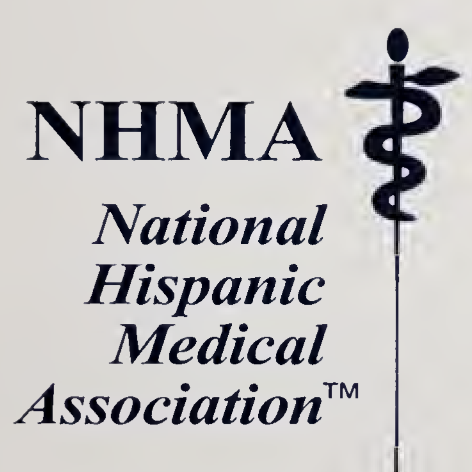

"A Report on Health Disparities And Hispanics Leadership Summit Series"

Partners:

National Hispanic Medical Association
And the
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INTRODUCTION

Health care spending is expected to consume 17.6 percent of Gross Domestic Product (GDP) in 2009, and it is projected to rise to 20.3 percent by 2018 if current trends continue. Since 2000, health care premiums have grown four times faster than wages. The U.S. spends twice as much per person for health care as any other country in the world, and yet continues to lag behind other countries in terms of coverage and quality. There are nearly 46 million uninsured people in America, and millions more have inadequate coverage. The U.S. has lower life expectancy rates than most of the other industrialized countries of the world.

According to the U.S. Census, Hispanics are 15 million or 15 percent of the U.S. population and by 2042 will be one out of four Americans. Hispanics are the subpopulation with the highest rate of uninsured as well as the highest rate of health care disparities. Hispanics are the ethnic group with this highest proportion who are uninsured and over one-third of Hispanics do not have health insurance. Without changes in policy, a growing number of Hispanics will become uninsured.

According to the U.S. Department of Health and Human Services National Health Disparities Reports, since published in 2006, Hispanics have consistently had the worst record with access to health care and the highest gaps in health disparities, compared to the non-Hispanic population groups.

Hispanics face severe lack of access to health care, lack of trust and knowledge, and are low-income, poorly educated with strong cultural and family values, limited English proficiency, mainly living in urban areas. Due to immigration and media, Hispanics have a strong identity. Hispanics suffer from high rates of obesity, diabetes, infectious and chronic diseases with a strong need for cultural competence, language and education services from the health care providers.

In order for health care reform policies to develop enrollment and awareness for insurance plans and primary care and prevention services, there is a critical need for cultural competence training of physicians, health providers and the general healthcare workforce; and language services including interpreters of oral communication and translators for written communication.

Moreover, should health reform be passed, there will be an increased support for disease prevention and health promotion, primary care services as well as a new public health infrastructure at the Federal and State level. However, the current healthcare workforce lacks Hispanic researchers, providers and leaders in public/private agencies who can provide strategies and solutions to reaching and including Hispanics in health care programs.

Thus, we need to approach thinking about the future and how to prepare for a New America? The new America will consist of populations who face severe lack of access to health care, lack of trust and knowledge, and are low-income, poorly educated with strong cultural and family values, limited English proficiency, mainly living in urban areas, suffering from high rates of obesity, diabetes, infectious and chronic diseases, and demanding health care reform.
THE FUTURE IS NOW… AND THE PARTICIPANTS OF THE SUMMITS ARE THE ANSWER.

The purpose of the NHMA and US DHHS OMH Health Disparities and Hispanics Leadership Summit Series was to

1) discuss the barriers of current programs that impact on the health of Hispanics*;
2) discuss strategies needed for future health care programs; and
3) build consensus on the Federal programs and policies that can be developed or enhanced to improve the quality of health care delivery to Hispanics in the United States over the next five years.

* Programs that decrease health disparities of Hispanics are those which are strongly linked to the community and have been shown to enhance one of the following: access to health care; prevention of obesity and/or diabetes; and increase diversity in the health professions.

One hundred participants were invited to three regional summits who were representatives from Federal, State and local governments, health insurance and pharmaceutical companies, hospitals, clinics, and other health providers, foundations, insurance and pharmaceutical companies, business, unions, media, academic health centers, K-16 education, and community agencies with experience in programs impacting the health of Hispanics.

The NHMA and OMH established a planning committee including members of NHMA and key staff from the national and regional offices of OMH. The planning committee agreed to the protocols and to the focus on three areas for discussion: How to Improve Access to Health Care for Hispanics? How to Increase Prevention of Obesity and Diabetes for Hispanics? How to Increase Hispanics in the Health Professions?

The participants were nominated by planning committee, federal and state elected officials, and government and private sector leaders. The NHMA Fellows were tasked with serving as facilitators at the working tables of ten participants with a balance of stakeholder “type”. A facilitator consultant was contracted to train the fellows and to guide the participants through the consensus development sessions.

The Summits were convened as follows:

November 26, 2007 – New York Academy of Medicine, New York City, New York
January 22, 2008 – Sheraton Grand Hotel, Sacramento, California
March 6, 2008 – Texas State Capitol Building, Austin, Texas

The recommendations were ranked by the participants and at the end of the three meetings, all the recommendations were incorporated, by ranking, into the top tier of recommendations.

The outcome of the project was to disseminate the recommendations to Federal policymakers. NHMA presented the recommendations to the 2008 Presidential campaign health care advisors at the NHMA Annual Conference in Washington, DC, in a policy briefing at the New York Academy of Medicine, and at the national democratic and republican conventions, and to Senate and the Congress staff writing health care reform legislation.

NHMA announced these recommendations in April 2008 at the 12th NHMA Annual Conference in Washington, DC to the health advisors of the Obama, McCain and Clinton presidential

campaigns and the presidents of the American Medical Association, the National Medical Association. All commented on the need to consider these health disparities recommendations for the impending national health care reform debate.

NHMA shared the recommendations with the delegates of both the democratic and republican national conventions and with the national minority coalitions that NHMA works with on health care advocacy. Starting in August 2008 with Senator Kennedy briefing from medical associations, NHMA has shared the recommendations with the Senate and Congress staff in all the major health reform committees as well as the Congressional Hispanic Caucus and Congressional Black Caucus and President Obama's White House advisors. For the past year, NHMA has also educated national groups on these priorities so that they too gain an understanding on how to improve health for Hispanics/Latinos and for all Americans.

Finally, the purpose of this report is to disseminate the key issues and recommendations to improve Hispanic health that came from the three summits held jointly between the National Hispanic Medical Association (NHMA) and the Office of Minority Health of the U.S. Department of Health and Human Services (US DHHS OMH) to policymakers and other healthcare leaders, so that they begin to incorporate these thoughts in their work to improve the health of all Americans.

U.S. Department of Health & Human Services
Office of Minority Health

The mission of the Office of Minority Health (OMH) is to improve and protect the health of racial and ethnic minority populations through the development of health policies and programs that will eliminate health disparities.

OMH was established in 1986 by the US Department of Health and Human Services (HHS). It advises the Secretary and the Office of Public Health and Science (OPHS) on public health program activities affecting American Indians and Alaska Natives, Asian Americans, Blacks/African Americans, Hispanics/Latinos, Native Hawaiians, and other Pacific Islanders.

OMH advises the Department on health policy issues affecting health status and access to care among minority populations. It coordinates programs to help HHS implement minority initiatives, including the HHS Disparities Initiative, the White House Initiative on Historically Black Colleges and Universities, the White House Initiative on Educational Excellence for Hispanic Americans, the White House Initiative on Tribal Colleges and Universities, and the HHS Minority HIV/AIDS Initiative.

OMH works with HHS operating divisions and other Federal departments to improve collection and analysis of data on the health of racial and ethnic minority populations. It monitors efforts to achieve Healthy People 2010 goals for minority health.

OMH develops and implements health campaigns to increase awareness of health disparities and promote prevention. Campaigns encourage communities, individuals, health providers, businesses, and national, state, community and faith-based organizations to get involved in eliminating health disparities.

OMH was proud to sponsor the 11th Annual National Hispanic Medical Association Conference March 22-25, 2007, in San Antonio, TX to bring together experts from across the nation to share their experience in eliminating health disparities for Hispanics.

In October 2004, OMH sponsored the First National Child Health and Child Welfare Conference to help address the health and welfare disparities of racial/ethnic minority children, bridge the health and human services systems, and achieve positive outcomes for racial/ethnic minority children.

OMH also sponsored the first National Leadership Summit on Eliminating Racial and Ethnic Disparities in Health, which drew 2,200 community representatives to Washington, D.C., in July 2002, for strategy and skills-building sessions.

National Hispanic Medical Association

Established in 1994 in Washington, DC, the NHMA represents 45,000 licensed Hispanic physicians in the U.S. Its mission is to improve the health of Hispanics and other underserved. The Association has recently established a Foundation—the National Hispanic Health Foundation to compliment the work of the Association. Based in New York City, its specific role is to develop educational activities and health policy research to improve the health of Hispanics. It is affiliated with The Robert F, Wagner Graduate School of Public Service at New York University.

The NHMA was developed as a result of a meeting of Presidents of Hispanic medical societies. During the meeting it was decided an organization was needed to fill a void in Washington, DC – the need for a voice for Hispanic/Latino physicians as advocates for Hispanic health with the Federal government. This decision grew from a history of organizing efforts dating back to the 1960s when Hispanic medical students formed regional associations and local societies focused on social and charitable activities. In 1982, Rios established the California Chicano/Latino Medical Student Association and in 1985, the Supernetwork Program to link CMSA with 25 undergraduate Chicano premed clubs. In1987 Rios formed the National Latin American Medical Student Network.

From 1995 to 1996, the U.S. Department of Health and Human Services (HHS) Health Resources and Services Administration supported 5 regional meetings with Hispanic health leaders around the country. The following year, NHMA convened its First Annual National Conference. In October 1998, Dr. Rios became the Executive Director of NHMA after receiving Federal funding through a Cooperative Agreement with the HHS Office of Minority Health. In 2000, NHMA opened its first office, expanded its staff , and began to receive funding from a number of Foundations , government, and the private sector for a variety of programs, including launching the Hispanic-Serving Health Professional Schools, NHMA Leadership Fellowship, the Resident Leadership Fellowship, the NHMA Public Health Fellowship, the NHMA Research Network, Cultural Competence Curriculum Project, eh National Hispanic Health Leadership Summit, Hispanic Health Professional Student Scholarship, Congressional Hispanic Health Briefing Series, Over the past 9 years, a total of $11.5 million has been raised for project support, although the core staff has remained very lean, averaging an annual budget of $1.5 m.

In 2005, NHMA completed a strategic review and has recently expanded its Board of Directors to include nationally recognized leaders in the health sector and NHHF established its Corporate Advisory Council. A formal affiliation was signed with NYU-Wagner. In 2006, NHMA contracted with a fundraiser to expand corporate sector financial support and an association development company to develop the strategy for infrastructure to support dramatic increases in membership. A first step in this strategy was the establishment of an association of State Medical Societies and a network of national Hispanic health professional organizations which NHMA will develop through its Obesity and Diabetes Education Project and new portal (www.hispanichealth.info).

Opening Remarks
Health Disparities and Hispanics Leadership Summit

Garth Graham, MD
Director
Office of Minority Health
U.S. Department of Health and Human Services

Good afternoon. I know we're all eating to get everyone more energetic. So I am going to keep my comments short. That is one of the things my dad taught me. If you ever want to be invited back keep it short and sweet. I am glad to see a lot of good old friends and colleagues from a number of different areas.

I am going to tell you a little bit about the federal government, one of the things that we are doing. More important, I want to tell you why in our earlier planning Elena and NHMA leadership, why it was important for this group to come together and how this is going to feed in to our overall set of processes that we are trying to generate around this country in terms of creating a cohesive agenda around health societies.

So two sections are about the Federal Office of Minority Health so you get a better picture of how the different people in the jigsaw puzzle fit together. So the Federal Office of Minority Health was really put in place a little bit more than 10 years ago as a result of something called Secretary's Passports on Black and Minority Health. It was the passports that were pulled back together back, you know, in 1985 or so. By then the Secretary of Health Education and Welfare, a very interesting lady by the name of Secretary Margaret Heckler.

Interesting, when you look at the nomenclature and the name of the report and a lot of the kind of various data points in the report you see where we were back in 1985 when we were looking at this issue on health society. That should, you see really more importantly where we were back in 1985 in terms of health and healthcare status for minority populations across the board and how that was viewed from the federal level and also at the state level as well. Interestingly it was called the Secretary's Passports on Black and Minority Health, so back in 1985, 1986 really the preponderance of data that we had was in the African American population. There was some data, actually a good deal of data on the Hispanic population. Some is kind of what I was taking data on the Asian American population and some other data that was reported back then on the Native American Population as well. But it was called the Secretary's Passports on Black and Minority Health because that was how things were viewed back in 1985, 1986 with the focus on the African American population because that was where the majority of data was collected.

Interestingly enough I have seen over the past 20 years we've seen a real surge, if not a real growth in the Hispanic population overall. I would venture to say, if you look at a lot of the challenges that our country are facing, you can look at kind of this asynchronous debate that we were having around immigration and all these various kinds of things that we have been talking about. We are probably struggling with these things as a country together, really that is starting to define where America is going to go in the future from where we are now in the present to where we need to be in the area.

So I started by giving you that data point back in 1985 to give you a better understanding to why it is important when we get together in groups such as this how we define the problem, how we

shape the problem, but more importantly how we shape our solution for the future. What Elena has done here is of pull together all of us to bring our various thought patterns around what needs to be done around health societies at this point in time.

We are at an interesting point in our country. I was telling about the point in our country we were in back in 1985 to 1986 and really what a lot of the health status indicators showed back then like I showed you before, was that minority populations across the board were disproportionably affected by disease. We know in 2008 that minority populations are still disproportionably affected. So not much has changed in terms of those health status indicators.

So then what do we need to do at this point? What is it that needs to be done? How do we get our country to where we want to be? It is interesting, like I was saying to your earlier, if you look at where we are as a country still the United States is ranked number 37 in terms of all the varied nations in terms of health status indicated across the board. We are spending about 18% of our GDP on healthcare. We are spending trillions and trillions and trillions of dollars on healthcare, yet our health status indicators actually are declining in many areas. For many of our minority populations, especially the Hispanic population if you look at the last National Healthcare Disparities Report in many of those indicators the actual outcomes are actually widening as well, so that health disparities are not getting smaller as we are spending more money. They are actually getting larger.

Now I want to give you the vision for the future in terms of how we get there. If you look at the history of healthcare in our country, you realize that healthcare is truly a team sport. Now what do I mean when I say that? You have all kind of big players in the healthcare industry. You have the federal government, and the federal government is a huge player when it comes to healthcare. You have state. You have private sector companies, and when I say that I mean medical device manufacturers to the pharmaceutical industry. You have the major health plans. You have large academic institutions. You have providers, entities from CNAs to nurse practitioners, to physicians, to physician assistants. Then you have the patients who are at the end of that overall spectrum in terms of people that need to be influenced.

All of those people make up the entire team when we look at health and healthcare. So if you do not have all the players on the field all at the same time then it is going to be pretty hard to win the game. So what we have been trying to do over the next year or two is actually to have a series of meetings, such as this. Elena has gladly taken on the leadership in terms of helping us craft an agenda for the Hispanic population. We were trying to have a series of meetings where reported from various experts, all of those different players that I was talking to you about, and start to reshape the agenda for how we actually make progress in the next 10 to 20 years.

I was telling you before that between 1985 to 2007 we really have not done much in terms of actually decreasing that gap and, in fact, in many instances those gaps have widened. So we cannot keep on doing what we have been doing all along. We need to start changing course. For us to be able to do that, we are going to need your thoughts, your ideas, your passion, we are going to need whatever ingredients that you bring to the table. We are going to need those to feed into the overall process.

This is actually a very, very serious endeavor for us. The other day I was doing a radio show and one of the radio callers called in and she said, so what are you guys going to do about fixing healthcare. I said, well what are we going to do about fixing healthcare, because as I pointed out

earlier it is really about how we all kind of come together in this overall teamwork pattern that I was talking about. We do not have to agree on everything. We do not have to have the same affiliations, whether that be academic or political. What we do have to agree on is that there are things that need to be done and that we each have an individual role and responsibility in terms of executing, if not actually coming up with that overall action plan that needs to be done from here on.

The other thing that I think Elena touched on a little bit earlier, is this is a very ripe season for healthcare. Opportunities abound when we look at the chance to make a change in healthcare. There are presidential politics that I do not need to talk to you about. There are state activities that I do not need to talk to you about. There are various things occurring at the federal level. So this is really the right time for us to have your input, your thought pattern, and your ideas as we move forward. I should tell you that concurrent to this train that is moving along, and as I understand moving along pretty well today, we have similar trains moving in varied industries and you will see some announcements coming out in the near future about different things from the Office of Minority Health. We are trying to pull together all of the various players in this overall team, in this overall spectrum of folks that we believe need to be included in the whole tapestry that will actually effectuate change.

So, all of that is to say that this is, again, a very important get together. Elena is going to have three of such meetings across the nation in different geographic locations so that we can really get the flavor for where things are happening, so another meeting in California, another meeting in Texas, and really try and pull together all of the pinpoints in terms of things effecting the Hispanic population.

I will say this last comment in terms of, again, understanding just how important the future of this country is intertwined with the growth of our Hispanic population across the board. I know I am speaking to the choir when I say this; but in most of our major urban cities right now the Hispanic populations are making up, if not the majority of those populations already are very close to doing that. Right? So we are seeing where the change in demographic in our country is really kind of defining where we are right now, but more importantly it is going to define where we are over the next 20, 15, 10 years, whatever time period you want to actually kind of draw a marker by.

So what does that mean? Well I said to you earlier that right now the United States is at number 37 and falling. There is no other way for us to actually reverse that tide in terms of starting to actually incrementally making our way up. But we have to start putting the ingredients in place that will actually start getting us moving from number 37 to number 1, and I actually believe that this meeting is part of how we go about doing so.

So with that being said and done, can I take two more seconds to talk a little bit, one second to talk a little bit about some of the other things we are doing. So some of the other things that we are doing at the same time are building a lot around the business case around health disparity. We believe that the private sector is an important engine in our country's motorcade around healthcare overall. As we are focusing on not just issues related to community-based organizations and academia we are also building a pretty strong network of folks in the private sector industry to help build the case for why health disparity is important.

From a business standpoint we are seeing where many of the major corporations and the major industries from GM to Ford are actually large healthcare organizations that just happen to make cars. So we are seeing where the major challenges that these folks are hitting are in the realm of health and healthcare. We are also seeing where a number of other major private sector industries, especially those folk, because you had a big meeting with those folks in the hotel industry who employ huge amounts of Hispanics and African Americans, and many Asian Americans as well. We are seeing where a lot of the bottom line in terms of how they are facing their future financing and infrastructure is based on dealing with health disparities and dealing with healthcare overall.

It is like I said to you; I mean this is a big team. It is a big, huge team. You all have been drafted as a part of this team. Really our goal over the next year or two is to start to pull all of these different tracks together so we actually have a successful agenda for our country over the next 5, 10, 15, 20 years, as I said before. So that being said and done I am going to stop right there. Thank you all again. I would like you to please take your work here seriously, even though it is in green, red, and all different kinds of colors. Elena is going to pull it together in actual black and white in a way that is readable and actionable and really we are going to start to pull of these things and varied ideas together so we can really elevate health disparities on the map across the board.

Elena Rios, MD, MSPH
President & Chief Executive Officer
National Hispanic Medical Association

On behalf of the NHMA and the US DHHS OMH, I would like to welcome you to the Health Disparities and Hispanics Leadership Summit Series –this is the first of 3 summits that we are convening. We will present the collective Federal health policy recommendations at the NHMA 12th Annual Conference in Washington, DC on April 18th.

At the outset, I want to thank the Summit Planning Committee – Guadalupe Pacheco, Claude Coliman and the others of the U.S. Department of Health and Human Services Office of Minority Health, George Friedman Jimenez, Norma Villanueva, Mark Diaz, Martha Zaragoza - Diaz of NHMA and all the Facilitators – NHMA Leadership Fellows, and staff – Tim and interns and our facilitator, Ralph Bates.

Thanks to Dr. Graham, Deputy Assistant Secretary of Minority Health, for his leadership and collaboration with NHMA to help promote the issues that can improve Hispanic health across all the agencies at the Department. I would also like to acknowledge Dr. Jo Ivey Boufford, President, The New York Academy of Medicine for hosting us at this historic site of medical education. Dr. Boufford is an outstanding leader in public health and we look forward to working with her as she directs the Academy's programs and research to reduce health disparities.

The National Hispanic Medical Association was established in 1994 in Washington, DC. The NHMA mission is to improve the health of Hispanics and other underserved. We actively develop Federal health policy and advocacy with the Congressional Hispanic, Black and Asian Caucuses and with Senator Kennedy and Senator Frist/now Senator Cochran, in collaboration with many partners – National Coalition on Hispanic Health, the Racial/Ethnic Health Disparities Coalition, Out of Many One and other boards we participate with in DC.

We also focus on developing leadership within our networks ---The Boards of Directors of NHMA and NHHF, the NHMA Council of Medical Societies, the National Hispanic Health Professionals Leadership Network, NHMA Leadership Fellows, NHMA Public Health Fellows, the NHHF Corporate Advisory Council, and all our members and partners.

We established our Foundation, the NHHF, which is now affiliated with Robert F. Wagner Graduate School of Public Service, New York University to develop educational and research efforts. For example, we established our National Hispanic Health Professional Student Scholarship Program to build our leaders for the future and our Portal (www.hispanichealth.info) ---to serve the clinicians for the new America. Besides our Scholarship Program, we are developing a new partnership with the Major League Baseball to reduce childhood obesity with our medical societies and a new partnership with the Office of Minority Health to develop health education and online community discussions through our new portal. We have developed partnerships with our NHMA Leadership Fellowship, Federal advocacy efforts, and cultural competence and medical education training through our annual conference.

The Institute of Medicine report, "The Future of the Public's Health System in the 21st Century" discusses the approach to improving health ---by understanding the factors that determine health –at the individual, family, institutional, community levels and their interrelationships…and the solutions at the society level are within different sectors. I believe that NHMA will be a stronger advocate if we can identify, with your help, those strategies that can transform the health of Hispanics in their communities.

The purpose of the Summit today is to discuss major barriers and priority recommendations to advance U.S. Federal policies and programs to better improve the health of our people ---those with the culture, values, beliefs, families & traditions from Mexico, Puerto Rico, Dominican Republic, Cuba and Central and South America.

There have been policy efforts within the Department on Hispanic health – especially, the Executive Order on Educational Excellence for Hispanic Americans started under the first President Bush; President Clinton Administration's Hispanic Health Agenda of 1996 (which incorporated Surgeon General Novello's TODOS Report), Culturally and Linguistically appropriate services (CLAS) guidelines and the Limited English Proficiency (LEP) Executive order of 2000, disparities research and Centers of Excellence and health professions focused on Hispanics, Healthy People 2010; which mandates that this country eliminate racial and ethnic health disparities by 2010; and HRSA's clinic collaborative, the HIT, CMS's performance projects on plans and doctors, AHRQ's quality programs, the CDC Future's Initiative transforming the agency research and programs based on new population and life stage-based health goals.

In Congress, the policies we are focused on are the Health Equity and Accountability Act (Solis/Fortuno) and Senate and House Minority Health and Health Disparities Improvement Act (Kennedy/Cochran and Jackson Jr.) and we will need your support in letters at our website --- http://www.nhmamd.org.

The future portends that Health Care Policy will rise to the forefront of our national policy agenda, especially, given the squeeze on the domestic budget brought on by the war in Iraq, at a time when there will be optimal demands based on chronic diseases in the aging baby boomers, the rise of the uninsured in the middle class, the rise in costs of health insurance in small

businesses, the shortage of doctors and nurses, the call for expanded Federal entitlements and fiscal incentives in the marketplace for more efficiencies. At the same time, we have tremendous opportunity as all the major Presidential candidates are supporting health care policy as a priority in the next White House. And, some of the candidates have prioritized health care disparities – so we have to be ready when they calls on us for solutions for the next National Health Care Reform Debate and the next Executive Order for Hispanic Americans and the nominations for future Hispanic Leaders for DHHS.

What we need in Washington, DC ---are new approaches and more effective ways to target existing and future Federal policies and programs to address racial and ethnic health disparities. And that includes all of your perspectives in dealing with the Hispanic community –business and worksites, health industry, schools, health provider, labor and community leaders.

In summary, today we ask you to focus your discussion on recommendations to improve Federal policies and programs to be more responsive to the needs of Hispanic – individuals, families, neighborhoods, institutions, worksites, community environment, as well as patients in the health care delivery system. You are the solution to improving health for our community.

Developing the Summit Recommendations

We will first hear from leading experts regarding the current issues surrounding each subject matter affecting the Latino/Hispanic communities across America and then the major recommendations for this particular topic. In terms of the getting to consensus, we hired a facilitator, who trained NHMA physicians to be the facilitators at each of the ten tables in the room. At each table is a mix of stakeholders invited. (See the Appendix for the participant lists)

Speakers have been assigned to address three topics, Access to Care, Prevention of Obesity and Diabetes, and Increasing Hispanic Health Workforce. Following each speaker, the participants were assigned to a table to discuss barriers and then vote on Priority Barriers and report out. Then there will be a working discussion on each Priority Barrier with Recommendations and a vote on Priority Recommendations and report out.

At the end of the three Summits, the Priority Recommendations will be consolidated in one database, by ranking, and we will produce a Final Report highlighting the speeches and top ranked Priority Recommendations to provide to Federal policymakers.

Lastly, we have collected samples of model programs, and conducted current literature reviews on each topic for the Summit participants.

New York Summit

Access to Health Care for the Hispanic Community

Maxine Golub, MPH
Senior Vice President
Institute for Family Health

Good morning. Thank you very much for inviting me to present this morning. I am honored to be here, and to share some of the work that we have been doing through the Institute for Family Health and the Bronx Health REACH project.

For those of you not familiar with the Institute, we are a non-profit health care organization dedicated to providing health care in underserved communities, training health professionals, and engaging in health services research. We currently operate 16 health centers in Manhattan, the Bronx, Ulster and Dutchess counties. We serve approximately 75,000 patients, more than half of whom are African American and Hispanic/Latino.

We also operate two residency training programs in family medicine – one in Manhattan, and one in Kingston, NY – and serve as the metropolitan regional office of the New York State Area Health Education System, a federally funded program designed to increase the diversity of the healthcare workforce, and to encourage health professionals to choose careers in underserved communities.

Lastly, I'll mention our work with Bronx Health REACH, a CDC funded coalition of 40 community and faith based organizations that has been addressing racial disparities in health outcome in the southwest Bronx since 1999. This year, the CDC elevated the project to a National Center of Excellence – permitting us to provide technical assistance to other groups throughout the state and country that want to address this concern.

Barriers to Health Access

Let me start by stating what we have identified as the barriers facing access to optimal health for the Hispanic/Latino community in NYC. I say we, because the thinking behind this presentation comes from years of discussion at the coalition – with community members, health care providers, clergy members, leaders of community based organizations, and staff.

Also notice that I say *health,* and not *health care,* because the factors to be considered go beyond the health care system itself. However, because I was asked to focus on access to health care, I have deliberately omitted some of outer edges of disparities – some of the environmental and social determinants of health – like disproportionate exposure to pollutants, and the lack of access to healthy foods and opportunities to exercise that we believe to be an important part of the problem, and a critical component to eliminating disparities.

I promise not to spend too much time on describing the barriers – because I think we're all pretty familiar with the problems, and I understand the goal of the day is to talk about solutions.

So, briefly –

1. Financial barriers – particularly insurance status results in limited access to care:

The Hispanic/Latino community is disproportionately represented in the ranks of the uninsured and those on Medicaid. In NYC, 60% of Latinos fall into one of these categories, compared to 50% of blacks and 25% of whites.

Even with community health centers and public outpatient clinics committed to caring for people regardless of their ability to pay, this results in significant disparities in access to care. REACH published a monograph on this topic, called *Separate and Unequal: Medical Apartheid in NYC*[1] that highlights the differences in care between private doctors' offices and clinic patients, often within the same facility. These differences include lack of continuity of care, lack of after-hours coverage, and limited access to diagnostic care, specialty care, and medications – all of which lead to poorer health outcomes.

2. Language and cultural barriers create an obvious obstacle in obtaining care:

In spite of legislation that requires language access in healthcare facilities, this has yet to become a reality. Too often there is no one available who speaks fluent Spanish, or there are Spanish speakers who lack training as medical interpreters. This is exacerbated by the very low representation of Spanish speakers among clinicians. This results in miscommunication, medical errors and other preventable problems. In addition, we occasionally find perfect clinical trials for patients, only to find out they have no Spanish speaking staff and no Spanish language materials to inform the patient. And even when Spanish speakers and materials exist, the lack of providers and staff that "look like you" contributes to apprehension, mistrust, and low utilization.

3. Lack of trust in the health care system results in reluctance to utilize the system:

In 1999, the first year of the REACH Coalition's work, we held nine focus groups of more than 100 community residents. Major themes emerged, which have been reiterated by community residents on multiple occasions over the years. These themes include widespread distrust and fear of the health care system, difficulty in communicating with doctors, and both the importance

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[1] Calman NS, Ruddock C, Golub M, Le L, *"Separate and Unequal: Medical Apartheid in New York City"* The Institute for Urban Family Health, Monograph 32pp. New York, October, 2005 and Calman NS, Golub M, Kaplan S. "*Separate and Unequal: Health Care in New York City*" Journal of Health Care Law and Policy. University of Maryland School of Law, Vol 9:1:2006

and difficulty of advocating for one's self. In short, people of color do not expect the health care system to work, and feel somewhat hopeless about getting adequate care.[2]

4. Self Advocacy:

Related to this is the difficulty of self advocacy. Patients need to know their rights, and know how to best advocate for themselves and their families within the health care system. These ought to be obvious – the right to be seen regardless of your insurance status, the right to have a provider that speaks your language, or a translator, the right to have a full explanation *that you understand* – of both your diagnosis and your treatment options, the right to a second opinion. I don't think I need to tell you that most patients are not aware of these rights, or, if they are, are reluctant to exercise them.

5. Gaps in Public Health Education:

I am a public health professional by training – so I must add this to the list. There is a general lack of suitable health education – particularly in poor communities. Look around – it's easy to find ads for alcohol and fast foods, but rare to find one that teaches you how to stay healthy. In 1998, for example, the National Cancer Institute spent roughly one million dollars to launch their "5 a Day" fruits and vegetable campaign, compared to the billion dollars spent by McDonald's alone that same year. Even when they exist, health education materials are often not culturally relevant or literacy level appropriate in any language, so people do not fully understand prevention and health maintenance.

6. Digital Divide:

We are witnessing an increased use of the internet and health information technology throughout the health care system. HIT can be used to provide better care through best practice alerts built into electronic health record systems, increase monitoring and tracking of patients' conditions, and improve communication between providers at different levels of the system. In addition, patients will soon be able to access their own health information via secure internet portals. Given the cost associated with these advancements, we must insure a) that low-income communities and safety net providers have the resources to fully participate, b) that residents of these communities have access to computers and computer training, and c) that the information available is linguistically, culturally, and literacy level appropriate.[3]

<u>Recommendations</u>

To achieve health equity, we must address these issues – via local, state and federal programs and policies. Here is some sense of the direction or approach I believe we must pursue:

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[2] Kaplan SA, Calman NS, Golub M, Davis JH, Billings J. *Racial and Ethnic Disparities in Health: A View from the South Bronx*, <u>J Health Care for the Poor and Underserved</u> 2006; 17:116-127)

[3] Calman, NS, Golub M, Kitson K, Ruddock C. *Electronic Health Records: The Use of Technology to Eliminate Racial Disparities in Health Outcomes.* In: <u>Medical Informatics: An Executive Primer</u>. Health Information and Management Systems Society, Chicago, IL. Kenneth Ong, MD, Editor. January 2007.

1. Financial barriers:

We must achieve universal health coverage, but while we fight for this on a national level, we must, in New York State, make sure that every eligible family participate state subsidized insurance.

- To make this so, NYS must streamline its application, enrollment, and recertification procedures; and,
- Our academic teaching centers must provide equal care for all – eliminating the two tiered system of care described above. One way to promote this is by rationalizing payment for comparable care – eliminating differences between "private" and "clinic" Medicaid rates, and eliminating the disparity between Medicaid and Medicare rates.

2. Language access and cultural competency:

- In order to achieve language access we need to promote the increased training of medical interpreters – and the use of such interpreters must be included in the calculation of revenues;
- We also need to come up with a definition of cultural competency that is truly linked to demonstrable competencies – and then tie that to revenue enhancement; and
- Finally, and I know this will be discussed later; we need aggressive strategies to increase the numbers of Hispanics/Latinos in every level of the healthcare workforce.

3. Lack of trust, self advocacy, and public health education:

- I've mentioned trust, advocacy and public health education together, because I believe the solutions go hand in hand. The solution is to mobilize the community around issues relating to health equity and health promotion;
- It also involves community based participatory research – where the community defines the problems to be addressed and identifies and implements solutions. Public dollars – through the Centers for Disease Control. The Office of Minority Health, the National Institutes of Health and the City and State Departments of Health must be made available to community groups and institutions that are committed to true partnerships – in order to educate community members about their rights, teach them about effective advocacy techniques, and develop community based health education and health promotion programs.
- Public dollars must also be invested in health education – in schools, in doctors' offices and health centers, and in the workplace, because so many of the health issues that affect us are influenced by the choices we make – whether or not we exercise, what we eat, our sexual behaviors, our use of alcohol and drugs, and so on.

4. Health Information Technology

Here I have to credit Dr. Neil Calman, the president of the Institute, who presented a set of recommendations to a congressional committee last week. His testimony was 20 pages though, and I am going to mention just two of his points:

- We must insure that all legislation that supports the implementation of electronic health records targets those patients at highest risk on our society; includes organized ways for community participation in their planning and execution; and funds safety net providers such as community health centers and public hospitals;

- We must also mandate that all EHR systems capture data on race, ethnicity, gender and primary language so that providers can examine disparities that exist in treatment within their systems, and address them through targeted efforts aimed at high risk populations.

In summary – in order to achieve health equity and eliminate health disparities, access to care must address all of the barriers that people face – barriers resulting from insurance status, the lack of linguistic and cultural competency, access to information, feelings of trust and empowerment, and the implementation of technology.

I hope this has been a helpful start to today's discussion. Thank you.

California Summit

Health Care Security and Cost Reduction Act

Richard Figueroa
Office of the Governor
State of California

A Broken Health Care System

6.5 million uninsured
- Stressed emergency rooms
- "The hidden tax"
- Rising health care costs
- Chronic illness; poor health choices
- Medical errors
- Financial strain, bankruptcy

Governor's Health Care Initiative
- Prevention / Wellness
- Shared Responsibility / Coverage for All
- Affordability

Prevention & Wellness

Healthier State – Long Term Affordability

- Benefit designs to incentivize and reward healthy practices
- Diabetes prevention and treatment
- Patient safety
- Obesity prevention
- Tobacco cessation

Shared Benefit

GOVERNMENT
Healthy, productive & economically competitive state

EMPLOYERS
Affordable coverage
Healthy, productive workforce

INDIVIDUALS
Access to affordable coverage
Health care security
Healthier CA

HOSPITALS
Expanded insured population
Fair compensation

HEALTH PLANS
Expanded market
Fair compensation

Shared Responsibility

GOVERNMENT
Promote functional health care market
Provide access to affordable coverage
Fairly compensate Medi-Cal providers

EMPLOYERS
Support employee access to affordable coverage

INDIVIDUALS
Obtain health coverage

HOSPITALS
Provide affordable, quality care
Share cost savings

HEALTH PLANS
Guarantee access to affordable coverage
Pass along savings

Expanded Access to Coverage

- Culture of Coverage (e.g.; Schools, Doctor's Offices, Local Government, Hospitals)
- New subsidies and tax credits for lower income individuals
- Expanded clinic services for persons ineligible for public program subsidies

Promoting Affordability

- A reduction of the "hidden tax"
- Individual market expansion ➔ Promotes competition for business
- Market reforms: 85% of insurance premiums on patient care ➔ Moderates premium increases
- Statewide purchasing pool: Competitive plan price point➔ Drives broader market

Promoting Affordability

- Tax system: Health Savings Accounts (HSAs), Section 125 plans ➔ Provides tax breaks
- System improvements: regulatory reforms, HIT, value-driven health care ➔ Promotes efficient, cost-effective health care
- Consumer and Family Assistance: No-cost Medi-Cal, low-cost subsidized coverage; tax credits for middle income.

Fixing Our Broken System: Shared Responsibility

- Reduce the hidden tax; lower costs
- Coverage for all; support better care
- Healthy California

Texas Summit

Access to Health Care for Hispanics

Juan Flores
Health Policy Director
Clinica La Fe
San Antonio, TX

I see a lot of well known faces in the room, faces that have been around for many, many years dealing with these topics that we're dealing with today. So, they're not new to us, and I know that these faces are still very young, very pretty, and very handsome. So, I want to make friends with you from the very beginning, and there are at least several hundred if not a couple of thousand years of experience in the room right now. All of us have dealt in trying to make sense of this big elephant called "healthcare," and we've come at it over the years from a variety of perspectives whether you as a physician, whether you as a pass-through advocate, whether you as a CEO of a community health center, etcetera. Trying to grab this issue of access to care as fundamental as it sounds and self explanatory, I'm not always sure that it is. But in a very fundamental level at least for today, at least with my perspective on the table and some food for thought.

My daughter has a real high fever. Can I get her in to come and see Dr. Boganara today? Will I be able to get that appointment? I would like us to just be real straightforward about the need

that people have when they have that need at whatever time they need it for what they perceive is a problem with their spouse, themselves, with their children, or their relatives, to be able to make that call and to get fundamental access to care period. We know that there are a lot of other peripheral issues and important critical issues that we now call disparities in language and so forth, but it seems to me that the first fundamental is to have that access. So, I would like us to keep our language simple because for our community when they make that call, they just want that care.

It seems rather ironic that those of us that have been around for a while that what we used to call Chicano health that we now call Latino health or Hispanic health, etcetera. I want us to take credit, all of us in the room, for our history because I think we also need to honor that. It's ironic because Chicano health talked about that the health care system was broken. Chicano health talked about that there was too much money, too much cost in health care, way above what people can afford. Chicano health talked about the need for our own people to look at what are we doing to take care of ourselves? What are we doing about preventing problems, about not being in the doctor's office or not being certainly in the hospital or in the emergency room? These things are not new to us, and we advocated for these things for years. Now, they're popular. Now, they're recognized. So, let's take credit for the fact that we raised those voices 20 and 30 years ago. We had the experience even though we still have to do more research. The fact of the matter is that everybody now recognizes from General Motors to the business sector that, yes, it costs too much money. We're doing something wrong. Regardless of the terminology, we should take credit that we have history and experience and that it is being recognized. The question then becomes what we can put on the plate like we're being asked to today in terms of some recommendations that can impact policy.

I'm going to make some observations and some statements as part of just trying to stimulate our thinking about access. Hopefully it will do that somewhat. I realize that we're all different, and ultimately we're looking at some recommendations that will feed into a national perspective. But you and I know that all politics and all healthcare politics are local. There's some context. We need to deal with that issue at a local level and see how it connects to national perspectives and find the common threads that we need relative to those recommendations that will help us with what we need to do locally in the valley, in [foreign audio], in Houston, in Dallas, in Lubbock, in Hereford, Texas, right? All politics around healthcare is local and our ability to do that. Now, you may not agree with the statements, but I think the intent is to set some context and some practicality to what I think most of us know.

Number one is health care or the second, or even third, depending on which survey you look at, as a major issue for all Americans. Recent surveys indicate that by and large the folks that are most worried, as indicated by those surveys, about their access to care are Latinos. The latest surveys that came out from the Kaiser Commission in combination with the Robert Wood Johnson Foundation, found that Latinos are the most worried, percentage wise, about their ability to maintain or even get access to health insurance and get access to care.

Health care decision making is about who benefits relative to financial stakeholders. It is not always about access and what would be a more efficient and cost-effective system. Let me say that again just as a statement. Health policy decision making is about whom benefits relative to financial stakeholders, not about access and what would make for an efficient, cost-effective system.

Vested interest in the health care dollar is everywhere. There are too many to count. We have been dealing with trying to create a competitive market in the healthcare sector for the last 20 or 30 years. At least from my perspective where people are talking about we need to have better competition in health care, is that really new? Didn't we start with managed care, and then there was something before managed care?

So, let's keep that in mind. Out-of-pocket expenditures for medical care have increased. The poor pay more proportionally of their income than anyone for health care, not the middle class, not the higher. As a proportion of your income, the poor pay more for their health care.

Choice—the idea of choice in health care, the idea that we're pushing more prevention and consumer responsibility right now. Just how real is that? Is it really going to be choice, or is it still about this rationing of care? What's your perspective on that? It seems that there is a lot of myth going around this idea of choice.

Another statement—the enormous cost of health care, yes, it's a valid concern and there is need for changes in the health care system, but I would say beware of the decisions and the usual statement—there's no money. Shouldn't we be asking—are we putting the money in the right place? Shouldn't we be asking, where is the waste? Or are we just accepting politically that someone is saying to us whether it's at the state level, at the local level, or at the national level there's no money. The budget is tight. Do we just accept that at face value when we talk about access?

The rise in health care costs is not due to entitlement programs per se. Medicare, Medicaid, S-CHIP—these are the most cost-effective systems compared to the private sector, and the research seems to validate that or at least there is more weighed that Medicaid and Medicare is more cost-effective than the private sector. You figure it out. What's your point of view on that?

The rising cost of health care is more attributable to the advances in technology, the growth in prescription drugs, profits, higher salaries of doctors, particularly the way they're compensated--we're not paying family practitioners what we should, but we're paying someone else what we shouldn't—to the intensity and the lack of coordinated care for chronic disease management. Why aren't we addressing or targeting that those are the reasons for higher costs? Why are we just blaming this and therefore our whole policies are about cutting this when there are some underlying issues that we're just not necessarily talking about. I think most of us sort of know it. And I think they know it as well.

Now, there are a number of things that are going on, as you know, across the country in terms of reforming healthcare, and people are trying different things. Basically, a lot of those reforms center around using Medicaid particularly for trying to address healthcare reforms across states because like immigration nationally there hasn't been what one would think aggressive leadership at the national level in terms of national health or universal healthcare. Only in the last two years has that really surfaced politically even though it's been there for quite a lot of years, as Dr. Rios said this morning in terms of what's going on nationally with that issue in terms of the electoral process we're going through right now. Fundamentally, states are trying to do their own thing and hopeful that there will be some national legislation that will help support healthcare reform, whatever forms it's going to take.

Now, I would like to just kind of have you think about those reforms and what you pick up in your own experience in terms of what direction people are taking. Some of the health care policy trends, social and health policy changes, that are targeting federal and state programs are focused on minimizing growth, services and cost. There are overall reductions in federal and state social and health policy safety net both at the national level and that is impacting at the state level.

The Deficit Reduction Act, that some of you may be familiar with, is providing extensive flexibility to states almost without monitoring to revamp Medicaid, and those things are called waivers. The whole idea with these incentives is to improve access, to improve quality and to improve costs. A lot of what the state is doing is they are applying quotes, and the state in our own bill here in Texas - - consumer driven/market driven. So there's a lot of talk about sharing costs, about the consumer taking more responsibility and so forth.

Then there is the health care marketing that's more extensive. As you know, since people have found out about us (this large Hispanic population) in the last ten years and all the things that you know about with our growth, the health care industry is being real aggressive in our community, in the hospital systems, and with insurance companies. People are marketing to us big time. That's a big element of what's occurring.

Then, there is the call for health care information transparency, the idea of universal IT systems for communications and for improving health care, and, of course, the debate around universal health insurance. If those are the trends, how do they fit our community relative to access? Think about it in terms of three areas. If you look at our demographics that you are very familiar with, our demographics are that we are young, we have a large immigrant population, and we have a lot of sub-groups. Cubans do not have the high-level of being uninsured in Florida as do Mexican Americans have in the country. It does not mean we do not have needs or that they're not similar, but Mexican Americans in the Southwest are the most uninsured in the whole country and certainly the immigrant population.

We unfortunately still have a long way to go with regard to education, below average education and below average income levels. We tend to be employed in industries more than others that do not provide health insurance for their employees. We still have a growing middleclass at the same time. So, if you just look at our demographics, our economic levels, and our education levels and then match that up against the research, your second column there that talks about health status issues, the fact that our healthcare health status is worsening and not necessarily improving in some areas—in a number of areas, issues of behavioral health, of chronic disease and so forth, and whatever the research is telling us at this time or what we know, and then thirdly the fact that we are uninsured and that there are certain things happening in the industry and wondering whether they're going to be matched.

Everybody says "affordability." What's "affordability?" Will someone explain the definition to me? Is what is affordable to me the same as what is affordable to you? So, we seem to be throwing out a lot, and there is this trend going on. The challenge to us is as you look at access and as we look at recommendations, we really have to be honest about what is our perspective. At least in my view, there are only two fundamental questions that have been there for the last 30, or 40 years that we're still debating. Is healthcare a right? Can people get it regardless of their ability to pay? Or is it a privilege? Do you believe in the market and that that is the way to go, and it will be more efficient, and everything in the healthcare system will become more affordable? There are some fundamental underlying issues, but it does come back to "us".

What are the perspectives and the observations that we have? Because ultimately and as we are being asked to look at this point about access and make some recommendations that can translate into policy. They inundate from our experience. They inundate to what our philosophy and perspective is in this issue, and as Mexican Americans, as Latinos, as Cuban Americans, as Puerto Rican Americans, as Hispanics, we are a very diverse group, and we are at different levels.

The second point I would make is how well organized are we as a population to influence this thing called health care and in particular the question of access for Latinos? Within the environment where there is a $2.2 trillion industry where there is a tremendous amount of political power, how organized are we to push the agendas we need to push from the perspectives that we have? I found it very ironic in the last two years even here in Texas and after being around with a lot of you for many years that I started to sort of hang around in Austin, and I'll finish on this point. I met with a lot of good groups and being involved organizationally with different organizations, so some of the policy think tanks here, whether it is the Children's Defense Fund, the Center for Public Policy Priorities, AARP and I am sorry but in every meeting that I have been in, I would say a good 12 to 14 organizations, I seem to have been the only Latino in the room. There were a couple of handfuls that showed up, but all of those organizations are Anglo-based organizations dealing with the issues that affect the Latino community. Now, I do not want you to misread that statement, okay. I really don't. These are good people doing good things, and we are partnering with them. But it is very telling to me.

Where is our Latino/Hispanic think tank? Where is our Latino/Hispanic policy research? Where is our Latino/Hispanic advocacy in an organized way? When was the last time that each of you testified at a hearing on behalf of our folks, (the Latino/Hispanic community)? And please do not say, "Oh, but I am with the medical school and they will not let me do that!" Aren't you a private citizen too? Okay, so ultimately how are we going to influence policy? Yes, we need data. Yes, we need to do our groundwork, but it is going to come back to how much we are willing to risk and the fact that all politics is local as well as national. So, as we think about access to health care the points that I have raised are just some food for thought. Thank you.

Recommendations for Improving Access to Health Care for Hispanics

POLICY RECOMMENDATION #1:

Develop universal and affordable health insurance coverage to increase the insured Hispanic population that addresses the following key policies:

Expand eligibility for insurance for Hispanics

Despite the development of health care insurance for the uninsured, in order to increase Hispanic participation in these insurance programs, it will be necessary to develop new policies that address eligibility. Since Hispanics are generally low income and working for small businesses, it is important to develop affordable policies such as subsidies by income, discount premiums for families, incentives for small businesses.

Expand public health insurance programs

Hispanics can't afford health care insurance. Moreover, they work for small businesses, which have decreased providing health insurance and the individual market is out of range. Thus, expanding Medicaid with a higher Federal poverty rate or expanding Medicare with a lower than 65 years age limit or creating a new public health insurance program would greatly increase the Hispanic coverage.

Support comprehensive benefit packages

In order to increase health status of Hispanics, it is critical to support a comprehensive benefit package that is based on prevention and medical treatment, oral health, mental health, and vision care. Optimally, the benefits should be linked to incentives for the average Hispanic, who is young and healthy, to consider seriously. For example, there could be tax deductions for gym memberships or for purchasing nutritious food or for cooking and physical activity and lifestyle change training courses.

Support individual mandates and automatic coverage

It would be important to provide individual mandates and automatic coverage protocols in the reform of health insurance.

POLICY RECOMMENDATION #2:

Develop the health care system that is more responsive to Hispanics by focusing on the following key areas:

Public-Private Partnerships and Community Demonstrations for Low Cost Health Care Delivery

It is critical for low income neighborhoods to have clinics become the focus of the medical care development and that they are developed with public-private partnership demonstrations that are evaluated for future widespread adoption. The Hispanics make-up a large proportion of clinic patient populations and with health care reform, this population would be expected to increase tremendously.

Standards for Culturally and Linguistically Appropriate Services

The Federal standards established by the U.S. Department of Health and Human Services should be adopted by all Federal programs that are related to health care delivery. The standards call for the improvement of care for multicultural and LEP populations and could lead to quality health care.

Develop cultural competence training of all health care providers, incentives through pay for performance and reimbursement, Federal clearinghouse

The U.S. Department of Health and Human Services Office of Minority Health should be supported to develop a national clearinghouse for cultural competence training programs for providers, to add to the current valuable internet self-instruction modules for doctors and nurses.

Develop language services training for health care providers, pooling of resources and expanding reimbursement by Federal programs

Language services, translation and interpretation, are needed in the health care sector to in facilitate communication between health care providers and patients as well as at the health care sector level with the community. To increase the insured, Hispanics who have a strong link to Spanish and some of whom are limited English proficient and have low literacy skills, need extra attention on language development. The training of health care students and providers, pooling of resources to have more efficient programs, and the reimbursement of language services by Federal programs are key priorities to increase Hispanic focus of the health sector.

Mandate data collection on race, ethnicity, and language preference

In order to follow trends in Federal program responsiveness, it is vital to develop and evaluate the data collection effort for Federal support to health care providers through the Medicare and Medicaid program - that includes race, ethnicity and preferred language. The evaluation of the quality of health care as well as resource planning can be targeted to Hispanic communities more expeditiously taking into account the resulting data profiles.

Support providers who serve in the underserved communities

In our nation, there are medically underserved areas and health professional shortage areas with high proportion of Hispanic and other ethnic bicultural groups who face limited health care facilities and limited access to quality health care services. In order to decrease health care disparities, it is important to support those providers who are the safety net – hospitals, clinics, medical practices through increased DHS funding, special reimbursements, loan repayment programs and the National Health Service Corps. The health system should refocus incentives toward improving the opportunities for quality care in underserved areas – where patients are sicker and require more time and education as well as more complex treatment regimens and referrals for co-morbid conditions, especially chronic disease and mental illness.

Invest in a diverse health care workforce

In order to increase the trust and responsiveness of health care programs to Hispanic patients, it is vital that the Federal government invest in the recruitment and retention as well as the deployment geographically of a diverse health care workforce. Incentives for the provider and the health professions schools need to be developed as well as an accountability system at the U.S. Department of Health and Human Services Health Resources and Services Administration to follow the trends in the workforce. See the workforce section for specific strategies.

Medical home that focuses on primary care and patient centered care

The medical home concept would increase the use of primary care providers and teams and would serve as a basis for a new reimbursement scheme for value of care management rather than episodic care. We strongly recommend that the community clinic become a medical home for safety net populations, with referral linkages to hospital networks of physicians.

Portability, Quality measures, Accountability

Other key issues that are recommended to be built into a reformed health insurance system include portability, quality measures and accountability.

Portability would permit more mobility among Hispanics moving from one employer to another, that is a part of the current economic climate as well as is related to economic and career advancement.

Quality measures are important to advance the quality of health care policy development. In order to address the quality of care that will reduce health disparities for Hispanics, these policies must include cultural competence and language measures. These measures have been discussed initially with the Hedis measures for health plans and hospital accreditation bodies. Of note, Hispanic health care providers should assist with the design of quality measures for health care delivery in Hispanic communities.

Accountability should include knowledge with data collected not only of racial and ethnicity but also language preference. Hispanics are a population with strong preferences for Spanish language; however, it is not asked in the health care system.

POLICY RECOMMENDATION #3:

Develop a major focus on health care education and marketing for Hispanics to increase awareness and participation in health care programs, through the following:

Standard health education curriculum in K-12

The priority mechanism to develop healthy lifestyle information as well as health care workforce careers to the Hispanic community is to institutionalize curriculum in the K-12 schools that focus on health promotion and disease prevention with fundamental concepts that can change behavior and increase critical thinking about personal responsibility for health. Most educational curriculum includes health through a science class which discussion is limited and dependent on the familiarity of the health care sector with the teacher. In addition, high school counselors need to be trained about encouraging K-12 Hispanic students to pursue higher education, especially to pursue health care professional careers.

Community health workers or "promotoras" increase access to services

Due to the lack of familiarity of health care systems, it is important to establish the community health worker or "promotora" as a part of the health staff, educating individuals about health promotion and disease prevention through basic information exchange. Peer education in public health would benefit the Hispanic community and at the same time assist with the enrollment and

National Hispanic health insurance media campaign

U.S. Department of Health and Human Services should plan and implement a national campaign through the Office of Minority Health on enrollment and awareness about health insurance options on an annual basis, built on the successful Medicare Spanish media campaign. Most Hispanics receive their health information from word of mouth and from the media, which warrants a health communication multimedia effort that could be co-branded by the National Hispanic Medical Association, other national Hispanic health professional organizations and community based programs.

Patient education expansion with health care provider incentives and reimbursement

In order to increase patient education services, there is a need to provide incentives beginning with increased reimbursement codes for primary care providers to provide the services. In addition, there should be incentives for hospitals and medical practices to provide group education that has been shown to be more effective (peer influence and support group positive affects to changing patient behavior) as well as to decrease costs of staff time. For Hispanics, these programs should be done by bilingual staff in Spanish and English and be focused on different generations within families and include caregivers.

New York Summit

Increasing Prevention of Obesity and Diabetes

Ileana Vargas, MD
Assistant Clinical Professor of Pediatrics
Morgan Stanley Children's Hospital of NYP &
Naomi Berrie Diabetes Center

Why Should We Concerned/Intervene?

- **Increasing Prevalence**

  Globally, obesity affects as many children as undernourishment

  Wang Y, et al. 2006, Int J Pediatric Obesity; 107: 311-315.

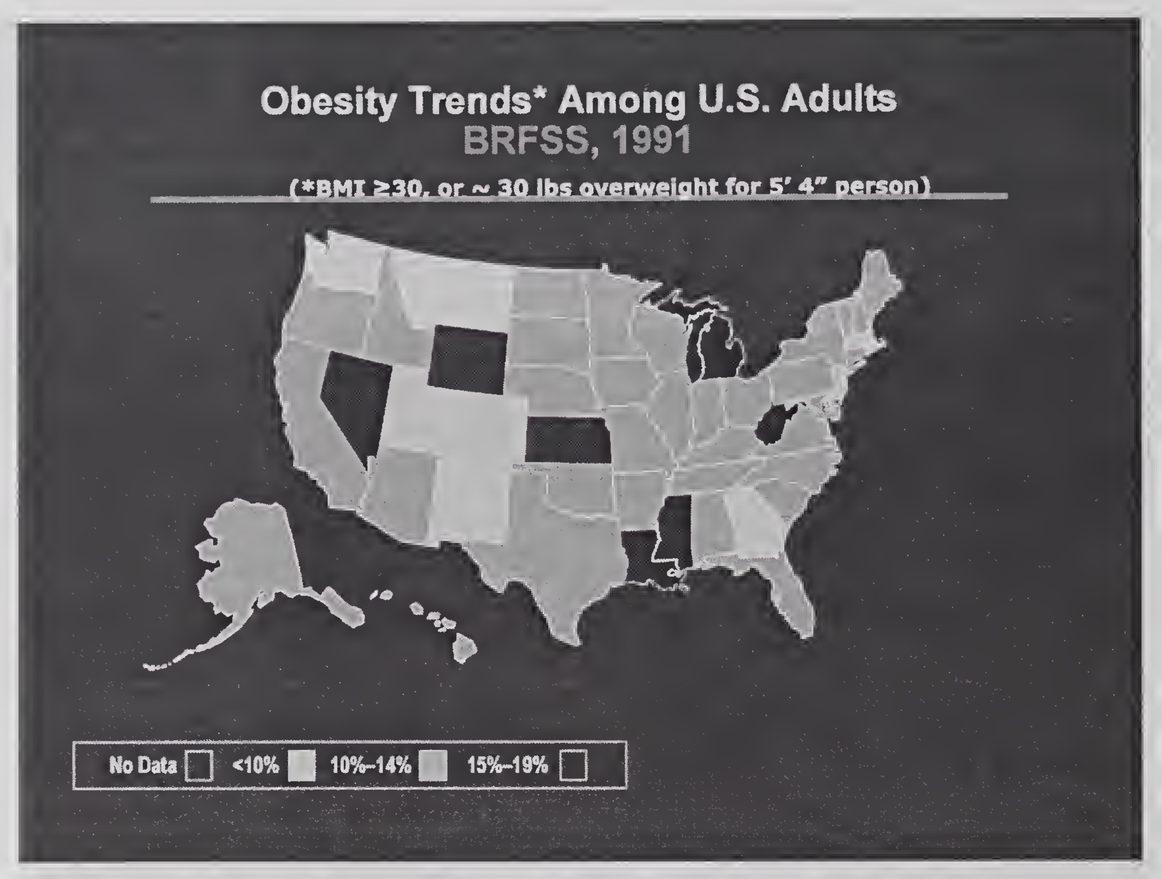
- **Prevention of Adult Obesity**

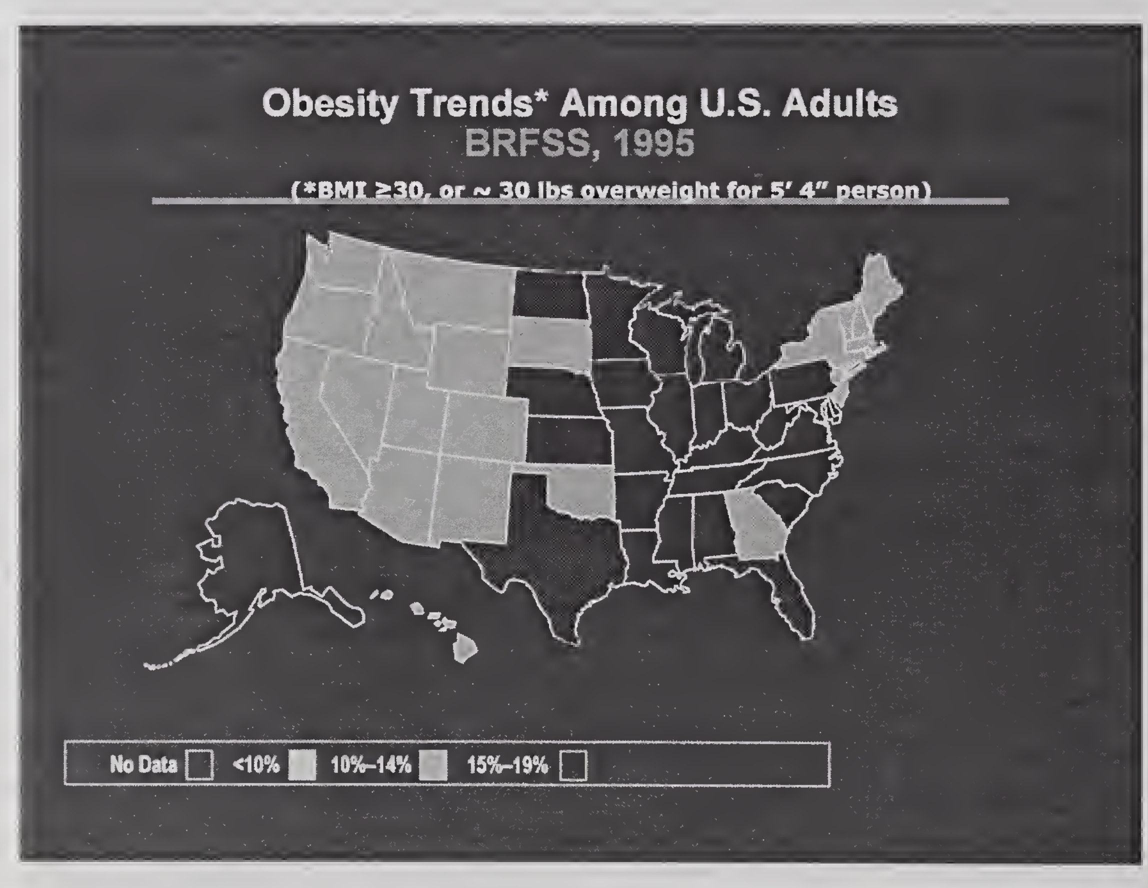
  Obese children are more likely to become obese adults compared to their lean counterparts,20-40%, by adolescence that increases to 70-80% especially if their parents are obese

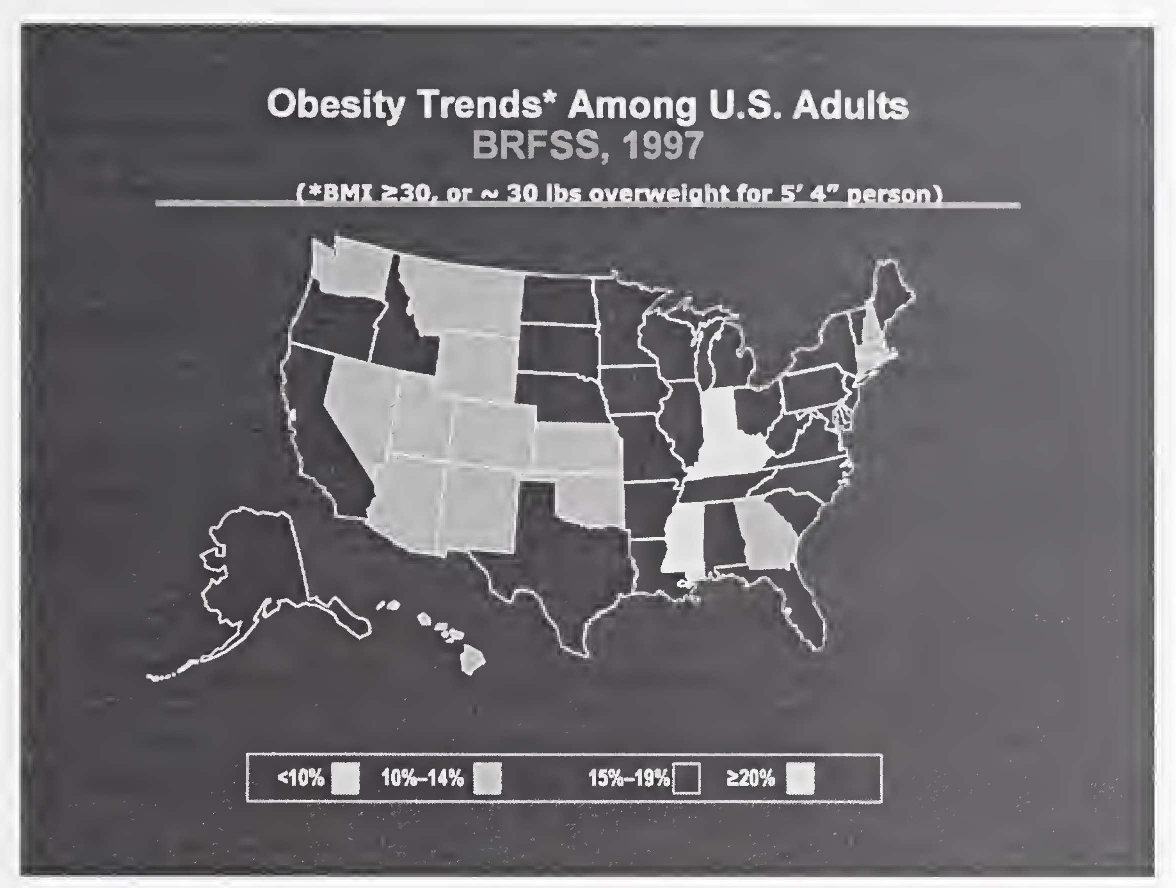
  Whitaker RC, et al. 1997, NEJM; 337: 869-873

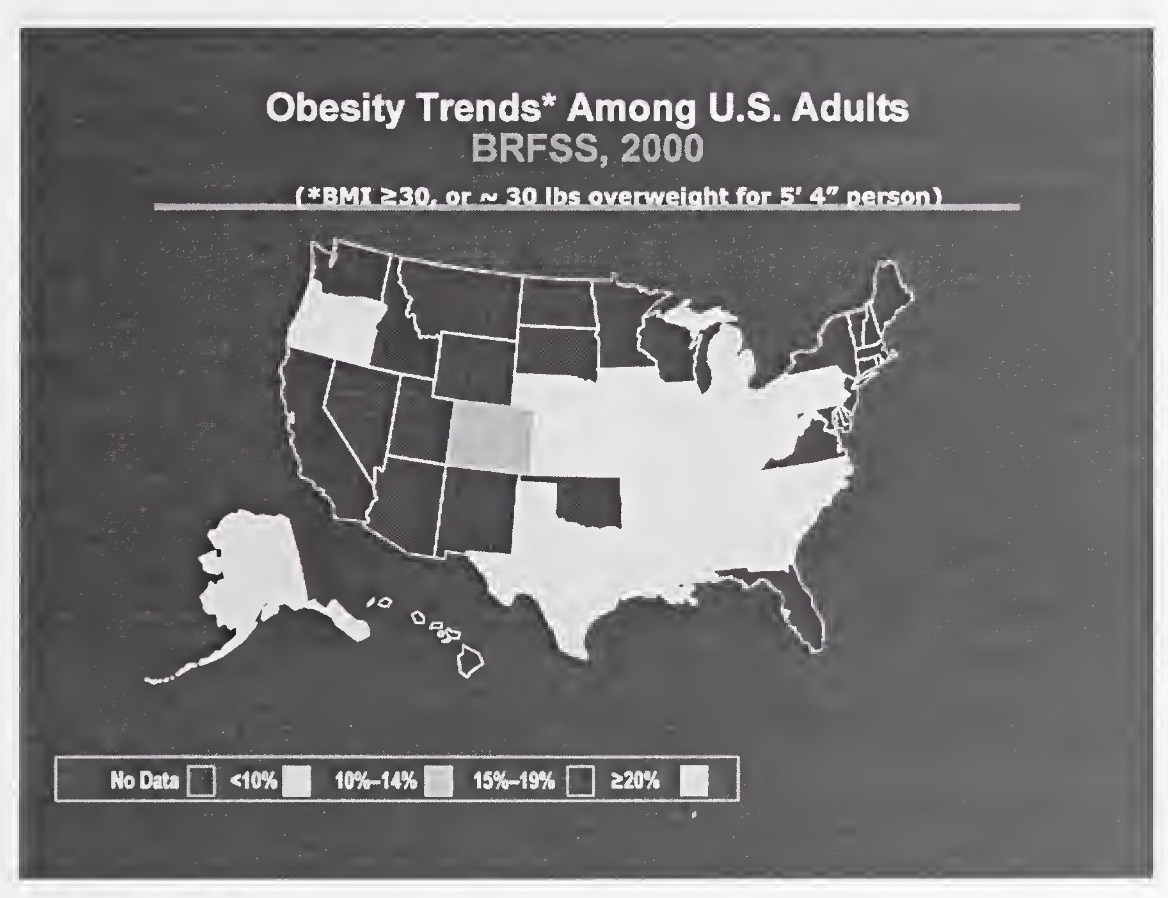
- **Health and Psychosocial Consequences**

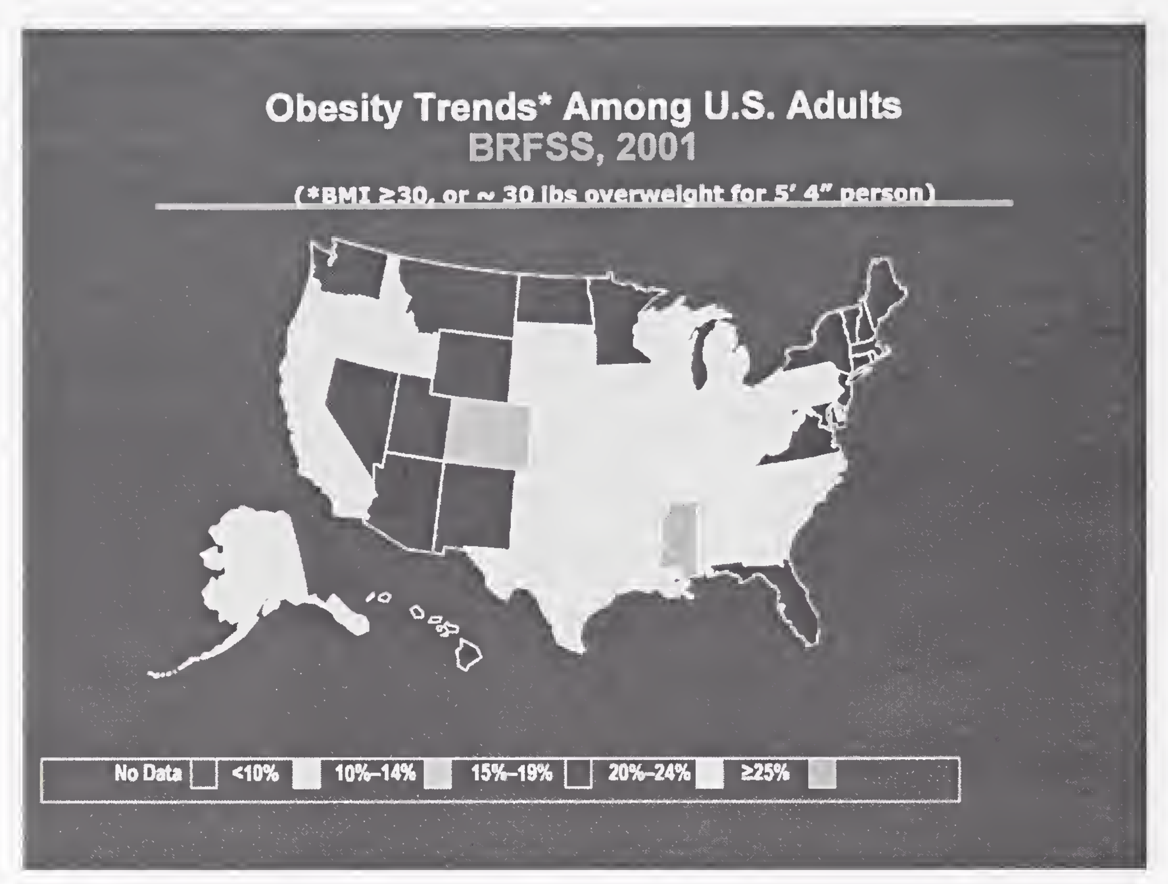
  Seen both in adults and children


Obesity Trends* Among U.S. Adults
BRFSS, 1991
(*BMI ≥30, or ~ 30 lbs overweight for 5' 4" person)
No Data
<10%
10%–14%
15%–19%

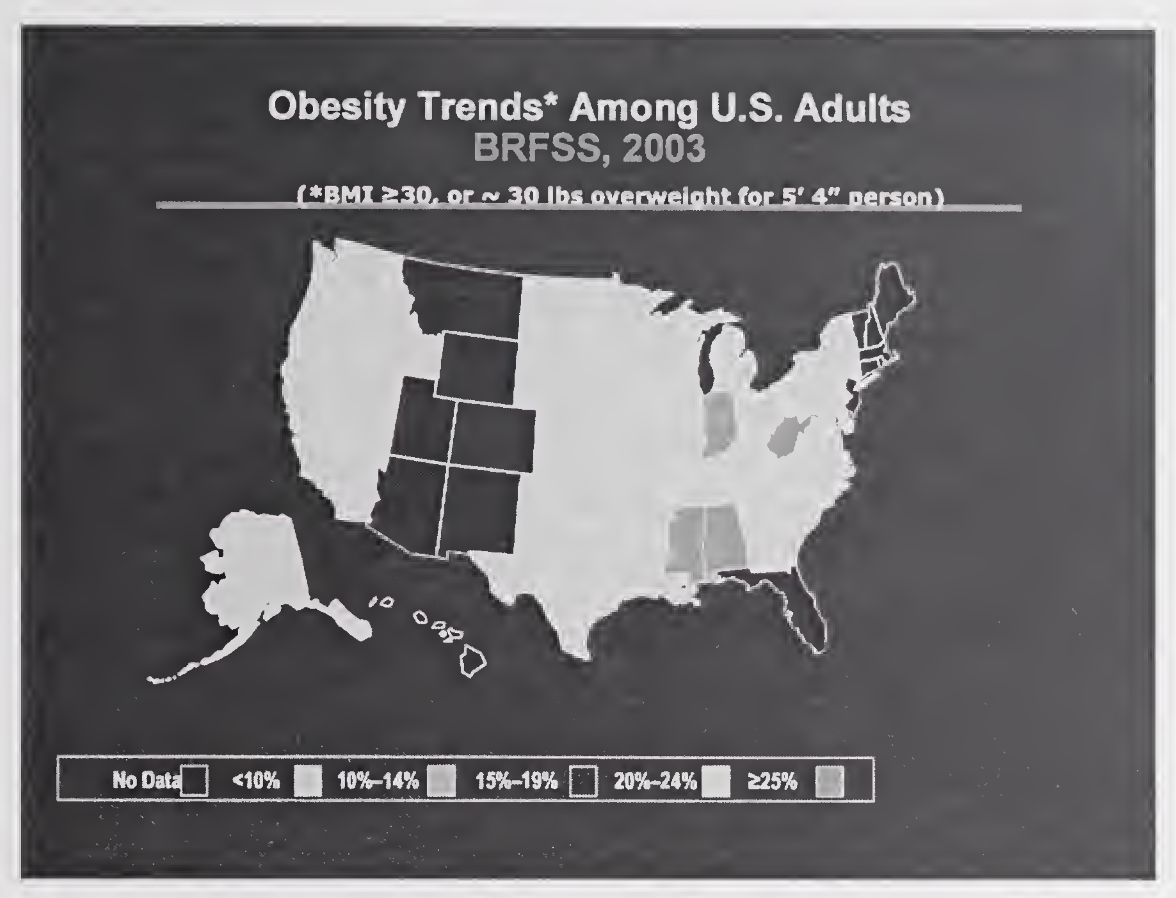

Obesity Trends* Among U.S. Adults
BRFSS, 1995
(*BMI ≥30, or ~ 30 lbs overweight for 5' 4" person)
No Data
<10%
10%–14%
15%–19%

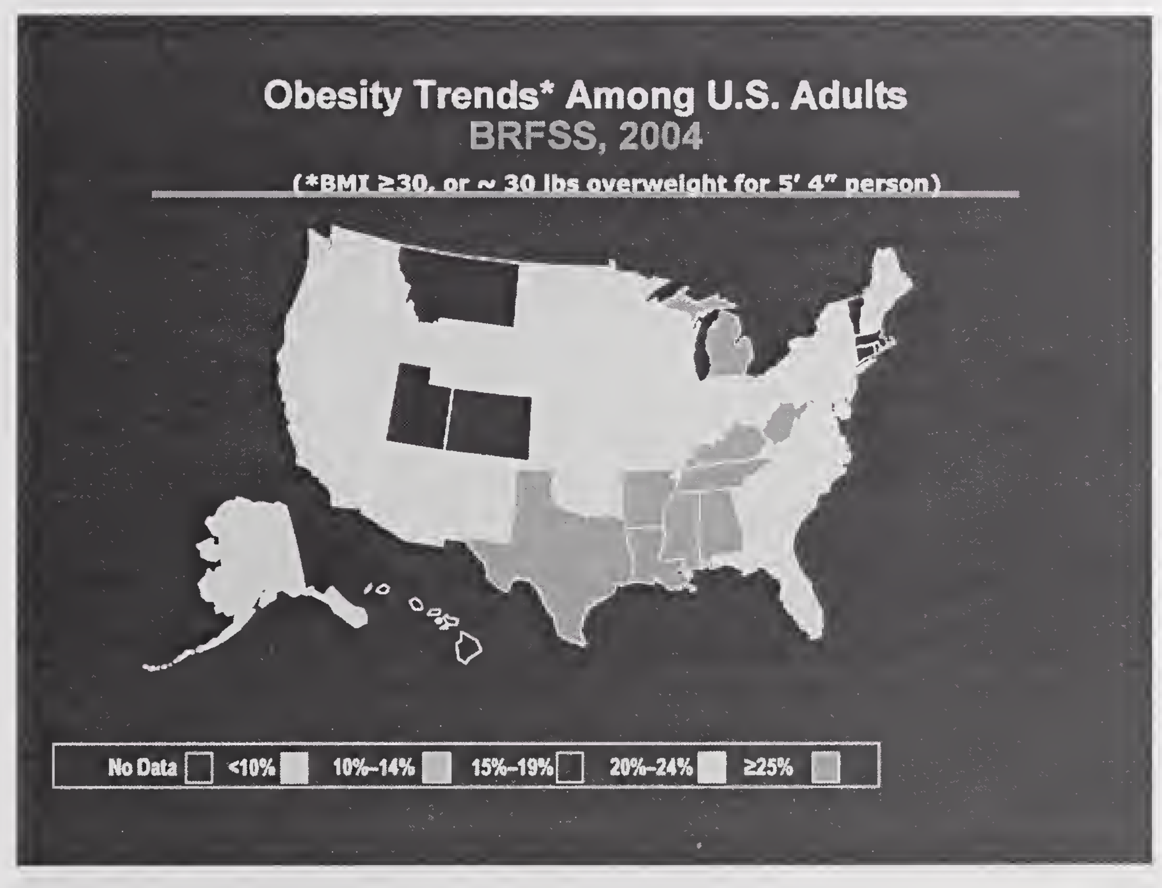

Obesity Trends* Among U.S. Adults
BRFSS, 1997
(*BMI ≥30, or ~ 30 lbs overweight for 5' 4" person)
<10%
10%–14%
15%–19%
≥20%

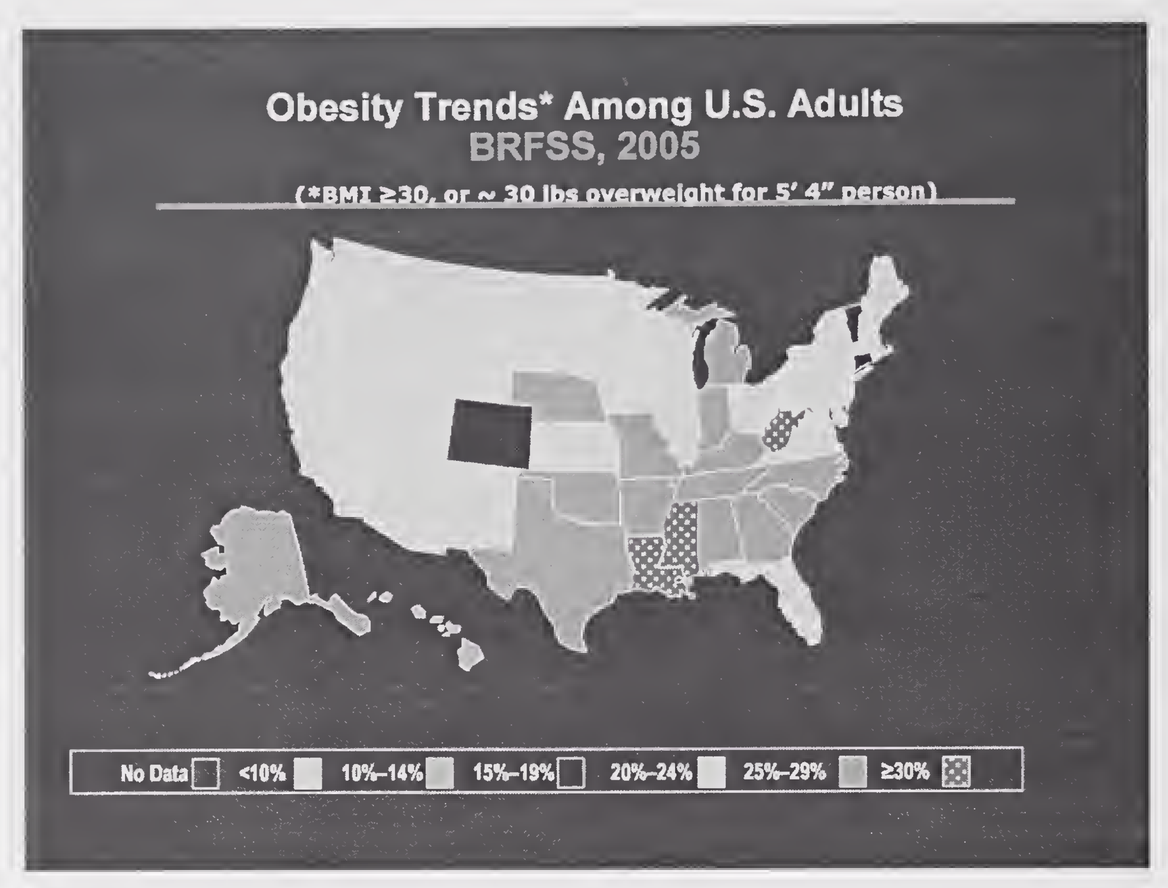

Obesity Trends* Among U.S. Adults
BRFSS, 2000
(*BMI ≥30, or ~ 30 lbs overweight for 5' 4" person)
No Data
<10%
10%–14%
15%–19%
≥20%

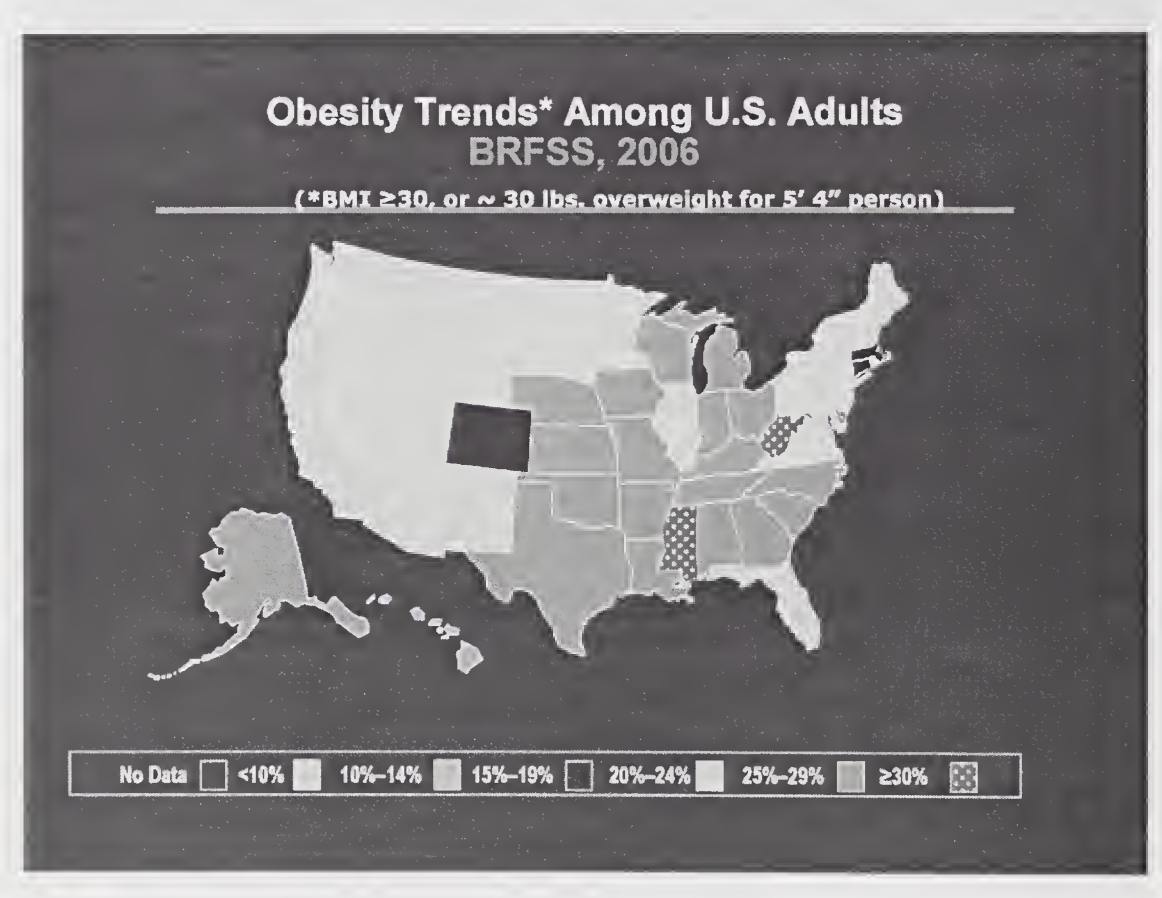

Obesity Trends* Among U.S. Adults
BRFSS, 2001
(*BMI ≥30, or ~ 30 lbs overweight for 5' 4" person)
No Data
<10%
10%–14%
15%–19%
20%–24%
≥25%

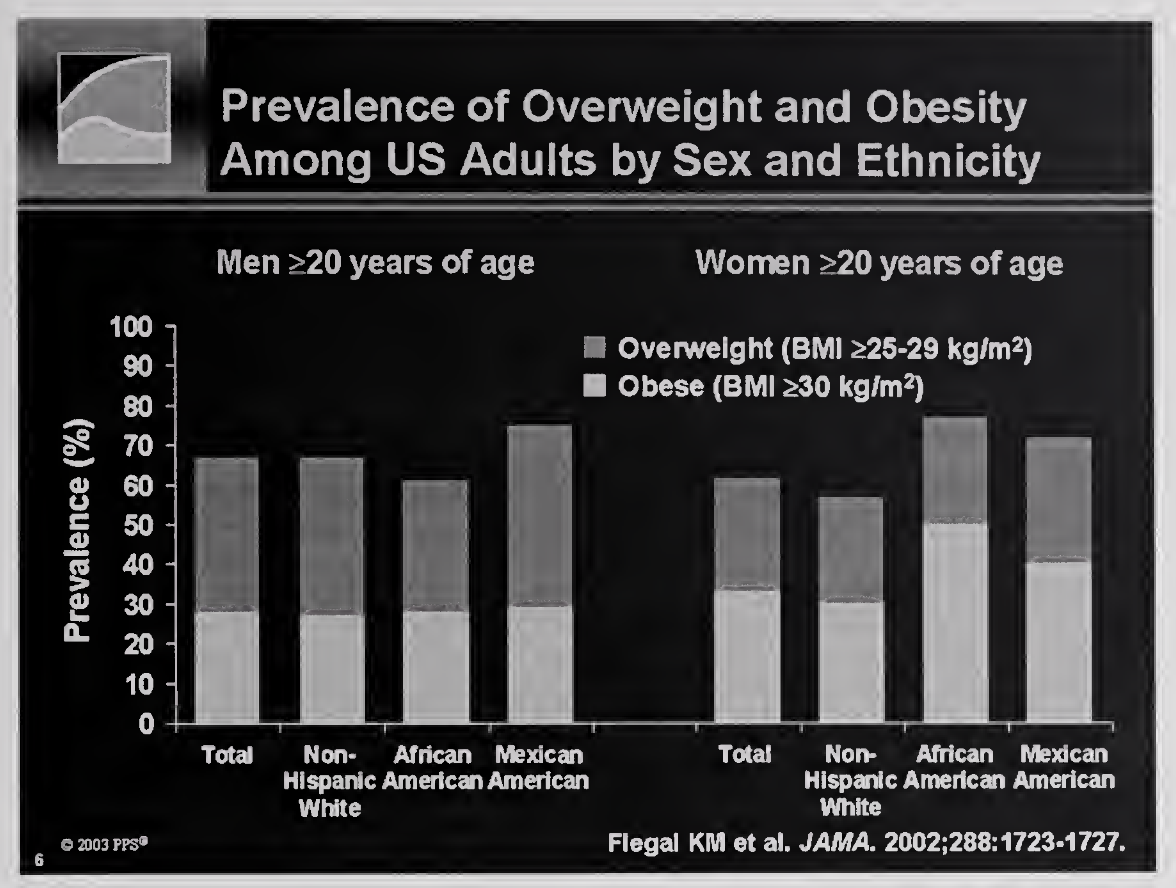
Obesity Trends* Among U.S. Adults
BRFSS, 2002
(*BMI ≥30, or ~ 30 lbs overweight for 5' 4" person)
No Data
<10%
10%–14%
15%–19%
20%–24%
≥25%


Obesity Trends* Among U.S. Adults
BRFSS, 2003
(*BMI ≥30, or ~ 30 lbs overweight for 5' 4" person)
No Data
<10%
10%–14%
15%–19%
20%–24%
≥25%


Obesity Trends* Among U.S. Adults
BRFSS, 2004
(*BMI ≥30, or ~ 30 lbs overweight for 5' 4" person)
No Data
<10%
10%–14%
15%–19%
20%–24%
≥25%


Obesity Trends* Among U.S. Adults
BRFSS, 2005
(*BMI ≥30, or ~ 30 lbs overweight for 5' 4" person)
No Data
<10%
10%–14%
15%–19%
20%–24%
25%–29%
≥30%


Obesity Trends* Among U.S. Adults
BRFSS, 2006
(*BMI ≥30, or ~ 30 lbs. overweight for 5' 4" person)
No Data
<10%
10%–14%
15%–19%
20%–24%
25%–29%
≥30%


Prevalence of Overweight and Obesity
Among US Adults by Sex and Ethnicity
Men ≥20 years of age
Women ≥20 years of age
Prevalence (%)
100
90
80
70
60
50
40
30
20
10
0
Overweight (BMI ≥25-29 kg/m²)
Obese (BMI ≥30 kg/m²)
Total
Non-Hispanic White
African American
Mexican American
Total
Non-Hispanic White
African American
Mexican American
© 2003 PPS®
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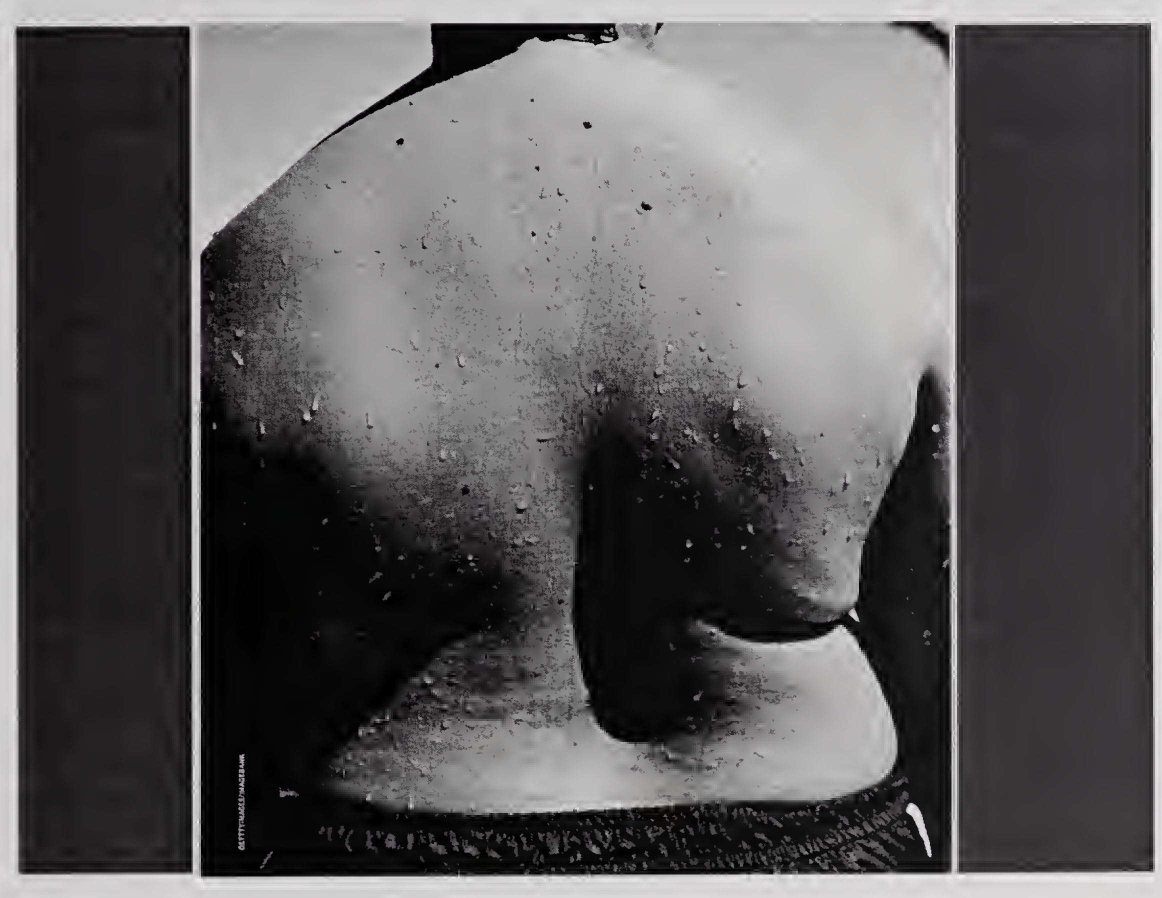
Flegal KM et al. JAMA. 2002;288:1723-1727.

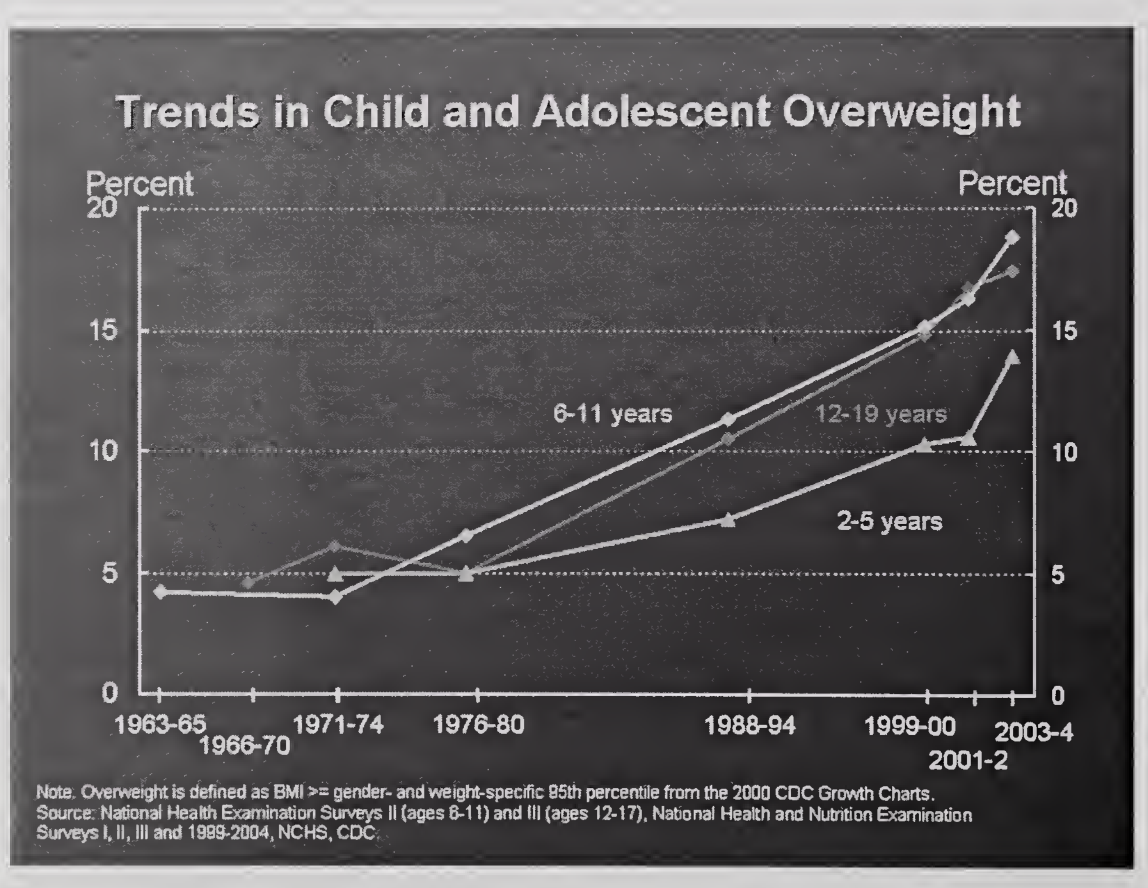


Childhood & Adolescent Obesity: Prevalence

According to NHANES between 1980-2002

overweight/obesity prevalence tripled in children and adolescents 6 to 19 years old and doubled in 2 to 5 years old

The most recent 2001-2004 NHANES, data indicate that this trend is continuing to increase



Prevalence of Obesity in Ethnic Groups

The National Longitudinal Survey Of Youth:

A prospective cohort study of 8,270 children age 4-12 years

Prevalence Rates in 1998:

BMI>85th Percentile: African Americans 38.4%,
Hispanics 37.9%
Caucasians 25.8%

BMI>95th Percentile: African American 21.5%
Hispanics 21.8%
Caucasians 12.3%

2001-2004 NHANES Data indicate that up to 42.9% of minority youth ages 6-11 yrs are at Risk for Overweight, AA females and Hispanic males have highest risk

Health Risk Associated with Obesity in Adults

- Premature Death
- Increased Surgical Risk
- Type 2 Diabetes
- Heart Disease
- Stroke
- Hypertension
- Gallbladder Disease
- Cancer: endometrial, colon,kidney gallbladder, & postmenopausal breast ca

- •Osteoarthritis
- •Sleep Apnea
- •Asthma
- •Breathing Problems
- •Hyperlipidemia
- •Complications of pregnancy
- •Menstrual Irregularities
- •Hirsutism
- •Stress Incontinence
- •Psychological disorders & difficulties

Higher Mortality & Healthcare Cost Associated with Adult Obesity:

- **According to CDC more 110,000 deaths in US every year are caused by Obesity**
- **Health problems attributed to obesity are estimated to cost $75 billion annually**

Health Risks Associated with Childhood & Adolescent Obesity:

- Type 2 diabetes mellitus
- Metabolic Syndrome
- Polycystic Ovarian Syndrome
- Hypertension
- Neurological
- Advanced Maturation
- Cardiovascular Disease
- Dyslipidemia
- Pulmonary
- Gastrointestinal
- Orthopedic
- Psychosocial
- Renal

Higher Healthcare Cost Associated with Childhood & Adolescent Obesity:

CDC estimates between 1979-1999, the rates of obesity-related hospitalizations increased and cost tripled among children 6-17 yrs (T2 DM, OSA, Asthma & GBD)

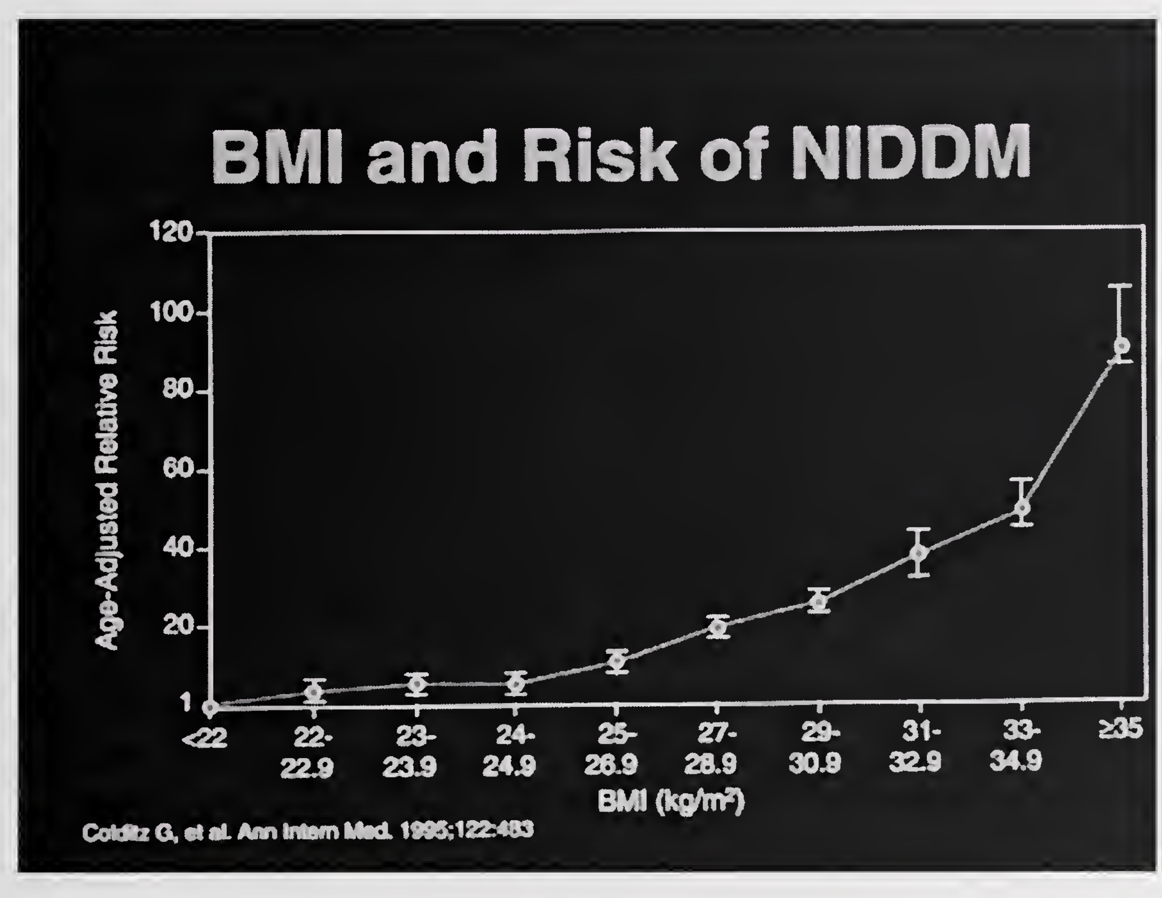
In addition, approximately 60% of the obese children had at least one additional risk factor for cardiovascular disease (HTN, Hyperlipidemia or IR)

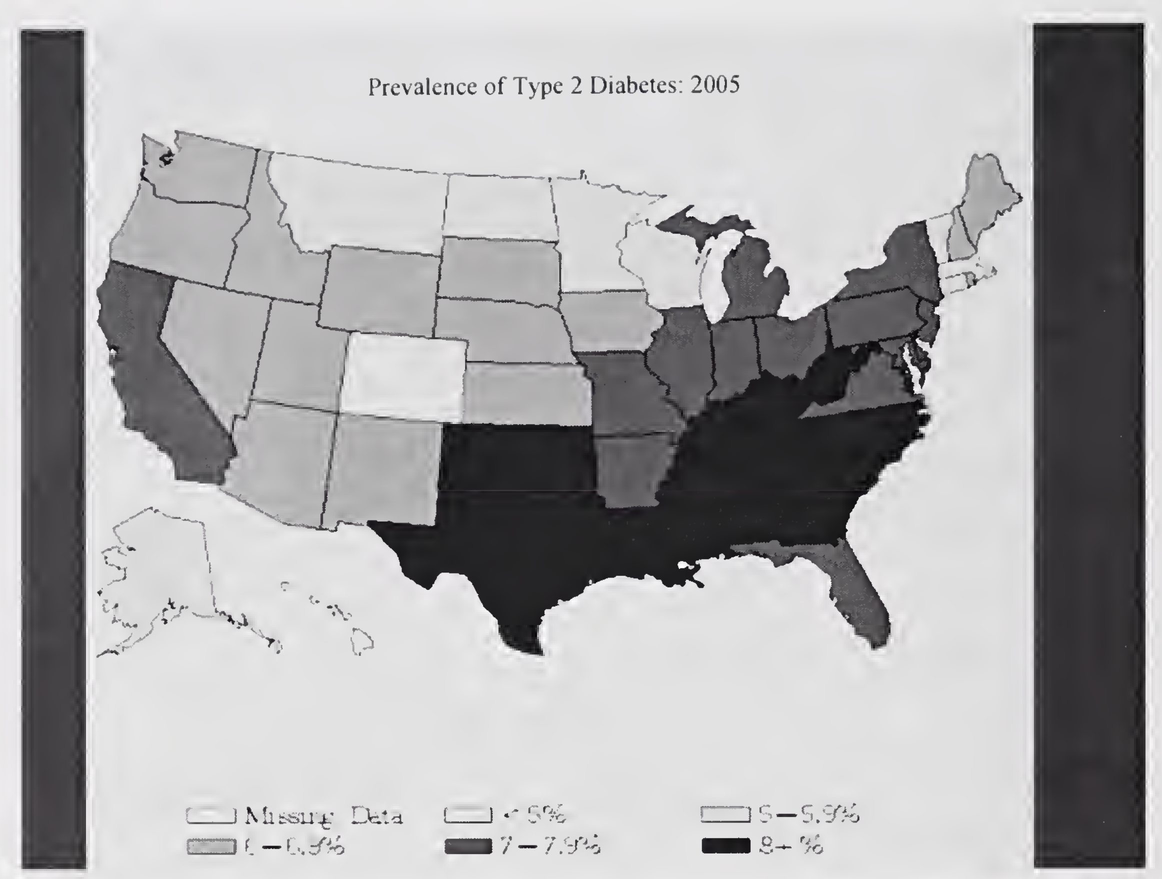
>25% had two or more of these risk factors

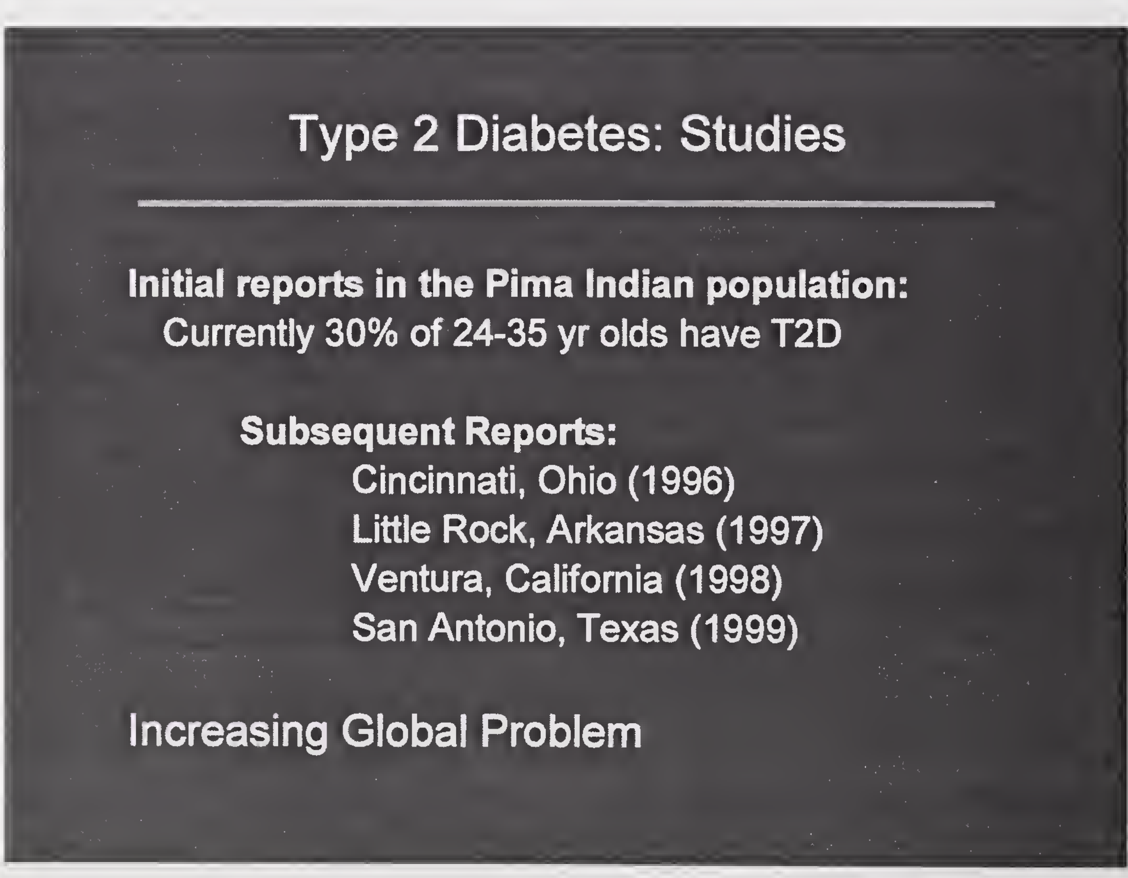
Wang G, et al. 2002, Pediatrics 109: E81

Overweight and obese children have higher overall health care charges and laboratory use; but Primary Care and ER utilization was not increased

Hampl SE, et al. 2007, Arch Pediatric Adolescent Med 161: 11-14




Prevalence of Type 2 Diabetes: 2005
Missing Data
< 5%
5 – 5.9%
6 – 6.9%
7 – 7.9%
8+ %


Type 2 Diabetes: Studies
Initial reports in the Pima Indian population:
Currently 30% of 24-35 yr olds have T2D
Subsequent Reports:
Cincinnati, Ohio (1996)
Little Rock, Arkansas (1997)
Ventura, California (1998)
San Antonio, Texas (1999)
Increasing Global Problem

Type 2 Diabetes in Youth

- Used to be uncommon cause of diabetes in childhood (<10%)
- Incidence increasing over the past 15 years, paralleling the increase incidence in obesity
- In US, reports ranging from 8-45% of the newly diagnosed diabetics, will be the predominant form of diabetes in many ethnic groups
- Has become a global problem

  In Japan, T2 DM accounts for 80% of childhood diabetes

CDC Estimates

Of children born in the year 2000

1/3 – 1/2 will develop Type 2 diabetes in their lifetime

32.8% Males

38.5% Females

50% Hispanics

45% African Americans

10% of those who get Diabetes will get it before the age of 30 & lose 14 years of life

Narayan V et al. 2003, JAMA; 290:1884

Type 2 Diabetes in Youth: Risk Factors

- Obesity and increased BMI
  85% are obese
- Family History of Type 2 Diabetes
  75-100% have 1st or 2nd degree relative
- Membership of ethnic minority
  (AA,HA, NA, Asian)
- Puberty
  Mean age of diagnosis 13.5 yrs
- Female gender
  2:1 Ratio
- Features of Metabolic Syndrome
  IR, Acanthosis Nigricans, Hyperlipidemia, HTN, PCOS
- In Utero Exposure of Diabetes in some ethnic groups

ADA Consensus Recommendation for Screening:

Major criteria: Obesity

With two additional minor criteria

Family History of Type 2 Diabetes

Belong to high risk/ethnic group

(NA, AA, HA, Asian)

Signs of Insulin Resistance

Metabolic Syndrome, Acanthosis nigricans, HTN, dyslipidemia, PCOS

Rates of IGT and Unrecognized T2D

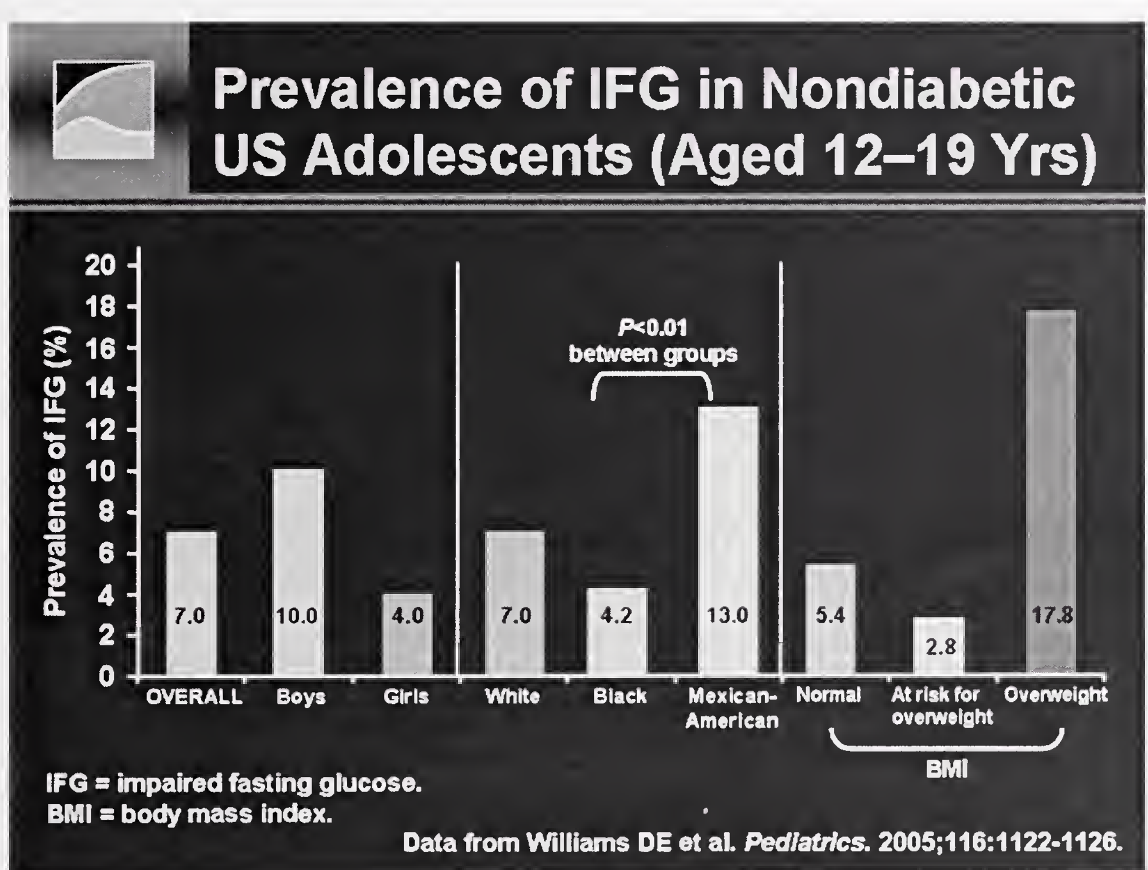
In a study of 71 high risk obese adolescents over a 2 year period 31 had IGT and 10 developed Type 2 diabetes

The conversion rate from NGT to T2D was none

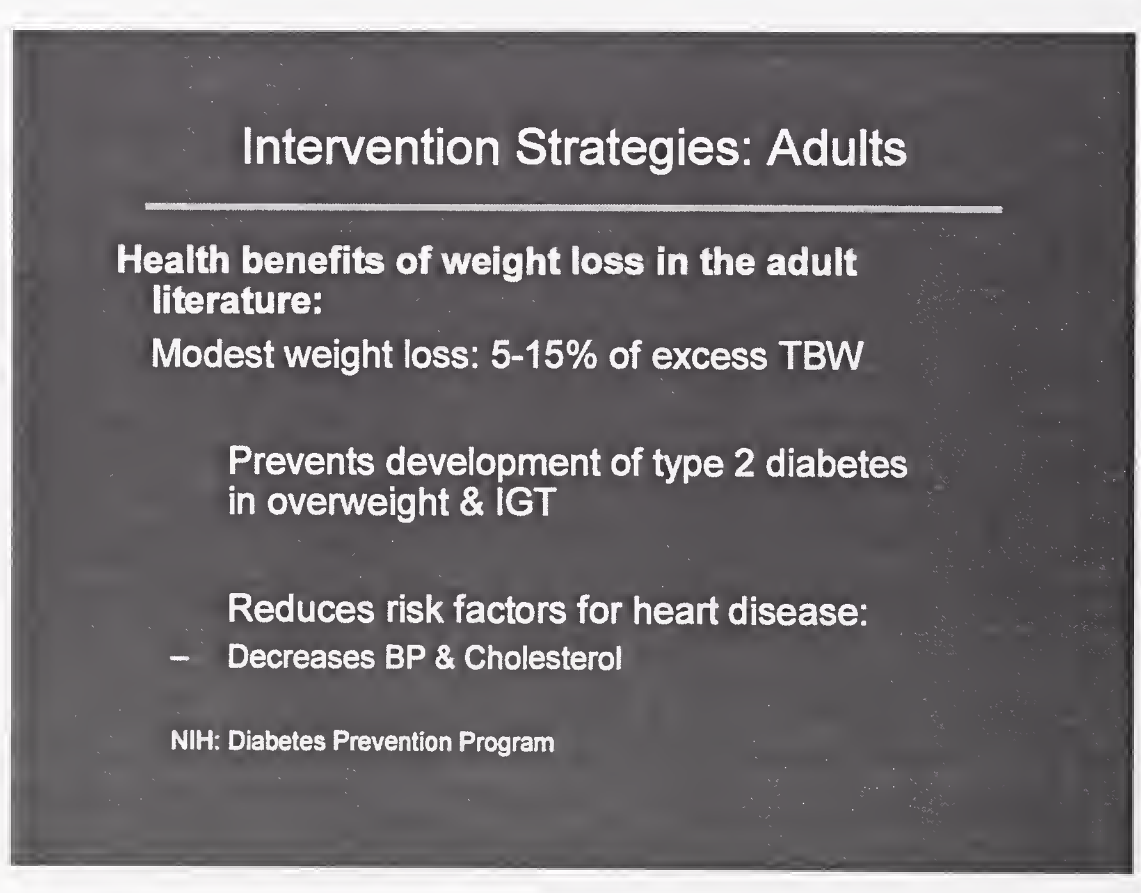
Weiss R et al. Lancet: 2003: 362:951-957

Study found silent diabetes rate is 4% in obese adolescents but up to 24% had IGT

Sinha R et al. NEJM 2002: 342: 802-810



Prevalence of Impaired Fasting Glucose in US Adults Aged 20 Years or Older*
15
10
5
0
Population (%)
Men
Women
All Races
Non-Hispanic White
African American
Mexican American
*Values are age- and sex-standardized.
18 © 2002 PPS®
Harris MI et al. Diabetes Care. 1998;21:518-524.


Intervention Strategies: Adults
Health benefits of weight loss in the adult literature:
Modest weight loss: 5-15% of excess TBW
Prevents development of type 2 diabetes in overweight & IGT
Reduces risk factors for heart disease:
– Decreases BP & Cholesterol
NIH: Diabetes Prevention Program

Effects of Weight Management Program on Body Composition & Metabolic Parameters in Overweight Children: Bright Bodies at YU

Study Group

- 2 x week for 6 months

Exercised 2-50 mins, Nutrition /Behavior 40 mins per week

Weighed weekly

Diet Better food choice

Parents/Caregiver participated

- Every other week for an additional 6 months

Results: No weight gain over 12 months, but growth

Fall in BMI –1.7(-2.3 to –1.1)

3.7 kg in body fat (4%)

Savoye, M, et al. JAMA 2007; 297: 2697-2704

Control Group

- Pediatric Obesity Clinic every 6 months

Received diet & exercise counseling by RD, Physician visit along with psychosocial counseling by social worker

Caregiver present

Results: Body weight , body fat & % body fat increased

Difference BMI –3.3, body weight –7.4 kg, body fat –9.2 kg (6%). Improved TC, IS (HOMA), SBP

Type 2 Diabetes in Youth

Prevention

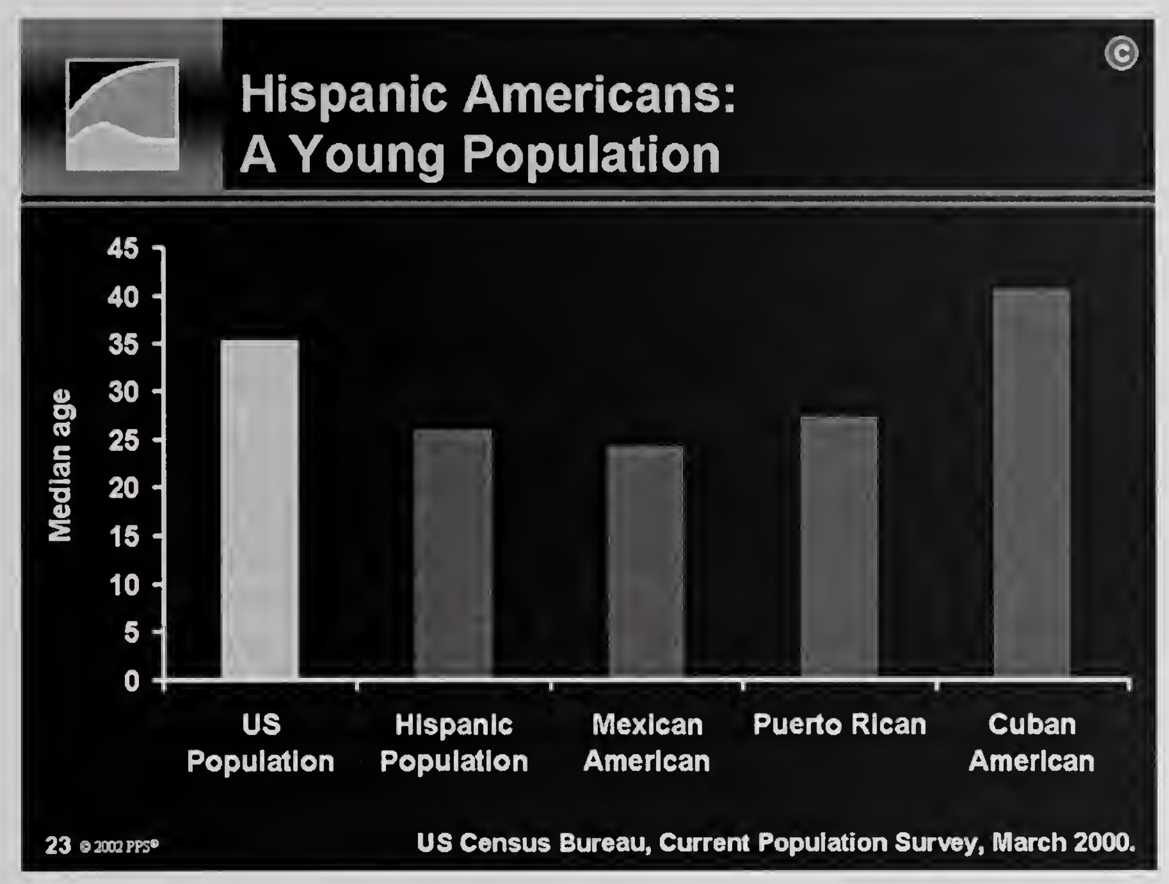
- Prevention of Obesity
- Early intervention is key to prevention
- Adolescence maybe too late or the beginning

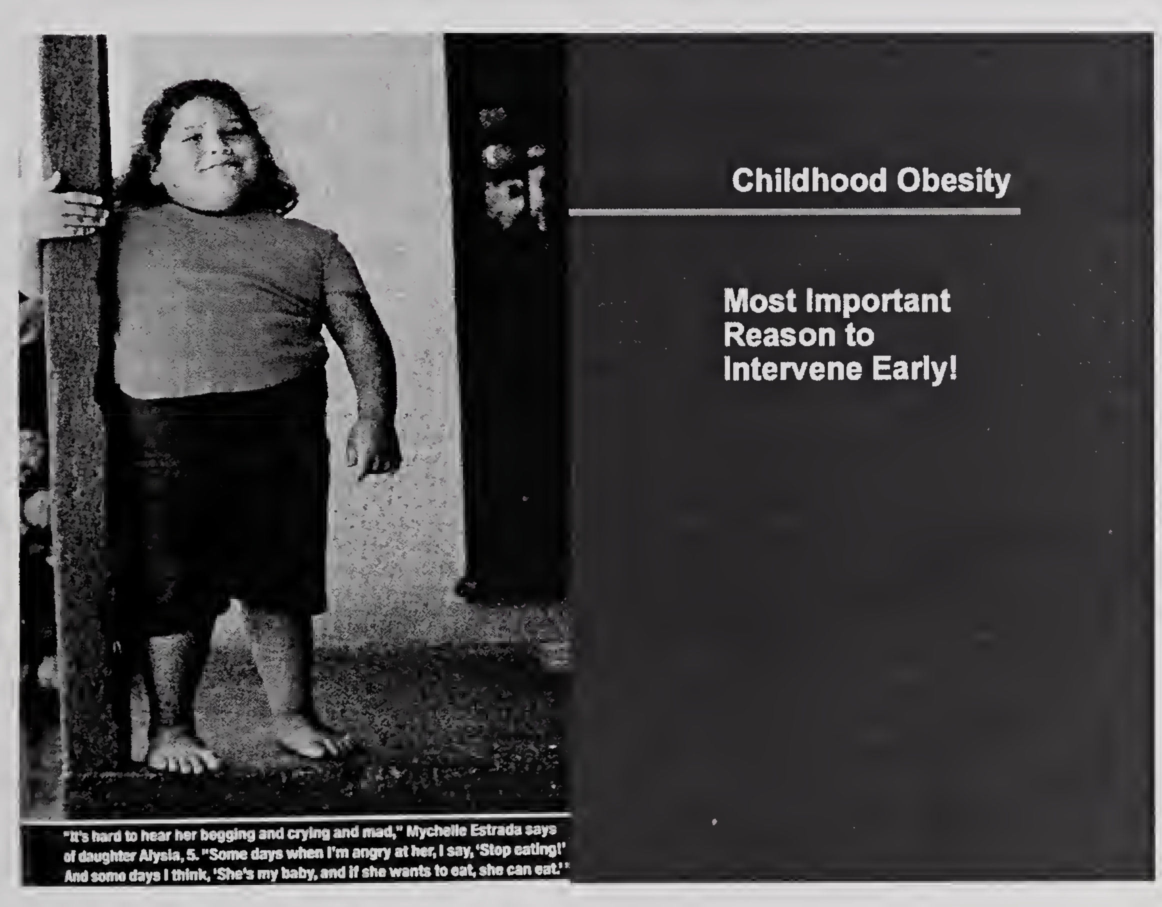
Obesity Prevention Strategies

- **Increase Breast Feeding**
- **Reduce Inactivity**
- **Increase Activity**
- **Promote Healthy Attitude Towards Eating**

Obesity Intervention/Prevention Strategies

- **Medical Setting**
  Raise Policy Makers' Awareness
  Improve treatment and prevention strategies
- **School**
  Increased PE Mandated
  Remove Vending Machines & Improve Nutritional Standards
- **Community**
  Safe Recreational Facilities
  Restructure Communities
  Patient Education/Awareness
- **Media**
  Can help disseminate health messages & display healthy behaviors


©
Hispanic Americans:
A Young Population
Median age
45
40
35
30
25
20
15
10
5
0
US Population
Hispanic Population
Mexican American
Puerto Rican
Cuban American
23 © 2002 PPS®
US Census Bureau, Current Population Survey, March 2000.


"It's hard to hear her begging and crying and mad," Mychelle Estrada says of daughter Alysia, 5. "Some days when I'm angry at her, I say, 'Stop eating!' And some days I think, 'She's my baby, and if she wants to eat, she can eat.'"
Childhood Obesity
Most Important Reason to Intervene Early!

California Summit

Increasing Prevention of Obesity and Diabetes

Barriers, Assets and Opportunities
Laura Brainin-Rodriguez MPH, MS, RD
Nutrition Services
San Francisco Department of Public Health

The Challenges

- Most deaths due to heart disease, cancer, stroke and diabetes
- Diabetes affects nearly 25% of all Mexican Americans ages 45-74
- Type 2 Diabetes rates are 1.5 times higher of those for non-Latino whites.
- High rates of overweight and obesity

The Barriers

- Low rates of health insurance
  - In adults, almost twice the rates of other ethnic groups
- High rates of poverty
- Immigration status and access to services
- Barriers to health care
  - Language barriers
  - Healthcare access and work schedule conflicts
  - Lack of access to primary prevention services
- High rates of food insecurity
  - In adults, almost twice the rates of other ethnic groups
- Low rates of screening rates for breast, colorectal and prostate cancers
- Lack of access to quality, affordable and nutritious foods.
  - Low amounts of fruits and vegetables eaten

The Assets

- Much cultural value placed on health
- Buffering effect of family and community ties
- Great work ethic and value placed on education
- Good food seen as a priority

What can be Done: Laws, Regulations and Policy?

- Educate Policymakers
- Build community capacity
  - Train advocates to apply the power of media
- Change Schools and children's environment
- Increase access to participation in Food Assistance Programs
- Policymakers can include nutrition education in primary care family health coverage

What can be Done: Workplace and Industry

- Prioritize access to healthy foods in lunchrooms and vending machines
- Increase access to physical activity
  - Organize exercise breaks
  - Make stairwells accessible
- Grocery stores can highlight healthy food products
- Offer and/or subsidize smoking cessation, exercise and stress reduction workshops

What can be Done: Community Institutions

- Work aggressively to impact school board policy
- Provide access to healthy foods
  - Sponsor Farmers Markets
- Use promotoras and community health workers to educate and support community mobilization

What can be Done: Healthcare Settings

- Increase pool of providers with language and cultural skills
- Increase screening of high risk groups
- Provide and/or link to community-based prevention and wellness activities
- Use registries to track gestational diabetes offspring

Some Programs That Work

- Statewide (California)
  - *Network for a Healthy California* – Cancer Prevention and Nutrition Section, California Department of Public Health
    - http://www.dhs.ca.gov/ps/cdic/cpns/
    - http://www.cachampionsforchange.org/en/index.php
- Local (San Francisco, California)
  - Mission Latino Family Partnership – Cook Well-Live Better curriculum
    - http://www.sfdph.org/dph/comupg/oprograms/MCH/FeelingGood.asp

The Road Ahead

- Collaboration
- Doing what we can, where we can
- Involving the Community in the analysis of the problems and the drafting of solutions

Parting Words

- ¡Si se Puede! (Cesar Chavez)
- Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has. (Margaret Mead)

Texas Summit

Increasing Prevention of Obesity and Diabetes

Eduardo Sanchez, MD
Director
Institute for Health Policy
University of Texas School of Public Health at Houston, TX

The last time that I was actually in this room, I shared one thing with Ed Colina. I won't share that. I was a little bit late. I will share it. I was a little bit late. We've got some time. I was a little bit late, and Senator Zafarini who is a stickler for people being on time was the one who was presiding. Jim Hine [phonetic] who is the commissioner of the Department of Aging and Disability Services and I had sort of an ongoing friendly feud, and he talked to Zafarini and he arranged to put a stool over in that corner and he put a dunce cap over in that corner. When I walked in, Zafarini said you are late, and you need to go to the corner. Now, Olga was pointing out that I was late, but I wasn't late. I'm actually here on time, and I actually had time to eat a little bit. But the other thing that happened in here is a little bit related to what Captain Delgado was talking about. The last time I was in here where I had some heartburn, it was the same day. It was the day that Senator Duels Rider [phonetic] that was going to take $10 million out of Title 10 and take it out of the community-based service system and put it into federally qualified health centers was announced, and I had to figure out a delicate way to say this may not be the best idea that we have come up with.

I felt that it wasn't a good idea because I was worried about a couple of things—disruption of services to women in community settings in a number of different Title 10 clinics that were suddenly going to have to find a new place to seek their care. I'm a little puzzled that a family physician had a recommendation that was going to disrupt continuity of care. It's not that it doesn't happen. It's not that it couldn't be even entertained. It's that there was going to be a fairly abrupt change from one thing to another, and I remember standing up. I didn't quite put it that way, and my remark was around my concern that the federally qualified health centers wouldn't be immediately ready to shift the way they do their operations and take on $10 million worth of business. Those of you who are in the FQHC world and followed that, you know that what happened at the end of the budget cycle was indeed money was left on the table. There wasn't the ability to absorb all of that money. So, I have sort of mixed feelings about being here, but thank you for the invitation. I appreciate the opportunity, and now we will get going with this presentation.

I'm going to talk a little bit about increasing prevention of obesity and diabetes. It's fitting that we're here today, two days after a monumental primary election here in the State of Texas. Issues were discussed. Latinos were being courted by at least two of the three candidates. I did a presentation earlier. One thing that I get to do now that I'm no longer a state government official is that I can say some things that I didn't used to say when I was a state government official. You can figure out where maybe I stand. I did have the opportunity just a little while ago. I was down in San Antonio. The Texas Public Health Association is meeting right now, and I was asked to give a talk on where the presidential candidates stand on health. They are not necessarily paying attention to the issues that we think they should be paying attention to.

So, the purpose of this summit and part of what I'm going to try to do is discuss the barriers that exist with current programs that impact the health of Latinos and discuss strategies needed for future health care programs and then talk about building consensus on federal programs and policies that can be developed or enhanced to improve the quality of care delivery to Latinos in the United States over the next five years. One of the things I've quit doing now that I'm no longer the health officer, I don't say Hispanics. I say Latinos. So, what's missing? What are some of the things that are missing, whether you want to call these barriers or just things that we need?

One is leadership. We lack leadership. We lack leadership in Washington around health in general, and we certainly lack leadership around Latino health issues. That is not meant at all to say that Elena Rios and others aren't doing what they can to put the issues front and center, but even when they try sometimes they're put off to the side to put those issues front and center. There is certainly no political will in our country to put the real health issues on the table and get them addressed, and what I'm talking about is the debate continues to be around who is insured and who is not insured. The debate needs to be around the health of the nation, and health insurance is but one way to get us there. It is not the only way, and if that's all we do is insure all Americans, we will have failed because that in and of itself is not going to help us be healthier.

We have to have bipartisanship. I had the opportunity to speak late last year to the National Association of Latino and Elected Officials, and one of the concerns that I would have, one of the concerns that I have is the inability to find common ground. If we can't find common ground, we can't necessarily talk about what's important. When one party's top issues are national security, the economy, and issues related to immigration and another party's top issues are health care, the war, not national security but the war, and then the economy, the common ground there is not as great as it could be. We've got to figure out how we find the common ground and even talk language that gets us to talking about common ground. We have to have honest debate, and whether we're talking about obesity, which I'm going to, and diabetes, or other issues, we have to be honest about what it is that's going on and we have to be honest about what the solutions are. I'm not sure that the solution for preventing and addressing obesity and diabetes in our nation is to focus singularly on the genomic sequence that defines diabetes. I'm sorry. The genomic sequence is going to tell us that, well, those people with that sequence ought to be eating healthy, being physically active and being in healthy environments. Well, you know what we don't need the genomic sequence to figure that out. We need compassion. We don't want to be blaming people for the situation they're in. We want to figure out solutions that will help them get out of those situations. Again, as I mentioned earlier, we need to find some common ground.

What else is missing? We need to be talking about the goal. The goal should not only be ensuring all Americans. The goal should be a healthy America, all Americans, every one of us, with the opportunity to be healthy. What that takes is a healthy environment and healthy behaviors. I don't focus on healthy behaviors first because if you live in a neighborhood where you can't get access to fresh fruits or vegetables or you live in a neighborhood where you can't really get out and be physically active or you live in a household where both parents have to work at least one job, if not two jobs, if not three jobs between the two, four jobs between the two, it is very difficult to live a healthy lifestyle when that's what defines your life. I would suggest to you that obesity and diabetes are symptoms of a larger problem, and I don't mean that euphemistically in any way.

I want to show you this slide, and for those of you who maybe don't believe in evolution, I apologize. This is meant to be a figurative depiction of where we have gone as human beings. In two and a half million years we went from being somewhat hunched over and hairy to being upright, and I use the example of Beaver Cleaver when I'm talking to some groups. I've got to think of who would be the Latino 1950s character who would fit that profile. Obesity is rare you could see at the bottom. Well, in 1950 in this country three things were introduced into our diet, french fries, hamburgers and Pepsis—actually that's a Coke isn't it? We live in a Pepsi state. We don't live in Georgia. What has happened is that all of those have increased in size. So, we've got super-sized sodas, super-sized burgers, and we have super-sized fries. Mr. Cleaver has increased his caloric intake by more than 500 calories a day, and he is no longer so stealth. He has become kind of Chubby Cleaver, and Chubby Cleaver represents America. Two hundred million individuals are overweight in our nation, but it's not only about eating. It's also about sitting on the recliner and watching the TV and not being physically active. It's a combination of too many calories in and really not much physical activity. Survey, after survey, after survey says we Americans are not moving our bodies as much as we should be, and in fact that worsens as we age. Oh, by the way, Latinos are less likely to be moving their bodies than the general population and certainly the white population.

It gets worse because those 200 million overweight are the denominator where the numerator is 50 million individuals with metabolic syndrome. There are plenty of physicians in this room, but when we talk about metabolic syndrome, the simple definition is having three of the following four things—if you're a man, abdominal girth that is over 40 inches, high blood pressure, a lipid abnormality (That's a fancy way of saying either cholesterol is not where it should be, triglycerides is not where it should be.), and then the fourth thing is a glucose abnormality, either full-blown diabetes or pre-diabetes. If you have one of those three things, you have the metabolic syndrome. Fifty million Americans have the metabolic syndrome. That's one out of six, and I suspect that if we were to look in Texas we're closer to one in five. That's a tsunami. That's a tsunami that will explode our ability to take care of our medical care needs, and this is a situation that is disproportionately born by Latinos.

Let's talk about Latinos. Latinos as a percentage of the population is increasing. In the State of Texas, it's increasing fairly dramatically and long before the year 2050 Latinos will be the majority population in the State. At a national level, the change is happening a little more gradually, but the nation will be almost one-third Latino by the year 2050.

When we look at obesity among children, what I want you to see over here is that Mexican Americans, and I would say that group represents Latino children, Mexican American children are more likely to be overweight and obese than white children. I know that in our State as we looked as school districts that were predominantly Latino, it's even more dramatic than those differences show on this bar graph. When you have a population that's emerging as the majority with the combination of being more likely to have childhood obesity is prevalent, which translates into adult obesity we've got a problem that we've got to deal with.

We know that Mexican American children and adolescents have greater obesity prevalence than whites, but let's be clear. One of the other things about Latino children is that those at highest risk for obesity often experience other social, economic and health disparities at the same time, and they live in environments that do not support healthy behaviors. I want to reiterate that. We can't expect healthy behaviors when you're in an environment where it's exceedingly difficult to exercise that decision to do the healthy thing.

Here is another thing that I believe we need to be mindful of and we need to pay attention to as we think about our health challenge for Latinos work that you're going to do today. Latinos are less likely to graduate from high school than any other major sub-population in the United States. That does not bode well, and so I would say to you that even as we think about a health agenda, that health agenda also has to include graduating our young people out of high school. What we know is that when you graduate out of high school you're more likely to have insurance. When you graduate out of high school, you have higher health literacy and are more likely to make good decisions about the things that are brought to you. You're less likely to be a smoker. You're more likely to be physically active. Our health agenda has to include an educational agenda, and we can't lose sight of that. If we only focus on the medical, we're not taking on the issue of how we improve the health of Latinos. Lower education equals unhealthy behaviors. Lower education equals a higher death rate. Look at this number. Less than 12 years of education, the death rate is almost three times higher for adults 18 to 65 than for individuals who have at least one year of college. Does that mean that if we suddenly got everyone to graduate from high school and take one year of college that changes? It would change some. It's not going to completely get everyone to here because there are some other factors I suspect. But it will increase the quality of life of those individuals and I believe will have a dramatic effect in improving the health of Latinos.

So, some obesity interventions, and this is meant to just have you think a little bit. An extreme example is the gastric bypass surgery. I'm not going to bash gastric bypass surgery. It works. There's evidence that it's cost-effective, but you had to have become a morbidly obese adult with a number of co-morbidities in order for that to be cost-effective. You do not go from a BMI of 20 to a BMI of 40 without having gone through 21, 22, 23, 24, 25, 26 and so on, and we need to figure out how we keep people from getting to that place where that becomes the cost-effective intervention. Cost-effective doesn't mean that it doesn't cost a lot of money, and this is probably a very conservative figure, $25,000 times a million Texans that are morbidly obese--$25 billion.

Let's contrast that with maybe a different way that we might think about addressing childhood obesity, and every time I say obesity think obesity and diabetes. They go arm in arm. If we're going to do something about diabetes, let's prevent obesity, and we will have done a lot. Comprehensive school health education programs—if all five million Texas public elementary school students—I actually think five million is total and it's two million elementary and I didn't make the change—sorry. Five million total—the cost of comprehensive school health education is about $10 per child per year. The cost--$50 million. Again, $50 million sounds like a lot, but let's contrast that with $25 billion. We're talking about 0.2% of the cost of doing gastric bypass surgery on every single person, and we would be able to reduce the trajectory that we're on in terms of adult obesity.

There is some data that suggests that comprehensive school health education is at least holding the line if not reducing childhood obesity. El Paso is the school district where that data is the most compelling.

So, some strategies—what are things that need to be happening? There's good evidence that media does work. There's good evidence that not only providing information but encouraging action, and I mean that literally—encouraging people to move their bodies not just the political action, environment change, access to healthy, affordable foods. If we're going to believe and insist that folks ought to eat healthier, they've got to be able to access those foods. We've all been in places that we drove through because we generally don't stop there where you look

around and you say where is the closest supermarket. I'm not talking about Whole Foods. I'm talking about a supermarket where you can get a decent selection of affordable fruits, vegetables and other healthy foods. Access to physical activity—instead of no child left behind maybe we need to have no child left inside and be able to get our children outside and ourselves and move our bodies with our children and go back to that which we did.

Universal comprehensive school health education—I talked about that. Worker wellness programs—we need to have worker wellness programs that not only serve the large corporations. We need to figure out ways that small companies can find a cost-effective way of doing worker wellness. Worker wellness doesn't have to be at the work site. Worker wellness can be for the worker wherever they do it. Community wellness—many, many, many Latinos don't have the jobs or even work in the companies where even the small wellness is a solution. What do we do about our communities to make sure that again there are the grocery stores, there are the places where one can be physically active—that there are the services in place that one can access to take care of one's business. There is good evidence, for example, that diabetes management, self diabetes management works best in community settings where people can establish social networks. How do we make that happen for Latinos?

Some strategies at the federal level—the USDA should adopt policies that promote health so instead of subsidizing soy and corn, maybe we ought to be subsidizing some healthier fruits and vegetables to make them affordable to Latinos and other low-income people.

Schools breakfast and lunch—there is good evidence, first of all, that when you provide universal breakfast and lunch more kids attend school both physically and mentally. They're paying attention, and those school breakfast and lunch programs ought to have fresh fruits and vegetables. WIC and food stamp redesign including incentives for healthy foods and farmer's market programs. You might have seen the *New York Times* editorial I believe it was on Saturday it could have been on Friday, about WIC that says, do you know what the WIC allotment is for a family for food for a month? It's $38. I don't know about you, but $38 is about what gets me personally through a week if I go to a supermarket and buy some food. We're talking about encouraging folks to buy fresh fruits and vegetables, and in that same editorial it says you know they kept yogurt off the list because yogurt was going to make it too expensive. That's ridiculous. Maybe we need to think about increasing that allotment.

Federal program redesign—the CDC, and I'm going to show you in a minute CDC—let's give CDC the resources, let's give the regional HHS offices the resources to get the job done. No disrespect, Captain Delgado, but the programs that he's trying to run, they're under-resourced, they're under-staffed, and they just do the best they can with what they have. That doesn't work. We certainly don't allow that in the medical care system, but on the population health side we're willing to do that. That disproportionately affects Latinos. You're getting a little too excited; you need to calm down [laughter].

So, I looked at the CDC programs. This is from fiscal year 2004, and I'm about to be finished. What I looked at were the number of states that are receiving funding for the following programs that the CDC has designed. There are a number of others that serve as examples, but for the purposes of the discussion today, heart disease and stroke because when you have diabetes, you have heart disease and stroke. Believe me, they go together. Diabetes, nutrition and physical activity—the BRFSS, fully funded. It's the only one. Youth risk surveys, 37, school health programs. The first number of the two is do they get any funding whatsoever? How many states

of them? And then the second number is how many states get enough funding to actually do a full-blown program, and what you see is whether it's heart disease, diabetes, every state gets funding but only 26 get enough. We need to have every one of those be 51. If diabetes is an epidemic, if obesity is an epidemic, how can it be that we under fund prevention programs and yet on the Medicare and Medicaid side we pay for whatever comes into the doctor's office regarding the complications thereof. Anyone who wants to clap, you go ahead and do it.

So, some ideas—and there are plenty of others. One is, and I think that this idea has been floated in Texas, but the idea is a CMS demonstration project that would fund comprehensive school health education in Title I schools. What does that do? Well, Title I schools are the ones that have the free breakfast and lunch programs. Those are going to be schools that have a lot of children that are Medicaid eligible. Wouldn't it make sense to do at least a demonstration project, a little research, to see if when you do those kinds of programs what affect that has on the utilization of Medicaid services? Wouldn't that be interesting, and then the Department of Education as I said earlier, and I don't mean to sound emotional—my voice cracked. As I said earlier, we can't do health without talking about education. Let's really not leave any Latino children behind because they're being left behind now, and we have got to do something about that in this state particularly. We're going to be the majority, and we're going to have a majority state where there's a lot of young people and a lot of working people who don't have an education. We are not going to be able to compete for the jobs and compete nationally or within the 50 states for the things we need to be an economically viable state.

We need to address immigration, and I think I'm close to the end. We cannot let this issue just go away. There are 12 million immigrants in this country, 12 million undocumented residents in this country. Some of their children are born here, and there are some who want to treat them as non-citizens. I say wrong, wrong, and some are here because their parents brought them here. We want to treat them as if they had a willful say in where they are, and that is just plain wrong. We need to hold children harmless. We're not going to do anybody any good by victimizing children. We need to have some thoughtful, caring, compassionate discussion about the answer to the immigration issue in our nation, which I don't even believe is a real issue. That's another matter, and we need to challenge the hysteria, the demonizing and the hate mongering, and every opportunity you have you need to challenges it because we hear it every single day among people who say insensitive things without thinking about what they're saying.

So, how do we change health policy? We demonstrated that two days ago in some regard. We need to vote, and we need to be involved in this process, and we need to be at the table, and we need to make sure that this white paper and the product of the work that you all are going to do actually finds its way not onto a shelf but into the discussion that is going to be had about what health policy for Latinos needs to look like in the United States.

How do we change policy? Not only by building grass root capacity, but I'd like to talk about changing the hearts and minds of the grass tops. Grass roots organizations are fine, but in the State of Texas they're not the ones that change policy in the state house. It's the "muckity mucks", and we've got to figure out how to change the minds of the "muckity mucks". How do we change it? We need to re-frame the frame.

It's about health. We need to recapture the word "compassion." Whoever invented compassionate conservatism, we need to take that word away from them because there's not really been anything terribly compassionate about what that has been called. We need to re-take

the moral high ground. We need to talk about health impact, what works and what doesn't. We do need to hold ourselves accountable to the science. We need to talk about cost impact, and remember that health over cost equals value. I'm learning that the "V" word is a word that's become very popular these days. So, value—remember that, and we need to take this message out to the field. I finish with a quote by Cesar Chavez, "You're never strong enough that you don't need help! and Don't let anybody convince you that it's all about personal responsibility. It's about societal responsibility to bring us all up as high as we can be." Thank you.

Recommendations for Prevention of Obesity and Diabetes For Hispanics

POLICY RECOMMENDATION #1:

Establish Education and Awareness Programs targeted to Hispanics about Diabetes and Obesity

In the Schools -

Standardize K-12 curriculum on health to include prevention

K-12 curriculum in general currently focuses on health within a science class. In order to decrease diabetes and obesity in the next generation, it is critical that the U.S. Department of Education reform K-12 curriculum to a comprehensive health and wellness curriculum. This curriculum should instruct our children on what is diabetes and obesity, the complications related to these diseases, and how to lead healthy lifestyles in terms of nutrition, physical activity and understanding their linkage to reduction of diabetes and obesity. Federal policies should require partnership with Hispanic physicians and health professionals to share knowledge with the school curriculum committees and students.

The Federal school lunch program should provide healthy foods and beverages

The Federal school lunch programs in K-12 schools are an important source of nutrition for poor Hispanic children. The U.S. Department of Health and Human Services and the U.S. Department of Agriculture should develop incentives for these programs to offer nutritious foods such as fruits and vegetables and beans and nuts, and decrease high sugar content foods and beverages.

The Federal policies should encourage school districts to purchase healthier foods and to develop nutrition education programs and materials for cafeteria workers, faculty and students.

In the Community -

Support community prevention coalitions in Latino communities

The Office of Minority Health, the Centers for Disease Control and Prevention and the National Institutes of Health should increase support and require programs that support community coalitions to include awareness of diabetes and obesity prevention among Latino populations, who are at higher risk for these diseases compared to the majority population.

These coalitions should include advisory committees and partnership among Latino community based agencies, civic organizations, businesses, and key Latino leaders that address prevention of obesity and diabetes and develop new programs that can be echoed throughout the communities.

Support the increase of green market penetration

In most low income inner city Latino neighborhoods, the community does not have access to fresh fruit and vegetables in the local independent markets. Federal policies should provide incentives to cities to have fresh fruits and vegetables sold in public venues.

Develop a new Federal nutrition program

Federal policies should require increased nutrition education that provides instruction on cooking skills, the national food pyramid, and the food label for Hispanics that decrease risk for diabetes and obesity.

Provide incentives for clinics to provide community education on diabetes and obesity

The Health Resources and Services Administration funds community health centers and rural health centers and currently, they are organized in learning collaboratives that focus on improving quality of care of patients with certain diseases, including diabetes. These programs should include a new reimbursement strategy to target community group education through face to face programs as well as multimedia technology channels in collaboration with Hispanic health providers.

Federal Leadership

The President should create an office on health policy and prevention in the White House that promotes the establishment the offices on health policy and prevention at relevant federal department. The Federal policies need to be increased focus on health prevention within each office.

The US Department of Health and Human Services Secretary should work with all the departments to lead prevention efforts. The Surgeon General should be supported to lead a public dialogue on healthy living and health promotion with the regional offices, states and local government public health leaders.

Federal Prevention and Health Disparities

The Office of Minority Health needs to have an advisory role to the Federal health offices through the Secretary of US DHHS on how to reduce health disparities.

The Director of the Office of Minority Health should be supported to 1) develop leadership among Hispanic health professional associations; 2) convene public health and private health industry leaders to increase Hispanic leadership as well as a focus on supporting Hispanic community with health promotion and wellness activities; and 3) develop Hispanic public health leadership resources – role models, career pathways, resources.

POLICY RECOMMENDATION #2:

Enhance Marketing Programs targeted to the Health Professionals who serve Hispanics as well as the Hispanic Consumer

Establish a new Federal multi-agency social marketing effort, led by the White House, with private sector partnerships to promote healthy lifestyles at the community level.

Federal policies should address the development of Health Information Technology programs for social networking purposes to increase dissemination of health information to Hispanics across generations. This multi-agency initiative should be part of a national vision to change health information from disease focus to prevention focus and from the HHS health care arena to the agencies such as Labor, Housing, Commerce, Energy, Agriculture, VA, DOD, Transportation that combined can address the social determinant of health and decrease health disparities.

Establish a National Hispanic Diabetes and Obesity Education Campaign

The U.S. Department of Health and Human Services should develop a *National Hispanic Diabetes and Obesity Education Campaign* across all the HHS agencies, led by the Office of Minority Health, in collaboration with the Centers for Disease Control and Prevention and the National Institutes of Health. This program should build upon the current programs that provide education for diabetes and obesity and expand the support for Hispanic health professionals to lead media efforts in the major Hispanic markets and in English and Spanish media across the nation.

POLICY RECOMMENDATION #3:

Federal Government should Promote Healthy Food in the United States

Reform farm subsidies, the Women, Infant and Children (WIC) and the Food Stamp programs to offer healthier foods

The Department of Agriculture should change the farm subsidy, the WID, and the food stamp programs to provide nutrition information to the participants in addition to increasing incentives for the programs to promote healthy foods – fruits, vegetables, dairy, and nuts.

Ban the food industry from marketing unhealthy foods to children

The Food and Drug Administration and the Federal Communications Commission should develop policies to ban food industry from marketing unhealthy foods to children through multimedia channels. There should be a report to Congress on the impact on marketing across multimedia in the U.S.

Strengthen nutrition literacy through food labels, restaurant menus

Federal policies should standardized evidence-based health education in schools and strengthen health literacy for nutrition by improved food labels and restaurant menus that address at a minimum fat, sodium, carbohydrate content and calories.

Redefine traditional Hispanic recipes as healthy

Federal programs should provide support to redefine traditional Hispanic recipes with healthy preparation and ingredients and disseminate the recipes to Federal websites, conferences and grantees. Hispanic families, especially, have a strong link to their traditional recipes and will need education to change their diets in ways that modify the ingredients in a more healthy way.

Federal policies should improve healthy food in schools

Federal policies should improve health food in schools by banning vending of junk foods/sodas, Requiring report cards with health information, providing incentives to good schools based on the report cards, and develop state standards

POLICY RECOMMENDATION #4:

Federal policies should increase Physical Activity

Build a healthier environment for poor Hispanic communities

The US Department of Housing and Urban Development should build safer public areas such as parks, sidewalks, and walking and bike trails in low income communities where Hispanics tend to reside.

Establish physical fitness programs in Hispanic communities

The Presidents Council of Physical Fitness should work with the U.S. Department of Health and Human Services to increase exercise programs in schools and after schools. Exercise programs should be supported for community agencies and worksites with incentives to the employers to offer Federal supported programs.

POLICY RECOMMENDATION #5:

Reform the Health System to increase Focus on Prevention Services

Increase Reimbursement for Prevention Services

The Centers for Medicare and Medicaid Services should change reimbursements to increase for primary care and prevention services and should support incentives to increase provider participation in prevention related to quality care and health information technology projects. The National Institutes of Health and the Centers for Disease Prevention and Control should expand incentives, including loan repayment programs for prevention and health disparities research and public health careers.

Redesign waiting rooms furniture, machinery for obese patients
CMS should provide infrastructure funding for clinics and health providers to fit their furniture and machinery for the growing obese patients.

Develop Demonstration Program that addresses low cost interventions
CMS should develop a demonstration program in regions of the country with high Hispanic populations that develop low cost interventions for prevention services with chronic diseases and their complications.

Provide Healthy Food in Hospitals
US DHHS should promote a public-private partnership to increase health food and education about nutrition in hospital cafeterias as a model to the patients and staff.

Develop CME requirements for physicians for prevention services

Support increased community-based research for prevention interventions targeted to Hispanics

Support health care with Multidisciplinary teams, including nutritionists and educators

Increasing Hispanics in the Health Professions Workforce

New York Summit

Increasing Hispanics in the Health Professions

Nilda I. Soto, MS, Ed
Assistant Dean
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Albert Einstein College of Medicine

My goal today is to communicate how can I make the speech as effective as possible after going through this whole day of activity.

I had an "ah-ha" moment and it came to me, I know how I could tackle this. I am going to share with you in a little bit how I plan to do this. I went ahead and, as you see, I am here. I want to apologize in a way upfront that the information I am going to share with you is only allopathic medicine. In the time that I had I just did not have time to research and get the data on the other health professionals. I know a nice, good colleague that I have is Mimi, and Mimi has been President of the Hispanic Nurse's Association. I saw her in terms of the participants, the people from dentistry. Before coming to Einstein, and I am going to be in Einstein almost 18 years, but I worked at the College of Optometry. I happened to serve on the National Advisory Committee for the [unintelligible] Medical Dental. So I just want to share with you that I do not think the world revolves around allopathic medicine. It was just what I had available to me. I want to just share that with you.

Also I am aware of the fact that in many instances, as has been stated, that if medicine, allopathic medicine sneezes, you know, optometry, chiropractic has already pneumonia. So the numbers are bad for medicine they are going to be worse for the other health professions. So you can sort of project what that is going to be.

What I am going to do is I am going to give you a quick overview of some numbers. I do not want to labor too much on the numbers, but I just want to give you an overview. I am also going to talk about a major campaign that the AAMC launched in order to address the number of minorities getting into the health professions. Lastly, I am going to share with you the surgeon general's Dr. Antonia Novello's program that she did her initiative, and I am going to share that with you. Okay, so let us get started.

Okay. A press release, the AAMC released a major press release in October talking about the individuals that entered medical schools in 2007. This year was the largest incoming class in the history of U.S. medical schools. So 17,759 individuals entered medical school, which was an increase of 2.3%. Some of you may know this, there is a campaign on them to increase the number of our entrants into medical schools by 30%. So slowly, but some medical schools have started to increase the incoming class size. In addition, new medical schools are opening up. I do not know if you are aware that El Torro College opened up a health school on 125th Street in

Harlem. They are also in the process of opening up an allopathic school in Hackensack, New Jersey, which the incoming class will come in the fall of 2008.

Unfortunately, even though this is a record number of both individuals applying to medical schools and people entering medical schools Latinos did not experience an increase. In 2006 last year, and this is every individual who is self-identified as a Latino. You can see there was almost 1,300 individuals entered medical school, which of the total enrollment into medical schools was 7.4%. This year it went down to 1,200 and you see then total enrollment they now constitute 7.19%.

There were two sessions at the Annual Meeting of Medical Schools, which was at the end of October which talked about the concern that with the increase in class size in the new medical schools that maybe minorities would not be an increase and minority enrollment would not be reflected. Just looking at this year, the Latinos, they did not benefit from the increase. One of the things that was interesting that we tend to monitor in particular are the number of minority men in medical school. Last year there were over 17,000 individuals who entered medical school and only 395 black men entered medical school, 2.2% of the whole. So we are particularly interested in our men in getting into medical school.

What was interesting, again looking at the AAMC's press release they put out there that medical school admissions, applications to medical school increased, like I said earlier, like 2.3%. However, that black men and Latino men the number of applications had increased by 9.2%. However, it did not translate into actual enrollment. If anything, we lost one guy compared to last year. Again, these numbers are absolutely miniscule.

So, some of you may recall that back in the 1990s the AAMC launched a program called 3,000 by 2000. What it stood for was that there would be 3,000 underrepresented minorities who would enter medical school in the year 2000. So the year it was launched there were 1,047 underrepresented minorities. A quick note, when the AAMC at one time, at the time of the 3 by 2, the underrepresented minority groups were Black, Mexican American, mainland Puerto Rican, meaning the Puerto Ricans here in the United States, and Native Americans. So that is what was tallied into the 1,047. The 3 by 2 had 2 major initiatives and 1 of them was the Health Profession's Partnership Initiative and the other was the Minority Medical Education Program, the MMEP.

One of the reasons I am sharing some of this stuff with you is… I want to share with you that I am not a jaded individual. No, I mean because I have been at Einstein 18 years. Some of this, what we are doing today in particular this afternoon's piece right now, we have done this. We have gone over this. We know, and you know as was stated in the morning, you know what are the barriers, now we are looking at the solutions. So solutions have been worked on. I wanted to let you know that for us, in the medical schools, the 3 by 2 was a major campaign. Each school had a coordinator. There were meetings and conferences where coordinators came in and they shared activities. One got elaborate reports on how your individual school was doing and how it was compared to other schools in your state, then compared to national statistics. A lot of effort was done with this.

One of the things was the HPPI. I am sure, as you will discuss this afternoon, you are going to talk about how we need to collaborate with the academic medical centers. We need to incorporate colleges, high schools, secondary and even elementary schools. I am sure you are

going to talk about how you have to outreach and work with community-based organizations. All of this was done with HPPIs. At the time they had 26 sites within 21 states. This was an initiative that was part of a program funded by the Robert Wood Johnson Family Foundation and the Kellogg Foundation.

The MMEP was a program that was launched for undergraduates, targeting juniors and seniors. The program helped prepare the students for taking the MCAT exam. They used to shadow physicians. The funding went to 11 schools. Each site was able to accommodate 120 college students. So these were big summer programs. In going through the literature over 9,000 young people participated in the MMEP. This was also funded by the Robert Wood Johnson Foundation. Because of something I am going to touch on, the Minority Medical Education Program after 1995 was changed to the Summer Minority Education Program and the requirements that you had to be one of the four underrepresented groups was lifted. Now the latest rendition is the Summer Medical Dental Education Program and 12 schools have these grants, the medical schools, and each site now accommodates 80 students.

Initially 3 by 2 was a success. There was a 30% increase in enrollment and then it dipped. By the time the year 2000 came around there were only 1,700 new RNs who were enrolled, which the goal was short by 1,300. So what happened? The Hopwood Case happened in the circuit courts in Louisiana, Texas, and Mississippi. Proposition 209 in California was passed and as a result after 1996 Latino/Hispanic enrollment numbers just slanted downward.

The impact of Proposition 209 and similar measures in other states was that legal action eliminated schools considering race, gender, and ethnicity as factors in the admissions process as one of the criteria. Now there are other issues going on, and court cases. There was the Michigan case, the Washington State. The state of Washington passed a proposition, and in my looking things up, in 2008 there are other states that are looking at trying to eliminate these factors in terms of admission.

So, now we do not have to re-invent the wheel. This was my “ah-ha” moment, okay, as to how I can do this presentation today. TODOS, how many of you participated in the TODOS Initiative? Okay, just one or two of you. This is the outcome of TODOS which is Together Organized Diligently Offering Solidarity. I am going to get my tongue tied if I say it in Spanish. These were conferences and summits that were held between 1992 and 1993. Do some of these offices look familiar? What is on the front of your binder? In addition to those offices there was the Congressional Hispanic Caucus, the National Hispanic Leaders, and other Hispanic Organizations.

TODOS had three goals; to reduce health disparities, to improve delivery of healthcare services, and ensure access to healthcare for all. It had five objectives. Do some of these look familiar? Especially number two today when somebody said health data collection and especially in our small group. Look at number four, which is the third category (Health Professions) for of us today. Because of time I am going through this quickly, just to give you an overview. There were regional and national meetings. New York, I guess, we are able to participate in both summits. This particular conference and initiative incorporated 1,000 participants. The report was produced in two versions. My office is covered with papers all over the place, but I can tell you when I had that “ah-ha” moment I knew exactly where to find that second version of the report.

Part of the report came out as the recommendations to the surgeon general and it has the statistics of all the findings, and the other one was the documents of all the events like this being taped. What I sent along, if you look on tab six is the TODOS section on the health professions. So pages 36 through 40 will identify six problems and issues. It will give you the desired aims and the implementation strategies. Pages 95 through 97 is going to give you the lack of representation in the health professions. It has a preamble, it has problems, it has a summary of three strategies, specific strategies, and it includes policy resources, public and private partnerships, and efficacy.

Again, it is unfortunate, like I said, I am not a jaded individual, but here we are 14 years later dealing with the same exact issues. And this includes the same organizations funding the summits. My task, the way I understood it was to review the materials provided, determine which problems and issues are currently pertinent, identify any additional problems and issues, and identify the solutions to address the problems. Thank you.

California Summit

Reducing Healthcare Disparities through Diversification of the Healthcare Workforce – The Need for a Comprehensive Health Professions Pipeline

Katherine A. Flores, MD, Director
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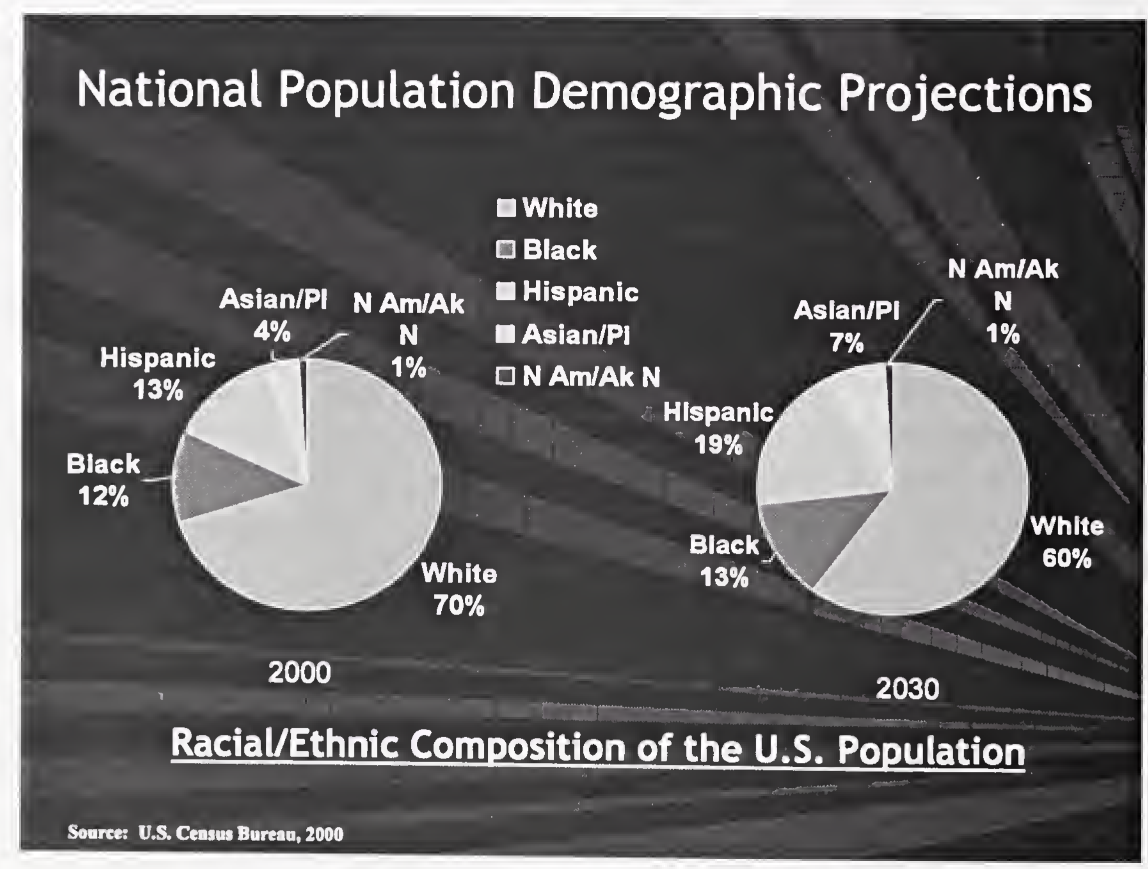
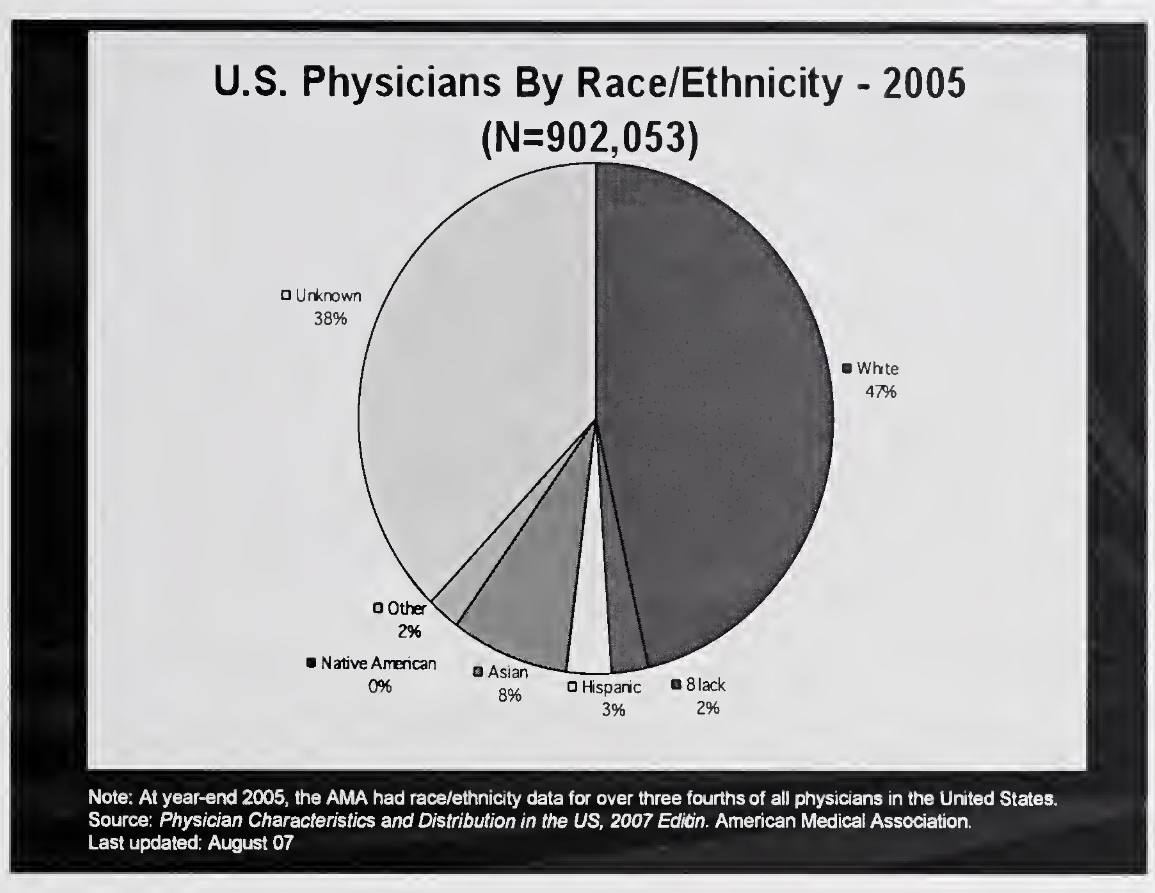
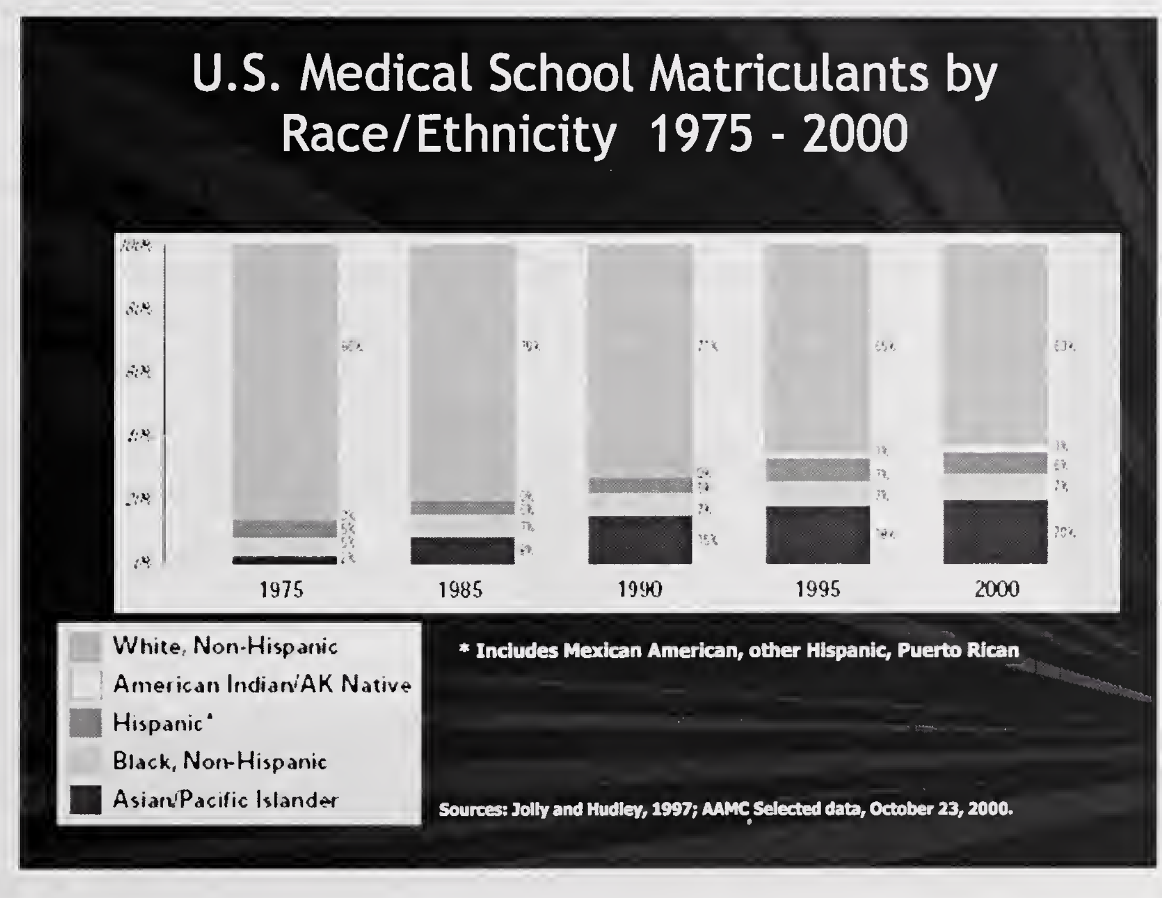
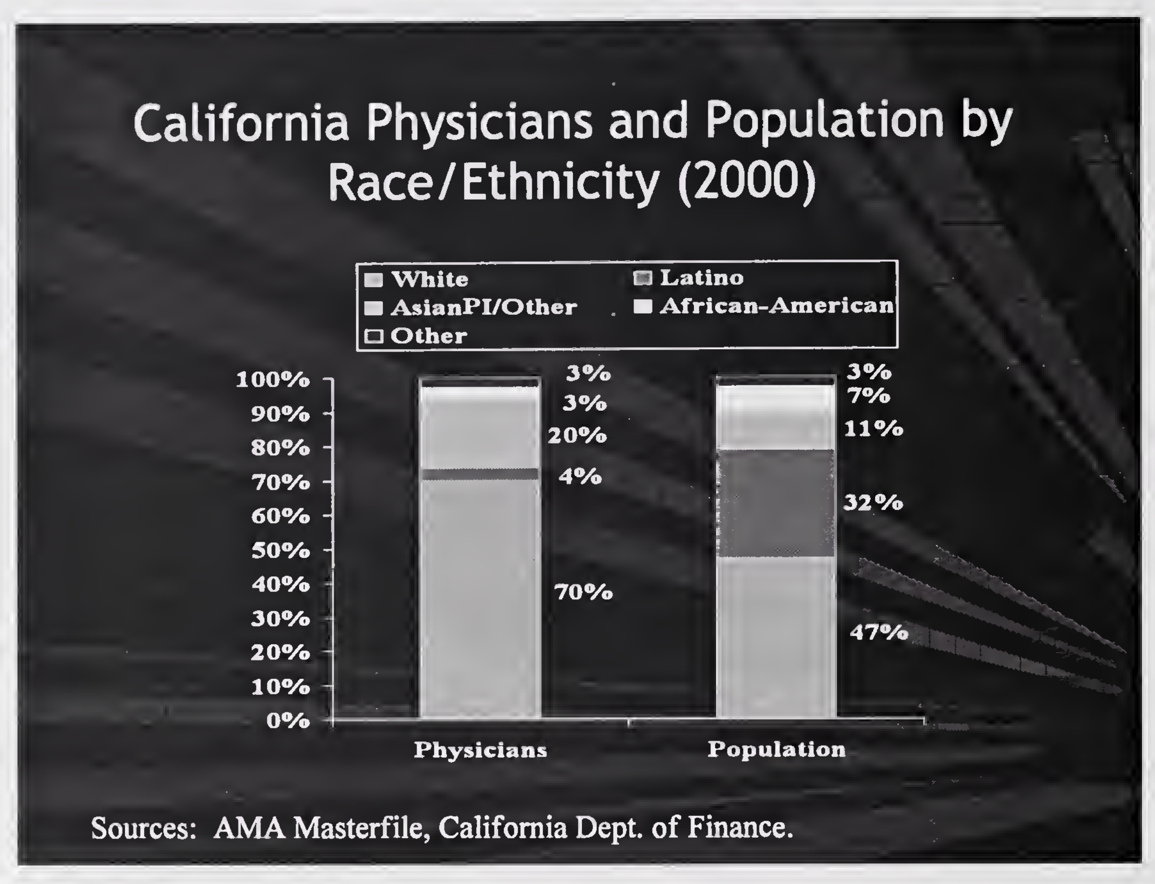
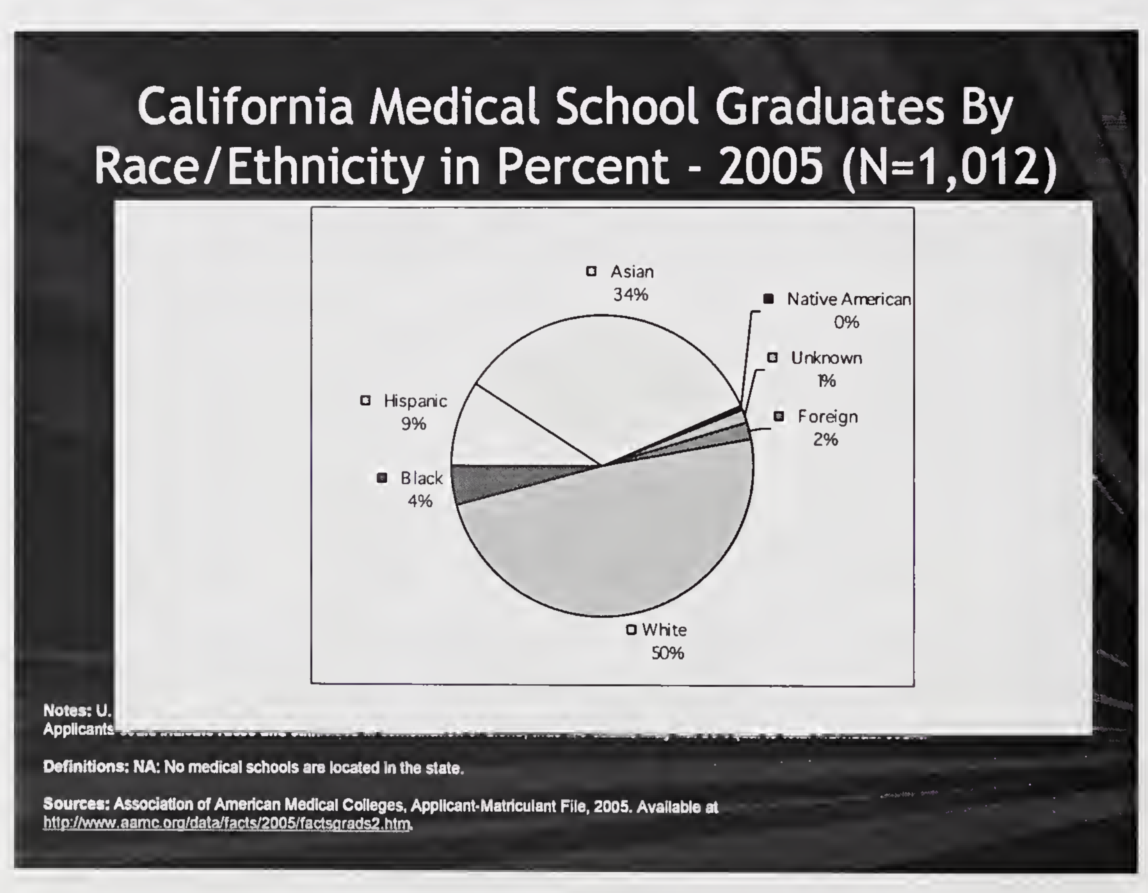
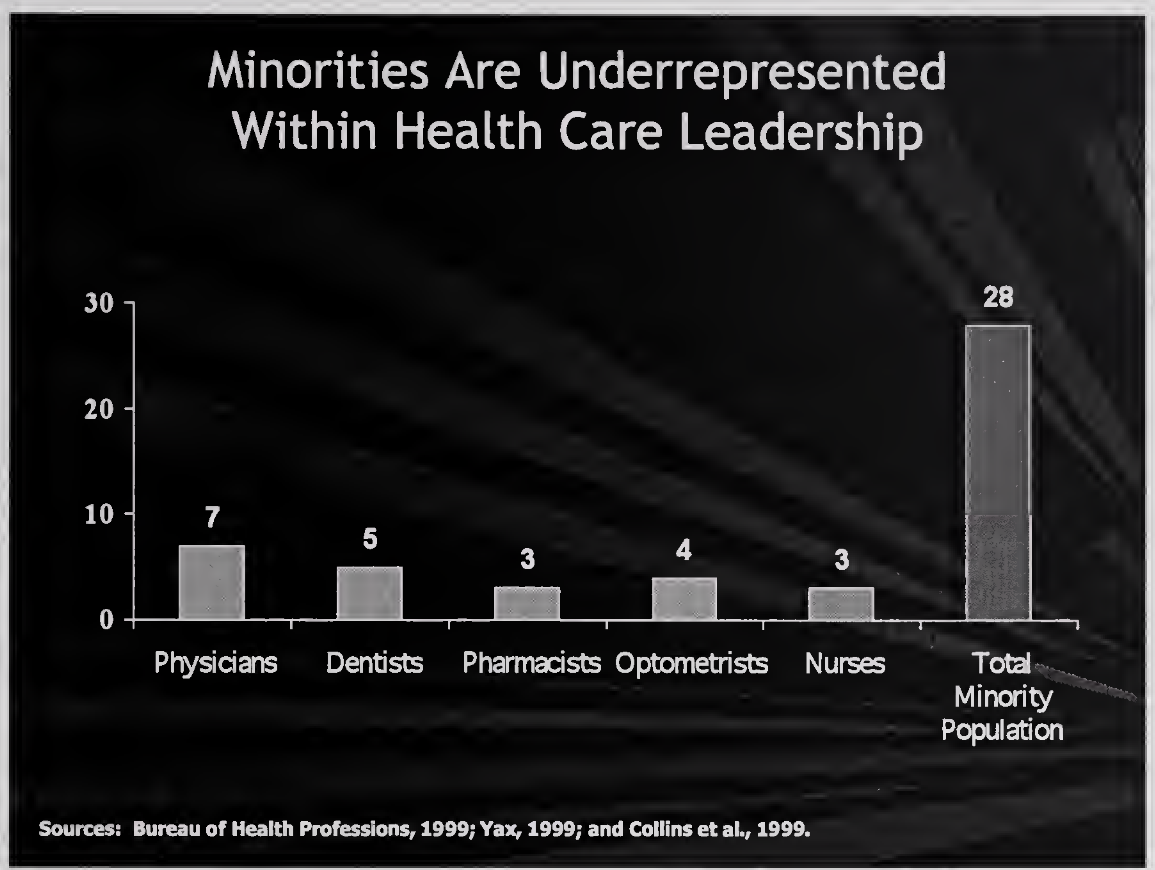



U.S. Physicians By Race/Ethnicity - 2005
(N=902,053)
Unknown
38%
White
47%
Other
2%
Native American
0%
Asian
8%
Hispanic
3%
Black
2%
Note: At year-end 2005, the AMA had race/ethnicity data for over three fourths of all physicians in the United States.
Source: Physician Characteristics and Distribution in the US, 2007 Editin. American Medical Association.
Last updated: August 07


U.S. Medical School Matriculants by Race/Ethnicity 1975 - 2000
1975
1985
1990
1995
2000
White, Non-Hispanic
American Indian/AK Native
Hispanic*
Black, Non-Hispanic
Asian/Pacific Islander
* Includes Mexican American, other Hispanic, Puerto Rican
Sources: Jolly and Hudley, 1997; AAMC Selected data, October 23, 2000.


California Physicians and Population by Race/Ethnicity (2000)
White
Latino
AsianPI/Other
African-American
Other
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
3%
3%
20%
4%
70%
3%
7%
11%
32%
47%
Physicians
Population
Sources: AMA Masterfile, California Dept. of Finance.


California Medical School Graduates By Race/Ethnicity in Percent - 2005 (N=1,012)
Asian
34%
Native American
0%
Unknown
1%
Foreign
2%
Hispanic
9%
Black
4%
White
50%
Notes: U.
Applicants
Definitions: NA: No medical schools are located in the state.
Sources: Association of American Medical Colleges, Applicant-Matriculant File, 2005. Available at http://www.aamc.org/data/facts/2005/factsgrads2.htm.



Health Disparities

Office of Minority Health 2005
National Healthcare Disparities Report
U. S. Department of Health & Human Services; AHRQ Report, Jan 2006

Disparities Still Exist

- Consistent with extensive research and findings in previous NHDRs, the 2005 report finds that disparities related to race, ethnicity, and socioeconomic status still pervade the American health care system. While varying in magnitude by condition and population, disparities are observed in almost all aspects of health care, including:

- Across all dimensions of quality of health care including effectiveness, patient safety, timeliness, and patient centeredness.

- Across all dimensions of access to care including facilitators and barriers to care and health care utilization.

- Across many levels and types of care including preventive care, treatment of acute conditions, and management of chronic disease.

- Across many clinical conditions including cancer, diabetes, end stage renal disease, heart disease, HIV disease, mental health and substance abuse, and respiratory diseases.

- Across many care settings including primary care, dental care, home health care, emergency departments, hospitals, and nursing homes.

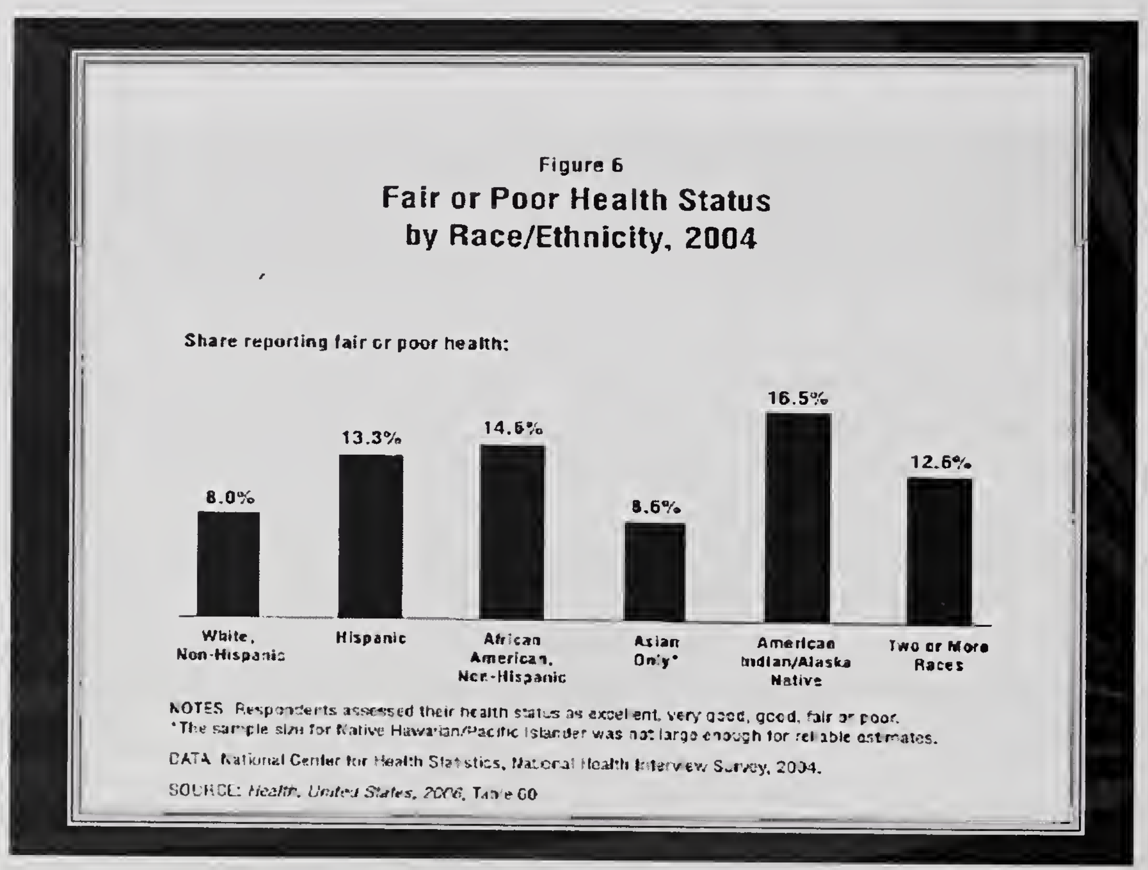
- Within many subpopulations including women, children, elderly, residents of rural areas, and individuals with disabilities and other special health care needs.

> ***"Overall, more racial disparities in quality of care were narrowing than were widening, and most racial disparities in access to care were narrowing (affecting African Americans, Asians and American Indians/Alaska Natives). But for Hispanics, the majority of disparities for both quality and access were growing wider."***
>
> ***National Healthcare Disparities Report***

Disparities of Healthcare for Latinos

Quality
Hispanics received poorer quality of care than non-Hispanic Whites for over half of core report measures (20/38) and better quality care for 16% (6/38) of measures.

Access
Hispanics had worse access to care than non-Hispanic Whites for 88% (7/8) of core report measures.



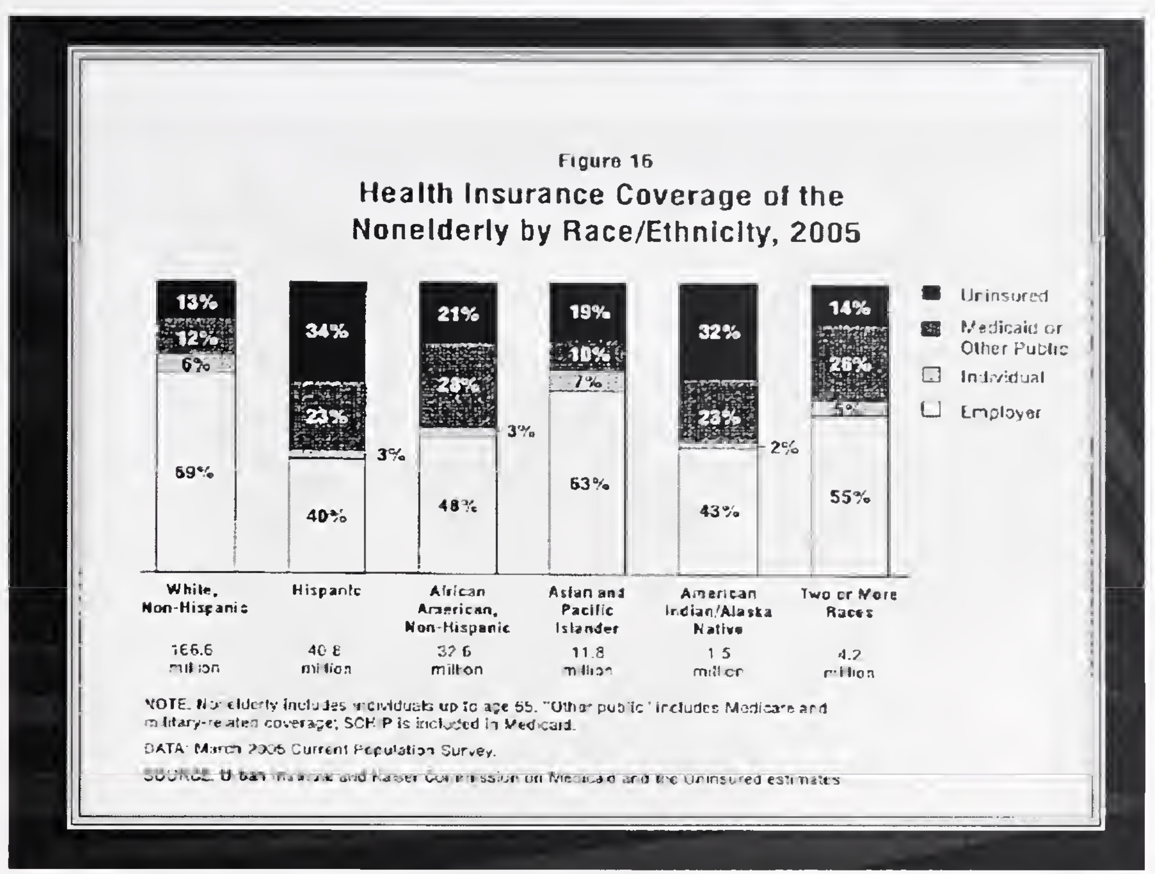


Figure 16
Health Insurance Coverage of the Nonelderly by Race/Ethnicity, 2005
Uninsured
Medicaid or Other Public
Individual
Employer
13%
12%
6%
69%
34%
23%
3%
40%
21%
28%
3%
48%
19%
10%
7%
63%
32%
23%
2%
43%
14%
26%
5%
55%
White, Non-Hispanic
Hispanic
African American, Non-Hispanic
Asian and Pacific Islander
American Indian/Alaska Native
Two or More Races
166.6 million
40.8 million
32.6 million
11.8 million
1.5 million
4.2 million
NOTE: Nonelderly includes individuals up to age 65. "Other public" includes Medicare and military-related coverage; SCHIP is included in Medicaid.
DATA: March 2006 Current Population Survey.

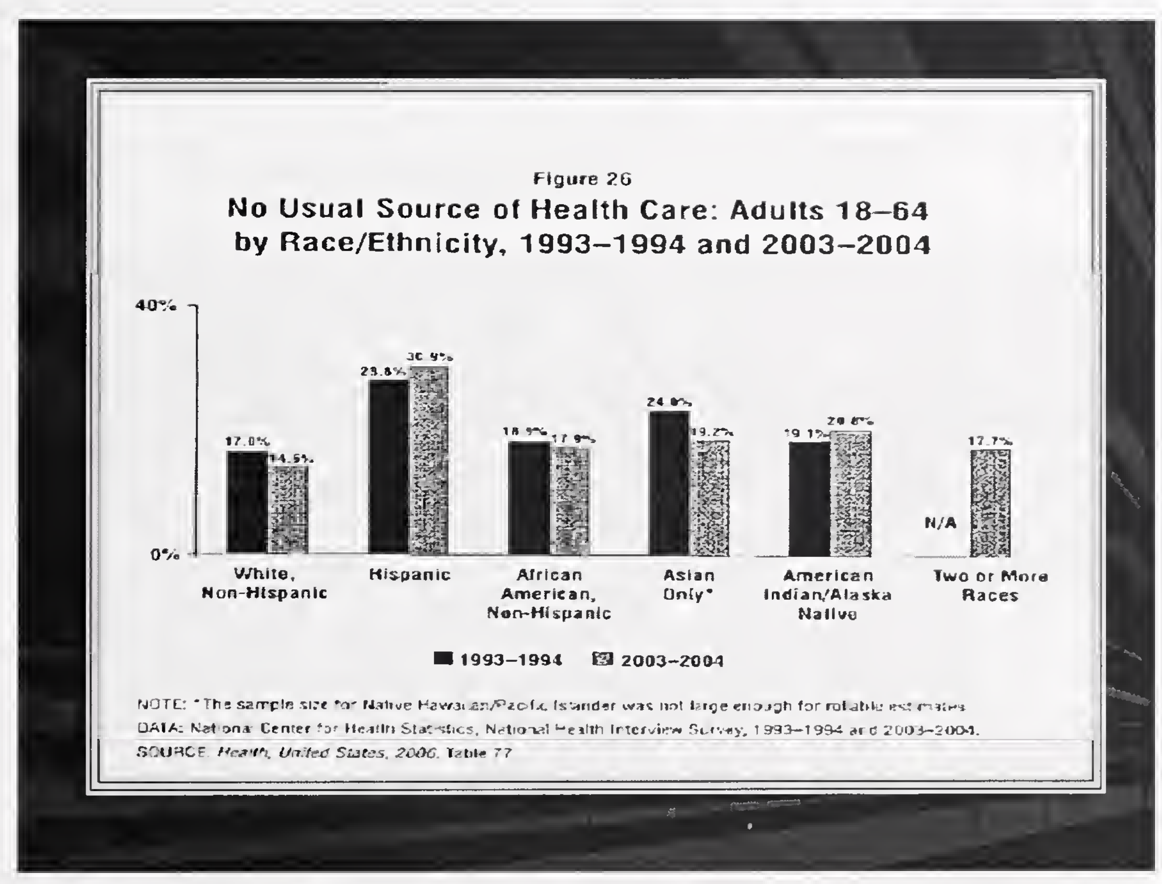
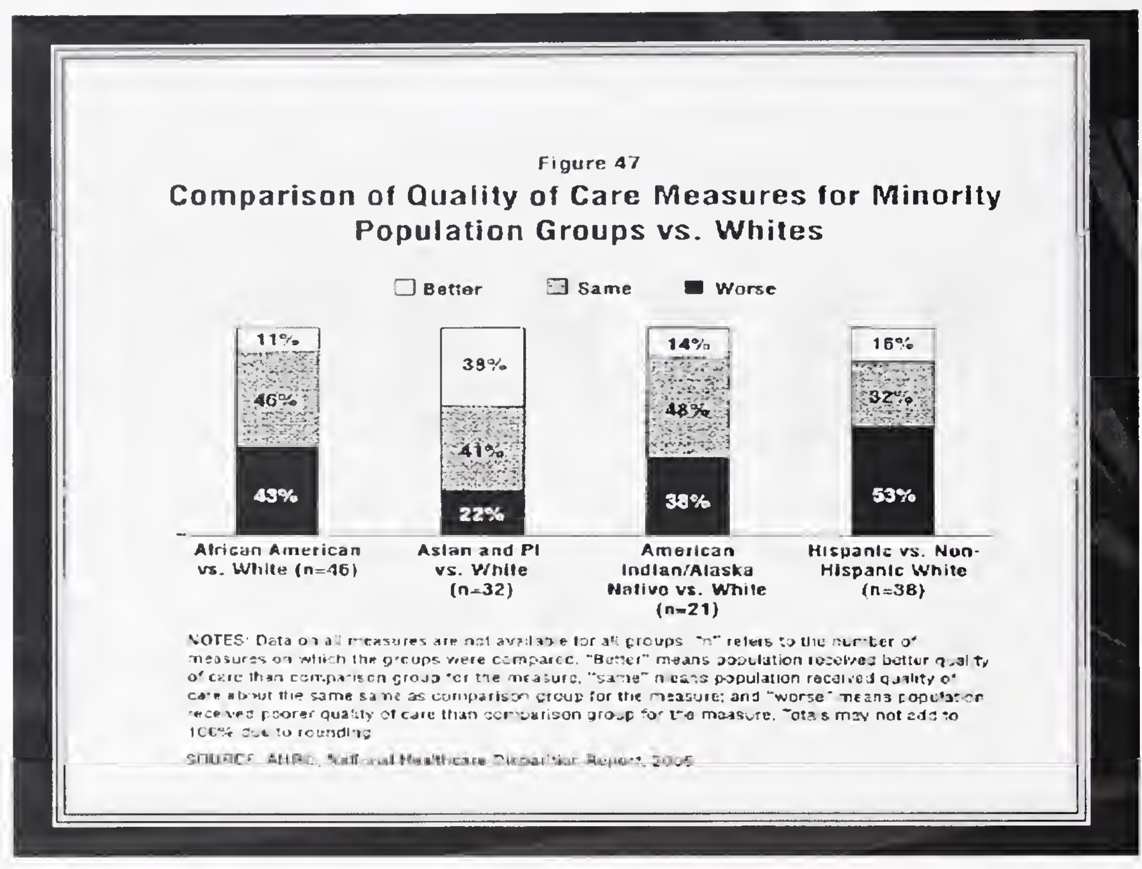
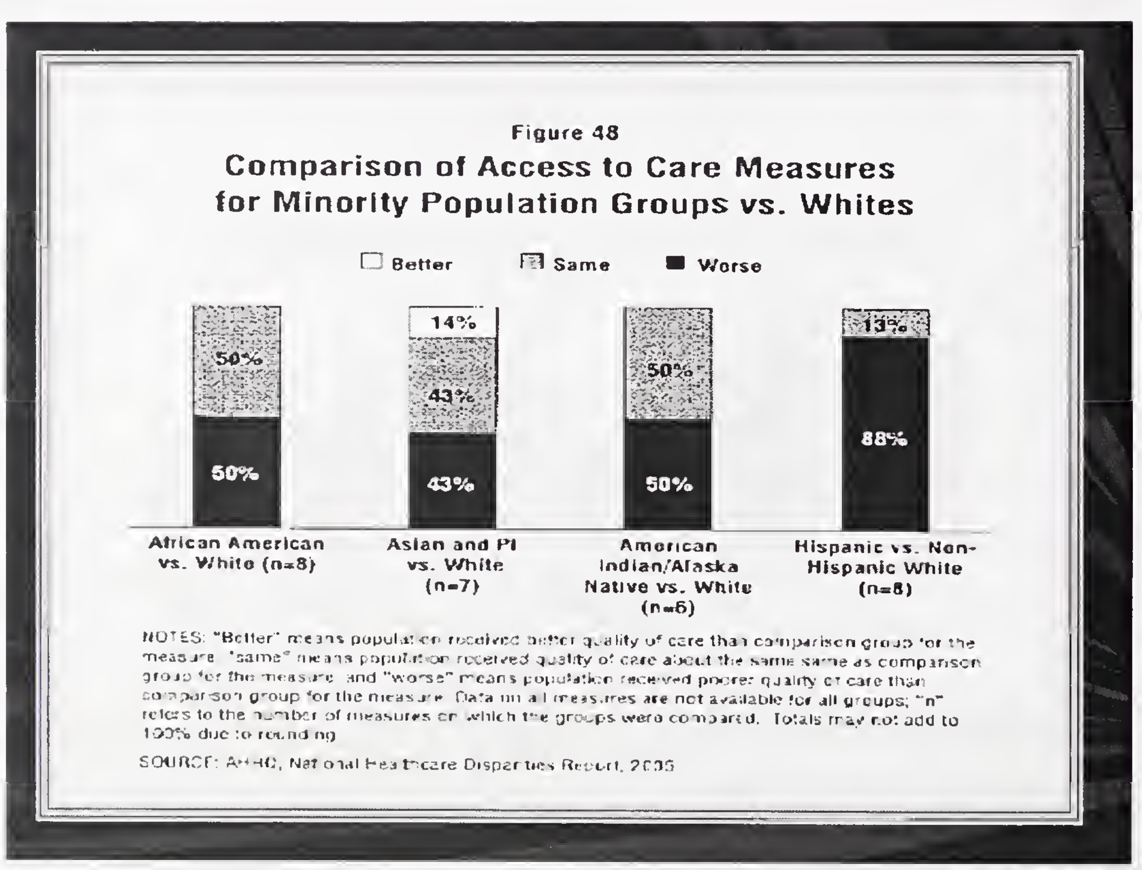


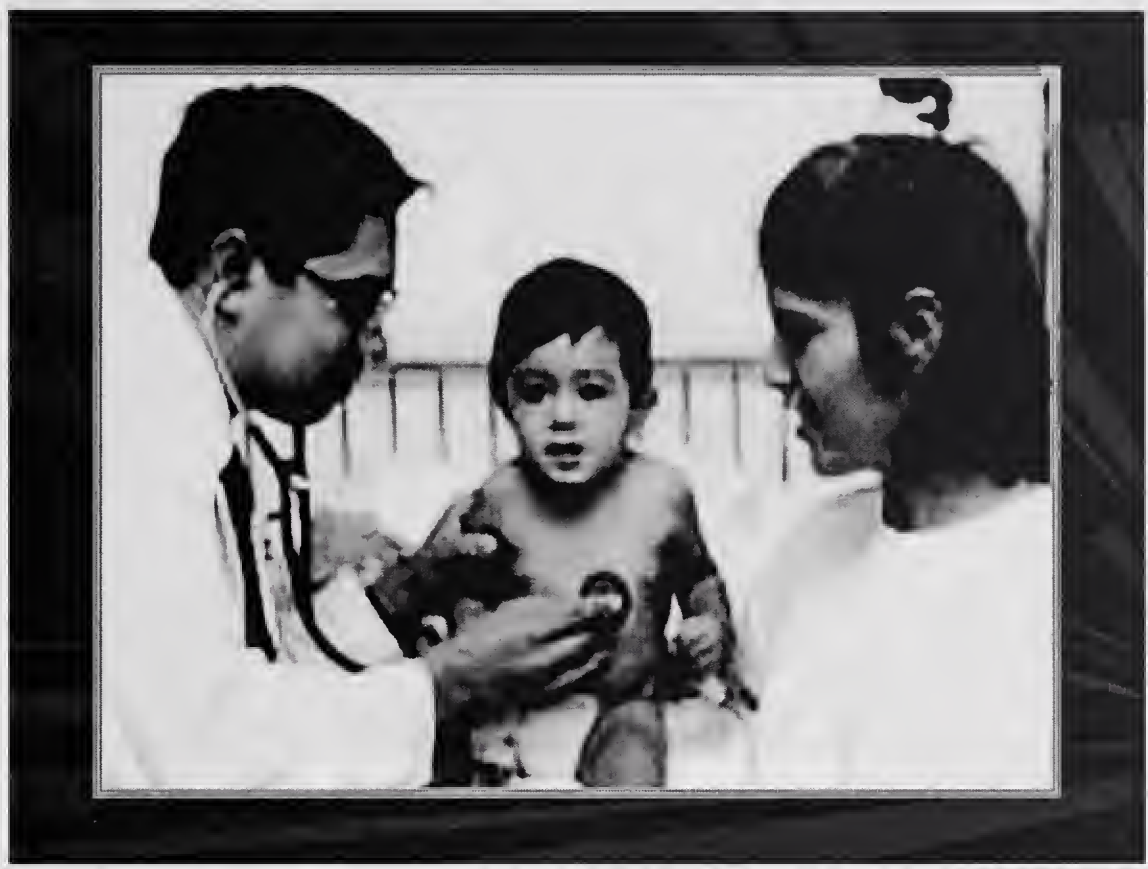
Figure 26
No Usual Source of Health Care: Adults 18–64 by Race/Ethnicity, 1993–1994 and 2003–2004
40%
0%
17.0%
14.5%
28.8%
30.9%
18.9%
17.9%
24.0%
19.2%
19.1%
20.6%
N/A
17.7%
White, Non-Hispanic
Hispanic
African American, Non-Hispanic
Asian Only*
American Indian/Alaska Native
Two or More Races
1993–1994
2003–2004
DATA: National Center for Health Statistics, National Health Interview Survey, 1993–1994 and 2003–2004.
SOURCE: Health, United States, 2006, Table 77





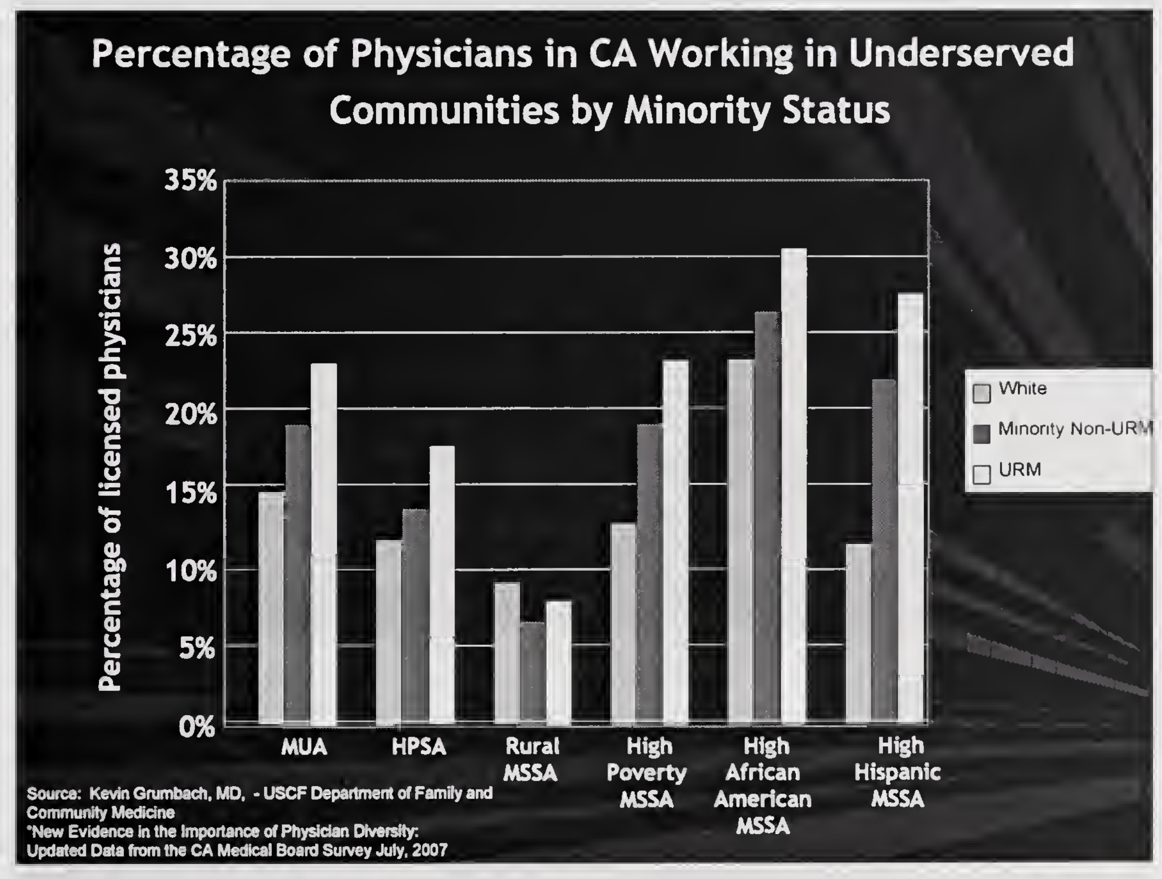
How do we make an impact to address these disparities?

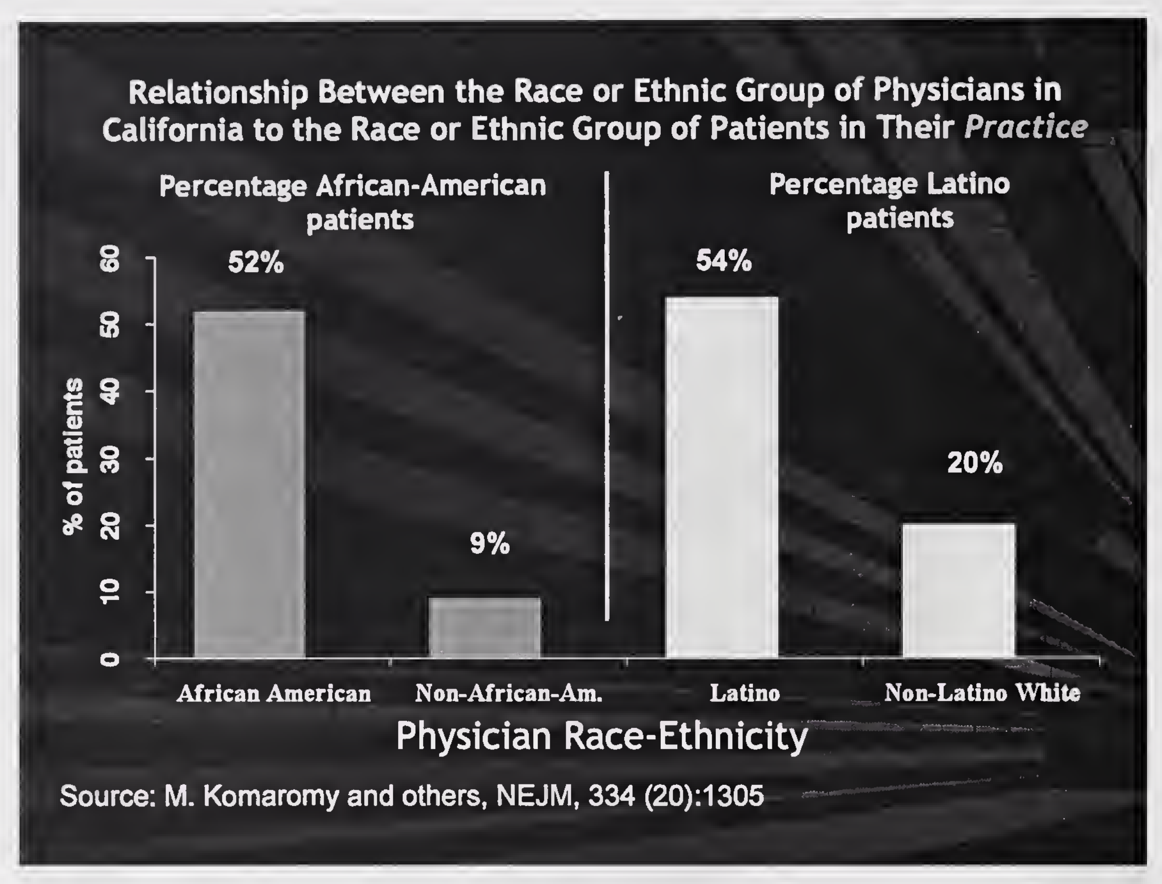
Diversification of the Healthcare Workforce

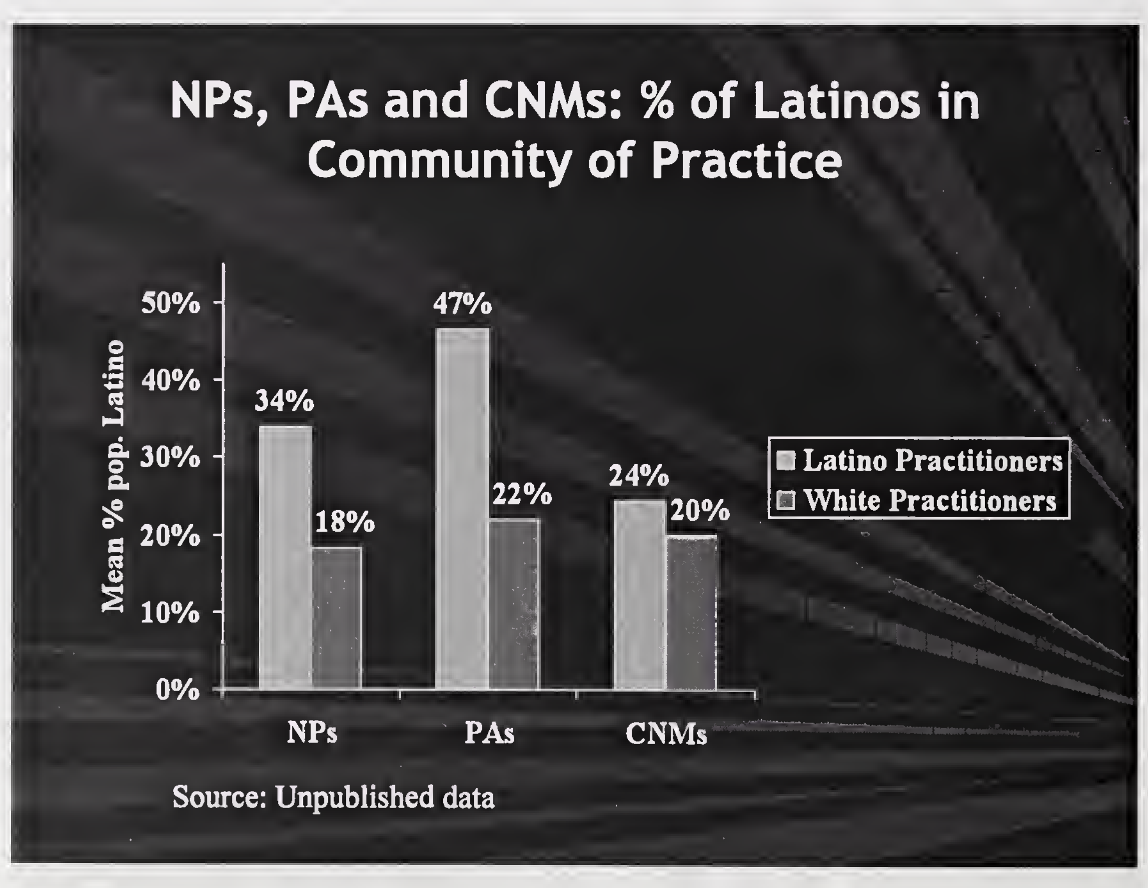


"Health professionals from underrepresented minority groups are more likely to practice in underserved areas and care for underserved minority populations."

Source: Kevin Grumbach, MD - UCSF Department of Family and Community Medicine
"The Case for Diversity in the Health Professions."



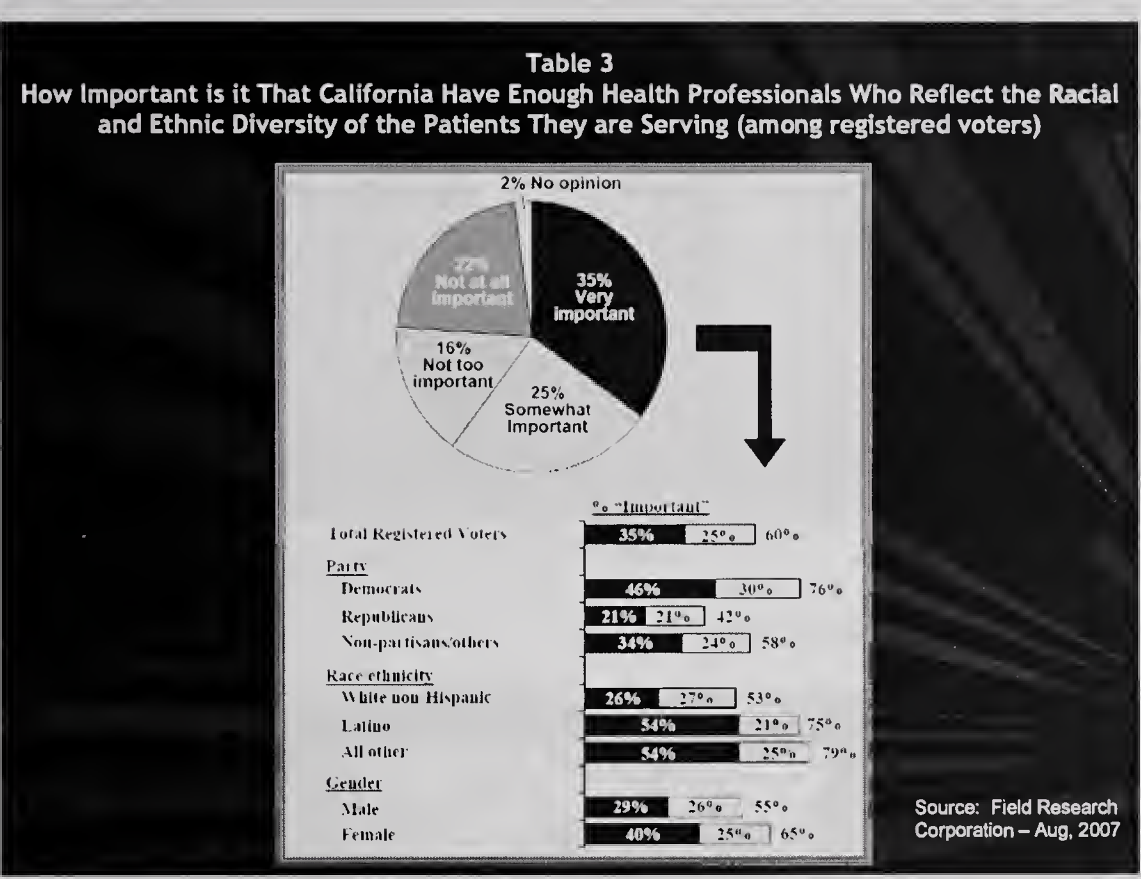




A Survey of California Voters
About Diversity in the Health
Professions
Source: Field Research Corporation – Aug, 2007

Most Californians Believe There Are Insufficient Numbers of Health Professionals In Predominantly Ethnic Communities

Six in ten voters (60%) maintain that it is important for California to have enough health professionals who reflect the racial and ethnic diversity of the patients they are serving. In addition, large majorities believe that doing so would result in greater patient satisfaction, better management of patient's health conditions, improve health outcomes and more effective control of diseases.



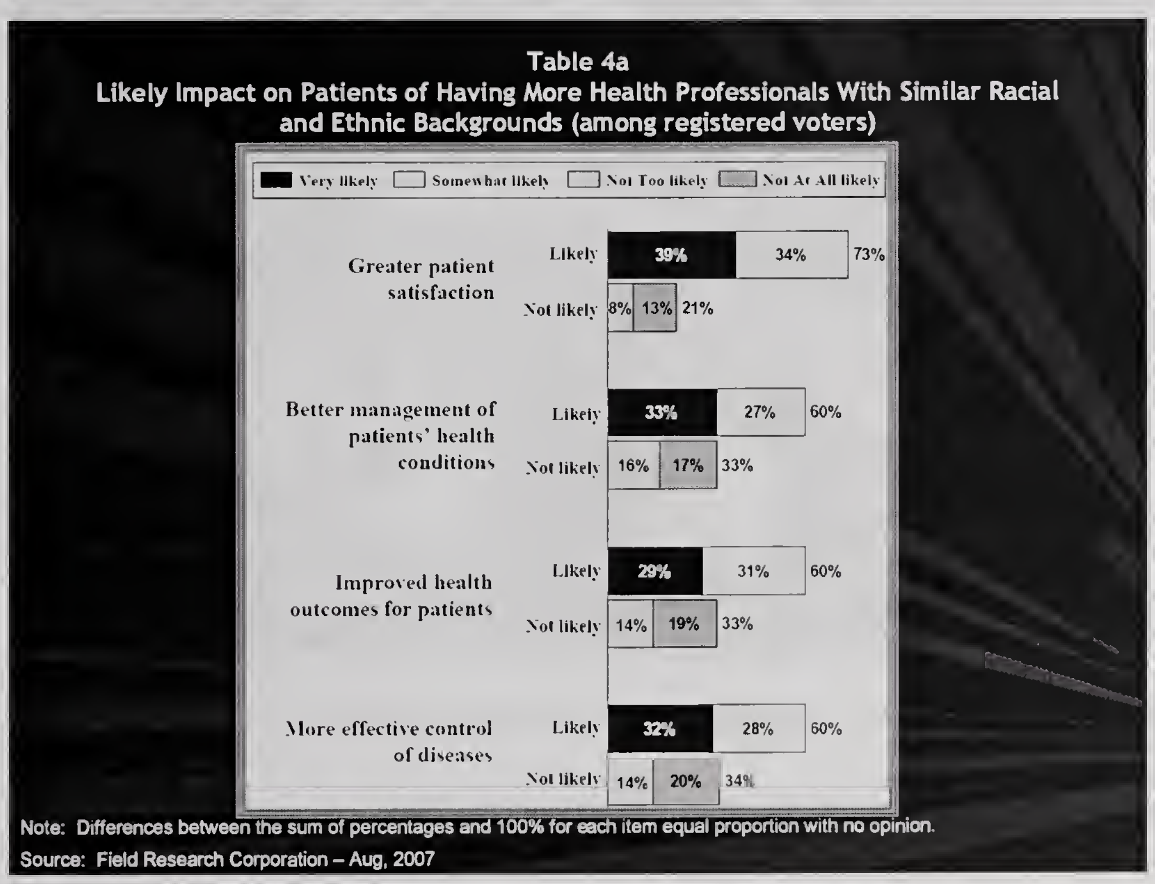


Table 4b
Likely Impact on Patients of Having More Health Professionals With Similar Racial and Ethnic Backgrounds - by Subgroups (among registered voters)

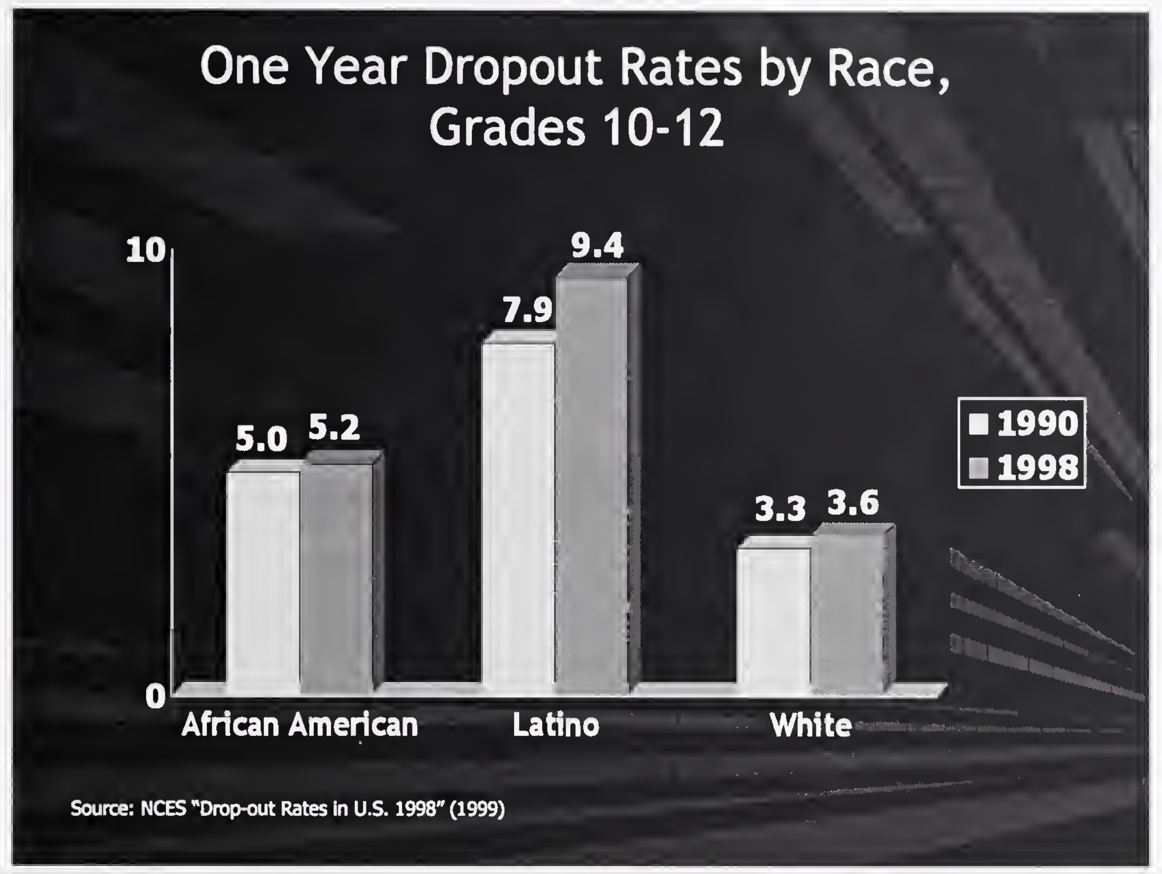
	- % Likely -			
	Greater patient satisfaction	Better patient outcome management	Improved health outcomes	More effective disease control
Total registered voters	73%	60%	60%	60%
Party				
Democrats	79	71	73	71
Republicans	64	47	45	47
Non-partisans others	75	57	61	56
Race ethnicity				
White non-Hispanic	70	54	53	53
Latino	83	75	77	72
All other	81	73	78	75
Gender				
Male	68	56	56	53
Female	78	63	65	65

Source: Field Research Corporation – Aug, 2007

Educational Interventions Need to be Made

"Each Year, One of Every Twenty High School Students Leave School."

Source: The Education Trust – High Schools in America 2001



Of Every 100 White Kindergartners: (24 Year-Olds)

- *91* Graduate from High School
- *62* Complete at Least Some College
- *30* Obtain at Least a Bachelor's Degree

Source: US Bureau of Census, Current Population Reports, Educational Attainment in the United States; March 2000, Detailed Tables No. 2

Of Every 100 African American Kindergartners: (24 Year-Olds)

- *87* Graduate from High School
- *54* Complete at Least Some College
- *16* Obtain at Least a Bachelor's Degree

Source: US Bureau of Census, Current Population Reports, Educational Attainment in the United States; March 2000, Detailed Tables No. 2

Of Every 100 Latino Kindergartners: (24 Year-Olds)

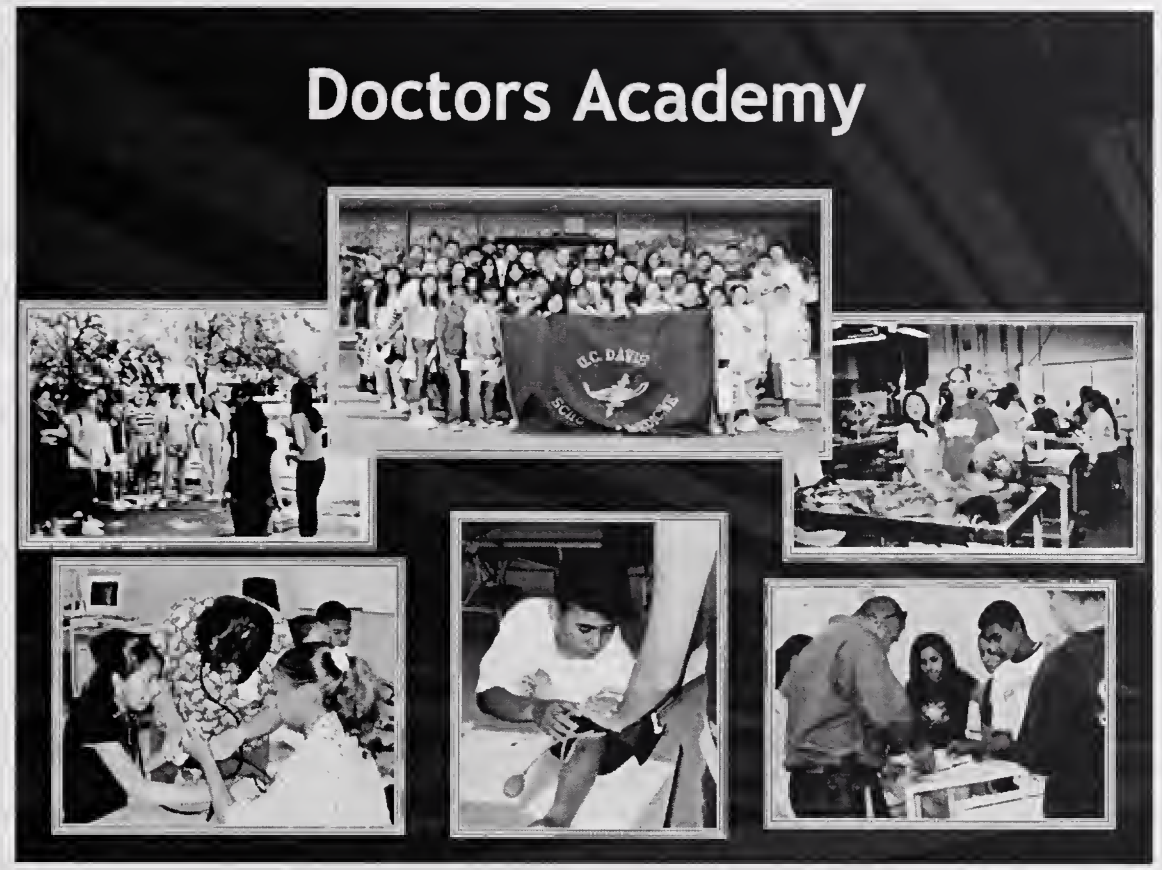
- *62* Graduate from High School
- *29* Complete at Least Some College
- *6* Obtain at Least a Bachelor's Degree

Source: US Bureau of Census, Current Population Reports, Educational Attainment in the United States; March 2000, Detailed Tables No. 2

A Unique Partnership Between

- University of California, San Francisco (UCSF) School of Medicine;
- UCSF-Fresno Medical Education Program;
- Latino Center for Medical Education and Research;
- California State University, Fresno;
- Fresno County Office of Education;
- Fresno Unified School District;
- State Center Community Colleges
- Community Medical Centers &
- Sequoia Community Health Centers

JDA students visiting the Children's Hospital of Central California



Doctors Academy Graduated Cohorts 2003-2007 = 161 Students

Cohort 1 - 5 have accomplished

- 100% graduation rate
- 100% acceptance rate into 4-year colleges and Universities
- Five each year were given early admission consideration to UCSF SOM
- Each cohort graduated 7 to 10 class valedictorians
- 80% of the graduating cohorts have declared health or science majors

Accomplishments of the Doctors Academy - 1st Cohort (Class of 2003)

- First DA alumnus started medical school in August 07 at Brown University
- One student in the midst of applications/secondaries
- Five are currently studying for the MCAT and will be applying next year
- At least 3 students are in the nursing program
- At least 3 students are applying to PA programs

Health Careers Opportunity Program at CSU-Fresno

Health Careers Opportunity Program (HCOP) helps prepare students for entry into graduate programs and health professional schools. It also provides student academic support in partnership with UC San Francisco LaCMER.

Student Benefits:

- *A chance to explore areas of academic and career interest*
- *Preparation for entry into graduate and professional programs*
- *Academic and career counseling services*
- *Mentoring*
- *Research and internship opportunities*
- *Pre-health services, i.e., MCAT/DAT courses*
- *Health/Allied Health professional school visits and workshops*

Policy Recommendations

- Develop a Comprehensive Statewide Strategy for Health Professions Pipeline Program Development.
- Consider new Legislation for Funding Joint Health Professions Pipeline Initiatives Between the Departments of Health and Education Focusing on Diversifying the Healthcare Workforce
- Explore New Legislation that Addresses Training of the Healthcare Workforce to Impact Health Disparities in Minority Communities
- Support Restoration and Expansion of Federal Funding for Title VII Health Professions Training Diversity Programs – HCOP's and COE's

Texas Summit

Increasing Hispanics in the Health Professions

Ciro Sumaya, MD, MPHTM
Chairman of the Board of Directors
National Hispanic Medical Association
Dean
Rural Public Health School
Texas A&M

First, it's a pleasure for me to be here this afternoon with you and discuss health professions, and that's a favorite theme of mine. When I was up in Washington heading HRSA, Health Resources and Services Administration, that agency had two major missions. One mission was to assure a quality healthcare workforce, physicians, dentists, nurses, allied health professionals, public health, etcetera, and the second mission related to it was to assure quality healthcare services to the people of the country. Knowing that by that second assurance of healthcare it involved working particularly with vulnerable, under-served, minority, rural populations, mother's and children's populations, and those who had complex illnesses like AIDS, which carries a lot of co-morbidities with it.

In the health professions I think I probably could just use this slide and that will be it, but I did want to give you some numbers. The numbers, as I see what my secretary sent, were actually the old ones. These are from in the nineties so they're 10 years old, but I have to tell you that the only difference in the representation of Hispanics as physicians and the other healthcare workforce disciplines is almost identical ten years ago. The only thing that has changed is there's a greater population of Hispanics in the country. So, in this one it's just a general slide. Disproportionately under represented in virtually all of the health professions, and the under representation is at all levels, whether you're going to go into practice, whether you're an academician, health professions institution, whether you're in the research fields, post-baccalaureate type programs, etcetera. We are in disproportionately low numbers.

This one is a look at physicians, and again so you can see the date. This is Texas, and the figures will be mainly for Texas. Anglos—percent of the population you can see is 57%, but percent of Anglo physicians is 75%. So, they are over represented, and Hispanics/Latinos, where we are 29% of the state's population and as you know here in Texas we're even higher than that in percentage, a little bit more now, but yet only equate to 10% of the physician population— we're under represented. If we look at nurses, the top you're going to see are White Non-Hispanic in the green, and as you see the number is 80%. For minority groups, including Hispanics, you can see that the table had to be rearranged so that it's no longer what you're seeing percents on the side there of 0, 10, 20. It's 5%, 6%, 8%, and for Hispanics in red, you can see the numbers, 5% going a little bit higher. But very different than what we see with the majority population.

In relation to nurses, again, when I started at HRSA, which was in 1994, the percent of Hispanics at HRSA, the federal agency, was 2%. It was 2% twenty years before that as well, and it is still 2% today. We work with nurses. At that point in time the percent of nurses nationwide was 2%. Twenty years before that it had been 2% as well. So, things have not really changed. If we look at nurses more recently who just finished, got their degree, graduation, in 1996/1997, look at the

third line, Hispanics/Latinos, 28.5% of the Texas population is Latino but 12.3% of the nurses in the State of Texas were Latino or Latina, under represented. And the under representation is in the advanced practice nurses. If you go below the baccalaureate degree, the numbers actually get a little better—so licensed registered nurses (RNs), vocational nurses, the numbers are a little bit better, but once you get into the baccalaureate degree it really gets quite low.

Dentists, low proportion whether you're in practice, a recent dental graduate, dental hygiene graduates. It seems to be a little bit better if you are a dental assistant. Again, those who got their DDS degree, dental degree in 1996/1997, third line Hispanic Latinos, 28.5% of the Texas population, but 10.8% of the dental population. Dental hygienists, same thing – 28.5% of the Texas population, 12.4% of the dental hygiene population. If we look at the Allied Health field, the percent of Latinos/Hispanics Texas population was 28.5%, but if we look at physician assistants, 11.7%, pharmacists 11%, psychologists 6%, and looking further social workers 11%, physical therapists 7.2%, occupational therapists 9.7%.

Related to this entire scenario is that the number or proportion of Hispanics in decision-making positions (management and leadership positions) in the health professions are also in extremely low numbers, and I would say that it's in the context of very low numbers in state and national sectors, including the business sector, educational sector, governmental sector, etcetera, which sometimes influences what is going on in the health professions field.

That is kind of what the cold facts are you might say. Now, what can we do about it? Actually, what can we do about it now since it's been such a recalcitrant problem for so many years? Is there anything we can do? I think we always have to be optimistic and say of course there is. We just haven't found all the best ways to make it happen, or the ways may take a period of time. But you have to be persistent. You have to do things over. You have to be on top of things.

There are strategies that were developed from an Institute of Medicine Committee, and I was fortunate to be on that committee. We laid out the strategies in 2004. At the same time as this committee was going on, there was a Sullivan Commission, and I think Dr. Elena Rios was very fortunate to be on that group as well. The Sullivan Commission had public testimony in various cities across the country. We met kind of in an academic setting at the Institute of Medicine and deliberated and discussed and worked with a lot of other people that provided data and thoughts as well and then formed an opinion piece. I think from the strategies of the Institute of Medicine in particular, the point is we have to start looking outside the box of what we've been doing before, and there are many, many things that could be done differently and I think could have something very positive. I think this is a very important issue particularly now because there's a major influx of interest, of increasing the pool of physicians in this country, not Hispanic physicians but physicians as a whole. There is a strong movement to increase the number of nurses in this country, not Hispanic nurses but nurses as a whole. The dental people are starting to get on-board with this. Pharmacy people and public health where I am now—we just had a congressional briefing, and talked about the crisis of the public health workforce shortage areas now and even worsening as we go on day-by-day.

I think the question we need to be on top of is with this push in dollars that are being funded from states and federal levels to make this happen to some degree, are we going to have an increased number of physicians, dentists, nurses and others going into the same system of care that we currently have, a system of care that we realize is fragmented, a health care delivery

system in which we don't have health professionals in a number of our communities or at least closely related to communities, particularly communities of need, where we have rising health care costs, where we have a very strong technology orientation occurring and new procedures and new techniques. But our health care delivery system must be able to reach all the people as opposed to some of the people in the country. Yet we're putting a lot of efforts to creating a larger workforce across the various disciplines. So, these are very important issues because it's leaving a lot of questions as to what is the direction that we need to take. I think NHMA needs to be right on top of this with your help.

So, let's look at some of these strategies. One was admissions policies and practices, nothing new. I think it has been voiced for a while that we need to have people from the community, particularly minorities on the admissions committees. They need to have a voice. They need to be able to vote, and we need to expand the diversity admissions committees. That has been done to some extent, yet it varies considerably across the country. But it appears that those are more words than actually the actions that have occurred via what we think we should, where we should be heading. We talk about and many, many groups will voice—well, of course, now we're going to diminish the role of the paper credentials, which is, you know, the grade point average and the aptitude test, and we're going to look at the "whole person" the experiences of the person, what they had to combat through their life and to try to succeed at least to this level. I'm in this age group now and have had a lot of experience, again it seems like a lot of words, but the actions once you get to a decision point haven't quite met where I think we need to be heading.

I think the whole thing that this revolves around is to whom are our health professional institutions accountable to, and really it's almost accountable to themselves, and I'm really part of that group now, to ourselves. There are some states that have some competencies that the institutions or outcomes that the institutions should have—how many graduates have passed the grade, how many are going into rural areas, etcetera. But it's not really looked at when that state then says these are the funds that are going to this institution for this coming year or the legislature has said that. And so that accountability in my opinion, is a biased opinion but I think the correct opinion, is that the accountability toward the community and to meeting the unmet needs of the total U.S. population is not fair. That needs to be rearranged.
Reducing financial barriers is another area I think we've all discussed, particularly related to minorities. Hispanics/Latinos are usually of a lower economic group, we need more financial support, and it's not just financial support because a lot of the data that we deal with are what's the income of your family. I think the better question would be what are the assets of your family because that shows your foundation and your real worth in the long-term basis. But we don't include that type of data. Nonetheless, we do have financial incentives and capacity within our institutions, but it's kind of a reactive type of financial assistance in that you come to me and I'll help you find the funds.

Where do our minority students fit into this if they come from poor families and the family is involved in some of the decision making for them. Do they understand that there may be a $100,000 or more debt involved in going to a professional school? These are things that are completely foreign to many of the families of Latino students that may be entering the field, and there needs to be not only the capacity of the financial aid activity but an orientation and understanding, an educational piece, that probably should include families as well as the individual who is applying.

The third one is accreditation. This one is a relatively new one, but I have to admit we at institutions know how to move and maneuver in various areas. I see institutions where "accreditation," the words are put in there of how you can apply with various accreditation criteria for your institutions. But many times the words revolve around the processes that you have. In other words, is there diversity in your student body? And the answer, well, we're trying to get there. These are the fourteen steps that our institution does. The question is what is the outcome, and that's where accreditation agencies usually soften up a bit on, well, if you tried hard and tried hard, we'll give you some good points for that even if you didn't reach a respectable outcome. What our Institute of Medicine study said was we have to have outcomes in this and not processes. That has to be whether you vote for or against the passage of a criterion for an educational institution as a school of medicine, or school of nursing, or school of public health.

Institutional climate is another one that was brought on board, and the institutional climate is from the top all the way down, at all levels whether it's custodial care to your staff, to your faculty, to your administrators, to your president, to your chancellor. There has to be direction within the hierarchy to where we want to go in terms of diversity in our institution, and I'm going to lead the way. That is something that I think our committee really focused a lot on because we see instances where people may go into an institution, but it's not a very friendly arena. It is kind of as you came into this institution because you are a minority. You were not quite at the same level as I am, and that change has to occur at the top to make it happen down that grouping of leadership.

Lastly, community benefit—many of our institutions and non-profits, receive benefits. They don't have to pay for their property taxes, and so is there not a sense of an accountability from our educational institutions be they health professionals or not because they're getting benefits from the state that they have to provide needs of the state and some of the needs of the state are to improve the health professional diversity and the healthcare infrastructure needs for underserved populations. Here is where I think we need to get a lot of support not only from ourselves but bring in support from legislators, governmental leaders and others to influence these things and make institutions accountable for the actual outcomes particularly in health professions education. I added just a few that I would offer up. One is the concept—it may be trite, but I think it's still very useful, *best practices*. What can we learn from one another? Because some institutions seem to be doing better than others, and I think we need to know how they did it and how we can spread that knowledge around. NHMA may be pivotal in making that happen across institutions. Clearinghouse of information, the ability for our students to get internships, to get fellowships, to get into faculty positions many times rests on who you know. Institutions recruiting for somebody, the department head, the dean, may know of somebody. There's a network out there across all of the health professions. Oh, this person is over here at this institution. I'd like to bring him over here or her over here. How do we get into that network? Part of it I think is to have a clearinghouse of information where we and others who are recruiting individuals have access to and would try to help foster that matching.
Others, Title 7, Title 8 of the Public Health Service Act, and those are two that were in my old agency at HRSA. Title 7 deals with mainly educational programs for physicians, much less for dentistry, and even less for public health. Title 8 deals with nursing. They had a good lobbyist, and they got their own Title, but these are bills that are extremely important because they contain health career opportunity programs where they help us form a pipeline for students entering the health professional field. They have centers of excellence where institutions can get these grants so that we have centers of excellence for minority populations, and Hispanics are in there.

African Americans have a bit more of the money there, but we've gotten pretty good money and Native Americans. It's only for selected health professions such as physicians, dentists, and pharmacists for the centers of excellence. The health career opportunity programs are broader, but they don't even include my discipline of public health there. Nonetheless, they're excellent programs. Every year the president, at least the current administration has zeroed them out, and then Congress comes back and puts dollars into them often at a lower amount. Yet, these programs are vital, and so I think NHMA has to be on the front-lines policy wise, advocacy to see that these things are funded because they're pivotal for us.

There are some other bills, the Minority Health Improvement Act and other bills that I think we as an organization need to be right on top of and pushing as well at the local, state and federal level to make it happen. The outreach with health professions degree program is also I think another important area in the sense that, and it may not apply to medicine as well but what we did in public health is we at Texas A&M, we have a school of public health. We have a degree program there. We have several now, but we started out with one. We had few Latinos in our class, in our group. Texas A&M was not known as the fountain of Latinos in their enrollment, and there were few in our school. What we did and in a very I think appropriate fashion was developed off-campus options for earning the Master of Public Health (MPH) degree program, and we went to Tyler, Texas. We also went to Scott, White, McAllen, Corpus Christi, and then Austin, and we developed a Master of Public Health degree program available through on-site activities with distance education and visits by our faculty to those particular sites. I have a very dedicated faculty. This was a major feat for such a small school. As I said, we're just kind of starting out, but this was kind of a different way. They can't come here because many people in public health don't have formal education in public health so they're working. They're at their home. They can't come to - - and get that degree or San Antonio or some other place, and what we did was take the degree to them. It still was I think a quality program that was very well accepted.

Next, science as a second language, and I really want that in there. Science is a second language. We use the word "English," but where can we place science in all of our curriculum starting from kindergarten on up? And where does the family help influence that? I think this is extremely important if we want to get more Latinos in the health professions. Networking and advocacy—I mentioned where NHMA is pivotal here. We need teamwork. Need to work with people who are at the legislature, etcetera to work on that. Contracts between educational institutions, and I think it's pivotal that our big - - particularly in Texas, University of Texas, Texas A&M, they all have campuses in different parts of the state. There needs to be, I think, a very strong relationship because many of these are in places where there are many Latinos. We need to see that there is a networking of all degree programs including doctoral degrees that reach down to these various institutional campuses that are under the flagship, outreach to community colleges, which are also feeder schools to many of the health professions institutions. So, in closing this is NHMA. We are an association of physicians, as I am, but I think what we're doing today is really public health. You're looking beyond your patients and their families. How do we help the Latino community in the broad sense, in the regional sense, in the state sense, and in the national sense? That's public health, population health. So, we're deputized as all public health practitioners in this room. The mission, I think, has to be well defined through NHMA but also with all the input that all the supporters of NHMA have. I think we have to have some very specific goals of how we're going to work together in trying to achieve them. I think as the ex-commissioner, Eduardo Sanchez said, it comes down to leadership. You see a lot of strategies here, but you have to have somebody champion them.

Besides strong individuals, you also need teams, and how do we get these leaders and not only the leaders whom are now in their 60's and 70's, but those that are in their 50's, and even younger, in their 30's who really have a lot of energy? How do we have the succession of leadership to assist with the Latinos in the health professions? I think that is absolutely pivotal, and lastly the advocacy that we have to have and advocacy in the sense of I can't say lobbying too much being at an institution that is funded by the state. But meet legislators, meet decision makers, be part of that group, and get them to hear what you think is appropriate. Get into the hearings as one can. Talk to the committees that are in the legislature, etcetera, and if you don't do it, see if somebody else will do it with you.

I just gave you some thoughts. I am very interested in hearing your thoughts on the future of the health professions and Latinos in the health professions. I am fortunate. I am very pleased that I have been here with you today. Thank you.

Recommendations for Increasing Hispanics in the Health Professions Workforce

POLICY RECOMMENDATION #1:

Build Political Will

The Federal government has supported programs to increase recruitment and awareness for health professions careers through the US DHHS Health Resources and Services Administration for K-12 and undergraduate students through the Health Careers Opportunity Program since the 1960s; the Hispanic Center of Excellence Program since the early 1990s. The medical school grantees show a positive impact on the diversity of the admissions statistics compared to the medical schools without these programs.

Policy experts, however, recognize that the programs need political support since having been criticized by the Office of Management and Budget Performance Evaluation Program for a lack of effective impact evaluation. Since December 2005, the programs have had drastic cuts from Congress and are in need of political will for the need to expand Hispanic representation in the health professions.

POLICY RECOMMENDATION #2:

Strengthen Educational Pipeline

Improve K-12 education

The education training of K-12 public schools in minority communities tends to be of lower quality with poor outcomes - higher drop out rates, lower achievement test scores and lower college application and admissions rates. In order to increase the number of Hispanics becoming health professionals, we must strengthen the K-12 education - math and science education, faculty preparation, health career counseling, and college preparatory education.

The Department of Education should target funds to low income school districts to increase counseling and faculty awareness about health careers

US Department of Health and Human Services grantees for the Health Careers Opportunity Program should be working with the Department of Education grantees in low income school districts with targeted funding to increase counseling about health careers and academic preparation for college.

Health career tracks in high schools –magnets, tutoring

There should be more support for high school education that has magnet schools with health sciences education, including academic preparation and counseling and tutoring for a greater cadre of students in the next generation who excel in math and sciences.

Provide more Hispanic mentors & role models from the health professions at all educational levels

Federal programs should support mentorship programs with Hispanic health professionals in order to provide role models to students who are already in the health care career pathway --- K-12, college, medical school and residency levels. Mentorship programs can increase the motivation of talented students interested in science education to continue to pursue their goals of a health care career. The National Hispanic Medical Association should develop a national mentorship program with its fellow medical societies in partnership with the Federal government.

Support Hispanic students in higher education by providing scholarships & loan repayment programs

Federal agencies should increase scholarships and loan repayment programs, such as the National Health Service Corps targeted to Hispanic students pursuing medical and dental careers who agree to work in clinics in underserved areas upon completing their education. In addition, Federal loan repayment programs should be increased for Hispanic students interested in careers in working in nonprofits and the Federal public health government agencies.

POLICY RECOMMENDATION #3:

Develop Health Career Outreach Programs for Students and their Parents in Low Income Neighborhoods

Develop value of education and awareness of financial aid

Health career training should include information to parents and students about the importance of a successful academic preparation, beginning with math and science achievement in high school and college. The education requirements for medical school need to be discussed to begin the understanding about the long-term commitment to higher education by parents and students. In addition, most low income parents have no knowledge about financial aid in higher education and that funding needed can be obtained as an investment in their child's future.

Federal health career programs should link to clinics, libraries, science museums

Federal health careers preparation programs, in order to outreach to more students and parents, need to provide information through community organizations in targeted regions that can link to clinics, libraries, science museums, and Hispanic Serving Institutions.

Develop a Marketing Campaign about health careers

Federal programs should develop a marketing campaign through multimedia that targets K-12 students and parents as well as college students about the opportunity for health careers and refers them to a national recruitment website. It would be important to measure the outcome and to provide resources such as academic preparation in regions of the country.

POLICY RECOMMENDATION #4:

Reform the Admissions Process of Health Profession Schools to Increase Accepted Hispanics

Fund COE and HCOP & expand focus

The Health Careers Opportunity Program and the Centers of Excellence Program have been supported by the Health Resources and Services Administration to increase the number of disadvantaged students, including minority students, admitted to medical school, dental school and public health school and other health professions.

HRSA has demonstrated that the schools with HCOP programs have had higher rates of admission of minority students compared to the schools without the HCOP program. Since the literature shows that minority physicians and dentists provide increased health care to minority, uninsured and Medicaid patients, we conclude that the HCOP program can increase access to care for underserved populations. The COE program has promoted cultural competence curriculum and minority faculty training which results in more role models to attract more minority students. Both programs have resulted in diversity in medicine.

In 2005, the Congress decimated the funding for both programs. It was strongly recommended that federal government continue to fund both programs at a greater rate and to expand the focus of the activities to enhance the admissions numbers of Hispanic students in medicine and health professions.

Change admissions – increase focus on background, leadership, and underserved interest vs. #s

Federal agencies should work with the medical school grantees to encourage admissions changes from focusing on the academic scores (GPA and the MCAT test scores) to an understanding about the need for students from underserved communities and with well rounded experience showing interest in a health career (leadership in student activities, extracurricular activities in health care, community service).

Increase Hispanic representation on health professions schools admissions committees and on decision making committees

Federal agencies should support leadership development programs that encourage health professions schools to include Hispanic faculty in admissions committees and other decision-making committees, such as dean's advisory committees and Boards of Trustees.

Link recruitment to professionals, alumni

Federal agencies should encourage linking the deans of medical, nursing, public health, dental schools and leaders of Hispanic health professional associations and Hispanic alumni to increase diversity in recruitment efforts of students and faculty

Conclusion

Elena Rios, MD, MSPH
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The National Hispanic Medical Association and the U.S. Department of Health and Human Services' Office of Minority Health sponsored the "Health Disparities and Hispanics Leadership Summit Series" that brought together 300 leaders from a range of occupations in New York, California, and Texas. These stakeholders were asked to discuss the challenges for the Hispanic community about access to health care; prevention of obesity and diabetes; and increasing Hispanics in the health care professions, and to come up with recommendations for Federal policy development for the next five years.

The Summit participants supported the charge for the National Hispanic Medical Association to share the recommendations with Federal policy-makers and to identify those who are the champions for health disparities to educate their colleagues during the future health reform debate.

The National Hispanic Medical Association and the U.S. Department of Health and Human Services' Office of Minority Health recommend that now is the time, during the national health reform debate, to call for a new vision for a comprehensive plan that includes eliminating health disparities and strengthening the health of all Americans.

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Appendix I

National Hispanic Medical Association
And
U.S. Department of Health and Human Services
Office of Minority Health

"Health Disparities and Hispanics Leadership Summit"

New York Academy of Medicine
November 26, 2007

AGENDA

8:30 – 9:00 am	Continental Breakfast
9:00 – 9:20 am	Welcome and Overview Jo Ivey Boufford, MD President, New York Academy of Medicine Elena Rios, MD, MSPH President and CEO National Hispanic Medical Association
9:20 – 9:35 am	Review of Ground Rules and Role of Facilitators Ralph Bates Bates & Associates Huntly, VA Facilitator
9:35 – 9:50 am	*"Increasing Access to Health Care for Hispanics"* Maxine Golub, MPH Senior Vice President The Institute for Family Health Bronx, New York
9:50 – 11:30 am	Small Group Discussion
11:30 am – 12:00 pm	Small Group Reports

12:00 – 12:45 pm	Lunch Garth Graham, MD, MPH Deputy Assistant Secretary Director, Office of Minority Health U.S. Department of Health and Human Services
12:45 – 1:00 pm	*"Increasing Prevention of Obesity and Diabetes"* Ileana Vargas, MD Assistant Clinical Professor of Pediatrics Pediatric Endocrinologist Columbia University
1:00 – 2:25 pm	Small Group Discussion
2:25 – 2:35 pm	Break
2:35 – 3:05 pm	Small Group Reports
3:05 – 3:20 pm	*"Increasing Diversity in the Health Professions"* Nilda I. Soto, MS, Ed Assistant Dean Office of Diversity Enhancement Albert Einstein College of Medicine
3:20 – 4:45 pm	Small Group Discussion
4:45 – 5:15 pm	Small Group Reports
5:15 – 5:30 pm	Concluding Remarks and Next Steps
5:30 – 6:30 pm	Reception

Appendix I-A

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And
U.S. Department of Health and Human Services
Office of Minority Health

"Health Disparities and Hispanics Leadership Summit"

New York Academy of Medicine
November 26, 2007

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Appendix II

National Hispanic Medical Association
And
U.S. Department of Health and Human Services
Office of Minority Health

"Health Disparities and Hispanics Leadership Summit"

Sheraton Grand Sacramento Hotel
January 22, 2008

AGENDA

8:00 – 8:30 am Continental Breakfast

8:30 – 9:00 am Welcome and Overview

8:30 – 8:35 am Guadalupe Pacheco, MSW
Special Assistant to the Director
Office of Minority Health
U.S. Dept. of Health and Human Services
Rockville, MD

8:35 – 8:45 am Elena Rios, MD, MSPH
President & CEO
National Hispanic Medical Association

8:45 – 9:00 am Review of Ground Rules and Role of Facilitators

Ralph Bates
Facilitator
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Huntly, VA

9:00 – 9:20 am *"Increasing Access to Health Care for Hispanics"*

Richard Figueroa
Healthcare Advisor
Office of Governor Arnold Schwarzenegger
Sacramento, CA

9:20 – 11:30 am	Small Group Discussion
11:30 am –12:00 pm	Small Group Reports
12:00 – 12:45 pm	Lunch Robert Ross, MD President The California Endowment Los Angeles, CA
12:45 – 1:00 pm	*"Increasing Prevention of Obesity and Diabetes"* Laura Brainin-Rodriguez MPH, MS, RD Coordinator Feeling Good Project San Francisco Department of Public Health, Nutrition Services San Francisco, CA
1:00 – 2:25 pm	Small Group Discussion
2:25 – 2:35 pm	Break
2:35 – 3:05 pm	Small Group Reports
3:05 – 3:20 pm	*"Increasing Diversity in the Health Professions"* Kathy Flores, MD Director UCSF–Fresno Center for Medical Educational Research California Area Health Education Center & Health Education Training Center Fresno, CA
3:20 – 4:45 pm	Small Group Discussion
4:45 – 5:15 pm	Small Group Reports
5:15 – 5:30 pm	Concluding Remarks and Next Steps

Appendix II-A

National Hispanic Medical Association
And
U.S. Department of Health and Human Services
Office of Minority Health

"Health Disparities and Hispanics Leadership Summit"

Sheraton Grand Sacramento Hotel
January 22, 2008

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Appendix III

National Hispanic Medical Association
And
U.S. Department of Health and Human Services
Office of Minority Health

"Health Disparities and Hispanics Leadership Summit"

Texas State Capitol
Legislative Conference Center
Room E2.002
March 6, 2008

AGENDA

8:00 – 8:30 am	Continental Breakfast
8:30 – 9:00 am	Welcome and Overview
8:30 – 8:40 am	Jenee Garza Gonzales Deputy Legislative Director Office of Senator Leticia Van de Putte Austin, TX
8:40 – 8:45 am	Garth Graham, MD, MPH Deputy Assistant Secretary for Minority Health Office of Minority Health U.S. Dept. of Health and Human Services Rockville, MD
8:45 – 9:00 am	Elena Rios, MD, MSPH President & CEO National Hispanic Medical Association Washington, DC
9:00 – 9:10 am	Review of Ground Rules and Role of Facilitators
	Ralph Bates Facilitator Bates & Associates Huntly, VA

9:10 – 9:25 am	*"Increasing Access to Health Care for Hispanics"* Juan Flores Health Policy Director Clinica La Fe San Antonio, TX
9:25 – 11:30 am	Small Group Discussion
11:30 am –12:00 pm	Small Group Reports
12:00 – 12:45 pm	Lunch Captain Henry Delgado, MS, CIH Regional Minority Health Consultant PHS-Region VI U.S. Department of Health and Human Services Dallas, TX
12:45 – 1:00 pm	*"Increasing Prevention of Obesity and Diabetes"* Eduardo Sanchez, MD Director Health Policy Institute University of Texas Austin, TX
1:00 – 2:25 pm	Small Group Discussion
2:25 – 2:35 pm	Break
2:35 – 3:05 pm	Small Group Reports
3:05 – 3:20 pm	*"Increasing Diversity in the Health Professions"* Ciro Sumaya, MD, MPHTM Chairman of the Board of Directors National Hispanic Medical Association Dean Rural Public Health School Texas A&M
3:20 – 4:45 pm	Small Group Discussion
4:45 – 5:15 pm	Small Group Reports
5:15 – 5:30 pm	Concluding Remarks and Next Steps

Appendix III-A

National Hispanic Medical Association
And
U.S. Department of Health and Human Services
Office of Minority Health

"Health Disparities and Hispanics Leadership Summit"

Texas State Capitol
Legislative Conference Center
Room E2.002
March 6, 2008

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