

**Today's Topics in Health Disparities:
Is the U.S. Making Progress in Reducing Disparities
in Health Care Access and Quality?
Kaiser Family Foundation Broadcast Studio
March 2, 2007**

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MARSHA LILLIE-BLANTON, DR.P.H.: Good Day and welcome to the Kaiser Family Foundation's Launch of the new webcast series, "Today's Topics in Health Disparities". I'm Marsha Lillie-Blanton, your moderator for today and the foundation's Senior Advisor on Race, Ethnicity and Health Care. This series will address issues relating to health and health care disparities in the US. For each topic we'll invite a panel of experts who'll discuss the issues and answer questions from our viewing audience. The goal is to raise the level of understanding of issues that tend to be the undercurrent of discussions, but rarely are openly a part of the conversation.

Today's topic, "Is the US Making Progress in Reducing Disparities in Health Care Access and Quality?" comes on the heels of two major reports released on the subject in the last three months. One report, the 2006 National Health Care Disparities Report provides a national overview of disparities in healthcare access and quality. The other report, "Strengthening Medicare's Role in Reducing Racial and Ethnic Health Disparities" provides recommendations on what more government could be doing to address disparities.

The 2006 disparities report tracked 20 measures of healthcare quality over time for several racial, ethnic and socioeconomic groups. It provides information on the quality

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of care people receive in relation to a reference population group. For people of color the comparison is whites, and the poor are compared with the non-poor. About a quarter of the 20 measures of disparities and quality experienced by African-Americans, Asians, Native Americans and Hispanics were improving. And a third were worsened. Two-thirds of the disparities in quality experienced by the poor where worsened.

So what is this report telling us about the problems and the progress we're making? What's working and not working? Are there public or private sectors efforts underway that might help explain the improvements we're seeing? Can government do more in setting standards or providing oversight? Are physicians, who are on the front lines, paying attention to these reports and taking actions to improve quality and reduce disparities? We're sure you have other questions too, so email us at topicstodaystopics@kaisernetwork.org.

For our panel today, we have three distinguished guests. Their bios are on the website, so I'll be brief in my introductions. In our studio, we have with us Dr. Carolyn Clancy, Director of the Agency for Healthcare Research and Quality, and Dr. Elena Rios, President and CEO of the National Hispanic Medical Association. Joining us by telephone is Dr. Reed Tuckson, Executive Vice President and Chief of Medical Affairs at the UnitedHealth Group. Due to the storms in the

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Midwest, his flight to Washington was canceled, so we are pleased he was willing to make arrangements to be with us by phone. Thank you all for joining us.

Dr. Clancy, I'll start with you. And I definitely want you all to know that this is a conversation, so while I might be asking one of you a question, you should feel comfortable jumping in, or if there are questions you have of each other you should feel comfortable asking those. Could you, Dr. Clancy, give us an overview first of what we mean by a healthcare disparity, and then tell us more about why is the Department of Health and Human Services issuing an annual report on national healthcare disparities.

CAROLYN CLANCY, M.D.: Sure. One of my favorite questions. By healthcare disparity, we mean a significant difference associated with a person's race, ethnic background, or their income or educational status. And what we see in general in this country is that there is a significant gap between best possible quality of care for everyone, all people, and the care that's routinely provided. But that, overall, that gap tends to be wider still for people of color, people who are poor, and people who are not well educated. That's what we mean by a disparity.

The, we produce this report every year, starting in 2003, so the 2006 report was our fourth one, in direct response

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to a mandate from the congress. And that mandate essentially says that we will report to the congress every year with two reports. One on quality of care, and one on disparities in care. Now we've linked these two reports very closely and the reason we do that is precisely because of the quality of care gap that exists for all Americans. In other words, we didn't think it was a very lofty goal to eliminate disparities in care, if everyone got the same quality of care now, that wouldn't be enough because we could be doing so much more to improve quality. So the overall goal of these reports is to let policy makers, clinicians, and the public know where we're doing well, where we're not doing so well, and where we need to focus our efforts.

MARSHA LILLIT-BLANTON, DR.P.H.: Dr. Tuckson, let's bring you in this conversation, is anyone outside of Washington paying attention to these reports?

REED TUCKSON, M.D., FACP: You know, I don't, first of all I think at some level they are, I think what you're seeing in, particularly now in the private employer market, that as employers start to look at their overall cost trends, as healthcare becomes more, the financing of healthcare becomes more challenging, they're starting looking into little greater detail at some of these statistics for their entire population and certainly by their population that has, that is broken down

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by ethnic categories. So I think that there is starting that. But I think at the big picture level, at the functional level, this is still not an issue that's really a major issue on the American radar. I think that what is particularly distressing for me, is that we do not, in America, view the challenge of disparities as an American problem. It is still viewed, I think, as an issue that is sort of ghettoized and off to the side, and that we don't realize as a nation, that this is a fundamental issue that when you have these kinds of statistics that, I'm sure we will get into in deeper detail in a moment, that this reflects something that means that we are all in this as a nation and this is not about the problems of one small group off to the side, but this is center court to the American experience.

MARSHA LILLI-BLANTON, DR.P.H: Dr. Rios, what about physicians? Are they paying attention, do they understand the reason for the report, or use the report?

ELENA RIOS, M.D.: Well, I think that physicians, from our point of view, from the National Hispanic Medical Association, we're very much interested in making sure that more physicians in the country understand what are specific issues that are critical to the, to improving healthcare for the Hispanic population. And this report certainly does add the armamentarium of a physician to be able to see what kinds

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of issues are worsening in general for the population, so that they can get up to speed with more educational material. Since physicians in this country are, there are so few physicians that are Hispanic, or African-American for that matter, we know that our responsibility is to train other physicians about the importance of understanding how to better treat the minority patients. And we also know because of the demographics, that for the Hispanics in particular, a very young population and very mobile and work and living all over the country now, that there's more and more doctors that do need information about how to better, with cultural confidence materials, etc, better take care of their patients.

MARSHA LILLIE-BLANTON, DR.P.H.: One of our email questions actually addresses that issue, we'll come back to it later, just in terms of the distribution and the numbers of physicians of color, but let's now try and look at the meat of the report, just a little bit. Let's talk about some of the findings. The report itself looks at both access and quality. Dr. Clancy, could you tell us more about some of the measures that are being tracked in this report, both, and what we know about those measures.

CAROLYN CLANCY, M.D.: Yes, now overall on the quality side, there's about 211 measures, and of that we select, a core of subsets to follow over time. And there's a smaller number

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of access measures but we also use a core set of those to follow so that we have some sense of trends. I think it's very important for people who are watching this and looking at the reports to understand that a real strike of these reports is that we actually do have trend data. Absent that, I think, every healthcare professional in this country goes to work everyday to make a difference and to provide the best care they can, and when confronted with evidence about, that we're systematically doing differently for some patients than for others, feels like, but no, I treat all people the same. So, if you see one study, it's a little bit easy to discount it as that's not where I live, or that's not where I see patients, so these reports actually do give us some sense, over time, as a country, as an American problem, as Dr. Tuckson said, how we're doing. And how were doing is reflected here.

We are seeing areas where quality of care is improving, or the disparities are beginning to narrow, and I think that's a good trend. However, it's very important to remember that disparities associated with race, ethnicity, and in particular, income, remain very, very prevalent. So we have a lot of opportunities for improvement, would be one way to say that.

MARSHA LILLIE-BLANTON, DR.P.H.: You mentioned the disparities by income and that was one that I mentioned in my opening remarks looking over time, we don't here a lot on the

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report about the disparities by income, and almost for every measure you're looking at, the poor are doing worse than the non-poor. Why is those finding get so little attention?

CAROLYN CLANCY, M.D.: As a personal point of view, I would say, I think in a way because everyone believes that if you're poor, that could change. Some believe more than others that people have the capacity to change that, but since you can't change your racial or ethnic background, I think the idea or the concept that what I look like is in some way going to inspire not as good care, kind of gets people more immediately. But that's a personal opinion.

MARSHA LILLIE-BLANTON, DR.P.H.: Dr. Rios, are there some main take home messages from this report that you want to share, things that you've learned that you think people need to grasp hold?

ELENA RIOS, M.D.: Yeah, I think for us, again, for the Hispanic populations, it's very important to see that the trends, despite some improvements in certain areas, in overall there was still a worsening for Hispanics in both the core quality measures and the core access measures. Up to almost 80 percent worsening and I think that that's a wake up call that we need to continually tell our communities and community based agencies, clinics, hospitals, how important it is to continue to develop programs and materials targeted to the Hispanic

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patients. Also, I thought that overall, again, there's quite a bit of new data now being looked at in this report, and I want to congratulate the government and AREHC for being able to start expanding the focus of data, especially related to our communities such as language, language assistance, was looked at and very positive trends in language assistance and LEP patients. Certainly, not enough but at least we can now start tracking, according to this report. Also, obesity, asthma were added in, very important diseases in our communities, especially with the rise in the epidemics and the environmental health focus of our different communities and states. And I do think that the disparities for the Hispanic sub-populations, that data is now part of this report, and I thought that was fantastic.

REED TUCKSON, M.D., FACP: This is Reed and I really do want to comment on both of those points and I think that it is amazing when we think about the fact that when we first started as a country, looking at these disparities with the Malone-Heckler task force report, which was really, relatively speaking, only a few years ago, there was no data. And so, I think it is important, I think that AREHC should really be commended for bringing us to the point where we actually have data now on, across the American diaspora [misspelled?] that is relevant and that is actionable. And that in and of itself is,

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I think, a praise worthy development. I think when you look at the statistics, I think that it is interesting that when you evaluate, as these measures do, care provided in a variety of settings, all the way from what's going on in chemo dialysis centers, to what's happening in special populations such as Medicare, to what's going on in nursing home environments, and then what's going on in the traditional ambulatory care experiences, that you see these statistics worsening throughout each of those domains. And I think that that is also, I think important. I think that what it is telling us, is that when you really look at this from a comprehensive health point of view, and when you marry this data with what's going on in population based prevention activities, which also have their challenges, you begin to see that the strategies and solutions and the conclusions that one would draw from this data, really do show us that this is a challenge across the health and medical care delivery system of our nation.

MARSHA LILLIE-BLANTON, DR.P.H.: Hmm hmm. Yeah. I want to go back to a couple of things Dr. Tuckson mentioned. First of all he mentioned the Malone-Heckler report, that was in 1985, and the reality, as he mentioned, was that we had very little data. And so, I think that it is good to talk about the fact that we are moving forward in terms of the data. But, at the end, you came to the question I wanted to ask you, since

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the Institute of Medicine report in 2002, the question is, are we making progress? And my sense from your last comment, as you look through the spectrum, spectrum of indicators, is that we're making progress but there's still a lot more to be done. Is that your sense Dr. Tuckson?

REED TUCKSON, M.D., FACP: It is my sense, is that, I'm actually though not a, first of all I think there's a delicate balance here and I think that, and I'll try to be very brief on this, that Dr. Clancy, I think is very appropriate, as did Dr. Rios, to celebrate America's physicians and American's hospitals. These are people who care, who are trying to do the right thing and we ought to praise them. And so this is not about finger pointing, that's one of the things that we have to be very careful about is that this does not become finger pointing to any particular sector of the American society, however, having said that, these numbers are outrageous. And I'm not at all prepared to say that we are making progress at the level of that anyone would feel good about, I think we just have to continue to find ways of encouraging and building on momentum where it exists, but this is an incredible ability that our nation has to tolerate these statistics year after year, especially when we realize that what the meaning of these statistics are is death. Misery and suffering, and so no, I'm not particularly pleased.

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MARSHA LILLIE-BLANTON, DR.P.H.: Well, that actually moves us to the next part that I'd like for us to spend some time on, and that's what's working and not working. And so, if we could look at some of the specific data indicators and just try and tease out, what do we think might be making the difference, and that also will allow us to go to some of the questions. I thought it would be helpful to talk about a couple of the measures where we have seen some gains over time, across population groups. And the two that I thought would be helpful to talk about is one, childhood vaccinations, and the other is new AIDS cases, surprisingly. Well we have seen some declines or a narrowing of the gap in childhood vaccinations, at least for Hispanics and for Asians, unfortunately for African-Americans and American Indians, we're seeing a widening of the gap. But it's a little unexpected to find a narrowing of the gap for Hispanics, given that we're seeing challenges in access. Any thoughts about what might be working, what might be happening that is explaining why over time, this is looking over time, this isn't for point in time, but it looks like there is a narrowing on childhood vaccinations. Any thoughts?

ELENA RIOS, M.D.: Yeah, I think one of the most important things that has happened, and Reed touched on it, is that there has been outrage at practically marginalizing minorities in this country and the healthcare system, but I do

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think that for the Hispanic population, it really wasn't until the 1990s, that our population was even being looked at more seriously because of the demographic changes. And the 1990 census showed that the Hispanic population was growing by leaps and bounds, and the projections were that we would become the largest ethnic group, which we did, a couple of years ago, or within the last couple of years, and I think that the federal government and the state governments, in their prevention efforts for vaccinations, for example, you mentioned that, started taking a look at how could we outreach and communicate through media, especially TV and radio, and through community based organizations, and I think that that's part of what's being , what's paying off in public health. That the Hispanic population has been looked at a little bit more than it was in the 1980s.

MARSHA LILLIE-BLANTON, DR.P.H.: Any thoughts, because it is, it's a different trend for Hispanics than you see for African-Americans.

CAROLYN CLANCY, M.D.: I would agree. I guess at a very high level, I would assume that this reflects in enough communities stronger linkages between clinical care and public health, because we know that Hispanics are much less likely to be insured. Even with S-CHIP and so forth, but we don't have enough detail in the report for, is to actually get at the

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level what does that look like. Does that mean that there's literally active coordination going on between, say, health plans or doctors offices and community resources for providing vaccinations. I'm just not sure, it is particularly noteworthy, though, because what we're looking at appropriately is kids getting vaccinations between 19 and 35 months. So it is not linked to getting into school, which historically was the way that we would, we had such very high vaccination rates for kids. But actually we now know that the vaccination, a number of immunizations have to be given at a younger age. But I think it's a very important question and I'd love to know more about the answer.

MARSHA LILLIE-BLANTON, DR.P.H.: The other one, which is, which is even more surprising, is new AIDS cases. And I think what's important to make sure people understand, is that we're talking about the disparity narrowing, there's still almost a seven fold difference between African-American's and whites, but what we're seeing is that for both African-Americans, for American Indians and Hispanics, there has been a narrowing of the gap. And I think the time period in the report is between 2000 and 2004.

CAROLYN CLANCY, M.D.: Yes. That's correct.

MARSHA LILLIE-BLANTON, DR.P.H.: What might explain the narrowing? What might explain the improvements? Any thoughts?

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I mean, is it this case, linkages with providers, is it health education, information?

CAROLYN CLANCY, M.D.: Well, I mean, I have to think that it is, and I do, I do think that there has been more awareness among the physician community and primary care doctors, especially about the importance of HIV/AIDS. I think there's been a lot more press, and in our media and the newspapers about the important advances made. And in communities like Washington DC, for example, just this last year, had everybody in the community start getting tested, I mean, there's been a cry out for an awareness across the board about the importance of HIV/AIDS and not just, I think the other thing for the Hispanic population, is the stigma attached to a disease like HIV/AIDS, is lessening somewhat as more families become associated with knowing somebody in their family that has it. So, I think that those are some of the reasons why.

REED TUCKSON, M.D., FACP: I think part of it also is that, I think is, I think what you're hearing from all of us is that this is a area where we have to be cautious. I think we're not sure of what this trend is really going to ultimately look like and we understand that without extraordinary vigilance, especially given that this is looking at new cases of people over the age of 13, so that we know that behaviors

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slip and slide and they wan and they go up and down, clearly what is, we've had some positive things that have occurred and I think that you've heard a few of those, and I think it's also been what you call a positive, that we've been able to talk about this disease a lot more frankly. I think also that we are learning a lot more about how to deliver these messages in ways that individual communities can hear it. When it's only been a few years that we have really started to learn about the most effective of messages that will get through to different cultures in ways that will actually result in change of behavior. But I think that when we sort of look at this overall, as you did really at the beginning, Marsha, when you set this up, is that the magnitude of the differences is still extraordinarily huge. And that I think we just have to sort of use this as encouraging, but I think it's too early to be particularly congratulatory.

MARSHA LILLIE-BLANTON, DR.P.H.: I agree.

CAROLYN CLANCY, M.D.: But I would also say that a particular strength of the reports is the opportunity to learn to not just inspire the questions of what are we doing wrong, but to actually say, wow, in order for us to see a narrowing, we know a lot of communities had to be doing something right.

REED TUCKSON, M.D., FACP: Yeah.

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CAROLYN CLANCY, M.D.: Later this month, we will be coming out with state reports and a lot of the, using a big chunk of these measures, and I think that will allow us to drill down a little bit further, but I think there's a huge opportunity to learn what happens in the communities who are doing the best job. What is it exactly that they did? So there's an opportunity to learn not only from bad grades, if you will, but also from areas of success.

REED TUCKSON, M.D., FACP: And I would continue to emphasize as well, is that the one thing that it ought to tell us is that we now have reason to be encouraged that programs do work, let's be able to continue to have the shackles taken off of the public health education system, that allows us to talk about these issues in frank terms, in terms that are realistic and meaningful to our young people, in terms in which families can understand an act and not have to worry about some of the constraints that have been put on these education programs in the past.

MARSHA LILLIE-BLANTON, DR.P.H.: It's interesting, that is one of the questions we got by email. How do we help the health and the education system to work better to better reduce disparities? And I think that there are many ways, but trying to better understand where we've had some successes is one way we can improve upon what exists now. You mentioned states, and

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that's also a question, I'm trying to turn to some of our email questions. One of our email questions, in fact, from the Center for Health Policy and Legislative Analysis is, are state legislatures doing what they can do to address disparities? And what kind of state level policies would you recommend be undertaken given states budgetary climates? Are there efforts we know now underway at states that work specifically either on the two issues that we talked about or on others?

REED TUCKSON, M.D., FACP: I think that the, one of the things, at least that I'm seeing that is extremely encouraging, is the National Governors Association trying to now exert really focused leadership on the part of state governments and their senior elected officials to try to improve health status overall. Which, then as I have observed their work up close, seeing that also starting to target the, their most difficult challenges, thereby putting them into the disparities fight. I think that one of the things that they will benefit from, going forward, is a much better and easier access to real knowledge and data about what works and what doesn't work, at the population based level for improving health status generally and for people of color and specifics. And so one of the things that I think is the untapped opportunity here, is that we need to do a better job of giving governors access to really granular information about what works and what doesn't work,

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and the cost effectiveness of intervention, so that they can then have a better chance of their leadership being focused on the right things, the things that will give them the best chance for success.

MARSHA LILLIE-BLANTON, DR.P.H.: Now, Dr. Tuckson, you mentioned information on what works and what doesn't, Dr. Clancy, I want to come back to you because I do know that with the quality report data are now available for states. Are there any plans to try and make data available for the disparities report by state?

CAROLYN CLANCY, M.D.: In some areas we can't do that, but when we, sorry, it went away. For some selected areas when we put out the state reports, we do have information on disparities, diabetes was one big focus area last year, we're hoping to grow that so that states can actually see not only how their doing but how they compare to other states across the country and, importantly, to states in their region. So, I think that begins to bring it down to the level that Reed was talking about. I've been impressed that a growing number of state legislatures have commissions on healthcare disparities. And I think that continues to raise awareness. I spoke to a legislator from my state, Maryland, very recently who was expressing great impatience that she couldn't get more done. This was in the past few weeks, and I, literally later that

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week her efforts allotted as a model for the nations. So, I do have the sense that this is beginning to trickle down to the states, which I think is great because that's actually where action is going to take place.

ELENA RIOS, M.D.: You know I, can I just add something?

MARSHA LILLIE-BLANTON, DR.P.H.: Yes.

ELENA RIOS, M.D.: The national conference of state legislators have some councils, one for the African-Americans legislators, and one for the Hispanics, and I was invited to their first disparities conference about three or four years ago, and I was re-invited this last year and saw immense energy and they have put together trends in terms of their different types of legislation that has been introduced, not only just introduced, and passed by the disease. So, as Carolyn was saying, disease, diabetes for example, is a major disease, cardiovascular disease, obesity, we're seeing the, I was just in New York yesterday testifying for trans-fat ban, for the city of New York and I think that there's a lot of cross-pollination of ideas, across the states through the African-American and Hispanic organizations for state legislators, as well as the leadership organizations, both in, for Hispanics you have a national Hispanic leadership agenda made up of the thirty top Hispanic organizations, African-Americans, all the

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top organizations are connected to our legislators we have in the different states. And I think that, I think that there needs to be more national recognition of these activities coming together. I know with the Office of Minority Health leadership conferences that they've had, for example, maybe that could be more of a way to use that as an opportunity to focus in on what data we have, so people could start focusing more on the efforts based on the evidence of the national report.

MARSHA LILLIE-BLANTON, DR.P.H.: We talked about patient and providers and their relation to disparities, we haven't talked much about the health system overall. And what I think was really important, or helpful with the Institute of Medicine report on equal treatment is that it laid out a framework for looking at how we address disparities. And they talked about patient level factors, provider level and health system level, and one of the health system level factors is just the availability of providers in communities and neighborhoods, and the quality of those providers. What's your sense on how much progress we're making in addressing the availability of providers who understand the communities and are capable of addressing the needs of the communities?

CAROLYN CLANCY, M.D.: I guess I would say that our progress has been glacially slow. Not for want of effort, and

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one thing that I'm really pleased to see is that the Association of American Medical Colleges and others are starting to try to recruit young people at a much earlier phase of their educational level. You don't go recruit college seniors because you're going to miss the kids who weren't there. We've seen from Joan Reeds program in Boston, that if you start identifying kids in high school, you can make a big difference if you hook them up with the right mentors and so forth. I don't mean to suggest that this is a magical, easy bullet, but if you look at how much more diverse our country is becoming, this is a pretty critical need.

ELENA RIOS, M.D.: I have to, we have to give a plug for the Health Careers Opportunity Program, at the federal level, which for 40 years has been supported by congress and this year, for the first time, congress, due to the budgetary issues, let it go, and we're very strongly advocating for the reauthorization of the Health Careers Opportunity Program, which is the program to recruit minority students and underserved students to all the health professions. As well as Centers for Excellence for the, not only the historically black colleges and universities, but we have Hispanics in centers of excellence, and Native Americans centers of excellence, and these are the really critical programs within our educational system, within the medical educational system, to be able to

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identify faculty and curriculum and students to be better prepared as they go into the health care workforce.

REED TUCKSON, M.D., FACP: I'm really glad that Elena brought that out, I mean, this is a really, really frustrating reality. That here we know that we are making, as Carolyn said, glacially slow progress in developing a pipeline of students in color in this country and here we, and we know that there are these challenges of disparities, we know that death statistics that accompany, and then we add, there is very little enthusiasm right now in the congress to move this legislation forward to appropriate, to re-appropriate the money for these health careers. Opportunity programs, these minority centers of excellence, these are the lifeblood programs that address this challenge and so we are encouraged a bit by the house appropriations and labor, health and human services appropriation committee that is starting to look at this, we urge any of the people that are listening to this call today, to please go online, look up labor health and human service appropriations committee, of the house, and if you have a congress person that is sitting on that committee, you need to contact him or her immediately around these kinds of things.

I would secondly say that, that we are really not doing very well in terms of the pipeline that Carolyn talked about, as you start to look at the quality of the science education

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programs for our children and public schools, early on in elementary school and junior high school, this is really where the problem is and again, we are connected to larger social forces when we try to look at the disparities agendas. So we have work to do there.

One thing that is very good, that Carolyn's AHRQ has done, and that is to create something called the Ambulatory Care, the AHCAPS Program, A-H-C-A-P-S, which is an evaluation of the patient experience with care. I think that that speaks now to being able to look at whether the physician who is taking care of a person of color, is whether that physician is black, white, or whatever ethnicity, it is starting to give the patient the power to be able to report on the quality of care and hopefully will provide an incentive for all physicians to do a better job of learning how to communicate.

One of the things that I read with some displeasure was to see the slippage in disparities gap, in the number of patients who believe that their physicians are listening, explaining, respecting and providing enough length of visit for, from their care experience. This is not a good sign.

MARSHA LILLIE-BLANTON, DR.P.H.: Right. And that went actually across all several different population groups, so I'm glad that you brought that the attention of our viewing audience. One of the questions we have from the California

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email, was what, I'm just going to read the email, it says, "In view of the fact that there are far fewer health providers of color than the proportions of the people of color in the general population, what steps do you think we should take to ensure rough parity twenty years from now?" We've already begun to start discussing that through the H-Cock [misspelled?] Grant Opportunities, but you talked about the pipeline, Dr. Tucson, what do you do to further develop the pipeline so that 20 years down the road we're not continuing to have this conversation.

REED TUCSON, M.D., FACP: You know it's interesting that when we are in the health sector and there are the conversations about what's going on in our American schools, the health people, we sort of, "Well that's not our issues", so we move onto something else, and I think that really is requires that we are deeply involved in what's going on with education policy in our community. Secondly, I think it means that we ought be inviting, in our academic, in our health centers, we ought to be inviting young students of color to spend Saturdays with us in these hospitals, in our, in clinics of enough size, and start to bring these kids in and exposing them in some non-intrusive way, to what's going on here. To be able to create small little programs in the conference room where you bring in the parent and the child and you're

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conducting parent sessions to help them to be better mentor and tutor their children around science and getting them excited. I think there's so many ways in which we can start to gear up, but where, right now, you don't ever, it is very rare that you see young people of color experiencing a healthcare setting other than as a patient.

MARSHA LILLIE-BLANTON, DR.P.H.: Lots of good ideas.

ELENA RIOS, M.D.: I'd like to just add, I think the important role of looking at reports like the Sullivan Commission Report, and also the IOM put out an academic report on pipeline development, that included pipeline development for minority health providers said that everybody needs to get involved and, I want to go back to Dr. Tuckson's opening statement and that it is an American problem with the demographics changing so much and we going to see the rise of the minority population becoming the majority in this country that all students of health professions need to understand how to better take care of minority patients. And we need to have more minority students understand that they can become doctors and nurses too. And I think that one of the things that the Sullivan Commission Report said, that was that health providers themselves, that are minority, should be out there talking at schools, letting other community members know, business leaders

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know that their children should consider healthcare careers.
Because we're the ones that have to beat the drum—

MARSHA LILLIE-BLANTON, DR.P.H.: Serve as mentors.

ELENA RIOS, M.D.: Serve as mentors, as role models, as Dr. Tucson was saying, but I think, I think there also needs to be a re-look at how we develop pipeline programs and there needs to be some connection between the department of education, department of health and human services, the national science foundation, for example, they've all had programs dealing with pipeline development for careers for better educational curriculum, but I think that this country needs to understand that healthcare, the healthcare system, such a big part of the economy, the jobs in this country, there are so many jobs in this country in the healthcare system, that we do need to take a look at how do we develop the workers for the next generation in the healthcare workforce. And the disparities issue would be why do target minority populations and one thing that we've been discussing with congress is the concept of a regional approach. Not just around one medical school, or one nursing school, but a regional approach with the medical schools and the nursing schools, but also with the community colleges and the high schools. And that there be a bigger, and community based organizations, so that there's a lot more people involved in the recruitment effort in getting

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the word out to the younger students that it can be done,
having that career.

MARSHA LILLIE-BLANTON, DR.P.H.: I want to focus the rest of the time on what more could be done, we have a number of questions that have come in, but I want to just start this with a question for Dr. Clancy, because some researchers and clinicians have questioned whether we can both improve quality and reduce healthcare disparities at the same time. And I wanted to know what you thought about whether both those things can be done. Are they competing priorities?

CAROLYN CLANCY, M.D.: No. I don't see them as competing at all, in fact, statistically, or simple math, were not going to be an excellent healthcare system unless we reduce disparities at the same time, or we can be equal or excellent to, and we're not going to be excellent unless we do close the disparities gap. Now that's very, very easy to say rapidly, but the reality is for a healthcare system like the one that Dr. Tucson works in, if you're trying to raise your overall quality of profile, the most efficient way to get there is to identify those at highest risk for poor quality and focus a lot of your resources there. You don't want to be bothering folks who are already doing very well. So, I think the two go hand in hand.

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MARSHA LILLIE-BLANTON, DR.P.H.: Now that's an excellent segue to the next question I wanted to ask Dr. Tucson, because I know that UnitedHealth Group has been involved in something called the National Health Plan Collaborative, can you tell us more about your efforts in that collaborative, why you all decided to participate, what you're learning, what you're doing?

REED TUCKSON, M.D., FACP: Well, I would say that it is, I commend and praise the Robert Wood-Johnson Foundation and the aides for health research equality for pulling together the health plans under this National Health Plan Learning Collaborative rulebreaker [misspelled?]. Supported very intensely by the way, by RAN, the Center for Healthcare Strategies, and Don Burwicks [misspelled?] IHI, Institute for Healthcare Improvement, and what we're trying to do here is simply to learn, to realize that our, the way that health plans generally work is, of course, to use best practices and then try to implement those best practices at scale. And so we are learning from each other in a variety of areas, everything from how do you collect data around race and ethnicity, how do you use data to identify the biggest gaps in care, especially those gaps that are being provided, or the care challenges by physicians, it's identifying those physicians and then reaching out to them in a direct way to try to get them to do better.

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Being able to provide patients with information that they can, that is more actionable and targeted towards the specific data identified challenges that we see for them. So really working across the board, I think that what we've learned the most is, of course, is that we have a responsibility and an opportunity at the health plan level, just as physicians and hospitals, and others, have their own sets of opportunities, challenges, and responsibilities.

I wanted to indicate one other thing that I think is important about this question you asked Carolyn about quality and disparities and the relationship between the two. At the end of the day, what companies like United Health Group are recognizing and are focused on, is that care now is patient centered. This is one of the most important of the six principles that came out of the ION report, patient centered care. And so the reality is that, if you are going to be able to care for the individual, you have to be able to care for the challenges that the individual presents. So it doesn't matter, ultimately, whether the person is African-American, Hispanic, Asian Pacific Islander, Native American, White American, rural, or whatever, you have to be able to develop a care system that meets the person. So I think that what we are evolving to is a wonderful synergy where ultimately you, if you are going to be in healthcare, you will have to be able to meet the

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comprehensive needs of each individual that comes to you and that will require the disparities agenda to become center core to the fundamental purposes of the healing institution.

MARSHA LILLIE-BLANTON, DR.P.H.: We actually have a question related to your focus on patient centeredness that I'll ask either of our panelists, this is actually from a public health office in Illinois, and the question says, "I see more emphasis being placed on the individual behavior change and lifestyle by public health to address, as opposed to examining the broader role played by social determinants of health. What can we do to address more of the root causes of health in equalities involved provider communities more in the broader issues that affect people's lives?"

CAROLY CLANCY, M.D.: Well let me just say that this week in the New England Journal of Medicine, there's a very interesting article looking at the impact of efforts to improve quality of care in a similar learning kind of collaborative that Dr. Tucson just described, but this was done in community health centers, no, this was sponsored by the health resources and services administration and they asked us if we would fund evaluations and we said yes, not as thumbs up or thumbs down, but to understand what worked well under what circumstances. And what you say in this article were two important findings, one is that some key processes of care improved quite

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dramatically. But they were processes, one of which was ordering a hemoglobin A1C test for diabetics, which are completely under the control of a provider or clinician or healthcare system, right? And in terms of the outputs, control of diabetes, those did not improve. Now that says to me that we know in a world of quality that public reporting has a big impact, once you can see how we are doing right here where I see patients, it makes a big difference. And that to me argues for much stronger linkages between the clinical care delivery system and the public health system, or the community at large. Do I think that doctors and healthcare professionals can solve the problem at the community level? No. But they are important reflections and witnesses, if you will, to the impacts of health inequalities that exist outside the healthcare system, and in some ways they're not going to succeed in their jobs in providing the best possible care unless they are hooked up with the right community resources.

ELENA RIOS, M.D.: Can I just add something to that, the, for our organization, we have been involved in taking a look at how would we develop a campaign to get doctors to become more advocates for their patients and connected to the policy makers in their states. And the campaign is obesity, childhood obesity with the Robert Wood-Johnson Foundation, and our goal is that we push for environmental changes, not just

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measuring the BMI of the patients, but increasing awareness of the patient population is very important. But that we do look at, for example, with the schools, not only looking at nutrition information or physical activity, which is a lot of what people are looking at to prevent obesity, but what about the curriculums in school and how do you include awareness of the importance of nutrition in curriculum, not just beverages in the, on the school, in the school site. Other things can be done if there is a connection between doctors who have a real passion for improving their community and want to understand how to change things and connecting them to policy makers. What we're doing is working with the Latino caucuses of the state, for example California, we actually started with three states, California, Texas and New York, because those are the largest Hispanic populations in the country and we're hoping to see some changes because of an involvement and an active involvement that really hasn't been part of the medical profession. And it is true, we need to push ourselves to get more involved in ways that can help the country move forward.

REED TUCKSON, M.D., FACP: Marsha, one of the things that I am encouraged by is just another example of that, that is the Texas Medical Association. As they have now provided significant leadership in the state of Texas through something that they call "Healthy Vision 2010". And again, just one of

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the best examples that I have seen where you find a medical society stepping out of it's traditional role of primary focus on clinical issues, but now moving into saying that we're going to have something to say about trying to help set a positive in health inducing agenda for the protection of the full population health of the state.

MARSHA LILLIE-BLANTON, DR.P.H.: Yeah, that's good. I want to talk about one particular example as we move to patient centered care in broader social factors, the Washington community right now is been very focused on a story of a 12-year-old who had a toothache that progressed to an abscess, to then seizures, to hospitalization, and unfortunately this 12-year-old died. He's a 12-year-old that was covered by Medicaid and in the course of having coverage, lost eligibility, mother thinks that it was partly because she moved to a shelter and the information on her coverage didn't move to her. But this is a case where you have a family reaching out to the health system, a family connected with coverage at one point in time, but then losing that coverage, what more could have been done? I mean, these are system failures and this is a story of one individual, but that one individual story is reflected in the statistics and the numbers and the data that we look at all the time. What more can our system do to make sure that a child like that doesn't fall through the cracks?

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CAROLYN CLANCY, M.D.: Well, when the state child's health insurance program was first passed, we partnered with another foundation, the Packard [misspelled?] Foundation, and worked with nine states to try to figure out what could be learned. Now the states, they're all different in terms of how they funded their S-CHIP program, how much was on Medicaid, so essentially the focus was on health insurance for poor children. And we were able to show that some states figured out some terrific strategies, for example, passive re-enrollment turned out to be a very, much easier way to keep people on the rolls, and so forth. And so, I think this speaks to the kind of networking across states that Elena was talking about. It's a tragic, tragic story and I don't know all the answers, but it sure is a giant wake-up call.

REED TUCKSON, M.D., FACP: One thing that it does also point out, and I think that as Carolyn mentioned, legislation that is coming up for the S-CHIP program, and again, by the way, if there are as many people that we know that are listening to these broadcasts decide to get active and petition their congress people to protect that program which is up right now for funding, is that some of us have advocated publicly through a process called the Healthcare Coalition for the Uninsured, that we need to have enrollment for public insurance programs like this to be much easier. That we need to be able

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to have it connected to any social service program that people are going to normally interact with. And so this mother, at best case, should have been able to keep their children, their child enrolled in this program, when she went to qualify for any other social program, so that all these systems are interconnected. It makes no sense for a woman who is struggling with the challenges that I'm sure that this mother was, to have to navigate 13 different means testing systems to be able to sign up for something that would have saved that kid's life. That doesn't make any sense.

ELENA RIOS, M.D.: You know, I was going to say, I think we need to move toward a country with a little bit more efficiency and we are trying to find ways to decrease costs, and having to re-enroll and re-enroll is very costly. And the federal programs, and I realize CHIP is state and federal, but the federal programs could all become like Medicare, where you do have enrollment once a year. And I realize that you come off of Medicaid and CHIP because of income, and the income testing, and I don't know all the details, but I think that we do need to think about how to move towards more efficiencies within our healthcare system.

CAROLYN CLANCY, M.D.: And I'd just like to re-emphasize Reed's point about being able to enroll at multiple points, when we worked with these states, looking at insurance

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reports for children, we also, by design, included a group of people who work administering these programs, they're not researchers at all but, that's not their beat. And one of the most important products we were able to develop for them early on was really a pretty simple chart that helped them with their outreach efforts. What was were the proportion of kids, for example, getting school lunches, or who's mothers were enrolled in WIC and so forth, so that for any particular area, people trying to run these programs and do outreach knew exactly how to do that.

MARSHA LILLIE-BLANTON, DR.P.H.: Dr. Rios, you mentioned Medicare, and I thought it would be good for us to spend just a little bit of time talking about the report that was just issued on Medicare's role in reducing disparities. The report was very bold in it's recommendations, calling for Medicare to be more involved beyond just seniors and disabled, but Medicare, because of it's broad role in our health system. What's your sense of whether that is a recommendation that we should seriously consider, and what kind of difference could it be if we use the tools available through Medicare to help reduce disparities?

CAROLYN CLANCY, M.D.: Well I think historically it's very important for people listening and joining us today, to recognize that the creation of Medicare was a very, very

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powerful force for integrating hospitals across this country, in fact, two or three years ago in the Department of Health and Human Services, as a sort of celebration, a number of the folks who were still around who'd gone out on these site visit teams and, this often involved not just a site visits to tell people what the new rules where, but also some follow-up to make sure that what they said they were going to do is what actually happens. And it was quite remarkable because I don't think an awful lot of people in their department had understood that history at all, it was very, very important, and of course, a lot of the studies that were done in the 1990s that led to the Institute of Medicine Board, certainly were informing the congress to direct us to produce an national healthcare disparities report, actually derived from Medicare data because they have a terrific source of data when you enroll in the program. So I do think that there are lots of opportunities and it's certainly an area that Medicare is trying to focus on.

MARSHA LILLIE-BLANTON, DR.P.H.: Dr. Rios, a question actually came in specifically directed to you, asking can a Medicare for all program have an impact on reducing disparities with the focus on the Hispanic community. And since it came directed towards you, particularly talking about Hispanics, I thought I'd give you an opportunity to respond to it.

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ELENA RIOS, M.D.: Sure, and I think that's in the spirit of what's happening right now and across the country with healthcare reform across the states, different policy makers are looking at different options. And Medicare for all, is an option, very, I would say, something that we'd all like to aspire to to have universal health coverage, and using Medicare as a program because we have had it around for so long to be able to expand all the way down to infants. But I do think that it's not going to happen, this time around, we have two years going towards a new presidential election and I think the healthcare reform debate, I think we would, I think it would be important to include disparities in that debate. And to have disparities in healthcare reform, that no matter, I think, I don't think we can get Medicare for all in this next go around, the next two years, but I do think we need to consider broadening our scope to include disparities.

MARSHA LILLIE-BLANTON, DR.P.H.: Dr. Tuckson, we're about to close, but are there some thoughts you have about where we go next, if it's not using Medicare's tool, are there other resources that at our disposal that we can use to make a larger impact on reducing healthcare disparities?

REED TUCKSON, M.D., FACP: I would say that the challenge and the opportunity are all in the same place, and that is these, this is a comprehensive problem that reflects,

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affects us across the spectrum of everything from where, how we live our lives to what's going on in our community environments, all the way to the quality of clinical care, and so forth. And so what that means to me is, that I'm not looking for a silver bullet solution, I'm looking for everybody to do their part everywhere along that continuum. So I would say the fight is right in front of you, regardless of your job, where you are today, you do your part, you keep pushing it, great leadership from people like Carolyn Clancy at the national level will be able to, I think, try to organize and structure the collective of these experiences as we go forward, but let's don't try to think of this in some simple bullet, let's just do our jobs in front of us the best way we can.

MARSHA LILLIE-BLANTON, DR.P.H.: I think that's an excellent for us to bring this session to a close. I certainly want to thank all of you for joining me, thank you Dr. Clancy, thank you Dr. Rios, and thank you Dr. Tuckson, we're sorry you couldn't be here in the studio with us but we're very pleased to have you join us by phone. And thanks to all of you for your questions, I'm sorry I didn't get to all of them but I did my best getting to as many as I could. On the webcast page you will find resources on today's topic that may be helpful to you. We appreciate your turning in. I'm Marsha Lillie-Blanton of the Kaiser Family Foundation.

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