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**2008 Spring CBC Health Braintrust Summit  
Health Equity and Justice Now!: Mobilizing Action in the 110<sup>th</sup>  
and 111<sup>th</sup> Congress  
Congressional Black Caucus Foundation and National Minority  
Quality Forum  
April 15, 2008**

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**FEMALE SPEAKER 1:** This next panel is called the Health Equity and Justice Now!: Mobilizing action in the 110<sup>th</sup> and 111<sup>th</sup> Congress. The format for this panel is that we will address certain questions to the panelists.

And then we will give the audience an opportunity to also ask a question. So I will first address the panelist with some and then it will give you the opportunity too. So, please be patient and let's again collaborate, network, and brainstorm and all of that good stuff into a great opportunity for health equity.

Somebody in the back please close the doors. I'd like to begin by introducing our panel. On our panel we have of course our distinguished Congresswoman Donna Christensen We have our co-host Dr. Gary Puckrein from the National Minority Quality Forum. We have Dr. Mohammed Ahkter from the - he is the Executive Director of National Minority Association - the National Medical Association, I'm sorry.

We have Debra Toney from the National Black Nurses Association, she is the President. We have Cheryl Hall the Executive Director of the Caribbean Women's Health Association and Vice President of Government and Corporate Affairs at Lutheran Family Health Centers.

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We Dr. James Bridges the Medical Director of Blue Cross Blue Shield of Michigan. Is he actually here? Did I - do we have him here on the panel? No? I'm looking if he's on the panel. Okay.

We have William Arnold from the Title II Community AIDS National Network. Is that person on the panel? No? He's here, okay, Daniel Dawes the Senior Legislative and Federal Affairs Officer of the American Physiological Association.

Michael Elhert President of the American Medical Student Association. And then we have Michelle Grant-Ervin the Medical Director for the Washington DC Office VITAS and Novice Health Care. Is Dr. Grant here? Okay, thank you.

Alrighty, okay so you can imagine there's so many topics that we can discuss, so we have a few questions here and we ask you to again also develop your own questions in response to what the panelist is going to talk about right now.

One of the first questions that we'd like to ask is in looking at the overall health care system, panelists, and the documented racial and ethnic disparities and gender and geographic disparities that are disproportionately and detrimentally effecting millions of Americans every year, what in your opinion is the number one issue that we should address

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in effort to better achieve health equity, and I'm going to address this question to Dr. Puckrein?

Oh come on. Okay. Well then I'll go to the next question - are you here, are you ready? Okay - okay come on. I will repeat the question for you of course. In looking at the overall health care system and the documented racial and ethnic gender and geographic disparities that disproportionately and detrimentally affect millions of Americans each and every year.

What in your opinion is the number one issue that we should address in an effort to better achieve health equity?

**GARY PUCKREIN:** I'm one who fundamentally believes that we got to start with good science and one of the real challenges that we really - I'm sorry. Great, I'm one who believes that we have to start with good science and one of the real problems is that we really do not invest a lot in trying to understand minority health patterns.

If you take hypertension, African-Americans have the highest level of hypertensions in the world. Is NH studying that? Is there a real push to understand what's the clinical causes of that and so if I had a place to start; it would be really sort of organizing scientific investigation around the problem.

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Some it clinical, some of it those residential patterns that were talked about earlier, but we're not going anywhere without good science.

**FEMALE SPEAKER 1:** Any other comments from the panel?

**MICHELLE GRANT-ERVIN:** Yes, I think just as important as the science and equally are two other issues that need to be addressed simultaneously. Number one is education, education of the community regarding what to expect regarding their health, maintaining their health, what to expect from the health care system and communication, communication of health care providers regarding and to and with patients regarding what their options are.

Respecting their cultures both their gender, their age and their community of color if they're from a community of color.

**FEMALE SPEAKER 1:** Thank you. Our next question is for Congresswoman Donna Christensen. The theme, Congresswoman, of this event of course is health equity and justice now. A very fitting theme given that the disparities and disparity of nation and health equity have been and will be - will continue to be one of the top priorities for the CBC Health Brain Fest.

And while health disparities eliminations are priority for all of us here today, it seems to be less of a priority for

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others. And so - and those who do not consider themselves to be effected by health disparities. So the question is how can we work together to change that and what next steps must we take and how do we build an even broader coalition of stake holders who are committed to strong and responsible health disparities eliminations? So it's a three part question.

**DONNA CHRISTENSEN, D-V.I:** And the first part is how do we - how do we get the message across - how do we get...

**FEMALE SPEAKER 1:** What next steps do we take?

**DONNA CHRISTENSEN, D-V.I.:** Well we talked a bit in my opening presentation and other people have mentioned that because we've gone through explaining that health disparities existed, even that was a challenge getting across to policy makers and legislators. And I think what we need to show them and I am and others have done studies demonstrating that in communities where, for example, some people lack insurance.

The cost of uncompensated care for them drives down the quality of health for everyone so the connectiveness of the issue of not only the uninsured but people who have are suffering from health disparities, the connectedness of that to the rest of the community and demonstrating that it's everybody's problem is another avenue that we probably have not gotten quite across as much as we need to.

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But everyone in Congress, definitely responds to economic models. And so being able to demonstrate the savings from prevention and the importance of making the investment in healthcare and how it pays off in the short term and in long term, I think is what we need to do in terms of getting the message across. What's the rest of the question?

**FEMALE SPEAKER 1:** The other part was also how do we build an even stronger coalition and actually how can we work together and how do we build an even stronger coalition?

**DONNA CHRISTENSEN, D-V.I.:** Well, I think I also addressed that a bit in the first session because across these entities sometimes we don't talk to each other. The funding comes down that way and we have to find - create the bridges among ourselves to be able to collaborate despite that and we on the legislative and policy level need to also facilitate that process.

But again we need to expand from just talk - dealing with organizations that deal with healthcare to talk to those that deal with housing and education and the other areas, and expand also our relationships with pharmaceuticals yes, but the larger business community because they have a lot of clout and they have the ability as someone said yesterday, to help us - it was Dr. Daily [misspelled?], to help us get the messages out

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and do a more effective job of reach - of getting our message across a broader audience.

So the economic model is something we need to develop and fine tune, we need to develop it more and fine tune and we need to broaden our coalition in those ways I think.

**FEMALE SPEAKER 1:** Thank you Congresswoman. Anyone else from the panel have a comment? Thank you.

**JAMES BRIDGES:** A couple - is this on, can you hear me? Yes. Thanks. A couple of thoughts to extend your idea of economic model. There is the mackerel level economic model, then there's the economic model as it relates to individuals.

And one of the things we've heard earlier today is the importance of, if you will, fixing the income disparity between doctors that talk to people and doctors that do procedures. Because a large part, we have data, and we have hospitals we still fundamentally have as many of us know, defecate in the number of primary care physicians geographically and in total and one of the key issues in that is the significant differential on how we reimburse them for their time spent.

Changing supporting people and changing their behavior is no small task it takes time and when physicians feel too pressed to do a good job of that for a number of reasons we don't have time to get into, that's a major gap in actually

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improving the outcome from minorities in the population in general.

So this whole idea of this major difference in the reimbursement, I think is very important for us also to resolve.

**FEMALE SPEAKER 1:** Thank you so much. I'd like to open up the floor to the audience to also ask a question on these two or ask that question to the panelists based on the two questions we just asked. If there's anyone who wants to ask a question at this time please come to the microphone. Or you can make comment as well. Anybody? Not yet?

**FEMALE SPEAKER 2:** Do you want to elaborate on anything?

**FEMALE SPEAKER 1:** Okay, well any of the panelists want to elaborate anymore before we go on? Dr. Ahkter?

**MOHAMMED AHKTER, M.D., M.P.H.:** Yes. Thank you. I want to talk a little bit about the first question about dealing with the disparities. You know, I heard in the past two days, you all guys are doing wonderful job, great work, but good is not good enough anymore. We're not making a real dent in dealing with these disparities.

Our elector leaders, our leaders who are within the Government are trying to do their best. But they have

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resistance. And what we need are the two areas that we know how to work it through, that we have almost forgotten. One area is political activism.

Unless its pressure from outside for change, the people from inside can do so much. And when we are out on the streets we can make a difference. It's not what - you don't get what you deserve, you get what you demand. What you ask for in a Democracy.

And the second area is truly the legal action. There's no reason - there's no excuse for an African-American not to get a defibulator. When it's indicated and Federal Government is paying for the care. Why are that, you know, only 70 percent of those people who are actually - there's medical indication that must get a defibulator they're not getting it. And if we take the legal action in saying why would Federal Government pay for such care watch how things change. Things change when when there's legislation.

Things change when there is legal action. Things change when there is financial incentive. And I think we really need to go after all of this, these disparities don't exist because our own folks make wrong choices. They exist because the choices we have.

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And there's reason we need to change a system whether it's reimbursement system, whether it is the legal action that we need to do that to make sure that this nation 40 years after Kings' death truly achieve his dream of having the equality for all people.

**FEMALE SPEAKER 1:** Thank you. Our next question has to do with the work force shortage. Yes, sir. Oh I'm sorry. Dr. Perez.

**DR. PEREZ:** To dovetail that question, Dr. Ahkter. I was so proud that the CBC hosted a Presidential debate, and I want to know and this is open to the entire panel, what can we do to assure once the primaries are over, and we move to the general election, that healthcare and especially healthcare for the traditionally unserved and under-served is a major agenda item for whatever president, of course, you know which one I want.

But whatever President will assume the White House or 1600 Pennsylvania Avenue. Could you all talk on that and what we should do, giving us our marching orders?

**MOHAMMED AHKTER, M.D., M.P.H.:** The National Medical Association is very concerned. That's in fact our reason for our existence, is they want to enable people who don't have access to health care. And we've been trying for now over 100

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years to really achieve that. What is the best way of going about doing this?

And we have now come to this great opportunity this election year where we have gotten out and said let's form Donna Christensen said, Congresswoman said, alliances with others. We have now established alliances with AARP. We have developed alliance with SIEU, Families USA, American Public House Association, American Cancer Society and purpose is just one to have access to care as a top agenda.

So duly this Presidential Campaign states that are going to be battleground states such as Pennsylvania, Ohio there are people now being assigned in different places so as the debates start, as the candidates go there, this will be the constant question because we want this to be up front.

And we are getting resources that we have gathered, collected some money to make sure that during - in these battleground states where candidates are going to spend most of their time that remains on the agenda of both parties, that ultimately without having the freedom from disease, there's no freedom.

In globalized world the country that's going to win, is the one that's going to have most healthy and most educated

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people. And if we have half of our people sick we just can't compete in the globalized world.

And so this has become the top priority and I want to tell you also that the business communities also joined into this debate and want to make sure that universal access comes to pass.

**FEMALE SPEAKER 1:** Thank you Dr. Ahkter. Mr. Arnold do you have a comment?

**WILLIAM ARNOLD:** I live and breathe the AIDS epidemic, particularly the domestic AIDS epidemic. And to address the question that was raised from there. One of the things that has to happen, is that frankly the people who are getting the shortest ends of the stick and in this room I don't think I have to point out who that is.

And the people who are represented by the Tri Caucus members in Congress are the ones who are getting a very, very short end of the stick. And the Public Debates, not just the Presidential debate, but even in local election races, the name of the game is to get the problem broken up and brought up as a demand from the people who are getting the shortest ends of the stick. I was going to use an improper term.

[Laughter].

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The - and we have had some luck there and in the AIDS arena, we've trapped McCain a couple of times on camera, the - we've had less luck trying to get at least on the AIDS issue, the Democratic candidates to bring up specifically, although they're tippy toeing into the general health care debate, but it's not in response to I'm a constitute this is not acceptable, you represent me or us or whoever.

What are you going to do about it? It's still very polite. We're going to have universal access. What's that mean? There's nothing wrong with it as an opening remark, but where is the details, where's the beef and how does it affect this Latino in Arizona, this African-American in Washington DC. I mean, Washington DC has the worst AIDS incidents in the country, by far, nobody else is even close.

One hundred twenty-eight per 100,000 I think it is and unfortunately number two at the moment according to the Kaiser figures that came out a couple weeks ago in terms of incidents, not total numbers, is the Virgin Islands.

So here you have the Capitol and one of the dependencies the handwriting is on the wall, Donna will, of course, raise all kinds of hell but we need about 40, 50, 60 other prominent folks raising as much hell at least as Donna does.

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**FEMALE SPEAKER 1:** I think also if I may make a comment, one of the problems that I have seen is that as long as it doesn't affect you right away, if it's not your cousin, your niece, your mother, your grandmother then it's not your problem. But when we used to talk about the HIV community it was only those who were affected, but the whole nation is the HIV community right now, we are no longer a specific community.

The whole nation is the HIV community, businesses are the HIV community, hospitals, nursing homes, schools, everyone is the HIV community but as long as we don't see that we will not address it as such.

**DONNA CHRISTENSEN, D-V.I.:** If I could just add - I mean the obvious thing is to get involved in the campaigns. I don't even think you need to wait till the primary until the convention and we've chosen a candidate, get involved in the campaigns and be a part of insuring that this is the part of the dialogue.

It's not always easy. I can - I mean I can tell you from firsthand experience and getting the candidates to talk about the issue the way you would like them to talk about it. We also have platform the each convention will have a platform. And find out where the platform committee is meeting and I'm sure there must be an avenue for organizations or coalitions to

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bring issues to the platform of each of the parties before the convention.

The convention is on the Web site and if you can't find a way to do it, you can always get in touch with me and I'll try to show you how - the way to get to them.

**FEMALE SPEAKER:** I appreciate that and I wanted to know given the depth and breadth of the expertise of this panel could we come together around three things that we can go back and say as a chorus that we are all standing united for moving forward. Because if we don't a chorus, and we leave it, you know, when we go I'm a revolutionary.

And you know, revolutionaries need the masses to move but the masses sometimes need a chorus. And if we could leave here from these two days even with a chorus that we all buy into, we can elaborate from our individual organizations.

But this is the core and if you don't follow this core, you don't have this constituency.

**FEMALE SPEAKER 1:** Thank you.

**DEBRA TONEY:** This is my chorus and I'm speaking from the National Black Nurses Association. Twelve years from now, 2020, there will be a shortage of almost one million nurses in this country. We are the pulse of the community.

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We're out in the trenches, working side by side with individuals, with patients each and every day. If we do not get more nurses in this country, we will not eliminate health disparities. We're with the patient 24/7, we're the ones that everyone knows, that everybody trusts.

So think about how old you are right now add twelve years to that. Who will be taking care of you? Now I'm not going to tell you how old I am, but I can tell you if I add twelve years onto it, I'm going to be thinking about who's going to take care of me. There was an IOM report and I see Congresswoman here on that Blackberry that I roll through and from the IOM. And it says that this country, the health care system is not prepared for the 78 million baby boomers that will be turning 65 years in the next few years.

And some of you by looking at you and you look good...

[Laughter]

You are 65 or you will soon be there so if we don't do something about this huge nursing shortage, and I've been a nurse for close to 30 years and it was a nursing shortage then. But the big difference is, is I'm a baby boomer and in the next few years, over 50 percent of the nurses will be retiring.

And we don't have people coming into the profession. So if there's one thing I want to mention is that we need

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nurses because you can't go anywhere, you can't go to the hospital without a nurse, you can't go to the emergency room without a nurse, you cannot have surgery without a nurse. Someone was talking the other day you cannot have clinical trials without a nurse. So, we need nurses.

**FEMALE SPEAKER 1:** And on that note thank you.

[Applause].

I'd like get to get Dr. Nesbitt to ask her question, I know you've been standing there for awhile.

**LAQUANDRA NESBITT, M.D., M.P.H.:** Hi, my question is more in line with the combining the economic model for achieving health equity, as well as, bringing in the issue of work force development. And I'm interested to know if anyone in the private sector or anyone who is involved with reimbursement, if there are any changes on the horizon that will shift from being heavily reimbursed from those who provide procedures versus those who talk to patients, are moving toward that model of the medical home.

And if you're opinions on how that impact will - how that will impact primary care in this country.

**FEMALE SPEAKER 1:** I'd like to ask Dr. Grant.

**MALE SPEAKER:** Or Grant, either one.

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**FEMALE SPEAKER 1:** I wanted to ask Dr. Ervin-Grant to respond to that first.

**JAMES BRIDGES:** Sure, I'm glad you asked that follow-up question because it's the issue of the medical home in particular, is actually one the national initiatives of Blue Cross Blue Shields Association. But in particular, the Michigan plan is really in - is really taking a leadership position in the unfolding, if you will, of the medical home.

And maybe for some that don't understand it, it might be good to sort of define it briefly, and because it really underpins a lot of what's - at least if ideally applied, it underpins a major part of the fix in what's wrong with ambulatory care with care that takes place in the office.

You've heard a bit about us, so I'll be brief, the idea that we experience or the way we experience things right now, you go to the office, the physician is talking to you with their hand on the door, interrupting you in eighteen seconds etcetera, you know the story.

So there is a trend. There's a change taking place now in health care that's being piloted across a number of Blue plans called medical home, you know, not invented here but we certainly have latched on to it. And the idea is that we want

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to provide physicians with greater information, support for electronic medical records.

Data feeds from the health plan, the ability to make better referrals into care and disease management and wellness programs for purposes of really doing a better job of supporting the needs of people who walk through the door.

The critical difference in medical home, though I think as it relates to this meeting, is that in all what I just described and much more, needs to be delivered in a culturally competent way.

So, the addition of the training, sensitivity, the data that was referred to, that's important to change the way that providers think about who they're treating and what should be done as a critical part of this.

And then additionally as a step in that direction, that is again, a building block of more effective primary care, is that we've started the reimbursement of something that's really something that's really sort of novel, but it's been around a long time. And that as we introduced a new reimbursement codes that allow physicians and nurses in their offices, to provide the local immediate reinforcement and education that physicians often described themselves as too busy to deliver.

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So there are models right now where people can come in and get greater attention, more explanation from the people that they trust, that help them that know their situations, that they've seen before and, of course that helps immensely when it's delivered in a culturally competent fashion by people that look by - look like the members.

**FEMALE SPEAKER 1:** Thank you.

**DONNA CHRISTENSEN, D-V.I.:** If I could just add that we've begun having discussions with the Ways and Means Health Committee Chair and members about increasing the reimbursement for primary care physicians, because of the importance of having someone there that can provide the anchor for that home.

And I understand that CMS is also maybe getting ready to pilot some demonstration some projects on in supporting the medical home concept.

**FEMALE SPEAKER 1:** One of the other questions that I want to ask in relation to this which Dr. Toney already started addressing, and I have to put this question out there, is there several factors that not only accessorate home disparities but also impede work force shortage.

And both current and those that we know now that are coming, are the nursing shortage and the physician shortage and lack of diversity within the health care providers system.

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What can we do and also as a nation premiere minority health stake holder, what can we do to remedy some of these trends in more effective ways.

And then I'll get to Dr. Edwards who I know has been standing there. Dr. Toney, please? I'm sorry, Dr. Cheri Hall. I'm sorry.

**CHERYL HALL:** I was just going to comment on one following up to Donnas' comments. It's great to talk about all the providers and medical homes and doing all of that. But when we back at the hospital as a hospital administrator was still asking our primary care doctors to get rid of that patient in 15 minutes, because national standards indicate that a new visit should last no more than 30 minutes and revisit should be 15. And when - if you're in medically underserved areas, you need to spend more time with the patients. They're coming to you much sicker, they have more needs.

And you don't always have a social worker or they may only want to talk to the doctor and in some cases not the doctor, the nurse. So I think until we look at and really stress that we must look at reimbursement and changing reimbursement that I think we're doing all the work outside. But when it gets around to us making decisions, we're still going to tell the doctor if we need to pay you we need you to

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work this - see this many patients in this many hours in the day.

So I stress and the importance of looking at our reimbursement structures.

**DEBRA TONEY:** Can I comment on that too?

**FEMALE SPEAKER 1:** Yes.

**DEBRA TONEY:** And I agree with you because primary care the way primary care is provided in this country, the system is broken. It is and I've been on the administrative end as well. And we really need to come up with some more innovative ways and I don't know what doc is going to say here on the end, but as things go on and when the patient comes into the office, and you do have other providers along the way.

Because they can't spend the amount of time that's necessary then that's when that you start peeling off who you're going to see and who you're not and that has created a niche for another provider system and another model and I'm not going to get into a lot of detail about it, but the retail health clinics, that's one of the reasons why the retail health clinics came up with the convenient care.

Because they can actually go in and no one wants to sit in the doctor's office for five or six hours for just a simple cold or something like that. So I think we really do need to

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take a look at some of the business models and how do they do it.

How does the airport, how does the airlines, how does the large grocery stores, the conceits services with Nordstrom's and some of those types of places, who have hundreds of people that come into their businesses but yet they're able to provide those type of services.

So I think we need to start looking at some of the other ways to do things when you look at chaos in the doctors' offices and some of those type of things, how can we identify that and get people to move through the system a lot quicker, but receive the type of care that they need because when you look at primary care and the reimbursement.

And I'm just going to say it, you're looking at volumetric. You're looking at how many people can you get in at a certain length of time because business must go on, overhead to pay, the nurses to pay, everybody at the end of the day, everybody has to count up the cash register and see if they can't pay their bills.

**FEMALE SPEAKER 1:** Question from the audience please, Dr. Lareese Edwards.

**LAREESE EDWARDS:** Hello, first I'd like to thank all of the entities involved in creating this intellectual committee

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to discuss health disparities. I actually have a comment and a question.

My comment is back in 1914 Dr. Booker T. Washington started National Negro Health Week to address the health disparities of that era. Here we are 94 years later, still talking about health disparities. It's really time to do something different about that.

I wish I had the answers, but I don't, but I'm willing to work and advocate the best I can. My question is, when we look at health disparities we know that minorities are disproportionately reparative. So in knowing that why is it that we do not have a public - school of public health in the historical black college and university?

**FEMALE SPEAKER 1:** Such a good question. And I do want to add that Dr. Lareese Edwards and I came from the same School of Public Health and it is a very hard to get one accredited, very hard. So I thank you for that question. Dr. Ahkter would you like to go into that, coming from Howard?

**MOHAMMED AHKTER, M.D., M.P.H.:** Howard University started two years ago a Masters in Public Health Program, and they're looking into expanding and going forward. But again the accreditation requires additional resources so the resources be there to meet how many staff you need to have.

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What kind of program structure you need to have. Also Morgan State is initiating a School of Public Health and we are going through their accreditation process. Plus many other schools have public health programs in the schools. I think when we really look at all of this; the issue is that we have really not come to grips with the fundamental disparity in the health manpower system.

We're in a nation where there's democracy and equal rights, and we all you know, believe in it. That's what our Constitution says but impracticality the difference is so stark that we are thirteen percent of the population yet only three percent are the physicians.

And the numbers have been going down instead rather than going up in the other direction. And same is true of nurses; same is true of other health professionals. Fundamentally the system needs to be changed.

And the reason system isn't changing is that we are talking to each other.

[Laughter].

We are not talking to the people who can bring about the change. And their position is not certain.

[Applause].

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By our discussion. So what we need to do is go out and talk to other people, other partners, who could amplify our voices and so that voices could be heard in Pennsylvania Avenue on both ends of Pennsylvania Avenue.

So that ordinarily the change comes. If it doesn't come, let's get on the streets. Let's go to the courts. I mean, you know, we really have become so timid because they get small amount of grants and we keep doing the same program over and over again.

And start looking the bigger system change that's really necessary. Small changes will make small improvements. Forty years after King's death, we need to really make another revolution really make a big jump in this process, change the system, reform the system so that we're this true equality.

America's all about choices. I don't care which way you cut it. I bet everybody tells you that. But if an African American doesn't have a choice of going to an African American provider, we don't provide the choice. Choice ends there.

And so if only three percent of the doctors are African-American and 13 percent of the population is African-Americans, Hispanics are even worse. Native America are even below that. And I think we really need to fix this system

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within the nation because people who run the system and people who are working in the system, there's disconnect.

They don't listen to us. And we need to find a way to amplify our voices and go up and knock at the door and say we are here and we must be taken - listened too properly.

**FEMALE SPEAKER 1:** Thank you Dr. Ahkter. Dr. Puckrein.

**GARY PUCKREIN:** Yes, the challenge is one of leadership and I think that's what Dr. Ahkter is referring too. When you look at the American health care system it's not really a system it's a bunch of silos that operate almost independently with some connection to payers.

So when you want to try to change those various silos, you've got to come to it with a coherent persistent and consistent plan, to make that change. And I think some of what we've been thinking through national minority quality forum, is how we broaden that coalition of to begin that dialog?

Some of what you haven't seen today there have been other side meetings going on with Faith Based Community, patient organizations all talking about so we're at this crossroads now, where we need to begin advocating. For me personally, and I realize this is a big elephant to chew on. I think you've got to start someplace to begin with.

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We look at some of the legislative issues that sit before Congress right now, comparative effectiveness, the bundling issue that Congresswoman Tubbs Jones spoke about. We also from the point of view of minorities in clinical trial, think there out to be a minority exclusivity provision, without digging deep in the leagues. Basically what it would do, it would incentivize industry to include minorities in clinical trials. The point I'm making here is that we have all of these issues that need to be resolved including the nursing shortages etcetera.

But we've got to start somewhere and that somewhere means you begin working on one issue and you learn how to work together. A lot of us do different things and have different interests and different beliefs and the only way we can find out who we can collaborate or what terms we can collaborate.

And think about this, we're talking African-Americans here, we're only 12 percent, Hispanics are about 15 to 18 percent so collectively we're 30 percent. So if we go after the system individually as African-Americans or Hispanics they're going to ignore us.

So that we need to work through those broader coalitions and that takes time. And it takes success. And so what we would advocate is that we pick something that we can

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agree on and go to the hilt and we want this and in that struggle in that fight, we'll learn how to work together or not work together but most importantly we'll have a unified voice in the Senate experiences.

If you look at Dr. King, Dr. King started with the Montgomery Bus boycott. He didn't start way up here, he started right down there in Montgomery - and it wasn't even deliberate, we're sitting here contemplating something deliberate. He was responding to an issue at the moment and it grew from there.

I would strongly recommend that we pick something and we engage the system and let them understand for the first time that the minority community, African-Americans, Hispanics, native Americans, Asians, patients, are coming together and demanding quality care from the system understanding that that system in itself is in need of tremendous change.

**FEMALE SPEAKER 1:** Thank you.

**DONNA CHRISTENSEN, D-I.V.:** You know we have a vehicle that it comes out of the Tri Caucus representing all of the racial and ethnic minorities that are impacted. That has really been written over a period of years with many of you who are in this room. And it's HR3410.

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Now through the process that may be changes made. And we may not get it exactly the way it's written today. And there may be changes we may want to make along the way, but I think we have something that we come get behind, that's already before the Congress that we have discussed with this White House in the past, that we can get behind and use as the vehicle to say, this is what we want.

**MALE SPEAKER 1:** I'd like to second that. I think that's a really tremendous idea.

**FEMALE SPEAKER 1:** Okay, our next question is for Daniel Doss, the Senior Legislative and Federal Affairs Officer at APA and I'd like to address the issue of mental health which is very much under address in health disparities.

The question is how can we ensure that integral part of the dialog will include mental health in our health disparities elimination? Daniel Doss, not here, there is no Daniel Doss here?

**FEMALE SPEAKER 2:** He's not on the panel.

**FEMALE SPEAKER 1:** Oh, I can't see the signs. I'm sorry. Well, I'd like to ask any of the other panelists. I'd like to ask Dr. Ervin then from the Washington, D.C. Department of Health, Mental Health.

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**MICHELLE GRANT-ERVIN, M.D.:** I'm sorry could you repeat the question.

**FEMALE SPEAKER 1:** The question of mental health is very much under address in health disparities and how can we better address this issue when we are trying to eliminate health disparities and we are creating a dialog around health disparities but yet mental health is constantly under address.

And also I want to add programs are constantly being cut for mental health. That's the first thing that goes.

**MICHELLE GRANT-ERVIN, M.D.:** I can answer your question both from an emergency physician standpoint and from a hospice physician standpoint since I practice both of those.

And from the viewpoint that post traumatic stress disorder which we see in our World War II veterans, our Korean veterans, our Vietnam veterans, which we will be seeing in our veterans of the Iraq War will really come to haunt us in the upcoming future if mental health is not addressed.

Right now in our broken healthcare system when patients present into the primary care physician or the emergency department with a mental health disorder the only way they can be really held for any length of time is if they say that they are suicidal or homicidal.

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Other than that they are evaluated, maybe held for 12 or 14 hours and then recycled back out into the streets. That's not taking care of the issues that caused them to impact on the mental healthcare system or to present into the community.

We need to have a comprehensive approach proactively addressing individuals that present with mental health disorders. Funding needs to surround that and the funding for education for both the community, the patients, and healthcare providers around the issues dealing with mental health.

**FEMALE SPEAKER 1:** Thank you, Dr. Bridges [misspelled?] would you like to add to that from Blue Cross Blue Shield? Provide a standpoint?

**JAMES BRIDGES:** Sure, the - this is for me clearly a two sided issue in that there is what the health system needs to bring to support people who have mental health issues.

But it's also a cultural, I guess, challenge as well for people who have issues as one of the big ones that is less extreme but is just as significant is depression. I think we had sessions about depression earlier.

And so it calls for a real change in how we treat each other as it relates to a comfort and willingness in providers and in us in individuals and even in our families to be willing

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to say I am depressed, as an example, when we get the plan interactive members around any healthcare need.

Because I think we heard in other sessions the very significant degree to which the presence of depression impacts other illnesses. I think we heard that at lunch, actually.

**FEMALE SPEAKER:** Yes.

**JAMES BRIDGES:** And so one of the things we have to do is to strengthen the front end of member identification with these problems. So what we do at our plan whenever we're talking to a member about anything we also screen them for depression.

Respectfully, professionally, we ask questions based on having created a relationship with them so it's not coming at them out of the blue. But we really have to go after this to some degree.

But the larger issue I want to get back to in terms of changing the system and being an advocate a lot of the discussion up to this point and I have to, I guess, blame myself for contributing to some of it. We're focusing in on improving and getting more out of an acute care health system for late phase disease.

And what we really if we really want, I believe, to make improvements in hearth [misspelled?] in minorities, as

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well as, the general populous is we have to get away from an acute care focused system. Part of the problem, I don't have anything against surgeons who get paid well for doing an hour's worth of work, more than I could as a primary care physician make in three days.

But that's not really the problem. The problem is that the way the system is funded and unfortunately supported by the way many of us think about healthcare. We're the magic bullet to society. We want to behave, eat, drink, etcetera in whatever way we like. And then when something happens we want to go to the hospital and have the magic bullet.

Okay, make me well. Cut this out, remove it, make it shrink, give me that x-ray. That's a real problem on our side, as well, that's only solved through where I thought the question was going to go with public health. It's really around community based, church based, home based, public school based education.

So one of the things that a number of the plans are attempting to do and more importantly work site based education. Because this whole transition that needs to occur in terms of how we consume healthcare if we have access has to also change in order for us to really make progress.

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**FEMALE SPEAKER 1:** Thank you. I would like to open the question to the audience. Thank you for waiting.

**FEMALE SPEAKER 3:** Good afternoon, a brief comment and a question attached and one overall arching question. I'm coming from the real world of CBO's.

We've - there's been a lot of conversation of efficacy and this has been patient talking about patient advocacy. One of the most difficult things that I have, you know, I run an organization with 23 staff. We manage three or four CDC grants. We have predominantly federal funding. And the truth of the matter is that it will take not funding one of those grants and I would be closed tomorrow.

I am the largest non-medical HIV testing facility in the state, the only organization with a mobile unit to go into rural communities and other. But yet my survival hinges on one grant. One of the things that I think about me and my colleagues what we miss, as I sit in this national meeting, and I should tell you that the only reason that I am here is because through Dr. Puckrein's office.

Somehow, I quite frankly don't know how I get here, I think it - I know it was Jesus but beyond that I don't have - I would not have had the funding to attend this meeting. And I know that there are other colleagues of mine who have the

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expertise, who have the vision, who are advocating in the community, who are attempting to mobilize, who have engaged in mobilization efforts where our legislature gave one \$500,000 to an AIDS Drug Assistance program and we had the largest waiting list in the nation as of last year.

And so I said that to say that we are in need of - my question is around mentorship. And how do organizations like ours that have the capacity get national mentorship which leads me to my last question. I recently was informed by, I'm not sure if this is politically correct, one of the largest providers of healthcare coverage in this country upon submitting a letter of intent to ask for additional dollars for our mobile unit program to tell me that HIV/AIDS was not on their agenda.

Now, my question is how does, at the local level, when we are faced with local politics with local companies who are present in this room but at the local level don't see our health concern as a priority. How do we link with people like you who can bring some pressure to bear so that we can deal with some of these issues that you've said we need to deal with?

[Applause]

**FEMALE SPEAKER 1:** Dr. Arnold?

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**WILLIAM ARNOLD:** You know, I just want to say, Bambi does tremendous work in South Carolina.

[Applause]

She, in fact, really she runs a fabulous organization there. We were deeply troubled by the fact that, was it last year, that some people died because they didn't have access to medication that leads back to the whole Ryan White discussion which I won't even start here today.

**FEMALE SPEAKER 3:** We get \$4 million from our advocates.

**WILLIAM ARNOLD:** But the point is she's at the point of care with a very serious epidemic, particularly in the American South now, with HIV/AIDS and it's all part of the same challenge here that we've got to figure out how do we resource and appropriately resource these community efforts.

Because in the case of HIV we're talking about spreading an infection here. We're not talking about a chronic disease that's not going to get passed on. This is - it's only going to get worse by our inaction. So, we're really pleased that Bambi had the time to come out and be part of this.

**DONNA CHRISTENSEN, D-V.I.:** Well, you know, ten years ago when we fought to have the HIV and AIDS in the African-American community declared a state of emergency we didn't get

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quite what we asked for. But we had a minority AIDS initiative which was supposed to pretty much do what you're asking for.

And it got lost along the way in these last seven or eight years. And this is the tenth anniversary and we're determined to do whatever we need to do to reclaim that initiative funded higher and get it back to what it was supposed to be doing which was to build the capacity of our community organizations too.

And for those organizations that had been out there and had the experience to help them mentor. But to put the - make sure that you had funding that was consistent, you know, so that you would not have to worry from day-to-day, year-to-year where your money was coming from. So, that's part of our bill and it's something that we're committed to taking up and using the fact that this is ten years now.

And it's gone away from what it was intended to do to bring it back and try to update it and revamp it and refund it and fund it higher.

**FEMALE SPEAKER 1:** So, we need all of you to come to the Hill and fight for that. Mr. Arnold?

**WILLIAM ARNOLD:** The, excuse me, I would just point out that a part of the answer of, Bambi, is a personification of because the way the problem in South Carolina got handled was

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by local mobilization. And local advocacy and then a wide national network that quietly and behind the scenes was able to help out hither, tither, and beyond.

But what really, I think Bambi would probably agree with me, what really turned the tide was that, "Hey, I'm here. You work for me at the state legislature. And this is a problem and this is a disgrace and you have to do something about." Once the conversation gets to that level movement is possible.

Now how do you get the national conversation around, in this case it was funding for the AIDS drug assistance program, and we got some rather larger issues on the table here. But you mark my words it's going to take a version of what went down in South Carolina last year to move at the national level, as well.

**FEMALE SPEAKER 1:** Thank you. Dr. Parks, question?

**DR. PARKS:** Yes, good afternoon everyone. Thank this outstanding panel for this discussion. A very much needed discussion. I would like to help us think outside the box a little bit.

It's where I live all the time so I would like to invite others out there with me.

[Laughter]

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**DONNA CHRISTENSEN, D-V.I.:** We know that, we know.

**DR. PARKS:** And certainly you would be welcome to join me. We're talking here again about the healthcare system from our perspective not from the perspective of the people that we're really dealing with that make decisions. And I think that is a disadvantage.

My only advantage in living in life is to be able to think about those people I'm dealing with. And I sort of guess I learned that from being a cowboy riding a lot of bucking horses. I had to think how a bucking horse thinks in order to stay with him in every jump that he would make.

I think the same thing about healthcare. Healthcare to me is an industrial profiteering system not a health system. If you understand that it is a profiteering system you'll understand it like the justice system is not a justice system. It is an imprisonment system.

If you think about national security as a profiteering system and the, excuse me, the military industrial complex instead of national security you then don't be surprised and confused about a lot of the activity that takes place. So, I would ask you to think very much about the same thing what you call a healthcare system is to think about it as a profiteering system.

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And then I think we can put our arms around this and wrap our minds around what's happening to our people. This thing that most of you all call disparities is a commodity system of which there is a great deal of profit in it for certain people. And it is how do they make profit out of it.

The moves they make if you want to counter them got to be based on what they do. And I hope those I'm thinking about is outside of this room.

[Laughter]

But knowing that some people are on certain teams by employment basis only and I won't hold that against you but I certainly will hold you accountable for what those institutions are doing to my people. And I would simply say to you in a capitalistic democratic society profiteering everything is a commodity that will make a profit. And that's where we are with certain populations in here that a profit can be made off of.

Even if you look at the money that's been handed down from the federal government none of it has been handed down with the intentions of eliminating the differences in healthcare but the profiteering of certain people who was in the business. It is none of the major people who really provide

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healthcare for African-Americans that receive any major money from the federal government.

It has been other institutions. Even if you talk about the AIDS money \$12 billion spent, less than two percent of it is in the hands of any African-Americans. Yet we are 60 percent, 70 percent of the African-American women with all the reported new cases. And some people say it's 90 percent of the new cases which you don't see 90 percent of the money from AIDS for combating new cases going into populations of African-American women. Why?

It goes to people who are going to make a profit off of it. And the way you make profit in the healthcare system now is get the money up front, do the least you can for certain people, and you make a profit. That's the way the profiteering system operates. If I may indulge with you just for another moment let me give you some real examples since I am a healer.

**FEMALE SPEAKER 1:** Another painful moment.

**DR. PARKS:** Let me share with you as healer and let me clarify how I participate in the profiteering system. I don't have any contracts with any insurance company. I refuse to have a relationship with an insurance company. That's just a moral issue in my life. All insurance companies who try to bait me every day to become contracted with them and etcetera

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because the process works simply if you sign a contract with one party the way our capitalistic system works you then cannot have a comparable, a contract with another party.

And in the patient, insurance company, doctor relationship is a party of three, it's going to be two against one. And it depends on who that two is. If you sign a contract with an insurance company your obligation is to that insurance company.

Now, this is where - let me give you a quick example. I sent in a bill to the insurance company for the patient but I don't contract the insurance I just provide my patient the service of sending the bill for them. The insurance company subcontracts my bill to another company who calls me and says, "Doctor, we have a bill here for a \$1,000 for this patient. Let's negotiate what you will take for the settlement of this bill. Will you take \$580?" And I said no. [Laughter]

Under no circumstances, they say, "Well listen you haven't heard our full deal yet. If you will take \$580 we'll send a check to you within ten days and guarantee you you will get it. If you refuse to take this contract with us in negotiation we will then reconsider it through another system in our company and pay you less than \$580 and send the money to

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the patient. And the patient may not give it all to you. Now which deal do you want to take?"

I simply say to that that is everyday in my office that I get those kinds of negotiation, profiteering kinds of concepts from insurance companies. And I simply say to you I ask the people this who are you? And they say we have a contract with the insurance company. And I say well we are in the healthcare system.

**FEMALE SPEAKER 1:** Dr. Parks, I am sorry to have to cut you off but in the interest of time can we keep it short so somebody else can ask a question.

**DR. PARKS:** Yes, I certainly will. [Applause]

So, I ask you to think outside the box in terms of the solution to this. How can we think outside the box in terms of looking at the system? And I'll close with asking this read two studies that's been done recently. The Pugh Study which is a very good study about one out of every ten African-American males being in the penitentiary in the justice system and we call that justice.

The healthcare is not any different. And I would ask you to read a study that was just put out by a Stanford research group. A young black lady psychologist at Stanford who was shocked and amazed when she asked white males between

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the ages of 20 and 40 what their thoughts were about African-Americans. And it was an overwhelming statement that they perceived them to be more animal like, to be more ape like, and to be more monkey like.

In addition to that perceived that they deserved more punishment for crimes. This is the same group of people who buys 70 percent of hip hop music. Use those two concepts which is the same people who in insurance companies is making decisions about disparities.

**FEMALE SPEAKER 1:** Thank you, Dr. Parks.

**DR. PARKS:** Thank you for thinking outside the box with me.

**FEMALE SPEAKER:** Okay, one comment by Dr. Ervin and then Dr. Payne can ask her question. Carol, just give me one minute.

**MICHELLE GRANT-ERVIN, M.D.:** I would like to follow up on Dr. Parks's statement regarding he really sees his role as helping to educate consumers to navigate our system. Is that - did I paraphrase you correctly? I don't want to put words in your mouth. No? Close?

**DR. PARKS:** I failed to communicate.

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**MICHELLE GRANT-ERVIN, M.D.:** You started out by saying you really thought one of your roles was to help your patients navigate the system that we have?

**DR. PARKS:** That's okay. That's a good start.

**MICHELLE GRANT-ERVIN, M.D.:** Yes, if I could pick up on that one part of our statement.

**FEMALE SPEAKER 1:** Okay.

**MICHELLE GRANT-ERVIN, M.D.:** We do have a home based system that is funded. That is available to everyone regardless of their ethnicity. And that's the Medicare Hospice benefit, it's the Medicare/Medicaid Hospice benefit. And I bring this up now as part of the AIDS discussion because I've actually taken care of patients referred to hospice because they were dying from their AIDS.

But who wound up graduating, that means gaining weight after taking their medicines and some had not been on their medicines. But part of their plan of care was to ensure that they were taking their medications. Under the hospice care the benefits they received were an R.N. case manager at their home. They did not have to come into the doctor's office. There wasn't a time limit on the nurse. There wasn't a minimum number of visits, a hospice aide to assist them in their daily care.

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All the medical equipment, all supplies that they needed for their care, all the medications around their care, all provided under the Medicare Hospice benefit. No charge to the patient at all. And the hospice was reimbursed based on the level of care, one of four levels of care. You cannot find a more economic, quality care system that's available right now. I am advocating that we educate our patients on navigating our present healthcare system because it's going to take time for any legal acts to pass.

It's going to take time to advocate and it will broaden our coalition because Medicare/Medicaid affects all of us at some point if not now.

**FEMALE SPEAKER 1:** Thank you. I have a question for the President of the American Medical Student Association because they are great advocates on Capitol Hill with regards to the health workforce. And I don't want to miss that. And I will get to Dr. Payne. I've seen you standing there.

But let me just ask this question so that we don't lose that in our discussion. And that is the role of the students who are going to be our future healthcare professionals in all of what we have been talking about. And my question is that how do we utilize our students who are now choosing the healthcare profession to become part of the health equity

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movement because there are a lot of students now a day's who because of all of the issues that we've mentioned are becoming discouraged.

We have students that - whose parents were physicians and are being discouraged actually by their parents to not go into the healthcare profession which is also a problem with the shortage right now. And we need all of those students to create this future movement for healthcare equity because we are not going to be here every day. But the students are going to be here to replaced the baby boomers who are retiring and to fill the gap for all the health workforce professions that we are now going to miss in a couple of years.

**MICHAEL EHLERT:** So, there is a lot of things I could say to this. Just to give people a little perspective of where, you know, I've come from, you know, I've just graduated from medical school and I took a year off from my clinical training to be here with the American Medical Student Association which for those of you who have been in D.C. enough know are at least the medical students that are engaged enough to come out and to work on these issues.

But I'll tell you by and large students are not engaged. Everybody here in this room who's a student could you raise your hand, please? Okay, see, and I'm surprised because

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I expected my colleague and maybe one or two other people. But, you know, where is the psychology students, where's the dental students, where is the podiatry students, where is the nursing students?

But...

**FEMALE SPEAKER 1:** Public health.

**MICHAEL ELHERT:** Why aren't there 500 of them here?

Because it's - you get a lot more bang for your buck in activating them. And this is in no disrespect to the policy makers here but I was at the Take Back America Conference big, big youth presence. And you know health isn't sexy to the. I tried to talk to them about a health movement. They want to talk about the environment, very important and they want to talk about the war, very important.

But it's so out there for them in healthcare. Unless they have a sibling who was born with a disease or a parent who has gone uninsured. But it's just not sexy for them. But it's relevant to the health profession students. And they are your captive audience. So, what we've done is we've talked about health equity.

Congresswoman Christensen, she's been there. Sheila Jackson Lee was at our conference. We brought Jocelyn Elder has come. We brought the people who have been the leaders and

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we try to put them in front them and say it's more than the receptors, and the insulin receptors, and it's more about the drug formulas and it's more about just learning about precautionary principals in public health. It's about stepping outside of your school which is very hard for people to do and look around.

And I don't care what you do but look around, whether you get involved in a community based, you know, I'm from Cleveland and we have one of the highest rates, about the highest of lead poisoning. Supposedly all the kids on Medicare were supposed to get tested once a year. They're not. And small thing that I did I went to the undergrad campus and I said do you guys want to have a lunch? And I brought in the community group that was doing the lead testing. And by the end of last year I think every Pre-Med student at Case Western had gone out to a community event on that.

So, the issue is make it relevant to them. And the health professional students are the first step. The other thing is you've got to give them something tangible to do. AMSA has tried to do that. We put - we were very active in the South Carolina event. I've got almost every Presidential candidate saying something at some sort of debate.

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But I made it very meaningful. I said come with me I'll take you. Let's do this one event. And the intent is make it easy for them because, you know, that's the mentorship. And I had mentors that brought me. I didn't just poof appear here. A great mentor and friend of mine, Jay Bauch [misspelled?] showed me a lot of things. And he's in Chicago and he came through the public health works of Chicago.

So, make it relevant, make it very easy for them to get involved. And for them right now is the health profession students and don't forget any of them. Because when you think about the student teachers a good friend of mine, Anthony Daniels over at the Student NEA, they are health profession students. Because education K through 12, I mean I love to genetics and I love to talk Nibeva law [misspelled?] and all that. You fix K through 12 you'll do more for inequities than you'll ever do by finding the little pail.

So, those are my three big things in getting the students involved.

**FEMALE SPEAKER 1:** Thank you. Thank you and I do want to mention that while I was on the Hill Congresswoman Christensen supported a bill on the physician shortage but what I noticed was that AMSA was one of the advocates of this bill. But a lot of the other student organizations were not there.

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And the other disturbing thing was that the nursing students were not there because they were not mad that we didn't include the nursing students.

But there was a pipeline program from K through 12 that would then encourage you to go into the health profession. So, it wasn't just for the physicians. It was going to increase the funding for the physicians but it would also increase funding for the nurses. But one of the things that we have - because we have such limited funding is that we create sort of a contention between different professions. And we can come together to fight for the collective work force shortage when that's actually what we have to do.

And to be able to do that we need to stop some of the contention between the different parties even though we know that we're not all going to get the same funding because ultimately healthcare doesn't really know the difference. We all need it. Thank you. Carol Payne?

**CAROL PAYNE:** Good afternoon. And I do want to thank everyone who has given us their insight today. All very valuable but I really, I guess, want to speak to the previous speaker in getting outside of the box. We are entirely too quiet in this room. There are too many people suffering for us to be this quiet.

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And I started as a nurse, 25 years at Johns Hopkins Hospital, and I am going to use my alma mater and my previous employment site as an example. I really think when we talk about that industry of research and those dollars that are coming into that community we need to ask what do health disparities look like in the community where the research dollars are?

Have we seen a reduction in those health disparities? What's the difference? I don't think we ask that question. We continue to fund that institution is number one. And I could talk about it because I'm a graduate. And I'm quite comfortable with talking about that. I think we need to be as bold as Bear Sterns, remember the foreclosure response we just had? It did not take a long time. It was quick. So, we need to figure out ways in which we can be more dramatic, out of the box because the suffering still goes on.

I do believe at the community level we need catalytic leadership. We have to look at those programs that are working well like the lady from South Carolina and go to scale. We should not continue to fund those initiatives as programs. We know they work so how do we take them to scale. I think the student perspective is a very good one.

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I'm one of those non-traditional students. My hair is very gray. But I can tell you that every day that I am in the community I hear the stories. I feel the pain. I cannot do what I must do. And so I would just ask the panel to help so to make sure that when we go back that we do have a movement that says we're not going to continue to fund research that continues the same. We're can't see a difference. We're going to ask the high questions and we're going to ask for lack of a better word that we're hearing all the time, change, whatever that might be.

**FEMALE SPEAKER 1:** Thank you, Carol. Thank you. One more question. [Applause] One more last question.

**MARIA OKAFOR:** Hi, my name is Maria Okafor. I am a clinical Gerontologist by training and a doctoral student in Gerontology and Epidemiology at the University of Maryland Baltimore. What I am about to say is a combination of a question and a plea to all the members of the panel and everyone that is here in this room. I think that there is maybe a lack of awareness as far as older adults are concerned.

So my question to the panel is how do you see yourselves addressing the issues of older adults? Particularly minority older adults and minority older adults in rural areas who are often overlooked and are in great need of healthcare

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services and attention and just basically what do you think that you can do to help those individuals.

And then also one thing I also wanted to mention was that there is a lack of training for - in gerontology amongst physicians and various other healthcare professionals. And there is indeed a shortage of Geriatricians. And so I think that in coming up with action plans or ways to address this issue of health inequity that these are some of the things that we need to discuss, the lack of training and the shortage amongst not just physicians and nurses but other healthcare professionals.

**FEMALE SPEAKER 1:** I would like to ask Dr. Elhert to first comment on that in terms of the incentives for students to go into certain specialties and then some other panelists.

**MICHAEL ELHERT:** So, it's actually interesting because I am in the process right now of creating, I think, maybe exactly what you're looking for. AMSA was lucky we had a five year grant from the NIH and a component of it was creating an ethno-geriatrics curriculum for medical schools which is out there and there is 23 medical schools that pilot that curriculum right now.

And that was a grant to the AMSA Foundation which was able to put that together. But you pointed out everything

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that's exactly right. So, rural I want to say that I am glad that the first HHS budget was vetoed by the President because it only had \$56 million to the National Service Corps in it. The Omnibus has about 125. I testified in December for 300.

And if you look at equal dollars from how we used to fund the National Service Corps in the 70s we should be giving it a billion. So, there is your rural component. As far as incentivizing it for students when you look at a commodities market in a way and how we reimburse any primary care provider, be in psychiatry, pediatrics, be it OB/GYN, well OB/GYN has a little caveat to it because there is a surgical component to it, but it's just not rewarding.

A good friend of mine who is a Dean of medical school not too far from here said students don't care into primary care because they're not stupid. They see that society has not placed that value on their primary care - I know I listened to it and I almost got a little upset until I realized when he explained himself is that we don't place the value on the primary care. And payment reform is going to be where it's at.

And our organization doesn't support physicians to live and work certain places. There are countries who have that. But there are ways to incentivize it and make it sexy, make it an opportunity for people.

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And I hope that - there is the John Hartford Foundation which the largest funder, I think, for geriatrics education in the United States. We're trying to work through them to at least expose students to the geriatric lifestyle because the wave of baby boomers is coming and we need to incentivize students to be interested in it. Because it's not as much a preventive care when people think about it but it is because there is a way to take care of older adults.

And we're not talking about the cost of Medicare and Medicaid, especially Medicare, that you can bring down the costs of taking care of older American's through prevention. And if you guys were, if anybody went to the CME session on taking care of cardiovascular disease and the racial disparities, there are a lot of things out there that no one is paying attention to peripheral vascular disease.

So, I would encourage you to maybe keep an eye on AMSA see if we can pull it off. And to all the payers over there and policy makers let's incentivize it. Let's create a value to being that type of provider because right radiology, cardi - the road to heaven happiness, radiology, ophthalmology, anesthesia, dermatology. Those are sexy right now.

**FEMALE SPEAKER 1:** One more comment.

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**JAMES BRIDGES:** Yes, I really love the question because it goes back to one of things that I mentioned before that we really need to return to if we're going to substantially improve things and that's a recognition that if you think about the insurance structure for Medicare you get coverage, partial coverage for things, you get coverage if you're in the hospital, in the absence of things like Medicare Advantage and Disease Management there is nobody rural or non-rural who is going to follow up with people post doctor visit.

If you're an elderly person, I mean I spend a lot of time right now taking care of my mother, I can identify what you're saying because I spend a lot of time quarterbacking for my mother. Well, in individuals who don't have a family relative close to them if they're rural or not rural the only option, I believe, is for there to be dollars placed in a different avenue, another commodity that's doing like Michelle mentioned earlier, that's calling the home, that's visiting the home, that's going over the medication, that's arranging transportations, that's dealing with the emotional needs, that's insuring that the social circle stays intact, etcetera.

And so for me it's a fundamental challenge of which programs like some of the additions that are being piloted now with Medicare are recognizing that just covering doctor visits

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or part of doctor visits and covering drugs and covering in the hospital people need more than that in order to live well. And so it's changing through the bills etcetera.

Our financing mechanism so that people can provide those services that are now a real gap for people.

**FEMALE SPEAKER 1:** Unfortunately we only have time for one more question.

**DONNA CHRISTENSEN, D-V.I.:** I just wanted briefly just say that everything that also from the CBC point of view everything that deals with Medicare, for example, we look at it through the lens of how does it impact poor and minority seniors. And if it is quite an adverse and the foundation helps us a lot with that. If it's going to adversely affect our seniors we're not going to support it. And we're 42 in the House and we can often get the Hispanic caucus and the Asian-Pacific caucus to stand with us. So, that's our role.

**FEMALE SPEAKER 1:** Last question.

**CHEVON LAIRD:** Good afternoon everyone. My name is Chevon Laird and I just completed this month the Pd.D program at the Johns Hopkins Bloomberg School of Public Health.

[Applause]

Thank you. I just wanted to make a comment about the pipeline as the gentleman from AMSA was talking about earlier

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and why, for example, minorities aren't choosing a career at medicine. And the problem is that they choose it at the beginning but you have to think outside of the box as far as reasons why they don't complete the pre-medical programs at the undergraduate level.

There are issues such as lack of mentorship. The Science classes as someone was talking about a lot of times people don't do well in them early on and decide that they're just going to change their track. But there are programs that are kind of helping increase the pipeline such as the Myra Huff Program at University of Maryland Baltimore County which within the past 20 years has graduated managed to have 66 PhD's or MD PhD's, 50 MD's, over 200 graduate level degrees within minority community or those who are interested in helping minorities and it's because they take a holistic approach. They don't just look at the strict course work. They look at all of the other factors.

For example, in my program I know a lot of my colleagues had parents who had PhD's already or MD's and told them what to do from high school, had them volunteering on studies early on, had them volunteering in hospitals. So, they immediately had an advantage that some of us, for example, I

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have immigrant parents didn't know about as far as the system works.

So, when thinking about making policies or looking for best practices it's really good to think about these issues. It's not just a financial barrier. There are all kinds of other determinants, as well. Thank you.

**FEMALE SPEAKER 1:** Well, this is the close of our session, unfortunately. I'm sure there is many more thoughts that are coming up or will be coming up. And we ask you to stay encouraged to stay in touch with the members and stay in touch with the panelists. Keep on collaborating and networking.

We have to end it here. You've been awesome. You've been very patient. We thank you for your participation and I want to give a round of applause to all of the panelists and every panelist who's been here today. [Applause]

And thank you specifically to Congresswoman Christensen and Dr. Puckrein to host this wonderful event.

**DONNA CHRISTENSEN, D-V.I.:** I want to also add my word of thanks to all of you, to everyone who came and to our sponsors, to everyone who was up here on the panel and everyone who participated in the discussion.

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Again if we can leave here united around one thing, we didn't really get into a discussion of one, two, three, but if we can leave her united around supporting HR3014, getting it to the hearing and moving it through the process I think it would be a good place to start. Again, it may change through the process but if we can just galvanize around that we have something that is already there. It's already in front of the Congress and we would ask you to make that the vehicle that we use to mount this effort to change healthcare for minorities in this country and bring wellness within the reach of all of the people in our communities. Gary, did you?

**GARY PUCKREIN:** Certainly what we will do everyone who is registered for the conference we have your email address we're going to send out a copy of the legislation and seek your support. And we'll try to figure out how we can engage to support this legislation. I think that's a good place to start and as we get through that process we'll - it'll help us on our journey.

So, I think it's an excellence idea to try to put some momentum and get this legislation passed. And I hope you will support it.

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**FEMALE SPEAKER 1:** I also want to remind those who have registered for the awards dinner it starts at 6:00 is the reception and 7:30 the dinner.

[END RECORDING]