

Meeting: A Town Hall on Eliminating Ethnic and Racial Health Disparities by Moving the Nation from Statistics to Solutions April 5, 2004

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[START RECORDING]

DR. BENJAMIN: Good morning.

GROUP: Good Morning. Now that's kind of weak
[laughter] try it again. Good morning.

GROUP: Good morning.

DR. BENJAMIN: See that's much, much better. I want to thank everyone here for being with us for our National Public Health Week for 2004. Let me start and thank all of our various sponsors. We have a whole group of people that have sponsored this week with us.

We have The American Legacy Foundation, The Robert Wood Johnson Foundation, the United Health Care Group, The Lewin Group, Henry Kaiser Family Foundation, The American Heart Association, The Commonwealth Fund, The Josiah Macy, Jr. Foundation, Research America, The California Endowment, an Association for American Medical Colleges, The Pfizer Public Health Group, The National Association of Community Health Centers Inc.

In addition to that we have over 200 individual groups that have signed up as national participants in this activity including all of our national affiliates all around the country. We certainly want to thank all of these folks for both their fiscal support as well as their personal involvement in this effort. It is something which we believe is a very important national issue in health care that needs to be

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addressed. Now this week, April 5th to the 11th marks the 14th Annual Observation of National Public Health Week. The American Public Health Association is certainly honored to be partnering with all these various groups and to make this week a success.

Now what we are trying to do is, as communities across the country are struggling with widespread health disparities and we believe the problem is growing, and certainly there have been lots of efforts to try and address this over the years, but we feel pretty strongly that enough is enough, and now it's time to not just measure the problem but time to start doing something very specific about it.

We believe disparities touch everyone at some level; that while this is a national issue, it is probably going to best be solved at the local level, and that local communities have a huge role in doing so. These disparities are absolutely alarming.

You look at the issue around race and ethnicity [inaudible] among African Americans are more than double those of whites. You look at the issue of environmental justice. Low income communities are often located in or near polluting industries, which often offer cheap, older housing where things like lead paint and pests are certainly a health threat. We have to deal with the issue of health literacy.

When I was practicing emergency medicine, it was often

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clear that the whole issue of making sure the patients understood what I was saying, and how I communicated with those patients often determined their clinical outcome.

You look at the rural communities in this nation and you look at the differences in access to care in many of our rural communities where we don't have an adequate number of health care providers for chronic diseases remain predominate in many of these communities, undetected and untreated. When you start looking at very specific diseases, I mean, look at all of these diseases amongst the various racial and ethnic economic groups in our country, this is something we have recognized needs to be addressed as we move forward.

So each day this week we are going to try to focus on additional issues to try to reduce the issue of health care disparities in our country. There are lots of very, very impressive programs that have been developed, and one of the things that we truly understood is, while these programs have been developed, the biggest problem is trying to share the impact of these programs from community to community, and that's what we are trying to hope to do this week.

So our theme for this week's Public Health Week is moving from statistics to solutions, and we are going to try to work very hard to develop these various programs, identify these various programs, and share them around the around the nation.

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What I would like to do now is bring to the podium a Dr. Virginia Cain, Dr. Virginia Cain is the President of the American Public Health Association. As many of you know, the APHA is the nation's oldest and largest public health association. She's an Associate Professor of Medicine and Infectious Disease at the Indiana University School of Medicine, and she's also Director of the Marion County Health Department, the President of the American Public Health Association, Dr. Virginia Cain. [applause]

DR. CAIN: Thank you, Dr. Benjamin. This is truly an exciting and important event. I cannot think of a more fitting way to kick off National Public Health Week than in a town meeting with community leaders. It is after all, what the American Public Health Association is about, and what National Public Health Week is about. It truly is a grassroots effort. Now National Public Health Week has been observed for more than a decade, and this year it will be bigger than ever. Hundreds of events are taking place in communities across the county. In Indianapolis I know that there are at least three events all intended to bring the communities together to make a difference.

Town Halls like this one will highlight different types of disparities throughout this week. Today, we are talking about racial and ethnic disparities. Tomorrow, a similar event in Memphis, Tennessee, will discuss disparities in rural

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communities. Wednesday, a Town Hall meeting in Chicago will highlight disparities in health literacy, in Houston, we'll address solutions to eliminating racial and health disparities. Thursday, we'll be talking about environmental disparities in New York City. Friday, a meeting in Oakland, California, will discuss disparities in chronic diseases such as diabetes and cancer.

Nearly every state, more than 40 are using National Public Health Week to bring communities together to talk about ways how we can combat health disparities. The only way we are going to end health disparities is by working together showing best practices, making the connections to the communities and populations that we need to serve better.

Now the American Public Health Association is committed to continuing this dialogue and to address this important issue. APHA's efforts will not end this week. The Association will continue to push for strong federal efforts to address disparities. We will continue to work to develop effective partnerships, and link communities to resources that empower them to end health disparities.

I want to welcome you all here, encourage you to stay engaged in this issue, become involved with APHA, and to continue the good work that you do to ensure that every American has the health care they need. Thank you. [applause]

DR. BENJAMIN: Born and raised in New York City,

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Dr. Carmona dropped out of high school and then enlisted in the U.S. Army where he then earned his G.E.D. And this is a very compelling story; one of the things he tells you is that's when he really got focused. After leaving active duty, Dr. Carmona attended Browns Community College of the City University of New York where he earned an Associate Arts Degree. He then later attended and graduated the University of California, San Francisco, with a Bachelor's of Science Degree; in 1979 also graduated from that school with a medical degree.

While there as a medical student, he was awarded the prestigious gold-headed cane as the top graduate. He also then earned a Master's in Public Health Degree from the University of Arizona back in 1998. Ladies and gentleman, our Surgeon General has worked in numerous positions in the health care field. He has been a paramedic, he's been a Registered Nurse, and of course, he is a physician.

What I find in kin with him, of course, is that he is a trauma surgeon, and I was an emergency physician. Understand what that means; understand the nights; understand the sleep deprivation; understand the schedules these fine surgeons do for us everyday. And you may find it strange to have a person whose interest is in traumatology now practicing prevention, but one of the things that you learn when you practice emergency medicine is that it is always better to prevent things than to have to deal with them on the tough end of these

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things.

I consider this gentleman my friend. I think he is an extraordinarily strong and forceful advocate for health. He is also an advocate for health care quality. He's been out here on this stop talking about the issue of how literacy and health disparities when nobody was listening, and now the world is listening.

Ladies and gentleman, the 17th Surgeon General of the United States of America, Vice Admiral Richard H. Carmona.
[applause]

DR. CARMONA: Good morning. Thank you, it's wonderful to be here. George, I just thank you so much for your wonderful introduction and your friendship; the passion you bring to the job with the Public Health Association.

As you all have heard, I am a recovering surgeon, and I went to Public Health as a second career over a decade ago, and never expected to become Surgeon General. But as Dr. Benjamin said, much of my commitment and passion to public health was shaped being on the front lines on the receiving end of the bad behaviors, the dysfunctionality we see in society to the point where I jokingly used to tell my residents and my medical students and fellows, that really I didn't see myself as a trauma surgeon. We're not trauma surgeons; we are repairers of society's indiscretions. We put people back together who continue to make bad choices throughout their life, either

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acutely or chronically. And so, I bring to the position a lot of personal experience from that aspect, but also my personal experience from life. And I'll share a little bit about that with you.

In Greenville [ph] I grew up poor, I grew up in the hood in Harlem, a high school dropout, as you heard, and I'll probably have that distinction of all the Surgeon Generals being the only high school dropout. But having grown up in the hood and dropping out of school at an early age, and having two brothers and a sister that also dropped out, and recognizing that growing up in the hood, dropping out of high school is hardly something that anybody notices. In fact, high school graduation may be a reportable event in the neighborhood that I grew up in.

But those experiences have shaped my life significantly as I understand the public's need for health, especially the area of health disparities, because I recognize from a firsthand basis, like maybe many of you, what it's like to be hungry, what it's like not to have access to care, because I was one of those kids before the term health disparities manifested itself and all of us ran on the streets.

I knew what it was to have a toothache and not go to the dentist, I knew what it was to have illness and not be able to get health care. It was my oulita [ph] who couldn't speak English who was the family gatekeeper for health who took care

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of us, and it was as a last resort you got to the doctor. So I learned about culture, and I learned about cultural barriers. And all of those great words we have today about cultural competence and stuff, I probably learned more from my grandmother who couldn't read a newspaper than I learned academically because I experienced it firsthand.

And so today, when we talk about complimentary medicine and alternative medicine, well if my grandmother was still alive she would tell you, I don't know why it's complimentary because my people have used this for centuries. [laughter] And the fact of the matter is, we are embracing that now because we understand that the wonderfulness of this country is based on diversity, and that diversity included unique cultures and how we see health, and how we see wealth, and how we see death.

So it was fortunate for me when I accepted this position as Surgeon General and I was trying to figure out what my portfolio should be, that engaging in conversations with the President and Secretary Thompson about this, I didn't really appreciate the monumental responsibility that this job has as being the nation's physician. And so when I try to think about what should this portfolio have, of course, I went to the science, I went to the evidence base and said this is what I am going to bring forward as an agenda for the Surgeon General and the country.

And it was very fortunate for me when I engaged in

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those conversations with President Bush and Secretary Thompson somebody on their staff - and they had done their homework also because we really came up with the same issues. And just briefly, the portfolio includes prevention, it includes preparedness, but in that - and I don't mean necessarily in that order because they do interrelate, was health disparities, and the President told me I want this to be a national priority; I want this issue of health disparities to be brought to the forefront; I want you to hold peoples' feet to the fire; I don't want this to go away.

He told me as a Governor, he struggled for years with issues of border health and immigration and health disparities, so he understood it firsthand also. Secretary Thompson, the same way, being Governor of Wisconsin had these same problems. So I was fortunate to have two people that I report to that I didn't have to sell anything to; they got it. They understood that disparities were important and needed to be part of our national agenda to eliminate health disparities.

In fact, the President said - now this is a guy from Texas, so he always talks big and thinks big, he said, "I don't want you to reduce, I want the goal to be to eliminate health disparities", to which I said, "okay, we'll go for that". Now I appreciated that even more because of my experiences as a child, and still have family members that struggle with access to health care and quality of health care in that access and so

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on.

So from the personal experience, it was very important to me and more than just an academic pursuit because I had some evidence base to suggest that health disparities were significant, but it really was a personal quest. It was a crusade of my own that I feel I owe it to my people, my communities of color that I grew up in because I have the chance now to return to those communities and keep this on the forefront. And it must stay on the forefront because it is intolerable what we have tolerated until now in our society as it relates to health disparities. So we must move ahead.

We have infant mortality that is at its all time low except in populations of people of color. We have immunizations rates that are at an all time high except in populations of people of color. We have cancer rates that are at an all time low except in populations of people of color, and as you know the list goes on. We can go to diabetes and hypertension, obesity, and other diseases and we'll find that those disparities continue to manifest themselves especially in populations of people of color.

America has its own unique disease. We suffer from racial and ethnic disparities in health care. Or as Martin Luther King, a great American once said, "the inseparable twin of racial injustice is health injustice," and we can no longer tolerate this. Researcher robust in the area - I am happy that

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the President kept his promise to double the funding of NIH, and with that 6 ½ billion dollars toward health disparities research at NIH. We must continue to grow and maintain the evidence base for what we do that is strongly supported in science.

We know that the human genome project is complete and 99 percent of our DNA is shared with our fellow humans - over 99 percent. So what does that tell us? We have learned that disparities appear to be more a social malady than a problem with biology.

The prevention agenda is extremely important as it relates to health disparities because the fact of the matter is that 7 out of 10 people are succumbing to chronic diseases. And as I draw on my own experience and the experience of Dr. Benjamin, talked about earlier, sitting in the trenches and every day admitting 3, 2, 3 out of every of the 4 patients that I admitted didn't have to be in front of me.

They were people that were involved in violence, they were gun shot wounds, there were drug problems, people who made bad decisions that day. And then we had people that made bad decisions across their whole life; sedentary, eating indiscriminately, gaining weight, unprecedented rates of Type II Diabetes, and on, and on, and on.

And yet, Dr. Benjamin, myself, and others who were in clinical practice expected to take the best science in the

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world, apply it to that person right then at a very high price to save them, only to turn them back to society without changing their behavior so that they can come back and do it again. That is the problem we face.

The good news is most of this disease burden and a very significant part that affects health disparities is preventable. So not only is it identifying the problem, but we really have to start reaching out to all of the communities of color, and making sure that they fully understand what is in their immediate control to make the plight in life better. It's not the only solution, but we must embrace prevention because the disease burden we have in society today is unsustainable.

We are going to all perish trying to keep up with paying for the disease burden we have in society. We can't afford it anymore, and the legacy we will leave our children will be higher cost care, and we'll have a greater disease burden unless we embrace prevention. So that when we talk about smoking, we talk about obesity, disproportionately affecting our minority populations, a lot of that can be prevented. We are losing 444,000 people a year to smoking and another 400,000 in obesity, unprecedented rates of Type II Diabetes, in our society, 9 million children who are overweight or obese with unprecedented rates of Type II Diabetes.

When we went to medical school, it was hard to find a

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kid with Type II Diabetes. They are all over the place now. And they are growing, and we are getting more unless we do something about it. We have many programs that I am happy to say have been moved forward to address the issue of disparities.

The President made a commitment to 1200 community health centers to try and reach the 40 million plus uninsured. Through the program of 1200 community health centers over five years, we estimated about 20 million people could be touched by prevention, wellness, primary care services.

Right now, I think we are at about 614 or so of those community health centers that are in place. We have the increased vaccine programs for children, which is doing well. The S-Chip program, which is getting over 5 million kids into healthcare that otherwise wouldn't have health care. And then, of course, we have AIDS with 40,000 new cases a year in the United States, 70 percent of which disproportionately affect minority populations still within our great country.

We've got 16 billion dollars put forth, an unprecedented amount of money to spend, not only for our country, but a global eradication of AIDS which primarily affects people of color. Disparities manifested once again.

We are very fortunate that Congress has decided to keep this on the front burner too. One of my colleagues, one of our friends, Senator Bill Frist, who's the Senate Majority Leader,

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not only does this on his own, where he goes to Africa and goes to other country and provides free services, but he in speaking to me, has said he wants to keep this on the front burner also. He wants to make sure that we deal with issues of disparities and make it part of the national agenda. So it's good to have somebody in Congress sensitive to this, and there is only one physician in the Senate, and that is Bill Frist. So it's fortunate that position is on our side.

The common currency for success as it relates to eradicating health disparities in my estimation, is health literacy that Dr. Benjamin already spoke of. We have to make sure that all people know what we know. But how do we deliver that message in a culturally competent manner that will effect behavioral change that will reduce morbidity and mortality and increase health and wellness?

That is the problem. We have enough science to move this agenda forward briskly, but how do we get the people to engage? How do get them motivated? How do we get them passionate about this? How do we give them the information so they can read that food label when we tell them to eat healthy? Because I have trouble reading food labels in the store and I've got an education in health, and I struggle; how many calories, how many grams of this, what about just plain old citizens that are out there trying to make it? It's real tough because the messages are complex. God help you if you watch

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infomercials in the middle of the night because you won't know what to think the next morning because someone is selling a pill, or a machine, or a gadget, or something that is going to guarantee your health, lose weight, look good.

And the fact of the matter is it only contributes to our problem because people are further confused, and the disparities are wider. The irony of health literacy is the people that need the health literacy the most are the ones that have it the least. And it's more difficult. So as we move our society forward, if we are not careful, we can make disparities worse because we leave those that need us more behind further. So we must be sensitive to this issue of disparities and the common currency for success in eradicating health disparities which is health literacy.

In closing, I would like to urge you all to get on board, to be a passionate advocate for this. Don't let this fall off the radar screen. Don't let it go away after National Public Health Week goes away. This must stay on our public agenda, legislatively, personally, community wise. I agree with Dr. Benjamin, we all in leadership positions have a profound responsibility - and it's an unbelievable honor to be able to serve our people, but we recognize that the strength and the changes are going to come from the community. They are not going to come from somebody in federal government telling you to do it this way. Because the fact is, each community is

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different; each community appreciates the culturally nuances of those people in their community. Those best solutions are going to come from the community. It is our job to provide technical assistance, to provide grant funding, to convene meetings, to bring people together as the group has done here today, but it's the communities that are going to save us and be our salvation in the future, and eradicate health disparities.

I want to stand with you at meeting like this in the future and report on how we have measurable outcomes showing that we are on the road to eradicate health disparities, but we can't do it without your commitment, and most of all your passion. You got to care; you got to want to do it. This just cannot be another thing. It has to be firmly focused in our minds irrespective of what our jobs are, and I am certain we can make progress so that all of those communities who suffer from this inequality, this injustice will benefit from your collective wisdom. Thank you very much. [applause]

DR. BENJAMIN: Thank you, Dr. Carmona. I am going to ask our panelists if they would like to come up now as we - yes, come on up. Turn your signs up, please. There we go. Okay. As we move to our next phase, we have three distinguished panelists here today to begin the discussion about how our nation can address existing health disparities. And I am going to introduce all three of them, and then lay out

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some basic questions, and then we can begin a dialogue. On the far right, we have Dr. Nathan Stinson. Dr. Stinson is the Deputy Assistant Secretary for Minority Health, at the U.S. Department of Health and Human Services.

As you know, the Office of Minority Health was created in HHS in 1985 as a result of the landmark report of the Secretary's task force on black and minority health. The mission of the office of Minority Health is to improve the health of racial and ethnic populations to the development of effective policies and programs that help to eliminate health disparities and gaps.

Dr. Stinson has directed this office since 1999, and certainly has served in a variety of positions in the Department of Health and Human Services including Director of the Division of Programs to Special Populations, and the Bureau of Primary Care at HERSA, the Deputy Director of the Division of Community and Migrant Health, Branch Chief of the Clinical Professional Activities, and the Branch of the Division of the National Health Service Corps, he was a clinical program consultant for the Associate Director of the Indian Health Service, Office of Health Programs, and also served as a primary care physician for a Navajo Reservation in Arizona from 1984 to 1988.

He in turn earned a degree from the University of Colorado Medical School and an MPH in Health Care

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Administration from the Uniform Services, University of
[inaudible] Sciences.

Sitting to his immediate left is Dr. Elena Rios, MD, Master's in Science and Public Health. She is the President and CEO of the National Hispanic Medical Association and the CEO of the Hispanic Serving Health Professional Schools Incorporated. She earned an MD of the UCLA School of Medicine in 1987, and her Master's in Science and Public Health at the University of California School of Public Health in 1980.

She has previously served as an advisor for the Regional and Minority Women's Health for the U.S. Department of Health and Human Services, Office on Women's Health from November of 1994 to October of 1998. In 1992, Dr. Rios served for the State of California, Office of Statewide Health Planning and Development as a policy researcher, and she has also served as President of the Chicano/Latino Medical Association of California, Advisor to the National Network of Latin American medical students, and a member of the California Department of Health Services Cultural Competency Task Force.

And to my immediate right is Michael Bird. Mr. Bird is the current Executive Director of the National Native American AIDS Prevention Center. For 21 years, Mr. Bird was with the Indian Health Service as an agency for HHS, and over his 25 years in public health experience, Mr. Bird has worked on a variety of health activities including, medical social work,

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substance abuse prevention, health education and disease prevention, and health care administration. He's a long-term member of the American Public Health Association, and from 1998 to 1999, Mr. Bird served as the first American Indian President in the history of the American Public Health Association, and we are certainly very, very proud of that. He's a past President of the New Mexico Public Health Association, and was a fellow in the U.S. Public Health Service primary care fellowship program, and a board member of the Healthnet New Mexico.

What I want to do now is really try to provide some focus for each of the panelists, and what we thought we would do is have each of the panelists speak for about 10 minutes and focus on a couple things. One, why are community based programs so crucial; and then secondly, talk a little bit about from their perspective what is working; and then finally talk about what's next. In other words, what as a community can we do to better ensure that we eliminate disparities.

With that, again, maybe I would start with - Dr. Stinson, I would start with you.

DR. STINSON: Thank you very much. First of all, let me applaud the American Public Health Association, Dr. Benjamin, and Dr. Cain for continuing along a path that is so crucial to this nation as a whole, and taking a look and putting together the components of addressing health disparities in a very, very

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broad way. We all know that the solutions to the unequal burden is not going to be accomplished by just looking at health itself. You have to look at the other parts of the infrastructure of this country, housing, the environment, and also bring in sectors such as the business sector. So looking at a very, you know, broad way, having these Town Hall meetings that look at health literacy and environmental health is really crucial to the progress that we need to make.

I have to say as I think about where we are now from where we have been over the last few decades, it seems as though, a few years ago, we were still debating and talking about the presence of health disparities and putting up a new chart of the new disease that showed desperate burdens of illness, when if you really look back at history, various health disparities have been present for decades, and decades, and decades. And now it's time for us really to focus our attention on what is it that we need to do to close the gaps. We don't need any more charts that show how unhealthy many communities in this country are.

A situation where there is an unequal burden in different communities in the country presents a real drag on the vitality of this nation as a whole, and has a real cost not only to us in health, but also to our children and also to our grandchildren. And so when I think about how are we going to do the things that are necessary to close those gaps, one of

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the things that is a critical component of that is the communities themselves.

About a year ago, we had a meeting with federal officials to talk about the intersection between environmental health and health disparities, and at that meeting, one of the speakers talked about the need to tap into the genius of the community. We don't have all the answers within the beltway of what really needs to be done. And there are people out there in communities, there is organizations that have served the communities for decades that have incredible ideas of what can be done, how to execute it, and how to improve the lives of people in their community.

One of the most prominent examples that is just burned in my mind was a couple of years ago I was at a conference talking about cultural competency. And in that meeting, some researchers from one of the academic institutions talked about the study that they did on the use of car seats on a Navajo Reservation. And they started this research because although every woman when she delivered her child on a Navajo Reservation was given a brand new car seat and instructed how to use it. The actual use of car seats was very, very low, and in the process of doing that research, they had some conversations with some Navajo elders, had a conversation about why people were not using those car seats. And what came out of that discussion was although we may feel very comfortable

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putting our children in a plastic and aluminum carrier and carrying them around the communities, that did not fit very well into a Navajo culture, Navajo tradition where the use of cradle boards and natural materials was still very prevalent. And what these women had was an idea, and their idea was to make slip covers out of traditional materials using traditional patterns and slide them over top of the car seats.

They did it. What happened was, the use of car seats went up, and there is no question in my mind that there are kids that are alive today because these women who did not have much of an education, who didn't have MD's or PhD's behind their name, but had an idea because they understood what the problem was and had a solution that worked. That's the genius of the local community, and that's something that we have to tap into if we are really going to solve this problem.

One of the other points that I want to make is that if we are going to eliminate health disparities, we need a blueprint. We need to know where we need to go. We can't have - we can't utilize shotgun techniques. Well let's try this, let's try that, let's try this, let's try that because so many of those things that we do may not work. Our department sticks on top of a warehouse of evidence base interventions that we know work. The science is there. We know that if we do certain things, we are able to close the gaps in many of these illnesses.

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What we haven't done as a nation, is to deliver them to the communities around the country that take what we have learned through the National Institution of Health and other academic institutions and make sure that that's the standard of care in every city, and every block, and every corner. In that, there's an expectation that whoever comes through those doors will really receive the same type of care, the same quality of care.

And Dr. Benjamin, when you talk about what are some of the things that work, the department just went through a progress review group in cancer where it brought together hundreds of experts, not only in cancer, but experts in public health, experts in health care delivery, to talk over this past year on developing a group plan, developing the action steps that this nation needs to do to close the gap in cancer. We need to have that type of dialogue; we need to have those types of discussions; we need to develop blueprints around the things that we know work.

And examples of our program in addressing the low rates of adult immunizations in African American and Hispanic communities around the country, we are doing some demonstrations, we are doing some pilots. There are a lot of things that we are doing to build that science, but we need to translate it into things that can occur at the community level.

The last point I want to make, the hallmark of health

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care is communication, communication, communication. We must do everything we can to maximize that communication between the patient who comes through the door, and the health care provider who sees them. Anything that disrupts that interaction is likely to end up in a less favorable outcome. And that means trust, trust, trust. We have to build trust between communities in this country and the health care system, and it's not just with individual providers, it's with systems whether it's health care organizations, hospitals, multi-practice groups.

If we do those things, we can continue to march forward and close those gaps. It's not a sprint, it's a marathon, but as long as you are moving forward, you're not standing still, and you're not moving backwards, I think that's where we are right now.

DR. BENJAMIN: Thank you, Dr. Stinson. [applause]
Dr. Rios.

DR. RIOS: Okay. I was told a couple of things to prepare for this, and I want to first of all thank Dr. Benjamin, and the American Public Health Association for taking the lead here in getting us all together again for Public Health Week. I think it's so important to rejuvenate our juices and get our collective thoughts together, but I am going to talk about what I think is important is working together to share the knowledge that we have from our communities, and I am

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going to give a few examples of a few community projects that work in the Latino community. But more importantly, I am going to start off with a couple of quotes, that we have to think about the future as leaders in this country and working together with the coalition.

And I think that that's probably the most important lesson that I have learned being here in Washington is that we can't do it on our own. I know - coming from East Los Angeles area, [inaudible] and coming from California ten years ago to Washington D.C., and as I say, "culture shock" and I am still in a state of culture shock, everybody has their own agendas, and everybody has their own goals, but in reality, we are all part of one country, and we are all here really for - really to eliminate health disparities.

We have to be responsible for sharing the lessons learned in our own communities in the coalition - oh, I am sorry; I didn't turn the button on. There was a book recently written in California out of UCC Santa Cruz by three authors, and African American, a Native American, and a Hispanic - an Asian American also; *Searching for the Uncommon Common Ground*. They suggest the 21st century leaders must be prepared to understand and lead under conditions of globalization, increasing stress to the environment, increasing speed and dissemination of information technology, growing diversity, rapid change, unprecedented complexity, increasing

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interdependence, and an ever widening gap between the have and the have nots. Frieda Carpa [ph] is actually from UC Berkeley wrote a book called *Hidden Connections* a year ago and he says, "the greatest challenge of the 21st century will be to change the value system underlying the global economy, so as to make it compatible with the demands of human dignity, and ecological sustainability," and perhaps the biggest barrier - and this is from again back *Searching for the Uncommon Common Ground* with these groups of minority think-tank thinkers coming together they say, "perhaps the biggest barrier to effective leadership in the area of racial equality is the American population's overall disengagement from issues of national and local importance."

And I would say that health disparities suffers from that barrier. We need effective leadership in our communities that teach each other at the community level that it is important to talk to your Congressman; that it is important to join your local community agency; it is important to volunteer; it is important to vote; it is important to become engaged in all of the opportunities that this country has not only for it's citizens, but for everyone that lives in the United States. And I think it's up to us. We have the responsibility as individuals in this country to share our knowledge with each other. That's really the bottom line.

Let me just give you some examples in the Hispanic

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communities across the country. In the Bronx, New York, there's a large community health center called the United Health Plan, Paloma [ph] Hernandez is the CEO, runs that health plan, and they developed a small, mom-and-pop - it was actually a medical practice that was started by her father, Dr. Richard Escardo [ph] in the 1960's. And they grew so big and the demand was so great that they had to buy the building across the street and they made a huge, big clinic, a brand new clinic - in fact, the Surgeon General, Dr. Richard Carmona came from the neighborhood, and he was honored with his picture upon the wall when they opened up the clinic.

The clinic is part of the HERSA's health collaboratives, and one of the projects that they decided to develop was to have greeters, or what we would call navigators help the patients coming into this new facility, and it was such a big change from the small, little mom-and-pop facility to this huge facility that they found it important to make sure that community workers and community people helped the patients come into their new facility. They've had tremendous success, just by having that system at the front end.

In Fresno, California - and I come from California and the farm workers have been organized since the 1960's under Caesar Chavez and now under Lara Escuarta [ph] and I think that the farm workers in California have taught the country a great deal about organizing, but more importantly, in health care in

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Fresno, California, they have been developing how to increase access to some of the poorest and most vulnerable in our communities - and we have the same problems over the migrant strings and the whole country, people that do not have the language or the educational wherewithal and there has been a movement for the farm workers in California, but they have leveraged their demand, their need, with the University of California President's Office in getting funding for research and with the California Endowment, which is an example of how a foundation can leverage it's resources and target a community in the state that has been often overlooked.

And in fact since most of these farm workers come from Mexico, the California Endowment is looking for ways to improve relations with the Mexican medical system and government and the United States medical system - especially in California, and looking how we can better improve ways to flow services between the U.S. and Mexico so that the farm workers can have better access to health.

In Texas, I know - and just a couple more examples. In Texas, the medical school in San Antonio has gotten funding - and again, this is from the community meeting the demands, to teach their residents in the valley of Texas, they decided to develop a regional or a satellite medical education system called the RAC, or Regional Academic Center - or Regional Academic Health Center in Arlington, Texas. And San Antonio's

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medical school galvanized the support from not only the state government, but the community to get doctors to be the teachers in a different site.

They used the community health center again, and a hospital and took the best and brightest minds in the community to build what would become another medical school. But it's right now connected to the san Antonio's medical school, and I think that there's a lot of pride in being able to serve a community that has never had its own medical school.

In Memphis, Tennessee - and I'll just end with this one, I am part of the National Advisory Committee for Hablamos Suntos [ph] and I see Dr. Nelson here in the front, and we have this very inspirational leader Yolanda Poratilla [ph] and I want to say she spoke at our dinner last week. Yolanda is from California, and she's - her background is public health. She has lead country hospitals. She comes from the community of Fresno. She worked in San Diego; she is now working in Los Angeles.

And she was given the job of putting together a national multi-site experiment where she would develop interventions for language services in different health systems around the country with a whole evaluation team and a National Advisory Committee, but in Memphis, Tennessee, we had a site visit last December, and in the county hospital of Memphis, which is in the tri state border area - my geography is bad, so

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I am not going to remember all the states, but there were so many Spanish speaking Hispanic immigrants to this area, an incredible increase overnight, over the last five years, that the OB/GYN services of the whole county system are flooded with Spanish speaking women who have nowhere else to go and the system itself was forced to respond by finding different ways to deal with this new on slot of Spanish speakers. And I would say that the cultural and the language transformation of this medical system is an incredible opportunity for this experiment called Hablamos Santos (ph).

In a couple of years we are going to see the data on how these different - and there are 10 sites around the country, and all of these communities and how they are doing with it. When I went there, I met a doctor who has been there over 15 years, a Hispanic doctor, who developed his own Hispanic medical society.

And I am going to end with what we are doing with our two organizations, but I think that it is important to realize that he developed his own medical society, not only of Hispanic doctors, but of doctors in Memphis, Tennessee to take care of this Hispanic population. And I would venture to say that the rest of the country is going through this in different parts, especially the south and the southeast where there haven't been that many Latino patients.

So let me just end with our mission from the National

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Hispanic Medical Association, and the Hispanic serving health profession school has been to improve the health of Hispanics, and we join the American Public Health Association, and we have joined other coalitions here in Washington, the Racial and Ethnic Health Disparities Coalition led by Ferdet West, the out of many one collation led by Shire, I think we recognize the responsibility and we recognize the importance of sharing success stories in models that work because that's the only way we are going to eliminate health disparities.

We need to provide mentorship, but more importantly what I think we have realized - and I'll just give you two examples. The Hispanic health profession schools never worked together before. The government in this country decided that it was time for those medical schools and public health schools, and hopefully in the future nursing schools and dental schools that have had significant numbers of Hispanic students, and Hispanic faculty that they start working together and sharing their successes; that they no longer just compete for the same grants.

And I have to say that the 20 or so institutions of HSHPS have formed a successful student internship program for CDC and are about to work with the FDA on the student internship program. And they have created a faculty development project. We have now databases of Hispanic Full-time faculty in medical schools and public health schools only

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in this membership, but I would say if you need Hispanic faculty and researchers for your projects, please call on HSHPS. And lastly, as far as an HMA, I think what we realized, and we formed our organization in 1994, it's been 10 years, and we realized that we needed to identify Hispanic doctors who could document and share their knowledge and experience with other doctors and other providers who take care of the Latino patients in this country. And we are building a portal called www.hispanichealth.info to be able to share that kind of knowledge.

We also developed a leadership training program. This one for doctors, the National Hispanic Medical Association Leadership Fellowship, but I think what is important about it is that we have identified and we trained 100 doctors in the last five years who are movers and shakers and I would dare say are the future leaders for this country, along with all of our sisters and brother organizations who know that we can't do it in one generation. It's going to take several generations, and we decided that our legacy would be to develop leadership for the future.

The other thing we decided to do is work with media; to work with Congressional - especially the minority caucus but also the leaders such as Senator Frist and Senator Kennedy, but we need to help them make sure that they don't get off track and that we keep telling them how important health disparities

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is to our communities, and that we support and we get letters of support for the health disparities legislation this year from the democratic side, from the republican side, and hopefully they all come together and at the end of this year we have health legislation that works because we know that we need everything that is in those bills, but what we really need is recognition that health disparities is very important to the American health system.

And let me just say that I brought books. We put together a Health Summit a couple of years ago - it was actually about a year and a half ago, the National Hispanic Health Leadership Summit, about 170 experts from the grassroots communities from around the country, nominated by the U.S. Department of Health and Human Services, Dr. Stinson was there, Dr. Carmona was there, HPHSA members were there, we also had Congress members there to hear again about models that work and we are here to share that book with you, and we have it on our website if you would like to get more information. Anyway, thank you very much. [applause]

DR. BENJAMIN: Mr. Bird.

MR. BIRD: Welcome. I want to mention how appreciative I am for this opportunity. Many people do not realize that there are in fact still American Indians and indigenous people on this continent in this nation. One of the major issues that we face is the fact that we are invisible.

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The only time that people think we really exist is when John Wayne is chasing us across their television screen at 12:00 at night. We are still here. This is our America as well. I am a first American I am from Santo Domingo in San Juan Pueblo in New Mexico. We have been in New Mexico for anywhere from 10 to 30,000 years. We are the first Americans; we are not the only Americans.

I have to say that we should rename our panel disparities are us [laughter] but the fact of the matter is we are more than the sum of our disparities. We are language; we are culture; we are tradition; we are religion; we are art; we are history; we are poetry; we are the essence of this country. And you could no more separate our contributions to this nation than you could any other populations. We belong here. This is our home.

In terms of many of the issues that we are hearing today, and I think there needs to be a contextual piece because we can talk about programs. There are many successes that I am aware of in my 27 years of working in public health with American Indian, Alaskan Native, and Native Hawaiian populations, but I think that the contextual piece that sometimes left out, many of us understand personal responsibility in a very real way. We would not be here had we not understood what that means today for ourselves and for our communities.

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But the fact of the matter is there has been significant dispassion, and there's no better example of that than the American Indian experience. When you dispossess people of their land, their language, their culture, their tradition, their religion, their economic base, it sets into motion a whole number of forces that you see mirrored in other peoples' experiences, not only in this nation, but with native Hawaiians, Australian Aboriginal people, the Mowri of New Zealand and Australian Canadian Aboriginal people, and you see the same sort of impact and the same resulting consequences. So it is more than just being personally responsible. We recognize that, we know that. I am not sure people understand the nature and extent of the dispossession that has occurred in this nation and it's long-term impact.

I would also say that when we talk about new initiatives and much of the topic of the day homeland defense, which is clearly important, we talk about personal responsibility, we talk about faith-based initiatives, well I have to share with you the fact that the first prayers offered in this land came from Indian people, indigenous people. The first prayers of this land were indigenous. The first prayers offered by indigenous people for the rain for crops, for sustenance for their people, those prayers are still being offered to this day, not just for our communities but for the world community. It is a global prayer that goes out and it

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includes all people. And that is something I think that we need to really take to heart.

So much of what we are engaged in is sort of a dominant sort of cultural sort of mentality that says that in order for me to be successful I have to be on top of everything, and we have still yet to learn how to share. We as indigenous populations have shared our country. We would ask you; we would call upon us as well as all of you in this nation to learn how to share.

Some of the philosophical values that come from indigenous cultures and values that are more relevant today than they have ever been not only for this nation, but for the world. When you talk about concepts that come from for example, [inaudible] poet Simon Ortiz when he says, "if you take care of the land, the land will take care of you, if you take care of the people, the people will take care of you".

We have in some ways lost - some people have lost sight of that, that we are interconnected and interdependent. That is indigenous knowledge, that is indigenous values, and it is more important today and more critical than it has ever been in the history of this planet. We are a global world; we are a global nation. And until we understand that we need to learn how to share, we will continue to have difficulties, we will continue to be challenged because fundamentally we are all - we were all put here for a reason. The Creator made us all. And

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until we understand and break out of some narrow concepts and constraints in the way that we are taught to think, we will continue to have the kind of issues and problems that we face today, not only in public health, but in terms of the economy, in terms of the environment, and a whole array of other issues.

So examples; here's a good example. The National Native American AIDS Prevention Center currently has a grantsmanship center. It was established and funded by HERSA for two years worth of funding. And it was established because one of the things that was real clear was that Indian communities, Indian tribes were not competitive in the whole grantsmanship arena. So they were not getting funded, and of course that's the mechanism; that's the game we all have to play.

So they funded us for two years, and of course, we are so good, we have turned everything around [laughter] I wish we could say that, but the fact of the matter is we have made a difference for 40 communities throughout this country in terms of their having better skills, better knowledge, better awareness of what it takes to be competitive in this worked that we live in. there are many more examples.

There are examples such as the Zuni Wellness Center it was developed in conjunction with the Indian Health Service, which is a wonderful example which builds in culture and traditions. The first runners of this nation, first runners of

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this continent were indigenous runners did not start with Bill - I am blanking on his name right now, but it was indigenous knowledge, indigenous value, indigenous runners that ran and coursed this whole nation.

And there are programs that are established to address issues of Diabetes and Hypertension and as a community-based type of approach there are many, many, many more examples; successful programs, CHR programs, Community Health Representative Program, which has been in existence over 30 years and worked with local people from the community to work as lay health workers - an interesting new concept right? But have worked within their communities to help and assist to promote health in their communities, people from their communities.

Many of these programs are working and are successful. The fact of the matter is there's a lack of commitment; there's a lack of spiritual and there's a lack of will on the part of many in this nation, and I would say I offer my own personal prayer to all of those people who, in fact, have not come to understand or appreciate the negative consequences in impact of disparities and I offer a prayer to them that they be touched and that their hearts will be open to better understand what it is that we all have to live with day in and day out.

It is our reality, it is not something we can turn on or turn off like the television. I want to thank you for the

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work you do. I want to say that if every time you call a meeting everybody looks like you, thinks like you, wants to be like you, then you probably are at the wrong meeting (laughter). We need to reach out beyond our comfort level. We need to make new friends. We need to build new relationships. We need to collaborate in ways that have been reflected upon because that will move a public health agenda. That will address the issues of disparities in this nation. And that will, in fact, create a healthier nation, and a healthier world. Thank you. [applause]

DR. BENJAMIN: Thank you, Mr. Bird. Let me just summarize. I think we heard Dr. Stinson talk about the issue of trust, the need for local solutions, the issue around focusing many of our work to try to look at the evidence base and he talked about the fact that there are many programs out there, which we are going to come right back to in a second. We heard Dr. Rios talk about health equity and values and the importance of local leadership, and the concept of partnering both to provide care and access as well as to ensure an adequate provider base, and then you heard Mr. Bird talking passionately about the importance of culture, building on old traditions and using those community health workers to solve many of our problems.

What we had hoped to accomplish this week of National Public Health Week is again, to move from the dialogue of

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measuring to the action of sharing solutions and so what we have worked on is crafting and we hope is one of the first, if not the first, national database of disparity programs. And I certainly want to thank our panelists for giving us some insight into the problem.

As we move to looking at this database, we now know that we have almost over 500 solutions today in the database and we certainly can take more. And just as a commercial announcement, to point out that you can do that at www.apha.org and you can actually type in your solutions. We are looking at this database to have in a life beyond certainly just this week. This database is going to be in existence, we are going to be working with several partners. One of our most important partners is United Health Foundation, who we already work very carefully with to look at the whole issue around health status in the United States. We do that with them and our partnership for prevention.

But this database, we hope will just be the star. It's something that was called for by Robert Wood Johnson Foundation study in which as one of its many recommendations recommended that there is such a national database and with the web being such a prominent tool now, we thought this was an excellent opportunity for us to build that database. So I get to play with it a little bit this morning, and just to show you some things. So for example, if you want to go to a category, and

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let's say we pick improving the quality of care for racial and ethnic groups since that's our theme for the day, and just access by just picking that - let me orient you first - just by picking that category, you can also look at key words, you can look at the state, you can go by the ethnic racial categories, it's a bit arbitrary, but they work for the purposes of their database. You can look at age, or even gender specific areas. But let's just go to that one case by category. And if you do that, you get these huge lists of programs, and I am going to go to one here, the Memphis Health [inaudible] if I can find it here - I don't know what happened. Let me go back. Okay. Let me go by the state now that will help me go down. That one is in Tennessee. So we do both of those categories. There we go. What you see is a description of the program, it tells you what the organization's name is, it tells you the project title, gives you the contact name. You can actually click through even further to actually go to the website of the organization. It talks about who their partners are. It talks about how long the project has been in place. It tells you the lessons they have learned, for example, it talks about one of the biggest challenges to their efforts. And it talks about which racial, ethnic categories, or gender that they were trying to focus on. Another one - let's just say we wanted to take a state. We'll go to California. There are several programs here that are of interest. There's the Nights Tobacco Awareness Program here;

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again, the same kind of layout for the program. It talks much about what the programs organization is, who runs it, where it is, who some of their partners are. This is one which is American Legacy Foundation partnered project. Again, talks about some of the ideas, and again, the idea of this database is for you to search by categories, search by areas of interest, and then pick up the phone and call them and try to find out a little bit more about their program. You can look at - let's say we wanted to do American Indian Alaskan native programs. Here there are five programs here that specifically match that category in the database. Here's a Diabetes Education Program that one might want to look at. Again, it might be an interesting program. And this is one in Hugo City, California. Let's say that we wanted to look at tools for assessment. We have listed some programs by tools. As you know, one of the things we are concerned about is how do you know that these programs work. Well we certainly have the usually disclaimer because we have not done any evaluation on the programs, but I need to say that one of the things that we are going to be doing over the next year is creating a panel to look over these programs and at least identify those that are evidence-based, those that have been evaluated and try to come up with some simple evaluation tool to give people some confidence that these programs have at least been evaluated. Now as you know, there are many programs that have been hard

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evidence based and many have been evaluated, and probably many many more that have not. And the idea, of course, is just to denote those that have, and then let people take these programs and re-craft them as much as they possibly can. Let's say for example you want to look at programs for cancer. Dr. Stinson talked about the issue of cancer. There are 60 in the database. Right here. [inaudible] There are specific categories. Just see what happens. Okay. They are telling me I should have played with this more this morning. [laughter] I'll find it. I'll find it before the day is over.

Technology.

The point is that there is highways and tools of critical steps, as usual, you have to play with these things more to get them to work. The idea being that you have to go in an identify programs that work and to share them with communities across the country and we are hoping as we go forward that we will be able to do that.

So with that, I though we would begin with taking some questions and answers from folks in the audience. I know we have some programs here and many of our panelists are available to answer some of these questions. Maybe I will just take the first one. And the basic questions, what can we do to emphasize the need for more state and federal support for many of these programs.

DR. STINSON: That's a great question from the

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prospective that - from my view. The voice of the community needs to be large and clear, loud and clear in the type of government that we have a representative government. The people have a voice, the community has a voice and I think in that case of unequal burden needs to stop now and I think you can stop by communities, really talking about what is needed, what type of investment should be made in their communities to address these problems. And in fact, it is my view that that's the only way the health of the whole nation will improve and if we make investments across the board. So I think it's really the development of the momentum and it's the will of the people to say disparities have to go.

DR. RIOS: I'll add to that, I think the prospective needs to change. We have been here in this country ignoring our minority communities and only until recently with the Civil Rights Movement of the 1960's where many of my colleagues even afforded the opportunity to go to college and to become doctors and that's why our National Hispanic Medical Association just started in 1994. We just got out of school; I just got out of school in 1992.

And we are the first generation for Hispanics in this country to rise up, to take our leadership roles and tomorrow the plight of the AMA, Dr. Nelson will be there, with the AMA's Disparities Health Task Force. And it's no accident that we are being asked to be a part of these meetings because we are

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the only organization - and I shouldn't say we are the only organization, there are several Hispanic Medical Societies, Hispanic nurses, Hispanic dentists, but we happen to be at a national level. And I think that not only do we have to get our communities to understand their roles and responsibilities, but the leaders in that community need to be helped, and networked and get to the national or to the state level if we are going to get national or state health for our local communities.

So whatever it takes to get to the tables the help to make decisions in this country, that's what we need to do.

MR. BIRD: Somewhere there is a historical document that says "we the people" [laughter] we are the people. But again, until we understand the nature of the disparities, the history, the contextual price, I think many people will not take it as seriously. Change does not come easily, it does not come overnight, and it takes a sustained commitment and a vision of what might be. And I think that the collaborative piece is essential and that's why I'm - that's why I am an APHA member because I see a real commitment to diversity, equity, and social justice. I see more than rhetoric, rhetoric comes and goes like the wind out there. Real change has to - I am not going to be anywhere where it's not real. You get to a certain age in your life and say, you know, the clock is ticking, I don't have time. If you are not real, I am gone.

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And I think we all need to be a little more serious about it in that way. The only thing we have guaranteed to us right now is -

DR. STINSON: Dr. Benjamin, I also want to make a point that this is not just about new resources. I think it's important for all of us whether you are in the federal sector or the state sector, or the city government to really look at how the current resources are being utilized and really go back to focus on the things that we have some evidence that we know work; that we know [inaudible] the outcome that we want. We have to shed the shackles of history. We have been doing this because we have been doing this. There is too much of that. We need to make investments if things are going to work.

DR. BENJAMIN: Thank you. Ms. (inaudible)

FEMALE SPEAKER 1: (inaudible)

DR. BENJAMIN: He is going to bring the mic to you.

FEMALE SPEAKER 1: There is a growing population in the United States that are both indigenous to Central American countries and Mexico, but yet are non-Spanish speaking. I want to know how the health system is done particularly, and the response on - the question I am addressing it to Dr. Rios and Dr. Bird, I would like to know how health systems are acting and responding to these health systems.

DR. RIOS: I don't know a specific example, but I do know that there is an awareness of the importance of language

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and communication to the point where the issue of institutionalizing incorporating language services in this country is a reality now. And I think that because of President Clinton's and President Bush's leadership at the national level to make the Civil Rights Act include language, and that the Civil Rights Office for HHS, and Dr. Stinson's office of Minority Health has included a whole center on language and cultural services, and certainly the class-standards that have been established.

I think the health system hospitals, HMO's, doctors, associations, need to embrace this leadership and trickle it down to make it reality. And like Dr. Stinson said, it's a matter of redirecting the resources within the system. And even our legislative efforts this year with - and it's not the first time the Hispanic health Improvement Act happened a few years ago, but it is significant to see that in both democratic and republican legislative action here on health disparities will be health education, equity act, and closing the gap act have language services reimbursement included which means that at the local level, if there is a need for language services for envisionists, people from Latin America and Mexico who do not speak Spanish, they are from the envisionists populations of the Incas and Aztecs people of the Native America Tribes, I don't even know how many tribes outside of the United States - there are 500 in the United States, but all these tribes have

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their own languages. And I think that at least the United States leadership has taken a step forward, a giant step forward to have all of us come up with the solutions and the strategies to translators and interpreters, but to have the leadership in the local hospitals embrace the need and the respect for these people who do not have English as their first primary language, and to have the leadership take the opportunity to have a real quality health care system.

MR. BIRD: I think the population you are speaking of is it's new and it's old in many ways, but at the same time, I think that those numbers are increasing and I think that we as public health professionals with people who are committed to the well-being of all people need to acknowledge and recognize that need. And I think often times it's not about - again it's about age and being open, and having an open heart and an open mind, and not being threatened or afraid of what somebody else has to offer or so much of what I see that impedes the real progress on a personal level that needs to take place is about power and privilege and it's about people being threatened or some perception of threat. I see this in many systems that exist where there is the law, there are regulations, but because of fear that maybe that they will lose their position - I mean, you see this happening or when there is competition for positions sort of rather than - are we opening doors, or are we closing doors. Are we on a personal level willing to challenge

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some of our consumptions, or preconceived notions, our stereotypes, and we call can be - we all have been oppressed and we all can find ourselves if we are not careful of being under pressure as well.

DR. BENJAMIN: Yes, sir?

MALE SPEAKER 1: While it is true about building awareness about preventative measures, and making interventions more accessible as an effective way to reduce disparities, are you aware of any community-based solutions that connect those with the information with those who are seeking the information that also overcomes the barriers of language, tradition, and technology, like the web? And are you interested?

DR. BENJAMIN: Certainly interested. I think one of the hopes we would have as we craft these databases is to build the more of these issues, first around health literacy, and again, health literacy is the capacity of a community to understand what the health care providers are saying to them both in their native language as well as according to their own customs. Certainly some of the managed care companies are putting together in their ask-a-nurse programs ensuring that they build culture competent seasonal systems as well as having people that clearly can communicate in the majority languages whatever they may be, of the population which they serve.

Also, I know that for example, in the State of Maryland when I was health officer there, we used to put out

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immunization messages in 15, 16 different languages. And then of course, tried to find people that were of that community to help us deliver an immunization message out, so there has been some efforts to try to do that.

The web, electronic communications presents a new challenge. This database certainly - many of our materials are in Spanish as well, and we are hoping, of course, over some time, to maybe expand in other languages as well. That is certainly something we are going to have to look at. And I think, as we look at this whole area of health communication, that's an important tool.

DR. STINSON: I was just going to say that one of the things we are looking at very critically right now is the use of advanced technology and to a certain degree focusing that technology whether it's medicine or different avenues on the provider community. It's one of the things that we know very, very clearly that same standards, same level of care, tends to lead to the same type of outcome, but we know in a nation like ours where it's not only geographically spread out across the board, but even within urban areas, we know that there are geographical pockets there that impede certain access to providers that have the latest type of treatments, or the latest modalities.

So we are looking at how we can do that to continue on the type of educational process providers that started when

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they went in to the health profession school where there was this ongoing and consistent relationship with experts across the board. So I think that as we look at the particular challenge we have, and addressing disparities - and Dr. Carmona was right on point, health disparities isn't biology. There's a societal - it's an environmental as an infrastructure context to all of this. But as you look at what are the things we need to do as a very, very diverse nation, I think we do look at things that play into certain strengths that we have as a country and technology is one of them.

DR. BENJAMIN: Let me ask, is there a Dr. Kim in the audience. Hi, Dr. Kim. I might talk a little bit about your program; I know you have a Tobacco Program.

DR. KIM: Yes, I would like to comment on two things. This really is where one side it is very exciting, and it is also a little disappointing. Of course, the disappointment is Asian Americans is the most recent member of this American community. And tons of health disparities, I believe we do not have so much reliable national database about Asian Americans. Because there's not much studies, and understudies and consequently leading to the disparities. That's one that should bring more attention; I want to pay more attention on Asian populations in American societies.

And second one is, the encouraging side is that
That is when I launched the committee based programs called

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Corrina Americans in Netherlands, initially started an anti-smoking [inaudible] founded by the American Legacy Association. And last year we implemented and started the self-help hypertension management programs designed by Charles Hopkins and nursing faculties and funded by American Arms Services for Asian Health Care and Research and colleges. And I think when we started the programs, we thought, oh this is fairly unique and we are on law, and didn't get much attention from the National Audiences. So we felt a little bit alone and very odd, it is a unique program and has great potentials, but now I know there are places all over the country where there are small community-based and community-initiated (skip) programs on preventable health risk factors. Thank you.

DR. BENJAMIN: Thank you, Dr. Kim. How about Rhonda Chapman? Is she here?

MS. CHAPMAN: Hi, I am Rhonda Chapman of the American Heart Association. We started a program called Search Your Heart back in 1996, it was a faith-based intervention, it is risk factor focus. We work on helping to build the infrastructure within the church to help strengthen and empower their health ministry to really continue health education throughout the years, throughout all of their activities within the faith community, and it's been very successful for us. We have had over 10,000 African American church partners, about 4,000 Hispanics. One of the things Dr. Stinson said that made

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me chuckle - we learned early when we started the program here in this market, and we tried to do it in an Islamic community. And we wanted to do blood pressure screening, well there's a whole different factor around in that culture, about who is going to take your blood pressure, who is going to touch you. I think we always have to talk to the community before we bring these programs in and figure out how we are going to work with them. We have great tools like the database and I'll go and put some of our information in there. But I really like the point that you need to always make sure that you talk to the community you are working with to figure out how it is going to work for them to make it an effective strategy for that community.

DR. BENJAMIN: Thank you. I know there is another program here. Spirit Education Health Circle? Ms. Cheryl Pearson Fields.

MS. FIELDS: Hi, thank you. A couple of comments. One to sort of reiterate what the gentleman said earlier about lack of inclusions. The program that I represent is actually in the database and it's providing services for African American lesbians and its part of a larger organization that provides cancer services and other services for lesbians and women who partner with women and for this community, there is also a lack of data. Because issues of sexual orientation and questions of sexual orientation aren't included on national health care data

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systems. We don't have the kind of evidence base from which to devote programs. But one of the things that Dr. Stinson mentioned is the issue of trust between providers and patients and that is so important for a community because there is a lack of trust because people have access to health care and been discriminated against, have been treated badly. And so in a study that we just finished, about 25 percent of the women are - 30 percent of the women are afraid to access health care from a primary care provider because they are afraid they are going to be treated badly based on sexual orientation and based on racial and ethnic issues; and then 25 percent of the women are actually delaying seeking health care.

So our program is really geared to supporting women and accessing cancer screening services and making people better health care consumers, as well as educating health care providers on cultural competence issues. So, that's one of the things I would like to highlight is the importance of including [inaudible] communities when we talk about health care disparities in this country.

DR. BENJAMIN: Thank you very much. And I would be remiss if I didn't bring up somebody from the D.C. Health Department. I would be run right out of town. Is someone here from Project Wish?

FEMALE SPEAKER 2: [inaudible] from the Department of Health. Project Wish is the D.C. for cervical cancer and

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early detection and prevention. We provide free mammograms and pap smears to women who are uninsured or underinsured who live in the district. And the program has been in existence since 1997. We have provided over 8,000 free mammograms, and about 8,000 free pap smears to women who live in the district. And in 2002, the D.C. passed legislation to provide any of these women who are diagnose with cancer free cancer diagnostic services through their treatment. So we are working here in D.C. for the women.

DR. BENJAMIN: Thank you. One more question. Ron?

MALE SPEAKER 2: Thank you, Dr. Benjamin. You mentioned health departments which I think are key in - and the best data that we have suggest that we send about 2 cents of every health care dollar on public health. We spend less than 2 cents of every research dollar on public health research systems. However, we know that there are huge public health systems and service disparities throughout this nation, and I am wondering how we will address the needs of the nation if these disparities in public health services continue because it is the public health agency and official, Dr. Cain, being one, who is able to take a lot of the science and translate it for use by the community so that the community can into great effective interventions, and I am wondering again, how we do this without rebuilding our nation's public health infrastructure?

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DR. BENJAMIN: Thank you, Ron. I will give the short answer, does someone else want to take that answer, because you know what I am going to say (laughter). We came. We came. We have to rebuild the nation's public health infrastructure. As you know, HPHSA has three priorities. One is universal access to health care, two eliminating disparities, and three is rebuilding the public health infrastructure, in no priority of order. We are going to make sure all three of those things happen as quickly as we possibly can. I appreciate your comments, but you are right. We need to spend more on education, and we need to rebuild this nation's public health infrastructure, and we need to more fully integrate it with the acute care health care system in a holistic way which recognizes communities.

I would like to ask Dr. Morrison if he would come up. He is the chair of the board of the American Public Health Association and maybe say a few words. Dr. Morrison.

DR. MORRISON: Thank you, Dr. Benjamin. As we begin to close out this kick-off of National Public Health Week, I want you to help me joining me, in thanking our speakers and our panelists for this program this morning. [applause] I also want to thank our sponsors because this is a collective partnership and without your assistance, we could not move forward. As you begin to reflect upon what you have heard this morning, I hope you agree with me that this has been a great

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opportunity to discuss issues that are important to the public's health; particularly health disparities. I hope you will also agree with me, that it is very, very important that we continue this dialogue. Every day in every community until the phrase health disparity is no longer relative to our conversation or to our society.

We can do this, but we do need your help. It's been a great turnout here this morning, we need each of you to be Ambassadors for Public health, and for the elimination of health disparities whether they be by gender, by race, by ethnicity, by geography or be any other characteristics of human society. We know the numbers, it is now time that we collect the answers.

There are hundreds of programs going on throughout this country. You have heard about some of them. If yours is not on the database, please put it on the database. Apha.org. We need to hear from you because we need to take your collective wisdom and translate that into actions so that we have a positive outcome. Disparities are not new, we have heard that. They have been around, but because they have been here for centuries, there's no need, there's no rational reason whatsoever for them to continue one day longer.

We need your help in moving this very vital public health agenda. It is not an agenda of race, it is not an agenda of gender, it is not an agenda of culture, it is a

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public agenda that embraces all of us in everything we do in the fabric of our everyday life.

I am somewhat moved to quote the famous Jedi philosopher trainer, Yoda [laughter] when he said, "there is no try, only do." Collectively, we can do. We look forward to working with you in the days; the months, the years to come whatever it takes until we realize that dull will no longer will we have to sue the word disparity in our vocabulary. I want to thank everyone for being here. It does not stop here; it does continue, and be mindful of the fact that disparities is part of all of us, as Michael said, we are disparities, disparities are us, it's important that we do everything we possibly can to reduce and eliminate this very very important, unfavorable characteristic of our society. So again, thank you. I will turn now back to Georges. [applause]

DR. BENJAMIN: Thank you very much, Dr. Morrison, just to remind you that this is a whole week. We are doing this is every state in our nation, and just want to again encourage you all to participate and have a pleasant tomorrow. Thank you. [applause]

[END RECORDING]

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