





## Acknowledgements

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### Authors

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Janelle Edwards, MPH, CHES, Heart Disease and Stroke Prevention Program, Ohio Department of Health;

Eric Greene, MA, the Center for Health Promotion, Ohio Department of Health;

Barbara Pryor, MS, RD, LD, Director, Heart Disease and Stroke Prevention Program, Ohio Department of Health.

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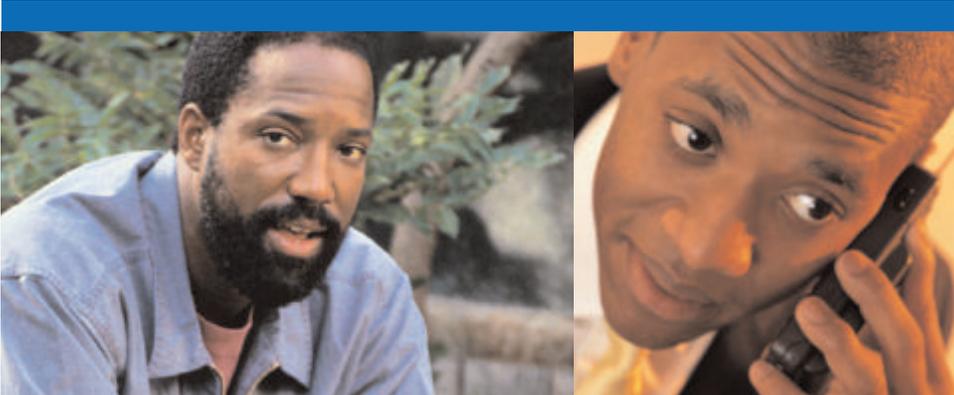
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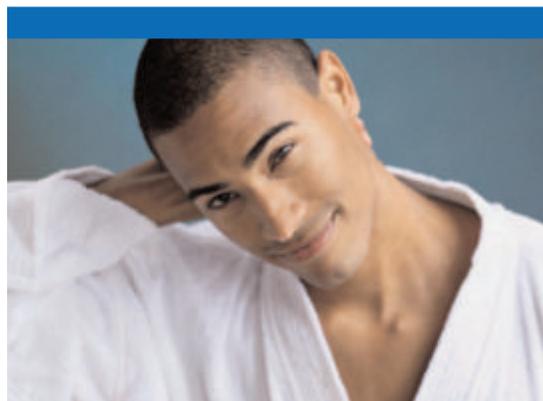
## Executive Summary

Data published in the 2006 Burden of Stroke in Ohio Report indicated that African American males have a stroke mortality rate that is 53 percent higher than any other racial-gender group. In 2007, the Ohio Department of Health Heart Disease and Stroke Prevention (ODH, HDSP) in partnership with the Ohio Commission on African American Males (CAAM) conducted focus groups with African American men in the three largest Ohio cities with a high concentration of African Americans (Cincinnati, Cleveland and Columbus) to assess their knowledge, attitude and beliefs about the prevention and control of high blood pressure.

In 2008, ODH HDSP conducted structured interviews with physicians and health care providers treating African American males to assess their practices; perceived barriers to prevention; treatment and management methods for high blood pressure; and provider communication strategies. The data from this study will be combined with findings from the focus groups to identify key strategies and messages appropriate for creating educational campaigns aimed at African American men and the health care providers who treat them.

Major findings from the focus group with African American men revealed:

- Family history of high blood pressure was more easily described for the maternal side of the family as compared to the paternal side.
- Younger African American men (ages 19 to 29 years old) did not consider high blood pressure major health issue; lack of awareness and financial cost of eating healthy were cited as deterrents to preventing and managing high blood pressure.
- African American men know eating a healthy diet (consuming less fatty food—particularly pork and sodium) and engaging in physical activity can help to prevent and/or manage high blood pressure.
- African American men generally expressed feelings of negativity and distrust toward health care providers and the health care system.
- African American men use traditional media sources, particularly those catering to the black community, to access health information. The information, however, must be tailored to meet the needs of the various African American male audiences.



- Younger males (ages 19 to 29 years old) named video games, celebrities and combining health messages with clothing discounts as possible vehicles for delivering health messages to this audience.
- Places of worship were named as good locations for disseminating health message for older (ages 30 and older) African American men.
- Tailored health education campaigns must be framed with culturally relevant messages and implemented with age-relevant strategies to increase their appeal and acceptance by African American men.

Major findings from the structured interviews with physicians and health care providers suggested:

- Nearly 96 percent of the health care providers had formal training or educational updates on the management of hypertension within the past five years.
- Seventy-five percent of healthcare providers had formal training or educational updates on the management of hypertension specific to the African American population within the past five years.
- Five different clinical guidelines were identified and used to determine a “goal blood pressure reading” for patients with high blood pressure.
- Seventeen of 24 health care providers spent on average, 11–20 minutes with each patient during a single visit.
- Health care providers indicated that their role in treating patients for high blood pressure was to: educate; prescribe medication; recommend lifestyle changes; and encourage patients to manage the condition.
- A number of different drug formularies, the lack of diversity in clinical trials and the inability to offer samples of prescription medication were cited as some of the system barriers in treating African American male patients for high blood pressure.
- The lack of culturally relevant educational materials and the cost of some support services not covered by health care insurance (for example, mental and behavioral health care providers, social service providers, fitness instructors and nutrition counselors, etc.) were cited by health care providers as possible challenges/barriers for African American men in treating and/or controlling their high blood pressure.

Key recommendations to create and implement educational campaigns directed at African American men at risk or currently diagnosed with high blood pressure and the health care providers offering them treatment are presented in this report.

# Background

## Focus Groups

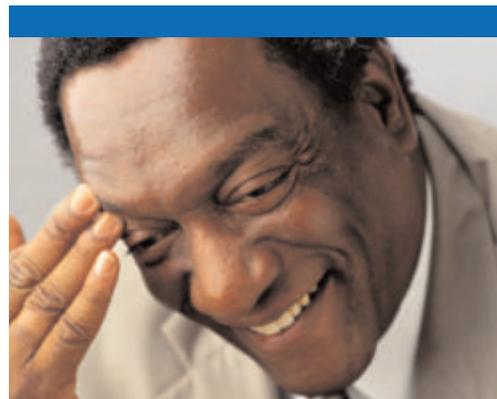
In 2006, The Ohio Department of Health, Heart Disease and Stroke Prevention Program's (ODH, HDSP) released the Burden of Stroke in Ohio Report. The report indicated African American males have a 53 percent greater stroke mortality rate than any other racial-gender group in Ohio.<sup>1</sup> As such, ODH entered into a memorandum of understanding with the Ohio Commission on African American Males (CAAM) to conduct age-stratified focus groups with African American males in Cincinnati, Cleveland and Columbus to assess their knowledge, attitude and beliefs about the prevention and treatment of high blood pressure. Additionally, the planned focus groups would investigate their perceptions of patient-provider relationships and query how best to present health information to African American men.

A 10 year (1997–2007) Medline search was conducted to review the preset themes from previous studies examining African Americans' knowledge, attitudes and beliefs about the prevention and treatment of high blood pressure. An additional Medline search was conducted for studies published between the same time period (1997–2007) focusing on patient-provider relationships and African Americans' perception of the quality of health care.

The literature review revealed several investigative categories:

- The definition of high blood pressure;
- Family health history;
- Perceived symptoms and consequences of high blood pressure;
- The prevention of high blood pressure.

Patient-provider relationship; patient-provider decision-making models and communication strategies themes were also noted.



## Structured Interviews

In 2008, ODH, HDSP hired an external contractor to conduct structured interviews with physicians and healthcare providers treating African American males to assess their practices; patient-provider communication strategies; and their perceptions of the barriers African American men face in treating and controlling their high blood

<sup>1</sup> Deflore-Hyrmer, J. and Pryor, B. The Burden of Stroke in Ohio. Columbus, OH: Chronic Disease and Behavioral Epidemiology, Ohio Department of Health; 2006.

pressure. The contracted firm conducted 24 face-to-face interviews (nine in Cincinnati, seven in Columbus and eight in Cleveland) with a diverse group of physicians and nurses in clinics; health centers and private practice settings. These providers served both insured and uninsured African American males at risk for or diagnosed with hypertension.

An initial literature review was conducted to:

- Identify findings about best practices and treatment options for African American males at risk for or diagnosed with hypertension;
- Identify findings about the barriers in treating African American men for hypertension within the health care system;
- Identify research findings related to the challenges and/or barriers African American males face in controlling their hypertension;
- Identify research findings about patient-provider relationships and effective communication strategies;
- Identify the findings related to the clinical practice guidelines utilized to diagnose and devise treatment plans for African American men with undiagnosed and diagnosed hypertension.

The data from both studies will be used to identify key messages and appropriate strategies to create educational campaigns directed at African American men at risk for or diagnosed with high blood pressure and the health care providers offering them treatment.



# Methodology

## Focus Groups

Qualitative focus group discussions were conducted to collect data from African American men. The focus groups were moderated by a trained facilitator matched by race and gender. The discussions were audio recorded and note takers also documented discussions and reactions. The discussions were guided by open-ended questions and follow-up questions after the introductory statement, “I’d like for you to tell us your name and one interest that you have.” Each focus group discussion lasted for approximately two hours.

Nine focus groups were conducted in Cincinnati, Cleveland and Columbus in the summer and fall 2007 (one focus group per age group in each city). Each focus group was stratified by age: 18 to 29 years old; 30 to 49 years old; and 50 to 79 years old and was comprised of four to 12 men giving a total of 79 respondents (30 respondents in Cincinnati; 24 respondents in Cleveland; 25 respondents in Columbus). The respondents included a diverse cross-section of socioeconomic groups and were recruited through various means including: CAAM Listserv, targeted television and radio advertising and word of mouth. Research respondents were asked to review and sign a consent form at the start of each focus group. Respondents were also given a monetary incentive for participating.

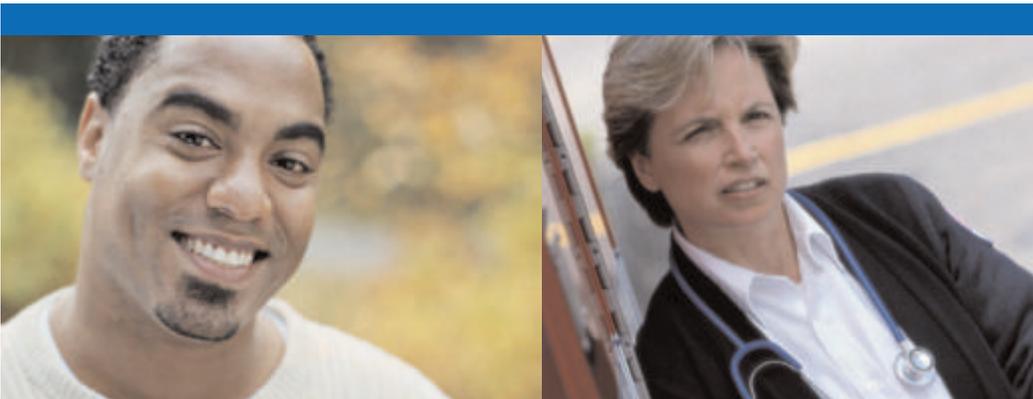
## Structured Interviews

The survey instrument included 14 discussion questions and 21 demographic questions and was based on reviewed literature findings. A review was also conducted of the National Medical Association of Physicians Listing for Cincinnati, Columbus and Cleveland; the Ohio Federally Qualified Healthcare Centers (FQHC) listing; the local health departments list; and a list of minority physicians in Columbus provided by the Ohio Commission on Minority Health (OCMH). Facilities believed to have the greatest interaction with African American male patients based on location and potential reach were then contacted. The external contractor also identified research respondents through personal contacts, respondent referrals, contacts provided by pharmaceutical representatives, and the Yellow Pages.



Potential respondents were contacted by telephone, fax and/or e-mail to introduce the consulting firm and to explain the study. The study respondents did not receive a copy of the survey instrument prior to the scheduled appointment. The research respondents were also asked to review and sign a consent form at the start of each interview.

During spring and summer 2008, the structured interviews were carried out with 24 health care providers (19 physicians and five nurses in Cleveland, Cincinnati and Columbus). The interviews in Cincinnati included nine physicians. In Columbus, seven interviews were conducted with four physicians and three nurses, while in Cleveland eight interviews were conducted with six physicians and two nurses. They included health care providers working in family medicine, cardiology, cardiovascular surgery, urology, nephrology and hypertension.



## Focus Group Findings

### Definition of high blood pressure

The majority of the focus groups 18-to 29-year-old respondents associated high blood pressure with medically related symptoms, lifestyle factors or personal experiences. Most frequently, food and diet were cited as causes of high blood pressure. Parallel findings were found among respondents 30 years and older.

### Family history of high blood pressure

A consistent finding from all nine focus groups was that most respondents described their family history of high blood pressure on their maternal side effortlessly, but had more difficulty describing their paternal family history of high blood pressure.

### Perceived symptoms

Respondents in all nine focus groups consistently noted symptoms of high blood pressure. In all nine focus groups, sweating was consistently cited as a symptom of high blood pressure. Weakness and/or fatigue and stress were other symptoms of high blood pressure consistently named by men ages 18 to 29. Additionally, men aged 30 to 49 cited losses of coordination, blurred vision and headaches as signs of high blood pressure. Fifty- to 79-year-old men in Cincinnati and Columbus also named blurred vision as a symptom of high blood pressure. In contrast, a number of respondents indicated high blood pressure was asymptomatic. One respondent in the Cleveland discussion group of the 30- to 49-year-old men stated, “When I found out I had it, I didn’t have any symptoms.”



Hypertension is a chronic condition that is often without symptoms until comorbidities develop leading to symptomatic diseases.<sup>2</sup> Therefore, it is surprising that there was some confusion between the perceived symptoms of high blood pressure and causes of high blood pressure. This was found among 19-to 29-year-old men in the Cincinnati and Cleveland focus groups and also among 30-to 49-year-old respondents in Cleveland.

<sup>2</sup> Luckoshek, P. (2003). African American's belief and attitudes regarding hypertension and its treatment: a qualitative study. *Journal of Health Care for the poor and Underserved*. 14, 506-587.

### **Deterrents to prevention/management**

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African American men ages 19 to 29 did not feel high blood pressure was a major health issue. A respondent from Cincinnati said, “What does blood pressure have to do with my daily life?” Men ages 18 to 29 also indicated competing priorities (such as worries about money, safety, etc.) prevented them from focusing on managing or preventing high blood pressure. A Cincinnati respondent stated, “I’m worried about being shot.”

Respondents ages 30 to 49 indicated that lack of awareness regarding the importance of treating and controlling high blood pressure among African American men may contribute to the lack of prevention. A respondent in the Cincinnati focus group said, “If it ain’t killin’ them, they ain’t going to the doctor, if they can walk and still party and dance, they ain’t going to the doctor.” Respondents from this age group also cited the financial cost of eating healthy as a deterrent for many men “If I eat healthy, it’s going to cost more and my family will eat less, one said.” This sentiment was echoed by a respondent in Cincinnati who said, “When you are poor, you can’t afford to be on no diet.”

### **Prevention of high blood pressure**

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Respondents in all nine focus groups were aware that eating a healthy diet (consuming less fatty food particularly pork and sodium) and engaging in physical activity are two activities that can prevent and/or manage high blood pressure. Moreover, the majority (four out of nine) of the focus groups members also believed smoking less or not at all was effective in controlling high blood pressure. Men ages 30 to 49 said engaging in spiritual activities is a means of controlling high blood pressure and cited meditation and being spiritual most often. Men ages 50 to 79 also noted the importance of establishing a good relationship with health care providers where open and honest communication can take place.

### **Patient/provider relationships**

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More often than not (five out of nine focus groups); there were general feelings of negativity and pessimism toward health care providers and the health care system. When asked about important factors for physicians to consider when conversing with a patient, a Cleveland respondent from the 30-to 49-year-old focus group stated, “Don’t blow smoke up my butt.” This belief was echoed by a Cincinnati respondent in the 50-to 79-year-old focus group said, “The experience [going to the doctor], it almost runs you away.”

Further, respondents also said respect from a health care provider is important. Long waits to see a physician and the perceived differential treatment based on insurance status were some of the identified signs of disrespect. A Cleveland respondent from the 30-to 49-year-old focus group said, “They’ll stick you in a little room, the nurse

will look at you for a few minutes, and the doctor will come in and spend about five minutes with and be gone.” Similarly, a Cleveland respondent from the 18-to-29 year-old focus group noted, “African American males don’t get the same attention as other minorities because most African Americans are from the inner city and they go to local doctors. If you live in the city, you don’t have a main doctor that can sit down with you— spend time with you...” A Cleveland respondent from the 30 to 49 years-old focus group related the story of a homeless man who was unable to get surgery he desperately needed, “He actually committed a crime, got arrested, so he could have his surgery done,” this man said.

Respondents also believed building a trusting relationship with health care providers was important, as the majority of the focus groups members (five of nine) cited honesty as a key trait of a good health care provider.

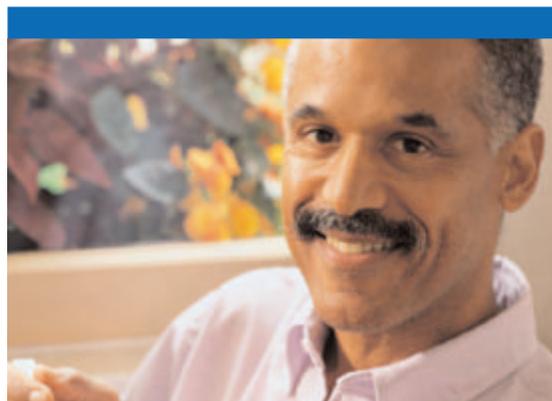
### Acquiring health information

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Respondents in all focus groups cited traditional media sources (radio, television magazines, newspapers, etc.) as sources they use to obtain health information. Respondents noted that radio/television/newspapers serving the African American community (for example, urban radio stations, BET television, The Call and The Post newspapers, etc.) were used most often.

Respondents also noted the information should be presented in various forms to meet the distinct tastes of diverse audiences of African American men. For example, a Cleveland respondent from the 30- to 49-year-old focus group said, he cannot relate to messages tailed to others. Similarly, a respondent from the Columbus 30-to 49 year-old focus group said messages targeting the hip-hop generation are irrelevant to his age group.

Younger respondents ages 18-to 29 year-old were more likely use the Internet as a source for health information than any other age group. The ineffectiveness of creating Internet-based education campaigns for older African American men was highlighted by a Columbus respondent from the 30-to 49-year-old focus group who said “Some can barely afford a television so; in general this would not be a good option.” Another respondent from the same focus group said of using the Internet, “That’s a fifty-fifty thing. Some of us might have access to a computer, some of us might not have access, but you’re not going to reach a whole lot of us.”



Conversations between family and friends were also mentioned as other possible sources of health information. Further, the majority of the respondents in seven of nine focus groups indicated discussions with women are how they received much of their health information. Important and respected women (including mothers, grandmothers and girlfriends) were cited most often by respondents.

The majority of the respondents in five out of nine focus groups also named neighborhood businesses and/or events as sources for health information including libraries, churches, beauty salons/barbershops, recreation centers (gyms) and health fairs.

Although clinical settings (clinics, health centers, etc.) were mentioned, respondents indicated these were not the first locations they visited to acquire health information. A Columbus respondent from the 30-to 49-year-old focus group explained, “The doctor’s office is not a good source of info because [black men] aren’t seeing the doctor until it is almost too late.”

### Framing messages

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Respondents from every focus group indicated that the manner in which a message was presented was important for its acceptance by African American men. However, what was considered effective varied among the age groups.



The 18-to 29-year-old respondents believed prevention messages, information about risk factors and the cost of having high blood pressure were important elements that should be included in the message. Respondents also said that message packaging was important for message acceptance within this age group. “We got to make it cool to get blood pressure taken, one respondent said.” The ability to control and manage blood pressure with their current lifestyle was also important to respondents ages 18 to 29. Simple and easy changes

that can be implemented into their current diet and exercise practices were cited as ideal educational messages.

Messages that include the personal/human element of having high blood pressure appealed more to respondents ages 30 to 49. More specifically, respondents from the Cincinnati focus group believed testimonials by African American men who have successfully controlled hypertension were ideal educational messages. Cleveland respondents from the focus group for men ages 30 to 49 stated medicinal and natural treatment options were other important elements that should be included in messages.

Fifty-to 79-year-old focus group respondents said messages depicting high blood pressure as major and silent killer of black men would appeal to men of this age group. Columbus respondents also said simple messages should be created.

### **Disseminating health information**

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Traditional media sources (radio, television magazines, newspapers, public service announcement, etc.) were named as key channels to disseminate health messages to the African American community. Respondents noted that black media outlets (radio/television/newspapers, etc.) were the best vehicles to disseminate health messages into their community.

Eighteen-to 29-year-old respondents also named video games as a possible channel to disseminate health messages. Likewise, music and celebrities were considered favorable vehicles for dissemination within this age group. Eighteen-to 29-year-olds also mentioned combining health messages with clothing discounts as another favorable avenue for message dissemination.

Older men ages 30-to 79-year-old named neighborhood businesses and/or events as good locations for disseminating health messages. More specifically, respondents cited churches, recreation centers and affordable sporting events as possible sites to disseminate health messages. Additionally, two of the three focus groups of men ages 30 to 49 named discussion groups and/or clubs as ideal locations for disseminating health messages.

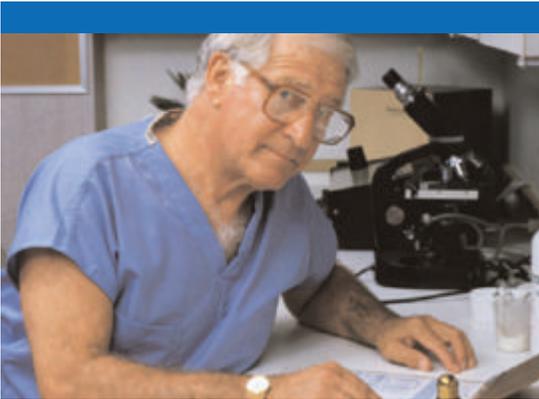


## Structured Interviews Findings

Interviews with health care providers included:

- Nineteen physicians, one nurse practitioner, one licensed practical nurse and three registered nurses.
- Eleven African Americans, one Asian/Pacific Islander, nine Caucasians and three classified as other (two Middle Easterners and one African) participated in the interviews. All 24 respondents are classified as Non-Hispanic.
- Fourteen males and 10 females, ranging in age from 31 to 70 years old participated in the interviews.
- Eleven private practice facilities, five community health centers, one local health department, one public health safety net, one urgent care facility, three academic research/group practices, one corrections facility and one kidney dialysis center participated in the study.

The respondents' years of experience in the health care field ranged less than one to more than 30 years of experience. Seventeen of the 24 respondents had more than 11 years of experience in the health care field. The number of years the practitioner



provided health care in Ohio ranged from less than one year to more than 30 years, with five of the 24 respondents having more than 20 years experience providing health care in Ohio. Ten of the 24 respondents have worked at their current facility for more than 10 years.

Nearly 96 percent (95.8 percent) of respondents have had formal training or educational updates on the management of hypertension within the past five years. Five respondents explained that educational updates on the management of hypertension were received by reviewing current medical literature. Two respondents explained that formal training or educational updates were acquired through participation in professional associations and grand rounds. Eight respondents cited The American Heart Association, the American College of Physicians, the American Society of Hypertension, the American College of Cardiology, the American Urology Medical Transplant Conference and the American Society of Nephrology as sources of formal training or educational updates on the management of hypertension.

Two Cincinnati respondents obtained educational updates through pharmaceutical companies while, three other Cincinnati respondents cited internal employee

development and self-assessment programs as sources to obtain formal training and educational updates. Additionally, two respondents from Cincinnati named coursework required to complete medical training and certifications as their sources for formal training on the management of hypertension. A private practice physician with less than six years of experience in Cincinnati said the notes of more experienced physician within the group practice (hypertension specialist) were used as a resource for the management of hypertension.

Eighteen of the 24 respondents (75 percent) have had formal training or educational updates on the management of hypertension specific to the African American population within the past five years. Nearly 91 percent (90.9 percent) of African American respondents have had formal training or educational updates on the management of hypertension specific to the African American population in the past five years. Further, nine respondents said the National Medical Association and local chapters in Cincinnati, Columbus and Cleveland provided formal trainings or educational updates on the management of hypertension specific to the African American population. Two respondents in Cincinnati cited the Journal Club, a local association of minority physicians, as a source.

### **Client's most preferred payment method:**

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In response to the question, "What percentage of your patients pay with Medicaid?" Nine of the 24 respondents said 26–50 percent of patients paid with Medicaid. Respondents' answers ranged from less than 10 percent to 75 percent.

In response to the question, "What percentage of your patients pay with Medicare?" Almost 38 percent (37.5 percent) of respondents said 26–50 percent of patients paid with Medicare; responses ranged from less than 10 percent to 75 percent.

Respondents were also asked, "What percentage of patients paid with private health insurance?" Nearly 38 percent (37.5 percent) of respondents said that less than 10 percent of patients paid with private insurance; results ranged from less than 10 percent to 75 percent

Finally, respondents were asked, "What percentage of your patients are self-pay?" Seventy-five percent of respondents said less than 10 percent of patients self pay.

### **Average Time Spent with Patient**

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Respondents were asked, "On average, how much time do you spend with each patient during a single visit?" Nearly 71 percent (70.8 percent) of respondents spent on average, 11–20 minutes with each patient during a single visit. Three respondents said they spent an average of 21–25 minutes with a patient during a single visit, while two respondents said the average time spent with each patient during a single

visit was more than 30 minutes. Some respondents were aware of the greater need to spend more time with patients: “The system is designed to see more patients with less time. Doctors are incentivized by volume, not quality.” –Private practice physician in Cincinnati.

### Conducting Blood Pressure Measurements

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Various responses were given to the question, “Generally who conducts blood pressure measurements at your facility?” (Respondents were asked to select all persons that apply).

- Fifty percent of respondents said a physician conducted the blood pressure measurements at their facility.
- Nearly 63 percent (62.5 percent) of respondents said a nurse practitioner, licensed practical nurse or a registered nurse conducted the blood pressure measurements at their facility.
- Seventy-five percent of respondents said a nurse aide/medical assistant conducted the blood pressure measurements at their facility.

A respondent from Columbus said there had been an increase in the number of inaccurate blood pressure readings at their facility because of the limited experience



of nurse aides and medical assistants using digital blood pressure monitors. As a result, it is not uncommon for the physicians and nurses to manually conduct a second blood pressure reading to ensure the accurate diagnosis of hypertension or pre-hypertension at this facility.

Fifty percent of respondents said the person conducting blood pressure measurements at their facility had formal training or educational updates on the management of hypertension within the past five years. Six respondents said medical associations provided trainings or educational updates on the management of hypertension. Five respondents said internal employee-development programs were used to obtain training or educational updates on the management of hypertension. Two Cincinnati respondents used pharmaceutical companies to obtain educational updates on the management of hypertension within the past five years. Two Cincinnati respondents also cited medical literature and coursework required to complete medical training and certifications as their sources to obtain formal training or educational updates on the management of hypertension.

## Patient adherence to recommended treatment plans

A number of different answers were given to the question, “Approximately what percentage of your hypertensive/pre-hypertensive African American male patients adheres to your recommended treatment plan?” Seven of the 24 respondents said 26–50 percent of patients adhered to their recommended treatment plan. Another seven said 50 to 75 percent, while five said that 76 to 100 percent of patients adhered to their recommended treatment plans.

## Goal blood pressure reading

The majority of respondents (54 percent) said they utilized the National High Blood Pressure Education Program’s Joint National Committee (JNC 7) clinical guidelines to help establish a patient’s “goal blood pressure reading.” A respondent from Cleveland stated, “JNC 7 Guidelines are the boiler plate.”

Other responses included: the National Heart, Lung, and Blood Institute (NHLBI) clinical guidelines, the American Diabetes Association (ADA) clinical guidelines, the Journal of American Academy of Family Physicians (AAFP) and the American Heart Association (AHA). A private practice physician (with less than six years of experience) in Cincinnati said, “The variation in guidelines confuses many physicians.”

## Describing a pre-hypertensive or hypertensive reading to patients

Respondents utilized various methods to describe hypertensive readings to their African American male patients. All respondents explained the importance of stating the actual and the goal blood pressure when describing a reading to their patients. Three respondents from Cleveland noted that they simply explained the meaning of systolic and diastolic blood pressure readings.

They said the top number (systolic pressure) is when the heart is working and the bottom number (diastolic pressure) is when the heart is at rest. A Cincinnati respondent referenced hoses, pumps, tools and other mechanical devices to explain the function of the heart, while another Cincinnati respondents found success by using wall charts and physical displays to describe hypertensive readings to African American male patients.

Further, three respondents noted the importance of obtaining two to four additional readings within a seven-day period to properly diagnose a patient with hypertension. A Cleveland provider stated, “We want to be sure the patient is not suffering from white coat syndrome, a false hypertensive or pre-hypertensive reading thought to



simply be caused by a patient’s interaction with the health care provider.” A Cincinnati provider also noted that there are other medical conditions known to cause a sudden increase in blood pressure readings that must be considered when conducting a reading (for example pheochromocytoma). The symptoms for this condition and others mimic those of high blood pressure and, therefore can lead to an incorrect diagnosis.

Four of the 24 respondents described pre-hypertensive readings to patients as “borderline” readings, while 16 of the 24 respondents recommended lifestyle changes to pre-hypertensive African American male patients.

It is important to note that two respondents working in publicly funded health care facilities said, pre-hypertensive readings were not currently being addressed because of a lack of resources. Further, a respondent from Cleveland said pre-hypertensive readings may affect a patient’s insurance premiums and, therefore are not documented in a patient’s chart at this particular health care facility. Lifestyle changes were recommended instead.

### **Role in treating patients for high blood pressure**

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Respondents generally believed a health care provider’s role in treating patients for high blood pressure is to detect the condition; educate patients about the condition and the health care system; prescribe medication; recommend lifestyle changes; and encourage patients to manage the condition. These ideas are supported by respondents from Cincinnati:

*“My primary role is to get them to their blood pressure goal. My second objective is to make recommendations that are affordable and compliment their lifestyle.”*

—Physician working in a publicly funded health care facility in Cincinnati

*“I act like a cheerleader and provide lots of encouragement and support.”*

—Private practice physician in Cincinnati

*“My goal is to extend and improve life.”*

—Private practice physician in Cincinnati

### **System barriers in treating African American male patients for high blood pressure**

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The cost of health care, inconvenient hours of operation, time restrictions (believed to be the result of complying with insurance company demands), insufficient resources, a lack of understanding about the health care system and the lack of culturally relevant patient education tools were identified as some of the system barriers to treating African American male patients.

Various drug formularies from insurance companies were cited as a barrier to treating African American males for high blood pressure by two respondents working in private health care. Because health care providers do not have access to the approved drug formularies for their patients with private health insurance, the patient may receive medication that is different than what the health care provider prescribed (a generic version, no medication due to the cost, etc.). A respondent from Cleveland said, “Everything is driven by what insurance covers.” A respondent from Cincinnati added, “The system is very cost driven.”

Additionally, patients do not always disclose their inability to pay for the prescribed medication which can also present barriers to treatment. This notion is supported by two respondents in private practice. As such, these providers will ask pharmaceutical representatives for drug samples to distribute to their patients who may not have the means to purchase the prescribed medications.

A shortage of primary care physicians and a shortage of African American physicians were individually cited by two respondents from Cincinnati as barriers in treating African American males for high blood pressure. A respondent from Cincinnati said, “The system is upside down. There are more specialists and fewer primary care physicians.”

Two respondents from Cleveland also said insurance barriers can prevent African American males from treating or controlling their high blood pressure. The cost of participating in recommended behavioral change programs such as tobacco cessation, alcohol cessation, physical fitness programs and access to dietitians/nutritionists, etc., are not covered by all health care insurance plans. As a result, African American men with or at risk for high blood pressure may not have access to the recommended education and support services needed to comply with the physician’s prescribed lifestyle changes. This belief is highlighted by a physician from Cleveland who said, “The system is good at prescribing medicine, not changing lifestyles.”



### Current clinical guidelines in use

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Respondents noted that current clinical guidelines are being included into the medical treatment plans prescribed for African American men; however, the recommendations used and the degree to which these guidelines are incorporated into treatment plans varied. Three respondents explained they used the JNC 7 clinical guidelines to develop treatment plans for African American men, while three respondents from Cleveland said they use a facility-approved formulary/algorithm to prescribe clinical treatment plans for hypertension.

Three respondents said they modified recommended clinical guidelines to develop high blood pressure treatment plans for their African American patients because of the belief that populations of African descent are much more likely to suffer from high blood pressure. A respondent from Cincinnati said, “We tweak (the current guidelines) for African Americans, not change them.” In contrast, two respondents noted that current clinical guidelines can be applied to the African American population without having to modify them. This idea is supported by another provider from Cincinnati who said “National guidelines are data driven and based on real information. They now address special populations.”

### **Improving Patient-Provider Relationships**

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Respondents were aware of the importance of improving patient-provider relationships with African American men to better treat and control high blood pressure. Five of the 24 respondents believed improving office policies and procedures (for example improving patient services and increasing staff’s cultural competence, etc.) creates a positive health care experience for African American men. Three respondents also said encouraging African American male patients to ask questions can improve patient-provider relationships.

Three respondents believed that by recruiting and training more African Americans to become health care providers could also improve patient-provider relationships with African American men. A respondent from Cincinnati said, “There is a shortage of black doctors and many are not choosing Ohio.”

Further, two respondents noted that continuity of care (ensuring the patient sees the same health care provider on repeat visits) could also improve patient-provider relationships with African American respondents. Additionally, two respondents said physical touch is important to some patients, “African Americans feel examined when someone touches them,” one respondent said. By making these small change, providers can possibly improve relationships with African American men.

### **Medical treatment options**

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Respondents recognized the importance of including clinical intervention in the treatment and control of high blood pressure. Ace inhibitors, beta blockers, calcium channel blockers and diuretics in generic, brand and combination forms were named by respondents as some of the clinical treatment options available to African American male patients. The beliefs about how these medications should be prescribed; however, varied significantly among respondents. A respondent from Cincinnati said, “African American male patients may be required to take up to five pills to manage hypertension due to genetics, in comparison to Caucasian males who may be required to take up to three pills.”

Additionally, 29 percent of respondents noted the importance of customizing clinical treatment options for hypertensive African American male patients. This idea is supported by a respondent from Cleveland who said “There is no real cook-book approach to treating hypertension because there are so many options.”

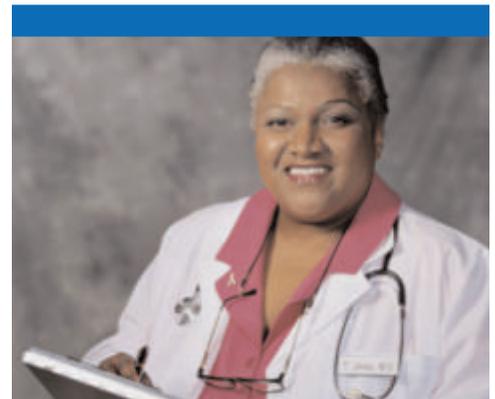
Further, 29 percent of respondents cited the importance of identifying and monitoring the sexual side effects of prescribed medications to increase the likelihood of patient compliance. Two respondents explained that using product samples can assist a health care provider in identifying the most effective clinical treatment options for patients with hypertension. Another respondent noted; however, that not all health care providers have access to product samples. This results in patients’ having to purchase a 30-day supply to test a prescribed medication. Further, a physician in private practice from Cleveland said, “It is hard to get the mixture right when the patient has to buy every test drug.”

Respondents’ opinions on the effectiveness of generic and newly released medications in treating African American male hypertensive and pre-hypertensive patients varied. A respondent from Cincinnati noted their facility used generic medications whenever possible. In contrast, two other respondents noted that newly developed and/or brand medications may really be the best options for African American male hypertensive patients. The respondents noted, however, that these medications may not be covered by the patient’s insurance company.

### **Lifestyle changes**

Respondents explained the importance of encouraging pre-hypertensive and hypertensive patients to make lifestyle changes to control their blood pressure. Nearly 46 percent (45.8 percent) of respondents identified exercise as an effective lifestyle treatment option for hypertensive/pre-hypertensive African American male patients.

Nearly 38 percent (37.5 percent) of respondents cited the importance of reducing salt intake. A Cleveland respondent said, “I give my patients a list of foods known to be high in salt and/or sodium, ask them to circle their favorite foods and [then I] leave the room. When I return, we review the list and develop our plan.” Almost 17 percent (16.6 percent) of respondents noted the importance of modifying one’s diet as effective lifestyle treatment options for African American male patients, while three respondents had success with their patients by reviewing a culturally relevant list of foods together.



In contrast, a respondent from Cincinnati said there is not enough time during a single visit to allow for lifestyle coaching and as a result, lifestyle changes are not always addressed at this practice. Additionally, four other Cincinnati respondents had little success when weight loss, smoking cessation or stress management were recommended as lifestyle treatment options to their patients.

### **Communication Styles**

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When communicating with their African American male patients, speaking the same language was cited by 29 percent of respondents as an effective communication method to deliver treatment plans. A respondent from Cleveland said, “I try to understand their challenges and dispel the myths.” Of further note, nearly 17 percent (16.6 percent) of the respondents said having a non-judgmental attitude aided with communication, while avoiding fear tactics was cited by 12.5 percent of respondents.

Additionally, a respondent from Columbus explained the importance of having health care providers communicate with one another so patients do not receive mixed messages and, consequently, become discouraged during the treatment process.

### **Challenges to treating African American males with high blood pressure**

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Respondents identified a number of challenges in treating African American males with high blood pressure. Twenty-nine percent of respondents said patients underestimate the importance of treating hypertension. Twenty-five percent of respondents also cited compliance with clinical treatment options as a barrier. Additionally, respondents said side-effects may make a patient feel worse than living with the symptoms of the condition and, therefore, they may not be medically compliant.

Respondents also said patient distrust of health care providers and the health care system are additional challenges to treating African American male patients with high blood pressure. A respondent from Cincinnati said, “Many [African American men] do not trust the system. They are reached by their employers or their wives.” Another respondent from Cincinnati noted, “African American patients want to see health care providers of their own ethnicity.”

### **Patient Compliance**

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Respondents recognized the importance of having patients comply with the recommended plan to treat and control high blood pressure. A respondent from Cincinnati noted the importance of assessing the likelihood of patient compliance during office visits to better design clinical and lifestyle treatment plans. Further, 29 percent of respondents said they developed treatment plans based on a patient's past level of compliance.

### **Patient Participation**

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Respondents also recognized the importance of having the patient actively participate in the treatment plan. Nearly 96 percent (95.8 percent) of respondents said a patient's active participation during the treatment process greatly improves their health outcomes.

### **Success in treating pre-hypertensive/hypertensive African American male patients**

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Respondents said success in treating pre-hypertensive and hypertensive patients can be enhanced when providers are supportive. Respondents said patient success could also be improved by including the women in their lives in developing treatment plans and by encouraging patients to learn their family health history. Further, a respondent from Cincinnati said success in treating African American male patients can be achieved by asking patients to revisit athletic activities they once enjoyed in younger years as a means of increasing their level of physical activity.

Two respondents from Cleveland noted the importance of factoring in a patient's social and economic environments when devising treatment plans. A respondent from Cleveland said, "We encourage our patients to continue their education or to become gainfully employed." Another in Columbus stated "I try to find something in their lives worth living for and build on that." Keeping these factors in mind when devising the treatment plan will help to create a realistic plan that may increase a patient's level of success.

## Recommendations

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The focus groups provided much insight into African American men’s knowledge, attitude and beliefs about the treatment and control of high blood pressure. This study also revealed opinions on patient-provider relationships and effective methods for disseminating health information. In contrast, the structured interviews provided insight into health care provider practices, patient-provider communication strategies and the perceived barriers in treating African American men for high blood pressure. Further, both studies revealed similar findings related to treatment barriers and effective lifestyle practices to prevent and/or manage high blood pressure. The studies also revealed contrasting findings related to patient-provider relationship expectations. Providers expected patients to be active participants in their care from the beginning of treatment; whereas, patients felt it was more important to first build a trusting relationship with a health care provider and then become empowered by their provider to ask questions and voice concerns as partners in their care.

Based on these findings, recommendations were developed to create an effective educational campaigns for both African American men at risk or currently diagnosed with high blood pressure and the health care providers who treat them.

### **Recommendations for an educational campaign aimed at African American men**

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#### **Recommendation No. 1**

**Create health messages encouraging young black males to make health a priority in their lives**

Focus group respondents ages 18 to 29 did not consider high blood pressure an issue of major concern. As many African American males deal with everyday inequalities related to housing, education, employment and in a broader perspective the political and economic climate, their health takes a back seat to daily survival. Therefore, campaigns created should be mindful of competing priorities and provide simple and easy methods for the men to implement health practices into their daily lives.

#### **Recommendation No. 2**

**Include aspects of religion or spirituality in health messages and consider places of worship to disseminate health messages to older audience**

Focus group respondents ages 30 to 49 said aspects of religion or spirituality such as praying, meditating and relaxing were methods they used to manage or prevent high blood pressure. It is therefore important to include a religious or spiritual component with any campaign in order to increase the effectiveness and the relevancy of the health messages for this age group.

Places of worship were cited as favorable vehicles for disseminating health messages to older African American men ages 30 to 79. Because religion is a central part of the lives of many African Americans<sup>3</sup>, any educational campaign should consider places of worship as a favorable site to disseminate the message and extend the reach of the campaign.

### **Recommendation No. 3**

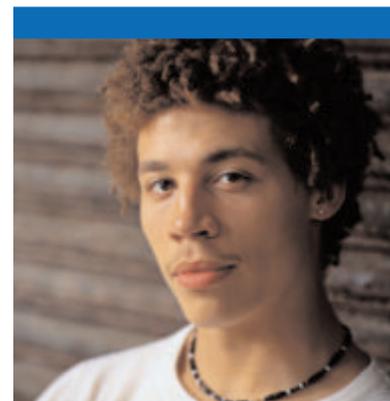
#### **Tailor messages for various African American male audiences**

Although respondents used similar media sources (television, radio, newspapers and magazines) to acquire health information, what they considered effective varied among the diverse audiences. For example, creating a message based on the hip-hop culture would better serve younger black males ages 18 to 29 rather than those individuals over 30. In addition, younger males ages 18 to 29 said the packaging of a campaign was important for its acceptance. Older males ages 30 to 49 said messages that included testimonials/success stories and both medicinal and natural treatment options were important components of an effective high blood pressure educational campaign. Therefore, messages targeting younger African American males should be visually appealing, while messages for an older audience should include human interest elements and treatment options. Additionally, the feedback and recommendations provided by African American men during the development of the message can help to increase the messages' appeal.

### **Recommendation No. 4**

#### **Target Web-based health education campaigns to younger men**

Younger respondents ages 18 to 29 were more likely than any other age group to use the Internet as a source for health information. Older African American men ages 30 to 79 cited limited computer access and deficient computer skills as some reasons they do not look to the Internet for health information. Therefore, a Web-based educational campaign would be a less effective channel for message dissemination for African American men aged 30 years or older.



### **Recommendation No. 5**

#### **Utilize trusted female figures in educational campaigns**

Findings suggested African American men frequently refer to the women in their lives to acquire health information. As a result, employing trusted women figures as spokespersons should be considered when designing high blood pressure educational campaigns.

### **Recommendation No. 6**

#### **Partner with trusted local businesses**

Results of the focus group discussions indicated African American men use local businesses and/or events to access health information. Therefore, it is important to

<sup>3</sup>Brown, C. (2000). Exploring the role of religiosity in hypertension management among African Americans. *Journal of Health Care for the Poor and Underserved*, 11(1), 19-32.

include and partner with neighborhood entities when designing the dissemination plan for an educational campaign. These established partnerships would increase the likelihood of the message being viewed and accepted by the intended audience.

**Recommendation No. 7**

**Use traditional media sources to disseminate health messages**

African American men named traditional media sources (television, radio, newspapers, magazines, etc.) catering to the African American community as the best vehicles for disseminating health information into their community. Thus, it is important to include black media outlets in any communication plan developed for an educational campaign designed for African American men.

**Recommendation No. 8**

**Consider the entertainment factor when creating campaigns for younger males**

Younger African American males ages 18 to 29 named video games, celebrities and clothing discounts as effective channels to deliver health messages to this age group. Therefore, creating messages endorsed by relevant celebrities or closely aligned with urban-labeled clothing (for example, Phat Pharm, Sean John Clothing, etc.) should increase the appeal of the educational campaign. Additionally, future studies should investigate the possibility of infusing health messages into video games.

**Recommendations for Creating an Educational Campaign Aimed at Health Care Providers**

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**Recommendation No. 1**

**Recognize the various high blood pressure clinical guidelines currently being utilized**

At least five different high blood pressure screening tools with their respective clinical guidelines were identified by respondents as a means of establishing a patient's "goal blood pressure" reading. It is important that any educational campaign be mindful that multiple screening tools and guidelines are being used by practitioners in the field. It is also important to note there are variations in what practitioners believe a goal blood pressure reading should be for their African American male patients.

**Recommendation No. 2**

**Recognize the limited time available for patient counseling**

Respondents noted that the limited time spent with patients during office visits does not always allow for counseling, patient education or the opportunity to further develop patient-provider relationships. Respondents did note; however, that it is important to spend time with patients to increase their likelihood of complying with their treatment plan. Therefore, any educational campaign should recognize the system's time limitations and be designed as a brief intervention.

**Recommendation No. 3****Ensure all resources are culturally relevant/encourage cultural competence training**

Limited access to patient education materials that are relevant to African American patients was cited by respondents as a challenge in treating and controlling hypertension. Respondents did note; however, that they had better patient compliance and increased patient success in controlling their patients' blood pressure when culturally relevant documents, displays and wall charts were used during counseling and education. It is therefore recommended that any educational campaign encourage providers to use patient education tools that are culturally and linguistically appropriate for the African American population. Further, it is recommended that the educational campaign encourage health care providers and staff to participate in trainings that emphasize providing services that are culturally appropriate, respectful and compatible with patients' beliefs and practices.

**Recommendation No. 4****Address current office policies and procedures**

Implementing patient-friendly office policies and procedures is believed to create more positive health care experiences for African American male patients. As a patient's level of comfort with navigating the health care system improves, they are also more likely to comply with the prescribed treatment plan. Thus, it is important for any educational campaign to promote to offices and clinics the importance of conducting initial and ongoing organizational self-assessments of their office policies and procedures. This will help to ensure health care providers present services that will improve the quality of care for their patients.

**Recommendation No. 5****Dispel myths about hypertension in the African American community**

Some respondents said a goal blood pressure reading for African American male patients should not be identical to the clinical guidelines established by national bodies because of the belief that high blood pressure occurs more frequently in the African American population than any other racial group. Additionally, practitioners noted that many African American patients underestimate the importance of treating and controlling their high blood pressure. Thus, any educational campaign created must address practitioner beliefs about a goal blood pressure reading and educate providers on how to convey the importance of controlling blood pressure to their patients.



**Recommendation No. 6**

**Recognize environmental and social factors that limit patient compliance**

Respondents said patients do not always have access to the resources necessary to make recommended lifestyle changes including: neighborhood grocery stores, convenient hours of operation of health care facilities, health insurance, etc. Any educational campaign should recognize these limitations and encourage health care providers to identify and partner with like-minded organizations to help their patients overcome these barriers.

**Recommendation No. 7**

**Address patient distrust of health care providers and the health care system**

Patient distrust of the medical community and the health care system can often result in inconsistent care and untreated high blood pressure. Any educational campaign should address these fears and provide health care providers with strategies to improve the relationship between patient, provider and the health care system.

**Recommendation No. 8**

**Identify opportunities to engage African American males during patient office visits**

Respondents noted that African American male patients were more successful in treating and controlling their high blood pressure when they were more engaged during the medical visit (i.e., asking questions, speaking openly during visits and actively participating in the design of their treatment plan). The educational campaigns designed for health care providers should, therefore, encourage providers to identify opportunities to further engage their patients during office visits and also encourage providers to devise strategies to increase a patient's comfort level with the health care provider.

**Recommendation No. 9**

**Recognize the importance of effective communication**

Providers said during interviews that speaking the same language as their African American male patients was important to effectively deliver the treatment plans devised. As such, any educational campaign should encourage providers to present messages that can be easily identified, understood and accepted by all patients.

**Recommendation No. 10**

**Encourage women to participate in the treatment process**

Providers experienced greater success in treating African American males for hypertension when the trusted women in their lives participated in the design and implementation of the recommended treatment plan. It is important to recognize the influence these women have on the lifestyles of their men. As a result, any educational campaign should encourage providers to actively engage these women during the treatment process to potentially increase patient compliance.

## Next Steps

The focus groups and structured interviews provided qualitative perspectives on the treatment and control of high blood pressure from both the patient and health care provider points of view. The knowledge, attitude and beliefs African American men have about high blood pressure treatment and control, perceived patient-provider relationships and the effective methods for disseminating information to African American men were addressed.

Further, the structured interviews provided insight into health care provider practices, patient-provider communication strategies, and the perceived barriers in treating African American men for high blood pressure. Although the small sample sizes limit the ability to generalize the findings to all African American men or to all health care providers, the data are useful.

As suggested by the focus group findings, ODH, HDSP will segment its audience and determine the most feasible group to address for the educational campaign. The campaign will be specifically tailored to appeal to the chosen African American male audience and the messages will be piloted and revised based on the recommendations provided.

An educational campaign will also devise key messages and strategies addressing health care providers treating African American men based on the findings from the structured interviews.

By infusing the key finding from both studies, incorporating culturally relevant messages and using appropriate strategies, the likelihood of campaign acceptance by both African American men and the health care providers who treat them will increase dramatically.



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## Summary Report and Recommendations 2007–2008

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# Addressing Health Disparities in Ohio



### **Ohio Department of Health**

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Heart Disease and Stroke Prevention Program's Focus Groups with African American Men and Structured Interviews with Health Care Providers 2007–2008