Governor's Task Force Report on Black and Minority Health

In 1985, the U.S. Department of Health and Human Services issued the **Secretary's Task Force Report on Black and Minority Health**. The Report, clearly established that a disparity in health status existed between the majority and minority populations in the United States. The minority population was defined as African Americans, Latino/ Hispanic Americans, Asian Americans and Native American Indians. The Report stated: **" Despite the unprecedented explosion in scientific knowledge and the phenomenal capacity of medicine to diagnose, treat and cure disease, Blacks, Hispanics, Native Americans and those of Asian/Pacific Islander heritage have not benefited fully or equitably from the fruits of science or from those systems responsible for translating and using health sciences technology."**

In 1986, in response to this disparity the State of Ohio created the Governor's Task Force on Black and Minority Health as a special project under the Ohio Department of Health. Executive Order 85-69 authorized the Task Force to:

- examine the conditions under which gaps in the health and health care services for black and minority communities exist and recommend methods by which the gaps could be closed;
- design methods for disseminating health information and education materials especially designed for the minority community;
- develop models to improve access and utilization of public health services;
- develop strategies to improve the availability and accessibility of health professionals to minority communities;
- establish the rules, regulations, and procedures which are necessary or desirable for discharging the duties of the Governor's Task Force on Black and Minority Health; and
- report to the Governor the activities, findings, and recommendations of the Task Force.

Attempts to quantify the health status of Ohio's minority population through traditional means proved futile. Data had been officially reported as white/non-white and there was a paucity of literature available specific to Ohio's minority population.

In the fall of 1986, the Task Force decided to capitalize on the strengths of minority communities. In the tradition of oral storytelling the Task Force solicited the assistance of indigenous community leaders; traditional providers of services to the population including physicians, community health centers, the faith community and elected officials (city, county and state), to schedule public hearings.

The public hearings, although standard in format, were designed to capture the unique flavor of each city. **Hearings were conducted in Cleveland, Columbus, Dayton, Youngstown, Cincinnati, Toledo and Akron**. With the guidance of indigenous leaders who were known, trusted and respected in their community, "real people" were identified to provide testimony. They shared their perspectives about their personal health status and that of their families and communities. Surprisingly, they also provided proposed solutions to the problems which were identified.

Providers and policy makers served dual roles at the hearings. In addition to supplementing panels, which listened to community concerns, they also provided testimony.

People giving testimony were allowed the options of submitting written text and/or simply showing up to speak. The Task Force listened to everyone who chose to participate. Court reporters were engaged for each city to assure that all comments were captured.

Approximately 2,000 people participated in the public hearings statewide. In addition to recording the testimonies, the names and addresses of those who attended were computerized, constituting the beginning of a data base which has been added to over the years.

The majority of the participants were uninsured, under-insured or seasonally insured. The essence of their collective testimony can be summarized as; desiring a focus on prevention of disease and wanting a vehicle to develop services in a culturally relevant manner. They also requested the creation of a state level entity to advocate for their health needs and with an ability to interface with all related human serving departments. They perceived the need to learn behaviors to improve their health but they also perceived the need for the

system to change its behavior e.g., the need for systemic changes to remove barriers to accessible, acceptable, available and affordable services.

The Task Force made a commitment to these communities. If afforded an implementation phase, the community would be intricately involved in all aspects of its work.

On April 4, 1987, following months of deliberations, the Task Force presented its report to the Governor. Among the recommendations was the creation of a **Commission on Minority Health**.

In July 1987, the Ohio General Assembly, passed Amended Substitute House Bill 171, creating the Ohio Commission on Minority Health. The Commission was the first concerted effort by a state to address the disparity in health status between majority and minority populations. The Commission is an autonomous state agency with a biennial appropriation of $3.5 million dollars of general revenue funds.

RECOMMENDATIONS

Task: Examine the conditions under which gaps exist in the health and health care services for Black and minority communities and recommend methods by which the gaps may be closed.

RECOMMENDATION 1: IMPROVE ACCESS TO HEALTH CARE BY IMPLEMENTING A PROGRAM OF HEALTH CARE COVERAGE FOR THE UNINSURED.

The lack of financial access to health care services at the primary care level constitutes a major barrier to receipt of health care, thus accounting for much of the disparity in health status between Ohio's majority and minority citizens.

Ohio does not finance a medically needy program: therefore those with pre existing conditions, the working poor, and the uninsured or underinsured are forced to defer seeking health care until disease processes have progressed to a more critical stage resulting in lower cure and survival rates, greater disability and excess cost. Out-of-pocket expenses for health care are compound by lost income due to illness.

A program designed to increase access for the uninsured should:

- Address health promotion activities as a method to prevent the onset of disease and promote health:
- Provide early diagnosis and intervention at the primary and secondary level of the health care system when the chance for the cure is best and health care is less costly:
- Include incentives for employers to provide insurance coverage for those in low paying positions.

RECOMMENDATION 2: REDUCE INFANT MORTALITY BY: EXPANDING MEDICAID ELIGIBILITY FOR PREGNANT WOMEN TO THE FEDERAL POVERTY LEVEL AS PROVIDED BY FEDERAL PROGRAM STANDARDS AND IMPLEMENTING PROGRAMS THAT WILL INSURE REDUCTION IN INFANT MORTALITY THROUGH OUTREACH, PUBLIC EDUCATION AND CASE MANAGEMENT OF HIGH RISK MINORITY WOMEN.

Statewide, minority infants are twice as likely as majority infants to die prior to their first birth date. Early prenatal care would reduce infant deaths; however, poor women either do not receive care too late to significantly affect pregnancy outcomes.

Ohio's Medicaid eligibility criteria are restricted to those who receive SSI and AFDC. Thereby excluding many medically needy women.

Expansion of Medicaid coverage to include medically needy women would:

- Provide access to health care during the critical first trimester of pregnancy for women at highest risk:

- Provide early and adequate prenatal care to improve pregnancy outcomes and reduce infant mortality rates. Medicaid recipients tend to accesses prenatal care earlier than women who have no source of payment:

- Represent substantial cost savings through investment in prenatal and obstetrical care compared to the massive financial resources required for the hospitalization of premature or low weight infants.

RECOMMENDATION 3: THE ALLOCATIONS AND COMMUNITY DECISION MAKING PROCESSES USED BY THE DEPARTMENTS OF MENTAL HEALTH AND HEALTH TO DISTRIBUTE BLOCK GRANTS INCLUDING THE MATERIAL AND CHILD HEALTH ALCOHOL AND DRUG ABUSE AND MENTAL HEALTH BLOCK GRANT AND PREVENTIVE HEALTH AND HEALTH SERVICES SHOULD REFLECT THE INCIDENCE AND RISK FACTORS OF DISEASES IN MINORITY COMMUNITIES.

Diabetes, hypertension, cancer, infant mortality and substance abuse account for an excess number of deaths in minority communities. This pattern of premature preventable loss of life is both chronic and historic.

Funding levels to providers serving minority areas are not comparable with the incidence or severity of diseases in these communities. If the disparity in health status is to be remediated health care providers serving minority populations must receive adequate funding for service delivery based on need as determined by risk factors and incidence.

RECOMMENDATION 4: PROVIDE A CONTINUUM OF CARE FOR INDIGENT DRUG AND ALCOHOL ABUSERS FROM DETOXIFICATION TO AFTER-CARE SERVICES.

Alcohol abuse is the single risk factor, which contributes directly or indirectly to each of the diseases or conditions accounting for excess mortality in minority communities. It also appears to be the service area for which the least funding is available for treatment a follow-through services for the medically indigent.

Although funds have been designated for awareness/promotion programs in minority communities there has not been a comparable commitment or resources for those who cannot afford to pay for treatment.

Various public funding sources reimburse for components of the continuum; however, access to treatment for substance abuse is limited because of lack of reimbursement mechanisms for the low income and the medically needy.

RECOMMENDATION 5: INCREASE THE RATE OF TAXATION OF CIGARETTES AND ALCOHOL EARMARKING THIS REVENUE FOR PRIMARY AND/OR SECONDARY PREVENTION EDUCATION AND TREATMENT.

Additional taxes generated from cigarette and alcohol sales would be utilized to provide education and treatment at the primary and secondary levels of health care.

Use of this associated tax base could greatly expand the ability of the health delivery system to provide education, early intervention and treatment of diseases accounting for excess deaths.

Task: Design methods for disseminating health information and education materials especially designed for the minority community.

RECOMMENDATION 6: A MAJOR HEALTH PROMOTION AND DISEASE PREVENTION PROGRAM SHOULD BE IMPLEMENTED WHICH INCLUDES.

A) HEALTH EDUCATION AND PROMOTION ACTIVITIES IN SCHOOL CURRICULUM K-12 EMPHASIZING AVOIDANCE OF RISK FACTORS.

Stressing avoidance of risk-producing behaviors for minority children is necessary to promote wellness during the formative years.

Providing positive options options for health behaviors, self-awareness and self-esteem from K-12 should impact health decisions resulting in healthier lifestyles.

Model: The Task Force observed a culturally sensitive puppet show geared to school age children. The program was designed to prevent smoking, while stressing self-esteem and the decision making process. It was a creative, upbeat presentation, which addressed peer pressure, health and the consequences of high-risk behaviors. The focus on self-esteem empowers minority youth to assume responsibility and control for their well-being and lifestyle.

B) EXPAND THE HEALTH INFORMATION NETWORK TO INCLUDE CULTURALLY SPECIFIC INFORMATION NETWORK TO INCLUDE CULTURALLY SPECIFIC INFORMATION MATERIAL (AUDIO, VISUAL AND WRITTEN) AND DEVELOP MARKETING STRATEGIES FOR EFFECTIVE DISTRIBUTION.

More resources have been expended in the minority community to promote risk-producing behaviors than to discourage them. The cigarette and alcohol industries have developed promotion activities, which are specific to the culture of minorities including advertisements and sponsorship of ethnic, cultural and social events.

Public health promotion activities should adopt the culturally specific development of materials and marketing strategies, which have proven effective for these industries.

The minority community is not homogeneous; therefore, programs should not be generalized.

Model: Tele-Med is a nationally produced, taped health information systems which includes information about local providers within a 3-5 minute message on a variety of health topics.

Model: Develop culturally specific radio and TV Public Service Announcements focused on prevention and early intervention information to be utilized in a statewide campaign.

Model: Develop and/or access audiovisual presentations, which are specific to minority cultures, to be utilized for patient and community education. The ECCO Family Health Center Hypertension program is an example of a culturally specific audiovisual presentation.

Model: EFNEP (Expanded Food and Nutrition Education Project) is a federally funded community outreach program which provides: door-to-door information, hands-on cooking demonstrations, participatory shopping skills, budgeting and information for six months to one year per household. EFNEP's outreach staff represents the racial and ethnic diversity of the population served.

C) FACILITATE THE DEVELOPMENT OF A COMMUNITY-BASED RESOURCE BANK WITH EMPHASIS ON METROPOLITIAN AREAS WITH HIGH CONCENTRATION OF MINORITY POPULATIONS.

Community resource banks would serve as clearinghouses for minority specific information and data, which would be used to plan and coordinate services and promote activities at the local level.

D) DEVELOP A REFERENCE BROCHURE FOR PROVIDERS THAT DELINEATES DIETARY PATTERNS, ATTITUDES, BELIEFS, AND COMMON CULTURAL PRACTICES OF MINORITY POPULATIONS.

Many providers have a limited understanding of the rich cultural backgrounds of the minority community; beliefs, dietary patterns and attitudes, which influence the acceptability of information and service. A reference brochure, although not applicable to every minority member of each community, might provide basic information, which could be utilized to develop acceptable services.

E) PLACE CULTURALLY SPECIFIC HEALTH INFORMATION IN WELFARE OFFICES, LIQUOR OUTLETS, GROCERY STORES, UNEMPLOYMENT OFFICES AND CHURCHES.

Health promotion is traditionally marketed in the work place and at meetings of civic and social organization. Many low-income minority citizens are more involved in survival than in participation in-group activities and are therefore considered hard-to-reach populations.

Health promotion activities, which appear successful in many minority communities, share at least one of the following characteristics:

- Are developed considering beliefs, perceptions and/or values of the population served:
- Are multi faceted in terms of content. I.e. although developed to convey information on one topic, they include culturally specific information or situations relative to interrelated topics.
- Involved direct one-to-one, time intensive, practical encounters such as outreach activities:
- Are conducted in conjunction with other activities of a social, cultural, entertainment or religious nature;
- Contained language and content which are simple but not condescending;
- Provided easy access to information at no additional direct or indirect (transportation, child care) cost;
- Established a comfort or trust level with the person disseminating the information.
- Task: Develop strategies to improve the availability and accessibility of health professionals to minority communities.

RECOMMENDATION 7: INCREASE THE NUMBER OF MINORITY HEALTH PROFESSIONALS:

A) THE GOVENOR SHOULD DIRECT THE BOARD OF REGENTS TO PREPARE WITHIN ONE YEAR A PLAN FOR INCREASING AND RETAINING THE NUMBER OF MINORITY HEALTH CARE PROFESSIONAL. THE PLAN SHOULD INCLUDE ESTABLISHING APPROPRIATE FINANCIAL SUPPORT AND INCENTIVES FOR GOAL ATTAINMENT.

Numerous studies have documented that physicians treat more patients of their own race and ethnic group.

The Ohio applicant pool for minority students continues to decrease. Additionally, the National Health Services Corp (NHSC), a federally funded scholarship program is being reduced.

NHSC financed physician education and placed physicians in Medically Underserved Arcas. By 1990, the number of placements in Ohio will dwindle, threatening the supply of clinicians available to provide medical services to low-income populations.

Approximately 20 percent of the NHSC physicians assigned to Ohio were minorities.

According to the Association of American Medical Colleges, between July 1983 and June 1984, of Ohio's 825 reported Medical School graduates only 39 were Black, 36 Asian/Pacific Islanders, 4 Native American Indians and 10 Hispanics.

The under representation of minorities in the medical profession will become more dramatic in the future, thereby impacting negatively on the availability of practitioners to minority populations unless a comprehensive plan is developed to increase the number of minority health professionals.

This under representation permeates the health professions, including nurses, health educators, psychologists, nutritionists, speech pathologists and audiologists.

The plan should include strategies to expose minority students, preferably at the Junior High level, to health care career options, academic counseling and exploration of potentially available financial resources.

A mentorship program between minority health professionals and students could facilitate recruitment and retention for health care occupations.

B) PROFESSIONAL SCHOOLS SUPPORTED BY THE STATE SHOULD ESTABLISH A MINORITY SCHOLARS CHAIR TO DEVELOP AND COORDINATE CURRICULUM ON MINORITY HEALTH AND CULTURAL ISSUES TO IMPROVE HEALTH STATUS.

To improve the acceptability of health services to the minority community and the availability of culturally sensitive providers, cross-cultural training should be included in academic curricula. It is imperative that students be made cognizant of the special needs of minorities, problems of minority populations and cultural differences as a part of their formal training.

C) THE STATE SHOULD DEVELOP A CULTURAL COMPETENCY CURRICULUM, FUND RESEARCH AND DEVELOP A TRAINING SITE FOR OUTREACH WORKERS AND HEALTH PROFESSIONALS AT CENTRAL STATE UNIVERSITY.

Health care professionals need to know significant aspects of diverse cultures in order to provide treatment regimes and information, which are acceptable to minority citizens.

It is not practical to expect that a training location could be established in every community in the State. It is feasible to establish one site to accommodate the training needs of professionals and paraprofessionals statewide. Central State University, the only State supported minority college in Ohio, is the most logical choice to provide short-term cultural competency training.

A curriculum, developed by Eastern Michigan University, provides a structured format to train health care providers. Information includes a historical perspective of the various minorities and their beliefs and practices, which might be in conflict with traditional health care models and proposes program designs based on cultural diversity.

RECOMMENDATION 8: STATE PROGRAMS SHOULD DEVELOP OR IMPROVE COMPUTERIZED MANAGEMENT INFORMATION SYSTEMS WHICH WILL INDENTIFY AND MEASURE MINORITY HEALTH DATA SUCH AS:

- Vital Statistics
- Morbidity
- Utilization
- Diagnostic Groups or Categories

Computerized systems in Ohio would provide the capacity for Departments and facilities to plan, initiate and evaluate services in a timely manner.

- **Vital Statistics**
  There is a paucity of health related data relative to minority populations in Ohio.

  The lack of race and ethnic specific data is the most consistent obstacle in determining the degree of disparity in health status for the Hispanic and Native American communities.

  Hispanic is an ethnic, not a racial identifier. Hispanics are reported as Whites in Vital Statistics reports; therefore, it is difficult to ascertain mortality trends specific to that population.

  Data reported in the categories of White, Black, Hispanic, Native American, Asian/Pacific Islander and Other. Would allow analysis of health status and serve as a signicificant-planning tool for health care providers.

- **Morbidity**
  Most health related information available in Ohio is retrospective based on mortality information.

  The potential for collecting prospective data based on morbidity would provide information to establish patterns of incidence of disease and afford an opportunity to plan services in accordance with needs for delivery of health services.

  Model: MATCH Program (Ohio Department of Health, Maternal and Child Health) was funded in 1983 by a SPRANS (Special Project of Regional and National Significanee) grant. This system is used to design and implement a useable primary care database of funded MCH projects and to function as a management system for clinics and State agencies.

  Model: If a statewide Tumor Registry were established to record cancer morbidity, reliance on mortality data to determine after-the-fact trends would be minimized. This information is collected statewide by hospitals but cannot be accessed at a central collection point.

- **Health Care Utilization, Diagnostic Groups**
  Utilization patterns for preventive health services frequency of diagnosis and utilization of primary/secondary services are difficult to verify statewide basis. Determination of diagnosis, hospital and health care professional utilization and diagnostic information would indicate the rate at which minorities were accessing public health services and the facilities/practitioners who provide services.

  Additionally, this information would be useful for setting priorities for grant funds directed to high-risk populations.

RECOMMENDATION 9: REDUCE THE RISK FACTORS ASSOCIATED WITH ALCOHOLISM IN MINORITY COMMUNTIES BY LIMITING THE AVAILABILITY OF LICENSES FOR THE SALE OF ALCOHOL.

There are a disproportionate number of facilities in minority communities licensed to sell alcohol. Stringent controls should be established to limit the availability of this drug.

RECOMMENDATION 10: ALL PUBLIC AND PRIVATE HEALTH RELATED BOARDS WHICH RECEIVE STATE FUNDS AND DETERMINE POLICY, FUNDING, EVALUATION/RESEARCH AND DIRECT SERVICES SHOULD REQUIRE MINORITY PARTICIPATION REFLECTIVE OF THE POPULATIONS SERVED.

Representation of minorities in decisions of development, implementation and evaluation of health services is critical. The involvement of those for whom services are intended, affords an opportunity to provide culturally relevant services, anticipate the acceptability of these services to minority communities and empower the community itself to actively participate in health care decisions which will affect it members.

RECOMMENDATION 11: TO IMPROVE SERVICE DELIVERY TO MINORITY COMMUNTIES ALL STATE AND LOCAL HEALTH RELATED DEPARTMENTS, AGENCIES AND SERVICE PROVIDERS MUST EMPLOY INDIVIDUALS WHO ARE CULTURALLY SPECIFIC IN THEIR ORIENTATION AND WHEN NECESSARY BILINGUAL.

Citizens in low income, minority communities have often been described as hard to reach and difficult to identify for health care services. Often service providers are not members of the population to be served, do not reside in the community where service is delivered and know little about ethnic groups in the community. In addition to employing staff specific to the population to be served, staff should be bilingual contingent on the needs of the community.

RECOMMENDATION 12: ESTABLISH A COMMISSION ON MINORITY HEALTH, WHICH WOULD MONITOR AND FACILITATE THE RECOMMENDATIONS OF THE GOVENORS TASK FORCE ON BLACK AND MINORITY HEALTH AND ASSIST WITH THE COORDINATION OF SERVICES TO THE MINORITY COMMUNITY.

Implementation of many the recommendations of the Governor's Task Force on Black and Minority Health is contingent on coordination of efforts between State Departments, regions, local providers and leaders in the minority communities.

There is no single formula applicable to all people in each minority community, which will remediate the disparity between the majority and minority communities. Therefore, the commission would facilitate coordination, planning and evaluation of proposed services and training activities specific to minority cultures and they would oversee the following:

- Provide technical assistance for minority health professionals (See Recommendation 6-C)
- Serve as an identifiable resource to the broader health/medical community to develop accessible, available and acceptable services.
- Focus on the organizational strengths in minority communities, e.g. Urban Leagues, Native American Indian Centers. Commission on Spanish Speaking Affairs and NAACP to coordinate efforts with public and private sector agencies.
- Report annually to the Governor and members of the Ohio General Assembly on the status of minority health in Ohio.