



Transcript provided by kaisernetwork.org, a free service of the Kaiser Family Foundation<sup>1</sup>  
*(Tip: Click on the binocular icon to search this document)*

---

**Confronting the Chronic Care Challenge  
Panel Two: Changing Delivery Systems  
to Address Healthcare Disparities  
Partnership for Quality Care  
March 19, 2008**

---

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

[START RECORDING]

**ROBERT ISSAI:** I'm Robert Issai, CEO and President of Daughters of Charity Health System and some might say as a recovering Republican I am really happy to be here today. [Laughter].

I thought that would be a safe thing to say in this room. I'm particularly proud to be here with our partners from the Partnership for Quality Care and with Dr. Luella Toni Lewis, the National President of SEIU Committee of Interns and Residents.

The next panel, Changing the Delivery Systems to Address Healthcare Disparities, is essential to the Daughter's mission. The mission of Daughters of Charity Health System consistent with the spirit of our founders Saint Vincent de Paul, Saint Louise de Marillac, and Saint Elizabeth Ann Seton is to serve the sick and the poor.

We start to provide comprehensive healthcare that is compassionate and attentive to the whole person. We start to promote healthy families and adjust society through value based relationship and collaborations with like partners in the communities we serve.

We also emphasize advocacy for the poor as one of our five core values. That is the reason that the panel is so essential to our mission. When we find out as the healthcare leaders that the outcomes of some of our communities,

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

communities of colors, communities of minorities, and the communities of financially disadvantaged are systematically worse than other communities we need to address the problem.

The next panel highlights important initiative that helped lay the foundation for a national healthcare system that creates access and delivers care to every American in the community. As the healthcare providers, it is our moral obligation to build on these initiatives. As a member of the Daughters of Charity Health System, it is central to our mission.

And as an American it is our most basic national interest. Before introducing Dr. Lewis to introduce the panel, a word about the Asian Pacific Liver Center at Saint Vincent Medical Center in Los Angeles, which you will hear from during the panel discussion.

The center reaches out to the Asian-Pacific communities in Southern California to address the prevalence of hepatitis B in those communities.

Asian-Pacific Liver Center also helps improve the quality of life for the people who are diagnosed with hepatitis B or also in the long run reduces the cost of care for those patients. To further work of APLC we are also sponsoring legislation carried by the California Assembly member Fiona Ma that would expand Medicaid eligibility for all suffering from hepatitis B and raise Medicaid reimbursement for those cases.

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Last but not least I would like to introduce Dr. Luella Toni Lewis, the National President of SEIU's Committee of Interns and Residents. She is a graduate of Georgetown School of Medicine, a Geriatric Fellow at Caritas Health Care in Jamaica, New York and is currently Chief Resident at her Family Practice Training Program at New York Medical College.

In her role as a National President Dr. Lewis will represent 12,500 medical residents. Dr. Lewis? [Applause]

**LUELLA TONI LEWIS:** Thank you very much. Good morning. It is my honor to be here today representing nearly 13,000 physicians in training and on our frontlines. Our members are your future physician activists poised to now participate in this discussion and implement some of the real world solutions that we're hearing today. And that will present it now and in future summits and now our panel and moderator.

First, Donna Zimmerman of Health Partners will discuss the system wide initiative her organization has undertaken to address health disparities, as well as, the impact it has had in addressing racial and ethnic disparities while improving preventative care.

Dr. Tse-Ling Fong from the Daughters of Charity Health System will present the Asian-Pacific Liver Center which was created to address the high prevalence of hepatitis B in the Asian-Pacific community of the greater Los Angeles area.

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Dr. Joseph R. Betancourt will discuss the work being done by the Disparity Solution Center at Massachusetts General which is focused on the development and implementation of strategies that advance policy and practice to eliminate racial and ethnic disparities in healthcare by developing and disseminating models for identifying and addressing racial and ethnic disparities in healthcare nationally, regionally, and locally.

Dr. Cathy Hebert will present a unique initiative that has decreased health disparities for un-insured, low income congestive heart failure patients in Miami giving them the right care so they avoid emergency rooms and repeat hospitalizations.

And our moderator Dr. Mohammad Akhter is the Executive Director of the National Medical Association and he is not only a leader in resolving healthcare disparities but he also has a long history of distinguished service to the public health in our nation.

He has served as the Director of Health for the state of Missouri, Health Commissioner here in the nation's capital, Senior Associate Dean for Public and International Health at Howard University, Executive Director of the American Public Health Association, and as the President of Interaction, the largest umbrella organization of all non-profit organizations working overseas in global health and development work.

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

And I must say that, by the way, Dr. Akhter was also a leader in CIR back in the day, my organization now. So, let us welcome our panel and distinguished moderator. [Applause]

**DONNA ZIMMERMAN:** Thank you very much for the introduction. I am really delighted to be here. And to talk about a subject that's very important to our organization and one that fortunately in my position I get to work.

So, it's one of those really fun issues to get to work on in terms of, not only the policy aspects of it, but the work that we do in our healthcare delivery system.

I thought just as a grounding and I am going to also run through my remarks and slides pretty quickly. But I just wanted to mention a little bit about Health Partners because it does kind of set the stage for how we view our work in what we call equitable care.

We're an organization that's an integrated non-profit healthcare program in Minnesota. We not only have a delivery system with 700 physicians and two hospitals, but we also have—we are a non-profit health plan with about 790,000 members. About 90,000 of those members are in state Medicaid programs and Medicare programs.

So we're a very diverse organization and we come at this issue from a lot different points of view. Our hospital, Regents Hospital in St. Paul, in its former life was actually a county hospital and is the second largest provider of charity

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

care services in Minnesota. So, when we look at all of the programs that we have this issue around equitable care is just very, very important to us, not only as a health plan, but as a delivery system.

I'm going to talk a little bit about kind of the fundamental basis of how we got going in this work. Some of the work we've done in the community but just give you an idea of where we're heading in terms of the clinical interventions.

And the good news for me is that actually all of the presentations from this morning are a pretty good setup to talking about the work in our medical group and at the hospital and how we actually can deliver healthcare for diverse populations, because it really focuses on a lot of the processes in improvement examples that you've already heard about.

I think this—of course the Institute of Medicine Report both for our own organization and, I think, it also really set the bar for us as healthcare providers around the country back in 2002 looking at what really were some of those very significant disparities.

We knew that nationally we had huge disparities in healthcare among different racial and ethnic groups. We knew it also in Minnesota that we had some huge disparities based on information that our state health department had collected and reported. But I think one of the challenges for us, overall,

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

is how do we take that information and apply it to our own delivery system? And how do we actually go about making the improvements?

And if you think about Minnesota you may think that all of us actually do come from Lake Woebegone. But it's not really true. And one of the really interesting things in terms of challenges for us, as well as huge opportunities for us, is that we have this very rapid growing immigrant population in Minnesota.

In fact, immigrants and new minority populations in Minnesota over the last 15 years has really represented most of the growth in our state and in particular in the Twin Cities area of Minneapolis and St. Paul.

So, we do boast now some of the largest populations of immigrants and it has a huge impact on us in terms of how we deliver care services. But also in terms of how we look at our future workforce, current and future workforce.

Health Partners, our CEO, Mary Brainerd, was actually part of a business leaders group in Minnesota that commissioned a report from the Brookings Institution to look at kind of the economic vitality of the Twin Cities region and it really focused on some of the emerging gaps that are occurring in our community with the influx of the immigrants that we've got.

And so part of our challenge is not only are we growing in this population but we are also experiencing huge

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

disparities in terms of the number of people who have insurance is not equal in Minnesota. Our communities of color are more likely to be uninsured. They're less likely to be educated and they're less likely to be able to own a home.

So, those factors combined make this a huge thing for us in terms of delivery. Our own Health Partners Medical Group were a little bit more diverse than the Twin Cities in general. We're not surprised by that because we have clinics located in the metro area largely.

And then just looking at, again, how did we get going in equitable care? Well, part of this kind of understanding our patients or members is how do we actually get the data as I mentioned in order to be able to plan improvement projects?

We started back in 2004 embarking on a process to begin to actually collect information from our patient's and our members that would lead us to be able to plan some of the interventions. These are the areas that we focused on, obviously language and interpreters.

We looked at race and we also looked at country of origin. It may seem very straight forward that medical groups should be and hospitals should be collecting this. But it's not really straight forward at all. In fact, it's a very inconsistent practice at least in our marketplace.

And it was one that we felt was fundamental to being able to move and improve, so we began on this process to

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

collect data. We focused on our clinics as probably the best way to begin to collect data because that's where we had face-to-face contact with our patients.

We used an opportunity with putting our electronic medical record in place that was through our clinics and the hospital as our huge opportunity to begin to be able to collect and store the information. In terms of data collection we're really pleased right now.

We've got data on over 425,000 patients. And that's really an accomplishment we think over those years. This is voluntary on the part of the patients. It was carefully worked on with our staff. We used a lot of scripting and our rates have improved as you can see over time in being able to collect that information and actually get it.

I'd say the success in this, I can't say more about how important it is for those front line workers, our nurses who are asking this information, putting it into our epic medical record, having leadership really support this all throughout the organization.

The ability to report on the data and actually get it back to our clinic staff and our hospital staff is really exciting now because they're starting to see kind of the fruit of their labor in terms of not only how much data we have but actually some of the projects that we're working on. But it would not happen without that really big cooperation.

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Now what are we working on exactly in equitable care? Well, we're focusing right now in the medical group and the hospital on a little bit different areas, but in the medical group on diabetes, preventative care and patient satisfaction.

Now let me just, a little rationale about why we went in this, obviously diabetes is a huge problem in terms of healthcare. It's an area where healthcare costs are very high in terms of untreated and poorly treated diabetes. And we also know that ethnic minorities are disproportionately impacted both in terms of prevalence and risk of death from diabetes.

This is an area of really focus for everyone. In terms of preventive screening we also know that particularly, and this was really true with our own data, colorectal screening and mammography, again big disparities between people of color and whites. That seemed like an important place for us to do some focus locally.

And then because we had been studying some disparities by payer status meaning for those of our patients that are on medical assistance versus those who are commercially insured we knew we had huge disparities there. As well as, we also knew that we had a higher proportion of people of color in our patient and our member population in the medical assistance group.

So we knew that we had some disparities by payer but we didn't exactly know how that translated into race. As we moved

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

toward looking at that by race, and this was after again I am way over simplifying three years of work to actually collect the data, but when we started to be able to look at this in 2007. Of course, what we figured would be true really was true in that we did have disparities by race in terms of optimal diabetes outcomes.

Now, optimal diabetes care is a measure that we use in Minnesota. We publically report this by medical group. It's on a Web site for Minnesota Community measurements. So, all medical groups are actually compared on their performance on this very important measure. And just in case you don't know what this measure is you have to actually be incredibly well controlled in diabetes to fire on all of this measure.

You have to have your blood sugar under control, cholesterol, blood pressure, regular aspirin use, and you have to be a non-tobacco user. All of those things must be present in order for you to be viewed as having received optimal diabetes care. You saw a slide this morning from the McGlin [misspelled?] Study on healthcare that Americans receive.

Well American's receive about half of the healthcare that they should receive and optimal diabetes is one of the examples of that. In terms of preventive services again we looked at some disparities in our medical group patients by race in that.

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

But it doesn't really tell us where that might be. So, in terms of a little bit more detail we looked at the opportunity here to be really in the area of colorectal screening and mammography. Not such a surprise but that's where we thought the most disparities were.

This is just an example of how you can take your data even narrow it down more to do some intervention planning. Moving to the hospital and then we'll come back to those results. These were the areas that we worked in the hospital.

These are Jayco [misspelled?] measures and so we wanted to look at something that was already standardized in terms of reporting. Perfect heart attack care is one of those. This is brand new information for Regions Hospital. So we don't have it broken down by different race groups. But we are able to break it down by white and people of color right now.

And it's just showing examples of the two measures around perfect pneumonia care and perfect heart care as we looked at areas of focus in applying interventions, moving to intervention, and I'll focus mostly on the third, but so what do you do about known disparities?

A lot of work we have done has been fundamental to improvement has been engaging our workforce in cultural competency activities, a lot of work around communicating with patients and language assistance. And then again the care delivery processes.

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

What were those things that we could do in the clinic? Here's some examples of some of the community engagement work we did. I would say that fundamental to this has been talking with our patients, talking with the community about how should we go forward with this?

We weren't exactly excited about being the only medical group in Minnesota to post disparities and have a big poster up there saying, we've got disparities, but it was very important for us to hear what the communities of color and the community leaders would think of it without any exception they said, we can't believe that clinics and hospitals aren't collecting and analyzing this already.

So, we felt pretty emboldened to just go forward and that's what we did. We did find that, also, that people told us, both our patients and also community leaders that physicians were important in this process, in reinforcing information in the clinic setting. And that different communities viewed that role of the physician as being quite critical.

We also knew that preventive care was not valued in all of the cultures that we were working with. That came through in some of our focus group and interview activity, so, again a focus on communication. Just an example, at the bottom there we did a bunch of trainings with our clinic staff, Lunch and

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Learns, around lunchtime. We actually used our interpreters to go out and do that kind of training.

And they very, very positively received. Care delivery, this is really the punch line on standardization. It isn't just the physician it's every team member delivering the right care on the visit, preparing for the visit.

It shows in the hospital in terms of as we've been able to really nail heart attack care. If we really nail heart attack care we nail it for everybody.

For diabetes care we're looking at some of the things that might help in terms of possibly doing hemoglobin A1C which is the blood sugar test at the time of the visit versus a separate lab test. We also provide physicians with the results. So they know all of their patients of color and what their diabetes results are.

We're beginning to see some impressive improvements, we think, particularly with the patients of color. In breast cancer screening just to say here same day mammography, we piloted it. It seemed to make a difference. And we expanded it throughout our program. So, offering mammography at the time of the appointment.

Colon cancer screening, just to finish up, this is still a big challenge for us. We have not seen huge differences in our results in spite of using some new cultural

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

specific materials. We think this is an area where we're going to need to work more closely with community.

And here's the summary. I guess the bottom punch line when we talked about cost we know from doing some claims examination back a couple of years ago that those people who have optimal diabetes care, again, firing on all five of those factors, as we looked at their claims experience over three years for well controlled diabetics it was about 5,000. For those who were not receiving that optimal care over the same time period was \$60,000.

So, we think that a focus, again, this requires a lot of operational attention from leaders, from frontline staff, but a focus on really standardizing that care providing language access, and community outreach we really think we can make a difference in disparities in our clinics. And we're very excited about what the future holds in terms of really being able to continue to measure that and, of course, move towards public reporting. So, thank you very much. [Applause]

**TSE-LING FONG, M.D.:** Good morning, my name is Tse-Ling Fong and I work with the Asian-Pacific Liver Center at St. Vincent's Medical Center. I would like to start off by showing a video.

[Video playing]

I'd like to just take a few minutes to reiterate some of the points made in the video and also to share with you some

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

of the challenges that we face as we grow as the Asian-Pacific Liver Center.

To put things into perspective, somewhere around 400 million individuals throughout the world are infected with chronic hepatitis B and approximately 70 percent of them reside in Asia. And the Asian-American population in the United States which I think at this time comprises about four percent of the U.S. population. The prevalence of hepatitis B mirrors what you see in Asia.

And as my colleague Dr. Hope Bay [misspelled?] stated in the video the prevalence rate is about ten percent, somewhere between 10 to 15 percent. Of these individuals with chronic hepatitis B 30 percent of them will develop cirrhosis and or liver cancer, hepatocellular carcinoma and really the treatment once you've developed end stage cirrhosis or liver cancer is liver transplant.

The cost of a liver transplant at my institution is about \$300,000. And what is not known by many is that hepatitis B is a preventable disease through vaccination and fortunately since the late 1980s or early 1990s the CDC has enacted universal vaccination.

So, all newborns are vaccinated against hepatitis B and every child that's entering grade school has to show evidence of hepatitis B vaccination. But the startling statistic is that among Asian adults who are susceptible to hepatitis B, in

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

other words they've never been exposed to hepatitis B yet they are at high risk, less than 30 percent of these people have actually been immunized.

And among patients who are chronically infected with hepatitis B less than 60 percent of them have actually been diagnosed. So, the majority of people with chronic hepatitis B in this country with a disproportionate number being Asian-American most of these people are walking around with this chronic condition and the only time they're going to figure out that they're infected is when they present with end stage liver disease.

And it is for these reasons that the Asian-Pacific Liver Center was created. And I—my first challenge was how to get this program started. I'm a full-time faculty at USC, at University of Southern California, and when I approached my department chair his first comment is whose going to pay for this?

And that is actually the reason why I went to St. Vincent's Medical Center which is a not-for-profit Catholic run hospital. And I was shocked but really just thrilled when the Board heard my presentation and embraced it. And this was about a year and a half ago. And through the generosity of the Daughters of Charity they gave us start up funding for this center.

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

And the purpose of this center is multi-fold, education of not just a community but the primary care physicians to instill the importance of screening which is a very cheap test. Outreach to the community but also to create a home, if you would, a liver center where patients are not faced with cultural or language barriers which brings up a subtle but very important point about Asian-Americans.

Asian-Americans are a very diverse group as my previous speaker just pointed out. There is no such thing as an Asian-American community. There is a Chinese-American community. But you can break down the Chinese community into people from mainland China from Hong Kong, from Taiwan, Chinese-American's who are from Vietnam.

You've got the Korean community, the Cambodian, Tai, Vietnamese, etcetera. And it isn't a one recipe for all of these communities. Well, just the simple issue of language, a person from Taiwan cannot communicate with someone from Southern China or Hong Kong. So, I speak Cantonese fluently but I end up speaking English to my patients from mainland China or from Taiwan.

And through the generosity of the Daughters of Charity we have been able to bring onto our staff nurse practitioner, two nurse practitioners, one is fluent in Korea. The other is fluent in Mandarin, Taiwanese, and several other dialects of Chinese. And these nurse practitioners play a critical role in

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

patient education. Because as most of you know compliance is really linked to the patient's understanding of their disease.

Hepatitis B is preventable through vaccination but once one has chronic hepatitis B the onset of cirrhosis and hepatocellular carcinoma is preventable by identifying patients who are at risk for these complications. And these are patients with active infection who can go on therapy. Ten years ago there was really no effective therapy for hepatitis B.

And in the minds of many primary care physicians, as well as patients, if you have hepatitis B it's essentially a slow death sentence. And it's the luck of the draw as to who gets cirrhosis or who gets hepatocellular carcinoma. We now have very effective therapy and studies from Asia have shown that patients at risk for developing cirrhosis if they are placed on anti-viral therapy the rate of developing complications is significantly decreased.

So, it leads me to my challenge to the audience, but also a dilemma that we're facing. We've so far identified over 100 patients with chronic hepatitis B at our screening processes. Ninety percent of them are uninsured. The cost for treatment is about \$700 a month. The cost for regular follow-up of all chronically infected patients is about \$400 a quarter. So, that's \$1,200 a year.

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

One might think well that's quite expensive but I want to remind you like many disease entities I think the cost for preventing the complications of advanced liver disease is far less in the long run than the cost of paying for a transplant. And the post-transplant care with chronic rejection therapy. Thank you very much. [Applause]

**JOSEPH BETANCOURT, M.D., M.P.H.:** Could I have the presentation on? Great, good morning, I see I'm sandwiched between a very touching story and a film and lunch. So, I ask that you all to bear with me. It's a great pleasure to be here. My name is Joseph Betancourt. I'm Director of the Disparity Solutions Center.

Also co-chair of our Disparities Committee at Massachusetts General Hospital, as well as, a practicing internist at Mass General Hospital. I'm going to be talking briefly today about the issue of racial and ethnic disparities in healthcare, improving quality, and containing costs. And focusing a bit on a program that we have that addresses diabetes.

I'll just say that for me these issues are particularly personal. I am—I grew up in New York City and originally from Puerto Rico. So, I grew up in a bilingual, bicultural home where the issues of language and culture and difference in quality in care was something that I grew up with, and saw in my family. But also saw in places where I trained.

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

New York, New Jersey are primarily a minority, under serf community. New York City at Cornell we're across river from Queens the most diverse square, perhaps, two miles on the planet down the street from Spanish Harlem and Harlem where we really everyday could see that despite our best efforts and really have wonderful quality care to offer we, I think, did less than McGlins [misspelled?] Study of delivering it half the time to many of the populations that we care for.

What I wanted to do very briefly was give a big picture look at the issue of disparities in health and healthcare to contextualize my comments, talk about what I think are some of the key drivers for addressing disparities from the quality standpoint, and then highlight some work that we're doing on improving quality and containing cost through a diabetes model.

As has been mentioned already in the example in the Health Partners diabetes as we know is an epidemic across the nation and particularly an epidemic among minority communities. Here we see the diabetes related death rate in 2004 and we see racial and ethnic disparities in health outcomes here. This is deaths per 100,000 populations.

Here you can see very clearly that African-Americans, Hispanic Latinos, American Indians, and Alaskan natives and in this case suffer higher rates of diabetes related mortality than their white counterparts. Now, there is no doubt that the reasons for this are various.

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Clearly minorities are over represented among those with lower socioeconomic status, lower levels of educations, may live if they are diabetics in communities where they can't follow my recommendations to go out and take a walk because the community may not have a sidewalk, or it may not be safe.

They may not be able to get the good foods and the healthy foods that we recommend because of the food the food—the stores that are located in their communities. So, clearly the social determinants, the public health issues are essential and if we were ever to eliminate racial and ethnic disparities in health we really need to be very attentive to these key issues related to public health.

They definitely are the largest contributors to disparities in healthcare and disproportionately impacted minority communities. Access to care is another important and I'd say the second largest contributor to disparities in health. We know that minorities are over represented among the uninsured. About 46 million uninsured American's, about a quarter of them are Hispanic Latino, just as an example. But we know the literature highlights the fact that nine out of ten of those Hispanic individuals have somebody in the family who's in the workforce but tend to work in jobs that don't provide employer based health insurance, agriculture industry or service industry.

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Nevertheless if you're a diabetic and you're depending on an emergency room or a community health center that's underfunded to receive your care in diabetes management I think we know that you're put at a disadvantage. But what I wanted to touch on here in more detail and what I consider the third pyramid and the third contributor to the disparities in health are disparities in healthcare.

And I had the great honor and pleasure of serving for two years on an Institute of Medicine Committee that we've already highlighted here today with Alan Nelson and others who studied the issue of disparities in healthcare in great detail. We were asked by Congress to look at disparities in healthcare.

So, they said take access out of the picture, take social factors out of the picture we want to know if two people present to the emergency room and they both have chest pain might one receive a different pathway, a different quality of care than the other. If two people as was recently highlighted present to an emergency room and they have a long bone fracture, fracture of their arm or a fracture of their leg might one group get more pain medication for the same exact fracture than the other.

And so in our committee over the course of two years we looked at over 600 articles in the Purity [misspelled?] literature, we had testimony from a variety of different stakeholders, commission papers, and all of the things that the

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Institute of Medicine does to make their reports rigorous and evidence based. And we found that without a shadow of a doubt racial and ethnic disparities in healthcare exist even when you control four factors such as co-morbidity, socioeconomic status, and education.

Now there is no one solution and no one suspect here. And we said in our report that clearly there are multiple factors related to this. Some are related to providers, patients, the system in which we work in. A lot of these factors contribute to these disparities.

But I think another set of drivers for addressing disparities has emerged. In addition to our report, the Institute of Medicine report on equal treatment we've had a greater understanding. And after our report which we really tried to contextualize the issue of disparities within quality to say that yes, disparities are a part of quality, they have a cost impact, and I think accreditors are also now paying more attention to the issue of equity, as well.

Now, I think touchtone that really cemented the impact of our report, unequal treatment for the healthcare system, was another very influential Institute of Medicine report, Crossing the Quality Chasm. You all, I'm sure, are very familiar with it. We understand that if we are to deliver quality we must sit on these six pillars of safety, effectiveness, patient centeredness, timeliness, efficiency, and equity.

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

What the equity component of the quality chasm has allowed us to do is bring this discourse to the level of the executive suite and our VP's of quality and safety to say we need to be monitoring for all of these six pillars, including equity. And equity is an essential part of that.

Equity being that there should be no difference in health outcomes based on a person's individual characteristics including their race and ethnicity. I'd say another very important driver has been more and more focus on the burden of disparities and their impact on cost.

We have plenty research to support the fact that some of the root causes that lead to disparities in health and healthcare also lead to mispreventive health screenings in colorectal cancer and some of the disparities that we've talked about already and I'll talk about in a moment, loss of follow-up and non-adherence with hypertension leading to cardiovascular disease downstream, less patient involvement in self management in diabetes, misdiagnosis and inappropriate test ordering in the emergency room in the absence of interpreters where clinicians are faced with a difficult scenario where they can't gather history and instead are ordering a \$700 or \$800 CT scanner for what may be a case of sinusitis when they can't get a good history in the absence of an interpreter.

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

And then finally research that has emerged over the last two years that has focused on avoidable ER visits, hospitalizations, medical errors, and increased length of stay. These last two articles came out last year, articles that looked at medical errors in a set of hospitals and found that individuals with limited English proficiency has more medical errors with greater clinical consequences obviously impacting effectiveness and efficiency.

Increased length of stay, as well, some studies that have come that have shown that two individuals with the DRG some individuals, minorities having longer length of stay for the same exact condition even when you control four other co morbidities. So, we know and we're connecting the dots on this issue of cost.

But that's been another driver. And I'd say finally from the standpoint of health plans and hospitals NCQA has been very attentive to this issue over the last few years. Several new efforts and disparities in considering measures in the future and Jayco [misspelled?] as well has had a wonderful project called Hospitals, Language, and Culture where they've really tried to look under the hood on this issue. And have included some new accreditation standards particularly around language this past year and thinking about others going forward.

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

So, this is on the radar screen of accreditors as well. We at Mass General Hospital have taken this issue of disparities very, very seriously and taken an approach that we need to mainstream the issue of disparities and equity into the quality fabric, into everything we do. And I think as has been mentioned there's been a real testament to our leadership both at the level of Partners Healthcare and Dr. Mong [misspelled?] and also at the level of Mass General Hospital and our President Peter Slavin.

I'll also say that the city of Boston for those of you who may not be familiar with this and our Mayor Thomas Menino took on this issue of disparities head on a few years back, brought together CEO's and leaders from across the community to talk about what we could do to address disparities. We were recently recognized by the CDC as a city of excellence in addressing disparities.

We have several million dollar grants coming out of the city to address disparities yearly. And so our underlying principle around the issue of equity and disparities at Mass General Hospital has been not one of let's prove that we have disparities first before we could act. But instead it's been one that said the Institute of Medicine has said that disparities in healthcare exist. We should assume that we are guilty until we prove ourselves innocent.

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

I think that's a very interesting paradigm shift to many institutions who've taken this on by saying let's just study this for five to ten years and see where we are. Our approach has been one that has included coordinating with the Mayor's effort. And really working to simultaneously identify and address disparities in health and healthcare wherever they may exist at Mass General.

And we've broken up ourselves into several committees that report regularly to the Board of Trustees, our General Executive Council, and other hospital leadership regularly. I just wanted to focus on a couple of pieces related to quality.

We now have a medical policy that requires that all of our quality improvement data be collected by race ethnicity. We stratify all our patient satisfaction by race ethnicity. We have hospital safety and quality rounds where our leaders go and inquire not only about safety and medical errors issues but also about issues related to what do you think might lead to a disparity in care here on this hospital floor?

We also stratify our national hospital core measures by race ethnicity. And as well as our outpatient HETAs [misspelled?] measures. So, those are some of the things that we've accomplished over the last few years. And I'm pleased to say that we have over the last two years reported this all internally into something we call our disparities dashboard

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

which is a parallel to our quality dashboard that goes to our leadership regularly.

This disparities dashboard gives a brief on who our patients are, where they're seen. It provides patient satisfaction by race ethnicity. It provides our core measures stratified by race ethnicity. And everything we do in a brief summary in a dashboard format for our leadership.

But I think we've taken a very important step forward in this regard in that very--within the last week or two we have put up a Web site publically on our quality and safety work. And we have a component here on Mass General Hospital's provision of equitable care. So, what you see here is our external Mass General Hospital Quality and Safety report that anybody could log into.

And you'll see that there is a variety of different components, delivering the right care, keeping patients safe, listening to patients, and providing equitable care. Anybody could log on to providing equitable care and take a peek at our national hospital core measures stratified by race ethnicity.

In summary internally our disparities dashboard has focused on these--a three light system. The green light area, areas where we found that care is equitable. Preventive care including mammography and pap smears, patient satisfaction, and our national hospital core measures.

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Orange light are areas where there are disparities nationally and we're exploring them locally. And that's mental health. And red light are areas where we have found disparities and action is being taken. And I just want to take about two minutes to highlight our work in diabetes.

But we too found disparities in colorectal cancer screening and have developed a navigator program that National Cancer Institute has been very advanced in pushing the concept of patient care navigators for breast cancer and cervical cancer. And now we've developed a program in colon cancer in that regard to help individuals in our health centers number one understand why they should get screen but help them be chaperoned. We've worked with our GI department to carve out times so that we can make sure the individuals could come in, get a colonoscopy. So, the navigator program has been very successful.

I wanted to take a minute just to talk about our diabetes program at one of our community health centers. We found in our explorations around the disparities dashboard that diabetics at one of our major health centers, a stone's throw away from our main campus, that diabetes at MGH Chelsea Hispanic-Latinos are doing particularly worse as it related to their diabetes outcomes.

Of 1,402 diabetics that we were able to identify nearly one-third of Hispanic-Latinos and about one-quarter of whites

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

had no hemoglobin A1C measured in the past nine months. Forty-one percent of Hispanic-Latinos compared to twenty three percent of whites had a hemoglobin A1C greater than eight indicating poor control, so, really a significant disparity there.

And again we know that these disparities in our analysis weren't just due to the doctors not prescribing the right medicines. It wasn't about that. It was a lot related to issues around social factors, access and follow-up and some of it related to whether individuals had glucometers and some of the quality care measures that we talk about routinely.

So, the bottom line is this is an issue that we try to tackle in all of its components, the public health component, the access component, and the quality of care component. We embarked on a program using what we call the standard cookie cutter tools of quality improvement. But link them with key factors that are important cross-culturally.

Addressing some of the patients misconceptions about diabetes, how they think they got it, how they think they should manage it. Other barriers, social and cultural barriers that the patients might face and we use the model of the health coach. We hired a bilingual health coach who basically sits at the health center and does a variety of things.

Number one reaches out to individuals by telephone to get them in to get tested and to see their healthcare provider.

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Number two spends time with them when they're there going through a socio cultural assessment of what barriers they might face. And also a psychological assessment because in some of our early work we saw about 50 percent of our patients involved in our diabetes program had depression in the last year. So, we knew that we needed to be attentive to mental health.

And we also got involved in group education. Now from the standpoint of cost two of these things were particularly powerful for us. One is the ADA. Our group education which met ADA requirements was reimbursable. And we also have some pay-for-performance contracts with Blue Cross Blue Shield of Massachusetts around diabetes. We don't have a very, very large insured population in MGH Chelsea but we do have a significant one and so that also related to some of the cost calculations.

Our coach again as I mentioned goes through a basic model that we have developed in some of my research on cross cultural care which gets at some of the key points around their prospectus around diabetes. The E being their explanatory model, how do they understand diabetes, what do they think will help control their condition, how do they view their treatment?

The S being social risks, do they have any trouble getting their medications? The F being fears and concerns, do they have any specific fears and concerns around side effects, color of pill, any other barriers that they might face around

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

medication adherence, and then them repeating back their plan for controlling diabetes.

Our program began in February of 2006 and we have enrolled about 350 patients who are seen routinely in our program, so about 175 a year over the last two years. We've done over 1,500 coaching visits, 90 patients now 100 have gone through our four session group education.

And we've seen decreases in hemoglobin A1Cs of close to one point, five points, which benchmarking against the HERSA disparities collaborative which was a large collaborative of community health centers addressing disparities in diabetes. They weren't able to move the needle on hemoglobin A1cC.

We're able to eliminate disparities in process measures. We were pretty excited about our progress. Now for the purpose of this meeting I just wanted to do a couple of quick back of the envelope calculations around cost. And I'll end here. Adult patients with diabetes as it relates to their hospitalizations we know that diabetic minorities are more likely to experience multiple hospitalizations in a year and have higher costs than their white counterparts.

Our population in Chelsea was primarily Hispanic, primarily Medicaid, and lived in a low income zip code. So, these were the highest risk patients to have multiple admissions over the course of the year, although only 30 percent of diabetics, and this is data out of AHRQ, although

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

only 30 percent of diabetic patients were hospitalized or re-hospitalized they count for more than half of all diabetes related costs. And these are all considered preventable hospitalizations.

A single hospitalization is about \$8,500, multiple hospitalizations over the course of the year about \$23,100. So, the recommendation that came out of ARC is that we should have enhanced interventions for vulnerable populations and minorities. We have done a very quick, again back of the envelope calculation, and I'll just highlight that our program costs us about \$170,000 a year, that includes the health coach, a quarter percent RN who oversees the program, point five percent nurse educator, and some clinical oversight by a physician with fringe it's about \$170,000 a year.

Our projected cost savings as we look at this if we base it on hemoglobin A1C levels on ARC's tiered system of hemoglobin A1C levels and likelihood of admission we can project hospitalization about 25 percent of the patients that are in our program. That's a cost of about \$374,000 a year. If we can prevent about 60 percent of these we can, if we can prevent about 60 percent of these the cost is about \$224,400 a year. So, that's a potential cost savings between the cost of the program and the cost of these hospitalizations of about \$54,000 a year if these patients only have one hospitalization.

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

But we know that about a third of them are much more likely to have multiple hospitalizations. In which case we might anticipate saving \$134,000 a year and again we could bring this up to scale. This is a fairly small program with one coach at the moment. But we think that we could achieve significant cost containment and cost savings.

I just wanted to end by saying that there is a significant amount of evidence that disparities in healthcare exists and equity is an essential component of quality. I do believe that hospitals can play a major role in their elimination. I think that quality, cost, and accreditation will continue to be drivers in this regard. And the essential elements that we've talked about here and really undergird our program are data collection, race ethnicity data collection, monitoring and measuring, and then being attentive with quality proven interventions that address the root causes that are leading to these disparities.

And again I'd highlight the fact that I do believe cost savings can be realized and quality improved. Thank you so much for your attention.

[Applause]

**DR. KATHY HEBERT:** The slides please. My background is a little bit different. I've spent 30 years working in the Safety Net system taking care of the most vulnerable population in Louisiana in our famous Charity Hospital system. And then

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

after Katrina blew my house and my hospital away I ended up here in Washington, D.C. for two years doing a Robert Wood Johnson Health Policy Fellowship and worked across the street in the Senate on the Subcommittee on Bioterrorism and Public Health Preparedness.

Then I worked at HHS in the office of Global Health Affairs and then at the NIH in the Fogarty International Center. After that I was recruited here to this hospital in Miami and Joseph I would love to recruit you there because I am taking care of patients from 16 different countries and islands of which 51 percent of my population only speaks Spanish.

So, on any given day it's not unusual for me to not be able to communicate with my patients since I can only speak introductory Russian.

[Laughter]

So, today I'm going to focus on impacting disparities in healthcare using a disease management model. And for those of you in the audience who are quite enthusiastic about universal healthcare coverage I don't want to disappoint you but you may want to read the book, "The System" which goes into very minute detail about what happened during the Clinton Administration and you will understand how it's such a political hot potato here on Capitol Hill.

So, I came here determined to give the uninsured and the indigent population a voice here on Capitol Hill. But I

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

can tell you that nobody is listening. So, I'll go through the past, present, and future as it relates to disparities in care. And share with you a quick story about what we did in Louisiana.

I focused on health services research and I highly recommend that if you're not doing some research component in your quality program you're really missing an incredible opportunity. This is probably my most important slide and that is contrasting the delivery models. And if you look in the right hand column we have used this concept in Louisiana and that is having a proactive approach to addressing care in this population instead of an individual care as you've heard on many of the other speakers.

We look at population medicine by using data registries. And having electronic medical record system so we can give our physicians feedback on how they're performing. We use a group approach. So, it's no longer one patient, one physician. It's a multi-disciplinary team.

And we focus on care more so in the clinic rather than in a hospital based approach. And we always use evidence based medicine. So, this is kind of the concept that we used quality and outcomes overlapping with health services research in disease management.

So, we call this the Big Free in Louisiana. This was Charity Hospital which you may have seen during the Katrina

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

saga and it flooded. We lost all of our paper charts. So, we had to take these patients and send them to other hospitals across our state which is a complete nightmare. We had no charts on these patients. So, think about the cancer patient who's halfway through their chemotherapy and nobody knows how many doses do they have left, what's going on. So, it was just a complete nightmare.

So, IT is a high priority. These are the stars where we have an indigent hospital. We have ten indigent hospitals in Louisiana. The hospitals were originally started 300 years ago when a sailor bequeathed his estate to start the first Charity Hospital which was named after the Nuns of Charity who began this hospital. And its mission was to take care of uninsured people. And we've never lost sight of that mission in 300 years.

We put this healthcare services effectiveness team together, you need to have everything from biostatisticians, to grant writers, data analysts, and this team helps support these ten hospitals. This was our criteria for success. Everything from quality teaching, revenue research, service, stakeholder satisfaction, and this was our disease management matrix.

So, today I'll focus just on the congestive heart failure column. Our population in Louisiana was incredibly poor. We had a mean income of \$11,892 and over 70 percent of our population had no insurance, 23 percent Medicaid and seven

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

percent Medicare. A very young population with a high African-American prevalence and then when you compare this to the population in Florida we have 51 percent Hispanic, 41 percent black of which the majority of that is from Haiti which these patients speak Creole.

And we have eight percent white population. In this clinic in heart failure that we've just started five months ago at Jackson 67 percent of the population is male and 44 of the population is indigent. They have no insurance.

We looked at our population by financial classification and you can see under the indigent column actually Hispanics have the highest prevalence of no insurance. And then we broke it down by male and females, male patients are more indigent. So, what we do both in Louisiana and in Jackson is we began a working dashboard.

So, this is our Excel spreadsheet that we use at every visit and we look at it before the patient walks in the room and look at their quality indicators to see what we need to work on on that particular visit. And I'll focus on racial and gender issues today.

So, we do—we penetrate the iron triangle. So, we increase access to care and we did this by offering patients the ability to walk in our clinic without an appointment if they need IV lasiks if they're short of breath. So, they no longer have to access the ER.

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

We improved quality and we do this all by decreasing costs. Not everybody is in favor of this model, however, so if you look at this article in our Journal of Acute Heart Failure when Heart Failure Disease Management programs started they were so successful that CEO's started closing them because they didn't want to pay for empty beds and cover the nurse or the nurse practitioner's salary who was accomplishing this.

So, patient acquisition, we streamline it where you can come to our clinic from primary care, ER echo departments and that's how we're proactive. We now look at patients who have an EF of less than 40 percent and we automatically enroll them in our program. We don't wait for a physician referral.

And going back on the last slide, which I don't know how to do that, but I don't speak Spanish and I don't speak Creole so we bought these teaching DVD tapes which explains the disease process, what you need to do, how you to take your medication, your activity, and your diet. And every patient sees one of these 12 minute teaching tapes.

We have them on a variety of topics. Everything from smoking cessation, weight loss, managing your diabetes, and end of life. This is our very simple algorithm that we use for all patients. In the *JAMA* article that tells us about our quality and Medicare beneficiaries Louisiana ranked 51<sup>st</sup> in the country with a 57 percent use of ACE inhibitors at discharge.

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

Florida ranked 41<sup>st</sup>. And this is what was accomplished in our indigent setting. You can see here that in our eight public hospitals with incredibly poor patients we were able to track these perimeters and get some places overall system wide 96 percent use of ACE inhibitors. We used the same model in Florida and you can see here based on whether you're white, black, or Hispanic, we had a 100 percent, 99 percent, and 95 percent use of ACE inhibitors and BETA blockers in this population.

So, there are no disparities whether you're indigent in Louisiana or Florida in this disease management model, same whether you're male or female. There is not a huge statistical difference in the use of these drugs in this population. So, what do we get for our bang for our buck? We decreased admissions by 72 percent, length of stay by 70 percent, ER use by 68 percent and saved a half a million dollars in the first hospital we used it at in Louisiana.

Rolling it out over the eight hospitals over two years we've saved \$27 million and remember that's taxpayer money because 70 percent of these people have no insurance. And the tax payers are picking up the tab. So, looking at race we compared mortality in the four groups, white, blacks, males and females, and you can see here that after we adjusted there was no discrepancy between the four groups.

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

And, in fact, black women had the lowest mortality. Looking at things for preventative care we know that it says that only 50 percent of Americans receive preventive care. So, we make sure building the entire tool so in our HMP form we have to check the box whether they've gotten their vaccines or not. And just in the first three months of starting our clinic we've been able to increase the vaccine rate in all of our groups, as well as, males and females.

So, we know that two-thirds of hospitalizations for heart failure are preventable. And so what we did now is we have a program where you can come to our clinic and get IV lasiks all day if you need to at a cost of \$279 instead of \$7,500 for an inpatient visit in Louisiana. It's much more expensive in Florida.

And we have an open access program where you can walk in and just get one dose of IV lasiks and leave after that. And we have a grant that pays for this free lasiks for three years at Jackson Memorial Hospital. In Louisiana we were able to increase this clinic use and you can see that the ER use resulting, you can see how it went down in the same proportion.

So, we decreased the ER use by about 350 visits. So, in Jackson we looked at the health policy can an open access model for IV dieresis and an outpatient disease management program reduce hospital costs? So, in the three months that we started the program we had 173 new patient visits, 54 patients

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

took advantage of this service to come in for free lasiks for 115 visits.

The ER cost is \$5,295. We've already saved \$680,000 in cost avoidance by this free program. We know that 96 percent of the people who come to the ER in Florida get admitted and that's an average cost of \$26,000. So, if 96 percent of this 155 patient visits we'd save almost \$3 million in just using this very, very simple program.

So, you can't stop there. For those of you who have already climbed your mountain where you're working and you're looking for a new mountain to climb chronic disease is the number one cause of death in developing countries. And cardiovascular disease leads the list and there is a higher proportion of it in middle and low income countries.

So, now we're focusing on doing this kind of care in the country of Georgia. So, we exported our CHF disease management model in August of last year in the former Soviet country which has the highest mortality of cardiovascular disease in any of the post Soviet regions.

And so we've been able to show that you can do it and you can do it successfully. So we've brought these simple tools, a laptop computer, a blood pressure cuff, a stethoscope and a portable echo machine.

And now you can see here that we've had a 173 patients enrolled in that program. If you look in the lower right hand

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

part of the slide 99 patients in this country came back for their second visit and they have a 75 percent use of beta blockers, ACE inhibitors, and diuretics.

If you look on the left hand slide 88 percent of this population is uninsured and the mean income in that country is \$1,200 a year. So, we're expanding disease management not only there but we also have plans to start a program in Ecuador in July and I've been invited to speak in Moscow because they visited our program in Georgia and they would like to get a disease management program up and running in Moscow.

So, in 2002 we won the safety net award in Louisiana. This is my crew who went to California to receive the award. And I would like to take this opportunity to thank all the team members including Mr. Marvin O'Quinn [misspelled?] and Jean [misspelled?] Bassett who's here because they are the ones who really made this all possible for me to be able to implement this program in Jackson. Thank you so much.

[Applause]

**MOHAMMAD AKHTER, M.D., M.P.H.:** Wow. Good afternoon. I'm so glad to see all of you here and thank you for listening to these very, very wonderful presentations. You know health disparity is a very important subject not only for the medical community but for our nation.

Right now 25 percent of all Americans are people of color, ethnic minorities. By 2030 it's going to be 40 percent,

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

by 2050 it's going to be 50 percent. And so in this globalized world whoever has the best educated and healthy population, workers is going to win.

So, if we want to keep the jobs here in America it's important for us to pay attention to disparities and try to eliminate them right now. Cost is one aspect but building a strong nation is another aspect. And that's why Mr. Stern President of SIU and Mayor Menino of Boston were at the Whitehouse in the year 2000 signing the document saying these disparities are no longer acceptable and must be eliminated.

And so this is a very important national subject matter. So, as a public health physician I want to ask the panel a question before opening it up to you all. Science is all about finding the truth. Medicine is taking that truth and treating a patient to the best of your ability.

Public health is taking that truth and making it available to all the people on an equitable basis. So, my question to the panel is why is it that you are doing all of this and the others are not doing this in our society? And what led you, your institution to take this extraordinary step? So, would you please start, Ms. Zimmerman?

**DONNA ZIMMERMAN:** I think what led us to begin the work was really the very highlighted reports Dr. Betancourt talked about, as well, with the Institute of Medicine. But we also understood, I think, pretty early on with the changing

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

demographics in Minnesota that if we wanted to differentiate ourselves in quality which we always we felt we had been able to do the next bar that we had to raise was that for our patients and our members of color.

And so we think that we can actually—we've done so well in our quality both as a plan and our medical group we think that by focusing on our patients and members of color we will be able to continue that trend and close that gap even more. I think we feel that there are just huge business reasons, quality reasons, and legal reasons why we need to focus on equitable care.

And we're in it for the long haul. And we're in it organization wide. And lastly our Board of Directors issued this challenge to us. And they're very engaged in the effort. We are governed by consumers and our Board is diverse and they're holding us accountable for changing this practice. And we will disseminate and encourage others to do the same.

**MOHAMMAD AKHTER, M.D., M.P.H.:** Dr. Fong?

**TSE-LING FONG, M.D.:** Dr. Akhter, that's almost a rhetorical question that I think your posing to us. For me personally as a transplant hepatologist I devote so much of my time and attention to the care of patients with end stage liver disease. And a disproportionate number of my patients are Asian-Americans dying of cirrhosis and hepatocellular carcinoma.

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

And it is just, from—without a background in healthcare policy but just coming from a very personal standpoint it just made a lot more sense to me as a physician to be caring for patients early in the beginning of their stage of disease to prevent them from developing these complications.

And I think my time is much better spent doing that and it's certainly much more rewarding. From an institutional standpoint the support of the Asian-Pacific Liver Center is in the keeping of the philosophy and principal of the Daughters of Charity Health System. They have had a long tradition in caring for the indigent and the traditionally underserved population.

**MOHAMMAD AKHTER, M.D., M.P.H.:** Thank you. Dr. Betancourt?

**JOSEPH BETANCOURT, M.D., M.P.H.:** I think as I reflect back if we look back after the release of the Institute of Medicine report on Equal Treatment, I think as you highlighted the issue of disparities are not something that were discovered with the IOM report. But I think it took the IOM and the impromptu of the IOM to raise it to the attention of many individuals who to be frank this is a anathema to many of us who are healthcare providers and to people in the healthcare system to think that we are raising a culture, I think, that makes us very uncomfortable to believe that we might treat

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

people differently based on race ethnicity or their culture, and so I think that's bit of a disconnect.

Our analysis in some of the work that we've done at the Disparities Solution Center around why are some people engaging this work and I'd say the broad majority not, I think, centers around the issue of leadership. And I think we've seen that leaders who have been particularly proactive in connecting the health to the well being of communities to the economy to employment activities, to market opportunities, have been the ones that have really stepped forward in this regard.

We've heard from health plans who've said, "Well, we understand that large purchasers are diverse. That there is an increasingly diverse patient population and if they consider contracting with us we will let them know that we will give all of their members and all of their employees the best we have to offer."

Similarly hospitals, I think, understand that the issues of disparities may not be just an additional cost. But there may be a variety of opportunities for cost containment and cost savings. So, I think that leadership gap is one that we need to do more to address. And we're trying to get opinion leaders from around the country to step to the table and kind of help, I guess, spread the word on this issue.

**MOHAMMAD AKHTER, M.D., M.P.H.:** Thank you. Dr.

Hebert?

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

**DR. KATHY HEBERT:** For us it's been leadership. It's been a top down approach where leaders both at LSU and in Florida understand the importance of quality, understand the concept of sick SIGMA where you're going to spend more money when you do wrong because you're going to have to do it over again.

So, we're fortunate enough to have really leaders with a cutting edge philosophy that quality is the way to go.

**MOHAMMAD AKHTER, M.D., M.P.H.:** Thank you. Sometimes the initiative comes from the top down but many times it's also the front line workers who make and initiate and support and advocate and fight for the change. Many of the improvements in New York City health hospital system took place in the early 70s because of CIR.

The young doctors raising the bar and saying, "No, we need to have better quality care." So anyone can really move this agenda forward not only for our own—your own organization but also for the nation.

We—I was told there was no more time for questions that lunch is ready. So, I thank the panelists for their wonderful presentation and thank the partnership putting this program together. Thank you very much. God bless.

[END RECORDING]

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.