



# WISCONSIN CHRONICLES ON BLACK HEALTH DISPARITIES

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## Childhood Obesity, A Gateway to Lifelong Health Disparities

Our children, the adults of tomorrow, are on course for a life of suffering unnecessary health problems as a result of high rates of children who are obese or overweight. Poor eating habits and the lack of physical activity are leading to a generation of children that are the heaviest than any other generation. This is especially true for African American children who later in life then struggle disproportionately from diabetes, high blood pressure, cardiovascular problems and other health concerns as a result of obesity.

Currently, there are approximately 25 million children who are obese or overweight. Clearly, what was once considered cut baby fat has progressed to deadly proportions. Undoubtedly, the soul food diets eating habits in our community also influence the onset of unhealthy weight levels.

One of the leading consequences to this national epidemic is diabetes. Specifically, Type 2 diabetes is a disease of special concern to children. This form of the disease more commonly was referred to as "adult onset" diabetes because typically only

adults would be diagnosed with it. Since the 1990s, more and more individuals under the age of 20 are being diagnosed with Type 2 diabetes. This sad reality is for the most part attributed to the rise in overweight and obese children along with the decrease physical activity. With children being now diagnosed with a disease that use to be exclusive to adults, this means that they are living longer with the ill effects of the disease. The longevity of the illness can lead to more severe complications such as blindness, kidney failure, and amputations. As a result, the quality of life for these individuals is diminished greatly starting at an early age.

This is a health disparity that we clearly have the power to change. An issue that has nothing to do with being thin and fitting in to white society, but an issue of being healthy. There are significant health risks associated with being too thin as well, thus the goal is keeping a healthy body-mass index - a mathematical calculation used by the government that takes into account your height and weight to determine one's state of health.

Within this publication are recommendations to restore

healthy weight for our children and youth. These recommendations include achievable steps for every sector of our society. Dieting is not the answer. Overall healthy eating and lifestyle habits must be maintained by not just children and youth, but entire families. Our children deserve better lives than past generations, improved quality of life should not just focus on education and financial advancement. It must also include positive health outcomes. The achievement and maintaining of healthy weight levels at an early age can be one valuable weapon in preventing the onset of adult staged racial health disparities.

Unlike adults, children have little control over what they eat. Generally, adults are the ones who buy the food, cook the food and decide where the food is eaten. Thus it is up to us adults to make childhood obesity and overweight unacceptable. It is up to us to make sure this generation and future generations of African American children are saved from this health concern and a gateway to healthy outcomes is achieved instead.

### Definition of Childhood Obesity

Children and youth between the ages of 2 and 18 years who have body mass indexes (BMIs) equal to or greater than the 95th percentile of the age - and gender- specific BMI charts developed by the Centers for Disease Control and Prevention (CDC).

**Newsletter Staff**

**Publisher**

Dr. Patricia McManus, Executive Director - Black Health Coalition of Wisconsin

**Editor**

Clarene Anderson, Consultant

**Review Team**

Jim Addison, Program Coordinator - Black Health Coalition of Wisconsin

Bevan K. Baker, Commissioner of Health - City of Milwaukee Health Department

Georgia Cameron, WI Department of Health and Family Services

Gregory Fanning, Board President -Black Health Coalition of Wisconsin

Rachel Morgan, Program Coordinator - Black Health Coalition of Wisconsin

Dr. Earnestine Willis - Medical College of Wisconsin



## Overweight/Obesity Terminology

**Added Sugars:** Sugars and syrups that are added to foods during processing or preparation. Added sugars do not include naturally occurring sugars such as those that occur in milk and fruits.

**Adequate Intakes (AI):** A recommended average daily nutrient intake level based on observed or experimentally determined approximations or estimates of mean nutrient intake by a group ( or groups) of apparently healthy people. The AI is used when the Estimated Average Requirement cannot be determined.

**Basic Food Groups:** In the USDA food intake patterns, the basic food groups are grains; fruits; vegetables; milk, yogurt, and cheese; and meat, poultry, fish, dried peas and beans, eggs, and nuts.

**Body Mass Index (BMI):** Is a practical measure for approximating total body fat and is a measure of weight in relation to height. It is calculated as weight in kilograms divided by the square of the height in meters.

BMI =	(Weight in pounds)	X 703
	(Height in inches) x (Height in inches)	

**Chronic Diseases:** Such as heart disease, cancer, and diabetes—are the leading causes of death and disability in the United States. These diseases account for 7 of every 10 deaths and affect the quality of life of 90 million Americans. Although chronic diseases are among the most common and costly health problems, they are also among the most preventable. Adopting healthy behaviors such as eating nutritious foods, being physically active, and avoiding tobacco use can prevent or control the devastating effects of these diseases.

**Discretionary Calorie Allowance:** The balance of calories remaining in a person’s energy allowance after accounting for the number of calories needed to meet recommended nutrient intakes through consumption of foods in low-fat or no added sugar forms. The discretionary calorie allowance may be used in selecting forms of foods that are not the most nutrient-dense (e.g., whole milk rather than fat-free milk) or may be additions to foods (e.g., salad dressing, sugar, butter).

**Energy Allowance:** A person’s energy allowance is the calorie intake at which weight maintenance occurs

**Estimated Average Requirements:** EAR is the average daily nutrient intake level estimated to meet the requirement of half the healthy individuals in a particular life stage and gender group.

**Leisure-Time Physical Activity:** Physical activity that is performed during exercise, recreation, or any additional time other than that associated with one’s regular job duties, occupation, or transportation.

**Moderate Physical Activity:** Examples of moderate physical activity include walking briskly, mowing the lawn, dancing, swimming, or bicycling on level terrain. A person should feel some exertion but should be able to carry on a conversation comfortably during the activity.

**Obesity:** An excessively high amount of body fat or adipose tissue in relation to lean body mass.

**Overweight:** Increased body weight in relation to height, which is then compared to a standard of acceptable weight.

**Recommended Dietary Allowance (RDA):** The dietary intake level that is sufficient to meet the nutrient requirement of nearly all (97 to 98 percent) healthy individuals in a particular life stage and gender group.

**Sedentary Behaviors:** In scientific literature, sedentary is often defined in terms of little or no physical activity during leisure time. A sedentary lifestyle is a lifestyle characterized by little or no physical activity.

**Tolerable Upper Intake Level (UL):** The highest average daily nutrient intake level likely to pose no risk of adverse health effects for nearly all individuals in a particular life stage and gender group. As intake increase above the UL, the potential risk of adverse health effects increases.

**Vigorous Physical Activity:** Examples include jogging, mowing the lawn with a non-motorized push mower, chopping wood, participating in high-impact aerobic dancing, swimming continuous laps, or bicycling uphill. Vigorous-intensity physical activity may be intense enough to represent a substantial challenge to an individual and results in a significant increase in heart and breathing rate.

Source:

Dietary Guidelines for Americans 2005, U.S. Department of Health and Human Services U.S. Department of Agriculture

## Publisher's Corner

Patricia McManus, PhD., RN  
 Publisher - President/CEO, Black Health Coalition of Wisconsin

What can be more important to a family, a community, or a society than it's children. Children represent our future and, therefore, everything and/or anything of importance. For African Americans, the ability to protect our children has always been a cause for concern. We were not allowed, for decades, to determine the course our children's lives would take. We knew that education was the key success. When we were told we would not be allowed to read, we learned everyway. Somehow we have lost the passion to learn, but we must get it back. The lives of our children is now in our hands. How we feed our children, how we watch what they eat, even how we eat before they are born will make a difference in their life course. We must learn so that they will learn. We use to eat food that was needed for labor intensive jobs which most of us worked. That is not the case anymore. Our children are obese or becoming obese. They do not have the ability to exercise at school and many of their neighborhoods do not afford the safety for such activities. We have not changed our diets for a variety of reasons, such as we like the taste, they are easier to prepare and save, they are cheaper, we are able to get them more easily than more healthy sources of food, and fast foods are easier to get. This must be the goal of parents, families, communities and society. We must do our part, but we must also demand that our elected officials and others in policy positions begin to address this issue in a comprehensive, family oriented, culturally appropriate manner. Healthy alternatives must be made available at the work site and at schools. Information must be made available at all levels and in at an effective reading level. This is not an option or a debate. This must be done!

### Adverse Outcomes in Childhood Obesity

#### Physical Health

- ◇ Glucose intolerance and insulin resistance
- ◇ Type 2 diabetes
- ◇ Hypertension
- ◇ Dyslipidemia
- ◇ Hepatic steatosis
- ◇ Cholelithiasis
- ◇ Sleep apnea
- ◇ Menstrual abnormalities
- ◇ Impaired balance
- ◇ Orthopedic problems

#### Social Health

- ◇ Stigma
- ◇ Negative stereotyping
- ◇ Discrimination
- ◇ Teasing and bullying
- ◇ Social marginalization

Source: *Childhood Obesity in the United States: Facts and Figures*, Fact Sheet - September 2004, Institute of Medicine of The National Academies

#### Emotional Health

- ◇ Low self-esteem
- ◇ Negative body image
- ◇ Depression

### Psychological & Health Consequences of Obesity in Childhood & Adolescence

A number of studies have documented how obese children typically become obese adults. Research also shows that obesity increases a child's risk for a number of health problems, including type 2 diabetes, increased cholesterol levels, hypertension, and the danger of eating disorders among obese adolescents. Research suggest that individuals diagnosed with diabetes before age 20 have a life span 15 to 27 years shorter than non-diabetic Americans, and that the earlier the onset of diabetes, the higher the incidence of nephropathy, retinopathy, neuropathy, and coronary and peripheral vascular disease. Youth overweight may also lead to orthopedic ailments and premature onset of menstruation.

Some studies show that obesity and overweight in children also negatively impact children's mental health and school performance. Overweight children have been found to engage in other unhealthy behaviors and tend to exhibit loneliness and nervousness.

The studies also emphasize that obesity and overweight in childhood and adolescence are often a path toward increased risk for and further development of a range of obesity-related diseases as children enter adulthood, leading to a lifetime of health problems.

Source: *F as in Fat: How Obesity Policies are Failing in America 2007*, Trust for America's Health

## Recommendations for Preventing Childhood Obesity

### 1. National Priority

Government at all levels should provide coordinated leadership for the prevention of obesity in children and youth. The President should request that the Secretary of HHS convene a high-level task force to ensure coordinated budgets, policies, and program requirements and to establish effective interdepartmental collaboration and priorities for action. Increased levels and sustained commitment of federal and state funds and resources are needed.

### 2. Industry

Industry should make obesity prevention in children and youth a priority by developing and promoting products, opportunities, and information that will encourage healthful eating behaviors and regular physical activity.

### 3. Nutritional Labeling

Nutritional labeling should be clear and useful so that parents and youth can make informed product comparisons and decisions to achieve and maintain energy balance at a health weight.

### 4. Advertising and Marketing

Industry should develop and strictly adhere to marketing and advertising guidelines that

minimize the risk of obesity in children and youth.

### 5. Multimedia and Public Relations Campaign

Health and Human Services should develop and evaluate a long-term national multimedia and public relations campaign focused on obesity prevention in children and youth.

### 6. Community Programs

Local governments, public health agencies, schools, and community organizations should collaboratively develop and promote programs that encourage healthful eating behaviors and regular physical activity, particularly for populations at high risk of childhood obesity. Community coalitions should be formed to facilitate and promote cost-cutting programs and community-wide efforts.

### 7. Built Environment

Local governments, private developers, and community groups should expand opportunities for physical activity, including recreational facilities, park, playgrounds, sidewalks, bike paths, routes for walking or bicycling to school, and safe streets and neighborhoods, especially for populations at high risk of

childhood obesity.

### 8. Health Care

Pediatricians, family physicians, nurses, and other clinicians should engage in the prevention of childhood obesity. Health care professional organizations, insurers, and accrediting groups should support individual and population-based obesity prevention efforts.

### 9. Schools

Schools should provide a consistent environment that is conducive to healthful eating behaviors and regular physical activity.

### 10. Home

Parents should promote healthful eating behaviors and regular physical activity for their children.

Sources: *F as in Fat: How Obesity Policies Are Failing In America 2005*, Trust for America's Health

Childhood Obesity in the United States - September 2004, Institute of Medicine of The National Academies

*"Of all of the forms of injustices, injustices in health care is the most shocking and inhumane.*

-Dr. Martin Luther King Jr.

## Causes of Childhood Obesity

- ◇ Urban and suburban designs that discourage walking and other physical activities;
- ◇ Pressures on families to minimize food costs, acquisition and preparation time, resulting in frequent consumption of convenience foods that are high in calories and fat;
- ◇ Reduced access and affordability in some communities to fruits, vegetables, and other nutritious foods;
- ◇ Decreased opportunities for physical activity as school, after school, and reduced walking or biking to and from school; and
- ◇ Competition for leisure time that was once spent playing outdoors and sedentary screen time including watching television or playing computer and video games.

Source: Childhood Obesity in the United States: Facts and Figures, Fact Sheet \* September 2004, Institute of Medicine of The National Academies

## Child & Youth Obesity/Overweight Disparities

	Children (ages 6 to 11) Prevalence (%)		Adolescents (Ages 12 to 19) Prevalence (%)	
Race	Overweight	Obesity	Overweight	Obesity
Black	35.9	19.5	40.4	23.6
White	26.2	11.8	26.5	12.7

Source: *Obesity in Youth Fact Sheet*, American Obesity Association

Overweight Rates of High School Students	
Black students	16.0%
White students	11.8%

Overweight Rates of High School Students			
Black female	16.1%	Black male	15.6%
White female	8.2%	White male	15.2%

Prevalence of Overweight Rates for Females, (Ages 6 to 19)		
1999-2002, Girls Ages 6 to 11	White(%)	Black (%)
	13.1	22.8
1999-2002, Girls Ages 12 to 19	12.7	23.6

Sources: Sources: *F as in Fat: How Obesity Policies Are Failing In America* 2006 & 2007, Trust for America's Health

## Lack of Sleep Contributes to Childhood Obesity

Finding from a new research study provides interesting insight on the link between poor sleeping habits and childhood obesity. The results were listed in the November 2007 issue of the *Journal of Pediatrics* and the study was conducted by researchers at the University of Michigan. The research involved the analyzing of data on 785 children who lived in ten U.S. cities. The data included comprehensive information on sleep, height and weight for the children in the third grade and sixth grade.

Getting kids to bed early may not just be a opportunity for parents to get a quiet house, but more importantly can lead to children becoming healthier. Specifically, the study asserts that children who get more sleep may lower their risk of becoming obese. Considering the many negative consequences that obesity has on a child's life, this could be a simple tool to lessen the toll of this national epidemic.

The researchers focused there efforts on comparing the sleeping habits and obesity levels of third-graders and then looking at them again in the sixth grade. They found that with every additional hour of sleep per night that a third-grader got, the child's chances for becoming obese in the sixth grade was diminished by 40 percent. On the other hand, the less sleep the child got each night raised their risk for becoming obese by the sixth grade. The recommended ideal amount of nightly sleep is nine hours and forty-five minutes. In addition to increase the sleep time of children, parents are also encouraged to decrease the amount of caffeine consumption and the viewing of television.

The biological explanation for the results can be attributed to two hormones, ghrelin and leptin. In looking at sleep-deprived adults, Eve Van Cauter, an endocrinologist at the University of Chicago, has noted the production processes of these two hormones. Adults who got less sleep produced more ghreline and less leptin. This finding is relevant to the gaining of weight as ghreline promotes hunger and leptin signals fullness, thus a sleep-deprived adult is more likely to eat more without having the bodies normal signal for fullness being triggered.

Another possible explanation for the link between lack of sleep and childhood obesity can simply be attributed to the youth being less likely to exercise and more likely to be sedentary and eat more because they are tired from their sleep-less nights.

Source: *Lack of Sleep May Lead to Fatter Kids*, Washington Post/Associated Press, November 5, 2007

## Need for More Participation by Blacks in Clinical Trials Addressed

The 2007 Minority Women's Health Summit focused their discussion on the need for more participation by Blacks in medical research programs. Blacks experience racial health disparities in almost all leading health indicators, thus the need for more research on possible contributing factors and cures. Yet this can not feasibly occur when low numbers of Blacks are willing to participate in the clinical trials. The lingering legacy of the Tuskegee syphilis experiment as well as other medical studies that have done more harm than good to the well-being of Blacks continue to make the population untrusting of medical research. This is especially true for research that the government is involved in. Past research showed an insensitivity to Blacks by treating them like guinea pigs and showing a biased to whites.

Institutions who seek to involve Blacks in medical research must seek to understand and respect the community as well as involve them in all aspects of the research. There is great importance on the need to establish long-term relationships as opposed to seeking to temporarily entering a community with goals that may be in opposition to them. This is even more so of a reality in a time where funds are being made available to target the reduction of health disparities. Yet many institutions that are obtaining these funds are groups that are not based in the communities that are impacted by the disparities or have longstanding preexisting relationships. Past cases and the fear of exploitation puts up an unbreakable brick wall to researchers.

Another factor to the low participation levels of Blacks in clinical trails is the lack of awareness. There is a lack of consistent and clear dissemination of clinical trials opportunities within the Black community. As a result, when Blacks are facing life-threatening illness, they are often not aware of treatment options that are available through clinical trails and the possibility of free medications as a result of their participation. Additionally, few medical research projects offer accommodations that would make it easier for Blacks to participate. Assistance for transportation, child or elder care, and respect of cultural norms could allow for greater participation.

According to the National Institute of Health, there are currently 2,379 clinical trials being conducted in Wisconsin. The categories for clinical trials include; treatment trials, prevention trials, diagnostic trials, screening trials, and quality of life trials. Patients in clinical

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## Lower Life Expectancy for Black Men is Researched

In America, Black men have been dying quicker than most other groups since the days of slavery. Many factors can be seen as contributors to this disparity, but new research has noted the toll of racism on Black men to have a physical impact that leads to lower life expectancy rates. These findings were the result of research conducted at the University of California Los Angeles Center on Research, Education, Training and Strategic Communication on Minority Health Disparities.

Although America is years past the legal practice of the enslavement of Blacks, the lingering affects is still experienced in the daily lives of Blacks as a result of racism. This is especially true for Black males. These experiences is said to create a chain of biological events referred to as the stress response. When a Black male experiences racism, he has a response to it, and the response then brings about a physiological reaction. Although the response is supposed to be a protective one, it puts one at increased risk for cardiovascular disease, diabetes and infectious diseases due to the bodies release of cortisol, the stress hormone. This process is seen to be, in part, why Black men are disproportionately represented in poor health indicators. In addition to experiencing lower life expectancy rates, they also are at higher risks for just about every health concern. This theory has also been validated by the Rand Center for Population Health and Health Disparities.

Currently, the life expectancy rate for Black men is 6.2 years less than that of white men and 8.3 less than the national average. According to the Centers for Disease Control and Prevention, the largest black-white mortality gap for males is seen in cardiovascular disease. Sadly, the heart disease death rate is 30% higher for black males. They also suffer from diabetes 70% more so than white males.

The negative health impact of racism on Black men was also published in the 2007 Annual Review of Psychology in which the research noted the process that occurs in the brain when one experiences racism. The individual's, most often Black males, brain goes through the fight or flight response. This response, like the stress response, is the bodies natural protective reaction to danger. When the body experiences this on a too frequent basis, it causes more negative consequences that can include heart disease, diabetes, obesity and infection. As a result of the continued experiences of racism, the Black male is constantly in the defensive mode mentally. His body is then not able to function properly and the resulting chemical imbalances become contributors to the shorter life expectancy.

These theories have been further documented by Dr. Bruce McEwen, one of the foremost researchers on the health effects of stress, in his book, "The End of Stress as We Know It". Within the text, Dr. McEwen states, "Stress hormones acting on the hippocampus can engrave important experience into long-term memory, but excessive or chronically elevated levels of these same hormones can damage the very part of the brain that shuts them off."

The area of research making the connection between racism and poor health outcomes for Blacks is relatively new, but a growing body of work is helping to give more credentiaing to these theories. Racism may not be the total cause to the lower life expectancy of Black males, but more evidence is pointing to it being a major cause. A cause that has spanned many generations and may not be as easily to address as the other causes, like poor diets and lack of exercise.

Source: *Racism's toll may be physical*, Los Angeles Times September 24, 2007

## More Black Organ Donors Needed

Minorities make up about 51% of those who are in need of an organ donation, this accounts for some 49,000 minorities who are in need of a lifeline. Yet there are not enough minorities who are registered on the national donor register. This is a discouraging disparity since minorities only make up 20% of the total U.S.

population and 23% of the registered donors. This is even more so of a problem for Blacks; they make up 27% of those on the national waiting list and 35% of those who need kidney transplants.

Many Blacks would be willing to donate and may even have intentions to, but the willingness and good intentions do not count without being listed on the national

donor registry. With the disproportionate number of Blacks who suffer from diabetes and may be in need of a kidney transplant the need for a viable organ donation often becomes a matter of life and death.

Individuals interested on becoming organ donors can log onto [www.donatelife.net/](http://www.donatelife.net/) to learn the steps they would need to take to become a registered donor.

Sources: *National Minority Donor Awareness Day Encourages Organ Donation* press release, The Henry J. Kaiser Family Foundation August 01, 2007

*Minorities Account for 51% of the U.S. Transplant Waiting List*, PRNewswire July 30, 2007

## Clinical Trials (continued from page six)

trials can play a more active role in their own health care, gain access to new research treatment before they are widely available, and help others by contributing to medical research. Those interested in participating in research should ask the following questions before doing so:

- ◇ What is the purpose of the study?
- ◇ Who is going to be in the study?
- ◇ Why do researchers believe the experimental treatment being tested may be effective? Has it been tested before?
- ◇ What kinds of test and experimental treatments are involved?
- ◇ How do the possible risks, side effects, and benefits in the study compare with my current treatment?
- ◇ How might this trial affect my daily life?
- ◇ How long will the trial last?
- ◇ Will hospitalization be required?
- ◇ Who will pay for the experimental treatment?
- ◇ Will I be reimbursed for other expenses?
- ◇ What type of long-term follow up care is part of this study?
- ◇ How will I know that the experimental treatment is working? Will results of the trials be provided to me?
- ◇ Who will be in charge of my care?

More information about clinical trials can be found at [www.ClinicalTrials.gov](http://www.ClinicalTrials.gov).

Sources: *Minority Women's Summit Addresses Health Disparities, Diversity In Research for Cures*, BlackAmericaWeb.com August 2, 2007

## Causes for Racial Bias in Care & Treatment Explored

In recent years there have been numerous reports pointing to unequal medical treatment being given to Black patients compared to white patients. But few, if any, of the reports empirically detailed the root causes for the discrimination. A recent study has now laid the foundation for more research on the causes. Through the use of 287 physicians at four academic medical centers participating in a psychological test for bias, the researchers were able to confirm that diagnosed and treatments offered by these physicians varied between racial groups. The telling aspect of these findings is that the bias is so deeply internalized in the psyche of the physicians that they themselves were unaware of their unfair practices.

This study focused on care for heart disease, but the results should also be considered for treatment biases in infant mortality, cancer and other health indicators that Blacks suffer from disproportionately. In reference to the findings for heart disease, Blacks were less likely to be properly diagnosed and/or receive needed aggressive heart-attack treatment. The study, conducted by researchers at Massachusetts General Hospital and other institutions affiliated with Harvard University, was published in a recent issue of the *Journal of General Internal Medicine*.

The testing tool, the Implicit Association Test, was developed in part by Harvard psychologist Mahzarin Banaji. In reference to the findings, Banaji stated, "The racial bias unearthed by the study is at odds with conventional views of bigotry— and perhaps more insidious. Rather than harboring deliberate ill will, the physicians had apparently internalized racial stereotypes, and these attitudes subtly influenced their medical judgment without them even realizing it."

In addition to completing the testing tool, the physicians were also given a case study of a 50-year-old man, a smoker with a history of hypertension, "who presents to the emergency department with chest pain. He appears to be in a lot of pain describing it as 'sharp,

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## New Tool May Help Black Cancer Patients

The recommending of a new breast cancer tool further validates the need for more race specific disease diagnoses and treatment methods. For the past twenty years, women have been able to obtain understanding of their probability of developing breast cancer through the Breast Cancer Risk Assessment Tool. This tool was primarily developed from studies involving white women and thus has not been an effect tool for Black women. Now new hope in this regard is expected in the Spring when a calculator specific to Black women is expected to be released. This benchmark comes out of research that was published in November issue of the National Cancer Institute. Unlike other research that notes the breast cancer mortality disparities between Black and white women, this report is promising because it not only identifies a problem, but it also looks to address it.

Although white women have incidences of breast cancer, Black women have higher breast cancer mortality rates. This new tool can help to address this disparity by helping to improve screening decisions and risk-reduction strategies. The current tool was developed by Dr. Mitchell Gail, and is often referred to as the Gail model, he was also a lead researcher in the current project.

Another flaw of the Gail model is that it has inadvertently excluded Black women from being involved in breast cancer clinical trails because it did not identify them as high-risk, thus not allowing them to be eligible to participate. This means thousands of Black women would could have benefited from opportunities to discuss options for risk reduction were not able to do so. The new model, called the CARE model, would more accurately identify Black women who are at higher-than-average risk for the disease.

Although the CARE model will not be an appropriate tool for Black women who have had breast cancer in the past or who have certain genetic mutations, it is expected to benefit those with moderate risk.

The current Breast Cancer Risk Assessment can be assessed at [www.cancer.gov/bcisktool](http://www.cancer.gov/bcisktool).

Source: *New cancer calculator will help black women*, Chicago Tribune, November 2007

“It is wrong to be unjust, to be dishonest, to hate. It is wrong now and was wrong 2,000 years ago.”

Dr. Martin Luther King Jr.  
Norfolk Journal and Guide  
March 9, 1957

## Racial Bias in Care & Treatment (continued from page 8)

like being stabbed with a knife. Some physicians were told that the patient was white, while others were told that he was Black. They were asked to determine if the pain was due to coronary artery disease and to prescribe the clot-busting drug thrombolysis. When the patient was identified as being Black, the doctors were more likely to diagnose him as having a heart attack, but the aggressive treatment was not prescribed. Yet, when the patient was believed to be white and diagnosed with having a heart attack, the aggressive treatment was more often prescribed.

Source: *The Color of Health Care: Diagnosing Bias in Doctors*, Washington Post, August 13, 2007

## Medical Homes Can Reduce Health Disparities

A report by the Commonwealth Fund asserts that individuals who have medical homes are more likely to receive consistent and quality care, despite their race. One is said to have a medical home when they have regular care providers that offer consistent, efficient and culturally sensitive medical care and advice. Another characteristic of a medical home include patients not having difficulty contacting a provider by phone or getting advice or medical care on weekends and evenings.

The report speaks to the need for improved quality standards by healthcare providers. "Understanding what is quality health care is very, very important," stated. Dr. Garth N. Graham, deputy assistant secretary of the U.S. Department of Health and Human Services' Office of Minority Health. He further noted, "We're talking about true American issues... We have made some progress, but not enough where any of us can be proud in terms of where we're going as a country."

Some of the specific results from the report include:

- ◇ Among adults ages 18 to 64, more than one of four African Americans (28%) were uninsured during 2006, compared with 21 percent of whites.
- ◇ African Americans also have differential access to a regular doctor or source of care, with Hispanics particularly at risk. As many as 21 percent of African Americans report they have no regular doctor or source of care, compared with 15 percent of whites.
- ◇ The vast majority (74%) of adults with a medical home always get the care they need, compared with only 52 percent of those with a regular provider that is not a medical home and 38 percent of adults without any regular source of care or provider.
- ◇ When minorities have a medical home, racial and ethnic differences in terms of access to medical care disappear. Three-fourths of whites, African Americans, and Hispanics with medical homes reported getting the care they need when they need it.
- ◇ When minorities have a medical home, their access to preventive care improves substantially. Regardless of race or ethnicity, about two-thirds of all adults who have a medical home receive preventive care reminders.
- ◇ The survey finds that adults who have medical homes are better prepared to manage their chronic conditions.
- ◇ Among hypertensive adults, 42 percent of those with a medical home reported that they regularly check their blood pressure and that it was controlled.
- ◇ Adults with a medical home reported better coordination between their regular providers and specialists.

Findings from the 2006 Commonwealth Fund Healthcare Quality Survey was the basis for the medical home report. The survey involved phone calls to more than 2,800 adults.

Sources: *Closing the Divide: How Medical Homes Promote Equity in Health Care: Results From The Commonwealth Fund 2006 Health Care Quality Survey*, Commonwealth Fund, June 27, 2007

*Home base for services boosts quality of health care*, Orlando Sentinel, June 28, 2007

## Asthma Education Materials in Wisconsin are Misleading for Minorities

Despite Black children in Wisconsin suffering disproportionately from asthma prevalence and hospitalization rates, a recently published report has identified take-home educational materials that are culturally misleading. The brochures were reportedly designed to meet the needs of Wisconsin's minority children, but in reality the only culturally relevant information in the

publications may just be in the artwork on the covers.

These findings were published in the autumn issue of the journal *Ethnicity & Disease*. The research was conducted by Dr. Jane Brotanek when she worked for the Medical College of Wisconsin. She currently is an assistant professor of pediatrics at the University of Texas Southwestern Medical Center.

Once one gets past the deceptive artwork, the educational information is no different than what is used for the general population.

"It's definitely concerning, because the African-American population in Wisconsin is growing, particularly in Milwaukee. It's now a minority-majority city," Brotanek stated.

Although there are other factors, like access to and quality of care,

that influence the asthma disparities, it is clear that educational materials that are truly culturally specific could help parents become more proactive in their care of children and increase prevention efforts.

Source: *Asthma Education Brochures Aimed at Minorities Miss the Mark in Wisconsin*, News Release, Center for the Advancement, November 15, 2007

## New Gene Discovery for Black Prostate Victims

Researchers at the University of Chicago have identified a gene variant that can be a missing link as to why black males are twice as likely to develop prostate cancer in comparison to white men. The findings are not conclusive, but could be the foundation to continued research on this theory.

Specifically, a variant on the 8q24 gene confers a particularly significant risk to black men. The report, featured in the October 31st issue of *Genome Research*, compared genotypes of 490 Black men with prostate cancer in 567 controls. "The gene is not exclusive to African-Americans," stated Rick Kittles, a lead researcher of the study and associate professor of medicine at the University of Chicago. "This variant may be in higher frequency in African-Americans, but it's not exclusive to African-Americans."

According to data from the American Cancer Society, prostate cancer is the second leading cause of cancer death among men. In 2007, an estimated 27,000 men in the United States will die from the disease. Prostate cancer is the single most diagnosed non-skin cancer among African Americans; 30,870 were estimated to be diagnosed this year. Prostate cancer is also the second-leading cause of death for African American men; with an estimated 4,240 deaths in 2007. This sad mortality disparity may

be linked to African American men being more likely to have aggressive forms of the disease. The disparity gap for Black men is just not confined to the United States, but is worldwide.

The state of Wisconsin was one of five states that received failing grades on the second annual Prostate Cancer Report by the National Prostate Cancer Coalition. Wisconsin also received a failing report for the second year in a row. The grades are based on measures including prostate death and screening rates, support for prostate cancer related legislation, and patient accessibility to urologists and clinical trial sites.

Sources: *Gene Variant Doubles Risk of Prostate Cancer in Black Men*, HealthDay News, November 2, 2007

*Prostate Cancer and African American Men* fact sheet, National Prostate Cancer Coalition

*2007 Prostate Cancer Report Card: Wisconsin*, National Prostate Cancer Coalition

## \*Positive Black Health Disparities News\*

Researchers have not yet identified the cause, but a new report announced that Blacks who are diagnosed with Alzheimer's live about 15 percent longer than whites with the same diagnoses. These findings are rare reporting of a positive health disparity for Blacks. This finding was validated even after factors such as age, gender and living environment were taken into account.

The study was conducted by researchers at the University of California, San Francisco and were published in the November 14th online issue of *Neurology*.

This is a matter of relevance for the Black community as the report estimates that by 2050 there will be more than three million non-white individuals with Alzheimer's. Overall, it is the 7th leading cause of death in the United States. Within the study, the death rate was 41 percent for the white patients compared to only 30 percent for the Black ones.

The results did not give a full picture of the mortality difference between the races due to the study population being made up of patients from Alzheimer's Disease Centers (ADCs) These Centers are standardized Alzheimer's care facilities funded by the U.S. National Institute on Aging. Most Alzheimer's sufferers receive care from non-government-funded medical centers.

Source: *Blacks, Hispanics Live Longer With Alzheimer's*, HealthDay, November 14, 2007

## Link Between Poor Blacks and Kidney Transplants Identified

A report released at the annual meeting of the American Society of Nephrology identified a link between Blacks in poor areas and their low representation on kidney transplant lists. This finding had nothing to do with Blacks living farther away from transplant centers.

The research involved looking at data over a span of four years from end-stage kidney disease patients in Georgia and the Carolinas. A total of 12,600 patients participated in the study, with 62% being Black. During the study period, 17 percent were placed on the kidney transplant waiting list. Blacks were 56% less likely to be placed on the transplant waiting list in comparison to the white patients. Additionally, the Black patients were more likely than whites to live in areas where more than 25 percent of the population lived below the poverty line.

"Racial disparities persist in the U.S. transplantation process," stated Dr. Sandra Amaral of Emory University and the co-author of the study. "The reasons for this are poorly understood, but multiple factors are likely involved. To our knowledge, this is the first study to examine the impact of community poverty on racial disparity in transplant waiting-list."

Source: *Blacks in Poor Areas Less Likely to Be on Kidney Transplant Lists*, HealthDay News, November 10, 2007



## WISCONSIN CHRONICLES ON BLACK HEALTH DISPARITIES

**Black Health Coalition of Wisconsin**  
 3020 W. Vliet Street  
 Milwaukee, Wisconsin 53208

Phone: 414-933-0064  
 Fax: 414-933-0084  
 E-mail: BHCPMc@aol.com

“Black people have always been in America’s wilderness in search of a promised land.”  
 -Dr. Cornel West, [Race Matters](#)

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 WWW.BHCW.ORG**

### **The Obesity Epidemic & Wisconsin Students**

The 2005 Youth Risk Behavior Survey indicates that among Wisconsin high school students:

**Overweight:**

- ◇ 10% are overweight.
- ◇ 14% are at risk for becoming overweight.

**Physical Inactivity**

- ◇ 65% did not meet currently recommended levels of physical activity.
- ◇ 8% had not participated in any vigorous or moderate physical activity during the past 7 days.
- ◇ 24% did not attend physical education classes.
- ◇ 40% did not attend physical education classes daily.

Source: Department of Health and Human Services, Centers for Disease Control and Prevention

### **Steps to Help Prevent and Decrease Overweight and Obesity**

Location	Recommendation
Home	Reduce time spent watching television and in other sedentary behaviors Build physical activity into regular routines
Schools	Ensure that the school breakfast and lunch programs meet nutrition standards Provide food options that are low in fat, calories, and added sugars Provide all children, from prekindergarten through grade 12, with quality daily physical education
Community	Promote healthier choices including at least 5 servings of fruits and vegetables a day, and reasonable portion sizes Encourage the food industry to provide reasonable food and beverage portion sizes Encourage food outlets to increase the availability of low-calorie, nutritious food items Create opportunities for physical activity in communities

Source: Division of Nutrition, Physical Activity and Obesity, National Center for Chronic Disease Prevention and Health Promotion