

# Closing the Gap

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Conferences

On behalf of the U.S. Department of Health and Human Services, I thank each and every one who participated in the first *National Leadership Summit on Eliminating Racial and Ethnic Disparities in Health*. More than 2,200 of you attended and thousands more viewed selected sessions on the Web.

This convocation of Federal, Tribal, state, local, and community leaders in minority health was too long in coming.

We packed a lot into three days—five major plenary sessions, more than 70 workshops, 57 poster sessions, three public hearings, and a play dramatizing cancer issues. We distributed more than 2,200 copies of a Community Resource Toolkit that is available on the web, and which we will be updating in January. More than 100 exhibitors shared their information and services with our participants. Kaisernet.org produced video webcasts of three major plenaries.

I am pleased that the evaluation forms show high levels of satisfaction with the breadth and content of the workshops, with most agreeing that the topics covered were relevant and appropriate, and that they learned things they could use in their work. For us in HHS, the bringing together of leaders from across the Nation who demonstrate their commitment and devotion to the elimination of racial and ethnic disparities in health was an equally satisfying endeavor.

*Closing the Gap* will devote two expanded issues to highlights of the Summit. In this first issue, we have featured workshops from each of the Summit tracks. We hope to capture the information presented, stimulate interest in areas that may be new to some readers, showcase programs that work, and highlight the efforts of individuals who are committed to those populations most in need. In an upcoming issue, we will complete our coverage of the Summit by highlighting more workshops of interest. We will continue to add to our Summit website as well.

I offer special thanks to the founding members of “Out of Many, One.” These individuals took my deep,

personal belief—that we must work together as **one**, to move the health agenda forward—and developed a united action plan that focuses on common health issues while respecting the differences among communities of color. I trust this message was heard throughout our Summit, and that each of you recognizes the power of partnerships. If our Nation is to reach its potential, all groups must come to the point where shared interests outweigh our differences. We lose too much—in resources, economies of scale, and people power—when we don’t work together. And our people suffer for it.

I extend heartfelt gratitude to my staff at the Office of Minority Health for their effort and dedication to making the Summit a success. I thank the members of the non-Federal and Federal planning committees, because an event such as this could not have been done without their hard work and strong advocacy. I offer thanks to our public and private sector sponsors for their generous contributions.

In planning the National Leadership Summit, we envisioned a series of three conferences. The July event was the first. The second should take place sometime around the middle of the decade, in approximately 2005. At that time, we hope to perform a reality check, to see if what we’ve been doing is working, what has not been working, and what we need to do differently. Finally, we want to come together again at the end of the decade, to evaluate our progress in reaching Healthy People 2010 goals.

For those readers unable to attend the first Summit, I hope that *Closing the Gap* provides you with a new look at some of the innovative programs being implemented today and the wealth of information exchanged at the conference. We hope it inspires you to join us and become a part of the discourse between now and 2005. Good health to all!

Nathan Stinson, Jr., PhD, MD, MPH  
Deputy Assistant Secretary for Minority Health



# Summit-At-A-Glance

Based on responses to a voluntary “participant profile” available when registering for the Summit online (about ½ of all attendees, number may not add to 100% due to rounding), participants were varied in terms of gender, race/ethnicity, focus on host organizations, budget, and other areas.

Gender	
Female	73%
Male	26%
Transgendered	< 1%

Race/Ethnicity of Participants	
African American	42%
White	27%
Hispanic	18%
Asian	6%
American Indian/Alaska Native	3%
Pacific Islander	2%

Race/Ethnicity of Clients Served by Agency	
African American	43%
White	28%
Hispanic	18%
Asian	6%
American Indian/Alaska Native	3%
Pacific Islander	2%

Age of Participants	
< 22	>2%
23 - 31	16%
32 - 40	20%
41 - 50	34%
51 - 60	24%
60 +	3%

Is Your Board of Directors 50 percent or more Minority?	
Yes	44%
No	56%

Agency Annual Budget	
<\$100,000	9%
\$100,001 - \$200,000	3%
\$200,001 - \$500,000	11%
\$500,001 - \$1 million	17%
Over \$1 million	60%

Primary Source of Funding for Agency	
Federal Funding	34%
State Funding	24%
Private Funding	23%
Local Funding	15%
Donations	4%

Agency Demographics	
Non-profit	45%
College/University	20%
Federal Government	15%
State Government	6%
Local Government	5%
For-profit	4%
National Organization	3%
Tribal Government/Affiliate	<1%

*Closing the Gap* is a free newsletter of the Office of Minority Health, Office of Public Health and Science, U.S. Department of Health and Human Services.

The Office of Minority Health Resource Center provides free information on various health issues affecting U.S. minorities.

Send an e-mail to [info@omhrc.gov](mailto:info@omhrc.gov) to join our mailing list or to update your address. Or, write to OMHRC, P.O.Box 37337, Washington, D.C., 20013.



To submit story ideas or to comment on *Closing the Gap* articles, contact Brigette Settles Scott, MA, Managing Editor at the address above or e-mail [bscott@omhrc.gov](mailto:bscott@omhrc.gov).

## Closing the Gap Staff

Blake Crawford  
Executive Editor

Brigette Settles Scott, MA  
Managing Editor

Kauthar B. Umar, MA  
Aimee Swartz  
Monique La Rocque, MPH  
Jody Vilschick  
Writers

John I. West  
Editor/Production  
Coordinator

Stephanie Singleton  
Graphic Designer

## Participant Comments . . .

- “The coming together of knowledgeable, committed speakers, great entertainment, and audience reflected the “real world.”
- “Dynamic speakers – gave helpful and important perspectives. They believe in what they are saying and conveyed it well.”
- “The speakers were excellent but there was too little time for them to complete their presentations.”
- “Cultural celebrations were excellent.”
- “The level of interest shows that this should be an annual event.”
- “Suggest fewer workshops, fewer speakers. This would allow for greater interaction.”

# Collaboration at its Best

## *Partnerships Key to Reducing Health Disparities*

Brigette Settles Scott, MA

According to Dr. Robert Ross, president and CEO of the California Endowment, there are no easy answers when it comes to solving the health care crisis facing racial and ethnic minorities in this country. But, with the help of his organization and others like it, numerous efforts across the country are helping to make quality health care more accessible and affordable, and improving the health outcomes of many Americans.

Dr. Ross was one of the headline keynote speakers for this year's National Leadership Summit where he addressed nearly 2,000 attendees at the luncheon plenary session on the importance of building public-private partnerships to eliminate racial and ethnic disparities in health. Joining him during this well-attended and popular session was Dr. James R. Gavin III, incoming president of Morehouse Medical School. In their separate remarks, both mirrored one another on the importance of developing and sustaining effective public-private partnerships as a key strategy to solving many of the complex challenges associated with eliminating disparities in health—encompassing every aspect of the health care and its related systems.

According to Dr. Ross, the importance of building effective partnerships is helped considerably by one's ability to build an "effective constituency."

"We need to take stock internally of our own ability to build an effective strategy and execute," he said. "Execution always trumps strategy. You execute a strategy to build a constituency to create the political environment under which people can act," he added.

Dr. Ross went on talking about what some may call "a subject that may be a little bit uncomfortable." "I'm going to put something on the table. I'm disturbed that if black folks are in this corner talking about what they must have on disparities and Latinos are in that corner talking about what they deserve and American Indians and Alaska Natives are over in their corners, the disabilities are kind of way over there in that corner, I'm afraid that we will lose a marvelous opportunity to form an extraordinary coalition . . . We cannot afford to be splintered on this issue," Ross said.

"The goals of eliminating health disparities cannot be achieved without a concerted and sustained effort on the development of effective, integrated, inter-agency, and cross-organizational partnerships between the public and private sectors," said Dr. Gavin.

"To make real progress on eliminating racial and ethnic disparities in this country, the full integrated participation of partners that comprise the public and private biomedical, epidemiological, clinical and behavioral research sectors, the social policy and health economy sector, health and healthcare training programs, the political sector, health-

care administration, especially managed care, public health workers and thought leaders, community- and faith-based organizations, private industry, philanthropy and an informed and empowered citizenry will all be required to achieve this goal," Gavin added.

Each year, private sector organizations such as the California Endowment, Ford Foundation, Kaiser Family Foundation, Robert Wood Johnson Foundation, and the Gates Foundation provide millions of dollars of funding to address core health issues. Without the resources expended by private sector foundations—in partnership with a wide range of other organizations—critical research and communication campaigns aimed at reducing racial and ethnic disparities in medical care would not be possible. It is through these collaborative efforts that quality health care programs are made available to consumers, which may otherwise not exist.

Cory Hoze, HHS Regional Director for Region V in Chicago, and plenary session moderator added that alliances underscore the importance of public-private partnerships working together and sharing resources and expertise to reduce disparities in health. "The Federal government itself, even working with state and local governments, cannot achieve its ultimate goal without building strong partnerships with the private sector," Hoze said. "HHS believes that building meaningful partnerships is key to achieving our goal of eliminating racial health disparities," he added.

### Partnerships at Work

When viewed on a broad scale, the elimination of racial and ethnic disparities in health may seem overwhelming and impossible to solve. However, Federal, state, and local public-private initiatives across the country offer hope that positive changes in the health status of minorities is possible. Moreover, community-based programs have made great progress in increasing access to care and improving the delivery of quality health care services.

Partnership activities are expanding throughout the country. The California Endowment is one example of the public and private sectors working together to reduce disparities in health. Created in 1996, the California Endowment is a private, statewide health foundation with \$3.1 billion in assets. Through October 2002, the Endowment has awarded more than 3,400 grants totaling more than \$968 million to community-based organizations throughout California. The Foundation's goal is to expand access to affordable quality health care for underserved individuals and communities within the state. The California Endowment expects to distribute more than \$200 million in funds over the next five years.

*Collaboration continued on 7*

# Latina Promotoras Educate Farmworkers

## *Diabetes Control is the Message*

Brigette Settles Scott, MA

At the Centers for Disease Control and Prevention (CDC), Racial and Ethnic Approaches to Community Health (REACH 2010) is a cornerstone initiative aimed at eliminating disparities in the health status experienced by ethnic minority populations in six priority areas—cardiovascular disease, immunizations, breast and cervical cancer screening and management, HIV infections/AIDS, infant mortality, and diabetes.

One coalition charged with heeding the call to reduce morbidity and mortality related to type II diabetes in the Texas Rio Grande Valley is the REACH Promotora Community Coalition. Led by Migrant Health Promotion, a community-based non-profit organization that develops, implements, and evaluates peer health educator programs in farmworker communities nationwide, the coalition brings together seven distinct agencies in collaboration with local, state, and national advocacy organizations. Each intervention of the coalition combines health education with advocacy for community and system changes that support healthy lifestyles.

### Models that Work

Building on its 1996 Department of Health and Human Services award for models that work, Migrant Health Promotion is extending its *promotora* (lay or peer health educator) model by implementing an intensive diabetes education program in the Texas-Mexico border region.

“*Promotoras* is a model that works in Mexican American communities on the border, and that model would exist with or without funding. It’s an informal leadership model of creative ways people get their needs met when they don’t have access to services. So, by superimposing some training, funding, and technical assistance on top of a model that already exists, it is truly the way community intervention should function. The community decides what works best for it. That seems to be what has risen out of the *promotora* model,” said Laura Regan, REACH program director.

The typical *promotora* is about 30, female, and Mexican American. She is usually a more mature woman who has taken on the leadership role in the community. She usually has children herself, and may or may not be married. Overall in the coalition, there are 22 trained *promotoras* who each receive 200 hours of training.

“The training our *promotoras* receive includes information on anatomy, diabetes risk factors, complications of diabetes, medical treat-

ment of diabetes, gestational diabetes, leadership, communication and advocacy, nutrition and physical activity, and how to work with the community to conduct health fairs,” said Regan.

The Coalition has three different areas of intervention: clinic, school, and community. Three clinics conduct the clinical interventions. *Promotoras* working with clinic staff, conduct home visits or accompany patients when they visit their health care providers. The school component is charged with making systemic change using CDC’s school health index. Three schools are implementing the recommendations. “So far, each school has been successful in getting rid of the snack and soda machines, as suggested by the school health index,” said Regan. “Others have secured funding through REACH to add water filtration systems.”

For the community outreach component, *promotoras* offer in-home support and education to residents on diabetes and are leading walking groups and conducting cooking classes with Mexican American residents in the valley. All services are provided in Spanish, and the *promotoras* use a variety of different materials and techniques to enhance learning and understanding. “One of the tools the *promotoras* use is a pictograph. Even in Spanish we have a low literacy rate, so even if you have good translated Spanish materials it might not service literacy needs. For example, *promotoras* use pictures that depict someone being thirsty—like holding their throats to indicate excess thirst—and relate that as being a symptom of diabetes. That’s just one example, but there is a symptoms list that’s all pictograph-related. It’s really powerful to go to one of these homes to watch the *promotoras* in action. The communication is really profound. *Promotoras* also have a training curriculum where we try really hard to expose them to other resources and agencies,” explained Regan.

### Grassroots in Action

Carmen Soto, a lay health educator has found the interventions to be rewarding to herself and her family, and has noted marked improvements in the healthy behaviors adopted by many residents.

“I’m a health promoter, and work with the REACH program in Progresso, TX, where I also live. I’ve been working for a year and half, and like it a lot. I can see changes in my community already. People are walking and involved in physical activity, have changed their cooking habits by using less fat when they cook, and they don’t use much salt because it compromises health. One of the most empowering things that I’ve seen is that we’ve taught people to read labels, and to my knowledge, that hasn’t happened before. I get comments all the time when we conduct that particular session in the community. They say things like, ‘Oh I never read that, I just buy what’s on sale,’” explained Soto.

Latina Promotoras Educate Farmworkers—Diabetes Control in the Message is based on the Summit workshop Promising Practices in Eliminating Health Disparities: Diabetes, Wednesday, July 10, 2002.

“Another thing that I’ve seen happen is that people now understand what the blood pressure numbers mean. In the past, the doctor would be a little patronizing with them, and say that ‘you’re fine, your blood pressure’s fine, your sugar’s fine. Before, people would never ask what the numbers were, what they meant, or how close to the border of risk they truly are. But now, folks feel that they can advocate for themselves a little better.”

Outreach activities are usually tailored to specific community needs. The *promotoras* first conduct outreach in a specific block area, where they go door-to-door, show the pictograph about the symptoms of diabetes, and recruit participants on the spot. According to Soto, many residents want the prevention interventions, and as a result, are able to unite the folks who express an interest, bring them together in one of their homes, speak about diabetes, and conduct cooking demonstrations right in their own kitchen.

“The outreach really becomes a community event,” said Soto. “We also walk around the neighborhood so that folks can have experiences that fit their lives. But, sometimes, there are folks that want to go to a park, and we’ll do that. So our walking classes can be early morning or late evening, we set our hours based on what the community wants.”

### Barriers to Prevention

Although Migrant Health Promotion has been successful in implementing its *promotora* model, barriers to effectively reaching those most at risk still exist. According to Regan, one of the primary barriers is transportation. Although the Rio Grande Valley has experienced phenomenal growth along the border, it is not yet considered a metropolitan statistical area. Because of this, many of the roads remain unpaved, and there is no public transportation.

“Right now, we are a lot of smaller communities stretched out on one highway, and it still has a rural feel to it, because it’s agriculture-based,” said Regan. “One of the big issues for our migrant population is transportation, which makes the *promotora* model even more important and impressive. *Promotoras* are indigenous folk in the communities that are trusted and known, and

live right there. We’re working toward getting the cities to chart out walking maps and safe lighted walking paths. That’s one of the things colonia [rural, unregulated, low-income neighborhoods] folks talk about a lot. There are dogs. Our streets are dirt, there’s not necessarily a safe walking place. So you know, access to parks requires systemic change.”

“There’s a community word of mouth about *promotoras* and their work, so we always need more of them,” added Regan.

“We can’t reach all of the people who need help and are asking for the intervention. Word of mouth gets out about the cooking classes, and walking classes, and the community really doesn’t understand that this is a research grant about health promotion intervention models. They see it more as a social service. We are having a little trouble from an administrative perspective because our control group wants the intervention. So, it’s hard to do this type of work, and remain in good graces with all of the residents.”

This year, more than 20 *promotoras* have played key roles as educators, planners, evaluators, and leaders. They have received over 200 hours of training in diabetes, nutrition, and physical activity and share this information with parents, teachers, students, colonia residents, patients at community health centers, and the community at large. In just the first six months of operating (October 2001-April 2002) community-based *promotoras* conducted nearly 1,200 individual educational encounters, and provided over 350 cooking classes for residents.

“Our success is built on grassroots, grassroots, grassroots! The *promotora* model is about adapting, enhancing, supporting, and funding the models that already exist in the community. We see *promotoras* as being that model that works,” concludes Regan.

*For more information on Migrant Health Promotion and the use of promotoras in health education and promotion, contact Laura Regan, REACH program director at LLReganMPH@yahoo.com or 956-565-0002. ♦*

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Office of Public Health and Science  
U.S. Department of Health and Human Services

\*In support of Departmental policies, the Summit did not accept sponsorship, exhibit, or advertisement requests from alcohol or tobacco companies. The Summit did not accept advertisements for specific medical products, devices, procedures, or services.

# Telemedicine Works

## *Quality, Access, and Cost Impacts Cited*

Kauthar Umar, MA

Today, the use of electronic information and communications technologies routinely provide and support health care, even when considerable distances separate patient and provider. Technology has made clinical care, distance education, medical research, and administration possible in parts of the world traditionally unexposed to such advancement.

"When you call the doctor and say, 'Doc this is the problem? Should I take a couple of aspirin, should I come in? What should I do? That's telemedicine,'" said Michael Ackerman PhD, assistant director for High Performance Computing and Communications at the National Library of Medicine (NLM), National Institutes of Health. "There's no magic here. We've been using it all along. We've been characterizing it in another way, but we've been using it [telemedicine] all along."

However, Dr. Ackerman argues, telemedicine extends far beyond this definition. It isn't simply a venue for long distance communication, but actually serves as the platform for introducing the latest research and technology.

### Making Global Connections

The NLM began experimenting with telemedicine as early as the 1970, and Dr. Ackerman believes that this format of health care is having a resurgence. The Internet, video conferencing, and electronic text have replaced equipment that took days to operate. Telemedicine supports medical decision-making in ways unheard of just ten years ago. For example, the emergency room at Umtata General Hospital/University of Transkei School of Medicine (UNITRA) in South Africa, which serves a large rural population, partnered with Washington, D.C.'s Howard University Hospital to develop the Emergency Medical Internet Technology Tool (EMITT).

The project, funded by the United States Agency for International Development (USAID), teaches emergency medical practices and principles to physicians and nurses in South African health care facilities, through self instruction modules, live teaching conferences from Howard University in emergency medicine, case consultations that allow physicians to collaborate in real time between the two institutions on difficult to manage emergency and trauma cases, and access to databases for medical information for health care professionals.

"Our goal is to help educate them in emergency room procedures from our experts at Howard. We get a lot of information from them on

how to do emergency medicine, as well," said Ernest Carter, MD, PhD, director of the Howard University Telehealth Sciences and Advanced Technology Center (HUTSATC) and executive assistant to the Dean, College of Medicine. "We found that with the solution that we put together, they are able to share in some of our emergency room conferences as well as our difficult diagnoses. Telemedicine really helped to move that forward."

Under the center, the EMITT project has expanded, and in 2001, Howard was the first university to partner with the Global Development Learning Network of the World Bank. As a one of the network's 80 program partners, the center has created new links with Ghana, Senegal, Uganda, and Benin to provide distance learning programs.

Despite the advantages, telemedicine has not gone without criticisms. "Telemedicine does not reimburse," said Dr. Ackerman. "There is no reimbursement because the people that make these decisions say that in order to have a relationship with a physician or health care provider, there has to be a one-on-one, eyeball to eyeball, touchy-feely, relationship. You can't do that across television or on the phone."

### Finances and the Indigenous Worker

Medical finances have been drastically altered due to telemedicine. In many places, it has provided a way for the medical community to cut costs without jeopardizing health care. In the U.S. Flag Territories (American Samoa, Guam, Commonwealth of the Northern Mariana Islands) and the Freely Associated States (Republic of Palau, Federated States of Micronesia, Republic of the Marshall Islands), telemedicine has literally changed the cost of medical care, access to it, and how medical care is administered.

Before the Internet was introduced in the mid-1990s, Pohnpei, like the other US-Pacific jurisdictions, spent 25 percent of all health care dollars on off-island medical referral costs for the fewer than one percent of patients who had to be transferred off the island. "The medical referral problem was the same throughout all the jurisdictions, with a large proportion of health care budgets being spent on just a few people to be sent off island," said Dr. Gregory J. Dever, MD, director of the Bureau of Hospital and Clinical Services in the Ministry of Health, Republic of Palau.

"In Palau the referral process was conducted by the governor and not by the physicians, so if you were related to the governor or part of the family then you got referrals for free," said Dever. "If you weren't politically or culturally elite then you weren't in. It's different now."

The Republic of Palau has a population of nearly 20,000 people that are highly vulnerable to communicable and non-communicable diseases, have high infant mortality rates and until recently, a medical

Telemedicine Works—Quality, Access, and Cost Impacts Cited is based on the Summit workshop Health Professionals and the Use of Telemedicine Technology, Wednesday, July 10, 2002.

community with little power to make change. The Pacific Island Health Care Program (PIHCP) and the Akamai Project, two programs at the Telemedicine Clinic at Tripler Army Medical Center (TAMC) in Honolulu, Hawaii, standardized the medical consult/referral process and dramatically improved organized and equitable access to the PIHCP for Palau and the participating US-Pacific jurisdictions.

In 1994, TAMC introduced to Palau the Picasso Still-Image Phone. Manufactured by AT&T, the Picasso, the size of a small briefcase, was a still-image capture system that transmitted over regular phone lines and operated like a full color, paperless, fax machine. Freeze-frame images captured at the sending end by a camcorder were transmitted to a remote receiver unit where they were displayed and stored.

"The problem with the Picasso phone was who pays for the long distance phone call? The program at TAMC has replaced the Picasso phone," said Dr. Dever. "However, telephone lectures with the use of previously downloaded Power Point presentations are still very effective. The Picasso set the stage

for what's in place today. The Akamai Project, in particular, is TAMC's telemedicine effort to provide distance medical consulting through an Internet-based web site. It is now an integral part of the PIHCP process, and all medical consult/referral requests to the PIHCP must go through the Akamai Internet system," said Dr. Dever.

Similarly, the University of Hawaii runs the PeaceSat system, a public interest communications system providing video teleconferencing capacity. The PeaceSat system increased the number and efficiency of distance medical consultations and referrals particularly to the TAMC Pacific Islands Health Care Programs. Today, specialists and physicians can request and provide medical consultation from their home or work computer with response times of 1-2 days. In addition CAT scans and echocardiograms can be read by TAMC radiologist through the Akamai/PIHCP website.

"These forms of telemedicine have decreased politically-based medical referrals and drastically changed many people's lives," said Dr. Dever. These have since been used for patient consultations, for delivering medical

lectures throughout the Pacific Basin, and for case conferences. This form of telemedicine has assisted with physician recruitment and retention, increased regional medical self-reliance, reduced professional isolation, and greatly reduced medical costs.

"It's getting easier and easier and more user friendly and it's working," said Dr. Dever. "I've been a critic in the past, but finally it's showing real results."

*For more information on telemedicine programs, contact President of the Pacific Basin Medical Association, Dr. Victor Yano, at [bmc@palaunet.com](mailto:bmc@palaunet.com)* ♦

*For more information on the National Library of Medicine's High Performance Computing and Communications division, contact Dr. Michael J. Ackerman, at [ackerman@nlm.nih.gov](mailto:ackerman@nlm.nih.gov)* ♦

*For more information on the collaboration of Howard University and the University of Transkei, South Africa, in Emergency Medicine visit <http://www.emitt.howard.edu>* ♦

*For more information on the Global Development Learning Network partnership with HUTSATC, go to <http://www.gdln.org/help.html>* ♦

### Collaboration from 3

"In order to help us achieve these goals, we firmly believe in the principle that communities must serve as the driving force for effecting change," said Dr. Ross. "Partnerships and alliances with key stakeholders to advance a health and well-being agenda are critical. Whether with our grantees, fellow foundations, state government, or others, we recognize the power of working together to leverage our resources."

All present seemed to agree that there is strength in numbers. Maximizing resources is a cost-effective benefit of creating partnerships. "Whether through financial support or human sweat equity, innovative strategies can be employed to reach the desired goal," Dr. Ross said.

Like the California Endowment, other foundations and health-related organizations have recognized the importance of building collaborative partnerships to make best use of resources and to have the greatest impact on eliminating health disparities. On the national level, the Kaiser Family Foundation funds activities in minority health focused

on efforts to reduce disparities specifically in health care access, such as policy research analysis and media and public education activities. Likewise, through its philanthropy efforts, the Robert Wood Johnson Foundation partners with hospitals, medical, nursing, and public schools, hospices, professional associations, research organizations, state and local government agencies, and community groups by funding training, education, research, and projects aimed at delivering quality health care services.

While the impact of public-private partnerships through national foundations, organizations and government is unquestionable, partnerships formed at the grassroots level can also yield significant results. According to Dr. Gavin, the key is to explore all of the possibilities. "Community- and faith-based organizations within the private sector are critical to effective partnerships," Dr. Gavin said. "It's because they are the most credible and persistent voices of individual accountability," he added.

Gavin further believes that more can be

done to leverage resources and create additional partnership opportunities. "I think that we have underutilized the potential of foundations," said Gavin. "Likewise, we have underutilized the potential of the pharmaceutical industry as a partner in elimination of disparities," he said.

Dr. Gavin stressed the need to be creative in the way all of us perform our public and private partnerships, assign resource allocation and promote integration of messages across the health system. "By focusing on new or more effective ways of developing these partnerships and allocating resources to address and eliminate health disparities, I believe we will provide the necessary forums and dialogs and the mechanisms for assaying whether we are targeting funds and human capital in the right direction for achievement of this increasingly urgent goal for the whole of society," he said.

*For more information on the organizations included herein, please contact the Office of Minority Health Resource Center at 800-444-6472.* ♦

# Appalachia Hit Hard By Cancer

Aimee Swartz

Cancer is the second leading cause of death in the U.S., but cancer death rates are not the same state by state or region by region. Appalachia has a high prevalence of risk factors for cancer, including tobacco use, physical inactivity, obesity, and inadequate access to health care, and its cancer rates are higher than in the rest of the U.S.

During a 1994-1998 study period, there were 173.1 cancer deaths for every 100,000 people living in Appalachia, compared with 166.7 cancer deaths per 100,000 nationally. In rural parts of Appalachia, the rate rose to 176.3, according to collaborative research conducted at the University of Kentucky, Pennsylvania State University, and the Centers for Disease Control and Prevention.

"In the past when looking at health disparities, we hadn't carved out Appalachia. State statistics often hide regional disparities," said Bruce Behringer, MPH, of the Office of Rural and Community Partnerships at East Tennessee State University. "Significant health disparities can be seen between this population and both the general and White populations."

Appalachia is a 200,000-square-mile region comprising 13 states and 410 counties, from the spine of the Appalachian Mountains in Southern New York to Northern Mississippi. The only state entirely within this region is West Virginia. Appalachia is home to predominantly White populations, but growing African American, Hispanic, and American Indian communities can be found within the region's lines. The population of Appalachia is approximately 8.3 percent of the total U.S. population.

Researchers found that death rates from breast, cervical and colorectal cancers varied within the Appalachian region, but that lung cancer death rates were almost universally higher in Appalachia than in the rest of the country.

Nationally, there were 48.9 lung cancer deaths per 100,000 people during the five-year study period. In Appalachia, however, the rate was 53.9; in rural Appalachian counties, the rate was 57.2, almost 17 percent above the national average.

Researchers found that the lung cancer death rate among Appalachian women to be almost the same as the national average. Among men in Appalachia, the rate was 17 percent higher, and almost 26 percent higher among men in rural counties.

The number of deaths caused by lung cancer is so high that it drives up the rest of Appalachia's cancer rates, explained Stephen

Wyatt, associate director for cancer control at the University of Kentucky's Markey Cancer Center.

While the region's higher rates of poverty, lower educational attainment, limited access to health care and insurance, lack of transportation, and social and cultural barriers have contributed to higher death rates, researchers found the epidemic of male smoking in Appalachia plays the greatest role in lung cancer deaths.

## NCI Addresses Appalachia's Cancer Burden

Having recognized the disproportionate cancer mortality rates in Appalachia, the National Cancer Institute (NCI) in summer 2000 launched the Special Populations Network for Cancer Awareness Research and Training to address the burden of cancer in marginalized communities like Appalachia. As part of this program, the Northern Appalachia Leadership Initiative on Cancer, administered by Penn State's College of Agricultural Sciences, received a five-year, \$2.1 million grant for the NCI to expand into the Appalachian Cancer Network (ACN).

ACN serves rural, medically underserved communities in Kentucky, Maryland, New York, Ohio, Pennsylvania, Tennessee, Virginia, and West Virginia. The ACN coordinating center is based at the University of Kentucky, with key regional affiliates at West Virginia University and Pennsylvania State University.

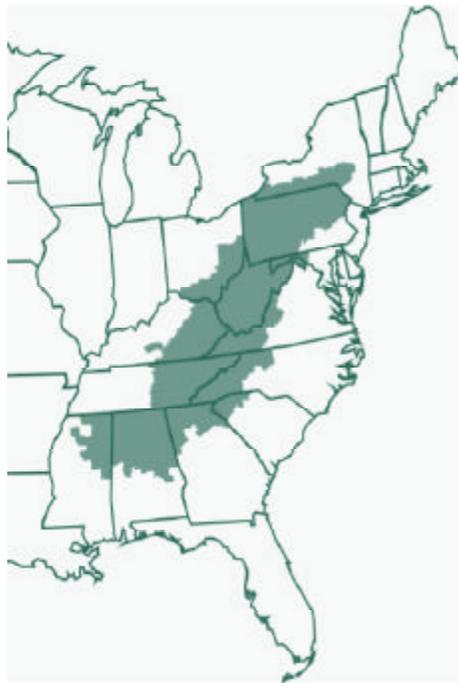
Now in its second year, the eight-state project, a consortium of academic researchers and community-based cancer control coalitions, is bringing more cancer control interventions to Appalachian communities, focusing

on increased treatment options and cancer research for rural, low-income families. ACN priority areas are cancer research, tobacco issues, and prevention and treatment for cancers of the lung, cervix, colon/rectum and breast. The ACN comprises three regional offices; each one is a diverse coalition of organizations with its own strategic programming in place to address cancer.

## Coalition for Southwest Virginia Takes Action

"The need for a cancer support and resource center initially emerged from local coalition and story-gathering meetings in the rural Appalachian areas of Lee, Scott, and Wise counties, and the city of Norton in the mid-1990s," said Becky Stapleton, ACN's regional

### Appalachia\*



\*Includes the 410 counties comprising Appalachia as determined by the Appalachian Regional Commission

program manager. The coalition for South-west Virginia was and is comprised of members of many different community groups, health care organizations, cancer survivors, and other community members.

After meeting for several years as a group, several coalition members were professionally trained to facilitate “story-circles,” through which cancer survivors and family members could share their cancer experiences. Several common themes emerged, including the need for increased information about cancer and the desire for a non-clinical, homelike atmosphere in which those affected by cancer could receive information and support. These findings led to the establishment in 2002 of the Mountain Laurel Cancer Support and Resource Center, in Big Stone Gap.

The center’s mission is to expand community awareness and education, and to enhance the quality of life of cancer patients, family members, and caregivers by addressing their psychological, social, emotional, spiritual, and physical needs related to the impact of a cancer diagnosis. They provide personalized cancer information and support in a community-based, welcoming, and private environment.

The center offers Internet resources, print and other media information about cancer, a general support group led by a licensed professional counselor, a women’s support group, educational programming and a story-telling project that includes a dramatic presentation of local cancer experiences.

“The center’s opening was the fulfillment of a 10-year dream for cancer patients and survivors in our area,” Stapleton said.

*For more information on the Appalachian Cancer Network, call 859-219-0774 or go to <http://www2.kcr.uky.edu/acn/default.html>*

*For more information on the Mountain Laurel Cancer Support and Resource Center, go to <http://www.mountainlaurelcancer.org/> or call 276-523-4202. ♦*



Photograph by Paul Davis, “Out of Many, One”

## Oregon Group Promotes Cultural Competency

The Salud Primero Medical Access Project is meeting the challenge of improving access to health care for the Latino LEP (limited English proficiency) population in Lane County, Eugene, OR. Its goal is to increase both accessibility and utilization of health care and expand the linguistic and cultural competence and the capacity of providers.

Salud Primero also addresses the health disparities among the Latino population for diabetes infection and HIV/AIDS transmission by focusing on preventive education in the community.

Salud Primero is engaged in training community members to reach the Latino LEP community with culturally and linguistically appropriate diabetes and HIV/AIDS information and prevention materials. By providing free testing for diabetes and HIV through collaborative relationships, Salud

Primero is striving to create a stronger treatment referral system for Latino diabetes and HIV/AIDS patients.

Currently, Salud Primero is in the process of collecting data from providers, medical administrators, project staff, Latino participants, and medical records/service utilization databases. An evaluation team, working with the Oregon Social Learning Center (OSLC), will analyze the data and provide feedback. Demographic data collected will help researchers pinpoint problem areas for concentrated efforts.

Salud Primero’s goals are: to decrease hospital emergency room utilization among the Latino population for diabetes and HIV; increase the number of providers with Spanish-speaking capability; increase access to health information for LEP Latinos; and improve Latino patient satisfaction with medical care in Lane County Oregon. ♦

Appalachia Hit Hard By Cancer is based on the Summit workshop Appalachian Health Disparities: Problems and Solutions, Friday July 12, 2002.

Centro Latino Americano’s Salud Primero Medical Access Project -Poster Session PA-17  
This profile was provided by Nedine Karakaplan, MA, Centro Latino Americano, Eugene, OR.  
Go to <http://www.omhrc.gov/summit/abstractoc.htm>  
to view individual poster presentations and see the abstract list from the Summit.

# Take Two Ginger Root and Call Me In The Morning

Kauthar B. Umar, MA

“Do you know why people still keep going to curanderas and curanderos, (spiritual healers),?” asked Elena Avila, RN, MSN, Curandera. “Because it works, that’s why. It works.”

In the United States, complementary and alternative medicine (CAM) is becoming a specialty, with racial and ethnic minorities representing a large portion of its consumers. Avila, a spiritual healer for 25 years, says Curanderismo—a blend of African, Spanish, and indigenous medicine and medical techniques—is used among minority communities in the United States, frequently alongside western medicine.

“I don’t treat a diagnosis. I treat the person,” said Avila. “You might come to me and maybe you wanted me to give you a magic herb for your diabetes. Then you discover I don’t have that, but I’ll help you with your nutrition. I’ll educate you. I’ll refer you to a physician. I have forty apprentices, most of them nurses, doctors, and massage therapists, with this idea of being inclusive,” stressed Avila. “I have one apprentice who is a doctor of oriental medicine, she’s a registered nurse, and now she’s an apprentice in Curandismo. I think that is our future.”

For years, CAM has been misunderstood and rejected by practitioners of conventional medicine in the U.S. However, within the past decade it has grown in popularity among the American public and medical community, although skeptics remain. Today, many untested CAM treatments that aren’t used in hospitals or reimbursed by medical insurance companies are widely used by patients without their physician’s knowledge.

In a 1998 *Journal of the American Medical Association*, article “Trends In Alternative Medicine Use in the United States 1990-1997 Results Of A Follow-up National Study,” Dr. David Eisenberg, of the Center for Alternative Medicine Research and Education, Beth Israel Deaconess Medical Center, reported that 40 percent of Americans used CAM, although 60 percent of the time patients didn’t inform their physicians.

Many patients opt not to disclose use of CAM to their physicians out of fear of embarrassment. Physicians, often reluctant to advise patients about CAM, either lack knowledge or believe it to be “witchcraft” and disregard it. Harmful side effects may occur if CAM is misused, and dangerous drug interactions can occur when combining certain CAM treatments with conventional medicine. Practitioners say this can be avoided with proper medical regulations.

“Caribbean people living in urban areas in the United States, feeling physically removed from their native culture, will turn to tra-

ditional health remedies from their culture, just as everyone else does from different ethnic groups,” said Jacqueline A. Watson, DO, MBA, of Health Concepts International, a health care management and consulting firm in Washington, D.C. “Providers must therefore enhance their communication with diverse populations and acquire the basic knowledge to understand culturally influenced health behavior.”

## Incorporating CAM

Acquiring knowledge of culturally influenced health behavior is easier said than done. The lack of communication between health practitioners and patients who use CAM presents difficulty in assessing patients needs, argued Dr. John C. Pan, clinical professor and director of the Center for Integrative Medicine at George Washington University Medical Center. Dr. Pan stressed the need for cultural sensitivity and praised an ongoing study of limited-English-proficient Asian American patients of Chinese and Vietnamese descent in community health clinics nationwide.

Supported by the Agency for Healthcare Research and Quality, this study is in the process of developing a questionnaire for use in evaluating the quality of health care provided to Asian Americans of Chinese and Vietnamese descent. According to Dr. Pan, research shows that many traditional healing practices present barriers to quality care, especially if providers lack sensitivity to these concerns, or are simply unfamiliar with CAM.

“The questionnaire is culturally sensitive. It deals with cultural health beliefs and practices and it’s very important,” said Dr. Pan. “In the practice of traditional Chinese medicine, one of the common things is the belief that health reflects the balance of yin and yang, hot and cold elements, within the body. The traditional custom of rubbing the body with oil and a coin to release the cold element may result in a lot of bruises. When you don’t understand it you think there’s some abuse going on. These are the things to which health providers need to be sensitive. So, these are the things that will be incorporated in this questionnaire.”

In an attempt to successfully integrate traditional Chinese medicine (TCM) into the U.S. medical system, NIH’s National Center for Complementary and Alternative Medicine, the University of Maryland, and the Health and Welfare Bureau of the Government of Hong Kong’s Special Administrative Region co-sponsored the workshop, “Enhancing the Evidence Base for Traditional Chinese Medicine—Practice Methodology and Grantsmanship,” in Hong Kong. Held October 30-31, 2002, the workshop created a forum to encourage further investigation and consolidated the evidence base for TCM as well as impacted the future of patient care and policy.

Take Two Ginger Root and Call Me In the Morning  
is based on Summit workshop  
Traditional, Complementary and Alternative Medicine in the Health  
Professions, Wednesday, July 10, 2002

Take Two continued on 11

# The New Old Disease: Hepatitis C

Aimee Swartz

**A**s a disease that has infected nearly four million Americans, a disproportionate number of whom are African American and Hispanic, hepatitis C is deservedly gaining attention in the research and the public health arenas.

The hepatitis C virus (HCV) causes inflammation of the liver. The majority of people infected with HCV experience chronic infection (defined as detection of the virus in the blood over a 6-month period) with no symptoms. If symptoms are present, they may be very mild and flu-like, such as nausea, fatigue, loss of appetite, fever, headaches, and abdominal pain. HCV virus is now the most common blood-borne infection in the U.S. Infection now occurs mostly through injection drug use, high-risk sexual behaviors, occupational exposures such as accidental needle sticks and mother-to-infant transmission.

HCV's incubation period varies from two to 26 weeks. Liver enzyme test results may vary from being elevated to normal for weeks or even a year. During this period, the virus is in the blood and may be causing liver cell damage, and the infected person can transmit the disease to others. The good news is that in 1995 an antibody test for HCV was finally implemented nationwide. However, the majority of people infected with HCV go undetected until their liver is involved.

"African Americans, in particular, have been shown to underutilize screening and treatment services and often present with more advanced disease than Caucasians," said Thelma King Thiel, chairman and CEO, Hepatitis Foundation. "Rates of infection are high, and outcomes are often worse."

## Kicking Hepatitis C

In response to this issue, the Hepatitis Foundation partnered with the Centers for Disease Control and Prevention (CDC) to develop HCV prevention videos. The videos are aimed at catching people

*Take Two* continued from 10

Panelists agree that CAM's legacy will continue to grow in the U.S., and the medical community must come to terms with this reality and embrace the challenge. Health professionals must become more culturally competent and this can begin in medical schools with the help of CAM experts from various ethnic communities. CAM practitioners believe, alongside conventional medicine, alternative medicine should be acknowledged and researched by the medical community to eliminate health disparities and ensure patients safety.

"We need to engage the traditional practices out there and we need to create a dialogue to tear down the wall between the practitioners and patients," said Dr. Pan. "We need to understand what herbs people are taking, and go from there."

*For more information, contact the National Center for Complementary and Alternative Medicine Clearinghouse at 888-644-6226 or go to <http://nccam.nih.gov/> or e-mail [nccamc@altmedinfo.org](mailto:nccamc@altmedinfo.org)* ♦

before they become infected and emphasize prevention. "Hepatitis C must be a priority," said Thiel. "Awareness of the disease is so low, which is why we've developed our educational videos."

Community-based STD clinics are encouraged to show *The Invisible Threat* and *The Silent Stalker* to teach clients how to avoid high-risk behaviors and symptoms of the virus. "We try to show them the importance of the liver because many people just don't know," said Thiel. "Children, especially, don't understand the importance of their livers."

The Hepatitis Foundation also produced a video aimed at children and youth, *Respect Yourself—Protect Yourself*. The video promotes taking responsibility for one's own health care and helps teens identify risky behaviors and liver-damaging activities.

"We have to start lifestyle changes before kids are involved in high-risk behaviors," Thiel explained. "We have an obligation to help kids stay healthy."

The videos, which are available in English, Spanish, Vietnamese, and Mandarin, as well as an "urban" version, can be found on the Hepatitis Foundation website.

In October 2002, the Foundation launched a partnership through which middle schools and high schools in Montgomery County, MD, will adopt a liver wellness program using information and videos provided by the Hepatitis Foundation. "We anticipate that this kind of collaboration will really take off in schools throughout the county," Thiel said. "Our videos have been recognized by the CDC, as well as other health agencies, for being an excellent resource in promoting hepatitis C prevention."

"We need to change the way people think about hepatitis C. We need to think more about prevention and diagnosis than treatment," Thiel said. "It is crucial to catch it before it becomes chronic. We need to prevent it, but if we miss out there, then we need to diagnose it within the first two weeks."

The Hepatitis Foundation also provides education, training programs, and materials for the public, patients, health educators, and medical professionals. In addition, it supports hepatitis research and maintains a patient support network, a toll-free hotline, a database of hepatitis support groups and a comprehensive website.

*For more information about the Hepatitis Foundation, go to <http://www.hepatitisfoundation.org> or call 800-891-0707.*

*For more information about the CDC's hepatitis programming, call 888-4-HEP-CDC.* ♦

The New Old Disease: Hepatitis C  
is based on the Summit workshop  
The New Old Disease: Hepatitis C, Wednesday, July 10, 2002.

# Lack of Minority Role Models Affects Nursing Shortage

Jody Vilschick

There are too few minority role models in the health care professions, according to Dr. Betty Smith Williams, president of the National Coalition of Minority Nurses and immediate past president of the National Black Nurses Association (NBNA).

The National Sample Survey of Registered Nurses, conducted in 2000 by the U.S. Department of Health and Human Services, indicated that 86.6 percent of registered nurses are White, and just 12.3 percent are non-White. African American nurses make up the largest subgroup of minority nurses.

This lack of diversity is a special concern to nurse educators concerned about the next generation of nurses. "Ethnic minority role models are essential to influencing minorities to pursue a career in nursing," Williams said. "If they aren't there, they cannot influence young minorities." The lack of nurse role models also discourages minority students from seeing themselves as successful nurses, Williams said.

This issue is acute because of the looming shortage of nurses in general. "We must tap minorities to fill the need for nurses," Williams said. "To do that, minority role models must be visible. We are not yet visible."

According to Williams, other barriers to minorities seeking nursing education include:

- ❖ Inadequate preparation for the healthcare professions in high school;
- ❖ A lack of information about nursing as a profession;
- ❖ The cost of pursuing an education in nursing;
- ❖ Entrance requirements;
- ❖ Perceived (as well as real) discrimination;
- ❖ Isolation in schools whose students are mostly White;
- ❖ Unsupportive students and faculty;
- ❖ Family responsibilities (many students who are minorities must also support families); and
- ❖ Financial aid that is linked to full-time status.

"Some of the strategies to overcoming the lack of minority nurses include developing an approach that addresses the students' need to support their families, target outreach to minority communities, develop programs that are geographically accessible as well as affordable for minority students, and to enhance institutional supports, such as minority student groups," said Williams.

Williams believes that ethnic minority nursing associations, such as NBNA, are well positioned to pursue these strategies, and to engage

in political advocacy. NBNA's mission includes lobbying for increased funding to establish a qualified cadre of nurse researchers who can address the health care issues that disproportionately affect African Americans, like cardiovascular disease, cancer, diabetes, HIV/AIDS, mental health, pain management, and a variety of women's health issues.

## Programs Aimed at Increasing the Roles

"National associations, serving ethnic or racial minority nurses, have a variety of programs in place to encourage members of various minority communities to enter the nursing profession," said Williams.

The National Association of Hispanic Nurses (NAHN) has two such programs. One is a scholarship program that helps outstanding nursing students of Hispanic ancestry. The other is the "adoption" of immigrants from Latin American countries who are licensed nurses in their original countries. The Miami chapter of NAHN helps these immigrant nurses to become eligible for the Board of Nursing Licensure Exam. In addition, it is working with Miami Dade Community College School of Nursing in developing an educational program for these nurses.

In 1998, a group of ethnic nurse organizations, including the NBNA and NAHN, came together to form the National Coalition of Ethnic Minority Nurse Associations. The mission of the coalition is to improve the provision of health care to ethnic populations in the nation. Other founding organization members are the Asian American and Pacific Islander Nurses Association (AAPINA) and the National Alaska Native American Indian Nurses Association (NANAINA).

*For more information on the National Black Nurses Association, go to <http://www.nbna.org>* ♦

To learn more about minority nurses, go to the following Web sites:

**American Nurses Association**  
<http://www.nursingworld.org>

**National Alaska Native American Indian Nurses Association**  
<http://www.nanaina.com/>

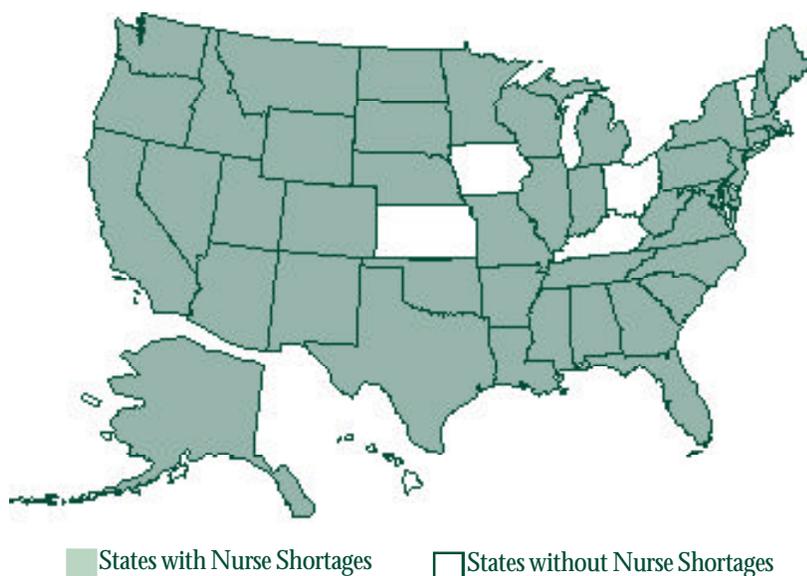
**National Black Nurses Association**  
<http://www.nbna.org>

**National Association of Hispanic Nurses**  
<http://www.thehispanicnurses.org>

**Philippine Nurses Association of America**  
<http://www.pnaamerica.org/>

Lack of Minority Role Models Affects Nursing Shortage is based on the Summit workshop Recruiting and Retaining Health Professionals, Thursday, July 11, 2002.

## Predicted Nursing Shortage in 2020



### The Registered Nurse Population

#### Findings from the National Sample Survey of Registered Nurses

The Seventh National Sample Survey of Registered Nurses was conducted in 2000 and published February 22, 2002, by the Health Resources and Service Administration, Bureau of Health Professions, Division of Nursing. It is the nation's most extensive and comprehensive source of statistics on all those with current licenses to practice in the United States, whether or not they are employed in nursing.

It provides information on the number of registered nurses their education background and specialty areas their employment status, including type of employment setting, position level, and salaries their geographic distribution; and their personal characteristics including gender, racial/ethnic background, age, and family status.

*For more information on this survey, go to <http://bhpr.hrsa.gov/healthworkforce/rnsurvey>* ◆

#### Minority Registered Nurses Compared to the General Minority Population, March 2000

U.S. Population	Race/Ethnicity	RN Population
69.1%	White	86.6%
.7%	American Indian/Alaska Native	.5%
3.7%	Asian Pacific Islander	3.7%
12.5%	Hispanic	2.0%
12.1%	Black	4.9%
1.8%	More than 2 races	1.2%

Map/Statistics courtesy of National Sample Survey of Registered Nurses, U.S. Department of Health and Human Services, Health Resources and Service Administration, Bureau of Health Professions Division of Nursing.

## Addressing the Shortage

In June 2002, U.S. Department of Health and Human Services (HHS) Secretary Tommy G. Thompson announced a series of grants totaling more than \$30 million to increase the number of qualified nurses and the quality of nursing services across the country.

Offered through the Health Resource Services Administration's, Bureau of primary Health Care, the awards will help to ease the shortage of nurses available to provide essential health care services across the country. More specifically, the grants include:

- **324 Advanced Education Nursing Traineeship** grants, totaling more than \$18.5 million, which support registered nurses in graduate programs who are studying to become nurse practitioners, clinical nurse specialists, nurse-midwives, nurse anesthetists, nurse educators, nurse administrators, and public health nurses;
- **71 Advanced Education Nurse Anesthetist Traineeship** grants, totaling more than \$3 million, which support registered nurses enrolled full-time in a master's nurse anesthesia program;
- **Nine Geriatric Nursing Knowledge and Experiences in Long Term Care Facilities** grants, totaling nearly \$225,000, which help schools of nursing provide hands-on clinical training for senior nursing students caring for elderly individuals; and
- **Three Nurse Faculty Development in Geriatrics** grants, totaling nearly \$760,000, which help nursing schools, nursing centers, academic health centers, and state or local governments develop effective geriatric nursing education programs.

In addition, another \$8 million will be designated to repay educational loans of clinical care nurses who agree to work for two or three years in designated public or nonprofit health facilities facing a critical shortage of nurses.

*For more information, go to the Bureau of Health Professions Web site at <http://bhpr.hrsa.gov/nursing/>* ◆

# Low Literacy: A Health Care Quality Issue

Brigette Settles Scott, MA

**T**ake two tablets by mouth every six hours. When lying down, elevate limbs above heart level to reduce swelling. Simple instructions? For some. Yet many Americans cannot understand common medical terms or follow their doctors' instructions.

Very few adults in the U.S. are truly illiterate, but there are many adults with low literacy skills who lack the foundation they need to find and keep decent jobs, support their children's education, and properly manage their health, according to the National Institute for Literacy (NIFL).

"Year 2000 statistics indicate that 45 percent of the adult population, or 90 million people, perform at Levels 1 or 2 (8th grade or below reading level)," said Carolyn Staley, deputy director, NIFL, as she opened the Summit session-Health Literacy and Quality Health Care.

Almost all adults in Level 1 can read a little but not well enough to fill out an application, read a food label, or read a simple story to a child. Adults in Level 2 usually can perform more complex tasks such as comparing, contrasting, or integrating pieces of information, but usually not higher-level reading and problem-solving skills. Literacy experts believe that adults with skills at Levels 1 and 2 lack a sufficient foundation of basic skills to function successfully in our society.

## Health Literacy

Loosely defined, health literacy is the degree to which people can obtain, process, and understand the basic health information and services they need to make appropriate health decisions.

"Health literacy impacts the quality of health and healthcare," said Dr. Cynthia Baur, health communication and e-health advisor from the Office of Disease Prevention and Health Promotion. "Reading health information materials, following prevention recommendations, filling out insurance forms, explaining the nature of a health problem, adhering to medication regimens, reading and signing informed consent documents—each of these routine tasks requires functional health literacy skills that we estimate a large segment of the adult U.S. population does not have. Moreover, many adults who do have low health literacy do not acknowledge it as a problem. They may be too ashamed, or they have developed coping mechanisms to deal with their limited skills. Yet, there is danger in leaving health literacy a hidden problem. The implications of limited health literacy for pa-

tient safety, medical errors, health status, and overall quality are enormous. Consider the implications if 25 percent of the adult population cannot read and understand directions, such as 'take four tablets daily by mouth.'"

Racial and ethnic minorities with basic English skills are more likely to have low health literacy. The National Adult Literacy Survey (NALS) data concluded that African American, American Indian/Alaska Native, Hispanic, and Asian American/Pacific Islander adults were more likely than White adults to perform in the lowest two literacy levels. "Fewer years of schooling and English as a second language are important contributing factors. Twenty-five percent of those

with the lowest level of literacy skills were immigrants. Lack of facility in English and lack of knowledge about the U.S. health-care system and its norms and expectations compound the problem for these individuals," added Baur.

According to the non-profit Center for Health Care Strategies of Lawrenceville, NJ, patients with poor reading skills have a hard time understanding basic medical instructions, have difficulty complying with their recommended treatments, and struggle to understand even basic medical forms. People who have difficulty reading are often ashamed and hide their illiteracy from health care providers.

Currently, the full scope of the health literacy problem is unknown. There have been some extrapolations from data collected in the NALS, although it assessed literacy skills rather than health literacy. "In general, we estimate that about 50 percent of English-speaking adults in the U.S. have limited enough literacy skills that they would have trouble handling some of the more basic, routine aspects of health and healthcare activities, such as taking medication in a correct dose and on schedule," explained Baur. "For the first time, beginning in 2002, there will be a national assessment of health literacy. The data that we will get from the 2002 National Assessment of Adult Literacy (NAAL), which is being sponsored by the National Center for Education Statistics, U.S. Department of Education, will give us the first national estimates of the scope of the problem, at least for the adult English-speaking population."

## Making the Connection

Professionals in the health community have long recognized that low literacy can be a barrier to quality health care. Likewise, literacy professionals have found that health is a topic often asked about most

*"Health literacy impacts the quality of health and healthcare."*

Low Literacy: A Health Care Quality Issue is based on the Summit workshop Health Literacy and Quality Health Care, Thursday, July 11, 2002.

in the educational setting. So, would it make sense to simply marry the two?

Charged with making this connection, Health Literacy El Paso (HLEP) was created to develop and implement a health literacy program to serve academically and economically disadvantaged Texas residents, so that they might have a better understanding of health-related issues, take an active role in preventing health problems, access available health services, and improve their understanding of the healthcare system.

Since its formation in 1998, HLEP has been incorporating health messages into its adult education and GED programs offered at El Paso Community College. "Philosophically, we believe that the best way to learn or improve communication and math skills in adults is to engage topics that have meaning to the participants," said Andres Muro, manager, of the El Paso Community College, Community Education Program. "Instead of using a textbook that was published some time ago, we introduce topics that affect their lives directly and have an impact. For example, if while learning to read or write, I'm learning to fill out a questionnaire that may be used in a doctor's office, or if reading about diabetes, cancer, or heart disease among Hispanics piques my curiosity, I'm going to have a greater desire to learn that information because it's something that affects me, my children, my spouse, and so on."

HLEP students range in age from 18 and up, but the majority are women, 30-35 years old, of Mexican ancestry, with one to two children. Because of this demographic, the emphasis on health issues is well received by program participants. To work the health information into the curriculum, classroom

teachers partner with health educators already working in the community. The program uses local health service providers, such as the county hospital, local health clinics, and the city health offices, as well as national consumer organizations like Planned Parenthood, the American Diabetes Association, and the American Cancer Society. Representatives from these agencies come into the classroom and speak on a given health topic. The classroom teacher then incorporates their information into instruction. Breaking news items are mixed into lessons to add clarity and increase understanding.

One hot issue in El Paso is the high level of lead and arsenic in the environment as the result of a recycling plant that has allegedly polluted a large area of the community.

"Our instructor is incorporating this news and its impact on the health status of El Paso residents by integrating it into a discussion on the periodic table of elements, and how these chemicals in certain forms can be harmful to your health," explained Muro.

### Are We There Yet?

The idea of incorporating health information into every aspect of general education is new. Too many may recall their high school experiences, of having health education taught for a semester by someone like a football coach, whether or not the instruction was effective.

"In practice, there are still some barriers that have to do with professional development and training, that our teachers and health educators have to receive to turn health information into something that can be well received by the students," Muro said.

"There's still a lot of work to be done. The whole idea that we are trying to implement is new. Some teachers are having difficulty changing their way of thinking about teaching. They want to teach from a book. They want to start on page 1 and end on page 10, with multiple-choice questions on tests. To tell teachers not to use a textbook and instead use a handout from the local health department for a lesson is difficult. Likewise, the students themselves expect a traditional class with textbooks. So, when you want to do something that is non-traditional, they resist. With resistance from the students, and resistance from the teachers, it requires a lot of work on our part. But, we believe it's worth it."

Results from HLEP's initial evaluation demonstrate that the approach is making an impact on the community. Of the 500 participants in the program, 400 were screened for diabetes and all female participants (90 percent of the total) received information on breast cancer and learned to perform a breast self-examination. Male participants were instructed in testicular self-examination, and 160 participants now have primary health insurance where they were once uninsured.

"HLEP has had a significant and beneficial impact on the El Paso community," concluded Muro.

*For more information on Health Literacy El Paso and the curriculum, go to <http://www.worlded.org/us/health/docs/el Paso/index.htm>.*

*To reach Andres Muro, e-mail him at [andresm@epcc.edu](mailto:andresm@epcc.edu). For more information on literacy, visit the National Institute for Literacy at <http://www.nifl.gov> ♦*

## The Summit on the Web

### The Summit on the Web

<http://www.summit.omhrc.gov>

### Schedule of Events

<http://www.omhrc.gov/summit/glance.htm>

### Community Resources Toolkit

<http://www.omhrc.gov/summit/toolkit.htm>

### Webcasts of Plenary Sessions

<http://www.omhrc.gov/summit/webcast.htm>

(Includes Opening Keynote Address; Plenary Session: "Access: Myths and Realities" and Plenary Session: "Public/Private Partnerships in Eliminating Racial and Ethnic Health Disparities")

### Poster Session Abstracts

<http://www.omhrc.gov/summit/abstractoc.htm>

# Minority Youth Encouraged To Enter Health Professions

Jody Vilschick

The lack of Hispanics in the healthcare professions is the primary focus of ¡ESCUCHA! (LISTEN!) a Latino student network in the Chicago area. Sponsored by the Hispanic Center for Excellence at the University of Illinois at Chicago College of Medicine, the program was designed to bring students together with Latino role models, and aims to educate students about health care issues in the Latino community.

Established in 1992 as a support mechanism for Latino students (although it accepts any student who wishes to become a member, regardless of ethnicity or heritage), ¡ESCUCHA! is a network of 900 high school, undergraduate, and medical students. Members attend public and private high schools, colleges and universities such as DePaul, Loyola, Northeastern Illinois, and medical schools of the University of Illinois and the University of Illinois at Chicago.

¡ESCUCHA! offers opportunities for established Latino health care professionals to mentor Latino students, and that is one of the most beneficial aspects of the program, said Pilar Bautista, assistant director of the Hispanic Center for Excellence. "It exposes member students to various physicians, specialties, and other medical students," she said. "It also creates a strong alliance of Latino students interested in medicine that offers a valuable support network. The early exposure also encourages students to pursue medical careers."

The ¡ESCUCHA! student network meets on Saturdays, six times a year, at the University of Illinois at Chicago College of Medicine. Each meeting is divided into three parts: the first is information that the Hispanic Center of Excellence shares with students; the second includes a featured guest speaker who addresses health issues related to Latinos; and the third lets students share information about ongoing activities at their schools. ¡ESCUCHA! members also attend work-

shops, seminars, and other events that promote student academic needs and interests.

"Through the network, we provide students with the resources they need to successfully enter and complete a medical education. As a group, we share the vision of reducing the number of preventable illnesses among the Latino community, as well as increasing the number of Latino physicians in the community," Bautista said. "As such, we will continue to address the concerns of our communities on the health issues and policies that affect us."

At first the difficulty was recruiting Latino faculty members and community representatives in health care, Bautista remembered. "They were already pulled in a number of different directions that it was hard to get them to clear space in their already tight schedules," she said. "But as ¡ESCUCHA! caught on with students, it became easier to recruit them to speak at meetings and become active mentors."

## What's Working in Indian Country

The Association of American Indian Physicians' (AAIP) mentoring and shadowing program, the National Native American Youth Initiative, serves Native American high school and university students who may wish to enter the health care field.

"We need Indian health professionals because we have the lowest percentage of minority entrants entering the medical field," said Carla Guy, coordinator for the National Native American Youth Initiative.

Indeed, the numbers aren't good. Native Americans continue to be the most underrepresented of minority groups in medicine. According to data published by the Association of American Medical Colleges, of the 66,253 students enrolled in U.S. medical schools in

2001, only 516 were American Indian. Only 103 or 0.6 percent of the 15,778 graduates of U.S. medical schools in 2001 were American Indian.

Native American health professionals are essential because they understand the needs of Native American people, according to Guy. "Non-Indian physicians are less likely to understand the culture and to really know their patient, therefore resulting in inadequate health care," she said. "A lot of elders do not speak English and are not comfortable being in a clinical or hospital setting. If they are seen by a Native physician, they would be more comfortable and more likely to continue to seek medical treatment."

The National Native American Youth Initiative brings 50 Native American high school students to Washington, D.C., for 10

Racial and Ethnic Backgrounds of Medical Students—Total Enrollment 2001-2002

	Men (#)	Women (#)	Total Number/Percent
African American	1,793	3,119	4,912(7.4)
Native American**	269	251	520(0.8)
Mexican American	938	770	1,708(2.6)
Puerto Rican (Other)	401	393	794(1.2)
Puerto Rican (Mainland)	215	209	424(0.6)
Other Hispanic	737	590	1,327(2.0)
Asian/Pacific Islander	7,127	5,945	13,072(19.7)
All other students*	24,479	18,983	43,462(65.6)
<b>Total</b>	<b>35,959(54.3%)</b>	<b>30,260 (45.7%)</b>	<b>66,219(100%)</b>

\*All other students includes white students (not of Hispanic origin), international students, and students of unknown race and ethnic backgrounds. \*\*Includes Native American, Native Alaskan, and Native Hawaiian. Source: Barzansky, B. & Etzel, SI. Educational programs in US medical schools, 2001-2002. JAMA. 2002;288:1067-1072.

days each summer. "They learned so much about what is available to them, about financial aide, scholarships, different programs in different agencies," Guy said. While they're in the nation's capital, they meet with representatives from the National Institutes of Health, the Indian Health Service, the National Naval Medical Center, the Uniformed Services University of the Health Sciences, the HHS Office of Minority of Health, and more.

"The program motivates them to stay in school and continue on in a health field," Guy said. "The biggest challenge is finding the students, and letting them know this program exists."

AAIP is also associated with another program: the Center of American Indian and Minority Health (CAIMH), which was established in 1987 at the University of Minnesota-Duluth and later expanded to include an office on the UM-Twin Cities Campus.

The CAIMH's mission is to raise the health status of the Native Americans by educating Native American students in the field of health care and Indian health. CAIMH encourages Native American students to return to their communities to deliver culturally sensitive health care to their own people.

To help students, the CAIMH has created the Indian Health Pathway (IHP), a program designed to provide students with academic support and individualized assistance as they move through all levels of the educational system, from kindergarten through health professions school. Through one-on-one counseling, enrichment programs, and academic and cultural support, the CAIMH helps students make decisions and choices along their pathway to becoming a health professional.

*For more information on the ESCUCHA! program, contact Pilar Bautista via e-mail at [pilarb@uic.edu](mailto:pilarb@uic.edu) or go to <http://www.uic.edu/depts/mcam/hcoe/escucha.html> on the Web.*

*For more information on programs for American Indian youth, contact the Association of American Indian Physicians at 405-946-7072 or on the Web at <http://www.aaip.com>* ♦

Minority Youth Encouraged To Enter Health Professions is based on the Summit workshop Calling All Role Models: The Importance of Mentors and Role Models on Minority Youth Thursday, July 11, 2002.

## "The Cancer Monologues" *A Comedy That Promotes Chicano Health*

"What's so funny about cancer? For the answer, go see 'The Cancer Monologues,' a production of Denver's El Centro Su Teatro and the Greater Denver Latino Cancer Prevention/Control Network. With honesty, sensitivity, and humor, the group presents a series of skits that portray women and men facing breast, prostate, and lung cancer. Summit participants were treated to an English-language performance, but the group also presents Spanish-language and bilingual versions as it travels around the country.

Written by Su Teatro's artistic director Tony Garcia, "The Cancer Monologues" is the first installment of a five-year cancer awareness program sponsored by the Latino/a Research and Policy Center at the University of Colorado at Denver under a grant from the National Cancer Institute. The group says that the play builds on the Latino traditions of challenging one's fears and using humor to triumph over sadness.

A Chicano/Latino cultural arts group dedicated to sustaining and developing Chicano and Latino communities through art, music, and theater, Su Teatro was charged by University of Colorado professor Estevan Flores and project director Paula Espinosa with creating a cancer awareness production accessible to the community. In developing the script, Su Teatro relied on up-to-date research on cancer and health behavior, but realized that neither a clinical discussion or another "disease of the month"

production would engage its audience.

The result is a play that drew on the expertise of cancer researchers, Latino cancer prevention staff, director Phil Luna, and actors Magally Rima, Hugo Carbajal, Laura Chavez, and Valerie Bustos. It gives the audience an introduction to the social and cultural issues surrounding cancer as a way to spark conversation about cancer

within the Latino community. Future versions of the play will focus on other aspects of dealing with a cancer diagnosis.

"The Cancer Monologues" premiered at El Centro Su Teatro in January 2001.

Afterwards, the audience was invited to talk with the actors and producers about the content, substance, and direction of the play. Su Teatro has made this a part of each performance, with a wide ranging question and discussion period after each play that engages actors, producers, and cancer prevention staff with the audience to provide more specific information about cancer.

Su Teatro performs the play throughout the country, making it easily accessible to those who need it most. The actors go into the community to perform the play at street fairs, churches, schools, and festivals. Before and after the play, the company provides a resource table of cancer prevention materials, available in both English and Spanish.

*For more information about "The Cancer Monologues," call 303-296-0219, or e-mail [canemologues@su-teatro.org](mailto:canemologues@su-teatro.org)* ♦



# We've Got the Cure for What's Ailing You

Kauthar B. Umar, MA

**“THIS IS NOT A TREATMENT FOR CANCER. IT IS A CURE!”** Sound familiar? Magazine ads and late night television infomercials promise quick cures with everything from anti-aging ointments, and electronic devices that cure AIDS, to immune-boosting teas. Each year, consumers spend billions of dollars on fraudulent cure-all products. Many are suffering from serious conditions and are desperate for any glimmer of hope.

According to Richard Cleland, assistant director for the Division of Advertising Practices at the Federal Trade Commission (FTC), such false hope is more than broken promises and empty wallets. It's health fraud. "Health fraud is the promotion, advertisement, or sale of a product, treatment, or service to provide a beneficial effect on health-based claims which are false or which are not supported by a reasonable basis," stated Cleland.

Advertisers must have a reasonable basis to support objective claims. Unqualified health claims require competent and reliable scientific evidence, which is based upon tests, analyses, research, studies, and other evidence, and on the expertise of professionals in the relevant area.

What does this all mean? In a nutshell, products can't state disease prevention and or/treatment claims without the Food and Drug Administration (FDA) and FTC approval. The FTC's primary interests are not necessarily in stopping the sale of these products, but preventing the sale of products backed with inadequate scientific evidence. So, why are so many consumers still lured by the eight-hour weight loss drink, and the immediate hair removal pill?

"Many companies targeting U.S. consumers are outside of the U.S. Thus, the companies are difficult to locate," said Cleland. "It's not legal to put a drug claim on a dietary supplement label. Companies will attempt to get around that by putting the unsubstantiated drug claim in advertisement.

TV and the Internet make it very easy for individuals and companies to become national marketers."

In an attempt to combat Internet health fraud, the FTC, in collaboration with other law enforcement authorities, developed "Operation Cure All" in 1997. In its first phase, two Internet searches identified over 1,600 sites worldwide making questionable claims for the treatment and cure of numerous incurable diseases.

In response to these results, a campaign was launched to raise consumers' awareness through online and related educational efforts. Warning marketers of their legal obligations via e-mail advisories, and bringing targeted enforcement actions that are closely coordinated with FDA and other authorities are the campaign's goals.

Cleland said that the FTC can force distributors to put safety warnings on a product and to take any unsubstantiated claims off product labels. However, FTC doesn't have the power to pull products off the market.

"Federal agencies are overwhelmed with consumer health claims. The FTC's focus is

primarily on stopping products with unsubstantiated and false treatment claims for major illnesses," argued Cleland. Ninety percent of the companies that the FTC challenges accept without fighting back, but more companies are beginning to fight back, he said. Companies are less likely to give up their advertising claim if the product is generating substantial revenue.

By putting products on the market, many consumers assume each product is FTC approved. Such an assumption misleads consumers and fuels fraudulent companies. "There is no FTC label," said Cleland. "Before purchasing, do research on the ingredients in the product. Be skeptical of any product offering itself as a miracle cure, whether it's for cancer or obesity."

*For more information on Health Fraud visit the Federal Trade Commission web site at, <http://www.ftc.gov/>*

*For more information on Consumer Education and Protection visit, <http://www.ftc.gov/bcp/online/edcams/infosecurity/index.html>*

*To file a complaint, or to get free information, call 1-877-FTC-HELP or 1-877-382-4357. ♦*

We've Got The Cure for What's Ailing You is based on the Summit workshop Healthcare Fraud: What is Out There and How Do I Protect Myself?, Thursday, July 11, 2002.

## Operation Cure All

This Web site offers the following:

- ☑ Consumer protection information includes consumer alerts on HIV home-testing kits; impotence treatment claims; dietary supplements for children, and more;
- ☑ Business information offers guidance on how to market health products and services truthfully;
- ☑ Press releases keep the public informed of the latest news on health care fraud;
- ☑ Resources provide links to other online organizations; and
- ☑ Spanish-language information is also offered.

*For more information, go to <http://www.ftc.gov/bcp/online/edcams/cureall/index.html> ♦*

## Sampling of Products That Have Been Legally and Successfully Opposed by the FTC

**Cat's Claw:** Primarily used in South America when first recognized. Purported to strengthen immune system, treat inflammation, reduce swellings in legs, cure acne, treat cancer, HIV/AIDS, and arthritis. FTC said claims were unsubstantiated, and claims were taken off advertisements.

**Cetyl myristoleate (CMO):** Purported to treat arthritis, MS, leukemia, lupus, emphysema, cancer, benign prostrate hyperplasia, silicone breast disease, asthma, fibromyalgia, and scleroderma. Marketed as a fatty acid derived from beef tallow. The FTC complaint alleged that claims were unsubstantiated and that claims about certain scientific studies were false.

**Colloidal Silver:** Purported to treat/prevent 650 diseases, including, arthritis, blood poisoning, cancer, cholera, diphtheria, diabetes, dysentery, gonorrhea, herpes, influenza, leprosy, lupus, malaria, meningitis, rheumatism, shingles, staph infections, strep infections, syphilis, tuberculosis, whooping cough, and yeast infections, by ingestion. ForMor, Inc. claimed that medical tests prove that ingestion of colloidal silver is safe and has no adverse side effects. A settlement ordered ForMor International to send a notice to all purchasers, informing them of the settlement and provide refunds upon request.

**Comfrey products:** Purported to be safe and beneficial for a wide variety of diseases and health conditions. The FTC argued that comfrey contains toxic pyrrolizidine alkaloids and, when taken internally, can lead to serious liver damage. Orders also restrict the parties from marketing comfrey products for ingestion, application to open wounds, and certain other uses.

**Essiac tea:** Purported to treat cancer, diabetic ulcers, and arthritis, lower blood pressure, stabilize or increase the T-cell count on HIV patients, reduce muscle spasms and nerve spasms, and increase bone density, immu-

nity, and circulation. Essiac Tea, aka, Rene Caisse's Original Herbal Tea Remedy or Rene Caisse's Essiac Tea, is a mixture of four herbs (burdock root, sheep sorrel, rhubarb root, and slippery elm bark). Natural Heritage Enterprises, the distributor, paid \$17,500 in consumer redress and sent notices to all consumers who purchased the product advising them that Essiac Tea has not been demonstrated to be an effective remedy in fighting cancer or any other disease.

**Glucosamine and Chondroitin Sulfate:** Purported to be a topical application for severe pain. Glucosamine and chondroitin are natural substances found in and around cartilage. The FTC complaint alleges that advertisements contained false claim that glucosamine and chondroitin sulfate in JointFlex contribute to pain relief when applied topically. The FTC argues that there is insufficient scientific evidence that the glucosamine and chondroitin sulfate in JointFlex are able to penetrate the skin and provide any relief as a topical cream. The proposed consent agreement to settle these allegations would prohibit JointFlex distributors, SmartScience and Weitz, from making such claims. This case is currently being examined.

**Herbal Cure Packages:** The FTC alleged in a complaint that Western Herb & Dietary Products was distributing "cure packages" as treatments and/or cures for various serious diseases, and claimed that use of their herbal products made surgery and chemotherapy unnecessary for persons with cancer. The FTC complaint alleged that these claims were unsubstantiated.

**Hormone DHEA:** Purported to prevent/reverse the aging process and prevent and treat numerous diseases. Dehydroepiandrosterone, or DHEA, is a steroid hormone, a chemical cousin of testosterone and estrogen. It is made from cholesterol by the adrenal glands, which sit atop each kidney. The FTC ordered MaxCell Bioscience to pay a \$150,000 fine,

which will be used to provide refunds for MaxCell's customers. The company was also accused of claiming that a urine test it sells provides a clinical gauge of an individual's overall healthiness and youthfulness.

**Shark Cartilage & Glycoalkaloid cream:** Purported to treat and prevent cancer. According to the FTC, the two companies deceptively marketed BeneFin, a shark cartilage product, and SkinAnswer, a glycoalkaloid skin cream, to consumers as cancer treatments. Lane Labs-USA, Inc., Cartilage Consultants, Inc. and their principals agreed to settle the FTC charges, which included a \$1,000,000 judgment.

**St. John's Wort:** Purported to treat HIV/AIDS safely with no known contraindications or drug interactions. The FTC argues that there is strong evidence that the herb can interfere with certain drugs, including some HIV medications, making them significantly less effective. To address this safety concern, the FTC ordered a strong warning about the drug interaction risk in all ads, promotional materials, and product labels where any claim about the products' safety or efficacy appeared.

**"Zapper Electric Unit":** An electrical unit sold as a cure for cancer, AIDS, Alzheimer's, and diabetes. Purported to shock the "parasites" causing disease. The settlement would require that Western Herb & Dietary Products agree to stop making claims that their products are effective in treating any disease or condition, unless they have scientific evidence to support the claims. The proposed settlement would prohibit Western Herb & Dietary Products from misrepresenting the use of their products, the "Zapper Electric Unit" and Herbal Cure Packages in the treatment of cancer makes surgery or chemotherapy unnecessary. The proposed order includes a suspended judgment in the amount of \$50,000. ♦

# Communities Take Their Loved Ones to the Doctor

Monique La Rocque, MPH

More than 400 organizations, U.S. Department of Health and Human Services' (HHS) leaders, elected officials, and celebrities across the nation participated recently in a national initiative called *Take a Loved One to the Doctor Day*—part of a campaign to help close the health gap for racial and ethnic minorities in this country.

The *Closing the Health Gap* campaign, co-sponsored by HHS and the ABC Radio Networks, was created to raise the awareness of health disparities and to encourage community action to get people to take a loved one to the doctor or another health professional on or near September 24, 2002. The campaign, which continues throughout the year, is aimed to strategically insert health messages in popular media; align partnerships with national, state, and local organizations from the public and private sectors; and encourage the provision of direct services and health information at the community level.

While visiting a clinic in the Anacostia area of Washington, D.C., on Doctor Day, HHS Secretary, Tommy G. Thompson praised the work of community health centers and reiterated his commitment to expanding the number of centers and available funding in the next five years.

HHS leaders including Deputy Secretary Claude Allen, Surgeon General Richard Carmona, Health Resources and Services Administration (HRSA) Administrator Elizabeth Duke, and the Assistant Secretary for Aging Josefina Carbonell visited community health centers and health fairs around the country to champion the message of disease prevention and the reduction of health disparities.

While experts agree there are many factors contributing to the health gap, obtaining care at an early stage and practicing healthy behaviors are important to the reduction of health disparities. Media personalities also helped to emphasize the importance of prevention. In an interview on ABC Radio's Tom Joyner Morning Show, nation-



## Dr. Day Kicks Off in Baltimore, MD

ally syndicated radio personality Tavis Smiley said that prevention is critical. "What is so tragic about why this day is even necessary is that so much of what ails us and is killing us is preventable," said Smiley. "It is treatable but only if we have the courage, the conviction, and the commitment to take ourselves to the doctor," he added.

The Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics report, *Health, United States, 2002*, says that the use of preventive health services can help to reduce morbidity and mortality and documents disparities in the use of these services by racial and ethnic minorities.

During the launch of Doctor Day at Howard University Medical School, Deputy Secretary Allen stressed that regular check-ups are "crucial."

"One thing we will stress in this campaign is the importance of regular medical check-ups. I remember as a senior in college, taking my own mother to the doctor after she had been under the weather for a long time. She was diagnosed with esophageal

cancer and passed away just six months later. Had we caught it sooner, she could very well be with us here today. That's why it is so important that each of us remember those that we have lost because of delay in seeking care," Allen said.

*Take a Loved One to the Doctor Day* targeted those with and without health insurance. Those with insurance were encouraged to use it and those without insurance were provided with information on how to access community health centers and local health departments for free or low cost care. Dr. Nathan Stinson, Deputy Assistant Secretary for Minority Health, said that he was deeply concerned about those without health insurance and worked with the National Association of Community Health Centers (NACHC) to help those without insurance obtain access to community health centers.

"We must get people to the doctor for checkups," Stinson said. "Prevention, early detection, and intervention are essential to saving lives," he added. The campaign supported this effort by providing locators for doctors and health centers in collaboration

with NACHC, HRSA, and the National Medical Association, a professional organization of African American physicians.

Public and private partnerships were key components of *Take a Loved One to the Doctor Day*. HHS, ABC Radio, and 240 affiliate stations of the ABC Urban Advantage Network collaborated to encourage a nationwide call to action to take a loved one to the doctor or other health professional. ABC Radio Personality Tom Joyner chaired the national campaign. HHS activities were directed by an interagency workgroup co-chaired by the Office of Minority Health (OMH) and the Office of the Assistant Secretary for Public Affairs.

In all, 12 HHS agencies banded together to provide their expertise and outreach capacities to special populations. OMH encouraged individuals and organizations to join in the initiative by distributing more than 13,000 promotional posters, 3,000 information kits, 1,000 fact sheets, and 400 community toolkits that allowed organizations to adopt or modify materials to fit their own programs.

ABC Radio donated more than \$10 million in airtime to run public service announcements and celebrity interviews integrated into regular programming, including those by HHS Secretary Thompson and Surgeon General Carmona.

"Tom Joyner and ABC personality Doug Banks have put their hearts, souls and reputations on the line to help the more than 17 million listeners they reach every week," said Darryl Brown, executive vice president and general manager of ABC Radio Networks.

The *Tom Joyner Morning Show* also distributed some 10,000 *Take a Loved One to the Doctor Day Pledge Cards* to people who promised to visit the doctor, make an appointment and take a family member, friend, or neighbor to the doctor. The Robert Wood Johnson Foundation, Pfizer, K-Mart, and the Amerigroup Foundation also signed on as sponsors in the campaign, helping to spread the message and providing support services and funding for local events.

Partners represented more than 200 communities in 47 states, D.C., and Puerto Rico. Organizations that hosted events included faith based organizations, local health centers, local and state health departments, national organizations, hospitals, HMOs, physician groups, school systems, universities, and agencies on aging.

National partners such as the National Association of Community Health Centers, the National Medical Association, and the American Diabetes Association advised member providers/centers of the need to provide culturally sensitive services, and offer extended hours. The National Association of City and County Health Officials promoted the event to city and county health departments and urged them to organize local events. The National Black Women's Health Project issued a print and video press release and conducted radio interviews, which resulted in almost 34,000 usages by national and local media.

HHS Regional Directors and Minority Health Consultants conducted activities in all 10 regions. These events ranged from large community health fairs to press confer-

ences. Some events provided services for 60 participants while others attracted as many as 1,200. Local events included health fairs with screenings for high blood pressure, diabetes, cholesterol, and HIV/AIDS, free transportation to health care facilities, and onsite applications for Medicaid and the State Children's Health Insurance Program.

With the help of partners across the nation, *Take a Loved One to the Doctor Day* was able to motivate many individuals who had not been screened for several years to see a doctor or other health professionals. Reports from partners revealed that some of those screened on Doctor Day were admitted to the hospital for immediate attention. One New York physician reported that the screening he did on one of the participants may have saved his life.

While Doctor Day was a small step in the direction of reducing health disparities, it encouraged healthy behaviors, preventive care, community action, and facilitated working relationships that may not have existed before. It also assisted in generating awareness about health disparities. *Take a Loved One to the Doctor Day* events and activities were featured in more than 70 newspapers. Media outlets, such as BET and CNN covered the event nationally and elected officials garnered more than 12 city and state proclamations.

Many participants and partners have already asked about joining the campaign next year. HHS intends to build upon the foundations of the *Closing the Health Gap* and *Take a Loved One to the Doctor Day* campaign and will expand it to other racial and ethnic minorities this year.

Go to <http://www.healthgap.omhrc.gov> for more information on the campaign.

For information on how to find low cost or free health care services for the uninsured, call the Office of Minority Health Resource Center at 1-800-444-6472 or visit their Web site at [http://www.healthgap.omhrc.gov/finding\\_provider.htm](http://www.healthgap.omhrc.gov/finding_provider.htm) ♦

**“**We got the word out through our various affiliates. Some got vans to take people to the doctor many set up hot lines for senior members in their community.

“We networked nationally through our website [www.blackcatholicforlife.org](http://www.blackcatholicforlife.org). All of the national organizations within the Black Catholic community got on board with the project and we embraced this day as a Life Day under the leadership of the National Black Catholic Apostolate for Life and your National Office.

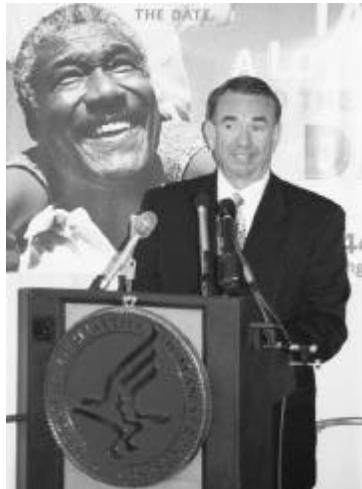
“More than 30,000 newsletters were published and distributed nationally. This project, TAKE A LOVED ONE TO THE DOCTOR DAY 2002, made a big difference in the life of many of our people.”

Father Jim Goode, President of the National Black Catholic Apostolate for Life

# Around the U.S. on Doctor Day

## Washington, D.C.

Secretary Thompson visited the Anacostia Health Center of Unity Health Care in the Anacostia section of Washington, D.C., where many people live below the poverty level. The Secretary reiterated the Department's support for community health centers and restated the Administration's request for nearly doubling the number and funding of community health centers, and congratulated the staff on their exceptional work. The Secretary was accompanied by HRSA Administrator Elizabeth Duke, Unity CEO Vince Keane, ABC Radio executives Darryl Brown and Kevin Miller, representatives from the D.C., Mayor's Office and Health Department, and Pfizer executive Forrest Harper.



*HHS Secretary Tommy G. Thompson*

An outreach effort for the students of Gage-Eckington Elementary School was coordinated by Howard University Hospital. More than 200 students participated in the event that offered blood pressure screenings, height and weight exams, and video viewings geared toward adolescent health. The students were provided with health information to share with family members. Howard University Hospital also collaborated with the D.C. Department of Health in another health event that was attended by an estimated 200 participants. Glucose and blood pressure screenings were provided.

## Pittsburgh, PA

Teams of volunteer physicians, nurses, health educators and other public health professionals visited three high-traffic barbershops providing a variety of health information and screenings throughout the day. Dr. Stephen Thomas of the University of Pittsburgh's Center for Minority Health led the effort, which promoted "Take a Health Professional to the People Day."

Among the health professionals were dentists offering screening, health educators providing HIV/AIDS information, and cardiovascular disease specialists providing blood pressure screenings and offering the opportunity for free continued care as part of a research study. Ninety-five percent of those that visited the barbershop received blood pressure screening.

The National Public Radio and the Pittsburgh Post-Gazette covered the campaign in Pittsburgh. The awareness and visibility that resulted from *Take a Loved One to the Doctor Day* in Pittsburgh sparked interest from other barbershops, salons, and faith-based communities.

## Miami, FL

An estimated 150 people attended Doctor Day activities organized by the Economic Opportunity Family Health Center at three sites in North Miami. Thirty-five parents attended the Norland Children's Center, a school-based community health center, and received physicals, blood pressure, and diabetes screenings.

The Caleb Center and Jesse Trice Center for Community Health hosted a health event that rotated participants through a series of services, which included a health forum, presentations on various health issues, referrals to the doctor, and screenings (diabetes, hypertension, HIV/AIDS, and oral cancer). Four participants were immediately sent to the hospital due to high blood pressure results.

Partnering organizations included: the American Heart Association, the Alliance for the Aged, Physicians Health Plan, Hot 105, Pfizer, the American Cancer Society, Bristol Myers Squibb, and the Haitian American Association Against Cancer.

## Baltimore, MD

In Baltimore, nearly 700 consumers, including HHS Deputy Secretary Claude Allen, attended a community health fair, which offered an extensive selection of screenings and referrals for HIV/AIDS, high blood pressure, breast cancer and more.

Screenings and services were provided to the homeless, students, and other participants. Physicians from local community health centers mingled with the crowd, disseminated information, and answered questions.

The Baltimore Times published an 8-page insert on *Take a Loved One to the Doctor Day* that was distributed free during the event. It included extensive lists of local health centers and community resources in Baltimore and the surrounding area.

It also contained messages from key health officials including the HHS Secretary Thompson; Secretary of the Maryland Department of Mental Health and Hygiene, the Deputy Administrator and Chief Operating Officer of the Centers for Medicare and Medicaid Services, Ruben King-Shaw, Jr., and the Baltimore City Commissioner of Health, Peter Beilenson.



*HHS Deputy Secretary Claude Allen*

# Take a Loved One to the Doctor Day • September 24, 2002



MLK Clinic Director Joyce Tapley Opens Press Conference



HHS Volunteers Sona Cook (ACF), Adriane Springs (OCR), Myra Fain (OCR), and Kenyatta Braggs (OCR)



Blood Pressure Screening



Visitors Wait to Check In For Health Screenings

## PHS Region VI, Dallas, TX Martin Luther King, Jr. Family Clinic

**M**ore than 1,200 people attended a community health screening hosted by the Martin Luther King, Jr. Family Clinic. Participation by former NFL and NBA stars, live radio coverage, concerts, dance performances, Hip/Hop aerobic dance classes, and giveaways drew community members and press to an event that offered mammograms, prostate exams, cholesterol tests, glucose tests, blood pressure checks, dental exams, bone marrow testing, HIV testing, and more.

KSOC, known locally as KSOUL-94.5, the ABC Radio affiliate in Dallas, broadcasted live from the event with radio personality Tom Joyner and his wife, fitness guru Donna Richardson, who closed the event with a light aerobic activity.

There were several giveaways, radio interviews, and appearances by elected officials. Head Start children also joined in the effort sending home letters to their parents encouraging them to make an appointment to see the doctor.

*For a complete list of Dr. Day partners, go to <http://www.healthgap.omhrc.gov/partners.htm> ♦*



ABC Radio Personality Tom Joyner and KSOC Radio Personality Jay Johnson Promote *Take A Loved One to the Doctor Day* on the Radio



MLK Clinic Director Joyce Tapley Receives Bone Marrow Screening



A Visitor Signs In For A Pediatric Check-Up



MLK Clinic Director Joyce Tapley and Former Dallas Cowboys Ron Springs and Tony Dorsett



A Visitor Stops by An Information Booth

## DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Public Health and Science  
Office of Minority Health Resource Center  
P.O. Box 37337  
Washington DC 20013-7337

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## Conferences

### March 2-4, 2003

#### **Eliminating Health Disparities by 2010 - Tools, Skills and Networks for Action**

The Third New England Regional Conference  
Radisson Hotel, Boston, MA  
Contact: <http://www.state.ma.us/dph/omh/regionalconference/4.2003conf@harborhomes.org>

### March 13-14, 2003

#### **Missouri Institute On Minority Aging Conference**

Lincoln University Campus, Jefferson City, MO  
Contact: Paula J. Carter, Center On Minority Health & Aging  
573-681-5530  
573-681-5546 Fax

### March 21-23, 2003

#### **Conference of the National Hispanic Medical Association**

Hyatt Regency Hotel, Washington, D.C.  
Contact: National Hispanic Medical Association  
<http://home.earthlink.net/~nhma/>

## Upcoming Health Observances

**February American Heart Month**  
Contact the American Heart Association  
<http://www.americanheart.org> • 800-242-8721

**March National Colorectal Cancer Awareness Month**  
Contact the Cancer Research Foundation of America  
<http://www.preventcancer.org> • 800-227-CRFA

**National Kidney Month**  
Contact the National Kidney Foundation  
<http://www.kidney.org> • 800-622-9010

**National Nutrition Month**  
Contact American Dietetic Association  
<http://www.eatright.org> • 800-877-1600

**April 20 - 26 National Minority Cancer Awareness Week**  
Contact the National Cancer Institute's Center to Reduce Cancer Health Disparities  
<http://www.cancer.gov> • 301-402-5557

*For a complete list of the  
2003 National Health Observances,  
go to <http://www.healthfinder.gov/library/nho/nhoyear.asp>*

