

**What Have We Learned and Where Do We Go From Here?
Three Years of the National Healthcare Disparities Report
The Henry J. Kaiser Family Foundation
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MARSHA LILLIE BLANTON, Ph.D.: Good morning. Can you hear me? On behalf of the Kaiser Family Foundation, let me welcome you to the Barbara Jordan Conference Center. The conference center, as many of you know, was named in honor of a former member of the foundation's board of trustees, Barbara Jordan, and also a member of congress. She was someone who fought fearlessly for the rights and privileges of every American to be included in our society and I think she would be pleased that today's event is being held in a center named in her honor.

I am encouraged to see so many of you in attendance today. Some of you joined with the foundation in 1999 when we convened a conference on race, ethnicity, and medical care. A lot has changed since then. In January of this year, the Agency for Health Care Research and Quality issued the third national health care disparities report as a companion piece to the national quality report. It is a report that monitors and tracks over 40 health care quality and access indicators for a number of population groups identified by their racial and ethnic background, by their income, by their education, by where they live, to name a few of the characteristics. The mere fact that the report was congressionally requested and has been annually released for three years is an indication that there has been some shift,

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even if not a lot, some shift in the recognition that disparities in medical care persists in this nation.

Now I also recognize that there are many who remain skeptical of the evidence, which is one of the reasons today's briefing is so important, and still there are others who are convinced of the evidence but are just trying to put together the pieces of the puzzle and they are trying to understand what does health care have to do with health disparities? How do deficiencies and quality relate to health care disparities and what role does insurance coverage play in health care disparities? Today's briefing is an opportunity to heighten the dialog in the conversation around some of those issues and to generally examine what we have learned in the three years since the release of the first National Health Care Disparities Report. It is also an opportunity for us to discuss where do we go from here? How can the report better be used to inform clinical practices, health policies, and the research agenda? With that mission in mind, we have included in your registration packets seven summary tables and I am going to do something a little unusual and that is ask you to look at those tables just so that you can get a sense of what is in them. There are seven summary tables and for lack of a better word, I am going to call it a chart pack, but it is organized as is the highlights of the report which, by the way, complete copies

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of the report will hopefully be here by the end of the session. They were delivered by Fed Ex but they have not arrived so for those of you who don't have a copy of the report, it will hopefully be here by the time this briefing ends.

The first two figures, figures H-1 and H-2, are from the report, part of the highlights that talk about where we are today. The second two figures, figures H-3 and H-4, talk about changes over time, and the last three figures are drawn from the section "Opportunities for Improvement Remain" and included in that section are figures H-1 and H-2, which were in the highlights, but also figure 3-1, which is on page 89 of the report that talks about changes in health insurance coverage. The intent of this chart pack is to make the contents of an incredibly rich and incredibly comprehensive report more accessible to those of you attending the briefing or listening to the webcast. They are the exact charts in the report. We have just done what we sometime call "Kaiserize" them. We try to make them so that you can digest them and absorb them better but they are the exact same reports.

We have also included in your packet a handout of several health care indicators on the racial and ethnic populations in each of the 50 states and the District of Columbia. This information is from Kaiser Health Facts

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Online, and it is background information that is helpful as contacts for people trying to understand how our national data useful in their state or local work. With those opening remarks, let me introduce our panelists. We are pleased to have with us five very distinguished panelists who, in the interest of time, I'll give you brief introductions but you will find their bios in your registration packet.

We have with us Dr. Carolyn Clancy, who is director of the Agency for Healthcare Research and Quality of the Dept. of Health and Human Services and is also a clinical associate professor at the George Washington University School of Medicine. She is a general internist and a health services researcher who serves on multiple editorial boards and is a member of the Institute of Medicine and she is also published widely. We have asked her to give us a brief overview of the report's findings and the major themes, as well as to participate in our panel discussion.

We are also pleased to have Dr. Kevin Fiscella, who is sitting next to Dr. Clancy. Dr. Fiscella is a 10 year associate professor of family medicine and community preventive medicine at the University Of Rochester School Of Medicine. He is an experienced clinician who provides care to a racially and ethnic diverse patient population and for over 20 years has practiced in community centers. He also was a member of the IOM report guidance on designing a

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national health care disparities report. We have invited him today in large part to be the voice of the physician in clinical practice, but also as a researcher involved in shaping the design of this report.

Next to Dr. Fiscella is Dr. John Nelson, who is the immediate past president of the American Medical Association and is an obstetrician and gynecologist with a practice in Salt Lake City, Utah. We are pleased that he has come so far from the west coast to join us today. Dr. Nelson has served on the AMA Board of Directors since 1994. He has and continues to serve on a number of other boards and commissions. In addition to being a physician, he brings to this panel former experience in state government, where he served as the former deputy director of Utah's Dept. of Health. Today, he is invited largely to bring a voice of organized medicine to the panel, but with his background experience both as a clinical practitioner as well as in state government, I am sure he will add those perspectives as well.

Sitting next to Dr. Nelson is Dr. Ruth Zambrana. Dr. Zambrana is a professor in the women's studies department and director of research at the Consortium on Race, Gender, and Ethnicity at the University of Maryland. Dr. Zambrana has worked in the areas of health disparities of low income and Latino women, children, and families for over 25 years. She

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has an impressive track record of research that intersects the areas of gender, race, ethnicity, and socioeconomic status, and I need to say that Dr. Zambrana is actually on sabbatical so I am especially pleased that she agreed to join us today. She is invited in large part to bring the voice of the research community to the panel.

Last, but certainly not least, is Dr. Dora Hughes. Dr. Hughes is the health and education advisor to Senator Barack Obama, where she helps to develop his national policy and legislative agenda on a broad range of health and education issues. She previously served as deputy director for health for Senator Edward Kennedy on the committee on health education, labor, and pensions. Dr. Hughes is a physician, board certified in internal medicine. She was asked to take the lead in discussing how the report can be used in foreign policy decisions and what are the findings that are most immediate on the minds of policy makers? So, I would like to welcome all of our panelists and thank you for agreeing to join us, and with that introduction, I would like to turn to Dr. Clancy for an overview of the key findings and the themes of the national health care disparities report. You can either sit or stand, it's up to you.

CAROLYN CLANCY, M.D.: Great, good morning. I want to thank the Kaiser Family Foundation for this opportunity today, and I think you have put together a terrific panel. I

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guess I would also speak for Dr. Ernest Moy who is here this morning and sort of conducts the multidisciplinary symphony orchestra of folks who put together the health care disparities report every year. They are from across the Dept. of Health and Human Services as well as Liza Dayton, who is with him, to say that we would be happy to have you "Kaiserize" our work anytime. I thought it was a really terrific way to distill a great deal of information. Let me also just tell you we are very optimistic that the printed copies will get here, a Federal Express issue, but if they don't, you can go onto our website and this is the address to get you most expeditiously to the disparities report. It is all one word: qualitytools.ahrq.gov; again, qualitytools.ahrq.gov. I will try to remember to repeat it at the end. By definition I can only give you a very brief overview because there is a lot of very rich information contained in the report but I am hoping you will get the printed copy as well because they are very pretty, even if not "Kaiserized." That will be next year's version.

So, I am very pleased to be here today to be able to talk about the national health care disparities report. This report, along with it's companion, National Health Care Quality Report, were released at the office of minority health summit in January of this year, and the fact that we released the two together is not a coincidence of having an

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opportunity so let's get a couple of reports out together. From the outset, we have designed the reports so that they would be very tightly linked and I certainly want to thank Kevin Fiscella and the others on the IOM committee who reinforced the importance of linking disparities in health care with assessing quality of care.

So turning just for a moment to the quality report, last year the overall quality of U.S. health care improved at a rate of 2.8-percent, the same rate of improvement as the year before. Now if you have been reading recent reports from the RAN Corporation and others, any movement forward seems like a good idea. On the other hand, health care expenditures have been going up every year for about 40 years at 8-percent, so you can see we kind of have a value problem. Costs up 8-percent, quality up 2.8-percent, and 2.8-percent of course is an aggregate number that rolls up performance across all settings and populations and there are areas where we are doing better than that, so for example where the hospitals are now reporting publically on performance for care for people with heart attacks, heart failure, and pneumonia, those measures performance improved a little over 9-percent. In addition, we find in the disparities report that significant disparities between whites and minorities continue but with some signs of improvements and let me just tell you that in putting out the 2005 report, the most

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exciting fact is that we now have trend data using the same measures that we can follow over time. Rather than having debates about one-time studies, we are actually tracking our progress over time and that feels like a very important development.

In measures related to quality of care, this is in the disparities report now, more racial disparities were narrowing than widening. For example, rates of late stage breast cancer decreased more rapidly among black women than among white women, resulting in a narrowing of that disparity. Treatment of heart failure improved more rapidly among American Indian medicare beneficiaries than among white medicare beneficiaries. Despite these trends, though, blacks receive poorer quality of care than whites in 43-percent of the core measures and American Indians and Alaskan natives received poorer quality of care than whites in 38-percent of measures. In access to care, because the disparities report reports both on quality and access, we saw reductions in most racial disparities affecting blacks, Asians, and American Indians and Alaskan natives. That doesn't mean we have solved the problem but we are definitely trending in the right direction. However, this trend has been reversed for Hispanics where we saw disparities in quality and in access to care growing wider in a majority of areas. Only 41-percent of quality disparities were narrowing for Hispanics

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while 59-percent were growing larger. The report also indicated the disparities were growing for most measures related to access to care for Hispanics. For example, the quality of diabetes care declined among Hispanic adults, even as it improved among white adults. In addition, the quality of patient provider communication that is reported by the patients themselves declined among Hispanic adults, even as it improved among white adults. Access to a usual source of care increased more slowly among Hispanics than among whites and overall, the disparities report shows that low-income people, regardless of race or ethnicity, experienced many of the largest disparities in health care quality and in access. So, in many areas we know the specific treatment steps and procedures to take for quality improvement or that is to say, we know what to do. The challenge continues to be to make sure everyone in the health care system knows what to do, knows how to do it, and is making it part of their everyday practice. We have seen that public reporting is a very powerful tool for improvements. The public reports coming from Medicare's hospital quality initiative, this is hospital compare, have been very useful in this area and we are seeing those results reflected in the national health care quality report. Another great example of the power of the spotlight was reported last summer in the *New England Journal of Medicine*. One study examined trends in the quality of care

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and racial disparities for medicare beneficiaries and managed care plans. Now, unlike for the commercially insured population, for medicare beneficiaries publically reporting is mandatory so you get to see how performance is for everyone. When the study began, the early data indicated that blacks consistently received lower quality of care than whites. However, after seven years of publically reporting performance through HEDIS, the health plans' clinical performance improved substantially in all measures. Gaps in quality associated with patient race, in this case African American, narrowed in seven of the nine measures. Now, in the other two areas which get at the really important stuff like control of diabetes and control of lipid levels, that shows us that we have gotten some of the more straight forward activities right, now we can focus our efforts on improving the outcomes of care. We also know that because of public reporting by nursing homes, which began several years ago, we have been able to see very swift and dramatic improvements reflected in our national health care quality report for nursing home performance. Both reports show a mixed record of success in improving quality of care in our nation in reducing health care disparities. While we find improvements in quality and access on a wide front, it is inconsistent and the need for action to improve quality of care for everyone is as great as ever. In addition, what we

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are seeing is an enormous opportunity not only to close the gap in health care disparities but to improve the overall health of all populations. These are inextricably linked. To say it a different way, if we eliminate racial and ethnic disparities but don't raise quality of care overall, it is not a terribly worthy goal, making sure that everyone gets kind of okay care. We can do so much better than that. That is why our reports are linked.

So how do we use these reports and build on the progress that has been made and try to accelerate it? As a researcher, I can appreciate how far we have come during the last few years working on these reports. Our knowledge base is growing and our measurement tools are getting more powerful and as these tools get better, of course we recognize that we still need to get better information. There are still significant gaps in racial and ethnic disparities at the state level and at the health plan level and in particular, no surprise to many of you, we need much better information at all levels on Hispanic subgroups, particularly related to language and dialect. We also need to have more data on race and ethnicity from health plans and insurers so that this data can be used to improve care. According to a report from America's health insurance plans published in 2004, almost half of health plan enrollees surveyed belong to a health plan that does not collect data

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on race and ethnicity. If this information gap is not closed, we are not going to understand the scope of the challenge and we need to include the study of priority populations in more of our research so that we can begin to continue expanding our knowledge base here. How we do this at AHRQ is that every application the researcher has to address how they are including priority populations whenever feasible. So, good data and measurements are important because you can't change what you can't measure. We need benchmarks and signposts along the way to show how we are doing, and I am very excited that the national health care disparities report has become sort of a roadmap for all of us, but it is a report. It is not results. We can't wait for research and we need to do what we can do to eliminate disparities right now. We need to design and test interventions that stress the disparities we find and learn as we are improving. We have been telling researchers since about the turn of this last century that we need to shift our focus from documenting gaps or describing problems to finding ways to close the gaps. Moreover, our results to do so are likely to yield additional important scientific insights. The key to these efforts is clearly going to be collaboration. One of the most far reaching examples is the national health plan collaborative to reduce disparities and improve quality in diabetes care. Nine of the nation's

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largest health insurance plans have joined together to improve the capacity to collect and analyze data on race and ethnicity. These data are linked to quality measures, that is to say they are expanding and building on what they already do to assess and improve quality of care and they are developing quality improvement in interventions to close the gaps in care and we are supporting this, along with the Robert Wood-Johnson Foundation, the Center for Health Care Strategies, and the Institute for Health Care Improvement. So, this group is doing vitally important work to close the gap in quality of diabetes care for African Americans, Hispanics, and Native Americans. Interestingly, one of the most important aspects of this collaboration to me is that a number of chief medical officers from these very plans came to us and asked to be included. What they said was we read the Institute of Medicine's report on equal treatments and we know we have a problem. We don't have data but we are so convinced that this problem is so pervasive that we know it has to exist for our members and we can't do that, so we need your help. We need to be convened. It isn't always naturally instinctive behavior for competitors to work together but we don't know how to do this, so out of that became this collaborative. For us, it is a very exciting research demonstration or initiative. For these plans, this is core business, and it is also new business in terms of

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their sharing their results with each other. The bottom line is that when it comes to disparities in healthcare, we simply don't have the luxury or the time to fund long-term definitive studies as in well we know we have a problem but we will wait for the results of the definitive study. As public and private entities work together and share ideas and resources, we can test different approaches, learn as we grow, and share what we learn. The growing commitment by health insurers and employer and the work of many disparities related collaboratives are making a difference not only nationally but locally, and it is at the local level where I think we have the greatest opportunity to inspire lasting progress. No matter how you cut it, at the end of the day, I'm from Massachusetts so I can paraphrase Tip O'Neil here, all health care is local, and the problems and the solutions that collectively contribute to what we know as disparities in health care at the national level look quite different from community to community. A solution that is going to work in my home county in Maryland is probably going to be quite a bit different than what is going to work in Miami or in the Midwest or in Seattle, Washington. Eliminating racial and ethnic health disparities is also a major priority for HHS. In 2004, HHS created the HHS Council on Health Disparities to coordinate and unify HHS actions and disparity

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issues, so this council ensures that HHS contracts, conferences, and grants are synchronized if you will.

We have also launched programs that attack health disparities directly by engaging racial and ethnic minority communities in the fight against specific diseases and conditions that have a major impact, so for example the National Breast and Cervical Cancer Early Detection Program, which provides breast and cervical cancer screening, diagnosis, and treatment to low income, medically underserved and uninsured women, so to date this program has provided more than 3.5 million screening tests for breast and cervical cancer to nearly 1.5 million low income women. In another example, the office of minority health's resource center serves as a national resource and referral service on minority health. The center collects and distributes information including print and electronic publications for professionals and consumers and also provides access to minority health experts from across the country and technical and capacity building assistance for community based organizations. We also support community based research and share our research tools at the county and state level and work with so many local health plans and non-governmental organizations and it is why we are very proud to work with HRSA and their community health centers and many other programs, but for the average person on a day to day basis,

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we know it is essential to have good measures but again, it all comes back to all health care is local. People want to know what is happening in the communities where they live, work, and raise their families. Each community has its own population characteristics and its own unique problems and unique solutions to the problem of disparities. Within each community, there are unique causes but there are also unique resources which can lead to different solutions for each community. Communities that use the powerful measurement tools we have developed for the national health care quality and disparities reports consistently are going to be able to gather disparities related information much more efficiently than we can at the federal level, and not only that they are not going to have that data lag that we have with National Datasets. It will be much more meaningful to them and our door is open to provide technical assistance to communities that want to do this. Through these reports and the resources we have available behind these reports, we are dedicated to making these standardized tools available at the grassroots level for the benefit of each community and the benefit of the nation as a whole. Thank you for your attention. [Applause]

MARSHA LILLIE BLANTON, Ph.D.: Thank you, Carolyn. I think you have provided us with an excellent overview as well as moved us in the next direction, or the next step, which is

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saying what do we do next? What do these findings mean for our work? We have asked each of the panelists to give us about a five to seven minute overview of their thoughts on the report, and then we will open it up for discussion.

KEVIN FISCELLA, M.D., M.P.H.: Good morning. I appreciate the invitation to reflect on the national health care disparities report, at least from the view of a clinician in the trenches. The report is truly a singular achievement. I am not aware of any other country who has really taken on this task. The report uses the best available data to inform clinical practice and quality improvement by showing where disparities exist and where they don't. It shows why they matter and in some cases it even hints at potential causes. Most importantly, it allows us to track our progress towards their elimination. Each year, additional measures and new data are added to the report. The report unequivocally demonstrates disparities in health care quality and access by race, ethnicity, social class, insurance, where patients live. It also shows that disparities are not omnipresent nor inevitable. For most groups, there has been some improvement as Carolyn has indicated. For Hispanics, things have gotten somewhat worse. African Americans are 25-percent more likely to die of colorectal cancer than whites, but are less likely to undergo screening. As clinicians, we must fully inform minority

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patients about options for cancer screening, but that is not enough. We need innovative ways to reach those who fall between the cracks of our broken system. One example is telephone care management, recently shown to increase colorectal cancer screening by 60-percent among at risk, predominantly low income and minority women. Diabetes has increased drastically among minorities in the past decade or so, yet Hispanics are less likely to receive key measures of quality of care for diabetes. Why? Seven out of ten Hispanics fail to obtain needed care due to cost compared to about 50-percent for other groups. Insurance is a huge factor, 40-percent of Hispanics lack health care insurance at some point during the last year. Clearly, universal health insurance is needed. As clinicians, we must be sensitive to the affordability of medications and tests. We need to link uninsured patients with community programs such as federally qualified health centers and the breast and cervical cancer screening programs that Carolyn talked about. We need to check medication copayments and Part D medicare coverage and ask patients about costs before prescribing. We need to tell patients to call us if there is a problem with affordability and reassure them that we will find a way to work things out together. That is all part of being a primary care provider but cost is not the only barrier. Hispanics are less likely to feel their doctor listens to them, explains things, or

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shows respect. These findings signal the need for improved linguistic and cultural competency for providers. Good training programs are out there now. We need to use them. Clinicians and payers must resolve their differences about who pays for language translation. The report shows African Americans and Hispanics are more often hospitalized for pneumonia but less likely to be vaccinated against it. Some of these disparities are likely rooted in patient skepticism about vaccines so we need to do a better job of talking to them about vaccines but we only get to talk to patients who come in for visits. Our own practice recently participated in an award winning national demonstration project named READY using community outreach workers. The program doubled rates of flu shots for elderly and minority patients. Unfortunately the program will soon be ending due to lack of funding. This shouldn't happen. We need to find ways to fund what works if we are to make progress. Poverty and racism exact a terrible toll on the human psyche. The report shows that minorities are less likely to receive mental health counseling than whites and less likely to report they are helped by that treatment, but referral for mental health counseling, particularly for culturally diverse populations, is not a simple endeavor. It takes more than just writing out a referral. It often involves complex negotiation with the patient to achieve share and understanding about the

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problem and the treatment. It means identifying culturally sensitive counselors and of course it means addressing costs. We need parenting for mental health coverage. My practice is part-time and I currently have half a dozen patients with kidney failure. All are African American. This reflects the epidemiology of kidney failure. African Americans have three to four times the rates as whites. The national health care disparities report documents that African Americans are less likely to have an AV fistula in place for dialysis. How does this happen?

Ten years ago one of my patients lost her insurance when she became permanently disabled, literally from back-breaking work in a nursing home. Worker compensation covered treatment of her back injury, but nothing else. Unable to work, she became depressed, overweight, diabetic, and hypertensive. Eventually her kidneys failed. When it came time for dialysis, the dialysis center initially hesitated to accept her without any insurance. Medicare usually covers the cost of dialysis but it doesn't kick in until four months later. The dialysis unit eats the difference. Surgery for replacement of her fistula was delayed until she became medicaid eligible due to cost, but dialysis is not usually the treatment of choice for kidney failure. It is kidney transplant, and the benefits are immense. Patients feel much better and are no longer tied to a machine for three half

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days a week or all night long. Life expectancy increases by about ten years. The report shows that African Americans are about one-third less likely to receive transplants than whites. Asians, American Indians and Hispanics also receive fewer transplants. What can be done? Rather than leaving the discussion of transplant patients exclusively to nephrologists, primary care clinicians can also explain to patients and their families the risks and benefits of transplant patient and also those associated with living organ donation, but again this is not enough. We need innovative ways to ensure that every American with kidney failure fully understands all of the treatment options and we need quality measures by race and ethnicity to ensure it really happens. When I checked my mail on Friday, I learned my patient had been scheduled for transplant evaluation. In closing, the national health care disparities report shows that disparities can be eliminated. The evidence base for effective interventions to reduce or eliminate disparities is growing. Health plans and hospitals are beginning to address disparities through quality improvement, as Carolyn indicated. The report represents an indispensable guide to these efforts. Most importantly, it provides an honest and objective assessment of our national progress for the goal of equality and quality in health care for all Americans. Thank you. [Applause]

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JOHN NELSON, M.D., M.P.H.: Good morning, great to be with you from Salt Lake City, the artificial heart of America. [Laughter] Greetings from the American Medical Association of physicians dedicated to health of America. I think it was 1920 when the writer, Anatole France made the comment "in order to accomplish great things, one must not only plan, but dream, not only act but believe." At the American Medical Association we believe we can make a difference. I want to refresh your memory, you renowned clinicians, how you make a diagnosis. A diagnosis is made 85-percent of the time by the history taken by the physician given by the patient, 10-percent has to do with the physical examination, and 5-percent is the use of the laboratory. Eighty-five percent of that interaction has to do with the information exchanged between patient and clinician. Now we have got to figure out a way, therefore, to eliminate all barriers between patient and physician. With due respect to my colleague, Dr. Clancy and Mr. O'Neil, I disagree that health care is local. Health care is personal, intimate, absolutely as deeply as one can get involved with another person, and we have got to make sure that we don't lose track of that. Therefore, we have got to make sure that whatever barrier is allowed to persist between physician and patient is eliminated.

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I am grateful to be part of the commission and health care disparities, now 45 organization, mostly of physicians, to get together to determine what we can do as clinicians to try to eliminate these disparities. What we are going to do is to use this incredible report from AHRQ as our roadmap. That will be our beacon of which way we are supposed to go and we hope that in the future we will be able to come and there will be a page where you can say that commission was able to eliminate one disparity or perhaps identify new ones as we will do. What we are going to do is to not only identify a disparity, but publicize what that disparity is and then, using an evidence-based best practice method, determine what the best way is to eliminate that disparity and because health care is so intimate and so personal, there maybe multiple different ways of which we will do that.

At the American Medical Association, we also have the consortium for practice improvement. According to their 80 organizations, mostly national specialty societies, but others as well, to determine how we might use practice guidelines in an attempt to make these disparities go away. We are able to [inaudible] these when there are disparities between the way that people want to go about eliminating disparities. We can come up with a single methodology and pool our resources and do a better job. We think that is going to be a better way to do this in the future. Now we

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clearly need to do a couple of things right now. One thing we need to do in addition to using the guidelines is to become more culturally competent as clinicians. I am grateful that the office on minority health has online now for free a nine hour CME credit which will help allow us to become more culturally competent. At the organization where I work, Health Insights, the QIO for Utah and Nevada, we as clinicians are obligated to take that course and I am proud to tell you I have taken that course, not to mention the nine free CME credits which was also nice, but the issue is it did in fact help us to become more aware of some of the things which we can do. We need to take advantage of partners. We need to do things together. We are certainly stronger as a group than we are individually. We need to find other individuals in other organizations who are interested in the issue of identifying and eliminating disparities and work with them and we need to identify new partners. Wouldn't it be interesting if my colleague, Dr. Burwick and his 100,000 Lives campaign could look more closely at the 100,000 lives that are going to be saved and see how many of those lives are, in fact, lives of minority patients? If we do apply the science as it should be applied, we ought to have an inordinate raise in the lives saved in the minority community. Hopefully that will be the case. Well, there are lots to go on. I think we need to be sure, though, that

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physicians are part of the solution. In a study done by our commission, and we did determine that physicians do believe that there are disparities which exist. We also believe that if given the tools, we can be part of that solution. We have got to change the perspective, though, our own personal perspective. How interesting it was for me just a few weeks ago in this city, Howard University, to attend a listening session where a handsome African American man told about his transplant. I was quite surprised later that one of my African American physician colleagues assumed that the transplant was a kidney transplant. Indeed it was a heart transplant. My African American colleague said he had never seen an African American man get a heart transplant before. So we have got to change our own perspectives and get better.

Well, as I close I would remind all of us of a great physician, William Ouster, who was talking about the patient physician relationship upon which all of this is dependent in my mind. He said in order for medicine to be practiced as it should be practiced, the physician must learn to love the patient. I love my patients, and because I do I hope I will be part, a small part of the solution. Thank you very much.

[Applause]

RUTH ENID ZAMBRANA, Ph.D.: Good morning. I am grateful for this opportunity to briefly comment on this report. I want to start out with a comment that Dr. Clancy

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made at the January summit on racial and ethnic disparities where she stated when one attends these meetings, one has to have perspective. One definition of perspective is a painting or a drawing technique in which objects seem to have depth and distance so in research, we need to have a perspective, and my comments will focus on what perspective that this report gives us. The report clearly reflects the impact of almost 30 years of research that reaffirms that in the United States as in all countries, socioeconomic status or poverty matters, that race ethnicity matters as it intersects with socioeconomic status, that immigration status matters as it intersects with poverty, especially now, and that a health care system that fails to provide quality health care to all its residents and that it is neither fair nor equitable, requires change. Its seminal landmark contribution is its inclusion of the Hispanic Latino population. What do these findings mean for us? I think that these findings mean that we do require a profound perspective on what makes a difference in the health of a nation for all of us. That is the powerful effects of race, ethnicity, and poverty.

Interestingly, the report throughout cautions has several cautions. One is that socioeconomic status explains some but not all racial and ethnic health care disparities yet the data are pretty lucid that incoming education are

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powerful predictors of quality of care and outcome. Thus we ask ourselves what is this perspective? SES only explains part and the other part is explained by health behaviors or individual attributes or by institutional barriers to care or a combination of all three. It is my hope that the perspective sees a painting where these are interconnected so as to avoid going back over very old ground. These findings again compellingly argue for the need to identify race, ethnicity, income and education in all our data systems if we are to truly deepen our understanding of the reasons for these disparities and who is most impacted.

Future research needs to address two critical issues which have already been mentioned. These data provide a national portrait but do not provide insight into specific geographic locations or communities where resources are limited. For example, if we were to study intragroup differences among Mexican Americans on the border and rural areas or inner cities, we would certainly find different indicators of disparities. Equally important, these data do not tell us anything about the systems that serve different groups of individuals. It does not address issues of equity in our health care delivery system. So funders, I think, are critical crossroads in terms of what do we fund? Should funding initiatives be developed by a perspective on the evidence or by existing researchers? As funders and

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researchers attempt to make some rational decisions on what areas to pursue, difficult issues need to be disentangled. Some of the evidence appears conflicting so what do we know? We know that not all agree that disparities exist. We know that not all agree on reasons behind disparities, and we know that not all agree on what is community based participatory research, which has been a struggle for 40 years. So in looking at new initiatives and directions for funding research, funders should consider this as an opportunity to invest in public health research and as was mentioned, the speaker before me, we need to fund what works so if funders are willing to take unprecedented risks, I propose the following: Public-private funding partnerships to expand community based health care clinics, grassroots outreach efforts to engage, involve, and ensure pivotal role of community based organizations and health care delivery systems including split fiscal accountability and equal partnership in decision making. We need to include lead investigators and fund community based organizations whose communities are most impacted by these disparities. However, there is a caution as we look at the research arena. New health care policies and restrictions, for example on access to contraceptives and immigration services, may initiate a whole new cycle of health effects that may drive funding

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initiatives begin, yet we cannot afford to reverse our progress.

A few suggestions for improvement: One is that Latinos cannot be studied as a monolithic group. We need to disaggregate Hispanics or very heterogenous groups by geographic location, level of insurance, and level of education. We need to increase the sample size in all national surveys from major electing of subgroups. This must be made a priority, particularly based on this report. Immigrants are not a generic monolithic group. We need to also look at immigrants in terms of their country of birth, languages spoken, and their income and education. Additional measures which have been found in the literature include literacy level, which is highly associated with education level, and health literacy, which is an issue of concern for the majority of Americans and this requires measurement. Finally, we have talked about the patient doctor relationship and communication measures which need to be expanded. How do doctors perceive their patients based on poverty, race, and ethnicity? How does this influence their quality of care, safety, and effectiveness?

Now fragmentation and fracture in our health care system are its distinguishing features compared to other world health systems. There is a significant agreement, although not full consensus, that our health care system

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requires transfusion. Full consensus has never been required to move forward and as Dr. Clancy has mentioned, we cannot continue as a nation to wait for more data. Recent report by the Commonwealth Bond and the Harvard Interfaculty Program for Health Systems Improvement argued for national reconciliation with the fact that indeed poverty, race, and ethnicity, that those groups of individuals have less access to health care and quality health care services and thus we must move forward towards universal health care access and work expansion of community based health care clinics. We need to address issues of equity and access and then perhaps quality will follow.

At this point, we simply would have a lax in ethical integrity if we permitted, as the Harvard Interfaculty Program Group has stated, a role back due to ideological and political gridlock. In our commitment to improve access and quality of care in America for those who are experiencing and have historically experienced this proportion of morbidity and mortality, namely the African Americans, Latinos, and American Indian/Native Americans. Thank you. [Applause]

DORA HUGHES, M.D., M.P.H.: Good morning. As I began to draft my remarks for this morning, I thought I should conduct a little background research and out this morning, of course with my penniless in recognizing a number of you in the audience, I should put the word research in quotes. My

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sample size is very small. I am sure my findings may not be statistically significant. There is plenty of bias considering the pool that I drew from, but even given these study limitations, I thought the findings were quite telling. When I asked staff members if they had ever heard of the National Health Care Disparity Report, the answer was always yes, but then when I asked if they had read the 2005 report or if they had ever read a report, invariably there would be a little shuffling of the feet and clearing of the throat and they would ask, what do you mean by read? [Laughter] Apparently there is more than one definition for that word read. Finally, the staffers would admit that no, they had not read the report, the most recent report, or the older reports. They had skimmed a few of the highlights. They had attended Dr. Clancy's briefing on the hill. Some of the home states, newspaper clipping may have included a few blurbs on the findings, and so I think given for the hill audience, the question might not be what have we learned but instead has the report had any real impact on our legislative and policy agenda on the hill? And despite the findings, I would say absolutely unequivocally the answer is yes. I went and also asked my colleagues so how do you think this report has been useful? What impact has it had? And I was able to condense the findings into three main responses, and the first was raising awareness. People may not have read the report but

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they knew out there was a report showing that there are disparities in health care quality, that some patient populations receive better care than others. The second response, also very common, was that this report helps to serve as a moral compass. Although not every hill staffer believes that health care is a right and certainly not that universal coverage should be a goal. Staffers for the most part would agree that the quality of health care that an individual receives should not be based on the color of their skin, their income or education level, where they live, but instead should reflect the professional standards and consensus and recommended guidelines by health professional expert groups. The National Health Care Disparity Report highlights gross inequalities and that compels us to act, and that relates to response #3, the report helps to hold our feet to the fire in the congress. The congress hates to be charged with not acting in the face of a clear problem or crisis, although we routinely do not act, we still just hate for that to be said.

The ongoing issue of the report is a problem frankly. In addition to that, we know that there are a number of reauthorizations that are overdue: The Office of Minority Health, the Title VII Program, and the National Center for Minority Health and Health Disparities. In addition to the disparities report, a number of reports from the National

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Academy of Sciences and other institutions have pointed out not that just much work remains to be done but they provided a roadmap, as Dr. Clancy alluded to earlier. Even the absence of authorizing language, the National Health Care Disparities Report also helps when we make our funding request to the budget and appropriations committees. We say every year we know that work needs to be done and for that we need to have sufficient funding for the offices and agencies that are doing this work.

The fourth response ties in again to what Dr. Clancy said, certainly the hazards of going last on any panel, is that tying it in with the dual release of the disparities report and the quality report reminds us that the elimination of disparities cannot be the ultimate goal. And then finally and perhaps most importantly for the staff is that the report gives us ammunition for why and what we want to do in our negotiations. It underscores for example the importance of racial and ethnic data collection or why we should promote language access services. Even if we can't site the page, we can still just elude to it. I'm pretty sure that is in the disparities report. [Laughter] Or in absence of that I sometimes just say well Dr. Clancy and Dr. Moy have suggested that this should be a priority. All of that helps because again no one else knows any better so that has been most useful. So understanding that even though we may not know

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the details or the nitty-gritty report it certainly can't site too many findings. I would still say and I believe the staff would agree that the report has been tremendously important.

So moving on, where do we go from here? I would say right now the NHDR is most directly influencing our work with regards to the upcoming 2006 Minority Health Bill. As many of you know, for the last year the senate, we start talking about then we start discussing, then debating and finally we are in frank negotiations on a minority health and health disparities bill. The last one passed in 2000 and given what we know and what we can do, the time for a new bill is overdue. Although the bill is far from complete, the giraffe language is attempting to expand and promote much of the work that you have heard about from the prior panelists. It will focus on minority health and health disparity data collection and analysis, quality improvement, work force training, research, and several reauthorizations, then HDR has helped to guide these efforts and in several sections of the bill we have explicitly stated that the secretary of HHS shall take into consideration or shall give priority in activities or grants to areas of need as identified by the NHDR and other reports. I think we all would agree that we don't want to duplicate the work of art, but instead make sure that these findings are used in a very practical fashion to improve the

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health of minority and help disparity populations at the national, state, local, and personal level.

Aside from the minority health bill, I would say that the discussion disparities public reporting has tied into some of the other legislative efforts regarding pay for performance and hospital report card bills, so it certainly has not just been marginalized into every five years and we have a minority health bill, but I think it does tie into our ongoing efforts and even indirectly has an influence in ways that you might not anticipate. The disparities report highlights improvements in health care quality for some diseases and conditions with at times minorities actually fairing better than whites for the same condition, and yet these improvements in health care and elimination or the reduction of health disparities clearly does not always translate to improvements in health status and outcomes. I am struck, for example, that African American women are more likely to get their mammograms, often get the same level of treatment, the same quality of treatment, and yet they are still much more likely to die from breast cancer and we still don't know the reasons why. We also see dramatic differences in the incidence and prevalence in the number of diseases, HIV/AIDS, diabetes, asthma, and so forth. My point is that although the disparities report shows this in dramatic fashion, that we can intervene quite successfully through the

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health care system. In order to achieve a truly healthy nation, we simply cannot ignore the real health impact of a number of other variables including economic and educational opportunity, talks in free environment, strong public health infrastructure, affordable and safe housing, I could go on and on. As Senator Obama likes to say, this is not an "either or" situation but a "both and" situation. We desperately need to improve both health care and health status, which is going to take a committed comprehensive and long-term approach, and with that I will end there.

[Applause]

MARSHA LILLIE BLANTON, Ph.D.: Thank you. I think this has been a great panel. I feel like I have learned a lot and you've already begun to touch on some of the issues that I think we need to talk further about. Let me just start with a very general question, particularly to Dr. Fiscella and Dr. Nelson. I got the sense from Dora that policy makers are aware of the report and making some effort to use it, could you give me a sense about whether or not the medical community, and I can use that broadly, clinicians in general, are paying attention? It is clear Dr. Fiscella that you are, but would you say that practicing physicians are paying attention?

KEVIN FISCELLA, M.D., M.P.H.: What I would say is I think physicians read the press and read about the report in

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the press and in the journals and probably follow it that way, so I think in that way it has some impact. I think probably your average physician probably does not go to the AHRQ website and read the entire report.

JOHN NELSON, M.D., M.P.H.: I'm afraid the average physician doesn't know about AHRQ. That is the truth. I apologize for that. I think I was struck some time ago when a colleague of mine, an African American ophthalmologist, a female, delightful person, was talking and in conversation all of a sudden had the "ah-ha" moment, she said you know, I think I treat my African American patients differently. That was a real "ah-ha" opening for me. I think physicians are aware that we can do a better job, and I think as long as we couch this in quality improvement we will do well. That is what we want to do. We want to do a better job.

MARSHA LILLIE BLANTON, Ph.D.: Should organized medicine be doing more though to help health plans, hospitals, providers understand the problem?

JOHN NELSON, M.D., M.P.H.: We should all be doing more. We should do things together. I think that is the advantage that we are trying to bring to the American Medical Association is to do it together. We can't do this alone, but with 45 organizations and the commission, we can do a better job. If we could find new partners, we could expand

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it even more. I think physicians are a part of the solution and when made aware want to be.

MARSHA LILLIE BLANTON, Ph.D.: Dr. Zambrana, you talked about the findings on the Hispanic population, what is your sense about why the patterns, why the core measures, are more worsening than improving for the Hispanic population?

RUTH ENID ZAMBRANA, Ph.D.: Well I think this is really the first time that we have data on Latinos/Hispanics, so I think that this report, and certainly today's dialog, opens up a new era for attention to this issue. I do not believe that the problem is new, it is documented. Part has to do with, and this has been documented and if you look back, we have reviewed thousands of studies looking at issues of access for Latinos back to 1960, and the issues have not changed. Low education, low income, living in areas where there are low resources, I believe fear of talking with the doctor and expressing their concerns, I think there are some issues there. These issues again are not necessarily unique to Latinos but they have to do with them not knowing what questions to ask, how to approach the system, and I believe that also the system, there are certain barriers within the system itself that prevent, because of the lack of coordination of care, that prevent individuals from really getting the care they need. I think most of these issues have been documented.

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Now what was interesting in this report, which I found fascinating, was that Latinos who spoke English still reported higher communication problems than other groups who spoke English at home. So a lot of the data is showing whether, while 70-percent of Latinos are citizens and 70-percent of Mexicans are citizens, and 85-percent of Mexican children for example, are citizens, so language in and of itself I don't think is the major issue. We are really talking about lack of resources in those communities and lack of knowledge on what to ask and how to approach the doctors. I am glad it is finally being documented but I think it has not been different before and I think it is an interaction of both institutions not knowing how to deal with Latinos and Latinos really not having access to insurance or lack of knowledge of where the resources are.

MARSHA LILLIE BLANTON, Ph.D.: I'm going to ask one more question before I open it up to the audience, Dr. Hughes you were great in terms of helping us to understand while the report may not be read in its entirety it is used, and that is a distinction but I think it is an important one to see, to help us understand that the report has value, but you also seemed to imply that there might be some question about whether this is something we should be doing and continuing to do as a nation. Could you, did I misunderstand what you said in your remarks?

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DORA HUGHES, M.D., M.P.H.: My point was that as much as we focus on health care quality to the extent that it is not going to completely address the health status for many populations, that we need to take a broader approach and certainly focusing on the health care system is important and should be a priority, at the same time we have to address some of the other issues that will affect the health of particularly low income and minority populations in terms of, for example, housing or if they have a job or if they have a good meal or if they have opportunities to exercise in their communities or issues like that and my point was that the disparity report, both shows what we can do to the health care system but it also points out that we are going to have to do more.

CAROLYN CLANCY, M.D.: Just to build on that, I actually couldn't agree with Dora more on that point. A few years ago I got asked one of the best questions I was ever asked by someone when I was testifying before the National Committee on Vital and Health Statistics, and I think they told me this was coming ahead of time but the question was what do we lose if we don't collect these data? And what I said was we lose the opportunity to learn far more about what we don't know about diseases. If you don't actually expose the fact that for some groups it appears that we actually are doing the right things in health care but the outcomes are

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different and we desperately need to learn what is going on there. If you don't measure that, you won't learn that either.

MARSHA LILLIE BLANTON, Ph.D.: Before I turn it over, I try not to go too much into the details of the report but I was surprised that one of the quality indicators is AIDS cases and you see the rate of AIDS cases for both African Americans and Latinos or Hispanics being higher than what we see for whites, why is that identified as a quality of care measure?

MALE SPEAKER: Dr. Moy?

DR. MOY: The reason why we attract it is because we think with the current medications that are available for HIV disease, that with appropriate care and treatment the incidence of AIDS, the end stage of HIV disease, can be affected and what we have observed of course is that the affects tend to be smaller on minority populations so there are much more new AIDS cases being reported.

MARSHA LILLIE BLANTON, Ph.D.: I could tell in reading the details of the report that there was a lot of thought given to the criteria used for both the quality and the access indicators so that is part of what I assumed, but I think it is helpful to state that. Why don't we take some questions from the audience? We have people with mics, so what I would like for you to do is to identify yourself,

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raise your hand, identify yourself before you ask your question and if you are directing it to a specific person, let us know that.

HILDA CRESCO: Hi, I am Hilda Cresco from Respite Association, I have one comment and two questions. One, I would like to echo the importance of collecting data across subgroups, not just for Latinos but for Asians and tribal groups. As you may know, there are 12 million undocumented Latinos residing in the U.S. Does this report reflect their data? That is the first question. The second question I have to do was would the board chart, where it talks about Hispanic vs. non-Hispanic white, within the Hispanic category, are you also including Hispanics that are identified as black?

CAROLYN CLANCY, M.D.: Answer to the first question, to the best of my knowledge federal datasets do not make the distinction, so does the report reflect the experience of immigrant populations? Yes it does. Can you break it out and say this is the impact of undocumented persons? No.

ORLENE GRAHAM: Hi, Orlene Graham from D.C. Primary Care Association.

FEMALE SPEAKER: What was the answer?

CAROLYN CLANCY, M.D.: Just that Hispanics could be of any race, so they are included in the whites when the comparisons are of the other racial and ethnic groups, but

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when the comparison group is the Hispanic population to non-Hispanic whites, of course Hispanics are not in the non-Hispanic whites. This is getting into the real nuances of the data. Next question?

ORLENE GRAHAM: I'll try this again. One of the things we have found in the D.C. Primary Care Association in trying to implement programs to eliminate disparities is the inability to track because the community health centers don't have any mechanism to do that. They are on paper records, very primitive systems. They do have an EMR and in trying to use HEDIS data indicates it is just impossible because we don't have the mechanism to track it sophisticatedly. The other part is a lot of undocumented immigrants that we have in the system which are flowing into the D.C. area, do you have any recommendations, I'm not sure who to address this to, probably Dr. Clancy or Dr. Nelson, how does a system that does not have the ability to track very well really try to implement change and then try to figure out is this effective at the local and the personal level?

CAROLYN CLANCY, M.D.: Could you direct that question to Dr. Fiscella because he has actually worked in community health as well.

KEVIN FISCELLA, M.D., M.P.H.: I think you bring up a very important point, which is that most community health centers don't have electronic health records and I have two

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answers. The first one is to use disease based registries and the health care disparities collaborative, through HRSA, in which about half of the community health centers participate, have developed registries that do include patients so it creates a population through which you can track patients over time and that is helping. The second thing is for community health centers to look for ways to move towards the EHR. I understand that New York City is looking at providing some support to the community health centers there, so looking for other ways to help move to the EHR because I think that will really facilitate tracking patients, particularly over time and between community health centers.

CAROLYN CLANCY, M.D.: If I could just add to that for a second, I think the potential for all of the interest in health IT to have a bit impact here, we haven't even begun to see yet and I am really excited that we are working very closely with HRSA on this and frankly there are earlier efforts looking at disease registries that are going to be very instructive. At the end of the day, most clinicians were trained or have been trained in this mindset that you see one patient at a time, you do the best that you can, and then you go to the next patient and these clinicians have not had access to any information that gives them a sense of how they are doing for a population and IT, once the registry

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functions are well developed and easy to use which at the moment remains a little bit dicey although we are working on it, offers that kind of capacity. It is kind of a reality check if you will that although you think you are doing the very best that you can for each patient, sometimes things aren't happening the way that you thought so I think that is going to be a very exciting development in the future.

MARSHA LILLIE BLANTON, Ph.D.: I'm going to go to the back of the audience and then we will come back to the front.

DR. BEVERLY COMEMILLER: Hi, Dr. Beverly Comemiller, I am interested in the role of the community in helping to get rid of the disparity and I am not hearing a lot about the communication between providers and communities, between institutions and communities, and I know that is how this is going to be fixed, that the community comes out from behind this effort and says we have to change it and therefore the personal responsibility issue also gets addressed. That is one part of the question. The second part is that I am hearing in New York now that they want to do a reporting system, on blood sugars for instance, that with diabetic patients because of the cost, they now want to make that a reportable problem just like STDs are, and I am wondering without the community's effort with us, whether that seems like a reasonable way to collect data?

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CAROLYN CLANCY, M.D.: I can speak about my own home county, Montgomery County, which is just north of the D.C. border here, and Miriam Grantham is here and she could tell you more about it afterwards, there is a Latino health initiative and also an African American initiative and both draw very heavily on the experience and participation of community groups. How I might imagine this working in New York City, for example, is that they could be able to map which communities they are seeing the highest numbers of problems and my impression has not been that cost is the driving factor in that effort. I think they are seeing the great increases in the incidence of diabetes and the complications of that disease as the face of a new epidemic and that this is a logical place for public health to do but they are not going to actually be able to intervene with patients. What they can actually do is alert clinicians and community based organizations to areas where the problem has been the most intractable, where the greatest efforts are needed.

RUTH ENID ZAMBRANA, Ph.D.: I think the issue of community, as some of us have pointed out, is key and this is where the issue of equity comes in, be it in D.C., be it with attempt of community based health care clinics who usually serve poor and low income, they are the least likely to have the type of quality improvement tools that are required to

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address the issues within those clinics. I think again when we talk about collaborations, we usually talk about collaborations within broader professional organizations and collaborations do have to be with those organizations that really know the nitty-gritty of the reality of those communities and I think we need to focus again on including lead researchers, lead practitioners who know these communities and who understand that there is a resource reality, that it includes housing, that it includes food and security, that it includes few physicians, perhaps low resources, and that they need to work together, and I think that is key and we sort of left that out and that is I think the most important issue that we need to address. We have struggled since the 1960's with this notion of collaboration and the role of community and until we I think understand that the community leaders, community physicians have a large body of wisdom to bring, regarding experiences of low income people, and that they can join with other courses that we will not get ahead, so equity and resource investment and bringing electronic medical records and that technology investment by the federal government or private funders to help those communities to get the resources required to document some of these issues I think are important.

JIM BYRNE: Hi, I am Jim Byrne, editor of Health Care Disparities Report, Dr. Hughes, you know we have been

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following this, putting together the great health bill in the sky for more than a year and this congress is going to be the most do nothing congress since the 47th/48th one that Harry Truman won reelection in running against, is there any realistic possibility there will even be a bill introduced?

DORA HUGHES, M.D., M.P.H.: I clearly agree it has been a very long and drawn out process. In part, Hurricane Katrina was probably the biggest wrench so for very good reasons we have had to divert focus. The bill will definitely be introduced this year. Will it move through the senate? I would give it a 60/40 chance. Senator Enzy has signed off on the bill and it is going through health community process, so whatever the final outcome is, Senator Enzy will have agreed to it as well as Senator Kennedy who is obviously the ranking democrat and the other interest that help members in the room are present at the sometimes twice, three times a week meetings. I am simply there because I am a holdover from my Kennedy days and they have graciously allowed me to remain. So to the extent that if we are able to reach consensus and then it could go straight to the floor that would give it the greatest opportunity of passing the senate. I don't anticipate that if it is not done by June that it will pass the senate just because as you point out, election year dynamics may shift priorities for some of the

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members on both sides, so not overly optimistic but not as pessimistic as I usually am. [Laughter]

FEMALE SPEAKER: Do you have any comments on its prospects in the house?

DORA HUGHES, M.D., M.P.H.: I hesitate to speak for the house. I know that a year ago our counterparts in the house had agreed to moving a bill, trying to move the bill in the house as well. I don't know what the conversations have been now on the republican side because there has been a tremendous staff turnover on both the house republican staffers who would be responsible as well as a number of frankly the staffers in the senate as well.

On the democratic side, we certainly have tried to keep the reprise of the process. Senator Frist has asked us not to necessarily share language at this point and obviously we defer to his lead on that, but to the extent that we are actively trying to include some of the priorities for the different minority caucuses as well as some of the other members of various committees, we hope that this will be something will they can embrace and obviously they will have an opportunity to provide feedback and input before the bill is introduced so they will have had an opportunity to modify the bill to the extent that we are able.

DR. JACKIE WATSON: Good morning. My name is Dr. Jackie Watson. I am the president of Health Concepts

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International and a former chair of the D.C. chamber of commerce's health and wellness committee, this question is for any of the panelists but your thoughts on the role the business community plays, if any at all, in the elimination of health care disparities, being a part of that solution?

DORA HUGHES, M.D., M.P.H.: I would make one comment just from the start. I have been surprised. The private sector has really helped to drive the minority health and health disparity legislation. It has been very unexpected but tremendously helpful to have the health plans for example coming in to share along with their other varied priorities that they are also by the way doing this health disparities collaborative or by the way we have this health literacy initiative and oh, you might be aware. I mean, certainly there is always a conflict of interest and it may not be a top priority but it has really helped to point out that the private sector has already adopted and embraced some of the ideals that we are trying to, or some of the activities that we hope to legislate and it is not quite so pie in the sky or unworkable. It is very feasible, it is helping. The private sector is doing it because it is the right thing to do and frankly it likely helps their bottom line but I would say on the hill, in this climate particularly, given our constraints on funding right now, the private sector involvement has been tremendously helpful.

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JOHN NELSON, M.D., M.P.H.: The American College of Occupational and Environmental Medicine can actually quantify what it costs when a person goes down for illness. Certainly the cost of replacing that person at however many dollars per hour, the lost productivity as a person gets sick, the lost productivity as the person comes back, the time and money it costs to train the person's replacement and so on, so there is a business case for keeping people healthy and well in the work place. I think as the business community understands that if there is a group of people who are disadvantaged by this, it is to their business sense to make sure that goes away; therefore the business community should be a strong ally.

KEVIN FISCELLA, M.D., M.P.H.: I agree with Dr. Nelson. I think the employers are certainly concerned if they are contracting for health care and then some of their members are not getting the same quality of health care as others and this has certainly been a major selling point for AETNA in their disparities initiative, that they have been able to go out and secure contracts from businesses who are particularly interested in ensuring that all of their members get the same quality of health care.

BRENDA WILSON: Yes, I'm not quite sure to whom to direct this question. My name is Brenda Wilson. I am with national public radio and Ms. Zambrana mentioned that this

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was no time to be backpedaling because of political or ideological differences. You all mentioned the need to collect data and someone mentioned that some of the wrench in this progress has been caused by Hurricane Katrina and focus on that, and I have been hearing stories of resources being, because of Hurricane Katrina for example, being diverted away from this kind of research to deal with that issue, that particular problem, and labeled essentially as health disparities research or focusing on mental health issues. I guess if any of you could tell me how essential this collection of data and this seeming disconnect between the need to collect data, the need to do good research, and other saying that funds are being diverted, grants are being dropped, people's funding for grants into this kind of research being cut. I don't care who answers it. I hope that question is halfway clear. Sorry. Thank you.

MARSHA LILLIE BLANTON, Ph.D.: Who knows about what is going on in government right now?

DORA HUGHES, M.D., M.P.H.: I just want to start by clarifying my comment with regards to Hurricane Katrina was more about we had hoped to finish the bill in the fall but then because Hurricane Katrina happened, obviously we diverted the staff level attention to addressing many of the needs for the affected states so that was about the extent of all I meant about Hurricane Katrina throwing a wrench in the

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plans. I am going to defer to the experts, I will say myself personally I consider data collection and analysis to be the lynch pen to all of our efforts to improve health care quality and to eliminate disparities, but I will defer to the experts to speak more about that.

CAROLYN CLANCY, M.D.: Just to say that I think that data collection is very important because if you don't know how you are doing, you can't actually identify or solve a problem. On the research side, I can say that this has been a challenging year budget wise for a number of parts of the Dept. of Health and Human Services. Having said that, government cannot solve this problem alone. Most people, certainly a great number of people in this country get their health care in private organizations so I have been very encouraged by the efforts of AETNA, the efforts of the other health plans we are working with to the point where I am actually getting phone calls from them saying wow, we actually realize now that if we did what AETNA did we could actually examine patterns of care and address this problem in a much bigger way than even we are doing through this collaborative, so I am not able to connect all of the dots that you just put on the table.

RUTH ENID ZAMBRANA, Ph.D.: I can't answer that question but I think that we have been doing work at the University of Maryland around Hurricane Katrina and there is

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no question that many of us feel that Hurricane Katrina is a prime example of health disparities that were invisible and became visible with this disaster, especially black/white differences and Latino differences and that they represent a microcosm of the type of differential access and different types of institutional racism that exists on a daily basis in this country but that are not visible to the eye and so there is Hurricane Katrina as an illustration of health disparities in the United States that was unveiled. I don't know that, I have not heard about funding being diverted, but the comparisons have certainly been there.

MARSHA LILLIE BLANTON, Ph.D.: Let me just follow-up on that question because it is interesting to me that many of the questions have been, or several have been around what the private sector can do and when you look at communities of color and the low income population, the public sector is a major source of insurance coverage for the low income population and disproportionately for communities of color so in my mind it seems as if there is more the government could do so that we are not just tracking and collecting data but helping to improve quality and eliminate disparities. Am I correct in my thinking? What is it we could encourage medicaid, medicare, and quality improvement organizations to do more of?

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JOHN NELSON, M.D., M.P.H.: I'll take a stab at it. I think there ought to be not explicit, at least an implicit policy suggestion that whenever there is a discussion of health policy, someone ought to ask the question wait a minute, what is that decision going to do to affect communities of color? I am currently serving on the medicaid advisory commission. We have asked that question. If we make a decision, how is that going to affect all people? I think we just need to do a better job. When you and I were on the commission at NAC at the AHRQ, the national advisory commission of AHRQ, it was a time when the two reports were obligated to come out, the disparities report and the quality report, and we said at the time, put them in the same folder because it's the same problem, so I think we have got to be careful not to let this be politically infeasible. This is quality of care at its base and this is America. We are supposed to be equal. The law says that. I think someone needs to raise a little flag, excuse me, how is this decision going to affect the minority population of everything we talked about?

MARSHA LILLIE BLANTON, Ph.D.: We have time, I think, for at least one more question before we have to bring it to a close.

RENEE BOMEY: Hi, good morning everyone. I am three weeks away from becoming Dr. Renee Bomey, an OB-GYN, Dr.

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Nelson. [Laughs - Applause] I am also the immediate past chairperson of the student national medical association and the health policy intern at the center for medicare advocacy. My question is regarding access to health care, specifically this is often an issue of availability, i.e., lack of health care professionals in certain communities. Nationally the National Health Service Corp. tries to address this issue. This is also a major factor in underserved communities and I just wanted to know has there been any correlation, if there is any correlation between the trends in medical education and access to health care, specifically the disproportionately low numbers of under represented minorities entering medical school, a decrease in funding and subsequent decrease in number of minority recruitment programs and also has there been any type of research regarding the impact of organizations promoting an increase in under represented minorities in medicine so that for the sake of actually addressing health care disparities?

JOHN NELSON, M.D., M.P.H.: That is an incredibly good question. I was told last week the approximately 16,700 medical students who were freshmen this year in the United States, 375 are African American males. That is regrettable. We have got to find ways to work with groups like the Sullivan Commission, which our Commission of Health Care Disparities is trying to do to find ways to encourage young

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people of color very early in their educational careers that they can and should be in the health care professions. We can't go to college, it's too late. High school is way too late. It's got to be in the grade school. We have got to find ways to deal with this, and we can't wait. If you are able to change the pipeline today, you are still 8-10 years out to have a physician go through the training that he or she needs so in the meantime while we are doing that, which is a very worthy goal, those of us who are in the trenches have got to become more culturally competent until we can make up the difference.

DORA HUGHES, M.D., M.P.H.: I would just point out that I completely concur with everything that you have said. I think the data is there. There is a relative, almost complete lack of advocacy by outside groups for programs that you mentioned, particularly Title VII and a lot of the pipeline programs, and yet we've watched every year how the budget for these programs is eliminated and this year was no different in the president's budget so it becomes hard for us to act, I think a few staff on the [inaudible] would wholeheartedly support the programs a lot more who halfheartedly support the programs but when the budget becomes tight these types of programs are often the first to go and to the extent that all of here can weigh in very loudly about the importance of these programs, that would be

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tremendously helpful and as part of that again, we hope to address some of this through the minority health bill, either in the bill or perhaps later this year as a separate Title VII, Title VIII reauthorization. I did want to just take one moment, I recognize my successor in the Kennedy office is here in the audience today, Kaya Lewis, and I just wonder if you can stand up. I've made so many mentions to the minority health and health disparities bill, and she is the lead democrat staffer on the bill and so I just wanted to point her out in the audience for all your questions and concerns. [Laughter].

FEMALE SPEAKER: Kaya, did you want to say anything more about the bill?

KAYA LEWIS: [Inaudible] working very hard [inaudible] wondering what the [inaudible] and I think her odds are about right [inaudible] and moving through the senate so we do, I can't underscore enough how important it is for us to hear from people on the importance of working on health disparities because a lot of the programs that we mentioned are on shaky ground in congress and we do need awareness raised so hearing from all of you on the groups that you represent on a regular basis over time can really make a difference.

MARSHA LILLIE BLANTON, Ph.D.: Thank you. Did you want to say anything in closing?

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KEVIN FISCELLA, M.D., M.P.H.: Yeah I was just going to add my thoughts. We do know that minorities are more likely to practice with underserved groups. That is a fact. We know that community health centers are right now having difficulty attracting primary care clinicians and we do have some idea of what works. Sophie Davis has a wonderful program that has been in operation for 30 years that starts very young and increases the pipeline of minority physicians. What we need to do is to fund these programs. We have some idea of what works. We just need to do it.

MARSHA LILLIE BLANTON, Ph.D.: I just want to close by thanking our panelists. [Applause] I think you all have done a great job helping people to understand the complexity of the issues that when we talk about disparities, while we talk a lot about disparities by race, disparities also very much exist by income, by other population characteristics, and this report helps us to understand where those disparities are and it helps us to understand what kinds of gains we have achieved and where we still have work to be done, so I want to thank you all for joining with us. I want to thank the audience as well for coming because the issue that we face requires, as one person mentioned, the community but it also requires informed members of the public, of the research community, of the clinical community, to help make sure people understand that the problem is real and that

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there are solutions to the problem and I think that is why it
is good to have so many of you here to help us get that
message out. So thanks again for coming. [Applause]

[END RECORDING]