

WHAT IS THE BEST WAY TO MEASURE PATIENT SATISFACTION WITH HEALTHCARE SERVICES?

Happy patients feel that the health-care service they have received is what they had expected. Patients who are not happy with the care they receive are less likely to follow medical advice and more likely to change to a different doctor.

Hospitals and healthcare providers are interested in knowing how well patients are satisfied with the health care services they receive. In this study, we changed a survey by the Group Health Association of America to make sure it included questions important to African Americans: respect, health education, and discrimination/stereotyping.

We mailed the survey to 300 African Americans and 300 Whites who received care from an outpatient clinic.

237 surveys were returned and analyzed. We found that both African Americans and Whites agreed that the following were important to healthcare satisfaction: general access to care, general convenience, technical quality, communication, paperwork, choice, interpersonal care, respectfulness, health education, services covered, information about health plan, office staff, discrimination/stereotyping, perceived quality of care, and general satisfaction with care. Each category was assessed using multiple survey questions. For example, *general access to care* was measured using five questions: 1) ability to get hospital care if one needs it; 2) ability to get medical care if one needs it; 3) ability to

get specialty care if one needs it; 4) how patient's need to see a specialist is handled; and 5) ability to get medical care in an emergency.

These results show that the survey was comparable for African Americans and Whites. The survey appears to be relevant for African Americans and can be used in future studies of their perceptions of health care.

Source: Psychometric Characteristics of a Patient Satisfaction Instrument Tailored to the Concerns of African Americans

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PREPARING DIABETES EDUCATION MATERIALS FOR TARGETED GROUPS

Diabetes is a serious disease that can cause problems such as heart disease, kidney failure, amputations, and blindness. Diabetes can be controlled through diet, exercise, and medications.

Of all ethnic groups, American Indians and Alaska Natives have the highest rate of diabetes in the United States. They are at greatest risk for diabetic eye disease (DED), which often leads to blindness. Eye health awareness and annual eye exams are important to detect diabetic eye disease before vision loss occurs.

Diabetes is a complicated disease that can be difficult to manage. In our research, we wanted to learn about American Indians and Alaska Natives' understanding of diabetes management,

benefits of early detection of eye disease, barriers to receiving or accessing diabetes-related eye health care, and preferred ways of receiving health information that would encourage them to take care of their eyes while managing their diabetes.

To obtain this information, our team conducted discussions (focus groups) with American Indians and Alaska Natives with diabetes. Through these discussions, we learned opinions about managing diabetes, knowledge of eye exams, awareness of vision problems associated with diabetes, and ideas on how to reach American Indians and Alaska Natives with health messages. We also conducted one-on-one interviews with community health represen-

tatives, nutritionists, diabetes educators, eye care professionals, nurses, tribal council leaders, and others to learn about the communities' health, diabetes-related resources and services and current ways of sending messages about health.

The research produced a range of findings on how American Indians and Alaska Natives with diabetes cope. For example, a lack of health insurance coverage and little funding for diabetes programs are major roadblocks to care for DED properly. Although diabetes ranked high on their list of community health issues in need of attention, research participants had only a basic level of diabetes-related knowledge, acknowledged the need for DED education, and emphasized the importance of the use of

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person-to-person and culturally appropriate communication methods.

With these research findings, we developed an education program that is driven by the preferences of American Indians and Alaska Natives for receiving

DED messages and materials uniquely suited to increasing awareness of DED in these communities.

Source: The National Eye Health Education Program: Increasing Awareness

of Diabetic Eye Disease Among American Indians and Alaska Natives

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MAKING CANCER EDUCATION MATERIALS USABLE BY DIFFERENT ETHNIC GROUPS

This study reviewed culturally sensitive cancer prevention resources proposed in the literature for ethnic minority populations. To be considered 'culturally sensitive,' cancer information should recognize the specific ethnic minority group, use of examples tailored for that group, and include symbolic and historical elements as well as cultural and spiritual beliefs of the group.

The goals of this study were: 1) To explore definitions of the term 'cultural sensitivity' and their application in the development and testing of cancer prevention educational materials for ethnic minority groups; and 2) To assess the use of instruments or scales used to measure the cultural sensitivity of cancer information resources.

A list of articles on the cultural sensitivity of cancer prevention education materials was found by searching

four databases (PubMed, CancerLit, PsycINFO, Sociological Abstracts) for articles published between 1994–2004. Ten studies were included in this review. Most articles included breast cancer resources (90%) and targeted African American populations (70%). Only four studies defined cultural sensitivity. Three studies used questionnaires or other measuring tools to evaluate the cultural sensitivity of printed cancer information resources.

Results of this study suggest that future research should avoid the confusion of 'buzz' words such as 'cultural sensitivity,' 'cultural competency,' 'cultural relevance,' and 'cultural appropriateness' and their application to cancer prevention. Best practice definitions and guidelines for culturally sensitive cancer prevention education need to be established. Ethnic minority individuals' cancer-related knowledge and beliefs

should be incorporated into all printed cancer education efforts.

The authors recommend a three-phase approach for developing culturally sensitive cancer prevention materials: 1) Develop a common definition of cultural sensitivity by expert groups on cancer prevention and with knowledge about the intended ethnic minority communities; 2) Test the cultural sensitivity of cancer information resources using valid and reliable instruments or scales; and 3) Involve stakeholders and lay persons from intended ethnic minority communities in evaluation of cancer resources to ensure cultural relevance.

Source: A Systematic Review of Culturally Sensitive Cancer Prevention Resources for Ethnic Minorities

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TRUSTING THE HEALTHCARE SYSTEM: PERSONAL EXPERIENCE, RACISM, AND LOCATIONS

If a patient trusts the healthcare system, he or she will have a better experience with doctors or hospitals. Some past studies have found that Whites have a higher level of trust in the healthcare system than Blacks and other minorities do. Other studies found no difference among the groups.

Levels of trust may not be the same within or among ethnic groups. Patients build their trust from experience. Afri-

can Americans and other Blacks often receive unfair treatment because of their race; racism may increase their distrust. In our study, we wanted to find out how Black and White persons view racism in healthcare and if their views play a part in explaining any difference in trust between the two groups. We also examined the effects of other participant factors on trust: a) personal traits; b) county; c) usual source of healthcare or advice; and d) view of how doctors and

dentists treat them during routine appointments.

We interviewed some Floridians in Duval and Miami-Dade counties. The results that we present are from the 550 who said that they were Black/African American and 394 non-Hispanic Whites. The University of Florida allowed us to carry out this study.

Both Blacks and Whites who took part in our study had a high level of

trust. Yet, Blacks reported a slightly lower level of trust than Whites did. Blacks scored 18 while Whites scored 19, with six being the lowest score possible and 21 the highest score possible. By asking about study participant's feelings about racism, we could conclude that the reason Blacks reported lower levels of trust was that Blacks reported more racism.

The most important reason trust differed was participants view of how doctors and dentists treated them during appointments. Those who liked how doctors and dentists treated them all of

the time were more trusting than those who did not. Trust was higher among those who used an office-based provider than it was among those who used a hospital-based provider.

The county of those who took part also affected trust; trust was higher in Duval County than it was in Miami-Dade County. Trust increased with age. The employed had a higher level of trust than the unemployed had. Sex or income did not affect trust levels.

Eliminating racism from health-care may remove the difference in trust between Blacks and Whites; how-

ever, strategies to enhance trust should focus on improving patients' healthcare experience and building community-level supports that help people to build trust.

Source: Perception of Racism Explains the Difference between Blacks' and Whites' Level of Healthcare Trust

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SEGREGATED NEIGHBORHOODS LINKED TO UNHEALTHY RESIDENTS

Many researchers believe that ethnic residential segregation is a major cause of poorer health for ethnic minorities. Some studies have found residential segregation to be linked with cardiovascular disease and infant mortality. Segregated neighborhoods typically are neglected by the larger society, lack access to quality medical care, have a high percentage of low-income or poverty-stricken residents, have weakened neighborhood systems, and little political power. All of these factors are important to health outcomes.

The purpose of this study was to examine the link between residential segregation (measured by the number of Blacks living in the neighborhood) and

self-reported health. The main findings from this study suggest that individuals living in highly segregated neighborhoods were almost two times more likely to think that their health was poor compared to their counterparts living in less segregated neighborhoods.

The results show how important the neighborhood is in the health of an individual. More than two-thirds of Black Americans live in major metropolitan areas that are still considered highly segregated. The findings of this study suggest that programs to reduce disparities must pay close attention to the neighborhood racial/ethnic composition.

Future research must continue to find out ways by which different features of neighborhoods are related to various health outcomes. We must also find out which features of segregated neighborhoods encourage health promotion and health-damaging behaviors. In addition, specific policies and programs to improve the economy and systems of segregated communities need to be addressed.

Source: Racial/Ethnic Neighborhood Concentration and Self-Reported Health in New York City

Kellee White, MPH; Luisa N. Borrell, DDS, PhD

IS TYPE OF BLOOD LINKED TO HYPERTENSION, TYPE 2 DIABETES?

High blood pressure (hypertension) and type 2 diabetes are known to be higher for people from Africa than for people from Europe and other areas. Family health history or genetic factors are thought to be a reason for this difference but the reasons have not yet been fully explained.

Scientists believe that high blood pressure may be shaped multiple genes, as well as by environmental factors. Blood groups (ABO, Rhesus, and Duffy) vary in different populations and have been used as markers of a particular family tree. We wanted to test our thought that markers of

African ancestry may be related to the higher rates of hypertension and diabetes among populations of African origin.

To find out whether particular blood groups are associated with hypertension and diabetes, we analyzed data from 1,253 participants from the Bar-

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bados Eye Studies (BES). The BES, designed to find out more about major eye diseases in an African-origin population, included data on blood pressure and diabetes status, medical history, and demographic information.

In the BES, 53% had hypertension and 17% had self-reported diabetes. Age and body size were linked to increased blood pressure and diabetes. We also found that those with higher diastolic blood pressure were more likely to be in the Rhesus blood group, while those with lower blood pressure were more likely to be in the ABO blood group. The likelihood of having diabetes de-

creased with the presence of the Rhesus C+ antigen. These findings support the hypothesis of possible genetic influences on both conditions in populations of African origin, where the distribution of these particular antigens is different than in European populations.

Given that approximately 1 of every 2 adults in Barbados has hypertension and 1 of every 6 has diabetes, it is of great public health importance to identify the factors that increase risk in this and other populations of African descent. Knowing blood group markers in individuals of African heritage may

provide clues for finding the genes that shape these two chronic conditions. Further research in other settings are needed to confirm these results and help us to fully understand how multiple genes and environmental factors may contribute to hypertension and diabetes in these high-risk populations.

Source: Hypertension, Type 2 Diabetes, and Blood Groups in a Population of African Ancestry

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DO AMERICAN INDIAN WOMEN RECEIVE SCREENING MAMMOGRAMS AT THE SAME RATE AS NON-HISPANIC WHITE WOMEN?

American Indian women are least likely to survive breast cancer compared to women of all other races. Screening mammography can detect breast cancer early and may improve survival time. A screening mammogram is an X-ray procedure that is part of a routine checkup, not follow-up on a lump or other symptom. Studies have shown that American Indian women report lower use of screening mammography than non-Hispanic White women. However, these studies were based on self-reported information.

The purpose of this study was to compare screening mammography patterns of American Indian and non-Hispanic White women in the six-county Denver metropolitan area in Colorado. We studied records of women attending mammography facilities that were part of the Colorado Mammography Project, from January 1,

1999 to December 31, 2003: 229 American Indian and 60,197 non-Hispanic White women.

Using the guidelines based on age and family history of breast cancer, we grouped mammograms for these women into annual and biennial (every other year) time span between mammograms. We also included age, education, health insurance, and family income. In our study, we wanted to see if American Indian women were less likely to following the guidelines for screening mammography even when we adjusted for these other factors.

On average, American Indian women were younger than non-Hispanic White women were at the time of their first screening mammogram. More American Indian women had less than a high school education, had no health insurance, and were from residences in areas where the average family income

was less than \$40,000 per year, compared to non-Hispanic White women. American Indian women were less likely than non-Hispanic White women were to get mammograms, both annually and biennially. The combined effect of low income and less education of American Indian women may have resulted in a lack of awareness of screening mammography. Additional research is needed to find out more about the barriers to screening among American Indian women.

Source: Factors Associated with Adherence to Recommendations for Screening Mammography Among American Indian Women in Colorado

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HEART DISEASE RISKS IN YOUNG ADULTS

Heart disease is the number one killer of US adults. Although consequences of heart disease are commonly seen in older adults, the risk factors are already present during adolescence and young adulthood. Many common risk factors present in young individuals tend to remain as these individuals get older (for example, overweight children tend to become overweight adults). While some risk factors such as overweight and high blood pressure are known, a risk factor that causes problem changes in the arteries is not fully recognized especially among young adults.

These problem changes cause the arteries to harden. Hardening or stiffening of the arteries is often termed "arterial stiffness." Similar to other risk factors, we found that arterial stiffness levels were different in young men and women. We also found that arterial stiffness levels were different among Whites, Blacks, and Hispanics. Arterial stiffness levels were the highest among Whites, followed by Hispanics and Blacks. However, more studies are

needed to verify racial differences in arterial stiffness.

We employed a measure of arterial stiffness using the systolic (first value) and diastolic (second value) blood pressure in our study. For example, if the blood pressure reading is 120 over 80, the person's systolic blood pressure (SBP) is 120 and diastolic blood pressure (DBP) is 80. The blood pressure value of 120/80 is considered normal. The difference in SBP and DBP is known as arterial pulse pressure (APP) and is also a measure of arterial stiffness. For a person with blood pressure value of 120/80, APP is 40. Currently, there is no cut off level of APP to distinguish normal or abnormal level of arterial stiffness. However, higher APP level means stiffer artery.

One of the important factors of increased arterial stiffness is age. Because age is unavoidable, young adults should be aware of factors that can be changed to prevent increased arterial stiffness. They include: overweight, high blood pressure and high blood chole-

sterol. Screening for these risks should begin early in life. Knowing arterial stiffness levels in young persons may improve heart disease outcomes in the future.

Our study suggests that more research studies on heart disease risk factors should be conducted in multi-racial populations. Future studies should focus not only on known risk factors (overweight and high blood pressure) but also on arterial stiffness, which might be considered a new risk for young adults. Moreover, health professionals should be made aware of relatively easy screening procedures for the young persons. To promote comprehensive heart health, APP should be considered jointly with SBP, DBP and other risks.

Source: Differences in Arterial Stiffness and its Correlates in Tri-Ethnic Young Men and Women

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DIABETES EDUCATION AND PERSONAL DOCTORS TEAM UP FOR BETTER CARE FOR PERSONS WITH DIABETES

It is known that having a personal doctor, nurse, or other healthcare professionals provides best care and improves health outcomes, but limited research has shown the effects of a regular source of care on diabetes preventive services. Diabetes self-management education (DSME) is an important component of the clinical management of diabetes and could also affect individuals' use of diabetes preventive services.

The researchers of this study looked at how DSME affected the health

of those with type 2 diabetes. The results of the study showed that having a regular doctor was not always associated with receiving all preventive services across the three racial/ethnic categories.

Looking at other factors beyond having a regular doctor, DSME appeared to have benefits for Whites and Blacks, but not Hispanics. The lack of benefits for Hispanics could be explained by diabetes education classes that were not culturally competent and/or poor communication. Based on the

results, it was concluded that access to personal doctors should be available to Whites, Blacks, and Hispanics and, DSME should be expanded among Whites and Blacks, but may need to be more effectively tailored and targeted toward Hispanics.

Source: Racial and Ethnic Differences in the Effects of Regular Providers and Self-Management Education on Diabetes Preventive Care.

Anita K. Kurian, DrPH, MBBS; Tyrone F. Borders, PhD

ENLARGED HEART FOUND IN NIGERIANS REPORTING WITH CHRONIC KIDNEY FAILURE

Chronic renal failure (CRF) or chronic kidney failure results from long-standing kidney disease. CRF is common all over the world but more so in developing countries. Diseases that cause CRF include hypertension (high blood pressure), diabetes mellitus, glomerulonephritis (inflammation of the kidney). Long-standing kidney disease is often linked with heart complications like left ventricular hypertrophy (heart enlargement), arrhythmia (irregular heartbeat) and later heart failure and heart attack.

The heart enlargement is caused by extra pressure and affects heart function. It can also be linked to sudden death from irregular heartbeats and heart attacks.

A study was carried out at the University of Nigeria Teaching Hospital (UNTH) in southeast Nigeria to look at

long-standing kidney disease and heart enlargement. The study center serves about a third of the Nigeria's 129 million people. The study evaluated the degree of heart enlargement and factors affecting it in patients with long-standing kidney disease at first presentation before they began dialysis.

Eighty-eight consecutive patients with long-standing kidney disease and 45 age- and sex-matched normal people were studied using echocardiography (an imaging device to study the heart).

Heart enlargement was present in 95.5% of the patients but in only 6.7% in the normal people. High blood pressure was present in more than 85% of these patients. The major causes of long-standing kidney disease were inflammation of the kidney (43%), high blood pressure (25%) and diabetes (15%). All the patients seen were in

the very late stages of long-standing kidney disease. The conditions that predicted the presence of heart abnormality in these patients were: presence of raised blood pressure, low hemoglobin, male sex and loss of ability to remove waste products from the body.

In conclusion, this study showed a strong link between long-standing kidney disease and heart enlargement in patients in a developing country. Early detection and treatment of causes of long-standing kidney disease should be followed aggressively as a preventive measure.

Source: Left Ventricular Hypertrophy in African Black Patients with Chronic Renal Failure at First Evaluation

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CORONARY HEART DISEASE ON THE RISE IN AFRICA

Coronary heart disease (CHD) was unknown in Black people in Africa before 1970. However, high rates of CHD are found in people of African descent living in Westernized countries.

In our study, we wanted to find out how CHD was linked with its known risk factors, such as high blood pressure, abnormal levels of cholesterol, type 2 diabetes, smoking, being overweight or obese, a family history of conditions related to cardiovascular disease (CVD), a history of stroke, male sex, and age

above 55 years. We also looked for the presence of damage to the organs such as the heart, kidney, and eye.

We found that those with CHD patients had many more of the risk factors compared to the control group. The risk factors with the strongest link with CHD were hypertension and a family history of heart disease. Our findings also showed that the risk factors that predict CHD also may predict organ damage.

This research should alert health policy makers in South Africa and other

countries with similar population groups that an epidemic of CHD could occur in the first half of the 21st century. It is expected that the death rate from heart disease for those between 35–64 years of age in South Africa will increase by 41% between 2000 and 2030.

Source: Coronary Heart Disease and Risk Factors in Black South Africans: A Case-Control Study

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SOUTH ASIAN HEALTH STUDIED

There is little research on South Asians in the United States. Over the last 10 years, the South Asian population had the largest growth of any ethnic group in the United States so it is important to understand more about their health. In this study, we took two surveys (the 2001 California Health Interview Survey [CHIS] and the Cardiovascular Health in Asian Indian survey [CHAI]) and compared them. There were 769 South Asians between age 25 and 83 years surveyed by telephone in the CHIS study, while in CHAI, 252 South Asians, ages 25 and older, were interviewed by telephone and 52 were interviewed in-person.

There were some areas in which the results were the same, but others

were not (for example, blood pressure levels were different in the two groups). Overall more people from CHIS reported very good or excellent overall health compared to people from CHAI (66% vs 53% of the people). People in CHIS were more educated, wealthier, more likely to be employed, and had a primary care doctor less often than people in the CHAI study.

People interviewed in CHIS were more likely to exercise, had a lower body mass index (a marker of weight and height) but were more likely to smoke than people in CHAI. People from CHIS had a lower rate of high blood pressure (as told by their doctor) and less diabetes.

We need much more research on South Asian health since heart disease tends to be a problem in this group of individuals all around the world. We should do some of the research in different South Asian languages since there might be differences related to regions of South Asia, such as diets and stress levels related to different types of migration.

Source: Prevalence and Correlates of Cardiovascular Risk Factors in South Asians: Population-Based Data from Two California Surveys

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RECRUITING BLACK WOMEN WITH DIABETES TO PARTICIPATE IN RESEARCH STUDY

Over the last 10 years, a growing number of studies have looked at successful ways to have Blacks participate in research studies. The studies have suggested using culturally sensitive methods (for example using Black recruiters, community advisory boards, and church support) in addition to more normal recruitment methods (for example mass mailings, media, and referrals). These methods have been shown to encourage Blacks to participate in research studies. However, we do not know much about best ways to recruit Blacks with type 2 diabetes into research studies.

The purpose of this study was to evaluate how recruitment methods re-

sulted in the participation of Black women with diabetes in a clinical trial. The study wanted to enroll 129 Black women with diabetes and 236 women responded to varying recruitment methods, both traditional and culturally sensitive.

The 236 women were screened and 109 agreed to participate in the study. The recruitment efforts had a rate of 46.2% and achieved 84% of its projected goal of 129 participants. Findings from our study show that Black women with diabetes may be recruited into clinical trials when culturally sensitive methods are mixed with more traditional methods. Community health

airs, participant referrals and advertising/marketing aimed at reaching Blacks were most successful in recruiting Black women. More traditional methods such as community clinic and private practice referrals also were productive, especially when referring doctors knew about the study.

Source: Recruitment of Black Women with Type 2 Diabetes into a Self-Management Intervention Trial

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