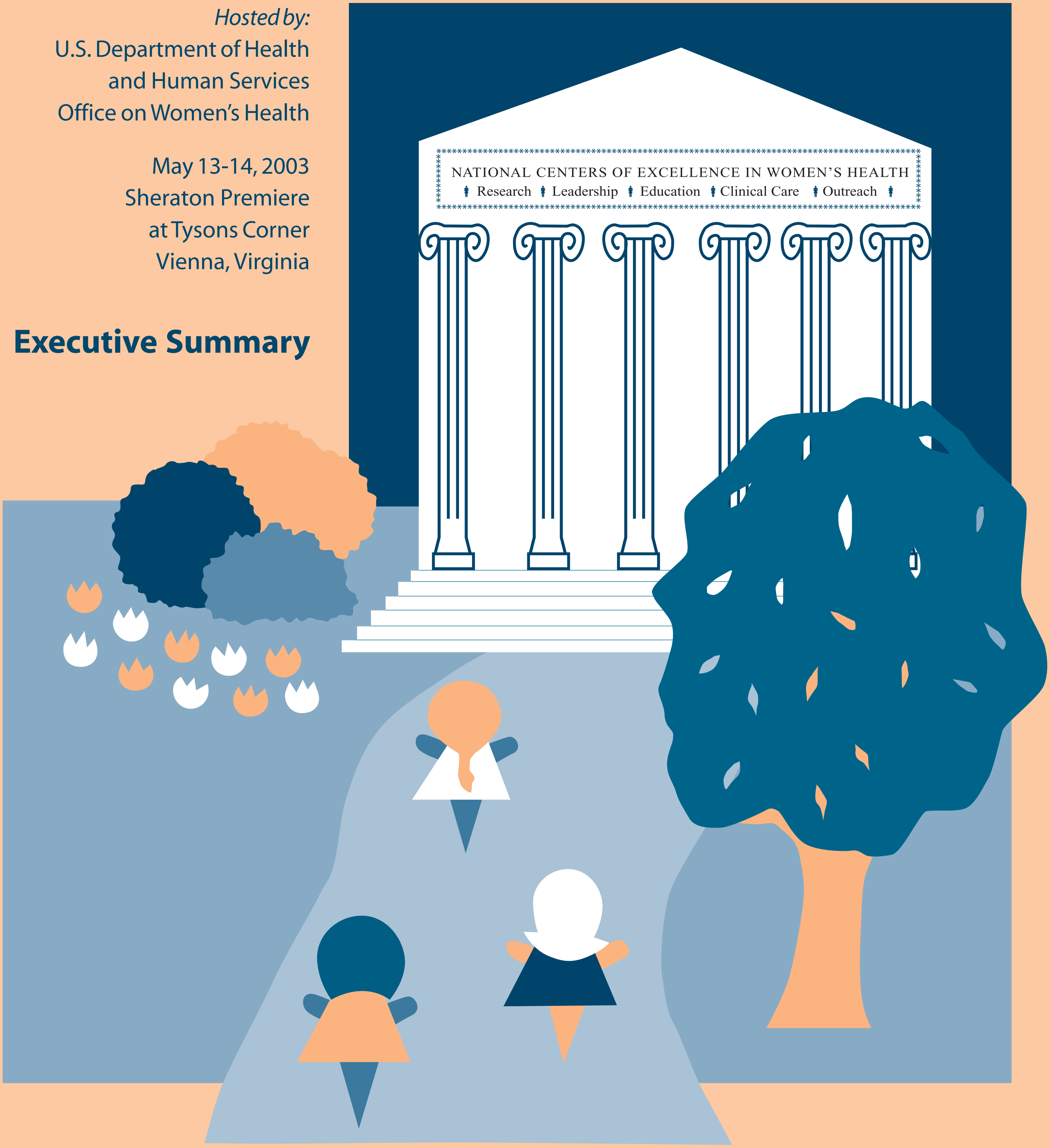
# National Centers of Excellence in Women's Health Second National Forum

## *Understanding Health Differences and Disparities in Women—Closing the Gap*

*Hosted by:*
U.S. Department of Health
and Human Services
Office on Women's Health

May 13-14, 2003
Sheraton Premiere
at Tysons Corner
Vienna, Virginia

## Executive Summary



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Joseph Bordogna, Ph.D., Deputy Director of the National Science Foundation (NSF)

Nathan Stinson, Ph.D., M.D., M.P.H., Deputy Assistant Secretary for Minority Health, U.S. Department of Health and Human Services (DHHS)

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# INTRODUCTION

This report summarizes the proceedings of the National Centers of Excellence in Women's Health Forum. Held May 13-14, 2003, at the Sheraton Premiere at Tysons Corner, Vienna, Virginia, the Second National Forum was hosted by the Office on Women's Health (OWH) within the U.S. Department of Health and Human Services (DHHS). With the support of Federal funding, the National Centers of Excellence in Women's Health (CoEs), located at leading academic health institutions, are providing leadership in advancing women's health research, professional training, public health education, clinical services, and community outreach. The CoEs also foster the recruitment, retention, and promotion of women in academic medicine. The Forum was designed to share progress, provide information, and share findings among CoEs and with representatives of other academic health centers interested in adopting the CoE model.

A conference planning group, consisting of representatives from each of the CoEs and OWH staff members, developed the content and program of the Forum. The Forum featured opening remarks, four plenary sessions, two panel discussions, a special satellite session, poster presentations, and a series of 22 concurrent workshops, representing various aspects of the CoE program. Cross-cutting themes and core concepts related to understanding health differences and disparities among women were addressed throughout each session.

This summary report presents highlights of the full proceedings of the plenary sessions and a summary of each of the concurrent workshops. A listing of the presenters is provided in Appendix A.

# OPENING PLENARY: CLOSING THE GAP

Opening remarks were offered by **Susan M. Clark,** M.A., Director, Division of Program Management of the Office on Women's Health and Project Officer for the CoE program; **Wanda K. Jones,** Dr.P.H., Deputy Assistant Secretary for Health (Women's Health), U.S. Department of Health and Human Services (DHHS); and **Cristina Beato,** M.D., Principal Deputy Assistant Secretary for Health, DHHS.

*Ms. Clark* welcomed the participants, noting that since the original request for proposals was released, the National Centers of Excellence in Women's Health (CoE) program has made a great deal of progress in creating systemic change to improve health care for women across the country. She stated one of the primary lessons learned since the inception of the program is that making CoEs a reality requires dynamic, dedicated and hardworking leaders, and committed staff. She also stated that the CoE program is a journey rather than a goal, but if it is adopted nationally, the CoE model will improve the health and lives of women.

*Dr. Jones* noted that in the last decade, women's health has become an important element of our nation's health agenda. Under the direction of DHHS Secretary

Tommy Thompson and President George W. Bush, DHHS has committed nearly $6.7 billion to women's health this year, an increase of roughly $1 billion since 2000. In addition, large-scale clinical trials that investigate the biological journey of women through their lifespan are under way, health care and preventive services are reaching more underserved women, and academic medical centers across the country are making significant contributions to improving the health status of all women.

Dr. Jones reported that the 13 academic medical centers currently serving as CoEs are developing and evaluating model health care systems for women that integrate academic research, medical training, public health education, and community-focused clinical and preventive services. The CoEs are committed to advancing the recruitment, retention, and promotion of women in academic medicine.

Dr. Jones remarked that beyond the successes in their own communities, the CoEs have galvanized significant support for and attention to women's health both from within their academic institutions and from external sources. With approximately $17 million in funding from the Office on Women's Health, the CoEs have leveraged more than $285 million in additional funds to promote the advancement of women's health an amount that is almost 17 times the initial Federal investment.

*Dr. Beato* opened by stating that both Secretary Thompson and President Bush are very supportive of women's health issues and committed to raising public awareness of health issues that have an impact on women. Dr. Beato stated that while there have been significant health improvements among racial and ethnic minority populations in the U.S., our health care delivery system still needs much improvement. The CoEs are models of how this can be done because they are patient-centered, accountable, effective, and focused on teaching personal responsibility.

## PANEL DISCUSSION: THE ROLE OF ACADEMIC MEDICAL CENTERS IN ELIMINATING HEALTH DISPARITIES

This plenary panel discussion included three presentations. **Brian Smedley**, Ph.D., Senior Program Officer at the Institute of Medicine (IOM), discussed an IOM study on the unequal provision of health care services to racial and ethnic minority patients. **Lois Colburn,** Assistant Vice President of Community and Minority Programs at the Association of American Medical Colleges (AAMC), presented on academic medicine's role in eliminating health disparities. **JudyAnn Bigby,** M.D., Director of Community Health Programs at the Harvard University CoE and Center Director of the Harvard University CoE, discussed challenges to eliminating disparities in health care.

## Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care

*Dr. Smedley* presented findings from an Institute of Medicine study focusing on racial and ethnic disparities in health care. The study's purpose was to assess the extent of racial and ethnic differences in health care that were not otherwise attributable to known factors such as access to care. It also evaluated potential sources of racial and ethnic disparities in health care, including the role of bias, discrimination, and stereotyping at the provider, patient, institutional, and health system levels. Finally, the study provided recommendations regarding interventions to eliminate health care disparities.

Dr. Smedley noted that access is the most important predictor of the quality of health care; that it is difficult, even artificial, to separate access-related factors from social categories such as race and ethnicity; and that the bulk of research on health care disparities has focused on differences between African Americans and whites. More research is needed, he added, to understand disparities among other racial and ethnic minority groups.

Dr. Smedley presented examples of research evidence showing that physician biases and stereotypes may influence the clinical encounter. One study found that African-American women were less likely to be referred for catheterization, even though they presented the same symptoms as white women and men and African-American men. Another study found that mental health professionals and trainees were more likely to evaluate a hypothetical patient more negatively after being "primed" with words associated with African-American stereotypes.

Dr. Smedley drew several important conclusions from the IOM study. He stated that unacceptable racial and ethnic disparities in health care exist and that often they are associated with inferior care. Such disparities occur in the context of broader historic and contemporary social and economic inequality, and persistent racial and ethnic discrimination in many sectors of American life. Many sources, including health systems, health care providers, patients, and utilization managers, contribute to racial and ethnic disparities in health care.

## Academic Medicine's Role in Eliminating Health Disparities

*Ms. Colburn* asserted that academic medicine plays an important role in eliminating health disparities. The AAMC, she reminded participants, represents the nation's accredited medical schools, major teaching hospitals, medical school faculty, and students. Its members are responsible for training the majority of this nation's physicians and medical scientists.

Using its accreditation procedures, the AAMC works to eliminate health disparities. The AAMC recommends that medical schools have procedures in place to ensure racial, cultural, and socio-economic diversity of student bodies. It also suggests that medical schools uphold a standard of cultural competence in the curriculum to ensure that faculty and students understand how people from diverse cultures perceive health and respond to various symptoms, diseases, and treatments and uphold a standard to eliminate biases and ensure that medical students recognize and address biases in themselves and others.

Ms. Colburn explained that AAMC supports health services research to build the knowledge base affecting both medical school curricula and patient care. This research focuses on issues related to real-world access and quality of care. Ms. Colburn maintained that the greatest roles the AAMC can play in eliminating health disparities are advocating for increased access to health care and funding the training of a more diverse group of medical practitioners.

## Challenges to Eliminating Disparities in Health Care

*Dr. Bigby* discussed the special role that academic medical centers (AMCs) play in the health care system. AMCs, she stated, exist to improve the health of their communities and the larger society. They have unique capabilities and roles as they perform nearly 30 percent of all the health care research and development and more than 50 percent of research supported by the National Institutes of Health (NIH). They train 50 percent of all U.S. residents and interns. They play major roles as safety net institutions caring for poor and uninsured patients, and they conduct clinical research required to innovate delivery of patient care.

Dr. Bigby stated that society's health-related needs are changing because our population is aging and becoming more diverse. There is also an increased incidence of chronic disease, especially among women. These changes have several important health implications for AMCs. To increase their efficiency and quality of care, AMCs need to prepare health professionals to care effectively for a more ethnically and culturally diverse patient population. They also should broaden participation of persons from all backgrounds in patient-oriented research, increase their role in caring for immigrant populations, and provide a full range of reproductive health services and maternal care to all women. In addition, AMCs need to learn how to minimize disparities in care provided to patients of different economic, social, racial, cultural, and ethnic backgrounds in the context of uncoordinated efforts to provide care for the uninsured. Finally, AMCs must develop effective strategies to address the consequences of the "feminization" of certain clinical services, which may lead to inadequate reimbursement for primary care, mammography, breast surgery, and reproductive health services.

In addition, Dr. Bigby stated, AMCs must change their culture to include more women in leadership positions and across the academic ranks. Presently, she noted, women of color are almost nonexistent both in leadership roles and in higher positions in academic ranks. AMCs must incorporate knowledge from demonstration projects and research that call for a comprehensive, community-oriented approach to address the needs of racial and ethnic minorities.

# LUNCHEON PLENARY: REFLECTIONS ON THE CAUSES OF HEALTH DISPARITIES

Plenary speaker **Harold F. Freeman**, M.D., Associate Director of the National Cancer Institute (NCI) and Director of the NCI Center to Reduce Cancer Health Disparities, has been working to reduce disparities in health care for four decades. Dr. Freeman stated that health care has made great progress in recent decades. Nonetheless, the burden of disease is borne more by some groups, particularly racial and ethnic minorities, than by others. Access to care is a major issue. For example, during any given year in the U.S., 60 million people have no health insurance.

Dr. Freeman spoke of the “three Ds” of health care: discovery, development, and delivery. To ensure optimal health care, these three Ds must be connected. Far too often, the advantages gained through discovery (research) and development (new medications and treatment options) are not delivered equitably. There is overwhelming evidence that members of racial and ethnic minorities, regardless of their insurance coverage or socioeconomic status, do not receive the same treatment as members of other groups.

Many factors influence health care disparities, but none is more important than race. Dr. Freeman asserted that race is “the single most defining issue in the history of American society. Racism is part of our cultural framework, and it even has an effect on scientific thought. We see each other through the ‘powerful lens of race.’” Moreover, we often do this without intending to do harm. Dr. Freeman concluded, the unequal burden of disease is a challenge to science and a moral and ethical issue for our nation. The answer lies in bridging the gap between discovery and delivery.

# WORKSHOPS

**“Altering Cultural Misinformation through Research”** was designed to provide information about the results of recent research on lesbian health issues and risks. The presenters described clinical interventions that health care providers can use, which meet the unique needs of non-heterosexual women.

*Suzanne L. Dibble,* D.N.Sc., RN, of the Institute for Health & Aging at the University of California, San Francisco, presented an overview of her study on similarities and differences in risk factors for breast and ovarian cancer between lesbians and heterosexual women. The study included data gathered from 255 triads each consisting of a lesbian, her sister, and a heterosexual female friend. In this study, participating lesbians had significantly more education than either their sisters or friends. Lesbians had significantly fewer children, abortions, and miscarriages than their sisters or friends putting the lesbians at higher risk for developing breast and ovarian cancer. In addition, lesbians had significantly higher body mass index and reported alcohol abuse. In theory, these findings would put the lesbians at greater risk for developing breast cancer. However, the actual rates of these cancers among lesbians are unknown because sexual orientation is not addressed in the cancer registries. Thus, Dr. Dibble recommended that sexual orientation be included in Surveillance, Epidemiology, and Environment (SEER) statistics and that more research on body-mass index of lesbians be conducted.

*Nina Markovic*, Ph.D., Co-Director of the Center for Research for Health and Sexual Orientation and Assistant Professor at the University of Pittsburgh, presented an overview of ESTHER (Epidemiologic Study of Health Risks in Lesbians). The study's objectives were to describe the health behaviors of women who partner with women in Allegheny County, Pennsylvania, and to identify factors that may put these women at higher or lower risk for chronic disease. ESTHER compared the results of a survey of 1,010 self-identified lesbians with those of a presumed heterosexual population of women who participated in the 1988 Behavioral Risk Factors Survey. Three risk factors—cigarette use, alcohol use, and high body-mass index—were found to be higher among lesbian women than among the heterosexual women. However, the lesbian population also reported a higher amount of vigorous activity and more recent mammograms.

Dr. Markovic concluded that there appear to be differences in the behavioral risk factors for chronic disease and screening practices between lesbians and heterosexual women, but that the influences of these differences on the risk of subsequent disease is currently unknown. Because lesbians make up one percent to ten percent of women receiving health care, more research should be undertaken to generate conclusive findings.

*Tonda Hughes*, Ph.D., Associate Professor at the University of Illinois at Chicago, presented information on the patterns of alcohol use and abuse among lesbians. She emphasized that behaviors are complex and that researchers should question the data from which they draw conclusions about lesbian health patterns. Dr. Hughes noted that many studies have found lesbians use alcohol more and have more alcohol-related problems than non-lesbians. Hughes' study found that even when rates of drinking among lesbians and heterosexual women are comparable, lesbians report more alcohol-related problems than heterosexual women. In addition, relationships among some demographic characteristics and drinking behaviors, such as age-related drinking patterns, are different for lesbians than for heterosexual women. Regarding alcohol use and its related problems, differences between lesbians and gay men are substantially smaller than differences between women and men in the general population.

To improve the understanding of lesbian health patterns and risks, Dr. Hughes recommended investigators involved in lesbian health research use standard measures of sexual orientation (using identity, behavior, or attraction as the means of definition) and representative samples. For example, researchers should not draw study samples solely from a population of lesbian women who frequent gay bars or from other arenas in which the population may be disproportionately influenced by secondary factors. Appropriate control and comparison groups should be included, and longitudinal studies performed.

*Jennifer Potter*, M.D., Assistant Professor in the Department of Internal Medicine at Beth Israel Deaconess Medical Center, presented some suggestions on how to make a medical practice more welcoming to lesbian clients. Lesbian, gay, bi-sexual and transgender (LGBT) individuals are considered special populations because social factors and cultural characteristics may differentially affect their risk for various diseases. When caring for LGBT individuals, clinicians must create a safe environment for disclosure, help the patient develop self-esteem, and take a comfortable and complete sexual history.

*Nancy Norman,* M.D., M.Ph.H., Director of Women's Health at Fenway Community Health, presented useful questions to ask when taking a sexual history that includes risk factors. Physicians should discuss with the patient what they are noting in her chart and assure her that the records are confidential. Some useful questions are:

> Are you sexually active? With men, women, or both?
>
> Do you have more than one partner?
>
> Do you have a need for birth control?
>
> How do you identify in terms of sexual orientation or behavior? (Not everyone identifies as "lesbian," "gay," or "heterosexual." Patients may use other words, such as "women who partner with women" or "women who have sex with men," etc.)
>
> Do you have sex with men currently? Have you ever had sex with a man?
>
> What are your significant relationships?
>
> Whom do you include in your family?

**"Funding Clinical Care: Public/Private/Academic Partnerships,"** presented four examples of how CoEs have financed women's health services by demonstrating the CoE's value to the institution.

*Robert Oye*, M.D., Professor and Vice Chair, Department of Medicine and Medical Director of the Internal Medicine Suites at the David Geffen School of Medicine at the University of California at Los Angeles, explained that the Iris Cantor-UCLA Women's Health Center is a multidisciplinary entity initiated through donor support. Most of the patients at the Center are covered by managed care organizations; however, the Center serves a large number of uninsured patients. Many patients come to the Center with different expectations than women who visit community health centers. To obtain support, the health center must prove its financial value by identifying the ancillary revenues that its patients generate.

*Karla Nacion,* Ph.D., C.N.M., Clinical Associate Coordinator, Nurse-Midwifery Practice, Clinical Associate Professor, and Clinical Co-Director of the Center of Excellence in Women's Health at the University of Illinois at Chicago, described the

Chicago area as being made up of many communities. In the area, Medicaid is an "acceptable" payer, sometimes providing more compensation than HMOs.

This model's advantages include increased referrals, an extension of the CoE's reach into the community, and the possibility of discovering new operational models. A particular challenge has been the time required to become successful in the community.

*Emily Y. Wong,* M.D., F.A.C.P., M.H.A., Center Director of the University of Washington (UW) CoE, said that this multidisciplinary facility provides primary care as well as specialty services in such areas as Ob/Gyn, sexual dysfunction, cardiology, urogynecology, and breast health. The facility serves a "front door" function to the UW Medical Center. She stressed that diversification is a key element in the success of a health center and that the Women's Health Care Center at UW had "inserted itself" into the UW Medical Center's strategic plan. For example, when the plan established priorities in oncology and cardiology, the clinic developed its own departments within these specialties.

*Myra Kleinpeter,* M.D., Associate Professor of Medicine at the Tulane Xavier CoE, described the Tulane Xavier CoE. It is the only CoE located in the Deep South and affiliated with a historically African-American university. Its sources of funding include collaborative assistance between the schools and hospital as well as government and foundation grants and charitable donations. Kleinpeter stressed the importance of demonstrating the CoE's financial value to the institution. She also noted that it is more effective to solicit the community's needs first, and to provide services that meet those needs, than to move forward without consulting the community and risk investing in a program that may not be used.

**"Promoting Diversity in Health Professions and Academic Achievement of Minority Women"** had three objectives: (1) to provide information on the American Association of Medical Colleges (AAMCs) effort to revise its definition of "underrepresented minorities" (URMs); (2) to describe methods being used to advance women of color within and outside academic medicine; and (3) to give attendees an opportunity to share effective practices for promoting diversity in academic medicine.

*Page Morahan,* Ph.D., Co-Director of the Executive Leadership in Academic Medicine (ELAM) Program at the MCP Hahnemann CoE (doing business as Drexel University), opened by stressing the importance of increasing women's participation in the political process.

*Myra Kleinpeter,* M.D. discussed the AAMC effort to redefine URMs. The current definition, issued in the 1970s, includes "Blacks, Mexican Americans, Native Americans (that is, American Indians, Alaska Natives, and Native Hawaiians), and mainland Puerto Ricans." In 2001, AAMC President Jordan Cohen, M.D., appointed an advisory committee to explore revising this definition to reflect changes in U.S. demographics and to eliminate racial and ethnic disparities in health care and health status. The Association hopes to have a new definition in place by the middle of this year.

*Gloria Hawkins*, Ph.D., Associate Dean for Multicultural Affairs at the University of Wisconsin-Madison, described effective practices for advancing women, particularly women of color, in academic health centers. Dr. Hawkins stressed that a commitment to diversity must permeate the university's atmosphere and organizational structure. It is a "blueprint" that must appear in writing in the institution's strategic plan and should include benchmarks that enhance credibility and accountability.

The university must have recruitment and hiring plans with procedures to ensure a diverse workforce. Search committees must include people of color and women. In addition, the university must make a special effort to highlight the contributions and accomplishments of women of color. Many of the contributions that women faculty make (e.g., as mentors) are not visible.

*Rosalyn Richman*, M.A., Executive Leadership in Academic Medicine (ELAM) Program at the MCP Hahnemann CoE (doing business as Drexel University), described issues related to promoting diversity beyond the walls of academic medical centers. She stressed the value of making a "business case" for diversity by showing that a diverse workforce will increase revenue, decrease costs, and increase productivity.

**"Recruiting and Retaining Women of Color in Clinical Trials"** described strategies and approaches that CoEs use to ensure women from ethnic and racial minorities are represented appropriately in clinical research studies.

*Juliet Rogers,* M.P.H., Co-Director of the University of Michigan (UM) CoE, offered an overview of national rates of women participating in clinical research. She said that researchers often lack information about the women who participate in clinical trials because few detailed records exist. Records of participation are reported to the funding agent, but they are rarely reported in journal articles.

Including women in clinical trials is important. It eliminates health disparities, increases a researcher's ability to generalize results to subgroups, and helps detect the effects of selection biases, Ms. Rogers stated. Moreover, inclusion of women is mandated by law for Federally-funded research.

*Beth Brown,* M.A., Research Specialist at the University of California, San Francisco (UCSF) CoE, discussed recruitment and retention strategies used in the Bayview Networks Study, a study of adolescent transmission of sexually transmitted diseases (STDs) focusing on the geographically and racially segregated community of Bayview Hunter's Point in San Francisco.

The study enrolled a random sample of African-American adolescents, their friends, their sex partners, and their sex partners' sex partners. For one year, these individuals were interviewed and tested for STDs every six months. In order to recruit and retain study participants, several tracking methods were used, including calling, paging, sending letters, making home visits, making jail visits, and examining yearbooks and public records.

*Donna Murasko*, Ph.D., Interim Dean of the College of Arts and Sciences at Drexel University, discussed her experiences from over 20 years of recruiting elderly research participants. She explained that to recruit Caucasian participants, the study team went to retirement communities, developed relationships with the medical director and staff, gave brief presentations to residents, and were able to enroll individuals in the study easily. These methods did not work to enroll minority participants.

After trying several methods of enrolling African-American and Latino participants with no success, Dr. Murasko placed a health care worker at a desk in a doctor's office for several months to answer general health questions. After developing relationships and building trust over several months, the health care worker began to ask patients to enroll in the study and succeeded in enrolling minority participants.

*Juliet Rogers* also presented information about the Women's Health Registry, an effort at the UM to increase the recruitment of women for clinical trials. She and her UM CoE colleagues surveyed researchers and discovered that the greatest challenges were funding research protocols, putting time and effort into recruitment and retention, and establishing a positive presence in the community.

The UM Women's Health Registry was created to link women who are looking for studies with investigators who need subjects. The Registry reduces barriers to participation because it builds the trust of women, reduces the intimidation factor, allows women to consider participation on their own timeline, offers a private initial step, and eliminates pressures or feelings of the "need to please," since initial communications are limited to Registry staff.

The goal of "**Working with CBOs and Consumers to Eliminate Health Disparities**" was to help participants better understand community dynamics and how they affect collaborative efforts to overcome disparities in women's health.

*Nancy Tartt*, M.S., Associate Director of Community Health at the University of Illinois at Chicago (UI), provided an introduction to the Breast Cancer and Beauty Salons Program, a collaboration between the UI CoE, the Westside Business Association, and various organizations and salons in Austin, Illinois. The program's goal is to provide breast cancer outreach, education, and support to traditionally underserved women by offering health training to salon owners and using salons as health resource centers for their patrons. The reason for using salons for this purpose was that they are frequented by women, tend to have customer loyalty, and serve as sources of information sharing and social support for women.

*Cindy Moscovic,* M.S.W., Director of Outreach and Education at the Iris Cantor-UCLA Women's Health Education and Resource Center, described the Center's Community Alliance program. The Alliance comprises both new and well-established organizations (e.g., local businesses, the Department of Housing and Urban Development (HUD), LA Unified School District, and the American Medical Women's Association (AMWA)). Besides providing networking, information, and partnering opportunities to its members, the Alliance provides UCLA with better opportunities to recruit minority women into clinical trials and other health research projects.

*JudyAnn Bigby*, M.D., Director of Community Health Programs at Harvard University and Center Director of the Harvard University CoE, gave an overview of the REACH 2010 Coalition, a community-centered initiative. REACH was created to respond to the increasing incidence of cancer and disparate mortality rates for breast and cervical cancer among African-American women. It is funded by the Centers for Disease Control and Prevention and aims to eliminate disparities by promoting cancer education, prevention, and treatment for African-American women in the Boston area.

The program is being evaluated by an independent contractor. REACH expects to see a decrease in cancer mortality rates for African-American women in the community, as well as increased patient satisfaction and improved understanding of the effect of racism on health.

**"Addressing Issues of Violence Against Women"** discussed issues related to violence against women across the lifespan and explored the role of community-based collaborative efforts to address violence prevention.

*Molly Carnes,* M.D., M.S., Center Director of the University of Wisconsin-Madison CoE, stated her belief that violence from personal violence to the effects of war is the most pressing health care issue for women.

*Susan Smith*, M.S.W., Co-Director of the Abuse Prevention Initiative at the University of Michigan Medical Center, presented information about the Center's current work to address violence across the lifespan.

Ms. Smith explained that the implementation of the Abuse Prevention Initiative included the launch of a 24/7 hotline, the production of educational materials, the training of faculty and staff, and the establishment of an abuse consultation team and oversight committee. Successes of the project have included increased screening and identification of patients who have experienced violence and institutional support for the initiative.

*Susan Knoedel,* C.I.C.S.W., M.S.W., Coordinator of the Women's Stress Disorders Treatment Program at William S. Middleton Memorial Veterans Hospital, discussed an interdisciplinary approach to sexual trauma in the military. She explained that it is difficult to obtain accurate statistics on sexual assault in the military due to under-reporting. The statistics that do exist indicate that women in the military experience a higher incidence of rape and other sexual assault than do their civilian counterparts.

Several factors may increase risk for military women, according to Ms. Knoedel. These include assaulters' easy access to weapons; more formalized, traditional power hierarchies; a history of polarized gender roles and gender discrimination; and isolation due to the low percentage of women in the military and the remote location of some military bases.

*Marnie Shiels*, Attorney Advisor for the Office on Violence Against Women at the U.S. Department of Justice, presented information on developing a national protocol for forensic examinations of victims of sexual assault. The protocol's goals are:

> Ensuring all victims, regardless of differences in background or location of service provision, receive the same high-quality medical and forensic exam and are treated with respect and compassion; and
>
> Improving prosecution of sexual assault cases through appropriate collection of evidence.

Ms. Shiels explained that thus far the Department of Justice has researched and reviewed existing state and local protocols; held focus groups of medical and forensic experts, advocates, and members of the criminal justice system; and created a working draft and circulated it to focus group participants.

The near-term next steps are to hold conference calls with survivors of sexual assault, hold conference calls focused on the impact of the project, and to seek input from relevant national organizations. The long-term next steps are to plan the dissemination of the protocol, along with periodic updates; to develop training standards based on the protocol; and to seek input on how to promote use of the protocol across the country.

*Lucia Beck-Weiss*, M.S., Associate Director of the Women's Health Education Program at the MCP Hahnemann CoE (doing business as Drexel University), discussed a medical school curriculum on domestic violence that has been developed and implemented at Drexel.

Ms. Beck-Weiss stated that the curriculum features a 40-hour training geared toward teaching medical students how to identify signs of domestic violence, ask about it, and refer their patients for assistance.

*Linda Laras,* M.D., M.P.H., F.A.C.O.G., Assistant Professor of Ob/Gyn at the University of Puerto Rico, addressed public health intervention in sexual and domestic violence. Dr. Laras explained that in 1998, the World Health Organization recommended that a public health approach be applied to sexual and domestic violence. This approach would bring the resources of health services, social services, community programs, the police, the judicial system, victim and survivor organizations, and other groups together to assist victims and survivors.

Dr. Laras stated that the system is fragmented. In each case, support systems are at odds with each other. Effective partnerships are needed to bring together the health, justice, police, social services, and education communities.

The session "**Caring for Women Who Are Multiply At-Risk, Including Women with Disabilities**" focused on issues facing women with chronic conditions such as HIV/AIDS as well as physical disabilities.

*Jaye Hefner,* M.D., Medical Director of the Department of Internal Medicine at the University of Pittsburgh Medical Center, presented findings from the Comprehensive Center for Women with Special Health Care Needs. More than 100 women between the ages of 18 and 100 were studied; of these, approximately one-third suffered from spinal cord injuries and another third from multiple sclerosis. The remainder had a variety of conditions such as spina bifida, cerebral palsy, and stroke.

Case studies of female clients from Pittsburgh showed significant systemic discrimination and demonstrated the need for better planning by providers and for specialized equipment in order to provide quality care to women with disabilities.

*Carmen Zorilla,* M.D., Associate Professor of Obstetrics and Gynecology at the University of Puerto Rico CoE, presented issues faced by women living with HIV. Worldwide, there are five million new cases of HIV each year. While combination treatment has lowered the incidence of AIDS mortality, these medications are not available for all affected people everywhere. In fact, the rate of new AIDS cases and related mortality among women (especially among minority women in developing countries) has increased. These women face multiple barriers to prevention and treatment, including fear of disclosure, unequal access to services, and an inferior quality of care.

**"Eliminating Health Disparities for Rural Women: Model Programs"** showcased different models used to reach rural women and provided suggestions on how to partner with private foundations, state, and Federal agencies and community organizations to address these women's health issues.

*Stephanie Lent,* M.S., Administrative Director of the University of Wisconsin-Madison CoE, described the Wisconsin Roundtables program. She said that the success of this program largely can be attributed to the efforts of Sue Ann Thompson, the wife of DHHS Secretary Tommy Thompson. Mrs. Thompson's goal is to have at least one program in each of Wisconsin's 72 counties. There have been more than 40 programs since the Roundtables commenced in 1999. The main goal of this program is to "create a cadre of informed women's health consumers who can share knowledge within their communities."

*Mary B. Laya,* M.D., M.P.H., from the University of Washington CoE, introduced the Rural/Underserved Osteoporosis Student Educator (ROSE) Project, a community outreach program that also provides online professional education. In rural

Washington State, 40 percent of families are "working poor." Older women have poorer health status than younger ones do, particularly because of chronic disease.

First- and second-year medical students from the group Rural Undeserved Opportunities (RUOP) and second-year physician assistant students assist in workshop presentations about osteoporosis. This topic was chosen because of the high rates of hip fractures in the area, the low levels of knowledge about this disease among rural women, and the need to inform women patients about effective, low-cost lifestyle interventions.

The ROSE Project goals are to:

> Improve knowledge of osteoporosis among residents of rural communities;
>
> Teach students about a provider's role as a public health educator; and
>
> Raise awareness among providers of resources available for osteoporosis education.

*April Mason,* Ph.D., Associate Dean for Discovery and Engagement in the Consumer and Family Sciences Extension at Purdue University, spoke about the Consumer and Family Sciences Extension that was established by the University. Programs offered by the Consumer and Family Sciences Extension focus on six topics: diet and prevention of chronic disease, diabetes education, diet and exercise; breast cancer, nutrition for at-risk and low-income families, and nutrition and lifestyle choices during pregnancy. Program directors partner with the Indiana State Cooperative Extension Service to expand outreach and "reach the hard-to-reach." Partners in this effort include the Indiana Extension Homemaker Association, Agriculture Natural Resource, 4H/Youth Development, and Consumer and Family Services.

*Jeanette H. Magnus,* M.D., Ph.D., Center Director of the Tulane Xavier CoE, spoke about that Center's collaboration with the Louisiana Office of Public Health. The need for such a program in this state is particularly acute, she said; Federally-designed benchmarks have deemed Louisiana the worst state for women to live. The partnership between the Louisiana Office of Public Health and the CoE serves as a statewide network for educational programs geared toward rural low-income women. It provides intern opportunities and practice sites for graduate students and preventive medicine residents. The program also collects extensive data that can be used in maternal child health related research. Dr. Magnus concluded that working with the Office of Public Health is an excellent opportunity to seek out partners and use lay health advisors to improve program sustainability.

"**Integrating Medical Abortion into Women's Health Primary Care**" was designed to help participants understand the possible role of medical abortion in women's primary care by presenting strategies, successes, and failures in integrating this service. Information on the historical background of medical abortion and the process of the provision of medical abortion were discussed. Information on the unique and common barriers to integration of medical abortion within internal medicine, family practice, and Ob/Gyn were presented as well.

*Tracy Weitz*, M.P.A., Project Director at the Center for Reproductive Health Research and Policy at the University of California, San Francisco, opened with an overview of specific medical abortion services and the historical development of these services. Medical abortion refers to early pregnancy termination, usually before nine weeks gestation, resulting from abortion-inducing medications and without primary surgical intervention. The preferred modality of medical abortion is a mifepristone (RU 486) and misoprostol combination.

Mifepristone was approved in France in 1988, but did not receive FDA approval in the U.S. until September 2000. FDA approval required that providers be able to date pregnancies and diagnose ectopic pregnancy; provide or arrange for back-up surgery if needed; ensure access to emergency care; and agree to dispense the Medication Guide and report all adverse events. Mifepristone providers were not required to be providers of surgical abortion, possess competency in ultrasound, or have hospital privileges to gain approval.

There are challenges to integrating medical abortion into primary care. Providers need to have training in the methods used. Primary care providers are often omitted or excluded from malpractice coverage for the services because abortion is considered “surgery,” even if surgical methods are not used. Insurance billing is a challenge, as are the drug ordering requirements, since they are distributed only to licensed physicians who sign and return a “Prescriber’s Agreement” and are not available through pharmacies as other drugs are. Other challenges include specification of the evidence-based protocol in patient consent information, access to ultrasound, and access to back-up for surgical intervention. Legal barriers include funding restrictions, institutional restrictions based on religion or state laws, and state restrictions such as consent laws, waiting periods, and counseling requirements.

*Gloria Sarto*, M.D., Ph.D., Professor of Ob/Gyn at the University of Wisconsin-Madison CoE, shared the results of a survey of Wisconsin physician views and practices regarding mifepristone. Importantly, the interest in using the mifepristone/misoprostol modality that physicians reported prior to FDA approval was not borne out after FDA approval. In three surveys between 1994 and 2000, between 26 and 54 percent of surveyed physicians stated that they would be likely to prescribe mifepristone/misoprostol if approved.

*Melissa Gilliam*, M.D., M.P.H., Assistant Professor**,** Divison of General Ob/Gyn, of the Department of Obstetrics and Gynecology at the University of Illinois at Chicago, presented an overview of the process of medical abortion at her center for reproductive health. The center operates the Kenneth J. Ryan Training Program in Abortion and Family Planning, which incorporates abortion into residency training and abortion services into an outpatient setting at a center for reproductive health. The program offers a two-year fellowship in abortion and contraception to gynecologists and family practitioners, who join the staff of the center for reproductive health.

Dr. Gilliam cited the main challenges encountered and solutions created at the Center. One challenge is obtaining mifepristone itself—if the medical facility is a hospital, a formulary may need to be used. A clinic has an advantage in being able to use a credit card. Another challenge that providers of medical abortion face is a high volume of follow-up phone calls to physicians. In response to this, the 24-hour phone service was created to offer counseling and provide information up front. The service requires coordination and training of ancillary staff in protocols for counseling patients.

*Karen Freund*, M.D., M.P.H., Center Director at the Boston University CoE, clarified the complex process of providing medical abortion services. She highlighted 6 elements that are essential to the development of medical abortion services in a primary care practice.

> *Need*—decide if there is a need for the provision of services to primary care patients or referral patients.
>
> *Personnel*—establish a primary care leader to organize the effort.
>
> *Personnel*—establish other primary care providers who are willing to learn the process despite lacking gynecological procedural experience.
>
> *Personnel*—find specialty providers who are willing to provide teaching and back-up services.
>
> *Coverage*—develop a small defined coverage group within primary care.
>
> *Institutional Resources*—have radiology services able to do dating ultrasounds.

Dr. Freund then recounted some of the experiences of a similar surgical/primary care collaboration that she had been involved in and that might serve as an example. In this collaboration for providing breast health services, primary care physicians received training and began to take over some breast diagnostic evaluation services because the surgical specialists were overburdened. The collaboration was able to develop primary care breast diagnostic services.

“**Medical School Curriculum in Women’s Health: Incorporating Cultural Competency**” gave presenters from four academic settings an opportunity to share their experience and insight on how to include cultural competency and skills-building opportunities in the education and training of health professionals.

Leading off this workshop was *America Facundo*, Ph.D., Co-Director of the Medical Sciences Center at the University of Puerto Rico. Dr. Facundo noted that cultural competency is incorporated into the curriculum at the University of Puerto Rico in two major ways. First, issues relating to diversity are integrated into the problembased learning approach used throughout the curriculum. Second, specific examples relating to various aspects of women's lives are woven into an ethics course.

*Susan Baillie*, Ph.D., Assistant Professor in the Department of Medicine at the David Geffen School of Medicine, University of California at Los Angeles (UCLA), spoke about the necessity of integrating cultural competency into the medical school curriculum in California, where large disparities in health care exist despite the fact that there is no longer a "majority population."

UCLA uses both general and specific strategies to increase students' cultural competence and awareness of racial and ethnic disparities. Faculty development is a major strategy behind the drive for cultural competency at UCLA.

*Cathy Lazarus*, M.D., Assistant Dean for Graduate Medical Education at the Tulane Xavier CoE, summarized her ideas in four short guidelines.

> Timing is everything. People must be comfortable with themselves—in their own environments—before they can learn about cultural competency.
>
> Culture Counts. Medical students are open to information when it is delivered in a context consistent with the teaching style to which they are accustomed.
>
> Anger and Guilt Interfere with Learning. Developing cultural competency cannot be done in an environment where learners feel they are being blamed for social inequities.
>
> Credibility is Key. Medical students prefer information provided by physicians.

*Ana Nunez,* M.D., of the MCP Hahnemann University CoE (doing business as Drexel University) College of Medicine, shared some of the methods used at MCP Hahnemann. She emphasized that there is no "one-size-fits-all," sure-fire guarantee of success, and stressed the need for a variety of educational formats. Hands-on learning experiences and the opportunity to work under preceptors are particularly effective.

"**Capturing Teachable Moments and Capitalizing on Learnable Moments: Diversity Training Models in Faculty Development and Medical Education**" introduced two examples of how academic medical centers address cross-cultural education in a clinically relevant manner.

The first speaker, *Sheila Chapman*, M.D., Assistant Professor of Medicine at Boston University School of Medicine, explained how that school's diversity task force developed the RESPECT model, which serves as a reminder to clinicians to consider the key elements present in cross-cultural care. This acronym stands for:

> Respect
>
> Explanatory model

Socio-cultural context

Power

Empathy

Concerns and fears

Therapeutic alliance/trust

While the diversity task force initially focused on the needs of the patient, it soon realized that it would be beneficial to also address the needs of residents. The task force developed a three-hour seminar for second- and third-year residents.

The school produced a video for faculty preceptors that demonstrates how culturally awkward clinical experiences can be valuable teaching opportunities. Based on actual clinical experiences, the video presents a patient–resident interaction. It then shows the resident's subsequent conference with the preceptor, and demonstrates effective teaching styles.

*Tricia Tang,* Ph.D., Assistant Professor at the University of Michigan Medical School, emphasized the need to tackle all levels of academia—faculty, residents, and students—in order to effect positive change. She stated that case-based learning is a particularly effective educational approach because it allows students to see practical applications of their knowledge.

In order to build a bank of these training cases, the school developed a "deposit slip" that faculty and students use to report clinical situations in which cultural differences negatively affected the outcome of a medical encounter. The innovative system helps ensure that these teachable moments are easily captured.

"**CoE—Collaborations and Funding Opportunities**" explored innovative approaches to securing and maintaining support for women's health programs and services.

*Sabrina Matoff,* M.A., Public Health Analyst at the Office of Women's Health in the Health Resources and Services Administration (HRSA), described collaborative efforts between the CoEs, other partners, and "Bright Futures for Women's Health and Wellness," a program sponsored by HRSA's Maternal and Child Health Bureau. The goal of Bright Futures is to provide materials for women and health care professionals to support increased delivery of preventive services to women.

Ms. Matoff described the upcoming pilot evaluation of the first of three tools that the program plans to develop for primary health care providers. The subject of this tool is physical activity and nutrition.

*Margaret Miller,* Ph.D., D.A.B.T., R.N., Senior Program Manager in the Office of Women's Health at the Food and Drug Administration (FDA), described the activities of FDA research initiatives that have involved the CoEs. The purpose of these programs, which were established in 1994, are to fill knowledge gaps relating to women's health and enable the FDA to make more informed regulatory decisions. In order to leverage funding for the CoE, programs are undertaken in collaboration with other funding sources.

*Janet Pregler*, M.D., Center Director of the University of California at Los Angeles (UCLA) CoE, described a program sponsored by the Centers for Disease Control and Prevention (CDC). The program focuses on identifying the offspring of women who used diethylstilbestrol (DES) to prevent miscarriage during their pregnancies. The daughters of women who used DES subsequently developed a high incidence of clear cell carcinoma, a rare form of vaginal cancer. Sons of women who used DES had an above-average incidence of minor genitourinary abnormalities. The CDC program was established in response to a 1999 congressional mandate to determine whether DES daughters experience any further effects of exposure as they age and to identify any effects in the DES "grandchildren." The goals of the CoE/UCLA effort were to update health care professionals' knowledge about DES, to increase awareness, and to assess the risk of those who might have been exposed. Several CoEs are taking part in this program, which also includes a consumer component.

*Roy White*, Vice President of the Educational Foundation of the General Merchandise Distributors' Council (GMDC), described a community outreach program of GMDC's called the "Women's Well-Being Initiative." The goal of the program is to place health information materials in retail stores. GMDC is a trade association of retail stores.

Mr. White noted that many studies have shown that women have key roles as health care consumers and decision makers. The Foundation's research has shown that women want good information. One-third of the women surveyed said that such information could be a factor in persuading them to change their lifestyle. Making health information accessible to women makes good business sense; it also helps business meet social goals.

**"Developing and Maintaining Effective Systems of Care for Elderly Women"** discussed the unique needs of our country's rapidly growing population of older women and presented strategies for meeting these needs.

*Suzanne Dibble*, D.N.Sc., Professor at the Institute for Health & Aging at the University of California, San Francisco, discussed planning for illness and care. Life expectancy in the U.S. is still increasing, with women now expected to live an average of nearly 80 years. Women who are 75 years of age and older may be considered at risk for several reasons because many of them experience the following:

living alone (more than half of them live alone),

limited physical mobility (e.g., problems with reaching, walking, stairs),

memory impairment,

chronic illness (e.g., arthritis, heart disease, depression),

increased social isolation,

higher health care costs,

poverty, and

other factors that strongly influence quality of life and access to care.

Given these trends, housing, managing future illnesses, ensuring adequate care, and documents and financial resources are issues for women, caregivers, and providers to consider.

*Pam Davies*, M.D., of the University of Michigan (UM) Health System, described the geriatric gynecology curriculum at UM. The University initiated the curriculum in response to the recognition that 20 percent of the U.S. population will be 65 years of age or older by the year 2030, and that 60 percent of those individuals will be women. By that same year, it is estimated that half of all health care spending will be on women aged 75 or older. The University has partnered with the Reynolds Foundation to train Ob/Gyn residents in geriatric medicine using the new curriculum.

**"Developing Community- and County Hospital-Based Women's Health Programs"** provided strategies for developing new women's health programs in a time of growing health care constraints.

*Karen Freund,* M.D., M.P.H., CoE Center Director and Professor of Medicine at the Boston University CoE, has helped spearhead the creation of four women's practices. Dr. Freund said that the following three components are key to starting a successful women's health clinical center:

A clinical leader committed to starting and maintaining the project;

A department head who understands the value of women's health; and

Administrative leaders who control financial assets with the goal of increasing market share to women.

The largest barriers to starting a new practice are costs and competition with existing Ob/Gyn and family medicine practices.

*Elizabeth Dupuis,* M.D., from the Boston University CoE, summarized reasons for this facility's success. The first reason is superior leadership; others are appropriate timing and the program's ability to provide specialty services that were otherwise unavailable. The goals of this community-based facility are to create women's health consultation services, fulfill a need, secure grant support and fund development. Quincy Medical Center possessed several advantages; for example, it met a need and strengthened comprehensive care and academic linkages while increasing utilization of hospital support services. The facility's success was measured by its clinical productivity, the generation of downstream revenue, patient and provider satisfaction, and the provision of support services for community health professionals.

*Ann Zerr,* M.D., Clinical Assistant Professor at the Indiana University School of Medicine, provided details on the development of a county hospital-based women's health program. Dr. Zerr stressed the importance of beginning by performing a needs assessment that identifies strengths and weaknesses. The county-based hospital experienced barriers similar to those faced by community-based women's health facilities, such as inadequate space and funds for expansion, duplication of services in a resource-poor environment, and the need to respect the chain of command. The strengths of this women's health facility include its ability to attract socio-economically diverse patients, several areas of unique expertise, and the ability to recruit women for clinical trials.

"**Innovative Educational and Psychosocial Support: Strategies for Women from Diverse Backgrounds**" identified program design principles and tools that are effective in health education programs for women from diverse backgrounds. Panelists discussed four health education programs in various communities and the elements of program design that were successful in those programs.

*Anna M. McDaniel*, D.N.S., R.N., of the Indiana University School of Nursing, discussed issues involved in designing interactive multimedia health communication programs for diverse audiences. Such programs are timely, because women are increasingly getting health information from an interactive communication source. Women are more likely to seek health information online than are men. Good multimedia health communication programs are based on two types of principles. The first are the principles of good design, which include visibility, memory load, feedback, access, navigation, legibility, and language. The second set of principles relates to user-centered design. These principles include cultural ideas such as values, beliefs, cognitive level, and individual preferences.

*Aswita Tan-McGrory*, M.S.P.H., Program Coordinator in the Office for Women, Family and Community Programs at Brigham and Women's Hospital, presented her experience in working on a minority women's health journal that was designed to help empower minority women to take charge of their health, talk with their providers, and take a proactive role in making decisions about their health care. Primary goals of the publication were to engage women in the community, develop content that focused on prevention, and encourage women to advocate for themselves.

*Tracy Battaglia*, M.D., M.P.H., Assistant Professor of Medicine at Boston University, presented information on a program that used a case coordinator to increase follow-up for women in an inner-city, multi-ethnic population whose previous screenings had revealed breast abnormalities.

The study was developed in response to two findings. Delays in follow-up to abnormal breast cancer screenings have been shown to have a negative impact on survival. Rates of non-adherence or untimely adherence are highest among ethnic minority, low-income, medically underserved women. The study took place at Boston Medical Center (BMC), an academic medical center with 12 affiliated neighborhood health centers. The Women's Health Breast Group model of care includes a complete diagnostic evaluation center based in a primary care practice site. It emphasizes multidisciplinary collaboration and care within the context of comprehensive health.

*Pam Dodge*, M.S.N, Director of Ambulatory Care at Magee-Womens Hospital, described an inter-generational community outreach program called "Families in Motion" to illustrate the work involved to create a community health event. The program was developed by the Magee-Womens Hospital African-American Womancare Advisory Board, and focused on organizing a series of community walks. The goals of the program were to:

> Promote healthy behaviors regarding obesity and chronic diseases that are impacted through lifestyle change;
>
> Promote physical activity;
>
> Promote healthy and safe neighborhood activities;
>
> Provide a setting where community members of all ages can interact;
>
> Create community awareness;
>
> Involve community partners;
>
> Encourage intergenerational activities; and
>
> Build individual, group, and community trust.

"**International Leadership Programs in Women's Health**" shared information on programs involving CoEs and international partners.

*Tina Darling*, Project Director at the Indiana University CoE, gave a presentation on behalf of *Rose Fife*, M.D., Associate Dean for Research at Indiana University School of Medicine, who was unable to attend. The presentation addressed HIV/AIDS and related women's health issues in rural Kenya. In this area, the incidence of HIV infection in the population is 10-15 percent. The average life expectancy has dropped from age 62 in 1980 to age 47 in 2003. AIDS is now the leading cause of death for women in rural Kenya.

Ms. Darling explained that in Kenya, most women are married and monogamous, but are infected by their spouses. Men typically have multiple sexual encounters, often with commercial sex workers. Men often blame their wives for contracting HIV and expel them and their children from the home.

Ms. Darling discussed a women's health initiative that has been developed by IU School of Medicine and Moi University College of the Health Sciences in western Kenya. The initiative focuses on voluntary counseling, testing, the prevention of mother to child transmission of HIV, education about safe sex, reduction of stigmatization and gender-related violence, and treatment.

*Page Morahan,* Ph.D., Co-Director of the ELAM Program at the MCP Hahnemann CoE (doing business at Drexel University), discussed the International Leadership Program for Medical School Faculty from Developing Countries. Dr. Morahan explained that there are several leadership programs for international educators, including in-depth programs, workshops, and fellowships. The Foundation for the Advancement of International Medical Education and Research (FAIMER) Institute was founded to target mid-level faculty. It focuses on both education and the development of leadership capacity.

*Signy Judd,* M.P.H., Project Director of the International Family Planning Leadership Program (IFPLP) at the University of California, San Francisco (UCSF), discussed the work of the IFPLP to address gaps in women's reproductive health resources in 12 countries.

The mission of IFPLP is to build on the 1994 International Conference for Population and Development framework for action, which established a legal precedent for the sexual and reproductive rights of women, men, and youth. IFPLP also aims to promote and support the development of family planning leaders to empower individuals, organizations, and populations in their countries to reach the highest possible level of sexual and reproductive health. IFPLP includes two concurrent programs: an Africa/Asia program, conducted in English, which includes participants from Ethiopia, Sudan, Nigeria, Pakistan, and the Philippines; and a Latin America program conducted in Spanish, which includes participants from southern Mexico, El Salvador, Guatemala, Honduras, and Nicaragua.

*Beverly McElmurry,* Ed.D., Associate Dean for International Studies at the University of Illinois at Chicago, discussed the Swaziland Rural Health Initiative, a program for community home-based care and HIV/AIDS risk reduction.

Dr. McElmurry noted that Swaziland and Botswana have an HIV prevalence rate of 34 percent. By 2010, it is estimated that there will be 120,000 orphaned children in those two countries. Several health problems commonly associated with HIV (e.g., tuberculosis, gastrointestinal disorders, respiratory infections, skin conditions, and nutritional deficiencies) also have an impact on families.

The Rural Health Motivators (RHM) program was established in 1976 as part of a national strategy to implement primary health care. RHMs are local women who receive 12-week training in basic health and hygiene. Each RHM then visits 30-40 homes to provide basic health education and promote personal and environmental hygiene. The RHMs also make referrals and link the community to the health care system.

*Eleanor Shore,* M.D., Dean for Faculty Affairs at Harvard Medical School, described international academic leadership and efforts that have been made at Harvard Medical School (HMS) and at the Medical School of Complutense University (UCM) in Spain to improve the representation of women in medical schools and in leadership ranks.

Dr. Shore presented statistics showing the growth of women faculty by rank at HMS from 1984 to 2002; the representation of women on medical school committees at HMS; the percentage of female faculty members in the United States, at HMS, and at UCM; and the percentage of women in science in Europe. She explained that HMS uses several approaches to ensure academic equity. These include monitoring of faculty representation of women and women in leadership positions, establishing the Joint Committee on the Status of Women, providing courses for women on grant and manuscript writing, and creating a fellowship program. Spain has government rulings that call for equal salaries for equal rank and equal space at rank, which is a benefit for the UCM program.

In the workshop titled "**Models of Care for Minority Women**," presenters described promoting cultural competence as a model for improving health outcomes.

*Jennifer Potter,* M.D., Assistant Professor of Medicine at Beth Israel Deaconess Medical Center, discussed a literature review on models of care for minority and other underserved women being conducted by the Committee to Advance the Health of Minority Women (CAHMW), a collaborative project of the Harvard CoE.

The objective of the literature review is to describe the components of the ideal model of care for minority and underserved women. The review will examine the definition of "diversity" and identify what disparities in health care exist and why. It will also explore what interventions to eliminate the disparities have been tried, how they have been evaluated, and strategies that can be used to implement these successful interventions on a large scale.

*Michele David,* M.D., M.B.A., M.P.H., Co-Director of the Women's Health Unit at the Haitian Health Institute at Boston Medical Center (BMC), discussed the work of the Institute.

Dr. David explained that the objectives of the Haitian Health Institute are:

> Facilitate access to optimal services, delivered in a culturally and linguistically competent manner;
>
> Educate the Haitian community about wellness and navigating the complex health care system;
>
> Develop a common plan through which to improve health care and education in the Haitian community;

Facilitate communication among Haitian health providers working in different primary care departments at BMC;

Identify areas of needs in culturally competent services for Haitians;

Link with community-based agencies; and

Research unmet needs and cultural beliefs affecting access to and compliance with health care.

Dr. David discussed some of the Institute's accomplishments. The Institute conducted a Haitian Breast Cancer Belief Study, a cross-sectional study involving personal interviews with Haitian women over 40 years of age in the greater Boston area.

The Institute also participates in Racial and Ethnic Approaches to Community Health 2010 (REACH 2010), a collaborative effort among health care providers in the Boston area to eliminate racial and ethnic disparities in breast and cervical cancer by creating a culturally competent system that promotes screening, education, prevention, and access to care for African-American women and women of African descent.

*Maya Hammoud,* M.D., of the University of Michigan (UM) Department of Ob/Gyn, presented information on the Middle Eastern Women's Health Initiative at the UM. She stated that the University thought it was important to establish such a program because Middle Eastern women are a large, underserved community with special needs. They lack preventive health care practices, they experience multiple barriers with care access, and they have special issues related to interacting with male health professionals due to traditions relating to gender roles in their culture.

It is important that clinicians understand that their Arab patients may be either Christian or Muslim, and that most of their Muslim patients are not Arabs. Clinicians also need to be aware that the practice of Islam has a profound impact on an individual's everyday life and can affect their health care.

*Susan Reed,* M.D., M.P.H., Assistant Professor of Ob/Gyn at the University of Washington Harborview Medical Center, spoke about comprehensive breast care services for minority populations.

Dr. Reed explained that Harborview serves mostly low-income women, over 50 percent of whom do not speak English. Harborview operates a program called "House Calls" that offers interpreters and culturally competent clinical mediators to help walk women through the breast cancer process, from the initial screening through care and treatment. In order to eliminate disparities in breast health, Harborview has focused on understanding the population to be served by conducting focus groups and surveys.

*Ann Zerr*, M.D., Clinical Assistant Professor at the Indiana University CoE, briefly described approaches to prevention through clinical care and outreach. She noted that Indiana University has a computer network and a shared information system. Any hospital in the system can access information and better coordinate patient care. The CoE has hired a bilingual health coordinator to better serve Spanish-speaking patients. The Center also has a minority health coordinator responsible for collaborating with community-based agencies and coordinating special projects. One such project is a new community access program to reach African-American women with diabetes.

"**Modifying the Message: Women's Health Education**" discussed strategies for tailoring health education messages to respond to the needs of select populations.

*Tina Darling*, Project Director at Indiana University CoE, focused her presentation on literacy. She emphasized that the presentation of health education messages should be influenced by a consideration of audience cultural factors and literacy level, and that low literacy affects all ethnic groups.

Literacy affects health. Patients need to be able to read consent forms, medicine labels, and other medical literature; to understand written and oral information from practitioners; and to be able to act upon procedures and directions. Ms. Darling presented findings from the 1992 National Adult Literacy Survey (NALS), which revealed that approximately one-half of adults—about 90 million people—are reading and living at low-literacy levels. A report published in the *Journal of the American Medical Association* in 1999 reported that patients with inadequate literacy have a 52 percent increase in the risk of hospitalization compared to patients with adequate literacy.

*Cindy Moskovic*, M.S.W., Director of Outreach and Education at the Iris Cantor-UCLA Women's Health Education and Resource Center, spoke about her experience assessing local health information gaps and creating programs to fill those gaps. This process often involves using nontraditional dissemination modes. It sometimes entails modifying an existing campaign to make it more developmentally and culturally appropriate for a new target audience.

Ms. Moskovic presented an example of a non-traditional means of getting a health message across to the target audience. After finding that local women were not aware that the warning signs for heart attacks in women are different than for those in men, Ms. Moskovic helped design the "Heart-Gram," which was to be used around Valentine's Day. Instead of a Valentine's message, the "Heart-Gram" was an attractive, pink heart that listed the warning signs of heart attacks in women.

*Melissa McNeil*, M.D., M.P.H., Chief of the Division of General Medicine at the University of Pittsburgh Medical Center (UPMC) at Montefiore, spoke about modifying messages to reach the medical community and to address women's health in the medical curriculum. Dr. McNeil emphasized that women's health is more than just reproductive health. It also covers diseases that are unique to women, diseases that are more common in women than men, and diseases that present differently in women.

When incorporating the message of women’s health into a medical school curriculum, health educators must consider at what level of training women’s health issues should be presented, whether women’s health issues should be treated separately or integrated into other educational experiences, and whether the training should be elective or mandatory?

*Lourdes de Soto de Laurido*, Ed.D., M.P.H.E., Co-Director of the Medical Sciences Center at the University of Puerto Rico, spoke about how to modify communication to meet the needs of health professionals, providers, and consumers. Communication is a basic process in all health promotion. Health communication involves the application of methods and concepts from diverse areas of communication science, such as language and behavior, non-verbal communication, interpersonal communication, group communication, persuasion, media studies, and intercultural communication. Health communication must be strategic, appropriate for the intended audience, adaptive to changing situations, and consistent across multiple messages and channels.

“**Promoting Collaborative Research in Minority Women’s Health”** presented several examples of how academic institutions are crossing institutional and community boundaries for mutual benefit.

*Delia Camacho*, Ph.D., Dean of Academic Affairs at the Medical Sciences Campus and Center Director of the National Center of Excellence in Women's Health at the University of Puerto Rico, presented an overview of her institution’s collaborative research initiative. At this CoE, the overall research goal is to “strengthen and enhance research efforts related to diseases and conditions that affect women in Puerto Rico.” The University, which has a six-school campus, strives to promote research between schools and disciplines. This is achieved through identifying faculty with less experience in research and pairing them with mentors, as well as by providing an extensive library to faculty, students, and other professionals.

Dr. Camacho discussed two examples of ongoing research projects. The first is an empowerment intervention for women with breast cancer; the other is an investigation of the health status of Hispanic women during midlife and menopause.

*Victoria Champion*, R.N., D.N.S., F.A.A.N., Associate Dean for Research at the Indiana University School of Nursing, discussed her institution’s difficulties in recruiting minorities and described strategies for overcoming these difficulties. They have found that incentive fees are essential to recruiting and retaining participants. The program has given money to clinics that refer patients and has solicited the assistance of “community advocates” who help promote research within a community.

*Tahnee Hartman-Prokopow*, M.P.H., Program Manager in the Diversity and Career Development Office at the University of Michigan Medical School, provided information about the University's Minority Health Research Program. The goals of this program are to reduce and eliminate minority health disparities and to provide education and outreach to the community. To do this, the program established a clinical research center in Ypsilanti, an ethnically diverse suburb of Ann Arbor, and staffed it with people particularly suited to promote community relations.

*Marcia Killien*, Ph.D., Professor of Family and Child Nursing at the University of Washington (UW) School of Nursing and the Co-Director (Director of Research) of the UW School of Medicine's CoE, described a partnership between UW and the University of Hawaii, Manoa. The purpose of this relationship is to provide mentorship opportunities to researchers, particularly minority researchers, with a focus on women's health and minority health disparities. Elements of the partnership include a UW grant program that provides seed money to researchers, the use of videoconferencing to present seminars and share research, consultations, resource sharing (such as a biological lab), and sponsorship of a summer institute where researchers can practice presentations in a supportive environment.

"**Promoting Women's Health through Community-Based Participatory Research**" brought together representatives from four National Community Centers of Excellence in Women's Health (CCOEs). Participants described their models and shared their ideas on overcoming the challenges associated with community-based participatory research (CBPR).

*Susan Nappi*, M.P.H., Program Coordinator at the Griffin Hospital Community Center of Excellence (CCOE) in Connecticut, noted that CBPR is a relatively recent development that is characterized by equitable involvement of and collaboration with the community (i.e., people who identify with one another through geography, belief system, social characteristics, or other share traits) in all aspects of the research process. CBPR promotes a high degree of control and ownership by community members by involving all partners (community and academic) in all aspects of a program or study.

*Milta Vega-Cardona*, M.S.A., C.S.A.C., and *Katherine Duffy*, M.P.H., both of St. Barnabas Hospital CCOE in New York, described the CCOE's approach to osteoporosis research among minority women using participatory action research. Researchers recruited African-American and Latina study participants through peer health educators, from St. Barnabas Hospital, and from focus groups for an existing cardiovascular disease (CVD) prevention program. Participants were assigned to structured focus groups on the basis of age. Members of the two groups will be involved in all stages of the research project—collective inquiry and education, data analysis and reflection, protocol development and interviews, survey analysis and review, and program planning and implementation.

*Jo Jean Elenes,* Program Coordinator of the Mariposa CCOE, described work being done in a rural clinic in Arizona that serves a young, low-income population of mostly Hispanic of Mexican descent. Before becoming a CCOE, the Mariposa Community Health Center focused primarily on reducing infant mortality (using health promoters and home visits), as well as reproductive health and cancer. Now the Center takes a more holistic, full lifespan approach to providing care. The Center views the community and its clients as stewards of their own health. The CCOE's objectives are to improve the existing health services network, increase woman-centered health promotion, empower women to become informed care consumers, increase community participation in research and health career opportunities for women, and transfer lessons learned.

*Jill Pyle* from the Santa Fe CCOE presented information on that Center's Research Involving Outpatient Settings Network (RIOS Net), a practice-based research network housed in the University of New Mexico's (UNM's) Health Sciences Center. RIOS Net consists of clinicians from multiple practices who collaboratively identify primary care research questions and develop practice-based studies that will improve health care delivery to traditionally underserved populations. Benefits of participating in RIOS Net include access to UNM academic resources and Web-based public health courses, opportunities for continuing medical education, and opportunities for manuscript writing. Consumers and community health board members are included in the Network.

Participants in the workshop entitled "**Quality of Care in Women's Health**" discussed one of the major challenges facing health care today—how to measure the quality of primary care. Although traditional tools such as patient satisfaction surveys remain helpful, new and more effective tools that focus specifically on women's needs are essential.

*Sarah Scholle*, Dr.P.H., Associate Professor at Magee-Womens Hospital, set forth the rationale for a special tool to measure the quality of women's primary health care. Patient satisfaction surveys have become a standard way to assess care from the patient's perspective. Existing tools, however, are limited. Few of them reveal disparities in satisfaction between men and women. The reason could well be that the tools are not designed to reveal such differences.

Primary care for women is more complex than care for men, Dr. Scholle stated. One reason is that women have two primary providers—a family practitioner or internist and an Ob/Gyn. Women have specific needs; they also have a range of expectations for themselves and their families.

*Karen Carlson*, M.D., of the Medical Evaluation Practices Center at Massachusetts General Hospital, defined quality care as "the right care, in the right place, and at the right time." When this type of care is delivered, it brings benefits both to women and to health care professionals.

With respect to the right care, Dr. Carlson said, diagnosis is not a biological fact. It is the outcome of a process that includes biological, cultural, and social factors. Likewise, treatment is not a fixed entity. The question should be "is this treatment right for this individual?" Shared patient–provider decision making can ensure that this question is answered correctly. She also said that co-location of services is key. Such services make it easier for women to receive care at the same time, and allow co-located staff to communicate easily with one another about patients for whom they have joint responsibility. Finally, it is important to coordinate schedules so that trips to the clinic or office are minimized. This leads to greater system efficiency.

The session on "**Women and Heart Disease**" provided information on sex differences in the epidemiology, pathophysiology, diagnosis, management, and outcome of cardiovascular disease.

*Jeanette H. Magnus*, M.D., Ph.D., Center Director of the Tulane Xavier CoE, talked about the use of long-term hormone replacement therapy (HRT) by menopausal women. Long-term HRT had been considered beneficial for women based on observational studies. Because HRT was reported to reduce the mortality rate among users, millions of women were encouraged to use HRT. However, long-term HRT was associated with an increased risk of breast cancer. A meta-analysis published in the *British Medical Journal* in 1997 reported that HRT substantially increased the risk of cardiovascular disease (CVD). Large placebo-controlled, randomized trials—the Heart and Estrogen/Progesterone Replacement Studies (HERS I and II)—produced important clinical findings supporting the 1997 report that HRT did not reduce the risk of heart disease in women.

The large Women Health Initiative (WHI) Study produced similar results. Only healthy, non-smoking women participated in this study. Age and HRT were found to increase the risk of deep venous thrombosis (VTEP). In addition, long-term HRT did not protect women from CVD, and there was an increased risk of breast cancer with its long-term use.

## PLENARY: CLOSING THE GAP: THE ROLE OF RESEARCH

Remarks were offered by **Molly Carnes**, M.D., M.S., Center Director of the University of Wisconsin-Madison CoE; **Gloria E. Sarto,** M.D., Ph.D., Professor of Ob/Gyn at the University of Wisconsin-Madison CoE; **Joseph Bordogna,** Ph.D., Deputy Director of the National Science Foundation; **Nathan Stinson**, Ph.D., M.D., M.P.H., Deputy Assistant Secretary for Minority Health at the U.S. Department of Health and Human Services (DHHS); and **Vivian W. Pinn**, M.D., Associate Director for Research on Women's Health at the National Institutes of Health (NIH).

*Dr. Carnes* welcomed the participants and introduced the panel chair Dr. Sarto.

*Dr. Sarto* noted that disparities in health care clearly exist. With relatively few exceptions health is poorer among minority populations than among non-minority groups. She stated that environmental, behavioral, and biological research for women is needed. The most important challenge is to increase the number of minority researchers and health care providers.

*Dr. Bordogna* discussed ADVANCE, a National Science Foundation (NSF) program aimed at increasing the participation and advancement of women in academic science and engineering careers. He reminded participants that the NSF is the Federal agency responsible for non-medical research in science and technology. The NSF focuses on developing the scientific workforce and sponsoring research across the scientific and technological fields.

Dr. Bordogna noted that while the general workforce now includes a more equal participation of women, the scientific workforce has not kept pace with national demographics. ADVANCE is one of the NSF's key strategies used to increase diversity in the scientific, engineering, and technological workforce. The goal of the ADVANCE program is to increase the representation and advancement of women in academic science and engineering careers, thereby contributing to the development of a more diverse science and engineering workforce. He noted that other NSF structures are in place to support a more diverse workforce.

*Dr. Stinson* discussed the DHHS approach to overcoming disparities in health care. He stated that problems such as disparities in health care do not just "go away." We must focus our assets and resources in order to close the gaps.

Dr. Stinson explained that the Office of Minority Health recently decided to take a step back to examine how it does its work. They determined that their work covers five main areas:

Shaping policy;

Enhancing the science base;

Linking people to services;

Creating partnerships; and

Strategically communicating the steps Americans can take to improve their health.

The Office has been examining how all of its branches intersect and overlap in these five areas. It is working to identify ways in which the different divisions can work more closely and maximize their impact on reducing disparities in health care.

*Dr. Pinn* addressed the topic of "Women's Health Research as a Paradigm for Utilizing Research to Eliminate Health Disparities and Effect Change in Public Health Policies and Practices."

Dr. Pinn reminded participants that disparities exist in different ways. There are disparities in health care between men and women as well as disparities among subgroups of women. In order to effectively address health care disparities, needs, and strategies must be based on scientifically determined knowledge. We must use biomedical and behavioral research to eliminate gaps in knowledge and address inequities in the prevention, detection, treatment, and outcomes of illnesses among women of all races, cultures, and socio-economic backgrounds. To properly address health disparities, Dr. Pinn said, we must do six things:

Identify disparities;

Develop a research agenda;

Disseminate research outcomes;

Advance community outreach activities;

Enhance public awareness; and

Increase health provider knowledge.

Dr. Pinn noted that in order to address health disparities through research, NIH has developed a strategic plan to address health disparities and established the National Center on Minority Health and Health Disparities (NCMHD). NIH uses three main approaches to eliminating health disparities through research: (1) inclusion policies for human subject studies that include women and minorities in all subject pools; (2) research initiatives that focus on the health of women and minorities; and (3) biomedical career development and enhancement for women and minorities.

## PANEL DISCUSSION: FINDINGS FROM THE EVALUATION OF THE NATIONAL CENTERS OF EXCELLENCE IN WOMEN'S HEALTH

This panel discussion was chaired by **Carol Weisman**, Ph.D., Professor of Health Evaluation Sciences and Ob/Gyn at Penn State College of Medicine; the panel members summarized the key findings of the national evaluation of the National Centers of Excellence in Women's Health (CoE) program and described the relevance of those findings for women and women's health programs. Speakers were **Nancy Milliken**, M.D., Center Director of the University of California, San Francisco CoE, and **Roger T. Anderson**, Ph.D., Associate Professor, Department of Public Health Sciences from Wake Forest University School of Medicine.

The two-year study evaluated the 15 CoEs that were in operation at the beginning of the study in 1999. It employed both qualitative and quantitative methodologies to assess the following: whether a national model developed for the CoEs was implemented (consisting of five core components: clinical care, research, professional education, leadership development, and community outreach); the type of impact that the CoE designation had on the academic medical centers that housed them; the CoEs greatest strengths and challenges; the quality of clinical care provided by the CoEs; and the level of satisfaction experienced by patients attending the CoE clinics. The evaluation methods included extensive interviews with representatives from the CoEs and their home institutions, and extensive surveys of

CoE patients for comparison with national data and local survey samples taken from three communities in which CoEs also reside.

*Nancy Milliken,* M.D., presented key results from the qualitative evaluation team. The goals of the national evaluation were to assess and understand the CoE developmental process as health care facilities move toward this new model, and to identify the CoEs' specific impacts. Evaluation respondents indicated that the CoE designation was a catalyst for institutional change in women's health, increasing an institution's ability to leverage other resources, including funds. Institutional administrators believed that the CoE's greatest strength, however, was in increasing collaboration and coordination. The directors also believed the CoE designation-legitimized women's health and enhanced opportunities to focus on it. The team also identified three main difficulties facing the CoEs: a lack of funding and resources, resistance to recognizing the importance of women's health, and "turf" issues.

*Roger T. Anderson,* Ph.D., presented the results of the quantitative evaluation team. First, Dr. Anderson spoke about the primary care objectives of CoE clinical centers, which are to improve the quality of women's health care by filling gaps in services; to foster an environment sensitive to women's health issues; and to "decompartmentalize" women's health care.

The quantitative evaluation team hypothesized that: (1) women served in the CoEs would receive more recommended services and report higher satisfaction with their care than other women; and (2) the extent to which a woman relies on the CoE for all her care would be associated with the degree to which the CoE met her need for clinical preventive services. The evaluation results were examined and compared to the results of a local community survey and to national benchmarks. Overall, women served by the CoEs received more services targeted to women's health than did women in both the national surveys and the community sample. Patient satisfaction was higher in CoEs than in either of the two other study groups. The more services a CoE provided, the more a woman tended to rely on the Center.

## CLOSING PLENARY

**Molly Carnes**, M.D., M.S., Center Director of the University of Wisconsin-Madison CoE, offered closing remarks. She noted that the CoEs were an "experiment" undertaken by the Office on Women's Health (OWH) in order to improve the health and health care of all women in the nation and to address not only gender gaps but also differences and disparities among populations of women.

Dr. Carnes reminded participants that in order to be a National Center of Excellence in Women's Health, an institution has to:

> Develop a multidisciplinary research agenda that will increase the number of women participating in clinical trials;

Restructure the health sciences curricula at all levels to include issues of women's health;

Support clinical models of care that better serve the needs of women and address the needs of underserved women, including women whose access to health care is impeded by interpersonal violence, race and ethnicity, poverty, geography, disability, sexual preference, and residence in prisons or nursing homes;

Implement a plan to increase the number of women researchers and faculty, especially women of color; and

Forge community partnerships, including partnerships with groups that speak for underserved women.

The impetus for the founding of the CoEs was the recognition that women had been excluded from most large Federally-funded clinical research studies. Dr. Carnes stated that when the General Accounting Office released its 1989 report that documented the exclusion of women from such studies, it caused broad realization that extrapolating data from research on men and using it as a basis to treat women was both scientifically and ethically unsound. It further led to the realization that racial and ethnic minorities of both genders were underrepresented in most clinical research, and that extrapolating data from white populations to treat racial and ethnic minorities was similarly scientifically and ethically unsound.

Dr. Carnes also noted that minorities of either gender are underrepresented both as students and as faculty members of U.S. medical schools. The Association of American Medical Colleges (AAMC) data indicate that in 2000, 1.1 percent of full professors at academic medical centers were African-American whereas African-Americans made up 12 percent of the U.S. population in that year. Low percentages are seen for other minority groups as well: all Hispanic groups together make up three percent of full professors, and Native Americans make up 0.1 percent.

Dr. Carnes stated that some barriers to women's advancement in academic medicine are institutional and visible; these include the absence of accessible and affordable child care and early-morning and evening meetings; these meetings pose a disadvantage for women who have family responsibilities. However, as documented by multiple studies, the biggest barrier remains the conscious and unconscious biases that result in consistently lower evaluations of women's work and impede women's career advancement. Dr. Carnes explained that OWH also insisted on interdisciplinary and multidisciplinary efforts in all five of the required program components, as well as integration across components. This helped decrease the isolation of women in academic medicine and empowered them to speak. Dr. Carnes noted that while institutional transformation may not be seen for many years, there have been some significant accomplishments:

There have been two national forums.

Quantitative and qualitative evaluations of the Centers have been performed, and the results have been published in peer-reviewed journals.

New models of care have been formed and new community partnerships created.

Several of the Center Directors have moved into local and national leadership positions.

New initiatives have built on the network of CoEs, including the newly funded Research Coordinating Center sponsored in part by the Food and Drug Administration, which will implement clinical studies across CoEs.

Alliances of women leaders across institutions have developed and led to mentoring and collaborating on research and education.

In conclusion, Dr. Carnes stated, the U.S. has many groups of women who are underserved by the health care system, and all women are underrepresented in leadership in academic medicine. The OWH experiment is addressing these issues by investing in a diverse group of women leaders in academic medical centers. While intermediate measures look promising, barriers to success, such as lack of funding and the continued marginalization of women's health, remain. The biggest barrier, however, is the current cultural norm, which makes it acceptable for groups of white men to make decisions that affect the lives of all people. This practice is not only outdated and unacceptable but also has a negative effect on our nation's health.

# IN CLOSING

The National Centers of Excellence in Women's Health Second National Forum brought together over 350 representatives from the Centers of Excellence (CoEs), other academic health centers, the philanthropy and business sectors, as well as State, regional, and national government representatives. For two days, participants shared ideas on how to respond to the changing needs of women's health care in a manner that is based on an integrated, multi-disciplinary, and holistic approach. They shared innovative strategies for adapting to the dramatic changes underway in health care policy and financing, and explored ways in which women's health—and the CoE model in particular—can serve as a catalyst for changing the knowledge, practice, and teaching of health care in our nation.

The Forum presentations demonstrated that significant progress has been made in women's health in the past century and since our last Forum. But there is still a long way to go. The Office on Women's Health, DHHS, would like to thank all of those who helped make the Forum a success. We look forward to continuing our partnership with you to improve the health of women of all ages, races, ethnicities, and backgrounds, across their lifespans.

# APPENDIX A: PRESENTERS

## OPENING PLENARY

***Closing the Gap***

Susan M. Clark, M.A.
Director, Division of Program Management
Office on Women's Health
CoE Project Officer
National Centers of Excellence in Women's Health
U.S. Department of Health and Human Services

Wanda K. Jones, Dr.P.H.
Deputy Assistant Secretary for Health (Women's Health)
Director
Office on Women's Health
U.S. Department of Health and Human Services

Cristina Beato, M.D.
Principal Deputy Assistant Secretary for Health
Office of Public Health and Science
U.S. Department of Health and Human Services

## PANEL DISCUSSION

***The Role of Academic Medical Centers in Eliminating Health Disparities***

Brian Smedley, Ph.D.
Senior Program Officer
Institute of Medicine (IOM)

Lois Colburn
Assistant Vice President
Community & Minority Programs
Association of American Medical Colleges

JudyAnn Bigby, M.D.
Director of Community Health Programs
Harvard University
Center Director
Harvard University National Center of Excellence in Women's Health

## LUNCHEON PLENARY

***Reflections on the Causes of Health Disparities***

Harold F. Freeman, M.D.
Associate Director
National Cancer Institute
Director
Center to Reduce Cancer Health Disparities

## WORKSHOPS

***Altering Cultural MisinformationThrough Research***

Suzanne Dibble, D.N.Sc.
Professor
Institute for Health & Aging
University of California, San Francisco

Nina Markovic, Ph.D.
Assistant Professor
University of Pittsburgh

Tonda Hughes, Ph.D.
Associate Professor
University of Illinois at Chicago

Jennifer Potter, M.D.
Assistant Professor of Medicine
Department of Internal Medicine
Beth Israel Deaconess Medical Center

Nancy Norman, M.D., M.Ph.H.
Director of Women's Health
Fenway Community Health Center

### *Funding Clinical Care: Public/Private/Academic Partnerships*

Robert Oye, M.D.
Professor and Vice Chair
Department of Medicine
Medical Director
Internal Medicine Suites
University of California at Los Angeles

Karla Nacion, Ph.D., C.N.M.
Coordinator
Nurse-Midwifery Practice
Clinical Associate Professor
Clinical Co-Director
University of Illinois at Chicago National
Center of Excellence in Women's Health

Emily Wong, M.D., F.A.C.P., M.H.A.
Department of Medicine
Center Director
University of Washington National Center
of Excellence in Women's Health

Myra Kleinpeter, M.D.
Associate Professor of Medicine
Department of Medicine
Tulane Xavier National Center of
Excellence in Women's Health

### *Promoting Diversity in Health Professionals and Academic Advancement of Minority Women*

Page Morahan, Ph.D.
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Gloria Hawkins, Ph.D.
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Medical School Administration
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Rosalyn Richman, M.A.
Co-Director, ELAM Program
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### *Recruiting and Retaining Women of Color in Clinical Trials*

Juliet Rogers, M.P.H.
Associate Hospital Administrator
Center Co-Director
University of Michigan National Center of
Excellence in Women's Health

Beth Brown, M.A.
Gynecology & Reproductive Sciences
UCSF National Center of Excellence in
Women's Health

Donna Murasko, Ph.D.
Interim Dean, College of Arts and Sciences
Drexel University

### *Working with CBOs and Consumers to Eliminate Health Disparities*

Nancy Tartt, M.S.
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Cindy Moskovic, M.S.W.
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Outreach and Education
Iris Cantor-UCLA Women's Health
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JudyAnn Bigby, M.D.
Director of Community Health Programs
Harvard University
Center Director
Harvard University National Center of
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OWFCP - Brigham and Women's Hospital

### *Addressing Issues of Violence Against Women*

Molly Carnes, M.D.
Professor
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University of Wisconsin National Center of
Excellence in Women's Health

Susan Smith, M.S.W.
Co-Director
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Susan Knoedel, C.I.C.S.W., M.S.W.
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Hospital

Marnie Shiels
Attorney Advisor for the Office on Violence
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Assistant Director
Women and Health Center
University of Puerto Rico

### *Caring for Women Who Are Multiply At-Risk, Including Women with Disabilities*

Jaye Hefner, M.D.
Medical Director
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Magee-Womens Hospital

Carmen Zorrilla, M.D.
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### *Eliminating Health Disparities for Rural Women: Model Programs*

Stephanie Lent, M.S.
Administrative Director
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Health

Mary B. Laya, M.D., M.P.H.
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April Mason, Ph.D.
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Consumer and Family Sciences Extension
Purdue University

Jeanette Magnus, M.D., Ph.D.
Professor and Director
Department of Community Health Sciences
Tulane University School of Public Health & Tropical Medicine
Center Director
Tulane Xavier National Center of Excellence in Women's Health

### *Integrating Medical Abortion into Women's Health Primary Care*

Tracy Weitz, M.P.A.
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Gloria E. Sarto, M.D., Ph.D.
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University of Illinois at Chicago

Karen Freund, M.D., M.P.H.
Professor of Medicine
Boston University National Center of Excellence in Women's Health

### *Medical School Curriculum in Women's Health: Incorporating Cultural Competency*

America Facundo, Ph.D.
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Susan Baillie, Ph.D.
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Ana Nunez, M.D.
Director, Women's Health Education Program
Drexel University, College of Medicine
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### *Capturing Teachable Moments and Capitalizing on Learnable Moments: Diversity Training Models in Faculty Development and Medical Education*

Sheila Chapman, M.D.
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Tricia Tang, Ph.D.
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### *CoE: Collaborations and Funding Opportunities*

Sabrina Matoff, M.A.
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Food and Drug Administration

Janet Pregler, M.D.
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UCLA National Center of Excellence in Women's Health

Roy White
Vice President
Educational Foundation
General Merchandise Distributors Council

### *Developing and Maintaining Effective Systems of Care for Elderly Women*

Suzanne Dibble, D.N.Sc.
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### *Developing Community- and County Hospital-Based Women's Health Programs*

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Elizabeth Dupuis, M.D.
Women's Health Group/Internal Medicine
Boston University School of Medicine
Ann Zerr, M.D.
Clinical Assistant Professor
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### *Innovative Educational and Psychosocial Support: Strategies for Women from Diverse Backgrounds*

Anna McDaniel, D.N.S., R.N.
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### *International Leadership Programs in Women's Health*

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Dean for Faculty Affairs
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### *Models of Care for Minority Women*

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### *Modifying the Message: Women's Health Education*

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### *Promoting Collaborative Research in Minority Women's Health*

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Marcia Killien, Ph.D.
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### *Promoting Women's Health through Community-Based Participatory Research*

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Milta Vega-Cardona, M.S.A
Program Coordinator
St. Barnabas Hospital Community Center of Excellence in Women's Health

Jo Jean Elenes
Program Coordinator
Mariposa Community Center of Excellence in Women's Health
Mariposa Community Health Center

Jill Pyle
Program Coordinator
Women's Health Services
Santa Fe National Community Center of Excellence in Women's Health

### *Quality of Care in Women's Health*

Sarah Scholle, Dr.P.H.
Assistant Professor of Psychiatry
University of Pittsburgh
Magee-Womens Hospital

Karen Carlson, M.D.
Medical Practices Evaluation Center
Massachusetts General Hospital

### *Women and Heart Disease*

Jeanette Magnus, M.D., Ph.D.
Professor and Director
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Tulane University School of Public Health & Tropical Medicine
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## PLENARY

### *The Role of Academic Medical Centers in Eliminating Health Disparities*

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## PANEL DISCUSSION

***Findings from the Evaluation of the National Centers of Excellence in Women's Health***

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