Health Disparities: Closing the gaps using Faith-Based Institutions

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I. Executive Summary

Population in rural America has been declining for decades. Across the country, in the smallest and most remote communities, there is very little access to healthcare or social services. Yet, the Center for Disease Control has identified spiritual leaders and places of worship (e.g. churches, synagogues, temples, monasteries, mosques, and other places of worship) as natural centers for physical, emotional, and spiritual wellness. By leveraging these organizations' unique relationships with the communities they serve, increased promotion of wellness, appropriate screenings, and enhanced social services availability can be achieved to help close the health disparities gaps experienced by rural communities.

II. Introduction

Throughout rural America, religious institutions provide the framework on which many communities are built. Rural America's unique relationship with religion provides an opportunity to utilize these connections to increase healthy behaviors in these populations. With the life expectancy gap between rural and urban Americans ever widening and health disparities between ethnic/racial groups in rural areas increasing, discovering ways to reach out to patients in rural communities are growing in importance.[1] Policymakers, health professionals and spiritual leaders can improve rural health by partnering to use this faith-based entry point into rural communities to decrease the health disparity gaps.

For the purpose of this policy, the faith-based approach is referring primarily to promoting wellness, similar to the Community Health Advisor Program, which is a program that can identify and train natural helpers who then help to improve the health of individuals and their communities.[2] Meanwhile, the potential to also use these partnerships to possibly provide direct services should also be recognized, even when working with protected health information or electronic health records (given the proper adherence to HIPAA laws). It would be a disservice to ignore that possibility, since there is a large health care burden and given the intense rurality barriers that disrupt the quality of life of rural residents, e.g. transportation, cost burden, the need to live near health services. The faith-based partnerships have the power to spread health information, actively manage chronic diseases, create communities with health seeking behaviors, and encourage (or in some cases provide) appropriate diagnostic screenings with the proper capacity, support, and management.

III. Background

According to the General Social Survey, rural Americans are generally more religious than those who live in urban or suburban areas.[3] This is determined by regular attendance of religious services and respondents having reported experiencing a "spiritual rebirth". In relation to rural community members' higher attendance, they also tend to receive higher quality social interactions from religious experiences. [4] Members of congregations tended to report more social connections, a broader social network, a stronger feeling of connection with their communities, and more favorable perceptions of their relationships with fellow religious people. [4] These strong social ties can be leveraged to disseminate health information and build up community norms around healthy behaviors. National expert leaders within the health profession recognize the importance of using faith-based partnerships to gain access to vulnerable populations in rural or urban areas. For example, the Center for Disease Control recommends a Practice-tested Interventions in which faith communities are included within the public health intervention. [5] The first faith-based intervention to gain this status was The Faithful Families Eating Smart and Moving More Program, which promotes healthy lifestyle habits around eating and physical activity in faith communities. [5]

IV. Scope of the Problem

When comparing the numbers of individuals who attained proper primary health care screenings, both rural men and women received appropriate services at a much lower rate than their urban counterparts. [6,7] Rural Americans also tended to receive primary care services at lower rates than their urban counterparts. [7] Addressing the barriers to achieving improved access and utilization of primary care services within this group is one crucial step in lowering the mortality of rural America. In addition, while rural communities are generally disproportionately affected by health outcomes than their urban counterparts, in a similar manner, there are health disparities between rural white residents and rural non-white residents. [8,9] While these disparities have strong geographic differences with unique perspectives, there is hope that a faith-approach is an effective way to promote wellness, especially within black rural communities.

Yeary et. al. found promise in a faith-based diabetes program that used a community based participatory approach. This diabetes management program was effective in reducing weight among black participants. Programs that have a community based participatory approach and are effective in improving health outcomes could help close the health disparity gap between ethnic/racial populations in rural communities. [10] Research indicates that faith-based health programs have been effective at increasing access to health services, particularly within minority communities. [11] One study indicated that many health delivery methods are not particularly designed to fit the population they are intended to serve. [12] Therefore, it is most helpful to include a

program design that allows for the community to help design the program. In sum, by focusing on existing institutions within rural areas, such as places of worship, and leaning on strong role models of community social behavior, like spiritual leaders, some socioeconomic barriers have a great potential to be mitigated when sensitivities to demographic differences such as ethnicity/race are also understood or community input included within the program design.

V. Framing and Historical Context

Generally, a faith-based approach to health education is mixed with a faith specific messaging and reinforced by the social ties that already exist within the faith community's social structure. Given that more rural people are part of religious communities, implementing front line primary health initiatives at these locations could be a pivotal piece in closing the healthcare gap between rural and urban Americans. Likewise, it can be an opportunity to close the gap between rural ethnic/racial differences that are vastly understudied. [9]

A faith-based approach could be especially effective in servicing micro communities that surround small towns but have little existing infrastructure on their own. These small clusters of population (generally less than 500 people) may feature very few businesses of their own and lack the population to support even a part-time clinic. However, many of these micro communities still feature at least one religious institution. These institutions are, in many cases, the only formal social support system in town. Strong relationships between small towns and their religious institutions makes utilizing these ties to improve the health of the population a uniquely rural opportunity.

Beyond being reliably located in the most remote locations, spiritual communities have had a long-standing presence in the provision of healthcare. [13] From the sociological perspective, faith communities and healthcare providers have a shared legacy of providing services for the most vulnerable individuals and caring for their communities. While healthcare providers have labored to decrease the gaps in care for communities across the country, the faith communities have taken a leadership role in providing relief to the poor as well as housing, meals, and counseling services that underpin these initiatives.[13] Faith communities can provide geographical convenience, volunteers, cultural competency, and a community legacy to healthcare providers' efforts to improve access to healthcare in rural communities; the relationship between healthcare providers and the spiritual communities are, therefore, a natural partnership. [13] Further, there are community models that can be applied to this faith-based partnership to help build capacity within faith communities to help support this concept, such as the Community Health Advisor model.[2] This model has been proven by The Deep South Network to reduce health disparities in both rural and urban communities, and can be a possible reference in how to equip faith leaders to engage in this partnership.

VI. Barriers to Care for Those in Rural Communities

1. Lack of Rural Providers and Geographic Challenges to Providing Care

The lack of access to care in rural communities is multifaceted. While 18% of Americans live in rural areas, yet only about 9% of the nation's healthcare providers practice there.[14,15] While urban areas boast a ratio of 53.9 physicians per 100,000 populations, rural areas only have 39.8 physicians per 100,000. [16] In addition, many healthcare providers are located in rural communities that are too deurbanized to be able to efficiently serve all parts of their service area all the time. As previously mentioned, there are many more religious institutions than clinics in small towns. These religious institutions could provide a base of operations for healthcare providers allowing them to extend their reach into the most remote communities. Additionally, religious institutions tend to have a cadre of volunteers who could help extend scarce rural healthcare resources.

2. Logistics of Services

Rural households have, on average, lower household incomes for similar level qualifications than their urban counterparts.[17]

Average wage within the following categories:	Paid holidays	Paid sick leave	Paid vacations	Paid personal leave	Paid funeral leave	Paid jury duty leave	Paid military leave
Lowest 25 percent	53%	41%	51%	21%	31%	33%	14%
Second 25 percent	83%	83%	70%	82%	44%	63%	65%
Third 25 percent	83%	88%	79%	87%	50%	72%	74%
Highest 25 percent	83%	83%	87%	79%	61%	81%	84%

This chart of paid leave time from employment created with data from the Bureau of Labor Statistics show that the lowest 50% of earners are more likely to have very little or no paid leave time. Given that rural Americans are more likely to make less money than their urban counterparts, according to United States Census data, the average American household income across all demographics was $55,750 dollars. Additionally, Census data reports that rural median household data is slightly lower across the nation at $52,386. [17] While not counting for statistical outliers such as pockets of deep poverty as well as rural communities of great affluence to offset them, rural Americans, on average, fall below the 50th percentile in household earnings. Given this, the average

rural household is more likely to fall in the two lowest quartiles for any kind of paid leave. Combining lack of paid leave with deep shortages in providers means that, logistically, getting appointments for regularly scheduled and appropriate healthcare maintenance may prove too difficult for utilization. However, rural Americans also have a higher rate of weekly religious observance. [3,18] Therefore, while they may not be seeking out preventative care services during normal clinic hours, they are attending religious services. This provides another advantage for reaching these populations to improve their access to adequate healthcare.

3. Rural Ethnic/Racial Concentrations and Migrations

While growth rates begin to stagnate in rural white communities across the country, population growth among the Hispanic and African American communities in rural America continues to climb. In 1990, 1.6 million Hispanics were living in rural areas across America. [19] By 2004, the number had climbed by an additional 1.4 million- a growth rate of roughly 87% in just 15 years. 19 By comparison, non-Hispanic whites accounted for 38.3 million of those living in rural areas in 1990, but only grew by 6% during the same time period.[19] This has caused an infusion of Hispanic minorities into rural communities who have been traditionally predominately white. Such rapid growth in these areas can create barriers to healthcare as providers struggle to earn the trust of this new group. This provides another opportunity for religious institutions to break down cultural barriers in order to better serve different ethnic/racial populations. With religious institutions being a key construct in rural communities, they offer access to rural ethnic/racial groups that are concentrated in specific geographical areas. This is vital to close the gap of rural ethnic/health disparities since half of all Hispanics and American Indians/Alaska Natives live in five states and half of rural Blacks live in just four states. 9 This makes partnerships that involve the community feasible and possibly geographically replicable while using a key component to the community infrastructure. Religious institutions are crucial in tackling misinformation and mistrust even among the traditional inhabitants of rural communities.[13] By creating offerings tailored to the specific cultures of rural communities, healthcare providers can help improve access and utilization of health services.

VII. Examples of Faith Based Institutions

1. Heart and Soul

The Heart and Soul Program is a Church-based curriculum used to increase health literacy, healthy behaviors and activity levels in middle aged, black, church going women. In one study, middle aged black women participated in the Heart and Soul program. [20] At a baseline of 6 weeks, there was a 34% average increase of physical activity among the women. Participants also reported feeling an increase in social support for physical activity. Additional study by Peterson found that, after completing the program, the women understood the role of physical activity in preventing chronic

diseases, but often felt domestic pressures interfered. However, the women noted the benefit of increased social support around an active lifestyle.[20]

2. Conetoe Family Life Center

Started by Reverend Richard Joyner in rural North Carolina as a response to high rates of chronic illness within the community, Conetoe Family Life Center coordinates a series of community farms that provide healthy food choices to residents who otherwise reside in a food desert. In addition, the farms are tended to by the community's children who also receive education about healthy lifestyle choices, business practices, and community stewardship. The children who are involved in the program reported having higher self-esteem, better social skills, and improved understanding of stress management techniques. Additionally, many of the children served as the impetus for their families, and the community at large, developing healthier habits such as smoking cessation, healthier cooking habits, and improved physical activity.[21]

3. Other Examples to Consider

There are other examples of faith-based programs including Parish Nurse Programs within Judeo-Christian faith traditions and Jewish synagogues incorporating health interventions. There is also literature that encourages health care professionals to address the rising Navajo health care needs. One such hospital, Sage Memorial Hospital in Ganado had a goal in 2001 to develop an integrative medical program of traditional native practices. [22] As well, research encourages attention towards one of the drastically increasing non-white populations, Muslims, as their health needs within the United States increases. [23] The research recommends that health care be administered and considered through the lens of these populations strong spiritual reference in which these groups highly identify with. It is important to consider a community-focused and perhaps, community directed, just any method that include community input within the design and implementation when dealing with rural communities, as they are all nuanced and have different challenges, even though they share a rural location.

VIII. Concerns with a Faith Based Approach

After conducting a focus group in Batesville, Indiana, church leaders expressed growing concerns over Health Information Portability and Accountability Act (HIPAA). Lack of understanding how not to violate HIPAA when handling exposure to Protected Health Information (PHI) causes many religious leaders to shy away from providing health care services within their organizations.

Additionally, with rural populations and therefore rural religious populations shrinking, many churches reported concerns with not having the relative size or bandwidth to provide these services. Many church leaders expressed concern over losing church members due to privacy concerns.

Another reported challenge to providing a faith-based approach is adequately capturing patient outcomes. Many existing programs do not have the capability to connect into the patient's Electronic Medical Record (EMR). Also, many of those who staff these programs do not have the ability to generate data in order to show the community benefits of such programs.

IX. Key Elements to Successful Congregational Health and Wellness Programs

A journal entry compiled for the Journal of Public Health Nursing sought out congregational health studies and reports and found seven common elements between successful congregational health programs. [24] These elements are as follows:

1. Partnerships
2. Positive health values
3. Availability of services
4. Access to religious facilities
5. Community-focused interventions
6. Health behavior change
7. Supportive social relationships

In the presence of these key elements, congregational health programs showed both short-term and sustained improvements in health metrics such as BMI, blood glucose, and physical activity.

X. Recommendations

1. We recommend that hospitals, FQHCs, and community health departments who service rural areas to seek out adequate community investment to address the social determinants of health.

1. We recommend training for those working with protected health information and access to electronic health records within faith-based health interventions. This is for health information that is reasonably deemed manageable by the health partnership teams, knowing that information within small towns are often openly shared.

2. We recommend that scenarios around protected health information and access to electronic health records be evaluated and shared broadly to help share best practices around how this important piece can be successfully managed or breeched unknowingly.

3. We recommend that additional funding be allocated to build capacity within religious institutions to support this health partnership. This includes research to identify present congregational activity and forming best practices/lessons learned around faith-based health programming, with a focus on increasing the data on ethnic/racial/cultural inclusion within interventions in rural health.

4. We recommend funding long-term sustainable programs that depend on community input in the design and implementation of interventions that also include innovative and creative methods to best support collaboration between rural health care providers and local religious organizations in areas of limited health care access. The point is to effectively identify and evaluate outcome metrics and health intervention strategies for successful interventions.

5. We recommend research to understand the effect of faith-community nurse interventions and building community capacity via long term training, which also builds trust with local providers, as stated by Dr. Teresa Cutts, who helped create an effective faith-based health model in Memphis with over 4,000 community and congregational members. This focus can help improve chronic disease health outcomes in lower income communities, who otherwise would have limited access to health services.

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