (33)            | 1 (11)             |
| <b>Race</b>                     |                              |             |                   |                    |
| African American                | 0 (0)                        | 0 (0)       | 1 (8)             | 2 (22)             |
| Hispanic                        | 6 (75)                       | 8 (89)      | 5 (42)            | 3 (33)             |
| White                           | 2 (25)                       | 0 (0)       | 6 (50)            | 4 (45)             |
| Mixed race (Hispanic and White) | 0 (0)                        | 1 (11)      | 0 (0)             | 0 (0)              |
| <b>Education</b>                |                              |             |                   |                    |
| Some college                    | 1 (13)                       | 0 (0)       | 4 (33)            | 2 (22)             |
| Bachelor's degree               | 4 (50)                       | 9 (100)     | 5 (42)            | 5 (56)             |
| Post-graduate degree            | 3 (37)                       | 0 (0)       | 3 (25)            | 2 (22)             |
| <b>Income</b>                   |                              |             |                   |                    |
| Under \$17,000                  | 0 (0)                        | 0 (0)       | 0 (0)             | 1 (11)             |
| \$17,000 - \$35,000             | 0 (0)                        | 5 (56)      | 6 (50)            | 1 (11)             |
| Greater than \$35,000           | 7 (88)                       | 4 (44)      | 6 (50)            | 7 (78)             |
| Unknown                         | 1 (12)                       | 0 (0)       | 0 (0)             | 0 (0)              |
| <b>Age</b>                      |                              |             |                   |                    |
| 18-34 years                     | 3 (37)                       | 5 (63)      | 5 (45)            | 5 (71)             |
| 35-64 years                     | 5 (63)                       | 3 (37)      | 6 (55)            | 2 (29)             |

- The focus group sizes varied from 8 to 12 participants, and the participants' ages ranged from 23 to 62 years.
- The majority of the participants were female (76%). More than half of all the participants were Hispanic (58%), while about one third (31%) were White, 8% were Black/African American, and 3% self-identified as mixed race/ethnicity.
- All the participants had more than a high school degree, with the majority (61%) having a bachelor's degree. In addition, 18% had received some college education, while 21% had earned a post-graduate degree.

- The majority (63%) self-reported annual incomes greater than \$35,000, while about one third (31%) reported incomes between \$17,000 and \$35,000, and 3% reported incomes below \$17,000.
- Employees from several types of organizations were present at focus groups, including health departments, academic institutions, health care services providers, city government, and nonprofit social service organizations.

## SUMMARY OF FOCUS GROUP RESULTS

### DEFINITION OF HEALTH DISPARITIES

Across the focus groups, participants defined health disparities primarily around disparities in access to health care, interaction with providers during the clinical visit, and health-seeking behaviors.

### REASONS FOR LOCAL HEALTH AND HEALTH CARE DISPARITIES

Based on the themes and subthemes that the analyses defined, participants perceived the major reasons for health and health care disparities to reflect:

- *Differences in socioeconomic status*  
Participants in all four focus groups identified differences in levels of education and incomes as the major factors responsible for the racial/ethnic disparities in health care.
- *Cultural norms and practices regarding health-seeking behavior*  
Participants serving the Hispanic-dominated counties noted that seeing a doctor is culturally perceived as a sign of weakness, particularly in males. It was also noted that patients tend to be passive and docile during patient-provider interaction, which might be rooted in cultural norms such as patient levels of education in interacting with someone who they perceive as an authority figure.
- *Poor community awareness of*
  - ♦ Available local health resources and programs
  - ♦ Eligibility for, and access to, federally available programs such as Medicaid
- *Barriers to accessing the health system such as*
  - ♦ Lack of health insurance
  - ♦ Inadequate numbers of providers, particularly in underserved areas
  - ♦ Lack of transportation to clinics and emergency rooms
  - ♦ Long wait times at doctors' offices and community clinics
- *Provider discrimination based on insurance status and type*

Individuals who are uninsured or underinsured are less likely to be seen by physicians. Providers were also said to be less likely to take on patients with Medicaid.

- *Poor physician-patient interactions marked by*
  - ♦ Language barriers
  - ♦ Lack of cultural competency on the part of providers
  - ♦ Perceived stereotyping of patients by providers
  - ♦ Lack of consistency in seeing the same provider at each visit
- *Low health literacy of community members relating to*
  - ♦ Understanding written medical advice
  - ♦ Reading and understanding food labels

Focus group participants in the counties near the Texas-Mexico border also noted that fear of deportation might prevent undocumented immigrants from accessing and using the healthcare system. Participants in one county pointed out that the perceived high cost of the U.S. healthcare system led many community members—especially the uninsured and underinsured—to utilize medical services in Mexico at pharmacies where they are diagnosed and prescribed medication.

Although participants generally agreed that most of the disparities in health care arise from socioeconomic differences, participants in three of the four focus groups still felt that elements of racism might be at play. Participants in the Lubbock/Hale County focus group stood alone and adamantly denied that race/ethnicity was a basis for discrimination in health care in the United States.

## ***ADDRESSING HEALTH AND HEALTH CARE DISPARITIES***

Participant suggestions given for correcting health and health care disparities centered on:

- *Educating the community about the existence and causes of health disparities*  
This would also encompass encouraging community members to adopt healthy lifestyles and change attitudes that revolve around cultural norms that may promote disparities.
- *Enlightening, helping, and actively engaging community members to access and use local, state, and federal health resources and programs designed to reduce existing health care disparities, and to address social determinants of health in these communities*
- *Community organization and empowerment for needed change in local attitudes and policies that might otherwise perpetuate health disparities*

Suggestions included forming walking groups, improving community safety for exercise, having political leaders re-allocate resources to address the social determinants of health.

- *Encouraging local employers to train their employees on health disparities and the role of institutional racism, with a view to ensuring that they plan and provide services in culturally-sensitive ways to actively correct elements of discrimination and racism in their services*
- *Encouraging health providers to train their staff to ensure their cultural competency*

Health providers are also encouraged to secure the services of health advocates to help patients navigate the system successfully, and to help bridge the communication gap between the providers and patients.

- *Improving the local school and education systems to ensure equitable and quality education that will help spur students to excellence*

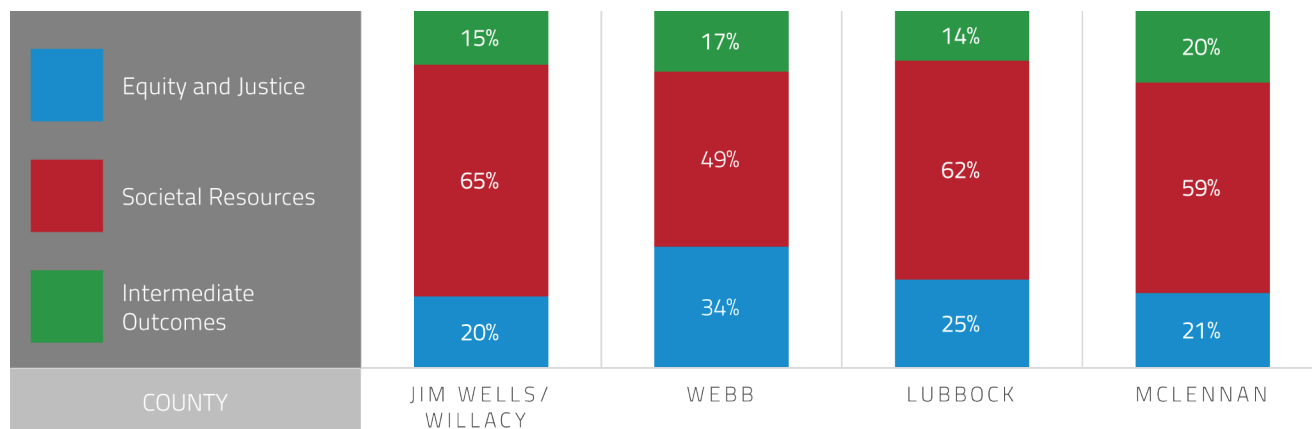
This effort would translate into leveling the educational differences that perpetuate health disparities.

- *Evaluating the structure and processes of operations and activities of health care providers, as well as social service providers such as the Child Protective Services (CPS), for equity in their services*
- *Collaboration and cooperation among local agencies rather than the “siloe” operations of local agencies*

## FOCUS GROUP ANALYSIS BY COUNTY

The focus group sessions provided important insights into what impedes and facilitates health equity promotion in four geographically and ethnically diverse areas of Texas. The figure below presents the frequencies with which each theme was addressed in the four counties selected for evaluation.

FIGURE 33. EXAMINATION OF FOCUS GROUP THEMES BY COUNTY



Societal Resources were commented on most frequently in all four focus groups, ranging from 49% in Webb County to 65% in Jim Wells/Willacy Counties. Intermediate Outcomes were commented on least frequently in all groups, ranging from 14% in Lubbock County to 20% in McLennan County.

A closer site-by-site analysis of each focus group session is offered below. The analyses organize the focus group discussion at each site around the three major themes used as parent nodes for the analyses—Equity and Justice, Societal Resources, and Intermediate Outcomes.

## JIM WELLS AND WILLACY COUNTIES

TABLE 4. DEMOGRAPHIC CHARACTERISTICS OF JIM WELLS AND WILLACY COUNTIES (2010 CENSUS)

|                                  | Jim Wells |       | Willacy |       |
|----------------------------------|-----------|-------|---------|-------|
|                                  | n         | %     | n       | %     |
| Total Population                 | 40,838    |       | 22,134  |       |
| <b>Sex</b>                       |           |       |         |       |
| Male                             | 20,107    | 49.2% | 12,030  | 54.4% |
| Female                           | 20,731    | 50.8% | 10,104  | 45.6% |
| <b>Age</b>                       |           |       |         |       |
| 20-24                            | 2,588     | 6.3%  | 1,950   | 8.8%  |
| 25-34                            | 4,887     | 12.0% | 3,341   | 15.1% |
| 35-49                            | 7,531     | 18.4% | 4,151   | 18.8% |
| 50-64                            | 7,495     | 18.4% | 3,393   | 15.3% |
| 65 and over                      | 5,332     | 13.1% | 2,587   | 11.7% |
| <b>Race / Ethnicity</b>          |           |       |         |       |
| White                            | 35,620    | 87.2% | 18,995  | 85.8% |
| African American                 | 237       | 0.6%  | 473     | 2.1%  |
| Other                            | 4,981     | 12.2% | 2,666   | 12.0% |
| Hispanic <sup>1</sup>            | 32,254    | 79.0% | 19,297  | 87.2% |
| White, non-Hispanic <sup>2</sup> | na        | 19.6% | na      | 9.9%  |

<sup>1</sup> Hispanics may be of any race, so also are included in applicable race categories.

<sup>2</sup> White, non-Hispanic is a sub-set of White, and should not be included in any race category totals (2011).

- The vast majority of residents in Jim Wells and Willacy Counties are Hispanic.

- Both are rural counties, located in South Texas, and relatively close to the Mexico border (within 50-100 miles of Mexico).

- Their proximity to Mexico and strong Hispanic culture gave the Jim Wells/Willacy County focus group a unique health equity perspective.

Jim Wells/Willacy County focus group participants centered on the broad community setting, and especially on the nearby *Colonias* (Colonias are scattered and mostly rural communities along the U.S.–Mexico border with poor infrastructure and housing facilities).

Jim Wells/Willacy County focus group participants were far more likely to provide comments on the Societal Resources (36 codes) subtheme than on Equity and Justice (11 codes) or Intermediate Outcomes (8 codes). Under Societal Resources, the discussion primarily centered around the Built Environment and Medical Services subthemes, while the importance of Formal Education was emphasized within Intermediate Outcomes. Greater elaboration is offered below.

### EQUITY AND JUSTICE

Topics related to the Equity and Justice theme were less common at the Jim Wells/Willacy County site than other themes. Participants focused on the role of socioeconomic status (SES), agreeing that higher SES leads to more opportunities for a healthy lifestyle. Participants also spoke about the role of discrimination and the relationship between race/ethnicity and health.



## SOCIOECONOMIC STATUS

Jim Wells/Willacy County focus group participants viewed health disparities as an effect caused by a “web” or “layers” of factors that worked together to create inequity. Participants agreed that socioeconomic status played a large role in this. One participant felt that socioeconomic status created a “disconnect” between “people in underserved populations [and] access to services that are available [and relevant based on] SES, education, and barriers tied to immigration, education, and language.” Another felt that poverty and related factors like poor transportation options and low education combined to promote health disparities. One participant elaborated on the relationship between socioeconomic status and health:

---

I do believe some groups are healthier than others. I believe that it's tied to socioeconomic status because if your status is better, you will probably do your annual physical, you will go visit the doctor, have your general lab work, and do things, have a gym membership, probably follow a good diet, and have a higher educational attainment.

---

Another explained health as a lifestyle, elaborating that, “by access to lifestyle changes, it's not a chosen lifestyle . . . There is a lack of opportunity to have those lifestyles that promote health based on socioeconomic status.”

## SOCIETAL RESOURCES

Participants from Jim Wells/Willacy County were most likely to discuss topics falling into the Societal Resources theme. The bulk of the discussion on Societal Resources was grounded in the local community's built environment concerning lack of communication and local infrastructure, which holds many Colonias. They view Colonias as deprived of health care services, and as lacking structural services such as public transportation and easy access to physicians. Participants criticized health care programs, including their own, for failing to adequately communicate opportunities to the local community. However, patient/physician communication also drew substantial attention in discussion of communication—participants believed that physicians did not sufficiently educate their patients, and that patients hesitate to ask meaningful questions.

## BUILT ENVIRONMENT

Colonias and local infrastructure, as noted above, dominated much of the focus group discussion. Participants also discussed the local built environment, including the importance of location and community members' ability to access services. Discussants explained that urban area residents take services like public transportation, running water, and sanitation for granted, but that these services were not for all local residents in their rural county. One participant contrasted the local infrastructure with that of larger cities in Texas by saying that cities are designed in a way that promotes health, so that urbanites can safely walk and affordably move about the city. Another commented that health disparities could be viewed as a function of location, stating that local rates of chronic disease were more highly concentrated in Colonias than other parts of the state. Participants also felt that the community's proximity to the U.S.-Mexico border presented a unique challenge because, even as health disparities are addressed for the current population, new residents with identical problems are arriving on an ongoing basis.

### *Colonias*

Jim Wells/Willacy County participants explained that well over 100 local Colonias are officially registered with the state, but that not all Colonias register. Colonias were described as areas with disparities due their lack of

infrastructure, which contributes to the prevalence of preventable diseases. Participants also noted that Colonias are rife with poverty, and populated by many recent immigrants. One participant had grown up in a Colonia and explained that Colonias lacked grocery stores, so shopping for food required access to transportation.

Although participants felt that programs needed to be more accessible to Colonias, it was widely believed that programs and research were out of touch with local needs. One participant felt that funding and research was based on Colonia needs, but failed to deliver relevant services because no formal needs assessments or community evaluations were used to design programs. In the end, grassroots community programs were believed to be more effective.

Services in general for Colonia residents were believed to be lacking. However, one participant pointed out that, due to poor transportation options, “even if [Colonia residents] knew where to go, they can’t get there.”

## MEDICAL SERVICES

### *Physician-Patient Communication*

For one Jim Wells/Willacy County focus group participant, the role of language in promoting health disparities was especially salient:

---

The patient is not only [hindered] by verbal communication, but then you’re going to give me a piece of paper that I can’t read either, then I’m going to go to another area to get my medicines and half the time (stutters) information about your medicine is in English because there’s a failure to ask . . . All this will just be adding to the mountain of insurmountable obstacles to be able to understand what the healthcare system is trying to tell me I should do.

---

Jim Wells/Willacy County focus group participants believe a lack of cultural competency between provider and patient affects the quality of care. They widely agreed that health professionals need greater understanding of patients’ environments so that providers can give culturally-relevant advice. This was especially true at the systems level. For example, one participant pointed out that in some cultures, the matriarch has the greatest ability to influence compliance, but that, “with all this HIPAA, the doctor will say ‘Oh no, no. I will only speak to the patient. Nobody else.’”

One participant explained patient preference based on cultural similarity and that quality of care can be defined through one’s cultural lens:

---

I feel more comfortable with an English-speaking physician than with someone whose first language was not English and who does not speak English very well. That’s just my own personal comfort level and has to do with my own culture. I also think that maybe someone who understands—who has a western culture, who would share similar lifestyle practices—would then be able to relate to my lifestyle practices better and be able to better offer me suggestions for improving my lifestyle, which we know is connected with health . . . Culture can sometimes connect with the quality of health care as we perceive it from our own perspective of culture.

---

Cultural competence was viewed as crucial to quality care and communication between physicians and their patients, but participants also believed that physicians were out of touch with their patients’ reality. One

participant, for example, felt that medical terms were above the literacy level of most people and that physicians failed to adequately inform patients.

One participant stated that failing to educate patients was a decision made by a lot of clinicians.

---

They will [think] 'I'm not even gonna waste my time, they're not gonna learn anyway. I'm not gonna make a difference, they're gonna go back out there and not comply,' especially when we're talking about diabetic patients. A lot of clinicians are frustrated.

---

Participants in Jim Wells/Willacy County focus group also suggested that the threat of discrimination was powerful, causing undocumented immigrants to self-select out of health care due to fear of discrimination in obtaining services and, most salient, deportation.

### *Program Outreaches and Partnerships*

Participants discussed the success of their community programs' outreach, while highlighting their programs' partnership capacity, and various elements of the programs' relevancy to the community. While one participant noted successfully working with other programs, another felt that local programs often do not work together and are disconnected despite similar goals. One problem that Jim Wells/Willacy County focus group participants identified was programs' relevance to the community's concerns. For example, one participant explained that program implementers don't always understand the needs of the community. Participants agreed that solutions were disseminated from "high above" without getting local input. Another barrier to program/public communication identified by this focus group was the ability of programs to get their message out. One participant believed that there simply weren't enough outreach coordinators to get the work done, while another stated that, despite a diversity of locations for flier placement, community turnout has remained low at health fairs and community outreach events. In the end, participants agreed that it was important for programs to ask, "Are messages going to who they need to go? Are they saying what they need to say?" Finally, one participant felt that "programs can exist and will exist to get the information for their research," and that once funding runs out, they leave, making locals feel that researchers don't care. Another participant disagreed, arguing that successful programs stay because they create partnerships at the community level.

## ADDRESSING HEALTH DISPARITIES

Jim Wells/Willacy County focus group participants felt that, "as a community, we are not raising our voice." This participant had been politically engaged in the past, and was told that, due to low voter turnout, politicians felt the community was unimportant. To counter this, the participant believed that coalitions needed to be empowered to speak for the community and to "get through the system."

To exercise political capital, one participant thought it would be a good idea to:

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[Increase] the overall voice of constituents so they may talk more with [their] legislator who will then be able to create local policies, go on and create state policies, and [influence] federal policies . . . . Connecting constituents more with their local politicians could be helpful.

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Finally, Jim Wells/Willacy County focus group participants felt that several entities shared responsibility for addressing health disparities. One participant stated, "I think we are all responsible as professionals in the community to be more aware of what our communities need [and be] accessible to them." Another thought

that addressing health disparities was best done at the county level. Finally, one participant felt that employers, policymakers, and individuals needed to share responsibility.

## INTERMEDIATE OUTCOMES

There were fewer comments related to the Intermediate Outcomes than the Societal Resources and Equity and Justice themes. Still, Jim Wells/Willacy county participants emphasized the importance of a formal education in increasing individuals' health literacy and likelihood of being healthy.

## EDUCATIONAL OPPORTUNITIES AND OUTCOMES

Participants explained that a basic level of health literacy leads to better health outcomes, though one participant acknowledged language as a barrier to better community health. However, the educational attainment of individuals was viewed as crucial to minimizing health disparities.

Educational attainment was believed to be a predictor of overall health literacy and health equity. Focus group participants in Jim Wells/Willacy County thought that better-educated individuals and populations that knew more about how to make healthy choices could obtain more prestigious employment and move beyond just "trying to get by." Moreover, the educational attainment level of local residents who are literate is unknown, so even if health documents are written in Spanish to overcome language barriers, they may be at a higher literacy level than that held by the community's population.

## SUMMARY

Although participants broached equity and justice and intermediate outcomes, the focus group session emphasized the role of the built environment and communication in creating or perpetuating health disparities. With respect to the built environment, participants recognized the impact of geographic separation on Colonia community members. Relatively removed from medical service providers and healthy food options, Colonia community members were believed to struggle to lead a healthy lifestyle. Moreover, communication barriers served to support health disparities. Physician/patient interaction was believed to be compromised by physician bias and language, while program/public communication was thought to be hindered by a breakdown in gathering community feedback when assessing the community's needs.

## WEBB COUNTY

- Like Jim Wells and Willacy Counties, Webb County is predominately Hispanic and is located on the Texas-Mexico border.
- The population is primarily urban (Laredo), which contrasts with the rural counties of Jim Wells and Willacy.

### EQUITY AND JUSTICE

Webb County focus group participants emphasized discrimination and socioeconomic status as primary causal factors for health disparities during their discussion. Participants agreed that physicians display personal biases in the clinic and that a healthy lifestyle simply is not affordable for many in their community.

### DISCRIMINATION

During their discussion, Webb County focus group participants shared several examples of discrimination as a barrier to equality and justice in health care. One participant explained this broadly, stating:

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Health disparities can be [that] sometimes you don't get health care 'cause of the way you look, your sexual orientation, or your background [or race] . . . People have said 'I didn't get the same treatment that you get 'cause we look different.'

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Participants offered more specific instances of discrimination as well. Income-based discrimination was commonly cited, and immigration status discrimination was also discussed.

Webb County focus group participants expressed an interesting view of discrimination based on race and ethnicity. One participant argued that, locally, “as far as racism is concerned, I don't believe there is much racism. Ninety-five percent of us are Hispanic.” This reflects the observations made above, while also rejecting race as a determinant of discrimination within the community. Although discrimination based on race and ethnicity was denied, Webb County focus group participants conceded that “providers discriminate [based on] if you have legal status.”

### SOCIOECONOMIC STATUS

Although community members were seen as potentially discriminated against based on their class, socioeconomic status was viewed as promoting health disparities by highlighting the gap in economic levels so that “people that live in poverty . . . have more barriers to access health care than people who are wealthy.”

TABLE 5. DEMOGRAPHIC CHARACTERISTICS OF WEBB COUNTY (2010 CENSUS)

| Characteristic                   | n       | %     |
|----------------------------------|---------|-------|
| Total Population                 | 250,304 |       |
| Sex                              |         |       |
| Male                             | 121,488 | 48.5% |
| Female                           | 128,816 | 51.5% |
| Age                              |         |       |
| 20-24                            | 18,350  | 7.3%  |
| 25-34                            | 35,156  | 14.0% |
| 35-49                            | 48,748  | 19.5% |
| 50-64                            | 31,460  | 12.6% |
| 65 and over                      | 19,507  | 7.8%  |
| Race / Ethnicity                 |         |       |
| White                            | 220,201 | 88.0% |
| African American                 | 1,132   | 0.5%  |
| Other                            | 28,971  | 11.6% |
| Hispanic <sup>1</sup>            | 239,653 | 95.7% |
| White, non-Hispanic <sup>2</sup> | na      | 3.6%  |

<sup>1</sup> Hispanics may be of any race, so also are included in applicable race categories.

<sup>2</sup> White, non-Hispanic is a sub-set of White, and should not be included in any race category totals (2011).

Incorporating healthy food into one's diet was also believed to be hindered by affordability. One participant stated that:

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If you have to feed eight kids, my mom's gonna buy the lard instead of the olive oil. My mom's gonna buy this because it's more, the wieners. The massive—1,000 for \$5 as compared to 5 for \$5.

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Fruit, vegetables, and lean meats were also viewed as less affordable than buying food off a dollar menu.

The working poor were of particular interest to these participants. They repeatedly defined this group of community members as “working, but [not] mak[ing] enough money to buy their own insurance.” Families and single parents were believed to be especially vulnerable because participants felt that many earned too much for government assistance, and too little to independently afford health care services. Participants agreed that these families had to make tough choices for their children, typifying this as “I want to provide for my family, but I can't because either I get you insurance and not make enough money to pay our bills, or I don't get insurance for you.”

Participants believed care seekers could be denied services based on income and insurance, as well as their appearance. One participant shared an account of a patient who had been denied care based on a lack of insurance. Similarly, Webb County focus group participants also believed that “higher income [individuals] probably get better medical care.”

## SOCIETAL RESOURCES

Participants discussed the impact of the built environment, medical services, and politics and power on health disparities. Medical services were especially considered during the Webb County focus group session, with much of the discussion highlighting the role of communication in health promotion and alternative care.

## BUILT ENVIRONMENT

Webb County focus group participants had to contend with a unique aspect of their built environment: Colonias. Colonias were defined in the following way by participants:

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The way I understand Colonias, it's a rural community of several hundred families and homes. They typically don't have running water or services—typical city services—sanitation, etc. a lot of the residents are—maybe their legal status is not clear—and because their status is not clear, they may not want to see a doctor because of that fear, rightly or wrongly, that they'll be taken away. These communities are typically rural, with low—like we said—socioeconomic status. That also affects how they interact with the healthcare system.

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The Colonias were believed to lack infrastructure and suffer from an interconnected web of barriers, ranging from immigration status and poverty to sanitation. To seek health care, residents of Colonias have to travel to the city due to the dearth of local services. The unique challenges faced by community members living on the fringes of Laredo were noted as life-threatening. One participant pointed out that an ambulance could take nearly an hour to get to one of the hospitals.



## Recreational Facilities

Webb County participants explained that local recreational spaces were plagued with inadequacies. The first barrier to accessing recreational areas was cost. Participants explained that a recent price increase at the local recreation center would keep children from having a place to play because the new fee was considered unaffordable. One participant added that “sometimes that’s the only . . . recreational activity those kids are gonna get. It’s a shame that, being that they’re such nice buildings, they won’t be able to access them because they won’t be able to pay the fees.”

Parks, considered an affordable alternative for exercise by focus group participants, were viewed as insufficient:

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Laredo is very hot . . . . I won’t take my kid to the park, maybe until it’s 7, 8 at night. The majority of our parks don’t have shades. If you’re out in the park, [you see] they’re getting vandalized. The equipment is not good for our kids to be playing [on].

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Another participant noted that “if there’s not enough trees, how are those kids gonna go to the parks? Where are they gonna stand? They cannot be running around all day in the sun.”

## MEDICAL SERVICES

Webb County participants discussed general constraints on the medical services community, alternatives to traditional care, and communication as factors important to reducing health disparities. Focus group participants believed that access to medical services was hindered by the conditions salient to the local care community. One participant explained that local “services that do exist for free or at a low cost are overwhelmed,” resulting in low-income individuals struggling to receive health care. Webb County focus group participants believed that access to medical services was also constrained by the geographic location of doctor’s offices. One participant suggested that “they should have a clinic nearer to” rural communities. Patients’ access to physicians was cited as further constrained by a lack of transportation.

Individuals with insurance were discouraged from seeking care by long wait times in clinics, as illustrated in the following example offered by one of the participants:

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My mother—she has Medicare [and] private extra insurance. She has her own doctor, but at times she doesn’t see her doctor and I tend to take her to the clinic . . . . It’s easier for them—I tell them ‘let’s go to the doctor.’ ‘No, because I’ll have to wait forever.’ I’ve gone with her in the morning. We’ve scheduled the appointment for 8 o’clock. We were there at 7:30 and we don’t get out till 12 o’clock. (Indecipherable). And then we’ve gone in the afternoon and it goes back to you’re there in the afternoon and you don’t get out until 4 o’clock in the afternoon because they’re closing.

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As a result of long wait times, even those with insurance who did not want to experience an hours-long wait would turn to one of the alternative forms of care, a local clinic, for health care services. One participant explained this, saying “I have insurance, and I’m sitting there in the doctor’s office for 3 ½ hours, 4 hours, so what do I do? I decide to go to the clinic. I’m gonna be seen by someone there and I’m gonna be out of there.” They felt that providers’ insensitivity toward patients’ needs and unique circumstances made obtaining an appointment difficult. One participant believed that physicians chose to discharge patients based on their method of payment (self-pay). Meanwhile, these patients were denied relevant education, and were offered a regimen that was either the cheapest or most expensive, rather than the most appropriate.

## Alternative Care

During the session, Webb County participants strongly focused on individuals who worked but did not make enough to pay for health care services, but also made too much to qualify for government assistance. These individuals and their families were perceived as being “caught in a gap.” Focus group participants explained that to overcome the financial and systemic barriers they faced in obtaining health care, locals sought alternative care for themselves and their children through day clinics, health fairs, home remedies, and visits to Mexico. For example, one participant explained that:

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There is some inequality because some are stuck in the middle. There’s no way out. It’s either getting sick, going to the emergency room, [or] their alternatives, like taking advantage of health fairs . . . . They take advantage of those resources.

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A local day clinic was known to provide relief for those who needed care but were unable to afford to see a traditional provider. One focus group participant admitted using the day clinic for their own health needs because “it’s reasonable. You go. They give you the medication. You go home . . . . I loved it.” Another participant’s family member would take their child to the day clinic due to a low monthly income “because all you have to do there is pay 40 bucks, get seen in an hour, you get the medication. You let them know ‘I don’t have insurance and I need the medication that’s generic. Don’t sell me expensive’—they work with you.” The community’s perception of the day clinic centered on its utility for low-income individuals and the staff’s sensitivity to financial constraints.

Another popular form of alternative care shared by Webb County focus group members was health fairs. An annual health fair offered basic screenings and services for community members. Participants believed that this helped address working parents’ needs to obtain care for their children without straining families’ incomes.

Webb County focus group participants also defined the popularity of home remedies and explained their popularity:

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Facilitator: What do you mean by home remedies?

Speaker 1: Herbal home remedies [passed] on generations.

Speaker 2: Vicks. Vicks vapor rub. That’ll cure everything (laughing).

Speaker 3: Marijuana with alcohol. It cures all your pain, arthritis, everything (laughing).

Speaker 4: It’s funny, but yes, you’ve heard of that. I remember my grandma had arthritis and I remember I would go to her house and I would see the little alcohol bottle—brown!—and I would be like ‘What’s that?’ ‘Oh, it’s my meds, you know, for my arthritis’ . . . . [It goes] back to our culture, because ‘Oh, so and so told me to take this and I’ll feel better’ [and] you believe it. I think it’s all because of our culture.

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Finally, visits to Mexico were the most common form of alternative care discussed by Webb County focus group participants. They believed that community members “go seek services in Nuevo Laredo . . . on the Mexican side because the cost is a lot cheaper.” One participant remembered being taken there as a child because, “it was faster, it was cheaper, we were in, and we were out.” Comments suggested that the affordability, proximity, and convenience of care in Mexico sustained its popularity as an alternative health care option within the community:



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We're just a bridge apart. It's one river that separates Laredo and Mexico and here, health care, you have to go through the doctors. They're the only ones that can prescribe [and then] you have to go to the pharmacy to get the medication. In Old Laredo, we know [we] can go to any pharmacy. I dare not travel to Old Laredo, but if I were to go to Old Laredo, I can get off, go to a pharmacy and ask 'I want this, this, and this,' and I paid the \$10 for the prescription medication . . . and I'm out of there.

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Multiple participants could describe the structure of pharmacies on the Mexico side of the border, and explained that pharmacists' duties varied so they could offer a one-stop center of care where individuals could be diagnosed, prescribed, and offered medications in one place. However, these steps were not all necessary, as any individual could simply ask for medication, even "heavy duty medication without a prescription" and expect to receive it at a lower rate and more quickly than possible in the United States. Though affordability and convenience were the most frequently-discussed reasons for individuals seeking care from across the border, they were not the only ones. Participants believed that immigrants legally in the United States were likely to travel to Mexico if they did not want their medical history to follow them due to the nature of their illnesses, such as HIV/AIDS.

Although not an alternative form of care, fear of health care services in the United States was believed to contribute to individuals' likelihood of seeking alternative care. Participants explained the role of fear in two different ways: fear of financial cost and fears faced by undocumented residents. One participant's family member was described as "liking medicine," which he gets from Mexico. The participant said that "he doesn't want to go anywhere here. It's expensive. That's his thing. 'No, no, no. It's too expensive. I don't want to go.'" The other fear identified by focus group participants was related to immigration status, even perceived immigration status. One participant said that "people are scared here . . . . Even [those with] documents. They're scared." The threat of deportation was so relevant for community members that participants believed that "people who live here illegally . . . don't seek health care services." Undocumented parents of sick children faced new barriers to traveling after-9/11, creating additional fears.

## COMMUNICATION

Participants felt that language barriers and lack of outreach from programs to the community also hindered health equity. In addition to limited access to medical services, poor communication was believed to impede health equity. For example, one participant noted that, "being a border town, lots of people lack language." However, aside from language skills, focus group participants looked internally at the poor communication of their own organizations and other community health care promotions. Poor communication from programs to the public was viewed a major barrier to community health. Participants explained that some community members suffered needlessly because "they were not educated well enough. People did not lead them to the right resources." This was believed to be partially due to programs' lack of getting "enough information out there for people to know, 'you know what, there's this'" because, "unless you're in the field, you don't know what's available." Poor communication was also partially attributed to misinformation.

## ADDRESSING HEALTH DISPARITIES

Webb County focus group members were sensitive to the role of politics and power, viewing them both as a barrier to, and an opportunity for, reducing health disparities. One participant noted that politics within organizations also determined whether individuals accessed health care, stating that for some programs, "if you know the director, you get services. It's not always a straight shot."

From a more traditional viewpoint, focus group participants viewed politics as an opportunity to leverage power in their favor. One participant wanted to address the recreation center's rising fees by inviting "local elected officials and [asking] 'how many families will be able to afford a rec center?'" Another simply stated that, to promote healthy lifestyles, the community should "get the politicians involved and say 'this is what is going on' [to] let them know what we see and what we need for a healthier community."

Finally, responsibility for addressing health disparities was viewed as political. Focus group participants believed that health disparities have "to do with the way the government distributes the resources. Some people are not receiving support or options." Another participant opined:

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The whole health care coverage should just be given to everybody. It should be a right for everybody to have access to health care and not people die because they can't afford it or it's too much . . . . Everybody has to vote for Obama! (Laughter) Come on people, it's the right thing to do. Obama's system is not perfect but it's a start.

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When asked directly "Who's responsible for addressing disparities in health?" two participants exchanged the following dialogue:

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Speaker 1: It starts at home. It starts with ourselves, what's out there, being informed, being aware. It's the community.

Speaker 2: It's a community effort.

Speaker 1: I depend on every single person here and I need them all. When it comes to cooperation, it's not 'I got that message out.' No. We got the message out. All of us care about our community.

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## INTERMEDIATE OUTCOMES

Participants discussed the role of education and culture in creating health disparities. They emphasized the importance of a formal education and agreed that cultural foods and health habits may promote unhealthy behaviors and lifestyle.

## EDUCATIONAL OPPORTUNITIES AND OUTCOMES

Having a formal education was viewed as promoting greater health literacy. For example, one participant believed that "people that are more educated are more open to look for more education [and] more information [about] how to take care of themselves." Another believed that:

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People that went to college or university seem to know the consequences of not exercising or portion control or reading labels, calorie intake per day. They seem more prone to getting those 30 minutes in per day running or walking than people [who] dropped out of high school, don't know what happens if you eat the whole plate, [and] they don't know how to serve themselves . . . . [It] overall deteriorates our health.

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Still, another participant stated that "you'll see a small child walking around with a Big Gulp soda. You don't need a college education to know that's not good for the kid."

While having a formal education was viewed as increasing one's likelihood of leading a healthy lifestyle, poor

habits learned in the home were believed to hinder health. One participant noted that grocery shopping as a child was based on “wants” and quantity instead of quality. Another participant observed that “when you’re from 0 to . . . 15, it’s the parent buying those hamburgers. It’s the parent eating an entire bucket of wings with the kid right next to them. That’s what I see a lot.” Thus, poor parental habits were viewed as impressionable upon children. However, one participant noted that modern society compounds these problems:

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Nowadays you have both parents working. They don’t have the time to show their kids this ‘is what we’re gonna eat. It’s healthy” [or] show kids to read the label, . . . especially when there’s just a working parent—maybe a mom [who] has to go to work.

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## PREVAILING COMMUNITY NORMS

Culturally-based foods were a dominant theme when participants spoke about community norms. One participant explained previous gatherings: “We would have tacos, bacon, beans, anything—it has to be greasy. If it’s greasy, it’s good . . . . It’s not healthy. It’s tasty.” Other tasty foods that were identified as culturally-favored, but unhealthy, included greasy foods traditionally found in Mexico that were specifically related to holidays. These examples reflect one participant’s observation that fruits are not considered to be part of the culture; instead, the speaker pronounced “our culture is abundance.” Finally, one participant shared a common dining experience: “My parents would serve me a big plate and tell me to eat the whole plate before I left the table. You would have to eat the food.”

As the above sections suggest, Webb County focus group participants believed that tradition and culture play a powerful role in the development of an individual’s health habits. One participant explained attempts to convince family members to fill out an application for health care services. This participant’s parents refused to fill out the application and see a doctor. The participant believed it was because their parents “don’t want to go get help.” Another participant explained that “we do have a situation [where] our culture is very much ingrained in ‘you don’t have to go see a doctor. Take over the counter medication.’”

## SUMMARY

Webb County focus group participants discussed alternative treatments at length, arguing that a mixture of tradition and socioeconomic barriers combined to encourage community members not to seek the care of an American physician. Like the Jim Wells and Willacy County participants, Webb County participants agreed that the physical separation of Colonia residents compromised their health by providing limited access to service providers and healthy food options. However, extreme weather, poorly shaded play spaces, and expensive recreational facilities were all considered barriers to health equity as well.

## MCLENNAN COUNTY

- McLennan County is an urban county located in Central Texas.
- Of all urban counties in TT, McLennan County has the highest proportion of African American residents.

### EQUITY AND JUSTICE

McLennan County participants spoke about discrimination at length and agreed that, in general, income- and insurance-based discrimination were more common in promoting health disparities than race/ethnicity. Participants also spoke about the relationship between SES and individuals' health.

### DISCRIMINATION

Participants discussed the role of discrimination based on income, insurance, mental health, and race/ethnicity, and pointed to perceived physician biases and culturally-relevant stigmas as well.

McLennan County focus group participants believed that racial discrimination was unlikely. Instead, most agreed that insurance-based discrimination was prevalent. One participant tried to explain this phenomenon using personal experiences:

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I was trying to think of an answer to this question and I put myself in the equation to try to answer it and say 'what have I experienced as an African American person that has interacted with the health community here?' Honestly, I can't say that I've ever . . . noticed anything. I don't feel like I've ever been discriminated against or anything like that.

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One participant felt income and insurance-based discrimination was especially true for patients in need of a specialist's attention because specialists were considered to be financially inaccessible for low-income individuals. The participant believed this was:

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Discrimination as far as giving [patients] knowledge and information . . . because they don't have access to those resources [due to] whatever their wage or their salaries are. Economic impacts. I think that's one of the major discriminations that we see here in our community.

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### Mental Health

McLennan County focus group participants were the only ones to discuss mental health. They explored the topic from several angles, including cultural differences and clinical experiences. Two participants shared their views of mental health from a racial/ethnic viewpoint. The first explained the Hispanic perspective:

TABLE 6. DEMOGRAPHIC CHARACTERISTICS OF MCLENNAN COUNTY (2010 CENSUS)

| Characteristic                   | n       | %     |
|----------------------------------|---------|-------|
| Total Population                 | 234,906 |       |
| Sex                              |         |       |
| Male                             | 114,169 | 48.6% |
| Female                           | 120,737 | 51.4% |
| Age                              |         |       |
| 20-24                            | 23,223  | 9.9%  |
| 25-34                            | 30,379  | 12.9% |
| 35-49                            | 41,943  | 17.9% |
| 50-64                            | 40,098  | 17.1% |
| 65 and over                      | 29,259  | 12.5% |
| Race / Ethnicity                 |         |       |
| White                            | 164,037 | 69.8% |
| African American                 | 34,767  | 14.8% |
| Other                            | 36,102  | 15.4% |
| Hispanic <sup>1</sup>            | 55,471  | 23.6% |
| White, non-Hispanic <sup>2</sup> | na      | 58.3% |

<sup>1</sup> Hispanics may be of any race, so also are included in applicable race categories.

<sup>2</sup> White, non-Hispanic is a sub-set of White, and should not be included in any race category totals (2011).

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As Hispanics, and I know this for a fact, mental health to us is kind of a negative stigma. It's something that we keep at home. It's something that we likely will not share with someone else unless they share the same culture that we do because that way we have a sense of something in common, something we can express—they can understand—and not be judgmental or seem like we're even crazier than they suggest.

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This culturally-based stigma and guarded approach to mental health was also reflected in a participant's view of African Americans' approach to mental health who "believe you keep it in the family. What happens in this family, we discuss it here, and then go outside."

Finally, one participant shared a personal experience:

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I had [an] experience a couple years ago with two family members. One was just a family member who needed stitches. He cut his finger. We were there for 4 hours. The nurse was very friendly, nice, bent over backwards to help him with anything he needed. Exactly 2 weeks later, to the day, I was there again with another family member with a mental illness and exactly the same nurse. Complete opposite treatment. She was just treated very poorly and stuck in a back corner, got ignored. They wouldn't turn the air conditioner on. It was summertime, we asked repeatedly and were told we couldn't do it. We propped the door open, told we weren't allowed to prop the door open. This patient was very quiet, calm, not threatening, just depressed and crying. I finally reached out to another nurse. The air conditioner (girl?) was outside the door and they just flipped it and turned it on. It was just the discrimination. Just because she was labeled with a mental illness that really was shocking to see.

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Although mental health was believed to be highly stigmatized in Hispanic culture, McLennan County focus group participants attributed much of this to low health literacy. For example, one participant noted that mental health is considered "a White disease," elaborating that "it's not a disease that impacts us." Still, another participant was optimistic about the influence of increased health literacy, and believed that health literacy education taught community members "things we wouldn't otherwise know if we had not been educated. [It makes] a big impact on us." In short, social stigma against obtaining or offering mental health care to individuals in need was viewed as a harmful practice and discriminatory in nature

## SOCIOECONOMIC STATUS

For McLennan County focus group participants, health disparities were based not only on discrimination, but also on one's socioeconomic status. For example, one participant considered:

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The different socioeconomic statuses that we have in the community. If you make your money, your family's more wealthy, then of course you're going to send your child or go to the doctor because you're thinking about preventative care and not always thinking about 'well, if I'm sick, then I will medicate myself and wait until it's really bad and then have to go to the hospital.'

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Low-income individuals were viewed as not only having fewer prevention and health care options, but also as having fewer dietary options. One participant explained how income impacted one's nutritional choices:

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Those that eat healthy most the time have money, because you go to places like McDonald's or any of these places you can buy a cheeseburger for a dollar. You want to buy a salad, it's like 7 dollars. Even myself, I'd rather spend a dollar on food versus 7 dollars on food. It's cheaper. It's hard—even a garden. It's expensive. I have a garden and it's so hard to tend. I spent so much money at the beginning of the year and if it drougths, there goes my garden. I just threw all that money in the trash. Low-income families, especially families that would have to live like in government housing or have food stamps, things of that nature, they can't afford these foods that keep us healthy.

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For McLennan County focus group participants, healthy lifestyles reflected the connection between nutrition and prevention; families able to afford better nutrition and focus on prevention were considered more likely to lead a healthy lifestyle.

Another participant saw income-based disparities as reflective of traditional “issues from many, many years ago . . . [that] are still impacting . . . those populations . . . [and] contributes to health issues that those populations are affected by.” Moreover, participants agreed that “people with insurance are so much more healthier than people without insurance.” Many participants linked income and insurance when explaining health disparities. For example, one participant stated that:

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Individuals that are low-income don't have good insurance [and] will not likely be able to access the best quality care possible. There's a bit of discrimination in that sense, that they're . . . unable to reach better resources.

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Other participants agreed that lack of insurance actively hindered individuals' access to services. Participants largely agreed that Medicaid patients were more likely to be denied services based on their form of insurance than other insured patients, because providers would “only take a handful, maybe 5 or 10 of our families.” These providers were within the organization's network.

## SOCIETAL RESOURCES

Societal Resources was the most common theme discussed by McLennan County focus group participants. Although participants commented on the built environment, topics related to medical services, particularly communication between physicians and their patients, dominated the session.

## BUILT ENVIRONMENT

Waco's built environment was emphasized by focus group participants, especially healthy options available in different neighborhoods.

### *Neighborhood*

One participant explained how differences in neighborhoods' built environments reflected local health behaviors. One neighborhood was cited as having a playground that was not used. At first, the participant felt that this playground would be put to better use in their own neighborhood, but upon reflection changed their mind, saying “look at my community and you see people running up and down the highway, just exercising. People with their children on their bicycles. They don't need a park to exercise together as a family.”



McLennan County participants also learned from their own focus groups with community members that many residents in certain areas of town felt “it wasn’t safe for them to walk around in their neighborhood and exercise.” McLennan County participants made suggestions that these community members create a walking group to overcome this barrier.

Neighborhoods were also believed to dictate the quality of food available. One McLennan County participant explained variation in access to healthy and unhealthy food, contrasting the ease of finding unhealthy food in low-income clients’ neighborhoods with the difficulty of finding unhealthy food in the participant’s neighborhood:

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We talk about telling people who are diabetic to make healthier choices, but everything that’s around their community—that food’s not there. They can go to a gas station and buy anything—or even a fast food restaurant. They can find a Church’s, a McDonald’s, a Whataburger, a Burger King in their neighborhood. (Pause) You don’t have that in ours. I can be starving a 10 or 11 at night—need to suck it up till the next day because I can’t go through a drive-thru to find something like that.

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McLennan County focus group participants agreed that transportation was a barrier to obtaining health services, with one participant stating that transportation is “one of the top three [problems] that has been identified by other community organizations.” Poor access to public transportation was viewed as troublesome for the community because “it’s not very frequent and the stops aren’t as near to the places that people need to get to.”

Finally, focus group participants maintained an optimistic approach to local health disparities, believing that Waco was becoming more gentrified and, as a result, more stable. They viewed local initiatives as “bringing everyone together” to make a better Waco.

## MEDICAL SERVICES

Topics related to the role of medical services in contributing to health disparities dominated the McLennan County focus group discussion, especially concerning communication between physicians and their patients and patients’ ability to access medical services. Both problems were viewed as particularly detrimental to low-income individuals.

### *Access to Medical Services*

Local barriers to accessing medical services were believed to promote health disparities, as were a lack of providers and language barriers. These were viewed as “a barrier to getting the best possible health services.” Crucial medical services such as those for rape victims and mental health patients were also viewed as overburdened. Meanwhile, access to specialists was widely believed to be restricted to those who could afford it. One McLennan County focus group participant believed that specialists were better able to pass along knowledge that would specifically benefit patients and promote greater wellness in the community.

McLennan County focus group participants also believed that doctors’ preferred areas for practice promoted health disparity because, “even if there were plenty of doctors in our community, they’re not always in the locations near to where the community that needs them.” The need to travel to the physician’s office presented more problems. One participant recalled meeting patients who sought care, but found that getting to the provider’s office and returning home presented a challenge:

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They don't have transportation to get there so they have to get a ride. That ride isn't gonna wait there. I was interpreting for one girl that came in for counseling and she waited 2 hours and they finally told her that her appointment had been cancelled. Her ride had left. They weren't coming to get her. She had no way of getting back home. I couldn't take her because it was against company policy. She had to walk home. She couldn't find anyone else.

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Participants argued that barriers to seeking care did not end once patients were in the office, as patients did not have enough time with their provider. One participant, an insured individual, stated that even those with insurance had little time to speak with their physician. They believed that a short timeframe in which to speak with a doctor kept patients from asking questions and learning about their condition.

### *Physician-Patient Communication*

Communication dominated the McLennan County focus group session. Participants at this site agreed that poor physician-patient communication contributed to local health disparities.

McLennan County focus group participants felt that linguistic differences could keep questions from being asked. However, one participant was especially concerned about inadequate attempts to overcome language barriers to provide clients with answers to their questions:

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[The] translators that [providers] used . . . weren't trained to be translators, so the clients were going home with information that wasn't accurate. The providers themselves identified it because they would send in providers that spoke Spanish, but providers wouldn't say 'I speak Spanish.' They would have the translator come in and when he would tell [a patient] 'Your triglycerides are high,' the translator would say 'your diabetes, something fatty cells.' [The translator] would completely change what [the provider] said . . . They would just pull in any random person that was cleaning the hallway, the maintenance guy, or the front desk girl would come in to do the interpreting, and the client was going home with the wrong information. They didn't understand how to use the medication or what the provider was saying and even the words that the provider was using for the interpreter, that interpreter didn't understand what the doctor was saying, you know? If he was talking about a cat scan and he said 'cat scan,' well, then that translator wasn't trained as to what a cat scan was. They were just telling 'Oh yeah, this thing you're gonna get done.' What thing? These are people we're working with. That's where they go for their health care and they're not getting what they need . . . and the person leaves with the same questions they came in with.

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For McLennan County focus group participants, culturally-based knowledge was imperative to meaningful communication between a doctor and patient. Providers were viewed as lacking cultural competence and, as a result, were challenged in their ability to begin a conversation because of cultural and linguistic disconnections. One participant believed that it was crucial for doctors to "[speak] at [patients'] level, but also in their language, in their culture." One participant defined cultural competence as:



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Knowing what that culture is. What are their values? What are their expectations, so that I can understand where they're coming from and not offend them in any way, whether I do it intentionally or unintentionally.

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Participants identified strategies to overcome providers' low cultural competency:

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For doctors, health literacy improvement would look like . . . facts or information . . . [about] how to best address the populations [and] who to address in certain populations. In some cultures it may be the father is more important than the daughter or the mother. Being able to identify key points.

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McLennan County participants also saw those with chronic diseases as suffering from a dearth of communication. One participant shared an experience with a recently diagnosed client:

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A client came in last week and she had a blood glucose level of over 700, which is extremely high . . . . She had gone to the . . . main clinic that sees populations that are underserved. The questions that she asked me made me realize that they did not do any education at all. They just told her 'your levels are high.' They didn't tell her anything—nothing. I was glad that they did refer her for some diabetes self-management classes, but they did not give her anything. You never know how long it's going to be until she can get in a class to meet. Just a lack of concern for her immediate health. She should have walked out of there knowing something . . . . The things she was saying to me made me realize that they didn't give her any kind of assistance . . . . This case, it wasn't a language barrier, they really—it was just a lack of information that was passed on to her.

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In the above example, the participant details a physician's disregard for the patient's immediate health needs, failing to offer adequate education of the diagnosis as well as proper self-management. Thus, McLennan County participants believed that providing meaningful education post-diagnosis was necessary for good communication between providers and their patients. Participants agreed that providers were aware of the education gap, but "don't feel the responsibility to do much about it. I do feel that the providers feel that they come in and they do a job: they diagnose. They provide the medication. That is the end of their duty."

Interestingly, although McLennan County participants felt they were "harping" on providers, they offered solutions that they felt would enhance doctor/patient communication:

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Maybe the providers can't do their job. Who can, but within the same system? Providing patient advocates in the clinics or public health nurses in the clinics who, after they see the doctor, they can sit and talk. Maybe that's taking some responsibility away from providers, but the point is, it needs to be done.

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Adding patient advocates was a popular solution to communication barriers, and one participant believed this would be most beneficial to those with "complex issues," while another thought "it would be better for everyone overall."

Another barrier to quality medical care was consistency. Focus group participants explained that their clients "never see the same provider; it's always a different provider." It was agreed that this kept doctors from gaining

a holistic view of patients' ailments. McLennan County participants also explained that those providers who were culturally-competent were too popular to be consistently available. Focus group participants believed that the ability to see the same doctor, especially one with cultural competence, was desirable, but not likely, for their clients.

One participant decried the treatment of patients by clinic staff saying:

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[Patients] can rarely see [a locally preferred physician] because everyone wants to see her. Their appointment's being cancelled, they're not having transportation, and then, when they do get seen by someone, they're rude. The nurses are rude to them, like they're begging for a service. It's not fair, but that's how it happens.

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### *Program Outreach and Partnerships*

One participant believed that "agencies that offer services don't know enough about each other to—like if I don't offer a service and she does, I need to know about what she offers so I can refer people to them." Another participant agreed that programs in Waco are "siloed in what we do . . . . We just focus on X and there's all these other aspects around that." One participant stated that "local agencies don't know each other so our group is trying to get them . . . connected together so they know what services everybody offers." Programs were also critiqued on their ability to reach the public. For example, one participant believed that local programs are "not reaching out to the people we should or helping them better understand how everything works." One participant posited that a potential cause of low outreach could result from a:

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Disconnect because unfortunately in communities . . . they feel like they have a different issue that we're not addressing. Although we're providing these wonderful services, sometimes they feel like 'Well, that's not the issue I need help with right now. I need you to solve a different issue and provide a different program.' Because we're not doing that, it kinda shuts the door down for them to come to other things that we are offering.

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Still, most participants agreed that poor program to public communication was a result of programs failing to properly educate people. One participant shared a personal experience:

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I was one of the families on the other end when I was growing up. I never knew that these things were available, like the Do Well, Be Well classes. We hear about them now, but there's always been WIC and there's always been programs like that that benefit our communities but yet my parents never knew how to access that stuff.

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## ADDRESSING HEALTH DISPARITIES

McLennan County focus group participants considered their own ability to address health disparities. They agreed that tackling health disparities in their community would be a "community effort. It's not any one person. It needs to be a broad initiative for everybody." More specifically, one participant believed that:

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Anyone who provides a health service should be responsible, but to go a little further, any health facility or any health agency that specifically deals with or has a high population of at-risk or minorities should take a stronger role because that is who their population is. While everyone should, if an organization tends to have 80% of their clients to be minority or at-risk, then they should [make] that extra effort.

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## INTERMEDIATE OUTCOMES

Intermediate Outcomes was the least discussed topic among McLennan County focus group participants. Education was believed to be crucial in the production of generally literate individuals who would be more likely to be health literate and make healthy choices. Meanwhile, cultural norms were believed to discourage individuals from seeking care and to encourage an unhealthy diet.

## EDUCATIONAL OPPORTUNITIES AND OUTCOMES

For McLennan County focus group participants, education was crucial to health literacy; they believed that without a basic education, students would grow up to be adults with a lower “register” of knowledge that excludes information about nutrition and health services. Moreover, barriers to attaining a formal education were viewed as barriers to leading a healthy lifestyle because they denied individuals the opportunity to gain the skills and knowledge necessary to become health literate.

### *Barriers in Education*

McLennan County participants strongly linked health disparities to education. One participant believed that biannual redistricting of schools in Waco “conveniently follows certain populations, so you just keep moving the same students around together.” Discrimination in schools was viewed as a burden on the community; McLennan County focus group participants felt that people with low English literacy and low income were especially targeted by the school system. For example, one participant spoke about the need for more ESL classes, saying that “if the tables were turned, chances are they would make sure someone was available for someone if they needed English.” Low-income families were believed to face similar discrimination from local schools:

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When parents are asking questions about their children as far as their grades and behavior, sometimes schools feel like, if it’s a lower-income family, ‘oh, we can just shove them off and not really deal with them.’”

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Another participant, who attended schools in Waco, shared a personal experience:

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When I went to school here . . . they didn't encourage me to go to college. I was going to be just like my mom. I was gonna clean houses like my mom and my husband was gonna be a construction worker like my dad and when I went to the counselor's office and asked for applications for scholarships—I was top 10%—she would tell me 'not top 5%. I don't have applications for you.' Every time I see that counselor, I still hold grudges against her because it's her fault that I didn't get a lot of scholarships because she didn't believe in me. A lot of her top 5% students, they didn't want to go to college, but they got all the scholarships. It's still like that to this day. I worked with a group of students—high school students—from that same school district and they would tell me, 'She still won't see us. She still won't help us.'

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Local teachers were believed to stereotype students and to be “passive, [thinking], ‘they’re not gonna graduate high school. They’re never gonna be this or they’re not gonna do this.’”

McLennan County focus group participants strongly related health and education, as further illustrated in the exchange below:

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Facilitator: You mentioned that health disparities had something to do with education. You linked those two together? (Participant agrees, saying ‘Mhmm.’) Can you talk about that a little more?

Speaker: I linked them because of the levels of education. You understand more, like if [a doctor] told me with diabetes management, ‘This is what you need to do to manage your diabetes,’ I would be like ‘yeah, ok,’ these are the steps I need to take. I need to consume less carbohydrates . . . . But if I told my mom, ‘Don’t consume those carbohydrates, they’re hurting,’ she’ll be like ‘What are carbohydrates?’ She has a lower literacy level than I do. She doesn’t understand; her register is completely different. She doesn’t read English to start with—she kinda does. But like my dad, he only got to 6th grade. He doesn’t know anything past 6th grade. If I’m telling him ‘Oh yeah, Dad, do this at work; this is how managed care works,’ he’s like, ‘Huh? I don’t know what you’re talking about.’ That’s what I was referring to. They don’t have the same level of understanding that I do because of their education.

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Another participant stated that:

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The higher educated you are, the more likely you can take the steps to take care of yourself, take care of your family, take care of your friends, develop a better environment, and start developing a new culture.

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## PREVAILING COMMUNITY NORMS

Like barriers to education, cultural barriers were viewed as inhibiting individuals’ opportunities to make healthful choices and lead healthy lives. McLennan County focus group participants acknowledged the power of cultural foods, with one stating that, “as a minority, as a Hispanic, I know that, for a fact, our lifestyles do contribute [to health disparities] because of the way we eat.” For example, one participant believed that, in general, health is:

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Largely due to our cultural practices. I do think that's why you see higher incidences of chronic disease in African Americans and Hispanics, due to our diets. What we tend to enjoy or be our—the things that kind of run our culture.

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McLennan County focus group participants agreed that health was “a cultural thing as well as an economic thing, whether you're going to the doctor . . . . There just are some cultures that 'Are you weak?'”

## SUMMARY

McLennan County focus group participants emphasized the importance of education, agreeing that academic achievement leads to greater health literacy. They were also sensitive to discrimination based on income, insurance status, and mental health standing, and recognized that greater outreach was needed to adequately address health equity in the community. Participants from McLennan County recognized the role of neighborhood and socioeconomic status, agreeing that individuals with higher SES were more likely to lead healthful lives voluntarily, and to be able to afford a healthy lifestyle, than individuals with a lower SES. Finally, participants believed that a breakdown in communication between physicians and patients was a great cause of health disparity. Language barriers and physician bias were believed to discourage patient education by physicians and their staff; a common solution offered was recommending patient navigators to help patients understand and manage their diagnosis.

## HALE AND LUBBOCK COUNTIES

TABLE 7. DEMOGRAPHIC CHARACTERISTICS OF HALE AND LUBBOCK COUNTIES (2010 CENSUS)

|                                  | Hale   |       | Lubbock |       |
|----------------------------------|--------|-------|---------|-------|
|                                  | n      | %     | n       | %     |
| Total Population                 | 36,273 |       | 278,831 |       |
| <b>Sex</b>                       |        |       |         |       |
| Male                             | 18,737 | 51.7% | 137,786 | 49.4% |
| Female                           | 17,536 | 48.3% | 141,045 | 50.6% |
| <b>Age</b>                       |        |       |         |       |
| 20-24                            | 2,872  | 7.9%  | 34,117  | 12.2% |
| 25-34                            | 4,790  | 13.2% | 40,625  | 14.6% |
| 35-49                            | 6,799  | 18.7% | 48,056  | 17.2% |
| 50-64                            | 5,735  | 15.8% | 44,508  | 16.0% |
| 65 and over                      | 4,435  | 12.2% | 30,622  | 11.0% |
| <b>Race / Ethnicity</b>          |        |       |         |       |
| White                            | 25,670 | 70.8% | 215,519 | 77.3% |
| African American                 | 1,925  | 5.3%  | 20,952  | 7.5%  |
| Other                            | 8,678  | 23.9% | 42,360  | 15.2% |
| Hispanic <sup>1</sup>            | 20,269 | 55.9% | 88,924  | 31.9% |
| White, non-Hispanic <sup>2</sup> | na     | 36.6% | na      | 56.6% |

<sup>1</sup> Hispanics may be of any race, so also are included in applicable race categories.

<sup>2</sup> White, non-Hispanic is a sub-set of White, and should not be included in any race category totals (2011).

■ Lubbock (urban) and Hale (rural) Counties are located in the north Texas Panhandle region.

■ Lubbock County has a relatively low Hispanic population, and the majority of residents are white.

The bulk of discussion generated by the Lubbock County focus group participants was related specifically to the city of Lubbock and Lubbock County; participants did not elaborate on Hale County.

### EQUITY AND JUSTICE

In discussing topics related to equity and justice, Lubbock County participants focused on discrimination and the role of SES in Lubbock.

### DISCRIMINATION

Discrimination and the concept of disparities proved a challenging topic for Lubbock County focus group participants. One participant defined disparities as based in:

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Differences, whether they're real or perceived, based on race, gender, nationality, where they reside, their income level, perhaps what generations before them did, and what they think their expectations are.

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Participants repeatedly denied race as a primary factor in health disparities throughout the session, but admittedly struggled with the concept of race in general, as illustrated in the following exchange between the facilitator and a participant:

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Facilitator: Do you believe racism and/or discrimination affect your community?  
(Silence)

Speaker: I'll break the awkward silence. (A lot of laughter) I think there's racism and discrimination everywhere you go. I think it's a matter of to what degree. You would hope that today's day and age, it wouldn't be as predominant as it's been in years past. It's . . . not necessarily that it's completely gone away. I think it's more the pink elephant in the room that no one wants to talk about. It's that awkward silence we just had. (Another Participant agrees by saying 'Yeah' while the Speaker is saying this.) I think here, even in Lubbock, there's a degree of discrimination that happens. I don't know if it's racism.

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Most participants agreed that "there's a pretty wide gap between discrimination and racism. I don't think it's a race thing as much as it is . . . an economic thing." Lubbock County participants largely agreed that economic and class-based discrimination was more likely than discrimination due to one's race or ethnicity. Participants understood that there was a link between race and economic standing, but stressed that disparities were due only to income, as in the following exchange:

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Speaker 1: It [disparity] has to do with race, but I don't think it's race in general. I think it's more along the lines of it is economically-based but because the lower economic status has a lot of one race or another, it's kind of tied in in that sense. In an indirect way, or a direct way, however you want to look at it, yes, it is tied to it, but not in the way that everyone needs to think about it.  
Speaker 2: I agree . . . . I don't think it's 'We're gonna give you this quality of care less than everyone else because of your race.' I think it goes back to your income level and your—when you go into a hospital, I don't think it matters what color you are, as far as what tests you're gonna get, other than what you can pay for [and] what your insurance will cover.

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It was common for participants to state that there was no "direct link" between race and the quality of care one receives, while acknowledging the relationship between race and income. One participant believed that health disparity is not as "ethnic-based as sometimes we're almost swayed to believe," while another had the following exchange with the focus group facilitator:

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Facilitator: Do you think there is a link between health disparities and discrimination?

Speaker: (Long pause followed by repeated starting and stopping) The thing between health disparities and discrimination, you would probably think that there might be. I would think that there might be because there's differences in groups, but in this area, not—I don't know specifically—I've never been confronted with it, so I'm (pause) . . . Having been working with different groups and having been at health events and (pause) you would—just what they say maybe they have encountered it, but I can't say direct link.

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## SOCIOECONOMIC STATUS

One Lubbock County focus group participant believed that people with a higher socioeconomic status had better health, explaining:

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You can afford more fruits and vegetables. You can afford more nutritious items and then you have the information that you need to get that information—to get the facts. You're watching the news, you're reading the paper, looking at the internet that you have. You find out 'this stuff is bad for me.'

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As with the role of income in promoting health equity, Lubbock County focus group participants believed that low-income individuals and families could not afford a healthy lifestyle. One participant explained the need for food in general, stating:

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There's so much people that are on food stamps and based on their income, their jobs, a lot of them can't buy their groceries, so the need of food is always a big—plus, even the people that go to the food bank to get vouchers are on food stamps. A lot of people here in this community need food based on their income or whatever the situation is.

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The ability to afford food in general was viewed as a barrier to health. It was believed that lower-income people simply did not have the means to make a choice to purchase healthy food:

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When you have X amount of dollars to go and spend on your family for food—and I know in particular like ground beef—it's cheap, you're looking at your options. You've got an 80/20 and a 90/10—whatever it is—when you're looking at 4 or 5 dollars in the difference of the 80/20 or the 90/10, you're gonna go with what's cheaper because you can get more and it's gonna go further to feed your family. Choosing that healthier ground beef is gonna end up being better for you, but you're not gonna be able to feed as many people; it's gonna take more of your money. Food costs are just—everything is skyrocketing.

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Purchasing healthy foods was viewed as impacted by financial ability, with wealthier individuals experiencing fewer limitations on their spending than lower income individuals. One participant explained access to healthy food based on income in the following way:



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If you have more money, you'll be healthier because you can afford to eat healthier. You can afford to have options. You're not gonna buy the 99 cent bag of chips or potatoes. You can afford more fruits and vegetables. You can afford more nutritious items.

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Another participant cited the influence of the perception that one's income was insufficient on granting access to health care, saying that:

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Most people have been told that health care is expensive and that you can't afford it, so a lot of them don't seek out those things because they assume that they are not going to qualify or they assume that they can't afford it, so they don't even bother to go and check out the resources.

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## SOCIETAL RESOURCES

Societal Resources was the most common theme discussed by Lubbock County focus group participants. Comments related to the Built Environment and Medical Services nodes dominated the Lubbock County focus group session.

## BUILT ENVIRONMENT

Participants explained segregation in the city of Lubbock; as with discrimination, participants were uncomfortable admitting to racially-based boundaries, but willingly acknowledged differences in neighborhoods based on income and economic standing. Participants also spoke about medical services, especially communication from programs and physicians to the public and patients. Finally, Lubbock County focus group participants shared their beliefs about how to appropriately address health disparities.

### *Neighborhood*

During the session, it became clear that participants viewed the city of Lubbock as divided, with meaningful implications based on location. Focus group participants explained the importance of location in Lubbock:

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Location in Lubbock seems to make a big difference. South, east, west, northeast . . . . When we're talking health disparities and discrimination, location to me is something that goes. It's not ethnicity, it's 'We're gonna do an event on that side of town . . . . Let's do it on the west or the east"—that's just kinda the way.

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When asked to further explain the different areas of Lubbock, one participant dissected the city:

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Whether it's north, south, east, or west, there is a stereotype that goes with the city, depending on what area of town you're talking about. I work predominantly on the east side of town and I see that there's fewer people that want to come to the east side of town to my Center, versus going to a Center that's in the center of town . . . . I don't think it's a knowledgeable stereotype. I think it's—they've heard it, so they assume it must be true. I don't think they have firsthand knowledge of it . . . . When people talk about going to the east side, they say 'Oh no, I don't—I'll just stay over here,' when they haven't been to the east side. People that don't have business or do business over there . . . they're gonna discriminate against that neighborhood because of what they've heard and that stereotype that goes with it. I think it's predominant in Lubbock.

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Interestingly, this speaker implies that the stereotyping of Lubbock's neighborhoods is simultaneously not based in "knowledge," but that it is still "predominant." Another participant explained further that:

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The east and the north to the central of town are considered the more low-income areas . . . . The south and the west is more considered newer homes, better schools, better neighborhoods, the income levels are different. I think the city kind of gets divided in half, I would, say crossways.

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Finally, one participant explained Lubbock's neighborhoods by adding race as a factor. The participant began by agreeing with previously-explained income differences, but elaborated, adding:

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Those [areas] are the lower-income, but it's also just like divided into race. You can say that the north side is probably Hispanic, the east side is predominantly black, the west and south side is predominantly, pretty much white. That's the reason why it's divided . . . . Pretty much, that's the way it's always been for a long time.

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Lubbock County participants were highly sensitized to the role of geography and neighborhoods in their community. One participant shared a personal experience:

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I have a child that's been in three different schools . . . in three different neighborhoods and I saw firsthand . . . how not only the kid's treated, but how the buildings look [and] how they're kept up. There's a pretty substantial difference between the lower-income neighborhoods and the upper-income neighborhoods. I think that breeds that discriminatory feel, whether it's intentional or not.

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Participants elaborated on the role of neighborhoods in their community with reference to the availability of healthy foods and stereotypes of neighborhoods, noting that some community members were denied or granted access to healthy foods based on geography. One participant explained:

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I grew up on the north side of town, so we only had one supermarket there. That's another thing—if that supermarket was predominantly just for Hispanic[s], of course they're gonna have a lot more beans, a lot more rice and everything like that so, when you go in there, even today, it's just Mexican food in there. If that's where you live and you don't have any transportation to move . . . then that's what you get.

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Another participant explained the availability of healthy foods in a different neighborhood, realizing the connection between location and food availability for the first time:

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If I go to 82nd Market Street, hey, fresh fruits and vegetables right up front when I walk in. That's the first thing I see. There's a huge difference from that standpoint. I hadn't even thought about the supermarkets in certain areas, but it's definitely distinguishable.

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While many focus group members connected food availability to location, one participant rationalized the variation of choice as reflective of supply and demand:

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The markets aren't going to stock rice and beans where they're not selling. They're not gonna put fruits and vegetables where people aren't gonna buy them. They can only put—they're there to make money, too.

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## MEDICAL SERVICES

Medical services were frequently discussed, with Lubbock County focus group members emphasizing the importance of communication (especially the Physician and Patient and the Program to Public nodes). Focus group participants believed that the community needed more dental and dialysis providers. Another participant felt that the community lacked a sufficient number of walk-in clinics.

### *Physician-Patient Communication*

Focus group participants agreed that good communication was important for patient care, but that the patient may not always be able to tell the provider what is wrong. They also agreed that patients needed more education about their illness, with one participant pointing out that clients:

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Ask questions of community educators—questions that they should be asking their physicians but they're either afraid to, don't know how to approach it, don't know how to word it, maybe they don't feel that they're listened to.

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One participant explained that this could be due to an “intimidation factor,” that provider/patient communication lacked “back and forth,” and that passive acceptance of a doctor's diagnosis caused patients to “still have the same symptoms, still feel bad, [and have to] go back to the doctor and do it all over again.”

Finally, participants noted that provider/patient communication could reflect cultural and generational differences, as illustrated in the exchange below:

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Facilitator: Do you think race is related to the quality of care one receives?

Speaker 1: I think to a degree it is, but I think it's because certain cultures don't use their medical professionals the way they should. I grew up, 'You don't question the doctor. He tells you what to do, that's it.' I feel like there's a little bit of that as far as—you get in there, you start asking questions and you start communicating with your health care professionals and talk to them, tell them what's going on and I just wasn't raised that way. Maybe there's a little bit to that.

Speaker 2: I also think it's generational. I think the older generations are still of that mindset—I'm almost the pupil and you're the all-knowing and I'll just do what you say, provided they have the resources to do that. I think we're seeing the younger generation starting to take more ownership. It's a slow, bumpy transition.

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### *Program Outreach and Partnerships*

Focus group members raised three areas of concern with regard to outreach. The first was programs' outreach ability, the second was community members' participation, and the third was location of outreach events.

Participants agreed that “there's kind of a lack of communication as to what's available.” One participant suggested this could reflect community members' skepticism of programs, saying that “even though we provide . . . information, they're still unsure what you're saying is correct or truthful.” Still another participant believed that “educating . . . or reaching out to [community members] in their language . . . is important. We play a vital role.”

Focus group participants noted two trends with respect to their clientele. The first was that there has been “a decline in participation in some of the things that we've offered.” The participant explained this could reflect the nature of the service, for example wellness screenings. The second trend noted by Lubbock County focus group participants reflected variation by gender and race/ethnicity:

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Some women will (stutters) do things differently than men will. They'll take advantage of certain things that are out there and a man might not. I think there's a difference when you're talking about races and quality of care, but taking advantage of the care that's available out there. Does the Lubbock community actually take advantage regardless of race of the type of care and opportunities that are out there? I don't think all races do.

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Finally, a topic of great discussion was location of outreach events. One participant stated that local programs “ask the people to come to our space and we're not taking them out to their space,” while several participants agreed that “going to their neighborhood is important.” On the other hand, one participant felt that “you don't necessarily bring services to the people. You bring the people to the services, where the services are. You have to do it in a way that's affordable.”

### ADDRESSING HEALTH DISPARITIES

The topic of addressing health disparities generated much debate; the question alone provoked a strong response:

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Facilitator: Who is responsible for addressing disparities in health and in what way should disparities in health be addressed?

(General laughter)

Speaker 1: Now we're starting to get into politics. I think it is a matter of opinion. My opinion in it is—especially in today's day and age . . . there's plenty of knowledge out there that can be had for people to make their life choices in an educated matter. We can go look up anything on the internet. Whether it's true or not, there's knowledge to be gained . . . I think it's our own responsibility to make ourselves healthy. I don't think it's anything that needs to be regulated or forced upon anybody. You make knowledge easily attained and people individually decide what they're gonna do with that knowledge.

Speaker 2: I agree with what you're saying. It's the individual who's gotta make the decision. Maybe if the food stamp program didn't allow you to buy foods that had so many trans fats in them or a high sugar level or you couldn't buy soda, you couldn't buy chips, you couldn't buy frozen pizzas, would that improve the health of that person? It probably would.

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The conversation took an interesting turn with the second speaker, who states agreement with the first speaker's belief that health is the individual's responsibility, then suggests that government should regulate the food certain individuals can buy with food stamps. This paradoxical paradigm was a popular belief, with other participants agreeing that "misuse" was frequent in the use of food stamps and that:

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[The] options are available . . . need to be reevaluated, and it's gotta be reevaluated by a higher entity. If the government's putting them out, then that's the one that's got to reevaluate it and keep those healthy options in mind when they're doing that whole system.

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Only one participant disagreed with regulating food stamp recipients' options, stating that "I don't think it's fair to say people that are getting food stamps should have their food regulated and schools should have their food regulated." Instead, this participant believed that individuals should be held accountable:

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If you ask who's responsible, you should also ask who's accountable. If we say 'It's okay for you to eat whatever you want,' then I'm gonna be responsible for paying for your dialysis for the next 14 years of your life, is that where we want to go? There's a disconnect between our choices and the long-term consequences, our entitlements, and the reality that we're living in. We're not connecting that as a community.

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Thus, an emphasis on individuals' choices with undertones of government involvement dominated the discussion of who should be responsible for health disparities.

Two participants looked at responsibility for health disparities at a systems level. One recommended that the community become more active in regulating the availability of certain food items that were known to be dangerous. The participant offered the example of working together to lower the sodium content in foods available at the grocery store and restaurants, believing that it would be best if everyone was working together to reduce the community's overall consumption of sodium. Another participant recommended that systemic change, like adding bike lanes, was helpful, but that "access to that comes from the top" because community members "would feel more confident if [they] knew the city was backing [a] plan of safety and having bike lanes."

## INTERMEDIATE OUTCOMES

Participants viewed education as important for producing health-literate individuals, but emphasized that the individual desire to become self-educated was necessary. Interestingly, participants also acknowledged that, due to cultural norms and the comfort that familiar foods can bring, making healthful choices can be challenging.

## EDUCATIONAL OPPORTUNITIES AND OUTCOMES

Focus group participants believed that many factors of health were related to a lack of education. For example, one participant believed that people living on food stamps could be as healthy as a wealthy person if they were “educated on how to use their food stamps.” This participant felt that:

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People that don't have that money and are on food stamps don't buy the right food because they're not educated on how they can use those—buy vegetables, what they're supposed to do. Instead, they buy name brand drinks and chips.

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Another participant believed that “there's plenty of knowledge out there that can be had for people to make their life choices in an educated matter. Whether they take advantage of that or not is beside the point.” With regard to educated diet decisions, one participant:

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[Wondered] if . . . people really, really understand where they're headed if they don't live a healthier lifestyle. I still think there's a gap there. I think we know more than we used to, but I still don't think that—it's not personal, it's not—it's that and then the mindset, of 'Even if I do know, my mother died of blah blah blah and I'm at risk for that.' I still don't think everybody really realizes or connects that when I eat this, then I'm increasing my risk.

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Participants also agreed that younger generations were more likely to understand healthy choices:

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Speaker 1: [Health education] lends itself to the younger generation having more knowledge, understanding what transfat can do if you eat it in certain quantities or if you eat it at all. How it affects you to drink sodas every day and I think that just having that knowledge at a younger age—'cause most of the kids now that are in school at any level have had the internet available to them their entire lives.

Speaker 2: I agree with what you're saying . . . . I have an 8th grader who is actually in a health class . . . . It's very refreshing for him to come and tell me what to eat that's healthy. It's so nice. It's different when it comes from this 'Oh, my teacher said you should eat this' instead of 'Mom said.' It's just entirely different.

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Lubbock County participants agreed that technology has made it possible for people to educate themselves about healthy choices because “now, we can go look up anything on the internet. Whether it's true or not, there's knowledge to be gained. It's a lot more easily obtained now.” One participant believed that young people in particular had benefited from advances in health literacy and technology's role in making health literacy available to the public.

## PREVAILING COMMUNITY NORMS

As with other sites, Lubbock County focus group participants believed that culturally-based lifestyles had an impact on health. One participant shared a recent experience at a conference in California that highlighted

regional variation in culture. Another elaborated, further highlighting regional and generational differences in culture:

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Speaker 1: We had a lunch at one of the conferences I was at . . . . They brought us a salad on a salad plate. We finished the salad and me and a guy that was from Georgia looked at each other and went 'Is that the main course?' (Laughter) It turns out that was the meal. It's just a difference. I don't think—this is an opinion, I don't have any facts or statistics or anything to back this up—I think it's a way—I love chicken fried steak 'cause my mom makes a really killer chicken fried steak and so I still eat chicken fried steak because that's what I was raised on . . . . I think a lot of it does have to do with what you were raised around, what you were brought up [with].

Speaker 2: We see it with our seniors. We do a lunch every day and in talking about preparing menus—whether menus are healthy . . . . I think it's more culture and where you were raised and how you were raised because when we serve lunch, if there's not a roll or a piece of bread, the seniors that we have here in Lubbock, they throw a fit because they don't have their bread, or 'Where's my roll?' Like you said, giving them a salad and going 'Here's your lunch,' they would look at you like you're crazy. 'Where's the meat? Where's the potato?' . . . . In the south especially, it's chicken fried steak, it's fried pickles, it's—everything's fried, everything's done the old fashioned, traditional way.

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Lubbock County focus group participants further explored the role of culture and how familiarity can hinder healthful practices. One participant explained “you don't want to be the one who's different from your group.” Another pointed out that the food bank's nutritionist holds classes on how to use food stamps for healthy eating, but that “she gets no feedback. Nobody wants to attend her classes.”

Finally, focus group participants explained reluctance to visit the doctor. One participant explained variations in willingness to visit the doctor by using a personal frame of reference:

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My father, he will not—he had a heart attack. Great care. He's Mexican. But it does not matter what race you are. He will not follow through. My father-in-law recently had some issues, too. He's of a different race. He went, is taking his meds, exercising, everything the doctor told him. My dad, same age, different races. No. He won't take his medicine, he won't follow through, so I think when you're talking about race and quality of care, I think it's available if you take advantage of it.

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The above speaker used a race-based example to explore variation in willingness to visit the doctor (saying first “it does not matter what race you are,” and then “he's of a different race”), but cannot decide if race impacts willingness to visit the doctor. Another participant strongly believed that biological sex was most likely to predict willingness to visit the doctor:

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I have a doctor's appointment tomorrow that my wife has literally had to push me into kicking and screaming because I hate going to the doctor. My wife looks forward to her annual visits to make sure she's okay and I'm [the] polar opposite. I made up a reason to cancel the first time. (Laughter) There's probably more of a difference between men and women than between races. (Someone says 'I agree.')

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## SUMMARY

For Lubbock County focus group participants, the City of Lubbock's racial/ethnic and economic segregation based on location was the primary cause of health disparities. Access to grocery stores offering healthy food options and nearby medical services was believed to be easier in wealthier parts of town than in areas considered lower-income. Although participants readily acknowledged the relationship between race/ethnicity and income, and that income was a predictor of an individual's health, they were loath to accept that a relationship between health and race/ethnicity existed; instead, Lubbock County participants insisted that local health disparities were a function of income and did not reflect a pattern of health based on race/ethnicity. Additionally, participants believed that culture and tradition were related to individuals' lifestyles, especially with regard to diet. Finally, Lubbock County participants agreed that health disparities were mainly the responsibility of individuals to manage.



# CONCLUSIONS

## INTEGRATION OF SURVEY RESULTS AND FOCUS GROUP FINDINGS

Together, the pre/post survey of the 18 sub-grantees and the focus group sessions with the 4 sub-grantees selected for evaluation provided insight into health professional's perceptions of health disparities. While survey results illustrated respondents' initial perceptions, as well as the impact of health equity training, focus group sessions allowed the evaluation team to fully explore perceptions of health disparities throughout Texas in participants' own words.

The pre/post survey, which collected data from all 18 sub-grantees, evaluated perceptions of racism and discrimination in a more general sense, asking questions such as: "People from which race do you think live the healthiest lifestyles," "People from which race are most likely to have health insurance," and "People from which race are most likely to be diagnosed with cancer/diabetes/high blood pressure." The focus groups, conducted among four sub-grantees, asked more community-specific questions about health equity such as: "Do you believe racism and/or discrimination affect your community, if so, how?" and "Would you say that health disparities exist in your community?" Although the two data collection techniques asked slightly different types of questions, there were several commonalities and contradictions observed.

At baseline, 52% of the survey respondents thought that the healthcare system "very often" treats people unfairly based on how much money they have. Another 38% thought this occurred "somewhat often." There was much discussion around income in the focus groups. Participants in three of the four focus groups talked about income and how it relates to health equity. One group suggested that lower-income individuals don't seek care because they believe it is too expensive and they won't be able to afford it. At baseline, 62% of the survey respondents thought that the healthcare system treats people unfairly based on whether or not they have insurance "very often." Again, participants in three of the four focus groups discussed insurance in relation to health equity. Often, insurance and income were mentioned in the same train of thought. For example, one participant from McLennan County stated "individuals that are low-income don't have good insurance [and] will not likely be able to access the best quality care possible. There's a bit of discrimination in that sense, that they're . . . unable to reach better resources."

Focus group participants discussed the influence of culture on health equity, in terms of foods and how they go about receiving medical care. In some Hispanic cultures, the often-consumed foods are not the healthiest choice, and individuals may turn to home remedies or cross the border to Mexico before seeking traditional health care services. The survey did not ask questions specific to culture; however there was the question, "How strongly do you agree or disagree that differences in genes are a cause of why some groups are healthier than others in the U.S.?" At baseline, 79% of the survey respondents either "strongly agreed" or "agreed" with this statement. At baseline, 69% also "strongly agreed" that differences in the communities people live in are a cause of why some groups are healthier than others in the U.S. Neighborhood resources, including access to healthy food and areas to be physically active within the community, were a chief concern expressed by many focus group participants. In Webb County, one participant stated, "Laredo is very hot . . . I won't take my kid to the park, maybe until it's 7 or 8 at night. The majority of our parks don't have shades. If you're out in the park, [you see] they're getting vandalized. The equipment is not good for our kids to be playing [on]."

Physician interaction was another common issue in both the survey and focus groups. Among baseline survey respondents, 56% said that they expect a doctor or health care provider to understand their personal cultural background and how their background may affect their quality of health care. One focus group discussed the idea of cultural competence, with a participant providing this definition: "Knowing what culture is. What are

their values? What are their expectations, so that I can understand where they're coming from and not offend them in any way, whether I do it intentionally or unintentionally.”

Both survey respondents and focus group participants had ideas of who they believe is responsible for making sure that health care is equitable for everyone in society. At baseline, 16% of the survey respondents reported “individuals” are responsible, 23% reported “healthcare organizations,” 42% reported “government,” 6% reported “the local community,” and 13% reported “other.” The majority of focus group participants believed that all of these entities are somewhat responsible for establishing and maintaining health equity. One participant’s response to this question was, “I think we are all responsible as professionals in the community to be more aware of what our communities need [and be] accessible to them.”

The survey and focus group results provide insight into how health professionals in Texas perceive health equity in general, and more specifically in their own communities. Issues related to income, insurance, education, culture, and community resources were common in both the survey and focus groups.

Race, one of the more controversial topics during focus group sessions, presented an apparent contradiction. Post-survey responses indicated that respondents believed that race is strongly related to unfair treatment in the healthcare sector. For example, most respondents (about 60%) agreed that Whites were the most likely to get quality care in the respondents’ communities, while those of other races and ethnicities were least likely to get quality care and to have access to health services and insurance. During focus group sessions, participants stressed the importance of income as a factor in the likelihood that individuals would have insurance, access to health care services, and quality care. Participants strongly denied the role of race in their communities, citing advances in racial equality and majority-minority population status during focus group sessions. This suggests that focus group participants denied discriminatory behaviors (like treating a minority patient less thoroughly), while delving into structural barriers to health equity (like educational achievement). They thus seemed to believe that minorities are less likely to receive quality care not because of racial discrimination or prejudice per se, but because their incomes and insurance status create racial and ethnic disparities in access to health services and quality care. What seems to be a contradiction as to the impact of race may thus instead reflect the focus group participants’ ability to explicate how the health care barriers associated with race and ethnicity arise primarily from differentials in income, insurance coverage, and education, rather than from discrimination or prejudice themselves. Essentially, the focus group discussion may reflect data that could have been gleaned if the survey had included follow-up questions about institutional and structural discrimination. This underscores the inherent value of a multimodal approach, which helps reveal that what seemed to be a contradiction actually reflects the ability of the qualitative focus groups to allow participants to explicate the reasoning underlying their close-ended responses.

Racism is a complex phenomenon that manifests itself in a wide variety of forms, including direct and intentional prejudice, unconscious biases, and structural institutional policies and practices. Different manifestations of racism may have differential effects on health disparities, as is suggested by respondents’ varying responses on the role of racial discrimination (a direct, individual form of racism) and the role of limited access to health insurance (a structural, institutional form of racism). Respondents seemed to associate racism with its more direct manifestations, and therefore ascribed it a limited or nonexistent role in causing health disparities. However, their association of race and health disparities with income and insurance status suggests that they do, in fact, perceive racism, in its more indirect, institutional forms, as having a strong impact on health disparities. Their conceptualization seems close to that of “institutional racism,” even if they do not explicitly use that term in their responses.

Another topic of contradiction was the role of individual choices in promoting health disparities. Interestingly, even after training, an overwhelming number of post-survey respondents agreed that differences in health habits and communities cause some groups to be healthier than others (each had over 60% agreement). This suggests that respondents continued to believe that individual choices, like what to eat and where to live, helped explain health disparities. Participants in focus group sessions largely disagreed. One's educational status, culture, and location were all viewed as more salient to promoting health disparity than individual choices. Focus group participants felt that personal health habits were often dictated by health literacy, the desire to eat familiar foods (many of which were considered unhealthy), and the ability to access a grocery store that offered healthy choices. Throughout the focus groups, culture, and especially the role of the built environment, dominated participants' perceptions of health disparities. Participants seemed to view health habits as an outcome of choice, with education, culture, and location acting as intervening variables.

Unlike the preceding topics, great consensus was reached on the government's role in health equity. On the post-survey, about half of all respondents agreed that government's role was crucial to ensuring equitable health care for all, and focus group participants overwhelmingly agreed that government was the best tool to reduce health disparities. As with survey responses, the role of health organizations, individuals, and the local community were also addressed, but these were identified as less essential to promoting health equity than government. Only the Lubbock focus group did not come to a consensus on this matter.

# RECOMMENDATIONS

The 2012 Institute of Medicine Roundtable on the promotion of Health and the Elimination of Health Disparities noted that “all disparities are local.”<sup>5</sup> This statement stems from the observation that local factors drive the individual and social conditions that contribute to health inequities and disparities. Our recommendations to TDSHS were developed by integrating national recommendations, the results from the pre- and post-workshop surveys, and results from the focus groups.

## 1. LOCAL DATA COLLECTION AND ANALYSIS ON HEALTH DISPARITIES

### a. Examine Local Data for Disparities in Health and Health Care

There is a paucity of local data, such as county-level or city-level health reports, hospital discharge data, hospice, and nursing home data or assessments, that describe health behaviors, risk factors, treatments, and outcomes by the longstanding axes of disparities such as race/ethnicity, gender, disability, and sexual orientation.

Examining such local data, where they exist, will provide the sub-grantees with evidence that disparities in health are real in their communities, and that disparities are not just local extrapolations of disparities existing in other parts of the county. Such local data may be useful in spurring the sub-grantees, their community partners, and other local agencies to address these disparities within the context of their activities.

### b. Collect Data Related to Transforming Texas Activities with a Health Equity Focus

The evaluation of all Transforming Texas activities should emphasize the collection of process and outcome measures that differentially assess the impact of activities on local health-disparate subpopulations.

Specifically, data collection for performance monitoring should assess whether or not programs are targeted to serve all residents, regardless of race, income, gender, etc., and if these diverse participants all benefit from the project activities.

## 2. INCREASE AND SUSTAIN AWARENESS ABOUT HEALTH DISPARITIES

### a. Regular Reinforcement of Health Equity Message to Sub-Grantees

This report only assessed the immediate changes in perceptions regarding health and health care disparities. The focus groups, conducted within 4 months after the training, show that sub-grantees' staff generally attribute health disparities to the socioeconomic disadvantages that racial and ethnic minorities face, rather than racism.

Sustenance of noteworthy changes in the beliefs, knowledge, and attitudes that resulted from the CEDD training may require reinforcing health equity messages to the sub-grantee staff and community partners, at intervals, through other workshops and technical assistance. While they may demonstrate the role of socioeconomic differences in perpetuating health and health care disparities, these messages should emphasize the existence and effects of institutional racism in promoting these disparities.

Furthermore, assessment of any sustained changes in understanding of health disparities should be conducted over the course of the *Transforming Texas* evaluation.

### b. Review Training Curriculum/Methods to Meet Health Equity Perspective of *Transforming Texas*

This report should be helpful in assessing the extent to which the objectives of the CEDD training were met. These results can also help in identifying changes that might be applicable to any component aspect(s) of the training.

The differential response patterns regarding perceptions about racism and discrimination in health care, by type of organizational settings in which the sub-grantee staff work, as well as their self-identified race/ethnicities, suggest that subsequent training sessions may need different emphases and training methods, based on the anticipated audience's sociodemographic characteristics and professional backgrounds. For instance, methods that actively engage participants, such as small group discussions, may be adopted for audiences whose baseline awareness regarding racism and health disparities is anticipated to be low.

c. Increase Awareness of the Local Community About Disparities

The local communities that are served by *Transforming Texas* should be informed about the existence of disparities in health and health care, its root causes, and perpetuating factors in their communities. They should also be informed of the existence and role of institutional racism as a cause of health and health care disparities.

Raising the community consciousness regarding health disparities to a critical level may help bring health equity and its guiding principles to the agenda table on local policies. This might help in addressing some of the social determinants of health that directly impact health disparities.

**3. DESIGN, IMPLEMENT AND EVALUATE ALL *TRANSFORMING TEXAS* ACTIVITIES WITH A HEALTH EQUITY LENS**

a. Design and Implement Health Equitable *Transforming Texas* Activities

To implement programs that will have meaningful impact on overall community health, as well as a health equity impact, it is imperative that *Transforming Texas* sub-grantees make health equity principles their guiding principles in designing their programs and activities.

For example, in designing community-wide media campaigns, the input of health-disparate racial populations should be sought during the formative process to ensure the final messages are culturally relevant. Similarly, the logistical issues of delivering the messages, such as the timing, must be considered from the vantage point of health equity.

Similarly, in establishing joint use agreements (JUAs), sub-grantees should examine whether the facilities are easily accessible to all members of the communities, irrespective of where they live. JUAs that are preferentially inaccessible to disadvantaged local populations are inconsistent with the health equity goal of community transformation grants.

b. Health Equity Evaluation of *Transforming Texas* Activities

All evaluation activities around *Transforming Texas* should involve the collection of data from all racial groups represented in the community.

**4. IMPLEMENT EVIDENCE-BASED INTERVENTIONS**

a. Implement Evidence-Based Community-Based Interventions

All *Transforming Texas* community-based interventions should be evidence-based, preferably where the evidence base has a health equity perspective. Implementing such evidence-based health-equitable interventions may particularly benefit low-capacity sub-grantees who may not have the

resources to screen and pre-test their interventions with scientific rigor.

b. Implement Evidence-Based Clinical Preventive Services Interventions

Implementation of Strategy 3B of the *Transforming Texas* initiative with a systems-change emphasis presents an avenue for evidence-based projects. The IOM has recommended the use of standard guidelines in disease/case management to reduce the potential racial/ethnic bias in medical-related decisions and in clinician recommendations regarding the use of preventive as well as referral services. Partnering with health systems to implement such recommendations and other evidence-guided recommendations affecting patients' interactions with the health system has great potential in reducing the disparities in health care in *Transforming Texas* counties.

**5. LEVERAGE LOCALLY EXISTING PROGRAMS AND POLICIES TARGETING HEALTH DISPARITIES**

a. Partner with Local Organizations

*Transforming Texas* sub-grantees should seek out other local organizations whose cross-cutting activities, though not necessarily directed towards health, may impact health disparities. Developing such partnerships in implementing *Transforming Texas* activities will help ensure sustenance of such efforts promoting health equity even after the conclusion of the community transformation grant.

b. Synergize with Other Locally-Existing Federal/State Programs

*Transforming Texas* sub-grantees should also leverage existing programs that target health-disparate racial groups where those are present in their communities. Such programs may include the CDC's Racial and Ethnic Approaches to Community Health (REACH) program, as well as the Communities Putting Prevention to Work (CPPW) program.



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# APPENDIX A

## SAMPLE SURVEY ON KNOWLEDGE, BELIEFS AND ATTITUDES TO HEALTH DISPARITIES AND HEALTH INEQUITIES: PRE-TRAINING SURVEY

Dear Participant,

You are invited to participate in our survey [Assessment of the Knowledge, Attitude and Beliefs of the Transforming Texas Contractors to Health Disparities and Health Inequities].

In this survey, participants at the *Transforming Texas* Health Equity Capacity Building workshop will be asked to complete a pre-training survey that asks questions about Health Disparities in the U.S. It will take approximately 15 minutes to complete the questionnaire.

Your participation in this study is completely voluntary. The risks associated with this survey are minimal and psychological in nature and may include feelings of sadness, anger, discomfort, shame, or embarrassment when discussing health disparities and its root causes. However, if you feel uncomfortable answering any questions, you can withdraw from the survey at any point. It is very important for us to learn your opinions.

Your survey responses will be strictly confidential and data from this research will be reported only in the aggregate. Your name and information will be coded and will remain confidential.

If you have questions at any time about the survey or the procedures, you may contact Dr. Kathryn Cardarelli at (817) 735-5192 or email at [kathryn.cardarelli@unthsc.edu](mailto:kathryn.cardarelli@unthsc.edu).

Thank you very much for your time and support. Please start with the survey now by filling in your assigned Unique ID, Site Name and date below.

PARTICIPANT ID (UIN): \_\_\_\_\_

SITE NAME: \_\_\_\_\_

SURVEY DATE (mm/dd/yyyy): \_\_ / \_\_ / \_\_\_\_

\*The pre and post survey asked the same questions

1. Gender:

- ☐ Female                      ☐ Male                      ☐ Transgender

2. Are you?

- ☐ Single
- ☐ Married/Partnered
- ☐ Never Married
- ☐ Separated
- ☐ Divorced/Ended Partnership
- ☐ Widowed
- ☐ Other (*Please Specify*) \_\_\_\_\_

3. What is your age? \_\_\_\_\_

4. What is the highest grade or year of school that you completed?

- ☐ Never attended school
- ☐ Elementary
- ☐ Some High school
- ☐ High school graduate or GED
- ☐ Some college or technical school
- ☐ College Degree
- ☐ Master's degree
- ☐ Doctorate degree

5. Racial/Ethnic Background: (Please select **ALL** that apply)

- ☐ Black/African-American
- ☐ Asian/Asian American/Pacific Islander
- ☐ White
- ☐ Native American/American Indian/Alaskan Native
- ☐ Hispanic/Latino
- ☐ Other (Please Specify) \_\_\_\_\_

6. What is your position/role in your organization?

- ☐ Entry level position
- ☐ Mid-level position
- ☐ Senior Level/Manager
- ☐ Other (Please Specify) \_\_\_\_\_

7. What type of organization do you work for?

- ☐ City/County/Regional Health Department
- ☐ Academic Institution (University, Health Science Center)
- ☐ Non-Profit Health Organization
- ☐ For Profit Health Organization
- ☐ Other (Please Specify) \_\_\_\_\_

8. Do you have any of the following health insurance/health payment plans?

- ☐ Private or employer based health insurance
- ☐ Medicare or Medicaid
- ☐ No health insurance or health payment plans
- ☐ Don't know/Not sure

9. In general, how would you rate your health?

- ☐ Excellent
- ☐ Very Good
- ☐ Good
- ☐ Fair
- ☐ Poor
- ☐ Don't know

10. What does the term 'Health Disparities' mean to you? *(Please answer in the space below)*

11. How big of a problem do you think racism is in the following areas of life?

|            | Major Problem            | Minor Problem            | Not a Problem            | Don't know               |
|------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Work Place | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Education  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Housing    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Health     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Government | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

12. How big of a problem do you think discrimination is in the following areas of life?

|            | Major Problem            | Minor Problem            | Not a Problem            | Don't know               |
|------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Workplace  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Education  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Housing    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Health     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Government | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

13. Do you think the color of one's skin determines the quality of health care they receive?

☐ Yes      ☐ No      ☐ Don't know

14. People from which race or ethnic background are the **MOST LIKELY**, on average, to have the **HEALTHIEST BIRTH OUTCOMES** in the U.S.?

- ☐ Whites
- ☐ Black/African Americans
- ☐ Latinas/Latinos/Hispanics
- ☐ Asian Americans or Pacific Islanders
- ☐ Don't know

15. People from which race or ethnic background are the **LEAST LIKELY**, on average, **TO HAVE THEIR BABY DIE BEFORE HER FIRST BIRTHDAY** in the U.S.?

- ☐ Whites
- ☐ Black/African Americans
- ☐ Latinas/Latinos/Hispanics
- ☐ Asian Americans or Pacific Islanders
- ☐ Don't know

16. People from which race or ethnic background do you think live the **HEALTHIEST LIFESTYLES**?

- ☐ Whites
- ☐ Black/African Americans
- ☐ Latinas/Latinos/Hispanics
- ☐ Asian Americans or Pacific Islanders
- ☐ Don't know

17. People from which race or ethnic background do you think live the **LEAST HEALTHY LIFESTYLES**?

- ☐ Whites
- ☐ Black/African Americans
- ☐ Latinas/Latinos/Hispanics
- ☐ Asian Americans or Pacific Islanders

☐ Don't know

18. On average, who do you think is the **MOST LIKELY** to receive **PREVENTIVE HEALTH SERVICES**?

☐ Whites

☐ Black/African Americans

☐ Latinas/Latinos/Hispanics

☐ Asian Americans or Pacific Islanders

☐ Don't know

19. On average, who do you think is the **LEAST LIKELY** to receive **PREVENTIVE HEALTH SERVICES**?

☐ Whites

☐ Black/African Americans

☐ Latinas/Latinos/Hispanics

☐ Asian Americans or Pacific Islanders

☐ Don't know

20. How likely do you think the:

|  | Very Likely              | Somewhat Likely          | Somewhat Unlikely        | Very Unlikely            | Don't know               |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| AVERAGE BLACK/AFRICAN AMERICAN is to receive QUALITY MEDICAL CARE IN YOUR COMMUNITY?             | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| AVERAGE WHITE is to receive QUALITY MEDICAL CARE IN YOUR COMMUNITY?                              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| AVERAGE HISPANIC/LATINO is to receive QUALITY MEDICAL CARE IN YOUR COMMUNITY?                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| AVERAGE ASIAN AMERICAN OR PACIFIC ISLANDER is to receive QUALITY MEDICAL CARE IN YOUR COMMUNITY? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

21. On average, who do you think is the **MOST LIKELY** to have **HEALTH INSURANCE**?

☐ Whites

- ☐ Black/African Americans
- ☐ Latinas/Latinos/Hispanics
- ☐ Asian Americans or Pacific Islanders
- ☐ Don't know

22. On average, who do you think is the **LEAST LIKELY** to have **HEALTH INSURANCE**?

- ☐ Whites
- ☐ Black/African Americans
- ☐ Latinas/Latinos/Hispanics
- ☐ Asian Americans or Pacific Islanders
- ☐ Don't know

23. People from which race or ethnic background are the, **MOST LIKELY**, on average, to be diagnosed with:

|   | Whites                   | Black/<br>African<br>Americans | Latinas/<br>Latinos/<br>Hispanics | Asian<br>Americans<br>or Pacific<br>Islanders | Don't<br>know            |
|---|--------------------------|--------------------------------|-----------------------------------|---|--------------------------|
| <b>Acquired Immune Deficiency Syndrome (AIDS) or HIV virus?</b> | <input type="checkbox"/> | <input type="checkbox"/>       | <input type="checkbox"/>          | <input type="checkbox"/>                      | <input type="checkbox"/> |
| <b>Cancer?</b>  | <input type="checkbox"/> | <input type="checkbox"/>       | <input type="checkbox"/>          | <input type="checkbox"/>                      | <input type="checkbox"/> |
| <b>Cardiovascular Disease?</b>                                  | <input type="checkbox"/> | <input type="checkbox"/>       | <input type="checkbox"/>          | <input type="checkbox"/>                      | <input type="checkbox"/> |
| <b>High Blood Pressure?</b>                                     | <input type="checkbox"/> | <input type="checkbox"/>       | <input type="checkbox"/>          | <input type="checkbox"/>                      | <input type="checkbox"/> |
| <b>Diabetes?</b>  | <input type="checkbox"/> | <input type="checkbox"/>       | <input type="checkbox"/>          | <input type="checkbox"/>                      | <input type="checkbox"/> |

24. People from which race or ethnic background are the, **LEAST LIKELY**, on average, to be diagnosed with:

|   | Whites                   | Black/<br>African<br>Americans | Latinas<br>/Latinos/<br>Hispanics | Asian<br>Americans<br>or Pacific<br>Islanders | Don't<br>know            |
|---|--------------------------|--------------------------------|-----------------------------------|---|--------------------------|
| <b>Acquired Immune Deficiency Syndrome (AIDS) or HIV virus?</b> | <input type="checkbox"/> | <input type="checkbox"/>       | <input type="checkbox"/>          | <input type="checkbox"/>                      | <input type="checkbox"/> |

|                                |                          |                          |                          |                          |                          |
|--------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <b>Cancer?</b>                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Cardiovascular Disease?</b> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>High Blood Pressure?</b>    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>Diabetes?</b>               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

25. How often do you think our **Healthcare System** treats people unfairly based on:

|  | Very Often               | Somewhat Often           | Not too Often            | Rarely                   | Never                    | Don't know               |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| How much money they have?                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| How well they speak English?                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Whether or not they have Health Insurance?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| What their race or ethnic background is?     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Their Gender?                                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Whether or not they are overweight?          | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Their Sexual Orientation?                    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| How educated they are?                       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Whether or not they are physically disabled? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

26. In your opinion what is **THE MOST IMPORTANT REASON** that different groups in the U.S. may be expected to **LIVE SHORTER LIVES**, on average, compared to the average American in the U.S?

- ☐ Bad Luck
- ☐ Personal Behavior
- ☐ Prejudice and Discrimination
- ☐ Inborn characteristics (genetic or biological)
- ☐ The Healthcare System
- ☐ The Economic System
- ☐ Environment
- ☐ Don't know
- ☐ Other (*Please Specify*) \_\_\_\_\_



27. In your opinion, please check one reason for **THE MOST IMPORTANT CAUSE OF PREJUDICE AND DISCRIMINATION** that causes the difference in the average number of years, people in different groups of society can expect to live in the U.S.

- ☐ Their Race or Ethnic background
- ☐ Whether or not they are poor
- ☐ Whether or not they live in a rural area
- ☐ Their Gender
- ☐ Their Sexual Orientation
- ☐ Whether or not they are physically disabled
- ☐ How well they speak English
- ☐ Don't know
- ☐ Other (*Please Specify*) \_\_\_\_\_

28. In your opinion, please check the most important reason why there is a difference in how likely a baby is to die before her first birthday among different racial/ethnic groups of society in the U.S.

- ☐ Bad Luck
- ☐ Personal Behavior
- ☐ Prejudice and Discrimination
- ☐ Inborn characteristics (genetic or biological)
- ☐ The Healthcare System
- ☐ The Economic System
- ☐ Environment
- ☐ Don't know
- ☐ Other (*Please Specify*) \_\_\_\_\_

29. In your opinion, how strongly do you agree or disagree with each of the reasons below as being causes of why some groups are healthier than others in the U.S?

|  | Strongly Disagree        | Disagree                 | Agree                    | Strongly Agree           | Don't know               |
|--|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| Differences in their healthcare coverage   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Differences in their physical environment such as the quality of air or water  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Differences in their health habits such as healthy food, getting exercise, or not smoking, and managing stress   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Differences in genes inherited from their parents  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Differences in the communities they live such as: having grocery stores selling healthy foods, having streets with side-walks, having safe parks to play and having supportive neighbors | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

30. Have you felt in the past that a doctor or healthcare provider judged you unfairly or treated you with disrespect because of:

|   | Yes                      | No                       | Don't know               |
|---|--------------------------|--------------------------|--------------------------|
| Your ability to pay for care?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| The type of insurance you have or because you do not have health insurance? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Your Race or Ethnic background?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| How well you speak English?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Your sexual orientation?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

31. Have you felt in the past that you received poor medical treatment or health care in the past five years because of:

|  | Yes                      | No                       | Don't know               |
|--|--------------------------|--------------------------|--------------------------|
| Your ability to pay for care?              | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Your Race or Ethnic background?            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Something in your medical history?         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Your accent or how well you speak English? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Your sexual orientation?                   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

32. When you see a doctor or healthcare provider, do you expect them to understand your personal cultural background and how your background might affect the quality of your health care?

☐ Yes      ☐ No      ☐ Don't know

33. In your own opinion, who do you think should be responsible for making sure that health care is equitable for everyone in society?

- ☐ Individual
- ☐ Healthcare Organizations
- ☐ Government
- ☐ Faith-based Institutions
- ☐ The local Community
- ☐ Other (*Please Specify*) \_\_\_\_\_

34. In the last year, have you heard of or read anything about racial and ethnic disparities in health and health care in America?

- ☐ Yes
- ☐ No
- ☐ Don't know

(If 'Yes', please list) \_\_\_\_\_

35. How do you typically learn medical information? (*Please select all that apply*)

- ☐ The Internet
- ☐ Newspaper
- ☐ Medical Journals
- ☐ By talking with my doctor
- ☐ Television (news/documentary)
- ☐ Radio
- ☐ Friends/family
- ☐ Don't know

☐ Other (*Please Specify*) \_\_\_\_\_

36. Have you ever heard of any of the following public health campaigns or read or seen any of the following publications or television series?

|   | Yes                      | No                       | Don't know               |
|---|--------------------------|--------------------------|--------------------------|
| The US Department of Health and Human Services' Healthy People 2020                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| The Agency for Healthcare Research and Quality's National Healthcare Disparities Report | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <i>Unnatural Causes</i>   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

# APPENDIX B

## FOCUS GROUP QUESTIONS REGARDING HEALTH EQUITY / HEALTH DISPARITIES

- In your opinion, what does health disparities mean?
- Would you say that health disparities exist in your community? What are they?
- What do you think are the main causes of health disparities?
- Do you think there is a link between health disparities and discrimination? In what ways?
- Do you believe racism and / or discrimination affect your community, if so, how?
- Do you think health (in general) and race are related?
- Do you think race is related to the quality of care one receives?
- Do you think that some groups of people are healthier than others? What leads you to say this? What makes you think this?
- Who is responsible for addressing disparities in health? In what ways should disparities in health be addressed?

# APPENDIX C

## QUALITATIVE CODEBOOK

|                     |  |
|---------------------|--|
| <b>Code:</b>        | <b>Infrastructure</b>  |
| Theme:              | Societal Resources   |
| Inclusion Criteria: | General observations about the availability and role of infrastructure   |
| Exclusion Criteria: | Specific references to only one community or societal structure  |
| Example:            | People (in urban areas) take for granted Public transportation, running water/sanitation. Not always viable in Rio Grande Valley. (from MHP notes) |
| <b>Code:</b>        | <b>Colonias</b>  |
| Theme:              | Societal Resources   |
| Inclusion Criteria: | Description of Colonias and residents of Colonias  |
| Exclusion Criteria: | Location   |
| Example:            | “Colonias, it’s a rural community of several hundred families and homes”   |
| <b>Code:</b>        | <b>Access to Services</b>  |
| Theme:              | Societal Resources   |
| Inclusion Criteria: | Ability of Colonia residents to access health care services  |
| Exclusion Criteria: | Location   |
| Example:            | “the Colonia doesn’t have the services that an inner city would have”  |
| <b>Code:</b>        | <b>Homelessness</b>  |
| Theme:              | Societal Resources   |
| Inclusion Criteria: | Assessments of the community’s infrastructure and services available to its homeless population  |
| Exclusion Criteria: | Discrimination and lifestyle affordability   |
| Example:            | “we don’t do a lot in the way of assessment of the homeless”   |
| <b>Code:</b>        | <b>Neighborhood</b>  |
| Theme:              | Societal Resources   |
| Inclusion Criteria: | General statements about neighborhoods   |
| Exclusion Criteria: | Transportation   |
| Example:            | “There’s a pretty substantial difference between the lower income neighborhoods and the upper income neighborhoods.”                               |
| <b>Code:</b>        | <b>Availability of Healthy Food</b>  |
| Theme:              | Societal Resources   |
| Inclusion Criteria: | Foods available in different neighborhoods   |
| Exclusion Criteria: | Colonia access to healthy food   |
| Example:            | “that supermarket was predominantly just for Hispanic”   |

|                     |   |
|---------------------|---|
| <b>Code:</b>        | <b>Neighborhood's Location</b>  |
| Theme:              | Societal Resources  |
| Inclusion Criteria: | Relationship between neighborhood's location and the racial/ethnic make-up of residents   |
| Exclusion Criteria: | Transportation  |
| Example:            | "Whether it's north, south, east, or west, there is a stereotype that goes with the city, depending on what area of town you're talking about." |

|                     |  |
|---------------------|--|
| <b>Code:</b>        | <b>Transportation</b>  |
| Theme:              | Societal Resources   |
| Inclusion Criteria: | General comments about community members' access to transportation |
| Exclusion Criteria: | Specific comments about public transportation and ambulances       |
| Example:            | "It is hard for them to come to me."                               |

|                     |   |
|---------------------|---|
| <b>Code:</b>        | <b>Emergency Response</b>   |
| Theme:              | Societal Resources  |
| Inclusion Criteria: | Response time of emergency vehicles   |
| Exclusion Criteria: | Location of doctors   |
| Example:            | In El Cenizo, it takes ambulance 23 minutes to get to actual city, then 30 minutes to get to the hospital. (From MHP notes) |

|                     |   |
|---------------------|---|
| <b>Code:</b>        | <b>Public Transportation</b>  |
| Theme:              | Societal Resources  |
| Inclusion Criteria: | Discussion of the community's need for or improvements to the community's public transportation system                    |
| Exclusion Criteria: | Proximity to services/healthy food  |
| Example:            | "We have a bus system, but it's not very frequent and the stops aren't as near to the places that people need to get to." |

|                     |  |
|---------------------|--|
| <b>Code:</b>        | <b>Play Spaces</b>   |
| Theme:              | Societal Resources   |
| Inclusion Criteria: | General comments about recreational sites and use by community members |
| Exclusion Criteria: | Societal shifts in physical activity; barriers to physical activity    |
| Example:            | "They don't need a park to exercise together as a family."             |

| <b>Code:</b>        | <b>Cost of Facilities</b>   |
|---------------------|---|
| Theme:              | Societal Resources  |
| Inclusion Criteria: | Fees associated with using community recreational sites                         |
| Exclusion Criteria: | Quality, location, and transportation to recreational sites                     |
| Example:            | “They won’t be able to access them because they won’t be able to pay the fees.” |

| <b>Code:</b>        | <b>Quality of Facilities</b>   |
|---------------------|--|
| Theme:              | Societal Resources   |
| Inclusion Criteria: | Ability of recreational activity areas to make community members feel safe while engaging in physical activity                 |
| Exclusion Criteria: | Fees, location, and transportation associated with using recreational sites  |
| Example:            | “The majority of our parks don’t have shades;” “talked about how it wasn’t safe for them to walk around in their neighborhood” |

| <b>Code:</b>        | <b>Medical Services</b>   |
|---------------------|---|
| Theme:              | Societal Resources  |
| Inclusion Criteria: | General traits and expectations of local service providers and services available   |
| Exclusion Criteria: | Cultural competence; ability to access services; discrimination; affordability  |
| Example:            | “There’s a lot of health standards now that require that certain things happen during a hospital visit and it doesn’t matter – male, female, whatever origin you come from – it’s just gonna be standard care.” |

| <b>Code:</b>        | <b>Access to Medical Services</b>                                       |
|---------------------|---|
| Theme:              | Societal Resources  |
| Inclusion Criteria: | Statements about the availability of providers                          |
| Exclusion Criteria: | Discrimination  |
| Example:            | “The services that do exist for free or at a low cost are overwhelmed.” |

| <b>Code:</b>        | <b>Location of Doctor’s Offices</b>  |
|---------------------|--|
| Theme:              | Societal Resources   |
| Inclusion Criteria: | Geographic location of providers’ offices and their proximity to neighborhoods |



Exclusion Criteria: Transportation/public transportation to providers  
 Example: “they should have a clinic nearer to that group of people”

| Code:               | Time   |
|---------------------|--|
| Theme:              | Societal Resources   |
| Inclusion Criteria: | Time spent in the waiting room to be seen by a physician or other medical service provider   |
| Exclusion Criteria: | Time spent waiting for an appointment to be booked; going to a clinic based on affordability |
| Example:            | “Sometimes they wait in the waiting room for an hour, 2 hours, 3 hours, 4 hours, 5 hours.”   |

| Code:               | Language Barriers  |
|---------------------|--|
| Theme:              | Societal Resources   |
| Inclusion Criteria: | How language impacts seeking/receiving quality care                              |
| Exclusion Criteria: | Failure to communicate due to cultural or personal characteristics               |
| Example:            | “information about your medicine is in English because there’s a failure to ask” |

| Code:               | Physician/Patient   |
|---------------------|---|
| Theme:              | Societal Resources  |
| Inclusion Criteria: | Communication as a result of cultural competence; solutions to poor communication; patients’ willingness to talk to a physician; physician’s willingness to educate the patient |
| Exclusion Criteria: | Health literacy; language; physician bias   |
| Example:            | “providers don’t always know how to speak to patients in a way that patients understand.”   |

| Code:               | Program/Program   |
|---------------------|---|
| Theme:              | Societal Resources  |
| Inclusion Criteria: | The ability of programs to work together to promote health in their community           |
| Exclusion Criteria: | The political power of coalitions; the ability of programs to engage in public outreach |
| Example:            | “working with other organizations”  |

| Code:               | Program/Public  |
|---------------------|---|
| Theme:              | Societal Resources  |
| Inclusion Criteria: | Ability for accurate outreach; relevance of events/activities to the public |

Exclusion Criteria: Language as a barrier to outreach  
 Example: “Social outreach coordinators that are trying to get the word out there”

**Code:** **Politics and Political Power**  
 Theme: Societal Resources  
 Inclusion Criteria: The ability of politics to impact community members’ access to care  
 Exclusion Criteria: Accessing specific representatives; suggestions for collaboration/coalitions  
 Example: A lot is politically motivated. If you know the director, you’d get services, it’s not always a straight shot. (From MHP notes)

**Code:** **Contact with Representatives**  
 Theme: Societal Resources  
 Inclusion Criteria: Statements regarding contacting political representatives as individuals or part of a collective to achieve community goals  
 Exclusion Criteria: Responsibility for addressing health disparities  
 Example: “Get the politicians involved and say ‘this is what is going on.’”

**Code:** **Responsibility for Addressing Health Disparities**  
 Theme: Societal Resources  
 Inclusion Criteria: Entities identified as pivotal to reducing health disparities at the local, state, and national levels  
 Exclusion Criteria: Engaging political representatives; statements about programs working together to address health disparities  
 Example: “here’s a role for individuals, there’s a role for community leaders, there’s a role for professional bodies”

**Code:** **Physical Activity**  
 Theme: Societal Resources  
 Inclusion Criteria: Societal changes in rates of physical activity  
 Exclusion Criteria: Access to play spaces/recreational areas  
 Example: “you don’t see kids playing in the neighborhood.”

**Code:** **Technology**  
 Theme: Societal Resources  
 Inclusion Criteria: Societal changes in the use of technology; statements regarding the impact of changes in the use of technology  
 Exclusion Criteria: Changes/advances in technology used by medical professionals  
 Example: “there’s more information at our fingertips than there ever has been in the past”

**Code:** **Alternative Care**  
 Theme: Societal Resources











