

VIEWPOINT

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Editorial and Viewpoint



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The Health of Young African American Men

Deaths in Ferguson, Missouri; New York City; Sanford, Florida; and other areas have focused international attention on young African American men. In a recent campaign, young African American men draw attention to key overlooked facts that describe their demographic: 1 of 3 goes to college, 3 of 4 are drug free, 5 of 9 have jobs, 7 of 8 are not teenaged fathers, and 11 of 12 finish high school.¹ How can clinicians help address existing health disparities and add to these positive outcomes?

Young African American men experience little benefit from the considerable health care spending in the United States. Their situation reflects a poor investment and calls attention to a blind spot in policy. African American men have a life expectancy 4.7 years less than their white counterparts, the lowest of any major demographic group in the United States. Heart disease and cancer each contribute roughly a year of reduced comparative life expectancy for African American men.² Another year of reduced life expectancy is related to homicide: 75 of 100 000

at a higher rate than those who are not incarcerated.⁶ The effect of mass incarceration on individuals' employment, voting, housing, credentials (such as drivers' licenses), and certainly health is profound and still poorly understood.

Although there have been calls for action from public health to address these overall disparities, much of the medical field has been more silent. Traditional models of medical practice generally stand apart—in place, time, and perspective—from the experiences and needs of young African American men. Instead of the traditional routes of enrolling in primary care, lower-income African American men more readily connect with health care through military service, prison, or emergency departments. Health care systems are not well designed to acknowledge, attend to, and successfully address the health issues that are most salient: violence, trauma, shootings, and the psychological anguish that accompanies them. Shortages of primary care practitioners in certain areas certainly add to this problem. Even when clinicians are available, they may recognize risks but have little to offer to ameliorate them.

Well-child care visits, the most common interaction youth and adolescents have with medical care, have limited success influencing behaviors. The American Academy of Pediatrics' violence prevention program, Connected Kids: Safe, Strong, Secure, was developed in 2006.⁷ However, the United States Preventive Services Task Force has not found evidence to update its recommendation for counseling to prevent youth violence from its 1996 finding of "insufficient evidence"; the topic has been made inactive.⁸ African American boys and men thus face 2 mismatches: funding that overwhelmingly favors health care over more effective social supports, and a traditional health care model that is limited in its ability to help. The care youth and men need most is the care least available.

Considering these barriers, are there effective practices that clinicians can implement? First, advocacy efforts are needed for public health and social supports to achieve health improvements at scale. These approaches require substantially more robust funding and emphasis; US public health is funded with only 3 cents of the health dollar.

Second, the advantages medical care can provide should be strengthened. Unlike violence prevention, engagement in health care can positively influence those disparities amenable to effective medical treatment, such as human immunodeficiency virus (HIV), cardiovascular disease, and mental health. Intentional changes in practice—patient-centered medical homes,

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African American men aged 15 to 29 years die from homicide each year, well in excess of the rates of 4 per 100 000 for white men and 23 per 100 000 for Hispanic men.³ During ages 1 through 14, homicide is either the second or third leading cause of death for African American males; from ages 15 through 34 it is the leading cause of death.

Is this excess mortality due to long-standing low socioeconomic status? The answers involve a complex calculus of poverty, geography, race, education, and family structure. Sixteen-year-old African American men living in cities, for example, have a 50% to 62% chance of survival to age 65 compared with urban white counterparts who have an 80% likelihood. Appalachian white men have less excess mortality than African American men, despite being 37% poorer.⁴

Disproportionate rates of incarceration among African American men also detract from their overall health.⁵ African American men are 6 times more likely to be imprisoned than white men, and current trends would suggest that 1 of every 3 African American men born today will be incarcerated. An especially unfortunate indictment is that African American men are half as likely to die if they are in prison compared with those who are not; incarcerated white men, in comparison, die

infrastructure and roles that support population health, and aligned incentives—are necessary, but not sufficient to improve care. As these changes are implemented, how can health services be designed, especially those in urban areas, to better meet the needs of young African American men? We suggest the following.

Proactive engagement and partnerships. Certain primary care interfaces may provide special opportunities to engage younger men who can benefit from a medical relationship: during a partner's pregnancy and after becoming a father; experience of physical trauma, mental trauma, or both and presentation to the emergency department; physical examinations for employment; drug courts; evaluation of hypertension in schooling, military, or occupational screening; and reentry from corrections. Lifestyle support such as the Diabetes Prevention Program (DPP) often falters without an effective distribution network; clinical practice has not been a successful structure. Instead, entities such as the YMCA, with a community-based reach of 21 million Americans, have been able to effectively scale up the DPP—implementing sustainable exercise and weight loss programs led by community members. Targeted partnerships between primary care and public health are also under way in the Bronx, New York; Durham, North Carolina; and Kansas City, Missouri. Treating violence as a public health matter allows for constructive and successful clinical partnerships with schools, public safety officials, social workers, employers, and others with strategies of primary, secondary, and tertiary prevention.

Meet men on their own terms. The medical visit is an invaluable time for clinicians to proactively recognize basic needs. The National Healthy Start Association, for example, bases its fatherhood program on first addressing survival needs to better ensure family involvement. Health care practitioners, together with partners, must develop the capacity to recognize and address social determinants of health and be funded to do so. Strategic partnerships and effective availability—via collocation of community-based resources, multidisciplinary partnerships, and home visiting programs—turn recognition of need into action. Outside the clinic, new colleagues, such as navigators and health coaches, can further this effort.

Create an open door and trusted space. Making care environments (physical and electronic) more male-friendly and father-friendly is essential. Just as athletic and electronics stores develop adaptive environments to invite their customers, health centers should provide a welcoming space for younger men (individually and in groups) when they are both well and sick. Other trusted spaces in the community that can contribute to healthy relationships—Boys and Girls Clubs, schools, barbershops, and centers of faith—should also be nurtured as alternative sites to health centers.

Build where medical care works, rebuild where it does not. Successful care has been demonstrated in mental health, substance use, hypertension, HIV/AIDS, posttraumatic stress disorder, and recovery from physical trauma. These areas point toward specific intersections in which men may be vulnerable and can be welcomed into a helpful medical relationship. Health care approaches to risks, however, often are limited by overassessing and underaddressing. A prerequisite for risk assessment is the ability to provide effective care for identified risks. Prevention begins with identifying an individual's most pressing needs such as housing, violence, drug or alcohol abuse, and depression (eTable in the Supplement).

Thoughtful use of newer technologies. Although technologies have potential to exacerbate disparities, they also have the capacity to reduce them. Newer methods of health care communication, such as texting, are desired by men and should be offered. Public health departments, such as Delaware's, have been using the web to engage men in topics such as preconception care. More is being learned about people's disclosure with virtual members of a care team; it equals (or may exceed) information reported to human colleagues.

Failures of the US health care system are most pronounced among historically marginalized communities. Improving the health of young African American men will require reimagining and repurposing efforts among clinicians, health care organizations, and communities.

ARTICLE INFORMATION

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REFERENCES

1. Johnson A. Statistics open eyes to the debate on race. *The Boston Globe*. <http://www.bostonglobe.com/metro/2015/02/09/video-focuses-some-lesser-known-stats-about-young-black-men/6USrz4VK7GIIkS2aszEL/story.html>. Accessed February 26, 2015.
2. Kochanek KD, Arias E, Anderson RN. How did cause of death contribute to racial differences in life expectancy in the United States in 2010? NCHS Data Brief. <http://www.cdc.gov/nchs/data/databriefs/db125.pdf>. Accessed February 26, 2015.
3. Logan JE, Hall J, McDaniel D, Stevens MR; Centers for Disease Control and Prevention (CDC). Homicides—United States, 2007 and 2009. *MMWR Surveill Summ*. 2013;62(suppl 3):164-170.
4. Geronimus AT, Bound J, Colen CG. Excess black mortality in the United States and in selected black

and white high-poverty areas, 1980-2000. *Am J Public Health*. 2011;101(4):720-729. doi:10.2105/AJPH.2010.195537.

5. Alexander M. *The New Jim Crow: Mass Incarceration in the Age of Colorblindness*. New York, NY: New Press; 2010.
6. Rosen DL, Wohl DA, Schoenbach VJ. All-cause and cause-specific mortality among black and white North Carolina state prisoners, 1995-2005. *Ann Epidemiol*. 2011;21(10):719-726. doi:10.1016/j.annepidem.2011.04.007.
7. Committee on Injury, Violence, and Poison Prevention. Policy statement—role of the pediatrician in youth violence prevention. *Pediatrics*. 2009;124(1):393-402.
8. US Preventive Services Task Force. Youth violence: counseling: release date: January 1996. <http://www.uspreventiveservicestaskforce.org/BrowseRec/InactiveTopic/354>. Accessed February 14, 2015.