U.S. COMMISSION ON CIVIL RIGHTS

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COMMISSION BRIEFING ON HEALTHCARE DISPARITIES

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FRIDAY, JUNE 12, 2009

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The briefing convened in Room 540, 624 Ninth Street, N.W., Washington, D.C., at 9:30 a.m., Gerald A. Reynolds, Chairman, presiding.

PRESENT:

GERALD A. REYNOLDS, Chairman
ABIGAIL THERNSTROM, Vice Chairman
TODD GAZIANO, COMMISSIONER
GAIL L. HERIOT, COMMISSIONER
ARLAN D. MELENDEZ, COMMISSIONER
ASHLEY L. TAYLOR, JR., COMMISSIONER
MICHAEL YAKI, COMMISSIONER

MARTIN DANNENFELSER, Staff Director

STAFF PRESENT:

DAVID BLACKWOOD, General Counsel
MARGARET BUTLER
CHRISTOPHER BYRNES, Attorney Advisor to the OSD
DEBRA CARR, Associate Deputy Staff Director, OSD
SOCK FOON MacDOUGALL
EMMA MONROIG, Solicitor/Parliamentarian
LENORE OSTROWSKY, Attorney Advisor to the OSD and Acting Chief, PAU

PANELISTS:

PANEL 1:
PETER B. BACH, M.D.
AMITABH CHANDRA, Ph.D.
SALLY L. SATEL, M.D.
RUBENS J. PAMIES, M.D.
GARTH N. GRAHAM, M.D.
LOUIS W. SULLIVAN, M.D.

PANEL 2:
BRUCE SIEGEL, M.D., M.P.H.
BARBARA V. HOWARD, Ph.D.
HERMAN A. TAYLOR, JR., M.D., M.P.H, FACC, FAHA
WILLIAM R. LEWIS, M.D.

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1 P R O C E E D I N G S

2 (9:32 a.m.)

3 CHAIRMAN REYNOLDS: Okay. Let's get
4 started.
5 I'd like to ask everyone with cell phones
6 to put their phones on vibrate. Bear with me.
7 Okay. Good morning. This is Chairman
8 Reynolds, and on behalf of the U.S. Commission on
9 Civil Rights, I welcome everyone to this briefing on
10 health care disparities. This project is examining
11 why, despite the continued advances in both care and
12 technology racial and ethnic minorities continue to
13 have more disease, disability and premature death than
14 non-minorities.
15 More specifically, the Commission will
16 examine racial disparities in the rates of
17 cardiovascular disease and the related condition of
18 hypertension. Experts will present the Commissioners
19 with results from ongoing research and information
20 regarding health care delivery systems, access to and
21 quality of community education, patient behavior, and
22 other aspects of health differences between population
23 groups.
24 The record of this briefing will be open
25 until July 13th. Public comments may be mailed to the

1 Commission at our address at 624 Ninth Street, N.W.,
2 Room 740, Washington, D.C. The zip code is 20425.
3 This morning we're pleased to welcome two
4 panels of experts that will address this topic. On
5 the first panel speakers will discuss the disparity
6 claims within the overall hearth care context, and
7 we'll also focus upon disparities in rates of
8 cardiovascular disease and hypertension specifically.
9 They will evaluate potential sources of the
10 disparities, discuss the research approaches taken in
11 various studies, and share their conclusions and
12 views.
13 Dr. Sullivan is the founding dean and
14 first president Morehouse School of medicine.
15 Welcome, Dr. Sullivan.
16 DR. SULLIVAN: Thank you.
17 CHAIRMAN REYNOLDS: In 1989 he was
18 appointed Secretary of the U.S. Department of Health
19 and Human Services. In January of 1993, he returned
20 to Morehouse and resumed the office of president. In
21 June of 2008, Dr. Sullivan accepted an appointment to
22 the Health Disparities Technical Expert Panel for the
23 Centers for Medicare and Medicaid Services at the
24 Department of Health and Human Services.
25 Next we welcome Dr. Garth Graham, who is

1 the Deputy Assistant Secretary for Minority Health in
2 the Office of Minority Health at the Department of
3 Health and Human Services, which coordinates federal
4 health policies that address minority health concerns
5 and insures that federal, state, local health programs
6 take into account the needs of disadvantaged racial
7 and ethnic populations.

8 Dr. Graham founded the Boston Men's
9 Cardiovascular Health Project, a project designed to
10 identify behavioral explanations for decreased
11 adherence to adequate diet and exercise by African
12 American men.

13 Then we have Dr. Rubens Pamies, who has
14 served as Vice Chancellor for Academic Affairs, Dean
15 of Graduate Studies, and Professor of Internal
16 Medicine at the University of Nebraska Medical Center
17 since September of 2003. Dr. Pamies was recently
18 selected as a new member and chair of the Advisory
19 Committee on Minority Health for the Department of
20 Health and Human Services' Office of Minority Health.

21 In 2005, he collaborated with former
22 United States Surgeon General Dr. David Satcher to
23 author and edit one of the first textbooks addressing
24 inequalities in health care titled Multi-cultural
25 Medicine and Health Disparities.

1 Next we have Dr. Sally Satel, who is a
2 psychiatrist at the Oasis Drug Treatment Clinic here
3 in Washington, D.C. She is a lecturer at Yale
4 University School of Medicine, a Resident Scholar at
5 the American Enterprise Institute, and author of the
6 Health Disparities Myth: Diagnose in the Treatment
7 Gap.
8 And next we have -- and I will need
9 assistance pronouncing the first name.
10 DR. CHANDRA: Amitabh.
11 CHAIRMAN REYNOLDS: We have Amitabh
12 Chandra, who is a Professor of Public Policy at
13 Harvard's Kennedy School of Government, and he is a
14 Research Fellow at IVA Institute in Bonn, Germany, and
15 the National Bureau of Economic Research in Cambridge,
16 Massachusetts.
17 His research focuses on productivity and
18 growth, expenditure growth in health care, racial
19 disparities in health care, and the economics of
20 neonatal health and cardiovascular care.
21 Then we have Dr. Peter Bach, who is a
22 physician at the Memorial Sloan-Kettering Cancer
23 Center. His work has focused particularly on
24 improving the quality of care for African American
25 patients in Medicare, including cancer care.

1 He previously served as senior advisor to
2 the Administrator of the Centers for Medicare and
3 Medicaid Services, where, among other things, he
4 oversaw the agency's cancer initiatives.
5 Folks, I am excited to have you here.
6 This is an issue that we've needed to have a fully
7 fleshed out discussion on these issues for quite some
8 time, and I'm glad you could make it here today.
9 The next thing we have to take care of, we
10 have to swear you in. So please raise your right
11 hand.
12 Please swear or affirm that the
13 information you have provided is true and accurate to
14 the best of your knowledge and believe.
15 PARTICIPANTS: I do.
16 CHAIRMAN REYNOLDS: Very good. Let's get
17 started. Here are the mechanics. Each speaker will
18 have ten minutes, and please try to stay within the
19 time frame. At the end of the presentations, we will
20 have a Q&A session.
21 And we will start with Dr. Sullivan.
22 DR. SULLIVAN: Thank you very much, Mr.
23 Chairman and Commissioners. It is a great pleasure
24 and genuine opportunity to be here with you today.
25 I'm here in my role as Chairman of the

1 Sullivan Commission.
2 COMMISSIONER YAKI: Point of order. I'm
3 sorry, Mr. Sullivan.
4 One of the things that's confusing about
5 this is these microphones are actually C-SPAN
6 microphones, but you'll find on your desk these little
7 things right here. Make sure that is turned for the
8 reporter and also so the audience in the back can
9 hear.
10 I apologize for that. I was confused,
11 too, until I realized, oh, there's a double mic here.
12 CHAIRMAN REYNOLDS: Thank you,
13 Commissioner Yaki. As usual, you've saved the day.
14 COMMISSIONER YAKI: I do try.
15 DR. SULLIVAN: Thank you very much.
16 I'm here as Chairman of the Sullivan
17 Alliance to transform the Health Professions, and I
18 want to address the issue of the health work force and
19 its diversity and its impact on health disparities in
20 the country.
21 The Sullivan Alliance to transform
22 America's health professions is a national effort to
23 enhance the health work force diversity initiatives
24 around the country. It was organized in January of
25 2005 to act on the reports and recommendations, first,

1 of the Sullivan Commission with its report "Missing
2 Persons, Minorities in the Health Profession," issued
3 in September 2004, and the report from the Institute
4 of Medicine Committee on Institutional and Policy
5 Level Strategies for increasing the diversity of the
6 U.S. healthcare work force.
7 This commission from the IOM produced the
8 report in the nation's compelling interest, ensuring
9 diversity in the health care work force. This was
10 issued in February of 2004.
11 The strength of our health work force is
12 central to the capacity of our health care system.
13 The PricewaterhouseCoopers Health Research Institute
14 predicts a shortage of 24,000 physicians by the year
15 2020, supporting a call by the Association of American
16 Medical Colleges for a 30 percent increase in medical
17 school enrollment, as well as an expansion of graduate
18 medical education physicians to be achieved by the
19 year 2015.
20 A severe nursing shortage has been
21 reported by the vast majority of our hospitals in our
22 country, and the U.S. Department of Health and Human
23 Services projects that by the year 2020, the shortage
24 of nurses in our country will be between 400,000 and
25 one million.

1 The Association of Schools of Public
2 Health estimates that by the year 2020, 250,000 more
3 public health workers will be needed in the nation.
4 And finally we have predicted a 150,000
5 shortfall in pharmacists for the nation by the year
6 2010.
7 Now, this health manpower shortage is
8 exacerbated by a maldistribution of physicians both by
9 geography and by specialty because it is well
10 documented there is a critical shortage of primary
11 care physicians and family physicians.
12 In addition, there is a dearth of health
13 providers in rural and inner city areas, which have
14 been designated by the U.S. Public Health Service as
15 health profession shortage areas. As many as 35
16 million Americans live in areas that have been so
17 designated.
18 And 2007 data from the U.S. Census Bureau
19 indicates that one-third of the U.S. population, that
20 is, 34 percent, is today a racial or ethnic minority.
21 More than 50 million Americans speak a language at
22 home other than English.
23 Furthermore, the U.S. Census projections
24 show that racial and ethnic minorities will become
25 the majority of the U.S. population by the year 2042.

1 In 2004, according to the commission which
2 I chaired in its report "Missing Persons," we noted
3 that only nine percent of the nation's nurses are
4 members of an under represented minority. Only 6.1
5 percent of physicians represent under represented
6 minority and 6.9 percent of psychologists are under
7 represented minorities, and five percent of dentists.
8 Now, there are a host of areas that are
9 impeding access to a health professions career by
10 ethnic and racial minorities. These include the
11 following: poor awareness of the health professions
12 careers, as well as poor academic preparation coming
13 from many of our school systems that are not
14 adequately preparing our young people.
15 They also include financial barriers and
16 the lack of role models and mentors for members of
17 under represented minority groups.
18 Now, at this time our supply of U.S.
19 health professionals is not keeping pace with the
20 growing needs of our population, which is increasingly
21 diverse racially and ethnically. Today minorities
22 account for, of Americans under the age of 20, 43
23 percent of them are under represented minorities, and
24 minority student enrollment in our nation's colleges
25 will reach nearly 40 percent in the next few years.

1 The dearth of minorities in the nation's
2 health work force is a major factor contributing to
3 health disparities. Achieving greater ratio and
4 ethnic diversity of the nation's health professionals
5 has distinct benefits.
6 First, minority physicians are more likely
7 to practice in medically under served areas and care
8 for patients regardless of their ability to pay. A
9 number of studies beginning in 1996 have shown this
10 pattern.
11 Secondly, minority physicians are more
12 likely to choose primary care practices, and minority
13 registered nurses are more likely to be employed in
14 nursing and to work full time, thus, improving the
15 care of vulnerable populations.
16 Finally, a diverse health work force
17 encourages a greater number of minorities to enroll in
18 clinical trials designed to alleviate health
19 disparities. In the United States there's also
20 evidence that the intellectual, cultural sensitivity
21 and the professional competence of all students is
22 enhanced by learning in an ethnically and racially
23 diverse educational environment.
24 And finally, there's evidence that a work
25 force equipped to serve culturally and linguistically

1 diverse individuals increases the number of initial
2 visits to hospitals, to clinics or physicians'
3 offices, results in higher utilization of care,
4 enhances high quality encounters, lowers medical
5 errors, and reduces medical emergency room emissions.
6 With the prospect for health reform on the
7 nation's docket, we have the challenge and the
8 opportunity to develop a successful model to eliminate
9 health disparities by addressing a central issue, and
10 that is the health care work force. The
11 administration and the Congress can lead this effort
12 for needed changes in our health care system.
13 Such an effort must not only address the
14 lack of health insurance or under insurance of more
15 than 47 million of our citizens, as well as the high
16 cost of care. It must also focus on the current and
17 increasing shortage and maldistribution of health
18 professionals and the need for more racial and ethnic
19 diversity among our nation's health professionals.
20 All of these factors have a significant
21 impact on access to health care, on protecting and
22 improving the health of Americans and eliminating
23 disparities in health status of the nation's racial
24 and ethnic minorities.
25 I thank you for this opportunity to

1 present these issues to the Commission, and I look
2 forward to your questions and comments, as well as
3 your leadership and your support in these efforts to
4 achieve our goal of eliminating disparities in health
5 status and access to health care for all of our
6 citizens.
7 CHAIRMAN REYNOLDS: Thank you, Dr.
8 Sullivan.
9 Dr. Graham.
10 DR. GRAHAM: Good morning, Mr. Chairman.
11 It's a pleasure to present to the
12 Commission on Civil Rights on the causes of health
13 care disparities, populations most affected by these
14 disparities, and actions needed to eliminate them.
15 First, a word about Office of Minority
16 Health. The mission of the Office of Minority Health
17 is to improve the health of racial and ethnic minority
18 populations through the development of health policies
19 and programs that will help eliminate health
20 disparities. We're located in the Office of the
21 Secretary within the Office of Public Health and
22 Science and the Department of Health and Human
23 Services, and we advise the Secretary, Deputy
24 Secretary, and the Assistant Secretary for Health on
25 public health policies and programs that impact racial

1 and ethnic minorities and coordinate HHS-wide efforts
2 at addressing minority health issues.
3 First, in terms of what we've talked about
4 when we say health societies, health societies can be
5 defined as significant gaps or differences in the
6 overall rate of disease incidence, prevalence,
7 morbidity/mortality, or survival rates in the
8 population as compared to the health status of the
9 general population. The Institute of Medicine defines
10 disparity in health care as racial or ethnic
11 differences in the quality of health care that are now
12 caused by differences in clinical need, patient
13 preferences, or appropriateness of intervention.
14 The landmark Institute of Medicine report
15 in 2002 served as a significant data point in terms of
16 tracking and analyzing issues related to health
17 disparities.
18 Overall health status in the U.S. has
19 improved significantly as demonstrated by increases in
20 life expectancies for the majority population.
21 However, in spite of the many improvements in health
22 over several decades, significant gaps still exist by
23 race, ethnicity, gender, disability, and other related
24 subpopulations. These gaps may be related in part to
25 demographic changes in the United States, but

1 according to the 2000 census data, the population of
2 the U.S. grew by 13 percent over the last decade, but
3 has increased dramatically in diversity at even
4 greater rates.
5 Racial and ethnic minorities are among the
6 fastest growing communities across the country. Today
7 they comprise 34 percent of the total U.S. population,
8 and it is projected that by 2030 40 percent of the
9 U.S. population will be comprised of minority
10 populations at large.
11 Consequently, the U.S. is not only
12 experiencing greater diversity, but people are living
13 longer, experiencing rising costs of health care and
14 emerging new diseases are posing challenges across the
15 board.
16 While the ratio in ethnic diversity is
17 increasing, minorities tend to die sooner from a wide
18 variety of acute and chronic conditions. Racial and
19 ethnic minorities receive a lower quality of care
20 compared to whites across a wide range of
21 preventative, diagnostic and therapeutic services.
22 These conditions in health care contribute
23 to continuing racial and ethnic differences in the
24 burden of illness and disease. For example, an
25 estimated 15.8 million people in the United States are

1 living with coronary artery disease. More than 5.7
2 million have felt the effects of stroke, which is the
3 second leading cause of death across the board.
4 African Americans continue to experience a
5 higher rate of stroke, have even more severe strokes,
6 and continue to be twice as likely to die from stroke
7 as the general population. Respiratory and
8 cardiovascular disease are among the most serious
9 public health problems. About 70 million Americans
10 fall into the newly diagnosed blood pressure risk
11 category defined as pre-hypertension, are in danger of
12 developing hypertension and related complications.
13 Hypertension, as you well know, leads to more than
14 half of our heart attacks, strokes, and heart failures
15 in the United States.
16 The prevalence of high blood pressure, a
17 major risk factor for coronary artery disease, stroke,
18 kidney disease, and heart failure is nearly 40 percent
19 greater in African Americans compared to the general
20 population.
21 Mexican Americans also experience an even
22 higher rate of hypertension and receive similar
23 numbers in the Native American community.
24 The rate of congestive heart failure and
25 hospitalizations in black non-Hispanics between the

1 age of 64 to 75 years are more than twice the rate of
2 that for white non-Hispanics.
3 In addition to heart disease disparities,
4 African Americans are 30 percent more likely to
5 develop cancer and 30 percent more likely to die from
6 cancer compared to the general population. Hispanics
7 in the U.S. are 50 percent more likely than whites to
8 suffer from diabetes and the incidence of diabetes,
9 and the Native Americans, that number as well is twice
10 as likely.
11 Asian Americans and Native Hawaiians and
12 Pacific Islanders are much more likely to suffer from
13 Hepatitis B and C, correlated liver cancer, compared
14 to the general population.
15 So we have seen over the past many, many
16 decades of health disparity reports an emergence and
17 reconfirming of data in terms of the impact of these
18 prevalence, morbidity and mortality on minority
19 populations across the board.
20 I want to mention that one of the
21 significant challenges that we face in documenting
22 health disparities are data gaps when we look at
23 specific populations. So we face data challenges and
24 collecting data on Native American and Pacific Asian
25 Americans, Native Hawaiian and Pacific Islanders

1 subpopulations, as well as for some specific Hispanic
2 populations across the board.
3 But from the data that we do see and I've
4 seen over the past two or three decades, we have seen
5 a continued confirmation of the existence of health
6 disparities in minority populations.
7 So what is the cause of these disparities?
8 Well, it's certainly multi-factorial, and I can tell
9 you as a practicing clinician, as well as a policy
10 maker, that I have seen the full spectrum of impact
11 just in the disease diagnosis and diagnosing specific
12 diseases within minority communities, but looking at
13 this at a population level as well, and it is
14 certainly related to the interplay between
15 socioeconomic, environmental, individual and personal
16 factors as well as other social determinants of
17 health.
18 You'll hear more from this panel about
19 issues related to social determinants of health, but
20 as we look in terms of the etiology of health
21 disparities, it's important to realize that there's
22 definitely a multi-factorial process in terms of these
23 disease processes on minority communities.
24 Individual factors include things as
25 poverty, low health literacy, behaviors, as well as

1 lack of health insurance or under insurance, as well
2 as a lack of a regular source of care.
3 Other system factors that contribute to
4 health disparities include lack of cultural and
5 linguistically appropriate care, as well as other
6 varied system factors that occur within the health
7 care system.
8 Disparities in health care have
9 significant implications for health professions,
10 administrators, policy makers, and health care
11 consumers, and present a significant challenge to the
12 health care system.
13 There are things that we can do both in
14 the individual level as well as a system level as
15 well. Individual changes include improved knowledge
16 and awareness of disease, changes in behaviors related
17 to smoking, exercise, nutrition, monitoring blood
18 pressure, and adhering to medical advice. Systems
19 level changes include such things as providing
20 practice staff with greater access to cultural and
21 linguistically appropriate care, improving access to
22 care through the availability of interpreters, and
23 making sure that we investigate strategies that
24 improve health insurance coverage for minority
25 populations.

1 There are a number of current research
2 activities, as well as a number of programmatic
3 activities related to health disparities that I think
4 you'll hear more about from our panel. I want to
5 highlight specifically as we're talking about
6 hypertension as I alluded to the impact of
7 hypertension on minority communities.

8 So what we continue to see is an under
9 diagnosis of hypertension and cardiovascular disease
10 in minority communities. I can tell you as a
11 clinician how often I have seen young African American
12 men who are in their late 20s or early 30s who are
13 suffering from kidney disease and other sequelae of
14 hypertension that have been probably going on for
15 years and have ravaged their bodies in terms of the
16 overall disease process.

17 But being able to adequately diagnose pre-
18 hypertension and hypertension in its early stages is a
19 significant factor in terms of modifying, if not
20 hopefully preventing, some of the sequelae from
21 hypertension that I mentioned earlier.

22 But there is an opportunity for us to
23 change much of these statistics not only in the
24 research that we do, but in some of the activities
25 related to changes in health care, as Dr. Sullivan was

1 pointed out.

2 Community-based participatory research is
3 a vital tool in helping to not only analyze but
4 hopefully address many of the disparities that we're
5 seeing in minority populations. Community-based
6 participatory research is a research methodology that
7 involves engaging the community at the grassroots
8 level in terms of research agendas and then feeding
9 back those research agendas to the community that was
10 initially engaged in that research.

11 I want to talk a little bit about some of
12 the examples that we have done in terms of CDPR timed
13 studies and highlight the role of other institutes or
14 other agencies such as the National Center for
15 Minority Health and Health Disparities that have done
16 a tremendous amount of work on issues related to
17 community-based participatory research.

18 Two years ago we sponsored CITIES
19 Initiative, an initiative looking at strokes as well
20 as hypertension within the black belt. That's that
21 area along the southeast corridor of the United States
22 where we've seen elevated rates of hypertension and
23 the sequelae of hypertension, i.e., kidney disease and
24 stroke, and we looked at interventions related to
25 possibly eliminating if not reducing those

1 disparities.

2 One of the things we found is the power of

3 awareness. Many times people just understand in terms

4 of the actual diagnosis that they have and realize

5 that there are certain things that they can do to take

6 charge of their own medical care. We see communities

7 engaging in preventative health behaviors that are not

8 only amazing but, in fact, inspiring. We saw church

9 members. We saw folks with the general community

10 really take their own health into their own hands and

11 participate in activities that subsequently led to the

12 reduction in hypertension and some of the sequelae

13 that we proposed from hypertension, i.e., kidney

14 failure, stroke, and some of the things that I've

15 alluded to earlier.

16 Within that context, the Office of

17 Minority Health has proposed a strategic framework for

18 eliminating health disparities. This strategic

19 framework is intended to help guide organizations and

20 coordinate the systematic planning, implementation,

21 and evaluation efforts of HHS' Office of Minority

22 Health, as well as our partners across the country

23 dealing with some of those individual and systemic

24 factors related to health disparities.

25 We also recognize that there are other

1 components related to the health care system that are
2 evolving in terms of not just health care reform, but
3 the digitalization of health care and the emergence of
4 such things as electronic health records and personal
5 health records which provide a powerful tool for
6 standardizing health care across the board.
7 CHAIRMAN REYNOLDS: Dr. Graham, I can
8 listen to you all day.
9 DR. GRAHAM: I'm sorry.
10 CHAIRMAN REYNOLDS: So if you don't mind,
11 we can follow up.
12 DR. GRAHAM: Thank you. I'm sorry.
13 CHAIRMAN REYNOLDS: Thank you.
14 Dr. Pamies.
15 DR. PAMIES: Thank you.
16 Members of the Commission, distinguished
17 co-panelists, and other honored guests, first I want
18 to thank you for holding this very important event as
19 we continue to shine a very bright light on this
20 critical and unfortunate topic of health disparities.
21 Before I begin, I think it's appropriate
22 to quote Martin Luther King when he said on the top of
23 all the forms of inequality, injustice in health care
24 is the most shocking and inhumane.
25 My name is Rubens Pamies. I'm Vice

1 Chancellor at the University of Nebraska. I'm a
2 physician and researcher and have spent the last 25
3 years trying to understand and find solutions to the
4 growing problem of health disparities. I think to
5 really better understand the issue, I need to discuss
6 very briefly nine different areas that I think
7 contribute to or explain the dilemma that we now face.
8 First, understanding the diversity. It's
9 important to look at diversity in America. Over the
10 past 20 years, the proportion of white Americans has
11 decreased from 83 percent in 1970 to 69 percent now in
12 2000. During that same period, the proportion of
13 African Americans has increased slightly from 11 to 12
14 percent. However, the proportion of Hispanic has
15 jumped from nearly five percent to 12 and half
16 percent.
17 It's obvious from these numbers that the
18 country is becoming increasingly more diverse and
19 making our health care issues uniquely different from
20 other comparable nations around the world. The U.S.
21 Census Bureau, in fact, had originally estimated that
22 by the year 2050 nearly one in two Americans will be a
23 member of a racial or ethnic minority group. However,
24 now they indicate that this can occur as early as
25 2037.

1 Currently, we have four states, including
2 the District of Columbia, who already have a majority
3 minority population.
4 The work force issue has been touched on,
5 and the issue today, our health care work force is not
6 representative of minorities in the general
7 population. Hispanics comprise 12 percent of the
8 population but only two percent of registered nurses,
9 3.4 percent of psychologists, and 3.5 percent of
10 physicians.
11 Similarly, African Americans constitute 12
12 percent of the population but only five percent of
13 physicians, nine percent of the registered nurses, and
14 only four percent of dentists. In the last ten years,
15 the percentage of African Americans in health care
16 careers has actually dropped in several key areas
17 while slightly increasing in some other areas.
18 In total under represented minorities
19 comprise less than eight percent of the nation's
20 physician work force and only four percent of the
21 medical school faculty, while almost 20 percent of
22 those four percent come from the four historically
23 black colleges that have medical schools.
24 I believe having a proportional
25 representation is important for a variety of reasons,

1 not only for patient care, but also for showing under
2 represented minority students that they, too, can
3 enter the health care field for enhancing cultural
4 competence and learning environment in the work force.
5 As has been mentioned, a landmark
6 Institute of Medicine report on equal treatment
7 articulated the increasing need for diversity. They
8 drew four conclusions for this.
9 First, under represented minority health
10 care professionals are significantly more likely to
11 serve the medically under served communities, which
12 often includes urban and disadvantaged areas.
13 Second, studies have shown that patients
14 are more likely to seek care from physicians of their
15 own race or ethnicity and report being more satisfied
16 in doing so.
17 And, third, minorities considering health
18 care professionals are more likely to pursue a field
19 where they see minority role models.
20 Finally, the reason concerning medical
21 research. Minorities are more likely to participate
22 in research studies when the research is conducted by
23 a health care provider of the same ethnic group.
24 Consequently under represented minority
25 health care professionals are also more likely to have

1 research interests in diseases where
2 disproportionately minorities are affected, thereby
3 helping to solve the mysteries regarding why certain
4 conditions disproportionately affect and have poor
5 outcomes among minorities. Because these researchers
6 often see first hand the various effects of these
7 diseases affecting the communities and their families,
8 and they become interested in learning more about
9 those diseases and the outcome.
10 Clinical research studies are vital to
11 understanding why certain racial and ethnic groups are
12 affected differently by disease and treatment. That
13 is why I think it is essential for us to continue to
14 collect racial data for minority health so that we can
15 better understand the disease outcomes.
16 It has been mentioned again, mortality and
17 morbidity incidence. The U.S. health care system has
18 said to be very good if you're healthy.
19 Unfortunately, that's not the case for many
20 individuals. Despite the overall improvement in the
21 U.S. populations, racial and ethnic minorities
22 experience higher rates of morbidity and mortality
23 than non-minorities. This point is simply proven by
24 looking at life expectancies.
25 African Americans have shorter life

1 expectancy, at 66 years, than white men who on average
2 will live until 74. Compare that with American
3 Indians who in some areas will expect to live in their
4 mid-50s.
5 While life expectancy for most groups have
6 risen, the life expectancy gap between white and
7 African American males has not changed significantly
8 in the past 40 years.
9 Even though our country can tout major
10 health and technological advances in the past 60
11 years, African American mortality rate is 1.6 percent
12 higher than whites, and this is identical to what it
13 was in 1950.
14 Infant mortality just as dismal as race
15 gaps in American Indians are 2.5 and 1.5 times higher
16 than whites.
17 Examining the prevalence of certain
18 diseases and conditions in racial and ethnic
19 minorities, we go to further evidence of health
20 disparities. African Americans have the highest rate
21 of mortality from heart disease, cancer, stroke,
22 HIV/AIDS and other disease conditions.
23 In fact, if you look at the HIV rate, it's
24 reaching epidemic proportions. More than 80 percent
25 of women who have been diagnosed with HIV or AIDS have

1 been either African American or Hispanic. American
2 Indians have higher rates of diabetes, as has been
3 pointed out, liver disease, and Hispanics are expected
4 to die more from diabetes which modern medicine now
5 can treat and manage adequately. As has been
6 mentioned, stomach cancers in Asian populations is
7 also very high.
8 Hypertension in African Americans leads to
9 80 percent higher stroke mortality rates, 50 percent
10 higher rates of disease and 32 percent higher rates of
11 renal disease than the general population. Half of
12 African Americans age 40 through 59 are hypertensive.
13 Compare that to 30 percent of whites.
14 When we initially look at these data, we
15 felt that access to care was the effective reason.
16 However, even in veterans hospitals where access is
17 not as much of an issue major health disparities
18 continue to exist. Studies have shown that physicians
19 are less likely to refer African American patients for
20 cardiac catheterization. African Americans are less
21 likely to undergo invasive cardiac procedures, and
22 current series on cardiovascular health disparities
23 center on various factors, including racial
24 discrimination in treatment, genetics, environment,
25 and demographics.

1 There are new theories emerging about the
2 burgeoning cardiovascular health disparities. The
3 first theory is epigenetics or changes in the DNA
4 caused by consistent environmental exposure, such as
5 diet and stress that can actually be passed on from
6 one generation to the next.
7 Epigenetics underscores the cumulative
8 effect of poor socioeconomic conditions,
9 discrimination and inequality of education and other
10 opportunities.
11 The second theory is the allostatic load,
12 which states that body experience biological changes
13 in response to stress. Specifically, corticotropic
14 releasing hormones which are found to be higher than
15 those that have experienced long periods of stress,
16 suggesting that years of feeling unequal or
17 experiencing discrimination can eventually lead to
18 worsen cardiovascular health.
19 The current economic situation is also
20 having detrimental effects. Recent reports have shown
21 that fewer prescription drugs are being filled. The
22 concern is that individuals are being successfully
23 maintained. Healthy blood pressures and other
24 cardiovascular conditions with medication may no
25 longer be able to afford these medications, which will

1 result in higher blood pressure, increases in stress,
2 hypertension and a number of other dangerous
3 conditions.
4 In the near future we may see a shift on
5 health maintenance with medication at a modest cost to
6 one that utilizes emergency room treatment at a much
7 more higher cost.
8 Health disparities places a
9 disproportionate burden of health disparities has been
10 well documented. There's several reports of
11 contributing factors, socioeconomic, racism,
12 discrimination, limited access and the quality of
13 service being provided. Patient and provider
14 behavioral factors also are factors.
15 The factors tend to compound one another
16 and create a cycle of problems. Despite increase in
17 care through immunization, the differences between
18 many minority groups to whites are significantly
19 getting worse or remaining stagnant.
20 Being in a lower socioeconomic class also
21 means having substandard housing, fewer opportunities
22 for higher education, less insurance coverage, limited
23 access to health care. The environment health risk
24 includes anything from air quality, water quality,
25 soil contaminants as well as other pollutants tend to

1 be more prevalent in lower socioeconomic communities,
2 and lower socioeconomic groups often life in more
3 segregated areas where there are higher poverties and
4 more drug and alcohol abuse.
5 Missing from these environments are green
6 space, access to healthy foods, job opportunities, and
7 access to health care. More than any other racial
8 group, African Americans tend to live in segregated
9 neighborhoods even when you factor in income levels.
10 In fact, some major urban areas in the United States
11 are as segregated as they were back before the civil
12 rights era and the apartheid era in South Africa.
13 Housing segregation showed that two-thirds
14 of African Americans would have to relocate in order
15 to achieve any statistical random distribution of
16 black and white households in America. Individuals
17 living in segregated areas typically do not have
18 resources to transfer wealth to the next generation.
19 Instead kids inherit a lifetime of poverty, a lack of
20 educational opportunity, and typically a lifetime of
21 poor health.
22 Just a few words about the educational
23 inequality. Low income segregated communities have a
24 lower tax base, less philanthropic ability to support
25 education. As a result, racial and ethnic minorities

1 have few educational opportunities, few role models,
2 and they tend to limit their goals to low paying and
3 in some cases hazardous occupations.
4 For many minority children other
5 expectations of them are set so low that they never
6 really reach their full potential. A recent report
7 shows that half of African American children and 40
8 percent of Hispanic children attended a high school
9 where the dropout rate was close to 50 percent. This
10 compared to only 11 percent of white children
11 attending those schools with those dismal statistics.
12 CHAIRMAN REYNOLDS: Dr. Pamies. Thank you
13 very much, and we will continue during the Q&A.
14 Dr. Chandra.
15 DR. CHANDRA: Mr. Chairperson and members
16 of the Commission, my name is Amitabh Chandra, and I'm
17 a professor at Harvard University's Kennedy School of
18 Government and a Fellow with the Dartmouth Institute
19 for Health Policy.
20 Thank you for inviting me to the
21 Commission to share my thoughts on how to improve
22 health care for minority patients.
23 We are all aware of the stubborn
24 persistence of racial disparities in treatment over
25 time, even when patients are fully insured. Many

1 believe that the clinical encounter is the most
2 pernicious source of these disparities. My main point
3 this morning is that we are unlikely to make great
4 strides in improving minority health by prioritizing
5 action on this channel.
6 The importance of the clinical encounter
7 is dominated by other shortcomings, such as the lack
8 of access to high quality providers which are far more
9 injurious to minority health.
10 The original disparities in health care
11 emanate principally from the clinical encounter,
12 embodies the idea that a provider treats two patients,
13 one white and one black, differently. More precisely,
14 differences in the clinical encounter may occur
15 because there is explicit discrimination where a
16 provider consciously withholds valuable care from
17 minority patients. This is the most malfeasance
18 explanation of racial disparities in care, and it's
19 perhaps one reason why there's so much interest in
20 this mechanism.
21 But disparities may also arise from
22 implicit discrimination, where a harried provider
23 operating in a time sensitive environment makes
24 unconscious mental decisions that are detrimental to
25 minorities. Stereotyping is one manifestation of this

1 indiscretion, and it occurs when a provider uses a
2 patient's race to produce information about the
3 benefit of treatment.
4 If, for example, African American patients
5 on average are less likely to be compliant, then a
6 physician may assume that her African American patient
7 is less compliant. Such reasoning will worsen
8 outcomes for that patient if he is different from the
9 typical African American patient and worsen outcomes
10 for all African Americans if the stereotype about them
11 is wrong.
12 The bias from implicit discrimination is
13 compounded by the presence of poor communication
14 between providers and their patients which may
15 generate enormous psychological barriers to minority
16 patients seeking care.
17 Finally, some researchers have posited
18 genetic or physiological differences between patients
19 that affect the benefit of treatment by race while
20 others have discounted such conclusions.
21 Given the discussion of the mechanism, the
22 question is to ask whether we have conclusively
23 established the role of the clinical encounter in
24 effecting racial disparities in health care.
25 Answering this very simple question carefully poses an

1 enormous and formidable empirical challenge. We would
2 need to observe the same provider treating two
3 patients with the same economic and social resources,
4 physiology, clinical history, severity, preferences,
5 compliance, and future prognosis.
6 These variables are routinely observed by
7 providers treating patients, but not by social
8 scientists observing providers. The fact that
9 multiple studies all note that minority patients get
10 less care is often interpreted a pervasive bias in the
11 clinical encounter which could just as well be
12 interpreted as one of the pervasive shortcomings in
13 all observational studies that focus on the clinical
14 encounter.
15 Second, because of patterns of
16 neighborhood segregation, the same provider is rarely
17 observed treating both black and white patients, and
18 so what we have been calling prejudice in the clinical
19 encounter is often a difference in neighborhoods,
20 referral patterns, and the resources of providers that
21 serve in these neighborhoods.
22 This is an unfortunate confusion because
23 improving neighborhood schools or changing the flow
24 pattern is not the same thing as reforming provider
25 behavior inside hospitals and offices.

1 Researchers have made some progress on
2 this challenge by using patient actors and implicit
3 association tests. Both physicians and the
4 researchers studying them observe the same information
5 in a laboratory setting. This an intriguing area of
6 academic research, but its findings are still nascent
7 for the purpose of informing policy and legislation.
8 We do not know if the decisions made by self-selected
9 physicians in these laboratory studies are
10 representative of physicians who actually take care of
11 minority populations.
12 My main point today is to elaborate on a
13 new explanation for racial disparities and care, but
14 they are partially the consequence of differences in
15 where minorities and white receive their care. If
16 different providers treat blacks and whites, then one
17 reason for racial disparities in care is not only who
18 you are, your race, but also where you live. Both
19 sources of disparities are injurious to minority
20 health.
21 The first type of variation which I call
22 within provider variation is the role of the clinical
23 encounter. The second, which I call the between
24 provider variation, relates less to race per se and
25 more to geographic variations in the quality of

1 treatment patterns for all patients. It considers the
2 racial disparities in treatment because minorities are
3 more likely to be cared for by lower performing
4 providers.
5 Some large academic medical centers are an
6 exception to this statement, but the link between
7 being treated at one of these centers and quality is
8 by no means automatic.
9 Differences in where minorities are
10 treated has to do with factors such as insurance and
11 lower socioeconomic status, but historical patterns of
12 discrimination and neighborhood segregation surely
13 exacerbates this variation.
14 Confronted with these realities, we should
15 be extremely cautious in concluding that malfeasance
16 and nonfeasance are the sole purview of the medical
17 profession.
18 So what is the evidence of the role of
19 geography as a determinant of racial disparities in
20 health care? Dr. Peter Bach and his colleagues have
21 demonstrated that blacks and whites have different
22 providers, and those providers who treat minorities
23 are often less clinically trained and have fewer
24 resources.
25 My collaborators and I have demonstrated

1 that 85 percent of all black heart attacks are treated
2 in only 1,000 hospitals, where 60 percent of whites
3 receive their care in hospitals that treat no African
4 American patients.
5 Within hospitals, we found, however, no
6 disparities in effective care, but found the patients
7 who were admitted to hospitals that disproportionately
8 serve blacks had a risk adjusted mortality rate that
9 was almost 20 percent higher than that of non-minority
10 serving hospitals.
11 Others have noted similar findings for the
12 performance of neonatal intensive care units in
13 minority serving hospitals. Forty years after the
14 passage of the Civil Rights Act, minority health care
15 is both de facto separate and unequal. Ironically, a
16 close cousin of this embarrassment, which was
17 segregated hospitals, was the original motivation for
18 Title VI legislation.
19 The new focus on the geography of minority
20 health care should not be viewed as taking attention
21 away from reforming the clinical encounter. Rather,
22 it notes that even if we could fully eliminate
23 disparities within the clinical encounter, the health
24 care of blacks would improve, but still lag behind
25 that of white because of differences in quality of

1 care where the two groups receive care. For many of
2 us, this is simply not good enough.
3 Because a small group of providers treat
4 minority patients causing quality improvements towards
5 minority serving providers would dramatically reduce
6 black-white disparities in care. Such interventions
7 would improve the health of both minority and white
8 patients, but the gains would disproportionately
9 accrue to minority patients whose care concentrates in
10 such providers.
11 In the context of ambulatory care for
12 diabetes, my collaborators at Dartmouth and I estimate
13 that aggressively improving the performance of the 500
14 largest minority serving networks would improve
15 minority health care more than the complete
16 elimination of racial disparities within every
17 provider in the United States. Indeed, given the
18 greater reliance on ambulatory care, one might want to
19 think about expanding the recent Title VI of the Civil
20 Rights legislation to go beyond the reach of hospital
21 care and encompass care that is delivered in office
22 visits and by managed care plans.
23 Finally, in closing let me make one simple
24 point. The determinants of racial disparities in
25 health are not the same as the determinants of racial

1 disparities in health care. The principal
2 determinants of health are genes, behavior, schooling,
3 neighborhoods, economic circumstance.
4 Health is secondarily affected by health
5 care, but more likely to be influence by prevention,
6 including the quality of ambulatory care which can
7 check the progression of diabetes, hypertension, and
8 chronic disease, and through this protection the
9 incidence of heart attacks and strokes.
10 Of tertiary importance, at the very end of
11 the causal chain is the role of disparities in medical
12 care. The quality of medical care matters much more
13 than the disparity in the quality within it. For the
14 six and a half year racial gap in life expectancy for
15 men and the four and a half racial gap for women,
16 which are surely larger when one accounts for the
17 condition of that life, are unlikely to be affected by
18 the focus on treatment disparities in the clinical
19 encounter. The preoccupation with treatment
20 disparities in the end game simply misses the fact
21 that minority patients find themselves confronting the
22 end game sooner than everyone else.
23 Thank you.
24 CHAIRMAN REYNOLDS: Thank you.
25 Dr. Satel.

1 DR. SATEL: Thank you for the invitation
2 to address you today.
3 COMMISSIONER GAZIANO: Could you move your
4 microphone up a little?
5 DR. SATEL: Okay.
6 COMMISSIONER GAZIANO: They're not that
7 sensitive. Thank you.
8 DR. SATEL: Okay. Thank you.
9 This better?
10 COMMISSIONER GAZIANO: Yes.
11 DR. SATEL: Thank you for the invitation,
12 Chairman Reynolds and Co-Chairman Thernstrom.
13 My name is Sally Satel. I am a Resident
14 Scholar at the American Enterprise Institute. I also
15 work at a methadone clinic in Northeast Washington,
16 D.C.
17 And I wanted to give you an overview today
18 of the contours of the health disparity issue. In
19 fact, I almost call it a health disparity debate.
20 What do I mean by "debate"? There is
21 certainly no controversy over the fact that minorities
22 have poor health status and often poor health care,
23 often both the variables that Dr. Chandra spoke of.
24 There is no dispute there.
25 But the debate has to do with the causes

1 of those differentials, and the causes, of course,
2 lead us to the remedies. So there are two starkly
3 different perspectives on the causes, and Dr. Chandra
4 spoke them already. He characterized them, in short,
5 as dynamics within the clinical encounter, biased
6 physicians, and even biased health systems. That's
7 one perspective versus the what I'd call a more
8 socioeconomic focus on inadequacies of health systems
9 that disproportionately serve lower income individuals
10 who are disproportionately minority.
11 The biased perspective came to the
12 forefront of the health disparities conversation with
13 the 2002 Institute of Medicine report, and I want to
14 spend a little bit of time on that. That report is
15 called "Unequal Treatment." They've gotten an
16 enormous amount of attention and is largely regarded
17 as an authoritative study. However, I wanted to
18 outline some of the methodological problems with it.
19 That study had an emphasis on the clinical
20 encounter and concluded that there was bias among
21 physicians towards minority patients overtly as well
22 as subtly, and I think that report really was almost a
23 watershed point in the dynamic of this debate because
24 it really catapulted the issue of minority health from
25 a public health issue to a civil rights one, as I

1 said, with the different kinds of remedies implies of
2 sensitivity training for doctors, affirmative action,
3 and even potential Title VI legal challenge.
4 The main problem with the Institute of
5 Medicine report is that it sought to prove bias or
6 discrimination, and I just speak from the standpoint
7 fully of methodology. This is an almost impossible
8 phenomenon to prove using retrospective approaches and
9 using large databases.
10 In a sense, charging a bias is a diagnosis
11 of exclusion. It's the kind of thing you arrive at,
12 which is not to say it doesn't exist. It could well,
13 but it's the kind of thing one arrives at after ruling
14 out variables that can measure and identify with other
15 kinds of variables that could lead to differences.
16 And with large databases, this is very hard.
17 There's one problem with the report. I've
18 chronicled most of them in this health disparities
19 myth booklet that I'll hand out to you afterwards, but
20 one of the problems is that of omitted variables. And
21 you referred to this as well.
22 When you look at large databases in
23 retrospect, you're not often going to find the kinds
24 of variables on which physicians make their clinical
25 decisions. For example if we're going to use an

1 angioplasty, we'd want to know certain EKG subtleties
2 that are not in large retrospective databases,
3 ejection fraction, for example, the position of
4 occlusion in an artery. These things don't come
5 across in these databases, but they are very relevant
6 to clinical decisions.
7 Another feature of the IOM report and
8 working health disparities is procedure counting. How
9 many procedures did one group get versus another as
10 opposed to looking equally or even with greater
11 emphasis on the outcome?
12 The research in cardiac procedures has
13 frequently shown that even though there are
14 differentials, the mortality rates are frequently the
15 same.
16 So ideally what one wants to use is
17 prospective studies and even more ideally ethnographic
18 observation and interviews with physicians as to why
19 they'd made the treatment decisions that they do. And
20 I'm really not familiar with those kinds of studies.
21 But for years the IOM report has set the
22 tone of this debate. Now, actually I think there is
23 somewhat less talk about biased positions today, and I
24 see that as a definite maturing of this issue, but
25 there's still an emphasis on one key concept that I

1 want to emphasize, which is, again, within the
2 disparities issue and almost exclusive focus on
3 relative health, almost a greater concern with the
4 health of groups in relation to each other than
5 whether people are receiving optimal care.
6 The reason why this is one of the problems
7 of this approach, to look at relative health, is that
8 you can often miss improvements when all of those
9 rise, so to speak. You will see no change in the
10 ratio of minority and white improvement, but it could
11 be there. You just won't see it because everyone has
12 improved together.
13 Another example of that has to do with the
14 classic example is black infant deaths, which between
15 the years 1980 and 2000 decreased by over one-third.
16 Now, that is certainly progress, but white infant
17 deaths decreased even greater. So it still looks as
18 if the ratio is unfavorable to black infant mortality.
19 But that's not really what the whole
20 picture shows. One can be misled by focusing on
21 relative health and on death, and one can also get
22 conversely a false sense of achievement. A 2005
23 Harvard study found greater improvement for blacks in
24 basic interventions and exams for diabetes and other
25 things. However, the rates for blacks and white were

1 suboptimal for both. So that wasn't necessarily
2 something to celebrate either.
3 Now, as far as the most relevant
4 determinants of health, you've already heard them from
5 Dr. Chandra and Dr. Bach. Geographical differences,
6 the quality of cost for those physicians, quality, the
7 idea that minorities and whites really don't even see
8 the same physicians, these are drivers of health
9 differentials that are very powerful, and in my view
10 swamp the value of looking for bias, assuming that
11 bias could even be satisfactorily empirically
12 demonstrated.
13 Now, perhaps even more profound in the
14 demographics of health care are the early determinants
15 that have been mentioned by my colleagues. The
16 mechanisms are very complex. They're called these
17 upstream factors of education and parental income and
18 neighborhood. The mechanisms are complex, but
19 scholars generally agree that good, structured
20 education in the early years enables children to
21 develop self-control, problem solving dispositions,
22 and no least, a sense of the future.
23 Now, what does this mean for health in
24 later life? Well, obviously it means more
25 opportunities to obtain decent jobs, jobs with health

1 benefits, more autonomy. That was one of the key
2 lessons of the class Whitehall civil servant study
3 which looked at the gradients of income and found that
4 the second to highest gradient still had
5 disproportionately higher cardiac mortality than one
6 would expect even though their incomes were very good.
7 But the conclusion was that they do not
8 have the latitude to determine how they work at the
9 job. There was a sense of stress, of responsibility
10 without authority. So stress is quite important.
11 Also, good education gives you the
12 financial security to cushion setbacks. People are
13 better informed, of course, about health matters and
14 have a much more positive view of technological
15 interventions.
16 Now, let me move from the more abstract to
17 what I see when I go to my clinic here. It's a
18 methadone clinic. So by definition we're treating
19 people who have heroin addiction, but they've also got
20 a lot of other medical problems.
21 What I had said, the foregoing was to call
22 attention to the factors that really do matter. These
23 are factors that they're by race, not necessarily
24 because of race, but in the weeds, in the clinic, we
25 see folks that I think everyone is really talking

1 about when we speak of the medically disenfranchised.
2 Now, there's no question that improved
3 access to care would help these folks, especially
4 black men who rarely have Medicaid unless they're
5 disabled, but even so there's much more to better
6 health than access. As was mentioned before,
7 continuity of care, the same doctor is so important, a
8 medical home, ample time.
9 The Commonwealth Fund did a wonderful poll
10 in the late '90s. I wish they would repeat it. Over
11 1,000 people, about eight different ethnic groups, and
12 asked them so many questions about how they determined
13 which practitioner they want to go to, and out of 13
14 options, race tied last with something else.
15 Medication, people should have the option
16 certainly to choose their physician based on race, but
17 the patients in this survey, and as I said, there were
18 over 1,000, said that was really the least relevant.
19 The doctor spending time with them was one of the
20 most. So that is very important.
21 Access, again, as I said, is huge, but the
22 determinants have to do often with engagement. Will
23 patients engage in the self-care that you mentioned
24 that is so important because so many have chronic
25 illnesses which contribute tremendously to the health

1 care burden?

2 So I personally for this kind of problem

3 and for my kinds of patients actually am a great fan

4 of local public health clinics. This is very much on

5 the ground. We're talking five feet above, not the

6 100,000 foot view, but where you can have hours for

7 open nights for the working core, a location that's

8 convenient to keep people out of the emergency rooms,

9 staff with local residents. I think that goes very

10 far to the cultural sensibilities that we're all

11 talking about.

12 The physician assistants and nurses, they

13 help the physicians. They do the support. They do

14 the outreach. They make the follow-up calls.

15 So in summary --

16 CHAIRMAN REYNOLDS: Doctor --

17 DR. SATEL: Can I make my summary?

18 CHAIRMAN REYNOLDS: Yes.

19 DR. SATEL: Okay. Three points very

20 quickly. Recognize that the elimination of health

21 differentials is not feasible because we cannot

22 eliminate the disparities, the social disparities,

23 many of which take their most profound toll in terms

24 of the habits of mind and view of the future.

25 Such an agenda clearly transcends the work

1 of public health and is best left to politicians,
2 voters and social welfare experts.
3 I'll stop there. Thank you.
4 CHAIRMAN REYNOLDS: Thank you.
5 Dr. Bach.
6 DR. BACH: Thank you very much for this
7 invitation. I'm really thrilled that you're having
8 this hearing, and I want to say metaphorically that
9 the fact that I'm jammed at the end of the table I
10 find to be a great turn of events that the Jewish
11 white guy finally feels marginalized.
12 (Laughter.)
13 DR. BACH: Chairman Reynolds, Vice
14 Chairman Thernstrom, esteemed members of the
15 Commission, my name is Peter Bach. I'm a physician at
16 Memorial Sloan-Kettering Cancer Center in New York
17 City where I do health services research.
18 My research discipline uses the hybrid of
19 text and techniques from economics, epidemiology, and
20 statistics in order to gain a representative
21 understanding of the health care delivery system. For
22 more than a decade, one of my main research interests
23 has been health disparities.
24 I'm grateful for the invitation to speak
25 with you today about my research and others. I'm

1 humbled by this opportunity, and I have to acknowledge
2 my funders for more than a decade, the National Cancer
3 Institute, the National Institute of Aging, the
4 Commonwealth Fund, the Robert Wood Johnson Foundation
5 and others, but I must specifically credit my
6 colleagues, Colin Begg and Deborah Schrag at Sloan-
7 Kettering and my time at the Center for Health System
8 Change. We have all worked together on these
9 problems. The names that appear and the orders they
10 appear on our work are less relevant.
11 About a decade ago my colleagues and I
12 wondered if the high mortality rates for cancer seen
13 among blacks when compared to whites could be due to
14 blacks receiving less effective treatments
15 specifically in the setting of cancer.
16 We chose to study a single cancer
17 procedure to address our question, surgery for early
18 stage lung cancer. We focused on this procedure
19 because it treats the number one cancer killer, lung
20 cancer, 25 percent of all cancer deaths, and is
21 enormously effective.
22 In an analysis we published in the New
23 England Journal in 1999, a decade ago, prior to the
24 IOM report that has been referenced many times, we
25 showed that in Medicare blacks with a curable

1 diagnosis received the surgery 13 percent less often
2 than whites with the same diagnosis. We showed that
3 this was not due to greater co-morbidity amongst
4 blacks or even due to differences in socioeconomic
5 status.
6 We also showed that we believed that this
7 treatment gap was the explanation for blacks' poor
8 survival outcomes in lung cancer. The study is
9 personally memorable for me. It was one of the first
10 major analyses publishers in the NCI Seer-Medicare
11 database, which has become a cornerstone of studies of
12 cancer care, and it was also one of the few studies
13 that had demonstrated at that time that treatment gaps
14 were important in terms of disease outcomes.
15 That has been since shown in numerous
16 other studies, but prior to that treatment gaps had
17 been illustrated without a link to outcomes. We were
18 unable to determine in our study why treatment rates
19 were lower for blacks. Our study wasn't designed with
20 that question in mind, and the data we used was
21 insufficient to address this sort of granular,
22 patient-level question.
23 We have used national data covering many
24 years and tens of thousands of patients that we had
25 little individual level information. Other work in

1 disparities is notably the opposite, sometimes
2 covering just a few patients and doctors in a single
3 practice setting in which a lot can be learned about
4 that setting, but less about the universe of care
5 settings.
6 The follow-up from the publication was
7 educational for me. A number of pundits, if you will,
8 stepped on top of our findings to use as a platform to
9 decry the health care system as racist and, by
10 extension, doctors as racist. The New York Times
11 "Week in Review" section carried on their front page
12 an article about our study which was titled "Not just
13 another case of health racism." It's framed in my
14 bedroom, by the way.
15 Too many people concluded too quickly that
16 the explanation of our findings was that doctors
17 discriminated against their minority patients, and I
18 noted a few years later in an essay in the New England
19 Journal of Medicine reviewing the IOM report on equal
20 treatment that the invocation of racism as the cause
21 of treatment disparities moves the problem, if you
22 will, one of health care system quality, to one of
23 health care providers' moral failure.
24 Our research group saw in some studies the
25 potential for another explanation that Dr. Chandra has

1 referred to, one that, if you will, blamed the system
2 rather than the doctor.
3 We hypothesized the key reason why blacks
4 received lower quality care than whites could be that
5 they went to doctors who for a variety of reasons were
6 less able to provide the high quality care routinely
7 received by whites. This could be the case because
8 the doctors were less well trained, less well
9 resourced, or simply less knowledgeable.
10 And so a few years later, in 2004, we
11 published another study in the New England Journal
12 that provided evidence supporting our explanation. We
13 documented two conditions that supported our theory.
14 First, we demonstrated that the key precondition for
15 our hypothesis existed. Blacks and white were,
16 indeed, not treated by the same doctors. We looked at
17 Medicare patients, and we were able to show that the
18 care of black patients was heavily clustered among a
19 small group of doctors. It took only 20 percent of
20 primary care doctors in the U.S. to account for 80
21 percent of all care received by blacks.
22 Whites were different. Their care was
23 mostly with other doctors. Then we showed that the
24 doctors at the level of individual level patient
25 visits were different. We asked the question: if I'm

1 a typical Medicare patient who is black, what are the
2 features of my doctor compared to if I'm a typical
3 Medicare patient who is white?
4 We found the doctors looked different. A
5 black patient was less likely to have a doctor who was
6 Board certified in their primary specialty. We
7 thought that was important because having Board
8 certification has been shown in decades of research to
9 be a key predictor of delivering high quality care.
10 We also found that the primary care
11 doctors who treated blacks took fewer resources to
12 direct at the care of their patients. They had harder
13 times making referrals for all of their patients.
14 They had trouble electively admitting patients for
15 work-ups to the local hospital and getting imaging
16 tests.
17 More interesting, the financing of the
18 practices was different. Blacks went to doctors who
19 more often provided free care and care to Medicaid
20 patients, and the net effect was that they had lower
21 revenues per patient and, therefore, less resources to
22 support the practices and the other caregivers in
23 them.
24 They also were more likely hurried,
25 something most recent research has shown.

1 Around the time of this paper and over the
2 years since, these findings have been reproduced
3 numerous times, including by Dr. Chandra and his
4 terrific colleagues. If doctors or hospitals,
5 surgeons, centers of managed care, insurance
6 companies, lower quality overall seems to be
7 associated with having more black patients and fewer
8 whites within a care setting.
9 Recently colleagues of mine looked at more
10 detailed aspects of practices that treat large numbers
11 of minority patients and estimated that the impact of
12 low payment rates for Medicaid itself were a sizable
13 contributor to access problems and led to shorter
14 patient visits, too.
15 My colleagues and I have some new
16 unpublished findings that I can give you a top line
17 review of. We are finding that for Medicare patients
18 the important predictors of getting lower quality care
19 are, first and foremost, your socioeconomic status for
20 the regional or local area economic climate in which
21 you live and how good the quality of care is that your
22 doctor gives his or her other patients, meaning his or
23 her white patients typically.
24 We are unable to detect any consistent
25 evidence that doctors are treating their black and

1 white patients differently per se. I believe our
2 findings are consistent with the plausible hypothesis
3 that care for blacks is of lower quality primarily
4 because blacks are accessing a part of the system that
5 is poorly functioning.
6 Little, if any, of the under treatment
7 appears to be due to doctors singling out minorities
8 for lower quality care.
9 Neither my colleagues nor I take the
10 challenges posed by this alternative explanation to
11 health disparities lightly, in ways that will be
12 harder to ameliorate, but the payoff will be more
13 durable and robust.
14 So you have asked me here today to talk
15 about health disparities and what our research
16 suggests about its origins. That research rests in a
17 social context in which many people arrived early at a
18 conclusion that discrimination, be it conscious or
19 unconscious, lay at the heart of treatment
20 disparities. Our work has provided a different
21 explanation, one in which we have a poorly distributed
22 health care system in which the lowest quality
23 resources are in the neighborhoods with the most needy
24 individuals. If correct the mechanism suggests that
25 the purse that targets these high-risk areas would be

1 the best way to improve care and outcome for the
2 patients in --. Thank you again for inviting me and I
3 look forward to your questions.
4 CHAIRMAN REYNOLDS: OK. I would like to
5 thank all the participants. This has been a fantastic
6 presentation. At this point I would like to open up
7 the floor for questions from the Commissioners.
8 Don't all jump in at one time folks,
9 Commissioner Melendez.
10 COMMISSIONER MELENDEZ: First, I wanted to
11 thank you all for being here today testifying on
12 behalf of the medical -- I just wanted to ask a
13 question of Dr. Graham.
14 As far as data collection, you had
15 mentioned that. I know that for the Native American
16 population, one of the issues we always had is the
17 census, and there were tremendous problems with the
18 statistics especially in 1990 and 2000 as far as, you
19 know, what the population of Native Americans actually
20 were on the census.
21 What do you think about how does that skew
22 the results?
23 DR. GRAHAM: Sure, and I'm glad you
24 emphasized that point because from my standpoint, one
25 of the very, very key issues -- we talked on some

1 other issues on health disparities here today. One of
2 the very instrumental issues is data collection.
3 Aside from some of the challenges you mentioned with
4 the Census Bureau; one of the major challenges we face
5 is in the tools that we use to collect data on health
6 statistics.
7 Many of the surveys that the Department of
8 Health and Human Services as well as state
9 organizations and state public health agencies use to
10 capture what is the health status of our country, many
11 times we miss important subsegments of our population,
12 such as the Native American population, as well as the
13 Native Hawaiian and other Pacific Islander
14 populations.
15 And so what that practically spells out is
16 that many data points you see asterisks and stars and
17 dashes instead of actual statistics on those specific
18 populations. We have actually taken that issue very,
19 very seriously on the HHS leadership standpoint, and
20 we have an organization that's called the Data Council
21 and all of these kinds of infrastructures within HHS.
22 We are taking a very serious look at how can we be
23 able to start capturing some of those demographics
24 because if what you don't measure you don't see; so
25 this idea of capturing, you know, some of the data in

1 terms of, you know, what is the true incidence of
2 heart disease, what is the true incidence of cancer or
3 what is the true incidence of all of these very
4 diseases that were mentioned on specific -- especially
5 the Native American population.
6 Part of it is just being able to capture
7 folks, to be able to reach folks and to be able to
8 actually have them answer some of the data questions
9 and then be able to put that within -- simplifying it,
10 but then be able to put that within some of the data
11 collection systems that we have.
12 So one of the strategies that we're really
13 employing is very targeted studies where we
14 specifically have specific efforts to reach folks and
15 be able to capture the population appropriately.
16 DR. PAMIES: If I could just follow up
17 with that because I think that one of the things that
18 was of interest to me as we had this discussion is
19 some of the different conclusions that we reached in
20 terms of the causes of health disparities and what it
21 highlights for me is the need to do more research, and
22 quite frankly, one of the concerns I've had with
23 regards to data is that there is a group and there's a
24 push now to eliminate collections of racial and ethnic
25 data in looking at health outcomes. I believe that

1 will be extremely dangerous.

2 I think we need to have more collections
3 of information on different racial and ethnic groups
4 in order to try to find out, tease out the specific
5 reasons why we have these wide variations in health
6 outcomes. So I'm really concerned about that.

7 CHAIRMAN REYNOLDS: Okay. First
8 Commissioner Gaziano and then Commissioner Yaki, then
9 Commissioner Heriot.

10 COMMISSIONER GAZIANO: I want to thank all
11 of the panel. It has been very, very informative, and
12 I come from a family -- my immediate family and their
13 spouses, I think, have eight physicians if I counted
14 correctly. I'm the only black sheep, the only non-
15 physician. So I'm very interested in all of the
16 testimony about the existence of the disparity, but I
17 will be glad to yield to HHS its particular share in
18 addressing some aspects of that.

19 Our special jurisdiction here is somewhat
20 limited, and that is to focus in or to try to focus in
21 on the causes and the extent to which there's implicit
22 or explicit racial discrimination. So I'm going to
23 focus a few of my questions or my basic question was
24 particularly to the last three who tried to get at
25 that.

1 And as I understand, this is a terrible
2 over generalization, but I think all of you have
3 testified very clearly some genetic differences
4 depending on the disease. There are behavioral
5 reasons, socioeconomic reasons that have a big role to
6 play before there's any interaction with the health
7 care system.
8 Some of these are epigenetic. So they're
9 experiential, and those experiential may be fabulously
10 complexly related with those other factors.
11 And then there are the impacts of the
12 health care system, and we've heard that there is at
13 least a concern and some research suggests it has to
14 do with the clinical experience and bias, and some of
15 it has to do with the unevenness in the quality of
16 care.
17 And I wondered particularly the last
18 three. I think, Dr. Chandra, you began to put some of
19 this in words. What percentage in maybe pick a
20 disease if you know it or some diseases are caused by
21 these factors? I should say what percentage of the
22 disparity is caused by these factors that don't really
23 have much to do with the health care delivery system?
24 And then what percentage is related within
25 the health care delivery system to possible bias and

1 implicit differences? What percentage, even if it's a
2 wide guess, a range, something like that, just to give
3 us a sense as to what your research suggests, and the
4 same for Dr. Bach.

5 DR. CHANDRA: Let me try to answer that
6 question in the context of a paper that I wrote with a
7 number of my collaborators at Dartmouth that we
8 published in the Journal of Circulation, and here's
9 what we found in the circulation paper. If the
10 outcome that one is interested in is black-white
11 differences in 30 or 90-day survival after heart
12 attack -- that was the thing that we were interested
13 in looking at -- what we found was when you look at
14 the role of provider quality in affecting or
15 influencing racial disparities in 90-day survival, the
16 role of provider quantity or differences in where
17 blacks and whites went explained about 60 percent of
18 the variation, saying that there's still 40 percent
19 that you could attribute either to the clinical
20 experience or the sort of acute phase of the
21 treatment.

22 You could also say that some of that 40
23 percent was the fact that within the particular
24 hospital blacks and whites were being treated by
25 different groups, maybe varying in quality.

1 So we weren't in that study able to drill
2 down completely, but we were able to say that when
3 you're looking at something like three-month survival,
4 there's an enormous role of the care system that you
5 were treated at which becomes more and more important
6 when you narrowed the window over which you are
7 looking at outcome differences.
8 So for example, if you change the outcome
9 measure to what is the role of geography or provider
10 differences in explaining 30-day mortality
11 differences, then the role of the hospital that you
12 were treated at explains 100 percent of the treatment
13 disparity, which is in a sense what you would expect
14 because the hospital is going to be very important for
15 the first week, for the first 15 days.
16 But once you are discharged from the
17 hospital, then a bunch of other factors or insults
18 start to affect racial differences in mortality.
19 CHAIRMAN REYNOLDS: Okay. Dr. Bach.
20 DR. BACH: Just I think Amitabh laid that
21 out nicely. It's hard to separate, and it obviously
22 varies by disease. You know, we don't think the
23 difference in cancer incidence, for example, which are
24 about ten percent adjusted between blacks and white,
25 black men getting about ten percent higher, had

1 anything to do with the health care system. We have
2 essentially no preventive cancer measures that we
3 distribute through the health care system. Obviously
4 things like smoking, things like that sort of sit a
5 little bit outside.
6 But you know, in the paper I alluded to --
7 and I regret that it's not yet published because I can
8 talk in more detail and you can review it, but
9 hopefully some day -- we looked at the delivery of six
10 preventive services in Medicare, and we were able to
11 assess that on average about half of the gap in
12 preventive services delivery were, like I said in
13 terms of socioeconomic status in the different
14 patients and another 30-plus percent or 40 percent of
15 that was between provider differences so that blacks
16 were going to doctors who treated more of them and
17 provided lower quality care, and then there was a
18 residual that had to do with co-morbidities and things
19 like that.
20 But of the six, they're split right down
21 the middle, a few percent in one direction, a few
22 percent in the other were due to, if you will,
23 different treatments of black and white patients by
24 the same doctor, things that we would argue are just
25 sort of a statistical anomaly.

1 So if the question is at least in the area
2 of preventive services, diabetic eye exams, monitoring
3 of lipid levels and things like that, that we're not
4 seeing any evidence that it's sort of within the
5 doctor's office. It is all sort of around the
6 doctor's office where patients are going.
7 COMMISSIONER GAZIANO: Thank you.
8 CHAIRMAN REYNOLDS: Okay. Commissioner
9 Yaki.
10 COMMISSIONER YAKI: Thank you very much,
11 Mr. Chair.
12 And I also commend the panel for a fine
13 presentation. I just had two very small questions.
14 The first one comes from research that's
15 been done in the Asian American community. As you
16 know, there are a lot of different perceptions of the
17 Asian American/Pacific Islander community in terms of
18 its health education benefits. Most of them tend to
19 be sort of bell curve, U-shaped curve in terms of
20 distribution of income, access, what have you.
21 And this actually goes probably to a lot
22 of new immigrant populations as well. To what extent
23 does linguistic and cultural competency and access
24 have an impact on access for and quality treatment of
25 health care for those who need it?

1 I just throw it open to the panel.
2 DR. GRAHAM: I think I'll take the first
3 stab at that.
4 I think as I mentioned earlier that has a
5 definite, if not significant, if not tremendous impact
6 in terms of some of the several factors that we
7 mentioned here today. Dr. Sullivan in terms of
8 presenting -- when he was presenting some of the data
9 on work force alluded to this issue of concordance and
10 better outcomes in terms of concordance between
11 providers.
12 That's something that's well established
13 in the literature. I think implicit with that is this
14 ability to provide cultural and linguistically
15 appropriate care, and I think the idea that a patient
16 understands what you're talking about, and not only
17 that the patient understands you, but you understand
18 the patient is a particularly important point.
19 Now, it's something that is harder to
20 capture significantly in some of the hard core
21 outcomes that Peter and others have spoken about, but
22 I think that is kind of what's implicit within that 40
23 percent and some of those other parts of the data
24 where you see some of these kind of intrinsic and
25 implicit factors.

1 I also want to allude to the other thing
2 that you pointed out, which is this myth I would say
3 within that Asian Americans are uniformly healthy.
4 When you look at the data around Asian Americans, you
5 see specific and significant health disparities in
6 subpopulations of Asian Americans that are troubling,
7 and it's up to us to make sure that we educate the
8 broader U.S. population on just what some of those
9 disparities are.
10 DR. SULLIVAN: If I might comment, I would
11 say this. I think the data that the system really has
12 bias in it is so overwhelming that it depends upon how
13 you define the issue. In research it is very easy to
14 define the way of problem by how you set the premise
15 forward.
16 I happen to serve on the board of Grady
17 Hospital, the public hospital in Atlanta. We have a
18 tremendous problem because we have a growing Hispanic
19 population, and the very issue that Dr. Graham
20 mentioned is one that we are dealing with, that we
21 don't have enough interpreters to speak to the Spanish
22 population that we're serving, and we've been told by
23 leaders within the Hispanic community that many of
24 their citizens don't come to the hospital because they
25 don't feel it's a welcome environment.

1 That's a fact that weighs on the care that
2 the individuals receive. In 1996, in the New England
3 Journal of Medicine, Dr. Miriam Konarami and her
4 associates with their studies from the University of
5 California, San Francisco, showed that black or
6 Hispanic physicians were three to five times more
7 likely to establish their practices in black or
8 Hispanic areas, and they showed that the health data
9 in those communities where they settled improved.
10 Now, one might say that this is not due to
11 bias in the system, but I think that depends upon how
12 you define it. So I think I don't refute the fact
13 that when one looks very closely with a lot of
14 caveats, indeed, you may not find differences if you
15 look very finely, but there are gross discrepancies in
16 the health care system that has an impact on people's
17 lives.
18 And I think it's important that as we are
19 working to improve the health of Americans that we do
20 not dispose of those factors that have a system that
21 really makes it very difficult for a growing segment
22 of our population to receive the care that they need.
23 This is important for everyone because one of the
24 challenges we face as a society is a growing health
25 burden as well as problems, frankly, in our

1 educational system; that if they're not addressed over
2 time, that's going to erode the strength of our
3 country.
4 So I think we have to look as broadly as
5 we need to, but certainly look finely as well, but not
6 dismiss those systemic problems that interfere with
7 the ability of people to receive care on the basis of
8 income, education, and bias.
9 I happen to be old enough to have grown up
10 in the South where my family drove 41 miles to see a
11 black physician rather than go in a room that said
12 black patients versus white patients. I define that
13 as bias. My parents defined that as bias that they
14 would not accept.
15 So I think we have to be careful not to
16 try and dismiss the factors in our system that do
17 impair the ability of our patients to receive the care
18 that they need.
19 COMMISSIONER YAKI: Well, Mr. Chair, my
20 second question was actually more along those lines.
21 I wanted also to get the panel's reaction.
22 I don't tend to think that as much -- and
23 certainly I think a lot of you have affirmed that --
24 to the degree that there is at the micro level
25 individual discriminatory decisions going on in some

1 physicians' minds that I'm not going to give this
2 person X or Y.
3 But the fact that these disparities exist
4 and that they are documented and that they seem to be
5 consistent over time, whether it's with native
6 American health care, whether it's with the Mong
7 populations or whoever, an Asian American with Latino,
8 with African American; there is, I think, as Secretary
9 Sullivan -- I call you by your highest title --
10 Secretary Sullivan --
11 COMMISSIONER GAZIANO: Maybe he thinks one
12 of his other achievements is higher.
13 (Laughter.)
14 COMMISSIONER YAKI: I just go by straight
15 protocol. That's how I was brought up.
16 But Secretary Sullivan seemed to indicate
17 that there's still something amiss, and the question
18 is now whether someone is sitting there saying, well,
19 I'm going to stick it to this group or that group, but
20 nevertheless, it comes under resources, doesn't it?
21 It comes under resource allocations, where people
22 decide to put their resources, in what neighborhoods,
23 in what clinics, in what areas of further study for
24 research.
25 And I'm just wondering from your points of

1 view where is it in that decision track that we still
2 keep coming up with the fact that there is a 60
3 percent we can't explain or attribute to this or what
4 have you. That to me is the real core of what this
5 hearing is about. Because hopefully, we're mainly
6 past the times when Secretary Sullivan doesn't want to
7 go to a room that says whites only and blacks only.
8 But there's still something wrong, and I
9 think we all recognize it, and the question is: what
10 is it? Because especially in the health care debate
11 going on right now, tremendous change is going to
12 occur. How that change will impact what we currently
13 are still struggling with right now is going to be
14 very important.
15 Doctor, and then Dr. Satel.
16 DR. PAMIES: I think you raise a good
17 point, and one of the things that I would hate for us
18 to walk away from this meeting is that somehow the
19 health care industry is somehow biased towards taking
20 care of patients, which it is not. I think the
21 overwhelming health care providers in this country try
22 to provide the best possible care and the most
23 equitable care to all of their patients.
24 And I've had the opportunity of working in
25 six different geographic regions and have met nothing

1 but some of the most ethically and morally highest
2 individuals in the country.
3 Having said that, we have to understand
4 that we all come into this profession, the health care
5 profession, with our own life experiences. Our
6 decision making is based a little bit on that life
7 experience, and we have to make judgments.
8 Some of those judgments are on our
9 interpretation, or at least our ability to figure out
10 whether or not our patients will be able to carry out
11 certain treatment plans or will be able to understand
12 certain treatment plans.
13 So some of the decisions that are made are
14 based on some of those type of findings that goes into
15 that interaction. I will say though one of the things
16 that you have to be concerned about is the average
17 interaction between a provider and a patient according
18 to various studies is between six and nine minutes,
19 and when you add the issue of language into that, it
20 creates even more complexities.
21 And having an interpreter doesn't solve
22 the issue because one of the things I was finding out
23 initially was that family members were serving as
24 interpreters, and many times the patients don't want
25 to tell their family members what's going on, and so

1 they have phone calls that you have to make informed
2 decisions or call an interpret line.
3 So even those weren't found to be
4 adequate. I think it speaks to a couple of issues.
5 One is having to do with work force diversity, and
6 this is one of the important aspects of it that I
7 think you need to look at.
8 The second thing has to do with the
9 overall poverty and educational level. Just by being
10 poor, you're likely to live six to nine years less
11 than if you were not poor. So those social
12 determinants are very, very critical.
13 But then just as a uniform answer, I think
14 we need to look at health literacy as a bigger picture
15 rather than just language because many of our patients
16 come to our offices and our facilities with not the
17 best literacy understanding, especially when you're
18 talking about medical jargon.
19 So I think we need to look at the
20 complexity of the health care industry and put the
21 resources in all of the other areas that impacts the
22 care of the individual rather than focus just on that
23 patient or provider patient information. We have to
24 utilize the entire service.
25 CHAIRMAN REYNOLDS: Commissioner Heriot.

1 COMMISSIONER GAZIANO: I think Dr. Satel
2 was going to answer.
3 CHAIRMAN REYNOLDS: Oh, sorry.
4 DR. SATEL: Quickly, I think the answer to
5 your question is that we really don't know what makes
6 up a lot of that noise, and that's why I mentioned
7 that really at that fine grained level, you really do
8 need prospective studies and actually need the
9 sociological focus.
10 That may sound touchy-feely, but there are
11 absolute ethnographic methods to standardize these
12 kinds of encounters and follow them.
13 As far as what is now referred to as the
14 cultural competency, I think that the physician is
15 clearly an important figure, but when it comes to
16 chronic illness and patients who have this lifelong
17 burden of diet and exercise and when you're poor and
18 your life is chaotic, that's not always a priority.
19 So to have a relationship with what I call the halo
20 personnel, the nurses and even the secretaries in the
21 clinic, they're often the ones that patients have some
22 of the best relationships with, but the nurses, the
23 LPNs and the PAs. Those are the folks who, again,
24 often draw from the community, too. They've the ones
25 who follow them up. They're the ones who engage them,

1 and again, with chronic care, which is so big of a
2 burden, that engagement is really huge.
3 So that's where I would focus. Now,
4 that's a local kind of thing.
5 COMMISSIONER YAKI: That makes Secretary
6 Sullivan's statistics on the shortages in those
7 categories even more severe.
8 DR. SATEL: Yes, oh, definitely. I agree.
9 CHAIRMAN REYNOLDS: Commissioner Heriot.
10 COMMISSIONER HERIOT: Thank you.
11 I just wanted to continue a bit down the
12 cultural competence area here. Obviously it seems to
13 me that cultural competence has got to be something
14 that is important.
15 On the other hand, there's a bit of a
16 tension between that and the studies of Dr. Chandra
17 and Dr. Bach. You would think that if cultural
18 competence is the root of the problem, that the
19 studies would have come out differently.
20 I mean, it sound like when minorities are
21 going to the same medical facilities that whites are
22 going to, you'd expect since those would specialize in
23 non-minority patients, that they'd be the least
24 culturally competent.
25 And yet if I'm understanding correctly,

1 where we're finding the problem is is not in that
2 area, but in the area where we'd expect greater
3 cultural competence because minorities are going to
4 those doctors more often.
5 So you know, regardless of who those
6 doctors are, they're getting repeat patients, and
7 you'd expect at least after a little while, they'd
8 become more culturally competent.
9 Is there some way that this can be pursued
10 in your studies to figure out just how important the
11 cultural competence issue is? Because it really does
12 strike me as a significant tension between what's
13 being discussed here and what we're actually getting
14 in outcomes.
15 I think it would be a travesty if we put
16 all of our efforts into developing cultural competence
17 if that's not the problem.
18 DR. CHANDRA: I guess my response to that
19 is I guess I don't think that the world is being
20 either Mechanism A or Mechanism B, and so sort of
21 there's a role for both mechanisms. When it comes to
22 things like treating heart attacks and treating
23 stroke, it seems to be more to the quality of the
24 provider, the quality of the hospital. Was this
25 hospital able to do angioplasty, rescue angioplasty

1 within 45 minutes of the patient being brought in?

2 That's going to determine survival a lot
3 more. Now, when you look at something like the
4 quality of ambulatory diabetes care, we actually do
5 see disparities within physician provider networks,
6 which might speak to a number of stories about
7 education and literacy and the potential benefit that
8 a patient perceived off a given treatment, but it
9 could also speak to cultural competency.

10 My only point was that the focus on
11 cultural competency is not going to yield the same
12 kind of benefit as the focus on raising the quality of
13 ambulatory care on the networks that serve minority
14 patients. We'll get a lot of benefit from actually
15 focusing on the clinical encounter, but it's just
16 swamped by the fact that at least when you're looking
17 at diabetes care, which is what we did, it looks like
18 again and again minority patients are, perhaps because
19 of the way they live, going to providers that are
20 having real trouble delivering high quality care.

21 DR. GRAHAM: I think the right way to kind
22 of clarify this in terms of full spectrum is that
23 there are a variety of issues at play here, and I
24 would have to, and we have to not try and find a kind
25 of unilateral or silver bullet solution, but we have

1 to understand all that is very effective.

2 So I think if you look at the data, quite
3 frankly, the spectrum of data, cultural competence is
4 very important, but I think if you look at the full
5 spectrum of data, you also find much of what Dr.
6 chandra and what Peter have published of particular
7 importance as well and begin to understand that there
8 are quality of care issues in terms of delivering
9 care, but if it were just a linear situation where it
10 was just that, I think as Dr. Chandra pointed out, it
11 wouldn't be kind of a 60-40. It would be a 100
12 percent kind of correlation.

13 So you do see where the number is really
14 spelled to a confluence of factors, and being able to
15 understand all of those factors, and understanding the
16 importance of work force diversity within all of that
17 is truly what we're trying to get at in terms of
18 understanding disparity.

19 And I think, again, some of the work that
20 Dr. Chandra and Peter have published has been
21 instrumental in understanding the role of geography,
22 but then the full spectrum of data also points to
23 other factors that are also important, and I think
24 cultural competency is one of them.

25 DR. SULLIVAN: If I might add a comment,

1 one of the major problems in health care is compliance
2 of patients with the instructions from the health
3 provider. We have a tremendous problem with lack of
4 compliance. Within the few weeks many patients, as
5 many as half may not be following their physician's
6 orders. That is often based upon not understanding
7 what the provider has said or not trusting the
8 provider.

9 And that's where cultural competence in
10 terms of better communication, better ability to
11 understand the patient and the patient's values really
12 affects the health outcome.

13 DR. BACH: May I answer that?

14 CHAIRMAN REYNOLDS: Jump in.

15 DR. BACH: I just have a couple of things.
16 the first is I want to be clear, and I'm going to
17 speak for Dr. Chandra, and he can jump in if he
18 disagrees, but you know, it's difficult for us as
19 researchers, if you will, who focus on sort of nuanced
20 distinctions like the one you just talked about, to
21 emphasize sufficiently that we still see the large
22 problem even as we drill down and eliminate possible
23 explanations.

24 And so I can speak for Amitabh and myself.
25 No one is sitting here suggesting that there aren't

1 important, large difference that are intolerable and
2 unconscionable. What we are focused on is very much
3 to your question: what is the right approach? What
4 are the most strategically effective approaches for
5 eliminating or reducing things to the extent we can
6 within our constraints?
7 And so on the top of cultural competence,
8 you are absolutely right. The correct interpretation
9 of our data, given that we detect no difference in the
10 treatment of blacks and white by individual doctors,
11 is that either the doctors are well matched to both
12 patient groups or that this cultural overlay is
13 uncorrelated, a different way of saying the same
14 thing.
15 On the topic of cultural competence, I
16 have some questions and concerns, but I find the
17 concept sort of intriguing. The first is that there
18 is a general conflation between the notion of cultural
19 competency and health literacy and linguistic
20 competency, if you will. I view those as somewhat
21 different issues.
22 The issue of health literacy challenges
23 for patients are real and well documented. Linguistic
24 gaps that patients suffer in many settings. Dr.
25 Sullivan -- sorry; Secretary Sullivan -- mentioned a

1 profound one, but those issues are often conflated
2 with the issue of cultural competency within
3 linguistic groups, and I think that that concept
4 currently lacks a sufficiently robust definition in
5 order for people like Dr. Chandra and I to study it.
6 And I also think it's uncertain, given the
7 lack of definition, how we address a cultural
8 competency shortfall if one exists. I'm not sure
9 necessarily that enriching the physician work force
10 with minorities and members of other ethnic groups,
11 which is something I'd fully support, by the way, is
12 something that would necessarily address this gap.
13 And I do think it's important. I'm a
14 physician educator. I teach at Cornell Medical
15 School. I have residents and fellows under my
16 tutelage, if you will, when I see patients, and I do
17 think it is important to appreciate that medical
18 schools are moving towards a culturally competence
19 focus within the curriculum, and we should appreciate
20 that medical education is a zero sum game.
21 And the work of Dr. Chandra and my work
22 and many other people, Dr. McGlenn (phonetic), the
23 groups at Dartmouth and the rest, have demonstrated
24 profound gaps in clinical knowledge amongst doctors,
25 and work force regulations and other features taking

1 away from an education environment. We do have to
2 appreciate that every layer of demand we put on them
3 academically to enrich their ability in one area
4 necessarily takes away from some other area.
5 And so I think we have to be very careful
6 that we don't take away the doctor's ability to read
7 an EKG in an instant, nor did they teach him to talk
8 to a patient about what's happening with their
9 myocardial infarction.
10 So that's my caution.
11 COMMISSIONER HERIOT: I've got one more
12 question. You mentioned geographical disparities. Do
13 you have any research that tells us what the
14 disparities are between not races but rural versus
15 suburban versus urban residence?
16 DR. CHANDRA: Amitabh, do you want to take
17 that one?
18 DR. CHANDRA: It's interesting. That work
19 speaks more to the enormous body of work that has come
20 out of the Dartmouth Atlas Program at Dartmouth
21 Medical School, and what you see there is a strong
22 association from northern New England states, along
23 with States like Utah and Montana, which are able to
24 deliver what the Dartmouth people call highly
25 effective care at not particularly high prices.

1 And then there's a gradient moving down in
2 certain states, including California. So for the
3 purpose of this analysis, California looks like a
4 southern state.
5 There is a rural-urban difference.
6 There's no question, and it's driven largely by a
7 handful of extraordinarily good academic medical
8 centers that are in urban areas, but it is not
9 automatically the case that urban hospitals out
10 perform rural hospitals. That's not true at all.
11 In general you also see gradients which
12 are aligned in ways that we don't completely
13 understand. There appears to be some linkage of
14 quality, and we can have a separate conversation about
15 what definition of quality I have in mind. I'm
16 thinking about the sort of highly effective care
17 that's very cheap, like you know, flu shot for elderly
18 Medicare beneficiaries, mammograms, beta blockers
19 after heart attacks.
20 If you look at those measures of quality,
21 it also appears to be the case that areas of the
22 United States that have greater specialists relative
23 to generalists -- these aren't areas of the United
24 States that have more specialists in an absolute
25 sense. It's just that the composition of the

1 physician work force is kind of biased more toward
2 specialists -- those are the areas that actually do
3 poorly in terms of delivering high quality care.
4 Now, that may or may not be causal, but
5 you know, you asked me a question about how does it
6 line up, and so there's something about the physician
7 work force. Even though given specialists may be
8 better at treating the particular condition that
9 they're trained to treat, it's possible that you have
10 some fragmentation of care that arises when you have
11 more specialists involved in the care process. But
12 that is a process that has never formally been tested.
13 CHAIRMAN REYNOLDS: Vice Chair Thernstrom.
14 VICE CHAIR THERNSTROM: In the first
15 place, thank you for coming and I apologize for being
16 late. I must come over tired. So I'm swimming
17 underwater here a little bit.
18 But I do have one remark and one question.
19 Well, I guess they're both questions.
20 The whole notion of cultural competency,
21 frankly, brothers me, and let me move to another area
22 where there are analogous arguments made, that is, in
23 the area of education, K through 12 education, and
24 there's a lot of kind of chatter in the world for
25 educational literature on the question of whether the

1 racial gap in academic achievement is due to
2 inadequate cultural competence on the part of a lot of
3 teachers.
4 And the record here is very, very clear.
5 What determines educational outcomes is the quality of
6 teachers by all the standard measures. You know, what
7 were their SAT scores? Where did they go to college?
8 What do they know? Teachers can't teach what they
9 don't know. Too many of our teachers don't know very
10 much.
11 And it has nothing to do with anything one
12 would call cultural competency or skin color, and
13 indeed, parents -- and this squares with the message
14 that one of you delivered. I can't remember which --
15 parents don't care. I mean, there's been a lot of
16 survey data on this. Parents don't care what the
17 color of their teacher is. They care about the
18 quality of their teacher in terms of the lessons that
19 are being delivered and the outcomes.
20 Does the fourth grade teacher know any
21 math? The answer is usually no, and are the children
22 learning any math?
23 And some of the best schools that I've
24 looked at in places like the South Bronx in New York,
25 just desperately poor, overwhelmingly minority places,

1 are actually run by whites, started by whites. The
2 charter schools I've been particularly interested in,
3 and none of the parents care. I mean, what they know
4 about that school is it's teaching kids.
5 The whole question of cultural competency
6 and how you define it really troubles me, and then in
7 terms of -- and I'll go back to my Bronx example -- in
8 terms of differences between care delivered in
9 different areas and the question was brought up, I
10 believe, by Commissioner Heriot of rural versus urban.
11 If you go back to my favorite school in the South
12 Bronx, there's a sign in the hallway, "Never Take a
13 Child to" whatever the local hospital is in the South
14 Bronx. Under no circumstances, and no teacher is to
15 go to that hospital.
16 So this is in one city. This is not rural
17 versus urban. This is a huge difference in quality
18 between hospitals, you know, a mile apart, and I'm not
19 sure what the reason is that you get such a
20 dysfunctional hospital in South Bronx in New York, but
21 I don't have any doubt that that message within that
22 school has been well thought out.
23 So, you know, two questions. What do we
24 mean by "cultural competency"? And you know, are we
25 really zeroing in on something that's ultimately very

1 important here?

2 And the second question, of course, is

3 when you look at that Bronx Hospital, and what's

4 going on?

5 DR. PAMIES: If I could just comment,

6 first of all, I think that there's a whole lot of

7 information and literature coming out now looking at

8 cultural competency in this culture and its impact on

9 health care and health care outcome. I call your

10 attention to at Harvard Joel Betancourt's program

11 right here in Georgetown at the National Center for --

12 VICE CHAIR THERNSTROM: And the definition

13 of cultural competency there is what?

14 DR. PAMIES: Well, I think you can narrow

15 it down into two things. Number one is respect,

16 respect for the person's culture and the impact that

17 person's culture has.

18 VICE CHAIR THERNSTROM: How do you measure

19 that?

20 DR. PAMIES: You can measure it how you

21 treat the patient, how you interact with the patient,

22 how your staff interacts with the patient. There's a

23 number of surrogates.

24 I think one of the things that we have to

25 do is to educate people on the role of culture. We

1 have a very large and growing Sudanese population in
2 my part of the state, in Nebraska, as well as growing
3 Mexican American population, and there's no question
4 that language, understanding some of the aspect of the
5 culture, making sure that just simply writing a
6 prescription or telling them what to do is going to
7 have them follow through, is really naive in the part
8 of the physician and the health care provider.
9 You have to understand who to communicate
10 with in the family structure in order for them to
11 adhere to the treatment plan.
12 VICE CHAIR THERNSTROM: Isn't that true of
13 low income white as well? I mean, I know a physician
14 who was running a clinic in a very low income white
15 area and finding exactly the same problem.
16 DR. PAMIES: Well, that's why I go back to
17 understanding and respecting those differences. It's
18 not a --
19 VICE CHAIR THERNSTROM: Well, that's
20 social class difference.
21 DR. PAMIES: Well, I'm not sure if it's
22 social class difference. It might be social class
23 difference, but it's much more broad if you look at
24 it.
25 My point was that there's an education

1 that needs to be given to the whole issue of one's
2 culture and the cultural competency and provision of
3 good care.

4 Unfortunately though, recent reports show
5 that less than half of health care academic
6 institutions actually have mandatory courses on
7 cultural competency. In fact, there has been a push
8 now in a couple of states, New Jersey being one of
9 them and a couple of other states have similar
10 statutes, to require as part of your new licensure to
11 have some continuing education on cultural competency
12 so you can understand a little bit better in terms of
13 providing the best possible care for your patients.

14 I would like to comment.

15 VICE CHAIR THERNSTROM: Can I just
16 interrupt one second?

17 Look. If I just switch back to education,
18 I think education courses in cultural competency, I
19 mean, they are ripe with ethnic and racial
20 stereotyping. They are really a disaster by and
21 large, and those courses worry me as a consequence.
22 Maybe it's not true in medicine. I know it's true in
23 education.

24 DR. GRAHAM: So let me help answer that
25 question. So I think we're hearing some good feedback

1 from Peter Bach and some of the research that they've
2 done there. I would harken this group and this
3 Commission to take a good look at the Institute of
4 medicine. For those of you who are familiar with what
5 the Institute of Medicine is and what the Institute of
6 Medicine does, they pull together a group of national
7 experts in any particular topic area to really
8 investigate and understand and be able to publish an
9 unbiased, nonpartisan view on a particular topic.
10 One of the things that the Institute of
11 Medicine report back in 2002 highlighted was the
12 importance of cultural and linguistic competency
13 obviously in health care, and I'm not a teacher. So I
14 can't speak to education, but I certainly have a
15 tremendous amount of respect for teachers and the
16 importance of work force diversity.
17 One of the other pieces of data that we
18 can certainly read for yourself or understand from
19 that very report is the importance of concordance
20 between groups in terms of understanding and being
21 able to understand particular patients.
22 Now, here is where I think we kind of get
23 to the heart of cultural competency, understanding the
24 patient and being able to understand the culture.
25 That could be a poor white patient. That could be a

1 rich white patient. That could be a Hispanic patient.
2 That could be a Russian patient. It's about
3 understanding cultural background of that patient and
4 being able to appropriate that in terms of the health
5 care setting.
6 When we're talking about cultural
7 competency, I think here we're specifically focusing
8 on race and ethnicity, but really what the broader
9 concept of cultural competency means is understanding
10 that particular patient and being able to rate that
11 patient.
12 Now, as a physician, I can tell you
13 reading EKGs are important, but patients care more
14 when you care about them and understand their stories
15 and where they are coming from, and one of the things
16 that I think, again, Dr. Sullivan alluded to in terms
17 of talking about some of the work force data is this
18 idea that we trained our work force that is reflective
19 of our nation and reflective of what our country
20 represents is important not just in terms of
21 altruistic goals, but it's important in some of the
22 health outcomes that we can point to, and I'm sure Dr.
23 Sullivan can answer some of those questions further.
24 DR. SULLIVAN: If I can add.
25 VICE CHAIR THERNSTROM: Dr. Satel had her

1 hand up.

2 CHAIRMAN REYNOLDS: Hold on. Okay. Hold
3 on, folks. Dr. Bach.

4 DR. BACH: I'm not on? Very quickly in
5 response to the EKG example, that wasn't an
6 arbitrarily chosen example. Data suggest that the
7 time to reperfusion in myocardial infarction is much
8 longer for black patients and process analyses in
9 emergency rooms and in cardiac cath labs -- pardon me
10 -- in places were people get reperfused have shown
11 that many of these steps have to do with indecision at
12 the point where data arrives, and so the reading of an
13 EKG is extraordinarily important if your interest is
14 in making sure that when blacks or other minority
15 groups have heart attacks, they get reperfused at the
16 same rate as white patients going to high performing
17 institutions.

18 So it wasn't just a throw-away. I've got
19 lots of health care things that aren't throw-aways.

20 CHAIRMAN REYNOLDS: Dr. Satel.

21 DR. SATEL: Commissioner Thernstrom is
22 right. I think that the definitions that I've seen --
23 I thought I had one in here. I'm sorry I don't -- of
24 cultural competence are mind numbingly vague, and the
25 distinctions you made between linguistic competence

1 and what I might call anthropological competence,
2 especially when you work with unacculturated
3 populations, you want to know what home remedies they
4 use. This kind of thing is extremely important.
5 At its worst, cultural competency training
6 devolves into a version of racial sensitivity training
7 with the stereotypes intact. I've always wondered how
8 I'm supposed to treat my black patients differently
9 than white ones.
10 You had mentioned though Joseph
11 Betancourt, and I have a quotation from him here which
12 I think is revealing because what he really shows is
13 kind of what you said, which is that this is about
14 universal factors in dealing with other human beings,
15 in this case within the medical setting, and it's a
16 very short quotation where he says that an enlightened
17 form of cultural competence that has "evolved from
18 implementing the principles of patient center care,
19 including exploration, empathy, responsiveness to
20 patients' needs, values and preferences."
21 And that's on an individual basis, and as
22 you said, to respect that in all individuals, but this
23 kind of group based ethos is very hard to translate
24 into a clinical setting.
25 CHAIRMAN REYNOLDS: Dr. Sullivan.

1 DR. SULLIVAN: Yes, Mr. Chairman. I'd
2 just like to -- I'm sorry. When we speak of cultural
3 competence, this is not simply racial or ethnic. A
4 good example of cultural competence is today half of
5 the medical students are women. When I went to
6 medical school, this was less than five percent. The
7 presence of women in medicine has helped to improve
8 women's health care because there are many efforts of
9 communication, trust, compliance, et cetera, that many
10 women do feel much better having a woman physician.
11 It doesn't mean that the male physician is
12 incompetent, but if the patient is reticent in
13 communicating, and we heard earlier about translators
14 using family where the family doesn't translate
15 everything, it really is a two-way street.
16 So in my view, cultural competence
17 includes that sort of thing. I think we are much
18 better off because today we have women health
19 professionals as well as men, because they can in many
20 cases when some women are reticent to share intimate
21 details of their medical care, they can do that with
22 women and they get better care.
23 That is one example of cultural
24 competence. It has nothing to do with race or
25 ethnicity.

1 CHAIRMAN REYNOLDS: Okay. At this point
2 I'd like to thank you. This has been an informative
3 exchange.
4 COMMISSIONER GAZIANO: I think
5 Commissioner Taylor.
6 CHAIRMAN REYNOLDS: Oh.
7 COMMISSIONER TAYLOR: I will be brief. I
8 know we're on a short schedule here. We have a second
9 panel.
10 I want to thank everyone for coming.
11 First of all, I want to encourage and since C-SPAN is
12 here the press to actually read the transcript and shy
13 away from taking the blunt instrument approach to this
14 issue that I see taken so often, ready to label any
15 disparity as a result of active bias or discrimination
16 because in my view it is a more complex picture, and I
17 think that has been borne out today.
18 I am concerned that what I hear that
19 minorities are clustered among a certain number of
20 physicians, and that's what I hear, and I'm not a
21 physician, but I come to this in many ways as a
22 consumer, and so I want to know why there isn't more
23 of a discussion about this clustering and why black
24 folks aren't told that the outcome in large part
25 depends upon where you're going, and by the way, we're

1 all going to the same place with a bad outcome. Why
2 isn't somebody telling us that?
3 I have a great concern about that, and you
4 know, it's not hard to document and chart. Let's put
5 it on the chart. Let's show where black folks are
6 going, other minorities are going so I can tell my
7 folks to go other places where the outcomes are
8 better.
9 So I'm going to leave on that point, and
10 if nothing else comes out, I am thrilled that that
11 came out today.
12 Thank you all for coming.
13 CHAIRMAN REYNOLDS: Okay. Well, there's
14 nothing left for me to day other than thank you very
15 much, and let's take a five-minute break and start the
16 second half.
17 (Applause.)
18 (Whereupon, the foregoing matter went off the record
19 at 11:26 a.m. and went back on the record
20 at 11:42 a.m.)
21 CHAIRMAN REYNOLDS: Very good. Let's get
22 started.
23 The speakers on the second panel will
24 discuss specific research and projects dedicated to
25 closing gaps in cardiovascular health of specific

1 population groups. The following experts will
2 participate in the second panel.
3 Dr. William Lewis is on the National
4 Steering Committee for the American Heart Association,
5 with the Guidelines Program. He is an Associate
6 Professor of Medicine at Case Western Reserve
7 University and Chief of Clinical Cardiology at Metro
8 Health Medical Center in Cleveland, Ohio.
9 Next we have Dr. Herman Taylor. In 1998,
10 Dr. Taylor arrived in Jackson, Mississippi to lead a
11 landmark Jackson study, the largest population based
12 study of heart and related diseases ever undertaken
13 involving African Americans. They study both sought
14 to answer questions about cardiovascular disease risk
15 within the black community and also provided
16 historically black colleges and universities
17 experience and large scale epidemiological research.
18 Dr. Taylor is also a founder of Heart to
19 Heart, a nonprofit organization that provides cardiac
20 surgical services for children from the developing
21 world.
22 Then we'll hear from Dr. Barbara Howard.
23 She is the senior scientist and former president of
24 MedStar Research Institute. She currently holds
25 faculty appointments in the Department of Medicine at

1 Georgetown University and the Department of
2 Biochemistry at Howard University. She is past chair
3 of the American Heart Association Council on
4 Nutrition, Physical Activity and Metabolism; past
5 chair of the Nutrition Committee of the American Heart
6 Association; and past chair of the Nutrition Study
7 Section of the National Institutes of Health.
8 Her major research interests are in
9 cardiovascular disease, particularly in relation to
10 diabetes and its occurrence in diverse ethnic groups.
11 Her current research projects include a strong heart
12 study, a multi-center study of cardiovascular disease
13 and its risk factors in American Indians, and a study
14 of the genetics of coronary artery disease in Alaskan
15 Eskimos.
16 Then finally we have Dr. Bruce Siegel, who
17 has served as co-director of the Robert Wood Johnson
18 Foundation Quality Improvement Collaborative,
19 Expecting Success, Excellence in Cardiac Care. He is
20 a research professor and a Director of the Center for
21 Health Care Equality in the Department of Health
22 Policy at the George Washington University School of
23 Public Health and Health Services.
24 At this time we will swear you in. Please
25 swear or affirm that the information that you have

1 provided and will provide is true and accurate to the
2 best of your knowledge and belief.
3 PARTICIPANTS: I do.
4 CHAIRMAN REYNOLDS: Very good. Okay.
5 Let's get started. Everyone will be limited to ten
6 minutes, more or less, and we will safe the Q&A for
7 the end. So let's start with Dr. Lewis.
8 DR. LEWIS: On behalf of the American
9 Heart Association, the American Stroke Division, and
10 the more than 22 million volunteers and supporters, I
11 want to express my appreciation for the opportunity to
12 address the U.S. Commission on Civil Rights and to
13 share information regarding our efforts to reduce
14 health disparities involving cardiovascular disease
15 and stroke.
16 Addressing health care disparities and
17 improving health care quality are high priorities for
18 the American Heart Association. Given the
19 fragmentation in the health care system, on average
20 Americans receive the care recommended by evidence
21 based guidelines only about half the time.
22 However, racial and ethnic minorities and
23 women generally receive even lower quality treatment
24 compared to their counterparts. Clearly, all
25 patients, but especially patients of color and women,

1 need higher quality care.

2 In our short time today together, I will

3 focus my discussion on the American Heart

4 Association's innovative quality improvement program

5 with the guidelines. Guidelines in cardiovascular

6 disease and stroke are published by the American Heart

7 Association and are the result of critical analysis of

8 studies on treatments proven to be beneficial to

9 patients. Adherence to these guidelines improves

10 patient outcomes. Unfortunately, the treatment of

11 cardiovascular disease is complicated, and the

12 treatment of patients must be a team effort.

13 For example, a patient with heart failure

14 may need as many as 15 Class I treatments or tests.

15 This care must be organized and coordinated.

16 In 2000, the American Heart Association

17 launched the Get With The Guidelines Program that

18 currently focuses quality improvement for three

19 conditions: coronary artery disease, heart failure

20 and stroke. The program provides multiple

21 interventions to help improve the care provided to

22 patients and helps providers adhere to evidence based

23 guidelines for treating and preventing these common

24 conditions.

25 Providers obviously remain free to

1 customize the care provided to each patient, but the
2 evidence based recommendations for these diseases
3 reflects noncontroversial aspects of care that are
4 supported by a wealth of scientific evidence.
5 The components of the Get with the
6 Guidelines Program include the following. First, a
7 Web-based patient management tool that permits real
8 time input of data regarding each patient.
9 Second, a clinical decision support
10 function which insures providers that they all
11 consider the recommended aspects of care for each
12 patient.
13 These are reminders, if you will.
14 Three, a real time benchmarking function
15 which allows individual physicians and hospitals to
16 compare their statistics with a variety of performance
17 measures against large databases providing statistical
18 averages for a variety of provider types. In some
19 cases, merely providing accurate physician level data
20 to physicians promotes improvement in adherence.
21 Four, educational materials are provided
22 for use by physicians, nurses, patients, family
23 members and other caregivers. The American Heart
24 Association provides targeted educational materials
25 for individuals from a variety of cultural backgrounds

1 written in a variety of languages.

2 Fifth, tools are often provided to help
3 providers communicate with community-based providers
4 regarding their patient's care and any recommendations
5 for follow-up. This improves the transition from the
6 hospital to the out-patient setting.

7 Sixth, this program also functions as a
8 robust clinical registry that permits further
9 scientific evaluation of the effectiveness of specific
10 intervention and the progress made in improving care,
11 including the analysis of the quality of care and
12 clinical outcomes on the basis of race, ethnicity and
13 gender.

14 Taken in combination, these elements form
15 a program that has been shown through extensive
16 scientific study to improve adherence to evidence
17 based guidelines and to reduce disparities among
18 various subgroups of patients. In particular, I will
19 highlight four observations from the clinical data in
20 the Get with the Guidelines Program.

21 First, Get with the Guidelines has
22 demonstrated substantial narrowing or elimination of
23 racial and ethnic disparities in health care services
24 provided within hospitals and upon hospital discharge
25 for patients with coronary artery disease, heart

1 failure and stroke. In fact, the clinical outcomes
2 for minority patients in hospitals participating in
3 the Get with the Guidelines Program are at least equal
4 for black and Hispanic patients in comparison to their
5 white counterparts.
6 In a preliminary analysis of 20,000
7 patients in the Get with the Guidelines heart failure
8 module, Yancy and colleagues demonstrated that African
9 American and Hispanic patients receive equitable care
10 compared to white patients. Additionally, in hospital
11 mortality was actually lower for African American
12 patients. Additional preliminary analysis of over
13 230,000 patients in the Get with the Guideline
14 coronary artery disease module demonstrated that
15 adherence to guidelines improved in both women and
16 older patients, and while slight disparities exist
17 between men versus women and older versus younger
18 patients, in baseline analysis these gaps narrowed
19 over time.
20 Number two, Get with the Guidelines has
21 enhanced the transparency of issues involving
22 disparities in health care on the basis of race,
23 ethnicity and gender. At the microscopic level, these
24 data help individual physicians and hospitals address
25 disparities in their own care on a case-by-case basis.

1 At the macroscopic level, the Get With the
2 Guidelines clinical registry is now providing a rich
3 source of data that highlights ongoing needs to
4 address disparities in care. This data on health care
5 disparities among patients with coronary artery
6 disease, heart failure and stroke is being reported in
7 the new American Heart Association 2009 statistical
8 update and will be published in future articles and
9 updates. Before we can eliminate these health care
10 disparities, we must first measure and highlight them.
11 Third, Get With the Guidelines has
12 permitted the study of health care disparities
13 involving additional interventions and technologies
14 beyond the core performance measures originally
15 captured in this registry. For example, this registry
16 has been used to study and identify significant
17 disparities in the use of cardiac devices, such as re-
18 synchronization therapy and implantable
19 defibrillators.
20 In a study of nearly 34,000 patients
21 admitted to 228 hospitals between 2005 and 2007, using
22 the Get with the Guidelines heart failure program, the
23 use of cardiac re-synchronization or CRT therapy was
24 analyzed. One of the major findings of this study was
25 that CRT use varies by age, race, hospital site, and

1 geographic location. CRT use was less common in black
2 patients compared with white patients, and this
3 disparity is particularly concerning because African
4 American patients have a higher incidence of non-
5 ischemic cardiomyopathy which has been shown to be
6 associated with greater rates of response to this CRT
7 therapy.

8 Additionally, African American patients
9 are more likely to develop advanced symptomatic heart
10 failure and have a higher rate of rehospitalization.

11 Fourth, participation in the Get with the
12 Guidelines program has been embraced by many hospitals
13 throughout the United States. These hospitals value
14 the significant benefits of participating in this
15 program. Currently there are 1,525 hospitals using
16 the Get With the Guideline programs. The largest
17 number of these hospitals, 1,300, participate in the
18 stroke program. Approximately 1,000 hospitals
19 participate in coronary artery disease and heart
20 failure programs, and this is about a third of all
21 hospitals in the United States.

22 Participating hospitals are a diverse
23 group of large, small, academic, community and rural
24 and urban hospitals located in every state.

25 In summary, at the American Heart

1 Association we believe that each person in the United
2 States should always receive high quality care
3 regardless of race, ethnicity, gender or other
4 factors, and that the promotion of evidence based
5 clinical guidelines will help insure that all patients
6 receive appropriate care.
7 The use of continuous quality improvement
8 tools that include decision support, such as that in
9 Get with the Guidelines, help to translate practice
10 guidelines into the consistent use at the patient
11 bedside and minimize clinician bias that can lead to
12 disparities.
13 As has been demonstrated by research, the
14 Get with the Guidelines program is a powerful tool to
15 improve patient care at the bedside. Using the
16 registry function of this program, we are able to
17 bring greater transparency to the issues of health
18 care disparities in cardiovascular disease and stroke
19 with meaningful scientific evidence from high impact
20 publications using the Get with the Guidelines
21 registry data.
22 As we extend our focus on quality, the
23 opportunity exists to use quality as a gender blind,
24 race and ethnicity blind, and age blind strategy to
25 reduce treatment gaps between groups of patients and

1 optimize outcomes for patients with cardiovascular
2 disease and stroke.
3 I thank you for inviting me to present to
4 the Commission and we'll entertain the questions that
5 you have.
6 Thank you.
7 CHAIRMAN REYNOLDS: Thank you, Dr. Lewis.
8 Dr. Taylor.
9 DR. TAYLOR: Thank you very much and thank
10 you for the invitation to be here today, and I thank
11 you on behalf of Jackson State University, Tougaloo
12 College and University of Mississippi Medical Center,
13 who are the home for the Jackson heart study.
14 I do have slides. They will illustrate
15 points, but if you can't turn around and look at them,
16 I think the text will cover my points adequately.
17 Since the larger terrain of the topic
18 health disparities has been well covered by several
19 speakers on both panels, I'll restrict my remarks to
20 specific results of my group's research principally
21 from the Jackson heart study and some reasonable
22 implications of that research.
23 The Jackson heart study, as has been said
24 is the largest single site longitudinal study of
25 African American cardiovascular health undertaken thus

1 far and sponsored by the National Institutes of
2 health. Our study is unique in its capacity to
3 examine psychosocial, nutritional, metabolic, and
4 genetic influences on cardiovascular disease. We will
5 also be able to compare our data with suitably
6 designed studies in other ethnic groups.
7 The Jackson heart study, it should be
8 remembered through my presentation, is a work in
9 progress. So much of what I say will describe early
10 results. Also it should be noted that the Jackson
11 heart study does not treat its participants. It is an
12 observations longitudinal study.
13 To tell you what I will be telling you, my
14 main points will be the following:
15 One, early results from our study
16 dramatically confirm the high risk for cardiovascular
17 disease among African Americans in the United States,
18 particularly in Jackson, Mississippi. In the specific
19 instance of hypertension, a leading cardiovascular
20 risk factor, increased levels of awareness, treatment
21 and control of hypertension have been achieved within
22 the Jackson African American community.
23 The improvement, number three, in
24 treatment and control of hypertension is encouraging.
25 However, because of the much higher occurrence of

1 hypertension and other CVD risks compared to other
2 groups in the United States, disparities in
3 hypertension related morbidity and mortality will
4 persist, and for efforts to prevent hypertension and
5 these other cardiovascular risk factors are critical
6 to a strategy to eliminate disparities in
7 cardiovascular health.
8 Next slide, please.
9 We recently compared the rates of obesity
10 of all -- next slide -- of the all African American
11 Jackson heart study with rates in the Framingham heart
12 study, a long running and well renown study of
13 cardiovascular disease in a white American population.
14 Jackson heart participants were twice as likely to be
15 obese. Severe obesity, that is, obesity with a BMI
16 greater than 35, was almost three times as high in the
17 all black study, ours, the Jackson heart study.
18 The data shown are for younger people, but
19 the older group had similar patterns.
20 Next slide
21 It's interesting to note -- and this is a
22 complex slide, but I will tell you what it says in
23 particular. Hypertension and diabetes increased with
24 each increase in BMI, which is basically weight
25 adjusted for how tall you are, in both Jackson and

1 Framingham.
2 It's also of interest that among normal
3 weight participants, the percentage of hypertension
4 was more than three and a half times higher in Jackson
5 than in whites in Framingham, and the ratio of
6 diabetes was six times higher in blacks of normal
7 weight.
8 Next slide.
9 The metabolic syndrome is a cluster of
10 risks that is gaining increased attention. These risk
11 factors tend to cluster together, and they increase
12 the risk of diabetes, a major epidemic in America and
13 cardiovascular disease. It is diagnosed when three or
14 more metabolic disorders out of the list of five occur
15 simultaneously.
16 Our analyses demonstrate that, first,
17 extraordinarily high metabolic syndrome prevalence
18 exists among our cohort. Among those age 35 to 84,
19 nearly half of the women and over a third of men have
20 metabolic syndrome. The national average is about 25
21 percent. These rates obviously suggest continued
22 future differences in diabetes and CVD. Notably the
23 prevalence of metabolic significantly declines with
24 higher household income and educational attainment.
25 Next slide, please.

1 Hypertension is likely the single most
2 treatable and controllable risk factor for
3 cardiovascular disease. However, controlling
4 hypertension, which we define operationally as
5 reducing blood pressure to less than 140 over 90, is a
6 problem for many Americans, particularly African
7 Americans. There are national reports of widening
8 disparities in the success of hypertension control
9 between blacks and whites.
10 Control rates are much less than desirable
11 on the national level for African Americans, and
12 actually this is seen in the future in the text.
13 Nationwide while 70 percent of whites who are treated
14 for hypertension gain good control, only about half of
15 African Americans do.
16 Data from the Jackson heart study on the
17 slide demonstrate data that are in distinct contrast
18 to the national data. The percentage of African
19 Americans who have hypertension who are under control
20 in our study is exactly the same as the national
21 average, which is about 70 percent.
22 Therefore, national data show a persistent
23 gap in hypertensive control rates. However, the
24 Jackson heart study carries a hopeful message that
25 under some circumstances equal rates of hypertensive

1 control are possible for blacks and white.
2 But is attaining equally good hypertension
3 control rates between the races enough to eliminate
4 disparities in hypertension related disease and death
5 between these two groups?
6 Despite favorable control rates in
7 Jackson, high levels of cardiovascular disease and
8 death persists among blacks. The latest surveillance
9 data are distressing. The incidence of heart attacks
10 during 2006 showed a 65 percent higher rate among
11 African American men than whites. Among black women
12 there was a threefold increase in the number of heart
13 attacks during that year, and this data is from the
14 most recent survey of a sister study of the Jackson
15 heart study called Eric.
16 Stroke rates for blacks were more than
17 double for whites. These data are occurring in a city
18 which has the Jackson heart study as a reflection of
19 what's going on in the city where hypertension control
20 rates are actually as good as the national average.
21 The disparity persist and these data suggest among
22 other things that major gaps can remain between the
23 groups despite the effective treatment of a most
24 important cause of disease.
25 One of the messages of such data is that

1 good health care alone will not resolve health
2 disparities. Health care most often happens after
3 something goes wrong or a high risk situation
4 manifests itself, whether that situation is an
5 elevation in cholesterol or a catastrophic heart
6 attack.
7 We most often discuss disparity solutions
8 by focusing on improving care for established disease,
9 and this is critically important. It cannot be over
10 emphasized.
11 However, what I'm emphasizing here is that
12 we need to focus on understanding and addressing more
13 upstream issues. We need to answer the question why
14 do blacks have more hypertension, diabetes, obesity,
15 those things that set the stage for the disparity.
16 When we ask and answer these questions and
17 apply the appropriate preventive interventions, we
18 will have a greater chance of eliminating disparities
19 in actual health, improvement in the quality and
20 availability for care for African Americans is
21 absolutely necessary, but not sufficient to raise
22 health standards to the level of the majority
23 population. We must address more fundamental causes
24 of disparate health status.
25 In short, a much more aggressive approach

1 and clear attention to prevention must be, will be
2 required if there is to be an elimination of
3 disparities in health as is called for in Healthy
4 People 2010. Much of the expertise in these fields
5 lies in the fields of nutrition, behavior, psychology,
6 and social epidemiology, and some of that was covered
7 in this morning's panel, and Drs. Pamies, Chandra and
8 Satel all in turn addressed these issues, but just to
9 briefly review, issues surrounding the food supply
10 characteristics, the amount of calories that the
11 average American takes in, particularly African
12 Americans and other minorities, directly tie into
13 health status. Salt intake, dependence on fast foods
14 and other issues regarding eating outside the home;
15 physical activity levels at school, workplace, in the
16 neighborhood, and to what extent does the built
17 environment encourage optimal levels of physical
18 activity?
19 And finally, the burden of persistent
20 discrimination either in a personal, institutional of
21 environmental.
22 In conclusion, the bottom line, I believe,
23 is that in order to eliminate disparities in
24 hypertension related death and disease, we must
25 provide equitable treatment across racial and

1 socioeconomic lines and we must decrease the number of
2 African American that become hypertensive in the first
3 place. If we are to reduce or eliminate the
4 disparities in cardiovascular disease in general, we
5 must educe the number of persons who develop the list
6 of risk factors discussed at the beginning of this
7 presentation.
8 Our research and that of others strongly
9 suggest that a multi-pronged approach is imperative.
10 One, equalization of awareness access and appropriate
11 utilization of care; two, investment in research to
12 further define the basis of higher risk factor levels
13 among ethnic minorities; and three, use of prevention
14 efforts that go beyond health care institutions into
15 the societal milieu; these are critical to resolving
16 America's ethnic health disparities.
17 Health equity cannot be achieved without
18 balanced attention to risk prevention and treatment.
19 CHAIRMAN REYNOLDS: Thank you, Dr. Taylor.
20 Dr. Howard.
21 DR. HOWARD: Thank you.
22 Mr. Chairman and members of the
23 Commission, I am honored to be invited here to talk to
24 you about the project that I've been able to be
25 involved with in the American Indian communities. I

1 hope that what I'm going to tell you will shed some
2 light on the issue that you are confronting and
3 perhaps strategies to begin to deal with it.
4 We started 22 years ago with a project
5 called the Strong Heart Study that was funded by the
6 National Heart, Lung and Blood Institute, and we have
7 been working all of this time under some basic tenets
8 that I think are relevant here.
9 One is that we have worked in full
10 partnership with the communities, receiving input at
11 all levels for our activities and with immediate
12 feedback to the communities of the results so that the
13 data would help for education about health problems
14 and translation into community programs.
15 The second main goal was that all of our
16 staff and more and more of our investigators are
17 American Indian. This is a group where there has been
18 a lag in education, as was discussed previously in
19 terms of health care. Thirty-two years ago there were
20 only 25 or 30 American Indian physicians. Now there
21 are many, many more, and I'm happy to say we've got 31
22 total American Indian physicians and scientists who
23 worked on this project, and I can assure you that many
24 of them will be happy to work with you in your
25 deliberations as you continue.

1 The first project, the Strong Heart Study,
2 is a population based survey. As it was mentioned
3 before about Census data, there is much diversity in
4 American Indian communities. We've worked in 14 of
5 them, but within each community, these communities
6 have Census data. So we have a population based
7 sample, and we were able to provide some solid data on
8 incidence rates of major chronic diseases, and we were
9 the first ones that actually pointed out to a lot of
10 people's surprise that the rates of cardiovascular
11 disease, both heart attacks and strokes, are higher
12 than the rest of the U.S. Actually the stroke was
13 higher than the data for blacks in the U.S. from
14 NHANES, anyway.
15 So that I think that the paradigm that's
16 occurred in this population is a lack of really
17 awareness on the part of providers about the
18 existences of some of the chronic diseases.
19 Now, you might be wondering. This
20 population, of course, is much smaller than African
21 American and Hispanic and Asians in this country, but
22 the data we have have turned out to be extremely
23 relevant to most of our ethnic minority groups
24 because they have shown what I call an epidemic of
25 obesity then leading to an epidemic of diabetes, then

1 leading to an epidemic of cardiovascular disease, and
2 that is happening all throughout the U.S. and the
3 world now, and so that is why I believe these data are
4 relevant.
5 And as I said, we worked closely with the
6 communities. As soon as we began to discover that
7 these rates were high, the health care providers did
8 become active and put more attention into being aware
9 of the possibility of cardiovascular events. Also our
10 data that pointed to a number of key risk factors like
11 cholesterol and blood pressure that people used to
12 think were low in these communities and we didn't have
13 to worry about them, now have become a major focus.
14 The second project stemmed out of the
15 first one, and it was actually a clinical trial funded
16 by the NIH, and that was to really test blood pressure
17 in lipid lowering, cholesterol lowering strategies and
18 their potential effect preventing, the cardiovascular
19 disease that was occurring in the people with
20 diabetes.
21 And that did show a number of things,
22 first, that we were able to reach and maintain
23 targets. Now, you heard from the previous speakers
24 that one of the problems is we know what should be
25 done about controlling blood pressure and cholesterol,

1 but very few patients in this country are reaching the
2 goals they should in all ethnic groups, but to more
3 extent in minority groups.
4 We set up a system in very rural settings
5 were very primary care, not your ideal medical centers
6 or settings for step-wise algorithms to actually treat
7 the cholesterol and blood pressure and bring it to
8 targets, and we trained non-physician providers to
9 deliver these algorithms, and they, of course, had the
10 back-up of appropriate specialists when needed, which
11 wasn't all that often.
12 And through that we were able to reach not
13 only standard targets for LDL, cholesterol and blood
14 pressure, but more aggressive ones because that's what
15 our study was doing.
16 But it's not the results of this study
17 that are as important to you as, I think, knowing that
18 we're never going to have enough specialists and high
19 level medical providers for all of the diverse rural
20 and inner city areas that we've got to treat, but by
21 developing appropriate algorithms and guidelines and
22 strategies, and by training the care providers who
23 come from those communities, one can achieve a lot in
24 terms of care.
25 The third thing we've been doing is

1 concentrating on younger people with what we call our
2 family study, and this, I think, is the most sobering
3 data we've come up with yet, and this is occurring in
4 other ethnic groups as well. There's a spiral. As
5 obesity and diabetes occur in a population, they begin
6 to occur at younger ages, and as you know, we have a
7 great concern with obesity levels in our young people,
8 even in the schools, and this is true in Indian
9 communities, and in fact, then we are seeing
10 occurrence of diabetes and other cardiovascular risk
11 factors like hypertension and abnormalities in cardiac
12 function that we're able to measure at a much earlier
13 age.
14 So I think the communities we work with
15 are beginning to focus more and more on the young
16 people in terms of trying to prevent this spiral that
17 I've talked about of obesity, diabetes, cardiovascular
18 disease, and so we've, of course, been giving our data
19 to them as we get it in that effort.
20 We also have more investigators, and they
21 actually happen to be our American Indian
22 investigators, focused on the psychosocial aspects of
23 what is leading to lack of proper prevention
24 activities on the part of the people, leading a
25 healthier life style and then taking care of

1 themselves once disease is diagnosed. We are finding
2 high levels of depression and other psychological
3 measures that clearly impede a person's ability to
4 take care of themselves.
5 And sometimes these are not severe levels
6 that would require a person prescribing major drugs
7 for depression or other psychosocial disorders, but
8 paying attention to the things that are bothering
9 people and the other aspects of their life, finding
10 that that in turn can lead to people taking better
11 care of themselves.
12 So in summary, my message is you need the
13 science to get the high quality data so that you can
14 be sure about what diseases we have and don't have in
15 each ethnic group in this increasingly diverse
16 country, and then secondly I think just like with
17 research, any kind of care development, any paradigms
18 or changes you make need to be done within the
19 community and with full community education so they
20 understand what the problem is and what changes may be
21 possible to improve their health.
22 And then the importance of identifying
23 barriers to adherence to prevention and treatment like
24 psychosocial barriers, as well as all of the economic
25 ones that were discussed earlier today.

1 So I thank you again for the time and
2 we'll be happy to answer questions.
3 CHAIRMAN REYNOLDS: Dr. Howard, thank you.
4 Dr. Siegel.
5 DR. SIEGEL: Thank you, Commissioners for
6 inviting us all here today. I'm delighted to be here.
7 I realize I'm in a difficult position. I'm probably
8 the one thing standing between everybody and lunch.
9 So I'll try to exercise some brevity. I will be using
10 slides today and will use some number of them.
11 I am here to talk to you today about the
12 Expecting Success hospital collaborative, which was
13 focused on reducing and eliminating disparities in
14 health care, specifically cardiovascular care.
15 If I could have the next slide, please,
16 next bullet.
17 Expecting Success was funded by the Robert
18 Wood Johnson Foundation. It was the first ever
19 collaborative undertaking by a group of hospitals to
20 eliminate disparities.
21 Next.
22 It was built on the Institute of
23 Medicine's unequal treatment.
24 You can click through actually some more,
25 which is evidence based care to promote equity and

1 reduce disparity. We heard earlier about the IOM, the
2 National Academy of Sciences. Its landmark report in
3 2002 really highlighted the issues around health care
4 disparities and the fact that every American
5 regardless of race got high quality care at the right
6 place and the right time we shouldn't have disparities
7 in care.

8 Next bullet.

9 Expecting Success was focused on improving
10 cardiac care for African Americans and Latinos. We
11 focused on this population because they are the
12 largest minority populations, and we certainly
13 realized there were disparities and issues for others.

14 Next.

15 And we focused on heart attack and heart
16 failures specifically, the most common and largest
17 diagnoses for heart disease and areas where we know
18 there are large disparities in both health as well as
19 health care for minorities.

20 Next.

21 The major pieces of it were threefold.
22 The first was a standardized collection of patient
23 race, ethnicity and language data. I'll talk more
24 about that using a new tool kit that's available from
25 the Health Research and Education Trust.

1 Secondly was using quality improvement
2 techniques in these hospitals to raise the bar on
3 quality.
4 And third, which was perhaps the most, I
5 guess, dramatic innovation, was on a monthly basis to
6 measure quality measures that hospitals are familiar
7 with, but to do it by patient race, ethnicity, and
8 language, to actually compare within the hospital the
9 care given to different populations.
10 Next slide.
11 These are the ten hospitals who
12 participated in the Expecting Success collaborative.
13 They were chosen through a competitive process. I
14 should mention that Herman Taylor was one of our
15 reviewers in our National Advisory Committee. One
16 hundred and twenty-two hospitals applied.
17 They were a wide range of places. Del Sol
18 Medical Center is an investor-owned hospital in El
19 Paso, Texas, a community hospital with 80 percent
20 Latino patients. We had the Washington Hospital
21 Center here in D.C., which is one of the largest
22 providers of cardiac care primarily to blacks. We had
23 Duke University Hospital, a major academic health
24 center, a wide range of places so we could show that
25 this could be done in a wide range of places across

1 the country.
2 Next slide.
3 The first step, and this is a key element,
4 was collecting accurate data on patient race,
5 ethnicity and language. Why is this important? Most
6 hospitals in America collect this data. They do it in
7 a relatively haphazard fashion. Most of them don't
8 believe it's reliable. They use different categories
9 even within their own organization sometimes, how to
10 categorize patients. It really is a very sort of
11 random event.
12 And if you're really going to measure
13 quality of different populations, you need to know who
14 belongs to what populations in order to make
15 comparisons.
16 One of the first key positives in these
17 ten hospitals was to no longer look at a patient and
18 decide who they were. Instead you ask them are you
19 Black, are you White, are you Asian? What do you
20 consider yourself? Are you Latino, are you not a
21 Latino? No more eyeballing instead you ask them for
22 the patient’s to report to the major change to the
23 practice at these hospitals that would be at most
24 hospitals. This put a lot of anxiety in these
25 organizations, anxiety as to whether registration

1 staff would want to ask these questions and would feel
2 comfortable and whether there would be issues with the
3 community being asked these questions. I can say in
4 retrospect a much greater issue in terms of anxiety
5 than it was in actual implementation. All of these
6 hospitals were able to do this. They educated their
7 staff. They educated their community. I'll talk in a
8 second about how they did that, and were able to
9 successfully collect this data with really a minimum
10 of push-back.

11 These hospitals now know who their
12 patients are. Let me give you one example. We had
13 one hospital whom we visited and early on in the
14 project told us, you know, "Our population is really
15 black and white. We know who people are here in our
16 community. We don't have many issues around Latinos
17 in our community because there are so few."

18 As they went through this process and
19 started asking their patients, they realized that they
20 were registering 500 Spanish speaking patients per
21 month in their hospitals. If you don't ask the
22 question, you're not going to know.

23 Next slide, please.

24 This is an example of one of the tools
25 that we developed in the collaborative. This was a

1 poster that was also used as tent cards in the
2 hospital cafeterias, this one in Spanish basically
3 saying we ask because it matters to us. You know, why
4 are you asking these questions? "Preguntamos porque
5 nos importa," and it was really part of the campaign
6 trying to educate patients and people working in
7 hospitals said why are we asking questions about race
8 and ethnicity. It wasn't because we were trying to
9 exclude somebody, but because we wanted to provide the
10 highest level of care for all the people in these
11 organizations.
12 Next slide.
13 We also had a focus on quality here. We
14 wanted to raise the bar on quality for all the
15 patients in these hospitals, not just the one group.
16 The three themes were making sure that people got
17 evidence based care; so, for instance, making sure
18 there were standard orders in the hospitals so that
19 when a patient was admitted with a condition, they got
20 everything they should get.
21 The second was redesigning some processes
22 like making sure that patients who were admitted with
23 a heart attack were quickly taken to the lab for
24 reperfusion, as was mentioned earlier.
25 And third, working on a discharge process.

These patients are going home, almost all of them. What's going to happen to them after they walk out the door? And so educating them on how to take care of themselves is a critical piece.

Next slide.

This gives you an example of one of our hospitals. The disparities they saw frankly shocked them early on. They found that their Hispanic patients were lagging far behind their non-Hispanic patients in terms of percent of them getting discharge instructions before they went home, which is a key quality indicator.

By knowing this and then really using quality improvement techniques, they closed that gap over the course of the project. Everybody gets discharge instructions at this hospital.

Next slide.

Another critical thing we looked at was how patients fared across all the organizations when you lump the data together, and this shows the disparities between patients getting all of the recommended heart attack care they should have gotten.

At the beginning of the project it was about an 11 point gap between black and white patients; at the end of the project, about a seven

1 point gap. Everybody got better. The gap got smaller
2 but still persisted.
3 Next slide.
4 When we looked at Hispanic versus non-
5 Hispanics on this measure, we saw a somewhat different
6 picture. Again, Hispanic patients lagged in our
7 hospitals behind non-Hispanic patients. By the end of
8 the collaborative, everybody had improved and the gap
9 had been narrowed considerably from about 11 percent
10 to about a two percent gap.
11 Next slide.
12 When we looked at people getting heart
13 failure care, again, blacks versus whites, we saw a
14 gap of about six percent with blacks lagging. By the
15 end that rate had improved, but that gap persisted.
16 And finally on these slides -- next slide
17 -- when we looked at heart failure care for Hispanics
18 versus non-Hispanics, we saw quite a significant gap
19 initially, and that gap was essentially eliminated by
20 the end.
21 Now, let take the point and just mention
22 one thing about these slides. These differences we
23 see here weren't because necessarily these hospitals,
24 you know, were treating blacks and whites differently
25 or Hispanics and non-Hispanics differently in their

1 hospital. It was also because the care at hospitals
2 that are predominantly black or Latino was not where
3 it should be, and by raising the bar for all the
4 patients in these hospitals, you saw some of these
5 gaps narrow.
6 Next slide.
7 Bottom line, these gaps can be closed.
8 High minority hospitals can dramatically improve care.
9 This is a big issue for many people. We don't think
10 this cannot happen. We think it can happen.
11 We think it also forces these
12 organizations through a journal of self-examination.
13 What's going on at my institution when I have
14 disparities? Is it about bias? Is it about what's
15 going on in my emergency room? What are the factors
16 that caused this?
17 And finally, yeah, we improved care within
18 hospitals, and we're very proud of that, but what
19 happens after these patients go home? That's really
20 the great unknown to us because many of these patients
21 are going home to nothing at all in terms of any kind
22 of organized system of care, and we are very concerned
23 that even though we have been closing disparity of
24 care in the hospitals, the disparities open up a
25 yawning chasm after they go home.

1 Next slide.

2 A couple other things. This is a frequent
3 issue we're asked about. This kind of data collection
4 on a patient's race, ethnicity and language is legal.
5 As a matter of fact, at last count, about 22
6 hospitals now mandate this. Massachusetts has the
7 most aggressive mandate in this area.

8 Medicare is supposed to start collecting
9 this data within the next two years under a law that
10 was passed last year. We're waiting to see what the
11 Secretary does about regulations.

12 It is legal to report this data for
13 quality improvement purposes, and the only exception
14 is that there are some states where this data cannot
15 be collected at the time of application for insurance
16 coverage. That's the one caveat here. For the most
17 part, this is very legal and in some states now a
18 mandated process.

19 Finally, last slide, the stimulus bill of
20 2009 has started to talk about some of these issues.
21 So HIT systems, there will be computer systems in
22 hospitals. They will be eligible for stimulus
23 funding. We're going to have to start addressing the
24 issue of how they collect patient race, ethnicity and
25 language data and use it for quality. It is actually

1 written in the bill. We await what the different
2 committees that have been set up under the stimulus
3 bill will do to actually implement this, but these
4 things have now really come of age.
5 Again, many thanks. I appreciate it and
6 look forward to your questions.
7 CHAIRMAN REYNOLDS: Okay. Well, I'd like
8 to thank all of the panelists. You lived up to my
9 expectations that I delivered during the break. At
10 this point I'd like to open up the floor for
11 questions.
12 And since Dr. Lewis has an engagement,
13 let's direct our questions toward him initially.
14 I was under the impression that you had a
15 flight to catch.
16 DR. LEWIS: Well, I do, but I think I'm
17 good.
18 CHAIRMAN REYNOLDS: Okay. Well, if that's
19 the case, then questions?
20 (No response.)
21 CHAIRMAN REYNOLDS: Okay, good. Let the
22 chairman start.
23 What's going on in urban hospitals? In
24 the first panel and with you, I have heard several
25 comments that point to a quality issue in urban

1 hospitals. Are we talking about is it due to the way
2 it's financed? Is it the credentials of the doctors
3 and the training of the doctors that work at these
4 hospitals?
5 I suspect that it's going to be a
6 combination of factors, but I'd like to hear from you
7 folks.
8 DR. SIEGEL: I've been offered up, I
9 think, as the first respondent.
10 I think there's a number of things going
11 on, and I don't think it's uniform. I think there are
12 some urban hospitals treating large numbers of
13 minority patients, some public hospitals doing a great
14 job, and if you look at the information they generate,
15 they're as good as anybody in the country.
16 However, that's not uniformly the case,
17 and there are gaps. I think there's a couple of
18 things going on here. I think part of it is where
19 those organizations are being sufficiently supported
20 financially and have the wherewithal to have the
21 systems in place to provide high quality care and the
22 training and the like.
23 I also think it's a question of
24 leadership. Quality is really in many ways about the
25 leadership of the organization taking it seriously,

1 and I don't think the leadership is necessarily worse
2 in some of these organizations, but I think sometimes
3 the leadership situation is more unstable and because
4 of financial issues you may see higher turnover. You
5 may see people coming and going. You see challenges
6 that the organization has which leads to turnover at
7 little more senior levels sometimes and even sometimes
8 perhaps in the more junior levels as well, and that
9 goes back to resources. And that can, I think, have a
10 profound impact on the quality that these places are
11 able to provide.
12 CHAIRMAN REYNOLDS: Anyone else like to?
13 DR. LEWIS: So, again, with the guidelines
14 program we don't see tremendous differences between
15 urban and rural hospitals, and the reason is likely
16 because those hospitals are committed to quality care
17 when they actually enroll in the program. So it's a
18 little bit hard for me to comment in that regard.
19 CHAIRMAN REYNOLDS: Okay.
20 DR. TAYLOR: And I tend to agree with what
21 Bruce has said, that the environment for some big
22 inner city hospitals is a very busy one. People feel
23 a lot of time pressure. The language issues have
24 already been alluded to and that there is possibly
25 much greater ethnic and language diversity in the

1 inner city hospitals.
2 Resources are an issue, and I think all
3 taken together it can be a bit of a perfect storm to
4 create a situation where an individual's care might be
5 suboptimal.
6 CHAIRMAN REYNOLDS: Dr. Howard.
7 DR. HOWARD: I think I can add to this not
8 from my work in the Indian communities, but from my
9 role when I was part of the MedStar Hospital System
10 leadership, and that is at least for the MedStar
11 hospitals in the cities, the ones that are having
12 trouble are the ones where there's not enough local
13 clinical care for the under served. So they are
14 presenting to the emergency room for things that you
15 or I would go to our physician provider to get taken
16 care of.
17 That, given the funding situation, creates
18 a load on these hospitals that trickles into really
19 all of these functions.
20 CHAIRMAN REYNOLDS: Commissioner Heriot,
21 did you have a question?
22 COMMISSIONER HERIOT: I'm still thinking.
23 CHAIRMAN REYNOLDS: Okay. Commissioner
24 Gaziano?
25 COMMISSIONER GAZIANO: And this relates

1 both to Commissioner Taylor's comments at the end of
2 the last panel and, I think, your comment, Dr. Lewis,
3 that those institutions that commit themselves to high
4 quality can make some big improvements.
5 What can we do or what -- I don't know --
6 can public policy makers do -- I'm not sure
7 Commissioners are on the right Commission -- to
8 advertise which institutions are doing a great job,
9 which need improvement, which you should keep your
10 relatives away from?
11 And the hope would be that, first, more
12 institutions would have the incentive to join some of
13 these innovative programs that several of you have
14 been talking about, and others is that our loved ones
15 will stay away from them. Maybe some of them will go
16 away.
17 This is really for any of you all on the
18 panel. What role is there in just educating? I can
19 imagine some friction, some cross-purposes in, you
20 know, institutions not wanting the success rate to be
21 exposed, but it's an important consumer information
22 point to make.
23 DR. LEWIS: So that information is
24 available. So you go to, you know, the CMS Website on
25 HospitalCompare, and you can look at what your

1 hospital's compliance rate with various parameters
2 are, and in this month you'll be able to look up 30-
3 day mortality rates for heart attack care and for
4 heart failure care, as well as readmission rates.
5 Those data are going to be available.
6 So there is a way for people who are
7 interested in how their health care will happen. They
8 can look that up. The problem is that when you're
9 developing chest pain in the middle of the night you
10 don't go to the Website and say, "Where should I go?"
11 So the idea behind these Websites is that
12 hospitals will bring themselves up. They're
13 embarrassed by looking bad, and they want to do
14 things, and that's why they themselves was to get
15 involved in programs such as these.
16 COMMISSIONER GAZIANO: Well, maybe we can
17 help draw attention to that data. How long has it
18 been generally available?
19 DR. LEWIS: So we originally did some
20 analysis of the first two quarters of 2004. So there
21 have been data now for about five years.
22 COMMISSIONER YAKI: There are actually a
23 number of consumer groups who actually do put that out
24 there. I have seen in California a lot of times press
25 releases have come out to talk about which hospitals

1 have the best survival rate for cardiac care.
2 COMMISSIONER GAZIANO: I've heard some of
3 the advertisements locally.
4 COMMISSIONER YAKI: They're not ads.
5 They're actually news stories that come out with the
6 rankings.
7 COMMISSIONER GAZIANO: Sure.
8 CHAIRMAN REYNOLDS: Dr. Siegel.
9 DR. SIEGEL: I would just add to that I
10 think that it is great that this information is out
11 there now, and a lot is through Medicare and the
12 HospitalCompare Website. Most consumers don't know
13 about it, and I would argue that the Website has not
14 been sufficiently promoted, nor is it as user friendly
15 as it might be. So it's not easy to navigate.
16 And I think about my mother who is 93
17 years old and is a user of hospital services. I don't
18 think she would have the ability to go there and find
19 information that could help her, you know form an
20 informed choice.
21 So I think in the policy arena we have to
22 really push to make this data not just present, but
23 really available and, you know, user friendly,
24 although I agree part of the process here is also just
25 having the hospital themselves look at it and know

1 they may not look that good and sort of react to that
2 and improve their own care.
3 The second thing I might add to
4 Commissioner Yaki's comment is that there is a lot of
5 data out there now on these sorts of issues not just
6 from the federal government, and to some degree that's
7 good, but it's a double-edged sword. Some of it you
8 don't know where it comes from. You don't know what
9 sort of black box was used to make these comparisons.
10 It's a very confusing landscape, and I think it needs
11 some clarity in addition to just getting the word out
12 there that it's not available.
13 DR. TAYLOR: And I think, too, that over
14 reliance on Internet based information may be an
15 issue. I think there's evidence of a shrinking
16 digital divide between the haves and have nots, but a
17 lot of people that we're most concerned about raising
18 their health status are also the very same individuals
19 who may have impaired access to Internet based
20 information.
21 DR. HOWARD: And there are two scenarios.
22 The hospital is there when there is an acute event or
23 problem, but the things that are going to really in
24 the long run improve the amount of chronic disease are
25 the out-patient services that do diagnostic and

1 preventive and treatment for things like diabetes and
2 hypertension.
3 And a lot of times the people who have the
4 biggest problem really have very little choice on
5 where they can go. I'm speaking from what I know here
6 in D.C. in the inner city, but also out in Indian
7 communities. You know, there's only one or two places
8 where they can go.
9 CHAIRMAN REYNOLDS: Would you like to
10 follow up?
11 DR. SIEGEL: Just one brief follow-up. I
12 would also add, I think, that what we're talking
13 about, the quality of hospitals, to Dr. Howard's
14 point, the quality of physicians is something that
15 also needs to be understood in the community, and
16 there's really very little information on that out
17 there now, and there are some programs like the
18 Aligning Forces for Quality program at the Robert
19 Wood Johnson foundation that's trying to get that
20 information out.
21 I have some involvement in that, so that
22 individuals in communities have not only information
23 about hospital, but about the ambulatory care and the
24 chronic care in their community. Because for most
25 people, that's the bulk of the care, and if that care

1 is better, we wouldn't need to have this discussion
2 necessarily to the extent that we are now about what
3 happens in the hospital. We'[d keep people out of the
4 hospital.
5 CHAIRMAN REYNOLDS: Commissioner Melendez.
6 COMMISSIONER MELENDEZ: Yes. Thank you
7 again for being here.
8 Dr. Howard, you referred to, as we heard
9 before, there are not enough survivors, you know,
10 nationwide, and you referred to a success in
11 developing procedures and training for non-physicians
12 who can work in under served communities maybe in
13 preventive type health measures.
14 Can any of you comment more on that, what
15 we can do along those lines?
16 DR. HOWARD: Yes, and I think some of that
17 is being done in places like the Indian Health
18 Service, for example. For many of the chronic
19 diseases like diabetes and hypertension and
20 cholesterol problems, overweight, it doesn't need a
21 subspecialist position to do the day-to-day
22 management. In fact, as many of the previous
23 panelists pointed out, people often will listen more
24 to the nurse or to the aide who they happen to know or
25 who they feel more familiar with.

1 But these lower level providers need to
2 have very careful guidelines drawn up for them of what
3 to do if the patient has this level of blood pressure,
4 what you should do next, and sort of a step care
5 approach, and then those need to be developed by the
6 high level physicians and overseen by them, and the
7 primary providers need someone to turn to because
8 there are cases that don't fit the neat algorithms and
9 need the expert advice.
10 But the best example I know is up in
11 Alaska. Most Eskimos, you know, live in villages
12 1,000 miles from any of the care hospitals, and they
13 have what they call community health aides who are
14 usually women who probably finished high school, who
15 have received a lot of training, and they have large
16 notebooks with algorithms of what they should do if
17 the person comes in with symptoms of anything from the
18 flu to their diabetes problems.
19 And then they communicate mainly by
20 telecommunication with the providers in Nome or
21 Anchorage, and then the physicians make visits perhaps
22 weekly or at intervals. But they do a decisively good
23 job of managing a lot of these problems.
24 CHAIRMAN REYNOLDS: Commissioner Yaki.
25 COMMISSIONER YAKI: Yes. This is for Dr.

1 Siegel.

2 I was just sort of struck by the one about
3 the improvement rate that you showed in your study,
4 but the other thing that kind of struck me was that
5 some of the deltas remained the same, especially in
6 terms of the African American. Everyone went up, but
7 that delta remained, whereas with the Hispanic
8 community that delta kind of closed.

9 Was there any explanation or any data or
10 speculations as to why one delta kind of remained the
11 same and the other one closed up, although everyone's
12 overall numbers went up?

13 DR. SIEGEL: That's a great question.
14 We're not sure, honestly, and we're trying to
15 understand that now. And the data I showed is
16 relatively new, and we haven't been able to sort of
17 dive in and understand what happened in each hospital
18 under that data.

19 We think -- I want to be careful here --
20 we think that it just may have been that some of the
21 hospitals in our sample who had larger Latino
22 populations may have started at a somewhat lower level
23 in terms of quality and improved more.

24 Now, whether that reflected something
25 about those hospitals or whether it was sort of the

1 randomness of the sample we had -- it's only ten
2 hospitals -- we're not sure. So we're trying to
3 understand that.
4 I do think in furtherance of your
5 question, you know, a lot of us in this field argue
6 about this. You know, will a rising tide lift all
7 boats --
8 COMMISSIONER YAKI: Right.
9 DR. SIEGEL: -- to the same level? And
10 we're not yet sure that it will, and I think this may
11 indicate that those gaps can persist even though
12 you've raised the bar on quality in a dramatic way.
13 CHAIRMAN REYNOLDS: Dr. Siegel, culture
14 plays a role. For example, in the South food, food
15 choices, whether exercise has been imbedded as a
16 routine in an individual's lives. Unless we deal with
17 those issues, isn't it likely that we would have
18 disparities?
19 The example you just discussed, yes, we
20 can have improvement, but there are these other
21 factors that will -- that unless the other factors are
22 dealt with, then the disparities, while they may
23 close, will remain.
24 DR. SIEGEL: Absolutely. You know, we
25 have focused on, you know, a piece of the health

1 system and some would argue a narrow, though expensive
2 piece of the system, what happens in hospitals. But
3 by no means should that be interpreted as being that
4 there are not disparities across the entire spectrum
5 of individual's experience as opposed to what the
6 health system may do or not do.
7 And I think that everything from what goes
8 on while literally the child is in the womb through
9 early acculturation and environmental exposure and
10 what behaviors are learned, all the way through to the
11 care system and what happens after the care system in
12 terms of potential rehabilitation and the like; you
13 can find disparities at every level which have a
14 critical implication for what happens afterwards.
15 So you know, we have focused on a slice of
16 it, which is important, and perhaps we focus on it
17 because we can measure it and control it, but there
18 are other things that absolutely have to be addressed
19 as well.
20 DR. TAYLOR: You know, comparisons to the
21 problems in education were alluded to earlier or used
22 as an example that might be illuminating for health
23 care, but I think it is absolutely critical to do what
24 we're doing in terms of equalizing utilization and
25 appropriate care for all peoples within the U.S.

1 But to only focus on health care and try
2 to get an outcome on health, I think, would miss an
3 important part of the equation. It would be sort of
4 like trying to improve education by focusing on the
5 ninth grade. You can improve literacy by focusing on
6 the ninth grade rather than somewhere further upstream
7 like first, second or third.
8 A lot happens before most people encounter
9 or seek to encounter the health care system, and it's
10 there where we need to really remind ourselves that a
11 balanced approach that includes prevention as well as
12 therapeutic intervention needs to be taken if we ever
13 hope to close this gap in a substantive way.
14 CHAIRMAN REYNOLDS: Commissioner Melendez.
15 COMMISSIONER MELENDEZ: Yes. Barbara, you
16 said something about barriers to adherence to
17 prevention and treatment and developing community-
18 based programs to address these barriers. What did
19 you actually mean about barriers?
20 DR. HOWARD: Well, as you can tell from my
21 background, I'm not a social scientist, but from what
22 I'm learning from my colleagues -- and this is true
23 again in all ethnic groups, not just Indians -- that
24 many aspects of the person's state of mind influences
25 whether they're going to be receptive to either eating

1 properly or being active or taking their medication,
2 et cetera.
3 One way to deal with this is with
4 community based programs. In Indian Country, talking
5 circles are used sometimes and people talk about their
6 issues and how they feel because they were told they
7 had high blood pressure or diabetes, and by that kind
8 of approach it builds their self-confidence that,
9 yeah, maybe I can do something about this. It isn't
10 all out of my control.
11 And those kinds of approaches are being,
12 as I understand it, tried in other communities, and
13 they've got to be very community specific; that
14 talking circle might be the exact wrong thing to do in
15 an Asian community, for example, but getting people to
16 take charge of their health and believe that they do
17 have power to improve it and what their own barriers
18 are is the kind of approach that these communities are
19 starting to talk about.
20 CHAIRMAN REYNOLDS: Okay. Commissioner
21 Taylor.
22 COMMISSIONER TAYLOR: This will be for Dr.
23 Howard. On the earlier panel Dr. Satel mentioned that
24 black men rarely have Medicaid unless they are
25 disabled. While Medicaid has to cover families with

1 dependent children, is this something that the
2 community health centers that you're talking about can
3 help fill that gap, that it's not dependent on having
4 that Medicaid status, that you can get health care
5 coverage or health care services regardless of your
6 insurance status?

7 DR. HOWARD: Yeah, I might not be the best
8 person to answer that, but what I do know from this
9 stuff we've run here in Washington is, yes, that a
10 nurse or any kind of a staff person when they know
11 what services are available to people without
12 insurance, when a patient comes in, they can guide
13 them into enrolling. They help them fill out the
14 forms and sign up so that they are eligible, and that
15 is something that the local clinical can do and could
16 then help people who have no coverage to, you know,
17 properly get coverage and improved care.

18 I think one of you who works in a local
19 clinic in the city might be able to answer that
20 better.

21 CHAIRMAN REYNOLDS: Okay. Any other
22 questions? Yes, Commissioner Heriot.

23 COMMISSIONER HERIOT: I'm still on the
24 first panel, speaking about the epidemiological
25 studies that were being discussed there, and the

1 notion that cultural competence didn't seem to be what
2 was going on since you'd expect the doctors involved
3 and the health care providers that were specializing
4 in minorities to be more culturally competent.
5 We mentioned a bit here on quality of
6 doctors. I'm a law professor, and I get a good sense
7 of where the most talented law students go to practice
8 law and what drives that market, but what drives the
9 medical market? Is there any mechanism that might be
10 attracting, you know, the more talented doctors to
11 hospitals, or not just doctors, nurses --
12 CHAIRMAN REYNOLDS: Money.
13 COMMISSIONER HERIOT: What's going on?
14 DR. TAYLOR: Well, if I start, I think
15 what attracts doctors to a particular locale or
16 practice environment would be quite parallel to what
17 attracts other professions to their particular
18 location. Obviously compensation is near the top of
19 the list, but I think a lot of physicians do look for
20 a sense of purpose in what they do as well.
21 And I think that you --
22 COMMISSIONER HERIOT: And just for the
23 record, I didn't want to suggest that lawyers
24 congregate all towards money. There are great lawyers
25 found everywhere, but they congregate in certain

1 spots.

2 DR. TAYLOR: Right, right, but I think --
3 and maybe other panel members can modify or correct
4 this -- but I think, you know, doctors tend to
5 congregate where there are, again, where the
6 compensation is right, where the cultural
7 opportunities are good, where education for their
8 children can be high quality.

9 So again, I think it's really a reflection
10 of the American dream for doctors as it is for anyone
11 else. I think it takes a special individual to
12 intentionally go to an area that is depressed or
13 deprived in some substantive way.

14 Some people go back to where they started
15 from, you know, and are happy to establish a clinic in
16 the delta in Mississippi because they feel a
17 particular sense of commitment, but then there are
18 challenges when you are remotely located to continuing
19 education, to perhaps even the education of your
20 children, things that, again, might intimidate or
21 discourage a lot of physicians from distributing
22 evenly across the geography of the United States.

23 CHAIRMAN REYNOLDS: Dr. Siegel.

24 DR. SIEGEL: I would agree with everything
25 that Dr. Taylor mentioned. I would add a couple of

1 things maybe. I think part of it might also be the
2 access to technology for your patients. Are there
3 tools there which, you know, you think are necessary,
4 which are easily accessible? Is lifestyle?
5 My wife is a pediatrician, and she has
6 spent a year working in an inner city environment in
7 New York in a very under served community, and she
8 felt insecure in that environment, personally insecure
9 for her safety at times, and eventually left that
10 environment. So that can be a challenge also in terms
11 of that issue.
12 But the one I also want to add is I think
13 we need to be careful. I'd love to hear from all of
14 the first panel about saying that, you know, if the
15 physicians are working in this area are bad or in this
16 community and others are good.
17 I say that because I've seen very bad
18 medicine practiced in very affluent, non-minority
19 settings. We know very little about the true
20 measurement of quality of physicians. We are at the
21 outset of that now and we're trying to sort of move
22 that agenda forward, but it's really not quite there
23 yet.
24 And there are instances in under served
25 communities that we can point to like many of

1 America's community health centers where really high
2 quality medicine is being practiced.
3 So I think we need to step back a little
4 bit before we come to certain conclusions about what's
5 happening.
6 DR. HOWARD: And I would add that, again,
7 just as there are good lawyers, there are bad lawyers
8 everywhere, too.
9 DR. LEWIS: If I can add to Dr. Siegel's
10 position on this, you know, when you look at it,
11 physicians in general are, you know, reasonably
12 educated in terms of guidelines. In one study looking
13 at understanding of the national cholesterol
14 guidelines, you talked to physicians.
15 Ninety-five percent of them knew what the
16 cholesterol guidelines were, but when you looked at
17 their patients, only about 18 percent of them were
18 actually treated to goal.
19 So this is a real system problem. It's
20 not necessarily a physician education problem.
21 CHAIRMAN REYNOLDS: Okay. If there are no
22 more questions, I'd like to thank the panelists.
23 You've provided some great information, and I
24 appreciate the fact that you've carved time out of
25 your busy lives to participate.

1 COMMISSIONER YAKI: Now just save some
2 lives.
3 (Laughter.)
4 DR. HOWARD: Not me. I just write papers.
5 (Laughter.)
6 CHAIRMAN REYNOLDS: Thank you very much.
7 (Applause.)
8 CHAIRMAN REYNOLDS: Let's take a break of,
9 say, 45 minutes.
10 (Whereupon, at 12:51 p.m., the briefing
11 was concluded.)
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