

CARE REPORT

Application and Dissemination of a culture-centered approach to tailoring Comparative Effectiveness Research Summary Guides (CERSG)

September 1, 2010 to August 30, 2013

Mohan J Dutta, Purdue University, National University of Singapore,
Purdue University

William Collins, Purdue University Titilayo Okoror, Purdue University
Calvin Roberson, Indiana Minority Health Coalition



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Center for Culture-Centered Approach to Research and Evaluation (CARE)

School of Communication, Journalism and Marketing

BSC 1.06 Level 1, Business Studies Central

Massey University Manawatu campus

Private Bag 11 222

Palmerston North, New Zealand

Tel: +64-06-951-9282; ext=86282

W www.carecca.nz

Mohan J. Dutta, Director, CARE
m.j.dutta@massey.ac.nz

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community (Allen County) was chosen as the control community for the project. The community grounded processes in Lake and Marion Counties of Indiana led to the development of the Heart Health Indiana campaign, involving community peer leaders, religious organizations, hospitals and clinics, and other community locations (mayor's office, public offices, state fairs etc). The intervention materials were disseminated through face-to-face overviews offered by community peer leaders, media channels (print, radio, and television) and community events (churches, sports fairs etc.). The effectiveness of the intervention was measured by assessing knowledge, attitude toward discussing the guides with the doctor, and behavioral intention at the end of the campaign and comparing with knowledge, attitude, and behavior in a comparison community (Allen County).

Results: Across Lake and Marion Counties, the overall intervention contributed to greater knowledge for each of the knowledge areas covered in the comparative effectiveness research summary guides (CERSGs) compared to the knowledge in the same areas in Allen County.

Key Words

Purpose: The purpose of this project was to develop, apply, and evaluate the effectiveness of the culture-centered approach (CCA) for tailoring Comparative Effectiveness Research Summary Guides (CERSGs) so that they impact selected target populations of African Americans in Lake and Marion Counties of Indiana. The CCA worked through a partnership with a local community organization - the Indiana Minority Health Coalition (IMHC) and its local affiliates in two counties with the largest African American populations in Indiana, Lake County and Marion County. We developed and disseminated culturally-centered CERSGs on treating heart disease (comparing blood pressure pills, renal artery stenosis treatments, radio frequency ablation for heart rhythm problems, and treating high cholesterol). We also built a health disparities hub (HDH) called Communities and Universities Addressing Health Disparities Hub (CUAHD-Hub) that served as a platform for collaboration and participation among community members, also becoming a key resource in community capacity building, given the low uses of health technologies among African Americans (Brodie, Flournoy, Altman, Blendon, Benson, & Rosenbaum, 2000; Basu & Dutta, 2008b; Dutta, Bodie, & Basu, 2008). By project completion in 2013, we expected to have achieved the following specific aims:

- 1) Developed and tested the CCA for training local leaders and members of African American communities on how to tailor CERSGs related to hypertension and how to develop a strategy for creating awareness of these tailored CERSGs that will work in their local context.

Structured Abstract

Purpose: The purpose of the project was to examine the effectiveness of the culture-centered approach (CCA) as a framework for developing and disseminating culturally rooted comparative effectiveness research summary guides among African Americans.

Scope: The project was carried out in partnership with the Indiana Minority Health Coalition in Lake and Marion Counties of India.

Methods: The key method for the project included the development of culturally-centered capacities for the development of comparative effectiveness research summary guides through local partnerships with various community organizations, led by the coalition partners of the Indiana Minority Health Coalition (IMHC) in Lake and Marion Counties of Indiana. An ethnically and socioeconomically similar

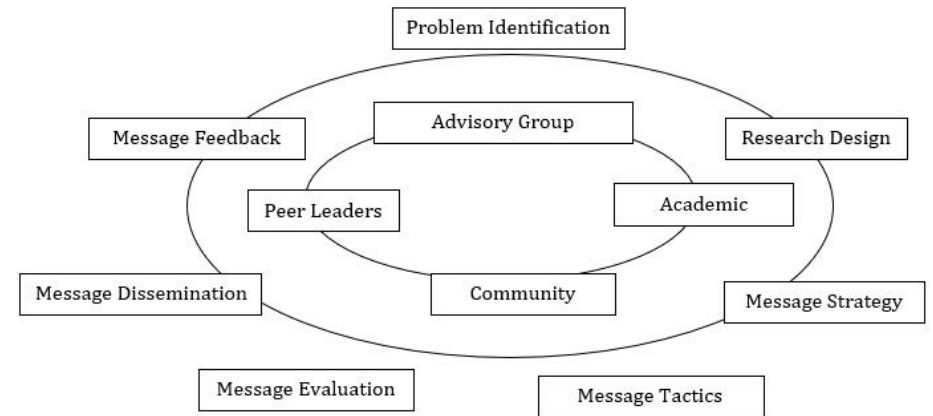
- 2) Developed and tested the CUAHD-Hub as a platform for collaboration among academic and community partners.
- 3) Increased the use of tailored hypertension CERSGs in underserved African American communities in Indiana.

Scope

Background

CERSGs provide summaries of the evidence comparing methods for treating a wide range of medical conditions. By the launch of the project in 2010, AHRQ had released fourteen CERSGs on topics ranging from osteoporosis to heart disease. Many of the CERSGs address clinical conditions of great importance to underserved populations. For instance, the four CERSGs on heart disease can potentially fulfill an important gap in the health information needs of African Americans, given the high prevalence of heart disease among African Americans (AHRQ, 2009). Figure 1 illustrates the community driven culture-centered approach (CCA) we worked with to develop community capacities to culturally tailor CERSGs to community needs (Dutta-Bergman, 2004a, 2004b; Dutta, 2006, 2007, 2008; Dutta & Basu, 2007a). The CCA seeks to develop academic-community partnerships that move the locus of decision making and strategic choice in the hands of the community partner (Basu & Dutta, 2008a; Dutta, 2008; Ford & Yep, 2003). The CCA utilizes community-based participatory strategies for addressing healthcare disparities by emphasizing the central role of the community in defining the health problem and corresponding health solutions (Airhihenbuwa & Obregon, 2000; Basu & Dutta, 2009; Campbell & Gillies, 2001; Campbell & Jovchelovitch, 2000; Dutta-Bergman, 2004a, 2004b; Dutta, 2008; Viswanathan, Ammerman, Eng, Gartlehner, Lohr, Griffith et al., 2004). Therefore, the solutions originate from within the community (neighborhood, community, faith-based groups), and the emphasis of the CCA is on creating processes, strategies and spaces through which local voices can play an important role in developing community-specific solutions (Baker & Motton, 2005; Dutta, 2008; Ford & Yep, 2003). Essential to the notion of developing community-specific solutions is the idea that engaging the local community in a partnership role creates an opportunity for really understanding the health problem as defined by the local community. Health disparities are addressed through the process of creating community-specific communication resources and infrastructures that are directed at addressing these disparities.

Figure 1: CCA-based Approach to Message Tailoring



When the CCA is applied in the realm of a specific disease state, the emphasis is on creating communication processes and infrastructures for listening to the inputs of the local communities in identifying gaps in communication infrastructures and resources, and in developing these infrastructures and resources. The community therefore emerges as a partner involved throughout the process of development of communication solutions, starting from need identification to the identification of communication resources directed at addressing this need (Campbell & Gillies, 2001; Dutta, 2008; Yehya & Dutta, in press).

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CCA involves the creation of community academic partnerships that facilitate the participation of the local community in the definition of problems and solutions and in the generation of knowledge. CCA differs from the culturally sensitive approaches to message tailoring by locating the locus of expertise and knowledge generation in the local community (Dutta, 2007; Dutta & DeSouza, 2008). Community-driven health promotion interventions are the most effective when the locus of knowledge production is located in the community, complemented with the clinical knowledge

base and the expert knowledge of communication solutions (Dutta-Bergman, 2004a, 2004b). Therefore, although the CCA shares some basic tenets with community based participatory research (CBPR) in terms of its commitment to academic community partnerships, it differs from CBPR in the emphasis on the community as the primary resource for knowledge generation. The core elements of the CCA involve the creation of dynamic spaces for knowledge sharing, collaboration and decision making at the community level, building on the various resources (knowledge, technology etc.) brought to the table by the academic partners. The communication processes that constitute the CCA include community participation and community dialogues that offer community-based communication solutions to the needs identified by the local community. The community-based dialogues in the CCA are directed toward creating dynamic communication processes that create resource-based capacities in the local communities (Dutta-Bergman, 2004a, 2004b; Dutta, 2008, 2009; Wang, 1999; Wang & Burris, 1994). Attending to the absence of communication infrastructures (such as the Internet) in marginalized communities, CCA seeks to utilize alternative infrastructures that are available to marginalized communities (such as churches and health fairs). In addition, it also seeks to build community capacity by investing in the communication infrastructures that are meaningful to the community (such as developing community collaborative platforms in online environments in collaboration with community-based training on the uses of online resources). In this context, the researcher does not claim to be the expert on the so-called lay theories articulated by the participants; rather, the role of the researcher is one of enabling access to communicative capacities for the community such that the community can make the critical decisions (Basu & Dutta, 2008a, 2008b, 2009; Dutta, 2008, 2009).

Context

The project was carried out in the Lake and Marion Counties of Indiana, identified as two of the Counties with the largest proportion of African Americans as well as disproportionate disease burdens that are borne out by African Americans within the state. The Indiana Minority Health Coalition, Inc. (IMHC) is a statewide non-profit organization, and served as the community partner of the project, given the explicit focus of the organization on addressing health disparities faced by minorities. The Minority Health Initiative in Indiana was the result of a grassroots movement that began in 1987 after the release of Secretary Heckler's report on minority health. The disparities noted in this report compelled the Indiana State Health Commissioner to hire staff whose main responsibility was to develop initiatives to address the health disparities of racial and ethnic minority populations. Staff worked with local communities to develop infrastructures to assist the State in reducing disparities. The local coalitions played a critical role for change in the health status of Indiana's minority populations and served as catalyst for the Indiana Minority Health Coalition.

IMHC was created in 1992 by local coalitions to address the disparities that exist between minority and white populations. IMHC advocates for minority populations by working with legislators and decision-makers to develop, provide testimony on, monitor, and/or evaluate policies and services affecting the health and well-being of minorities; educates and increases awareness among individuals and organizations on the prevalence of health disparities, as well as provides practical ways for individuals and agencies to assist in reducing these health disparities; administers health delivery services focused on special populations related to chronic disease and behavioral health; provides volunteer and sponsorship opportunities for individuals and corporations to join in the effort to address health disparities in Indiana; collects, performs analysis, and disseminates information to influence minority health policy, program development and healthy lifestyle practices; and provides capacity building, technical assistance, and training to organizations seeking to provide the best quality, culturally and linguistically appropriate services.

Settings

The project was carried out in community meetings with advisory board meetings, community-wide meetings and press conferences, community workshops, as well as in a variety of community settings such as churches, public works buildings, grocery stores, community clinics and other community organizations. The project began with a community-immersed ethnography of African American lived experiences in Lake and Marion Counties of Indiana. This was integral to the development of the advisory boards in both communities. In addition, focus groups, community wide workshops and public meetings offered the settings for collaborative work with the community.

Participants

25,812 African American community members in Lake and Marion Counties were reached through the project. In Lake County, the project reached 12075 African American community members who received some form of intervention material directly. In Marion County, the project reached 13737 African American community members through the intervention material directly (such as face-to-face intervention or a postcard being handed out). In addition, a larger proportion of community members were reached out through the mass media (radio advertisements, television advertisements, and print advertisements). Community-wide presentations were held during health fairs that included between 80 and 3675 African American participants. The post-test was carried out with 251 African American participants in Allen County who provided usable data, 561 African American participants in Lake County, and 497 participants in Marion County.

Incidence and Prevalence

In Indiana, African Americans are 1.2 times more likely to die of heart disease compared to Whites. This picture of incidence and prevalence of heart disease bears out the national-level health disparities in heart health experienced by African Americans.

Methods

Study Design

The study used a combination of the participation-based culture-centered approach (CCA) and message tailoring methods to develop a framework for the development, implementation, and evaluation of culturally adjusted CERSGs (four CERSGs on heart disease). Because of the grassroots-driven and dynamic nature of the CCA, the community partners (Indiana Minority Health Coalition, Lake County Minority Health Coalition, and Minority Health Coalition of Marion County) were involved in all phases of the research process including the identification of the problem, development of research design, preparation of the proposal, implementation of the research proposal, development of tailored solutions, dissemination of the tailored solutions and the evaluation of the tailored intervention. To address the specific aims of the proposal, we used qualitative methods (in-depth interviews, n = 100 in Lake and Marion Counties, and focus groups, total of 16, with each focus group having 9-12 participants), 18 advisory board review workshops, and 9 community workshops with leaders and members of community organizations in Lake and Marion counties. Also, we developed the communities and universities addressing health disparities hub (CUAHD-Hub) as a capacity building resource for online collaborations.

Data Sources/Collection

Once the tailored CERSGs had been created, a baseline survey was conducted to measure CER knowledge, attitudes, and behavioral intention. The baseline data was gathered in both Lake and Marion Counties. The post-intervention evaluation was conducted one year after the launch of the tailored CERSGs in the two local communities, as well as in a comparison community (Allen County). Data was gathered through face-to-face community-wide surveys conducted at specific community sites that were randomly selected for data gathering. Participants for the surveys were randomly selected from within the community sites. Peer leaders gathered the data in the communities.

Intervention

The intervention comprised of four components, built on the four CERSGs on heart disease (ACE Inhibitors versus ARBs, AFib, Renal Artery Stenosis, and Cholesterol). The intervention was delivered in the form of face-to-face peer leader explanation of materials, culturally-based post cards handed out by peer leaders, television advertisements placed on prime cable channels, radio advertisements, print advertisements in primarily African American papers, website, Facebook, community events and exhibits, and performances.

Measures

Given the nature of the CERSGs, the primary measure of the intervention was knowledge as outlined in the CERSGs. The knowledge items were internally consistent and had high reliability (Cronbach's alpha of 0.91). The in-depth interviews, focus groups, workshops and advisory board meetings served as platforms for the development of a knowledge attitude behavior survey to be implemented at the baseline and then to be implemented after the tailored intervention. In order to evaluate the effectiveness of the tailored CERSGs, the post-intervention measures were compared with the baseline measures through Analysis of Variance (ANOVAs). In addition to the pre-post measures, data from the in-depth interviews, focus groups, and follow-up interviews were also utilized for analyses.

Limitations

One of the key limitations of the study was the lack of random assignment at the community level. Given the participatory nature of the CCA, the intervention communities were already preselected as these were the communities where the collaborations occurred.

Results

(Principal Findings, Outcomes, Discussion, Conclusions, Significance, Implications)

Principal Findings

This section reports the results of the interventions that were carried out in the communities receiving the culturally centered intervention at the community level, accompanied by the testing of the guide-specific interventions. At the community level comparison, the culture-centered intervention led to greater community-wide overall knowledge of the comparative effectiveness research covered in the four heart disease related guides in the culturally-centered communities (Lake and Marion County) as compared to the control community (Allen County).

Overall knowledge in Marion County (M = 10.14; SD = .27) and Lake County (M = 9.42; SD = .26) were greater than overall knowledge in Allen County (M = 8.04; SD = .38); F = 9.99, p < .001. Also, in pre-post comparison, Marion County demonstrated significant improvement in knowledge of the comparative effectiveness research covered in the four heart disease related guides from the pre (M = 15.60; SD = .30) to the post (M = 16.43; SD = .27) condition.

Within each community, participants were randomly assigned to a control, standard, and experimental group within the context of the guide-specific intervention. Participants in the control group received no face-to-face intervention; participants in the standard group received the standard CERSG developed by AHRQ; and participants in the culturally centered group received the culturally centered card along with the face-to-face intervention. The results presented here compare the differences in knowledge between the experimental, standard, and control conditions.

For the CERSG on Afib, below are the comparisons of the experimental, control, and standard groups. Across the three conditions, post-exposure conditions (T2) demonstrate improved knowledge, awareness, and the intention to ask questions to the doctor compared to the pre-exposure condition (T1).

Tests of Between-Subjects Effects for Afib

Dependent Variable: Difference in Knowledge about Afib

Source	Type III Sum of Squares	Df	Mean Square	F	Sig.
Corrected Model	1589.538 ^a	11	144.503	11.299	.000
Intercept	18.708	1	18.708	1.463	.227
Age	1.466	1	1.466	.115	.735
Gender	63.775	1	63.775	4.987	.026
Heartdis	15.602	1	15.602	1.220	.270
heartdis_family	12.567	1	12.567	.983	.322
diabetes_ufamily	14.831	1	14.831	1.160	.282
hb_youfamily	.208	1	.208	.016	.899
Location	996.623	1	996.623	77.929	.000
Condition	39.380	2	19.690	1.540	.215
location * condition	401.820	2	200.910	15.710	.000
Error	14029.367	1097	12.789		
Total	19090.000	1109			
Corrected Total	15618.905	1108			

a. R Squared = .102 (Adjusted R Squared = .093)

Differences between T2 and T1 (Paired T-tests)

		Paired Differences				T	Df	Sig. (2-tailed)	
		Mean	Std. Deviation	Std. Error Mean	95% Confidence Interval of the Difference				
					Lower				Upper
Pair 1	Knowledge	1.77281	3.75086	.11003	1.55692	1.98869	16.111	1161	.000
Pair 2	How aware are you of guides that evaluate the effectiveness of different kinds of medication and procedures for heart disease	.091	.787	.023	.045	.136	3.905	1144	.000
Pair 3	How aware are you of research that compares the effectiveness of different kinds of medication and procedures for heart disease	.099	.776	.023	.054	.144	4.336	1147	.000
Pair 4	How aware are you of the Heart Health Indiana campaign	.151	.755	.022	.107	.195	6.768	1144	.000
Pair 5	How comfortable do you feel discussing health information with a doctor, nurse, or other health prof	-.104	2.124	.063	-.020	.228	1.651	1131	.099
Pair 6	How comfortable do you feel asking questions to a doctor, nurse, or other health professional during	-.137	2.104	.063	.014	.260	2.191	1129	.029

Similarly, for the CERSG explaining Ace Inhibitors and ARBs, there was consistent difference from pre to post across the condition, with increase in knowledge from pre (T1) to post points of comparison (T2).

Tests of Between-Subjects Effects

Dependent Variable: Change in knowledge about ACE Inhibitors versus ARBs

Source	Type III Sum of Squares	Df	Mean Square	F	Sig.
Corrected Model	494.668 ^a	5	98.934	15.981	.000
Intercept	1662.508	1	1662.508	268.554	.000
County	411.482	1	411.482	66.469	.000
Condition	23.371	2	11.686	1.888	.152
county * condition	34.414	2	17.207	2.780	.062
Error	7329.648	1184	6.191		
Total	9514.000	1190			
Corrected Total	7824.316	1189			

a. R Squared = .063 (Adjusted R Squared = .059)

In sum, for both of the conditions, the intervention was accompanied by changes in knowledge. Through these two examples, we demonstrate the relative success of interventions when comparing the individual guides.

Outcomes

The project led to greater community-wide knowledge of the comparative effectiveness research covered in the four heart disease related guides in the culturally-centered communities (Lake and Marion County) as compared to the control community (Allen County). Also, in pre-post comparison, Marion County demonstrated significant improvement in knowledge of the comparative effectiveness research covered in the four heart disease related guides from the pre to the post condition.

Discussion

Culturally-centered implementations of comparative effectiveness research summary guides distributed through mass media, community wide channels, and face-to-face intervention generate greater knowledge of comparative effectiveness research summary guides in Lake and Marion Counties as compared to Allen County. The greater level of knowledge in the intervention communities is observed across all four areas. This observation is also borne out by the qualitative data that suggest greater knowledge of the comparisons of risks, benefits, and side effects covered in the comparative effectiveness research summary guides. The qualitative data gathered through post-exposure in-depth interviews pointed to audience preference for images of African Americans in the messages, a sense of belonging with the effectiveness data when presented by African American health professionals, and the important roles of community spaces such as churches and health fairs as spaces for conversing about comparative effectiveness research summary guides. The culture-centered processes in the communities also emerged as avenues for additional conversations on different facets of heart disease, thus spring-boarding several projects on different aspects of heart disease among African Americans.

Conclusions

In conclusion, culturally-centered processes of developing comparative effectiveness research summary guides present opportunities for rooting comparative effectiveness information within cultural contexts, cultural meanings, and the lived experiences of community members. The moderate effect sizes call for additional research into the culture-centered processes for community wide collaborations. Unlike the stronger effect sizes that are observed in behavior change interventions grounded in the CCA, the comparatively smaller effect sizes are perhaps the product of the complex layers of knowledge covered in the comparative effectiveness research summary guides.

Significance

The significance of the findings lies in documenting the role of culturally-driven processes of collaboration in building community wide infrastructures for the dissemination of comparative effectiveness research. The collaborations between local media agencies, community organizations, and academic partners are constituted around various relational tensions, and communicating across these tensions is integral to the processes of the CCA.

Implications

Culture plays an important role in the development of information capacities in local communities. The framing of comparative information needs to be constructed in culturally meaningful ways through the participation of cultural members in decision-making processes. The development of additional projects from the roots of the CCA project is vital to the sustainability of the project.

List of publications and products

Products

HeartHealthIndiana Website

One page small cards for each of the four guides.

Heart Health Indiana Facebook page

Heart Health Indiana videos explaining the guides

Heart Health Indiana audios walking listeners through the guides

Training materials for community peer leaders and key staff at the IMHC to carry out the intervention

Training materials on the CCA for cultural tailoring

Book Chapter

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