**GENERAL**

American Medical Association. The Ethical Force Program.  


These important reports contribute to the infrastructure needed to track progress toward eliminating disparities.


In order to address health care disparities, cultural competence has been emerged as an important strategy. This article reviews the literature on cultural competence strategies and provides a working definition, defines key components for intervention and provides a framework in which to operate to improve disparities. Three principal intervention approaches to addressing health care disparities come forward after their review: minority recruitment in the health professions, development of interpreter services and language-appropriate health education materials and provider education on cultural issues.


**SELF MANAGEMENT**


Objective: To create a culturally appropriate Spanish version of the “Five Steps to Safer Health Care” messages.  
Setting: Several predominantly Spanish-speaking urban sites in the United States.  
Method or Intervention: The “Five Steps to Safer Health Care” messages, or “Tips to Prevent Medical Errors,” were developed by the U.S. Department of Health and Human Services to educate the general public about simple steps that can be taken to ensure safer health care. To ensure the messages could also be understood and used by the Spanish speaking population in the United States, Bearing Point and the Centers for Medicare and Medicaid Services (CMS) conducted a study to determine the most appropriate way to develop and disseminate these messages to that population. Instead of directly translating the messages from English into Spanish, which has proven to be an ineffective way to communicate with this population, we employed a three-stage methodology of 1) translating the messages into Spanish, 2) back-translating the messages to ensure that the original meaning and intent were not compromised by the translation, and 3) conducting cognitive interviews with a diverse representation of Hispanics in the United States. Our research not only measured how well participants were able to comprehend the messages but also took into account cultural differences in communication styles, both between the Spanish speakers and their English-speaking counterparts, as well as between various groups of
Spanish speakers. Research participants, therefore, included Spanish speakers with diverse backgrounds, including country of origin, length of time living in the United States, age, education, and income levels.

Result or Outcome: The study found that some of the concepts of “Patient Safety” were not well understood or recognized by this population. We also found that cultural differences, particularly related to the patient-provider relationship, play an important role in the likelihood of this population using the messages. The study showed that modifying the messages to reflect these cultural differences would make Hispanics more likely to comply with them and would, furthermore, allow them to recognize the importance of the suggested actions and to understand that they have the right to carry them out. On the basis of these findings, we created a culturally appropriate Spanish version of the “Five Steps to Safer Health Care” messages.

Conclusion or Significance: The study discusses strategies that may further increase consumer comprehension and the intended use of the Spanish version of “Five Steps to Safer Health Care” messages.


Objective: Research has shown aspirin to be highly effective as both a primary and secondary prevention treatment for cardiovascular outcomes, including myocardial infarction (MI) and stroke. The U.S. Preventive Service Task Force and the American Heart Association recommend aspirin for men over age 40 and postmenopausal women. Since African Americans suffer from a greater risk of cardiovascular disease (CVD) than whites, aspirin use may provide a relatively inexpensive way to reduce health disparities. This study is an analysis of the factors that influence the use of aspirin as a primary preventive treatment for CVD.

Setting: Data from the Regional Assessment Health Surveillance Study (RAHSS), a survey of a representative sample of African American and white adults residing in six counties in Georgia, were used. The study population (n = 651) was men aged 40 and over and women aged 60 and over with no previously diagnosed CVD.

Method or Intervention: Race, gender, education, income, insurance status, urban/rural residence, having a regular physician, obesity, smoking status, and diagnosed high cholesterol and blood pressure were examined as predictors of aspirin use. Chi square tests and logistic regression were the statistical methods used.

Result or Outcome: Chi-square univariate analyses showed that race, education, smoking status, high blood pressure, and high cholesterol were significantly related to aspirin use. A multivariate logistic model adjusted for all predictor variables revealed that whites are 72% (odds ratio [OR] = 1.72, 95% confidence interval [CI] = 1.13-2.61) more likely than African Americans to use aspirin as a preventive treatment for CVD, and those without a high school education are 45% (OR = 0.55, 95% CI = 0.31-0.96) less likely to use aspirin as a preventive treatment for CVD.

Conclusion or Significance: African Americans and the less educated are less likely to use aspirin as a preventive measure independent of their insurance status, access to health care, and health status. Reasons for this disparity in aspirin use as a CVD preventive measure should be further investigated.


Objective: Although self-management programs are popular and highly endorsed in a variety of settings, little community-based 'real world' impact data exist. This study examines programs across Australia and New Zealand. We compared the specific Arthritis Self-management Course (ASMC) with the generic Chronic Disease Self-management Program (CDSMP) in people with arthritis. Finally, the effectiveness of peer educators versus health professionals was examined.
Setting: Community-based attendees of the ASMC/CDSMP (Stanford Model) and Osteoporosis Education and Self Management Programs.

Method or Intervention: Questionnaires were completed prior to and 2 months after attendance. Questionnaires included SF-36 (range 0-100), Assessment of Quality of Life (AQoL) instrument (death (0.0)-full health (1.0)) and Kessler Psychological Distress scale (K10; 10-50). Recruitment was through course leaders in their 'natural environment' with passive mail follow-up (opt in). 468 individuals completed baseline and 267 provided follow-ups. No substantial differences were found between those who did and did not complete follow-ups.

Result or Outcome: Improvement in the health status for all programs was demonstrated in 7 of 8 SF-36 scales (General Health-no change). The largest improvements were Role Physical (mean improvement 9.1, p

Conclusion or Significance: Overall, the program resulted in small to medium improvements in well-being in several areas. Courses led by two peers produced somewhat greater improvement than those led by health professionals. Finally, both the arthritis-specific and the generic course delivered a similar effect for people with arthritis. The short term effects of the program in the community are over and above usual care in people with chronic diseases. The modest improvements suggest the program has had an effective transition from the research setting to the community.


Objective: To convey the structure, function, and potential contribution of a National Quality and Monitoring system for self-management programs for people with chronic diseases that is being implemented in Australia.

Setting: Quality and Monitoring system chronic disease education programs designed in partnership with course leaders, physicians, funders, policymakers (Commonwealth, State and Veteran' Affairs), and consumers.

Method or Intervention: The development of the system was informed by 29 interviews with key stakeholders, an Outcomes Hierarchy Program Logic workshop, two Concept Mapping workshops (involving policymakers, course leaders and participants, physicians and educators), national teleconference with Arthritis Foundations CEOs, two waves of application with more than 900 individuals, and a national workshop with Master Trainers.

Result or Outcome: The system involves administering a purpose build questionnaire (HEI-Q) filled in by people with chronic diseases participating in self-management/education programs. Information is collated in a standardized “Course Report” and fed back to course leaders and managers in a timely fashion. The report incorporates five key elements, all of which facilitate national benchmarking: 1. Overall course impact on individuals in several domains, including positive and active engagement in life, health behavior change, and skill and technique acquisition. 2. Participant-reported quality of course delivery (pre- vs. post-assessments). 3. Summated course scores for individual course leaders. 4. Summated scores for course leaders trained by specific master trainers. 5. Summated overall program performance for managers, policymakers, and government funders presented in standardized formats against national norms.

Conclusion or Significance: The HEI monitoring system is user-friendly, relevant, and psychometrically valid protocol for evaluation of health education programs for people with a broad range of chronic conditions. The HEI-Q appears to be ideal for quality monitoring and research, with the capacity to empower course leaders and facilitate accountability. The output of the system is a highly endorsed by course leaders through to policymakers and will support identification of “chronic disease education delivery excellence” and provide clear data for implementing and monitoring quality assurance programs.


Objective: To demonstrate the effectiveness of self-help empowerment programs designed to reduce racial and ethnic disparities in cardiovascular health.

Setting: The Atlanta Empowerment Zone/Renewal Community is a federally funded program that provides grants or loans to nonprofit or for-profit organizations to implement a broad range of human services, safety, housing, and economic development programs within target areas in the City of Atlanta. The City of Atlanta's Empowerment Zone is made up of 30 neighborhoods and has a poverty rate of 57.4% and a population of 50,000.

Method or Intervention: Data was collected from study participants at two time points: baseline and follow-up upon program implementation and completion. Baseline and follow-up data were collected via survey instrumentation from 192 and 128 participants, respectively. The data collection instrument collected information on participants' demographic characteristics, knowledge of cardiovascular disease (CVD) risk, and health practices regarding physical activity and dietary behavior. Chi-
square and t tests were conducted to determine if there were significant associations between participants' responses or differences between data collection periods.

Result or Outcome: Study findings indicated significant changes in participants' knowledge of best practices regarding the reduction of cholesterol in the blood (P<.005), saturated fat intake (P<.018), best ways to stop smoking (P<.014), and which types of cholesterol may help protect one against heart attack (P<.042). Program participants also reported positive dietary behavior practices regarding increased consumption of drinking fruit juices (P<.003), eating more fresh fruits and vegetables (P<.001), and reduction in consumption of fried potatoes, French fries, and potato chips (P<.005).

Conclusion or Significance: The study presents data that supports gender-specific interventions designed to reduce CVD risk among African American men. Such interventions are effective if they engage men to be proactive in their own health care. Integrating CVD risk reduction efforts with other health service programs and organizations can assist in connecting marginalized clients with active prevention.


**DECISION SUPPORT**


Objectives: To investigate the relationship between race and the use of BRCA ½ counseling among women with a family history of breast or ovarian cancer and to determine the contribution of socioeconomic characteristics, cancer risk perception and worry, attitudes about genetic testing, and interactions with primary care physicians to racial differences in utilization.


Objective: To examine the association between BMD and incident nonspinal fractures in older black and white women.

Objective: The objective of the Project is to maximize the length and quality of life for patients with COPD and satisfy patient and caregiver needs while maintaining or decreasing the cost of care. This will be achieved by implementing a system-wide model of care that focuses on improving interactions between patients and providers using evidence-based COPD guidelines.

Setting: Horizon Health Services Presque Isle Aroostook County, Maine.

Method or Intervention: A variation of the Institute for Healthcare Improvement (IHI) collaborative model was used to guide implementation of this project. The COPD evidence-based changes were based on the GOLD guidelines developed by the Global Initiative for Chronic Obstructive Lung Disease. The model addresses practice issues, patient barriers and community support systems in the health care improvement process. An advisory committee consisting of primary practice physicians, pulmonologists, researchers and change managers was convened to select evidence-based guidelines for diagnosis and management of COPD and adapted them to meet the specific needs and capacity of the rural practices recruited for the study. Baseline measures of office practice were established through patient records review by staff of the Institute for Medical Improvement (EMH). Each physician practice identified a specific population of COPD patients that could be monitored during the duration of the Collaborative. A patient registry was developed during the Collaborative to document and track results of interventions. Participating practices were open to changing actions and systems in order to improve clinical management and office efficiency. Participating organizations capitalized on the learning and improvement by coaching senior leaders in participating organizations to develop a system for spreading the practice redesign to other locations/ offices/clinics.

Result or Outcome: Results demonstrated that the health care providers have accepted and implemented the guidelines as part of routine practice. Practice outcomes improved significantly from pre- to post intervention based on practice gap analysis and patient chart review.

Conclusion or Significance: 1. Rural physician practices are motivated to adopt evidence-based guidelines in their practices, given the appropriate support for change. 2. In busy practices, external support to assist with process transition is crucial. 3. In the rural setting, adoption of evidence-based guidelines does improve patient care.


Objective: To reduce health disparities by developing, evaluating, translating, and disseminating a program to improve quality of care for asthma in pediatric clinics.

Setting: Forty-five pediatric clinics serving low-income, minority communities in New York City.

Method or Intervention: We conducted a controlled trial in 22 of the clinics to evaluate an intervention to improve quality of care for asthma, with funding from the National Heart, Lung, and Blood Institute (NHLBI). The intervention included five interactive training sessions for all clinic staff to screen patients for asthma, provide treatment according to NHLBI guidelines, and provide asthma education to families. A goal of the training was to improve patient-staff communications and staff-to-staff teamwork, thus creating a comfortable medical home for families trying to manage childhood asthma.

Result or Outcome: Follow up over 2 years showed that, compared with controls, intervention clinic staff increased identification of clinic patients with asthma from 2.5% to 6.9% (P<.001); scheduled visits for asthma by 75% (P<.001); controller medications given to patients to 25% vs. 2% in controls (P<.001); and asthma education by physicians (P<.01) and nurses (P<.05). Emergency department (ED) visits decreased by the second year of follow up (P<.05), but urgent visits for asthma to the clinic increased (P<.01), suggesting families shifted urgent care visits from the ED to the clinic, a better use of health care resources. Following the trial, staff from intervention clinics delivered the program to staff of the remaining 23 clinics plus new hires, showing the program could be sustained within the organization. Subsequently, the Centers for Disease Control and Prevention (CDC) funded translation of this program from research into practice through a contract with RTI International. The translated materials for this program can be downloaded free of charge from the New York City Department of Health Web site (www.nyc.gov/html/doh/html/cmha/index.html) and include modules on getting started, conducting training, implementing the program after training, and evaluating program impact. Materials include videotapes, slide presentations, detailed guides for leading sessions, a handbook for program participants, screening forms and written treatment plans for patients, medical care protocols, and links to other resources.
Conclusion or Significance: This project has developed a successful program to improve quality of care for asthma in pediatric clinics serving low-income communities, thus addressing a major cause of health disparities in asthma. Translated Web-based materials make this program available for use by other pediatric clinics.


Objective: This research was conducted with the ultimate goal of developing effective health messages for the prevention of sexually transmitted diseases (STDs) and their complications in high-risk, minority populations.

Setting: Certain STDs can lead to chronic and life-threatening conditions, if left untreated. Complications from syphilis (e.g., heart disease, dementia, congenital syphilis in offspring) and human papillomavirus (HPV) infection (e.g., cervical cancer) disproportionately affect minority populations in the United States.

Method or Intervention: In 2001, the Centers for Disease Control and Prevention (CDC) conducted key informant interviews in nine U.S. counties with high syphilis morbidity. Interviewees were identified “change agents,” including opinion leaders, community-based organization representatives, and health care providers (N = 238). Between 2001 and 2003, CDC conducted a total of 43 exploratory focus groups with general and at-risk audiences (N = 381) across 10 U.S. sites, which were selected based on high rates of cervical cancer mortality and syphilis prevalence. Participants were segmented by gender (male/female) and race (white, African American, Hispanic), among other variables. This qualitative research assessed participants' STD-related knowledge, attitudes, and beliefs, with a focus on syphilis and HPV, as well as their communication preferences and perceived barriers to effective communication. Interpretive analyses were conducted on qualitative data.

Result or Outcome: Similar to members of the general population, participants in the African American and Hispanic focus groups knew very little about syphilis or HPV. Upon learning about HPV, participants became suspicious of the public health and government agencies' silence on it, given the apparent prevalence, invisible nature, and potential consequences of this STD. In discussing both syphilis and HPV, African American groups, in particular, voiced distrust of the health system and government agencies, referencing the Tuskegee Trial and suspected government conspiracies regarding HIV. This distrust was echoed by change agents in African American communities, who noted that it would serve as a barrier to effective communication around syphilis.

Conclusion or Significance: Distrust of public health authorities can have serious implications for the acceptance of prevention, screening, and treatment messages for these STDs and their complications. In light of past mistakes in federal public health research and beliefs in government conspiracies, public health authorities must be exceptionally cautious when communicating to ethnically diverse audiences about often asymptomatic or unrecognized STDs with potentially deadly consequences. Recommendations are made for developing messages that effectively reach diverse audiences, without causing undue panic, defensive reactions, or instilling further distrust of health authorities in minority populations.


Objective: To examine whether racial and ethnic differences in the distribution of individuals across types of health plans explain differences in satisfaction and trust with their physicians.


Objective: To examine the negative experiences of primary care patients in health care settings and the impact of the negative experience on patterns of subsequent health care utilization.

Setting: Three primary care centers or clinics in a large Midwestern city serving three diverse patient populations. Site 1 was a large private medical center, Site 2 was a public hospital, and Site 3 was a primary care clinic serving predominantly lesbian, gay, bisexual, and transgendered patients.

Method or Intervention: We conducted a retrospective survey study from 2001 to 2003 at each of the three sites (N=400) funded by a NIH/NCI Research Supplement for Underrepresented Minorities (#R01 CA77525-
02S1). All participants were recruited and surveyed at their treatment site. Consent for this study was oral, and participants received a small monetary incentive for their participation. The self-administered survey assessed patient satisfaction with health care services, satisfaction with the quality of medical care and quality of relationship with provider, types of medical interactions, prevalence of previous negative experiences in health care settings, and patterns of subsequent health care utilization.

Result or Outcome: Study findings indicate that, on average, patients were very satisfied with their health care services and providers. However, nearly 25% of the sample reported previous negative experiences in health care settings. Patients reported a variety of health care utilization patterns following a negative experience in a health care setting. Sixty-five percent reported they decided not to follow provider advice, 58% stayed with the same provider but trusted him or her less, 52% stopped going for medical treatment as often as required, 50% did not return for their next medical appointment, 46% did not go for medical treatment the next time they were ill, and 37% stopped going for medical treatment entirely. We discuss the potential impact of these patterns of health care utilization on the management of chronic disease.

Conclusion or Significance: Patients may report reduced health care utilization following negative experiences in health care settings. These patterns of health care utilization may have an impact on the management of some types of chronic disease.


Some care disparities among blacks may be due to low technology use in hospitals that treat mostly black patients. (July 2005). *Research Activities, AHRQ*, 299, 11-12.


Objective: To determine whether an ACE inhibitor or CCB is superior to a thiazide type diuretic in reducing cardiovascular disease (CVD) incidence in racial subgroups.


DATA


This toolkit is a result of the recommendations by the National Advisory Panel Meeting. This resource provides a user-friendly guide for collecting race, ethnicity, and primary language information from patients. There is a section addressing the major issues in this area (i.e., legal issues and privacy and confidentiality) and is a guide for integrating multiple sources in the health care setting to accomplish the task of collecting these data (i.e., clinicians, registration and staff, IT departments, as well as patients). In addition, this website provides impetus for using the data to improve health care through quality initiatives.


How indirect measures of race/ethnicity and socioeconomic status can be used by the nation’s health plans to demonstrate disparities.


A major health insurer takes the lead in collecting race/ethnicity data—and learns some lessons along the way.


Many of these projects have worked, but there is still much room for improvement.


Health Research and Educational Trust (Nov. 2003). *Eliminating disparities through community and hospital partnerships: Phase I: Developing and testing a uniform framework for collecting race, ethnicity and primary language data in a hospital; A summary of the National Advisory Panel Meeting.*

This summary describes the goals developed by a panel of experts for collecting race, ethnicity and primary language data in hospitals. The advisory group members each contributed recommendations and suggestions for undertaking this important task. They proposed to create and test a uniform framework for collecting the data and then implement the framework in hospitals and health systems around the country. There is a discussion focused in three areas: The Big Picture and the Business Case, Logistical and Implementation Questions, and Disseminating the Message. Finally, a consensus of the panel included a suggestion of a toolkit for hospitals and training recommendations for collecting race, ethnicity and primary language data.


Beirman and colleagues illuminate the need for better data collection to address health care disparities. They posit that health plans as well as other healthcare system players will play a critical role in collecting this type of data in order to better assess health outcomes and patient satisfaction among diverse enrollee groups. The authors briefly describe examples from the private and public sectors that have collected this type of data in order to assess and improve quality. Finally, there is a discussion of the perceived legal barriers, privacy and confidentiality issues, public reporting and accountability, concerns about the misuse of race/ethnicity data and costs of data collection. With the changing demographic of the United States, collection of this type of data is integral to reducing health care disparities.
ORGANIZATIONAL LEADERSHIP


LANGUAGE


Assessing the language available resources in your organization is a first step in providing LEP individuals with quality medical care. This toolkit from the California Academy of Family Physicians (CAFP) and the CFAP Foundation provides a systematic step-by-step guide for making your practice or in a broader sense your organization ready to handle more diverse and LEP patients in your health care environment. It also offers a set of pros and cons of language assistance options that are currently in use. The use of trained medical interpreters is advocated and new technologies for interpretation are introduced.


Helping the millions of Americans with limited English proficiency can improve the quality of care and reduce the risk of medical errors.


Complete and accurate communication of your medical problems to a healthcare provider in a timely matter is critical to receiving high quality health care. With the rapidly changing demographic in the United States, many healthcare organizations are facing challenges to providing quality medical care to individuals with limited English proficiency (LEP). This resource discusses the need to provide culturally and language-appropriate services to all patients. It also describes the need for healthcare organizations to use an evaluation tool to assess their ability to meet the needs of and improve access to culturally diverse patients.


TRAINING/EDUCATION

Do cultural competence training and education programs work? Increasing resources and attention are being devoted to training and educating health professional in cultural competence. These efforts have focused on improving: a) knowledge; b) attitudes and c) skills for practitioners caring for diverse patient populations, but the field is still learning about their impact on and value for patient care. Results from an extensive review of training and education programs suggest improvements for practitioners in these three dimensions of patient care. However, only 3 studies specifically evaluated patient outcomes, with all reporting “favorable” patient satisfaction measures and one showing improvement in treatment adherence; only four reports discussed the costs of cultural competence training—two areas where further work is needed. As the authors conclude, “Future studies ought to link specific provider skills (e.g., communication skills to address cultural barriers to adherence) to the relevant patient outcomes of interest (e.g., adherence to recommended treatments).”

Efforts to help physicians improve care for underserved patients should address issues of communication and respect. (July 2005). Research Activities, AHRQ, 299, 12.

COMMUNITY

Examples of asthma and obesity show the potential for communities to act on their own behalf to make health policy changes.

Objective: This study evaluates the capacity of the program “Just for Us” to treat chronic conditions in the residents of low-income housing units administered by the City of Durham Housing Authority, as measured by achievement of treatment goals for hypertension and diabetes.
Setting: Coordinated in-home primary-adjunct medical care, mental health services, and social work services are provided to patients in their homes at no cost to them.
Method or Intervention: Continuing medical care is provided by midlevel practitioners through cooperation of Duke University Medical Center and Lincoln Community Medical Center, a federally qualified community health center, and The Durham Center, an area mental health agency. Visits are regularly scheduled in patients' homes every 3 to 6 weeks by the nurse practitioners or physicians' assistant.
Result or Outcome: The average income of patients served by “Just for Us” is approximately $6000/year, and their average age is 70. Eighty-two percent are African American, and 84% of the patients have hypertension. According to the HEDIS goal of blood pressure less than or equal to 140/90, 83% of current hypertensive patients were at goal at their last appointment. Hypertensive patients receiving care from a single provider were more likely to achieve HEDIS standards for control of hypertension. Forty-two percent of the patients have diabetes. Diabetic patients with hypertension were more likely than nondiabetic patients to achieve the HEDIS goal, 88% versus 78% for the last blood pressure measured. Seventy percent of current diabetic patients met the American Diabetes Association (ADA) 2004 goal of a blood pressure less than 130/80; 84% of diabetic patients met the HEDIS goal of 9.5% glycosylated hemoglobin A1c; and 43% met the ADA 2004 goal of less than 7% glycosylated hemoglobin A1c.
Conclusion or Significance: “Just for Us” meets recognized standards of care for diabetes and hypertension at high rates on several important measures in a population traditionally considered difficult to treat: poor, elderly, and majority African American. There are clinical and financial advantages in the combination of a leading medical center and a federally qualified
community health center in providing a high-quality sustainable program for the management of chronic conditions. “Just for Us” demonstrates that continuing in home primary-adjunct care can meet important needs for chronic condition management among the elderly living independently in low-income housing.


Objective: To demonstrate the use of Geographic Information Systems (GIS) as an integral tool in the surveillance and visualization of health inequalities in disadvantaged communities-targeting especially local public health decision makers and stakeholders-for cost-effective intervention investment.

Setting: Eight-county area of northeast Ohio, focusing on Cuyahoga county and the City of Cleveland (Statistical Planning Areas made up of whole or partial contiguous census tracts).

Method or Intervention: We apply the use of GIS to examine and visualize spatial-temporal characteristics of community health and well-being in Cleveland's African American community. We incorporate into maps community measures of public health outcomes with associative predisposing and census-derived area-based socioeconomic measures.

Result or Outcome: We are able to show important measurable differences between the nation, the state of Ohio, the northeast region of Ohio, Cuyahoga County, the city of Cleveland and Cleveland African American neighborhoods for key indicators of public health. Cleveland's African American neighborhoods are in stress, bearing an inordinate public health burden in terms of infant mortality, environmental lead exposures, inadequate prenatal care, low weight births, preterm births, teen births, and access to care, among other problems.

Conclusion or Significance: Use of standardized health and other socioeconomic measurements with census geography, in a GIS, provides for uniform and evidenced-based public health assessment of geographic need in disadvantaged minority communities.


Objective: Breast cancer is the leading cancer in American women and the second leading cause of cancer mortality. Early detection is our major weapon against breast cancer. Although mammography rates have risen substantially, success may be offset by low follow-up rates in women with abnormal mammograms, especially among African American women. Lack of follow-up for abnormal mammograms delays diagnosis and treatment of breast cancer, and contributes to breast cancer mortality. Therefore, this lack of follow-up might contribute to the increased mortality in black women compared with white women with breast cancer. Community Lay Health Advocates (CLHA), trusted community members serving as a linkage between the health care system and the community, may be instrumental in encouraging compliance with follow-up for abnormal mammograms. The purpose of this study was to evaluate the effectiveness of a CLHA intervention in promoting compliance with follow-up among African American women with an abnormal mammogram.

Setting: An inner-city, comprehensive breast center serving low-income women in Atlanta, Georgia.

Method or Intervention: A pilot study was conducted in 2002-2003, including women aged 25 years and older with abnormal mammograms classified "suspicious abnormality" or "highly suggestive of malignancy." Fifty-four weeks of the study were randomized into two groups: 27 CLHA intervention weeks and 27 usual care weeks. Women in the intervention group were encouraged and assisted by CLHAs to comply with FNA/core biopsy recommendations by answering the women's questions, providing reminder phone calls, and assisting them on their appointment days. Medical record abstraction ascertained whether women complied with their follow-up appointments, and the dates and reasons for the follow-up appointments.

Result or Outcome: Intervention group women were significantly more likely than usual care group women to keep their first follow-up appointment for their abnormal mammogram (95.8% vs. 77.1%, P<0.05).

Conclusion or Significance: These findings suggest that CLHAs are effective in promoting compliance with follow-up recommendations for abnormal mammograms among African American women. By answering their questions, allaying their fears, providing friendly support, and navigating them through the health care system, they can serve as an important resource in reducing the racial disparity in breast cancer mortality by ensuring timely breast cancer diagnosis and treatment.

Objective: To explore the influence of social, political, physical, and cultural factors on physical activity among African Americans using structured focus group techniques.

Setting: Current research indicates that physical activity rates as well as many associated disease rates vary by race/ethnicity. A national study also indicates that physical activity rates vary by income status: adults with incomes below the poverty level are three times as likely to be physically inactive as adults in the highest income group. Given the importance of physical activity and its strong association with various chronic diseases, it is imperative that we understand better the combined effects of race, gender, and income so we can develop effective interventions that highlight the multiple factors influencing physical activity.

Method or Intervention: Structured focus groups were conducted with a stratified random sample of African American men and women from high- and low-income groups. Participants were asked to list challenges to participating in physical activity specific to their race and gender as well as to their geographic location. Transcripts of the focus groups were then analyzed using deductive focused coding techniques.

Result or Outcome: The four subgroups identified some similar as well as unique challenges to participating in physical activity, including lack of safety, decreased neighborhood cohesion, physical environment, generational lifestyle changes, lack of facilities, motivation, transportation systems, financial issues, and social norms.

Conclusion or Significance: Interventions developed to increase physical activity need to take into consideration these various contextual barriers rather than individual barriers alone. In addition, it appears that the importance of these barriers varies by both gender and income, suggesting that different interventions may be necessary to increase physical activity for various subgroups.


Objective: Using collaborative relationships to decrease the incidence of breast cancer deaths in an African American Community in Tulsa, Oklahoma.

Setting: Breast Cancer Screening and Mammography Services were provided in an African American community at various locations including churches, clinics, nutritional centers, and pharmacies.

Method or Intervention: Several public and private agencies such as Oklahoma Foundation for Medical Quality, the Oklahoma BCCEDP Program, Tulsa Area Agency on Aging, Tulsa Project Woman, Hillcrest Chapman Breast Center, Oklahoma State University Take Charge Program, and community churches, community volunteers, and community health care professionals came together to provide Breast Cancer Screening for African American women at numerous locations between August 2004 and the end of October 2004. Outreach to the community included community-specific radio and TV announcements, community-specific newspaper articles, and widespread flyers, presentations, and meetings with community ministers.

Result or Outcome: One of the outcomes was the establishment of the community group, Screen Our Sisters, that will remain ongoing to promote health for the African American women in the Tulsa, Oklahoma, community. Public and private groups that have not worked together for one targeted population came together and brainstormed with the community volunteers to plan this massive community intervention. Strengths and limitations for this type of collaboration will be discussed. The resulting data from the interventions (currently in process) will be analyzed and presented.

Conclusion or Significance: The number of deaths due to breast cancer can be reduced in a targeted population through networking and collaborating with public and private agencies, community volunteers, and faith-based organizations. Positive collaborative experiences can extend to other areas of health care and increase opportunities to intervene at a more extensive level.


Objective: To present and discuss lessons learned after one year of a 3-year Administration on Aging Initiative to implement evidence-based prevention programs for older adults.
Setting: Over 50 diverse community-based organizations serving highly heterogeneous older adult populations, as well as the National Resource Center on Prevention at the National Council on the Aging.
Method or Intervention: In 2003, Assistant Secretary for Aging, Josefina Carbonell announced that the Administration on Aging (AoA) would launch an initiative to increase older people's access to programs that have proven to be effective in reducing their risk of disease, disability, and injury. The 3-year project is demonstrating how results from rigorous research conducted through the NIH, CDC, and others can be effectively translated into community practice through aging services provider organizations. The interventions being implemented throughout the country are focused on disease self-management, falls prevention, nutrition, physical activity, and medication management. Local partners are drawn from public health, health care, aging services, and academe; the latter are overseeing in-depth evaluation to assess fidelity and outcomes.
Result or Outcome: The first year of this evidence-based prevention initiative has brought challenges and great progress. With assistance from the National Resource Center, AoA, and a number of expert consultants including members of the CDC's Healthy Aging Research Network of the Prevention Research Centers, the twelve programs have been launched and are reaching hundreds of older adults. Although maintaining fidelity to the original research has been difficult at times, in general the organizations are finding the structure of the programs to be helpful, and many of the older adult participants appreciate the fact that these programs have been proven to work.
Conclusion or Significance: Although still in progress, the evidence-based prevention initiative has brought awareness about the importance of evidence-based programming to the aging services network. Programs to support and promote healthy aging are continuing to progress — learning and overcoming barriers. Evidence-based programs provide community-based organizations with opportunities to expand their programming and reach out to older adults with programs that have proven to be effective. Our current assessment is that these programs have the potential to positively impact community-level risk factor rates among older adults, especially those in hard-to-reach populations.


DELIVERY SYSTEM DESIGN


Objective: To test the reach and effectiveness of a CD-ROM to promote informed decision-making for prostate cancer screening.
Setting: Prostate cancer affects over 200,000 American men each year, disproportionately affecting African American men. Most medical organizations recommend that men make informed personal decisions about prostate cancer screening, because of medical uncertainty about the benefits and risks. This study utilized direct mail to distribute a CD-ROM about the risks and potential benefits of screening to Colorado men age 50-79. Men residing in African American neighborhoods were over-sampled.
Method or Intervention: 9000 men drawn from purchased lists of community residents and the enrollment of a large MCO were randomly assigned either to be sent the CD-ROM by mail, or to a no-intervention, usual care control group. Use of the CD-ROM, knowledge of prostate cancer screening, decisional conflict about screening, and realistic expectations about the likelihood of developing and dying of prostate cancer were assessed in a telephone interview 3-6 months after the CDROM mailing.
Result or Outcome: Preliminary results are available for the first 1304 follow-up interviews (interim response rate = 26%). Reach: Of 554 men randomized to receive the CD-ROM, 227 (41%) reported receiving the CD-ROM, and 78 (14%) used it in a computer. Users of the CD-ROM had higher education, higher income, higher levels of computer usage, and were more likely to have had a PSA test compared to non-users. Effectiveness: In an “intention to treat” analysis, prostate cancer
knowledge was slightly higher in the intervention group (mean score 6.5 vs. 6.2 on a 13 point scale; p=0.002); there were no differences between study groups in decisional conflict or realistic expectations. However, comparing those who did and did not use the CD-ROM using multiple regression analysis and controlling for age, race, education, income, insurance status, previous prostate cancer screening, and computer usage, use of the CD-ROM was significantly associated with higher prostate cancer related knowledge, lower decisional conflict, and more realistic expectations about risk of dying from prostate cancer.

Conclusion or Significance: Studies examining the reach of educational interventions face methodological difficulties in testing effectiveness among users, due to low rates of usage and self-selection biases. We found that use of the CD-ROM was associated with lower levels of decisional conflict, and higher levels of knowledge and realistic expectations related to prostate cancer screening. This low-cost intervention can be distributed to vast numbers of men. While only a portion will use it, users appear to benefit.


Objective: To assess the effectiveness of a mobile screening and referral program to the medically underserved, high-risk, and difficult-to reach population of Dutchess County.

Setting: By U.S. Census 2000 population estimates, whites comprise 80% of the Dutchess County population; African Americans, 9.3%; and Hispanics, 6.4%. However, African Americans are 15 times more likely to have HIV than whites; Hispanics are almost 11 times more likely to have HIV than whites. The outreach van targets two low-income neighborhoods with the greatest burden of HIV disease at nontraditional service hours and high-risk venues.

Method or Intervention: Mobile van outreach workers surveyed each individual screened, and results were reviewed to assess the needs of the HIV-positive out-of-care clients. Outreach service forms and screening forms were analyzed to quantify the number of clients served. Lastly, follow-up phone calls to designated service providers verified whether clients referred made medical visits.

Result or Outcome: In 2003, the outreach van screened 179 individuals, identified 35 (19.5%) HIV-positive individuals, and linked 22 (62.8%) individuals to primary care. Among the identified HIV-positive individuals, outreach workers linked 17 (77.3%) African Americans and 5 (22.7%) Hispanics to primary care. There are 657 estimated HIV/AIDS-positive individuals out of care in Dutchess County. The outreach van linked 5.3% of these individuals to care. Some of the challenges this program faces include the need to contact high volumes of people to identify the individuals with HIV infection and the safety of the outreach staff and security of the van in high-risk neighborhoods. The success of the program can be attributed to the following factors: 1) basic primary care services are brought to the client; 2) the outreach van is staffed with racially diverse peers, outreach workers, and a nurse; 3) the program does not “label” the van as an HIV-care provider only: it provides various other low-threshold screenings, education, and support services; and 4) over time, trusted community leaders began to refer others in the community to use the van services.

Conclusion or Significance: This initial evaluation indicates that mobile van outreach program is successful in keeping the minority, out-of-care population in underserved neighborhoods engaged in primary care. In addition, the outreach van provides an opportunity for surveillance of the HIV and the general health status of high-risk communities, and increases access to primary care through unique partnerships among service providers.

OTHER


Among stakeholders in managed care, government, and academe, cultural competence is emerging as an important strategy to address health care disparities.


A coalition of health professionals and community and faith-based organizations uses its knowledge to drive change.


Medicare has played some role in reducing health disparities but has not yet realized its potential.


Objective: To identify potential best practices for eliminating health disparities to include in the National Healthcare Disparities Report (NHDR).

Setting: The NHDR provides an assessment of disparities in health care among racial, ethnic, and socioeconomic groups in the general U.S. population and among priority populations. In recognition of the importance of translating research into practice, the NHDR will highlight selected programs and interventions that have been successful at reducing healthcare disparities. This will inform users of the report on how the information in the reports can be used in real solutions to eliminating health disparities.

Method or Intervention: Based on this preliminary study, a database has been created to summarize interventions that are believed to be potential promising practices. Several sources of information were used. - The American Public Health Association's Community Solutions to Health Disparities database - The National Association of County and City Health Officials' Model Practices Database – CDC Office of Minority Health - Foundations including The California Endowment, The Commonwealth Fund, The Kaiser Family Foundation, The Robert Wood Johnson Foundation, and The W.K. Kellogg Foundation. A preliminary review of the interventions assessed project strategy and objectives. Interventions that emphasized community-based and targeted health services delivery and behavior change, as well as strong cross-cutting collaborations and partnerships were selected to be included in the database.

Result or Outcome: - Access is important. Programs or interventions targeting specific racial or ethnic populations, in particular, have shown some success at reducing cultural and linguistic barriers. - Health literacy interventions may require further development. Preliminary assessment of interventions found these interventions to have less well-defined objectives and strategies. - Some disease condition-specific interventions are more developed than others. In general, heart disease, cancer and diabetes initiatives have received more support. - Partnership with local service providers is important. Local initiatives remain an important source of health services for individuals.

Conclusion or Significance: Identifying best practices is a challenge. There are numerous ways to conduct program evaluations and measure success. However, for the purposes of the NHDR, we need to link measures of access and quality from the report to existing intervention objectives in communities. This preliminary study and creation of our best practices database is the first step in identifying possible best practices to include in the NHDR. Further study is needed to determine specific parameters to define best practices for disparities interventions and how the NHDR can be utilized by program staff to measure progress in reducing health disparities.


QUALITY


The federal government is uniquely positioned to influence progress toward eliminating disparities and improving quality.


Objective: To convey lessons learned from 3 years of a coordinated program of disease management and health navigators in a community with high numbers of uninsured, underserved populations.
Setting: The Community Access Program (CAP) of Miami-Dade County, Florida, is a consortium of over 20 organizations that plan, advocate for, or deliver health services to uninsured and underinsured populations. Miami-Dade County is one of the most culturally and economically diverse metropolitan areas in the United States. More than half of the population is foreign-born, and more than two-thirds of the population does not speak English at home.
Method or Intervention: For the past 3 years, with funding from the Health Resources and Services Administration (HRSA), the consortium of members of the Community Access Program of Miami-Dade County has developed innovative solutions with two overarching goals: 1) to increase the number of individuals with health insurance and 2) to increase the use of primary care and preventive services among the uninsured (thus reducing inappropriate emergency room use). To achieve its goals, the consortium includes a disease management initiative that focuses on diabetes, congestive heart failure, and Axis I Behavior Disorders, and culturally sensitive health navigators to assist populations in appropriate understanding and utilization of complex systems of care and funding. Our external evaluators with the University of Florida have assisted in the evaluation of this project.
Disease management (DM) is based on the premise that a small percentage of very sick patients consume large amounts of health care resources. DM should cut down on expensive visits to emergency rooms, minimize inpatient hospital stays, and prevent complications. The net effect of DM should be cost savings and better quality of life for patients. Our preliminary evaluation suggests that DM programs represent operationally relevant, innovative practices to help participants identify and document specific operational DM best practices; identify importance and challenge using accepted standards of care; and provide recommendations for practice in other community programs for the uninsured. These practices include meeting patients where they can meet, being flexible with respect to meeting times, accommodating those with jobs, making multiple phone calls to remind patients about medical appointments and medications, and using materials in multiple languages with simple pictures.
Result or Outcome: From the first 2 years of the DM program, $1,432,606 in costs have been avoided from decreases in emergency room utilizations, crisis stabilizations, and hospitalizations.
Conclusion or Significance: Designing and implementing disease management for uninsured populations result in cost savings, but present unique challenges.