

THE SECOND ANNUAL PRIMARY CARE CONFERENCE—PROGRAMMING TO ELIMINATE HEALTH DISPARITIES AMONG ETHNIC MINORITY POPULATIONS: AN INTRODUCTION TO PROCEEDINGS

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From October 31, 2002 through November 2, 2002, the Second Annual Primary Care Conference was held, sponsored by the Morehouse School of Medicine's National Center for Primary Care and its Prevention Research Center.

The conference was designed as a collaborative activity with the Atlanta Regional Health Forum; The Carter Center; Emory University's School of Medicine, Nell Hodgson Woodruff School of Nursing, and Rollins School of Public Health; Georgia Chapter of the American College of Physicians/American Society of Internal Medicine; Georgia Nurses Foundation; Southeastern Primary Care Consortium, Inc./Atlanta Area Health Education Center; St. Joseph's Mercy Care Services; United States Department of Health and Human Services; Agency for Healthcare Research and Quality; Centers for Disease Control and Prevention; Health and Human Services (Region IV); Health Resources and Services Administration; Office of Minority Health (Region IV); and Office on Women's Health (Region IV).

The 2 and a half-day conference featured 5 plenary sessions and 3 tracks of medical education for primary care physicians and other healthcare providers. The tracks were categorized as: Track A: Adult Health; Track B: Public Health and Prevention; and Track C: Maternal/Child/Youth Health. Within each track, 6 working sessions were presented on topic areas including diabetes, obesity, cardiovascular disease, cancer, mental health, infectious disease, behavioral and social health, women's health, stroke, and asthma. A total of 18 working sessions took place and each working session included 3 presentations. Continuing medical education credits or continuing education units were granted to participants.

In all, 485 individuals participated in the conference, with the majority of the participants from the southeastern United States. Of the attendees, 35% were physicians (MD); 13% were nurses (RN); 12% held master-level degrees; and 12% held other doctorate-level degrees. (*Ethn Dis.* 2003; 13[suppl3]:S3-1–S3-5)

Key Words: Primary Care, Prevention, Public Health, Health Disparities, Adult Health, Maternal-Child-Youth Health, Diabetes, Obesity, Cardiovascular Disease, Cancer, Mental Health, Behavioral and Social Health, Women's Health, Stroke, Asthma

BACKGROUND

The Second Annual Primary Care Conference was convened to address health disparities in health care and health outcomes, particularly as found in the southeastern region of the United States. Through its 2 and half day programming, sessions explored best practices, health policy, and healthcare systems that would assist primary care providers, in partnership with public health professionals, to improve health outcomes and decrease health disparities among under-served populations.

Evidence of these disparities, both nationally and regionally, has been well demonstrated, with extensive reviews recently published by Kressin; Geiger; Mayberry et al¹⁻³ and other researchers. In the Southeast, rates of health disparities among ethnic minority populations have been found to exceed rates found in other regions of the United States. The high rate of cardiovascular disease (CVD) and stroke, for example, has earned the Southeast region the nickname, "The Stroke Belt," with a high percentage of CVD in the region found among African Americans. According to the recently released *Atlas of Stroke Mortality*,⁴ not only are African Americans

1.4 times more likely to die of stroke than Whites, but the highest stroke death rates were found in the South-eastern states and the Mississippi Delta region. South Carolina ranked the highest in overall stroke death rate for adults, with 169 deaths per 100,000.⁴

Eliminating racial and ethnic inequalities in mortality and life expectancy is the optimistic goal of *Healthy People 2010*. Since its inception in 1979, the *Healthy People* initiative has worked to improve health status of the general US population. Yet, population differences in health outcomes were first recognized only in *Healthy People 2000* and, until 1998, the Black:White ratio of age-adjusted, gender-specific mortality increased for all but one of 9 causes of death that accounted for 83.4% of all US mortality in 1998. Further, from 1980 to 1998, the average numbers of excess deaths per day among American Blacks compared to Whites increased by 20%.⁵ Although African Americans have the highest rates of morbidity and mortality of any US racial or ethnic group, American Indians and Alaska Natives also have higher rates of all causes of death than Whites.⁶ For selected causes of death, Hispanic and Asian and Pacific Islander populations also continue to experience higher rates of morbidity and mortality than Whites.⁶ The National Institute of Diabetes and Digestive and Kidney Disorders reports that Mexican Americans have 2- to 4-times the rate of diabetes compared to non-Hispanic adult Whites and are at greater risk for more severe complications.⁷ Compared to non-Hispanic Whites, Puerto Ricans also experience higher rates of mortality due to

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myocardial infarction, pneumonia, asthma, chronic liver disease and cirrhosis, and homicide, with rates similar to those of African Americans.⁸ According to the Strong Heart Study in 1995, American Indians were found to have the highest rates of diabetes in the United States.⁹

WHY DO RACIAL AND ETHNIC DISPARITIES EXIST?

In the search for reasons for these racial and ethnic disparities, as well as disparities caused by age, income, education, and gender, researchers and health professionals have reviewed problems related to access to health care, differences in quality and patterns of medical care, and lack of cross-cultural competence among healthcare providers. In addition to disparities in health care, experts also reviewed root causes of health disparities, such as social and economic factors, poverty, structural racism, personal lifestyle and health behaviors, community factors and the environment.

ACCESS TO HEALTH CARE

Lack of access to health care can be defined as a lack of access to preventive services, or lack of access to medical care.¹⁰ In 1997–1998, 17.5% of adult Americans, aged 18–64 years, had no usual source of health care. There was little racial difference in availability of a usual source of health care; however, 23% of males, and 45% of all uninsured individuals, had no usual source of care. Forty percent to 52% of all uninsured individuals, regardless of income status, had no usual source of health care.¹¹

Differences in Quality and Patterns of Medical Care Treatment

Differences in medical treatment for various medical conditions based on race and gender have been reported in

the literature. In a 2002 study by Schneider and colleagues, Blacks were less likely than Whites to receive: breast cancer screening (62.9% vs 70.9%; $P < .001$); eye examinations for patients with diabetes (43.6% vs 50.4%; $P = .02$); beta-blocker medication after myocardial infarction (64.1% vs 73.8%; $P < .005$), and follow-up after hospitalization for mental illness (33.2% vs 54.0%; $P < .001$).¹²

In a review of recurrent hospital admissions for congestive heart failure in a predominantly Black population in Atlanta, Ofili et al found that most Black patients had suboptimal dosing of angiotensin converting enzyme inhibitors (ACEI), and that use of calcium antagonists in Black patients with severe left ventricular dysfunction was associated with hospitalizations for heart failure.¹³ Other studies have documented racial differences in the use of medical services by patients with coronary or ischemic heart disease^{14–16} even among patients in the Department of Veterans Affairs health system,¹⁷ for whom there is no difference in access to care by race.

In its recent report on inequalities in health, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, the Institute of Medicine provides a comprehensive review of more than 100 studies that assess racial and ethnic disparities in clinical procedures, including the use of diagnostic and therapeutic technologies.¹⁸ The report provides ample evidence for the existence of racial and ethnic disparities in the care of cardiovascular disease, cancer, cerebrovascular disease, HIV/AIDS, asthma, and diabetes, as well as disparities in renal transplantation, analgesia, rehabilitative services, maternal and child health, children's health services, mental health services, and other clinical and hospital-based services.

Lack of Cross-Cultural Competence among Healthcare Providers

Provider-patient communication and a provider's sensitivity to a patient's

cultural influences have been linked to patient satisfaction, compliance, and better health outcomes.¹⁹ Several studies have found that, when cultural and socioeconomic differences between provider and patient are not taken into account, patient dissatisfaction led to poorer health outcomes and greater disparities in care.^{20–24} Two studies have demonstrated that failure to take these differences into account leads to stereotyping, and in some cases, biased treatment of patients based on race, gender, education, culture, language proficiency, or social status.^{25,26}

CONFERENCE CONVENED

To address these and other issues that may contribute to health disparities, the Second Annual Primary Care Conference was sponsored by Morehouse School of Medicine (MSM), an institution maintaining a strong focus on researching and treating diseases that disproportionately affect under-served populations and on providing training in primary care and health promotion, as well as disease prevention services. The primary care conference was developed by MSM, in coordination with its National Center for Primary Care and its Prevention Research Center. Conference goals and objectives appear in Appendix A; a conference program description can be found in Appendix B; and Conference Planning information can be found in Appendix C.

As a collaborative effort, the conference included many partners: the Atlanta Regional Health Forum; The Carter Center; Emory University's School of Medicine, Nell Hodgson Woodruff School of Nursing, and Rollins School of Public Health; Georgia Chapter of the American College of Physicians/American Society of Internal Medicine; Georgia Nurses' Foundation; Southeastern Primary Care Consortium, Inc./At-

lanta Area Health Education Center; St. Joseph's Mercy Care Services; United States Department of Health and Human Services; Agency for Healthcare Research and Quality; Centers for Disease Control and Prevention; Health and Human Services (Region IV); Health Resources and Services Administration; Office of Minority Health (Region IV); and Office on Women's Health (Region IV).

Together, these partners, 89 speakers, and 485 participants came together to continue their work to eliminate disparities that affect health outcomes among ethnic minority populations. The conference platform increased opportunities for primary care health professionals to exchange prevention and treatment information from both research and practice perspectives. Guided by sessions presented during the conference, primary care healthcare professionals returned to their communities to implement new strategies and treatment approaches in their practices. Based on the success of this conference, opportunities for additional learning and exchanging of information will be offered at the Third Annual Primary Care Conference, scheduled for September 18–20, 2003 in Atlanta, Georgia.

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APPENDIX A: CONFERENCE GOALS AND OBJECTIVES

An overarching goal and several objectives were the driving forces for the conference. Based on the priorities as established in *Healthy People 2010*, the conference embraced the goal: To eliminate health disparities among ethnic minority populations in the southeastern region of the United States. Conference objectives to reach that goal were:

- To equip healthcare professionals with knowledge, the latest research, treatment protocols, and guidelines related to providing primary care to adults, children, and adolescents;
- To equip public health professionals with strategies for community-wide application of evidence-based health promotion

initiatives and approaches to translating community preventive services from research to practice;

- To provide an opportunity for discussions to develop and implement regionwide strategies that address the goals of *Healthy People 2010*;
- To provide tools for participants to implement recommended strategies to close the gaps in health disparities in their individual practices and in the community;
- To offer solutions for eliminating barriers that prevent the translation of best science to practice for individuals and communities;
- To enhance the capacity and the role of primary care practitioners to improve health outcomes;
- To clarify the impact of health prevention on measurable improvement in health outcomes and the role primary care practitioners play in incorporating prevention strategies into patient care;
- To increase awareness about the role that public policy and partnerships play in improving health outcomes.

APPENDIX B: CONFERENCE PROGRAMMING DESCRIPTION

The conference, the second such effort focusing on optimizing healthcare outcomes among ethnic minority populations, featured work of the Southeastern Partnership to Eliminate Health Disparities and served as a “think tank” for healthcare professionals to assess primary care and public health strategies and interventions that work. To address the *Healthy People 2010* goals, the conference targeted 4 major disease areas with marked disparities in health outcomes between populations: diabetes, cardiovascular disease, mental health, and cancer. In addition, an emphasis on behavioral health (health conditions affected by lifestyle choices) offered information on a practitioner’s role in assisting in behavior changes.

The conference took place from Thursday, October 31, 2002 to Saturday, November 2, 2002 at the Sheraton Atlanta Hotel in downtown Atlanta, Georgia. The conference theme, *Prevention, Public Health, and Primary Care: Partners in Eliminating Health Disparities in the South*, represented the underlying message for topics and speakers.

The 2 and a half-day conference featured 5 plenary sessions and 3 tracks of medical education categorized as: Track A: Adult Health; Track B: Public Health and Prevention; and Track C: Maternal/Child/Youth Health. Within each track, 6 working sessions were presented on topic areas including diabetes, obesity, cardiovascular disease, cancer, mental health, infectious disease, behavioral and social health, women’s health, stroke, and asthma. A total of 18 working sessions took place and each working session included 3 presentations.

The conference provided continuing medical education credits for physicians, nurses, and other health professionals, and thus, educational objectives were developed in accordance with continuing medication education requirements. A total of 485 individuals participated in the conference, with the majority of the participants from the Southeast. Participants comprised physicians (35%), nurses (13%), individuals with masters-level degrees (12%), and other doctorate-level degrees (12%).

Ninety-two individuals served as conference faculty; of those, 23 served as moderators and 69 served as speakers.

APPENDIX C: CONFERENCE

PLANNING

To convene the conference, a 22-member advisory committee developed conference programming and provided assistance in conference coordination and outreach. Conference sponsors and organizers are grateful for the assistance from these committee members:

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