

C310 Health Disparities in Communities, Fall 2004-05

A Course Portfolio

Instructor: Millicent Fleming-Moran, Ph.D.

Portfolio Abstract

“Health Disparities in Communities” is a recent multidisciplinary course offered by Applied Health Sciences as an elective for junior-senior pre-health professional undergraduates. Course goals include: 1) enhancing a student’s cultural sensitivity and competency, 2) teaching students the costs of “cultural blindness” in terms of poor patient-provider trust, inappropriate care and outcomes, & increased costs, and 3) encouraging students to apply these socio-cultural elements to various levels of decision-making needed to reduce health disparities. I have been working on improving and evaluating the first learning goal, and exploring ways (qualitative and quantitative) to evaluate a student’s growth in cross-cultural sensitivity. A major teaching goal is to move health-professions students away from factual, clinical approaches to “presenting cases”, toward critically assessing how their own, their patient’s, and even “institutional” cultures ways of interacting and health outcomes. A major aim of this portfolio is to elicit suggestions and comments from health and liberal arts faculty, as well as recent graduates, on ways to achieve this first goal.

I. Introduction: Background to the C310 course

Major differences in the health status and access to care among ethnic, low SES, immigrant and other U.S. groups affects all of societies' members--directly or indirectly. This 3 hour course explores how social-cultural factors, gender, ethnicity and age affect health status disparities seen in US populations which are not members of the dominant U.S. Caucasian, middle-class culture. We examine how these factors: aid in understanding causes of disease; can be applied in promoting health in at-risk groups; foster more culturally appropriate health care, and ultimately, reduce these disparities.

Students are introduced to concepts and strategies to foster cultural competency in health practitioners and organizations, and reduce barriers to health service use and acceptance, -- to meet the emerging needs of diverse and growing minority groups in our health system. They examine evidence of health status and access to care disparities for major U.S. ethnic/gender/age groups and the role of social factors in these patterns. Health services receiving federal funds now face EEOC requirements to assure “equitable access” and acceptable care by ethnic and non-English speaking clientele (Office of Civil Rights, 2000, see [Appendix A. Portfolio References](#), for full citations). Case studies from public health, health services, policy changes, and community and behavioral interventions are used to introduce the variety of strategies needed to promote equity in care. The students will apply concepts from the curriculum to develop a project to reduce at least one factor contributing to health disparity in a specific U.S. population.

II. Course History and Philosophy

In Fall 2002, I took over the C529/C310 courses, first offered in 2001 by another Applied Health Science faculty member. The overall goal of the course was to introduce students to the major health disparities and health care needs among cultural, ethnic, and socially disadvantaged groups in America.

In the first year I taught the course I narrowed its focus to four major cultural subgroups to give greater depth, promote more topical group discussions. I wanted to allow the constructs of class, race and social power to be applied to our health system's promotion of access (or barriers) to timely and appropriate care.

Students

Half the 25-36 undergraduates come from the School of Health Physical Education and Health (HPER)'s various programs; the remainder are from social sciences, social work, and pre-health professional programs, such as nursing, pre-medicine and optometry. The majority are juniors and seniors. Some students have prior work experience in clinical, public health or community agency settings. Few have had much travel or inter-cultural exposure. I felt that the course lacked a major element, i.e. assuring students gained self-awareness and competencies in working with culturally diverse others.

The 2002-03 class included both genders, and a variety of ages, disciplines, and ethnic groups. They learned to work with their teams, but cultural "self-awareness" was not an explicit course objective. Our Master's of Public Health accreditation body (Consortium for Education in Public Health, CEPH) suggested our program enhance students' exposure to cultural diversity and promote cultural competency.

Instructor

As the course instructor, I have worked in a variety of health settings, both here and abroad, and have studied disparities in health firsthand (See [Appendix B Short Biography](#)).

Course Philosophy

Like many colleagues I try to shift students from the memorizing "facts", to learning contexts which make facts relevant, toward evaluating how actors interpret these data, and, hopefully, becoming a "critical thinker" who can make practical, theoretical and value driven decisions of their own. Epstein (1999), for example, prepares new physicians to be "*mindful practitioners*, [whose] ... critical self-reflection enables [them]...to attend to [other's] distress, recognize [their] errors, ... and clarify values so [they] can act with compassion, competence, insight."

While not all my students are destined to become health care providers, they will *all be health care consumers*. In either role, they need to understand that all health care reflects society, that some members meet barriers in getting needed care, and that such barriers affect not just an individual's, but society's well-being. This understanding was my primary goal for the course.

I realized I was missing one critical "cultural competency" goal for the course when I recently heard David Orr outline several of his "principals of education" (Orr, 1994). I had already thought about his notions that knowledge requires *responsible* use, and *understanding its effects* on others. But more importantly in the context of this portfolio, are the assertions that students learn as much through the *process* of learning and the *power of examples* in their environment, as they do the course content. And finally, education is about the *use* of ideas and knowledge to "*forge one's personhood*".

That "forging of personhood" was the missing link of achieving cultural self-awareness and sensitivity. In conversations with colleagues from other IUB health professional programs, COAS, social work, and University administrators in a health diversity working group, I found several programs are attempting to build these skills in their majors. One model for revising the "cultural competency/ sensitivity" portion of this course came from IU colleague Howard-Hamilton's ideas on creating a culturally responsive learning environment (2000).

That is why **I hope to use this portfolio to expand and evaluate the process by which students come to understand 1) that they have cultural viewpoints that may differ from others, and 2) the need for cultural sensitivity in the health setting.**

III. Goals of the Course

Cultural competence has been defined as "... a set of behaviors, attitudes, and policies ... among professionals, [which] *enable effective interactions in a cross-cultural framework*."(Cross 1989). "Effective interaction" is continually threatened as the US becomes more diverse, patients feel less rapport with providers, and health professionals are increasingly pressured to see more patients in less time. Competence is operationalized as integrating knowledge about individuals and groups into appropriate practices and attitudes to improve service... and [ultimately] health outcomes (Davis, 1997), and is a *developmental process* (Cross, 1989). Elements contributing to competency include: (1) valuing diversity, (2) cultural self-assessment, (3) appreciating the "dynamics" when cultures interact, (4) institutionalizing cultural knowledge, and (5) adapting practices to reflect diversity of the clientele (APA 2000). These are promoted by the Office of Minority Health, Department of Health & Human Services (OMS-DHHS), as goals for individual providers, as well as their institutions.

In the course we discuss the Western medical model's focus on immediate symptoms, the emphasis on "physical" sickness and organ system pathology, and a need for a "quick fixes". I encourage students to think about the perspectives of the person behind the complaint. It is

infeasible to provide sufficient “cultural” knowledge for insight into *any one* culture, much less the multiple communities a clinician will encounter. A focus on “cultural essences” or “critical incidents” of minority patients in clinical settings has been criticized for re-enforcing stereotypes, at best impeding communication ; at worst causing patients to refuse care (Guest 2002).

Translating OMH/DHHS Goals to Course Goals and Objectives

A critical aspect of the course content is to promote self-assessment, cultural sensitivity, and recognition of the need for improved competency in multicultural relationships with others in their professional work. Some issues of racism, power, privilege, gender, and social inequity may evoke emotionally charged reactions. Thus providing an opportunity to discuss the interface of professional development with personal reactions with fellow students is an important overall goal.

The dual focus of the course on 1) factors leading to disparities in health status and access to care; and 2) student exploration of their own socio-cultural assumptions about patient and provider actors --requires command of a large body of theoretical and empirical literature. Understanding the potential sources of disparity in a socio-ecological context allows students to understand the need for multi-level and organizational strategies to address disparities in care.

Learning Goals

As indicated in the course syllabus, (See [Appendix B syllabus.doc](#)) I want C310 students to:

1. Gain knowledge of theory, research, and practice of multicultural health services.
2. Be aware of training, professional, and ethical issues for multicultural practice.
3. Increase cultural self-awareness and intercultural sensitivity by recognizing one's own respective culture(s), values, and biases; as well as the differences between oneself and diverse individuals one may serve.
4. Be informed about U.S. ethnic minority groups and their differing care needs and disparities in health status.
5. Gain minimal competence in interaction with culturally diverse populations.

A major goal of this course is to convince early professionals to mentally “take off” the clinician's white coat. They need to practice listening *through* the cultural influences that color their practice “environment”, their own responses, and that of their patients who may have little understanding of health care, spoken English, or perhaps, American society.

IV. C310 Class Activities

Course Objectives & Major Methods

Students are expected to develop attitudes, knowledge and skills, through the following major activities:

Attitudes:

1. Understanding of their own cultural attitudes / beliefs regarding cross-cultural interactions. experience/background
2. Sensitivity to multicultural understanding of persons from different populations.
3. Recognition of needed diversity within, and multicultural training for, health care professions. views”
4. Understanding the need for organizational change to reduce cultural and social barriers to care.

Major Activities /Student evaluation

1. Individual weekly diary postings
2. Oncourse Surveys on
3. Individual/group culture “encounters”
4. Readings on patient-provider “world views”
5. Film-base discussions
6. Pre-, Post-course surveys

Knowledge:

1. Awareness of major ethnic minority groups and their disparities in health status.
2. Understand of socio-historical antecedents of distrust of health care in some groups
3. Understand barriers, biases, and sources of miscommunication fostering inequitable care.
4. Identify major consequences of poor communication between health care providers and their clients.
5. Understand federal training, practice, and professional ethics required in multicultural practices.

Major Activities /Student evaluation

1. Web searches, group discussion
2. Lectures; readings, group discussion
3. Tests (objective & essay)
4. Individual project; Group presentation

Skills:

1. Basic competence in interacting with diverse groups encounters
2. Review / critique research on minority health and use of care.
3. Recognize criteria indicating bias in care; and its documentation.
4. Identify multi-level factors (individual, social, cultural, and environmental) to implement appropriate health care; change.

Major Activities /Student evaluation

1. Group discussions; Cross-cultural
2. Self-assessments
3. Group Discussion materials
4. Individual papers

The literature on appropriate minority health care emphasizes the need for health providers to develop inter-cultural sensitivity skills (Kocereck et al. 2001). Currently, however, such “training” includes a host of activities and pedagogical methods (lectures, self-exploration, experiential activities) as well as courses of varying lengths (Pena Dolhun et al. 2003). Unlike most professional-focused short-courses, this is a traditional undergraduate, 3-hour full 16 week semester course. It incorporates both cultural sensitivity development, as well as exposure to major issues in U.S. health care delivery and policy and their influences on health disparities.

As the focus of this Portfolio is on the development of the Cultural sensitivity & Self-Awareness skills, I will limit the illustration of activities which are most pertinent to that learning goal.

The following illustrates activities in 1) Self-Assessment of Cultural Skills and Attitudes; 2) Identifying Personal Cultural Identity(ies) 3) Exploring the social constructs of race and ethnicity; 4) Learning to Identify Sources of Health Disparities, and 5) Integrating Cultural Barriers in Care and Self-Awareness as a (potential) actor in the Health Care System. The first 4 of these activities are introduced in the first Module of the course, and their placement in the course schedule is illustrated below:

Module I. Thinking about Race, Ethnicity and Social Status: How are they related to health?

Learning Objectives:

Self-Awareness...

Recognize student's own "cultural identities": community; social; professional (2)
Understanding their own cultural attitudes/beliefs re: cross-cultural interactions.(1)

Knowledge ..

Cultural factors in adopting the sick role; accepting care.(3)
Is "health" ethnic/racially pre-disposed? (3, 4)
Health care systems affecting appropriate care: the Western medical model (4)

Skills..

Where to find data on disparities in health status and access to care (4)
Researching social "roots": attitudes of families, familiar organizations and professions (2)

Unit 1: Race and ethnicity: How do we identify these "communities-at-risk"?

Reading: Oppenheimer, GM. Paradigm Lost: Race, Ethnicity, and the Search for a New Population Taxonomy *AJPH* 2001, 91(7): 1049-56.

Group Activity: What are our concepts of race/culture? (Discussion)

Individual Activity: Getting to know you (Oncourse survey)

Unit 2 Health Disparities: What roles for Genes, Culture; Social Environment?

Readings: Goodman, A.H. Why Genes Don't Count. *AJPH*, 2000, 90(11):1699-73.

Thomas, S.B. The Color Line: Race Matters in the Elimination of Health Disparities. *AJPH*, 2001, 91(7):1046-9.

Group Activity: Can we ignore the role of "race" (or other social labels)?
(Oncourse-posting and Class Discussion)

Unit 3 Who are the major actors in our Health System? "Medical Culture" and Concepts of Disease

Readings: Cockerham, M, 1998 *Medical Sociology*, Doctor-Patient Interaction

Class Activity: Film "Hospital: Temple of Science" Doctors in Training
(Oncourse Group Assignment; Class Discussion)

Unit 4 Who are the actors?...The Patient's Cultural context: Taking on the Sick Role

Reading: Cockerham, M, 1998 *Medical Sociology*, The Sick Role

Group Activity: How does your culture decide when you are "sick"?

Activity 1. Preliminary Attitudinal and Knowledge Assessment:

Instrumentation to gauge progress in cultural sensitivity is also still in its infancy, and mostly tests *global clinical skills* of new professionals – not the knowledge and attitudinal changes of *pre-professionals* (Epstein and Hundert 2002). Scales measuring individual change in sensitivity/awareness and inter-cultural knowledge/skill have been developed by the Office of Minority Health, DHHS, and by Crandall et al. (2003) as a short, 16 item scale evaluating individual progression in knowledge, cultural awareness, and skills.

I administered the OMH survey at baseline (pre-course) in the Fall 2003 C310 course (See [Appendix_CCquiz.doc](#)). I wanted to evaluate the dispersion of individual item and total scores, and determine appropriate coding of the instrument (with the help of David Perry, Director, Evaluation and Testing, IUB). The OMH survey appears to have good dispersion of item scores for knowledge and attitudes. Sub-scales for knowledge, and attitudes/beliefs will be computed individually; and totaled for an overall score. In the next semester I hope to evaluate the OMH scale in comparison to Crandall's instrument which was designed for undergraduate pre-professionals. I have applied for separate SOTL funding to undertake that project.

Applications: If existing scales are appropriate for use in undergraduates, this would be useful for:

- a) *Making personal growth* in attitudes; cultural skills a recognized part of the learning process; a process which is as important as learning the “knowledge” content.
- b) *Making the process of change in attitude; skill more transparent* to learners.
- c) *Course tailoring:* If scores are influenced by age, prior cultural exposure, or major.
- d) Providing *data comparing pre-professionals* to studies among established practitioners.

Understanding One's own “Roots”:

As C310 enrolls students from sophomore through senior ranks, I devised a short first exercise to acquaint them with Oncourse's various resources, as well as other Web-based tools for researching health disparities. As part of that exercise, students begin to outline their own cultural heritage in a “Getting to know you” questionnaire, and responded to one of their first articles describing the history of fluid U.S. concepts of “race” and its various applications in immigration policies, labor decisions, health care, scientific research, vital statistics, and political actions.

Activity 2: Getting to Know You Survey:

Students were asked to complete the 7 item background survey (See Appendix E. [Getting to know you a survey assignment.doc](#) and results). I attempted to move from the more academic/ professional affiliations (School, rank, major) to family, home, language, and cultural group ties. What struck me was how few students had been outside the country; even a handful had only been to nearby tourism locations in Mexico and Canada. Even fewer had familial or individual familiarity with a non-English language. What was more surprising was that the majority of these IUB students described their cultural identity as “none” or

“white” even when the question prompted inclusion of known family ancestry such as Native American or immigrant grandparents. These data were used when the class moved to group discussions of the students’ cultural “self-definitions”, and the utility of the concepts of “race” and “ethnicity”. Representative responses include:

Where in Indiana (or the world) do you consider "home"? Some responses indicate a distancing from their birth or parental home; but at least one respondent went to great lengths to identify “family” as equaling “home”!

I am from Fort Wayne, Indiana. However, I really consider Bloomington my "home" now. I am originally from a really small town (Milford) in Northern Indiana, it's right in between South Bend.

Vincennes is where my parents and younger brother reside and where my siblings and I grew up; however, my older brother is a pharmacist here in Bloomington, and his wife is a pharmaceutical sales rep. for Ortho-McNeill; also, I live with my sister who is a 3rd year in Optometry School. We are very close-knit to say the least; thus, wherever it is that I am with my family is where I consider "home." :)

Do you or other family members (include elders like grandparents or aunts/uncles) speak any other language besides English when "at home"? If so, what language?

The majority responded that no other language was ever used in the household.

Nope, We all speak English

Those with limited acquaintance readily admitted that the language had rarely been used or needed.

I have taken many years of spanish though, so I could have communicated in mexico with a native if I had needed to do so.

My Grampa speaks a little Dutch, but not very often, and I don't think this really counts.

Have you traveled outside your home country? If so, in what country have you spend the most time outside your native land?

Again, the majority had not traveled outside the U.S.; and even those who had noted it was primarily of short duration and vacations did not provide much contact with non-Americans.

The only other country I've been to is Canada which doesn't even really count. I have traveled to Belgium and France, and it seems as if everyone catered to the English language.

Does your family identify with any particular ethnic group, or regional or cultural heritage (directly or by ancestors)? If so, what group(s) and give an example of how your family would identify itself (or celebrate) as members of that group?

No, although my father's mother spoke English at school and German at home when she was a child.

No, we are Americans, part of the melting pot; therefore, the 4th of July is our big day. :)

My family doesn't really have a strong cultural heritage. I know some of my great grandparents came from Germany and Lithuania, but my heritage is not something that I was taught a lot about growing up.

An occasional student claimed a cultural identity other than middle-class White: including:

My mother's side is Mexican and my father's side is Puerto Rican. We celebrate or represent both cultures through food that we eat that is of Mexican and Puerto Rican influence, through music and dancing...etc.

Activity 3: Exploring the social constructs of race and ethnicity: Reacting to the social definitions of "Race"

In the first week students read two articles concerning the shifting definitions of "Caucasian", or "White" categories of U.S. citizens, depending on the period of history, and view of "race" as an immutable biological fact. Most students were amazed that the definition had ever been fluid—or had been so recently debated. Nursing and other "clinical" students were bemused by their biological training which emphasized the "genetics" of racial classifications, and the implied predisposition of certain "races" to particular diseases. Their reactions to these articles were first posted on Oncourse to provide groups with material to discuss "Is the concept of "race" or "ethnicity" useful to health providers?"

Representative responses to the articles include:

(Jennifer) I found it very interesting that Italians were known as non-whites when they first came to America. As an Italian myself, I was so surprised to find out that information, especially since I would never classify myself as a non-white individual. It really made me think about how people from other countries must feel when they are entering our country. As soon as they immigrate to our country they have to be given a label.

Also, the use of the words "race" in the health field is like a double bladed sword, either way diagnoses/observations could be skewed, my thought is how are we as a health society supposed to overcome this problem?

The authors also introduced the concepts of "biological race" as a precursor to "racism" and racial bias in policies:

"When we focus on race in reproductive health, syphilis control, cancer treatment, and other interventions, it seems clear that racism may affect the way decisions are made by medical and public health professionals." I strongly agree with this passage taken from Thomas's article. Although we as a society are "trying" to move away from having racist thoughts, they still occur and I think they will continue to occur for a long time because of the type of society we live in.

(Megan) "Until there are no racial distinctions in aspects of life such as access to employment....a society that purports to be just... needs to track racial differences and the political-economic consequences of a racial system." This was an interesting way to end the article, because after stating that racial genetics are no longer applicable, the author focuses on the social impact and asserts that it still is an item to be considered

I enjoyed the conversation in class today about the articles. It is interesting to question just how different medical professionals would act according to the various races that come into the offices.

A similar activity involves watching a film about Johns Hopkins hospital, its residents and attending physicians, and the low income African American neighborhood that surrounds this institution (See Appendix F. Assignment [Group Ex 8 Johns Hopkins.doc](#)). I use this film to show differences in attitudes and treatment of low income patients by various members of the medical staff, and the influence of their environmental “culture” of the hospital as an embodiment of the expectations of Western medical practice. The film also provides a “voice” for the neighborhood, in the person of a local minister who has promoted community-based primary care through the church (in collaboration with JHH). Students are then asked to discuss aspects of professional training and organizational practices which might promote bias in care.

Activity 4: Learning to Identify Sources of Health Disparities: The role of “culture” versus the individual.

Students begin this learning process in the first weeks of class and carry it through to their final individual papers and group presentations. The earliest exercise requires finding an example of a health disparity between White Americans, and any “minority” group, as designated by the U.S. Census. Then the students are asked to try to pose some “hypotheses” about why this group might have such a disparate health outcome. In the early weeks of the course, there is an introduction, but not full discussion of issues such as health care access, barriers to care, SES influences on health status, and cultural influences in health behaviors and decision making. A representative posting is given in Appendix G. ([Group Assignment 4 Health Disparity.doc](#).)

I am curious about what I think is an interesting shift in discussion health risk behaviors. In early “hypotheses” students often denote health (risk) behaviors as something which is an “individual’s responsibility” and thus subject to an individual’s “control”, but which is also somewhat culturally “determined” by the individual’s cultural “group”. The statement below reflects this early position:

Two hypotheses that we had for this disparity [in obesity status] were:

- 1) In overweight African American communities, there is a lack of proper exercise facilities because of socioeconomic status.*
- 2) There is a sense of social acceptance of African American women who are overweight, so these women will not feel the need to go to a nutritionist or a doctor.*

Later statements made in class discussions and final projects show students are able to distinguish the variety of factors influencing health behavior, such as appropriate patient-provider communication, financial and social barriers to behavior change, and available resources in a community. What I would like to explore at some point is – when do they move from the simplistic, to more complex way of thinking? Are there particular experiences or exercises that help them reach that point?

Activity 5: Integrating Self-Awareness as an actor in the Health Care System with knowledge about cultural factors in health behavior and barriers to care.

At this point in the development of the course I expect students to show an ability to analyze different cultural, economic, health system, and social effects leading to demonstrated health disparities in our minority populations by the end of the course. I look for this in their final papers, and in their group presentations. Students know that I will be grading using these criteria (see Final Project and presentation instructions and grading sheets in Appendix H. [papergrade.03.doc](#)).

What is more difficult however, is to see whether students are embracing values such as *diversity in the health workforce, culturally appropriate care for high-risk groups, and the need for professionals and their institutions* such as hospitals and universities to *promote diversity, and policies to reduce cultural barriers*.

I enclose a sample of a student's final paper and her Group's presentation on disparities in cancer rates and mortality in African Americans. (See Appendix I: [Cancer and African Americans paper.doc](#) , and Appendix J: [African Americans and Cancer presentation.doc](#).)

V. Students' Reactions to the course:

At this point in time I only have the final course evaluations used by HPER to get a sense of what the students take away from the course, in terms of personal growth in cultural sensitivity or awareness, and valuing diversity in a variety of settings. Some representative comments include:

The best part about this course was that it got me to think about these important topics. I was able to organize methods that might help with some of these disparities.

The [course] gave me alternative view[s] to the problems involving .health disparities.

[The course] expanded and developed a broader view on health disparities. It introduced disparities I didn't even know existed.

[I liked most about the course] was the discussions and group work.

These comments however were less frequent than I would like, and less oriented toward reflections of the student's perceptions about their own growth in cultural sensitivity or awareness (due to the phrasing of the standardized questionnaire). In future I will ask for evaluations of specific learning goals, as well as the overall assessment of the course.

As far as making the *process* of learning greater cultural sensitivity skills more transparent to both the learner and the instructor, I am moving toward some changes in the course for the next time that it is offered. These changes are described in the next section.

VI. Future Directions for C310:

- A. Measuring changes in cultural attitudes and knowledge:** In the Fall 2004, I hope to administer baseline assessment instruments at beginning of C310, and then again at the end of the course. I plan to use both the OMH instrument that was used in 2003, as well as the 16 item instrument designed for undergraduates. In sharing the (expected) change in attitudinal and knowledge scores with students, I believe this pre-, post- course evaluation may make personal growth more apparent to both parties.
- B. Qualitative journals of Course experiences:** I will also ask students to keep weekly Oncourse diary entries of personal insights, experiences during course exercises. In so doing I might be able to gauge which exercises are most provocative of discussion, and reflection.
- C. Provide video-clips of patient-provider interactions:** While use of “critical encounters” has been criticized by some writers, I have used a couple of short clips to highlight aspects of multicultural care which might be otherwise difficult to discuss. One example is the ethical, privacy, and cultural issues surrounding the use of a family member as a translator (See [Appendix K video-clips.doc](#)). The students in C310 have not had much health care exposure either as professionals or as patients. The vignettes may help them picture the somewhat rarified nature of the patient-provider interchange, and the likelihood of miscommunication in situations of anxiety, time pressure, and gender-influenced exchanges.
- D. Promote Multicultural Interactions:** Research indicates that a significant contributor to multicultural competency is actual work with racial and ethnic minority people. While my first C310 included a great mix of cultural and ethnic groups, the second did not. It is ideal to get out of the classroom and into multicultural settings to experience exchanges where the student is no longer in the majority as far as race, ethnicity, culture, class, sexual orientation, or other status, is concerned.

There are at least 2 different options to fulfill this ideal:

Option One: Groups can meet and talk with key informant(s) of a cultural minority in the US who has had experience in using the US health system for **10 meetings of approximately 40 minutes each**.

This provides opportunities to talk with a culturally diverse person in order to (1) have a multicultural interaction, (2) exercise culturally diverse perspectives, (3) learn about the individual's multicultural experiences in the family, social settings, and organizations, and (4) demonstrate attentive listening and relational skills. Examples

might include volunteering guidance to foreign students of immigrant families about U.S. life; assisting with information to assist an agency with outreach activities; or interviewing community members of different social justice and advocacy groups. Key Informants would need to be advised about the purpose of these group projects, the duration of contact, and determine when meetings could be scheduled.

Option Two: Groups can develop a project in a community organization requiring **approximately 8-10 hours duration**. This might include volunteer mentoring/tutoring in international organizations or clubs whose members are not native speakers of English, or who ethnic US minorities. One difficulty in the current class mix is the rigid class scheduling of many of the pre-clinical students who have little flexibility for scheduling non-classtime activities as a group. Another challenge is that agency settings often require preliminary work to gain approval; often before the start of the course. While the learning potential is greater for the students, this Option may require more advanced/mature students to be able to carry it out.

Appendices

- A. Portfolio References
- B. Short Biography
- C. C310 Course syllabus
- D. Office of Minority Health, DHHS, Cultural Competency Self Evaluation Quiz
- E. Getting to Know You survey
- F. Group Assignment: The Johns Hopkins example
- G. Group Assignment: Health Disparity/Hypotheses
- H. Instructions and Grading Sheets for papers and Group Presentations
- I. A Sample Student Final Paper
- J. An Outline of a Final Group Presentation
- K. Potential Clinical Video-clips, OMH Website

Appendix A. References

American Psychological Association, APA Council of Representatives (2002) *Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists*.

American Psychological Association's *Basic Guidelines for Multi-Cultural Training for Health Professionals* (2000),

Cross T., Bazron, B., Dennis, K., & Isaacs, M. (1989). *Towards a culturally competent system of care*, Vol. I. Washington, D.C.: Georgetown University Child Development Center, CASSP Technical Assistance Center.

Crandall (2003) *Academic Medicine*, 78(6) 588–594.

Culhane-Pera K.A., Reif C., Egli E, Baker N.J., & Kassekert R., (1997) A curriculum for multicultural education in family medicine. *Family Medicine* 29, 719-723.

Davis, K. (1997). *Exploring the intersection between cultural competency and managed behavioral health care policy: Implications for state and county mental health agencies*. Alexandria, VA: National Technical Assistance Center for State Mental Health Planning.

Epstein RM and Hundert EM (2002) Defining and assessing professional competence. *JAMA* 287(2) 226-235.

Epstein RM (1999) Mindful Practice *JAMA*.282:833-839.

Kocarek, C. E., Talbot, D. M., Batka, J. C., & Anderson, M. Z. (2001). Reliability and validity of three measures of multicultural competency. *Journal of Counseling and Development*, 79, 486-496.

Office for Civil Rights, HHS. (2000) Title VI of the Civil Rights Act 1964: Policy Guidance on the prohibition against national origin discrimination as it affects persons with limited English proficiency. *Federal Register* 65(169), 52726-52774.

Orr, D. (1994) *Earth in Mind*, Island Press, pp.12-14.

Peña Dolhun E., Muñoz, C., & Grumbach, K. (2003) Cross-cultural Education in U.S. Medical Schools: Development of an Assessment Tool. *Academic Medicine* 78(6), 615–622.

Scott Collins K, Hughes D.L., Doty M.M., Ives B.L., Edwards, J.N. and Tenney, K. 2002. "Diverse Communities, Common Concerns: Assessing Health Care Quality For Minority Americans", Findings From The Commonwealth Fund 2001 Health Care Quality Survey. March 2002.

Tervalon M. and Murray-Garcia J. (1998) Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved*. 9(2), 117-125.

Appendix B: Brief Author's Biography, Millicent Fleming-Moran

Background: My work as an epidemiologist focuses on chronic diseases (hypertension, arthritis, diabetes, and heart disease), and evaluating preventive and clinical management of these conditions in reducing functional limitations in American society. My research, while varied in population, disease emphasis, and question, is integrated by effective identification of, and early intervention in, preventing premature disability and death. Within this framework, I feel individual decision making is critical to understanding delayed access to care and poorer outcomes for women, the elderly and low-income minority populations in general.

Research & Teaching:

I've continued an interest in gender and ethnic differences in cardiovascular disease and other chronic conditions, from my UNC-Chapel Hill epidemiology dissertation on blood pressure in a biracial population of working women. I came to epidemiology by way of an undergraduate focus in medical anthropology in Latin American populations (U of Florida), and a Masters-level training in health planning and program evaluation (IUB). I have broad experience in health evaluation: from the effectiveness of medical therapies, patients' access to care, major state health policies and programs, state-level needs as I have investigated the role of patient-level decision making, health behaviors, use of health services, and equity of access. I organized a prospective cohort of over 700 knee osteoarthritis patients for the Total Knee Replacement Patient Outcomes Team study. I also worked in the Indiana Heartland Center on Aging, and studied gender differences in two leading causes of institutionalization: falling, and incontinence, using the national Longitudinal Study on Aging database.

While chronic diseases in developed countries reflect risk throughout the lifespan, in the developing world chronic disability is often a result of infectious disease exposure early in life. I was funded by the National Science Foundation, to study the biological and human dimensions of a national-level vector control program for Brazil's endemic Chagas' disease. Infectious disease distribution is fostered by increased mobility of people, goods, and disease vectors by trade and environmental change, requiring an international approach to disease monitoring, and control. I collaborated with a National Research Council historical review of global warming effects on human disease, on epidemiology's environmental focus on disease causation.

I've taught epidemiology to physicians, health agency personnel, and graduate students in the Regenstrief Institute, IUPUI, the University of Arizona, and the IUB Master's of Public Health program, and in IU's School of Medicine's Dept. of Public Health. I regularly teach the undergraduate and graduate level epidemiology courses (H311/C611) at IUB, and epidemiology research methods at IUPUI. In addition I have taught undergraduates in Topics courses on emerging infectious diseases and health care in an aging population. I developed a new course on Health Disparities in Diverse Communities, for graduate and undergraduate students (C310/C529). Understanding causal linkages from epidemiologic and behavioral perspectives allows evidence-based interventions and policy decisions.

Appendix C. Course Syllabus, Fall 2003-04

C310 Health Disparities in Communities, Fall 2003

Instructor: Millicent Fleming-Moran, Ph.D.

Office: HPER 116

Phone: (812) 855-8361

e-mail: mfmoran@indiana.edu

Hours/Room: MWF 11:15-12:05

Office Hours: W 12-2 pm; F 9-11 am or ask for appointment by email to Prof. Fleming-Moran.

Introduction:

Major differences in the healthiness of ethnic, SES, and other groups, affects all of societies' members--directly or indirectly. This course explores how social-cultural factors, gender, ethnicity and age affect health status disparities seen in identifiable US populations. We also examine how these factors: aid in understanding causes of disease; can be applied in promoting health in at-risk groups; foster more culturally appropriate health care, and ultimately, reduce these disparities.

Students will be introduced to concepts and strategies to foster cultural competency in health practitioners and organizations, and reduce barriers to health service use and acceptance, for the emerging needs of diverse groups in our health system. Students will examine patterns of disease for major ethnic/gender/age groups and the research in the role of social factors in these patterns. Case studies from public health research, health services, community and behavioral interventions, will be used in class, and students will develop a semester project to reduce health disparities in a specific population.

Course Objectives:

At the successful conclusion of the course, students will be able to:

- Recognize the need for:
 - Understanding their own cultural attitudes and beliefs affecting cross-cultural interactions.
 - Sensitivity to multicultural understanding of clients from different populations
 - Diversity within, and multicultural training for, health care providers
 - Greater research on minority health status and use of care
 - Organizational change to reduce cultural and social barriers to care
- Estimate individual health risk, and disparities in health status for population groups.
- Identify disparities in health care by age, gender, race, and socio-economic status
 - Identify pertinent health behaviors and access- to- care issues for at least two minority populations
- Recognize forms of bias in care for a specific cultural group, and its potential effects
- Identify some historical and social antecedents of patient distrust of care for this group
- Identify factors in the US health care system affecting access to timely, appropriate care.
- Identify major cultural factors in adopting the sick role, use of care, and treatments
 - Identify multi-level factors (individual, social, cultural, and environmental) needed in social and systems models in health care, and community prevention efforts

Required Texts:

1) 2003 Institute of Medicine, **Unequal Treatment**, National Academies Press.

2) **Additional Readings:** HPER Library On-line Reserve (see C310 IU *Oncourse* site)

Auslander W, et al."Community Organization to reduce the risk of NIDDM among low-income African American women" *Ethnicity & Disease*, 1992; 2:176-84.

Cockerham, M, 1998

The Sick Role (Chapter 8) and

Doctor-Patient Interaction (Chapter 9), in *Medical Sociology*, second edition.

Ell, Kathleen *et al.*, "Acute chest pain in African Americans: Factors in delay in seeking emergency care" *Am J Public Health* 1994;84:965-70.

Glasgow, Russell E.; Hiss, Roland G.; Anderson, Robert M.; Friedman, Neal M.; Hayward, Rodney A.; Marrero, David G.; Taylor, C. Barr; Vinicor, Frank, *Diabetes Care*, Jan2001, Vol. 24 Issue 1, p124

Goodman, Alan H. Why Genes Don't Count (for Racial Differences in Health).

American Journal of Public Health, Nov2000, Vol. 90 Issue 11, p1699, 4p,

McKinlay, John B., "Some contributions from the social system to gender inequalities in heart disease", *J Health & Social Behavior*, 1996; 37:1-26.

Oppenheimer, Gerald M. Paradigm Lost: Race, Ethnicity, and the Search for a New Population Taxonomy

American Journal of Public Health, Jul2001, Vol. 91 Issue 7, p1049, 7p

Shea, Steven *et al.*, "Predisposing factors for severe, uncontrolled hypertension in an inner-city minority population", *New Engl J Medicine*, 1992;327:776-81.

Thomas, Stephen B. The Color Line: Race Matters in the Elimination of Health Disparities.

American Journal of Public Health, Jul2001, Vol. 91 Issue 7, p1046, 3p

Thomas, Stephen B., Curran, James W., 1999, Tuskegee: From Science to Conspiracy to Metaphor

(Editorial) *Southern Medical JI*, 317(4):1-4

C310 Course Requirements:

Overall Evaluation: Students will be graded on the following criteria:

30% (3 of) 4 tests (including one during finals week) -lowest score will be dropped

30% Paper – independent research and data supporting group project

20% Group Activities: 10 Individual products from Discussion participation

20% Group Project Development and Presentation

Course Requirements:

Tests: Four in-class non-cumulative tests will be given. These will be given on the dates noted in the syllabus, and on the class final exam date. The exams will include multiple choice and short essays.

Makeup exams will not be scheduled!! Illness and other emergencies happen to all of us, so the following policy has been adopted: Students may drop any *one* of the exams (for any reason), and that grade (0) will be counted as the lowest of the 4 tests, and dropped from the calculation of the average of the 3 remaining test scores for final “Test” portion of your grade. Generally I advise students to attempt all the tests and then determine which low grade will be omitted. *Any student satisfied with the average of their first 3 tests may elect not to sit for the last test during exam week.*

Students without 3 test grades **must** take Test 4 during “Finals week”. Should any student with fewer than 3 tests miss the scheduled final test they must:

- 1) notify Dr. Moran by email at least the morning of the final exam, but prior to exam time, and
- 2) provide written evidence of a medical emergency care and arrange with Dr. Fleming-Moran to schedule a make-up test.

Class participation: Students are expected to attend on time, have read assignments before each lecture and to take an active role in discussion groups. Reading your materials will make the lectures easier to follow and the lectures will help put your readings in context. Ten Group Assignments will be given for discussion (normally Friday classes in weeks without tests) and products from each student from these activities will be counted as part of the participation grade. The lowest of these grades will be dropped in the final grade calculation for participation.

Religious Holidays: If a student must miss a class on one of the religious holidays recognized by the University Dean of Faculties office, he/she should arrange for the absence ahead of time with the Instructor, and schedule to complete any missing work/materials for that date.

Project Papers: These 10-12 page papers allow students to expand on a topic which has been discussed in class and is a focused contribution toward an overall group project, but which is graded individually for each group member. You may add new sources, insights and questions that interest YOU. A guide for the papers will be provided early in the term. Projects will usually focus on a topic or issue regarding social/ behavioral factors in reducing disparities in health care and health status, e.g. : 1) special provider training and/or health care delivery interventions targeting ethnic or other groups and their impact on the group’s health or use of care, 2) recognizing cultural or community features that impede/enhance individuals’ access to or use of care or 3) a review of socially competent, community-based interventions to improve some aspect of health in a cultural group or community. Topics for these papers should be discussed with the instructor early in the course.

Papers are due **Monday Nov. 24** at class time or before. Late papers will only be accepted through 5:00 pm Tuesday 11/25 by successful email transmission (please get MFM confirmation of receipt) or received and dated by the Department secretary, in the instructor’s Departmental office (HPER 116). These papers will receive one lower letter grade; later submissions will *not be graded*.

Paper Grading: Each project will be graded on a 100 point scale:

10 Pts Defining the problem. What is this disease/health condition important?

10 Pts. Who makes up the “population at risk?” What do we know about them?

30 Pts. Presentation of relevant data. Supporting information: properly referenced and discussing the problem’s relevance to the public, a risk group, policy makers, or other major players in the health system.

Maximum points will be given for:

- 1). Quality of references adequate to support text (e.g. current professional journals, major newspapers, or access to such sources through their Web-sites). Web-based federal or state sources (spell out agency, date of release and author, if applicable, in the bibliography) may be used.
- 2) Logical, well-organized presentation
- 3) Student's analysis (versus description)
- 4) Objective discussion (citing varying positions; pros/cons; other alternatives offered?)

10 Pts Proposal(s) to resolve the problem:

- 1) What seems reasonable; feasible (Costs? Acceptance?)
- 2) Interventions likely to be accepted by targeted group? Other "players" in the system?
- 3) Your Conclusions: Are they consistent with the above evidence and options?

10 Pts Format and style:

All references appropriately cited (*Consistent* style from professional journal)
Grammar, Punctuation, Spelling. Proper paragraphs. etc.....
Neatness (typed or word-processed papers only)
Page formatting (double spaced), margins (at least 1 "), pagination
Text Length: 10-12 pages, excluding title page, bibliography, illustrations

10 Pts Allocated per percentage of Summary score for group’s class presentation

20 Pts Self-evaluation of your own growth in thinking about issues related to diversity, ethnic disparities in health and approaches to making care more acceptable/accessible.

100 Pts Total per paper

Paper resources: A guide for your papers will be provided by the instructor. If you would like to look at some excellent papers from other courses, these will be available on reserve in the HPER library, under our course number. The Writing Center: The second floor of Ballantine Hall houses the COAS Writing tutorial center with assistants and resources to make anyone’s writing shine. If you haven’t visited them, it’s worth the trip.

Following Indiana **University’s Honor Code**, projects will not be accepted if prepared for another course, is the work of another student, or reflects the unacknowledged work of others. All submitted projects are to be the student's original work. Any material, data, figures, etc., used from another source (published, interviews, website materials, etc.) must be properly acknowledged, or guidelines/sanctions from the IU Code of Student Rights, Responsibilities, and Conduct (Honor Code) for plagiarism will be applied. See the website: (<http://www.campuslife.indiana.edu/codeindex1.html>)

Project Development and Presentation:

Students will prepare an informal presentation (using poster, demonstration or clear overhead slides) of 15-20 minutes regarding their group work performed for the project, and engage the class in discussion of this material. Not all members need to speak during the presentation, but each member's role in its preparation must be demonstrated. A guide for the project will be provided. Groups must meet at least once with the instructor in the early phase of project development.

Final Grades: This grading scale applies to all tests, papers and final grades, and follows the usual Departmental ranges for letter grades, e.g.:

97+	A+
93-96	A
90-92	A-
87-89	B+
83-86	B
80-82	B-
77-79	C+
73-76	C
70-72	C-
67-69	D+
63-66	D
60-62	D-
Below 60	F

The grade of "Incomplete" (I) is *not* given unless the student has satisfactorily completed all work and tests prior to the request for an incomplete. A grade of "I" therefore normally will not be used unless in extreme circumstances, is at the instructor's discretion, and must be arranged before the scheduled date for the final test. The instructor and student will develop a contract and a time schedule for completing the remaining course work or test. Without this arrangement, any work not completed for the course will be given a grade of "F" and averaged into the final grade, as indicated above.

Course evaluations: Mid-term (informal) and standardized final course evaluations prior to the end of class meetings will be used in this class, according to the policies of the School of HPER. Students' responses are anonymous and are helpful feedback to the Instructor and the Department

Helpful Websites:

Our own State Board of Health (IN):

<http://www.in.gov/isdh/index.htm>

The IU Library's "EBSCO Host plus" search engine

http://www.indiana.edu/~libej/EBSCO_or_INSPIRE/Health_Source_Plus/

The Centers for Disease Control and Prevention (CDC): <http://www.cdc.gov>

CDC's Morbidity & Mortality Weekly Report (MMWR)

<http://www.cdc.gov/mmwr>

This weekly online publication contains "current health events" as reported to CDC; Some issues have special reports on specific diseases -- like the June 1 2001 special issue on the history of AIDS

Healthy People 2010 Home Page:

<http://web.health.gov/healthypeople/>

US Plan to address reducing disparities in special populations and US population as a whole.

Department of Health & Human Services:

Office of Disease Prevention & Health Promotion: National efforts to reduce disease/promote health:

<http://www.odphp.osophs.dhhs.gov/>

HRSA Bureau of Primary Health Care, State profiles of underserved populations (%minority, migrant, %poverty, uninsured, medically underserved no Primary care MD etc.. <http://www.bphc.hrsa.gov/bphc> click "databases" then HRSA State Profiles

CDC's Division of HIV/AIDS Prevention: Fact sheets, slides --demographics:

http://cdc.gov/nchstp/hiv_aids/dhap.htm

Department of Health & Human Services: **Office of Disease Prevention & Health Promotion:** National efforts to reduce disease/promote health:

<http://www.odphp.osophs.dhhs.gov/>

Course Schedule

Date	Topic	Reading
<i>Unit I. Health Disparities: Thinking about Race, Ethnicity and Social Status</i>		
Week 1		
9/1-5	Defining race and communities “at -risk” Group Activity: Basic Concepts of race/culture	Goodman, Thomas
Week 2		
9/8-12	The Demographics of Health Disparities : Genetics/Culture? Group Activity: Provider Concepts of Disease	Oppenheimer Cockerham 9
Week 3		
9/15-19	Framework for studying Disparities in health and care I Patient Cultural context: Gender, Family, Status and & Local Resources Enabling Factors: Literacy, Language, & Networks	McKinley
Week 4		
9/22-26	Framework for studying Disparities in health and care II Patient Perceived Risks, Illness and Causes	Ell Cockerham 8
Week 5		
9/29-10/3	Framework for understanding disparities in health and care III Patient’s control of the social environment Provider skills in negotiating care options	
Test 1	Friday 10/3 (weeks 1-4)	
<i>Unit II. Disparities in Care: Factors in Access to Care</i>		
Week 6		
10/6-10	Linking Health disparities to disparities in care	Text 1
Week 7		
10/13-17	Access: Available, Affordable? Structural & Financial	Text 2 Shea
Week 8		
10/20-24	Acceptable care? Patient Care-seeking System Cost & Time Constraints patterns	Text 3
Test 2	Friday 10/25 (weeks 5-8)	
<i>Unit III. Disparities in Care: Factors in receiving Appropriate Care</i>		
Week 9		
10/27-31	Appropriate Care?	Quality Issues: Communication Errors Text Ch 4 Provider bias; assumptions; training
Week 10		
11/3-7	Appropriate Care?	Patient mistrust of “the system” Thomas &Curran Historical cases of unethical care Patient rights and advocacy
Week 11		
11/10-14	Appropriate Care?	Role of Self/Family care & “Compliance” Glasgow Other treatments

Appendix D: Office of Minority Health, DHHS, Self Evaluation Quiz
DHHS-OMH Self-Evaluation Quiz

This self-evaluation tool is used to gauge student attitudes, beliefs and knowledge applicable in cross-cultural interactions found in any health care setting. There are no “right” or “wrong” answers, but your responses will allow your instructor to better evaluate the success of the course, and areas which may need improvement. If you agree to assist by answering this questionnaire, please type or sign your name here:

_____ Thank you for your help!

For items 1-5, circle the letter which best indicates the degree to which you agree or disagree with the statements:

1. Cross-cultural misunderstandings between providers and patients can lead to frustration, but are unlikely to significantly alter objective clinical outcomes.

Strongly Disagree

Strongly Agree

A B C D E

2. Regardless whether the patient and provider come from different cultural backgrounds, the medical history record is likely to be accurate.

Strongly Disagree

Strongly Agree

A B C D E

3. A *provider's* expectations about a patient's understanding of their medical condition and complying with treatment influences the patient's likelihood of adhering to their prescribed regimen.

Strongly Disagree

Strongly Agree

A B C D E

4. A conscientious provider may eliminate his or her own prejudices or negative assumptions about types of patients.

Strongly Disagree

Strongly Agree

A B C D E

5. When a patient who hasn't followed his/her treatment regimen, and says the prescribed medications are too expensive, cost is likely the primary barrier to adherence for this patient.

Strongly Disagree

Strongly Agree

A B C D E

In items 6-9, circle the letter that best indicates how you would rate the following as “Not at all Useful”... to “Very Useful” when taking a medical history from a patient with a *limited ability to speak English*,

6. Asking questions that require a simple “yes” or “no” answer, such as “Do you have trouble breathing?”

Not at all Useful

Very Useful

A

B

C

D

E

7. Encouraging the patient to give a description of her/his medical situation, and beliefs about health and illness.

Not at all Useful

Very Useful

A

B

C

D

E

8. Asking questions such as “How has your condition changed over the past two days?” or “What makes your condition get better or worse?”

Not at all Useful

Very Useful

A

B

C

D

E

9. Asking whether he or she would like a qualified interpreter for the medical visit.

Not at all Useful

Very Useful

A

B

C

D

E

In items 10-12, circle the letter that best indicates how you would rate the following *techniques* as “Not at all Useful”... to “Very Useful” during a medical interview with a patient from a different cultural background.

10. Asking what the patient believes has caused the illness, how severe it is, and what type of treatment is needed

Not at all Useful

Very Useful

A B C D E

11. Gently noting which beliefs have little scientific evidence or support.

Not at all Useful

Very Useful

A B C D E

12. Explaining the most current medical knowledge and approach to the patient’s illness

Not at all Useful

Very Useful

A B C D E

In items 13-16 circle the letter that best indicates how you would rate the following *approaches* as “Not at all Likely” ... to ..“Very Likely” to improve adherence when a patient is not following a prescribed treatment after several visits,

13. Involve family members.

Not at all Likely

Very Likely

A B C D E

14. Repeat instructions in simple language, several times to emphasize their importance.

Not at all Likely

Very Likely

A B C D E

In items 13-16 circle the letter that best indicates how you would rate the following approaches is “Not at all Likely” ... to ..“Very Likely” to improve adherence when a patient is not following a prescribed treatment after several visits,

15. Work out a compromise in the timing or amount of treatment

Not at all Likely

Very Likely

A

B

C

D

E

16. Listen to discussion of folk or alternative remedies.

Not at all Likely

Very Likely

A

B

C

D

E

In items 17- 20, select the statement with which you most agree:

17. Viewing our own values and norms as a culture:

- A. Provides a yardstick against which to evaluate others' values and norms.
- B. Provides a better understanding of how patients make their decisions.
- C. Allows us to explain to patients of different backgrounds what we would do in a similar situation.
- D. Suggests there is no majority culture from which all others deviate.
- E. Is helpful in understanding a patient's point of view

18. Differences in health outcomes across racial and ethnic groups:

- a. Have genetic and environmental and cultural causes.
- b. Disappear when access to care is controlled for.
- c. Disappear when income differences are controlled for.
- d. Are due principally to culture-related variations in use of health services.
- e. Are entirely genetic.

19. Which is NOT an important part of responsive care?

- a. Identify disease prevalence and drug response differences among groups.
- b. Treat patients as individuals in the context of research findings about disease prevalence in the groups which they are members.
- c. Understand the languages and customs of all your patients.
- d. Ensure that patients understand what you are doing and telling them.
- e. A and C.

20. Which of the following is a benefit of culturally responsive care?
- Reduced disparities in health outcomes.
 - Reduced inappropriate variations in use of health services.
 - Minimize the likelihood of miscommunication and treatment error
 - Enhance patient's completion of treatment
 - All of the above.
21. The percentage of the US population that would be included in the categories of "illiterate" and "limited literacy" is about:
- 10 percent
 - 29 percent
 - 50 percent
 - 72 percent
22. Which of the following methods is NOT helpful in communicating with patients who have limited literacy?
- Show or draw pictures.
 - Speak slowly.
 - Limit the amount of information given at one time.
 - Have a non-physician explain the illness and treatment to the patient in non-technical language.
23. Errors in cross-cultural communication:
- Can be avoided if everyone on the clinical team has the patient's best interest in mind and acts accordingly.
 - Can be difficult to avoid because the error often involves behavior and activities so commonplace that clinicians do not inquire about them.
 - Can be reduced by listening to the patient's narrative and asking questions.
 - Are usually due to language barriers.
 - B and C.
24. Patient-Provider Concordance Theory suggests:
- Patients experience greater satisfaction when they see clinicians who are members of the same gender or ethnic group.
 - There is no support that concordance affects communication.
 - Justification for affirmative action policies in health employment.
 - A and C.

Chose A or B to indicate which statements you think are TRUE OR FALSE

	True	False
25. A provider should make eye contact with the interpreter when speaking, then look at the patient while the interpreter translates what you said.	A	B
26. A family member speaks English as well as the patient's language, is the best possible option to act as interpreter	A	B
27. People who speak the same language share similar cultural practices.	A	B
28. A provider can usually predict a patient's health behaviors by knowing their country of origin.	A	B
29. Friendly (nonsexual) physical contact is an important part of communication for many Latinos.	A	B
30. If a patient will not make eye contact with a provider, it is likely that the patient is not telling the full truth.	A	B
31. Many Asian people think it is disrespectful to ask questions of a provider.	A	B
32. Japanese men who migrate to the US retain their low susceptibility to coronary heart disease.	A	B
33. Complications of diabetes, including amputations and renal disease, occur twice as frequently among African-American diabetics than Whites.	A	B
34. As Hispanics have a lower incidence rates of certain cancers than the US White population, their death rates from these diseases are also lower.	A	B
35. Immigrant patients who use traditional healers and medicines generally avoid conventional Western treatments.	A	B
36. The use of non-prescribed treatments and remedies is a greater problem among minority than non-minority patients.	A	B
37. Some gestures— e.g .a positive nod of the head, are universal and can help bridge the language gap.	A	B
38. A provider should begin by seeing an adult patient alone to preserve their privacy and draw in the family as needed.	A	B
39. An organization which posts signs and education materials in different languages, and provides professional interpreters has met the needs of their non-English speaking clients.	A	B
40. <input type="text" value="313977"/> A female Muslim patient may avoid eye contact because modesty is very important in Islami	A	B

Appendix E: Assignment 1 Getting to Know You....

Please post your responses to the next few survey questions. I'll post them for each group. They'll help me get to know you better, and understand the areas of health that interest you.

1. In what School (HPER,COAS, etc.,) year/graduate status (Jr., MPH..), and field (major area) are you enrolled? If still "undeclared/undecided" which field are you considering?

[Representative responses]

I am a freshman Majoring in nursing
Sophomore in the school of Nursing
Sophomore. I am considering Public Health Education
Exercise Science from HPER, and I am a sophomore.
A sophomore, and a pre-nursing student with a minor of public health education.
I am enrolled in the humanities and arts school. I am a sophomore, and I am a nursing major.
Pre-Optometry, Junior
I am in my first semester of Nursing school (NURS) but I am a junior in class standing.
I am currently trying to gain admission to the Nursing program at IUPUI. I am a junior.
senior in HPER majoring in Public Health Education with a minor in Human Dev./Family Studies

2. Where in Indiana (or the world) do you consider "home"?

[Where I feel "at home"]

I am from Evansville, IN but I feel the most at home here in Bloomington or anywhere that is warm and by the ocean.
I am from Fort Wayne, Indiana. However, **I really consider Bloomington my "home"** now.

[The Geographic response]

I am a true "region rat," **born and raised in Griffith**, Indiana (near Merrillville, Scherrillville, about 30 minutes southeast from Chicago).
I am **originally from** a really small town (Milford) in Northern Indiana, it's right in between South Bend.
I am from Lemont Illinois. It is a southwest suburb of Chicago

[Born in; or "where family is"]

Vincennes is where my parents and younger brother reside and where my siblings and I grew up; however, my older brother is a pharmacist here in Bloomington, and his wife is a pharmaceutical sales rep. for Ortho-McNeill; also, I live with my sister who is a 3rd year in Optometry School. We are very close-knit to say the least; thus, wherever it is that I am with my family is where I consider "home." :)

[Single Town response]

I consider Clarksville,In. my home.
I am from Indianapolis, Indiana.
Right here in good old Bloomington (8)
I consider Anderson, Indiana home
Fort Wayne, Indiana (4)
North Vernon, Indiana
South Bend

Russiaville IN
Hobart IN
Boca Raton FL
Boise ID
Wheaton IL

3. In what occupation(s) are your parent(s)?

[N.B. most listed professional categories for both parents; few "at home" mothers; Representative responses]

My mom works at Pillsbury and my dad is a salesman at Corken Steel.
My mother works for the city of Indianapolis, and my father owns his own telephone company.
Father: Math Professor and Head Baseball Coach Mother: Former developmental mathematics instructor
My mom is a nurse, and my father worked for Ameritech for 31 years and is now retired.
My mother is a Dental Hygienist and my father works in sales.
My mom is a clinical medical asst. and my dad is a plastic surgeon
My dad is an electrical engineer. My mom works in the international student services.
My dad is an engineer who specializes in mechanical predictive analysis, and my mom is a nurse in .. Hospital in Chicago.
My dad is a farmer and my mom teaches fourth grade.
My father is the VP of Mental Health Services for..... hospitals. My mother is a manager at Williams-Sonoma.

4. Do you or other family members (include elders like grandparents or aunts/uncles) speak any other language besides English when "at home"? If so, what language?

[No other language at home or by relatives]

No; Nope, We all speak English; Only English
We are all English speaking, and my mom can speak some old country Gaelic.

[Limited language exposure- 4 respondents]

I can speak a little Spanish.
My cousins are missionaries in Honduras and speak Spanish and my Great aunt is a missionary on an Indian reservation and speaks Navjo.
I have taken many years of Spanish though, so I could have communicated in Mexico with a native if I had needed to do so.
My Grampa speaks a little Dutch, but not very often, and I don't think this really counts
[Yes, other language in family—3 respondents only]
Yes, Urdu/Hindi and Gujarati.
My grandparents on both sides and several of my aunts and uncles on both sides of my family speak Spanish.

5. Have you traveled outside your home country? If so, in what country have you spend the most time outside your native land? Did you need another language?

[None- 12 respondents]

The only other country I've been to is Canada which doesn't even really count.

[Some foreign travel]

I have traveled to Belgium and France, and it seems as if everyone catered to the English language. Senior year in high school, I spent two weeks in Europe.

I have traveled to China. I needed to know the most basic of the Chinese language, for example Hello or Where's the bathroom :)

I visited Mexico briefly for a mission trip with my church. I didn't really need to know the language, because we had interpreters there to help us with communicating with the locals.

I have traveled outside of the country once to Tijuana Mexico, but only for a little while because we were on vacation in California. Spanish wasn't necessary for such a short stay.

Most of the places I've gone people spoke English because they were tourist spots.

[Extended foreign travel- 2 respondents]

I have been to Spain (in high school) for about 9 days and I did a study/service abroad program at the college I used to go to, I lived in the Dominican Republic for 3 months, and I definitely needed my Spanish!

I have travelled to India, Bangladesh, Pakistan, the United Arab Emirates, London, and Canada. I have spent the most time in Canada, where another language was not necessary. I spent equal amounts of time in India and Bangladesh where understanding urdu/hindi helped.

6. Does your family identify with any particular ethnic group, or regional or cultural heritage (directly or by ancestors)? If so, what group(s) and give an example of how your family would identify itself (or celebrate) as members of that group?

[No ethnic identification noted- class majority responded in one of the following ways]

No, although my father's mother spoke English at school and German at home when she was a child.

No, we are Americans, part of the melting pot; therefore, the 4th of July is our big day. :) My family doesn't really have a strong cultural heritage. I know some of my great grandparents came from Germany and Lithuania, but my heritage is not something that I was taught a lot about growing up.

My family is pretty regular; my mom is half German, half Scottish-Welsh and my dad is mostly English. We don't identify with a particular ethnic group, so to speak

My family just identifies as "white." Other than this, my family does not identify with anything else.

We rarely talk about our ancestry. We have a mix of German and Jewish and I don't remember what else.

I think that our family is mostly considered a regular white-Caucasian family.

[A noted ethnic or cultural identity-5 respondents]

We consider ourselves African-American, however we do acknowledge our Native American and Caucasian roots. For example, light skin, fine hair, freckles. We identify ourselves as Indian. My father and all of my grandparents were born in India. My mother was born in Burma. My parents immigrated to America thirty years ago.

My mother's side is Mexican and my father's side is Puerto Rican. We celebrate or represent both cultures through food that we eat that is of Mexican and Puerto Rican influence, through music and dancing...etc.

I do know that on my father's side, there is a slight identification with American Indians, as my great grandmother, whom I never knew, was an American Indian.

On my dad's side of the family we identify with Russia and the Ukrain. My mother's side, Scott-Irish. We identify with my dad's side of the family in being Orthodox christians and practicing some customs.

We are Irish through and through...though we have a bit of German blood, we usually ignore it :)

We are a mixture of German and Russian. I guess as an identifying mark would be my last name, which is German, and my maternal grandparent's last name, which is Russian.

[Other identity]

We are Roman Catholic but not really identified as any particular ethnic group.

[HPER senior]

My whole family is Mennonite now, so it's always interesting to hear how people from other places describe Mennonites

7. Is there a particular health issue and/or demographic group/gender/age-set that you would like to explore in this class?

Specific health conditions:

[A pre-optometry junior focused on clinical conditions]

Anything eye-related, such as glaucoma, macular degeneration in the elderly, etc., or heart-related because of both sides of my family's LONG history of heart disease.

Culture and health:

[A minority sophomore]

I would like to explore the effects of cancer on different minority or mulatto groups. I hope to explore this during the course of this class.

[A traveled senior]

I'm interested in all the different aspects of health in the community, especially in minority and low income families. I'm also really interested in international health issues.

[Student of immigrant parentage or ancestry]

The health issue that I am interested in is HIV/AIDS and the different methods that must be used to educate various ethnic groups and classes about HIV/AIDS.

I would like to learn more about diabetes and it's association or dominance, if any, in the hispanic population.

I would like to look more into the American Indian group because that interests me the most since I have ancestors that belong in that.

[Youth health focus]

I have spent a lot of time researching the prevalence of eating disorders and body obsessions in adolescents, particularly college aged girls, because I think it is an absolute travesty what women are expected to look like. The media has destroyed the self-respect and in many cases the lives of millions of girls, and this saddens me.

I'd like to explore something that my age group is directly affected by,

Appendix F: Group Exercise 8

Friday October 23, 2003

Following the film: “Hospital: Temple of Science” there are examples of social distance & distrust that are created between patients and their physicians.

Identify some examples of the distance created by: the backgrounds of the doctors, their training process and setting, their schedules, the current focus of the practice of medicine especially in hospitals, the financial constraints of caring for costly patients, frustrations of MDs caring for low income patients, MDs social perspective on low income patients.

On the patients’ side: what barriers do the patients have in communicating with MDs in caring for chronic conditions? Finding care resources?

What aspects of these social communication problems would you say are amenable to change—and how might that be done?

Persons missing Wednesday’s film can view it in the Kent Cooper media room- ground floor, Main library (by cafeteria). Ask for Medicine at the Cross-Roads, Part 1: Temple of science (call # R 690 M385/ 1993 part 1),

Appendix G. Group Assignment: Health Disparity/Hypotheses

Directions:

Pick one group from list “A” and one general health problem from list “B”:

A list:

African American

Hispanics

Native Americans

Asian Americans

B list:

Breast cancer

Infant Mortality or Low birth weight infants

Diabetes or Hypertension

Hepatitis or Tuberculosis

Recent Immigrant group

(SE Asia, Central American, undocumented Mexican American , etc..)

- 1) Determine whether there is a health disparity (rate of the condition; severity or impact) between this ethnic group and Caucasian Americans. Use any source from your text or web sites on Oncourse (CDC or others).*
- 2) Do you believe this disparity to be an accurate description of a true difference in health status (or can it be attributed to over/under-reporting; other data “problem”?)*
- 3) What are some of the “unequal health care access/use”; “ecological-environmental” and “cultural/behavioral” causes that might influence this disparity in health status for this sub-population (Suggest some hypotheses that could be tested)?*

Bring some of your conclusions to discuss with the rest of the group on Wed & Friday.

Disparity/Hypotheses: Representative responses

Group 2 We researched diet (weight) in the African American female community. There is a growing disparity in obesity according to this chart from the CDC:

This table reflects the percentages of individuals who are obese within specific categories such as, gender, age, race, education, and smoking status.

Percent Obese

		1995	1998	1999	2000	2001
	12	15.3	17.9	18.9	19.8	20.9
		15.6	17.7	19.1	20.2	21
		15	18.1	18.6	19.4	20.8
		10.1	12.1	12.1	13.5	14
		14.4	16.9	18.6	20.2	20.5
		17.9	21.2	22.4	22.9	24.7
		21.6	23.8	24.2	25.6	26.1
		19.4	21.3	22.3	22.9	25.3
		12.1	14.6	16.1	15.5	17.1
		14.5	16.6	17.7	18.5	19.6
		22.6	26.9	27.3	29.3	31.1
		16.8	20.8	21.5	23.4	23.7
		9.6	11.9	12.4	12	15.7
		20.1	24.1	25.3	26.1	27.4
		16.7	19.4	20.6	21.7	23.2
		15.1	17.8	18.1	19.5	21
		11	13.1	14.3	15.2	15.7
above						
		15.2	17.9	19	19.9	20.9
		17.9	20.9	21.5	22.7	23.9
smoker		12.3	14.8	15.7	16.3	17.8

This fact was found at www.heartcenteronline.com:

“Although people of all races are more health-conscious these days, the traditional African American diet remains high in saturated fat, calories and protein. Unless these energy sources are used up through exercise or other physical activity, they are all stored as body fat. The typical African American diet appears to be unhealthy all over the United States but particularly in the Southern states, according to a 1998 article from the *American Journal of Public Health*.”

Two hypotheses that we had for this disparity were:

- 1) In overweight African American communities, there is a lack of proper exercise facilities because of socioeconomic status.
- 2) There is a sense of social acceptance of African American women who are overweight, so these women will not feel the need to go to a nutritionist or a doctor.

Group 3 Asian Americans and Smoking Cessation (Ashley, Ericka, Kara)

- Smoking is higher among Asian American males than Asian American females or the US male population.
- It is very difficult to get accurate data on the statistics of Asian Americans and smoking because of the lack of ample sample sizes, the studies have been conducted in English, and disaggregation of national tobacco use is unknown.
- Overall, adult smoking prevalence was lower among Asian Americans (16.9%) compared to the 25.3% among whites. The gender difference in cigarette smoking for Asian Americans was much higher than others. Asian women-12.4% and Asian men-21.6%.
- The challenge of promoting tobacco control among AAPIs (Asian Americans and Pacific Islanders) in the United States is also compounded by a more global problem that of tobacco use in Asia and the Pacific Islands. According to estimates of Jha and colleagues, the highest percentages of smokers 15 years and older reside in East Asia and the Pacific. There, the smoking prevalence is 34%, with 62% of men and only 5% of women estimated to be smokers. Because 67% of the AAPI population is foreign born, tobacco use overseas may have a major impact on use among AAPI groups in the United States

HYPOTHESES

- There could be such an influx of Asian American males smoking as opposed to females because they are assuming the dominant role in the family by making all the money and therefore feel they should enjoy the pleasure of smoking. It could be a living standard issue.
- Those who had a higher English language proficiency and living in the U.S. longer were less likely to be smokers. Therefore, it makes sense why the

percentage of Asian Americans is much less than whites. Also, the fact that Asian Americans tended to be influenced more by smoking parents and less by smoking siblings/friends and pro tobacco media is another reason less Asian Americans smoke.

- The use of culturally competent interventions overseas as well as the United States can target specific groups that are most at risk for starting and continuing smoking. According to the fourth fact stated above the population at the most risk are AAPI males in East Asia and the Pacific. When health education improves in these areas then like effects will be illustrated in the United States.

SOURCES:

www.trdrp.org/PageGrant.asp?grant_id=38

Asian Americans and Pacific Islanders and Tobacco

www.cdc.gov/tobacco/sgr/sgr_1998/sgr-min-fs-asi.htm - 21k - Sep 18, 2003

Lew, Rod & Tanjasiri, Sora Park

Slowing the Epidemic of Tobacco Use among Asian Americans and Pacific Islanders
American Journal of Public Health; May 2003, Vol. 93 Issue 5, p764, 5p

Appendix H: Student Guide to Term Projects:

Important Dates:

- 10/6 M Introduction to class projects/ presentations.
- 10/15 M **Assignment:** possible study question (see below), study population choice and one sample article from a public health, social and behavioral or health services journal (1 copy) that would be a likely reference for your paper.
- 11/24 M **Project papers due (11/25 last day to turn in paper for credit)**
- 12/2-6 **Student presentation days**

I. October 15 assignment:

In your group you will have a defined community and a major health issue in that community to address. Think of a hypothesis (a question of cause & effect) which states a possible relationship between a cultural, behavioral or social *factor* for your US ethnic/minority group and:

1) disparity in *a health condition* (infant mortality, pregnancy outcomes, heart disease, AIDS, breast cancer mortality, etc.) **or**

2) *disparity in use of health care*, (e.g. mental health, prevention programs, emergency rooms, exercise programs, diabetes self care, child immunization, cancer screening, etc.)

Discuss some major questions which might need an answer to plan on how to go about reducing some of the disparity in health status for that community (insurance coverage; health education, environmental improvement; language help? Etc..) From among these questions, you can begin to select smaller, individual aspects of the broader topic to cover for your own paper.

Bring a clearly written statement of your own study question (including defined study population and outcome), and a copy of one article that is a likely source of information for your project to class on 10/15. Two basic approaches may help you focus your paper topics:

A **Needed data:** Pick a high-risk groups (for x condition) whose disparity in health status for some condition suggests we may need special targeting for prevention or treatment. What might we *still need to know about this group* and their: social networks; health beliefs; structural barriers to care (pick one major aspect which seems most appropriate to the condition or health state of interest.) in order to *effectively address the disparity this group has in condition x* ?

B. **Attempted Interventions:** Programs have been developed to reach high-risk groups (e.g. peer-delivered health ed to youth; social- support to frail elders; health access programs for poor children, church-based screening for African Americans etc.) How successful have these programs been? Pick one major approach for the intervention(s) that have been developed for a specific health

problem and ethnic group. Discuss ways in which the program was tailored to the culture?

Some sample starting questions or hypotheses might include:

1. Does spouse support help (Mexican American; Chinese..) women get to cancer screening?
2. What biological; environmental; other factors put (Black; Hispanic...) kids at risk of asthma? early sexual initiation? Child-bearing?
3. Do measures of acculturation (integration into US society) put Asian immigrants at greater or lesser risk of obesity? smoking?
4. What social networks might be used to target improved hypertension detection and control among African Americans?
5. What barriers (access; perceptual; etc.) best explain low-SES levels of use of child immunization programs in some ethnic groups?
6. Are peer education programs for reducing substance abuse effective in low-SES or minority youth?
7. Do different ethnic groups exhibit different rates of mental illness (depression, other disorders..) ? Is this a real difference in rates? Perception/labeling of these conditions? Do they use non-medical/mental health providers?
8. Does the social status of women in (x group) help/hinder their use of (family planning; condom negotiation with partners, etc.)? What programs have targeted the women's knowledge? Other barriers to prevention/use of care?
9. Are certain groups at greater risk of occupational cancers or respiratory diseases? What interventions have addressed these forms of worker risk?
10. Can low infant birth weight be prevented by prenatal programs for low income, minority moms?

These should probably be narrowed down as you get your first look at articles on the subject and go with the area of strongest evidence. **Remember , the more you can focus your question, the easier your literature search, and ability to state the highlights about what is known/ not known** will be.

2. ***Where to go for an article and quick literature search:*** A number of databases exist on the IU Libraries websites which offer a quick way to look at, and copy abstracts from recent articles, simply by using keyword terms. MEDLINE for health and clinical interventions; risk factors (Biology Library, Jordan Hall), HEALTHPLAN for health care use; perceptions, barriers for at-risk groups (SPEA/BUS library), and psychology/social science abstract systems for the general social literature at Main Library are available with helpful research librarians at each site. Google.com also gets some good first articles—but to get the scientific literature, I suggest using key authors and terms from these first sources in other search engines to avoid the “popular press” and less reliable sources.

Main search terms like “Hispanics”; “peer-educators”; “adolescent pregnancy”; when called up by subsets and combined will give you a cross-section of recent articles, plus abstracts you can look at quickly to determine if *other* key words might get you better results (e.g. Mexican Americans versus ‘Hispanics’; ‘community health workers’ instead of ‘peer-educators’). You can refine your search/question by the keywords in abstracts.

Most health-and-social science journals are in Main Library (*Social Science and Medicine, Journal of Health and Social Behavior*, etc.), public health publications are in SPEA, HPER and Main libraries; while journals with “community/ health behavior intervention” articles are mostly at HPER. Medical journal articles are in the Biology library, can be ordered by on-line interlibrary loan to the Medical School at IUPUI; and many have full-text available online.

3. Paper: general format:

1. *Title page* with your name and SSN, and course number, and title

2. *Text*: 10-12 double spaced pages of text (not including title page, references or illustrations) in 12 point type (this is 12 point Times Roman type), .

Style & Form: All pages should be numbered, have 1" margins on all sides. Correct paragraph and sentence structure, grammar, and spelling will be expected (details count!). See the Writing Tutorial Service in Ballantine 206 if you need help. All papers should be typed or word-processed. **Make 2 copies before turning in paper, and back-up your diskettes regularly while working on papers.**

3. *Bibliography* with all complete references (which may be single- spaced).

Bibliography: All cited ideas (direct quotes, data or factual information, or opinions/conclusions paraphrased from other’s work) should be properly attributed to the original author. You need a reference even if you re-cite information from *another* primary source (e.g. US Bureau of the Census: *Vital Statistics* 1994... for mortality data used in one of your primary articles). Using text directly from web-sources, or any work authored by others and claimed as your own, without proper citation (in text body) and references (in bibliography) constitutes plagiarism and is subject to sanctions from the IU Code of Student Rights, Responsibilities, and Conduct (Honor Code). (<http://www.campuslife.indiana.edu/codeindex1.html>)

Bibliography: USE American Psychological Association or other standard citation format. Give at least 3 of the primary authors’ last names and initials, publication date, full title of article or book chapter, name of journal or book *in italics* or underlined, volume number (1995;5:) and pages (1-10). Give *book* editors’ names (if appropriate); place and publisher (NY: Plenum Press) and relevant pages (pp.1-10, 12-13.). Use the reference style for any of our class articles and you will be in good form. Unsure? check with the Writing Center in Ballantine Hall.

Text citations: You will need to either: 1) include authors’ last names, year of publication in parentheses after sentences using their thoughts/work, (Nakamura 2001) or 2) sequentially number each reference in parentheses (or as super-script) as you use it the first time in your text, following the referenced idea¹. If you use Word, endnotes places the same number for the reference in the bibliography

“Web” references are not suggested unless: 1) they are on-line *articles* by scholarly journals, cited as you would general articles 2) major policy of a federal agency, 3) state/federal health agency or national health organization (American Cancer society) *data releases*. 4) Major newspaper articles (*New York Times, Wall Street Journal*). Text citations should give author and date, or sponsoring agency and date of the referenced webpage material was created.

Paper Grade: a 100 point scale:

Name _____
Topic _____

___ 15 Pts Introduction: Defining the problem. What is this disease/health condition important?

___ 15 Pts. Who makes up the "population at risk"? What do we know about them?

___ 20 Pts. Presentation of relevant data. Supporting information: properly referenced and discussing the problem's relevance to the public, a risk group, policy makers, or other major players in the health system. Maximum points will be given for:

- 1). Quality of references adequate to support text (e.g. current professional journals, or major newspapers, or access to such sources through their Web-sites). Web-citations from federal or state sources (spell out agency, date of release and author, if applicable, in the bibliography) may also be used.
- 2) Logical, well-organized presentation
- 3) Student's analysis (versus description)
- 4) Objective discussion (citing varying positions; pros/cons; other alternatives considered)

___ 20 Pts Proposal(s) to resolve the problem:

- 1) What seems reasonable; feasible (Costs? Acceptance?)
- 2) Interventions likely to be accepted by targeted group? Other "players" in the health system.

___ 10 Pts. Conclusions: Are they consistent with the above evidence and options?

___ 20 Pts Format and style:

Any References appropriately cited (use consistent style from any professional journal)

Grammar, Punctuation, Spelling. Proper paragraphs. etc.....

Neatness (typed or word-processed papers only)

Page formatting (double spaced), margins (at least 1 "), pagination

Text Length: 10-12 pages, excluding bibliography and illustrations

100 Pts per paper

4. **Due date:** Monday **November 24 during class**. Late papers will only be accepted through **Tuesday 11/26, 5:00 pm**, received and dated by the Department secretary, in the instructor's Departmental office (HPER 116). These papers will receive one lower letter grade; later submissions *will not be graded*

A Guide to Class Presentations

1) Student s will prepare an 20-30 minute presentation of their research projects. Presentations will be scored by your instructor on timing, clarity, adherence to professional form & presentation, and engagement of colleagues in discussion. A sample score sheet is attached.

Objectives: Think about integrating your presentation with issues and applications discussed in class and your group discussions. You'll offer some new information. More importantly, your listeners should be prompted to think about how public health professionals (like yourselves) must consider new tools, ways of thinking, working with a various communities, learning other people's perspectives, etc. to:

- 1. Know where at-risk communities are likely to accept change**
- 2. Apply health data & information toward bring about change in community health.**
- 3. Understand what we still need to know about this community or their health.**
- 4. Use your listeners.** Leave them prompted with questions and help bring out new ideas or perspectives about your topic's complexities as those questions emerge. This is one of the major objectives of the presentation.

Questions will be held until after each presentation. The instructor will facilitate getting the maximum number of questions addressed in the 10-12 minutes allowed for discussion of each presentation.

2) Materials: You may elect to use overheads; or individual handouts. Speakers should have materials in order to go at presentation time. Turn in a paper copy of overheads or e-mailed copy of the Powerpoint presentation to your instructor in the class period following your presentation.

3) Test Questions: You will turn in 1-2 multiple choice and 1-2 short response/essay questions prepared from your presentation material, and submitted along with the above materials. The instructor will use these questions or versions of them for the final test in the course.

4) Scoring of presentation: You will receive comments from their professor following the presentation and class discussion, covering content, clarity, timing, and engagement of the audience (See scoring sheet).

Instructor's grading of presentation: Each of 10 aspects is awarded up to 3 points using the following scale:
Aspects: Definition of Health question (focus) and Study population, Significance of focal theme, Clarity/ organization of presentation, Quality/clarity of visual aides, Professionalism: kept to time limits, organized, Engagement of audience.

- (1) Average; could be better
- (2) Good- satisfactory performance
- (3) Exceptional- above average

Group: _____ Presenter: _____

Date: _____

Comments/questions represent suggestions for improvement.

- (1) Average; could be improved/polished/clarified
 (2) Good- satisfactory performance/ minor polishing helpful
 (3) Exceptional performance: Clear, professional, engaging

Scores:

1. ____ Organization: Presentation topic well organized; Comments:
2. ____ Clear statement of disease/ health problem or general theme of presentation? Comments:
3. ____ Significance of problem addressed... why should we care? Comments:
4. ____ At-risk population(s) identified: discussed? Comments:
5. ____ Clear, but brief, intro to risk factors for disease/condition? Comments:
6. ____ Issues in prevention; intervention offered? Comments:
7. ____ Quality/clarity of visual aides? Comments:
8. ____ Offers a coherent theme, supporting material and major issues for public health? Comments
9. ____ Audience engaged? Generated good questions; commentary? Comments:
10. ____ Professionalism: little fumbling? Kept to time? Comments:

____ Total Presentation Day Score

Appendix I: Sample Student Final Paper

AN EXPLORATION OF THE CANCER EXPERIENCE IN THE AFRICAN
AMERICAN POPULATION: ACCESS TO CARE, INSURANCE, AND OUTCOMES
Sabeen _____
November 24, 2003
C310

Cancer is a group of diseases characterized by uncontrolled growth and spread of abnormal cells, and left untreated can cause death. This year, approximately 132,700 new cases of cancer will be diagnosed in the African American population, and 63,100 African Americans are expected to die from cancer (American Cancer Society 2003). The most common cancers in the African American population are prostate, breast, lung, and colorectal cancers (Cooley and Jennings-Dozier 1998). African Americans have higher rates of cancer incidence and mortality than any other group. Research shows that this is due to many factors. The main cause of such high numbers of cancer and cancer deaths is attributed to problems accessing health care. There are many barriers that African Americans face in accessing health care. These barriers include socioeconomic status, health insurance coverage, inadequate health care, lack of knowledge about cancer, distrust of the medical community, and cultural barriers in the African American community. These barriers lead to worse outcomes for African American cancer patients.

African Americans experience many health disparities, and in the case of cancer, these disparities can lead to fatal outcomes. One of the greatest barriers to accessing medical care is socioeconomic status. Though African Americans only make up twelve percent of the population in the United States, they account for one-third of the nation's

poor. Socioeconomic status can affect other factors such as health insurance coverage, inadequate health care, and amount of knowledge about cancer. One of the listed factors or a combination of them can lead to poorer outcomes due to lack of prevention programs and delayed detection and treatment in the African American community (American Cancer Society a 2003). In a poor African American community, unless there is a community-based initiative like a church prevention program, an outside organization may come into start a cancer prevention program. Since this group is not coming from within the community, community members may be less likely to actively participate in the program. This means that health problems may go undetected until the symptoms become apparent, giving the cancer an opportunity to metastasize. Once the cancer starts to metastasize, the survival rate decreases. Early detection is key to increasing cancer survival rates, and access to prevention and diagnosis are major barriers to early detection.

Financial factors cause health disparities in many areas. When financial resources are already scarce before cancer diagnosis, many times they become depleted once cancer treatment starts. Treatment is not the only expense.

“Some patients, even those with insurance, find that uncovered financial costs for items such as transportation, child care and medical supplies can rapidly drain family resources causing some patients to sell assets including the family home, farm, or other business, or to go without care.” (National Cancer Institute 2002)

In the African American population, there are many single mothers. It is especially hard for single African American mothers to financially support their families if they are diagnosed with cancer. This becomes an issue of importance to the general public because taxpayer dollars go to relieving the financial burden of these cancer patients who are the heads of their household. If money went toward more prevention programs and

public cancer screening sites, less money would have to go towards treatment. Treatment is more expensive than prevention and screening programs, therefore it would save taxpayers money if there were more publicly funded prevention programs and screening sites while decreasing the health disparities in the African American population who are in the low socioeconomic group.

Health insurance coverage can be a result of financial factors or overall socioeconomic status. According to a press release for “Cover the Uninsured Week 2003”, an initiative of former Presidents Jimmy Carter and Gerald Ford, in the year 2001 and 2002, nearly two out of five African Americans were uninsured, while less than one-fourth of whites were uninsured. Not having health insurance can cause minor health problems to become serious and even fatal. Risa Lavizzo-Mourey, an African American physician and president of The Robert Wood Johnson Foundation, stated:

“...African Americans who lack health insurance, even for a short period time, are forced to put their physical and financial health in jeopardy. Because they do not have health insurance, uninsured Americans delay needed health care, live with illness, and often die sooner as a result.” (Gorski 2003)

There are serious consequences when people delay health care. The uninsured are more likely to delay seeking treatment because of the financial burden, thus putting their health at serious risk. When looking at survival rates and insurance coverage, it is evident that lacking insurance puts a person at serious risk. Uninsured women with breast cancer are twice as likely to die as insured women. Uninsured men are almost fifty-percent more likely to be diagnosed with colon cancer at a later stage than men with insurance (Gorski 2003). This gives the cancer more time to metastasize, resulting in decreased survival rates.

African Americans are also less likely than whites to have job-based insurance, and they are more likely to receive assistance from government programs. By not having health insurance, these African Americans are less likely to have a primary care physician. Twenty-eight percent of African Americans report having no regular doctor, and twenty-two percent of African American adults are more likely to report hospital emergency rooms, clinics, and “nowhere” as their regular source of care. Twenty-two percent also report having little or no choice in where they go to receive care (Collins, et al. 2002). Lack of a primary care physician can greatly affect the quality of health care a person receives. African Americans without a regular doctor are less likely to receive preventative services and screening. Also, they are more likely to report communication problems and are less satisfied with their care (Collins, et al. 2002).

There is a perception in the African American community that people with insurance receive a better quality of health care than those without insurance (Miller, et al. 2001). In a study conducted in a predominately African American community in the southeastern United States, youths, patients, and church leaders believed that the type of insurance also affects the quality of health care a person receives. The participants of this study were youths between the ages of fourteen and eighteen, patients of different chronic diseases, residents of subsidized housing, church leaders, and health care providers. The youths, patients, and church leaders also felt that insurance providers limit treatment options for profit reasons. Other thoughts expressed by the community included discrimination towards the uninsured and complex policies. The complex policies regarding coverage and reimbursements lead to confusion in the African American community. Another area of concern included denial of health insurance due to pre-

existing conditions. Lack of or inadequate health insurance coverage affect access to care, and even when care is available, there is a problem with quality of care (Miller, et al. 2001).

In the study, some of the participants believed that people with private insurance receive better care because they get the best physicians. Participants in the study also believed that patient overload led to longer wait times, affecting the quality of care. Some participants who could access care did not want to due to negative past experiences. Some said that the doctors that had seen lacked comprehensive knowledge and skill leading to ineffective communication, while those that were competent could not have effective communication due to patient overload (Miller, et al. 2001). All of these factors lead to avoidance of getting health care.

Another factor that is a barrier to accessing care is a lack of knowledge, especially in African Americans with a low socioeconomic status. According the American Cancer Society, a lack of or limited education can lead to delayed detection, and African Americans are more likely than whites to be diagnosed during a later stage of cancer than whites. The less educated may not recognize symptoms, or they may not realize the significance of them (American Cancer Society a 2003)2003). This delays detection and causes late detection, which may result in a lesser survival rate because the cancer has the opportunity to metastasize. Some African Americans also believe that they are less susceptible to getting cancer, and they are less likely to see a physician for cancer-related symptoms. While fifty-four percent of whites recognized common cancer symptoms, only twenty-five percent of African Americans were knowledgeable about symptoms (Cooley and Jennings-Dozier 1998). This is a huge barrier to accessing care because

three-quarters of the African American population may not even realize that they need care. For example, a study was conducted in an urban African American community about colorectal cancer. Only thirty-nine percent of those surveyed knew that a screening for colorectal cancer is recommended. Seventy percent did not know the symptoms of colorectal cancer, and sixty-one percent felt that they would not develop colorectal cancer (Schulmeister 2000). Even though they are more likely to need health care, African Americans are less likely to receive it, and a lot of that is due to a lack of knowledge in the community (Cooley and Jennings-Dozier 1998).

There is also a strong distrust of the medical community that causes African Americans to not access health care. In the study in the southeastern United States, many participants expressed the feeling that physicians were only in the profession to make money, not to save lives. They questioned the sincerity of the medical community. The youths in the study were afraid of misdiagnosis, and did not trust physicians to deliver a high quality of care (Miller, et al. 2001). Compared with other groups, African Americans are more likely to feel like health care providers are looking down upon them, and they feel like they are being treated with disrespect (Collins, et al. 2002). With sentiments like these, African Americans are less likely to access care.

Cultural barriers also cause African Americans to not access health care. Fatalism is a common view in the African American community, especially those who fall into the low socioeconomic status group. Fatalism is defined as “the categorical surrender of the human spirit to the external forces of life that destroys the human personality, potential, hope, and life” (Cooley and Jennings-Dozier 1998). This is a significant barrier to care because people with who have a fatalistic attitude are more likely to focus on the

everyday aspects of life rather than on health promotion and prevention behaviors. These feelings of fatalism are reinforced many times due to late diagnosis when little can be done to change the outcome of a decreased survival rate. Since many African Americans have a fatalistic attitude towards life, they feel helpless in regards to their health (Cooley and Jennings-Dozier 1998). Health care providers must recognize this view and learn to work with it to better understand and care for the African American community.

Medical providers must be culturally competent to provide the best care possible. Physicians have to be knowledgeable about patients' cultures, and they have to learn to work with them instead of trying to change them. Culturally incompetent care leads to "lack of appropriate health care services, misdiagnoses, needless suffering, and potentially harmful complications" (Cooley and Jennings-Dozier 1998). There are some lifestyle changes within the African American community that need to be made, and some of these changes fall into the realm of the African American culture. Diet is one of these lifestyle factors that put African Americans at risk, but it is part of their culture. Large meals are weekly, and sometimes daily, traditions within the African American community. These meals are not prepared healthily, many times cooked in lard or other animal fats. This is a cancer risk, but it not a widely known risk among members of the African American community. Health care providers need to address risks like this in a culturally sensitive way in order to make lifestyle changes in the African American community.

In the African American community some improvements are being made. Screening rates are increasing, though the outcomes rates are still worse for African Americans than for other groups. According to the American Cancer Society, screening

rates in the African American community are becoming more consistent with whites. The same percentage of people are getting screened, but these screenings occur less frequently and more time lapses before actual diagnosis and treatment (American Cancer Society b 2003). This leads to worse outcomes because the cancer has a chance to metastasize, and treatment options decrease with delayed diagnosis. Because access to care is such a big problem, even when a person goes to a free public screening site, he or she may not be able to follow-up with treatment due to financial reasons with accessing care. According to SEER Cancer Statistics Review 1975-2000, five-year survival rates in the African American community are more than ten percent lower than whites. Some reasons why while screening rates are increasing, outcomes are still not comparable with other groups include access to specialized care and the patient's ability to carry out instructions at home (Collins, et al. 2002). Screening does not help if there is no access to treatment, and as long as there is no access to treatment, outcomes will inevitably be worse for the African American community, especially those with a low socioeconomic status.

There are some initiatives currently being taken to decrease the health disparities in the African American community. The University of Pittsburgh Cancer Institute sponsored a pilot-program to increase cancer awareness, provide cancer education and early detection, and overcome barriers to care in the African American community. There were four interventions in the program, which were a celebration of life project, a cancer education program, a cancer screening program, and an anti-smoking program for elementary-aged children. To make the programs successful, culturally specific strategies were used. This included using clergy, community leaders, appropriate

educational materials and lay volunteers. So far, the community's response to the program has been positive, but evaluation is on-going (Cooley and Jennings-Dozier 1998).

Programs are slowly working towards relieving the health disparities that African Americans experience, but there is still more that needs to be done. Cultural values, such as family, extended kin networks, and religion, need to be incorporated into programs to make them effective (Cooley and Jennings-Dozier 1998). Community involvement in every aspect of planning, implementing, and evaluating must be a part of any successful health promotion program or treatment plan for the African American community. Incorporating churches into cancer programs has proven to be highly effective. Clergy have been very helpful in facilitating programs to better the community's health by promoting healthier lifestyles among the church members. Since the education comes from within the community, African Americans are more trusting and willing to access health care.

It is also important for nurses to be educated about the African American community. A one-day educational program, sponsored by the Oncology Nursing Society and the National Cancer Institute, educated nurses about cancer prevention and early detection. This program used African American nurses because research has shown that programs are more effective when health care providers come from within the community in which they are working. This program helped nurses to help develop, implement, and evaluate programs geared towards the African American community. Though this program started with just African American nurses, it has grown to include all nurse educators, and it will slowly work its way into undergraduate and graduate-level

nursing curriculums (Cooley and Jennings-Dozier 1998). This program has proven to be successful, but more programs like this are necessary. Programs like this increase knowledge and make African Americans more likely to access care.

Though steps are being taken to decrease the amount of health disparities in the African American community, there still remains huge gaps. These gaps are mostly due to the financial aspect of health care. Prevention and health promotion programs can do a lot to increase knowledge about cancer, but they do not relieve the financial burden of getting diagnosed and receiving treatment. The only way that cancer outcomes will get better in the African American community is for health care to be affordable or free. This means that there must be a major overhaul of the current health insurance in the United States. Medicare and Medicaid need to be revamped, and access to care needs to work its way to being free for everybody. The United States is the only developed country without universal access to health care. To change the system, there needs to be a change in mentality among both the public and politicians. This will be a slow process, but it can happen. Health care needs to be seen as a right not a privilege. The public needs to stop discriminating against the poor and work to decrease the health disparities that exist among all groups. If more money goes into prevention, then less money will have to go into treatment.

There is no cure for cancer, but there are many ways that it can be prevented. If prevention measures are taken and health care is accessible for all, the United States will have a more productive society. Access to health care barriers such as socioeconomic status, health insurance coverage, inadequate health care, lack of knowledge about cancer, distrust of the medical community, and cultural barriers in the African American

community can all be overcome if politicians and citizens, including health care providers, patients, and communities, work together. If people realize that money can be saved, they will more willing to look into the option of free access to health care. The United States spends the most money on health care, but we are not even in the top ten for positive health outcomes. Other countries are more successful at not only paying for their citizens' health care, but also increasing survival rates. The United States can also be successful in increasing life expectancy among cancer patients, especially African American patients. Making it a priority is key to fighting the battle against cancer.

REFERENCES

- American Cancer Society (2003). Cancer facts and figures for African Americans. Atlanta, Georgia.
- American Cancer Society (2003, Apr 02). Cancer rates improving among African Americans: disparities compared to other racial groups still large. Retrieved on November 15, 2003 from <http://www.cancer.org/>
- Collins, Karen Scott and Katie Tenney, Dora L. Hughes (2002). Quality of health care for African Americans: findings from the Commonwealth Fund 2001 health care quality survey. Retrieved on November 15, 2003 from <http://www.cmfw.org/>
- Cooley, Mary E. and Jennings-Dozier, Kathleen (1998). Lung cancer in African Americans: a call for action. *Cancer Practice*, 6(2), 99-106.
- Gorski, Liz (2003, Mar 10). Cover the uninsured week: March 10-16, 2003. Washington, DC
- Miller, Stephanie and Hope M. Seib, Sheila Dennie (2001, July). African American perspectives on health care: the voice of the community. *Journal of Ambulatory Care Management*, 37-44.
- National Cancer Institute (2003). What are cancer health disparities? Examples of unequal treatment and unequal access to care. Retrieved on November 15, 2003 from <http://crchd.nci.nih.gov/>
- Schulmeister, Lisa (2000, July/August). Focusing on quality cancer care. *Clinical Journal of Oncology Nursing*, 4(4), 189-191.

Appendix J: An Outline of a Group's Presentation

African Americans and Cancer: Understanding Disparities and Possible Solutions Terri L., Julie K., Sabeen P., Gretchen B., Eric N.

Cancer

- Cancer is a group of more than 100 different diseases.
- The unregulated growth of specific cells in the body.
- If a normal cell begins to grow abnormally and reproduces too rapidly, a mass of abnormal cells eventually becomes a tumor.

Risk Factors for Cancer

- Tobacco use
- Lack of physical activity
- Poor diet
- 5-10% inherited - genes
- Environmental exposure
- Age
- Modifiable or non-modifiable

Cancer Treatments

There are three typical treatments for cancer:

Surgery – removal of the tumor.

Radiation therapy to destroy cancer cells.

Chemotherapy, or the use of toxic chemicals (drugs) to kill cancer cells.

African Americans

- Approximately 36.6 million citizens
- 12% of the U.S. population
- Diverse cultural, religious, geographic backgrounds
- Historically ignored and/or on the receiving end of social injustice
- Consequently, their health status is generally worse

African Americans and Cancer

- Cancer is an enormous problem in this community
- Lung cancer in both sexes
- Breast cancer in women
- Prostate cancer in men
- Colon cancer in both sexes

African Americans and Cancer

Incidence

- Between 1992 and 1999, 526/100,000 African Americans were diagnosed
- This rate was 480/100,000 for whites
- In 2003, 132,700 new African American cancers
- The rate of cancer is generally 20% higher for African Americans

Mortality

- Cancer will claim 63,100 African American lives in 2003
- This death rate is one-third higher than white Americans

Contributing Issues

- Socioeconomic status
- Cultural beliefs and practices
- Treatment quality
- Access to care
- Environment
- Inherited factors
- Discrimination
- Individual risk factors

Access to Care

- Generally measured through insurance status
 - Private insurance 53%
 - Medicaid 19%
 - Uninsured 23%

Access to Care - Screenings

- Detecting cancer early has been shown to save lives
- African Americans receive screenings at a much lower rate than whites
 - Mammography
 - Sigmoidoscopy
 - PSA
- Highest level of Pap screenings!!

Access to Care - Screenings

African American cancers are often diagnosed at later stages than whites!!!

African Americans and Cancer

Access to Care - Medications

- African Americans are less likely to receive all of the prescriptions that they need
 - Publicly funded programs
 - Need for supplemental insurance
- African Americans receive less pain medication than whites
- Often they do not receive the recommended doses

Knowledge, attitudes, and beliefs

- Fatalism
- Distrust of medical system
- Misconceptions about risk, warning signs, and treatment
- Information sources

African Americans and Risk

High prevalence of smoking

- Very high overweight / obesity
- Poor diet
- Lack of physical activity

Alcohol consumption

Quality of Care

Programs

National Cancer Institute - Fed

American Cancer Society

Universities

Community building

Community involvement / empowerment

Natural helpers

What can be done?

Access to care / screenings

Education about risk


Behavioral change


Integrated systems

Culturally appropriate care


Appendix K: Clinical video-clips, OMH website


[Contact Us](#)




 Clinical Exchanges

- [Prior Assumptions & Prejudices](#)
- [Medical History & Diagnosis](#)
- [Patient Adherence](#)
- [Working with an Interpreter](#)
- [Non-verbal Communication](#)
- [Relating to Patient's Families](#)

 The Provider's Guide to Quality & Culture



Clinical Exchanges are video scenarios illustrating patient provider interactions. Each scenario is divided into scenes. Learning exercises accompany each scene. The exercises help viewers recognize the effect of provider behavior on clinical outcomes.

Note: To view the videos, please install Flash 6. This software is free and can be downloaded from [Macromedia Flash Download Center](#). Please note that this download may take several minutes.

To further develop your skills in a particular area, select a video.

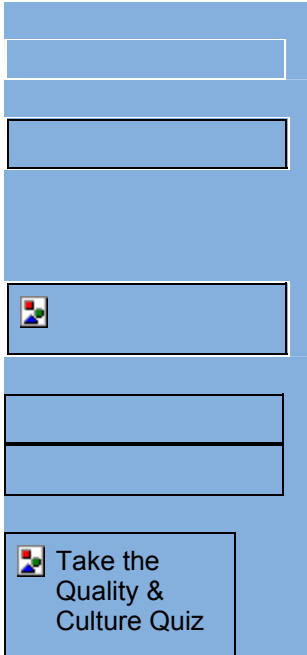
Clinical Exchanges

Patient Provider Interaction

<input type="checkbox"/> Adolescent Obesity	Video
<input type="checkbox"/> Diabetic Compliance (Effective communication)	Video*
<input type="checkbox"/> Diabetic Compliance (Ineffective communication)	Video*
<input type="checkbox"/> Immigrant Healthcare	Video
<input type="checkbox"/> Limited English Proficiency	Video
<input type="checkbox"/> Sexual Orientation	Video

Cultural Groups

<input type="checkbox"/> Breast Cancer Care	Video
<input type="checkbox"/> End of Life Care	Video



Take the
Quality &
Culture Quiz

*Please note that this video contains sub-titles that may be hard to read. We will be adding larger text shortly.