

SOUTHEASTERN PARTNERSHIP TO ELIMINATE HEALTH DISPARITIES

Ann Rosewater, MA

Southeastern Partnership to Eliminate Health Disparities

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INTRODUCTION

Ann Rosewater, consultant to the emerging Southeastern Partnership to Eliminate Health Disparities, brought the audience up-to-date on what has been learned during the past year and what to expect from the new 8-state initiative. She emphasized the importance of primary care providers and community partners in meeting the goal to improve health and productivity in the southeast.

LESSONS LEARNED

1. The issue of health disparities in the south is substantive and real and is of concern to many partners, individuals, and groups in the area. “We don’t need to spend time convincing you,” Rosewater said. “The data shared over the past 2 and a half days has been striking and you wouldn’t be here if you weren’t focused on these issues in your own work.”

2. We need multiple partners—federal government, state government, and local communities—committed to working together to eliminate health disparities. “That is the kind of partnership that is evolving,” Rosewater said. This conference has provided “excellent examples of the value of collaborations in achieving results in policy, in practice and in getting services to people who need them.” It has also shown how to build support in the community and bring partners to the table in a sustained way, she said.

3. We need to concentrate in areas that will bring particular focus and value to the work. The Southeastern Partnership is concentrating on 3 areas:

- Identifying and helping translate information and data effectively for different audiences, including practitioners, policymakers and the public;
- The role of communities in creating consensus around local focus, a climate of engagement, and bridges to care; and
- The economic impact of disparities. The effort needs to involve many stakeholders beyond health care—business leaders, elected officials, and educators. “They will be more likely to see the need for this effort if they understand how learning and productivity are affected by disproportionate health outcomes,” Rosewater said.

4. It is essential to be realistically bold with targeted, measurable, doable goals. “This conference has focused on hypertension, obesity, diabetes, depression, immunizations, and other extremely important issues with demonstrable disproportionate and preventable impact on certain groups in the southeast,” Rosewater said. “When I made rounds earlier this year at Grady Memorial Hospital—the public hospital that serves 2 major counties in Atlanta—it was painfully apparent that these issues are important and that we can make a difference.” Another approach is to “pick any of these health issues, look at a map of the United States and watch the ‘hot spots’ light up in the southeast,” Rosewater said. “You will see that something is drastically wrong.”

The startling truth is that “improvements in health disparities have either reached a plateau or, in some instances such as diabetes and obesity, have begun to get worse again,” Rosewater warned. “This is happening despite all of the terrific and dedicated efforts of communities, public health departments, physicians, nurses, the faith community, advocates, and many others.”

What can be done? “We need to think creatively about new stakeholders and new strategies,” Rosewater said. “We need to think differently—in a broader and more strategic way—about health disparities, why they really exist, about their impact, about why in so many ways they remain invisible, and about what it will take if we are serious about eliminating them.”

The speaker noted that the Primary Care Conference has a dual purpose—to provide updates on evidence-based medicine and to expand how everyone working together can find new ways to eliminate disparities in health care. “We need to learn, work, collaborate, and be open to making course corrections as we move forward,” Rosewater said.

The Southeastern Partnership to Eliminate Health Disparities has selected 2010 as its target year—in keeping with the US Surgeon General’s benchmarks for *Healthy People 2010*. “To make an impact, communities and the primary care providers in those communities will be the ‘crucible’ where it works or doesn’t work,” Rosewater said. “All the other partners will bring talents, expertise, and technical capacity that will lend added value and resources to the communities, but we have learned clearly and repeatedly that if anything is going to happen, it must happen locally in the communities.”

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The past year has been devoted to fact-finding and discussions with healthcare providers across the southeast. “My hope is that our vision will be translated into reality by next year—or even sooner,” Rosewater said. “My best estimate is that it will happen sooner.”

The Primary Care Conference emphasized that primary care is essential to addressing disparities and that a broader group of stakeholders needs to “come to the table,” Rosewater said.

She listed those stakeholders as government, the faith community, business leaders, community organizations, the media, and others. Two preconference working group sessions brought representatives from across the southeast to discuss: 1) the effective uses of data and information; and 2) examples of effective community involvement in addressing health disparities. The data group agreed to work on a collaborative report over the next 18 months to tell the disparities story.

“You have heard that primary care is the first point of contact for heart disease, diabetes, and depression and that you represent health care for most people,” Rosewater said. “We are making progress in designing ways to collaborate with you through community health centers, professional nursing and medical groups, faith communities, and other ways.

“You will be the ones that will be able to celebrate in 2010, because it will be due to your work that health disparities will be eliminated—and through your work that we will have positive, productive, healthy people throughout all our communities in the southeast,” she concluded.

TAKING CHARGE: MAKING PARTNERSHIPS WORK FOR BETTER HEALTH OUTCOMES

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INTRODUCTION

The ambitious goal of eliminating racial and ethnic disparities in health care will require a strong message, creative approaches and close collaboration by public and private partners across the health system, Dr. James Gavin, new president of Morehouse School of Medicine, told the audience at the closing session of the Primary Care Conference. The goal cannot be reached without “a concerted and sustained focus on development of effective, integrated interagency and cross-organizational partnerships,” he said.

“This conference has addressed issues that are at the very core of our efforts at the Morehouse School of Medicine to train physicians, healthcare providers, leaders, and physician-scientists to serve the medically under-served, especially those who are burdened by the impact of health disparities,” Dr. Gavin said.

“The impact of health disparities is so devastating because the safety net is in tatters, the system is seriously broken, and the partnerships for effective repair are not sufficiently in place,” he stated. “We must take charge.”

POTENTIAL PARTNERS

Dr. Gavin listed the following potential partners: the public and private biomedical research sectors, the social policy and health economist sectors, health and healthcare training programs, the political sector, healthcare administration (especially managed care), public health workers and thought leaders, community and faith-based organizations, private industry, philanthropy, and an informed and empowered citizenry.

“First, we must formulate a credible and executable health promotion/disease prevention message,” Dr. Gavin said. “We must identify the elements of such a message, the strategies that derive from these elements, and the roles of public and private partners and funding agencies.” For example:

- Cigarette smoking causes lung cancer and pulmonary disease.
- Use of latex condoms can halt HIV transmission during heterosexual or homosexual intercourse.
- Lowering LDL cholesterol reduces the risk of cardiovascular disease.

- Lowering HbA_{1c} to less than 6.5% prevents or delays the development of diabetic retinopathy, neuropathy and nephropathy.

“These are powerful, evidence-based messages directed toward reduction of substance abuse, behavioral change in high-risk sexual behavior, and risk reduction in the setting of major metabolic diseases, all of which are important aspects of racial and ethnic health disparities,” Dr. Gavin said.

PARTNERSHIPS IN THE DISCOVERY ARENA

These messages exist because public and private funders supported research scientists who produced the data, Dr. Gavin pointed out. “There have been impressive partnerships between the public and private sectors in the discovery arena,” he continued. “One has only to look at the catalytic functions served by seed grants from the American Diabetes Association, the Juvenile Diabetes Research Foundation, and the American Heart Association.”

The next step, Dr. Gavin said, is to activate the multiple components of the complex health system. He used cigarette smoking as an example:

“The presence of compelling evidence for harm led to social policy formulation, with designation of no-smoking areas, health policy changes with designation of cigarette smoking as a risk factor for cardiovascular disease, and a justification for warning labels. To play their part in eliminating this acknowledged health risk, the politicians got into the act, levying taxes on the product to discourage the habit. It is unlawful to sell to minors. Physicians now routinely advise patients against the use of cigarettes, and insurers provide discounts for non-smokers, while smokers are rated. Foundations and public health organizations have turned up the heat with vigorous public awareness and education programs to create an informed and empowered citizenry.”

This is a pretty impressive demonstration, Dr. Gavin said, “of how the different elements of public and private partnerships and integrated efforts have begun the process of synergy across the health system, with each sector doing what it does best in pursuit of the goal of eliminating the use of cigarettes in a healthy society.”

'FAR SHORT OF THE GOAL'

Despite advances that have been made—including litigation that generated large sums of money from tobacco manufacturers for compensation and prevention—we are “far short of the goal,” Dr. Gavin said. “We are seeing alarming rates of increase in teenage smoking, especially among girls.”

There are many reasons to explain why we have done less than we intended to do in curbing cigarette smoking, but there is one major lesson that represents a potential hurdle for health-promotion/disease-prevention strategies, Dr. Gavin said. “The lesson is straightforward: Health promotion and disease prevention messages and strategies to eliminate disparities face a daunting challenge when countered and resisted by the deep pockets and power of marketing and the economic incentives of a well-established, profitable retail market enterprise.”

The lesson looms large in obesity and type 2 diabetes—a major area of racial and ethnic health disparity, Dr. Gavin said. “The problems are enormous and well-known to you: Over 60% of our adult population is obese or overweight, and the numbers are rising, especially within high-risk minority groups. Similar increases are being seen in our children and adolescents.

“There are many health consequences of these trends, but the major and most dramatic outcome is the explosion of type 2 diabetes,” Dr. Gavin said. “Almost a million new cases are being diagnosed each year, with the fastest rates of increase occurring in the youngest age groups, including children and adolescents. Disease rates and complication rates are 2 to 5 times higher in high-risk racial and ethnic minorities. Over 17 million persons are known to be affected and over 20 million other persons are at risk of developing diabetes.”

Powerful therapies for type 2 diabetes are available, but we are not reaching our treatment goals, Dr. Gavin pointed out. “We spend billions of dollars in support of diabetes-related complications, with poor return on the investment.”

'RAMPING UP' PREVENTION

What can be done? Dr. Gavin recommends “ramping up” efforts to promote better health and to aggressively pursue prevention strategies as the principal approach to eliminating this health disparity.

“What is more, given the enormity of the problem and the urgency for addressing it in a meaningful way, we simply must create and disseminate appropriate health promotion and disease prevention messages and integrate them across the health system,” he said.

The researchers have done their job. Clinical trials—such as the Diabetes Prevention Program in the United States, the Finnish Diabetes Prevention Study, the Chinese Da Quing Study, the Canadian/European Stop-NIDDM (Non-Insulin

“Non-pharmacologic strategies, such as walking/exercising 150 minutes a week and making prudent dietary choices can reduce the development of diabetes by almost 60% both in high-risk minorities and in others. This is remarkable. It can be done!”

Dependent Diabetes Mellitus) trial and others—have shown that type 2 diabetes can be prevented.

“The most powerful interventions are with dietary therapy and increased exercise with rather modest weight loss,” Dr. Gavin said. “Non-pharmacologic strategies, such as walking/exercising 150 minutes a week and making prudent dietary choices can reduce the development of diabetes by almost 60% both in high-risk minorities and in others. This is remarkable. It can be done!”

NEW DIRECTIONS

Where do we go from here? Healthcare providers must believe that diabetes prevention is possible and health policymakers must provide standards, goals and incentives to make it attractive for healthcare providers to use prevention strategies, Dr. Gavin said.

“We must pursue a new paradigm of public health to address the new epidemics of our time that are driven not by fate and victimization from microbes but by lifestyle choices that people make that lead to chronic and devastating diseases,” Dr. Gavin said. “Public health officials and health educators must help legislators craft appropriate legislation and social policy to promote healthy behaviors.

“Good science and good intentions and goodwill are wonderful, but as currencies, they are routinely trumped by economic incentives and tax credits,” he continued. “Can school systems receive graduated bonus payments by successfully integrating physical education into their curricula? Can employees receive time-off credits or graded discounts on health insurance premiums by reaching and maintaining certain body weight milestones and by certifying the attainment of certain thresholds of activity by having their pedometers routinely checked?

MAKING PARTNERSHIPS WORK - Gavin III

“The IRS has been allowing tax credits for certain weight loss plans prescribed by providers as part of treatment strategies,” he continued. “But can’t we do better than to have the IRS drive public health policy to eliminate disparities?”

Dr. Gavin offered creative suggestions for ensuring that partnerships are wide-ranging and appropriately structured:

Managed care organizations: Convince them that the science is strong and help them design cost-effective strategies for achieving and maintaining patients’ healthy behaviors.

Centers for Medicare and Medicaid Services (CMS): Involve them at all levels, from the generation and validation of the science to the development of goals and standards and the translation of feasible and economically defensible models into practice.

Community organizations and faith-based organizations: They must be the ones to mold, shape, and inspire the public’s will to change. They should be the “preachers and teachers” of messages and strategies of health promotion and disease prevention. Effective integration of community-based efforts with academic centers will result in strength for both programs.

Federal and state government: They have the outreach and resources to be the drivers of the process. One example is the National Diabetes Education Program (NDEP), a joint effort to promote provider and public awareness to improve diabetes-related illness and death. This is the federal government’s major outreach effort and it seeks to engage multiple partners in the public and private sectors in promoting awareness and changing behaviors and practices. Dr. Gavin is the new national chairperson of NDEP. “Recently, Secretary Tommy Thompson charged NDEP with responsibility for developing the strategy for translating the results of NDEP into widespread and routine clinical practice,” Dr. Gavin said. “This is a litmus test for the ability to use an evidence-based set of health promotion and disease prevention findings across our entire health system. In doing so, we are beginning to see where we have underutilized some potential and underestimated some potential problems in attempts to form public and private partnerships to eliminate health disparities.”

Private foundations: They should be the leaders in ensuring coordination that benefits the public and occurs in the most economic and efficient way possible. They are the “venture capital firms for novel ideas,” Dr. Gavin said. “They can probe and test and pilot new strategies for information dissemination and behavior changes while allowing medical research agencies to generate new findings, while allowing health advocacy organizations to get in the faces of policymakers and while allowing public health authorities to be architects of the design of

cogent, credible public health principles and practices. [They can assume] a leadership role in testing what works in the public marketplace by using academic centers as their test stations and in convening the appropriate stakeholders, including the community, across the health system for analysis of current status and future directions. In this way, we can be more assured that funding priorities will be thoughtfully made. I think we have underutilized the potential of foundations.”

Pharmaceutical industry: This sector can be utilized to a much greater extent than previously in making sure that messages are disseminated consistently to residents of communities across the nation. “Too many times, the newsletters and brochures from government agencies and volunteer health organizations are simply not getting to the right targets or not being adequately interpreted,” Dr. Gavin said. “Too often, much of the valuable information on websites is simply not being accessed—for reasons of time or expertise.” What is missing is the human touch. “One solution is to make better use of the vast network of provider contacts within the pharmaceutical industry,” Dr. Gavin said. “Pharmaceutical reps cover every village, hamlet, town, and city across the nation. This is a readily available network into which we could tap to assure timely and comprehensive dissemination of key messages and findings to providers.” In terms of incentives, Dr. Gavin suggests devising a formula to translate hours of documented service by pharmaceutical companies—with some measure of impact or penetration of the information—into “carefully titrated incremental extensions of exclusivity of a drug.”

What are the potential hurdles in advancing the messages and findings about obesity and type 2 diabetes?

“We can expect a serious push-back from the fast-food industry, just as we witnessed from the tobacco industry,” Dr. Gavin predicted. “Usually, it will take the form of economic incentives—offering terrific bargains on things like super-size and value meals, making it difficult for people to justify spending the same amount of money for what appears to be less.”

The food industry will find a variety of ways to push back, Dr. Gavin said. “That is the nature of well-established, profitable commercial enterprises. We must anticipate these responses and plan appropriate counters. In this area, we must depend heavily on the actions of an empowered community voice.”

The health of our nation is under assault—across ages, genders, and ethnicities, Dr. Gavin said. “We must meet such assaults with resolve, creativity, and well-designed approaches to the formation of partnerships for integrating health promotion and disease prevention across the healthcare system.”

Dr. Gavin’s algorithm for partnership development includes:

- Can we focus on a specific question and target a specific venue in which to address it?

“We must meet such assaults with resolve, creativity, and well-designed approaches to the formation of partnerships for integrating health promotion and disease prevention across the healthcare system.”

- Are data available to define the scope, impact, and demographics of the issue?
- Which organizations/agencies would engage this problem in the usual course of events? Are they doing so? What have been the effects? Are there data to inform and guide planning?
- What are the barriers to greater success?
- Who is the best convener to set up a forum for partnerships to address the problem?
- Is not the Southeastern Consortium for Elimination of Health Disparities a paradigm for what is needed?

“By focusing on newer, more effective ways of developing partnerships and allocating resources to address and eliminate health disparities, I believe we will provide the necessary forums and dialogues and the mechanisms for assuring that we are targeting funds and human capital in the right direction to achieve this increasingly urgent goal of better health outcomes for the whole of society,” Dr. Gavin concluded.