

Health Education to Racial/Ethnic Minorities in Nebraska



In the fall of 2006, the Nebraska Office of Minority Health and Health Equity sponsored focus groups across the state to discuss health education to racial/ethnic minority populations. Eighty-seven organizations participated in the focus groups, and provided information on current efforts, partnerships, gaps, barriers, and how they feel the Office of Minority Health and Health Equity can best support their efforts. Focus group participants were not shy about discussing these topics, and we enjoyed some great conversations.

Results of the focus groups indicate that the *Strategic Plan of the Nebraska Office of Minority Health*, published about the same time, is well designed to address many of the needs of communities throughout Nebraska.

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AA/EOE/ADA

Who is being served?

- Non-immigrant, immigrant, and refugee groups
- Native Americans
- African Americans
- Mexican Americans
- Other Hispanic populations - from Mexico, Central America, South America
- Africans - primarily Somali and Sudanese
- Asian Americans - primarily Vietnamese and Laotian
- Eastern Europeans
- Middle Easterners

What is happening currently?

Current health education efforts targeted to racial/ethnic minority populations include the following.

- Adult immunizations
- Asthma
- Bioterrorism
- Cancer awareness/screening
- Cardiovascular health
- Chronic disease management
- Diabetes
- Domestic violence
- Eye exams
- Food safety
- Health access/insurance
- Healthy lifestyles
- Healthy relationships
- Hearing exams
- HIV/AIDS/STDs
- Maternal and child health
- Men's health
- Mental health
- Nutrition
- Obesity/weight loss, management
- Oral health
- Orthopedics
- Pandemic flu
- Physical activity
- Prescriptions & medications
- Sex education/pregnancy prevention
- Sexual assault/harassment
- Smoking
- Substance abuse
- Tuberculosis
- Women's health

How is it being delivered?

Health education is delivered via bilingual guides, and community health workers, among others. It is offered at ethnic community centers, health clinics, home visitation programs, and mobile health clinics. It is often tied to events such as festivals/cultural events, health career fairs, health conferences/institutes, lunch and learn programs, newsletters, and nutrition and health forums.

Who is doing it?

Partners varied among communities, but in general, partners include human service agencies, community-based organizations, faith-based organizations, colleges and universities, local health departments, other academic institutions, and the following.

- Behavioral health providers
- Businesses
- Childcare providers
- City government agencies and programs
- Community and cultural centers
- Community coalitions
- Community wellness programs
- Domestic violence agencies
- Employers of minority persons
- Federally Qualified Health Centers
- Financial institutions
- Health care providers
- Health systems
- Hospitals
- Insurance companies
- Interpreter service providers
- Libraries
- Local foundations
- Media
- Mental health providers
- Multicultural coalitions
- Native American tribes
- Nursing homes
- Probation offices, juvenile justice
- Service clubs
- State chapters of national organizations
- State government agencies and programs

What are the keys to effectiveness?

Health education efforts to racial/ethnic minorities must be culturally competent and linguistically appropriate. The education must also be visible, inviting, and easy to access. It should include motivating and effective programs and materials. Finally, it must include a supportive environment for the individual to adopt and sustain healthy behaviors. Suggestions include:

- Develop an understanding of the culture, including differences between our health care system and that of the home country
- Involve representatives of the minority groups in planning
- Use presenters who are credible, trusted, and accepted by the community
- Have information available in various languages
- Integrate programs into existing programs and services:
- Have ongoing education at regularly scheduled days and times
- Combine health education with health care services:
- Locate programs within the community at places people go:
- Use culturally-centered social marketing strategies
- Provide non-stigmatizing, non-threatening environment
- Depoliticize health issues
- Overcome the power differential
- Make specific, practical recommendations
- Offer realistic, specific alternatives for nutrition, physical activity:
- Provide realistic information on costs and time commitment
- Encourage family support
- Recognize that housing, food, and transportation are health issues
- Build needed support systems
- Offer integrated, holistic health programs

Where are the gaps?

While there are a lot of health education programs in existence, there are also gaps. Focus group participants feel that additional attention needs to be placed on the following.

- Cancer – early detection
- Cardiovascular health
- Domestic violence/violence
- Food safety
- Health care resource guides
- Health coverage access
- HIV/AIDS/STDs
- Maternal and child health topics
- Medicare and/or Medicaid information
- Men’s health
- Nutrition
- Mental health, including overcoming stigmas and resistance, depression, and stress reduction
- Oral health
- Pandemic flu
- Physical activity
- Routine prevention (screenings/exams)
- Sex education/family planning/reproductive health
- Substance abuse
- Women’s health

What are the obstacles?

Obstacles include cross-cultural conflicts and misunderstandings, specific beliefs and attitudes of certain cultures, language and literacy barriers, poverty and other socio-economic issues, limited program resources, health system hurdles, and certain public policies.

Cultural Differences. Cultural differences may result from ignorance, disrespect, feelings of oppression, hostility, indifference, insensitivity, or lack of trust. There are also negative feelings between minority groups and the white, non-Hispanic majority; and negative relations and dynamics among different minority groups.

Beliefs and Attitudes. Beliefs and attitudes that disrupt health education efforts include ongoing prejudices, poor cross-cultural communications and misunderstanding, lack of understanding or acceptance of the concept of preventive health behavior, a fatalistic attitude towards illness, unwillingness to seek care until there is a severe problem, inadequate health knowledge and literacy, serious misunderstandings of certain health issues, strong belief in certain traditional remedies, the lack of a cultural concept of mental health, and cultural rules about females and what may or may not be discussed.

Language and Literacy. Language and literacy barriers include lack of health education materials in specific languages, availability and cost of interpreters and translators, difficulty in recruiting outreach workers who speak the native language, providers who will not provide interpreters, providers who do not know how to work with interpreters, using children to interpret, interpreter’s lack of medical certification or adequate training in health issues and terminology for interpreters, low literacy levels, and messages that are too complex.

Socioeconomic Issues. Socioeconomic issues further complicate the delivery of health education – and the willingness of minority populations to listen to and implement that education. Families and individuals struggling with poverty and fighting to meet basic needs such as food, housing, and transportation are often not placing a high priority on health education, or even health care. Recommendations on healthy diets are likely to seem irrelevant to people who experience food insecurity. Transportation and child care also present barriers

to health education among those living in poverty. Health coverage is often lacking, which severely limits their options to health services. Additionally, funding for medications or other treatments is often not available.

A major barrier in outreach to immigrant communities is that a number of immigrants are undocumented, which cuts them off from many assistance programs. Fear of deportation keeps them (and even some with documentation) away from programs that would serve them.

Resource Limitations. Program resource limitations include financial, personnel, and data inadequacies. It is often difficult for organizations to obtain the level of funding they need to meet their health education program needs, and it can be especially difficult to obtain funding to sustain these programs for the long term needed to be truly effective. High staff turnover disrupts community connections; and limited staff (in people and time) restricts the amount of health education available. In addition, some funding sources are inflexible about how funds can be used, some require excessive paperwork, and some include rigid requirements for evaluation. Lack of adequate minority population data that are current, local and specific to different minority groups is a huge issue.

Health System. The fragmented, complex health care system is difficult enough to navigate for those who are advantaged by income, education, and health coverage and speak fluent English. For immigrants and refugees, and other racial/ethnic minorities, health education is even less accessible though most health care services (even if they can access those services) because of the language and culture barriers discussed earlier.

Health education within the health care system is largely treatment-based and confined to issues directly related to the diagnosis and treatment of a specific health problem. Although disease prevention gets considerable publicity, the U.S. health care system is more oriented to medical treatments than to education and support of measures that would prevent disease. Prevention efforts are primarily in the form of medical screenings and exams that can detect problems, which if treated, could prevent more serious ones, or detect serious problems at an early enough stage where treatment is more likely to be successful.

Patients who seek preventive health education advice from professionals such as nutritionists or physical fitness experts are not likely to have their costs covered by health insurance. Covered health services are likely to be available only when serious health problems occur as a result of poor diet and inactivity. Likewise, the system offers treatments to quit smoking or control alcohol and drug addictions, but has less involvement in efforts to prevent substance abuse.

Public Policies. Public policies and the lack of enforcement of those policies may present obstacles to reaching racial/ethnic minorities with health education. One example of this is the lack of compliance and enforcement of Title VI of the Civil Rights Act and the Culturally and Linguistically Appropriate Services (CLAS) standards which require health providers to provide interpreters and translators for their limited- and non-English speaking patients. In addition, Title VI violation complaints often are not resulting in provider compliance.

Public policies also present a barrier to increasing the number of minorities in the health professions. Higher education and employment obstacles for undocumented immigrants reduce the numbers who could pursue health careers. In addition, the certification process for health professionals trained in other countries prevents many from pursuing U.S. qualifications. There are many health professionals trained outside of the U.S. who could be

providing health care to limited- or non-English speaking patients, but are unable to meet the testing requirements for certification.

Also of great concern are the restrictions on providing services to undocumented immigrants. In particular, the requirements of a Social Security number for many assistance programs makes it very difficult for organizations to reach this population group with health education and assist them with access to the health care services they may need.

Who else could help?

Increasing partnerships may involve inviting new partners to the table, or expanding the involvement of existing partners.

- Business sector, including major employers of minorities
- Chamber of Commerce
- Financial sector
- Foundations, both local and national
- Colleges and universities
- Local government
- State agencies
- Churches and other religious congregations
- Media
- Health care providers
- Civic organizations
- Child care providers
- Nursing schools
- Minority health professionals
- Minority community leaders
- Law enforcement

What can the Office of Minority Health and Health Equity do to help?

Suggestions on how the OMH can better support local efforts include improving relations and communications with partners, facilitating networking and collaboration, improving data collection efforts, providing a link to the legislature and other policymakers, assisting with message dissemination, taking the lead on cultural competency, assist in efforts to increase the number of racial/ethnic minorities in health professions, lead assessment and strategic planning, assist with program and project development, coordinate and provide technical assistance with funding, provide training, and increase health services available to racial/ethnic minorities.

OMH Relations and Communications with Partners

- Have more face-to-face and personal contacts and communications with community partners
- Improve communication and provide more advanced notice of meetings, etc.
- Offer more encouragement to partners
- Clarify and distinguish OMH's role from community partners
- Provide more information about what OMH does
- Place more trust in local partners and find ways to work within partners' rules to help them help their community

Networking and Collaboration

- Facilitate community networks and partnerships
- Take leadership in forming collaborations (state participation comes with no turf issues)

- Provide a list of key contacts for advertising health education opportunities to minority populations
- Need community contacts – location of education/enrollment sites
- Keep track of who has what resources and facilitate sharing
- Convene groups to exchange information on resources and best practices and facilitate partnerships
- Sponsor meetings to support a dialogue process – round tables, working teams, etc. on minority health

Data and Information

- Advocate for and help provide better minority population data that is accurate, up-to-date, at local level, and specific to different populations
- Provide up-to-date information on health disparities, gaps, and number of uninsured and under insured that is specific to the community
- Establish connection to university public policy center for data specific to different groups
- Help put together local guides to health services and other resources, including those for low-income and uninsured
- Develop website to be a clearinghouse for minority health information. Include useful links, calendar of events, catalog of multi-lingual resources, health status reports, best practices, collaboration opportunities, health services by location, funding opportunities
- Develop a unified, single set of health education resource materials, instead of each entity creating their own handouts
- Provide information on what resources are already available from OMH
- Ensure accuracy of available information
- Share with community partners studies and research on delivering health education

Advocacy and Public Policy

- Use authority of state office to open door – “bully pulpit”
- Provide connection to legislators and advocacy assistance
- Provide link for service providers to policy advocacy
- Set the tone for leadership
- Provide analyses on key issues
- Advocate for needed policies and programs
 - ~ More federal and state dollars and grants
 - ~ Non-politicized public policies
 - ~ Health literacy pilot program
 - ~ Comprehensive approach to meeting needs (economic and health)
 - ~ Policy changes at federal level, especially enforcement of Title VI of the Civil Rights Act
 - ~ Cultural competence training of doctors and dentists
 - ~ Credentialing programs for immigrant providers

Community Outreach to Minority Populations

- Raise OMH public profile and awareness of who you are and what you do
 - ~ Staff more visible and plentiful in local community (e.g., health fairs, interagency meetings)

- ~ Continue Minority Health Conference and link back to community
- Give voice to community perspective
- Develop leaders and recognize leadership
 - ~ Provide recognition of great efforts in communities – annual awards, etc.
 - ~ Host youth leadership conferences
- Target younger people with health education, involve parents through groups like 4H
- Need state-wide health education campaigns
- Need more public health announcements in English and Spanish
- Visit reservations and tribal leaders (reservation and non-reservation) to assess resources, gaps, etc.
- Host an Indian Health Summit, including tribal leadership and key DHHS people
- Establish relationships and conduct education with business owners

Cultural Competence and Diversity

- Provide more education to health care personnel on cultural issues
 - ~ Offer CME's for cultural competence education – reach the physicians
 - ~ Provide in-depth, intensive cultural competence education, broader than just interpreters, for all
- Medical school education curriculum should include cultural competence
- Include Native American cultures within school curriculum

Language

- Provide specific language materials
 - ~ Spanish
 - ~ Lakota
 - ~ African languages (Sudanese and Somali)
 - ~ Vietnamese and Laotian
 - ~ Mayan and other non-Spanish dialects from the Americas
 - ~ Arabic, Bosnian, Russian
- Key is communication – interpretation and translation
 - ~ Continue staff initiatives for interpreters and translation
 - ~ Need certification for medical interpreters
 - ~ Get word out to provider re: medical translation and interpretation – cannot cover now but working on it
 - ~ Need more bilingual health educators

Minority Health Professionals

- Recruit and train more minority health professionals
- Provide scholarships for minorities to go into health professions – especially mental health
- Think long-term – catch high school kids through college, through graduate school, stay and work here in Nebraska in health professions

Assessment and Strategic Planning

- Establish common goals that could be incorporated into organizations' strategic plans for minority health
- Sponsor a 2020 visioning process
- Do with work plan as you do with conference – focus on key issues

- Assessment of what is out here, with local input
- Help conduct client satisfaction surveys
- Understand the demographics of minority populations: numerators and denominators
- Allow for differences in how rural areas function
- Need quality outcome measures for evaluation

Program and Project Development

- Need health education programs that are scientifically based and medically accurate – not politicized
- Include the target audience in on the program development, implementation and evaluation process
- Must be holistic – mental health, substance abuse, primary care providers
- Identify and disseminate best practices – success stories
- Need strategies to motivate people to participate
- Need basic nutritional programs -entire diet of traditional foods
- Intensively fund model program for healthy nutritional lifestyle – conduct study to show benefits
- Provide ideas for programming at collegiate level to connect with experts, resources, programming
- Lead statewide Healthy Lincoln, Activate Omaha type campaign to encompass and set example for all of state

Funding and Resources

- Improve funding procedures and information
 - ~ Centralized person sending out information on all grants/funding on all issues – government, private, public, etc., sort by relevancy
 - ~ Remove personal/political biases from funding process and incorporate views of public health professionals into planning
- Facilitate increased funding
 - ~ Connect to state and federal funding and facilitate applications
 - ~ Put Nebraska lottery money into healthcare
 - ~ Tie dollars generated by minority population groups (i.e. Keno dollars) to benefit those groups
 - ~ Help us keep and sustain successful programs
- Need funding for specific purposes
 - ~ Facilitate funding for interpretation and translation –
 - ~ Support for immigrants after office of refugee resettlement dollars expire
 - ~ More funding for health education
 - ~ Need funding for minority health educator on staff
- Need additional resources
 - ~ More resources to manage grants
 - ~ More resources for health for families and for agencies
 - ~ OMH needs more resources
 - ~ Need capacity building

Training

- Provide training and workshops
- Need training programs and train the trainer

- Need local training and support on community outreach
- Need health training for bilingual staff (case management, translation, etc.)
- Provide education on how to use existing resources
- Need effective marketing tools and training

Health Services

- Need locally available health services
- Need free clinics including dentists and optometrists
- Inform and recruit more dentists
- Need transportation to services, funding and drivers
- Help people understand how insurance works – what is said and how it’s said
- Bring immigrants into one-stop health care
- Need health education department in health clinics
- Reach illegal children with health screening, prevention, etc.

Final thoughts from participants?

Health education should be more closely integrated and coordinated with health care services to ensure appropriate follow-up to education screenings, etc., and to ensure appropriate health education in connection with treatments.

Health education and health care services need to be more integrated and coordinated with other social services for those families that struggle to meet basic needs. Access to health care services should be addressed in the context of the family’s other basic needs. Health education is a relatively low priority for families who are struggling with shelter, food, and transportation issues. More practical, realistic steps can be identified when taking into consideration the family’s status in terms of basic needs.

Many health issues are interrelated and should be addressed comprehensively in health education initiatives. Health education program funding should encourage a broad approach rather than a addressing a narrow, single issue.

The cultural competence and delivery of health education programs to minority populations are more problematic for community partners than determining what health topics to address. OMH should enhance its efforts to help its partners obtain or develop culturally competent and linguistically appropriate materials. OMH should enhance its efforts to help partners’ outreach efforts to minority populations in their communities.

OMH needs to learn more about its community partners and how they function in different areas of the state. More visits to individual community partners at their facilities would provide greater opportunities for OMH to communicate to them about their services and, more importantly, for OMH to look, listen, and learn from those partners.

OMH needs to communicate better to its community partners about its mission, objectives, and services. Better communication would not only result in more services to partners, but also, give the community partners opportunity for feedback on existing or planned OMH services.