



## Community Story



Arizona Healthy Athletes

## Healthy Athletes Program Improves Quality of Life for People with Intellectual Disabilities

By Patricia Barney

Did you know that Special Olympics' Healthy Athletes program is the largest health care provider for people with intellectual disabilities in the world? Although "health" and "athletics" tend to be two topics that are believed to go hand and hand—that is not always the case, as Special Olympics leaders became aware of over the years.

"We found out that people with intellectual disabilities have a 40% greater risk for health issues. They lack access to quality health care or health care professionals who are trained in or experienced with caring for people with intellectual disabilities (ID)," says Special Olympics Arizona (SOAZ) CEO Tim Martin. SOAZ then followed the lead of Special Olympics International by launching the Healthy Athletes program in 2008 with an overwhelming positive response from athletes in need. The program began providing health screenings free of charge to athletes competing in Special Olympics competitions.

The program has seven disciplines: Fit Feet (podiatry); Fun Fitness (physical therapy, general fitness); Health Promotion (healthy lifestyle choices); Healthy Hearing (audiology); MedFest (sports physical exam); Opening Eyes (vision); Special Smiles (dentistry and dental hygiene). Kara Stoughton, SOAZ Director of Corporate Relations and The Healthy Athletes Program says, "Preventive measures such as varnish on teeth, eye glasses cut on the spot, and free hearing aids are all a part of the screenings as well!"

Athletes aren't the only ones benefiting from Healthy Athletes. "While participating in Special Smiles, I felt rewarded that I could provide athletes with a positive dental experience, and I look forward to volunteering in years to come," says Krysta Mann, SOAZ Special Smiles Clinician.

Roxanne Johnson is one of Arizona's own 10,600 Special Olympics Athletes who benefits from the healthy athletes program. She says, "It is nice learning what we can do better when they teach us about how to eat better, exercise, how to clean our teeth, and [about] feet problems and eyes. They are so nice to everyone; it is a great experience."

The goal of SOAZ's Healthy Athletes program is to improve the quality and length of life for athletes through healthy physical and mental behaviors.

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# “No One Should Have to Die from Embarrassment”

By Celia Nabor

## Personal Story

At 58 years old, my Mom was the picture of health and doing the things she enjoyed: spending time with family and loving her role as a third-grade teacher. I always considered my Mom to be invincible, I never imagined that she was about to be stricken by a disease that would change our lives forever. I hope that my experience will help to raise attention to something so simple and get others to recognize the importance of asking their loved ones about the health questions that can be embarrassing to talk about.

### Cancer Through My Eyes

Our humbling experience with colon cancer began on June 10, 2010. Life felt somewhat like a tornado in the months that followed. On the day of my Mom’s colonoscopy, the gastroenterologist informed us that he had found tumors and in a few days he would have results of the biopsy. The following days were grueling as we waited. Finally, the call came and he spoke the words I had been dreading “your mom’s results are in and the tumors that I found in her colon were cancerous. I have a few surgeons whom I would like for you to call because she needs to have surgery immediately.”

Three days later my Mom was in surgery for a colon resection (16 inches of colon was removed), and we would learn that she had Stage III colon cancer with significant lymph node involvement, which meant that she would need to endure chemotherapy. While in the hospital, we also met the oncologist who would oversee her chemo treatments. His message was heartbreaking as he told us, “ from this point you should make sure your Mom’s financial matters are in order. Tell all the family what’s going on so they have the chance to see her. We are looking at 1-3 months of life left.” The feeling of going from having a healthy mother to all of a sudden being told I had 1-3 months left with her was completely paralyzing.



Author’s mom, Rosemary Nabor had last day of her treatment.

### 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.

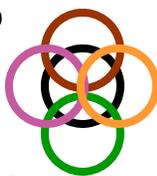
#### Vision:

#### 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:

Arizona Health Disparities Center  
Bureau of Health System Development  
Arizona Department of Health Services  
150 North 18th Ave. Suite 300  
Phoenix, AZ 85007  
602-542-1219  
602-542-2011 fax



<http://www.azminorityhealth.gov>

### Feelings of Guilt

One of the deepest emotions, that I experienced happened a few months after my Mom’s diagnosis, was an intense feeling of guilt. Guilt really grabbed hold of me and shook me to my core, because I came to the realization that I had really dropped the ball in my role as a public health professional, and most importantly, I had dropped the ball in my role as a daughter.

It started when I was packing my things to travel back home to care for my Mom during one of her chemo treatments. I came across the colon cancer awareness pin that I had worn almost two years before when our office participated in the Colon Cancer awareness, Dress in Blue Day. I remember wearing my blue shirt with the pin and the feeling that I was doing something good by raising awareness. Little did I know that the disease would later affect my own mother and our entire family.

As that particular day came to an end, I called my Mom on my way home, just like I do every day. In hindsight I now realize that it wasn’t just any other day. It was the day I failed to take the initiative to ask my own mother about whether she had received a colonoscopy, it was the day I could have helped my Mom in diagnosing her cancer at an earlier stage. *Continued on page 6*

## UA Awarded \$3.2 Million to Train Public Health Workforce in Arizona

Joining 26 other entities at schools of public health and other public or non-profit institutions across the United States, the Mel and Enid Zuckerman College of Public Health at the University of Arizona was awarded a \$3.2 million, five-year grant from the U.S. Department of Health and Human Services to support a Public Health Training Center (PHTC) in Arizona.

The new center will be known as the Arizona Public Health Training Center (AzPHTC) to address workforce training needs with health and education partners throughout the state. The center will provide free or subsidized training to public health workers in state, county and tribal health departments in addition to community-based organizations addressing health concerns. The training center will also focus on individuals and organizations that provide services to populations with poor health outcomes that live in the underserved major metropolitan centers of Phoenix and Tucson, rural areas, along the US-Mexico border and Native American tribes in Arizona. In addition, the training center will provide much needed face-to-face and web-based training for the public health workforce to strengthen its capacity to protect and promote health in the state. This is particularly important for Arizona which has some of the greatest health disparities in the nation and faces unique challenges to ensure the health of our population.

For more information about the center, please contact Jean McClelland at [jmcc@email.arizona.edu](mailto:jmcc@email.arizona.edu). ♦

## UDS Mapper

By Tracy Lenartz

The Uniform Data System (UDS) Mapper is a free mapping and decision-support tool that can assist in evaluating the geographic reach, penetration and growth of the Section 330-funded Health Center Program and its relationship to other federally-linked health resources. Users can map U.S. Census data and see the locations of all federally (Section 330)-funded health center grantees and their access points, locations of other federally-linked providers (Federally Qualified Health Center Look-Alikes, National Health Service Corps Sites, Rural Health Clinics, Tribal Organization Facilities, etc.), and shortage areas such as Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas/Populations (MUA/Ps). UDS Mapper is a Health Resources and Services Administration (HRSA)-funded project directed by the Robert Graham Center, and is available to the public at no cost with a simple registration process. For more information about UDS Mapper or to register, visit <http://www.udsmapper.org/about.cfm>.

The Robert Graham Center offers free web-based trainings on the UDS Mapper. Please watch for future Arizona-specific UDS Mapper trainings offered by Arizona Department of Health Services. ♦

## Public Health Hero through the Lens

By RJ Shannon

This year, the Arizona Department of Health Services (ADHS) can boast that one of its own has been recognized for bringing public focus to some of Arizona's most important health issues through the lens of an ADHS visionary. Dallas Teat (third person in the picture from left), ADHS Video Production Supervisor, received both the Unsung Hero Award by the Arizona African American Legislative Committee-Health Pillar and an Outstanding Achievement Award by the ADHS Black History Committee within a short period of this year. In his 15 years of state services, Dallas has received numerous rewards due to his work ethics and qualities and his passion for community services. He donates time, talent and resources to help support community and cultural events by videotaping ADHS cultural events as well as other events. As soon as he's aware of a conversation, campaign or other significant Arizona event, Dallas' first response is, "Do you want me to film?" ♦



### *Familias Sanas: An Intervention Designed to Increase Rates of Postpartum Visits among Latinas*

*Familias Sanas* (Healthy Families) is an educational intervention designed to reduce health disadvantages of low-income, immigrant Latina mothers by empowering them to take an active part in the management of their health and by encouraging them to advocate for themselves. Published by the *Journal of Health Care for the Poor and Underserved*, the article studied the *Familias Sanas* intervention at a prenatal clinic located at a major urban hospital in the southwestern region of the U.S. The authors, Flavio F. Marsiglia, PhD, Monica Bermudez-Parsai, PhD and Dean Coonrod, MD, MPH, evaluated the efficacy of the intervention through a randomized control trial measuring the participants' rate of postpartum visits and other relevant well-being measures. Their findings show that the intervention had significant desired effects, with participants in the experimental group returning for their postpartum clinic visit at a higher rate in comparison with the control group. Based on the results and literature review, the authors recommended first that educational materials be available to improve the health literacy of mothers who do not speak English as their first language. This first step could improve knowledge about interconception care and the importance of healthcare for women and their children. Policies that create new opportunities to finance interconception care should be identified and considered a high priority. Second, due to the lack of bilingual/bicultural medical personnel in many communities, having a psychosocial intervention at clinics can greatly benefit access and compliance with care. Third, although insurance eligibility alone does not guarantee compliance, this is an important area in need of reform.

One simple change that may have an impact on women reaching out for medical services between pregnancies would be to extend the number of months of insurance coverage from six months to a year after birth of the baby. Increasing access to healthcare services and/or increasing insurance coverage for preventive care will also improve the health of this population. ♦

This study was supported by the Hispanic Health Services Grant Program/ Centers for Medicare and Medicaid Services, award 1H0CMS03207. It was hosted by the Southwest Interdisciplinary Research Center (SIRC), an exploratory center of excellence on minority health and health disparities research funded by award P20MD002316-03 of the National Institute on Minority Health and Health Disparities (NIMHD) of the National Institutes of Health (NIH). The Tuskegee University National Center for Bioethics in Research and Health Care (TUNCBRHC) provided feedback on the biomedical content for this article.

## News from the Network

A number of successes have resulted from the Living Well with Disabilities (LWWD) Coalition in the couple of years since it formed. For example, the Community Development Process organized the foundation for a consumer-controlled, community-based, cross-disability coalition in which the majority of active members are persons with disabilities – something new to the Phoenix area. During 2009 and 2010, Life Skills trainers completed two days of training for peer facilitators and delivered several series of the 20-hour *Living Well* curriculum. They also provided a 250 plus page user manual, available in alternate formats to each participant and launched the Living Well Booster club. What's more, peer Leadership recruited and trained Living Well Graduates to assist as co-facilitators, coalition members and active disability advocates for health promotion and systems change.

The LWWD Coalition was formed in 2008. The coalition aims to build the capacity of Maricopa County communities to prevent substance abuse among adults, both civilian and veteran, with physical disabilities. The LWWD Coalition targets three distinct populations: (1) civilian and veteran adults with physical disabilities; (2) caregivers, gatekeepers, and veteran-serving organizations for the first population; and (3) healthcare practitioners who may be prescribing and/or dispensing specific medications for the first population.

The project leaders in the LWWD Coalition are inspired by the evidence-based curriculum *Living Well with a Disability* that

## Living Well with Disability

By April Miles

was developed by the Rural Institute on Disabilities at the University of Montana and by Kansas University's Research and Training Center on Independent Living. This 20-hour/10-week Living Well program is presented by peer facilitators and has been effective in reducing secondary conditions, the contributing factors for substance abuse, and in reducing utilization of costly health care services. The curriculum has also been shown effective in reducing both personal and environmental conditions that limit activities of daily living for adults with physical disability and chronic health problems. There have been a number of people who have completed *Living Well* who have reported fewer problems with their secondary conditions and reduced use of costly medical services.

The success can be attributed to coalition membership consisting of Valley of the Sun YMCA, Arizona Bridge to Independent Living, AZ Chapter Paralyzed Veterans of America, Asian Pacific Community in Action, the AZ Chapter Spinal Cord Injury Association, Area Agency on Aging Region I, Peer Solutions, Stand and Serve, the National Alliance on Mental Illness – AZ, Mayor's Council on Disability Issues, Living Well Graduates and other individuals living with disabilities.

The coalition continues to work in collaboration with its members and expects continuing success in future endeavors. If you would like more information about the Living Well with Disabilities Coalition, please contact Raquel Lewis at [rlewis@vosymca.org](mailto:rlewis@vosymca.org) or Leonard Smith at [leonards@abil.org](mailto:leonards@abil.org). ♦

# Basic Health Access Workforce Disparity by Design

By Robert C. Bowman, M.D.

## Physician's Perspective

The nation's Community Health Centers (CHCs) are at the front lines of basic health access, delivering care to those in most need of care. But who actually delivers the care? How is the United States doing with regard to the workforce needed? Which health professionals are more likely to seek CHCs, and which health professionals are sought by CHCs?

A national study by Rosenblatt in the *Journal of the American Medical Association* captured health professional workforce data from 86% of the nation's CHCs. According to the author, the CHCs had 6,561 FTE (Full-time equivalent) physicians practicing (78% urban and 22% rural). Of all physician FTEs, 47% were family physicians (FPs), 19% general pediatricians, 22% general internists, 8% obstetrician/gynecologists, 3% psychiatrists and only 1% other types of specialists. By way of comparison, there were 3,429 registered nurse (RN), 2,103 nurse practitioner (NP), 1,095 physician assistant (PA), 1,125 dentist and 439 pharmacist FTEs.

Those found in CHCs can be compared to the national workforce levels listed in government reports and health professional association surveys for the same period of 2004 and 2005. For example, less than 1% of RNs, masters and doctoral nurses, advanced practice nurses, psychiatrists, physicians and internists by training were found in CHCs. Specific workforce is a better CHC solution, with 2.5% to 3% in CHC practice.

Family practice is a career choice that multiplies primary care, rural and underserved contributions in NP, PA, MD and DO. The 4% level or above is for family physicians who remain in office based primary care or nurse practitioners listed in family practice position employment in annual surveys. Over 5% of the physician assistants in family practice are found in CHCs. Only 20% of PA graduates now enter family practice and this 6-times boost in CHC location is being lost (AAPA). The PA must enter training, choose family practice at graduation and choose to remain in family practice year after year to be most effective in front line health access. Nearly every other career pays better and has better support--and is increasing in the numbers and proportions of the PA workforce.

### So Why Not Increase Family Practice?

Tragically the United States does not have a direct route

to family practice in any source – RN, NP, PA, DO or MD. There are only indirect routes involving multiple decisions. With each of 2 or 3 or more decisions required, US health policy shapes decision away from what most Americans need.

Family medicine residency graduates have not increased in 30 years from the 3000 per year set in place by the 1970s design. There has been zero growth or no expansion in this important source of CHC, elderly, rural, lower income, middle income, poor, near poor and disadvantaged workforce (Ferrer). To have more family physicians requires that more decide upon this permanent primary care source during medical school training. Few are influenced by medical education or by health policy to trust this permanent choice associated with lowest health spending (primary care) and lowest health spending going to the locations where family physicians are more likely to be found.

Similarly, the designs of health spending send family nurse practitioners, physician assistants, and even those beginning careers in family practice on a path away from family practice and primary care and where need exists. Increasing health care demands inside of concentrations for subspecialty positions, hospital positions, and teaching hospital positions (tens of thousands more positions added) have captured more non-physician clinicians. The non-physician clinician workforce has become 65% not in primary care – by design. Less than one-third of all 28,000 annual primary care graduates from six sources will be found as primary care workforce in the decades after graduation – by design.

### In Summary

The United States does not have a design that supports a primary care, family practice or most needed workforce. Nurses, physicians, physician assistants, primary care trained nurses and primary care trained physicians have many other options, other than what the nation needs – by design.

Family practice training for RNs, NPs, PAs, MDs and DOs would work, but only if the selection is family practice and the training is family practice and the graduates remain permanently in family practice. Actually, any source that begins and ends careers in primary care is needed. The problem is that the United States fails in this area – by design. ♦

## Snapshot of Motor Vehicle Traumas in Native Americans in Arizona\*

By Anne Vossbrink

Persons involved in motor vehicle collisions in Arizona requiring transport to a trauma center frequently sustain major injury.

Arizona's overall rates for persons involved in motor vehicle collisions resulting in transport to a trauma center were down in 2008 from 2009. However when motor vehicle collision injury rates for years 2008 and 2009 were examined by

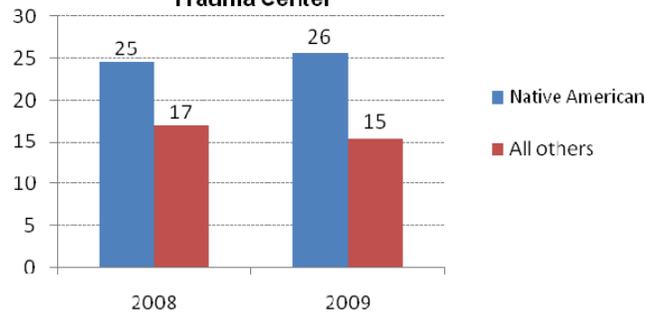
race, rates for Native Americans involved in motor vehicle collisions resulting in transport to a trauma center were higher than for all other races combined. In 2008, Native Americans had a rate of 25 per 10,000 persons involved in motor vehicle collisions resulting in transport to a trauma center, versus 17 per 10,000 for all other races combined. During 2009, Native Americans had a rate of 26 per 10,000 persons involved in motor vehicle collisions resulting in transport to a trauma center, versus 15 per 10,000 persons of all other races combined in Arizona.

The use of protective devices or restraints by occupants during motor vehicle collisions may prevent injuries or reduce the severity of injuries. When examining the percent of occupants who did not use protective devices or restraints, Native Americans were less likely to use protective devices or

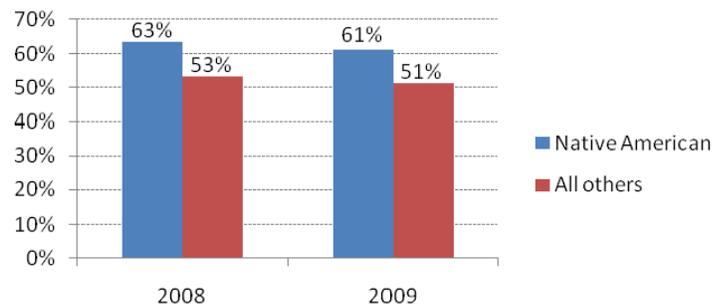
restraints during a motor vehicle collision resulting in transport to a Trauma Center than all other races combined. In 2008,

63% of Native Americans involved in a motor vehicle collision resulting in transport to a trauma center did not use protective devices or restraints; in contrast 53% of all other races combined did not use protective devices or restraints. Observations in 2009 were consistent with 2008. Sixty one percent of Native Americans involved in a motor vehicle collision resulting in transport to a trauma center not using protective devices or restraints, compared to 51% of all other races combined. ♦

**Rates per 10,000 Persons Involved in Motor Vehicle Collisions Resulting in Transport to a Trauma Center**



**Percent of Occupants not using Protective Devices during Motor Vehicle Collisions Resulting in Transport to a Trauma Center**



\*Data retrieved from the Arizona State Trauma Registry (ASTR) for years 2008-2009, containing information on patients who met ASTR criteria for inclusion and transported to a designated trauma center, or healthcare institution voluntarily submitting data to the ASTR. Not all Arizona acute care hospitals submit data to the ASTR; therefore, the presented population based rates may be greater than calculated.

### “No One Should Have to Die from Embarrassment” continued from page 2

#### Growing From the Experience

In January my Mom had her last chemotherapy treatment, we are all positive about what the future holds. Just as I expected, my Mom has proven many of the early prognoses wrong, as she continues to get stronger every day. Although I wish my Mom had never been diagnosed with cancer, I have come to terms with recognizing the many things that I wouldn't have experienced or learned had my Mom not been diagnosed.

I'm truly thankful for each moment that I have with my Mom and feel that it is important to share our story. I encourage others to be advocates for their loved ones, ask the important questions about getting screenings done and be a support system when it comes to their health because no one should have to die from embarrassment. ♦

## Bureau of Public Health Emergency Preparedness

By Antonio Hernandez

Potential disasters and naturally occurring disease outbreaks have raised concern about the nation's public health and healthcare systems' capacity to respond to emergency events. The federal government has provided assistance to states in order to help prepare for public health emergencies and strengthen resiliency among public health systems. The Arizona Department of Health Services (ADHS) Bureau of Public Health Emergency Preparedness (BPHEP) was established in 2004 and is underwritten by the Centers for Disease Control and Prevention (CDC) and the U.S. Assistant Secretary for Preparedness and Response Hospital Preparedness Program (HPP). The Bureau partners with internal, governmental and community partners (e.g. county health departments, tribal nations, hospitals and clinics, emergency management, homeland security and medical associations) to satisfy CDC and HPP grant directives and preparedness requirements. The purpose is to strengthen public health resiliency and protect the wellbeing of Arizonans during a major health emergency.

The bureau staff facilitates statewide and community-based planning to assist hospitals and public health entities in enhancing response capacities as well as developing systems for training health care professionals. These plans are practiced and tested throughout the year. In addition to the primary function of grants management, the Bureau maintains an Education and Exercise Section, a Logistics Section and a Planning Section. These Sections within the Bureau provide program guidance and technical assistance for ADHS and program partners. During a public health emergency, the Bureau supports the state emergency operations center in the Health Medical Branch and provides statewide multiagency coordination support within the ADHS's Health Emergency Operations Center.

For more information on BPHEP or to review and provide feedback on public health emergency response plans visit [www.azdhs.gov/phs/edc/edrp](http://www.azdhs.gov/phs/edc/edrp). If you are a health care or public health professional interested being called upon to volunteer during a major disaster event, register today at [www.azdhs.gov/volunteer](http://www.azdhs.gov/volunteer). ♦

## Arizona Coordinated School Health Program

By Hope Wilson

Coordinated School Health (CSH) is a framework, proposed by the Centers for Disease Control and Prevention (CDC), that centers around eight interrelated components for planning and coordinating school health activities: health education, physical education, health services, mental health and social services, nutrition services, a healthy and safe environment, family and community involvement and staff wellness. When all of the individual components function together to support the adoption of health-enhancing behaviors, student health and learning improve.

Arizona is one of twenty-two states with a grant from the CDC to implement CSH. The Arizona Departments of Education and Health Services work together to implement this five-year grant to improve CSH infrastructure and capacity in the state, increase professional development opportunities and address health disparities among youth.

In addition to regularly bringing together CSH stakeholders, the team has revised Arizona's Health Education and Physical Education Standards and developed a comprehensive Arizona Coordinated School Health website, [www.healthologyaz.com](http://www.healthologyaz.com), that acts as a one-stop shop for school health resources. Each year, the team organizes the Annual CSH Conference to provide professional development opportunities to educators, administrators, school staff, community members and health professionals across the state.

For more information, please contact [hope.wilson@azdhs.gov](mailto:hope.wilson@azdhs.gov). ♦

## Healthy Athletes Program

continued from page 1

Stoughton says, "Healthy Athletes promotes the overall health and awareness of people with ID who frequently have medical conditions such as heart disease, obesity and diabetes...[T]he program has been monumental in altering athletes' health."

On April 29<sup>th</sup>, more than 1,300 athletes gathered at SOAZ's 36<sup>th</sup> Annual Summer Games at Mesa Community College and competed in seven sports: Athletics, Power lifting, Artistic and Rhythmic Gymnastics, Tennis, Volleyball and Kayaking. In addition to the thrill of the competition, Summer Games attendees enjoyed Healthy Athletes screenings, vendor row, Special Olympics Merchandise and the Olympic Village.

For more information on how you can help, please contact at Kara Stoughton at 602.476.0840 or [kara@specialolympicsarizona.org](mailto:kara@specialolympicsarizona.org). ♦

## Publications of Interest:

### *Measuring the Gaps: Collecting Data to Drive Improvements in Health Care Disparities*

This paper highlights the importance of health care provider involvement in collecting data on racial and ethnic health care disparities. It also recommends collecting larger data sets based on race and ethnicity, which can be used to design targeted programs to provide patient-centered care. <http://www.americanprogress.org/issues/2010/12/pdf/measuringgaps.pdf>

### *DHHS Announces Plan to Reduce Health Disparities*

On April 8, 2011, U.S. Department of Health and Human Services (DHHS) launched two strategic plans aimed at reducing health disparities. The *DHHS Action Plan to Reduce Health Disparities* outlines goals and actions DHHS will take to reduce health disparities among racial and ethnic minorities. DHHS also released the *National Stakeholder Strategy for Achieving Health Equity*, a common set of goals and objectives for public and private sector initiatives and partnerships to help racial and ethnic minorities and other underserved groups reach their full health potential. The strategy, a product of the National Partnership for Action (NPA), incorporates ideas, suggestions and comments from thousands of individuals and organizations across the country. <http://www.hhs.gov/news/press/2011pres/04/04hdplan04082011.html> ♦

## Events of Interest:

### Mental Health America's 2011 Annual Conference

Dates: June 9 – 11, 2011

Location: Hyatt Regency on Capitol Hill, Washington, DC  
<http://www.mentalhealthamerica.net/go/conference/>

### 8<sup>th</sup> Annual Disparities in Health in America In A Global Context Workshop

Dates: June 20 – 25, 2011

Location: R. Lee Clark Clinic Building, Robert C. Hickey Auditorium, 11th Floor, 11.400, University of Texas M.D. Anderson Cancer Center, Houston, TX

Contact: Cynthia Clark at [cyclark@mdanderson.org](mailto:cyclark@mdanderson.org)

### 2<sup>nd</sup> Cross Cultural Health Care Conference: Collaborative and Multidisciplinary Interventions

Dates: October 7-8, 2011

Location: Hyatt Regency Waikiki Resort and Spa, 2424 Kalakaua Ave., Honolulu, HI 96815

[www.cchc-conference.com](http://www.cchc-conference.com) ♦

## Funding Opportunities:

### Mitsubishi Electric America Foundation: National Grant Program to Support Young People With Disabilities

Deadline: Jun 1, 2011

Eligibility: nonprofit organizations

<http://www.meaf.org/how-to-apply.php>

### National Institutes of Health: Development and Translation of Medical Technologies to Reduce Health Disparities (R43/R44)

Deadline: January 07, 2012

Funding Opportunity Number: RFA-EB-11-001

Eligible Applicants: Small businesses

<http://www07.grants.gov/search/search.do?&mode=VIEW&oppld=78294> ♦

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

## Editor's Note:

The *AHDCConnection* 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). ♦

