



NIH CONFERENCE ON UNDERSTANDING AND REDUCING HEALTH DISPARITIES

CONTRIBUTIONS FROM THE
BEHAVIORAL AND SOCIAL SCIENCES

OCTOBER 23-24, 2006

NATCHER CONFERENCE CENTER
NIH CAMPUS
BETHESDA, MARYLAND



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October 23-24, 2006

Natcher Conference Center
NIH Campus
Bethesda, Maryland





ACKNOWLEDGMENT

The NIH Conference on Understanding and Reducing Disparities in Health: Contributions from the Behavioral and Social Sciences is supported primarily by the NIH Office of Behavioral and Social Sciences Research and in part by the NIH Office of Disease Prevention. The reception is sponsored by Kellogg Scholars and Fellows Programs.

FOREWORD

Welcome to the **NIH Conference On Understanding and Reducing Health Disparities: Contributions from the Behavioral and Social Sciences**. Along with our colleagues on the Conference Planning Committee, we are looking forward to two-days of presentations and conversations on some of the vital issues of disparities in the health of the American people.

We will not devote much time, if any to describing already well-documented disparities. Instead the conference focuses on three broad areas of action influencing health disparities: policy, prevention, and health care. It emphasizes both basic research on the behavioral, social, and biomedical pathways giving rise to disparities in health and applied research on the development, testing, and delivery of interventions to reduce disparities in these three action areas. The conference employs a multi-level analytic framework (i.e., ranging from individuals to societies) as well as a biopsychosocial approach. It includes research relevant to a wide range of population groups (e.g., variation by SES, race, ethnicity, gender) residing in the United States, while not attempting to provide detailed analyses of each and every group. Consideration is given to multiple public health issues and their interactions (e.g., multiple morbidities rather than single illnesses) and to risk factors or causal processes common to various health conditions (e.g., smoking, diet, exercise, access to health care).

For the purposes of this conference, we are defining these action areas as:

Policy: The means employed by governments and other institutions to influence the function and well-being of individuals, groups, communities, and society as a whole.

Prevention: Interventions at the individual, group or community level to provide targeted audiences the knowledge and skills to avert or minimize health risks.

Health Care: The timely delivery of care and/or medical services by general or specialty providers to persons in need for the purpose of diagnosis, assessment, or treatment in order to improve or protect health status.

The goals of the conference are threefold:

1. To highlight and demonstrate the actual and potential contributions of behavioral and social sciences research to NIH's mission of reducing disparities in health through improving knowledge about the processes underlying the origin and maintenance of health disparities, and through improved interventions based on this knowledge.
2. To identify areas requiring increased conceptual, empirical, and methodological development (i.e., a trans-NIH research agenda in behavioral and social science research on health disparities).

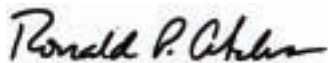
3. To recruit additional researchers to investigating health disparities and to developing and implementing behavioral and social interventions to reduce disparities in health.

The initial idea to convene this conference grew out of discussions at the bimonthly meetings of the NIH Behavioral and Social Sciences Research Coordinating Committee. The members of the Coordinating Committee identified volunteers from their respective Institutes and Centers to serve on the planning group. Over the course of almost two years, the planning group considered various alternative themes and schemes before arriving at the current configuration. The NIH Office of Behavioral and Social Sciences Research is the primary source of financial support for the conference, and the NIH Office of Disease Prevention has also contributed financially. We are particularly grateful to the Kellogg Scholars and Fellows Programs for financing the reception in conjunction with the research poster exhibition on October 23rd.

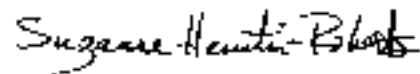
Again, welcome and thank you for your participation and assistance in addressing our goals for the conference, the NIH research agenda, and the health of the American people!

Sincerely yours,

Co-Chairs, Conference Planning Committee



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Office of Behavioral and Social Sciences Research
Office of the Director, NIH



Suzanne Heurtin-Roberts, Ph.D., M.S.W.
National Cancer Institute, NIH

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David B. Abrams	Hilary W. Hoynes	Bernice A. Pescosolido
Nancy E. Adler	James S. Jackson	Ken Resnicow
Margarita Alegria	Meyer Kattan	Marguerite Ro
Gay Becker	Raynard Kington	John Ruffin
Llewellyn J. Cornelius	Nancy Krieger	Rochelle N. Shain
Janet Currie	Marsha Lillie-Blanton	Julie Solomon
Morris W. Foster	Nicole Lurie	David Takeuchi
Lee Hargraves	Philip A. May	Howard Waitzkin
Suzanne Heurtin-Roberts	Peter Messeri	David R. Williams

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- | | | | |
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| 5. | Gloria J. O. Carpenter | 33. | Vincent Mor |
| 6. | Theresa Chapple | 34. | Joy P. Nanda |
| 7. | Charlton Coles | 35. | Deborah E. Polk |
| 8. | Vicki Collie-Akers | 36. | David Quissell |
| 9. | SH Crixell | 37. | R. Salazar R. Salazar |
| 10. | Gustavo D. Cruz | 38. | David G. Schlundt |
| 11. | Christine Dehlendorf | 39. | Geoff Severtson |
| 12. | Cheryl R. Dennison | 40. | Salma Shariff-Marco |
| 13. | D. Phuong Do | 41. | Nah-Mee Shin |
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| 20. | Hector M. González | 48. | Donna Vallonea |
| 21. | Kathleen A. Griffith | 49. | Glen D. Vinson, Jr. |
| 22. | Lauren Hale | 50. | Katrina M. Walsemann |
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| 27. | R.V. Katz | 55. | Frances M. Yang |
| 28. | Patricia J. Kelly | | |



AGENDA

AGENDA

DAY 1, OCTOBER 23, 2006

8:00 AM

Registration and Continental Breakfast

Opening Session

9:00 AM

Welcome and Setting the Stage

Ronald P. Abeles, PhD

Organizing Committee Chairs

Office of Behavioral and Social Sciences Research, NIH

Suzanne Heurtin-Roberts, PhD, MSW

National Cancer Institute, NIH

9:20 AM

Remarks from NIH Leadership

Raynard Kington, MD, PhD

Deputy Director, NIH

John Ruffin, PhD

Director

National Center on Minority Health and Health Disparities, NIH

9:40 AM

The Role of the Office of Behavioral and Social Sciences Research (OBSSR) at NIH

David B. Abrams, PhD

Director

Office of Behavioral and Social Sciences Research, NIH

10:00 AM

The Elephants in the Room: Social Justice, Social Science, and Health Inequities

Nancy Krieger, PhD

Harvard University

10:45 AM

Discussion

11:00 AM

Refreshment Break

11:30 AM

Health Disparities: Monitoring, Mechanism, and Meaning

Nancy Adler, PhD

University of California, San Francisco

12:15 AM

Discussion

12:30 PM

Lunch (on your own)

Public Policy and Health

The goal of these presentations is to demonstrate the actual and potential contributions of behavioral and social sciences (BSS) research to informing policy so as to reduce or eliminate health disparities. For the purposes of this session, we define policy as measures employed by governments and other institutions to influence the function and well-being of individuals, groups, communities, and society as a whole. This goal requires presentations to:

Present BSS research that examines the relationship between policy variation or change and health disparities or the health of low SES groups; and

Demonstrate the pathways through which policy does or could influence health disparities, including those at higher levels (e.g. community safety, housing standards) and those at individual and biological levels of analysis (e.g., individual and family resources, stress).

Panel 1: Social and Economic Policies Impacting Health

Moderator: **Marguerite Ro, DrPH** (APIAHF)

This panel focuses on social and economic policies that influence pathways leading to health disparities. It reflects on the broad range of non-health-directed policies that may have implications for health disparities; reviews the basic science related to the pathways involved, and highlights specific research that examines specific policies or sets of policies.

1:30 PM

Behavioral and Social Science Evidence for Reducing Health Disparities Through Policy

David R. Williams, PhD, MPH

Harvard School of Public Health

2:00 PM

Effects of Employment Policies on Health and Health Disparities

Jody Heymann, PhD, MD

McGill Institute for Health and Social Policy

2:20 PM

Welfare Reform and Health: Do Welfare and Other Income Transfer Policies Affect Health Disparities?

Hilary W. Hoynes, PhD

University of California, Davis

2:40 PM

Discussion

3:00 PM

Refreshment Break

Panel 2: Health Policy and Health Disparities

Moderator: **Marguerite Ro, DrPH** (APIAHF)

This panel begins with two talks addressing programs and policy areas that specifically focus on improving health outcomes and concludes with a summary overview of the health implications of policies, including those directly and indirectly related to health.

- 3:30 PM **Effects of the Women, Infants and Children (WIC)
Program on Health Disparities**
Janet Currie, PhD
Columbia University
- 3:50 PM **The Role of Insurance Coverage in Reducing Health Disparities:
Policy Challenges and Opportunities**
Marsha Lillie-Blanton, DrPH
Henry J. Kaiser Family Foundation
- 4:10 PM **Can Public Policies Affect Health and Health Disparities?**
Nicole Lurie, MD, MSPH
RAND Corporation, Washington, DC
- 4:40 PM **Discussion**
- 5:00 PM **Poster Session & Reception**
- 7:00 PM **Adjournment of First Day**

DAY 2, OCTOBER 24, 2006

8:00 AM **Registration and Continental Breakfast**

Prevention of Disease and Disability

For the purposes of this conference, we may define prevention research as studies of interventions at the individual, group or community level to provide targeted audiences the knowledge and skills to avert or minimize health risks. Consequently, the emphasis is on “translational” research in the pragmatic sense of taking basic social science findings about how humans behave individually and in groups and putting them to work in communities. Each speaker will address the tensions between targeted interventions and universal ones, and between generic approaches to “health” and focused programs on a particular problem. Then a final speaker will address the challenges to program fidelity inherent in scaling up for public health use.

Panel 1:

Moderator: **David Takeuchi, PhD** (University of Washington)

- 8:30 AM **Fetal Alcohol Syndrome among American Indians, Italians, and South Africans: Disparate Risks, Different Prevalence, and Prevention**
Philip A. May, PhD
The University of New Mexico
- 8:55 AM **Prevention of Sexually Transmitted Infections in Inner-City Mexican- and African-American Women**
Rochelle Shain, PhD
University of Texas Health Science Center
- 9:20 AM **Asthma in Inner City Populations**
Meyer Kattan, MD, CM
Mount Sinai School of Medicine, New York City
- 9:45 AM **Discussion**
- 10:00 AM **Refreshment Break**

Panel 2:

Moderator: **David Takeuchi, PhD** (University of Washington)

- 10:30 AM **Church-Based Health Promotion Programs**
Ken Resnicow, PhD
University of Michigan
- 10:55 AM **Cancer Prevention in Latino Populations**
Eliseo J. Pérez-Stable, MD
University of California, San Francisco
- 11:20 AM **Fidelity and Adaptation Challenges in Replication and Going to Scale**
Julie Solomon, PhD
Sociometrics Corporation, Los Altos, CA
- 11:45 AM **Discussion**
- 12:00 PM **Lunch (on your own)**

Health Care

The health care session includes presentations that will demonstrate the actual and potential contributions of behavioral and social sciences research to inform and improve how people access health care and the form, delivery, and organization of those services in order to reduce health disparities. For the purposes of this conference, “health care” encompasses the timely delivery of quality care and/or medical services by general or specialty providers to persons in need for the purpose of diagnosis, assessment, or treatment in order to improve or protect health status. This includes conventional as well as alternative and complementary health services.

Panel 1: Cultural Influences

Moderator: **Peter Messeri, PhD** (Columbia University)

- | | |
|---------|--|
| 1:00 PM | Introduction by the Moderator |
| 1:05 PM | Ethnographic and Qualitative Approaches to the Role of Culture in Disparities Research
Gay Becker, PhD
University of California, San Francisco |
| 1:30PM | Cultural Influences as the Structure and Content of Social Networks, Large and Small
Bernice A. Pescosolido, PhD
Indiana University |
| 1:50 PM | Health Disparities Due to the Emergence of Genetic Medicine: Perspectives from Native American and African American Communities
Morris W. Foster, PhD
University of Oklahoma |
| 2:10 PM | Discussion |
| 2:30 PM | Refreshment Break |

Panel 2: Social Structural and Economic Influences

Moderator: **Lee Hargraves, PhD** (University of Massachusetts, Medical Center)

- | | |
|---------|--------------------------------------|
| 3:00 PM | Introduction by the Moderator |
|---------|--------------------------------------|

- 3:05 PM **Social Structural and Economic Influences on Health Care Disparities: 1 1/2 Centuries of Forgetting and Remembering**
Howard Waitzkin, PhD, MD
University of New Mexico
- 3:30 PM **Socio-cultural Frameworks for Understanding Disparities in Mental Health Service Provision**
Margarita Alegria, PhD
Harvard Medical School and Cambridge Health Alliance
- 3:50 PM **Impact of Provider Continuity on Outcomes, Intersection of Ethnicity and Underserved Populations**
Llewellyn J. Cornelius, PhD, LCSW
University of Maryland
- 4:10 PM **Discussion**
- Closing Session**
- 4:30 PM **Capstone Presentation**
James S. Jackson, PhD
University of Michigan
- 5:00 PM **Conference adjournment**



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* Moderator



SPEAKER ABSTRACTS

THE ROLE OF THE OFFICE OF BEHAVIORAL AND SOCIAL SCIENCES (OBSSR) AT NIH

DAVID B. ABRAMS

This overview briefly outlines the Office of Behavioral and Social Sciences' strategic prospectus for NIH. The pressing demands to address historical, emerging and re-emerging public health challenges requires strengthening partnerships that integrate biomedical, behavioral and social-ecological conceptual models in a transformative manner. Elements include strengthening: Transdisciplinary (TD) science from cells to society across the lifespan; next generation basic science; and several domains of applied research that embrace systems thinking and modeling, capitalize on informatics/communications tools, and expand the science-base of effective and efficient dissemination/implementation/policy. A central challenge remains for NIH-supported research to find new, transforming, ways to understanding the mechanisms and to helping eliminate health disparities (Abrams, 2006).

Abrams, DB. 2006. Applying Transdisciplinary Research Strategies to Understanding and Eliminating Health Disparities. *Health Education & Behavior*, Vol. 33(4):1-17.

THE ELEPHANTS IN THE ROOM: SOCIAL JUSTICE, SOCIAL SCIENCE, AND HEALTH INEQUITIES

NANCY KRIEGER

Rigorous scientific research on understanding and reducing health disparities is essential, as is federal support for this work. The problems of unjust suffering that we confront are huge, both within the United States and globally. To rectify these wrongs, we need a clear understanding of their causes. This requires, among other things, bringing together the best of the biological and clinical sciences with the best of the social and behavioral sciences. The research we need to do necessarily draws on insights from many disciplines and must be concerned with multiple levels of determinants and outcomes and their embodiment across the lifecourse, in different historical generations and different geographic locales. While the specifics of how we approach these issues may vary by research topic, we nevertheless all confront the same three fundamental questions. These are: (1) what are health disparities?; (2) what are their causes?; and (3) who is responsible for health inequities? In my presentation, I will contend that while there may be many partial correct answers to these questions, not all answers are equal and some are outright wrong. To make this case, I will first offer a brief historical reminder that we are not the first to debate these issues. Second, I will argue for why we need an analytic, rather than descriptive, definition of health disparities. Third, I will present several case examples, including some of our new work on current and changing inequities in US premature mortality, to clarify why the science of health disparities is about correct science, not “politically correct” science. And throughout, I will draw attention to some salient elephants, including several in the room whom we need to name if our work is to make a dent in eliminating health inequities.

HEALTH DISPARITIES: MONITORING, MECHANISM AND MEANING

NANCY E. ADLER

Eliminating health disparities requires: (1) an adequate scientific foundation for developing and evaluating interventions and policies, (2) widespread adoption of these interventions and policies, and (3) ongoing monitoring to assess trends in health as a result of these and other societal changes. The NIH has played a crucial role in supporting research that establishes the scientific base and sets the stage for policy and practice. The results can be seen in the marked increase in research addressing health disparities. This talk will review this research which can be divided roughly into four generations. Each generation continues the work of the former era, but has added new considerations..

The first generation of research documented health effects associated with poverty and with race and ethnicity.

The second generation, inspired by the Whitehall Studies, was the era of the gradient, documenting graded associations between socioeconomic status and health. While maintaining concern about the substantial risk of those in poverty, new research documented that socioeconomic factors continued to exert an influence at all levels of the hierarchy, up to the top.

The third generation, was the era of mechanism. While still documenting both effects of poverty and race/ethnicity and establishing the gradient in different populations and for different diseases and conditions, new research identified mechanisms and pathways by which the gradients develop.

Current research represents a fourth generation. While still addressing the questions of the first three eras, new research is further refining the meaning and measurement of socioeconomic status and race/ethnicity. This work recognizes that our categorizations are rather crude and may vary in their meaning in different groups (e.g. high school graduation confers different benefits depending on the quality of the school from which one graduated; college graduation may confer different advantages to members of different racial/ethnic groups). This research is attempting to develop more refined measures which will allow us to answer earlier questions more effectively and provide more sensitive measures for monitoring.

In this talk, I will provide an overview of the four generations and conjecture about what the next generation may bring.

**BEHAVIORAL AND SOCIAL SCIENCE EVIDENCE FOR REDUCING HEALTH
DISPARITIES THROUGH POLICY**

DAVID R. WILLIAMS

The presentation will provide an overview of findings from behavioral science research that have implications for developing effective public policies to reduce disparities in health. It links specific research findings on the determinants of health to key pathways that policy makers need to address in order to reduce social inequalities in health.

EFFECTS OF EMPLOYMENT POLICIES ON HEALTH AND HEALTH DISPARITIES

JODY HEYMANN

Adult working conditions are one of the major determinants of both child and adult health. Enormous disparities in these conditions across gender and class exacerbate already existing disparities in health. Data illustrating the myriad of ways in which child health is tied to the quality of adult working conditions will be presented from survey research of over 10,000 households in the United States and over 50,000 households globally, as well as from more than 1,000 in-depth interviews conducted in five world regions.

**WELFARE REFORM AND HEALTH:
DO WELFARE AND OTHER INCOME TRANSFER POLICIES AFFECT HEALTH DISPARITIES?**

HILARY W. HOYNES

Low income families with children are eligible for many cash and in kind transfer programs. This presentation will briefly review these programs and summarize what is known about their effects on health disparities. Given the dramatic changes in cash assistance brought about from welfare reform, summarizing the impact of TANF on health disparities will be an important focus of the remarks. Other programs that will be discussed include the Earned Income Tax Credit, Food Stamps, and housing assistance. The social science research summarized here is of very high quality, using both experimental and non-experimental methods. The emphasis in the research is on evaluating the impact of transfer programs on labor market outcomes and income, while evaluating the impact on health is less developed. In general, the research shows that cash assistance programs may lead to some improvement in health, but the improvements are small. However, not all programs are alike. The most robust gains in health occur with generous programs, those that lead to increases in family income. In addition, there is some evidence that the food stamp program leads to improvements in health. One challenge in this area is that the pathways for how income transfer programs affect health are complex and indirect.

EFFECTS OF THE WOMEN, INFANTS AND CHILDREN (WIC) PROGRAM ON HEALTH DISPARITIES

JANET CURRIE

A great deal of evidence shows that women who participate in the Supplemental Feeding Program for Women, Infants, and Children (WIC) during pregnancy have healthier infants than other similar women. Thus, WIC narrows disparities in health at birth. This “healthy start” is important because of accumulating evidence that the effects of low birth weight, for example, are negative and long lasting. Questions have recently been raised about the quality of the evidence in favor of positive effects of WIC on infant health outcomes. At issue is whether those women who participate in WIC are more favorably selected in some unobservable respect than the eligible women who do not participate. Favorable selection has become a greater possibility because the income cutoffs for WIC have risen along with Medicaid cutoffs in many states, since women eligible for Medicaid are automatically eligible for WIC. However, careful examination of the selection issue suggests that it is the most disadvantaged women, who would otherwise be expected to have the worst birth outcomes, who are most likely to participate in WIC. This makes the estimated positive effects of WIC on birth outcomes all the more remarkable.

Much less information is available about the effects of WIC on infants and young children. Several studies suggest that by providing free formula, WIC provides a powerful disincentive to breast feed. But recent attempts to increase the value of the WIC packages available to nursing women, along with efforts to actively promote breastfeeding may have counteracted these disincentives to some extent. Little information is available about the effects of WIC on young children, although children 1 to 4 are the most rapidly growing part of the WIC caseload. A few studies suggest that WIC reduces the probability of overweight in this age group.

Finally, while it appears that “WIC works” to reduce health disparities among children, we know little about why it works. The dollar value of the average food package is small (on the order of \$50 per month) and there is little evidence about the effectiveness of the nutrition counseling that is available. Moreover, since WIC offices are often located in clinics, or in offices with other services available to poor women, it is possible that at least some of the effect operates by bringing women into the orbit of social service agencies. Future work could attempt to open this “black box” and determine which aspects of the WIC program are responsible for the positive program effects.

THE ROLE OF INSURANCE COVERAGE IN REDUCING HEALTH DISPARITIES: POLICY CHALLENGES AND OPPORTUNITIES

MARSHA LILLIE-BLANTON

Approximately 46 million Americans younger than age 65 lacked health insurance in 2004. A series of reports issued by the Institute of Medicine's Committee on the Consequences of Uninsurance provides considerable evidence that people who are uninsured are less likely to use preventive services or have regular outpatient care, more likely to be hospitalized for avoidable health conditions, and more likely to die prematurely than those with insurance. The risk of being uninsured is not equally shared in the population. Persons from low-income families and communities of color are at greater risk of being uninsured than their counterparts, and thus more likely to experience inequalities in access to care and poorer health outcomes. Although multiple, inter-related factors influence disparities in health care and health outcomes, lack of health insurance is one of the factors that is amenable to change through public and private sector policies. This presentation examines how health insurance coverage affects disparities in health care access and quality by gender, income, and race/ethnicity. It reviews evidence from several studies to assess the benefits of expanding sources of coverage on reducing disparities in health care and ultimately in health, and discusses the challenges of developing evidence-based strategies for reducing disparities that include expansions in coverage.

CAN PUBLIC POLICIES AFFECT HEALTH AND HEALTH DISPARITIES?

**NICOLE LURIE
TAMARA DUBOWITZ**

The US boasts one of the most technologically developed health systems in the world, but ranks poorly on measures of population health. Disparities in both health and health care associated with race/ethnicity and socioeconomic status are profound. Commensurate with the expanding knowledge of factors that promote or inhibit good health, there is a growing evidence base that policies-- implemented in both the public and private sector-- can ameliorate these disparities. We first review evidence from both the 'health' and 'non-health' sectors that public policies can have important health impacts. We then provide examples of research from the RAND Center for Population Health and Health Disparities that seek to further identify potential policy interventions that may impact health on a neighborhood level. These include research on: 1) recreational facilities and physical activity in Los Angeles; 2) neighborhood effects of disablement in the elderly; 3) neighborhood impacts on biological markers of disease; the 4) impact of the built environment on mental health. Finally, we provide an example from the National Health Plan Disparities Collaborative to illustrate how health and non-medical data and interventions can converge at the community level to improve overall health and reduce disparities.

FETAL ALCOHOL SYNDROME AMONG AMERICAN INDIANS, ITALIANS, AND SOUTH AFRICANS: DISPARATE RISKS, DIFFERENT PREVALENCE, AND PREVENTION

PHILIP A. MAY

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) has funded studies of the diagnosis, epidemiology, and prevention of fetal alcohol syndrome (FAS) and other levels of fetal alcohol spectrum disorders (FASD) in the three populations described here: American Indians of the Northern Plains, South Africans in the Western Cape Province, and the Lazio Region in towns near Rome, Italy. Across the three populations, there are many similarities in the key diagnostic and etiologic features of the syndrome. Children from each of these populations with FAS and other FASD are smaller, microcephalic, less intelligent, and suffer more behavioral problems than their normal peers in the same populations. They also suffer from a number of similar facial and other anatomical anomalies, although different racial and ethnic groups manifest somewhat different variations of these symptoms. Maternal risks for producing a child with FASD are also shared across populations (e.g. binge drinking, advanced maternal age, low socioeconomic status, poor nutrition, and drinking throughout all trimesters), but unique variations in mix of risk factors exist in various populations. Because of variable combinations of risk factors in these populations, the rates of FAS and other FASD vary greatly: from a low in Italy of 3.7 to 7.4 per 1,000, to a high of 68 to 89 per 1,000 in South Africa. With a solid knowledge and understanding of the epidemiology of FASD in these specific populations, targeted prevention can be designed and implemented. A comprehensive model of FASD prevention that was defined by the U.S. Institute of Medicine is being implemented and studied for efficacy in the Northern Plains of the United States and will soon be implemented in South Africa. Even though preventing FASD is a very challenging task, specific areas of success exist and will be highlighted.

PREVENTION OF SEXUALLY TRANSMITTED INFECTIONS IN INNER-CITY MEXICAN- AND AFRICAN-AMERICAN WOMEN

ROCHELLE SHAIN

Women of color, usually of low SES, have disproportionately higher rates of HIV and other sexually transmitted infections (STIs) than white or “Anglo” women in the United States. Whereas there are many relatively immutable aspects of their lives contributing to these and other health disparities, the purpose of a behavioral intervention, is to focus on elements that can be modified and motivate individuals to want to do so. It is thus critical to understand why individuals make the decisions they do within their life constraints and determine culturally meaningful ways to motivate them to want to lead more healthful lives and provide them with the skills to follow through.

A good way to accomplish this is through ethnographic fieldwork structured according to a relevant theoretical framework. This presentation will show how we designed and evaluated a cognitive-behavioral intervention to prevent STIs, including HIV, for minority, inner-city women. Principles and processes used to design sexual-risk reduction interventions can be applied to other high-risk behaviors.

Design of our Project SAFE (Sexual Awareness For Everyone) intervention was based on integration of a relevant theory of behavior change with 18 months’ of ethnographic data collection. We adapted the AIDS Risk Reduction Model (ARRM, developed by J. Catania and colleagues) to provide structure and cohesion to our fieldwork and intervention; ethnographic data provided substance. The ARRM consists of the following three stages: recognizing one’s risk, making a commitment to reduce risk and following through on commitment by seeking and enacting solutions. Factors important to Stage 1 include recognition of personal susceptibility and knowledge of disease transmission. Factors important to Stage 2 include knowing what works to reduce risk, knowing ways to increase enjoyment from low-risk activities, recognizing barriers to change, recognizing benefits to change, and self-efficacy – confidence in one’s ability to change. Factors important to Stage 3 include social skills attainment (primarily sexual communication) and condom application skills. Social support is important at each stage. The ARRM is primarily focused on achieving consistent condom use. However, our approach to data collection and intervention design was multi-focused; e.g., much time was given to male-female relationships.

In and of itself, the ARRM provided no direction on how to accomplish its directives. For example, how do we make individuals fully aware that they are susceptible to risk and encourage motivation to change? The answer is in knowing your target population, their belief systems, values, behaviors, lifestyles, and cultural strengths. This presentation will

provide a synopsis of qualitative data collected and show how they were interwoven with theory to create the three intervention workshop sessions.

All women in both randomized trials (SAFE and SAFE 2) had a curable STI at entry, showing that they were high-risk. Results of the first SAFE project demonstrated that the study group was significantly less likely than controls (16.8% vs. 26.9%, $p = .004$) to be infected with chlamydia and/or gonorrhea during the 12-month study period (Shain et al, NEJM 340, 1999). SAFE 2 had two study arms, the standard (as above), and an enhanced version consisting of the standard, plus the option of attending 5 monthly support groups. Both standard and enhanced groups had significantly lower infection rates with chlamydia and/or gonorrhea than controls in the first year (15.7% and 15.4% vs. 26.8%, $p=.006$, $.004$); second year (14.7%, 14.8% and 23.1%, $p=.03$, $<.03$); and throughout the 2-year study period (26.2%, 23.7% and 39.8%, $p<.008$, $<.001$) (Shain et al, STD 31, 2004).

ASTHMA IN INNER CITY POPULATIONS

MEYER KATTAN

Asthma affects more than 18 million people in the United States. Prevalence, morbidity and mortality have increased over the last two decades. These rates differ markedly by region and ethnicity. Poor urban communities bear a disproportionate burden of disease. The populations affected are predominantly racial and ethnic minorities that are socioeconomically disadvantaged. Hospitalization and emergency department visit rates in black children are more than three times greater in blacks compared to whites. Interventions can target health care delivery in the community, patients or providers. Factors associated with the development of asthma must be distinguished from factors associated with reduction of morbidity in asthmatics. Risk factors for development of asthma include family history, diet, obesity and environment. Factors associated with morbidity include environmental and psychosocial factors, adherence and access to care. There is little information on reducing the risk for developing asthma. Since 1991, the National Institute of Allergy and Infectious Diseases has supported research on children with asthma living in inner cities. Several interventions have been developed and studied in controlled clinical trials. The asthma counselor intervention program developed by the National Cooperative Inner City Asthma Study empowered families to increase asthma self-management and to improve the interaction with the primary care provider. Social workers were trained as asthma counselors and contacted patients monthly for one year. Content of the interactions was based on an initial assessment of the patient's asthma risk factors. Topics included environmental control, improving communication with providers, adherence and assistance with psychosocial issues. The intervention reduced symptom days and the beneficial effect continued for a second year, at which time the families did not have access to the asthma counselor. Another intervention trained a community worker as environmental counselors. The goal of the intervention was to provide the knowledge, skills, motivation and equipment necessary to perform comprehensive environmental remediation. Intervention activities were tailored to the individual's allergy profile and environmental exposures. This intervention reduced symptoms over the two years of the study. A third intervention was aimed at community providers. Providers were targeted not because they volunteered for an educational program but rather because patients identified them as their providers. Thus more providers were reached than would be expected with usual continuing education programs. Computerized feedback on the patient's asthma symptoms and unscheduled visits with treatment recommendations based on guidelines were sent to providers on a bimonthly basis. Providers improved prescribing patterns and patient outcome improved. The Centers for Disease Control funded 22 sites across the country to translate the asthma counselor program into the real world setting. This effort met with some success. Of 4174 children enrolled, 52% were retained in the program. Barriers to implementation of the program and retention of

patients included limited collaboration between asthma counselor and supervising physician and between asthma counselor and provider, language barriers between the counselor and the family and logistical problems getting allergy skin testing. Interventions aimed at individuals such as those outlined are more likely to be cost-effective if they target those with more severe disease.

CHURCH-BASED HEALTH PROMOTION PROGRAMS

KEN RESNICOW

The majority of Americans regularly attend an organized religious institution, making this a prime venue to deliver health promotion programs and conduct health-related research. The Black church represents a particularly logical setting to conduct health programs, as many Black churches address health as part of their overall mission. Black churches also provide access to the full socioeconomic spectrum of the African American population. This presentation will review a series of NIH-funded nutrition and physical activity programs conducted in Black churches over the past 10 years. Studies to be reviewed include, Eat for Life; Healthy Body/Healthy Spirit, Go Girls and Body and Soul.

Eat for Life was an NCI-funded study to increase fruit and vegetable intake using culturally-tailored, behaviorally-based intervention materials and Motivational Interviewing. Healthy Body Healthy Spirit was an NHLBI-funded intervention to increase physical activity and fruit and vegetable intake again using culturally-tailored, behaviorally-based intervention materials and Motivational Interviewing. GO GIRLS, was an NHLBI-funded study designed to test a physical activity and nutrition program for overweight African American adolescent females. Body and Soul project is an-ongoing collaboration between the National Cancer Institute (NCI), American Cancer Society (ACS), and the two research groups to disseminate effective church-based health promotion programs.

Methods and results from each study will be reviewed and synthesized. Future directions as well as limitations of conducting church-based research will also be presented.

CANCER PREVENTION IN LATINO POPULATIONS

ELISEO J. PÉREZ-STABLE

Compared to Whites and African Americans, Latinas in the U.S. have lower rates of breast cancer and higher rates of invasive cervical cancer. Surveys indicate that Latinas obtain fewer recommended screening tests for breast and cervical cancers at recommended intervals. Cancer control interventions developed for Latinos need to be based on the linguistic, cultural and socio-historical realities of this ethnic group. Latinos in the U.S. have important cultural differences from Whites that transcend language use. The heightened concerns with family, the importance of positive interpersonal interactions (*simpatía*), and respect for authority figures are three important cultural concepts that characterize Latinos. . For example, interventions targeting Latinos can incorporate *familismo* by directing messages to the family unit to collectively discuss and support change in high-risk behaviors and by promoting parents' health behavior as role models for their children. For Latinos, the role that physicians maintain as friendly authority figures (*personalismo*) forms part of the *respeto* theme, an attitude which can be utilized to promote use of cancer screening tests.

Latinos living in the U.S. share a common language and a cultural identity with Spain that includes the Catholic tradition, and similarities exceed differences among national origin groups. The role that acculturation may have in changing behavior must also be considered and studies show that as Latinos acculturate they adopt mainstream U.S. lifestyles and as a consequence cancer rates may increase. Given the apparent protective effect against cancer of Latino culture, a culturally appropriate community intervention may result in increased early detection of cancer and lead to lower mortality rates.

The *En Acción Contra el Cáncer* community intervention consisted of dissemination of culturally appropriate information on breast and cervical cancer and the corresponding screening tests, community outreach through peer role models, and facilitation of Latinas' interaction with the health care system. The themes addressed, outreach strategies, educational materials, and media channels emphasized are based on previous experience with smoking cessation, surveys of Latinos and Anglos on cigarette smoking and cancer, and published experiences from a community intervention program.

The intervention was tested in Northern California Latino communities in the cities of San Francisco, Modesto, San José, and Fresno. Two cross-sectional population-based surveys were conducted with 837 Latinas in 1993 and 977 Latinas in 1996, age 40 to 74 years. The main outcome was obtaining mammography within 2 years and Pap smears within 3 years of interview. Knowledge and attitudes about cancer, perceived barriers to obtaining cancer screening tests, other cancer-related behaviors, and demographics were asked.

Among women 50-74 years, self-reported mammography in the previous two years increased from 70% to 87% in SF compared to 67% to 80% in the comparison cities ($p < .01$). Self-reported Pap smear also increased from 69% to 79% among women in SF, compared to no significant change in the comparison cities (71% and 73%). There were no significant changes by city or year of interview among women 40-49 years. Multivariate models for mammography among 50-74 year old women showed a significant effect by site (OR=1.55; 95% CI=1.08-2.21), but a borderline significance of site by year of interview interaction (OR=1.74; 95% CI= 0.86-3.52). A higher proportion of women in SF reported having heard of “En Acción” in the previous 6 months (36% vs. 28%). Culturally appropriate health promotion and disease prevention interventions that target ethnic-specific concerns need to be developed implemented and evaluated in increasingly diverse communities.

FIDELITY AND ADAPTATION CHALLENGES IN REPLICATION AND GOING TO SCALE

JULIE SOLOMON

This talk will discuss key fidelity and adaptation challenges that arise in initial replication and in scaled-up dissemination of empirically-validated behavioral prevention interventions, and it will offer some strategies for addressing these challenges. Examples will be drawn primarily from teen pregnancy prevention and youth and adult STD/HIV prevention programming, but the audience will be encouraged to consider the extent to which the challenges and strategies presented are applicable to other behavioral health areas. After reviewing the empirical evidence on the importance of both fidelity to an empirically-validated program's core components and appropriate adaptation to meet the needs of the new program context, a set of research-based fidelity/adaptation guidelines will be presented. These will focus on the importance of understanding the context of the replication (target population, community, implementing agency); selecting a program that is the best match for this new context, based on a set of specific criteria; identifying the program's core components; using a logic modeling process to systematically adapt the program by reducing mismatches between the program and the new context, while retaining fidelity to the core components; and documenting the adaptation process and evaluating the adapted program as it was implemented. Researchers are often involved only minimally or not at all in individual program replications, particularly once program dissemination is scaled up. It is therefore important for researchers and practitioners to collaborate in the development of training and technical assistance resources that can help practitioners to use research-based fidelity/adaptation guidelines to replicate programs on their own. In particular, practitioners would benefit from resources that help them to conduct practical needs and asset assessments, use program theory and logic models in adaptation, and carry out basic evaluation processes. Examples of these kinds of resources (both completed and under development) will be presented. The talk will close with a brief consideration of some key fidelity and adaptation issues and opportunities as we move into the future.

ETHNOGRAPHIC AND QUALITATIVE APPROACHES TO THE ROLE OF CULTURE IN DISPARITIES RESEARCH

GAY BECKER

This talk overviews social science contributions to our understanding of health disparities that are specifically qualitative and ethnographic in nature. Cultural aspects of health disparities are examined in relation to ethnic minorities, including the relationship to socioeconomic status and to broader social-structural phenomena. An initial discussion of what anthropologists mean by “culture” facilitates an understanding of how culture can be operationalized in qualitative research on health disparities. Because of its inductive approach, qualitative research often seeks to understand the whole picture. This holistic view facilitates the process of discovery, often of factors that are unforeseen.

Qualitative research with ethnic minorities in the community and in the clinic is addressed. From discussing selected studies, it will become clear that health disparities are multifactorial and that culture is not the cause of health disparities. Despite their focus on specific cultural groups and practices and their emphasis on people’s experiences, the studies, taken together, point to the centrality of social structural forces in perpetuating health disparities. These forces include socioeconomic status, the institutional hierarchy, access issues created by that hierarchy, racism and discrimination, and policies that undermine health care delivery, all of which play major roles in creating and perpetuating health disparities. Discussion of these studies leads to an analysis of gaps in research and future directions.

Although anthropology has taken the lead in the qualitative realm in addressing health disparities, qualitative perspectives on health disparities in other disciplines have much to offer in amplifying our understanding of the many issues involved. The overall approach to health disparities should be transdisciplinary and should encompass both qualitative and quantitative approaches. Only by working with each other across disciplines can we address this complex problem satisfactorily.

CULTURAL INFLUENCES AS THE STRUCTURE AND CONTENT OF SOCIAL NETWORKS, LARGE AND SMALL

BERNICE A. PESCOLIDLO

While socio-demographic characteristics have been most important in documenting health disparities, they fail to provide us with any sense of the mechanism underlying cultural influences and differences. Using the case of the recognition and response to health problems, the Network Episode Model (NEM) proposes one way to conceptualize the dynamic, cultural processes underlying health disparities by focusing on the resources, information, beliefs and hopes that are embedded in social interactions with others and even within large institutions. This presentation reviews the dominant approaches to understanding these health and health care issues, points to their strengths and weakness, and offers social networks as a synthesizing framework. Tracing the development of the NEM suggests how and where alternative conceptualizations have provided powerful insights and where conceptual and methodological challenges remain.

**HEALTH DISPARITIES DUE TO THE EMERGENCE OF GENETIC MEDICINE:
PERSPECTIVES FROM NATIVE AMERICAN AND AFRICAN AMERICAN COMMUNITIES**

MORRIS W. FOSTER

Like other new technologies, genetic diagnostics and therapeutics are being made available to patients on a differential basis modeled largely on existing access to specialty services and the existence and quality of health insurance reimbursement. This suggests that the emergence of genetic medicine will, at least initially, contribute to ongoing health disparities with some possibility of creating new disparities. Prospective interviews, focus groups, and public meetings with members of rural Native American and African American populations in Oklahoma identified a range of community-based perceptions of how genetic medicine may affect people who already experience significant health disparities, as well as potential strategies for reducing those disparate outcomes. Notably, the concept of race can be used both to exacerbate disparities due to the introduction of genetic medicine and to reduce the potential for those disparities. Cultural factors also play a role in differing Native American and African American perspectives, as well as in differences among local Native American and local African American communities.

**SOCIAL STRUCTURAL AND ECONOMIC INFLUENCES ON HEALTH CARE DISPARITIES:
1 1/2 CENTURIES OF FORGETTING AND REMEMBERING**

HOWARD WAITZKIN

Conditions of society that generate illness and mortality, as well as the impact of a society's political economic system on illness-generating social conditions, have been largely forgotten and rediscovered with each succeeding generation. Now, when disease-producing features of society threaten the survival of humanity and other life forms, it is not surprising that such problems would receive attention. But there is a long history of research and analysis about the relationships among political economic systems, the social determinants of health, and the health of populations that has been neglected, despite its relevance to our current predicament.

In this presentation, I trace some historical roots of work about social structural and economic influences on health care disparities. I focus particularly on the contributions of Friedrich Engels, Rudolf Virchow, and Salvador Allende. Then, I describe critically some of the main recent findings in this area. I conclude by thinking about some usually "unthinkable" implications for research and potential intervention efforts. These efforts focus on policy changes at the social structural and economic levels to address the enduring disparities that continue to plague us.

SOCIO-CULTURAL FRAMEWORKS FOR UNDERSTANDING DISPARITIES IN MENTAL HEALTH SERVICE PROVISION

MARGARITA ALEGRÍA

Health care service disparities are defined by a recent Institute of Medicine report as differences in treatment provided to members of different ethnic or racial groups that are not justified by the underlying health conditions or treatment preferences of the patient (IOM, 2002). The report recognizes the need for more research on how context, ethnicity, race and language influence the expression of illness, the help-seeking pathways, and ultimately treatments selected and received. Using the IOM's definition as a foundation, we expand a framework for studying service disparities and call attention to the operation of the community-, patient-, and family-level factors, as well as the environmental context, including social and political forces that impact communities. Because we are interested in the entire process of disparities in care, we recast the IOM framework using previous theoretical and empirical work from help-seeking and treatment effectiveness models which consider the role of the community and patient (McLean et al., 2003; Goldsmith et al., 1988; Ajzen & Fishbein, 1980; Pescosolido, 1991; Wells et al., 1996), and culture (Rogler 1987).

The Sociocultural Framework for Service Disparities (SCFSD) defines disparities as racial and ethnic differences in access, intensity, quality and outcomes of healthcare that are not due to clinical differences (Alegría et al., under review). Differing from the IOM, we include patient preferences as potential sources of disparity on the grounds that they lead to differing treatment patterns for minorities within the healthcare system, and cannot be disentangled from people's available options in care and health literacy. In our effort to integrate culture as well as the IOM understanding of disparities into a model for health service disparities, it is important to highlight the inclusion of the socio-cultural elements pertinent to service delivery for ethno-cultural populations (Cauce et al., 2002) and how ethno-cultural populations interact or fail to interact with the health care system (van Ryn, 2002). This model hypothesizes that six impact health service disparities for ethnic/racial minority populations: (1) health care policies and regulations at the state and federal level; (2) the operation of the health care system and provider organization; (3) provider level factors; (4) the environmental context; (5) the operation of the community system, including the family, friend and lay sector; and (6) patient level factors. These six domains are likely to influence service disparities in several ways. The presentation will describe how these factors operate and the potential repercussions for these disparities.

IMPACT OF PROVIDER CONTINUITY ON OUTCOMES, INTERSECTION OF ETHNICITY AND UNDERSERVED POPULATIONS

LLEWELLYN J. CORNELIUS

Conceptual frameworks, such as the Aday and Andersen Behavioral model of the Use of Medical Services, have served as guiding tools in helping researchers examine the contributions of continuity of care in disparities research. More than 40 years of research has established that African Americans were less likely than others to have site continuity of care. Recent research has noted that having continuity of care is correlated with improved health screenings, reduced medical utilizations and costs savings. These studies have also found that having site continuity (a usual source of care) leads to better outcomes than having no continuity of care. At the same time, having provider continuity (seeing the same provider at each visit) is better than either site continuity or having no continuity of care. Nonetheless, the findings were mixed in terms of determining whether having a provider of the same race led to additional improvements in care. These findings are eclipsed by the larger issue of the barriers that providers are currently facing in providing the level of quality of care that is implied under the notion of continuity of care, given the time constraints of an office visit.



BIOSKETCHES

RONALD P. ABELES, PHD

Dr. Abeles is a Special Assistant to the Director of the Office of Behavioral and Social Sciences Research in the Office of the Director at the National Institutes of Health. From 1994 to 1998, he served as the Associate Director for Behavioral and Social Research at the National Institute on Aging (BSR/NIA). Previously he served at BSR/NIA as the Deputy Associate Director (1980-1991) and Acting Associate Director (1991 to 1994). He received the National Institutes of Health Award of Merit twice for “leadership and contributions to the advancement of behavioral and social research on aging within the Federal Government and nationally” (1993) and for “exceptional leadership in advancing a program of research to understand and apply knowledge about the relationship between psychosocial factors and health” (2002).

Dr. Abeles has been instrumental in fostering behavioral and social research throughout the National Institutes of Health. From 1980 to 1993 he served as the Executive Secretary and Acting Chair of the ad hoc NIH Working Group on Health and Behavior. From 1993 to the present he was first the Vice Chair and then the Chair of the NIH Health and Behavior Coordinating Committee and then of its successor, the NIH Behavioral and Social Sciences Research Coordinating Committee. The committee facilitates behavioral and social research across the NIH and is an advisory group to the Director, Office of Behavioral and Social Sciences Research, NIH. For these activities, he received the NIH Director’s Award in 1990. From June, 1992 to October, 1994 he served as the Executive Secretary for the Congressionally-mandated Task Force on Aging Research, which prepared recommendations on aging-related research by federal agencies for submission to the Secretary, DHHS, and the Congress. He is a founding member (1985-2001) of the Advisory Panel on Behavioral and Social Sciences and the Humanities for the Brookdale National Fellowship Program in Gerontology, a founding member (1996) of and Senior Consultant (1997-) to the Board of Trustees (Kuratorium) of the German Center for Aging Research (Deutsches Zentrum für Alternsforschung, Heidelberg), and was co-chair of the German-American Academic Council’s project on Gerontological Research in Germany and the U.S.: Towards Intensified Cooperation and Future Strategies.

Dr. Abeles has held elected offices in the aging sections of the American Psychological Association (APA) and the American Sociological Association (ASA). He was the Chair (1999-2000) and newsletter editor (1988-2002) of the ASA’s Section on Aging and the Life Course. He was twice the Program Chair of the APA’s Division (20) on Adult Development and Aging (1990 and 2000) and was its President (2001-2002). He is a Fellow of the APA, the American Psychological Society (APS), the Society of Behavioral Medicine (SBM), and of the Gerontological Society of America (GSA). In 2004 the American Psychological Association presented him with its Meritorious Research Service Commendation, and APA Division 38 honored him with its Career Service to Health Psychology Award.

His 1971 doctoral degree in Social Psychology (with a minor in sociology) is from the Department of Social Relations, Harvard University. His experience as a Staff Associate at the Social Science Research Council (1974-78) for the Committee on Work and Personality in the Middle Years and the Committee on Life Course Development stimulated his interest in life course issues. He has organized several symposia at the annual meetings of professional societies, published chapters, and edited books on various aspects of life-course and aging research, most frequently in regard to the sense of control and to the interface between social structure and behavior. He is the editor of *Life-span Perspectives and Social Psychology* (Erlbaum & Associates, 1987), co-editor of *Aging, Health, and Behavior* (Sage Publications, 1993) and of *Aging and Quality of Life* (Springer Publishing Company, 1994), and is an associate editor of the *Handbook of the Psychology of Aging*, Fourth, Fifth, and Sixth Editions (Van Nostrand Reinhold, 1996, 2001, and 2006).

DAVID B. ABRAMS, PHD

Dr. David B. Abrams is Director of the Office of Behavioral and Social Sciences Research (OBSSR) in the Office of the Director (OD) of NIH. OBSSR serves as the focal point for establishing agency-wide policies and goals in behavioral and social sciences research. OBSSR functions as a liaison between the NIH intramural and extramural communities, other Federal agencies, academic and scientific societies, national voluntary health agencies, the biomedical research community, the media, and the general public on matters pertaining to behavioral and social sciences research.

Prior to joining OBSSR, Dr. Abrams was Professor of Psychiatry and Human Behavior and Professor of Community Health at Brown University Medical School, Providence, Rhode Island and co-director of Transdisciplinary Research at Brown-affiliated Butler Hospital. Dr. Abrams holds a B.Sc. (honours) in computer science and psychology from the University of Witwatersrand, Johannesburg, South Africa and Masters and Doctoral degrees in Clinical Psychology from Rutgers University, New Jersey. He joined Brown University in 1978 and he was the founding Director of the Centers for Behavioral and Preventive Medicine for the past 16 years. Dr. Abrams is a licensed clinical psychologist, specializing in health psychology/behavioral and preventive medicine. His research is on addictive behaviors and lifestyle risk factors for chronic disease.

Dr. Abrams is a past President of the Society of Behavioral Medicine, a fellow and a recipient of the Societies' distinguished scientist award, a fellow of the American Psychological Association, a member of the Board of Scientific Advisors of the National Cancer Institute, and a member of the Robert Wood Johnson Foundation's Transdisciplinary Tobacco Etiology Research Network. He has served various expert consultant roles nationally and internationally including: chaired the NCI program review group on Cancer Control; consulted to the National Cancer Institute of Canada and the Osaka Cancer Center, Japan; served on numerous NIH consensus panels and review groups; member, External Scientific Advisory Board of several NCI Designated Cancer Centers; invited contributor, 1988 U.S. Surgeon General's Report on Smoking and Health: Nicotine Addiction; reviewer, National Academies of Science (NAS), Institute of Medicine (IOM) 2004 report "Improving Medical Education: Enhancing Behavioral and Social Sciences in Medical School Curricula"; and served on other NAS-IOM expert panels on Prevention of Alcohol Abuse and Reducing Tobacco Use Prevalence.

Dr. Abrams has published over 220 scholarly articles, has been a Principal or Co-Investigator on over 65 research grant awards from various NIH Institutes, most recently including Principal Investigator of a NCI program project award -Transdisciplinary Tobacco Use Research Center and an R-25 Career Development Training Grant -Transdisciplinary Training of Scientists in Cancer Prevention, Control and Population Sciences. Dr. Abrams is the lead author of *The Tobacco Dependence Treatment Handbook: A Guide to Best Practices*: Guilford Press, 2003 - a recipient of a book of the year 2004 award from the American Journal of Nursing.

Dr. Abrams' research contributions range from basic human laboratory research on bio-behavioral mechanisms in the self-regulation of addictive behavior, to outcomes evaluation of behavior change interventions in clinical and community settings, to health policy research. His primary research foci over the past 25 years have included: (1) basic scientific research on self-control mechanisms in nicotine, alcohol, stress and mood regulation; (2) translational clinical research on evaluating behavioral/pharmacological treatments for tobacco and alcohol abuse, obesity and physical activity; and (3) on dissemination and policy-related research to improve the widespread delivery of cost-efficient interventions to defined populations and across settings and channels including worksites and most recently using new bio-informatics screening technologies and interactive communications via the internet.

Dr. Abrams has had an abiding interest in systems theory, conceptual models to improve population health and in the processes that nurture the training of scientists to conduct "team science", that is research that fosters a transdisciplinary and translational integration among biomedical, socio-behavioral, and public health disciplines to reduce population level metrics of preventable disease burden and improve the public health.

NANCY E. ADLER, PHD

Nancy E. Adler, Ph.D. is Professor of Psychology, Departments of Psychiatry and Pediatrics at the University of California, San Francisco, where she is also Vice-Chair of the Department of Psychiatry, and Director of the Center for Health and Community. She received a BA from Wellesley College and a Ph.D. in Psychology from Harvard University. After serving as Assistant and Associate Professor at UC, Santa Cruz, she came to UCSF to initiate a graduate program in Health Psychology. She has served as director of that program, an NIMH-sponsored postdoctoral program in “Psychology and Medicine: An Integrative Research Approach,” and a new postdoctoral “Health and Society Scholars Program” funded by the Robert Wood Johnson Foundation. Dr. Adler is a Fellow of the American Psychological Society and the American Psychological Association. She has served as President of the Division of Population and Environmental Psychology of the APA and received its Superior Service Award; currently she serves on an APA Taskforce on Socioeconomic status and health. She is also a member of the Society for Experimental Social Psychology, the Academy of Behavioral Medicine Research, and the Society for Behavioral Medicine. Dr. Adler has been awarded the UCSF Chancellor’s Award for Advancement of Women and the George Sarlo Prize for Excellence in Teaching, and the Outstanding Contribution to Health Psychology award from the American Psychological Association, Division of Health Psychology. She is a member of the Institute of Medicine (IOM) and serves on the IOM Membership Committee and on the Report Review Committee of the National Academies of Science. She is currently the Chair of an IOM committee on psychosocial services for cancer survivors. She was named a National Associate of the National Academies. She is also a member of the Advisory Committee to the Director of the NIIH. Dr. Adler’s earlier research examined the utility of decision models for understanding health behaviors with particular focus on reproductive health. This work identified both determinants of consequences of unwanted pregnancy. Her current work examines the pathways from socioeconomic status (SES) to health. As director of the MacArthur Foundation Research Network on SES and Health, she coordinates research spanning social, psychological and biological mechanisms by which SES influences health. Within the network she has focused on the role of subjective social status in health.

MARGARITA ALEGRÍA, PHD

Dr. Margarita Alegría is the Director of the Center for Multicultural Mental Health Research (CMMHR) at Cambridge Health Alliance, and a full professor of the Department of Psychiatry at Harvard Medical School. She has devoted her professional career to researching disparities in mental health and substance abuse services, with the goal of improving access, equity, and quality of these services for disadvantaged and minority populations. She currently serves as Principal Investigator of three National Institute of Mental Health-funded research studies, including the National Latino and Asian American Study (NLAAS), which aims to estimate mental health and substance abuse disorders as well as rates of service use for a nationally-representative sample of Asians and Latinos. The Advanced Center for Latino and Mental Health Systems Research endeavors to formulate methods and conduct research that will contribute to designing interventions aimed at reducing disparities in mental health services among Latino populations. The NCMHD-funded Excellence in Partnerships for Community Outreach, Research on Health Disparities and Training (EXPORT) study proposes to generate and test interventions that can remedy service disparities in asthma and mental health for disadvantaged Latino and African Caribbean populations. Dr. Alegría's published works focus on the areas of services research, conceptual and methodological issues with minority populations, risk behaviors, and disparities in service delivery. She was awarded the 2003 Mental Health Section Award of the American Public Health Association.

GAY BECKER, PHD

Gay Becker is a medical anthropologist who received her Ph.D. degree from the Joint Program in Medical Anthropology, University of California, Berkeley and San Francisco. Currently a professor of medical anthropology at the University of California, San Francisco, she is the author of four solo books, one edited volume, and many peer reviewed articles. Her research interests include health disparities and ethnic minorities, reproductive health and technologies, the experience of illness, aging and the life course, and unexpected disruptions to life. She is the recipient of many RO1s from NIH, including a Merit Award from the National Institute on Aging, and is currently funded by NIA and NICHD. She is a recipient of the Textor Prize for Excellence in Anticipatory Anthropology, American Anthropological Association, and is a former editor of Medical Anthropology Quarterly.

LLEWELLYN J. CORNELIUS, PHD, LCSW

Llewellyn J. Cornelius, is a professor at the University of Maryland School of Social Work. He has more than 20 years of experience in evaluation research. For the last eight years he taught a doctoral research practicum, where he assisted students in the development, pilot testing and fielding of surveys. In addition to teaching survey research, he has been involved in the design and implementation of a multitude of studies, including the fielding of a statewide survey which examined the cultural competency of mental health providers; the development and implementation of surveys which assessed the use of technology in social work; participating in the design and implementation of a statewide survey on minority physicians' attitudes towards managed care and coordinating portions of a data management contract for a federal survey of 15,000 households (the 1987 National Medical Expenditure Survey). Along with having extensive experience in the development and implementation of surveys, he is equally facile in the use of in the use of SAS, SPSS and SUDAAN to analyze complex survey data.

He is currently involved in the design and implementation of three community based cancer disparity research projects in the state of Maryland: one involving the Piscataway Conoy Tribe in Southern Maryland; a second project focusing on the residents of Somerset County on Maryland's' Eastern Shore, and a third involving a statewide cancer outreach effort with community partners. He recently completed a four year evaluation of the Baltimore Needle Exchange Program with the Johns Hopkins University School of Public Health. In March of 2001 he completed the development of a model of statewide coalition building for people of color called SMOTA- Sustained Minority Oriented Technical Assistance that is being used by the Maryland Cigarette Fund Restitution Program (Maryland's Tobacco Settlement Program) to empower communities of color around issues of smoking cessation and cancer reduction. He also recently completed the 3rd edition of the book *Designing and Conducting Health Surveys* with Lu Ann Aday (published in April of 2006).

He received his doctorate from the University of Chicago, School of Social Services Administration and has extensive research experience in examining access to Medical Delivery and the Outcome of Care for African Americans and Latinos.

JANET CURRIE, PHD

Janet Currie is a Professor of Economics and Chair of the Department of Economics at Columbia University. She received her Ph.D. from Princeton University in 1988, and has taught at Princeton, MIT, and at UCLA where she held the Charles E. Davidson Chair in Economics. She has served on several National Academy of Sciences panels including the Committee on Population, and currently serves on the Executive Committee of the American Economic Association. She is a Fellow of the Society of Labor Economists, a Research Associate at the National Bureau of Economic Research, an affiliate of the University of Michigan's National Poverty Center, and an affiliate of IZA in Bonn. She is on the advisory board of the National Children's Study and on the editorial board of the Quarterly Journal of Economics. She has served several other journals in an editorial capacity including the Journal of Health Economics, the Journal of Labor Economics, and the Journal of Public Economics.

For the past decade, her research has focused on evaluating programs aimed at poor children and families. She has written about early intervention programs, programs to expand health insurance and improve health care, public housing, and food and nutrition programs. Much of this research is summarized in "The Invisible Safety Net: Protecting the Nation's Poor Children and Families", Princeton University Press, May 2006. Currently, she is interested in social determinants of child health, and in the relationship between socioeconomic status and health.

MORRIS W. FOSTER, PHD

Morris W. Foster is a professor of anthropology at the University of Oklahoma, Norman. He also is Associate Director for Population Sciences at the OU Cancer Institute and Assistant Program Director at the OU General Clinical Research Center. Dr. Foster has conducted extensive research on the ethics of genetics research in diverse American Indian and African American communities. He also has been involved in genetic studies of scleroderma and lupus among members of those populations. Dr. Foster has published articles on the use of community consultation in planning genetic and other kinds of biomedical studies as well as on the use of racial and ethnic identities in biomedical research.

LEE HARGRAVES, PHD

Dr. Hargraves, a social scientist in the Department of Family Medicine and Community Health at the University of Massachusetts Medical School, has extensive experience in the development of survey instruments and analysis of complex survey data. To this end, he has served as Senior Project Director in the Center for Quality of Care Research and Education at the Harvard School of Public Health, as a Senior Survey Scientist in the Picker Institute in Boston, and as a Senior Health Researcher in the Center for Studying Health System Change in Washington, DC. Dr. Hargraves has published extensively on methods to measure patient assessments of medical care, health care system performance (hospital and ambulatory care practice), and quality of care. He has studied racial and ethnic differences in access to medical care, and also has examined the association between patient-centered processes of care and long-term outcomes in patients hospitalized after heart attack, the contribution of insurance coverage and community resources to reducing racial/ethnic disparities in access to care, and characteristics of primary care physicians who treat Whites and Blacks in the U.S. The primary objectives of Dr. Hargraves' research are to improve the health care system by identifying and eliminating barriers/obstacles that minorities face in the U.S. while attempting to access the health care system. Dr. Hargraves received his B.S. degree from the University of Great Falls, his M.A. from the University of Montana, and earned his Ph.D. in sociology from Boston College.

SUZANNE HEURTIN-ROBERTS, PHD, MSW

Suzanne Heurtin-Roberts is a Medical Anthropologist (Ph.D. University of California, San Francisco) and Social Worker (M.S.W, University of California, Berkeley) who also holds a Master's degree in Sociology (University of New Orleans). Dr. Heurtin-Roberts has long worked in the areas of health inequities and ethnic minority health. Currently on detail with NCI's Center for Cancer Research, she serves as the Director of Community Relations and Outreach for NCI's Cardozo Clinic in Washington DC. Dr. Heurtin-Roberts is part of the NIH Social Work Task Force which is being given an NIH Director's Merit Award for its development of Social Work Research infrastructure in health. In Dr. Heurtin-Roberts home division, the Division for Cancer Control and Population Sciences, she served as Program Director of NCI's Centers for Population Health and Health Disparities, and the Health Disparities Research Coordinator for NCI's Behavioral Research Program. She is the former Chair of DCCPS' Health Disparities Research Coordinating Council and Health Disparities Working Group. Dr. Heurtin-Roberts founded and is former Chair of the NIH's OBSSR's Cultural and Qualitative Research Interest Group and led the task force that produced the 2001 OBSSR report "Qualitative Methods in Health Research" (NIH pub. No. 02-5046). A native of New Orleans, she served as a volunteer to the New Orleans Department of Health and also represented the NCI on post-Katrina health and research. Dr. Heurtin-Roberts research interests include the social determinants of health and health disparities, cultural representations of illness and behavior, adherence, and qualitative methodologies. She has published in the areas of chronic illness, hypertension, qualitative methodology, African American and Russian health and mental health. Prior to coming to NCI, Dr. Heurtin-Roberts was Director of the Prevention Research Program for Special Populations at the NIAAA. Dr. Heurtin-Roberts was on the faculty of the National Catholic School of Social Services at of the Catholic University of America from 1994-1999 where she taught graduate courses in the health care system, cultural diversity, and research methods and led a student cultural diversity group. Active in professional organizations in both anthropology and social work, Dr. Heurtin-Roberts served on the Executive Board of the Society for Medical Anthropology (1999-2002) and is currently on the Editorial Board of the Medical Anthropology Quarterly. She recently participated in a week-long Advanced Seminar on "Cultural Perspectives of Cancer: From Metaphor to Advocacy," held at the School of American Research in Santa Fe, NM. Dr. Heurtin-Roberts currently serves as a staff member on the DHHS Subcommittee on Populations of the National Committee on Vital and Health Statistics.

JODY HEYMANN, PHD, MD

Jody Heymann holds a Canada Research Chair in Global Health and Social Policy. Dr. Heymann is a Professor of Epidemiology in the Faculty of Medicine and a Professor of Political Science in the Faculty of Arts at McGill University and an Adjunct Professor at the Harvard School of Public Health and Harvard Medical School. She is Founding Director of the Institute for Health and Social Policy at McGill University and the Project on Global Working Families at Harvard University, and the founding chair of the Initiative on Work, Family, and Democracy. She has served in an advisory capacity for the United Nations Educational, Scientific, and Cultural Organization (UNESCO); the U.S. Senate Committees on Labor and Human Resources and Health, Education, Labor, and Pensions; the World Health Organization; and the U.S. Centers for Disease Control and Prevention. Dr. Heymann has more than a hundred publications, including, among others, *Forgotten Families: Ending the Growing Crisis Confronting Children and Working Parents in the Global Economy* (Oxford University Press, 2006), *Healthier Societies: From Analysis to Action* (Oxford University Press, 2006), *Unfinished Work: Building Democracy and Equality in an Era of Working Families* (New Press, 2005), and *The Widening Gap: Why America's Working Families Are in Jeopardy and What Can Be Done about It* (Basic Books, 2001). Her work has been featured on CNN Headline News, Good Morning America, and National Public Radio, and in *The New York Times*, *Washington Post*, *Los Angeles Times*, and *USA Today*.

HILARY W. HOYNES, PHD

Hilary W. Hoynes is a Professor of Economics at the University of California, Davis. She is an authority on welfare and low-income tax policy, low-skill labor markets, and government transfer programs. Her ongoing work studies the effects of welfare reform on demographic and economic outcomes, the Earned Income Tax Credit on labor supply and family structure decisions, and the Food Stamp program on family well-being. She also investigates the effects of business cycles on groups differentiated by race, gender, and skill level. Professor Hoynes' research is published at many prestigious academic journals. She has research affiliations at the National Bureau of Economic, the Institute for Fiscal Studies, the National Poverty Center and the Institute for Research on Poverty. She has received research grants from the National Institute on Aging; the National Institute for Child Health and Human Development; the Institute for Research on Poverty; and the Joint Center for Poverty Research. Professor Hoynes received her PhD from Stanford University in 1992.

JAMES S. JACKSON, PHD

James S. Jackson is the Daniel Katz Distinguished University Professor of Psychology, Professor of Health Behavior and Health Education, School of Public Health, and Director and Research Professor of the Institute for Social Research. He has conducted research and published numerous books, scientific articles, and chapters on international, comparative studies on immigration, race and ethnic relations, physical and mental health, adult development and aging, attitudes and attitude change, and African American politics. He is former National President of the Black Students Psychological Association and the Association of Black Psychologists. He is a fellow of the Gerontological Society of America, American Psychological Association, Association of Psychological Sciences, and the AAAS. He is an elected a member of the Institute of Medicine of the National Academies of Sciences. He is currently directing the most extensive social, political behavior, and health surveys on the black American and Caribbean black populations ever conducted; the National Institute of Mental Health, National Institute on Aging, and National Institute on Drug Abuse supported “National Survey of American Life” and “Family Survey Across Generations and Nations”, and the National Science Foundation supported “National Study of Ethnic Pluralism and Politics”.

MEYER KATTAN, MD, CM

Meyer Kattan, MD received his medical degree from McGill University in Montreal, Canada. He was an intern and resident in Pediatrics at Children's Hospital Medical Center in Cincinnati. Dr. Kattan was a Medical Research Council Fellow in Pediatric Pulmonology at the Hospital for Sick Children in Toronto. He is currently Professor of Pediatrics and Chief of the Pediatric Pulmonary and Critical Care Division at the Mount Sinai School of Medicine.

Dr. Kattan is internationally recognized in the field of asthma. He has published extensively in peer-reviewed journals on asthma management and on epidemiologic and environmental aspects of asthma.

He is currently conducting research studies and developing clinical programs aimed at reducing the asthma burden on children. For over 15 years he has been a Principal Investigator in national multicenter studies on inner-city asthma funded by the National Institute of Allergy and Infectious Diseases (NIH-NIAID). One group of projects identified factors associated with increased morbidity in asthma in inner-city children and developed an asthma counselor intervention to help asthmatic children and their families manage asthma and improve outcome. The Centers for Disease Control funded 22 sites across the country to translate this asthma counselor intervention into the community. Dr. Kattan was the project director at two of these sites, in East Harlem and Queens in New York. Another series of projects examined the relationship of allergens, irritants and pollutants in the indoor and outdoor environment to asthma. Dr. Kattan and his colleagues have developed a successful environmental intervention to improve the indoor environment in homes of inner-city children with asthma. They have also developed a novel intervention to improve physician asthma practice in underserved communities where the asthma burden is highest. He is currently a Principal Investigator in the Inner-City Asthma Consortium of the NIAID that seeks to identify new approaches to asthma management and to determine the effects of viral and environmental exposures and stress on the development of asthma. He is also studying the relationship of obesity to asthma.

Dr. Kattan is Director of the HRSA-sponsored Pediatric Pulmonary Center that trains physicians and allied health professionals to assume leadership roles in the field. He serves on the Data and Safety Monitoring Boards for the Childhood Asthma Management Protocol (CAMP) of the National Heart, Lung, and Blood Institute and the NIH-funded study on Reducing Barriers to Pediatric Asthma Treatment Adherence at Case Western Reserve University.

RAYNARD S. KINGTON, PHD, MD

Dr. Raynard S. Kington was appointed Deputy Director of the National Institutes of Health (NIH) as of February 9, 2003. The Deputy Director, NIH, functions as the Principal Deputy Director to the Director, NIH; and shares in the overall leadership, policy direction, and coordination of NIH biomedical research and research training programs of NIH's 27 Institutes and Centers. Prior to this appointment, he had been Associate Director of NIH for Behavioral and Social Sciences Research since September, 2000. In addition to this role, from January, 2002 to November, 2002, he served as Acting Director of the National Institute on Alcohol Abuse and Alcoholism. Prior to coming to NIH, Dr. Kington was Director of the Division of Health Examination Statistics at the National Center for Health Statistics (NCHS) of the Centers for Disease Control and Prevention (CDC). As Division Director, he also served as Director of the National Health and Nutrition Examination Survey (NHANES), one of the nation's largest studies to assess the health of the American people. Prior to coming to NCHS, he was a Senior Scientist in the Health Program at the RAND Corporation. While at RAND, Dr. Kington was a Co-Director of the Drew/RAND Center on Health and Aging, a National Institute on Aging Exploratory Minority Aging Center.

Dr. Kington attended the University of Michigan, where he received his B.S. with distinction and his M.D. He subsequently completed his residency in Internal Medicine at Michael Reese Medical Center in Chicago. He was then appointed a Robert Wood Johnson Clinical Scholar at the University of Pennsylvania. While at the University of Pennsylvania, he completed his M.B.A. with distinction and his Ph.D. with a concentration in Health Policy and Economics at the Wharton School and was awarded a Fontaine Fellowship. He is board-certified in Internal Medicine and Public Health and Preventive Medicine.

Dr. Kington's research has focused on the role of social factors, especially socioeconomic status, as determinants of health. His current research includes studies of the health and socioeconomic status of black immigrants, differences in populations in willingness to participate in genetic research, and racial and ethnic differences in infectious disease rates. His research has included studies of the relationship between wealth and health status; the health status of U.S. Hispanic populations; the determinants of health care services utilization; the economic impact of health care expenditures among the elderly; and racial and ethnic differences in the use of long-term care.

MARSHA LILLIE-BLANTON, DRPH

Marsha Lillie-Blanton is a vice-president of the Henry J. Kaiser Family Foundation where she directs the Foundation's policy research on access to care for vulnerable populations. She also holds an adjunct faculty position in the Department of Health Policy and Management at the Johns Hopkins University Bloomberg School of Public Health. Her research and policy interests are in the areas of substance abuse, racial/ethnic disparities in health and health care, and HIV/AIDS.

Prior to joining the Foundation, Dr. Lillie-Blanton served as Associate Director of Health Services Quality and Public Health Issues at the U.S. Government Accountability Office (GAO). Dr. Lillie-Blanton has over fifteen years of work experience in health policy research and management positions. She has authored and co-authored numerous articles, book chapters, and reports on health care access and financing issues for vulnerable populations. She also served on the Institute of Medicine (IOM) Committee on Guidance for Designing a National Healthcare Disparities Report.

Dr. Lillie-Blanton currently serves on a number of boards including the American Journal of Public Health and Health Affairs editorial boards, and the AcademyHealth board of directors. She is also an elected member of the National Academy of Social Insurance. Dr. Lillie-Blanton is active in civic and local affairs. She is a former chair of the D.C. Department of Health Medicaid Medical Care Advisory Committee, a current member of the D.C. Health Coverage Advisory Panel, and member of the board of directors of the Greensboro Justice Fund.

Dr. Lillie-Blanton received a bachelor's degree from Howard University and a master's and doctorate degree from the Johns Hopkins University School of Public Health.

NICOLE LURIE, MD, MSPH

Dr. Lurie is a Senior Natural Scientist and the Paul O' Neill Alcoa Professor of Policy Analysis at RAND. Along with that, she serves as Co-Director for Public Health for the RAND Center for Domestic and International Health Security and is Director of the RAND Center for Population Health and Health Disparities. Prior to joining RAND in early 2002, she had a long affiliation with the University of Minnesota, where she was Professor of Medicine and Public Health, and most recently, Medical Advisor to the Commissioner at the Minnesota Department of Health. From 1998–2001, she took a leave of absence to serve as Principal Deputy Assistant Secretary of Health in the U.S. Department of Health and Human Services. In that role she worked intensively on operationalizing the Health Disparities Initiative and on HealthyPeople 2010. Dr. Lurie also helped to launch the health disparities activities in Minnesota. She is currently working with a large collaborative of national insurers that have come together to address disparities through data collection and testing of interventions. Dr. Lurie has been a leader in the area of public health preparedness as well, and has successfully led RAND's work with the Department of Health and Human Services, among other projects, over the past 3 years. Dr. Lurie has a long history in the health services research field, primarily in the areas of access to and quality of care, managed care, mental health, prevention, and health disparities. Much of Dr. Lurie's career has been dedicated to translating research in these areas into policy and action.

Dr. Lurie attended college and medical school at the University of Pennsylvania, and completed her residency and MSPH at UCLA, where she was also a Robert Wood Johnson Foundation Clinical Scholar. She serves as Senior Editor for Health Services Research and has served on editorial boards and as a reviewer for numerous journals. She has served on the council and was President of the Society of General Internal Medicine, is currently on the board of directors for AcademyHealth, and has served on multiple other national committees. She is the recipient of numerous awards, including the AHSR Young Investigator Award, the Nellie Westerman Prize for Research in Ethics, the Heroine in Health Care Award, and is a member of the Institute of Medicine. In addition to her work in health services research and health policy, Dr. Lurie continues to practice clinical medicine in the health care safety net and is the mother of three children.

PHILIP A. MAY, PHD

Philip A. May, Ph.D. is a sociologist trained in demography and population studies, who specializes in the epidemiology of behavioral health problems of various populations. For over thirty years, he has dedicated much of his research to behavioral health problems among American Indians and for the past decade he has worked extensively in South Africa as well. He is a former commissioned officer in the U.S. Public Health Service who first worked with NIMH and the Indian Health Service. He has been a Professor of Sociology at the University of New Mexico (UNM) since 1978. Dr. May served as the first Director of the Center on Alcoholism, Substance Abuse, and Addictions at UNM (1990 through 1999). Dr. May is a Principal Investigator on research and training grants from The National Institute of Alcohol Abuse and Alcoholism (NIAAA), and The National Institute of Mental Health (NIMH). In the past his projects have also been funded by The National Institute of Justice, The Centers for Disease Control and Prevention, (CDC), the Robert Wood Johnson Foundation, the Health Resources and Services Administration (HRSA) and other agencies. He currently studies the diagnosis, epidemiology, and prevention of fetal alcohol syndrome, adult drinking and substance abuse among American Indians, South Africans, and more recently has carried out a project in Italy. He also investigates suicide epidemiology, and the relationship of alcohol and crime among American Indians. His study participants are located in communities in four states (MT, ND, SD, and NM), Washington, D.C., South Africa, and Italy. Dr. May directed two NIMH predoctoral training programs spanning 1979-1987, and he has been the Director of the University of New Mexico's NIMH Career Opportunities in Research Education and Training (COR) Honors Undergraduate Research Training Program since 1989.

PETER MESSERI, PHD

Peter Messeri, PhD, is an Associate Professor of Clinical Sociomedical Sciences at Mailman School of Public Health, Columbia University, where he has been a member of the faculty since 1985. He is deputy chair for Doctoral Programs in the Department of Sociomedical Sci. Dr. Messeri is trained in sociology and has both basic and applied research experience. He has an extraordinarily varied research career that has ranged from the etiology and health consequences of substance use, community health promotion interventions to the care and delivery of services for persons living with HIV. Many of these have concentrated on understanding and reducing race and ethnic health disparities.

Earlier in his career Dr. Messeri collaborated with Ann Brunswick on the etiology and consequences of use of tobacco and other illegal substances for a cohort of African Americans who grew up in Harlem during the late 1950s early 1960s. For the past six years he has been a senior consultant to the American Legacy Foundation. In that capacity he has been involved in the evaluation of the truth campaign, a hard-hitting anti-tobacco industry campaign aimed at teenagers. He has been a senior investigator on evaluation of a state level youth empowerment program sponsored by the American Legacy Foundation.

He has designed and evaluated several community-level health promotion interventions with a focus on the health of minority communities. He has collaborated on several health promotion interventions in Harlem that have focused on heart disease, Sexually transmitted infections and currently a workplace intervention for small Harlem businesses.

Dr. Messeri has been involved in numerous HIV-related projects with an emphasis on the delivery of HIV care and treatment. The project which has been most central to this work is the CHAIN study, now going on 13 years. This is a multi-wave panel of HIV infected individuals. He and his SMS colleagues have produced numerous reports and publications that have examined virtually every aspect of the lives of HIV infected individuals including social factors influencing the delivery of services and health outcomes. He was the principal investigator for a 5-year cross-site evaluation of 34 HIV service delivery demonstration projects. He has extensive experience in provider education and training related to HIV treatment.

His theoretical work has focused on application of framework for analyzing optimal group and organization structure developed by long-time SMS Professor and Department Head, Eugene Litwak. He has applied Litwak's task specific theories to social support, inter-organizational relationships, and health education interventions. In collaboration with Hilary Silver from Brown University and Angela Aidala from SMS, he has undertaken a series of exploratory studies examining for lack of better shorthand is the social and spatial ecology of health in New York City. These studies have established strong associations between seventeen health outcomes and the level of poverty and presence of minority populations

in New York City zip codes. In past and continuing studies we are exploring to what extent zip code level measures of the quality of the built environment, air quality and community resources function as pathways between the inequality measures and health outcomes.

Dr. Messeri is the co-director of the methods core for the recently funded Center for Homelessness Prevention Studies. Among his responsibilities for the center, he is learning about the alchemy of imputation of missing information in survey data.

His research has been published in both sociology and public health journals.

ELISEO J. PÉREZ-STABLE, MD

Eliseo J. Pérez-Stable, M.D. was born in La Habana, Cuba and immigrated to the United States at age 8. Eliseo is Professor of Medicine at the University of California, San Francisco (UCSF) School of Medicine. He holds degrees from the University of Miami (B.A. and M.D.), trained in primary care general internal medicine at UCSF, and completed a Henry J. Kaiser Family Foundation fellowship in general internal medicine before being appointed Assistant Professor at UCSF in July 1983. Dr. Pérez-Stable follows a panel of patients in general internal medicine, and teaches residents and students in primary care internal medicine every week and is chief of the division of general internal medicine. Dr. Pérez-Stable's research has focused on cancer control and prevention interventions for Latino populations and health care disparities.

Dr. Pérez-Stable was the Principal Investigator of the Hispanic Smoking Cessation Research Project (Programa Latino Para Dejar de Fumar) which was a community-based intervention to decrease nicotine dependence in San Francisco Latinos funded by the National Cancer Institute (NCI) from 1985-1996. He led the Latina Project in the NCI funded program Pathways to Cancer Screening in Four Ethnic Groups to promote screening procedures for early detection of breast and cervical cancer. Dr. Pérez-Stable led the San Francisco site in the National Hispanic Leadership Initiative on Cancer (En Acción) that was a community-based intervention to promote cancer control. These projects were an extension of prior work that compared knowledge, beliefs, attitudes and practices of Latinos and Anglos in the San Francisco Bay Area. As a result of these programs three booklets for Spanish speaking population were produced. The Guia para Dejar de Fumar which has been published four times by the NCI and is available free on the NCI PLANET web site, a guide for women to promote use of breast and cervical cancer screening tests (La Mujer y El Cancer) and a general information booklet on cancer prevention and control.

Dr. Pérez-Stable evaluated the effect of English language ability of Latino patients on medical outcomes and culture specific barriers to communication. This work led to the observation that Spanish monolingual Latino patients felt better with bilingual clinicians than with clinicians using interpreters. Dr. Pérez-Stable is Director of the UCSF Medical Effectiveness Research Center for Diverse Populations (MERC) and of the Center for Aging in Diverse Communities (CADC) that focus on health and health care disparities in African American, Asian American, and Latino populations with a special emphasis on cancer, tobacco, and reproductive health. Dr. Pérez-Stable collaborated with other MERC investigators to develop a measure of Interpersonal Processes of Care that can be applied to persons from different ethnic groups in English and Spanish. We hypothesize that the some of the observed ethnic disparities in technical processes of care or in disease outcomes may in part be related to the quality of the patient-clinician relationship. Dr. Pérez-Stable completed a study of women from four ethnic groups with abnormal mammography exam that evaluated women's psychological reactions to the abnormal study, the quality of the communica-

tion with their clinicians, satisfaction with the evaluation, and the timeliness of follow-up tests. Current projects include a study on communication of cancer risk, evaluation of new technology in medical interpretation, and continuing the community-based cancer prevention activities among Latinos. Dr. Pérez-Stable is the PI on a Fogarty International Center Tobacco Project in collaboration with investigators in Argentina. The project is building capacity by training investigators from Argentina and conducting an observational study of 13-15 year old youth in Jujuy (a province in northwest Argentina with a high proportion of indigenous population). Through his leadership roles in CADC and MERC, Dr. Pérez-Stable leads efforts in training of minority scientists by focusing on mentoring relationships with established faculty. CADC funds pilot studies for minority investigators, have established a network of community based organizations working in minority communities, and is evaluating the appropriateness of using measures in diverse groups. Over 40 minority investigators from multiple disciplines have been mentored and supported through MERC and CADC over the past 12 years.

BERNICE A. PESCOSOLIDO, PHD

Bernice Pescosolido is Chancellor's Professor of Sociology and Director of the Indiana Consortium for Mental Health Services Research at Indiana University. Trained as a medical sociologist at Yale, she began to work on theoretical issues surrounding help-seeking, adherence and outcomes. She later focused this work on the situation of serious mental illness, receiving two career awards and a series of grants from the National Institute of Mental Health, the Fogarty International Center, OBSSR, the Robert Wood Johnson Foundation, and the MacArthur Foundation, among others. Her Network Episode Model, which provides a more community-based understanding of these issues, continues to be developed and tested. Along with many collaborators which include Margarita Alégria and David Takeuchi, she has examined the patterns and pathways to care in the U.S. and Puerto Rico; the cultural context surrounding the recognition of and response to both adult and child mental health problems, as well as treatment with psychiatric medications; and the long term community integration outcomes for individuals released from a closed state hospital. She has led research teams fielding nationally-representative studies of the stigma attached to adult mental health problems in 40 years and the first study of public response to child and adolescent mental health problems.

In 2005, she was presented with the American Sociological Association's Leo G. Reeder Award for a career of distinguished scholarship in medical sociology. Her address (forthcoming in the *Journal of Health and Social Behavior*) takes on the challenge of synthesizing social and biological issues in understanding current challenges in epidemiology and health services research.

Her current projects include an 18 country study of the stigma of mental illness which follows up on the WHO International Study of Schizophrenia's conclusion that cultural differences underlie the better recovery of individuals in developing (versus developed) nations; a 10 year follow-up of the National Stigma Study which has originally documented continued high levels of prejudice and rejection even in the face of growing knowledge and sophistication among the American public; and an examination of the influence of the media on beliefs and attitudes about mental illness. In addition, she has begun to collaborate on a project bringing together the social and genetic influences on mental health problems.

KEN RESNICOW, PHD

Ken Resnicow is a Professor in the Department of Health Behavior and Health Education at University of Michigan School of Public Health. His research interests include: the design and evaluation of health promotion programs for special populations, particularly cardiovascular and cancer prevention interventions for African Americans; understanding the relationship between ethnicity and health behaviors; substance use prevention and harm reduction; motivational interviewing for chronic disease prevention; Type II diabetes prevention, and comprehensive school health programs. Current studies include: Healthy Body Healthy Spirit an NHLBI-funded intervention to increase physical activity and fruit and vegetable among African Americans recruited through Black churches using motivational interviewing; GO GIRLS, an NHLBI funded study to develop an obesity prevention program for overweight African American adolescent females; Body and Soul, an NIH/ACS collaboration to disseminate proven cancer control interventions using lay health advisors: a FOG-ARTY/NIH study to develop smoking prevention programs for South African Youth; and an NCI-funded project to test the impact of ethnic tailoring of dietary intervention materials. He has published over 130 peer-reviewed articles and book chapters and has served on numerous advisory panels and review groups.

MARGUERITE RO, DRPH

Marguerite Ro, DrPH is the Deputy Director of the Asian and Pacific Islander American Health Forum. Formerly an Assistant Professor at Columbia University, she held appointments in the College of Dental Medicine, the Mailman School of Public Health, and the Center for Community Health Partnerships. Dr. Ro spent the last several years working with underserved communities across the U.S. on improving access to healthcare through policy improvements and systems changes, primarily as the Senior Health Policy Analyst for the W.K. Kellogg Community Voices Initiative. Dr. Ro has conducted program management and evaluation for the American Legacy Foundation and the Community Health Foundation of Western and Central New York. She has authored numerous publications on issues including API health, community health workers, men's health, mental health, and oral health. Dr. Ro received her Masters and Doctorate from the Johns Hopkins School of Hygiene and Public Health.

JOHN RUFFIN, PHD

Dr. John Ruffin is the Director of the National Center on Minority Health and Health Disparities. He is a well-respected leader and visionary in the field of health disparities. He has devoted his professional life to improving the health status of minority populations in the United States and to developing and supporting educational programs for minority researchers and health care practitioners. His success has been due in large part to his ability to motivate others and gain the support of key individuals and organizations, as well as to his expertise in strategic planning, administration, and the development of numerous collaborative partnerships. For over 15 years, he has led the transformation of the NIH minority health and health disparities research agenda from a programmatic concept to an institutional reality. He has served as the Associate Director for Minority Programs, Office of Minority Programs; and the Associate Director for Research on Minority Health, Office of Research on Minority Health. As the NIH federal official for minority health disparities research, through multi-faceted collaborations, he has planned and brought to fruition the largest biomedical research program in the nation to promote minority health and other health disparities research and training. He has spearheaded the development of the first comprehensive Health Disparities Strategic Plan at NIH. His efforts have impacted local, regional, national and even international communities and have resulted in a growing portfolio of:

- Research, training, and capacity building programs
- Health professionals and scientists of racial/ethnic minority populations
- Centers of Excellence conducting cutting-edge health disparities research
- Endowment awards to academic institutions, and
- Community-based participatory research initiatives

Dr. Ruffin has been committed to conceptualizing, developing and implementing innovative programs that create new learning opportunities and exposure for minority and health disparity students and faculty, as well as minority-serving institutions. In his quest to eliminate health disparities, the hallmark of his approach is to foster and expand strategic partnerships in alliance with the NIH Institutes and Centers, various Federal and state agencies, community organizations, academic institutions, private sector leaders, and international governments and non-governmental organizations.

His life-long commitment to academic excellence, improving minority health and promoting training and health disparities research, has earned him distinguished national awards. Dr. Ruffin has received an honorary doctor of science degree from Spelman College, Tuskegee University, the University of Massachusetts, Boston, and North Carolina State University. He has been recognized by: the National Medical Association, the Society for the Advancement of Chicanos and Native Americans in Science; the Association of American Indian Physicians, the Hispanic Association of Colleges and Universities; the Society of Black Academic Surgeons; and the National Science Foundation. The John Ruffin

Scholarship Program is an honor symbolic of his legacy for academic excellence bestowed by the Duke University Talent Identification Program. He has also received the Samuel L. Kountz Award for his significant contribution to increasing minority access to organ and tissue transplantation; the NIH Director's Award; the National Hispanic Leadership Award; Beta Beta Beta Biological Honor Society Award; the Department of Health and Human Services' Special Recognition Award; and the U.S. Presidential Merit Award.

ROCHELLE SHAIN, PHD

Dr. Rochelle Shain received her Ph.D. at the University of California at Berkeley in Socio-cultural Anthropology in 1974. She completed two years of postdoctoral training in the department of Obstetrics and Gynecology at the University of Texas Health Science Center at San Antonio (UTHSCSA) in Reproductive Biology and Voluntary Regulation of Fertility in 1976. She joined the Ob-Gyn faculty at UTHSCSA in 1976, became Professor in 1987, and received an endowed professorship in 2001. She has been conducting behavioral research in women's reproductive health since 1977 and has had continuous NIH or CDC funding as principal investigator since 1980. Her early work focused on the psychosocial and physical sequelae of female sterilization; contraceptive acceptability, and racial/ethnic differences in adverse pregnancy outcomes.

Since 1991, Dr. Shain has researched the etiology (psychosocial and behavioral) and prevention of sexually transmitted infections (including HIV); she and colleagues have designed and evaluated culture and gender specific behavioral risk-reduction interventions for low-income Mexican- and African-American women (Project SAFE). The SAFE interventions are based on an adaptation of the AIDS Risk Reduction Model integrated with extensive ethnographic data. Given her anthropological background, the interventions are multi-focused, opposed to those primarily addressing condom use. Results of the first study (retention rate 89%) showed that women who received the study intervention were significantly less likely than controls to be infected with gonorrhea and/or chlamydia during the 12-month follow-up period; the effect size was close to 40% (Shain et al, *NEJM* 340:93, 1999). The second study (retention rate 91%) demonstrated very similar results across two follow-up years (Shain et al, *STD* 31:401, 2004). Analysis is ongoing for the remaining 3 follow-up years. She was recently refunded by NIAID (part of a Sexually Transmitted Infections, Topical Microbicide Cooperative Research Center) to conduct a third randomized trial to determine the impact of couples' intervention (separate sessions for each gender) on risky sexual behavior and STI rates. Recently the SAFE intervention met all of the CDC Prevention Research Synthesis (PRS) "Best Evidence" criteria for their recent efficacy review. The review has been accepted for publication in the *American Journal of Public Health* and should appear in the January 2007 issue (Lyles CM, Kay LS, Crepaz N, et al. Best-evidence interventions: Findings from a systematic review of HIV behavioral interventions for U.S. populations at high risk, 2000-2004, *Amer J Public Health*, in press). The Dallas STD/HIV Behavioral Intervention Training Center (University of Texas Southwestern Medical Center), funded by CDC, has developed a curriculum to train facilitators in Project SAFE. Project SAFE kits are being used by Dallas and 1 or more of the other Training Centers to train 15 agencies across the U.S. These Centers train HIV and STD prevention program providers (health educators, nurses, outreach workers, STD-clinic disease intervention specialists, social workers, drug counselors, and other counselors) in health departments and community-based organizations. The African-American version of SAFE is currently being adapted for Caribbean Black women in London by a group at London University.

Dr. Shain has devoted a great deal of time to understanding sexual behaviors most responsible for reduced infection rates. Using a very detailed data base (c. 1000 variables annually), she and colleagues determined that mutual monogamy, not douching after sex, avoiding unprotected sex with an incompletely treated partner and other forms of unsafe sex, and taking time between sexual partners played key roles (Shain et al, STD 29;519-529,2002).

JULIE SOLOMON, PHD

Dr. Solomon serves as a Senior Research Associate and the Director of Training Support at Sociometrics Corporation (www.socio.com), an applied social science research and development (R&D) company based in Los Altos, California. As a Senior Research Associate, she has directed R&D, evaluation, and consulting projects in diverse behavioral health areas, including teen pregnancy prevention, youth and adult STI/HIV prevention, prevention of preterm births, violence prevention, substance abuse prevention, and clinician-patient communication in the context of (patient) communication disorders. These projects have been funded by a variety of public and private entities, including the National Institute of Allergy and Infectious Diseases (NIAID), National Institute of Mental Health (NIMH), National Institute on Deafness and Other Communication Disorders (NIDCD), David & Lucile Packard Foundation, Johnson & Johnson Pediatric Institute, California Healthy Kids Resource Center, and Santa Clara County (California) Public Health Department.

As Director of Training Support at Sociometrics, Dr. Solomon develops and delivers workshops on a variety of prevention programming topics, including logic modeling, evaluation, and replication, to diverse audiences, principally practitioners in the sexual and reproductive health fields. Her past workshop clients have included the Adolescent Pregnancy Prevention Network of Santa Clara County, David & Lucile Packard Foundation, Michigan Public Health Institute, Planned Parenthood of Wisconsin, State of California Office of Community Challenge Grants, Wisconsin Department of Public Instruction, and Women's Foundation of California.

A common thread that runs through much of Dr. Solomon's R&D, evaluation, and training work is a desire to empower health and social service providers to carry out appropriate cultural adaptation and successful replication of empirically-validated prevention programs. She has recently published on these topics through the National Campaign to Prevent Teen Pregnancy and in the journal *Evaluation and the Health Professions*. She is also a co-author of two forthcoming books (in 2007, from Springer Publications) on HIV/AIDS, one of which focuses specifically on culturally competent HIV prevention programming.

Dr. Solomon joined Sociometrics in 1999 after completing a Ph.D. in linguistics at Stanford University. Her dissertation research focused on the relationship between Spanish language variation and social factors (e.g., gender, socioeconomic status, and cosmopolitan orientation) in a small urban community in Yucatán, Mexico. While in graduate school, she taught in the Department of Linguistics, Department of Spanish and Portuguese, and School of Education at Stanford. During those years, she also worked for ETR Associates, the American Institutes for Research (AIR), and the Palo Alto Medical Foundation Research Institute on several federally-funded reproductive health projects addressing sexual behavior and HIV risk among Latino youth and adults in California.

DAVID T. TAKEUCHI, PHD

David T. Takeuchi, Ph.D., is a sociologist and currently Professor in the Department of Sociology and the School of Social Work at the University of Washington. He currently serves as Associate Dean for Research in the School of Social Work. His research investigates the social, structural, and cultural contexts associated with different health outcomes, especially among racial and ethnic minorities. He also examines the use of health services in different ethnic communities. His current research is the National Latino and Asian American Study (NLAAS) funded by NIMH (co-principal investigator, Margarita Alegria, Cambridge Health Alliance and Harvard University). NLAAS is the first national study of Latinos and Asian Americans designed to investigate the rates and correlates of mental disorders and to identify the barriers that may prevent some people from receiving help for their problems.

HOWARD WAITZKIN, PHD, MD

Howard Waitzkin is Distinguished Professor, Departments of Sociology, Family and Community Medicine, and Internal Medicine, University of New Mexico. He received his PhD (sociology) and MD degrees from Harvard University and obtained his subsequent clinical training as a resident and fellow at Stanford University and Massachusetts General Hospital. His work has focused on health policy in comparative international perspective and on psychosocial issues in primary care. He coauthored the proposal for a single-payer national health program that was published in the *New England Journal of Medicine* and later was introduced in the U.S. Congress. He has been involved in advocacy for improved health access and currently is conducting studies of Medicaid managed care in New Mexico, the diffusion of managed care to Latin America, and global trade and public health, supported by the U.S. Agency for Healthcare Research and Quality, the World Health Organization, the National Institute of Mental Health, and the United Nations. His work on patient-doctor communication and psychosocial issues in primary care has been funded by the National Institute on Aging, the National Institute of Mental Health, the Agency for Healthcare Research and Quality, and the Robert Wood Johnson Foundation. Dr. Waitzkin has received recognition as a Fulbright New Century Scholar, fellow of the John Simon Guggenheim Memorial Foundation, recipient of the Leo G. Reeder Award of the American Sociological Association for Distinguished Scholarship in Medical Sociology (highest career achievement award in the social sciences pertinent to medicine), and recipient of the Jonathan Mann Award for Lifetime Commitment to Public Health and Social Justice Issues from the New Mexico Public Health Association. He is the author of four books, including *The Politics of Medical Encounters: How Patients and Doctors Deal With Social Problems* (Yale University Press, 1991), *The Second Sickness: Contradictions of Capitalist Health Care* (Rowman and Littlefield, updated edition, 2000), and *At the Front Lines of Medicine: How the Health Care System Alienates Doctors and Mistreats Patients... And What We Can Do About It* (Rowman and Littlefield, 2001, paperback edition, 2004) and more than 140 articles and chapters.

At the University of New Mexico, he has taught courses on medical sociology, globalization and health, health communication, public mental health, comparative international health systems, social medicine in Latin America, and the first seminar in the new B.A.-M.D. Program.

He sees patients clinically and teaches in internal medicine and family medicine.

DAVID R. WILLIAMS, PHD, MPH

Dr. David R. Williams, Ph.D., M.P.H., is the Norman Professor of Public Health at the Harvard School of Public Health and Professor of African American Studies and of Sociology at Harvard University. His previous academic appointments were at the University of Michigan (14 years) and Yale University (6 years). He holds a master's degree in public health from Loma Linda University and a Ph.D. in Sociology from the University of Michigan.

He is centrally interested in social influences on health and his research expertise includes the trends and determinants of socioeconomic and racial differences in health. He has given special attention to the multiple ways in which racism can affect health. He is the author of more than 130 scholarly papers in scientific journals and edited collections and his research has appeared in leading journals in sociology, psychology, medicine, public health and epidemiology. He has served as a member of the editorial board of 8 scientific journals and as a reviewer for more than 50 others. According to ISI Essential Science Indicators, he was one of the Top 10 Most Cited Researchers in the Social Sciences during the last decade. In 1995, he received an Investigator Award in Health Policy Research from the Robert Wood Johnson Foundation. In 2001, he was elected as a member of the Institute of Medicine of the National Academy of Sciences. In 2004, he received one of the inaugural Decade of Behavior Research Awards.

Between 1992 and 1996, he served on the Department of Health and Human Services' National Committee on Vital and Health Statistics. He also chaired its subcommittee on Minority and Other Special Populations. He has also served on six panels for the Institute of Medicine/ National Academy of Sciences, including the committee that prepared the Unequal Treatment report. He has held elected and appointed positions in professional organizations, such as the American Sociological Association, Academy Health and the American Public Health Association. Currently, he is a member of the of the MacArthur Foundation's Research Network on Socioeconomic Status and Health.

Dr. Williams has appeared on national television including ABC's Evening News, CNN, PBS, C-SPAN and the Discovery Channel. His research has been featured or he has been quoted in the national print media including the New York Times, Newsweek, Time, the Wall Street Journal, the Washington Post, Jet and USA Today.

His current research includes studying the health of Black Caribbean immigrants in the U.S., examining how race-related stressors (racial discrimination in the U.S. and exposure to torture during apartheid in South Africa) can affect health, and assessing the ways in which religious involvement is related to health.



POSTER SESSION

SOCIAL, CULTURAL, AND BEHAVIORAL FACTORS ASSOCIATED WITH OVERWEIGHT IN CALIFORNIA ADOLESCENTS: A MULTIVARIATE ANALYSIS OF THE 2003 CALIFORNIA HEALTH INTERVIEW SURVEY

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Background: Childhood and adolescent overweight has become a major public health concern in the United States. Evidence for specific risk factors that promote or protect against overweight in children and adolescent is limited. We investigated social, cultural, and behavioral factors associated with overweight among adolescents.

Methods: A cross-sectional analysis of adolescents aged 12 to 17 years from the 2003 California Health Interview Survey was used to estimate prevalence of overweight. Associations between overweight and risk factors were examined using multivariate logistics regression models. Overweight was defined as body mass index at or above 85th percentile of sex and age specific growth charts.

Results: 28.8% of California adolescents were overweight. Males were more likely to be overweight than females (32.5% vs. 24.9%). American Indians/Pacific Islanders (39.0%) had the highest prevalence of overweight followed by Hispanics (36.6%) and African Americans (34.6%). There were significant differences in overweight prevalence by gender and race. For male adolescents, race, acculturation, and health conditions were statistically significantly associated with overweight. Asians were less likely to be overweight (vs. White). Males who were born or lived in the U.S. for more than 10 years (vs. <10 years), or who were in fair/poor health conditions (vs. excellent) were more likely to be overweight. For female adolescents, age, race, poverty level, asthma, and vending machines at school had statistically significant associations with overweight. Younger adolescents were more likely to be overweight (vs. older adolescents). Being African American (vs. White), having asthma (vs. no asthma), or having vending machines at school (vs. no vending machine) were at higher risk of overweight.

Conclusions California adolescents have similarly high prevalence of overweight compared to results from national data. Intervention strategies should be tailored based on gender, race, and other relevant factors to be effective in preventing the increase in prevalence of overweight.

PLANNING FOR THE FUTURE: MEMORY TRAINING IN MINORITY POPULATIONS

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Older adult African Americans consistently show lower memory test scores and are diagnosed with Alzheimer's disease at a greater rate than Caucasian counterparts. Conversely, research on memory improvement has largely focused on well-educated Caucasian older adults. The current literature suggests a direct link between lowering memory scores and development of mild cognitive impairment (MCI), believed to be a precursor to Alzheimer's disease. While an active memory lifestyle appears to cognitive reserve, thereby protecting from MCI, few older adults heed this advice. Further, with overwhelming evidence that active engagement buffers the progression of dementia, why have minority populations largely been ignored? We offered traditional memory training to two distinct groups, with most participants in both groups having a high school education: Group A (Caucasian, n=18) and Group B (largely African American, n=11). Significant findings most multivariate analysis revealed differences, favoring Group A, on list and name recall memory performance (all $p < .05$), list and name strategy usage (all $p < .05$), and occupation (chi-square $< .02$); however, no differences existed in education ($p > .2$), highest degree obtained (chi-square $> .1$), self-rated health ($p > .1$), story recall ($p > .05$), memory self-efficacy ($p > .1$) and Need for Cognition ($p > .2$). In light of these findings, we will recommend practical methods for tailoring memory training to African American older adults to reduce memory score disparities.

RACIAL/ETHNIC DISPARITIES IN PRESCRIPTION DRUG UTILIZATION AND OUT-OF-POCKET COSTS

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Objectives: There is very limited research on national-level racial/ethnic disparities of prescription drug utilization and out-of-pocket prescription drug (OOP PD) expenditures among working-age adults. This analysis used the 2002 Medical Expenditure Panel Survey (MEPS) to study pharmaceutical use and OOP PD expenditure differences across racial/ethnic groups, in a nationally representative population of Asian, Black, Hispanic and White adults age 18-64.

Methods: The Andersen Behavioral Model of Health Services Utilization, covering socio-demographic, access to resources, and health status factors, was used to guide hypotheses and variable selection. MEPS is a national survey of healthcare use, expenditures, sources of payment, and insurance coverage. A negative binomial regression model was used to analyze the number of annual prescriptions and a two-part model was used to model annual OOP PD expenditures. These models adjusted for various demographic, health status, income and insurance coverage variables.

Results: In unadjusted analyses, Whites filled an average of 10.1 medicines in 2002; this was significantly greater than prescription drug use for Hispanics (4.72), Blacks (8.55) and Asians (4.1), p -value <0.05 for all comparisons. After adjusting for predisposing, enabling and need factors, statistically significant differences in levels of medication use across racial/ethnic groups remained: compared to Whites, Asians used 47.8%, Blacks 26.2% and Hispanics 39.1%, fewer prescription drugs per year. In unadjusted analyses, Whites had OOP costs of \$218, compared to \$110, \$163, and \$75 for Hispanics, Blacks, and Asians, respectively. After adjustment, among subjects with any drug expenditures, these groups had 38%, 30% and 56% lower expenditures compared to Whites, respectively.

Conclusions: This study found significant disparities in pharmaceutical use and OOP expenditures across racial/ethnic groups, even after controlling factors such as income, insurance coverage and health status. Pharmaceutical therapy is critical to healthcare and lower utilization among minorities may explain why these groups suffer disproportionately from the effects of chronic diseases.

INSURANCE STATUS AND DENTAL DISEASE IN VIRGINIA SCHOOLCHILDREN

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Background: The availability of, and access to, quality health care directly affects the health of children, especially those at high risk due to chronic health conditions or lower socioeconomic status. Despite the recent reduction in cases of caries, more than half of all children have caries by the second grade, and about 80% have caries by the time they finish high school.

Objective: This study examines the relationship between a child's insurance status and indicators of oral-health status.

Methods: The Division of Dental Health (DDH) in the Virginia Department of Health (VDH) completed the 1999 Virginia Statewide Oral Health Needs Assessment (VSOHNA). The survey uses a probability-proportional-to-size (PPS) sample design in selecting schoolchildren from public schools in the commonwealth of Virginia. Each child received an oral-health examination by a dentist using explorers and mirrors, and no radiographs were taken. Surface (DMFS/dfs) and tooth-level (DMFT/dft) data were collected as indicators of dental disease on all children. Child-level data also was recorded for each student consisting of grade, race, gender and insurance status. A regression analysis was completed to examine the relationship between insurance status and oral-health status indicators.

Results: In the primary dentition, schoolchildren with medical and dental insurance had the highest level of caries-free teeth at 46%, compared to the schoolchildren with no insurance at 34%, and those with only medical insurance at 31%. In the primary dentition, schoolchildren with no insurance had the highest prevalence of untreated decay at 65%, when compared to schoolchildren with only medical insurance at 42%, and those with both medical and dental insurance at 25%. There were no significant relationships between insurance status and caries experience or untreated decay in the permanent dentition.

Conclusion: In the primary dentition, children with no insurance or medical insurance only were more likely to have untreated decay than those with both medical and dental insurance. Insurance status does not appear to be associated with caries experience or with untreated disease in the permanent dentition.

ADDRESSING DISPARITIES IN SICKLE CELL DISEASE: AN EXAMINATION OF GROWTH TRAJECTORIES

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Sickle Cell Disease (SCD) affects more than 70,000 Americans. The disease disproportionately affects persons of African descent as indicated by one in 600 African Americans having the disease and one in 12 being a carrier of the trait for the disease. The life expectancy for a person with SCD is approximately 50 years, which is shorter than the average of 70.2 years for African Americans in general. Despite medical advances and nutritional supplementation, patients with SCD experience significant medical complications including organ damage, poor growth, low bone density and delayed skeletal and bone maturation. Given the potential for delayed development and low bone density, it is essential that we understand growth trajectories and risk factors for growth delays in persons with SCD in order to develop preventative interventions. Failure to design effective interventions which address growth-related issues could lead to increased morbidity (e.g. organ damage, fractures) and decreased quality of life (e.g. social problems), particularly for youth with SCD. The current study examined growth patterns in 133 patients ages 6-18 with SCD. Study objectives were: (1) To examine growth patterns of children with SCD compared to CDC norms and (2) To determine predictors of weight status during adolescence. Results yielded a relatively normal growth trajectory for children with SCD; however, analyses indicated a potential for higher than normal growth/obesity among adolescent females with SS disease and a potential for poor growth/underweight among adolescent males with SS disease. In addition, several health variables (gender, childhood weight status, disease type and health utilization) predicted weight status during adolescence.

These results suggest a bimodal distribution of growth patterns in this population with some patients at risk for underweight/undernutrition and other patients at risk for overweight/obesity. Additional research is needed to further explore protective and risk factors for growth in this population.

ARE RESEARCHERS' VIEWS OF STRESSFUL STIMULI BIASING THE ASSOCIATION BETWEEN STRESS AND PRETERM BIRTH?

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Background: Stress is postulated to be a major factor contributing to the Black/White disparity in preterm birth (PTB), and is caused by complex social phenomenon. The biological mechanisms from which stress can lead to PTB have been well documented. However, we have mixed results when measuring the effects of stress on PTB. This may be due to our lacking the ability to measure stress using the existing epidemiological research paradigms and tools. Epidemiology methods dominate our attempts to understand the impact of stress on PTB, but there may be serious limitations to using these methods before we have adequately developed the ability to quantify the overall impact of stressful exposures.

Objective: This methodological study examined if researchers adequately captured and specified stressful exposures experienced by women and if not, determine the extent that it biases the association between stress and PTB.

Methods: The kappa statistic was used to test for agreement between researcher and maternal view of stress. Logistic regression models assessed the association between maternal report of stress and PTB, and researchers' views of stress and PTB. Also a correlation matrix examined the extent to which the study instrument was correlated to a previously validated stress scale.

Results: Discordance between maternal report of stress and researchers' appraisal was found in 3-10 percent of the cases. The odds of PTB differed according to which method was used to report stress, however neither was statistically significant. Also the study instrument was found to be weakly associated with the Cohen Perceived Stress Scale.

Discussion: Although we did not detect significant bias between researcher and maternal report of stress as it relates to PTB, we determined that some misclassification does exist in the appraisal of stressors. In about 10% percent of cases, we need to cross validate these appraisals of women's self-assessment of stress.

THE LIFE PROJECT: DESIGNING AND PILOT-TESTING AN OBESITY-REDUCTION PROGRAM FOR RURAL AFRICAN AMERICAN WOMEN

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Obesity is a growing health problem for African American women. A significant portion of this population is obese, especially when compared to other ethnic and gender groups in the United States. Chronic health conditions associated with obesity include Type-II diabetes, cardiovascular disorders, cerberovascular disorders, and certain forms of cancer. However, the majority of effective obesity-reduction interventions with African American women have been conducted with urban samples. As a result, the LIFE project was developed as a 10-week intervention designed by the Clemson University-Voorhees College NCMHD/NIH-funded EXPORT project to reduce obesity in rural African American women. Given the number of African Americans who use spirituality as a healing mechanism, churches were recruited to deliver the program. A community health educator familiar with the area was recruited to deliver the LIFE project curriculum to two churches located within the selected community. Two different interventions (spiritually-based and non-spiritually-based) were pilot-tested in a group of rural African American women utilizing a pre-test, post-test design. The following measures were collected: weight, body mass index (BMI), systolic and diastolic blood pressure, physical activity, communication with physicians, and spirituality. The results demonstrated that both interventions had statistically significant reductions in weight. In addition, the non-spiritually-based sample had significant declines in systolic blood pressure, while the spiritually-based group had significant increases in self-reported physical activity levels. The initial pilot testing of the LIFE project confirmed that there can be effective obesity-reduction interventions with rural African American women. In addition, it was found that a community-based health educator can be effective in delivering weight-reduction interventions. However, there is a need for more longitudinal studies.

MOBILIZING NEIGHBORHOOD AND FAITH ORGANIZATIONS TO ADDRESS RISK FOR HEALTH DISPARITIES IN A REACH 2010 INITIATIVE

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The purpose of this empirical case study is to examine how supports may optimize neighborhood and faith organization involvement in addressing health disparities and to assess the contribution of these groups to a coalition's efforts to reduce risk for chronic diseases. The Kansas City-Chronic Disease Coalition is a REACH 2010 project addressing health disparities among African-Americans and Latinos in Kansas City, Missouri. KC-CDC's provided supports to neighborhood and faith organizations in the 11 zip code target area to facilitate community change on behalf of the Coalition, including provision of grants, program supplies, and technical assistance. Coalition members used an online documentation system to record the activities they facilitated. Preliminary results indicate that between 10/1/2001 and 9/30/2005, 48 neighborhood and faith organizations facilitated 204 community changes, 39% of all changes facilitated by members of KC-CDC. Community change, defined as a new or modified program, policy, or practice facilitated by the initiative and related to the goals and objectives of the coalition, served as an intermediate outcome representing a product of community mobilization. Examples of these changes include construction of a walking trails, walking clubs, and healthy cooking demonstrations. The number of community changes facilitated by each organization ranged from 1 to 13. These changes employed multiple strategies, principally providing information and enhancing skills (42.16%) and modifying access, opportunities, and barriers (37.74%). Additionally, 71.57% of these changes are ongoing or occurred more than once. These results suggest that KC-CDC successfully mobilized neighborhood and faith organizations to serve as catalysts for sustained change addressing risks for health disparities in their community.

THE IMPACT OF PROMOTORAS ON PROMOTING WEIGHT LOSS AND ENHANCING HEALTH-RELATED PHYSICAL FITNESS AMONG MEXICAN AMERICAN WOMEN ENROLLED IN A NUTRITION EDUCATION AND EXERCISE PROGRAM

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This study examined the efficacy of utilizing promotoras (Hispanic community members with experience/training in health promotion) to promote weight loss and improve health-related physical fitness (HRPF) in overweight/obese, low socioeconomic (SES), Mexican American (MA) women enrolled in an 8-week structured, culturally sensitive program. Thirty-six volunteers (ages 19-55) were encouraged to attend five 60-min exercise sessions/week and one 30-min nutrition education class/week during which lessons, snacks and recipes were provided. Women were divided into two groups: Counseling (CG, n=13) or Promotora (PG, n=23). Women in CG were subdivided into two smaller counseling groups of 6 and 7 women each, and met with a trained counselor for 60 minutes/week. Women in PG were subdivided into 4 groups of 5 or 6 women and met with a promotora for a 60-min “walk and talk” group session each week. PG also received one phone call/week from their promotora. The curriculum for CG and PG was based on cognitive/behavioral principles focusing on health and wellness, including goal setting, thought and feeling recognition, etc. Pre- and post-testing, including measurements of HRPF, were compared to wait-listed controls (CON, n=14). One-way ANOVA revealed no significant differences in baseline characteristics among the 3 groups in all measurements except two: CON had larger waist and hip circumferences than PG ($p < .05$). Repeated measures ANOVA revealed significant reductions in blood pressure, body weight, and waist circumference in the PG group versus the CON group and significant reductions in body weight and waist circumference in the CG group versus the CON group ($p < .05$). Post-hoc analysis revealed no significant differences in the magnitude of improvements between the CG and PG groups for any variable. Results suggest that groups led by promotoras are as effective as those led by trained counselors in decreasing body weight and girth of low SES, overweight/obese MA women.

THE CULTURAL AND SOCIAL CONTEXT OF ORAL AND PHARYNGEAL CANCER RISK AMONG HISPANICS IN NEW YORK CITY

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Background: New York City has one of the highest incidence and mortality rates of oral and pharyngeal cancer for Hispanics among any major city in the US. Upon completion of comprehensive quantitative studies conducted by the authors, the present study was designed to qualitatively assess oral cancer awareness, attitudes, and screening practices among at-risk Hispanics, community leaders, and health care providers in New York City.

Methods: Four focus groups (N=39, 8-13 participants per group, self-identified current/past smokers) were conducted in upper Manhattan and the Bronx where Hispanics comprise the majority. In addition, investigators conducted structured interviews with health care providers (4 physicians, 4 dentists, 2 dental hygienists) and three key community leaders serving Hispanic communities. Data was analyzed utilizing Folio Views.

Results: Major gaps in oral and pharyngeal cancer awareness were prevalent among all stakeholders. Many culturally specific factors such as “fatalism” were cited as barriers for screening and utilization of preventive services. Health care providers did not have familiarity with oral cancer prevention and early detection practices and did not feel adequate to deal with oral cancer sequelae. Community leaders lacked the knowledge and resources necessary for advocating oral cancer prevention and early detection for their respective constituencies. Conclusions. Hispanics at high risk in New York City lack awareness of OPC. Cultural barriers for prevention and early detection are prevalent in the community. There is a need for developing a multisectoral, culturally competent, health communication program that targets all key stakeholders.

CONTRACEPTIVE METHODS BY RACE/ETHNICITY IN THE CALIFORNIA FAMILY PACT PROGRAM

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Racial/ethnic disparities in unintended pregnancies are well documented, with the National Survey on Family Growth finding that 72% of pregnancies among African-American women were unintended, compared with 49% among Hispanics and 43% among Whites. Differences in contraceptive use may explain some of this disparity, and may be related to access, patient preference, and/or provider and system factors. The Family PACT program is a state funded family planning program in California for residents up to 200% of the Federal Poverty Level serving over 1.5 million clients per year. Program claims data and a 2002 medical records review reveal that even when access to services is assured disparities in use of contraception and the distribution of specific methods persist. White women are most likely to receive a contraceptive method, at 82%, whereas Latinas and African Americans are less likely at 70% and 68% respectively. Of the racial/ethnic groups, White women are most likely to be dispensed oral contraceptives, the IUC and the contraceptive ring and are least likely to be dispensed the contraceptive patch and contraceptive injections. In contrast, Latinas are more likely to be dispensed the contraceptive patch and African American women are more likely to be dispensed barrier methods and contraceptive injections. In the medical record review, White women were more likely than Latinas and African-Americans to leave a family planning visit with a more reliable method compared to the method used prior to the visit (16% vs. 11% and 12%). Among women using oral contraceptives, White women were more likely to be continuing to use this method at one year than African-American and Latina women. These data provide insight into contraceptive use among women with equal access to contraceptive services and suggest potential opportunities for research and intervention.

Note: Edited version. Please contact the author for the full content of this abstract.

UNDERSERVED URBAN BLACK MEN: HYPERTENSION TRIAL OUTCOMES AND MORTALITY OVER 5 YEARS

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Background: Black men with hypertension (HTN) in low socioeconomic urban environments continue to achieve poor rates of HTN control.

Methods: In a 5-year randomized clinical trial with 309 hypertensive urban Black men ages 21-54 years, the effectiveness of a more intensive (MI) educational-behavioral-pharmacological intervention provided by a nurse practitioner-community health worker-physician team was compared to less intensive (LI) information and referral intervention. Changes in behavioral factors, health care utilization, blood pressure (BP) control, left ventricular hypertrophy (LVH) and renal insufficiency were evaluated.

Results: Follow-up rates exceeded 89% of available men. The ranges of mean annual SBP/DBP change from the baseline to each year follow-up were -10.1/-9.1 to 4.9/-12.3 mm Hg for the MI group and -3.7/-4.9 to 0.1/-1.8 mm Hg for the LI group. The annual proportion of men with controlled BP (< 140/90 mm Hg) was 17%, 42%, 38%, 44%, 36%, and 41% in the MI group and 21%, 31%, 36%, 31%, 28%, and 33% in the LI group. At 5 years the MI group had less LVH than the LI group and 17% of the men were deceased primarily due to narcotic or alcohol intoxication (36%) and cardiovascular causes (19%).

Conclusion: An appropriate educational-behavioral intervention significantly improved BP control and reduced some sequelae of HTN in a young black male population. Improvement in risk factors other than HTN was limited and sustained control of HTN was difficult to maintain over five years.

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**DOES YESTERDAY'S POVERTY EXPLAIN TODAY'S RACIAL HEALTH DISPARITY?
A LONGITUDINAL APPROACH TO EXPLAINING THE BLACK/WHITE HEALTH GAP****D. PHUONG DO, M.PHIL.**

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Background: Blacks persistently experience worse health than Whites. Socioeconomic factors, though key determinants of racial health disparity, have been unable to fully account for the gap¹⁻³. However, at both the individual and neighborhood levels, socioeconomic status is often treated as static, with only single-point-in-time measures used as controls. Because longer spells of poverty have a greater negative impact on health than shorter spells^{4,5} and Blacks tend to experience longer poverty spells than Whites,⁶⁻⁸, not accounting for possible heterogeneity in socioeconomic histories may be why the Black/White health gap remains unexplained.

Data and Analytical Framework: I use longitudinal data from the geocoded Panel Study of Income Dynamics to account for both current and past socioeconomic conditions (at both the individual and neighborhood levels) of Black and White respondents and investigate whether controlling for socioeconomic history further explains the Black/White health gap. I use respondent-rated health as the outcome measure and two statistical adjustment strategies: multivariate regression and propensity score modeling to adjust for systematic differences in socioeconomic factors between Blacks and Whites. (Propensity score modeling is an alternative to regression modeling and is less sensitive to regression model misspecification.)

Results: Regression model results show that accounting for long-term income and neighborhood poverty reduces the unexplained Black/White health disparity, compared to estimates based on cross-sectional models (e.g. from OR=1.51 to OR=1.33). However, a significant racial health gap remains. In contrast, results from propensity score models fully accounted for the Black/White health disparity (e.g. OR=.92). This suggests that the elusiveness of being able to fully explain the Black/White health gap may stem not from insufficient information on the determinants (e.g. genetics) of the health gap but from model misspecification in regression adjustments. As such, reaching our goal of understanding the sources of racial health disparities may be closer than we first thought.

Note: Edited version. Please contact the author(s) for full content of this abstract.

RACIAL AND ETHNIC DIFFERENCES IN TUMOR STAGE AND SURVIVAL FOR COLORECTAL CANCER IN AN INSURED POPULATION

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Background: Despite declining death rates from colorectal cancer (CRC), racial/ethnic disparities have continued to increase. We examined racial/ethnic differences in survival rates among a cohort of patients diagnosed and treated in integrated healthcare delivery systems.

Methods: This study was conducted among patients diagnosed with CRC 1993-1998 while enrolled in one of 6 integrated healthcare systems that are affiliated with the Cancer Research Network. Using centrally generated computer programs, we used the functionality of a Virtual Data Warehouse to identify eligible patients from participating sites' tumor registries and then linked to information in administrative databases. The sample was restricted to non-Hispanic whites ("Whites") (n=10,585), non-Hispanic blacks ("Blacks") (n=1,479), Hispanics (n=985) and Asians/Pacific Islanders (n=909). Differences in tumor stage and survival were analyzed using polytomous and Cox regression models, respectively.

Results: In multivariable regression analyses, Blacks were more likely to have distant or unstaged tumors compared to Whites. In Cox models that adjusted for non-mutable factors, Blacks had a higher risk of death from CRC (hazard ratio (HR); 95% confidence interval (CI): 1.17; 1.06-1.30). Hispanics had a risk of death similar to Whites (HR; CI: 1.04; 0.92-1.18), while Asians/Pacific Islanders had a lower risk of death from CRC (HR; CI: 0.89; 0.78-1.02).

Adjustment for tumor stage decreased the HR to 1.11 for Blacks; addition of receipt of surgical therapy to this model further decreased the HR to 1.06. The HR among Hispanics and Asians/Pacific Islanders were stable to adjustment for tumor stage and surgical therapy.

Conclusions: The relationship between race/ethnicity and survival from CRC is complex and appears to be related to differences in tumor stage and therapy received even in insured populations. Targeted interventions to improve the use of effective screening and treatment among vulnerable populations may be needed to eliminate disparities in CRC.

VALIDATION OF THE MORISKY MEASURE OF MEDICATION ADHERENCE IN A SAMPLE OF HYPERTENSIVE AFRICAN AMERICANS

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Introduction: Despite the frequent use of self-report to assess medication adherence among hypertensive patients there is a paucity of data on their validation, especially among African Americans - a group with the highest rate of hypertension. The aim of this study was to examine the reliability and validity of a self-report measure of medication adherence compared to an objective electronic medication event monitoring systems (MEMS) in a sample of hypertensive African Americans.

Background: 79 patients, mean age 53.6 years (SD+12.46) and 85% female completed the four-item Morisky measure at baseline and 3 months. The items assess forgetfulness and carelessness about taking medications, and ADH based on presence or absence of symptoms. Additional ADH data was gathered with MEMS electronic caps concurrently. Patients were categorized as nonadherent if they responded yes to one self-report item or if they took less than 80% of prescribed doses by MEMS at three months. Test-retest reliability was assessed. Sensitivity, specificity, and accuracy of the self-report measure were compared against the MEMS as the gold standard.

Results: Self-report ADH rate was 35.4% at baseline; 58.2% at 3 months; 45.6% at 3 months via MEMS. Regarding test-retest reliability, 62% responded in a similar manner to self-report at baseline and 3-months (Kappa = .31, $p = .004$). When self-report data was compared to MEMS data at 3 months, it had a sensitivity of 69% with a specificity of 51%. Its positive predictive value was 54%, with a negative predictive value of 33%.

Discussion: Self-report ADH rates were similar to some of the lower estimates in the current literature, while MEMS ADH rate was lower. Kappa for test-retest was low. Participants tended to over-report adherence via self-report when compared to MEMS, a finding that is also common in the literature. The measure appears to have low to moderate sensitivity and specificity. Further studies are needed on the performance of this measure in hypertensive African Americans.

PATIENT PERSPECTIVES ON DISPARITIES IN HEALTHCARE FROM AFRICAN AMERICAN, HISPANIC, MANDARIN, AND NATIVE AMERICAN SAMPLES: SECONDARY ANALYSIS OF INSTITUTE OF MEDICINE FOCUS GROUP DATA

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Racial and ethnic disparities in healthcare have been well documented by healthcare professionals in the scientific literature. The purposes of this study were to focus on the patients' perspective in identifying health disparities related to processes of care; and identify recommendations and strategies for improving health disparities based on patient focus group data.

This study was a secondary qualitative analysis of original data collected by the Institute of Medicine (2002; Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare). Subjects were interviewed in focus groups with 9 subjects in each group. The racial/ethnic backgrounds of the different groups were Chinese, Native American, Hispanic, and African American. The QSR NUD*IST Vivo software program was used to analyze focus group transcripts using the Priority Sequence model. Transcripts were independently reviewed by research team members for themes related to processes of care. Transcripts yielded a total of 1460 focus group responses for data analysis. The majority of these responses fell under the theme of experiences of perceived racial/ethnic bias or unequal treatment in healthcare, which has been reported previously in the IOM report. Three hundred fifty-three (24.2%) additional responses were identified as related to processes of care for improvement and thus germane to this secondary analysis. Health disparities themes identified: Provider selection (33.9%); Provider communication and cultural competency (30.5%); Treatment setting and service (17.7%); Medical visit efficiency (12.3%); and other Patient related factors (5.7%). Patients' recommendations for improving processes of care were to: provide varied educational experiences for providers regarding populations served, settings and treatment to increase cultural competency; provide processes for patients to make informed choices regarding service provider; and promote patient self-advocacy and monitoring systems. These recommendations are especially valuable because they provide information from the patients' perspective and could serve as a basis for developing interventions to improve health disparities.

COMPARISON OF PSYCHOSOCIAL FACTORS, CORTISOL, AND CYTOKINES BETWEEN LOW-RISK AND HIGH-RISK PREGNANT AFRICAN-AMERICAN WOMEN

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Purpose: To compare psychosocial factors, cortisol, and anti-inflammatory cytokines between low-risk pregnant African-American (AA) women and AA women diagnosed with gestational hypertension or preeclampsia (high-risk).

Sample: 78 pregnant AA women will be enrolled in the study. Women enrolled so far in the study (n=54) have a mean maternal age of 25.4 years (SD=5.18) and a mean gestational age at the time of data collection of 33 weeks (SD=2.18). Most of them are single (80.8%), unemployed (53.8%), have an annual household income of less than \$10,000 (47.1%), and have some college education but did not receive a degree (37.3%). The mean gestational age at birth (n=46) is 38 weeks (SD=2.04). Of women who delivered, eleven were preterm or less than 37 weeks gestation (23.6%).

Design: Cross-sectional correlational comparative

Preliminary results: Women reported low levels of uncertainty, moderate levels of optimism, moderate levels of distress, and high levels of social support. Women used prayer most often and avoidance least often to cope with their pregnancy. The levels of cortisol and anti-inflammatory cytokines of IL-1ra and sTNF-RII showed high variability among the samples. Women who reported lower levels of optimism, higher levels of uncertainty, used avoidance more often, and used positive interpretation less often also reported higher levels of psychological distress. Women who reported high levels of optimism and lower levels of uncertainty had higher levels of sTNF-RII. Cortisol and IL-1ra were not related with any psychosocial variables in this study. Compared with low-risk pregnant women, high-risk pregnant women were more optimistic, used avoidance less often, and delivered at an earlier gestation. Surprisingly, compared with women who delivered at term, women who delivered preterm reported less distress. Two-tailed tests were used in these analyses. These preliminary results show promise for potential relationships between psychosocial factors and immune function in pregnant AA women.

REDUCING DISPARITIES IN VIOLENCE-RELATED MORBIDITY AND MORTALITY THROUGH THE ASSESSMENT OF PATTERNS OF PERPETRATORS' ABUSIVE BEHAVIORS

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Background: Intimate partner violence and homicide disproportionately affects women of color in the US. Reducing disparity in violence-related morbidity and mortality require effective strategies based in part on women's assessment of patterns of abusive behaviors perpetrated by the partner.

Objective: Determine unique patterns of perpetrators' abusive behaviors and explore if these patterns differ between perpetrators' of Latina and non-Latina abused women.

Methods: Data is from a larger study interviewing women on abusive behaviors perpetrated within the past year. Hierarchical cluster analysis was used to determine patterns of abuse across seven items (choked, forced sex, threats to kill, threats/use of weapon, stalking, control, jealousy) followed with K-means cluster and discriminant analysis to determine percent of cases correctly reclassified into clusters. Ethnicity was related to cluster membership and other study variables to validate interpretation.

Sample: Ninety-four adult women (56% Latina) who spoke English or Spanish and had been in an abusive relationship in the past year.

Findings: Based on the agglomeration schedule, percent classified, and interpretability, four mutually exclusive clusters representing unique patterns of abusive behaviors were extracted (92.6% percent of cases correctly reclassified into the clusters). The first cluster (N=26) characterized perpetrators who used all seven abusive items and was named pathological abuser. The remaining clusters were named based on predominate abusive behaviors; forced sex/controlling abuser (N=34), psychological abuse/controlling abuser (N=17), and physical violence/controlling abuser (N=17). The majority (85.3%) of Latina women

characterized her abuser within the forced sex/controlling abuser cluster. Latina women reported their perpetrators were significant less likely to use illegal drugs ($p=.002$), own a gun ($p=.005$), and be unemployed ($p=.024$) when compared to perpetrators of non-Latina women.

Conclusion: Findings are useful to clinicians, researchers and advocates working with diverse abused women to assess risk factors for violence and develop safety strategies to reduce disparity in morbidity and mortality.

WORK SITE PUBLIC-PRIVATE PARTNERSHIP: SUPPORTING NEW YORK CITY EMPLOYERS IN HEALTH PROMOTION EFFORTS

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Funded by the Centers for Disease Control and Prevention (CDC), the Cornell University Institute for Health and Productivity Studies, the New York City Department of Health and Mental Hygiene (NYC DOHMH), Thomson Medstat, and the Wellness Councils of America (WELCOA) have formed a private-public partnership to study and document how a public sector agency can effectively support New York City employers in their efforts to design, implement, and evaluate evidence-based health promotion and disease prevention programs. Ten New York City employers serve as study sites. This demonstration tests the incremental effects of high-intensity, comprehensive worksite health promotion interventions above and beyond interventions already being delivered by employers. Program impact will be assessed based on a number of critical success factors including health behavior, biometric measures, productivity, and health care utilization and cost. A return on investment (ROI) analysis is also planned. The project began in the Fall of 2004 and is scheduled to conclude in the Fall of 2007. This poster will review study results to date including formative research, the design of moderate and high intensity interventions using baseline data, the development of data collection tools, collection and analysis of baseline organizational and individual data (including health risk appraisal data: health risk profile, health care utilization and absenteeism, workplace performance) and current activities/next steps. Of the 31,535 eligible employees 5,539 responded to the health risk appraisal survey with the following demographics: 33.2% men, 68.8% women; 25.0% African American/Black, 13.3% Asian/Pacific Islander, 37.1% Caucasian/White, 17.8% Hispanic, 6.8% other or mixed race/ethnicity. This project highlights the importance of establishing partnerships across private and public sectors to provide evidence based health promotion and disease prevention programs for improving population health.

DISPARITIES IN ANTIDEPRESSANT USE AMONG COMMUNITY-DWELLING BLACK AND WHITE AMERICANS: RESULTS FROM THE NATIONAL SURVEY OF AMERICAN LIFE AND THE NATIONAL COMORBIDITY SURVEY REPLICATION

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Background: Nationally, spending for antidepressant drug use has increased rapidly. We know little, however, about the distribution of antidepressant use among community-dwelling Black and White Americans.

Methods: The prevalence and correlates of antidepressant use by Blacks and Whites in the U.S. were obtained from two independent, national probability sample surveys (2001 to 2003) of Blacks (National Survey of American Life) and non-Latino Whites (National Comorbidity Survey Replication). The structured Composite International Diagnostic Instrument using Diagnostic and Statistical Manual of Mental Disorders IV criteria were used to ascertain anxiety and depressive disorders. Antidepressant use was assessed by self-report and inventories of pill bottles. The correlates of antidepressant use were examined with bivariate and multivariate regression analyses. Independent samples were compared using large-sample Z-tests.

Results: Among individuals with major depression, Blacks (13.4%) had significantly lower ($p < .0001$) antidepressant use than Whites (41.1%). Blacks (59.8%) and Whites (48.2%) not meeting criteria for the psychiatric disorders examined used most antidepressants. Many Blacks (7.1%) and Whites (15.5%) with chronic medical conditions used antidepressants. Psychiatric disorders and medical conditions increased the odds of antidepressant use; however, antidepressant use by those with medical conditions was independent of diagnosable psychiatric disorders.

Conclusions: Few White, and fewer Black Americans, with psychiatric disorders receive pharmacotherapy. Most antidepressant use occurred in Blacks and Whites without psychiatric disorders. Antidepressant use was associated with chronic medical problems, but was independent of coexisting psychiatric conditions. These results suggest disparate mental health treatment between Black and White Americans. The rapid rise in antidepressant prescriptions may be related to uses other than their primary clinical targets, artificially inflating costs for mental disorder treatment.

TIMELY COLORECTAL CANCER SCREENING IN AFRICAN AMERICANS

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Background: African Americans have low rates of colorectal cancer (CRC) screening, and little is known about factors influencing their participation. This study sought to identify biological, psychosocial/behavioral, and social factors that predicted timely CRC screening (i.e. completion of risk-appropriate tests within a recommended time frame) in African American (AA) men and women aged > 40 in Maryland.

Methods: Using the Biopsychosocial (BPS) Model, data from 580 AA participants in the 2002 Maryland Cancer Survey (MCS) were examined in a secondary analysis to determine whether biological (age, gender, CRC family history), psychosocial/behavioral (mammogram and prostate specific antigen [PSA] screening history, body mass index, activity level, fruit/vegetable consumption, alcohol, smoking, cancer concern, cancer perceived risk, perception of familial cancer), and social (education, employment, insurance, access to healthcare provider [HCP], and HCP recommendation of fecal occult blood test and/or sigmoidoscopy/colonoscopy) factors predicted timely CRC screening. Simultaneous, hierarchical block, and stepwise entry logistic regression analyses of individual and grouped variables were conducted.

Results: For individuals without a family history of CRC (n=473), HCP recommendation of fecal occult blood test (OR 11.90, 95% CI: 6.84, 20.71) and sigmoidoscopy/colonoscopy (OR 7.06, 95% CI 4.11, 12.14), moderate/vigorous activity (OR 1.70, 95% CI: 1.02, 2.82), and history of PSA screening (OR 2.81, 95% CI 1.01, 7.81) predicted timely CRC screening. For individuals with a family history of CRC (N=86) recommendation of sigmoidoscopy/colonoscopy (OR 24.3, 95% CI 5.30, 111.34) and vigorous activity (OR 5.21, 95% CI: 1.09, 24.88) predicted timely CRC screening. CRC family history did not predict screening when age, education, and insurance were controlled.

Conclusions: HCP recommendation was the most important predictor of timely CRC screening, regardless of family history of CRC. Investigation of other potential predictors of screening not available in the MCS dataset and socioeconomic and other variables that limit access to HCPs is warranted.

DO DIFFERENCES IN SLEEP DURATION HELP EXPLAIN RACIAL DISPARITIES IN HEALTH?

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Study Objectives: To investigate whether sleep duration varies by race/ethnicity.

Background: The significant life expectancy gap¹ between blacks and whites can be attributed to a variety of medical causes: infant mortality,² cancer screening and management,³ cardiovascular disease,⁴ diabetes,⁵ HIV/AIDS infections,⁶ and immunizations.^{7, 8} However, the social determinants underlying these explanations are unclear, and cannot be fully explained by differential health behaviors or access to care. Recent objective sleep data show that black men and women spend less time in bed, get less overall sleep, have less sleep efficiency, and have higher sleep latency than their white counterparts.⁹ While shorter sleeping among blacks may help explain associations between race and health, this overlooks other literature on sleep that suggests that “overly” long sleeping is also associated with increased morbidity and mortality.¹⁰⁻¹⁷ We respond to this by allowing both short sleeping and long sleeping to be pathways to poor health. **Methods:** With data from 32,184 respondents in the nationally representative National Health Interview Study (NHIS), we estimate a multinomial logistic regression that predicts short, mid-range, and long sleep behavior including covariates for race/ethnicity, among an extensive set of socioeconomic, demographic, health, and neighborhood characteristics.

Results: Black respondents have an increased risk of being short and long sleepers (OR=1.54, $p < .001$ and OR=1.57, $p < .05$, respectively) relative to the white respondents. Hispanics (excluding the Mexican Americans) and Other non-Hispanic racial category is also associated with increased risk of short sleeping (OR=1.40, $p < .01$ and OR=1.37, $p < .01$, respectively). About half of the racial difference is explained by adding controls for residence in city centers, perhaps due to excess noise, pollution, segregation, or other stressors associated with city-living. **Conclusions:** Blacks and other minorities have sleep durations that are associated with increased mortality. Our results support the hypothesis that unhealthy sleep patterns among minorities may contribute to health differentials

Note: Edited version. Please contact the author(s) for the full content of this abstract.

PREDICTORS OF DEPRESSION IN LOW-INCOME AFRICAN AMERICAN SINGLE MOTHERS

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Purpose: To test a model of predictors of depression in low-income single African American mothers with children from 2 to 6 years of age. Design: A secondary analysis of existing data was conducted using data from the NINR-funded study by Drs. Peden, Hall, and Rayens, "Prevention of Depression in Low-income Single Mothers" (Grant #R01 NR05065). Data for that study were collected between September 2000 and October 2002 as part of the baseline data collection for a randomized controlled clinical trial. A total of 205 women at risk for depression participated. Forty-eight percent of those women were African American ($n = 98$), and the data collected from those women were used for this secondary analysis.

Methods: Path analysis was used to test a model of predictors of depressive symptoms with chronic stressors, general health status, self-esteem, and negative thinking included and negative thinking as a potential mediator. Findings: Sixty-three percent of the women scored 10 or above on the BDI, which is indicative of at least mild depression. More than 40% of the sample had BDI scores of 18 or above; scores in this range correspond to depressive symptoms that are moderate to severe. In addition, the women had highly positive self-esteem scores. The final path model included chronic stressors and self-esteem, with negative thinking as the mediator. Negative thinking totally mediated the relationship between chronic stressors and depressive symptoms and self-esteem and depressive symptoms. Conclusions: These findings support the theoretical framework underpinning the study. Negative thinking is an important factor in the development of depression for these vulnerable women. Both self-esteem and negative thinking should be important considerations in designing interventions to improve the mental health of at risk African American women. Self-esteem is strength of African American women. Further exploration of this is warranted. These findings may be used as the basis for further research and for the development of culturally sensitive, empowering interventions that improve the mental health of African American women.

PREVENTING DISPARITY-GENERATED INJURY THROUGH PROFESSIONALS OR PROMOTORAS?

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Monolingual Spanish – speaking populations are underserved related to language and other barriers with children suffering disproportionately from childhood injury. The purpose of this research was to compare delivery of culturally-appropriate home visit interventions with non-English speaking (NES) populations in randomized studies conducted in New Mexico and Texas. Although the value of lay health workers (LHW) has increased over the past decade and is the recent topic of a Cochrane review, the literature lacks any systematic review of collaboration with Spanish-speaking LHW known as promotoras. Effect sizes are “equated” for differences in sample sizes in two studies to compare safety intervention outcome measures following two studies, one with visits conducted by a RN, the other with visits conducted by promotoras.

A pre- and post-test experimental design tested differences in maternal self-efficacy for home safety behaviors and controllable hazards between mothers who did or did not receive a visit intervention. Mothers were clients of agencies serving those at or exceeding 185% of the poverty level. These mothers were then randomized to one of two groups. The intervention included a home hazard assessment, teaching, anticipatory guidance related to injury prevention and safety items. Several outcome measures included: self-efficacy for home safety behaviors, CES-D, and controllable hazards scores from the baseline home visit to the third and final visit.

Developing the knowledge base for serving vulnerable populations is crucial to applying research methods and results across populations and settings. The goal is to best serve a monolingual population experiencing health disparities and threatened by an often preventable etiology plaguing neglected populations, injury.

RACE-BASED DISPARITIES IN PATIENTS' CONCERNS OVER UNDERSTANDING CANCER DIAGNOSIS AND TREATMENT PLAN: A URCC CCOP RESEARCH BASE STUDY.

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Backgrounds: Studies that examined the roles of socio-demographics in illness perception and healthcare communication among cancer patients are relatively absent.

Methods: The sample included 973 (904 whites, 69 non-whites) patients undergoing treatment for cancer at 20 geographically separate sites. Concerns over understanding the diagnosis and treatment plan were assessed on a 5-point scale (“1=no concern” to “5=a great deal of concern”). Patients were also asked if: a) whether or not information was available to them, b) if yes, did they use it or not, and c) would more information have been helpful, were also assessed. Analyses: χ^2 were conducted to examine group differences in education, occupation, and perception of availability and utilization of information. ANCOVAs were performed to examine the role of race in concerns over understanding the diagnosis and treatment plan. Logistic regressions were conducted to assess the predictive power of race, adjusting for the other demographics.

Results: χ^2 showed no significant difference between whites and non-whites in education and occupation ($P > .05$). Subsequent ANCOVAs showed significant group differences, in concerns over understanding the diagnosis ($F(1, 967) = 9.13, p = 0.003$) and treatment plan ($F(1, 967) = 7.95, p = 0.01$), adjusting for education, occupation, age, and gender. Additional χ^2 showed significant group-differences in indications that more information would have been helpful ($p < .05$). More non-whites (70.3%) than whites (53.1%) indicated that additional information would have been helpful to understanding the diagnosis. Similarly, more non-whites (69.4%) than whites (53.4%) indicated that additional information would have been helpful to understanding the treatment plan. Logistic regressions showed race significantly predicted patients' indications that more information would have been helpful to understanding the diagnosis (OR = 1.96, 95%CI = 1.12, 3.42) and treatment plan (OR = 1.84, 95%CI = 1.05, 3.22).

Conclusion: The findings underscore the need for oncology professionals to consider and integrate information about socio-demographics in their treatment intervention and communication with non-white patients.

REGULAR ALCOHOL USE TO DEPENDENCE: SUBSTANCES USED IN A COHORT OF URBAN AFRICAN AMERICANS

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Introduction: Progression from regular consumption of alcohol to a diagnosis of alcohol dependence often involves multiple drug use. It is especially important to understand how this progression occurs in African Americans as they are disproportionately affected by negative outcomes of drug use.

Objective: The purpose of this study was to examine the sequence of regular drug use in a cohort of African Americans.

Methods: Data from 411 adult African Americans was analyzed. The mean age of onset of regular drug use was ranked for alcohol, tobacco, marijuana, cocaine, opiates, sedatives, stimulants, and any other drugs reported. Spearman’s rho assessed the correlation between ranks for alcohol dependent and non-dependent participants. T-test indicated differences in age of regular use between alcohol dependency groups for each drug. Adjustments were made using the Bonferroni correction.

Results: Generally, regular drug use began with marijuana (mean age= 18.52 years) and ended with use of cocaine (mean age =28.30 years). Progression from one drug to another was similar regardless of alcohol dependency status ($R_s=.91$, $p<.01$). Differences were seen in the age of regular use of alcohol and, to a lesser degree, marijuana. Alcohol dependent participants had an earlier age of regular use of alcohol compared to the non-dependent participants (18.25 years vs. 22.12 years, $p<.01$). Additionally, alcohol dependent participants began using marijuana earlier than non-dependent participants (17.59 years vs. 20.17 years), but this difference was not statistically significant after adjusting for multiple drug use.

Conclusion: While sequence of regular use appears similar between alcohol dependency groups, this study demonstrates that age of onset of regular use may vary for specific drugs. In African Americans, age of regular use, rather than the sequence in which co-occurring substances were used, may play a greater role in development of alcohol dependence.

INFLUENCE OF TYPE OF SITE-SPECIFIC CANCER SCREENING ON LIKELIHOOD OF PARTICIPATION IN CANCER SCREENINGS: BLACKS VS WHITES VS PUERTO RICAN HISPANICSRV KATZ¹, NR KRESSIN², BL GREEN³, C. CLAUDIO⁴, MQ WANG⁵, ANDSL RUSSELL¹

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Introduction: The purpose of this analysis of the 3-City Cancer Screening Study was to compare the influence of site-specific type of cancer screenings on the self-reported comparative likelihood, for Blacks, Whites and Puerto Rican Hispanics, to participate in cancer screening exam events. Material and

Methods: The Cancer Screening Questionnaire, an instrument developed within the NYU Oral Cancer RAAHP* Center (* = Research on Adolescent and Adult Health Promotion), an NIDCR/NIH U54 Oral Health Disparities Center, was administered via random-digit dial (RDD) telephone interviews by ORC Macro, Inc to adults in three cities: New York City, NY; Baltimore, MD; San Juan, PR. Results: A total of 1,148 interviews were completed (30.9% Blacks, 27.1% Puerto-Rican Hispanics, and 42.0% Whites) with a response rate of 50%, and a completion rate of 84%. For 10 different site-specific type of cancer screenings, the findings showed that: 1) the range of likelihood of participation, for all racial/ethnic groups combined, was highest for the sex site specific cancer screenings (93% for breast cancer and 85% for prostate cancer) with a low of 70% for oral cancer, 2) when compared to Whites, PR Hispanics were 1.6-2.5 times as likely to indicate likelihood of participation for 7 site-specific cancers (95% CI excluded 1.0), and Blacks were 1.8-2.0 times as likely for 4 site-specific cancers (95% CI excluded 1.0); and, 3) only for skin cancer screenings were Blacks less likely than Whites to indicate likelihood of participation (OR=0.5, 95% CI 0.4, 0.7).

Conclusions: The findings show that both Blacks and PR Hispanics were more likely than Whites to indicate a likelihood to participate in cancer screenings for most different site-specific cancers, and that oral cancer screenings ranked lowest among 10 site-specific types of cancer screenings.

LIMITATIONS OF SURVEY RESEARCH IN UNDERSTANDING HEALTH DISPARITIES

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Background: Community-based participatory action research (CBPR) can have a significant impact on health disparities, by increasing understanding of problems and informing interventions. Familias en Accion, an NIH-funded intervention, is addressing violence, a major cause of health disparity for low-income communities. In our first year of funding, academic researchers paired with a local organization representing parents, school officials and community leaders to conduct a baseline community survey.

Methods: A survey of 228 randomly selected households in a Hispanic school district was conducted to determine baseline attitudes about violence. Interviewers were 23 community members who received 12 hours of training in IRB protections and survey collection methods. Interviewers provided field notes, oral feedback and photographs of their work. We compared statistical analysis of the survey data with a qualitative analysis of this material.

Findings: In the initial analysis, key differences between the quantitative and qualitative analysis were present in 3 areas: substance abuse problems, gun ownership, and community self-efficacy. For example, 7 respondents (3.1%) acknowledged alcohol, and 5 (2.2%) acknowledged substance abuse as a serious problem in their families, the qualitative data provided by the interviewers and their field notes about the environment revealed at least twice as many respondents' families had these problems.

Conclusion: In this CBPR project, information provided by community interviewers provided a richer picture of the problems faced by the community than the results of the quantitative analysis alone, which was particularly apparent in several key areas. Survey data, even when collected by carefully trained data collectors from the community, is subject to bias arising from the unwillingness of people to share potentially embarrassing information, and thus have minimal validity. Triangulation of both quantitative and qualitative data may be necessary for researchers to accurately understand community attitudes and also to correctly assess the impact of health disparities interventions.

DETERMINANTS OF BETWEEN AND WITHIN GROUP HEALTH INEQUALITY IN THE US

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Using information on self-assessed health and several different diseases/risk factors and socio-demographic characteristics we estimate an index of individual health in an Ordered Probit framework in which the unobserved threshold parameters are scaled to control for heterogeneity. Gini coefficients and Lorenz curves are utilized to measure health inequality (Kakwani et al., Journal of Econometrics 1997) along several dimensions. In addition, health-adjusted life expectancy (HALE) is computed based on the estimated index and U.S. life table. To be useful for policy purposes, the health inequality is decomposed into its determinants for different racial/ethnic groups as well as for different states (cf. van Doorslaer and Jones, Journal of Health Economics 2003). The data used in this study comes from the Behavioral Risk Factor Surveillance System over 1999-2004. Since information on all diseases/risk factors were not collected in all years for all states, we impute missing values using a Bayesian MCMC multiple imputation method to avoid model misspecification.

In terms of the average quality of health and health inequality, American Indian/Alaskan Native and Hispanic groups are found to be the worst, whereas Kentucky and West Virginia lag behind the rest of the states. Compared to the CDC procedure, the minority disparity indices reported in this paper are found to be more robust with respect to alternative definitions of good health. Four major contributing factors to health inequality are found to be employment status, education, income, and age. However, the importance of each of these factors varies considerably among racial/ethnic groups as well as across states. The strongest contributor to health inequality for Blacks, Hispanics, and AIANs is employment status, whereas age is the most dominant factor for Whites and Asians. These results suggest that public health initiatives to reduce health inequality should be targeted differently for different racial/ethnic groups and regions in the US.

**OPERATION CHURCHBEAT
DEVELOPING A MODEL “CHAIN OF SURVIVAL” COMMUNITY THROUGH FAITH-BASED PROGRAMS IN A PREDOMINATELY AFRICAN-AMERICAN URBAN NEIGHBORHOOD**

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Outcomes related to heart disease and disparities support the need for community-based programs targeting high-risk groups such as African-Americans. This pilot study evaluated the effectiveness of a faith-based education program on participants’ knowledge, skills, and willingness to respond effectively to cardiac emergencies (heart attack/sudden cardiac arrest). Specific aims included increased: 1) knowledge of risk factors for heart disease and early recognition of symptoms; 2) self-reported actions in a cardiac emergency; 3) willingness to respond to cardiac emergencies; and 4) ability to perform CPR (with AED). The long-term goal was to develop a model “Chain of Survival” community.

This project used a quasi-experimental, before-after design with participants as their own controls. Approximately 142 adults from ten churches in an African-American urban neighborhood completed the Lay Assessment Survey (Lockhart, et al., 2002) prior to/following a culturally appropriate educational program conducted at each church. The program was based on American Heart Association (AHA) standards. Sessions were designed, implemented, and evaluated with respective ministers/health ministry leaders. Focus groups after each program evaluated program outcomes, refined study procedures, and assessed learning needs. To sustain the project, three members from each church were trained as AHA CPR instructors; each church was given equipment, supplies, and educational materials to conduct future CPR sessions.

Significant changes occurred in participants’ knowledge: increased sodium intake as risk factor ($p = .047$), recognizing symptoms of jaw pain ($p=.007$), indigestion ($p=.003$); actions: calling 911 in an emergency ($p=.000$); recognizing 911 as a first step ($p=.00$). CPR

performance varied. Focus groups revealed expressions of confidence, comfort with CPR, empowerment, and perceptions of comfortable learning environment. Focus group at one year revealed continued interest and need for coaching. Operation Churchbeat has the potential to improve health outcomes related to cardiac emergencies in African-Americans and to assist other community leaders in developing similar initiatives.

This project was partially funded through a Commonwealth Universal Research Enhancement (CURE) Grant, PA Department of Health

NONLINEAR MIXED-EFFECTS DYNAMIC MODELS WITH INCORPORATING CLINICAL FACTORS AND COVARIATES: A BAYESIAN APPROACHTAO LU,¹ YANGXIN HUANG,¹ AND HULIN WU²

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In last decade, many mathematical models describing HIV dynamics have been proposed to investigate the pathogenesis of HIV infection as well as treatment strategies. However, most of them can only be applied to short-term viral dynamics. Until recently, a hierarchical Bayesian modeling approach under a non-linear mixed-effects (NLME) model framework was proposed to characterize the long-term viral dynamics with antiretroviral therapy. In this paper, we not only incorporate time-varying antiviral drug efficacy (drug concentration, adherence and drug susceptibility), but also individual baseline characteristics, such as individual-specific viral load, CD4+ T-cell count, age, weight, into the model. Simulation results show that the parameter identifiability problem was successfully avoided by taking fix-effect for baseline characteristics while simultaneously random-effect was treated for others in stage 2 of our Bayesian implementation.

We further apply the methodology to a real data set from an AIDS clinical trial. Our results suggest a relationship between baseline characteristics and antiretroviral drug efficacy.

KEY WORDS: Bayesian mixed-effects models; Non-linear differential equations; longitudinal data analysis; Antiretroviral drug therapy; Pharmacokinetics; Pharmacodynamics; drug exposures; drug resistance; HIV dynamics; HIV clinical trial; MCMC; parameter estimation.

NEIGHBORHOOD SOCIAL CONTEXT, ACCULTURATION, AND CULTURAL ALIENATION IN IMMIGRANTS FROM THE FORMER SOVIET UNION

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The purpose of this study is to examine relationships among neighborhood social context, acculturation, and alienation for recent immigrants from the former Soviet Union (FSU). Immigrants' neighborhoods provide the context for the way they adjust to life in a new country, but few studies have studied neighborhood social context in relation to post-migration adjustment and mental health. Methods: An ecological model of immigrant adaptation guided the study. Questionnaires were mailed to a cohort of women who recently completed a four-year longitudinal study of acculturation and health; 80% (n=151) were returned. Using geographic information system (GIS) software, each participant's address was geocoded to identify her census tract, which served as neighborhood proxy. Ethnic composition was estimated using two indicators from the 2000 Census: percent residents reporting Russian as primary language and percent non-U.S. citizens. Social context was also measured by self-reported sense of community and social support from friends and neighbors. Self-report instruments assessed acculturation and alienation. Results: Mean age was 62.50 (SD 8.79), and mean time in US was 8.45 years (SD 8.45). A hierarchical Ordinary Least Squares (OLS) regression analysis was conducted. Variables were entered into the regression in 3 steps: demographic (age; time in US), social context, and acculturation. Social context variables account for 25% of the variance in alienation: specifically, lower sense of community and lower social support, proportionately fewer non-US citizens, and proportionately more Russian-speaking residents predict higher alienation. Acculturation variables account for another 25% of variance: lower American and Russian identity, lower English language, and higher Russian behavior predict higher alienation. Demographic variables were not significant in this model, which explains 57% of the variance in alienation. Conclusions: Neighborhood social context and acculturation contribute to cultural alienation in complex ways. Understanding contextual factors that affect alienation will facilitate interventions targeting individuals and communities at risk.

SEPARATE AND UNEQUAL: THE QUALITY IMPLICATIONS OF RACIAL SEGREGATION IN NURSING HOMES

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This study examines the racial segregation of nursing home care in the U.S. and its effect on racial disparities in the access to care and quality of care nursing home residents receive. We use the national repository of Minimum Data Set (MDS) resident assessments in 2000 that provides demographic information, including race on nursing home residents, and the Online Survey Certification and Reporting System (OSCAR) that provides information on nursing home quality. Our findings suggest that across the Metropolitan Statistical Areas (MSAs) nursing home care remains segregated, as indicated by relatively high levels on the Index of Dissimilarity, and largely mirrors patterns of residential segregation. There is a great extent of concentration of Blacks in relatively few nursing homes, with almost 80% of Blacks residing in 20% of all facilities nationally, and this pattern persists in most metropolitan areas. Facilities highly concentrated with Blacks are more likely to suffer operational problems such as poorer payer mix, more deficiencies, lower occupancy, understaffing, and ultimately termination from the Medicare/Medicaid programs—all hindering the provision of quality. In contrast to past patterns of more limited use, Blacks use nursing homes at higher rates than Whites in almost all metropolitan areas (on average, at a ratio of 1.33). However, the segregation of nursing home care results in Blacks entering poor-quality nursing homes and receiving poorer quality care in most metropolitan areas. Since nearly all nursing homes and all nursing home residents in the U.S. are included in the databases used in this study, our findings make it possible to assess patterns of segregation and disparities in access and quality at the local area level creating a degree of local accountability.

Note: Edited version. Please contact the author for full content of this abstract.

EPIDEMIOLOGY OF RACIAL DIFFERENCES IN CIGARETTE SMOKING AMONG ADOLESCENTS AND YOUNG ADULTS IN THE U.S: ANALYZING POTENTIAL EXPLANATORY FACTORS AND FIVE YEAR TRENDS

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Considerable variations exist in drug use rates among racial and ethnic groups. African American adolescents and young adults report cigarette smoking at a significantly lower rate than other racial groups of comparable ages. Understanding factors which may explain these differences in cigarette smoking may provide insight into effective prevention strategies for this gateway drug, and can have policy implications for promoting and reinforcing healthful behaviors in different settings.

We analyzed five years of data on cigarette smoking (12 month and 30 day prevalence) among 12-23 year olds to examine the distribution of several prevention activities which might explain the variations in the relationship between race and cigarette smoking. We selected participants from the National Survey of Drug Use and Health (NSDUH) for each year between 2000 and 2004. We compared smoking among Non-Hispanic Whites, African Americans, and Hispanics. We included health factors and prevention behaviors available for analysis in all the 5 years to evaluate their potential mediating or moderating role on race-cigarette smoking relationships while controlling for confounders of smoking. The NSDUH, a multi-stage area probability sample survey by the DHHS provides annual estimates of drug use and their correlates for individuals 12 years and older. Prevalence of smoking was the lowest for African Americans followed by Hispanics and non-Hispanic Whites ($p < 0.01$). Smoking also increased with age ($p < 0.01$). Significant differences in smoking were observed between races within each age group. Participation in greater number of prevention activities (problem solving and prevention programs participation) was significantly associated with lower smoking rate ($p < 0.01$) in each age-race-year stratified group.

Racial differences persisted when the prevention activities were introduced individually or in a composite form, along with demographic and antecedent factors in multivariate models. New models are being developed to explore the role of economic and mental health variables.

**SOCIOECONOMIC STATUS DISPARITIES IN COLONIZATION WITH PERIODONTAL PATHOGENS:
DO SMOKING, FLOSSING, OR PROPHYLACTIC CLEANINGS ACCOUNT FOR THIS DISPARITY?
A STUDY FROM THE CENTER FOR ORAL HEALTH RESEARCH IN APPALACHIA**

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The burden of periodontal disease is not carried equally by all persons in society. The risk of chronic periodontal disease is greater among people lower in income, education, and occupational status (i.e., socioeconomic status). Previously, we showed that the income-related disparity in the presence of periodontal probing depths is driven by a disparity in colonization by periodontal pathogens. The purpose of the present study is to determine the degree to which this disparity can be accounted for by smoking, flossing, or receiving regular prophylactic cleanings. The sample included 319 persons age 25 – 45. We excluded persons who had diabetes mellitus; who required premedication with antibiotics; who were taking medications that altered immune function; or who had previously received surgery for periodontal problems. We assessed the presence of periodontal pathogens at 4 sites in the mouth using the BANA test. In addition via interview and self-report questionnaire, subjects reported their household income, smoking behavior, flossing behavior, and receipt of prophylactic cleanings. Generalized estimating equations were used, nesting observations within participants and participants within families. Household size was included as a covariate. As expected, the probability that a site was colonized was higher among those with lower household income. When we added smoking, flossing, and receipt of regular prophylactic cleanings to the model, household income continued to be associated with colonization. However, smoking, flossing, and receipt of regular prophylactic cleanings were not associated. This pattern of associations suggests that the disparity in periodontal health due to income cannot be accounted for by smoking, flossing, or receipt of regular prophylactic cleanings. Future studies should examine alternative pathways through which the socioeconomic status disparity may occur, such as psychosocial stress.

RURAL NATIVE AMERICAN COMMUNITY-BASED ORAL HEALTHCARE PROGRAM REDUCES CARIES IN PRESCHOOL CHILDREN

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Rural Native American preschool children rarely receive dental treatment and as a result have one of the world's highest prevalence and severity of Early Childhood Caries (ECC).

Objective: To eliminate the disparity of preschool dental caries (ECC) on the Native American Reservations in western US.

Hypothesis: Tribal allied health professionals, who have specific training in oral disease prevention, can be utilized to implement and sustain an oral disease prevention program that is effective in a rural Native American population – Community Oral Health Specialists (COHS).

Methods: Tribal health departments hired community members to provide prevention services and they managed the day to day operations of the program. COHS completed a 120 hr training program that included both didactic and clinical sessions.

The training curriculum content included: preventive dentistry, patient behavioral modification, nutrition, charting & coding, HIPAA training and fluoride varnish application. Children, ages 0 to 4, were enrolled and were provided fluoride varnish 4X per year. Toothbrushes, floss and toothpaste were provided to the entire family along with oral health and nutrition instruction. Community-based oral health education included radio, TV, newspapers, country fairs & powwows.

Results: A random sample of 100 children was followed to evaluate the success of the program. Calibrated dental examiners performed baseline caries status exams. Eighteen month follow-up exams were completed at one of the tribal communities. Children who were under 3 years old at the time they enrolled in the program were re-examined. Using baseline examinations as a comparison there was a 50% reduction in caries prevalence and a 50% reduction in untreated decay.

Conclusion: When provided with technical knowledge and skills, specially trained community members can implement and maintain a program effective in reducing ECC.

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INTEGRATING THE SOCIAL AND BEHAVIORAL SCIENCES IN UNDERGRADUATE MEDICAL EDUCATION AS A METHOD OF ADDRESSING HEALTH DISPARITIES

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Background: There is a lack of sufficient training to prepare physicians to meet the rapidly evolving healthcare needs of diverse communities. Training to understand and alter the social and behavioral determinants of health is one strategy to improve quality and eliminate racial/ethnic disparities in health care.

Objectives: 1. Identify essential social and behavioral science (SBS) content and optimize its instruction in medical school. 2. To address health disparities by providing relevant training on cultural competence and cross-cultural issues to medical trainees.

Program Description: This five year, NIH funded curriculum development project builds on the IOM's 2004 report on SBS in medical education, which suggests inclusion of 6 priority SBS content areas: mind-body interactions, patient behavior, physician role and behavior, physician-patient interactions, social and cultural issues, and health policy and economics. SBS "building blocks" are being developed for all years of the curriculum and placed in an appropriate longitudinal teaching plan to create the "ideal" SBS curriculum.

Findings to Date: We assessed the quality of the current 4-year undergraduate medical curriculum by comparing the "ideal" SBS content per IOM report with "actual" content using multi-component curriculum mapping. SBS skill-based competencies were created and the importance of topics was rated by a panel of national experts. Our survey of national experts yielded a response rate of 37% (n=204). Survey results will be used to revise and further develop, implement and evaluate skill-based competencies including cultural competency over the next 4 years. Conclusions: The creation of an SBS curriculum based on national standards and integrated across all four years may facilitate adoption and improve the translation of SBS basic concepts into clinical practice. Such training of future physicians will create the cultural shifts required to better meet the medical needs of diverse populations.

**PROCESS AND OUTCOME EVALUATION OF THE NASHVILLE REACH 2010
COMMUNITY-BASED PARTICIPATORY RESEARCH PROJECT TO REDUCE DISPARITIES
IN NORTH NASHVILLE**

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The Nashville REACH 2010 project is funded by the CDC to reduce health disparities in diabetes and cardiovascular disease among African Americans living, working, worshipping, or attending school in North Nashville, TN. The project was planned and implemented by a coalition including a community health center, the faith community, the Health Department, and several local universities (Fisk, TSU, Meharry, Vanderbilt).

Evaluation includes process evaluation, using an innovative web-based data collection tool, and outcome evaluation, using a series of random telephone surveys. Process evaluation allows us to track events over time including capacity building, planning meetings, community outreach, media coverage, coalition resources, and systems changes. To date, over 9,500 forms -- including 2,000+ meetings and 1,600+ community events -- have been documented allowing us to perform detailed tracking of coalition activities over time. We are using the following phone surveys to track outcomes over time: REACH baseline (2000-2001, n = 3,014), REACH follow-up (2004, n = 1,538); Nashville BRFSS survey (2001, n = 5,749); National Opinion Research Center North Nashville Surveys (2001, n = 918; 2002, n = 905; 2003, n = 912; 2004, n = 944); and the Tennessee BRFSS surveys (2001, n = 2,924; 2002, n = 3,207; 2003, n = 2,589; 2004, n = 3,782). We have used these data to estimate disparities in health behaviors and health outcomes and to track changes in disparities over time. We have also used Geographic Information System software and Census data to understand how neighborhood differences and environmental conditions contribute to health disparities. Examples of data looking at process, outcome, and geographic analysis of disparities will be presented. The Nashville REACH project is an example of a successful collaboration of behavioral scientists with a diverse community coalition.

ETHNIC DIFFERENCES IN HIGH-RISK BEHAVIORS AMONG HEROIN USERS REPORTING A HISTORY OF INJECTION DRUG USE**GEOFF SEVERTSON AND WILLIAM LATIMER**

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Previous research suggests that while African Americans report less substance use overall; problem use and infectious disease rates tend to be higher among African American drug users. However, recent research in Baltimore, MD has found a higher prevalence of Hepatitis C among White substance users, whereas rates of HIV were more prevalent among African Americans. The current study sought to explore possible reasons for these differences with respect to risk factors among intravenous drug users reporting heroin as their drug of choice. The current study is based on data from the International Neurobehavioral HIV Study, an epidemiological examination of neuropsychological, social, and behavioral risk factors of HIV, and Hepatitis A, B, and C in the U.S, South Africa, and Russia. The total U.S. sample consists of 632 injection and non-injection drug users between 15 and 50 years of age in the Baltimore region. The sample of the present study was limited to 228 individuals with a reported history of injection drug use. Thirty percent were African American and 61.0% were male. Results indicated ethnic differences in the progression of and risk factors associated with injection drug use. Findings indicated that whites tended to progress from marijuana use to injection heroin use faster than African Americans (HR =1.44, 95% CI: 1.07-1.94). With respect to high risk behaviors, Whites were more likely to report injecting with a used needle (OR=2.76, 95% CI: 1.44-5.29) than African Americans. However, African Americans were more likely to report participation in sexual exchange (OR=2.42, 95%: 1.28-4.55). Current findings are consistent with observed differences in infectious disease prevalence. Findings are discussed with respect to different social and neighborhood contexts within Baltimore that may explain differences in the progression of drug use, and consequently, ethnic differences in risk factors for infectious disease among injection drug users.

AN EXAMINATION OF THE PREVALENCE OF PERCEIVED RACISM AND ITS ASSOCIATION TO CANCER RELATED HEALTH BEHAVIORS ACROSS AGGREGATE RACIAL/ETHNIC GROUPS

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Background: Applications of social justice frameworks to racial/ethnic cancer health disparities have shifted attention from race as a socio-demographic characteristic to racism as a determinant of these disparities. Racism is hypothesized to contribute directly and indirectly to increased cancer risk behaviors and worse outcomes through multiple pathways including stress, social/material deprivation, access to health care, and environmental factors. In the US, this phenomenon has been primarily studied among African-Americans, with increasing attention to Hispanics and Asian Americans in the last decade.

Methods: This study examines the prevalence of perceived racism, self-reported exposure to racism, across aggregate racial/ethnic groups and identifies psychosocial characteristics as well as lifestyle and screening health behaviors associated with racism. This is a secondary data analysis of the 2003 California Health Interview Survey with weighted analyses conducted in SUDAAN to estimate population prevalence rates and odds ratios.

Results: The prevalence of perceived racism varied by racial/ethnic groups, ranging from 11.60% to 56.05% for some perceived racism in general and from 2.73% to 12.89% for perceived racism in health care. Associations were significant between perceived racism and several of the lifestyle behaviors as well as breast and cervical cancer screenings. In general, risk behaviors were positively associated with exposure to racism. However, these associations varied across racial/ethnic groups, with respect to both magnitude and direction of the associations.

Conclusions: The study findings provide population-based estimates of the prevalence of racism across the 5 major racial/ethnic groups and their associations with individual characteristics and cancer risk behaviors, which generate additional hypotheses about the mechanisms through which racism may affect cancer control behaviors and outcomes. Further research is needed to ensure that these measures are cross-culturally relevant. Expanding our understanding of racism and its effect on health behaviors will better position us to reduce the cancer burden in the US.

**CARDIOVASCULAR DISEASE RISK ASSESSMENT FOR ASIAN RESIDENTS
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Since Cardiovascular disease (CVD) is the leading cause of mortality and morbidity in Michigan as well as in the United States, efforts to improve quality of health services to prevent CVD for all Americans become more important. Although prevalence of CVD among Asian Americans (AA) has been reported to be lowest (5.4 %) in MI and size of this population is smaller than other racial groups, CVD has been known as the leading cause of death for AA yet not much is known about their risks and preventive behavior patterns. Therefore, AA minorities in Michigan deserve more attention from health care providers and researchers. In order to expand CVD screening opportunities to this marginalized group, Healthy Asian American Project (HAAP) of the University of Michigan provided several health fairs in Southeastern MI where 70% of the AA in MI live from year 2004 to 2006. This project aimed to assess CVD prevalence among AA and explore risk factors. Data of 195 AA aged 20 and older (mean age=60) were analyzed. Eighty-one percent of them had no health insurance, 77% had pre-hypertension or hypertension, 44% had borderline or undesirable total cholesterol, 27% had undesirable HDL, 51% were not physically active, and 19% were smokers. Framingham Heart Study, a risk assessment tool showed that the mean estimated risk level of having an MI in the next 10 years was 7.4% of 118 participants and the risk level is significantly higher in men ($t = -7.6, p < .01$). Multiple regression analysis indicated that age, gender, HDL, and availability of health insurance are significant predictors of the participants' risks (adjusted R square = .82). To improve access to health care and provide culturally competent preventive health services are urgent strategies needed to reduce risk factors of CVD and prevent MI among AAs.

TUBERCULOSIS (TB) PREVENTIVE BEHAVIORS OF A PATIENT RECENTLY DIAGNOSIS WITH PULMONARY TB IN SISAKET, THAILAND

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Individual and family factors affect TB preventive behaviors of people recently diagnosed with pulmonary TB. Model linking family stress, appraisal of TB, appraisal of TB prevention, family functioning, family coping efforts, and TB preventive behaviors was tested using data from 200 TB patients residing in the Sisaket province of Thailand for my dissertation. The model was tested by a confirmatory structural equation modeling (SEM) analysis using EQS program (Bentler, 1995). The SEM analysis provides simultaneous estimation of the hypothesized regressions using the covariance matrix generated on the basis of the observed covariance matrix of the variables measured.

The model I examined addresses the subsequent set of hypotheses: (1) Stress increases TB appraisal, family coping efforts, and appraisals of TB preventive behaviors; (2) Family functioning increases TB preventive behaviors but decrease family coping effort; (3) TB appraisal has a direct effect on TB preventive behaviors. Individuals who have high levels of perceived TB appraisal have better preventive behaviors than those whose level of perception is lower; (4) TB preventive appraisals increase family efforts to cope with TB illness and TB preventive behavior. When a person perceives that TB prevention would be beneficial to the family wellbeing, he or she will put more efforts to engage in TB preventive behaviors; (5) TB preventive appraisal has a positive relationship with family coping and TB Preventive Behaviors; (6) Family coping effort has a positive effect to TB preventive behaviors, and (7) The relationship between TB preventive behaviors and family coping efforts is due to the influence of TB appraisal, TB prevention appraisal, and family functioning on these variables.

THE IMPACT OF HERBAL REMEDIES ON THE TIMELY DELIVERY OF HEALTH CARE FOR RURAL AFRICAN-AMERICAN CHILDREN

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Background: The use of herbs by adult and elderly African-Americans has been well documented. However, little is understood regarding the use of herbs for African-American children and its impact on timely health care delivery. The purpose of this study was to describe the traditional health practices, types of herbal remedies, and hierarchy of resort used for children of African-American descent in a semi-rural southern US setting.

Methods: A focused ethnographic approach was used to describe the cultural context in which herbal remedies were used to treat rural African-American children. The setting for this study was in rural East Texas and the informants were chosen by a nominated sampling technique that started with two key informants knowledgeable about the use of home remedies for children.

Results: 15 herbal remedies were documented as being used by the informants of this study. These remedies were utilized prior to contact with any health care provider. The family and close social networks were considered the first line in prescribing herbal remedies for childhood illness, followed closely by elders and herbalist in the community. Since this hierarchy of resort was utilized, many African-American children were not seen in the health care system until four or five days after the initial onset of symptoms, thus they presented with worsening symptoms.

Conclusions: African-Americans have a rich history of herb use dating back to Africa. African-American children in this rural setting have received and continue to receive herbal treatments for health promotion and treatment of illness prior to entering the health care system. Health care providers not only must be familiar with the types of herbal remedies used but also must consult with their clients on when to use these remedies and the appropriate time frame for seeking medical care.

**A CASE OF NARROWING THE GAP?
EVIDENCE FOR DIFFERENTIAL EFFECTS OF THE CALIFORNIA ANTI-TOBACCO MEDIA CAMPAIGN
FROM 1990 TO 1993.**

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As researchers look for real ways to eliminate disparities, can health communication campaigns be used as tools to narrow the gaps which are often forged in formidable social problems? To answer this question, this study examines data from the California's Anti-Tobacco Media Campaign for possible evidence of gap narrowing in smoking prevalence between African Americans and white adults. This study also presents conditions where health campaigns will be most effective in narrowing health gaps.

The data used for the analyses are from the first three waves of the California Tobacco Surveys (CTS), conducted by the University of California, San Diego, the California Department of Health Services, and Westat, Inc. The surveys were administered in 1990-1991, 1992, and 1993 using RDD telephone surveys.

This study offers multiple pieces of evidence to support the claim that the California Anti-Tobacco Media Campaign was influential in decreasing gaps in smoking prevalence between African Americans and other racial groups. Most importantly, there is evidence to support the actual closing of the smoking gap between African American and white adults during the campaign. As shown in Table 1, there were clear differential declines in smoking status during the campaign period.

In addition, the findings suggest that there were differences in exposure to the campaign by race, with African Americans reporting 37% greater likelihood of campaign exposure. African Americans and young adults reported the greatest campaign exposure and also exhibited the greatest declines in smoking. We also found that these robust declines among African Americans were not replicated nationally.

While this study was not a formal evaluation of the California's Anti-Tobacco Campaign, it did attempt to explore differential effects of the health campaign on African Americans. Considering the evidence, this study suggests that health campaigns may be useful for addressing racial health disparities under certain conditions.

CULTURE, STRESS, AND HEALTH: EXAMINING EVERYDAY LIVES OF URBAN AFRICAN AMERICAN YOUTH

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Objective: Psychosocial stress may be an important mediator of racial and socioeconomic health disparities. However, this phenomenon is difficult to measure, and conventional approaches can preclude objective measurement of culturally relevant stressors in particular social contexts. This study employs innovative anthropological methods to operationalize culturally significant psychosocial stressors for African American youth.

Methods: This study employed cultural consensus methods to construct a cultural model of stress for African American youth in Maywood, Illinois – a predominantly African American community on the west side of Chicago. Data were collected in two phases from a total of 49 participants. The first phase involved 20 semi-structured ethnographic interviews in which locally meaningful stressors were elicited. The second phase involved a survey of 29 participants in which they rated the community-level relevance of each stressor on a 3-point scale. Cultural consensus analysis (CCA) was then used to determine the extent of participant agreement around the relative importance of each stressor.

Results and Significance: A coherent cultural model is considered to exist in CCA when the ratio of the first to the second eigenvalue is at least 3 to 1, indicating high inter-respondent agreement. This analysis revealed remarkably high participant agreement, with a ratio of 30 to 1 between the first and second eigenvalues. Average ratings for each stressor, weighted by their correlation with the confirmed consensus model, were computed to yield a list of twenty-four psychosocial factors agreed by respondents to be the most salient in their social context. This final list revealed a range of school, home, community, and peer-based psychosocial stressors that are highly significant in the everyday lives of these African American youth. Using these culturally relevant stressors to predict variation in mental and physical health will enhance understanding of psychosocial contributions to racial health inequalities.

DISPARITIES IN PREVALENCE AND CORRELATES OF ARTHRITIS-ATTRIBUTABLE WORK LIMITATION IN THE U.S. POPULATION AMONG PERSONS AGE 18-64, 2002 NATIONAL HEALTH INTERVIEW SURVEY (NHIS) DATA

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Purpose: Work limitation is an important measure of arthritis impact. We generated the first national prevalence estimates of arthritis-attributable work limitation (AAWL) among U.S. adults ages 18-64 and examined correlates of AAWL among those with doctor-diagnosed arthritis. **Methods.** We analyzed 2002 NHIS data (n=31,044), an annual interview-administered survey (conducted in English or Spanish) designed to be representative of the U.S. civilian, non-institutionalized population. Persons with arthritis were those responding “yes” to “Have you EVER been told by a doctor or other health professional that you have some form of arthritis, rheumatoid arthritis, gout, lupus, or fibromyalgia?” The prevalence and correlates of AAWL (limited in: whether you work, the type of work you do, or amount of work you do) was estimated among those with arthritis. Data were analyzed in SAS and SUDAAN, accounting for the complex sample design.

Results: 5.3% of all U.S. adults, and ~30% of those with arthritis reported AAWL. AAWL prevalence was highest among persons aged 45-64 years (10.2%), women (6.3%), non-Hispanic blacks (7.7%), those with less than a high school education (8.6%), or an annual household income of <\$20,000 (12.6%). In the multivariable modeling, we observed the odds of AAWL was moderately higher among non-Hispanic blacks (OR=1.7, 95% confidence interval (95% CI)=1.3-2.3) and Hispanics (OR=1.6, 95% CI=1.2-2.2) while decreased among those with a college education (OR=0.6, 95% CI=0.5-0.9) or annual household income ≥\$20,000 (OR=0.7, 95% CI=0.5-0.9).

Conclusion: AAWL is highly prevalent, affecting 6.8 million Americans, and one-third of adults with arthritis. Disparities by gender, race/ethnicity, education, and income suggest the need for more targeted research to better understand the natural history of, and work-specific factors, leading to AAWL. Public health interventions specifically directed at AAWL (and especially those bearing the greatest burden) including self-management education and worksite accommodations may be effective in countering AAWL.

AN ANALYSIS OF FACTORS CONTRIBUTING TO SUBSTANCE ABUSE AMONG AFRICAN AMERICAN WOMEN

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Over one million Americans suffer daily with drug addiction. Moreover, an increasing number in the population include African American women. Research efforts have been made to understand the factors associated with substance abuse, and alcohol abuse, much of it relying on quantitative approaches. While this approach provides some interesting and relevant data, it fails to adequately give a human component to the devastating effects of addiction.

The qualitative data presented is a component of a larger quantitative study, which examined spirituality and African self-consciousness among 41 African-American women substance abusers between the ages of 24 and 55. Women in this study were participants in substance abuse treatment facilities in Baltimore city. The purpose of this quantitative component was to provide information regarding the respondents' ascribed meanings of spirituality and its use in recovery. The qualitative component conducted two semi-formal focus groups. Each focus group consisted of 5-7 participants from the larger study and were between 1-2 hours at the treatment facilities. Raw data from the focus groups included tape recordings, which were transcribed verbatim. After transcribing the tapes a thorough reading, with consequent re-reads and notation of topics, themes and issues were recorded. This process involved a methodical categorization of data for the purpose of noting similar and dissimilar patterns.

Three themes emerged from the qualitative analysis when the participants were asked to ascribe meaning to spirituality. The themes identified were (1) having a relationship with God or recognizing a presence of a higher power; (2) prayer; and (3) church. These findings were consistent with the literature, which states that women define spirituality as a connection with god or belief in a higher external power, and organized worship (Mattis, 2000). Two themes emerged among all of the women in response to the relationship between spirituality and their addiction experience. The two themes that emerged from the qualitative analysis were (1) The women believed that spirituality was the center of their recovery, and (2) Guidance from a higher power was thought to increase their success in recovery. The women in this sample attributed their success and ability to strive for recovery to their renewed sense of spirituality, namely their relationship with God

or a higher power. The women discussed in detail how spirituality assisted them in regaining their self-worth and awareness of their surroundings.

This quantitative analysis points to some very obvious implications for the field of social work; (1) Social work researchers should explore more appropriate research methods that accurately assess the relationship between psychosocial and socio-environmental variables and the severity of drug abuse among African-American women, and (2) Assessment of these variables may lead to treatment modalities that address the particular needs of African-American women, thereby increasing treatment success.

HOW VALID IS THE BRIEF SENSATION SEEKING SCALE (BSSS-4) FOR YOUTH OF VARIOUS RACIAL/ETHNIC GROUPS?

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Aims: To assess the internal consistency of the four item sensation seeking scale BSSS-4 by race/ethnicity.

Design: Six waves of nationally representative, cross-sectional, Legacy Media Tracking Survey (LMTS) data. Total sample size is 25,560. Response rates for the individual survey administrations range from 60% to 30%.

Setting: Data were collected by telephone, from April 2001 through January 2004.

articipants: Youth, ages 12 to 17 who completed the LMTS.

Measurements: Sensation seeking was measured using the four item scale, BSSS-4, published by Stephenson, Hoyle, Palmgreen & Slater in 2003. A series of items from the LMTS was used to measure youth intention to smoke and smoking behavior.

Findings: Mean sensation seeking scores increase as the risk for established smoking increases, with higher scores for White and Hispanic than for African American and Asian youth ($p < .05$). Alpha values suggest the BSSS-4 may be less valid for African American youth compared with youth of other races/ethnicities.

Conclusions: The BSSS-4 is a useful tool for identifying youth at risk for smoking, however, it may be less internally consistent for African American youth compared with other youth. Future research should investigate whether other existing sensation seeking scales are equally valid across race/ethnicity, and whether an alternative scale could be developed that would be more valid for African American youth.

EPINEPHRINE, NOREPINEPHRINE AND THEIR RELATIONSHIP TO FORGIVENESS

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Studies show that social stressors can increase levels of epinephrine (EPI) and norepinephrine (NEPI) (Kiecolt-Glaser, 1996). This study examines the relationship of forgiveness on levels of EPI and NEPI. It is designed to answer the following questions: What is the relationship between forgiveness on levels of EPI and NEPI? What is the significance of this study regarding health? Participants were from a community sample of individuals in the Washington, D.C., Metropolitan Area. Included were 143 African Americans who were aged eighteen years and older. There were 74 males and 69 females. Participants were asked to complete the Transgression-Related Interpersonal Motivation Scale—12-Item Form (TRIM-12), a measure of forgiveness through avoidance and revenge motivation. EPI and NEPI were measured through urine samples provided by participants. Surprisingly, preliminary findings suggest that avoidance motivation is strongly correlated with increase NEPI levels, ($r=.228$, $p<0.037$). Results also show that there is a positive relationship between avoidance motivation and EPI, ($r=0.339$, $p<0.002$). There was no significant relationship between revenge motivation on either NEPI or EPI levels. These preliminary results imply that unforgiveness may lead to negative health outcomes.

This research investigation is part of a larger study entitled, “Stress and Psychoneuroimmunological Factors in Renal Health and Disease,” that is funded by The National Center on Minority Health and Health Disparities, Grant# 1P20 MD 000512-03.

ACCUMULATING DISADVANTAGE: A LONGITUDINAL STUDY INVESTIGATING THE RELATIONSHIP BETWEEN EDUCATIONAL ADVANTAGE IN YOUTH AND HEALTH IN EARLY TO MID-ADULTHOOD

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Objectives: Researchers examining the impact of education on health have mainly conceptualized education as the number of years of schooling completed or degree obtained. Such a focus disregards the underlying mechanisms that place individuals on divergent academic trajectories, such as the quality of one's education or one's access to educational opportunities. The purpose of this paper is to investigate whether these educational advantages in youth are associated with an individual's health trajectory from young to mid-adulthood, independent of educational attainment.

Methods: We conduct longitudinal analysis using the National Longitudinal Survey of Youth (NLSY); a national U.S. probability sample of youth ages 14-22 in 1979. We analyze data collected from 1979 through 2002. A total of 9,050 white, black, and Hispanic civilians are included in our analysis.

Results: We find a widening health disparity in mid-adulthood between respondents with greater and those with fewer educational advantages in youth. We also find that among respondents with few educational advantages, blacks experience a greater health burden as they age compared to their white and Hispanic counterparts.

Conclusions: Differential access to educational advantages during youth may contribute to persisting health disparities in adulthood. To fully understand the impact of education on health, future investigators should consider other aspects beyond the quantity of education completed, such as educational quality and early educational opportunities, in their analysis. Our results also suggest that policies targeted at increasing the educational opportunities of disadvantaged students could be considered preventive actions that benefit the public's health.

AFRICAN AMERICAN WOMEN'S BELIEFS ABOUT MENTAL ILLNESS AND COPING BEHAVIORS

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Little is known about African American women's beliefs about mental illness and coping behaviors. Using the Common Sense Model, which postulates that people have common sense beliefs about illnesses and these beliefs influence their ways of coping with illnesses, this study examined: (a) African American women's beliefs about mental illness, (b) coping behaviors in response to mental illness, (c) relationships between beliefs and coping behaviors and whether these relationships vary by age, and (d) perceived stigma associated with seeking mental health services. This study utilized a cross sectional design with the following sample: young (n = 69), middle-aged (n = 64), and older (n = 52) community-dwelling African American women. Participants completed: demographic, illness perception, coping, and stigma measures. Results indicated the women believed mental illness is caused by several factors including family related stress, childhood trauma, violence, and social stress including racism. They believed mental illness is cyclical, has serious consequences, but can be controlled by treatment and personal motivation. Praying, seeing a doctor, and relying on faith in God were major coping strategies reported by the women. Age differences were found in representations and coping; older women were more likely to believe substance abuse caused mental illness, and were more likely to use religious and formal coping compared to young and middle-aged women. All of the women reported low level of perceived stigma associated with seeking mental health services. In summary, these women's beliefs about mental illness were accurate, they endorsed seeking treatment, but also identified faith and prayer as major ways of coping with mental illness. This study is the first to comprehensively examine African American women's beliefs about mental illness, coping behaviors in response to mental illness, and perceived stigma.

SPIRITUAL HEALTH LOCUS OF CONTROL AND BREAST CANCER RISK REDUCTION IN AFRICAN AMERICAN WOMEN

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Background: Mortality from breast cancer in the United States is disproportionately highest among African American (AA) women. Risk factors for breast cancer in this population include lack of physical activity, and obesity caused in part by high intakes of dietary fat. Psychosocial risk reduction initiatives that integrate behavior change with AA women's cultural values and beliefs are needed to close the gap in breast cancer-related health disparities. An increasing literature suggests an unexplained positive relationship between spirituality, fundamental to many AA women's lives, and AA women's health behavior.

Methods: The current study examined Spiritual Health Locus of Control (SHLOC) as a potential explanation for that relationship in a community sample of 46 overweight/obese AA women who completed a larger study of a weight loss/breast health intervention. The current study used the follow-up data. The core hypothesis was that SHLOC would be associated with positive change in health outcomes, specifically, that internal HLOC would be more highly associated with decrease in weight and body mass index (BMI) than external HLOC. Data collected included demographics (age, education, income), psychological measures (SHLOC), cultural assessments (spirituality), objective physiological measurements (height, weight), and physical activity and dietary practices.

Results: Mean age of participants was 47 years. On a scale from four to 16, the participant mean on internal LOC was high at 13.2. On a scale from two to eight, mean external LOC was near the top of the range at 5.9. Bivariate analyses showed a positive association between external HLOC and weight gain and external HLOC and increased BMI.

Conclusions: Spiritual Health Locus of Control appears to be associated with health outcomes in AA women. Further study of this construct as well as the potential role of spirituality as a facilitator in breast cancer risk reduction behavior for AA women is warranted.

MULTILEVEL MODEL OF PERIODONTAL DISEASE STATUS: CONTRIBUTION OF FAMILY-LEVEL FACTORS

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Like many diseases, periodontal disease demonstrates a gradient in prevalence associated with socioeconomic status (SES), where increasing SES is associated with lower risk for disease. Moreover, for many diseases, the risk associated with SES is robust and can equal or exceed the risk posed by traditional, individual-level (behavioral) factors (e.g., smoking, BMI, oral hygiene). Consequently, the Institute of Medicine has called for consideration of social level variables in etiological models.

The purpose of this poster is to begin the exploration of how social levels variables (family income, education, family structure) fit into the complex etiological model for periodontal disease. In so doing, we hope to advance our understanding of the role of these factors, and how these factors interact with more traditional risk factors, thus informing interventions, especially at the family and population levels.

In the present study, we examined the degree to which family level (e.g., income, family size) and community level (e.g., normative attitudes, rurality) factors were associated with the development of periodontal disease and its progression/resolution at both the individual and population level. We examined 345 adults from 252 households in rural West Virginia and Western Pennsylvania who were participating in a study of family-based risk for oral disease. Multivariable regression methods were used to quantify main effects and to evaluate hypothesized moderation and mediation effects. Two SES associated variables (Family Income, Family Size) emerged as independent predictors of periodontal disease status and suggest a family-level risk model. This poster presents the quantified multilevel pathways of all factors contributing to periodontal disease (colonization, inflammation, tissue destruction) status. One benefit of identifying families where all the members may have increased risk is that interventions can be designed that address not only current (e.g., among the parents) disease but prevention of future (e.g., among the children) disease.

UNDERSTANDING AND REDUCING OBESITY AMONG AFRICAN AMERICAN WOMEN: THE CONTRIBUTION OF SOCIAL-HEALTH PSYCHOLOGY AND THE TRANSACTIONAL MODEL OF STRESS AND COPING

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Problem: Approximately 77 percent of African American women are overweight or obese and at risk for obesity-related illnesses, (e.g., type-2 diabetes). Research suggests that stress is associated with eating behavior, weight gain, and obesity. These associations may be particularly strong for African American women, because the social context of African American women's lives results in high levels of stress exposure. Associations between stress and obesity may be influenced by how African American women interpret and cope with stressors. The transactional model of stress and coping, an important framework in Social-Health psychology, emphasizes stress appraisal and social and cultural resources. Examining the interrelationships between obesity, stress, and coping strategies using a culturally-relevant contextual lens may be critical to understanding obesity in African American women.

Methodology/ Analysis: The present study used a social-health psychological perspective guided by the transactional model of stress and coping to examine how stress and coping strategies predicted obesity severity in a community-based, economically-diverse sample of 189 African American women. Structural equation modeling and analysis of variance were used to examine these relationships.

Findings: Obesity severity was greater among women who reported feeling obligated to present an image of strength in the face of stress compared to women who did not report this obligation. Obesity severity was greater among women who reported engaging in stress-related eating behavior compared to those who did not. The association between psychological stress and physical and psychological symptoms of distress was stronger among women who reported engaging in stress-related eating behavior. These findings were statistically significant ($p < .05$). Implications: Solving the problem of obesity and obesity-related health disparities among African American women will require the use of comprehensive interdisciplinary research strategies. Social-Health psychology and the transactional model of stress and coping are valuable research frameworks that can help to achieve this goal.

MEASUREMENT DIFFERENCES IN DEPRESSION: CHRONIC HEALTH-RELATED AND SOCIO-DEMOGRAPHIC EFFECTS IN OLDER AMERICANS

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This study simultaneously examines the effect of five common chronic medical conditions (high blood pressure, heart condition, stroke, diabetes, and lung disease) and sociodemographic characteristics (age, gender, education, and race/ethnicity) on the measurement properties of depressive symptoms in a nationally representative sample. The 2004 Health and Retirement Study (HRS) of adults aged 65 and older (N=9,387) living in the United States were asked nine items from a modified Center for Epidemiologic Studies-Depression (HRS/CES-D) Scale. Both exploratory and confirmatory factor analyses were conducted to determine the dimensionality of the HRS/CES-D. Measurement differences attributable to health and background variables were assessed with a hierarchical multidimensional model using the multiple indicators, multiple causes (MIMIC) model framework. Results demonstrated three dimensions of the HRS/CES-D: 1) Dysphoria (depressed, lonely, and sad), 2) Psychosomatic (trouble getting going, no energy, everything was an effort, and restless sleep), and 3) Affect (happy and enjoy life). A second-order general latent factor of depression was significantly related to each of the chronic health conditions and the background variables. The latent psychosomatic factor was significantly related to chronic health conditions, but not sociodemographic characteristics. The affect factor was significantly related to a subset of sociodemographic characteristics, but not chronic health conditions. Our findings demonstrate differences attributable to chronic health conditions may reflect distinct phenomenological features of depression experienced by persons with specific health conditions. However, because the effects are limited to the psychosomatic dimension, we infer that these effects reflect variance irrelevant to the general depressive construct. Therefore, the detected differences attributable to both chronic health conditions and sociodemographic variables reflect measurement bias. Failure to control for this measurement noninvariance leads to an over-estimation of depression among those with chronic health conditions and an under-estimation of depression among African-Americans.



NOTES

