Fostering Health Equity in Our Communities:
Barriers, Facilitators, and Strategies

A Gerontological Perspective

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Getting to Know Each Other
You are here today as a_______

A. Community Member
B. Healthcare Provider
C. Community Based Organization Representative
D. Faith Based Organization Representative
E. Policy Maker
F. Academic/ Educator
G. Other
“Of all the forms of inequality, injustice in health care is the most shocking and inhumane.”

~Dr. Martin Luther King, Jr.
Figure 1. Factors that can influence Health Equity

- Social Class
- Gender
- Geographic Region
- Family & Social
- Sexual Orientation
- Race/Ethnicity/Culture
From Pyramid to Pillar: A Century of Change
Population of the United States

Ages
85+
80-84
75-79
70-74
65-69
60-64
55-59
50-54
45-49
40-44
35-39
30-34
25-29
20-24
15-19
10-14
5-9
0-4

1960
Male
Female

2060
Male
Female

Millions of people
15
10
5
0
5
10
15

Source: National Population Projections, 2017
census.gov/programs-surveys/popproj.html
On average health events occur at a more rapid rate among older adults than any other age group.

A. True
B. False
Figure 1. Factors that can influence Health Equity

- Social Class
- Gender
- Geographic Region
- Family & Social
- Sexual Orientation
- Race/Ethnicity/Culture

AGE

Health Equity
Barriers and Facilitators to Health Equity in an Aging Population

- Availability
- Accessibility
- Acceptability
- Quality of Care
Is there a Solution(s)?
Community Partners

• An alliance or collaborative relationship among various types of organizations to achieve a common goal or outcome
  • Health Care Organizations/ Practice-Based Organizations
  • Senior Centers
  • Long-term Care Facilities
  • Faith-Based Organizations
  • Schools
  • **Non-Traditional Partners**

• Selecting community partners should be based on key factors
  • Target Audience (Be Specific)
  • Common Goals or Mission
  • Feasibility
Involving Community Partners: Study Example
Background

• Chronic diseases disproportionately affect older adults in general and older African Americans in particular.

• Chronic-Disease Self Management Education (CDSME) Programs shown to be effective.

• African Americans are underrepresented in access to and completion of chronic disease self-management education programs.
Background

• While limited attention has focused on the unique experiences of Blacks in the dissemination and implementation (D&I) of chronic disease management programs, research has primarily focused its efforts within faith-based organizations (FBOs).

• Using FBOs as a dissemination vehicle has increased utilization for Blacks but widespread uptake and sustained implementation of evidence-based self-management programs has not been achieved.

• Therefore there is a need to consider an alternative mechanism or diverse partnership that could increase D&I and ultimately mitigate health and healthcare disparities among this target population.
Research Objectives

• To determine the feasibility, acceptability, and appropriateness of the Chronic Disease Self-Management Program (CDSMP) among aging African Americans.

• To provide recommendations for non-traditional partnerships that could enhance dissemination, implementation, and sustainability.
What is CDSMP?

• Evidenced-based peer led intervention created by Stanford University School of Medicine

• Workshops geared toward reducing chronic disease burden, increasing self-efficacy, and developing self-management skills

• Six weeks, one day a week, 2.5hrs per day, 2 lay leaders

http://patienteducation.stanford.edu/programs/cdsmp.html
## Participant Characteristics

<table>
<thead>
<tr>
<th>Demographic Variable</th>
<th>African American Participants (N=50)</th>
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<tbody>
<tr>
<td>Age (M in Years)</td>
<td>68.9</td>
</tr>
<tr>
<td>Education (% HS or Less)</td>
<td>14.0</td>
</tr>
<tr>
<td>Marital Status (% Married)</td>
<td>54.0</td>
</tr>
<tr>
<td>Gender (% Female)</td>
<td>70.3</td>
</tr>
<tr>
<td>Income</td>
<td></td>
</tr>
<tr>
<td>&lt;$15,000</td>
<td>6.0</td>
</tr>
<tr>
<td>$15,000 - $49,999</td>
<td>24.0</td>
</tr>
<tr>
<td>≥50,000</td>
<td>70.0</td>
</tr>
<tr>
<td>Comorbidities (Mean)</td>
<td></td>
</tr>
<tr>
<td>Arthritis (%Yes)</td>
<td>30.6</td>
</tr>
<tr>
<td>Lung Disease (%Yes)</td>
<td>12.2</td>
</tr>
<tr>
<td>Cancer (%Yes)</td>
<td>6.1</td>
</tr>
<tr>
<td>Depression/Anxiety (%Yes)</td>
<td>6.1</td>
</tr>
<tr>
<td>Diabetes (%Yes)</td>
<td>28.6</td>
</tr>
<tr>
<td>High Cholesterol (%Yes)</td>
<td>26.5</td>
</tr>
<tr>
<td>Hypertension (%Yes)</td>
<td>65.3</td>
</tr>
<tr>
<td>Chronic Pain (%Yes)</td>
<td>18.4</td>
</tr>
<tr>
<td>Disability (%Yes)</td>
<td>18.8</td>
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Research Methods

Participants

• 50 African Americans
• 6 Atlanta Metropolitan Area FBOs
• Age: 50+
• Doctor-diagnosed Chronic Conditions
Research Methods

Procedure

- Targeted Recruitment Strategies
- Pre/posttest
- Intervention (i.e., CDSMP)
- 6 Focus groups
  - valuable components
  - least valuable components
  - describing a preferred intervention
  - recommendations for change
### Partnerships: Faith Based Organizations

<table>
<thead>
<tr>
<th>Facilitators</th>
<th>Barriers</th>
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<tbody>
<tr>
<td>Accessibility to a broad African American audience</td>
<td>Structural variation in authority across denominations and churches</td>
</tr>
<tr>
<td>FBOs are widely available and accessible within community</td>
<td>Very active organizations with limited resources or ability to incorporate new programming</td>
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<tr>
<td>History of collaborative relationships with public health researchers and practitioners</td>
<td>Variation in priority of health and health programs within the existing infrastructure</td>
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<td></td>
<td>Congregational size (mega church vs. small congregation)</td>
</tr>
<tr>
<td></td>
<td>Limited ability to recruit participation beyond membership</td>
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<td></td>
<td>Sustainability - Commitment to embedding the program into existing infrastructure over a long period of time</td>
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# Partnerships: Non-Traditional Organizations

## Facilitators

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<thead>
<tr>
<th>For over a century, Black Greek Letter Organizations (BGLOs) have served as a foundation, and contributor to the social tapestry of the Black community.</th>
<th>BGLOs have a significant connection to the Black community through membership and community service which enhances the opportunity to maximize the reach of evidence-based health programs.</th>
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<tr>
<td>The existing structure of Alumnae/Alumni Chapters of BGLOs provide contextual factors that essentially support dissemination and sustainability of evidence-based programs.</td>
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## Barriers

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<tr>
<th>Historically, BGLO health programming has been focused on education and increasing awareness, therefore lacking a culture of delivering manualized evidence-based programs.</th>
<th>The lack of a physical location (e.g., a building with meeting rooms) may be perceived as a barrier to consistency in delivery over time.</th>
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<tr>
<td>Capacity and membership size (small vs. large)</td>
<td>Sustainability - Commitment to embedding the program into existing infrastructure over a long period of time</td>
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Developing a Partnership

- Organizational Readiness Assessment
- Communicate value proposition
- Use theories and conceptual frameworks as a way to guide interaction with potential community partners (i.e., CBPR)
- Engage potential community partners in research at all phases
- Engage potential community partners in action planning
- Engage in early discussions of costs and opportunity for implementation and sustainability
- Establish reciprocity norms
What Makes a Good Partner

• Relationship with target audience (e.g., Social Capital)
• Capacity to implement and sustain program
• Identifying the role of the partner (i.e., roles may vary)
• Consideration of multiple partners (e.g., FBOs and BGLOs)
• Partners engaged in in programming
• Liaison between researcher and community
• Culturally and contextually appropriate/relevant/accepted
• Positioned to gain experience in partnership building
• Engaging and supportive or evaluation and ongoing research to provided necessary evidence needed for sustainability
• The potential to have a individual and community impact (micro and macro level)
What else can we do?

• Let’s Brain Storm Together
  • Barriers
  • Facilitators
  • Other Strategies
Strategizing Together

• What interventions or programs are you and/or your organization currently offering to the populations you serve?

• What actions do you think can be taken in your line of work to address them?
Strategizing Together

• What will/can you do differently in the programs/work you are engaged in in light of what you’ve learned today?

• How would you think about this given the complexities of aging?
How confident are you that contribute to the reduction of health inequities?

A. Extremely Confident  
B. Moderately Confident  
C. Not Confident at All
Bringing It All Together

• Barriers
• Facilitators
• Strategies
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