

Healthcare Disparities Report

Strategies † Funding † Programs † Policies



WASHINGTON, SEPTEMBER 2004

No. 04-09

INSIDE THIS ISSUE

Outreach:

- U. Of MD Center Out To End Disparities 1
- Johns Hopkins, Neighbors Benefit From Cooperation 2

Research & Reports:

- Study Raises Questions About Causes Of Racial Disparities 3

Kidney Disease:

- Paid Media Push Seeks Donors 4

HIV/AIDS:

- Blacks Believe U.S. Losing Battle Against HIV/AIDS 5
- Sensitive Test Finds Outbreak At NC Colleges 5
- Minority AIDS Initiative Grows But Faces Challenges 5

Medicare/Medicaid:

- Prescription Drug Regs Leave Most Issues Unresolved 6

- Analyses Disagree About Discount Card Savings 6
- Medicare Recipients Report Dissatisfaction With New Law 7

Washington Watch:

- Healthcare Is Campaign Issue, But War, Economy Dominant 7

Cancer:

- Mutation May Cause Higher Mortality In Black Women 8

Federal Funding:

- \$5M Available At HHS For Obesity Study 9
- Info Sought By NIH On Obesity Programs In Schools 9
- Cancer Institute Looking For Effective Navigation Systems 9
- NIH Offers \$6M For Childhood Obesity Prevention 10

OUTREACH

U. Of Maryland Establishes Center With Goal Of Ending Disparities

Maryland: “My dream is to get the entire state completely absorbed in activities to reduce and ultimately eliminate healthcare disparities,” says Dr. Claudia Baquet, associate dean for policy and planning at the U. of Maryland School of Medicine and director of its newly established Center for Health Disparities.

Baquet (pronounced BAW kay) tells *HDR* the new center is the culmination of years of outreach to the state’s communities and cooperation with healthcare providers in all 23 counties and the city of Baltimore.

The effort meets the desire of the New Orleans native to actively engage in meeting the medical needs of people after more than a decade as a top policy official at the federal Health & Human Services Dept., including a stint as deputy assistant secretary for minority mental health.

She was working to end healthcare disparities when “disproportionate disease burden” and “avoidable mortality” were used to describe disparities.

The new center will target cancer, diabetes, kidney diseases, glaucoma and other maladies that disproportionately affect minorities and the poor.

Maryland’s medical school has long been active in serving communities and, with funds from the state Cigarette Restitution Fund, established the U. of Maryland State-wide Health Network in 2000. The network is now a principal program of the disparities center.

Network offices at six locations throughout the state provide cancer and tobacco-related disease prevention and control activities. In addition, they offer continuing education programs for health professionals and promote cancer screening, early detection and the latest treatment programs. Finally, community health professionals provide education on clinical trials.

Feedback from health professionals in those community offices led to an 18-month, 212-question survey of 5,000 persons in Baltimore and a dozen counties in western Maryland and on the eastern shore of the Chesapeake Bay to establish a knowledge baseline, explains Baquet.

The results revealed health disparities and barriers and previously undocumented cancer risks, she reports. For example, 17.8% of black women said they needed a doctor but couldn’t afford one within the previous year compared with 14% of white women. The figure for white men was 6.9% and for black men 11%.

Another program within the disparities center is the Comprehensive Center for Health Disparities Research, Training & Outreach. This center fosters research on renal and eye disease, cancer and mental health. The goal is to reduce and eliminate disparities through technology and translation of research advances from bench to clinic and clinic to community, says Baquet. The Nat’l Institutes of Health are providing \$4.7 million over four years to fund

the center, which is a partnership with the U. of Maryland Eastern Shore.

A third initiative comes from the Area Health Education Center program, with an urban center in Baltimore and rural centers in western Maryland and on the eastern shore. They provide training and experience in treating the underserved.

A fourth program is the university's telemedicine network, which enables physicians throughout the state to confer with School of Medicine doctors on diagnosis and treatment. Home telehealth monitoring for Medicare patients with congestive heart failure or other chronic diseases is occurring in Baltimore and soon will be expanded to western Maryland.

Info: Baquet, 410/706-1742; www.medschool.umaryland.edu/disparities

Community Outreach Pays Off For Johns Hopkins And Its Neighbors

Maryland: Diane Becker is renowned for her success working with the mostly black community in Baltimore where the Johns Hopkins School of Medicine is located. But the director of the school's Center for Health Promotion declines to describe a grand plan or a set of best practices that led to her success.

"My method is seat-of-the-pants," she tells *HDR*. "The first thing you have to learn when working in the community is that most systematic methods have failed. I work in the community and with the people who live there. I learn what needs to be done in their domain and join efforts that optimize their natural assets and ours. You can't impose a system on a community that is already rich in its own culture and capable of working with us to find a solution to the problems we both face."

Hopkins was once emblematic of the racial segregation practices that preceded the civil rights movement of the 1960s-blacks were not often admitted into residency programs until the 1960s and wards weren't fully integrated until the early 1970s. The history of mistrust made her work in minority health a challenge. Becker, who is white, worked for 17 years in those wards before she got her doctorate from the Johns Hopkins School of Public Health in 1984.

Including minorities in the trials is important to ensure the results are reflective of the entire population. The Nat'l Institutes of Health, beginning in 1993, began requiring researchers to make an effort to include minorities.

Hopkins is the top recipient of NIH research money with \$556 million last year. In the past decade, Becker won about \$10 million in grants for community-based research.

But it took a change in tradition by Becker and colleagues to make a breakthrough in a neighborhood where distrust of the once-segregated institution ran high.

Becker took an important step, approaching leaders of local black churches to preach the gospel of good health behavior to their parishioners.

Grant won by community organization

In 1987, she wrote a grant proposal for a successful community-research grant to lower smoking rates and diseases that were related to smoking among blacks. Working closely with the pastors, a minority health nonprofit organization, Heart, Body & Soul emerged. The partnership of Becker and the community pastors won several grants and quickly enlisted local residents to work on projects designed to improve the health of the community.

This led to careful scrutiny by the community itself to assure that blacks were recruited appropriately for clinical trials.

Those community relationships are even stronger at Hopkins today, says Becker.

"There are many clinical studies in our community that offer major benefits like prostate cancer screening, mammography and tests that help define the very best treatment for HIV/AIDS," says Becker. "In my own study, community members get about \$10,000 each of free treatment and referral for optimal care for any problems we find."

Hopkins is planning a 22-acre research park for the neighborhood and it is drawing some opposition from the neighbors, including a minister who was one of her earliest partners and who remains a close colleague.

But Becker does not think it will hurt her work. "In the long run, it has great potential for the community," she says.

"New jobs with excellent career training are planned. If it flourishes, it should help heal a pretty scarred landscape."

Becker says the community is upset that some families have had to move from their homes to accommodate the research park.

"But there is not universal displeasure at all," she adds. "The community is watching cautiously and would like to participate more in the planning."

Info: Becker, 410/955-7781

RESEARCH & REPORTS

Medicare Patient Study Sheds Light On, Raises Questions About Racial Disparities

New research renews the debate about the root cause of racial disparities in healthcare.

A study of elderly white and black Medicare patients finds different groups of physicians treat elderly black and white patients, with the former having less access to important clinical resources and less training clinically than the latter. The majority of doctors in both groups were white.

The results of the study by researchers at the Memorial Sloan-Kettering Cancer Center and the Center for Studying Health System Change spark questions about the fundamental cause of racial and ethnic disparities in healthcare.

“Because patients who are members of minority groups and white patients to some extent reside in different locations and seek their care in different settings, it is possible that doctors who treat these patients may differ with regard to both their clinical qualifications and their clinical resources,” the researchers say in the Aug. 5 issue of *The New England Journal of Medicine*. “We hypothesized that such discrepancies account for the pervasiveness of racial and ethnic disparities in health care.”

The evidence they produce lends support to that view. The study found:

- Of all U.S. primary-care physicians, 78% (68,311) accounted for 78% of visits by white patients but only 20% of all visits by black patients. The remaining 22% of primary-care physicians (19,492) accounted to 80% of all visits by black patients and 22% of visits by white patients. The majority (59.7%) of doctors treating most black patients were white while 85.3% of those treating mainly white patients were white.
- More than one-quarter (27.8%) of visits by black patients took place with physicians who reported they could not consistently deliver high-quality care to all of their patients compared with only 19.4 visits by white patients.

HEALTHCARE DISPARITIES REPORT

Copyright 2004 by CD Publications, est. 1961. *Healthcare Disparities Report* (ISSN 1548-8268) is an independent monthly news service, started in 2004. 8204 Fenton St., Silver Spring, MD 20910; www.cdpublications.com; e-mail: hdr@cdpublications.com
 Editorial questions: 301/588-6380; Subscriptions: 800/666-6380 (8:30 a.m.-5:30 p.m. Eastern Time); Fax: 301/588-6385. \$229/yr online; \$254/yr. print; \$279/yr print and online (U.S. funds). Single issue: \$20 prepaid.

Editor: James S. Byrne; **Editorial Director:** John Reistrup; **Publisher:** Mike Gerech.

Photocopying or reproduction prohibited without permission through Copyright Clearance Center, 978/750-8400.

- Visits by black patients were more likely to occur with physicians who reported they could “not always” provide access for their patients to high-quality specialists (24% of visits by black patients compared with 17.9% for visits by white patients); high-quality diagnostic imaging (24.4% for blacks compared with 16.6% for whites); and hospital admissions (48.5% compared with 37%).
- Visits by white patients (86%) were more likely to occur with physicians who were board certified in their primary specialty area than visits by black patients (77.4%).

“These findings are both reassuring and disturbing,” says Dr. Arthur Epstein, associate editor of *NEJM*, in an editorial. The findings, he says, “point away from interpersonal discrimination” as a cause of racial disparities.”

Role of long-standing discrimination

He adds: “They still point, however, to long-standing societal discrimination. The residue of segregation that probably accounts for differences in the locations where patients seek care plays a role in all kinds of opportunity, including the opportunity to obtain health care.”

Dr. H. Jack Geiger, professor emeritus of community medicine at City U. of New York Medical School, takes issue with the researchers’ hypothesis that the differences they found “account for” rather than “contribute to” disparities. “This strikes me as an overstatement,” Geiger tells *HDR*. “Nothing in the article explains the overwhelming evidence, contained in myriad hospital studies, that differential black-white treatment is, at least in part, the result of conscious or unconscious racial bias,” he adds.

The role of such bias may differ regionally, suggests Dr. Kevin Fiscella, associate professor of family, community and preventive medicine at the U. of Rochester School of Medicine.

A study he conducted in New York State found the incidence of more bedsores among black patients was entirely attributed to the hospital to which patients were admitted, not discrimination. Black patients were concentrated in hospitals with high bedsores rates.

In contrast, preliminary data from Florida suggest even within individual hospitals, blacks frequently developed more bedsores than whites following admission, he tells *HDR*.

Info: www.hschange.org; Epstein, 617/734-9800; jgeiger@igc.org; Fiscella, 585/506-9484, ext: 106

KIDNEY DISEASE

Paid Media Push Seeks Kidney Donors In Washington Metro Area

Commuters listening to the morning drive radio shows in the Washington area are sometimes startled to hear advertisements asking for one of their kidneys.

As the director of community affairs for the Washington Regional Transplant Consortium, which pays for the spots, Cindy Speas is passionate about increasing the number of kidney donors—especially among minorities, who suffer disproportionately from kidney disease.

WRTC, one of 58 federally designated organ procurement organizations throughout the United States, is pushing its Washington Regional Voluntary Living Donor Program, a pilot effort to persuade individuals to donate one of their kidneys to help meet the needs of the nearly 2,400 persons in the area in need of transplants. The program is trying to get persons to donate a kidney even though they do not have a relative or friend who needs one.

Move to top of waiting list

But the program encourages people who have a relative or friend who needs a kidney but are not suitable donors for that person to participate anyway. The donor can give a kidney to the program and the relative or friend is moved to the top of the waiting list in the WRTC region for a suitable kidney. So far there have been 20 kidney donors to the program.

The WRTC, based in Falls Church, VA, in partnership with the Minority Organ Tissue Transplant Education Program, is asking the Health & Human Services Dept. for \$300,000 for a media campaign in the District of Columbia, where blacks comprise 60% of the population.

MOTTEP has contributed to an increase to 13% from 9.5% in the percentage of kidneys donated by blacks since 1988 (*HDR*, 04-7p1). But 35% of the national kidney-transplant waiting list are blacks, who are just 12% of the U.S. population.

By paying for radio advertising, the sponsors can get their message on prime radio time instead of depending on free public-service announcements, which are made in non-prime hours.

The Coalition on Donations paid more than \$300,000 in 2003 to produce high-quality PSAs and received \$100 million in free advertising, reports David Fleming, executive director of the group.

In addition to those who contribute to the WRTC program because their kidneys are not compatible with a

friend or relative, contributors can make a donation with no specific recipient designated. Another option is the paired exchange. If a donor wants to donate a kidney but it is not compatible with a relative or friend, an exchange may be possible with another pair in the same predicament.

Out of 11 regions established in the U.S. to facilitate organ allocation, Region 1, which covers New England, and 10 OPOs from other regions have followed the WRTC concept of swapping to the list for a friend or relative.

The federal government, several states, including VA and MD, the District of Columbia, and many companies, permit employees to take 30 days leave if they donate organs.

At least two states—PA and WI—permit donors tax deductions for related expenses.

“We desperately need kidney donations,” says Speas. “Our living donor program is one small effort to meet that need and we view participants as genuine heroes and heroines.”

Info: Speas, 866/BeADonor; www.beadonor.org

No National Organ Donor Registry

A major problem for those in need of organs is the lack of a national registry of donors. Moreover, at least two-thirds of the states have no registry or maintain ineffective ones, says David Fleming, executive director of the Coalition on Donations, located at Richmond, VA-based United Network for Organ Sharing, which has a Health & Human Services Dept. contract for keeping tabs on donations.

This means when a person listed with one organ procurement organization moves to another area, he or she must register with the OPO serving that region.

“My personal goal is to get a national registry established,” says Fleming.

Nationally, there are 59,000 persons on waiting lists for kidneys, by far the most common organ transplant. UNOS reports there were 15,123 kidney transplants in 2003 out of 25,454 transplants of all organs. That includes kidneys from living and deceased donors. The next highest category is liver transplants (5,671). Third were heart transplants (2,057)

Info: Fleming, 804/782-4920; www.donatelife.net; UNOS, 804/782-4800; www.unos.org

HIV/AIDS

Most Blacks Believe U.S. Losing Battle To Curb HIV/AIDS, Kaiser Study Finds

Blacks are more pessimistic than whites and Hispanics/Latinos about progress in getting HIV/AIDS under control, a study by the Kaiser Family Foundation finds. In addition, blacks rank HIV/AIDS the No. 1 health problem in the country while the overall population ranks it second behind cancer.

“The sense of urgency revealed in the survey should send a message to, local leaders and especially elected officials that HIV is something the African American community cares about,” says Drew Altman, president and CEO of KFF.

A majority (56%) of blacks believe the United States is losing ground on HIV/AIDS, an increase from 38% reported last October. The young are even less optimistic, with 67% of blacks between 18-29 holding that view.

The survey found 33% of whites and 30% of Hispanics/Latinos think the battle is being lost.

Blacks (64%) are most likely to know someone who has or has died from AIDS compared with 42% of whites and 41% of Hispanics/Latinos.

Concerned about getting HIV/AIDS

In addition, blacks (43%) are more likely than Latinos (30%) and whites (10%) to report being personally very concerned about contracting HIV/AIDS.

Most people (57%) surveyed believe spending more money on HIV/AIDS will lead to meaningful progress. But 64% of blacks, 49% of whites and 45% of Hispanics/Latinos think the country is spending too little.

The public is well informed about some aspects of the HIV/AIDS epidemic but less so about others. Most (90%) know there is no cure for AIDS, there are drugs that can lengthen the lives of those with HIV (88%) and that a third of HIV-positive people don't know they are infected (84%).

But only 43% know pregnant women can reduce the risk of their children being born with HIV. Only 36% of whites in the survey knew having another sexually transmitted disease increases the risk of getting HIV compared with 57% of Hispanics/Latinos and 54% of blacks.

Most (71%) of the public gets its information about HIV/AIDS from the news media.

Info: www.kff.org/newsroom/pomr080404anr.cfm

Sensitive AIDS Test Turns Up Outbreak Of Cases At NC Black Schools

North Carolina: An expensive but extremely sensitive blood test designed to catch HIV infection early has turned up what state Health & Human Services Dept. researcher Dr. Peter Leone calls “a potential genocidal issue” threatening young, black college men.

North Carolina, apparently still the only state to use the test routinely for HIV examinations, implemented it in November 2002. By the end of 2003 the number of North Carolina college men infected with HIV rose to 84 of whom 73 were black.

Interviews with the male students' sexual contacts brought the total to 119 cases, at 24 colleges in six states and the District of Columbia.

“We now recognize the problem and are taking action to resolve it,” Phyllis Gray, project manager of the Minority Initiative in the department's HIV/STD Prevention & Care Branch, tells *HDR*.

Among other things, the department has increased its HIV education effort, not easy in a state where the official policy is to teach abstinence-only instead of sex education.

A few of the state's 11 historically black universities and colleges have increased the number of HIV peer counselors.

HIV/AIDS has struck the black community extremely hard. Blacks accounted for 54% of new HIV cases in 2002 despite making up just 12% of the U.S. population.

Prevention and treatment are complicated by ignorance and by resistance among blacks in the culturally religious and socially conservative South to admit they are gay or homosexual.

There is a possibility the more effective AIDS test may have to be halted, Gray reports. The department must find about \$500,000 to keep the test going for the rest of the year, she says.

Info: Leone, 919/715-1664; peter.leone@ncmail.net; Gray, 919/733-7301; phyllis.gray@ncmail.net;

Minority AIDS Initiative Has Grown But Challenges Loom, Study Finds

The Minority AIDS Initiative of the Health & Human Services Dept. has grown substantially since it was created in 1998, but it faces challenges. These include maintaining

and enhancing its focus on capacity building, effectively targeting minority community-based organizations, disseminating information on program activities and evaluation results, managing program and political expectations, integrating new providers into the HIV service-delivery system and continuing the program, a Kaiser Family Foundation reports.

The MAI is designed to improve HIV-related health outcomes for racial and ethnic minority communities and to reduce HIV-related healthcare disparities. Funding has risen to \$404 million in FY 2004 from \$166 million in FY 1999.

A principal goal is building the capacity of MCBOs to improve the amount and quality of services to HIV/AIDS victims, and it has had success in doing this, the study reports.

But the analysis found that making services available doesn't mean they will be used. Location of service providers, outreach to communities and community attitudes toward the problem affect utilization, the study says.

The legislation requires targeting funds to MCBOs, but there has been disagreement among the Bush administration, Congress and MCBOs about the extent to which a specific targeting policy is constitutional.

The Supreme Court in 1995 ruled in *Adarand Constructors Inc. v Peña* that federal affirmative-action programs must meet strict-scrutiny standards to be constitutional. There is no consensus on whether an explicit targeting policy for MAI funds is permissible.

Some respondents favored incorporating MAI into the Ryan White CARE Act to ensure its continuance while others believe that would weaken its distinct focus on capacity building for MCBOs.

Info: www.kff.org, click on HIV/AIDS, then on HIV/AIDS in the U.S.

MEDICARE/MEDICAID

Medicare Prescription Drug Regs Leave Most Issues Unresolved

The Centers for Medicare & Medicaid Services publish more than 200 pages of proposed regulations to implement the new Medicare prescription drug program, but they resolve very few of the problems raised by experts.

For the most part, the regulations state the statutory language and ask for comments, which are due Oct. 4.

Many stakeholder groups are working together to ana-

lyze the proposed rules. Families USA is organizing a Capitol Hill briefing by representatives of several groups, tentatively set for Sept. 15. Participating organizations are expected to file their own comments on the proposed regulations.

Almost none of the concerns raised in a Kaiser Family Foundation study are resolved by the proposed rules (*HDR-04-8p4*).

A huge gap in the regulations is how persons with dual eligibility for Medicaid and Medicare will be registered for the new Part D prescription drug program, says Patricia Nemore, an attorney for the Center for Medicare Advocacy.

When the Part D goes into effect Jan. 1, 2006, dual eligible persons will lose their Medicaid drug coverage, which is sometimes more generous than Medicare (*HDR-04-1p5*).

"The regulations seem to say states can register the Medicaid people in the Part D but no additional funds are authorized to pay for it," says Nemore.

The regulations appear to have a fairly liberal asset test for low-income persons, says Nemore, with liquid assets defined as those which can be sold within 20 days.

No specific answers are contained in the proposed regulations to concerns raised by the Kaiser study, CMA and many other stakeholder organizations about how participants in Part D and the current transitional prescription drug discount card program will be helped to make accurate comparisons among program choices.

Info: Families USA, 202/628-3030; www.familiesusa.org; Nemore, 202/216-0028
Federal Register, 8/3, pp46632-863

Analyses Disagree About Savings Possible With Discount Cards

Analyses by two healthcare advocacy organizations of the temporary Medicare prescription drug discount program find conflicting results, although they agree savings are possible.

The discount program went into effect June 1 and will be replaced Jan. 1, 2006, by prescription drug coverage under new Medicare Part D, included in the Medicare Modernization Act of 2003 (PL 108-173).

The Center for Medicare Advocacy says two studies it sponsored found discounts vary by ZIP code, pharmacy and prescription. In some cases, prices available with Medicare drug cards were significantly more expensive

than those available from the commercial www.drugstore.com.

In four-week study of four common drugs prescribed for multiple sclerosis, CMA concluded it is unclear which Medicare prescription card would prove most dependable and least expensive.

“There is a lack of consistency or universality in the discounts offered by the cards,” CMA says. “Drug cards may discontinue service for a week or more and the card that offers the greatest discount on prescription drugs one week may significantly raise its prices the next.”

CMA calls for uniformity of drug card benefits across the country, the ability for participants to switch cards at will and a reduction in the 70-plus cards currently available.

A study by the Lewin Group for the Healthcare Leadership Council says participants in the discount program will save an average of \$1,247 on their purchases by the time the program ends in 2006. Low-income beneficiaries will save an average of \$1,548, the study reports.

The study says by combining the discount card, the low-income discount (\$1,200 through the end of the temporary program) and the use of drug-manufacturer assistance programs, low-income persons can reduce their costs by more than half.

For example, a low-income beneficiary taking a typical regimen for diabetes and high cholesterol could save \$2,198, or 66%, off current retail costs, the study says.

Info: CMA, 860/456-7790;
www.medicareadvocacy.org; HLC, 202/452-8700;
www.hlc.org

Study Says Half Of Medicare Recipients Don't Like New Drug Prescription Law

Nearly half (47%) of seniors and other participants in Medicare say they have an unfavorable impression of the new Medicare Modernization Act, a study by the Kaiser Family Foundation and the Harvard School of Public Health finds. Just 26% of respondents say they have a favorable impression.

A substantial percentage of respondents say their dissatisfaction will have an effect on how they vote for president (28%) and Congress (38%). About half (44% or 12% of all persons on Medicare) of those saying it will affect their presidential vote favor Sen. John Kerry (D-MA), and 18% (5% of all persons on Medicare) support President Bush.

Of those saying it will affect their congressional vote,

53% (20% of all persons on Medicare) say they are likely to vote Democratic and 21% (8% of all persons on Medicare) favor Republicans.

Two-thirds of respondents say Congress should work to fix problems in the law, 13% say it should be left alone and 10% want it repealed.

Of the 47% of respondents reporting an unfavorable opinion of the new law, 81% (39% of all persons on Medicare) say it does not provide enough help with drug costs.

Other reasons cited for dissatisfaction include the law's complexity (72% of those with an unfavorable opinion or 34% of all persons on Medicare) and the belief the law will benefit private health plans and drug companies too much (69% of those with an unfavorable impression or 33% overall). Nearly half (47%) of people on Medicare say they think the new law will do more to benefit drug companies while 32% say it will do more to benefit Medicare recipients

Just 34% of dissatisfied respondents (16% of all persons on Medicare) said the long-term cost of the program is a reason for their discontent.

Of the 26% with a favorable opinion of the new law, 78% (or 20% of all persons on Medicare) believe it will help provide enough help with drug costs.

Field work was conducted by telephone June 16-July 31 among a sample of 1,223 respondents. The margin of sampling error is plus or minus 4 percentage points for total respondents and for respondents 65 or older, says KFF.

Info: <http://www.kff.org/medicare/pomr081004pkg.cfm>

WASHINGTON WATCH

War, Economy Dominate Campaign, But Healthcare Still Important

(CD Publications) While jobs, the economy and the war on terrorism clearly rank as U.S. voters' highest priorities heading into this year's presidential campaign, healthcare issues should play a key role in the outcome, too, panelists tell a policy forum.

Healthcare, education and social security/retirement issues make up the second tier of issues important to voters in virtually every survey, says Republican pollster David Winston during an Alliance for Health Reform/Robert Wood Johnson Foundation discussion of healthcare as an issue in this year's election.

Democratic pollster Daniel Gotoff agrees, saying 12% of voters identify healthcare as their top priority issue. But more importantly, he suggests, 94% say they are concerned

about rising healthcare costs.

Those concerns suggest a possibility for the Democrats, Gotoff adds, because voters trust the Kerry/Edwards ticket over the Bush/Cheney ticket on questions of who would handle healthcare and prescription drug policy the best. The Democrats are favored 51%-36% on prescription drugs and 48%-34% on healthcare costs in a June poll by Gotoff's firm, Lake-Snell-Perry Associates.

Winston says voters' interpretation of the Medicare Modernization Act (PL 108-173) will be "extremely important" in the election. The Bush/Cheney ticket's hope, he suggests, will be while people don't see everything they want in the MMA, they will perceive progress, better access and improved affordability of prescription drugs.

A survey by the Harvard U. School of Public health found substantial dissatisfaction with the MMA on the part of Medicare recipients (see story above).

Megan Hauck, a deputy policy director for the Bush/Cheney campaign, says the ticket will run proudly on enactment of the MMA. Experts predict the Medicare prescription drug benefit (Part D) going into effect in 2006 will cut most beneficiaries' drug costs in half, she adds.

Another Bush/Cheney policy, Hauck says, is to continue a five-year plan to fund or expand 1,200 community health centers, which will serve about 6.1 million Americans and lower healthcare costs by reducing emergency room visits by people without medical insurance.

Speaking for the Kerry/Edwards campaign, Chris Jennings says the number of uninsured Americans has risen by 4 million in the past four years, while insurance premiums have seen double-digit increases. Rising healthcare costs are hurting the ability of U.S. firms to compete globally, he adds.

The campaign's priorities are to make health insurance more affordable and predictable, Jennings explains. The Kerry/Edwards ticket wants to expand upon what already works—private group health insurance and the Federal Employee Health Benefit Program.

Kerry and Edwards propose healthcare tax credits for small business, workers in between jobs and people aged 55-65, Jennings says, and providing the uninsured with an option to buy into the FEHBP system at limited premiums.

Hauck asserts the Democratic plan would cost about \$951 billion over nine years, without any plausible plans for reducing healthcare costs. Jennings suggests the Republican plan would help only about 2 million uninsured people and rely on health savings accounts, which do little to help people deal with catastrophic healthcare costs.

Info: www.allhealth.org/event_080404.asp

CANCER

Yale Study Finds Mutation May Cause Higher Mortality Among Black Women

A genetic mutation occurring four times more often in black than white women may partly explain why black women are more likely than whites to die of breast cancer even though they are less likely to develop the disease in the first place, a Yale U. School of Medicine study finds.

Past explanations for the differences included socioeconomic factors, nutrition and healthcare behavior. But Beth Jones, assistant professor in the Epidemiology & Public Health Dept. of the medical school, says while many factors contribute to the relatively poor outcome for some black women, understanding the underlying biological mechanisms is important.

"Our goal is to continue to illuminate the reasons for the differences so we can ultimately develop prevention strategies and tailor treatments more effectively," says Jones.

"Because black women have more aggressive tumors and they occur at a younger age, they should begin screening early," she tells *HDR*. She recommends black women follow American Cancer Society guidelines calling for annual mammograms, beginning at age 40.

Jones and her colleagues looked at how patterns of alterations of genes related to worse prognoses for black women. They examined the breast tumors of 145 blacks and 177 whites and found the blacks were four times more likely than whites to show significant alterations in the tumor-suppressor p53 gene.

"This is the first population-based study to report a clearly significant increase in p53 mutations that is independent of race differences in other tumor characteristics, socioeconomic status and other biomedical and lifestyle factors," says Jones.

The researchers confirmed tumors in black women were more likely than tumors in whites to display characteristics associated with poor prognosis, explains Jones.

Their findings will appear in the September issue of *Cancer*, the journal of the ACS.

Info: Jones, 203/785-2890; beth.jones@yale.edu

Planning a Meeting, Workshop Or Seminar?

Tell us about your upcoming events so we can let our readers know. We'll also send you free sample copies for your attendees. For details, call Subscriber Services, 800/666-6380.

FEDERAL FUNDING

NIH, CDC Have \$5M To Study Impact Of 'Built' Environment On Obesity

Agencies: *Nat'l Institutes of Health, Centers for Disease Control & Prevention.*

Program: *Obesity and the Built Environment.*

Funding: *\$5 million in FY 2005 to fund 10-12 new grants.*

Eligibility: *For-profit or nonprofit organizations; public or private institutions, such as universities, colleges, hospitals and laboratories; units of state and local governments; eligible agencies of the federal government; domestic institutions and organizations; and faith-based or community-based organizations.*

Deadline: *Letters of intent due by Nov. 17; applications due Dec. 17.*

Summary: This initiative will support studies in two specific areas related to the built environment and obesity: first, understanding the role of the built environment in causing/exacerbating obesity and related co-morbidities; second, developing, implementing and evaluating prevention/intervention strategies that influence the built environment in order to reduce and prevalence of overweight, obesity and co-morbidities.

The RFA will support projects that delineate the significance and impact of the built environment on overweight and obesity by enhancing understanding of the roles played by city and regional planning, housing, transportation, media, access to healthy foods and availability of public and green spaces as determinants of physical activity and nutritious dietary practices.

Info: <http://grants1.nih.gov/grants/guide/rfa-files/RFA-ES-04-003.html>

NIH Will Fund Studies Of School-Based Interventions To Prevent Obesity

Agency: *Nat'l Institutes of Health.*

Program: *School-based interventions to prevent obesity.*

Funding: *N/A.*

Eligibility: *For-profit or nonprofit organizations; public or private institutions, such as universities, colleges, hospitals and laboratories; units of state and local governments; eligible agencies of the federal government; domestic institutions and organizations; and faith-based or community-based organizations. Foreign organizations are eligible.*

Deadline: *Nov. 2, 2007.*

Summary: This initiative is designed to encourage partnerships between academic institutions and school systems to get baseline data in children and elementary or middle schools, devise and implement intervention programs in a controlled fashion and assess independent outcome variables at varying lengths of time after the intervention.

Examples of projects that would be responsive to this announcement:

- Curriculum changes designed to improve knowledge of healthy food choices and active lifestyles, and behavioral modification programs designed to attain healthy diets and active lifestyles.
- Evaluations of various controlled dietary interventions, such as changes in school food-service programs or interventions aimed at parents who prepare children's lunches.

Info: <http://grants1.nih.gov/grants/guide/pa-files/PA-04-145.html>

Cancer Institute Has \$4.8M For Patient-Navigation System Research

Agency: *Nat'l Cancer Institute.*

Program: *Patient Navigation Research.*

Funding: *\$4.8 million for six five-year grants.*

Eligibility: *For-profit or nonprofit organizations; public or private institutions, such as universities, colleges, hospitals and laboratories; units of state and local governments; eligible agencies of the federal government; domestic institutions and organizations; and faith-based or community-based organizations.*

Deadline: *Letters of intent due Oct. 18. Applications are due Nov. 18.*

Summary: Patient-navigation systems are designed to help people find health services they need and thereby reduce healthcare disparities. NCI is seeking applicants for research to find effective patient navigation interventions.

A central issue is underserved cancer patients face a variety of barriers, including standard cancer prevention, information, screening, diagnosis, treatment and followup.

This request for application invites research applications for cooperative agreements to develop and implement structured patient-navigation interventions in communities with an adequate number of cancer patients to answer primary and secondary research questions.

Examples of navigation services may include: arranging

for financial support, arranging for transportation and childcare during scheduled diagnosis and treatment appointments and coordinating care among providers.

Info: <http://grants.nih.gov/grants/guide/rfa-files/RFA-CA-05-019.html>

NIH Offers Nearly \$6M For Childhood Obesity Prevention, Treatment

Agency: Nat'l Institutes of Health, Health & Human Services Dept.

Program: Prevention & Treatment of Childhood Obesity in Primary Care Settings.

Funding: \$5.75 million from several institutes within NIH.

Eligibility: Public or private organizations, including for- and nonprofits; state, local and federal governments; public and private institutions such as hospitals, universities or colleges; and faith-based and community organizations.

Deadline: Letters of intent due Oct. 25 (not required); applications due Nov. 23.

Summary: This is a research program designed to test interventions offered in primary care settings, including the dentist's office.

Programs tested should be applicable in various settings, including primary care clinics, managed care organizations and pediatricians' and dentists' offices.

NIH seeks interventions to encourage physical activity and healthier eating. The program should start in the primary care setting, but others—such as a hospital's dietician—can be included.

The guidelines say applications “must propose [their] own specific research question and methods, including specific aims, description of and justification for the proposed intervention program and to whom it is directed, the primary and other outcomes to be measured, intervention process measurements, the informed consent processes, and statistical methods to be used, including justification of the sample size and power.”

NIH has different sizes and scopes for its research. This particular program is accepting applications under the R01 and R21 types.

R01 is the standard NIH research grant, meant for researchers. An R01 requires pilot or feasibility data and usually deals with budgets of \$250,000 or more annually for three years.

An R21, however, may be better for organizations not accustomed to dealing with NIH. R21 is designed for ex-

ploratory or developmental research that could provide possible breakthroughs in research or methodology by being supported in the early stages.

R21 projects run for two years and have a total budget of up to \$275,000.

Preliminary data aren't necessary, but if you have it, you can include them, NIH says.

Potential applicants are encouraged to contact NIH to discuss ideas.

Because nine different institutes or offices are involved, there are as many as 17 contacts. Please see the RFA for the best contact.

Info: <http://grants.nih.gov/grants/guide/rfa-files/RFA-HD-04-020.html>

Try Healthcare Disparities Report, Risk Free!

That's right – you can try **Healthcare Disparities Report** at NO RISK, because you get our money-back guarantee: **If you're not satisfied within 90 days, you can get a full refund promptly on request, or a refund for all undelivered issues thereafter.**

You get 12 monthly issues, access to our editorial hotline, free web resources, and more! With no risk and so much to gain, why wait? [Subscribe today!](#)

1 year, \$229 online \$254 print

1 year, \$279 print **AND** online

Please bill me. P.O. # _____

Check enclosed (Md. residents add 5% tax)

CHARGE Visa MasterCard AMEX

CC # _____ Ex. _____

Name: _____

Title: _____

Co./Org: _____

Address: _____

City, State, Zip: _____

Ph: (____) _____ Fax: (____) _____

E-mail: _____

Signature: _____

Visit our website for monthly specials, other resources, or to purchase or renew subscriptions!

www.cdpublications.com PO4

CD Publications, 8204 Fenton St., Silver Spring, MD 20910
Fax: 301-588-6385 **Toll-free:** 800-666-6380