

# **Recommendations for Advancing the Quality of Life for Urban Appalachians**

## **The Research Committee of the Urban Appalachian Council**

A Research into Action mini-conference was held on April 16, 2007 to identify and discuss the issues affecting urban Appalachians in the areas of education, employment, and health (Appendix A). Further discussion by three working groups within the Research Committee resulted in the following recommendations for addressing the issues and enhancing the quality of life of urban Appalachians served by the Urban Appalachian Council (UAC). Within each of the three areas, the recommendations focus on (1) further research needed for improving understanding of the issues and/or potential problem solutions; (2) potential services provided or facilitated by the UAC to address specific needs; and, (3) advocacy efforts required for issue resolution.

The recommendations are based on the premise outlined in Appendix A that increased graduations and higher education lead to increased employment which leads to increased health insurance and access to health care. These contribute to an improved quality of life by empowering urban Appalachians with adequate income and better health.

## **Recommendations**

The UAC Research Committee recommends the formation of three task forces, one each for health, education, employment, with a UAC Board liaison to each. Each task force will be charged with moving forward the action agenda suggested below and reporting progress to the UAC Board.

### ***Health***

The proposal for health consists of a coordinated multi-faceted agenda that focuses on the creation of a pilot program for cardiovascular health improvement. (See Appendix B for the full proposal from this working group.)

#### **Research:**

- *Recruit and convene interested university and community stakeholders to plan a pilot program that would begin with assessment of community readiness and identification of points of intervention for health improvement. Solicit and review proposals for components of the pilot program.*

- *Once the pilot program has been launched, monitor and evaluate implementation, outcomes, and potential for expansion and replication.*

**Services:**

- *Serve as convener of the principal stakeholders and interface with community members for pilot health improvement program.*
- *Develop materials to enhance cultural sensitivity in implementing the pilot program.*

**Advocacy:**

- *As participants in the pilot program experience institutional and community barriers such as access to services, advocate for changes in policy.*
- *Promote modifications of lifestyle to affect cardiovascular health.*

**Education**

The recommendations for education focus, first, on more fully establishing the issues facing retention of urban Appalachian students through research. This would be followed by seeking support for the creation of a position within the UAC to develop programs and provide important linkages and advocacy with institutions and organizations key to supporting urban education.

**Research:**

- *Build on the research into patterns of high school enrollment and dropping out begun by John Bryant and seek to expand this line of research with additional funding and support, with the possibility of extending the research to other urban areas in Ohio by assembling a statewide network of researchers to address the issue. Consider extending the research to include Northern Kentucky.*

**Services:**

- *Seek support for an Education Advocate on the UAC staff who could help to expand existing education services, provide important linkages to groups such as STRIVE and Parents for Public Schools, seek funding for, and help to coordinate ongoing research, as well as attend to the significant advocacy agenda suggested by the Education group.*

**Advocacy:**

- *Utilize the Education Advocate position to leverage connections with community groups to advocate for the service and policy changes needed to better serve the education needs of urban Appalachian students at all levels.*

**Employment**

Action steps recommended for employment attempt to establish models for on-the-job training coupled with education, particularly for urban Appalachian males; develop greater awareness of the unique needs of urban Appalachians in job training and job placement; and provide advocacy for support services for workers participating in apprenticeship programs.

**Research:** See overarching research goals at the end of the recommendations.

**Services:**

- *Develop one or more pilot programs that combine GED education with employment. Programs should make strong efforts to employ positive urban Appalachian male role models/support personnel.*
- *Develop systematic outreach to service providers accessed by urban Appalachians for job training and job placement. Outreach needs to build awareness of 1) the urban Appalachian population and its needs and 2) how to design programs, services and outreach that will be accepted by urban Appalachians.*

**Advocacy:**

- *Advocate for the development of support systems for workers in apprenticeship programs with employers and unions typically accessed by underserved urban Appalachians.*

Additionally, the UAC Research Committee recommends the adoption of the following **overarching research goals:**

- *Determine migration/relocation patterns of urban Appalachians within the Greater Cincinnati area, including patterns of educational attainment, employment, health, and economic status.*
- *Determine educational and career or apprenticeship paths that have tended to work for broadening opportunities and empowering urban Appalachians.*

**Appendix A:**  
**Urban Appalachian Conference: Research into Action**

# Urban Appalachian Conference: Research into Action

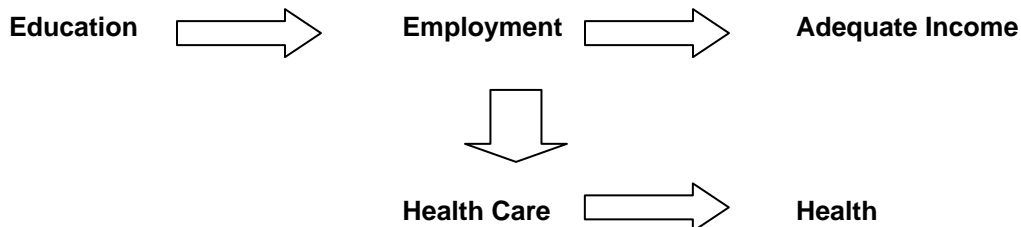
April 16, 2007

The Research into Action mini-conference was the result of eight months of planning by the Urban Appalachian Council's Research Committee. Discussion about the issues affecting urban Appalachians in the areas of health, education, and employment were followed by an effort to document the research that addresses these issues (shown in Appendixes A-1 and A-2).

On April 16, 43 researchers, advocates, and service providers gathered at the Health Foundation from 9:00 a.m. to noon. The greater part of the morning was spent in three facilitated break out groups, one each for Health, Education, and Employment. Participants were asked to specifically address the questions of what is working for underserved urban Appalachians and what more is needed for research, services, and advocacy. (See Appendix A-3 for the participant evaluation of the mini-conference.)

Notes from these rich discussions were then brought back to three working groups within the Research Committee, one each for health, education, and employment health, to digest and prioritize action steps to present as recommendations to the UAC Board. The Research Committee adopted a set of criteria for these recommendations:

1. Relevancy to urban Appalachians
2. Actionable (Something can be done about it.)
3. Measurable
4. Within "our" area of control and capability (We can do or entice someone to do something about it.)
5. There is a potential for resources that will make a difference.
6. There is an order/flow (theory of change) to the agenda Increased graduations and higher education lead to increased employment which leads to increased health insurance and access to health care. These contribute to an improved quality of life through adequate income and better health.



7. There is a window of opportunity or favorable political environment.
8. Successful models exist.

9. Clarify: specific to urban Appalachians or shared with other groups (implying need for a cooperative approach)

Following is a summary of the April 16 discussions, organized as follows:

- Perceptions of what is working (and what is not working)
- Perceptions of what more is needed.

## **Perceptions of What Is Working (and Not Working)**

### ***Health***

Participants in the Health breakout group identified a number of strengths that “work” for health and health care for underserved urban Appalachians. These included a strong sense of community, community leadership on health issues, a high level of awareness of environmental health issues, and increased access to health care as a result of meetings between community leaders and health providers leading to changes in the system. Strong family bonds were discussed as a strength, but some health care providers commented that this can be problematic when patients listen to family members over providers.

Also discussed were specific liabilities. Included were the physical environment in which many underserved urban Appalachians live – low income communities, many with environmental problems, and difficulty in defining the urban Appalachian community with generations having passed since initial migration to this area. Another liability mentioned was the documented decrease in health status from the first to the second generation of Appalachian migrants, possibly attributed to a change in lifestyle, removal from family support, or a lack of access to health care or other benefits. Additionally, it was noted that resources for Appalachians in Ohio go to geographic Appalachia, not urban Appalachians.

### ***Education***

Participants in the Education breakout group discussed a number of initiatives and strategies that appear to be “working” for urban Appalachians in the area of education. Chief among them was Oyler School, its adaptations to Appalachian culture and community, and its PreK-12 design and online courses in the upper grades that have contributed to increased enrollment and improved retention. Participants also noted the role of leadership in this school and the work toward locating social services within the school.

Other programs that were noted as “working” or showing promise included the network of GED programs in the city; family approaches to literacy (Every Child Succeeds, home visitation and Hippy), the early childhood programs at Santa Maria, the Strive initiative, the mentorship program for underclassmen at Northern Kentucky University, and the reporting requirements of No Child Left Behind that shed more light on education for underserved students. Participants discussed Cincinnati Public Schools’ responsiveness to requests for K-12 schools, including the new school in the East End, but identified a need for the schools to recognize Appalachians as a minority, establish programs to reach this group of students, and recognize those who do overcome barriers and excel.

Strategies that were mentioned as important for facilitating educational attainment for underserved urban Appalachians included parent involvement, community ownership of programs, cultural competency training for teachers, early intervention, and school counselors that serve as student advocates. Community Learning Centers were mentioned as having promise, but these efforts are experiencing a gap in connecting with the community.

## ***Employment***

The Employment breakout group identified strengths and resources that are “working” for urban Appalachians in regard to employment. Some of the resources included the skills training (e.g., time management, accountability) offered by the Urban Appalachian Council, Cincinnati Works, community schools, apprenticeships, particularly for more middle class urban Appalachians, and the Benefits Bank. Strengths that were discussed were family, the community itself, and networks of communication by word-of-mouth, as well as the availability of “under the table” employment.

Gaps or needs were also discussed. The changing employment picture with traditional factory jobs leaving the area and other jobs lacking appeal, the reduced influence of trade unions, and shrinking resources such as community schools, were some. Also mentioned was the fact that some skilled jobs offer lower pay than unskilled jobs or public assistance, and the perception that “as you gain, you lose.” A criminal record can also be a liability in seeking employment. Families seeking self-sufficiency do not always have access to services they may need. These include child care, health insurance, and other government programs such as service jobs for youth.

Participants noted the poor retention rate of underserved urban Appalachian youth in school, and the question was raised whether school curricula are truly relevant to employment. They also noted that, in some instances, funding for employment programs are targeted to agencies not frequented by urban Appalachians due to a perception that the need is not as great in low income Caucasian neighborhoods. In general, there is less recognition of the needs of this population.

## Perceptions of What More Is Needed

### *Health*

**Research.** Areas identified as needing further research were:

- Better identification of urban Appalachian people: who we are/why it matters.
- Effective models of community education/empowerment/advocacy (research to practice)
- Effective health literacy education
- Substance abuse among Urban Appalachians and effective interventions
- ER usage by urban Appalachians
- Cardiovascular research: there is a project going on now in WV. Link with it, get funding to do a combined rural/urban Appalachian study
- Before genetic research in urban Appalachian communities begin, need to increase knowledge/empowerment around informed consent, protocol, etc.
- Become more intentional about disseminating/using information about what research money is available to do what we want to do.

**Services.** Participants discussed the fact that a focus on health care services is not sufficient. There is a need to look at what is needed for a healthy community comprehensively, including awareness and action around the relationship of health to education, employment, and other issues, and strong community institutions, generally – schools, police services, etc. It was discussed that an advocacy/action agenda needs to follow the lead of community leadership.

Specific service needs as well as needs for access to quality services were also identified.

#### Specific Services:

- Comprehensive services (including mental health)
- Substance addiction services
- Sexual/Reproductive health services
- Services targeted to adolescents (gap between services to children and those to adults)

#### Access to/Quality of Services:

- Health promotion in schools and at earlier age.
- More services to community (long waiting list for services, especially preventive services.)
- Health insurance/benefits/services for uninsured
- Other options for neighborhood-based services in addition to clinics (for example school-based.
- Culturally appropriate provision of services

**Advocacy.** The following were discussed as needs for advocacy in the areas of health and health services:

- Advocate for support to community health education/empowerment/advocacy; support to grass-roots advocacy across city and in suburbs
- Leadership to change practices/policies to make the services that exist more useful/accessible, for example “friendly gate-keepers” (receptionists, etc.)
- Positive reinforcement for health programs that get it right
- Positive reinforcement for what urban Appalachian communities are doing right in terms of health leadership
- Advocacy directed to key individuals within institutions who are positioned and show willingness to become “champions.”
- Change societal attitude that there are “throw-away people”; There needs to be a bottom-line: “this is a standard of service accessible to all.”
- Cultural competency of health care providers, both in term of education about Appalachian health care practices/ concerns/beliefs and to change negative attitudes.
- Change Council on Aging policy NOT to recognize Appalachians (urban or rural) in their demographics
- Advocacy toward services that say they represent or include urban Appalachians, but don’t.
- Advocacy for specific services:
  - Routine screening for mental health services and for community-based and grass-roots (e.g., support groups) mental health services
  - Community-based health services (per above)
  - Increased access to indigent care programs at UC and Children’s Hospital (advocacy to providers and education support to communities to use)

## ***Education***

**Research.** Needs for research that were discussed focused on better understanding the experiences of urban Appalachian students. Accurate information needs to be sought on whether and why urban Appalachians may be represented differently from the general population in the percentage of drop outs; disciplinary actions, including suspensions and expulsions; special education designation; and membership in advanced placement and honors classes as well as extracurricular and after-school activities. Moreover, there is a need to establish accurate graduation/drop out rates for schools and GED programs known to have significant populations of urban Appalachians, and to determine the extent to which urban Appalachian families are accessing early childhood services such as Head Start.

Participants also discussed a need for more qualitative research on students who “make it” and those who don’t and how both can be supported, as well as research to better understand how different generations of urban Appalachians perceive their own history. Case studies of schools and school systems that appear to be “working” for urban Appalachians might also be conducted to establish facilitators of success.

**Services.** Services that were noted as needed included comprehensive services for education, health including mental health, jobs, and community advocacy and empowerment. Further work to maintain and expand the network of GED Preparation programs was discussed, as well as the provision and promotion of cultural competency training for educators serving in schools with significant populations of urban Appalachians. Participants also discussed services needed to promote and address negative attitudes toward literacy, as well as expansion of the GED network and dropout recovery services. Fathers and men in general were mentioned as needing specific attention and outreach to get them to avail themselves of existing services.

**Advocacy.** Participants in this discussion group acknowledged that many of the ideas discussed for research and services require active advocacy. Also discussed were promotion of programs for mathemacy (mathematical literacy), as well as problem solving and critical thinking in general. Participants noted that advocacy with the public schools is needed to insure that they focus on “what matters.”

Specific areas for advocacy work were further delineated by the Education Working Group:

- Promote parent involvement in, and community ownership of, children’s education through participation in Parent Leadership Academies, particularly as they may involve establishing positive attitudes and practices regarding literacy and mathemacy.
- Promote the expansion of drop out recovery programs.
- Promote the expansion of comprehensive services in schools and encourage urban Appalachians to participate in planning for Community Learning Centers.
- Advocate for public schools’ recognition of Appalachians as a minority group.
- Lobby for the GED to be counted the same as high school completion.
- Advocate for the provision of student advocates in schools.
- Advocate for the provision of transportation for high school students.
- Work with STRIVE to ensure that the particular needs of urban Appalachian youth are considered in the STRIVE agenda.

## ***Employment***

**Research.** Participants identified areas where better information is needed, including information about youth employment programs, apprenticeship programs and pathways, as well as accurate information about the outcomes of urban Appalachians in Cincinnati Public Schools and the career/education paths of GED students. They also discussed the need for further research into employment as it relates to cultural identity and to patterns of, motivators for, and generational differences in migration and relocation among urban Appalachians, particularly in Northern Kentucky.

**Services.** Services that were discussed revolved around specific programs for men/fathers, as well as improving existing service providers' outreach to urban Appalachians.

**Advocacy.** Advocacy concerns included service networks, equity in access to publicly funded jobs programs, the changing role of unions, accountability and curricular relevance of schools, and stereotypes about Appalachians.

**Appendix A-1:**  
**Appalachian Health Status of Greater Cincinnati**

## APPALACHIAN HEALTH STATUS IN GREATER CINCINNATI

Regional health data on urban Appalachians are rare. The following are samples of health data from three current surveys. The three surveys are the *2005 Community Health Status Survey* which analyzed data by subgroups including the adult Appalachian population in the Greater Cincinnati Area, *The Women's Health Study* which reported on the health of the women in Lower Price Hill in Cincinnati, and *The 2005 Child Well Being Survey* which analyzed data by subgroups including Appalachian children.

**2005 Community Health Status Survey** (2,454) findings of a subset of first and second generation white Appalachians (467) within a 22-county Greater Cincinnati area.

Condition	Appalachian	Area	National
Hypertension	46%	32%	27% (BRFSS 03)
Hyperlipidemia	40%	29%	25%
Heart Disease or Angina	15%	11%	
Smoking	31%	30%	21%
Diabetes	13%	10%	7%
Arthritis	37%	28%	
Migraine Headache	30%	20%	
Cancer	7%	6%	
Chronic Lung	6%	5%	
Depression	25%	21%	
Teeth fair or poor	30%	24%	
Dental Home	66%		
Medical Home	77%	80%	
MH-CBC	14%	9%	
MH-ER	3%	3%	

### Lower Price Hill Women's Health Study (N=144)

#### Most Commonly Diagnosed Medical Condition

##### Ages 18-49

Allergies	31%
Depression	30%
Weight Problem	23%
Heavy/Irregular Periods	22%
Asthma	22%
Anemia/Low Iron	20%

Age 50+

Hypertension	56%
Arthritis	51%
High Cholesterol	47%
Allergies	42%
Diabetes	28%

Current smoker every day 59%

Most Common Cause of Death Among Biological Parents, Age at Death

Father: Cardiovascular Disease 23%; Cancer 20%, 64 years

Mother: Cardiovascular Disease 31%, Cancer 29%, 62 years

78% have a family history of cancer

Breast 31%, Colon/bowel 26%, Lung 24%, Cervical 18%, Throat/Larynx 14%,  
Liver 12%, Skin 12%, Uterine 10%, Kidney 7%, Prostate 6%

Perceived Health Status

	<b>Lower Price Hill</b>	<b>CHSS General Pop</b>
Excellent	6%	19%
Very Good/Good	55%	62%
Fair/Poor	39%	20%

Source of Primary Care

Cincinnati Health Department Clinic	55%
Private Physician	24%
None	4%

Reproductive History

	<b>Women Ever Pregnant (128)</b>	<b>Total # of Pregnancies (492)</b>
Premature Births	27%	10%
Low Birth Weight	16%	7%
Birth Defects	16%	5%

Common concerns of CHSS and WHS

- Cardiovascular Disease
- Smoking
- Hypertension
- Hyperlipidemia
- Arthritis
- Depression

Other concerns: Oral Health (CHSS), Low birth weight, birth defects, low rating of health, family cancer (WHS)

## Child Well Being Survey (CWB) 2005

Child Policy Research Center of  
Cincinnati Children's Hospital Medical Center

Supported by  
Health Foundation of Greater Cincinnati  
United Way of Greater Cincinnati



## Description of CWB

- Telephone survey of parents and other primary caregivers about health and well-being of children.
- Conducted by UC Institute for Policy Research
- October-December, 2005
- 1,559 completed interviews
- 22 county region in OH, KY, IN
- Weighted sample data to reflect Greater Cincinnati children



## CWB Topics and New Content

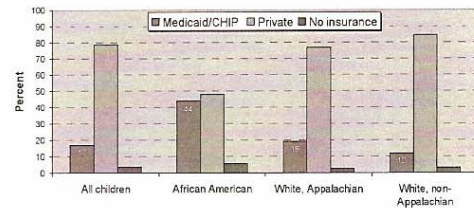
- Child's health status
- Medical home
- Usual source of care
- Health insurance coverage
- Chronic health conditions
- Behavioral/emotional health
- Child care arrangements
- Middle childhood/adolescence
- Substance use
- Caregiver's health status
- Caregiver's health insurance
- Food security
- Caregiver's perception of child's weight
- Early learning

Change the outcome



## African American children are twice as likely to rely on Medicaid for HEALTH INSURANCE

Insurance Type by Child's Race/Ethnicity

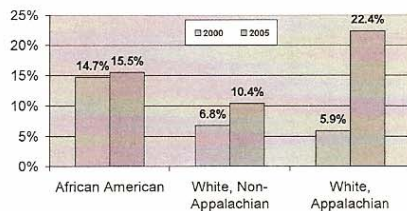


Change the outcome



## EMOTIONAL HEALTH among white Appalachian children worsened dramatically

Children with 'high problem level' emotional health by race



**Appendix A-2:**  
**Appalachian Education and Employment in Greater Cincinnati**

**APPALACHIAN EDUCATION AND EMPLOYMENT IN GREATER CINCINNATI**

While urban Appalachians have been a significant portion of the Greater Cincinnati population since the 1950s, they remain an “invisible minority,” facing significant economic, educational, and social barriers. According to studies by the Urban Appalachian Council, many urban Appalachians are blue-collar workers living at the margins of the economy. Smaller but significant portions are the urban poor. The Urban Appalachian Council estimates based on an analysis of census data that 67% of Appalachians in low-income Cincinnati neighborhoods lack a high school diploma<sup>1</sup>. (Source: *Down Home, Down Town: Urban Appalachians Today*, ed. Phillip Obermiller, Kendall/Hunt 1996.) The Schott Foundation for Public Education reported that Cincinnati has one of the lowest graduation rates for White male students among the major urban districts in the United States<sup>2</sup>. Only 43% of White males in Cincinnati graduated with their cohort in 2003/04. This compares poorly with a state graduation rate of 45% for African American males and 75% for White males.

The following chart illustrates the problem. These are the neighborhoods with a high percentage of Appalachian and African American students showing the alarmingly high number of persons without a high school diploma:

Neighborhood	# of persons 25 and over without a high school diploma	percentage
E. Price Hill	3678	35%
Corryville	983	24%
West End	2165	45%
Evanston	1773	37%
Bond Hill	1650	27%
Pleasant Ridge	950	15%

Social Areas Report – University of Cincinnati<sup>3</sup>

Across the river, dropout rates for Covington and Newport, Northern Kentucky school districts with a significant urban Appalachian and African American populations, were 88% and 71%, respectively.<sup>4</sup>

The jobs of the future increasingly require more than just a high school diploma. The gap between the wages that can be earned with a degree and without is increasing. No longer can a person take a job on the line in a manufacturing facility and expect to

<sup>1</sup> Phillip Obermiller, Kendall/Hunt (1996) *Down Home, Down Town: Urban Appalachians Today*  
<sup>2</sup> Holzman, M., (2006) *Public Education and Black Male Students: The 2006 State Report Card*. Schott Educational Inequity Index, Cambridge, MA; The Schott Foundation for Public Education.  
<sup>3</sup> Maloney, Michael E. and Christopher Auffrey (2004) [The Social Areas of Cincinnati: An Analysis of Social Needs](#). *Patterns for Four Census Decades*, 4<sup>th</sup> Edition, University of Cincinnati., UC Institute for Community Partnerships (UCICP)  
<sup>4</sup> Mitsoff, Tom, (2006) “Big Fat Zero: Walton-Verona has had no dropouts for nearly seven years”, [The Kentucky Post](#), May 25.

earn a living that will support a family. Young people (ages 17-24) who have not graduated from high school face a much more difficult time obtaining employment than their more educated peers. The Center for Labor Market Studies at Northeastern University found that 50% of these young people were unemployed or hold low-paying (earning less than \$300/week) part or fulltime jobs. In 2000, less than half of Cincinnati's 48 neighborhoods had equal to or less than the city wide unemployment rate of 9.0 percent. In 2000 there were six Cincinnati communities with unemployment rates double the city average compared to eleven in 1990, seven in 1980 and five in 1970. African American and Appalachian neighborhoods made up all those with higher unemployment<sup>5</sup>.

According to the U.S. Department of Commerce, the American worker can expect the following average annual salary, based on education level:<sup>6</sup>

- high school dropout: \$19,000
- high school graduate with no postsecondary education: \$26,200
- associate's degree: \$33,400
- bachelor's degree: \$42,200
- master's degree: \$52,300
- doctoral degree: \$70,700
- professional degree: \$81,500

Many questions remain as to the likelihood of success in education and employment for urban Appalachians, particularly those in low-income neighborhoods. For example:

- Are Appalachian children overrepresented in special education and discipline incidents?
- Are Appalachian children underrepresented in magnet schools, Gifted/Talented programs and AP classes?
- Are there successful models within area schools for working with Appalachian children and families? If so, are these models replicable?
- Do second and third generation Appalachians show differences in their educational experiences?
- Are Appalachians overrepresented in unemployment? If so, is the unemployment of Appalachians increasing?
- Are Appalachians concentrated in particular industries?
- Are there programs that show success in decreasing unemployment for Appalachians?
- Do youth employment programs have appropriate representation of Appalachian youth?

---

<sup>5</sup> Op Cit, Maloney and Auffrey

<sup>6</sup> *Saving Futures, Saving Dollars: The Impact of Education on Crime Reduction and Earnings*, Issue Brief, August 2006. *Healthier and Wealthier: Decreasing Health Care Costs by Increasing Educational Attainment*, Alliance for Excellent Education, Issue Brief, November 2006. The Alliance for Excellent Education

- Does the inclusion of Appalachian children in youth employment programs have a positive outcome for future educational and/or employment success?

These questions and others need to be kept in mind in planning research and advocacy efforts for those urban Appalachians who need support traversing the education and employment institutions.

**Appendix A-3:**  
**April 16<sup>th</sup> Conference Evaluation Summary**

# April 16<sup>th</sup> Conference Evaluation Summary

50 people attended the Conference held at the Health Foundation.  
 15 were scheduled for the Education Break-out Group;  
 17 were scheduled for the Health Break-out Group; and  
 15 were scheduled for the Education/Employability Break-out Group.  
 26 individuals returned the Conference Evaluation Feed-back forms. (Results below)

## Urban Appalachian Conference: Research Into Action

1. Did the session meet your expectations? (Please Circle)

Minimally	Satisfactory	Worthwhile	I'd Come Again
		8	18

(maybe focus on other areas where we didn't have a chance to give ideas today.)

2. Would you be interested in a follow-up session? (Please Circle)

Yes	Maybe	No
21	4	1
	As long as it is short and productive	No more discussion: time to get to work

(what we did today will be lost if we don't follow-up) (Include stats from all three break out groups)

(want to know what direction this will go) (More focus in Northern KY) (Liaison Govt/Non-profit ?)

3. What would you like to learn about or discuss more?

- Drop-out Issue; Program Design; What Works;
- Measurement of Appalachians/Who is Appalachian?
- More about Specific Research Going On;
- The Generational Piece of Appalachians –What happens to the 4<sup>th</sup>, 5<sup>th</sup> generations? Do they still have Appalachian Heritage?
- More specifics on Educational and Employment Issues;
- More Data. Barriers; More about the visibility of Appalachians;
- Dispersed Appalachians and Individual Experiences of Appalachians;
- Future Research Efforts;
- Defining the message so that Advocacy can be more effective;
- More in-depth information about each of the three areas—need a minimum of 8 hours or more;
- How can UAC Research Committee act on this information?
- How is this information going to benefit the Appalachian Community?
- Decisions for new initiatives;
- What was simply discussion and what was actualized; Topics were complete;
- UAC relationship to CPS: How are they working together, if at all;
- More about Health Care Studies/Access; How can we access the money? Small business start-up; Preventive Health ; Health is such a huge topic;

- Would like to know more about math cultural practices (Quilting, others) related to urban Appalachians;
- Issues related to Classroom Teachers (not administrators or school system-wide issues).

#### 4. What did we miss?

- What to ask of Brewster/ Governor's Office of Appalachian;
- Needed more time;
- Would have liked to discuss funding sources and opportunities;
- Would have liked to have moved through all groups/topics;
- Testimony from youth on what they feel the problems and solutions are;
- Invite people from Service Organizations, Cancer Society, Deans of Nursing Schools, Health and Human Service Professionals;
- Consideration of Appalachian heritage in Kentucky;
- How can Ohio and Kentucky work together?
- Overall, a good job.

#### 5. What did you like best?

By a large majority, respondents to this question indicated that the most valuable aspect and what they liked best was the open discussion, the diversity of participants, and the value of being able to hear a variety of viewpoints shared. Some specific comments are:

- Acknowledgement of interrelated nature of health/education/occupation.
- The wealth of "brain power" sitting at the table—the collegial work;
- Information, conviviality;
- the Format and the Participants;
- Areas of Research addressed;
- All of it.

#### 6. Additional Comments Though there were only a few last comments they were generally good:

- Good/Nice length of time, good facility, excellent participants, nice job/conference.
- How about developing partnerships with university groups in community?
- Great Discussion in groups;
- A couple of miscellaneous questions or comments;

**Appendix B:**  
**Cardiovascular Health – An Option for UAC to Address**

## CARDIOVASCULAR HEALTH – AN OPTION FOR UAC TO ADDRESS

In 2006, heart disease, the leading cause of death of both men and women in the United States, will cost \$258 billion for health care services, medications, and lost productivity (Centers for Disease Control and Prevention 2006a). Since the late 1960s there has been a decrease in overall death rates from cardiovascular disease, but an increase in deaths from cardiovascular diseases among people aged 15 – 34 years. In 2002, the age-adjusted rate death rate for heart disease in the United States was 241 per 100,000 population. The average person lives 5.5 years longer than they did 30 years ago and 4 years or 73% of that gain can be attributed to progress against cardiovascular disease (CDC 2006).

Heart disease is not equally distributed across the states. Overlaying the CDC map of Heart Disease Rates from 1996-2000 and a map of designated Appalachian states leads to a striking match of many of the areas with the highest rates of heart disease. A 2002 report from the American Heart Association confirms that for cardiovascular disease age-adjusted death rates by state, all 13 Appalachian states rank in the bottom half of the nation. Basically, studies have found that the designated Appalachian region has higher death rates due to heart disease and stroke than the non-Appalachian U.S. (Halverson et al. 2004). In addition, the Appalachian region has higher *premature* death rates from heart disease compared to the non-Appalachian U.S. Heart disease is the primary reason for hospitalization in the region, accounting for approximately 15% of all hospitalizations. Stroke is the fourth most frequent reason, with over 3% of hospitalizations.

The Centers for Disease Control and Prevention have identified conditions and lifestyle factors that put people at higher risk for developing heart disease. The conditions include hyperlipidemia (high blood cholesterol), high blood pressure, and diabetes. The behavioral factors are tobacco use, diet, physical inactivity, obesity, and alcohol use. Heredity is also identified as a factor. Many of the risk factors for cardiovascular diseases are prevalent in Appalachian areas. Compared to the non-Appalachian U.S., the Appalachian region has a greater prevalence of obesity, cigarette smoking, and physical inactivity (Halverson et al. 2004). In addition poverty and geographic location, especially in rural areas, present a challenge to the prevention, identification, and treatment of cardiovascular disease in Appalachia.

The results of the Greater Cincinnati Community Health Status Survey and the Lower Price Hill Women's Study confirm that Appalachians are at increased risk not only for developing cardiovascular disease, but also for most of the risk factors for cardiovascular disease. Compared to the general population, a disproportionate number of Appalachians suffer from high cholesterol, hypertension, and diabetes. In addition, first generation Appalachians in the Greater Cincinnati area: (1) are more likely to be cigarettes smokers; (2) less likely to engage in physical activity at least 3 times a week; and, (3) less likely to have their blood pressure checked in the past 2 years than non-Appalachians. However, historically, the Appalachian population has been characterized as one with a cultural reluctance to participate in preventive health measures (Weller 1965) and to change lifestyle patterns (Reed et al. 1995). Thus, culturally appropriate interventions targeting healthy lifestyle behaviors and access to effective health care are

needed to assist Appalachians in overcoming the cardiovascular problems that continue to shadow them.

While there are some programs that attempt to address a particular segment of the cardiovascular problems that persist among Appalachian people, there is not a comprehensive lifespan approach. The following are examples of programs among the Appalachian population. The Coronary Artery Risk Detection in Appalachian Communities (CARDIAC) project in West Virginia (Neal et al. 2001) screens and treats children for high cholesterol. When a child is identified with high cholesterol, the entire family is tested and treated if necessary.

Other new intervention efforts are targeted toward specific risk behaviors. For example, the Be Active North Carolina-Appalachian Partnership focuses on increasing physical activity. Activities under this initiative include assessing the physical activity needs and challenges of western North Carolina, providing physical activity resources in schools, and collaborating with worksites and community agencies to encourage regular physical activity.

Cardiovascular Disease meets the following criteria set up by the UAC Research Committee as a potential problem area to address. These criteria include the following:

- Relevancy to UAC
- Actionable (something can be done)
- Capability – what is in our area of control
- Probable Outcomes
- There are potential resources that will make a difference
- Specific to UAC or shared with other groups
- Order/flow to the agenda
- Political environment/windows of opportunity
- Are there working models?

As noted above, cardiovascular disease is problematic to Appalachians. The disease is also actionable, in that, many of the risk factors are prevalent and preventable. While UAC may not be capable of the volume of work that would be involved in changing the picture, they are capable of being advocates and acting as a catalyst for change in this area. Given the research that has been done with other populations with cardiovascular disease and given culturally appropriate interventions, there is a high probability that the outcomes for this disease can be changed. Moreover, work done in this area will be pivotal in ultimately changing the outcomes for all Appalachians.

The region is rich in the resources needed to make a difference. The University of Cincinnati has many competent resources. The College of Medicine has a history of leadership in the cardiovascular field with pioneering efforts in stroke treatment. Currently, the College of Nursing is working with school children with respect to obesity, hypertension, and hyperlipidemia. The Program of Health Promotion and Education within the College of Education graduates competent health educators that work in a variety of key settings. Our work within the Appalachian network has positioned us to network with the West Virginia program to reduce high cholesterol in children. A project at Ohio State University uses a promotores program, similar to our own Lower Price Hill Women's Group, to promote health among Appalachian populations. Most exciting at this time is an emerging window of opportunity. The University of Cincinnati recently created a Department of Public Health Sciences within its College of Medicine. Sharing its infrastructure with the University's Institute for the Study of Health and working collaboratively with the Health Promotion and Education program, this Department will house a new Master of Public Health program, with student enrollment and first course

offerings planned for fall 2008. All students will be required to complete a practicum and a capstone research experience within the community. In addition, the Department is establishing an Office of Community Health comprised of senior staff from the tri-state region's public health departments and other community leaders, such as from the UAC, to serve as an academic base for public health practice in the region and give health practitioners an active role in designing, maintaining and teaching within the program, including providing sites for practica and capstone experiences. We believe that the cardiovascular needs of the Appalachian population would provide a signature project for this new public health initiative with advantages for both the University and the Appalachian community.

Therefore we propose that the UAC research committee priority be the cardiovascular health of Appalachians across the life cycle. We believe that our strategy should be one of fostering wide spread collaboration. For example, the Health Promotion and Education Program could be invited to design culturally appropriate educational materials and programs for children to older adults. The Department of Public Health Sciences could design a public health program that includes both research and service delivery including the promotores model. The College of Nursing could expand its program in the schools to those schools with high Appalachian enrollments.

The UAC Research Committee would adopt the role of convener and facilitator. The process would include a planning process to assess community readiness, identify points of intervention for health improvement, and delineate the roles of all principals. Multiple proposals would be submitted for different components of the program. The UAC would continue to convene the principals during the implementation phase. UAC

would act as an interface with community members. UAC would be active in the development of materials to enhance cultural sensitivity. Moreover, as Appalachian program participants experience barriers, such as access to services, UAC will effectively advocate for the process to policy changes needed.

While the first problem addressed will be cardiovascular health, we do not think that this is the only problem in the community. We are also aware that mental health and substance use disorders are also a problem in the community. However, given the effort required and the window of opportunity presented at this time, we will begin with cardiovascular health and disease. Thus, we will “test” our approach on cardiovascular health, knowing that in the future we hope to expand the convening, planning, facilitating, and supporting model to other areas of concern.