

A Resolution to Address Health Disparities

As those responsible for providing healthcare to the citizens of Atlanta and its surrounding areas, we have tremendous accomplishments for which to feel proud—including advances in technology, public health and life expectancy; strong leadership among our organizations, and a culture of innovation. Despite this, we are reminded of one harsh reality: even with healthcare advances there remain disparities in health evidenced across race and ethnicity, gender, region, and economic status. The causes of health disparities are numerous and complex, often resulting from the interrelatedness between numerous social, economic, behavioral and environmental factors. The reality is that they exist. For instance in terms of health access, we know that rural communities have less access to healthcare providers than urban dwellers (due to factors such as fewer available providers and transportation issues) and that Latinos have the highest rate of uninsured adults. In terms of health indicators, we also know that African Americans have higher mortality rates for diseases such as cardiovascular disease, certain cancer and infant mortality, even when income, edu-

cation background and the like are taken into consideration.

Georgia has some work to do. In 2009 the United Health Foundation's America's Health Rankings report ranked Georgia 43rd in overall health status. Among some of the report's many findings, such as the high prevalence of obesity in our state, it notes that African-Americans experience more premature deaths than their white counterparts. In 2008 the Georgia Department of Community Health released the Health Disparities Report, which looked at various county-level data and provided a grade for each Georgia county based on its health outcomes for minorities. The purpose of the report was not just to highlight the many indicators that impact health outcomes, such as primary care access, but to inform and encourage stakeholders to develop priorities in order to focus efforts for improvement.

Georgia has some real opportunities. We are fortunate to benefit from a population rich in diversity and culture. As healthcare providers we have tremendous opportunities to engage our staff, consumers and constituents in discussions on patient

healthcare needs and how to improve our efforts to increase access and quality for all. We can also glean from best practices on how to appropriately and intentionally address the reduction of health disparities. Strategies should be practical and doable, addressing areas that can enhance access to or quality of care and that are meaningful to our local communities. This could mean developing strategies to improve transportation for patients, ensuring the cultural and linguistic appropriateness of patient education materials, or starting and supporting charitable clinics which provide needed healthcare for the uninsured who have the inability to pay.

For us at the Center for Black Women's Wellness, we have committed ourselves to addressing health disparities head on by addressing the issues of access to care, the cost of care, health behaviors, health education, and workforce diversity. Examples of the ways we have dealt with access and cost include expanding our hours to



BY JEMEA S. DORSEY

include some evening and Saturday clinic hours, and developing a volunteer healthcare professional workforce (used along a paid workforce) which allows us to provide lower cost services. We address health behaviors and education by focusing on prevention and the early detection and treatment of health conditions before chronic diseases arise, and providing extensive, culturally appropriate health education to

address the risk factors which contribute to the onset of chronic disease. Finally, we address workforce diversity by preparing a qualified and diverse workforce reflective of the clientele we serve.

It starts with a resolution. Let us take advantage of the many resources and opportunities available to assist us in a quest for health equity. Ultimately, the goal is this: to take strides to ensure health equity for all, because improving the health of those at greatest risk improves the health of all.

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Addressing the End-of-life Spiritual Needs of Atlanta's Religiously Diverse Community

Visiting Nurse / Hospice Atlanta recently held an interfaith blessing of the new garden at the Hospice Atlanta Center, the 36-bed inpatient facility in Buckhead. A Jewish rabbi and clergy from several Christian denominations – including Catholic, Methodist and Episcopal - were joined by representatives of Islam and Hindu faiths. It was a transcendent moment to see and hear the communion between these men and women, and to realize that their prayers shared com-



BY DAPHNE CLEMENT

up-to-date on the changing needs of our

mon themes of love and understanding. It is also a valuable lesson for those of us who care for patients' spiritual needs.

Death comes to all of us regardless of our religious affiliation, and hospice chaplains are trained to be accepting of every person's approach to end-of-life. As the population of Atlanta becomes more culturally and religiously diverse, however, we need to stay

patients and families.

Atlanta is in what is traditionally known as the Bible Belt – predominantly Protestant – and most of our families fall into this category. Roman Catholic churches have been gaining members for some time however, especially with the growth of the Hispanic community, and the already strong Jewish community has grown rapidly as families move here from states such as New York and New Jersey.

We have also seen an influx of people from around the world: metro Atlanta now is home to more than 80,000 Indian residents the majority of whom practice the Hindu faith. The largest Hindu temple out-

side India is in Lilburn. The city also has more than 50 mosques for those of the Islamic faith. As immigrant families assimilate, the younger generations have diverse needs that may include elements of their families' faith, overlaid with components of their new culture.

Add to that the people who claim to be spiritual hybrids or of no particular faith, and it's clear we need to educate ourselves about the needs of these different populations. Beliefs about the afterlife, and the ways we mourn, vary dramatically from one religion and culture to another. As chaplains, however, we know that at the end of life people have deep spiritual needs that are universal. With this approach, we can stay present with patients and families at this difficult time. We can also reach out in specific ways:

- Provide a few simple things that make families and patients feel at home – a text from their faith, a cross, a prayer rug, a warm welcome in our non-denominational chapel.
- Ask respectfully what is needed and make it clear that we have no religious agenda – all beings are spiritual and it is our responsibility to address spiritual, not religious, needs. There is a difference.
- Don't interfere where we are not wanted or needed. Some families have their own spiritual caregivers and their own ways of handling death. We honor their right to follow their path without us.

It's the mission of every hospice chaplain to serve patients and families compassionately, authentically and respectfully, and to embrace their spiritual needs whatever they may be.

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