Expert Interview: Dr. Rodney Hood

Dr. Rodney Hood *practices internal medicine in San Diego, California. He is President of MultiCultural IPA, a local, independent physicians association whose membership includes 120 primary physicians and 200 specialists. Dr. Hood is past president of the National Medical Association, an organization of more than 30,000 African-American physicians.*

CapRadio News: Who is most at risk of developing diabetes?

Dr. Hood: First of all, we've been seeing a worldwide epidemic in the incidence and prevalence of diabetes. Worldwide, probably the highest increase in diabetes is in North America, especially in the minority populations and communities of color. There is underlying genetic predisposition no matter what your ethnicity, but environmental influences tend to exacerbate diabetes, so those who have poor food choices and become obese, those who have inability to detect diabetes early and do interventions that could prevent the further development of diabetes are the ones at risk. We tend to see that more in the African-American, Latino-Hispanic, and Asian communities.

CapRadio News: How is the diabetes epidemic affecting our way of life and quality of life here in North America?

Dr. Hood: I think quality of life is one of the risk factors to developing diabetes. I think when you develop diabetes, that further limits your quality of life because diabetes can lead to an increased risk of cardiovascular disease, stroke and heart attack. It can lead to what we call end-organ damage where you get damage to your eyes, kidneys and vascular system, ending up in blindness and kidney failure. It limits your activity levels if you develop any of those end-organ changes. So I think the lifestyle in America is bad for your health, especially if you have poor access to resources. Once you develop diabetes, that adds to it.

CapRadio News: Why do communities of color suffer more from this disease?

Dr. Hood: Well, it's true that African-Americans, Native Americans, Latinos and Asians have higher incidences of diabetes. However, most scientists believe that the diabetes epidemic in the minority population is mostly influenced by lifestyle and environmental factors. What are those environmental factors? The communities they live in, many times they have poor food choices, they have inability to do adequate physical activity resulting in obesity. As a matter of fact, we see a direct relationship between the obesity epidemic and the increase in diabetes, and we're seeing more prevalence of both of those in communities of color.

CapRadio News: Is there any genetic evidence, research or science that suggests that certain ethnic groups or races may be more predisposed to diabetes than other groups?

Dr. Hood: There are two types of diabetes. Type 1 diabetes, we used to call early onset diabetes, is believed to be a genetic auto-immune disorder, and that probably accounts for 5% of the people with diabetes. Type

1 diabetes is more common in the European communities. Then we have Type 2 diabetes, which is the diabetes we see more in 90-95% of the African-American, Latino and Native American communities. As I stated, probably anybody that develops diabetes has some type of underlying genetic predisposition but they won't develop diabetes unless exposed to what I call toxic environments. That's an environment that's exacerbated by poverty with poor access to health care, poor access to healthy food choices, poor lifestyle activities, and exposure to certain toxins and drugs. And because that's more prevalent in the communities that I mentioned, I think it's the environment or social factors that are more important in the diabetes epidemic than the genetic component.

There is a genetic component. There's an example of a group of Indians called the Pima Indians of North America. Pima Indians in the United States have an extremely high rate of Type 2 diabetes. Similar populations of Pima Indians that are located in North Mexico have a much lower rate of diabetes, and I think the difference is that the Pima Indians in America tend to have adopted more of the American lifestyle. I'm using that as an example to suggest how genetics and environment interplay, and a lot of times the genetic aspects won't be expressed unless there's an environmental factor.

CapRadio News: Can you tell us why it's important to talk about the disparities that exist in this epidemic? Why is it important that communities of color are disproportionately impacted by this disease?

Dr. Hood: I think it's important if we're interested in really putting a significant imprint on the rise of diabetes. You need to focus on the communities it's impacting the most. I call it the law enforcement approach. In law enforcement, they actually do a geographic mapping of where the high rates of crime are, then they identify the resources that they need and that's where they apply the resources. Rather than just looking at having the resources spread throughout the city or throughout the county, they focus it.

Similarly with diabetes, if you don't know where the major problems are, it's more difficult to really make a dent. Plus when we look at the various groups that are affected the most, they're in ethnic communities. Approaches to effectively decreasing the incidence in those areas will vary depending upon the ethnic group. Whether it's Latino, African-American or Asian, various interventions may differ because of the cultural barriers, i.e. in the Hispanic community, language barriers are significant. They have one of the highest incidents of uninsured people and therefore lack of access is an issue.

In the African-American community, they may have better access but educational levels and navigating the system appear to be much more difficult. So if you're not discussing or identifying the problem, looking at the disparities especially by race and ethnicity, you may improve overall but not make a dent in disparities.

CapRadio News: Talk about how income plays a role in developing this disease.

Dr. Hood: I think your socio-economic status and your ethnic background are both independent variables. It's what I say, place and race matter as independent variables. Too often, we assume by addressing the issue of socio-economic status, that we're dealing with the ethnic situation because proportionately there are more poor Hispanics or African-Americans, and therefore by just looking at socio-economic status we're going to make a dent. We see narrowing of disparities as the person's income increases, but it doesn't necessarily totally go away.

Poverty or low income status puts a limit on your resources, it makes it more difficult to access quality healthcare. Many folks are living in areas that they feel are unsafe to make healthy choices, as far as being able to walk or exercise in their communities, as far as being able to access what we call healthy foods versus fast foods. The education level is usually lower, making it more difficult to understand what healthy

choices are. Most are relegated to public schools, and many of the public schools in those areas have cut back as far as engaging the students in physical activity. The food and drink choices at the schools are not what many would call healthy choices. So those are the environmental ways that I think poverty adds to problems with diabetes.

CapRadio News: Now for the general population, why would you say the rates of diabetes are going up nationwide and worldwide?

Dr. Hood: First of all, there's a correlation in the industrialized world with increased obesity. This is not only in the United States but elsewhere. Diabetes is a result of the body's decreased ability to produce insulin, or the effectiveness of the insulin is decreased. Obesity, for whatever reasons, makes the insulin less effective. When you see unhealthy choices throughout the country and throughout the world, you can expect to see an increase in diabetes. And again, it's not just in the poor areas. You're seeing it in non-poor areas where they've gotten away from eating healthy. The lifestyle in the first world, of working two to three jobs, eating on the go, lack of sleep, has caused increased productivity, but not necessarily improvement in health.

CapRadio News: Once people have diabetes, who is most likely to suffer from severe complications such as eye problems or kidney failure?

Dr. Hood: Diabetes can be very, very devastating. It's not a benign disease. The earlier you detect diabetes and initiate intervention, the more you help prevent the complications of diabetes. Once they do have the diabetes, the more aggressive you are at controlling the diabetes as far as their blood sugars and a protein we call A1C, the better the outcomes. A1C is a hemoglobin protein that actually carries sugar and it can tell you how well controlled the sugar is. So by monitoring that, we can tell how well controlled somebody is. The higher that A1C is, the worse control. So those that do not have good or excellent control are at a greater risk of developing the complications: diabetic retinopathy which leads to blindness; kidney disease which can lead to kidney failure, dialysis, transplants and death; cardiovascular disease because diabetes also attacks the vascular system and can lead to heart attacks and strokes; and nerve system neuropathy. All of those complications could be decreased simply by identifying diabetes earlier and treating it aggressively once it is identified.

CapRadio News: Can you give us an overview about how the African-American community is suffering from this disease?

Dr. Hood: The African-American community has one of the highest death rates from diabetes. African-Americans also have one of the highest rates of obesity, especially the youth, than other communities. Once the disease is diagnosed, there's evidence to suggest that the control of diabetes isn't as well controlled as in other communities. A lot of that has to do with the cultural barriers, the access barriers, the poverty and all the things that I have mentioned before, but it's a very devastating thing within the African-American community.

There aren't adequate programs specifically directed at the African-American community. There are some programs being developed at the National Medical Association. There's a diabetes educational program on a national level that's directed at the African-American community. Locally, here in San Diego, there's a program called Project Dulce that's not only directed at the African-American community but at the Latino and Asian communities, and I think it's programs like that that will begin to show a change in the discrepancies that I just described.

CapRadio News: On a statewide level, do you see any successful healthcare interventions or community-based programs that are helping to tackle the disease among the African-American community?

Dr. Hood: Project Dulce was started at the Scripps Whittier Institute here in San Diego. It's a community-based diabetic care and education program directed at culturally diverse communities.

It now has about 20 locations working out of mostly community clinics. They train peer educators or patient facilitators or promotoras to provide diabetic self-management and support to other patients with diabetes. They've developed clinical standards and treatment guides, electronic diabetic registries, and they're developing a curriculum that was mostly, in its initial phase, focused on the Latino-Hispanic community. But they're now developing social-cultural approaches that are more specific for the African-American, Filipino and Vietnamese communities.

They've had significant success as far as monitoring the A1C's and seeing the A1C's come down. They've been doing it for about ten years or so, and certainly the control of diabetes in their patients has been documented to be much better. What this program shows is that in minority communities, they need more community-based approaches. Simply just doing a media approach, TV ads and things like that have been successful maybe in larger audiences, but I think that the backbone of Project Dulce is the promotoras or the patient facilitators. They actually call the patients, go by and visit the patients, help them with their physician visits, etc. It has been shown to be very effective in getting better control in their population.

CapRadio News: What would it look like for the African-American community to have culturally-relevant care models that could help reverse the disease or epidemic? What is culturally relevant care?

Dr. Hood: I think, first of all, they need to have access to healthcare systems and healthcare providers. And when you ask them, many of them, they need to have access to providers that either look like them and/or are culturally appropriate for their population and kind of understand their population. I think, similar to what I just described with Project Dulce, I think you need to have community-based facilitators, you need to involve some of the community organizations that are very strong in the African-American community. I would say that that would include sororities, fraternities and churches. And there are several programs throughout the country that have tapped into those resources as far as diabetic education in African-American communities focused on trying to improve compliance with their medications and doctor visits that have been very effective. So I think in the African-American community, there needs to be focus on getting more providers that are in tune to the needs of that community and utilizing the organizations in the community that are willing to be helpful interacting with that population.

CapRadio News: What policies would you recommend on a national or statewide level that could help curb the diabetes epidemic, and specifically help with the disparities in the epidemic.

Dr. Hood: At the federal, state and local level, policies can help make communities safer. When folks are planning or redeveloping, are there adequate free spaces for folks to walk and exercise? It's more of a holistic approach. Do they have access to healthy food choices? If not, maybe policies to support and bring in larger food chains. I know here in San Diego, there's a farmers market being established. There may be zoning changes that are needed to create healthier environments. I think we need policies within schools that would assist students to get more exercise and also offer better and healthier choices at school. Smoking cessation policies are important. So at a local level, the community needs to define what its barriers are and what its concerns are, and then they need to advocate with their local health care leaders, politicians and school leaders to implement those policies that would make those changes.

CapRadio News: How would you characterize the policy that already exists in the state or nationally or locally surrounding the diabetes epidemic?

Dr. Hood: Extremely fragmented. Not very coordinated. I think we need more research. Most folks know what they need to do (individually). It's mobilizing the forces to convince the folks who have the power to make the changes to do it. One of the programs I've been involved in locally was a grant from the California Endowment that was headed by San Ysidro Health Center, which is a local, federally qualified clinic. I and some other community leaders actually chaired the community advisory committee that advised the grant.

We had a lot of community forums, telling them what we were trying to do, asking them what the issues were, and we brought together members form the health community – administrators, hospitals, local community organizations as well as churches. The other thing we did was we had a survey that had 20 or more questions. And our initial thought was we'd get 100-200 responses. We were able to get over 1200 responses on the survey that gave quite a bit of insight. Basically, one of the questions was what do you consider some of the barriers are? From that population, a significant number said we would like more providers that look like us. Now the majority of the respondents were Hispanic, African-American and Asian. They also said that there are several federally qualified clinics in the area, but the majority of the individuals have private insurance and they said they would prefer – they have nothing against the clinics - but they would also prefer to have private physicians. The issue of a youth focus came up, which was surprising to us. That came from the community. They were concerned that there was not enough health emphasis on youth as far as mental health and how they deal with the violence and gang activity.

One of the recommendations coming out of this study was that we consider putting together an application for what we're calling a "health empowerment zone" – areas that meet the criteria of under-served populations would be designated. Both private and non-private providers who came and practiced in this area would be able to have loan forgiveness programs. That's a problem in recruiting providers into areas like this, in that they leave medical school with a huge debt and when they're looking for a job, sometimes the reimbursement rates and the amount of money they can make in an area like this isn't what they feel they need to make in order to start paying off their loans. So having loan forgiveness in the "health empowerment zone" would help that. Put on tax credits for health care businesses that setup in the area. So creating a financial incentive that would attract the providers that are needed, the businesses that are needed, and make that successful. That came out of just talking to the patients in the community as far as what they felt they wanted.

CapRadio News: People talk about the importance of personal choice in combating this disease on a personal, individual level. We've been talking a lot about environmental factors and policy. What would you say about the importance of personal choice?

Dr. Hood: You know in America, personal choice is always an issue. But personal choice is also very influenced by your environment. So it's much more difficult for somebody to make personal choices that are healthy when you're in a toxic environment. So if you're living in an environment where the poverty level is not high and you have access to affordable, healthy foods, you can afford to exercise. So personal choice is very important and clearly everybody needs to start being educated about what personal choices are. But what we found is that, especially in ethnic populations, that will only take you so far because of where they live, the cultural barriers, etc. that make it difficult for them to make those personal choices.

CapRadio News: Research that I've read shows that the prevalence of diabetes among non-US born population increases with the time that they've lived in the United States. Why would you say that is?

Dr. Hood: I say American culture is toxic for your health. We see, whether we're talking about diabetes, whether we're talking about health disparities and other diseases, certain ethnic populations when they first come to the United States actually have better health outcomes and better health status that gets worse the longer they stay. Nobody really has studied that, and in the Hispanic community they call it a paradox, but I think it goes along with the fact that when they come here, they're changing their lifestyle and they're changing their activities and I think that that has an effect on the whole social determinant that winds up making their disease states worse.

I mentioned the Pima Indians. Certainly there are a lot of benefits to being in the United States, but much of the lifestyle, especially if you're poor, is not necessarily conducive to a healthy lifestyle.

CapRadio News: Has the recent downturn in the economy had any effect on the diabetes rates or the ability for the public to combat the diabetes epidemic?

Dr. Hood: Well you know, to be honest, I haven't seen the recent data since 2008 or 2009 when we had the recession. Diabetes and obesity was significantly on the rise. Since then, I know it's continued. However, I must believe that it's certainly putting the country in a situation where it's being compounded. We have, with the downturn, more folks are losing the jobs and unemployment has gone up. That means they're not having health coverage, therefore they don't have access. The poverty level is increasing. More folks are in poverty, and so we're forcing folks into situations that we've already talked about and said will lead to worsening of diabetes and increased obesity. So I think it's a very toxic situation, not only for diabetes but all levels of disparities.

CapRadio News: As we're seeing healthcare reform rolling out in California, are there new opportunities to do something about diabetes?

Dr. Hood: You know, that's probably one of the positive highlights in the current health system and that is the whole health care reform or the accountability care act. If executed the way I understand and have read, I think it can have a significant impact. By 2014 healthcare reform proposes to cover over 30 million new people who didn't have insurance. People who do have insurance, they'll be able to, through the exchange, hopefully get insurance at a more affordable cost. They have, in the stimulus funds, actually put in significant funding to expand access for the community clinics to be able to care for some of these new folks.

There is also something called ACOs, Accountable Care Organizations, which are pilot programs that will focus on providers like myself to solve the problem of fragmented care, meaning that I may see a patient, but the patient may be seeing different, other physicians, on different medications, and how they access the system and access their specialists and tertiary care may vary. With an Accountable Care Organization, that's an organization of providers coming together with not only physicians but hospitals and putting together a plan that would better integrate the care of the patient. For example, there's funding available for electronic health records. I think electronic health records will help the disease registries and manage diabetes in a better way. So I think there's lots in health reform that could greatly help reduce the diabetes epidemic.

CapRadio News: We are also talking about the Native American community and the Hmong-American community. Is there anything that you wanted to add about the prevalence of diabetes in those communities and what could specifically be done to combat the epidemic among Native Americans and Hmong people?

Dr. Hood: Certain Native American communities have some of the highest rates of diabetes in the country of all ethnic groups. And so clearly, there needs to be a focus on those communities, looking at the social barriers and the issues that are specific to their communities. I'm not that familiar with any specific programs directed at the Native Americans, but I think the approaches need to be the same that I talked about for the Latinos, African-Americans, etc. There just needs to be a program put together that specifically addresses their needs.

CapRadio News: Is there anything else that you'd like to add?

Dr. Hood: In order to make an impact on the diabetes epidemic, I think whatever we do needs to be holistic. I think we need to ask the communities that we're talking about how they see their problems, what the issues are, rather than developing programs that come from the top down. I think more programs need to be developed from the bottom up. The problem with that is sometimes it's more frustrating and takes time, but I think data suggests that it's more effective. So I'm hoping that those are the programs that we see coming out of healthcare reform, where we're developing more community-based diabetes management programs.

CapRadio News: And finally, why do you care about this issue of diabetes and disparities in the diabetes epidemic?

Dr. Hood: Diabetes kills. It's one of the reasons why there are disparities. It is causing poor quality of life, more so in certain communities than others. It's a huge cost and burden on the health system. I forget how many billions of dollars have been estimated to be wasted just because of the existence of health disparities in general, and a significant percentage of that because of diabetes in particular. I've been practicing in a low-income, diverse community for 30 years. I've personally seen the devastation from disparities and diabetes, and it's just been a passion that I've had over the past 30 years that we need to pay more attention to these communities.