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MAXINE WATERS
MEMBER OF CONGRESS
35TH DISTRICT, CALIFORNIA

COMMITTEES:
BANKING AND FINANCIAL
SERVICES
JUDICIARY

Congress of the United States
House of Representatives
Washington, DC 20515-0535

October 16, 1997

The Honorable Albert Gore, Jr.
Vice President of the United States
Office of the Vice President
Old Executive Office Building
Washington, D.C. 20501

Dear Mr. Vice President:

I would like to bring to your attention the concerns of the Congressional Black Caucus that the proposed tobacco settlement does not adequately address the interests of African Americans and other minorities, nor have their interests been adequately represented in the discussions and negotiations surrounding the proposed settlement.

As you know, there is significant evidence that African Americans and minorities have been targeted by tobacco companies for years, and have disproportionately suffered from the negative health effects of tobacco use. But, unfortunately the interests of African Americans have once again been overlooked. The attorneys who brought the main claims have overlooked it. The tobacco industry has overlooked it. And the negotiators for the Administration have, to date, overlooked it as well.

I have appointed Representative Bennie Thompson to address our concerns and organize a comprehensive response to the proposed tobacco settlement from the Caucus. Congressman Thompson has been working with representatives of all major African American groups concerned with the effects of tobacco including medical schools, health care, legal, media and religious organizations.

The Congressional Black Caucus wishes to be a part of any major meetings regarding the tobacco settlement in which the White House is involved.

Sincerely,



MAXINE WATERS
Member of Congress

MW:mjs

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Congress of the United States
House of Representatives
Washington, DC 20515-2402

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October 15, 1997

Honorable William Jefferson Clinton
President
United States of America
The White House
1600 Pennsylvania Avenue, N.W.
Washington, D.C. 20500

Dear President Clinton:

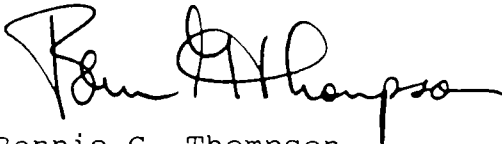
I am currently a member of the Democratic Caucus Tobacco Settlement Agreement Working Group and the Chair of the Congressional Black Caucus (CBC) Tobacco Settlement Agreement Task Force. I am very much interested in meeting with your policy advisors on this issue, Mr. Bruce Reed and Mr. Bruce Lindsey.

I have requested a meeting on Monday, October 20, 1997 at 1:30 p.m. I understand that Mr. Reed's schedule will allow his participation. There will be other Members of the CBC attending the meeting which will be held in my office, 1408 Longworth HOB. I am pleased that Mr. Reed will be able to bring your perspective to the work that we are doing on this important issue.

Further, I request your support for a continuing dialogue to be established between myself and Mr. Reed and, whenever possible, Mr. Lindsey. Thereby assuring continuity and accord between the Administration's positions on various parts of the Agreement and the issues I champion on behalf of the CBC.

Thank you for your attention to this request. Should you or your staff have questions, please do not hesitate to contact me, or in my absence, Marsha McCraven, my Administrative Assistant or Todd Gee, my Senior Legislative Assistant.

Sincerely,



Bennie G. Thompson
Member of Congress

BGT/mgm

cc: Janet Murguia
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Congressional Black Caucus

Congress of the United States

2344 Rayburn Building • Washington, DC 20515 • (202) 225-2201

September 11, 1997

The Honorable William Jefferson Clinton
 President of the United States
 1600 Pennsylvania Avenue
 Washington, D.C. 20500

Dear Mr. President:

The Congressional Black Caucus (CBC) believes the proposed national tobacco settlement announced in June offers the first genuine step towards establishing an effective national tobacco control policy, and we encourage you to continue advancing negotiations towards a settlement.

As you know, significant evidence has been discovered which supports the long-held belief that the tobacco industry has disproportionately targeted children, minorities, and women in its campaigns to increase tobacco use. The CBC has already held a national summit with the major African-American medical, legal, and financial organizations to discuss minority issues raised by the settlement, and it has also been working with the State Attorneys General to address these concerns.

The CBC believes a nationwide tobacco settlement will serve as the best vehicle for correcting these past wrongs, provided that it includes provisions supporting smoking cessation programs, medical research, and countermarketing efforts that are directed toward these populations. We look forward to working with you to ensure that this settlement protects all sectors of the American public from the dangers of tobacco use, and would appreciate either Bruce Reed or Bruce Lindsey contacting Congressman Bennie Thompson, the Chairman of the Congressional Black Caucus Task Force on the Tobacco Settlement, to discuss this matter further.

Sincerely,

Maxine Waters
 Maxine Waters, Chair
 Congressional Black Caucus

MW:mjs

DATE: 10/23

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REMARKS:

*Here some background material on
the minority community concerns
with the Tobacco settlement. This
was prepared by CDC's office of
Smoking & Health. See you tomorrow
at 4:00 in Stokes's office.*

Secretary's Briefing Memo: Minority Issues
October 21, 1997

BACKGROUND

During its analysis of the proposed settlement, the Department concluded that the proposed settlement does not adequately address minority communities. Minority groups and other special populations suffer a disproportionate burden of tobacco-related disease and are among the greatest users of tobacco products. As part of the Department's analysis of the settlement proposal, the Department identified several issues that impact minority communities and deserve special consideration (Tab A).

Most recently, a proposal has surfaced recommending the formation of a non-profit entity to address the special needs of minority communities that relate to tobacco (Tab B). The objectives of this entity are (1) to receive funds to address smoking related behavior in minority communities and tobacco targeting of the minority communities; and (2) to assure that language addressing issues important to minority communities is included in any tobacco legislation. Two issues regarding this proposal are of particular concern:

One over-arching minority coalition is unlikely to adequately represent the various and diverse interests of individual minority groups and communities; and

Several of the "example" organizations listed in this proposal have a history of accepting support from the tobacco industry.

TALKING POINTS

- Because of the diversity within minority communities, HHS needs to develop a position on how to best address the various and diverse needs of individual minority communities. The formation of an over-arching minority coalition is one possible approach. Another approach is to give priority to minority issues through the existing nationwide infrastructure which provides support through state health departments and national organizations.
- During the Department's analysis of the settlement proposal, the Department sought input from various minority communities. The Department will continue to seek input from minority communities on tobacco related issues, and not prematurely endorse the objectives of any specific coalition.
- The Department is due to release the Surgeon General's Report on Reducing Tobacco Use Among U.S. Ethnic Groups in the next few months.

TAB A
Minorities and Special Populations

Minorities and Special Populations

Background:

The proposed Agreement does not adequately address minority communities. Minority groups and other special populations suffer a disproportionate burden of tobacco-related disease and are among the greatest users of tobacco products. Nationally, black men are approximately 50% more likely to die of lung cancer than are white men. Smoking rates are highest among American Indian/Alaskan Natives (42%) and blacks (27%), as well as for those, regardless of race, who are living below the poverty level (35%).

Because of these differentials, minorities and special populations are the most likely groups to be affected by changes in tobacco control policies, such as those contained in the proposed Agreement. These changes can be expected to have a positive effect, provided that assurances are given that the programs and other benefits actually reach the communities most at risk. However, minority communities are often dependent on the tobacco industry for philanthropic support of civic, cultural and community activities. Accordingly, because of this heightened dependence on tobacco industry largesse, minority communities may experience a disproportionate adverse economic effect.

Issues Deserving Special Consideration:

- **Full Access to Programs and Services:** Minority groups and other special populations need to be assured full access to targeted, community-appropriate programs, media and smoking cessation services, particularly so that cost is not a barrier to accessing cessation services.
- **Research Focused on Racial and Gender Differences:** Tobacco research programs should explicitly address gender and racial differences in tobacco use and its sequelae. Inclusion of representative researchers should be emphasized.
- **Replacement Sponsorship:** Because minority communities are disproportionately dependent upon tobacco industry largesse and philanthropy, settlement funds allocated for replacing tobacco industry sponsorship should extend beyond sports sponsorship and include sponsorship for community, cultural and civic events.
- **Governance and Decision-making:** Explicit involvement of minority and ethnic communities is needed in governance and decision-making bodies established as a result of the proposed Agreement. In particular, the ability of communities to create more protective tobacco control ordinances must not be pre-empted.
- **Inclusion of Tribes:** In addressing Tribal issues, the proposed Agreement uses a formula based on tribal population as percent of state population. This does not provide adequate funds for successful program implementation, especially considering that Native Americans experience the nation's highest tobacco use rates.

TAB B
Formation of Non-Profit Entity

OBJECTIVES

1. FORMATION OF NONPROFIT ENTITY TO RECEIVE FUNDS TO ADDRESS SMOKING RELATED BEHAVIOR IN MINORITY COMMUNITIES AND TOBACCO TARGETING OF THE MINORITY COMMUNITIES (New Corporation ("NEWCO")).
2. INCLUSION OF LANGUAGE ADDRESSING ISSUES IMPORTANT TO MINORITY COMMUNITIES IN ANY LEGISLATION REGARDING THE TOBACCO SETTLEMENT.

FORMATION OF NONPROFIT ENTITY

1. ARTICLES OF INCORPORATION
2. BYLAWS
3. PROCESS FOR OBTAINING TAX-EXEMPT STATUS

ARTICLES OF INCORPORATION

ISSUES TO CONSIDER

- 1. Name**
- 2. Purpose**
 - Engage in activities designed to reduce smoking in minority communities;
 - Develop educational and marketing program targeted to the minority communities to counter efforts of tobacco promotions;
 - Conduct/fund research designed to examine smoking effects in minority communities and ways of reducing smoking related behavior; and
 - Raise/invest/expend funds to benefit specified classes of nonprofits.
- 3. Board of Directors**
- 4. State of Incorporation**

BYLAWS

ISSUES TO CONSIDER

1. COMPOSITION OF BOARD OF DIRECTORS

2. APPOINTMENT PROCESS FOR DIRECTORS

-- Directors would be selected by designated groups of organizations representing various minority communities. Groups of organizations would appoint a specified number of Directors to represent their community's interest. This process could entail the creation of various nominating committees in which each organization would appoint one person. These committees would prepare a slate of Directors for approval by their respective organizations. Once approved, those Directors would be appointed to the Board.

-- The following list provides examples of organizations that could appoint Directors. This list is not all inclusive, more organizations may be added/deleted based on interest and tax-exempt status.

Congressional Black Caucus
Congressional Hispanic Caucus
Congressional Asian Pacific Caucus
National Medical Association
National Black Nurses
African American Medical Schools (4)
Hispanic-Serving Medical Schools (4)
Native American Serving Medical Schools (2)
National Black Leadership Initiative on Cancer
National Hispanic Leadership Initiative on Cancer
Native American Cancer Network
Coalition on Civil Rights
National Minority Bar Associations
National Black Publishers
National Financial/Banking Organizations
United Negro College Fund

3. COMMITTEES (STANDING/ADVISORY)

-- Each committee responsible for establishing guidelines for distribution of funds/grants that will be approved by the Board of Directors. Such guidelines will be consistent with parameters established in legislation.

Possible Committees

- **Executive**
- **Research**
- **Education**
- **Counter-Marketing**
- **Cessation Programs**
- **Financial/Investment**

- 4. Staffing - The Board would determine the appropriate staffing needs for NEWCO.**

PROCESS FOR OBTAINING TAX-EXEMPT STATUS

1. IRS Application Process (Form 1023)

- **Required Information**

- **Activities and Operational Information**
- **Technical Requirements**
- **Financial Data**

- **3 to 12 Month Time-frame for Obtaining Determination**

- **This process can be expedited by ensuring that legislation mandates that NEWCO be "tax-exempt."**

2. Legislative Process

- **Include in Legislative Language that new entity will be tax-exempt**

3. State - File for nonprofit status in various states as needed.

PROPOSED RESOLUTION**OUTLINE**

1. Title I. Reformation of Tobacco Industry*
2. Title II. "Look-Back" Provisions/State Enforcement*
3. Title III. Penalties and Enforcement; Consent Decrees; Non-Participating Companies
4. Title IV. Nationwide Standards to Minimize Involuntary Exposure to Environmental Tobacco Smoke
5. V. Scope and Effect
6. Title VI. Programs/ Funding*
7. Title VII. Public Health Funds*
8. Title VIII. Civil Liability*
9. Title IX. Board Approval

*Titles with suggestion revisions.

PROPOSED RESOLUTION

ISSUES FOR CONSIDERATION

1. Title I. Reformation of the Tobacco Industry

a. Restrictions on Marketing and Advertising

Include requirement that such marketing/advertising not only reduce appeal to minors, but to minority communities.

b. Regulation of Tobacco Product Development and Manufacturing

Consider a requirement that the FDA's Scientific Advisory Committee not only examine the effects of alteration of nicotine yield, but also the effects of mentholated products in cigarettes based on its prevalence in cigarette brands consumed by minorities. (This suggestion is based on the fact that the amount of research evaluating the combined effect of menthol and nicotine in cigarette products appears limited.)

c. Non-tobacco ingredients (see b)

2. Title II. Look-Back Provisions

a. Proposal imposes required reductions in underage tobacco. If reduction targets are not met, surcharge imposed on cigarette manufacturers. Industry can request an abatement based on certain issues. Ninety percent (90%) of the funds collected by the surcharge are transferred as grants to state and local public health agencies to be used by the agencies or nonprofits to reduce underage smoking.

Consider imposing a requirement on agencies that a certain percent of those funds be targeted to minority communities.

Consider distributing funds directly to nonprofits, e.g., NEWCO, in addition to state and local public agencies.

3. Title VI. Programs/Funding

Tax Treatment. Proposal calls for all payments to be deductible as ordinary and necessary business expenses. Payments to NEWCO would be deductible as charitable contributions.

**PROPOSED RESOLUTION
ISSUES FOR CONSIDERATION (Cont')**

4. Title VII. Public Health Funds from Tobacco Settlement

- a. **Allocation of Grant Monies.** Proposal allocates grant monies among various programs, (e.g., \$75 to \$125 million) to fund state and local tobacco control community-based efforts modeled after the ASSIST program.
 - Consider distributing funds directly to designated nonprofits, e.g., NEWCO.
 - Consider allowing local community groups to receive funds that have new and innovative smoking behavior programs that may not be modeled after the ASSIST program.
- b. **HHS Programs.** Proposal allows HHS to make grants to state health department for Reduction in Tobacco Usage programs.
 - Consider expanding HHS grant authority to include nonprofit entities, (e.g., NEWCO).
- c. **Public Education Campaigns.** Proposal creates an independent nonprofit organization made up of "prestigious individuals" and leaders of "major public health organizations" to provide grants to nonprofit entities who have "a demonstrated record of working effectively to reduce tobacco product use and expertise in multi-media communication campaigns."
 - Consider granting certain entities, e.g., NEWCO, the right to appoint a specified number of individuals to this organization.
 - Consider requiring that funds be given to NEWCO to address the needs of the minority community and allowing NEWCO to provide grants in this area.
- d. **Tobacco Use Cessation.** Proposal puts \$1 billion to \$1.5 billion in a Trust Fund to assist individuals wanting to quit. Secretary of HHS must promulgate regulations to govern (i) criteria and procedure for approval of smoking cessation programs; (ii) eligibility requirements of individuals seeking assistance from the Fund; and (iii) procedures to govern such programs.

**PROPOSED RESOLUTION
ISSUES FOR CONSIDERATION (Cont')**

- .. Consider requiring Secretary to use a negotiated rule-making process to include NEWCO and other entities.
- .. Considering providing funds directly to programs that provide services to individuals meeting the eligibility requirements.
- e. **Public Health Trust Fund Presidential Commission.** Proposal creates a Commission including public health representatives, Attorney Generals, Castano Attorneys and others to determine the specific tobacco related medical research for which the \$25 billion Public Health Trust Fund will be used.
 - .. Consider requiring the Commission to include representatives from NEWCO and various organizations representing minority communities.
 - .. Consider requiring a specific percent of those funds be used to conduct research that targets minority populations.

5. Title VIII. Civil Liability

Proposal provides that in the event the annual aggregate cap is not reached in any year, Presidential Commission determines how that credit is allocated among various uses (e.g., public health, governmental entities, and others).

- .. Consider requiring the Commission to include representatives from NEWCO and that a specific percent of the funds be used to support smoking behavior programs and research targeted at minority populations.

**CENTER FOR RESEARCH ON MINORITY HEALTH
CONCEPT PROPOSAL**

BY

**LOVELL ALLAN JONES, Ph.D.
AD INTERIM DIRECTOR**

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MISSION STATEMENT

The University of Texas M.D. Anderson Cancer Center (MDACC) proposes to create the Center for Research on Minority Health (CRMH) which will focus on health issues relevant to minority and medically underserved populations living in Houston, the State of Texas and ultimately the nation. The objective of the CRMH is to ameliorate the significantly disproportionate incidence and prevalence of cancer morbidity and mortality in minority and medically underserved populations and thereby position the MDACC as a national leader in the growing area of minority health research. The CRMH will accomplish this by addressing the cancer problem **holistically**, addressing related health issues, e.g., nutrition, that impinge on minority and medically underserved populations. This broad approach will create an environment supportive of cancer research through education and community outreach. The initial key to its success will be achieved by building trust and respect between MDACC investigators and the underserved populations in metropolitan Houston.

INTRODUCTION

The University of Texas M.D. Anderson Cancer Center (MDACC) is a leader in the area of cancer research. However, only a small portion of these endeavors has been translated into reducing the disproportionate health disparities in minorities and the medically underserved. Therefore, MDACC has decided to create the Center for Research on Minority Health (CRMH) to assist in delivering its successes in research and education to the state's minority and medically underserved populations. Such an effort will blend with the established mission of MDACC, which is directed towards the elimination of cancer and allied diseases as significant health problems throughout the Texas, the nation and the world by developing and maintaining integrated quality programs in patient care, research, education and prevention. The CRMH will aid MDACC in this mission by providing links to those communities who still suffer from a significantly disproportionate incidence and prevalence of cancer morbidity and mortality.

One way the CRMH will begin this important role, is by increasing the recruitment and retention of minorities into clinical trials at MDACC. As the year 2000 approaches, this country will become a more heterogeneous nation as many new immigrants find their homes in the United States. Houston is a great example of this trend; a city where multiculturalism is evident and even celebrated. Therefore, the timing is right to bring MDACC to the forefront of minority health and research by developing study populations that are more accurately reflective of our multicultural society.

There are many different ethnic groups in the Houston, in Texas and the United States that are classified as minorities. It is calculated by the year 2000 the Houston Census will breakdown to the following: 39% Hispanic, 29% Anglo, 25% African American, and 7% Asian (Klineberg, 1996). As the trend shows, Houston is perfectly suited to provide a cross sample of many populations. It should be noted that presently, Houston has the largest population of African Americans and Latinos in the South as well as the largest population of immigrants (Rodriguez, 1996). Each of these groups is itself heterogeneous in terms of geographical origin, socioeconomic resources, history, culture and even language. Although the primary focus of the CRMH will include ethnic minorities, the center will also include the medically underserved in health care and research. Included in this group are populations from lower socioeconomic status and women. Therefore, for the purpose of this proposal when the term minority or minorities is used it refers to all ethnic minorities in the US as well as medically underserved populations in health care and research. It should be noted that the medically underserved and minority populations comprise about one of three persons in the United States, about one of two persons in Houston and Texas

Beyond the sheer numbers, however, the importance of minority health in overall public health, derives from the health disadvantages experienced by these communities. Both health status and the availability of data vary greatly across the different minority groups and subgroups; with the vast majority of the data on African American and significantly less on Hispanics and other minority populations. Although our knowledge is limited, there is sufficient data to state with confidence that African Americans, Hispanics, Native Americans, and some Asian Americans populations have a diminished health status and increased risks when compared to white Americans or the population as a whole. Moreover, because of restricted economic resources and lack of adequate political representation, medically underserved Americans are often more dependent on public health systems for personal health care and environmental protection.

As mentioned above and detailed later, minority populations suffer disproportionately from a number of major diseases. It would be impossible for the CRMH to address all of these at once. However, the problem still exist in terms of addressing the health of these communities with a single message. The dilemma is how will such a center avoid the failures of others. One way that has been successful on a small scale has been to take a holistic approach. Because cancer

disproportionately affects a large number of minorities as well as the medically underserved, the CRMH will focus on cancer prevention and the overlapping risk factor that exist with those other major diseases, diabetes and cardiovascular diseases. As will be outline in the proposal, justification will be provided for this approach and some of the methodology that will be used.

RATIONALE

The rationale for the CRMH derives from: 1) the importance of minority health in addressing public health issues; 2) the relative neglect of research on minority health; 3) the special challenges in conducting minority health research; 4) the need for more minority researchers; and most importantly, 5) low survival rates among minority and medically underserved populations.

To understand the need for the CRMH, the center's holistic approach and its initial focus on cancer, we must first understand that cancer is not the only problem facing ethnic minorities in the United States. Furthermore, we need to discuss our current knowledge of minority health and the gaps in research. For example, though the overall U.S. 1989 age-adjusted death rate of 523/100,000 was a record low, the age-adjusted all-cause mortality rate for Black Americans compared was 60% greater than that for white Americans (US National Statistics, 1996). These increased mortality rates remains the same even today. Life expectancy is also markedly different. The difference in life expectancy between whites and Blacks narrowed from 7.6 years in 1970 to 5.6 years in 1984, but has widened steadily since to 8.5 years in 1993 (US National Statistics, 1996). Cause-specific mortality ratios for major causes of death are often markedly higher for Black Americans for heart disease (1.4), cancer (1.3), stroke (1.9), accidents and adverse effects from causes other than motor vehicular crashes (1.8), pneumonia and influenza (1.5), diabetes mellitus (2.3), chronic liver disease and cirrhosis (1.7), homicide and legal intervention (6.6), HIV (3.3), nephritis, nephritic syndrome, and nephrosis (3.1), septicemia (2.7), and perinatal causes (2.9). Similar Black-White differences exist in Houston and Texas. Although the above statistics are for African Americans, there are similar disparities in comparing other minority groups to the white population.

Cancer incidence, mortality and survival rates in minority communities also differ from the general population. Recent epidemiological studies by the National Institutes of Health (NIH) have shown that the overall cancer survival rate for the general population has increased, while the survival rate for certain segments of the population has declined. Comparing some of the survival rates from cancer between white and minority groups the difference is highly noticeable. The overall survival rate for cancer of any site is 60.6% in Whites but only 44.9% in Blacks (U.S. Nat'l Center for Health Statistics, 1996). Many minorities experience disadvantages and have some special risks of their own (e.g., stomach cancer mortality in Hispanic Americans and Native Americans, colon cancer in Alaskan Natives, and cervix uteri cancer in Vietnamese community, and prostate cancer in African American men (SEER, 1996) while mortality rates for other minority groups have no disadvantage in mortality or even an advantage compared to whites and/or the overall population (e.g., infant mortality in Hispanics and malignant melanoma in African Americans). Ethnic minority communities, in some instances are less likely to exhibit high risk behaviors (e.g., low rates of smoking among young Black and Hispanic females while males in these two groups are more likely to smoke). In the early 80s' the National Cancer Institute (NCI) established a goal of 50% cancer survival rate by the year 2000. If the NCI goal of a 50% cancer survival rate by the year 2000 is ever to be met, innovative programs incorporating minority communities will have to be developed. Therefore, making qualitative changes in these populations will make a significant improvement in overall survival rates. Unfortunately, this goal is unattainable at the current rate of prevention, detection, and treatment in these communities. In addition, an increased research involving minority groups can not only yield benefits from which minority Americans can directly gain, but findings may be of benefit in improving the overall public health of all communities. Therefore, it is imperative that such a targeted effort, like the one being proposed, be initiated in a timely fashion.

Cancer, as well as other health problems, is not just an issue concerning ethnic minority populations. Although ethnic minorities are often equated with economically disadvantaged, these two groups and data regarding them, are not interchangeable. There are, however, certain characteristics that these groups share. The United States, with a population of over 267 million,

has nearly 40 million persons who are below the poverty level. In Houston, 45% of African Americans and 55% Hispanics and 46% Asians report a yearly income of less than \$25,000, while less than 21% of Anglo families report this figure. In reviewing health insurance less than 50% of Hispanics living in Houston are covered by health insurance while 90% of the Anglo population is covered (Klineberg, 1996). The American Cancer Society's Subcommittee on Cancer and the Economically Disadvantaged, headed by Dr. Harold Freeman, reported that people of lower socioeconomic status have a higher incidence, higher case fatality rates and increased mortality from cancer. This study was an outgrowth of a report given by Dr. Freeman at the 1979 American Cancer Society's Science Writers' Seminar where he noted that half of the 165 consecutive patients with breast cancer seen at Harlem Hospital were incurable on admission. All of the Harlem patients were black and poor. In a subsequent report to the American Cancer Society's Science Writers' Seminar in 1981, Dr. Freeman reported on data that demonstrated the relationship between low socioeconomic status and death caused by cancer. Studies, such as those mentioned, resulted in the ACS Regional Hearings on Cancer and the Poor, held around the country in 1989. However, it became apparent to me as a chair of one of these committees, that **socioeconomic status was not a risk factor per se, but a proxy for other environmental factors and possible genetic predisposition's that are more prevalent in particular groups in our society. The greatest impact being on cancer mortality and not cancer incidence.** Following this belief, Dr. Marc Goodman of the University of Hawaii reported, at the First Biennial Symposium on Minorities and Cancer, that Filipinos and Hawaiians (both of lower socioeconomic status in Hawaii) have widely divergent rates for many types of cancer (Jones, 1989). Therefore, Dr. Goodman stated that other factors which are independent of education, income or other socioeconomic indicators may exert a significant effect on the incidence of cancer. Such a finding could easily be investigated with the populations in Houston.

Employing a Holistic Approach

In beginning to attack the higher incidence of cancer in these groups it is necessary to use a holistic approach. A *holistic approach*, takes into account other factors that influence the perceived need for health care and the attention to health concerns. Knowledge, attitudes, and practices are important in how an individual responds to health situations, in determining availability of health services, and how that individual seeks health care when available (Jones & Newell, 1989). The CRMH approach to the minority health problems is an approach that recognizes all factors that contribute to the gaps in research and health care. As stated earlier, minorities tend to be equated with the underprivileged and this sometimes contributes to a lack of effort on those institutions' part, for fear of losing profitability, to address minority health issues. However, minority communities and the medically underserved do share some common socioeconomic features including such high interrelated factors as, education, income, occupation, cultural habits, ethnicity, place of residence and exposure to safety and environmental hazards may contribute to common health problems as well. Recognizing these factors collectively, the CRMH will listen to the problems within the communities and work in and with the communities to enhance our understanding of illness, in particular cancer. This global, holistic approach will allow the CRMH to identify problems and develop interventions that will enhance our ability to prevent and treat these diseases.

As indicated above, increased death rates in minorities are mirrored by risk factors, environmental threats, and inferior health care as well as higher rates in morbidity. Minority Americans often have higher rates of disease risk factors such as of diabetes, hypertension, obesity, and cigarette smoking and HIV. In addition to increased risk factors, American minorities are disproportionately situated in areas with fewer health care resources, inferior public facilities and services, high rates of drug abuse, crime, and interpersonal violence, poor housing, and environmental hazards. Violence and consequences of unprotected sexual activity are also major health hazards for the youth in these communities, in particular African American and Hispanic

communities. The leading cause of death for minority teenagers is violence while teenage pregnancies continue to raise.

Often a separate and forgotten part of society, Native Americans, are also adversely affected. Among Native Americans, infectious diseases have played a major role in epidemiological history. The excessive burden of such diseases in Native Americans is reflected in the national records. During the period of 1984-88 incidence of infectious disease was three times higher than the U.S. all-race rate. Although this seems alarming, this was a tremendous improvement from previous decades. As the incidence of infection decline, there is a sharp rise in the emergence of "chronic" diseases (i.e. cancer). The hazard ratios (i. e., risk of not surviving), adjusted for stage of disease, treatment, age and sex were significantly elevated for breast, cervix, rectum, bladder and non-Hodgkin's lymphoma (Samet, 1987).

It has also been noted, by the National Institutes of Health and other federal agencies, that women are underrepresented in research. At greatest risk is the poor, minority female whom research scientists have seldom studied. For instance, high blood pressure is a problem affecting many women. Over 50 % of white women in the United States suffer from hypertension but more alarming is that almost 80% of black women over 45 have increased blood pressure (Wenger, 1995). There are many factors that contribute hypertension, the most noted are: alcohol intake, obesity, physical inactivity and stress. Death rates for black women are consistently higher at any given age than white women starting with more than double the number of deaths per 100,000 from birth to age four. Black and hispanic women also suffer from lower survival rates from gender specific cancers (i.e. breast, ovary, cervix uteri) than white females (US National Statistics, 1996). As mentioned earlier Black women have a high prevalence of low-birth weight babies and the highest infant mortality rates, yet still receive less adequate access to prenatal care than any other group. Minority women also experience a different view of the world in which they live. As an example, the rate of self-reported suicide attempts for Latina high school students is the highest among all gender and ethnic groups in the nation (Kann, 1995). Sociodemographic factors and societal conditions such as: economic instability or deprivation, social disintegration, racial and ethnic discrimination, interpersonal violence, criminal behavior, family mental illness, family instability and abuse are associated with depression and attempted suicide. There are, however, no theories which can begin to explain this phenomenon. Examining gender-specific cancers, minority women have increased incidence in almost every site (SEER, 1996).

In the growing recognition of the importance of minority health for public health and to address this issue, numerous governmental agencies (including the US Centers for Disease, US Department of Health and Human Services, and National Institutes of Health) and a major of voluntary organizations (American Cancer Society and American Heart Association) have established offices or programs for minority health. Minority health is one of the six highest priorities for chronic disease control. Among the primary reasons for setting an explicit focus on minority health is the recognition that an improved general health status does not ensure health improvements for minorities and the medically underserved.

A second reason for an explicit focus on minority health is the realization that minorities have been understudied during past decades. Results and many of the advances in current medical knowledge and treatments do not necessarily benefit minorities. Consequences of past exclusion have led to gaps in diagnosis and treatment, inadequate prevention/protection methods and lack of access to participation in clinical trials. This realization has led to the National Institutes of Health and the Food and Drug Administration requiring all new grant applications to describe the demographic and ethnic characteristics of all study populations. Researchers must also justify using any population that does not contain at least a proportional representation of minority persons. As noted by NCI, " these groups remain largely understudied...additional efforts are needed to improve minority group participation in cancer prevention trials..."

Third, poor public health is a costly consequence to the nation. Being able to identify possible causes and effects of behaviors, genetic make-up, or environmental factors, will aid in controlling and possibly eliminating excessive medical costs. As an example, it has been clearly noted that cigarette smoking is responsible for about 90% of all incidence of lung cancer.(US Dept. of Health & Human Services, 1992). Tobacco companies have been accused of targeting particular segments of the market for advertising, particularly Black male youths. Due to this direct and effective marketing effort, Black males are 30% more likely to smoke and 44% more likely to develop lung cancer. It is estimated that the cost to the nation of smoking was \$70.3 billion in 1985. It was also shown that nonsmokers pay for 62% of the total economic cost of cigarette smoking (an approximate \$22 billion in health care cost and \$38 billion in loss of productivity). Health care for insufficient prenatal care and teen pregnancies cost taxpayers millions. Federal and state governments spend approximately \$400 million on providing contraception for high risk women. This actually saves an approximate \$1.8 billion on services that would have otherwise been rendered for those women who would have given birth (Private Choices & Public Policy, 1992). For every dollar that can be spent in contraception, it is estimated that the US saves \$4.40 that would be spent on postnatal cost for the child and mother. Additional costs are similar when examining other diseases: cardiovascular disease, diabetes, substance abuse, violence, and cancer. Prevention, detection and treatment would help considerably in curbing yearly expenditures paid for by citizens, businesses, and health care institutions.

However, devoting more attention to minorities requires knowledge about effective research techniques and the ability to overcome various barriers. The neglect of minority research has also resulted in a lack of research experience in studying minority populations and a scarcity of researchers with the necessary experience. There are also numerous logistical and cultural obstacles that often must be overcome in studying minority populations. Therefore,

focusing on minority health involves a concerted effort to support research and training programs that consider social, economic, demographic, and environmental risks of minorities. Research also needs to focus on health effects and health behavior of minority populations and should be designed to improve the health of minorities, in particular cancer incidence. Training programs and research proposals must be culturally sensitive and must reflect an understanding and appreciation for the history, customs, beliefs, and values of all ethnic groups. Increasing the amount of minority researchers to study minority health problems and to design interventions, will help improve health by being reflective intermediaries of the subjects being examined.

Besides culturally sensitive research, there is a need to have training programs which provide a solid foundation for health professionals working with minority populations. Within these programs, there should be courses or training aspects which focus specifically on the health of minorities. Other training elements should be designed to make sure that the students understand and appreciate the role that history, customs, values, and beliefs play in shaping the behavior, including the health practices, of individuals in all ethnic groups.

What should be apparent is that it will take a broad based effort to address the disproportionate health issues, i.e. cancer, in minority and medically underserved populations. Based on previous studies, it is important that one brings all of the needed efforts together as soon as possible (Jones et. al, 1997). The question is how to manage this when the CRMH will neither have the resources nor the personnel to address all that is needed. Although not presently an official arm of the CRMH, the Breast Cancer Prevention Nutrition Program has ongoing activities in each of the area in the research, education and service section. This proposal is based on the years of experience in developing such a holistic research effort. As its motto, the Breast Cancer Prevention Nutrition Program firmly believes that **“health in minority communities cannot be approached as a single issue.”** This reality is widely known by those in the public health sector; that minority and medically underserved communities do not have the luxury of putting health care as a high

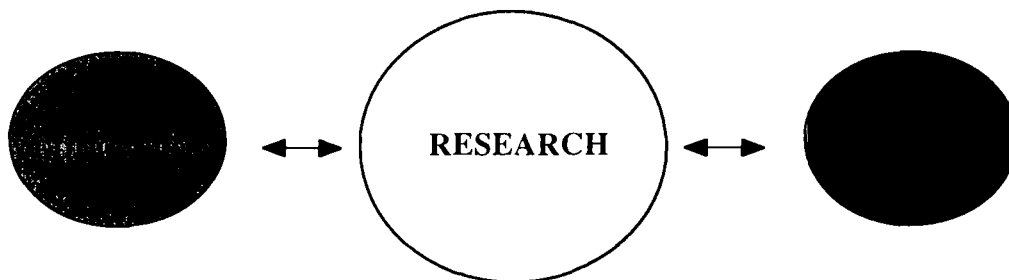
priority. In other cases, health is important but lack of adequate access and distress caused by other non-medical problems take precedence in daily existence. Therefore, one cannot go into a minority community and talk about cancer without addressing other issues (a holistic approach); i.e., infant mortality, diabetes, hypertension, as well as housing and a series of other non-health related issues. Today we need this type of approach to address the health crisis occurring in minority and medically underserved communities, blending the areas of research, education and service together into an effective program. To do this, we need to establish strong ongoing relationships in minority and medically underserved communities, asking for and listening to advice, and working with these communities to initiate change. Unfortunately, many major health organizations do not enter in effective partnerships with these communities, not receiving input from those persons for whom they are drafting strategic plans. As a result, such programs have failed; as indicated by the increasing cancer rates in these communities. Therefore, the CRMH will establish a multidisciplinary center of excellence in basic, applied and clinical research and an center without walls, formulating collaborations between investigators both internally and externally while involving the targeted communities as full partners. **The CRMH will begin by focusing on five areas: a) establishing research collaborations, b) establishing programs that lead to the increase of culturally sensitive researchers, especially in minority researchers in leadership roles, c) increasing the recruitment and retention of minority and medically underserved participants into clinical trials; d) developing the capability of the CRMH to address causes of health disparities in these populations, i.e. cancer prevention and intervention studies; and then, e) creating effective methods for translating these results to the community.**

RESEARCH, EDUCATION AND SERVICE

OVERVIEW

The CRMH will initially enhance the existing and future activities in cancer research and education. Thereby, faculty and students will be more effective in their work in this vital area and achieve a collective impact greater than the sum of their separate efforts. Once developed at MDACC, a union between MDACC, Baylor College of Medicine and other entities, is ideally suited to create a model to address the disproportionate health needs of minority populations, (e.g., diabetes and cardiovascular diseases). In addition to aiding MDACC staff, the CRMH will also reach out into the communities to introduce research activities and explain their significance. The CRMH will collaborate with other minority-oriented programs in the Texas Medical Center and elsewhere across the state. For example, the CRMH will work very closely with the various minority programs, such as the Office of Minority Health in Austin, community-based organizations which are minority-oriented (i.e. LULAC-League of United Latin American Citizens, LINKS, etc..) and various other organizations and groups committed to eliminating the health status gaps between white populations and minority and medically underserved populations in Houston and Texas.

The CRMH's mission will be accomplished primarily through: a) the research and health promotion activities of interested faculty and staff at MDACC, cooperative initiatives involving the various entities at M.D. Anderson and other institutions in the Texas Medical Center (e.g., Baylor College of Medicine) and cooperative initiatives involving other constituencies including educational institutions outside of Houston and Texas, private and public health agencies and community based individuals and organizations; b) education and training of students and professional about minority health research; and, c) research collaborations which involve community leaders as well as the community itself.



I. RESEARCH

The CRMH will be establish multidisciplinary, scientifically sound studies of cancer and other health issues and concerns affecting minority communities. The CRMH will focus on cancer prevention (building on already ongoing programs while developing new ones), as it pertains to minority populations initially. There are a number of other areas of research the CRMH can focus on, e.g., environmental factors as they pertain to special populations, do all ethnic groups respond in the same manner to standard therapy, and what is the role of genetics in determining risk for developing certain cancers. It will be the prime purpose of the Brain Trust, a group composed of national and international scientists and members of the community, to aid in setting other specific research objectives of the CRMH. The Brain Trust will also be involved in preparing an annotated bibliography and executive summary on the state of knowledge regarding the substantive area of the CRMH. Such will aid in helping the CRMH identify important research questions that should be addressed. These research activities will be coordinated with Office of Research, the Office of

Protocol Research and the Division of Cancer Prevention at MDACC, with a member from each area acting as liaison with the CRMH's Basic and Clinical Research Component.

To accomplish this the CRMH will begin by providing information to MDACC investigators and staff as well as the public at large to begin a true discussion on the course that research should be focused.

The goals for achieving the identified aims are discussed below:

- To develop and/or provide effective strategies and tools to manage health issues in minority and medically underserved communities, initially focusing on both basic and clinical studies as they relate to cancer and nutrition, then subsequently cardiovascular disease and diabetes, by developing an effective interface between the experts in the field of minority health and community leaders.
- To conduct research which moves forward the CRMH's agenda, to address the disproportionate health gaps by initially focusing on nutritional issues as they relate to minority populations.
- To provide support for conventional and innovative research efforts in the area of minority health.
- To provide support for the design, implementation and rigorous evaluation of interventions for the improvement of minority health.
- To maintain databases containing information that could be used to address minority health issues.
- To qualitatively and quantitatively evaluate outcomes of improved health status and behaviors. This is quite important in determining the success of the project and not just the amount of funding.

II. EDUCATION & TRAINING

The area of education encompasses a wide range of topics involving patient education, community (public) education and professional education. This section will focus on professional education. Training initiatives for the CRMH will encompass a broad range of activities. MDACC, with its affiliation with the UT Graduate School for Biomedical Research and UT Medical School as well as Baylor College of Medicine, can provide a mechanism to address the above issues at the masters, doctoral and M.D. levels. The building blocks of these curricula will include classroom instruction in content areas, internships, research projects, master's reports and doctoral dissertations. The CRMH will provide the impetus to incorporate minority health topics into the curriculum of various departmental programs where appropriate. The interplay between research and training should be seamless so that research projects will generate new knowledge and understanding of the issues. It is crucial that the material be incorporated into the classroom along with the fundamentals of each discipline. Faculty who participate in the CRMH will be encouraged to modify their own course offerings in their departments as well as encouraging other educators to do the same. All of the following programs will be done in conjunction with the Offices of Academic Affairs and of Institutional Diversity.

An extension of this educational program will be professional training. The aims of such a training program will be as follows:

- train faculty and staff to be cultural sensitivity as well as in proper recruitment and retention strategies,
- facilitate the inclusion of minority health issues in the mission statement of MDACC,
- foster career training and development of young minority researchers,
- develop and provide continuing education programs in minority health, research, and evaluation for state and local professionals.

A. MINORITY RESEARCHERS

The need for more minority research professionals is vital. Increasing the numbers of minorities entering the profession requires a multi-faceted plan. Elements of this plan include: financial support for students, seed money for faculty, research, senior-junior faculty mentoring programs, strong linkages between Historically Black Colleges and Universities (HBCUs), minority service institutions and majority institutions. The pipeline for minority career development is very long. Our program will focus primarily on the undergraduate - graduate portion. This is not to say that we will not be involved in elementary and secondary education. However, the preparation of minority graduates will be a primary aim of the mission of CRMH. The CRMH will met the aims as listed:

- Identify financial resources to assist minority students with their education. The forms of financial assistance will include direct grants in aid, research fellowships and loans.
- Provide mentorship and support for minority students in general as they participate in the academic life of their departments within the school.

The other area of importance for development of minority researchers is the support of new and current faculty. This will also be accomplished in conjunction with the Office of Institutional Diversity at MDACC. Funding programs will be developed to provide seed money for research projects focusing on minority health. Recruitment and retention of such faculty will aid in expanding the diversity of medical studies and ease the transition into more minority health research. Using the aforementioned informational services provided by the CRMH, MDACC will be able to attract other active researchers from around the country who have a strong interest in minority health.

B. CONTINUING EDUCATION FOR MDACC INVESTIGATORS & STAFF

The CRMH will provide continuing instruction to MDACC researchers and staff on the ideologies, perceptions and obstacles present in minority communities. This education will serve as a tool to train research staffs in cultural sensitive methods to overcoming barriers of clinical research participation. The CRMH will also guide researchers in determining and analyzing factors associated with increased disease incidence. This will be accomplished by identifying and developing health education techniques, appropriate for targeted communities, that facilitate the CRMH's goals of cancer prevention, early detection, and treatment. To accomplish this the CRMH will:

- Educate researchers and staff on the differences in concepts and perceptions of medical care and research that are held by some minority groups.
- Provide consultation to investigators concerning their research proposals, as they pertain to the recruitment and retention of subjects, in meeting federal standards.
- Provide support for the design, implementation, and rigorous evaluation of interventions for the improvement of minority health.
- Develop and foster continuing education in minority health programming, research, and evaluation for state and local professionals and to enhance the capacity of private and public health agencies to address salient minority issues.

The significance of the program proposed is the promise to enhance the recruitment and retention of minority subjects into the clinical research of MDACC and ultimately other major research institutions. The methods discussed and presented by the program are the methods that have been proven to be effective in eliminating or avoiding the barriers are outlined in the recruitment and retention component of this proposal. The proposed culturally sensitive methods should reduce the risk of widespread alienation of one community's minority groups that could jeopardize future research for all investigators from MDACC and other institutions. In addition, the proposed program will increase knowledge of recruitment and retention of minorities and result in improved methods and more productive studies of disease prevention and management. Ultimately, minority communities will gain the immediate benefits of participating in research. Such benefits will include:

- potential for clinical improvement of their illness and/or health,
- a more thorough evaluation of the patient's condition through discussion with specialist and repeated laboratory evaluations,
- full medical care provided to those enrolled in clinical trials, especially intervention and prevention trials.

III. SERVICE

In order to accomplish the CRMH research agenda one needs to address patient education, and community (public) education. Such efforts will be integrated into service activities linking the center's efforts with those of Patient Education, Public Affairs, Clinical Cancer Prevention at MDACC and the Department of Community Medicine at Baylor College of Medicine. CRMH will provide services to the community **deemed necessary** to accomplishing the stated objectives of center. Strategies for addressing the issues of services will consist of identifying the various societal components targeted by the CRMH for partnership in service and itemize a set of component strategies for implementing a successful service program.

A. CRMH/PROFESSIONAL/GOVERNMENTAL PARTNERSHIP

Partnership in the CRMH by business, labor unions, churches, foundations, community organizations, civic organizations--the vast network of private and voluntary institutions that compose the fabric of American society--is essential to promoting a successful service activity. Because of their strong influence and well-established position within minority communities, practically all of these organizations are prime targets as vehicles through which the CRMH can promote well-defined outreach and advocacy initiatives in and among minority communities. Joint activities such as sponsorship of health awareness programs, talent searches, publications, internships, scholarship and student assistance programs, training initiatives, enrichment activities, and financial resources are some of the many possibilities inherent in such relationships. Moreover, many of these institutions currently engage in a contribution to programs and activities relevant to minority health. Therefore, the CRMH should, where possible, explore possible ways to expand existing activities to include initiatives germane to the service mission of CRMH. Accordingly, the effective and successful programs should be highlighted as models for other private and voluntary organizations to emulate.

The greatest advances in the improvement of minority health has involved partnerships, with the government as an important element, from the White House to the local level. If the CRMH is to achieve its service mission which will allow it to cover out its **prime mission of research**, this partnership need to be established and nurtured, with the leadership of CRMH playing a skillfully role in mediating this partnership. Therefore, it is essential, that there be clear, articulate, vigorous leadership from the CRMH to local, state and federal elected officials informing them of the CRMH's mission, encouraging their support and outlining specific ways of becoming involved in various activities.

As part of the CRMH/Professional/Governmental Service Partnership agenda, the CRMH will incorporate the following:

- Educate officials regarding minority health issues and related concerns;
- Establish strong relationships with existing state and national minority health agencies;
- Encourage participation of various agencies and groups in the Biennial Symposium Series;
- Solicit co-sponsorship of local and state minority health outreach and education programs and related activities;
- Provide technical assistance on minority health research and training activities to local, state and federal agencies; and

- Encourage and support initiatives aimed bettering the health of minority and the medically underserved.

B. CRMH/COMMUNITY SERVICE PARTNERSHIP

The establishment by the CRMH of a strong service component in concert with existing outreach and education programs in minority communities is of greatest importance. By utilizing the expertise and experience of grassroots leadership and community based action groups within minority communities, the CRMH will further enhance its service directive and simultaneously facilitate the opportunity for communities to expand and improve their ongoing service activities.

The CRMH will address community education by developing a program that outlines volunteer's benefits, risks, and responsibilities. The program will also address minority perceptions of clinical research hoping to explain the processes that are now in place to protect participants. Due to the abuses in the past, minority groups are fearful of participation in medical research. In addition, social and logistical barriers to recruitment are such as the following: not enough bilingual staff, fear of traveling to the medical center, lack of childcare, etc..(see Recruitment and Retention Component). The purpose of an intensive educational program is to open the door to all volunteers that are qualified and interested in clinical trials. Methods employed will be based on techniques already proven effective in Houston minority communities, successful descriptions of techniques in literature, and advice and guidance from the to be named coalition. These methods also include creation and use of all types of media needed to deliver the information discussed above, to the communities.

Some possible strategies for accomplishing the above include:

- Programs designed to promote health and identify health issues and concerns which impact adversely upon minority populations;
- Promoting educational leadership activities that accentuate interdependence among all aspects of society, and encouraging the formation of community coalitions to address and assess minority health issues;
- Encouraging joint development of educational materials on health promotion and disease prevention with emphasis on minority health issues for dissemination within minority and medically underserved community, and
- Facilitating community cooperation with and participation in area institutional outreach activities such as conferences, seminars, retreats and related programs.

To address the myriad of options and opportunities necessary for establishing a comprehensive and innovative service and initiative, cooperative leadership is essential. Accordingly, **leaders at all level of participation in the CRMH must recognize their interdependence and focus upon the total system as their highest priorities.** The success of the efforts to provide strong outreach and advocacy as part of the CRMH's program depends almost entirely upon a strong organizational infrastructure that fosters cooperation, mutual respect, and creative interaction among all factions in partnership with the CRMH.

C. CRMH/ACADEMIC/COMMUNITY PARTNERSHIP

Implementation of service activities will also include: strong outreach and education initiatives in partnership with institutions of higher learning, private and voluntary organizations, government and most of importantly, minority and medically underserved citizens themselves. Specifically, the CRMH/Academic/Community Partnership activities will be accomplished by:

- Establishing, facilitating and maintaining active partnerships among interested professionals and organizations from the academic, public and private sectors addressing many issues related to minority health.
- Developing an effective interface between experts in the field of minority health and community leaders.
- Organizing a current accessible information system on minority health and intervention.
- Assisting in the formation of community-based groups to address and assess minority health issues at the local level.
- Promoting awareness of the activities of the CRMH within the public health and academic communities and among individuals with an interest in minority health issues.

Efforts will be made to identify those institutions of higher learning having interest in research and training activities relevant to minority health, i.e. UT Medical Branch at Galveston, UT-School of Public Health. Special emphasis will be focused upon devising creative and cooperative ways in which the targeted institutions and the CRMH can co-sponsor service programs and activities of mutual interest.

Historically Black Colleges and Universities (HBCUs') and minority service institutions, such as those with Research Centers at Minority Institutions (RCMI) grants, will be prime targets of the CRMH, as these institutions are the breeding grounds of a significant proportion of minority leadership and tend to be major forces in providing inspiration and motivation to minority citizens. In regard to the latter, it is desirable to promote an atmosphere that supports partnership in service between these institutions and predominantly non-minority institutions.

Strategies directed at institutions of higher learning will include:

- Sponsoring cooperative programs at the various campuses that accentuate issues germane to minority health;
- Fostering and supporting an environment that inspires and excites students into considering the health professions as possible areas;
- Supporting joint academic programs designed to enable the participation of students in exchange programs, and
- Establishing programs involving inter-institutional faculty activities including joint seminars and teaching ventures.

SPECIFIC PROGRAMS OF THE CRMH:

As with other component of this proposal, some of the items listed will be a joint effort with already existing entities, such as the Office of Institutional Diversity, the Office of Academic Affairs, and the Office of Research. These programs will be develop once funds are identified to support each of the following programs.

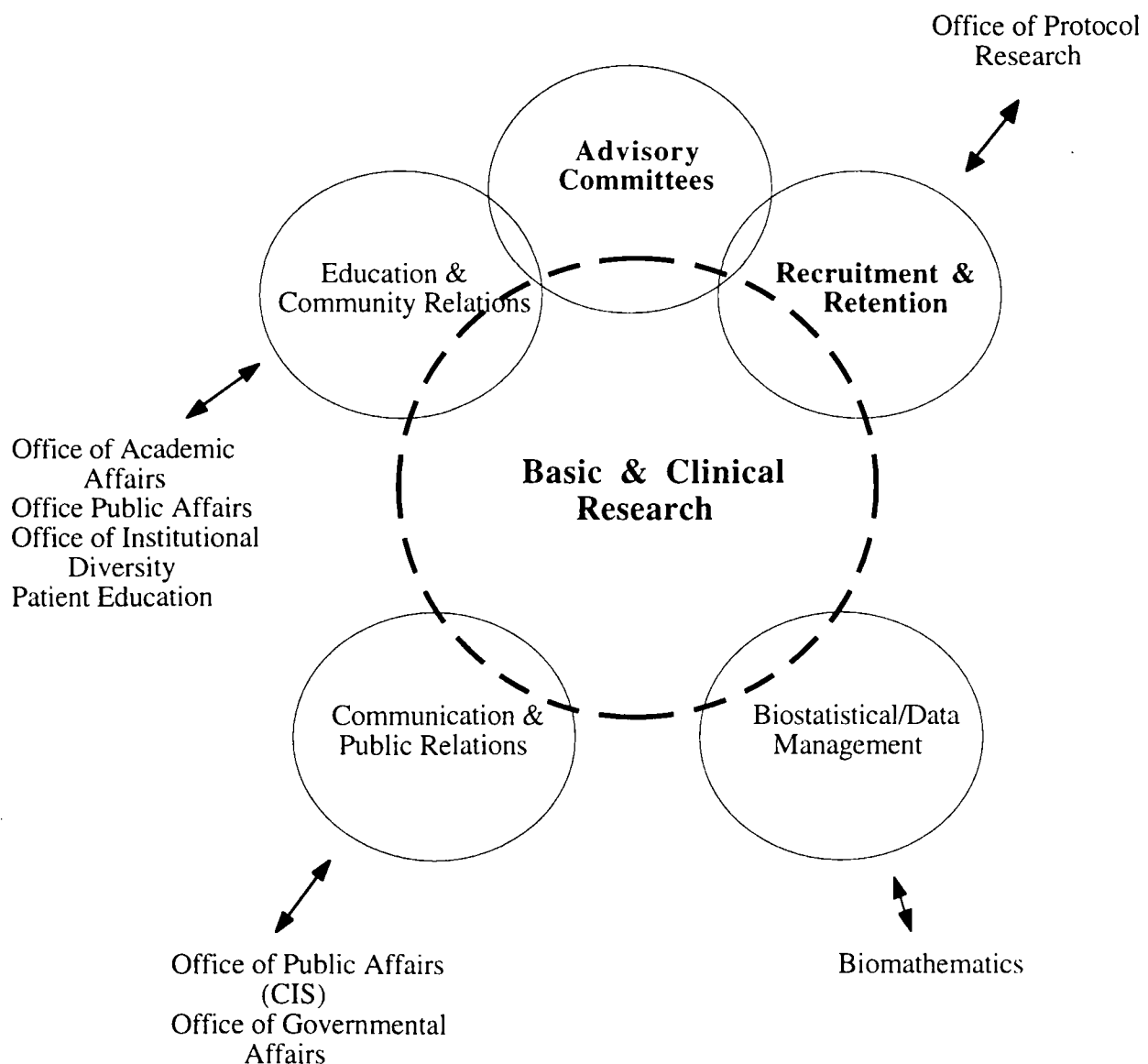
- **Support Grants/Call for Proposals**
Financial support will be made available on a competitive basis to MDACC faculty, academic staff, and students for scholarly projects and other activities that pertain to the study, understanding, and appreciation of racial/ethnic health issues, i.e. cancer.
- **Category A - Research**
Support for scholarly research on racial and ethnic topics by CRMH faculty and instructional staff. Such research with the goal of publication is highly encouraged, as are collaborative efforts between individuals from different departments as well as institutions, especially minority serving institutions.
- **Category B - Curriculum Development**
Support for the development and offering of new courses pertaining to racial and ethnic health topics. The goal will be to encourage more such courses to be adopted permanently into the curricula of the UT- Graduate School of Biomedical Sciences, UT- School of Public Health, and UT- Medical School Houston, and the prospect for this occurring is a criterion in the annual evaluation process.
- **Category C - Miscellaneous Projects**
Support for such activities as workshops/seminars, lecture series, guest speakers, cultural exhibits, fine arts performances, professional development, curricular and instructional improvement, materials acquisitions, etc. All proposals must have a racial/ethnic/underserved theme, and MDACC faculty, academic staff, and students/student organizations (with faculty/staff sponsorship) will be eligible to apply.
- **Faculty Research on Minority Health Awards**
These awards free non-tenured faculty members who hold probationary, tenure-track appointments from all institutional responsibilities for either a semester or summer, thus enabling them to conduct research/scholarly activities solely. The aim is to increase the opportunities of these individuals to have their scholarly works recognized and published, thereby enhancing their prospects of achieving tenure and ultimately adding to the base of minority faculty at MDACC.
- **Faculty Study Seminars**
Small groups of faculty from throughout MDACC and possible the TMC, who have been nominated by the Vice President for Institutional Diversity, meet to engage in critical and rigorous inquiry and discourse concerning a major work that is germane to the study of race, and/or ethnicity. These face-to-face exchanges among colleagues serve as an impetus for further discussions among faculty and students at the participants' respective campuses.
- **Brain Trust Meeting**
Faculty and Researchers who teach courses and do research focusing on racial/ethnic studies, or whose courses and research have a significant racial/ethnic component, meet to exchange ideas, research designs and data, bibliographies, reading lists, syllabi, audio-visual resources, and pedagogical techniques that will be employed in the field.

- **Faculty Associate Roster**
A computerized roster will facilitate a quick and easy sharing of expertise pertaining to the study of race and ethnicity across the UT System and possibly the nation. Relevant data will be compiled for each participant on his/her courses, research, publications, and public service activities. The faculty member's interest in serving as a guest speaker, as well as in leading forums and workshops, will also be solicited. A future project will be to make the roster available through the Web.
- **Newsletter (To be Named)**
This academic newsletter will be published once each quarter and serves as an outlet for articles pertaining to race and ethnicity, as well as a source of information on Institute activities and news in the field from across the UT System, the Texas Medical Center and eventually the nation.
- **Miscellaneous Activities**
To keep the CRMH programming fresh and vibrant, over the CRMH will engage in a number of other activities, a faculty/student mentorship program described in this proposal, a faculty exchange with historically black institutions and minority serving institutions, and a Visiting Scholars Program among others. The essential component of the CRMH programming as highlighted above, as well as its continual exploration of new programming ideas and options will be a prime component of the CRMH.

COMPONENT UNITS (PRELIMINARY CONSTRUCTION)

The CRMH will have five component units: Basic & Clinical Research Unit (Collaboration) Biostatistical/Data Management Component, Education & Community Relations (Community Outreach) Component, Communication & Public Relations Component, and Recruitment and Retention Component. The purpose of these component is to clearly delineate responsibilities listed above. Each component will have its own leader and those leaders will meet on a regular basis to ensure that the aims are being met.

The center piece of the CRMH will be the research component, with the other components facilitating the mission of the CRMH. Each of these components will also be link to corresponding units within M.D. Anderson Cancer Center. In addition, each of these components will also be able to participate as a research component in its own capacity.



I. BASIC & CLINICAL RESEARCH COMPONENT (COLLABORATIONS)

The intent is to develop multidisciplinary research initiatives across departmental and/or institutional boundaries.

As stated previously, the research effort of the CRMH will focus on Cancer Prevention (building on already ongoing programs while developing new ones), as it pertains to minority populations initially. As illustrated in the appendix, letter from members of the Division of Cancer Prevention as well as other entities will provide a fertile ground to begin addressing many of the research questions that face minority and medically underserved community. For instance, there are a number of other areas of research the CRMH can focus on, e.g., environmental factors as they pertain to special populations, do all ethnic groups respond in the same manner to standard therapy, and what is the role of genetics in determining risk for developing certain cancers (Wilson, 1989; Jones 1990, 1997). It will be the prime purpose of the Brain Trust to aid in setting other specific research objectives of the CRMH. The CRMH has already received a commitment from Dr. Franklyn Prendergast, Director of the Mayo Cancer Center, Dr. G. Marie Swanson, Director of the Michigan State University Cancer Center; Dr. Linda Burhanstipova, director of the Native American Excellence Research Program at AMC; Dr. Amelie Rameriz, Associate Director of the Center for Cancer Control at Baylor College of Medicine; Dr. Richard Payne, director of Pain Clinic at MDACC; Dr. Margaret Spitz, Chair Department of Epidemiology at MDACC; Dr. Moon Chen, Chair Department of Public Health at Ohio State University; Dr. David Curb, Director of the Pacific Cancer Research Health Institute in Hawaii and others. All have had a chance to review the proposal and a letter of support for the concept as well as a willingness to participate is attached.

II. BIostatistical/Data Management Component

This component will be lead by a faculty member in the Department of Biomathematics at MDACC. It will create and maintain centralized, electronic databases of all data collected by the CRMH personnel. All statistical analyses of data collected by the CRMH research personnel will be conducted in consultation with the head.

- **Data Management**

To the farthest extent possible, data collected by the CRMH research personnel will be electronically managed using existing state of the art database management computer software. Only in very unusual circumstances will the biostatistical/data management section create a database using non-existing software developed by the section's personnel. The database management system (DBMS) will be chosen so as to allow the greatest flexibility for the CRMH research personnel to enter, store, and retrieve data for analyses, reports, and presentations.

It is also the goal of the biostatistical/data management section, in conjunction with Biomathematical research personnel, to develop a catalog of all past published studies which have included minority populations of notable size and/or focus. Whenever possible, data from those past studies will be obtained by the CRMH with the idea of making the data readily available to the CRMH research personnel and all other interested parties. At a minimum, developing a database which catalogs all past published studies which have included minority populations will allow researchers to be able to quickly identify studies,

using various key words and phrases, which are relevant to their particular research and training needs.

The data analysis and management section will give the CRMH researchers the flexibility of having individual research projects create and maintain separate databases with the understanding that copies of those databases will be forwarded to the section. Databases created in this way would be developed in consultation with the biostatistical/data management section's personnel so that some reasonable amount of compatibility will be maintained between databases.

Available technology will allow most, if not all, of the data management to be performed on personal computers (PC) and/or multi-user workstations as opposed to mainframe computers. Initially the PC's will exist in a stand-workstations through a local area network (LAN). As standard operating procedure, backups of all data will be routinely performed. Most of the software and hardware computer support will be provided by the section.

- **Design and Statistical Analyses**

All statistical data analyses from data generated by the CRMH will be done in consultation with the biostatistical/data management section. The section will provide a broad range of statistical support for the CRMH research and training projects.

The section will help design experiments, participate in the collection and cleaning of data, and provide support analyzing and presenting the data. Where needed, the section will provide short courses on statistics to the CRMH personnel with special consideration given to graduate student trainees.

Statistical data analyses will include summary statistics, cross-sectional analyses, univariate/multivariate repeated measures analyses, and hypothesis testing. Support for graphical presentation of data will also be provided.

III. EDUCATION & COMMUNITY RELATIONS (COMMUNITY OUTREACH) COMPONENT

This component will emphasize the need for community involvement in any endeavor. The communities must be aware of what is being done and what the benefits will be along with the potential risks. In doing so we can begin a true attack on the existing health problems and influencing change in order to fulfill the mission statement. The CRMH will develop a model educational program using interpersonal communication, that can be used in striving for excellence in minority health. The outreach component of the program, linked with those units at M.D. Anderson targeted at outreach, will strengthen and expand all current efforts of the MDACC within Houston's minority communities, examining prevention, early detection, behavior modification and treatment of cancer and other diseases acting as a model for the state and nation.

The CRMH will accomplish this through the following aims:

- Develop and execute educational programs in minority communities on the benefits, risks, responsibilities and implications of clinical research. In addition, the CRMH will assist in the formation of community based coalitions to address and assess minority health at the local level.

- Seek out exemplary programs on research in minority health research which will serve as models for other communities and develop others where none exist. Additionally, the CRMH will assist communities in the replication, implementation and dissemination of strategies, interventions and tools to address the most urgent health needs of the communities.
- Establish a partnership between the minority communities and MDACC Investigators to open the doors of communication and increase minority participation in clinical research trials.
- Establish satellite office(s) in minority communities to aid both researchers trying to recruit volunteers and communities willing to participate in offered programs. Doing this will gain a strong and enduring presence in these targeted communities gaining access through trust.
- Establish a reporting mechanism by which researchers will be asked to report back, in form of brief report, to those communities any results uncovered by the investigations. These results should be published with a detailed explanation of what information was found and how this effects the community. Recommendations to improve health care, discuss risk factors, etc. will be included in this report.
- Address other issues that effect medical research, whether directly or indirectly, to eliminate barriers.
- Create various educational materials that will aid in the recruitment and retention of volunteers and medical subjects in research studies.

IV. COMMUNICATION & PUBLIC RELATIONS COMPONENT

The objective of this component is to promote the actions of this office, gain support, and ignite interest in the field of minority health and research. This component will be linked with the Office of Public Affairs (CIS) and the Office of Governmental Affairs. This will also function in assisting to identify potential sources of support.

- Work closely with the Public Relations offices of all involved institutions to inform MDACC staff as well as other institutions of the formation of the CRMH, and to promote the operations, and educational outreach provided.
- Develop a website that can be linked to other established offices of research, community medicine, and offices of minority health. In this way we can capitalize on all resources available and tap into the already established system of communication on a local, state and national level.
- Utilize the community based media network as a platform to announce the CRMH's objectives and develop community recognition. Employ the use of press releases and Public Service Announcements when possible to promote office and its operations.
- Establish, facilitate and maintain active partnerships among interested professionals and organizations from the academic, public and private sectors addressing many issues relating to minority health.

- Create awareness of the CRMH's activities and services within the public health and academic communities and among individuals with an interest in minority health issues.
- Assist in translating and disseminating research findings about minorities and the medically underserved to the public at large.
- Lending institutional names to such a venture, as it did with the Biennial Symposium Series, will help promote the CRMH. This will assist in providing an initial stable base and supportive environment for a core group of scientists dedicated to studying the health related problems facing minorities and the medically underserved, especially those that are cancer related.
- Prepare and distribute a newsletter regarding minority research and health issue, grants available and funding agencies. This newsletter will be distributed to MDACC and other institution staff to promote additional interest in the CRMH and its services.

V. RECRUITMENT & RETENTION COMPONENT

As discussed earlier in this proposal, there is an established criteria that increased participation in clinical trials by these groups is needed. However, understanding the reason why participation is limited is important in addressing this problem. It is thus necessary to expand the explanation for the need of such a program at this point. Although we have discussed at length the need for the overall improvement of minority health, recruitment and retention of minorities into clinical trials has continued to be a significant problem facing many researchers. The recruitment of volunteer minority subjects into clinical research studies and the long term retention of the minority subjects has generally been only partially successful. Of the multiple causes for this, the most prominent have been:

1. fear of unethical treatment
2. distrust of the investigator's motives;
3. the subjects incomplete understanding of their benefits, responsibilities, and risks, and the safeguards for study subjects.
4. the investigators' apparent lack of respect for the subjects and their cultures;
5. the history of episodic research without long-term programs having tangible benefits.
6. cost and/or lack of insurance,
7. lack of access to clinical trial (transportation, child-care, time off of work) and
8. lack of true partnerships in study design

The key to addressing this challenge is to develop the most efficient, most culturally sensitive methods to encourage participation. Culturally sensitive methods for conducting research and administering care have been developed over the last two decades. It should be noted that these methods have had limited use in studying general health and other major diseases in minorities. Successfully minority recruitment and retention procedures have been developed for individual projects with a single minority. However, there has not been a national demonstration model for institutional or multi-institutional in the broad application of these methods for a variety of studies in diverse minority groups.

The overall responsibility of this component is to create a program for the recruitment and retention of minority volunteers subjects from the Houston community into clinical research studies at the University of Texas M.D. Anderson Cancer Center.

The proposed component will facilitate collaboration between individual clinical investigators and potential minority study subjects in the Houston metropolitan community. The component will enable MDACC to present minority communities with a single, permanent recruitment entity in place of a variety of brief, seemingly random, investigator-initiated efforts. It will provide investigators with effective recruitment avenues to the minority communities; and informs the minority community about research volunteers' benefits, responsibilities, risks and safeguards. It will promote the communities' trust in the MDACC and their investigators. The program's operation and budget gains from the economy of scale achieved by a single program serving the entire institution. MDACC will be better equipped to adhere to the NIH 1994 guidelines on the inclusion of women and minorities as subjects in clinical research. This research resource will have five major functions, supported by specific aims:

The CRMH will facilitate and service each clinical study's minority recruitment by a program, optional for each investigator, which:

- provides the investigator and study staff with information and training on culturally sensitive recruitment procedures,
- informs the community about the responsibilities, risks, benefits, and safeguards for study subjects,
- establishes community support for recruitment by building a collaboration between the institution and the minority community through its leaders and health professionals, and health care gatekeepers,
- honors each investigator's independent responsibility for the design, staffing, and operations and funding of the study's recruitment.

The CRMH will develop optimal methods of recruitment and retention of minority study subjects by seeking to define the factors associated with recruitment and retention activities for each minority group in the Houston area. To do this, the CRMH will enlist the help of community health care providers who will be useful as liaison between minority communities and the investigators in facilitating the recruitment and retention activities.

The program will be evaluated for efficiency of recruitment, sensitivity of recruitment procedures to culture, efficacy of retention, sensitivity of retention procedures to culture, and comparative analysis of costs of procedure modification. By doing this we hope to provide a national demonstration model of a program for minority subject recruitment and retention in a single metropolitan area served by a comprehensive cancer research institution.

CANCER PREVENTION MODEL PROGRAM

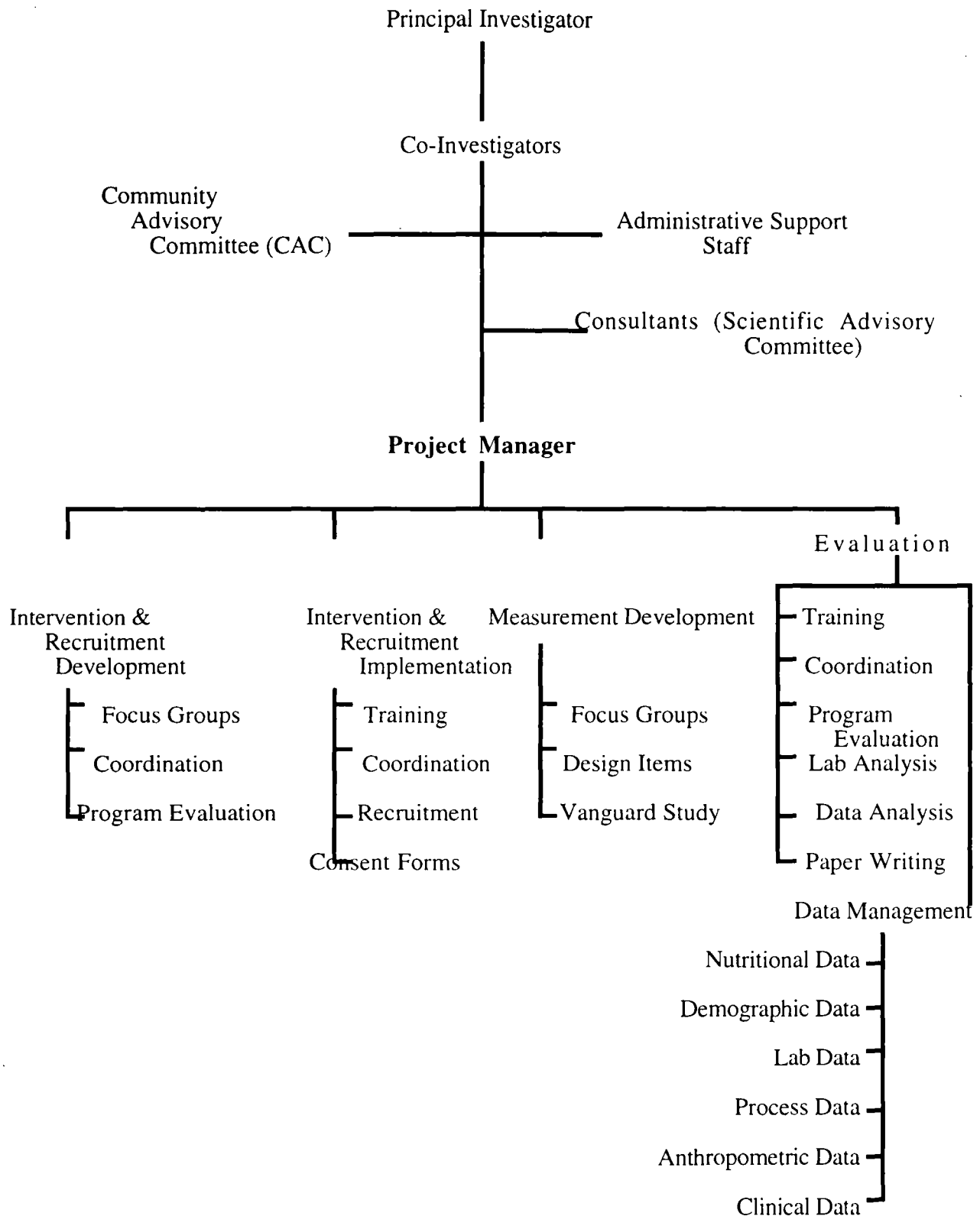
Such words as unique, bold and visionary have been applied to the concept on which this proposal has been built. Others have said that it lacked focus, that it was too much to expect of any program. And in truth, all of these apply. But to address the spiraling cancer crisis, as well as health crisis, affecting minority and medically underserved communities such efforts are going to have to be attempted. Such a program that has been built on years of experience taking various concepts and modifying them through trial and error is described in this document (Jones et al, 1997, Jones 1997). The program described here includes those of Glanz (1994), who developed and implemented a plan to encourage voluntary, long-term adoption of healthful eating patterns in a living-free population. Her plan involves three levels of activity, i.e., the education of community leaders, the coordination of media for message reinforcement, and the development of community outreach activities. The model proposed in this proposal reflects ongoing efforts to develop effective recruitment strategies. The plan is a composite of a number of activities originally conceived by Lovell Jones (Jones, 1990) and fused with the effort of the Kellogg's Nutrition Pilot Study, the National Black Leadership Initiative on Cancer and Glanz (1994) form the basis of "Compañeras Sanas" and a program targeted toward African American women.

"Compañeras Sanas" was the initial funded program target toward postmenopausal hispanic females which allow the ideas expressed in the proposal concerning clinical trials to be put into practical. The experiences of the "Compañeras Sanas" along with the experience and expertise of the study's Community Advisory Committee members was vital to the development of this proposal and the successful implementation of the recruitment strategies targeted toward minority and medically underserved populations. The following is an attempt to illustration some of the aspects of "Compañeras Sanas".

A variety of community settings and channels held opportunities for reaching the target population--postmenopausal, hispanic women. These same recruitment channels, however, posed obstacles and limitations for conducting the intervention research. For example, although older hispanic women tend to be heavy users of electronic media, a city-wide mass media appeal was deemed not the best option because the population had limited access to transportation. Therefore, in recruiting in any given community access to transportation and availability of time must be taken into consideration from the beginning and be incorporated into the study design. Issues involving transportation of participants to screening exams and intervention sessions were an anticipated access barrier and had an impact on all recruitment decisions. To lessen the impact of this access barrier, the recruitment of participants was accomplished via mediating structures and community institutions through developing relationships with minority community leaders. The Community Advisory Committee was invaluable in this point of the recruitment.

Interpersonal communication strategies with study personnel routinely at study sites and highly visible were the key to this successful campaign. Such efforts led to the recruitment of over 500 potential participants. Some of the detailed methods and as to what was learned with regard to solving transportation problems, working with community organizations/agencies/gatekeepers, obtaining informed consent, translating materials, and obtaining dietary assessment data have provided above in other sections of the proposal.

Each of the studies mentioned, as well as others, have the followed the design based on the concept of Research, Education and Service, as illustrated on the next page (page 28). The following figure illustrates each of the components as structured in the grant application submitted to the Kellogg's corporation:



As a product of the research experiences the above organizational structure was developed. Such a structure allowed for all of the various aspects of the intervention/prevention study to blend into the a **study model**. In referring to the Kellogg's Intervention/Prevention

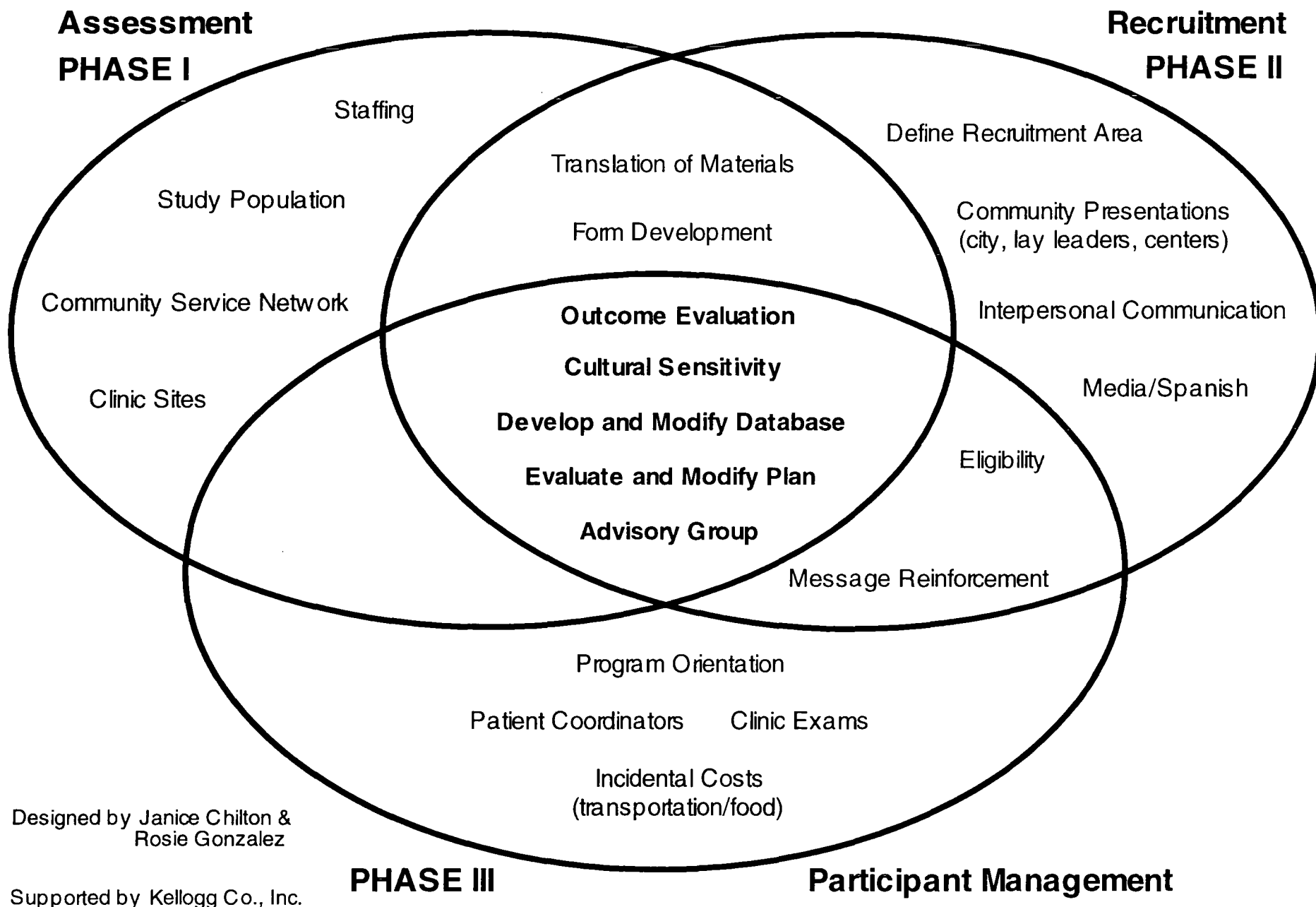
Community/Research Model illustrated on page 30, **paramount** to all activities and included in all phases of the model is the concept of **cultural sensitivity, developing and modifying databases, a Community Advisory Group engaged during the research project development phase, and outcome evaluation.**

Compañeras Sanas Study Model- Intervention , Prevention, Community , Research Model

- In **PHASE I** entitled **ASSESSMENT**, the following should be accomplished, the selection of the study population, a community service network within that population, the identification of clinic sites near the study population and adequate staffing to achieve the goals of the study. In phase one, form development begins and if need, translation of materials.
- In **PHASE II** entitled **RECRUITMENT**, defining eligibility, defining the recruitment area, developing forms, presentations to the advisory group and then to the community, interpersonal communication activities, engaging the media, and if need conned translation of materials to be used, along with message reinforcement.
- In **PHASE III** entitled **PARTICIPANT MANAGEMENT**, one will still be determining eligibility and reinforcing the message as well as doing patient orientations and clinic examination. In this phase one will also be exposed to addressing incidental cost and well as outcome evaluations. At this point their is a need for patient coordinator(s).

On a small scale the "Compañeras Sanas" was able to successfully focus on those three areas outlined in the proposal: a) establishing research collaborations, b) successfully recruitment and retention of minority and medically underserved populations into clinical trials, and c) developing the capability to address health disparities in the population recruited but ruled ineligible for the trial. In that way, creating an effective way for translating health messages to the community, i.e. if something is detected there are possible ways to treat the diseases.

It is understood that for each population and locality the methods and activities mentioned will have to tailed for each study undertaken. It should also be noted that the success of the Center will be determined by its ability to take what has been achieved on a small and expanded it to other studies with other investigators involved and that will take sufficient resources.



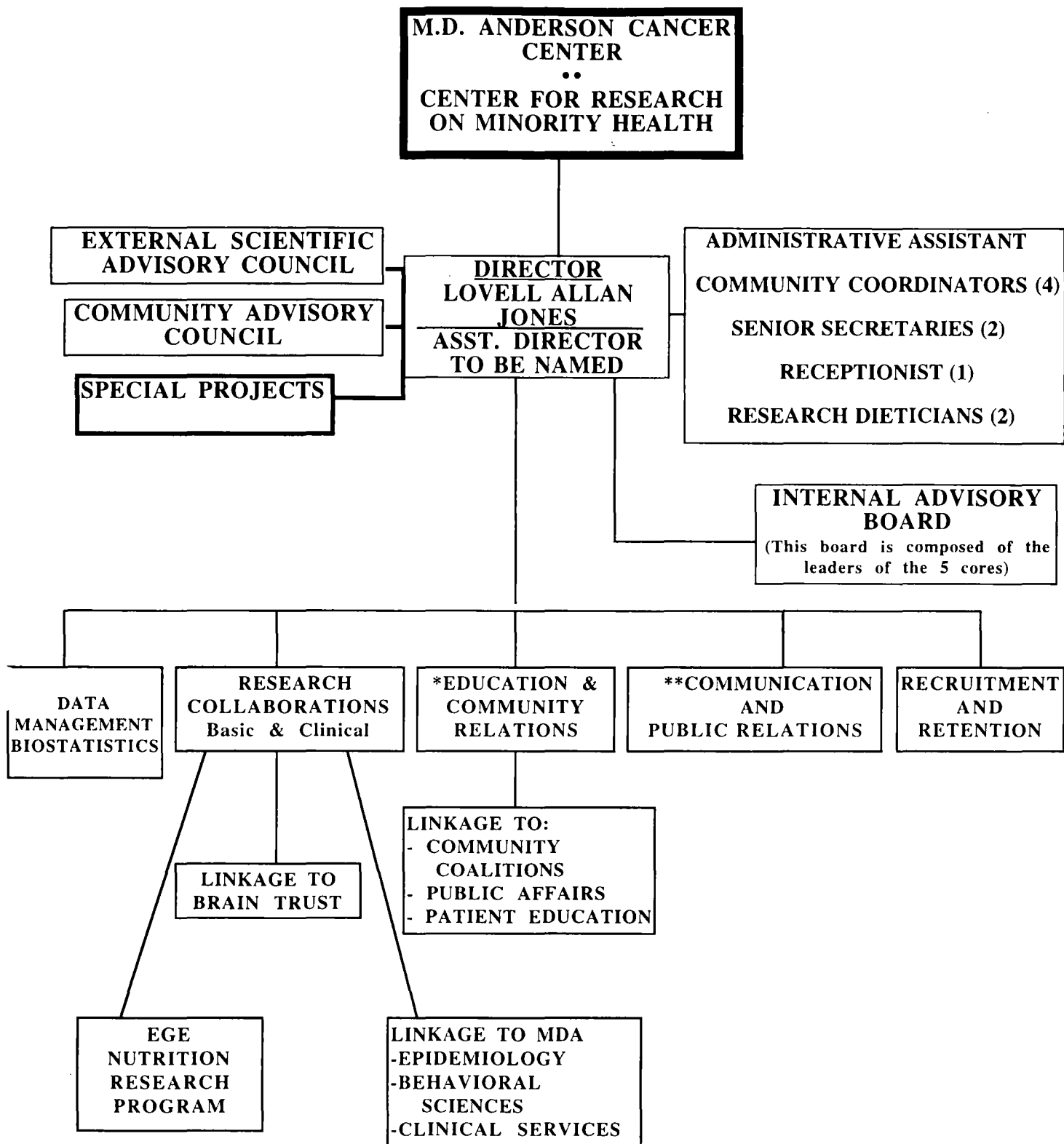
ORGANIZATIONAL STRUCTURE

(See Organizational Chart)

The initial administrative structure of the CRMH will include a Director, one Assistant Director and a support staff that will include Community Coordinators for each ethnic population addressed by the Center, an Administrative Manager and two Senior Secretaries. In addition, the Center will need supplemental support for those investigators/administrative staff who will coordinate each of the component units. With nutrition being the initial focus of the Center, it will need support for at least two Research Dietitians.

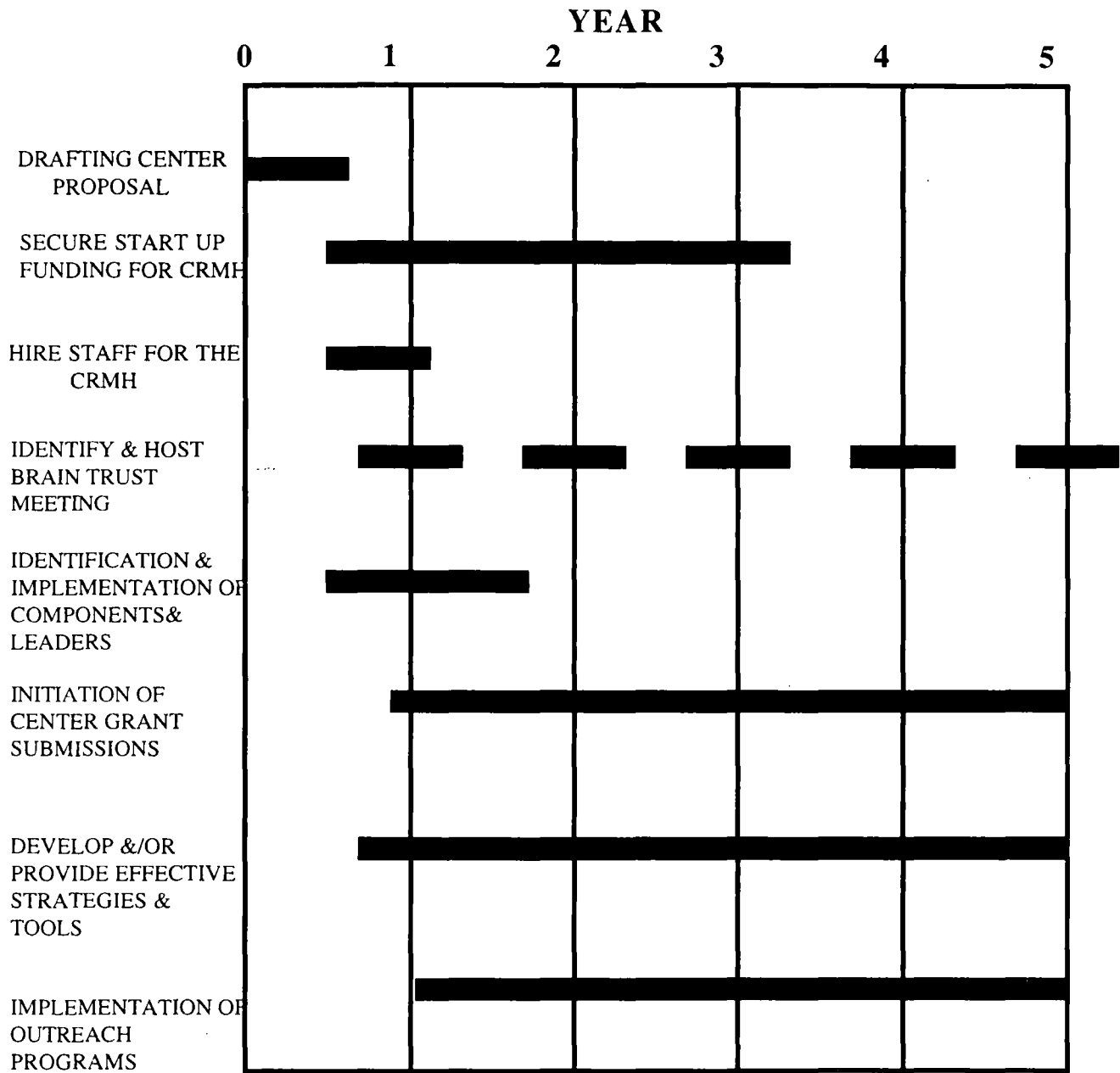
The Director will be responsible for the overall administration of the CRMH; direct CRMH activities in the acquisition of funding for the development and continuation of the CRMH; act as a spokesperson for the CRMH; and represent the CRMH in policy activities. The CRMH's -Director will relate to an External Scientific Advisory Council, an Internal Advisory Committee and Community Advisory Council. The External Advisory Council will consist of at least 8 to 12 members. The composition of this council is critical. The people on this council should represent key areas of the institution's involvement. Appointing people to this council should not be left to the Director alone. The role of this Council will be to review the overall strategies and progress of the center within the context of the broad issues in the area of minority health. This Council will also facilitate linkages with other institutions, and public and private agencies and organizations at the state and local levels.

The Coordinators will function under the direction of the CRMH's Director and Assistant Director and will be responsible for the day-to-day management of each of the CRMH's Component's (see attached diagram). In addition, they along with members of the community advisory committee will aid in administering the Special Programs of the CRMH. The CRMH's Assistant Director, along with the Coordinators, will assist the Director in preparing require reports to grant agencies; providing publicity for the CRMH; assisting researchers in the preparation of proposals originating from the CRMH; and coordinating activities of the advisory committee. The CRMH's Community Coordinator will develop and plan activities to increase public awareness through marketing programs on the CRMH at local, state and national levels. The Community Coordinator will also work closely with participating institutions, government agencies, funding agencies, and MDACC departments to help guide in funding, education, and community outreach. The Center's Secretaries will be responsible for clerical support. Specifically those persons will be responsible for keeping records, maintaining all paperwork at each site and typing correspondence, publications and reports.



TIMETABLE FOR THE PROJECT (see time line)

The initial activities, after securing the final approval of the President of UT MD Anderson Cancer Center, will be to form the Advisory Committees. One of these Committees will be a Scientific Brain Trust of national and internationally prominent scientists representing relevant disciplines. Funds will be secured to host an initial meeting of these committees, especially the Brain Trust. It goes without stating that the advisory committees, which plans and supervises the programs, will include persons who represent the population targeted to be served. Within a short time frame those Specific Programs of the CRMH outlined in this proposal will be implemented, especially the grants program and the formation of the Basic and Clinical Component. In addition to this Component, other individuals will be sort out to help in the development of the four other Components outlined in the proposal. All of this will be done with input from the Community Advisory Committee. It is evident that funds will be need to hire a staff to administer the committee and the initial needs of the CRMH. A grant has already been submitted under the Center's name for funding a nutrition intervention study. Over the next six months other funding will be sorted out. As stated earlier the Breast Cancer Prevention Nutrition Program has an effective cancer prevention program which has received national recognition. This program will be built upon within the context of the CRMH. Other ongoing programs in Cancer Prevention have expressed an interest in being linked with new projects that will be developed by the CRMH. The Intercultural Cancer Council has created a world-wide web. It has been called the most comprehensive website on cancer and minorities on the Internet (icc.bcm.tmc.edu, see attachment). The CRMH will form a link with this web site as well as others highlighting those specific efforts the CRMH will be undertaking. The Community Advisory Community will also be started within six months. This committee will be crucial to the creation and implementation of the Communication & Public Relations Component and the Recruitment and Retention Component. Having these in place will allow the Center to seek external funding for the Center itself. These grants will be based on 1) a clear definition of the problem(s) to be address and 2) the use of a wide range of methods, capitalizing on the strength of each to address the problem(s). This will allow the CRMH to establish a baseline so that the instrument(s) or procedure(s) used to measure the CRMH's success accurately reflects the progress or lack there of. However, as important is the fact that the success of this proposal will be also based on sufficient funds and manpower being provided to carry out the initial phase to secure outside funding.



Glossary of Terms:

Clinical Trials- Research studies conducted with patients. In this case the majority of these trials are in cancer research.

Community Advisory Committee- A group of community leaders that advise investigators and their staffs on the concerns and wishes of the community. This committee is vital in developing and maintaining a strong and dependable relationship with communities.

Compañeras Sanas- (Healthy Partners) Nutritional study sponsored by the Kellogg Corporation that is referred to in this proposal as a model by which the following methods were developed.

Holistic Approach- This approach takes into account all factors that influence the perceived need for health care and attention to health concerns. Knowledge, attitudes, and practices are important in how an individual responds to health situations, in determining availability of health services, and how that individual or group seek health care when available. In addition, this approach also closely examines other factors that may impinge on health care for these communities, both health and non-health related.

MDACC- M.D. Anderson Cancer Center

Minority (minorities) Group(s) - As stated early in the proposal this term refers to ethnic minority groups as well as underrepresented females (particularly minority females) as well as other medically underserved.

NCI- National Cancer Institutes

NIH- National Institutes of Health

TMC- Texas Medical Center

UT/UT System- Throughout the proposal the initials UT are used to represent the University of Texas and all affiliated institutions.

REFERENCES

1. Klineberg, Stephen L. Houston's Ethnic Communities-Third Edition 1996. Department of Sociology, Rice University, Houston, Tx p.2.
2. Rodriguez, Nestor. University of Houston- Department of Sociology, interviewed via phone.
3. Centers for Disease Control. Mortality patterns--United States 1989. JAMA3118192:267(11):144-145.
4. Vernon N. Ilouk, MD, Director, National Center for Environmental Health and Injury Control, Centrs for Disease Control.
5. Centers for Disease Control. Weapon-carrying among high school students- United States, 1990. MAWT 1991 (October 11);40(40):681-684.
6. United States National Center for Health Statistics, *Vital Statistics of the United States*, (Annual,1995). Table No. 223. Cancer-Estimated New Cases,1996, and Survival Rates, 1974-77 to 1986-91.
7. Jones, L. A., Minorities and Cancer.1989. Springer-Verlag, New York.
8. Freeman,H.P., Muth,B. J., Kerner, J.F.(1995). American Cancer Society; Expanding Access to Cancer Screening and Clinical Follow-up Among the Medically Underserved: *Cancer Screening in Underserved Populations*, 9-19.
9. Kann, L., Warren, C.W., Harris W.A. Collins, J.L., Douglas, K.A., Collins, M.E., Williams, B.I., Ross, J.G. & Kolbe L.J. (1995). Youth risk behavior surveillance-United States, 1993. *Morbidity and Mortality Weekly Report*, 44 (SS-1), 1-56.
10. Wenger, 1995 as cited in Private Choices Public Policies.
11. McElmurry, B.J., Parker, R.S. Annual Review of Women's Health, Vol. III. *Racial Disparities*, National League for Nursing Press, Pub. No. 14-672X. New York, 1996.
12. Hammerle, N., Private Choices and Public Policies: Praeger Publishers. Westport, CT. 1992.
13. Center for Populations Options (1025 Vermont Av, NW, Suite 210, Wash C 20005). Teenage pregnancy and too-early childearing: public costs, personal consequences. (Cited in The Nation's Health, July 1992, p16)
14. Centers for Disease Control. MMWR 1g1 (October 18); 40(41):697-700.
15. Sibbison JB. USA: lead in soil. The Lancet, April 11, 199;339 921 2.

16. Miller, BA, Kolonel LN, Berstein L., Young, Jr. JL, Swanson GM, West D, Key CR, Glover CS, Alexander GA, et al (eds). Racial/Ethnic Patterns of Cancer in the United States 1988-1992, National Cancer Institute. NIH Pub. No. 96-4104. Bethesda, MD, 1996.