Tools for Teaching COPC

Following are didactics and self-directed activities related to COPC, used in our 3 COPC-Service-Learning Programs: Summer Assistantship, Clerkship and Residency. See program links for more information on these programs. Tools are delineated by pink highlights.

**Workshop: Community Oriented Primary Care And Healthy People 2010: Nuts and Bolts**

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**Brief Description:** This 1 ½ hour workshop uses short lecture, interactive discussion and videotape to expose students to the concepts of COPC. In small groups, students have the opportunity to apply some of the skills reviewed by working through a COPC plan for a particular health issue.

**Intended Audience:** pre-clinical students, third year medical students, residents, faculty, other clinical-level students such as nurses/nurse practitioners, physician assistants. The case used in the small group will vary depending on the group of learners.

**Goal/Purpose of workshop:**
To expose students to an approach to health care that focuses on caring for the community or populations

**Learning Objectives:**
- Discuss the rationale for engaging in COPC  
- Describe the steps of COPC  
- Define your role in the COPC process  
- Define your role in addressing HP 2010 objectives  
- To apply the steps of COPC to a case/health issue  
- Recognize that COPC can be applied incrementally

**Resources/materials needed:** data on a community (demographics, health status, etc.) copies of instructions for small group work

**Attachments:** handouts/overheads needed.

**Lesson Plan**
1. **Ask the group to venture a guess at what we mean by Community Oriented Primary Care**

As its name implies, COPC is about looking beyond the individual patient in the exam room, assuming responsibilities for the health of a community or particular population and following through by taking action beyond the traditional mode of treating complaints and problems of patients as they approach one by one. Rather it aims to systematically assess and address the issues of the defined population, evaluate results, involving the community/population in all steps: It takes the best of primary care and public health and provides a strategy that can be practiced in a private practice as well as other settings. Combines principles of primary care, epidemiology and public health, and continuous quality improvement. OH: Show circle overhead. Emphasize importance of involving the community. As you would certainly involve your patient in coming up with the treatment plan, in COPC the community is a partner at every step of the process -- this is a means to empower a community to address it’s health problems. COPC could focus on geographically defined populations such as a town or county; specific population groups such as the elderly or the homeless; people congregated at particular sites such as the workplace or church. The key is that the community is involved in every step. Makes it different from simple “population-based medicine”. Why is it important to involve the community?

COPC cycle/steps:
“COPC is a systematic process for identifying the health problems and assets of a defined population, developing interventions to address health issues and evaluating efforts. COPC is generally divided into four steps, involving the community in each:
1. Define and characterize the community;
2. Identify community health problems and community assets;
3. Develop programs/interventions to address the identified health problems; and,
4. Monitor the impact of programs/interventions.”

2. Ask participants what do they consider their community- go around the room or select people. Will get geography initially, perhaps community of medical students, people in same racial, ethnic, religious group. Ask “how many consider the other patients in the practice where you get your care, to be your community?” Discuss difficulty of identifying a community that is a “true community- comprised of people sharing common social, cultural, economic, and political systems. Examples of communities may be:
Migrant Farm Camp
A defined neighborhood
Workers in a factory, company, students in a school, members of a church, clients of a soup kitchen
Less “true communities”, given how little they actually have in common are:
People registered as potential users of a practice, HMO, Health center or defined service
Users of a defined service – active patient population.

3. Why do we think about community health? Why not just treat patients one by one as they come into the office? (Main reason is that they may not be coming in- we want to reach people who are not accessing care, who feel our care is not accessible, not culturally appropriate, etc, also, the health of the community does not only depend on the care one gets in the office- many factors that cause health problems that can only be addressed on a community level (e.g. good housing, safety, education,).
True COPC looks at an entire community (not just those in care) and seeks to answer the following questions about a population or community:
1. What is the community’s state of health?
2. What are the factors responsible for this state of health (genetic, behavioral, environmental, social, cultural, political, etc)?
3. What is being done about it?
4. What more can be done and what is the expected outcome?
5. What measures are needed to continue health surveillance of the community and to evaluate the effects of existing programs


Take lead as an example. What are the causes of lead poisoning (environmental- poor housing, use of ceramic pots with lead-based enamel) What needs to be done to address this problem- better housing, “safe houses” for people to go during lead abatement, screening for all ages, not just children, education in cleaning houses to reduce lead dust, etc.)

COPC interventions, ideally should be developed with “true communities”. The goal is to have the community take ownership of the intervention.

4. Discuss example of “ideal COPC effort.” If you have one, use a local example of a community health initiative that uses the steps of COPC, perhaps one sponsored by the Department of Health. Or discuss history of COPC as developed by Sydney and Emily Kark in South Africa (see American Journal of Public Health, November, 2002 issue for examples. Our example is the Healthier New Brunswick 2010 initiative coordinated by Robert Wood Johnson Medical School and a community organization, New Brunswick Tomorrow with Rutgers University in partnership with over 50 community organizations and businesses. It’s goal is to improve the health status of New Brunswick residents by 2010. It uses Healthy People 2010 as a blueprint, doing community assessment – surveys, interviews, focus groups to identify perceptions of health issues to be addressed. Have formed the following action coalitions: domestic violence, Get fit New Brunswick, Lead, Mental Health.

5. Now, what do we take from a huge community effort like this, that we can apply in our own practice?

Share example of a local practice-based COPC effort or find examples in Harper, 2000, Rhyne, 1998, APHA journal, Nov. 2002. Describe it in terms of the COPC steps, being honest about steps that may have been left out (e.g. assessment of community problems, evaluation). Ask group how one would pursue steps that may not have been done. Assessment: What are the ways of learning about a population? (Primary data: surveys, focus groups, interviews, ask your patients; secondary data, if you wanted to learn about the town you grew up in or the town you practice medicine in – where would you look, what kinds of measures would give you an idea of the population?) What are ways you could measure whether this intervention made a difference?
6. **Using Healthy People 2010 objectives.** One way to help focus your COPC efforts is to look at HP 2010 for guidance. A set of national objectives promulgated by the Dept of Health and Human Services. Sets targets for improving the health of the nation. 467 objectives in 28 focus areas – roadmap for developing and tracking health promotion efforts. (Show overheads of leading health indicators, focus areas, racial/ethnic health disparity areas. HP document provides population-based data on focus areas which you can generalize to your patient population and community. Why need objectives? As with anything, the way you make progress or change is to set goals and work toward them – it doesn’t just happen. HP 2000- “A lot of progress was made since HP 2000 was developed: significant reduction in infant mortality; childhood vaccinations at highest levels ever in US; fewer teens becoming parents; tobacco, alcohol, illicit drug use leveling off; death rates of CHD and stroke have declined. Significant advances made in diagnosis and treatment of Cancer.” But, this is not the case for racial and ethnic minorities – huge disparities. Long way to go: Obesity in adults has increased 50% over past 2 decades, Nearly 40% adults engage in no leisure time activity, diabetes and other chronic conditions continue to present a serious obstacle to PH. Mental disorders go undiagnosed and untreated

**Overhead HP 2010:** Overarching goals: to increase quality and length of healthy life; and eliminate disparities in health outcomes based on race and/or ethnicity. Example of health disparity? Definition: differences among subpopulations (racial/ethnic, populations with differing income levels, education levels) in the incidence, prevalence, morbidity or mortality, burden of disease and other adverse health conditions or differences in rates of health care access and utilization.

Idea is if health care orgs can work towards this it can make a big difference in health outcomes. Physicians can play an important role in achieving these objectives by systematically addressing them in their practices.

7. **Small groups:** Have learners work in small groups to apply COPC concepts to an issue of interest (e.g. prevalent problem in their site, or select HP 2010 LHI). See attached case as an option

8. **Conclusion. What do you think are the essential elements of COPC?**

   1) Involve the community or population you intend to reach: you must be very humble and assume that comm.. usually knows best what’s its needs are and what how best to address them – ask, have pats review materials, participate on CQI meetings, patient satisfaction surveys, empowering. Learning barriers, strengths/assets and involving them in all phases from problem identification, to determination and implementation of intervention and evaluation.

   2) Form partnerships with other comm.. orgs, can be as simple as having a really good referral list – know the AA group, smoking cessation group, overeaters anonymous group you can send a patient to more involved – a coalition to do strategic planning – healthier NB 2010
3) Interdisciplinary Teams – within a clinic setting most of the issues are complex – biopsychosocial, economic, most COPC efforts require the skills of several disciplines. MD not necessarily the leader of the team

4) Working in area of prevention/health promotion

5) Collecting data and measuring results

6) Lends itself to focusing on underserved, hard to reach pops with barriers to access though not necessary – can be practiced in any setting with any population.

Family Medicine has embraced COPC and really tried to take it on (although you will find out that few comm. docs know what it is, residency programs are beginning to try to incorporate it in their training). That’s why we want to introduce it because you won’t get it anywhere else in training most likely, and you especially won’t get it out in practice. We think it can provide you with a new and useful perspective for practicing medicine. Family Medicine takes such a holistic view of the patient, knowing that you must consider in addition to the health problem, psychosocial issues, economic, cultural, community. COPC has become particularly important as the disparities in health outcomes have been highlighted – need to look at populations, collect data and see if programs are making a difference. (coronary artery disease, cancer, asthma). You can do this incrementally, in small steps.

Review objectives to see if obtained.

Evaluation- students complete satisfaction survey, assess understanding at conclusion of workshop.

References:


Healthy People 2010 (www.health.gov/healthypeople) or Healthy NJ 2010 (www.state.nj.us/health/chs)


COPC Small Group Exercise
(This case study is relevant for clinical level students)

In your office you recently saw a 15 year old female for a routine physical. She was 62 inches tall and weighed 160 lbs. Her mother, who accompanied her to the visit, was also overweight. You obtained information about her diet and physical activity during your history, which included the following:

- She frequently eats at the MacDonald’s up the street with her friends and enjoys their “Happy Value Meal” including a double cheeseburger, fries and a coke
- During the day at school she has sodas from the vending machine
- She reports disliking vegetables but enjoys fruit
- She spends about 3-4 hours a day watching TV or surfing the internet
- She takes a bus to school
- She lives in an apartment building on the 10th floor and uses the elevator.

The Medical School, in partnership with other New Brunswick-based organizations and corporations has launched Healthier New Brunswick 2010. One of its initial goals is to address the problem of overweight and obesity in the New Brunswick population through its “Get Fit” coalition. As a practice, you would like to contribute to this effort. Consider the key elements of COPC in doing the exercise (involve community, partner with community orgs, interdisciplinary teams, prevention, measuring results of intervention, attention to underserved populations):

1. How would one assess the overweight/obesity problem among the patient population? What can you extrapolate from the attached data?

2. What is currently being done with respect to obesity your practice?

3. What interventions might you develop to address obesity?
   
   patient/practice level:
   community/outreach level:
   advocacy/policy level:

4. How would you evaluate at least one intervention?

5. Given the interventions you proposed what can you realistically envision carrying out? What are the challenges, resources?

Healthy New Jersey 2010 Objectives and Data to address Adult Obesity

1) Increase the percentage of persons aged 18 and over eating at least five daily servings of fruits and vegetables (including legumes) to 50%
2) Reduce the percentage of persons aged 18 and over who are overweight but not obese to 25%
3) Reduce the percentage of persons aged 18 and over who are obese to 12%
4) Increase the percentage of persons aged 18 and over who participated in frequent leisure time physical activity during the past month to 50%

Baseline Percentages, 1996 – 99
(Each column corresponds to one of the objectives listed above)

<table>
<thead>
<tr>
<th>Populations</th>
<th>(1) % eating 5 serv. fruit &amp; veg.</th>
<th>(2) % overweight</th>
<th>(3) % obese</th>
<th>(4) % exercising</th>
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</thead>
<tbody>
<tr>
<td>Total</td>
<td>26.7</td>
<td>36.7</td>
<td>15.5</td>
<td>36.9</td>
</tr>
<tr>
<td>White non-Hispanic</td>
<td>28.0</td>
<td>36.3</td>
<td>14.7</td>
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<td>30.4</td>
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<td>Hispanic</td>
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<td>16.0</td>
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<td>DSU</td>
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<tr>
<td>Male</td>
<td>45.6</td>
<td>16.7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>28.2</td>
<td>14.4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adults 65+</td>
<td></td>
<td></td>
<td></td>
<td>28.6</td>
</tr>
<tr>
<td>2010 target</td>
<td>50%</td>
<td>25%</td>
<td>12%</td>
<td>50%</td>
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Source: New Jersey Dept. of Health and Senior Services, Center for Health Statistics, Behavioral Risk Factor Surveillance System, adapted from tables in Healthy New Jersey 2010

Middlesex County Health Profile 2001

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<tr>
<th></th>
<th>Healthy People 2010 Objective</th>
<th>United States</th>
<th>New Jersey</th>
<th>Middlesex County (Eagleton 1996)</th>
<th>Middlesex County (County Health Department survey 2001)</th>
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<tr>
<td>Percent who exercise daily</td>
<td>30</td>
<td>15</td>
<td>N/A</td>
<td>19</td>
<td>14</td>
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<tr>
<td>Percent overweight (120% or more ideal weight)</td>
<td>15</td>
<td>23</td>
<td>35</td>
<td>40</td>
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</table>

2000 Census Data

<table>
<thead>
<tr>
<th></th>
<th>United States</th>
<th>New Jersey</th>
<th>Middlesex County</th>
<th>New Brunswick</th>
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<tr>
<td>Percent living below poverty level</td>
<td>13%</td>
<td>9%</td>
<td>7%</td>
<td>27%</td>
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<tr>
<td>Percent children living below poverty</td>
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<td>Percent Black</td>
<td>12</td>
<td>14</td>
<td>9</td>
<td>23%</td>
</tr>
<tr>
<td>Percent White</td>
<td>75</td>
<td>73</td>
<td>68</td>
<td></td>
</tr>
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<td>Percent Asian or Pacific Islander</td>
<td>4</td>
<td>6</td>
<td>14</td>
<td></td>
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<tr>
<td>Percent American Indian, Eskimo, or Aleut</td>
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<td>.2</td>
<td>.2</td>
<td></td>
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<tr>
<td>Percent of Hispanic Origin</td>
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<td>14</td>
<td>39%</td>
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<td>Percent with children &lt;18</td>
<td>26</td>
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<tr>
<td>Homeownership</td>
<td>64</td>
<td>65</td>
<td>67</td>
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<table>
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<th>Median Household Income</th>
<th>$37,005</th>
<th>$47,903</th>
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In New Brunswick 27% of individuals and 16.9% of families fell below the poverty level; 23% of the New Brunswick population is black and 39% is Hispanic.
Didactics for COPC and the Office Small Groups Activity

Family Medicine Clerkship

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Goal: To expose students to the methods, challenges and rewards of implementing COPC in clinical practice.

Objectives:
1. Discuss the rationale for engaging in COPC
2. Apply the steps of COPC to a health issue, with a focus on population assessment
3. Describe Healthy People 2010 Objectives and physician’s role in addressing them
4. List 3 challenges of implementing COPC in the primary care setting
5. List 3 methods for making COPC more feasible in the primary care setting

Time needed: 2 one-hour sessions for in-class small group meetings, 3-4 weeks in between the 2 sessions for students to do the self-directed activity.

Activities:

Session 1 (approximately week 3 of clerkship): Applying COPC in your Clinical Practice

Below is abbreviated outline for this session. Refer to “COPC and Healthy People 2010 Nuts and Bolts” above for details.

1. Share objectives for this self-directed activity
2. Ask for volunteer(s) to explain/define COPC. (This should be review after they’ve had COPC talk.) Reiterate: It is about looking beyond the individual patient in the exam room, beyond treating complaints and problems of patients as they approach, one by one but rather assuming responsibility for improving the health for a particular population within the practice (e.g. seniors) or a population that is not currently accessing care. It’s about being pro-active. Setting a goal to make a change in health outcomes or at least health practices, collecting baseline data, making a change/intervention and evaluating whether it made an impact. We want you to be able to express it so you can explain it to your preceptor who may not be familiar with the term.
Define COPC – Four steps, involving the community/population in each: 1) Characterize the community – learning more about your patient population as well as people living in the community where you practice – demographics. Before joining a practice you would want to know about population you might be seeing (e.g. what languages are spoken, is there a large senior population?); 2) Identify prevalent health problems – is there a large percentage of people with diabetes, asthma, HIV? Identify strengths or assets of a community; 3) Plan and implement an intervention: Given these issues, what can you do to pro-actively address them? One practice has a monthly breakfast for seniors – drug reps pay for the bagels, doctor leads discussion on pertinent health topic. 4) Monitor/evaluate intervention.

3. Discuss Healthy People 2010 objectives as a potential starting point for determining health issues to address if you don’t have the resources to do a community assessment: US Dept. of Health and Human Services provides a comprehensive nationwide, health promotion and disease prevention agenda: 467 objectives in 28 focus areas – roadmap for developing and tracking health promotion efforts.

Show Overhead of HP 2010 Goals and Leading Health Indicators and Discuss

Discuss Racial/Ethnic Disparities: Ask class for examples of areas where disparities exist in incidence, prevalence of or outcomes of illness among racial and ethnic groups. Have them brainstorm reasons for a particular disparity (discuss access issues, cultural issues regarding acceptability of care; racial bias among providers).

4. Refer students to section in the manual on “COPC and the Office Small Groups Activity” (see student handout below): Begin by asking students to call out the prevalent health problems they are seeing in their office. Generate list of five or so on the blackboard. Display the Healthy People 2010 overhead of leading health indicators. Ask the class to select 3 topics they’d like to focus on as a class based on these two lists. Have each student select one of the three health issues they would like to address over the course of the clerkship and to form three small groups.

5. Small Groups: Ask students to spend approximately 20 minutes on part one of the activity: determining as a group what data they will collect to learn more about this problem. Have each group report out to the large group, their assessment plan. Review what is expected of them over the next few weeks before meeting again in small groups in week 6 or 7 to share their results and develop a COPC plan. Emphasize the importance of discussing the COPC assessment and plan with their clinical preceptors -- suggest that students can be the ambassadors of the Healthy People 2010 objectives and COPC since preceptors may not be familiar with either.

Session 2: (Week 6 or 7 of clerkship): Sharing Results of Assessment/Brainstorming Interventions

1. The second session of the COPC and the Office Activity will be primarily devoted to working in the small groups- give students about 30 minutes in small groups. Have them report back their major findings (about 5 minutes each). Invite their feedback on the process of data collection and the feasibility of attempting COPC in clinical practice.
Discuss challenges. Emphasize the value of small, incremental steps, not biting off more than one can chew. Discuss rewards.

2. Conclusion: In your practices you could see patients on a demand basis, one by one as they enter your office or you can try to take a bigger perspective and think about how you might be proactive in helping to improve the health of the community, state and the nation.

COPC and the Office – Small Groups: Handout in Manual

Student Instructions
1. As a group, further define the health problem you will propose to address in your community/population.
2. Collect basic “data” about the demographics of your office, prevalence of this problem, possible causes or contributing factors, and about possible interventions, copc efforts in place for this or other issues.

Small Group Session I - Decide what data/information you want, how to collect it and who will do what. All students should speak with their preceptors and patients; other tasks can be divided:

a. Discuss with preceptors – obtain “off the cuff” and/or computer generated demographics and prevalence data from practice database of ICD codes, possible causes or contributing factors, discuss interventions in place for this problem, brainstorm potential new interventions- see #3)

b. Obtain population-based data/Healthy People (HP) objectives via internet - collect NJ or national data on prevalence of problem and distribution among racial and ethnic groups from Healthy NJ 2010 or HP 2010, (http://www.health.gov/healthypeople - (http://www.state.nj.us/health/chs, click on Healthy NJ 2010) or other source (copy for small group, overheads). Review the relevant HP or HNJ 2010 objectives.

c. Discuss with community “partners”/patients – talk with patients, office staff, related community organizations, “man/woman on the street” about possible causes or contributing factors of the problem and ways of addressing the problem. (May get some prevalence information from Comm. Organizations). Discuss as a group what questions you will ask, review any questions asked of patients, with your preceptor)

Consider obtaining information from other sources as well (e.g. literature search on community-based interventions implemented for this problem.)

3. Reconvene in small groups to (1) share the data you collected; (2) propose interventions based on the data collected and (3) develop a plan to evaluate at least one of the interventions.

Small Group Session II - Develop potential interventions (on patient/practice level, community/outreach level, advocacy/policy level). Develop evaluation plan.

Consider: (1) barriers (cultural, language, cost, etc.) and (2) specific indicators for use in measuring success. See attached format for your small group discussion.

4. Present plans to class and discuss challenges, feasibility and value of COPC approach.
COPC and the Office: Small Groups
(used when students meet in their second small groups to help structure their report-out)

1. What methods did you use to collect data about your population and health issue? What did you find out?

2. What interventions might you develop to address your health issue?

   patient/practice level:

   community/outreach level:

   advocacy/policy level:

3. How would you evaluate whether your intervention(s) are effective? What measures would you use?

4. What are the challenges, feasibility and value of COPC approach?
Community Assessment – Treasure Hunt

(This is an activity used in our Summer COPC Assistantship. Students conduct a mini-community assessment of the community in which their site/projects are based)

Directions

The way you approach a community can make or break the success of any health promotion effort. Working with different cultural groups can be challenging, but if you approach it with an open and inquiring mind, you will find the rewards and treasures. Spending time in the community gives you an opportunity to observe and listen before you start asking questions.

Here are some things to keep in mind as you begin your treasure hunt:

- Since our cultures determine how we interpret and interact with the world, it can have a profound effect on the way we define and experience health. Be non-judgmental in your attempts to understand beliefs and practices, as well as how they differ from your own.
- Avoid cultural stereotypes (oversimplifications, inaccurate assumptions)
- Keep in mind what have been and are the major social, economic and political concerns of the community.

Getting Started:

- Avail yourself of census data, maps, and other government documents, reports and statistics. Local newspapers and libraries are a good source of information about the community.
- Get to know the physical layout of the community. Try to learn the major streets, buildings or other landmarks in the different neighborhoods.
- Try using public transportation if it is available.
- Select places where you can observe and have informal observations. Take notes on the types of activities you observe. How do people interact with one another? How do they greet one another (embrace vs handshake)?
- **Informally talk to at least 5 people in the community to try to gather some of the information on the next 2 pages.** During informal conversations just listen – don’t take notes. Don’t forget to explain who you are and what you are doing.
- Attend community events your site is sponsoring (e.g. church picnic, health fair)
- Feel free to discuss this assignment with your site supervisor and ask for additional resources.

Gathering information for this treasure hunt is a process that will give you an opportunity to learn and understand more about the community (and its treasures) your agency/facility serves. Find out what you can about the cultural context of the community as well as what problems and assets present in that community.
Geographics

1) Define your “geographic community”. Conduct a drive/walk through of the area. Write down your first impressions of the area. Notice the housing, schools, streets, etc? Is it clean? Well maintained? Residential or business?

2) Locate any schools and daycare centers and describe.

3) Locate any health facilities and or hospitals. Note their location, services offered.

4) Locate and visit food stores (see what kind of food they are selling).

5) Locate services for seniors, describe.

6) Locate services for teenagers, describe.

7) What kind of businesses are in the area?

8) What public transportation is available?

9) What evidence is there of local law enforcement?

Demographics

Much of the following can be obtained from the census. You can also ask people who live there.

10) Who lives in the area? What are the predominant family structures (i.e. two parent household, single parent or extended family)?

11) What kinds of jobs do people have (e.g. blue/white collar?) What is their annual income?

12) What are the socioeconomic levels? (upper-middle-lower)

13) What is the cost of an average house in the area? Do people rent or own?

14) What are the political statuses? (i.e. undocumented, refugee, legal immigrant, citizen)

15) What is the predominant ethnic group(s)?

16) What are the languages or dialects that are spoken?

17) What are the different religions?
Medical Orientation

18) What are some beliefs about the cause, prevention, diagnosis and treatment of disease?

19) To what extent is there use of traditional medicine or healers?

20) What roles do foods play in health and religion?

Reflection

Summarize your feelings about the area. Imagine living there. What would it be like?

What was it like observing people? Talking to people?

How did you open up conversation/build rapport?

What were their reactions to you? Were they open/trusting or suspicious? Were they able to provide answers to your questions?

Prepared by Linda Whitfield-Spinner, LCSW, Director, National Health Service Corps New Jersey SEARCH program for the Community Oriented Primary Care Summer Assistantship. Adapted from Gonzalez, VM, Gonzalez, JT, Freeman, V., Howard-Pitney, B, Health Promotion in Diverse Cultural Communities, Palo Alto, CA: Health Promotion Resource Center, Stanford Center for Disease Prevention, 1991.

Assessment of your Community/Project Site

Find out the following information about your community site. Not all of these will be relevant to your site. It is not necessary to write this up as part of the treasure hunt but it will be helpful for your reflection paper.

- Its history and mission
- Funding sources
- What are the demographics (age, sex, cultural/ethnic background, residence and the predominate social, economic issues) of the population served? Does this reflect the demographics of the surrounding community?
- Staff: number, disciplines, roles, do they reflect population served in terms of race/ethnicity/language?
- What services community agency provides
- How do clients access services? Who is eligible to receive services? What are the barriers if any, to clients accessing services?
- How many patients/clients are generally helped on average in a given month? Is this meeting the actual need in the community?
- How are “undocumented immigrants” handled– can they utilize agency’s services?
- % patients/clients with no health insurance
• Type of health insurance patients/clients have
• Prevalent health problems of the population
• Partnerships the community site has established with other agencies to better meet the needs of clients
• Community site’s efforts to reduce barriers to accessing health care
• Find out from staff, what are the challenges and the rewards of working with an underserved population
Maria's Story- Planning a COPC Intervention

(This is a small group activity that students do in conjunction with a field trip to a Migrant Farm Camp through our Summer COPC Assistantship)

Maria had wanted to only breastfeed her baby. This had long been the tradition of women in her community. However, in order for her family to survive, Maria had to work in the landowner's field from dawn to dusk. With the long hours of separation from her baby, she had little choice but to give her baby other foods. Soon she no longer could produce much breast milk. As a migrant farmworker she put in long hours of exhausting work for which she was paid little. Since the age of seven, her older son, Jose Luis also worked to help make ends meet.

While she was working in the distant fields, Maria left her baby in their room on the farm labor camp in the care of her five-year-old daughter, Silvia. Each day after grueling hours of work, Maria would prepare supper in a small rundown kitchen. She would make homemade tortillas, beans and rice and once in a while, a piece of meat. The well water used for the cooking often smelled and tasted bad due to contamination. The fields were ten feet away from the kitchen where pesticides were often stored. Although there was often not enough to fill all their stomachs, Maria would always leave a little on the plate, instructing Sylvia to feed it to the baby while Maria was at work.

Even with the older child also working, the family's earnings could scarcely buy enough food. The baby, like the rest of the family, often went hungry. Worsening malnutrition and repeated bouts of diarrhea soon became a vicious cycle. Sometimes Maria took the sick baby to a traditional healer or “curandaro”, who gave him “manzanilla”, a form of herbal teas. The baby would usually get better for a few days, but soon Maria’s baby became thinner and thinner. One day he developed severe diarrhea that did not get much better even when Maria gave him the traditional remedies. His "chorrillo" continued for several days, until the baby was limp and shriveled.

In desperation, Maria decided to take her baby to the hospital in the city. This was a hard decision, as Maria had to miss a day's work and a day's pay. At best this meant a day without food, for the family had no reserves. At worst Maria knew she might lose her job. But Maria's love for her baby was strong. She sold a bronze pot she had inherited from her mother -- the last of her remaining possessions of any value -- to pay for bus fare and medicine, and took her baby to the hospital. After hours of waiting in the emergency room at last her baby was seen. By then the baby was on the verge of death.

The doctor scolded Maria for waiting so long, and for not taking better care of her baby. He referred her to a nurse, who, despite not speaking Spanish, tried to explain to her the importance of breastfeeding and something called "hygiene". Above all the nurse emphasized, her baby needed more and better food. Maria listened in silence. Meanwhile, the doctor put a needle into a vein in the baby's ankle and connected it by a thin tube to a bottle of glucose water. By evening the baby's shrunken body filled out a bit, and he seemed more alert. The diarrhea had stopped, and the late night nurse removed the needle from the baby's leg.
The next morning a doctor gave Maria a prescription for medicines to buy in the pharmacy and sent them home. On the way home the baby's diarrhea began again. Arriving back home, Maria had neither food, nor money, nor anything left to sell. Her baby died a short time later.

A Migrant Farmworker's Story- Small Group Work

You are the newly established COPC team based at the hospital where Maria was treated. A new VP at the hospital formed the team to better serve the migrant farmworker community. You are charged with preventing a tragedy like this from happening again.

1) Your first task is to determine what caused the death of Maria’s baby? List the biological/physical causes as well as the specific underlying root causes (e.g. environmental, social/cultural, economic, health care delivery system)

2) Based on the causes you listed, what sorts of interventions/changes would you implement or advocate for, to address this problem? Consider who would be on your COPC team and other community organizations with which you can collaborate. Consider the resources/strengths that might currently exist in the community of farmworkers upon which a successful program can be built.
Patient-Family-Community Assessment Form
(This is used in the Cross-Cultural Community Medicine Rotation as a way to explore COPC by starting with one patient and expanding to a population)

Directions: Interview 4 patients using this form- put completed form in chart

Patient Name: ________________________________  Date: ___________________________

Brief Patient Profile:
Age  Gender  Race/Ethnicity  Language  Need for Interpreter (Y/N)  Insurance (Y/N)

Primary Clinical Issue Addressed:

Family Profile
Household Structure (who lives there and relationships, prepare genogram)

Language(s) spoken, understood/Literacy issues:

Financial Situation of Household:

Family Problems (e.g., domestic violence, alcohol or drug problem, marital discord, illness):

Family Supports (how does family help with clinical problem addressed):

Cultural Profile
Diet (24 hour diet recall):

Religious Beliefs (and degree of importance in life):

“My health is controlled by” ME ____________________________________________GOD

(USE ETH of ETHNIC) Patient’s explanation (E) of primary clinical issue addressed:

Use of alternative treatments(T) and healers(H):

Community Profile
Workplace Issues (possible exposures, muscle strain, injury risk):

Neighborhood Description:

What does patient like about neighborhood?

What would patient like to change about neighborhood?
Accessibility to Healthcare (primary care, dental, vision)(consider transportation, language, availability of appointment)

Accessibility of Other Services (grocery, pharmacy, medical supplies):

Additional in-depth questions:
1. Identify a problem that this patient faces that is common to other people in the community. Identify the Healthy People and/or Healthy NJ 2010 objectives and national and state data that relate to this problem by accessing the websites:
2. Does St. John’s address this problem on a community level? How?
3. What do other health centers or private physicians do to address this issue? Consider contacting other physicians to find out.
4. What other resources/services already exist in the community to address this issue? Contact or visit 2 or 3 of these resources to learn more about them.
5. What other health/social service professionals or “lay health/para-professional/other healers” besides physicians can be helpful with this issue?
6. What creative ideas do you have for addressing this issue on a community level? Consider performing a literature search. Consider using this issue as a starting point for your senior project.
Sample COPC Plan

(This is distributed to Summer COPC students, Clerkship and Residency students as an example of how to think through a COPC plan)

Problem:
Pneumonia and influenza together constitute the fifth leading cause of death among NJ residents; almost 90% of these deaths occur in persons aged 65 and older. High death rates for pneumonia persist despite the existence of an effective vaccine against pneumococcus. Relatively low rates of pneumococcal vaccination, particularly among black non-Hispanic population are related to the high volume of deaths. People living in institutionalized settings are at particularly high risk. CDC recommends that everyone over 65 and over have at least one lifetime does of pneumococcal vaccine. Half of these deaths could be prevented through use of vaccine.

Ways to assess this problem in your population from least labor intensive to most:

1. Level 1: Your impression from seeing patients– gut feeling that this is a problem
2. Level 2: Generalize from outside data – Healthy New Jersey 2010 stats show that vaccination rates are low in the senior population, since 20% of your practice is comprised of seniors, you can generalize from secondary data collected about seniors and assume that problem exists in your practice as well, review literature.
3. Level 3: survey of population – collect own data (e.g. through chart review, survey, interview) on prevalence and causes
4. Level 4: put processes into place for data to be collected routinely

Possible Causes for low vaccination rate: (ideally elicited from patients, discussion with preceptor, or the literature):
Lack of access
Lack of knowledge about problem
Fear /myths

Services currently provided:
Office provides vaccine - offered when patient comes in. Problem is you may only immunize those patients visiting in the fall when the vaccine is typically given.

Objective: Increase the percentage of persons 65 and over who have ever received a pneumococcal vaccine to 90% by 2005 (this may be your patient population or a community population with whom you are working (e.g. senior group)

Intervention:
**Team:** physician, nurse, front-desk staff, patient if possible

**Potential community partners:** Local Health dept, pharmacy, NJ Peer Review Organization, newspapers, nursing homes and senior centers in your community.

**Potential Strategies (individual level, practice level, community level, advocacy):**

- Find out what other organizations are doing to increase immunizations and see if you can help (e.g. Collaborate with health dept- volunteer to give immunizations at health fair.)
- Put reminder on the patient charts to prompt you to ask and discuss.
- Identify/develop culturally appropriate literature to explain/dispel myths
- Do mailing to your senior patients suggesting they come in for the vaccine.
- Write health column on the issue for local weekly newspaper. Identify press release material from a website and forward to an editor.
- Present to senior groups on the topic.

**How would you involve patients/community?** There are several ways to involve patients/community in the assessment, implementation and evaluation phase– some may best be done by a partnering organization but following are strategies: Conduct one-on-one interviews with patients to explore reasons for not getting the vaccine; conduct focus groups with seniors at a senior center, participate in a committee that includes seniors and community agencies concerned with the issue. Pilot-test literature or videos with patients (have them review and provide you comments on appropriateness). Work with an organization in recruiting “lay health advisors” - seniors that can promote this issue to others.

**Evaluation:**
Chart review to see if number of vaccinations has increased
Statistics from NJ Peer Review Organization by zip code- they collect this data.
Track numbers of seniors attending a health fair for immunizations.

**Challenges:**
Will depend on particular intervention chosen. Generally, challenges include staff time to implement, resources to carry it out. However, COPC can happen incrementally, starting as small and manageable as necessary.

**Potential Benefits:**
Satisfaction in seeing a change as a result of your efforts. One practice saw a dramatic increase (evaluated through chart review) in number of seniors vaccinated over a 5-year period. They associated this change with their efforts (through chart reminders) to discuss immunizations with their patients.
COMMUNITY ORIENTED PRIMARY CARE (COPC): OVERVIEW

Definition: Community oriented primary care (COPC) is a model in which a primary care practice or program systematically identifies and addresses the health problems of a defined population. \(^{(1)}\)

COPC is generally divided into **four steps**, carried out in a cyclical fashion and **involving the community in each step:**

1. Define and characterize the community;
2. Identify community health problems and community assets & prioritize for action;
3. Develop programs/interventions to address the identified health problems; and,
4. Monitor the impact of programs/interventions.

Rationale: Health depends on many factors beyond what goes on in the examining room. Individual lifestyle factors as well as economic, social, cultural, environmental and political factors influence the health of patients, families and communities. COPC combines the practice of primary care with public health in an effort to promote health, prevent illness, and provide accessible, comprehensive and coordinated preventive, curative, supportive and rehabilitative services.

**COPC Practitioners:** \(^{(2)}\)

- are interested not only in people who seek their care, but also in those in the community who are at-risk but may not seek care;
- use epidemiological and ethnographic data from both their practice and the identified community to define health needs of the community (community diagnosis);
- determine, with community members, the underlying economic, social, cultural, environmental and political causes of health problems and together address the causes;
- emphasize prevention and wellness so that people with risk factors can be prevented from getting ill;
- involve the patient, family and community in developing treatment plans and programs, recognizing the presence of consumer expertise in a community;
- build partnerships with other community organizations to practice comprehensive, community-based, coordinated health care which addresses the economic, political and cultural needs of the community; and,
- evaluate the effect of their practice on the community's health status.


What Is Healthy People 2010?

Healthy People 2010 is a comprehensive set of disease prevention and health promotion objectives for the Nation to achieve over the first decade of the new century. Created by scientists both inside and outside of Government, it identifies a wide range of public health priorities and specific, measurable objectives.

**Overarching Goals:**
1. Increase quality and years of healthy life
2. Eliminate health disparities

**Focus Areas**

<table>
<thead>
<tr>
<th>Focus Area</th>
<th>Overarching Goals</th>
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<tbody>
<tr>
<td>1. Access to Quality Health Services</td>
<td>1. Increase quality and years of healthy life</td>
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<tr>
<td>2. Arthritis, Osteoporosis, and Chronic Back Conditions</td>
<td>2. Eliminate health disparities</td>
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<tr>
<td>3. Cancer</td>
<td>15. Injury and Violence Prevention</td>
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<td>6. Disability and Secondary Conditions</td>
<td>18. Mental Health and Mental Disorders</td>
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<td>7. Educational and Community-Based Programs</td>
<td>19. Nutrition and Overweight</td>
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<td>8. Environmental Health</td>
<td>20. Occupational Safety &amp; Health</td>
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<td>10. Food Safety</td>
<td>22. Physical Activity and Fitness</td>
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<td>12. Heart Disease and Stroke</td>
<td>24. Respiratory Diseases</td>
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<td>13. HIV</td>
<td>25. Sexually Transmitted Diseases</td>
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<tr>
<td>14. Immunization and Infectious Diseases</td>
<td>26. Substance Abuse</td>
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<tr>
<td>15. Injury and Violence Prevention</td>
<td>27. Tobacco Use</td>
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<td>17. Medical Product Safety</td>
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<td>28. Vision and Hearing</td>
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What Are the Leading Health Indicators (LHIs)?

The Leading Health Indicators are 10 major health issues for the nation.

The LHIs are:

<table>
<thead>
<tr>
<th>1. Physical Activity</th>
<th>6. Mental Health</th>
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<tr>
<td>2. Overweight and Obesity</td>
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<td>3. Tobacco Use</td>
<td>8. Environmental Quality</td>
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<td>4. Substance Abuse</td>
<td>9. Substance Abuse</td>
</tr>
<tr>
<td>5. Responsible Sexual Behavior</td>
<td>10. Access to Health Care</td>
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</table>

Healthy People 2010  
http://www.healthypeople.gov  
Healthy People Information line: 1 (800) 367-4725

healthfinder®  
http://www.healthfinder.gov  
Office of Disease Prevention and Health Promotion  
http://odphp.osophs.dhhs.gov  
last updated 11/02
Racial and Ethnic Disparities in Health

Despite great improvements in the overall health of the nation, Americans who are members of racial and ethnic minority groups, including African Americans, Alaska Natives, American Indians, Asian Americans, Hispanic Americans, and Pacific Islanders, are more likely than whites to have poor health and to die prematurely, as the following examples illustrate:

- **Breast and cervical cancer**: Although death rates from breast cancer declined significantly during 1992–1998, they remain higher among black women than among white women. In addition, women of racial and ethnic minorities are less likely than white women to receive Pap tests, which can prevent invasive cervical cancer by detecting precancerous changes in the cervix.

- **Cardiovascular disease**: In 1999, rates of death from diseases of the heart were 29% higher among African Americans than among whites, and death rates from stroke were 40% higher.

- **Diabetes**: Compared with whites, American Indians and Alaska Natives are 2.6 times, African Americans are 2.0 times, and Hispanics are 1.9 times more likely to have diagnosed diabetes.

Prevalence of Cardiovascular Disease, by Race/Ethnicity

![Prevalence of Cardiovascular Disease, by Race/Ethnicity](image)


- **HIV/AIDS**: Although African Americans and Hispanics represent only 25% of the U.S. population, they account for roughly 56% of adult AIDS cases, 73% of new HIV infections among U.S. adults, and 82% of pediatric AIDS cases.

- **Immunizations**: In the 1998–2000 National Immunization Survey, 11 major urban areas reported racial/ethnic disparities of greater than 10% for at least one age-appropriate childhood immunization. Additionally, in 2001, Hispanics and African Americans aged 65 or older were less likely than whites to have received influenza and pneumococcal vaccines.
**Infant mortality**: Although the 2000 U.S. infant mortality rate of 6.9 infant deaths per 1,000 live births was the lowest ever recorded, African American, American Indian, and Puerto Rican infants continue to have higher mortality rates than white infants. In 2000, the black-to-white ratio in infant mortality was 2.5.

**U.S. Infant Mortality Rates, by Race/Ethnicity of Mother, 1998**

![Bar chart showing infant mortality rates by race/ethnicity in 1998 and 2000.]

Source: National Center for Health Statistics, CDC

Because racial and ethnic minority groups are expected to comprise an increasingly larger proportion of the U.S. population in coming years, the number of people affected by disparities in health care will only increase without a concerted effort to eliminate these disparities. Culturally appropriate, community-driven programs are critical for eliminating racial and ethnic disparities in health. To be successful, these programs need to be based on sound prevention research and supported by new and innovative partnerships among federal, state, local, and tribal governments and communities.

Centers for Disease Control and Prevention
National Center for Chronic Disease Prevention and Health Promotion
Mail Stop K-45
4770 Buford Highway, NE
Atlanta, GA 30341-3717
(770) 488-5269

cdinfo@cdc.gov
http://www.cdc.gov/reach2010
COPC Resources

**Video:** *Community Oriented Primary Care*, by Marc E. Babitz, M.D. and the National Health Service Corps.
To order this video, contact (1) your NHSC regional office or, JSI Research and Training Institute, Video Library, 1738 Wynkoop St., Suite 201, Denver, CO 80202-1116; phone (303) 293-2405; fax (303) 293-2813; email: denver@jsi.com for rental, $10.


Healthy People 2010 ([www.health.gov/healthypeople](http://www.health.gov/healthypeople)) or Healthy NJ 2010 ([www.state.nj.us/health/chs](http://www.state.nj.us/health/chs))


Kretzmann, J.P. & McKnight, J.L. Building Communities from the Inside Out: A Path Toward Finding and Mobilizing a Community’s Assets, Evanston, IL, Center for Urban Affairs and Policy Research, (1993), (800) 397-2282 or (708) 491-3395


National Health Service Corps Health Promotion Disease Prevention Project Student Orientation Manual 1995, AMSA, Reston VA, (703) 620-5873


