THE STATE OF AFRICAN AMERICAN HEALTH: THE NATIONAL ACTION PLAN, VOLUME I

FINDINGS FROM THE 2013 SUMMIT ON AFRICAN AMERICAN HEALTH

NMA
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Association

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This Handbook is dedicated to Americans everywhere who are unaware that the information described in this Handbook exists. It is also dedicated to those public officials, researchers, providers and practitioners who are actively engaged in efforts to reduce racial/ethnic and gender-based differences in morbidity and mortality. We hope this Action Plan will make it easier for you to become an active participant in the now emerging movement to reduce or eliminate health disparities as the nation undergoes the greatest transformation of its healthcare infrastructure in its 237 year old history.

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Foreword

The work of the National Medical Association (NMA) is varied. NMA is specifically charged with the ask of using research, outreach, cross-institutional mentoring, and other tools and processes to reduce the incidence and prevalence of unidentified and/or poorly managed diseases and illnesses among African Americans or other medically underserved populations. However, our implied mandate is a much broader one. The 2013 Summit on African American Health brought together national leaders in order to gain their insight and input regarding programs, initiatives, and policies to reduce health disparities. The purpose of this book is to stimulate healthcare professionals, policymakers, educators, and the general public to engage in efforts to reduce current asymmetries in health outcomes. The purpose of this book is also that of motivating individuals and families to replace unhealthy lifestyles with behaviors that support longevity. Through this document, we have also sought to more effectively transfer research findings from the annals and journals of medical public health organizations into the hands of practitioners and community residents who want to engage in a movement of change.

Much of the work that must be done, however, is predicated upon all key stakeholders having a common knowledge-base of the nature, magnitude, and cause and correlates of the lower life expectancy and greater prevalence of disease and illness that affects America's growing minority and of strategies that can remediate these circumstances. The 2013 African American Summit addressed many of these issues and populations. Americans must know that a sick population creates an unproductive workforce and an unproductive workforce threatens the way of life of all Americans.

And so, we are pleased that the 2013 Summit on African American Health has allowed NMA to create, in collaboration with our diverse partners, an Action Plan that captures so many strategies to reduce health disparities within one document. The research and resources on health disparities has exponentially grown over the last ten years alone. Thus, while much has been revealed regarding health disparities, the findings are scattered across federal statistical databases, in the many publications of the federal statistical databases, in the many publications of the federal government on healthcare, and in the hundreds of regional and national healthcare journals. However, no single document exists that seeks to systematically effect change.

While this book – the State of African American Health: An Action Plan, Volume I - includes only a fraction of the strategies that are currently available for adoption, it will ease and simplify the work of those who need strategies of solution rather than merely more research and analysis. We hope that whether you are a consumer seeking information that can help you better manage your healthcare, a student of medicine or public health with an interest in health outcome differentials, a practitioner, and/or a policymaker, this Action Plan will, indeed, stimulate you to join the health disparity movement.

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Chapter 1
Health Disparities: Defining the Concept

By Rahn Bailey, M.D.
113th President,
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Overview

The theme of this book – the State of Health of African Americans – embodies the implicit premise that there is an urgent need for healthcare interventions to improve, addend, or otherwise modify the processes and outcomes descriptive of African American health. This is not a new or novel construct. Since the inception of the National Medical Association, there have been concerns and challenges regarding the provision and receipt of healthcare among African Americans. Despite the fact that mortality and morbidity rates have decreased, many of these challenges remain relevant today. The purpose of the 2013 Summit on African American Health was that of developing additional strategies to address prevailing and emerging health issues that characterize persons who define their ethnicity as African Americans.

As is now common knowledge, whether speaking diagnostically, pharmacologically, surgically, and/or technologically, the healthcare of African Americans is asymmetrically distributed. Accordingly, we apply the terms inequities, inequalities, and disparities, as frameworks to describe the differences in healthcare and treatment for this population. Health disparities can be defined as population-specific differences in the presence of disease outcomes and access to care. This definition is key for it asserts that there are differences between populations and subpopulations as measured by key indicators of health. These indicators transcend the clinical to include institutional variables such as access to healthcare.

As a collective of stakeholders seeking to intermediate change, it is necessary to identify those paths of causation that parametrically related to health disparities and, as a result, are not available for intervention. Likewise, the ability to effect change in disparate outcomes also requires that causal patterns be identified and strategies of change implemented. Such a differentiation is key to the increasingly growing discussions regarding health disparities and their remediation.

In contrast, health equity is considerably different as a conceptual framework for the exploration of African American health outcomes. Health equity references the <u>absence</u> of systemic disparities in health. It addresses whether major differences in wealth, power, prestige, and other social determinants of health exists. Inversely, those health inequities suggest the presence of such differences. Even the most casual review of census data reveals that such differences are monumentally present in African American communities. For example, data from the Bureau of the Census reveal that while overall poverty rates are 15%, approximately 27.5% of African Americans fall at or below the federally defined poverty line.[1] These numbers align with the disproportionate number of African Americans in the U.S. who do not have adequate access to healthcare. Is this health inequality? Since there is a difference in rates of access to healthcare amongst different segments of our population, this trend does, indeed, qualify as an inequality. But, do these trends constitute a health inequity? This answer depends, of course, on

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[1] *Short, Kathleen (2011) The Research Supplemental Poverty Measure: 2011 Current Population Reports. U.S. Census Bureau.*

whether one's idea of social justice involves the right to healthcare. If so, then yes, it is unfair and unjust that there are differences in this fundamental right and the right to healthcare.

We, who hold membership in the NMA, have applied the premise that for the entirety of our history, healthcare should be the right of every American irrespective of geography, race/ethnicity, gender, age, sexual preference, or socioeconomic status. Yet, transforming this belief into action has been a challenge. Despite NMA's active, vigorous, and even rancorous debate about access to care, who is going to pay for care, who is going to receive care, and how care is managed, a question that prevails in our society is whether healthcare is an inherent right. In this regard, the 2013 Summit on African American Health selected to bypass the philosophical issue of health equity and address the empirically verifiable question, "Are disparities in health real?"

Racial/Ethnic Health Disparities in Healthcare Access

Preliminary to an effort to identify strategies and resources to be used in addressing racial/ethnic disparities is the need to condense and collate data that describe the magnitude and nature of prevailing health disparities. Independently of medical specialty and/or area of research interest, knowledge of health resources can serve as a starting point in an effort to remediate health disparities. The subsections below describe merely a few of the racial/ethnic disparities that exist in terms of accessibility to healthcare.

- **Health Insurance Coverage**

First, it is necessary to acknowledge that tremendous progress has been made in the area of improving access to healthcare amongst African Americans. Data from the CDC/National Center for Health Statistics, National Health Interview Survey reveal that in the year 2006 the percentage of African Americans with incomes below 100% of poverty who did not have health coverage equaled 46%. However, by 2009-2010, the percentage of impoverished African Americans with no health coverage had dropped to 37%.

Moreover, it may surprise many to know that racial/ethnic disparities in insurance coverage for individuals 18-64 with incomes at or below poverty are highest for Latino and Asians. However, these rates are also highly significant for African Americans and Caucasians.

- ❖ Approximately 61% of impoverished Latinos 18-64 years of age, 39% of Asians, 37% of African Americans, and 35% of Caucasians in this income/age group are uninsured.
- ❖ Although these differences are only statistically significant for Latinos, this data suggest a need for NMA and its stakeholders to partner with other ethnic stakeholder groups in educating the public regarding the changes in Medicaid and Medicare eligibility that will allow even more impoverished populations to access Medicaid or Medicare.

Source: CDC/NCHS. Health United States 2011, June 2012, pg. 45.

- ❖ In contrast, 14% of Latinos, 10% of African Americans, 7% of Asians and 6% of Caucasians 18-64 years with incomes 300% or more higher than poverty are also uninsured.
- ❖ NMA and its stakeholders will support enrollment through the Exchanges that are currently being established by states as centralized mechanisms for accessing insurance for persons with income up to 300% above poverty. One way that stakeholders can help is by conducting outreach and education to these populations.

Source: ibid

- Persons with incomes above poverty but less than 300% above poverty may be eligible for subsidies to reduce the costs of their insurance. This is critical since 37% of African Americans with incomes 100%-199% of poverty, and 22% of those with incomes 200% to 399% of poverty are uninsured.

Source: ibid

- The uninsured rates for Latinos, Asians, and Caucasians in these income brackets are 57% and 35%, 39% respectively for those with incomes 100%-199% of poverty. When the income threshold is increased to 200% to 399% of poverty, the rates for Latinos, Caucasians, and African Americans are 22%, 18%, and 6% respectively.
- Again, the high prevalence of uninsured status across the other racial/ethnic groups suggests a basis for collaboration.

- **Health Disparities: Utilization and Access**

It is important to note that the presence of insurance does not guarantee access to healthcare. While co-payments and other cost-sharing arrangements may appear to be minimal, these co-pays can prevent some persons from seeking needed healthcare. In addition, childcare, transportation, and/or other expenses can cause persons 18-24 to delay or not seek medical care as a result of financial shortfalls. However, as a result of the past efforts of stakeholders, the disparities are now more significant by income level than by race/ethnicity. Nevertheless, interventions are needed.

The disparities in the percentage of African Americans (24%), Caucasians (27%), and Latinos (21%) who delay or do not receive medical because of cost are not significant.

Source: ibid, pg. 46.

- However, African Americans below poverty (24%) fail to access healthcare because of costs 166.65% more often than their counterparts with incomes 300% above the poverty line (9%).

Source: ibid

- Caucasians with incomes below poverty (27%) do not access healthcare because of costs 285.71% more often than their counterparts with incomes 300% higher (7%).

Source: ibid

- Latinos with incomes below poverty (21%) do not access healthcare because of costs 162.5% more often as their counterparts with incomes 300% above poverty (8%).
- Asians with incomes below poverty (16%) do not access healthcare because of costs 300% more often than their counterparts with income 300% above poverty (4%).

Source: Calculated from data from CDC/NCHS National Health Interview Survey

These data suggest that advocacy and policy change to reduce disparities in the past have been successful. However, the described findings also suggest that supplemental funding may be needed to ensure that other barriers to healthcare are reduced by impoverished populations. Social workers and/or other groups can lead changes in this area.

- **Health Disparities: Prevention**

In addition to the success of past efforts to reduce disparities in access to healthcare, programs of intervention have also successfully impacted other areas.

- In 1987, 29.6% of Caucasian women 40 years and over and 24.0% of African American women received mammograms. In 2010, the latest date for which data are available, 67.4% of Caucasian women, 67.9% of African American women, 71.2% of Native American women, 62.4% of Asian women, and 64.2% of Latinas received mammograms.

Source: *Health, United States 2011, pg. 295; Table 90.*

- Similarly, the percent of African American women (77.9%) who reported received pap smears in the last three years now exceed the percent for women age 40 and over of other ethnicities. The percent for Caucasian women is 72.8%. Approximately 73.6% of Latinas, 68.0% of Asian women, and 73.4% of Native American women reported receiving pap smears in the last three years.

Again, such data serves as evidence that caucuses, meetings, forums, summits, and other efforts to organize for health improvements in African American communities can and have been successful. However, data of this type also raise the question, “Where are the areas of health disparities that currently require intervention?”

- **Healthcare Disparities: Mortality Rates**

Despite the successes of the past, empirical data reveal a number of areas in which racial/ethnic health disparities continue to exist. One major health outcome differential exists for mortality rates. As Table 1 indicates, African Americans have higher mortality rates for nearly all causes of death.

Table 1:
Incidence Rates by Race/Ethnicity
(per 100,000 persons)

	Caucasians, Non-Hispanic		**African Americans, Non-Hispanics**		Latinos		Asians		Native Americans	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
I.0. Age-Adjusted Death Rate for all causes per 100,000 persons *Health, United States 2011, pg 129-132*	908.5	636.9	1150.4	778.4	630.7	445.7	492.8	353.1	717.3	515.1
I.1. Death rates for diseases of heart per 100,000 *Ibid, pg 133-135*	229.9	147.2	295.6	197.5	151.9	104.6	129.7	81.7	149.1	94.3
I.2. Death rates for cerebrovascular diseases per 100,000 *Ibid, pg 136-138*	39.0	38.6	62.1	53.4	33.1	28.4	34.0	32.1	24.5	24.0
I.3. Death rates for malignant neoplasms per 100,000 *Ibid, pg 139-141*	211.7	148.5	272.4	170.6	139.6	96.6	128.8	102.3	142.0	102.3
I.4. Death rates for malignant neoplasms of the	63.4	42.5	78.5	36.9	29.7	13.7	35.1	17.8	41.7	26.3

Table 1:
Incidence Rates by Race/Ethnicity
(per 100,000 persons)

	Caucasians, Non-Hispanic		**African Americans, Non-Hispanics**		Latinos		Asians		Native Americans	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
trachea, bronchus, and lung per 100,000 *Ibid, pg 143-145*										
I.5. Death rates for malignant neoplasm of breast among females per 100,000 *Ibid, pg 146-148*	--	22.5	--	31.1	--	14.3	--	11.7	--	12.6
I.6. Death rates for human immunodeficiency virus (HIV) ages 25-44 *Ibid, pg 149*	3.0	1.1	23.5	15.0	5.3	2.1	1.6	--	4.2	--
I.7. Death rates for drug poisoning and drug poisoning involving opioid analgesics *Ibid, pg 150*	18.0	11.3	11.6	5.5	8.3	3.3	1.2	1.4	15.7	10.3
I.8. Death rates for motor vehicle-related injuries per 100,000 *Ibid, pg 153-156*	19.5	7.8	19.1	6.5	16.7	5.7	8.3	4.4	27.6	14.6
I.9. Death rates for homicide per 100,000 *Ibid, pg 158-159*	3.9	1.8	34.4	5.5	10.5	2.4	3.1	1.4	10.7	3.6
I.10. Death rates from suicide per 100,000 *Ibid, pg 161-163*	22.9	5.4	9.5	1.7	9.3	1.9	8.2	3.7	17.7	5.8
I.11. Death rates for firearm-related injuries *Ibid, pg 164-166*	16.1	2.7	34.4	3.5	11.8	1.5	4.5	0.8	13.3	2.7

- **Disparities in Overall Death Rates**

As Table 1 indicates, severe disparities exists in death rates between African Americans and persons of other ethnicities. These patterns also differ by gender.

- African American males have an overall death rate of 1150.4 per 100,000 persons in the population. The rate for Caucasian males is 908.5. Thus, African American males die at a rate that is 26.62% higher than Caucasian male.
- Similarly, with a death rate of 778.4 per 100,000, African American females die from all causes at a rate that is 22.22% higher than Caucasian women (636.9).

In order to reduce these disparities in mortality rate, customized interventions that are linearly related to the root causes of the patterns are required.

- **Disparities in Death Rates from Major Illness and Disease**

Table 1 also identified the sources of the overall death rate disparities for African Americans.

- African American males and females respectively die from diseases of the heart 28.57% and 34.17% more often than their Caucasian counterparts of the same gender.
- African American males and females respectively die from cerebrovascular diseases 59.23% and 38.34% more often than their Caucasian counterparts of the same gender.
- African American males and females respectively die from malignant neoplasm 28.67% and 14.47% more often than their Caucasian counterparts of the same gender.
- African American males die from malignant neoplasm of the trachea, bronchus, and lungs 23.8% more often than their Caucasian counterpart. However, African American females die from this type of malignant neoplasm 15.44% less often than Caucasian women.
- African American females die from malignant neoplasm of the breast 38.22% more often than Caucasian females.
- African American males and females ages 25-44 respectively die from human immunodeficiency virus respectively 683.33% and 1263.63% more often than their Caucasian counterparts.
- In contrast, Caucasian males and females respectively die from drug poisoning involving opioid analgesics 55.17% and 105.45% per 100,000 more often than their African American counterparts.
- Caucasian males and females respectively also die from motor vehicle-related injuries at a rate that is 2.61% and 2% higher than for their African American counterparts.
- Similarly, death rates from suicide are 141.05% and 217.65% higher for Caucasian males and females than for their African American counterparts.
- In contrast, death rates from homicide are 782.05% and 205.55% higher for African American males and females respectively than is the case for their Caucasian counterparts.
- Finally, death rates for firearm-related injuries are 113.66% and 29.62% higher for African American males and females respectively than for their Caucasian counterparts.

As these disparity ratios reveal, the differentials in mortality rates for African Americans are more distinct in the areas of immunodeficiency virus and homicide. However, efforts are needed to reduce disparities in each of the areas cited.

Summary

The data described are far from exhaustive. Disparities in a number of areas have become common knowledge. For example, colorectal screening data reveal that African Americans and

Native Americans and Alaskan natives have lower rates of screening for colorectal cancer than is true for Caucasian Americans. Similarly, during influenza seasons, these groups have lower vaccination coverage. Because there are numerous health activities that currently have barometers that can be used to measure disparities, NMA may be required to engage in continual tracking. In particular, such tracking is needed regarding areas that can lead to serious adverse outcomes including progressions in degree of morbidity and early mortality. For example, data on obesity disparities are readily available. Currently, among the majority of age groups, the prevalence of obesity is lower in Caucasians than in African Americans or Mexican or Hispanic Americans. Similarly, among females, obesity as a chronic disease is highest among African Americans. However, among males under 20 years of age, it is highest among Mexican Americans. But, obesity intermediates numerous chronic diseases and, as a result, is most appropriately tracked on an annual basis.

Behavioral health also affects other health areas. As a psychiatrist, disparities in mental healthcare and disparities in access to behavioral healthcare have been observable over several decades. Under the Affordable Care Act, more mental health facilities will become medical homes for all clients. It is necessary to ensure that coding, payments, reimbursements, co-pays, and lifetime caps do not contribute to disparities. A number of studies have found that African Americans are less likely to receive antidepressants than their Caucasian counterparts. Again, centralized tracking by NMA and other stakeholders is critical to health disparity reductions. Simply having a different race or ethnicity has been shown to alter whether or not physicians in various areas will prescribe the best forms of medications such as antidepressants. Yet, one need not be an African American psychiatrist to appreciate that there are multiple circumstances in African American communities that may be related to or influenced by clinical depression. These conditions may include high teenage pregnancy rates, issues regarding violence or aggression, or even domestic violence. The linkages between such issues must be identified and integrated into health disparities intervention. For example, Burford, Low, and Matthews (2013)[2], in a study of 239 low income, high school students, found that the presence of “negative emotions, lower positive resources, and more unpleasant interactions”, was linked with higher levels of hypertension during both day and night. Other studies also demonstrate the strong linkages between mental and physical health. Thus, in order to reduce health disparities in mental and physical health, a psychiatrist must consider issues of language, health literacy, as well as medication management in order to maximize value from each visit.

It is our position in the NMA that it is the physician’s responsibility or the clinician’s responsibility to communicate with the patient and that often requires not only listening, but recognizing that the patient may not be listening to what is being said. It may involve speaking to patients in a way so that they can speak back that which has been said. Such points highlight the complexities that are integrated into efforts to reduce health disparities. Nevertheless, the successes of the past demonstrate that there can be successes in the future. These successes can ultimately result in the elimination of not merely disparities in the prevalence and incidence of disease, but disparities in mortality rates as well.

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[2] *Burford, TI, Low, CA, Matthews, KA. (2013) Night/Day Ratios of Ambulatory Blood Pressure Among Healthy Adolescents: Roles of Race, Socioeconomic Status, and Psychosocial Factors.*

Chapter 2
Complexities in Addressing Health Disparities: The Case of HIV

By Sharon D. Allison-Ottey, M.D.

Overview

The theme of this 2013 Summit on African American Health – organizing key stakeholders and creating an action plan that will ultimately result in decreased disparities in morbidity and mortality among African Americans – is quite complex. At one level, it involves engaging key stakeholders such as Black Entertainment Television, TVOne, Bounce, PunchTV Network, Affirm, and other media in order to educate the public regarding the magnitude and nature of current disparities. Policy-based groups such as the National Association for the Advancement of Colored People (NAACP), the National Urban League, the National Urban Coalition, 100 Back Men of America, National Coalition of 100 Black Women, National Black Chamber of Commerce, etc. are critical allies because of their ability to influence policy. Medical entities such as the American Medical Association, the Black Cardiologists, the National Black Nurses Association, National Dental Association, and others are needed to conjoin with the National Medical Association, Howard University School of Medicine, and others so that clinical and practice-based variables that can reduce disparities can be rigorously defined. The American Pharmaceutical Association and similar organizations actually house data that can be used to support and strengthen the growth of ethnopharmacology – an emerging field that examines racial/ethnic difference, in responses to various pharmaceutical agents. Private, corporate, and pubic funding agencies can play a key role in allowing researchers and scholars to formulate and answer new queries regarding sources of disparities and disparity causation. However, concurrent to the involvement of these groups is the need to continually review and compile published research so that the nuances associated with health disparities in various areas can be characterized and translated into action by one or more of those stakeholders who choose to participate in what the participants in the Summit are seeking to grow into a movement.

Given this need, it is appropriate to initiate this Action Plan by reviewing several articles that demonstrate the complexities associated with disparities. More specifically, this article reveals that health disparities and their solutions are far less linear areas of inquiry than is commonly thought.

Addressing Health Disparities: The Case of HIV

Data introduced in Chapter 1 reveals that extreme disparities exist in the prevalence and incidence of HIV. Such statistical differences raise the question, “How does HIV manifest itself among African Americans relative to their Caucasian counterparts as well as in African Americans intra-ethnically as well as inter-ethnically?” Even more importantly, it is necessary to explore how current research can be used to support disparity reductions.

For example, for those in the medical community, particularly physicians, nurses, physician assistants and others, a quiet crisis is occurring in emergency rooms relative to HIV testing. As is known, the Center for Disease Control and Prevention has implemented a number of programs to reduce barriers to early diagnosis of HIV infection and to increase access to quality medical care, treatment, and ongoing prevention services for HIV positive persons and their partners. Likewise, tremendous progress has been made in making HIV testing a routine part of the medical examination.

However, research by Ganguli et al (2013)[3], based upon the USHER clinical trials in Boston, found that females, lower income persons, younger patients, persons without a medical home, and African Americans, who were offered and who completed rapid HIV tests when they presented in the emergency room, were more likely to refuse confirmation even when the rapid HIV tests were reactive. As a result, despite the rapid testing, some portion of persons with HIV positive tests fail to enter into treatment. While only 21% of persons who presented at a Boston, MA emergency department refused confirmation, 30.7% of this group were HIV positive.

Because the sample size (N=62) was so small, these findings must be considered exploratory and not conclusive. Nevertheless, they suggest the need for healthcare professionals to launch a campaign that urges at-risk African Americans to not only get tested, but to also find out the results and enter into treatment. This could be addressed by film and television producers writing a film, documentary, or TV series that demonstrates the individual and community risks associated with refusals to complete confirmation testing.

One thesis that is oftentimes used in explanation of patterns of noncompliance in the area of HIV testing and treatment is a pattern of distrust due to the now historic Syphilis Study at Tuskegee. However, it appears that the impact of this event may have been overstated. Mays, Coles, and Cochran (2012)[4], in a study of knowledge of this study, found that while African Americans were more knowledgeable about this experiment than Latinos (only 28% of African Americans and 6% of Latinos had ever heard of the Syphilis Study at Tuskegee), most African Americans know nothing about this study.

This is not to say that trust does not play a role in disparate HIV outcomes. Veinot et al (2013)[5] held focus groups with 75 African American youth with either HIV or other sexually transmitted infections regarding the design of an online intervention for educating youth about HIV and other sexually transmitted conditions. The overriding theme that emerged from the focus group was the youth's feeling of distrust. This feeling extended beyond the use of the proposed technology and included an absence of trust regarding: 1) the value of condom use; 2) the findings from HIV tests; 3) the motives of those who run HIV programs, and 4) other issues. Gaston (2013)[6], using a sample of 202 HIV-positive African Americans, also investigated trust. They discovered that Provider trust and a belief that medical providers should provide culture-specific care was both directly related to HIV outcomes via greater self-care. This suggests that providers themselves may wish to monitor their interactions with African American and other patients. Based upon such self-monitoring, it will become possible to increase the level of trust with patients. A friendly demeanor, a touch, a nod, an unhurried appointment, instructing office staff to call to check on a client who failed to appear for a scheduled visit, and a brief query regarding medical adherence are samples of behaviors that can strengthen trust.

Still another burden for reducing health disparities in the area of HIV falls upon physicians and other healthcare providers. As is known, data from the CDC National HIV

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[3] *Ganguli, I, Collins, J.E, Reichmann, W.M, Losina, E, Katz, J.N, et al. (2013) Missed Opportunities: Refusal to Confirm Reactive Rapid HIV Tests in the Emergency Department. PLoS ONE 8(1): e53408. doi:10.1371/journal.pone.0053408*

[4] *Mays, V.M, Coles, C.N, & Cochran, S.D (2012): Is There a Legacy of the U.S. Public Health Syphilis Study at Tuskegee in HIV/AIDS-Related Beliefs Among Heterosexual African Americans and Latinos?, Ethics & Behavior, 22:6, 461-471*

[5] *Veinot, T.C, Campbell, T.R, Kruger, D.J, Grodzinski, A. "A question of trust: user-centered design requirements for an informatics intervention to promote the sexual health of African-American youth." Journal of American Medical Information Association March 2013*

[6] *Gaston, G.B. (2013) "African-Americans' perceptions of health care provider cultural competence that promote HIV medical self-care and antiretroviral medication adherence" AIDS Care: Psychological and Socio-medical Aspects of AIDS/HIV, DOI:10.1080/09540121.2012.752783*

Surveillance System confirm that 57.4% of youth age 13-24 with HIV are African American.[7] However, because of low rates of testing more than 59.5% of all infected youth have no knowledge of their status. Again, when such data are combined with the risk of youth refusing to confirm reactive rapid HIV tests, the need for schools, parents, and other influencers to educate youth regarding the importance of testing is further enlarged.

A number of investigators have addressed the issue of trust. Their findings suggest that while cultural factors such as differential degrees of "trust" and other ethnic-specific beliefs, attitudes, and norms do contour existing disparities, structural factors that may be embedded in healthcare systems continue to be operative. For example, Ebrahim et al (2004)[8] found that while HIV testing rates are actually higher among African Americans, overall HIV knowledge is lower among African Americans than any other group. As is the case in other health areas, the knowledge gap between African Americans and other groups narrowed as years of education decreased. This research suggests that virtually every African American who is tested for HIV be given an engaging DVD that transmits HIV knowledge using language and scenarios that will retain the attention of this group while elevating health knowledge.

One area of need for those organizations who choose to participate in this new movement to reduce health disparities in HIV is the building of new social networks. Fraternities and sororities, groups such as 100 Black Men, and other entities may wish to consider forming specialized support groups for persons with HIV. The reason for such a recommendation is a pressing one. Kuramoto, Wilcox, and Latkin (2013)[9], in a study of 819 African Americans from the longitudinal database, Self-Help in Eliminating Life-Threatening Diseases (SHEILD), found that suicide-related ideation and planning was much greater among African Americans with HIV who do not have strong social networks. Nunn et al (2013)[10], for example, reports on the successes of 40 African American faith-based institutions in increasing HIV testing and overall awareness. However, faith-based organizations also offer a perfect opportunity for the creation of social networks for HIV-infected persons so that suicide ideation is reduced.

In addition, faith-based organizations can play a key role in the reduction of HIV disparities in another way. Duvall et al (2013)[11], in a study of 206 African American women, found that one causative factor that may influence the disparate prevalence rates for HIV among this group is a willingness to engage in unprotected sex in the hopes that this high-risk act will help strengthen the relationship with their partner of the moment. Women's groups in faith-based institution are also positioned to provide informal counseling to African American women that addresses this issue.

Another intervention that can be initiated by the African American faith-based institutions is the recruitment and training of community health workers to support community

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[7] *American Journal of Transplantation "Vital Signs: HIV Infection, Testing, and Risk Behaviors Among Youths – United States" 2013 February 13(2):510-5 doi:10.1111/ajt.12172*

[8] *Ebrahim, S.H, Anderson, J.E, Weidle, P, Purcell, D.W. Race/ethnic disparities in HIV testing and knowledge about treatment for HIV/AIDS: United States, 2001. AIDS Patient Care STDS 2004;18:27-33.*

[9] *Kuramoto, J.S, Wilcox, H.C, Latkin, C.A. "Social Integration and Suicide-Related Ideation from a Social Network Perspective: A Longitudinal Study among Inner-City African Americans."* *Suicide Life Threat Behavior* *2013 Mar 26. doi: 10.1111/sltb.12023*

[10] *Nunn, A, Cornwall, A, Thomas, G, Callahan, P.L, Waller, P.A, Friend, R, Broadnax, P.J, Flanagan, T. "What's God got to do with it? Engaging African-American faith-based institutions in HIV prevention."* *Global Public Health. 2013 March; 8(3):258-259*

[11] *Duvall, J.L,, Oser, C.B, Mooney, J, Staton-Tindall, M, Havens, J.R, Leukefeld, C.G. Feeling good in your own skin: the influence of complimentary sexual stereotypes on risky sexual attitudes and behaviors in a community sample of African American women. Women Health. 2013 Jan; 53(1):1-19.*

residents with HIV. Kenya, Jones, Arheart et al (2013)[12], in a study using 91 African Americans with HIV, observed that persons who participated in activities through a community health worker experienced statistically significant improvements in their viral load and CD4 cell count. Faith-based institutions are perfectly positioned to start and execute these training programs.

Because HIV rates vary by geographical areas, the efforts of stakeholders, whether community-based or from the ranks of the medical profession, may wish to initiate the first tier of actions to reduce disparities within those geographical areas with the greatest disparities. For example, while the greatest proportion of people whose HIV has progressed to Acquired Immunodeficiency Syndrome (AIDS) live in the south, centers of high HIV disparities may differ. For example, Scheer et al (2013)[13] found that while HIV infection rates for men who have sex with men are 3 to 18 times higher in San Francisco than for other at-risk groups, this same group had HIV infection rates that were 100 times higher in Los Angeles County. For African American men who have sex with men, the rates were even higher. This suggests that as the movement to effect reductions in health disparities continue, geographical disparity maps must be produced by NMA and its partners to guide work at the community-level.

In a similar fashion, the National Medical Association, the Black Nurses Association, and other groups with clinical expertise may choose to produce addenda to practice guidelines that highlight key clinical issues that may affect treatment outcomes for different diseases and illnesses. For example, Apps et al (2013)[14] conducted research to determine whether differences in HLA-C can explain, in part, differences in HIV outcomes for African Americans with HIV. HLA or the human leukocyte antigen is a human gene that impacts the body’s ability to produce proteins. These proteins affect immune function. This study built upon past research that revealed that HLA-C, one of many human leukocyte antigens, has a positive impact on HIV control in persons of European descent. However, this study of 5243 persons with HIV infection revealed that higher levels of HLA-C expression positively impacted HIV outcomes for persons of African as well as European descent. However, Proudnikov et al (2013)[15], studied how prodynorphin, a hormone that is embodied in endorphins and which affects cell communication, and chemokins, proteins that can positively or negatively affect immune response; and other receptors affect the progress of HIV before and after highly active antiretroviral therapy (HAART). This research team did find differences in the progression of the disease before and after HAART by race/ethnicity and type of receptors.

Similarly, Heffernan et al (2013)[16], in a study of 21 African American men and 21 Caucasian men with HIV who were receiving HAART treatment found that the greater risk of cardiovascular disease in HIV-infected African American men is due, in part, to greater pathology related to the left carotid arterial system. Physicians who treat HIV patients may require regular health communications that keep them informed of progress in this area.

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[12] *Kenya, S, Jones, J, Arheart, K, et al. “Using Community Health Workers to Improve Clinical Outcomes among People Living with HIV: A Randomize Controlled Trial” AIDS Behavior 2013, March 21*

[13] *Scheer S, Nakelsky S, Bingham T, Damesyn M, Sun D, et al. (2013) Estimated HIV Incidence in California, 2006–2009. PLoS ONE 8(2): e55002. doi:10.1371/journal.pone.0055002*

[14] *Apps, R, Qi, Y, Carson, J.M, et al “Influence of HLA-C expression level on HIV control” Science. 2013 April 5;340(6128):87-91*

[15] *Proudnikov, D, Randesi, M, Levran, O, et al “Polymorphisms of the Kappa Opioid Receptor and Prodynorphin Genes: HIV Risk and HIV Natural History” JAIDS Journal of Acquired Immune Deficiency Syndromes: 1 May 2013, Vol 63, Issue 1, p. 17–26*

[16] *Heffernan, K.S, Wanke, C.A, Dong, K, et al “Racial Differences in Central Hemodynamic burden in Men with HIV: Preliminary Findings, Ethnic Disparities 2013 Spring; 23(2):217-22*

Summary

In Chapter 1, the concept of health disparities was introduced and sample data on mortality rates were provided. In Chapter 2, the argument has been made that organizing a national movement to respond to health care disparities is less than simple. To demonstrate this point, an overview was provided of the HIV disparities. In Chapter 3, a representative from the U.S. Office of Minority Health provides a portrait of some of the resources and opportunities available to NMA and other stakeholders for addressing health disparities in any health area.

Chapter 3

Addressing Health Disparities: The Work of the U.S. Department of Health and Human Services, Office of Minority Health

By Jacqueline Rodrigue
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The Office of Minority Health

Overview

Research by Hoyert and Xu (2013)[17] indicates that overall life expectancy in the United States is 76.3 years males and 81.1 years for females. However, data from the CIA World Factbook reveals that the United States ranks 51st in the world in terms of overall life expectancy. Yet, data from the National Health Expenditure Accounts[18] documents that national health expenditures increased from $518.9 billion in 1987 to $2.48 trillion in the year, 2009. This represented a growth rate of 379.1%. In the year 2011, national health expenditures had increased to $2.7 trillion. This ongoing differential between the country's global rank in terms of life expectancy and its rank in terms of per capital health expenditures has catalyzed a continual search for strategies to improve the efficiency and effectiveness of the American health system. The Patient Protection and Affordable Care Act represents the country's most recent effort to contain health costs, increase access to health care, and elevate the quality of those medical and other health care services that are delivered.

On March 23, 2013, the country celebrated the third anniversary of the Patient Protection and Affordable Care Act. This Act has created an unprecedented moment of opportunity for the Office of Minority Health. By crafting, passing, and now implementing this comprehensive act of health reform, all parties in government have truly made health, wealth, and prevention major priorities in the public agenda. The Affordable Care Act has not only put forth measures that make health insurance more affordable, it provides better access to care and includes measures to improve the quality of care.

In implementing these new policies, programs, and initiatives, the federal sector is building upon a rich history of success in improving health outcomes for its citizenry. As is known, while businesses, households and other private revenues contribute 56.49%[19] to the country's two and one half trillion dollars in health care expenditures, it is federal, state, and local governments that apply 43.6%[20] of all revenues collected to pay for healthcare services and supplies. Moreover, the contributions of the government sector to the total bill for health expenditures has continued to grow. For example in 1987, the public sector only contributed 31.8% to healthcare expenditures. Additionally, total health expenditures were only 20.9% as large as the dollars spent for healthcare today.

Successes of the Past

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[17] *Hoyert, D.L, Xu, J.Q. Deaths: Preliminary data for 2011. National Vital Statistics reports; Vol 61 No 6. Hyattsville, MD: National Center for Health Statistics. 2012.*

[18] *See http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.html*

[19] *ibid*

[20] *ibid*

But, as we lament the overall costs of healthcare, it is important to also note that the leadership provided by the federal government has resulted in improvements in the health of the public. Table 1 briefly outlines merely a few of the successes that have occurred over time as the nation has sought to reduce and/or eliminate illness and disease.

Table 1:
Successful Health Initiatives of the Past

New cases per 100,000

Disease Area	1950	2010	% change
● Diptheria	3.83	--	100% decrease
● Pertussis (Whooping cough)	79.82	8.97	88.76% decrease
● Rubeola (Measles)	211.01	0.02	99.99% decrease
● Shigellosis	15.45	4.82	68.8% decrease
● Syphilis	146.02	14.93	89.78% decrease
● Gonorrhea	192.50	100.76	47.66% decrease

Source: Calculated from data from the CDC, Office of Surveillance, Epidemiology, and Laboratory Services (OSELS), Public Health Surveillance Program Office (PHSPO), Division of Notifiable Diseases and Healthcare Information. See http://www.cdc.gov/std/stats11/surv2011-Complete.pdf

Nevertheless, the message to the Nation delivered by the Affordable Care Act is that even more progress is needed.

Of particular interest to the Summit, The Patient Protection and Affordable Care Act offers a window of opportunity to reduce health disparities and improve health outcomes for all Americans. The public sector knows, for example, that African Americans and other minorities are less likely to have access to the preventable services they need to stay healthy. For example, in 1984, 79.9% of Caucasians and only 58.1% of African Americans under 65 years of age had private health coverage. Thus, Caucasians were 37.5% more likely to have private insurance. In 2010, the absence of private insurance had decreased for both groups. A mere 64.9% of Caucasians and 44.8% of African Americans had private insurance. Moreover, the disparity ratio had increased. That is, Caucasians were 44.9% more likely to have private insurance in 2010.[21] Such, data suggest that many African Americans do <u>not</u> have the preventive care available through their health insurance and/or they are reliant upon the public sector to provide such services.

In 1984, 4.6% of Caucasians and 20.5% of African Americans were reliant upon Medicaid. Thus, African Americans were 345.7% more likely to be enrolled in Medicaid than their Caucasian counterpart. In 2010, even Caucasian dependence upon Medicaid had increased from 4.6% to 14.5%, a growth rate of 215.2%. The percent of African Americans who received Medicaid had increased to 30.4% - a growth rate of only 48.3%. This growth in Medicaid enrollment among Caucasians decreased the disparity ratio so that African Americans in 2010 were 109.6% more likely than Caucasians to be Medicaid enrollees.[22] However, even within the Medicaid and/or private health systems, African Americans do not necessarily access preventive services at rates that are comparable to their Caucasian counterpart. For example, 66.9% of

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[21] *Source: Calculated from data in the CDC/NCHS, National Interview Survey*

[22] *ibid*

African Americans with incomes below poverty did not meet the aerobic activity nor muscle-strengthening guidelines in 2010.[23] Similarly, 47.7% of African Americans with incomes 300% or more above poverty but 35.2% of Caucasians in the same income bracket had not met either guidelines.[24]

This suggests that cultural factors and not merely access to income or insurance coverage or status must continue to be addressed in order to reduce health disparities via preventive health measures. Similarly, the treatment of dental caries, a preventive service that is available to all persons with incomes below poverty, is an area in which preventive services are disparately utilized. For example, 39.8% of Caucasians with income below the federally defined poverty line have untreated dental caries but 54.1% of African Americans have untreated dental caries.[25,26] Yet, studies have shown that obtaining the right preventive care such as cancer screenings, vaccines, etc., is one of the best ways to preserve one's health. One objective of the Affordable Care Act is to ensure that both public and private insurances not only provide preventive care services including regular checkups and cancer screenings as well as other preventive services, but that greater monitoring is provided so that patients will be motivated to use these services. Such changes can greatly benefit over 41 million minorities since African Americans, Hispanics, and other minorities are less likely to have access to the care they need.

The Affordable Care Act

The new health policy framework is seeking to create improvements in access to quality healthcare, particularly in underserved communities. Importantly, the Affordable Care Act also increases funding to community health centers that provide quality healthcare services. In 2009, more than half of the patients who were provided services through community health centers were minorities. In addition, the healthcare law calls for innovative strategies by community health infrastructures to manage chronic disease. This is also particularly important for African Americans who experience higher rates of illness and death from diseases such as diabetes, heart disease, kidney disease, cancer, and other chronicities. For example, physician-diagnosed and undiagnosed prevalence rates of diabetes mellitus are approximately 55.1% higher for African Americans than for Caucasians.[27] Similarly, stroke prevalence rates are 56% higher in African Americans than within Caucasian communities.[28] End-stage renal disease rates are 218.9% higher for African-Americans than for their Caucasian counterparts.[29]

The Affordable Care Act also expands initiatives to increase diversity in the healthcare professions and also strengthens cultural concordance through training to healthcare providers. This is important since some research indicates that health outcomes may be superior with culturally concordant providers. This new healthcare law is also ending the discriminatory practice of insurance companies against patients who have pre-existing conditions. Thus, those with HIV/AIDS, diabetes, asthma, and/or other conditions will not be excluded from coverage or charged a higher premium. Again, these measures help reduce health disparities since African

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[23] *ibid*

[24] *ibid*

[25] *CDC/NCHS, National Health and Nutrition Examination Survey*

[26] *Dye, B.A., Barker L.K., Li, X., Lewis, B.G., Beltrán-Aguilar, E.D. Overview and quality assurance for the oral health component of the National Health and Nutrition Examination Survey (NHANES), 2005-08. Journal of Public Health Dent. 2011 Winter;71(1):54-61.*

[27] *Calculated from data from CDC/NCHS. National Health and Nutrition Examination Survey*

[28] *Calculated from data from CDC/NCHS, National Health Interview Survey*

[29] *Calculated from data from the United States Renal Data System, USRDS2012 Annual Report, see http://www.usrds.org/reference.htm*

Americans are disproportionately represented among such patients. For example, 16% of African American children but only 8.2% of Caucasian children currently have asthma. Thus, African American children have asthma 95.1% more often than Caucasian children.[30]

Beginning this October, more than 27 million racial and ethnic minorities will be able to access coverage through the new health insurance marketplaces. Through the State Exchanges and a system of Navigators, Americans will be able to compare different health plans, shop for affordable insurance options, discover whether they qualify for a free or low cost plan, and, in some cases, tax credits that will lower the cost of their premiums. The Office of Minority Health has been assigned the task of providing leadership in enrolling over 27 million racial and ethnic minorities in healthcare. The Office of Minority Health has now existed for 28 years. The same types of leaders who were active in 1980 in establishing the Office of Minority Health are replicated in the leaders who head this office today.

The Role of the Office of Minority Health

The mission and the function of the Office of Minority Health involves a number of key priorities. In 1985, the Secretary's Task Force was established to address minority health. Out of that effort, the Office of Minority Health was created. Thus, it has been in existence for over 28 years. The Office of Minority Health has five key functions. It funds research; demonstrations and evaluations; awareness campaigns; develops policies, programs, and practices; collects and archives disparity data; and creates and supports partnerships that seek to reduce health disparities. Awareness involves increasing knowledge and understanding of the major health areas in which disparities exists and the needs of racial and ethnic minorities in this area.

It is also important to note that the Office of Minority Health not only seeks to track and define disparities between and across racial/ethnic groups, we seek to identify all disparities. For example, we know that from 1997-1998, 3.1% of Caucasians and 4.0% of African Americans reported experiencing serious psychological distress. However, by 2009/2010, the percent of Caucasians reporting serious psychological stress had started an upward trend by reaching 3.2% while the proportion of African Americans experiencing serious psychological distress had dropped to 3.8%.[31] Although none of these changes are statistically significant, our Office would like to understand the cause of these changes. We know that in 2009, Caucasian youth (10.5%) in grades 9-12 were 34.6% more likely to have considered suicide than an African American youth (7.8%). We also know that a Caucasian youth (29.3%) was 39.5% more likely to have carried a weapon than an African American youth (21%). Thus, despite our name, our Office monitors all health disparities. In particular, our data focus involves promoting the collection of health data by racial and ethnic categories so that disparities can be identified. Our partnerships are established to strengthen community, political, and other partnerships and networks across America. Our policies and programs also support the growth of new and innovative approaches to addressing racial and ethnic disparities. Research, demonstrations, and evaluation is another key function. For example, we conduct highly sophisticated data analysis. This work is critical as a basis for improving ethnic and minority health.

The economic consequences of health disparities, that is, the combined economic consequences of disparities have been estimated to equaled alone over 1.2 trillion dollars from 2003 to 2006. Eliminating health disparities have thus far reduced the direct amount of medical care expenditures by over 229 billion dollars. Between 2003 and 2006, 30.6 million dollars was

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[30] *CDC/NCHS, National Health and Nutrition Examination Survey, op. cit.*

[31] *CDC, National Health Interview Survey, op. cit.*

spent on direct medical care expenditures for African Americans, Asians, and Latinos as excessive costs due to health inequities.

Currently, the Office of Minority Health has three key priorities. First, our Office seeks to support the development and implementation of the provisions of the Affordable Care Act. The Office of Minority Health currently serve as the lead for the Affordable Health Care action plan to reduce racial and ethnic disparities. The Office also coordinates the national partnerships for action to end health disparities, and for achieving health equity.

As mentioned, the Affordable Care Act has ended insurance practices that had the impact of excluding large segments of Americans from healthcare. It is helping to make health insurance more affordable. It is strengthening our Medicare and Medicaid programs, and it is providing better health coverage for all Americans. For example, based upon the Office of Minority Health's latest data, an estimated 5.5 million African Americans now have private insurance and have gained access to preventable services with no cost-sharing. More than 900,000 Latino youth have gained health insurance. More than 867,000 elderly and disabled Asian Americans and Pacific Islanders have received health coverage.

Similarly, the permanent reauthorization of the Indian Healthcare Improvement Act was passed. In June 2012, $128 million dollars were awarded to Community Health Centers to continue to provide needed care to vulnerable populations. The National Health Services Corps has more than tripled its numbers. It is currently up to 10,000 members. The Health Resources and Services awarded over $23 million dollars in grants to over 37 centers to provide training to community health workers. The CDC has provided $25 million to support fellowship programs. The Office of Minority Health, through Affordable Care Act, has also established six Offices of Minority Health throughout Health and Human Services. This Act has also elevated the National Center for Minority Health to the status of an NIH Institute rather than merely an office. This Act also mandates a report to Congress on minority health. It also established national data collection standards by race, ethnicity, sex, primary language, and disabilities so that disparities can be identified. As mentioned, the Office of Minority Health is charged with the Health and Human Services Disparities Action Plan. Thus, like NMA and its partners, we envision a nation free of disparities with healthcare for all. To achieve this goal, the Plan includes strategies to transform health; strengthen the nation's health and human infrastructure and workforce; advance health, safety, and overall well-being for the American people; advance scientific knowledge and innovation; and increase transparency and accountability throughout all of HHS' programs and initiatives.

The other primary focus of the Office of Minority Health is creating a national partnership and action. This partnership will be mobilized nationwide using comprehensive community approaches that can combat disparities. HHS alone cannot eliminate disparities. Thus, HHS is seeking partners that can help address the five primary goals of increasing awareness, providing leadership, designing health systems and life experiences, increasing cultural and linguistic competency, and expanding health disparities, data research, and evaluation. This partnership involves 2000+ leaders who have come together and established five primary goals to guide an action agenda.

The NPA includes four major components. It includes a federal inter-agency health equity team that is composed of twenty HHS offices and twelve departments across the federal government, including housing, transportation, veterans, etc. The goal of this health equity team is to identify opportunities for federal collaboration and partnership. It will also coordinate actions and efforts to address health equity issues across the nation. The infrastructure also includes ten regional Health Equity Councils throughout the US. These ten Regional Health Equity Councils are located in the public health service regions. Another aspect of the infrastructure includes State Offices of Minority Health. Approximately six state partnership grantees have also been funded. More than 900 national partners have joined this partnership to reach the NPA's goals and strategies. This effort also includes a National Prevention Strategy that was created under the Affordable Care Act. This consists of 17 Federal Departments, agencies, and offices. It is chaired by the US Surgeon General. The Office of Minority Health has partnered with Centers for Medicare and Medicaid Services to conduct a nationwide campaign to ensure that 27 million racial and ethnic minorities are enrolled in the new insurance marketplaces. Towards this goal, the Office of Minority Health and CMS just launched the first webcast to increase the number of stakeholders and over 300 stakeholders joined that call. These stakeholders include community-based organizations, faith-based organizations, nationally based organizations, and other. National Minority Health Month has been established as well. The 2013 theme is "Advancing Health Equity Now" by uniting communities to bring healthcare coverage to all.

Summary

Chapter 1 defined the concepts of health disparities and health equity and provided a brief sample of areas in which healthcare disparities continue to exist. Chapter 2, however, demonstrated that continual research and the application of strategies that reflect that research are critical because of the complexity of the health disparities issue. Chapter 2 utilized HIV as a case study that demonstrates these complexities. In contrast, Chapter 3 confirms that organized efforts to improve healthcare are successful. It also describes the work of the Office of Minority Health as the county's leader in health disparities reduction. Integrated into this discussion was an overview of the Patient Protection and Affordable Care Act as a major policy change that provides a framework for decreasing health disparities. The next chapter looks in greater detail at this law, its potentialities, and areas of fragility.

Chapter 4
Using the Patient Protection and Affordable Care Act to Reduce Disparities

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National Medical Association

Overview

The primary framework in which NMA and its partners will be able to decrease health disparities is within context of the Patient Protection and Affordable Care Act. Table 1 summarizes key elements of this Act.

Table 1: Key Elements of the Patient Protection and Affordable Care Act
Cost:
• The costs of this measure is an estimated $940 billion.
Deficit:
• Preliminary analysis suggests that the deficit will decrease by $1.2 trillion dollars within the 20 years of the implementation of the Bill.
Coverage:
• Based upon the current number of uninsured persons, more than 32 million Americans who are currently uninsured would receive coverage.
Health Insurance Exchanges:
• Through outreach and education, state-based Exchanges are making insurance subsidies available to individuals and families with income from 33 percent to 300 percent above the poverty level.
• Exchanges have also been established for small businesses to purchase coverage for their employees.
Subsidies:
• In addition to Medicare and Medicaid, subsidies are available for persons whose incomes are above the poverty line but no more than 300% above poverty. Only persons who do not have insurance eligibility through public sources or their employment may receive these subsidies.
(The Federal Poverty Level for family of four is $22,050)
Paying for the Plan:
• For the first time, higher income persons will pay a Medicare Payroll tax on their investment income - a 3.8 percent tax on investment income for families making more than $250,000 per year ($200,000 for individuals).
• Excise Tax - Beginning in 2018, a 40 percent excise tax will be levied on high-end insurance plans worth over $27,500 for families ($10,200 for individuals). Dental and vision plans will not be included in the $27,500.
• Tanning Tax - a 10 percent excise tax on indoor tanning services will be collected.
Medicare:
• The Medicare prescription drug "donut hole" problem will be eliminated by 2020. Seniors who are involved in the donut hole will receive a $250 rebate.
• These seniors will also receive a 50 percent discount on brand name drugs. The Bill also includes $500 billion in Medicare cuts over the next decade.
Medicaid:
• Persons with incomes 33% above the federal poverty level (which is $29,327 for a family of four) are now able to receive Medicaid.
• Childless adults can also receive Medicaid beginning in 2014.

Table 1: Key Elements of the Patient Protection and Affordable Care Act
• The Federal Government will pay 100 percent of the costs for covering the newly eligible individuals with incomes 33% above poverty until 2016.
• Illegal immigrants are not eligible for Medicaid.
Insurance Reforms:
• Insurance companies may no longer deny children and youth coverage because of a preexisting condition.
• By 2014, insurance companies may not deny coverage to anyone with preexisting conditions.
• Insurance companies are required to permit children to remain on their parent's insurance plans until they turn 26.
Abortion:
• Individuals who pay for abortion coverage must make separate payments with private funds being kept in a separate account from federal and taxpayer funds.
• No health care plan is required to offer abortion coverage. States may pass legislation choosing to opt out of offering abortion coverage through the Exchange.
Individual Mandate:
• By 2014, everyone in the country is required to buy health insurance or face a $695 annual fine. Low-income people may receive coverage through Medicaid.
Employer Mandate:
• Only employers with more than 50 employees are required to provide health insurance or pay a fine of $2000 per worker each year if any worker receives federal subsidies to purchase health insurance. Businesses with less than 50 employees may receive subsidies through the Small Business Exchange if they select top provide insurance.
Immigration:
• Immigrants without a green card cannot purchase insurance through the Exchange.
Other numerous other measures are also included.

The Patient Protection and Affordable Care Act: Understanding Its Potential

As mentioned in the last chapter, this highly controversial and complex law literally provides an opportunity to make affordable care accessible to at least 30 million persons within the next few years. However, in order to maximize outcomes from this Act, it is necessary to transform healthcare from a seller's market into a buyer's market. By doing so, consumers rather than healthcare providers will acquire market power. But, this power cannot be actualized unless partnerships such as this one educate consumers so that they can accurately compare health plans and their services. Consumers must not only know how these plans differ in price, but how they differ in quality as well. Even more importantly, consumers must be trained to reward plans that serve their needs and achieve positive outcomes through continued enrollment. However, those providers who do not distinguish themselves through improved health outcomes for consumers must be replaced during the next open enrollment period.

The primary barrier to gaining market power is knowledge. For example, consumers generally know the market for automobile repairs. If one business is running a special, one may pay $19.99. If another seller charges $100 dollars for an oil change, consumers, whether they're driving a Porsche or another car, know and understand prices and services. This is not so in healthcare. In healthcare, many consumers do not yet have the knowledge base to operationalize their market power. The task of comparison shopping is extremely difficult for even those in the healthcare profession. One reason is that prices in healthcare are opaque and not transparent. Consumers know that, depending upon provider, prices vary tremendously. The Affordable Care

Act seeks to change that dynamic. Measures are currently underway that, if successful, will enable the market to move from the sellers as the group with the most leverage, to consumers having far more of the leverage. As a result of this and other severe changes, although the Bill was signed into law in March, 2010, it has survived a multiplicity of challenges. However, even those who were once opponents must now accept the fact this is the law of the land and that its worth can be enormous.

Even in the absence of this newest healthcare reform measures, a fundamental truth that must be understood is that change was very much needed. Specifically, change was needed because, as mentioned in Chapter 3, healthcare expenditures are higher than in any other country but the life expectancy rates of our citizenry is only the 51st highest in the world. America spends one sixth of its Gross Domestic Product on healthcare. Yet, one out of six Americans receive no healthcare. The United States is the only economically affluent country in the world where this is the case. Every other advanced country in the world does ensure coverage for all of its citizens. Additionally, other countries typically spend only half of what the United States spends per capita. Indeed, currently, the United States has per capita healthcare expenditures of $7,000 per person per year while still not providing access to one in six Americans. If aggregated, America's uninsured population equals the population of the country's 25 smallest states.

The Affordable Care Act seeks to remediate such circumstances. Thus, there are variegated reasons why every person seeking to remediate health disparities should invest time in acquiring detailed knowledge of the new policy framework whether driven by economic, policy, or moral motivation. For example, from the viewpoint of the economy, one may argue that healthier citizens are more productive. From a financial perspective, it can be argued that unpaid medical bills are now the number one cause of personal bankruptcy in this country. Thus, for many, the dual pressures of illness and bankruptcy coexist. Additionally, the 77 million+ baby boomers who are turning 65 require that the Medicare system remain strong enough to absorb the numbers while remaining solvent. The Affordable Care Act, as the law of the land, provides an opportunity to reduce health disparities through improved access and decreased costs.

Step One in Reducing Disparities: Enrollment

In order to activate these opportunities, as many persons as possible must participate in open enrollment so that they obtain coverage through the mechanisms available through the Affordable Care Act. Open enrollment begins on the first of October this year. This open enrollment resembles the open enrollment process currently used by managed care plans. Between October 1st and the 1st of January, those who qualify for Medicaid or who qualify for services through the Health Insurance Exchange, must select a plan and enroll.

As this description indicates, this Bill will reduce health disparities by allowing access to health insurance by all Americans. It will allow the poorest of the poor as well as the near poor, who didn't before qualify for Medicaid, to enroll in this public health plan. For those who do not qualify for Medicaid because their income is more than 33% above poverty, buying into the Health Insurance Exchange is an option. Thus, the Exchanges are a marketplace that will operate like Expedia, Orbit or Priceline for it will allow consumers to engage in comparison shopping. It is a marketplace that is designed by the State or by the Federal government that allows ordinary consumers to purchase insurance.

As mentioned, those who don't qualify for Medicaid can buy insurance through the Exchange with a public subsidy. Open enrollment begins on October 1, 2013. Enrollment is from October 1st until the first of January. On January 1, 2014, coverage will begin. However, coverage has already begun for certain categories of consumers, i.e. young people who can be placed on their parents plan; youth who have pre-existing conditions, and others. In addition, insurers must now spend between 80 and 85% on healthcare rather than the 70% spent in the past. This requirement will, overtime, reduce costs and/or improve quality. Medicaid for example, spends 90% or more of expenditures on direct care.

How the New Law is Being Implemented

Implementation of the Affordable Care Act is occurring on a state-by-state basis. At the top level, the federal government does assume a major role in the implementation process. However, actual implementation has been relegated to the States if they choose to accept the responsibility. That is, States had to decide whether they were going to design and operate their own Exchanges, work in partnership with the federal sector, or allow the federal sector to come into their State and establish the Exchanges. As would be expected, some states have begun their outreach process, others are complaining, while others remain in the very early phases of implementation. Stakeholders must pay attention to their own state's approach. For example, Maryland and California are both states that have taken the initiative to not only expand Medicaid, but to build their own health insurance exchanges. These states are advanced in their implementation effort. In some respects, this is a perfect time for involvement by stakeholders.

Community advocates, health advocates, groups who have constituencies, participants in the Summit, and other stakeholders can help prepare their membership for enrollment in the exchanges through outreach and education. The White House website at the Department of Health and Human Services, Healthcare.gov, delivers the official word on everything concerning the Affordable Care Act. It includes fact sheets about what the Affordable Care Act will mean for African American consumers. It informs readers that an estimated 3.8 million African Americans who would otherwise be uninsured will gain coverage by 2016. As mentioned, individuals with higher incomes will be able to purchase subsidized coverage from the exchanges. Additionally, this law triples funding to train African Americans to become physicians or healthcare professionals. Funding is also available for investments in data collection and research. As mentioned, funding for community health centers has increased in all fifty states. These resources are available to be used to educate the constituencies of stakeholders.

The Exchanges are actively seeking individuals and groups to provide education. Many resources exist to support stakeholders in conducting outreach and education to African Americans so that they will be able to access insurance under the Affordable Care Act. For example, CMS, the government agency that runs Medicaid and Medicare, and Office of Minority Health, the agency that addresses minority health for the federal government, will both provide materials for dissemination.

As mentioned in the previous chapter, the Affordable Care Act creates new Offices of Minority Health in all of the healthcare agencies in the federal government. Resources are also available through NMA. Non-partisan health data available from the Kaiser Family Foundation can be used in helping to refine your organization's knowledge. Budget data and analyses are available from the Center for Budget and Policy Priorities. Enrollment information is available from Enroll America, a non-profit which has been established to help individuals enroll in the Exchanges. NMA has worked with this organization in creating an outreach and education system throughout the country. Families USA can also be helpful. Multiple non-profits and community-based organizations will also assist by making their own constituencies knowledgeable about how to enroll, and making them aware of available resources.

In order words, it is critical that those who wish to reduce health disparities begin immediately by providing information, education, training, and technical assistance to consumers and other stakeholders. Provide training that is specifically directed toward one-on-one counselors so that they can better counsel consumers. As a result, these persons will be uniquely positioned to disseminate accurate information through their in-person, telephonic, and other meetings with consumers and their families. Additionally, these one-on-one trainees can go into the community and disseminate information and education through presentations, displays, and media events and interviews. Their sole purpose will coincide with that of Patient Protection and Affordable Care Act – assisting uninsured and insured consumers. These one-on-one staff must, of course, receive unique training to be able to provide the needed education.

A customized curriculum can also be designed that directly focuses upon the revealed needs of those who are best served through one-on-one contact. The unique needs of consumers from different geographic areas must also be addressed in the training. For example, in areas with the largest proportion of residents who are uninsured with adverse health outcomes, the persons providing one-on-one counsel will require extensive training. In highly underserved areas, training will be required on how consumers can enroll in services when there are no contracted certified providers in an area. In areas with high diabetes prevalence rates, the education will require literature and discussions on how to access diabetic supplies. Other geographical areas served by the one-on-one counselors will also have both core and specialized informational needs.

- **Informational Materials That Can Be Used**

Again, an abundance of informational materials are available. For the most part, these materials can be selected from those available. Table 2 is a brief bibliography of some of the materials that are currently available.

Table 2: Center for Consumer Information and Insurance Oversight (CCIIO) Materials Available for Consumers

Fact Sheets for Consumers

- Affordable Care Act FAQs:
- September 20, 2010
  Affordable Care Act Implementation FAQs (Set 1)
  This set of FAQs addresses implementation topics including compliance, grandfathered health plans, claims, internal appeals and external review, dependent coverage of children, out-of-network emergency services, and highly compensated employees.
- October 8, 2010
  Affordable Care Act Implementation FAQs (Set 2)
  This set of FAQs addresses grandfathered health plans, dental and vision benefits, rescissions, preventive health services, and ACA effective date for individual health insurance policies.
- October 29, 2010
  Affordable Care Act Implementation FAQs (Set 4)
  This set of FAQs addresses grandfathered health plans.
- April 1, 2011
  Affordable Care Act Implementation FAQs (Set 6)

Table 2: Center for Consumer Information and Insurance Oversight (CCIIO) Materials Available for Consumers

This set of FAQs addresses grandfathered health plans.

- ♦ Consumer Support and Information
  - External Appeals
  - Summary and Glossary of Benefits and Coverage

Outreach and Education Resources

- ♦ April 7, 2011
  Consumer Fact Sheets
  - Adding Adult Children to Your Health Plan (PDF – English 178 KB, Spanish 89 KB)
  - Curbing Insurance Cancellations (PDF – English 170 KB, Spanish 63 KB)
  - Eliminating Dollar Limits on Your Benefits (PDF – English 184 KB, Spanish 104 KB)
  - Getting Value for Your Premium Dollar (PDF – English 172 KB, Spanish 104 KB)
  - Lowering Your Cost for Preventive Services (PDF – English 353 KB, Spanish 111 KB)
  - Protecting Children With Pre-Existing Health Conditions (PDF – English 252 KB, Spanish 450 KB)
  - Protecting Your Choice of Health Care Providers (PDF – English 219 KB, Spanish 94 KB)
  - Are You in a Grandfathered Health Plan (PDF – English 307 KB, Spanish 57 KB)

- ♦ April 7, 2011
  Consumer Posters and Brochures
  - State Consumer Assistance Poster (PDF – English 1 MB, Spanish 884 KB)
  - State Consumer Assistance Brochure (PDF – 2 MB)
- ♦ Health Market Reforms
  - Annual Limits
  - Coverage for Young Adults
  - Grandfathered Plans
  - Patient’s Bill of Rights
  - Prevention
  - Review of Insurance Rates
  - Student Health Plans

In some cases, stakeholders may need to engage in Materials Development if their review of selected materials reveal that the information is difficult to follow.

- **How Materials Can Be Disseminated**

When materials are disseminated to consumers, certain guidelines such as those below can be followed.

Table 3: How Materials Should Be Disseminated

A. Complete Research

■ Research regarding effective health information dissemination strategies for different demographic groups should be followed. A sample of consumer behaviors by key demographic variables which have implications for materials disseminated are included below.

Variable	Recommended Marketing Action
GENDER ➢ Women have become the major decision-makers in the area of healthcare.	➢ Target women to encourage them to urge the men in their life to participate in the Exchange.
INCOME ➢ Lower-income consumers engage in a shorter decision-making process before purchasing a good or service. ➢ Lower-income consumers tend to shop closer to home.	➢ Make it easy and simple for the desired actions to take place when the impulse occurs. ➢ It is important that the education materials disseminated are easily accessible by these incomes close to home.
AGE ➢ Research suggests that elderly consumers are more cautious than younger consumers.[32] ➢ The elderly feel younger than they are.[33] ➢ Courteous treatment and personal assistance are service elements that are important to older patients.[34]	➢ The process of disseminating materials to older consumers and their families may be longer and more education will probably be needed to encourage this age group to enroll. ➢ Materials disseminated for this effort should portray the older persons as younger. ➢ These elements will be basic components of all aspects of the dissemination plan.
RACE/ETHNICITY – Latinos ➢ Nationwide, 82 percent of Latino households speak Spanish. ➢ Latino consumers are particularly offended if Spanish translations are incorrect. ➢ More than 80 percent of Latino households listened to Spanish language T.V. and radio. ➢ Latinos prefer Spanish-speaking providers. ➢ A sense of nostalgia helps create an important connection with the Latino consumer with regard to smells, sights, colors, etc.[35]	➢ Spanish language materials must be disseminated to Spanish-speakers. ➢ Professional translators may be used. ➢ Materials must be disseminated through Spanish media to target this market.

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[32] *Cole, Catherine A. and Sirk K. et al. "Age Differences in Consumer's Search for Information: Public Policy Implications," Journal of Consumer Research. Vol. 20 (June 1993), pp 157-169.*

[33] *Sandor, Gabrielle. "Attitude (Not Age) Defines the Mature Market." American Demographics. January 1004, pp. 18-21.*

[34] *Bernhardt, K.L. and Kinnear, T.C., "Profiling the Senior Citizen Market," Advances in Consumer Research. Vol 3. (Ann Arbor, MI: Association for Consumer Research, 1976) pp. 449-452.*

Table 3: How Materials Should Be Disseminated

➢ Different strategies are sometimes required by each group of Latinos.	➢ Special dissemination strategies will be needed. ➢ Materials should reflect the sights and colors of Mexico and other homelands. ➢ The program should use Latino providers in order to disseminate materials.
RACE/ETHNICITY – African Americans ➢ While approximately 80% of African Americans speak dialect, its use in materials dissemination should be limited.[36] ➢ While rap music is popular among lower-income African Americans, the middle income group often responds negatively to the use of rap. ➢ About 25% of African Americans prefer an African American provider. ➢ One research study revealed that *Black Enterprise*, *Ebony*, and *Essence* were identified as some of the most trusted black print media.[37]	➢ Media advertising to African Americans should make limited use of AAVE (African American Vernacular English). ➢ Rap should not be used in this promotion. It is not consistent with a market that includes older African Americans. ➢ Stakeholders may wish to use culturally and gender similar staff. ➢ Places where Black Enterprise, Ebony, Essence are disseminated should be targeted for program coverage.

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[35] *Nielsen as cited in Hispanic business.com 9/24/07. See http://www.hispanicbusiness.com/news/2007/9/24/ nielsen_reveals_hispanic_consumer_shopping_behavior.htm.*

[36] *Escalas, Jennifer, "African American Vernacular English in Advertising: A Socio-linguistic Study," Advances in Consumer Research. Vol. 21, Chris J,. Allen and Deborah Roedder John eds. (Provo, UT; Association for Consumer Research, 1999) pp. 294-301.*

[37] *Ashanti et al, Advertising in Black Magazines Do Advertisements Reflect African American Consumer Behavior? Services Marketing Quarterly. Vol. 27, No.2, 1/10/2006.*

Table 3: How Materials Should Be Disseminated

RACE – Asian Americans	
➢ In 2005, Asian Americans 63% attended community events.[38] ➢ Print media is ranked higher than other types of media (radio, TV) across all ethnic segments of Asian Americans.[39] ➢ However, Filipinos and Koreans watch television at higher rates.[40] ➢ Radio is popular among Vietnamese and Chinese.[41] ➢ More than 50% of American Asians visit ethnic web portals/sites seeking information.[42]	➢ Stakeholders can sponsor cultural events for this population. ➢ Print media should be disseminated for this ethnic segment. However, other types of media can also be used. ➢ A PSA can run on Korean television in each market. ➢ Radio PSAs should be concentrated in Vietnamese and Chinese markets. ➢ Web portals are effective disseminating information to this group.

Other guidelines can also help stakeholders be more effective in their outreach and education. Table 4 outlines other guidelines that can guide the dissemination of information.

Table 4: Other Notes on Dissemination Strategies

A. Create Dissemination Plans for Each Targeted Geographic or Socio-Economic Group of African Americans

Utilizing the research, prepare communication plans that outline when each informational item collected will be released and to which audiences. A catalogue of all materials with the release time should be completed.

B. Monitor materials use after dissemination

Continual monitoring must used to ensure that each stakeholder group is responding. Data from the web portal should be reviewed on a daily basis.

C. Conducting Materials Dissemination

Utilizing the Dissemination Plans, carefully plan information dissemination outreach so that it serves as an introduction and follow-up to the enrollment referral and outreach efforts.

- Develop a Web-Based Program for Materials Dissemination

Develop the web-based program to serve the various customer service segments/stakeholder groups. Materials can be placed in the web portal.

- Section 508 Compliance

Independently of the type of materials disseminated, ensure that it is equally available to people with and without disabilities.

Summary

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[38] *Intertrend Communications, Inc., Study on Asian American Consumption Trends: interTrend's Knowledge Center Unveils Results of a Recent Study that Sheds Light Onto Asian American Trends and Insights. Internet article at www.aaja.org/news/community/2005_11_04_1/.*

[39] *Ibid.*

[40] *Ibid.*

[41] *Ibid.*

[42] *Ibid.*

This monograph began with an overview of the concept of health disparities and a brief description of healthcare disparities in terms of mortality. One area of high disparities in mortality rates. HIV was selected and reviewed as a case study of how to use research to design disparity-reducing implementation strategies in Chapter II. Chapter III introduced the Office of Minority Health and described how the implementation of the Affordable Care Act can be used as a tool for disparity reduction. Chapter IV continued reviewing the Affordable Care Act and its potential for addressing disparities. Chapter IV also described resources available for outreach and education to African Americans and others through the Center for Consumer Information and Insurance Oversight (CCIIO) and other variables. In Chapter V, the author discusses perceived limitations to the use of the Affordable Care Act as a tool for health disparity reductions.

Chapter 5

Perceived Challenges to the Use of the Affordable Care Act As a Tool for Health Disparity Reduction

By Dr. Michael A. Lenoir
President-Elect,
National Medical Association

Overview

As the President-Elect of the National Medical Association, past president of the National Association of Physician Broadcasters; and Medical Editor for CBS radio, it is clear that a major task in maximizing the Patient Protection and Affordable Care Act as a framework for disparity reduction will be the quality of the health communications that is presented to the targeted groups. In order to reduce communication "noise" in the materials developed and disseminated to both community residents and stakeholders, it is necessary to explore current perceptions regarding this Act. This chapter summarizes some of the views of Summit participants regarding the type of concerns that may need to be addressed so that they will not impede aggressive participation in the processes of outreach, education, and enrollment of various segments of the African Americans uninsured into healthcare plans through the Exchanges.

As emphasized in Chapter 4, despite anticipated glitches, despite the litany of complaints that have accompanied this current reform measure, this measure may offer a major opportunity for the improvement of healthcare to approximately 30 million persons. As Chapter 4 also suggests, in spite of the glitches, in spite of the policy areas in which this new law may elevate and not reduce costs, in spite of the urges of some stakeholders to refuse federal dollars base on ideological rationales, in spite of the conclusion that some African American physicians may earn less money while experiencing a greater burden of care, NMA and its partners agree that the strategic application of this law can begin to reduce disparities. Indeed, benefits are already observable. The Center for Medicare and Medicaid Services, Office of the Actuary, compiled data from various sources and found that the average annual increase in healthcare expenditure from 1960-2009 was 9.6%. For example, since the passage of this Bill, the growth in healthcare inflation in the United States in the last two years has decreased. Indeed, the consumer price index for healthcare increased from 364.1 to 388.4 - a change of 6.67%. Some evidence that also indicates more Americans are now accessing preventive care, more seniors can now afford their drugs, more young people no longer use the ER for routine care thereby reducing quality and pressure on emergency room systems, and generally, more Americans are accessing care. Thus, the law is working.[43] Perhaps it is not performing ideally, but the law is working thereby creating an opportunity for concerned stakeholders to step in and make it perform even better. Nevertheless, it becomes helpful to ask, “What are the ongoing perceptions regarding limitations of the Affordable Care Act?” Second, one must ask, “What are perceptions regarding the ability of this Act to address disparities in the health of African Americans?”

Perceptions of the Affordable Care Act

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[43] *Pourat, N. et al, (2012) “In Ten California Counties, Notable Progresses in System Integration within the Safety Net, Although Challenges Remain.”* *Health Affairs, 2012 August 31(8): 1717-27*

Based upon the discussions at the Summit, one concern of the public is the political concessions that are incorporated into the Bill. The Affordable Health Care for America Act (or HR 3962) was first introduced into the House as HR 3962 on October 29, 2009 by Representative John Dingell, a Democrat from the State of Michigan. This Bill rapidly moved through various Committees and was passed by the House on November 7, 2009. This Bill was subsequently discarded and, on December 24, 2009, the Senate passed its own Bill, the Patient Protection and Affordable Care Act.

It is interesting that while many persons consider the House as having made severe compromises in accepting the Senate version, the key aspects of the Bills differed in only three areas - public options, abortion coverage, and tax equity for domestic partners. However, NMA and its partners can assist in maximizing the outcomes possible through this Bill by doing that which is being done by the Summit - focusing marketing communications on access to care and other areas in which African Americans can unequivocally benefit. This is not to say that policymakers know the exact course that will be assumed. Yet, few can deny that this is a great step in terms of access to care. However, the many dynamics involved at the beginning of this process, requires that stakeholders actively advocate for their own constituencies. For example, organizations such as the National Black Church Initiative can do everything within its power to enroll every single African American into a health plan whether it is expanded Medicaid or a program represented by the Exchanges.

This is not to say that eliminating 100% of uninsured status will have the impact of ending health disparities. Yet, it is an important starting point. While much of the early aspects of health reform focused on the insurance industry in terms of changing underwriting habits and things of that nature, NMA and its stakeholders must begin monitoring the experience African Americans are having in terms of all of the various factors that impact their health and their ability to navigate the new systems so that health outcomes will improve. For example, new evidence is emerging regarding the differential genetic basis of some illnesses and diseases. Whether an oncologist or an allergist, all physicians concerned about disparities should track this research. Some researchers now argue that there may be a genetic basis for prostate cancer (Ledet et al, 2012).[44] All physicians should know this fact. Similarly, because African Americans use more prescription medications and fewer supplements than their Caucasian counterparts, African American physicians should routinely inquire of pharmaceutical sales representatives where clinical trial data revealed differences in outcome by race/ethnicity.

This suggests that as Exchanges construct side-by-side charts comparing the benefits of alternate health plans, NMA and its stakeholders may advocate for the inclusion of disparity-related performance data in key areas. In other words, some incentives may be needed to drive the configuration of the delivery system in certain directions. In particular, accountability for results in all health areas including disparity outcomes is needed. Because this accountability is not yet present, NMA and other Summit participants may wish to introduce strong standards of accountability for disparate treatment processes and outcomes. Data will be needed as this process evolves so that the trajectory of change and overall cost trends can be analyzed. The findings from this data will open up another cycle of refinements, evaluation, and assessment.

Thus, the organizations involved in the Summit must be proactive in defining the measures that will be used to assess outcomes and the analytical techniques that will be used to accurately determine the outcomes. Because some of the terms used to describe outcomes are

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[44] *Ledet, E.M., Hu, X, Sartor, O, et. Al., "Characterizations of Germline Copy Number Variation in High-Risk African American Families with Prostate Cancer". Prostate, 73(6): 614-623 doi: 10.1002/pros.22602.*

ambiguous, more rigid definitions are also required. For example, health providers are suppose to deliver comprehensive care. What does this term mean in terms of actual services? Is the insurance industry also excited about the Affordable Care Act and have they discussed what it means to diverse populations?

It appears that insurance companies are pleased that healthcare will be expanded for so many Americans. When considering that 30+ to 50+ million Americans are going to now have healthcare because of the law, all Americans appear to applaud this outcome. Relative as to "What's not included?" it appears that everyone is in a pattern of wait and see what happens. Yet, overall, an insured American population is a win/win for the public and the insurance industry.

Adjustments in services and costs may be necessary because there are differences in mortality and morbidity across diverse populations. Insurance companies will need to track the new risks assumed and provide health services to address the more complicated health issues that these new patients will embody. For example, data from the CDC/NCHS, National Health and Nutrition Examination Survey reveal that while no statistically significant differences exist in mean serum total cholesterol levels, mg/dL between Caucasian males (193) and African males (191), significant differences exist in other areas. For example, while hay fever and/or respiratory allergies among Caucasian children (19.4%) are higher than among African American children (15.1%)[45], the percent of persons with fair or poor health is higher among African Americans (14.9%) than among Caucasians (8.2%)[46]. Thus, these new enrollees will not merely require education about their care, education about how to access care, new types of health promotion will also be needed to encourage these previously unenrolled populations to make lifestyle changes.

Current and new technology, regular print information and other strategies can be used to transfer messages in a form that is compelling and easy to understand. More specifically, these messages should be delivered using language that does not exceed a fourth grade level so that the content can be understood. Because large numbers of enrollees will have chronic diseases that have progressed to later stages because they did not have access to care, a number of challenges will occur after the uninsured are enrolled and begin receiving care.

Another challenge that may occur was observable in the State of Tennessee. Tennessee conducted a pilot project that was extremely unique at the time. It was one of the first states to seek a waiver and enroll the Medicaid population in managed care. At the time, this was the largest transfer of public dollars to a private entity in the history of the state. The Medicaid program in Tennessee was valued at $3 billion dollars. The initial outcomes were remarkable. At baseline, Tennessee was at the top of the charts in terms of poor health outcomes i.e. hypertension, diabetes, obesity, or other chronic diseases. Similarly, the State ranked very low in terms of the number of people insured and other measures. As a result of managed care, all beneficiaries had a gatekeeper that ensured them access to healthcare through Medicaid. The outcomes revealed that the number of visitors to emergency rooms decreased. Care being provided in the physician's offices also rapidly accelerated. But one weakness of the program was in the area of reimbursements to the providers.

As one analyzes the Affordable Care Act, a parallel trend is observable. Under Medicare, this Act eliminated $155 billion dollars. Part of that budget included reimbursements to the

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[45] *CDC/NCHS, National Health Interview Survey*

[46] *CDC/NCHS, National Health Interview Survey, op. cit.*

providers. As a result, a number of states will not participate in the expansion. In particular, southern states are denying the Medicaid expansion. A similar pattern occurred in Tennessee. Nearly everyone was covered and had an insurance card but a shortage of providers who would accept the lowered payments occurred. Thus, NMA and its stakeholders may wish to ensure that those aspects of this Bill that supports medical education are maximized. Moreover, such measures are immediately needed. HBCUs may need to become involved in pipeline programs to begin anticipating the level of new demand. One hundred years ago, African Americans were 3% of all physicians. In 2013, African Americans remain 3% of all physicians. In addition, there are not enough African American Physician Assistants nor Nurse Practitioners or other healthcare providers. Even in the area of Health Administration, shortages exist. While the numbers of African American Health Administrators in major positions within insurance companies have increased, more are needed. Moreover, some community clinics now have a 9-month waiting list.

Again, NMA and its partners and stakeholders must become active forces in the recruitment of youth and young adults in STEM courses so that they will be positioned to choose the medical field. This suggests that Summit participants need to advocate for an expansion of funding for Physician Assistant training as well as Physician training. The Physician Assistant community includes educators and membership organizations. There is a project called Project Access in which Physician Assistants literally go into African American communities to speak with students in Junior High and High Schools about the Physician Assistant profession. As is known, Physician Assistants are not often discussed as a viable health career choice. When a young person indicates an interest in health, they are automatically directed toward medicine or nursing. However, a broader issue involves elevating the number of participants in the pipeline. Fewer African American students are now enrolling in Medical or Dental schools and/or in the other health professions. Nursing schools have fewer African American students. African American Medical School students are not able to obtain the residencies that they desire. Such pipeline issues will ultimately impact the kind of care received throughout the healthcare structure.

A number of researchers have advanced the case that culturally concordant providers improve quality and outcomes in diverse populations. However, admission committees are oftentimes challenged in recognizing that a particular candidate will add to the diversity of a medical or other class. Additionally, some admissions committee members are unfamiliar with the literature that demonstrates that diverse candidates are more likely to practice and serve a community that other students may not. In addition, such candidates may not add to the prestige of the school. Academic Deans are motivated to admit those students with the absolute highest grade point average. Such students support the school’s ranking on US News and World Report. There is tremendous pressure at one level for professional schools to demonstrate that they’re the best school. This position is further reinforced by the fact that medical schools do not want a potential legal challenge. Thus, there are strong incentives that can screen out diverse candidates from the pool of admittees. For those who are seeking to promote diversity, the race of the individual must be inferred. Thus, it is a challenge to identify, assess and admit African American candidates to professional schools.

In addition, a second challenge that is increasing in influence is the declining economic returns to a degree in some health professions with a particular emphasis upon Medicine. As is known, physician’s salaries continue to drop. In the year 2008, physician salaries averaged $190,182. Data from the Department of Labor indicates that physician salaries now average

$166,400. Indeed, the membership of NMA is disproportionately skewed towards physicians with solo practices and nurse practitioners. Moreover, it is in the neighborhoods with the greatest needs that physician salaries are decreasing. This creates discontent as physicians and healthcare providers struggle to provide for their families. Thus, there are major financial disincentives for entry into a healthcare profession.

However, current data do reveal that the returns to higher education in general remain high. Table 1 provides data on employment and earnings by education.

Table 1: Employment and Earnings by Education

	UNEMPLOYMENT RATES			**EARNINGS**		
MAJOR	**RECENT COLLEGE GRADUATE**	**EXPERIENCED COLLEGE GRADUATE**	**GRADUATE DEGREE HOLDER**	**RECENT COLLEGE GRADUATE**	**EXPERIENCED COLLEGE GRADUATE**	**GRADUATE DEGREE HOLDER**
AGRICULTURE AND NATURAL RESOURCES	7.0%	3.5%	2.4%	$32,000	$50,000	$65,000
SCIENCE- LIFE/PHYSICAL	7.7%	4.7%	2.2%	$32,000	$60,000	$87,000
ARCHITECTURE	13.9%	9.2%	7.7%	$36,000	$64,000	$71,000
HUMANITIES AND LIBERAL ARTS	9.4%	6.1%	3.9%	$31,000	$50,000	$65,000
COMMUNICATIONS, JOURNALISM	7.3%	6.0%	4.1%	$33,000	$54,000	$64,000
COMPUTERS AND MATHEMATICS	**8.2%**	**5.6%**	**4.1%**	**$46,000**	**$76,000**	**$91,000**
EDUCATION	5.4%	3.9%	1.9%	$33,000	$43,000	$56,000
ENGINEERING	7.5%	4.9%	3.4%	$55,000	$81,000	$100,000
LAW AND PUBLIC POLICY	**8.1%**	**4.5%**	**3.5%**	**$34,000**	**$55,000**	**$70,000**
SOCIAL SCIENCE	8.9%	5.7%	4.1%	$37,000	$60,000	$85,000
INDUSTRIAL ARTS	—	4.7%	—	—	$71,000	—
HEALTH	**5.4%**	**2.2%**	**1.9%**	**$43,000**	**$63,000**	**$81,000**
PSYCHOLOGY AND SOCIAL WORK	7.3%	5.9%	3.2%	$30,000	$45,000	$60,000
RECREATION	8.3%	4.5%	2.0%	$30,000	$50,000	$61,000
ARTS	11.1%	7.1%	6.2%	$30,000	$46,000	$55,000
BUSINESS	7.4%	5.3%	4.4%	$39,000	$63,000	$84,000

Source: Georgetown University Center on Education and the Workforce. Hardtimes "College Majors, Unemployment and Earnings: Not all College Degrees are Created Equal"

Thus, it may be necessary for NMA and other stakeholders to educate students within the pipeline regarding the economic returns to STEM subject matter in general with a focus upon health. Ultimately, however, the recruitment of youth into medicine or health must be based upon the notion that there is value in working in the helping professions. For example, the focus now is on training general family practitioners. Efforts are also underway to bring their reimbursements up to the rates received by specialists. There are, of course, discrepancies between what specialists earn and what primary care providers earn. However, a contrariety exists. The new reformed healthcare system will require more primary care providers. This includes not merely physicians but, nurses, physician assistants, and others. However, the marketplace rewards scarcity. Thus, because specialists are more scarce, it becomes difficult to force equality of earnings between primary care physicians and specialists. Thus, youth must enter into the pipeline to become a physician because that's what they want to do. Yes, one must justify the costs, of a medical education. Likewise, it is reasonable to expect to be able to pay off the associated educational loans. But, ultimately youth must like the field and say, "This is what we want to do." A new workforce of health professionals will be much more committed to thrive during the entire process of debt and training when driven by personal desire rather than financial priority. Relatedly, however stakeholders may need to play a role in opening up opportunities for current students to obtain the residencies that they need. This too, is quite a challenge.

Other challenges to using the Affordable Care Act as a tool for disparity reductions also exists. Preliminary to NMA and its stakeholders using these reform measures to address disparities, is the need to know the contents of this Act. A recent lecture to a group of physicians at the American Academy of Allergy revealed widespread illiteracy regarding this Bill. Simple terminology lifted from the Act such as the concept of a medical home appeared foreign to the participants. This trend is not uncommon. While physicians are intense consumers of research and data that affect their practice of medicine, they oftentimes fail to involve themselves in the area of health policy. Therefore, there is a need to educate physicians and other stakeholders so that they will know how to utilize this new law to effect change.

Indeed, even those who are expert in communications are still seeking to fully grasp the various components of the Bill. Thus, NMA and its stakeholders and partners must first learn more about the Affordable Health Care Act. It is true that while many stakeholders know some of the basics, the full Act has not yet been fully absorbed. It must be disseminated and made a part of everyday people's lives and of the lives of NMA's stakeholders. NMA can assist stakeholders in digesting and absorbing information and determining the best way to disseminate the findings. Some research indicates that the percentage of the public who really know what the Affordable Care Act is may be low.

In reviewing some of the challenges to the task of using the Affordable Care Act, it is also necessary to remind the public of clear benefits of interest to this legislation. Again, it will allow millions of uninsured Americans to obtain access to healthcare. This area alone is a major accomplishment. This new law also supports preventive measures such as being screened, and being able to access screenings. However, once enrolled, we must make sure African Americans use the benefits. For example, data from the CDC/NCHS, National Health Interview Survey reveals that 13.1% of Caucasians with Medicaid eligibility and 14.2% of African Americans with Medicaid eligibility had made no healthcare visits to a physician's office or clinic for their children within the past 12 months. Likewise, 52.7% of Caucasians but only 40.0% of African Americans 18 and over had received an influenza vaccination in 2010 (the latest year for which were available.)[47]

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[47] *CDC/NCHS National Health Interview Survey*

This suggests that healthcare providers are merely one-half of the equation that is needed in order for the Affordable Care Act to have the maximum impact upon disparities. Consumers and patients are the other half.

Embedded in the Affordable Care Act is a new model that attempts to address the needs of consumers before they become sick. Therefore, this Action Agenda must involve strategies to incentivize consumers to use the system so that their healthcare is improved. Additionally, physician outcomes improve when patients and consumers are adherent. Thus, intensive interventions are needed in order to develop a basis for a campaign to promote improved self-management as a strategy to reduce currently observed health disparities.

The self-management of diabetes is an excellent case in point. Okosun, Glodener, and Denver, in a study of Caucasian and African American women with diabetes, discovered that diabetic African American women engage in higher risk behavior than diabetic Caucasian women. Therefore, it is less than surprising that their diabetes rates are higher and that the disease progresses more rapidly.[48] African American females were less likely to have been diagnosed with diabetes. African American women who had been diagnosed with diabetes had a 25% probability of smoking and a 58% chance of being physically inactive. Such data reveal a profound need for greater self-management education. Other researchers have also confirmed poor self-management behaviors among racial/ethnic group members who have diabetes.[49] Bonds et al. (2003), using data from the Insulin Resistance Atherosclerosis Study, revealed that African Americans are significantly more likely to experience poorly controlled diabetes as measured by HbA(1c) tests with values >8% Latinos as well as African Americans with diabetes had rates of uncontrollable hypertension that were significantly higher than their Caucasian counterparts.

Self-management is needed in the area of substance use since substance use is a risk factor for diabetes. Some researchers have found that recent substance use is higher among populations experiencing health disparities.[50] Children who belong to populations experiencing health disparities have a greater prevalence of diabetes and hypertension. More aggressive involvement in the parental management of diabetes and its related disease, hypertension, is needed.[51] Indeed, Baumann, Chang, and Hoebeke (2002) argue that adverse lifestyle factors are so dominate among these populations that the efforts of providers to manage such conditions are compromised.[52]

Thus, it becomes even more important to campaign for improved consumer cooperation in reducing disparities as the Affordable Care Act ushers in an era of new opportunities for disparity reductions. One of the factors, however, that can limit program's ability to advance through self-management is budget cuts. As is known, programs that have already been in place are now being cut. Thus, the Affordable Care Act is being implemented within the framework of budget cuts. One example that illustrates this point is that of a caretaker of an 85-year-old Aunt who was a nurse for 40 years. Despite very good benefits in addition to having Medicare, the

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[48] *Okosun, I.S., Glodener, M, Denver, G.E., "Diagnosed Diabetes and Ethnic Disparities in Adverse Health Behaviors of American Women,"* Journal of National Medical Association, *2003 July; #95(7):523-32.*

[49] *Bonds, D.E., Zaccaro, D.J., Karter, A.J., Selby, J.V., Saad, M, Goff, D.C. Jr., "Ethnic and Racial Differences in Diabetes Care: The Insulin Resistance Atherosclerosis Study." Diabetes Care, 2003 April #26(4):1042-1046.*

[50] *Buka, S.L., "Disparities in Health Status and Substance Use: Ethnicity and Socioeconomic Factors,"* Public Health Report, *2002: 117 Suppl. 1:S118-25.*

[51] *Sowers, J.R., Ferdinand, K.C., Bakis, G.L., Douglas, J.G., "Hypertension-related Disease in African Americans: Factors Underlying Disparities in Illness and Its Outcomes.* PostGraduate Medicine. *(2002) October; 112(4); 24-26, 29-30, 33-34.*

[52] *Baumann, L.C., Chang, M.W., Hoebeke, R., "Clinical Outcomes for Low-Income Adults With Hypertension and Diabetes,"* Nursing Research *(2002) May-June; 51(3):191-198.*

Aunt had a very good secondary insurance policy. However, budget cuts are now creating difficulties for her to adhere to her dialysis treatment schedule. This is because the handicap van, because of budget cuts, no longer runs on holidays although the dialysis center is open on holidays.

While such examples are probably numerous, such challenges do not foreclose the fact that while the Affordable Care Act may not be capable of closing the disparities gap, it does have the potential to narrow it. For example, a potential readmission for heart failure who doesn't have access to primary care, doesn't see a physician within 30 days, and doesn't get prescriptions refilled, would have a low chance of survival. As a result of the Affordable Care Act, institutions will allocate resources to address these needs because economic incentives will be in place for that patient not to be readmitted. Thus, despite budget cuts, opportunities exist to reduce disparities.

But, in order to maximize the possibilities inherent in this Act, stakeholders nationwide must immediately begin to prepare themselves. For example, while there are fewer physicians and other healthcare professionals, it is important to note that the supply of healthcare professionals varying widely by geographical area. For example, many African American physicians in patient care are clustered in the District of Columbia. Approximately 65 physicians per 10,000 civilian population practice in the District of Columbia. Nationwide, the rate is only 25.4.[53] Thus, there are 155.9% more physicians in the District than is the norm for the country. Howard University College of Medicine, Morehouse, Meharry, Drew, and other schools that train African American physicians may wish to direct them to areas of physician shortage. Likewise, the State of Mississippi, a state that is 37.3% African American has only 17.3 physicians per 10,000 civilian population. Georgia, particularly those areas outside of Atlanta has only 19.9 physicians per 10,000 civilian population. This suggests that over the short-run, it may be in the interests of African American physicians and the African American communities to support voluntary re-allocation so that a bottleneck does not occur as states with high rates of uninsured African Americans enroll these populations through Exchanges and through expanded Medicaid.

In addition, as these new populations obtain access to care, measured disparities may increase because of screening and diagnosis may detect untreated illnesses and diseases. In order to prevent healthcare facilities from resembling overfilled parking lots, it may be necessary for physician and other health professionals to expand their practices, convert their solo practices into group practices, increase their staff to include more nurse practitioners, physician assistants, and other staff, and integrate teams of trained community health workers into their practices to support prevention. Stated differently, the work of those who support health disparities reduction at this stage of the movement must involve "pushing the system" to achieve much. This can be achieved by: 1) engaging in outreach and education of providers and consumers; 2) training providers regarding how to best organize to serve the rapidly increasing patient loads; 3) case managing consumers to use the services by serving as the medical home for new caseloads of consumers; 4) coordinating screenings and diagnosis of these new enrollees; 5) using community health workers, family members and friends to support treatment compliance; and 6) collecting and analyzing data so that disparity improvements can be measured.

NMA and stakeholders can also review ongoing best practices. For example, Massachusetts has had a version of the Affordable Care Act implemented for several years and yes, a provider shortage has impeded progress. Additionally, the system have been difficult to

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[53] *See American Medical Association, Physician Characteristics and Distribution in the United States 2009-2011.*

serve populations that were uninsured who came into the system. Nevertheless, improvements have occurred. Tracking improvements is key to the concept of health disparities. In the Affordable Care Act, data collection is mandated. Under-utilization will reduce the availability of real-time data that can be used to assess whether the asthma rates or other outcomes truly decreased in particular areas and zip codes. Yes, such trends must be defined in order to support disparity reduction. Thus, all community supporters must urge individuals to utilize their providers so that this data are captured, analyzed, and used to improve treatment of African Americans.

Summary

The Summit began with a discussion of the concept of health disparities and with a brief illustration of health disparities in the area of mortality. The complexities involved in the analysis of the nature of health disparities was demonstrated by utilizing HIV as a case study. The actions of the public sector in improving health and reducing disparities were then discussed. The possibilities implicit to the Affordable Care Act were then outlined. Finally, some of the challenges to using the Affordable Care Act as a tool for disparity reductions were described. In the next and final chapter, strategies and directions for moving forward have been outlined.

Chapter 6
…But Still I Am One
Strategies and Actions to Reduce Disparities Within the Framework of the Patient Protection and Affordable Care Act

Overview

Based upon the various speakers and discussants, the Summit members focused upon the question, "What can the organizations represented by the Summit and their membership do in order to reduce health disparities?" In order to answer this very vital question, the Summit participants divided into workgroups who were tasked with the duty of identifying strategies that could be implemented over the next year. Each subsection below describes the issues discussed by these various groups.

Access and Advocacy

This session focused on access to care. The topics of discussion extended beyond insurance coverage and barriers to care. It also addressed the topic of insurance coverage after enrollment in a health plan has occurred. In addition, the session focused upon advocacy and if, how, and when organizations should advocate for health policy changes. The discussions were guided by the goal of emerging with plans and strategies. That is, each workgroup was instructed to focus upon solutions rather than problems. Key questions addressed in the area of access and advocacy were: 1) Is access to healthcare services a contributor to health disparities in African Americans? 2) If yes, how can organizations address these access issues? 3) Is advocacy an activity that can impact health disparities? 4) If so, what should be the advocacy plan for health disparities? 5) Who should lead the discussion about policy issues related to access and advocacy? 6) What role can individuals and organizations play? 7) What outcomes will occur as a result of increased access to care? 8) How much will increased access reduce healthcare disparities? 9) What can be done from 2013-2014 to decrease health disparities via access and advocacy?

This group began their discussion by briefly reviewing data on access to healthcare services and analyzing access as a factor that contributes to disparities in African Americans. The group expanded the issue of access beyond the areas of insurance, number of healthcare professionals, and number and quality of clinics and hospitals. Areas explored included access to green space for exercise; access to stores that house food with the nutrients needed to nourish the body on an everyday basis; the time and the money to access healthcare; and access to the digital technology that is needed to navigate the information. By applying an expanded definition of access to healthcare, the probability that health disparities will decrease, exponentially increases.

The group also mentioned that many issues regarding disparities need to be reframed. Moreover, strategies selected must reflect urgency. In addition, the group suggested that the measures used to define success include new policies that translate into practice; and qualitative as well as quantitative studies that assess the outcomes of the revised practices. To achieve higher degrees of traction in accomplishing health disparities, NMA and its partners will maximize potential assistance from the public sector, participate in Congressional hearings that address health disparities, and ensure that the issues are clear. The partnership recognizes that there is strength in numbers. However, the Summit members will maintain health as the priority, and will use a consistent message. Thus, communication is key and redefining access to include direct and indirect measures.

A second breakout group added to these remarks by identifying three challenges access and advocacy. First, the group can be most effective by bypassing politics and focusing upon implementation issues such as seeing and assigning patients to providers, and increasing the impact of practitioners when disparities are observed. In addition, some research may be needed that identifies how managed care service sites are distributed across African American and other neighborhoods, whether insurance companies pay different rates for the same procedures based upon practice location, and other matters that represent systemic barriers to access. When such systemic factors are identified through research, it will be necessary to inform the Congress of these practices and to work with Congressional supporters in drafting supplemental legislation to eliminate the identified systemic practices.

However, in order to strengthen any advocacy activity the number of partnerships must be broadened and strengthened. This suggests that partnerships not only be broadened in terms of ethnicity. Rather, supporters among Fortune 500 companies since it is in their best interests for people of African American descent and other Americans to have good health. In addition, a common message will be created for all Stakeholders. This practice will strengthen outcomes. For example, because health equities embody themes of social justice, the partnership will on the financial costs of health disparities to the nation.

It was also recommended that several spokespersons be selected to serve as the “faces” of the new movement to reduce health disparities. Last, this group recommended that the most immediate goal is achieving 100% enrollment in the Exchanges under the Affordable Care Act. By achieving 100% enrollment of African Americans and teaching those enrollees to use the system, a foundation will be established for further action. However, because access must be linked to quality of care, the Action Agenda will also include promoting lifestyles and the collection and analysis of quality data so that outcomes can be tracked.

In effect, the Summit suggested implementing a grassroots campaign, engaging the targeted groups, and reintroducing the Affordable Care Act from a public health perspective. This suggests that all partners and their constituents will assist in getting the message out about how to enroll in the Exchange. This process can be done cost-effectively because Enroll America has materials that can be used. For example, the National Council on Aging works with 10,000 Senior Centers across the country. These Centers can inform their constituents regarding Medicare changes under the Affordable Care Act. This is particularly important for those who are dual eligibles for both Medicare and Medicaid. Likewise, blackdoctor.org can build a separate channel to educate different constituents on the Affordable Care Act and the opportunities that it presents. While this strategy will reach only a limited number of seniors since fewer seniors are online, it will reach large numbers of the uninsured. Likewise, NMA can assist in providing culturally competent messaging. Similarly, Sigma Gamma Rho has a large membership of persons from 20 to 80 and older.

While much of the work of the partners in this movement must be funded within the existing budget of the organizations who choose to participate, there are some grant monies for Community Navigators to assist in enrollment in the Exchanges. These dollars can only be awarded to non-profit groups. However, it may be too late to apply for a Navigator grant in many states. Yet, as the administrative unit, NMA will research funding opportunities. When opportunities are found, the various partners can apply as a collaborative. This strategy will reduce inter-organizational competition and increase the chances of a successful outcome.

Barriers to Care and Stigma

This session focused on addressing stigma from a broad range of perspectives, i.e. financial, racial, cultural, educational, geographical, type of illness, disease and others. Participants sought to answer questions such as 1) Are barriers to care and stigmas contributors to health disparities in African Americans? 2) If yes, how do these forces operate? 3) What can be done to address these barriers? 4) What are some specific methods by which stigma can be reduced? and finally, 5) What can we do from 2013-2014 to decrease health disparities by addressing stigma as a barrier to care?

As is known, health is a multifaceted phenomenon. It embraces the physical, the spiritual, the environment, attitudes and beliefs, and other components. However, despite the emphasis on the preventive, data reveal that healthcare is ignored by many Americans until it becomes a crisis. Thus, two key barriers to the remediation of health disparities are complacency and even apathy. Data were introduced earlier in this book that describes the poorer self-managed practices of African American diabetics and hypertensives. This complacency and apathy are even operative when African Americans understand what resources are available and even when such patients have been educated regarding various illnesses and diseases. In some instances, apathy and complacency are accompanied by a glorification of counter-health measures. That is, African American culture sometimes makes it more popular to do unhealthy things. For example, African American male culture includes admiration for males with a multiplicity of sexual partners. African American female culture may literally embody physical activity constraints because of the costs associated with the grooming of their hair. It is only through collaboration that these embedded and oftentimes unspoken of cultural issues can be first defined and then addressed.

For example, the National Black Nurses Association (NBNA) can partner with NMA in the dissemination of information to change ways of life that exists in the African American community that support disparities. But, a skills audit is needed so that informal skills that have developed in some groups that can be used to support disparity reductions can be defined. For example, nurses are the informal disseminators of information to a greater degree than physicians. However, whether physicians, nurses, pastors, or social workers are disseminating information, we will tailor our core messages to the audience. Likewise, each partner will engage in health education at both the patient level and at the provider level. For example, Chapter 2 demonstrates how providers will be trained to not merely skim medical journals articles. Rather this information will be read so that new findings that have implications for health disparities reductions can be identified.

In addition, this movement will use technology more abundantly and more creatively. Because fewer seniors are online, we target their children and grandchildren who are online and use them as conduits to disseminate health information to their parents and grandparents. We teach younger family members about the apps that are available in the area of health. Because youth and young adults are on Facebook and Twitter, high schools and HBCUs can create Junior Health Ambassadors to deliver messages to all age groups among African Americans. The campaign to reduce tobacco use is a case in point. Youth were used to help get their parents to stop using tobacco. Thus, there are opportunities within the family structure to use stigma and to allow youth to be informal health educators. Movies and TV series can also serve as informal health educators. Indeed, successes have also occurred in TV shows and novels that dramatize what it is like to live with a number of conditions. Such approaches both educate and simultaneously reduce stigma.

While health education will be used to remove one barrier – health illiteracy, the tools of health education will also be used to reduce stigma. However, groups such as sororities and fraternities and faith-based leaders are particularly positioned to reduce stigma because of their roles as creators of norms. In addition, NMA and its partners will create a web portal where visitors can view videos and materials that target stigma reduction in the African American community. Additionally, the web portal will include self-posted, YouTube type videos from persons who have overcome hurdles associated with areas of stigma. The website will include blogs, questions and answers, and a monthly newsletter. In addition, illness management strategies such as the use of the evidence-based WRAP for severe mental illness, and/or Seeking Safety for trauma will be accessible through the web portal.

There is also a need to address not merely the stigma associated with HIV/AIDS and/or mental health but other types of stigma as well. Stigma is attached to overweight and obesity. Some individuals see the use of hypertension medications as an area of stigma. Stigma may be associated with diabetes care, erectile dysfunction, hysterectomies, and even cancer.

Other Barriers to Health Disparity Reduction

Given the increased diversity of the American population and the acknowledged body of literature on the intersection of culture and health, this movement to reduce healthcare disparities will also advocate for a voluntary program of training and certification in health disparities. This training will be specific to various medical specialties. For example, the State of New Jersey has a requirement for physicians to demonstrate that six hours out of the 100 hours (over 2 years) required for re-licensing involved cultural competency education. In addition, advocacy for cultural competency training for the pre-professional students in nursing school, medical school, pharmacy school, physician assistance and other schools will provide more advanced knowledge of cultural competency.

Unique Barriers to Disparities in Specific Disease Areas

The last session focused on priority disease and illness areas. The goal of the discussion was to identify specific disease areas that require special attention in African Americans. A major focus was on specific African American gender and age groups. The key questions were: 1) What are the major disease states that will be a priority for African American health professionals who participate in this movement and why? 2) What can be done to improve awareness, prevention, screening and diagnosis, and the treatment of these high disparity disease areas in African Americans? 3) Should these disease states in African Americans be addressed by using different practice guidelines than with other populations? 4) How will disparities in children, the elderly, and women be addressed and are there unique challenges? 5) What are the priority disease states for each age group and gender? 6) Do these sub-segments of the African American population have intra-racial disparities in outcomes based on gender or age? 7) If yes, what are some of these disparities? and 8) What three actions can be completed from 2013 to 2014 to address health disparities in children, adults, the elderly, men, and women?

The major diseases/illnesses identified were oral health, cancer, mental health, cardiovascular disease, diabetes, and obesity. As Table 1 indicates, prevalence rates do differ by ethnicity, gender, and age in selected areas.

Table 1:
A Sample of Disparities in Oral Health, Cancer, Mental Health, Cardiovascular Disease, and Stroke by Race/Ethnicity, Age, and Gender:
Prevalence Rates

Disease/Illness	Total for Caucasians	Total for African Americans	Male	Females	Male	Females
• Heart Disease	11.6%	10.2%	12.8%	10.3%	30.8%	20.2%
• Cancer	6.3%	4.7%	5.5%	6.6%	17.6%	14.9%
• Serious Psychological Diseases	3.2%	3.8%	2.8%	3.7%	--	--
• Stroke	2.5%	3.9%	2.7%	2.6%	6.9%	5.7%
• Untreated Dental Caries	19.3%	39.7%	27.2%	20.2%	--	--

Source: Health, United States 2011

Key variables that are associated disparities in the above areas include health wellness, prevention, education, vaccination, and appropriate pediatric and adult screening. However, because the correlates of these diseases are so similar across these various morbidities, a holistic health and wellness message and intervention can simultaneously address each of these disease areas. In addition, the social determinants of health will also be addressed in order to reduce disparities. That is, socioeconomic status, educational attainment, pollution, and neighborhood characteristics are all important factors that influence health. Any effort to reduce disparities will therefore require partnerships with the National Urban League, the NAACP, HBCUs, and other entities whose missions include socioeconomic change.

However, in order to promote improved outcomes in the above areas, specific knowledge of how these diseases manifest themselves among African Americans is needed. This cultural knowledge will affect outcomes at the provider level and the patient level. Thus, the pipeline of culturally concordant providers will need expansion. Table 2 demonstrates that pipeline programs in the past have successfully increased enrollment in professional schools.

Table 2:
African Americans as a Percent of all Total Enrollment in Schools for Selected Occupations 2008-2009

	1980-1981	2008-2009
• Medicine (Allopathic)	5.7%	7.1%
• Medicine (Osteopathic)	1.9%	3.5%
• Optometry	1.3%	3.0%
• Pharmacy	4.4%	6.4%
• Podiatry	4.3%	9.0%
• Public Health	6.3%	11.5%

Source: American Medical Association; American Dental Association, Association of Schools of Public Health, College of Optometry, etc.

Similarly, African Americans must be reached with the right message at the right time. This will allow patients to have a true understanding of their illness. For example, some hypertensives appear not to understand that they have a chronic, lifelong disease that requires addressing on a daily basis with lifestyle changes and/or medication. Cultural sensitivity and ensuring that patients understand the message, are connected with their healthcare provider and trust the provider and the prescribed medications is critical.

Given that the disparities differ by gender and age, a relatively simple strategy can be used to simultaneously reduce disparities across these subpopulations. Because of the role that women play in the family – women will schedule appointments for the men, their children, and the grandparents and not address their own health – primary care providers will be requested to schedule woman's appointment at the same time as the children and other family members. This practice can reduce disparities across all genders and ages. It is also important to expand funding for pilot projects to reduce health disparities. The Affordable Care Are supports the testing of new ideas and provide resources that are not available through the federal government, state governments or other funding agencies. Currently, children are a funding priority with a particular focus upon childhood obesity. However, a needs assessment that takes a comprehensive look at both children and other groups in the African American community is needed so that, in spite of the current funding priorities of public and private entities, this new disparity reduction movement targets those areas that will generate the greatest narrowing of health outcomes. For example, funding will be sought that is directed towards environmental and social factors. Numerous examples exist of how the environment impacts our diseased states. Data from the Environmental Protection Agency reveals that exposure to pollution, and pests and pesticides, affect health. Research on alcohol and other drug use reveals that youth who know how to access alcohol in their neighborhood also have higher rates of underage drinking. In some urban schools, as many as 50% of the school's population have asthma. Funding will be sought to educate parents about environmental triggers for asthma such as second-hand smoke. Funding will continue to be solicited in order to elicit greater participation in clinical trials. Funding requests will be submitted to explore how to improve the patient/provider relationships. Funding is needed for remedial education at HBCUs so that more African American students can enter in healthcare. Funding is needed to train community health workers on conducting peer-to-peer outreach at the community level. As mentioned earlier, funding will be acquired to test the efficacy of disparity reduction interventions that affect multiple health disease states.

That is, we will address issues that affect heart disease, cancer, and other illness simultaneously. For example, fraternities and sororities can provide outreach and education in preparation for enrollment of residents through the Exchanges. Disparity-focused healthcare providers can ask questions of patients that reflect specific areas of cultural competency. And finally, providers can routinely begin using IT as a tool to support not merely medical record storage and exchange, but as a form of telemedicine and prevention. The need for technology is an urgent one. For example, electronic medical records are critical since many patients in our communities see multiple doctors who do not currently provide coordination. Additionally, technology can also benefit these patients by providing health education and opportunities to communicate with a provider when transportation, childcare, and/or other barriers to access prohibit usage.

Summary

Helen Keller is oftentimes credited as the author of the quote below.

"I am only one,
But still I am one.
I cannot do everything,

But I can do something;
And because I cannot do everything,
I will not refuse to do the something that I can do."

In many respects, the purpose of the 2013 Summit on African American Health was guided by the above words. Some of the nation's most prestigious individuals and organizations were assembled in order to not merely re-define a problem that has already been broadly characterized, but to engage in a collective search for strategies that will support change. Even more importantly, the objective of the Summit was that of creating an action agenda that, if implemented over the next year will lead to measurable improvements in health disparities.

Based upon the consensually validated views of the Summit participants, the measurable actions that will be undertaken by this group of leaders and their membership over the next year includes those listed in Table 3.

Table 3: Year One's Action Agenda

Outcome Objective	**Tracking**
• As a result of the Action Agenda, the participants in the 2013 Summit on African American Health will, through the co-occurring actions of the public and private sector, create a statistically significant decrease in African American/Caucasian disparities in at least five health areas from March 2013 to March 2018.	Changes in 5 year mortality disparity rates.
One-Year Process Objectives In order to support the accomplishment of the outcome objectives, the following process objectives will be met.	
• The Consortium of organizations engaging in disparity reduction activities will increase from 28 in March 2013 to 100 by March 2014.	Number of organizations in listserv
• The proportion of consortium organizations whose members will use accurate data to define the magnitude of African American/Caucasian disparities in mortality and key morbidity areas will increase by a statistically significant percent as measured by a pre-post disparity awareness test by March 2014.	Analysis of variance and t tests
• The number of articles, opinion editorials, online blogs and tweets, media interviews, fliers and posters disseminated, presentations to community groups on health disparities made by consortium members will generate 10 million media impressions by March 2014.	Number of media impressions
• At least five trainings will be conducted by each consortium member to their members by March 2014.	Number of attendees present at teach meeting; copy of sign-up sheets
• Each organization that is a member of the consortium will organize and implement one or	Number of uninsured who enroll in insurance per organization

Table 3: Year One’s Action Agenda	
Outcome Objective	**Tracking**
more, Have You Got Health Insurance? ENROLL TODAY! activities between October 1, 2013 and January 1, 2014.	
• At least one African American newspaper, T.V. station/network, or radio stations in the cities where each consortium member is headquartered will interview a spokesperson regarding the importance of enrolling in insurance through the Exchanges and on how to enroll by January 1, 2014.	Number of interviews held
• Each partner/stakeholders will disseminate information about health disparities, how to enroll in healthcare, how to use the selected plan, and the importance of treatment adherence and self-management to public school systems, colleges/universities, African American services, African American community-based healthcare outlets, African American serving employers, African American neighborhoods, etc. and at other sites. (Materials for dissemination will be obtained from public sources but will be assessed by NMA.)	Number of materials distributed as assessed through tracking sheets
• Each partner will identify at least two faith-based leaders in their service areas who will use their pulpits to reduce stigma against persons with HIV, mental illness problems, and substance use disorders by March 2014.	Number of HIV positive persons who access healthcare and/or social support through this church outreach
• At least five African American serving physicians and other healthcare providers in each major city will voluntarily extend hours from January 1, 2014 in order to accommodate newly insured persons in their area.	Number of new patients acquired
• Solicit at least 20 HBCUs as partners and organize student newspapers and STEM faculty to educate youth about careers in healthcare as well as other STEM subjects.	Change in enrollment in STEM courses at targeted HBCUs
• At least two pharmaceutical companies will create materials that list those medications which they sell that work well with African Americans and distribute the list with samples to African American serving physicians.	Change in medication adherence as reported by patients to their physicians
• At least 50% of NMA’s membership will sign an agreement to ask each patient about their medication adherence at each visit and to make inquiries with notes in medical files regarding any problems encountered. These notes will be reported to the companies selling the medications in the form of a report.	Self-reports for physicians that this strategies have been adapted

Table 3: Year One's Action Agenda	
Outcome Objective	**Tracking**
• NMA will submit at least three proposals to the public sector to fund national collaboratives to promote use and prevention services in the Affordable Care Act and disease/illness self-management by March 2013.	Copies of proposals
• NMA will conduct a process and outcome evaluation of Year 1's activities and to guide the Summit and Action Planning process for 2014/2015.	Copy of evaluation and agenda for the 2014 Summit

Over the course of the Summit, one of the largest gathering of influential organizations in the country engaged in an intensive dialogue of action. As a result of these conversations and discussions, a preliminary action plan was generated to guide the growth of the Health Disparity Movement over the next year. This monograph is a call to action for other organizations to participate in this historic effort.

Conferences, Summits, and other meetings to address a "cause" have, in some respects, gained a poor reputation. This is because the meetings occur, the adrenalin runs high, and conferees return to their real worlds and the dreams that ignited during the meeting are quickly extinguished. This will not be the case with the 2013 Summit on African American Health. It is oftentimes said that the greatest predictor of what will be done is what has been done. The participants in the Summit have already been engaged in disparity-reducing activities. The purpose of this chapter is that of providing a brief review of some of the very important work already underway by the participants in the Summit.

Health Disparities? Not in My Country!

Health disparity reduction efforts are already occurring throughout the country. For example, the participants reported being active in the recruitment of youth into the STEM pipeline so that they will be eligible for a career in medicine.

> "I remember when I used to work in a community health center, I used to go out to the local junior high school…At first, we simply sought to increase our patient population – we wanted these young students to come and use the services of the clinic. As I reflect, I realize that this model of exposure to medicine was like a mentoring program because we went into the community. We provided health education in the community and as they came into our practice. We as providers can, at the community level, encourage students to go into a health profession. "

In addition, another participant urged the organizations that attended the Summit as well as other organizations in the community to reach out and embrace other organizations.

> "I think that the primary theme of this Summit is breaking down organization silos. Each of our organizations has its

> own listserv or other database. Whether you’re a physician, a nurse practitioner, a social worker, a pharmacist, or a retired individual, someone in each zip code in your database has an interest in increasing the population of future healthcare professionals. To reach that person, all we must do is break down these silos of information.”

Another theme that was raised is the transfer of accurate information from one organization to another with a different type of expertise.

> “The shortage of physicians isn’t quite as dire as many believe. In 1980-1981, only 5.7% of those enrolled in a School of Allopathic Medicine was African American. By 2008-2009, this number had increased to 7.1%, or 5408 students. Assuming dropout hasn’t been extreme, we should have 4,000-5,000 new allopathic physicians graduate this June. We must always make sure that our data are correct.”

One program that helped to generate an enrollment of 5408 students in medical school was a unique NMA program started by an NMA Auxiliary in 1992.

> “I don’t know if most of you know but beginning in 1992, the Auxiliary actually had a pipeline program. It was a residential program where we selected about 60 to 70 students across the nation including the US Virgin Islands. These students were flown into DC where they became part of an 11 day residential program. During this period, we promoted healthcare careers. We did that for about 18 years…until we ran out of funding. Other efforts were also made. I did one in Wilson, NC. I already had a relationship with the three high schools there. The Guidance Counselors helped to identify students who were interested in healthcare. The students were from the three high schools and from an early entrant College program. We had about 20 students to come in for a one day workshop at my church. My church did not charge so we had the event there. We had representatives from the health department, the Area Health Education Center and a person from the guidance department at a high school. Everyone discussed preparing for a career in a healthcare field. I also had a panel of 10 people from different healthcare fields, physicians, nurses, nurse practitioners, pharmacists, physical therapists, etc., I even had someone from mortuary science to come in and talk to them about the healthcare

> field. This is something that can be done without external funding."

Still another participant described their efforts in increasing the number of participants in the pipeline.

> "…we currently fund a project that networks all HBCUs in the area of behavioral health. While we focus on student health as a retention factor, the program also includes paid internships for any student who has an interest in the healthcare career…this may be a strategy that communities can use..."

In order to shift the new movement from the fragmented effort of individuals, greater collaboration is needed. One attendee described how her organization currently collaborates.

> "The Black Women's Agenda is an organization of organizations. We collaborate with 19 major Black women's organizations. We have been doing this for more than thirty years. These are not affiliate organizations. We agree to collaborate around major issues. We bring major issues to the collaborative and then implement strategies."

Taken together, then, the participants in the Summit agree to move forward utilizing the strategies outlined in this final chapter and throughout the monograph. While the first year's outcome and process objectives have been defined, this movement will over time, implement each strategy listed in Table 4.

Table 4: An Overview of The Five Year Action Plan

Over the course of the next five years, the Health Disparities Movement will:

- Develop clear and concise guidelines for the early detection of conditions that have a high prevalence among African Americans such as Prostate and Breast Cancer and create statistically significant increases in screenings for these conditions.
- Increase partnerships with organizations that can improve the social determinants of African American health.
- Activate community resources that can be use to address lack of knowledge, lack of health insurance, and other barriers to disparities.
- Provide health education that has been tested with African Americans and found to be culturally competent and science-based.
- Ensure 100% health coverage in African American communities.
- Create statistically significant decreases in barriers to access to care; increases in health literacy; increased confidence in the sources of health care and in health treatment; increase understanding of preventative care and its importance; promote the use of daily time to care for health.
- Identify primary care physicians and/or behavioral health providers to serve as medical homes for 100% of African Americans.
- Create measured increases in knowledge about conditions and experiences that elevate health and health status.
- Increase community-based health education through media partnerships.

Table 4: An Overview of The Five Year Action Plan

Over the course of the next five years, the Health Disparities Movement will:

- Improve linkages between ethnic media outlets and relevant/accurate health information.
- Involve community-based healthcare advocates and organizations, churches, businesses, and public school systems in disparity reduction.
- Find funding for additional health disparities collaborative activities.
- Continually use research and experience to identify barriers to disparity reduction activities.
- Communicate more appropriately with patients and stakeholders.
- Learn more about how communities/people exchange information and use these mechanisms more effectively.
- Give individuals and communities the knowledge needed plus the motivation to initiate change.
- Work with local community groups to help health become a priority. Improve healthcare providers in certain areas. Increase the number of patient advocates. Identify free and low-cost resources e.g. transportation, Rx costs, in each community.
- The identification of strategies that are working and the sharing of these positive results.
- Working through church leadership to provide health messaging to congregations. Use social media campaigns and solicit prominent individuals to assist in the effort.
- Provide access to healthcare in community-based settings as well as in tradition settings.
- Provide reinforcements for participation in disparity reduction activities.
- Increase awareness of the barriers that threaten disparity reduction.
- Increase the percentage of minorities in the healthcare workforce through an aggressive effort.
- Train all healthcare providers to be more culturally sensitive and culturally competent.
- Share information across organizations.
- Use education to reduce stigma as a barrier to healthcare.
- Encourage journalists to tell stories about the people behind the statistics. Launch tailored social media campaign enlisting celebrities to educate their followers about health disparities.
- Provide a series of sermons on health using a common set of sermon notes.
- Increase cultural competency by urging all healthcare professionals to voluntarily enroll in a certification program.
- Tell stories using real-life examples to humanize disparities on TV, in the movies,
- and through plays.
- Target HBCUs to stimulate interest in health careers.
- Increase and refine prevention programs in targeted health areas.
- Educate participants in the movement to apply original thinking.

Overtime, the five year list of strategies will be extended. Through such collective action, health disparities will not merely be reduced, they will be eliminated.