

Preventing Heart Disease and Stroke in Minnesota

Community and Professional Leaders Discuss Cardiovascular Health and Disease Prevention

**As reported by members of the American Indian,
African American, Asian, and Hispanic/Latino Communities**



**Summary Report - February 2003
Minnesota Department of Health
Minnesota Heart Disease and Stroke Prevention Initiative**



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Background Information

The Minnesota Department of Health (MDH) received core capacity funding from the Centers for Disease Control and Prevention (CDC) on September 30, 2000. The goal of the core capacity funding was to undertake a broad and inclusive planning process to build consensus among representatives from medical, educational, tribal, and community-based organizations to develop a cardiovascular health (CVH) plan for all people living in Minnesota.

Cardiovascular disease (CVD) refers to a wide variety of heart and blood vessel diseases and conditions, including coronary heart disease, stroke, high blood pressure, and rheumatic heart disease. The underlying disease process of the major forms of CVD is a slowly progressive condition that begins in childhood. It is associated with several modifiable risk factors including: high blood pressure, high blood cholesterol, cigarette smoking, physical inactivity, diabetes, and poor diet. Control of these risk factors is key to preventing CVD and its complications.

In order to develop strategies for improving a population's health status, it is crucial to understand how different populations view and experience cardiovascular health and cardiovascular diseases. It is important to understand cultural variation in language, diet, lifestyle, spiritual beliefs, health beliefs, health experiences, immigration, discrimination, racism, poverty, and lack of education, and how these factors impact the health status of different populations and their use of, and trust of, the Minnesota health care system.

Overall, Minnesota has one of the lowest rates of cardiovascular disease in the United States. However, some populations in Minnesota suffer disproportionately from cardiovascular disease, including American Indians, African Americans, and Asians. American Indians in Minnesota have a death rate from diseases of the heart that is 36% higher than the national death rate of American Indians and a 30% higher death rate than Caucasians in Minnesota. African Americans in Minnesota have a 26% higher death rate from diseases of the heart and a 38% higher rate of stroke compared to the Caucasians in Minnesota. Asian Americans in Minnesota suffer disproportionately from stroke—the death rate from stroke is 59% higher than the national stroke death rate of Asian Americans and 44% higher than Minnesota Caucasians¹. Because of these disparities, it is important to study these populations to begin to understand the factors that contribute to these high rates.

To better understand the disparities in CVD, the Minnesota Department of Health embarked on a process to understand how people think and feel about cardiovascular disease, its risk factors, and the health care system. Also from this process, MDH hoped to learn which community and environmentally based strategies might best help people start and maintain healthy behaviors. The process included interviews with individuals from the American Indian, African American, Hispanic/Latino and Asian American communities. The purpose of these interviews was to gain an understanding of the institutional and organizational

¹ These percentages are based on the 1999 age-adjusted rates, adjusted to the 2000 total US population.

barriers to maintaining healthy lifestyles for populations at risk for cardiovascular disease. The following report describes the key messages and findings that were collected as a result of the meetings and conversations with these community members.

Key Findings

Cardiovascular Health Awareness

- « People are not thinking about preventing heart disease or stroke, unless they have a family member or friend who has been personally affected by a heart attack or stroke.
- « Some people are unaware of the disease because they don't understand the risk factors (e.g., high blood pressure, high cholesterol.)
- « People do not think about cardiovascular disease unless they have experienced a symptom.
- « Heart disease does not have the same heightened level of awareness as diabetes does in the American Indian community. In addition, American Indians expect to get diabetes.
- « A teenager is more likely to be aware of cardiovascular disease if their parent or grandparent has had an acute event. Youth think they are invincible, or they want to enjoy life now and worry about their health in the future.
- « A variety of words and phrases are used to describe heart disease and stroke, such as “heart attack”, “indigestion”, and “paralysis”.

Barriers to Healthy Lifestyles

- « Racism, poverty, alcohol use, drug use, fear of deportation, illiteracy, and fear and mistrust of the health care system complicate securing medical care or sustaining healthy behaviors.
- « Mental health conditions, such as depression and anxiety, impede a person's ability to implement healthy behaviors.
- « The two most frequently reported barriers to receiving medical care were lack of cultural sensitivity and lack of health care insurance.

Beliefs

- « Many people believe that family history, genetics, or affiliation with one particular ethnic group is the cause of heart disease or stroke.
- « Some people believe that “it was just something that happened to me” or that it was a “curse” or “bad destiny” to have a stroke or heart attack.

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- « Some people have an understanding that risk factors are the underlying cause of heart disease.
 - « Community members will believe a health prevention message that comes from a member of their same ethnic group.

Risk Factors and Behavior Change

- « The ability to make behavior changes (e.g., quitting smoking, changing diets, engaging in physical activity) is influenced by income, age, and education level.
- « Some immigrants to the United States are not familiar with the concepts of preventing chronic disease or modifying health behaviors.
- « The three most influential factors on youth in regards to their health decisions are peers, media, and family.

Section I: Cardiovascular Disease Awareness

Q In the health industry, there are a several terms to describe heart disease and stroke, such as heart attack, hypertension, high blood pressure, high cholesterol and cardiovascular disease. What is it called in your community?

Heart attack, heart problems, high blood pressure, stroke and high cholesterol were the most popular answers in descending order. However, communities have different perspectives on the terminology used to describe the disease. For example, an African American community leader explained it this way:

“...People do not talk about heart disease. If they do, it is in general terms, not medical terms. They may say things like “I had to give up salt”, “I have high cholesterol”, or “I have hypertension”.”
- Program Director, Urban Early Childhood Development and Family Services Agency

An Asian community leader eloquently described the confusion that exists about chronic conditions in her community:

“In the Hmong language, there isn’t always terminology to describe disease. People will use expressions such as “My blood is too high” or “I have heart problems”. There is some confusion in our community where people think that high blood pressure and diabetes are the same problem. We are trying to educate people that they are two separate illnesses.”
- Hmong Health Coordinator, County Public Health Department

Q Based on what you see and hear, are community members thinking about heart disease?

From these discussions, four different levels of heart disease and stroke awareness were described. First, some people are not at all aware about cardiovascular disease or the disease process. Next, a majority of people responded that they are more aware of the disease after a family member or friend had a heart attack or stroke. This association with someone who had already suffered an acute event, had increased their personal awareness of their own health status. The third level of awareness is that people are not thinking about cardiovascular disease unless they have personally experienced some type of symptom or risk factor (e.g., high blood pressure or high cholesterol). Lastly, some people are aware of cardiovascular disease and its risk factors, but unaware of how to change their behavior in order to prevent the disease. For example, they need to know how to cook low-fat meals or incorporate more physical activity into their lives.

It was reported that American Indians are more aware of diabetes than heart disease. And American Indians expect to get diabetes, but not necessarily heart disease. The heightened awareness of diabetes was attributed to the physical effects caused by diabetes, such as blindness or amputation. Seeing their friends and family members with these conditions, plus taking insulin medication, made some people more aware of diabetes. It was difficult to describe how someone would look if they had cardiovascular disease.

Many theories were provided as to why people are not aware of preventing heart disease and stroke. The three most commonly cited reasons relate to economic status, education, and cultural background. First, people living at, or below, the poverty level are more concerned with basic needs such as food, clothing, and housing, rather than preventing a chronic health condition. Many people place all their energy into earning a living that they do not have time to think about preventing illnesses; they only hope that no one in the family becomes ill. The issue is especially applicable to recent immigrants to the United States.

Secondly, many people said that the lack of formal education impedes the community members’ awareness of heart disease and stroke. Whereas, if someone grew up in a household in which a parent completed college or received some type of health care training,

his or her children were more likely to grow up knowing that it was important to eat nutritious food and participate in physical activities.

And lastly, a person's cultural background may inadvertently put them at a disadvantage for being aware of cardiovascular disease. For example, for some community members, taking steps to prevent disease is a concept that is unfamiliar to them, especially for Southeast Asians and Hispanics/Latinos. Their homelands did not have systems or programs in place to prevent disease, only to treat disease. People visited a doctor or a medical man, only when they were ill, and not for a routine physical. Or, people would visit the pharmacist for consultation, and not necessarily the doctor if they were ill. And some immigrants didn't have access to medical care at all in their homeland. The United States' health care system, which does have an emphasis on prevention, is quite different from what some people are accustomed.

Q When a community member finds out, from a health care provider, that they have heart disease or have had a stroke, what would he or she think caused it?

Many people believe that family history, genetics, or affiliation with one particular ethnic group is the cause of heart disease or stroke. Several people also believe that "it was just something that happened to me." And some stated that it was a curse or bad destiny that brought about their disease. A Vietnamese woman who coordinates a health program at a social services agency described the cause of heart disease and stroke in the following way:

"People will think that the disease was caused by ancestry. Or they would think "it's a curse", and has been caused by spiritual influence, such as someone else's behavior and activities, such as my aunts and uncles. Or they will think that it has been caused by not eating well. Their response will depend on their understanding of the body and Western medicine."

- Health Coordinator, Vietnamese Community Social Services Agency

Several people reported that as the education level increases, more people are going to understand that heart disease or stroke are caused by several modifiable risk factors. And as that level of awareness of increased, people were able to distinguish that they had more control over their health status and wellness.

Section II: Barriers to Preventing Heart Disease and Stroke

During the interview process, many people mentioned issues that impact the family system, the individual's behavior, and their attempt to live heart-healthy. These issues were described as barriers that had to be removed before people could make healthy choices and lead healthy

lifestyles. These barriers include racism, poverty, alcohol use, drug use, depression, illiteracy, and fear and mistrust of the health care system. The following quote explains these forces that people encounter.

“To quit smoking would be very hard, especially if your insurance does not pay for it. Making changes in your lifestyle, for example reducing coffee and soda pop, or stop smoking, would be real hard. American Indians use things for stimulants (coffee, cigarettes, soda pop) because of depression due to grief issues; it is not likely that they would change drug, alcohol, and cigarette use.”
- Program Director, American Indian Social Service Agency

Some of the experts interviewed believe that unless these issues are addressed first, people will continue to live unhealthy lives. For example, people explained how there is a relationship between eating unhealthy meals and living in poverty. If a family is poor, they are more likely to afford the cheaper selections served at fast-food restaurants than the nutritious, sometimes more expensive, fruits and vegetables.

“In North Minneapolis, liquor stores are easier to find than grocery stores. There are no major grocery stores here, which make it easier for people to acquire bad habits. There are plenty of McDonald's and Burger Kings in North Minneapolis, but no grocery stores. There is a [grocery store], but they have poor quality and their prices are high. There is no accessibility to things that increase healthy habits.”
-Administrator, North Minneapolis Health Services Agency

In addition to addiction and poverty, it appears that mental health plays a role in health promotion choices. For example, while speaking with Asian American community leaders, feelings such as “worry” and “stress” were cited more frequently than in conversations with leaders from the other ethnicities. The following quote illustrates the impact of one’s mental health status on one’s physical well-being.

“I am concerned about the physical and spiritual components of health. I want to help change the attitude in our community, so people are happy and less worried. If people are not eating well or sleeping well, that will make them unhealthy. People are depressed, and not living healthy...”
- Executive Director, Vietnamese Social Services Agency

Many people said that before people can work on being heart healthy, they have to reduce stress, racism, poverty, illiteracy and limited access to health care. However, when people were asked to give specific examples of how they would make changes to their community, or how they would improve heart health, they still were able to make concrete suggestions. (See page 15 to review these recommendations for preventing cardiovascular disease.)

Section III: Health Care Services and Cardiovascular Health

Q If a community member had a health care problem or was feeling ill, who is someone they would trust to get information from?

Family, friends, doctors and nurses were frequently mentioned as trusted people from whom to get health information or advice. A health and social service program director at a Hispanic community agency said that Hispanics/Latinos would trust a teacher, a *consejera*, or a counselor for health information. A Latino community member would also trust a non-profit organization providing health and human services. These sources are trusted because they do not pose a threat to a Latina's immigration status.

When this question was asked to the representatives from the American Indian community, many commented on the lack of trust and comfort that American Indians feel with medical providers. That lack of trust is the result of medical providers lacking cultural sensitivity or cultural knowledge.

People across all the communities said that community members will try home remedies, or will try to fix their own health problems, before they seek assistance from someone else-- whether it be a doctor, nurse, or health educator.

Q What are the barriers that prevent community members from getting care from a health care provider?

The two most frequently reported barriers are lack of cultural sensitivity and lack of health care insurance. People described lack of cultural sensitivity with two primary examples. The first is in patient treatment and care. People of color do not always feel respected by health care providers, and consequently mistrust the medical system. They do not feel respected as an individual, or as a member of a minority community. This feeling of disrespect stems from the providers' lack of knowledge about the minority communities. Community leaders from all four minority populations described this feeling.

The clinics' physical environments manifest the second example of how clinics lack cultural sensitivity. For example, some community clinics or hospitals are designed for the majority, Caucasian population, and they are not culturally affirming to people of different cultures.

Interviewees explained that people did not have health insurance primarily because they could not afford to pay for it. If they did have health insurance, the co-payments were high

and prevented them from visiting a health care provider. In fact, treating maladies with home remedies was cited as a response to a health problem.

Additional barriers noted were poverty, illiteracy, and fear of deportation because they all complicated the process to secure medical care. In addition, other barriers mentioned were the lack of transportation, lack of awareness of available services, or lack of awareness of health care problems. One community member stated, “Some people lack education as to why primary care is important.” Tribal communities staff members stated that the lack of adequate space to host physical activity programs or nutrition classes was a barrier to meeting the medical needs of their community members. One person described obesity as a barrier to improved health outcomes, because that condition makes it more difficult for youth to participate in physical activities with their peers, increasing social isolation and stigmatism.

Section IV: Risk Factor Identification

Q When a community member finds out from a health care provider that they are at risk for heart disease, how would they react? What kind of changes, if any, would they make or try to make to their lifestyle?

Leaders said that it was hard to generalize and describe how all people would react to the news that they were at risk for heart disease. They indicated it was likely that educational background and income factor in how they would react to the news. For example, if someone was raised in a household that had adequate access to health care, he or she would probably be less fearful of a diagnosis.

People stated that it is difficult for anyone to make behavioral or lifestyle changes. They said it was hard to respond to a question that asked generally about which changes people would make. Behavior changes are influenced by personality, history of care within the medical system, and cultural history. However, two common responses were provided.

The first is that some people would be full of worry or fear when told by their doctor that they are at risk for heart disease or stroke. In some cases, those feelings of worry and fear could paralyze people from taking steps to reduce their risk. Or, in other cases, that fear and worry could inspire them to follow the doctor’s orders for mitigating the risk factors. For example, in the Asian American community, fear and worry were the most common responses to a risk diagnosis. These community leaders explained that some would be frozen

in fear, or the fear would motivate them to carefully listen to the doctor, and share the treatment information within the community, especially with the elders².

The second response was one of fatalism or a death wish. Some people would respond that “we’re all going to die anyways” or “this is the way it is in my community.” This concept of uncontrolled destiny, or lack of control over one’s health condition, was most frequently mentioned by American Indian community members. However, representatives from all the interviewed communities shared this philosophy. People explained that this belief of uncontrolled destiny was the result of several different factors, such as the influence of alcohol use, depression, and poverty in the household. In some cases, this lack of control over one’s life was due to the lack of education about the disease, the disease process, or the risk factors. This lack of education, along with the presence of larger issues in one’s life, will prevent a person from making changes in some instances. For a person living in poverty, it would be difficult to make healthy changes; they would be less likely to afford a membership to a health club, or pay for health insurance, or buy fruits and vegetables.

However, for people who are economically stable, cardiovascular disease symptoms would have to be present to motivate healthy lifestyle changes. Or they would have to feel pressure from a family member or friend to implement changes.

When asked what type of change people would be likely to make after given a diagnosis by a doctor, there was no consensus. Some people stated that diet would be difficult to change, while others felt that smoking would be more difficult to stop. Many people stated that people would comply with taking medication if prescribed by a doctor, and if they could afford to pay for it. The ability to change a specific health behavior depends on income, age, and education level. A few people explained that in order to help prevent cardiovascular disease, more time for discussing how to change behaviors was needed. One person believes that it is the “medical field’s attitude to treat and not to prevent.”

² Elder is a title given to a member of an Asian or American Indian community. An elder is someone who is respected for his or her wisdom, knowledge of traditional American Indian culture and practices, and whose life experiences are shared with the younger generation. No specific age range is affiliated with an elder.

Section V: Ecological and Societal Influencers on Health Behavior

What organizations or individuals influence the decision adults make with regard to health habits?

Trusted health care providers, family, friends, and someone who can speak from personal experience about their disease, have the most influence over adults' health related decisions. For example, people cited that it is helpful to hear a former smoker describe how they quit smoking. This personal testimony is especially valued in the American Indian community. People within the same community can learn from others who have made positive health-behavior changes in their lives.

In the African American and Hispanic/Latinos communities, religion or faith influence people's behavior. For these communities, their religion or faith provides a framework for making decisions.

In the American Indian community, it was suggested that a person who holds firmly to traditional native values, could positively influence other people in the community to make healthy decisions. A tribal board member of an urban tribal community elaborates:

“We need to bring and instill Native based values into our children. If a person learns to respect the environment and integrate a balance into their lives, and if a person lives the culture, consequently, he will eat healthy foods, be physically active and treat others well. It takes knowledge to do that and a special person. Someone who is truly Indian, and knows what that means. If you would find someone like that, people who live the culture, that would help our community's health.”
- Tribal Board Secretary/Treasurer

Some people believed that changes in adult lifestyle or behavior are not possible. For example, after several years of eating high-fat foods, or physical inactivity, it is extremely difficult for people to initiate new lifestyle practices and changes. Consequently, some people reported that adults cannot be influenced by anything in order to change.

Additional influences include the fast-paced lifestyle, the availability of fast-food restaurants, the media and children. Children were mentioned as being a positive influence on their parents' health habits. For example, a child could encourage their parent to quit smoking.

Q What organizations or individuals influence the decisions youth make in regards to health habits?

In descending order of frequency, the three most influential factors on youth in regards to the decisions they make about their health habits are peers, media, and family. Television, radio, Internet, movies, and entertainment stars were all listed as influential.

Four interviews were conducted with professionals who work with youth, either in the school or recreational settings. Specific health questions for the youth population were developed for these meetings. The following information represents their responses. If a child learns positive health behaviors in the home at a young age, they'll be less influenced by negative behaviors by peers in their teens. For example, if parents role model healthy behaviors to their children, such as eating healthy food and not smoking cigarettes, the children will have a stronger base to reject unhealthy food and smoking when they get older.

Conversely, a few experts explained that if a child is exposed to a message about healthy eating or physical activity, it's crucial for that message to be reinforced in the home. The following quote describes this process:

“Learned behavior comes from the community, family, and individuals. For example, if a community is filled with gambling, alcohol and drugs, young people will do what they see. And if someone comes to teach about health and the adults laugh at them, the youth will learn this and do the same.”
- American Indian Patient Advocate, Local Hospital

Members of the Asian American and Latino communities explained how peer pressure is extremely complicated for youth. For example, Asian American and Latino youth are encouraged to maintain their families' traditional values and practices, while also being influenced by the American society. Acculturation into the American lifestyle tends to support unhealthy behavior such as eating more fast-food and being physically inactive. These habits were not part of their lifestyle prior to immigrating to the United States, but now, children are exposed to these frequently. Someone described this situation as a “power struggle”, where youth are caught between their native culture and the American popular culture.

“Eating habits depend on socio-economic status and if parents are working. If both parents are working, it is harder to cook nutritious food and kids are more likely to eat more fast food. Eating does have a lot do with economics and what is cheaper and more convenient to eat, but Hispanic teens are also influenced because they want to be more American and sometimes this means changing the way they eat.”
- Hispanic Patient Advocate, Local Hospital

According to the professionals who worked solely with the youth population, youth are similar to adults in that their awareness of heart disease and stroke increases after a parent or grandparent has a heart attack. Youth think they are invincible, or they want to enjoy life now and not worry about their health until later on in the future.

If health education messages are developed regarding cardiovascular disease risk factors, it is important to understand from whom youth will trust to receive information. Youth will trust someone with whom they have an established relationship, such as teachers, parents, youth workers, and friends. The following statement provides some insight into why they may distrust the system:

“Another barrier may be the parents, because they put into their kids’ minds to distrust the health care establishment. This distrust comes from the past history of studies and research on African Americans, for example the Tuskegee study. Also, with medication-some African Americans believe that the research studies for medication are done all on White people. Some believe that the medication may affect them differently because they are African American and not White. The distrust of the medical system needs to be broken down-by having people of color involved-this can help break down the distrust.”

- Social Worker, Duluth Area High School

Section VI: Community Recommendations for Improving Cardiovascular Health

Q We would like to assist you in making your community healthy. What changes would you like to see happen?

The following is a list of suggestions from community members. An asterisk indicates that more than one community member suggested this intervention. The changes that were suggested by community members appear to fall into one of two categories. Some suggestions are very specific in nature and could be implemented in the short-term future (less than one year.) Other suggestions were more systemic in nature, and most likely would require a longer period of time and more resources to implement.

Education (relating to several risk factors)

General Recommendations:

- ... Improve health messages and health education programs in schools, especially with teens.
- ... Find and create good role models in the community for health and well being.

... Educate medical providers about the connection between the mind, body and emotions, in order to develop comprehensive treatment plans with patients.

Specific Recommendations and Strategies:

- * Create lay educators, who could visit with men or women, to discuss preventing heart disease, and to encourage people individually to change their behaviors. La Prometora is a model program that is being implemented to some degree via the Andersen Elementary School in Minneapolis.
- * Create culturally appropriate education materials about heart disease and stroke risk factors that are colorful and easy to read.
- ... Provide brochures in clinic waiting rooms.
- ... Develop nutrition education programs for adults and youth.
- ... Incorporate healthy eating and exercising into existing programs. Offer incentives such as gift certificates for healthy foods.
- ... Offer programs that could teach people how to read food labels.
- ... Educate people about the symptoms of heart disease and stroke.
- ... Encourage Health Maintenance Organizations (HMOs) to advertise their services and educate people about health in community and local newspapers that serve communities of color.
- ... Encourage people to go to the doctor for annual physicals and to follow the doctor's orders to take medication to control blood pressure.
- ... Utilize and leverage community resources to improve marketing and advertising, so messages can be more powerful.
- ... Develop a prenatal education program for Hispanic/Latino mothers that encourages them to take care of themselves and their babies as it relates to nutrition and exercise.
- ... Rewrite curriculum in public schools to reflect an accurate history of American Indians. To help resolve poverty, educate people and validate the contributions of American Indians' role in American history. This would create a classroom that is welcoming, and the dropout rate will decrease. American Indians have a high drop out rate in school because it is not fun to go to school. Parents also have a history of not feeling welcome at school, and will be sympathetic to their kids and stop sending them to school.
- ... Re-define the image that American Indians have in the community. Develop a movie to educate people about the American Indian population and the genocide of indigenous people. Talking about the abuses and negative history experienced by a community can help with depression.
- ... We need to improve the dropout rate for American Indians in school.
- ... Fitness centers on reservations and in urban areas that teach nutrition and positive outlets for stress and depression.
- ... Teach more about the importance of good health, how to manage diabetes, and what to expect if someone suffers from a heart attack or heart disease.
- ... Involve churches in the process to educate African Americans about healthy eating.
- ... Extend clinic hours.
- ... Include the family in addressing the patient's illness or risk factors, so the family can support the person to make changes.

Physical Activity

General Recommendations:

- ... Incorporate exercise into people's lives.

Specific Recommendations and Strategies:

- ... Find and organize physical activity events that people of all ages can do together.
- ... Some community facilities that are available for physical activity are problematic because the locker rooms are not conducive to modest people. American Indians are modest people and utilizing these locker rooms can be a barrier.
- ... Develop walking clubs with small groups of people so they feel encouraged to continue.
- ... Provide child care where physical activities are offered, so it easier to participate.
- ... Educate people about what qualifies as a cardiovascular health workout.

Youth

General Recommendations:

- ... Need to teach youth that exercise is a tool for managing anger and can be a positive activity.
- ... More programs are needed for young people.
- ... Utilize different types of media to reach youth population, including famous people such as entertainment stars and athletes.

American Indian Community Recommendations

- ... For the American Indian community, focus on cultural traditions. Use creative methods for educating American Indians so they can make positive health changes in their lives.
- ... One-to-one interventions are more successful.
- ... Use American Indian media resources, including community newspapers, such as *The Circle*.

Appendix A: Methodology

In August 2001, the Minnesota Department of Health requested and received approval from its Institutional Review Board (IRB) to conduct key informant interviews with community members about heart disease and stroke.

In order to develop questions for the interview, staff reviewed studies that related to CVD and its risk factors that had been conducted with similar priority populations. These studies were reviewed to avoid collecting information that had previously been collected from the priority communities. For example, staff reviewed the Inter-Tribal Heart Study coordinated by CDC and the Minnesota Student Survey. After reviewing several studies, MDH staff developed questions and pre-tested the questions with individuals from the ethnic communities. Pre-testing occurred with at least one, and in some cases two or three, people per ethnic group. A final list of the interview questions is attached.

MDH staff from across several programs generated an initial list of potential interviewees. These potential interviewees were contacted by phone and asked if they would be willing to meet with staff to discuss heart disease and stroke. In the end, thirty-five interviews were conducted throughout the state. Interviews lasted between 45 minutes to 90 minutes.

The number of interviews conducted with leaders from each community were:

- Fourteen from the American Indian community;
- Seven from the African American community;
- Six from the Asian American community;
- Five from the Hispanic/Latino community; and
- Three from the multicultural community (worked with more than one ethnic group)

The people who participated in the interviews hold the following types of positions:

- ... American Indian tribal and urban health clinic directors, diabetes' program coordinators, and public health nurses;
- ... American Indian tribal administrators, tribal board members, and community leaders;
- ... Community clinic health educators, health administrators and program coordinators;
- ... Youth recreational program coordinators;
- ... High school social workers;
- ... Early childhood development program directors;
- ... Hospital patient advocates;
- ... Staff and board members from state agency minority councils;
- ... Foundation officers;
- ... American Indian school program coordinators
- ... County health department Hmong health coordinators;
- ... National Association for the Advancement of Colored People (NAACP) members;
- ... Community leaders; and
- ... Program directors or coordinators at non-profit health and social services organizations.

Prior to the starting the interview, MDH staff provided an introduction with some background information on the cardiovascular health program, and the timeline for developing a state cardiovascular health plan. Staff also defined the words “community” and “health care provider”. For example, “community” was defined as people of the same racial/ethnic background as the interviewee. And when the word phrase “health care providers” was used, it implied several different positions from within the medical care system, such as nurses, public health staff, doctors, counselors and others.

Interviewed community leaders identified additional people with whom to meet. Many of these people were contacted and interviewed.

MDH requested permission from the community leaders to share their comments and ideas in this final report. All the information recorded in this report is from conversations and interviews in which permission was secured.

Appendix B: Limitations

Many people stated that they would be pleased to give their opinion and answers to the questions, but they wanted to note that they could not speak for every person within a specific ethnic group. For example, when a staff person from a Vietnamese social services agency was interviewed, she shared her belief or understanding of how community members felt about a particular issue, but she was clear in pointing out that not all Vietnamese people would hold the same opinion. Thus, one limitation of this study is that these opinions may not be representative of all members of a community.

Another limitation of this project is that there was unequal geographic representation of people interviewed. Of the 35 interviews, only six were conducted with people who live outside the Twin Cities area. Time and travel constraints prevented additional out-state interviews.

For many of the interviews, two MDH staff were present. One staff person facilitated the conversation, while the other staff person recorded notes. In some cases, due to staffing constraints, only one person attended the interview, and performed both tasks, perhaps impacted the quality of some of the recorded field notes.

In some instances, it was not possible to compare findings across different cultures. This was due to the relatively small sample size per ethnic group.

In some cases, particularly for those conducted with people on the American Indian reservations, there were more than two people invited to attend the meeting, making it more difficult to differentiate comments made by several people answering questions simultaneously.

A final limitation is that two interviews were conducted via phone, which may affect the responses given or the information recorded.

Appendix C: Interview Introduction and Questions

Thank you for taking time to talk with us. The Minnesota Department of Health received a planning grant from the Centers for Disease Control to prevent heart disease. Approximately 25 other states also received grants. Eventually, we hope to improve cardiovascular health for people living in Minnesota. So far, we have met with the tribal health directors and the Indian Affairs Council to talk about this project, and we've sent letters to the Minnesota tribal chairmen and women about the project. We've visited five reservations. Locally, we've spoken to representatives from the _____. We met with staff from _____. We are scheduled to meet with _____ and _____. We have put calls into _____ and _____. As of the end of June, we're fully staffed for the project. At this point, we're not able to give out grant money. But, in future, if we were to receive additional funding, grant dollars may be available.

Today, we'd like to get your opinion and impression about heart disease, lifestyles and the health habits of people in your community. For our discussion, we will use the words "community" and "health care provider" frequently. When we say community, we mean the people of the same racial/ethnic background as you. When we say health care providers, we mean nurses, public health staff, doctors, counselors and others.

Finally, we will summarize the comments made by the people with whom we conduct meetings, in a final report. If you agree to have your comments included, your name will remain anonymous in this report. However, we would like to mention your position title and organization, collectively, with the other people with whom we speak. While we are compiling the report, if we find that we would like to utilize your name, we will call you and request that from you. You still have the option to say "no" at that point in order to keep your comments confidential. If at any point you no longer want to participate please let me know and we will conclude our meeting. There are no right or wrong answers to these questions. If you do not want to answer any particular question, just say so.

Now, do you have any questions before we begin?

- 1.) Based on what you see and hear are community members thinking about heart disease?
If answer is NO: Probe 1b.) If not, why?
If answer is YES: Probe 1c.) If they are thinking about it, how important is it?
- 2.) If a community member had a health care problem or were feeling ill, who is someone they would trust to get information from?

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- 3.) In the health industry, there are a lot of different terms for heart disease and stroke, such as heart attack, hypertension, high blood pressure, high cholesterol and cardiovascular disease; what is it called in your community? *Note: Interviewer briefly describe risk factors.*
 - 4.) When a community member finds out from a health care provider that they are at **risk** for heart disease, how would they react?
 - 5.) What kind of changes, if any, would they make or try to make to their lifestyle?
 - 6.) When a community member finds out that they are at risk for heart disease, what health services or resources are they most likely to use?
 - 7.) When a community member finds out, from a health care provider, that have heart disease or have had a stroke, what would they think caused it?
 - 8.) We would like to assist you in making your community healthy. What changes would you like to see happen?
 - 9.) What organizations or individuals influence the decisions youth make with regards to health habits?
 - 10.) What organizations or individuals influence the decision adults make with regard to health habits?
 - 11.) I'd like to ask your opinion on community-wide health care issues. What do health care providers do that is helpful to prevent heart disease? (By health care providers, we mean those working on the reservation, at Indian Health Services or in the local town or city.) *Circle the health care provider's affiliation the interviewee describes.*
 - 12.) What do health care providers do that is not helpful in preventing heart disease?
 - 13.) What advice would you give the health professionals to better serve your community?
 - 14.) What are the barriers that prevent community members from getting care from a health care provider?
 - 15.) Do you know of any successful programs that are currently trying to address heart disease or stroke in your community?
If NO, go to #16
If YES: 15b.) Why is it successful in your opinion?

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- 16.) Do you know of any programs that have not been successful at addressing heart disease or stroke in your community?
If NO, go to Question #17
If YES: 16b.) What do you think were the reasons that program [isn't or didn't] work in your community?
- 17.) Can you name any person or organization, who is an advocate for your community, that you recommend we talk to about heart disease and stroke? (This person can be employed at an organization that serves one particular ethnicity, or someone who knows the issues of their friends and neighbors.)
- 18.) I'd like to start wrapping up our discussion, but I'm wondering if you have any final thoughts or advice you would like to share about working with your community on the issues of heart disease and stroke?

Thank you for your time, our next step in the planning process includes recruiting planning committee members. I hope you consider participating. May we contact you again if we need additional information?