Attachment—Additional Questions for the Record

Subcommittee on Health
Hearing on
"Health Care Inequality: Confronting Racial and Ethnic Disparities in COVID-19 and the Health Care System"
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The Honorable Frank Pallone, Jr. (D-NJ):

1. Dr. Brooks, what specific actions do you recommend Congress, the scientific community, and industry take to help close the gaps in research diversity, both in terms of the make-up of research participants as well as the pool of investigators carrying out research?

The following is an excerpt from a document that was developed by a consortium of physicians:

"Sponsor applicants (for clinical trials) shall submit in all requests for clearance for the conduct of clinical trials evaluation of a new drug or biologic entity, a comprehensive outreach plan for enrollment of minority patients required to reach stated inclusion goals. Progress, or lack thereof, on racial and ethnic American minority inclusion in ongoing clinical trials shall be reported to FDA and published, minimally on a semi-annual basis with plans for any necessary corrections to achieve stated goals.

Sponsor applicants' outreach plan to achieve minority population subgroup inclusion of patients shall comprise strategies to engage clinical trial investigators and other medical practitioners/providers who can reasonably be anticipated to be directly involved in the medical care of the identified subgroup of patients."

The Honorable Eliot L. Engel (D-NY):

For clinical trial results to apply in the real world, the demographic mix of patient volunteers should mirror that of the population with the disease. Unfortunately, there are wide disparities in the representation of different groups in clinical trials, with racial/ethnic populations, low-income, elderly, and those in rural geographic locations underrepresented in

research across many diseases. In cancer, there is a 4-fold disparity in proportion of Blacks diagnosed with cancer in the U.S. as compared to the proportion participating in clinical trials submitted to U.S. Food and Drug Administration (FDA) for drug approval. Twenty percent of Alzheimer's patients in the U.S. are African American, but only 3%-10% are trial participants. COVID-19 is a disease with roughly two-fold higher rates in diagnosis and mortality between Blacks and Whites, stressing the need for diverse research participation in order to fully understand the disease.

In many cases, patients are willing to participate in clinical trials; however, numerous obstacles outside of a patient's control often restrict individual's ability to do so. These barriers include a lack of available trials that are local, restrictive eligibility criteria, transportation to trial sites, taking time off from work, and potentially increased medical and nonmedical costs.

1. Given the current pandemic and progress towards a vaccine for the coronavirus, what legislative steps should Congress implement to eliminate barriers and increase diversity in vaccine trials as well as diversity in trials for various disease states such as cancer, heart disease, Alzheimer, diabetes, etc.?

   At the moment the Department of HHS is convening focus groups and key opinion leaders to solicit actions that will increase diversity and general numbers in the current vaccine trials. Congress can support funding that supports efforts such as these, along with more novel ideas such as funding to HBCUs and community based organizations to canvas neighborhoods and broad communities to obtain more diverse involvement in all clinical trials. Lastly there should be specific legislation that mandates specific diversity, which will motivate the researchers/investigators/companies to increase diversity in clinical trials.

The Honorable Lisa Blunt Rochester (D-DE):

1. How can cultural competency help address barriers in accessing mental health services and do you have any recommendations for how we can further use cultural competency as a pillar to advance health equity?

   The first step to have cultural competency help address barriers in accessing mental health services will be to have cultural competency (CC) mandated as a routine curriculum in medical school and residency training. As simple as this seems, it will put on the table health inequity/equity. Related to mental health, with CC training along with trauma-informed care will engender a better understanding of the underlying cultural strains a patient experiences. There can then be more targeted questioning/interviewing which can uncover previously unknown mental health

conditions that would/may normally not be found. With this, the patient can be referred for specific mental health services.

2. There are a disproportionate number of underlying health conditions that makes COVID-19 more fatal among Black and Hispanic communities. Lung disease is a leading co-morbidity among COVID-19 patients, and smokers are more likely to have severe COVID-19 symptoms than non-smokers. There are huge disparities in our nation regarding who smokes. For example, Medicaid beneficiaries smoke at twice the rate of those on private health insurance, despite being just as likely to want to quit. That's why I introduced legislation that would expand tobacco cessation coverage to all Medicaid beneficiaries during this critical time. What role does tobacco use play in COVID-19 related complications and in health disparities more generally? How important is it to assist smokers who want to quit?

   Tobacco users are much more likely to have cardiovascular (CV) disease, and CV disease is a major risk factor for an adverse outcome from COVID-19. Smoking also is the primary cause of COPD, which is another major risk factor for an adverse outcome. The direct link is unclear as evidenced from the quote from a study published July 31, 2020 in *Nicotine & Tobacco Research: "*(Our**) study provides evidence supporting the utilization of smoking cessation programs, especially in younger populations**, as part of a strategy to minimize the adverse consequences of COVID-19 pandemic," Karanasos and colleagues wrote. "Although smoking increased the risk of severe disease in hospitalized COVID-19 patients, it is not clear whether this hazard derives from nicotine itself or from other toxic components of tobacco smoke; therefore, a positive or neutral impact of nicotine alone on disease severity cannot be excluded based on the current study". *So the bottom line is that support for smoking cessation programs is indicated.*

3. Increasing workforce diversity is critical to achieving health equity. Why do you think it is critical that Congress enact legislation that aims to increase workforce diversity, like H.R. 3637, the Allied Health Workforce Diversity Act?

   Studies show that when AAs are treated by AA doctors they have better outcomes. Also studies show that AA physician trainees are more likely to go into primary care which in the US is under-represented (everyone wants to be a specialist to make more money to pay off high student debt!) and more likely to practice in a community needing more MDs.

The Honorable Jan Schakowsky (D-IL):

A New York Times report published on May 21, 2020 revealed that in my home state of Illinois, nursing homes in which Black and Latinx residents comprise at least 25 percent of the

resident population are three times more likely to have COVID-19 cases than nursing homes in which Black and Latinx residents represent fewer than 5 percent of the population. Nursing home industry officials have waved off this disparity by saying it reflects the racial inequities we have unfortunately seen in COVID-19 cases and fatalities across the United States.[1]

1. Do you agree with the assertion of the nursing home industry?

   No I do not agree. While I have no studies, the issue may also be substandard care provided, poorer infection control, and lack of access to proper PPE, all unrelated to medical underlying conditions, just added onto them.

2. Are there more specific issues around quality of care and Federal support for nursing homes caring for primarily Black and Latinx residents that may fuel this disparity?

   There is at present from the current administration lax oversight and less potential penalties for not complying to routine standards, just as staffing, care documentation, and infection control, as examples. Therefore, the nursing homes may be emboldened to provide substandard care, and this is more likely to occur in all nursing homes but more so in those utilized by Black and Latinx residents, as they are more likely to be in a nursing home at the lower end of quality, related to Medicaid funding.

The Honorable Greg Walden (R-OR):

1. We are seeing that COVID-19-related health disparities for racial and ethnic communities are not entirely unique to the United States. Alarmingly, the death rates from COVID-19 appear to be higher for people of color worldwide:

   - On May 7, 2020, the Office for National Statistics in the U.K. found that COVID-19-related deaths for ethnic groups in England and Wales exceeded those of white ethnicity. [2] [3] Black males and females were reported to be 4.2 and 4.3 times, respectively, more likely to die from a COVID-19-related death than their white

[1] *The Striking Racial Divide in How Covid-19 Has Hit Nursing Homes*, The New York Times (May 21, 2020) (www.nytimes.com/article/coronavirus-nursing-homes-racial-disparity.html).

[2] *Coronavirus: Risk of death is higher for ethnic minorities*, BBC (June 2, 2020), (www.bbc.com/news/health-52889106).

[3] United Kingdom Office for National Statistics, *Coronavirus (COVID-19) related deaths by ethnic group, England and Wales: 2 March 2020 to 10 April 2020, Coronavirus (COVID-19) related deaths by ethnic group, England and Wales Articles* (Apr. 7, 2020) (www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/coronavirusrelateddeathsbyethnicgroupenglandandwales/2march2020to10april2020).

counterparts. This also proved similar for people of Bangladeshi and Pakistani, Indian, and mixed ethnicities.[4]

- The Canadian Government does not release data on race and socioeconomic status, but a study from University of Western Ontario reported that like the U.S., COVID-19 has disproportionately affected black and immigrant communities in Canada.[5]

- Norway's public health experts looked into the backgrounds of those infected by COVID-19 and found that people born in Somalia had infection rates more than ten times above the national average.[6]

- Official statistics on COVID-19 deaths in France do not include a breakdown by race and ethnicity—or even by country of origin or nationality.[7] However, there have been abnormally high death rates in low-income neighborhoods such as Seine Saint-Denis.[8] According to five mayors and the head of the Seine Saint-Denis department, the network of urban doctors in Seine Saint-Denis is much smaller than in other places, and the population is more vulnerable due to pathologies that expose them to chronic diseases such as diabetes, hypertension and cardiovascular disease.[9]

A. What do you think are the causes of these global disparities?

Global disparities are directly related to poverty, and racism. Any condition that requires care from an entity that is of a different ethnicity/race than the one seeking the care with demonstrate poorer outcomes. The racism that is endemic in a global community that for centuries allowed enslaving individuals related to race, and that allows the poor to receive poorer care will find the outcomes noted. Also those population eluded to are more likely to work in occupations that do not allow for sick pay or working from home, hence more likely to be exposed to the virus.

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[4] *Id*.

[5] Kate Choi, et. al., *Studying the social determinants of COVID-19 in a data vacuum*, Department of Sociology, University of Western Ontario (May 10, 2020) (osf.io/preprints/socarxiv/yq8vu/).

[6] *Nations look into why coronavirus hits ethnic minorities so hard*, Financial Times (Apr. 29, 2020) (www.ft.com/content/5fd6ab18-be4a-48de-b887-8478a391dd72).

[7] *France's data collection rules obscure the racial disparities of Covid-19*, QUARTZ (June 5, 2020) (qz.com/1864274/france-doesnt-track-how-race-affects-covid-19-outcomes/).

[8] *France is blaming the poor for their own deaths. But look at how it treats them.*, The Washington Post (Apr. 30, 2020) (www.washingtonpost.com/opinions/2020/04/30/france-is-blaming-poor-their-own-deaths-look-how-it-treats-them/).

[9] *Id*.

B. Are the underlying causes of the disparities outlined above similar to what we are seeing in the U.S.?

Yes, just as stated above.

C. In your opinion, why haven't the health systems of the countries highlighted above been able to reduce these disparities?

The issues that are leading to the disparities referenced are entrenched in the global society. It will take specific acknowledgement of the issues surrounding race and poverty before there can be effective actions taken. Universal health care coverage is a start (and is present in these referenced countries, in general) but the effect of implicit racial bias needs to be directly addressed.

The Honorable Gus M. Bilirakis (R-FL):

1. Dr. Brooks – COVID-19 has interrupted routine and non-emergent care visits. Recently ProPublica highlighted the amputation epidemic in the African American community driven by Peripheral Artery Disease (or PAD), a circulatory deficiency that leads to blockages in the blood vessels that supply the lower extremities. The amputation rate among African American Medicare beneficiaries is nearly three times higher than the rate among other beneficiaries. Hispanics and Native Americans are also disproportionately impacted by higher amputation rates.

   A. Would patient education and preventative screenings for at-risk populations represent a patient-centric and more cost-effective approach to care?

   Patient education and preventative screenings for at-risk populations is already a standard of care. Many health centers have Patient Care Medical Home (PCMH) designation, a designation received from NCQA that states that the approach to care is patient-centric. (My health center, the Watts Healthcare Corporation, in south Los Angeles has attained this recognition.). Amputations are due to diabetes, uncontrolled. There are a multitude of reasons for this situation, however I agree that intense (**culturally sensitive**) patient education and a focus on diabetes prevention would reduce the ultimate complications of diabetes; amputation. There is a CDC program, the Diabetes Prevention Recognition Program (CDC-DPRP) that is active in this area. (My health center, the Watts Healthcare Corporation, in south Los Angeles has conditionally attained this recognition.)

2. Dr. Brooks – Clinical trials sometimes provide patients with the best—perhaps only—treatment option for their condition. However, without coverage of routine costs associated with participation in clinical trials, many Medicaid beneficiaries do not have

access to these potentially life-saving treatment options. Medicaid serves many demographics, including ethnic minorities, that are underrepresented in current clinical trial enrollment. For instance, African Americans are more than 2.5 times more likely to develop cancer but remain underrepresented in clinical trials. Hispanics and Latinos make up more than 18% of the population; however, they represent less than 3% of participants in cancer clinical trials.

A. Does increased access to clinical trial participation for Medicaid enrollees help ensure medical research results more accurately capture and reflect patient demographics and why would that be important?

Yes it is critical to have Medicaid enrollees included in clinical trials. The science is demonstrating that one size does not fit all in treatment modalities, such that inclusion will provided better data. There is a whole science now of Precision Medicine, where therapies are targeted at specific individuals. Medicaid enrollees included in clinical trials will also allow for more trust in the whole mechanism of review and approval of treatments by the FDA by minority communities.

3. Dr. Brooks – Along with Representative Blunt-Rochester, I introduced the bipartisan Collecting and Analyzing Resources Integral and Necessary for Guidance (CARING) for Social Determinants Act of 2019 (H.R. 4621) which would provide guidance to states to address social determinants of health under Medicaid and CHIP, building upon the success that some state Medicaid programs have already had since testing innovative delivery and payment models. Additionally, several members of this Committee (including Representative McMorris Rodgers) are championing the Social Determinants Accelerator Act (H.R. 4004), which would help states and communities devise strategies to better leverage existing programs and authorities to improve the health and well-being of those participating in Medicaid.

A. How might the U.S. Department of Health and Human Services (HHS) do more to coordinate social determinant efforts, even without additional congressional authority?

There is presently a tool used for screening for SDoH, called PRAPARE, built into most electronic health records. Mandating or incentivizing this along with a plan of action developed by HRSA, or HHS, under the Office of Minority Health (OMH), embedded in HHS, would be beneficial.

B. Could you explain how HHS could use its leadership in Medicaid to more broadly catalyze efforts to better coordinate and measure the impact of resources and initiatives that address social determinants of health?

This was addressed somewhat in the answer to question A, however I can add that there can be a meta-analysis, a review of the present knowledge of Best Practices and a Position Paper stating initiatives that successfully address social

determinants of health. Also, the HHS could fund grants that focus on broad SDoH factors such as access to healthy foods or housing that fund activities that have **already been PROIVEN** to be effective (and to try to track these related to health outcomes).