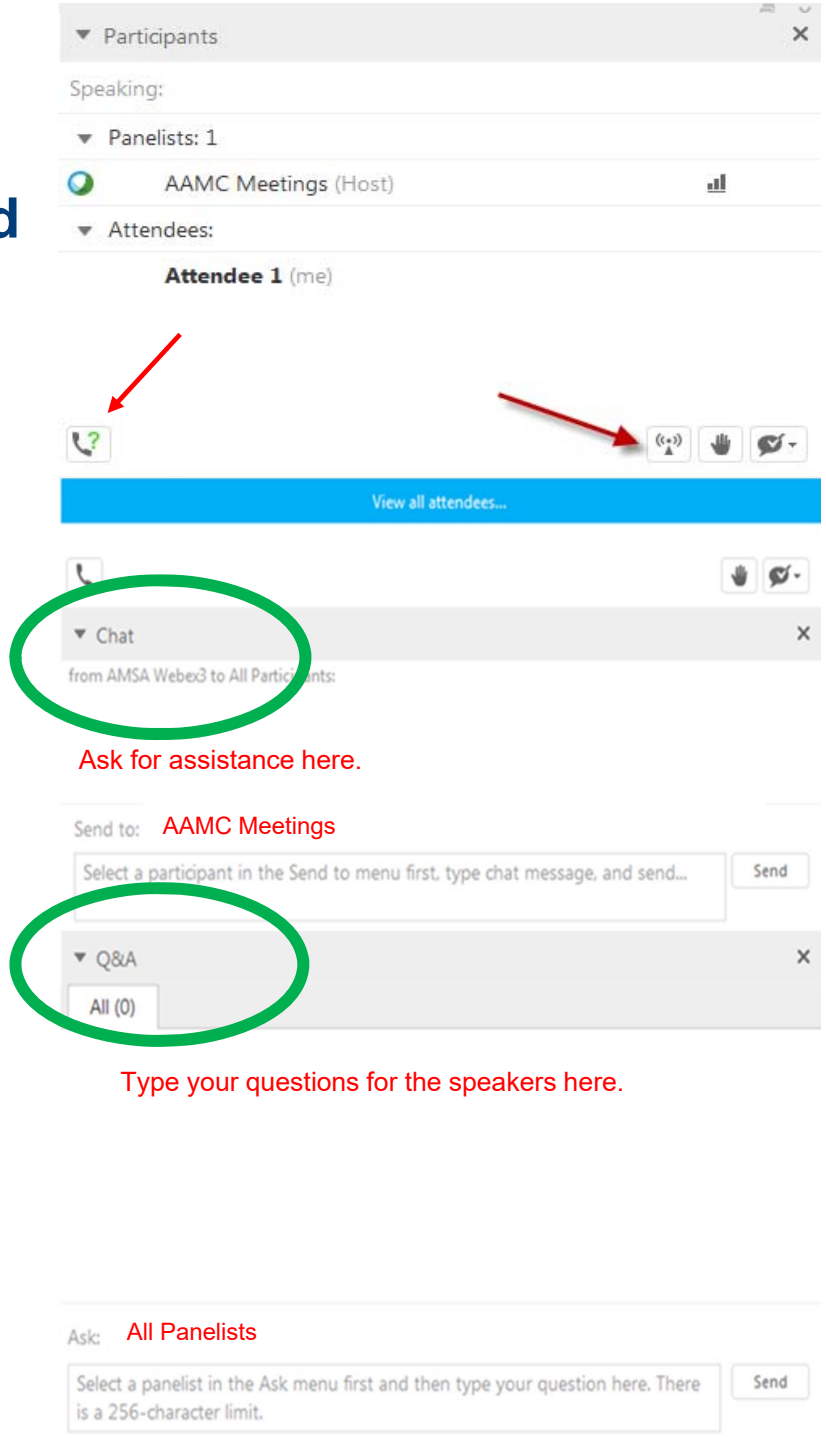
- **We will begin momentarily.**
- **This webinar is being recorded and will be available online next week.**
- Audio will be through your computer speakers.
  - Make sure your speakers are on and the volume is turned up.
  - If you have no sound once the webinar begins, click
  - To request the phone number, click
- For assistance, send a **Chat** message to "AAMC Meetings."
- Type your questions for the speakers in the **"Q&A"** panel at the bottom. Send to "**All Panelists**."



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Tomorrow's Doctors, Tomorrow's Cures

Promising Practices to Improve Hispanic Health

Collaborative interprofessional forum to discuss advancement of Hispanic health

Learn

Serve

Lead

The State of Hispanic Health and Implications for the Future

Tuesday, April 24, 2018

Association of American Medical Colleges

Maria M. Garcia, MD, MPH, FACP

Professor of Medicine
University of Massachusetts Medical School
Vice President on the Executive Board of Directors for the Hispanic-Serving Health Professions Schools (HSHPS)

HSHPS
HISPANIC - SERVING HEALTH PROFESSIONS SCHOOLS

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Malika Fair, MD, MPH, FACEP

Senior Director, Health Equity Partnerships & Programs
Association of American Medical Colleges (AAMC)

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Learning Objectives

1. Describe unique health challenges facing Hispanic communities in the U.S

2. Discuss local and national public health efforts to improve Hispanic health outcomes

3. Identify common approaches within academic medicine to advance Hispanic health.

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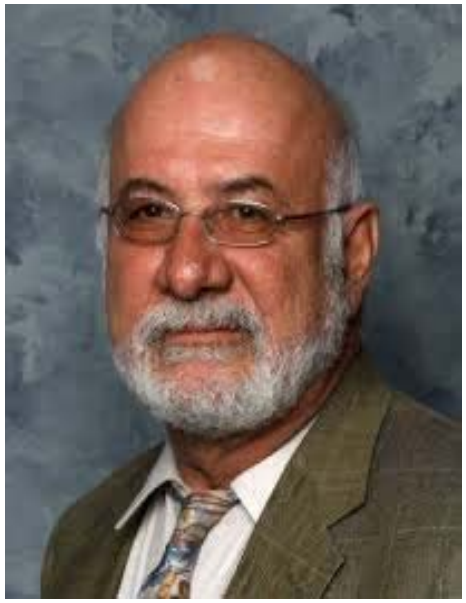
Panelists

Kenneth L. Dominguez, MD, MPH
CAPT USPHS
CDC, National Center for HIV, Viral Hepatitis, STD, TB Prevention



Kyriakos Markides, PhD
Annie & John Gnitzinger Distinguished Professor of Aging Studies
University of Texas Medical Branch

David Acosta, MD, FAAFP
Chief Diversity and Inclusion Officer
Association of American Medical Colleges

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Kenneth L. Dominguez, MD, MPH

- CAPT USPHS
- CDC, National Center for HIV, Viral Hepatitis, STD, TB Prevention
- Division of HIV/AIDS Prevention
- Epidemiology Branch, Prevention for Negatives Team

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Leading Causes of Death, Prevalence of Diseases and Risk Factors, and Use of Health Services Among Hispanics in the United States — 2009–2013

Kenneth L. Dominguez, MD, MPH, CAPT USPHS

Medical Epidemiologist

National Center for HIV, Viral Hepatitis, STD, TB Prevention

Division of HIV/AIDS Prevention

Centers for Disease Control and Prevention

Promising Practices to Improve Hispanic Health

Collaborative Interprofessional forum to discuss advancement of Hispanic Health

Webinar #1:

The State of Hispanic Health and Implications for the Future

Tuesday, April 24, 2018

Centers for Disease Control and Prevention

Office for State, Tribal, Local and Territorial Support

Disclaimers

- The findings and conclusions in this presentation are those of the author(s) and do not necessarily represent the official position of the Centers for Disease Control and Prevention/the Agency for Toxic Substances and Disease Registry.
- We have no conflicts of interest related to this presentation.

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Early Release / Vol. 64
May 5, 2015

Vital Signs: Leading Causes of Death, Prevalence of Diseases and Risk Factors, and Use of Health Services Among Hispanics in the United States — 2009–2013

Kenneth Dominguez[1], Ana Penman-Aguilar[2], Man-Huei Chang[1], Ramal Moonesinghe[2], Ted Castellanos[3], Alfonso Rodriguez-Lainz[4], Richard Schieber[5]

CDC Coauthors:
Man-Huei Chang, MPH
Ramal Moonesinghe, PhD
Ted Castellanos, MPH
Alfonso Rodriguez-Lainz, PhD
Richard Schieber, MD, MPH

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CDC Staff

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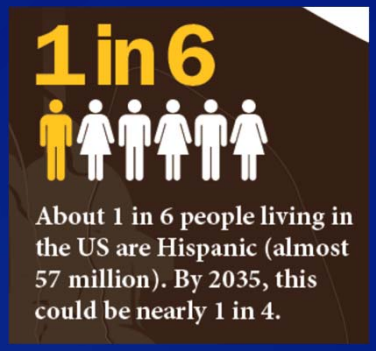
- Hector G. Balcazar, PhD, University of Texas School of Public Health in Houston, El Paso Regional Campus
- Venus Ginés, MA, Baylor College of Medicine; Día de la Mujer Latina.

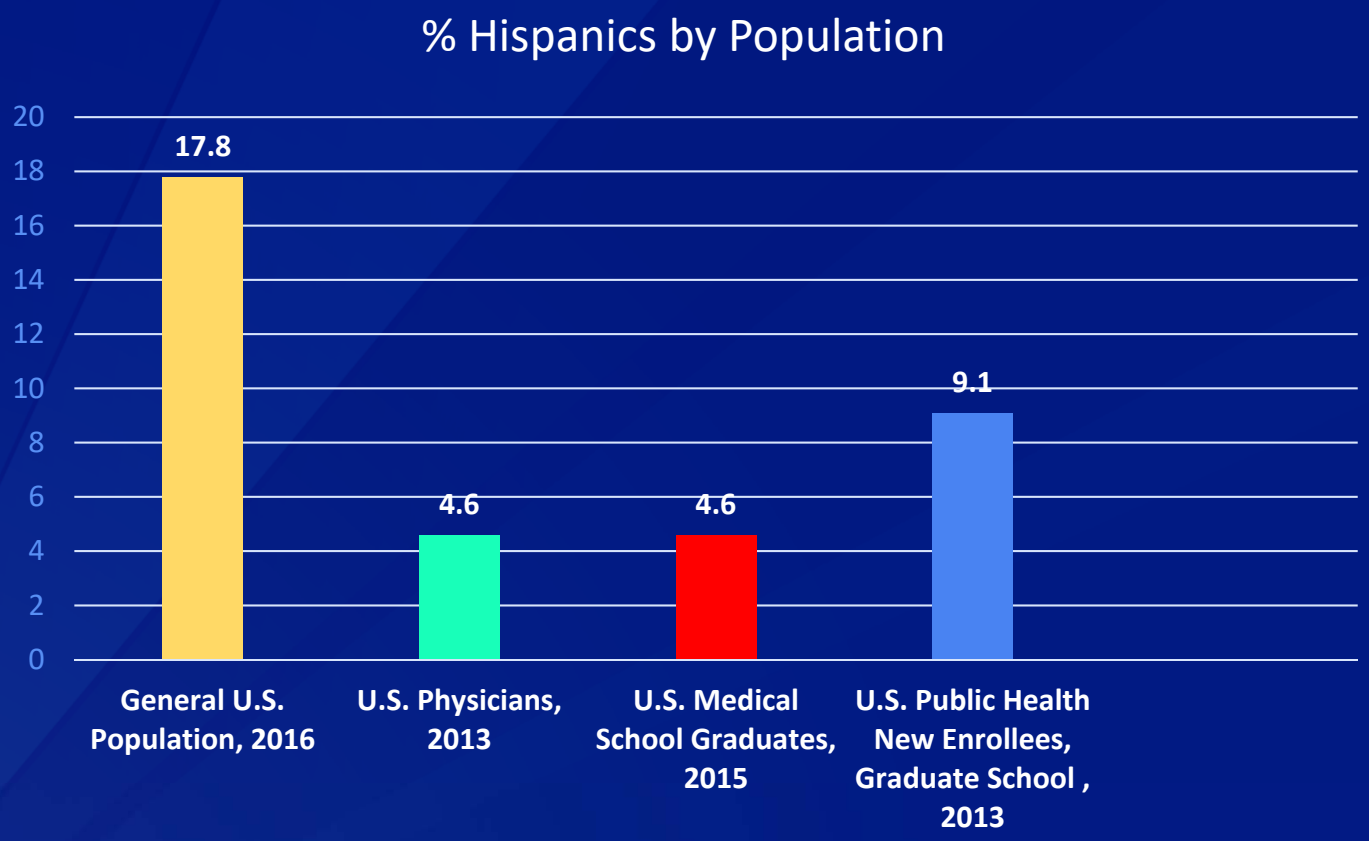
Introduction

- Hispanics estimated to represent about 1 in 6 people (2015) & 1in 4 people (2035) in the U.S.
- Largest racial/ethnic minority population in U.S.
- Hispanic Community Health Study in four cities in U.S. - shows key differences by Hispanic origin and other factors.
- Published national health estimates by Hispanic origin and nativity are lacking.



(1): Hispanic community health study/study of Latinos data book: a report to the communities. Bethesda, MD: National Institutes of Health; 2013. NIH Publication No. 13–7951.

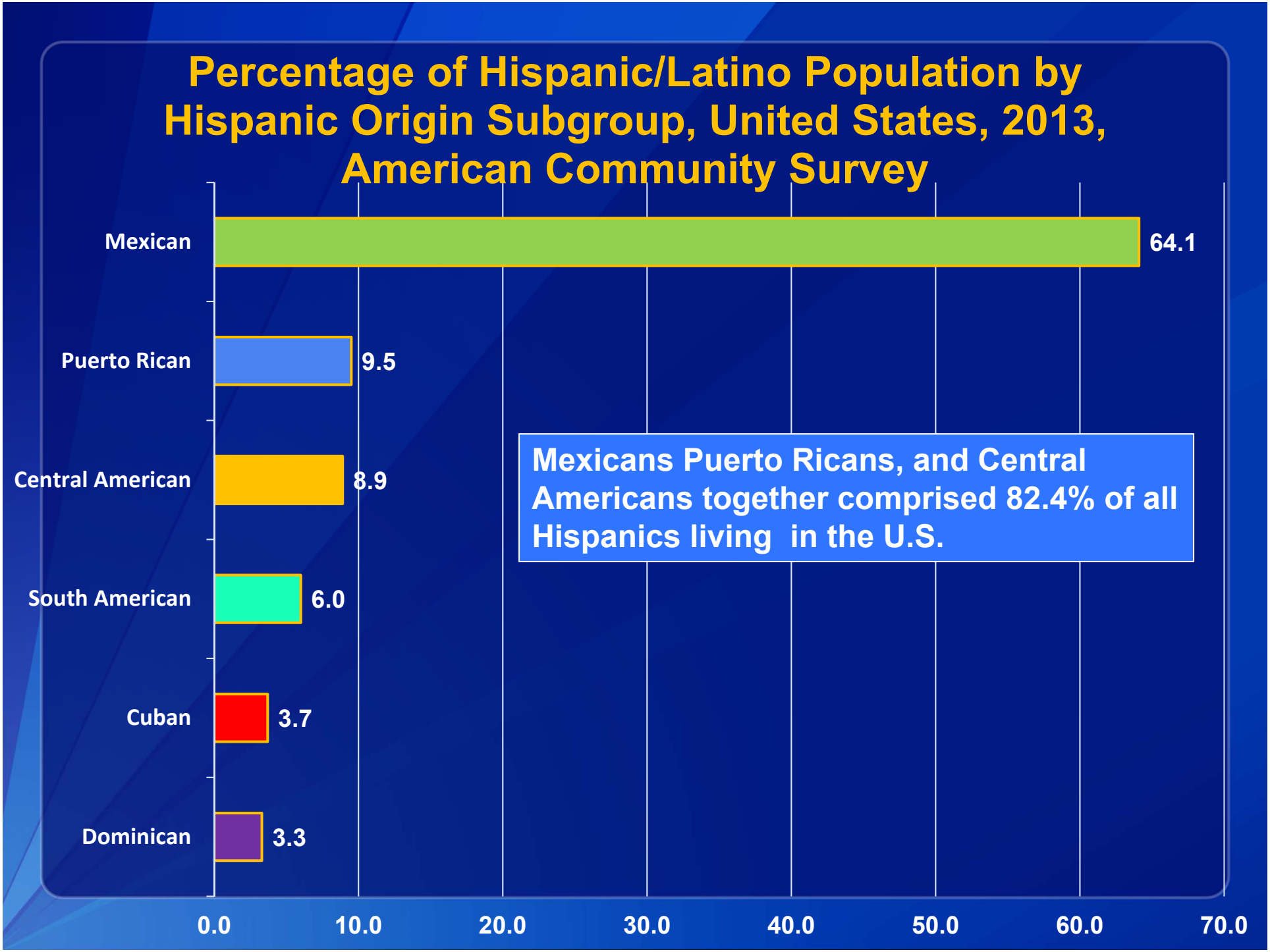
Hispanics Severely Underrepresented in Fields of Medicine and Public health



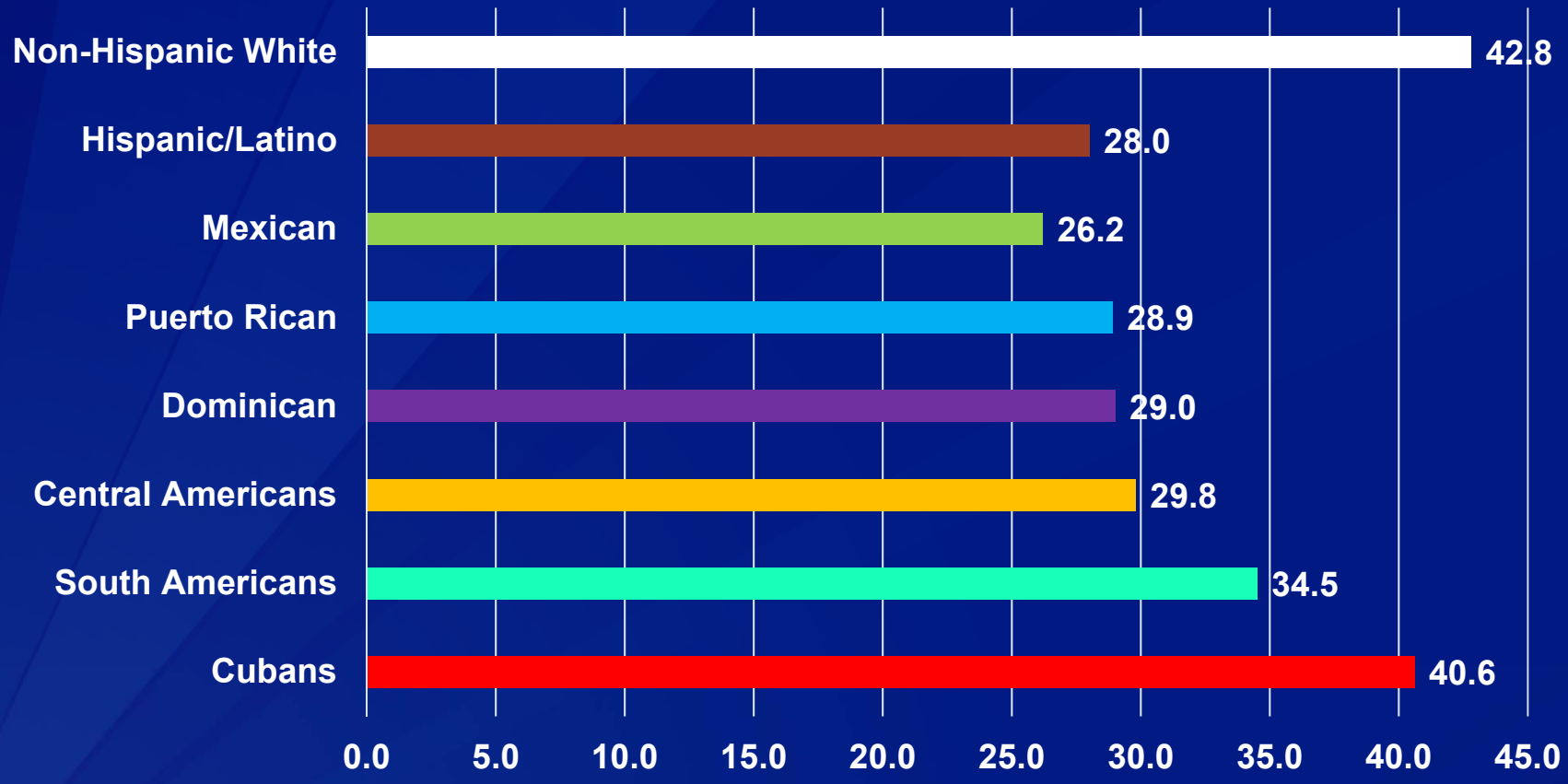
1. Association of American Medical Colleges. Diversity in the Physician Workforce, Facts and Figures 2014. Available at https://www.aamc.org/data/workforce/reports/439214/workforcediversity.html.
2. Association of American Medical Colleges, Current Trends in Medical Education, 2016. Available at http://aamcdiversityfactsandfigures2016.org/report-section/section-3/#figure-19B
2. Association of Schools and Programs of Public Health Application and New Enrollment Data Report 2013.

Purpose/Methods

- **Purpose: Nationally representative study of causes of death, prevalence of disease and risk factors, and use of health services**
- **Methods:**
  - Compared Hispanics, Hispanic subgroups, and non-Hispanic whites by nativity and sex (where possible)
  - Ages 18-65 during 2009-2013 (unless otherwise specified)
  - Socio-demographics – American Community Survey (Census)
  - Leading causes of death – National Vital Statistics System (CDC)
  - Disease prevalence and risk factors– National Health Interview Survey and National Health Examination and Nutrition Survey (CDC)
  - Use of health services – National Health Interview Survey (CDC)

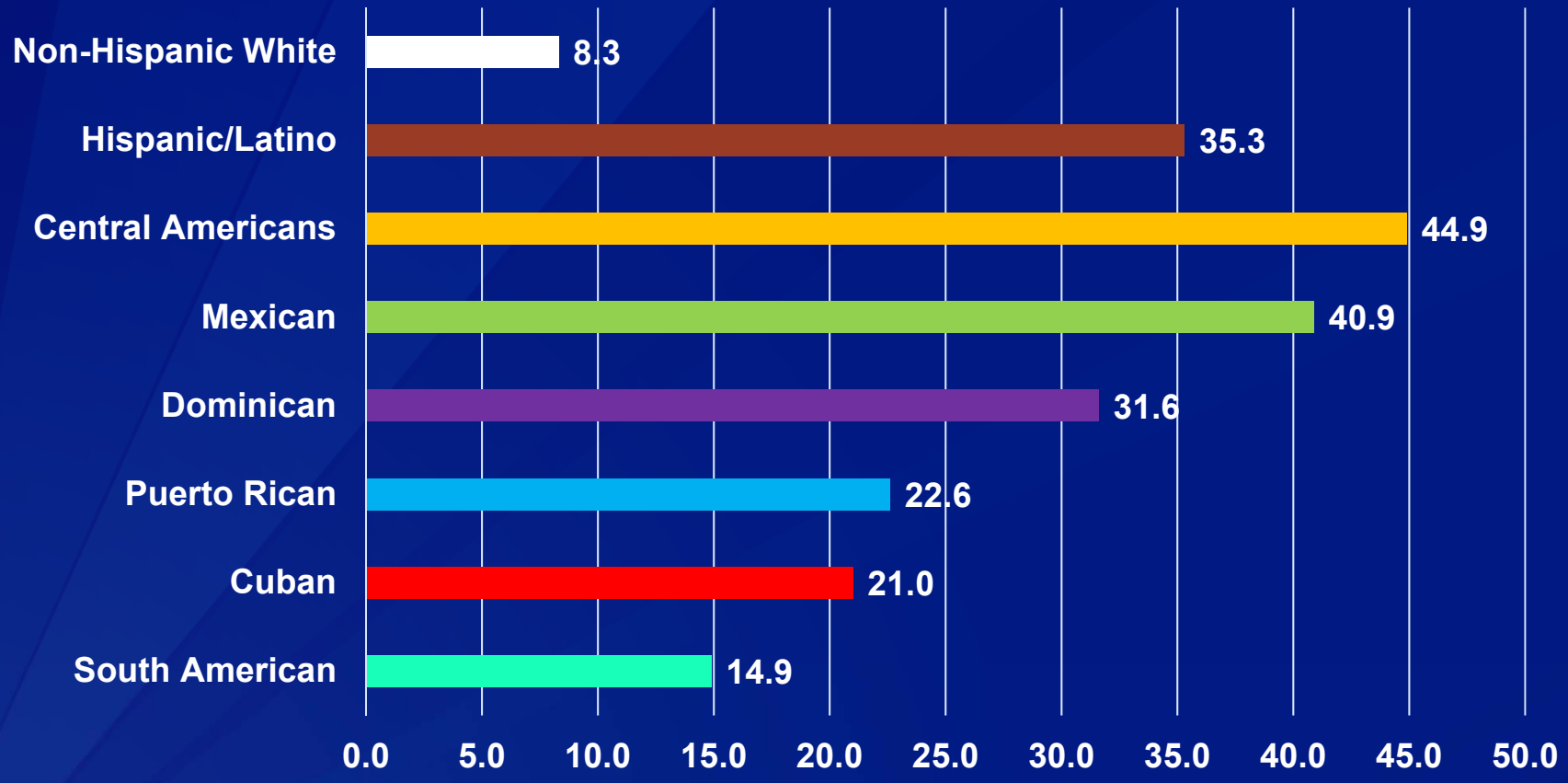

Percentage of Hispanic/Latino Population by Hispanic Origin Subgroup, United States, 2013, American Community Survey
Mexican
64.1
Puerto Rican
9.5
Central American
8.9
South American
6.0
Cuban
3.7
Dominican
3.3
Mexicans Puerto Ricans, and Central Americans together comprised 82.4% of all Hispanics living in the U.S.
0.0
10.0
20.0
30.0
40.0
50.0
60.0
70.0

Median Age (years) of Hispanics by Hispanic Origin Subgroup and of non-Hispanic Whites, United States, 2013, American Community Survey



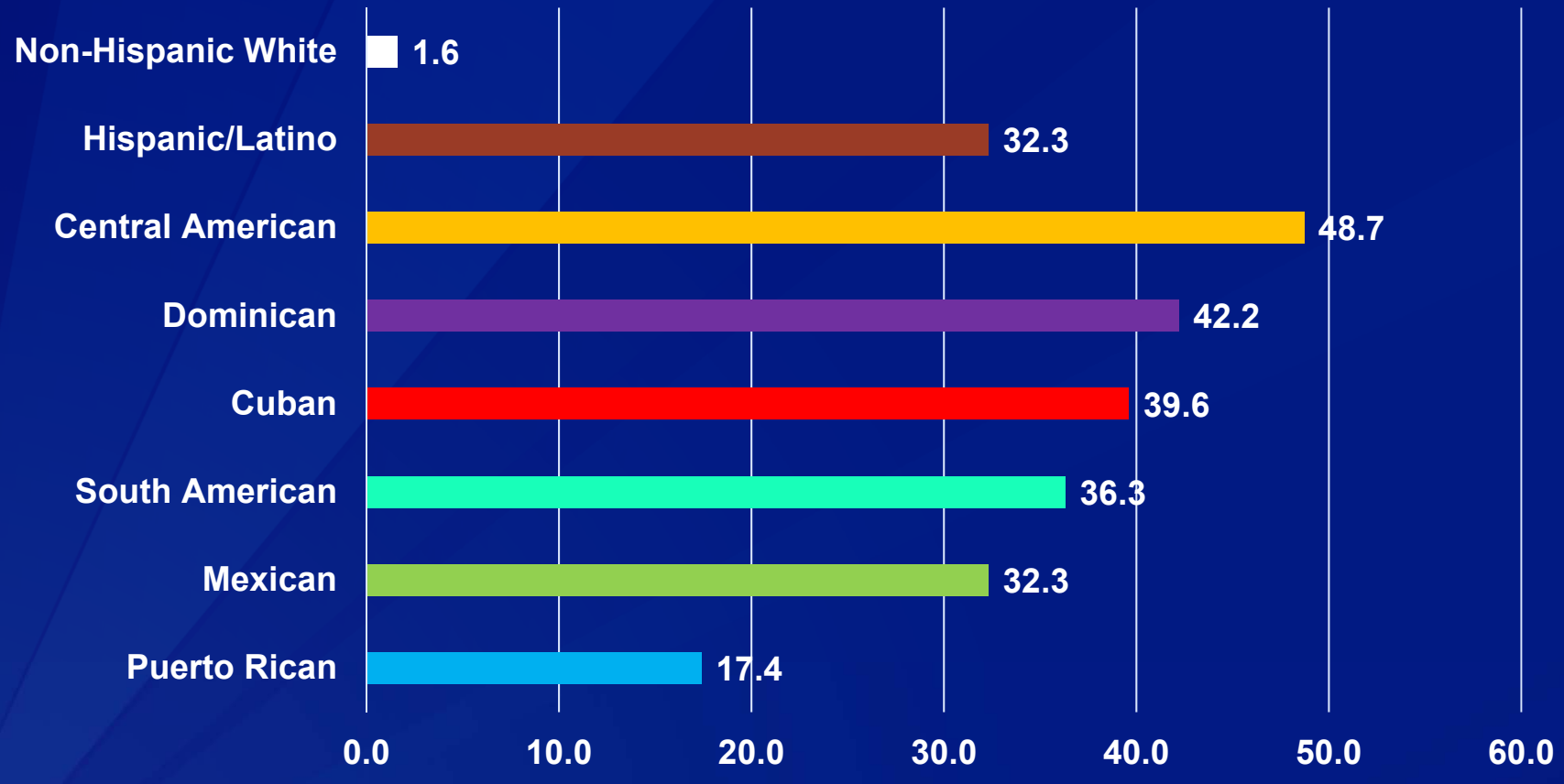
Hispanics were on average 15 years younger than non-Hispanic whites

Percentage with less than a High School Diploma of Hispanics by Hispanic Origin Subgroup and of non-Hispanic Whites, United States, 2013, American Community Survey



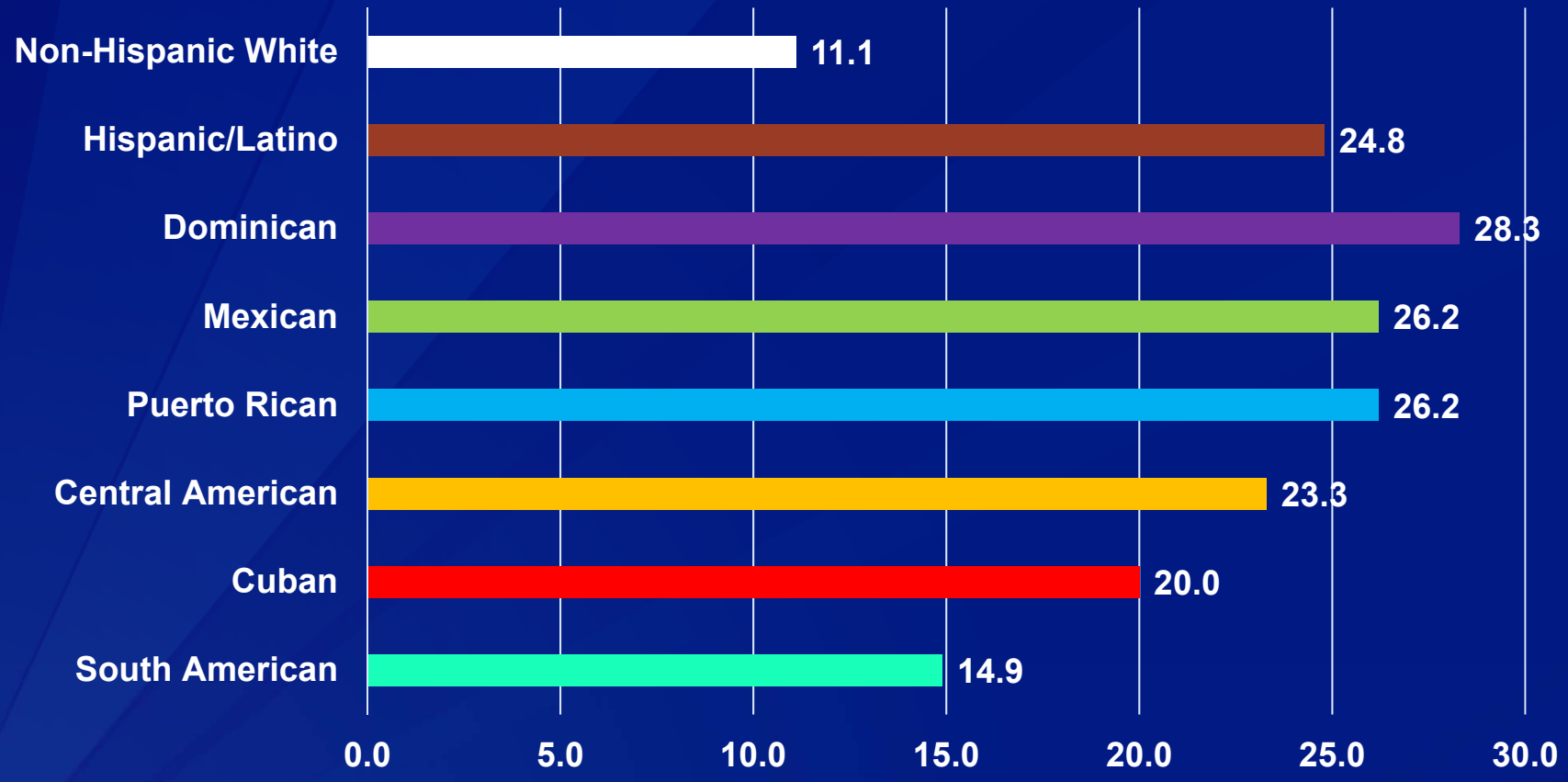
Hispanics were about 4 times as likely as non-Hispanic whites not to have completed high school

Percentage who speak English less than very well among Hispanics by Hispanic Origin Subgroup and of non-Hispanic Whites, United States, 2013, American Community Survey



Hispanics were about 20 times as likely to speak English less than very well compared with non-Hispanic whites

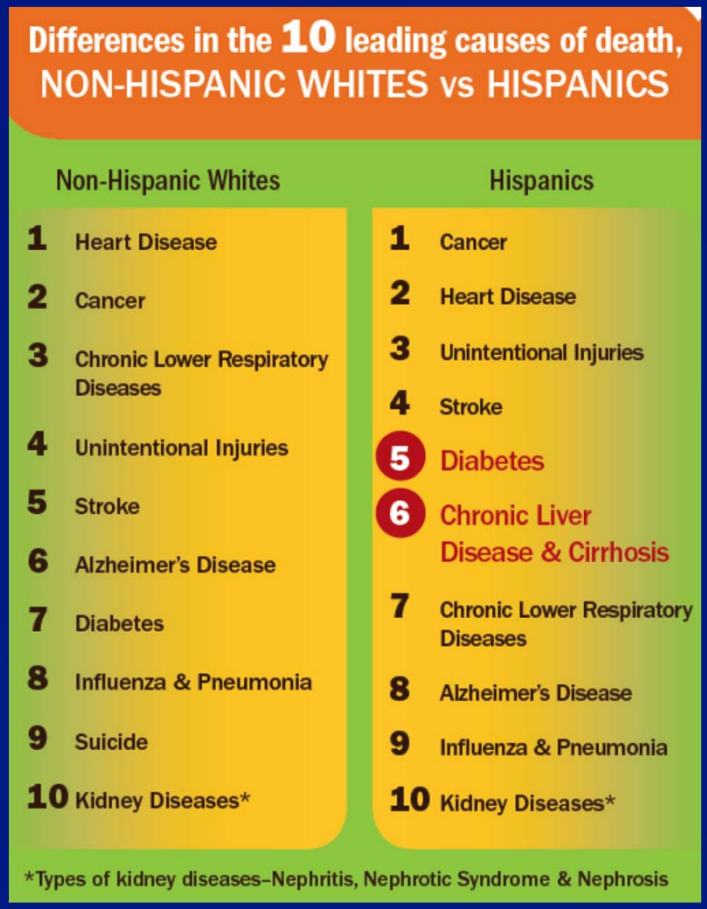
Percentage Living below the Poverty Line among Hispanics by Hispanic Origin Subgroup and of non-Hispanic Whites, United States, 2013, American Community Survey



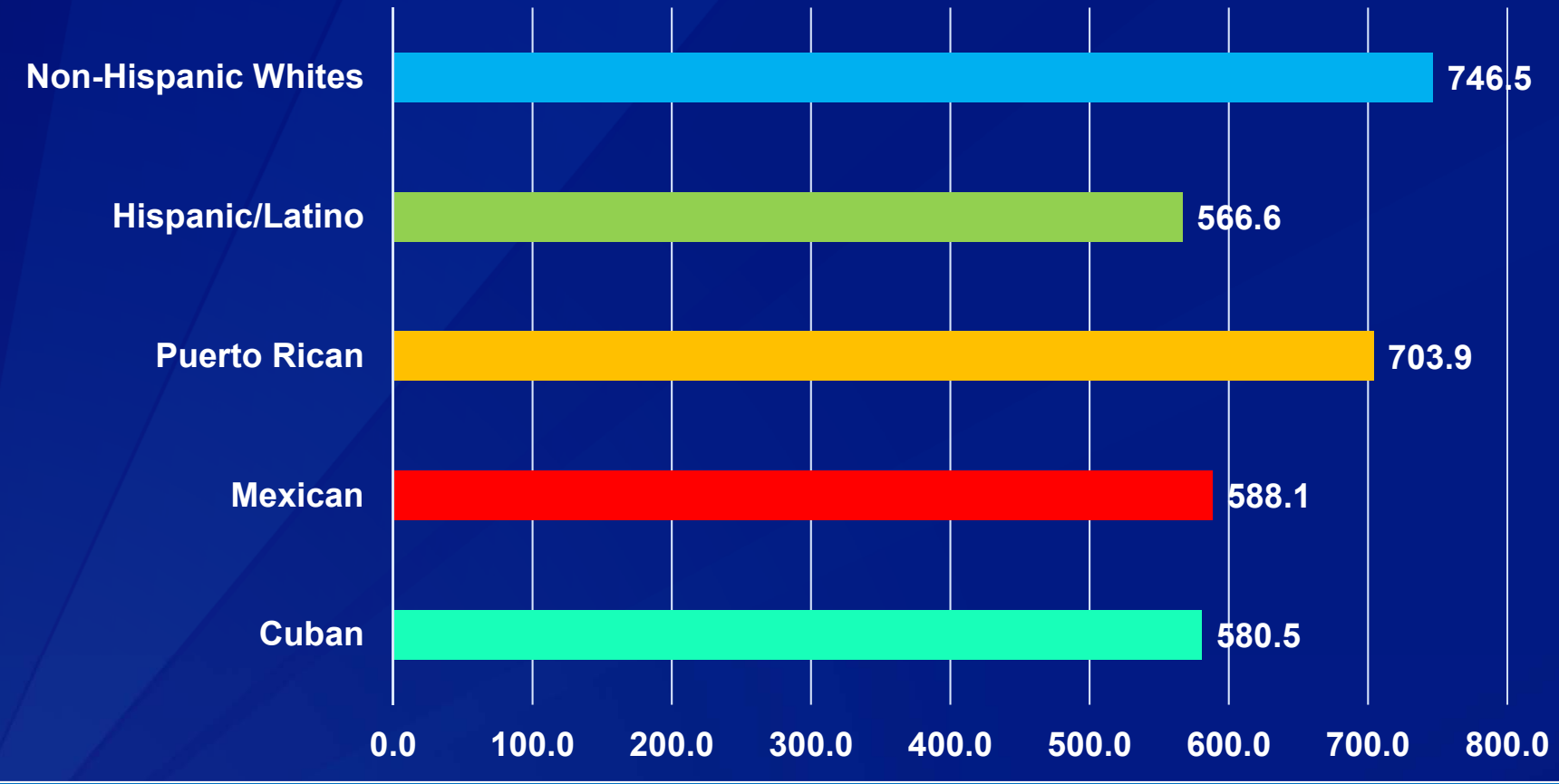
Hispanics were about twice as likely to live below the poverty line compared with non-Hispanic whites

Results - Leading Causes of Death (LCOD) in U.S.

- Cancer and heart disease - first two LCOD of death for Hispanics and non-Hispanic whites (NHWs) (2 in 5 deaths)
- Cancer is first LCOD in Hispanics, heart disease in NHWs
- Hispanic death rates for 7 of 10 LCOD lower than NHWs (#1,2,3,4,7,8,9). Similar death rates for kidney disease (#10).
- Hispanic death rates higher than NHWs for diabetes and chronic liver disease & cirrhosis (#5, 6).

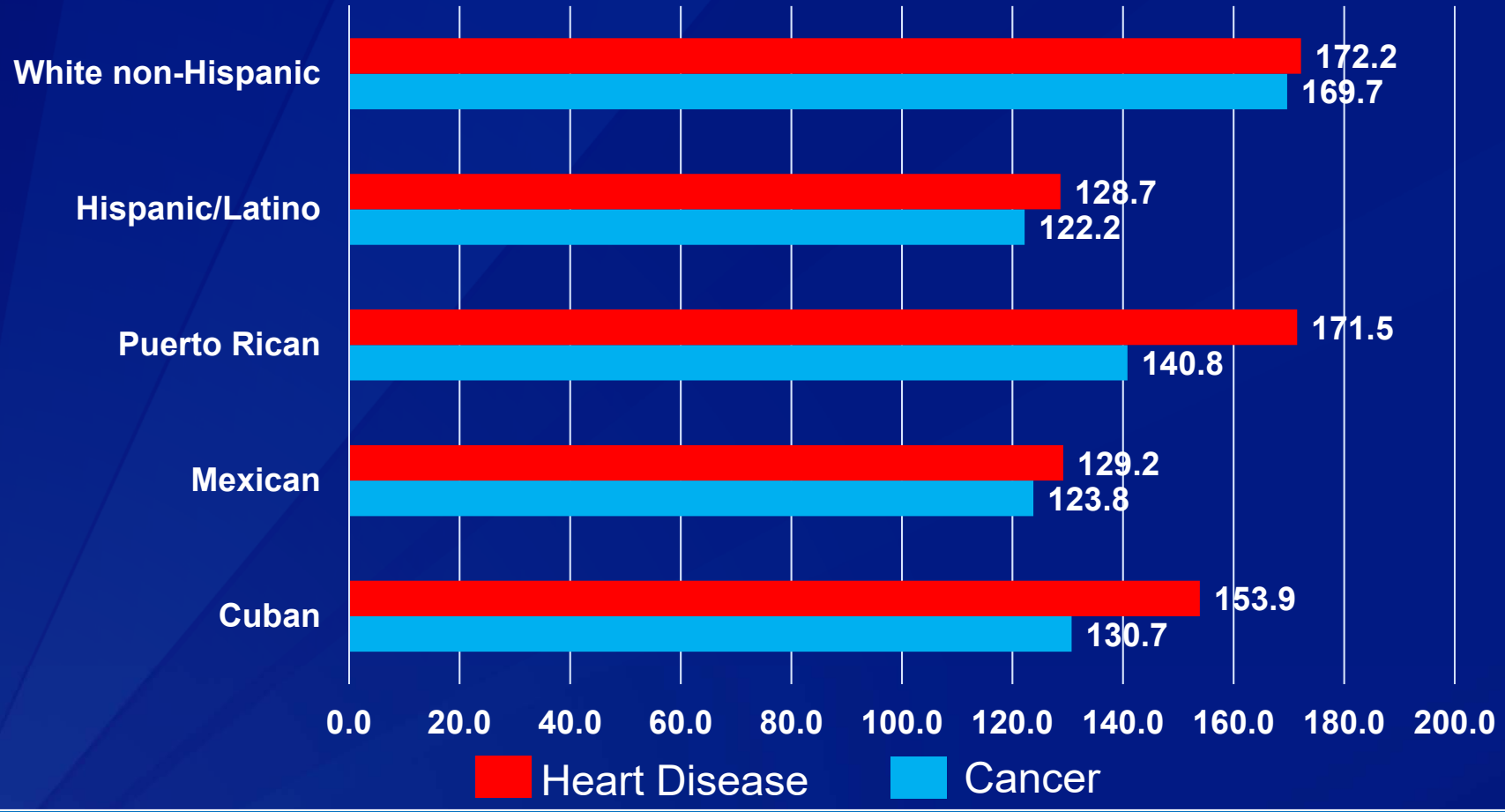


All Cause Mean Age-Adjusted Death Rates (per 100,000) among Hispanics by Hispanic Origin Subgroup and of non-Hispanic Whites, United States, 2013, Vital Statistics Cooperative Program



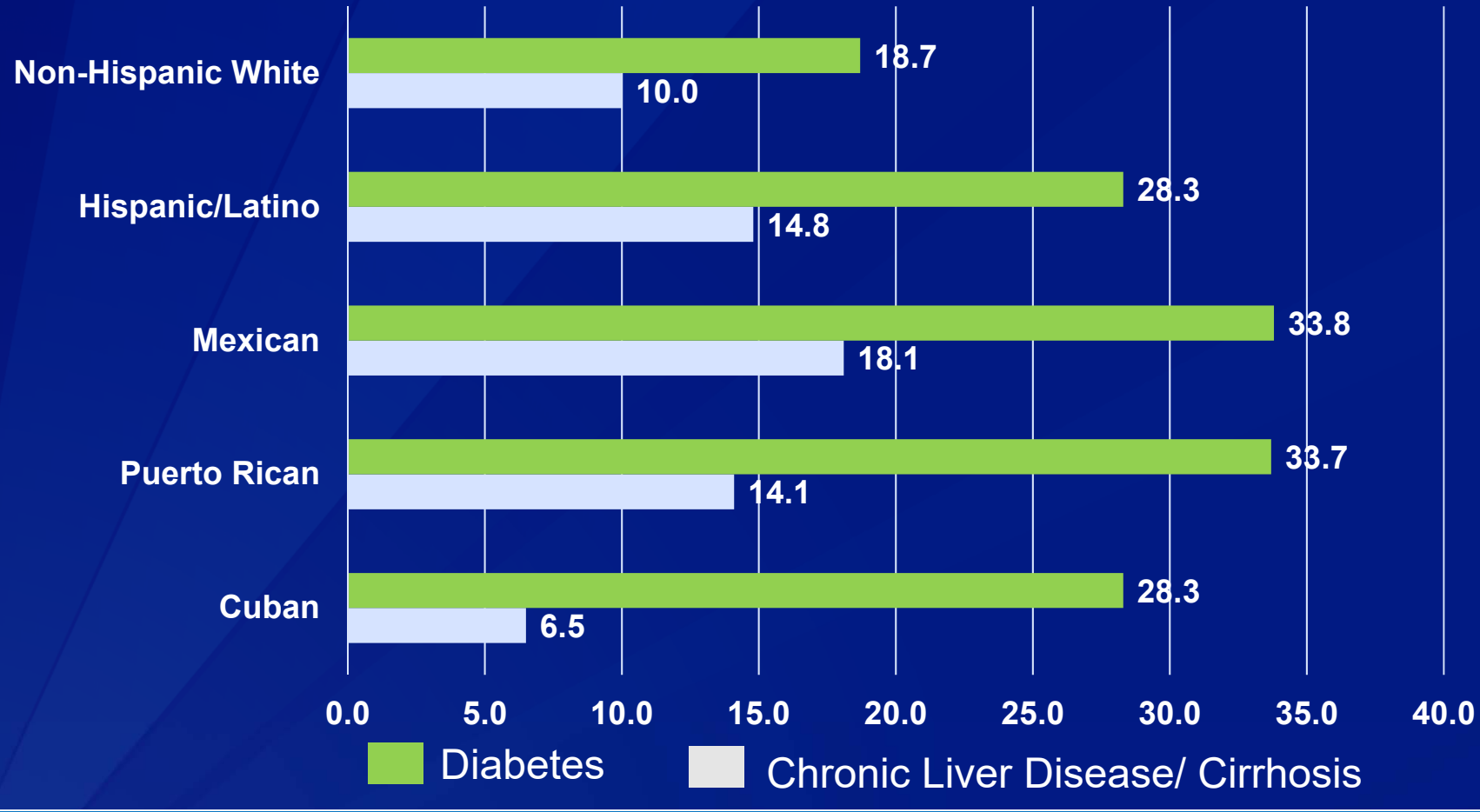
The overall Hispanic all-cause mortality rate was 24% lower than for non-Hispanic whites. However, the all-cause mortality rate for Puerto Ricans was 20% higher than for Mexicans and Cubans and only 6% lower than for non-Hispanic whites

Mean Age-Adjusted Death Rates (per 100,000) for Cancer and Heart Disease among Hispanics by Hispanic Origin Subgroup and of non-Hispanic Whites, United States, 2013, Vital Statistics Cooperative Program



Non-Hispanic whites had greater death rates from heart disease and cancer than Hispanics overall. Puerto Ricans had similar death rates from heart disease as non-Hispanic whites and higher death rates from cancer than Mexicans and Cubans.

Mean Age-Adjusted Death Rates (per 100,000) for Diabetes Mellitus and Chronic Liver Disease/Cirrhosis among Hispanics by Hispanic Origin Subgroup and of non-Hispanic Whites, United States, 2013, Vital Statistics Cooperative Program



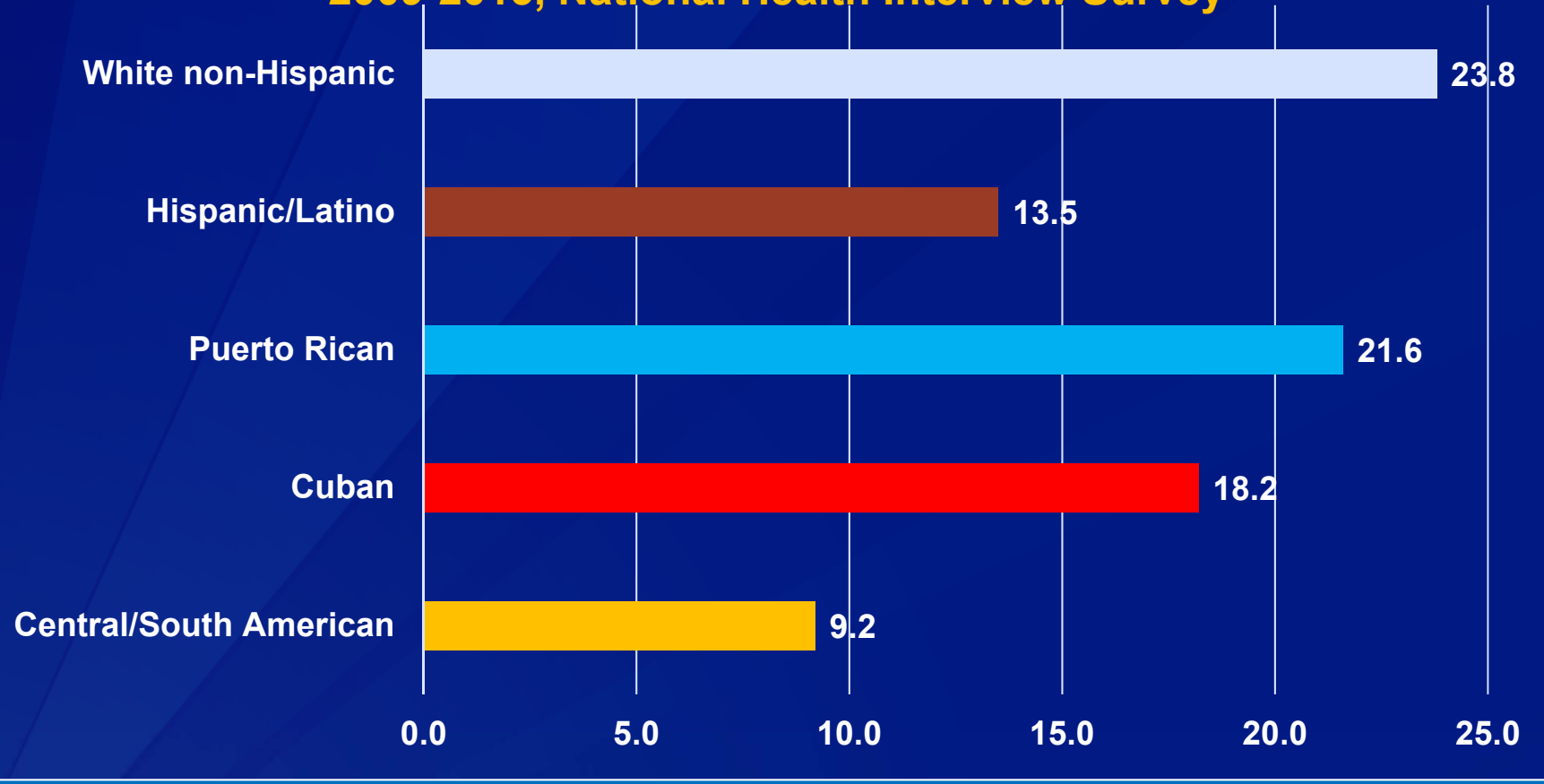
Hispanics had about 50% greater death rates from both diabetes and chronic liver disease/cirrhosis than non-Hispanic whites.

Mexicans and Puerto Ricans had about 80% and 40% greater death rates, respectively, from chronic liver disease/cirrhosis than non-Hispanic whites.

Disease Prevalence and Health Care Utilization - Key Differences between Hispanics and non-Hispanic Whites

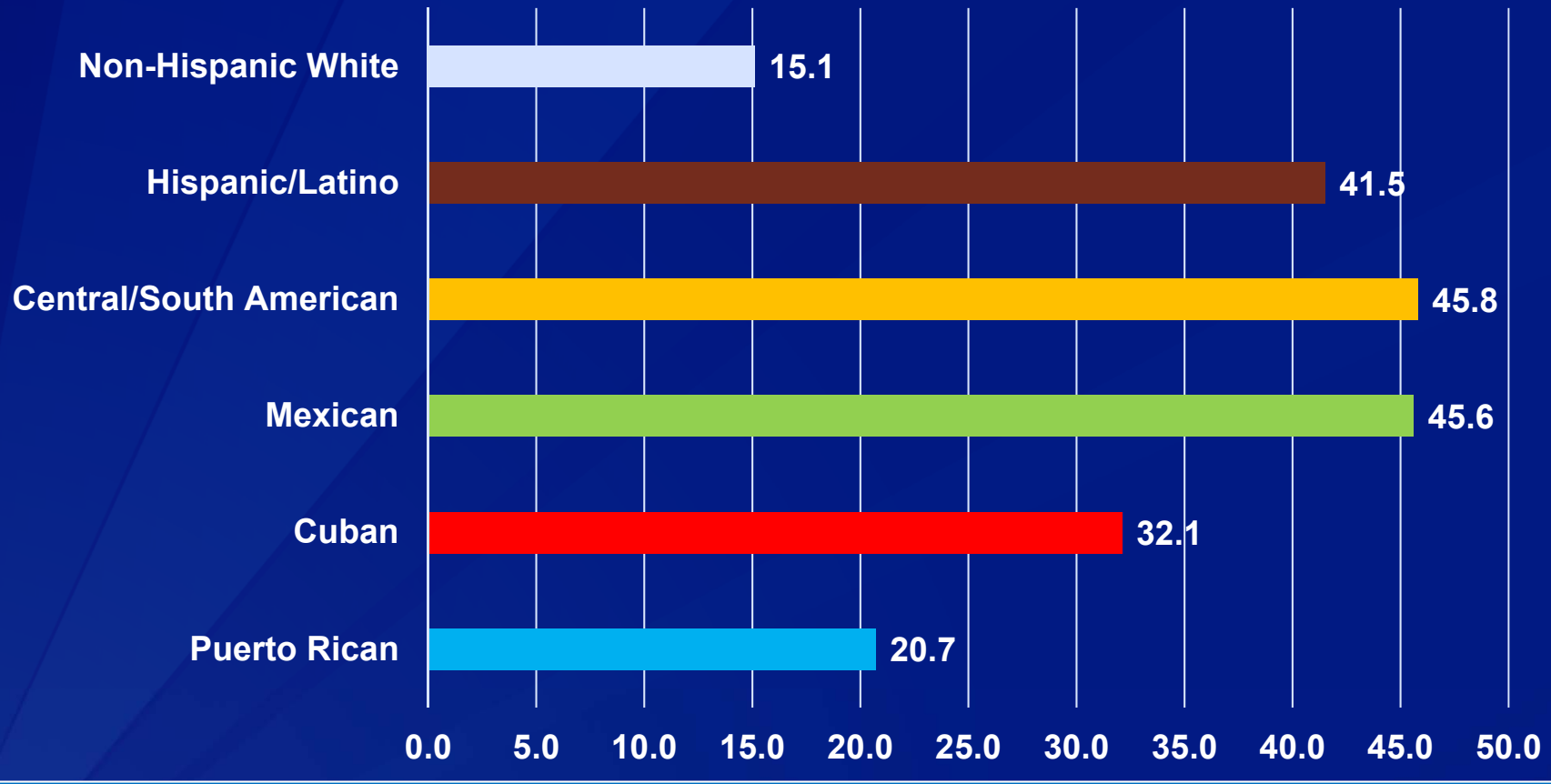
- Hispanics had lower self-reported prevalences of cancer (↓49%) & heart disease (↓ 35%), but showed higher diabetes prevalence (↑ 133%).
- Hispanics less often reported smoking (↓ 43%), but showed a higher prevalence of obesity (↑23%).
- Hispanics were 28% less likely to report having had recommended colorectal cancer screening.
- Hispanic women were 7% less likely to report having had recommended screening for breast cancer (mammogram) and cervical cancer (Pap test).

Prevalence (%) of Current Cigarette Smoking among Hispanics, age 18 – 64 years, by Hispanic Origin Subgroup and of non-Hispanic Whites, United States, 2009-2013, National Health Interview Survey



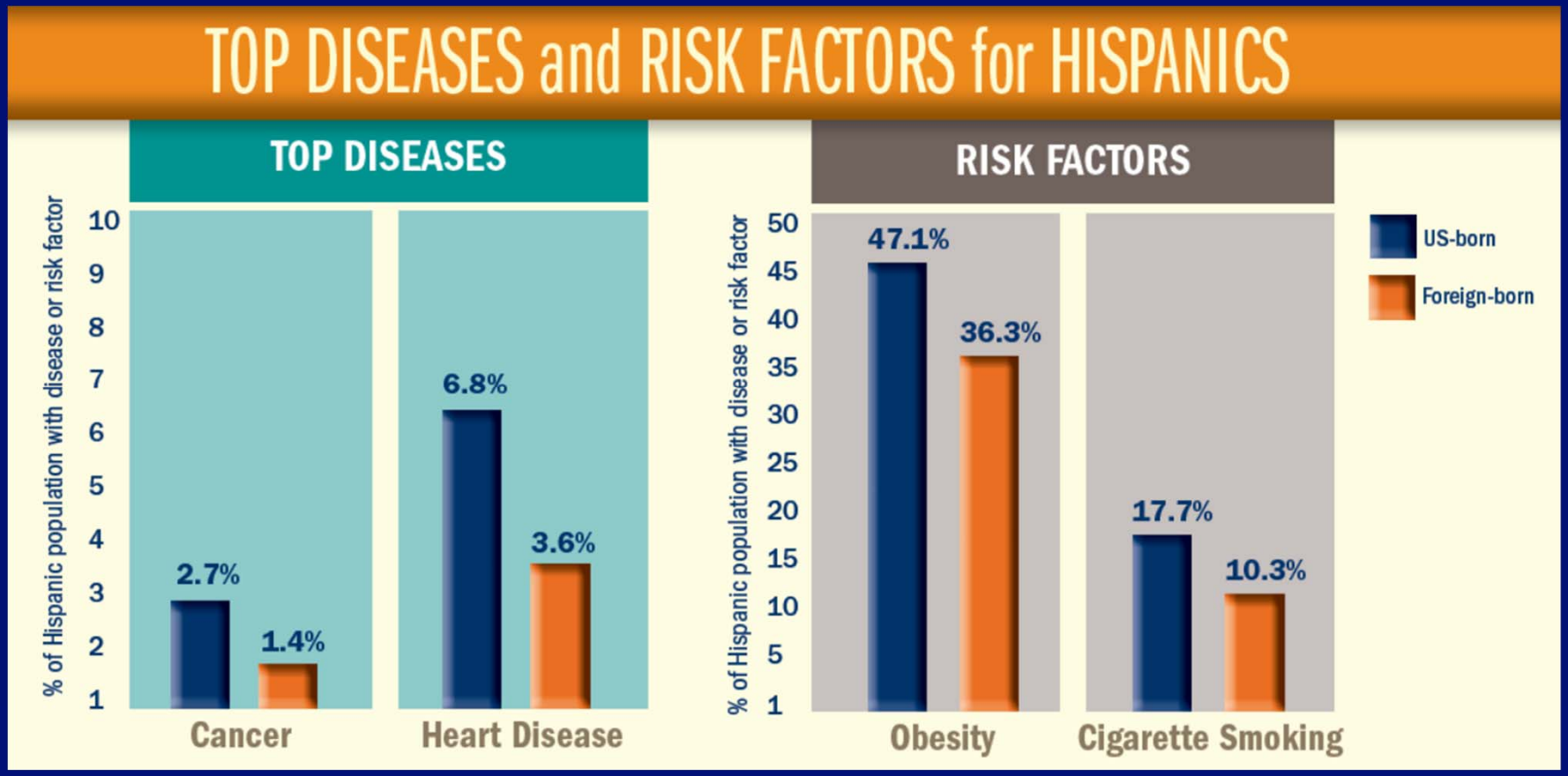
Hispanics overall were on average 57% as likely as white non-Hispanics to report being cigarette smokers. However, Puerto Ricans were equally as likely as non-Hispanic whites to report being cigarette smokers. Cubans were *statistically* as likely as Puerto Ricans (but not as likely as non-Hispanic whites) to report being smokers.

Prevalence (%) of Lack of Health Insurance among Hispanics, age 18 – 64 years, by Hispanic Origin Subgroup and of non-Hispanic Whites, United States, 2011-2013, National Health Interview Survey



Overall, Hispanics were on average nearly 3 times as likely to report lack of health insurance compared with non-Hispanic whites. Central Americans/South Americans (combined) and Mexicans were about 2 times as likely to report not having health insurance compared with Puerto Ricans.

Prevalences of selected diseases and risk factors among US-born and Foreign-born Hispanics



SOURCES: National Health Interview Survey, 2009-2013, National Health and Nutrition Examination Survey, 2009-2012.

Discussion

- **Better health outlook for all Hispanics combined compared with white non-Hispanics despite many social factors that present barriers to health - termed "Hispanic Paradox" (1).**
- **Hispanic paradox is partly explained by lower Hispanic smoking rates, migration to the US of healthy immigrants, and reverse migration of elderly or sick Hispanics (2)(3).**

(1) Palloni. Et al. Demography 2004; (2) Blue, et al. Int. J Epid (2011) ; (3) Singh, et al. Scientific World J 2013.

Discussion

- **The following findings in Hispanics may be interrelated (1):**
  - Elevated death rates from diabetes and chronic liver disease
  - Elevated obesity prevalence
  - Positioning of cancer as the first leading cause of death.

(1) Palloni. Et al. Demography 2004; (2) American Cancer Society. Cancer Facts & Figures for Hispanics/Latinos 2012-2014. Atlanta: American Cancer Society, 2012

Discussion

- **Potential causes of elevated deaths from chronic liver disease in Hispanics:**
  - Higher deaths[1]from and lower vaccination[2] for Hepatitis B virus infection
  - Chronic hepatitis B virus (HBV) infection strongly associated with cirrhosis and liver cancer[3]
  - Higher prevalence of binge drinking of alcohol[4]
  - Higher levels of obesity
  - Overdose of liver toxic drugs[5]
- **Effects from any of these potential causes can be additive**
- **Citations**

(1) National Center for Health Statistics. Deaths: Final Data for 2013. National Vital Statistics Report. 2013 http;//www.cdc.gov/nchs/data_access/vitalstatisticsonline.htmDonato F. et al. *Int J Cancer* 1998; 75 (3): 347-354.

(2) Williams et al. *MMWR* 2015; 64:95-102

(3) Donato F. et al. Int J Cancer 1998; 75 (3): 347-354.

(4) Kanny D, et al. CDC health disparities and inequalities report, United States, 2013: binge drinking–United States, 2011. MMWR Surveill Summ 2013;62(Suppl 3):77–80.

(5) Los Angeles County Department of Public Health. Office of Health Assessment and Epidemiology. Disparities in Deaths from Chronic Liver Disease and Cirrhosis. June 2012

Obesity associated with Type 2 Diabetes and Cancer

- **Chronic obesity is associated with nonalcoholic fatty liver disease, morphologic changes to liver cells, and liver cancer.**

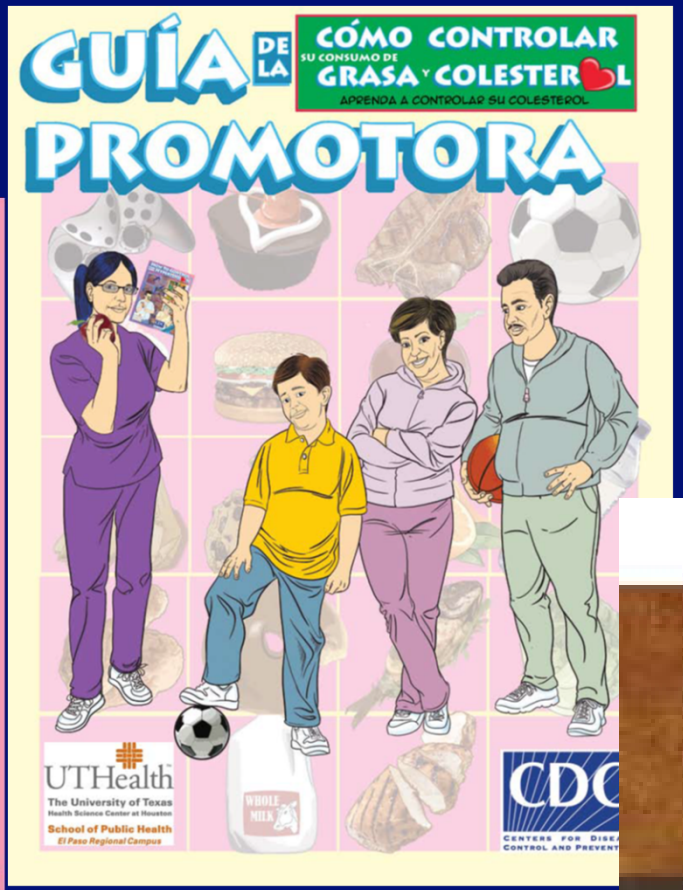
- **Chronic obesity is also associated with elevated levels of Type 2 diabetes due to effects of fat on pancreatic islet cells that produce insulin.**

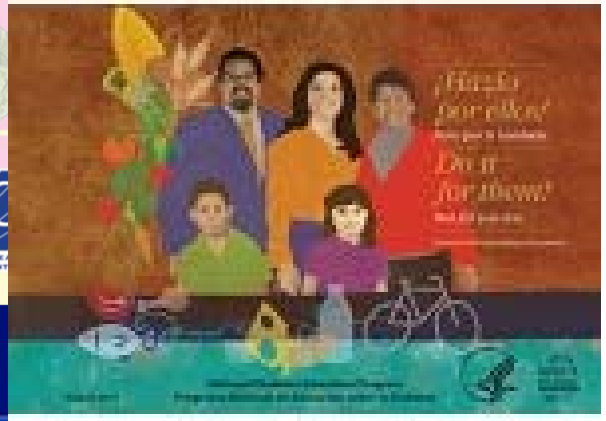
1. Gallagher EJ, LeRoith D. Epidemiology and molecular mechanisms tying obesity, diabetes, and the metabolic syndrome with cancer. *Diabetes Care* 2013;36(Suppl 2):S233–9.

Key Health Messages, Strategies, and CDC Programs for Hispanics related to findings from Hispanic *Vital Signs*

http://www.cdc.gov/minorityhealth/promotores.htm

http://www.cdc.gov/minorityhealth/promotores.htm





AMIGAS – Cervical Cancer Prevention

- Evidence-based bilingual educational outreach approach[1]
- Helps lay health workers (promotoras)/educators increase cervical cancer screening among Hispanics who have rarely or never had a Pap test
- Stresses how information and skills learned in the intervention will help women, their families, and their communities stay healthy
- Includes an administrator's guide, promotora instruction guide, bilingual flip chart, and body diagrams.
- https://www.cdc.gov/cancer/gynecologic/what_cdc_is_doing/amigas.htm

1. Byrd TL, et a.. AMIGAS: A multi-city, multi-component cervical cancer prevention trial among Mexican-American women. *Cancer* 2013;119(7):1365–1372.

http://millionhearts.hhs.gov/Docs/4_Steps_Forward.PDF

Million Hearts™

National Alliance for Hispanic Health
www.hispanichealth.org

4 PASOS ADELANTE

Para reducir el riesgo de un ataque al corazón o un derrame cerebral

Todos los años en los Estados Unidos, las personas sufren más de **2 millones de ataques cardíacos y derrames cerebrales.** Pero, siguiendo estos 4 pasos, usted puede ayudar a reducir el riesgo y mejorar la salud de su corazón.

1. Tome aspirinas si el proveedor de servicios de salud se lo indica.
2. Controle su presión arterial.
3. Controle su colesterol.
4. No fume.

Chronic Liver Diseases and Liver Cancer Prevention

- **Prioritize messaging around following liver health-related public health education topics in Hispanic communities;**
  - Get vaccinated for HBV and screened for HCV
  - Avoid drinking alcohol, but for those who choose to drink, drink in moderation, that is < 1 drink/day for women and < 2 drinks/day for men
  - To decrease risk of chronic fatty liver disease due to obesity, exercise at a brisk rate at least 30 minutes per day
  - Follow directions on medication bottles and as directed by your physician to avoid damage to your liver

http://www.cdc.gov/hepatitis/hbv/pdfs/hepbgeneralfactsheet_sp.pdf

HEPATITIS B

Información general

¿Quién está en riesgo?

A pesar de que cualquiera puede

¿Qué es la hepatitis?

"Hepatitis" significa inflamación del hígado. El hígado es un órgano vital que procesa los nutrientes, filtra la sangre y combate infecciones. Cuando el hígado está inflamado o dañado, su función puede verse afectada.

En la mayoría de los casos, la hepatitis es provocada por un virus. En los Estados Unidos, los tipos más comunes de hepatitis viral son hepatitis A, hepatitis B y hepatitis C. El consumo excesivo de alcohol, las toxinas, algunos medicamentos y determinadas afecciones médicas también pueden causar hepatitis.

¿Qué es la hepatitis B?

La hepatitis B es una enfermedad del hígado que es contagiosa y resulta de la infección por el virus de la hepatitis B. Cuando una persona se infecta, puede desarrollar una infección "aguda," que puede variar en gravedad de una enfermedad muy leve con pocos o ningún síntoma a una afección grave que requiere hospitalización. La hepatitis B **aguda** se refiere a los primeros seis meses después de que alguien ha estado expuesto al virus de la hepatitis B. Algunas personas pueden combatir la infección y eliminar el virus. En otras, la infección permanece y da lugar a una enfermedad "crónica" o de por vida. La hepatitis B **crónica** se refiere a la enfermedad que ocurre cuando el virus de la hepatitis B permanece en el cuerpo de la persona. Con el tiempo, la infección puede causar problemas graves de salud.

La mejor forma de prevenir la hepatitis B es a través de las vacunas.

http://www.cdc.gov/vitalsigns/alcohol-poisoning-deaths/index.html

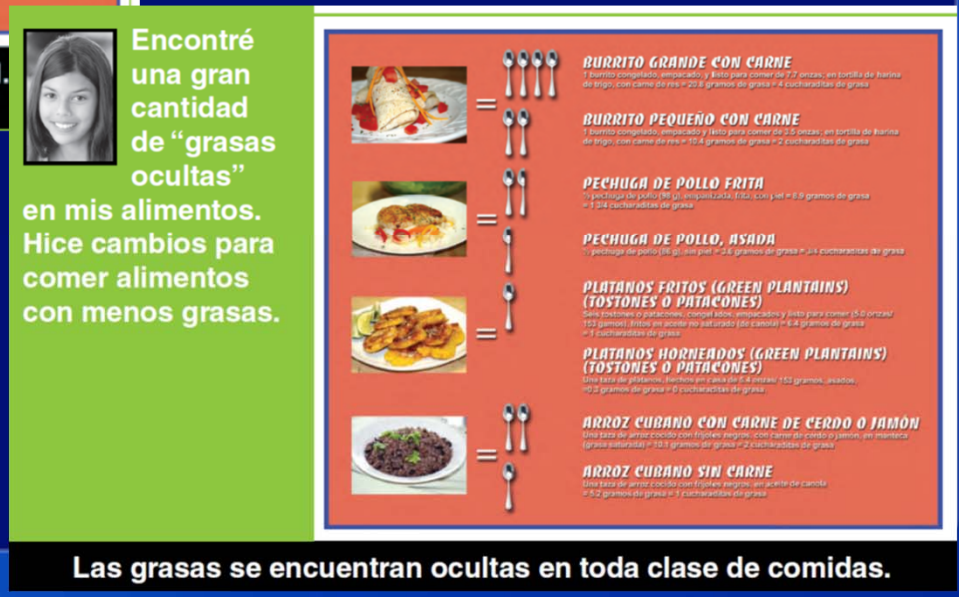
Obesity Prevention

- **Eat more fruits and vegetables and fewer foods high in fat and sugar.**
- **Drink more water instead of sugary drinks.**
- **Limit TV watching to less than 2 hours a day; avoid a television in the bedroom**
- **Promote policies and programs at school, at work, and in the community that make the healthy choice the easy choice.**
  - Market – request fruits and vegetables be displayed front
  - Vending machines in parks and schools – eliminate sugary beverages and other sugary snacks
  - Provide safe areas to exercise in the neighborhood or to plant vegetable gardens
- **Try going for a 10-minute brisk walk, 3 times a day, 5 days a week.**

National Diabetes Prevention Program

- **Components – Lifestyle Change Program**
  - Trained lifestyle coach
  - CDC-approved curriculum (culturally relevant Spanish translation)
  - Year-long group support
- **Helps participants make lasting behavior changes**
  - Eating healthier
  - Increase physical activity
  - Improve problem-solving skills
- **Cultural training Strategies**
  - Prioritize taking care of family over themselves
  - Multiple options for engaging in physical activity
  - Incorporating food traditions into curriculum
- **National DDP Website – Spanish version now available**
  http://www.cdc.gov/diabetes/prention/Index.html

http://www.cdc.gov/diabetes/ndep/pdfs/19-road-to-health-flipchart-spanish.pdf



- **Smoking is linked to 2 of every 10 deaths in the United States:**
  - If you don’t smoke, don’t start!
  - If you smoke, get help to quit smoking!
  - See: www.espanol.smokefree.gov or http://smokefree.gov/

Smoking Prevention

- Ban advertisements for smoking targeting minority youth from minority neighborhoods
- Target young Hispanics at highest risk for smoking cessation activities in schools

Limited English Proficiency

- **Encourage interventions to reduce barriers to health associated with limited English proficiency**
  - Use of interpreters
  - Use of promotores de salud
  - Promoting a pipeline Hospital staff reflect the racial/ethnic cultural diversity of the community it serves
  - Health education materials in English and Spanish
  - Labeling of medication dosing instructions in English and Spanish in both over-the-counter and prescribed medications

Improving representation of Hispanic/Latinos and other key variables in Public Health Databases

- **Hispanic/Latinos should always be reported as a category**
- **Report Hispanic subgroup where possible based on**
  - U.S.-born vs. Foreign-born
  - Specific place of birth
  - Self reported Hispanic ethnicity especially for U.S.-born Hispanics
- **Report primary language spoken, limited English proficiency**

Teach newly insured how to maximize health benefits

- Dispel myths about using health insurance (differs from auto insurance)
- Teach newly insured how to use their insurance
- Understand the importance of going to the doctor both when one is ill and for the purposes of prevention
- www.cuidadodesalud.gov/es/
  https://www.healthcare.gov/
- https://marketplace.cms.gov/technical-assistance-resources/c2c.html

Conclusion

- Social determinants of health, including Hispanic origin and nativity, and infectious disease etiologies are important considerations in decreasing leading causes of death in Hispanics.

- Need for a feasible and systematic data collection strategy to reflect the health diversity in major Hispanic origin subpopulations, including by nativity.

Conclusion

- Need for culturally and linguistically appropriate health care and preventive services for Hispanics (e.g., bilingual health materials, use of bilingual health workers)
- Need for increased outreach to decrease the proportion of uninsured Hispanics and to educate insured Hispanics how to best utilize their insurance.
- Need for patient-centered medical homes to ensure use of key services among Hispanics (e.g., recommended screenings).

CONTACT INFORMATION:

CAPT Kenneth L. Dominguez, MD, MPH

Division of HIV/AIDS Prevention,

National Center for HIV, Viral Hepatitis, STD, TB Prevention,

CDC

Email: kld0@cdc.gov

For more information, please contact CDC's Office for State, Tribal, Local and Territorial Support

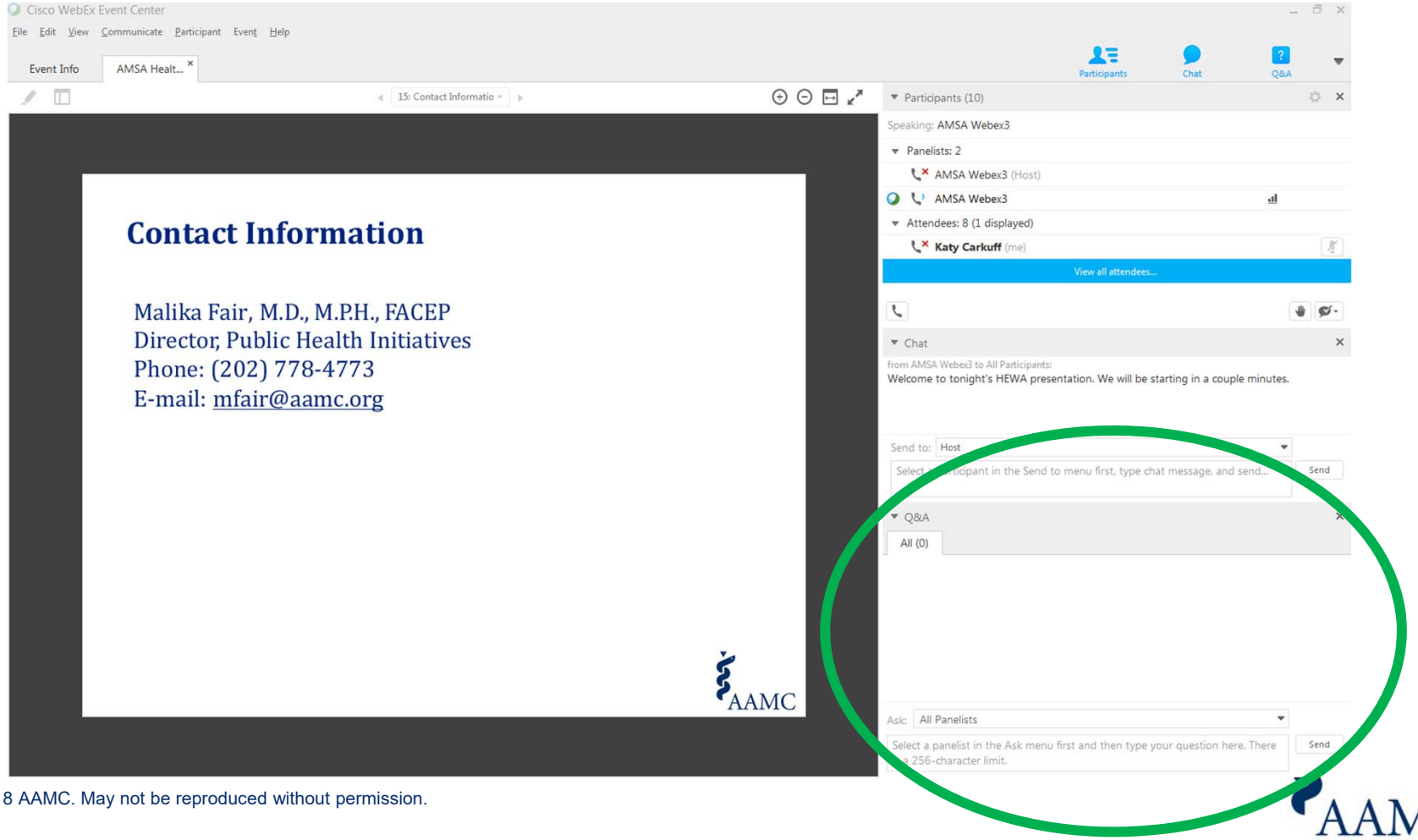
4770 Buford Highway NE, Mailstop E-70, Atlanta, GA 30341

Telephone: 1-800-CDC-INFO (232-4636)/TTY: 1-888-232-6348

E-mail: OSTLTSfeedback@cdc.gov Web: http://www.cdc.gov/stltpublichealth

Questions?

Type your questions in the ‘Q&A’ box at the bottom right of your screen and send to “All Panelists”



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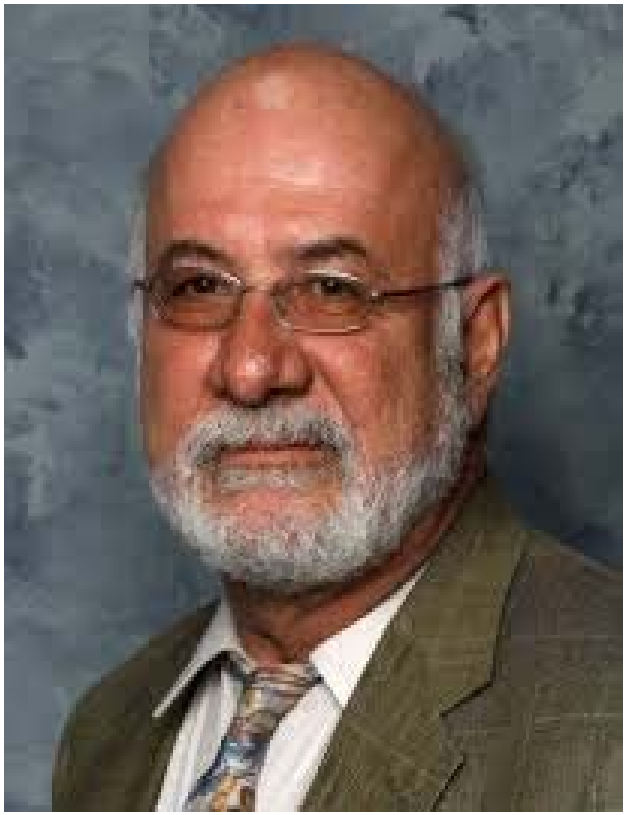
Kyriakos Markides, PhD



- Annie & John Gnitzinger Distinguished Professor of Aging Studies
- Editor of Journal of Aging and Health
- Department of Preventive Medicine and Community Health
- University of Texas Medical Branch

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Hispanic Health Concerns in the US: Lessons learned from the Hispanic EPESE

Kyriakos S. Markides, Ph.D.
University of Texas Medical Branch
Galveston, Texas, USA
contact: kmarkide@utmb.edu

utmb Health

Presented at the 2018 HSHPS WEBINAR-The state of Hispanic Health and implications for the future, April 24, 2018

AN EPIDEMIOLOGIC PARADOX

- Hispanics (except Cuban Americans) are socioeconomically disadvantaged, but have favorable overall mortality

Markides and Coreil (1986)

Risk factor profiles

- High rates of DIABETES
- High rates of OBESITY
- Similar rates of hypertension, cholesterol
- High SMOKING rates among men, lower among women (fewer cigarettes). Cuban American males smoke the most
- High ALCOHOL (binge) drinking rates among men, low among women. Alcohol consumption in women increases with acculturation
- Low rates of physical ACTIVITY
- Strong families
- Migration selection

AGING, MIGRATION AND MORTALITY: CURRENT STATUS OF RESEARCH ON THE HISPANIC MORTALITY PARADOX

- Data based on Vital Statistics show the greatest mortality advantage compared to Non-Hispanic Whites for all Hispanics combined. The advantage is greatest among older people.

- National Community Surveys linked to the National Death Index show a narrowing of the advantage and one study suggests that the Mexican origin mortality advantage (Palloni & Arias, 2004) can be attributed to selective return migration of less healthy immigrants to Mexico.

- The Medicare – NUDIMENT data show a much lower advantage of Hispanic elders than the Vital Statistics Method.

Markides & Eschbach, J. Gerontology:
Social Sciences (2005)

CONCLUSION (Markides & Eschbach, 2005)

- The majority of the evidence continued to support a mortality advantage at a minimum for Mexican Americans. Greatest advantage is in old age.
- Self-reports of health status in old age do not support an advantage.
- Suggested that older Mexican Americans live longer with more disability.
- Greatest challenge was Palloni & Arias' (2004) suggestion of a "salmon bias".

RECENT EVIDENCE OF A SALMON BIAS

- Turra & Elo (2008) used the Medicare-NUDIMENT data to examine the existence of a salmon bias.
- Data supported a salmon bias: foreign-born social security beneficiaries living abroad had higher mortality rates than foreign-born beneficiaries living in the U.S. Too small to explain mortality advantage.
- Effect of salmon bias on death rates is partially offset by the high mortality of Hispanic emigrants returning to the U.S.

A DIFFERENT TEST OF THE SAMON BIAS

- Hummer and colleagues examined infant mortality rates among Hispanics by nativity and in comparison to non-Hispanic whites.
- They found that first hour, first day and first week mortality rates among infants born in the U.S.A. to Mexican immigrant women are about 10% lower than those of infants of the U.S. born non-Hispanic white women.
- It is unlikely that such favorable rates are the result of out-migration of Mexican origin women and infants.

EVIDENCE FROM MHAS (Wong and Colleagues)

- While there is considerable return migration back to Mexico, MHAS data show that the vast majority of return migrants are younger.

- Very few older people return to Mexico because their children live in the U.S.

UNITED STATES LIFE TABLES BY HISPANIC ORIGIN (2006)
E. Arias, NCHS, 2010

Life Expectancy at Birth	Total	Male	Female
Hispanic:	80.6	77.9	83.1
Non-Hispanic White	78.1	75.6	80.4
Non-Hispanic Black	72.9	69.2	76.2

Adjusted for misclassification of race and Hispanic origin on death certificates.
80+ rates for Hispanics based on Non-Hispanic White rates.

OVERALL IMMIGRANT ADVANTAGE (Singh & Hyatt, 2006)

- Immigrant mortality advantage not confined to Hispanics. There appears to be an overall immigrant advantage which may have increased in recent years. Immigrant advantage was evident for cardiovascular diseases, major cancers, diabetes, respiratory diseases, suicide, and unintentional injuries. These trends due to growing heterogeneity of immigrant population, continuing advantages in behavioral characteristics, and migration selectivity.

- Asian/Pacific Islanders had the highest life expectancy followed by Hispanics and non-Hispanic Whites. For each ethnic origin, there was an immigrant advantage except for Asian/Pacific Islanders which likely reflects compositional differences between the native-born and immigrants (Markides & Colleagues, 2007)

OVERALL IMMIGRANT ADVANTAGE continued (Mehta et al, 2016)

- A 2.4 –year advantage in life expectancy at age 65 relative to the U.S. – born.
- Those migrating more recently had lower mortality compared with those who migrated earlier.
- Immigrants born in much of Asia and South America had a 2.5 – year advantage over those born in Northern and Eastern Europe, Canada, and Oceania.
- Asian immigrants enjoy the highest advantage.

IMMIGRANT ENCLAVES

- Osypuk, Diez Roux, Hadley & Kandula (2009) used data from the Multi-Ethnic Study of Atherosclerosis in four U.S. cities (New York, Los Angeles, St Paul and Chicago). They found that high neighborhood immigrant concentration was associated with lower consumption of high fat foods among Hispanics and Chinese but also less walk ability, fewer recreational exercise resources, worse safety, and other negative characteristics.

IMMIGRANT ENCLAVES CONTINUED

- Fenelon (2016) found that Mexican immigrants in new and minor destinations have a significant survival advantage over those in traditional gateways, casting doubt on the protective effects proof enclaves, since non-traditional destinations have less establishes immigrants communities.
- Immigrants to new destinations are more recent – more selected.

TIME TO SPILL THE BEANS? (Young and Hopkins 2014)

- In this review the authors suggested that a diet rich in legumes may explain, in part, the Hispanic Paradox, given the traditionally high consumption of legumes (beans and lentils) by Hispanics. Legumes are high in fiber and have recently been shown to attenuate systematic inflammation significantly, which has been previously linked to susceptibility to COPD and lung cancer in large prospective studies.
- A similar protective effect could be attributed to the consumption of soy products (from soybeans) in Asian populations.
- Confirmation is needed in cohort studies and clinical trials.

AN EPIGENETIC CLOCK ANALYSIS
Horvath et al, 2016

- Examined data on seven racial/ethnic groups and found lower intrinsic epigenetic aging rates in Hispanics (Mexican Americans in Central Valley). Findings were confirmed with a novel saliva test.
- Hispanics of Mexican ancestry recruited from on-going studies in California had lower rates of intrinsic aging in blood than did non-Hispanic Whites.
- Challenging findings of an exploratory nature.

Another Paradox

- Hispanic (Mexican Americans) are a high longevity population who experience high rates of comorbidity and disablilty in middle and older age. (Markides & Gerst, 2011; Hayward et al, 2014).

A LONGITUDINAL STUDY OF THE HEALTH OF MEXICAN AMERICAN ELDERLY (HISPANIC EPESE)

1992-2018 FUNDED BY NIA

UTMB, GALVESTON, TX

PI, *Kyriakos S. Markides,Ph.D.*

CO-INVESTIGATORS:

- *Soham Al Snih, MD., PhD*
- *Karl Eschbach, Ph.D.*
- *Nai-Wei Chen, Ph.D. – Biostatistician.*
- *M. Kristen Peek, Ph.D.*
- *Mukaila Raji, MD..*
- *Laura A. Ray, M.P.A. -Project Director 1992-2011*
- *Nai-Wei Chen, PhD Project Director, 2013-*

NIA STAFF:

- *Georgeanne Patmios*

FIELD STAFF:

- *Nielsen*

OUTSIDE CONSULTANTS:

- *Carlos Mendes de Leon, Ph.D.*
- *Robert Wallace, MD.*
- *Maria Aranda, Ph.D.*
- *Richard Schulz, Ph.D.*

Investigators - continued

UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER, SAN ANTONIO, TX

CO-INVESTIGATORS:

- *PI Ray Palmer, Ph.D., Biostatistician*
- *Co-Investigator, Donald Royall, MD*

UNIVERSITY OF TEXAS, AUSTIN, TX

- **PI,** *Ronald J. Angel, Ph.D.*

CO-INVESTIGATOR:

- *Jacqueline Angel, Ph.D.*

Hispanic EPESE Summary: Baseline, Wave 2 to Wave 9

	Total	Proxy+	Proxy-reported Deceased	Refused	Not Located	Age
1. 1993-4	3050	177				65+
2. 1995-6	2439	143	241	109	261	67+
3. 1998-9	1981	145	432	122	274	70+
4. 2000-1	1682	101	290	133	272	72+
5. 2004-5	1167	93	504	139	277	75+
Added Sample						
2004-5	902	49	-	-	-	75+
2004-5 Combined 2069						75+
6. 2007-8	1542	159	418	157	368	78+
7. 2010-1	1078	182	374		368	82+
8. 2012-3	744	58	262	33	69	84+
9. 2016-	480	77	142	47	88	87+
(925 Informants) at Wave 7 Updated 2/27/2012						
(460 Informants) at Wave 9 Updated 11/15/2016						
Cumulative Deceased = 3110 Updated 12/10/2016 (NDI Search and Proxy-reported)						

Table 5: Trends in the health of older Mexican Americans aged 75 +

	Men		Women	
Health Conditions	1993-4	2004-5	1993-4	2004-5
ADL Disability (≥ 1)	93 **(20.2)**	237 **(29.7)**	176 **(26.8)**	524 **(41.2)**
Diabetes mellitus	100 **(21.3)**	248 **(31.3)**	142 **(21.5)**	442 **(34.8)**
Hypertension	233 **(49.8)**	435 **(61.7)**	399 **(60.5)**	780 **(69.6)**
Stroke	45 **(9.6)**	118 **(14.9)**	66 **(10.0)**	164 **(12.9)**
Obesity (BMI ≥ 30)	72 **(18.0)**	148 **(22.8)**	153 **(26.7)**	313 **(31.5)**
Cognitive impairment (MMSE < 21)	96 **(23.2)**	310 **(41.3)**	157 **(26.0)**	477 **(40.3)**
Total N	469	797	662	1272

Odds Ratios from Logistic Regression of Predictors of Surviving to Age 85 Hispanic EPSESE (1993/1994-2010/2011)		
	Survived to Age 85	
Demographics		
Education	0.98	(0.95-1.02)
Female	1.42**	(1.15-1.75)
Born outside U.S.	1.23*	(1.00-1.51)
Health Status		
No Diabetes	1.97***	(1.58-2.46)
No Hypertension	1.25*	(1.00-1.54)
No Heart Attack	1.29	(0.95-1.74)
No Stroke	1.01	(0.71-1.44)
No Cancer	1.35	(0.90-2.00)
No Depression	1.26*	(0.99-1.79)
Underweight	0.71**	(0.57-0.89)
Overweight	0.96	(0.71-1.30)
Obese	0.72	(0.49-1.05)
Health Behavior		
Currently smokes	0.54***	(0.39-0.75)
N=1696		

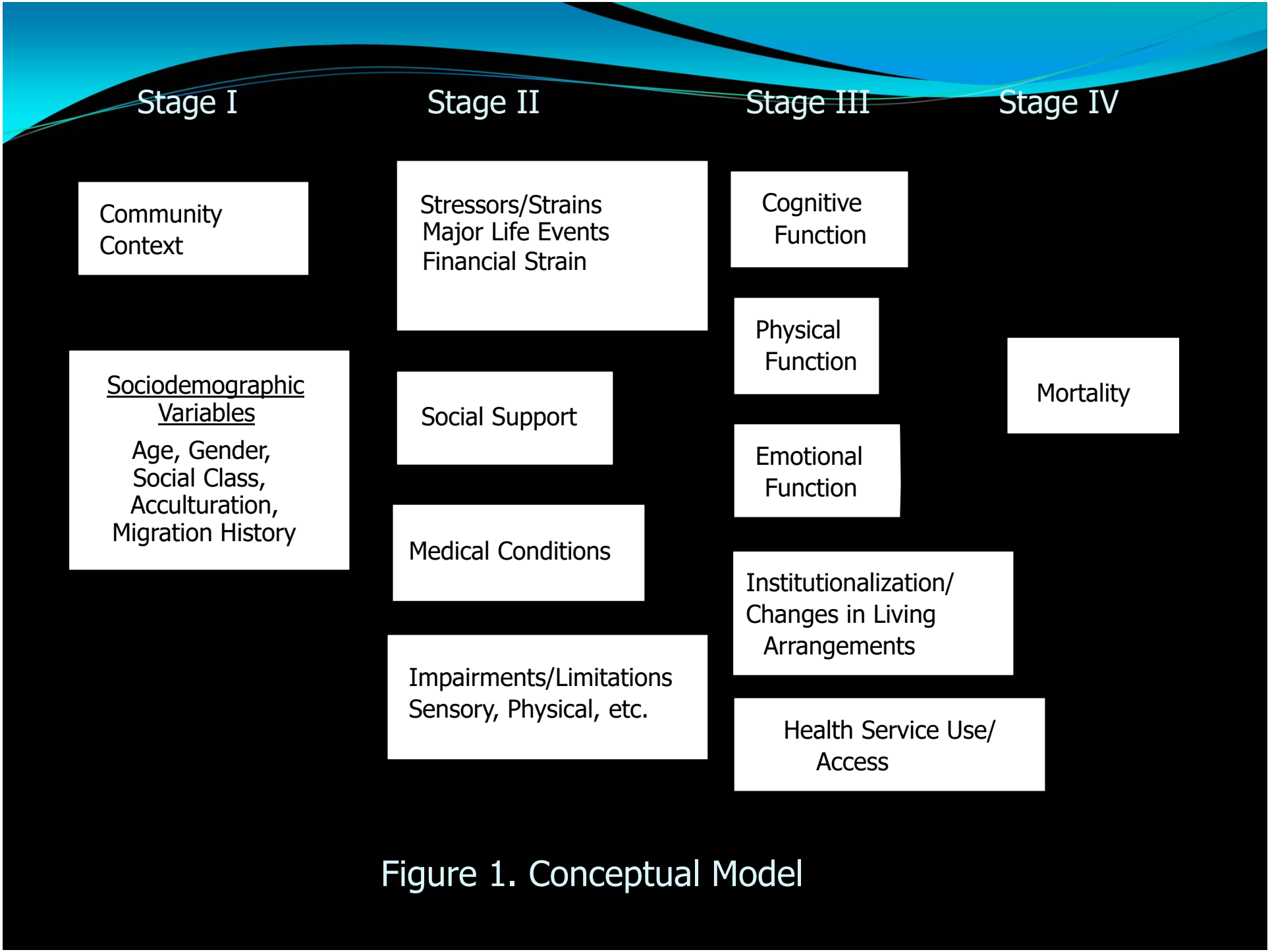
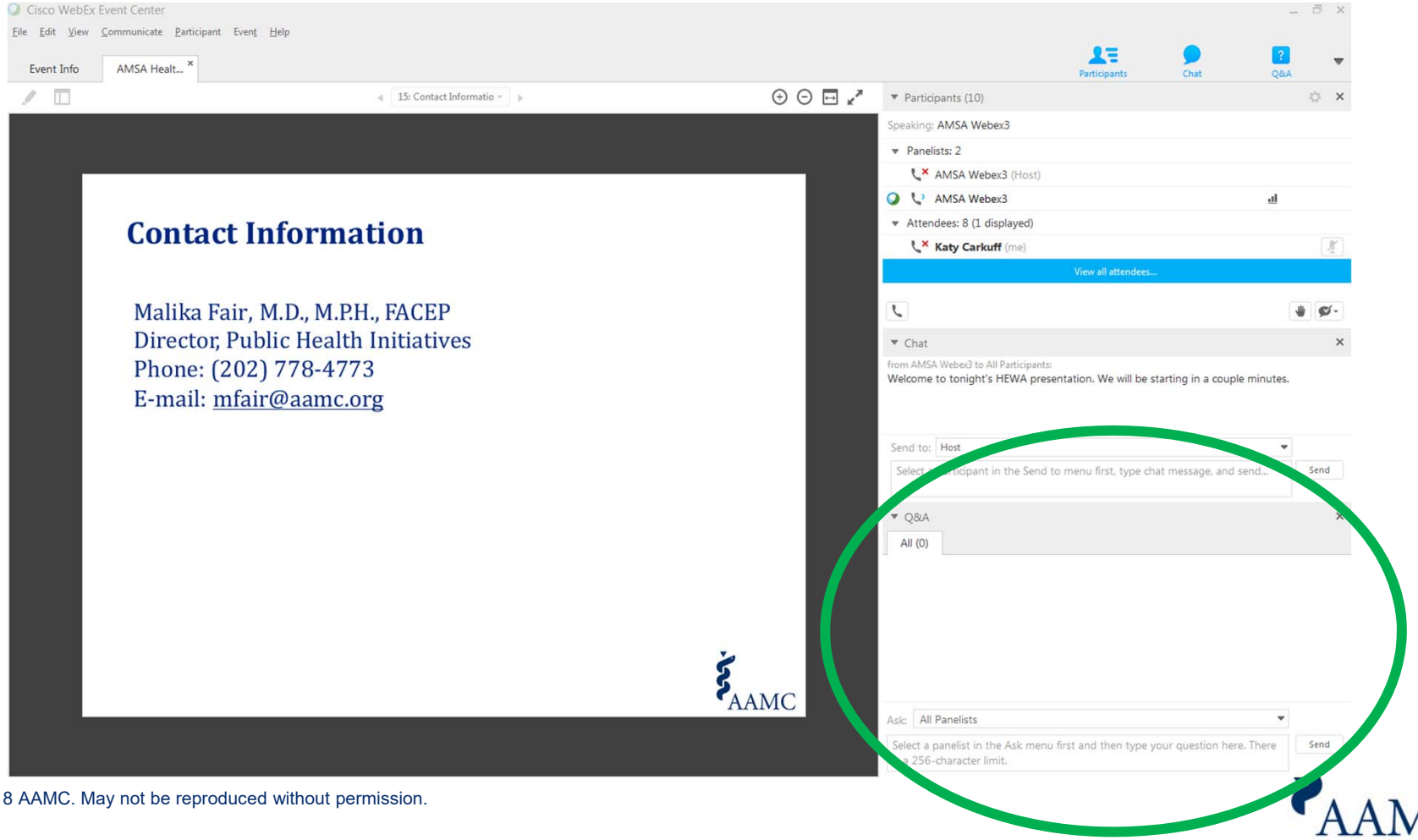


Figure 1. Conceptual Model

Questions?

Type your questions in the ‘Q&A’ box at the bottom right of your screen and send to “All Panelists”



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David Acosta, MD, FAAFP

- Chief Diversity and Inclusion Officer, Association of American Medical Colleges
- Physician of Family Medicine
- Former Senior Associate Dean for Equity, Diversity, and Inclusion at University of California, Davis School of Medicine
- Former Associate Vice Chancellor for Diversity and Inclusion and Chief Diversity Officer for UC Davis Health System

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Promising Practices to Improve Latino Health: How Academic Medicine Is Holding Itself Accountable

Learn
Serve
Lead

David A. Acosta, M.D., FAAFP
Chief Diversity & Inclusion Officer

Association of
American Medical Colleges

Agenda

- Discuss the accreditation standards in both UME & GME that keep academic health centers focused
- Explore innovative programs in medical education & research that advance knowledge, skills, attitude/behavior, and advocacy in Latino health
- Explore positive exemplars in community engagement
- Discuss new initiatives on the horizon

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LCME Accreditation Standards – Element 7.6 Cultural Competence & Health Care Disparities

- "…medical school **ensures** that the medical **curriculum** provides opportunities for medical students to learn to recognize and appropriately address gender and **cultural biases** in themselves, in others, and in the health care delivery process. The medical curriculum **includes instruction** regarding the following:
  - Perceptions of health & illness in **diverse cultures**
  - Principles of **culturally competent** health care
  - Recognition & development of solutions for **disparities**
  - Meeting health care needs of **medically underserved**
  - Development of **core professional attributes** in providing effective care to diverse society"

LCME, 2018-19 accessed on 4/20/2018 at http://lcme.org/publications/

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LCME Accreditation Standards
Element 6.6 Service Learning

- **Element 6.6 Service-Learning** – The faculty of a medical school ensure that the medical education program **provides sufficient opportunities** for, encourages, and supports medical student participation in service-learning and **community service** activities.

LCME, 2018-19 accessed on 4/20/2018 at http://lcme.org/publications/

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ACGME CLER Pathway Requirements

- **Health Quality Pathway 5**: Resident/fellow and faculty member **education on reducing health care disparities**
  - Receive education on identifying & reducing health care disparities *relevant to the patient population served*…
  - Receive cultural competency training….
  - Know the clinic site's priorities for addressing local health care disparities
- **Health Quality Pathway 6**: Resident/fellow engagement in clinical site **initiatives** to address health care disparities
  - Engaged in **QI activities** addressing health care disparities for vulnerable populations served…

CLER, National Report of Findings 2016, Issue Brief #4, Health Care Disparities accessed on 4/20/2018 at http://www.acgme.org/Portals/0/PDFs/CLER/CLER_Health_Care_Disparities_Issue_Brief.pdf

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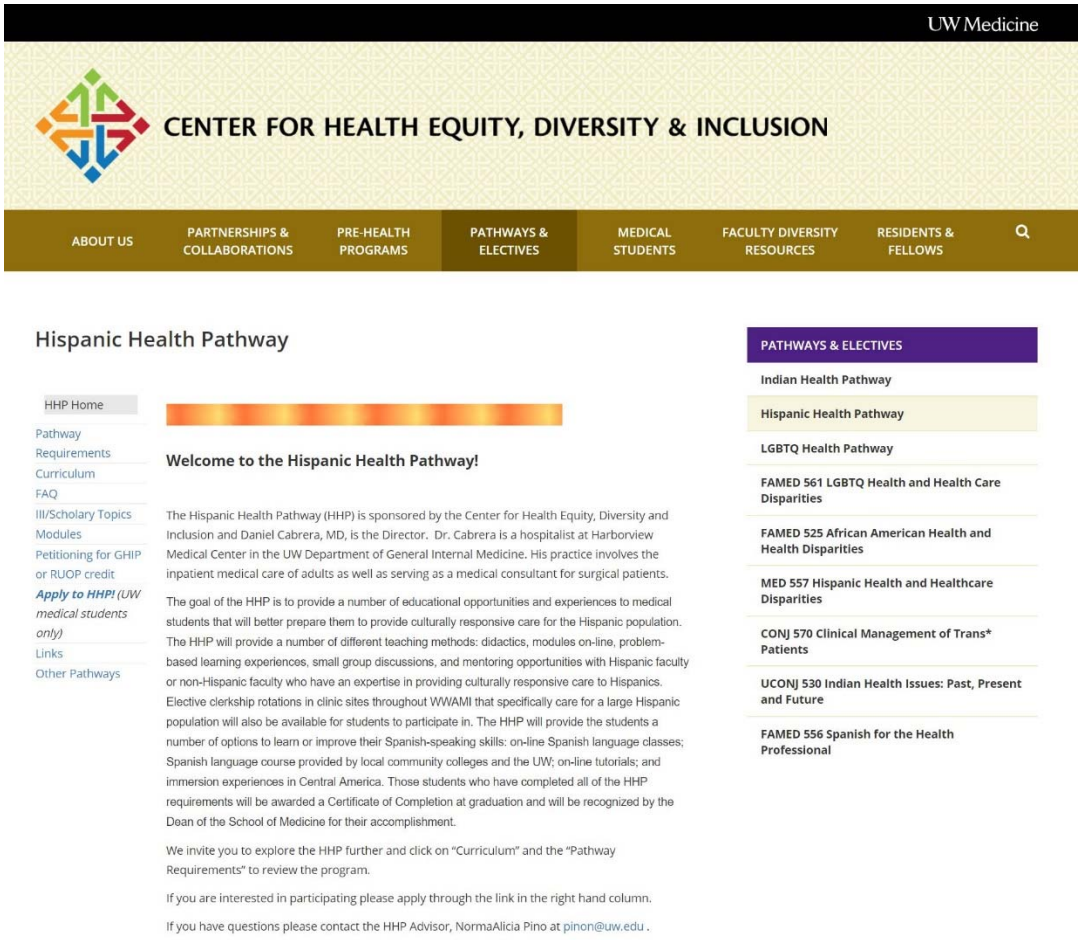
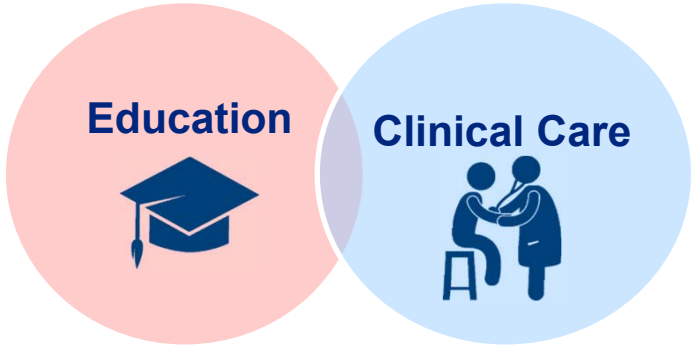
Medical Education





University of Washington School of Medicine: Hispanic Health Pathway

- **4-year certificate program**
- **Required & elective clerkship rotations → caring for large Hispanic population**
- **Scholarly project on Hispanic health topic**

Source: http://cedi-web01.s.uw.edu/pathways-electives/hispanic-health-pathway/

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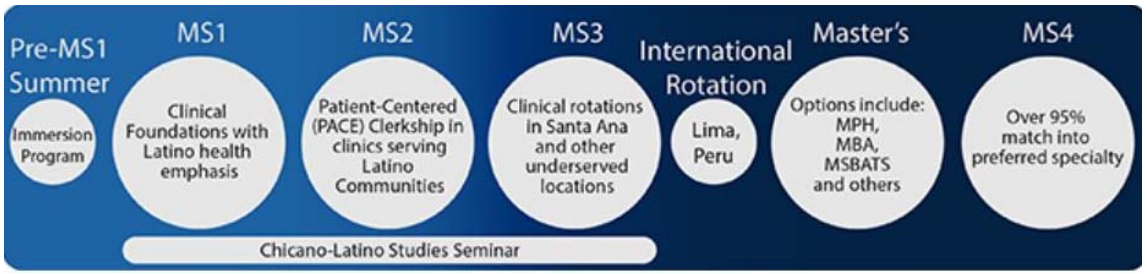
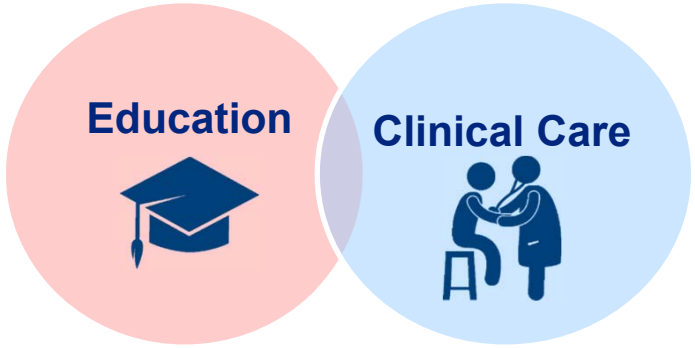
Medical Education





University of California, Irvine – PRIME-LC

- **5-year MD/Master's program**
- **Chicano-Latino Studies Course**
- **International clinical rotation in Peru**

Sources: https://www.meded.uci.edu/curricular-affairs/prime-lc.asp; https://journals.lww.com/academicmedicine/fulltext/2007/12000/Addressing_Health_Care_Needs_of_the_Latino.7.aspx

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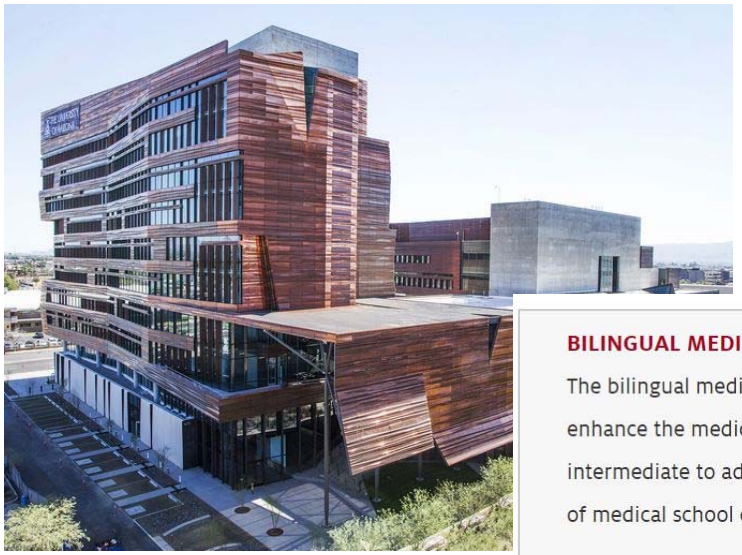
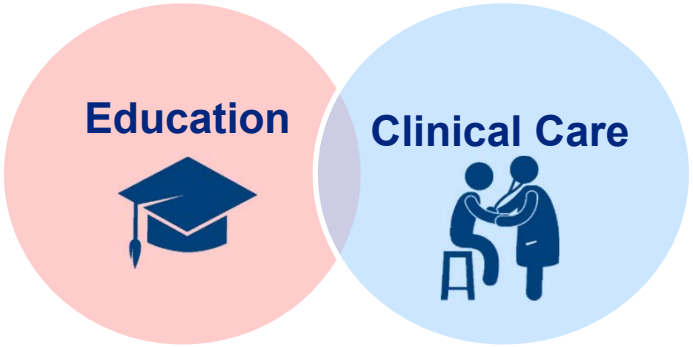
Medical Education





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Diversity & Inclusion

BILINGUAL MEDICAL SPANISH DISTINCTION TRACK

The bilingual medical Spanish distinction track is a longitudinal program designed to enhance the medical Spanish communication skills of medical students entering with intermediate to advanced proficiency level. Instructional activities throughout the four-years of medical school emphasize the development of:

- Oral/Aural Proficiency in Medical Spanish
- Cultural Competence
- Core Medical Competencies

The main goal of the program is to graduate cohorts of physicians who are competent to work as bilingual Spanish-English healthcare providers. Students enrolled in this track will be better prepared to serve the healthcare needs of Limited English Proficiency, Spanish-speaking patients.

https://www.medicine.arizona.edu/education/md-program/distinction-tracks

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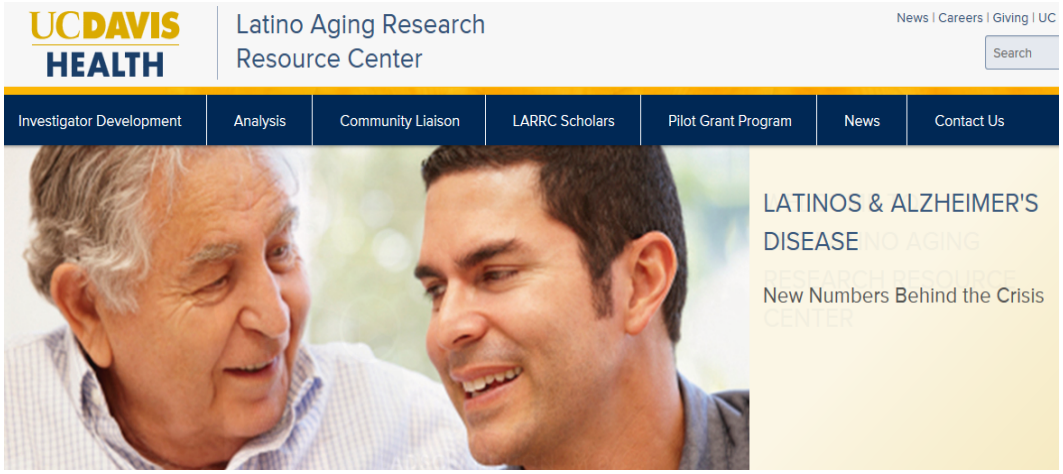
Research Centers Working on Hispanic Health & Health Care Disparities



Source: https://www.ucdmc.ucdavis.edu/latinoaging/

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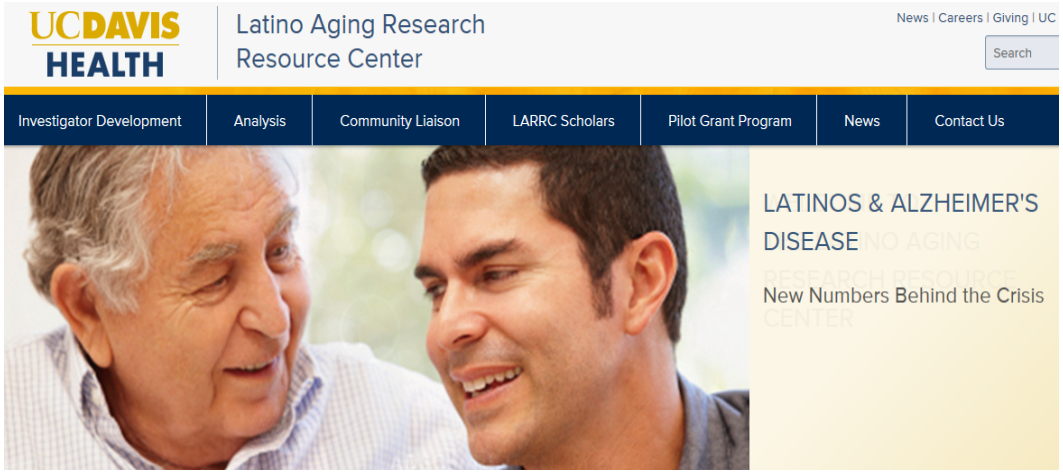
Research Centers Working on Hispanic Health & Health Care Disparities



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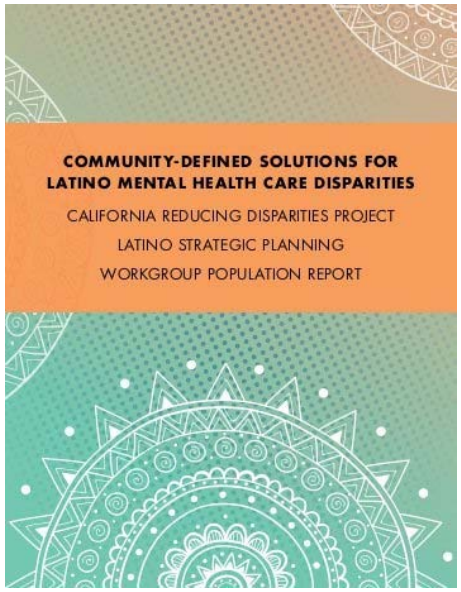

Source: http://www.ucdmc.ucdavis.edu/crhd/research.html

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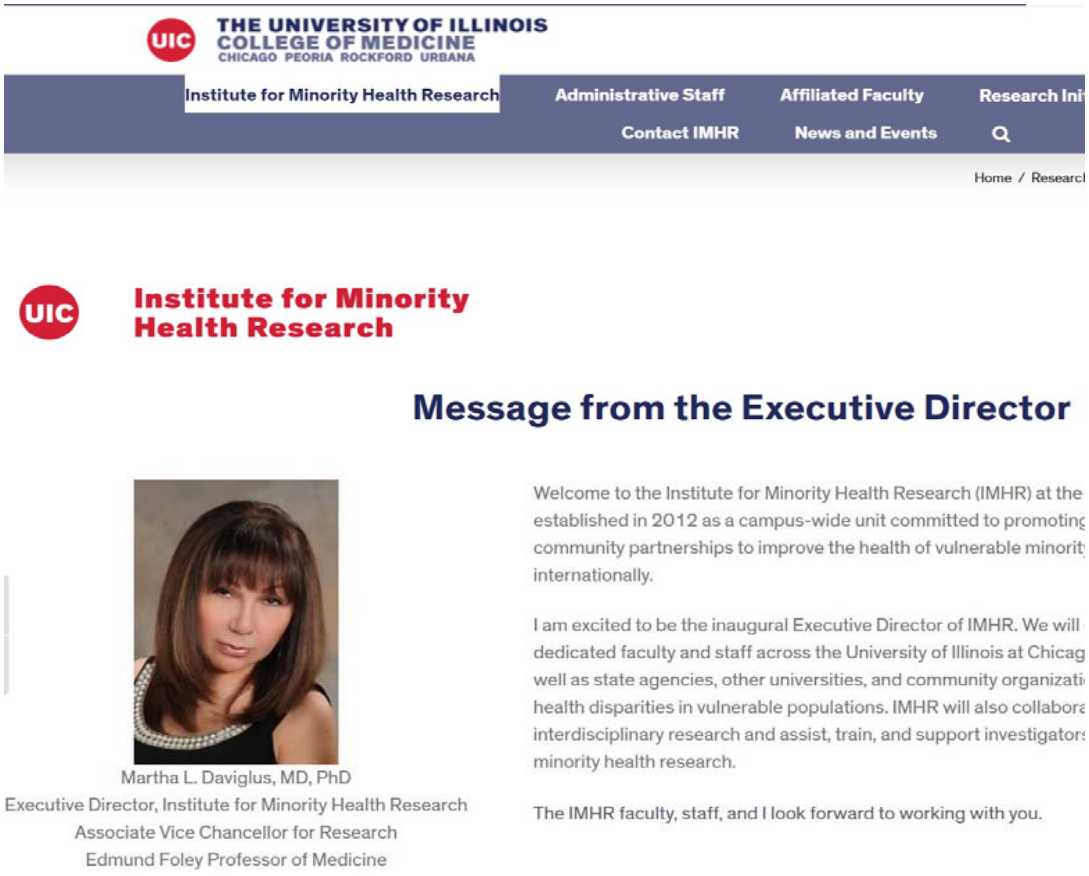
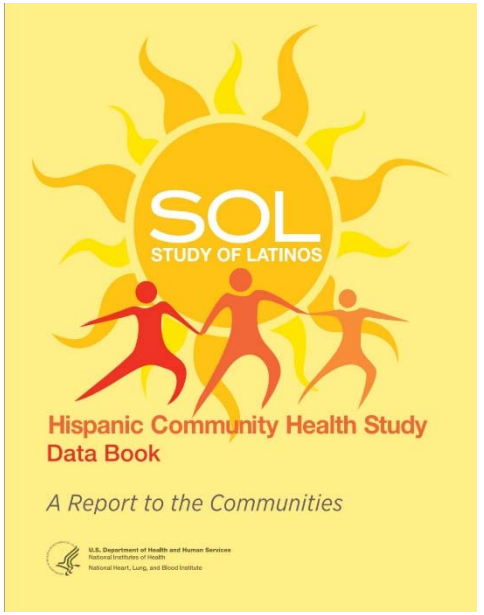
Research Centers Working on Hispanic Health & Health Care Disparities





https://chicago.medicine.uic.edu/research/research-in-chicago/institute-for-minority-health-research/

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Community Engagement

UC Davis Health
Mini-Medical School in Spanish

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Medical Spanish Curriculum Initiative

- AAMC/CDC Webinar: “Teaching Medical Spanish to Improve Population Health”

https://www.aamc.org/initiatives/diversity/portfolios/485628/medicalspanishwebinar.html

Speakers:

David Acosta, MD
Chief Diversity and Inclusion Officer
Association of American Medical Colleges
Email: dacosta@aamc.org

Norma A. Pérez, MD, DrPH
Director, School of Medicine Special Programs
Executive Director, Hispanic Center of Excellence
Author, Clinical Conversational Spanish for English and Spanish Healthcare Professionals©
Office of Student Affairs and Admissions
University of Texas Medical Branch
Email: noaperez@utmb.edu

Brenda Robles, BA
Coordinator, Language Interpreters Program
National Institutes of Health
Email: roblesb@cc.nih.gov

Yumi Turmelle, MD
Associate Professor of Pediatrics
Advanced Medical Spanish course faculty advisor
Washington University in St. Louis School of Medicine
Email: turmelley@wustl.edu

Moderator:

Pilar Ortega, MD
Clinical Assistant Professor
University of Illinois Chicago – College of Medicine
Attending Physician, Advocate Illinois Masonic Medical Center
Author, Spanish and the Medical Interview
Email: POrtega1@uic.edu

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Medical Spanish Curriculum Initiative

- Faculty working group
  - Lead: Pilar Ortega, M.D., University of Illinois, Chicago SOM
  - Collaboration: NHMA, AAMC
- Recent summit of content experts convened at pre-conference at recent NHMA conference

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Medical Spanish Curriculum Initiative

- Faculty working group
  - Lead: Pilar Ortega, M.D., University of Illinois, Chicago SOM
  - Collaboration: NHMA, AAMC
- Recent summit of content experts convened at pre-conference at recent NHMA conference
- Purpose:
  - Address the need for medical Spanish in medical school curriculum;
  - Establish competencies & milestones
  - Standardize content & teaching;
  - Pre-course language proficiency testing;
  - Certified training for medical educators;
  - Certification (evaluation) for students/residents

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Promising Practices to Improve Latino Health

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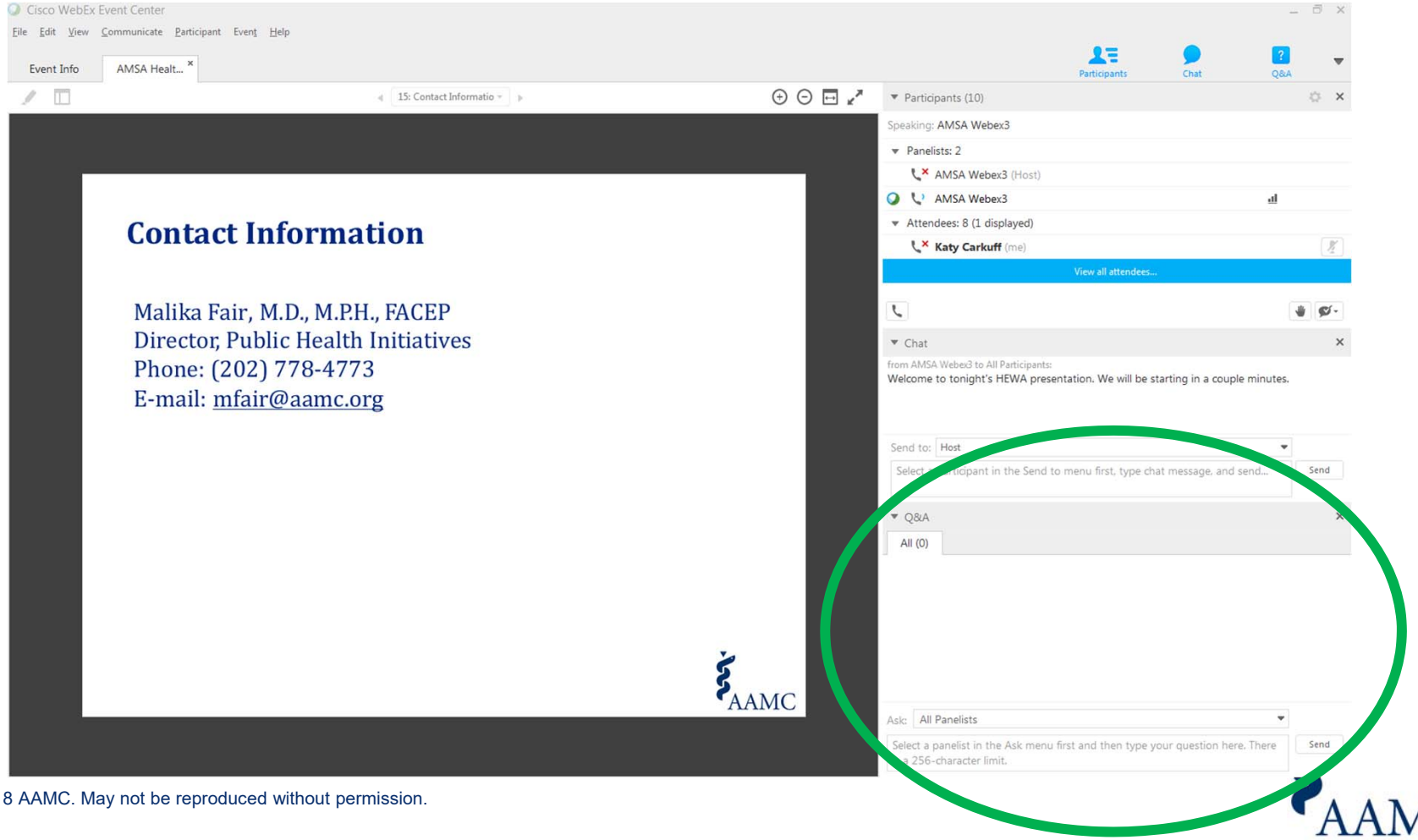
Questions?

Type your questions in the ‘Q&A’ box at the bottom right of your screen and send to “All Panelists”



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Next webinar coming soon...

Promising Practices to Improve Hispanic Health

Collaborative interprofessional forum to discuss advancement of Hispanic health

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- ✓ Medical/Graduate Students
- ✓ Residents/Postdocs
- ✓ Early Career Physicians & Scientists

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aamc.org/phpathways

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Addressing the needs of junior faculty and post docs who aspire to leadership positions in academic medicine.

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The Camby Hotel
Phoenix, Arizona

Registration Open June 2018!

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Diversity & Inclusion Culture and Climate Toolkit

THE CALIFORNIA Wellness FOUNDATION

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- Funded by the California Wellness Foundation
- Collaboration with APLU/USU
- Toolkit will be piloted with 8 California medical schools and universities in 2016-2017 and 2017-2018

Self-Assesment Rubric

Rubric with 113 questions

Dashboard

Dashboard to show your progress

Scorecard

Understand your results

Campus Action Plan

Develop and track your campus action plan

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Urban Universities for HEALTH

OUR VISION:

Enhance and expand a culturally sensitive, diverse, and prepared health workforce that improves health and reduces health disparities in urban communities

"Learning Collaborative" structure

Partnership of USU/APLU, AAMC, & NIH

Improve evidence, measure progress, & share knowledge

AAMC

Metrics Toolkit

- **Metrics Generator:** an interactive web tool for selecting strategies, indicators, and measures aligned with key health workforce goals
- **Evidence base:** supports each workforce strategy
- **Case studies:** highlight best practices using the strategies and data in the toolkit from the five demonstration sites
- **Sample institutional dashboards:** demonstrate how data might be displayed
- **Other supporting materials:** indicators one-pager, complete list of metrics, & glossary

AAMC

Tomorrow's Doctors, Tomorrow's Cures

Learn

Serve

Lead

Association of
American Medical Colleges