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yale health care

NEWS FROM THE YALE HEALTH PLAN

VOL. VIII NO. 3

MAY-JUNE 2005



This issue of *yale health care* explores just a few of the many intersections between cultural diversity and the delivery of health care. All of us belong to any number of groups—related to our national origins and ethnicities, our genders, our ages, our religions and an array of other factors. For any given individual, some of those factors may have a significant impact on health status and health care needs. The increasing attention to how these factors affect us—as well as a firm commitment to our common humanity—are essential elements in the delivery of the best care. As always, we welcome your feedback.

—Rhea Hirshman, editor

Sense of “Different-ness” Presents Challenges And Opportunities

Ethnic minority college-aged students may need to reassess the meaning of being part of a group and reexamine how belonging to that group shapes beliefs, world views, and values. Students of color are more likely than not to be the first generation of college students from their families. They may arrive with what they believe are clear ideas about the meaning of occupying any number of identity niches—ideas cultivated by families and communities of origin. Being thrust into a state of “absolute numerical minority-ness” leads to an intensification of focus on perceived differences.

The significance of perceived difference usually depends on social context. If you are the only woman in a room full of men, or vice-versa, you will become more acutely aware of your gender. Being an absolute minority, especially a visible one, enhances a sense of “different-ness.” Regardless of background, the cognitive and emotional dimensions of feeling “different” can pose major challenges.

Leaving familiar surroundings and moving into a state of absolute “minority-ness” may prompt ethnic students to evaluate the meanings and influences of their own ethnicities.

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I Say Tortilla, You Say Chapati

Around the world, food is nourishment, celebration, identity and ritual. The foods we eat, how we prepare them and how we consume them vary depending on geography, income, cultural mores, ethnic background, health status, and religious beliefs—as well as on personal preference. Consideration of cultural factors is essential in helping people make sound nutritional choices related to their health needs.

In dealing with the need to avoid certain foods, for instance, dietary modifications that might be difficult for a person with one cultural eating style are less problematic for those whose diet already contains little of the food that should be avoided.

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SENSE OF DIFFERENT-NESS

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A student may determine that ethnicity has either greater or less salience in everyday life than previously thought. Some may find that having ethnicity highlighted is a catalyst for social activism; they may search for more accurate depictions of their culture or even decide to explore new academic directions.

Students may discover that they have to rework their own race-based ideologies and preconceptions about other groups, especially majority groups, because their new circumstances offer more intimate knowledge of and interaction with them.

...the cognitive and emotional dimensions of feeling “different” can pose major challenges.

Being in the spotlight can present opportunities to shine. However, while the idea of being scrutinized can be a motivation for some to do well, it can be a burden for others. Because some ethnic individuals in predominantly white environments may feel overwhelming responsibility to be “model” persons, they may feel their behaviors restricted by concern that errors could be used to indict their entire race/ethnic group. Some also struggle with whether they are “authentic” (are you Asian, or Black, or Latino enough?).

Of course, this idea of authenticity is based upon the flawed notion that all members of a group have the same beliefs, behaviors and value systems. Still, young people are vulnerable to these questions because they are in the process of self-definition and because they desperately want to fit in.

The sense of “different-ness” may emerge also in relation to parents, siblings and old friends. As minority students—of whatever background—refine critical thinking skills, live and socialize and exchange ideas with diverse groups, and try on new self-definitions, they may find themselves drifting away from the family of origin, creating a sense of alienation and of loss. As one student told his family about his excitement about his paper for a religious studies class, he realized that his parents had little idea of what he was explaining.

He felt deflated and saddened by a sense that he was eclipsing the limits of his parents’ understanding and moving towards having less in common with them. Some students may feel guilty about acquiring status not available to families or peers from home. In extreme cases, inner conflicts may become so intense that students may undermine themselves and fail in an effort to return home.

Ethnic minority students and others in majority settings must also determine how far to pursue perceived ethnic slights and insults, or how to respond to excessive interest in their “backgrounds” or their opinions about “racial matters.” Does one try to educate others about one’s culture and viewpoints? How does one establish oneself as an individual and not a representative of an entire, diverse group? Does one respond aggressively to perceived slights or let them slide? How much should one view events through a racial lens?

Chet Pierce, an esteemed, Harvard-trained, African-American psychiatrist, has noted that every African-American has to make countless decisions daily about whether to challenge how another person responds to them. He calls these situations “ultimate dilemmas.”

Because African-Americans have been sensitized to racially-based disrespect and hostility, they have to assess whether such incidents are racialized or not. Doing so requires a capacity to step back. Did that person’s actions have anything to do with ethnicity or race? Could the person have just been having a bad day or be irritable from a recent experience? Is this person just always rude? And if one concludes that something was racially motivated, how should one respond? Such analyses must be made in seconds in order to free oneself to manage the other tasks of daily living. Learning to do so takes time and must be done; otherwise one could spend every waking hour angry or brooding.

Some ethnic students may have had experience dealing with such matters before coming to a predominantly white institution; others may just be learning how to respond.

in touch

IMPORTANT TELEPHONE NUMBERS

Urgent Care	203-432-0123
<i>Open 24 hrs/day, seven days per week</i>	
Toll free out of area	1-877-YHP-CARE
General information	203-432-0246
Pharmacy	203-432-0033
<i>Hours of operation</i>	
Monday, Tuesday,	
Wednesday, Friday	8:00 AM–6:30 PM
Thursday	8:30 AM–6:30 PM
Saturday	8:30 AM–3:30 PM
Patient Representative	203-432-0109
Medicare/Retiree Coordinator	203-432-8134
Outpatient referrals	203-432-7397
Claims	203-432-0250
Inpatient Care Facility	203-432-0001

If a Black student is asked for ID when white classmates are walking unimpeded through, he has to deal with an additional emotional burden. If he is stopped repeatedly by the police while driving, he has to temper his response. There is a danger that if he objects the situation will escalate. Ultimately, each person has to figure out how to decide which situations are worth challenging.

While I have referenced primarily African-Americans, variations on the ultimate dilemma apply also to other identity niches (GLBT individuals, ethnic students of all stripes, people with disabilities, economically disadvantaged white students, and so on). And while I have focused on college students, many of these challenges continue—although perhaps in different forms—for members of minority groups at different developmental stages and in a range of settings.

Howard C. Blue, MD
Department of Mental Hygiene



from the desk of

PAUL GENECCIN, MD

DIRECTOR, YALE UNIVERSITY HEALTH SERVICES

As a physician, I rely on my patients to help me to become more culturally competent.

There are many ways to think of “diversity” in a clinical setting and we carefully considered how to take on this challenging topic in Yale health care. I recognize that we cannot do justice to an issue that has been the subject of a lengthy tome from the Institute of Medicine entitled *Unequal Treatment: Confronting Racial and Ethnic Disparities in Healthcare* (2002), and numerous books and articles. The failure of health care organizations to address challenges posed by diverse populations has fueled a crisis of medical quality in America. Confronting this issue at Yale Health Plan is central to our mission to deliver high quality care and service to the Yale community.

Inequities in clinical quality and access plague American health care, with abundant examples of diagnosis and treatment disparities based on socioeconomic class, race and ethnicity, gender, sexual preference and many other factors. Members of racial and ethnic minority groups—even when insurance coverage and income are similar—are less likely than whites to receive the most advanced and/or appropriate treatments. Examples include well-documented disadvantages for African-Americans in cardiovascular care, kidney disease care and many other interventions. Latino and Asian Americans are likewise disadvantaged in studies examining referrals for tests such as mammography and Pap smears and even treatment for cancer pain.

Stereotypes are part of the problem. Consciously or not, we tend to categorize people and sometimes mistakenly ascribe to individuals the attributes

thought to be common to a group. The fact that a person is an undergraduate, an emeritus professor or a police detective should not lead us to erroneous assumptions. Likewise, the fact that the student is Asian, the professor is Russian and the police detective is Latina should not result in assumptions about health histories, attitudes, risk factors or likelihood of medical compliance. The same applies to groups that we do not ordinarily think of as minorities, such as women, children or midlife Caucasian men.

At the same time that we acknowledge the limitations of stereotypes, we must also distinguish stereotype from bias. Stereotypes can sometimes be helpful because certain generalizations have clinical validity. For example: the concerns, interests and health behaviors of college students do tend to differ from those of retirees. A Muslim woman in a burka is likely to have different attitudes about physical examination by a male clinician than does an American male. African-Americans do have a greater incidence of cardiovascular complications arising from hypertension. Although the gene for Tay-Sachs Disease is occasionally found in non-Jews, the chance of being a Tay-Sachs carrier is much higher among those of Eastern European Ashkenazi Jewish heritage.

Generalizations can be useful, provided that we do not assume that individual people automatically have “representative characteristics” of their groups. Bias is quite different from such relevant considerations. I think of bias as a negative attitude towards a person or group based on perceived attributes.

There is no place in medicine or in life for attitudes reflecting bias.

While clinicians are part of the culture in which they function, I am confident that the overwhelming majority of health care workers try to avoid judging their patients and struggle against biased attitudes. The Yale culture embraces and deliberately recruits for diversity. At YHP, we carefully monitor data on quality and utilization; those data show that we evaluate, treat and refer without reference to race, ethnicity, socioeconomic status or other population characteristics. At the same time, we must recognize the challenges posed by the diverse population we serve.



Some issues are mundane. For example, we must have access to translators. While many of our members from foreign countries are fluent in English, they may not know medical terms for explaining symptoms. Much more challenging are patients whose cultural beliefs about health care—deriving from systems radically different from Western models—make effective communication extremely difficult.

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New in Town?

Translation Service Smooths Health Care Access

Imagine yourself in a foreign country, just beginning to learn to speak the language. One day you wake up feeling a little under the weather. Uh oh. How do you say “under the weather” in your host country? For that matter, how do you say, “I have an ache behind my eyes, my ears are stuffed up and my stomach doesn’t feel so great either”?

Such situations are bound to occur at a place like Yale. With its population of students, faculty and staff from six continents, the Yale University community is an international one. And even for persons fluent in English as their second (or third or fourth!) language, explaining to a health care provider the details of how and where it hurts can feel daunting.

To address this situation and provide the best possible care, Yale University Health Services (YUHS) has partnered with CyraCom International to provide interpretation services, which can be delivered over-the-phone in 150 languages within moments of the call’s being placed, 24 hours a day, 365 days a year. When a translation between English and another language(s) is needed, YHP staff can quickly access the service through dual-handset telephones which put the caregiver, patient and interpreter on the line at the same time.

The portable dual-handset telephones are located in various departments throughout 17 Hillhouse Avenue and at YHP administrative departments at 55 Whitney Avenue. To protect privacy these sets are located away from public areas.

In addition to being able to use the service during a particular appointment, patients who would like to be able to use the translation service on an ongoing basis can obtain a card from Member Services. This card can be presented at the time of a visit to let staff know that the patient wishes to use the service.

Since its inception at YUHS in April of 2004, the translation service has helped facilitate clinical encounters for speakers of Chinese (several dialects), French, Hebrew, Hindi, Korean, Russian, Slovak, Spanish and Turkish. Requests for translation have come through Internal Medicine, Urgent Care, Ob/Gyn, Student Medicine, Surgical Specialties and Dermatology.

Rhea Hirshman, editor

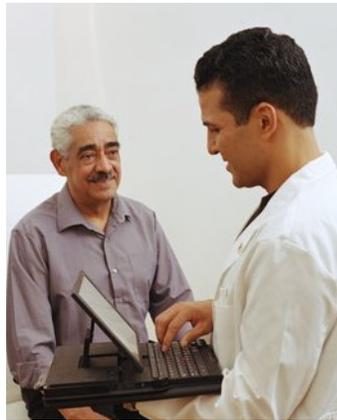
Bonjour...Hallo...Hola...Hello

FROM THE DESK OF
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Perceptions of pain and how to communicate about it, beliefs about stigma associated with psychological and sexual concerns, overvaluation of stoicism and distrust of health care providers—these are just some examples we face every day.

The first step is to ensure that our clinicians get as much information as possible about cultural diversity. But because the very nature of “diversity” is that it involves so many variables, we cannot put all of our faith in educational programs for clinicians. We must also educate our members about our own limitations. While derivation of the word “doctor” is “teacher,” the patient can and should become the teacher in a clinical scenario where a health care provider may not adequately understand a patient’s situation.

There is a great deal more to say about this topic, but I will finish with these three points.



First: we must monitor our delivery of health care to ensure that problems arising from unconscious bias or cultural ignorance do not result in substandard care or poor clinical outcomes. Second: each patient, regardless of “category,” is an individual and must be treated as such. And finally, I reiterate that we depend on our members to give us constructive feedback about ways to become better informed and to eradicate the insidious effects of unconscious bias in health care encounters.

Gender differences also affect health and medical care. For more on this topic, see our May/June 2002 issue, which was devoted to gender and health. More extensive information on this issue is available in the 2001 Institute of Medicine report—*Exploring the Biological Contribution to Human Health: Does Sex Matter?*

Women have enhanced immune systems compared to men. This makes them more resistant to many types of infection, but also increases the risk of autoimmune diseases such as lupus, multiple sclerosis and rheumatoid arthritis.

Cardiovascular disease kills 500,000 American women each year—over 50,000 more women than men—and strikes women, on average, 10 years later than men. Women are more likely than men to have a second heart attack within a year of the first one.

The life expectancy of African-American males is eight years less than for white males. The life expectancy of African-American females is five years less than for white females.

While overall infant mortality in the U.S. has declined, African-American and Native-American babies still die at a rate two to three times higher than the rate for white babies.

According to The American Medical Students’ Association (AMSA), generalist physicians in the near future can expect 40% of their patient populations to come from minority cultures.

I SAY TORTILLA

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Someone whose health would benefit from a gluten free diet (eliminating wheat, rye, oats and barley) would need to make less radical dietary changes if they were already used to eating a traditional rice-based Asian cuisine. On the other hand, someone accustomed to a wheat-based diet with lots of the pastas, breads, and cereals that are consumed liberally in the US and much of Europe, would have to make much more dramatic shifts in daily food consumption.

Another example is dairy foods. Many cultures use little or no dairy and the products made from it. However, in the US, a diagnosis of lactose intolerance or an allergy to dairy products, which would require cutting back or eliminating such American staples as cow's milk, cheese and ice cream, is often seen at least as an inconvenience and sometimes even as a hardship. Even though there is wide availability of lactose reduced or lactose free dairy foods—including those made from soy milk, rice milk and nut milks—dairy products are “staples” of many people's diets in the US.

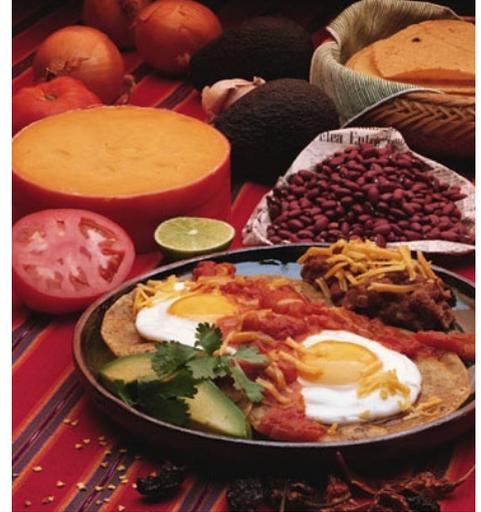
To help people make medically needed dietary modifications, health practitioners need a clear understanding of which foods are the major components of an individual's diet. For example, if dietary modifications of carbohydrate foods are needed, the portions of starchy foods and sweets may need to be changed. Because the types of carbohydrate foods most often eaten vary among different cultures, we need to be clear about which foods fall into the problematic category for a given individual. Examples of starchy foods eaten in various cultures: American: muffins, potatoes, sliced bread, tortillas, ready to eat and cooked cereal, crackers. Chinese: rice, cellophane or mung bean noodles, taro root. Indian: idli, rice, naan, chapati. Italian: pasta, polenta, rice, Italian bread. Mexican: bolillo, corn, tortilla, taco shell, pan dulce.

To help promote culturally sensitive nutrition counseling, the American Dietetic Association provides lists showing appropriate portions of foods and food practices for several cultural groups, such as Chinese, Creole, Filipino, Hmong (from Laos), Indian, Mexican, Pakistani, native Americans

(including the practices of several different tribes), and others. These lists assist in conversations about typical eating style and what modifications may be beneficial for health goals.

Culturally appropriate food lists are one resource available when people receive nutrition counseling at Yale Health Plan. Plastic food models facilitate communication by helping people with minor language barriers show what types of foods they eat most frequently. Our translation service is available for those with a more significant language barrier (see accompanying article). Food choices and food habits are highly personalized, even as they typically reflect cultural norms and practices. Talking with your clinicians about your food choices and eating habits can be an important part of health care.

Linda Bell, MS, RD, CD/N
YHP nutritionist



THINKING OUTSIDE THE PYRAMID

In the US, we use a pyramid to illustrate the national food guidelines. The Philippines also uses a pyramid. But check out the shapes used by some other countries:

- Canada: a rainbow
- Great Britain and Mexico: a plate or dish
- Portugal, Sweden, Germany: a circle
- Korea and China: a pagoda

Reference: Comparison of international food guide pictorial representations, by James Painter, Jee-Hyun Rah, and Yeon-Kyung Lee. JADA, Vol 102:4, p. 483-489, 2002.

healthy ideas



Move that brain

The brain needs exercise just as the body does, especially as we age. Compared to people who preferred activities such as gardening or household tasks, at least one study has shown that people who regularly engaged in cognitively complex leisure time pursuits stayed sharper as they aged. Engage in activities such as attending cultural events, taking classes, or playing games that involve strategy and memory (such as chess, word games and certain card games).

Watching weight? Don't skip sleep

Recent research shows that blood levels of leptin, a hormone that acts as an appetite regulator, appear to decrease during sleep deprivation. Most adults need at least six to eight hours of sleep per night; regularly getting less sleep could depress leptin levels and lead to overeating and weight gain.

SUMMER HOURS

Pharmacy From Wednesday, May 18 through Friday, July 8, the Pharmacy will close at 6:30 on Tuesdays and Wednesdays. Then from Monday, July 11 through Friday, August 19, the Pharmacy hours will be 8:30-6:00 on weekdays. Saturday hours will remain the same: 8:30-3:30.

Primary care departments (Internal Medicine, Pediatrics, and Ob/Gyn) will have their last extended evening hours on Wednesday May 18. Student Medicine will have its last evening hours on Thursday, May 19. Extended hours will resume right after Labor Day.

Linguistic and cultural minority populations constituted 26.4% of the U.S. population in 1995. By 2010, minority populations will constitute 32% of the U.S. population. By 2050, nearly half of the U.S. population will be composed of members of ethnic and racial minorities.

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What's In A Name? With Drugs, More Than You May Think

While consumers are accustomed to fixed brand names for products ranging from soft drinks (Coca Cola is Coca Cola wherever you go) to electronics (think of all the Japanese brands sold here in the U.S.), the same assumption cannot be made about pharmaceuticals. Some examples:

- Dilacor XR (diltiazem), a calcium channel blocker used in the U.S. to treat hypertension is a brand name in Serbia for digoxin, which is used to treat congestive heart failure.
- Dilacor XR (diltiazem) is a brand name in Brazil for verapamil, used to treat angina, arrhythmia and hypertension.
- Dilacor XR (diltiazem) is a brand name in Argentina for barnidipine, a once-daily calcium channel blocker not available in the U.S.
- Cartia XT (diltiazem) is a brand name for diltiazem with aspirin in Israel, Australia, New Zealand and Hong Kong.
- Norpramin (desipramine) is an anti-depressant in the U.S. However, in Spain, it is a brand name for omeprazole, a proton pump inhibitor which is sold in the U.S. as Prilosec.
- Flomax (tamsulosin) in the U.S. is used for benign prostatic hyperplasia (BPH) or enlarged prostate.
- Flomax (tamsulosin) is an analgesic (pain medication) in Italy.
- Vivelle (estrogen) is an oral contraceptive tablet in Austria.
- Vivelle (estrogen) in the U.S. is estrogen formulated in a skin patch for symptoms relating to menopause.
- Somnex (diphenhydramine), a sleep medication, is called promethazine in the U.K.

In addition, some foreign names for medications are phonetically similar to our brand names. For instance: Ambien (zolpidem) is a sleep medication here and Amyben (amiodarone) is a cardiac medication in the U.K.



To avoid medication mix-ups when you are traveling, bring enough of your regular medications with you to last throughout your trip. Also, make sure you are familiar with the generic names of medications, which are the chemical names and therefore do not change from country to country as brand names do. If you have any questions, the YHP Pharmacy will be glad to answer them.

Martha Asarisi, RPh
YHP Pharmacy

Update concerning Celebrex

Because Celebrex is in the same class of drugs as Vioxx, there was speculation that Celebrex would also be withdrawn following the Vioxx recall. In light of the FDA's decision about Celebrex, however, patients should consider it to be safe, when prescribed within the guidelines published for its use. If you have any concerns, talk with your prescribing clinician. Yale Health Plan's physicians, nurses and pharmacists carefully review safety data on all medications so that patients can have the best available assurance that medications prescribed and dispensed at YHP are deemed safe and are appropriate for members' needs. We apologize for any confusion about Celebrex arising from the information provided in the previous issue of *yale health care*.

Openness Important for GLBT Health Care

Issues faced by gay men, lesbians, bisexual and transgendered (GLBT) individuals have been prominent in the news over the past few years. No longer invisible in popular culture—witness the popularity of shows such as “Queer Eye for the Straight Guy” and “The L Word”—gay, bisexual and transgendered people have seen much progress, but are still faced with threats of violence, discrimination and lack of legal recognition for their relationships.

People with same-sex partners constitute approximately 10% of the U.S. population. While many of their health care issues are similar to those of their heterosexual neighbors, these individuals have some particular needs and concerns.

Clinicians often use the terms “men who have sex with men” (MSM) and “women who have sex with women” (WSW) to acknowledge that some individuals who do not self-identify as lesbians or gay men—and who in fact may be heterosexually married—may have same-sex sexual partners. What is important in determining health needs and concerns is not a label but someone’s health and family history, behaviors, and risk factors.

The health care concerns of people with same-sex partners fall into three main categories: health risks caused by exposure to infectious diseases more common in this group; mental health issues related to the unique stresses caused by cultural norms and negativity; and the consequences of lack of routine care and screenings due to misgivings about health care providers. While these conditions are common to all people, they occur at higher rates in this population.

The days have long passed when homosexuality itself was defined as an illness. We know that the vast majority of those with same-sex partners live stable, satisfying and productive lives. However, social stresses do result in higher rates of depression, suicide, body image disruption and eating disorders than found in the general population.

Teens in this population or those questioning their sexuality need special consideration, since teens are usually reluctant to discuss sexual matters with clinicians, and may feel alone, confused and rejected. Studies show that gay teens face significantly more violence from other teens, more school disruptions, and have a higher rate of suicide attempts and completed suicides than other teens. In caring for all adults and adolescents a safe, neutral environment is essential, as is providing reassurance about respect and confidentiality.

Gay or bisexual men or MSM have a range of physical health concerns. While HIV/AIDS has traditionally been the main topic that clinicians discuss with this group, MSM in long-term, monogamous relationships are at no greater risk for HIV/AIDS than monogamous, married straight couples. On the other hand, the rates of HIV/AIDS have recently been rising alarmingly in MSM and present a major public health crisis, especially in men of color in larger cities such as New Haven. Syphilis rates have also been rising in MSM and the use of barriers such as condoms and regular testing and treatment are crucial in taking care of any male patient who is sexually active. MSM are also at increased risk of Hepatitis A, so men in this group should receive the the Hepatitis A vaccine. Hepatitis B is also an increased risk for MSM. While many individuals born after 1982 have been vaccinated against Hep B, others have not, so testing and vaccination are strongly recommended for sexually active males of any sexual orientation.

A major health concern for lesbians is lack of care. Studies show that lesbians are much less likely to get regular health care than other women and a significant number reported being treated by clinicians with hostility or insensitivity. Many same-sex couples cannot receive health benefits through their partners. Many gay men and lesbians do not have health insurance and so do not get routine care.



As a result, rates of breast cancer and cervical cancer may be higher in lesbians and bisexual women than in other women—not because of intrinsic risk, but because of delay in or lack of screening exams. WSW should also be aware that they are at risk for STDs, including HIV/AIDS.

Older patients in this population often are the most reluctant to “come out” to clinicians if they have experienced a lifetime of hiding. Due to legal and policy inequities, older patients may find themselves unable to afford homes that they shared for decades with same-sex partners and may not be able to have visitation and other basic end-of-life rights taken for granted by heterosexually married couples. Depression and isolation can result. At the same time that older patients have developed numerous survival skills which should be recognized, they should also be encouraged to get health screenings and mental health care. Everyone should have, and inform their clinicians about, advance directives and end-of-life care documents.

Yale University recognizes the benefits that diversity brings to the University community and offers health care benefits to same-sex domestic partners. We encourage our patients to discuss their experiences with us so that we can provide thorough and appropriate care. We welcome your feedback.

James Perlotto, MD
Chief, Student Medicine

Rhea Hirshman, editor

Ed note: As this issue goes to press, Connecticut has become the first state voluntarily to pass legislation allowing civil unions for same-sex couples.

Keep Medication Needs In Mind When Traveling

If your summer plans include travel—especially travel overseas—make sure to plan in advance as much as possible for your medication needs.

Pack enough medications for your entire vacation, including any over-the-counter drugs that you take regularly. Medications that are over the counter here are not always OTC overseas. Keep medications in their original containers; this is especially important when going through each country's Customs department. Labeled medications kept in original containers are not held up in Customs while unlabeled medications can cause you delays. While domestic travel does not require that you carry paper copies of your prescriptions, you should carry such copies on overseas trips. These may be obtained from your clinician(s).

Many medications become unstable in heat, rendering them ineffective or even dangerous. Never pack medications in checked baggage or in a suitcase that you leave in or on your car. Those areas are not climate controlled and often reach very high temperatures. In addition, you may not be able to retrieve your medications in an emergency.



Medications should be packed in carry-on luggage if you are traveling by air, train or bus and kept with other valuables when you travel by car. Keeping the medication in its original packaging provides the necessary dry environment.

Other medications, such as insulin or liquid antibiotics, need even cooler temperatures or refrigeration. Insulin can be kept in an insulated lunch bag in an air conditioned environment. If a liquid antibiotic has been prescribed, your clinician may be able to prescribe it in a different, more stable form such as a tablet. If this is not an option, a pharmacist can give you instructions for proper storage.

The Pharmacy can coordinate your medications so that you have enough to cover your time away. Please allow at least 7–10 days to make sure that the medication is in stock and that questions can be answered. For more information call the Pharmacy at 203-432-0033.

Martha Asarisi, RPh
YHP Pharmacy

BENEFIT CHANGES

Please note the following benefit changes for YHP members, effective July 1, 2005

Pharmacy benefits

The prescription deductible will be increased to \$200 per person per year, up from the current \$150 per person. Family maximum deductible is \$600 per year. Co-insurance remains at 20% up to a \$700 individual out-of-pocket expense. Pharmacy expenses over \$700 per individual are covered at 100%, up to the Pharmacy maximum.

Mental health benefits (faculty and staff only)

The mental health reimbursement will be raised to \$60 per visit, up from \$50. The number of reimbursable visits per person remains at 30 visits per year, with a lifetime maximum of 150 visits per person.

In 1940, immigrants to the U.S. were largely (70%) from Europe. By the mid-1990s the percentages were: 15% from Europe, 37% from Asia and 44% from Central and South America and the Caribbean.

Ethnogeriatrics addresses the influence of race, culture, and ethnicity on the health and well-being of the elderly. Census data predicts that the U.S. elderly population may increase by 45.1% by 2015, while African-American elders as a group will increase by 71.8% by 2015. There will be a significant need for health care providers trained to work with these groups.

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Please remember that free parking for YHP members is available both in the lot right next to 17 Hillhouse Avenue and in parking lot 37, just across Trumbull Street.

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