“Understanding the Economics of Healthcare Disparities”

The American Apartheid Healthcare System:
(1) Regulatory Captured Corporate Health Insurance → (2) Information Hoarding →
(3) The Christopher Columbus Syndrome

November 14, 2024
Presented by: Edwin C Chapman MD
Addiction & Internal Medicine
Washington, DC

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High rates of preterm birth and infant deaths get the US another D+ grade: ‘It’s a travesty’

By Jacqueline Howard, CNN

10 minute read · Published 9:00 AM EST, Thu November 14, 2024

Ashley O'Neil and her husband, Jorge, had their second child, Kolin, baptized in the NICU. Courtesy Ashley ONeil

A leading cause of babies dying

Preterm birth is a leading cause of infant deaths in the United States. For every 1,000 babies born in 2023, about six died, according to provisional data released Thursday by the US Centers for Disease Control and Prevention. The data showed that the infant death rate last year – 5.6 deaths per 1,000 live births – was unchanged from the rate in 2022. The rate of preterm births – in which babies are born before 37 weeks gestation – also remained at a high rate of 10.4% last year, unchanged from 2022, according to the infant and maternal health nonprofit March of Dimes. “That means that over 370,000 babies – that’s 1 in 10 babies – are born too early,” said Dr. Amanda Williams, interim chief medical officer for March of Dimes. Racial disparities persist, she added; for Black people, the preterm birth rate is 1.5 times higher than the rate among all other babies.

NBC NEWS

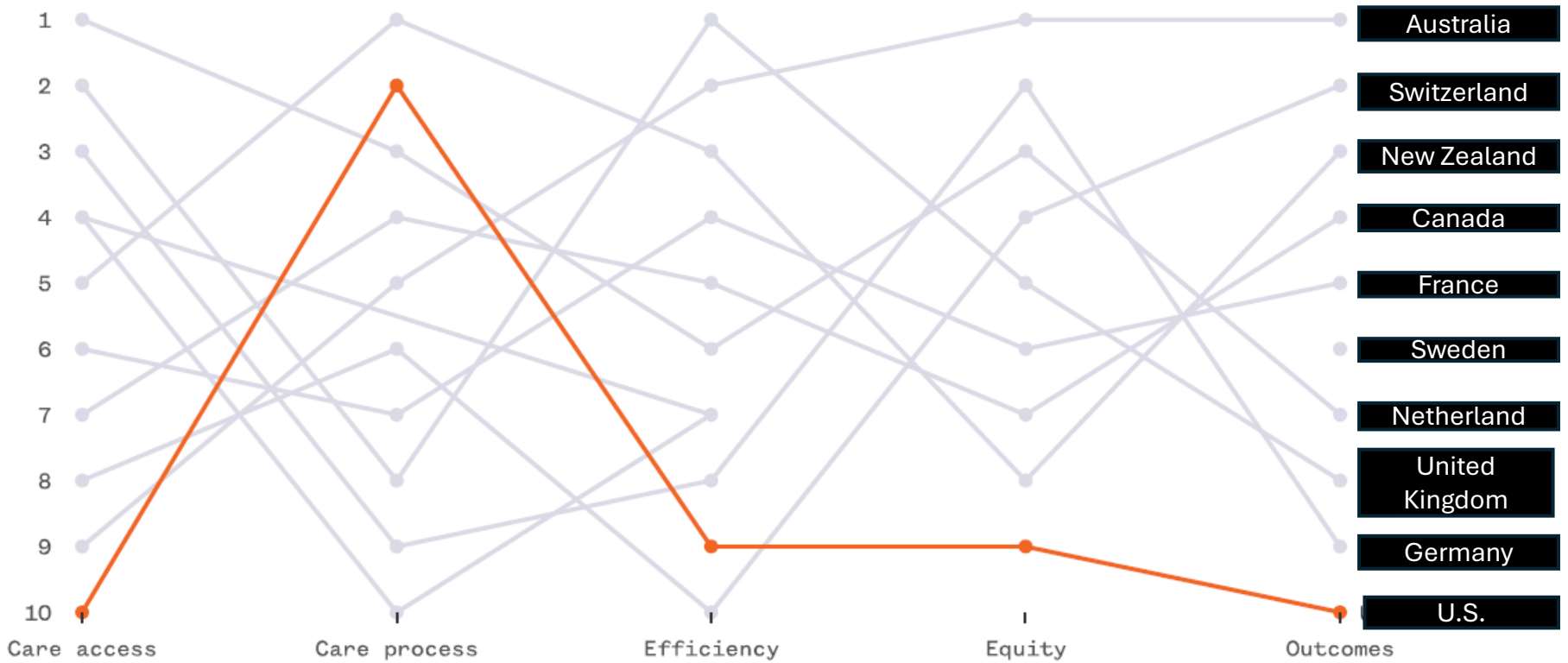
Sept. 19, 2024

U.S. ranks last in health care compared with nine other high-income countries, report finds

People in the U.S. die the youngest and experience the most avoidable deaths, despite spending much more on health care.

U.S. health care, ranked

The U.S. ranked last in three of the five categories, as well as last overall.



Source: Commonwealth Fund

Graphic: Joe Murphy / NBC News

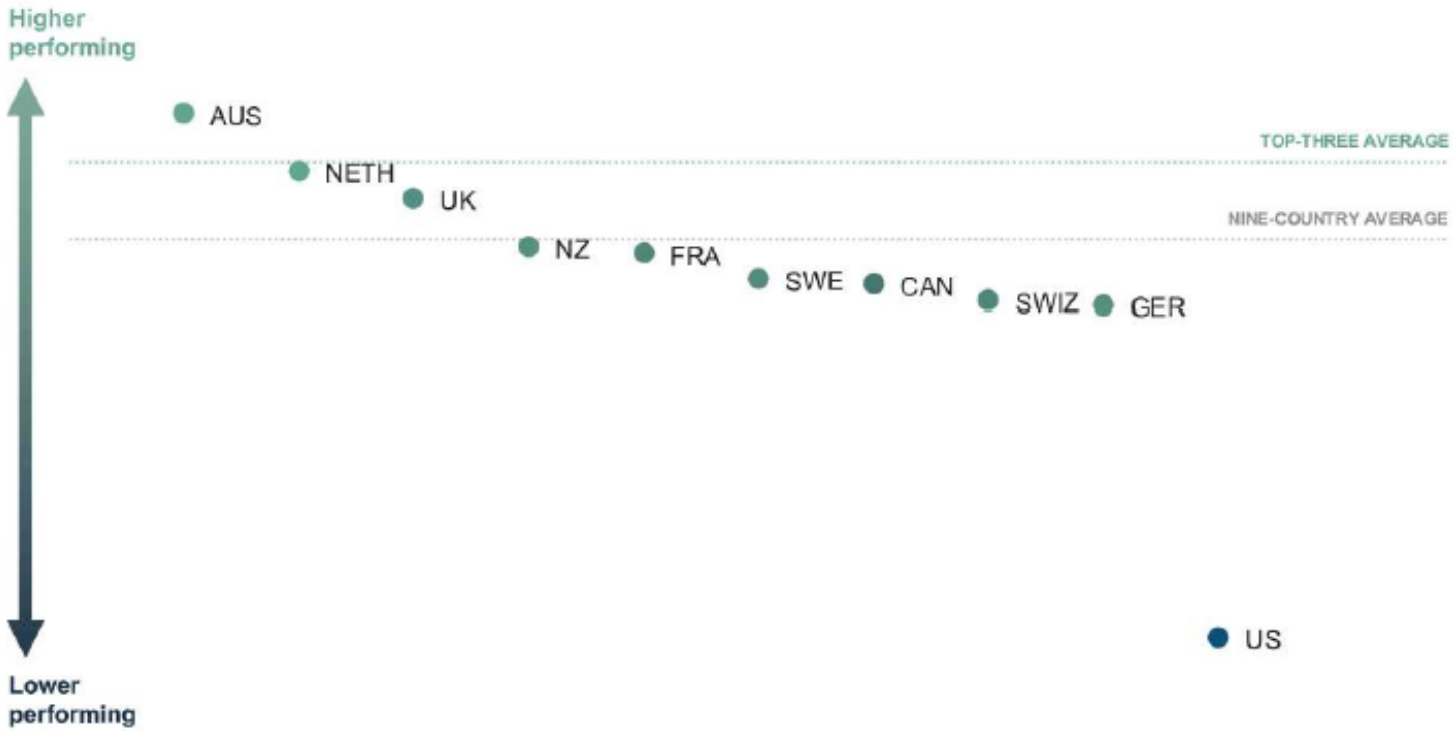
Illustration by Maria Corte

Mirror, Mirror 2024: A Portrait of the Failing U.S. Health System

Comparing Performance in 10 Nations

EXHIBIT 2 — *Overall Performance Ranking*

The United States lags its international peers considerably on health system performance.



Note: To normalize performance scores across countries, each score is the calculated standard deviation from a nine-country average that excludes the US. See "How We Conducted This Study" for more detail.

Data: Commonwealth Fund analysis.

Source: David Blumenthal et al., *Mirror, Mirror 2024: A Portrait of the Failing U.S. Health System — Comparing Performance in 10 Nations* (Commonwealth Fund, Sept. 2024). https://doi.org/10.26099/ta0g-zp66

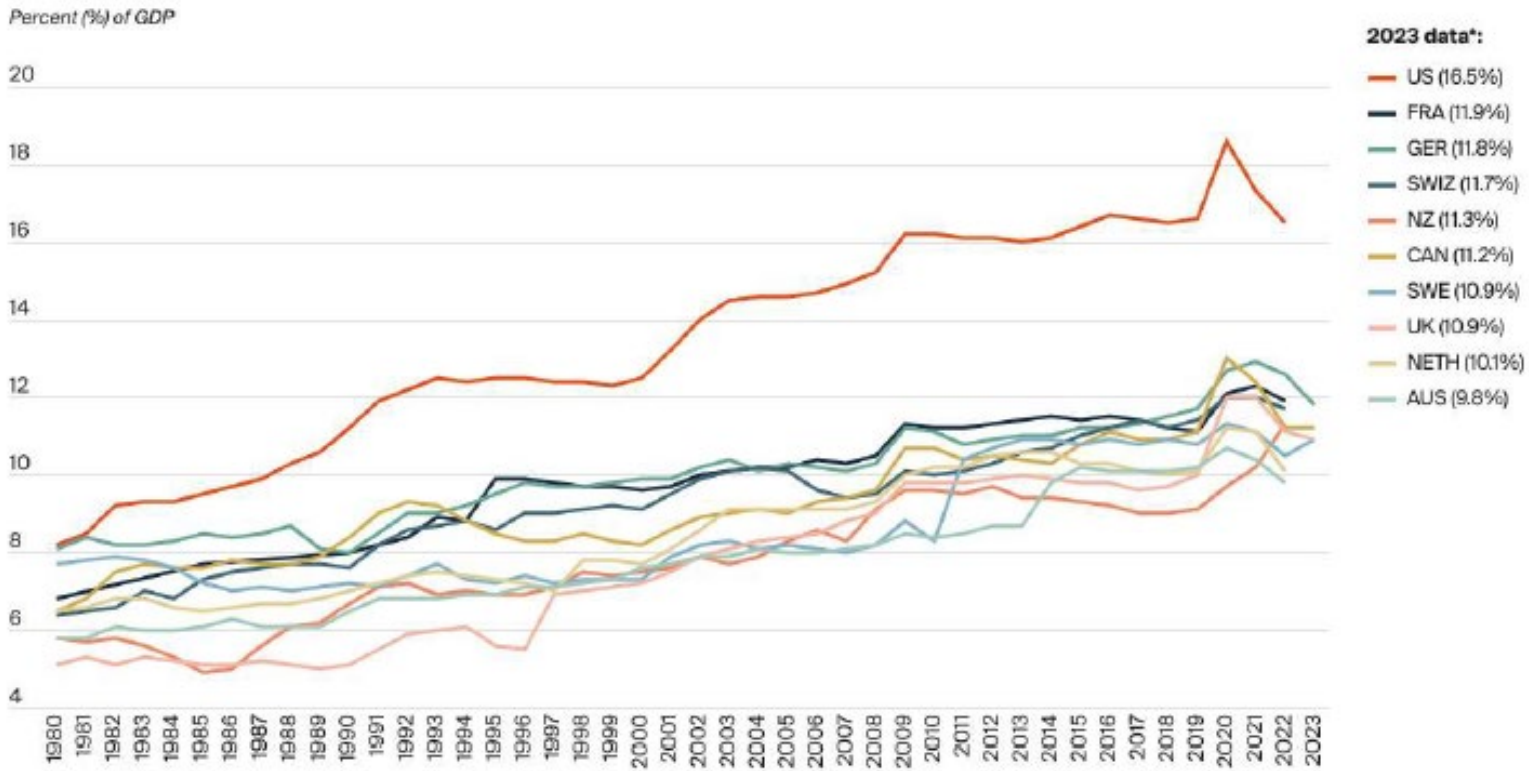
▲ Illustration by Maria Corte

Mirror, Mirror 2024: A Portrait of the Failing U.S. Health System

Comparing Performance in 10 Nations

EXHIBIT 3 — *Health Care Spending*

Health Care Spending as a Percentage of GDP, 1980–2023



Notes: GDP = gross domestic product. Current expenditures on health. Based on System of Health Accounts methodology, with some differences between country methodologies.
* Data for CAN, GER, SWE, and the UK from 2023; data for AUS, FRA, NETH, NZ, SWIZ, and the US from 2022.

Data: OECD Health Data, July 2024.

Source: David Blumenthal et al., *Mirror, Mirror 2024: A Portrait of the Failing U.S. Health System — Comparing Performance in 10 Nations* (Commonwealth Fund, Sept. 2024). https://doi.org/10.26099/ta0g-zp66

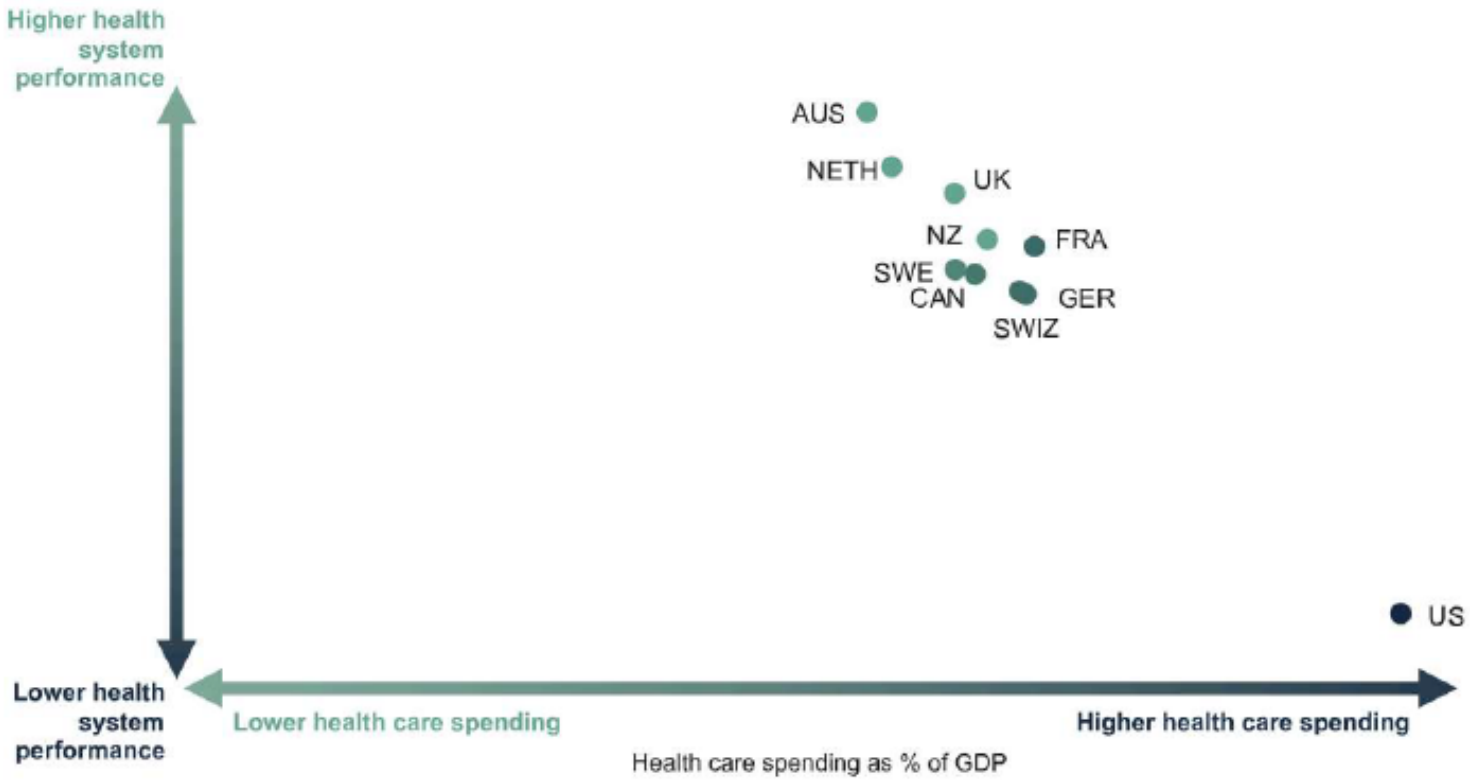
Illustration by Maria Corte

Mirror, Mirror 2024: A Portrait of the Failing U.S. Health System

Comparing Performance in 10 Nations

EXHIBIT 4 — *Performance vs. Spending*

Health Care System Performance Compared to Spending



Notes: GDP = gross domestic product. Health care spending as a percentage of GDP. Performance scores are based on standard deviation calculated from the nine-country average that excludes the US. See "How We Conducted This Study" for more detail.

Data: Spending data are from OECD for the year 2022 and 2023 (updated in July 2024).

Source: David Blumenthal et al., *Mirror, Mirror 2024: A Portrait of the Failing U.S. Health System — Comparing Performance in 10 Nations* (Commonwealth Fund, Sept. 2024). https://doi.org/10.26099/ta0g-zp66

Illustration by Maria Corte

Mirror, Mirror 2024: A Portrait of the Failing U.S. Health System

Comparing Performance in 10 Nations

EXHIBIT 5 — *Access to Care*

Americans face the most barriers to accessing and affording health care.

Note: To normalize performance scores across countries, each score is the calculated standard deviation from a nine-country average that excludes the US. See "How We Conducted This Study" for more detail.

Data: Commonwealth Fund analysis.

Source: David Blumenthal et al., *Mirror, Mirror 2024: A Portrait of the Failing U.S. Health System — Comparing Performance in 10 Nations* (Commonwealth Fund, Sept. 2024). https://doi.org/10.26099/ta0g-zp66

▲ Illustration by Maria Corte

Mirror, Mirror 2024: A Portrait of the Failing U.S. Health System

Comparing Performance in 10 Nations

EXHIBIT 6 — *Care Process*

The U.S. is among the top performers for care delivery process.

Note: To normalize performance scores across countries, each score is the calculated standard deviation from a nine-country average that excludes the US. See "How We Conducted This Study" for more detail.

Data: Commonwealth Fund analysis.

Source: David Blumenthal et al., *Mirror, Mirror 2024: A Portrait of the Failing U.S. Health System — Comparing Performance in 10 Nations* (Commonwealth Fund, Sept. 2024). https://doi.org/10.26099/ta0g-zp66

▲ Illustration by Maria Corte

Mirror, Mirror 2024: A Portrait of the Failing U.S. Health System

Comparing Performance in 10 Nations

EXHIBIT 7 — *Administrative Efficiency*

U.S. physicians and patients are most likely to face hurdles related to insurance rules, billing disputes, and reporting requirements.

Note: To normalize performance scores across countries, each score is the calculated standard deviation from a nine-country average that excludes the US. See "How We Conducted This Study" for more detail.

Data: Commonwealth Fund analysis.

Source: David Blumenthal et al., *Mirror, Mirror 2024: A Portrait of the Failing U.S. Health System — Comparing Performance in 10 Nations* (Commonwealth Fund, Sept. 2024). https://doi.org/10.26099/ta0g-zp66

Illustration by Maria Corte

Mirror, Mirror 2024: A Portrait of the Failing U.S. Health System

Comparing Performance in 10 Nations

EXHIBIT 8 — *Equity*

The U.S. and New Zealand trail peers for equity in health care access and experience.

Note: To normalize performance scores across countries, each score is the calculated standard deviation from, in this case, an eight-country average that excludes SWE and the US. See "How We Conducted This Study" for more detail.

Data: Commonwealth Fund analysis.

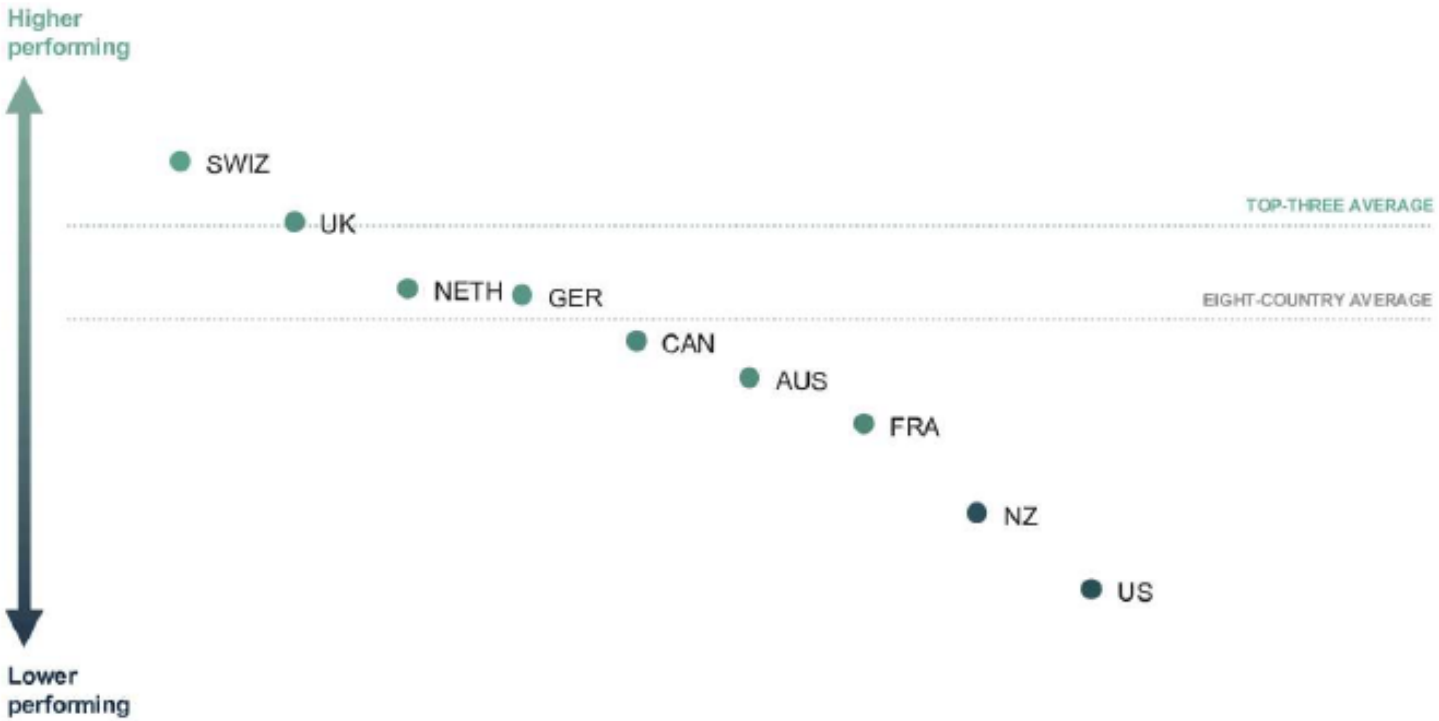
Source: David Blumenthal et al., *Mirror, Mirror 2024: A Portrait of the Failing U.S. Health System — Comparing Performance in 10 Nations* (Commonwealth Fund, Sept. 2024).
https://doi.org/10.26099/ta0g-zp66

▲ Illustration by Maria Corte

Mirror, Mirror 2024: A Portrait of the Failing U.S. Health System

Comparing Performance in 10 Nations

With expanded definition of equity, the U.S. and New Zealand continue to rank lowest.



Note: To normalize performance scores across countries, each score is the calculated standard deviation from, in this case, an eight-country average that excludes SWE and the US. See "How We Conducted This Study" for more detail.

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Illustration by Maria Corte

Mirror, Mirror 2024: A Portrait of the Failing U.S. Health System

Comparing Performance in 10 Nations

EXHIBIT 9 — *Health Outcomes*

Americans live the shortest lives and have the most avoidable deaths.

Note: To normalize performance scores across countries, each score is the calculated standard deviation from a nine-country average that excludes the US. See "How We Conducted This Study" for more detail.

Data: Commonwealth Fund analysis.

Source: David Blumenthal et al., *Mirror, Mirror 2024: A Portrait of the Failing U.S. Health System — Comparing Performance in 10 Nations* (Commonwealth Fund, Sept. 2024). https://doi.org/10.26099/ta0g-zp66

CNN Health

US ranks last on key health care measures compared with other high-income nations, despite spending the most, report says

By Jacqueline Howard, CNN

7 minute read · Published 12:01 AM EDT, Thu September 19, 2024

“We’re not getting the best value for our health care dollar,” **Dr. Georges Benjamin, executive director of the** American Public Health Association, who was not involved in either report, said last year.

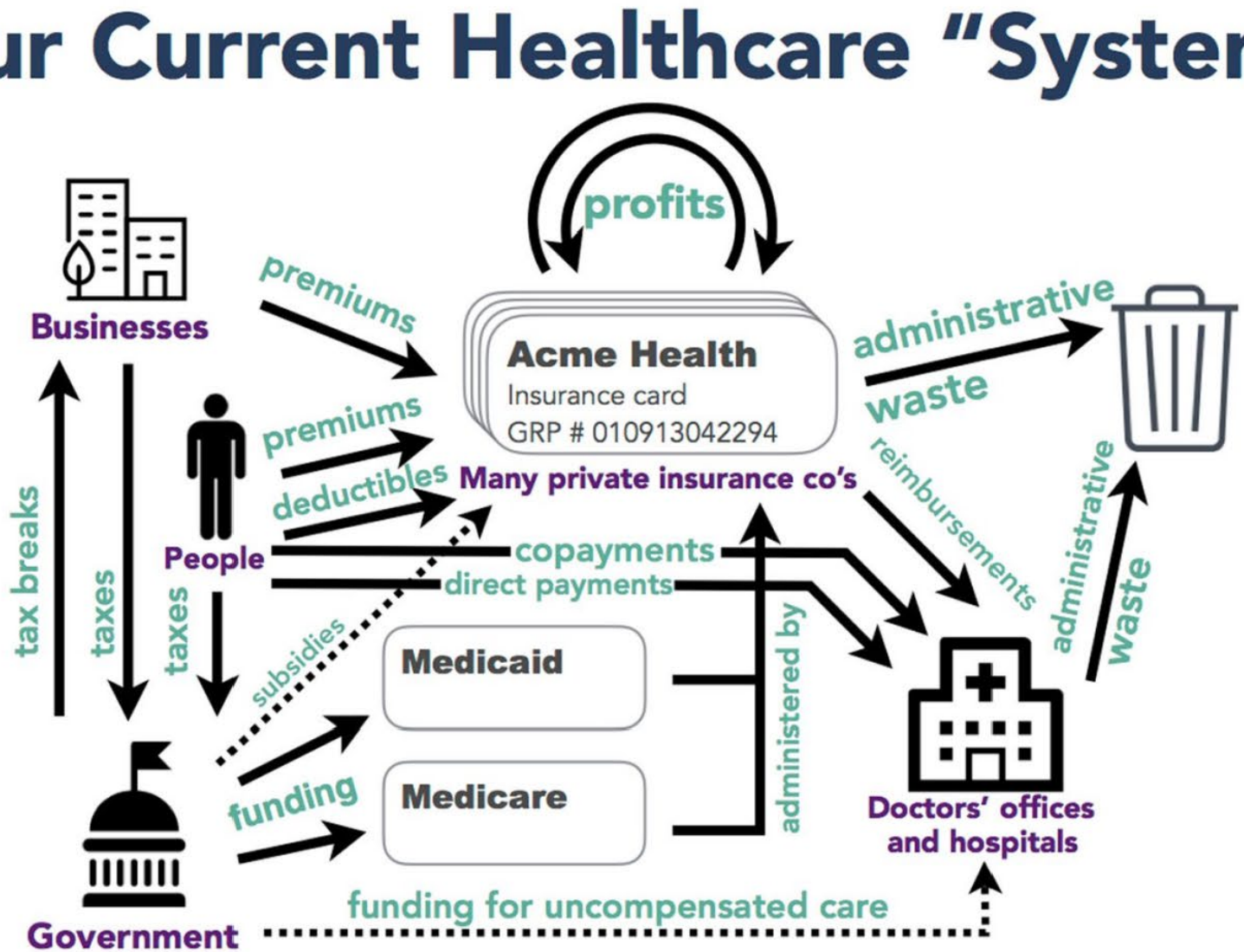
To help fix the holes in the US health care system, Benjamin said, there are three steps the nation can take.

(1) “We’re still the only nation that does not have universal health care or access for all of our citizens,” Benjamin said.

(2) Second, “we don’t do as much primary care prevention as the other nations, and we still have a public health system, which is fractured,” he said.

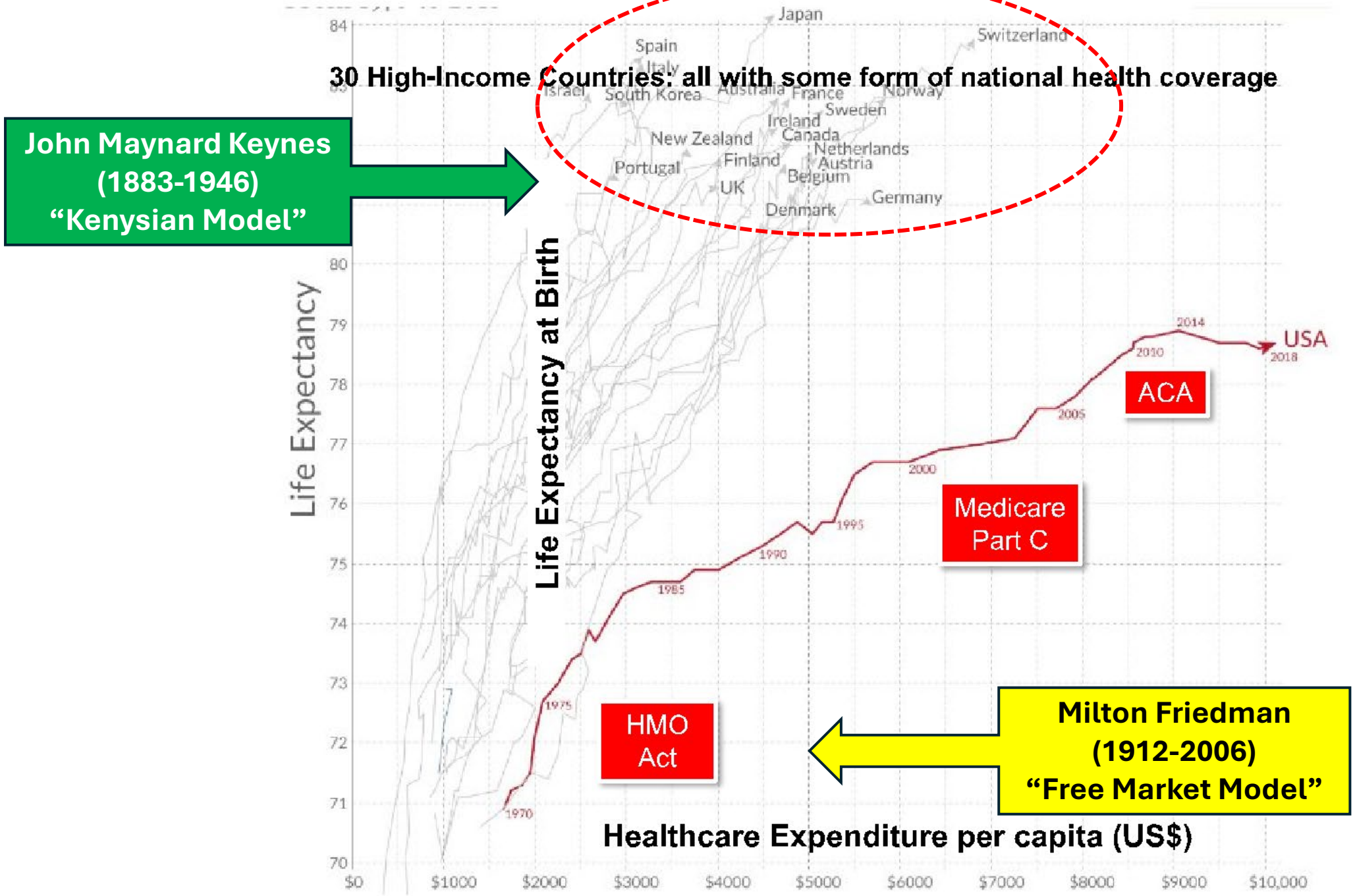
(3) “The third thing is, we under-invest compared to other industrialized nations in societal things. They spend their money on providing upfront support for their citizens. We spend our money on sick care.”

What About US Health Care During Same Time Period?



Private Equity: Profit by Financialization Strategies, Not Productivity

Bibliography: https://drive.google.com/file/d/1iiia0Cxj9AotmD6SLsDAXeDCTRO54swG/view?usp=sharing

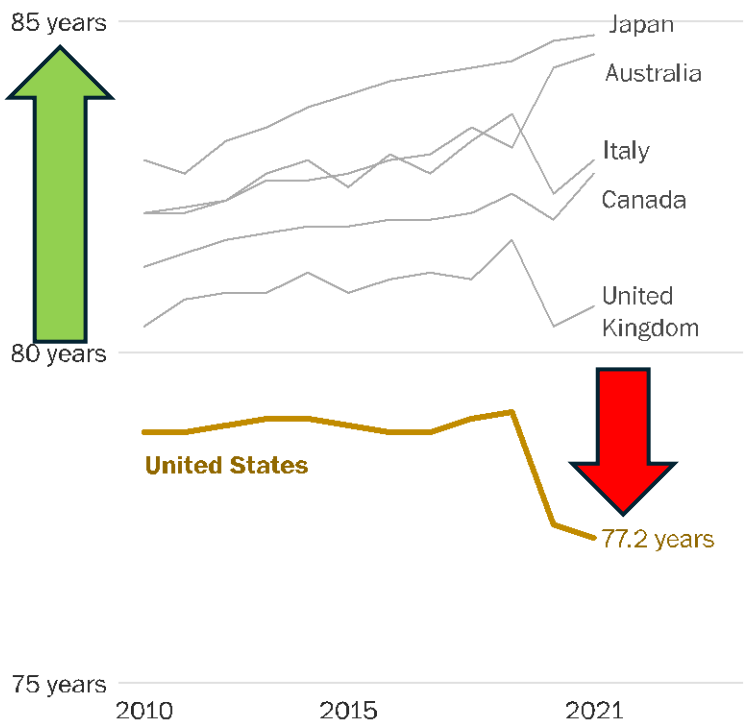

30 High-Income Countries: all with some form of national health coverage
John Maynard Keynes
(1883-1946)
"Kenysian Model"
Japan
Switzerland
Spain
Italy
Israel
South Korea
Australia
France
Norway
Sweden
Ireland
New Zealand
Canada
Netherlands
Portugal
Finland
Austria
Belgium
UK
Germany
Denmark
Life Expectancy
Life Expectancy at Birth
84
80
79
78
77
76
75
74
73
72
71
70
1970
1975
1985
1990
1995
2000
2005
2010
2014
2018
USA
ACA
Medicare
Part C
HMO
Act
Milton Friedman
(1912-2006)
"Free Market Model"
Healthcare Expenditure per capita (US$)
$0
$1000
$2000
$3000
$4000
$5000
$6000
$7000
$8000
$9000
$10,000

Opinion | American life expectancy is dropping — and it's not all covid's fault

By Steven H. Woolf and Laudan Aron

June 1, 2023 at 6:15 a.m. EDT

Life expectancy in selected countries



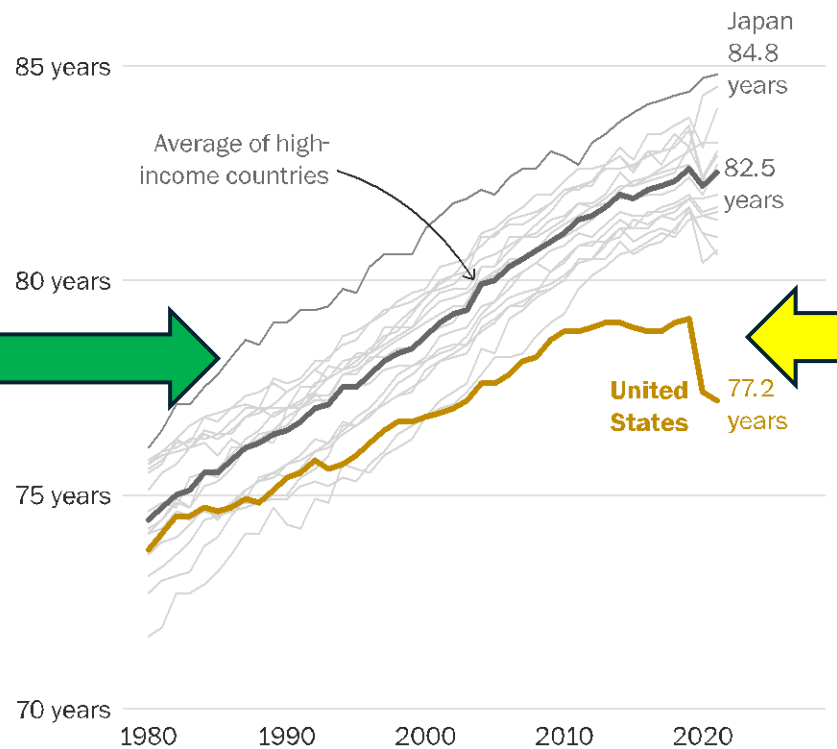
Source: United Nations, Department of Economic and Social Affairs, Population Division.

Opinion | American life expectancy is dropping — and it's not all covid's fault

By Steven H. Woolf and Laudan Aron

June 1, 2023 at 6:15 a.m. EDT

Life expectancy in wealthy countries



Source: United Nations, Department of Economic and Social Affairs, Population Division.

John Maynard Keynes (1883-1946) "Kenysian Model"

Milton Freidman (1912-2006) "Free Market Model"

UNDERSTANDING THE HEALTH INEQUITY PROBLEM

Reconstruction

The New York Times Magazine

Magazine | Why Doesn't America Have Universal Health Care? One Word: Race

By JENEEN INTERLANDI AUG. 14, 2019

The nation's first federal health care program served freedmen after the Civil War. From the beginning, white legislators argued it would breed dependence.

The 1619 Project examines the legacy of slavery in America. Read all the stories.

The New York Times Magazine

Magazine | Why Doesn't America Have Universal Health Care? One Word: Race

Reconstruction

The smallpox virus hopscotched across the post-Civil War South, invading the makeshift camps where many thousands of newly freed African-Americans had taken refuge but leaving surrounding white communities comparatively unscathed. This pattern of affliction was no mystery: In the late 1860s, doctors had yet to discover viruses, but they knew that poor nutrition made people more susceptible to illness and that poor sanitation contributed to the spread of disease. They also knew that quarantine and vaccination could stop an outbreak in its tracks; they had used those very tools to prevent a smallpox outbreak from ravaging the Union Army.

The New York Times Magazine

Magazine |Why Doesn't America Have Universal Health Care? One Word: Race

Reconstruction

Smallpox was not the only health disparity facing the newly emancipated, who at the close of the Civil War faced a considerably higher mortality rate than that of whites. Despite their urgent pleas for assistance, white leaders were deeply ambivalent about intervening. They worried about black epidemics spilling into their own communities and wanted the formerly enslaved to be healthy enough to return to plantation work. But they also feared that free and healthy African-Americans would upend the racial hierarchy, the historian Jim Downs writes in his 2012 book, "Sick From Freedom."

The New York Times Magazine

Magazine |Why Doesn't America Have Universal Health Care? One Word: Race

Reconstruction

White legislators argued that free assistance of any kind would breed dependence and that when it came to black infirmity, hard labor was a better salve than white medicine. As the death toll rose, they developed a new theory: Blacks were so ill suited to freedom that the entire race was going extinct. "No charitable black scheme can wash out the color of the Negro, change his inferior nature or save him from his inevitable fate," an Ohio congressman said.

Flexner Report

Reconstruction → Segregation

Background

During the nineteenth century, American medicine was neither economically supported nor regulated by the government.[12] Few state licensing laws existed,[13] and when they did exist, they were weakly enforced. There were numerous medical schools, all varying in the type and quality of the education they provided.

In 1904, the American Medical Association (AMA) created the Council on Medical Education (CME),[14] whose objective was to restructure American medical education. At its first annual meeting, the CME adopted two standards: one laid down the minimum prior education required for admission to a medical school; the other defined a medical education as consisting of two years training in human anatomy and physiology followed by two years of clinical work in a teaching hospital. Generally speaking, the council strove to improve the quality of medical students, looking to draw from the society of upper-class, educated students.[15]

In 1908, seeking to advance its reformist agenda and hasten the elimination of schools that failed to meet its standards, the CME contracted with the Carnegie Foundation for the Advancement of Teaching to survey American medical education. Henry Pritchett, president of the Carnegie Foundation and a staunch advocate of medical school reform, chose Abraham Flexner to conduct the survey. Neither a physician, a scientist, nor a medical educator, Flexner held a Bachelor of Arts degree and operated a for-profit school in Louisville, Kentucky.[16] He visited every one of the 155 North American medical schools that were in operation at the time, all of which differed greatly in their curricula, methods of assessment, and requirements for admission and graduation. Summarizing his findings, he wrote:[17]

Abraham Flexner

Flexner Report

Reconstruction → Segregation

Impact on African-American doctors and patients

The *Flexner Report* has been criticized for introducing policies that encouraged systemic racism .[2][3][4][31][32]

Flexner advocated for the closing of all but two of the historically black medical schools. As a result, only Howard University College of Medicine and Meharry Medical College were left open, while five other schools were closed. Flexner emphasized his view that black doctors should treat only black patients and should play roles subservient to those of white physicians. Flexner promoted the idea that African American medical students should be trained in "hygiene rather than surgery" and be employed as "sanitarians," with a primary role to protect white Americans from disease.[33] Flexner stated in the *Report*:[1]

> "A well-taught negro sanitarian will be immensely useful; an essentially untrained negro wearing an M.D. degree is dangerous."

Furthermore, along with his adherence to germ theory, Flexner argued that, if not properly trained and treated, African-Americans posed a health threat to middle and upper-class whites.[34] Flexner argued that African American physicians should be educated in order to stop the transmission of diseases among African Americans and to prevent the contamination of white people from those same diseases.[1]

Reconstruction → Segregation → Post WW II

JOSEPH C CHAPMAN, Sr

1st Executive Director (1945-1949)

Urban League Gary, Ind.

July 22,1947

ASK ADMISSION OF NEGRO M. D.'S TO HOSPITALS

Prejudices Analyzed at Meeting

After a careful analysis of the causes of racial feelings, Joseph Chapman, Urban League secretary, last night in a speech deplored the prejudices which keep Negro physicians and technical workers out of Gary hospitals.

Chapman spoke before the B'nai B'rith members at organization headquarters. He said hospital segregation practices here have kept fine doctors from coming to the community, and fine women from getting nursing experience.

The speaker, who was introduced by Samuel M. Terner, program chairman, opened his talk with a general analysis of all the things that make up racial prejudice.

Fear Ignorance Blamed

He said it was due to fear, ignorance and insecurity, and to the fact that people crave a feeling of superiority.

"Children are born without prejudices," he said. "But in older people the desire for money or prestige, when both are absent, too often gives way to accentuating racial differences in their search for a feeling of importance."

Chapman, who was heard by more than 150 members who crowded B'nai B'rith headquarters, drew word pictures of central district crime which he blamed to a great extent on crowded conditions and improper housing.

He added that poor health and disease there resulted from those things, plus lack of adequately trained medical personnel here, and lack of facilities.

Hospitals Stand Cited

Pointing out that Gary's two top rated hospitals will admit Negro patients, but will not admit Negro physicians and Negro nurses, he said:

"I feel we can hope for enlightened progress in both these hospitals because of growing evidences of current intelligent, Christian thinking."

Those thought trends however do not alter the fact that at the present time there are Negro physicians in Gary qualified by training and experience to attend their patients in any hospital, he said.

"There are young Negro women in the community eligible for nurse training who are now barred from such experience here.

"Some well-trained Negro medics refuse to come to Gary because they lack first class facilities for operating," he said.

Chapman said that the Negro here, in his frustration, was seeking to establish hospital facilities which, because of inadequate funds, can be only a second rate substitute for the best.

Solution Offered

"The answer," he claimed, "is in breaking through the prejudices that prevent trained Negroes from using Gary hospital facilities."

To those who might say it can't be done, Chapman said his reply is "experience belies such a statement."

He cited Sydenham hospital in New York City. Two years ago, according to Chapman, the hospital inaugurated an inter-racial policy that has brought to light a number of interesting facts.

Negro and white internes in the hospital now live together and work together. Of the several who threatened to quit when the innovation was made, none resigned.

There has been a 25 percent increase in white patients there in the last two years. Negroes have begun to use private rooms heretofore barred to them. Not one white patient has objected to sharing a semi-private room with a Negro.

Results Cited

Since the new policy began, several Negro physicians have been admitted to the College of Physicians and Surgeons, something never before allowed.

Patients, asked for criticism, rarely mention the interracial aspect of the hospital.

In his conclusion, Chapman became optimistic as he looked to the future. He said that in spite of the picture of glaring evils one could draw, there were many phases of recent developments to which one could point with pride.

The National YWCA has abolished segregation, and the Federal Council of Churches has broken through many of its prejudices, he said.

Women Voters Take Stand

The League of Women Voters at the Kansas City convention two weeks ago refused to meet where Negroes would not be admitted.

All these things carry emphatically the conviction that racial differences can be ironed out, and that they are being carried out, Chapman asserted. He claimed that the solution to international problems begins in the community, and that in Gary there is a strong trend toward community-problem solutions.

In a business meeting that preceded the Chapman talk, a report on the state B'nai B'rith convention in Indianapolis was given by Arnold A. Weiner. Dave Levy, president of the organization, presided at the meeting.

AIRS URBAN PROGRAM

Officers of B'nai B'rith show their interest as Joseph Chapman, Urban League executive secretary, lists specific points in the speech he gave last night on race relations. From left to right are David R. Levy, organization president; Chapman, and Samuel M. Terner, program chairman.

GARY POST TRIBUNE

MAY 22, 1946

off ⅛
off ¼

THE GARY POST-TRIBUNE

7 TWO SECTIONS GARY, INDIANA, TUESDAY, JULY 22, 1947

Methodist Hospital O.Ks. Negro Medics

Action Follows Staff Approval; Year's Probation for Applicants

The Methodist hospital board announced today the lifting of long-standing restrictions against practice by Negro physicians within that institution.

The board action, taken yesterday and following by nearly two weeks a similar move at Mercy hospital, was made public with the following formal announcement:

"The board of directors of the Methodist hospital at their regular quarterly meeting last night, acting upon the recommendation of the medical staff, voted unanimously to make all appointments to the staff on the basis of qualifications alone without regard to race, creed or color."

Eligible to Apply

It probably will be October before any Negro physicians actually will begin practicing at the hospital.

While Negro doctors may request application blanks for staff membership at any time now, hospital officials said that some time would be required for a thorough background investigation of qualifications and that no formal action can be taken on appointment until the next board meeting in three months.

As in the case of Mercy hospital, Negro physicians admitted to practice will undergo a customary period of one year's probation. During that time, for example, no Negro physician can perform a major operation except when a regular staff member is present to observe.

Negro patients long have been admitted to both of Gary's major hospitals and the action to permit practice by Negro doctors was the culmination of a long, quiet campaign.

Financial Report

The Methodist board also made public after its meeting a semi annual financial statement showing an increase in revenue which was more than offset by an increase in expenses.

The hospital finished the year with a net of $12,127.84, but Milo Anderson, hospital manager, pointed out that all funds for improvement must come from that fund and that it should be at least $50,000 a year to place the hospital on a sound financial basis.

Methodist, along with Mercy and Patients hospitals, is now seeking to be added to the list of Gary Community Chest beneficiaries. The question is being considered by a committee of 29 representative citizens expected to report within the next 10 days.

The hospital's financial statement showed total earnings from January through June of $384,-672.38, about 22 percent above the $314,849.49 figure for the same period in 1946.

Expenses Higher

However, expenses rose approximately 24 percent to $271,945.32 in the same six months period over $220,664.85 in the first half of last year.

The net a year ago was $15,164.64, was $3,666.78 higher than this

months budget had called
of $350,454, expenses of
d a net loss of $2,876.
some figures included
In charges to patients
$1.25 for bad debts and
for deductions, plus $19.-
after earnings. Outgo was
for operating expenses
16.93 for non-operating ex-

Negro Doctors Get Mercy Hospital OK

Lay Board Votes Approval; Methodist Action Is Expected Soon

The lay board of Mercy hospital has voted to permit practice by qualified Negro physicians within that institution, and similar action is expected at Methodist hospital.

The Mercy board's decision, culminating a long quiet campaign, was taken unanimously, the Post-Tribune learned. The board's formal action was approval of a recommendation made by the community of sisters which operates the hospital.

Neither A. C. Colby, chairman of the Methodist hospital board, nor Milo Anderson, hospital manager, could be reached today for direct comment.

However, a board spokesman said unofficially that members had been working quietly toward the same goal for some time in conjunction with the Mercy board and that early action could be anticipated.

Formal notification of the Mercy ruling will be made to members of the hospital's medical staff probably late today or tomorrow.

It will be up to the medical groups in both institutions to pass on the qualifications of Negro physicians applying for permission to practice.

Any Negro physician may now apply at Mercy for permission to take advantage of the liberalization of previous restrictions.

After the filing of the application an investigation will then be made to determine whether the applicant meets medical and surgical requirements of the Lake County Medical society and the American Medical association. Only those meeting these requirements which apply to all applicants will be admitted.

Members of the board which acted to remove the previous restrictions are Capt. H. S. Norton, Fred Cassidy, E. M. Jenks, M. J. Coyle, John Fadigan and Judge Fred Egan.

St. Catherine's hospital in East Chicago, operated by the same community of Catholic sisters which operates Mercy here, has admitted Negro physicians to visit and treat patients there for some time.

There was some conjecture in East Chicago today as to whether the Mercy action might result in lifting of the long-standing St. Catherine's restriction against performance of surgery by Negro doctors. However, no official available today would comment.

Post-Tribune July 19, 1947

Post-Tribune July 22, 19

Dr. Martin Lovell Named To Staff Of Mercy Hospital

GARY—Dr. Martin H. Lovell, 1606 Broadway, was appointed to the staff of Mercy Hospital recently, and became the second Negro to be admitted to practice or gain admission to the staff of that institution.

Dr. Lovell did his preliminary training in New England, where he was graduated from Mount Herman Boys School, Northfield, Mass., after which he completed his premedical training at Boston University. He then attended and graduated from Meharry Medical College and Hubbard Hospital, Nashville, Tenn.

At present Dr. Lovell is doing post-graduate work in obstetrics and gynecology at Cook County Graduate School of Medicine in Chicago. He has been practicing medicine in Gary for seven years, having come to this city from Cincinnati.

He is active in church and civic affairs, and is a member of the steward board of Israel CME Church; a member of the board of directors of the Visiting Nurses' Association, Lake County Lodge of Elks, and Omega Psi Phi Fraternity.

His wife, Mrs. Martha Lovell, is a teacher at Roosevelt school.

Reconstruction → Segregation → Pre Civil Rights

Answer Man Delves Further Into the History of D.C. Hospitals That Are No More

Many alumnae of **Adams Hospital, at 1520 Ninth St. NW,** wrote in after last week's question from Jacqueline Brown about the hospital. Frances Carter Johnson wrote to say that Jacqueline wasn't "possibly born there due to segregation," but "definitely.“ "How do I know?" Frances wrote. "I had my tonsils and adenoids removed there in 1942 at the age of seven. The operation was performed there because my doctor, Dr. Bruce , could not practice at any 'white' hospital in D.C."

Frances pointed out that **Dr. Edward C. Mazique** was one of the first two African American doctors allowed to practice at **Georgetown University Hospital in 1954**. "The color line had thus been broken," she wrote. "I believe that Adams Hospital was no longer needed."

12/15/23 Med Schools Are Struggling to Overcome Racism in Health Care | TIME

TODAY

The Association of American Medical Colleges(AAMC) has since acknowledged the harm caused by the Flexner report, but itsinfluence on medical education is still felt today—perhaps most painfully inthe shortage of Black physicians in the U.S., who make up just **5%** of the doctor workforce. Closed Black medical schools could have trained approximately 35,000 additional Black physicians by 2019, one study found.

VIEWPOINT

AI IN MEDICINE

TODAY

JAMA 10/1/2024

Addressing AI Algorithmic Bias in Health Care

Raj M. Ratwani, PhD
MedStar Health Research Institute, Washington, DC; and Georgetown University School of Medicine, Washington, DC.

Karey Sutton, PhD
MedStar Health Research Institute, Washington, DC.

Jessica E. Galarraga, MD, MPH
Georgetown University School of Medicine, Washington, DC; and MedStar Health, Columbia, Maryland.

As artificial intelligence (AI) algorithms become an increasingly integral part of health care, ranging from diagnostic decisions and treatment plans to population health management, it is vital that rigorous processes to mitigate algorithmic bias are established.[1,2] Addressing bias is not only about ensuring fair and just opportunities for optimal health outcomes but also about promoting universal safeguards for patient safety. Biased AI algorithms can result in certain patient populations not receiving appropriate care, potentially leading to significant harm. Previously, an AI algorithm developed to proactively support patients by predicting additional complex care needs yielded biased results along racial lines. The algorithm used health care costs as its target variable, underrepresenting Black patients due to systemic barriers in access to care despite their having a significant burden of illness. The algorithm may have regorithms that could benefit their communities due to the inability to assess for bias. Alternatively, underresourced facilities without internal AI expertise may rely on AI developers for assurances that their algorithms have been assessed for bias and, despite the best intentions, introduce algorithms that result in biased outcomes without their awareness. Both scenarios could exacerbate health inequities in underresourced communities, underscoring the imperative for equitable access and support in developing processes to mitigate AI algorithmic bias.

The ability to mitigate algorithmic bias can be significantly enhanced through a model of shared responsibility. In this model, all key partners, including health care facilities, AI developers, and regulatory bodies, take action to address bias. This approach supports underresourced facilities adopting valuable AI algorithms for clinical care and provides greater rigor in bias control

TODAY

JAMA
10/1/2024

VIEWPOINT

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[redacted] Biased AI algorithms can result in certain patient populations not receiving appropriate care, potentially leading to significant harm. Previously, an AI algorithm developed to proactively support patients by predicting additional complex care needs yielded biased results along racial lines. The algorithm used health care costs as its target variable, underrepresenting Black patients due to systemic barriers in access to care despite their having a significant burden of illness. The algorithm may have reduced the number of Black patients identified for extra care by more than one-half.[3]

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Pediatrician Alexandra Epee-Bounya raised questions about the use of race in a tool used by Boston Children's Hospital clinicians to judge the risk of urinary tract infections in very young children.
KAYANA SZYMCZAK FOR STAT

A STAT INVESTIGATION

[EMBEDDEDBIAS]

Doctors use problematic race-based algorithms to guide care every day. Why are they so hard to change?

By Katie Palmer *and* Usha Lee McFarling

Sept. 3, 2024

TODAY

But a STAT investigation found that race-based algorithms are still widely used across medicine, on millions of patients a year. Growing numbers of clinicians, researchers, and health care leaders argue that it is wrong to consider people of different races as biologically different, and to incorporate those outdated notions into clinical tools. They had early successes, as in Boston, but now are confronting powerful headwinds, including challenges from the political right. "The minute it's no longer in vogue, we don't hear about it," said Epee-Bounya.

That's only part of the explanation. In more than a hundred interviews with clinicians and researchers, STAT found a health care system struggling to reassess its scientific and ethical assumptions about race. Clinicians have been locked in fierce debates about the best way to modify their tools to reduce harm and create fairer outcomes for patients. If race is scratched out of a tool, it's often an exasperating process to get the revamped version used consistently across America's disjointed health care system. And there's currently no way to enforce standards for how race is used by clinicians or researchers.

Race-based calculators became a flashpoint after the murder of George Floyd in 2020, which ignited a movement for racial justice that rippled into medicine. Lawmakers and scientists issued calls to eliminate clinical tools that perpetuate bias and may harm patients of color. A kidney health calculator kept Black patients from receiving needed transplants. Lung function testing with race corrections led to missed diagnoses of severe pulmonary disease. And in all likelihood, UTI guidelines for little kids — created to avoid subjecting them to needless catheterizations — left Black girls with undiagnosed infections, and in some cases, long-term kidney damage. Since then, a handful of race-based calculators used nationally have been revised, and several more are subject to debate.

Is there a common thread in the following statements during the height of the COVID Epidemic?:

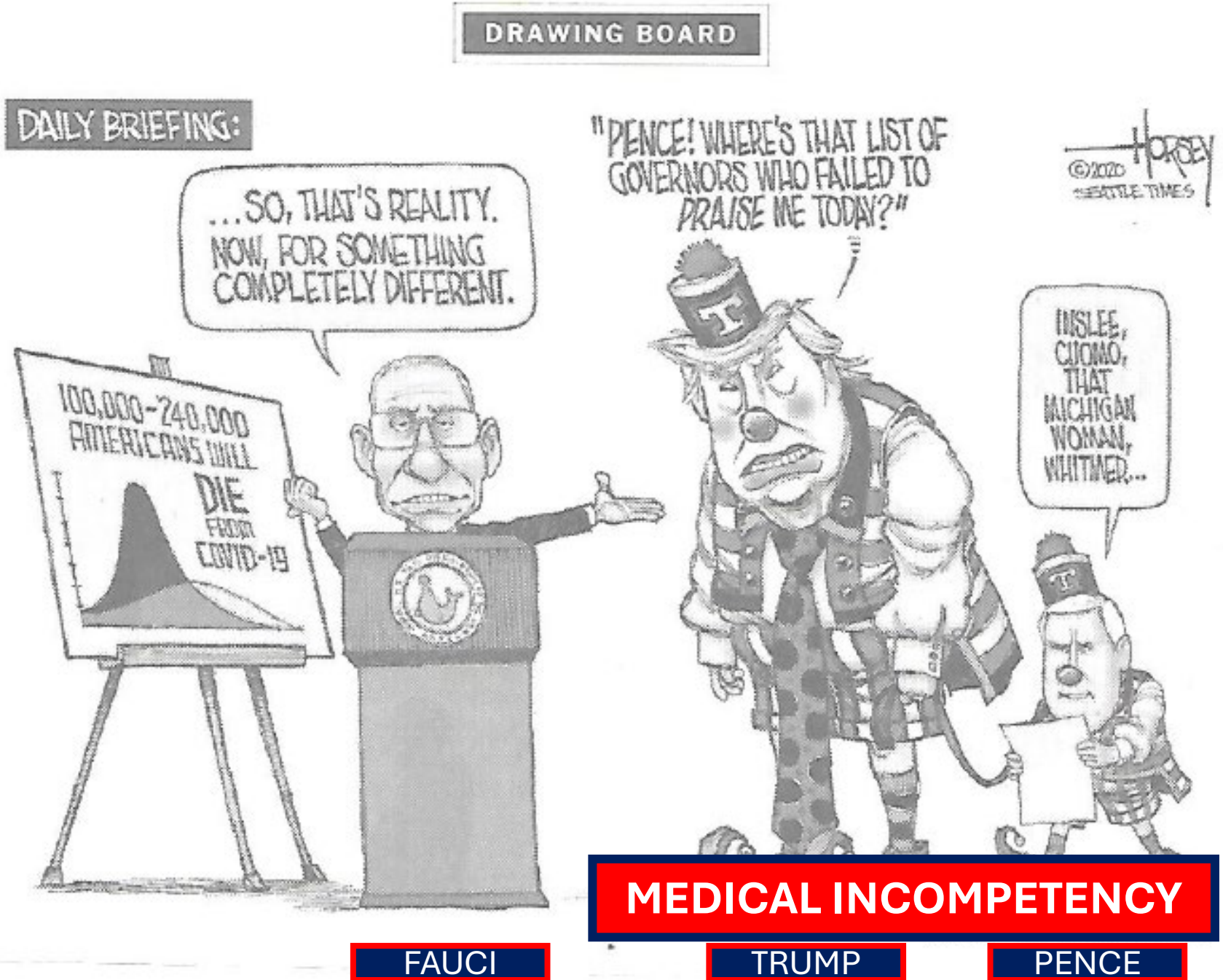
(1) A Lawyer and the Lt. Governor of Texas Suggest Seniors Should Sacrifice for the Good of the Country ....and

(2) President Trump Said "that's life!" in reference to the shortcomings in COVID-19 supplies, access to care, and his goal to prematurely reopen businesses:

Value of a Statistical Life (VSL)

Remember, there is an economic upside to Trump's selective "do nothing" approach on the COVID-19 and opioid crisis. **Both epidemics disproportionately impact vulnerable populations: the old, homeless, unemployed, and addicted. Cynically speaking, eugenicists would calculate that one saves money when certain people (non-productive or economically useless people) die by reducing costs related to Medicare and/or Medicaid, Social Security, welfare,** or other social supports related to a person's indelible biological footprint. In other words, one can achieve certain goals simply by doing nothing for economically targeted selected populations. Likewise, one could even theorize that Trump might ignore imported fentanyl from China since it accelerates and achieves a non-verbalized goal and perception that addiction is not a disease ("it's a moral failing") and... that "they did it to themselves." This approach to life, as clearly demonstrated in previous actions and inactions indicates that at certain points in the COVID crisis that he valued money over people and admittedly "does not take responsibility for anything!"

EDWIN C CHAPMAN, MD



"Cognitive Dissonance"
or
"Alternative Facts "
(Kellyanne Conway)
are
simply lies perpetrated without a scientific basis !!

TRUMP ADMINISTRATION'S "2016-2020" HEALTHCARE & OPIOID TREATMENT CONUNDRUM

PRES. DONALD TRUMP

"Lock'um Up!!

JEFF SESSIONS – Attny Gen

EUGENICS by FIAT

DR. PRICE – HHS Sec.

"Medication Treatment Simply Replaces 1 drug for another!!"

"Able Bodied Should Work to Get Medicaid!!"

SEEMA VERNA – CMS

VP MIKE PENCE

"Needle Exchange Encourages Drug Use !!"

Edwin C. Chapman, MD

Racism was called a health threat. Then came the DEI backlash.

A growing number of institutes exploring the nexus between racism and health — and their researchers — are under attack.

15 min 1872

By Akilah Johnson

October 11, 2024 at 9:00 a.m. EDT

David R. Williams and Rachel Hardeman are population health researchers at different universities with one thing in common: Both have been added to a right-wing "watch list" for teaching about and researching the ways racism affects health.

DEI = DIVERSITY- EQUITY-INCLUSSION

VS.

DIE = DOMINACE-INCOMPETENCE-EXCLUSSION

and

NO TEACHING CRT

Panelists

Dr. Edwin C. Chapman, *Private Practice, Internist, Addiction Medicine, Washington, DC*

Dr. Edwin Chapman

Dr. Chapman presented "The Opioid Crisis and the Black Community." He started his presentation by analyzing the current state of health care in the United States. He referred to it as a "eugenics model." He provided evidence that the nation's health care system is based on the idea that some people deserve to get care and others do not. Basically, some lives are worthier of preserving than others. Typically, poor people, people of color and people who are on Medicaid in general, are considered to be undeserving of care. Dr. Chapman cited several states that are trying to exclude people from Medicaid and health care by implementing a work requirement. Dr. Chapman noted that this "eugenics model" has affected the national response to the opioid epidemic. Specifically, before the opioid epidemic began to affect rural white communities, the solution for African Americans who were addicted to drugs was to incarcerate them. Dr. Chapman also provided statistics that showed that opioid overdoses, while typically believed to be a "white problem," are rampant in the African-American community due to PTSD, racism and other social determinants, such as the lack of affordable housing, crime and violence. Dr. Chapman concluded that the same treatments and resources proposed to solve opioid overdoses in white communities should be extended to African-American communities. He cited the treatment models in France and Portugal as examples of how the United States could begin to solve the opioid epidemic.

Community Wide "TOXIC STRESS"

Homelessness

Mental Illness

Substance Use Disorder

Criminal Activity

Unemployment

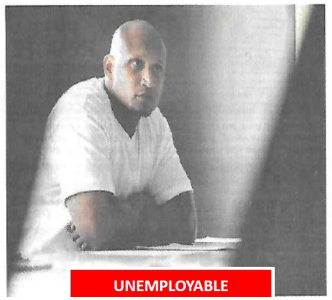
After prison, more punishment

Legal hurdles can make it impossible for the formerly incarcerated to obtain the jobs they've trained for

BY TRACY JAN

PROVIDENCE, R.I. — He had spent 17 of his 46 years behind bars, locked in a pattern of addiction and crime that led to 16 prison terms. Now, Meko Lincoln pushed a cart of cleaning supplies at the reentry house to which he had been paroled in December, determined to provide for his grandchildren in a way he failed to do as a father.

"Keep on movin', don't stop," Lincoln sang, grooving to the British R&B group Soul II Soul on his headphones as he emptied trash cans and scrubbed toilets at Amos House. He passed a bulletin board plastered with hiring notic-



record, but not enough for him.

Lincoln, who is training to be a drug and alcohol counselor, wants those lost years to count for something more.

"I lived it," he said. "I understand it. My past is not a liability. It's an asset. I can help another person save their life."

Yet because regulations in Rhode Island and most other states exclude people with criminal backgrounds from many jobs, Lincoln's record, which includes sentences for robbery and assault, may well be held against him.

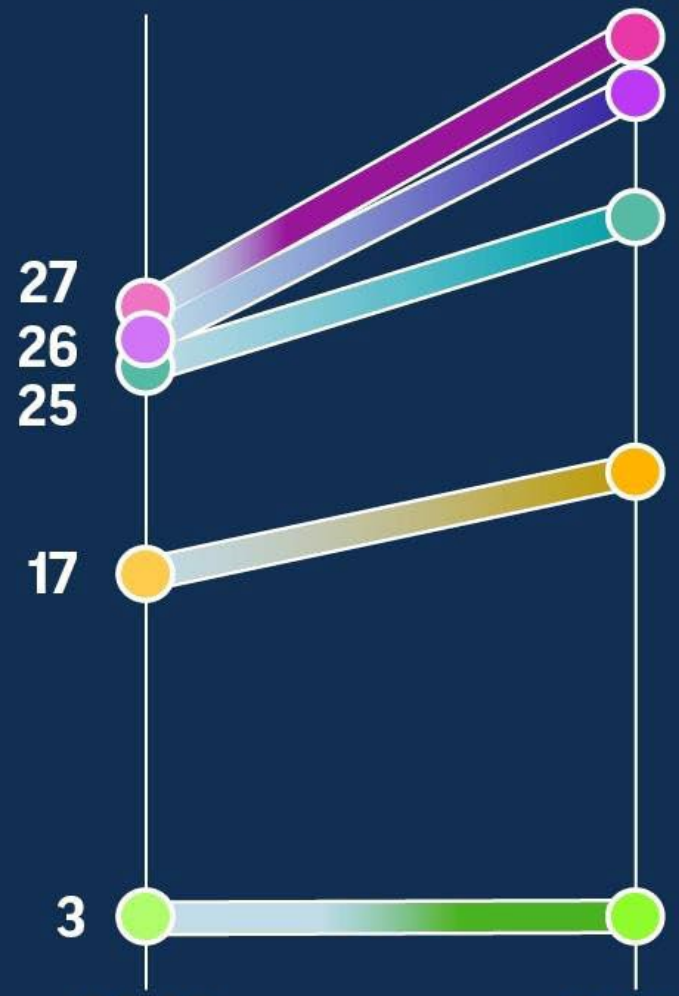
Across the country, more

"In the capital city Washington, DC, three out of four young African American males are expected to spend time in prison." (11)

(11) Donald Braman, *Doing Time on the Outside: Incarceration and Family Life in Urban America* (Ann Arbor: University of Michigan Press, 2004) p.3

OVERDOSE DEATHS

Per 100,000 People



39 Black/Non-Hispanic

36 American Indian, Alaska Native/ Non-Hispanic

31 White/Non-Hispanic

21 Hispanic

3 Asian, Pacific Islander/ Non-Hispanic

The Washington Post

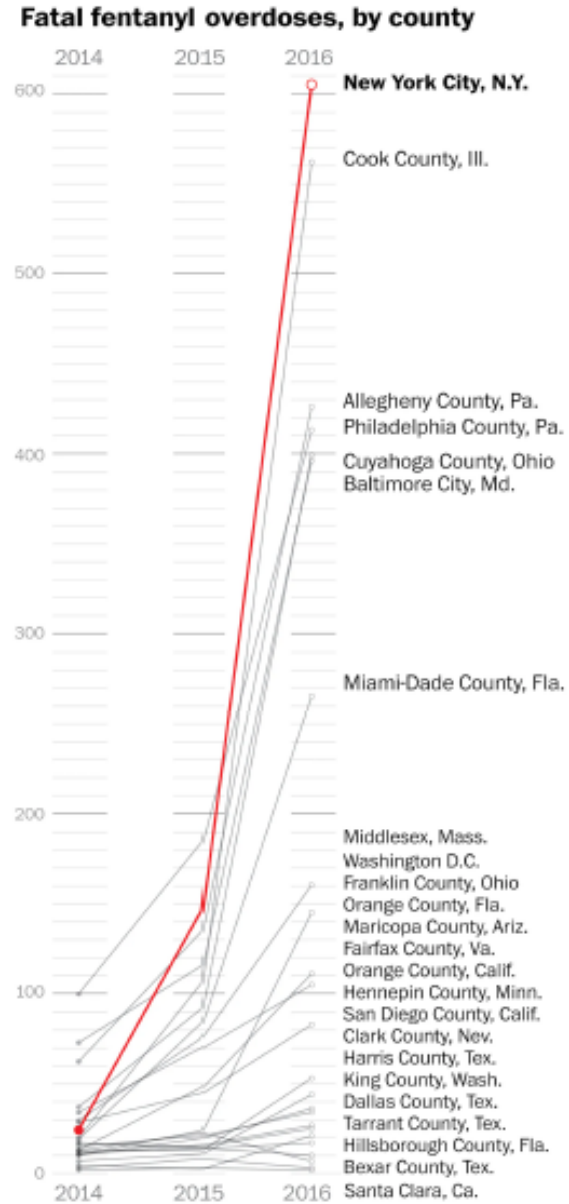
National

Fentanyl linked to thousands of urban overdose deaths

In two dozen of the nation's largest cities, fentanyl is becoming a major part of the national opioid crisis

An empty chair sits near train tracks in Philadelphia's Kensington neighborhood, where opioid abusers have littered the ground with needles and other trash. Fentanyl was responsible for more than 400 overdose deaths in Philadelphia last year. (Salwan Georges/The Washington Post)

By Nicole Lewis, Emma Ockerman, Joel Achenbach and Wesley Lowery
Aug. 15, 2017



Source: The Post requested fatal drug overdose data from 40 of the nation's most populated counties and received data from 24 of them, shown above.

THE WASHINGTON POST

Implementing Best Practices Across the Continuum of Care to Prevent Overdose

Project Team:

- Marianne Gibson, Program Director, Behavioral Health, NGA Center for Best Practices
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- Erin Daneker, Policy Analyst, Public Safety & Legal Counsels, NGA Center for Best Practices
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- Leo Luberecki, O'Neill Institute at Georgetown University Law Center
- Madison Fields, O'Neill Institute at Georgetown University Law Center

A Roadmap for Governors

Acknowledgements

NGA would like to thank the following subject matter experts, including several representing states, who contributed to the roundtable event held in March 2023, *Optimizing a Continuum of Care and Opioid Settlement Funds to Address Overdose.* Information shared at this event was used to develop the Roadmap.

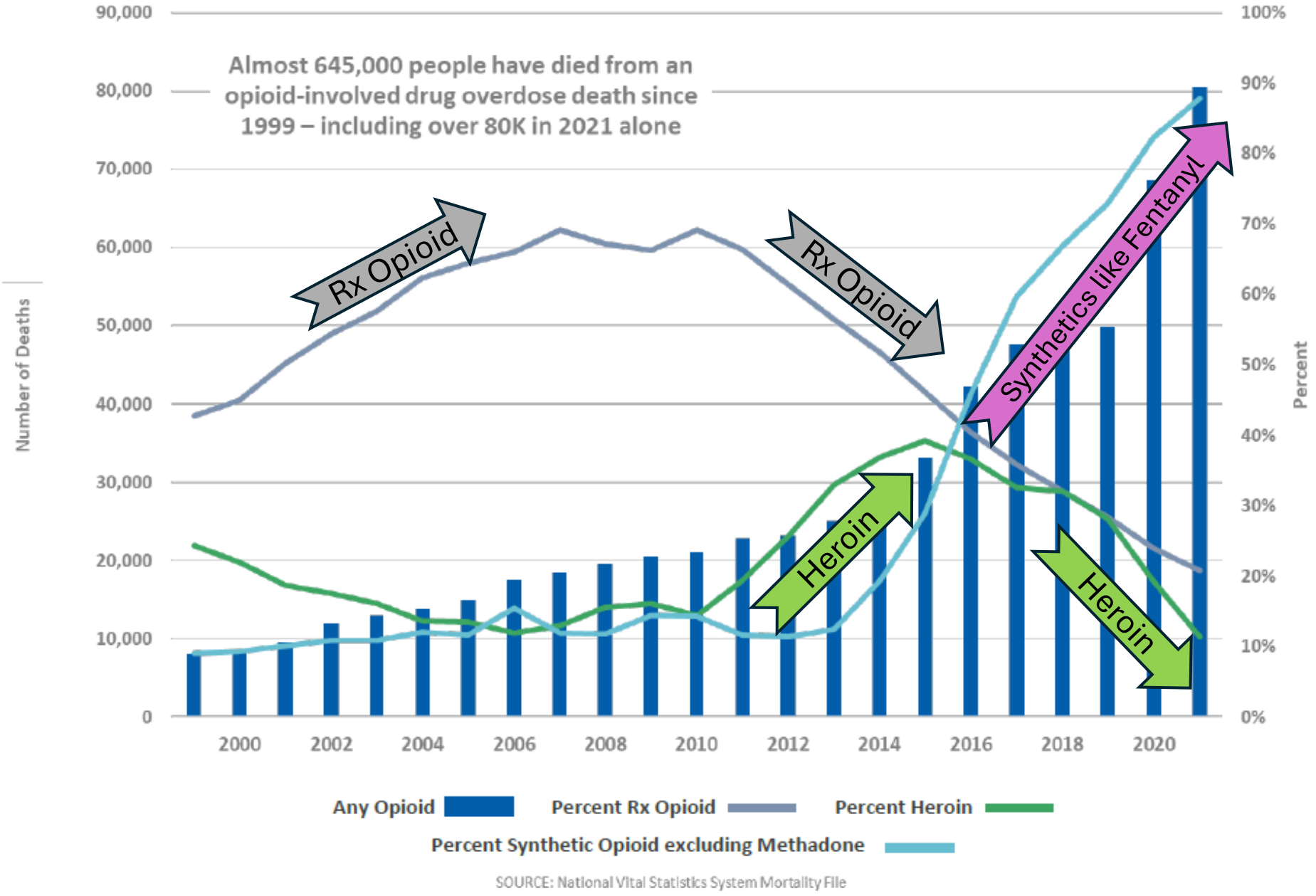
- Brittney Allen (Kentucky)
- Katherine Marks (Kentucky)
- Michael Baier (Maryland)
- Annaliese Dolph (Oregon)
- Seth Eckel (Michigan)
- Jonathan Holth (North Dakota)
- Doug Huntsinger (Indiana)
- Steven Mange (North Carolina)
- Lauren Nocera (Rhode Island)
- Marlies Perez (California)

- Grant Baldwin (CDC)
- Redonna Chandler (NIDA)
- Edwin Chapman (Leadership Council for Healthy Communities)
- Tom Coderre (SAMHSA)
- José Esquibel (University of Colorado)
- Diana Fishbein (University of North Carolina Chapel Hill)
- Kimberly Freese (SAMHSA)
- Michele Gilbert (Bipartisan Policy Center)
- Traci Green (Brandeis University)
- Katie Greene (NASHP)
- Samantha Karon (NaCo)
- Amanda Latimore (American Institutes for Research)
- Stephen Loyd (Cedar Recovery)
- Robert Morrison (NASADAD)
- Kristen Pendergrass (Shatterproof)
- Philip Rutherford (Faces and Voices of Recovery)
- Brendan Saloner (JHU BSPH)
- Andrew Whitacre (Pew)
- Rachel Winograd (University of Missouri at St. Louis)

Implementing Best Practices Across the Continuum of Care to Prevent Overdose

A Roadmap for Governors

Historical Trends in U.S. Opioid-Involved Drug Overdose Deaths - 1999-2021[12]



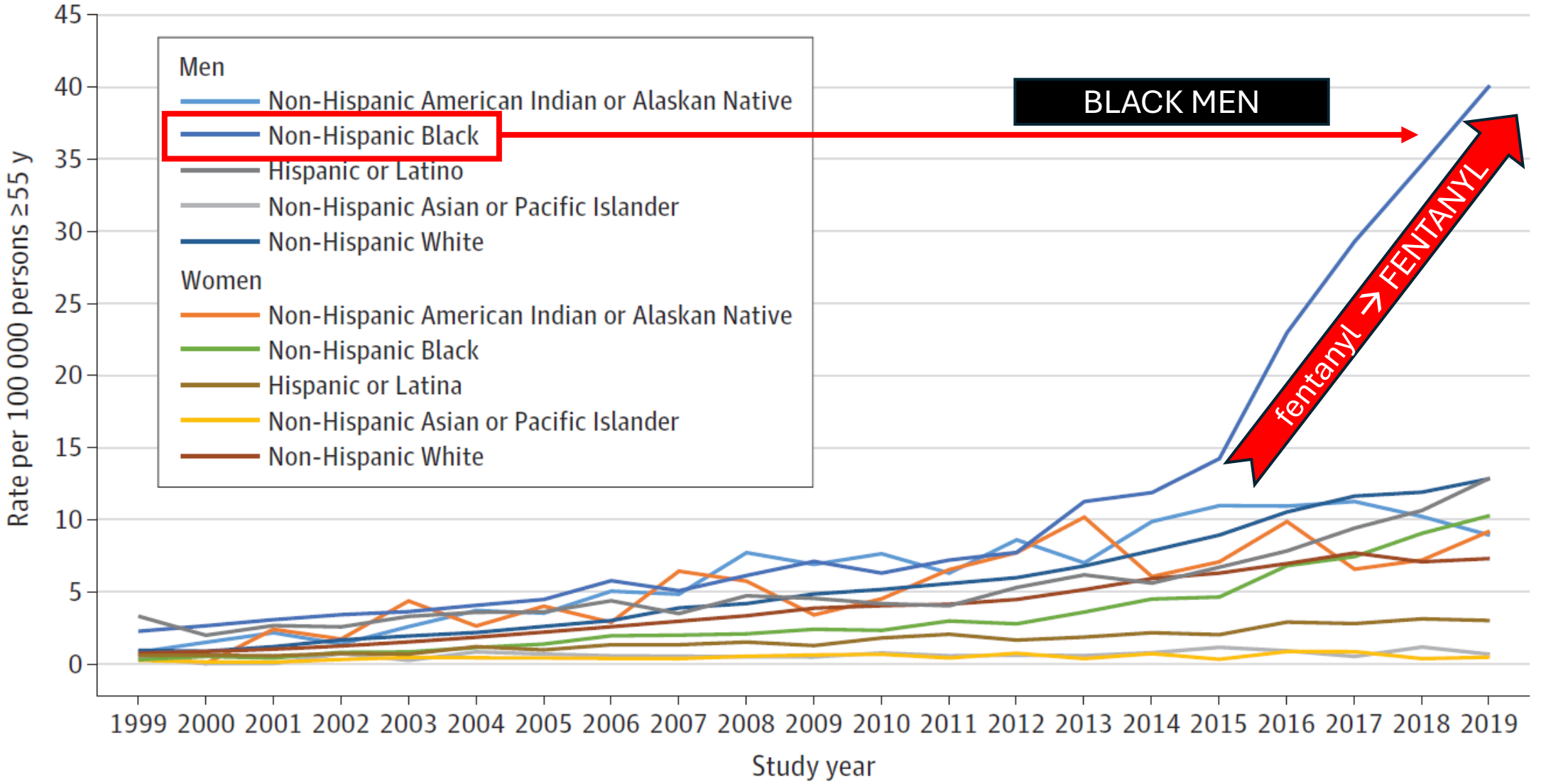
SOURCE: National Vital Statistics System Mortality File

JAMA Network Open
Original Investigation | Substance Use and Addiction

Disparities by Sex and Race and Ethnicity in Death Rates Due to Opioid Overdose Among Adults 55 Years or Older, 1999 to 2019

Maryann Mason, PhD; Rebekah Soliman; Howard S. Kim, MD, MS; Lori Ann Post, PhD

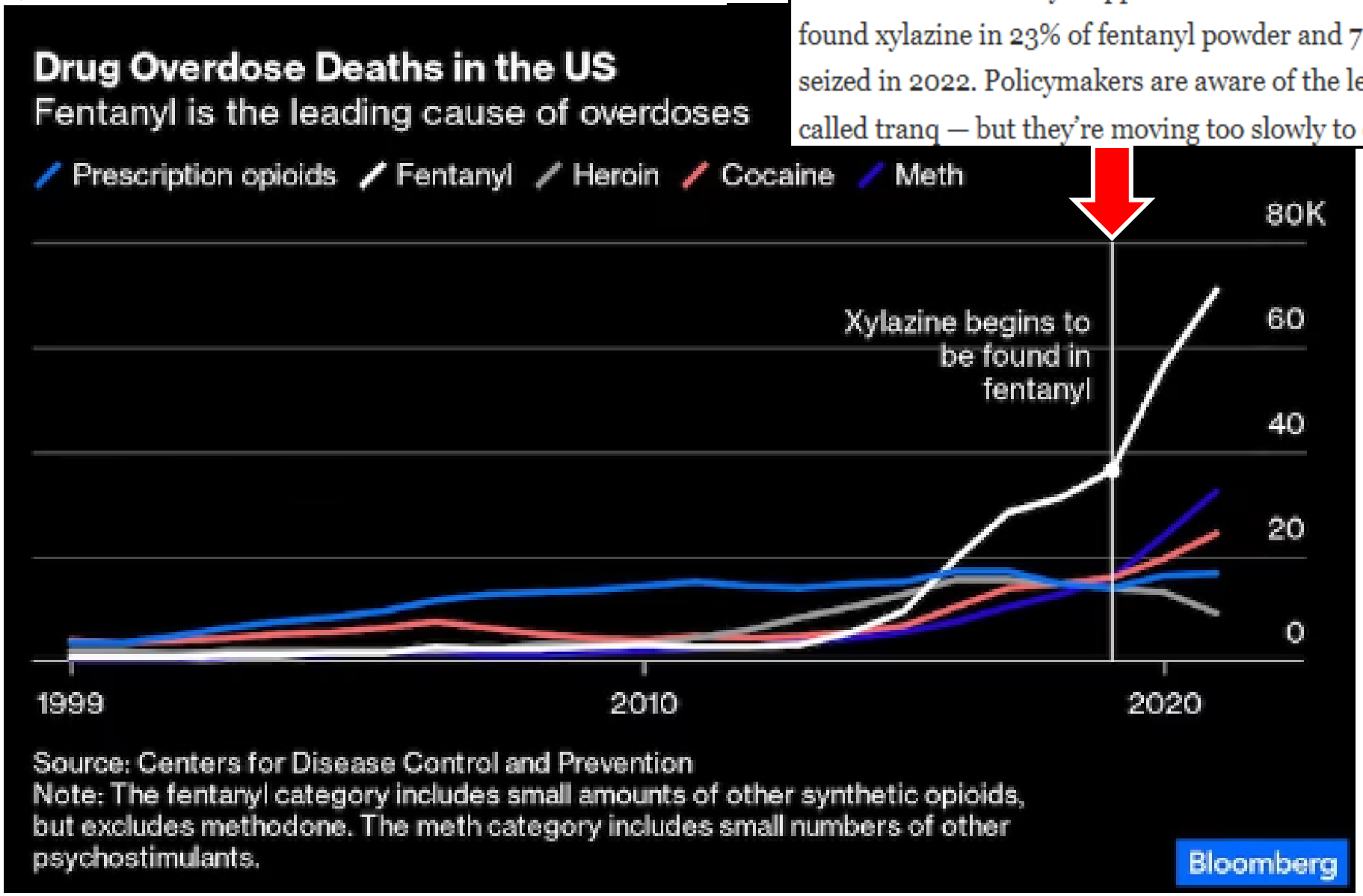
Figure 2. Rates of Opioid Overdose Deaths per 100 000 Persons 55 Years and Older by Sex and by Race and Ethnicity, 1999 to 2019

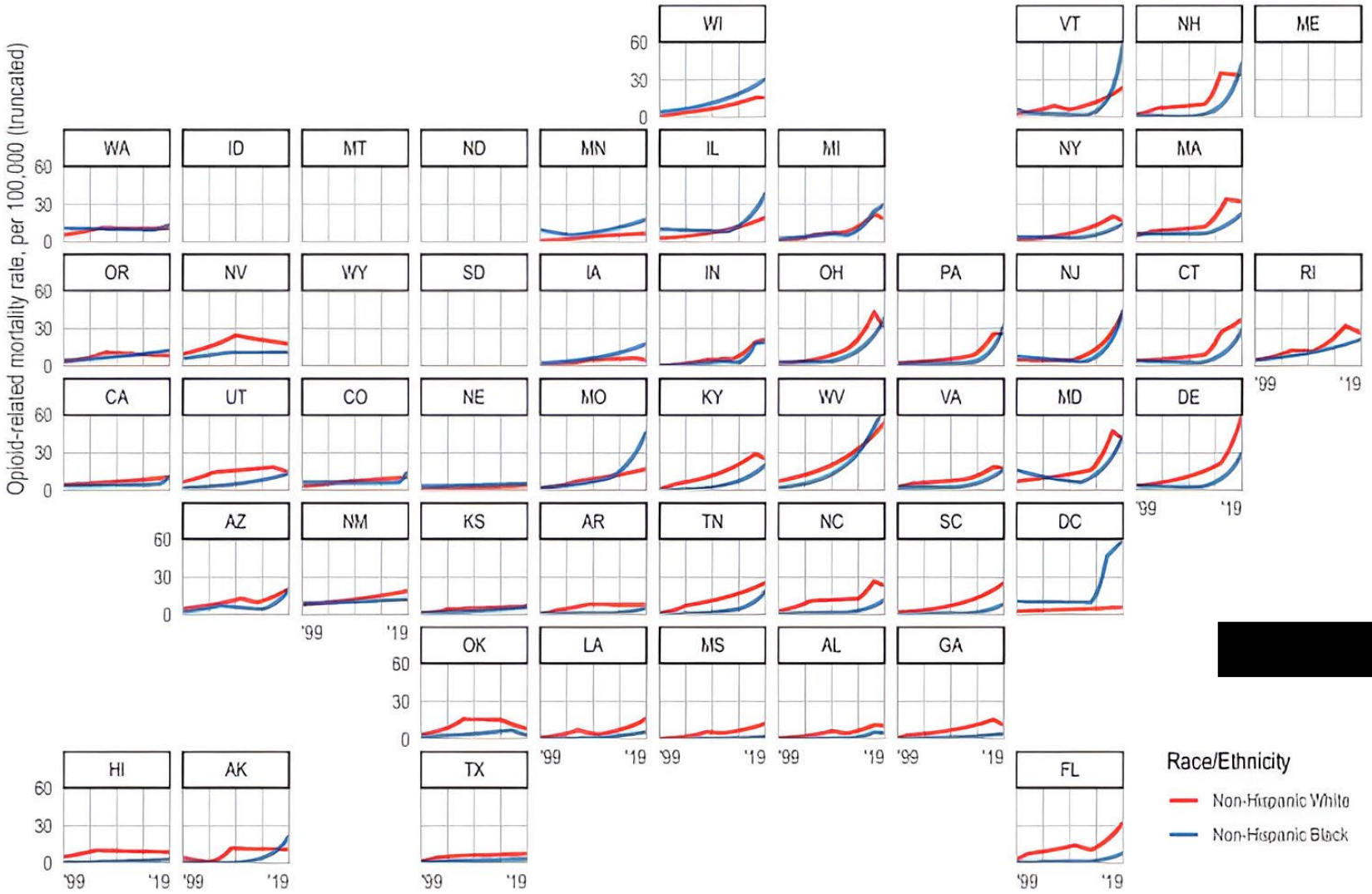


Xylazine Spreads Faster Than Officials Can Act

Analysis by Lisa Jarvis | Bloomberg
April 22, 2023 at 8:36 a.m. EDT

The Drug Enforcement Administration recently issued a warning about a drug that's making the nation's deadly opioid epidemic even deadlier. It's xylazine, a powerful veterinary sedative that's increasingly being found in illicit fentanyl supplies around the US. The agency's lab system found xylazine in 23% of fentanyl powder and 7% of fentanyl pills it had seized in 2022. Policymakers are aware of the lethal mixture — also called tranq — but they're moving too slowly to contain it.





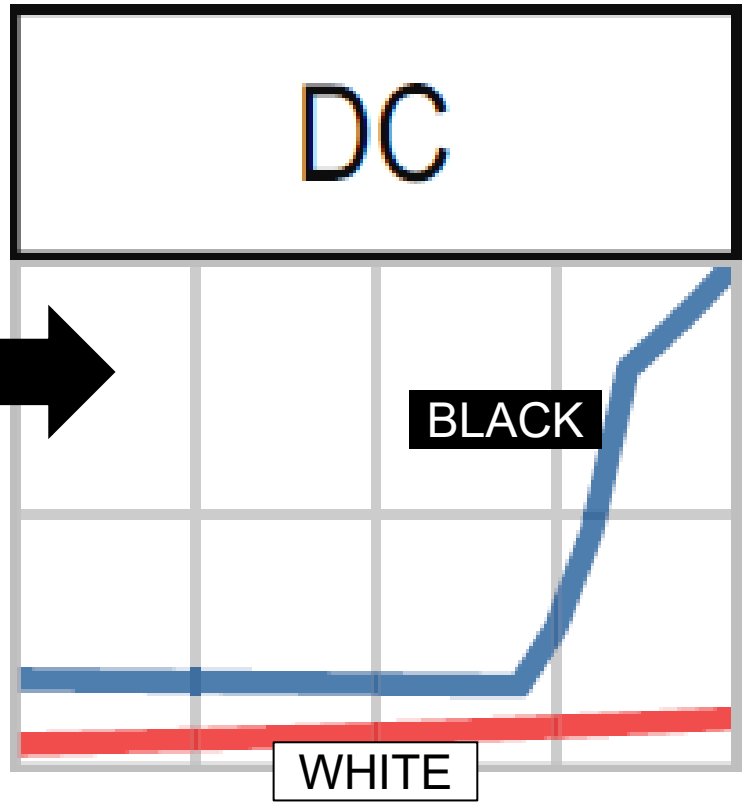
J Urban Health (2021) 98:589–595
https://doi.org/10.1007/s11524-021-00573-8

BRIEF REPORT

Racial/Ethnic Disparities in Opioid-Related Mortality in the USA, 1999–2019: the Extreme Case of Washington DC

Mathew V. Kiang · Alexander C. Tsai · Monica J. Alexander · David H. Rehkopf · Sanjay Basu

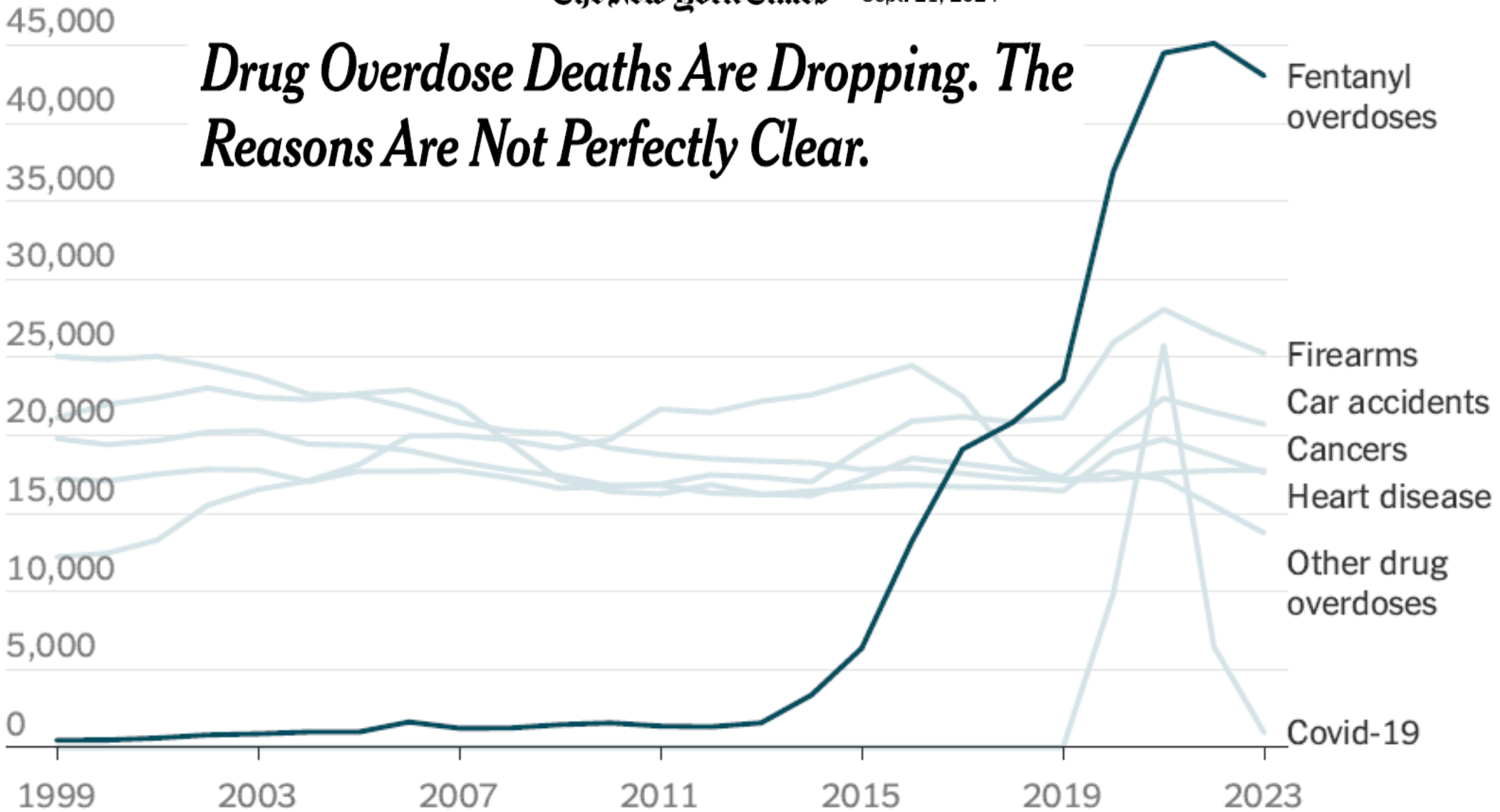
August 2021



THE CYCLE OF DESPAIR

The New York Times Sept. 21, 2024

Drug Overdose Deaths Are Dropping. The Reasons Are Not Perfectly Clear.



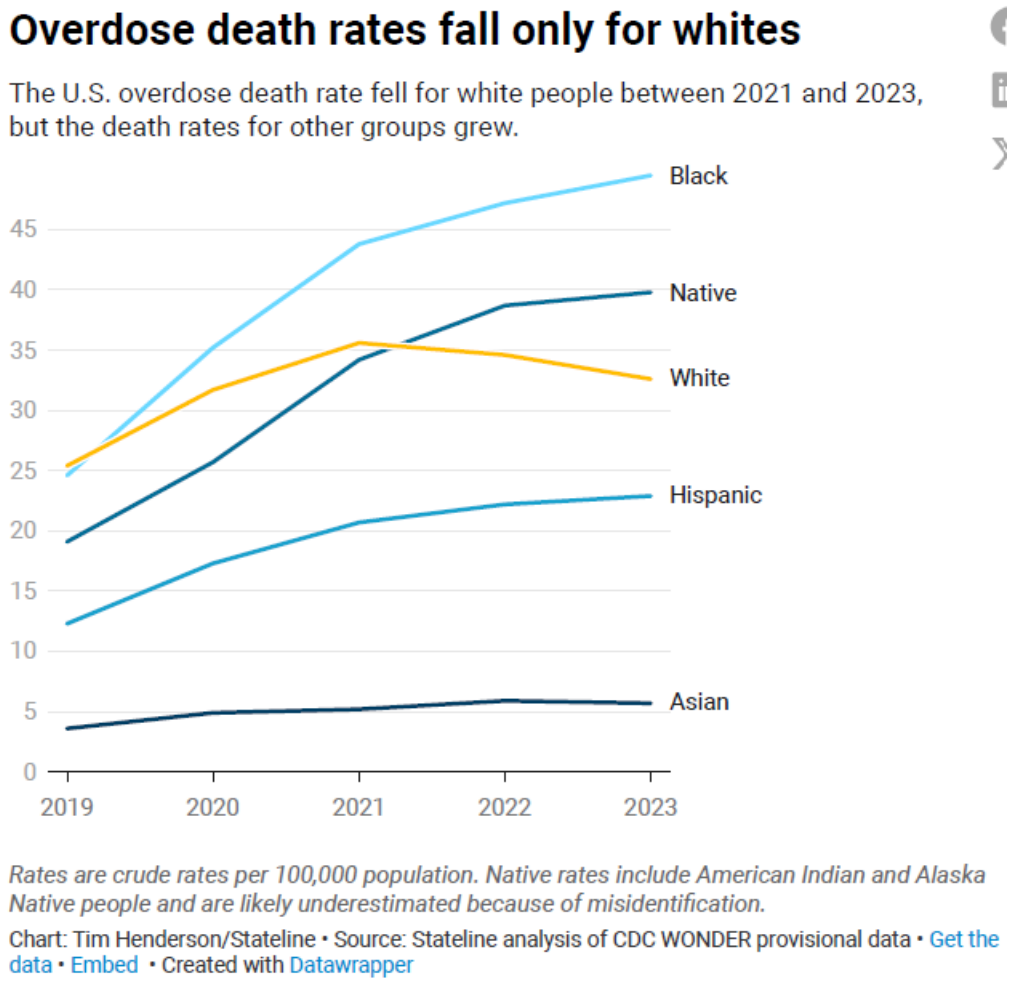
Fentanyl overdoses include all deaths caused by drugs, where the most prevalent drug was a synthetic narcotic, excluding methadone. • Source: Centers for Disease Control and Prevention • By The New York Times

Stateline
PART OF STATES NEWSROOM

Overdose deaths are rising among Blackand Indigenous Americans

Experts say responses such as mobile and mail-order safety suppliesare needed.

BY: **TIM HENDERSON** - **OCTOBER 29, 2024**



White people had the highest rate of overdose deaths in 2019,before the pandemic, at 25.4 deaths for every 100,000 people in the U.S. population. But rates for Black and Native people quickly surpassed white rates and continued to grow as white rates declined between 2021 and 2023. In 2023, the death rates were 49.5 and39.8 per 100,000 for Black and Native people, respectively.

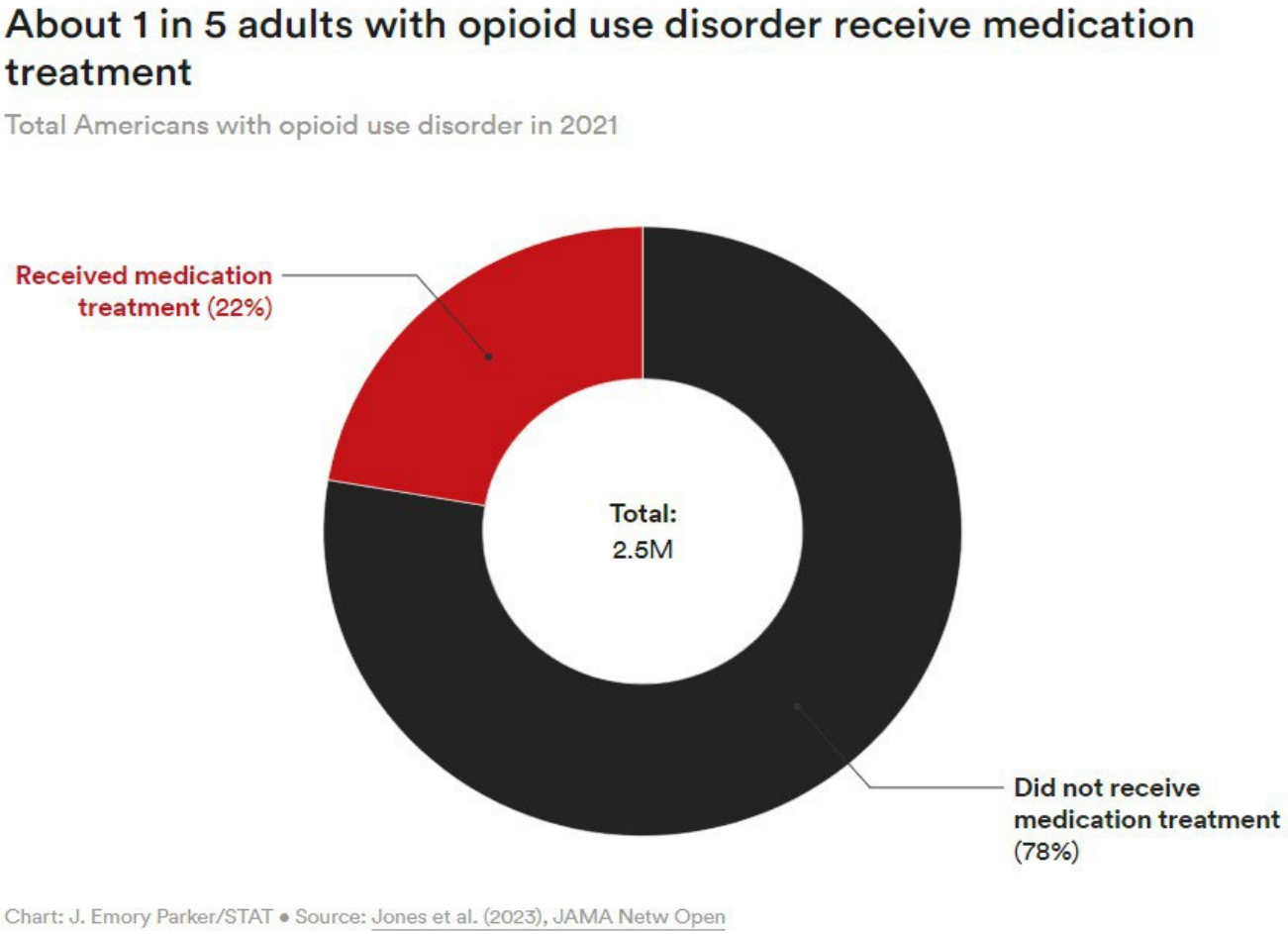
Tracie Gardner, co-director of the National Black Harm ReductionNetwork, said Black and Native people often have trouble navigating white-dominated institutions, including many harm reduction agencies. Such agencies need to have more people ofcolor in leadership positions to gain the trust of Black, Native and other people who use drugs, she said.

“It is our contention that Black harm reduction isn’t about drug use,it’s about the harms of not being a white person in this country,” Gardner said. “The only people doing worse or as poorly are Native Americans.”

How the U.S. is sabotaging its best tools to prevent deaths in the opioid epidemic

By Lev Facher

March 5, 2024



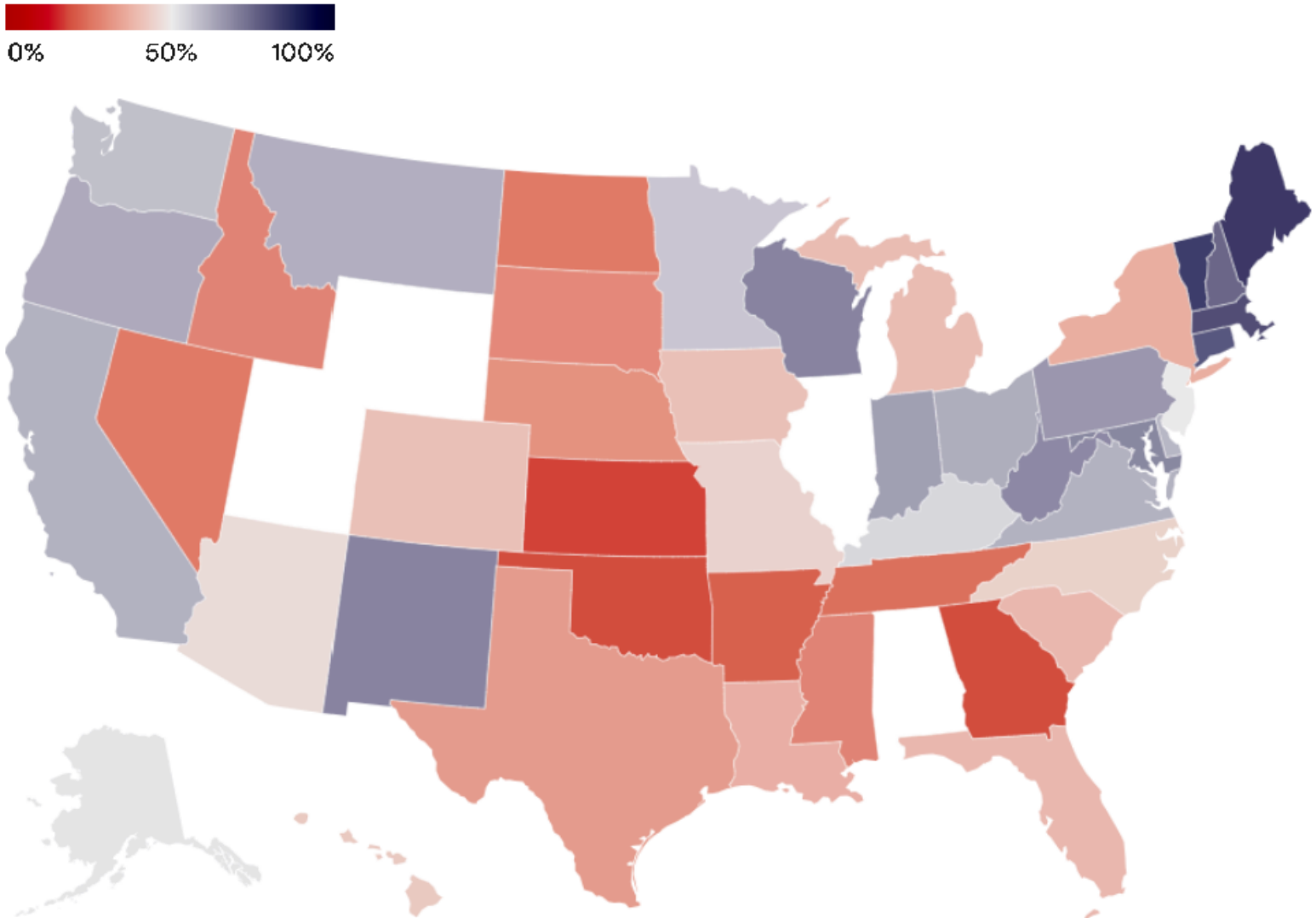
In an interview, **Nora Volkow, the director of the National Institute on Drug Abuse**, estimated that if methadone and buprenorphine were made universally available nationwide, opioid overdoses would fall by half, if not more.

"We have these very effective medications, and the question is why are they not being implemented," she said. "I estimate that we would have at least 50% less people dying, and that's conservative. I think it would probably be much more consequential."

Systemically denying Americans access to addiction medications has also exacerbated racial health disparities. The first decades of the opioid crisis claimed far more white lives than Black lives. But as of 2022, the trend has flipped**: Black people now die of opioid overdoses at higher rates — in part because Black people seeking treatment for opioid use disorder are far less likely than white people to be prescribed an addiction medication**.

Extensive geographic disparities for opioid use disorder treatment

Percent of Medicaid enrollees with opioid use disorder receiving medication treatment



Note: AL, IL, RI, UT, and WY were excluded from analysis due to missing or low-quality data

Map: Simar Bajaj/STAT, J. Emory Parker/STAT • Source: Lindner et al. (2023), JAMA Health Forum

STRUCTURAL and REGULATORY BARRIERS to MOUD

There are many **STRUCTURAL** reasons for poor uptake of MOUD post-COVID (including **12% increase in homelessness**, **state specific disenrollment in MEDICAID**, etc.)

Additionally, outdated federal and state **REGULATORY** barriers are contributing to increased deaths in the presence of fentanyl analogues and other HPSOs ("High Potency Synthetic Opioids") including:

(1) historical racial discrimination in access to buprenorphine as documented for more than 2 decades by Dr Helena Hansen.

(2) outdated state and insurance dosing caps for buprenorphine (16-24 mg) based on erroneous FDA guidelines in the new age of fentanyl / synthetic opioids.

(3) DEA targeting of buprenorphine providers and pharmacies.

(4) rampant insurance fraud and payment abuse of treatment providers and pharmacies.

52nd

POLICY & SCIENCE PLENARY SESSION

Saturday, April 24, 2021 | 10:00 am – 11:30 am ET | Virtual [illegible] and On-Demand

Advancing Racial Justice & Structural Compet[illegible] Addiction Medicine

This plenary session, moderated by ASAM Board Member, Anika Alvanz[illegible]S, FACP, DFASAM, will feature addiction and policy experts who will explore how racism influences addiction prevalence, a[illegible] evidence-based treatment, treatment outcomes, research and drug policies, with a specific focus on Black Americans. Speaker[illegible]ll provide guidance on how healthcare professionals who treat addiction can identify racism and promote structural compete[illegible]eir practices and beyond. These talks will be followed by a panel discussion on how racism affects addiction treatment practic[illegible]eople who use drugs, and steps that panelists have taken to promote structural competency as part of patient care and advocacy.

Edwin C. Chapman, MD, FASAM

Helena Hansen, MD, PhD

Tracie Gardner

Edwin [illegible]
Medici[illegible]

Dr. Cha[illegible]
cializing[illegible]
informa[illegible]
evidenc[illegible]

Helena[illegible]
in Trans[illegible]
School[illegible]

Dr. Har[illegible]
petenc[illegible]
to Treat[illegible]
provide[illegible]
tency and provide guidance on how healthcare professionals who treat addiction can adopt a structural competency framework and apply it to practice.

Tracie Gardner – Vice President of Policy Advocacy, *Legal Action Center*

Tracie Gardner has worked more than 30 years in the public health, public policy, and not-for-profit fields as a policy advocate, trainer, and lobbyist. To better inform healthcare professionals who treat addiction, Ms. Gardner will speak about the impact of racism on people of color who use drugs from the perspective of a seasoned policy professional and a Black woman in recovery.

SESSION MODERATOR

Anika Alvanzo, MD, MS, FACP, DFASAM
Board Member, *American Society of Addiction Medicine*
Eastern Region Medical Director, *Pyramid Healthcare*

Published in final edited form as:

Biosocieties. 2017 June ; 12(2): 217–238. [illegible]0.1057/biosoc.2015.46.

White opioids: Pharmaceutical race and the war on drugs that wasn't

Julie Netherland[a] and **Helena Hansen**[b,c,*]

[a]Drug Policy Alliance, 330 Seventh Avenue, New York, NY 10001, USA.

[b]Departments of Anthropology and Psychiatry, New York University, New York, NY 10003, USA.

[c]Nathan Kline Institute for Psychiatric Research, 140 Old Orangeburg Road, Orangeburg, NY10962, USA.

American drug policy is racialized, using the lesser known lens of decriminalized White drugs. Examining four 'technologies of whiteness' (neuroscience, pharmaceutical technology, legislative innovation and marketing), we trace a separate system for categorizing and disciplining drug use among Whites. This less examined 'White drug war' has carved out a less punitive, clinical realm for Whites where their drug use is decriminalized, treated primarily as a biomedical disease, and where their whiteness is preserved, leaving intact more punitive systems that govern the drug use of people of color.

Example #1: INEQUITABLE ACCESS to MEDICATION: Buprenorphine and Methadone

Table. Demographic Characteristics Associated With Buprenorphine Prescribing in Outpatient Care in the United States in 2004-2007 and 2012-2015

Variable	2004-2007		2012-2015		
	Visits Without Buprenorphine (n = 244 274), %[a]	Visits With Buprenorphine (n = 183), %[a]	Visits Without Buprenorphine (n = 204 527), %[a]	Visits With Buprenorphine (n = 718), %[a]	Adjusted OR (95% CI)[b]
Race/ethnicity[c]					
White	83.5	90.5	83.1	94.9	1.00
Black	11.5	6.5	10.6	2.7	0.23 (0.13-0.44)
Other	5.0	3.0	6.3	2.4	0.27 (0.08-0.90)
Payment method					
Private insurance	52				1.00
Medicare/Medicaid	35				1.16 (0.74-1.82)
Self-pay	4.5	37.8	4.5	39.6	12.27 (6.86-21.91)
Other or unknown	8.5	11.0	8.2	7.5	1.35 (0.78-2.35)
Sex					
Female	58.8	47.5	58.3	39.7	1.00
Male	41.2	52.5	41.7	60.3	2.22 (1.82-2.70)
Age, y					
<30	29.9	40.0	25.4	30.3	1.00
30-50	23.8	47.5	21.4	47.2	1.68 (1.33-2.12)
>50	46.3	12.5	53.2	22.4	0.38 (0.27-0.52)

Abbreviation: OR, odds ratio.

for a given visit characteristic during 2012 to 2015. The 2004 to 2007 visit

BUPRENORPHINE MEDICATION DIVIDE

EQUITABLE ACCESS to BUPRENORPHINE

POLICY & SCIENCE PLENARY SESSION

Saturday, April 24, 2021 | 10:00 am – [illegible] am ET | Virtual-Live and On-Demand

Advancing Ra[illegible]stice & Structural Competency in Addiction Medicine

This plenary session, moderated [illegible]M Board Member, Anika Alvanzo, MD, MS, FACP, DFASAM, will feature addiction and policy experts who will explore how [illegible]nfluences addiction prevalence, access to evidence-based treatment, treatment outcomes, research and drug policies, with a s[illegible]ocus on Black Americans. Speakers also will provide guidance on how healthcare professionals who treat addiction can iden[illegible]m and promote structural competency in their practices and beyond. These talks will be followed by a panel discussion on ho[illegible] affects addiction treatment practices and people who use drugs, and steps that panelists have taken to promote structural competency as part of patient care and advocacy.

Edwin C. Ch[illegible]

Edwin C. Chapman [illegible]
Medicine Specialis[illegible]

Dr. Chapman has p[illegible]
cializing in Internal [illegible]
information on how[illegible]
evidence-based tre[illegible]

Helena Hansen, M[illegible]
in Translational So[illegible]
School of Medicin[illegible]

Dr. Hansen recent[illegible]
petency in Mental [illegible]
to Treating the Social Determinants of Health". Dr. Hansen will provide a high-level, conceptual overview of structural competency and provide guidance on how healthcare professionals who treat addiction can adopt a structural competency framework and apply it to practice.

Tracie Gardner – Vice President of Policy Advocacy, *Legal Action Center*

Tracie Gardner has worked more than 30 years in the public health, public policy, and not-for-profit fields as a policy advocate, trainer, and lobbyist. To better inform healthcare professionals who treat addiction, Ms. Gardner will speak about the impact of racism on people of color who use drugs from the perspective of a seasoned policy professional and a Black woman in recovery.

11:30 am ET **Closing Remarks & Adjourn**
Anika Alvanzo, MD, MS, FACP, DFASAM

SESSION MODERATOR

Anika Alvanzo, MD, MS, FACP, DFASAM
Board Member, *American Society of Addiction Medicine*
Eastern Region Medical Director, *Pyramid Healthcare*

Addictive Behaviors Reports 6 (2017) 8–14

Contents lists available at ScienceDirect

Addictive Behaviors Reports

journal homepage: www.elsevier.com/locate/abrep

Commentary

Pharmacogenomics-guided p[illegible]n opioid use disorder (OUD) management: An ethnically-diverse case-based approach

Earl B. Ettienne[a,*], Edwin Chapman[b], Mary Maneno[a], Adaku Ofoegbu[a], Bradford Wilson[c], Beverlyn Settles-Reaves[d], Melissa Clarke[c], Georgia Dunston[c], Kevin Rosenblatt[e]

[a] Howard University College of Pharmacy, 2300 4th St NW, Washington, DC 20059, United St[illegible]
[b] Department of Psychiatry & Behavioral Health Sciences, Howard University Hospital, 2041 Geo[illegible]
[c] National Human Genome Center at Howard University, 2041 Georgia Ave. NW, Washington, D[illegible]
[d] Howard University Department of Community and Family Medicine, Towers Building, Suite 36[illegible]
[e] Consultative Genomics, PLLC, 5909 West Loop South, Suite 310, Bellaire, TX 77401, United St[illegible]

2017

A[illegible]BSTRACT

Opioid agonist treatment
Buprenorphine
Pharmacogenomics
Policy

R E S E A R C H P A P E R

Pharmacogenomics and OUD: Clinical Decision Support in an African American Cohort

2019

Earl B. Ettienne, I.P.D., M.B.A., R.Ph., Adaku Ofoegbu, PharmD., Mary K. Maneno, Ph.D., Jayla Briggs, [illegible]n, M.D.

[illegible]ding to clinically significant [illegible]nanifested by at least two of 11 a 12-month period.[1] Presently, [illegible]cant public health burden as [illegible]ave continued to rise in the [illegible]000 people that died of a drug [illegible]l 2017, almost 400,000 people [illegible]volving any opioid, including [illegible]oids.[2] In 2017, the number of [illegible]opioids (including prescription like heroin and illictly-manufactured fentanyl) was 6 times higher than in 1999 and approximately 130 Americans die of an opioid overdose

process. We conducted a retrospective cohort study of 113 patients undergoing buprenorphine-based OUD management in Northeast Washington D.C. to [illegible]

EXAMPLE #2: INSUFFICIENT DOSING

OUR FENTANYL SURVIVING (AA) PATIENTS DO BETTER ON BUPRENORPHINE 24 mgs – 32 mgs : (1) Decrease Cravings, (2) Increased Negative Urines for Opioids, (3) Increased Retention in Care

HOWARD UNIVERSITY COLLEGE of PHARMACY:
MOUD Medication Competency in the "Age of Fentanyl"

The Washington Post

May 24, 2023

A pill quells his opioid cravings – if he can get it

Nationwide, access to buprenorphine is complicated by bias, mistrust and insurance bureaucracy

BY DAVID OVALLE

It had been four days since Kevin Hargrove last took the medication that stilled his dangerous cravings. He awoke with a queasy stomach and achy muscles, then vomited on the sidewalk as he set off from his encampment under a D.C. bridge this month.

Hargrove recently changed his Medicare-funded insurance company and was unable to fill his prescription for buprenorphine, the medication he has taken for years to treat his opioid addiction. The withdrawals proved too much. The 66-year-old found a dealer on the street, paid $6 for two pills he believed were codeine painkillers and washed them down with a can of Olde English 800 malt liquor.

Less than an hour later, Hargrove passed out inside his sister's Columbia Heights apartment, overdosing on what was suspected to be fentanyl. "Don't

SEE BUPRENORPHINE ON A2

RICKY CARIOTI/THE WASHINGTON POST

Kevin Hargrove, 66, of D.C. overdosed on what was suspected to be fentanyl after an insurance change left him without enough buprenorphine, which he takes to treat his opioid addiction.

S.C. votes to restrict abortions at 6 weeks

Governor says he will sign Senate's measure "as soon as possible"

"They know they did wrong and wish they could go back and do it over again."

A year on, few consequences for botched Uvalde response

TOP: Lesnar waited on Monday at Robb Elementary School, where 19 students and two teachers were killed in a May 24, 2022, shooting. ABOVE: Kimberly Mata Rubio and Felix Rubio, whose daughter Lexi died at the school.

Federal agencies urged to pay later

TREASURY EXPLORES DELAYS TO BUY TIME

A scramble to save cash as debt deal talks go on

In Texas, lines between church, state are blurring

Russia's hold on Bakhmut could prove short-lived

A pill quells his opioid cravings – if he can get it

Nationwide, access to buprenorphine is complicated by bias, mistrust and insurance bureaucracy

Kevin Hargrove, 66, of D.C. overdosed on what was suspected to be fentanyl after an insurance change left him without enough buprenorphine, which he takes to treat his opioid addiction.

IN THE NEWS

Crash outside White House An unarmed man was charged after ramming into a barrier with a truck that contained a Nazi flag. B1

INSIDE

FOOD How to grill a hamburger

STYLE Zelda's legacy

There's medicine to quiet his opioid cravings. Getting it can be hard.

By David Ovalle

May 21, 2023 at 6:00 a.m. EDT

Kevin Hargrove has dealt with addiction for decades. A medication helps control his cravings — if he can get it. (Ricky Carioti/The Washington Post)

Listen 10 min | Comment 6 | Save | Gift Article | Share

It had been four days since Kevin Hargrove last took the medication that stilled his dangerous cravings. He awoke with a queasy stomach and achy muscles, then vomited on the sidewalk as he set off from his encampment under a D.C. bridge this month.

Chapman said Hargrove's case illustrates a persistent problem for addiction-treatment doctors: that insurers' "prior authorization" policies hinder treatment. Hargrove receives disability benefits, D.C. Medicaid and Medicare Advantage, in which an insurance company contracts with Medicare. Hargrove's previous insurance covered a month's supply of four daily 8 milligram doses of buprenorphine, with him checking in monthly to Chapman's office for a prescription renewal.

Hargrove recently switched to UnitedHealthcare. In March, Chapman and Hargrove said, the company would agree to only three doses a day, meaning he had to stretch out his supply for the month. "That first month was hell," Hargrove said.

Hargrove overdosed on the suspected fentanyl pills May 11, before he was authorized to pick up his new prescription of three daily doses. Inside his sister's apartment, he plopped down on a chair in her bedroom and passed out. The whites of his eyes turned gray. His sister, Claudette Inge, called 911, frantically poured a glass of cold water on his face and began chest compressions.

Paramedics used Narcan to revive him. "I died on that chair," Hargrove said the next day, recounting the scene while inside his sister's apartment.

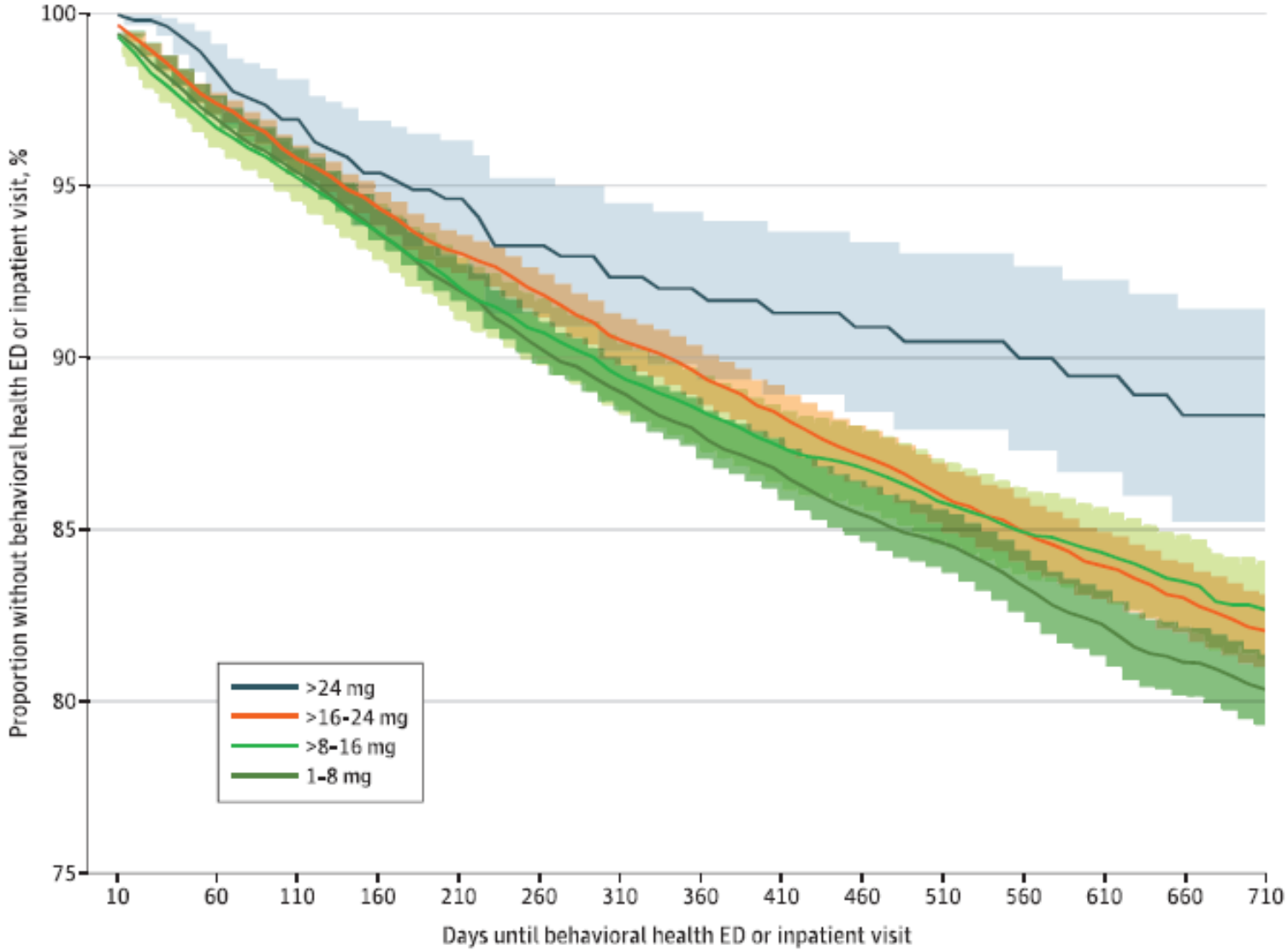
Said Chapman: "This was really scary, and you hate to see a stable patient become unstable for no reason at all just because of the bureaucracy."

The day after the overdose, Hargrove could finally pick up his buprenorphine. "I'll just have to stretch it out like I'd been doing," he told Chapman on speaker phone.

That afternoon, Hargrove walked into an Anacostia pharmacy, picked up his medication, pulled out a brown tab of buprenorphine and popped it in his mouth. "I'll feel better in about three minutes," he said before walking to a bus stop.

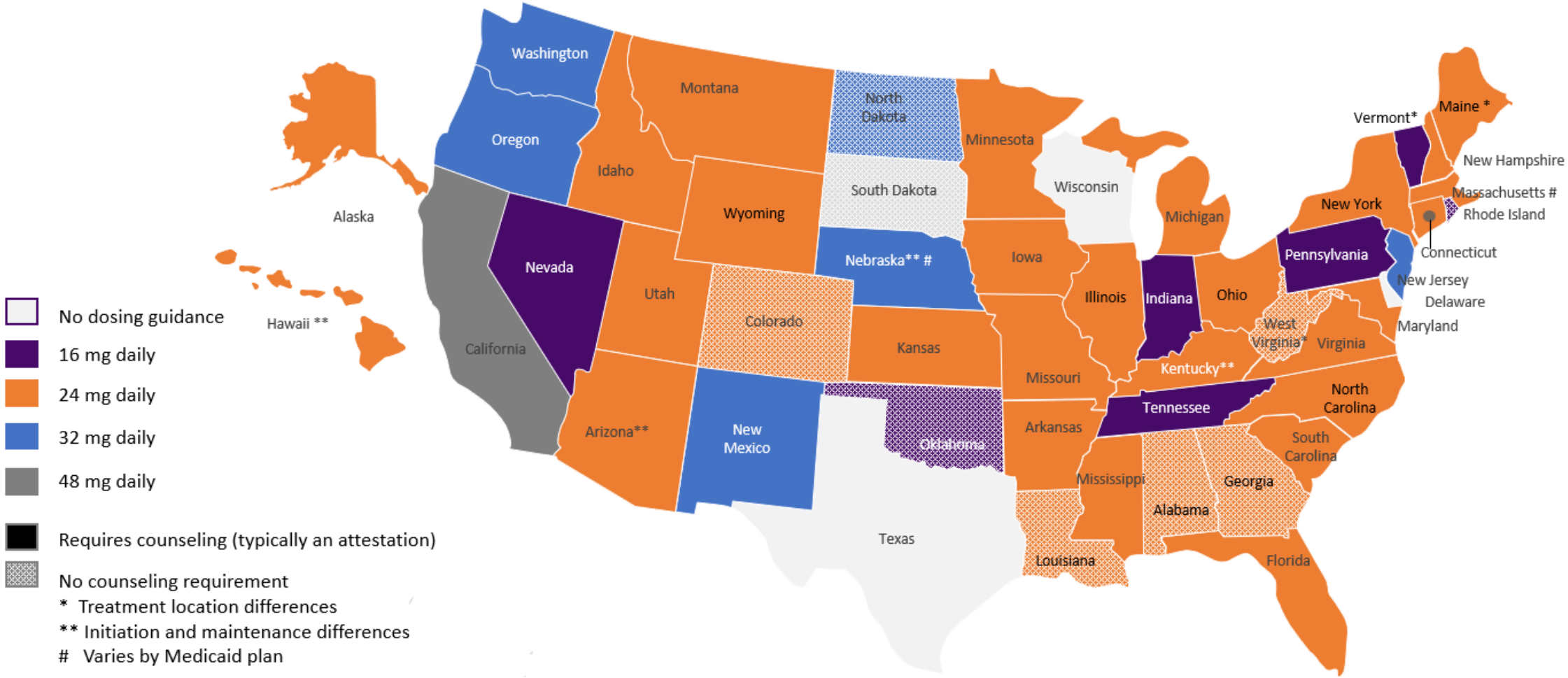
He would later learn that the insurer, responding to an urgent appeal from Chapman, approved an extra daily dose — only after his near-fatal overdose.

Figure. Days Until ED or Inpatient Services for Behavioral Health Diagnosis in 2 Years Following First Fill of a Patient's Highest Stable Dose of Buprenorphine



ED indicates emergency department; shaded areas represent 95% CIs. Time to ED or inpatient claim is measured in days from the first fill of the patient's highest stable dose of buprenorphine. All patients required 90 days of enrollment prior to filling first buprenorphine prescription (at any dose). Data presented is truncated at 720 days for presentation purposes, but the observation window lasts up to 2191 days.

Buprenorphine Coverage Requirements (Dose or Quantity) by State Medicaid



Publicly Available Information from Preferred Drug Lists, 2021 CMS DUR Reporting, and Public Sources. Analysis October 2023.

04/17/2024

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Office of the Senior Deputy Director and Medicaid Director **Transmittal 24-16**

TO: DC Medicaid Providers

FROM: Melisa Byrd
Senior Deputy Director and Medicaid Director

DATE: April 17, 2024

SUBJECT: **Suboxone and Buprenorphine-Containing Products Daily Dosing Limit Increase**

Purpose
The purpose of this transmittal is to inform facilities and providers about a change in the District of Columbia's (DC's) Suboxone and Buprenorphine-containing products daily dosing limit. Effective May 1, 2024, the daily dosing limit for Suboxone and Buprenorphine-containing products without a prior authorization will increase to 32mg. The current daily dosing limit is 24mg.

Effective May 1, 2024 the daily dosing limit for Suboxone and Buprenorphine – containing products without a prior authorization will increase to 32 mgs.

If you have questions, please contact Cavella Bishop, Program Manager, Office of the Chief Medical Officer, Department of Health Care Finance (DHCF) at cavella.bishop@dc.gov or (202) 724-8936.

09/25/2024

National Institute on Drug Abuse

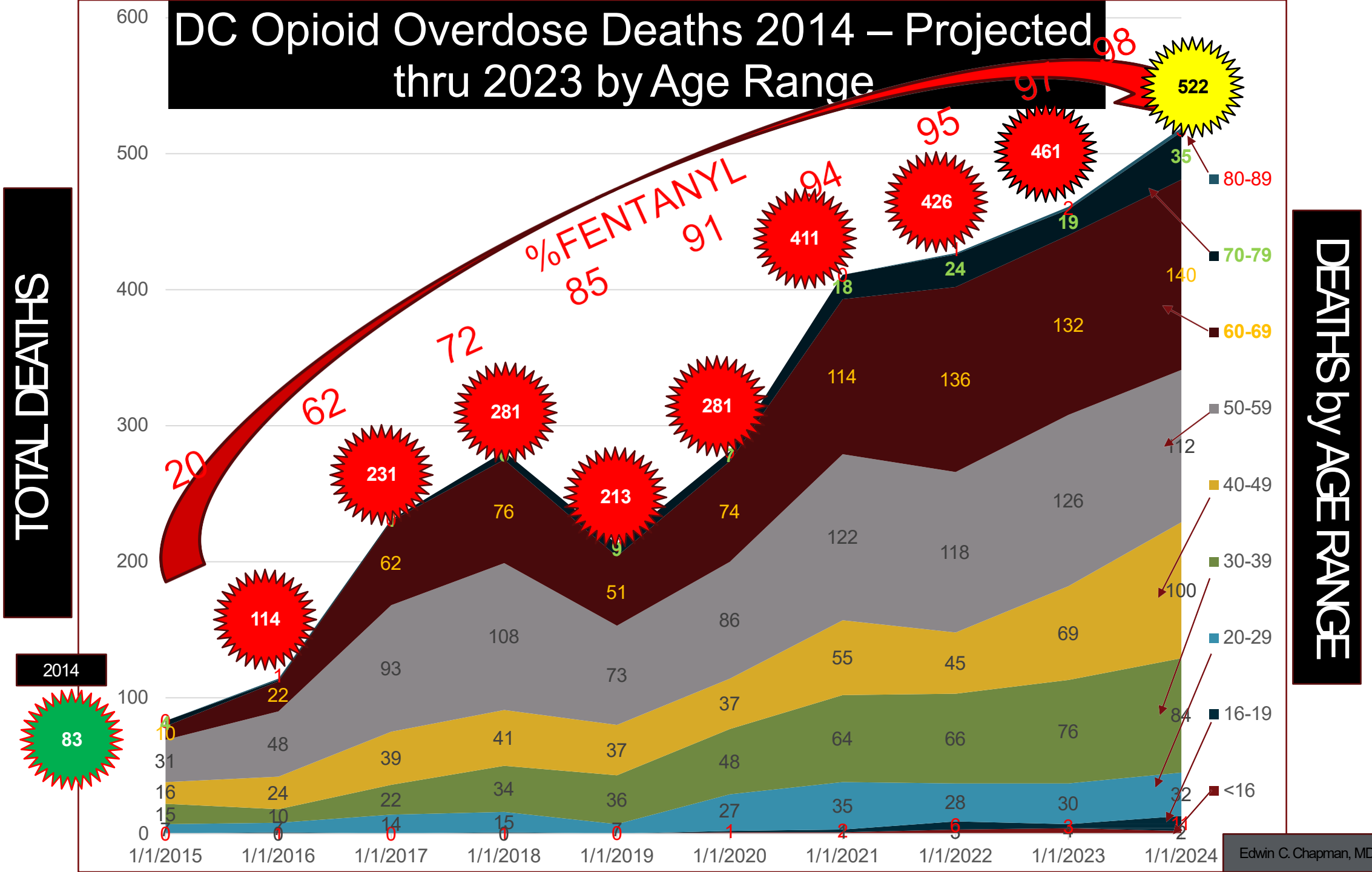
FOR IMMEDIATE RELEASE
Wednesday, September 25, 2024
11:00 am ET

Contact: NIDA Press Office
301-443-6245
media@nida.nih.gov

Higher doses of buprenorphine may improve treatment outcomes for people with opioid use disorder

NIH-funded analysis suggests higher doses of buprenorphine were associated with lower rates of future behavioral health-related emergency department and inpatient care

Adults with opioid use disorder who receive a higher daily dose of the opioid addiction treatment medication buprenorphine may have a lower risk of subsequent emergency department visits or use of inpatient services related to behavioral health (such as for mental health and substance use disorders) than adults receiving the recommended dose, according to an analysis funded by the National Institutes of Health (NIH). These findings suggest that higher buprenorphine doses could be more effective in managing opioid use disorder, which may be particularly relevant for improving treatment for those who use fentanyl, a major driver of the overdose crisis.



The Washington Post

Democracy Dies in Darkness

No room on the street: D.C. orders homeless out of underpass in fast-developing neighborhood

By **Joe Heim** and **Justin Wm. Moyer**

Jan. 10, 2020 at 5:41 p.m. EST

The tents of homeless people liv
Washington Post)

Health Affairs

content.healthaffairs.org

doi: 10.1377/hlthaff.2015.0393

Health Aff January 2016 vol. 35 no. 1 20–27

Formerly Homeless People Had Lower Overall Health Care Expenditures After Moving Into Supportive Housing

Bill J. Wright[1,*], Keri B. Vartanian[2], Hsin-Fang Li[3], Natalie Royal[4] and Jennifer K. Matson[5]

Author Affiliations

*Corresponding author

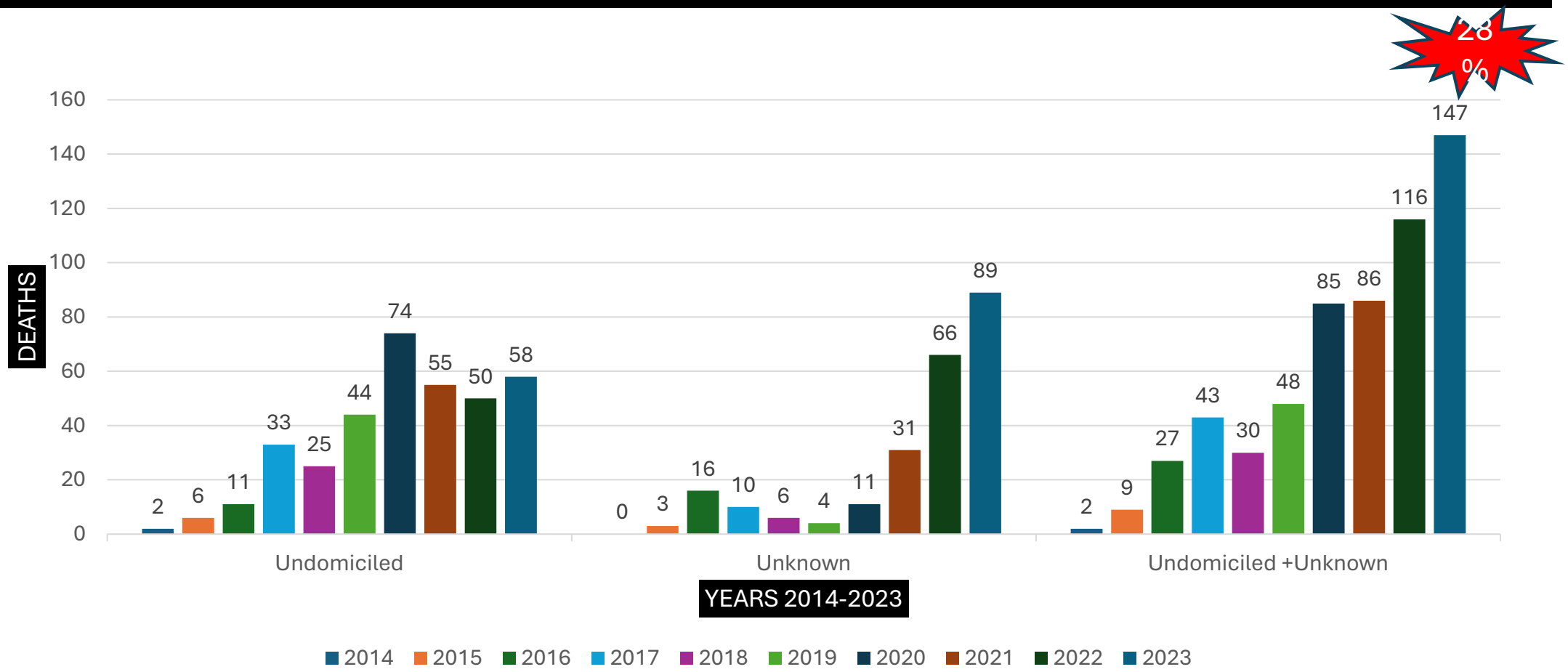
Abstract

The provision of supportive housing is often recognized as important public policy, but it also plays a role in health care reform. Health care costs for the homeless reflect both their medical complexity and psychosocial risk factors. Supportive housing attempts to moderate both by providing stable places to live along with on-site integrated health services. In this pilot study we used a

to evaluate outcomes for
pportive housing facility in
e claims analysis showed
for the people after they
s were driven primarily by
ata suggest that the savings

HOUSING COMPETENCY:
SAFE HOUSING *IS* GOOD MEDICINE

DC OPIOID DEATHS:
UNDOMICILED + UNKNOWN (2% in 2014 to 28% in 2023)



EXAMPLE #4: SOCIAL DETERMINANTS of HEALTH

To: M.I. Mother's Keeper <advocates4mi@gmail.com>
Sent: Thursday, May 16, 2024 at 10:50:01 AM EDT
Subject: Fw: ATTENTION! Tonight's the night that DC citizens will speak! Human & Civil Rights are important! Have you RSVP'd? It's time to show up for them!

GM Dr Hamilton,
In addition to inhumane housing, food, and drug treatment policies by the local **Bowser Administration**, our people are dying due to our "neoliberal health care corporations" (**e.g United Healthcare Group, AmeriHealth Caritas DC, et al**) who are systematically robbing BOTH patients and providers of legitimate services and payments.

For-profit healthcare is an oxymoronic, "magical thinking," economic mirage bogusly progated and sold to distressed communities all across America! **(see attached)**
Edwin C Chapman, MD

SUPPORT THE AHSO PAC

HEALTHY DC & ME

Are you "fed up" with the current failure of DC's policies and governing?

What's on your mind?

It's time to join with DC Citizens who are ready to act!

"Human & Civil Rights Matter" Public Town Hall Meeting

"No More Low Standards"!

Did You Know?
Research connects **Poor Quality Housing** with many negative health outcomes, including chronic disease, injuries, and poor mental health.

Your testimony is needed.
Add your voice to the "demands for change."
This is about us! All are welcome to attend!
#WeAreDC!

DATE
Thursday, May 16, 2024

TIME
6PM - 8:30PM

LOCATION
Friendship Baptist Church
900 Delaware Ave. SW
(On the green line metro.)

For more information and to RSVP,
Call: (240) 274-9436

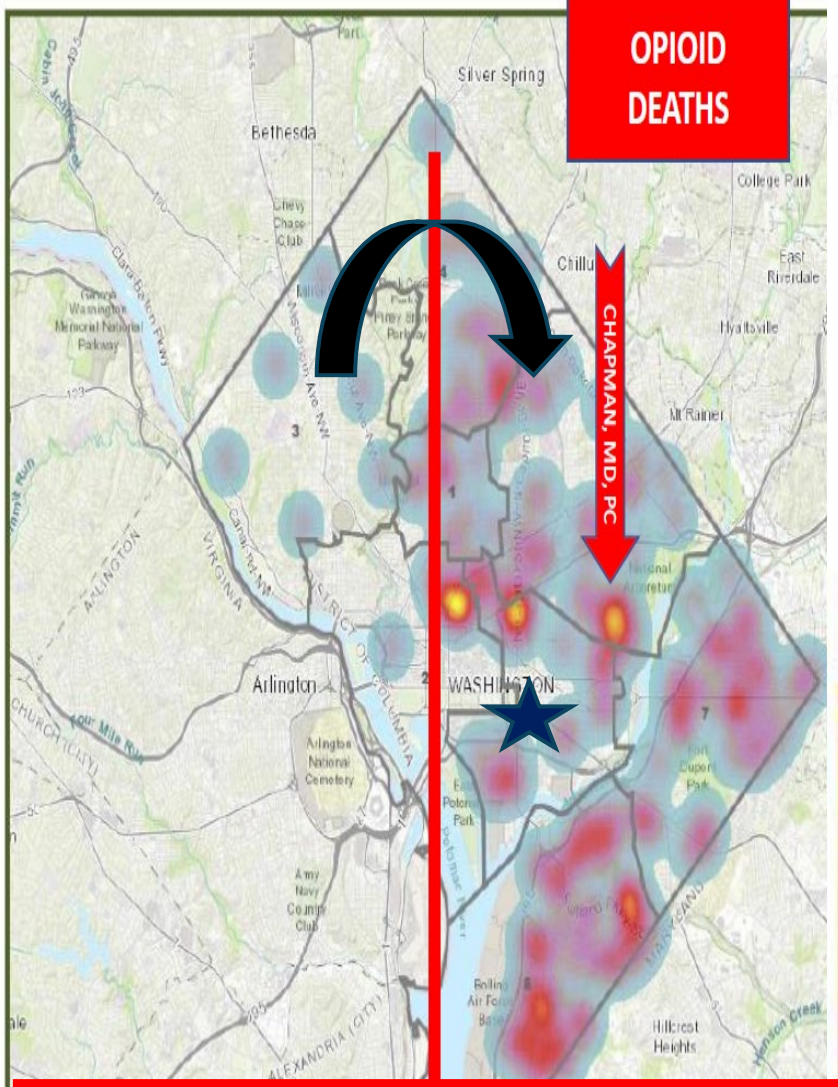
A TALE of TWO CITIES: In Black & White

Map of Opioid Overdoses by Jurisdiction of Residence

The map below displays opioid overdoses in 2017 by jurisdiction of
opioid overdoses are prevalent in Wards 5, 6, 7 and 8. The map also

EAST END

OPIOID DEATHS

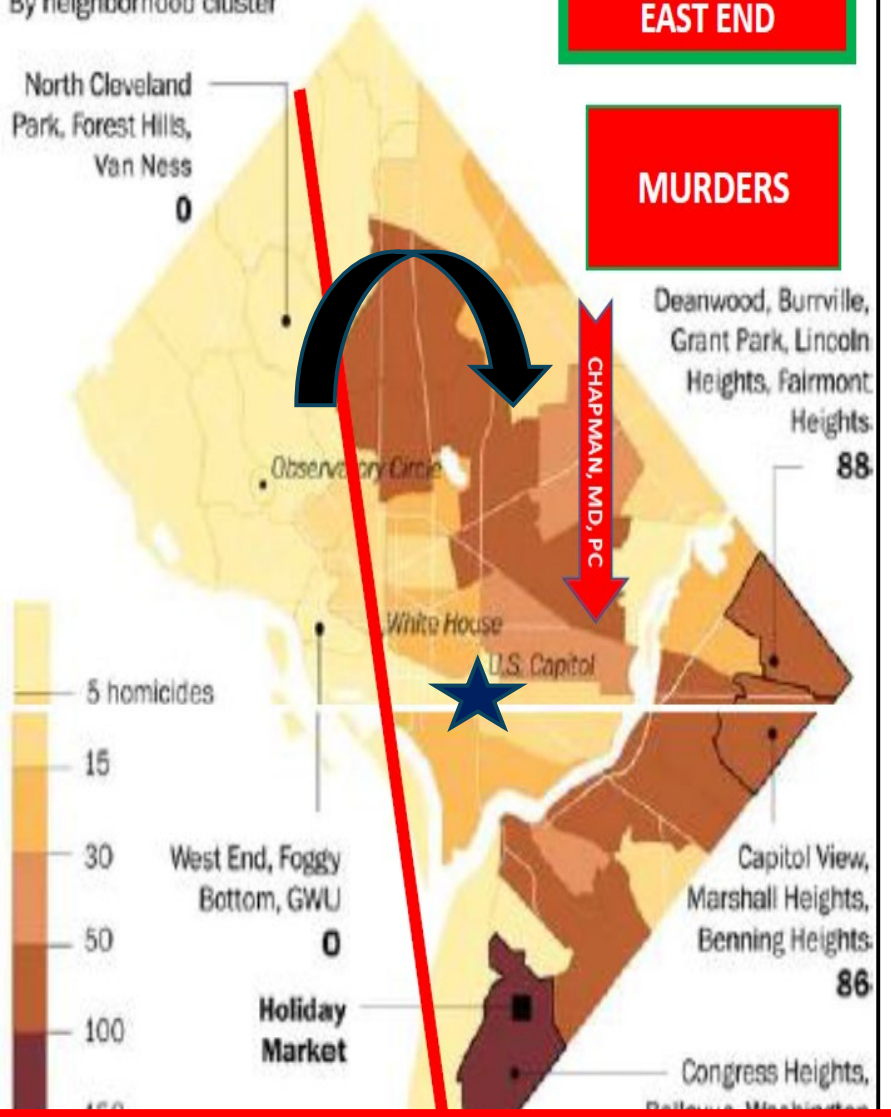


Homicides in the District, 2010 through 2019

By neighborhood cluster

EAST END

MURDERS

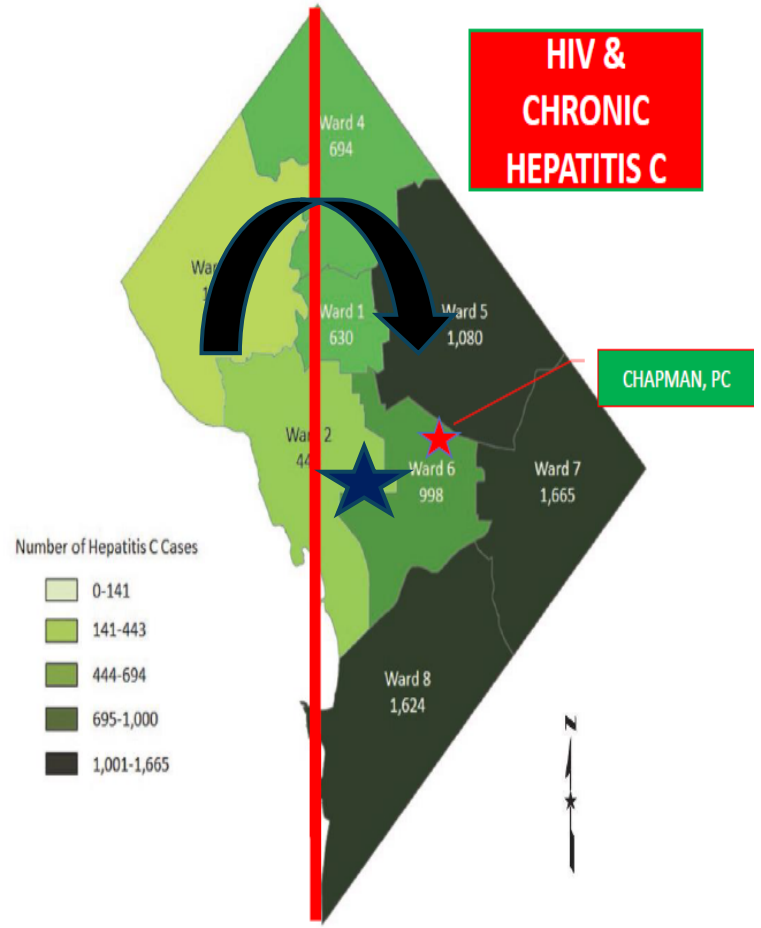


District of Columbia Department of Health

Map 7. Number of Newly Reported Chronic Hepatitis C Cases by Ward
District of Columbia, 2008-2012

EAST END

HIV & CHRONIC HEPATITIS C



- Address and ward information was available for 74% of newly reported chronic hepatitis C cases.
- Wards 7 had the highest number of newly reported chronic hepatitis C cases between 2008 and 2012

A TALE of TWO CITIES: In Black & White

VIEWPOINT

Less Care at Higher Cost—The Medicare Advantage Paradox

Adam Gaffney, MD, MPH
Department of Medicine, Cambridge Health Alliance, Cambridge, Massachusetts; and Harvard Medical School, Boston, Massachusetts.

Stephanie Woolhandler, MD, MPH
Department of Medicine, Cambridge Health Alliance, Cambridge, Massachusetts; Harvard Medical School, Boston,

Celebrating a Medicare Advantage (MA) milestone—enrollment in those private plans surpassed 30 million—the health insurance industry's trade group proclaimed MA "a good deal for members and taxpayers."[1] The first part of that claim is debatable, while the second part is false. Medicare Payment Advisory Commission

ing, new MA enrollees had incurred below-average Medicare costs (after adjustment for their risk scores), a pattern consistently present since 2008, ie, MA plans were selectively enrolling Medicare beneficiaries who were inexpensive for their risk scores. Moreover, among those who had switched to MA, enrollees associated

Before MA payments were adjusted for diagnoses, MA insurers used a cruder profit-boosting strategy: avoid the expensively ill, so-called favorable selection. In that era, private plans cherry-picked healthier than average older adults and managed to chase away ("lemon drop") those requiring expensive care.

November 13, 2023 at 5:07 p.m. EST

Regarding the Nov. 7 news article "Biden administration seeks further crackdowns on private Medicare plans":

Medicare Advantage plans are part of our broken privatized insurance health-care system. Issues include restricting doctor access, requiring preauthorization for treatment, plan selection errors, aggressive insurance company marketing, high deductibles and co-pays, increased hospital and doctor administrative costs by dealing with multiple insurers, and profit incentive to restrict care. A complete system change is required, not more regulation, which doesn't work.

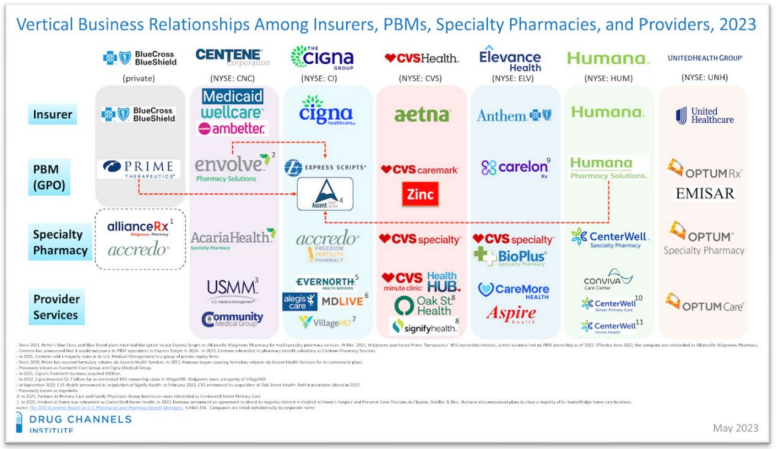
Single-payer universal health care, such as Medicare-for-all, would provide comprehensive health-care coverage for all Americans, including those eligible for Medicare Advantage plans, with no premiums, deductibles, co-pays, doctor access restrictions, or insurance company's requirements and limitations resulting from profit motivation. And it is quite cost-effective. The cost of health care in the United States is almost double that in other advanced countries, with limited access and poorer quality. Single-payer health care has proved to be less costly in other countries. It will wring out the redundant and wasteful administrative costs of the insurance marketplace and provide negotiating leverage to stabilize pharmacy, doctor and hospital costs. Major studies, including in highly respected medical journals, have reported estimated savings on overall health-care spending of as much as $600 billion per year if Medicare-for-all were adopted.

SO… Why have Black MOUD providers with the BEST outcomes for AFRICAN AMERICAN patients been selectively targeted by insurers ?

The Role of Pharmacy Benefit Managers in Prescription Drug Markets

Report Prepared by the House Committee on Oversight and Accountability Staff

Figure 2: Vertical Integration in PBM Markets[28]



Executive Summary

Pharmacy Benefit Managers' (PBMs) role as intermediaries between drug manufacturers and health insurance providers should have made them, in theory, the best positioned entities to decrease the cost of prescription drugs.[1] The three largest PBMs, CVS Caremark (Caremark), Cigna Express Scripts (Express Scripts), and UnitedHealth Group's Optum Rx (Optum Rx), control more than 80 percent of the market and are vertically integrated with health insurers, pharmacies, and providers.[2] As large health care conglomerates, some have argued that these PBMs' vertical integration with insurers and pharmacies would better position them to improve patient access and decrease the cost of prescription drugs.[3] **Instead, the opposite has occurred: patients are seeing significantly higher costs with fewer choices and worse care.**

Americans spend more today on prescription drugs than any other country, and prescription drug prices in the U.S. are more than double the cost of identical drugs in other high-income nations.[4] In 2023, the U.S. health care system spent $772.5 billion on prescription drugs, including $307.8 billion on retail drugs.[5] This mammoth spending is largely driven by a small number of high-cost products; brand name drugs accounted for 80 percent of prescription drug spending, despite the fact that 80 percent of prescriptions in the U.S. are for generic drugs.[6] Additionally, the cost of specialty drugs, which accounted for 54 percent of spending in 2023,[7] has increased more than 40 percent since 2016.[8] Patient out-of-pocket costs for prescriptions were $91 billion in 2023 alone.[9] Higher drug utilization and new drugs are also contributing to higher costs, with Americans being prescribed more and paying for more prescription drugs.[10]

This report describes the Committee on Oversight and Accountability's findings that PBMs inflate prescription drug costs and interfere with patient care for their own financial benefit.

The Role of Pharmacy Benefit Managers in Prescription Drug Markets

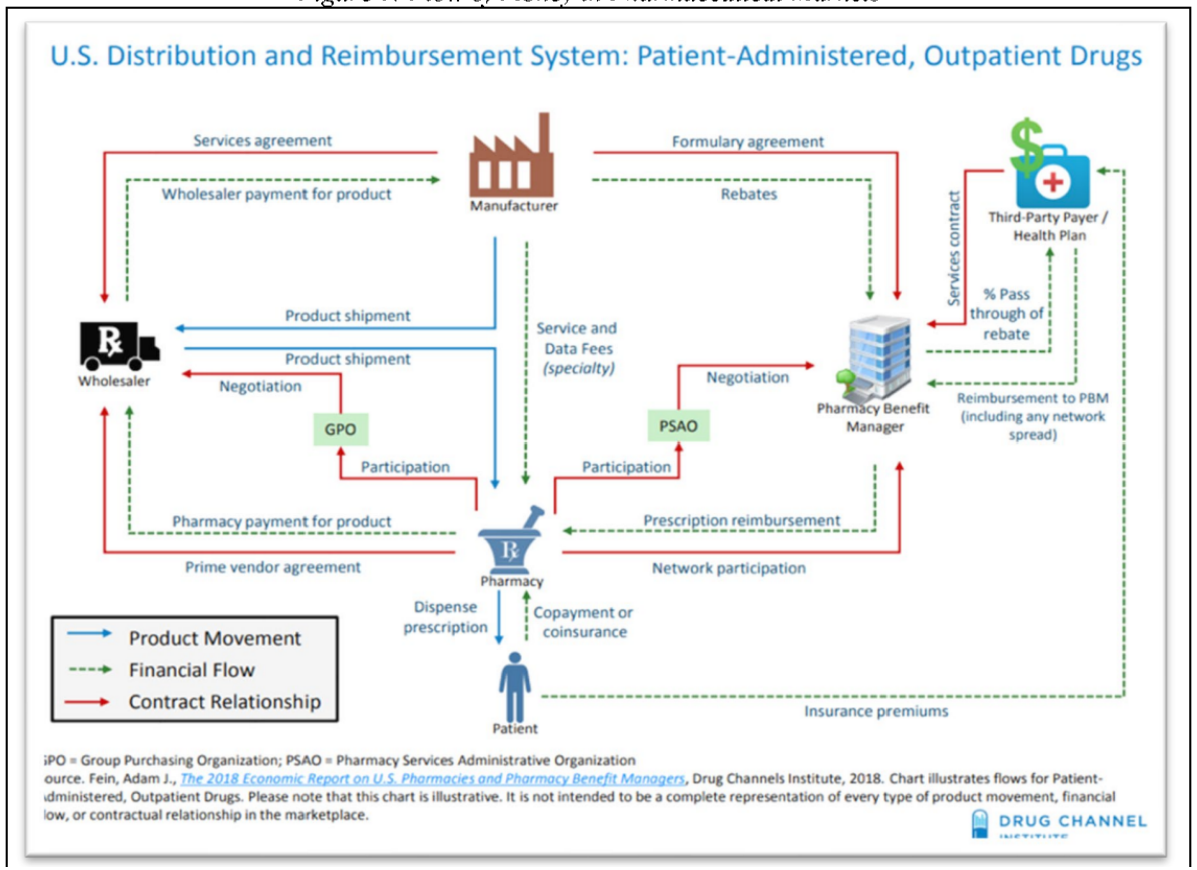
Report Prepared by the House Committee on Oversight and Accountability Staff

Background

I. The Role of Pharmacy Benefit Managers

PBMs are companies that manage prescription drug benefits for health insurers, Medicare Part D drug plans, self-insured employers, and other payers, such as state Medicaid programs (collectively known as "payers").[11] When they were originally created in the 1960s, PBMs functioned as passive processors of prescription drug claims.[12] However, as the pharmaceutical industry has evolved, the role of PBMs has evolved with it.[13] Today, PBMs have a more significant role and function as intermediaries between drug manufacturers, payers, and pharmacies. PBMs' central role in the pharmaceutical market is clearly observable in Figure 1:

Figure 1: Flow of Money in Pharmaceutical Markets[14]



MAY 01 | MORE ON PRIVACY & SECURITY (/RESOURCE-TOPIC/PRIVACY-SECURITY)

UnitedHealth Group CEO Andrew Witty grilled on Change cyberattack

Witty confirmed he made the decision to pay $22M in ransom to protect patient information.

UNITED HEALTHCARE-CHANGE

Photo: U.S. House Committee on Energy & Commerce

A STAT INVESTIGATION

Denied by AI: How Medicare Advantage plans use algorithms to cut off care for seniors in need

By Casey Ross and Bob Herman March 13, 2023

The nation's largest health insurance company pressured its medical staff to cut off payments for seriously ill patients in lockstep with a computer algorithm's calculations, denying rehabilitation care for older and disabled Americans as profits soared, a STAT investigation has found.

UnitedHealth Group has repeatedly said its algorithm, which predicts how long patients will need to stay in rehab, is merely a guidepost for their recoveries. But inside the company, managers delivered a much different message: that the algorithm was to be followed precisely so payment could be cut off by the date it predicted.

Internal documents show that a UnitedHealth subsidiary called NaviHealth set a target for 2023 to keep rehab stays of patients in Medicare Advantage plans within 1% of the days projected by the algorithm. Former employees said missing the target for patients under their watch meant exposing themselves to discipline, including possible termination, regardless of whether the additional days were justified under Medicare coverage rules.

Optum layoffs: naviHealth CEO out; Virtual care business shuttered

By **Noah Tong** · Apr 25, 2024 9:00am

Optum | UnitedHealth Group | layoffs | Change Healthcare

Example #5:
UNITED HEALTHCARE-OPTUM Rx

JULY 2-3, 2024

Ciox Outreach ID:

Chart R

To: Unknown

Fax Number: (202) 388-4461

ACTION REQUESTED: Please respond within 8 days of receipt of this request.
Please call (877) 445-9293 or email chartreview@cioxhealth.com with any questions.

**To learn how to reduce the phone calls and faxes from Ciox and eliminate the bur
medical record retrieval in the future, visit www.cioxhealth.com/betterway**

Medical records can be submitted through the following options:

1. Digitally Respond:
Securely respond to Any/All Ciox requests in a single digital queue at https://idsb-portal.datavant.com/onboarding/setup
OR respond to this single request at www.cioxlink.com using these credentials:

- Username: C46601985
- Password: 6a^Ab919

2. Remote EMR Retrieval:
Set up secure remote connection from an EMR directly to Ciox for timely remote retrieval by trained Ciox associates. Contact

3. Onsite Chart Retrieval:
Schedule on-site retrieval with a complimentary Ciox Chart Retrieval Specialist or review any aspects of the on-site retrieval services at Ciox by contacting

4.Fax:
Send secure faxes to 1-972-957-2143

5. Mail:
Mark "Confidential" on the envelope and mail the medical records to: Ciox
2222 W. Dunlap Ave
Phoenix, AZ 85021

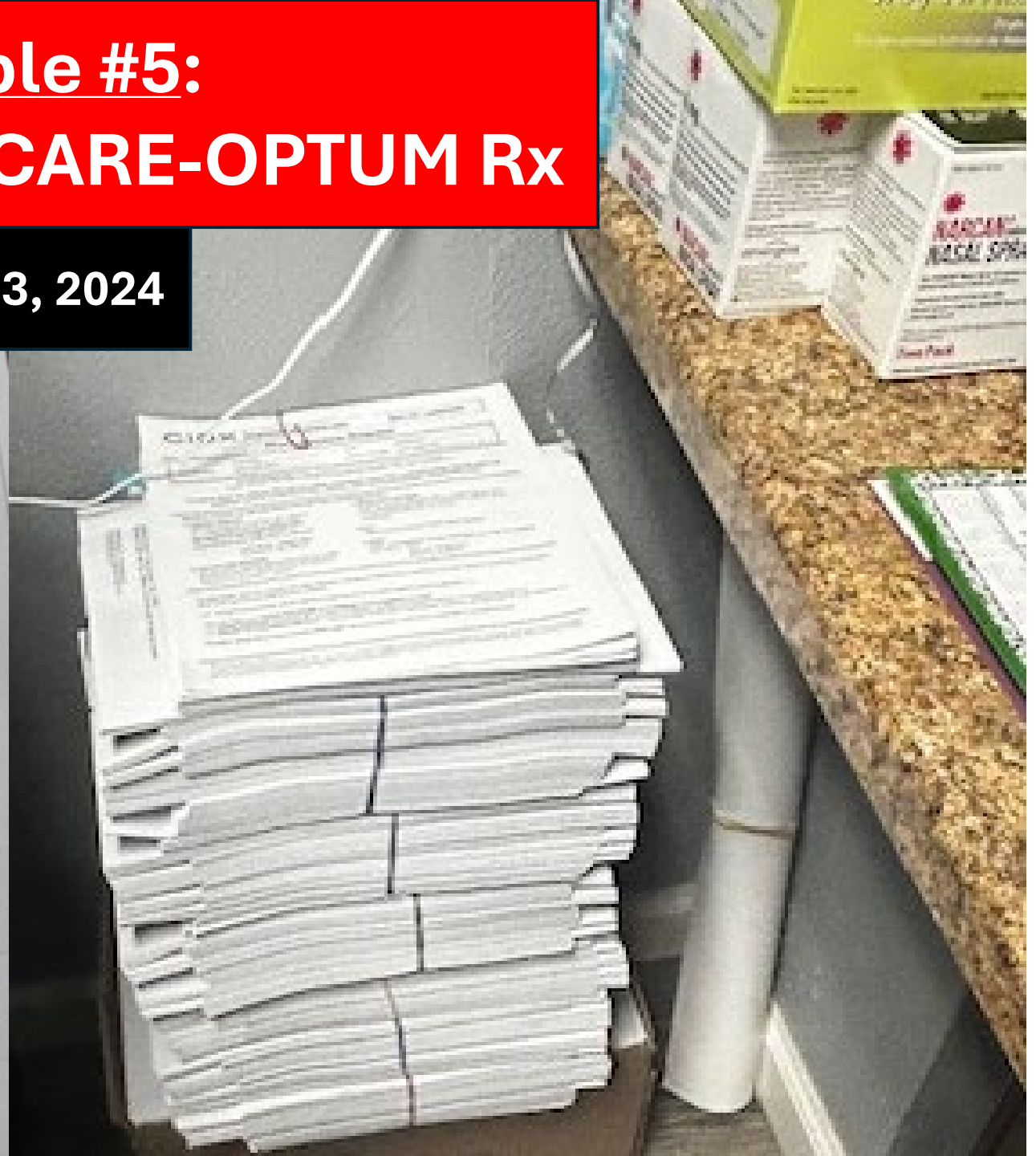
ATTENTION: With the COVID-19 Public Health Emergency declaration coming to an end, record submission extensions that were previously offered have ended.

>>> Going forward there will be significantly less time to fulfill medical record requests <<<

Ciox can help
>>> Digital R
>>> Release
trieval <<<

To learn mor

AUDIT !!!!
UNITED HEATHCARE
75 Buprenorphine Patients x 1 Year
Fentanyl /Cocaine / Amphetamine / Xylazine
(2023)



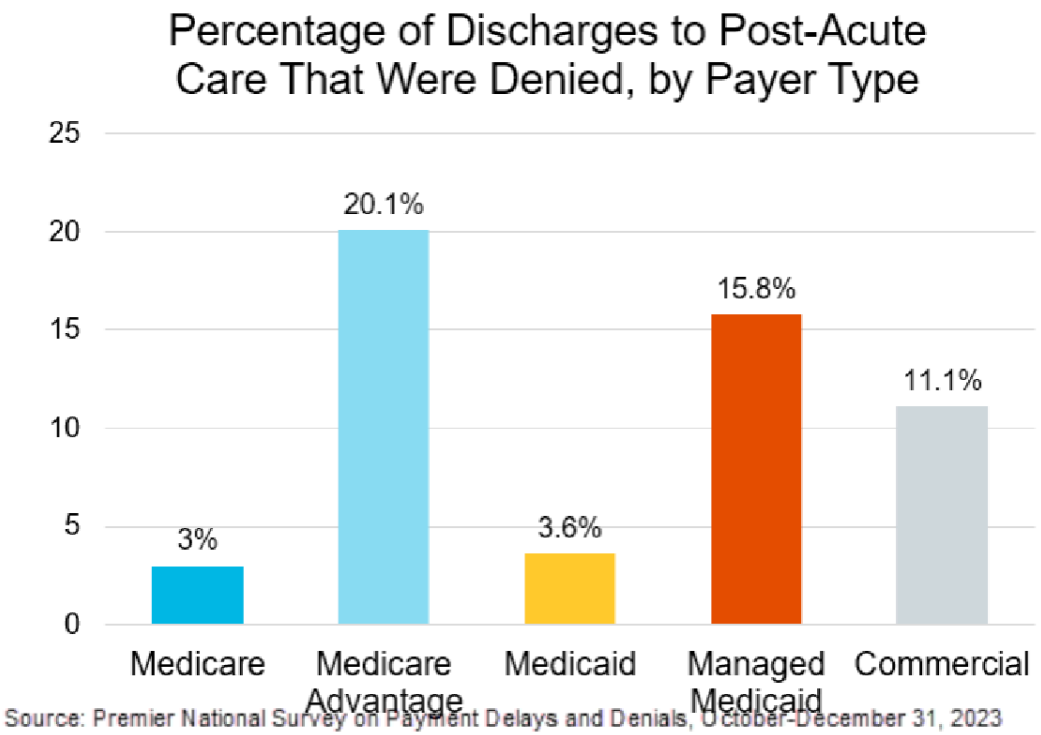
PREMIER

March 21, 2024

Trend Alert: Private Payers Retain Profits by Refusing or Delaying Legitimate Medical Claims

Population Health | Cost Management | Blog | Policy

3/24, 10:46 AM Premier | Trend Alert: Private Payers Retain Profits by Refusing or…



Key Takeaways:

- Nearly 15 percent of all claims submitted to private payers for reimbursement are initially denied, including many that were pre-approved to move forward through the prior authorization process.
- Denied claims tended to be more prevalent for higher-cost treatments, with the average denial pegged to charges of $14,000 and up.
- Over half (54.3%) of denials by private payers were ultimately overturned and the claims paid, but only after multiple, costly rounds of provider appeals.
- The average cost incurred by providers fighting denials is $43.84 per claim – meaning that providers spend $19.7 billion a year just to adjudicate with payers.

The net result of these denials is longer than expected hospital stays, which adds expense and risk, as patients with longer stays have greater rates of secondary infections, falls and exposure to other contagious diseases. Moreover, payer denials have downstream effects on care availability, as patients requiring a hospital admission may not have access to a bed until other patients are approved for discharge to the SNF setting of care.

Downstream Impact of Denials on Quality Ratings and Reimbursement

Department of Health and Human Services

Office of Inspector General

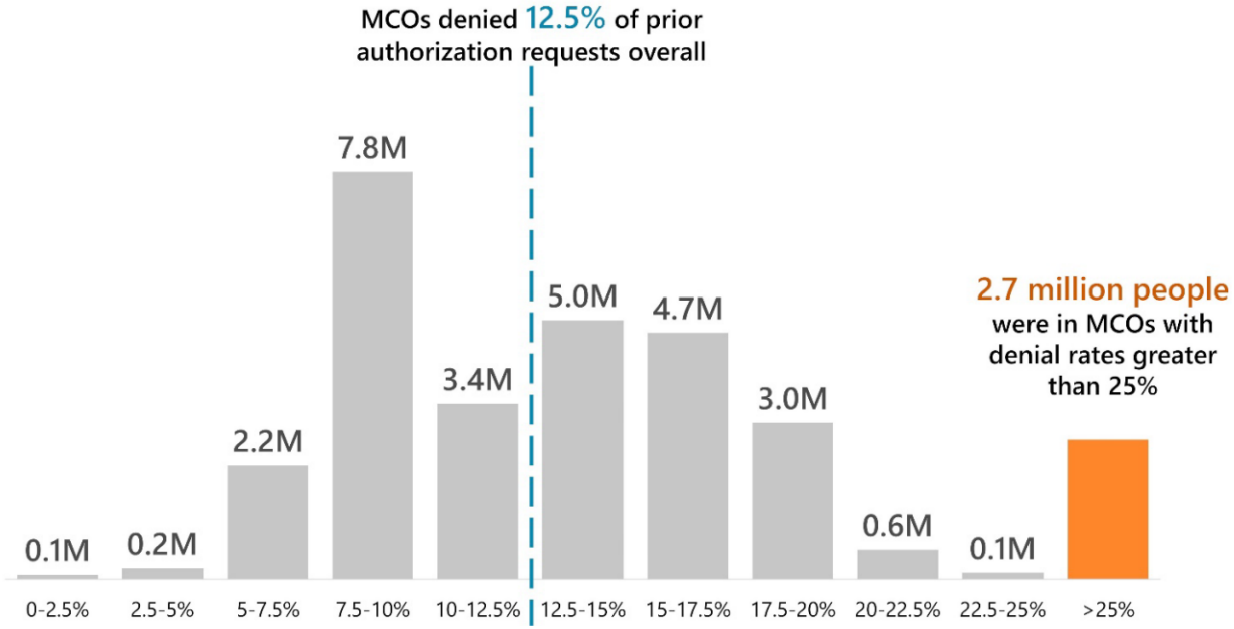
High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care

Christi A. Grimm
Inspector General
July 2023, OEI-09-19-00350

FINDINGS

Overall, MCOs denied one in eight requests for the prior authorization of services, and some MCOs had much higher denial rates

Exhibit 2: In 2019, approximately 2.7 million people were enrolled in MCOs with prior authorization denial rates greater than 25 percent



Source: OIG analysis of 2019 MCO prior authorization denial data and enrollment data, 2023.

Exhibit 3: In 2019, the seven parent companies operated MCOs with a wide range of denial rates, from as low as 2 percent to as high as 41 percent

Parent company	Lowest MCO denial rate	Highest MCO denial rate	Overall denial rate	Number of MCOs	Number of MCOs >25%
Aetna Inc.	5%	29%	12.1%	14	1
AmeriHealth Caritas	2%	20%	6.1%	11	
Anthem Inc.	6%	34%	12.9%	19	3
CareSource	8%	16%	15.4%	3	
Centene Corporation	3%	23%	12.2%	33	
Molina Healthcare Inc.	7%	41%	17.7%	12	7
UnitedHealthcare	7%	27%	13.6%	23	1

Source: OIG analysis of 2019 MCO parent company prior authorization denial data and operations data, 2023.

Department of Health and Human Services

Office of Inspector General

High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care

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Inspector General

July 2023, OEI-09-19-00350

Parent company	MCO name	State	2019 average enrollment	2019 prior authorization denial Rate
AmeriHealth Caritas	AmeriHealth Caritas District of Columbia	DC	124,022	20.0%
AmeriHealth Caritas	AmeriHealth Caritas Delaware - Diamond State Health Plan	DE	58,785	13.5%
AmeriHealth Caritas	Prestige Health Choice	FL	77,182	10.4%
AmeriHealth Caritas	AmeriHealth Caritas of Louisiana	LA	213,540	9.1%
Anthem	Blue Cross of California & Delegates	CA	1,194,381	7.8%
Anthem	Amerigroup District of Columbia, Inc.	DC	42,994	14.1%
Anthem	Simply HealthCare Plans, Inc.	FL	457,851	10.5%
Anthem	AMGP Georgia Managed Care Company, Inc.	GA	381,831	33.7%
Anthem	Amerigroup Iowa, Inc.	IA	266,142	6.2%
Anthem	Anthem Insurance Companies, Inc.	IN	453,865	12.7%
Anthem	Anthem Kentucky Managed Care Plan, Inc.	KY	133,859	11.7%
Anthem	Community Care Health Plan of Louisiana, Inc.	LA	258,971	12.5%
Anthem	Amerigroup Maryland, Inc.	MD	233,424	26.8%

JUNE 27, 2024
22 - AMERIHEALTH CARITAS DC CHARTS

10/04/2024

RE: Fwd: Purchase order

From: Moghimi, Yavar (ymoghimi@amerihealthcaritas.com)

To: echap1647@aol.com

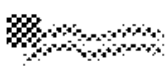
Date: Friday, October 4, 2024 at 10:31 AM EDT

Dr. Chapman,

My value-based care team got back to me after doing a SUD episode analysis of your panel with Amerihealth. The results showed that you had 54 clients that were active in care with you and only 17 of those were eligible for the SUD episode. Based on these small numbers, it's difficult to create a SUD value-based program as you don't meet the denominator thresholds for most of the quality measures.

Feel free to reach out if you have additional questions or thoughts on this.

Yavar Moghimi, MD
Medical Director, Behavioral Health
AmeriHealth Caritas Family of Companies
P: 202-326-8992 **C:** 571-228-5031
E: ymoghimi@amerihealthcaritas.com
www.amerihealthcaritas.com [amerihealthcaritas.com]



AmeriHealth Caritas

AmeriHealth Caritas
District of Columbia

May 24, 2024

EDWIN C CHAPMAN MD PC
1647 BENNING RD NE STE 200
NE
Washington, DC 20002-4570

Example: "LEMON DROP" Patient

Re: Enrollee Name: [redacted]
Enrollee ID: [redacted]
Patient ID: [redacted]
Date of Service: 11/27/2023
Total Billed Amount: $250.00
Claim Number: 146016988202

DISPUTE DETERMINATION

Dear Provider,

Thank you
AmeriHea
reference
is a summ

If you hav
3570.

Sincerely,

AmeriHea

Enclosure:

***Confiden
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received t
destructio***

AmeriHealth Caritas
District of Columbia

Patient List for EDWIN C CHAPMAN MD PC

Case ID	Patient ID	Patient name	Date of Birth	Date of Service	Claim Numb
239520029060200	[redacted]	[redacted]	12/05/1966	11/27/2023	14601698820
	CPT Description: OFFICE/OUTPATIENT ESTABLISHED HIGH MDM 40 MIN Denial Description: Upcoding of E/M code Additional Remarks: Not supported. Claim line previously reviewed and remains denied. The submitted medical records d documentation Number and complexity of problems addressed, Amount and/or complexity of data to be reviewed and ana management did not meet the level billed. Of note, to qualify for a particular level of medical decision making, two out of				

AmeriHealth Caritas
District of Columbia

June 18, 2024

EDWIN C CHAPMAN MD PC
1647 BENNING RD NE STE 200
NE
Washington, DC 20002-4570

Re: Enrollee Name: [redacted]
Enrollee ID: [redacted]
Patient ID: [redacted]
Date of Service: 12/19/2023 - 12/19/2023
Total Billed Amount: $250.00
Claim Number: 146050234102

PROVIDER APPEAL DETERMINATION - OVERTURNED

Dear Provider,

Thank you for being a valued AmeriHealth Caritas District of Columbia (DC) provider. This letter confirms that AmeriHealth Caritas DC has received your request for an Appeal regarding the claim number(s) referenced above. Based upon a review of all the information, the denial determination has been overturned. Enclosed is a summary of each claim line.

The claim(s) will be reprocessed for payment as appropriate. No further action is required.

If you have questions regarding this determination, please contact the Optum Provider Inquiry Response Team at 866-447-3570.

Sincerely,

AmeriHealth Caritas District of Columbia

Enclosure

Confidentiality Statement: The documents accompanying this transmission contain confidential health information that is legally protected. This information is intended only for the use of individuals or entities listed above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these documents.

99214 (High Risk/Stable) vs. 99215 (High Risk/Unstable)

AmeriHealth Caritas
District of Columbia

Patient List for EDWIN C CHAPMAN MD PC

Case ID	Patient ID	Patient name	Date of Birth	Date of Service	Claim Number	Patient Account Number	Claim Line	CPT HCPCS Code	Mod(s)
239520029060200	[redacted]	[redacted]	12/05/1966	11/27/2023	146016988202	[redacted]	1	99215	
	CPT Description: OFFICE/OUTPATIENT ESTABLISHED HIGH MDM 40 MIN Denial Description: Upcoding of E/M code Additional Remarks: Not supported. Claim line previously reviewed and remains denied. The submitted medical records do not support a High level of medical decision making. Per medical record documentation Number and complexity of problems addressed, Amount and/or complexity of data to be reviewed and analyzed and Risk of complications and/or morbidity or mortality of patient management did not meet the level billed. Of note, to qualify for a particular level of medical decision making, two out of the three elements for this level must be met or exceeded.								

Denial Description: Upcoding of E/M
Additional Remarks: Not supported. Claim line previously reviewed and remains denied. The submitted records do not support High level of medical decision making. Per medical record documentation Number and complexity of problems addressed, Amount and/or complexity of data reviewed and Risk of complications and/or morbidity or mortality of patient management did not meet the level billed. Of note, to qualify for a particular level of decision making, two out of the three elements for this level must be met or exceeded.

MedStar Family Choice

DISTRICT OF COLUMBIA

3007 Tilden St., N.W.
Pod 3N
Washington, DC 20008
P: 855-798-4244
MedStarFamilyChoice.com

MEDSTAR FAMILY CHOICE DC COMPLIANCE
BILLING & DOCUMENTATION REVIEW
Edwin Chapman, MD
September 2024

09/24/2024

September 24, 2024

Edwin Chapman, MD
1647 Benning Rd NE
Ste 200
Washington, DC 20002

Compliance Audit Results with Corrective Action Plan

Dear Provider,

Background

MedStar Family Choice - District of Columbia (MFC-DC) has completed a compliance audit of Edwin, Chapman MD. We perform these routine compliance audits to verify compliance with federal and District of Columbia regulatory guidelines.

Audit Objectives

- To verify the provider's compliance with Federal and District of Columbia guidelines for Opioid Treatment Programs (OTP).
- To verify that medical record provided supports a "Comprehensive Medical History" for the level of service billed.
- To verify that each medical record provided supports a "Comprehensive Medical Examination" for the level of service billed.
- To verify that each medical record provided supports a "Medical Decision Making of High Complexity" for the level of service billed.
- To verify that the provider was documenting in the medical record in accordance with MFC policies, established standards and correct coding and documentation guidelines.
- To determine if any overpayments and potential recoupment exists.

Methodology & Sampling

Medical claims data was generated for dates of service 01/01/2023 – 10/31/2023. A sample of 162 claims for 10 enrollees were selected and medical records were requested for each encounter and reviewed.

MedStar Family Choice

DISTRICT OF COLUMBIA

7. Drug Diversion Plan
   Requested drug diversion plan was not provided for review. Drug diversion occurs when a medication is taken for use by someone other than whom it is prescribed or for an indication other than what is prescribed. Prescription drug diversion has significant health, legal and social implications. It is a requirement that a OTP has a written plan in place to prevent diversion of opioid treatment medication from its intended purpose.

8. Laboratories utilized for drug screening were outside the District of Columbia
   The two laboratories used for the drug screen tests were outside the District of Columbia:
   - Gravity Diagnostics: 812 Russell Street, Covington, KY 41011
   - Elite Diagnostics: 10996 Four Seasons Place, Crown Point, IN 46307

9. Two of the ten enrollees whose records were reviewed, died in December 2023.

Audit Results/Findings

Opioid treatment programs provide medication coupled with counseling services for people diagnosed with an opioid use disorder. The failure to comply with Federal and the District of Columbia's requirements for providing and documenting opioid treatment services, may lead to poor treatment outcomes for individuals, including relapses, overdoses, drug diversion or death.

A total of **162 claims** were down coded from CPT 99215(153 claims) and 99214 (9 claims), to CPT 99213 for insufficient documentation to support the level of service billed. This resulted in an identified overpayment of thirteen thousand, four hundred and ninety dollars, sixty-four cents. ($13,490.64)

Summary of Overpayments Identified

Procedure Codes	# of Claims	Overpayments Identified
• 99214	9	$387.72
• 99215	153	$13,102.92
Total	162	$13,490.64

Recoupment

Attached is a spreadsheet that details the overpaid claims. Recoupment of these claims will be performed in 30 business days. As outlined in the MedStar Family Choice DC Provider manual, providers have (90) days from receipt of the audit findings letter to file a written appeal to the address below:

10/01/2024

VIEWPOINT

AI IN MEDICINE

Addressing AI Algorithmic Bias in Health Care

JAMA October 1, 2024 Volume 332, Number 13

Raj M. Ratwani, PhD
MedStar Health Research Institute, Washington, DC; and Georgetown University

As artificial intelligence (AI) algorithms become an increasingly integral part of health care, ranging from diagnostic decisions and treatment plans to population health management, it is vital that rigorous processes to

GEORGETOWN UNIVERSITY et al:

"Biased AI algorithms can result in certain patient populations NOT receiving appropriate care, potentially leading to significant harm. Previously, an AI algorithm developed to proactively support patients by predicting additional complex care needs yielded biased results along racial lines. The algorithm used HEALTH CARE COSTS as its target variable, underrepresenting Black patients due to SYSTEMIC BARRIERS TO ACCESS TO CARE despite their having a significant burden of illness. The algorithm may have REDUCED THE NUMBER OF BLACK PATIENTS IDENTIFIED FOR EXTRA SERVICES BY MORE THAN ONE-HALF.

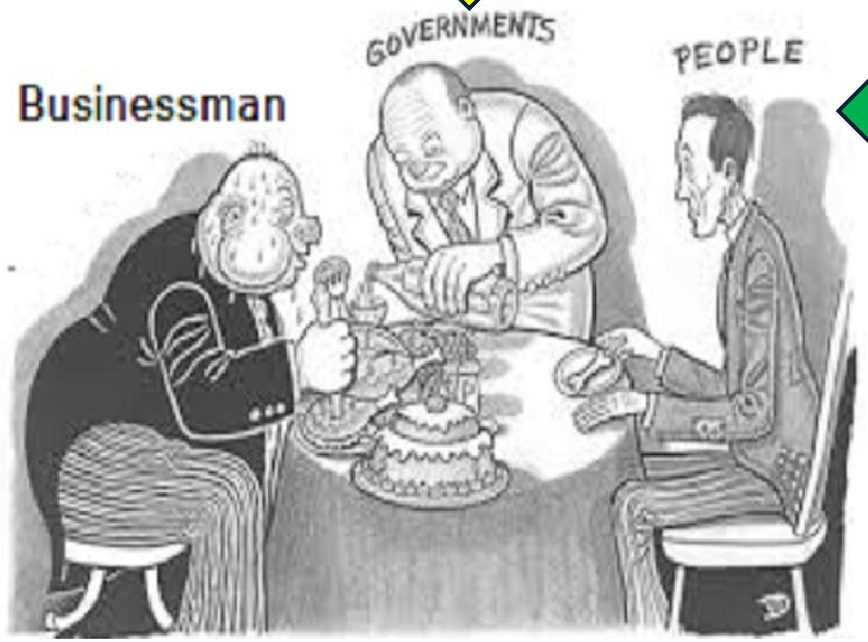
The Regulatory Capture of the U.S. Health Agencies

First of all, what is "**regulatory capture**"? Investopedia defines it as:

> *"an economic theory that says **regulatory agencies** may come to be dominated by the **industries** or **interests** they are charged with regulating. The result is that an agency, charged with acting in the public interest, instead acts in ways that **benefit incumbent firms** in the industry it is supposed to be regulating. Industries devote **large budgets** to **influencing** regulators, while individual citizens spend only limited resources to advocate for their own **rights**."*2

NO REGULATORY OVERSITE

INSURANCE COMPANY DENIALS, UNDER PAYMENT, & PAYMENT TAKEBACKS



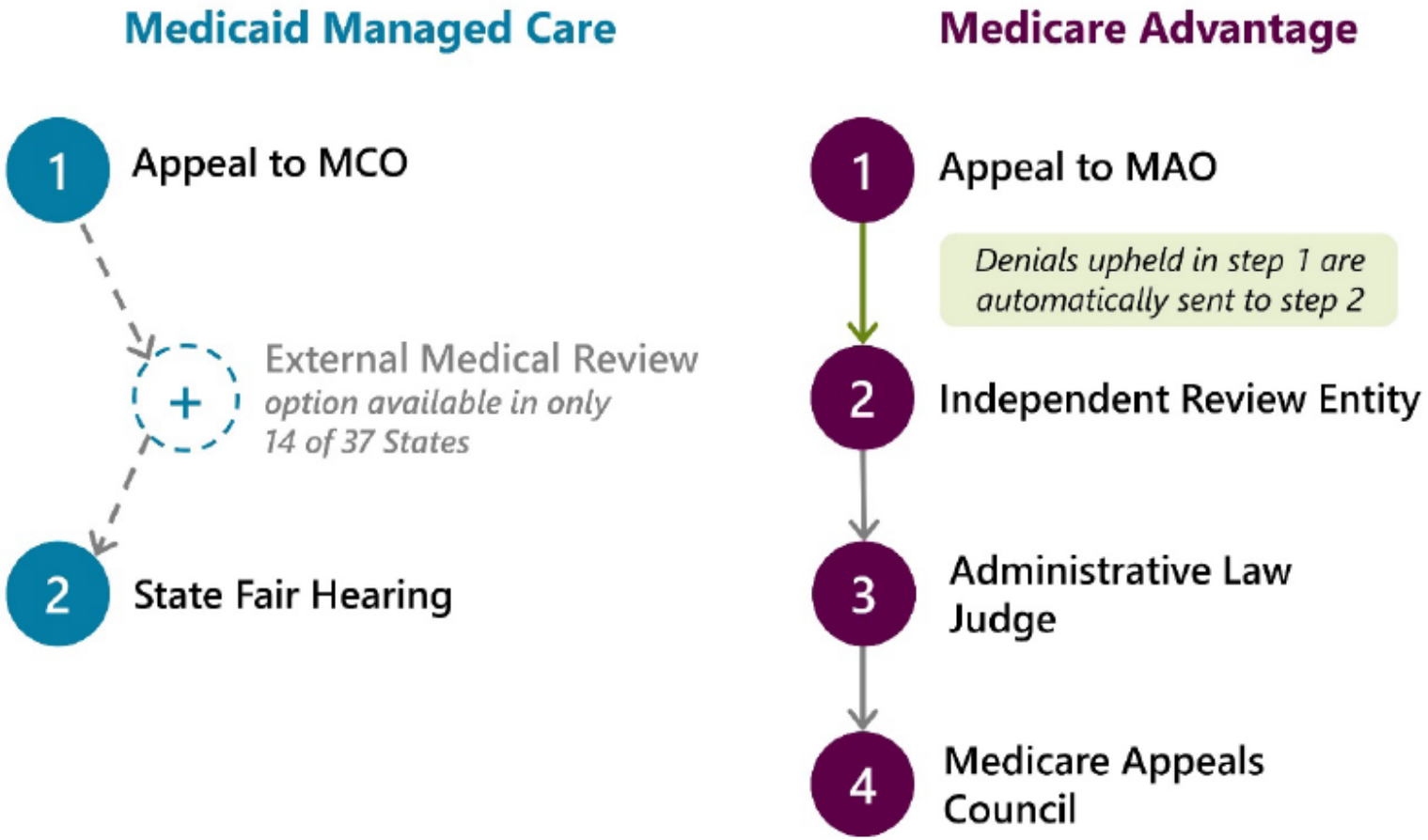
PATIENTS & MEDICAL PROVIDERS

High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care

Christi A. Grimm
Inspector General
July 2023, OEI-09-19-00350

Department of Health and Human Services
Office of Inspector General
Report in Brief
July 2023, OEI-09-19-00350

Exhibit 6: People enrolled in Medicaid managed care are guaranteed access to only two levels of appeal, compared to four levels of appeal guaranteed in Medicare Advantage



Note: "MAO" stands for Medicare Advantage Organization, which is an insurance company that offers health plans for Medicare enrollees. In Medicare Advantage, denials upheld by the Medicare Appeals Council can be challenged in Federal District Court. In Medicaid managed care, some States allow people to request a rehearing or judicial review of State fair hearing decisions.

High Rates of Prior Authorization Denials by Some Plans and Limited State Oversight Raise Concerns About Access to Care in Medicaid Managed Care

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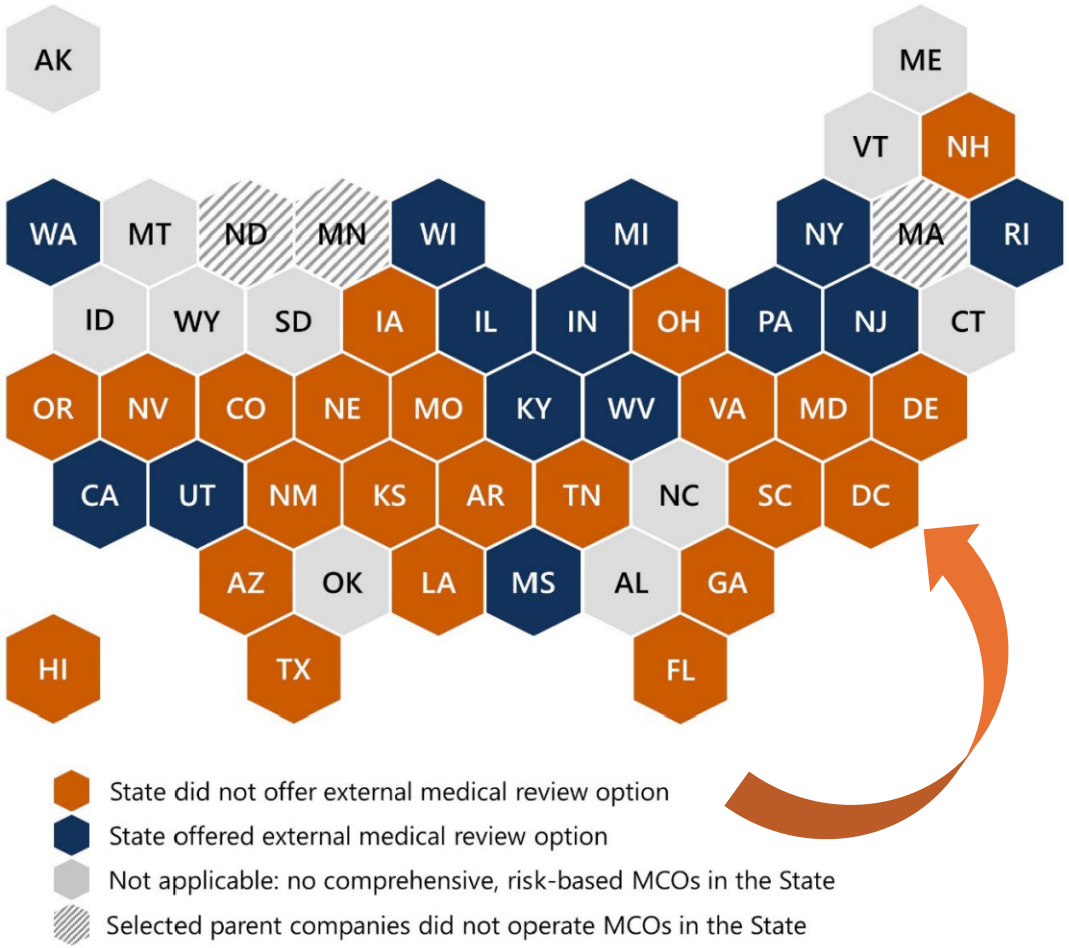
Exhibit 7: Most States with comprehensive, risk-based MCOs in 2019 did not offer external medical reviews



Source: OIG analysis of surveys of State Medicaid officials and analysis of Kaiser Family Foundation, *Medicaid Enrollment in Managed Care by Plan Type* for 2019, 2023.[38]

When enrollees appealed, MCOs usually upheld their own denials, and enrollees rarely escalated those appeals to State fair hearings

Effi Barry Training Institute

WEBINAR SERIES

Register Today

Medical Redlining: Challenges Accessing Equitable Care

Wednesday, November 20, 2024 at 12:00pm ET

Learning Objectives

At the end of this webinar, you will be able to:

- Describe the history and concept of medical redlining.
- Identify the impact of geographic barriers on healthcare access.
- Develop strategies to address health disparities.
- Explore the relationship between socioeconomic status and healthcare inequities.

Please note that continuing education credits are not available for this webinar.

Register Here

Faculty

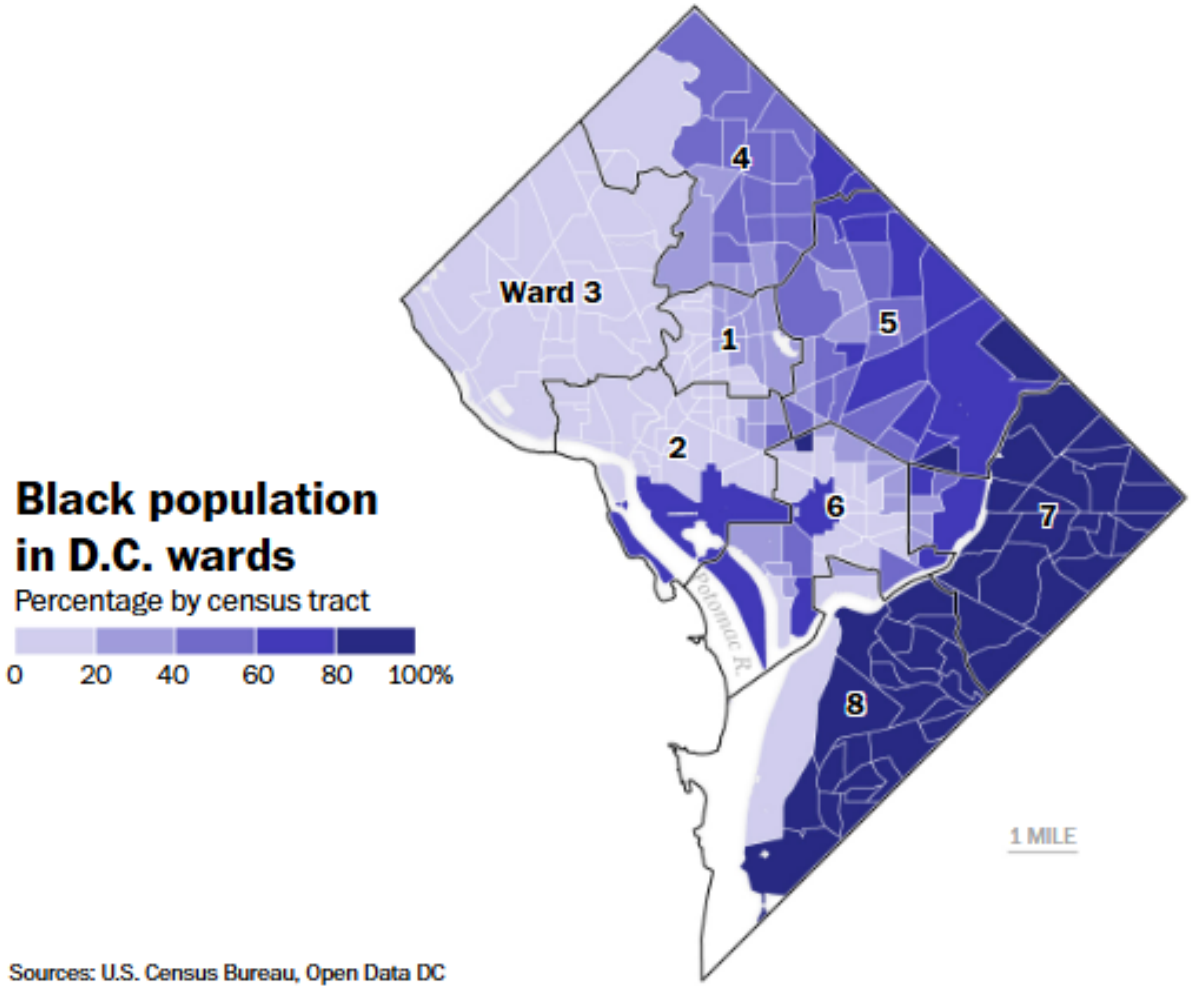
Judith Garber, MPP, is a Senior Policy Analyst at the Lown Institute. She joined the Lown team in 2016, after receiving her Master of Public Policy degree from the Heller School of Social Policy. Her research interests include hospital community benefit policy, overuse and value-based care, and racial health disparities. She has authored several white papers, journal articles, op-eds, and other publications on these topics. Judith previously worked at the Aspen Institute Financial Security Program, the Midas Collaborative, and Pearson Education.

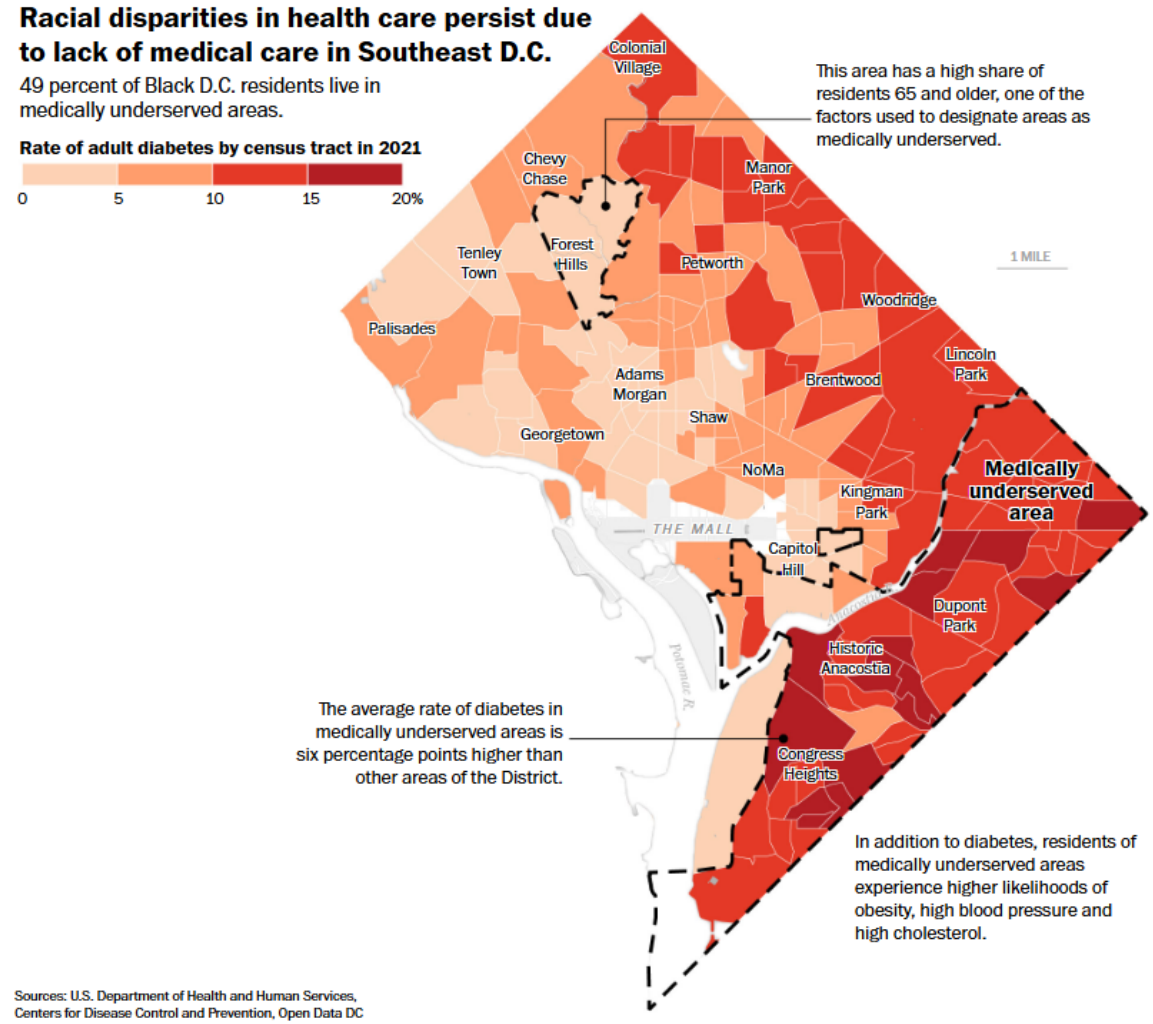
The Washington Post
Democracy Dies in Darkness

Half of Black D.C. residents lack easy access to health care, analysis shows

By Michael Brice-Saddler, Jenna Portnoy, John D. Harden and Janice Kai Chen

January 3, 2024 at 6:00 a.m. EST





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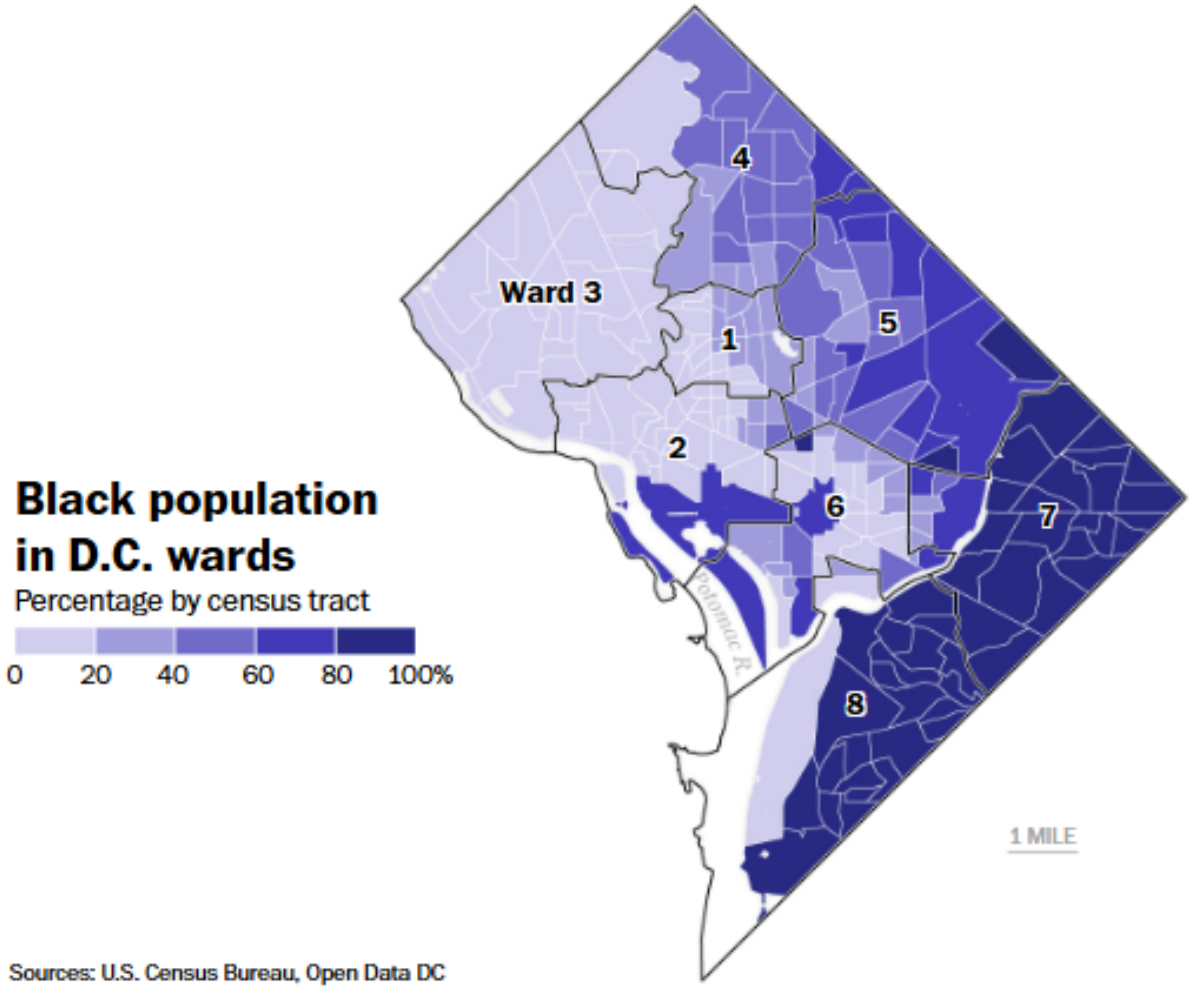

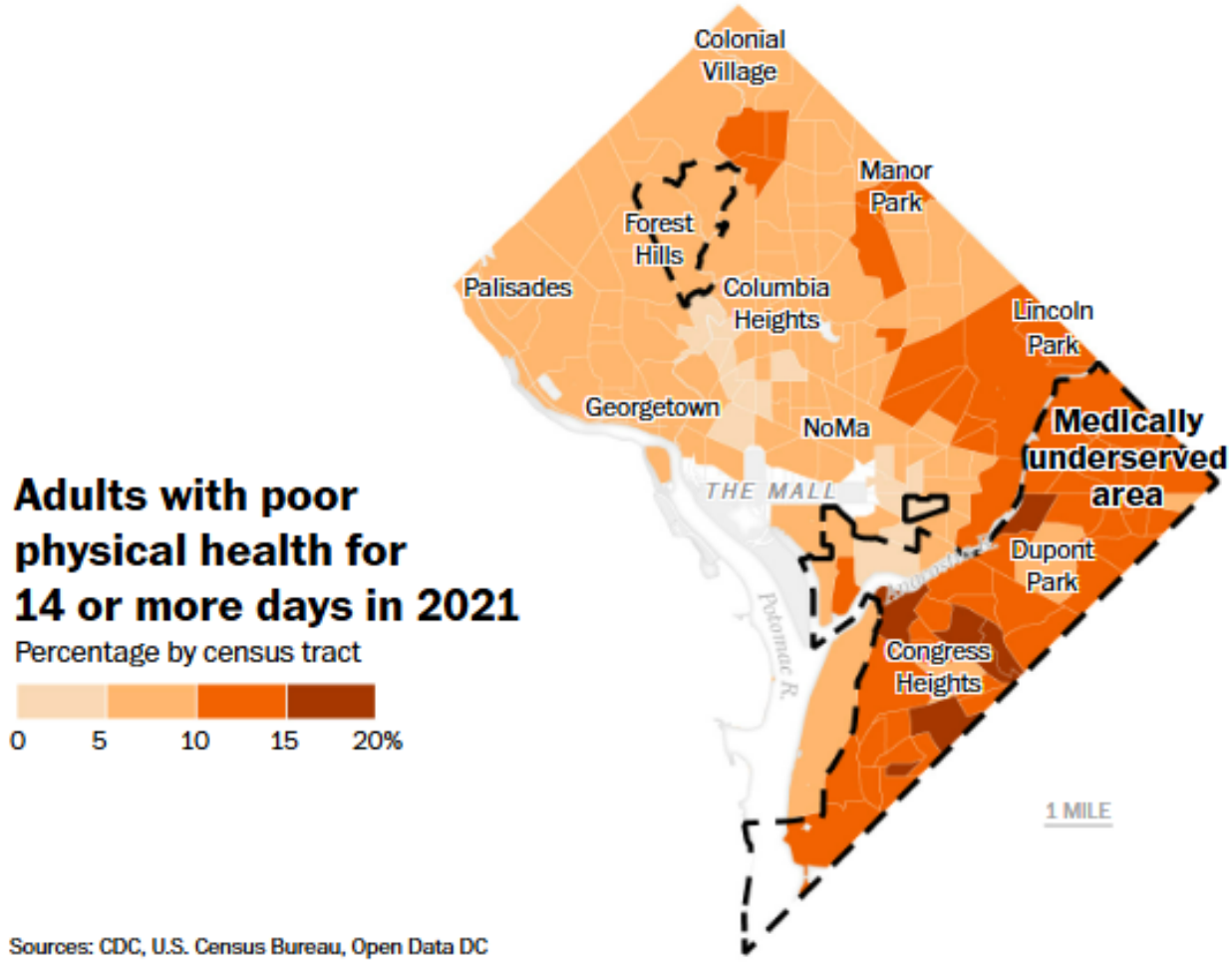

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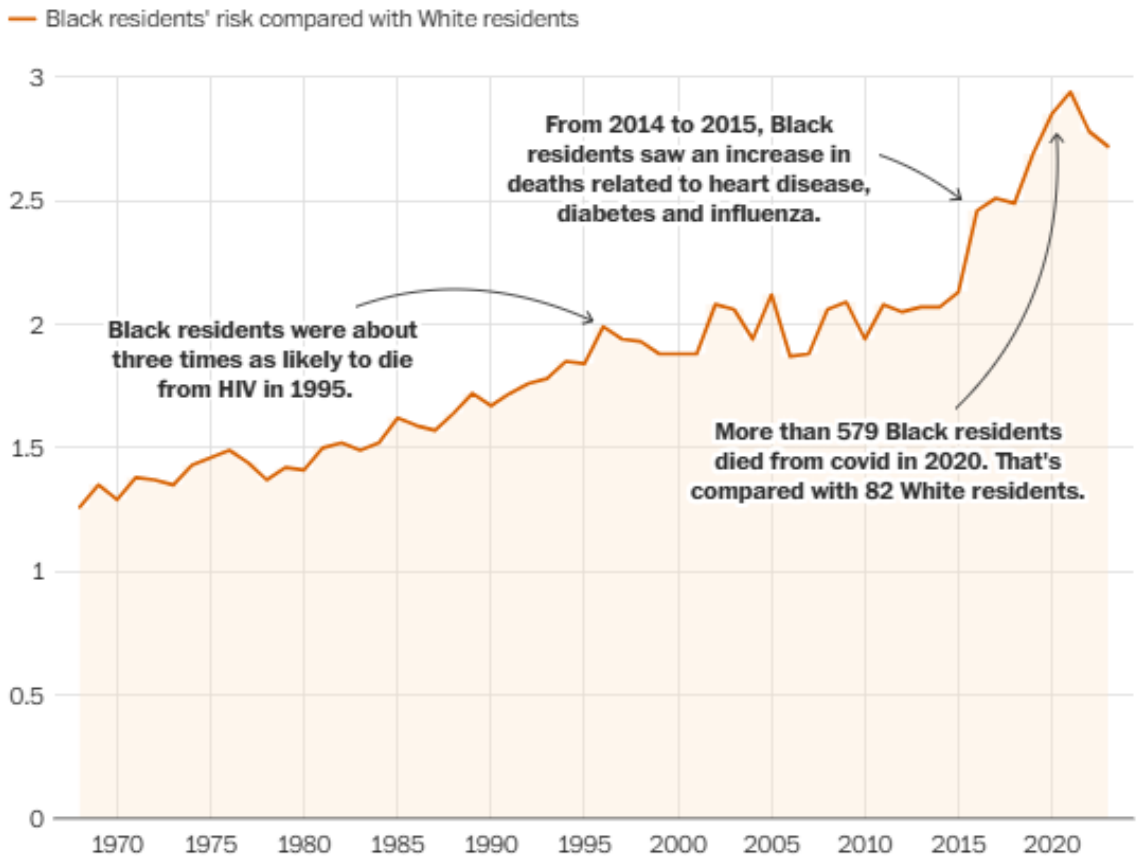
By Michael Brice-Saddler, Jenna Portnoy, John D. Harden and Janice Kai Chen
January 3, 2024 at 6:00 a.m. EST

The mortality gap has existed since the 1970s, but it widened during the pandemic

Black residents were almost three times as likely to die in D.C. as White residents in 2022, preliminary data shows. The mortality gap has grown steadily since the 1960s.



The CDC data is age-adjusted. Data from 2022 through 2023 is provisional.

Source: CDC

JOHN D. HARDEN / THE WASHINGTON POST

12/15/23 Med Schools Are Struggling to Overcome Racism in Health Care | TIME

TODAY

The Association of American Medical Colleges(AAMC) has since acknowledged the harm caused by the Flexner report, but itsinfluence on medical education is still felt today—perhaps most painfully inthe shortage of Black physicians in the U.S., who make up just **5%** of the doctor workforce. Closed Black medical schools could have trained approximately 35,000 additional Black physicians by 2019, one study found.

News and Information for the Howard University Community

HOWARD UNIVERSITY

BORN BLUE - LIVE BLUE - BLEED BLUE

HOWARD UNIVERSITY ONLINE COMMUNITY

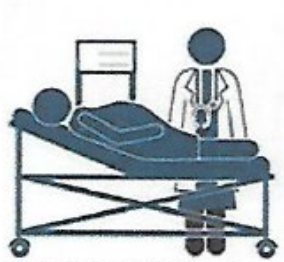
UPDATE @ HOWARD

News and Information for the Howard University Community

HU COMMUNITY CALL TO ACTION
#HowardMedicineMatters

December 1, 2018

IMPACT OF THE EAST END ACT ON HOWARD UNIVERSITY COLLEGE OF MEDICINE



Howard University Hospital supports the College of Medicine education of 475 medical students and 265 resident physicians.

Currently 1700 Howard University College of Medicine physicians practice in the DC area.

Total Howard University Hospital Volume

A significant volume of patients come from wards 7,8 (35%), and ward 5 (15%).

The Problem:

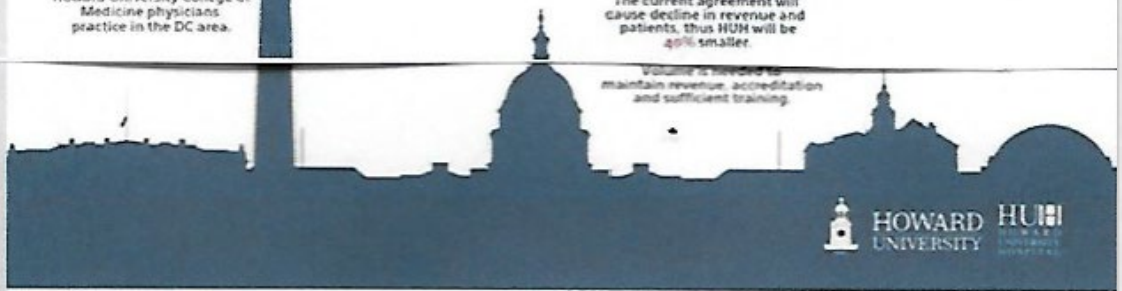
The new East End Hospital threatens the viability of Howard University's College of Medicine, and will cause the number of patients at HUH to decrease.

The current agreement will cause decline in revenue and patients, thus HUH will be 40% smaller.

The Solution:

The College of Medicine will need access to the new hospital across specialties to maintain its accreditation and training of its students and residents.

Volume is needed to maintain revenue, accreditation and sufficient training.



HOWARD UNIVERSITY HUH

Please rally and support Howard University College of Medicine and Howard's Medical Center! #HowardMedicineMatters

As an alum and supporter of the Howard community, you know the importance of the Howard University College of Medicine (HUCOM) and Howard Medical Center. HUCOM and Howard's Medical Center have been critical staples in the city's health care community for more than 150 years.

The D.C. Council is positioned to approve legislation **next week** on December 4th that would pave the way for an exclusive deal for a new hospital on St. Elizabeths campus. Howard supports a new East End hospital, but the agreement currently proposed would exclude Howard's faculty physicians; medical students and residents; nursing; allied health; pharmacy; and, dentistry students from providing services and receiving training at the new hospital. As a result, the more than 1,000 health professional students currently being trained at Howard will be in severe jeopardy.

We remind everyone that more than 90 percent of these students are from underrepresented minority groups whose predecessors have long demonstrated a willingness to serve citizens of the District and surrounding communities, as well as our Nation.

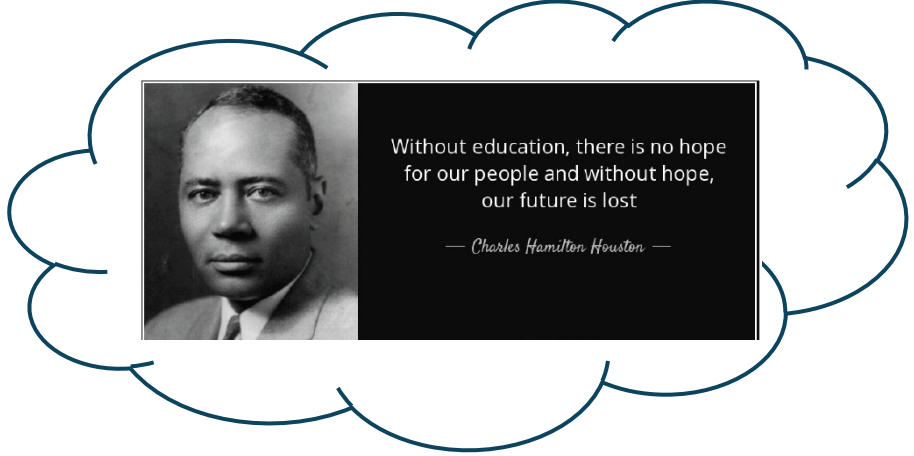
Without an equal opportunity for Howard physicians and medical residents to practice and train in the new hospital, the proposed deal will ***decrease revenue and volume at HUH, disrupt the pipeline of 750 minority physicians in training, and threaten the viability of the College of Medicine and Howard's Medical Center.***

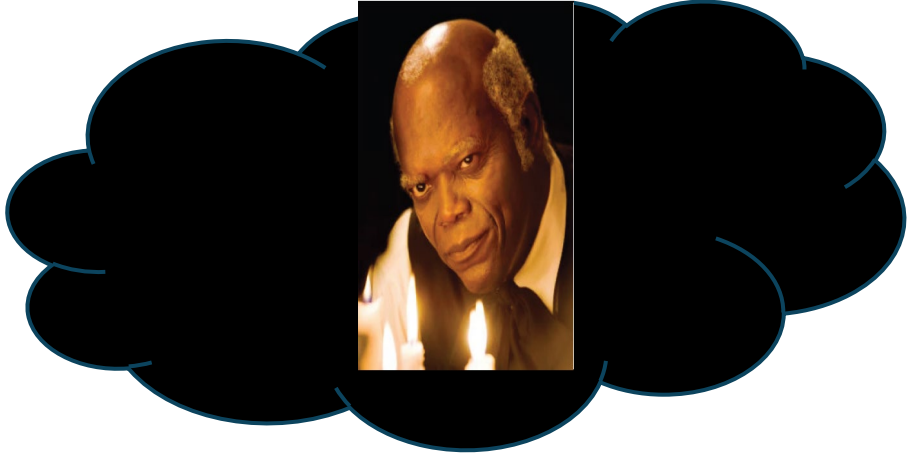
HOW CAN YOU HELP?

Join the conversation on social media. Use the hashtag #HowardMedicineMatters

AND

CONTACT THE MAYOR AND D.C. COUNCIL.





HOWARD UNIVERSITY

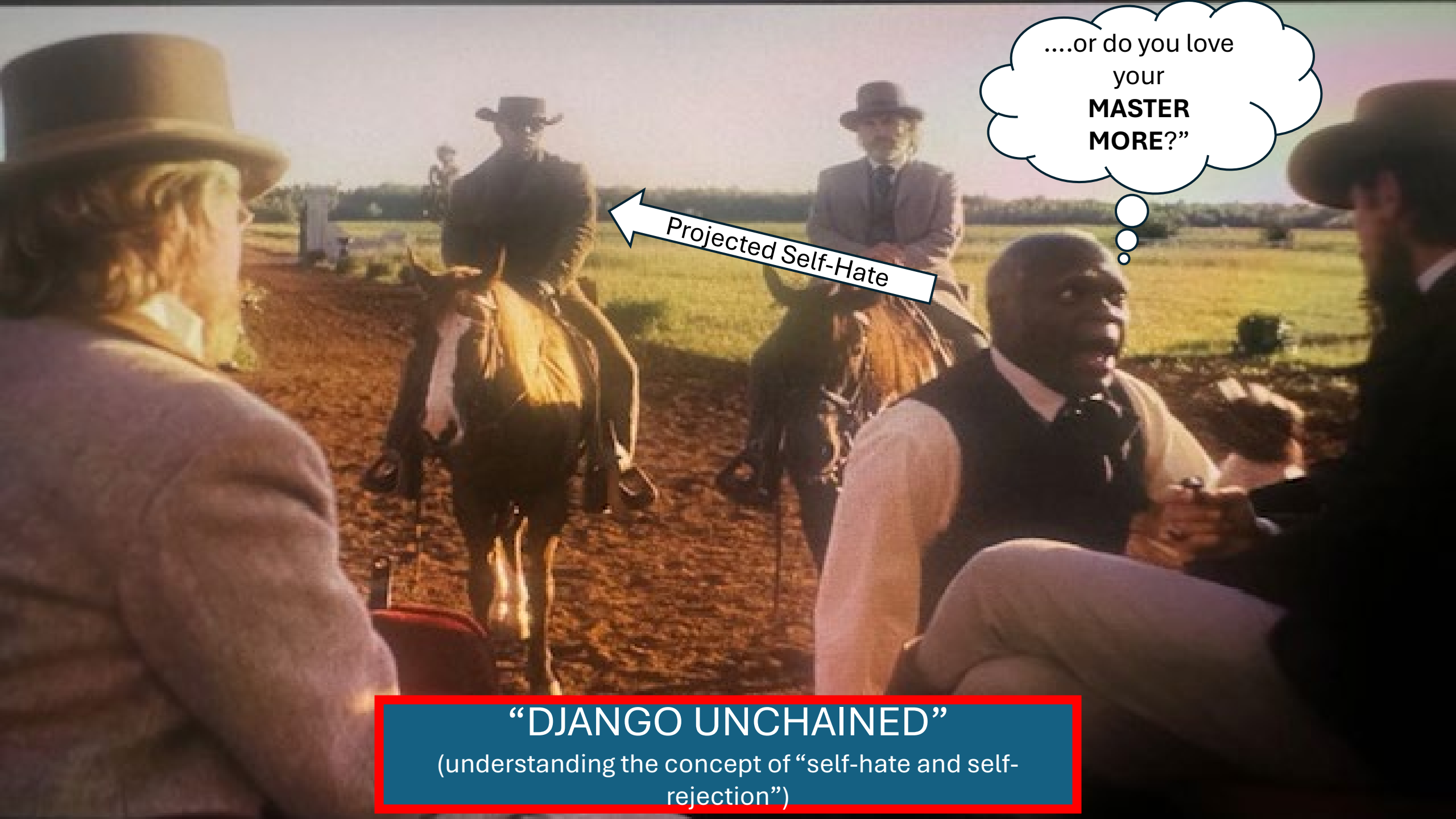
Office of the President

Without education, there is no hope for our people and without hope, our future is lost

Charles Hamilton Houston

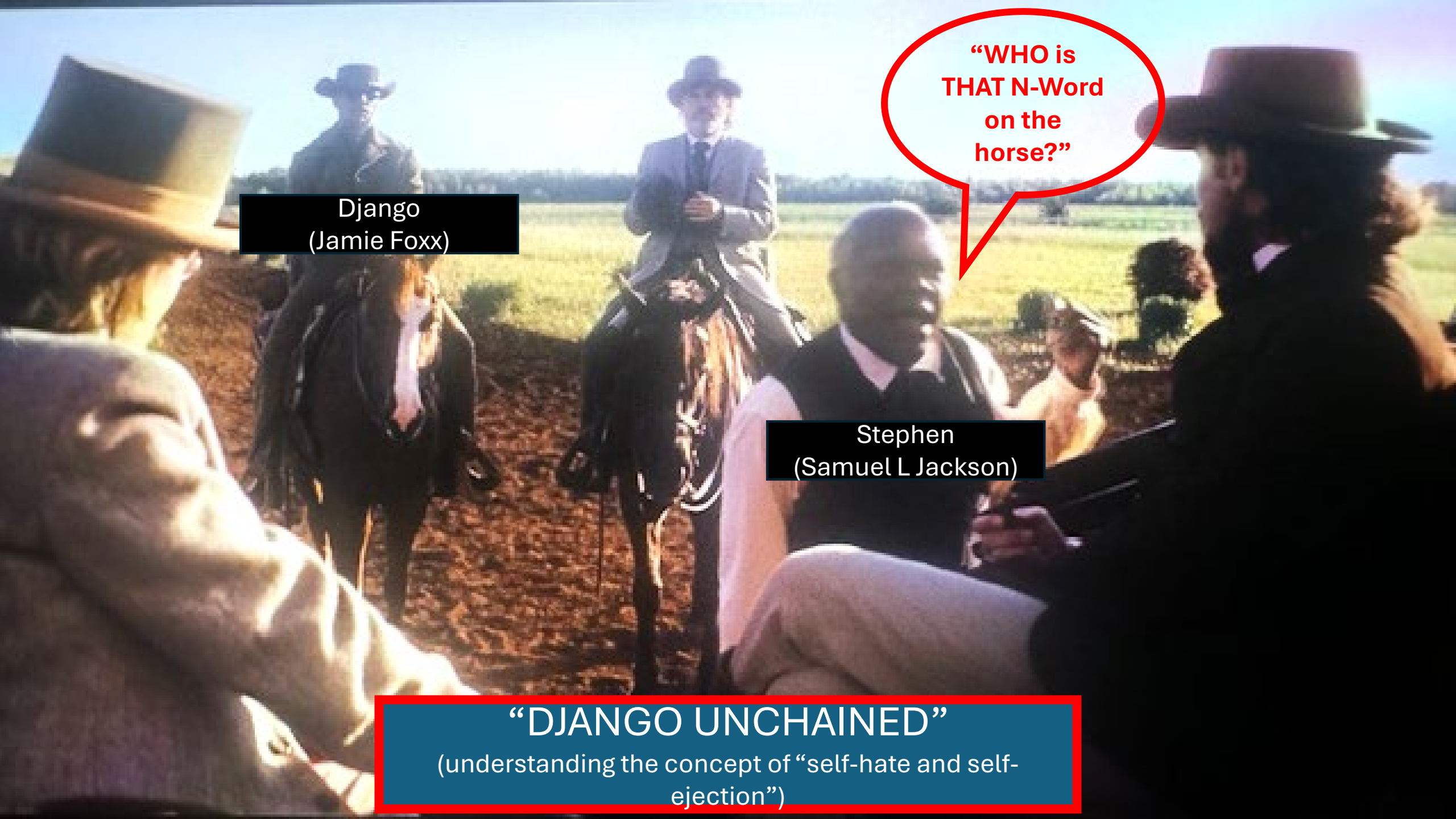
Washington, D.C. Mayor Muriel Bowser Announces Partnership with the George Washington University Hospital to Build New Hospital

We are getting rid of Howard University too … Just like we did Providence Hospital, OB and Cancer Services at UMC, and over 1000 addicts!!



"DJANGO UNCHAINED"

(understanding the concept of "self-hate and self-rejection")



“DJANGO UNCHAINED”

(understanding the concept of “self-hate and self-ejection”)

First Read - DMV

YOUR FIRST STOP FOR POLITICS IN D.C., MARYLAND AND VIRGINIA

Jaffe Report: Money, Power and Dead Bodies in DC's Worst Hospital

By Harry Jaffe

Published Nov 6, 2017 at 12:17 PM | Updated at 4:32 PM EST on Nov 6, 2017

TURNAGE:

"No big hospital with the preponderance of patients under Medicaid and Medicare can survive financially," he says, "and that's the situation right now. "But," he predicts, "there's potential for success if there's GENTRIFICATION."

In other words, a hospital for poor people can work, once more white people move into the neighborhood. Perhaps. But it certainly doesn't help D.C. residents who still rely on UMC -- and will for years to come.

Testimony of EDWIN C. CHAPMAN, SR., MD, DABIM, FASAM
to
The District of Columbia City Council
Committee on Business and Economic Development
and
Committee on Health

RE: B23-0777 and B23-778

June 30, 2020

BLACK and EXILED in YOUR OWN HOME: Will This Third Time Be the Charm?

50 years from now some astute historian might look back and wonder what kind of people would have approved the current Universal Health Systems (UHS) contract that (1) explicitly excluded Howard University faculty and students, (2) bared battle proven unionized black nurses and workers, and (3) backhanded the will of culturally knowledgeable activists in the community while approving a hospital with 2nd tier services in the midst of the historic Covid-19 pandemic? No one would believe that our fait was actually in our own hands only to have been given away to a reportedly corrupt and obviously racist company by a black mayor, black deputy mayor for health, black director of the department of health, and black council health chair.

Retrospectively in 2070, how could one imagine and justify after all that this community and country had been through in 2020 with the pending ouster and imprisonment of Donald J. Trump to have subjugated jobs, education, and self-sufficiency to such subservient mentality... that WE WERE, IN FACT, INCAPABLE of TAKING CARE of OUR OWN?!

11/11/2019

From: "Turnage, Wayne (DHCF)" <wayne.turnage@dc.gov>
Date: November 11, 2019 at 8:18:46 PM EST
To: Patricia Quinn <pquinn@dcpca.org>, EDWIN CHAPMAN <echap1647@aol.com>
Cc: ATD EOM3 <eom@dc.gov>, "Mendelson, Phil (COUNCIL)" <PMENDELSON@DCCOUNCIL.US>, "Evans, Jack (COUNCIL)" <JACKEVANS@DCCOUNCIL.US>, Vincent Gray <vgray@DCCOUNCIL.US>, Trayon White <twhite@dccouncil.us>, "kmcduffie@dccouncil.us" <kmcduffie@dccouncil.us>, Robert White <rwhite@DCCOUNCIL.US>, David Grosso <dgrosso@DCCOUNCIL.US>, "Cheh, Mary (COUNCIL)" <MCheh@DCCOUNCIL.US>, Elissa Silverman <esilverman@dccouncil.us>, "abonds@dccouncil.us" <abonds@dccouncil.us>, "Todd, Brandon (COUNCIL)" <BTodd@DCCOUNCIL.US>, "bnadeau@dccouncil.us" <bnadeau@dccouncil.us>, "Allen, Charles (COUNCIL)" <CAllen@DCCOUNCIL.US>, "Racine, Karl (OAG)" <Karl.Racine@dc.gov>, "Nesbitt, LaQuandra S. (DOH)" <laquandra.nesbitt@dc.gov>, "Riley, Pamela (DHCF)" <Pamela.Riley2@dc.gov>
Subject: Re: Memo on MAT barriers

Pat:

Please do not send me any emails from Dr. Chapman. His typically rude, racist, demeaning, and disrespectful attacks on me and my staff are no longer tolerated. In this case, we made a technical change to our system designed to expand access to MAT, and the change unknowingly created another problem that limited access. We fixed the problem as soon as it was discovered.

Deputy Mayor Wayne Turnage to Pat (Quinn):
Please do not send me any emails from Dr Chapman. His typically rude, racist demeaning, and disrespectful attacks on me and my staff are no longer tolerated. In this case, we made a technical change to our system designed to expand access to MAT, and the change unknowingly created another problem that limited access. We fixed the problem as soon as it was discovered.

communication to send to pharmacy providers.

My staff works exceptionally hard and without complaint to maximize health care access to those who rely on Medicaid, and the frequent and disgusting comments by the likes of Dr. Chapman at the first hint of any problem, have simply worn thin.

WT

Democracy Dies in Darkness

D.C. Mayor Muriel E. Bowser proposes legislation to buy Capital One Arena

Under the proposal, the city, which already owns the land under the arena, would buy the building for $87.5 million.

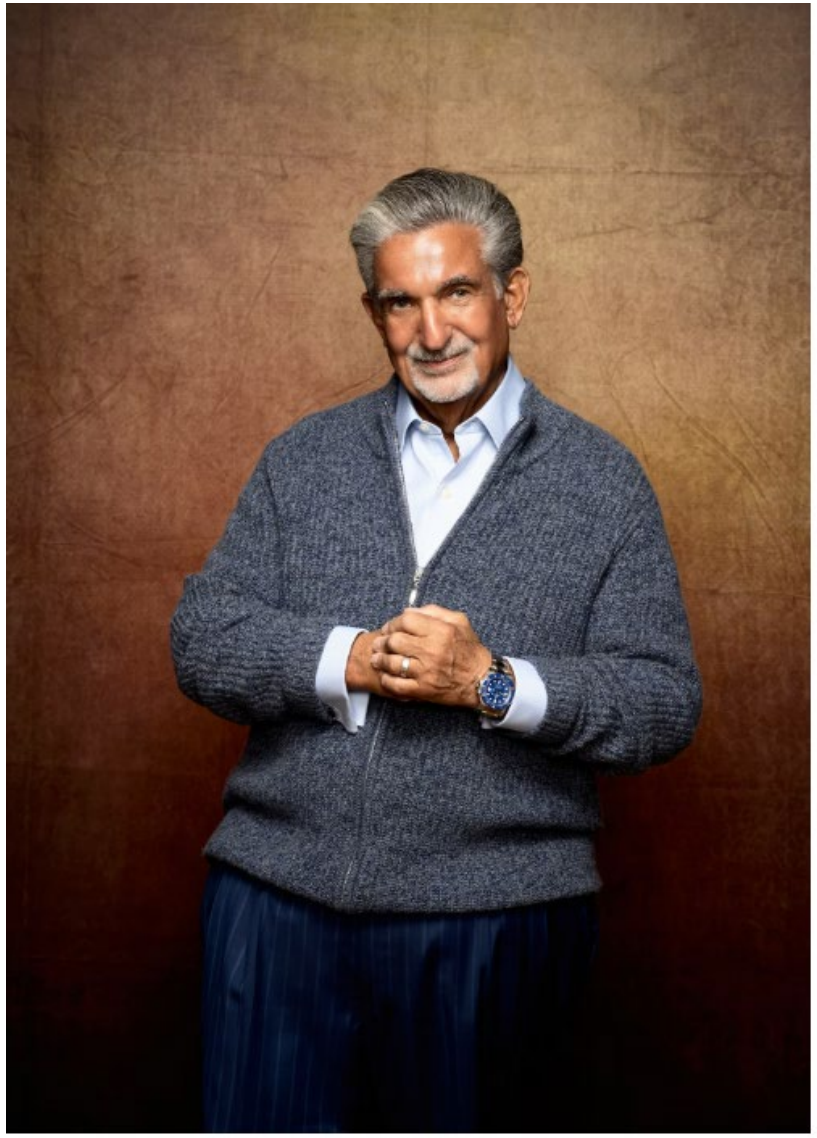
D.C. Mayor Muriel E. Bowser (D) and Ted Leonsis, CEO of Monumental Sports & Entertainment, at a news conference in March following the announcement that Monumental Sports would be staying in the District at Capital One Arena. (Craig Hudson for The Washington Post)

Stung by the backlash, Ted Leonsis is trying to win back Washington

The Monumental Sports & Entertainment CEO says he wants to unite the region, but a failed arena deal in Virginia turned him into a polarizing figure.

By Rick Maese

October 25, 2024



The backlash to his plan for a new arena in Virginia surprised Monumental CEO Ted Leonsis. "For such a good people person, I really misjudged a lot of that," he said. (Marvin Joseph/The Washington Post)

Those in the car remembered stopping at a traffic light, where they watched a man step into the road, drop his pants and defecate in the middle of the street. Leonsis was stunned, but he chuckled. While his brain started churning about ways the system needs to better support a struggling population, **he also was struck by how happy the man seemed. Leonsis flashed him a thumbs-up as his car rolled past.**

"I wish I could be that carefree," remarked **Bob Schneider, Leonsis's chief of staff. They idly discussed what it would be like to trade places with the man.** ***"I mean, he was not worrying about a thing,"*** **Leonsis later recalled.** ***"His worries and concerns are much different than mine. This guy's taking a dump outside on a beautiful day, and I'm wondering what it'd be like to change places with him. Can you imagine?"***

The moment of levity, of course, did not erase the frustration and disappointment from the preceding days and weeks. The drumbeat from detractors was loud and incessant.

Nathan Hare, scholar who led fight for Black studies, dies at 91

June 22, 2024

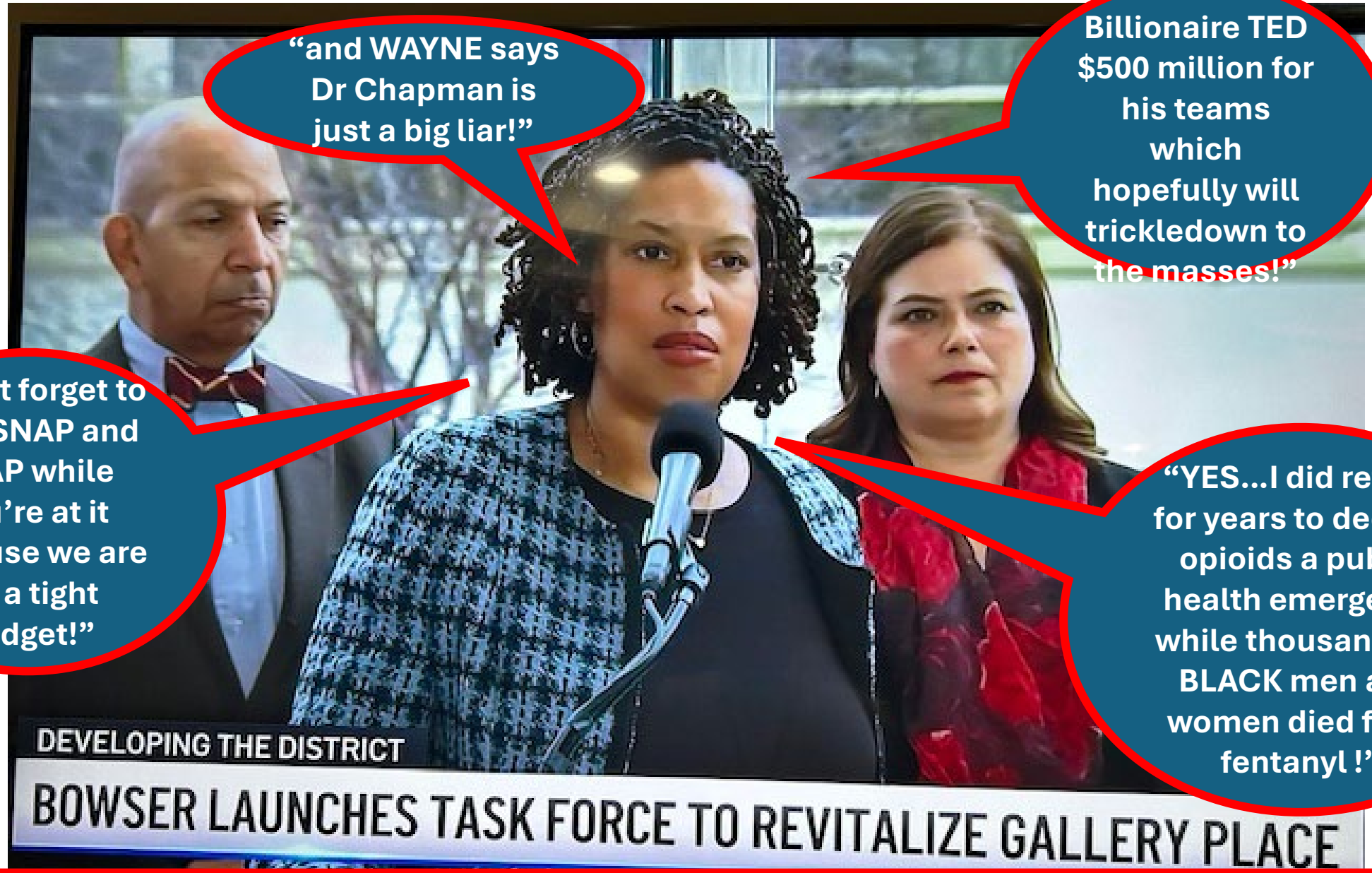
A 1965 treatise by Dr. Hare, “Black Anglo-Saxons,” asserted that African Americans have lost their way and identity by trying to assimilate with White culture. He expanded his influence by pushing the academic and literary debates into protest action.

In 1966 he wrote a letter to the campus newspaper, *The Hilltop*, mocking Howard president James Nabrit's statement to the *Washington Post* on September 3, 1966 that he hoped to increase white enrollment at Howard to as much as 60%. Nabrit had been part of the NAACP legal team to successfully argue the 1954 *Brown vs. Board of Education* case before the U.S. Supreme Court, which ruled that segregation of public schools was unconstitutional. By 1966, the civil rights movement had achieved passage of the Civil Rights Act of 1964 and Voting Rights Act of 1965. After that, some activists were seeking "Black Power," as declared Stokely Carmichael in Montgomery, Alabama, who was a former student of Hare. (Hare had also taught Claude Brown, future author of *Manchild in the Promised Land*).

Nathan Hare

On February 22, 1967, Hare held a press conference, with students identified as "The Black Power Committee," and read "The Black University Manifesto." It called for "the overthrow of the Negro college with white innards and to raise in its place a black university, relevant to the black community and its needs." Hare had previously published a book called *The Black Anglo Saxons*; he coined the phrase, "The Ebony Tower," to characterize Howard University.

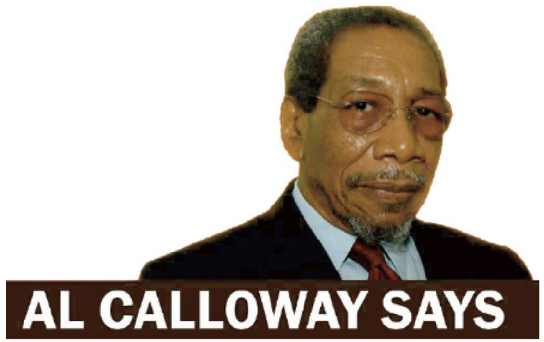
In the spring of 1967, Hare invited the champion fighter Muhammad Ali to speak at Howard. He was controversial for statements about black power and as one of numerous opponents to the Vietnam War. The champion gave his popular "Black Is Best" speech to an impromptu crowd of 4,000 gathered at a moment's notice outside the university's Frederick Douglass Hall. The administration had padlocked the Crampton Auditorium to prevent Ali from speaking there because of his statements against the war, days before he refused to be drafted. Hare was dismissed effective in June 1967.



"OUR ENEMY WITHIN!!!!"

SOUTH FLORIDA TIMES
sfltimes.com
"Elevating the Dialogue"

ARE 'BLACK ANGLO-SAXONS' IN THE WAY?



My initial answer to the question is yes, because Black Anglo-Saxons are worse than white nationalists for they are the enemy within. This injurious development metastasized on America's plantations along with taking black women and thus producing mulatto slaves. Black and shades of brown house slaves, trained, finely dressed and fed, differed markedly from ill-clothed, housed and slop-fed black field slaves.

House slaves could always carefully sneak a little something to a favorite field slave and thereby be privy to very important information that further enhanced their value to the plantocracy. Several slave rebellions were put down in this way. Today, Black Anglo-Saxons are the valuable assets white America has in placating and containing the nation's black masses.

‘Health equity tourists’: How white scholars are colonizing research on health disparities

“THE CHRISTOPHER COLUMBUS SYNDROME”

By Usha Lee McFarling

Sept. 23, 2021

Monica McLemore, an associate professor of family health care nursing at UCSF, studies reproductive health and rights in marginalized communities.
Constanza Hevia for STAT

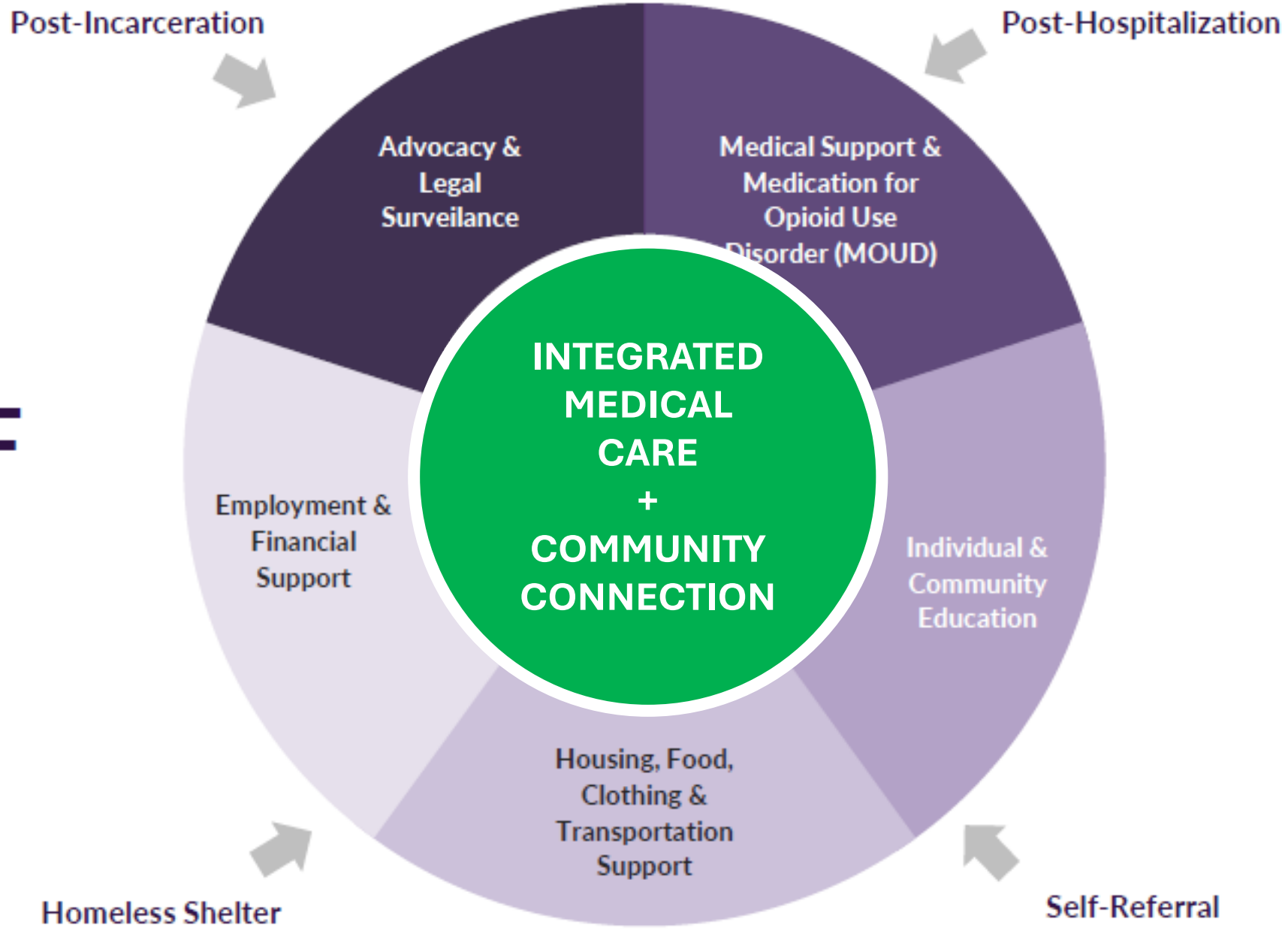
Fueled by the massive health disparities exposed by the coronavirus pandemic and the racial reckoning that followed the murder of George Floyd, health equity research is now in vogue. Journals are clamoring for it, the media is covering it, and the National Institutes of Health, after publicly apologizing for giving the field short shrift, recently announced it would unleash nearly $100 million for research on the topic.

This would seem to be great news. But a STAT investigation shows a disturbing trend: a gold rush mentality where researchers with little or no background or training in health equity research, often white and already well-funded, are rushing in to scoop up grants and publish papers. STAT has documented dozens of cases where white researchers are building on the work of, or picking the brains of, Black and brown researchers without citing them or offering to include them on grants or as co-authors.

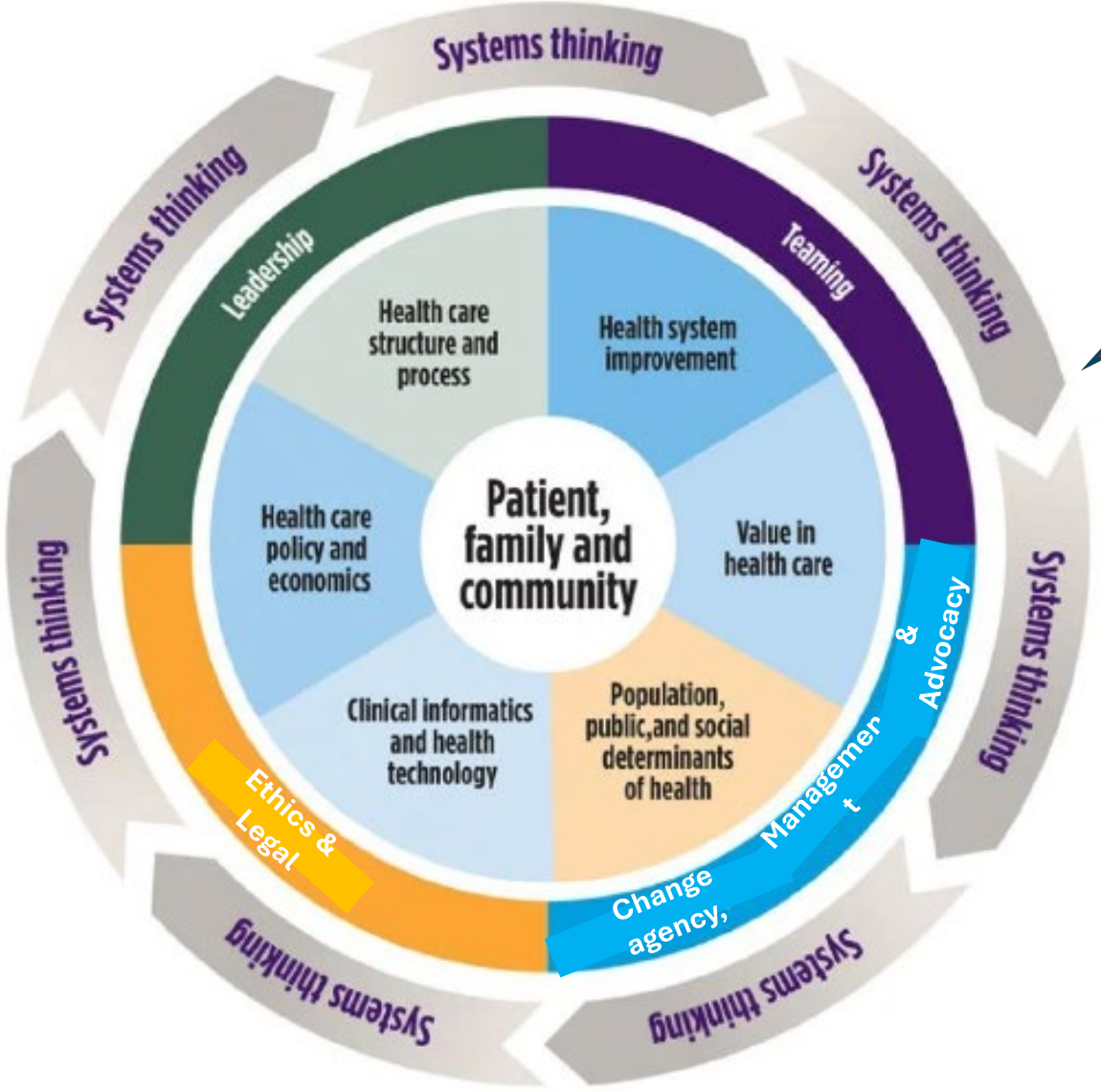
A glaring example occurred in August when the Journal of the American Medical Association — a leading medical journal already under fire for how it handles issues of race — published a special themed issue on racial and ethnic health disparities in medicine. Meant to highlight JAMA’s new commitment to health equity, it served up an illustration of the structural racism embedded in academic publishing: Not one of the five research papers published in the issue included a Black lead or corresponding author, and just one lead author was Hispanic.

A JAMA spokesperson said its editors do not consider the demographics of authors in selecting research papers, but critics say that neutral stance perpetuates long-standing inequities rather than addressing them.

THE CYCLE OF REPAIR



2022-2023 Health Systems Science Scholars



Core functional, foundational, and linking domains of health systems science

COMMUNITY-CENTRIC TREATMENT

The AMA Health Systems Science Scholars program equips faculty who have significant responsibility for—or who anticipate having responsibility for—implementing and/or teaching topics related to health systems science, with the knowledge and skills needed to be outstanding teachers and leaders. Specifically, the program provides an overview of how to design, implement and evaluate health systems science curriculum at participants' local institutions.

Dikembe Mutombo, shot-blocking NBA center and humanitarian, dies at 58

A top prospect out of Georgetown, he became an eight-time all-star, served as the NBA's first global ambassador and was inducted into the Basketball Hall of Fame.

Dikembe Mutombo in 2015, when he was announced as a finalist for the Basketball Hall of Fame. He was inducted into the hall later that year. (Julio Cortez/AP)

By Harrison Smith

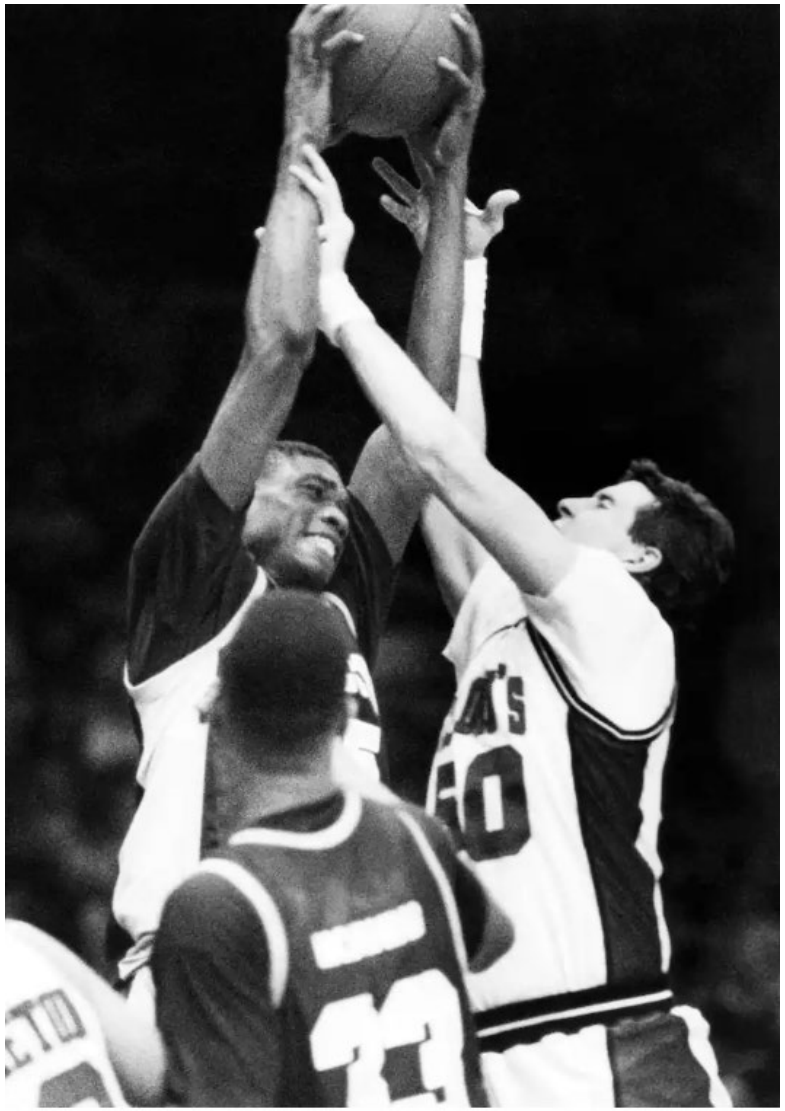
September 30, 2024 at 10:55 a.m. EDT

Dikembe Mutombo, a shot-blocking, finger-wagging basketball Hall of Famer who dominated on defense at Georgetown and in the NBA, turning opponents away from the rim while building an off-court legacy through his humanitarian work in Central Africa, died Sept. 30 in Atlanta. He was 58.

Raised in the Democratic Republic of Congo, then known as Zaire, Mr. Mutombo spoke nine languages, but he barely understood English — or what a zone defense was — when he came to the United States in 1987 to study at Georgetown University. **He had planned to pursue a career in medicine but instead embraced basketball** under Hoyas Coach John Thompson, who was known for cultivating tenacious, defense-minded big men such as Patrick Ewing.

Dikembe Mutombo, shot-blocking NBA center and humanitarian, dies at 58

A top prospect out of Georgetown, he became an eight-time all-star, served as the NBA's first global ambassador and was inducted into the Basketball Hall of Fame.



Mr. Mutombo, left, grapples under the basket with St. John's Sean Muto during a Georgetown game at Madison Square Garden in 1990. (Susan Ragan/AP)

Mr. Mutombo spent a decade trying to finance and build the $29 million hospital, personally donating $15 million to the project and soliciting funds from fellow NBA players. The Congolese ambassador at the time, Faida Mitifu, told USA Today that the hospital was "a godsend" for the city, and President George W. Bush, at the State of the Union address in 2007, praised Mr. Mutombo as an example of "heroic kindness, courage and self-sacrifice."

In part, Mr. Mutombo said, it simply felt good to give back and be recognized. "I like to be loved; I like to love others," he told the New York Times. **He often cited what he described as an African proverb: "When you take the elevator up to reach the top, please don't forget to send the elevator back down, so that someone else can take it to the top."**

Dikembe Mutombo, shot-blocking NBA center and humanitarian, dies at 58

A top prospect out of Georgetown, he became an eight-time all-star, served as the NBA's first global ambassador and was inducted into the Basketball Hall of Fame.

Mr. Mutombo and his wife, Rose, at a 2021 fundraiser for UNICEF in New York. (Evan Agostini/Invision/AP)

Some coaches said that his offseason activities were damaging his career, distracting him from developing his hook shot or working on his ballhandling. But Mr. Mutombo suggested that his critics had it backward: **Basketball, he said, was only "a vehicle that I used to get me where I'm going."**

"I am not trying to become Americanized, because [in] American society when you succeed you succeed for yourself," he once told the Rocky Mountain News. "But in African society, you succeed for your family. People helped me when I grow up. I cannot stop helping people now."

Can family medicine improve America's mental health?

Barriers to mental health services are being lowered by offering services at primary care clinics. (Spencer Platt/Getty Images)

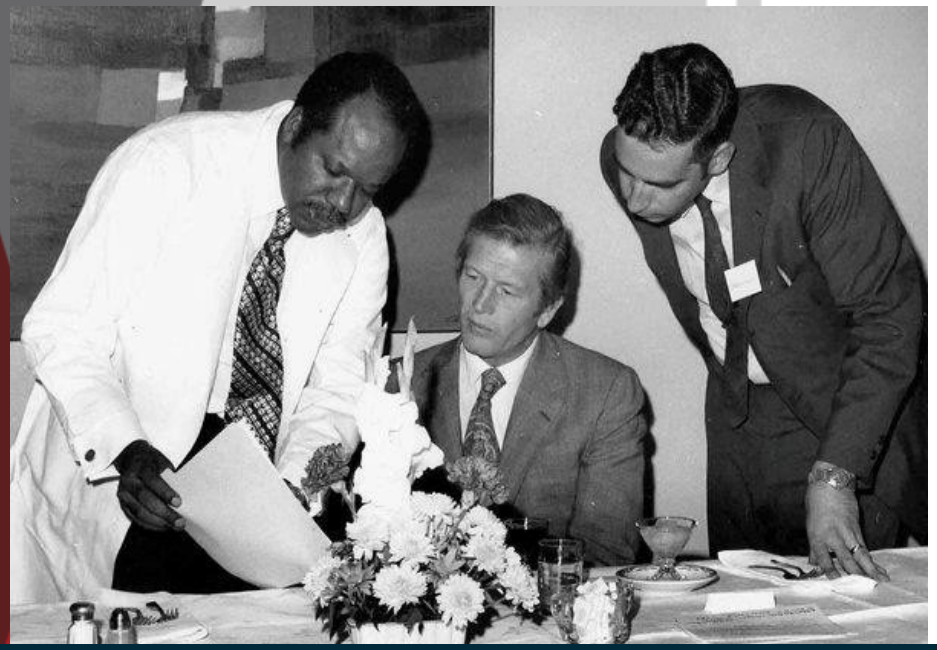
By Akilah Johnson

February 10, 2023 at 6:00 a.m. EST

Now, the federal government is trying to bring down those barriers, too, by awarding 24 medical schools and hospitals a total of $60 million to train the next generation of primary care physicians — family medicine doctors, pediatricians, internists — to address behavioral health needs.

Using money from the federal grant, family medicine residents at Charles Drew — which is a historically Black college and university in Los Angeles — will do more mobile outreach, caring for young people in homeless encampments and at community organizations. At Meharry doctors training in family and preventive medicine will work on motivational interviewing skills, learning to skip stern lectures and scare tactics when talking to patients and to instead uncover their motivation for change. And family medicine residents at the University of Buffalo will deepen their understanding of how to use medication treatment for opioid-use disorder

Dr. Beny Primm, Pioneer in Addiction and AIDS Prevention



Dr. Beny J. Primm, left, with Mayor John V. Lindsay of New York, center, and Dr. Bertram S. Brown, director of the National Institute of Mental Health, in an undated photo. As mayor, Mr. Lindsay secured money used by Dr. Primm to open a methadone clinic in Brooklyn in 1969.

1980's

Patients do better with comprehensive psychosocial, vocational, medical, psychiatric and behavioral therapy

By William Grimes
• Oct. 24, 2015

Beny J. Primm, a doctor who started some of New York City's first methadone clinics to treat heroin addicts in the 1960s and who, during the AIDS epidemic in the 1980s, became a nationally prominent advocate for changing public health policy toward intravenous drug users.

Because of his AIDS work, **Dr. Primm** was named to **Ronald Reagan's** Presidential Commission on the Human Immunodeficiency Virus Epidemic in 1987. When the commission drafted a 600-point plan for dealing with the AIDS crisis, **he inserted the recommendation that intravenous drug users be given treatment on demand**.

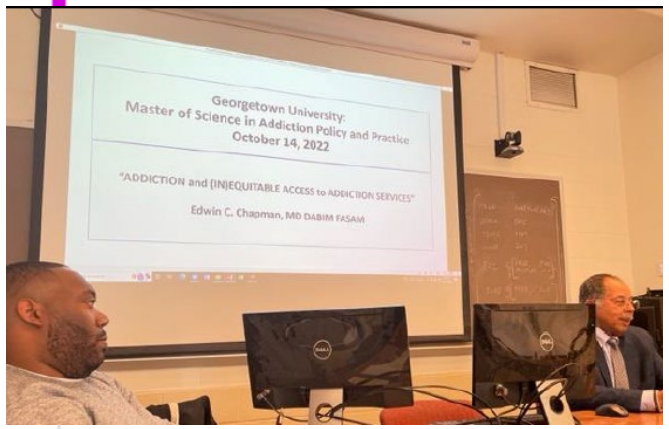
Under **President George Bush**, Dr. Primm served on the **National Drug Abuse Advisory Council** and was associate administrator of the **Office of Treatment Improvement** (later the **Center for Substance Abuse Treatment**), an agency of the **Department of Health and Human Services** that works with state programs and community groups offering drug and alcohol treatment.

In addition to serving as executive director of the Addiction Research and Treatment Corporation (now Start Treatment and Recovery Centers) until his retirement in 2013, Dr. Primm was president of the Urban Resource Institute, which he founded in 1981 to provide career counseling and job training for addicts and to provide a safe haven for victims of domestic violence.

INTEGRATED TREATMENT MODEL

- **Integrative/Collaborative Care**
  - **Service Settings**
  - **Meeting patients where they are**
- **HIV testing and counseling**
- **Antiretroviral treatment**
- **Prevention and treatment of sexually transmitted infections**
- **Peer-support and education**
- **Group Support-AA and NA**
- **Individuals with substance abuse were significantly less likely to discontinue HAART in the first and second years of treatment. Treatment of substance use disorders can prevent AIDS**

https://www.psychiatry.org/psychiatrists/practice/professional-interests/integrated-care



THE CYCLE OF REPAIR

Post-Incarceration

Advocacy & Legal Surveilance

Medical Support & Medication for Opioid Use Disorder (MOUD)

Individual & Community Education

Sullivan Robinson

Employment & Financial Support

Homeless Shelter

Housing, Food, Clothing & Transportation Support

NW

Geographically Distributed Medical Practices"

NE

CHAPMAN HYBRID INTEGRATED-COORDINATED CARE MODEL: MENTAL HEALTH + SUD + PRIMARY CARE + SDoH

Geographically Distributed Medical Practices

SERVICES

- PRIMARY CARE
- PSYCHIATRY
- SUD
- SOCIAL WORKER
- INFECTIOUS DISEASE
- COMMUNITY NAVIGATORS

COMMUNITY HOSPITAL

FAITH INSTITUTION WRAPAROUND SERVICES

OTHER & ASSOCIATES

CHAPMAN, MD, PC COMMUNITY PRACTICE

Geographically Distributed Medical Practices

Geographically Distributed Medical Practices

SW

SE

The Washington Post

METRO

A streetwise hustler turns into a single father of two sons

Nate Morris III wrote a book on fatherhood that also tells the story of a life transformed

Perspective by Courtland Milloy
Columnist

April 11, 2023 at 1:44 p.m. EDT

Nate Morris III with his sons Nate IV, left, and King. (Courtland Milloy/The Washington Post)

For much of his life, Nate Morris III was a streetwise hustler in D.C. He made a living selling counterfeit jewelry, having honed his skills by enrolling in a school of gemology just long enough to learn the lingo. He became a heroin addict and nearly died after overdosing on fentanyl. He's been in and out of prison for a variety of offenses, including parole violations.

The silver tongue that helped him unload fake Rolexes also helped him attract women looking to share in the spoils of his con. One of those eventually became the mother of his two sons.

Unfortunately, their relationship ended with a bitter break up. A child-custody battle ensued in D.C. Family Court. In 2020, Morris prevailed — an extraordinary outcome considering his checkered past and, especially, given the ages of the boys. The youngest son, Nate IV, is now 4 years old; the older son, King, is 6.

He said he wrote it over 18 months, between 4 a.m. and 6 a.m. "while the boys were asleep."

"I wanted to say something that would inspire some of these youngsters to start stepping up and taking care of these babies because the babies didn't ask to be here," Morris told me.

His turning point, however, proved to be gut-wrenching.

"Not long ago, I literally died," he writes in the book. "And only through God's grace and mercy were first responders able to bring me back." That was seven years ago. D.C. paramedics just happened to be nearby when Morris overdosed on fentanyl he'd purchased behind a laundromat near Benning and Bladensburg roads in Northeast Washington.

It took four injections of the anti-overdose drug Naloxone to revive him. He was also lucky to have overdosed in front of Edwin Chapman's medical offices. Chapman is one of the few physicians in the country that specializes in treating opioid addiction among low-income and homeless African Americans.

Morris is 60.

During the custody hearings, Morris maintained that he was a changed man — the street hustle, the jewelry con, the drug addiction were all behind him. D.C. Superior Court Judge Carmen G. McLean agreed, noting that King had been diagnosed with autism spectrum disorder and that Morris had made "significant efforts" to get special services and education programs for King and Nate IV.

The boys' mother appeared to have given up before the final ruling. She had failed to attend hearings and had refused to take a drug test or psychological exam, according to the court record.

McLean found Morris was a "fit and proper person" to be awarded sole custody of the children. And so, with the stroke of a pen, he went from being a former con artist to the sole custodian of his two sons.

The transformation sounded almost miraculous. How had he done it? Morris answers in part in a short but insightful and heartfelt book that was published in December: "An Open Letter to My Sons, and the Power of Prayer: The Life and Love of a 60-year-old Single Father Raising Two Toddlers."

Chapman helped stabilize Morris after the Naloxone kicked in and put him on a treatment program that involved enhanced dosages of buprenorphine, which reduces cravings for opioids. Morris says he's been drug-free ever since.

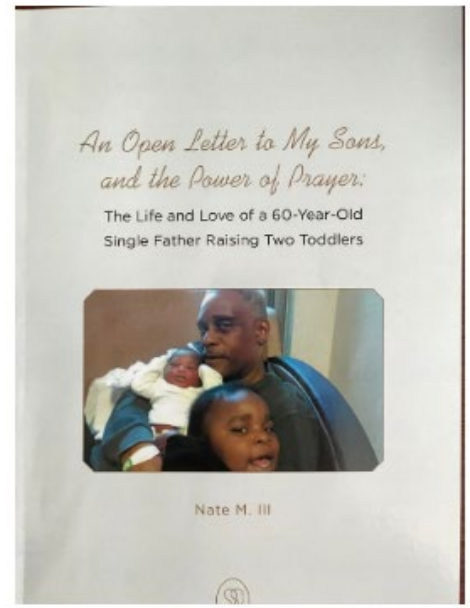
[*A more powerful naloxone is on the way. The question is whether it's needed.*]

"You see, God wasn't finished with me yet," Morris writes. "At the time, I didn't know why. But I do now. I unknowingly had kids on the way, and they were going to need all of my love and compassion."

King was 3 months old before Morris learned the baby was his. The mother was an ex- girlfriend and was living with another man when Morris found out she was pregnant.

"I did the math and realized that I was with her at the time," he recalled. So, he arranged for a paternity test.

The old Morris — the hustler and con artist — might have run from the situation, certainly not run toward it. Whatever hardship the mother encountered would not have been the hustler's concern. As for the baby, there are many cases in which children from such chaotic relationships end up neglected and abused, in prisons, homeless shelters and morgues.



"An Open Letter to My Sons, and the Power of Prayer: The Life and Love of a 60-year-old Single Father Raising Two Toddlers" by Nate Morris III. (Courtland Milloy/The Washington Post)

In this case, Morris brought the mother and child into his home. Two years later, Nate IV was born. A photo on the cover of his book shows Morris with his sons — Nate IV in his arms, just a few hours after being born, and King leaning on his dad's chest. Morris had been in the delivery room to witness Nate's birth and even cut the umbilical cord.

Morris's near-death experience had marked the end of his drug use. But the mother did not have such an awakening. She was unable to kick her habit, and untenable family drama ensued.

"The minor children had fallen off the bed in her care on more than one occasion when she was not paying attention," according to McLean's ruling. "And on one occasion, Mr. Morris found scissors in the playpen."

Morris never spoke ill of her. "She's still the mother of my children," he told me. In his book, he wrote, "I pray for her."

[*Snake eyes on the street, he had a lucky roll in prison*]

For the most part, though, he tries not to look back. Nothing can change the past, he's concluded; there is only the present moment to tend to. And if he sometimes wonders whether it is fair for such young boys to have a 60-year-old dad, he's convinced he is a better dad today than he would have been in his earlier years.

Several months ago, Morris stepped on one of the children's toys and injured his spine. Now, he sometimes uses an electric wheelchair to get around. Because he can't work, government entitlements pay for most of the household living expenses. Still, the cost is less than underwriting two boys being kept as wards of the state, not to mention the possible societal cost of them growing up without a caring father.

The babies are here, *and they didn't ask to be here*. That's his mantra. And he's stepping up and taking responsibility.

"Hey, stop that," Morris yelled at the boys after Nate put King's stuffed teddy bear in the toilet. The room fell silent. "I'm going to pop your butts," Morris declared. That threat was greeted with snickers of laughter. Perhaps because they had learned their dad does not employ corporal punishment — and not just because the custody ruling forbids

"My mother used to beat me with an electric cord," Morris recalled. "It was abusive. I'd never do that to a kid."

No time for punishment, anyway. The boys are in kindergarten and pre-K much of the day. Then comes the therapeutic and educational enhancement programs. At home, there are games to play, TV shows to watch, books to read. For shopping, he can use the wheelchair or call a car through Uber so all three can take a ride.

Endless questions from the kids also take up quite a bit of time — even if he doesn't always have the answers.

"Nate is asking to see a picture of his mommy," Morris said of his 4-year-old. "All the other kids in pre-K keep talking about 'mommy, mommy, mommy.' So, I asked two friends of mine to be their godparents, so they'd have a godmother. The boys liked that. But then Nate started asking, 'Can I see a picture of my real mother?'"

The mother has visiting rights, but she has not seen her sons in 18 months, Morris said.

Still, he presses on. "I'm the father and the mother," he said. "To all the single parents out there, I salute you."

In his book he writes, "Never in my life have I sacrificed the way I sacrificed for my sons. Even to the extent of my willingness to forgo any type of social life." He confided, "I know guys will lie about their sex life, but I have been celibate for two years."

Definitely a sign that Morris the hustler was dead.

Long live Morris the dad.

“I did not know that I suffered with the disease of diabetes” …

“I did not know that I suffered with the disease of hypertension” …

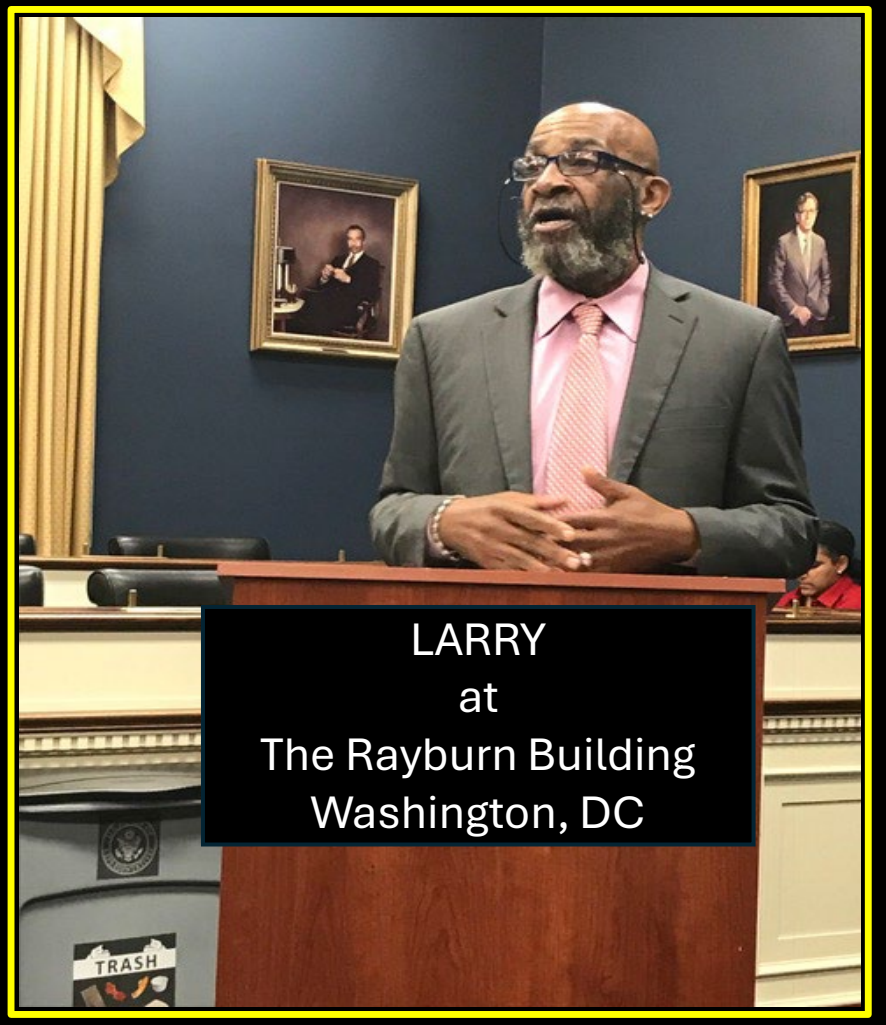
“I had hepatitis C and Medicaid did not want to pay for it” ….

“It took 5 times for the doctor that I was referred to by Dr. Chapman to get Medicaid to pay for it!!” …

“Medicaid paid $90,000 for 3 months treatment and… I no longer have the hepatitis C virus” …

THERE ARE "ELEPHANTS" in OUR COMMUNITY !!!:

The 1999 "60 MINUTES STORY"



POTENTIAL SOLUTIONS

(1) End ALL for-profit Insurance Contracts →

SINGLE PAYER UNIVERSAL HEALTH CARE

(2) End ALL "voluntary homelessness" (those who are not economically disparate are either mentally incompetent or incompetent due to an underlying substance use disorder —> our failure to intervene IS CORPORATE GENERATED, CULTURAL INHUMANITY & MALPRACTICE)

(3) Begin Local Community Control and Regulatory Oversight of ALL Medicaid and Medicare/Medicaid Dual Eligibles

Single Payer Universal Healthcare

it's just better!

How does single payer healthcare work?

1 Businesses and residents pay affordable premiums to the government.

2 The government funds a public health insurance plan which reimburses doctors & hospitals for care provided.

3 **Everyone is covered. Period.**

It's that simple.

CORYN MAYER RN MS:
“Homeless De-Encampment Re-Organization”

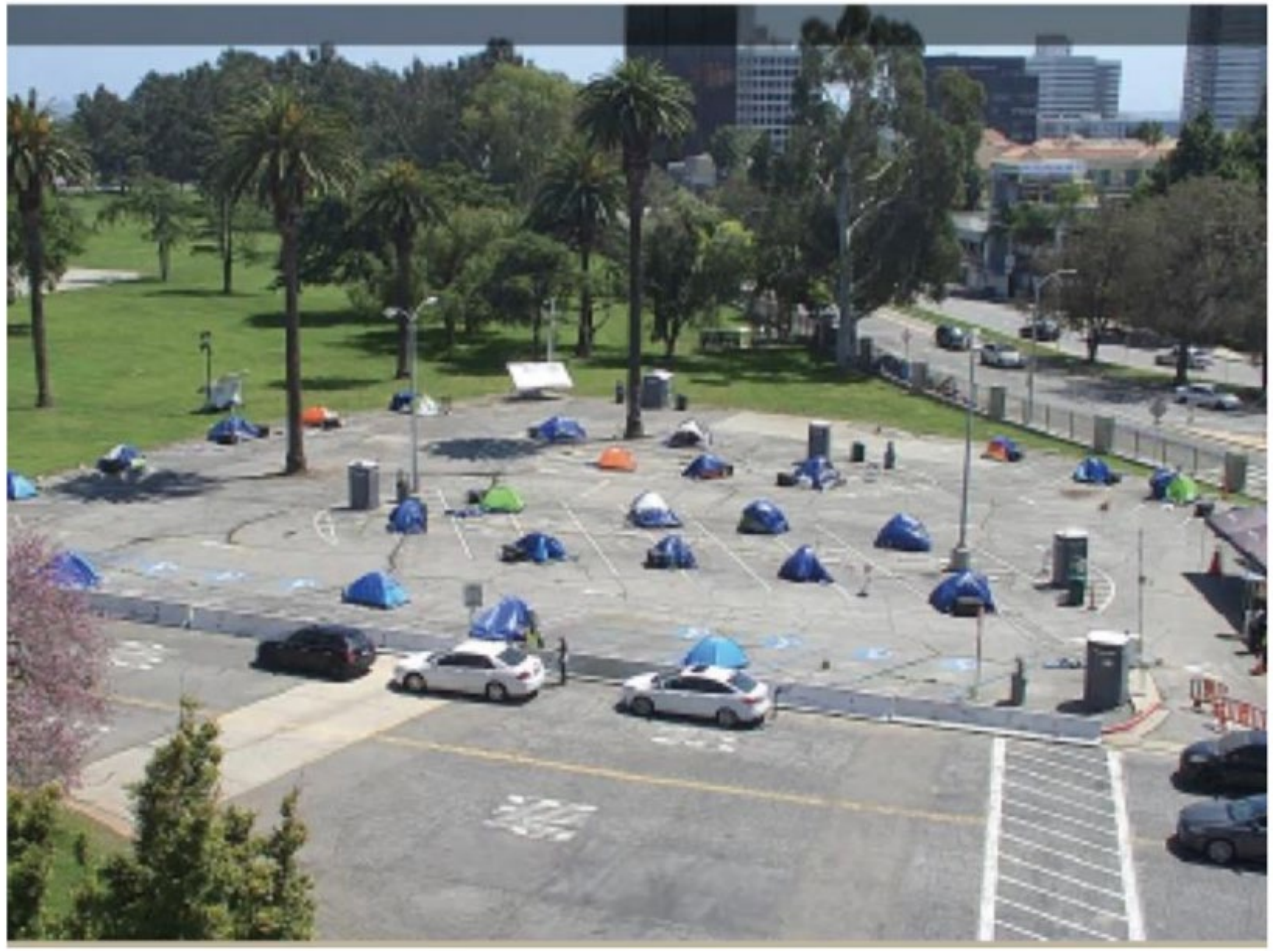
GEORGETOWN UNIVERSITY

BIG PICTURE - Field Hospital

Steps

(1) reauthorization opioid crisis w/ housing crisis modification
(2) Mayor coordinates with USDHHS Secretary to deploy PHSCC with partnerships from FQHCs and academic health centers
(3) Deploy and FQHC jobs to sustain
(4) Secure parameters
(5) Triage medical, legal, and social needs

There is no reason the opioid and housing crisis should be treated differently than other public health emergencies.



SUPPORTING ORGANIZATIONS

THE TAIFA GROUP
JUSTICE ROUNDTABLE
WPFW 89.3 FM
WBAI FM, NEW YORK
THE INNER VOICES
WASHINGTON LAWYERS COMMITTEE
FOR CIVIL RIGHTS
VOICES FOR SECOND CHANCE
MBI HEALTH SERVICES, LLC
UNITED BLACK FUND

CEASE FIRE DON'T SMOKE THE BROTHERS AND SISTERS
UNIVERSAL MADNESS
OPPORTUNISTIC GENTLEMEN
FAMILY & FRIENDS OF
INCARCERATED PEOPLE
ST. LUKE'S EPISCOPAL CHURCH
INCARCERATED PARENTS AND EX-OFFENDERS
DON'T MUTE DC
CAPITOL CITY ASSOCIATES
BEN'S CHILI BOWL
BLACK WOMEN FOR JUSTICE
HELPING OURSELVES TO TRANSFORM
NATION OF ISLAM
NAARC
ONE FLAG
CAN DO
BLACKS IN LAW ENFORCEMENT OF AMERICA
THE NATIONAL REENTRY NETWORK FOR RETURNING CITIZENS
NEW COVENANT BAPTIST CHURCH
BLACK LIVES MATTER
FREE MINDS
WE GOT US NOW
UNION TEMPLE BAPTIST CHURCH
BLACK WOMEN FOR JUSTICE
THE WIRE
DC JUSTICE LAB
THE WASHINGTON INFORMER
NATIONAL ASSOCIATION FOR ADVANCEMENT OF RETURNING CITIZENS
PARENT WATCH
AMAZING GOSPEL SOULS

HELP US TO HELP US

Returning Citizens Rally for Affordable Housing and Jobs

by **Sam P.K. Collins**
December 20, 2022

Roach Brown speaks in front of the John A. Wilson Building in D.C. during the Emergency Rally for Returning Citizens on Dec. 19. (Marckell Williams/The Washington Informer)

REENTRY CENTRAL
HOPE HOUSE
RETURNING CITIZENS UNITED
DC CORE
DC CURE
EAST OF THE RIVER PUBLIC CONSORTIUM
REPRODUCTIVE JUSTICE INSIDE
RETURNING CITIZENS UNITED

EMERGENCY RALLY POTENTIAL SPEAKERS

Moe Moten	Don't Mute DC
Big Ghee	Junk Yard Band / HBO'S Award winning "THE WIRE"
PG Councilman	Calvin Hawkins
Dr Carmen Johnson	Former head of Prince George's NAACP/ Court Watch PG
Kimberly Haven	Executive Director, Reproductive Justice Inside
Rev Willie Wilson	Union Temple Baptist Church
Kevin Flyte	Missing for 8 months (2 decades & health challenges)
Rev Graylan Hagler.	DC Core
Ju Ju	ONE FLAG
Leshonia Thompson -Bey	The WIRE (Women iinvolved in Reentry Efforts)
Minister Kadera	Nation of Islam Mosque #4
Tyrone Parker	Former Director, Alliance of Concerned Men
Trayon White	DC City Council

Robert White DC City Council

April Goggins	Black Lives Matters
Kevin Petty	Amazing Gospel Souls (rally coordinator)
Arthur Burnett	Judge DC Superior Court (retired)
Johnny Gill	Grammy Award winning Singer (via cell phone)
Roach Brown	WPFW 89.3 fm. / Your New Beginings

QUESTIONS ?

"A Lawyer *(physician)* is either a social engineer or a parasite on society"
Charles Hamilton Houston, JD

Howard University School of Law
Brown vs. Board of Education
(mentor to Thurgood Marshall)