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Addressing Health Disparities: It Didn't Begin with HIV and Won't End with COVID-19

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Michelle Collins-Ogle, MD, FAAP, AAHIVS

Activity Dates: May 28, 2020
Estimated time to complete activity: 1 hour

Questions?

Questions: To ask questions to our speakers, please utilize the **"Q&A"** option on the bottom of your screen.

Comments or Resources: To share comments or appropriate resource links, utilize the "**Chat**" option on the bottom of the screen.

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This activity is jointly provided by Annenberg Center for Health Sciences at Eisenhower and the American Academy of HIV Medicine, in collaboration with Postgraduate Institute for Medicine.

This activity is supported by independent education grants from Gilead Sciences, Janssen Therapeutics and Merck Pharmaceuticals.

Speakers

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Target Audience/Program Overview

Target Audience

This activity has been designed to meet the educational needs of physicians, physician assistants, nurse practitioners, registered nurses and pharmacists.

Statement of Need/Program Overview

Learners are expected to leave the webinars with a clear understanding of what treatment options are available to address a number of topics related to treatment of HIV and the needs of various populations. Learners should feel more comfortable choosing appropriate treatment plans for a number of topics, with the goal of improving quality of life while decreasing disease-related morbidity and mortality. Potential uses, drawbacks, barriers, and advantages of various interventions and treatment plans should be well understood following each webinar. Providers participating in a given webinar should be able to more accurately tailor treatment needs to their individual patients with co-existing conditions, taking into account their unique needs and situations.

Continuing Medical Education

Accreditation Statement

This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of the Annenberg Center for Health Sciences at Eisenhower and the American Academy of HIV Medicine. The Annenberg Center for Health Sciences at Eisenhower is accredited by the ACCME to provide continuing medical education for physicians.

Physician Continuing Medical Education

The Annenberg Center for Health Sciences at Eisenhower designates this live activity for a maximum of 1.0 *AMA PRA Category 1 Credit(s)*™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

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Continuing Medical Education

Continuing Pharmacy Education

The Annenberg Center for Health Sciences at Eisenhower is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education.

This program has been developed according to the ACPE Criteria for Quality and is assigned ACPE Universal Activity #0797-9999-20-046-H02-P. This program is designated for up to 1.0 contact hours (0.1 CEUs) of continuing pharmacy education credit.

Type of Activity

Knowledge

Continuing Nursing Education

The Annenberg Center for Health Sciences at Eisenhower is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation. Credit Designation - 1.0 contact hours may be earned for successful completion of this activity.

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Disclosure Information

Disclosure of Conflicts of Interest

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Faculty Disclosures

Ada D. Stewart, RPh, MD, FAAFP, AAHIVS

Nothing to Disclose

Michelle Collins-Ogle, MD, FAAP, AAHIVS

Nothing to Disclose

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Planners and Managers Disclosures

American Academy of HIV Medicine (AAHIVM)

The AAHIVM planners and managers have nothing to disclose

Postgraduate Institute of Medicine (PIM)

The PIM planners and managers have nothing to disclose

Annenberg Center for the Health Sciences at Eisenhower

Annenberg Center for the Health Sciences at Eisenhower staff involved in this activity have no relevant commercial relationships to disclose.

Disclosure of Unlabeled Use

This educational activity may contain discussion of published and/or investigational uses of agents that are not indicated by the FDA. The planners of this activity do not recommend the use of any agent outside of the labeled indications.

The opinions expressed in the educational activity are those of the faculty and do not necessarily represent the views of the planners. Please refer to the official prescribing information for each product for discussion of approved indications, contraindications, and warnings.

In this activity the faculty do discuss the use of investigational antiretroviral agents and treatment regimens that are not approved by treatment guidelines.

Disclaimer

Participants have an implied responsibility to use the newly acquired information to enhance patient outcomes and their own professional development. The information presented in this activity is not meant to serve as a guideline for patient management. Any procedures, medications, or other courses of diagnosis or treatment discussed or suggested in this activity should not be used by clinicians without evaluation of their patient's conditions and possible contraindications on dangers in use, review of any applicable manufacturer's product information, and comparison with recommendations of other authorities.

Fee Information

There is no fee for this educational activity.

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Learning Objectives

- Describe the evolving epidemiology of HIV disease in the U.S., with an emphasis on age, gender, sexuality, race/ethnicity, socioeconomic status, emerging subtypes, and viral resistance or other topic specific subjects.
- Implement appropriate and current HIV testing methods and tailor ARV treatment to unique populations with HIV.
- Provide up-to-date HIV care to a broad spectrum of infected patient populations, including pediatrics, adolescents, injection-drug users, incarcerated individuals, and an aging population.
- Modify ART for HIV based upon the various co-morbidities that are often found in HIV-infected individuals including cardiovascular, renal, and neurologic disease.
- Discuss the ethical and legal issues related to caring for HIV-infected individuals.

Tonight's Take-Away Objectives

- Review and discuss existing health disparities in HIV
- Classify the emerging health disparities in COVID19
- Identify how systemic racism contributes to HIV and COVID19 epidemics in communities of color
- Discuss what we can do to change the trajectory

Achieving Health Equity in the Black Community is an Uphill Battle

"Of all the forms of inequality, injustice in health is the most shocking and inhuman"

Martin Luther King, Jr., March 25, 1966

400 Plus Years of Institutional and Structural Racism

even if remove income, insurance, coverage, and education, blacks still have worst outcomes – race is an independent factor that affects our health – implicit bias affects outcomes

Before HIV There Was This

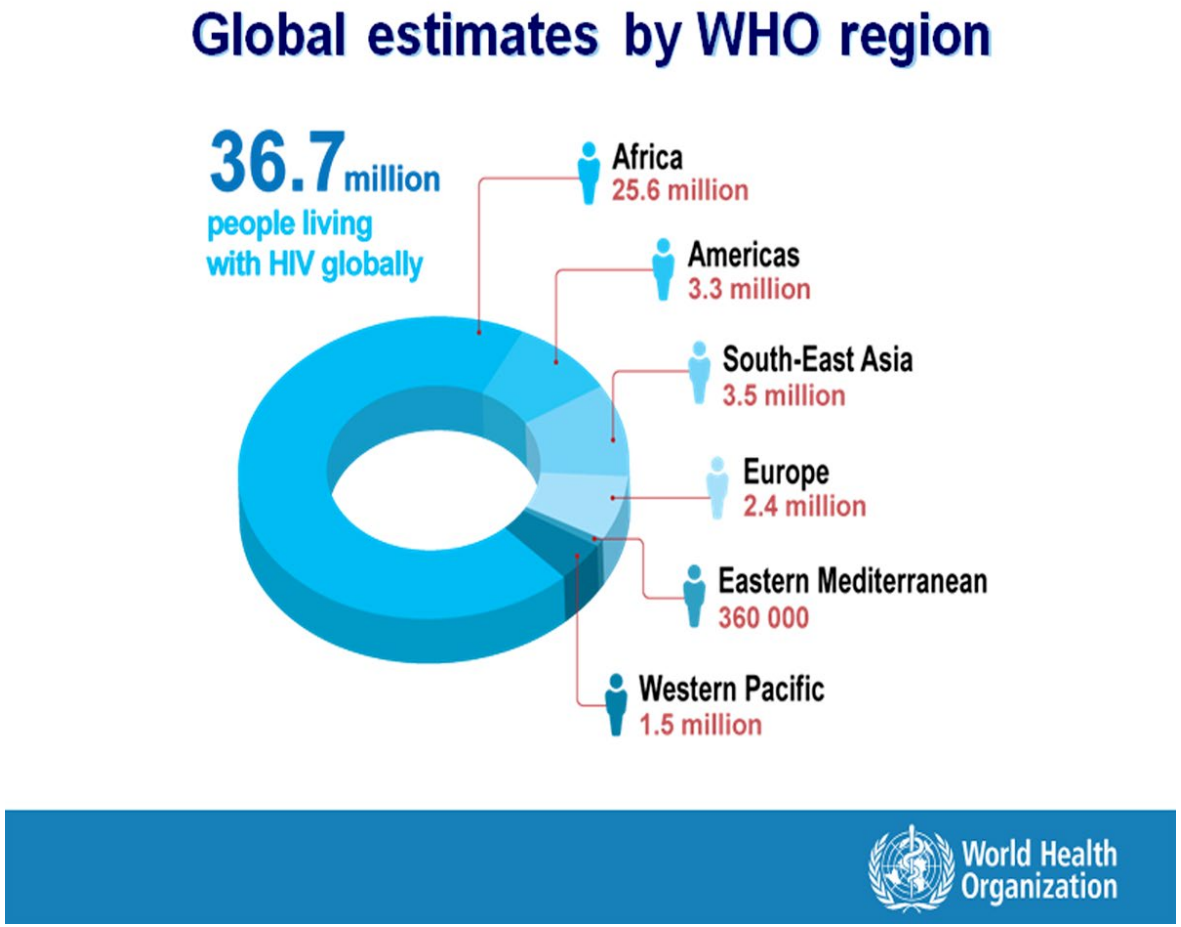
- The Tuskegee and Guatemala Syphilis Studies

1932 U.S. Public Health Service In collaboration with the Tuskegee Institute in Alabama called "Tuskegee Study of Untreated Syphilis in the Negro Male." In Guatemala, the U.S. government paid for similar research to be conducted on vulnerable people such as people with mental illness and prisoners.

- Women of Color Mass Sterilization and the "Mississippi Appendectomy"

1930s – 1970s North Carolina Eugenic Commission sterilized thousands of Black women Puerto Rico eventually earned the dubious distinction of having the highest sterilization rate in the world. What's more, some Puerto Rican women died after medical researchers tested early forms of the birth control pill on them. Native American women reported being sterilized at Indian Health Service hospitals after going in for routine medical procedures such as appendectomies.

HIV Remains the Largest Pandemic in the World



30 Years of HIV in the African American Community

- 1981 – CDC reports first known cases of AIDS (26 cases, 1 African American)
- 1984 – CDC reports 50% of pediatric AIDS cases are among African Americans
- 1995 – NEJM Publishes Dr. Ira Chasnoff's research on "Crack Babies"
- 1988-1990 – For the first time, the number of new infections among African Americans exceeds the number of infections in whites and remains that way; the Magic of Earvin Johnson

*Centers for Disease Control

30 Years of HIV in the African American Community

- 2000 – HIV cases among Black and Latino men who have sex with men exceed those among their white counterparts
- 2001 – First Annual National Black HIV/AIDS Awareness Day
- 2008 – The Black AIDS Institute reports that if Black America were its own country it would rank 16th in the world in terms of number of people with HIV–ahead of Ethiopia, Botswana and Haiti
- Today – African Americans, have the highest rates of HIV infection in the nation. Although just 13% of the U.S. population, blacks account for nearly 50% of those living and dying with HIV / AIDS. Among African Americans, gay and bisexual men are the most affected, followed by heterosexual women.

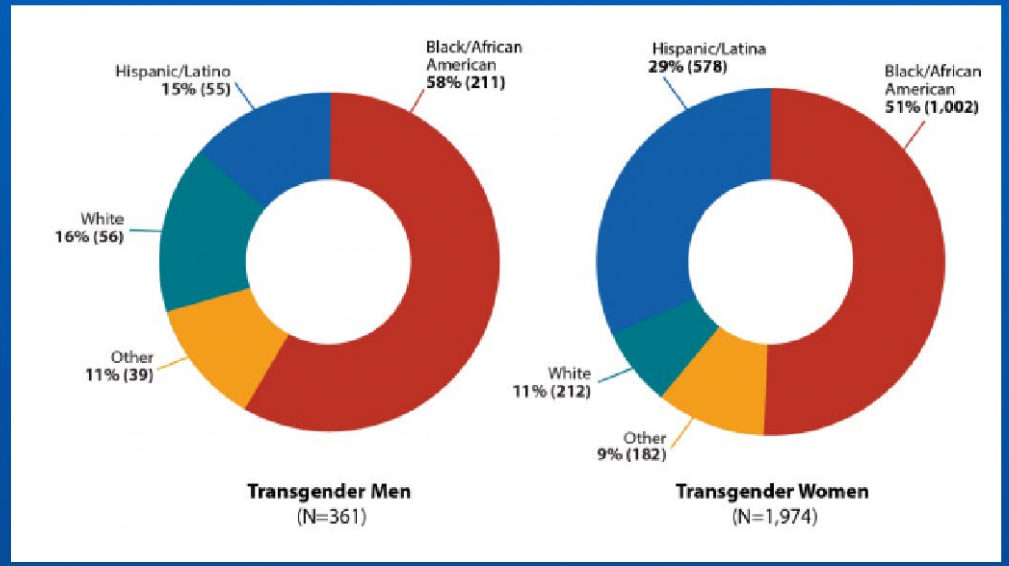
*Center for Disease Control

HIV Among Transgender People

- In 2017, an estimated 1 million adults in the United States are transgender.
- From 2009 to 2014, 2,351 transgender people were diagnosed with HIV in the US
- *Transgender Discrimination Survey* found that 12% of transgender youth report being sexually assaulted in K–12 settings by peers or educational staff; 13% of African-American transgender people surveyed were sexually assaulted in the workplace; and 22% of homeless transgender individuals were assaulted while staying in shelters.
- Gay and Transgender youth have a higher risk of infection than their heterosexual counterparts and are subject to homophobia, transphobia and violence therefore less likely to seek healthcare.

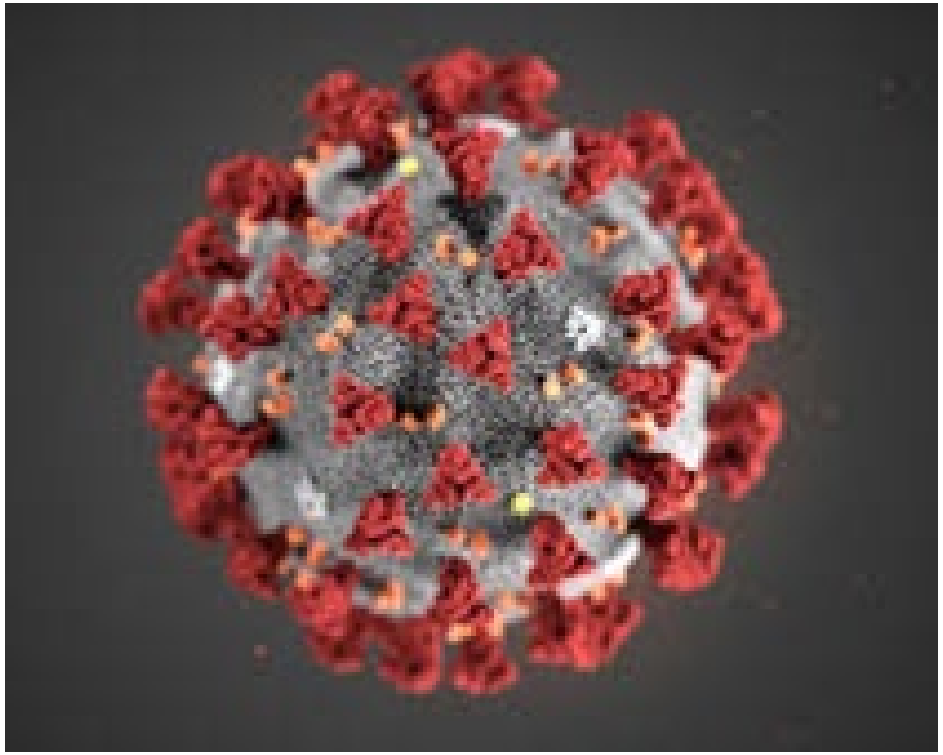
CDC, November 2018

HIV Diagnosis Among Transgender People in the U.S. by Race / Ethnicity 2009-2014



- Source: Clark H, Babu AS, Wiewel EW, Opoku J, Crepaz N. Diagnosed HIV Infection in Transgender Adults and Adolescents: Results from the National HIV Surveillance System, 2009-2014. 2017;21(9):2774-2783. Hispanics/Latinos can be of any race.

FAST FORWARD - 2020 CORONAVIRUS



Intersection of HIV and COVID19
Uninsured, Unemployed, Unstable housing

- Compared to whites, Hispanics are almost 3 times as likely to be uninsured, and African Americans are almost twice as likely to be uninsured. In all age groups, blacks were more likely than whites to report not being able to see a doctor in the past year because of cost.
- Inadequate access is also driven by a long-standing distrust of the health care system, language barriers, and financial implications associated with missing work to receive care.
- Nationally, African Americans have the highest unemployment rate at 6.5% followed by Hispanics at 4.5% and Whites at 3.1%**
- More than 50% of homeless families are African American***

*Gallup National Health and Well Being Index

**Bureau of Labor and Statistics 2018

***U.S. Housing and Urban Development report 2019

Coronavirus Cases in the United States *USA Facts

CURRENT CONFIRMED CASES (UNITED STATES)

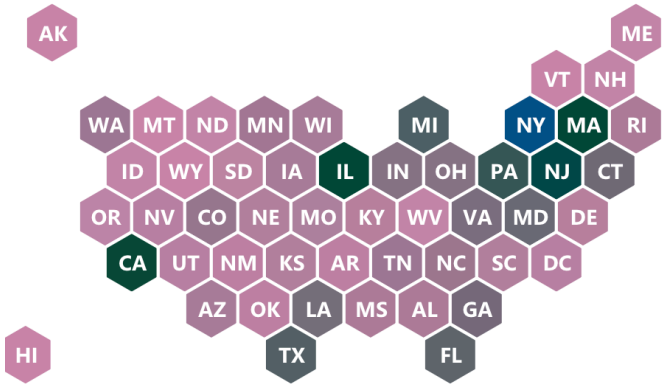
1,541,055

CURRENT RELATED DEATHS (UNITED STATES)

92,260

CORONAVIRUS IN THE STATES

Select a state for more details.

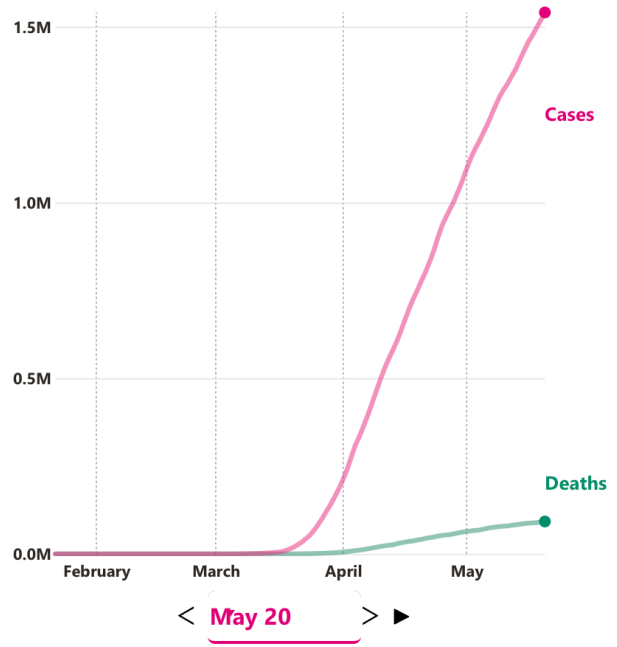


CONFIRMED CASES | PER 100K RESIDENTS | DEATHS

1 — 400,000

CONFIRMED CASES OF COVID-19

CASES AND DEATHS OVER TIME (UNITED STATES)



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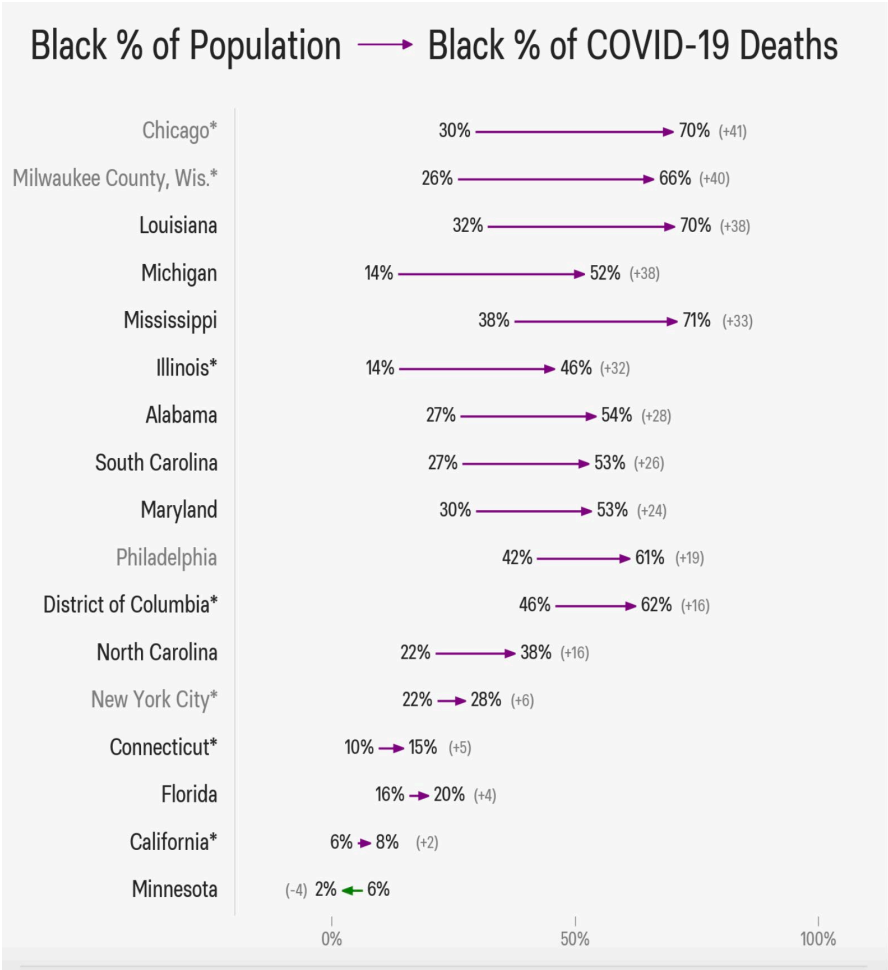
“You can’t drive a bus or wash dishes on Zoom,” said one doctor. “These are people we count on to do essential jobs, and they are going unprotected.”



Asterisks (*) indicate that official reports combine race and ethnicity into one variable. In these cases, the death and population percentages do not include people identified as Hispanic/Latino.

Jeremy Singer-Vine / BuzzFeed News / Sources: State and local agencies, collected Apr. 9 (deaths); American Community Survey (population).

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Disproportionate Burden

Even though African Americans make up 13 percent of the US population, they account for 30 percent of the country's Covid-19 patients.

WHY…

ANSWER: Existing Health Disparities

- “The effects of COVID-19 on the health of racial and ethnic minority groups is still emerging; however, current data suggest a disproportionate burden of illness and death among racial and ethnic minority groups”. … *CDC*

- Existing health disparities:
  - Due to structural and institutional racism
  - Social Determinants of Health
  - Medical Mistrust
  - Lack of access – no health insurance

Deadly Toll on African Americans is Not HIV

Cause of death	Mortality rate
Assault	94.2
Accidents	52.1
Suicide	17.5
Heart disease	14
HIV	6.8
Cancer	6.2
Police use of force*	3.4
Diabetes	2.8
Influenza and pnemonia	2
Chronic lower respiratory disease	2
Cerebrovascular diseases	1.9

A new study finds that about 1 in 1,000 black men and boys can expect to die as a result of police violence over the course of their lives – a risk that's about 2.5 times higher than their white peers.

Annual mortality rates are reported as deaths per 100,000 black men ages 25 to 29.
Source: Centers for Disease Control and Prevention, 2015. *Figure is the median of 2013-2018 mortality rate calculated in PNAS study led by Frank Edwards.

Structural Racism: When Improving Your Health While Black Goes Wrong

- Jogging while black
- Sleeping while black
- Drinking water while black
- Walking while black

Institutional and Structural Racism

- One of the strongest predictors of health are socioeconomic status and race.
  - Red-lining
  - Implicit Bias
  - Lack of clean water safe neighborhoods live in food deserts
  - Not able to work from home – essential workers (bus drivers, bus or train for transportation, domestic workers, healthcare, and restaurant workers)
  - Over representation in jails/prisons

- ***"The current crisis highlights the racism embedded into our structures and institutions, and how race significantly impacts health outcomes at all socioeconomic levels. It also gives us the opportunity to begin making the structural changes necessary to come out of this into a better "new normal." "***
  https://www.opportunityinstitute.org/blog/post/structural-racism-explains-covid-19-disparities/

“Breaking News”

The **Coronavirus pandemic** is amplifying preexisting social inequities tied to race, class, and access to the health care system.

WHAT CAN BE DONE

- Collecting **data to monitor and track disparities** among racial and ethnic groups in the number of COVID-19 cases, complications, and deaths to share broadly and inform decisions on how to effectively address observed disparities. This data will be translated into information to improve the clinical management of patients, allocation of resources, and targeted public health information.
  - Just as with HIV – test, track and treat
- Provide means for people of color to be able to self isolate.
- Advocate for better housing, food, Medicaid expansion and access
- Improve diversity within the workforce.

END	THE HIV EPIDEMIC
END	THE CORONAVIRUS PANDEMIC
END	THE HEALTH CARE DISPARITIES THAT ARE DRIVING BOTH!!!!!

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“Pandemics do not create inequalities but unmask them”

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Problems with CME?

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THANK YOU!!

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