



National Association of County and City Health Officials

Strengthening Minority Health Data Collection

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Strengthening Minority Health Data Collection

Introduction

As the United States population becomes increasingly diverse, addressing the linguistic and cultural needs of its residents becomes progressively more complex and important. According to *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*, by the year 2000 members of racial and ethnic minority groups will account for one-fifth of the U.S. population. This increasing diversity has profound public health implications for local health departments in their function of assuring that the health needs of residents within their jurisdictions are met.

Additionally, it is vitally important that public health activities are designed to reach all residents. This entails the incorporation of approaches and strategies that recognize the influence of linguistic differences and cultural group membership. At the present time a paucity of data exists in this important area, and in particular, there are no baseline data for several of the culturally and linguistically specific objectives in *Healthy People 2000*.

To address the need for data on how to meet the needs of culturally and linguistically diverse communities, the National Association of County and City Health Officials (NACCHO) received funding, through a cooperative agreement with the Centers for Disease Control and Prevention (CDC), in cooperation with the Office of Minority Health, Department of Health and Human Services, to collect information on minority health issues and culturally appropriate services.

The study objectives were to:

1. Measure the percentage of local health departments that meet their community's health needs through linguistically appropriate and culturally sensitive interventions as outlined in *Healthy People 2000*, Objective 8.11.
2. Establish baseline measures, where needed, for *Healthy People 2000*, Objective 8.11.
3. Address related public health issues when applicable and appropriate.

Data Collection and Analysis Activities

As stated above, one of the main goals of this study was to establish baseline measures for *Healthy People 2000*, specifically the Service and Protection Objective 8.11. The specific text of the objective states:

Increase to at least 50 percent the proportion of counties that have established culturally and linguistically appropriate community health promotion programs for racial and ethnic minority populations. *Note: This objective will be tracked in counties in which a racial or ethnic group constitutes more than 10 percent of the population.* [italics in original] (*Healthy People 2000*, p. 102).

In developing baseline measures, NACCHO worked closely with Healthy People 2000 8.11 Work Group consisting of representatives from the Department of Health and Human Service's Office of Minority Health and the Centers for Disease Control and Prevention's National Center for Health Statistics and the Public Health Practice Program Office. The research strategy also involved participation from the public health community, specifically soliciting input from minority health organizations on their data needs, relationships with local health departments and suggestions for the survey questionnaire.

Data collection consisted of two major phases: a key informant interview, and a nationwide survey of local health departments' (LHDs) culturally sensitive and linguistically appropriate activities. The survey phase included a pilot test of the study's survey questionnaire and subsequent mailing of a revised survey to the study sample. These phases are described in detail in the following sections of this report.

Key Informant Interviews

As part of the survey development process, and in order to assure that the data collection effort met the needs of interested constituencies, the Office of Minority Health recommended that NACCHO conduct a key informant interview study with representatives of minority health organizations. Information from these interviews was used to frame survey questions and highlight important issues from the field. In addition, data gathered in the key informant interview study may prove useful for future programmatic and policymaking decisions.

During September and October, 1997, interviews were conducted with representatives of 47 minority health agencies and organizations. These groups ranged from state minority health offices to local health councils. Selection of these agencies was conducted in consultation with the Office of Minority Health using the Office's on-line listing of the minority health organizations nationwide. To supplement this listing, contacts were

made with other agencies that have carried out efforts to assess minority health status and relevant minority health issues. NACCHO publications and staff recommendations led to additional sources of information, as did the recommendations from the key informants themselves. A complete listing of the key informants can be found in *Appendix A*.

Interviews were carried out over the telephone and were made to a specific contact person if listed, or with the director of the organization. In some cases, referrals were made by the contact person or director to the minority health information specialist within the organizations. Telephone interviews averaged 10 to 15 minutes depending on the time respondent had available and the information they provided during the interview session.

Although the telephone interview was meant to be an unstructured conversation, the general question “what types of minority health information would be valuable for your organization to obtain from local health departments?” was used to frame interview discussions. When respondents had difficulty providing answers, further probing was conducted. For example, Hispanic health institutes were asked if there were priority health issues within the Hispanic community and how the activities of LHDs might relate to these priority issues.

A wide range of information was gathered through discussions with key informants. For example, health organizations that had a specific focus, such as cancer, were very interested in local health department programs that targeted minority populations focusing in that focus area. Health organizations with a broad scope of issues were interested in knowing about the sustainability of minority health programs offered by local health departments. Respondents also wanted to know about the racial composition of the LHD workforce, especially in relation to the constituency the respondent’s organization represented.

Collaboration between the responding organization and the local health department and other public and private sources of health education and information was another common theme that arose in conversation with respondents. Key informants were also interested in knowing how local health departments engaged community members in their health programs, specifically in outreach to minority communities in the jurisdictions they served.

Several issues were predominate among organizations representing specific racial/ethnic groups. For example, most Hispanic health organizations were concerned about the type of linguistically appropriate services offered by the health department, including the use of translators within the department. Many Asian health organizations mentioned interest in gaining information about the acceptance of specific non-Western cultural health practices and their acceptance within the United States’ medical system. At a general policy level, agencies would like to have more information about the impact welfare reform, child care initiatives, and the increased influence of managed care organizations on the quality and types of services LHDs provide to different racial/ethnic communities.

Key informants also wanted data on the role of local health departments in carrying out community needs assessments. Specifically, organizations were interested in knowing if LHDs conduct them and, if so, did LHDs target follow-up funds toward areas determined to be in need of services? Similarly, questions dealing with program monitoring and evaluation were also mentioned. Finally, some organizations thought it would be helpful to develop reciprocal relationships with local health departments and asked if there was information that LHDs would want from minority health agencies and organizations.

Many minority health groups inquired about receiving information that they could in turn provide to their constituency regarding the types and interventions of culturally and linguistically appropriate programs that are available from local health departments. Furthermore, there were a small number of basic questions regarding the location, hours of the clinic(s), any specific bilingual service hours, type of intake information required, and the available modes of transportation to and from the department's primary care facilities or clinics.

In several interview sessions, key informants noted that they perceived a lack of connection between the LHD and community residents. This "disconnect" was seen as leading local health departments away from understanding the needs of the community and created a situation where LHDs did not have a mechanism to communicate which services are available to members of their community.

Sample Design and Survey Development

In addition to collecting interview data on the needs of minority health agencies, this study also sought to enumerate the culturally sensitive and linguistically appropriate activities of local health. Because the *Healthy People 2000* Objective 8.11 is limited to local health departments that serve populations with greater than 10% racial or ethnic minorities, the study sample was selected from the population of health departments serving jurisdictions with more than ten percent (10%) racial or ethnic minority populations.

Information on local health department jurisdictions was gathered from *NACCHO's 1997 Profile of United States Local Health Departments*, a comprehensive survey of local health departments' services and demographic characteristics. Of the 2,492 health departments that responded to the 1997 Profile questionnaire, 2161 (87%) served jurisdictions that had at least 10% racial or ethnic populations. From these 2161 local health departments, a simple random sample of 300 departments was selected to receive the survey questionnaire. This sample size was sufficient to detect significant differences between department groupings while also staying within the limitations of the project's resources.

Of the 300 local health departments in the survey sample, 187 returned completed survey questionnaires resulting in a response rate of 62% (187/300). Follow-up techniques included a post-card reminder sent at two weeks after the first mailing, a follow-up letter

with an additional survey questionnaire sent to nonrespondents four weeks into the project and a telephone call to the contact person at the local health department urging them to respond six weeks after initial surveys were sent. The response rate of 62% is slightly higher than the standard 60% response rate usually obtained with a follow-up postcard and second questionnaire mailing (Dillman, Don A., et al., 1974. “Increasing Mail Questionnaire Response: A Four State Comparison.” *American Sociological Review*, 39:755).

An analysis of the survey respondents found that there were no significant differences between the 187 survey respondents and 113 survey non-respondents. When responding health departments were compared to the population of local health departments from which the sample was drawn, however, several differences emerged. Study respondents served slightly larger jurisdictions than the overall population, responding health departments served jurisdictions with an average population of 184,373 residents (ranging from 1,950 to 7,332,564 residents). The overall jurisdiction average for all local health departments was 108,772 residents (ranging from 300 to 9,250,000 residents.) Table One presents the number and percent of cases in various population jurisdictions for both the study sample and the overall study population.

Table One. Population of Jurisdiction for Responding Departments and All Departments

Population of Jurisdiction	# of Responding Health Departments (n)	% of Responding Health Departments (%)	# of All Health Departments with > 10% ethnic or racial population	% of All Health Departments with > 10% ethnic or racial population
0 to 24,999	54	29	868	40
25,000 to 49,999	50	27	487	23
50,000 to 74,999	15	8	202	9
75,000 to 99,999	7	4	130	6
100,000 to 249,999	31	16	275	13
250,000 to 499,999	16	9	105	5
500,000 to 999,999	9	5	65	3
1,000,000 or more	5	3	29	1
Total	187	101%*	2161	100%

* Note: Percentage adds to 101% due to rounding.

Departments that responded to the survey also had larger staffs and larger budgets when compared to the population of local health departments overall. The average number of employees in responding health departments was 135 compared to the overall population

average of 98 employees. The annual, median departmental expenditures in responding departments was \$1,416,419 while the overall population median was \$711,188.

The differences observed between responding departments and the overall population are not surprising. It is NACCHO's experience that larger health departments are more likely to have the capacity to respond to surveys due to their larger budgets and staff size. Large local health departments, serving jurisdictions greater than 350,000, are a small portion of NACCHO's membership but are also among the most active NACCHO members. In addition, larger departments may be more likely than smaller departments to be involved in the topic and have staff resources dedicated to the area of minority health and culturally sensitive and linguistically appropriate programming. Hence, it is expected that larger departments would be the most likely to respond to the NACCHO questionnaire.

Sample sites were located in 34 of the 50 states, including the state with the largest percentage of racial/ethnic minorities in the country. Sites in Puerto Rico, the Virgin Islands, and other United States Territories were not included in the 1997 Profile and therefore are not included in the study sample. States with local health departments that responded to the survey are shaded in Figure One.

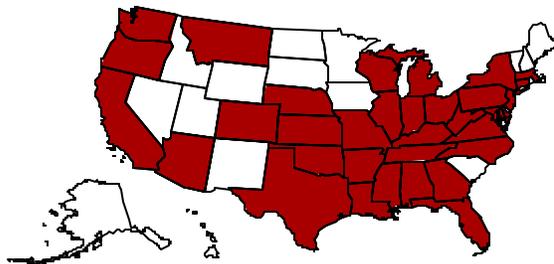


Figure One. Map of states with responding departments.

Before the questionnaire was sent out, eighteen (18) pilot sites were non-randomly selected to pilot the survey instrument. Two versions of the questionnaire (a "short" and a "long" version) were distributed. The only difference between the two versions was the depth of detail in the intervention columns. The long version included specific breaks of the "Informational Materials" category into "Print" and "AV", the "PSA" category into "Radio" and "TV", and the "On-site" and "Off-site" Instruction categories into "Individual" and "Group" subcategories.

In addition to the short or long version of the questionnaire, three other pages were sent to the pilot sites. The first was a comment page which allowed the pilot sites to write

down their comments on the survey. The second was a demographics page listing the racial and ethnic composition of the local health department jurisdiction provided from data in the 1997 Profile questionnaire. This data page requested respondents to review their race and ethnic data and make corrections in the space provided. The third page included definitions for meeting special language needs through linguistically competent services and materials and addressing cultural differences through culturally appropriate programs and interventions and, at the bottom, the identification information that was provided by the LHD in the 1997 Profile.

Suggestions from pilot respondents were reviewed, and when feasible, included in the final questionnaire. The Health People 2000 Objective 8.11 Work Group evaluated the pilot site data with NACCHO staff and decided to administer the “long” version of the survey.

In developing the final survey instrument, keeping the survey to a manageable length was a constant challenge given the aim of the study was to collect a great deal of specific data on local health department programs and communications modes.

The final survey questionnaire was designed to collect information in three major areas:

- Overall LHD Programs and Interventions
- Meeting Special Language Needs Through Linguistically Competent Services and Materials
- Addressing Cultural Differences Through Culturally Appropriate Programs and Interventions

In order to keep respondent burden to a minimum, a grid system was used to allow respondents to “check” their answers to survey questions. This allowed the survey to remain short (three pages, one for each area) while simultaneously allowing for the collection of detailed data. Using the grid system, Healthy People 2000 Objective 8.11 program areas were listed in the first column, and communication modes were listed along the top row. An example of the final questionnaire is contained in *Appendix B*.

Respondents were asked the following three questions, each corresponding to a grid page on the final survey:

- In the past year, which of the **following programs and interventions were provided in your jurisdiction**, either directly by your local health department or through a contractual agreement with another organization?
- In the past year, which of the following programs and interventions were adapted and/or provided to meet the **special language needs of any racial/minority population you serve**, either directly by your local health department or through a contractual agreement with another organization?

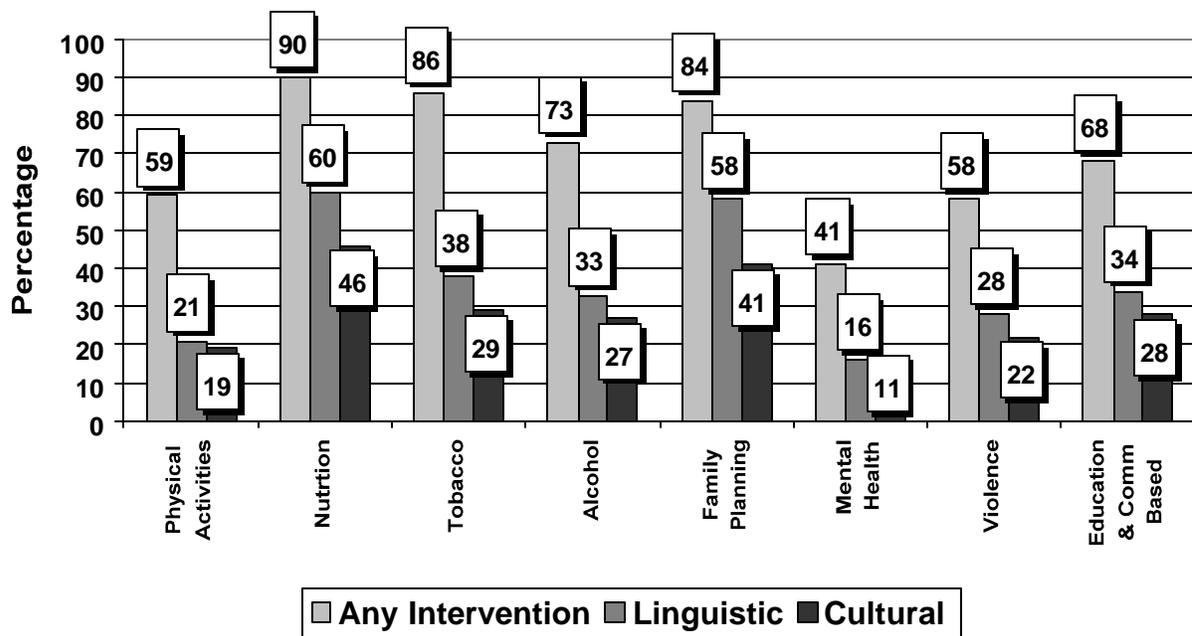
- In the past year, which of the following programs and interventions were adapted and/or provided to address the **cultural differences of any racial/ethnic minority population you serve**, either directly by your local health department or through a contractual agreement with another organization?

When a respondent checked the box relating to a specific intervention and program area, that response was considered a “yes.” When boxes were left blank, the response was considered a “no” or a “no answer” response.

Programs and Intervention Data

Figure Two present a graphic illustrating the percentage of all respondents who checked “yes” on the survey for specific health promotion categories.

Figure Two. Health Promotion Percentages, All Respondents

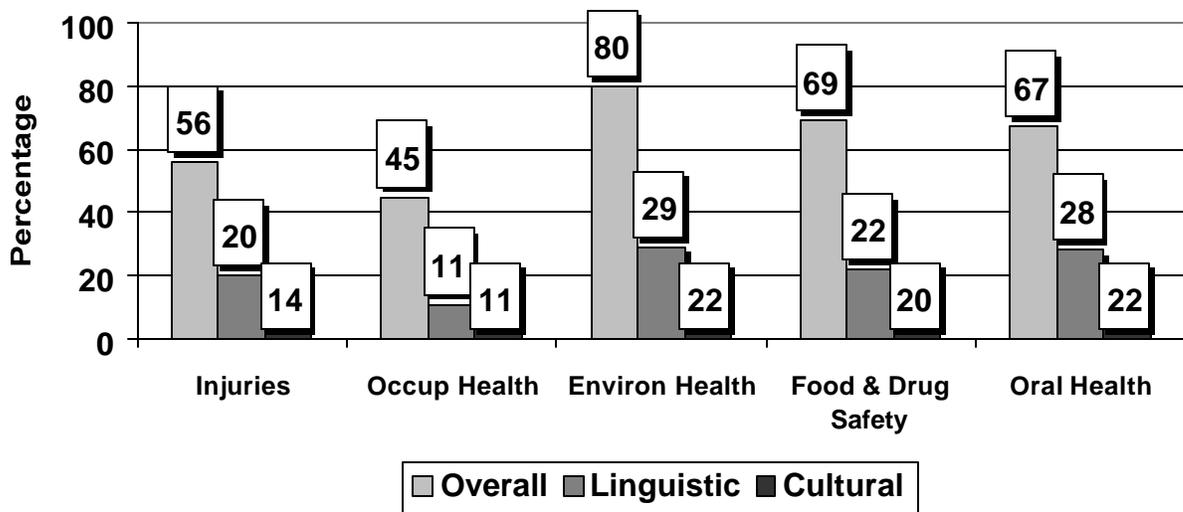


In the area of health promotion, most local health departments have a nutrition based intervention (90%), followed by tobacco (86%), family planning (84%) and education and community based programs (68%). Linguistically appropriate intervention or communication modes follow this trend. Health promotion interventions addressing cultural differences are the lowest percentages across all types, with nutrition and tobacco as the most frequent program modified to address cultural differences and mental health and physical activities and fitness the least common. The most common intervention

type in the health promotion category are printed information materials. The least common were internet-based health interventions.

Figure Three illustrates the percentage of respondents who indicated they provided health protection interventions. Overall, environmental health, food and drug safety and oral health interventions were the most common health protection program areas. There is a large difference between the health protection interventions provided overall, and the health protection interventions that are culturally sensitive and linguistically appropriate as shown below. For example 56% of department indicated they had an injury prevention program, however only 20% reported that the intervention was linguistically appropriate and 14% reported that the intervention was culturally sensitive.

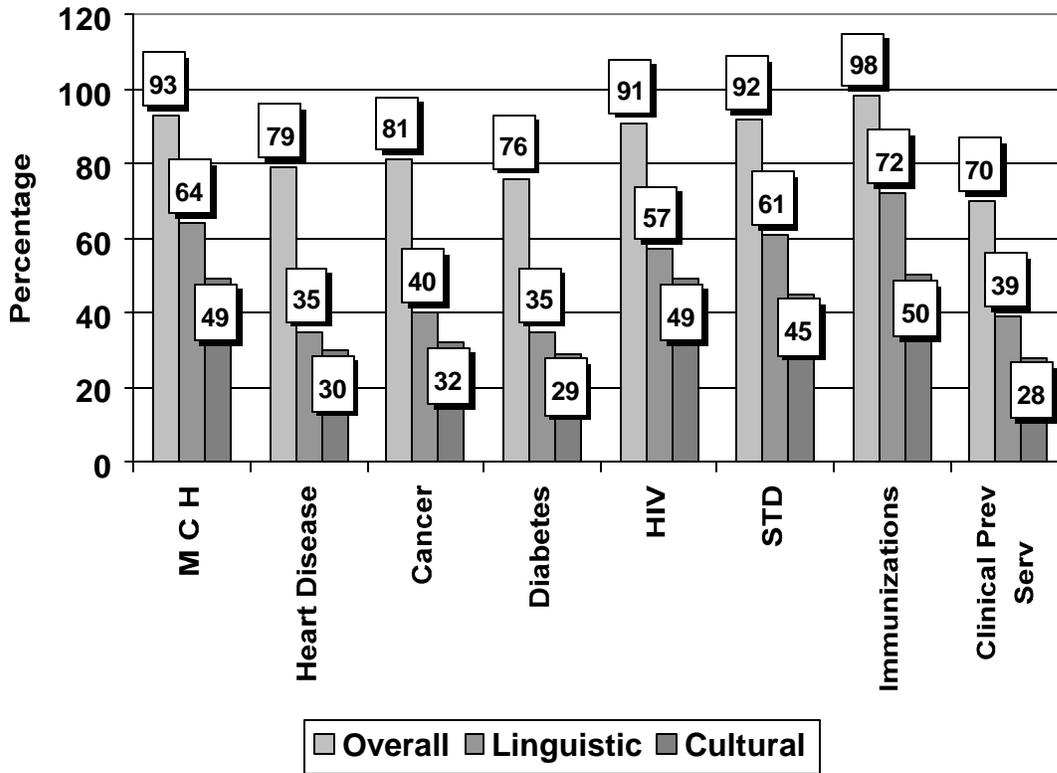
Figure Three. Health Protection Percentages, All Respondents



Preventive Services

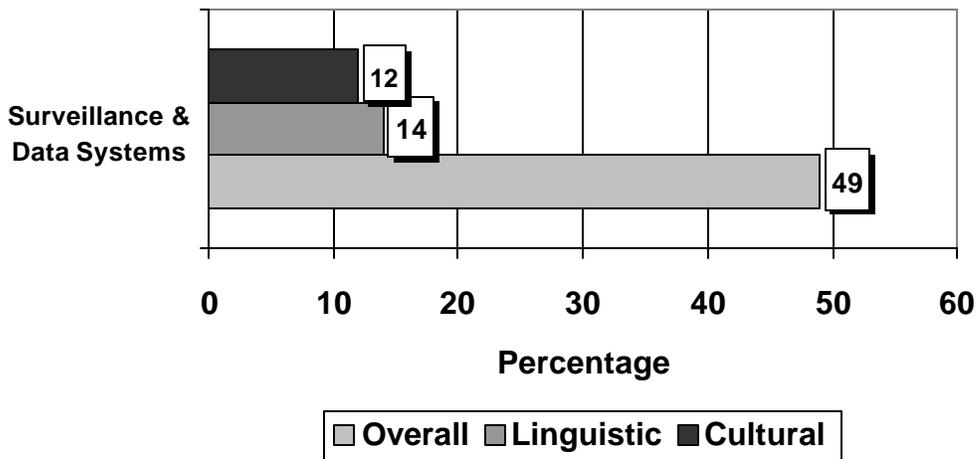
The most common program area among responding departments was the preventive services area. Almost all departments indicated that they provided prevention immunization services (98%), followed by maternal and child health programs (93%), Sexually Transmitted Disease (STD) programs (92%) and HIV programs (91%). Cancer, heart disease and diabetes prevention were also common. With the preventive services categories, health departments also offered the most culturally sensitive and linguistically appropriate interventions. Figure Four shows the percentages of health departments providing these services in several different preventive service program areas.

Figure Four. Preventive Services Percentages, All Respondents



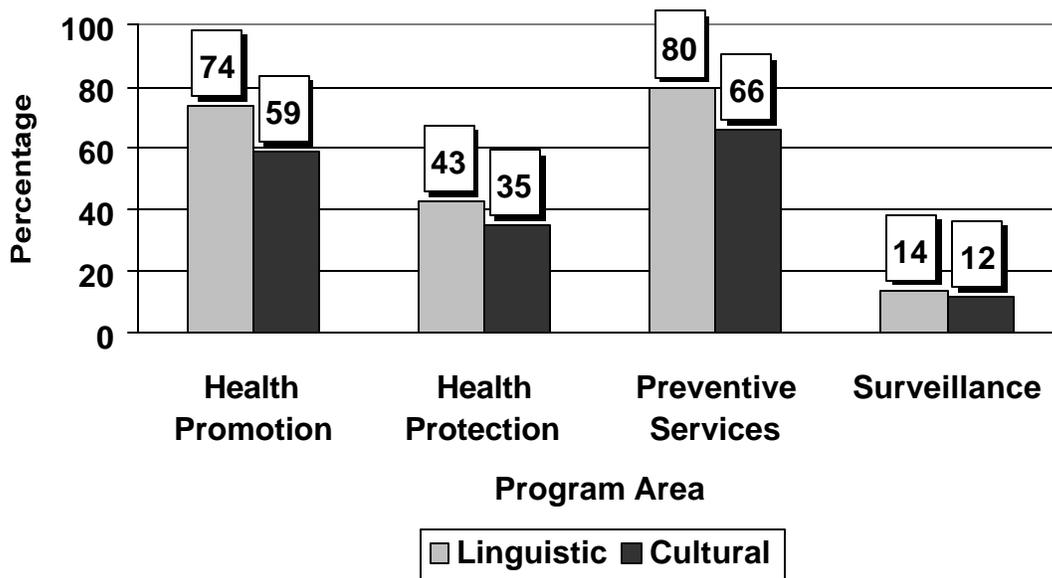
Surveillance and data systems were not a frequent area for linguistically appropriate or culturally sensitive interventions. However, overall, only 49% of responding health departments had programs in this area. Figure Five illustrates the responses for the surveillance and data systems area.

Figure Five. Surveillance and Data Systems Percentages, All Respondents



The figures above illustrate the percentage of responding health departments with interventions in the specific program areas. In order to assess the results at an aggregate level, intervention types were combined within the broad categories of health promotion, health protection, preventive services and surveillance and data systems. The following figure (Figure Six) is comprised of health departments that indicated they provided any intervention in the broad category listed. It is important to note that departments may provide a range of interventions. In this graphic, any mention of an intervention in the area counted toward the percentage displayed below. As noted above, preventive services was the most common program area and contained the highest percentage of respondents offering any culturally sensitive and linguistically appropriate interventions.

Figure Six. Linguistically Appropriate and Culturally Sensitive Interventions in Major Program Areas, All Respondents



As noted above, health department size may determine the number of interventions and their program areas. In order to examine the relationship between the population of the health department's jurisdiction and interventions provided an analysis of program areas by jurisdiction size was undertaken. Tables Two and Three show the relationship between interventions in program area types and the population of the health department jurisdiction. There is a trend that supports the notion that departments serving larger jurisdictions will also have the most culturally sensitive and linguistically appropriate interventions. This may be due, in part, to the fact that larger jurisdiction are the most likely to have racial and ethnic diversity and departments will have the need to provide appropriate and sensitive interventions to diverse populations.

Table Two. Linguistically Appropriate Interventions by Program Area and Population of Jurisdiction Served

Jurisdiction Size	Health Promotion	Health Protection	Preventive Services	Surveillance
0 to 24,999	59%	22%	63%	8%
25,000 to 49,999	64%	36%	76%	8%
50,000 to 74,999	87%	53%	93%	20%
75,000 to 99,999	100%	43%	100%	43%
100,000 to 249,999	87%	55%	94%	19%
250,000 to 499,999	88%	56%	88%	19%
500,000 to 999,999	100%	100%	100%	33%
1,000,000 and over	80%	80%	100%	0%

Table Three. Culturally Sensitive Interventions by Program Area and Population of Jurisdiction Served

Jurisdiction	Health Promotion	Health Protection	Preventive Services	Surveillance
0 to 24,999	46%	15%	43%	9%
25,000 to 49,999	50%	32%	58%	8%
50,000 to 74,999	53%	40%	73%	13%
75,000 to 99,999	86%	29%	100%	14%
100,000 to 249,999	68%	45%	84%	16%
250,000 to 499,999	88%	50%	88%	19%
500,000 to 999,999	67%	78%	89%	11%
1,000,000 and over	100%	80%	100%	20%

Intervention Types

The above figures aggregate for intervention type across all program areas. Interventions included: informational materials, public service announcements, Internet, community outreach, on and off-site individual and group instruction. However, it is important to stress the majority of interventions were delivered through print materials and on-site individual and group instruction. Radio and television public service announcements and the Internet were not common communication modes, instead the majority of culturally sensitive and linguistically appropriate interventions were delivered through printed information materials or in-person individual and group sessions. *Appendix C* includes the specific frequencies for each of the intervention types across all program areas.

Summary Discussion

After conducting the key informant interviews, it is evident there is great interest among minority health organizations to obtain more information from LHDs. LHDs, in their governmental role of assuring the health needs of all residents with a jurisdiction, play a key role in reaching minority populations.

The interpretation of these data are limited by the fact that no information was gathered on the content of the interventions or the scope of the program area described. Each respondent was free to define the program area as they chose. Definitions were provided for “meeting special language needs” (linguistically appropriate) and “addressing cultural differences” (culturally sensitive). Overall, this study provides important baseline data and sets the stage for additional contextual research on intervention strategies and modifications to enhance cultural sensitivity and linguistically competent programs.

Using the baseline data gathered in this effort, especially the aggregate data presented in Figure Six, it appears that most local health departments are engaged in some sort of culturally sensitive and linguistically appropriate intervention in the areas of health promotion and preventive services. In the area of health protection, 43% of health departments reported at least one linguistically appropriate intervention and 35% reported a culturally sensitive intervention. These percentages are below the 50 percent guideline noted in the objective. In addition, many jurisdictions are not providing linguistically appropriate or culturally sensitive surveillance and data systems programs. Exactly what can be done to increase the percentage in this area should be the focus of continued discussion.

The results of this study yield important data for public health practitioners, policymakers, health educators, academicians, and other community health stakeholders. As health equity becomes an increasingly visible federal priority, NACCHO encourages additional research in this area. This study provides a baseline for continued collaborative efforts to strengthen and improve the health of all communities.

Appendix A

Appendix B

Appendix C

Question 1: Programs and Interventions

In the past year, which of the following programs and interventions were provided in your jurisdiction, either directly by your local health department or through a contractual agreement with another organization? Please place an "X" in all boxes that apply.

PROGRAMS	INTERVENTIONS										
	Informational Materials		Public Service Announcement		Internet	Community Outreach	On-Site		Off-Site		Other (specify)
	Print	AV	Radio	TV			Individual Instruction	Group Instruction	Individual Instruction	Group Instruction	
HEALTH PROMOTION											
Physical Activities and Fitness	48	26	7	5	2	27	25	25	17	33	
Nutrition	81	37	19	12	5	51	73	52	38	49	
Tobacco	78	31	20	18	4	50	52	33	31	47	
Alcohol and Other Drugs	64	18	9	7	3	31	45	19	27	33	
Family Planning	75	35	14	8	4	45	72	32	40	39	
Mental Health and Mental Disorders	27	4	2	3	1	13	24	12	16	14	
Violent and Abusive Behavior	48	12	6	5	1	23	28	14	17	21	
Educational and Community Based Programs	56	23	18	14	6	47	33	34	32	51	
HEALTH PROTECTION											
Unintentional Injuries	50	18	10	8	4	26	28	24	21	31	
Occupational Safety and Health	37	13	3	3	1	12	22	18	17	23	
Environmental Health	70	26	18	16	8	37	48	36	51	49	
Food and Drug Safety	61	19	12	10	6	30	35	32	34	39	
Oral Health	59	24	6	5	3	33	43	21	33	39	
PREVENTIVE SERVICES											
Maternal and Infant Health	86	39	19	12	4	55	82	43	53	47	
Heart Disease and Stroke	73	21	12	10	4	37	51	22	30	39	
Cancer	74	22	14	11	3	42	56	23	35	36	
Diabetes and Chronic Disabling Conditions	71	18	9	8	4	32	54	21	28	32	
HIV Infections	84	39	18	14	5	53	75	34	45	58	
Sexually Transmitted Diseases	86	37	12	9	5	50	78	33	44	53	
Immunization and Infectious Diseases	93	43	40	24	7	65	84	41	54	58	
Clinical Preventative Services	61	18	13	10	4	40	57	29	33	34	
SURVEILLANCE AND DATA SYSTEMS											
Surveillance and Data Systems	32	3	4	3	6	21	16	14	14	17	
OTHER (specify)											

Question 2: Meeting Special Language Needs Through Linguistically Competent Services and Materials

In the past year, which of the following programs and interventions were adapted and/or provided to meet the **special language needs of any racial/minority population you serve**, either directly by your local health department or through a contractual agreement with another organization? Please place an “X” in all boxes that apply.

PROGRAMS	INTERVENTIONS										
	Informational Materials		Public Service Announcement		Internet	Community Outreach	On-Site		Off-Site		Other (specify)
	Print	AV	Radio	TV			Individual Instruction	Group Instruction	Individual Instruction	Group Instruction	
HEALTH PROMOTION											
Physical Activities and Fitness	18	4	1	2	1	9	10	6	7	10	
Nutrition	54	17	3	3	1	16	43	19	21	17	
Tobacco	37	9	5	2	0	16	19	11	13	14	
Alcohol and Other Drugs	29	7	1	2	0	11	18	9	12	14	
Family Planning	50	14	2	2	1	18	47	19	17	16	
Mental Health and Mental Disorders	8	2	0	1	0	6	10	4	5	6	
Violent and Abusive Behavior	21	4	1	2	0	11	15	7	9	9	
Educational and Community Based Programs	27	5	2	2	0	17	18	14	17	20	
HEALTH PROTECTION											
Unintentional Injuries	16	4	2	2	0	8	10	7	10	9	
Occupational Safety and Health	8	2	1	1	0	4	6	4	4	5	
Environmental Health	26	5	2	2	1	10	14	7	14	12	
Food and Drug Safety	19	4	2	1	0	6	12	7	10	9	
Oral Health	24	6	2	2	0	11	21	10	16	13	
PREVENTIVE SERVICES											
Maternal and Infant Health	56	16	4	2	0	21	49	22	29	20	
Heart Disease and Stroke	27	5	0	2	0	11	21	10	16	11	
Cancer	35	5	1	3	0	14	23	11	16	13	
Diabetes and Chronic Disabling Conditions	28	7	1	3	0	13	25	10	16	10	
HIV Infections	50	10	3	3	1	21	44	19	28	25	
Sexually Transmitted Diseases	53	10	2	2	0	17	45	18	25	21	
Immunization and Infectious Diseases	65	14	6	4	0	26	56	24	33	26	
Clinical Preventative Services	28	5	2	2	0	17	29	13	14	14	
SURVEILLANCE AND DATA SYSTEMS											
Surveillance and Data Systems	11	1	0	0	1	6	6	2	4	4	
OTHER (specify)											

Question 3: Addressing Cultural Differences Through Culturally Appropriate Programs and Interventions

In the past year, which of the following programs and interventions were adapted and/or provided to address the **cultural differences of any racial/minority population you serve**, either directly by your local health department or through a contractual agreement with another organization? Please place an “X” in all boxes that apply.

PROGRAMS	INTERVENTIONS										
	Informational Materials		Public Service Announcement		Internet	Community Outreach	On-Site		Off-Site		Other (specify)
	Print	AV	Radio	TV			Individual Instruction	Group Instruction	Individual Instruction	Group Instruction	
HEALTH PROMOTION											
Physical Activities and Fitness	15	4	3	2	1	12	8	5	6	10	
Nutrition	37	10	4	3	1	18	30	17	17	17	
Tobacco	26	7	5	3	1	17	16	11	12	14	
Alcohol and Other Drugs	21	4	1	1	0	11	13	9	12	12	
Family Planning	34	10	3	2	0	16	30	13	17	14	
Mental Health and Mental Disorders	7	2	1	1	0	4	7	4	4	5	
Violent and Abusive Behavior	16	4	1	1	0	8	11	5	6	6	
Educational and Community Based Programs	21	6	4	4	1	16	16	11	11	15	
HEALTH PROTECTION											
Unintentional Injuries	11	5	2	2	1	8	9	6	9	11	
Occupational Safety and Health	6	3	1	1	0	5	7	4	6	5	
Environmental Health	17	5	2	3	1	14	1	9	14	12	
Food and Drug Safety	13	3	2	2	1	9	13	8	10	7	
Oral Health	17	5	2	1	0	10	14	9	13	12	
PREVENTIVE SERVICES											
Maternal and Infant Health	37	11	6	4	1	22	34	15	23	18	
Heart Disease and Stroke	23	5	2	3	1	14	20	11	12	14	
Cancer	24	5	4	3	1	16	20	10	13	17	
Diabetes and Chronic Disabling Conditions	22	6	3	3	1	11	19	9	13	12	
HIV Infections	41	12	5	3	1	27	37	21	30	30	
Sexually Transmitted Diseases	37	10	4	3	1	24	33	20	26	27	
Immunization and Infectious Diseases	40	10	6	5	1	27	39	18	25	22	
Clinical Preventative Services	22	6	4	2	1	18	22	14	15	16	
SURVEILLANCE AND DATA SYSTEMS											
Surveillance and Data Systems	9	1	2	1	1	6	3	2	3	4	
OTHER (specify)											

NACCHO Minority Health Project: Key Informant Interview Report September - October 1997

Background:

As the United States population becomes increasingly diverse and the health care system becomes increasingly complex, addressing the linguistic and cultural needs of its residents, in terms of receiving adequate health care, will become progressively more important. According to *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*, by the year 2000, members of racial and ethnic minority groups will account for one-fifth of the U.S. population. In addition, within many communities, right now, minority as a word to identify a ethnic group is no longer correct in terms of actual numbers.

This increasing diversity has serious public health implications for local health departments (LHDs) in its function of assuring that the health needs of all residents within a jurisdiction are met. For example, according to *Healthy People 2000*, minority communities, many of which are disadvantaged, lag behind the overall U.S. population on virtually all health status indicators. It is also well documented that mainstream health education activities fail to reach minority populations. Additionally, it has become vitally important that public health activities are designed to ensure complete understanding, linguistically and culturally, between the public health workforce and community residents. This entails the incorporation of approaches and strategies to recognize the influence of linguistic differences and cultural group membership.

Introduction:

In 1996, the Office of Minority Health, U.S. Department of Health and Human Services (OMH) contracted with the National Association of County and City Health Officials (NACCHO) to develop, implement, and evaluate the results of a study, which would provide some much needed baseline data for *Healthy People 2000* Service and Protection Objective 8.11. This objective states, "Increase to at least 50 percent the proportion of counties that have established culturally and linguistically appropriate community health promotion programs for racial and ethnic minority populations." At that time, it was recommended that the questionnaire for this study may also provide a mechanism to collect other much needed information pertaining to local health department minority health activities.

As part of the process of developing further lines of questioning, NACCHO, in cooperation with OMH, has undertaken a key informant study. Information gathered from these interviews will be useful in framing questions and providing information that will be helpful for future programmatic and policymaking.

Methodology:

Between September 22 and October 3, 1997, key informant interviews were conducted with representatives of 47 minority health agencies. Organizations ranged from state minority health offices to local health councils. Selection of these agencies was not random. The Office of Minority Health world wide web page (<http://www.omhrc.gov/>) was used to obtain an initial listing of the minority health organizations nationwide. This list is broken down by racial/ethnic group and specific disease (AIDS, heart disease, etc.). This categorization helped to select agencies that represented many various racial/ethnic groups, locations, and health diseases.

In addition, contacts were made with other agencies that have designed similar surveys dealing with ethnic groups and/or health issues. A listing of organizations was also obtained from other NACCHO publications and staff members who have worked on similar projects. Furthermore, discussions with key informants led to recommendations for further contacts. Several of these recommendations were used for follow up.

The key informant calls were usually made to either specific contact persons, if listed, or with the director of the organization. In some cases, referrals were then made to minority health or information specialists. The conversations usually lasted between 10 to 15 minutes depending on the respondent.

One general question was asked:

What types of minority health information would be valuable for your organization to obtain from LHDs?

If individuals had difficulty providing answers, further probing was conducted. For example, Hispanic health institutes were asked if there were predominate health issues within the Hispanic community and whether activities of LHDs might relate to these. Through probing, several additional areas of interest surfaced.

In addition, as a result of one of the phone conversations, a NACCHO staff member was invited to a meeting with the Virginia State Health Commissioner's Minority Health Advisory Committee in Falls Church, Virginia, to gain additional insight. The present committee was made up of eight members from varying races and professions. Only one hour was allotted for the presentation and it was obvious that the issues presented were only the beginning of the conversation. Talks are continuing with some of the members to further develop possible questionnaire questions.

A complete listing of the key informants can be found in Appendix A. (NOTE: There is a predominant number of Hispanic community health organizations. This was the result of a large listing received through one of the informants and is not intended to over-represent any racial/ethnic group.)

Results:

A wide range of information was gathered through the key informant discussions. This information will help in the development of a survey instrument. While many of the responses from individuals varied due to their constituency and location, there were numerous common themes that ran through many of the conversations. The following describes some of the information attained during the key informant interviews.

First of all, health organizations that had a specialty, i.e. cancer, were very interested in programs that targeted minority populations focusing on that specialty. Even general health organizations would like to know about the sustainability of programs being offered. Questions about the racial composition of the LHD workforce, especially in relation to their constituency, were also frequently mentioned.

Collaboration was another common theme from many organizations. Not only collaboration with other private and public health institutes to provide linguistically or culturally appropriate services, but collaboration of the LHD with the community it serves.

Some issues were predominate among certain racial/ethnic groups. For example, most Hispanic health organizations were concerned about the type of linguistic services being offered, especially in the area of translators. In addition, many Asian health organizations mentioned interest in gaining information about the acceptance of cultural (homeland) health practices and their place within the U.S. medical system.

Furthermore, there were some responses that were not as common, but provide a good backdrop for other issues that concern minority health agencies. For example, some agencies would like to have more information about the impact welfare reform, the child care initiative, and the increased influence of managed care organizations have had on the quality and types of services LHDs provide to the minority community.

There were also a few responses regarding needs assessments. Specifically, do LHDs conduct them and if so, are they able to target funds toward areas in need. Similarly, questions dealing with program monitoring and consumer evaluation and their effectiveness at changing policy were also mentioned. Finally, some organizations thought it would be helpful to provide a section for LHDs to identify what information they would like to receive from outside health agencies.

In addition, many health organizations inquired about receiving information that they could in turn provide to their constituency regarding the types and interventions of culturally and linguistically appropriate programs that are available. Furthermore, there were a small number of basic questions regarding the location, hours of the clinic(s), any specific bilingual service hours, type of intake information required, and the available modes of transportation to and from the clinic. Issues of family involvement in making health decisions were also mentioned.

In essence, most key informants representing health agencies perceived a lack of connection between the LHD and community residents. This lack of connection leads to not understanding the needs of the community and to not having a mechanism to communicate the services that are available.

A complete listing of key informant responses is found in Appendix B. They are not direct quotations from the respondents, but a summary of their responses.

Discussion/Recommendations:

After conducting the key informant interviews, it is evident there is great interest among minority health organizations to obtain more information from LHDs. LHDs, in their governmental role of assuring the health needs of all residents within a jurisdiction, play a key role in reaching minority populations.

Clearly, some of the desired information will be collected in the aforementioned study that NACCHO will conduct to establish baseline data for *Healthy People 2000* Service and Protection Objective 8.11. This study will assess types of programs being offered that are meeting cultural and linguistic needs of racial and ethnic minority populations.

Other information, such as the types of collaboration and specific linguistic and cultural programs currently offered as well as those needed within a community could be collected in a companion study. Combined they will create an essential baseline from which to work in creating a greater understanding of minority and culturally diverse populations, as well as to develop and implement programs to better meet the various needs of all of our nation's residents.