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**Partnerships to Achieve Health Equity
Plenary Session II: Social Determinants of Health:
The Role of Policy, Organization, and Social Structure
in Achieving Health Equity
Society for Public Health Education
November 1, 2007**

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MALE SPEAKER: Hello, everybody. Thank you for coming to this last afternoon session, plenary session on social determinants of health, the role of policy, organization, and social structure in achieving health equity. If you were at the morning plenary or the keynote address by Doctor Satcher, you would have been heard or be reminded of the two lofty goal of Healthy People 2010 addressing issue of quality and addressing issue of eliminating disparities in health. We are very fortunate to have two distinguished speakers this afternoon who spent their life addressing these two areas, each looking at it from one of the perspective of one of the goal, Doctor Carolyn Clancy, who'll be joining us momentarily, and Doctor David Hayes-Bautista. I would like to introduce Doctor Bautista and he will give us his presentation and then I will, of course, introduce Doctor Clancy when she gets here. I should- She is here. [Laughter]

I should point out that the work of these two great minds is one that's really central to the mission and vision of SOPHE as you would have heard this morning presentation and subsequent breakout session. The issue of how to-we talked about how disparity in the context of this country and, of course, from what Doctor Satcher shared with us, that on a global level we are looking at issue of equity, hence the theme of this year's conference. So, what I'd like to do is

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introduce our first speaker and after his presentation we'll get to our second speaker and I will introduce her at that time.

Doctor David Hayes-Bautista is a professor of medicine and health services and the founding Director of the Center for the Study of Latino Health and Culture in the division of the General Internal Medicine and Health Services Research at the David Geffen School of Medicine at UCLA. In his research, he employs both qualitative and quantitative methods to study the dynamics and process of the health of the Latino population. He is the author of several publications, *The Burden of Support: Youth Latinos in an Aging Society*, *No Longer a Minority: Latino Social Participation in California*, *Healing Latinos: Phantasia Y Realidad*, and most recently, *La Nueva California: Latinos in the Golden State*. Ladies and gentlemen, you join me assuring Mark that we tried to get Doctor Bautista here in 2005 at the inaugural summit on health disparity and because he couldn't make it at that time, we did promise that the next time we were meeting at this hotel, we would have him come here since we met here for that summit. Doctor Bautista.
[Applause]

DAVID HAYES-BAUTISTA, PH.D.: Thank you. And I guess I'll stay at this hotel until the next presentation.

[Laughter] Now, let's see if I can get my presentation up on the screen, please? We've got a little technical thing here.

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Coming up. You know, we always have these little glitches. Well, the screen here is fine, but these folks out here can't see this little itty-bitty screen. Let's see, we're not on the big screens yet. Everything was working perfectly in practice. Hmm.

Well, we can always— You know, in the old days we did this without Power Points. [Laughter] So, let me just start and I'll just catch up with the slides when the slides get on the screen. Well, here it is. Always the promise, okay.

MALE SPEAKER 2: Getting close?

DAVID HAYES-BAUTISTA, PH.D.: We've got something up there. Well, as I said before, we used to do this before Power Point, so this is not an issue, although it would be easier if I had a blackboard. Oh, no wonder! It's called the plug. [Laughter] Do you have to reboot? Okay, alright, okay! [Applause] [Moans] Hold your applause, hold your applause! [Laughter] Okay.

Well, I'm proud to say I'm a faculty member of the only campus of the University of California founded by a Latino— UCLA! [Applause] Founded by Reginaldo Francisco del Valle, who, by the way, was a first generation of Chicanos. He was born in 1854 after California had become a part of the U.S. So, he was born a U.S. citizen of Spanish speaking parents. Now, you couldn't call them immigrants if they'd been living there for 100 years and the U.S. kind of crossed them.

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[Laughter] But, he was bilingual, bicultural and he founded, in 1881, the Institution that grew up and became UCLA. So, I'm proud to say, I'm part of that. Unfortunately, he has been dropped from UCLA history. There was a Mexican at the bottom of this. But, there are Mexicans all over.

I'm sure you remember reading about three or four years ago how about over half the babies born in California are Latinos. My Center did that report. Every year we get the master birth file and we crunch the numbers. So, we got the birth file for 2001, in 2003 crunched the numbers and lo' and behold, beginning the third quarter of 2001—in fact, the first day that this happened was July 4th, 2001—over 50-percent of the babies born in California have been Latino. Now, that's been continuing. Texas crossed that line last year. New Mexico is way ahead. In the Southwest we're seeing the return of Latino majorities. That's just a demographic fact.

The question is what does this mean for medical education? Do we have to teach students interested in the health professions anything different? What about for medical research? Do we have to research things differently? And how about delivery? Can we just go on doing everything we've done before or do we need to do things differently? These are pretty big questions.

Well, in the area of medical education, the answers haven't been exactly resounding. I mean, there's somewhat of

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an awareness we need to deal with diversity, so we've been doing different things. As you can see here from some of the medical schools try to offer courses in literature and other and fine arts. And, then we have a colleague at the University of Arizona that takes his first year medical students out and gives them horseback riding lessons. Yes, they learn how to ride horses as part of their first year medical curriculum. Why do they do that? Well, I guess the idea is if you can communicate with a horse, certainly you can talk to an irate patient. [Laughter]

Well, a couple years ago the *Chronicle of Higher Education* sent a reporter out to look at these efforts in medical education on cultural competence. And, the first place he went to was the University of Arizona. And, the first thing he looked at were these medical students taking horseback riding classes. And, then he went and looked at some others. He went back and wrote his article and you can tell by the headline, he did not like what he saw— "*Horse Sense or Nonsense?* Critics decry what they consider the softening of medical education."

Who was the critic? Of course, it was the reporter. And, he came to the conclusion all this cultural competence stuff are simply distractions that produce warm and fuzzy doctors who are ill informed about human biology and disease. And, has basically been there, done that, yes, stop it.

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At the same time, some of you might remember, the Task Force on Community Preventive Services were doing their analysis. They wanted to find out, does providing culturally competent health services have any affect on the outcome? And so, they were doing a macro study, trying to put their samples together. So, they got all the literature, all the articles they could find on cultural competence, health care delivery, and outcome. And, they started off with about 1,000 articles. By the time they through out all the op-eds, and the letter to the editor, and the stuff that didn't have any data, when they got right down to it, they couldn't find one single scientific article that said anything about the relationship between culturally competent services and medical outcomes. They came, somewhat sadly, to the conclusion that a research base on program effectiveness of cultural competency that would allow informed decision making is lacking. Hmmm.

Okay. So, here's the situation. To begin with, there aren't many programs on cultural competence. And, you better believe they don't get a lot of support from the schools and they have to pull in their own money. Then on top of that, there's no evidence they make any difference. So, I was sitting in my office about three years ago one morning and the phone rang. So, I picked it up. It was the editor of the *American Journal of Preventive Medicine*. He said, "Boy, did you see that article in the *Chronicle of Higher Education*?"

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Yes, pretty bad.

"And, you saw what happened to the Task Force of Community Preventive Services?"

Yes, that's pretty bad.

"Well," he said, "why, how would you like to write an article defending the role of cultural competence in medical education?"

Great! So, what do I do? Say, okay, let's give up, folks, there's no evidence. But we had just published a report over 50-percent of the babies born in California were Latino. If you add in African American, and Asian, American Indian, over 70-percent of the babies born in the great state of California are what we used to call minority. Only when it's 70-percent, this is not a minority, is it? It's the norm. And we know very little about what drives the norm. So, I said, sure, I'd love to! Boy, we really need to do this. So, I wrote my piece. It was called "Research on Culturally Competent Health Care Systems." Ah, but the subtitle, "Less Sensitivity, More Statistics." I'm a nerd. Okay? Let's get some numbers into this debate. And here's what I suggested that we ought to do.

First, I suggest we probably needed to redefine cultural competency. That we needed to kind of move up from just the sensitivity aspects alone. I'm sure riding a horse makes us all better people. I like horses. Okay? It makes us all better people, but is that where you want to start the

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argument about cultural competency? Maybe you want to move up from that. Instead, let's look at the relationship between culture, behavior, and health outcomes. That has a lot to do with culture. And, in order to do this, I somewhat modestly suggested, all we have to do is simply reconceptualize the major theoretical model that drives most of our research. That's all. And, that is the minority health disparity model.

Now, I took this definition right off the web page of the Office of Research on Minority Health. I'm sure it's pretty familiar. African American, American Indian, Alaska Native, Asian, and Pacific Islander, and Hispanic citizens suffer poor health and higher rates of premature death than the majority of population. I'm sure you've heard this before. Right? Okay, it's an old epidemiological model. It's based on the risk factor model. If you're going to compare the health of two populations, let's just call them Population A and Population B. And, Population B has higher risk factors, usually operationalizes lower income, lower education, less access to care. Then Population B is going to exhibit higher incidence of adverse health outcomes, higher rates of mortality, higher infant mortality, shorter life expectancy, et cetera, et cetera, et cetera. Familiar, right? I mean, we should be able to recite this in our sleep.

Now, as I looked at a case in the Southwest, we know that Latinos—actually, it's probably true everywhere in the

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country, except Miami—can be characterized as having far lower income compared to non-Latinos, lower education, far less access to care. Don't even get me started on the Latino physician shortage—you're not going to get out of here until Sunday. Okay, so, here's a population that has all the risk factors that we generally assume are highly correlated with bad health outcomes. I was taught this when I was a student at UCSF. Well, is it true?

Well, let's look at some data. I'm a data junky. Okay. Here we have the top ten causes of death in the U.S. Number 1 cause of death is heart disease, number 2 is cancer, number 3 is stroke for 2004. Likewise in California, the number 1 cause of death is heart disease, number 2 is cancer, actually stroke for us is number 5. We've got bad air, so we've got all this respiratory stuff in between. You know, have you ever been in smog in LA in August? Let me tell you, it's pretty bad.

Well, let's look at the number 1 cause of death, which is heart disease. Now, according to this model, the group that has the worst risk factors—lowest education, least income, least access to care—should have the higher age adjusted mortality rate for heart disease. Correct? Now, I'm a researcher and in research a theoretical model has to have predictive power. If you put these inputs in, you must get these outputs—not once in a while, not occasionally, almost

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every single time. So, from this model we would project that Latinos should have a much higher age adjusted heart mortality rate compared to non-Hispanic whites. Correct?

Okay, let's look at the data. The age adjusted rate for non-Latino whites is 217.5 deaths/100,000. For Latinos, it's 160.8. 34-percent lower. Whoa! How did they manage that? Well, maybe California's just kind of weird. Maybe 2004 was weird. Well, here we have some longitudinal data from 1999 to 2004. This is the non-Hispanic white rate. This is the Latino rate. Very consistently about 35-percent lower. If we look at the national picture in all 44 million Latinos in the U.S., we see pretty much the same picture. As we look at Arizona, New Mexico, Texas, Illinois, Florida, New York, New Jersey, everywhere you have a sizable enough Latino population and you compare it to the local non-Hispanic white, this is pretty much what you see. Latino heart disease rate is about 30 to 35-percent lower. How do they manage that? Is it the beans? [Laughter] Is it the tortilla? Hmmm. Interesting.

Well, this has a title now, in the literature. It's called the Latino Epidemiological Paradox. Now, what's a paradox? It's a Greek word. It's something that shouldn't be. Now, according to the model, Latinos should have much higher mortality than non-Hispanic whites. How come they have much lower? Well, we don't understand it, so we're going to call it a paradox. Okay? And, so you're going to tell me that 50-

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percent of the babies in California have an infant mortality profile that's a paradox? When I was taking stats, we used to call that the norm. This is the norm. And we're calling it a paradox?!

Okay. Let's look at the number 2 cause of death—cancer. Non-Hispanic white rate is 181.0. Latino rate is 120.2. 40-percent lower! Likewise at the national level. Hmmm. Remember that model that we were taught that minority health disparity, minorities always have worse health.

Okay. Let's look at number 3—stroke. Well, here the Latino rate is only 15-percent lower than non-Hispanic white. But, I think we're starting to pick up a pattern here. That, in fact, as those babies grow up, we have to wonder what effect will they have on an area's health. We can get a foretaste of that by looking at CDC's Atlas of Stroke Mortality. They mapped out stroke county by county, not by ethnicity. And, of course, the way you read this chart is the lighter colored counties have lower stroke mortality. The darker colored have higher. Well, you notice those counties that tend to have a lot of Latinos, like Southern California, Arizona, New Mexico, South Texas, Southeast Florida, Mid-east Cook County, New York, New Jersey, have really light colors. It's because you've got a lot of Latinos and they lower stroke mortality.

Whereas, the places that don't have a lot of Latinos like the Northwest, the Mississippi valley, the Appalachian

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seaboard, the stroke rate is higher. So, the lesson from this— As you get more Latinos in a population, in the aggregate, the stroke rate goes down. Also, in the aggregate, the cancer rate goes down. And, in the aggregate, the heart mortality rate goes down. Now, when's the last time you ever heard that having more diversity is going to do something good for your health? [Laughter]

Well, let's look at the numbers. In fact, as you know, that whole corridor, Mississippi corridor, from the Great Lakes to the Gulf of Mexico is called "heart attack alley." And, a lot of it has to do with culture. And, food. And, behavior. And, of course, if you've ever eaten there, about everything is deep fried. I had deep fried ice cream once there. Okay.

Let's look at all causes of death. And, in California the funeral rate is about 30-percent lower. Now, in the top ten cause of death there's one cause for which Latinos do have a higher rate and that's diabetes. But, that's the number 7 cause of death. It's a far rarer occurrence than heart, cancer, stroke, and everything else, but it is an area of concern. And, as we look nationally, we see pretty much the same situation. The overall Latino age adjusted death rate, all causes, about 30-percent lower.

So, we've been looking at death. Let's go to the other end. Let's look at birth. Remember over 50-percent of the births are Latino. Here we have 34 years of infant mortality

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in California, from 1970 to 2004. This is the non-Hispanic white infant mortality rate. Now, Latina moms have lower education, less income, they get less prenatal care, they initiate it later in the pregnancy. What does this do to the infant mortality? Well, what would the model have us believe? It should be quite elevated. What we see in the data is that it's virtually identical to non-Hispanic white. Even though Latina moms and non-Hispanic white moms live worlds apart in terms of these risk factors—income, education, access to care. How do these moms do it?

So, the infant mortality in California is getting better and better and better. But, it's not because we're doing anything. It's because you've got more and more Latinos giving birth. They just make the state look good.

So, here we have, in summary, the Latino Epidemiological Paradox. About 34-percent heart mortality, about 43-percent lower cancer mortality, 30-percent lower stroke, identical infant mortality. And it's not because Latinos have great income, education, or access to care. So, they're doing something. But, what is it? That's why I call this a "bio cultural model." We've got to look at culture. Because you have these other structural things—cruddy schools, poorly paid jobs, lack of benefits—and yet Latinos are bringing something to the table that can kind of hold those off at bay for a while. As it turns out, Latinos tend to be healthier

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while also illustrating a services utilization paradox.

Latinos use services a lot less. Whether children, adolescents, or adults, Latinos average 1 fewer doctor visit less per year compared to non-Hispanic white. Generate half the number of hospital bed days. Hmm. Interesting.

Well, normally, as we look at what we spend, you know, in this country we spend more on health care services than any other industrialized country. We spend about twice as much, however you want to compute it. You know, per capita, percent GDP, you name it. And, of course, when we're compared internationally, the U.S. ranks down towards the bottom. And usually, way out in front are Japan and Sweden. And, the U.N. just did its report a little while back, they discovered that Japanese have the longest life expectancy. But, we've discovered a group that has an even longer life expectancy than Japanese in Japan. Latinos in California have a 3 year longer life expectancy than Japanese in Japan. This is for women, you see the same thing for men. Yes. So, hey, diversity might actually be of some benefit if we can figure out what the heck they're doing. Okay.

So, for me, the real goal of cultural competence in medical research and education is this. In any given year, on average, about 68,000 Californians are going to die of heart disease. About 51,000 will die of cancer. About 17,000 are going to die of stroke. Just of these top one, two, three

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causes of death, every year about 136,000 people in California die every single year. As a result, ever since I got into this business, we've been trying to find The Cure for cancer, The Cure for heart disease, and we have invested a lot in this human genomics project and Henry would know. How many billions? We've put over two billion into this right now, approximately, something like that. And how many therapeutics have we gotten out of it? Mmmm, a few. And, by the way, could you access those if you have anything less than absolutely gold plated health insurance? Probably not.

So, we've invested a lot and getting something, but not a whole bunch of folks are going to be able to benefit from it just yet. So, I tell my colleagues, well, gee, you know, I'd like to look at some situation whereby we could reduce the risk of heart disease by 34-percent. They said, "Really, you can do that?"

I think so. And I bet we could reduce the risk for cancer mortality by 43-percent.

"Really?"

And we can reduce the risk for stroke by 24-percent.

"Wow! What is it?" [Laughter]

I don't know, but something this kid is doing when he goes home at night and has dinner with his family is reducing his risk for heart disease by 34-percent. Don't you think we might want to try to figure out what it is?

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"Oh, but they're just a bunch of Mexicans."

Sorry. Then, if you don't want to live five years longer, you can take that attitude. But, I would like to live five years longer. Actually, I'm going to do it. I'm Latino. [Laughter] I want to share this. I'd like to share this.

But it's culture that has to be factored in. Yes, we need to talk about education, income, benefits, et cetera. We also need to put culture on the table. I think we have a good example of the wonderful strengths we can find in culture. And, also, as we're talking about prevention, this is one of the biggest threats to Latino health is cultural assimilation. And, assimilation is what happens when immigrant parents have U.S. born kids, just as Reginaldo Francisco del Valle was U.S. born. If we look at kids, or Latino families in LA County, 88-percent of Latino children, 14 and under are U.S. born. I know there's all this talk about undocumented kids crowding up the school. Let me tell you, there aren't that many undocumented kids. They're all solid U.S. born. Yes, their parents tend to be immigrant.

So,—whoa, I just did something I didn't want to do there. I'll get rid of that. There we go.

Let's look at what happens to the U.S. born children. And, here we're going to look at three different Latino groups—Mexican, Puerto Rican, and Cuban. This is from the old Hispanic Haynes, but it was the best, most complete,

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comprehensive, thorough data set you're going to get on this. And, if you look at drug use, this happens to be marijuana, these are the U.S. born Cuban Americans, Puerto Ricans, Mexican Americans, and these are the immigrants. You notice how immigrants use far less, their U.S. born are using drugs a lot more. And, if we look at this by language, interestingly, those who are English dominant use drugs the most, those who are bilingual use it less, and those who are Spanish dominant use it the least. So, as we look at U.S. born Latinos, they tend to smoke more, use drugs more.

Here we have, this is for teen to moms. These are data right from the birth certificate. U.S. born Latinos are about 5 times as likely as immigrant to smoke. Now, they're both a lot less likely than non-Hispanic white, but this is not something you would want to emulate. Wouldn't you want the non-Hispanic whites to look like immigrant moms? They'd have to learn how to make tortillas then. But, for being pregnant, having low smoking rates is very good.

U.S. born Latinos have more sexually transmitted diseases. We can see here U.S. born Latina moms, here are immigrant moms. U.S. born about twice as likely to have a sexually transmitted disease. U.S. born are less likely to be married when they give birth, whereas immigrants are most likely to be married. And, U.S. born do drugs more. And we saw that earlier with the H. Haynes and we have from the birth.

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I mean, 0.04 of 1-percent of Latina immigrant moms that gave birth used drugs. I think it's like 3 cases in the entire state. Whereas, U.S. born were getting right up there with their U.S. born non-Hispanic white counterparts.

Even though the U.S. born have higher income and higher education, now by all the models I was taught, well if they have better income, better education, better access to care, they should be in better health, but we need to take culture into account. They're losing something in the culture that that loss doesn't correspond with any gains they're getting from better income and better education.

In fact, if I'm doing a 30 second risk assessment, if I have a bunch of Latinos, who's going to be at risk for poor health outcomes, I don't care if they didn't even graduate from high school. I don't care if they're earning minimum wage. I don't care—what? I do care, but in terms of the risk, that's not what drives it. It's the U.S. born Latino who does not speak Spanish, is at greatest risk. Particularly if they didn't go onto college. That is the group that you see on television every night, you know, with the tattoos, drug use, gang violence, you name it. If they went to college, they don't behave like that. But, it's those don't speak Spanish that are at greater risk.

Now, I could take these kids and I could teach them to speak Spanish. Okay? So, they could conjugate a verb. That's

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probably not going to change their behavior. I think, and this is now, I'm speculating a little bit—that those who speak Spanish get messages from their parents and grandparents every single day. Indirectas [misspelled?] they're called, indirect messages that they pick up and it guides their behavior. Whereas, those who don't understand Spanish don't get those messages. Just teaching them Spanish doesn't give them messages. Maybe we can figure out what those messages are and get it to them.

So, for Latinos culture, behavior and health are a major social determinant that we need to keep on the table. Ideally, I think we have to figure out what this is so that we can share the Latino Epidemiological Paradox.

Let me just leave you with this thought. If everybody in California had the same epidemiological profile as Latinos for heart, cancer, and stroke, we could save 23,000 from dying of heart disease. We could save 22,000 people from dying of cancer, 4,000 from dying of stroke. We could save 49,000 lives every single year and not have to build a whole bunch of new hospitals or invest in new human genomics or whatever else. So, my reply to the *Chronicle of Higher Education*, to begin with we need more research on cultural competence, not less. I mean, they were saying, "Been there, done that, forget it. Unh, unh." We aren't finished. In fact, we have barely, barely begun. And we need to build on the fact that in

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California medical services have been provided in Spanish every single day for 238 years. There's something we can learn from that. So, that rather than saying that the growing Latino population's going to be a real drag to the nation's health, maybe we ought to consider maybe being Latino is really the 21st Century way to be healthy Americans.

Thank you very much. [Applause]

MALE SPEAKER: Thank you, Doctor David Hayes-Bautista for challenging us to examine this privilege location from which you have examined this issue. Being able to challenge assumption that inform the way we do research and we think about policy. And, I ask you to note any question or comment you may have and we'll take those at the end of Doctor Clancy's presentation.

Our next speaker is not new to SOPHE. At least, not in the product of her continuous, tireless labor. And, when we met at this hotel two years ago for the Disparity Summit, we identified three documents that we felt everyone should read. One was referred to this morning by Doctor Satcher, an IRM [misspelled?] report on—I'm blank now, that report now—one of the IRM reports. The second one was Missing Persons that came out of Sullivan's report. And the third one, of course, was the 2005 National Health Care Disparity Report. So, again, thinking back to Healthy People 2010, the work that our two speakers do cut across the two goals, quality and eliminating

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health disparity. And, I think, no one has spent more time addressing the area of quality more than Doctor Clancy. She is the Director for the Agency for Healthcare Research and Quality, has been in this position for four years. She served as Acting Director and Director of the Agency's Center for Outcome and Effectiveness Research before assuming the position of Director. She's a general Internist and her service is researcher. Is a graduate of Boston College and UMASS Medical School. She holds an academic appointment at George Washington University School of Medicine clinical associate professor in the Department of Medicine. And, serves as Senior Associate Editor in *Health Services Research*. Her major research interests include various dimensions of health care quality in patients, including women's health, access to care services, and the impact of financial incentives on physician decision.

Ladies and gentlemen, join me in welcoming Doctor Carolyn Clancy. [Applause]

CAROLYN CLANCY, M.D.: Now, I need to bring this up here. Whoa, two of these. Good afternoon, everyone. Once again, the PowerPoint paused, but we're trying to handle it gracefully.

I am really pleased to be here. You know, about 10 or 12 years ago, I had the privilege of running for the executive board of APHA. I shouldn't have been doing this at all. I had actually no idea what was involved. I didn't know you actually

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needed a campaign. So, what I did was to actually tag along behind someone who did have a campaign. That's how I did it. But, what I learned at the time was just what an amazing force public health educators are in that organization. You know, you go around and you visit every little section and interest group and they're pretty small.

Medical care is an okay crowd. I tended to know some of those people. Then you get to the public health educators and it's like a mini convention. But, when I look out at some of the challenges facing our populations, I realize that you need to actually clone yourselves, because this is exactly what we need in health and health care if we're going to live up to our potential.

Let me also just acknowledge a true confession as well—you can shoot me later—that evidence report on cultural competence, we funded it. So, my take on it was not that we don't know it works, but that we had an awful lot of small studies. And, I'll tell you that the woman who presented this at a national meeting was shaking like a leaf when she did it because she was presenting it to a group of people who believed passionately that this is important. And, I think she thought they would, you know, as a group, rise up and mob the stage and, you know, throw her off in some fashion. They were very respectful, but what we had were a lot of very small studies that used very different approaches to thinking about cultural

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competence and, also, very different strategies for accessing the outcomes.

So, I would say that the jury's out, in terms of what we're doing now, and we shouldn't let beliefs get in our way, but we should actually address a lot of the issues that Doctor Hayes-Bautista talked about. And, we've had the real privilege of having him advise the agency in the past as a member of our advisory council.

So, what I want to talk about is disparities more in health care today, although I do see a critical need to link what we think of as social determinants of health, or disparities in health overall, with what goes on inside the health care system. And, right now, we are actually sponsoring a round table at the institute of medicine to try to bring those two communities of folks together. It sounds pretty easy. Oh, you guys should talk to you. In real life, it doesn't happen all that much but I think we're starting to make progress. I'm then going to talk about some opportunities and tools for addressing disparities and what we can do together moving forward.

So, quality of care. Everyone in this room wants high quality care. When you get health care, you want it for your parents, your loved ones, friends, and so forth. That's a given. So, what do we mean? Well, it's the right care for the right patient at the right time. Now, those of you who are

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devotees of *Time* magazine may remember the picture shown there. This is a picture of a doctor as a patient. And, there was a big cover story about doctors as patients who found out that, although when they're ambulatory and walking around the hospital and the clinic in their white coats, they're in charge and in full control, that when they put on one of those hospital gowns, they're just like all the rest of us. And, some of the stories were pretty amazing.

So, we have big quality challenges facing our country. The Institute of Medicine, over the past seven to eight years has done us the enormous service of defining, what are the properties of quality? Quality is a kind of vague term. It's vague enough that, when I bring it up to my family, they look at me like, there she goes again, please, not now. And, my husband keeps telling me, I don't want you to ask me, what does the person on the street think about quality? But, what the Institute of Medicine was very clear about was that, we're talking about care that's safe, that's timely, that's effective—that is, we bring the best science to bear for every person in a way that meets their needs and preferences—that's sufficient, that's patient centered, and that's equitable.

And, what I've been very impressed by is, a lot of employers and people who invest a lot of money in health care for their employees and so forth, are almost banging the table now, saying they want the IOM6. This is not the moment to ask

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them, do you know what the IOM6 are? It doesn't matter. What matters is that there's a growing recognition that an authoritative group has defined what we mean by quality. We know how to measure it and we're getting smarter about making it better.

So, AHRQ's mission is to improve the quality, safety, efficiency, and effectiveness of health care for all Americans. Now, we're a relatively small research agency as compared with the NIH for example. Our annual budget is in about \$320 million until such time as we get an appropriation for this fiscal year. And, that's likely to be a continuing evolving story for a little while now. And, we spend about \$2 trillion in health care. So, you can either look at this mission and think that we're ambitious, or maybe even psychotic. I like to think that we're right at that fine line between the two. But, the point is, if we're not producing information that's useful to you, and useful to people who are working with patients in a variety of ways every day, then, we can't possibly fulfill this mission.

So, starting in 2003, we've had the privilege of submitting to the congress every year, twin reports: one on quality of care and one on disparities in care. And, just by way of a brief story, these reports were mandated in our reauthorizing legislation in late 1999. And, the idea of a quality report had been kind of kicking around for a while.

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And, the idea was sort of like, well, we have leading health economic indicators, shouldn't we do something like that for quality of care to know what we're doing. And, that seemed pretty reasonable, so we weren't surprised by that.

But, 1999 was also the year of really a ground breaking study done by researchers at Georgetown. And, what they showed, was that disparities in health, which are sadly a very old story. But, when I was training, I think there was a common belief that all of that occurred outside the health care system. Once people came to our door, we treated everybody the same. And then, Kevin Shulman and his colleagues did a very clever study. They got actors to portray patients. And, I have to tell you—and they made videos—and, they were able to control all the things in real life that you can't control. So, the actors used all the same words, the same inflections to describe their chest pain. And, they found that doctors who saw these videos, were substantially and significantly less likely to recommend evidence based treatment for older African American women. Well, you know what, everyone can understand what that means. Right? Exactly the same symptoms, same background, socioeconomic status and so forth, and they voted differently. Said they would make different recommendations. This was a big fire storm, to put it mildly, and we believe that that's what really inspired the disparities report.

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Now, no matter how you look at quality of care in this country, there's always two findings in every study where there's information on patient demographics. The first finding is, we are doing badly! Okay? So, the Rand Corporation finds that, on average, Americans receive recommended care 55-percent of the time. For kids, it's actually a little worse. It's about 46-percent, published very recently. And, it doesn't matter where you live. So, those of you who think your denial is intact, this is really sad, but I know where to get good care, I just want to make you aware that it's pervasive. It's a real problem. So, a big gap between best possible and actual care and that gap is larger still for people who are members of racial or ethnic minorities, are poor, or not well educated. It fits David's epidemiologic model very, very well. So, how we do these reports is, we've got a set of about 211 quality measures. And, in the quality report, we compare by states or we have information and so forth and the disparities report, we put that out by different population groups. It looks like consumer reports. And, you can see how each group is doing for every single measure compared to the reference population and you can see whether they're doing the same, worse, or better.

Now, what's great about this is, after all these studies and the Institute of Medicine report that I know Doctor Satcher referenced, what we had as a result of a huge array of studies, many of which were funded by our agency, was a lot of

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snapshots. What the disparities report gives us is a way to systematically track our progress over time. In addition, the disparities report also has a lot of different types of measures of access to care.

So, the disparities report actually gives us the capacity to see how we're doing over time. And, we can see for each group, where we're doing better, where things are pretty stagnant, and where things are actually getting worse. And, that gives us a map to move forward, which, I think, is very important. It isn't the same thing as solving a problem, but it's a critical input to focusing and prioritizing our efforts.

So, we know that these disparities are pervasive, And again, it doesn't matter where you live. The specifics are going to be quite different. Now, Henry and I have been part of a Latino health initiative in Montgomery County in Maryland. And, the challenges facing Montgomery County, because we've seen a tremendous increase in the Latino population, mostly as a result of recent immigration from Central and South America. But, those challenges are very different than many of the parts of southern California. Right? Different backgrounds, different cultural patterns, certainly different assets to work with locally. So, many of the solutions have to be local. But, what's stunning about this report is, again, it doesn't matter where you live. We've got pretty big challenges in front of us.

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So, we know that there are disparities and gaps in all dimensions of quality, in all dimensions of access, in many levels and types of care, and from many clinical conditions, and within many subpopulations. We also know from this report that there are some subpopulations for whom we simply don't have enough data. But, I actually think it's a service to say, we can't say anything here, so the people have a sense of those groups for whom we don't have enough data to make a reliable statement.

So, what do we know? We know that, for quality of care over all for everyone, we're seeing improvements. Now, if you believe the 55-percent is our baseline, right, 3.1-percent is nothing to sneeze at. Now, a policymaker or someone paying for care might say, but wait a minute Doctor Clancy, every year costs go up 8-percent. I think that's kind of a little disconnect, don't you? And, I would agree. But, nonetheless, we're seeing steady progress moving forward. And, we see bigger increases where there's public reporting. So, for all those quality report cards you see, they're actually a good thing because they focus people's attention.

But, we also see, particularly in last year's report, that we're really missing huge opportunities for prevention. So, just over half of adults reported receiving recommended colorectal cancer screenings. You know the worst part about this is, this is a dramatic improvement from just a few years

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ago. So, we're headed in the right direction. We still have a long way to go.

About 58-percent of obese adults were given advice about exercise from their doctor. And, just under half of adults with diabetes receive all their recommended screenings. We're not talking high-tech stuff, genomic interventions, or anything like that. This is pretty basic. We know what to do. It's just not happening.

If you look at minority populations on the other hand, obese African Americans are less likely to have this issue brought up by a clinician that whites are. Colorectal cancer screening rates are significantly lower for blacks and Asians. And, among people 65 and older, blacks, Hispanics, and those in lower income groups were less likely to have ever received a vaccine to prevent pneumonia. This is a really easy thing. You get it once. And, do you know how many avoidable hospitalizations and deaths we can reap with that one vaccine? Medicare pays for it. Most insurers pay for it. It's easy. It has almost no side effects. And, we still haven't reached universal penetration.

So, what we have done is to try to use these reports, not just to have a lovely report, and I'm not denigrating the amazing efforts of my colleagues here, because producing a reliable comprehensive report is a huge amount of work, but

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what we're trying to use the reports for is, literally, a map for how we can work together to make improvements.

So, one of the ways we take that data and try to make it more tangible. Okay? If you read about a national quality report, what's the first response? Ooh, not so good. Thank God it's better here. Right? That's not us. Right? Denial is very, very protective. If you start to see that it's about your state, then it's a little closer to home. So, we actually have a web-based tool for state snap shots. We've also used these reports to create some resource guides for states and communities to be able to improve care. So, diabetes is an obvious example. We know what to do. Now, notice that rolls right off my tongue. Just because we know what to do doesn't mean that it's easy to do it. But, nonetheless, we know what to do. And yet, it's not happening a little over half the time.

So, this resource guide gives people a clear sense for how they can develop a quality improvement plan and there's, you know, a variety of tools and strategies that can be used. And, you know what? This is sometimes the basis for research and we're very proud to fund some of that research. But, we've also seen breathtaking results when some local communities have just decided, this is not acceptable. And, that's really the kind of frame we need to begin to accelerate the pace of change.

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We've done a similar kind of guide for improving the quality of asthma care. So, this could work in southern California where you talked about respiratory diseases, and yet, we still see that most patients with asthma do not leave their doctors office with a written management plan. Not a new idea. This is not about even what language you speak. This is just simply not happening. So, we've got a long way to go. Now you understand why I think so highly of public health educators. We need you everywhere.

Now, we also know that health literacy is a huge part of some of what we're seeing in disparities. I don't want to say that the two problems are identical. They're not. But, we do know that there are 90 million adults in this country with lower than average reading skills, and they are even more likely to get poor quality care. Now, understand that we're not doing even such a great job for people with great literacy skills but for people who have trouble reading or understanding the instructions we're giving them, it's worse.

One of the things I learned when I first went into practice, I used to have a little intake form that I had developed with a colleague. We were HMO doctors, so we thought it'd be a good idea if we got some information about patient's histories. And, it turned out that we were an amazingly inefficient practice. So, the bottom line is, if one of our patients came in, they'd be given the clipboard with this form

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to fill out and they usually had a good wait of 45 minutes to an hour, so if you didn't fill it out, I knew that it wasn't they didn't have enough time. Everybody had plenty of time. But, a lot of people came in and all they could fill out was their name and address. I couldn't have learned anything more important. And they'd never tell you. In fact, those same people would have thanked me if I handed them brochures that they couldn't read. This is really a silent epidemic that we need to take very seriously.

And, we've also been trying to train researchers. So, we've got a couple of ongoing research training programs, one focused on minority research infrastructure support and the other focused on building research infrastructure and capacity in states that don't have much capacity for health services research. And, we've begun to see great advances in the capacity to do the kind of work that we're going to need that makes sure that it reflects the needs of the communities we're trying to reach.

Now, one of the great things about having a disparities report that gives you a map for action is, it actually allows us to go to sister agencies or private foundations or other partners and say, oh, so you want to do something about disparities? Well, we have a report and we can tell you where to go. So, in this case, we actually went to our sister agency, the Administration on Aging. How many of you are

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familiar with them? They're a great group. Right? They're hooked up to all the area agencies on aging. I mean, you go to one of their meetings and it is fabulous because just really terrific people. So, they've got a reach that a research agency would never have. And we said, you know, in our report, we see that many Hispanic elders are not getting the preventive care that they need. So, what that has resulted in is a partnership with eight metropolitan communities selected to participate in a pilot that are shown here. And, what we're focusing on is helping them participate in a Medicare drug plan and to improve diabetes care. This is a big reach for us, but it's a way, again, of taking findings from a report which can be pretty dry statistics until you start seeing the real people that are represented in those dry statistics. And, by working with an agency that's got the capacity to reach those communities, we're very excited about the potential ahead.

Now, one of the most underused resources in the health care system are actually the patients themselves. Right? If you want to learn more about culture, you have to ask the patients. And, if you want patients to get involved in their own health and health care, something that I know a lot of you focus a great deal of time and energy on, they have to ask questions and be engaged. Hmm, that sounds pretty easy. So, I call my father who's in the hospital and I say, so how are you feeling?

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I'm better, and tonight at 11:00 I'm going to have a CT scan.

Oh, why are you having a CT scan?

Long pause. My father has an MBA. The idea that he would ask a question like, why am I having this test, hasn't dented his consciousness. And, he isn't alone. Sometimes you hear clinicians say, oh these patients, they ask too many questions, they're pestering us, we don't have enough time, we're too busy. It turns out that on average, for most encounters, on average people ask 1.4 questions from the time they arrive till the time they leave. This includes questions about parking. So, it would be a little hard to say they were being inundated. Sometimes, people don't know what to ask and, even worse, sometimes—like my dad does this—he does ask and he doesn't hear the answer because he's hard of hearing and a little vain about the hearing aid and so forth. So, what does he do then? He nods. Oh, I got it, yes. I'll figure this out later. I'll call my daughter. Right?

So, and some people don't know what questions to ask. So, on our web site and a variety of media from our clearing house and so forth, we've actually given people a list of possible questions so that they can build their own list. Because, if you ask people, do you think it's important to ask questions?

Oh yes.

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And do you think about that ahead of time?

Yes, I do that.

Do you make a list?

Well, not really. I expect that somewhere when I'm sitting in the waiting room it's going to magically come to me. Then I'll make the list.

So, what we've done is to partner with the Ad Council and, if technology is friendly, I'll actually be able to show you the ad, which is very entertaining. And, look for it when you're traveling since it's shown in a lot of airports.

Nope, it's not showing. So, let me just say, it's 30 seconds, it's amazingly entertaining and you'll see doctors and nurses dancing all over a hospital like setting—doesn't look a thing like any clinical care setting I've ever been in. But, it's a way to get people very positive about this because we know that, if patients are involved, we can learn much more about what's bothering them and they can help us avoid making avoidable mistakes in health care.

Double click? Okay. No, I don't think it's working. So I think I'll just keep moving here. Alright. So moving forward.

You know, I alluded to the fact that the challenges facing the initiative that I've had the privilege to be part of for several years in Montgomery County, Maryland, look different than are going to—we're going to need some unique

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solutions for our county that are going to be different than other parts of the country. And, we believe that neighborhood solutions are going to be key to achieving the elimination of health care disparities. Now, that doesn't mean that there aren't some common components and common strategies and that there's not a huge opportunity for us to learn from each other. There is. But, at the end of the day, how it's going to play out, what we need specifically in Montgomery County is different than in other parts of the country. We know that many of the causes of disparities and the priorities for addressing them are going to similarly vary by community and, what that means is, that we are going to have to support projects and support learning across many communities in this country.

Now, we know that there are a lot of frustrations here. Health care is really complicated. I'm sure that all of you get the same question I get from many people. This is the kind when someone pulls you aside, someone often who's very well educated and says, okay, so my relative was admitted to the hospital or has this problem or that problem, has a new diagnosis, whatever, this has happened and this has happened and now there's all this stuff that needs to happen and we don't know what to do next. Did we miss the plot here? You know, were we supposed to pick up a card somewhere that tells

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us what the next steps are? And, the short answer to that question is, no. You're on your own.

We know that people often get conflicting information. We know that many practitioners are more than challenged by time demands, by reimbursement disincentives. Right? If you spend a lot of time talking to someone about what's the right thing for them to do, you don't get paid very much. If you actually go do some expensive procedure on them, we pay you a lot. Our payment system doesn't really support the kind of communication that we need. And, we know that the systems that we're working in aren't always aligned to help us provide the best quality of care.

But, we also know that we're beginning to see the outlines of what it's going to take for us to achieve equitable safe care. We can create much, much better health care if we're working in teams. If we're using evidence and you have evidence available from AHRQ and others when you need it in real time, if we use technology to be a part of that solution of having the information that you need when you need it, when you're making decisions, and if we work as partners with our patients. So, I think it is past time to rededicate ourselves to achieving high quality of care in all of its forms in all six areas for all Americans all of the time. We're going to need better tools to identify and analyze trends, particularly for some subgroups where we don't have good data today.

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But, we have to increase the use of health education to eliminate disparities and to drive other health care enhancements. Public, private, national, local, bottoms up, top down, sideways collaboration is going to be essential to getting us to where we need to be. I can't think of a better group, a better choir, to be delivering this message to and I want you to know that we consider you partners in our work moving ahead.

Thank you very much for your attention. [Applause]

MALE SPEAKER: Thank you very much, Doctor Clancy.

And, I think you've really taken us through a journey on both the breadth and depth of what quality means. And, how hardly cut across the whole issue of social determinants that we don't really get to address an issue of quality unless we understand the context that it does favor or disfavor what will lead to quality as an outcome. I also very much appreciate the way in which your two presentations really intersect and overlap.

And, as a token of our appreciation for your presence here and sharing with us your wisdom and knowledge, on behalf of SOPHE President, Doctor Libby Howze, the various esteemed Harry Montez, who was the captain of the ship for organizing this conference on our variable, Executive Director Elaine Auld, I'd like to present each of you, and on behalf of the SOPHE family, each of you a token of our appreciation for your taking the time to come spend some time with us.

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Do I have to read that? [Laughter] It says, "Carolyn Clancy, M.D., for exemplary leadership and dedication to achieving health equity, Society for Public Health Education, 2007 Annual Meeting." [Applause]

And, of course, to David Hayes-Bautista, "For exemplary leadership and dedication to achieving health equity, Society for Public Health Education, 2007 Annual Meeting."

DAVID HAYES-BAUTISTA, PH.D.: Thank you. Appreciate it. [Applause]

MALE SPEAKER: Do we have time for questions? Alright. We have time for maybe a couple of questions. Could I ask if you have questions to go by the microphone. I think they're being recorded.

MOHAMMED SHABAZI: My name is Mohammed Shabazi [misspelled?] with Jackson State University. My question is for Doctor Bautista.

Doctor Bautista, as a medical anthropologist, I do believe that culture has a role to play and has an impact on our health status. And if you really assume that all Latinos have this, a Culture with capital C, I don't understand how you can, we can say, really, "Latino Culture" as if you were to say "American Culture." There are lots of variations. What specific cultural elements or components are there in Latino Culture that impacts their positive health? Thank you.

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DAVID HAYES-BAUTISTA, PH.D.: It's called tortillas. Just kidding! [Laughter] I hope you heard loud and clear, I don't know. I wish I could give you three or four things. I wish I could put numbers to them. I can't. Our research is not at that phase. But, there has to be some reasonable explanation. We need to develop different theoretical models. We need to be capturing different sets of data to understand what goes into that.

I know that there are a lot of different Latino groups—Cubans, Puerto Ricans, Dominicans, Columbians, Salvadorans, Mexicans—but, you know, across the country, across the country, epidemiologically, Latinos look more like one another than Latinos look like anyone else. But what does that translate into in terms of actual behavior? We don't know. We have to do the research. All I can give you is the outcome. We see this year after year, state after state, across the country. There has to be a reasonable explanation. But, we do need to put the time to task. We have to do the science.

MALE SPEAKER: Alright. We have someone here.

ANGEL SIMOSAS: I'm Angel Simosas [misspelled?] from Brooklyn, New York City, where I think we have the highest immigrant population in perhaps the United States. We're the entry port for more than half of the immigrants that come to the city of New York. And, I can really appreciate what was said about culture because immigrants that come to this country

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are those who are able to leave their country are the healthiest. And, by the time we get to the second and third generation of our children who are here, they become among the sickest in the United States. So, something about culture and assimilation, not only for Hispanic groups, but I think it goes for immigrants in general.

So, this morning—that is just to precede—this morning as I opened the paper, there was an article about cancer and food. And, my question to you as—well, first let me say whenever I come to these conferences I like to leave with some new ideas and things that maybe I can go back and apply. And, one of the things that bothered me is as we talk about the social determinants and we talk about policy, what are some of the recommendations that we can use when we get reports like the one that's in the *USA Today* that says that cancer and the food industry, you know, are intricately linked. The kind of foods you get on the shelves to eat that are mostly available in poor communities, the hot dogs, the processed food. What are some of those things that we can do in terms of these social determinants when we go back that can affect the policy issues?

DAVID HAYES-BAUTISTA, PH.D.: We'll tag team on this question? Well, clearly, there are the policy determinants. It's true in every big city in the U.S. where poor folks tend to live, where recently arrived immigrants tend to live, you

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don't have whole food stores. You have little convenience stores. They don't really have a great selection of fresh fruits and veggies, it's usually high processed, high sugar, high carb, everything else. So, where do you go for food? Now, that's a structural issue.

On the other hand, we also need to recognize that immigrants bring tremendous strengths, tremendous cultural strengths, tremendous helpfully behaviors. And, we need to understand that our job is to preserve them and help that be passed on to the next generation. And, that's not part of the healthcare mission. In fact, usually, given a lot of the tone of the immigrant, the notion is—particularly if you're a Latino—you'll be sickly and that's why you're crowding up the ER room and that's why I can't get an appointment. But, if you look at the actual data, that is not sustained by the data.

So, we need to also create part of our new model, what do we retain? How do we pass on to the next generation? And, how can we all share from it? So, that's like a whole new perspective on what we need to do for both research and services.

If you want to take a crack?

CAROLYN CLANCY, M.D.: So, just a general comment on the relationship between cancer and food. It can be hard to sort of keep a clear map or sense in your head because we're often getting conflicting reports. Some preliminary

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epidemiological findings are reported as facts, or sort of like the Eleventh Commandment and so forth. And, then they turn out not to be the case. I think, actually, probably the more compelling case for thinking about what kinds of foods are available to people actually relates to obesity and heart disease and so forth. And, to that end, I think one of the most powerful studies I've ever seen was one that was done in New York state, because, for reasons unknown to me, there is actually a regulatory part of the state that keeps all kinds of information about which stores sell what kinds of food. So, they could actually map out by very minute areas of zip codes and demonstrate what Doctor Hayes-Bautista, you know, said very clearly. We know if you live in a poor neighborhood, you have access to much worse food.

Now, one of the exciting things that we are seeing is that in some poorer communities, as a result of philanthropy or other efforts focused on economic development, people are starting to say, you know what? We could actually have different kinds of stores here. We could have different kinds of outlets for food. So, there's a whole foods like enterprise in a part of Philly that is pretty challenged economically, which seems to be making it. The Robert Wood Johnson Foundation is putting a lot of resources behind this effort in the name of obesity.

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I think, the biggest thing that can defeat us is a sense that we can't do better. It's a given that if you live in this kind of neighborhood you just have to have crummy stores and bad food and so forth. It isn't a given. Moses didn't bring it on the tablets. What's going to be required is that we work together to change that.

Let me say that, just to reinforce David's point about how important data and evidence are. This morning I was very excited. I stopped and I was meeting a ride at a hotel and there was a big sign, the Cancer Institute's actually having a meeting about developing metrics for different types of food and food components and the built environments. That's exactly what we need to move ahead to figure out what community factors do we need to have in place that are going to help us deal with obesity risk factors for heart disease, cancer, and so forth.

MALE SPEAKER: We'll take on final question. And then we can talk with our speakers individually afterwards.

RINA MITCHELL: Thank you. Rina Mitchell. I guess Brooklyn is here. I'm from SUNY Downstate Medical Center Physician Assistant program. It's very interesting coming here because, as a clinician, I don't see very many of my colleagues here. My question is related to, we looked at some of what is done that has been done with health disparities, eliminating health disparities, but what I don't get appreciative explanation about is how are we doing with actually, really

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recruiting clinicians that look like those communities? I mean, I come to this meeting, and to be honest with you, being a physician's assistant for over 20 years, 20 years from now, I can honestly say who did the work, from my perspective, SOPHE did the work, a lot of the work, on eliminating disparities. It was one of our president's agendas and it went away. But, I don't know what the clinicians have, clinicians, I don't see have taken this really to heart and have done the work that I have seen at this conference. And I just want to know what is been done with just increasing the number of ethnically and culturally diverse clinicians, because physicians, physician's assistants, dentists, nurses—they just don't look like the populations that are in America.

CAROLYN CLANCY, M.D.: Well, I think David threatened to keep us here until Sunday if we got off on this topic, so I'm not suggesting that we should do that. But, this is an area that's represented a huge challenge and I think, frankly, a failure collectively.

So, you have to acknowledge that up front. Not for a shortage of good intentions. What I am seeing more of that's a little bit encouraging because it feels to me like the right thing to do, although it's going to be a while before we see results, is that rather than recruiting college seniors who are from different backgrounds and are doing extraordinarily well, medical schools and others are beginning to reach down to

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younger ages. I'm almost sure it's not enough and not sustained enough. It does seem to me like that suggests the basis for a potential collaboration between medical and other health professional schools and public health educators. You know the kind of clinical community partnerships that we're talking about all the time. Because I think it's very powerful if the AAMC or some other group has a big workshop and they invite in even junior high and high school students in for a day. I mean, that's a big deal, right? You're selected, you go, and so forth. But, while that is one part of one day in the rest of your life. Or, you know, and there's a whole lot of other things going on for you. To have that kind of message, that you can do this, reinforced, takes a whole lot of people who live around you, from family to friends to others you interact with in the community who are constantly letting you know, yes, you can do this. So, that's where I think there might be a potential partnership between folks at SOPHE, between people who are in health professions schools and so forth.

I'd have to say, you know, periodically we see what looks like good news in enrollment of medical students and it's usually a very minor bump. We have not seen a sustained "Wow, we did this and we saw a big increase." We're still waiting for that. People are working very hard and I don't want to

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denigrate their efforts, but it's clear that we need to do a whole lot more.

MALE SPEAKER: Again, if you'd like to talk with her or our speakers, so feel free to do so. And, I know it's kind of between you want to be social and Elaine has an announcement.

ELAINE AULD: Let's give both of our speakers one final round of applause. Thank you very much. Thank you.

[Applause]

Just a few final plugs for the day. I know it's been a long one. First of all, continuing education forms, if you're not—first of all, if you're applying for continuing education, you should sign in at our CE desk and that includes not only certified health education specialists, but nurses, social workers, and registered dietitians. If you're not applying for those credits, please complete an evaluation form so we can share your reactions with our speakers.

Our opening social starts at 6:30. We invite you both to join us. We'll have a book signing by one of our two books that we're featuring as by Collins, Aria, and Bouah [misspelled?]. And, I think you'll enjoy that. Please dress in anything state or native related for door prizes. Tomorrow we're starting at 7:15, for those early risers. And, I know we do have some of them. We'll be providing you some continental breakfast. And, then we will convene here again at 8:30 in the morning.

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So, enjoy your evening. There are shuttles to Pentagon City and to downtown King Street and Alexandria for dinner alternatives. And, of course, there's the hotel and there's a Clyde's Restaurant right in back here. So, enjoy your evening.

And, the Poster Session with authors. We have 42 posters that are featured this evening.

Thank you! [Applause]

[END RECORDING]