U.S. COMMISSION ON CIVIL RIGHTS

COMMISSION BRIEFING ON HEALTHCARE DISPARITIES

FRIDAY, JUNE 12, 2009

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.
# INDEX

<table>
<thead>
<tr>
<th>Introductions, Chairman Reynolds</th>
<th>4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presentation by Dr. Louis W. Sullivan</td>
<td>8</td>
</tr>
<tr>
<td>Presentation by Dr. Garth N. Graham</td>
<td>15</td>
</tr>
<tr>
<td>Presentation by Dr. Rubens J. Pamies</td>
<td>25</td>
</tr>
<tr>
<td>Presentation by Dr. Amitabh Chandra</td>
<td>35</td>
</tr>
<tr>
<td>Presentation by Dr. Sally L. Satel</td>
<td>44</td>
</tr>
<tr>
<td>Presentation by Dr. Peter B. Bach</td>
<td>53</td>
</tr>
<tr>
<td>Questions by Commissioners</td>
<td>61</td>
</tr>
<tr>
<td>Presentation by Dr. William Lewis</td>
<td>103</td>
</tr>
<tr>
<td>Presentation by Dr. Herman a. Taylor, Jr.</td>
<td>111</td>
</tr>
<tr>
<td>Presentation by Dr. Barbara V. Howard</td>
<td>120</td>
</tr>
<tr>
<td>Presentation by Dr. Bruce Siegel</td>
<td>126</td>
</tr>
</tbody>
</table>
(9:32 a.m.)

CHAIRMAN REYNOLDS: Okay. Let's get started.

I'd like to ask everyone with cell phones to put their phones on vibrate. Bear with me.

Okay. Good morning. This is Chairman Reynolds, and on behalf of the U.S. Commission on Civil Rights, I welcome everyone to this briefing on health care disparities. This project is examining why, despite the continued advances in both care and technology racial and ethnic minorities continue to have more disease, disability and premature death than non-minorities.

More specifically, the Commission will examine racial disparities in the rates of cardiovascular disease and the related condition of hypertension. Experts will present the Commissioners with results from ongoing research and information regarding health care delivery systems, access to and quality of community education, patient behavior, and other aspects of health differences between population groups.

The record of this briefing will be open until July 13th. Public comments may be mailed to the
This morning we're pleased to welcome two panels of experts that will address this topic. On the first panel speakers will discuss the disparity claims within the overall hearth care context, and we'll also focus upon disparities in rates of cardiovascular disease and hypertension specifically. They will evaluate potential sources of the disparities, discuss the research approaches taken in various studies, and share their conclusions and views.

Dr. Sullivan is the founding dean and first president Morehouse School of medicine. Welcome, Dr. Sullivan.

DR. SULLIVAN: Thank you.


Next we welcome Dr. Garth Graham, who is
the Deputy Assistant Secretary for Minority Health in
the Office of Minority Health at the Department of
Health and Human Services, which coordinates federal
health policies that address minority health concerns
and insures that federal, state, local health programs
take into account the needs of disadvantaged racial
and ethnic populations.

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

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

In 2005, he collaborated with former
United States Surgeon General Dr. David Satcher to
author and edit one of the first textbooks addressing
inequalities in health care titled *Multi-cultural
Medicine and Health Disparities.*
Next we have Dr. Sally Satel, who is a psychiatrist at the Oasis Drug Treatment Clinic here in Washington, D.C. She is a lecturer at Yale University School of Medicine, a Resident Scholar at the American Enterprise Institute, and author of the Health Disparities Myth: Diagnose in the Treatment Gap.

And next we have -- and I will need assistance pronouncing the first name.

DR. CHANDRA: Amitabh.

CHAIRMAN REYNOLDS: We have Amitabh Chandra, who is a Professor of Public Policy at Harvard's Kennedy School of Government, and he is a Research Fellow at IVA Institute in Bonn, Germany, and the National Bureau of Economic Research in Cambridge, Massachusetts.

His research focuses on productivity and growth, expenditure growth in health care, racial disparities in health care, and the economics of neonatal health and cardiovascular care.

Then we have Dr. Peter Bach, who is a physician at the Memorial Sloan-Kettering Cancer Center. His work has focused particularly on improving the quality of care for African American patients in Medicare, including cancer care.
He previously served as senior advisor to the Administrator of the Centers for Medicare and Medicaid Services, where, among other things, he oversaw the agency's cancer initiatives.

Folks, I am excited to have you here. This is an issue that we've needed to have a fully fleshed out discussion on these issues for quite some time, and I'm glad you could make it here today.

The next thing we have to take care of, we have to swear you in. So please raise your right hand.

Please swear or affirm that the information you have provided is true and accurate to the best of your knowledge and believe.

PARTICIPANTS: I do.

CHAIRMAN REYNOLDS: Very good. Let's get started. Here are the mechanics. Each speaker will have ten minutes, and please try to stay within the time frame. At the end of the presentations, we will have a Q&A session.

And we will start with Dr. Sullivan.

DR. SULLIVAN: Thank you very much, Mr. Chairman and Commissioners. It is a great pleasure and genuine opportunity to be here with you today.

I'm here in my role as Chairman of the
Sullivan Commission.

COMMISSIONER YAKI: Point of order. I'm sorry, Mr. Sullivan.

One of the things that's confusing about this is these microphones are actually C-SPAN microphones, but you'll find on your desk these little things right here. Make sure that is turned for the reporter and also so the audience in the back can hear.

I apologize for that. I was confused, too, until I realized, oh, there's a double mic here.

CHAIRMAN REYNOLDS: Thank you, Commissioner Yaki. As usual, you've saved the day.

COMMISSIONER YAKI: I do try.

DR. SULLIVAN: Thank you very much.

I'm here as Chairman of the Sullivan Alliance to transform the Health Professions, and I want to address the issue of the health work force and its diversity and its impact on health disparities in the country.

The Sullivan Alliance to transform America's health professions is a national effort to enhance the health work force diversity initiatives around the country. It was organized in January of 2005 to act on the reports and recommendations, first,

This commission from the IOM produced the report in the nation's compelling interest, ensuring diversity in the health care work force. This was issued in February of 2004.

The strength of our health work force is central to the capacity of our health care system. The PricewaterhouseCoopers Health Research Institute predicts a shortage of 24,000 physicians by the year 2020, supporting a call by the Association of American Medical Colleges for a 30 percent increase in medical school enrollment, as well as an expansion of graduate medical education physicians to be achieved by the year 2015.

A severe nursing shortage has been reported by the vast majority of our hospitals in our country, and the U.S. Department of Health and Human Services projects that by the year 2020, the shortage of nurses in our country will be between 400,000 and one million.
The Association of Schools of Public Health estimates that by the year 2020, 250,000 more public health workers will be needed in the nation. And finally we have predicted a 150,000 shortfall in pharmacists for the nation by the year 2010.

Now, this health manpower shortage is exacerbated by a maldistribution of physicians both by geography and by specialty because it is well documented there is a critical shortage of primary care physicians and family physicians.

In addition, there is a dearth of health providers in rural and inner city areas, which have been designated by the U.S. Public Health Service as health profession shortage areas. As many as 35 million Americans live in areas that have been so designated.

And 2007 data from the U.S. Census Bureau indicates that one-third of the U.S. population, that is, 34 percent, is today a racial or ethnic minority. More than 50 million Americans speak a language at home other than English.

Furthermore, the U.S. Census projections show that racial and ethnic minorities will become the majority of the U.S. population by the year 2042.
In 2004, according to the commission which I chaired in its report "Missing Persons," we noted that only nine percent of the nation's nurses are members of an under represented minority. Only 6.1 percent of physicians represent under represented minority and 6.9 percent of psychologists are under represented minorities, and five percent of dentists.

Now, there are a host of areas that are impeding access to a health professions career by ethnic and racial minorities. These include the following: poor awareness of the health professions careers, as well as poor academic preparation coming from many of our school systems that are not adequately preparing our young people.

They also include financial barriers and the lack of role models and mentors for members of under represented minority groups.

Now, at this time our supply of U.S. health professionals is not keeping pace with the growing needs of our population, which is increasingly diverse racially and ethnically. Today minorities account for, of Americans under the age of 20, 43 percent of them are under represented minorities, and minority student enrollment in our nation's colleges will reach nearly 40 percent in the next few years.
The dearth of minorities in the nation's health work force is a major factor contributing to health disparities. Achieving greater ratio and ethnic diversity of the nation's health professionals has distinct benefits.

First, minority physicians are more likely to practice in medically under served areas and care for patients regardless of their ability to pay. A number of studies beginning in 1996 have shown this pattern.

Secondly, minority physicians are more likely to choose primary care practices, and minority registered nurses are more likely to be employed in nursing and to work full time, thus, improving the care of vulnerable populations.

Finally, a diverse health work force encourages a greater number of minorities to enroll in clinical trials designed to alleviate health disparities. In the United States there's also evidence that the intellectual, cultural sensitivity and the professional competence of all students is enhanced by learning in an ethnically and racially diverse educational environment.

And finally, there's evidence that a work force equipped to serve culturally and linguistically
diverse individuals increases the number of initial visits to hospitals, to clinics or physicians' offices, results in higher utilization of care, enhances high quality encounters, lowers medical errors, and reduces medical emergency room emissions.

With the prospect for health reform on the nation's docket, we have the challenge and the opportunity to develop a successful model to eliminate health disparities by addressing a central issue, and that is the health care work force. The administration and the Congress can lead this effort for needed changes in our health care system.

Such an effort must not only address the lack of health insurance or under insurance of more than 47 million of our citizens, as well as the high cost of care. It must also focus on the current and increasing shortage and maldistribution of health professionals and the need for more racial and ethnic diversity among our nation's health professionals.

All of these factors have a significant impact on access to health care, on protecting and improving the health of Americans and eliminating disparities in health status of the nation's racial and ethnic minorities.

I thank you for this opportunity to
present these issues to the Commission, and I look forward to your questions and comments, as well as your leadership and your support in these efforts to achieve our goal of eliminating disparities in health status and access to health care for all of our citizens.

CHAIRMAN REYNOLDS: Thank you, Dr. Sullivan.

Dr. Graham.

DR. GRAHAM: Good morning, Mr. Chairman.

It's a pleasure to present to the Commission on Civil Rights on the causes of health care disparities, populations most affected by these disparities, and actions needed to eliminate them.

First, a word about Office of Minority Health. The mission of the Office of Minority Health is to improve the health of racial and ethnic minority populations through the development of health policies and programs that will help eliminate health disparities. We're located in the Office of the Secretary within the Office of Public Health and Science and the Department of Health and Human Services, and we advise the Secretary, Deputy Secretary, and the Assistant Secretary for Health on public health policies and programs that impact racial
and ethnic minorities and coordinate HHS-wide efforts at addressing minority health issues.

First, in terms of what we've talked about when we say health societies, health societies can be defined as significant gaps or differences in the overall rate of disease incidence, prevalence, morbidity/mortality, or survival rates in the population as compared to the health status of the general population. The Institute of Medicine defines disparity in health care as racial or ethnic differences in the quality of health care that are now caused by differences in clinical need, patient preferences, or appropriateness of intervention.

The landmark Institute of Medicine report in 2002 served as a significant data point in terms of tracking and analyzing issues related to health disparities.

Overall health status in the U.S. has improved significantly as demonstrated by increases in life expectancies for the majority population. However, in spite of the many improvements in health over several decades, significant gaps still exist by race, ethnicity, gender, disability, and other related subpopulations. These gaps may be related in part to demographic changes in the United States, but
according to the 2000 census data, the population of the U.S. grew by 13 percent over the last decade, but has increased dramatically in diversity at even greater rates.

Racial and ethnic minorities are among the fastest growing communities across the country. Today they comprise 34 percent of the total U.S. population, and it is projected that by 2030 40 percent of the U.S. population will be comprised of minority populations at large.

Consequently, the U.S. is not only experiencing greater diversity, but people are living longer, experiencing rising costs of health care and emerging new diseases are posing challenges across the board.

While the ratio in ethnic diversity is increasing, minorities tend to die sooner from a wide variety of acute and chronic conditions. Racial and ethnic minorities receive a lower quality of care compared to whites across a wide range of preventative, diagnostic and therapeutic services.

These conditions in health care contribute to continuing racial and ethnic differences in the burden of illness and disease. For example, an estimated 15.8 million people in the United States are
living with coronary artery disease. More than 5.7 million have felt the effects of stroke, which is the second leading cause of death across the board.

African Americans continue to experience a higher rate of stroke, have even more severe strokes, and continue to be twice as likely to die from stroke as the general population. Respiratory and cardiovascular disease are among the most serious public health problems. About 70 million Americans fall into the newly diagnosed blood pressure risk category defined as pre-hypertension, are in danger of developing hypertension and related complications. Hypertension, as you well know, leads to more than half of our heart attacks, strokes, and heart failures in the United States.

The prevalence of high blood pressure, a major risk factor for coronary artery disease, stroke, kidney disease, and heart failure is nearly 40 percent greater in African Americans compared to the general population.

Mexican Americans also experience an even higher rate of hypertension and receive similar numbers in the Native American community.

The rate of congestive heart failure and hospitalizations in black non-Hispanics between the
age of 64 to 75 years are more than twice the rate of that for white non-Hispanics.

In addition to heart disease disparities, African Americans are 30 percent more likely to develop cancer and 30 percent more likely to die from cancer compared to the general population. Hispanics in the U.S. are 50 percent more likely than whites to suffer from diabetes and the incidence of diabetes, and the Native Americans, that number as well is twice as likely.

Asian Americans and Native Hawaiians and Pacific Islanders are much more likely to suffer from Hepatitis B and C, correlated liver cancer, compared to the general population.

So we have seen over the past many, many decades of health disparity reports an emergence and reconfirming of data in terms of the impact of these prevalence, morbidity and mortality on minority populations across the board.

I want to mention that one of the significant challenges that we face in documenting health disparities are data gaps when we look at specific populations. So we face data challenges and collecting data on Native American and Pacific Asian Americans, Native Hawaiian and Pacific Islanders.
subpopulations, as well as for some specific Hispanic populations across the board.

But from the data that we do see and I've seen over the past two or three decades, we have seen a continued confirmation of the existence of health disparities in minority populations.

So what is the cause of these disparities?

Well, it's certainly multi-factorial, and I can tell you as a practicing clinician, as well as a policy maker, that I have seen the full spectrum of impact just in the disease diagnosis and diagnosing specific diseases within minority communities, but looking at this at a population level as well, and it is certainly related to the interplay between socioeconomic, environmental, individual and personal factors as well as other social determinants of health.

You'll hear more from this panel about issues related to social determinants of health, but as we look in terms of the etiology of health disparities, it's important to realize that there's definitely a multi-factorial process in terms of these disease processes on minority communities.

Individual factors include things as poverty, low health literacy, behaviors, as well as
lack of health insurance or under insurance, as well as a lack of a regular source of care.

Other system factors that contribute to health disparities include lack of cultural and linguistically appropriate care, as well as other varied system factors that occur within the health care system.

Disparities in health care have significant implications for health professions, administrators, policy makers, and health care consumers, and present a significant challenge to the health care system.

There are things that we can do both in the individual level as well as a system level as well. Individual changes include improved knowledge and awareness of disease, changes in behaviors related to smoking, exercise, nutrition, monitoring blood pressure, and adhering to medical advice. Systems level changes include such things as providing practice staff with greater access to cultural and linguistically appropriate care, improving access to care through the availability of interpreters, and making sure that we investigate strategies that improve health insurance coverage for minority populations.
There are a number of current research activities, as well as a number of programmatic activities related to health disparities that I think you'll hear more about from our panel. I want to highlight specifically as we're talking about hypertension as I alluded to the impact of hypertension on minority communities.

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

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

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

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

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

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

One of the things we found is the power of awareness. Many times people just understand in terms of the actual diagnosis that they have and realize that there are certain things that they can do to take charge of their own medical care. We see communities engaging in preventative health behaviors that are not only amazing but, in fact, inspiring. We saw church members. We saw folks with the general community really take their own health into their own hands and participate in activities that subsequently led to the reduction in hypertension and some of the sequelae that we proposed from hypertension, i.e., kidney failure, stroke, and some of the things that I've alluded to earlier.

Within that context, the Office of Minority Health has proposed a strategic framework for eliminating health disparities. This strategic framework is intended to help guide organizations and coordinate the systematic planning, implementation, and evaluation efforts of HHS' Office of Minority Health, as well as our partners across the country dealing with some of those individual and systemic factors related to health disparities.

We also recognize that there are other
components related to the health care system that are
evolving in terms of not just health care reform, but
the digitalization of health care and the emergence of
such things as electronic health records and personal
health records which provide a powerful tool for
standardizing health care across the board.

CHAIRMAN REYNOLDS: Dr. Graham, I can
listen to you all day.

DR. GRAHAM: I'm sorry.

CHAIRMAN REYNOLDS: So if you don't mind,
we can follow up.

DR. GRAHAM: Thank you. I'm sorry.

CHAIRMAN REYNOLDS: Thank you.

Dr. Pamies.

DR. PAMIES: Thank you.

Members of the Commission, distinguished
co-panelists, and other honored guests, first I want
to thank you for holding this very important event as
we continue to shine a very bright light on this
critical and unfortunate topic of health disparities.

Before I begin, I think it's appropriate
to quote Martin Luther King when he said on the top of
all the forms of inequality, injustice in health care
is the most shocking and inhumane.

My name is Rubens Pamies. I'm Vice
Chancellor at the University of Nebraska. I'm a physician and researcher and have spent the last 25 years trying to understand and find solutions to the growing problem of health disparities. I think to really better understand the issue, I need to discuss very briefly nine different areas that I think contribute to or explain the dilemma that we now face.

First, understanding the diversity. It's important to look at diversity in America. Over the past 20 years, the proportion of white Americans has decreased from 83 percent in 1970 to 69 percent now in 2000. During that same period, the proportion of African Americans has increased slightly from 11 to 12 percent. However, the proportion of Hispanic has jumped from nearly five percent to 12 and half percent.

It's obvious from these numbers that the country is becoming increasingly more diverse and making our health care issues uniquely different from other comparable nations around the world. The U.S. Census Bureau, in fact, had originally estimated that by the year 2050 nearly one in two Americans will be a member of a racial or ethnic minority group. However, now they indicate that this can occur as early as 2037.
Currently, we have four states, including the District of Columbia, who already have a majority minority population.

The work force issue has been touched on, and the issue today, our health care work force is not representative of minorities in the general population. Hispanics comprise 12 percent of the population but only two percent of registered nurses, 3.4 percent of psychologists, and 3.5 percent of physicians.

Similarly, African Americans constitute 12 percent of the population but only five percent of physicians, nine percent of the registered nurses, and only four percent of dentists. In the last ten years, the percentage of African Americans in health care careers has actually dropped in several key areas while slightly increasing in some other areas.

In total under represented minorities comprise less than eight percent of the nation's physician work force and only four percent of the medical school faculty, while almost 20 percent of those four percent come from the four historically black colleges that have medical schools.

I believe having a proportional representation is important for a variety of reasons,
not only for patient care, but also for showing under
represented minority students that they, too, can
enter the health care field for enhancing cultural
competence and learning environment in the work force.

As has been mentioned, a landmark
Institute of Medicine report on equal treatment
articulated the increasing need for diversity. They
drew four conclusions for this.

First, under represented minority health
care professionals are significantly more likely to
serve the medically under served communities, which
often includes urban and disadvantaged areas.

Second, studies have shown that patients
are more likely to seek care from physicians of their
own race or ethnicity and report being more satisfied
in doing so.

And, third, minorities considering health
care professionals are more likely to pursue a field
where they see minority role models.

Finally, the reason concerning medical
research. Minorities are more likely to participate
in research studies when the research is conducted by
a health care provider of the same ethnic group.

Consequently under represented minority
health care professionals are also more likely to have
research interests in diseases where disproportionately minorities are affected, thereby helping to solve the mysteries regarding why certain conditions disproportionately affect and have poor outcomes among minorities. Because these researchers often see first hand the various effects of these diseases affecting the communities and their families, and they become interested in learning more about those diseases and the outcome.

Clinical research studies are vital to understanding why certain racial and ethnic groups are affected differently by disease and treatment. That is why I think it is essential for us to continue to collect racial data for minority health so that we can better understand the disease outcomes.

It has been mentioned again, mortality and morbidity incidence. The U.S. health care system has said to be very good if you're healthy. Unfortunately, that's not the case for many individuals. Despite the overall improvement in the U.S. populations, racial and ethnic minorities experience higher rates of morbidity and mortality than non-minorities. This point is simply proven by looking at life expectancies.

African Americans have shorter life
expectancy, at 66 years, than white men who on average will live until 74. Compare that with American Indians who in some areas will expect to live in their mid-50s.

While life expectancy for most groups have risen, the life expectancy gap between white and African American males has not changed significantly in the past 40 years.

Even though our country can tout major health and technological advances in the past 60 years, African American mortality rate is 1.6 percent higher than whites, and this is identical to what it was in 1950.

Infant mortality just as dismal as race gaps in American Indians are 2.5 and 1.5 times higher than whites.

Examining the prevalence of certain diseases and conditions in racial and ethnic minorities, we go to further evidence of health disparities. African Americans have the highest rate of mortality from heart disease, cancer, stroke, HIV/AIDS and other disease conditions.

In fact, if you look at the HIV rate, it's reaching epidemic proportions. More than 80 percent of women who have been diagnosed with HIV or AIDS have
been either African American or Hispanic. American Indians have higher rates of diabetes, as has been pointed out, liver disease, and Hispanics are expected to die more from diabetes which modern medicine now can treat and manage adequately. As has been mentioned, stomach cancers in Asian populations is also very high.

Hypertension in African Americans leads to 80 percent higher stroke mortality rates, 50 percent higher rates of disease and 32 percent higher rates of renal disease than the general population. Half of African Americans age 40 through 59 are hypertensive. Compare that to 30 percent of whites.

When we initially look at these data, we felt that access to care was the effective reason. However, even in veterans hospitals where access is not as much of an issue major health disparities continue to exist. Studies have shown that physicians are less likely to refer African American patients for cardiac catheterization. African Americans are less likely to undergo invasive cardiac procedures, and current series on cardiovascular health disparities center on various factors, including racial discrimination in treatment, genetics, environment, and demographics.
There are new theories emerging about the burgeoning cardiovascular health disparities. The first theory is epigenetics or changes in the DNA caused by consistent environmental exposure, such as diet and stress that can actually be passed on from one generation to the next.

Epigenetics underscores the cumulative effect of poor socioeconomic conditions, discrimination and inequality of education and other opportunities.

The second theory is the allostatic load, which states that body experience biological changes in response to stress. Specifically, corticotropic releasing hormones which are found to be higher than those that have experienced long periods of stress, suggesting that years of feeling unequal or experiencing discrimination can eventually lead to worsen cardiovascular health.

The current economic situation is also having detrimental effects. Recent reports have shown that fewer prescription drugs are being filled. The concern is that individuals are being successfully maintained. Healthy blood pressures and other cardiovascular conditions with medication may no longer be able to afford these medications, which will
result in higher blood pressure, increases in stress, hypertension and a number of other dangerous conditions.

In the near future we may see a shift on health maintenance with medication at a modest cost to one that utilizes emergency room treatment at a much more higher cost.

Health disparities places a disproportionate burden of health disparities has been well documented. There's several reports of contributing factors, socioeconomic, racism, discrimination, limited access and the quality of service being provided. Patient and provider behavioral factors also are factors.

The factors tend to compound one another and create a cycle of problems. Despite increase in care through immunization, the differences between many minority groups to whites are significantly getting worse or remaining stagnant.

Being in a lower socioeconomic class also means having substandard housing, fewer opportunities for higher education, less insurance coverage, limited access to health care. The environment health risk includes anything from air quality, water quality, soil contaminants as well as other pollutants tend to
be more prevalent in lower socioeconomic communities, and lower socioeconomic groups often live in more segregated areas where there are higher poverties and more drug and alcohol abuse.

Missing from these environments are green space, access to healthy foods, job opportunities, and access to health care. More than any other racial group, African Americans tend to live in segregated neighborhoods even when you factor in income levels. In fact, some major urban areas in the United States are as segregated as they were back before the civil rights era and the apartheid era in South Africa.

Housing segregation showed that two-thirds of African Americans would have to relocate in order to achieve any statistical random distribution of black and white households in America. Individuals living in segregated areas typically do not have resources to transfer wealth to the next generation. Instead kids inherit a lifetime of poverty, a lack of educational opportunity, and typically a lifetime of poor health.

Just a few words about the educational inequality. Low income segregated communities have a lower tax base, less philanthropic ability to support education. As a result, racial and ethnic minorities...
have few educational opportunities, few role models, and they tend to limit their goals to low paying and in some cases hazardous occupations.

For many minority children other expectations of them are set so low that they never really reach their full potential. A recent report shows that half of African American children and 40 percent of Hispanic children attended a high school where the dropout rate was close to 50 percent. This compared to only 11 percent of white children attending those schools with those dismal statistics.

CHAIRMAN REYNOLDS: Dr. Pamies. Thank you very much, and we will continue during the Q&A.

Dr. Chandra.

DR. CHANDRA: Mr. Chairperson and members of the Commission, my name is Amitabh Chandra, and I'm a professor at Harvard University's Kennedy School of Government and a Fellow with the Dartmouth Institute for Health Policy.

Thank you for inviting me to the Commission to share my thoughts on how to improve health care for minority patients.

We are all aware of the stubborn persistence of racial disparities in treatment over time, even when patients are fully insured. Many
believe that the clinical encounter is the most pernicious source of these disparities. My main point this morning is that we are unlikely to make great strides in improving minority health by prioritizing action on this channel.

The importance of the clinical encounter is dominated by other shortcomings, such as the lack of access to high quality providers which are far more injurious to minority health.

The original disparities in health care emanate principally from the clinical encounter, embodies the idea that a provider treats two patients, one white and one black, differently. More precisely, differences in the clinical encounter may occur because there is explicit discrimination where a provider consciously withholds valuable care from minority patients. This is the most malfeasance explanation of racial disparities in care, and it's perhaps one reason why there's so much interest in this mechanism.

But disparities may also arise from implicit discrimination, where a harried provider operating in a time sensitive environment makes unconscious mental decisions that are detrimental to minorities. Stereotyping is one manifestation of this
indiscretion, and it occurs when a provider uses a patient's race to produce information about the benefit of treatment.

If, for example, African American patients on average are less likely to be compliant, then a physician may assume that her African American patient is less compliant. Such reasoning will worsen outcomes for that patient if he is different from the typical African American patient and worsen outcomes for all African Americans if the stereotype about them is wrong.

The bias from implicit discrimination is compounded by the presence of poor communication between providers and their patients which may generate enormous psychological barriers to minority patients seeking care.

Finally, some researchers have posited genetic or physiological differences between patients that affect the benefit of treatment by race while others have discounted such conclusions.

Given the discussion of the mechanism, the question is to ask whether we have conclusively established the role of the clinical encounter in effecting racial disparities in health care. Answering this very simple question carefully poses an
enormous and formidable empirical challenge. We would need to observe the same provider treating two patients with the same economic and social resources, physiology, clinical history, severity, preferences, compliance, and future prognosis.

These variables are routinely observed by providers treating patients, but not by social scientists observing providers. The fact that multiple studies all note that minority patients get less care is often interpreted a pervasive bias in the clinical encounter which could just as well be interpreted as one of the pervasive shortcomings in all observational studies that focus on the clinical encounter.

Second, because of patterns of neighborhood segregation, the same provider is rarely observed treating both black and white patients, and so what we have been calling prejudice in the clinical encounter is often a difference in neighborhoods, referral patterns, and the resources of providers that serve in these neighborhoods.

This is an unfortunate confusion because improving neighborhood schools or changing the flow pattern is not the same thing as reforming provider behavior inside hospitals and offices.
Researchers have made some progress on this challenge by using patient actors and implicit association tests. Both physicians and the researchers studying them observe the same information in a laboratory setting. This an intriguing area of academic research, but its findings are still nascent for the purpose of informing policy and legislation. We do not know if the decisions made by self-selected physicians in these laboratory studies are representative of physicians who actually take care of minority populations.

My main point today is to elaborate on a new explanation for racial disparities and care, but they are partially the consequence of differences in where minorities and white receive their care. If different providers treat blacks and whites, then one reason for racial disparities in care is not only who you are, your race, but also where you live. Both sources of disparities are injurious to minority health.

The first type of variation which I call within provider variation is the role of the clinical encounter. The second, which I call the between provider variation, relates less to race per se and more to geographic variations in the quality of
treatment patterns for all patients. It considers the racial disparities in treatment because minorities are more likely to be cared for by lower performing providers.

Some large academic medical centers are an exception to this statement, but the link between being treated at one of these centers and quality is by no means automatic.

Differences in where minorities are treated has to do with factors such as insurance and lower socioeconomic status, but historical patterns of discrimination and neighborhood segregation surely exacerbates this variation.

Confronted with these realities, we should be extremely cautious in concluding that malfeasance and nonfeasance are the sole purview of the medical profession.

So what is the evidence of the role of geography as a determinant of racial disparities in health care? Dr. Peter Bach and his colleagues have demonstrated that blacks and whites have different providers, and those providers who treat minorities are often less clinically trained and have fewer resources.

My collaborators and I have demonstrated
that 85 percent of all black heart attacks are treated in only 1,000 hospitals, where 60 percent of whites receive their care in hospitals that treat no African American patients.

Within hospitals, we found, however, no disparities in effective care, but found the patients who were admitted to hospitals that disproportionately serve blacks had a risk adjusted mortality rate that was almost 20 percent higher than that of non-minority serving hospitals.

Others have noted similar findings for the performance of neonatal intensive care units in minority serving hospitals. Forty years after the passage of the Civil Rights Act, minority health care is both de facto separate and unequal. Ironically, a close cousin of this embarrassment, which was segregated hospitals, was the original motivation for Title VI legislation.

The new focus on the geography of minority health care should not be viewed as taking attention away from reforming the clinical encounter. Rather, it notes that even if we could fully eliminate disparities within the clinical encounter, the health care of blacks would improve, but still lag behind that of white because of differences in quality of
care where the two groups receive care. For many of us, this is simply not good enough.

Because a small group of providers treat minority patients causing quality improvements towards minority serving providers would dramatically reduce black-white disparities in care. Such interventions would improve the health of both minority and white patients, but the gains would disproportionately accrue to minority patients whose care concentrates in such providers.

In the context of ambulatory care for diabetes, my collaborators at Dartmouth and I estimate that aggressively improving the performance of the 500 largest minority serving networks would improve minority health care more than the complete elimination of racial disparities within every provider in the United States. Indeed, given the greater reliance on ambulatory care, one might want to think about expanding the recent Title VI of the Civil Rights legislation to go beyond the reach of hospital care and encompass care that is delivered in office visits and by managed care plans.

Finally, in closing let me make one simple point. The determinants of racial disparities in health are not the same as the determinants of racial
disparities in health care. The principal determinants of health are genes, behavior, schooling, neighborhoods, economic circumstance.

Health is secondarily affected by health care, but more likely to be influence by prevention, including the quality of ambulatory care which can check the progression of diabetes, hypertension, and chronic disease, and through this protection the incidence of heart attacks and strokes.

Of tertiary importance, at the very end of the causal chain is the role of disparities in medical care. The quality of medical care matters much more than the disparity in the quality within it. For the six and a half year racial gap in life expectancy for men and the four and a half racial gap for women, which are surely larger when one accounts for the condition of that life, are unlikely to be affected by the focus on treatment disparities in the clinical encounter. The preoccupation with treatment disparities in the end game simply misses the fact that minority patients find themselves confronting the end game sooner than everyone else.

Thank you.

CHAIRMAN REYNOLDS: Thank you.

Dr. Satel.
DR. SATEL: Thank you for the invitation to address you today.

COMMISSIONER GAZIANO: Could you move your microphone up a little?

DR. SATEL: Okay.

COMMISSIONER GAZIANO: They're not that sensitive. Thank you.

DR. SATEL: Okay. Thank you.

This better?

COMMISSIONER GAZIANO: Yes.

DR. SATEL: Thank you for the invitation, Chairman Reynolds and Co-Chairman Thernstrom.

My name is Sally Satel. I am a Resident Scholar at the American Enterprise Institute. I also work at a methadone clinic in Northeast Washington, D.C.

And I wanted to give you an overview today of the contours of the health disparity issue. In fact, I almost call it a health disparity debate.

What do I mean by "debate"? There is certainly no controversy over the fact that minorities have poor health status and often poor health care, often both the variables that Dr. Chandra spoke of. There is no dispute there.

But the debate has to do with the causes
of those differentials, and the causes, of course, lead us to the remedies. So there are two starkly different perspectives on the causes, and Dr. Chandra spoke them already. He characterized them, in short, as dynamics within the clinical encounter, biased physicians, and even biased health systems. That's one perspective versus the what I'd call a more socioeconomic focus on inadequacies of health systems that disproportionately serve lower income individuals who are disproportionately minority.

The biased perspective came to the forefront of the health disparities conversation with the 2002 Institute of Medicine report, and I want to spend a little bit of time on that. That report is called "Unequal Treatment." They've gotten an enormous amount of attention and is largely regarded as an authoritative study. However, I wanted to outline some of the methodological problems with it.

That study had an emphasis on the clinical encounter and concluded that there was bias among physicians towards minority patients overtly as well as subtly, and I think that report really was almost a watershed point in the dynamic of this debate because it really catapulted the issue of minority health from a public health issue to a civil rights one, as I
said, with the different kinds of remedies implies of
sensitivity training for doctors, affirmative action,
and even potential Title VI legal challenge.

The main problem with the Institute of
Medicine report is that it sought to prove bias or
discrimination, and I just speak from the standpoint
fully of methodology. This is an almost impossible
phenomenon to prove using retrospective approaches and
using large databases.

In a sense, charging a bias is a diagnosis
of exclusion. It's the kind of thing you arrive at,
which is not to say it doesn't exist. It could well,
but it's the kind of thing one arrives at after ruling
out variables that can measure and identify with other
kinds of variables that could lead to differences.
And with large databases, this is very hard.

There's one problem with the report. I've
chronicled most of them in this health disparities
myth booklet that I'll hand out to you afterwards, but
one of the problems is that of omitted variables. And
you referred to this as well.

When you look at large databases in
retrospect, you're not often going to find the kinds
of variables on which physicians make their clinical
decisions. For example if we're going to use an
angioplasty, we'd want to know certain EKG subtleties that are not in large retrospective databases, ejection fraction, for example, the position of occlusion in an artery. These things don't come across in these databases, but they are very relevant to clinical decisions.

Another feature of the IOM report and working health disparities is procedure counting. How many procedures did one group get versus another as opposed to looking equally or even with greater emphasis on the outcome?

The research in cardiac procedures has frequently shown that even though there are differentials, the mortality rates are frequently the same.

So ideally what one wants to use is prospective studies and even more ideally ethnographic observation and interviews with physicians as to why they'd made the treatment decisions that they do. And I'm really not familiar with those kinds of studies.

But for years the IOM report has set the tone of this debate. Now, actually I think there is somewhat less talk about biased positions today, and I see that as a definite maturing of this issue, but there's still an emphasis on one key concept that I
want to emphasize, which is, again, within the disparities issue and almost exclusive focus on relative health, almost a greater concern with the health of groups in relation to each other than whether people are receiving optimal care.

The reason why this is one of the problems of this approach, to look at relative health, is that you can often miss improvements when all of those rise, so to speak. You will see no change in the ratio of minority and white improvement, but it could be there. You just won't see it because everyone has improved together.

Another example of that has to do with the classic example is black infant deaths, which between the years 1980 and 2000 decreased by over one-third. Now, that is certainly progress, but white infant deaths decreased even greater. So it still looks as if the ratio is unfavorable to black infant mortality.

But that's not really what the whole picture shows. One can be misled by focusing on relative health and on death, and one can also get conversely a false sense of achievement. A 2005 Harvard study found greater improvement for blacks in basic interventions and exams for diabetes and other things. However, the rates for blacks and white were
suboptimal for both. So that wasn't necessarily something to celebrate either.

Now, as far as the most relevant determinants of health, you've already heard them from Dr. Chandra and Dr. Bach. Geographical differences, the quality of cost for those physicians, quality, the idea that minorities and whites really don't even see the same physicians, these are drivers of health differentials that are very powerful, and in my view swamp the value of looking for bias, assuming that bias could even be satisfactorily empirically demonstrated.

Now, perhaps even more profound in the demographics of health care are the early determinants that have been mentioned by my colleagues. The mechanisms are very complex. They're called these upstream factors of education and parental income and neighborhood. The mechanisms are complex, but scholars generally agree that good, structured education in the early years enables children to develop self-control, problem solving dispositions, and no least, a sense of the future.

Now, what does this mean for health in later life? Well, obviously it means more opportunities to obtain decent jobs, jobs with health
benefits, more autonomy. That was one of the key lessons of the class Whitehall civil servant study which looked at the gradients of income and found that the second to highest gradient still had disproportionately higher cardiac mortality than one would expect even though their incomes were very good.

But the conclusion was that they do not have the latitude to determine how they work at the job. There was a sense of stress, of responsibility without authority. So stress is quite important.

Also, good education gives you the financial security to cushion setbacks. People are better informed, of course, about health matters and have a much more positive view of technological interventions.

Now, let me move from the more abstract to what I see when I go to my clinic here. It's a methadone clinic. So by definition we're treating people who have heroin addiction, but they've also got a lot of other medical problems.

What I had said, the foregoing was to call attention to the factors that really do matter. These are factors that they're by race, not necessarily because of race, but in the weeds, in the clinic, we see folks that I think everyone is really talking
about when we speak of the medically disenfranchised. Now, there's no question that improved access to care would help these folks, especially black men who rarely have Medicaid unless they're disabled, but even so there's much more to better health than access. As was mentioned before, continuity of care, the same doctor is so important, a medical home, ample time.

The Commonwealth Fund did a wonderful poll in the late '90s. I wish they would repeat it. Over 1,000 people, about eight different ethnic groups, and asked them so many questions about how they determined which practitioner they want to go to, and out of 13 options, race tied last with something else.

Medication, people should have the option certainly to choose their physician based on race, but the patients in this survey, and as I said, there were over 1,000, said that was really the least relevant. The doctor spending time with them was one of the most. So that is very important.

Access, again, as I said, is huge, but the determinants have to do often with engagement. Will patients engage in the self-care that you mentioned that is so important because so many have chronic illnesses which contribute tremendously to the health
care burden?

So I personally for this kind of problem and for my kinds of patients actually am a great fan of local public health clinics. This is very much on the ground. We're talking five feet above, not the 100,000 foot view, but where you can have hours for open nights for the working core, a location that's convenient to keep people out of the emergency rooms, staff with local residents. I think that goes very far to the cultural sensibilities that we're all talking about.

The physician assistants and nurses, they help the physicians. They do the support. They do the outreach. They make the follow-up calls.

So in summary --

CHAIRMAN REYNOLDS: Doctor --

DR. SATEL: Can I make my summary?

CHAIRMAN REYNOLDS: Yes.

DR. SATEL: Okay. Three points very quickly. Recognize that the elimination of health differentials is not feasible because we cannot eliminate the disparities, the social disparities, many of which take their most profound toll in terms of the habits of mind and view of the future.

Such an agenda clearly transcends the work
of public health and is best left to politicians, voters and social welfare experts.

    I'll stop there. Thank you.

CHAIRMAN REYNOLDS: Thank you.

Dr. Bach.

DR. BACH: Thank you very much for this invitation. I'm really thrilled that you're having this hearing, and I want to say metaphorically that the fact that I'm jammed at the end of the table I find to be a great turn of events that the Jewish white guy finally feels marginalized.

(Laughter.)

DR. BACH: Chairman Reynolds, Vice Chairman Thernstrom, esteemed members of the Commission, my name is Peter Bach. I'm a physician at Memorial Sloan-Kettering Cancer Center in New York City where I do health services research.

    My research discipline uses the hybrid of text and techniques from economics, epidemiology, and statistics in order to gain a representative understanding of the health care delivery system. For more than a decade, one of my main research interests has been health disparities.

    I'm grateful for the invitation to speak with you today about my research and others. I'm
humbled by this opportunity, and I have to acknowledge my funders for more than a decade, the National Cancer Institute, the National Institute of Aging, the Commonwealth Fund, the Robert Wood Johnson Foundation and others, but I must specifically credit my colleagues, Colin Begg and Deborah Schrag at Sloan-Kettering and my time at the Center for Health System Change. We have all worked together on these problems. The names that appear and the orders they appear on our work are less relevant.

About a decade ago my colleagues and I wondered if the high mortality rates for cancer seen among blacks when compared to whites could be due to blacks receiving less effective treatments specifically in the setting of cancer.

We chose to study a single cancer procedure to address our question, surgery for early stage lung cancer. We focused on this procedure because it treats the number one cancer killer, lung cancer, 25 percent of all cancer deaths, and is enormously effective.

In an analysis we published in the New England Journal in 1999, a decade ago, prior to the IOM report that has been referenced many times, we showed that in Medicare blacks with a curable
diagnosis received the surgery 13 percent less often than whites with the same diagnosis. We showed that this was not due to greater co-morbidity amongst blacks or even due to differences in socioeconomic status.

We also showed that we believed that this treatment gap was the explanation for blacks' poor survival outcomes in lung cancer. The study is personally memorable for me. It was one of the first major analyses publishers in the NCI Seer-Medicare database, which has become a cornerstone of studies of cancer care, and it was also one of the few studies that had demonstrated at that time that treatment gaps were important in terms of disease outcomes.

That has been since shown in numerous other studies, but prior to that treatment gaps had been illustrated without a link to outcomes. We were unable to determine in our study why treatment rates were lower for blacks. Our study wasn't designed with that question in mind, and the data we used was insufficient to address this sort of granular, patient-level question.

We have used national data covering many years and tens of thousands of patients that we had little individual level information. Other work in
disparities is notably the opposite, sometimes covering just a few patients and doctors in a single practice setting in which a lot can be learned about that setting, but less about the universe of care settings.

The follow-up from the publication was educational for me. A number of pundits, if you will, stepped on top of our findings to use as a platform to decry the health care system as racist and, by extension, doctors as racist. The New York Times "Week in Review" section carried on their front page an article about our study which was titled "Not just another case of health racism." It's framed in my bedroom, by the way.

Too many people concluded too quickly that the explanation of our findings was that doctors discriminated against their minority patients, and I noted a few years later in an essay in the New England Journal of Medicine reviewing the IOM report on equal treatment that the invocation of racism as the cause of treatment disparities moves the problem, if you will, one of health care system quality, to one of health care providers' moral failure.

Our research group saw in some studies the potential for another explanation that Dr. Chandra has
referred to, one that, if you will, blamed the system rather than the doctor.

We hypothesized the key reason why blacks received lower quality care than whites could be that they went to doctors who for a variety of reasons were less able to provide the high quality care routinely received by whites. This could be the case because the doctors were less well trained, less well resourced, or simply less knowledgeable.

And so a few years later, in 2004, we published another study in the New England Journal that provided evidence supporting our explanation. We documented two conditions that supported our theory. First, we demonstrated that the key precondition for our hypothesis existed. Blacks and white were, indeed, not treated by the same doctors. We looked at Medicare patients, and we were able to show that the care of black patients was heavily clustered among a small group of doctors. It took only 20 percent of primary care doctors in the U.S. to account for 80 percent of all care received by blacks.

Whites were different. Their care was mostly with other doctors. Then we showed that the doctors at the level of individual level patient visits were different. We asked the question: if I'm
a typical Medicare patient who is black, what are the
features of my doctor compared to if I'm a typical
Medicare patient who is white?

We found the doctors looked different. A
black patient was less likely to have a doctor who was
Board certified in their primary specialty. We
thought that was important because having Board
certification has been shown in decades of research to
be a key predictor of delivering high quality care.

We also found that the primary care
doctors who treated blacks took fewer resources to
direct at the care of their patients. They had harder
times making referrals for all of their patients.
They had trouble electively admitting patients for
work-ups to the local hospital and getting imaging
tests.

More interesting, the financing of the
practices was different. Blacks went to doctors who
more often provided free care and care to Medicaid
patients, and the net effect was that they had lower
revenues per patient and, therefore, less resources to
support the practices and the other caregivers in
them.

They also were more likely hurried,
something most recent research has shown.
Around the time of this paper and over the years since, these findings have been reproduced numerous times, including by Dr. Chandra and his terrific colleagues. If doctors or hospitals, surgeons, centers of managed care, insurance companies, lower quality overall seems to be associated with having more black patients and fewer whites within a care setting.

Recently colleagues of mine looked at more detailed aspects of practices that treat large numbers of minority patients and estimated that the impact of low payment rates for Medicaid itself were a sizable contributor to access problems and led to shorter patient visits, too.

My colleagues and I have some new unpublished findings that I can give you a top line review of. We are finding that for Medicare patients the important predictors of getting lower quality care are, first and foremost, your socioeconomic status for the regional or local area economic climate in which you live and how good the quality of care is that your doctor gives his or her other patients, meaning his or her white patients typically.

We are unable to detect any consistent evidence that doctors are treating their black and
white patients differently per se. I believe our findings are consistent with the plausible hypothesis that care for blacks is of lower quality primarily because blacks are accessing a part of the system that is poorly functioning.

Little, if any, of the under treatment appears to be due to doctors singling out minorities for lower quality care.

Neither my colleagues nor I take the challenges posed by this alternative explanation to health disparities lightly, in ways that will be harder to ameliorate, but the payoff will be more durable and robust.

So you have asked me here today to talk about health disparities and what our research suggests about its origins. That research rests in a social context in which many people arrived early at a conclusion that discrimination, be it conscious or unconscious, lay at the heart of treatment disparities. Our work has provided a different explanation, one in which we have a poorly distributed health care system in which the lowest quality resources are in the neighborhoods with the most needy individuals. If correct the mechanism suggests that the purse that targets these high-risk areas would be
the best way to improve care and outcome for the
patients in --. Thank you again for inviting me and I
look forward to your questions.

CHAIRMAN REYNOLDS: OK. I would like to
thank all the participants. This has been a fantastic
presentation. At this point I would like to open up
the floor for questions from the Commissioners.

Don’t all jump in at one time folks,
Commissioner Melendez.

COMMISSIONER MELENDEZ: First, I wanted to
thank you all for being here today testifying on
behalf of the medical -- I just wanted to ask a
question of Dr. Graham.

As far as data collection, you had
mentioned that. I know that for the Native American
population, one of the issues we always had is the
census, and there were tremendous problems with the
statistics especially in 1990 and 2000 as far as, you
know, what the population of Native Americans actually
were on the census.

What do you think about how does that skew
the results?

DR. GRAHAM: Sure, and I'm glad you
emphasized that point because from my standpoint, one
of the very, very key issues -- we talked on some
other issues on health disparities here today. One of the very instrumental issues is data collection. Aside from some of the challenges you mentioned with the Census Bureau; one of the major challenges we face is in the tools that we use to collect data on health statistics.

Many of the surveys that the Department of Health and Human Services as well as state organizations and state public health agencies use to capture what is the health status of our country, many times we miss important subsegments of our population, such as the Native American population, as well as the Native Hawaiian and other Pacific Islander populations.

And so what that practically spells out is that many data points you see asterisks and stars and dashes instead of actual statistics on those specific populations. We have actually taken that issue very, very seriously on the HHS leadership standpoint, and we have an organization that's called the Data Council and all of these kinds of infrastructures within HHS. We are taking a very serious look at how can we be able to start capturing some of those demographics because if what you don't measure you don't see; so this idea of capturing, you know, some of the data in

NEAL R. GROSS
COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
(202) 234-4433
WASHINGTON, D.C. 20005-3701
www.nealrgross.com
terms of, you know, what is the true incidence of heart disease, what is the true incidence of cancer or what is the true incidence of all of these very diseases that were mentioned on specific -- especially the Native American population.

Part of it is just being able to capture folks, to be able to reach folks and to be able to actually have them answer some of the data questions and then be able to put that within -- simplifying it, but then be able to put that within some of the data collection systems that we have.

So one of the strategies that we're really employing is very targeted studies where we specifically have specific efforts to reach folks and be able to capture the population appropriately.

DR. PAMIES: If I could just follow up with that because I think that one of the things that was of interest to me as we had this discussion is some of the different conclusions that we reached in terms of the causes of health disparities and what it highlights for me is the need to do more research, and quite frankly, one of the concerns I've had with regards to data is that there is a group and there's a push now to eliminate collections of racial and ethnic data in looking at health outcomes. I believe that
will be extremely dangerous.

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

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

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

Our special jurisdiction here is somewhat limited, and that is to focus in or to try to focus in on the causes and the extent to which there's implicit or explicit racial discrimination. So I'm going to focus a few of my questions or my basic question was particularly to the last three who tried to get at that.
And as I understand, this is a terrible over generalization, but I think all of you have testified very clearly some genetic differences depending on the disease. There are behavioral reasons, socioeconomic reasons that have a big role to play before there's any interaction with the health care system.

Some of these are epigenetic. So they're experiential, and those experiential may be fabulously complexly related with those other factors.

And then there are the impacts of the health care system, and we've heard that there is at least a concern and some research suggests it has to do with the clinical experience and bias, and some of it has to do with the unevenness in the quality of care.

And I wondered particularly the last three. I think, Dr. Chandra, you began to put some of this in words. What percentage in maybe pick a disease if you know it or some diseases are caused by these factors? I should say what percentage of the disparity is caused by these factors that don't really have much to do with the health care delivery system?

And then what percentage is related within the health care delivery system to possible bias and
implicit differences? What percentage, even if it's a
wide guess, a range, something like that, just to give
us a sense as to what your research suggests, and the
same for Dr. Bach.

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

You could also say that some of that 40
percent was the fact that within the particular
hospital blacks and whites were being treated by
different groups, maybe varying in quality.
So we weren't in that study able to drill down completely, but we were able to say that when you're looking at something like three-month survival, there's an enormous role of the care system that you were treated at which becomes more and more important when you narrowed the window over which you are looking at outcome differences.

So for example, if you change the outcome measure to what is the role of geography or provider differences in explaining 30-day mortality differences, then the role of the hospital that you were treated at explains 100 percent of the treatment disparity, which is in a sense what you would expect because the hospital is going to be very important for the first week, for the first 15 days.

But once you are discharged from the hospital, then a bunch of other factors or insults start to affect racial differences in mortality.

CHAIRMAN REYNOLDS: Okay. Dr. Bach.

DR. BACH: Just I think Amitabh laid that out nicely. It's hard to separate, and it obviously varies by disease. You know, we don't think the difference in cancer incidence, for example, which are about ten percent adjusted between blacks and white, black men getting about ten percent higher, had
anything to do with the health care system. We have
especially no preventive cancer measures that we
distribute through the health care system. Obviously
things like smoking, things like that sort of sit a
little bit outside.

But you know, in the paper I alluded to --
and I regret that it's not yet published because I can
talk in more detail and you can review it, but
hopefully some day -- we looked at the delivery of six
preventive services in Medicare, and we were able to
assess that on average about half of the gap in
preventive services delivery were, like I said in
terms of socioeconomic status in the different
patients and another 30-plus percent or 40 percent of
that was between provider differences so that blacks
were going to doctors who treated more of them and
provided lower quality care, and then there was a
residual that had to do with co-morbidities and things
like that.

But of the six, they're split right down
the middle, a few percent in one direction, a few
percent in the other were due to, if you will,
different treatments of black and white patients by
the same doctor, things that we would argue are just
sort of a statistical anomaly.
So if the question is at least in the area of preventive services, diabetic eye exams, monitoring of lipid levels and things like that, that we're not seeing any evidence that it's sort of within the doctor's office. It is all sort of around the doctor's office where patients are going.

COMMISSIONER GAZIANO: Thank you.

CHAIRMAN REYNOLDS: Okay. Commissioner Yaki.

COMMISSIONER YAKI: Thank you very much, Mr. Chair.

And I also commend the panel for a fine presentation. I just had two very small questions.

The first one comes from research that's been done in the Asian American community. As you know, there are a lot of different perceptions of the Asian American/Pacific Islander community in terms of its health education benefits. Most of them tend to be sort of bell curve, U-shaped curve in terms of distribution of income, access, what have you.

And this actually goes probably to a lot of new immigrant populations as well. To what extent does linguistic and cultural competency and access have an impact on access for and quality treatment of health care for those who need it?
I just throw it open to the panel.

DR. GRAHAM: I think I'll take the first stab at that.

I think as I mentioned earlier that has a definite, if not significant, if not tremendous impact in terms of some of the several factors that we mentioned here today. Dr. Sullivan in terms of presenting -- when he was presenting some of the data on work force alluded to this issue of concordance and better outcomes in terms of concordance between providers.

That's something that's well established in the literature. I think implicit with that is this ability to provide cultural and linguistically appropriate care, and I think the idea that a patient understands what you're talking about, and not only that the patient understands you, but you understand the patient is a particularly important point.

Now, it's something that is harder to capture significantly in some of the hard core outcomes that Peter and others have spoken about, but I think that is kind of what's implicit within that 40 percent and some of those other parts of the data where you see some of these kind of intrinsic and implicit factors.
I also want to allude to the other thing that you pointed out, which is this myth I would say within that Asian Americans are uniformly healthy. When you look at the data around Asian Americans, you see specific and significant health disparities in subpopulations of Asian Americans that are troubling, and it's up to us to make sure that we educate the broader U.S. population on just what some of those disparities are.

DR. SULLIVAN: If I might comment, I would say this. I think the data that the system really has bias in it is so overwhelming that it depends upon how you define the issue. In research it is very easy to define the way of problem by how you set the premise forward.

I happen to serve on the board of Grady Hospital, the public hospital in Atlanta. We have a tremendous problem because we have a growing Hispanic population, and the very issue that Dr. Graham mentioned is one that we are dealing with, that we don't have enough interpreters to speak to the Spanish population that we're serving, and we've been told by leaders within the Hispanic community that many of their citizens don't come to the hospital because they don't feel it's a welcome environment.
That's a fact that weighs on the care that the individuals receive. In 1996, in the *New England Journal of Medicine*, Dr. Miriam Konarami and her associates with their studies from the University of California, San Francisco, showed that black or Hispanic physicians were three to five times more likely to establish their practices in black or Hispanic areas, and they showed that the health data in those communities where they settled improved.

Now, one might say that this is not due to bias in the system, but I think that depends upon how you define it. So I think I don't refute the fact that when one looks very closely with a lot of caveats, indeed, you may not find differences if you look very finely, but there are gross discrepancies in the health care system that has an impact on people's lives.

And I think it's important that as we are working to improve the health of Americans that we do not dispose of those factors that have a system that really makes it very difficult for a growing segment of our population to receive the care that they need.

This is important for everyone because one of the challenges we face as a society is a growing health burden as well as problems, frankly, in our
educational system; that if they're not addressed over
time, that's going to erode the strength of our
country.

So I think we have to look as broadly as
we need to, but certainly look finely as well, but not
dismiss those systemic problems that interfere with
the ability of people to receive care on the basis of
income, education, and bias.

I happen to be old enough to have grown up
in the South where my family drove 41 miles to see a
black physician rather than go in a room that said
black patients versus white patients. I define that
as bias. My parents defined that as bias that they
would not accept.

So I think we have to be careful not to
try and dismiss the factors in our system that do
impair the ability of our patients to receive the care
that they need.

COMMISSIONER YAKI: Well, Mr. Chair, my
second question was actually more along those lines.
I wanted also to get the panel's reaction.

I don't tend to think that as much -- and
certainly I think a lot of you have affirmed that --
to the degree that there is at the micro level
individual discriminatory decisions going on in some
physicians' minds that I'm not going to give this person X or Y.

    But the fact that these disparities exist and that they are documented and that they seem to be consistent over time, whether it's with native American health care, whether it's with the Mong populations or whoever, an Asian American with Latino, with African American; there is, I think, as Secretary Sullivan -- I call you by your highest title -- Secretary Sullivan --

    COMMISSIONER GAZIANO: Maybe he thinks one of his other achievements is higher.

    (Laughter.)

    COMMISSIONER YAKI: I just go by straight protocol. That's how I was brought up.

    But Secretary Sullivan seemed to indicate that there's still something amiss, and the question is now whether someone is sitting there saying, well, I'm going to stick it to this group or that group, but nevertheless, it comes under resources, doesn't it? It comes under resource allocations, where people decide to put their resources, in what neighborhoods, in what clinics, in what areas of further study for research.

    And I'm just wondering from your points of
view where is it in that decision track that we still keep coming up with the fact that there is a 60 percent we can't explain or attribute to this or what have you. That to me is the real core of what this hearing is about. Because hopefully, we're mainly past the times when Secretary Sullivan doesn't want to go to a room that says whites only and blacks only.

But there's still something wrong, and I think we all recognize it, and the question is: what is it? Because especially in the health care debate going on right now, tremendous change is going to occur. How that change will impact what we currently are still struggling with right now is going to be very important.

Doctor, and then Dr. Satel.

DR. PAMIES: I think you raise a good point, and one of the things that I would hate for us to walk away from this meeting is that somehow the health care industry is somehow biased towards taking care of patients, which it is not. I think the overwhelming health care providers in this country try to provide the best possible care and the most equitable care to all of their patients.

And I've had the opportunity of working in six different geographic regions and have met nothing
but some of the most ethically and morally highest
individuals in the country.

Having said that, we have to understand
that we all come into this profession, the health care
profession, with our own life experiences. Our
decision making is based a little bit on that life
experience, and we have to make judgments.

Some of those judgments are on our
interpretation, or at least our ability to figure out
whether or not our patients will be able to carry out
certain treatment plans or will be able to understand
certain treatment plans.

So some of the decisions that are made are
based on some of those type of findings that goes into
that interaction. I will say though one of the things
that you have to be concerned about is the average
interaction between a provider and a patient according
to various studies is between six and nine minutes,
and when you add the issue of language into that, it
creates even more complexities.

And having an interpreter doesn't solve
the issue because one of the things I was finding out
initially was that family members were serving as
interpreters, and many times the patients don't want
to tell their family members what's going on, and so
they have phone calls that you have to make informed
decisions or call an interpret line.

So even those weren't found to be
adequate. I think it speaks to a couple of issues.
One is having to do with work force diversity, and
this is one of the important aspects of it that I
think you need to look at.

The second thing has to do with the
overall poverty and educational level. Just by being
poor, you're likely to live six to nine years less
than if you were not poor. So those social
determinants are very, very critical.

But then just as a uniform answer, I think
we need to look at health literacy as a bigger picture
rather than just language because many of our patients
come to our offices and our facilities with not the
best literacy understanding, especially when you're
talking about medical jargon.

So I think we need to look at the
complexity of the health care industry and put the
resources in all of the other areas that impacts the
care of the individual rather than focus just on that
patient or provider patient information. We have to
utilize the entire service.

CHAIRMAN REYNOLDS: Commissioner Heriot.
COMMISSIONER GAZIANO: I think Dr. Satel was going to answer.

CHAIRMAN REYNOLDS: Oh, sorry.

DR. SATEL: Quickly, I think the answer to your question is that we really don't know what makes up a lot of that noise, and that's why I mentioned that really at that fine grained level, you really do need prospective studies and actually need the sociological focus.

That may sound touchy-feely, but there are absolute ethnographic methods to standardize these kinds of encounters and follow them.

As far as what is now referred to as the cultural competency, I think that the physician is clearly an important figure, but when it comes to chronic illness and patients who have this lifelong burden of diet and exercise and when you're poor and your life is chaotic, that's not always a priority. So to have a relationship with what I call the halo personnel, the nurses and even the secretaries in the clinic, they're often the ones that patients have some of the best relationships with, but the nurses, the LPNs and the PAs. Those are the folks who, again, often draw from the community, too. They've the ones who follow them up. They're the ones who engage them,
and again, with chronic care, which is so big of a
burden, that engagement is really huge.

So that's where I would focus. Now, that's a local kind of thing.

COMMISSIONER YAKI: That makes Secretary Sullivan's statistics on the shortages in those categories even more severe.

DR. SATEL: Yes, oh, definitely. I agree.

CHAIRMAN REYNOLDS: Commissioner Heriot.

COMMISSIONER HERIOT: Thank you.

I just wanted to continue a bit down the cultural competence area here. Obviously it seems to me that cultural competence has got to be something that is important.

On the other hand, there's a bit of a tension between that and the studies of Dr. Chandra and Dr. Bach. You would think that if cultural competence is the root of the problem, that the studies would have come out differently.

I mean, it sound like when minorities are going to the same medical facilities that whites are going to, you'd expect since those would specialize in non-minority patients, that they'd be the least culturally competent.

And yet if I'm understanding correctly,
where we're finding the problem is not in that area, but in the area where we'd expect greater cultural competence because minorities are going to those doctors more often.

So you know, regardless of who those doctors are, they're getting repeat patients, and you'd expect at least after a little while, they'd become more culturally competent.

Is there some way that this can be pursued in your studies to figure out just how important the cultural competence issue is? Because it really does strike me as a significant tension between what's being discussed here and what we're actually getting in outcomes.

I think it would be a travesty if we put all of our efforts into developing cultural competence if that's not the problem.

DR. CHANDRA: I guess my response to that is I guess I don't think that the world is being either Mechanism A or Mechanism B, and so sort of there's a role for both mechanisms. When it comes to things like treating heart attacks and treating stroke, it seems to be more to the quality of the provider, the quality of the hospital. Was this hospital able to do angioplasty, rescue angioplasty
within 45 minutes of the patient being brought in?

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

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

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

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

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

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

DR. SULLIVAN: If I might add a comment,
one of the major problems in health care is compliance
of patients with the instructions from the health
provider. We have a tremendous problem with lack of
compliance. Within the few weeks many patients, as
many as half may not be following their physician's
orders. That is often based upon not understanding
what the provider has said or not trusting the
provider.

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

DR. BACH: May I answer that?
CHAIRMAN REYNOLDS: Jump in.

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

And so I can speak for Amitabh and myself.
No one is sitting here suggesting that there aren't
important, large difference that are intolerable and unconscionable. What we are focused on is very much to your question: what is the right approach? What are the most strategically effective approaches for eliminating or reducing things to the extent we can within our constraints?

And so on the top of cultural competence, you are absolutely right. The correct interpretation of our data, given that we detect no difference in the treatment of blacks and white by individual doctors, is that either the doctors are well matched to both patient groups or that this cultural overlay is uncorrelated, a different way of saying the same thing.

On the topic of cultural competence, I have some questions and concerns, but I find the concept sort of intriguing. The first is that there is a general conflation between the notion of cultural competency and health literacy and linguistic competency, if you will. I view those as somewhat different issues.

The issue of health literacy challenges for patients are real and well documented. Linguistic gaps that patients suffer in many settings. Dr. Sullivan -- sorry; Secretary Sullivan -- mentioned a
profound one, but those issues are often conflated with the issue of cultural competency within linguistic groups, and I think that that concept currently lacks a sufficiently robust definition in order for people like Dr. Chandra and I to study it. And I also think it's uncertain, given the lack of definition, how we address a cultural competency shortfall if one exists. I'm not sure necessarily that enriching the physician work force with minorities and members of other ethnic groups, which is something I'd fully support, by the way, is something that would necessarily address this gap.

And I do think it's important. I'm a physician educator. I teach at Cornell Medical School. I have residents and fellows under my tutelage, if you will, when I see patients, and I do think it is important to appreciate that medical schools are moving towards a culturally competence focus within the curriculum, and we should appreciate that medical education is a zero sum game.

And the work of Dr. Chandra and my work and many other people, Dr. McGlenn (phonetic), the groups at Dartmouth and the rest, have demonstrated profound gaps in clinical knowledge amongst doctors, and work force regulations and other features taking
away from an education environment. We do have to appreciate that every layer of demand we put on them academically to enrich their ability in one area necessarily takes away from some other area.

And so I think we have to be very careful that we don't take away the doctor's ability to read an EKG in an instant, nor did they teach him to talk to a patient about what's happening with their myocardial infarction.

So that's my caution.

COMMISSIONER HERIOT: I've got one more question. You mentioned geographical disparities. Do you have any research that tells us what the disparities are between not races but rural versus suburban versus urban residence?

DR. CHANDRA: Amitabh, do you want to take that one?

DR. CHANDRA: It's interesting. That work speaks more to the enormous body of work that has come out of the Dartmouth Atlas Program at Dartmouth Medical School, and what you see there is a strong association from northern New England states, along with States like Utah and Montana, which are able to deliver what the Dartmouth people call highly effective care at not particularly high prices.
And then there's a gradient moving down in certain states, including California. So for the purpose of this analysis, California looks like a southern state.

There is a rural-urban difference. There's no question, and it's driven largely by a handful of extraordinarily good academic medical centers that are in urban areas, but it is not automatically the case that urban hospitals out perform rural hospitals. That's not true at all.

In general you also see gradients which are aligned in ways that we don't completely understand. There appears to be some linkage of quality, and we can have a separate conversation about what definition of quality I have in mind. I'm thinking about the sort of highly effective care that's very cheap, like you know, flu shot for elderly Medicare beneficiaries, mammograms, beta blockers after heart attacks.

If you look at those measures of quality, it also appears to be the case that areas of the United States that have greater specialists relative to generalists -- these aren't areas of the United States that have more specialists in an absolute sense. It's just that the composition of the
physician work force is kind of biased more toward specialists -- those are the areas that actually do poorly in terms of delivering high quality care.

Now, that may or may not be causal, but you know, you asked me a question about how does it line up, and so there's something about the physician work force. Even though given specialists may be better at treating the particular condition that they're trained to treat, it's possible that you have some fragmentation of care that arises when you have more specialists involved in the care process. But that is a process that has never formally been tested.

CHAIRMAN REYNOLDS: Vice Chair Thernstrom.

VICE CHAIR THERNSTROM: In the first place, thank you for coming and I apologize for being late. I must come over tired. So I'm swimming underwater here a little bit.

But I do have one remark and one question. Well, I guess they're both questions.

The whole notion of cultural competency, frankly, bothers me, and let me move to another area where there are analogous arguments made, that is, in the area of education, K through 12 education, and there's a lot of kind of chatter in the world for educational literature on the question of whether the
racial gap in academic achievement is due to inadequate cultural competence on the part of a lot of teachers.

And the record here is very, very clear. What determines educational outcomes is the quality of teachers by all the standard measures. You know, what were their SAT scores? Where did they go to college? What do they know? Teachers can't teach what they don't know. Too many of our teachers don't know very much.

And it has nothing to do with anything one would call cultural competency or skin color, and indeed, parents -- and this squares with the message that one of you delivered. I can't remember which -- parents don't care. I mean, there's been a lot of survey data on this. Parents don't care what the color of their teacher is. They care about the quality of their teacher in terms of the lessons that are being delivered and the outcomes.

Does the fourth grade teacher know any math? The answer is usually no, and are the children learning any math?

And some of the best schools that I've looked at in places like the South Bronx in New York, just desperately poor, overwhelmingly minority places,
are actually run by whites, started by whites. The
charter schools I've been particularly interested in,
and none of the parents care. I mean, what they know
about that school is it's teaching kids.

The whole question of cultural competency
and how you define it really troubles me, and then in
terms of -- and I'll go back to my Bronx example -- in
terms of differences between care delivered in
different areas and the question was brought up, I
believe, by Commissioner Heriot of rural versus urban.
If you go back to my favorite school in the South
Bronx, there's a sign in the hallway, "Never Take a
Child to" whatever the local hospital is in the South
Bronx. Under no circumstances, and no teacher is to
go to that hospital.

So this is in one city. This is not rural
versus urban. This is a huge difference in quality
between hospitals, you know, a mile apart, and I'm not
sure what the reason is that you get such a
dysfunctional hospital in South Bronx in New York, but
I don't have any doubt that that message within that
school has been well thought out.

So, you know, two questions. What do we
mean by "cultural competency"? And you know, are we
really zeroing in on something that's ultimately very
important here?

And the second question, of course, is when you look at that Bronx Hospital, and what's going on?

DR. PAMIES: If I could just comment, first of all, I think that there's a whole lot of information and literature coming out now looking at cultural competency in this culture and its impact on health care and health care outcome. I call your attention to at Harvard Joel Betancourt's program right here in Georgetown at the National Center for --

VICE CHAIR THERNSTROM: And the definition of cultural competency there is what?

DR. PAMIES: Well, I think you can narrow it down into two things. Number one is respect, respect for the person's culture and the impact that person's culture has.

VICE CHAIR THERNSTROM: How do you measure that?

DR. PAMIES: You can measure it how you treat the patient, how you interact with the patient, how your staff interacts with the patient. There's a number of surrogates.

I think one of the things that we have to do is to educate people on the role of culture. We
have a very large and growing Sudanese population in
my part of the state, in Nebraska, as well as growing
Mexican American population, and there's no question
that language, understanding some of the aspect of the
culture, making sure that just simply writing a
prescription or telling them what to do is going to
have them follow through, is really naive in the part
of the physician and the health care provider.

You have to understand who to communicate
with in the family structure in order for them to
adhere to the treatment plan.

VICE CHAIR THERNSTROM: Isn't that true of
low income white as well? I mean, I know a physician
who was running a clinic in a very low income white
area and finding exactly the same problem.

DR. PAMIES: Well, that's why I go back to
understanding and respecting those differences. It's
not a --

VICE CHAIR THERNSTROM: Well, that's
social class difference.

DR. PAMIES: Well, I'm not sure if it's
social class difference. It might be social class
difference, but it's much more broad if you look at
it.

My point was that there's an education
that needs to be given to the whole issue of one's
culture and the cultural competency and provision of
good care.

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

I would like to comment.

VICE CHAIR THERNSTROM: Can I just
interrupt one second?

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

DR. GRAHAM: So let me help answer that
question. So I think we're hearing some good feedback
from Peter Bach and some of the research that they've
done there. I would harken this group and this
Commission to take a good look at the Institute of
medicine. For those of you who are familiar with what
the Institute of Medicine is and what the Institute of
Medicine does, they pull together a group of national
experts in any particular topic area to really
investigate and understand and be able to publish an
unbiased, nonpartisan view on a particular topic.

One of the things that the Institute of
Medicine report back in 2002 highlighted was the
importance of cultural and linguistic competency
obviously in health care, and I'm not a teacher. So I
can't speak to education, but I certainly have a
tremendous amount of respect for teachers and the
importance of work force diversity.

One of the other pieces of data that we
can certainly read for yourself or understand from
that very report is the importance of concordance
between groups in terms of understanding and being
able to understand particular patients.

Now, here is where I think we kind of get
to the heart of cultural competency, understanding the
patient and being able to understand the culture.
That could be a poor white patient. That could be a
rich white patient. That could be a Hispanic patient. That could be a Russian patient. It's about understanding cultural background of that patient and being able to appropriate that in terms of the health care setting.

When we're talking about cultural competency, I think here we're specifically focusing on race and ethnicity, but really what the broader concept of cultural competency means is understanding that particular patient and being able to rate that patient.

Now, as a physician, I can tell you reading EKGs are important, but patients care more when you care about them and understand their stories and where they are coming from, and one of the things that I think, again, Dr. Sullivan alluded to in terms of talking about some of the work force data is this idea that we trained our work force that is reflective of our nation and reflective of what our country represents is important not just in terms of altruistic goals, but it's important in some of the health outcomes that we can point to, and I'm sure Dr. Sullivan can answer some of those questions further.

DR. SULLIVAN: If I can add.

VICE CHAIR THERNSTROM: Dr. Satel had her
hand up.


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

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

CHAIRMAN REYNOLDS: Dr. Satel.

DR. SATEL: Commissioner Thernstrom is right. I think that the definitions that I've seen -- I thought I had one in here. I'm sorry I don't -- of cultural competence are mind numbingly vague, and the distinctions you made between linguistic competence
and what I might call anthropological competence, especially when you work with unacculturated populations, you want to know what home remedies they use. This kind of thing is extremely important.

At its worst, cultural competency training devolves into a version of racial sensitivity training with the stereotypes intact. I've always wondered how I'm supposed to treat my black patients differently than white ones.

You had mentioned though Joseph Betancourt, and I have a quotation from him here which I think is revealing because what he really shows is kind of what you said, which is that this is about universal factors in dealing with other human beings, in this case within the medical setting, and it's a very short quotation where he says that an enlightened form of cultural competence that has "evolved from implementing the principles of patient center care, including exploration, empathy, responsiveness to patients' needs, values and preferences."

And that's on an individual basis, and as you said, to respect that in all individuals, but this kind of group based ethos is very hard to translate into a clinical setting.
DR. SULLIVAN: Yes, Mr. Chairman. I'd just like to -- I'm sorry. When we speak of cultural competence, this is not simply racial or ethnic. A good example of cultural competence is today half of the medical students are women. When I went to medical school, this was less than five percent. The presence of women in medicine has helped to improve women's health care because there are many efforts of communication, trust, compliance, et cetera, that many women do feel much better having a woman physician.

It doesn't mean that the male physician is incompetent, but if the patient is reticent in communicating, and we heard earlier about translators using family where the family doesn't translate everything, it really is a two-way street.

So in my view, cultural competence includes that sort of thing. I think we are much better off because today we have women health professionals as well as men, because they can in many cases when some women are reticent to share intimate details of their medical care, they can do that with women and they get better care.

That is one example of cultural competence. It has nothing to do with race or ethnicity.
CHAIRMAN REYNOLDS: Okay. At this point I'd like to thank you. This has been an informative exchange.

COMMISSIONER GAZIANO: I think Commissioner Taylor.

CHAIRMAN REYNOLDS: Oh.

COMMISSIONER TAYLOR: I will be brief. I know we're on a short schedule here. We have a second panel.

I want to thank everyone for coming. First of all, I want to encourage and since C-SPAN is here the press to actually read the transcript and shy away from taking the blunt instrument approach to this issue that I see taken so often, ready to label any disparity as a result of active bias or discrimination because in my view it is a more complex picture, and I think that has been borne out today.

I am concerned that what I hear that minorities are clustered among a certain number of physicians, and that's what I hear, and I'm not a physician, but I come to this in many ways as a consumer, and so I want to know why there isn't more of a discussion about this clustering and why black folks aren't told that the outcome in large part depends upon where you're going, and by the way, we're
all going to the same place with a bad outcome. Why isn't somebody telling us that?

I have a great concern about that, and you know, it's not hard to document and chart. Let's put it on the chart. Let's show where black folks are going, other minorities are going so I can tell my folks to go other places where the outcomes are better.

So I'm going to leave on that point, and if nothing else comes out, I am thrilled that that came out today.

Thank you all for coming.

CHAIRMAN REYNOLDS: Okay. Well, there's nothing left for me to say other than thank you very much, and let's take a five-minute break and start the second half.

(Applause.)

(Whereupon, the foregoing matter went off the record at 11:26 a.m. and went back on the record at 11:42 a.m.)

CHAIRMAN REYNOLDS: Very good. Let's get started.

The speakers on the second panel will discuss specific research and projects dedicated to closing gaps in cardiovascular health of specific
population groups. The following experts will participate in the second panel.

Dr. William Lewis is on the National Steering Committee for the American Heart Association, with the Guidelines Program. He is an Associate Professor of Medicine at Case Western Reserve University and Chief of Clinical Cardiology at Metro Health Medical Center in Cleveland, Ohio.

Next we have Dr. Herman Taylor. In 1998, Dr. Taylor arrived in Jackson, Mississippi to lead a landmark Jackson study, the largest population based study of heart and related diseases ever undertaken involving African Americans. They study both sought to answer questions about cardiovascular disease risk within the black community and also provided historically black colleges and universities experience and large scale epidemiological research.

Dr. Taylor is also a founder of Heart to Heart, a nonprofit organization that provides cardiac surgical services for children from the developing world.

Then we'll hear from Dr. Barbara Howard. She is the senior scientist and former president of MedStar Research Institute. She currently holds faculty appointments in the Department of Medicine at
Georgetown University and the Department of Biochemistry at Howard University. She is past chair of the American Heart Association Council on Nutrition, Physical Activity and Metabolism; past chair of the Nutrition Committee of the American Heart Association; and past chair of the Nutrition Study Section of the National Institutes of Health.

Her major research interests are in cardiovascular disease, particularly in relation to diabetes and its occurrence in diverse ethnic groups. Her current research projects include a strong heart study, a multi-center study of cardiovascular disease and its risk factors in American Indians, and a study of the genetics of coronary artery disease in Alaskan Eskimos.

Then finally we have Dr. Bruce Siegel, who has served as co-director of the Robert Wood Johnson Foundation Quality Improvement Collaborative, Expecting Success, Excellence in Cardiac Care. He is a research professor and a Director of the Center for Health Care Equality in the Department of Health Policy at the George Washington University School of Public Health and Health Services.

At this time we will swear you in. Please swear or affirm that the information that you have...
provided and will provide is true and accurate to the best of your knowledge and belief.

PARTICIPANTS: I do.

CHAIRMAN REYNOLDS: Very good. Okay. Let's get started. Everyone will be limited to ten minutes, more or less, and we will save the Q&A for the end. So let's start with Dr. Lewis.

DR. LEWIS: On behalf of the American Heart Association, the American Stroke Division, and the more than 22 million volunteers and supporters, I want to express my appreciation for the opportunity to address the U.S. Commission on Civil Rights and to share information regarding our efforts to reduce health disparities involving cardiovascular disease and stroke.

Addressing health care disparities and improving health care quality are high priorities for the American Heart Association. Given the fragmentation in the health care system, on average Americans receive the care recommended by evidence based guidelines only about half the time.

However, racial and ethnic minorities and women generally receive even lower quality treatment compared to their counterparts. Clearly, all patients, but especially patients of color and women,

NEAL R. GROSS
COURT REPORTERS AND TRANSCRIBERS
1323 RHODE ISLAND AVE., N.W.
WASHINGTON, D.C. 20005-3701

(202) 234-4433
www.nealrgross.com
need higher quality care.

In our short time today together, I will focus my discussion on the American Heart Association's innovative quality improvement program with the guidelines. Guidelines in cardiovascular disease and stroke are published by the American Heart Association and are the result of critical analysis of studies on treatments proven to be beneficial to patients. Adherence to these guidelines improves patient outcomes. Unfortunately, the treatment of cardiovascular disease is complicated, and the treatment of patients must be a team effort.

For example, a patient with heart failure may need as many as 15 Class I treatments or tests. This care must be organized and coordinated.

In 2000, the American Heart Association launched the Get With The Guidelines Program that currently focuses quality improvement for three conditions: coronary artery disease, heart failure and stroke. The program provides multiple interventions to help improve the care provided to patients and helps providers adhere to evidence based guidelines for treating and preventing these common conditions.

Providers obviously remain free to
customize the care provided to each patient, but the
evidence based recommendations for these diseases
reflects noncontroversial aspects of care that are
supported by a wealth of scientific evidence.

The components of the Get with the
Guidelines Program include the following. First, a
Web-based patient management tool that permits real
time input of data regarding each patient.

Second, a clinical decision support
function which insures providers that they all
consider the recommended aspects of care for each
patient.

These are reminders, if you will.

Three, a real time benchmarking function
which allows individual physicians and hospitals to
compare their statistics with a variety of performance
measures against large databases providing statistical
averages for a variety of provider types. In some
cases, merely providing accurate physician level data
to physicians promotes improvement in adherence.

Four, educational materials are provided
for use by physicians, nurses, patients, family
members and other caregivers. The American Heart
Association provides targeted educational materials
for individuals from a variety of cultural backgrounds.
written in a variety of languages.

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

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

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

First, Get with the Guidelines has demonstrated substantial narrowing or elimination of racial and ethnic disparities in health care services provided within hospitals and upon hospital discharge for patients with coronary artery disease, heart
failure and stroke. In fact, the clinical outcomes for minority patients in hospitals participating in the Get with the Guidelines Program are at least equal for black and Hispanic patients in comparison to their white counterparts.

In a preliminary analysis of 20,000 patients in the Get with the Guidelines heart failure module, Yancy and colleagues demonstrated that African American and Hispanic patients receive equitable care compared to white patients. Additionally, in hospital mortality was actually lower for African American patients. Additional preliminary analysis of over 230,000 patients in the Get with the Guidelines coronary artery disease module demonstrated that adherence to guidelines improved in both women and older patients, and while slight disparities exist between men versus women and older versus younger patients, in baseline analysis these gaps narrowed over time.

Number two, Get with the Guidelines has enhanced the transparency of issues involving disparities in health care on the basis of race, ethnicity and gender. At the microscopic level, these data help individual physicians and hospitals address disparities in their own care on a case-by-case basis.
At the macroscopic level, the Get With the Guidelines clinical registry is now providing a rich source of data that highlights ongoing needs to address disparities in care. This data on health care disparities among patients with coronary artery disease, heart failure and stroke is being reported in the new American Heart Association 2009 statistical update and will be published in future articles and updates. Before we can eliminate these health care disparities, we must first measure and highlight them.

Third, Get With the Guidelines has permitted the study of health care disparities involving additional interventions and technologies beyond the core performance measures originally captured in this registry. For example, this registry has been used to study and identify significant disparities in the use of cardiac devices, such as re-synchronization therapy and implantable defibrillators.

In a study of nearly 34,000 patients admitted to 228 hospitals between 2005 and 2007, using the Get with the Guidelines heart failure program, the use of cardiac re-synchronization or CRT therapy was analyzed. One of the major findings of this study was that CRT use varies by age, race, hospital site, and
geographic location. CRT use was less common in black patients compared with white patients, and this disparity is particularly concerning because African American patients have a higher incidence of non-ischemic cardiomyopathy which has been shown to be associated with greater rates of response to this CRT therapy.

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

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

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

In summary, at the American Heart
Association we believe that each person in the United States should always receive high quality care regardless of race, ethnicity, gender or other factors, and that the promotion of evidence based clinical guidelines will help insure that all patients receive appropriate care.

The use of continuous quality improvement tools that include decision support, such as that in Get with the Guidelines, help to translate practice guidelines into the consistent use at the patient bedside and minimize clinician bias that can lead to disparities.

As has been demonstrated by research, the Get with the Guidelines program is a powerful tool to improve patient care at the bedside. Using the registry function of this program, we are able to bring greater transparency to the issues of health care disparities in cardiovascular disease and stroke with meaningful scientific evidence from high impact publications using the Get with the Guidelines registry data.

As we extend our focus on quality, the opportunity exists to use quality as a gender blind, race and ethnicity blind, and age blind strategy to reduce treatment gaps between groups of patients and
optimize outcomes for patients with cardiovascular
disease and stroke.

I thank you for inviting me to present to
the Commission and we'll entertain the questions that
you have.

Thank you.

CHAIRMAN REYNOLDS: Thank you, Dr. Lewis.

Dr. Taylor.

DR. TAYLOR: Thank you very much and thank
you for the invitation to be here today, and I thank
you on behalf of Jackson State University, Tougaloo
College and University of Mississippi Medical Center,
who are the home for the Jackson heart study.

I do have slides. They will illustrate
points, but if you can't turn around and look at them,
I think the text will cover my points adequately.

Since the larger terrain of the topic
health disparities has been well covered by several
speakers on both panels, I'll restrict my remarks to
specific results of my group's research principally
from the Jackson heart study and some reasonable
implications of that research.

The Jackson heart study, as has been said
is the largest single site longitudinal study of
African American cardiovascular health undertaken thus
far and sponsored by the National Institutes of health. Our study is unique in its capacity to examine psychosocial, nutritional, metabolic, and genetic influences on cardiovascular disease. We will also be able to compare our data with suitably designed studies in other ethnic groups.

The Jackson heart study, it should be remembered through my presentation, is a work in progress. So much of what I say will describe early results. Also it should be noted that the Jackson heart study does not treat its participants. It is an observations longitudinal study.

To tell you what I will be telling you, my main points will be the following:

One, early results from our study dramatically confirm the high risk for cardiovascular disease among African Americans in the United States, particularly in Jackson, Mississippi. In the specific instance of hypertension, a leading cardiovascular risk factor, increased levels of awareness, treatment and control of hypertension have been achieved within the Jackson African American community.

The improvement, number three, in treatment and control of hypertension is encouraging. However, because of the much higher occurrence of
hypertension and other CVD risks compared to other
groups in the United States, disparities in
hypertension related morbidity and mortality will
persist, and for efforts to prevent hypertension and
these other cardiovascular risk factors are critical
to a strategy to eliminate disparities in
cardiovascular health.

Next slide, please.

We recently compared the rates of obesity
of all -- next slide -- of the all African American
Jackson heart study with rates in the Framingham heart
study, a long running and well renown study of
cardiovascular disease in a white American population.
Jackson heart participants were twice as likely to be
obese. Severe obesity, that is, obesity with a BMI
greater than 35, was almost three times as high in the
all black study, ours, the Jackson heart study.

The data shown are for younger people, but
the older group had similar patterns.

Next slide

It's interesting to note -- and this is a
complex slide, but I will tell you what it says in
particular. Hypertension and diabetes increased with
each increase in BMI, which is basically weight
adjusted for how tall you are, in both Jackson and
Framingham.

It's also of interest that among normal weight participants, the percentage of hypertension was more than three and a half times higher in Jackson than in whites in Framingham, and the ratio of diabetes was six times higher in blacks of normal weight.

Next slide.

The metabolic syndrome is a cluster of risks that is gaining increased attention. These risk factors tend to cluster together, and they increase the risk of diabetes, a major epidemic in America and cardiovascular disease. It is diagnosed when three or more metabolic disorders out of the list of five occur simultaneously.

Our analyses demonstrate that, first, extraordinarily high metabolic syndrome prevalence exists among our cohort. Among those age 35 to 84, nearly half of the women and over a third of men have metabolic syndrome. The national average is about 25 percent. These rates obviously suggest continued future differences in diabetes and CVD. Notably the prevalence of metabolic significantly declines with higher household income and educational attainment.

Next slide, please.
Hypertension is likely the single most treatable and controllable risk factor for cardiovascular disease. However, controlling hypertension, which we define operationally as reducing blood pressure to less than 140 over 90, is a problem for many Americans, particularly African Americans. There are national reports of widening disparities in the success of hypertension control between blacks and whites.

Control rates are much less than desirable on the national level for African Americans, and actually this is seen in the future in the text. Nationwide while 70 percent of whites who are treated for hypertension gain good control, only about half of African Americans do.

Data from the Jackson heart study on the slide demonstrate data that are in distinct contrast to the national data. The percentage of African Americans who have hypertension who are under control in our study is exactly the same as the national average, which is about 70 percent.

Therefore, national data show a persistent gap in hypertensive control rates. However, the Jackson heart study carries a hopeful message that under some circumstances equal rates of hypertensive
control are possible for blacks and white.

But is attaining equally good hypertension control rates between the races enough to eliminate disparities in hypertension related disease and death between these two groups?

Despite favorable control rates in Jackson, high levels of cardiovascular disease and death persists among blacks. The latest surveillance data are distressing. The incidence of heart attacks during 2006 showed a 65 percent higher rate among African American men than whites. Among black women there was a threefold increase in the number of heart attacks during that year, and this data is from the most recent survey of a sister study of the Jackson heart study called Eric.

Stroke rates for blacks were more than double for whites. These data are occurring in a city which has the Jackson heart study as a reflection of what's going on in the city where hypertension control rates are actually as good as the national average. The disparity persist and these data suggest among other things that major gaps can remain between the groups despite the effective treatment of a most important cause of disease.

One of the messages of such data is that
good health care alone will not resolve health disparities. Health care most often happens after something goes wrong or a high risk situation manifests itself, whether that situation is an elevation in cholesterol or a catastrophic heart attack.

We most often discuss disparity solutions by focusing on improving care for established disease, and this is critically important. It cannot be over emphasized.

However, what I'm emphasizing here is that we need to focus on understanding and addressing more upstream issues. We need to answer the question why do blacks have more hypertension, diabetes, obesity, those things that set the stage for the disparity.

When we ask and answer these questions and apply the appropriate preventive interventions, we will have a greater chance of eliminating disparities in actual health, improvement in the quality and availability for care for African Americans is absolutely necessary, but not sufficient to raise health standards to the level of the majority population. We must address more fundamental causes of disparate health status.

In short, a much more aggressive approach
and clear attention to prevention must be, will be
required if there is to be an elimination of
disparities in health as is called for in Healthy
People 2010. Much of the expertise in these fields
lies in the fields of nutrition, behavior, psychology,
and social epidemiology, and some of that was covered
in this morning's panel, and Drs. Pamies, Chandra and
Satel all in turn addressed these issues, but just to
briefly review, issues surrounding the food supply
characteristics, the amount of calories that the
average American takes in, particularly African
Americans and other minorities, directly tie into
health status. Salt intake, dependence on fast foods
and other issues regarding eating outside the home;
physical activity levels at school, workplace, in the
neighborhood, and to what extent does the built
environment encourage optimal levels of physical
activity?

And finally, the burden of persistent
discrimination either in a personal, institutional or
environmental.

In conclusion, the bottom line, I believe,
is that in order to eliminate disparities in
hypertension related death and disease, we must
provide equitable treatment across racial and
socioeconomic lines and we must decrease the number of African American that become hypertensive in the first place. If we are to reduce or eliminate the disparities in cardiovascular disease in general, we must reduce the number of persons who develop the list of risk factors discussed at the beginning of this presentation.

Our research and that of others strongly suggest that a multi-pronged approach is imperative. One, equalization of awareness access and appropriate utilization of care; two, investment in research to further define the basis of higher risk factor levels among ethnic minorities; and three, use of prevention efforts that go beyond health care institutions into the societal milieu; these are critical to resolving America's ethnic health disparities.

Health equity cannot be achieved without balanced attention to risk prevention and treatment.

CHAIRMAN REYNOLDS: Thank you, Dr. Taylor.

Dr. Howard.

DR. HOWARD: Thank you.

Mr. Chairman and members of the Commission, I am honored to be invited here to talk to you about the project that I've been able to be involved with in the American Indian communities. I
hope that what I'm going to tell you will shed some light on the issue that you are confronting and perhaps strategies to begin to deal with it.

We started 22 years ago with a project called the Strong Heart Study that was funded by the National Heart, Lung and Blood Institute, and we have been working all of this time under some basic tenets that I think are relevant here.

One is that we have worked in full partnership with the communities, receiving input at all levels for our activities and with immediate feedback to the communities of the results so that the data would help for education about health problems and translation into community programs.

The second main goal was that all of our staff and more and more of our investigators are American Indian. This is a group where there has been a lag in education, as was discussed previously in terms of health care. Thirty-two years ago there were only 25 or 30 American Indian physicians. Now there are many, many more, and I'm happy to say we've got 31 total American Indian physicians and scientists who worked on this project, and I can assure you that many of them will be happy to work with you in your deliberations as you continue.
The first project, the Strong Heart Study, is a population based survey. As it was mentioned before about Census data, there is much diversity in American Indian communities. We've worked in 14 of them, but within each community, these communities have Census data. So we have a population based sample, and we were able to provide some solid data on incidence rates of major chronic diseases, and we were the first ones that actually pointed out to a lot of people's surprise that the rates of cardiovascular disease, both heart attacks and strokes, are higher than the rest of the U.S. Actually the stroke was higher than the data for blacks in the U.S. from NHANES, anyway.

So that I think that the paradigm that's occurred in this population is a lack of really awareness on the part of providers about the existences of some of the chronic diseases.

Now, you might be wondering. This population, of course, is much smaller than African American and Hispanic and Asians in this country, but the data we have have turned out to be extremely relevant to most of our ethnic minority groups because they have shown what I call an epidemic of obesity then leading to an epidemic of diabetes, then
leading to an epidemic of cardiovascular disease, and
that is happening all throughout the U.S. and the
world now, and so that is why I believe these data are
relevant.

And as I said, we worked closely with the
communities. As soon as we began to discover that
these rates were high, the health care providers did
become active and put more attention into being aware
of the possibility of cardiovascular events. Also our
data that pointed to a number of key risk factors like
cholesterol and blood pressure that people used to
think were low in these communities and we didn't have
to worry about them, now have become a major focus.

The second project stemmed out of the
first one, and it was actually a clinical trial funded
by the NIH, and that was to really test blood pressure
in lipid lowering, cholesterol lowering strategies and
their potential effect preventing, the cardiovascular
disease that was occurring in the people with
diabetes.

And that did show a number of things,
first, that we were able to reach and maintain
targets. Now, you heard from the previous speakers
that one of the problems is we know what should be
done about controlling blood pressure and cholesterol,
but very few patients in this country are reaching the
goals they should in all ethnic groups, but to more
extent in minority groups.

We set up a system in very rural settings
were very primary care, not your ideal medical centers
or settings for step-wise algorithms to actually treat
the cholesterol and blood pressure and bring it to
targets, and we trained non-physician providers to
deliver these algorithms, and they, of course, had the
back-up of appropriate specialists when needed, which
wasn't all that often.

And through that we were able to reach not
only standard targets for LDL, cholesterol and blood
pressure, but more aggressive ones because that's what
our study was doing.

But it's not the results of this study
that are as important to you as, I think, knowing that
we're never going to have enough specialists and high
level medical providers for all of the diverse rural
and inner city areas that we've got to treat, but by
developing appropriate algorithms and guidelines and
strategies, and by training the care providers who
come from those communities, one can achieve a lot in
terms of care.

The third thing we've been doing is
concentrating on younger people with what we call our
family study, and this, I think, is the most sobering
data we've come up with yet, and this is occurring in
other ethnic groups as well. There's a spiral. As
obesity and diabetes occur in a population, they begin
to occur at younger ages, and as you know, we have a
great concern with obesity levels in our young people,
even in the schools, and this is true in Indian
communities, and in fact, then we are seeing
occurrence of diabetes and other cardiovascular risk
factors like hypertension and abnormalities in cardiac
function that we're able to measure at a much earlier
age.

So I think the communities we work with
are beginning to focus more and more on the young
people in terms of trying to prevent this spiral that
I've talked about of obesity, diabetes, cardiovascular
disease, and so we've, of course, been giving our data
to them as we get it in that effort.

We also have more investigators, and they
actually happen to be our American Indian
investigators, focused on the psychosocial aspects of
what is leading to lack of proper prevention
activities on the part of the people, leading a
healthier life style and then taking care of
themselves once disease is diagnosed. We are finding high levels of depression and other psychological measures that clearly impede a person's ability to take care of themselves.

And sometimes these are not severe levels that would require a person prescribing major drugs for depression or other psychosocial disorders, but paying attention to the things that are bothering people and the other aspects of their life, finding that that in turn can lead to people taking better care of themselves.

So in summary, my message is you need the science to get the high quality data so that you can be sure about what diseases we have and don't have in each ethnic group in this increasingly diverse country, and then secondly I think just like with research, any kind of care development, any paradigms or changes you make need to be done within the community and with full community education so they understand what the problem is and what changes may be possible to improve their health.

And then the importance of identifying barriers to adherence to prevention and treatment like psychosocial barriers, as well as all of the economic ones that were discussed earlier today.
So I thank you again for the time and we'll be happy to answer questions.

CHAIRMAN REYNOLDS: Dr. Howard, thank you.

Dr. Siegel.

DR. SIEGEL: Thank you, Commissioners for inviting us all here today. I'm delighted to be here.

I realize I'm in a difficult position. I'm probably the one thing standing between everybody and lunch. So I'll try to exercise some brevity. I will be using slides today and will use some number of them.

I am here to talk to you today about the Expecting Success hospital collaborative, which was focused on reducing and eliminating disparities in health care, specifically cardiovascular care.

If I could have the next slide, please, next bullet.

Expecting Success was funded by the Robert Wood Johnson Foundation. It was the first ever collaborative undertaking by a group of hospitals to eliminate disparities.

Next.

It was built on the Institute of Medicine's unequal treatment.

You can click through actually some more, which is evidence based care to promote equity and
reduce disparity. We heard earlier about the IOM, the National Academy of Sciences. Its landmark report in 2002 really highlighted the issues around health care disparities and the fact that every American regardless of race got high quality care at the right place and the right time we shouldn't have disparities in care.

Next bullet.

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

Next.

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

Next.

The major pieces of it were threefold. The first was a standardized collection of patient race, ethnicity and language data. I'll talk more about that using a new tool kit that's available from the Health Research and Education Trust.
Secondly was using quality improvement techniques in these hospitals to raise the bar on quality.

And third, which was perhaps the most, I guess, dramatic innovation, was on a monthly basis to measure quality measures that hospitals are familiar with, but to do it by patient race, ethnicity, and language, to actually compare within the hospital the care given to different populations.

Next slide.

These are the ten hospitals who participated in the Expecting Success collaborative. They were chosen through a competitive process. I should mention that Herman Taylor was one of our reviewers in our National Advisory Committee. One hundred and twenty-two hospitals applied.

They were a wide range of places. Del Sol Medical Center is an investor-owned hospital in El Paso, Texas, a community hospital with 80 percent Latino patients. We had the Washington Hospital Center here in D.C., which is one of the largest providers of cardiac care primarily to blacks. We had Duke University Hospital, a major academic health center, a wide range of places so we could show that this could be done in a wide range of places across
the country.

Next slide.

The first step, and this is a key element, was collecting accurate data on patient race, ethnicity and language. Why is this important? Most hospitals in America collect this data. They do it in a relatively haphazard fashion. Most of them don't believe it's reliable. They use different categories even within their own organization sometimes, how to categorize patients. It really is a very sort of random event.

And if you're really going to measure quality of different populations, you need to know who belongs to what populations in order to make comparisons.

One of the first key positives in these ten hospitals was to no longer look at a patient and decide who they were. Instead you ask them are you Black, are you White, are you Asian? What do you consider yourself? Are you Latino, are you not a Latino? No more eyeballing instead you ask them for the patient’s to report to the major change to the practice at these hospitals that would be at most hospitals. This put a lot of anxiety in these organizations, anxiety as to whether registration
staff would want to ask these questions and would feel comfortable and whether there would be issues with the community being asked these questions. I can say in retrospect a much greater issue in terms of anxiety than it was in actual implementation. All of these hospitals were able to do this. They educated their staff. They educated their community. I'll talk in a second about how they did that, and were able to successfully collect this data with really a minimum of push-back.

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

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

Next slide, please.

This is an example of one of the tools that we developed in the collaborative. This was a
poster that was also used as tent cards in the hospital cafeterias, this one in Spanish basically saying we ask because it matters to us. You know, why are you asking these questions? "Preguntamos porque nos importa," and it was really part of the campaign trying to educate patients and people working in hospitals said why are we asking questions about race and ethnicity. It wasn't because we were trying to exclude somebody, but because we wanted to provide the highest level of care for all the people in these organizations.

Next slide.

We also had a focus on quality here. We wanted to raise the bar on quality for all the patients in these hospitals, not just the one group. The three themes were making sure that people got evidence based care; so, for instance, making sure there were standard orders in the hospitals so that when a patient was admitted with a condition, they got everything they should get.

The second was redesigning some processes like making sure that patients who were admitted with a heart attack were quickly taken to the lab for reperfusion, as was mentioned earlier.

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
point gap. Everybody got better. The gap got smaller but still persisted.

Next slide.

When we looked at Hispanic versus non-Hispanics on this measure, we saw a somewhat different picture. Again, Hispanic patients lagged in our hospitals behind non-Hispanic patients. By the end of the collaborative, everybody had improved and the gap had been narrowed considerably from about 11 percent to about a two percent gap.

Next slide.

When we looked at people getting heart failure care, again, blacks versus whites, we saw a gap of about six percent with blacks lagging. By the end that rate had improved, but that gap persisted.

And finally on these slides -- next slide -- when we looked at heart failure care for Hispanics versus non-Hispanics, we saw quite a significant gap initially, and that gap was essentially eliminated by the end.

Now, let take the point and just mention one thing about these slides. These differences we see here weren't because necessarily these hospitals, you know, were treating blacks and whites differently or Hispanics and non-Hispanics differently in their
hospital. It was also because the care at hospitals that are predominantly black or Latino was not where it should be, and by raising the bar for all the patients in these hospitals, you saw some of these gaps narrow.

Next slide.

Bottom line, these gaps can be closed. High minority hospitals can dramatically improve care. This is a big issue for many people. We don't think this cannot happen. We think it can happen.

We think it also forces these organizations through a journal of self-examination. What's going on at my institution when I have disparities? Is it about bias? Is it about what's going on in my emergency room? What are the factors that caused this?

And finally, yeah, we improved care within hospitals, and we're very proud of that, but what happens after these patients go home? That's really the great unknown to us because many of these patients are going home to nothing at all in terms of any kind of organized system of care, and we are very concerned that even though we have been closing disparity of care in the hospitals, the disparities open up a yawning chasm after they go home.
Next slide.

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

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

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

Finally, last slide, the stimulus bill of 2009 has started to talk about some of these issues. So HIT systems, there will be computer systems in hospitals. They will be eligible for stimulus funding. We're going to have to start addressing the issue of how they collect patient race, ethnicity and language data and use it for quality. It is actually
written in the bill. We await what the different committees that have been set up under the stimulus bill will do to actually implement this, but these things have now really come of age.

Again, many thanks. I appreciate it and look forward to your questions.

CHAIRMAN REYNOLDS: Okay. Well, I'd like to thank all of the panelists. You lived up to my expectations that I delivered during the break. At this point I'd like to open up the floor for questions.

And since Dr. Lewis has an engagement, let's direct our questions toward him initially.

I was under the impression that you had a flight to catch.

DR. LEWIS: Well, I do, but I think I'm good.

CHAIRMAN REYNOLDS: Okay. Well, if that's the case, then questions?

(No response.)

CHAIRMAN REYNOLDS: Okay, good. Let the chairman start.

What's going on in urban hospitals? In the first panel and with you, I have heard several comments that point to a quality issue in urban
hospitals. Are we talking about is it due to the way it's financed? Is it the credentials of the doctors and the training of the doctors that work at these hospitals?

I suspect that it's going to be a combination of factors, but I'd like to hear from you folks.

DR. SIEGEL: I've been offered up, I think, as the first respondent.

I think there's a number of things going on, and I don't think it's uniform. I think there are some urban hospitals treating large numbers of minority patients, some public hospitals doing a great job, and if you look at the information they generate, they're as good as anybody in the country.

However, that's not uniformly the case, and there are gaps. I think there's a couple of things going on here. I think part of it is where those organizations are being sufficiently supported financially and have the wherewithal to have the systems in place to provide high quality care and the training and the like.

I also think it's a question of leadership. Quality is really in many ways about the leadership of the organization taking it seriously,
and I don't think the leadership is necessarily worse in some of these organizations, but I think sometimes the leadership situation is more unstable and because of financial issues you may see higher turnover. You may see people coming and going. You see challenges that the organization has which leads to turnover at little more senior levels sometimes and even sometimes perhaps in the more junior levels as well, and that goes back to resources. And that can, I think, have a profound impact on the quality that these places are able to provide.

CHAIRMAN REYNOLDS: Anyone else like to?

DR. LEWIS: So, again, with the guidelines program we don't see tremendous differences between urban and rural hospitals, and the reason is likely because those hospitals are committed to quality care when they actually enroll in the program. So it's a little bit hard for me to comment in that regard.

CHAIRMAN REYNOLDS: Okay.

DR. TAYLOR: And I tend to agree with what Bruce has said, that the environment for some big inner city hospitals is a very busy one. People feel a lot of time pressure. The language issues have already been alluded to and that there is possibly much greater ethnic and language diversity in the
inner city hospitals.

Resources are an issue, and I think all taken together it can be a bit of a perfect storm to create a situation where an individual's care might be suboptimal.

CHAIRMAN REYNOLDS: Dr. Howard.

DR. HOWARD: I think I can add to this not from my work in the Indian communities, but from my role when I was part of the MedStar Hospital System leadership, and that is at least for the MedStar hospitals in the cities, the ones that are having trouble are the ones where there's not enough local clinical care for the under served. So they are presenting to the emergency room for things that you or I would go to our physician provider to get taken care of.

That, given the funding situation, creates a load on these hospitals that trickles into really all of these functions.

CHAIRMAN REYNOLDS: Commissioner Heriot, did you have a question?

COMMISSIONER HERIOT: I'm still thinking.

CHAIRMAN REYNOLDS: Okay. Commissioner Gaziano?

COMMISSIONER GAZIANO: And this relates
both to Commissioner Taylor's comments at the end of the last panel and, I think, your comment, Dr. Lewis, that those institutions that commit themselves to high quality can make some big improvements.

What can we do or what -- I don't know -- can public policy makers do -- I'm not sure Commissioners are on the right Commission -- to advertise which institutions are doing a great job, which need improvement, which you should keep your relatives away from?

And the hope would be that, first, more institutions would have the incentive to join some of these innovative programs that several of you have been talking about, and others is that our loved ones will stay away from them. Maybe some of them will go away.

This is really for any of you all on the panel. What role is there in just educating? I can imagine some friction, some cross-purposes in, you know, institutions not wanting the success rate to be exposed, but it's an important consumer information point to make.

DR. LEWIS: So that information is available. So you go to, you know, the CMS Website on HospitalCompare, and you can look at what your
hospital's compliance rate with various parameters are, and in this month you'll be able to look up 30-day mortality rates for heart attack care and for heart failure care, as well as readmission rates. Those data are going to be available.

So there is a way for people who are interested in how their health care will happen. They can look that up. The problem is that when you're developing chest pain in the middle of the night you don't go to the Website and say, "Where should I go?"

So the idea behind these Websites is that hospitals will bring themselves up. They're embarrassed by looking bad, and they want to do things, and that's why they themselves was to get involved in programs such as these.

COMMISSIONER GAZIANO: Well, maybe we can help draw attention to that data. How long has it been generally available?

DR. LEWIS: So we originally did some analysis of the first two quarters of 2004. So there have been data now for about five years.

COMMISSIONER YAKI: There are actually a number of consumer groups who actually do put that out there. I have seen in California a lot of times press releases have come out to talk about which hospitals
have the best survival rate for cardiac care.

COMMISSIONER GAZIANO: I've heard some of the advertisements locally.

COMMISSIONER YAKI: They're not ads. They're actually news stories that come out with the rankings.

COMMISSIONER GAZIANO: Sure.

CHAIRMAN REYNOLDS: Dr. Siegel.

DR. SIEGEL: I would just add to that I think that it is great that this information is out there now, and a lot is through Medicare and the HospitalCompare Website. Most consumers don't know about it, and I would argue that the Website has not been sufficiently promoted, nor is it as user friendly as it might be. So it's not easy to navigate.

And I think about my mother who is 93 years old and is a user of hospital services. I don't think she would have the ability to go there and find information that could help her, you know form an informed choice.

So I think in the policy arena we have to really push to make this data not just present, but really available and, you know, user friendly, although I agree part of the process here is also just having the hospital themselves look at it and know
they may not look that good and sort of react to that and improve their own care.

The second thing I might add to Commissioner Yaki's comment is that there is a lot of data out there now on these sorts of issues not just from the federal government, and to some degree that's good, but it's a double-edged sword. Some of it you don't know where it comes from. You don't know what sort of black box was used to make these comparisons. It's a very confusing landscape, and I think it needs some clarity in addition to just getting the word out there that it's not available.

DR. TAYLOR: And I think, too, that over reliance on Internet based information may be an issue. I think there's evidence of a shrinking digital divide between the haves and have nots, but a lot of people that we're most concerned about raising their health status are also the very same individuals who may have impaired access to Internet based information.

DR. HOWARD: And there are two scenarios. The hospital is there when there is an acute event or problem, but the things that are going to really in the long run improve the amount of chronic disease are the out-patient services that do diagnostic and
preventive and treatment for things like diabetes and hypertension.

And a lot of times the people who have the biggest problem really have very little choice on where they can go. I'm speaking from what I know here in D.C. in the inner city, but also out in Indian communities. You know, there's only one or two places where they can go.

CHAIRMAN REYNOLDS: Would you like to follow up?

DR. SIEGEL: Just one brief follow-up. I would also add, I think, that what we're talking about, the quality of hospitals, to Dr. Howard's point, the quality of physicians is something that also needs to be understood in the community, and there's really very little information on that out there now, and there are some programs like the Aligning Forces for Quality program at the Robert Wood Johnson foundation that's trying to get that information out.

I have some involvement in that, so that individuals in communities have not only information about hospital, but about the ambulatory care and the chronic care in their community. Because for most people, that's the bulk of the care, and if that care
is better, we wouldn't need to have this discussion necessarily to the extent that we are now about what happens in the hospital. We'd keep people out of the hospital.

CHAIRMAN REYNOLDS: Commissioner Melendez.

COMMISSIONER MELENDEZ: Yes. Thank you again for being here.

Dr. Howard, you referred to, as we heard before, there are not enough survivors, you know, nationwide, and you referred to a success in developing procedures and training for non-physicians who can work in under served communities maybe in preventive type health measures.

Can any of you comment more on that, what we can do along those lines?

DR. HOWARD: Yes, and I think some of that is being done in places like the Indian Health Service, for example. For many of the chronic diseases like diabetes and hypertension and cholesterol problems, overweight, it doesn't need a subspecialist position to do the day-to-day management. In fact, as many of the previous panelists pointed out, people often will listen more to the nurse or to the aide who they happen to know or who they feel more familiar with.
But these lower level providers need to have very careful guidelines drawn up for them of what to do if the patient has this level of blood pressure, what you should do next, and sort of a step care approach, and then those need to be developed by the high level physicians and overseen by them, and the primary providers need someone to turn to because there are cases that don't fit the neat algorithms and need the expert advice.

But the best example I know is up in Alaska. Most Eskimos, you know, live in villages 1,000 miles from any of the care hospitals, and they have what they call community health aides who are usually women who probably finished high school, who have received a lot of training, and they have large notebooks with algorithms of what they should do if the person comes in with symptoms of anything from the flu to their diabetes problems.

And then they communicate mainly by telecommunication with the providers in Nome or Anchorage, and then the physicians make visits perhaps weekly or at intervals. But they do a decisively good job of managing a lot of these problems.

CHAIRMAN REYNOLDS: Commissioner Yaki.

COMMISSIONER YAKI: Yes. This is for Dr.
I was just sort of struck by the one about the improvement rate that you showed in your study, but the other thing that kind of struck me was that some of the deltas remained the same, especially in terms of the African American. Everyone went up, but that delta remained, whereas with the Hispanic community that delta kind of closed.

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

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

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

Now, whether that reflected something about those hospitals or whether it was sort of the
randomness of the sample we had -- it's only ten hospitals -- we're not sure. So we're trying to understand that.

I do think in furtherance of your question, you know, a lot of us in this field argue about this. You know, will a rising tide lift all boats --

COMMISSIONER YAKI: Right.

DR. SIEGEL: -- to the same level? And we're not yet sure that it will, and I think this may indicate that those gaps can persist even though you've raised the bar on quality in a dramatic way.

CHAIRMAN REYNOLDS: Dr. Siegel, culture plays a role. For example, in the South food, food choices, whether exercise has been imbedded as a routine in an individual's lives. Unless we deal with those issues, isn't it likely that we would have disparities?

The example you just discussed, yes, we can have improvement, but there are these other factors that will -- that unless the other factors are dealt with, then the disparities, while they may close, will remain.

DR. SIEGEL: Absolutely. You know, we have focused on, you know, a piece of the health
system and some would argue a narrow, though expensive piece of the system, what happens in hospitals. But by no means should that be interpreted as being that there are not disparities across the entire spectrum of individual's experience as opposed to what the health system may do or not do.

And I think that everything from what goes on while literally the child is in the womb through early acculturation and environmental exposure and what behaviors are learned, all the way through to the care system and what happens after the care system in terms of potential rehabilitation and the like; you can find disparities at every level which have a critical implication for what happens afterwards.

So you know, we have focused on a slice of it, which is important, and perhaps we focus on it because we can measure it and control it, but there are other things that absolutely have to be addressed as well.

DR. TAYLOR: You know, comparisons to the problems in education were alluded to earlier or used as an example that might be illuminating for health care, but I think it is absolutely critical to do what we're doing in terms of equalizing utilization and appropriate care for all peoples within the U.S.
But to only focus on health care and try to get an outcome on health, I think, would miss an important part of the equation. It would be sort of like trying to improve education by focusing on the ninth grade. You can improve literacy by focusing on the ninth grade rather than somewhere further upstream like first, second or third.

A lot happens before most people encounter or seek to encounter the health care system, and it's there where we need to really remind ourselves that a balanced approach that includes prevention as well as therapeutic intervention needs to be taken if we ever hope to close this gap in a substantive way.

CHAIRMAN REYNOLDS: Commissioner Melendez.

COMMISSIONER MELENDEZ: Yes. Barbara, you said something about barriers to adherence to prevention and treatment and developing community-based programs to address these barriers. What did you actually mean about barriers?

DR. HOWARD: Well, as you can tell from my background, I'm not a social scientist, but from what I'm learning from my colleagues -- and this is true again in all ethnic groups, not just Indians -- that many aspects of the person's state of mind influences whether they're going to be receptive to either eating
properly or being active or taking their medication, et cetera.

One way to deal with this is with community based programs. In Indian Country, talking circles are used sometimes and people talk about their issues and how they feel because they were told they had high blood pressure or diabetes, and by that kind of approach it builds their self-confidence that, yeah, maybe I can do something about this. It isn't all out of my control.

And those kinds of approaches are being, as I understand it, tried in other communities, and they've got to be very community specific; that talking circle might be the exact wrong thing to do in an Asian community, for example, but getting people to take charge of their health and believe that they do have power to improve it and what their own barriers are is the kind of approach that these communities are starting to talk about.

CHAIRMAN REYNOLDS: Okay. Commissioner Taylor.

COMMISSIONER TAYLOR: This will be for Dr. Howard. On the earlier panel Dr. Satel mentioned that black men rarely have Medicaid unless they are disabled. While Medicaid has to cover families with
dependent children, is this something that the community health centers that you're talking about can help fill that gap, that it's not dependent on having that Medicaid status, that you can get health care coverage or health care services regardless of your insurance status?

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

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

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

COMMISSIONER HERIOT: I'm still on the first panel, speaking about the epidemiological studies that were being discussed there, and the
notion that cultural competence didn't seem to be what was going on since you'd expect the doctors involved and the health care providers that were specializing in minorities to be more culturally competent.

We mentioned a bit here on quality of doctors. I'm a law professor, and I get a good sense of where the most talented law students go to practice law and what drives that market, but what drives the medical market? Is there any mechanism that might be attracting, you know, the more talented doctors to hospitals, or not just doctors, nurses --

CHAIRMAN REYNOLDS: Money.

COMMISSIONER HERIOT: What's going on?

DR. TAYLOR: Well, if I start, I think what attracts doctors to a particular locale or practice environment would be quite parallel to what attracts other professions to their particular location. Obviously compensation is near the top of the list, but I think a lot of physicians do look for a sense of purpose in what they do as well.

And I think that you --

COMMISSIONER HERIOT: And just for the record, I didn't want to suggest that lawyers congregate all towards money. There are great lawyers found everywhere, but they congregate in certain
spots.

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

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

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

CHAIRMAN REYNOLDS: Dr. Siegel.

DR. SIEGEL: I would agree with everything that Dr. Taylor mentioned. I would add a couple of
things maybe. I think part of it might also be the
access to technology for your patients. Are there
tools there which, you know, you think are necessary,
which are easily accessible? Is lifestyle?

My wife is a pediatrician, and she has
spent a year working in an inner city environment in
New York in a very under served community, and she
felt insecure in that environment, personally insecure
for her safety at times, and eventually left that
environment. So that can be a challenge also in terms
of that issue.

But the one I also want to add is I think
we need to be careful. I'd love to hear from all of
the first panel about saying that, you know, if the
physicians are working in this area are bad or in this
community and others are good.

I say that because I've seen very bad
medicine practiced in very affluent, non-minority
settings. We know very little about the true
measurement of quality of physicians. We are at the
outset of that now and we're trying to sort of move
that agenda forward, but it's really not quite there
yet.

And there are instances in under served
communities that we can point to like many of
America's community health centers where really high
good quality medicine is being practiced.

So I think we need to step back a little
bit before we come to certain conclusions about what's
happening.

DR. HOWARD: And I would add that, again,
just as there are good lawyers, there are bad lawyers
everywhere, too.

DR. LEWIS: If I can add to Dr. Siegel's
position on this, you know, when you look at it,
physicians in general are, you know, reasonably
educated in terms of guidelines. In one study looking
at understanding of the national cholesterol
guidelines, you talked to physicians.

Ninety-five percent of them knew what the
cholesterol guidelines were, but when you looked at
their patients, only about 18 percent of them were
actually treated to goal.

So this is a real system problem. It's
not necessarily a physician education problem.

CHAIRMAN REYNOLDS: Okay. If there are no
more questions, I'd like to thank the panelists.
You've provided some great information, and I
appreciate the fact that you've carved time out of
your busy lives to participate.
COMMISSIONER YAKI: Now just save some lives.

(Laughter.)

DR. HOWARD: Not me. I just write papers.

(Laughter.)

CHAIRMAN REYNOLDS: Thank you very much.

(Applause.)

CHAIRMAN REYNOLDS: Let's take a break of, say, 45 minutes.

(Whereupon, at 12:51 p.m., the briefing was concluded.)