



## SIRC Researchers Built Culturally Specific Substance Abuse Prevention Strategies Successfully

“Being a part of a great research family at the Southwest Interdisciplinary Research Center (SIRC) has opened my eyes to the culture, diversity, and health disparities in the southwest,” says Crescentia Tso, an MSW research assistant with SIRC and a member of the Navajo Nation from northern Arizona. The research internship helped her make the connections between the main stream and her native culture, and between the rural Native American culture that she grew up with and the urban Native American culture that was relatively new to her. She learned much about different Native American cultures and beliefs from Native American adolescents for whom she provided training through her research internship. Now, Crescentia even applies the prevention intervention techniques she learned from her research internship to her substance abuse counseling practice at the NDNS4Wellness in Phoenix. “Going from working in prevention to intervention has shown the great need for prevention programs,” says Crescentia.

Crescentia benefited from the “Living in Two Worlds” project conducted by SIRC researchers at Arizona State University and community partners at the Phoenix Indian Center and the Mesa School District. “Living in Two Worlds” is a research project designed to produce, validate, pilot, implement and assess the feasibility and efficacy of a culturally grounded prevention program targeting urban American Indian adolescents. “Living in Two Worlds” was created through a theoretically guided adaptation of an existing universal prevention program, *Keepin’ it REAL*, which is a SAMHSA (Substance Abuse and Mental Health Services Administration) Model program developed at SIRC. *REAL* stands for the strategies that SIRC researchers found youth use most often to avoid alcohol and drugs: refuse, explain, avoid and leave.

The *Keepin’ it REAL* program is a school-based prevention program, and was funded by the National Institute on Drug Abuse of the U.S. Department of Health and Human Services after studying a decade of research. The program’s developers perceived the need to build and test culturally specific substance abuse prevention interventions that would incorporate the already present cultural strengths represented in the country’s ethnically and racially diverse school population. Based on the research results, they developed a classroom curriculum of ten 45- to 50-minute-lesson to teach youth from 10 through 17 years of age to live drug-free lives by drawing on their strengths and the strengths of their families and communities. Using *REAL* strategies, students learn how to recognize risk, value their perceptions and feelings and embrace their cultural values (e.g., avoiding confrontation and conflict in favor of maintaining relationships and respect) and make choices that support themselves.

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## Community Story

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Crescentia Tso (center) demonstrated a substance abuse counseling technique to her colleagues.

# Living with Hepatitis B

By Doug Hirano

Personal Story

In March 2006, Mei Yu was a healthy 50-year-old woman with a husband, two children and a successful professional career in the Phoenix area. Then, the results of her husband's routine pre-surgical blood test suggested that she be tested for the hepatitis B virus, a major cause of liver disease. When her test results came back positive, her world came crashing down.

"I thought was that I was going to die," she recalls. "Here I am, a relatively young woman, and I am going to die from this disease. I didn't know what to do." Mei stopped going out and even stopped going to work. There seemed to be little hope, even from the medical community.

"My family doctor referred me to an internist," she remembers. "But the internist had never treated anyone for hepatitis B infection. I couldn't believe it."

For four years now, Mei has been living with chronic hepatitis B infection. She says in general that she feels fine, even though her initial liver ultrasound showed signs of liver cirrhosis due to the virus. She's since switched to a physician at the Mayo Clinic with experience in treating Asian people with hepatitis B.

Mei exercises every day. "I keep myself busy," she says. "I don't want to sit and think about it. I don't want to be haunted by it."

She still worries prior to her doctor's visits, which occur every six months. "I start worrying that the exam and tests are going to show that I'm not going to be any better. I still pray every day that the treatment works."



Mei has learned a lot about hepatitis B in the past few years. She now knows a few important facts about hepatitis B. It's not spread through "casual contact" such as hugging or kissing; Asian Americans tend to be infected in their native countries during childbirth; and, perhaps most importantly, there are relatively new medications that can successfully slow the replication of the virus.

Still, she worries about other Asian Americans who may unknowingly have hepatitis B infection. "Most people, including doctors, don't know that as many as one in ten Asian Americans carry the hepatitis B virus," she says. "They need to know that hepatitis B infection can be silent for decades, that there is a simple blood test for hepatitis B, and there's a vaccine to prevent infection."

"I feel lucky that I found about my infection when I did. If it had not been for my husband's test result, I still would not know. And probably, my cirrhosis would be getting worse. Liver cancer would be a possibility as well." She says that she has found out that one in four individuals with chronic hepatitis B infection will develop serious liver disease, including liver cirrhosis and liver cancer.

Mei says that she has also learned a lot about herself since she found out she was infected with hepatitis B. "I found out that I'm stronger than I thought," she reflects. "I feel obligated to turn my own misfortune into something positive for other people." Mei takes the opportunity to tell her story about hepatitis B to other Asian Americans in the valley. "If I can make a difference in even one person's life, then it will be worth it." ♦

## Arizona Health Disparities Center

### Mission:

To promote and protect the health and well being of the minority and vulnerable populations of Arizona by enhancing the capacity of the public health system to effectively serve minority populations and reduce health disparities.

### Vision:

#### Health equity for all

We envision a state where each person has equal opportunity to prevent and overcome disease and live a longer, healthier life.

### Contact:

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602-542-1219  
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<http://www.azminorityhealth.gov>

## AHDC Received Two Federal Grants to Build Health Communities

By Zipatly Mendoza

The Arizona Health Disparities Center (AHDC) is proud to announce the recent award of two grants. The AHDC was awarded the State Partnership to Improve Minority Health grant from the Department of Health and Human Services, Office of Minority Health (OMH). The second grant awarded to the AHDC is the Centers for Disease Control and Prevention's REACH CORE grant (Racial and Ethnic Approaches to Community Health for Communities Organized to Respond and Evaluate).

Under the State Partnership grant the AHDC will develop health initiatives to support OMH National Partnership for Action (NPA) to End Health Disparities. The mission of the NPA is to create a nation free of health disparities by achieving health equity through the following five objectives: increase awareness of health disparities, strengthen leadership at all levels for addressing health disparities, improve health and healthcare outcomes, improve cultural and linguistic

competency in health services and coordinate and utilize research and evaluation outcomes.

The purpose of REACH CORE grant is to reduce health disparities related to diabetes, cardiovascular disease and other conditions among targeted populations in Arizona. The focus of this two-year funding will be to identify and address policy, systems and/or environmental changes. Utilizing a community driven process and applying comprehensive, evidenced-based approaches to achieve health equity improvement, the AHDC will develop and implement a community action plan, provide trainings to strengthen and build capacity, build partnerships with decision- and policy-makers and assist in the development of linguistically and culturally appropriate programs and materials.

For more information, please contact Zipatly Mendoza at 602-542-1219. ♦

## Latina Teens Learned about Health Lifestyles and Folic Acid

By Diane Ziplej

On August 28, 175 Latina teens met for the Latina Agent of Change Conference hosted by the March of Dimes and Arizona Spina Bifida Association to learn about healthy lifestyles, the importance of folic acid and how to prepare folate-rich foods. Dr. Edith Allen from St. Joseph's Hospital and Medical Center spoke to the girls about prevention of obesity, diabetes and hypertension, all of which are prevalent in the His-

panic community. In the photo, Cristina Nevarez, a March of Dimes volunteer, a culinary institute graduate and a TV personality on *Univision*, gave a cooking demonstration for the participants. She also prepared folate-rich recipes for the conference participants. Participants took a pre- and post-test to measure their increase in knowledge about folic acid, which showed a 46% increase. ♦



## Age Less, Live More

By Fred Taylor

In August, Mr. Bernando LaPallo (109 years young, right) and Mr. Herschel Phillips (90 years young, left) attended the executive board directors' meeting of the Southwest Prostate Cancer Foundation (SWPCF) in Phoenix. Both gentlemen spoke about diet, exercise and spirituality, and how these were responsible for their longevity, at the meeting. Mr. Phillips is the Executive Board member of the Tucson SWPCF Chapter. Mr. LaPallo has a book out entitled *Age Less, Live More* and is working on his second book. The gentleman in the center is Mr. Fred Taylor, SWPCF Executive Director. ♦



(Picture is courtesy of Mr. Wardell Holder.)

## Dr. Johnson Received 2010 Health Care Heroes Award

By Linda Madrid

Dr. Crista Johnson, the Medical Director for the Refugee Women's Health Clinic (RWHC) at Maricopa Integrated Health System (MIHS), was chosen from a pool of over 200 nominations to receive the *Phoenix Business Journal's* Health Care Heroes Award under the category of community outreach on August 19, 2010.

Dr. Johnson specializes in obstetrics and gynecology (OB/GYN) and is also an expert on the practice of female genital cutting – a cultural procedure that remains prevalent in some developing countries despite international bans. Her expertise and sensitivity help her and the RWHC reach out to refugee women and girls who have been subjected to the genital cutting procedure in their home countries. Since it opened in October 2008, the RWHC has served more than 500 refugee women, speaking 14 different languages, from over 18 countries. “Dr. Johnson provides culturally sensitive, comprehensive women's health services across the life span of refugees,” said Dr. Dean V. Coonrad, Department Chair and Research Director of the OB/GYN department at MIHS.



Dr. Crista Johnson is in the center.

Dr. Johnson is also an Arizona State University Research

Assistant Professor and plays an integral role at Southwest Interdisciplinary Research Center as Clinical Research Affiliate and Principal Investigator for the Refugee Women's Health Project. ♦

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The curriculum includes a Teacher's Manual, educational videos, worksheets, overhead transparencies and other instructional aides and Spanish-language materials. The program's key learning tool is a series of videos produced by youth, based on actual student experiences from Phoenix South Mountain High School. Distinct Mexican - American and multicultural versions of *Keepin' it REAL* were developed so that students can recognize themselves in the prevention message and see solutions that are sensitive to their unique cultural environments.

The research results show that as a result of the curriculum intervention, there was a 32%-44% reduction of marijuana, tobacco and alcohol use for the participating students, a 30%-38% increase in knowledge about and a negative attitude toward drug use and a 29% -34% decrease in intent to accept substances.

The curriculum has been recognized and used by many schools nationally and even internationally. From 2004 to 2010, a total of 315,675 copies of its student workbook in English and Spanish were distributed and a total of 1,508 copies of its teacher guide were sold. The *Keepin' it REAL* intervention continues to reach many children all over the nation and in some international settings such as Mexico and Spain. It has been adapted by other projects, including “Living in Two Worlds,” which relied on a community-based participatory research approach to find out from the urban American Indian community how best to anchor the curriculum in their cultural values and strengths.

“It's great to know I am able to contribute to a greater cause and give back to the Native communities,” says Crescentia. She is involved with the Social Work American Indian Student Association, and is a member of the Urban Indian Coalition of Arizona. ♦

By Robert C. Bowman, M.D.

To be able to address health disparities, our most important basic health access workforce (registered nurses, physicians, physician assistants and nurse practitioners) must not be penalized for choosing to serve underserved populations. Major physician and nurse practitioner journals agree that the methods used to assess quality are methods that rate those who care for the underserved more poorly. This has much to do with the arbitrary methods used to rate quality. Those caring for the underserved are branded as “guilty” when their only problem was that they chose to care for underserved populations. The methods used to rate quality do not account for the finances of patients, barriers to care such as transportation, housing situations that contribute to poor health, chronic stressors that damage health, difficulties with language or communication or inability to access the specific tests that would rate the provider as higher in quality.

This is not about low quality in many cases. It is about the scheme used to rate quality. It is clear now that new payment systems will make it even more difficult for those facing disparities to get the care that they need. Payment systems are often known as schemes in Australia or the United Kingdom. This is a fitting name for payment systems involving health care in the United States. The schemes that are most questionable are known as “Pay for Performance” or P4P. New studies link P4P to lower pay for those who care for the underserved.

What the P4P people forget is that social determinants of health contribute substantially to health care quality outcomes. This is particularly true for lower-income patients. When patients face the most barriers to care and the greatest degree of barriers to care, their care will be shaped much more by social determinants with less impact of site, practitioner, team, nurse or other factors. This is magnified by the use of various measures that may or may not represent quality across all types of patients. Polishing up the one percentage point better from 7.5 to 6.5 in Hemoglobin A1c may not mean the same to patients with different income levels, family issues, drug costs, culture, language, housing needs or agendas for health care visits. Physician associations have noted the potential damage that can be done by more procedures or tests rather than patient specific care. There are patients who do not receive certain medications for very good reasons involving quality, but the physicians not prescribing such medications are rated down in quality. Where care is most needed, patients often fail to see the same providers or come in for acute-care visits. Quality ratings suffer in these situations that are most common in the most underserved locations and populations. This is a design flaw that cannot be adjusted to allow quality ratings to be fair or to guide funding.

Lower funding remains a problem by design. Lower health funding can already be tracked going to Native American, Medicaid, Medicare, lower income, middle income, Community Health Center, poor, near poor and rural populations. The design results in less funding for health care. Less funding for health care per person makes health care more challenging. Less funding shapes increasing disparities in more than just health care. Less cash flow going to locations that serve the underserved also results in less cash flow in the neighborhood, fewer jobs and economic damage. Businesses avoid locations that lack access to health care.

P4P reimbursement schemes are experiments. Dr. Arnold Epstein of the Harvard School of Public Health agreed with this, noting that P4P “is fundamentally a social experiment likely to have only modest incremental value.”<sup>1</sup>

Many of the various plans involve Medicaid patients. These are patients are not given options to avoid the new experiments. There is not a focus on benefitting the Medicaid or other patients. There is mainly a focus on cost savings. This is particularly damaging to primary care that would require about 60% more funding to be near adequate--not 20-30% less. Widespread adoption of these plans has proceeded without studies that would help minimize poor outcomes and maximize good ones.

Studies note that patient care outcomes are often beyond the control of physicians or the health care system. Ferrer and Carrasco note that “[a]mong the most powerful influences on self-management are the social and environmental constraints on healthy living, yet the clinical response to these environmental determinants is poorly developed. A potential approach for addressing social determinants in practice, as well as planning and evaluating community responses, is the capability framework.”<sup>2</sup>

Questions should be raised about any number of design schemes by government, insurance companies and employers. The most pointed questions must be raised by those attempting to resolve disparities that need fewer barriers to care, not more. ♦

#### References:

1. Epstein AM. *Pay for Performance at the Tipping Point*. *The New England Journal of Medicine*. 2007; 356(3): 515-517.
2. Ferrer RL, Carrasco AV. *Capability and Clinical Success*. *Annals of Family Medicine*. 2010; 8:454-460.  
<http://www.annfammed.org/cgi/content/abstract/8/5/454>

## Editor's Note



Starting this issue, the newsletter will feature the programs at the Arizona Department of Health Services (ADHS). The various programs at ADHS tirelessly try their best to improve the health and safety of all Arizonans. This column's purpose is to provide basic information on each program's functions and highlight its role to reduce health disparities in Arizona.

### Arizona Cancer Control Program

The Arizona Cancer Control Program provides leadership for and coordination of statewide cancer control efforts. It is funded by a grant from the Centers for Disease Control and Prevention as part of the National Comprehensive Cancer Control Program and is currently in year 4 of a 5-year-implementation phase. The program uses a comprehensive cancer control approach or "an integrated and coordinated approach to reducing cancer incidence, morbidity and mortality of cancer through prevention (primary prevention), early detection (secondary prevention), treatment, rehabilitation and palliation" through collaborations between public and private agencies in Arizona. With the guidance of the Arizona Comprehensive Cancer Control Plan, the first Arizona cancer plan, the program's six Arizona Cancer Coalition committees, including a health disparities committee, work collectively on tackling different cancer-related issues and also implementing strategies towards reducing health disparities. Cancer is the second leading cause of death in Arizona. Breast, prostate, lung and bronchus and colorectal cancers are the four most common cancer and account for the most deaths attributed to cancer in the state. When a comparison is made the overall cancer burden among the multitude of racial/ethnic communities in Arizona, non-Hispanic Whites have the highest cancer incidence rate and African Americans have the highest cancer mortality rate.

For more information, please visit <http://www.azcancercontrol.gov/> or contact the program's director, Kendra Sabol, at 602-542-2808 or [Kendra.Sabol@azdhs.gov](mailto:Kendra.Sabol@azdhs.gov). ♦

### Office for Children with Special Health Care Needs (OCSHCN)

For OCSHCN, culture is more than language and interpretation. Culture influences what we take for granted in our everyday lives. Every family has expectations about what life will be like when their baby is born, which must be renegotiated when confronted with a special health care need. We make assumptions about parents' job participation, daycare, healthcare, school, everyday family life, and ultimately transition to adulthood and independence.

Institutions, such as healthcare, education, and work, are all designed with certain assumptions and rules for what is acceptable and how to participate. These assumptions and rules may present barriers to a person with special healthcare needs, who must constantly find ways to negotiate expectations. Sometimes personal adaptations are needed, but often full participation requires institutional change in terms of policies and practices.

OCSHCN offers resources and training on topics that include: breaking the diagnosis, Americans with Disabilities Act (ADA), resiliency in families, cultural beliefs about health, diversity of families, family centered care, medical home, care coordination, inclusion, and transition to adulthood. OCSHCN can be reached at 602-542-1860, 800-232-1676 or by email at

[OCSHCN@azdhs.gov](mailto:OCSHCN@azdhs.gov). Website: <http://www.azdhs.gov/phs/ocshcn/index.htm> ♦

Editor's Note

Starting this issue, the newsletter will highlight research in health disparities. We work closely with the Southwest Interdisciplinary Research Center (SIRC), a national Exploratory Center of Excellence on Health Disparities Research and Training to present the latest research information, including findings and recommendations by the researchers. We hope that the highlighted research information can assist our effort to reduce health disparities in Arizona.



## Ecodevelopmental context for preventing type 2 Diabetes in Latino and other racial/ethnic minority populations

Published by the *Journal of Behavioral Medicine* in 2009, this paper presents an expanded ecodevelopmental model which is intended to serve as a tool to aid in the design of multi-level diabetes prevention interventions for application with Latino and other racial/ethnic minority populations. According to the authors, Drs. Felipe González Castro, Gabriel Q. Shaibi and Edna Boehm-Smith from Arizona State University, racial/ethnic and socioeconomic factors influence the development and course of diabetes at multiple ecodevelopmental levels including genetic, individual, familial, community and socio-cultural. From an ecodevelopmental perspective, cultural variables assessed at one level (e.g., family level dietary practices) may interact with other types of variables examined at other levels and across time (e.g., the availability of healthy foods within a low-income neighborhood), thus prompting the need for a clear analysis of these systemic relationships, as they may increase risks for disease. Therefore, the need exists for models that aid in “mapping out” these relationships and to that aim the authors present two ecodevelopmental models, including a model that presents a multi-level life stages analysis of risk and protective factors as these may influence the incidence of type 2 diabetes. The authors summarize several key approaches for overcoming challenges to diabetes prevention in racial/ethnic populations, with the aim of informing the design of more effective diabetes prevention interventions. The authors indicate that the diversity that exists within each ethnic group must also be recognized and addressed by the use of population segmentation that identifies ethnic-cultural subgroups that can be defined by the intersection of socioeconomic status, level of education or literacy, age group and perhaps by gender, as this segmentation aids in focusing and tailoring the content of the prevention intervention curriculum.

For more information, please contact Principle Investigator, Dr. Felipe González Castro at [Felipe.Castro@asu.edu](mailto:Felipe.Castro@asu.edu). ♦

Data analysis was supported by the National Institutes of Health/National Center on Minority Health and Health Disparities (Grant Number P20MD002316) to: Southwest Interdisciplinary Research Center (SIRC), an Exploratory Center of Excellence on Health Disparities Research and Training.

## Funding Opportunities:

American College of Healthcare Executives: Minority Internship  
**Deadline:** December 01, 2010

**Amount:** The intern will receive a salary of \$18.68 per hour.

This position is not eligible for benefits.

<http://www.ache.org/CARSVCS/internship.cfm>

Let's Move! Initiative: Recipes for Healthy Kids Challenge

**Deadline:** December 30, 2010

**Purpose:** to invite chefs, students, food service professionals, parents and others to work together to develop tasty, nutritious, kid-approved foods.

<http://www.recipesforkidschallenge.com/>

W.K. Kellogg Foundation: Food, Health & Well-Being grant

**Deadline:** ongoing

**Purpose:** to focus on healthy kids has as one of its emphases, to foster stress mitigation and reduction efforts designed to improve mental health and well-being, and create conditions that support mental and physical well-being of marginalized children and families.

<http://www.wkkf.org/what-we-support/healthy-kids.aspx> ♦

## Publications of Interest:

*Advancing Effective Communication, Cultural Competence, and Patient- and Family-Centered Care: A Roadmap for Hospitals*

The Roadmap for Hospitals includes example practices, information on laws and regulations and links to supplemental information, model policies and educational tools.

<http://www.jointcommission.org/PatientSafety/HLC/>

*Health Reform and Communities of Color: How might it Affect Racial and Ethnic Health Disparities?*

This issue brief examines some of the key provisions of health reform legislation that are likely to have a significant impact on people of color and also highlights the specific provisions of the proposed legislation that focus on health disparities.

<http://www.kff.org/healthreform/8016.cfm> ♦

For more information about funding opportunities, publications of interest and events of interest, please visit [www.azminorityhealth.gov](http://www.azminorityhealth.gov). ♦

## Events of Interest:

Lecture Series – The Challenge of Reducing Disparities in America: We May Need a Different Approach

**Speaker:** Leonard Syme, Ph.D., Professor of Epidemiology and Community Health (Emeritus), School of Public Health, University of California, Berkeley

**Date:** November 17, 2010 from noon to 1:00 pm

**Location:** Arizona State University Downtown Phoenix Campus Cronkite Building #122, 555 N. Central Ave., Phoenix, AZ 85004

4<sup>th</sup> Annual 2010 Children's Obesity Conference: It Takes Our Community to Raise a Child

**Date:** December 2, 2010

**Location:** Desert Willow Conference Center, 4340 E. Cotton Center Blvd., Phoenix, AZ 85040

[www.worthyinstitute.com](http://www.worthyinstitute.com)

2011 Annual Conference – Achieving Health of Individuals and Populations within Their Communities

**Dates:** February 24-25, 2011

**Location:** Hyatt Regency Washington on Capitol Hill, Washington DC

[http://www.qualityforum.org/Events/Conferences/](http://www.qualityforum.org/Events/Conferences/Annual_Conference_and_Membership_Meeting.aspx)

[Annual\\_Conference\\_and\\_Membership\\_Meeting.aspx](http://www.qualityforum.org/Events/Conferences/Annual_Conference_and_Membership_Meeting.aspx) ♦

## Editor's Note:

The *AHDConnection* is published quarterly on January 31, April 30, July 31 and October 31. We are looking for community stories and other leads that are related to efforts to reduce health disparities in Arizona. Because of space limitation, each community story should not be more than 500 words. Ideas for community stories are also welcome. Our deadline is the 15th of month prior to the publication date. Please email articles or ideas to the editor at

[hong.chartrand@azdhs.gov](mailto:hong.chartrand@azdhs.gov). ♦

