

Briefing: NCSL 2004 Annual Conference: Multicultural Health and Health Disparities July 21, 2004

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SHIRLEY NATHAN: And as a registered nurse I have been following the issue on racial and ethnic disparities for over 40 years. Various groups have studied this topic. It has been called many names, but it is now 108 years. In 1896, W.E.B. Dubois and Booker T. Washington met in Atlanta at the Atlanta Expedition and they debated the changes in Negro health as it relates to that of white. And the word that they used then was deficiencies.

If you remove the word deficiencies and today put in disparity in every way, you realize we have not come that far. And so in 1903 and again in 1906 W.E.B. Dubois wrote two books, *Souls of Our Fools* that spoke to this issue and again *Health and Physique*. And I don't have time to give you the full historic perspective, but I wish I did, but time doesn't permit. But understanding multicultural health is so very important. Lack of knowledge, of cultural sensitivity, cultural competency and health literacy is causing our nation and our states billions and billions of dollars.

In Maryland between 2002 and 2003 and four, in our general assembly we passed three pieces of legislation, Senate Bill 451, Senate's [inaudible] legislation that started this ball rolling and in 2003 House Bill 886 health care prevention act and this 2004 session the office of minority health and health disparity. This is a way for us to begin the

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dialogue. The National Black Caucus of State Legislatures and the National Hispanic Caucus have been meeting regularly to begin to put strength behind what needs to be done to address this issue. The Institute of Medicine Study and I will close on equal treatment confronting racial and ethnic disparities in healthcare states, "racial and ethnic minorities tend to receive a lower quality of healthcare than non-minorities even when access related factors such as patient insurance status and income are controlled. The sources for these disparities are complex and are rooted in historic and contemporary inequities and involve many participants in several levels including health systems, their administrative and bureaucratic processes, utilization managers, healthcare professionals and the patient."

I will now turn over to our distinguished panel which I will introduce all of them at the same time and they will fall in this order. Dr. Lovell A. Jones is a professor at the Department of Biochemistry and Molecular Biology at the University of Texas, MD. Anderson Cancer Center in January 2002. I mean 2000, I'm sorry. He was named as the first director of Congressionally-mandated Center for Research and Minority Health. Dr. Jones was honored on the floor of the US House of Representatives for his work in addressing health disparities in the underserved. Our next presenter after Dr. Jones will be Gloria Lewis who is the director of Minnesota's

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Office of Minority Health. As director Gloria Lewis is responsible for providing direction and leadership to the Office of Minority Health which develops policies and strategies aimed at reducing health disparities and affecting Minnesota's ethnic and racial communities. And our final speaker is Representative Curtis Anderson who was elected to the Florida House of Representatives in November. I'm sorry, Representative Curtis Richardson and that's a slip but there is my colleague by the name of Curtis Anderson. Curtis Richardson, representative was elected to the Florida House of Representatives in November of 2000. He is currently a consultant to the University of South Florida's Shared Services Network project. Prior to that he was a deputy director for cabinet affairs where he advised the governor on these select issues. Again thank you so very much for now entertaining our distinguished panel. Dr. Lovell. Jones.

[LAUGHTER]

LOVELL JONES: That's okay. People call me Dr. Lovell, doctor whatever. I respond to a lot of things. I want to thank the organizers of this session as well as the conference for the invitation to speak to you today about health disparities. I will try in my allotted time, I know it has gotten shorter, to provide you with a few perceptions of the problem and a few solutions.

I also say perception is a person's reality whether

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it's real or not. And this is the reality I live in. If you don't really deal with the community on a regular basis, sometimes your perceptions are quite different than theirs. Let me provide you with a few solutions up front for you to think about as I speed through my presentation.

If we continue to push a solution to the problem or problems only as a social issue, we'll continue to grow and threaten this nation's survival. I will not go into the details but I'll just say that Brass Ricky had to borrow money when he wanted to buy Jackie Robinson's contract for him to play in baseball and integrate baseball with regards to Brooklyn Dodgers. Think about this in 1946, wanting to integrate baseball and going to talk to bankers about borrowing money. And what these bankers said to [inaudible], "Mr. Ricky, if you're doing this as an instrument of social change you're not going to get any money from our institution, however if you're telling us that it will make the Brooklyn Dodgers stronger, we will support you and we will have a business relationship." As someone frequently said, it's economics stupid, it's economics. What I'm saying to you is to address health disparities will make this nation stronger. The problem is not just access to care or should I say add or declare is a variety of issues and then addressing only one of them will continue to make the problem worse. It is access. It is genetics and biology. It is social determinacy and all the

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factors that occur under it.

Data, data, data. What is the state of your state's registry? Do you fund it adequately? Think about it. Unfortunately we are enamored by national data and national trends, but as Tip O'Neal once said, "All politics are local. All data is local." With that one needs a coordinated effort to improve the collection and coordination of the health information and better link this to specific populations and communities of color. We must address indigent care as well or we will all perish. Again health disparity is just not a minority issue, it is an American issue. And if I don't have time during the question and answer session that you want to if you can ask me about the benefits enrollment program. It makes indigent care profitable. Now where does all the data come from? For instance, incident data, the majority of the data comes from these colored areas on the slide. I should tell you that in the last report there was no data from Texas, Mississippi, Tennessee, Oklahoma, Arkansas, Virginia, Maine and South Dakota. If you live in those states you were not in the national trend.

Data for example, looking at this slide you would think that it would be better to be poor from Asian-Pacific islanders. They tend to do better based on this slide. If you are rich Asian, you die earlier and you have a car. If you're poor, you do better off. Disparities incidentally if you take

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from this slide you would say disparities only exist between blacks and whites. If you look at this slide for instance in terms of women, you'd say there's not much of a problem in terms of poverty with regards to women. These are national statistics that are put out every year. And people use these to make policy on.

But let's take a look at one particular state, the state I know pretty well, Kentucky as an example of looking at these things closely. Look at eastern Kentucky. It's that red area over there. It's part of Appalachia. If you look at that with regards to most distressed it is those red areas that are on the slides to your right. If you take that and look at the top as poverty if you look at that in terms of school dropouts, all the indicators with regards to poor health at least in terms of white Americans. And then that you take this data, this really illustrates the problem of looking at national data and why local registries are essential. As I said, we talk about black white differences but what is white. Is it just a homogeneous population? If we just focus on three Kentucky counties and compare the black to white differences we see that the health disparity is an American problem and not just a minority problem.

And what are the problems? Well, first of all health is not a national priority. I mean it's a given. Just look at this, basic education for all \$7 to \$8 billion dollars,

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cosmetics in the US in terms of what we spend \$8 billion, clay and waterfall \$9 billion, ice cream sold in Europe in 1997 \$11 billion, reproductive health for all women \$12 billion, pet food in Europe and the US \$17 billion. And I need not go into the military spending that we spent. Is health a priority in this nation? No.

Disparities in health in America, are they real? I'll just quickly go through this data that says for each and every ethnic group including poor whites that they do more. These are in your slides handout and I'm not going to go through all of them.

Race as a biological construct is a blessing and a curse. Why do I say that? Well, the idea is that there is no genetic basis for racial classifications. Race is a social construct. It is not a biological one. And as long as we keep focusing on that, we're going to have problems.

That's not to say that race doesn't play an important role in health. And you'll hear me talk about populations because it is based on populations. There's not one single classification for African-American. This nation is quite diverse. In the city of Houston we have 182,000 Nigerian families. 182,000. They are not "African-American." Their diets are different. Their cultural habits are different. Their disease profiles are different. But when we collect data on them we collect data as African-American. As I said there

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are differences that are picked up with regards to populations and these are only some of them. We can't throw out the baby with bathwater, but we need to move towards a better way of defining populations if we're going to address this situation. And the issue of race; race, racism, racialism are still not resolved. We still don't want to talk about the issue. As my friend says, the R word becomes ignored and it still exists in this country. We only need to look at the Institute of Medicine Report on unequal treatment and know that it is a problem.

In terms of solutions, the solution to help disparities require no new laws but a willingness on our part to change the way we address the problem. It will take no dramatic increase in new money but a change in the way that we allocate money that we already have. When I talk to all inspectors to get him to do the unequal burden of cancer report, the first question he asked me is how much money is this going to cost? All you need to look at the budget and see where we are spending the money. If the problem of prostate cancer is highest in African-American men, why is it we only spend one percent of the budget on that problem? When you go to war, you direct your forces at the greatest enemy. You don't address it in other places. The solution to the problem will also require the willingness and commitment to take first real steps towards a solution. If the problems are in the community then the

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solutions are in the community.

And then we also talk about community participatory research. This is becoming the big buzz word to make institutions as well as major researchers. However the problem is not for the research, it's how researchers look at. Researchers also look at community-based research as something to be placed in a community as opposed to something being faced within that community. And with that I approach Congress to educate them, not lobby them. As a state employee I cannot lobby but I can sure educate. And when I went there I tried to educate them towards the problem. And I said that the way that we're approaching science; the way that we approach in the 20th century cannot work in the 21st century. We need to change the way that we look at this issue. That led to the formation of the Center for Research on Minority Health.

The traditional way that science has worked is that we think of any idea. We get the money, contact the community with the project or if we're forward thinking we get letters from the community to say that they're going to support our research. We get the grant. We do the study. We publish the paper and then we start the cycle again. And then the community may read about what's going on in the *New York Times* or their local newspaper, but in terms of reporting back to them it's nada. And you wonder why communities get very resistant about research being done on them as opposed to with

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The new model that we have proposed integrates the community at every phase of a process, before the money is gotten, when the money is gotten and when the research is completed the data is given to them before we attempt to publish it.

I've already told you about the first principle and these are the three guiding principles that the Senate works with. These were recently written by me from the Institute of Medicine when they were dealing with health and health issues especially environmental health issues. And I thought they were good enough with regards to the Senate. If one looks at key words, these are six key words to end the solution. Trust, you have to gain the trust of the community and remember trust is hard to come by but so easy to lose. Secondly, respect is a two-way street. You need to respect them as if you want them to respect you. Partnership, community leaders know about communities. They live in that community and have more knowledge about what is going in that community and can relate that to you. Communication, the communication needs to be involved at the beginning, the middle, at the end and then again at the beginning. So in reality if you want to work for the community, it needs to be on their time and not your time, not 8 to 5. It may be in the evening. And then lastly, knowledge, don't assume that you know especially if you don't

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live in that community about what's going on in that community.

Our approach is a bio-psycho-social [misspelled?] approach. This is an approach that's been used by nurses for three decades. It has yet to be used in a clinical environment and we are trying to get that to be used.

Think about the major research groups that you have come in contact with and major institutions and look at this group. People sometime have a hard time picking out the researchers and the support staff of the Center. They can't. The researchers are now all up-front and they're not all of one color. And if you want to see that little guy poking his head next to the tall guy that's actually number [inaudible] who came by to look at the center.

And it's care reimbursement, and this is why I said in terms of making indigent care profitable. The traditional approach is a mom and kid approach. The new approach is to look at disabilities. And most diseases have a disability component to it. The bottom line is a net that was gotten by my institution last year. The year before they were only able to recoup two million in indigent patient care cost. Last year they recouped 74 million. Next year, in fact this year at the end of August 31 they will recoup \$131 million. Indigent patient care can be profitable.

For patients it provides financial access to cancer care. It improves mortality. It provides other disability

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based benefits for my institution and creates reimbursement. That's the first thing. It's a sales and mission by saving more lives and increases outreach to the underserved community. But you also have to look at partnerships. We formed a consortium. Because one thing that we don't want to happen is each and every institution descending on minority communities like a herd of cattle. There's now money in health disparities and everybody wants that dollar no matter what it does with regards to the community. We're also a site of the Keller [misspelled?] college program. We're training individuals. We're taking people from K through post-graduate education. If you hear anybody talking about the problem, it has to be started at K. It can't, you can't wait to start to do something about the problem in college.

And finally, I believe that we have a voice inside us that tells us what is right and wrong. How we listen to that voice and act on it produces the people we are. And lastly, data again; if you look at the slide, the bottom yellow is a national average with regards to prostate cancer. If you base this on data and say well if I'm an African-American I'd rather live in Arizona than in Michigan with regards to the incidence of prostate cancer.

Thank you.

[APPLAUSE]

[Inaudible]

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GLORIA LEWIS: Good morning. It's really good to be here. This is sort of like waiting on eliminating health disparity. You wait and wait and then one day you start to do something about it. So I am really pleased to be here. I bring you greetings from the state of Minnesota. And first before I start, how many Minnesota state legislatures are out here in the audience. Anybody? Good now I can say what I want to say.

[LAUGHTER]

Good morning. I am very pleased to be here this morning to talk with you about sort of following in the footsteps of Dr. Jones, because we are actually implementing to eliminate racial and ethnic health disparities initiative in Minnesota. And this is just unbelievable the work that is taking place. Much of what Dr. Jones described to you this morning is how this initiative came about and it is how we implement it.

Many of you know about Minnesota. Minnesota consistently is the healthiest state in the nation. We always get this great ranking every year. It has one of the lowest teen pregnancy rates in the nation. The infant mortality rate in our state is one of the lowest in the nation and is tied with three other states for the lowest rates of heart disease. However, although we are the healthiest state in the nation and have been named that for many years, at least for almost eight

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now. Sometimes we tie with New Hampshire so we usually come in there. But for populations of color and American Indians, we have some the highest rates in the nation. When we talk about health disparities, we're talking about that difference in health status between a defined group and the majority people. And our goal here is to give all populations of color and American Indians the opportunity to enjoy good health. And we hope that that's not only in Minnesota but across the nation.

Just a couple of slides for you to look at, what our population looks like in Minnesota. Only 11% of our population are African-American, African-born, Latino, Asian, American Indian, 89 points. Four percent of our population are white. So therefore we have and our highest poverty rates as you can see again are among populations of color. Our teen pregnancy rates for African-Americans and Hispanics and Latino are the first and second highest in the nation. And we base that on rates. So it's not our population, it's based on the rate. We also know that according to NCHS the Minnesota infant mortality is also among the highest in the nation as well. We have high cardiovascular rates and we have Asian specific [inaudible] population has low immunization levels of all the population racial and ethnic groups in our state.

I'm going to skip through some of these slides this morning because I want to get to some of the other issues. Actually no matter what slide I show you, populations of color

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are going to be higher than anybody else in that state. And if you want to see more of that it's on the handout that I brought with me.

One of the things that we knew that we needed to do in the state of Minnesota is address that issue. It wasn't about how small the population is and I say this to all of you who are state, all of you out there it's not about the number. You know one of the things that we need to shift in the paradigm when it comes to public health. And if you hear anything about public health 101 says it's for the greater good. Well if you're not in the greater good that means that you're left out. And it means that you're not in that bell curve where all the people are clustered in here so let's do everything for that group and then it'll trickle down to the other groups. The shift in the paradigm now as I said says that we need to do something on both sides of that bell curve. And we need to make sure that everybody gets in the middle somehow. And to achieve that, the eliminate health disparity initiative was established by our Minnesota legislature in 2001 and it's our state's statute. You can go look it up. It's right there. And this program is administered through the Office of Minority Health.

We have two goals. By 2010 we are to decrease the infant mortality rates and adult and child immunization rates for our populations of color and American Indians by 50%. And

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we are to close the gap in health disparities for those populations as well as compared with the rates for whites. And we have six priority health areas. This is what we're working on: breast and cervical cancer, cardiovascular disease, diabetes, HIV/AIDS and STI, violence and unintentional injury, and health youth development, which is nothing but preventing teen pregnancy. So we're looking at those as the six disease areas. They do come from healthy people 2010. So we're not anywhere veering off the task in terms of what we have learned from our health and human service and from the surgeon general. And what's so amazing about this is that we did this different.

Now here's what's different. And this is what I resonated so much with Dr. Jones in his presentation. We went to the community. We said you know what, we've been working on this for 10, 20, 30 years. All we've toiling; we have been toiling in the field around infant mortality rates. We all know what to do. We've brought our best practices and we laid them over the communities of color and American Indians. And they just don't get it. That's called blaming the victim. What we decided to do was go to the communities and say what works for you? I am a proponent of emerging and promising practices and let me tell you why I use that term. Emerging and promising practices mean that everybody does not fit into the same mold. So you cannot lay your best practice because most best practices are really those practices that work for

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the majority population. And they work best for those populations. We had to find ways in which we were going to work with communities across the state, rural, tribal. We are working with urban, suburban. If you live in the state of Minnesota and you are within any of those communities across that state and you have representative populations of color that are impacted by these disease we work with them. We cover 41 counties out of 87 counties in that state. We cover every population, every racial and ethnic group and every tribal nation in that state.

These grants are provided with an opportunity to do the following things. We promote the health and quality of life of individuals in communities. We build on community strength and assets. We come from the glass is half full perspective not from the glass is half empty. You want to know the basic where that premise comes from, it comes from John McKnight [misspelled?] and Jody Pressman [misspelled?] as they talk about the ABC, Asset Based Community development. That's what you start from. You start from the fact that what we work with in our systems is something called a deficit base of perspective. We know all that's wrong with you. We know all your problems. We have all the data on you that says oh woe is you. You got children in the street. You dropping dead. You're families are broken. You're [inaudible] don't work. You don't have a job. You're undereducated. You don't have

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any, you're just bad off and we got all the data.

[LAUGHTER]

But we can't do anything about it. We work from the perspective of you have a community. There's a house there. It may not look like the house you want it to be. There are people. There are churches. There are schools. The library is open. The books may not be as up to date as you want them but the library is there. We know that in your community you have access. And you know what you have in communities? You've got people. People are assets. So we work from asset base perspective. We develop [inaudible] working relationships among community member and organizations and leaders who serve them. We do not look for perceived leaders. We look for leaders who are real leaders. Perception is somebody's reality but when you dig past that I have what I call a drive by evaluation. Now I have an evaluator. We pay them \$400,000 a year to evaluate this initiative over two years because we have a biennial system in our state. And I know that I need all of that scientific evaluation. But here's what a drive by evaluation is. I drive by to my grantees office and I drive around the community. And I ask do you know anything about that program? Has anybody ever told you about eliminating health disparity initiative? Have you ever been to a health fair? Have they ever worked with you? And if they tell me no, that's my drive by evaluation, because I have already evaluated

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whether or not you are effective in your community.

In addition to our formula grants that were distributed to our community health force and they were for health screening and follow up. We gave money to our local community health board to do TB screening and et cetera. Remember this money did not go to the local public health entity. It went to the where? The community. And that legislation said that it had to go there. We had planning grants and we have implementation grants. We are now working this only implementation because this initiative is now three years old. We are hanging in there. We are going for the four, five annual and we are going back into the legislature to look for our money again so that we can get to 2010. We have 50 community grantees and we have 10 tribal grantees. We have now the total of 50 grantees because we are no longer doing planning. Those planning folks went right on into their initiative and moved into their work. We're still working in these areas. Now that was what we put out in docs [misspelled?], 3.9 million per year in state general fund monies and 2 million per year in [inaudible]. We started out with a biennial of \$13.9 million. We said if we're going to go work, let's go to work. We said you know there's nothing worse than somebody giving you just enough money to fail. And that's what you don't need. When you go back to your state legislatures and you think about this move ahead and do it

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right. Here's some of our grantees, our Indian Health Board, our North Suburban Group. These are the groups that we serve. We have staff support. We have nine staff working on this. Our staff, we have an Asian health community coordinator, African-born an African-American coordinator, an urban American Indian health coordinator, a tribal health coordinator and we have a Latino. So we are covering. We have steering committees who work with us to make this happen. But I want to end right here and I want to say a little bit about this research piece.

This is what we have formed in the state of Minnesota. And we call it the participatory research partnership. We told the University of Minnesota you know you've got a lot of smart people over. You know all about what to do. You've got all kind of research, but you're not going to do this by yourself. So we're all going to come to the table. And we found community groups that were researchers. The American Indian Policy Institute, John Puppard [misspelled?], we are working with Atoom [misspelled?] Afahere [misspelled?] who has the, her center that looks at all world cultures in health. And they do research. So all these researchers, community based researchers, the university, the states and the community came together. We do no evaluation, no research unless it comes through here. And we report back to our community.

Let me end by saying that one of the major pieces I

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would like for you to take a look at and understand.

Eliminating racial and ethnic health disparities is a human rights issue. It's a civil rights issue because in 1964 when the Civil Rights Act was passed it did not say you could not collect data on populations of color in America. You can collect that data because if you don't have data you know you can't tell anybody what's wrong. Collect the data. We know that it's a health issue. We also know that we have to give up focusing only on race because race becomes the issue. We can't get past it. We have to deal with the issue of racism that prevents us from doing it. And we have to be able to discover that everyone should have, must have good health. And finally, I'd like for you when you go back to your state or whether you're here looking at your web, looking at your computer on the internet, I want you to look up a new term. It's called syndemics. You know, I'm beginning to feel that syndemics, s y n d e m i c s. And syndemics is going to change the way we look at public health. You know why. Because syndemics; here's the definition. It says two or more afflictions interacting synergistically contributing to excess burden of disease in any given population, which says that disease is not just caused because you got sick. It's caused by the condition of your environment in terms of pollution, environmental health. It's caused by whether or not you've got a job. It's caused by whether or not you can get your grandmother to the

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doctor and get to work on time because you're no longer employed. It's caused whether you live in a rural where you are totally isolated. So that, that whole all of that impacts on disease.

So finally I want to just thank you for allowing me to come from Minnesota all this way to be with you. And to tell you that it is not an impossible task to begin eliminating racial and ethnic health disparities in your state. And I want to hear that you go back and do that and vote for the money. Thank you.

[APPLAUSE]

[Inaudible]

CURTIS RICHARDSON: Good morning. I am state representative Curtis Richardson. I represent the eighth district in the Florida House of Representatives and I'm completing my second term as a state representative and do not have a background in health. My background is actually in education. But this became a very important area for me for a number of reasons. One when I was elected to legislature I was first appointed as vice chairman of our Health Communities Council. And now I serve on the Health Appropriations Subcommittee of our full appropriations committee. I first want to thank NCSL for inviting me to be a part of such a distinguished panel. I feel inadequate being a part of the panel because they have such background and expertise. But I

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will share with you what we have done in Florida to address this issue.

We're just beginning to address the issue. And I think we have a moral imperative to address this issue in our state and across our nation because we have people, citizens of the United States of America the greatest country on the face of the earthy, the wealthiest nation on the face of the earth that are dying prematurely. And they're dying from preventable, from treatable illnesses. And we have a moral imperative to address that. We have a fiscal imperative to address it. We all know about the spiraling cost of healthcare in each of our individual states and across the nations. We're at the three trillion dollar mark nationally in terms of health spending in our country. And so we have a fiscal responsibility to address this issue as well. Medicaid spending in each of our individual states is increasing. In Florida Medicaid costs are just about 25% of our general revenue budget. And we're doing some drastic things to get a handle on that spending. We're cutting programs and services to some of the most needy in our state so we can contain the cost of Medicaid. And so we have lots of reasons why we should be looking into this year.

Florida as you all know is the fourth largest state in the country. We're growing rapidly. Our minority population is about 25% now including Hispanics and African-Americans. And that population is grown rapidly. By the year 2010, we will

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probably be about one third of the population in Florida.

We're getting more, enough students per year in our classrooms to fill an entire elementary school. Eight hundred to 1,000 new students are moving into the state each year, many of those from Latin American and the Caribbean, from Haiti and other areas around the world. And so we have a very diverse population in our state primarily in central and south Florida, in the Orlando and Miami-Dade county areas. And so this is a preeminent for us in the state of Florida. And we have done some things recently in the last few years to begin to address this issue. Particularly for me I represent a district that is inner-city; part of it is inner-city suburban. I represent the state capital, Tallahassee, part of it anyway. And so part of my district is an inner-city urban district and the other part is a very rural agriculturally based area that is predominantly African-American. Sixty percent of that county, Gaston [misspelled?] County, is African-American. It is the only majority African-American county in our state of the 67 counties that we have. The health condition, the health status of the individuals in that county probably compare to any third world nation in the world, probably compare to any third world nation in the world. It is a sick county. Our rate of Chlamydia for instance is seven times the state average. Unlike Minnesota, Gloria, we have the highest teenage pregnancy in that county in the nation per capita. It's a county of

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45,000 people. We have one of the highest rates of HIV and AIDS infection. You name it, whatever the statistic; Gaston County leads at least the Southeast if not the nation. And so I felt compelled to make sure as their representative that we did some things to begin to address the racial and ethnic health disparities that exist in the state of Florida.

Like Minnesota what we have done in 2000, the Florida legislature created and funded through the Patient Protection Act the racial and ethnic health disparities *Closing the Gap* at grant program. What this program provides for is funding for projects again within Florida communities. It did not go out to the public health system. It went to Florida communities and front porch Florida communities, hat's a designation from the governor's office, for additional funding to revitalize our inner-city and rural communities. What we don't have on the slide is also called for the creation of an advisory committee to be appointed by the Secretary of the Department of Health to advise him on issues related to racial and ethnic health disparities. That advisor group also is responsible for reviewing and approving the grants that are awarded to counties and to community-based organizations.

We've got a problem here.

Okay. The purpose is to improve health outcomes of Florida's racial and ethnic populations, to stimulate the development of community-based and neighborhood-based projects

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and to foster development of a coordinated and collaborative and broad-based participation by public and private entities and faith-based organizations. This program is housed in Department of Health of course. And I understand that I'm running out of time so I'm going to go through this fairly quickly. The objectives of course as our speakers before have said is to decrease racial and ethnic disparities and morbidity and mortality rates relating to those disease areas that you see there that are the ones usually addressed, the maternal and infant mortality rates, racial and ethnic disparities in oral healthcare. Through my initiative during this past legislative session we added oral healthcare as one of the disease areas that would qualify for these grant funds. Because what we found is that there is significant disparity in oral healthcare among minority populations and the general population and to increase immunization rates among children and adults. It was a data based approach not just by the county or a neighborhood. We actually identified areas by zip code where we had data available. This is Dade County, Miami-Dade County in south Florida and it shows the black cardiovascular death by zip codes. This is for Hispanics in that same area. This is the stroke mortality rates for white men, white women, non-white men and non-white, it should be non-white, women. And as you can see they're significantly much higher for non-whites. This is Brower [misspelled?] County again, which is in south

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Florida, cardiovascular deaths by zip code, mortality rates of breast cancer for white females, non-white females. These are mortality rates for the four cancers, colon-rectal, prostate, breast and cervical. Again we currently have 49 projects in 33 counties that are funded by the grant program. We got an additional \$1.2 million added to the program for additional funding this year. The first year that we implemented *Closing the Gap*, the legislature funded it at \$10 million.

Unfortunately because it was just getting started we weren't able to spend the full 10 million and so the legislature came back the next year and reduced it. So now we're at about \$5 million that we're spending in this program.

I'm just going to run through this. This is a methodology of awarding the grants. We do have a local match requirement in our grant program. So 50% local match and it can be any kind local match. It doesn't have to be cash. Counties, we have a number of rural counties in our state with populations less than 50,000. Their match can be 100% in kind. And you see how much since we started this program in 2000 how much the legislature has appropriated from general revenue funds. These are the areas where we have *Closing the Gap* grant programs existing. And these are two to three year grants. They're not the typical one year grants. These are awarded for two or three years. And these are some of the services.

I'm just going to run through this because you all have

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copies of this and I wanted to mention a few other things before I end. Okay, I'm just going to stop there. You have the rest of the presentation.

I want to mention some of the things that we accomplished during our last legislative session which just ended in May. We do have an Office of Minority Health which was not statutorily established. This year we established in statute our Office of Minority Health within the Department of Health. We also passed legislation requiring the Department of Health to fully implement the Healthy People 2010 program. We expanded a minority cancer prevention program called the Jessie Trise [misspelled?] Cancer Prevention Center. It was a pilot project in the Miami-Dade County area and we've now expanded that statewide. And finally we again established the Office of Minority Health and included oral health as one of the diseased areas to be funded through that program. So we're doing some things in Florida. We've got a long ways to go. Because the program is new we haven't gotten the evaluative data yet. But each of the grantees is required to have an evaluation component in their grant. And so we expect to see good things happening in Florida and will continue to press this issue in the legislature.

Thank you all very much.

[APPLAUSE]

SHIRLEY NATHAN: Now we are about ready to take

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questions and I just wanted to say that you have heard from this distinguished panel and as I said earlier that it's over 108 years of discussion on this topic of disparity in healthcare. With the window now open again, just open, due to the [inaudible] reports, we cannot let this window close without making a significant difference. Each of us in this room as policy makers, legislatures and whoever you are, you have a responsibility to address this American crisis. I thank you. If you want to see what we're doing in Maryland, we had our first statewide conference on June 8th. You can go to www.mdhealthdisparities.org and you can link you to all the things that we're in fact starting in our state.

Yes, may I take the first question?

RAY MILLER: My name is Ray Miller. I'm a member of the Senate in Ohio and sponsor of the legislation that established the first Office of Minority Health in the nation in 1987 and now I think we're up maybe 37 or so offices across the country. I'd like to commend all of the panelists and certainly as well as yourself in your excellent comments, appreciated everything you had to say. There are a few things that I'd like to add if I could just for everyone in attendance and particularly the legislatures to focus on. And number one I think there's a need to focus on racial disparities and race discrimination in addressing these issues, issues of health issues for people of color. It almost sounded like we needed

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to shift away from race. I think we need to deal with both. What happens in the legislature is when you say we don't need to talk about race then there are members who will repeat that and say well there's no need to address issues of race and therefore you won't get the resources that are being advocated.

Secondly on minority health offices, again, not speaking to the panelists but speaking necessarily to the legislators. On minority health offices I wouldn't want somebody to believe that well we created this office of minority health. And all problems related to African-Americans, Asians, Hispanics, Native Americans, etc., this office will take care of all of that. That's not the way we should look at our offices of minority health. They're much too small for that. So we've got to make sure that we're working with and holding the various departments accountable for what they should be, what they're supposed to do in health and in mental health and etcetera.

On benchmarking and quantifying, I think that's so critically important. If we identify today here's where we are, let's make sure that we do in fact benchmark and then we quantify our progress; quantify our progress, so critically important. And then I think we also need to talk about mental health and substance abuse as well. Only one thing from my brother from Florida, the 50% requirement seems to be a bit steep to me. And you can exclude people when you have that

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kind of 50% cash requirement.

SHIRLEY NATHAN: Thank you so very much. I know that Ohio has been the giant in leadership and please from now on, just get to the, I know he has a lot to say because he started this whole thing because I worked with Congressman Stokes when he worked with him in creating it in Ohio. But could you just be brief, to your point, because we are running short on time.

STEPHANIE DIKEMPER: Hi. My name is Stephanie Dikemper [misspelled?] and I'm representing Indiana Minority Health Coalition, which is the counterpart to our state Office of Minority Health; a community-based group statewide. I have a question for Dr. Jones. Dr. Jones, how do we address the issue of evidence-based medicine? Yesterday we heard a lot about evidence-based medicine and how that is affecting preferred drug lists and formularies. When, and my concern is that there isn't sufficient evidence on racial ethnic groups on the effectiveness of different medications. And if we're starting to see that around the state and legislatures are looking at adjusting PDL's based on some of those national recommendations how do we weigh in as communities of color on this issue?

LOVELL JONES: I think one of the things that people get confused with and let me address it in the representative's question. I think the issue is the way that I said we look at data. Because if you look at African-Americans or you look at Hispanic-Americans or you look at any other group as a solid

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group that's where problem has arisen. Because if you look at the history of the slave trade coming into the US. Africa is one of the most genetically diverse populations in the world. And so to assume that everyone responds the same way is making, and that's why you get data from one group that says one thing and data from another group that says another thing. And that's why I said we have to redefine how we look at this issue. And I think that's where the problem is coming up. In terms of having someone say yes, this group responds this way and this group responds a different way. Now there are groups in populations where that may be the case. For instance, as a group in terms of looking at Asian-Americans and it's starting to come out very well. If you go; if you look at pharmaceutical companies they probably have the best data of drug response of any group because they are in the business of avoiding suits. And so they try to get as much data as they can with regards to any group in terms of adverse reactions. And I would suggest that you would talk to personally; there are several individuals in the nation that look at ethnic form of kinetics. Jerome Wilson who used to be at Morehouse [misspelled?] has left Morehouse and I think he's now going to become part of the [inaudible] as one individual that does that. There is Julie Downs who's at Hopkins who at looks at ethnic form of kinetics. There are very few people who focus on that but if you want data with regards to that and look at

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that, those are the individuals I would suggest.

WANDA JONES: Good morning, Wanda Jones, deputy assistant secretary for health at the US Department of Health and Human Services. I'm from the federal government and I'm here to help.

[LAUGHTER]

I'm pleased to see Lovell here and our colleague Miss Lewis from the Minnesota Department of Health. I wanted to share with you all just a resource that will be available because I know many of us who don't work with data our eyes glaze over. How can we get it? What does it mean? Who's analyzing it? And how are they cutting it? State, women's and minority health coordinators and liaisons have alerted us to the need for simple, simple, simple data products that they can use. We have funded, my office has funded and we will be releasing this fall a data warehouse down to the county level by racial ethnic group, by sex, across the lifespan. We have about 1800 different indicators in this data warehouse and it will have a GIS tie-in. So you can look at border issues where you might share a problem with a state, clusters of counties across the borders at a number of different dimensions. And it is literally click, drag and drop. I can do it so be looking on www.forwomen.gov for this resource this year, sometime this fall. We'll have the beta test version out. We'll be sure NCSL knows about it and can send that out on the list serve or

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whatever. But we think this will be a great tool at the state and local levels to help folks understand data pictures without having the data capacity to do full analyses.

SHIRLEY NATHAN: Thank you very much. Can we have you last?

LOVELL JONES: But my word of caution to that. That data depends on your state and your funding of your registry. Because garbage in is garbage and you do not fund your registries adequately to get the data sufficiently to know where we are and where we're going. If you think that by getting national trends is going to help you, those national trends come from your databases.

SHIRLEY NATHAN: Thank you Dr. Jones. And I hope Maryland will hear that. There are a lot of us here.

TIM ALFER: Yes ma'am, I am Tim Alfer [misspelled?]. I am family physician from Mississippi. I am on behalf of American Academy of Family Physicians but I'm speaking as an individual. We a couple of years ago had an individual named Dr. Cartcourier [misspelled?] who moved to Issaquena [misspelled?] county in Mississippi where the data at that time was blatantly obvious. At that time Issaquena County exceeded even Gaston County in infant mortality rate. I think the infant mortality rate was in the high twenties. He went there with a missionary zeal and established a lay home visit program, literally got the community behind him. Almost, it was almost

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an army that he created to attack that problem. It's really too early to tell but it looks like the trend would indicate that he impacted that county along the lines of around three to five per now versus the 27, the 28 infant mortality that he originally faced. Meantime, he was sued three times and had no recourse, had to endure these law suits, was demoralized in a sense and moved to North Dakota as far away from Issaquena County as he could get. My point is that I think that even though Miss Lewis makes a good point that we need to put the money in those areas where the data is blatantly obvious, there is also a key ingredient. And that is to that if we're going to impact these areas you've got to be able to protect or provide a base especially when they have shown an intent to help the problem. And I think we ignore a major element in this whole discussion when we don't protect the provider base in those areas. Thank you.

GLORIA LEWIS: I'd just like to say, I don't know what the particular situation was in that county. But I still will say to you that protection of the provider base, yes it is important. I would wonder where was the community. I don't know what the suits were. I don't what occurred. But I am concerned that where was the public health entity at that time? Where was the support from the medical community at that time? And what was the response of the community? Mobilizing people to address their issues is key. And I agree with you that

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there needs to be support but I would not all steer away from communities being mobilized to assist themselves to bring that point through and to make those. Because we know when we do that in communities we do see results and numbers do go down.

SHIRLEY NATHAN: Thank you so very much. I have one final thing to show to you before we end.

And this is what Maryland did in an effort to educate her legislators.

[VIDEO BEGINS]

MALE SPEAKER: This is a very exciting day for us. That you are trying to come to the fact that we recognize that healthcare is the major concern for all of us, particularly those of us who live in heavy African-American districts when it comes to cardiovascular, diabetes and other issues. We believe that it's imperative that we as leaders step up front and make sure that our community is fully aware of the consequences of some of these types of diseases.

MALE SPEAKER: Absolutely a phenomenal vehicle for getting the word out to our legislators who in turn have to get the word out to our constituents of how important health and health screening, health issues are to our community.

FEMALE SPEAKER: My background is as a registered nurse and I've been practicing in this state for over 40 years. In practicing and walking, going into the various homes, I see the problem. I know the problem. I know the pain. I see the

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suffering and as a legislator I could not continue to sit on health and government operations and not continue to fight for this issue.

FEMALE SPEAKER: I mean there's a huge disparity all across Maryland in what various different groups and ethnic groups and their ability to access healthcare and to get adequate healthcare. This event really helps to sort of elevate that issue.

FEMALE SPEAKER: Health has to be your personal health and your personal commitment to your health has to be at the forefront of your life.

MALE SPEAKER: Now the important thing is as the tide raises all votes the disparity remains the same. What we have to do is identify creative ways of reaching those who are most in need and that's why this day is so very particularly important, because we are focusing in on the African-American community and other communities of color. And we are developing programs specifically designed to meet the socio-cultural needs of these communities.

MALE SPEAKER: What a pleasure it is to be in a room of solutions. The other area that we focus in on is access to affordable medications and not just affordable medication but affordable, innovative medications. And we talk about this all the time but what can we do as a corporation? We can't do anything unless we do it in partnership with the community, the

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legislators, and the medical profession to get out there and do this.

MALE SPEAKER: We are with Senator Paula Hollinger, the only nurse in the Senate. Tell us what the importance of today's event is.

PAULA HOLLINGER: Well the importance of today's event number one is to put emphasis on the fact that there is disparity.

FEMALE SPEAKER: When I came in this morning I didn't realize my blood pressure was this high, which is 160 over 95.

MALE SPEAKER: Wow.

FEMALE SPEAKER: Which is terribly high. This is over my highest of a lot of things. I have to take better care of myself and to encourage others to take care of themselves.

FEMALE SPEAKER: Well, I came to get my cholesterol checked because I want to ride her about it. I'm very conscious about health and exercise and doing all the right things just because I think it's important to take care of one's body. And I think it's one of the best commitments an individual can make in changing our lifestyle and changing the community's lifestyle because many people will follow the model if we model good healthy behavior.

FEMALE SPEAKER: It's very important for us to understand all the health issues and screening is something that is sometimes delayed to our detriment. So this is really

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wonderful. Thank you for having it.

FEMALE SPEAKER: This is an important day. I think we need to have more days like this to remind people of the disparities in health.

MALE SPEAKER: It has been a wonderful day and we're delighted that all of our participants here. This is very educational to not only us as legislators but to our staff as well.

FEMALE SPEAKER: And so the bill really speaks to cultural competence, cultural sensitivity, and health literacy which is costing us billions of dollars. Because if the patient does not understand, does not read at the same level where the instruction is given, it is very difficult for them to follow and to take care of themselves.

FEMALE SPEAKER: Thank you very much and I'm sure that the Maryland Black Caucus Foundation will really and truly do everything they can to find a bright fellow to be able to carry out the work. Thank you very much.

FEMALE SPEAKER: You're welcome.

FEMALE SPEAKER: Thank you.

FEMALE SPEAKER: This event really exceeded my wildest expectations. Taking legislators to the doctor had lots of legislators is here. Over two-thirds signed up and we had an incredible crowd and their staff. So many people showed up with their pedometers. They were really into it. And so much

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energy in the room, really exciting, great day and we're going
to see you again next year.

[MUSIC BEGINS]

[END RECORDING]