"Pathways Linking Education to Quality Women's Health Care and Promotion"

Women's Health Symposium Tool Kit

Mid-Atlantic Association of Community Health Centers

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Authored By:

Yesenia Flores

Introduction

Welcome to the Women's Health Symposium tool-kit! This resource was created for providers, clinical educators, and the interested public, to retrieve basic information on breast cancer, diabetes, and heart disease. The following pages contain treatment and prevention information, listing of risk factors, national and state-wide (i.e., for Maryland and Delaware) statistics of disease prevalence, as well as further reference information.

The Mid-Atlantic Association of Community Health Centers (MACHC) hosted a one-day Women's Health Symposium on November 20, 2003. Co-sponsored by the U.S. Department of Health and Human Services (DHHS), Office on Women's Health (OWH), the Symposium focused on improving the quality of life for female health center consumers through exploration of pathways that influence high morbidity rates of breast cancer, diabetes, and heart disease among women who seek health care from community health centers (CHCs).

Through workshops and open dialogue, clinicians and health educators provided opportunities to discuss and review best collaboration practices, methodologies and associations between education, illness, community health promotion and outreach strategies. Addressing the vital need for continuous education and idea exchange among health professionals, the Symposium presenters provided suggestions for the development and implementation of effective programming to prevent adverse health disparities as well as educate consumers. For example, Dr. Raymond Terry, of the University of Maryland, presented a session entitled: "Innovative Strategies for Influencing Behavior Modification" which incorporated health promotion and lifestyle enhancement techniques to influence current behaviors and empower women as trailblazers for a new health perspective. Additionally, Ms. Marisa Brown, of the Georgetown University Center for Cultural Competency, presented a session on "Examining and Implementing Culturally and Linguistically Competent Care" that focused on the definition and framework for cultural and linguistic competence as well as the guiding principles for providing culturally and linguistically competent care. To view these and other presentations, go to the special section on Women's Health at www.machc.com.

MACHC was honored to have Dr. Marilyn Hughes Gaston, physician and former U.S. Assistant Surgeon General and recently retired Director of the Bureau of Primary Health Care (BPHC) within the Health Resources and Services Administration (HRSA), serve as a moderator at the Symposium. As the first African-American woman to direct a Public Health Service Bureau, Dr. Gaston is committed to issues focusing on health and wellness. Prior to her appointment as Bureau Director, Dr. Gaston was the Director of the Division of Medicine, which provides funding for training grants in Family Medicine, Internal Medicine and Pediatrics. Earlier in her career, Dr. Gaston assisted in establishing a community health center serving a large, low-income African-American population. She is the co-author of *Prime Time: The African American Woman's Complete Guide to Mid-Life Health and Wellness*.

We hope you find the enclosed information helpful and welcome your feedback and comments.

Table of Contents

About the Women's Health Symposium

Dr. Marilyn Hughes Gaston, well-known to the Community Health Center world for years of leadership at the BPHC, was the featured speaker at MACHC's 2003 Women's Health Symposium. A passionate advocate for African-American women's health, Dr. Gaston spoke with fire in her eyes about the toll that breast cancer, diabetes, and heart disease take on African-American women in the form of early death and avoidable disease and disability. During her presentations, both opening and closing the day's activities, Dr. Gaston enlightened her audience with startling statistics on women's health risks and challenged participants to better care for one another and their patients.

Reading from her recently published book, Prime Time, The African American Woman's Complete Guide to Mid-Life Health and Wellness, Dr. Gaston cited the story of a women who suffered an undiagnosed heart attack and whose symptoms included fatigue, anxiety, and breathlessness. Studies and statistics carry out the message that women delay seeking medical care for themselves at a greater rate than men. Women, especially African-American women, are at significant risk for heart attack and stroke. Too many African-American women die from preventable causes or from late diagnosis of disease.

Dr. Gaston closed the day with a challenge to all women to "Put ourselves first". She exhorted women of all races, particularly African-American women, to make better nutrition, smoking cessation, weight control, and daily exercise, a priority in our lives. She reminded participants that lifestyle accounts for 50% of the determinants of good health, whereas health care only drives about 10-15% of our health status. She encouraged the audience to "Take the message back to friends, families, and patients". Energized by her engaging manner and passionate presentation, Dr. Gaston's message will not be forgotten.

Breast Cancer

What is breast cancer?

Among American women, breast cancer is the most common form of cancer (excluding skin cancer). Breast cancer is second only to lung cancer in cancer-related deaths. Breast cancer is the leading cause of cancer death for all women aged 35-54. Breast cancer most often begins as a painless or thickening in the upper outer portion of the breast, although it can occur anywhere in the breast, including the nipple. Breast cancers may spread to lymph nodes in the armpit and then to other parts of the body, such as the lungs, liver, bone, and brain (American Cancer Society, 2003).

What are some cancer facts?

In 2003, an estimated 211,300 new cases of invasive breast cancer were said to have been diagnosed among women nationally. An estimated 39,800 women died of breast cancer in the year 2003. If detected early, the 5-year survival rate for localized breast cancer is 97% (American Cancer Society, 2003).

In the U.S., a woman dies of breast cancer every 12 minutes (CDC, 2004). African-Americans are more likely to develop cancer than persons of any other racial or ethnic group.

Only 52% of American Indian/Alaska Native women aged 40 years and older have had a recent mammogram. American Indian/Alaska Natives have the poorest survival from all cancers combined in comparison with all other racial and ethnic groups.

What are some indicators associated with cancer among certain minority populations?

Physical activity, overweight and obesity, tobacco use, substance abuse, mental health, environmental quality, and access to care.

What are the risk factors for breast cancer?

Increasing age (older than 40 and especially older than 50), family history, never giving birth or giving birth after 30, recent use of hormones or oral contraceptives, having a long menstrual history (American Cancer Society, 2003).

Early detection amongst breast cancer patients.

Many deaths from breast cancer could be avoided by the increase of cancer screening rates amongst at-risk women. Cancer screening may be performed by one of three ways. First, a breast self-exam may be performed on a monthly basis. Secondly, a breast physical exam may be performed by a doctor or other medical professional

during a woman's annual exam. Lastly, a mammography may be used as a screening tool in addition to the aforementioned. Timely mammography screening among women aged 40 years or older could prevent approximately 17% of all deaths from breast cancer and should be performed every 1-2 years (AHRQ, 2003). Mammography is the best available method to detect breast cancer in its earliest, most treatable stage—an average of 1-3 years before a women can feel a lump (American Cancer Society, 2003).

Deaths from breast cancer occur disproportionately among women who are uninsured or underinsured. Mammography examinations are underused by women who have less than a high school education, are older, live below the poverty level, or are members of certain racial and ethnic minority groups (CDC, 2003) .

Statistics on Breast Cancer Patients.

- 4,200 new cases of breast cancer will be diagnosed among women in Maryland (CDC, 2003).
- 800 women will die of breast cancer in Maryland (American Cancer Society, 2003).
- Delaware ranks 2nd in the U.S. for the incidence of *in situ* breast cancer (DBCC, 2002).
- Delaware ranks 7th in the U.S. for the incidence of invasive breast cancer (DBCC, 2002).
- Maryland has the 10th highest breast cancer mortality rate in the U.S. (DHMH, FHA, 2004).

The Role of Federally Qualified Health Centers (FQHCs) to assist breast cancer patients:

The National Breast and Cervical Cancer Early Detection Program (NBCCEDP), administered by the Centers for Disease Control and Prevention (CDC), helps low-income, uninsured, and underserved women gain access to lifesaving screening programs for early detection of breast cancer. The success of NBCCEDP depends on collaborative efforts with partners to implement health programs targeting underserved women. One such partnership effort exists with the Bureau of Primary Health Care (a division of the Federal Health Resources and Services Administration [HRSA]) and the community health centers (i.e., FQHCs) that it funds; the Institute of Healthcare Improvement; the National Cancer Institute (NCI); CDC; and other organizations. This particular project is focused on increasing screening for breast, cervical, and colorectal cancers within the populations served by community, migrant, and homeless

health centers, as well as on improving follow-up for patients with abnormal screening results. Health center personnel are learning how small, incremental changes in clinic practices (e.g., linking screening to non-routine clinic visits) can lead to improved health outcomes for the populations they serve. They are being taught how to plan and pilot-test such changes as well as how to assess and use test results in implementing effective changes (CDC, 2003).

Tools for Clinicians

Dr. Christine Teal, of the George Washington University Breast Care Center, presented a clinical session entitled: "Update on Breast Cancer and Detection". The session focused on the impact of breast cancer, its devastating effects on the entire family, and provided the latest methods for detection and treatment of breast cancer and future potential. To access Dr. Teal's presentation, please view the special section on Women's Health at www.machc.com.

Diabetes

What is diabetes?

Diabetes mellitus is a group of diseases characterized by high levels of blood glucose resulting from defects in insulin production, insulin action, or both. Diabetes can be associated with serious complications and premature death, but persons with diabetes can take steps to control the disease and lower the risk of complications (NIDDK, 2002).

How many types of diabetes exist?

Type 1 diabetes is known as juvenile-onset diabetes. This form of diabetes usually strikes children and young adults, although disease onset can occur at any age. Type 1 diabetes may account for 5% to 10% of all diagnosed cases of diabetes (NIDDK, 2002).

Type 2 diabetes is known as adult-onset diabetes. Type 2 diabetes may account for about 90% to 95% of all diagnosed cases of diabetes and is increasingly being diagnosed in children and adolescents (NIDDK, 2002).

Gestational diabetes is a form of glucose intolerance that is diagnosed in some women during pregnancy. After pregnancy, 5% to 10% of women with gestational diabetes are found to have Type 2 diabetes. Women who have had gestational diabetes have a 20% to 50% chance of developing diabetes in the next 5-10 years (NIDDK, 2002).

Other types of diabetes exist and may result from genetic conditions (i.e., maturity-onset diabetes of youth), surgery, drugs, malnutrition, infections, and other illnesses. Such types of diabetes may account for 1% to 5% of all diagnosed cases of diabetes (NIDDK, 2002).

What are the risk factors for diabetes?

Type 1 diabetes risk factors may include autoimmune, genetic, and environmental factors (NDEP, 2004).

Type 2 diabetes is associated with older age, obesity, family history of diabetes, history of gestational diabetes, impaired glucose metabolism, physical inactivity, and race/ethnicity. African-Americans, Hispanic/Latino Americans, American Indians, and some Asian Americans and Native Hawaiians or other Pacific Islanders are at particularly high risk for Type 2 diabetes (NDEP, 2004).

Gestational diabetes occurs more frequently among African-Americans, Hispanic/Latino Americans, and American Indians. It is also more common among obese women and women with a family history of diabetes (NDEP, 2004).

How is diabetes treated?

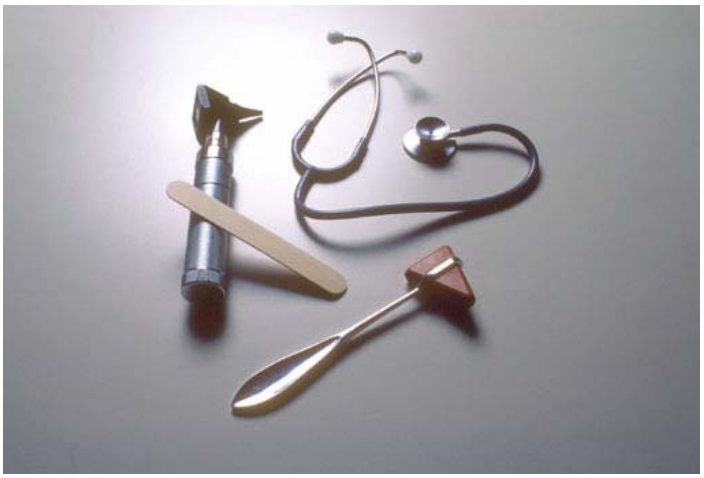
Diabetes self-management education is an integral component of medical care. Among adults with diagnosed diabetes, 12% take both insulin and oral medications, 19% take insulin only, 53% take oral medications only, and 15% do not take either insulin or oral medications (NIDDK, 2002).

More specifically, persons with Type 1 diabetes must have insulin delivered by injections or a pump in order to survive. Persons with Type 2 diabetes are able to control their blood glucose by following a careful diet and exercise program, losing excess weight, and taking oral medication. Furthermore, in addition to their diabetic complications, many diabetics also need to take medications to control their cholesterol and blood pressure (NIDDK, 2002).

How can diabetes be prevented?

There are no known methods to prevent Type 1 diabetes.

Lifestyle changes can prevent or delay the onset of Type 2 diabetes among high-risk adults. Lifestyles interventions may include, but not be limited to, diet and moderate-intensity physical activity (i.e., walking for 2 ½ hours per week) (NIDDK, 2002).



What are the complications of diabetes?

Heart disease, high blood pressure, blindness, kidney disease, nervous system disease, amputations, dental disease, and pregnancy complications (NIDDK, 2002).

How can diabetes complications be prevented?

Diabetes can affect many parts of the body and can lead to serious complications such as blindness, kidney damage, and lower-limb amputations. The detection and treatment of diabetic eye disease with laser therapy can reduce the development of severe vision loss by an estimated 50% to 60%. Additionally, the detection and treatment of early diabetic kidney disease by lowering blood pressure can reduce the decline in kidney function by 30% to 70%. Similarly, comprehensive foot care programs can reduce amputation rates by 45% to 85% (NIDDK, 2002).

Working together, diabetics and their health care providers can reduce the occurrence of these and other diabetes complications by controlling the levels of blood glucose, blood pressure, and blood lipids and by receiving other preventive care practices in a timely manner.

What are the costs associated with diabetes?

In 2002, the total cost associated with diabetes in the United States was $132 billion.

Direct medical costs (i.e., cost of medical care and services) totaled $92 billion and indirect costs (i.e., cost of short-term and permanent disability and premature death) totaled $40 billion (NIDDK, 2002).

In 2001, the total cost (i.e., including direct and indirect costs) of diabetes in the State of Maryland totaled about $2.9 billion (DHMH, FHA, 2001). The direct and indirect costs of diabetes in the State of Delaware were about $349 million (CDC, 1994).

Tools for Clinicians

Dr. Lelin Chao, of People's Community Health Center, presented a clinical session on "Group Visits for High Risk Diabetes Patients". During the interactive and "reality-based" session, Dr. Chao discussed the rationale behind the group visit model, explained how the group visit model can be applied to current practice, and identified some of the model's challenges and pitfalls. To access Dr. Chao's presentation, please view the special section on Women's Health at www.machc.com.

Cathy Tibbetts, RN, MPH, CDE, of the INOVA Diabetes Center, presented a clinical session entitled: "Importance of Disease Management in Diabetes Care". This session focused on the processes and tools clinicians and patients can utilize to decrease variability in practice; reduce short and long-term complications; increase quality life as well as meet regulatory standards. To view Ms. Tibbetts' presentation, access the special section on Women's Health at www.machc.com.

Tools for Health Educators

Usha Ranji, MS, of the Kaiser Family Foundation presented "Major Influences on Women's Access to Health Care" at MACHC's Women's Health Symposium. This session focused on the role of public policies on health care access and quality for women, particularly low-income women as well as women of color. Key influences on women's access to health care, including public and private programs, relationships with health care providers, and balance of other family health responsibilities were reviewed. Moreover, rising health care costs, fiscal crisis in the states, and proposals to reform Medicaid and welfare were discussed. To view Ms. Ranji's presentation, go to the special section on Women's Health at www.machc.com.

Sharon Hawks, Maj, USAF, CDE, of the Nutrition and Diabetes Education Center presented "Role of the Health Educator in Diabetes Prevention" at MACHC's Women's Health Symposium. This session focused on the factors contributing to the increased prevalence of diabetes in the United States, included tips on how to identify individuals at risk for developing diabetes as well as various techniques health educators may utilize to disseminate the message of diabetes prevention. To view Ms. Hawks' presentation, go to the special section on Women's Health at www.machc.com.

Another presentation given by Ms. Hawks was "Partnering with Consumers to Foster Healthy Lifestyle Choices". This session provided simple techniques to motivate consumers to make healthy lifestyle changes, demonstrated the concept of "train the trainer", and explained how this specific technique can be utilized by health professionals to foster healthy lifestyle choices. Additionally, Ms. Hawks discussed ways to encourage dialog between health professionals and the consumers with the goal of promoting a healthy lifestyle. To view this presentation, go to the special section on Women's Health at www.machc.com.

Heart Disease

What is Heart Disease?

Coronary heart disease is the main form of heart disease. Developed over many years, coronary heart disease affects the blood vessels of the heart. It can result in heart attack, disability, and death. A heart attack occurs when an artery becomes blocked, preventing oxygen and nutrients from getting to the heart.

Often called "heart disease", coronary heart disease is one of various cardiovascular diseases, which are diseases of the heart and blood vessel system. Other cardiovascular diseases include stroke, high blood pressure, and rheumatic heart disease. Heart disease can be managed; however, it cannot be cured. Without lifestyle changes such as being physically active, following a healthy diet, and not smoking, heart disease will steadily worsen (NHLBI, NIH, 2004).

What are the risk factors of heart disease?

Family history of early heart disease, age, smoking, blood pressure, high cholesterol, overweight/obesity, physical inactivity, and diabetes (NHLBI, NIH, 2004).

What are some facts on heart disease?

Heart disease is the #1 killer of women in the United States. One in three women dies of heart disease. About 3 million American women have had a heart attack. About 6.5 million American women have had a heart attack and/or chest pain. Two-thirds of American women who have had a heart attack do not make a full recovery. Nearly two-thirds of American women who die suddenly of a heart attack had no prior symptoms (NHLBI, NIH, 2004).

What are the screening tools for heart disease?

Electrocardiogram (ECG or EKG), Stress test (or treadmill test or exercise ECG), Nuclear scan (or thallium stress test), Coronary angiography (or angiogram or arteriography), Ventriculogram, and Intracoronary ultrasound (NHLBI, NIH, 2004).

How is heart disease treated?

Heart disease and its risk factors may be treated in three ways: (1) by making lifestyle changes; (2) taking medication; and, (3) having a medical procedure (NHLBI, NIH, 2004).

What are the warning symptoms of a heart attack?
Chest discomfort, upper body discomfort, shortness of breath, nausea, light-headedness, cold sweats.

What are some statistics on women and heart disease?

- Coronary heart disease (CHD) accounts for over 250,000 deaths in women per year (AHRQ, 2003).
- 435,000 American women have heart attacks each year; 83,000 are under age 65 and 9,000 are under age 45. The average age is 70.4 (American Heart Association, 2002).
- Heart disease is the leading cause of death of American women and kills 32% of them (American Heart Association, 2002).
- Women with diabetes are two to three times more likely to have heart attacks (American Heart Association, 2002).
- Nearly 80% of black women are overweight or obese, increasing the risk not only of heart disease but also a host of other conditions, including stroke, gallbladder disease, and some cancers (NHBLI, 2003).
- Nearly 60% of Latinas are physically inactive (NHLBI, 2003).

Tools for Clinicians

At MACHC's Women's Health Symposium, Dr. Rosaly Correa-de-Araujo, of the Agency for Healthcare Research and Quality, presented "Cardiovascular Disease: Meeting the Needs of Women". Dr. Correa-de-Araujo's presentation explored major gender and race differences relating to cardiovascular disease, clinical and preventive services for women with cardiovascular disease, and discussed "filling the gaps" in providing the best care for women with cardiovascular disease. To view Dr. Correa-de-Araujo's presentation, access the special section on Women's Health at www.machc.com.

Tools for Health Educators

Karen Carmody, MS, CRNP, of the Clinical Regional Advisory Network (CRAN), presented "Health Disparities Collaborative: Best Practices and Women's Health". Ms. Carmody's presentation discussed the innovative multi-year health initiative to reduce health disparities and described the collaborative to delay or decrease the complications of cardiovascular disease as relating to women's health. To view Ms. Carmody's presentation, go to the special section on Women's Health at www.machc.com.

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MACHC Membership

The Mid-Atlantic Association of Community Health Centers (MACHC) is comprised of Federally Qualified Health Centers (FQHCs) throughout Maryland and Delaware. To locate a satellite site nearest you, contact any of the health centers listed below.

Maryland

Baltimore Medical System, Inc.
3501 Sinclair Lane
Baltimore, MD 21213
Phone: (410) 732-8800

Chase Brexton Health Services
1001 Cathedral Street
Baltimore, MD 21201
Phone: (410) 837-2050

Choptank Community Health System, Inc.
301 Randolph Street
Denton, MD 21629
Phone: (410) 479-2650

Family Health Centers of Baltimore
631 Cherry Hill Road
Baltimore, MD 21225
Phone: (410) 354-2000

Greater Baden Medical Services
9440 Pennsylvania Avenue
Upper Marlboro, MD 20772
Phone: (301) 599-0460

Park West Health System, Inc.
3319 W. Belvedere Avenue
Baltimore, MD 21215
Phone: (410) 542-7800

Total Health Care, Inc.
1501 Division Street
Baltimore, MD 21217
Phone: (410) 728-4090

Walnut Street Community Health Center
24 North Walnut Street, Suite 200
Hagerstown, MD 21740
Phone: (301) 393-3419

Delaware

Delmarva Rural Ministries
26 Wyoming Avenue
Dover, DE 19904
Phone: (302) 678-2000

Henrietta Johnson Medical Center
601 New Castle Avenue
Wilmington, DE 19801
Phone: (302) 427-9693

Associate Member

La Red Health Center
505-A W. Market Street
Georgetown, DE 19947
Phone: (302) 855-1233

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Prepared by:

Yesenia Flores, MS, Healthcare Outreach Coordinator for the Mid-Atlantic Association of Community Health Centers. For more information, visit www.machc.com or contact Yesenia Flores at: Yesenia.flores@machc.com.

About the Mid-Atlantic Association of Community Health Centers (MACHC)

The Mid-Atlantic Association of Community Health Centers is a non-profit, membership organization. MACHC's membership consists of community, migrant and homeless health centers, local non-profit and community-owned health care programs, whose mission is to provide health care services to the medically underserved and uninsured in Maryland and Delaware. MACHC is built on delivering accessible, affordable, cost effective, and quality primary health care to those in need in rural and urban communities.

MACHC believes: health services are a right, not a privilege. All people have a right to accessible, affordable, quality health care. Community partnerships maximize the use of resources to enhance community health and well-being. We seek partners who share our vision and look for opportunities that enable us to achieve our mission.

Mid-Atlantic Association of Community Health Centers (MACHC)

4483-B Forbes Boulevard

Forbes Center Building II

Lanham, MD 20706

Tel. (301) 577-0097

Fax (301) 577-4789

www.machc.com