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Racial and Ethnic Disparities: States and Feds to the Rescue? Alliance for Health Reform and Commonwealth Fund May 12, 2008

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ED HOWARD: Good afternoon, my name is Ed Howard. I am with the Alliance for Health Reform. On behalf of Senator Jay Rockefeller and Senator Susan Collins and our Board of Directors, I want to welcome you to this briefing on Racial and Ethnic Disparities in our health care system. How wide spread they are what policy tools are available to lessen them? Our partner in today's program is the Commonwealth Fund, soon to start its second century of activity on a range of health policy issues with an emphasis on vulnerable populations.

And, we are pleased to have Assistant President, Anne Beal from the Fund with us today. We have a couple of terrific information resources, as well as our usual terrific human resources on which to build today's discussions, and if you did not get them on the way in, I urge you to pick them up, either now or on the way out.

There is a new chart book produced by Holly Mead and Bruce Siegel and their colleagues at the George Washington School of Public Health and Health Policy, and the March/April issue of *Health Affairs* with a whole passel of articles on different aspects of disparities.

Today, we are going to take a special look also, at what states are doing, or are proposing to do to address health and health care disparities and what federal policy makers might learn from those efforts.

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Before I introduce my co-moderator and today's panel, let me just do a little logistical business if I can. By close of business tomorrow, certainly you will be able to view the webcast of this session on kaisernetwork.org, where you will also be able to look at electronic versions of the materials that were in the kits you got. Those materials will also appear on the Alliance's website, allhealth.org.

There will be a transcript available on both those websites in just a few days. You can download a Podcast if that is your desire. You cannot get away from these briefings, no matter what you do. [Laughter] and at the appropriate time, I encourage you to either go to one of the microphones, there are two in the back and one here in the front, to ask questions and make comments, or fill out the green question card that is in your packets.

And that eventually there is a blue evaluation form in your packet which we would also appreciate your taking the time to write down a few comments so that we can make these briefings ever better for your edification. So, we are ready to go. Please take a moment to turn your cell phone to vibrate or to off, and we will go forward.

As I said, we are very pleased to have representing the Commonwealth Fund today, Dr. Anne Beal, who is the Assistant Vice President for the fund's program on quality of care for underserved populations. She is a pediatrician, she has got an

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extensive background in assuring quality of care for minorities. She is very active with several different national quality organizations. The full biographical sketch of Anne Beal and our panelists is in your packets as well.

Today, she is both going to share the duties of keeping this discussion going, and offer us some context for the discussion to follow. So, Anne we are very happy to have you with us.

ANNE BEAL, M.D., M.P.H.: Thank you, Ed. So if you will bring up the slides. As you heard from Ed, I am from the Commonwealth Fund, and the goal of the fund is to try to get the United States towards a high performance health care system. But, particular with an emphasis on vulnerable patient populations, which includes, minority patients, low income patients, uninsured and underinsured people within the United States, as well as children and the elderly.

As so the program that I direct focuses specifically on low income and minority patient populations, and we are really very much taking the tact of trying to address high performance for those populations, from the point of view of how do we get to high quality care.

And so I just wanted to take a little bit of time as Ed said, to provide a bit of back drop in terms saying, but why is it that we are choosing to address disparities as an issue of health care quality? I think that most of us who are familiar

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with the issues of health care disparities know that they exists, but we very immediately want to get to the question of, what are the causes of health disparities? And obviously, in order to understand the causes that is what leads you to then saying, okay, if I understand the causes and this is going to give me information as to trying to get to solutions.

And so I think first it is worth taking the time to recognize that when we are talking about health disparities, that there are disparities in terms of health, and then disparities in terms of health care. And so the question remains, in terms of what are the causes of some of those disparities? So when we are talking about outcomes, such as life expectancy or health status, or even asthma rates or diabetes rates, everyone I think would agree that any disparities that we see in terms of those measures or any factors that we see associated with those measures, are really going to be related to, both non medical factors as well as health care factors. And the non medical factors are things such as health behaviors, where people live and work, income, stress, other things like that.

While the health care factors are obviously things such as access to care, the clinical effectiveness of care that is delivered, safety, financing and making sure that providers are adequately resourced to provide high quality care, and the acceptability of care to their patients.

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And so the question first becomes, is that when you are thinking about certain types of health care outcomes, what is the relative contribution of seeing, non medical factors verses health care factors? And the reason why this is important as you heard Ed say, I am a pediatrician, so I am often giving this talk to medical audiences and providers in general say, well, they feel very much at a loss, they try to address the societal factors. And then the doctor well say, well my patients come to me with significant challenges and I do not know really what to do about housing or education or the lack of economic opportunities in the communities where I work.

But the fact is, that if you look at data, and these are data actually from Canada, and you look at a variety of health different health outcomes, that the relative contribution of non medical factors to health care factors is about 50/50, depending upon what is the outcome that you are looking at.

And so at the Fund, we very much take a role of saying, okay, recognizing that there are a number of factors that do contribute to health disparities, we are very much going to focus on health care, because we recognize that it does have an impact on about 50-percent of the outcomes that we are interested in.

And so then from the perspective, let us say we take the case of asthma, if one were to recognize that we know that

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there are differences in asthma. So you know that for example, African American and Latino populations are much more likely to have asthma. You know that when people do actually get into health care, they are much more likely to have poor outcomes and not receive the same quality of care. And we know also that the mortality rates for asthma are much higher among African American and Latino patient populations.

And so if anyone in this room were given the charge of trying to address health disparities, you might at first feel very overwhelmed, because there are so many disparities that contribute to the differences that we see in terms of asthma. So you can say such things as, what is going on in the community, whether people are responding well to the medications, are they adhering to the medications, is there any issues in terms of the environment, which is contributing to it, or people's economic conditions, which does not allow them to engage in some of the factors that help to prevent asthma.

And I think at first it can seem very overwhelming because there are so many different factors that can contribute to the disparity, and in this case, asthma. But, what I have found that has been very helpful is to really think about it as the sorts of the kinds of things which happen before patients come in, the kinds of things that happen when patients come in, and then the kind of things that happen when patients leave health care settings.

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As so the way that I like to think about it is that, in terms of a disparity, there is a gap between the ideal outcome that you see and then the gap in terms of the actual outcomes that we see. And so, some of the precursor things could be things such as, genetic predisposition, environmental factors, what is going on in the community, and those are the sorts of things which can contribute to the gap before a patient ever sets foot into a health care provider's office. But then in addition, there is issues such as access to care, making sure that people not only have financial access to care through having the appropriate health care coverage, but also even simple factors such as making sure that there are adequate numbers of providers in the communities where there are high rates of asthma. In addition, making sure that the quality of care which is delivered is the standard of care that is currently acceptable within healthcare.

And then lastly, once then patients do come in, are there other factors such as permeabilities or physiologic response to meds, or the ease and ability that patients have to respond to certain lifestyle changes.

And so, one of the things that I think is a bit misleading about this, is that when we think about this in terms of say, the drops that it takes to get to disparities. The way that I mapped it out here, is that I said that each and every step towards this disparity is actually equal in size.

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But I think in fact, that when we look at issues such as access to care, and the differences, particular for racial and ethnic minorities, in terms of health care coverage, I think it is actually a huge step, as well as the differences that we see in terms of the quality of care.

And so again, I want to remind you going back to that slide which talked about, what is the relative contribution of what happens in the community, verses what happens when people come into health care settings, is actually about half of the differences in terms of health care outcomes that we see are really just attributable to health care alone.

And so I think it is important, because as we are going to hear in today's presentations, that really in order to get to the absolute elimination of health disparities, it is going to require a focus on a number of different factors, that include community and health care. But from my perspective in terms of really being able to say, what is the first step, and the first place where we are going to try to have an impact? The place where you go with the biggest bang for your buck is, in terms of issues of access and issues of quality.

And so for today, we are going to hear about some of the work which has been funded by the Commonwealth Fund. First, we are going to hear from Dr. Bruce Siegel who is Research Professor in the Department of Health Policy at George Washington, and his full and lengthy bio is in your packet.

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Then, we are going to hear from Dr. Brian Smedley, who is currently the Research Director at The Opportunity Agenda. Then afterwards we are going to hear from Becky Shipp, who is from the Minority Staff on the Senate Finance Committee and then from Caya Lewis who is on the Majority Staff for the Senate HELP Committee.

So with that, I will now turn it over to Dr. Bruce Siegel.

BRUCE SIEGEL: Thank you Anne, how is everybody today? How is lunch? [Laughter] Is it good, I did not get lunch, [laughter] so; I thought at a minimum I could get that, and the grant ran out months ago, [laughter] so I am still here.

I am actually honored to be here with Anne and other folks to talk about this chart book called, *Racial and Ethnic Disparities in US Health Care*, funded by the Commonwealth Fund, and available on their website.

If you will look in the chart book, and you will see on the next slide here, we get a little bit of the purpose of it. The goal is to make it an easily accessible resource that can help policy makers, teachers, researchers and others begin to understand the disparities in their community and begin to formulate solutions.

So this is not a chart book designed for only for one segment or only for people with advance degrees or whatever. It is really something we hope is accessible to everyone,

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something that can be used to begin a conversation, whether you work here on the Hill, whether you work in a clinic or a hospital or for a health department, something that can begin to stimulate your thinking and your colleague's thinking about what disparities you may encounter in whatever setting you work in, and what is out there that can help you think through what can be done to begin to address it.

Let me talk a little bit about the structure of the book. It is a fairly broad array of issues get dealt with in several fairly simple chapters. We talk first of all about the demographics of America and how it is changing. I will spend a minute on that later. Talk about disparities in health status and mortality. So we get into public health and we get into risk factor, and we get into mortality and the like. Then we talk about access, because people often do not realize that some of the darkest disparities and differences we see in health care for racial and ethnic minorities, for Blacks, Latinos, Asians, Pacific Islanders, Native Americans and others, are around access to care. As well as we get into issues around disparities in health insurance coverage, where we also see these sorts of disparities.

But, then there is also a very specific focus on the last two chapters you see up there. First on quality, there is an emerging, I think consensus in America, that when we see disparities in health care, we are also seeing disparities in

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quality, that when people suffer disparities, what you are basically seeing is a failing of our health care system to insure high quality for everyone. And people often do not even realize, many people who I talk to, doctors and nurses and others that one of the six domains of quality, according to the Institute of Medicine, is equity. And a failure in equity leads to disparities. We are trying to get that message out and it is starting to get through, but it may take a while.

And the last thing that we have here, are strategies for closing the gap. What are the potential solutions and it is great to talk about all the problems, but there is an emerging body of literature that starts to at least point us in a direction of actions we can take. Of things we can do in our system, delivery systems and finance systems, in our practices, in our bureaucracies to begin to close these gaps and make a difference.

In all these chapters there are not only charts, but there is some explanatory texts. It talks about the dynamics of why these disparities may exist. Now let me give you an example of each of these chapters. So for instance, in our demographic chapter, we look at the demographics of America in the year 2000 and the year 2050. A nation, that as some would say is rapidly browning, rapidly changing in composition. Going from a nation that is 69-percent white to probably 50-percent or less white by the year 2050, with a huge growth in

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the Latino population and substantial growth in other populations, including African American population.

If we think disparities are failing in quality of care, and we realize that those who suffer disparities, ethnic and racial minorities are going to increase perhaps exponentially in numbers in the next four decades, then America is going to fall further behind in its quest to provide high quality care to everyone. It is an earthquake and they are changing dramatically.

Then we talk about health status and mortality. And this is just one example of something that you all hear about. Seven of ten Blacks are either overweight or obese, and Blacks are substantially more likely to be obese than other groups. This is just one example of the kind of information that we provide here, from the population based health literature. By the way, virtually all the charts in this book come from published literature. It is already out there, but trying to put it in a coherent whole. And so this is one example, we know that obesity is not only just a problem, it is also a risk factor for so many other things, like cardio vascular disease, stroke, et cetera.

Next example gives an example, and here if you can read this, you get an A+ [laughter] I know I cannot at the age of 47. This is a chart from the chapter on access, showing that really, frank differences in disparities exist in access as

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well. And what you see here is the light blue bar, especially I want to point your attention to, those are Hispanic Americans, and what you see here is that they are least likely on the left to be going to a doctor's office or private clinic to get their health care. And the next cluster, the second cluster from the left, you will see there are most likely to be going to a community health center. If you look at the third cluster, emergency rooms, Black Americans are most likely to be using emergency rooms. So the differences we find are not just around health or health status, they are also differences in where people get health care in America. Really dramatic differences that can have important implications, and ones that we have to understand.

In chapter five, we talk about coverage and health insurance status. You know we talk very often in America about how there are many uninsured, 47 or 48 million, tens of millions more who are underinsured, really a crisis, and in many ways a shame in our country. We do not often do not realize that there are frank disparities and huge disparities in this as well. This gives you the sense of what proportion of each population is uninsured at some point in the past year. This is data from the Commonwealth Fund's Health Care Quality Survey in 2006.

We looked at a percentage of adults, age 18 to 64, uninsured in a given year 2006, virtually half of Hispanics

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reported not having health insurance. It is an amazing statistic, and again, huge ramifications for our health care system and for our strategies in terms of closing these gaps. For Blacks it was 28-percent, for Whites, 21-percent. It is high across the board, but for Hispanics it is really stunning.

In the next chapter, we turn to quality. Now, I am going to give you two examples of quality. Could we arrange it by the domains of quality, safety, timeliness, effectiveness, efficiency, et cetera. We arranged it along those domains to point out that when we talk the various areas of quality, like safety, like efficiency, like effectiveness, there are disparities in all of those that disparities permeate the issues we see in health care quality in America.

And when we talk about quality, which so many of us do, we need to have that discussion joined at the hip, with a discussion around disparities, because disparities are seen throughout, it is really stunning.

One example, around patient safety, the percent of nursing home residents who are physically restrained. Restraining a nursing home resident is really considered a poor practice today, it is dangerous to that resident, it is demoralizing to staff as well. It raises all sorts of issues. If we look at who gets restrained in nursing homes, we see disparities here, as we see in so many other areas of quality. And this is domain of safety. Asian and Pacific Islanders are

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considerably more likely to be restrained, as well as Hispanics, relative to Whites. So again, we see the issue of equity playing out.

Another example, in the area of quality is in the area of effectiveness. This is the percent of patients who get a pneumococcal vaccination, who are age 65 and over. We know that most people who are elderly in America should get a pneumococcal vaccination, it is good medicine, it is good prevention. 61-percent of White non Hispanics get the vaccination. According to ARK, that number drops at 39-percent for Blacks, 34-percent for Hispanics and 35-percent for Asians. Again, a big difference.

In the last chapter, we have given you all the bad news, now we try to give you some good news. Because there is some hope here, and perhaps more than hope, there is some real things we can start to do. I will give you a couple of examples. This is the result from a classic study that was done looking at the End Stage Renal Disease Program and Dialysis. And it looks at the percent of patients who got what is considered an adequate Hemodialysis Dose, as part of the End Stage Renal Disease Program for patients with kidney failure. And what we saw is the federal government took action and said, we want to raise quality for patients in the End Stage Renal Disease Program who have kidney failure. And not only did quality get better, but the black/white gap dropped

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substantially. So the point here is that, quality improvement efforts can close these gaps, can begin to reduce or eliminate disparities, as well as improving quality for all patients. And this is a classic study, but one that I think people are starting to replicate in many ways, and it gives us hope that quality improvement things we are doing can really make a difference.

And finally, on the last slide this look at the whole issue of medical homes. Some in the Commonwealth Fund and others have been talking about very eloquently in the past few, having a regular provider or place of care, having no difficulty in contacting a provider by phone, all these various elements that make for a medical home. And what we find is that when minorities have a health care setting that looks like a medical home, that has these attributes, there is likely as Whites to get these critical reminders for preventive health care visits.

So again, another strategy of a medical home that may have important payoffs in terms of closing the gap and reducing disparities.

So that is our chart book, we ask you to use it. We ask you to steal from it shamelessly [laughter] give us credit if you would, we like that once in a while, it is as almost as good as having a sandwich, [laughter] and the good news is that it is absolutely free. Thanks, Anne and back to you.

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ANNE BEAL, M.D., M.P.H.: Alright, so we will then hop over to Brian.

BRIAN SMEDLEY: Great, thank you very much. I am really delighted to be here. I want to thank Ed Howard and the Alliance for having this panel and the Fund as well. I also want to thank the Fund for supporting this document on *Identifying State Strategies for Addressing Equity in Health Care Reform*. This is a report that The Opportunity Agenda did with Families USA, so I want to acknowledge Rea Panares of Families USA and our colleagues there. This was a truly collaborative effort and we were really honored to work with Families USA to do the report.

I will be talking about what state's can do to address equity and to address some of the issues that Bruce identified so well in the chart book. As part of state health care reform, as many of you know, there are a number of states that are looking at significant legislation to address health care challenges in those states. And most of this legislation would address issues of expanding insurance coverage. In addition, they all attempt to address quality as well as costs, and they are using a combination of approaches. Some states obviously, are using individual mandates or so called pay or play kinds of provisions.

But we think that these opportunities for addressing health care reform should importantly also address equity, in

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many of the issues that Bruce has identified. Our basic point in this report is that coverage reform is necessary, but not sufficient to address equity in health care reform. So, in other words, putting an insurance card in folk's hands is certainly important, but it is not enough to address disparities as Bruce has pointed out.

There is a growing literature that points to a number of strategies that states can adopt to address disparities. So, certainly the Institute of Medicine has a large body of work. A number of reports that have important implications for states to address equity, one of those is the report released in 2002, called *Unequal Treatment*, which documents the fact that people of color tend to receive a lower quality of health care, even when we adjust for or control for differences in insurance status or income. But, the Commonwealth Fund has also released a number of reports in the last few years, particularly the report that Anne did on medical homes and how medical homes can address equity. John McDonald's paper on state reforms, Ruth Perot and Mara Youdelman did a report on addressing data collection, Bruce has a report looking at public hospitals, reporting of data, and David Barton Smith's paper on *Eliminating Disparities and Treatment*.

So, we looked at this body of literature to identify a set of strategies that states can adopt to address equity as part of their health care reform strategy.

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Okay, I want to just provide a few examples of the types of strategies that state's can adopt based on this literature. There is six domains of so called equity benchmarks that we identified. The first relates to access, and the point here again is that, coverage alone does not insure access, particularly for people of color. So there are a number of important strategies that state's can look to. Medical homes as Bruce just discussed, the idea that a certain set of practices that can integrate care and provide better access, by expanding office hours and a number of other important practices that are particularly important for people of color, is an important equity strategy, and you saw evidence that this kind of model can reduce disparities and care and access. Improving and stream lining enrollment in public insurance programs, and evaluating outreach efforts is another important strategy, and promoting diversity among health care providers. Many states are looking at ways to increase the racial and ethnic diversity of their provider workforce.

And this is important, because we know that greater diversity can reduce cultural and linguistic barriers, and providers of color often have a higher case load of racial and ethnic minority patients. States can also take a number of steps to improve quality and reduce quality disparities. So, importantly, among these is the question of data collections. States can adopt a number of strategies to collect data on the

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basis of race, ethnicity, language and incomes, so that we can see where disparities and access in quality occur. But this is not enough, we also have to publicly report this kind of information so that consumers can vote with their feet if they have a choice, and public reporting these quality indicators we think can also go a long way toward promoting competition and spurring innovative practices to address disparities in quality.

We also need to insure that as we go about undertaking quality improvement or pay for performance types of standards, that we address disparities and make the reduction of disparities a key goal of p for p and other efforts.

Other strategies, state's can also take steps to better educate and empower patients by developing health literacy programs, importantly these must be tailored to the needs of cultural and linguistic minority groups. Using community health workers or lay health navigators as a liaison between patients and the health systems that serve them. And states should also address the health care infrastructure in their states. Importantly, because of high rates of un-insurance in communities of color, we often find that both the availability and the quality of health care resources in communities of color is less than adequate to meet the needs of these communities. So, we have a mal distribution of health care resources, relative to community need.

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So state's can address this by strengthening safety net institutions such as community health centers, and providing incentives for providers to work in underserved communities. A number of states are doing this already, but expanding and enhancing these kinds of these programs can go a long way toward strengthening the health care infrastructure.

Okay, the policy and program infrastructure can be addressed by expanding or improving a number of state level policies, such as certificate of need policies. These are policies that allow states to regulate where health care services are located, and again state's can do this more robustly to address the mal distribution of health care resources.

Finally, state's can also address social and community level determinates. And as you heard Anne talk about, these are very important to address. If we are interested in improving health status in communities of color, addressing living conditions, health risks and resources in communities, and we can do this in a number of ways. State's can better coordinate relevant state agencies. So we know that in terms of health determinants, that education policy, transportation policy, housing policy, all of these areas importantly relate to health outcomes and states can better coordinate the services of relevant state agencies so that we are addressing health and equality.

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So, as part of our Commonwealth Fund Report, what we did was to look at how some states are addressing these kinds of equity provisions or equity benchmarks in either enacted legislation or in proposed legislation. We looked at five states, Washington State and Massachusetts, both of which in the last couple of years have passed significant health reform legislation, as well as three very large states that, within the past couple of years, whose legislatures have looked at significant health care reform legislation. And these include California, Illinois and Pennsylvania. So obviously, the health care reform debates continue in these states. Obviously in California there was a significant effort that failed last year to reform the health care system.

We found that many of these states are doing a number of very important and innovative efforts to address disparities. So, in terms of addressing access to care for example, we found that several states, Massachusetts, Illinois and Pennsylvania in particular, are looking at strategies to address diversity in the health care workforce. Massachusetts and Illinois sought to streamline enrollment into public health insurance programs, and all of these states are looking at provision to evaluate outreach and enrollment procedures. All of the states are also looking at strategies to improve data collection as an effort to improve the quality of care and

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Massachusetts and California, are looking at strategies to publicly report this information.

In terms of the other benchmarks, we found that several states are looking at ways to improve patient education and empowerments. And Massachusetts for example, is looking at a study to determine the effectiveness of community health workers. Several of the states in our analysis are looking at strategies to improve the health care infrastructure, such as supporting community health centers. And Illinois is looking at strategies to increase incentives for providers to work in underserved communities.

In terms of the other benchmarks, again, in terms of addressing the policy infrastructure, Washington and Illinois are looking at community health planning to better align health care resources with community needs. And Massachusetts has done a number of innovative things, and in particular, they have created a Health Disparities Counsel to address a number of issues and coordinate state activity to address disparities.

Finally, Washington State has a very important provision to address social and community determinants of health in their recently inactive legislation.

Finally, we concluded from this analysis that there are many opportunities for policy makers and advocates to address disparities. The first is an obvious one, but is one that bears repeating, and that is that universal coverage, universal

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health insurance is essential to address disparities. But as I said earlier, it is necessary, but not sufficient. We have got to cover everybody and not leave gaps because this is the most important step for reducing disparities in health care access. We also recommend that groups expand coverage and assess how these policies are going to affect currently underserved groups, so there is reason to be concerned and to evaluate whether policies, such as individual mandates will have an equal effect in improving coverage for all communities. So states if they are looking at individual mandates strategies, should assess the affect of this kind of policy on various groups in the state.

We encourage policymakers and advocates to follow the implementation of new health care reform expansion laws, so we have got to look at the impact of these various policies on communities of color. And finally, we need to link disparities as a core goal of health care reform in any state that is looking at health care reform legislation.

So, again in addition to addressing coverage, costs and quality, we need to make the reduction of disparities a key goal of our health care reform efforts in these states. Thank you.

ANNE BEAL, M.D., M.P.H.: Thank you, Brian. So, if there are only four things that you walk away from this session knowing, one is that I want you to definitely know that the

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Commonwealth Fund is a major source of information on these issues. So, our work is really only as good as the work that we commission, so projects such as the work that we supported Dr. Siegel to do to create the chart book, looking at state level initiatives as well as some of the other papers that you heard Dr. Smedley refer to are all available on our web page at commonwealthfund.org.

And so, Bruce was really not joking when he said, use us, make use of all of our information. So definitely think about the Fund as a resource.

The other thing that I would want you to walk out of here knowing is that, disparities do exist. I think that it is still worth reminding people that it is an issue. And then third, though is that while disparities do exist, they are not immutable. And so, we have heard some examples today of how high quality can actually gets us towards equity in health care and that it really is a powerful intervention for trying to address the pervasive disparities that we have heard about.

But then lastly, is that states actually can be models for federal action. And so you have heard from Dr. Smedley, some proposals for things that can occur at the state level to try to address health disparities, and particularly within the construct of health reform. And I think obviously, we are in what I call the season of health reform, both at the federal level as well at the state level, and so there is a lot of

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opportunity to really hear from the state's what they have been doing in terms of their experiments and what could possibly be applied at the federal level.

So, with that as a back drop, we are now going to turn it over to our federal staffers. And, first we are going to hear from Becky Shipp, who is from the Senate Finance Committee.

BECKY SHIPP: Thank you, thank you very much. Thank you, Ed from the Alliance and Dr. Beal from the Commonwealth Fund for inviting me to participate here today. I appreciate the opportunity. I would like to preface my remarks, my remarks are my own. They do not reflect the views of my boss or any other members of the Senate Finance Committee.

I have got four main points to respond to the excellent presentations by Dr. Siegel and Dr. Smedley. And, the first is that I agree with Dr. Beal, the problem is real. There are disparities and they are important public health issues that need to be resolved. And I would also appreciate Dr. Beal's discussion of the non health factors and how those have a great deal of implications for ethnic and low income populations.

The disparities are not confined just to health care. A few years ago, Senator Grassley and Senator Baucus asked the general accounting office to take a look at the underutilization of non English speaking populations on child care. And one of the reports back from the field was, the GAO

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undertook a number of focus groups and found a number of these communities believe that if they access federal programs, i.e. child care, that they would then have to have the child for whom the services were provided do a stint in the army. That they thought that they would then have to draft the child as sort of payment for these services, and those were widespread and fairly commonly held belief amongst some of these communities. So the issues are very real.

The solutions however, to these issues are not necessarily combined to certain socio and economic and ethnic groups. For example, some of the proposals that have been outlined such as outreach and enrollment efforts, patient education programs, support and training for community health workers, would benefit everybody who is eligible for assistance. As certainly no one can dispute the benefits of a medical home for everyone. And certainly the data and reporting from states on a number of these populations are willfully inadequate at least for federal policy makers.

The third point is that from a federal perspective, simply expanding coverage options should not be the only option. As everybody who participated in the debate last year on the state children's health insurance program, learned there is generally a consensus that individuals who are eligible for public programs should have access to these programs. One of the main goals of our work last year on SCHIP was to address

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the six out of ten million children who are eligible for Medicaid and SCHIP, but who are not uninsured.

But another of the things that we learned, that expanding eligibility especially in programs of the higher income level such as SCHIP, does lead to crowd out, which is as you know a situation where individuals leave private coverage for public coverage. Now crowd out, in and of itself, why is that a problem? And it is problematic for a number of reasons. It makes it more difficult for employers to offer health insurance coverage for their workers. It leaves the employer contribution essentially on the table and we also learned instances where some employers who had a great deal of their workers and their workers families leaving for private coverage found that they could not afford to provide coverage for all of their workers. So, as a result of crowd out, some individuals potentially lost coverage. In looking from a federal standpoint on how we address issues of racial and ethnic disparities, there should be from my perspective a blend of both public and private coverage options.

And finally, it is always interesting and I appreciate that the state's specific work in the report and very much appreciated the charts. Those of us who labor in the Medicaid SCHIP and TANF world, you know one state's Medicaid program, it is unlike Medicare's, where there is sort of a uniformity. So it is always fascinating what states are doing and we are

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always interested in reform efforts, especially in Massachusetts we are tracking pretty closely.

But that there needs to be from a federal prospective, congress will need to see what sort of outcomes these efforts produce. For example, do these efforts lead to a reduction on the alliance of emergency rooms. Is it resulting in a lowering of incidents of diabetes, asthma, childhood obesity. It is important as we continue our work in examining what is going on in the states that there be ideally quantifiable outcome that is reported. But that being the case, I do agree with Dr. Beal, this is the season for health reform, if not in the next Congress, in the next few years. The system as it is currently is unsustainable. The number of uninsured are rising and certainly this a very important component of health care reform and one that I know that the committee's and our members, my boss and Caya's boss are very interested in taking on. So, I thank you and I look forward to questions.

CAYA LEWIS: Good afternoon. I want to thank Ed and Anne for inviting me here to participate today. And I am thankful for all you that you showed up. We have a really good crowd today, and I appreciate that.

I am just going to take a few minutes to talk a little bit about some of the legislative history around minority health and health disparities legislation. Talk a little bit about what I think we can do at the federal level, not only

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within the programs at CMS, but in many of the other HHS programs that we have that can get a closing the gap in racial and ethnic health disparities, and I may highlight a couple of things from the State of Massachusetts for obvious reasons.

They have done some really good work there about making sure that racial and ethnic disparities are linked to health reform and health care quality and I think that is something that we will definitely be taking into this season of reform as we move forward.

Just very briefly, there have not been many comprehensive pieces of legislation that really focused directly on racial and ethnic health disparities. The last big piece of legislation was passed in 2000 by Senator Kennedy and Senator Frist. And I wanted to bring that up just because I think sometimes these things fly under the radar and some of the piece of that legislation really have proved themselves to be the crux of what we talk about and use today when we look at racial and ethnic health disparities.

That legislation elevated the Office of Minority Health at NIH to the National Center for Minority Health and Health Disparities, which was significant because it really raised the bar, raised the profile of what minority health and health disparities research should be and allowed for an avenue for across NIH monitoring of minority health and health disparities research. A lot of what we are talking about here is figuring

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out what is going on and what is happening really, and we have to be able to have someone to monitor that.

The other thing that that legislation did was allow for the National Academies of Sciences to create their report on data measurement for racial and ethnic health disparities. And it is something that we will talk about more, but that really gives a lot of recommendations on what we should be doing on racial and ethnic data collection to make sure that we can really see what is happening in our population.

And finally, and one of the really key pieces of that legislation was that it mandated the ARK health care quality and health care disparities reports. And I think that none of us may have known at the time how important those pieces of data were going to be to us. I think we have all benefited from being able to really see what is happening on a yearly basis, to really be able to track what is happening within all the populations in the United States.

And so, while things like data collection can seem very unsexy to people, actually for these issues we are talking about they are extremely important. And so that was eight years ago and since then we have seen different pieces of legislation that have focused in more disease specific ways, but we have only had really two larger comprehensive pieces of legislation. One piece was a Democratic Caucus Bill that was a bicameral product that was introduced for the first time in 2003, around

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the same time Senator Frist introduced a Bill that was also trying to look at minority health and health disparities on some similar, but different measures.

Since that time, Senator Kennedy had joined up with Senator Frist and decided to try to work on a bipartisan piece of legislation hoping that we could get something that would actually be able to move through the Senate. And for the past several years I have worked on a bipartisan piece of legislation that mostly focuses on programs that are within the jurisdiction of the HELP Committee to talk about reducing racial and ethnic health disparities. There is a companion to that Bill in the House that Representative Jackson has introduced. Representative Jackson also worked our previous legislation in 2000 to help get that through. And there is also a piece of legislation that Representative Hilda Solis has introduced on the House side that has many of the components that the Kennedy Bill, which we are now doing and Senator Cochran has, but also several components what would be within the finance jurisdiction here, dealing with expansion of coverage.

So, that is where we are with legislation. We are working with our Republican counterparts in the HELP Committee to try to see where we could come to common ground on some really basic, public health efforts to reduce health disparities. And I want to back up and say, what everyone has

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said today is so true. We cannot reduce disparities without getting universal coverage. And we are all going to be working towards that in the coming years and months.

But what is really important to understand that it is not just about coverage. And so with that, there are a couple of things I think we can do federally that follow the leads of the state's and also help give states resources. One of the clear things that we can do at the federal level is to support the training of minority health providers. And by doing that specifically, working to reauthorize our Title 7 Program, specifically, the diversity portfolio of programs. These are programs that allow for funding to go to schools that train underrepresented minorities in the health professions.

We have a few institutions in our country, historically black medical schools and universities. We have some Hispanic serving institutions and schools that train Native American providers. These allow those schools with resources to help make sure students can matriculate. There are loan repayment programs for faculty to teach in places that are turning out underrepresented minority health professionals. There is also a program called Scholarship for Disadvantaged Students. Which basically helps underrepresented minorities and folks with lower economic levels go through health profession schools.

This is very important. People have mentioned that the data shows that minority health professionals are much more

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likely to serve in underserved areas. It is very important we are learning that cultural competency is extremely important in quality of care and satisfaction of care. And having a more diverse workforce is important in that area.

When it comes to data collection there are in the Medicaid and Medicare program and the CHIP program, there are different standards for data collection on race and ethnicity. And I have been looking at it a lot lately. One of the recommendations that many people have made is that we should mandate a standardized way of collecting race ethnicity, primary language and perhaps socio economic factors within our federal health care programs. Only by doing this will we really be able to figure out how we are doing, how we are serving the people of America. And there is different standards for those different programs. And so, I think at looking at how we can make sure that those data are being collected in a standardized way is very important.

The other piece that is really important is making sure that we continue to focus on cultural competency and medical training and allow resources for providers to be able to access different resources on how to really work towards communicating in an effective way, in a culturally competent way with their patients.

The Office of Minority Health has created the CLASS Standards, Culturally and Linguistically Appropriate Service

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Standards, and I think we can do more about communicating what those standards are to providers, to making sure that we are holding providers and institutions accountable for continuing to teach medical students the culturally competent way to provide care.

And then, finally because I have gone on too long. Doing things like supporting our health care safety net, the community health centers, the National Health Service Core. We are working to reauthorize the community health centers and trying to make sure that that safety net is there. This is a place where racial and ethnic minorities really get their care. We saw that on the slide before and we want to make sure that those safety nets are shored up.

ED HOWARD: Excellent, thank you Caya. Now it is time for you to get your two cents in. Let me remind you there are microphones, both in the front and the back of the room. There are green cards that can accommodate written questions, which if you will hold up, someone will snatch from your fingers and bring them forward.

Dr. Siegel has to leave us a little bit early, so if you have questions particularly directed to him, I would urge you not to wait to get them on to the agenda right now.

ANNE BEAL, M.D., M.P.H.: So, while we are waiting for those questions to come up, one of the things that I actually want to put in a plug for is actually the Commonwealth Fund is

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releasing on June 3 an evaluation of Massachusetts health reform looking at a number of issues, including this question of the crowd out issue, and so because the findings are embargoed until the 3rd, I cannot tell you what we have found, but I can tell you that it is very exciting and promising. And so, I would encourage all of you to come to our web page on the third to really see that because, as we have heard across the table making the decisions based upon having data and information and looking at actual experience which is out there really can help to inform some of the initiatives that we have been talking about at the federal level. So, this is actually an important issue that we have heard quite a bit about and so we now have the experience at Massachusetts that can tell us how much of an issue it really is.

ED HOWARD: Okay, yes, if you want to identify yourself please.

BOB GRISS: Bob Griss with the Institute of Social Medicine and Community Health. Most of the programs that take place here focus on some of the many indicators of inefficiency and ineffectiveness in the health care delivery system. And now we are focusing here on health disparities. It is pretty obvious why minorities are hurt by health disparities, but how is the total population hurt by the existence of health disparities? Is there any evidence that eliminating health disparities actually can increase the efficiency and in

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effectiveness and equity of the health care delivery system to everybody's benefit. Brian gave us some good examples of policies that could be used for reducing disparities, but unfortunately, most of them cost money. Are we talking about adding to the costs of health care spending or can addressing these health disparities actually improve quality and reduce total health care spending, because if that is the case I am looking for strategies that do that.

ED HOWARD: Good question. Go ahead, Bruce.

BRUCE SIEGEL: Just take a first crack at that. I think a lot of the things, and you will see in the chart books, some of it is discussed, some of the differences we see are disparities are not just about poor health or low quality care, but also about over utilization for minorities very often. Like avoidable hospitalizations, avoidable emergency department visits. These are things which costs not only minority's money, they costs all Americans money. And as long as you have people who for instance, are being readmitted to the hospital more frequently for, say congestive heart failure, which I think there is a number of studies that show as more common for many minority populations. That is an expense that should not be there. That is in some ways someone were to argue that that is a form of waste.

Another place we see some disparities, which lead us toward inefficiency, very often we see that African Americans

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receive less care, but there is one place where they receive more care, that is end of life care. Very expensive care, at a time when it is probably least able to make a difference. And this has been the findings of the Dartmouth Atlas and the folks up at Weinberg and Fisher and that crowd. Again, another example where disparities elimination, reduction could pay off, in terms of better efficiency.

BRIAN SMEDLEY: I just want to add to that, implicit in your question Bob is that, addressing disparities can improve the efficiency and quality of our health care system for everybody. And so some have suggested that people of color in some respects, are the canary in the coal mine of inequitable, inefficient health care. And to the extent that we adopt policies that improve the equity and quality of care for all, we are going to see real benefits. And I would just add that disparities of course, health disparities carry a huge, human and economic tolls. So these are issues that do not just hurt communities of color, they hurt everybody. They hurt our nation's health, they hurt our nation's economy and productivity, and as the slide that Bruce showed reveals, by mid-century nearly one in two people in the United States is going to be a person of color.

So our health care systems and our health policies more broadly, including policies outside of health care have to account for this growing diversity of our country.

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CAYA LEWIS: I just want to say I think that underscoring that reducing racial and ethnic health disparities or disparities of any sort brings us to a healthier America. It is the only way we are going to get there. And so, focusing on what we can do to close the gap is the same that will help improve health care overall for everyone. And so, I think it is a win, win on so many levels, not least of which, but on the moral level, on the economic level it makes sense.

ED HOWARD: Thank you, here is a question directed to you. Given the enormity of structural barriers to good health, what degree of quantifiable evidence does the Senate look for in order to determine whether policy driven programmatic change has met its goals?

BECKY SHIPP: That is an excellent question, thank you. I think that discussion should be part of the context of a broader health reform agenda. What does it mean to reform health care? Is it simply a number of the points that were made in the presentation, is that access is not everything. Simply, having an insurance card I believe, Dr. Smedley said was not tantamount to providing quality care. That is though, very much an open issue. What outcomes actually will mean that we have achieved a lessening of the disparities, will it be again as some of the slides pointed out there is a great deal on an over high instance of diabetes among these populations, asthma among the young and obesity. Will we have been

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successful for reducing that or is there another proxy for success? As I said that is one of the open questions that I look forward to addressing as we engage on this issue.

ED HOWARD: Here is a question for Bruce Siegel. What role does a person's immigration status play in their access to health care and does your report attempt to take this factor into consideration in its sampling.

I was noting, I think it was one of your slides that showed that Hispanic use of emergency rooms was lower than some of the other ethnic groups, and I wonder if that is not part of that phenomena?

BRUCE SIEGEL: Yes, great question. Well, two things. First of all, we think immigration status plays a big role in people's either ability to access care or their perceived ability to access care. Whether or not they think they can go somewhere and what would be the ramifications of them going there, will they think they will implications that they are undocumented in terms of follow-up. And that maybe more perceived in real subversionary time but if it is real to people who cannot take that risk.

In a lot of the work that we present here, which again is based on the work of many others, this is not always taken into account. So, for instance, in the Hispanic population do we cleave immigrant versus non immigrant or in the Black population for that matter. It would be nice if there was more

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like that out there, but very often we do not get to that level of granularity in these studies. Hey, I just wish we would just collect data on people's race and ethnicity to just to start with, let alone their immigration status and then hopefully we would get the data someday. We have not gotten to that point yet, hopefully we will get to this point as well.

There are a couple of charts in the book that do look at immigrants, are they a separate group or individual or a group of people. Looking at for instance, immigrant children being more likely to become uninsured in the past decade, and a couple of other issues like that. But unfortunately, it is not a huge focus of the chart book, very often, because the data is just not there.

ANNE BEAL, M.D.,M.P.H.: The other thing that I would add to that is that one of the charts actually looks at the question of infant mortality and asks about mothers who are born in the United States versus mothers who were born outside of the United States. And across all races including, Whites, African Americans and Latinos, the mothers who were born in the United States their children had higher rates of infant mortality than the mothers who were foreign born.

And so the question of the immigrant status can have sort of the usual disparities that one would see in terms of issues such as health care coverage, but also has, what is

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called paradoxical outcomes in terms of other outcomes such as infant mortality.

ED HOWARD: Becky, can I turn to you following up on what Bruce Siegel was just talking about. Caya was describing some of the efforts to standardize data collection among a number of programs that fall in the finance committee jurisdiction, and I wonder if you had any insight into the future of legislation that might move in that direction.

BECKY SHIPP: Yes, thank you. For those of us who were spent all of last year in broiled in the SCHIP discussion, data actually became one of the key central elements of that debate. One of the panelists said it was not as sexy a topic. And I grant you sort of when you are in the deep end of the geek pool

[laughter] what is sexy to you there, is maybe not sexy to everybody else, [laughter] but it really became a very, very compelling issue and our ability to legislate became inescapably tied to what data was available.

It was really a fascinating journey because in order to simply determine whether or not the legislation that we were working on was successful, i.e. were we actually able to cover eligible but un-enrolled kids, we really did not know given the paucity of data that currently exists.

Dr. Siegel said he would just be interested in learning data on ethnic and racial decisions. From our prospective it would help us if they wrote down that they were eligible for

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Medicaid or SCHIP. The current population survey that we have does not even distinguish which public program individuals maybe eligible for.

So it is a key overriding issue. We did legislate on it in the bipartisan, bicameral SCHIP Bill, and those of us who worked on that were pretty satisfied about where we ended up. But we will be back revisiting in the context of SCHIP and other issues because it is very, very important that we have a better tool, a better instrument to inform public policy at least on the federal level.

ED HOWARD: The gentleman in the back.

AL GRATA: Yes, hi, my name is Al Grata [misspelled?], I am a lobbyist for the community mental health center. This is a question for Dr. Siegel and Dr. Smedley.

In 2006 The Substance Abuse and Mental Health Services Administration did an eight state study of the public mental health system. That system serves about 10 million Americans disproportionately members of ethnic minority groups. What the study found was that individuals with severe mental illnesses died on average 25 years sooner than other Americans and the study found that what was unfortunately killing this population was co-occurring chronic diseases, diabetes, heart disease, cancer. And so I had just two very quick questions.

Number one is, should mental illness or more broadly mental disability or cognitive disability be considered a

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health disparities population and then secondly, that 25 year metric, is that among the worst mortality data in the public health system overall?

BRUCE SIEGEL: A couple of things, and I am not an expert on mental health. But the first time I saw this data before, I would say that it is some of the worse mortality that you will see because of the number of coexisting, co morbidities, other chronic illnesses that often go with this, and other things that happen to those. And we talk a little bit about mental distress and mental health in this chart book, but not a huge amount.

As to whether or not it should be considered to be a separate group for purpose of disparities, personally I have no objection to that. The problem many of us face in the field is do we look only at racial disparities, do we look at ethnic disparities, do we look at ethnic disparities, do we look at language disparities, do we look at disparities around mental health? What about gender disparities?

So there are many ways to cut this and all of which are very valid and important ways. So, we give you in this chart book, I think a sampling of it. And I touch upon some of these issues, but there are certainly many other dimensions one could look at, to look at this and to understand the different sub populations in America fair, including the one that you just mentioned.

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BRIAN SMEDLEY: Yes, I would just add to that, I think it is a great question, thank you for raising it Al.

I agree with Bruce. I mean this is an important health condition and a set of health outcomes that needs to be looked at. As we look at other outcomes we tend to focus on issues within the medical arena, because unfortunately, we separate and segment out these different kinds of services. But this is a set of health issues that deserves as much a focus as cardiovascular disease, or whether or not people get cabbage or other kinds of services.

But the other thing that this issue speaks to is the need to integrate mental health services and substance abuse services with other types of health services that we provide. So, integrating these services is critically important particularly, within safety net institutions.

I think that a number of community health centers are doing wonderful work to better integrate these services but much, much more needs to be done and certainly, in particular, we need more funding to better provide substance abuse and mental health services and increase the availability of these services as part of integrated primary care and other services that are available in safety net institutions.

JIM RESCHOVSKY: Hi my name is Jim Reschovsky [misspelled?] and I am from the Center for Studying Health System Change. First of all, I would like to commend Anne and

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the Commonwealth Fund for sponsoring this session. It is very good.

One of the things that has not come up during this session has to do with funding of the Medicaid program. Minorities are disproportionately represented among Medicaid beneficiaries and Medicaid, be it for hospital care, physician care, nursing home care systematically tends to pay providers a lot less than Medicare or private insurers. And at some point, paying less means poor quality care, and the ability of providers to cost shift from other payers is really diminished because minorities tend to be geographically concentrated in certain areas. So providers tend to, who treat minorities are often treating the majority of their patients are minorities and since they cannot, their opportunities to cost shift from other payers is diminished. So I was wondering whether Brian and the Congressional Representatives might speak to the role of simply, whether paying more money for Medicaid might be a solution?

BRIAN SMEDLEY: I think it is an excellent question and a terrific issue that we have not discussed as yet. I mean we are here among folks who are concerned largely about federal policies. So the question from my perspective is, what can the federal government do to encourage states to address equity, Medicaid is a huge issue. So right now, we are talking about a situation where Medicaid, we are looking at potential cuts.

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Medicaid is willfully under funded as we know and your point about reimbursement rates is a huge driver of the geographic mal distribution of health care resources. Few providers are willing to accept low reimbursement rates. As you pointed out, cost shifting becomes much more of a challenge. And so until we address and I might add that many of the states that are attempting to develop innovative strategies to address equity are handcuffed because of inadequate Medicaid resources.

And of course, the current crisis in many state budgets also contributes to that problem. So addressing the challenge of funding Medicaid at appropriate levels is a huge issue and challenge for addressing equity.

ED HOWARD: Brian, before we go on, was not California's reform plan one that included increases in Medicaid reimbursement rates?

BRIAN SMEDLEY: Yes, a number of states are attempting to expand eligibility for Medicaid, but this is becoming much more of a challenge, and so many of the states that are looking at strategies that would mix public and private coverage strategies are attempting to expand Medicaid but of course, it becomes a real challenge in the context of the budget crunch that many states are experiencing.

So absolutely, this is one of the things that handcuffs states, I think to a very significant degree in addressing equity.

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BECKY SHIPP: I think it goes to the point that was made earlier, expansion of Medicaid is certainly a topic that folks are considering, but that does not necessarily translate into actual better quality of care. A number of us about a year ago were just devastated when a young Maryland boy, Diamonte Driver died of a tooth abscess. There were a number of factors that went into that. But one was there was not access to good dental coverage for children on Medicaid. So, thank you, I appreciate the question.

CAYA LEWIS: One thing to this point, and I will let Becky take care of the Medicaid stuff. But in your paper on this issue one of the things that I really noticed is the disproportionate amount of minority providers that are in underserved communities. And it sort of just loops back to many of the issues we are talking about here that, being able to support schools that are turning out providers that go to underserved communities, allowing for loan repayment and allowing more providers to be able to get the cultural competent education that is needed to actually go into communities and make a difference is really important.

We have got a small sub segment of providers that are really providing the care to the most neediest patients and they come up against a lot of issues with quality and access to specialty services. Figuring out how we can support those providers, hooking them into health information technology and

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all those other things in a way that is supportive and not punitive along the way is something we should also think of as we are looking at health reform in the context of reducing health disparities.

ED HOWARD: We actually have a question from another person on a card wanting to know, what kind of help was available to assist providers in obtaining the skills necessary to be culturally competent.

CAYA LEWIS: I will start, I am sure others can chime in. First of all, we are seeing a wave of cultural competency in curricula in health professions training schools and med schools. One of the actions we have asked for in our minority health bill is to really get an assessment of what is going on out there in medical training. Who is doing what? We know that some schools have one class some people infuse it the whole time they are in school. So, I think looking at different curricula's is very important. Joe Benton Court up at Harvard is just one of the best on these issues. He has written lots of papers. Joe worked with you guys at Commonwealth a lot.

About the resources out there for culturally competent care. Another piece in our legislation actually is to look at the Office of the Minority Health. They have a great resource center. What we are trying to do is beef that up a little bit and allow for the website at the resource center to have more

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materials on cultural competent care. Lots of times doctors find themselves with patients that are coming in speaking a different language, or even just having a different health literacy level, and needing things like basic forms and needing models and guides for those types of things.

So, I think there are some really good resources out there, but one of the things that we want to do is continue to encourage medical training schools, health professions training schools to infuse this concept of cultural competency into what they are doing, so that we are turning out a whole generation of health professionals that have had this training.

ED HOWARD: Yes, go ahead.

ANNE BEAL, M.D., M.P.H.: And one of the other things that Caya has spent a lot of time, cultural competency in terms of medical training, but then there is also cultural competency in terms of practice, and so if there are 100 people in this room and I ask you how would you know that you are receiving care in a culturally competent center, I would get a hundred different answers to define what is culturally competent care. So we have actually funded the National Quality Forum to create standards for cultural competency, which will be used to help create actual measures so, as anyone knows quality improvement 101 says you have to be able to measure it in order to improve your performance on it.

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And so, we have this project with the National Quality Forum and we actually just very recently funded the Joint Commission to create standards for cultural competency which we hope one day will be used as part of their accreditation standards for hospitals.

And so, this work in terms of what is cultural competency, how do you put it into place, how do you improve your performance is I think, actually the cutting edge of defining what is culturally competent care and we will now have a set of standards that everyone will be able to have some agreement as to exactly what it is when we see it, so, both in terms of training as well as in terms of practice.

ED HOWARD: Yes, in the back of the room.

GUADALUPE PACHECO: Guadalupe Pacheco [misspelled?], Office of Minority Health and I would like to thank the panelists for excellent presentations.

We spend, I think 90-percent on treatment, and we spend maybe 10-percent on prevention. So we are a disease, kind of driven, oriented health care system. How can we turn that around and address prevention, getting to the diseases or chronic diseases that affect all Americans, not only racial and ethnic, minority communities.

ED HOWARD: And a question was raised on a card as well, so.

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BRIAN SMEDLEY: I would just say and I hope that I am not being provocative, but you look at part of the problem with the way that we structure, let us just take health insurance. You have a situation where there is really very little incentive to put money into prevention, because of churning. Patients are going to churn in and out of different health insurance programs. What is the incentive for insurer, A to invest money in prevention, as oppose to care or denying care. So, we have kind of a perverse sick care system, where there is little incentive to put money at the front end.

So, I think ultimately, if we achieve a single payer system in this country, we have a better incentive to put money into prevention because we are not going to be dealing with the problem of churning, and we will not have the problem of private insurer's not wanting to invest money in prevention, because if I invest money in prevention for a beneficiary and that person ends up at in a different plan ten years from now, then I have lost my investment.

So, we need to address this perverse problem of a sick care system that provides no incentive to have a balance. And I think that what we have seen is that ultimately, we need to put at least the same amount of dollars into prevention that is proportionate to the problem of upstream determinants. What happens in communities, what happens in the living and working conditions that create disease in the first place?

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ANNE BEAL, M.D., M.P.H.: And where I heard Brian starting to go is also I think that this divide between public health and health care is an artificial divide and really does not allow us to start to address some of these preventive issues. I think that this is something which is endemic to the way that health care is administered within the United States and really gets us to fundamental reform even beyond health care reform as much of a holy grail as that is.

But this issue of the fact that people do trend through insurance, so when you look at for example, even for employer based coverage the average length of time that people are in an employee based coverage is just six years. And so as a very concrete example, last year the *New York Times* did a series on diabetes within New York City and really talked about the fact that while we had excellent diabetes care, they were not able to provide coverage for just basic nutritional counseling of those patients with diabetes, which obviously leads to some of the prevention of long-term sequelae of diabetes.

So, I think this issue, as we have heard from Watergate, follow the money, that it really does make a difference in terms of those who are making that upfront investment then are able to reap the benefits, whether it is six years, 12 years or 22 years later.

CAYA LEWIS: I just wanted to comment a little bit on that same note. It just brings to mind the support we need for

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basic primary care services. And the way our payment system works is that a lot of primary care doctors really do not get paid for the time that they spend putting in to trying to manage chronic conditions, talking to people about preventive measures. And so, as I think as we move forward we really do need to look at this broader system of payment where primary care doctors that really can make a difference in talking to people about prevention and managing their disease get the money in the time that they need to be able to do that.

ED HOWARD: Yes, please.

ELENA RIOS: Yes my name is Dr. Elena Rios [misspelled?], I am President of the National Hispanic Medical Association, and we work with lots of coalitions here in town with racial and minority coalitions. Out of many one, the Reddick [misspelled?] Coalition, the National Coalition of Hispanic Health, the National Hispanic Leaderships Agenda, and everybody is very, very supportive of the health disparities work that all of you are doing, but in particular, I have to say that we are really, really waiting for the next Bill.

Since the year 2000, as was mentioned, we have not had a major comprehensive Bill in the Senate or the Congress to go to the White House, and we are really waiting for this. And I am just wondering if you could speak to, given that there is disparities and I think that everybody recognizes the demographic changes in this country and how important it is to

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have a functional workforce to pay for the next generation of baby boomer retirees.

Where is the stalemate happening, or where is there obvious clusters of negativity around these comprehensive Bills, and is there, I do not mean names, I am just thinking in terms of concepts, is there a way that we can better structure our arguments when we go up to the Hill and talk to people in general? There is so many people in this country that Congressmen and Senators who have minorities in their districts I know they have got to understand the issues and how important this legislation is. But is there certain groups or issues that we can better learn about to make our arguments stronger.

CAYA LEWIS: Thanks for the question. And I know somebody asked about the Bill numbers. The Kennedy, Cochran Bill, the bipartisan Bill that we are working on now, that is S-1576, the house companion is HR-3333 to that. And the Solis Bill on the House side is HR-3014. And the last comprehensive Bill we have done which was in 2000 was the Frist-Kennedy Bill and that is Public Law 106-525. So you guys can look those up.

There is a lot to that question, but I would say a couple of things. First of all, I think all of us working on these issues know that the reason Anne and Brian and Bruce reemphasize the fact that the disparities are real and that they are happening because there are actually people that sort of doubt that the disparities are really here.

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There is actually a lot of people that just really just do not know about the consistent persistent racial and ethnic health disparities that we have had in this country. And sometimes you just have to talk to folks to say, this is a problem that we have had. And in many ways it is not getting any better. We are all getting healthier, but that gap is not closing. A lot of people need to be aware of that. A lot of staff and members need to be aware of it.

I think when we are talking about a limited amount of federal resources the issue is, is that we do have health disparities along lots of the slices of the pie. There are gender disparities, there are disparities between diseases, there are disparities between groups. When you want to focus on racial and ethnic health disparities, for which have been the most persistent over time and where are some of the biggest disproportionality is, you do begin to get into the same discussions we have about any other targeted programs for certain groups, and there is members that do not like that whole way of doing policy.

Once you get beyond that though, I think really it is about having limited resources, making people aware, but then also really being able to talk really in a bipartisan environment which is what we deal with in the Senate and in many ways the House as well. How you can come to common ground on issues. When we talk about data collection, how much data

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should the government be collecting? Is the federal government the one to mandate this? Those are sort of philosophical tugs that we have around the issue.

I think we have done a good job working with Senator Cochran, who has been great on this issue. He is from a state, where there is the Mississippi Delta, he knows about the populations in his state and is not afraid to jump out there and say, we need to focus on these populations. I am doing stuff for everyone else too, but we have a specific need in these populations. I think unfortunately, there is a lot of members where that is not a comfortable place for them to be, considering their broader constituency.

But, I think be able to try to work these things out and for all of us on both sides to realize that everybody has to give a little, that there are a lot of things we would like see happen, a lot of programs that we like to see expanded, a lot of money we like to see put in. And then for our counterparts on the side they are really looking at what can we do with the resources we have? How can we improve the programs that we already have? How can this be a fair process?

So, I think it takes a while, but it should not be once every ten years that we work on legislation for racial and ethnic populations. We should be able to chip away at the pie the whole time. And I can speak for my boss in this regards, he believes in just making incremental steps and moving forward

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and forward. He has done a pretty good job of it over the years, so that is what we are trying to do.

BECKY SHIPP: I just have one quick comment. I do not have much advice for you. But, I do want to say, sort of without sounding unduly glib, health policy is really hard, it is really hard to get stuff done. Last year, I recalled when you were talking the conversation I had with a House Leadership Aide, who was not sort of enmeshed in sort of the health policy world, and this poor man was just disparaging. He was like, how on earth are we going to do health reform if we cannot even pass a health care Bill for kids. I mean who could possibly be against health care for kids? And everybody was surprised when we were not able to do that.

So, hang in there, it is tough, but it is important. Every once in a while you capture lightning in the bottle. So that is what we are endeavoring to do.

ED HOWARD: And you can SCHIP away at it. [Laughter]

CAYA LEWIS: And I want to thank you and all the other advocates that continue to keep us to task. You are the people that opened the eyes of staff and members that keep sort of the wind under our sails as we keep moving forward. And we need to continue to hear those voices to say, let us keep doing this and not let it go by the waist side.

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ED HOWARD: Let me just say we are going to probably end up in just a couple of minutes. So, if you have any last minute questions, get you to the microphones or to the cards.

And, also as we are finishing up these last few minutes, you might want to pull out that little evaluation form and fill it out.

Anne, did you have something that you wanted to mention?

ANNE BEAL, M.D., M.P.H.: I just wanted to mention that a lot of the foundations work on issues of health care disparities, and so I just wanted to announce that Kaiser actually this Wednesday is going to be doing a live webcast, again, looking at state initiatives to reduce racial and ethnic disparities. Brian Smedley is going to be talking. It starts at 1:00, it is not on the form, but there is a form here in the back announcing it. So, again many of the foundations were interested in these issues, and so encourage anyone who has a shared interest to make use of the resources that we try to make available to you.

ED HOWARD: Okay, we seem to come back to collecting data. And Becky, I guess you get first crack at this one if you would like from one of your Congressional staff colleagues.

In collecting data, what is the role of Medicare with respect to disparities. Are Medicare advantage plans

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collecting data on this topic and are there any standards for how those data are collected?

BECKY SHIPP: Well, I get to plead that while I speak conversational Medicare, [laughter] I am not the Medicare person. So, I will differ on that.

CAYA LEWIS: I can tell you just a little bit about it, as far as collecting data by race and ethnicity in Medicare. Medicare gets their data from the Social Security Administration. And that is a historical link that has been made. So SSA provides the data to Medicare, and one of the challenges is that SSA only collects data by race and they only do black and white and other. They have not updated to the OMB Standards for which many other programs, that is what is mandated for CHIP and that is what is encouraged for Medicaid. But for Medicare because they are getting the data from SSA, there is a lot of bad data.

Now they have a new system in Medicare, where it is called Numident, and they are updating it and sort of merging it together every once in a while. But, part of the issue is really the link between SSA and Medicare and trying to figure out how to get the right type of data collected. So, that is a challenge and we are looking into that as we are working on our legislation to figure out how can we get this data to be the most up to date.

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ED HOWARD: And that would encompass the answer to this question, which is. What can be done to increase data on Native Hawaiian's and Pacific Islander's with respect to disparities?

CAYA LEWIS: I mean the data collection challenge is just difficult and there is basic standards from the OMB, and we are generally pleased with those. But when we start looking at sub groups of ethnicities it becomes really difficult. And I think we are at a place that for Medicare, Medicaid and CHIP we do not have mandated standardized measures on the basics, on just race and ethnicity by OMB standards.

And I think then going the next step and looking at getting data by sub groups is difficult. So, I think it is really a challenge and something that we have to be vigilant on and be creative about. In other HHS programs, there is a Data Inclusion Policy at HHS, that ask that all other HHS programs that are not CMS collect data by race and ethnicity. They do not have primary language in that. But I think they are actually open to just maybe amending that Data Inclusion Policy so that all the other programs from CDC to everyone else that is reporting back on what their health promotion programs, prevention programs are doing. At least they are including primary language data, now that we know how important that is for populations.

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So, I think there is avenues, and we in the HELP Committee certainly will be happy to encroach on the finance committee's jurisdiction [laughter] to do that in our Bill if they let us. So I will talk to Becky about that. [Laughter]

ED HOWARD: Some things are more than a disparities, right Becky. [Laughter]

Got a question here that touches on a broader topic with respect to disparities. Many are predicting a shortage in primary care physicians in coming years, if not already. Given Dr. Beal's research on medical homes and their ability to reduce or eliminate disparities, is this not a troubling trend and how might it be reversed? Anne, you want to take a crack at that?

ANNE BEAL, M.D., M.P.H.: Well first, one of the things that came out of the report that we did called, *Closing The Divide*, which did demonstrate that patients of all colors who receive their health care in medical homes received higher quality care. One of the responses that we had to that, is to really ask the question, can we promote medical homes, but particularly promoted in the safety net?

So, if you think back to some of Dr. Siegel's slides when he talked about where do minorities get their care? While the vast majority do receive their care in private practice settings, there are large numbers who are in community health centers and other safety net settings.

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And so as a result, the Fund is actually launching a major initiative to promote medical homes in safety net settings in four regions around the country. And Wash [misspelled?] should be releasing that call in the fall.

But in addition, thinking about working with some of our federal partners, we have actually had some discussions on what role could community health centers play in terms of trying to promote the medical home as a model of high quality primary care. And so again, this question of the medical home really does hold promise for addressing health disparities.

Getting to the issue of the pending, or even current shortage of primary care providers. It is a very real issue and it is an issue that we are hearing about from all of the primary care societies. So the Academy of Pediatrics, the American Academy Family Practitioners, the American College of Physicians, the Internists, all of them are really saying that we cannot sustain this system as it currently is. The current primary care providers, currently age 55, so it is within five to ten years of retirement. And given the aging of the US population we are just simply not going to have enough primary care providers to go around.

And so there has been a number of discussions about how can we make primary care a specialty that people are interesting in going into? And so one of the things that has emerged is the Patient Centered Primary Care Collaborative

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which has really been a coming together of a number of people including the primary care societies, many purchasers, many businesses to really say how can we promote primary care and enhance primary care, especially using the medical home model.

And so one of the proposals that has come out of that particularly, from the physician's themselves is to say, well why don't you help us pay for it and to be reimbursed for the types of services that we want to provide? So the kind of counseling that one would want to provide for example, if a patient can just call or email their physician, rather than coming into the office to answer a question, or the sort of coordination which can occur in terms of a primary care provider trying to make sure that patients get to see all of the appropriate sub specialists that they need to.

And so the ACP in particular, has come out with a proposal which really looks at a combination of methods of enhanced payment for primary care providers who are certified as being providers of the medical home. Also looking at enhanced payments, in terms of a per member, per month payment, which then allows for additional payments to help with some of that coordination of care which does not necessarily get paid for under classic fee for service, as well as a pay for performance component which really says, if you are able to achieve a certain level of performance then you should get paid for that.

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And, so there is actually a number of initiatives which are going on. And in fact, the Fund is now also evaluating some of the, again the state experiments which have occurred. And one of the areas that we are very particularly interested in studying has been North Carolina where they have actually done some significant interventions around promoting the medical home through Medicaid.

So again, through low income patient populations and they have been able to achieve significant, significant cost savings through this program which took eight years for them to get into place, but by being able to do that, one they have been able to demonstrate higher quality. Two, they have been able to show to show that you can in fact, pay physicians an enhanced payment. And hopefully it then helps to set the stage where primary care is now a specialty in an area that people want to go into because they can actually make a living doing it.

CAYA LEWIS: I just want to say quickly, just anecdotally from Massachusetts standpoint, where we have near universal health care reform going on. Everybody understands how crucial having primary care is. When you are bringing more people into the system, they have to have a place to go. And so the Mass Medical Society, who I think, are all good doctors anyway, but they all have made primary care the top priority. The specialists that come in talk to me about primary care.

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They know that in order for health reform to work, for all of them that we have to focus on primary care and making sure that we have enough primary care doctors.

In Massachusetts, they have even gone as far as doing some public, private partnerships around training of health professionals. Bank of America and the Mass Medical Society and I think it is the Harvard Pilgrim, they actually, Bank of America put \$10 billion into a program where they are actually getting scholarships from folks to do loan repayment and are going to train about 50 to 60 new primary care doctors over the next couple of years. And that is really a small effort, but that is how important it is to people in states to know that we need better primary care.

So, as we look at health reform, we really need for the broader medical community to get behind promoting and encouraging primary care as something that folks are willing to go into and continue to practice.

BRIAN SMEDLEY: If I could just add to that quickly. These issues of the primary care workforce are also imminently tied in with the issues, the Title 7, health professions, workforce issues. We need to stimulate and encourage medical students to look at primary care as a viable option for a lot of reasons, because of lifestyle, income and so forth. Primary care has become less attractive for a lot of physicians. So we need to provide incentives, loan forgiveness, other kinds of

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incentives to encourage folks to go into primary care because there is a real growing problem and we need to better balance primary care as a key specialty.

ED HOWARD: Brian, we have got one more question that probably comes most directly toward you and has to do with what the questioner labels as consumer transparency.

Oh, I am sorry. I am blinded by the light to coin a phrase. [Laughter] Let me four square this for a little while and go to the microphone.

Yes, go ahead.

DIXON ORAH: Hi, my name is Dixon Orah [misspelled?] I am from the Men's Health Network. Actually the groups that were identified as having the bulk of the problem here, as far as racial and ethnic minority or ethnic disparities are concerned, happen to be groups where culturally, as far as their homes are concerned, there are groups that are male dominated in terms of, the ways things are done in their homes and the panelists did a great job as far as strategies were concerned, but I am wondering if they could also think about structurally creating something that can also get these males who happen to dominate these homes, to have some exposure like women do have with the Office of Women's Health.

If something can be done like that structurally to also organize the men so health care or access can also be oriented somehow to get men involved, I truly think that that also can

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be a way that can create some significant in growths into addressing this problem that we are talking about here. I just wish that the panelists weigh in on this.

CAYA LEWIS: I would say briefly, traditionally the challenge had been for medical research and many other things to actually include women over time. We have done a lot better with that recently, but that was because of the weight of offices, like the Office of Women's Health that needed to be created to drive that point home.

I think in talking about health promotion and prevention is where we can really begin to look at programs that are focusing on men. We actually know that women make the health care decisions in most households, and so focusing on women and getting their kids and the rest of their families in, has been an affective tool over time to try to reach out even to men in the homes.

But, I think the point is, is that all of us in our own sociological corners and circles have our particular challenges. And the important message is that we have to reach out on health prevention and health promotion with messages that reach the people that need to be reached. And whether that is in a different language, or in a different tone, or in a sports club or a gym or on the basketball court, then that is how we need to think about doing health promotion and health prevention and invest in that way, instead of putting our money

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into things that have not been proven to work or trying to reach everyone with the same message when it does not work.

ED HOWARD: We are going to bury the question on consumer transparency, [laughter] in favor of the gentleman at the microphone.

GUILLERMO BRITO: Thank you. My name is Dr. Guillermo Brito with the Legacy Foundation. In my spare time I also serve on the board for the National Latino Behavioral Health Association or NLBHA. One of the things that this group is working on is investigating what they call practice based evidence, as oppose to evidence based practice.

So the idea is to look at things that communities, especially traditional communities, communities of color have been doing for a long time for generations, if not hundreds of years that tend to promote health and tend to be affective at alleviating illness, disease. Someone just mentioned the lay worker which would be a prematores model which you find in the southwest.

For example, Native American communities, the use of the sweat lodge to combat stress, tension and other illnesses. Do you see this kind of approach helping the agenda in terms of saying, look you know we know that we cannot insure everybody, at least not right now, maybe someday. We know a lot of folks are underinsured, but if we can get in there and look to see what communities are doing in terms of the practices that

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actually improve health and improve people's conditions, that this is a way to go which maybe more cost effective and that maybe actually leading to positive outcomes in the long run.

ANNE BEAL, M.D.,M.P.H.: Actually you are bringing up a very important point, because one of my issues has been around disparities is that we have been really thinking about this issue from a deficit model, really saying what are the problems in these communities, rather than asking what are the attributes and strengths that are currently available in certain communities.

So, earlier I had mentioned the fact that when one looks at certain populations, immigrant populations in particular, that many of those populations have what is called the paradoxical outcomes where, the people who are recent immigrants who are low income, who really have more challenges in terms of access to care, but often will have some of the healthier babies that we see.

There is also a study that came out. I think it was in the *Journal of Public Health*, which looked at who has access to fruits and vegetables and really incorporates it into their traditional foods. And there were some of the more recent immigrant populations in fact, have some of the healthier eating habits.

And so I think recognizing that the populations and the communities that we are talking about actually do have a lot of

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access, do have a lot of health promoting behaviors and we need to try to think about how to capitalize upon those, rather than just taking that, there is a deficit model and looking at what is not getting done, but to also look at what is happening and how we can build upon that. So, I think that that is also a very important issue.

CAYA LEWIS: Just really quickly, it is a similar issue, but I think also focusing on community based participatory research. And the research that we do at NIH and other places really engaging communities in a equal type of way into the research that we are doing on health could really make a difference.

ED HOWARD: Good note to end on. I want to thank you for hanging in there, for coming in the rain and the wind to talk about a topic that often does not get the attention it deserves.

I want to thank the Commonwealth Fund for its participation in and support of this briefing. And I want to ask you to join me in thanking our panel for a really useful discussion. [Applause]

[END RECORDING]

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