Cross-Cultural - Community Medicine Rotation
St. John’s Health Center
New Brunswick, NJ

Residents’ Guide to Activities

Department of Family Medicine
UMDNJ-Robert Wood Johnson Medical School
Steven Levin, MD
Jan Gottlieb, MPH
Co-Directors
Overview

Welcome to the Cross-Cultural Community Medicine Rotation. Through this rotation you will learn a great deal from the staff of St. John’s Health Center of Catholic Charities all of whom are committed to providing quality health care to the diverse and indigent population of New Brunswick. You will learn about the challenges this population faces in terms of access to health care, jobs and social services but you may also be surprised to learn about the wealth of community resources available to them. We hope you will find it rewarding to provide patient care and community service for this population. We also hope you will recognize the necessity of understanding, learning about and respecting the cultural beliefs and practices of your patients in order to minimize the chance of misdiagnoses and poor patient outcomes.

Structure of Rotation: You will devote approximately 3 full days per week to the rotation: half of that time you will see patients at St. John’s Health Center of Catholic Charities. The rest of the time will be devoted to learning about community resources and providing community service (e.g. in a soup kitchen, conducting a community presentation.). Think about what you would like to get out of this rotation and pursue it!

About New Brunswick: The city of New Brunswick has been designated by the state of New Jersey as a medically underserved area despite the abundance of health care services available. According to the 2000 US Census, 27% of individuals and 16.9% of families living in New Brunswick fell below the poverty level; 23% of the New Brunswick population is black and 39% is Hispanic. Approximately 80% of the patient population at St. John’s Health Center is Hispanic and of these, 50% do not speak English. We encourage you to learn much more about New Brunswick and it’s diverse population.

Goal of Rotation: To promote residents’ interest in practicing in medically underserved urban areas by offering a rewarding learning experience that enhances their skills in providing culturally sensitive, community-oriented primary care to a diverse and indigent population.

Objectives: By the end of the rotation residents will be able to:
- demonstrate the use of an interviewing tool (ETHNIC) to elicit culturally-based health beliefs and practices and incorporate these into the patient’s care plan;
- describe the philosophy/steps of community oriented primary care (COPC);
- access the Healthy People 2010 website and state it’s goals, the 10 leading health indicators and the 6 focal areas for eliminating racial and ethnic health disparities
- discuss 3 examples of St. John’s Health Center’s COPC efforts;
- describe the benefits of the physician-physician assistant model of interdisciplinary collaboration
- demonstrate clinical competence in caring for vulnerable/at-risk populations (addressing such issues as delayed immunization schedules, managing elevated lead levels, management of patients with substance abuse problems and patients with HIV/AIDS)
- list 5 causes for lack of or decreased access to the health care system experienced by homeless and indigent populations;
- describe 5 common health problems of the homeless and indigent patient;
- describe 3 resources available for uninsured patients and how to access them;
- describe the mission and function of 3 community resources for indigent patients;
- conduct a community presentation

We hope you will come away with a desire to help not only the individual patients you treat but a commitment to improving the health of the community as a whole - helping to eliminate racial and ethnic disparities in health and contributing to the advancement of the Healthy People 2010 objectives for the nation. But most of all, we hope you find this to be an enriching and rewarding experience.

Activity Checklist
Cross-Cultural Community Medicine Rotation

To ensure that you have a meaningful experience during your rotation you will be expected to complete the activities listed below, except where it says N/A. In preparation and throughout your rotation, please review the background readings and activity sheets; and the wealth of information in the “Red Binder” (located in Dr. Levin’s office) You will meet regularly with Dr. Levin and Jan Gottlieb to discuss your progress on the activities. Please refer to the attached schedule for your activities. Be sure to turn in the evaluation at the end of the rotation. Enjoy your experience!

Steven Levin, M.D. (Bp. 390-2632, phone 745-9800, e-mail: slevin@umdnj.edu), Jan Gottlieb, M.P.H., (732-235-7574, e-mail: gottlija@umdnj.edu) Co-directors

Name:________________________________________                 Date Completed

Enhancing Skills in Culturally Sensitive and Competent Care to Diverse Populations

1. Review articles on cultural issues in manual

2. Complete two Family Health Beliefs and Behaviors Assessments- one on yourself, and one with someone else

3. Use ETHNIC with at least 3 patients, either as part of “Patient-Family-Community Assessment form” or as needed. (Be sure to write information you obtained using ETHNIC in the patient’s chart)

4. Attend the Bilingual Interview Workshop. Review and use the skills you learned including the guidelines for initiating a “pre-session” with your interpreter (see below)

Community Oriented Primary Care in Practice

1. Review COPC articles in manual

2. Complete the Patient-Family-Community Assessment Form with four patients (a homeless person, person with HIV, person with chronic illness, another patient of your choice- select patients with Dr. Levin, prior to the patient session. You will be able to spend extra time with these patients in order to complete the interview). For three of the patients, just complete the table. For the 4th patient, complete the in-depth questions as well. Include the completed forms in the patient’s chart.

3. Review information in the Red Binder and current annual reports and talk to Dr. Levin and health center staff to learn more about St. John’s Health Center: See “Learning about St. John’s Health Center”
4. Participate in the community-based health care activities listed on your calendar and others as time permits. Be prepared to discuss your impressions of your field visits within the context of COPC and review “Getting More out of Your Field Visits” sheet. Potential activities include the following:

a. Child Health Conference (first Friday morning/month at St. John’s)  

b. HIPHOP student clinic (Tuesday & Wednesday eve at St. John’s- optional)  

c. Ozanam Men’s Homeless Shelter visit  
   Wesley Moore: 729-0850  

d. Board of Social Services -- Gregory Lavine: 745-3790  

e. Accompany St. John’s outreach worker(s)  

f. Tour of a Botanica and Bodega, Mariam Merced, RWJUH  
   Department of Community Health Promotion, 247-2050.  

g. Volunteer at Elijah’s Promise Soup Kitchen, contact Anthony  
   MacLauchlan 545-9002 ext. 16  

h. Department of Health Pap/mammo day at St. John’s  

i. Other  

Recognize the Relationship Between Poverty and Health and the Needs of Vulnerable/At-Risk Populations in New Brunswick  

Date Completed  

1. Review material about homelessness in the Red Binder.  

2. Interview a homeless patient to learn more about what lead to his/her homelessness and how he/she is managing the situation. This may be part of the interview when you use the Patient-Family-Community Assessment form.  

   (To identify the patient, review the patient schedule with Dr. Levin prior to the patient sessions. You will be able to spend extra time with this patient in order to complete the interview.)  

3. Observe/conduct an intake of a patient with HIV/AIDS.  

Demonstrate Clinical Competence in Caring for Vulnerable/At-Risk Populations  

Recommend delayed immunization schedules using information from health organizations, textbooks, and journal articles.  

Follow lead screening guidelines for inner city children and know the basic algorithm for managing elevated lead levels.
Utilize the protocol for management of abnormal PPD tests.

Demonstrate a familiarity with the management of a substance abuser with an HIV infection and identify potential areas of patient education.

Demonstrate an understanding of the resources available for uninsured patients and the ability to access and utilize them.

**Final Presentation**

**Do a presentation for a community group** (discuss with Jan/Dr. Levin) based on meeting with the organization representative, identifying topic of interest to the population served, and your area of interest/expertise. For presentations at Homeless Shelter, see focus group notes in Red Binder – Homeless Tab. Complete presentation form and turn into Jan or Dr. Levin.

**Sites for presentations** (contact site to discuss topic ideas and arrange time):

Ozanam Homeless Shelter: Wesley Moore: 729-0850, talk with homeless men, evenings 7:00 p.m.
New Brunswick Counseling Center: Ron Trautz: 246-4025 – HIV/drug abusers support group – Wednesday 10:00 – 12:00, Intoxicated Drivers class, Wednesday, 6:00 – 7:00 p.m.

**Mid-way meeting and wrap-up:** Be prepared to discuss the reflection questions below.

The assessment below may be completed and discussed with rotation advisors or used as part of a didactic session small group activity.
FAMILY HEALTH BELIEFS AND BEHAVIORS ASSESSMENT

Your Name: __________________________ Date: __________________________

Complete this Assessment on yourself and interview one other person from a different background.

1. How do you define your ethnic group? ________________________________________

2. How long have you and/or your family been in the United States? ______________________________________________________________________

3. What is your religious background? ______________________________________

4. What did your parents believe caused illness (e.g., natural causes, punishment from God, exposure to drafts, eating poorly)? Are your views different from your parents? ______________________________________________________________________

5. How did your parents view and treat common childhood illnesses like colds and stomach aches? _______________________________________________________

6. Who did the family consult when ill (include all popular, alternative/complementary and professional sources of care)? __________________________________________

7. How was emotional illness viewed? ______________________________________

8. Did religion play a role in curing illness? __________________________________

9. What were some of the family practices or home remedies to prevent illness or to stay healthy (e.g., laxatives, herbs, spiritualist consultations, regular visits to physicians, prayers, vitamins, fresh air, exercise, nutrition, use/avoidance of certain foods)_______________________________________________________________

_______________________________________________________________________

10. Who made the decisions about health and illness (e.g., grandparents, parents)? Who took charge of the sick person? How are/were elderly relatives cared for? By whom? ______________________________________________________________________

_______________________________________________________________________

11. How might your health beliefs/upbringing influence the way you approach patients?

_______________________________________________________________________

Adapted from a form developed by Patricia Carver, Ph.D. and Robert C. Like, M.D., M.S., Department of Family Medicine, Robert Wood Johnson Medical School, based on the work of Spector R.: Cultural Diversity in Health and Illness, New York: Appleton-Century-Crofts, 1979, Chapter 3 and Boufford, JI, Shonubi PA: Community Oriented Primary Care: Training for Urban Practice, New York: Praeger, 1986, Chapter 7.

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ETHNIC
A Framework of Culturally Competent Clinical Practice

Use ETHNIC with at least 3 patients. (This may be done in conjunction with the Patient-Family Community Assessment.)

An understanding of the patients' perceptions of their health problems ("illness explanatory model") and what they are expecting from the medical encounter can help the health care provider in negotiating treatment plans that will be most effective from both the provider's and the patients' perspectives. The following questions have proved especially helpful with people from diverse cultures, immigrant patients and refugees, although they are important for all patients. These questions would be asked after routine introductory questions (e.g., How can I help you today?).

**E:** Explanation
What do you think may be the reason you have these symptoms?
What do friends, family, others say about these symptoms?
Do you know anyone else who has had or who has this kind of problem? Have you heard/read/seen it on radio, newspaper, T.V.?
(If patient cannot offer explanation, ask what most concerns them about their problem.)

**T:** Treatment
What kinds of medicines, home remedies or other treatments have you tried for this illness? Is there anything you eat, drink, or do (or avoid) on a regular basis to stay healthy? Tell me about it. What kind of treatment are you seeking from me?

**H:** Healers
Have you sought any advice from friends or other people (non-doctors) for help with your problems? Tell me about it.

**N:** Negotiate
Negotiate options that will be mutually acceptable to you and your patient that do not contradict, but rather incorporate your patient's beliefs. Ask what are the most important results your patient hopes to achieve from this intervention.

**I:** Intervention
Determine an intervention with your patient. May include incorporation of alternative treatments, spirituality and healers as well as other cultural practices (e.g. foods eaten or avoided in general, and when sick.)

**C:** Collaborate
Collaborate with the patient, family members, other health care team members, healers and community resources.

Guidelines for Pre-Session with Untrained Interpreter

Practice holding a pre-session when working with your interpreters using the following guidelines:

1. “Thank you for interpreting for me today. Please allow me to briefly explain some things that will help us work more efficiently together.

2. Please interpret **everything** I say, exactly as I say it and everything the patient says exactly as he/she says it. For example you don't need to say "The doctor is asking if you are taking any medicine", just say "Are you taking any medicine?" If the patient says "I have back pain", you say "I have back pain" rather than "he has back pain."

3. Please stop me if there are any terms you don't understand or are having trouble interpreting. I can say it in a different way. Also feel free to stop me if I am saying too much before allowing you to interpret.

4. Is there anything I should do that will make it easier for you to interpret for me?

5. When you introduce yourself to the patient, please explain that everything will be kept confidential.”
Community Oriented Primary Care (COPC): Overview

Definition: Community oriented primary care (COPC) is a model in which a primary care practice or program systematically identifies and addresses the health problems of a defined population.\(^{(1)}\)

COPC is generally divided into five steps:
1. Involve the community
2. Define and characterize the community;
3. Identify community health problems and community assets;
4. Develop programs/interventions to address the identified health problems; and,
5. Monitor the impact of programs/interventions.

Rationale: Health depends on many factors beyond what goes on in the examining room. Individual lifestyle factors as well as economic, social, cultural, environmental and political factors influence the health of patients, families and communities. COPC combines the practice of primary care with public health in an effort to promote health, prevent illness, and provide accessible, comprehensive and coordinated preventive, curative, supportive and rehabilitative services.

COPC Practitioners:\(^{(2)}\)
- are interested not only in people who seek their care, but also in those in the community who are at-risk but may not seek care;
- use epidemiological and ethnographic data from both their practice and the identified community to define health needs of the community (community diagnosis);
- determine, with community members, the underlying economic, social, cultural, environmental and political causes of health problems and together address the causes;
- emphasize prevention and wellness so that people with risk factors can be prevented from getting ill;
- involve the patient, family and community in developing treatment plans and programs, recognizing the presence of consumer expertise in a community;
- build partnerships with other community organizations to practice comprehensive, community-based, coordinated health care which addresses the economic, political and cultural needs of the community; and,
- evaluate the effect of their practice on the community's health status.


Patient-Family-Community Assessment Form
Interview 4 patients using this form- put completed form in chart

Patient Name: ___________________________  Date: ___________________________

<table>
<thead>
<tr>
<th>Brief Patient Profile:</th>
<th>Age</th>
<th>Gender</th>
<th>Race/Ethnicity</th>
<th>Language</th>
<th>Need for Interpreter (Y/N)</th>
<th>Insurance (Y/N)</th>
<th>Race</th>
</tr>
</thead>
</table>

| Primary Clinical Issue Addressed: |

<table>
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<tr>
<th>Family Profile</th>
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<tr>
<td>Household Structure (who lives there and relationships, prepare genogram)</td>
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</table>

Language(s) spoken, understood/Literacy issues:

Financial Situation of Household:

Family Problems (e.g., domestic violence, alcohol or drug problem, marital discord, illness):

Family Supports (how does family help with clinical problem addressed):

<table>
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<tr>
<th>Cultural Profile</th>
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<tr>
<td>Diet (24 hour diet recall):</td>
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</table>

Religious Beliefs (and degree of importance in life):

“My health is controlled by” ME -----------------------------------------GOD

(USE ETH of ETHNIC) Patient’s explanation (E) of primary clinical issue addressed:

Use of alternative treatments(T) and healers(H):

<table>
<thead>
<tr>
<th>Community Profile</th>
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<tr>
<td>Workplace Issues (possible exposures, muscle strain, injury risk):</td>
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</table>

Neighborhood Description:

What does patient like about neighborhood?

What would patient like to change about neighborhood?

Accessibility to Healthcare (primary care, dental, vision)(consider transportation, language, availability of appointments, in
Accessibility of Other Services (grocery, pharmacy, medical supplies):

Additional in-depth questions:

1. Identify a problem that this patient faces that is common to other people in the community. Identify the Healthy People and/or Healthy NJ 2010 objectives and national and state data that relate to this problem by accessing the websites: [http://www.health.gov/healthypeople](http://www.health.gov/healthypeople), [http://www.state.nj.us/health/chs](http://www.state.nj.us/health/chs)
2. Does St. John’s address this problem on a community level? How?
3. What do other health centers or private physicians do to address this issue? Consider contacting other physicians to find out.
4. What other resources/services already exist in the community to address this issue? Contact or visit 2 or 3 of these resources to learn more about them.
5. What other health/social service professionals or “lay health/para-professional/other healers” besides physicians can be helpful with this issue?
6. What creative ideas do you have for addressing this issue on a community level? Consider performing a literature search. Consider using this issue as a starting point for your senior project.
Tips on Preparing for Work in the Community

General

• Find out as much as you can about your population from your site supervisor so you know what to expect. Be aware of your assumptions about a population/organization and be open to changing them!
• Find out from site supervisor, best ways to gain trust/rapport – it may take several weeks before people feel comfortable with you.
• Be open to learning from your population.
• Always call the day before or even day of, to confirm a meeting or presentation.
• Think about what you’d like to get out of the experience and pursue it!
• Make the organization aware of your skills and what you might contribute.
• Think broadly in terms of how this experience can help you in your future clinical practice even if it is not a clinical experience (e.g. gaining more understanding of a population-- they may be your future patients; presentation skills, how to talk with people in lay terms; how to evaluate written material for the layperson, etc.)
• Immerse yourself – take initiative

Doing community presentations

• Get a sense of your audience (knowledge level, attitudes, behaviors) in advance if possible or at least at the start, so you can tailor your workshop. Talk with your site supervisor about what you are planning to do - they usually know what will work with their population.
• Make presentations as interactive as possible: ask questions, use discussion, hands-on, visuals, props. People retain less than 10% of what they hear from lecture and learn most from hands-on experiential activities. Never lecture more than 20 minutes. With adult learners especially, be sure to create opportunities for them to share their experiences- they bring a wealth of expertise from their “life experience.”
• Don’t assume “games” are too amateurish, most people enjoy them, regardless of their age, if you approach it with a sense of humor and confidence
• Refreshments always help (must be appropriate for talk – e.g. no candy at a nutrition talk!)
• Recognize that some participants may not be at your workshop by choice and may not want to be there (don’t take it personally, stay positive)
• Provide opportunity for people to ask questions anonymously (e.g. have them write on index cards)
• Be flexible and prepared to change course – don’t feel you have to go by curriculum strictly if it’s not working for your group.
• Have alternate plans if audiovisual equipment is not there or malfunctioning. Don’t depend on it for your presentation.
• Assess understanding throughout. Do a quick evaluation at the end of a workshop to assess whether goals have been achieved, what group liked best and least and what they’ll remember most. at yourself on the back!
• Debrief with someone when you’re done and pat yourself on the back
### Community Medicine Rotation Calendar – Resident’s name, MD

**August 2002** (where dates are blank, residents have other commitments)

<table>
<thead>
<tr>
<th>Sunday</th>
<th>Monday</th>
<th>Tuesday</th>
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<td></td>
<td>29</td>
<td></td>
<td>1:00 Patients-St. John’s</td>
<td>9:00 Patients-St. John’s</td>
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<td>1:00 – 5:00 Patients - SJ</td>
<td>1:15 Homeless Shelter tour</td>
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<tr>
<td></td>
<td></td>
<td>9:00-12:00 Patients –St. John’s</td>
<td>1:00-5:00 Patients - SJ</td>
<td>9:00 Patients-St. John’s</td>
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<td>12:45 Board of Social Services site visit</td>
<td>All day</td>
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<td></td>
<td>9:00-12:00 Elijah’s Promise Soup Kitchen</td>
<td>1:00 Patients-SJ</td>
<td>9:00 – 12:00 Patients-SJ</td>
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<td>1:00 – 3:00 Accompany Outreach worker</td>
<td>1:00 Tour of Botanica and Bodega</td>
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<td>9:00 – 12:00 Patients-SJ</td>
<td>7:30 pm. Presentation on TB Homeless Shelter</td>
<td>9:00 Patients-SJ</td>
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<td>PM: Prep for presentation</td>
<td>Adult Substance Abuse Program site visit</td>
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</table>

Sites, contacts and phone numbers are listed here.

**Call sites day before to confirm visits/presentation.**
Learning about St. John’s Health Center

Review information in the Red Binder and current annual reports/grants and talk to Dr. Levin and health center staff to learn more about St. John’s Health Center. Below are the kinds of things you may want to find out. You do not need to write down what you learned, it is for your information only.

- Its mission
- Funding sources
- Demographics of patient population – does this reflect the demographics of the surrounding community?
- % patients uninsured/what type of insurance do patients have/fee structure for visits/medications
- Prevalent health problems
- Partnerships the health center has established with other agencies to better meet the needs of clients and to provide affordable care
- The Health Center’s COPC efforts to reduce barriers to accessing care
- What are the challenges and what are the rewards of working with an underserved population (discuss with Dr. Levin, Michelle (PA), nursing and other staff.)

Getting More Out of Your Field Visits

Preparing for your field visits:

The purpose of the field visits is to learn more about the resources available to your patients and, in the case of Elijah’s Promise, to provide a service at the same time. To get the most out of your field visits, be prepared with questions to ask of those you encounter during your visit (in the case of Elijah’s Promise you may want to speak with the other volunteers who may have been clients at one time). Following are the kinds of questions you may want to ask – some may be applicable, others not, feel free to add your own. (You do not need to write the answers to these questions)

- What services does your agency provide? How are you funded?
- How do clients access your services? Who is eligible to receive services? What are the barriers if any, to clients accessing your services?
- What are the demographics (age, sex, cultural/ethnic background, residence) and the predominate social, economic, health issues of the population you serve?
- How many clients do you generally help on average in a given month? Is this meeting the actual need in the community?
- How do you handle “undocumented immigrants” – can they utilize any of your services?
- What is expected of the clients who utilize your services (e.g. esp. in homeless shelter – what are the men who are provided a bed, required to do in return?)
• What kinds of staff are employed by your organization and what are their roles?

• What do you think is important for me as a clinician, who may be treating your clients, to know about your services or to “take away” from this meeting?

Site Information

If you are unable to attend a field visit please contact the site directly since they will be expecting you and then call or leave a message on Jan’s voice mail: 235-7574.

Middlesex County Board of Social Services
181 How Lane - P.O. Box 509
New Brunswick, NJ 08901
732-745-3790 fax 745-6634
Ask for: Jackie Jennings or if she is not available, Greg Lavine

Directions: From the Medical School, go south on Route 27 (headed toward North Brunswick). Make a left onto Howe Lane (same street where St. Peter’s pediatric health center is located). It’s a main intersection with a light – Veronica Plaza shopping center is on the right. After you make the left, the large gray building is almost immediately on the left. Turn into the driveway at the low blue sign that says Board of Social Services and the name of a corporation.

The Board of Social Services, formally called the “Welfare Office” is a “one-stop shopping” agency for social services and financial assistance for Middlesex County residents. You will be observing a “screening” with a client (an interview that determines their eligibility for services) and an “intake” (an interview with those who have been deemed eligible for services, where a case worker asks for detailed information and completes numerous forms.) The purpose of observing these encounters is to learn more about the resources and what a client must go through to obtain them. Please refrain from asking questions during the interviews since the caseworkers have a lot to do but feel free to speak with them afterwards or speak with Jackie Jennings who will be hosting your visit. You will also meet with Jana Vits, a public health nurse employed by the Middlesex County Health Department who is based at the BSS. Her role is to provide immunizations to any child in need.

Elijah’s Promise Soup Kitchen
Reverend Lisanne Finston, Director
Yvette Molina, Director of Social Services
Anthony MacLauchlan, Soup Kitchen Supervisor
18 Nielson St.
New Brunswick, NJ 08901
732-545-9373(Kitchen) 545-9002 (main #) ext. 16 for Anthony, 15 for Yvette, fax: 545-1996
**Directions:** Coming from St. John’s Health Center, make a left onto Commercial Avenue and the next left onto Neilson St. The soup kitchen is just beyond the parking lot to the group of stores (coming from St. John’s you can also cut through the parking lot and make a left). You will enter in the first entrance, down the stairs and go to the kitchen. Ask for Anthony MacLauchlan and tell him you are the community resident from St. John’s.

**Elijah’s Promise Soup Kitchen:** In addition to serving lunch and dinner 7 days a week the organization provides health services by contracting with a nurse from Robert Wood Johnson University Hospital who visits weekly to do health screenings. A third year medical student providing service as part of the family medicine clerkship assists the nurse. The Director of Social Services assists clients in finding housing and meeting other needs of daily living. The organization also sponsors a culinary arts training program for which St. John’s provides physicals to the participants. You will be assisting in the kitchen in preparation for lunch. Take the opportunity to learn more about the services by talking with Mr. MacLauchlan or the other volunteers.

**Ozanam Men’s Shelter**
20-22 Abeel St.
New Brunswick, NJ 08901
729-0850, e-mail: wmoore@ccdom.org
fax: 729-0784
Wesley Moore, Executive Director
Bruce Carey may conduct tour

**Directions:** This is the yellow building right next door to St. John’s – coming from Commercial Ave it is just before St. John’s on the left.

**Men’s Homeless Shelter:** You may be surprised that there are no men at the shelter when you take your tour. That’s because one of the conditions of getting a bed there is that the men look for a job during the day – they cannot be in the shelter. Take this opportunity to learn more about the services provided by the shelter and more about the types of clients who utilize them.

**Botanica/Bodega Tour**
With Mariam Merced, MA, Director, Department of Community Health Promotion, RWJUH
732-247-2050
Meet in front of the Rutgers Bookstore
Ferren Mall

**Directions:** On Route 27 right across from the train station, New Brunswick.

This tour is provided by Mariam Merced, Director of Community Health Promotion or her assistant, Rebecca Escobar. A Botanica is a store that sells herbs, incense, religious statues and other spiritual items to help with a variety ailments/problems. It is utilized primarily by the Latino community in New Brunswick. When you visit, try posing a health problem you are experiencing and ask for a remedy. A Bodega is a grocery store utilized by the Latino population in New Brunswick. You will look at the types of foods sold to get a better idea of the diet of this population.
Community Medicine Presentation

Review “Tips on Preparing for Work in the Community: Making Presentations”. Meet with community site representative and rotation advisors to discuss presentation.

Please complete this form. It will help you plan your presentation and help future residents.

<table>
<thead>
<tr>
<th>Your name: __________________________</th>
<th>Date of Presentation: ____________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organization you presented for: ____________________________________________________________________________</td>
<td></td>
</tr>
<tr>
<td>Type of Audience: ________________________________________________________________________________________</td>
<td></td>
</tr>
<tr>
<td>Title of Presentation/topic: ____________________________________________________________</td>
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</tbody>
</table>

Identify relevant Healthy People 2010 objectives on the website http://www.health.gov/healthypeople

Objectives of presentation: By the end of this presentation, participants will be able to: (Think in terms of knowledge, attitudes/beliefs and skills/behaviors)
1. _____________________________________________________________________
2. _____________________________________________________________________
3. _____________________________________________________________________

Description of teaching methods/format (e.g. how will you make it interactive?)
_______________________________________________________________________
_______________________________________________________________________
_______________________________________________________________________

References Used: ____________________________________________________________
________________________________________________________________________
________________________________________________________________________

Attach any handouts you distributed.

Please reflect briefly on what you gained/learned by presenting to this group: ________
________________________________________________________________________
________________________________________________________________________

What would be helpful for a future presenter to this group to know? ________________
________________________________________________________________________
Reflection Questions

Be prepared to discuss questions with Jan or Dr. Levin when you meet midway and at the end of the rotation.

What insights did you gain about cultural differences and similarities by completing the Family Health Beliefs and Behaviors Assessment on yourself and the person you interviewed?

How, if at all, did the use of ETHNIC enhance your rapport with patients and impact your treatment plan? – give an example.

What insights did you gain about the condition of homelessness as a result of talking with a patient or your visit to the Soup Kitchen and Homeless Shelter?

What insights did you gain by doing the Patient-Family-Community Assessment?

How can you envision applying the principles of COPC to your clinical practice? How might you utilize Healthy People 2010?

For each field visit think about:

- What were your main impressions of the organization/site? How were they similar or different from what you expected?
- What assumptions did you make about the population served by this organization/site? Did your views change as a result of the visit?
- How will you be able to apply what you learned from your visit in your clinical practice?

What did you gain/learn by doing your community presentation? What are you most proud of? What would you improve or do differently in the future?

What insights did you gain about an interdisciplinary collaborative practice model employing a physician and physician assistant?

Review the rotation objectives and demonstrate verbally, how you have achieved them.

What are the challenges and what are the rewards of working with an underserved population?
Final Evaluation of Cross Cultural Community Medicine Rotation

Please rate the following components of your Cross Cultural Community Medicine Rotation experience by circling the number that corresponds to your response. Your comments and suggestions will assist us in continually improving the rotation. If you did not participate in a particular activity please circle “N/A” (not apply).

<table>
<thead>
<tr>
<th>How valuable were the following:</th>
<th>Not valuable</th>
<th>Very Valuable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Completing Family Health Beliefs Surveys</td>
<td>1 2 3 4 N/A</td>
<td></td>
</tr>
<tr>
<td>Utilizing ETHNIC in patient interviews</td>
<td>1 2 3 4 N/A</td>
<td></td>
</tr>
<tr>
<td>Interviewing a homeless patient</td>
<td>1 2 3 4 N/A</td>
<td></td>
</tr>
<tr>
<td>Completing Patient-Family-Community Assessment</td>
<td>1 2 3 4 N/A</td>
<td></td>
</tr>
<tr>
<td>Doing a community presentation</td>
<td>1 2 3 4 N/A</td>
<td></td>
</tr>
<tr>
<td>Participating in HIPHOP Clinic</td>
<td>1 2 3 4 N/A</td>
<td></td>
</tr>
<tr>
<td>Bilingual Interview Workshop</td>
<td>1 2 3 4 N/A</td>
<td></td>
</tr>
<tr>
<td>Readings in Red Folder and Red Binder</td>
<td>1 2 3 4 N/A</td>
<td></td>
</tr>
<tr>
<td>Reflection questions</td>
<td>1 2 3 4 N/A</td>
<td></td>
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Comments: ________________________________________________

Please rate the following Community Site Visits

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<thead>
<tr>
<th>Board of Social Services</th>
<th>Not at All</th>
<th>Very</th>
<th>N/A</th>
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</thead>
<tbody>
<tr>
<td>How informative?</td>
<td>1 2 3 4</td>
<td></td>
<td></td>
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<tr>
<td>How interesting?</td>
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<tr>
<td>How helpful/relevant?</td>
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<tr>
<td>Worthwhile keeping activity?</td>
<td>1 2 3 4</td>
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Comments: ________________________________________________

<table>
<thead>
<tr>
<th>Tour of Men’s Homeless Shelter</th>
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<td>How interesting?</td>
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<td>How helpful/relevant?</td>
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<td>Worthwhile keeping activity?</td>
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Comments: ________________________________________________

<table>
<thead>
<tr>
<th>Tour of Botanica-Bodega</th>
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<th>Very</th>
<th>N/A</th>
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<tbody>
<tr>
<td>How informative?</td>
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<td>How helpful/relevant?</td>
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<tr>
<td>Worthwhile keeping activity?</td>
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Comments: ________________________________________________

Elijah’s Promise Soup Kitchen Experience

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<th>3</th>
<th>Very</th>
<th>N/A</th>
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</thead>
<tbody>
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<td>How informative?</td>
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<td>How interesting?</td>
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<td>Worthwhile keeping activity?</td>
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Comments:__________________________________________________________________

Accompanying Outreach Worker

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<th>3</th>
<th>Very</th>
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<tbody>
<tr>
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<td>How interesting?</td>
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<tr>
<td>Worthwhile keeping activity?</td>
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</table>

Comments:__________________________________________________________________

Do you have other suggestions for field visits? ______________________________________

How satisfied were you with

The direction you received from rotation co-supervisors 1  2  3  4
The community component of rotation 1  2  3  4
Your clinical experience 1  2  3  4
Your rotation experience overall 1  2  3  4

Comments:___________________________________________________________________

Prior to this rotation, did you have any:

experience with “underserved” populations? ___ No ___ Yes
community service experience? ___ No ___ Yes

How has this rotation influenced your interest in working with underserved populations/providing community service in the future (either paid or volunteer)?

a. ___ Less interested now
b. ___ Was never interested- still not
c. ___ Was always interested-this had little effect
d. ___ More interested now

What did you like most about the rotation? ______________________________________

What did you like least about the rotation _______________________________________

What recommendations do you have for improving the rotation?______________________

_____________________________________________________________________________

Thank you!

Useful Websites

Healthy People 2010 objectives
http://www.health.gov/healthypeople: On top of page (beneath Healthy People 2010 title, click “search”, and then “objectives”. At homepage, click “Healthfinder” for education resources/websites on your topic of interest.

NJ Dept. of Health
http://www.state.nj.us/health/chs: click icon Healthy NJ 2010, click volume 1 and volume 2)

UMDNJ website for information and links specific to health in NJ
http://www.healthynj.org

US Census information
http://www.census.gov

Centers for Disease Control and Prevention
http://www.cdc.gov/

Initiative to Eliminate Racial and Ethnic Disparities in Health, US Dept. of Health and Human Services
http://raceandhealth.hhs.gov

EthnoMed
http://www.ethnomed.org

Resources for Cross Cultural Health Care
http://www.diversityrx.org

Center for Healthy Families and Cultural Diversity
http://www2.umdnj.edu/fmedweb/chfcd/INDEX.HTM

Association of Clinicians for the Underserved
http://www.clinicians.org

County level statistics on health from HRSA
http://www.communityhealth.hrsa.gov/

National Center for Health Statistics
http://www.cdc.gov/nchs/default.htm


NJ Medicaid and Family Care site:
http://www.state.nj.us/humanservices/DMAHS/dhsfc1.html

Forum on Child and Family Statistics
http://childstats.gov/
What Is Healthy People 2010?

Healthy People 2010 is a comprehensive set of disease prevention and health promotion objectives for the Nation to achieve over the first decade of the new century. Created by scientists both inside and outside of Government, it identifies a wide range of public health priorities and specific, measurable objectives.

Overarching Goals:  
1. Increase quality and years of healthy life  
2. Eliminate health disparities

Focus Areas

<table>
<thead>
<tr>
<th>1. Access to Quality Health Services</th>
<th>15. Injury and Violence Prevention</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Chronic Kidney Disease</td>
<td>18. Mental Health and Mental Disorders</td>
</tr>
<tr>
<td>7. Educational and Community-Based Programs</td>
<td>21. Oral Health</td>
</tr>
<tr>
<td>8. Environmental Health</td>
<td>22. Physical Activity and Fitness</td>
</tr>
<tr>
<td>10. Food Safety</td>
<td>24. Respiratory Diseases</td>
</tr>
<tr>
<td>11. Health Communication</td>
<td>25. Sexually Transmitted Diseases</td>
</tr>
<tr>
<td>12. Heart Disease and Stroke</td>
<td>26. Substance Abuse</td>
</tr>
<tr>
<td>13. HIV</td>
<td>27. Tobacco Use</td>
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</tbody>
</table>
**What Are the Leading Health Indicators (LHIs)?**

The Leading Health Indicators are 10 major health issues for the nation.

The LHIs are:

<table>
<thead>
<tr>
<th>1. Physical Activity</th>
<th>6. Mental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Overweight and Obesity</td>
<td>7. Injury and Violence</td>
</tr>
<tr>
<td>3. Tobacco Use</td>
<td>8. Environmental Quality</td>
</tr>
<tr>
<td>4. Substance Abuse</td>
<td>9. Substance Abuse</td>
</tr>
<tr>
<td>5. Responsible Sexual Behavior</td>
<td>10. Access to Health Care</td>
</tr>
</tbody>
</table>

Healthy People 2010  
http://www.healthypeople.gov  
Healthy People Information line: 1 (800) 367-4725  
healthfinder®  
http://www.healthfinder.gov  
Office of Disease Prevention and Health Promotion  
http://odphp.osophs.dhhs.gov  
last updated 11/02
Healthy People 2010, a broad-based collaborative effort among Federal, State, and Territorial governments, as well as hundreds of private, public, and nonprofit organizations, has set national disease prevention and health promotion objectives to be achieved by the end of this decade (www.healthypeople.gov). The effort has two overarching goals: to increase the quality and years of healthy life and to eliminate health disparities. Healthy People 2010 features 467 science-based objectives and 10 Leading Health Indicators, which use a smaller set of issues and objectives to track progress toward meeting Healthy People 2010 goals. More information on the Leading Health Indicators, including links to Federal Web sites with data, planning tools, scientific information, and details about various programs are available at http://www.healthypeople.gov/lhi.

Listed in this handout are the 10 Leading Health Indicators, with corresponding sample resources available from the Federal government. The Federal consumer health information Web site, www.healthfinder.gov, is also a good starting point for more information on these topics.

PHYSICAL ACTIVITY

President’s Council on Physical Fitness and Sports
202-690-9000
http://www.fitness.gov

Centers for Disease Control and Prevention (CDC)
888-232-3228
http://www.cdc.gov/nccdphp/dnpa

OVERWEIGHT AND OBESITY

Obesity Education Initiative, National Heart, Lung, and Blood Institute Information Center
301-592-8573
http://www.nhlbi.nih.gov/about/oei/index.htm

The Weight-Control Information Network
National Institutes of Health (NIH)
877-946-4627
TOBACCO USE
Office on Smoking and Health, National Center for Chronic Disease Prevention and Health Promotion, CDC
800-CDC-1311
http://www.cdc.gov/tobacco
Cancer Information Service, NIH
800-4-CANCER
http://cis.nci.nih.gov

SUBSTANCE ABUSE
National Clearinghouse for Alcohol and Drug Information Substance Abuse and Mental Health Services Administration (SAMHSA)
800-729-6686; 800-487-4889 (TDD)
http://www.health.org
National Institute on Drug Abuse, NIH
301-443-1124
http://www.nida.nih.gov
National Institute on Alcohol Abuse and Alcoholism, NIH
301-443-3860
http://www.niaaa.nih.gov

RESPONSIBLE SEXUAL BEHAVIOR
CDC National AIDS Hotline
800-342-AIDS (800-342-2437)
http://www.cdc.gov/hiv/hivinfo/nah.htm
CDC National Sexually Transmitted Diseases (STD) Hotline
800-227-8922
http://www.cdc.gov/nchstp/dstd/dstdp.html
CDC National Prevention Information Network
800-458-5231
http://www.cdcnpin.org
Office of Population Affairs
301-654-6190
http://opa.osphs.dhhs.gov
MENTAL HEALTH

Center for Mental Health Services, SAMHSA
http://www.mentalhealth.org/cmhs/index.htm

National Mental Health Information Center, SAMHSA
800-789-2647
http://www.mentalhealth.org

National Institute of Mental Health Information Line, NIH
800-421-4211
http://www.nimh.nih.gov/publicat/depressionmenu.cfm

INJURY AND VIOLENCE

National Center for Injury Prevention and Control, CDC
770-488-1506
http://www.cdc.gov/ncipc/ncipchm.htm

Office of Justice Programs, U.S. Department of Justice
202-307-0703
http://www.ojp.usdoj.gov/home.htm

National Highway Traffic Safety Administration
U.S. Department of Transportation
Auto Safety Hotline 888-DASH-2-DOT (888-327-4236)
http://www.nhtsa.dot.gov/hotline

ENVIRONMENTAL QUALITY

Indoor Air Quality Information Clearinghouse
U.S. Environmental Protection Agency
800-438-4318 (IAQ hotline)
800-SALUD-12; (725-8312) Spanish
http://www.epa.gov/iaq/iaqinfo.html

Information Resources Center (IRC)
U.S. Environmental Protection Agency
202-260-5922
http://www.epa.gov/natlibra/hqirc/about.htm

Agency for Toxic Substances and Disease Registry, CDC
888-442-8737
http://www.atsdr.cdc.gov
IMMUNIZATION

National Immunization Program/CDC
800-232-2522 (English); 800-232-0233 (Spanish)
888-CDC-FAXX (Fax-back)
http://www.cdc.gov/nip

ACCESS TO HEALTH CARE

Agency for Healthcare Research and Quality
Office of Healthcare Information
301-594-1364
http://www.ahrq.gov/consumer/index.html#plans

“Insure Kids Now” Initiative
Health Resources and Services Administration
877-KIDS NOW (877-543-7669)
http://www.insurekidsnow.gov

Maternal and Child Health Bureau
Health Resources and Services Administration
1-888-ASK-HRSA (HRSA Information Center)
http://www.mchb.hrsa.gov

Office of Beneficiary Relations
Centers for Medicare & Medicaid Services
800-444-4606 (customer service center)
800-MED-ICARE (Info Line)
http://www.Medicare.gov

For more health promotion and disease prevention information—
Search online for thousands of free Federal health documents using healthfinder® at

For health promotion and disease prevention information in Spanish—
Visit http://www.healthfinder.gov/espanol/.

For print resources—
Write to the ODPHP Communication Support Center (OCSC), P.O. Box 37366,
Washington, DC 20013-7366, for
- Federal Health Information Centers and Clearinghouses
- Toll-Free Numbers for Health Information
- Resources for Action in Spanish.

For more information about Healthy People 2010, visit http://www.healthypeople.gov
or call 800-367-4725.
Racial and Ethnic Disparities in Health

Despite great improvements in the overall health of the nation, Americans who are members of racial and ethnic minority groups, including African Americans, Alaska Natives, American Indians, Asian Americans, Hispanic Americans, and Pacific Islanders, are more likely than whites to have poor health and to die prematurely, as the following examples illustrate:

- **Breast and cervical cancer**: Although death rates from breast cancer declined significantly during 1992–1998, they remain higher among black women than among white women. In addition, women of racial and ethnic minorities are less likely than white women to receive Pap tests, which can prevent invasive cervical cancer by detecting precancerous changes in the cervix.

- **Cardiovascular disease**: In 1999, rates of death from diseases of the heart were 29% higher among African Americans than among whites, and death rates from stroke were 40% higher.

- **Diabetes**: Compared with whites, American Indians and Alaska Natives are 2.6 times, African Americans are 2.0 times, and Hispanics are 1.9 times more likely to have diagnosed diabetes.

![Prevalence of Cardiovascular Disease, by Race/Ethnicity](image)


- **HIV/AIDS**: Although African Americans and Hispanics represent only 25% of the U.S. population, they account for roughly 56% of adult AIDS cases, 73% of new HIV infections among U.S. adults, and 82% of pediatric AIDS cases.

- **Immunizations**: In the 1998–2000 National Immunization Survey, 11 major urban areas reported racial/ethnic disparities of greater than 10% for at least one age-appropriate childhood immunization. Additionally, in 2001, Hispanics and African Americans aged 65 or older were less likely than whites to have received influenza and pneumococcal vaccines.
• **Infant mortality**: Although the 2000 U.S. infant mortality rate of 6.9 infant deaths per 1,000 live births was the lowest ever recorded, African American, American Indian, and Puerto Rican infants continue to have higher mortality rates than white infants. In 2000, the black-to-white ratio in infant mortality was 2.5.

**U.S. Infant Mortality Rates, by Race/Ethnicity of Mother, 1998**

![Graph showing U.S. Infant Mortality Rates, by Race/Ethnicity of Mother, 1998](image)

Source: National Center for Health Statistics, CDC

Because racial and ethnic minority groups are expected to comprise an increasingly larger proportion of the U.S. population in coming years, the number of people affected by disparities in health care will only increase without a concerted effort to eliminate these disparities. Culturally appropriate, community-driven programs are critical for eliminating racial and ethnic disparities in health. To be successful, these programs need to be based on sound prevention research and supported by new and innovative partnerships among federal, state, local, and tribal governments and communities.

Centers for Disease Control and Prevention  
National Center for Chronic Disease Prevention  
and Health Promotion  
Mail Stop K-45  
4770 Buford Highway, NE  
Atlanta, GA 30341-3717  
(770) 488-5269  

cdinfo@cdc.gov  
http://www.cdc.gov/reach2010
References

COPC


Video: Community Oriented Primary Care, by Marc E. Babitz, M.D. and the National Health Service Corps. To order this video, contact (1) your NHSC regional office or, JSI Research and Training Institute, Video Library, 1738 Wynkoop St., Suite 201, Denver, CO 80202-1116; phone (303) 293-2405; fax (303) 293-2813; email: denver@jsi.com for rental, $10.

Cultural Competency


*Diaz-Duque, O. Overcoming the Language Barrier: Advice from an Interpreter, American Journal of Nursing, September, 1982, pp. 1380-82.


*Provided to students.