Bridging the Divide:
Medicare's Role in Reducing Racial and Ethnic Disparities
Alliance for Health Reform
and National Academy of Social Insurance
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ED HOWARD: My name is Ed Howard. I'm with the Alliance for Health Reform and I want to welcome you on behalf of our chairman, Jay Rockefeller; our co-chair, Susan Collins; and the other members of our board of directors to a briefing on a topic that goes right to the heart of equity and fairness in our health care system. That is the role that Medicare plays and could play in reducing racial, ethnic and income disparities in health care. Our partner today is the National Academy for Social Insurance which is, for those of you who are not familiar with them, a nonpartisan group of which, as a matter of fact, I am a member and Carolyn Clancy is a member, in the interest of full disclosure.

NASI often convenes prestigious panels to look at policy questions involving social insurance programs and on this occasion the task was to examine how Medicare can help us move toward a solution to the persistent problem of disparities in health care. Medicare is the biggest single health care program in the country and the view of the panel, among other things, is that it needs to lead the way in moving us toward greater equity and fairness.

I want to thank NASI, Pam Larson, Paul Van de Water, Jill Braunstein, the rest of the folks for its active participation in putting together today's program and its

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partial support of the briefing, and I should say their annual conference is later this week so I know how difficult it has been for a small staff, nonprofit, to handle two very important meetings at the same time. On behalf of NASI, let me reiterate the acknowledgements that are printed at the bottom of today's agenda. NASI's work on disparities has been supported by the Robert Wood Johnson Foundation, by the California Endowment and by the Joint Center for Political and Economic Studies. And on behalf of NASI, let me thank you to those folks. I should say that the issue brief from the Alliance on this topic that's in your materials was also supported by the Robert Wood Johnson Foundation, so we're very pleased to have them actively involved in this issue.

A couple of logistical items before we go on – in your packets, of course, a bunch of materials that are relevant including speaker biographies that are more extensive than I'm going to have time to give them, and copies of the slides that we had received in time to include them. By tomorrow, you'll be able to view a webcast of this briefing on kaisernetwork.org, along with electronic versions of the materials in your kits and the copies of the slides that we didn't get in time to include therein. And in a few days, there will be a transcript that you can take a look at as well.

At the appropriate time, you're going to want to fill out those green cards and ask tough questions of our panel or come to one of the microphones and ask them in person. At the end of the briefing, we would very much appreciate you filling out the blue evaluation form so that we can make improvements in these programs as we go along for you.

We have an extremely distinguished panel of speakers today, so if you would turn your cell phones and pagers to vibrate or whatever you need to do. I want to get started.

First off, Dr. Carolyn Clancy – Dr. Clancy has been directing the Agency for Health Care, Research and Quality for almost four years now. Her academic and professional credentials are immensely impressive, as set out in her bio, and her expertise in matters of health care quality is recognized worldwide. She is responsible for producing AHRQ’s annual report on quality and on disparity as directed by Congress since their inception. The newest additions of those two reports are summarized in your materials. She is also, I'm pleased to say, a veteran of a number of Alliance programs and we're very pleased to have you with us today. Carolyn.

CAROLYN CLANCY, M.D.: Thank you, Ed. Good afternoon, everyone. I'm also very pleased to be here because you're hearing news that is almost hot off the press.

So we released the 2006 versions of the National Health Care Quality Report and the National Health Care Disparities Report on January 11. There is a huge amount of information in both reports, and I couldn't begin to cover it here, although I'd be willing to stay till midnight if people want to hear all of the details. But I'm just hit some of the highlights with respect to disparities today.

Before going there, I just want to give you a little bit of background about why are we doing these reports. When the agency was reauthorized in late 1999, we were directed by the Congress to produce on an annual basis two reports, and the literal legislative language is up here. To start in fiscal year 2003, the secretary acting through the director of AHRQ shall submit to the Congress an annual report on the national trends in the quality of health care provided to the American people.

The second report charged us to track prevailing disparities in health care delivery as it relates to racial factors and socio-economic factors in priority populations. This last sentence clause is very important because some people hear the word disparities and they think it's about race and ethnicity only. The mandate to us, actually, is much, much broader than that and has to include not only income and education, but geography and other factors as well.

So the question is, why are these reports useful? We believe it gives the Congress a very high-level view of what's happening in the American health care system on an annual basis and because these reports are produced annually, you can actually see progress or in some cases, the lack thereof over time, which gives you a sort of deeper and richer understanding than you might get from single study because we're using the same measures year after year.

Now the Quality Report this year has 211 measures, but in order to make this more digestible, we have 40 core measures that we track over time and it gives us a sense of where we're going. We can actually give national and state trends from 1994 on and we're also hoping that this helps us advance what I think is a national agenda in aligning measurement activities. These days, there is no shortage of quality report cards. Sometimes you might argue that we have too many. There is a great deal of interest in the public and private sectors in aligning around a core set of measures and we think that these reports can help facilitate that alignment.

So the Disparities Report provides a snapshot of disparities across multiple domains in this country whereas the Quality Report provides an overview of quality of care.

The Disparities Report focuses on quality and access. The Quality Report obviously on quality. I want to make the point, though, that they're the same quality measures in both reports and we've linked them very closely for one very important reason. Achieving equity and getting to only okay care didn’t seem to us to be a terribly lofty goal in terms of reducing or eliminating disparities associated with patient's characteristics. In other words, if you think about Beth McGlinn's [misspelled?] famous report saying that Americans receive recommended care 55-percent of the time, achieving equity at that level of care didn't seem terribly ambitious to us, so that's why we think it's very important to link the two very closely.

The Quality Report focuses on four of the six dimensions of quality that have been recognized by the Institute of Medicine, and I must say I'm always intrigued and are now referred to very broadly by people who don't follow the technical details. So you often hear employers and health care purchasers talk about the IOM6. So the Quality Report focuses on safety, effectiveness, timeliness and patient centeredness. The Disparities Report focuses very broadly on equity. Neither report, as yet, focuses on efficiency. The Disparities Report focuses on variation across populations, whereas the Quality Report gives us some

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sense of variation across states. So I will take two seconds for a public service announcement to say we will be having state reports, state snapshots, coming out in March.

New in these reports, our focus on obesity, hospice care, adverse drug events, communication in the hospital, workforce diversity and the response to the recommendations put forth by the commission led by Secretary Sullivan and language assistants. There are some specific composite measures that speak to post-operative complications as well as composite measures related to communication in the hospitals. Some of you are aware that HCAPS or the standard survey of patients experience of are in the hospitals will be reported publicly for the first time by virtually all hospitals in this country later this year. You'll get to see a preview of what that looks like in those hospitals that participated early, not at the individual hospital level but at a high level view. And we also have more trends and information on Hispanic subpopulations.

For the Quality Report, we found that improvements are being seen. We're headed in the right direction. That's the good news. The slightly less good news is that the overall improvement rate is relatively modest at 3-percent. Headed in the right direction but my statistician tells me it will take us about 20 years at that rate to close the gap between best possible care and the care that is routinely provided. The use of proven preventive strategies seem to us to be a very, very important set of opportunities to highlight as we publish the reports a couple of weeks ago specifically just over half of all adults report receiving recommended colorectal cancer screening – really, really important, because if we don't find it early, it's not curable. Only 58-percent of obese adults were given advice about exercise from their doctor and just under half of adults with diabetes received all their recommended screenings.

Let me just pause and re-emphasize the point about trends here. You could look at 48-percent and say, "What is going on in health care?" On the other hand, in our first report in 2003, that number was 32-percent, so we're definitely seeing improvement in the right direction, but it's clear that we have to accelerate that trend even more than has been done to date.

The Disparities Report finds that disparities in care associated with patient race, ethnicity, income and education persists. Blacks, Hispanics and the poor are worse off on 75-percent of quality measures. Asians and American Indians are worse off on 40-percent of quality measures. Hispanics and the poor are worse off on 90-percent of access measures, and blacks and Asians are worse off on one-third of access measures.

Just to give you a sense of what this looks like. What you can see on the left hand side of this slide are – in order, are black versus white, Asian versus white, and American Indian and Alaskan Native versus white. So the yellow bar that is circled there are the proportion of areas where disparities are improving. The pink bar is where the disparities are staying the same and that aqua bar – you can speak to me about colors if I've got them wrong later – are areas where disparities are actually increasing. You can also see that for the poor, 25-percent of disparities are actually improving, but almost two-thirds are worsening.

Similarly, if you look at access – most disparities in access seem to be getting smaller which is good news and particularly you can see that 80-percent of access measures for American Indians and Alaskan Natives are improving. On the other hand for Hispanics, that's only 20-percent, and for the poor, only 40-percent.

Now to say that opportunities for improvement remain, I think, is self evident so I don't want to dwell on that. All groups are worse off on some measures of care covering multiple domains and moreover all groups are worse off on some measures of care where the gap is growing larger. So

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there is no shortage of areas where we could bring focused efforts. We believe very strongly that solutions need to be tailored to local communities. Our Disparities Report is providing a very high level overview, a little bit like flying in an airplane over the countries health care system if you could picture that.

But in terms of getting down on the ground, it's reasonable to think that the needs of one community are going to be quite different from the needs of another. So an awful lot of our work at AHRQ is focused on trying to figure out how can we create and implement effective partnerships with people who want to improve care. By way of example, we're working with a number of states to reduce disparities in pediatric asthma.

We also see that the information is improving but we still have some gaps. This year, specifically, estimates were not possible for most quality measures for Pacific islanders and individuals who identify themselves as being of multiple races. And in addition to that, we weren't able to provide reliable estimates for 60-percent for quality measures for American Indians and the poor.

Just some very specific snapshots — what you're looking at here are disparities in black Medicare beneficiaries for post-operative care complications. You see

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total white, and then black moving across the slide. You can see there have been improvements in all, but black rates remain higher than whites.

Similarly, disparities in Hispanic Medicare beneficiaries for any type of colorectal cancer screening in the past two years and what you can see are some areas where there is a very high prevalence of Hispanic populations, and you can see here that in general, whites are doing a whole lot better than Hispanics. The purple bar is total, the brown bar in the middle is the rate for whites and the whitish bar is for Hispanics. You can also see that the high watermark here is for whites in Miami, Florida, which is 22-percent, which is way, way lower than it should be.

Similarly disparities among Medicare beneficiaries – you can see vary a lot by income with those in the highest income groups having the highest rates. We see this for a lot of measures and we also see that in other countries.

Disparities in appropriate timing of antibiotics received among Medicare patients who are having surgery, this makes a huge difference in terms of the incidents of post-operative infections and what you can see is that the total is about 57-percent. No significant differences between whites, blacks and Asians. It starts to be a little bit lower for American Indians and lower at 49-percent for

Hispanics.

I might be stuck here. That was just the end, so let me just say in conclusion, thank you for your attention and also to tell you that you can get to much, much more information on our Web site. Ed said I was responsible for leading these reports, I would say I'm responsible for taking credit. The two experts who really do the hard work are also here with me today, so I'd be happy to hook you up with them as well. Thank you for your attention.

[Applause]

ED HOWARD: Thank you so much, Carolyn. Terrific basis for our discussion. I'm going to continue building that base, if you will, with our next speaker, Renee Landers. I am definitely not the next speaker.

Renee Landers is one of those people whom people like me are in awe of. She is a law professor at Suffolk Law School in Boston, where she teaches, among other things, health law. She's been a senior official in both the Justice Department and at HHS. She's practiced law at one of the most prominent, private firms in the country, Ropes and Gray and not coincidentally, Professor Landers was a member of the study panel of Medicare and disparities that was convened by the National Academy for Social Insurance, the report that occasions are gathering here today. And we're very pleased to have you with us.

RENEE LANDERS, J.D.: Thank you very much. Thank you very much, Ed. I really appreciate being here and having the opportunity to talk about the NASI report on what Medicare can do to reduce racial and ethnic disparities in health care.

Ed did a fantastic job of talking about the mission of NASI to promote understanding and good public policy on social insurance issues, which include things as economic security and access to health care which is the reason that we're here today. On the panel on racial and ethnic disparities – just to emphasize the point – that NASI tries to convene study panels that represent a diverse range of disciplines and perspectives to bring to bear in thinking about these complicated problems that in some ways some to be intractable from time to time. The study panel's report, which I think is in your packets, is just part of the work product of the study panel. We also commission some working papers and briefs which you have one of them in your, but also the working papers are available on the NASI Web site.

As Carolyn noted, the most – I think it's not terribly – it's not news to anyone that there are disparities in health care and health outcomes in this country because they've been documented again and again, not only by the

National Health Care Disparities Report but also by the IOM studies and the work of people on this panel. The study panel’s goal was really try to determine how Medicare could help reduce disparities because Medicare, as has been noted, is the largest purchaser of health care services in the country and has tremendous influence on all components, therefore, of the health care system, not only for the programs beneficiaries but for public generally, and how the public experiences health care.

As I indicated, Medicare finances care for 43 million beneficiaries, nine million of whom qualify as members of some racial or ethnic minority group. And one of the important premises that the panel started from was that as a contributory social insurance program, Medicare really has the responsibility, the obligation from a legal point of view, and also from the point of view of how government programs should function in democracy to ensure that all beneficiaries receive the appropriate care on a fair and non-discriminatory basis. So I think one of the first things we thought it was important that we do in our report was to acknowledge that the Department of Health and Human Services has made really a substantial amount of progress.

Historically, as our report notes, Medicare was instrumental in eliminating segregation in hospitals –

legally sanctioned segregation hospitals in America. And more recently, the Health Care Disparities Report that AHRQ prepares, CMS demonstration projects on cancer prevention and treatment, being a notable one that is aimed at eliminating racial and ethnic disparities in the delivery of care, the quality improvement organizations and partnerships with health plans and provider organizations are all the kinds of things that Medicare is trying to do to really address this question of disparities.

Some of the partnerships worth noting — the partnership with the NCQA and with health plans directly, and some of the organizations representing minority health professionals are all things that CMS has done or is contemplating in the future doing to try to focus on this question of eliminating disparities. And also focusing and collecting improved data. Carolyn noted in her talk that data is a barrier to try to get a handle on what the extent of the problem is and what the right solutions are, and I think that CMS is aware that that's an issue. But I think that we all also thought that there was more that could be done by Medicare to produce an improvement in disparities and to reduce disparities. By definition, Medicare has overcome one of the major factors contributing to disparities, which is access to insurance. People in the Medicare population

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that's sort of access to some basic coverage is not their issue. But disparities persist and I think one of our goals was to talk about ways in which Medicare could really use its leverage and its activities to try to reduce these disparities.

One of the visions that the panel had was that equity of access of all beneficiaries was really important. That all beneficiaries should have access to providers with whom they could communicate effectively, that providers needed to understand how culture affects health and health care, and that health care that is responsive to individual needs and is appropriate under the circumstances is really what the system should be driving to produce. We also thought that as with all programs targeting improvements for minority populations, these improvements will provide information and improvements for the program, the Medicare program overall.

Then finally, one of my personal goals which is not on the slide, was to communicate a sense of urgency about this problem – that it's very undermining in a democratic system where people contribute to fund the Medicare program through payroll deductions, taxes – that these disparities persist and also it does not reflect well on the nation, among the Western democracies that these disparities continue to exist.

To get to the report recommendations, we made recommendations in five categories — quality of clinical care, access to care, education of health professionals, the capability and practice of institutions and administrative priorities and structure. I'll highlight one or two of the recommendations in each category in the interest of time, and then if you want to go back over some of the other ones, we can talk about them during the discussion, but the slides provide a list of all the recommendations in each category.

On the quality issue, I think the most significant feature to point out here is that quality improvement efforts should focus explicitly on reducing disparities. The members of the study panel felt strongly that efforts to improve quality overall do help at the margins — eliminate or reduce disparities, but usually there needs to be a much more targeted focus in order to see changes in the disparities improvement there. In fact, some efforts to improve quality may worsen disparities, and I can talk a little bit more about that.

On the quality of care, one of the major recommendations of the report is that Medicare should work very hard to ensure that beneficiaries have a primary provider of care. This is a common theme, I think, throughout a lot of the literature on disparities that having a health care provider that a beneficiary sees regularly, can consult with and that person can help coordinate the care the other person is receiving is incredibly important to eliminating disparities and improving access.

One of the other recommendations in this area is thinking about structuring incentives to improve quality and these incentives, we have to be careful here as the literature has pointed out in structuring the incentive so that they don't have some perverse effect of actually exacerbating disparities as providers try to make their numbers look good and improve their numbers. This is one of the concerns I have.

I come from Massachusetts, as Ed indicated, where we've just enacted this new health care reform legislation to try to improve coverage, insurance coverage for large numbers of the uninsured in Massachusetts, and there is a provision for providing incentives for providers to eliminate racial and ethnic disparities, and I think it will be very crucial to see how those incentives end up being structured so that we don't exacerbate the problem we're trying to solve.

On access to care, one of the recommendations of the report was to make sure on the parts of the Medicare programs where there are deductibles and co-payments, that Medicare really be cognizant of socioeconomic status and try to set deductibles and co-payments to try and reduce disparities so that people can have access to those other parts of the Medicare program. And also to improve education to beneficiaries and to their families about health care and about using the health care system.

One of the other projects I'm involved in is the medical legal advocacy program at Boston Medical Center which has, for a number of years now, had lawyers who are employed by the pediatric department, and physicians can refer patients to the lawyers. It's not intended to generate more malpractice litigation, so don't worry about that, but recognizing that problems with housing, benefits, insurance, education or employment for the parents or the children can have tremendous impact on the ability of people to take advantage of their access they have to the health care system. These lawyers are on site and have improved, so this is just one example of the kind of thing that programs — the Medicare program can think about doing. This is not in our report, but it's the kind of thing that isn't necessarily intuitive, but that could really actually work to improve health care status and access to health care by thinking about what are the contributing factors to health care status and problems with access to health care.

Education of professionals is another major focus of

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our report. Obviously, there is a lot of literature about encouraging enhancing training on cultural competence for providers. We talk about institutions really thinking about how many people in the institution really are conversing in foreign languages. I have a college friend who went to medical school in Montreal, for example, and it was just assumed that it was her problem to learn French sufficiently to deal with patients who would come in to the hospital when she was in her training program. So I think emphasis on that and all professionals, but medical professionals is incredibly important.

The capability and practice of institutions – I think again as I mentioned earlier and as Carolyn had alluded to that collecting data necessarily for assessing, monitoring and targeting disparities is really important. Right now, there are a lot of weaknesses in the data, especially as Carolyn noted, the really specific data and sufficient quantities of people who identify themselves as multi-racial. Some of the data are not very good for some of the smaller racial and minority groups. The data on economic status that can be correlated with the racial and ethnic data is also not very good and our report recommends that several steps that Medicare and the Social Security administration could take to try and improve the quality of the data. Obviously, as new people enroll in the program, the Medicare program, there is an opportunity to start fresh in collecting the kind and range of data that the program needs, but also the Medicare program needs to really try to collect that same level of quality data from existing beneficiaries. Otherwise, it's another problem that's 20, 30, 40 or 50 years in the solution.

On administrative priorities and structure, again, the report makes several recommendations that CMS ought to identify performance goals for reduction of disparities. It has some of these demonstration projects and other kinds of programs that are attempting to do that, but to really raise the profile of addressing this issue within CMS and to really try to enhance the organizational structure that CMS has brought to bear on this issue because I think it's one of the issues — out of sight, out of mind. If it's everyone's responsibility, it tends not to be anyone's direct responsibility. I think that's basically the thrust of the recommendations of the report, to really identify officials within CMS for whom this would be a specific priority.

So, in sum, I would say what I said at the beginning, that Medicare and CMS are beginning to use the tools available to help reduce disparities. That Medicare and CMS needs to use all the tools because I don't think there is any

— this is not the kind of issue where there is any one solution to a very persistent and pervasive problem. What's needed are commitment, energy and additional resources that I personally would have thought in the 40 years since the beginning of the real act of Civil Rights movement in the United States, that some of these problems would not be persistent in our culture but they remain. At some point, we have to adopt a sense of urgency in order to really try to make them go away. So thank you for your attention. I'd be happy to answer questions later.

[Applause]

ED HOWARD: Thank you very much, Renee. We turn for our final presentation to Peter Bach. For almost two years ending in last November, Dr. Peter Bach was a senior advisor to the administrator of CMS where he handled a lot of questions related to quality and quality related payment, and the evidence base for treatments. He's one of the countries most respected researchers in the areas of quality variations and care disparities, among other topics and, obviously, that is an invaluable focus for us to have given our topic for today. Peter, thanks for being with us.

PETER BACH, M.D.: Thank you very much. It's a nice thing to say. I get the pleasure of talking about this topic I care about greatly and also the pleasure, I think, of disagreeing on a few of the points.

Put simply and to get back to Carolyn's slides for a second, there is sometimes a math problem when addressing the sort of shortfall in quality that we have and the disparity gaps that we face. I think we do have to accept the algebra around this – and there's a reason I'm being this technical – that it is possible we could programs in place that would widen disparities while increasing the quality of care achieved or received by both groups, if you're comparing blacks and whites. I think that if forced, and if you put it in an administrative structure like CMS around something like quality improvement or disparities reduction and there are targets and goals put in place – if forced to reconcile potential problems with that algebra or potential problems of widened disparities by improving quality, we will, or CMS will have to decide, or the secretary will have to decide how one set of progress is weighed against what would otherwise be viewed as a failure on the other end.

That's a really hard problem, I think, just in the pedestrian, technocratic sense of running a major agency that's charged with the care or at least the insurance coverage of 43 million people. So it's an intriguing problem and it's real. On some of those slides, there were actually widening of gaps when even as the boat, if you will, was rising for all. Same goes with this recent [inaudible] study in *JAMA*. It's very clear that some of the MA plans, there is sort of net improvement and net widening of gaps all at the same time.

I guess my personal view of this is if forced to choose, I would go for quality improvement over reduction in disparities that doesn't sort of make the whole improve because I focus on disparities specifically as trying to get a better ticket to a bad movie. I think what we need, really, is to try to get a better movie, and then maybe we can get better tickets for everyone as well.

I think that's one of the challenges in an agency trying to focus on both. Another is that Medicare, obviously a very large payer responsible for paying almost a million providers in the care of tens of million beneficiaries — Medicare, through its demonstration authority and through other sorts of vehicles like voluntary reporting, and even vehicles like hospital quality reporting, is pretty good at targeting specific conditions, specific patient subgroups, specific measures, process measures, structural measures and even capable through some sorts of steps and conditions of participation around hospitals of mandating particular types of behavior or resources are present. But there isn't a lot of runway to pursue something like really looking at making sure that care is, let's say, equitable or that care is fair or it achieves a certain standard for all beneficiaries because the issues of defining such things are so vexing and there are a lot of different ways of doing it, although that makes sense sort of hypothetically as an administrative function, would be very, very difficult to do.

I do think to differ with one of the points on the slide that one of the ways to do that is to focus on evidence based medicine. There are lots of areas in health care where the evidence is insufficient. There is no question. There are different estimates floating around, but it's probably the majority of processes that aren't thoroughly based and available evidence, and there isn't evidence to support them necessarily. But there certainly is a raft of emerging measures, many of them which were on the slides just now from Carolyn, of things that are evidence based and that Medicare can continue to focus on and through demonstration authorities and cancer in 2006, for example, Medicare asked doctors to specifically state if they were following evidence based guidelines in the care of cancer patients. Such an approach of getting doctors to adhere to evidence should at least drive consistency of care, and given that all the measures that we look at are focused on those evidence-based guidelines should drive improvements in quality as well.

So I think there are places to go there through the quality direction, but I do think we have to be careful even if Medicare could be highly successful at these things, we have to be careful at appreciating the amount of variation, if you will, that is attributable to the health care system and can be manipulated or improved by a payer, even a very large payer like Medicare – even if followed by all the private payers or in conjunction with the private payers.

Much of this data, some of which I've been lucky enough to work on, demonstrates that there are disparities in health care and the most important variable in the one that sort of controlled for and accounted for before we start to look at race and that's socioeconomic status. The presence of insurance, whether you have supplemental insurance or not, or adequate coverage of your co-pay in Part B or whatever it is, that the sort of stubborn challenges that poverty play extend far beyond the brick walls of health care of institutions or physician offices. Although Medicare should be able to drive the sorts of quality improvement it's trying to do drive, the extent of its scope is far narrower than the sort of underlying cultural problems that have to be addressed. Although I'm ambitious and I was at the agency, that Medicare should be a leader on this, I think there has to be a reasonable set of expectations around the goals that could be achieved, simply through a large social insurance program like this.

The next culprit probably after socioeconomic status is geographic or between provider or between facility contribution as opposed to within provider, within facility contribution. I think the data support that idea that maybe the biggest problems that minorities are facing in health care has to do with the door they walk into when they receive it as opposed to the treatment they get within that facility as compared to other individuals who are white or are not members of minority groups.

That becomes a structural issue, one not necessarily well addressed through things like cultural competency training or other things like that where the underlying tenant is that doctors or other health care providers are discriminating against one group of patients versus another. It's more likely, and the data suggests at least, that what's going on is that people enter facilities where the ambient quality of care if lower. Certainly some of that – Carolyn's slides – times to antibiotics after surgery or prior to surgery are very unlikely to vary based on the race of the patient due to something like discrimination. That's a process within a hospital. It's very unlikely to be heavily influenced by the skin color or the ethnic background of a patient, I believe.

That said, some of the other things Medicare is doing to improve quality do need particular attention so that, as Renee pointed out, they don’t exacerbate disparities. If we're going to have pay for performance, and I think that we're headed that way, we have to decide how we're going to measure that performance. It will have to be some sort of change, again, in something else. Whether or not that's an absolute rate of performance, an absolute improvement, a performance this year divided by the performance last year or whatever it is, the algebra around that equation will drive provider behavior. I think it is important to ask questions given the other issues, stubborn challenges of poverty, lower quality of facilities available to minorities, some of the other challenges of resources available in local communities, whether or not P for P should be directly risk-adjusted based on the racial, ethnic or socioeconomic makeup of patients who are being treated. Such a thing is basically being done in the United Kingdom under the deprivation payment system.

Medicare has direct tools for doing that either through P for P or could use other sorts of resources as the modified version – the dish system that is used in hospitals, like the health professional shortage area, payment that is currently used to deal with rural areas. But there are other mechanisms at Medicare's disposal which could create greater financial incentives and perhaps buff up infrastructure in core and minority communities, and that could yield benefits directly. So I think that kind of direction is worth thinking about.

One other comment, for P for P to work in hospitals, and you can view the recent article in *The New England Journal* as evidence of that premiere is outperforming. Hospitals are just doing quality reporting or you can view it as premiere is not doing that much better depending on whether you focus on the size of the gap that's closed or the size of the gap that was attacked. But either way, it's quite easy, it's not that easy but in hospitals to identify what the accountable unit is, it's the hospitals. So the patient goes in the door. The patient comes out the door on the other side and during that period the hospital is the accountable unit.

We don't have that in the physician side, in Medicare at least, in the indemnity program. What we have, if you imagine a medical home or a marriage between doctor and patient, what we have is some strange form of polygamy in the health care system where patients are married tend to see different physicians, many of them – they IOM report on P for P focused on a number – I think the number seven being a

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number of different unique providers that Medicare beneficiaries see in any particular year to receive their services. So if we're going to hold doctors or practices accountable and we're going to credit them for the increase in the ambient quality of their practice or the quality of care provided to a particular patient, we'd better have a way of assigning those patients to the doctors and we better have a way that the doctors feel that they have enough of a toehold in that patients care that they can influence it. Right now the current structure of fee-for-service Medicare is not compatible with that.

So the idea that a medical home, although absolutely evidence-based and theoretically makes sense, has nothing to do with how fee-for-service Medicare works right now. And I'm not sure that CMS has the authority to require it. Maybe something can be done under demonstrations, but even in the physician's group practice demo, there is no such requirement or even structure around it. It's a post-hoc calculation – whose home belongs to whom?

The last comment is that I view language barriers to be one of the most serious challenges in the application of clinical care. I speak only one language and I don't speak it well, but the patients I see at Sloan-Kettering speak lots and lots of different languages. The patients I saw at other places I worked — Johns Hopkins and the University of Chicago — same goes. It is very difficult to access language services. It's uncertain how qualified they are. Accessing such services is a major impediment to the chaotic flow of clinical care and I do think that is something where we already have standards in place that are probably just not adequately enforced.

That would be a place where I would see real potential for improvement although we have to acknowledge that similarly will greatly drive up the costs of care to have more rigorous enforcement of translation requirements and things like that. But I do think it would be very important in terms of the care of patients and in terms of the ability of providers to have satisfactory, long-term relationships with patients and help them manage their chronic diseases if we had adequate translation services. I don't think we can expect doctors, for example, to learn — for me it would probably be about six or seven languages that I would have to deal with working in New York City. Thanks very much.

[Applause]

ED HOWARD: Thank you, Peter. Now you have a chance to ask some questions and what I'd like to do is give our other panelists a chance to respond to what I think is a very provocative and useful entry into this topic. I would invite comments from both Carolyn and Renee, particularly with respect to Peter's observations and actually Renee's as well about the possibility that making overall quality improvements might actually worsen disparities. In other words, by putting money into a better script, you're going to make sure people get worse seats to that movie. And whether that holds for an overall strategy or if there is a way that one can steer between the difficulties on both shores of that dilemma. Carolyn.

CAROLYN CLANCY, M.D.: Let me start off with a strong belief statement, and I'll follow that with an empirical statement. So the belief statement is in health care we can be equal and excellent to peering [misspelled?]. The empirical statement is we can't have excellence in health care unless we are providing equitable care. It just simply won't work, given the changing demographics of this country. If we have disparities for certain subpopulations, we can't possibly get to the kind of excellence in health care that we all want for ourselves. It's simply not going to happen.

There have been areas where a targeted focus purely on quality improvement actually was associated with a significant reduction in disparities and the clearest example that comes to mind is in the end stage renal disease program so very serious focused efforts on improving care for people in dialysis led to overall improvements and significant reductions in disparities associated with race, in this case African-American and gender. So that's the good news.

The not-so-good news is our reports show every year really suboptimal quality for controlling hypertension, diabetes and the other factors that get you a ticket into the end-stage renal disease program. So it's very clear that we need to move upstream, and I think some of what Peter had to say about the accountable unit issue starts to become a little bit worrisome. The article in your booklets, the relationship between quality of health care and racial disparities in Medicare health plans, I think illustrates a couple of points. Number one is that when performance is transparent and public people pay attention, the number that you see in that article reflect significant improvements overall for blacks and for whites. This particular article focuses not on the processes, that was an earlier paper, something about salami science here getting many papers out of one study. An earlier paper focused on improvements and equalization or near equalization for process measures. Did you order the right tests for diabetes? Did you order the right tests to check on bad cholesterol? That kind of stuff.

This paper in your booklets talks about outcomes.

And that's where you start to see some widening, which to me raises the question, how is it that the health care system can begin to partner with supports in the community and so forth. I also have to point out this little brochure in your books — we began working with nine of the nation's largest health plans a couple of years ago and they were simultaneously incredibly enthused about a joint collaborative effort to reduce disparities and also a little nervous, right? Because after all, nobody wants to announce that we're doing a terrible job here but we're going to be working on it. That was a little bit anxiety-provoking. And most of the plans started off with a fairly discreet sort of project with the idea that if that worked, they would try to roll it out across their plan, and they came to the conclusion that until they had data and could actually see performance across the entire population that they served, that they weren't going to make substantial progress, so they are still working together. I often say that this is a research evaluation project for us. We want to learn which strategies work, but for them, it's core business and they're taking it very, very seriously, which I find encouraging.

RENEE LANDERS, J.D.: My button isn't as sensitive isn't as sensitive as you told me it would be. I guess I would like to agree with a lot of what Carolyn said. I think that what Peter said is true that when people come to the Medicare program they have a lifetime of health care experiences and interactions with the health care system that Medicare can't change at that point. That's history and the question is what's going forward, so in some ways the Medicare program may be dealing with a base line health status that's very challenging for the program, but I guess the question is given that, what Medicare can do to try to even the playing field once the person enters the Medicare program.

So that's one focus of our report, but I think our report also really did focus on Medicare's broader role in the system. What Medicare can do to provide incentives for health care providers, for example, to locate an area with large numbers of low income beneficiaries and people of color. How can Medicare really think about eliminating some of those geographic and perhaps socioeconomic differences in access to care? Also, the recommendations about getting people into Part B and all that sort of thing, I think are not insignificant for once the person gets into the Medicare program. But I think also Medicare's role in educating beneficiaries and their families will actually start to make changes in the overall health care system because I think by educating beneficiary families who often are the people who are sort of trying to navigate the health care system for the Medicare population, they'll learn things about how to access the health care system for themselves. I think that Medicare really taking this broad public education role, not just the broad role about educating providers and providing incentives and standards for institutional providers and physicians — that's, I think, a too-limited view of what Medicare can do even with it's current mandate.

ED HOWARD: One of the things, Renee, you had said and then Peter amplified that in some cases pursuing higher quality overall would exacerbate or had the potential to exacerbate the disparities in treatment and I wonder — we heard an example from Carolyn of the opposite being true. Is there some easily graspable example or examples of it going the other direction?

PETER BACH, M.D.: I wasn’t trying to suggest one thing versus the other would happen. I just was raising the issue that just thinking about it from an administrative standpoint, if there are going to be targets set, it's theoretically possible that achieving one set of targets would cause you to have a shortfall on the other side. But Carolyn is absolutely right in the dialysis program, the net quality improvement also led to reduction in disparities, and that's terrific and that really should be the model, but it's not assured.

That was all I was pointing out. For example, you could argue that a pay-for-performance system is rolled out among physicians or hospitals, as it's starting to be, and the goal is quality improvement. Well, would it be bad if hospitals where there were more white patients outperformed the hospitals where there were more black patients but everyone improved. I don't think we would want to view that as a failure. I think it could be something that could be tweaked or maybe just wholesale so that you see something even better as Carolyn correctly notes, we need to have an equitable system to have a high-quality system.

But I was simply pointing out something having sat on the agency side, if you're told to do something, or asked or requested – the secretary has to do something – you have these basic problems like how do you achieve this and what's the tradeoff and is it possible that – you don't want the opposite unintended, set of unintended consequences where the focus becomes reducing disparities and the easiest way to get there is lowering the quality of care for whites.

RENEE LANDERS, J.D.: But I think that the opposite of the last thing you said is probably what's most likely to happen because if you pay for incentives, the danger is – one analogy might be and it might be an imperfect analogy – back to the No Child Left Behind. It's that you then get incentives to weed the most difficult patients, the weakest students out of the system and in an effort to try to elevate the overall numbers to meet the performance incentives goals and that's a consequence that we don't want to happen. That's not going to leave people better off in the system than they are now — having an uneducated kid or someone who has no doctor because the doctors are running away because it's not going to improve their performance numbers. So the question then becomes, what's the performance that the system rewards?

And the study that was in *The New England Journal* last week is rewarding the highest quality, not necessarily closing the gap from where you were and making a big leap in improving quality overall. It's not one or the other that's going to be better, because you don't want to depress the performance at the top end either, but what you want to do is you want to try to have a system where both kinds of quality can be rewarded. That takes — quality improvement can be rewarded, reducing disparities and improving overall performance to some more objective level of excellence. So I think the question is coming up with the resources to do both things.

PETER BACH, M.D.: We completely agree and so I was

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pointing out technical issue with it, but that's why I mentioned risk adjusting, patient populations maybe even by race or ethnicity or socioeconomic status would be a mechanistic way of doing exactly what you're talking about.

ED HOWARD: By the way, Carolyn made reference to several things that are in the packets, including the brochures from our AHRQ and the report that the study panel, the full report of the study panel, which wouldn't fit into all of these packets. If you didn't get one on the handout table in the back, I'd urge you to get one on the way out.

CAROLYN CLANCY, M.D.: You can't have mine, though.

ED HOWARD: But you can't have hers, even though there are some great notes in the margins. Yes, go ahead. Do you want to identify yourself?

BOB GRIS: Bob Gris [misspelled?] with the Institute of Social Medicine and Community Health. I'm very pleased to see this discussion of Medicare and Civil Rights because we usually don't talk about health care in a Civil Rights context. We usually talk about it strictly in a market driven context. It's very significant as the panel mentioned that the desegregation of the hospital system occurred when Medicare said that as a condition of participation, hospitals had to desegregate. Sure enough, within a few months most of the hospitals in the country desegregated including in the

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South. But what we also see is that political compromises were made so that the nondiscrimination standards were only applied to hospitals and Medicare doctors were excluded from having to meet those nondiscrimination requirements. In other words, the hospital had to meet them, but doctors were not viewed as recipients of federal financial assistance even though they were getting paid by Medicare. This fiction unfortunately interferes with the health and humans services department applying nondiscrimination standards to the health care delivery system.

ED HOWARD: Bob, I know you're getting to a question here.

BOB GRIS: The question is coming. The inequalities that Peter has identified in his research where minorities often go to poorer hospitals — I'm curious how we are going to address that problem through a pay-for-performance incentive to providers or even to hospitals when some hospitals have better facilities than others. How are we going to address this underlying institutionalized inequality?

CAROLYN CLANCY, M.D.: Let me just say, Bob, that I think that you're underscoring what is going to be a very significant strategic policy issue for incentives programs. Several studies that have been published have shown that —

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these were just natural experiments comparing one group of doctors, for example that got some kind of financial reward with better quality with those who didn't. They found — not terribly different from the study published last week — that there were significant improvements bordering on clinically meaningful - not huge improvements, but definitely in the right direction and that most of the improvement came in the physicians side from those who are already doing really well. That's where most of the reward went. Most of the improvement came from physicians who weren't doing so well before, so I think, I'm just restating what Peter said earlier, the question becomes, to what extent do you reward achieving some threshold of performance and to what extent do you hold some resources aside to reward improvement and how much improvement does that have to be, and so forth?

I think it's also important to note given the ambitious aims of the NASI study, which I think is fabulous, is that right now in the public or private sectors the amount of resources on the table for incentive programs is relatively modest, particularly compared to the overall payment system. You could achieve a wonderful sort of split in allocation there, if you will, but it might not be enough resources, particularly at the physicians practice level because the two-thirds of patients in this country are seen by doctors in groups of five people or less. These are not units or entities with a lot of infrastructure to put it mildly.

OLGA PIERCE: Hi, I'm Olga Pierce from United Press International and I guess my question is, if we assume that there are things that Medicare can and should be doing, I'm wondering if each of the people on the panel could point out maybe one or two things that are doable soon that we should start looking at.

RENEE LANDERS, J.D.: I think the data collection piece is key. I think that that's what we we've been saying all along – all of us on the panel that better data will give us a better idea of what exactly are the problems and how to go about solving them. I also think, as I said in response to the earlier question, public education is just a really important thing. Its payoff is not going to be immediate, but this has been a problem that's 150 years in the making in the culture. So looking for instantaneous and overnight results is not going to solve the problem, so I think public education is a tremendously important piece.

CAROLYN CLANCY, M.D.: If you're a clinician seeing patients, you learn something very, very early. That is that patients who speak up and make noise tend to get listened to. If there is one experience that I think that we could build upon right now it's been the enormous outreach that went on across this country for enrolling people in and trying to help them figure out the choices they had to make for Medicare Part D. Regardless of where you stand on that, you have to acknowledge that this was a huge public effort where people across the country sat down at tables in churches and community centers, and the whole nine yards, across the table from folks to explain to them what was up.

I think that's an enormous experience to build upon, because I do think that patients who are more empowered and engaged in what happens to their own health and health care do have an enormous advantage. It's much, much easier to say that than to make it happen, but again, I think we've got all this concrete experience to build on. I think we need to be figuring out how to do a lot more work with churches and other resources that can also be part of the solution here.

ED HOWARD: Peter.

PETER BACH, M.D.: I already mentioned my two. One being that I think that there is a lot more mileage on the language translation and services for deaf patients and other people with communication impairments that could be gotten with current regulations in place; the other is that thinking about quality measurement in the physician office and the hospitals, that appropriate risk adjustment and geographic adjustment, neighborhood level adjustment – things like that will go a long way towards ensuring that the game doesn’t get played in a way that adversely affects the underserved.

ED HOWARD: A couple of years ago when we were talking about this topic, Aetna had just launched an effort to collect racial and ethnic data and were met with a fair amount of resistance from the minority community. I wonder in either your partnerships with the plans or in the experience of the other panelists that has either diminished or turned around.

CAROLYN CLANCY, M.D.: Aetna is part of the collaborative that we've been working with and their experience has been very, very instructive. It was slow at first. I think they've made it incredibly clear to people that are already enrolled that this information will not be misused, that it's voluntarily provided. As I understand it, most patients do this now through a portal and after sort of very slow progress, suddenly there has been – not suddenly, but over the past year or two, there has been great increases in the number of people who are participating. You don't have to. And I think they are very, very careful to assure folks that the information won't be misused.

ED HOWARD: The new data that docs are supposed to submit in order to get the 1.5-percent bonus, does it allow collection of racial, ethnic and economic data?

PETER BACH, M.D.: I believe that would all just come from the Medicare enrollment files, which come from Social Security.

ED HOWARD: Okay. Very good. We have a question here and then in the back.

RUTH POIROT [MISSPELLED?]: My name is Ruth Poirot. I'm the executive director and CEO of Summit Health Institute for Research and Education. I want to commend the panel. I must express some disagreement with Dr. Bach's dichotomy if, in fact, we're looking at through the lens of justice and equity, the choice of which you address, disparities or quality it seems to me would be fairly clear. We simply can't perpetuate that pattern of inequity as I see it. I rise with some mixed feelings.

Our organization put together a report published by the Commonwealth Fund in 2001 that zeroed in on some of the very same findings and recommendations that the National Academy found. We did another report commission by CMS in 2003 and found the same kinds of patterns and issues, and made the same recommendations and findings. Now it is 2006. Is someone tone-deaf here? I'm trying to get a sense of, what do you feel are the obstacles in getting these kinds of recommendations implemented, knowing how important the data issue is? The very same observations we make you have made in this most recent report and I'm concerned.

RENEE LANDERS, J.D.: This reminds me of the conversations we have all the time about reform and access to the judicial system, and things like that. The problems seem to not be solved from one generation to the next. And I think part of the answer is that the problems and difficulties having to do with race and ethnicity are problems that the entire culture hasn't solved and the health care system is very much part and parcel of that culture, and we can't actually, even though at some level you might want to expect a better result there, it's people living in the culture who have to implement these changes. I think that's part of the problem.

That's the pessimistic answer, but I do think that there is some value though in all the studies coming out and saying the same thing. At some point, there is a choir and a chorus there that can't be ignored. I think that that's the real advantage in continuing to do it. I don't think – it can be frustrating but I do think that the multiple voices make a louder noise as Carolyn was saying and maybe the system will listen.

I think also – I don't want to say that the problems are so hard that they can't be solved, but they are hard and bureaucracy is like – and I used to be part of the same bureaucracy – to find an easy solution that will make people in the Congress happy and will make the headline writers happy.

So taking on a difficult problem like this isn't necessarily going to make either group happy with you in the next appropriation cycle. But I do think that, like with all things in public policy – this is a long speech, I'm sorry – but we need to take a longer view. We're not asking that tomorrow that we expect that everything will suddenly be fixed, but that somebody has got to start and has to start to measure and has to start to focus, otherwise we will be having the same conversation 10 years from now and that will be really tragic not only that we have to keep having the same conversation, but that there will be a lot of people who will have died or will be impaired because they didn't get the right health care. That's what the real tragedy is for not doing something about this problem.

CAROLYN CLANCY, M.D.: First, I need to say for Ruth what she couldn't say on her own behalf. The reports that she led were spectacular. So if you haven't seen them, they are definitely worth looking at.

Ruth, I think part of the problem is less that people don't recognize the issue now, but that describing the problem is much easier than solving it, which is why I had a point on a slide about local solutions. Now, the problem with that is that gets the right people on the ground together who need to address the problem in the District of Columbia, or Maryland, Virginia or whatever. It doesn't fit nicely into broad legislative language which tends to be a little bit easier to tailor when you've got a very specific solution that will fit everywhere. I'm less convinced that that's the case.

What I hear from physicians a lot is, tell me what to do. Tell me which piece of this problem I own and which piece of this problem I need to hook up with others or partner with others to figure out how they can be helpful here too. I know that I'm telling my patients in some cases what to do and it's the right thing and it's not happening, so how do I work with others to make it happen?

ED HOWARD: Yes, in the back? Yes, go ahead.

DEBRA REED: Yes, my name is Debra Reed and I'm from the National Health Law program. My question is directed toward Renee Landers. You mentioned during your presentation that the issue of reducing racial and ethnic disparities should be addressed through a Civil Rights enforcement perspective. I was wondering if you could tell us what are the benefits of using that approach – I agree, just

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incidentally, but what are the benefits of using that approach. But also could you tell us, what are some of the mechanisms that are currently being under utilized in Civil Rights that could help in addressing these disparities?

RENEE LANDERS, J.D.: That's a good question because I didn't want to focus on that part of the report unless people were interested, but we've talked about it a little bit in two different ways. I think the reason that it's beneficial to have Civil Rights enforcement as a part of the toolbox in solving this problem is that there are some people, some institutions that only respond to coercive threats. I think we know this on the payment side, on the Medicare system. That people didn't really pay as much attention as they should have to the billing rules until obviously the inspector general and the Justice Department got really serious about enforcing anti-kickback statutes and in some cases the start [misspelled?] statutes. That gets people's attention. Trouble damages gets people's attention as soon as it costs them money.

A part of me that thinks that there is a certain part of the world that only responds to that kind of incentive – negative though it may be. So I think it's really important to have it out there. I think that after the movement to the requirement that hospitals desegregate at the beginning of

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the Medicare program in the 1960s that – and I used to work at this agency too – HHSs enforcement efforts on Civil Rights fronts have been fairly week. There have not been a lot of resources devoted to it and you can certainly think of only a few high profile enforcement actions over the last several years, maybe the last 10 years, 20 years that have really captivated the public attention. So I think it's an under-utilized tool.

Now, there is a danger because I do think that as Carolyn said, and as Peter has pointed out, a lot of doctors are well intentioned. They don't know what to do and maybe we think they should know what to do and what their role is, but the fact of the matter is that they don't and it may be largely inadvertent. So I'm not trying to label the behavior. I'm just trying to see the consequence and figure out what's a good solution. Some of the behavior might be intentional race discrimination in the legal system and HHS should be a part of using those tools to solve it. I think one barrier on the physicians side is as the gentleman in the front of the room pointed out earlier, is that this fiction has been adopted that even though hospitals are receiving payments from the same Medicare programs that the physicians are receiving payments from, the hospitals are providing public accommodation services and the physicians aren't, and they're not receiving federal financial assistance in the way the hospitals are, and therefore, the legal standard for going after the physician behavior is a much more difficult legal standard.

One possible change is for HHS to take a different view of that statute or for Congress to amend the statute so that it's clear that physicians are also receiving federal financial assistance. So there are some statutory tweaks. Also, there is one final point on the legal analysis. A couple of years ago the Supreme Court – not a couple of years, but a few years ago, the Supreme Court decided a case in which it said, it held that only the government could go after desperate impact, racial discrimination cases and that there was no private right of action to go after desperate impact cases, only intentional discrimination cases.

I think that's another tremendous barrier. That's a core decision, it's not a constitutional decision that Congress could overturn. So that's another statutory change that we need to have happen in order to make it easier for ordinary people to bring litigation against institutions that have sort of a problem in this area – that's a desperate impact problem, not necessarily an intentional discrimination problem.

DEBRA REED: Thank you.

ED HOWARD: Yes, sir.

BILL CLARK: Yes, my name is Bill Clark. I'm with the Center for Medicare Medicaid Services. Two questions – the first one is Congress and the Medicare Modernization actually passed a provision, I think, that is commonly referred to as Welcome to Medicare Benefit, which I think has intriguing potential with respect to the concept of the medical home for those people who do enter Medicare. I assume that Congress in passing that provision recognized that there could be a lot of unmet need by people when they first became eligible for Medicare who may not have had previous sources of health insurance and this was a way to try to assure that people would find someone to see early on and get a comprehensive screening assessment and then go forward from there.

My understanding though, is that benefit applies to standard rules for Medicare cost sharing so that there is a barrier – initial financial barrier to access to even that initial preventive visit because they must meet the deductible and cost sharing requirements of Medicare. I'm wondering if there might be a way to tweak that benefit a little bit to either incentivize people to stay with a provider for 90 days or in some ways or waive that fee and some ways that would be a coster [misspelled?] I would think

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to simply do away with it. But if there was some way to incentivize the use of the medical home — taking the medical home concept and applying that in the already passed Welcome to Medicare Benefit — that's question one.

Question two is if the Balanced Budget Act passed provision that enabled states to pay lower cost sharing with respect to dual eligible beneficiaries so that they would reimburse the Medicare provider based on the prevailing — I believe it's the 75-percent of the states fee that they would charge for the same services — in some cases, that meant that there were zero dollars that were being paid by states to Medicare providers. And I'm wondering what the panelists felt about what impact that might have on disparities. Thank you.

ED HOWARD: Good questions. Peter, do you want to try?

PETER BACH, M.D.: The first one is about the Welcome to Medicare visit. I think it's just a good idea. I don't know what to say other that that. I think you're right about the cost sharing. I think the uptake of the Welcome to Medicare visit has been a little bit more sluggish than Congress anticipated but the belief is that a lot of that is conversion [inaudible] visits, out of the context of Welcome to Medicare visits because problems are discovered which are billable and actually raises the level of reimbursement. I don't know if there is going to be a medical home in Medicare; it would certainly take more than that, not the least of which reasons because Welcome to Medicare is only the first six months for people entering the program. So you'd still have the 40-odd million people floating around who are already in the program, so you'd need some other vehicle other than that. There has been a fair amount of talk about using things like the referring provider, U-pin number on the Medicare claims as a way of default, assigning medical home and things like that, but there would need to be more than that.

The other thing, though, you commented about Medicaid is that you're right – that's the math. I don't think it's clear what the impact is on services. It's very clear on oncology that it's had an effect on drug reimbursement and some of these drugs in cancer are extremely expensive and given the structure of the AXP plus 6 system, it's left doctors under the water on those patients specifically for particularly high priced biologics and that's a challenge I don't believe Medicare has the discretion to address that without Congressional movement on it. That could presumably affect people's access to particularly high priced therapies.

ED HOWARD: I have a question here. I have a question there. Go ahead.

RICK LAKE: I'm Rick Lake. I'm the senior health policy advisor to Congressman Towns. We sit on the Subcommittee on Health on the Energy and Commerce committee. As you are well aware, you're not holding this discussion in political [inaudible] so the Senate will probably retry what we consider a weak health disparities bill and we on the House side, and people in here in particular, are going to re-craft the health disparities bill.

So one, I wanted to welcome any of you in here and wanted to inform the House bill to get in contact with me. Then two — since CMS is here I can't resist — the president's health plan is going to have a great impact on health disparities probably in our view, negatively, in particularly New York City, New York State Hospitals are going to suffer greatly if the Medicaid payment streams are affected the way that it seems that they will be. While some of this dialogue is, I think, long term, I just wanted you all to realize that we don't have forever. Thank you.

ED HOWARD: So here's your opportunity. Tell them what to put in the bill. I'm sure your going to get suggestions from a number of people in the audience and on the panel, and good luck getting to yes on that. Yes.

LISA SUMMERS: I'm Lisa Summers with the American College of Nurse Midwives, and I actually know Rick's name but I hadn't put a face to this name, and the Congressman is actually sponsoring a bill that would — but that's not what I got up here to say, but I did want to say a related question that I noticed that Dr. Clancy used the term clinician several times and on Renee's slides there is a reference to providers. I think it underscores a subtle, but I think very important, point that a vast amount of the care that's provided in this country to the underserved and their communities that we've been talking about is in fact provided nurse practitioners, nurse midwives — folks other than physicians. And there very often are policy instructural [misspelled?] decisions that are made that set up barriers. It's a financially driven health care system and physicians have been traditionally very powerful in this system. So I think it's just important to underscore that as these policy decisions are made that indeed when we think about providers, we think about providers as a very large group.

You talked about the importance of the speech language hearing issues, the speech language hearing folks are part of a coalition of non-physicians providers that have been working very hard on issues like pay-for-performance so I appreciate that being recognized subtlety and I just wanted to say very publicly that we do, in fact, appreciate when that distinction is made and there are decisions made that

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facilitate care being provided by those groups of people.

ED HOWARD: Okay. I have a question that relates back to an earlier comment about cultural competency. "No one really talked about Medicare's role in increasing such competency," the questioner writes, "or the role that cultural beliefs play in how minorities seek care or perceptions of the care they receive. Perhaps Medicare can work to educate patients on how and when to seek care and to advocate for quality care. Also, Medicare could work through gradual medical education at increasing physician work force diversity and therefore cultural competency." I guess there is a question at the end of that that says, "Don't you agree?"

RENEE LANDERS, J.D.: We certainly agree in our report with all of those points so I think that goes without saying. This sort of relates back to one of the comments that Carolyn made about Aetna's slow efforts at first in trying to collect racial and ethnic data from its subscribers, because I think that they're different – there are different cultural conventions about when it's appropriate to seek help of any kind including health care. Also deep suspicion among some minority and racial groups about the health care system because they have been misused by it in the past and memories of these unfortunates' experiences are very long.

So I think that there is a lot to be done here to try to really change that perception, but the reality has to be there to meet the new expectations so we can sort of send people in and then have them disappointed by the outcome that the quality has to be there if we get them to the door.

CAROLYN CLANCY, M.D.: I would agree with that and I do think that patient empowerment and activation is critically important. Notice how easily I said that. That is much, much easier for people who are well-educated and know what questions to ask, and feel that they have the confidence and the skills to simply go in and say, "I'm not sure I agree or I need to hear more." Mind you, I'm fully aware that for many people of all backgrounds, this is an increasing challenge in health care today, so I don't want to walk away from that. I do think it's a particular problem for people who are not well educated and who are poor which is why I was very excited to meet a woman this weekend who is a physician working with an interdenominational effort to try to figure out how to bring that support through churches. I don't want to say that they own the whole situation.

I'm just recognizing that it is a challenge to follow up on a recommendation that speaking up on your own behalf, your own health and health care or for a loved one or family member, friend – is really important, but knowing how to do it is really important too. We have to figure that out.

PETER BACH, M.D.: I agree completely with what Carolyn has just said, that better information for patients and their families is clearly a necessity for navigating the system as it currently stands. And there is every reason to work very hard to do that in every possible vehicle and venue that we have, and appropriately translated and the rest of it. I do differ with the sort of unspoken supposition that the problem – one reason that minority patients don't receive as good care as non-minorities is because physicians and other providers discriminate between patients based on race or ethnicity. The data for that, and I'm just being empirical, is weak at best. In fact, the data suggests, I believe that most of the disparities in care after you adjust for differences in income have to do with between provider differences, not within providers differences. The Travadi [misspelled?] study not withstanding – that's health plans across the country so it isn't really at the level of granularity that's needed, but there is an implicit – and I'm a physician – there is an implicit suggestion that doctors discriminate because they don't know how to talk to patients or understand patients from different cultural backgrounds. That may be correct. If true, we should pour massive resources into addressing that, but first we need empiric evidence before we go down a road may not yield a great deal of fruit, even though it makes us feel like we're doing the right thing. I think that would be a terrible mistake. We do have limited resources. We do have a limited number of lessons we can spell out, lay out and preach to patients and doctors. We have a very limited number of carrots and essentially no sticks.

So it would be a real mistake, I think, to decide that the epidemiologic or mathematical explanation for disparities are within the physician or within the providers if they're not, because the solutions are fundamentally different and that doesn't mean that these things are important for other broader social goals. But my biggest objective is to actually just improve the quality of care that patients get in respect to their race or ethnicity, and I think we need to take the most targeted approach to that even if it's not the one that feels the most politically correct.

ED HOWARD: Okay, we have 10 to 15 minutes left here and I just want you to pull that blue evaluation form out and start filling it out so you won't forget as we get to the rush at the end. In the meantime, we have another questioner in the back of the room.

MIRANDA FRANCO [misspelled?]: My name is Miranda Franco and I'm with the American Society of Plastic Surgeons. I actually ask this question in regards to a thesis I'm currently working on, on this topic. There seems to be a great deal of research on race and class as a combined component, but there's not much as race as a proxy for class. Hypothetically, if racial discrimination didn't exist, would these disparities still exist just based on one's class? And all the data efforts seem to be based on collecting those – that type of information as a combined component. I was wondering if there was anything that Medicare is working on doing. I was looking at it distinctly to see if you could collect data on those as two different issues and see how that would affect the disparities that exist.

PETER BACH, M.D.: I don't speak for Medicare or for the administration. There are inherent – if by class you mean economic standing, there is limited information and that was, of course, one of the issues with rolling out Part D, was identifying the people who were eligible for limited income subsidy as a consequence of that. But I do think some of the research has tried to tease apart at least the effects of socioeconomic status from the effects of race or ethnicity. There has been some movement on that. But there are problems with attribution, sensitivity and specificity and geographic measures of socioeconomic status which are imperfect. There are lots of methodological challenges, but I don't think it would be fair to at least characterize at least the research as bundling them.

I think most of the research, certainly the stuff in the packet has attempted to separate but there are great challenges in doing that methodologically.

CAROLYN CLANCY, M.D.: Let me just add to that for one minute. You're completely right, so I wish you a lot of good luck with this thesis, that we don't have very good data on class and economic standing in particular. I will also just note, though, that it's a very, very sensitive topic. There have been some very interesting studies conducted by the Cancer Institute where patients who are willing to provide all kinds of fairly intimate details about their physical functioning, and I won't get into specifics, but when it came to the income question, they would leave it blank. So they were more willing to admit in this particular example information about demographics and so forth. I think one open question is, how much precision do we need? We certainly need enough precision to be able to get good empirical evidence for the right solutions. At the same time, boy, we know an awful lot now about who are the subgroups at highest risk of poor quality to begin testing solutions.

RENEE LANDERS, J.D.: The other fact is that right now lower economic class status is associated with race. That income disparities among racial groups persist and so it's fine to say separate the two, but I think there is a substantial overlap even if you were – that's what the studies have basically pushed that conclusion. So I don't think that the two – I think you're right – that the two are very much related.

ED HOWARD: I have a question that's addressed, on the card anyway, to Carolyn Clancy, regarding pediatric asthma since you brought up pediatric asthma. To what extent does AHRQ have an ability and interest in exploring survey data linked at the individual level to Medicaid or SCHIP and what sort of knowledge investment would be appropriate for Congress and HHS to consider for this kind of research? Not exactly a Medicare question, I would say.

CAROLYN CLANCY, M.D.: That's right. Let me just say it's a topic we're very, very interested in. For a number of years researchers have been looking at a phenomenon called avoidable hospitalization. In fact, the whole idea for measuring hospitalizations that are potentially avoidable started right here in the District of Columbia when a researcher who was doing work for D.C. General noticed that there were an awful lot of people in the waiting room who would be re-admitted. It turned out, of course, that many of these patients were leaving the hospital — patients with chronic illnesses leaving the hospital with superb flow discharge instructions except they had nowhere to go. So I actually think if you look in the report that there is big variation in potentially avoidable hospitalizations related to pediatric asthma. They are the highest rate for African-American children. Moreover, the variation between the states is quite remarkable so the state with the highest number of potentially avoidable admissions for pediatric asthma is five times higher than the state with the lowest number. That suggests to me a very, very important opportunity for learning. So whoever asked the question, consider us engaged and interested.

RENEE LANDERS, J.D.: Oh, I'm sorry. One of the programs that I mentioned at the Boston Medical Center — the Medical Legal Partnership program is aimed exactly at that problem, that is does the physician no good to prescribe the right medications, the right home care and all of that if the person can't afford the prescription, there is wall to wall carpeting in the home, the shag carpeting that the landlord won't remove for the child with asthma. So these things need different kinds of interventions. The health care system

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alone can't solve the problems that are contributing to the poor health care outcome. So that's why an investment in a multidisciplinary kind of approach to solving some of these things is really important to improve health care outcomes.

ED HOWARD: Quick question.

KIRSTEN SUTHERS: Quick question. My name is Kirsten Suthers. I'm from the American Public Health Association. And I actually have more of a comment, but also I guess a question. With what Dr. Bach was saying earlier about within provider differences or – I really question the research on cultural competency and physicians attitudes towards patients because much of it is self-report. You're in this type of research and you're essentially asking a provider to look at their own behavior and decide whether they are behaving in a racist or biased way. If you want to talk about political correctness, the responses that people would give on those kinds of surveys would be extremely biased. So I understand what you were saying in the world of resources we need to figure out which goals are most important but I also urge you not to let go of this really important area, because I attend a lot of health disparities – racial health disparities seminars, and most of the time I'm in the minority because I'm a white person and I think there should be a lot more white people around the table, because we are part of the problem. So I just urge you not to let go within provider issue.

PETER BACH, M.D.: Thanks for the comment, and I just want to clarify. I'm just raising skepticism as a possible explanation. I didn't suggest at all that we should let go of it. If you look at the empiric data and it's not just survey research, it's also analyses done at the level of the provider. The empiric evidence does not support that the primary driver, even a large proportion of the source of disparities are at the provider level. So does it mean that it may not be a good vehicle? I don't know. Is it cost effective to pursue it? I don't know. But I just want to raise some skepticism about it, because I do think there is a danger around the group think around this theory of cultural competency and that racism and discrimination drive disparities.

Like I said, my objective just as a physician in the health care system is to improve the quality of care that patients receive irrespective of their race and I think social equity is an excellent objective, but I don't think we should assume – if I can back up for half a second, and I know I should think of a quick response – I was the author of this study in 1999 that showed that the difference in surgery between blacks and whites for lung cancer was responsible for the survival gap between blacks and whites. And watched that be picked up by the media and be picked up by people here in D.C. as evidence that blacks were being discriminated against by their doctors. We looked at our data that night when we started to hear people saying that, and we realized that all the black patients were going to about 15-percent of the doctors and all the whites were going to other doctors. And we realized that that couldn't possibly be the arithmetic explanation for what was going on. So it was a little vexing to hear that explanation marched out when we suspected, although we didn't have the data at that time, that this was a system problem and that blacks were going to facilities where the ambient rate of surgery was lower.

The empiric data now suggests that that is a more likely explanation for major procedures and it also suggests that maybe in some primary care spaces, it's also the major explanation.

So do I think it makes sense? Sure. Do I think that doctors are already perfectly trained to communicate with their patients about their problems? Not really. So yes, it's a good avenue to pursue, but we neither should put all of our eggs in that basket because I don't think that it arithmetically will solve the problem, nor should we assume that the empiric evidence is sufficient right now to justify that course over alternatives because we do have good resources and we do have a limited attention span we can take advantage of and I think we need to use that in a most effective way possible to get what we want, which is better quality of care for patients who deserve the best that they can get.

RENEE LANDERS, J.D.: Can I just add one other sort of gloss on this issue? I think what Peter says about the structural problem is absolutely clear, because I think that one of the things that Hurricane Katrina revealed was – and I think the Kaiser Foundation has really good stuff on it's website about what the status of health care institutions was in New Orleans was before the hurricane and now the disaster that's followed. But it was a health care system virtually in crisis before the hurricane hit and largely based on socioeconomic status and race. The people in the racial and ethnic minority groups were being seen at a small group of public hospital where they were overwhelmed and they were really operating on fumes – the financial resources they had available were very weak.

So that's a structural problem and the question is, why does that structure problem persist? Why is it that the 15-percent that were seen by these minority patients weren't referring them to surgery? What is it? Why don't they have the right referral networks? Why don't they have access to the facilities where theses surgeries can be performed? These kinds of questions – and I agree with Peter, that I don't think discrimination is the explanation or maybe even the majority explanation today at this moment in time, but that it is one explanation and that we have to address that and the ability of people to communicate with each other along with really drilling down on some of these other structural and financial barriers to achieving equity in health care.

ED HOWARD: Carolyn.

CAROLYN CLANCY, M.D.: I was just going to make a point. It turns out to be pretty challenging to study communication between physicians and patients. In the early '90s, a researcher who was sent from Pittsburgh did a study at VA and found pretty significant disparities among veterans, so they're all insured, fairly similar social class, very significant disparities in receiving cardiac care. Needless to say, this got a lot of people's attention, and he followed it up with a study of communication. He gave the physicians and the patients questionnaires before and after the encounter, so when he presented this at a national meeting to a totally packed room and I know because I was behind the door, so every time someone came in I realized that there were yet more people interested in these results. The bottom line from this study was that all of the patients heard stuff that the doctors never said they said. There were no differences among black patients and white patients. The patients were hearing in the case of bypass surgery that they were going to live much, much longer. The doctors reported that they didn't say anything like that. So communication in health care needs a lot of work.

ED HOWARD: That is a pretty good way of ending this discussion. We're not done with this communication yet and I hope that we can continue it, but I think we've taken a lot of strides forward in trying to sort out what some of the variables are here.

For that, I want to thank NASI, its staff, its study panel and the supporters of its work. I want to thank the staff of the Alliance for working so hard in putting together a very good program and ask you to join me in thanking our panelists for an extremely useful discussion.

[Applause]

[END RECORDING]
