

CDC *Vital Signs* Town Hall Teleconference

Hispanic Health in the US

May 12, 2015

2:00 pm (EDT)

Coordinator: Welcome and thank you for standing by. At this time all participants are in a listen only mode. During the question and answer session please press star 1 on your phone. Today's conference is being recorded. If you have any objections you may disconnect at this time.

Now I'd like to turn today's meeting to Sam Taveras. You may begin.

Sam Taveras: Hello everyone. Bienvenida y saludo a todos. Good afternoon. Buenas tardes. I'm Samuel Tavares. And I am the associate director for Partnership Support here at CDC's Office for State, Tribal, Local and Territorial Support. I'm glad you could join us today.

We'll be discussing the latest *Vital Signs* report on Hispanic Health. Before we get started let's go over some housekeeping details. First you can go online and download today's PowerPoint presentation so you can follow along with the presenters.

The web address is [www.cdc.gov/stltpublichealth](http://www.cdc.gov/stltpublichealth). That's S-T-L-T public health. Look on the far right side of the page for the *Vital Signs* Teleconference link or you can Google, CDC *Vital Signs* Town Hall and click on the top of the link. That should get you there.

On the same web page you can access biographies for today's presenters. Also on the same web page you can access the audio recording and transcript, which will be available next week.

There will be time for questions after today's presentations but you can get in the queue at any time to ask a question. Just press star 1 and say your name when prompted. So now back to our topic for today, Hispanic Health in the United States of America. We are going to hear from three colleagues.

First we will hear from Dr. Kenneth Dominguez, a Captain in the US Public Health Service and a medical epidemiologist in the Division of HIV/AIDS Prevention, here at CDC's Center for HIV/AIDS, Viral Hepatitis, STD & TB Prevention. He will discuss this month's *Vital Signs* report.

Then we'll hear from Dr. Jaime Torres who will present, and he is the president for Latinos Healthcare Equity. He will discuss the role of community health workers as well as primary prevention of diabetes.

And then hand the call over to Dr. Theresa Byrd, the associate dean and chair of the Department of Public Health in the Graduate School of Biomedical Sciences at Texas Tech University Health Sciences Center.

She will talk about AMIGAS, an intervention to increase cervical cancer screening in women of Mexican descent. So now I will turn over the call to Dr. Kenneth Dominguez.

Dr. Ken Dominquez: Thank you very much Samuel. Today's talk is entitled, *Vital Signs*, leading causes of death, prevalence of diseases and risk factors, and use of health services among Hispanics in the United States 2009–2013.

And I would like to acknowledge my co-authors, Ana Penman-Aguilar, Man-Huei Chang, Ramal Moonesinghe, Ted Castellanos, Alfonso Rodriguez-Lainz, and Richard Schieber. And we're going to be moving to slide number 5, which is the introduction.

Hispanics are estimated to represent about one in six people in 2015 and one in four people 20 years from now in 2035, in the US. Hispanics are the largest racial and ethnic minority population in the US.

Recently, the Hispanic community health study in four cities in the US showed key differences by Hispanic origin and other factors, however published national health estimates by Hispanic origin and nativity are lacking.

The purpose of this study was to conduct a nationally representative study of causes of death, prevalence of disease and risk factors, and use of the health services. Our methods were as follows: we compared Hispanics, Hispanic subgroups, and non-Hispanic whites by nativity and sex where possible.

We looked at ages 18 to 65 during the years 2009 to 2013 unless otherwise specified. For socio-demographic data we include data from the American Community Survey which is from the Census.

For leading causes of death we looked at death certificates that were collected through the national vital statistics system through the CDC. For disease prevalence and risk factors the national health interview survey and the national health examination and nutrition surveys, both CDC surveys.

And in terms of looking at use of health services we focused on National Health Interview Survey data from the CDC. Slide number 7. So in terms of results here are some results regarding socio-demographics.

Among Hispanics living in the US, Mexican, Puerto Ricans, and Central Americans made up a majority of all Hispanics representing 64%, 9.5%, and 8.9%, respectively. About one in three had not completed high school compared to about one in ten non-Hispanic whites.

And about one in four lives below the poverty line compared to about one in ten non-Hispanic whites. Also, about one in three does not speak English well compared to about two in 100 among non-Hispanic white. Slide number 8 please.

Looking at leading causes of death in the United States, cancer and heart disease were the first two leading causes of death for Hispanics and non-Hispanic whites. They are responsible for, as I mentioned, two out of five deaths.

Cancer is the first leading cause of deaths in Hispanics and heart disease is the first leading cause of death in non-Hispanic whites. The Hispanic death rate is about 24% lower than non-Hispanic whites.

Also, Hispanic death rates for seven of ten leading cause of death were lower than those in non-Hispanic whites. And we also had - the Hispanics also had similar death rates for kidney disease.

Slide number 9. Other issues around leading cause of death included that Hispanics are 50% more likely to die from diabetes or liver disease than non-

Hispanic whites. Puerto Ricans had about a 20% higher overall death rate compared with Mexicans and Cubans. Next slide, slide number 10.

What were other key differences in health indices comparing Hispanics and non-Hispanic whites? These included the facts that Hispanics had lower self-reported prevalence of cancer and heart disease but higher diabetes prevalence.

Hispanics less often reported smoking but showed a higher prevalence of obesity. Hispanics were 28% less likely to have had colorectal cancer screening.

And Hispanic women were less likely to receive recommended screening for breast cancer in the form of a mammogram and cervical cancer in the form of a PAP test. Slide number 11, please.

We also found difference in prevalence of diseases and risk factors among US born and foreign born Hispanics. So you can see that US born compared to foreign born had higher prevalence of cancer, heart disease, obesity and cigarette smoking.

Foreign born Hispanics had higher prevalence of total - high total cholesterol, which is not shown on the slide. Slide number 12, please. The better health outlook for all Hispanics combined compared with white non-Hispanics despite many social factors that present barriers to health is termed the Hispanic Paradox.

And this is partly explained by lower Hispanic smoking rates, migration to US of healthy immigrants and reverse migration of elderly or sick Hispanics. The

findings of elevated death rates from diabetes and chronic liver disease, elevated obesity prevalence.

And position of cancer as leading causes of death of Hispanics may be interrelated. So in conclusion, slide number 13, there's a need for culturally and linguistically appropriate health care and preventative services for Hispanics.

For example, bilingual health material, use of promotores de salud, or community health workers, a need for patient centers, medical homes, and increased outreach to decrease the proportion of uninsured Hispanics.

Also, there's a need for feasible and systematic data collection strategies to reflect the health diversity in major Hispanic origin subpopulations including by nativity. Slide number 14, we provided some contact information in case you'd like to contact us directly regarding the article.

Next I'd like to turn it over to Jaime Torres, the president for Latinos for Healthcare Equity. He's going to be discussing the role of community health workers/promotores in 2015 and primary prevention of diabetes.

Dr. Jaime Torres: Thank you Ken. So the purpose of my presentation is in keeping with one of Dr. Dominguez's conclusion, the need for cultural and linguistic appropriate health care and preventive services for Hispanics with really the community health workers (CHWs) intervention. Next slide, 16.

So community health workers have a long and proud history of accomplishments in the US and abroad, reaching traditionally underserved

populations that typically have both complex medical and social needs. They may be known by different names.

Outreach workers, community health representatives, navigators, peer educators, advocates—but what they have in common is a relationship based on trust with the communities they serve.

While formal participation of community health workers in health and human services program in the US has been documented since the 1950s, it was not until the 1960s that the federal government began supporting these program as a means of expanding access to health care for the underserved communities.

And by promoting literacy, family planning, and immunizations. By the 1970s they're role became more important due to the lack of health care access. So they became really a bridge between communities - the community and health care services.

In 2007, we had the first community health care worker National Workforce Study conducted by HRSA. This report estimated that there were at least 127,000 CHWs in the USA at that time. Next slide, 17.

So community health workers have worked on a variety of programs in various settings, performing a wide range of roles and as they become more professionalized, their responsibilities have become more defined over time.

For example, they now work for outreach and community mobilization as a community liaison. They even do care management and care coordination.

Some do home-based support. Others, they provide health promotion and health coaching.

They provide assistant navigators, including enrollment for the Affordable Care Act, and they also participate in research. Slide 18. By now the evidence is clear that CHWs play an important role in addressing the social determinants of health as well as helping to reduce the use of high cost health care services.

CHW programs for which the return on investment had been calculated, fall in the range of \$2 to \$6 savings for every dollar spent. For example, from promotores working in underserved - with underserved men in the Denver Health System, were able to shift them from costly inpatient or urgent care to primary care.

Achieving a \$2.00 return on investment which an analyst - which resulted in a saving of \$95,000. In Baltimore, African American Medicaid patients, with diabetes, who participated in CHW intervention had a 40% decrease in ER visit, 30% decrease in ER admissions—making for an average savings of \$2,200 per year.

Next slide, number 20. Another milestone in the history of CHWs' professional identity was in 2010 when the Bureau of Labor and Statistics recognized them as a distinct occupation by creating a standard occupational specification for that field.

On March 2010 as the health care in the US entered a new era with the passage of the Affordable Care Act in 2010, CHWs have been identified as an important component in the health care workforce. In fact, the law

specifically mentions the use of CHWs as an effective way of improving health outcomes as part of the health care team.

Also on July 15, 2013, the Centers for Medicare and Medicaid Services, Medicaid, CMS created a new rule which allows states' Medicaid agencies to reimburse for preventive services provided for professionals that may fall outside the state's clinical licensure system as long as the service had been recommended by a physician.

This new rule would allow CHWs to be reimbursed when they provide these services. In terms of state initiatives around CHWs they have organized themselves and made recommendations.

And even in some cases passed laws regarding workforce standards in their respective states according to local needs. According the CDC, as a matter of fact, 15 states and the District of Columbia have enacted laws addressing CHWs infrastructure, professional identity, and workforce development.

Six states have created advisory boards, eight states have established a scope of practice, and five states have enacted workforce development laws that create certification process or require CHWs to be certified and there's more than that in that report. Next slide, number 20.

So I want to read, kind of expand on the quote there that was provided by Dr. Jeff Katula. He said, "we wanted to take this intervention out to the people in the community rather than having them come to us in a clinical setting." So also I want to quote from the diabetes prevention in Hispanics.

A report from a randomized controlled trial that was printed on February 2014 where they showed that a home-based intervention delivered by community health workers was associated with a clinically and statistically significant reduction hemoglobin A1C.

Using five session of home based educational curriculum and those levels were maintained for over six months. Next slide, number 21. So the National Diabetes Educational Program (NDEP) is a combined CDC and NIH program.

That works with partners to reduce the burden of diabetes and pre-diabetes by facilitating the adoption of proven approaches to prevent or delay the onset of type 2 diabetes and its many complications.

NDEP and its diverse partners have developed educational messages, materials, and tools that are based on evidence from clinical trials. As we know from these trials have shown that changing the behavior of people with diabetes can prevent or delay complications.

And people with pre-diabetes can prevent or delay getting diabetes. One of the resources is the Road to Health and Camino a la Buena Salud toolkit that was written for Hispanics who are risk for type 2 diabetes.

The toolkit has also been adapted successfully for other ethnic groups and that can be downloaded on the website that will be listed. It includes a portal flipchart, several posters in plain language, a music CD, and a whole wide range of training and evaluation and guidance tools that would be very useful for community health workers.

The toolkit outreach is led by the NDEP Hispanic Latino Stakeholder Group which is the largest group within NDEP under the leadership of deputy director Betsy Rodriguez. Betsy is well known in the diabetes field for her pioneer work with the community health workers.

This group, of which I have been a member since 2001, has been crucial in helping NDEP develop, test and use bilingual resources for people with diabetes. Next slide, number 22.

As of today there are over 85 organizations that are part of the Hispanic Latino Stakeholder Group representing academia, grassroots organizations, national organizations, community health workers, representatives from pharm, and other state programs.

And I invite everyone in the call to find out more how they can join the workgroup. It meets every other month, on the last Tuesday of the month. They also have a phConnect which is online community where this group connects, shares lessons learned, and news and resources for everyone involved.

And of course they offer top of line webinars with the best experts in the field. Some of the most recent topics have been diabetes and nutrition in the Latino community.

New beginnings, managing the emotional impact of diabetes, the art of storytelling and use of culturally adapted tools to educate people with diabetes. And lastly, diabetes, distress and depression, incorporating the emotional side of diabetes into clinical care. Next slide.

So these are some of the lessons learned. I won't read them. They're very clear. But I also, as part of the evaluation that we have done with NDEP we have - many people have commented on the flexibility of the toolkit.

How you can either use it as a whole or as in components that is easy to adapt and is really the need to have sustainable funding for the promotores for to make sure that this type of program is used more.

And the NDEP is working on a demonstration project and evaluation and we will have results after the use of the toolkit and how useful it has been for the community. So the last slide has my contact information. And now I'll pass it to Dr. Theresa Byrd. Theresa.

Dr. Theresa Byrd: Thank you so much, Jaime. I am happy to be with you this afternoon and tell you about AMIGAS which is a program that we developed along with our community. And I'm going to show you how we developed and tested very briefly, that project.

So AMIGAS stands for Ayudando a Las Mujeres con Información, Guía, y Amor para su Salud, which means helping women with information, guidance, and love for their health.

And it's a theory based intervention and we developed this intervention based on several behavioral science theories but I think most importantly with the participation of folks who live in the community. And I really think that's probably the most important point.

It was aimed at increasing cervical cancer screening in women of Mexican origin and my start - I started this many years ago. This is a long term project

but it has been funded every time by CDC. And so why was AMIGAS important?

Well first of all, because here in the United States, Hispanic and Latino women have higher rates of cervical cancer and lower rates of Pap test screening than non-Hispanic, white women. And we know that regular screening can prevent cancer. It's one of the few cancers that can be prevented through screening.

The other being colorectal cancer, because we can find changes that happen early and we can also improve the outcomes if it's cancer if we find the cancer early. So screening is very important and most people who get cervical cancer are people who have not been regularly screened.

So phase 1 of AMIGAS was we just got interested in figuring out why Hispanic women in El Paso, Texas were not being screened so we did a pilot study with young women.

And then we did a larger study where we went door-to-door and knocked on doors and talked to 500 women and asked them a series of questions using behavioral science theory. And using those data we developed an intervention together with community members.

So we actually brought folks in from the community and from the promotoras de salud who worked with us as we looked at the data and as we decided what kind of techniques we would use to help people change their behavior. And we've pilot tested that.

It was really kind of interesting because when we finished shooting the video and put the flipchart together, one of my students went and presented at the American Cancer Society, this is many years back. And they said, oh, that's really nice.

Did you know that they changed the cervical cancer screening guidelines yesterday? So that was kind of a shocker for us and we kind of put things on hold for a little while and then we got together with folks from CDC, with people from Battelle.

And with a large group of lay community health workers who came from San Diego, from Yakima, Washington and from El Paso and Houston and we kind of reinvented the material. We included the new guidelines.

We added English because we originally had only done this in Spanish and we added some games and activities. And you can see, this is the toolkit. It's really quite simple. It's not something that's difficult to reproduce.

There is a DVD, a flipchart, a promotoras training guide, and other training materials that the promotoras used to help them as they delivered education to women in their homes. This is a scene from the video and the video was kind of a novella.

We were trying to reach women of all ages and so we started out with the two young women in the middle talking about a data and then they got into talking about birth control and the need to have cervical cancer screening which one of them had never heard of before.

And then mom who is a promotores comes in and starts talking to them. Then grandma who walks by and hears them talking about this and can't believe it and she's just shocked that they're talking about this. Comes in and then admits that she also has not been screened.

And so it kind of takes us through all of the barriers that women pointed out to us that we tried to resolve with this novella. And then in phase 3 we did a clinical trial to test the effectiveness of this intervention and we conducted the trial in Houston, El Paso, and the Yakima Valley.

And so what we had were four arms to our groups. We had the full AMIGAS arm which included the movie, the flipchart, and the other components and all of them include the promotores.

And then we had an arm with the movie and the other components and an arm with the flipchart and the other components and then our control group had no intervention. But six months after we completed we went back and did the intervention with them. And what we found was really quite wonderful.

That is that the control group at the end of six months - none of these women had been screened by the way. They were all under screened. So in the control group 28.6% of those women had chosen to get a Pap test. And then the full AMIGAS it was 61.7%.

In the just movie it was 56% and in the just flipchart it was 50.8%. So you can see between the control group and any of the interventions the P-value was quite small. So we were very happy. But comparing the three non-control arms there was really no statistically significant difference.

So that speaks to how much we need to actually pay for interventions. We might not need all of the interventions. Sometimes we just use a piece of it. So the question is, you know, why did AMIGAS work?

And, you know, as a behavioral scientist, I like to think that, you know, the theory base had a lot to do with it and I think that probably has something to do with it. Also as a community development person, I like to think that the involvement of the community in the development had a lot to do with it.

But when we interviewed women after the intervention the one thing they kept mentioning was how happy they were to have a promotores come to visit them in their home.

And so, you know, I think there is some evidence that even without effective interventions that are developed by scientists, community health workers can probably have a major impact on the health of people just because they are that person who goes to them and cares about them. And I'm sorry.

I haven't been telling you the slide numbers. I apologize. So I'm actually on the last slide, 35, and this is my contact information. And I thank you so much for giving me the opportunity to talk about AMIGAS. And I'm going to turn it back over to Sam now.

Sam Taveras: Okay, great. Thank you all for excellent, excellent presentations. I love the data that Dr. Dominquez presented with the health risk and the death rate and really important information to build on. Love the information shared by Dr. Torres, community health workers.

Such a critical component in us addressing the Ebola epidemic and critical component with polio eradication in India and great diabetes program and community based. And thank you so much Dr. Byrd for your presentation.

That was excellent information about the AMIGAS project. Again emphasizing the importance of the involvement of the community and promotoras. Also, thank you so much.