



Public Health Live! Broadcast Transcript

February 2015: Confronting Health Disparities in African American Communities

Moderator Rachel Breidster: Hello and welcome to Public Health Live!, the Thursday breakfast broadcast. I am Rachel Breidster, and I'll be your moderator today. Before you get started I ask that you please fill out your online evaluations at the close of today's broadcast. Continuing education credits are available after we continue our short post-test and your feedback is helpful in planning future programs. We encourage you to let us know what topics are of interest to you, and how we can best meet your needs. As for today's program, we will be taking your questions throughout the hour by phone. The toll free number is 1-800-452-0662, or you can send us written questions, throughout the hour at phlive.ny@gmail.com. Today's program is *Confronting Health Disparities in African-American Communities*. Our guest is Dr. Thomas A. LaVeist, the founding director of the Hopkins Center for Health Disparities Solutions, and professor at Johns Hopkins University School of Public Health. Thank you very much for being here.

Dr. Thomas A. LaVeist: Thank you for the invitation.

M: Sure. So we have a lot to cover today, it's a pretty broad topic. I wonder if you would start our conversation by trying to give us a general idea about what we mean when we say health disparities.

D: So, health disparities are differences in health outcomes, health care, health care quality and access by various demographic groups by race, ethnicity, gender, geography—urban versus rural, for example—as well as lesbian, gay, bisexual and transgender (LGBT) people. For example, one of the things that is best documented on race disparities is where we find there are substantial differences in life expectancy by race and gender, with males having lower life expectancy than females. This has been the case for as long as we've collected data on this topic.

M: How do disparities manifest themselves in New York State?

D: Well in New York State, I think it's emblematic of the country—a pretty good illustration. Here we see differences by obesity, especially by gender with black women having higher rates of obesity as well as Hispanics, compared to whites and Asians in New York. Diabetes is another condition related to obesity, where we find a similar pattern with African-Americans and Hispanics having higher rates than whites and Asians. This pattern is consistent across the country, including New York of course.

M: New York is a microcosm of the bigger picture.

D: Sure.

M: What else do we know about disparity in obesity and diabetes?

D: Some underlying causes, of course, are going to be diet, exercise and consumption of sugary beverages, and this is one of the things getting a lot of attention especially in New York State -- you

know the whole Big Gulp® controversy – and in New York there are much higher rates of consumption for racial ethnic minority groups, particularly African-Americans and Hispanics.

M: Now we have a sense what we're talking about in terms of health disparities. I like to hear about the work you do and how you came to be doing the work you're doing now.

D: Actually it's a pretty embarrassing story. Back to my years as a graduate student, I was working on a PhD in political sociology when I discovered there were health disparities. If you're going to write a dissertation, anyone who has done that can relate to that point where you become so bored from the isolation and tedium of writing a dissertation that you want to find something else do—anything! So, one day, I was at that point and decided to take a walk. I was taking a walk along downtown Ann Arbor, Michigan. Anyone who has been there can tell you that it's a short walk—it's not a big place. And I come across a used book store, wander into the book store and make a beeline into the clearance section and I start looking for something to read. I find a book called *A Night To Remember*. This is a book about the *Titanic*. So, I start thumbing through this book and I come to this page where they are talking about survivors on the *Titanic*. This is before the film, so at that time I didn't know that there *were* survivors, I didn't know much about the story. I thought the ship sank and that was it. They talked about who survived as a function of the class of ticket that they had. So I'm standing there, in the clearance section of the used book store calculating death rates—which probably tells you something even more about my mental state—and I see that first class ticketed women had a much higher likelihood of surviving the *Titanic* compared to the second and third class women. I found it a fascinating allusion to the U.S. health care system. Big expensive ship, giving out unequal treatment, destined to sink. And when it sinks I think the results will look something like this—those who have more will have better outcomes.

M: I think you make a very compelling argument and that's certainly a powerful metaphor for the situation we're in, but I think there are people who might say the *Titanic* was a long time ago. Do you think that's still relevant today?

D: I *do* think it still is relevant today. If you remember a few years ago, [there was] the U.S. airliner that landed on the Hudson River. You know, there's this picture that I've come across of those who survived that crash. And [in it] you see the first-class passengers are in life boats, coach class passengers standing on the wing. So, I mean, it's a set of policies that create this. It's corporate policy, as well as government policy. The government could pass a policy saying you cannot operate an airliner in the United States without enough life boat space to accommodate everyone. **U. S. Air** (US Airways) could have a policy that says they will not purchase an airliner which doesn't have enough space for anyone, but those things have not been done. More than 100 years and here we see a possibility that a similar outcome as the *Titanic* is still present.

M: When I first saw this photo I thought, “Is that photo-shopped?” It's hard to imagine. It's such a clear picture you're talking about. This is a very powerful example. Doctor LeVeist has been working on a

documentary titled *The Skin You're In*, and he shared excerpts of health disparities of African-American communities and what is being done. Let's take a look.

>>Roll-In Clip<<

Annette March-Grier: *We, as African-Americans go to funerals like we go to a supermarket—just that frequently. Death is a continuous event in our community. It is not uncommon for a middle school-aged child to go to one or two funerals a week.*

(People in Documentary): **showing a picture of a young man* 19, and he went into a diabetic coma.*

AMG: *For a young black man to say, "I'll be lucky if I live past 25", that's a common phrase.*

(Person in Documentary 2): *When we are lost and sick at heart, we do remember them.*

Dr. Sharon Jones-Eversley: *My father and my husband, both of them passed away at the age of 40. The two most important male images in your life passing away at such a young age from cardiovascular related illnesses—no way this is coincidental.*

(Person in documentary 3): *I'm thankful for my life. I have my strength...*

DSJE: *I think African-Americans have not really grasped that they have control over their health.*

(Person in Documentary 5): *I thank you for my children. They have only brought joy to me...*

DSJE: *We accept sugar runs in our family, diabetes runs in our family, high blood pressure runs in our family, obesity runs in our family. Knowing that's one thing, doing something about that to reverse the generational trend, is something completely different.*

(Person in Documentary 5): *No pork in the collard greens, no pork in the string beans, no pork in the cake...but we do have pig tails and salad!*

Doctor Thomas A. LaVeist: *We looked at the consumption of comfort food—as we call it, soul food. This is a way of coping with stress.*

Terri C. Braxton: *Food is a constant in our culture, that's how we express love, happiness, sadness...put food on table.*

Lauren McCreary-Hawkins: *Being a woman and being black, there is just so little room for error. When I walk into Corporate America, people were instantly wondering if I was just there to fulfill a quota.*

TCB: *The best anesthesia most people find are drugs and alcohol. In our family, it's food. In most places, it's drugs and alcohol.*

RR: *You don't want to do drugs, and you don't want to drink or smoke, but you can eat a brownie. It's quick, and easy, and temporarily makes you feel better.*

DD: *The women in my family have died from obesity-related disorders.*

HHL: *I kind of push it out of my mind, honestly! You don't want to go to a family gathering, imagine the people who are going to die because of their body size.*

NN: *It's scary. I had sleep apnea at 23, I had high blood pressure, I was pre-diabetic. Poor quality food. It's part of our lifestyle because it's what we had easiest access to. That's what we saw our parents eat, that's what we see our friends eat, that's what is in our neighborhood.*

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M: That's some very powerful footage you've collected there. I think -- you know, we think as a general rule, at least health care providers are, starting to have some understanding what health disparities are. Why is it important we're having this conversation here today?

D: Most of the time we talk about health disparities we talk about it from a social justice standpoint, and to be sure it is a social justice issue, but it's more than that. I think it's important that we highlight other ways that health disparities impact the society. So, for example, a few years ago, we conducted a study of the -- we did an analysis of the U.S. economy. We wanted to estimate, *what does it cost the U.S. economy?* What is the impact on the economy of having health disparities -- having people sicker than they should be; people that are less productive at work than they should be. As a society, we develop people's human capacity by paying for public school for example. But then, by dying prematurely, they die before society can reap the benefit of that investment. And we calculated that cost. That's \$1.2 trillion, which is the size of the economy of India, the 11th largest economy in the world. It's quite expensive to maintain the disparities; it's an inefficiency to the economy and an inefficiency that we shouldn't continue to maintain.

M: So, it's more than a social justice conversation, there's financial impact as well.

D: [And] there's military argument that can be made, as far as military preparedness. There are impacts; there are costs to the economy that go far beyond simply the toll on individuals.

M: So, it's clear that this is multifaceted, and there's a social justice imperative, but why? Why do these disparities exist?

D: Let me first talk about why they don't exist. So typically, when I talk to people about disparities, three arguments come to people's minds. First, it's really a health care access issue --if we can only increase access to health care--more doctors, more hospitals--we address health disparities issues. Second, health disparities about biological or genetic differences, that there is something ordained by God that there will be genetic differences between race groups, and these will have different health outcomes. Third, it's not really race, it's really socioeconomic status. All three have been well documented to be untrue. So, first of all, even if it was socioeconomic status, why would that be any more acceptable? Why would it be any more acceptable that people would have bad health problems--that's also a problem. So, to illustrate each of these points, we conducted a study a few years ago at three hospitals in the Baltimore area. We went into those hospitals and we pulled every medical record, about 10,000 records of

patients that were seen at those hospitals for cardiovascular disease. We then identified which patients were appropriate candidates to receive coronary angiography, or cardiac catheterization. What we found is, if you look at all patients that had insurance, that would have covered it—these were all medically appropriate patients, all of whom wanted and came to the hospital seeking care, who had insurance that would have covered the procedure— what we found was that 82% of the white patients got referred, but only 58% of the black patients were referred. We had an overall quality problem because while not all patients got referred, there was still disparity. So access to care won't in and of itself solve this problem. There's another study at the VA in Pittsburgh where they looked at revascularization. What I like about the study is that it is done at one hospital, the VA hospital, and the patients were all VA patients, and 100% were appropriate candidates for revascularization. What we find is an overall quality problem, because only about half of the white patients got the referral, but, half again of the black patients got the referral. There's a quality problem we have in the country overall, but then there's disparities in quality.

M: To be clear, in those studies, you're talking about all people who had access to health care. They all had some sort of coverage.

D: More than that. Not only did they have access to coverage, it wasn't about their desire to get care because these were patients with whatever barriers they may have had, they overcame the barriers—and they did show up at a hospital, actually did get seen at a hospital, and actually got a diagnosis. So, we're taking all of those other issues off the table and saying, among people that had a diagnosis that were found to be medically appropriate—to receive a service and could have paid for the service—we're still finding disparity.

M: Okay. Another argument that you say, or another reason people give for health disparities is a genetic or biological component. You say that's also—doesn't hold water. So can you talk about that?

D: Your question begs the question, “what is race?”

M: Sure.

D: So, is race biology, or is race a social or political construct? It can be pretty easily illustrated that race is a social, not a biological, concept. Let's take three famous African American men. All right? President Obama, Colin Powell, and Tiger Woods. All three of these men are African American, by the definition we use in this country, but if we look at their ancestral background they're quite different. You have President Obama, who has two grandparents from Kenya, and two that are white American. By the way, Kenya is in East Africa; the African ancestry of most African Americans comes from West Africa. Colin Powell has one [grandparent] from Ireland, one [grandparent] from Scotland, and two [grandparents] from Jamaica, and he's born in the Bronx, [yet] he's [also] African American. And Tiger Woods has one Chinese grandparent, one Thai grandparent with Chinese ancestry, one white American grandparent with Native American ancestry, and one African-American grandparent with Native American ancestry. So if all of these men, with very different background from different parts of the world, are all considered African Americans, then I believe this suggests that the concept is social not a biological concept.

M: If it's not biological why would there be differences in health based on that social construct we defined?

D: I think that's the crux of the issue.

M: The last thing I think you mentioned and I think many people would say, "Okay, it's not biological." But if we control for funding, it's an economic issue. We see economic disparities between communities of color and white communities. Isn't this a socioeconomic issue? You say, no?

D: I say no. Socioeconomic status is clearly a big issue, it's a problem. People with lower incomes have the worst health outcomes. That's probably the best documented fact that we have, period, across the board. But even if you're within income levels or education level, you still find differences by race. So I have a series of charts that we can scroll through, looking at a variety of different health outcomes and you see it doesn't matter if it's diabetes or hypertension, we see a disparity at all levels of education here. We have obesity, and again, at all levels of education we find race differences in obesity rates. We have infant mortality rates, again, at all levels of education. We have race differences in infant mortality. You can also look at income: for obesity we again find race differences across all levels of income, for hypertension, we find the same pattern here. What's even interesting about this one is that, whereas in every case, as income increases or education increases, the prevalence of the condition decreases, but with hypertension and income levels, we actually find the opposite for African Americans. So, as income levels increase, the rate and risk of hypertension actually increases for African Americans.

M: Which I think is very surprising. I don't think many people would expect to find that. So, even when we're looking at controls for education levels, controls for income levels, we're seeing disparities between different racial groups.

D: Exactly.

M: This begs the question in the room, so what are we looking at? If it's not biology, not access to care, if it's not economic disparity, not these things we've grown comfortable attributing to the health disparity, what are we looking at here?

D: I think that we live in this country together, people of different racial and ethnic groups, but we experience the country very differently. The United States is a very racially segregated society, and because of that, people live in risk environments that are very different. If we don't account for those differential risk environments, we could think the disparities we see in the national statistics are disparities attributable to race rather than to place, to where we live. So, when you screen down, you see a map that was produced at the University of Virginia. This map was produced from the 2010 census and they actually plotted on the map, the residence of every American—can you imagine that? That's fascinating! Every American in the United States, and it was color-coded. Blue dots are white American, green dots are African Americans, and orange dots are Hispanic. So if you go to the next slide you'll see New York City, and I've circled here Brooklyn, because I'm from Brooklyn and Brooklynites think that the world revolves around Brooklyn. That's Brooklyn, and that mass of green there in the center in central Brooklyn is the Brownsville East New York community, which is where I was born and raised. As you can see, the colors in Brooklyn and Queens are very distinct, very different. You can see very distinct borders

where one community ends and another begins. And although they all live in Brooklyn, they are experiencing Brooklyn very differently. Now if we would overlay that map with food deserts, or availability of liquor stores—things like that—I think we would see those things would track along these different colors.

M: Sure. I would absolutely believe that. So really what you're kind of saying the underlying cause of a lot of the health disparities we're seeing is attributable to racial segregation.

D: And the community conditions that people live in.

M: And has there been research that documents this?

D: So one of the things we did at the Hopkins Center for Disparity Solutions is we did a study to try to document this issue, and the question we asked was, “what if we can find communities where black and white Americans live together in an integrated community, and where there are no race differences in income, or educational levels, would you still find the same disparities?” So, we went out and identified census tracts in the country. Fortunately for us, we found two census tracts in Baltimore City that met that criterion. So, in this community – there are two census tracts together that are 44% white.

M: Okay.

D: And 51% African American.

M: Okay.

D: And there are very little differences in educational levels. Very low income community, about \$25,000 median income in that community, but no race difference in income levels.

M: Pretty comparable so far.

D: Very comparable. Also, we find poverty rates were very high for that time, \$2,000, very high, but again, no race differences in poverty levels. Educational status was also very comparable between the groups. This is as close to a laboratory condition, if you will, that you're going to find in a naturally occurring community. So, we asked the question, “if we went into this community and replicated protocols from national studies, NHANES and the [National] Health Interview Survey], would we find the same result that we find in the national statistics?”

M: So, the neighborhood you were looking at was pretty integrated, 50/50, black and white, pretty comparable in all of the other indicators, whether it's income or education. Then you look to see what the outcomes are, and what are things that you found?

D: We found interesting outcomes there. What we found is that if you look at diabetes, for example, in the national studies, in the Health Interview Survey, when we did analysis there of diabetes, we find that African Americans have a 61% greater odds of being diabetic. In this community we find no race difference in diabetes. So, let be clear here. It's not - the lack of difference is not because the African American rate went down. The African American rate is very high in that community, virtually as high as the national level, in fact higher. But what we find is that the whites living in this community are just as sick, so their rates also very high. We look at obesity, again national statistics, 81% greater odds of black

women being obese compared to white women—in this neighborhood that we studied no race difference was found in obesity among women. The one area where we do find difference is hypertension. So, in the national statistic, we find double the rate for African Americans and 100% higher rate. But in the community we studied, the difference was only 42%, so it was a much smaller disparity but there still is disparity there. So, what this tells us is that when people live in similar, very difficult, very trying conditions, their health outcomes are very similar. So, it's not necessarily race, per se, but it is place...but race determines place.

M: Absolutely. Has there been other research done that had similar findings?

D: There have been other studies looking at these issues. The study published in *The New England Journal* two years ago where they looked at CPR, whether or not when someone was unconscious, whether there was someone around who knew CPR. What you find is if you happen to be in a low income, predominantly African American community, the odds that there would be someone nearby who knew CPR, dramatically lowers compared to other communities, other racial, and income levels. This is part of the infrastructure that leads to worse health outcomes. Even here, we don't have people who are able to take action and know what to do.

M: All of what you presented so far is fairly stark. I mean when we're looking at disparities that exist, the numbers themselves pretty striking but when we look at the community where people are actually integrated, how those disparities disappear, it's hard to not be impacted by the information you're sharing. And you have more information on film that you're working on. So I'm wondering if you can talk a little about your documentary, why you wanted to make it, and how it's relevant to the conversation we're having.

D: This issue of disparity, it got onto the national agenda, exactly 30 years ago with the publication of the *Secretary's Taskforce on Black and Minority Health* in 1985. Secretary Margaret Heckler issued these reports, in the 11-volume report showing disparities across racial and ethnic groups in a wide variety of outcomes. This report led to the creation of the Office of Minority Health and a variety of other things, ultimately leading to the creation of the National Institute on Minority Health and Health Disparities. So the entire infrastructure and apparatus around health disparity only got started 30 years ago. But in that 30-year period there's been so much research done and so many things we learned about why disparities exist and what we can do about it, but it's locked away in the library—medical libraries—where very few people can access it. We got the idea, what if we can take some of that information out of the library and put it into a format that people can actually access. Can we make change that way? That's where the idea of creating this documentary film comes from. Documentary film can be very powerful and can be transformative, so we're hoping to use this media to reach these people.

M: Seems like an excellent idea. I agree we've got all of the research but [still the question of] is it in the right hands? Are people accessing the information? This is a great idea to try to disseminate the information and get it in the hands of the people. Now, Dr. LaVeist's research shows that along with

structural, and policy initiatives, there's a need to engage and consider the responses of those living in the most impacted communities. Let's take another look.

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Annette March-Grier: *We have an enormous amount of resilience and endurance to just contend with so much. Every day, I'm amazed. I say, wow...wow.*

Doctor Thomas A. LaVeist: *In this film we'll meet people who have made change in their personal lives; who have transformed their communities; who made changes to the policy process. Just as there's proof all around us that we have this cycle of death, there's also proof all around us that we can make change, that we can break that cycle.*

Doctor Edward James: *My doctor turned me toward education, thank goodness. Because so many of my family suffered and died prematurely from these diseases; thank goodness for this support group.*

(Person in documentary 6): *No community should be poisoned and the fights that we wage, these are not sprints, these are marathons.*

DSJE: *We can choose to live, as opposed to accepting a fate of death as if there's nothing we can do about it.*

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M: So, there's some very interesting ideas there and I wonder if you might be able to share with us—certainly we can't cover all of the content of your film—if you can talk about community approaches you've seen that seem to be more promising, I think the audience would benefit from hearing that.

D: We plan to feature some of that from the film. What we wanted to do is say, okay, we don't want to just alert you, there's a problem. Many other documentaries do that. They get people upset, there's an issue, and then it doesn't go anywhere. What we wanted to do is create something that at the end says, there's hope. There's no reason to despair. There are people making a difference. There are organizations making a difference as well. We wanted to show people that no matter where you are there's something you can do for this health disparities problem. If you're an individual, there are things you can do for yourself. There are things you can do for your family and things you can do for your community. If you're with an organization, there are things your organization can do with, or without financial support. We want to highlight people that fell into each of those categories. I want to share with you a couple of individuals and groups that we found and we're going to feature in this film. I talked about being from Brooklyn and one of the things that I worked on was an organization called Man Up. This organization is a really interesting group. These guys are working with the issue of violence. They have a relationship with the hospitals there (Brookdale Hospital) where, when an ambulance call is coming to the hospital, bringing someone who has been a gunshot victim to the hospital, they get a call from the hospital, and told there's a case coming. They dispatch one of their members to the hospital who begins the process of counseling the individual, as well as counseling their family members and friends, to try to reduce the likelihood that they will retaliate and accelerate the violence. The members

of this group are all men who, themselves, have been victims of violence and through that experience they want to try to make something positive out of it and I think it's just a very impressive organization doing important work.

M: How long has that been going on for? Do you know?

D: I am not sure just how long they've been doing it.

M: But certainly seems like a great idea, though.

D: Right, right.

M: Where are some additional community approaches for addressing health disparities in the African-American community?

D: Another person we want to feature in the film is Katherine Brown, who is in Nashville. She is the “CPR Queen.” She literally goes around neighborhoods, knocking on doors, people's doors, saying, “Do you know how to do CPR?” If the answer is no, she's going to teach them right now on their doorstep. She has probably saved countless lives. She couldn't estimate how many people whose lives have been impacted because someone knows how to do CPR – something easily taught. But there are so many people that don't know how to do it. She taught me how to do it. She said, “Have you been trained?” And I said, “Actually, no” and she said, “I'm not going let you leave this room until you learn it!” But, again, she doesn't need an organization.

M: Right.

D: Or a grant or – not that she wouldn't want a grant --

M: Sure.

D: But you don't need that to go out there and make a difference, and she is making a difference.

M: Yeah, I think that's an important message, too. Because everyone is competing for the same funding, for waiting on grants or higher funding sources to make things happen—change happens more slowly. That's an example of going out there and making the change happen yourself.

D: I have to say this, because Katherine probably will see this, if she had a grant she could do so much more, but point is, that she said, look, this is something I can do. I'm going to do it and she just does that, and I think that's really important.

M: Absolutely. Are there other community approaches that you've learned about through your work that you've like to share?

D: Another person that we're going to feature in the film is Ron Finley, who was in South Central, Los Angeles. And Ron Finley, noting that how many people in this community were hungry – South Central is a classic food desert – he just decided, you know, what if I planted a food garden in the median strip out

in front of my house? And he just said, "Let me see what would happen." And he started planting seeds, and this garden grew, and people in the community would come and get food, and he would let them have the food for free. Then he began teaching people how to create their own gardens. Now he travels all over the world helping people in poor communities to do similar types of things. So, these are all individuals who just, you know, make a difference through just their will, and the desire, and seeing a need, and figuring out a way to step in, and meet that need.

M: Very impressive and certainly very empowering or inspiring to see the difference that just one person can make. Now, the doctor's film focuses on empowerment within African American communities to make their communities healthier. We recently visited the WATCH School– the World Academy for Total Community Health, in Brooklyn–to hear some programs they have under way to do just that. Let's take a look.

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Ashley Cornett: *Hi, my name is Ashley Cornett. I'm the program manager for the school-based health center at Thomas Jefferson campus, and we are the lead partner for WATCH High School. WATCH, as a whole, is a helping school. Currently, we try to expose the kids to a number of health exposure programs. We partner with Memorial Sloan during the summer. This is where a subset of students is selectively chosen to participate in shadowing clinicians during the summer.*

Kiera Williams (11th grade student): *Being here, especially in certain classes, like forensics, made me want to be in a college that has to do with science, like young scientists, and studying the body, and stuff like being in a lab. That is basically where I see myself.*

AC: *The biggest health issues that impact the study body are, number one, obesity, diabetes, and then other cardiovascular issue, but number one is obesity. I would contribute that to the area we are in. If you walk possibly a mile away, you are exposed to a number of fast food franchises.*

T'Sahay Douglas (11th grade student): *I see a lot of health issues in my community. Recently went to Brookdale to videotape for the Johns Hopkins trip. And when I went there, all of the doctors expressed that the most frequent health problems that they see are diabetes, hypertension and things of that sort– and those are all things that can be prevented and those are due to eating healthy habits.*

AC: *Currently we have a garden on the corner of the high school here, but we're not using it, of course, because of the weather. But normally what happens is the students get to work on putting beds into the garden, growing fruits and vegetables of their liking since, of course, because of the weather, we can't work in the garden but that's the most exposure they have in the gardens within the community.*

The project 100 Days in Brownsville was introduced by Dr. LaVeist, from Johns Hopkins. Basically he's doing a documentary, 100 Days in Brownsville, and we selected 20 students to canvass the community and find access to healthy food. Of course, their results were just like my results which were that there's a one-mile radius of fast-food franchises.

KW: *First, me being a part of this community, I live in the area, and I see the day-to-day struggles with obesity, diabetes–especially in my own family. So, that kind of pushed me to want to actually speak on it, because, you know, one or two people can make a change and not a lot of people have somebody to go*

to and talk to about it. Or they don't know, like, what options they have. What they can do to change their life style.

AC: *The importance of this project for the students selected, I feel are that it brings awareness. Now they think twice about indulging in a fast food, a hamburger. Now, start selecting items that are healthier for their life styles and, in addition, I think it's about bringing education awareness as well to the community. Those participants now, they'll question the healthy food options, or now this can bring in some involvement or some campaign, I think that's the impact. And if it is continuous enough, it can have a greater message of using the gardens in those communities, having farmer's markets.*

TD: *One day we went around the neighborhood to compare—because the East New York and Brownsville community actually had farms (there are three farms), but within the one block there's five corner stores, and corner stores do not sell fruits at all—they sell soda and chips. Chips are like 50 cents, soda is like 50 cents and that's really cheap. You go to the farm and it's not really cheap.*

AC: *How can we get access to healthy food? They've incorporated more gardens into the community but now its education, because you can have a number of gardens in the community. But it's not to say everyone is going to utilize them. They can be underutilized. It's one thing to have the gardens in the area, but for myself, I can pass the garden all day long and not think about healthy eating. We have education – if you have those voices out there saying, hey, you can live a long-life, have a campaign, or something, a demo to share, just thinking of what you're consuming. I think that's another way to just campaign, to give people the voice. You know, gardens are here, but are they underutilized? Are we over utilizing it? Having more farmers' markets. Having a day the community comes out to the gardens, a garden day or something. You know? It's really good, because one is developing a relationship, a deepening relationship, but also education.*

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M: Sounds like the school is certainly very inspiring for students who are there and they are doing incredible things. Can you tell us how you got to be involved with the WATCH School?

D: I was in the neighborhood shooting for the documentary that I'm working on, and one of the people who helped me with the documentary—I had help from the New York Health Department—and they kept saying, we want you to take a trip over to the WATCH School. And I never heard of the WATCH School. And he kept pressuring me, and I said, okay, I'll go to the school. So we get to the car and drive over to what I know as Jefferson High School, which is what it was called when I was there. I get to this building; we go in through metal detectors, through the police, up the steps. Jefferson High School, if you don't know about it, has a reputation for being violent and one of the most challenging high schools in the country, certainly in New York City. But when I walk into this classroom, there are these 30, bright, energetic, engaged and interested students. So all of the stereotypes about Jefferson are thrown out the window, because the kids I'm seeing are kids that are turned on and excited about learning. They're learning about health and public health in particular. They're studying public health and have apparently read articles I've written but didn't know I was from the neighborhood—I was a kid from the neighborhood like them. And what they don't know, but I know they see this, is that I was much more impressed to meet them than they were to meet me. I was excited about meeting them. I spent an hour in the classroom talking about public health and what it was all about, and what we can do and how we

believe the public's health can change. They asked me to be their graduation speaker which I was honored to do last year. And now we have another film project that we're working on together which is called, *100 Days in Brownsville*, where we actually gave them some training on shooting film, and they're going around the neighborhood, interviewing people, and we're going to edit that into a short film. They're going to be coming down to Johns Hopkins in April, and we'll give them a campus tour, a tour of the hospital, and have them sit in on a few classes and we'll show the film. It's just been a great relationship and hopefully we will be able to keep that relationship going and be able to do more with them.

M: Absolutely, and both of these documentaries you mentioned, *The Skin You're In*, and *100 Days in Brownsville*, when and how will those be accessible if they want to view information? Certainly they'll have a wealth of public information.

D: We're working hard on the both projects and film making costs money. Raising funds is always a big part of that process. If anyone is interested in just following up on the process, you can certainly come to the website or come to my personal website: thomaslavist.com and you can get linked to the website to sign up to receive updates. There's also a Facebook page for "The Skin You're In" - you can login and sign up to updates on the project.

M: Great, that's terrific. We have questions from the audience. Let see what we can get through. The first question is, how can or should communities partner with researchers like you to make changes in these disparities?

D: Wow, that's tough. I'm going to be candid here: in the academy, the incentive structure doesn't always work to create those kinds of community partnerships. Many universities are focusing on promoting, and your career advances because of publication and academic journals and it's not just the quality but the quantity as well. So if you can spend a few weeks writing two or three papers, locked away in your office, that does more for your career than going out in the community, building those relationships, developing the trust necessary to have a real community-university partnership. It could be very time consuming and it could take years before you ever produce those products that was necessary for your promotion. So that's part of the issue. So I think what's important for community people to understand is that these are the incentives, and these are the pressures that the university person is under. The person in the university has to have a true desire to develop those kinds of relationships and do that work and realize that the mission here should be more than just getting a publication together, but rather in making change. So, I think it's about understanding each other, and understanding what each other's needs are in finding ways to build commonality, or common goals that meet needs in both the university and community.

M: Sure. Another question, what is the role of state and local government in assisting local efforts to increase access to healthier foods and beverages and increasing the opportunity for physical activity within communities and higher poverty rate?

D: I think New York has been really forward-looking in this area. The government has tried a number of approaches, including the beverage issue, which received much national attention. [The government needs] to try to create an infrastructure, to make the healthy thing the easy thing to do. Right now, in most cities, the healthy thing is not the easy thing. If you go to stores they don't have the healthiest food. If they do have healthy food it's not readily available. It's more expensive. There is more cooking involved. I think what the government can do is use ability to create incentives, and to set policies, to try to help make healthy things, the easier thing to do.

M: Sure. I would agree with that wholeheartedly. We've got another question, when considering that it is place, not race, are there special considerations for our surveillance of obesity?

D: I think it's place, not race. I think that there are considerations for surveillance that we might want to take into consideration. I think the race-based surveillance is still valuable, but place-based surveillance is really important. I think if you did that, you would start to see geographic patterns. If we took race out and mapped geography of obesity, we would see patterns there as well. I think it's valuable to look at both.

M: So, let me ask you as a follow-up to that, do you think the conversation at this point should take more of a direction at looking at place and what are the policy implications about that? What I find interesting about some of the information you shared is we've got disparities but when you see people living in somewhat integrated communities the disparities go away. So is the end goal to try to really reach integration, or are we just trying to create more equitable communities? What do you see as kind of the goal?

D: The goal in that study was to demonstrate that the race disparities were not because of biological differences. So, you have drugs coming into the market that were targeted into specific race groups with this idea that this drug is more effective at treating people of a certain racial and ethnic group. Even today you have physicians, some may be watching this show, who will disagree with me and say, black patients do better on diuretics than on calcium channel blockers, or beta blockers for hypertension.

These types of issues are out there and there are lots of people in very subtle ways that believe race is about biological differences. And what we wanted to do was say that is not the case. If we find solutions to health disparities by race, it's not likely that it will come through race-specific drugs. It's more likely it will come from understanding that there's something about the environment that people live in. so, it was really more about where do we target the solutions. But we need to first have a diagnosis of what the problem is. I think often we operate from the wrong diagnosis when it comes to racial disparity.

M: Absolutely. I think the information you found in that study is pretty...I don't want to say unknown, but I think a lot of people are more likely to attribute the disparities to the three factors that we showed were not really causal, than to looking at the actual segregation and physical space. We have a question,

is the cancer disparity likely influenced by poor quality environment? For example, lower quality housing, industrial pollution, and can you talk a bit about prostate cancer disparity?

D: I think -- here's the complexity of the whole thing: I'm not saying there isn't a biological component. What I'm saying is that the biological component is not that there are biological or physiological aspects that only belong to one race group and those differences are producing disparities. We know there's intergenerational transfer of risk. So that risk for disease begins in utero. That risk is transferred from one generation to the next to the next to the next. We also know there's epi genetics. Epi genetics says the environment impacts our physiology, our physical manifestation of the differential environment so that you can find differences or patterns in the data if we map certain physiological characteristics. We can find patterns that map and trap with race. So, what is the directionality? Is it that there's something difference about the race groups that is being manifested, or something different about their exposures that's leading us to find these differences? I believe it's the exposures that are leading to the differences, and this is the complexity of it. So this is an extremely complex issue and there's an interaction between genes and environment and disease. I'm not suggesting there's no biological component or that biology doesn't play a role in it.

M: Sure. We have another question, in which ways can we turn wealth of research into actual practice-- if money is an actual necessity? So, I guess we're looking at, we've got research, and universities are kind of pushing people to publish. You're saying there's not a natural set-up for researchers to partner with community organizations so, how can we help turn all of the research that's being done into practical application and solutions?

D: I did make that statement and I still stand by that, but on the other hand, increasingly there are researchers and areas that are developing and people trying to translate research into practice. And that's increasingly becoming an emphasis even into the federal government--NIH--to begin to do that. I do think that's happening and at some universities--even my university--looking more into public health practice, and clinical work, in giving that more sway in the promotion and tenure process. So, these things are changing and there's more of an effort overall to do more in getting the information out. I'm not saying we don't need money and we certainly should be investing in translating research into practice, but as some of these examples I showed. People who were able to make that translation without needing a lot of money and they were able to find ways to do it. One of the problems we have in the clinical area is getting new knowledge, adopted--practicing it based on evidence rather than experience. This change happens slowly, but there are efforts to try to make that change happen.

M: Okay. They've got a few more questions here, in your work both in Baltimore and here in New York and Brooklyn, what do you think are the most promising community responses to counteract disparities that you see?

D: That's a tough one. The most promising ones are the ones I'm trying to illustrate. The school is really important because it's going to touch so many people, so many of those kids will not go into health professions but they'll go out with a greater knowledge of what is a healthy life style--we talk about

healthy life style all the time. If you ask people, what does that mean? They say, "I don't know, eating salads?" If that's what a healthy life style means, then most people are not going to live a healthy life style. They'll be more knowledgeable, sophisticated, better consumers and hopefully that translates into them living healthier life styles. I think the most promising things are things that change the environment. Try to improve the quality of housing, try to incentivize grocery stores to open in communities that are food deserts, trying to incentivize stores that are there to provide better quality foods, things like that. I think the structural approaches as opposed to individual approaches, we've featured a lot of individual approaches in this film but going to feature structural as well.

M: Really the solution needs to come from multiple levels, multi-faceted intervention we're looking for.

D: Absolutely.

M: One final question I want to ask you, if you had to share a take-away message for our participants to leave with today. What would be your kind of parting word for folks viewing this?

D: It would be that racial disparities are not immutable. It's not something that was ordained by God. That it can change and people are making change and we need to learn more how to make change and get the word out about the change that can be made.

M: Well, thank you. It seems like from the work you're doing, you're a shining example we can make change. I think that—especially when we hear a lot about the disparities that exist, these conditions that exist and kind of get mired in this way of thinking that maybe this is the way it's always going to be—it's terrific to hear a message of, we can make this change and see the work you're doing to further that cause. So, thank you so much for sharing everything with us today.

D: My pleasure.

M: Excellent. And thank you. And thank you very much for joining us today. Please remember to fill out your evaluations online. Your feedback is always helpful to the development of our programs and continuing education credits are available. To obtain nursing continuing education hours, CME and CHES credits, learners must visit www.phlive.org and complete an evaluation and the post-test for today's offering. Additional information on upcoming webcasts can also be found on our Facebook page. Don't forget to like us on Facebook, to stay up to date. This webcast will be available on demand on our website within two weeks of today's show. Please join us on the next webcast March 19th, about reducing pressure ulcers and forthcoming tool kit. I am Rachel Breidster, and thank you for joining us on Public Health Live.