

W.K. KELLOGG FOUNDATION

**STRATEGIES FOR INCREASING DIVERSITY
IN THE U.S. PHYSICIAN WORKFORCE**

APRIL 12, 2002

WASHINGTON, D.C.

DR. WILLIAM RICHARDSON: Well, good morning everyone and thank you for being here today and a warm welcome to one and all. For those of you who know me, you know that this voice that you're hearing isn't natural. I made the mistake last week of telling somebody that I hadn't had a cold for a year and a half -- knock on wood -- and I knocked on Formica. And so that was the fly in that ointment.

The other remark I want to make, for those of you who are back in that far right corner, if I seem to be giving you undue attention it's because I packed my bag personally this morning and want to make sure it's under my immediate and continuous control until I go to the airport.

Well, on behalf of the W.K. Kellogg Foundation and the Robert Wood Johnson Foundation and the Henry J. Kaiser Family Foundation, let me welcome you to this National Leaders Forum on Diversity in the Healthcare Workforce.

We're very fortunate today to have with us so many healthcare leaders and experts, including Secretary Louis Sullivan and Dr. Robert Ross, who we'll hear from in just a few minutes.

I'm sure that most of us here would agree that, in many respects, US healthcare is the best in the world. We have, after all, remarkable technology, superb professional training, and wonderful facilities.

And yet, despite all of our capabilities, you also know, as I do, that we often don't deliver what we know and that there are far too many people who lack access to what we have. Compounding this problem is the lack of cultural diversity in the healthcare workforce, particularly among physicians, but more generally as well.

As an example, while African-Americans constitute 13 percent of the population, you well know that they constitute only about 3.5 percent of the nation's physicians. Similar shortages and disproportionate allocations, if you will, exist among other minority groups.

In my experience at the Kellogg Foundation over the last seven years, and then in my life before that at the University of Washington in the Health Sciences Center, and at Penn State and then as President of Johns Hopkins University, it was -- and working in East Baltimore, it was very clear to me how

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important it is for patients to receive care from someone who speaks their language and who understands their culture.

The lack of diversity among physicians and other health professionals can be a barrier that deters people both from seeking care and, if they've sought it successfully, from actually receiving the kind of care that we know how to deliver. And so, in many respects, this is a professional as well as a social problem and, if we're serious about increasing access to care, it's a problem, as far as I'm concerned, that we simply cannot ignore.

There is, I think, some reason for optimism because this problem is beginning to receive the attention that it deserves. At this moment, as many of you know, Congress is holding hearings on the status of the progress of the Health and Human Services Initiative to eliminate racial and ethnic disparity in healthcare.

Congress also will be hearing testimony from Institute of Medicine representatives about the release of Unequal Treatment -- that new report that covers many of the same issues. And also testifying will be representatives from foundations and national associations.

We're very fortunate in many ways that these individuals who are here will be able to join us as the day goes on. We're a little bit unfortunate in some ways because some of them are on the Hill right now, and so we'll have to adjust the schedule a little bit. But, nonetheless, by the time the session is over, we will have the benefit of the people who've been on the Hill this morning.

Our purpose here today is to discuss the potential creation of a national committee that would seek to increase healthcare workforce diversity. Our three breakout sessions will consider various possible aspects of such a committee's work.

In session one, Dr. Brenda Armstrong, Dean of Admissions at Duke School of Medicine, and her fellow panelists will highlight the good work that Duke has done to promote diversity through the recruiting and admissions process.

In session two, Dr. Marsha Lillie-Blanton, Vice President of the Kaiser Foundation, will lead the conversation about possible goals and focus and composition of a Blue Ribbon Committee to promote workforce diversity.

And in session three, Dr. Terri Langston, a Program Officer at the Public Welfare Foundation, will look at the role of community engagement in health professions education, including the very important topic that we've been working on for a number of years, and to explore the value of, community benefits principals, which we think holds some promise.

If there's one thing that we ask from each of you it is your full participation. And since I know a number of you, I'm not too worried about that but I wanted to put that out front right at the beginning of the morning.

This is not intended to be a lecture series or a briefing. It's intended instead that each of you, who are after all experts in your own right, will contribute your ideas and suggestions and viewpoints, and also, we need your advice and recommendations as well as possible contacts with respect to who can help move this effort forward.

If you know individuals or institutions as you look around the room that you think are not represented but should be represented in a group such as this, I hope that you'll let us know.

If there's one word that should describe our work, as it often does the work of the Kellogg Foundation, it's partnership. The issue of physician diversity is far too complex for any foundation or any medical school, or community or government agency, to tackle alone. We need support for this initiative that is broad and deep, support that begins at the community level and extends through higher education, the private sector, and policy makers at both the local and state as well as the federal levels.

I mentioned earlier that we have assembled for this forum some of the nation's foremost leaders in healthcare. Our next speaker, Dr. Louis Sullivan, certainly fits that description.

Dr. Sullivan is President of the Morehouse School of Medicine in Atlanta, a position he returned to, as you'll recall, after distinguished service as Secretary of Health and Human Services from 1989 to 1993.

Dr. Sullivan also has served on the faculties of the Harvard Medical School, Seton Hall College and Boston University and, additionally, was founding President of the Association of Minority Health Profession Schools.

So please join me in a warm welcome, and a welcome in a back in some ways, to Lou Sullivan.

DR. LOUIS SULLIVAN: Dr. Richardson, thank you very much for those kind remarks. And let me welcome all of you here this morning and, again, thank you for your participation.

I thought I would try and put a few historical incidents in perspective as to how I see what we are about today. Clearly, we have in the most affluent nation on earth with, as Bill Richardson has said, the most sophisticated healthcare system, we have a supply and distribution problem.

Now, American medical education has gone through some significant changes over the past century because, not quite 100 years ago in 1910, a microbiologist, Dr. Abraham Flexner, issued a report that was very critical of medical education in America. At that time, the United States was not the leader in medical education. Leadership in medical education was in Europe, in such centers as Bologna, Heidelberg, London, elsewhere.

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In America, we had a number of proprietary medical schools that were owned by physicians, very little in the way of curriculum standards, admission standards, etc. And the Carnegie Foundation in 1908 commissioned Dr. Flexner to do an evaluation of medical education in the United States, which he did over a two-year period, and issued his report in 1910. That report, which is still available in medical libraries around the country, I invite you to read because it is very historic, as well as sometimes entertaining.

He pointed out that in many instances there were hardly any laboratories, no anatomical dissection, examinations were given infrequently, teaching was often by apprenticeship. But he, in evaluating the 148 medical schools in the United States and Canada at that time, found the model that he felt should be followed, and that was indeed at Dr. Richardson's old haunt, the Johns Hopkins School of Medicine. Because, in contrast to many other medical schools at that time, at least a high school diploma was required, preferably one or two years of college.

The medical curriculum was organized with instruction first in the sciences basic to medicine, followed then by instruction in the clinical sciences. And he recommended such a model and we still use the term today the "Flexnerian Model of Medical Education" because, by 1925, as a result of that report, the number of medical schools had been reduced from 148 to 80 and, indeed, a number of curriculum changes and accreditation standards were introduced, which over time -- now 100 years later, we can say the United States represents the pinnacle of medical education for the world. We've added to that a strong biomedical research enterprise starting with the National Institutes of Health, Centers for Disease Control, and elsewhere.

Well, in 1950, 2.1 percent of the nation's physicians were African-Americans. There were reports being developed that pointed out that we as a nation, still with only 80 medical schools in a growing population, might soon be facing a shortage of physicians.

There was a Kogashaw (sp) Report that was issued Chaired by Dean Lowell Kogashaw at Yale and the Bayne (sp) Report, which led Congress in 1963 to pass legislation to provide federal dollars and incentives for the expansion of medical education. That began with two medical schools that opened in 1956 -- Albert Einstein in the Bronx and Seton Hall Medical School in Jersey City, New Jersey. They were the beginning of a flux of 46 new schools that opened between 1956 and 1981 -- dollars being made available for construction of new facilities, adding faculty, scholarship support, and many other incentives.

As a result of that, in contrast to the 8,000 physicians being graduated from the nation's medical schools in 1980, we're now graduating some 16,000; virtually have doubled the number of physicians being graduated.

There was concern about the number of minority physicians and efforts were undertaken. But, as you have heard, in spite of a number of genuine efforts on the part of a lot of groups, not only medical

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schools but organizations around the country, state legislatures and the Congress, we have fallen short of a significant increase in the number of minority physicians. And here I refer to not only African-Americans, but Hispanic Americans and Native American physicians as well. These groups are underrepresented in the nation's physician population.

So, while we had an opportunity with the doubling of the number of people trained in medicine annually, because of the expansion that occurred between 1956 and 81 -- and I remind you, there have been no schools that have opened since 1981, and those dollars that Congress made available for expansion are no longer there, or they are greatly attenuated. So here we are on the beginning of a new millennium and we are faced with an ongoing problem.

So, what we hope that you will help us do with your deliberations today is come up with strategies that will help us break through this problem that we have not been able to find solutions. Are there strategies that we can develop? Are there incentives that can be offered? Or what can we do to increase the number of minority physicians in the country because, as Dr. Richardson said, successful physicians are not only scientifically competent, but they are culturally competent as well.

They are familiar with the community, they are familiar with the language, they can engender trust, they have effective communication skills because, a successful medical encounter depends upon, first, a good scientific base, but then the ability to use that information in communicating with the patient and motivating the patient so that, indeed, there will be effective responses.

So this is what we ask you to help us with today, and we look forward to your comments, to your recommendations, to help us figure out what can be done indeed to get us off of dead center from what we are today.

And I'll now let Dr. Richardson move our program along by introducing our first speaker, who will indeed help us in this regard.

Dr. Richardson.

DR. RICHARDSON: Dr. Sullivan, thank you very much. It is our very good fortune today to have with us Dr. Robert Ross, who is President and CEO of the California Endowment.

The California Endowment is a \$3.4 billion health foundation established in 1996 to expand access to affordable quality healthcare for the under-served, and to promote basic health improvement, the improvement of health status among all Californians. The endowment has regional offices in Los Angeles and San Francisco, in Fresno and San Diego, with program staff who do in fact work all across the state of California.

With Dr. Ross, the California Endowment has an extraordinarily capable and experienced CEO. Many of you know him from the work that he has done before going to the Endowment. He has an extensive background in both -- as a clinician and as a public health administrator.

Among his professional positions have been Director of Health and Human Services for San Diego County and formerly, as many of you know, he was Commissioner of the Philadelphia Department of Public Health. He has served on the Board of the National Marrow Donor Program, was Chairman of the National Boost for Kids Initiative, and is a diplomat of the American Academy of Pediatrics.

So, we're very fortunate this morning and I'm delighted to introduce to you Dr. Robert Ross.

Rob.

DR. ROBERT ROSS: Thank you very much everyone for having me. This is one of those presentations where the speaker will wake up about 45 minutes into the presentation because I am on California time. So at some point, this babbling stream of words will hopefully find some coherence and you'll understand at least a few sentences of what I have to share with you today.

It is terrific, nonetheless, to be back on the East Coast. The trip has already been made worth it. Even if this conference, this convening today, were a colossal failure, which I know it will not be, the trip has been worth it because I have my Philadelphia Pretzels in this box. And that is, Judy Straviski (sp) was kind enough to -- from my Philadelphia days recall how we used to bump into each other at the Redding Terminal at the Redding Market downtown, and the Farmer's Market downtown in Philadelphia, and there was nothing better than a Philadelphia Pretzel, and certainly a chocolate covered Philadelphia pretzel, and I'm sure there is a number of you that would love to see me leave this box behind, but I will not do so.

Thank you, Judy, for doing that.

Dr. Sullivan, it's great to see you again. It is amazing. You are a paragon of persistence and consistency. You continue to wear that little red smoking button, which you were wearing exactly in the same spot on that lapel, about 12 years ago when you came to Philadelphia during the height of the measles epidemic, and I was the Philadelphia Health Commissioner. And you came in to give us a strong infusion of leadership and support around that -- handling that measles epidemic. And I thank you, sir, for your leadership, your guidance and everything you did for us in Philadelphia during those dark days of epidemic. Thank you, sir.

Dr. Richardson, thank you very much for you and your words. Where'd he go? There he is.

I was thrilled to hear about this convening, what's been happening. We're a late comer to this party but, hopefully, you'll see by the end of this conversation, after I share with you what I'm going to share, that we hope to join the party and, even though we're late comers, you know, the person that comes

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late to the party but brings the noise makers -- hopefully we can play a bit of that role from the Left Coast and thank you for the leadership that you and your team has exerted on this issue.

With that, let me -- I don't know that I'm gonna share with you anything that is an aha or an epiphany this morning. I don't know that I'll share with you anything that you did not know.

What I'd like to be able to do, if nothing else, is just to leave with the sense that there is another partner out there on that other coast very interested and committed to these issues, and is still struggling to figure out what we have to do with our vast, vast array of resources.

I've been telling my communications staff to strike two phrases that I get tired of hearing about every time I get introduced at some conference or another as the Foundation President, and that is that we're California's largest healthcare foundation because, quite frankly, who cares that we're the largest healthcare foundation in California.

And secondly, that we have \$3. -- whatever the number is this week -- 4 billion in assets. Because, when you speak to a community group particularly, and they hear that a foundation has \$3.5 billion in assets and that this man is in charge of all that money, you just make more enemies with people who did not get a grant from you.

And it's very difficult for those who don't understand this very subtle isolated world of philanthropy that, well it's not -- yeah, it's 3.4 billion, but it's -- we don't give out that much. It's like 5 percent of that each year, and that's because there's this IRS requirement and then there's the stock market thing and you've got to invest the money, and then you lose them by the time you try and explain all that.

So it's better just not to have -- to tell the figure in there at all because you just make enemies with someone who got turned down for a \$25,000 grant. All I want is \$25,000 to help my community and this guy, who's sitting on \$3 billion, won't give it to me!

So, I am looking for a new Vice President of Communications, by the way so if anyone is -- seriously -- if anyone has any suggestions, please let me know.

I want to talk about -- and this, I'm going to tread on dangerous ground because I want to start this conversation from the standpoint of values. And it's a tricky place to start because, in this country right now, it's hard to get anything done talking about values. And it just doesn't get enough traction in our very pragmatic, incremental, bipartisan, moving to the center of things world.

But, I was watching -- I haven't been able to get rid of since my college days, which is watching television with the television on mute and my favorite jazz playing on in the background. And I was doing that as usual one evening, sort of multi-tasking, you know, dinner plate and newspaper and music playing and TV on with the mute.

And I kind of, as I was interminably channel surfing, I saw this gentleman on a C-Span channel, you know, well dressed, forcefully making some point. I couldn't hear what he was saying but, you know, finger in the ear and kind of yammering away.

And we was well dressed and it was clear that this was -- he was in front of an audience -- actually not an audience, an audience of empty seats in the background. And as you might suspect, that was a Congressional hearing because there's no other civic public venue in the country where someone gets free television time and there's no audience in the background except on C-Span and our Congress.

At least, you know, at city council meetings and school district -- you know, the room is never empty. But, for some reason on C-Span, when a Congressional leader is talking, all the seats behind him or her are empty. And I'm not a Washingtonian and I don't understand the dynamics of that. I'm sure there's a good reason for it.

But, he was making his point very forcefully to this empty room. So I just kind of got, well, you know, what's he talking about that's got him riled up? Turned up the volume and he is talking about -- he is discussing, or rather lamenting, the openness of our border between the United States and Mexico.

And he was -- there was a little graphic comes on that shows who the person is speaking and whether they're a Democrat or a Republican, you know, D or R, and then the state after that.

He was from a southwestern state. He was a white male. He was a Republican. And he was talking about how terrible it is that people are trying to ruin our country, and the sanctity and integrity of the American way of life because we have such open borders. And was using September 11th as proof positive that we need to clamp down on these borders.

So that was, you know, I mean, I grew up in the last seven years of my public life working for five Republicans in San Diego County, which all of you know is a very conservative county. That was not new to me to hear that.

But, what was interesting was he said, he used a term "multiculturalists." And he said, "These multiculturalists," you know, blah, blah, blah. And what was interesting was a couple of things. One is, I had just sort of finished a one year planning effort with my Board of Directors, asking them to frame our grant making approach around a multicultural approach to health for California.

So after, you know, many months of saying why this is a good thing that, you know, California is the most diverse nation state in the world, and healthcare does play out in terms of diversity and ethnicity, and diversity not limited to race and ethnicity, but diversity and ethnicity in a number of ways, and that we need to focus our work on those issues, I had come to feel that multiculturalism was a good thing to be proud of.

But this gentleman spat out the word sort of the same way you hear politicians talk about anthrax, like it's, you know, a disease -- with a sense of venom behind it.

And that -- what was even more interesting and ironic was the gentleman had an Italian surname. So I was -- I kind of, you know -- and my mind kind of works this way. And I thought about, I wonder what his grandfather was thinking as his grandfather shuffled his way through Ellis Island trying to become a member of this country, when then some then lost politician was saying we need to protect the sanctity of our borders because we have all these Italians or Irish or fill in the blank coming in that are going to destroy the sanctity and integrity of our great nation.

So that was -- let me put aside for a moment. That happened the same week that, during the Olympic Games, the Winter Olympic Games, which as someone who grew up in the Bronx, it's not something I typically tune into. You know, it's not that I have anything against skiing, but it's not something I would naturally be glued to the television to watch.

But this particular year, what was fascinating for me as one of those bad multiculturalists, was that this United States Olympic Team, as you may know, had the best showing of any United States Olympic Team in its history. And helping to bring home the gold were two African-Americans, two Asian-Americans, and a Mexican American. Each of them, I believe, for the first time bringing home a gold medal or a silver medal in the history of the United States Olympic Games.

And you know that sense of sort of jingoistic pride that we get around the Olympics that, you know, the medal count and, you know, you look in the paper and let's see, okay, Germany's two medals ahead of us, you know, we got to -- maybe we can catch up. And I wondered if this Congressman, he of the jingoistic pride, swelled up a bit when he heard that our Olympic Team, United States Olympic Team, had such a great showing in the Olympics.

And it's just another example and indicator of the stark level of contrast and the inability -- the inability of this country to make up its mind about whether diversity is a good thing, or not a good thing.

And in my view, this country, which is the greatest country in the world -- to be improved upon, but the greatest country in the world, is what it is because of its multiculturalism. We are a country of people with what is -- in our DNA, of risk takers, of innovators, of people who have a history. And each one of us in this room can trace someone back, if you go back far enough, who took the risk and took the innovation to either get here or be here, weather the storm and have a vision of making this a better place to live for our families, okay?

Now, whether you kind of ended up here on a boat that ended up at Ellis Island, on the bottom of a boat that left Gambia, or climbing a fence in Mexico, or perhaps another boat that left China and came through Angel Island, every one of us as an American has in our gene pool, or in our family ancestral collective experience, being an immigrant or a slave or a refugee.

And America loves to brag about and swell up with pride about our diversity and our multiculturalism and how it makes this place a better place to live. And you wonder about, for example, the soul of America without you know, a John Coltrane, a Maya Angelou, a Cesar Chavez, a Diego Rivera, Yo-Yo Ma. How would this place be American without the contributions of a number of different peoples that have contributed to our culture?

So, diversity for me is not really a good thing; it is a value. I think it is a fundamental value of this nation. And values are things that programs and plans and policies emanate from and are driven by. It is an underpinning; it is a foundation, okay?

And unfortunately, the issue of diversity in this nation seems to be a hothouse flower. It is a hothouse value. It is a value that only thrives under certain environmental, re political conditions.

When it is convenient to brag about how diversity enriches our nation in music, in art, at the Winter Olympic Games, then all the sudden diversity is a good and wonderful thing for America.

But, when you fast-forward to what our healthcare delivery system ought to look like, now it's, well, I don't know. It could be unconstitutional. It maybe not be a good thing. And I don't know about that. And there's a lot of trepidation and anxiety around this notion of diversity in general in the professions, but particularly in the healthcare profession.

Diversity is a value. It is either a good thing or it is not. And if it is a good thing consistently, it must be applied to everything we do.

The problem is, of course, as all of you know -- for those of you who grew up as I did, and many of you I see have in terms of the era, many of us were touched by individuals like King and the Kennedys and Chavez, who grew up either professionally or younger or a little older in the sixties. We were touched by a sense a social activism. We were touched by a sense of social responsibility. We were touched to move by a sense of justice.

And for—and to those times, many of you are in this room at this day doing what you're doing because you were touched by that period of time, as was I. I went into this field to make a difference. Because I was compelled, at least in part, not by just what mom and dad said, but by King and Chavez and the Kennedys.

The problem is that right now it's not a very good time to move social justice issues. As a journalist friend of mine once remarked, "America is now a hot bed of social rest," you know? Things don't move just because they have a sense of values and it's the right thing to do and because it has a justice agenda attached to it. In fact, things get killed and snuffed for that very reason right now. We live in a time of extreme pragmatism, and everyone is really careful.

How do we move this agenda that we know matters when the social justice argument is compelling but is insufficient? That is what I have been concerned about as a leader of one foundation interested in these issues. And I just want to talk a little bit about that and make some observations, and then end up as offering the California Endowment as a partner but not necessarily with brilliant ideas.

The California Endowment Board of Directors approved a five-year strategic plan at the end of last summer. It was really more a strategic framework than a detailed plan. And our work over the next five years and beyond, if I have anything to do with it, is at the crossroads of why you're here today and what is happening across the street or down the street in the Congressional hearings.

Issues of access to care for the under-served, workforce diversity, health workforce diversity, cultural competency in health and disparities in health are our four major goal areas for funding.

I don't want to get into an argument or a discussion why we separated out cultural competency from health workforce diversity. I had that fight with my staff. I don't want to talk about that. Bottom line was, I felt it was important for the diversity of the health workforce to stand on its own as a program and a goal.

We are looking to move probably close to \$1 billion over the next five years in those four goal areas. Most -- the lion's share of those dollars going into access to care, but we will probably spend a minimum of \$125 million over the next five years on workforce -- health workforce diversity alone.

Now, that having been said, it's not enough money to move the issue through grant making alone. We cannot make grants out of our -- we just can't grant make our way out of this issue. We can't grant make our way from where we are today to the place that we want to be, even if every state in the Union had the kind of resources that we had committed to the issue, okay?

And those of you that have been around the block, you understand this. You understand it sounds like a lot of money but, in the absence of other strategies and leveraging opportunities and coalition building, it just is not gonna get us there.

As I let folks know when I give talks about the California Endowment and our grant making strategies to -- in the state of California, our \$170 to \$200 million a year in grant making is less than one percent of the state's Medi-Cal budget, which is just one funding stream in the state of California.

So if you to Medicare plus Medi-Cal, plus all the private commercial dollars, plus all the other public dollars that are not Medi-Cal or Medicare spent in the state of California, then our \$175 million a year is a rounding error on what is spent in California in healthcare.

Additionally, the category is health workforce diversity, not merely physician workforce diversity. We just announced a grant in the Central Valley for a \$10 million three-year initiative to move the issue of nursing workforce diversity, diversity in the nursing workforce, into Central Valley. So we just moved

\$10 million over three years just to try and make a dent on that issue in the Central Valley, which has a terrible nursing problem, all right? And my staff was bugging us about moving more money there. So you can see how quickly you can churn through some of these dollars to get these issues moved.

So how do we, even when we don't have enough resources to move this issue just on grant making, how do we get there from here and at a time when social justice doesn't seem to be able to move mountains and make a case?

I want to make a comment about the use of evidence and data. You'll hear from Brian Smedley at some point this morning about the IOM report. He's probably over there giving the report to Congressional leaders now.

The IOM report, which all of you I'm sure are familiar with in terms of its sufficiency of its works and its conclusions, has essentially verified through the use of evidence and the review of the literature, what our intuitive sense has been all along, that culture and diversity matters in the healthcare setting and we are paying a price in terms of lost lives and productivity in this country for not having culturally competent healthcare systems and not having a culturally diverse workforce.

That having been said, here's the problem. If, in fact, we remain under the delusion, and many of us in this room either come from the world of philanthropy or come from the academic world. And there's one thing that those two worlds have in common that I've observed, both as a newcomer to philanthropy and as someone who's spent some their life, part of their professional life, in an academic setting.

We are not going to be able to move this issue politely through the scientific accumulation of data and papers. It is a terribly rude awakening for many of us in academia and many of us in philanthropy.

There is a sense -- and I think it's probably worse in Washington, it's probably worse inside the Beltway, and it certainly is a terrible problem within the Ivy Leagues, the Ivy Towers of significant leading academic medical centers, because I was trained as a medical resident and as a medical student that good data drives good policy.

Those of you that have been around and have seen things move and have seen things stopped know that good data is necessary, but it is vastly insufficient; that whenever any of us have seen either social change or policy movement or reform, it is generally in the combination of a movement occurring because there's data perhaps in the left hand, and the evidence base in the left hand, and the extraordinary power and will and determination and resolve of a coalition in the right.

If in fact we conclude as a result of the IOM report that more study is needed, we will not move this issue. The IOM report has the ability to be a landmark report, but landmark reports only get termed landmark reports in the retrospective.

You don't get to release a report today and say this is a landmark report. It is a landmark report only if -- and I hate to use a sports metaphor but, as I mentioned, I love sports and its -- there's clarity for me in watching a game. The game starts, 90 minutes over, the game is over, there is a winner and loser and you get to look back at sort of what happened, all right.

And sometimes in a game there's a fumble or there's a rebound or a kid drives into the stands to try and get a ball. And then eight minutes later you realize, boy, the momentum changed. The score is now different than it was before. It seemed to have started when that kid dove for the ball or that guy made that free throw or whatever happened. It was a landmark event for that moment, but you never know until you see what happens that follows.

So the IOM report will either be a shelved report or a landmark report, basically depending on what we do in this room over the next year to two years to five years. And in fact, we will know in two years whether the IOM report was a landmark and pivotal report or a shelved report. We will know in two years.

If in fact the language access issue has not been moved off the vine within two years; if in fact we have not resolved as a group of us to invest and expand the pipeline support to get more young people of color interested in seeing health and science and research as a viable realistic career for themselves; if in fact we have not been able to define cultural competency as a quality of healthcare issue, not say that it's just talked about in terms of PC babble but, in fact, it becomes and is moving to become part of a board certification examination for an internist or a pediatrician, that is when we know that the IOM report was a pivotal report that resulted in action that you can touch and see and feel that makes a difference, or just a shelved report that strengthened our intellectual curiosity.

And finally, and I know because there are a number of leaders from academic medical centers and medical schools, and this is not to point fingers at any of you because we need to be partners with you in this effort.

If, in fact, there appears to be real tangible sweeping movement beginning to occur in medical education, medical education and training, in the way that students are recruited and sought out and retained and trained and educated because medical education and training, as Dr. Sullivan has mentioned -- we are now in need of a Sullivanarian rather than Flexnerian reform on medical education.

But we need reform. This country is not producing the kinds of physicians that our communities need. It simply isn't. On a whole range of issues. And I have to tell you that my best read is that medical education has not changed a whole lot since I was a medical student, okay?. Not a whole lot, but there's some folks doing some great things. But we have seen reform in other areas, badly needed, where the public and the community have said we need you to be accountable to us in our needs as a community.

So we are seeing education reform sweeping this country. You may not like what you see in some of it, but education reform is now a leading reform issue. And there's voucher programs and there's charter reform and there's magnet schools and there's all kinds of things happening in education.

We've seen it in the military in terms of how they decide to fight battles, okay? How a soldier is trained today and equipped today is fundamentally different than 20 years ago, for a different kind of battle.

We've seen it in law enforcement. Now take a step back for a minute; think about it. Police in this country are reforming the way they do business to be more accountable and responsive to the needs of communities through community policemen in much more substantive ways than medical education and training.

Who would have thought that 20 years ago you would see more community responsive reform from white cops than academic medicine. They are being held accountable. Communities are saying we want you to work better with us and to treat us as equals and as partners in making our community safer.

Now, for some reason, medical education and academic medicine, we've kind of escaped that, even philanthropy, too. We've kind of escaped, we've kind of dodged that bullet from the communities zeroing in on us and demanding a response to the reform.

It doesn't mean we have to wait for it to happen to move there, although I think about, and it's mentioned in your paper, the paper by the Committee Catalyst folks, the notion of how we perhaps even drum up community engagement and communities targeting the healthcare delivery system, and targeting medical education and training as demanding accountability and you must reform. Our communities need different kinds of doctors who can serve our needs.

If I were speaking in front of a Congressional committee with mostly Republicans, I would not use the social justice argument. Here's what I would say. I would hold up a book of Robbins and Angel (sp). Remember the old pathologic basis of disease books? It describes more than 600 diseases, okay? From uric acid, metabolic diseases to heart disease. And I would say to those Congressmen, Ladies and gentlemen, this is a book of over 500 diseases that plague Americans and people around the world. Of the 500 or more diseases, there are ten that account for the overwhelming majority of illness, disease, emergency room costs, hospitalizations, lost days of work, lost days of productivity."

Those ten are heart disease, cancer, stroke, diabetes, pneumonia influenza, cirrhosis of the liver, emphysema, HIV/AIDS, homicides, suicides and injuries in accidents. Those are the ten.

Every single one of those ten are either wholly or significantly preventable through personal responsibility and health. If we can teach Americans to be more personally responsible about their behavior, in terms of owning their own health and own their own healthcare, we can not only have America as a more productive and healthy place, but we can cut down on the double digit rises in premium costs that

business leaders are now coming in and complaining about.

It is -- and you can make the case if this really is, cultural competency, is the mechanism to enhance personal responsibility in health. That is not politically correct babble. And the data, by the way, shows that it—this is to be true. The data shows, and it is logically intuitive that, if a diabetic or an asthmatic or an epileptic communicates with someone who could help that individual take charge of his or her own health and change their behavior, they will have a healthier outcome for that person, and that person will cost their healthcare delivery system less.

That leaves us with sort of what to do. So, there are basically—there are basically three avenues of moving this agenda. One is through the social justice/civil rights way, which is described in your paper and I subscribe to. The second is the outcomes case and the productivity case, which I subscribe to. And the third is the business case.

And it's interesting -- I read on the plane coming out here two papers, one by the Washington Business Group on Health and the other by the American Association of Health Plans, both targeting diversity in the health care workforce as an imperative for their membership. Those are two extraordinary new sets of partners to this issue. They're not in the usual suspects, okay? We have got to figure out a way to engage both of those—both of those institutions and their membership in getting on board in this issue.

Whenever I would go to meet with my Republican Board of Supervisors on an issue that I felt I needed to have moved, whether it was access to healthcare for kids or an after school program, or improved mental health, I had with me the Sheriff, the Police Chief, the President of the Chamber of Commerce, and the President of the Children's Hospital. And community groups and some of the other usual suspects.

And it struck me seven years later in San Diego, in ten years as my career as a public sector leader in healthcare that, whenever I had that combination with me, I always won. Let's do a study on that! How do you move an issue? What new partners do we need? We must have business at the table.

And the business case is really simple. In California, a rapidly diversifying state, if you're head of Kaiser or Sharp Healthcare or Scripts Healthcare or Sutter Health Plan, it is a business imperative to have a workforce that looks better like the community you serve. It is a competitive marketing advantage. You will keep patients, you may even attract patients and covert lives from other institutions.

So, in closing, I want to say the following. We do not have a detailed strategic grant making plan for the \$125 million or so we're gonna spend over the next five years to move this issue. I think, for the purposes of this partnership, that is probably a good thing.

The Board of Directors understands that we need to move this issue, they understand that it's important, they understand it from the standpoint of values and outcomes. The IOM report has now confirmed what we of staff have been saying to them.

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But, it is a wonderful opportunity for us to join you to talk about the highest and best use of these resources. Do we need more data to make the evidence case? Of course we do. But I will tell you that we are not going to spend the lion's share of that \$125 million commissioning papers. We really need movement.

There are wonderful think tanks in healthcare. We need more "do tanks." We want to be the place where it takes the findings and the data and moves them into tangible activity at the ground level that people can see, touch and feel because momentum is an incredible thing. It builds success.

So, I do not have a bright idea about exactly what we should do next. I do know that the idea of a national commission is a good thing. The idea of a structured alliance and partnership between and among philanthropy and other leaders is a good thing. Count us in. We bring our resources to the table. Yes, we have to spend them to benefit Californians, but we believe that we can benefit the national agenda even by doing that. And let's make certain that, on this issue, do not forget the importance of coalition building and advocacy.

Nothing that has ever been achieved that is worth achieving, has been achieved without a fight. We're in a fight. And we must behave as if we are in a fight. And if we behave, waiting for the data to move mountains, it will not happen. That much I know. I'm not sure that I know exactly what will move the mountains, but the data -- the accumulation of data alone will not do it.

And in closing, I'll just -- reminded of a comment that my father used to make, which was, "Son, if you're gonna be a bear, be a grizzly."

Thank you.

DR. SULLIVAN: Thank you very much for that very challenging presentation.

And Dr. Ross has indicated he would receive your questions or comments, so the floor is open for those who would like to raise issues -- .

DR. ROSS: -- One comment that I—I'm sorry, that I neglected to share. I know the issue of community benefits was an organizing force for this—for this group. I've had considerable experience with community benefits as a moving force in San Diego County and, somewhat to a lesser degree, in California. I think it is a tool to be exploited. It is a tool to be utilized. I think it is one tool in a tool box of tools.

It is not my belief that the community benefits doorway alone will get us there. I think we need to fight this battle on a wide range of fronts and, every time we pick one, we need to do it with resolve and determination and aggressiveness.

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It's -- unless there's -- unless there is a significant reeducation of state legislators in California, I'm not sure the -- and that's possible, I'm not sure the Community Benefits issue will move this -- will move this mountain.

Term limits is turning out to be a terrible public policy idea. We're having people turning over every two to four years in the legislature. It is a real problem. This issue of diverse if you're healthcare workforce is a 20 year agenda. Elected officials cannot possibly pragmatically look past their last -- their upcoming election, and it is very difficult to get traction on an issue for a 10 to 20 years period of time and stay close to it. Philanthropy has the luxury of doing that.

Now, we have a five year plan approved by our Board of Directors, Lou. If they were to hear that we at the California Endowment have worked -- are now working in an active, vibrant, dynamic partnership with other foundations like Commonwealth and RWJ and Kellogg and others, then I can look them in the eye and make the compellant for straits of case that we have partners that are in this for the next ten years, and we are among that partnership and I need you to support that. And in the absence of that kind of national partnership, it makes the case tougher.

But, I would like to ask my Board of Directors to take the workforce diversity issue and not have it merely a five year grant making strategy, but a ten year plan and beyond and that's because of the pipeline issue. We make investments today, we may not see the benefits 9, 10, 12 years from now, and we need to be able to stay the course.

DR. SULLIVAN: Yes, questions? If you would identify yourself and your -- .

MR. RICHARD VANHORN: I'm Richard VanHorn, the Mental Health Association, Los Angeles. I'm the real minority here today. The only person representing behavioral health, I think, out of -- we're 10 percent of the health costs now.

Dr. Ross, I really applaud your comments. I think that—I hope that we're one of the “do tanks” that they may (inaudible) in Los Angeles. But, the real issue for the “do tanks” is what happens when you go after pilot funding to build the database to prove the case to business, and prove the case to government.

It takes more than the one, two and three year grants that foundations will give. It takes an investment policy, which you're talking about now with your nursing initiative in the Central Valley. It may take more than three years to build that to the point where it then gets public sector funding.

I know the example for us in developing a model -- an integrated service program for people with serious mental illness, took eight years before we could get the Governor to put serious money behind it. And then, within the last three years, before our stupid energy crisis, he chunked all of a sudden \$65 million to expand that kind of program. But, it wouldn't have happened without the data and without the eight or nine years of pilot program stuff.

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DR. ROSS: I guess I agree with you. You will know that, in terms of our workforce of nursing initiatives, we're looking at some key professions to hone in on; physicians, dentistry, nursing, mental health. We think that we can have an impact in those areas. And basically, I agree with most of what you said.

I will say that the beauty of this gathering and this group is that my paranoia is (inaudible). And it is—it is my hope that we—that what this group allows us to do is not feel alone.

And perhaps, too, there are a couple of provocative ideas in that paper that was written for the purposes of this gathering, and I hope some of them get some—get some light. Such as, you know, what would be the impact if all the foundations said, “We're not gonna give any more money to academic centers until we see evidence of medical education reform.” That's interesting.

And, you know, it would—you know, we have to think that there are wonderful people in academic studies now doing great work. We don't want to penalize them. But, at the same time, how do we get the attention—or, should we be investing community organizing and advocacy dollars to put pressure on—and not only in Sacramento and in Washington, but on medical education and training to reform what they do, such as what has happened with law enforcement. I don't know.

I mean, these are all ideas that we're thinking about. Within a year, I've got to come back to my board with a more detailed plan and, hopefully, I will have the imprint of the thinking of this group.

MR. STEVEN THOMAS: Dr. Ross, thank you very much for your comments. My name is Steven Thomas. I direct the Center for Minority Health, University of Pittsburgh and the Graduate School of Public Health. And I, too, saw the release of the IOM report as a potential hallmark and something to rally behind.

But, it's interesting on the ground around the issue of race and racism. And I say this because, when you're talking about the helping professions, people who have come into the field to dedicate their lives to helping others, the “R” word stops the conversation and yet it must be confronted.

We have learned how to talk about race in the context of affirmative action and desegregation, and in a lot of the business areas you've talked about. But, this is a new arena and it seems that we don't have the words and the language to talk about race in ways that bring us together, rather than polarize us.

And so I'm faced at -- the University of Pittsburgh established the School of Public Health in 1948. I was the first tenured African-American Professor in the history of the school. I say that not to bring attention to myself, but to bring attention to how difficult this issue is. I have an -- .

DR. ROSS: -- As long as you're not the only tenured African-American Professor.

MR. THOMAS: In the School of Public Health, I am.

DR. ROSS: Still.

MR. THOMAS: Yes, as we speak.

DR. ROSS: That's a problem.

MR. THOMAS: I hold an endowed chair in Community Health and Social Justice that was endowed by a local foundation, The Maurice Falk Medical Fund. So the foundations have power in helping them move the agenda, but we have to talk about race in the context of health that does not polarize. Can you help us sort that out in ways that can help us move this agenda?

DR. ROSS: Probably not. I—let me just say one thing though. There are—one of the things that's important for me, particularly in this business where we're dealing with issues that have decades, if not centuries, of root cause behind them on poverty discrimination, unemployment, leading to bad health outcomes, is that I—I'm a big believer in looking at indicators and signs. It's the clinician in me—in us.

And one of the—among the indicators and signs that I would look for in terms of reforming medical education and training is whether the issue of race and racism, and stereotyping and bias is imbedded in medical school curriculums and in training programs. That doesn't mean I know what the curriculum ought to look like or that I can write the lesson plan. But, if I can touch that and see that—and in a few medical school places and a few training programs we have begun to see that. It's not there.

I carry an anger, and the anger is the following. I think I went to a wonderful medical school and I had a wonderful residency training program. But, I left with a void, having been one of those who benefited from affirmative action, I believe, who passed my boards without anyone else in the room helping me.

That -- when I left my medical education and training program to enter the world of caring for patients, okay? So, you know, I stopped being a resident on June 30th and, on July 2nd, I'm now a practicing physician in a community. And when the first patient I see, the very first patient I saw on my first day as a practicing physician in the community, was a little Hispanic girl who's nine years old who came in for a regular checkup and was overweight. And how mightily I struggled with that little girl and her family to get this child to lose weight.

And I won't go into the details of that, but you—I think you understand. Because I was much better equipped in my training to recite the 29 steps of the Krebs Cycle, to explain Boyle's Law, to let someone know how I could manage a patient with Reyes Syndrome in the middle of the night with DIC and a fallen blood pressure. But, I could not for the life of me have been equipped to work with this family to get this overweight nine year old child to lose weight.

It was a gap for me. Wait a minute. A board certified—I went to Penn, Children's Hospital, licensed,

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but no one has equipped me to deal with a family in the context of a neighborhood and a community that's dealing with a crack cocaine crisis which was going on at the time? What happened?

So, that is where I believe academic medicine and training needs to be shaken a bit. I know you've been doing this since the Flexner report but, maybe it's time to take another look at this.

Are we preparing physicians for what they have to deal with in terms of being responsive to letting a patient and a community be healthier. And my argument that is racism is one among a number of things that needs to be imbedded—even though we may now know how to teach that, we better get to stepping on it.

MR. THOMAS: Thank you.

MS. SHIRLEY MALCOM: Thank you so much for your comments. I really enjoyed them. I'm Shirley Malcom and I head education programs for the American Association for the Advancement of Science.

In the comments that you have made, you seem to be advocating structural approaches that begin to get at the root of problems. For example, cultural competence for all physicians, looking at strategies for beginning to address some of the thornier problems that occur.

In the context of the suggestions that are provided in the report, we talk about the pipeline issue, which is a—one that affects us all, whether we're talking about providing for more physicians or for more bench scientists, or for anything where there's the need for that kind of educational background.

And the report talks about the need for more pipeline projects. But, in a way, that is insufficient because it is not getting at the structural problems of the overall issues within the elementary-secondary school system. And that some attention needs in fact to be paid to the more structural issues, and at least some investment in more structural issues of getting at the root of some of this so that the pipeline problems—pipeline projects are not necessary but that, in fact, they begin to be an imbedded part of the way that students are prepared from the beginning, including things like career academies that are a part of high school, an integrated part rather than something that is separated.

And I was just wondering about your reaction to this whole question about investing in at least a small portion in terms of targeted experiments that begin to try to look at and capture this larger structural problem.

DR. ROSS: Yes, well count us in on that one. Again, not because we have the answer, but I agree with you. I think that has to be done.

One of the interesting partners in this, as we think about new partners to the table, and perhaps an issue where we may be able to ride the wave is this issue of education reform.

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Los Angeles is going to build like 120 new schools over the next 10 years through education resources and school bonds and all kinds of things. And I wondered as I was reading that article in the newspaper, it's like, boy, I wonder if we can get some health and science academies in here. A couple.

And if that scenario's being played out all across California and all across this nation, not just in new schools, but in charter schools and voucher programs and more accountability to preparing kids for futures that have relevance for them, I wonder sort of how do we get traction, how do we get our foot in the door with the education reform effort and link up with people that are moving the issue.

Now, as I talked to one person who is involved with education reform in Los Angeles, he said great idea and you could do that. The problem is another—I'm sorry, infrastructure capacity issue and that is the number and quality of teachers to be able to turn the light on in kids about a health and science career in general. So that leads us to another problem. And I don't want to go to my Board of Directors and say, listen, I need a grant to pay for 500 new teachers in California.

So—but there's—I think there's an opportunity there and I wonder if one of the—one of the—is a (inaudible) that is one of the ideas of the commission, as we're looking for new partners, is to think about the opportunity that education reform provides in terms of getting more young people in the pipeline for health and science careers.

DR. SULLIVAN: Thank you. We have time for two more questions. Here and then here.

DR. TERRI LANGSTON: I'm Terri Langston from Public Welfare Foundation in Washington here. It's just terrific to hear—to know that you are one of the leaders in health science (inaudible) now because it has been so long that foundations have only funded their friends. They tend to be in the academic world and have produced reports that sit on a shelf.

I noticed that you have regional offices also in California. And I've often wondered if the big foundations shouldn't split themselves up into regional foundations and only would—that way would they be effective that would include us. I mean, I think our \$400 million probably would be more effective concentrating on a region.

That said, my point in that I think, in order to get these communities to take personal responsibility to health, to affect the educational system, to be advocates, and heaven knows advocacy and correlation building is a key to this, is for foundations and, among them the large foundations, which they've been hesitant to do, to make small grants to the community based organizations that are led by minority people.

DR. ROSS: Right.

DS. LANGSTON: It just seems beyond the ability of so many large foundations to get down there

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and I would encourage you to. I hope you have some ideas for the rest of us. We try to do that and I know how difficult it is, but I think it's key to this issue.

DR. ROSS: Yeah, we do it as well. I think advocacy is a—is a terrific—on a dollar-per-dollar basis, a terrific investment in terms of return, return investment. When it's effective advocacy of course. I do believe in—or we do believe in supporting grass roots organizations for community organizing purposes.

But, this doesn't—I think what it means is for us to come together as philanthropic partners and colleagues, is that we each bring kind of either a competency and a bent and, as long as we're working together, we can have a foundation that does think tank stuff.

Okay, you crank out the papers, I'm gonna look at the findings and move them. That guy's gonna do the advocacy front. I mean, I don't know that we could ever get it to be that neat, but I would love to see this look like a team effort. And roles and responsibilities are kind of carved up, we hold each other accountable for it, and then the issue will move if we're firing on all cylinders, because it needs to be a multipronged approach and I think we're gonna need a number of partners to get those issues moved and come back and meet and hold each other accountable for the progress that we are or not making. Not in a way that is vindictive or to have shame, but in a way that also says good job, you know, what's the next issue that we have to tackle.

DR. SULLIVAN: One more question before the break.

Thank you for allowing that to me, Dr. Sullivan. My name is Rudy Williams. I'm the Executive Director of the National Medical Association.

To preface this, let me say that I spent 32 years as a Dean, Associate Dean, a Vice President of Medical Education in academic health centers. I have chaired admissions committees in medical school, or co-chaired or vice-chaired for some 25 years, and it started in 1970, so it was a difficult period.

And I'm just thinking here, as I'm preparing to say this, that that should have been the most difficult period. It should be easy for us now to admit minority students to medical school. And I'm dismayed somewhat and really heartbroken, for lack of a better word, I've got a better word, but it's not right for polite company, about what's happening today in medical education. We had more minority medical students back in 1992 and 1990 than we have today.

We fought just as hard, we did all the things we had to do, we were Assistant Deans for Minority Affairs and Directors of this and that. Very few of us. And I was one of the fortunate ones who carried an Associate Dean title and chair of a committee and was able to change things and do things, where people could call and say, Rudy, I got a kid that I want in school and what can you do to help.

And when the Governor of the state would call. I mean, this is the way deals are made and things

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happen in medical education. But, we admitted minority kids to medical school.

I applaud the Kellogg Foundation. I applaud all of you for what you're doing in this effort. We've got to do something about this because one of the things I used to say while I was at Down State (sp) is that, when my mother wakes up in the morning at Kings County Hospital, I want her to be able to say that that's a kid who graduated from the medical school next door. That was Down State at the time. And she shouldn't have to ask whether that individual is culturally competent or not. She shouldn't have to feel that way.

The bottom line of what I'm saying here today in representing the National Medical Association is, we stand ready to assist in whatever way we can and we offer our constructive participation in whatever programs come out of this. We feel that cultural competence is a serious issue that must be addressed.

And personally, I feel that we must regain the momentum—and you're right, momentum swings in games, left and right and here and there. We must regain that momentum to invigorate the medical school admissions process so that we admit students, we recruit them, and we graduate them. That's an important factor, too, is graduating those students.

And I've got some history in that and I must tell you, no brad, just fact. I graduated a bunch in my life, okay?

DR. ROSS: Thank you, sir. And I think we need to take stock of the places that are doing great work. Perhaps the work that you've done at Duke University, others that are doing a good job and find out why.

I get—the last point—I know we're behind schedule, Dr. Sullivan. I think it's time, and this is gonna be difficult. This is gonna be really hard.

It is going to be a moment to take a look at our basic assumptions about recruiting and admitting and educating and training physicians. To this day, I am still flabbergasted as to why, when I was a pre-medical student at the University of Pennsylvania as an undergraduate, why I had a number of people look me in the eye and tell me the most important courses for you are calculus, physics, organic chemistry and biochemistry. And your performance on those are going to determine your readiness as a physician in training. And as I look back at my years in practice in a community, if I think about the number of times that I had to reach into my calculus and biochemistry and organic chemistry and physics and Boyle's Law to help this patient, in the context of this family in this community, for the life of you, I do not why people would look me in the eye and told me that. I do not know.

And it is stunning to me that, generally, we continue to do that. Of all of the undergraduate professors I had, I cannot remember the name of my physics, biochemistry, organic chemistry—I can't remember any of those people.

The one course where I remember the professor and had the most significant impact for me, in terms of preparing me to think about my career, in terms of being responsive to the community through health, was Professor Anthony Camtolla (sp), my freshman year at Penn, who taught the sociology of the family. I remember him, I remember his course, I remember the impact that his course had on me in thinking about my career, and I can not remember a blessed thing about my calculus professor.

Thank you.

DR. SULLIVAN: Dr. Ross, thank you very much for getting us off on such a stimulating note this morning, and thank all of you for your participation.

END

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