



Addressing Disparities in Ohio's Priority Populations



Summary Report and Recommendations 2007



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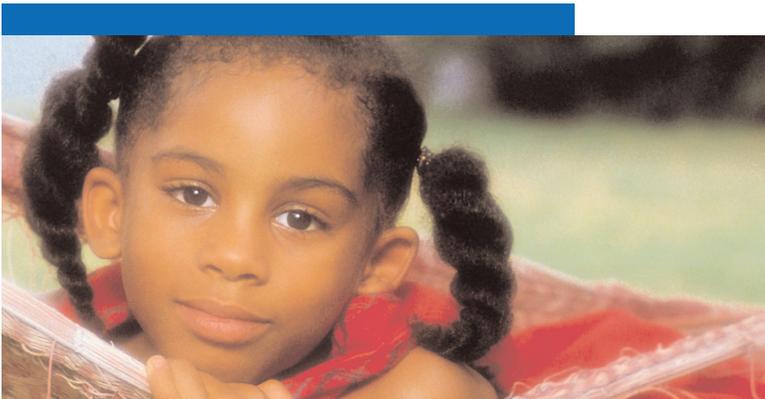


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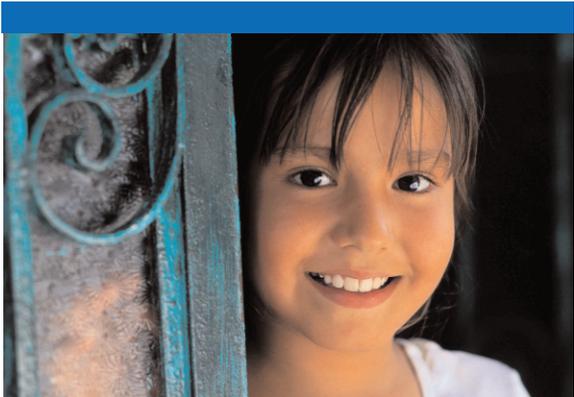
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Executive Summary

This report reflects the enthusiasm and dedication of state level organizations serving racial and ethnically diverse communities in working toward the elimination of disparities related to heart disease and stroke.

The Ohio Department of Health (ODH), Heart Disease and Stroke Prevention Program (HDSP) conducted a strategic planning session May 23, 2007. This planning session was held to provide HDSP with guidance in identifying and implementing culturally appropriate approaches that promote cardiovascular (CVH) health within its priority populations. Representatives from organizations serving African American, Appalachian, Asian and Asian Americans, immigrant, Hispanic/Latino, and refugee populations along with their respective urban or rural components, participated in this day-long planning session.

Meeting participants emphasized the need to encourage and create meaningful partnerships with organizations that serve priority populations. This new alliance will aid mainstream health care entities enhance their level of linguistic and cultural competence.



Summary

This report provides insight into the disproportionate rates of heart disease and stroke related disparities in Ohio. The publication also provides specific actions that can be taken by ODH's Heart Disease and Stroke Prevention (HDSP) program to identify and develop culturally competent strategies that will best serve its priority populations.

These recommendations are based on the input and hard work of organizations serving the African American, Appalachian, Asian and Asian Americans, immigrant, Hispanic/Latino and refugee populations. These recommendations include:

- Creating a needs assessment to identify commonly held beliefs and collecting information regarding heart disease and stroke prevention within priority populations.
- Forming and maintaining meaningful working relationships with community based agencies that serve priority populations.
- Instituting or augmenting existing standards for a meaningful assessment of an organization's linguistic or cultural competence.
- Supporting policies that require norming culture health care service entities and like organizations that receive funding, to integrate community health care workers into prevention programs for heart disease, stroke and other chronic diseases.

Meeting participants presented recommendations for policy and environmental change at the system level in order to influence the greatest number of Ohio's underserved residents.



Background

In Ohio, as in the nation, cardiovascular disease (CVD) including heart disease and stroke are the first and third-leading causes of death, respectively. Cardiovascular disease accounts for 37 percent of all deaths in Ohio. What is more, there are ethnic, racial, socioeconomic and geographic communities throughout the state that are affected at greater rates. Additionally, certain health behaviors can increase one's risk for CVD. These include high blood pressure, obesity and smoking.

According to the 2004-2006 Ohio Behavioral Risk Factor Surveillance Survey:

- 40.6 percent of Hispanic males aged 18 years or older had high blood pressure.
- Almost 40 (39.8) percent of blacks and 25.7 percent of Hispanics were classified as obese.
- Black females had the highest prevalence of obesity at 41.9 percent, compared to 23.6 percent of white females.
- The smoking prevalence for the Appalachian region was 29.0 percent compared to a rate of 23.5 percent for all Ohioans.

According to the 2004 Ohio Family Health Survey:

- The prevalence of hypertension in the Appalachian region was 32.9 percent.
- Nearly 28 percent of Ohioans with hypertension reported at least one emergency room visit in the past year, and four percent of Ohioans with reported hypertension used the hospital emergency room as their usual source of care.
- 6.3 percent of Ohioans with reported coronary artery disease (CAD) did not see the same physician at each medical visit.

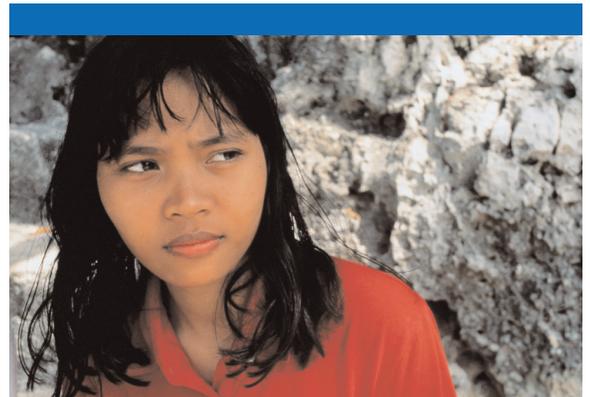


The ODH HDSP program's Burden of Stroke in Ohio Report released in May 2006, also provides striking findings related to ethnic, racial and geographic disparities:

- Black females have the highest overall likelihood of suffering a stroke.
- Black males have a stroke death rate that is 53 percent higher than any other racial-gender group.
- Only 23.5 percent of black males and 28.8 percent of black females were likely to recognize all five symptoms of stroke and to call 911 as the first response.
- Counties in rural Appalachia had the longest average EMS transport time to hospitals (41.2 minutes) for patients with suspected stroke.
- Only 24 percent of black male nursing home residents with stroke received physical therapy, compared to 30 percent of white males.

Disparities related to heart disease are also well documented throughout the state:

- Black males die prematurely from heart disease compared to whites. Forty-one percent of black males who died of heart disease died before the age of 65 and 65 percent died before the age of 75 (includes deaths before age 65). This is compared to 23 percent of white males dying before the age of 65 and 43 percent before the age of 75 (includes deaths before age 65).
- In 2003, the heart disease mortality rate for black males (354 deaths per 100,000 persons) was 18 percent higher, compared to white males (300 deaths per 100,000 persons) while the mortality rate for black females (251 deaths per 100,000 persons) was 27 percent higher, compared to white females (198 deaths per 100,000 persons).
- Twenty-four percent of black females died of heart disease before the age of 65 and 42 percent died before the age of 75 (includes deaths before age 65). This is compared to 9 percent of white females who died before the age of 65 and 21 percent before the age of 75 (includes deaths before age 65).



Ohio Heart Disease and Stroke Prevention Program Response

Findings from the May 2006 Burden of Stroke in Ohio Report prompted the HDSP program to further explore the existing disparities and devise practices and strategies to address these issues. Before developing any strategies; however, it was important to the HDSP program that agencies that serve priority populations were engaged and included in the planning process to ensure specific plans and strategies devised were culturally appropriate and relevant. Thus, representatives from organizations serving African American, Appalachian, Asian and Asian Americans, faith-based, immigrant, Hispanic/Latino, and refugee populations, along with their respective urban or rural components in Ohio were contacted and invited to participate in a day-long strategic planning session held May 23, 2007.

The meeting objective was to provide HDSP program with some guidance related to identifying and implementing culturally appropriate approaches that promote CV health within Ohio's African American, Appalachian, Asian and Asian American, immigrant, Hispanic/Latino and refugee populations. Participants were divided into groups by the priority population they represented or served and asked:

“For the population you serve, or have the greatest interest in, what do you feel are the issues or challenges around heart disease and stroke prevention?” The groups then identified and prioritized these issues for their respective communities (see Figure 1.0 for methodology).

The responses were then reviewed by all the meeting participants and concerns common to each of the priority populations were identified.



The following categories were used to classify the responses:

- a. Community/Culture/Education—This includes a community's culture, current education and beliefs on health and health care.
- b. System Issues—This includes the mainstream or norming culture's* health care systems' attitude towards and knowledge of priority populations, policies and procedures.
- c. Access to the health care system.

With the categories identified, participants then brainstormed ideas and strategies to address the area of focus. Finally, the participants provided a number of recommendations to HDSP to support these strategies and ensure they would be culturally relevant to the intended audience.

Figure 1
Facilitation process employed



*the norming culture is that which sets the norms around behavior, education and health for a given country. The United States' norming culture is sometimes referred to as the mainstream or dominant culture.

Recommendations

Before HDSP implements any of the recommendations, it is important that agencies that serve priority populations are engaged and included to ensure the plan or strategy chosen is culturally appropriate and relevant.

Participants of the strategic planning meeting came to a consensus with regard to the most addressable issues of heart disease and stroke prevention in priority populations. These recommendations are based on their hard work, experience, passion and honest comments.

While many participants spoke of the need for more funding, the session was structured to acknowledge other ways to address the issues by:

- a. Looking at programs and models that already exist and enhancing, expanding or adapting them for use by HDSP program.
- b. Building and leveraging organizational relationships.
- c. Identifying possible changes to policies and procedures.

Many of the recommendations proved to be mutually supportive. For example, trained community health workers could prove to be invaluable when gathering data from the priority populations. Having partnerships with community-based organizations could enable mainstream health care entities to enhance their levels of linguistic and cultural competence.



Recommendation #1

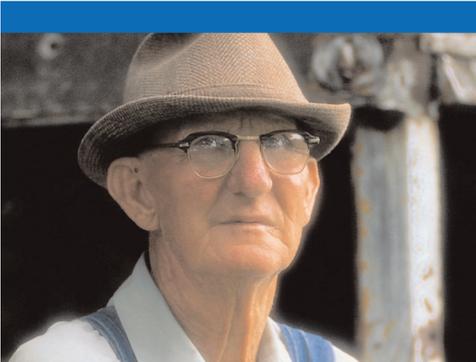
Priority population needs and knowledge assessment

It is recommended HDSP program, working with community-based organizations, create a needs assessment that identifies commonly held beliefs about heart disease and stroke and the related risk factors in priority populations. Data and insight gained from the assessment should be used to address the given community's knowledge and understanding of heart disease and stroke prevention. *Data out of context provide no useful information and therefore, any method chosen to gather data must be culturally appropriate for the priority population.*

Examples of data that an assessment of needs and knowledge should gather from priority populations and their sub-populations are:

- a. Health seeking behaviors;
- b. Methods to improve access to the health care system;
- c. Experiences with health care entities and suggestions to improve these experiences;
- d. Basic knowledge of heart disease and stroke.

It is suggested HDSP program review methods that not only collect data, but also educate the community members.



Recommendation #2

Partnerships and collaborations between the health care system and organizations that serve the priority populations

Some participants felt community-based agencies were merely being used by large health care organizations in order to obtain grants to work with priority populations. It is recommended that ODH encourage organizations that receive its funding to create and maintain a meaningful working relationship with community-based agencies that

serve priority populations. ODH should set some measurable standards for example:

- a. Length of relationship;
- b. Ongoing mutual contact and support outside of specific grants;
- c. Contact and demonstration of commitment from top decision makers;
- d. An agreement of relationship.

It is recommended HDSP program use as a model Ohio's Tobacco Prevention Program's (ODH) Cross-Cultural Tobacco Control Alliance to create partnerships between norming culture health care service entities and community-based organizations.

Recommendation #3

Linguistic and cultural competence throughout the health care system

It is recommended HDSP program create or augment existing standards to use for a meaningful assessment of an organization's linguistic or cultural competence. Standards should lend themselves to assessing: a) organizational attitudes and commitment that can be demonstrated in policies, procedures and organizational self-evaluation; and b) skill development of organizational staff.

HDSP program should identify within community-based organizations those individuals who are able and willing to act as cultural liaisons for their communities. It is important that any liaison come from within the community of interest. For example, members of the urban African American population of Cincinnati will have some different norms than the rural African American population of Coshocton. Community-based organizations will have a great deal of knowledge about their clients. They should serve as key cultural informants from whom health entities can gather information to provide proactive care to the respective communities.

Recommendation #4

Community health workers

Many participants agreed that community health workers, within a respective priority population, were very effective in educating their fellow community members and helping them navigate complex health care systems. While training may be provided for community health workers:

- a. Mainstream health care entities may not hire them;
- b. Universities and like organizations prefer to use their own staff.



It is recommended HDSP program support policies that encourage norming culture health care service entities, and like organizations that receive funding to integrate community health care workers into prevention programs for heart disease, stroke and other chronic diseases. This may require that ODH create a clearinghouse or database of qualified community health workers; those who have received training and have some affiliation with organizations that serve priority populations.

Next steps

With the input from organizations that represent or have experience with priority populations, HDSP program will devise and implement an action plan based on the recommendations from the strategic planning process. The recommendations will be prioritized and the most immediate concerns will be addressed at the outset.

These recommendations will also be integrated into the revised version of the Ohio Plan for Heart Disease and Stroke to be published in 2008.

The HDSP program will also continue to cultivate relationships with the organizations that represent or work with priority populations by maintaining active communication and inviting these organizations to participate in heart disease and stroke prevention-related alliances, councils and program activities.

With the continued collaboration between ODH HDSP program and organizations that serve racial and ethnic minorities, it is believed that CV health among priority populations in Ohio can be improved significantly.



Appendix: Glossary of Terms

Culture—The beliefs, values, attitudes and ways of seeing the world that are common to a group of people. (Biggers, 2003)

“Culture represents the vast structure of behaviors, ideas, attitudes, values, habits, beliefs, customs, language, rituals, ceremonies and practices ‘peculiar’ to a particular group of people and which provides them with a general design for living and patterns for interpreting reality.” (Nobles, 1994)

Cultural Competence—Understanding a people’s culture with the intention of building skills that lead to the provision of appropriate and beneficial interactions or services. (Biggers, 2004)

Norming culture—The culture that sets the standards or norms for a country around behavior, commerce, education, gender roles, opportunity, religion, social dominance and other social and cultural markers. (Biggers, 2007)

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