

**U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
ADVISORY COMMITTEE ON MINORITY HEALTH**

**EXECUTIVE SUMMARY**

**January 30–31, 2020  
Rockville, Maryland**

**Members Present**

Winston F. Wong, M.D., M.S., FAAFP, Chair, Advisory Committee on Minority Health  
Sheri-Ann Daniels, Ed.D., B.S., SCP, CSAC  
Linda D. Bane Frizzell, Ph.D., M.S.  
Raul I. Garcia, D.M.D., M.Med.Sc.  
Sela V. Panapasa, Ph.D.  
Veronica G. Parker, Ph.D., B.S.  
Veronica Vital, Ph.D., M.S.N., B.S.N., RN  
Kimberlydawn Wisdom, M.D., M.S.  
Clyde W. Yancy, M.D., M.Sc.

**Members Absent**

Gregory J. Maddox II, M.D., M.S.  
Beverly Patchell, Ph.D., APRN, PMHCNS-BC

**Federal Staff**

Violet Woo, M.S., M.P.H., Designated Federal Officer, Office of Minority Health  
CAPT Samuel Wu, Pharm.D., Office of Minority Health

**Invited Presenters**

RADM Felicia Collins, M.D., M.P.H., Deputy Assistant Secretary for Minority Health, Office of Minority Health, Office of the Assistant Secretary for Health, U.S. Department of Health and Human Services  
Justin Mills, M.D., M.P.H., Medical Officer, U.S. Preventive Services Task Force, Center for Evidence and Practice Improvement, Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services  
Robert A. Hahn, Ph.D., M.P.H., Coordinating Specialist, Community Guide Office/Community Preventive Services Task Force, Office of the Associate Director for Policy and Strategy, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services  
Machell G. Town, Ph.D., Branch Chief, Population Health Surveillance Branch, Division of Population Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, U.S. Department of Health and Human Services  
Dawn Alley, Ph.D., Deputy Senior Advisor to the Secretary for Value-Based Transformation, U.S. Department of Health and Human Services  
Melissa A. Simon, M.D., M.P.H., Vice Chair of Clinical Research, Department of Obstetrics and Gynecology, George H. Gardner Professor of Clinical Gynecology, Professor of Obstetrics and Gynecology, Preventive Medicine and Medical Social Sciences, Founder/Director of

Chicago Cancer Health Equity Collaborative, Member of U.S. Preventive Services  
Task Force  
Mae-Gilene Begay, M.S.W., Program Director, Navajo Nation CHR/Outreach Program, Navajo  
Nation Department of Health

**Day One—Thursday, January 30, 2020**

**Call to Order, Welcome and Introductions, and Landscape of Meeting**

*Winston Wong, M.D.*

Chair, Advisory Committee on Minority Health

Dr. Wong welcomed the Advisory Committee on Minority Health (ACMH, or Committee) members and attendees to the meeting and conducted a round of introductions.

Dr. Wong opened the meeting. As the first order of business, the Committee formally approved the recommendations from the August 2019 full committee meeting. Ms. Woo explained the formal clearance procedure within the U.S. Department of Health and Human Services (DHHS, or the Department) through which the recommendations will proceed. After formal clearance, the recommendations will be posted on the Office of Minority Health (OMH) website.

CAPT Wu reported that he presented an overview of these recommendations at the Presidential Advisory Council on HIV/AIDS (PACHA) meeting in October 2019. He reported that the Council members were very interested in the Committee's work. OMH planned to share the recommendations with PACHA and identify opportunities to work with PACHA through the Office of Infectious Disease and HIV/AIDS policy.

Dr. Wong proceeded with the topic of the meeting. The focus was to determine how clinical preventive services could be more effectively utilized by racial and ethnic minority populations. The meeting objectives were to develop recommendations for the OMH to maximize the utilization of clinical preventive services in racial and ethnic minority and Tribal and urban American Indian and Alaska Native communities by: (1) identifying and addressing barriers to access preventive services; and (2) developing and adopting evidence-informed interventions or promising practices to increase awareness, access, and utilization of preventive services.

**Office of Minority Health Welcome and Updates**

*RADM Felicia Collins, M.D., M.P.H.*

Deputy Assistant Secretary for Minority Health, Office of Minority Health, DHHS

RADM Collins presented to the Committee on OMH's 2019 accomplishments and future/continuing activities including opioid use disorder; sickle cell disease; Youth Engagement in Sports Initiative; National Minority Health Month; and a data compendium of federal datasets on health, race and ethnicity, and socioeconomic status. In her presentation, RADM Collins reiterated that culturally and linguistically appropriate services are foundational to the mission and functions within OMH.

RADM reported that 2020 OMH budget appropriations had increased from 2019. However, the list of diseases in which health disparities exist is long. Therefore, OMH may shift from focusing on specific diseases to: (1) supporting states, territories, and tribes in implementing disparity-reducing policy, programs, and practices; and (2) developing the workforce, particularly the community health workers. Activities on prevention and activities addressing individuals' social needs and social determinants of health would be handled through that framework. RADM Collins concluded her presentation with highlights of the Federal government's prevention efforts. One such activity was the National Institutes of Health (NIH) has a Pathway to Prevention (P2P) program. A recent workshop focused on achieving health equity in preventive services. The workshop produced 26 recommendations to address research gaps and needs in overcoming impediments and barriers to utilization of 10 preventive services that were the focus of the workshop.<sup>1</sup>

### **U.S. Preventive Services Task Force**

*Justin Mills, M.D., M.P.H.*

Medical Officer, Center for Evidence and Practice Improvement, Agency for Healthcare Research and Quality, DHHS

The U.S. Preventive Services Task Force (USPSTF, or Task Force) makes independent recommendations about clinical preventive services in three main areas: (1) screening—the most common area, (2) cancer (behavioral) counseling, and (3) preventive medications. The scope of the Task Force is limited to services offered in the primary care setting or services that can be referred by a primary care clinician (this excludes cancer treatments, and specialties outside the scope of the Task Force). The Task Force makes recommendations that apply to adults and children with no signs or symptoms (or unrecognized signs and symptoms) and, thus, the focus is on primary prevention.

The Task Force makes recommendations through rigorous review of the available evidence on clinical preventive services and assigns letter grades based on the availability and strengths of evidence in the literature. Dr. Mills presented on the methodology of the review process, including the role of the public in the selection and review of topics. The Task Force would engage the public by soliciting nominations for topics and public comments on the proposed topics and addressing issues or concerns about a specific recommendation. Relative to racial and ethnic minority populations, the Task Force would consider whether the recommendations can apply to specific segments of the U.S. population based on the available evidence. If health disparities are known to exist and if no evidence base is available, the Task Force attempts to address that in the recommendation statements.

Dr. Mills stated that the USPSTF consists of non-Federal experts in prevention and evidence-based medicine and includes members from primary care medicine, internal medicine, nursing, obstetrics and gynecology (OB/GYN), pediatrics, and behavioral medicine.

Federal agencies and organizations that represent primary care clinicians, consumers, and other stakeholders help the Task Force to ensure that recommendations are useful for clinicians and

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<sup>1</sup> Carey, et al. 2020 National Institutes of Health Pathways to Prevention Workshop: Achieving Health Equity in Preventive Services, *Ann Intern Med*.

support the Task Force in dissemination efforts. All Task Force recommendations are also disseminated through partnership with the Journal of the American Medical Association. In The Task Force submits an annual report to the Congress that highlights evidence gaps and future research needs.

### **Community Guide Office/Community Preventive Services Task Force**

*Robert A. Hahn, Ph.D., M.P.H.*

Coordinating Scientist, Office of the Associate Director for Policy and Strategy (OADPS), Centers for Disease Control and Prevention, DHHS

The Community Preventive Services Task Force (CPSTF) contributes to the Community Guide, a collection of evidence-based interventions that improve health and prevent diseases. While there is some overlap with the USPSTF, the CPSTF conducts systematic reviews of population-based interventions, in both healthcare systems and communities, and focuses on complementary rather than duplicative efforts. The CPSTF has a public health prevention perspective compared with the primary care prevention perspective of the USPSTF. The focus of the CPSTF is on improving the use of available critical preventive services.

Dr. Hahn described the methods of the CPSTF reviews. He presented on resources in the community guide that may help address health disparities among minority and ethnic populations. The preventive services that were available to address some health issues appear to be underutilized in racial and ethnic minority populations. Many barriers to utilization could be mitigated by addressing the social determinants of health, such as education and housing. Health equity was one of the newer categories of review and includes educational interventions and housing. He provided several illustrations of the CPSTF's work, with highlights on applicability of various prevention activities.

Dr. Hahn suggested some potential strategies to the Committee for developing their recommendations that would address disparities in clinical prevention services utilization. Briefly, these strategies include: (1) consider the social and economic conditions of the populations that underutilize these preventive services and identify potential obstacles to using these services; (2) consider using targeted focus groups among those populations to determine what they know about preventive services, whether they use them, and reasons/challenges to utilizing these services; (3) consider reviewing existing literature for potential interventions with racial and minority populations; and (4) consider reviewing and potentially adopting those interventions that have shown promising results in general populations but lacked evidence of effectiveness for racial and ethnic minority populations.

Access to services can be enhanced through reducing costs, expanding hours to match patient availability, expanding language intermediaries, etc. Increasing patient knowledge and clarifying the value of prevention could enhance the uptake of preventive services. Factors that impede the utilizations such as competing needs, childcare, and transportation should be assessed and addressed. Finally, resources and incentives could be developed and delivered to increase patient completion of preventive interventions – for example, reminders and home visits.

## **Clinical and Preventive Service Indicators on the BRFSS**

*Machell G. Town, Ph.D.*

Branch Chief, Population Health Surveillance Branch, Division of Population Health, National Center for Chronic Disease Prevention and Health Promotion, Centers for Disease Control and Prevention, DHHS

The Behavioral Risk Factor Surveillance System (BRFSS) is a state-based survey conducted in all 50 states, District of Columbia, and the six U.S. territories. The survey began in 1984 and collects data on adults 18 years and older. Over 400,000 interviews are conducted each year on chronic health conditions, injuries, preventable infectious diseases, health risk behaviors, and healthcare access and utilization. Detailed race/ethnicity, sexual orientation and gender identify, and other demographic information are collected. Dr. Town described mechanisms through which they contact hard-to-reach populations and the use of oversampling strategy on specific subpopulations. Certain states or regions may be oversampled because of the demographic makeup in those areas. She described what data are collected and ways the data can be extracted as needed for specific analyses.

Dr. Town presented a series of analyses on measures of access to care, immunization, screening and testing, and status of hypertension and diabetes. In most cases, the analyses suggested that racial and ethnic minority populations and American Indians/Alaska Natives had significantly poorer indices of health and preventive outcome measures compared with non-Hispanic Whites, which is concordant with the literature. However, Dr. Town noted several caveats and limitations to the analyses and emphasized the analyses were for illustrative purposes and only to show the variables that are available. The main takeaway was that BRFSS data aggregated across states are available to the public, and state-level data are available to each state.

## **HHS “PreventionX”**

*Dawn Alley, Ph.D.*

Deputy Senior Advisor to the Secretary for Value-Based Transformation, DHHS

Over the past several years, life expectancy in the United States has decreased. The DHHS launched the PreventionX Initiative, a new initiative intended to address the accruing burden of morbidity and mortality and the financial cost of preventable chronic conditions. Overall, the investment in spending on treatment far outweighs that on prevention. PreventionX Initiative focused on a broad range of preventive services and a variety of behavioral and economic approaches to drive changes. One example that illustrates both the success and challenges learned in this area is the CDC’s Diabetes Prevention Program. The first definitive trial of the Diabetes Prevention Program was published in 2002, but it was not until 2019 that Medicare started covering program participation. Strategies are needed to grow the pipeline of interventions and shorten the timeframe of clearing hurdles toward cost reimbursement.

Using CDC’s “Three Buckets of Prevention” framework,<sup>2</sup> PreventionX focuses on opportunities in Buckets 2 (innovative clinical prevention) and 3 (community-wide prevention) because of the greater need in those areas of prevention.<sup>3</sup> Examples of innovative clinical prevention include

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<sup>2</sup> Auerbach J. The 3 Buckets of Prevention. *J Public Health Manag Pract.* 2016;22(3):215–218.

<sup>3</sup> Bucket 1 is focused on increasing the use of traditional clinical preventive services.

services that extend care outside the clinical setting – for example, home visits by either a licensed professional or a community health worker who would help identify key triggers for asthma in the home.

Dr. Alley also shared some thoughts on areas viewed as important innovations to grow the pipeline (e.g., community resource referral platforms, virtual diabetes prevention program, ride share programs to address healthy food access, local wellness funds/community trusts). Those may include opportunities for commercialization of interventions that have not previously been viewed as primary opportunities for business and entrepreneurship.

PreventionX is in its formative stage. A request for information (RFI) was released in fall 2019 soliciting input on novel interventions at the individual, community, and systems levels. The RFI focused on preventable chronic health conditions and broad upstream risk factors that affect multiple conditions, with an emphasis on health behavior. Seventy-eight RFI responses have been received. An emerging theme points to community participation and community engagement as an important part of scaling any innovative or active interventions. PreventionX initiative emphasizes innovation and entrepreneurship, and suggestions on how to foster entrepreneurship amongst communities that may be underrepresented are welcomed. HHS is particularly interested in feedback from the Committee.

### **Community-Based Strategies to Increase Access to Clinical Preventive Services for Minority Populations**

*Melissa A. Simon, M.D., M.P.H.*

Vice Chair of Clinical Research, Department of Obstetrics and Gynecology, George H. Gardner  
Professor of Clinical Gynecology  
Professor of Obstetrics and Gynecology, Preventive Medicine and Medical Social Sciences  
Founder/Director, Chicago Cancer Health Equity Collaborative  
Member, U.S. Preventive Services Task Force

Dr. Simon presented an elaborate framework through which she improved the deliveries of preventive services to populations traditionally left behind. The framework was organized as a series of questions for the Committee to consider while developing its recommendations to OMH. She described several examples of her prevention efforts to illustrate a number of points within the framework. One example was how breast cancer disparities between Black/African American and White women in Chicago were reduced by improving the quality of care in the mammography centers on the south side of Chicago where African American women were predominantly being screened. Specifically, as these patients were not being informed of their results by the centers that performed the screening, the patients presumed their mammogram was normal since no one from the center contacted them, leading to poor health outcomes. Informing the women of their results contributed to decreased mortality.

Dr. Simon described structural elements that could contribute to health disparities if not strategically addressed. For example, screening alone will not improve prevention if the arc of the preventive service (i.e., diagnostic resolution through treatment) cannot be engaged. The arc of treatment requires a great deal of maneuvering that many have difficulty with even without all

the other challenging social, economic, and contextual factors that exist among racial and ethnic minority populations.

As described by Dr. Simon, the patient's view of healthcare is daunting. From a cancer care perspective, patients see a multitude of specialists and might be under the impression that the clinicians are on the same team when most often that is not the case. Working with system engineers, Dr. Simon developed the "4R" concept of care (right care, right time in the right sequence with the right person) to integrate and lay out a sequence of care. The patient uses a paper chart of the sequence at every visit to keep track and ensure that the boxes in a given sequence are checked. There is shared accountability with the providers, and health equity principles are embedded in the design.

Dr. Simon also presented a consolidated framework for implementation research, which describes internal and external factors that iterate through rapid cycle processes, to adapt a program from one community to fit with another (e.g., from the DuPage County suburb to African-American communities in Chicago, other Latin communities in Chicago, and Chinese communities in Chinatown). Dr. Simon has used these frameworks of prevention and implementation science to reduce healthcare disparities across many populations and across chronic diseases and maternal and fetal health.

Dr. Simon concluded by summarizing strategies that can be tweaked and applied to chronic conditions and across communities.

- Use a consistent and systematic approach to examine ways of engaging the local community so that implementation in each community can be tailored. Trust and respect building are critical as is acknowledging and managing discrimination and bias.
- Clinicians must stay current with state-of-the-art guidelines and recommendations. Tools can include the electronic health record (EHR) and learn-to-unlearn outdated practices.
- Workforce diversity should reflect the people in the community who are being served and the healthcare team members who work to support those needing care and services (e.g., community health workers, patient navigators).
- Be creative about shared care and transitions of care (e.g., integrating social determinants of health into healthcare delivery and EHR) and work directly with the health and human services community organizations to better deliver those types of services.
- Use checklists and care plans; consider where patients are being sent; be mindful of trust in the history with the other healthcare systems and how clinical results will be received.
- Consider alternative ways to deliver healthcare, health education, and connecting patients to healthcare (e.g., Walmart, Walgreens, CVS, Target) and leverage the places that are frequented by community members.

### **Community-Based Strategies to Increase Access to Clinical Preventive Services**

*Jacqlyn Atkins, M.P.H., MCHES®*

Health Systems Manager, Division of Diabetes and Heart Disease Management, South Carolina Department of Health and Environmental Control

The South Carolina Department of Health and Environmental Control (SCDHEC) is one of the few States that has a centralized public health department. The 76 local health departments are an

extension of the State office and do not operate separately or independently; they operate completely in conjunction with guidance from the central office. South Carolina is unique in that environmental services within the state are also combined with the public health agencies.

Through a Centers for Disease Control and Prevention (CDC) cooperative agreement (2013 to 2018), the SCDHEC focused on State and local public health actions to prevent obesity, diabetes, heart disease, and stroke. Ms. Atkins provided their methodology for selecting the counties on which to focus the prevention activities. Designated staff hired for the grant project included clinical coordinators and prevention coordinators. Ms. Atkins presented the South Carolina Pharmacy Association Blood Pressure Coaching Program. In partnership with the pharmacy association, they recruited independent pharmacists who wanted to work individually with patients to deliver five individual sessions over 12 months to patients. Sessions covered nutrition, physical activity, stress management, tobacco cessation, medication adherence, and self-monitoring of blood pressure. Over half of the 348 patients enrolled completed the program (attended all five sessions). Systolic and diastolic pressures decreased, and 14 percent of patients went from hypertensive to normal across all years.

In the current funding cycle, the focus is to increase access and coverage to the National Diabetes Prevention Program and diabetes self-management; increase ways for pharmacists to work at the top of their licensure and other ways they can be utilized in primary care settings; increase reporting, monitoring, and tracking on a clinical level; utilize evidence-based guidelines; and increase patient engagement. The project used tailored messaging and communications to promote the program among minority populations. Composite scores were calculated to estimate the burden of diabetes and heart disease. Counties with the greatest burden were selected to be target counties. More than half of the 25 counties fell along the I-95 corridor.

The program is being implemented with the Pharmacy Association (renamed MTM (Medication Therapy Management) Lifestyle Coaching Program). It has been modified primarily to group-based intervention; the topics remained similar. To date, 33 pharmacists have been trained across 13 counties (with five in target counties), and additional 151 pharmacists have enrolled in the program. The target counties have a higher minority population than the state average.

In the previous study, pharmacists were positive about the program and stated the need for this program for their patients. Program sustainability is important, and efforts are underway to try to integrate pharmacists into primary care settings at federally qualified health centers and rural health centers.

### **On the Frontline: The Navajo Nation CHR/Outreach Program**

*Mae-Gilene Begay, M.S.W.*

Program Director, Navajo Nation CHR/Outreach Program, Navajo Nation Department of Health

The Community Health Representative (CHR) program in the Navajo Nation was established in 1968 and has been in existence for 52 years. CHRs are the frontline public health workers who serve as a vital link between the clinical setting and the community to facilitate access to healthcare and services and improve the quality and cultural humility of service delivery. CHRs

serve as a liaison between the community, the patients, and the providers—sometimes also the researchers.

Ms. Begay provided facts about the CHR program and described the program's structure. She reviewed processes, services, and features of the CHR program, including the multiteam and patient-centered approach. Of the over 300,000 Navajo Nation tribally enrolled members, 85 percent of the members rely on services delivered by CHRs. CHRs aim to meet the following needs of American Indians/Alaska Natives (AI/ANs) to reduce health disparities: (1) involvement in their own health and through empowerment, (2) collaboration and partnership between AI/ANs and the Indian Health Service staff so patients receive adequate health services, (3) improvement of cultural communication between all (particularly new) healthcare providers, and (4) an increase in basic health and education services to AI/AN rural communities through preventive health education so that people are informed and participate to determine the necessary steps to take care of themselves.

While the CHRs follow the national standards, each tribe has unique designs for delivering services based on patient needs. In terms of public health and health prevention, CHRs deliver services based on primary, secondary, and tertiary preventive care, working with agents within the community (e.g., tuberculosis and sexually-transmitted infections technicians who deploy in events of outbreak). CHRs are highly trained and certified. They respond to urgent situations and specialize in several areas of health screenings. All services delivered by CHRs are entered into a data warehouse, which is shared with the Indian Health Service. Ms. Begay shared examples of CHR partnerships with other organizations such as the American Dental Association; trainings, and education and screening tools; and comments from patients about increased empowerment through their CHRs and from providers who now recognize CHRs as a part of the Navajo Nation health service team.

### **Eliminating Hepatitis B Health Disparities: A Community Coalition-Building Model**

*Kate Moraras, M.P.H. Deputy Director of Public Health Hepatitis B Foundation*  
Director, Hep B United

An estimated 2.5 million individuals in the U.S. are living with chronic hepatitis B. Most are undiagnosed or unaware that they are infected. Of those small numbers that are aware of their status, less than half are able to access treatment and care because screening is not routinely conducted among health systems. Only 25 percent of adults in the United States are vaccinated against hepatitis B. Spikes in acute hepatitis B infection rates have been reported in certain parts of the country tied to injection drug use.

There are major disparities associated with chronic hepatitis B, particularly among Asian Americans and Pacific Islanders (AAPI) who carry over half of the burden. There are also some major disparities amongst African immigrant communities who carry 30 percent of the burden in the United States. Recently released CDC surveillance data from 2017 showed that AAPIs continue to experience the highest hepatitis B-related mortality rates (5.3 times higher than Caucasians). Left untreated, hepatitis B leads to liver disease, cirrhosis, and liver cancer. There continues to be stigma and discriminatory practices around hepatitis B.

The community coalition-building model addresses barriers to vaccination and screening. Hep B United is a national coalition started in 2011 with support from OMH that convened over 40 local coalitions and organizations nationwide from about 28 cities and 20 states. The mission is dedicated to reducing health disparities associated with hepatitis B. All of the partners within the coalition are working to increase testing, vaccination, and linkage to care. The coalition members also work on improving access to treatment to prevent liver disease progression and liver cancer.

Ms. Moraras presented a range of programs and projects of the coalition that encompass prevention activities including a national communications program; a digital storytelling campaign; preventive and clinical services interventions; and a peer mentoring program. The Hep B United coalition has served as a model for improving the accessing to services (screening, testing, treatment, etc.) the mitigating the burden of diseases in other populations.

### **History of Prevention in American Indian Health Care and Services**

*Linda Frizzell, Ph.D. Associate Professor*

School of Public Health, University of Minnesota

Dr. Frizzell described the complexity of the American Indian and Alaska Native (AI/AN) health system, which includes the federal Indian Health Services (IHS), federally recognized tribes and tribal organizations, and Urban Indians (commonly referred to as ITUs). The Indian health system serves 574 federally recognized tribes, tribes operate under specific unique federal laws, approaches, and cultural traditions. AI/ANs are recognized as a political entity not a racial group. Each tribe has its own governing structure and duly ratified *Constitution*. The tribes have government-to-government relationships with the federal government, and tribes are not bound by state laws. The highest elected person of a tribal government (e.g. Chairperson, Governor, Principle Chief) is the same level (hierarchy) as the President of the United States.

Health services for qualified AI/ANs Medicaid beneficiaries are funded 100 percent by federal dollars. Where as in the public sector, states must use their dollars to pay the match difference. However, tribes are not able to directly access funds for public health services from the CDC. CDC funds are only assessible by states. Similarly, with the exception of one Tribe, block grants from the Substance Abuse and Mental Health Services Administration (SAMHSA) are only assessible by states. Inequality in funding, among many other factors, has required AI/AN tribal communities to address public health challenges in innovative and resourceful ways as described by Dr. Frizzell. Tribes in some states have developed local collaborations with state and county health departments.

The ITUs have a long history of developing effective prevention intervention services. One example is the staged diabetes management which was implemented more than 20 years ago. Currently, the rates of diabetes have plateaued. This staged diabetes management program has now been emulated within the U.S. healthcare system, which lagged many years behind the ITUs. Prevention intervention programs have been developed for other chronic diseases, such as asthma, obesity, and cardiovascular disease. A majority of tribes across the country have achieved immunization rates over 90 percent.

Dr. Frizzell described models for physical, behavior, environmental health services support, as well as a public/community health nursing model that promotes the practice of healthy life styles such as: attending prenatal and parenting classes, use of car seats, adherence to post-partum appointments, and avoidance of “risky” behaviors. One of the best models I have seen is a program where mothers receive “points” for practicing risk-reducing activities, which can be traded for commodities (e.g. receiving blankets, diapers, toys) at the local “store” operated by the community health nurses.

Dr. Frizzell also described how the term “public health” historically referred to welfare and how people, especially those in rural parts of America may still feel stigmatized utilizing public health services. Other initiatives have included funding to establish sanitation facilities in rural regions, tobacco cessation at satellite clinics, services for traditional healing, unintended pregnancies, accidental injuries/death, violence against women, and bullying.

### **Hypertension in African American Communities**

*Winston F. Wong, M.D Medical Director, Community Health*

Director, Disparities Improvement and Quality Initiatives The Permanente Federation  
Kaiser Permanente

Kaiser Permanente, a large health system with almost 13 million members covered across eight states, is unique in its model of care. Permanente is a separate entity from Kaiser Health Plan and Kaiser Foundation hospitals. It employs physicians who are contracted only to Kaiser Health plans to care for those patients. As such, the medical group is uniquely positioned to provide medical care that offers a tremendous advantage by overcoming fragmentation that is much typical of other health care systems across the country.

With barriers to healthcare access and continuity/coordination of care significantly reduced, Dr. Wong stated his assumption that disparities are less likely between African American and Caucasian males for hypertension control in the Kaiser Permanente member population. However, hypertension control rates were 82 percent in African Americans compared with 87 percent in Caucasians. There was no natural reason for this difference to occur. It is important and necessary that leadership act to understand what quality care improvements need to be made. Biases needed to be exposed through leadership initiatives and messaging.

Strategies were deployed within the health system to improve care for all patients. With respect to health equity initiatives, disaggregating data was the first step toward unmasking health disparities. Physicians improved their accountability to follow established protocols; for example, medication regimens for blood pressure control, and to build patient trust through techniques such as AIDET (addressing the individual, introducing the individual, duration, the explanation of why we are suggesting something and thank you).

### **Summary of Invited Speakers’ Presentations**

*Winston Wong, M.D., Chair, Advisory Committee on Minority Health*

Dr. Wong requested each Committee member to reflect on the presentations and provide thoughts and comments regarding the framework and actionable recommendations. The

Committee subsequently discussed its strategy for developing draft recommendations on the second day.

### **Public Comment**

There were no public comments submitted.

The meeting was adjourned at approximately 5:15pm.

## **Day Two—Friday, January 31, 2020**

### **Call to Order, Agenda, and Open Discussion (ACMH Members only)**

Winston Wong, M.D.

*Chair, Advisory Committee on Minority Health*

Dr. Wong opened day two of the meeting by acknowledging that this is Violet Woo's last meeting in her official role as the Designated Federal Officer (DFO) and that CAPT Samuel Wu will be taking over that role starting as soon as next week. Dr. Wong expressed his gratitude, on behalf of the ACMH, for all of her hard work put in over the past year and a half. Ms. Woo expressed her gratitude as well for the hard work of the Committee members.

Dr. Wong requested Committee members to bring forth reactions, insights, or reflections from the previous day's discussion to share with the group as takeaways from the day. The following section summarizes themes, discussion points, and guiding questions to help the Committee with developing recommendations.

Build a consensus on how the ACMH will define prevention to help guide the thought process and set parameters for identifying and prioritizing recommendations:

- What are the parameters of the application and applicability of prevention?
- What is the scope of where/how prevention is applied (e.g., clinical, community, formal, or informal)?
- What is the scope of the populations to which the prevention? The Committee advocates for all minority populations, including America Indians and Alaska Natives and other subpopulations as well those in geographically remote areas (i.e., rural).
- From a clinical perspective, will it be primary prevention, versus secondary or tertiary prevention?

Elements of framework to consider for forthcoming recommendations:

- The "Buckets of Prevention" framework. If this framework is adopted, how would the Committee fill in gaps that speak to minority populations and what additional aspects should be included to complete the whole picture.
  - Be mindful of the shadows under the buckets that represent health care, public health, and the overlap between the two under "innovative clinical prevention." The overlap may be the most important area of focus.
  - Buckets 1 and 3 represent areas where different minority population groups are under resourced, lack services, and access to bigger services at both the clinical

level and community level. They are important to focus on. Bucket 2 is the bridge. The Community Guide could help (Bucket 3) with engaging minority population groups and bridging them into care, services and access to traditional clinical services (Bucket 1) known to work from the Prevention Services Task Force.

- The SAMHSA structure for prevention: behavior health interventions for the universal population, with prevention targeted for populations with high incidence/prevalence of diseases or conditions. Using that framework, targeted populations could be a race of people, a whole community, or a geographic part of the country, etc.

Value proposition and agency/empowerment:

- These constructs as well as cultural perspectives, generational learning/wisdom, are unique contributions that the ACMH can make to existing prevention frameworks.
- This is a key construct for individuals to self-manage where possible and to address health inequities gaps.
  - Encompasses self-monitoring, home monitoring, telemedicine, and building environments conducive to physical activity, promotion and health, access to healthy foods, etc.
- Allows clinicians to work to scale interventions.

Determine barriers to prevention activities and why utilization is low in minority population communities:

- Examine the data and recommendations of what works and what doesn't work.
- Determine community assets to help address barriers and low utilization.
- Focus groups will be needed to tailor messages to the community that prevention activities are as important as other necessities of living (e.g., health is also important, along with housing and food) and need not be competing priorities.

Develop partnerships/collaborations with national and local organizations already in this space because the need to practice preventions is difficult to understand, and why it is especially necessary for individuals, families, and communities to lead the way.

Efforts to support prevention services should be sustainable in the long term. This will require resources as well as support to sustain long-term changes to behaviors.

- Training and development of a diverse workforce.
- Asset assessments can help identify resources already in place in the community.
- Encompass change agents, such as banks, barbers, librarians, schools, USDA extension agencies and other community-trusted individuals with social capital.

At that time, the Committee decided to organize themselves into two groups to develop the initial set of recommendations.

### **Subgroups Meet for Discussion and Presentations to ACMH**

The first workgroup led by Dr. Frizzell focused on the following constructs rather than specific recommendations. These are constructs and themes that OMH can advocate for as important to

racial minorities and ethnic communities populations whenever OMH interacts and works with interagency committees and taskforces.

- Survey community assets and acknowledge that communities have value and can help themselves. These assets can be leveraged relative to a community prevention strategy plan.
- All efforts at implementing prevention should be centered upon family, and the individual within the family.
  - Engage families and individuals early and listen to their recommendations. Otherwise programs can be built, but they will not come.
  - Trust-building.
  - Messaging has to be very targeted and specific.
- Regarding evidence-based and promising practices, use the best from the CDC and other agencies.
- Sustainability when funding is over. Effective, promising projects often discontinue when funding is unavailable.

The workgroup also focused on the need for data that accurately reflects the diversity within the ACMHs respective populations, groups, and communities to be able to identify where the needs are for prevention.

- In that data collection process, highlight the strengths and the assets of the groups and communities. There have been some very cost effective, innovative programs out there that are driven by the community and by families, cultures, and cultural groups.
- Invest in training and capacity building to foster agency and empowerment.

The workgroup led by Dr. Wong suggested the constructs and concepts above can provide the overarching or foundational principles (framework) from which more specific recommendations can be made.

### **Draft Recommendations**

The initial set of recommendations from Dr. Wong's workgroup are listed below.

#### 1. Community demonstration grants

- Look at what OMH and others currently have in their pipeline and apply funding to engage communities to build their community engagement component and workforce models.
  - Funds could be stand-alone or specific to areas, such as hepatitis B, sickle cell, or HIV, and/or used to build workforce models to enhance community engagement, but grantees should have the opportunity to create and be innovative in those areas.
  - A funding model that speaks to sustainability and potential replication in other communities based on performance metrics.

#### 2. Partnerships/collaborations

- Align and partner/collaborate with existing national organizations that are well-curated and inhabit the prevention space (e.g., volunteer health organizations, American Diabetes

Association, American Cancer Society, Association Heart Association, and a variety of others).

- OMH can convene spokespersons representing those organizations and influence the development of unified messaging that includes prevention strategies/components that are important for the community and that the community would embrace.
  - Local communities and organizations can be very impactful, and many already work with health organizations and clinics, including grass root organizations, to educate the community about better lifestyle choices. OMH can play a convening role, both national and local partners, around promulgating prevention models.
    - Invite exemplars to share their best or promising practices with other local communities/organizations, similar to the process in which ACMH developed recommendations for ending the HIV epidemic in racial and ethnic minority and tribal populations.
    - Target communities and organizations for community development grants.
    - Endorse effective programs with resources that allow them to grow and build.
3. Develop targeted public awareness campaigns
    - Develop prevention activities, such as modifying behaviors toward healthy lifestyles, environmental agents, and medications.
    - Incorporate and encourage local community agencies that are doing the grassroots efforts to get involved.
    - Understand that community is not defined geographically, but includes affinities that exist such as where people collect, pray, play, etc.
    - ‘Healthy lifestyles’ should include the clause ‘based on cultural norms’ to give the leeway for people in the community to have a say.
  4. Utilize the CLAS standards and OMH’s role to disseminate CLAS standards to evaluate the strength of recommendations that come forward from the task forces (such as USPSTF and the CDC CPSTF).
    - CLAS standards should be utilized as a tool to evaluate the strength of cultural humility as recommendations come forward from these agencies that address prevention.
  5. Include in grant criteria and subsequent evaluations of grants components of the prevention framework disseminated by the ACMH.
    - Consider assigning ‘points’ in scoring for small providers, and develop criteria that targets small, isolated communities, minority populations, and cultures.
  6. Direct the OMH’s Division of Policy and Data to develop and identify metrics (to be defined) to evaluate the consistency of proposals and efforts against the forthcoming ACMH prevention framework.
    - OMH should advocate for more data granularity, for improving measures, and for data collection to be desegregated in the collection, tabulation, and reporting (dissemination).
    - The 2020 census in particular is an enormous opportunity for OMH to ensure that racial, ethnic minority population groups are not undercounted.
    - Accuracy, completeness, and granularity of the data are needed to understand the distribution of race and ethnicity in the United State since these data dictate resource

allocations. OMH should be proactive and deliberate in advocating that the limitations in data collection be addressed in the upcoming census.

7. Adopt a prevention framework that OMH promulgates.
  - OMH currently does not have a prevention framework. The ACMH proposes that the framework developed for the recommendations report could be utilized for this purpose.

The following items were proposed by individual committee members and were not fully discussed by the committee; however, they were deemed important to consider in subsequent deliberations of the final recommendations.

- Advocate for the involvement of school systems. Teachers are often the first line of defense and would be a huge asset for prevention intervention.
- Leverage technologies. Prevention efforts should utilize the multitude of technologies and platforms available.

#### **Public Comment**

There were no public comments submitted.

#### **Wrap up and Next Steps**

A draft of the recommendations will be circulated to ACMH members for comment and revisions.

The meeting was adjourned at approximately 1:45 p.m.