

Balancing the Equation: Ending Disparities in Health Care Delivery for Racial and Ethnic Minorities December 9, 2005

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ED HOWARD: Welcome. I'm Ed Howard with the Alliance for Health Reform. On behalf of our Chairman, Jay Rockefeller, our Vice Chairman, Bill Frist, and the rest of our board, I want to thank you for coming to this briefing that's designed to examine one of the most disturbing phenomena in the American healthcare system; that is, disparities that are based on race or ethnicity in the way that system treats or, I guess, or doesn't treat different people. It's a topic that both Senator Frist and Senator Rockefeller have been both interested and active in. I guess I should also say that we can be grateful for some disparities; that is for example, between forecasted precipitation levels and actual participation levels so that we were able to connect with you and have this program go forward. So congratulations to all of you for making it into the room. Our partner in today's program is the Robert Wood Johnson Foundation, America's largest philanthropy that's devoted solely to health and healthcare. I want to thank Risa Lavizzo-Mourey, John Lumpkin, Minnie Young, and their colleagues at the Foundation for their interest in this important subject and we were to have representing the Foundation today, the President and CEO of the Foundation, Risa Lavizzo-Mourey, who was also on the program as a featured speaker and really sorry that she's not here. Risa not only has a strong interest in this topic as

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evidenced among other things by the three new programs that the Foundation's just launched that you'll get more information about in the course of the briefing but she's also a nationally recognized expert as well having been, for example, a member of the Institute of Medicine Panel that reported on disparities a couple of years ago but the snow has claimed her. It was a lot worse in New Jersey and New York than it was here and still is, I'm told, so Risa won't be with us and neither will be Peter Bach from CMS, who is stranded in New York City but we have a star pinch hitter, Dr. Garth Graham, whom you'll meet in a moment. I can't do a plausible Risa Lavizzo-Mourey imitation. She's far too articulate and knowledgeable about this topic but I can call attention to one or two of the points that she wanted to make and that are important to our discussion today so if you'll bear with me, I'm going to steal a couple of her slides and try to illustrate the parameters of what we're talking about.

First, you've got to remember that the connection is very clear between eliminating disparities and improving overall quality. You're going to hear more about that. It's no coincidence, for example, that the Agency for Healthcare Research and Quality issues its reports on these two subjects that it does annually on the same day. There is, by the way, a flyer. There's a new one about to be issued and there's a flyer

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about that in your materials.

Second, there's a new poll being released by the Foundation today that they've produced in conjunction with the Harvard School of Public Health about Americans' attitudes toward disparities. You'll find detailed information about the poll in your materials. One important finding in view of the past controversy over whether it was even proper to collect the information on race and ethnicity in the first place in a health context is—lets see here—is the second slide, which I'm going to ask Laura to find for me, that most Americans do approve of collecting those data if they're used for the right purposes. The survey also shows that most Americans agree that disparities exist though minorities are a whole lot sure of it than whites are and there's detailed information about that in the survey information in your packets. Also in the survey and here, I'm looking for slide 11 Laura—we seem to feel that there really is a legitimate federal role in eliminating disparities, 2/3 of us overall and very, very strong majorities in the African American and Hispanic communities believe that and finally, if you'll back up a little bit to slide 9, I want to comment to you the information about three new Robert Wood Johnson initiatives on the topic and you'll find that information in your materials in some detail.

A few logistical items before we get to our

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program—in your packets, you’re going to find a lot more material than I have mentioned including, by the way, speaker biographies—more extensive than the introductions I’m going to have time to give them, with the exception of Dr. Graham’s, which will be posted on our website later today. Also by the end of today, you’re going to be able to view the webcast of this session on Kaisernetwork.org and within a few days, there’ll be a transcript of today’s discussion on that website and on our website, that is allhealth.org. We’ll send you an e-mail to let you know that the transcript’s available. At the appropriate time, those of you who have been here before, know this drill, there are green cards in your materials that you can write a question on. There will also be an opportunity for you to get up and ask the question orally and at the end of the session, there’s a blue form that we’d ask you to fill out to help us improve these sessions with the evaluation. Well, I’ve talked a lot longer than I should have, we have a terrific lineup of speakers today so lets get started and I should say that when we did our program on this topic almost 2 years ago, we were very interested in making sure that people understood that disparities in healthcare really existed and they were a really big problem and we need to make sure that in light of the data that have large minorities of the population still doubtful about that to reiterate that finding. We need to help

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people understand the extent and the persistence of this problem but we're also looking for help in identifying solutions that are being worked on in both the private and public sectors and I ask you to keep in mind that search for solutions as we go through the session today.

We're going to start with Dr. Ashish Jha and as I said, I apologize for the introductions that I'm going to give to our distinguished speakers but I don't want to take up the time that they deserve in getting those introductions and those in front of [[inaudible]]. He's an assistant professor of Health Policy at the Harvard School of Public Health. He's an assistant professor of Medicine at Harvard Medical School, staff physician at the VA Boston Health Care System at Brigham and Women's and author of a couple of very important studies on trends in racial disparities that were published this year just a couple of months ago in the *New England Journal of Medicine* and we're very pleased that you made it in by coming yesterday and beating the three-hour delay out of Logan airport. Ashish, please begin.

ASHISH Jha, M.D., M.P.H.: Thanks very much. It's actually very nice to be here and it's sunny outside. I just talked to my wife a few minutes ago and it's still snowing in Boston so happy to be out of there. Let me start by just framing what I'm going to discuss. My job is to talk a little

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bit about the data and what we know about what's happening with racial disparities. I am going to talk, as Ed mentioned, I'm going to talk about the study that we published in the August 18th issue of the *New England Journal*. I'm also going to talk about two other studies that accompanied ours that looked at very similar questions about what's happening with racial disparities.

Racial disparities and racial differences in healthcare are pervasive. There are over 600 studies that have looked at racial differences in major surgeries and procedures alone and hundreds of studies that have looked at other aspects of the healthcare system. A vast majority of these have found, consistently, that blacks and whites receive very different healthcare—so much so that in the Institute of Medicine Report on Equal Care, the IOM came right out and said it—minorities tend to receive a worse quality of healthcare than white Americans and the gaps in care are not explained by clinical factors. They're not explained by patient factors. What's the response to all of this? Well, in 1993, you saw the NIH say that we need to ensure that the studies that we fund, the diseases we study, we need to ensure that they are ones that are common and prevalent in minority populations and in 1996, the Department of Health and Human Services, in an effort to decrease disparities, increased its funding for the Office of

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Minority Health and really made a renewed push to decrease disparities. There have been various state and local initiatives across the country. Thirty-seven states over the last decade or so, at times, have created Offices of Minority Health. Some of them have been funded very well, some of them have not. The research question that we were interested in was what's happening? Given all this attention to racial disparities, are things getting better? The study that I was involved in looked at rates of major surgery among Medicare enrollees. We looked nationally and then we looked at local regions across the country. The notion here was that whatever's happening on a national level, we might be able to identify some local regions that have been very effective at reducing and eliminating disparities and learn from them. The second study that I'm going to talk about is the Tervati [misspelled?] study [misspelled?], which basically looked at the Medicare managed care program and what's interesting here is that they were looking at a series of programs where quality improvement has been pretty dramatic. The quality has improved for all of its beneficiaries and they wanted to see what was happening with disparities. Finally, the third study I'm going to talk about, which again, was a part of the same issue of the New England Journal, looked at what was happening with disparities in the setting of acute MIs, people getting admitted nationally

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for heart attacks. We know that blacks and whites are treated differently. There's been a lot of improvement in quality of treatment for heart attacks and they were interested in—has that quality improvement made a difference?

Okay, so very quickly—the study that I was involved in—here's what we did. We looked at Medicare in-patient files from 1992 through 2001, we focused on 9 surgeries, these are common expensive surgeries that have a very important impact on people's lives and wellbeing. There are surgeries like heart bypass surgery, hip replacement, knee replacement, things that are well known and we looked at procedure rates for whites and blacks separated by gender. So we looked at men and women separately. We looked both nationally and, as I said, in regions across the country. The take home point from our study, what we found in terms of results—what did we find in our study and I'll show you the data but the mean results are that the gaps in care between whites and blacks are overall persistent or widening and that there are no local regions that we could identify that have eliminated gaps.

Let me orient you to this. What's happening here is that if you look at the Y axis all the way over to the left, those are rates per thousand enrollees and what you see is that in 1992, again the X axis at the bottom are years from 1992

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through 2001, if you look all the way over to the left, what you see is that in 1992, white women and white men received many more hip replacement surgeries than black women and black men. This is in the context of very similar rates of underlying osteoarthritis, the things that for which people actually need hip replacement. Throughout the 90s through 2001, you see pretty dramatic increases in the rates of hip replacement for everyone except for black men where it's actually pretty stable but the gaps between whites and gaps certainly aren't narrowing. They seem to suggest that the gaps are actually getting bigger. The data on bypass surgery—Cabbage [misspelled?], is actually pretty interesting in the sense that there are differences between white women and black women but what's dominant here is white men and the fact that white men receive these surgeries at 3, 4, 5 times the rate of other groups and that's not because rates of heart disease are 5 times greater in white men compared to black men so that's clearly not the underlying factor. What you see is small increases in the early 90s, small dip downs at the end but really no clear movement toward narrowing of the gaps.

This is carotid endarterectomy. It's a mouthful but it's a surgery done on the neck. It's a surgery done to prevent strokes. In the early 90s, two major clinical trials came out that suggested that this surgery is very effective at

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preventing strokes in high-risk patients. As a response, it's very interesting. You see dramatic increases in rates of these surgeries but most of those increases were for whites for white men, white women, small increases for blacks but certainly no narrowing of the gaps.

So here's the summary slide on national analyses. For five of the nine surgeries that we examined, the change in gaps—so the gap actually got bigger. For one of the nine—triple A repair, which is abdominal aortic aneurism repair. It's a repair of a big vessel in the abdomen. The gap narrowed slightly. For the other 3 cardiac procedures, we really see no change at all from 92 through 2001.

This slide is a little bit of an ugly slide and I actually want to spend a minute or so on this because I think it's important. Our goal was to look locally across the country and when I say local regions, what do I mean? I mean regions like the greater metropolitan Washington DC area, Jackson, Mississippi, Atlanta, Georgia—not all big cities but regions of that size and what we did was we took three surgeries—hip replacement, carotid surgery, and heart bypass and looked, in 1992 and said in how many of those regions do whites receive these surgeries more often than blacks? The answer was—and if you look at men—hip replacement, 1992 you'd see that 100% of the regions, in every single region, whites received more of

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these procedures. The gaps actually widened in 85% of those regions and then when we looked at 2001 for, lets say men in hip replacement, what we found was that there was not a single region we could identify where the gap between whites and blacks had gone away. So if you take a step back and look at these 3 surgeries, both men and women, what's the take home message from this? I think it's pretty clear. In the early 90s, in every single local region, whites received more of these procedures compared to blacks. The gaps increased in some, decreased in others, but in 2001, there was not a single region anywhere in the country that we could identify where the gap between whites and blacks had gone away.

All right. I'm going to shift gears and spend about two minutes talking about the two other studies that accompanied ours and then I'll wrap up. The second study that I want to talk about is the Tervati [misspelled?] study. They looked at the Medicare managed care programs and asked what's happening with disparities in the context of quality improvement. What they found was that for simple tests, the gaps are beginning to narrow but for more complex clinical management such as getting people's cholesterol under good control, the gaps between whites and blacks are persistent or even widening so if I could have the next slide, I'll show you the data.

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Here is cholesterol testing for diabetics. What you see is that in 1999, there is a small to moderate size difference between whites and blacks. Quality gets better for everybody and by 2003, the gaps between whites and blacks has essentially gone away and then if we go to the next slide—that was pretty easy. That was—among diabetics, do they get a cholesterol test or not? This is harder, which is among people with heart disease, do you actually get their cholesterol under good control? What you see is a moderate difference between whites and blacks in 1999. Even though everybody seems to get better, the gaps, in fact, seemed at least stable if not widening. Quality improvement, I think, is clearly an important thing but it is unto itself not enough and then I'll talk about the final study, which is the Vacarino [misspelled?] study. The results here are essentially the same as the Tervati [misspelled?] study and lets go ahead and look at a simple table of what they found.

They were looking at people who were admitted with heart attacks. This is a national sample of patients admitted with heart attacks. What they found is—and we knew this from before that in the mid-90s, for very simple things like getting an aspirin or getting a beta blocker, which is a simple medication that has a profound impact on people's lives, there was actually no racial gap in the mid-90s but for more

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complicated things like reperfusion, which is basically opening up of the blocked artery, critical to do and it has a very important effect of whether you live or die, there was a significant gap between whites and blacks in the mid-90s as there was for angioplasty, heart bypass surgery, and through 2002, what they found was that the gaps basically didn't change. For all of those treatments, the gaps that had been there in the mid-90s persisted.

How do we put this all together? I think there are a couple of key things. What we see is that for some simple aspects of healthcare such as testing for cholesterol, aspirin after a heart attack, racial gaps in care seem to be improving and in some contexts, actually going away but for more complex therapies, certainly for major surgeries, the gaps are persistent and if anything, getting worse.

I think every set of studies has limitations. Let me talk, quickly, about a few of them. The first point about limited adjustment for financial status—let me explain what it does mean and what it does not mean. First, it's not about insurance. Every single patient in our study and in the other 2 studies had health insurance. This is not about access to healthcare but none of these studies did a good job of accounting for other things like education and income, which we also know play a role. None of our studies that I've talked

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about mentioned data on Hispanics because most of the national data sets really have inadequate information about Hispanics. The numbers are small. They're not very good quality data and that's a huge problem, I think, for understanding disparities in healthcare. We have almost no information about Hispanics and then finally, the last point, is no data on patient preferences. Patient preferences are important. We know they make a small difference and none of our studies really looked at that. Patient preferences don't account for the size of differences we're talking about but they're important and worth remembering.

The final slide—what are the implications? I think there are two important points. We've had two decades of research on this topic. We've had at least a decade of national and local policy initiatives. Despite all of this, blacks and whites continue to receive very different healthcare in this country and we clearly need new efforts to close the gaps in care. I'll stop with that. Thank you.

ED HOWARD: Thanks so much Ashish. Food for a lot of thought and more on the way. We're going to shuffle the lineup a little bit and we'll hear next from Bernard Tyson. Bernard Tyson is the senior vice president for Brand Strategy and Management, is that right—for the Kaiser Foundation Healthplan and Kaiser Foundation Hospitals. He's been active in a variety

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of positions within Kaiser Permanente including being very active on the—in the region that includes Washington, D.C. He knows how impressive it is that we have an audience like this in the vice of a snowstorm and we're very pleased that he's with us today. He's got an incredible list of accomplishments. He's been a winner of the NAACP Freedom Award—Freedom Friend Award in the past and I know of no system in the American healthcare system that is more aware of and trying to do more than Kaiser Permanente with respect to disparities. We're very pleased to have you here. Bernard?

BERNARD TYSON, M.B.A.: Thank you. I'm very happy to be here. A couple of things as I get started—the first is I will not touch that remote control. The second one is, you don't know this but there's a very threatening little tool here that tells you when to talk, tells you when to [[inaudible]] and tells you when to stop so this is—and it just started on me so I'd better move forward. It's always good to come back to Washington, D.C. especially when you're preparing for your last day on earth when you listen to the news about how bad the storm is going to be on the east coast. I happened to be up about 4:00 in the morning and I saw this poor reporter out somewhere in Maryland waiting for a snowflake and one came and she said here it is. It's coming now. It's amazing.

Let me provide you with a context here for my

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remarks. The first one is I tend to divide health disparities and healthcare disparities into two arenas. One side is we have a problem and so it is the data, the studies, the evidence, the individuals who I talk to on a regular basis that demonstrate that we have a problem. The other side of the equation is so what are we doing about it and I call that the solution space. I am a corporate executive with massive responsibilities for a \$30 plus billion organization and I know how to get things done. I want to offer my talk in the context of solutions that we have put in place as well as findings around that and also what I believe to be some core ingredients that are needed to move to a more rigorous solution space for this unacceptable problem, healthcare disparities. In many circles that I run in, healthcare disparities is called the unfinished business of the Civil Rights Movement and so that gives you a context of where we come from. The second level setting comment is I choose not to insert racism in the solution space of healthcare disparities. Now, I am not ignoring that racism clearly could play a role in it but racism in the backdrop of a country that has yet to really deal with race relations creates too much negative and defensive connotations to get to an inclusive solution space to an unacceptable problem and so please don't think that I'm ignoring some of the ingredients that I believe and the studies have shown that goes into healthcare

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disparities but as it pertains to the solution space, it has to be an inclusive set of solutions in which when racism is inserted into that, defensive behaviors happen every single time.

The second thing is healthcare disparities in this country is another piece of a very fragmented and questionable healthcare delivery system overall as it pertains to quality of care. There are many studies around the country that raises the overall issue about the quality of care received by the American people in this country. The healthcare delivery system in this country has many flaws in which this is one of them as well as the flaw of preventable deaths that can happen to other populations as well. Then the last point is what I raised earlier, which is I believe that there's got to be some key ingredients in place to really get to the healthcare solution. If you go to my first slide, the only point that I want to make with this slide and what I usually do is actually—when I give this talk—I actually have pictures of people and I have gained permission from families to actually show their child who died unnecessarily from asthma because he did not get equal care or I will show a grandfather who, by statistical reasons, could have been living longer but is not because he did not receive the same procedure and my point is sometimes when you look at a lot of statistics, you get caught up in the statistics and miss

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the point that these are real people dying every single day so the sense of urgency, from my perspective, is front and center because every single day, this is happening across the country.

Second point is we had Dr. Dunn Burich [misspelled?], who came and spent some time with the Board of Directors for Kaiser Foundation Healthplan and Hospitals and he made a very interesting observation to the Board that actually blew them away. He said with all the advances in medicine and technology, can anyone in the room predict the best test to predict the quality outcome or demise of an individual? And people started to raise their hands. Somebody said a blood test and somebody else raised their hand and said sugar or cholesterol or whatever and he said no, the simple answer is an eye exam, an eye test. All you have to do is look at the color of the skin of the person you're talking about and you have a better chance of predicting the outcome of that individual than any other sophisticated test that we're doing. I find that to be startling and unacceptable.

I believe that there are some core ingredients that are necessary to really up the stake on the elimination of healthcare disparities in this country. The first one is we believe strongly that an accountability system must be in place to get results and that this, like any other problem, while good will and good minded individuals could work on the

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problem, without setting up certain systems and certain processes and certain resources requirements, you get progress because good willed people are willing to do good things but, at the same time, you don't get the same level of progress as you would when something is resourced like many of the other issues that we deal with. The core ingredients that I believe are needed in this and work toward the elimination of health disparities is first, leadership. I believe that's where you get the vision, the strategy, the expectation. At Kaiser Permanente, healthcare disparities are one of my six strategic priorities for the corporation. I report directly to the Chairman and CEO, and the Board of Directors. I am accountable to them. They are actively involved in the elimination of healthcare disparities. In Kaiser Permanente, if any should exist, it is resourced and the people who work with me understand that that's where I apply resources as one of the six key priorities. We should ask ourselves where is the leadership in all of the different arenas on this particular issue of healthcare disparities.

The second core ingredients are the right incentives and those are the incentives that incent, the desired behaviors we would like to achieve. The unacceptable charts that you saw earlier—the question is so what happens—or what did happen given those gaps and those results that we've

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seen here.

The third one is the system of accountability and last, but certainly not least are resources. We tend to talk about this from the three frameworks here. The government, we believe, has some clear accountability as well as, quite frankly, the big stick because as it pertains to the healthcare industry, the government is our biggest purchaser, the biggest buyer of healthcare in this country. A lot of clout to deal with this issue as well as other issues. We also believe that this issue is clearly a public policy issue. The healthcare industry, we believe, has an accountability for the healthcare disparities. The studies that you heard about just a minute ago—this is not a case where you're talking about the uninsured in which we also have an obligation for caring for the uninsured. You're talking about people like me who is fully covered, can be a part of healthcare disparities if I'm not knowledgeable about how do I ask certain questions as how to make sure that the resources are brought to bear on me as they are for anyone else and by the way, the other part of that study—it may not mean that their quality of outcome is much better in the long run but it certainly means that the resources are allocated to do certain procedures to that population at the expense of not doing it equally to the other populations.

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Last but not least, we believe in the accountability of the individuals from two perspectives. One, we believe that the individuals have some accountabilities about their health habits as well and secondly, we believe strongly that the imagery of the healthcare disparities tend to take people to negative places that does not represent where people of color are really coming from. That is to say people of color are proud, empowered. They are making the best out of small resources and need to be shown in that way as opposed to an imagery of these are victims of society and so we're very clear in our agenda about how to deal with the accountabilities of the individuals.

Next, I'll just briefly go over a couple of examples and you could just fly through all of those—a couple examples of what's going on in the industry and then at Kaiser Permanente and I have many more but this is to give you an example of there are some solutions that are being implemented and explored across the country and obviously, I want to highlight Kaiser Permanente. The first one, just to touch on briefly, is the National Healthplan Collaborative. That's a wonderful piece of work that's going on with 9 health plans across the country. It's been sponsored by the Robert Wood Johnson Foundation. It's getting technical support from the Rand Corporation. It is a well staffed project that is going on

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across the country and Kaiser Permanente is actively involved in this work. The work, in essence, is intended to collect and use data on outcomes from these organizations who are dealing with the elimination of healthcare disparities and specifically, the project that is being worked on now as we speak is diabetes and the plan is that each of our organizations are collecting the data as we care for these populations with diabetes. We will then come together and pool the learnings to understand what's working, what's not working and from those learnings, we will dispense them out to the rest of the healthcare industry. So I think it's a great example of a collaborative, in some cases, of competing health plans that are coming together for the greater good. Then, you could see some of the others. I want to touch on a couple from Kaiser Permanente to make my point and also to do the commercial of Kaiser Permanente because we're proud of what we're doing. One big one is we have invested millions of dollars over the last 10 years in what we call our Culturally Competent Care Institute. This is now the brainchild of our diversity program at Kaiser Permanente. We have, in fact, developed protocols for most, if not all, of our people of color—African Americans, Asian/Pacific Islanders, Latinos, and others and we've put together guidelines for women and we've put together guidelines for gay, bisexual, transgender and the point is we believe,

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strongly, that culturally competent care has to be applied to every provider in the healthcare system, that the ideal scenario would be that there are more matches of the people of color in the industry caring for the people of color who are receiving disparities of care. That's not reality but the expectation is that no matter who you are as a provider, you have to be culturally competent in providing the care necessary for the recipients to both accept it, receive it, and to follow the instructions that our physicians and others offer. We also have—proud to say—implemented a new initiative called our Farmer's Market in which we have 22 now in five states across the country. Here's the significance of that. One of the things that I'll end on now is—this is a [[inaudible]]—one of the things I'll end on now is in many of our communities of color, grocery chains have exited those communities and so as we talk to these communities of color about eating healthy, what we have found in return is there is no place to go unless you either get on a bus or drive 5 miles out to go get, Bernard, all that healthy colored food that you keep talking about because we have a promotion about eat colors—fruits and vegetables and so we have planted Farmer's Markets in some of our communities where we have our Kaiser facilities and it is amazing how the community now comes to our facility to get fruits and vegetables at least one or two days a week. This

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program has been so successful that I'm also in conversations with Safeway and McDonalds to talk about ways in which that they may want to re-enter communities of color in which they can, in fact, leverage this much more than Kaiser Permanente organization. I will stop but can I just show one more quick piece here? I want to talk just a second about the five-point plans for individuals. Kaiser Permanente launched an initiative last year under my direction to touch 100,000 African American families around caring for your health. We had set a goal to achieve this objective within two years but this program has been so successful that we are over 100,000 now and next year, we're projecting another 100,000. We also now have received inquiries from other organizations who would like to join us in the promotion of this five-point plan. This five-point plan is an attempt to give individuals a plan for what they can do to improve their health because we believe that there's an individual accountability also in what's going on with health that leads to the need of getting healthcare. Very briefly is know your numbers. We're promoting that every single individual should know your blood pressure, your blood sugar, your cholesterol, and your body mass index and you should know that just like you know your tire pressure or whatever else and by the way, I see heads nodding. You should know that also, everyone in this room.

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The second one is that you should know your family history. You should know if your family has diabetes, cancer, etc. not so you walk around depressed for the rest of your life but so you have a better sensitivity to what to pay attention to.

Third, we talk about eat colors and that's your fruits and vegetables—eat more fruits and vegetables. We have a series on fried foods, how that goes back to the slavery days and God knows that we would never degrade our tremendous forefathers and foremothers who had to fry the 5 and 6 day old pieces of meat so they could kill the bacteria to eat the food versus how it's treated today as soul food and we have a whole series about how to eat properly. Be active—that's talking about activity. We promote—walk 10,000 steps a day. We tell people you don't have to join a big gym to exercise. Next time you go to the store, instead of driving around trying to find that park closest to the door, go all the way to the end and walk back—even that will do you good and the last one is establish a relationship with a healthcare provider.

If I could leave you with the three recommendations, they are—we believe that there must be a better movement in the collecting of data that allows us to look longitudinal at this issue. Secondly, needs to be incentives put in place for the healthcare providers to provide

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culturally competent care and we also believe that we also need to tap into the medical schools and to make sure that the future physicians and other providers are being trained in culturally competent care for the diverse populations that they will be caring for. Thank you.

ED HOWARD: Thanks very much Bernard. Now, I want to introduce our last panelist—two hours ago, I would say, Dr. Garth Graham didn't know he was going to be here speaking so he deserves an audience that will cut him some slack. The irony, of course, is that he probably doesn't need anybody to cut him any slack. He's the Deputy Assistant Secretary for Minority Health within HHS. He's also the Director of HSS' Office of Minority Healthy. He's the founding senior editorial board member of the Yale Journal of Health Law Policy and Ethics. He was a graduate of the Yale School of Medicine. He won the 2002 AMA Leadership Award and because of his special situation, he doesn't need to worry about the quirks of our wireless mouse so we're really pleased that you were able to join us on such short notice. Dr. Graham.

GARTH GRAHAM, M.D.: Thank you Ed. One, I want to just describe to you the journey in which I undertook to come and spend some time with you here this afternoon. So I started off this morning at 4AM. I was supposed to be actually back in Boston and then start a

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trek from Boston to New Jersey and all over the place and heading back on to Philadelphia so then I got up at 4 a.m., saw what the weather was like, thought I would still try and make it to the airport. I made it to the airport, found out luckily so that my connecting flight was cancelled—went back home, got out the warm, fuzzy slippers, and was feeling all good and happy about being at home this morning because there was a paper that I was supposed to be working on for a while now that a group of us had been trying to publish so got out my warm, fuzzy slippers, got out my laptop, sat down, starting typing away then got a call from some of my staff folks asking and, of course as many of you are well aware, the federal government gave us a little bit of a break in terms of time we needed to arrive in this morning so I thought I'd take advantage of that as well then got a call from my staff and I should have known—I should have been suspicious about the call because the call started with well what are you doing right now and so then I didn't admit it at first. I said well I'm busy doing some work, well why? They were like well what are you doing in two hours? I said well I'll be in the office in two hours. Then the caller's like well what do you have planned for as soon as you get here? Well nothing really. They said well they need some help in terms of filling in for Peter and so forth so glad to be here. I still have my warm, fuzzy slippers. I took it with me. I took it in the car and I'm going to put those back on later on this afternoon when I get back to work so

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definitely I'm definitely glad to be here and I'm glad to be a part of what I think is a very, very important conversation and not just this issue of health disparities but really the findings in terms of the awareness of health disparities and where the various levers and keys need to be turned in terms of effectuating change so I think Ashish talked about this earlier—the fact that over the past—not even just 10 years but I would say over the past 20 years—the federal government has had a relatively robust effort in terms of dealing with this issue of health disparities and lets talk about what happened 20 years ago. Twenty years ago, Secretary Margaret Heckler [misspelled?], who was then Secretary of HEW, which then subsequently became Health and Human Services, formed a task force called the Secretary's Task Force in Black and Minority Health and one of the things that was impetus for that task force and then one of the results, in fact, in that task force was the fact that there was a relative lack of consistent data documenting this issue of minority health and health disparities. Now, many of you who are practitioners and I see actually the faces of some folks who I know have been around from the start, from the formation of the task force and from the beginnings of our office could probably tell the story better than I could but really one of the things that the secretary wanted to do was to show that disparities existed and then figure out what is it that we do from that point on. So the task force documented that health disparities existed in at least 6 primary areas—diabetes,

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cardiovascular disease, cancer, infant mortality, among others and that task force activity actually led to the formation of the Office of Minority Health back in the period of what—1985, 1986. For those of you who are not aware, we're celebrating our 20th year anniversary. January of next year, we're having a big conference, a big summit—we need you to register at www.omhrc.gov and omhrc.summit. Okay, that was a plug. Moving on—talking about this issue of data and then what it is that we should do with the findings that are being released today as well as the findings that have been accumulating over the past 20 years or so and pertains to minority health and health disparities. As I said before, this Secretary's report documented quite firm, in black and white, for all to see that health disparities existed between primarily then routine [misspelled?] African American and the Caucasian population but subsequently as more data has been accrued over the next subsequent two decades, we know that health disparities between all the various minority populations for a variety of disease—of different disease entities. As Ashish pointed out, a number of federal activities have taken place since 1985. We know that in the 1990s and even beyond, in this decade as well, HHS has done a number of activities and pushes in terms of highlighting this issue of health disparities but what we're really seeing and I think this is underscored by the findings that are being released today in this new poll is that in terms of the activities that have occurred at the 10,000 foot level in the

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treetops that we haven't done that well in filtering these activities down to the grassroots level to the individual physician, to the individual person and I think the findings here today, as being released, really underscores that issue and I actually did know these findings prior to coming here but interesting because it was where I was going to go in terms of my remarks and comments to you here earlier on today. Now, let me take this from a personal perspective in terms of understanding health disparities and what this means and then how this affects a person's individual decision-making. Prior to coming here, I was a physician, a clinician at Massachusetts General Hospital back in Boston and I had been studying minority health and all of these things for a while, had been part of activities back at Yale, prior activities in the Roxborough community and felt I was quite versed in this issue of health disparities, studied all of the cultural competency courses, thought I was not only versed but almost a genius when it came to this thing of health disparities—I'm kidding—but then something happened that really showed not just a flaw in my knowledge but the idea of why it is integrally important not for us to just define health disparities at the 10,000 foot, 30-foot level but really to drill this down to the individual person and individual physician in terms of decision-making. So I saw a patient in the emergency room, she was an Asian American lady who had come in with cough, fever, chest pain. Chest X-rays showed a left lower lobe pneumonia. We admitted her in overnight because of her age, gave her

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some IV antibiotics and then gave her her prescription for Levofloxacin and sent her on her way home, saw the lady and made an appointment for this lady to follow up in my clinic two days later just to make sure she was doing okay. She showed up for that appointment. The appointment was brief. She looked like she was not doing so well. We talked a little bit more about the medication, making sure—I thought—that she was taking her medication, talked to her about making sure that she's taking her Levofloxacin pill at least she should be taking it once a day. Two days later, this lady came back into the emergency room complaining of fever, chest pain was a little bit different, cough had gotten worse. She had basically not been getting better but had actually been getting worse in terms of her clinical disease. We knew she had a left lower lobe pneumonia, admitted her again over night and gave her some IV antibiotics, talked to her and her family a little bit. They were so appreciative of us as clinicians, thought we were doing just a great job, sent her home. A couple of days later, came back in again, same complaints, same issues. We were talking to the family and we were just upset that this patient wasn't doing as well as we'd thought. We knew she had pneumonia. She had all the classical signs of pneumonia. So we were like well, what's going on? In talking to this patient, her family—they started thanking us - us great doctors for all the work that we do and said you know doctor, thank you for all of your medicines. As you said, we've been giving her 1 tablet. We've been

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taking 1 tablet a day and here they are, right? So what they had been doing is taking 1 tablet a day and putting it on this little string because that was their concept of what I was saying to her—take 1 tablet a day. That's what they understood in terms of taking 1 tablet a day. We sat there for a second and we thought well we never actually explained to her what we thought she already understood in terms of taking 1 tablet a day. This really speaks about this issue of culturally competency and that understanding that when you understand cultural competency not in the esoteric broader conceptual level but as it pertains to individual patients and individual cultures and that idea of health literacy and patient communication that you actually think through what you're doing and actually practice differently. Despite all the education and education [misspelled?] that I had had in terms of cultural competency didn't actually click in my mind what that actually meant because I thought that had to do with Caucasian patients learning more about the African American community or Caucasian—not patients—Caucasian clinicians learning more about the African American community and things along those lines not knowing that it meant that I needed to take some time and understand my individual patient and communicate to that patient effectively. I say that to say that one of the things I thought, prior to taking this job and one of the things I think very strongly is that what we need to do in dealing with this issue of health disparities is drill the information down to the individual

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patient, individual clinician level, individual doctor/patient interaction. If we're going to really tackle effectively this issue of health disparities and healthcare disparities—and I agree with Bernard that there is a difference between the two. For us to do that, it takes a lot more effort than we've been doing so far. I think, quite frankly, we can talk a lot about all the things that we've done but I think data has shown that what we've done hasn't worked as effectively as we thought and the interesting thing about some of the findings that was recently published in the New England Journal was all of the studies except for one basically show that despite what we're doing, there's been very little difference over the past 20 years but the data that John [[inaudible]] and some of [[inaudible]] that group published actually showed that one of the potential effective mechanisms that we can employ in dealing with health disparities is this issue of data collection, strengthening data collection, and the feedback that data collection does in terms of the issue of health [[inaudible]] so I think why data collection is so important because it raises awareness. Going back to what I talked about earlier that one of the key arrows in the [[inaudible]] in health disparities is awareness—awareness at various tiers in terms of not just at the federal level but really boiling down to the state level, the health plan level, health practitioner level, and then down to the individual patient. Troubling as these findings show in terms of this new poll that 68% of individuals in America aren't

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aware that disparities exist—even more troubling was some data and I see that Marcia's actually here in the audience today—Marcia and some of the folks at ACC and some others have published a couple years back showing that cardiologists and individual practitioners had an awareness level of less than 40% or so in terms of believing that health disparities existed in their own practice and within their own sphere; going back to what I was just saying in terms of my own personal experience, if folks don't believe that health disparities exist as it pertains to them as much as they hear about this issue out there in the general world then individual activities are not going to change. We're going to keep behaving in a certain manner in a certain level that will not actually change your behavior but will actually perpetuate the system. I can't believe I've been speaking for that long—no. Okay—that we won't change our activities and that there will not be the change that's needed in terms of what we need to see over the next 20 years moving forward. So a quick word—really, really quick word in terms of what we're going to be doing and how we're thinking from the Office of Minority Health perspective—in terms of this issue of not only increasing awareness but putting the data behind that and putting the resources and finances behind that because these are the things that we think we need to do. It will touch a little bit on this issue of the state Offices of Minority Health. We believe that, back in 1990, when the Office of Minority Health started really investing in state offices—there were about 9 state

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offices of minority health. Now, we know that there's a little bit less than 40 state Offices of Minority Health. We believe that these state offices are very, very, very, very important for carrying on the work at the local level in terms of dealing with this issue of health disparities. These state offices for the most part, rely on a very, very, very small budget to do the work but the work that they do in their individual communities is very, very important this year. We gave a significant amount of funds to help move forward the states work and will be continuing to do so over the next couple of years but we're also going to be working with the states on really individualizing data collection at the state level so that states can be able to look across the various activities that are occurring in each state and see where each state is compared to the other. So that's very, very important because going back to this idea, I really, really believe that awareness is important in terms of understanding this issue of what it is that we must individually do. Now, Carolyn Clancy [misspelled?] and Nick Lorey [misspelled?] and the folks at ARC have been working with the health plans in terms of collecting data and information at the health plan level. That's good and we applaud that and I think that is the kind of partnership we need in terms of awareness at various levels. Like I said before, federal government doing what we need to do, state down to the federal plan level and then really going down to individual physician level. We've been encouraged by the enthusiasm expressed by John

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Nielsen and the folks at the American Medical Association about educating individual physicians. A majority of physicians joining the AMA and the MHA have been doing their work within their populations educating the majority of physicians about the existence of health disparities not that health disparities exist out there in the general world but that potentially health disparities exist in your own individual practice. Again, though not the end all, be all solution in terms of awareness, this is a belief I felt because of my own personal experience but I believe that really at all the various tiers of activities that awareness—true awareness—not that this is somebody else's problem but that this is our own problem, needs to occur at all the various levels.

Touching on a sore issue but, I think, underlying this area of awareness and how awareness triggers a variety of activity, as we know with hurricane Katrina, there were some issues that came up in terms of the existence and the plight of individuals within our own United States of America as it pertains to socioeconomic conditions that has changed the view of many individuals in the majority of the population about what's been occurring down there and what it is that needs to be done. When we look at this idea of health disparities from the Office of Minority Health standpoint—realize that what we need is a true movement. We need a true filtering down of activities, various levels and just in the same as had happened post-Katrina where now folks realized that there's something that we

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all individually can and should do. We believe that that is what now needs to be extrapolated into the health disparities conversation. There is something that we all each individually can do at our various levels of activity. So this is not just, I think as Bernard pointed out, the federal government needs to have strong leadership, states need to have strong leadership but then this needs to filter down to the individual level—practitioner and patient in terms of understanding their own healthcare. So wow—time just goes by but so that's how we're approaching it. Our emphasis right now is on this idea of public/private partnerships and engaging the various physician associations—not just minority physician associations, which are important because they've been doing a lot of good work but the majority of physician associations engaging the private sector. There's a good group called the Minority Health Obesity Coalition that is working on—with a number of private sector entities including a number of the grocery stores and grocery chains and all the various people that need to be involved that we're working with as well so different levels, different areas of activity as has been shown—the federal government, though, having an important leadership role is not the only player on this field and what we really need is for this point is for the full team on board in terms of understanding the various roles that we all must undertake. So that's it. I can't believe I went over my time. I really pride myself on trying to stick to the time allotted but I guess I didn't this time but thank you all

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for having me here and being able to express and our vision and our thought pattern at least from the Office of Minority Health perspective.

ED HOWARD: Terrific. Thank you. Thank you very much.

It's a phenomenon called time flies when you're having fun Garth. Now comes time for your questions. By the way, as we go through this and we have time for significant amount of questioning, don't forget that if you have to leave, we want to get your opinions about this program, how we can make our programs better on that blue evaluation form. If you have a question on a green card, emulate your colleagues around you, hold it up and someone will bring it to us. We had some folks who submitted some questions in advance. Let me start with one of those if I can. Are racial and ethnic disparities in healthcare as common in government operated programs like the VA and the military as in the healthcare system as a whole? Ashish? Then Garth.

ASHISH Jha, M.D., M.P.H.: I'm happy to take the first stab. There actually are some good data that suggests that disparities are significantly less in both the VA and the military healthcare system. The problem is that that just has not been explored nearly as well as it needs to be so I think the answer is we're not sure because we just don't have the data but to the extent that we do, there seems to be a difference and it seems to be in those two healthcare systems the gaps in care may be much smaller.

GARTH GRAHAM, M.D.: Yeah and I would underscore

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that. We recently reviewed a paper on this journal that I sit on that was—when it gets published will actually add to the body of data that does show that there are significant disparities that exist within the VA healthcare system. Again, to underscore what Ashish said, it's not as bad as it is in the majority of the population but there are disparities that do exist within those programs. One thing to underscore when we think about solutions and Ashish talked about this and I'm realizing that insurance in its various form was not necessarily a significant contributor when we talk about this issue is when we define access, socioeconomic conditions that that is not the sole explanation for why health disparities exist. There is no doubt that data has shown that insurance plays a major factor but even in areas where insurance is controlled—when we look in terms of the Medicare population, a lot of studies that have been done there and even when we control for socioeconomic conditions, there was a study looking at women and infant mortality in New Jersey and even the higher echelons of black women who are well educated and have significant income still suffer from an extremely troubling burden of disease as it pertains to infant mortality so when we think about this issue, we need to think about the fact that it is multifactorial and that's why I actually think we need to look at pulling all the levers.

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ED HOWARD: Thank you. Let me remind you that there are microphones that you can use if you would prefer to voice your question and let me just ask a follow up question if I can Garth, based on what you just said, we happen to have a card that's relevant and actually it is directed also to Dr. Jha. You said that all the patients in your studies had insurance so it wasn't an access problem. Did they have similar levels of insurance; that is, what about the wide range of insurance levels among those who are technically insured? Is underinsurance taken into account in any of the studies? Is it a significant problem?

ASHISH Jha, M.D., M.P.H.: Sure. It's interesting. Actually, the studies vary, of course, and for instance, the Tervati study I talked about looked at people enrolled in the Medicare managed care programs—I would say most of those people, whites and blacks, had relatively similar levels of insurance so I guess the answer here is that even when you really equalize access, there clearly are still gaps but access is not a simple yes or no. There are different levels of access and that clearly varies by race so I think they are both important issues but the critical one to understand is that in a lot of studies you really see true equal access where you have the same level of insurance and despite that there are important gaps in care between whites and blacks.

GARTH GRAHAM, M.D.: Ditto. No, I'm just kidding. Let me expand on that just a little bit. I think what we need to be able to

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identify is whether insurance—how big a role insurance plays in terms of eliminating the issue of health disparities and I think why I said ditto to what Asish said is that we see that when there is equality in terms of insurance at various levels so even in those who are underinsured, when we see that there is relatively equality across the definition of underinsurance as it pertains to that particular level, that disparity still exists. When we think about solutions, we have to realize that even at various tiers of insurance, underinsurance, or overinsurance—if there's such a thing—that it's still there. So it's not the end all, be all.

ED HOWARD: Someone at the microphone. Go ahead.

Identify yourself, please.

LINDA LUBAIR [misspelled?]: My name is Linda Lubair [misspelled?]. I'm a political economist at Morgan State University and a volunteer at Maryland General Hospital on a medical floor. My question is when we understand there are these disparities that exist, why doesn't an entity like NIH continue to keep the same criteria for researchers who are wanting to do research on this especially African American researchers and which selectively prevents them from doing it—why can't they come up with a new criteria be it—and the reason I'm asking this is because I just recently saw a film that the NIH put out as to how you get research done with them and it just floored me that well, only white people basically who have experience can get money to do more research and

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yet we see that the research that has been done has not been helpful and I talked to some people. I'm not doing the research but—and they said well we can't get any money from NIH. We've got these novel ideas but oh—our model didn't fit the way the people who were reviewing it saw that it should. Why can't there be something from the government that assists, perhaps, in making sure that the model is right because the idea is there for making some changes.

GARTH GRAHAM, M.D.: Yeah. Let me just say that I'm not sure what their personal experience might be but I can say confidently that the NIH has a number of models to deal with dealing with health disparities and one of the best models and a guy who's working extremely hard to do this is the work that emanates out of the National Center for Minority Health and Health Disparities, John Ruffin [misspelled?] and John's level of funding - he—when you talk about a champion in terms of health disparities, you're looking at a man who's done a lot of work so not to belittle your point but I think if I could disagree respectfully, I would say that John and those folks and Andy Von Escheberg [misspelled?] the folks at the National Cancer Institute have actually created a lot of programs and a lot of models to deal with health disparities. One of the most recent things that John created is funding community-based participatory research so what he's done there is try to fund - not your generic bench research, which we do need but also to be able to fund community-based organizations that do work and then fund that

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over a time period where you can see where your intervention was and then reciprocally what is it that you do with that information. John funds a lot of NIH minority health disparities training programs - a ton of funding—so health disparities training programs. NIH allows loan forgiveness for those people who take on health disparities research. The National Cancer Institute spends—don't quote me on this—but upwards of about \$200 million or so dollars in terms of health disparities focused programs and—I'm sorry—that's just NCI and then NHLBI has all these programs so there are really a number of programs. Now, what I think the solution should be is how do we then connect folks who are out there doing this good work to the program monies that are there and then have them understand where it is that their work fits in, in terms of the overall funding but I think it would be not correct to say that NIH doesn't put a number of—and then John funds Centers of Excellence, Morehouse and all these different places that does non-traditional work when it comes to health disparities so they're doing a lot of good work.

JOHN RUFFIN [misspelled?]: And let me just say as a completely interested party, I'd love to see the NIH do more funding in this area so there is no doubt that we could do more and we clearly need to do more but let me reiterate what Garth said—it's that I think there are a number of programs we clearly need more minority physicians and minority physicians scholars who are doing this kind of work. I guess it's a statement to say we're not there.

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We're not doing this as well as we should be but it would not be fair to say there have been no efforts to address this issue.

BERNARD TYSON, M.B.A.: Just to finish on that, I also think that, similar to organizations like mine, Kaiser Permanente who conducts a lot of research that we should also make sure that that's happening in the healthcare industry as well because that is where you can have great collaborations and partnerships and we have a wonderful partnership with the NIH on many of the projects that we're working on.

ALBAN KASTLE [misspelled?]: Thank you. Alban Kastle [misspelled?] with the Center for Studying Health System Change and I'd like to—I'm going to be Peter Bach's proxy here and point out that we've had a lot of discussion today about changes or disparities within providers and the care that minorities receive but there's also a growing body of literature out there that points to the fact that minorities tend to be clustered among certain physicians and certain hospitals and these physicians and hospitals tend to have fewer resources than the hospitals and physicians who are treating majority population and it seems to me that if you want to talk about policy levers, the one you can pull is to give those folks who are caring for minority patients in great numbers -he Bach article points out that for primary care physicians—20 percent of physicians take care of 80 percent of the minority

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Medicare patients and they report much greater problems getting admissions for their patients, referrals to subspecialists, referrals to imaging. It's a resource issue that our healthcare system, in some respects, is as segregated as our housing patterns and cultural competency is a wonderful thing and we need to put resources there but we also need to put resources into these other issues as well. Thanks.

ED HOWARD: Go ahead.

GARTH GRAHAM, M.D.: Yeah. I actually think that's a good point. There's another kind of part two to Peter's article, which is also showing that hospitals, individual hospitals—exactly right, exactly—so there's no doubt that there is various tiers of disparities that exist. One of the things that we have been pushing out now just in terms of underscoring that you are correct in terms of pulling some of the policy levers is that we have recently began on some discussions with the American Heart Association about this issue of clinical guidelines and putting some—enabling smaller hospitals to work—be able to implement clinical guidelines in a way that is effective so the same way that majority of hospitals have that ability and capabilities to allow the smaller rural hospitals. Now there is some data that has not been published, which would be the part three to that, which is showing that in rural hospitals and rural minority hospitals, there are similar issues as well. I agree with you that there is various tiers in terms of dealing with that

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and that one of the solutions should be directed at allowing folks or giving folks the ability and capabilities to do more so yes.

BERNARD TYSON, M.B.A.: One of the discoveries for us at Kaiser Permanente—and I'll globalize this but we have come to learn that some of the community-based health organizations—in some cases, we've changed our strategy where we are helping to fund those community-based organizations instead of trying to replicate it in those communities because we have discovered that the community-based organizations, quite frankly, are better equipped to deal with the challenges and the issues and they have even greater credibility than large organizations in some cases like Kaiser Permanente and so taking a million dollars, for example, and running something ourselves—giving it to that community-based organization with a contractual relationship, we have found that the money is well spent and, in fact, you get more than the million dollars of what you spent. The whole resource and particularly, in the communities of color is really a critical issue.

ED HOWARD: And Garth?

GARTH GRAHAM, M.D.: This actually goes back to talking a little bit about what Dr. Ruffin does and some of the work that is being done in terms of community-based organizations. The getting the message down to the ground level in terms of activity can be effectuated better if we enable the communities to be able to run with the baton in terms of dealing with this issue and I encourage

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some of you who are interested in community-based participatory research and true community-based participatory research—take a look at some of the funding that [[inaudible]] has been putting out.

ED HOWARD: By the way, there is an article about Peter Bach's article in your materials reprinted from USA Today and if I can ask our questioners at the microphones to bear with me a minute, if Risa were here she would inject the question—related question at this point of the extent to which disparities reflect where minorities get care as opposed to attitudes among those who give it to them or cultural sensitivities, whether that's from region to region or from facility to facility or doctor to doctor, what do you do about that if it is a significant part of a problem?

ASHISH Jha, M.D., M.P.H.: The answer of is it region to region, facility to facility, or doctor to doctor, I think the answer to that is yes. It's all of those. There are good data and we need a lot more data on this too to understand this better but there is clear data that disparities vary a lot based on where you live so in some places, disparities are small, in other places disparities are very large. It clearly varies by where you get care and we do have good evidence that black Americans get care in very different places and where white Americans get their care and it varies by individual providers. The solutions are not going to be to focus on any one of these three things. This is an extremely complicated problem. That's why the data that I showed you with no movement -

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it's because there aren't going to be easy solutions. There's nothing that we're going to do that's going to be a silver bullet. We're going to have to attack this problem at every one of those levels and that's the only way we're going to see real movement.

GARTH GRAHAM, M.D.: It's interesting. Again, ditto in terms of what Ashish just said—in terms of attacking this at different levels. Interesting in how we define the health disparities problem. We keep defining this as—too much as a black/white issue or a racial issue. There is influence of race but then there's really this issue of quality of care and I think if Carolyn was here—Carolyn Kleins [misspelled?] was here, she'd be able to articulate this better but it's really, really, really looking at quality of care to particular communities as opposed to looking at this in terms of race so even if we looked at particular regions and took out the race issue, we would still be able to see that there are huge chasms in terms of quality of care so it's important to understand the racial dynamics of this but it's also important to understand that we're talking about quality of care for all Americans.

BERNARD TYSON, M.B.A.: Yeah. Actually I was going to make the same point. A couple of years ago, to make this point—my boss George Haverston [misspelled?] was doing some research in preparation for a book he was writing and he has written "Epidemic of Care," and he sent the details of a patient to 132 providers, same data, same information—everything and he asked them present to me, in

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essence, your treatment plan and he got something like 82 different treatment plans. The point being the whole issue of the variation of care is not a unique and specific issue for healthcare disparities. It's a compounding effect when you add some of these other features but I was going to tag on to your point as well about the overall issue of health disparities in this country vis-à-vis quality of care. The last point is the healthcare industry itself is so fragmented and, in fact, in many cases and this goes back, I think, to your eloquent point earlier that at the end of the day the judgment is still left to 1 physician, 1 person, and the best interest of that 1 patient and to the extent that there isn't a system of care in which you are not just potentially using what you learned 10 years ago but yet you are really up to date on the latest proven practices. You may, in fact, find that inside of the industry, you have those kind of variations that are going on because the knowledge base could be much farther ahead than where the people really are and their learnings of what's going on.

ED HOWARD: Thank you. You've been very patient back there. Identify yourself and ask your question.

ROXANNE UGUBIA [misspelled?]: Sure. I'm Roxanne Ugubia [misspelled?]. I'm one of the Washington representatives for the Association of Minority Health Profession Schools. I wanted to thank Mr. Tyson on your comments on how medical schools need to learn how to become more culturally competent—that is the basis of our mission

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over at the Association that I work for and I wanted to let everyone know that the FY06 Labor HHS bill, which could be coming up on the floor of the House in the next couple of days would severely damage and eliminate a lot of the funding for medical schools that try to teach culturally competent kind of things and work to eliminate health disparities so we encourage all of you to please contact your legislators and tell them to fully fund these programs. I have more of these action alerts if you need them. Just come and find me. Thank you.

ED HOWARD: Yes? Go right ahead.

JACKIE DAVISON: Yes. My name is Jackie Davison and I represent the Summit Health Institute for Research and Education. We have just finished a study in California of health disparities between African and Caribbean immigrants and, of course, we found the disparities are profound and we know that African and Caribbean immigrants are in large urban areas so is there any expectation that there'll be studies of health disparities on a national level? And my second question is when you—let me word this—when you present the data or collect the data on African Americans, does it include African and Caribbean immigrants?

GARTH GRAHAM, M.D.: That's interesting. I'd love to see that data because I am a Caribbean immigrant and I came here about 16 years ago. No we don't really obviously collect data right now differentiating between African and Caribbean. I think there's been

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some anecdotal data in the past especially when you look at educational concepts and educational achievements and things along those lines in terms of African and Caribbean data but I actually was not aware of specific data that Shara and Ruth and you all are doing and Shara is one of those groups that we talk about people who do good community-based participatory research and activity, you all are one of those groups who do that kind of stuff that is very, very important but I don't know much about the data in terms of governmental data in terms of the difference between African and Caribbean populations. Obviously, I can say that I'd be personally interested in that [[inaudible]] differences.

JACKIE DAVISON: Okay. We'll see that you get a report.

GARTH GRAHAM, M.D.: Thank you very much ma'am.

ED HOWARD: We've got a couple of questions on cards, by the way, about other ethnic groups. We mentioned Hispanics, Alaskan Native groups. Clearly, there aren't enough data on those groups to document a lot of the same disparities, is that something that there is attention being paid to? Is there an initiative to try to do something about that?

ASHISH Jha, M.D., M.P.H.: Let me say from the other end—from just the consumer of data - I take data and I try to do analysis with it as a researcher, this is an extremely frustrating issue because when we talk about, for instance, Hispanics—the data

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quality for Hispanics is terrible and Hispanics are not a monolithic single group of Americans. Cuban Americans in Florida are very different from Mexican Americans who are very different from Latinos from other parts of Central and South America. I guess what we're left with is we use these very broad categories—white, black, latino, Asian American rarely if you can ever get any data but even that's an extremely diverse group of people so I think the issue here is that if we care about this issue, we need to do a better job starting to collect this data. We have no idea what we're doing in terms of caring for people of different groups and we will never know until we actually measure it and there is a lot of resistance, I still feel, by a lot of provider organizations to collect this data in a systematic and careful way. Let me say just one last thing. I heard this story about a hospital—the way they collect data on race—true story—is when the person calls up on the phone, they actually do it by what the person sounds like. Do they sound like a white person? I have no idea how you do that but you can imagine what quality data that is so we have a long way to go in terms of being able to do this stuff in any kind of a systematic and thoughtful way that's going to give us good answers.

ED HOWARD: Bernard?

BERNARD TYSON, M.B.A.: Specifically, to your point and using the example of Kaiser Permanente, last year we passed a

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policy in our organization to do race based data collection to do our own analysis of whether or not healthcare disparities exist within the Kaiser Permanente population with the commitment that if we find anything, we're going to get rid of it but also to serve as a model for the rest of the industry. We think it's perfect because we care for almost a million African Americans, about one and a half million Latinos and about 700,000 Asian Pacific Islanders and others. It was a watershed event to get our organization to that policy agreement and indirectly, I have to give credit to Ward Connerly [misspelled?]. I never thought that I would ever give Ward Connerly [misspelled?] any credit but Ward Connerly [misspelled?] attempted, as you know, to get an initiative passed to eliminate collecting any race based data of any organizations, which federally funded with [[inaudible]] system, etcetera—you know the background and we were opposed to that initiative and fought him and his team over it openly. At the conclusion of this, when we actually celebrated that it was not passed, we stepped back and asked ourselves, wow that was a significant event because I think we finally internalized this to say look this is really another dimension of information to see how well we are performing on our quality goals. This is not to indict anyone. This is to say lets really assess where we are in our performance. Lets walk our talk and we've passed it and now we're implementing it across the program and probably will have our first real slice at the analysis in about a year.

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ED HOWARD: Terrific. Yes?

DR. MARYLOU DELEON [misspelled?]: Yes. I'm Dr. MaryLou DeLeon [misspelled?]. I'm a professor and nurse scientist at Georgetown University School of Nursing. I am also a past president and founding member of the National Association of Hispanic Nurses. So my question to you is when will the dialogue begin in the 21st century among healthcare professionals—physicians, nurses, dentists, public health professionals - to really create the coalitions that will move not only cultural competence forward but also really work towards eliminating the health disparities not only in service but research and academia as well. The problems are so great and the manpower is not great enough that no one profession really has the service, vision, ability, or the unique methodologies that will answer all the questions and we really do continue to exist in silos. Among the ethnic minority nurses, we have created a coalition of ethnic minority nurse groups and that's moving that agenda forward as is the American Academy of Nursing, which is I'm here at their invitation but I continue to be fascinated by the fact that these silos continue in the 21st century when we can't afford it for it to continue that way given the relatively huge size of the problem that we're confronting. Thank you.

GARTH GRAHAM, M.D.: I agree and I underscore that point in terms of talking about this concept of partnerships. Now one thing

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I will say is that the AMA had taken a big step in terms of the AMA creating this AMA Commission too in health disparities that has numerous, numerous, numerous groups involved so far and we're working with them now in terms of trying to create that playing field like we just talked about where we're all going towards the same goal simultaneously but I can't underscore enough, I think, what that last—I think you are right. I think the fact of the matter is that we have a lot of people who are concerned, a lot of people who believe in this. We have a lot of foundations, academic institutions, people who are in the government, people who are all over and it's not that people don't care about this enough. I think people care a great deal but I think the problem is huge. I think the problem is vast and I think if we try and simplify it at any particular level or tier, that we'll be doing it an injustice. Then it's now how to get all of us working on the same field so yeah.

ED HOWARD: Okay. Bob?

BOB GRISS: Bob Griss with the Center on Disability in Health. There's been a lot of lip service to cultural competence without really addressing the lack of resources that culturally competent providers need, there's been a lot of lip service to data collection without identifying the levers that the federal and state governments have that could require the collection of data for Medicare and Medicaid. We are sitting in Washington, DC, which is probably one of the best laboratories, potential laboratories for

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studying health and healthcare disparities. It is all around us and yet in Washington, DC, there is a debate about whether we need to build a new hospital on the east side or whether we need to build more community-based services. I don't hear a debate or a discussion even of what kinds of changes would be needed within the healthcare delivery system that the government, which happens to have the same power as any other state, which the government has control over that could respond to healthcare and health disparities as a lever or as a trigger for resource reallocation. In other words, the focus is on how do we build something new—a new hospital or a new clinic in underserved areas and we will measure those underserved areas and prove they're underserved but there's no attention to the administrative mechanisms that need to be moved on the basis of disparities and I'm wondering if anyone on the panel has ideas around that?

BERNARD TYSON, M.B.A.: I would offer a couple of comments and I'm resonating with where you're coming from. I guess I would go back to my foundation that I talked about earlier, quite frankly, from my own experience and what I see going on across the country. I start to ask these questions—where's the leadership coming from? I would offer to you, without clear leadership, that brings the vision, the strategy, the incentives, the mandates—you have a lot of good will going on. I think the second one is making sure that the right incentives are in place and the systems of accountability. The

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federal government has a big stick and it's the stick of payment to the healthcare industry. I think that the federal government needs to continue to enforce that we have to start collecting the data and demonstrating that healthcare disparities are not existing in our institutions across the country. I think also the federal government can incent the healthcare industry to look at how to share best practices across the industry as each of us learn different ways to care for populations of color. Then my last comment is I think that there's a foundational issue that is being discussed quite a bit in the federal government and in the country. The healthcare industry is the only industry that is totally dependent on paper. We are still a paper-bound system called the medical record and so we care for millions of people every single day with a paper record. That makes collecting data very difficult. That makes mining data very difficult. That makes it very time consuming, very cumbersome and I think that the federal government needs to continue incenting and enforcing the healthcare industry to computerize the medical records and the information so we can share best practices across the organization in very different ways.

ED HOWARD: And sometimes those paper records get washed away in a hurricane.

ASHISH Jha, M.D., M.P.H.: That's true.

GARTH GRAHAM, M.D.: Can I just say one thing? I appreciate your patience sir. I would say there's more than lip

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service being paid to this. I think one could argue about the amount of money that's being spent but I can give you a couple of examples. For one, if you want to talk about the funding and so forth that's going toward cultural competency and some of the administrative actions that's occurring at various levels, in terms of from the federal government level. One is within the scope of work of the QIOs—of the quality improvement organizations at the physician level. CMS has implemented a lot of mechanisms there to incentivize cultural competency and they're in the process of doing more so if Peter was here, he could probably articulate this better but there are researches going now. There are, from our standpoint—the Office of Minority Health, we have created a training tool and worked with different folks and worked with various community and state organizations to actually understand what this issue of cultural competency is. I think you could argue—yes about the amount of money and I think that's where people have various aspects of debate and strategies and so forth but I don't think it would be totally correct to say that it's just lip service and, of course, I'm biased in that answer.

ED HOWARD: And I might point out—there's a dear colleague in your materials from Senator Lieberman and some others urging the retention in conference of some related language that was inserted in the Senate version reconciliation package having to do with the use of data that are relevant to disparities in the creation

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of the standards for the pay for performance language that is going forward.

BOB GRISS: And if I could just follow up on this question of data and lip service. In this very room, when it's hospital quality initiative, they were creating incentives for hospitals to start reporting on various measures but they did not require any of those measures to be by race. Why was that strategic opportunity not used to collect some of the data that you're saying we all need?

GARTH GRAHAM, M.D.: Yeah. I can answer for CMS and I think, like I said before, I think there are various discussions that can be had about opportunities and further opportunities and increasing efforts and funding but I will reiterate that I think it is incorrect to say that it's just lip service from the federal government's standpoint. I think there have been various efforts through various administrations so not to wrongly [misspelled?] politicize the cause of health disparities but I think we realize that we missed opportunities and potential opportunities at various points along the field that we've all undertaken over the past 20 years. So I can't speak to particular opportunities—particular issues because like I said, I think we could probably, over the past 20 years, find different areas where we could have, should have, might have done something but I think we have to recognize that there is a significant amount of funds that have gone towards health disparities. Actually, we did an inventory—we started doing an

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inventory of health disparities activities—if you look at what HRSA is doing with the health disparities collaborative, if you look at some of the monies that CDC is doing, if you look at really—if you look at what ARC has been doing and some of the funds that they have been putting there - that is all part and parcel of what the federal government is doing. CMS is part and parcel but if you look at what NIH is doing so we can't just say the federal government is doing nothing because that's not true. We can say—it is true to say that there might be more.

ED HOWARD: Both Ashish and Bernard have things to say.

BERNARD TYSON, M.B.A.: I just want to make a—and I appreciate your passion. I want to make a quick observation about this because I think to drive home my earlier point around the individual—I don't want to make it sound so simple that people of color is just wide open to the collection of data about themselves and so there's a sensitivity here that has to do with some—and this, by the way, goes back to culturally competent has some historical significance about how data was used in our history and in our past and so it's not as simple and I'm not suggesting that you're saying this that we in our institutions and the federal government can simply impose now lets collect data and assume that everybody is in agreement that they want data collected on them especially if you are feeling suspect about what's going to be the use of the data. We have that issue inside of Kaiser Permanente. We've debated this long and

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hard before where we want to make sure that the populations of Kaiser Permanente have no fears that the collection of this data is really to say people of color are of higher risk so lets charge a higher premium. We have to be very careful in how we really deal with the implications of an aggressive approach for data collection. That's not in any way suggesting we shouldn't do it but I don't want to leave you with the impression that it's just a matter of lets decide to do it and not really think through all of the effects that we have to incorporate into our planning process.

GARTH GRAHAM, M.D.: And let me say this is a point I've been trying to drive home. This is not as simple as many of us would like to think. There's a reason why it's taken like 20 years despite all these efforts, things haven't changed. Again, It's not just, again in respect to your passion—it's not just that people in this area are going to say lets solve it right now and it'll be done. That would not be true so we have to be truthful and factual firstly to understand where we're at and then think through the process and not just try to generalize or make this germane and generic but actually to put some thought back into what we're saying and doing.

ED HOWARD: We have time to hear from the questioners who are standing at the microphones now if they are brief and if our responders are brief. Yes, go ahead Alan.

ALAN GEISS [misspelled?]: Alan Geiss [misspelled?], [inaudible] Two very, very brief questions. One is how do the

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research studies and treatment approaches take into account the fact that in many rural areas and inner cities, the medical care for the minority populations is actually provided by immigrant physicians from foreign cultures themselves—how does that factor into cultural competence? Second thing is are you confident that you've diagnosed the problem before you're going ahead to treating it if, for example, as was suggested by Dr. Graham, a major component of the racial disparities is a communication problem then that would seem to require one treatment approach. We defined the problem and yet we seem to be jumping to the treatment of the problem without diagnosing the causes of the problem.

ASHISH Jha, M.D., M.P.H.: Well let me take your second point first. A couple of things—I think that this issue is urgent enough that I don't think we have the luxury of waiting until we sorted all the issues out but, at the same time, there are certain things that we know. I think there is no doubt that there are issues around communication that has its own set of solutions. There are issues about where blacks and Latinos get their healthcare—that has its own set of solutions so do we need to understand this stuff better? Absolutely, but do we need to wait until we understand it with much more clarity before we act? I don't think that's wise and I do think there are things that we can do today and as we learn more we can shift course and change things but we do need to start moving towards some solutions now.

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ED HOWARD: Do you have anything, Bernard, to say about culturally competent immigrant physicians? You probably employ a few of those.

BERNARD TYSON, M.B.A.: Yeah. I think that, once again, this speaks to what happens when you globalize and potentially put an imagery of something that doesn't represent reality. I'm not suggesting that that was in there but we have a total of 15,000 physicians practicing at Kaiser Permanente and a part of that population are from immigrants and the quality of care that is delivered by those physicians is as high if not greater in the communities that we have staffed. The second thing is in terms of the culturally competent issue and I thought Dr. Graham eloquently touched on this issue, at the end of the day, I describe it as understanding and seeking to understanding the nuances that is needed to appropriately care for the people that are entrusting their lives in your hands and we go through a series of learning opportunities within Kaiser Permanente for both the executives and for the providers of care because we have discovered that, at the end of the day, if the resources are coming from one part of the organization, without a full appreciation for what that means, if we tell a doctor you have 15 minutes to do an appointment and, in fact, the doctor is seeing a particular patient that is going to require 25 minutes, it's very important that I'm watching that happen to

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have a better appreciation when it comes to the resource allocation and so the competency and the competent care that we describe to works its way down to the individual interaction that will happen between the physician, the physician's staff, the nurses, and the patient, and the patient's family.

ED HOWARD: Yes? Last question.

REESA IRVEY [misspelled?]: Hi. My name is Reesa Irvey [misspelled?] and I'm a third year medical school student at Harvard taking a month to intern on the Hill in Senator Kennedy's office. The first thing—I just wanted to make a statement and ask for everyone in this room to continue to support legislation that gives money to the pipeline programs that exposes minorities to science and healthcare professions early on in college because almost all of my classmates have been through those programs and also to support legislation that gives funding to historically black colleges and Hispanic serving institutions, which put a higher percentage of students into graduate and professional schools. My question is in a lot of the work and forums I've put on in Boston dealing with ethnic and racial disparities is that there is a lot of sympathy towards the issue but there's not personal responsibility amongst my classmates or the physicians there in terms of dealing with these numbers and how do we get people to take that personal responsibility for those numbers and also with the American society as a whole, how do we get people to acknowledge the issues and the social determinants that lead to these

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issues such as poverty and I say that in light of Katrina that just happened and a lot of the forums we had at school were oh, it's so bad that Katrina happened and did these things to those people but it wasn't Katrina that created that situation but the poverty and the things that we allow to exist in America that create those conditions.

ED HOWARD: Very good last question.

GARTH GRAHAM, M.D.: I think—and I feel like I planted you in the audience. That's my point that we need to drive this down to the individual level. I appreciate much of the passion that people expressed about the role of the federal government but what people do when they do that is that they then take the role off of them and say well the federal government isn't doing enough or whoever they want to put the blame on and say that person's doing nothing and that takes responsibility off of me and that's not true. I, just like you actually, would not have even seen a medical school if it wasn't for a pipeline program so I'm very supportive of those programs but I also understand much like you do and so I think rightly stated that health disparities needs to be personal. People need to understand they're personal—personal responsibility and we can pass the buck as much as we want to but that's not what's going to create changes when your classmates, us, the gentleman who stood up further, to have you here—what everybody figures out their role and what the real concept means for them and start really kind of acting on it. I think we're

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going to start seeing some differences.

BERNARD TYSON, M.B.A.: I think also you hit a cord with me in that in many cases, once the person is in the healthcare system, the damage is already done so and that's proven by the fact that, as many of you probably know, the majority of the dollars spent in healthcare is really about 20 percent of the population consumes about 75 to 80 percent of the total healthcare costs so you're talking about a system that is designed to react to issues once it's presented. Health disparities—those factors, those stresses that communities of color have to deal with day in and day out is, in fact, where we have to continue to make sure that our public policies and other issues are addressing those particular issues. I hope and pray that the image that the television that allowed to come into each of our homes is now burnt inside of our minds where we will not forget about it next year when we start talking about some of the resource allocations, etc. because this problem exists all over the country and so this whole issue of health disparities is a major one. One that I'm working on right now is the issue of the high—an unacceptable unemployment level for African Americans in this country. In some of our cities, it's upward of 80%. That is mind blowing and so when you get to the basic of not being able to work, everything else from there goes even deeper downhill and so the health disparities issues are very relevant in this country and absolutely critical to be solved to in the context of health

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disparities, etc.

ASHISH Jha, M.D., M.P.H.: Just a quick comment and thank you for your comment. There is a tremendous amount of defensiveness around this issue that's always striking to me and the people who are up here are not a random sample of healthcare executives and researchers in this country—it's a very biased sample but when I talk to people about health disparities, there are a lot of people who say absolutely a problem. Of course, I treat everybody the same and I think that too. I care a lot about this issue and I'm sure I treat everybody the same except I probably don't so once we begin to have those kinds of conversations and I think talking to your classmates when I attend on the wards at the Brigham or at the VA, I talk to patients. I talk to housestaff and medical students about this, it's absolutely critical to have that personal conversation, to take away the defensiveness from individual providers, take away the defensiveness from organizations. Kaiser is not your typical organization. Most organizations are not willing to collect race data in any kind of a systematic way because they're nervous and we need to make it a non-issue and it has its complexities but we need to de-stigmatize this and really try to move forward away from a conversation about are you a racist to we have issues in this country around disparities and we need to address them. Thank you so much for your comment.

ED HOWARD: Okay. Well I want to thank a lot of people

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here—Risa and Lisa. Risa Lavizzo-Mourey from Robert Wood Johnson with her colleagues for her continuing interest and support in partnership in connection with this particular program and Lisa Swersky [misspelled?], our staff member who took the lead on organizing this in an excellent way with the help of Robin DeMuth and others on our staff. I want to thank you for coming out on a less than ideal afternoon and I want to ask you to join me in thanking our panel for what I think is one of the liveliest most thoughtful discussions we've had on this topic or any other in our briefing series.

[END RECORDING]