



# NEWSLETTER

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### WELCOME FROM THE DIRECTOR'S DESK

We look forward to working with you and appreciate your comments and feedback on the contents of the Newsletter. All suggestions for future editions are welcomed. If you have articles you would like to include in the HDQIOSC Newsletter, please submit to [HealthDisparitiesQIO@hcdi.com](mailto:HealthDisparitiesQIO@hcdi.com). Thank you. Jan Kelley, Project Director, HDQIOSC, 1-877-QIO-6465 (1-877-746-6465).

Although most Americans are affected by problems with the health care delivery system, an overwhelming body of evidence demonstrates that certain populations are significantly more likely to receive lower quality health care than others. Tackling the root causes of health disparities can be done by addressing differences in access to health coverage and promoting prevention and public health, both of which play a major role in addressing disparities. Reducing disparities can also be accomplished by working with the medical system to eliminate inequities in health care by requiring hospitals and health plans to collect, analyze, and report health care quality data for disparity populations; by diversifying the workforce to ensure culturally effective care; by implementing and funding evidence-based interventions, such as patient navigator programs; and by supporting and expanding the capacity of safety-net institutions, which provide a disproportionate amount of care for underserved population. The HDQIOSC looks forward to working with Federal agencies, QIOs, local and state governments, and national partners to improve health disparities and provide quality of care to all.



reducing health disparities

## HOW THE HEALTH DISPARITIES QUALITY IMPROVEMENT ORGANIZATION SUPPORT CENTER (HDQIOSC) CAN SUPPORT YOUR QUALITY IMPROVEMENT ORGANIZATION (QIO)

**The 9th Scope of Work (SoW) for QIOs** continues the core mission of the QIO program by elevating the quality of the processes and outcomes of health care services delivered to Medicare beneficiaries. As a part of this goal, the 9th SoW extends the duties and responsibilities of QIOs in documenting and reducing the magnitude of health disparities in both the Theme and Sub-National Task areas. The HDQIOSC can offer a number of support services in each of the following areas:

### BENEFICIARY PROTECTION

Through the collection and analysis of individual patient complaints as well as medical record case reviews, QIOs track quality of care issues and design quality of care improvement activities that can significantly address the Medicare beneficiary's concerns. The HDQIOSC can support these activities by:

- Providing literature and/or other research that strengthens QIOs' knowledge of the nature and magnitude of beneficiaries protections and rights that have been documented across Medicare beneficiaries;
- Assisting QIOs in designing quality improvement activities that can effectively address disparate beneficiary protection issues.
- Working with cases referred for investigation to the DHHS' Office for Civil Rights, if it is suspected that care provided to Medicare beneficiaries is being compromised or denied due to discrimination on the basis of race, color, national origin, disability, or age.
- Providing support to CMS to analyze data to identify health disparities in the areas of beneficiary protection.
- Addressing customized requests for assistance.

### PATIENT SAFETY

Medicare beneficiaries hospitalized and/or institutionalized in nursing homes are at risk of various factors such as pressure ulcers, physical restraints, surgical safety issues, nosocomial Methicillin-resistant Staphylococcus aureus (MRSA) infections, drug safety, and other problems. The HDQIOSC is available to support the QIOs in measuring and addressing disparities in this area. Our support services include:

- Identifying resources that can be used to create a baseline assessment of patient safety health disparity needs.
- Providing QIOs with culturally-specific messaging for provider and Medicare beneficiary recruitment.
- Providing analysis of data so that correlates of patient safety disparity issues can be identified.

### PREVENTION THEME

Consistent with the emphasis on prevention that has dominated the field of health care for more than four decades, QIOs are partnering with selected participating practices in order to increase the rates of breast and colorectal cancer screenings and influenza and pneumococcal vaccination rates. In order to support QIOs in reducing the health disparities in this area, HDQIOSC offers the following services:

- Assistance in identifying participating practices that serve medically underserved Medicare beneficiaries.
- Assistance with identifying and recruitings.
- Providing QIOs with culturally—specific messaging for provider and Medicare beneficiary recruitment.
- Tracking statewide rates by race/ethnicity, socioeconomic status, gender, and other variables.

## PREVENTION: DISPARITIES

While the issue of disparate treatment and health care outcomes has been integrated into the 9th SoW Theme and Sub-National Task areas for all QIOs, the Prevention Disparities Sub-National Task focuses on diabetes self-management education among Medicare beneficiaries in the District of Columbia, Georgia, Louisiana, Maryland, New York, Tennessee, and the U.S. Virgin Islands. The HDQIOSC can support QIOs in these efforts in the following ways:

- Assisting QIOs on how to engage and retain Medicare beneficiaries with diabetes from health disparity populations.
- Providing QIOs with culturally-specific messaging for provider and Medicare beneficiary recruitment.
- Assisting QIOs with recruiting underserved Medicare beneficiaries with diabetes for project participation.
- Monitoring and tracking provider recruitment and diabetes self-management education training activities.
- Tracking and monitoring statewide diabetes rates by race/ethnicity and other measures.

## CARE TRANSITIONS

QIOs from Alabama, Colorado, Florida, Georgia, Indiana, Louisiana, Michigan, Nebraska, New Jersey, New York, Pennsylvania, Rhode Island, Texas and Washington are seeking to create significant improvements in the processes used to transition beneficiaries across the health care system. The HDQIOSC's staff is available to support these QIOs by:

- Providing QIOs with culturally-specific messaging for provider and Medicare beneficiary recruitment.
- Designing culture-specific interventions to address care transitions.
- Monitoring and measuring changes in care transitions for underserved Medicare beneficiaries.



## PREVENTION: CHRONIC KIDNEY DISEASE (CKD)

QIOs in Florida, Georgia, Missouri, Montana, Nevada, New York, Rhode Island, Tennessee, Texas, Utah and the U.S. Virgin Islands are improving CKD detection in Medicare beneficiaries with diabetes; measuring the use of an angiotension-converting enzyme and other agents to delay the onset of kidney failure; and ensuring proper counseling before the beginning of dialysis and the placement of an arteriovenous fistula in hemodialysis patients. QIOs working on CKD also engage in collaborative actions to create CKD system-wide changes. The HDQIOSC can support these QIOs by:

- Providing CMS with statistical analysis and making available to QIOs research on CKD disparities.
- Introducing newly released research on CKD disparities.
- Analyzing data provided to the CKD QIOs so that changes in health disparities can be tracked.

In addition to the activities listed, the HDQIOSC can also provide assistance in outreach, data quality and reporting and messaging.

## UNIQUE PARTNERSHIP BRINGS BENEFITS AND SUSTAINABILITY TO LOUISIANA'S *EVERY DIABETIC COUNTS* PROGRAM

benefits and sustainability

Louisiana Health Care Review (LHCR) and the Southern University Agricultural Research and Extension Center (SUAREC) have formed a unique community partnership to help African-American Medicare beneficiaries with diabetes improve their diabetes self-management techniques through the *Every Diabetic Counts* program.

Southern, a Historically Black College and University established SUAREC as a multi-disciplinary center allowing for collaboration between research scientists and cooperative extension personnel. Cooperative extension agents are paraprofessionals who bring life-skills education on nutrition, diet and health to their constituencies.

SUAREC will provide diabetes self-management materials to the African-American Medicare beneficiaries with diabetes participating in Louisiana's *Every Diabetic Counts* program. The materials focus on the important role diet plays in controlling diabetes. One extension agent in each of the five Louisiana



*Every Diabetic Counts* parishes will have the opportunity to be trained as a community health worker and assist LHCR as a Diabetes Empowerment Education Program (DEEP) curriculum trainer.

Disparities Theme Director, Linda Harkey, reports that the relationship with SUAREC and others like it will strengthen Louisiana's efforts and help ensure the sustainability of the program beyond the current Quality Improvement Organization Program's 9th Scope of Work. For additional information about the partnership, contact Linda Harkey at [lharkey@lhcr.org](mailto:lharkey@lhcr.org).

## USING A PERSONAL TOUCH TO IMPROVE DIABETES OUTCOMES

By Dr. Lenore T. Coleman, Pharm.D, CDE, FASHP

### INTRODUCTION

Persons affected by diabetes require assistance and guidance for establishing appropriate priorities in their efforts to attain the full spectrum of health care (e.g., nursing, medical, ophthalmic, dental, nutrition, and podiatry) required to improve outcomes. Usually the responsibility for managing even complicated cases of diabetes falls on the individuals themselves. The array of responsibilities they face includes the challenge of aligning regimens of meal planning and timing, physical activity, blood glucose monitoring, management of acute complications, and adjustments in therapies and lifestyle behaviors.

African Americans with diabetes face the unique, combined challenges of an increased prevalence of diabetes, greater frequency of associated hypertension, as well as earlier onset of long-term complications. Unfortunately, there are very few culturally competent diabetes education programs that address the barriers to diabetes care within much of

the African American community. For example, very little information is available on how to achieve a well-balanced diet on a limited income, or how to decrease complications rates through the application of routine daily self-care behaviors.

One area where there is a critical need for behavior change to improve both diabetes and high blood pressure control is adherence to medication therapy. In our work with high-risk patients, we have found that most patients with diabetes do not understand how their medications work, what side effects to expect, and the clinical goals of treatment.

In order to address some of the barriers to more effective management of diabetes and hypertension in African Americans, Healing Our Village, Inc. has developed an innovative education model incorporating a "personal touch." Through several interactive activities, including home visits, telephonic outreach, and/ or web-based

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spotlight on community resources

consultation, an initial assessment is made to determine the specialized needs of the individual patients. Our first line of contact is with specially trained **Wellness Coaches**. This group has a strong background in shaping patient behavior and has received intensive, specialized training from Healing Our Village-certified diabetes educators (CDEs) and registered dietitians in the basic concepts of diabetes self-management. The **Wellness Coach Program** is a unique component of Healing Our Village, Inc. that assists in enrolling targeted diabetes patients into our Wellness Connexions™ program. Targeted patients (noncompliant diabetes patients with A1C greater than 8% and/or co-morbid conditions) begin by learning basic diabetes survival skills. Wellness Coaches provide training in the appropriate use of self-monitoring tools (e.g. blood glucose monitors).



During the Wellness Coach visit, patients are shown our specially-designed educational videos on diabetes management and given the opportunity to create a personalized health record. During the visit Wellness Coaches record the following clinical measurements:

- Height and weight
- Body fat %
- Blood pressure
- Hemoglobin A1c
- Blood glucose
- Total cholesterol

All information collected during the Wellness Coach visit is entered into a web-based proprietary software database for review by our clinical pharmacists, CDEs and registered dietitians. After the initial consultation, our diabetes care team provides individualized educational sessions as well as ongoing diabetes, weight management, and support groups. Clinical pharmacists provide one-on-one consultation on the

appropriate use of medications, avoidance of medication side effects, and review of drug interactions. Critical alerts are provided to the primary care provider related to potential drug therapy problems and drug regimen modifications. Wellness Coaches are trained to identify and address the personal concerns that patients express about their medication regimen.

Wellness coaches and health educators use Healing Our Village books and videos as an integral part of the adult learning process. Through our podcasts generated from Village Talk (our “live talk radio show” WOLAM 1450 or WOLAM.com), we are able to reinforce the health messaging that is provided in the educational program. *The Healing Our Village* low-literacy educational books and videos are specifically written using a question/answer format that allows the patient to understand the critical diabetes care issues that must be addressed on a daily basis. We use an “edu-tainment” type format with visuals and graphics designed for low-literacy, numeracy-challenged populations. All materials were developed to be used together to reinforce the importance of self-care practices and to teach patients how to interact with their healthcare providers to optimize improvement of diabetes and hypertension control.

Our approach has demonstrated effectiveness in the high-risk groups that we target. For the past two years, Healing Our Village, Inc. has been working in the Washington, D.C. area with a managed Medicaid population. In this population we have been able to:

- Improve hemoglobin A1c in adult patients with diabetes by an average of 1.7 percent.
- Increase referrals for retinal exams by 30 percent.
- Decrease mean systolic blood pressure in “at risk” populations by 16 mmHg and diastolic pressure by 8 mmHg.
- Improve patient knowledge regarding chronic diseases (asthma, diabetes, hypertension) in a Managed Medicaid Plan by 20 percent.
- Improve use of health care resources by decreasing hospitalizations and emergency room visits in patients with diabetes with an initial yearly cost savings of \$243 dollars per patient, while improving health outcomes.

Thus, we are convinced that there is great benefit to be achieved by the application of this unique approach that makes use of the ***personal touch*** for improved diabetes outcomes.

**Disclaimer:** The HDQIOSC in no way is endorsing the community resources it features. It is only providing an opportunity to share ideas with the QIOs.

## EVERY DIABETIC COUNTS PROGRAM

### HOW TO GET YOUR STATE INVOLVED

**Have you considered** contacting the following individuals in your state/jurisdiction to ensure that they are aware of the *Every Diabetic Counts* program?

- Governor
- Mayor
- State Senator
- State Delegate
- Health Department Commissioner
- Housing Commissioner
- Centers for Disease Control and Prevention Representative
- Other Potential Partners/Organizations

### RECOMMENDED STEPS TO FOLLOW:

- Make a personal call to the Governor, Mayor or State Senator's Office, etc.
- If you are not able to talk to the Governor personally, request the name of a designated representative.
- Send a follow-up letter explaining the *Every Diabetic Counts* program and the benefits to Medicare beneficiaries and providers in your state. Emphasize how educating Medicare beneficiaries to monitor their diabetes saves lives and money.
- Request a face-to-face meeting and to give a presentation on the *Every Diabetic Counts* program.
- Make recommendations and suggestions on how the potential partner/organization can be of assistance to you and how you can work together
  - o Assist in disseminating materials on the *Every Diabetic Counts* program
  - o Be a guest speaker at major *Every Diabetic Counts* program events
  - o Spread the word through newspapers, magazines, television interviews, radio shows, etc.

Getting everyone in your state on board with this effort can not only improve the overall health and increase the quality of life for Medicare beneficiaries living in your state, but reduce morbidity and mortality among people with diabetes.

### WORKING WITH FAITH-BASED ORGANIZATIONS

- Identify a church or other faith-based organization in your targeted area.
- Contact the Lead of the Health Ministry to talk about the *Every Diabetic Counts* program and request a meeting with the Lead or a designated person. If there is not a Health Ministry in the church, ask if there is a Senior Citizens Group.
- Ask if the clergyman's wife is involved in any health-related initiatives. If so, schedule a meeting with the clergyman's wife to discuss the *Every Diabetic Counts* program.
- Discuss the benefits of participating in the *Every Diabetic Counts* program.
- Request space to conduct the *Every Diabetic Counts* classes.
- Request to have the clergyman talk about the *Every Diabetic Counts* program during his sermon, and if possible, include the program as a part of his/her sermon.
- Request to include information about the *Every Diabetic Counts* program in the Sunday program on a weekly basis.
- Request to be a guest speaker during the Sunday morning church service and also invite a senior (Medicare beneficiary) to talk about his/her experiences and how diabetes education changed his/her life.
- Request space to set-up an information table before any group meeting and after church to disseminate *Every Diabetic Counts* materials.
- Schedule *Every Diabetic Counts* classes during the week during the day, earlier hours are better (8:30 a.m.–10:30 a.m.). Seniors feel safer attending classes during the day. Problems with vision may be a factor in seniors attending classes after daylight hours.
- Schedule *Every Diabetic Counts* classes in the evening only when other activities are taking place.
- Honor the faith-based organization with a "Certificate of Appreciation" plaque for participating in the *Every Diabetic Counts* program.

## CALENDAR OF EVENTS AND CONFERENCES (JANUARY – APRIL 2009)

calendar



- **January 20, 2009**  
Obama – Biden Inauguration,  
*Washington, D.C.*
- **January 26–28, 2009**  
Native Diabetes Prevention Conference  
*Phoenix, AZ*
- **February 2009**  
Heart Health Awareness Month
- **February 8–13, 2009**  
Annual Indian Health Services National Combined  
COUNCILS MEETING: “Partnership for Change”  
*San Diego, CA*
- **February 18, 2009**  
Center for Health Promotion and Disease  
Prevention Research in Underserved Populations:  
Health Disparities: From Local to Global  
*Austin, TX*
- **February 23–25, 2009**  
Centers for Disease Control and Prevention:  
Cultivating Healthy Communities: 20th National  
Conference on Chronic Disease Prevention  
and Control  
*Gaylord National Resort and Convention Center,  
National Harbor, MD*
- **February 25–27, 2009**  
Third National Leadership Summit on Eliminating  
Racial and Ethnic Disparities in Healthcare  
*Gaylord National Resort and Convention Center,  
National Harbor, MD*
- **February 27, 2009,**  
The 30th Annual Minority Health Conference:  
Our World, Our Community: Building Bridges  
for Health Equality  
*Chapel Hill, NC*
- **March 2009**  
National Colorectal Cancer Awareness Month
- **March 2009**  
National Kidney Month
- **March 2009**  
National Nutrition Month
- **March 6–7, 2009**  
The Fourth Annual Health Disparities Conference:  
Achieving Cultural Competency: Acquiring  
Requisition, Knowledge, Attitudes, and Skills  
for an Evidence-Based Revolution Bringing  
Equity in Health to All  
*Columbia University Teachers College, NY*
- **March 19–22, 2009**  
The National Hispanic Medical Association:  
13th Annual Conference  
*Brooklyn, NY*
- **March 24, 2009**  
American Diabetes Alert Day
- **March 25–27, 2009**  
National Association of Chronic Disease  
Directors 2009: Chronic Disease Academy  
(Cultivating Healthy Communities) – CDC  
*Seattle, WA*
- **April 2009**  
Cancer Control Month
- **April 2009**  
Foot Health Awareness Month
- **April 2009**  
National Minority Health Awareness Month
- **April 6–12, 2009**  
National Public Health Week
- **April 21–24, 2009**  
CDC Diabetes Translation Conference  
*Long Beach, CA*

## HEALTH DISPARITIES RESOURCES ACROSS ALL 9<sup>TH</sup> SOW TASKS

resources

### BENEFICIARY PROTECTION

The Commonwealth Fund, **Enhancing Public Hospitals' Reporting of Data on Racial and Ethnic Disparities in Care**, Authors: Bruce Siegel, M.D., M.P.H., Marsha Regenstein, Ph.D., Karen Jones, M.S.,

[http://www.commonwealthfund.org/publications/publications\\_show.htm?doc\\_id=452681](http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=452681)

Commonwealth Fund: **Health Care Disparities**: Previous Commonwealth Fund work focused on reducing health disparities through improved data collection and reporting found that low-quality providers serve disproportionate numbers of minorities.

[http://www.commonwealthfund.org/programs/programs\\_list.htm?attrib\\_id=9133](http://www.commonwealthfund.org/programs/programs_list.htm?attrib_id=9133)

The **Office for Civil Rights**, U.S. Department of Health and Human Services, helps to protect people from unfair treatment, or discrimination, because of race, color, national origin, age or disability. OCR protects the privacy of health information.

<http://www.hhs.gov/ocr/healthdisparities.html>

### PATIENT SAFETY

**Race/Ethnic Differences in the Prevalence of Incontinence, Perineal Dermatitis and Pressure Ulcers in Nursing Home Residents**, D. Bliss, K. Savik, S. Harms, L. Eberly, and J. Garrard, [http://www.nursing.umn.edu/img/assets/15662/Bliss\\_PPT.pdf](http://www.nursing.umn.edu/img/assets/15662/Bliss_PPT.pdf)

**P.U.L.S.E. (Persons United Limiting Sub-standards and Errors in Healthcare)** The Website of PULSE (Persons United Limiting Sub-standards and Errors in Healthcare) provides useful information on both the national and local divisions of the organization. [www.pulseamerica.org](http://www.pulseamerica.org)

### PREVENTION: CORE

**Talking Points, Racial and Ethnic Health Minorities**: Support adoption of health information technology in health care organizations including electronic disease registries and remote monitoring systems to track and analyze chronic disease trends in all populations, and identify areas where disparities exist. <http://www.healthystates.csg.org/NR/rdonlyres/BEF17D76-746E-403C-80EF-C4614272AD60/0/DisparitiesSourcespdf.pdf>

**Racial and Ethnic Disparities in U.S. Health: A Chartbook**, H. Mead, L. Cartwright-Smith, K. Jones, C. Ramos, and B. Siegel, [http://www.commonwealthfund.org/usr\\_doc/mead\\_raceethnic\\_disparities\\_chartbook\\_1111.pdf](http://www.commonwealthfund.org/usr_doc/mead_raceethnic_disparities_chartbook_1111.pdf)



### PREVENTION: DISPARITIES

**Medline Plus**, a service of the U.S. National Library of Medicine and the National Institutes of Health Website at <http://www.nlm.nih.gov/medlineplus/diabetes.html> includes Health Topics, Drugs and Supplements, Medical Encyclopedia, Dictionary, News, Directories, Go Local, Other Resources (Libraries, Organizations, Governments health sites from other nations, Databases, MEDLINE/PubMed) and Multiple Languages.

- **African-American Health**, <http://www.nlm.nih.gov/medlineplus/africanamericanhealth.html>
- **Asian-American Health**, <http://www.nlm.nih.gov/medlineplus/asianamericanhealth.html>
- **Hispanic-American Health**, <http://www.nlm.nih.gov/medlineplus/hispanicamericanhealth.html>, and
- **Native-American Health**, <http://www.nlm.nih.gov/medlineplus/nativeamericanhealth.html>

**Centers for Disease Control and Prevention, Office of Minority Health and Health Disparities (OMHD)** web site at <http://www.cdc.gov/omhd/default.htm>. Population-specific information includes Demographics, 10 Leading Causes of Death, High Prevalence Health Issues, Health Disparities, Brochures, Slides, Government Resources, Non-Government Resources, Funding, Sources and Notes for the following populations:

- **Black or African American Populations,**  
<http://www.cdc.gov/omhd/Populations/BAA/BAA.htm>
- **Asian American Populations,**  
<http://www.cdc.gov/omhd/Populations/AsianAm/AsianAm.htm>
- **Hispanic or Latino Populations,**  
<http://www.cdc.gov/omhd/populations/HL/HL.htm>
- **Native Hawaiian & Other Pacific Islander (NHOPI) Populations,**  
<http://www.cdc.gov/omhd/Populations/NHOPI/NHOPI.htm>

American College of Physicians **Diabetes Portal** at <http://diabetes.acponline.org/vnr/#pr> provides patient and clinical resources. The patient education materials and tools are designed specifically to help patients and their families manage diabetes. The clinician tools and information are designed to assist health care teams in efficient and effective management of patients with diabetes.

[https://www.acponline.org/atpro/timssnet/products/tnt\\_products.cfm?action=long&primary\\_id=150200200](https://www.acponline.org/atpro/timssnet/products/tnt_products.cfm?action=long&primary_id=150200200).

## CARE TRANSITIONS

**National Transitions of Care Coalition (NTOCC):** The NTOCC has created the following information to help health care professionals and consumers understand how poor transitions impact care delivery and how you can help improve transitions in your facility.

<http://www.ntocc.org/Home/tabid/36/Home/tabid/36/Default.aspx>

**Improving the Quality of Transitional Care for Persons with Complex Care Needs,** American Geriatrics Society (AGS) Position Statement developed by Eric A. Coleman, MD, MPH, and Chad Boulton, MD, MPH, MBA, May 2002.

[http://www.americangeriatrics.org/products/positionpapers/complex\\_care.shtml](http://www.americangeriatrics.org/products/positionpapers/complex_care.shtml).

## PREVENTION: CHRONIC KIDNEY DISEASE

**CJASN, Screening for Chronic Kidney Disease Complications in US Adults: Racial Implications of a Single GFR Threshold,** Hassan N. Ibrahim, Changchun Wang, Areef Ishani, Allan J. Collins, and Robert N. Foley, Department of Medicine, University of Minnesota, and United States Renal Data System Coordinating Center, Minneapolis, Minnesota,

<http://cjasn.asnjournals.org/cgi/content/abstract/3/6/1792>.

**Clear Racial Discrepancies Exist among Patients with Chronic Kidney Disease Due to Sociological Factors, Black Patients Face Higher Rates of Death in Early Stages of the Disease,**  
<http://www.asn-online.org/press/pdf/2008-edia/Racial%20Discrepancies%20Release.pdf>.

# COMING TO YOU SOON!

## Be On the Lookout for Your Health Disparities Messaging Toolkit!

