2005

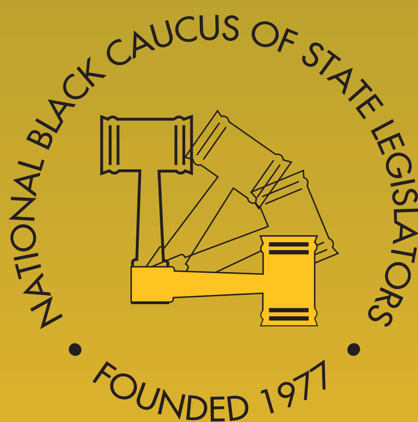
NBCSL and NHCSL

Health Disparities Conference

The Health Care Imperative:

Eliminating Disparities,

Equalizing Access



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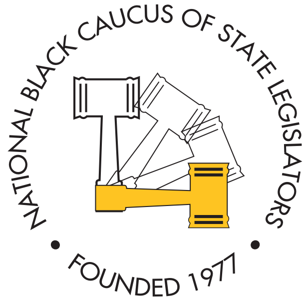
introduction



This year, for the first time, legislators had an opportunity to record television public service announcements (PSAs) on the new Medicare Prescription Drug Benefit, Medicare Part D. The PSAs, filmed throughout the conference, gave legislators an opportunity to encourage their constituents to seek information and enroll in Medicare Part D. Scripts articulating key information on the benefit were available in Spanish and English so that legislators could record in the language best suited to the communities they serve.

Members of the National Black Caucus of State Legislators (NBCSL) and the National Hispanic Caucus of State Legislators (NHCSL) gathered in Monarch Beach, CA, September 15-18, 2005, for the Third Annual Health Disparities Conference.

The gathering serves as a forum for the exchange of information, ideas, legislation, and strategic initiatives to reduce health care disparities in the United States. The 2005 conference focused on traditional areas of health disparities (e.g., mental health and cardiovascular disease), as well as the Medicare Modernization Act and Medicaid.

Introductory speakers for this year's event included North Carolina State Representative Beverly Earle, Health Chair of the NBCSL; Mississippi State Representative Mary H. Coleman, President of the NBCSL; and New York State Assemblyman Felix W. Ortiz, President of the NHCSL. Kenneth Ashton Freeman, MD, JD, Principal and Managing Partner of Baltimore-based Health One Consortium, a health care consulting group, moderated the conference. Garth Graham, MD, MPH, from the Office of Minority Health, gave the keynote address.

This report is based on transcripts from the Health Disparities Conference of the presentations by health care experts to state legislators, as well as synopses of discussions among conference attendees. It is intended for state legislators across the country and for anyone who is interested in the issue of health disparities. We hope the contents of this report will not only educate and enlighten readers but also spark discussion and action toward resolving the many issues of health disparities among minorities.

conference opening

State Representative Beverly Earle (NC)
Representative Earle is the first African American woman to represent a district in Meckelberg County, NC; serve as Democratic House Majority Whip; chair the North Carolina Legislative Black Caucus; and serve as first Vice Chair of the North Carolina Democratic Party. Representative Earle welcomed participants to the Third Annual Health Disparities Conference, stressed the importance of confronting health disparities, and introduced Representative Mary H. Coleman (MS).

Beverly Earle – North Carolina State Representative

State Representative Mary H. Coleman (MS)
As National President of the NBCSL, Coleman represents more than 600 African American legislators from 46 states including the District of Columbia and the Virgin Islands. "In probably any area of health that we can think of, there are huge gaps. It is up to us to focus on where we try to close that gap," she said. In a brief talk, she noted problems with access to health care and the need to reach out to communities in different ways.

" We're all here to make sure that we do the right thing for the people we represent."

Felix W. Ortiz – NHCSL President and New York State Assemblyman

"We have to set policy and identify funds in our legislation to make changes happen," she said.

State Assemblyman Felix W. Oritz (NY)
Representative Coleman introduced NY State Assemblyman Felix W. Ortiz, President of the NHCSL. As president of the NHCSL, Ortiz speaks on behalf of more than 300 Hispanic legislators. Assemblyman Ortiz welcomed participants to the conference and thanked AstraZeneca for its continued support in making health disparities a priority.

Kenneth Ashton Freeman, MD, JD

Dr. Freeman is the Principal and Managing Partner of Health One Consortium, and an Assistant Professor of Health Policy and Bioethics at the Howard University School of Medicine in Washington, DC. His health law practice focuses on federal legislative affairs, technology transfer, and bioethics. Before introducing the speakers, Dr. Freeman asked the audience to pause for a moment of silence in memory of the victims of Hurricane Katrina.

" We have to set policy and identify funds in our legislation to make changes happen."

Mary Coleman – NBCSL President and Mississippi State Representative

opening remarks

Kenneth Freeman, MD, JD

Dr. Freeman discussed topics that the day's speakers would cover in more detail. These included new legislative concerns and issues coming out of Washington, DC, including: the Medicare Modernization Act (MMA); a new payment paradigm for physicians, pay-for-performance; and the racial and ethnic gap in biomedical research. He also spoke about the uninsured and disparities in the prevalence and treatment of cardiovascular disease, mental illness, diabetes, and obesity.

Dr. Freeman noted that a recent paper in the *Journal of the American Medical Association* reported significantly longer door-to-door times for myocardial infarction patients identified as African American and Asian/Pacific Islander compared with those identified as white. There were also significantly longer door-to-balloon times for African American or Hispanic patients compared with their Caucasian counterparts. "You'd like to think that in America, heart attack patients would get the same type of treatment across the board, but that isn't so," he said.

"We're here together to try to figure out strategies and policy considerations that will be good not only for African Americans and Hispanics but for all the American people."

There are also racial and ethnic differences in the prevalence of diseases, particularly diabetes and obesity. "Between 5 and 7 million people of Hispanic ancestry have type 2 diabetes," he said, "and this is an estimate. It may indeed be more." According to Dr. Freeman, African American and Hispanic communities are especially hard hit by diabetes and obesity. "One of the biggest challenges," he said, "is obesity in children and teens." Dr. Freeman cited education as a primary weapon in the battle against the disease.

He also talked about the exclusion of minority patients and clinicians from biomedical research in the United States and around the world. "Historically," he said, "Black and Hispanic clinicians and patients have been left out of clinical trials. Those are policy considerations that need to be addressed." Before introducing the keynote speaker, Dr. Garth Graham, he summed up the goals of the conference: "We're here together to try to figure out strategies and policy considerations that will be good not only for African Americans and Hispanics but for all the American people."

keynote address

Garth N. Graham, MD, MPH

Garth N. Graham, MD, MPH, is the Deputy Assistant Secretary for Minority Health in the Office of Minority Health (OMH) at the Department of Health and Human Services. The mission of the OMH is to improve the health of racial and ethnic populations through the development of effective health policies and programs that help to eliminate health disparities.

Dr. Graham began his presentation by stating that he had changed the original focus of his talk because of Hurricane Katrina. According to Dr. Graham, storm-related insights and responses have shifted the perspective on minority health and altered the context of the conversation on health care disparities. "The key word is change," he said, "change in the challenges faced by the Department of Health and Human Services, change in the challenges faced by the Office of Minority Services, and change in the challenges faced by all of us involved in what is perhaps one of the greatest population displacements in the history of this country."

According to Dr. Graham, a new understanding of some of the personal challenges faced by displaced people has altered perspectives on the issues of minority health and health disparities. He noted the need to shift government and nongovernmental assistance from short-term aid to long-term support. "The conversation is about endurance," he said, "how we'll deal with the issue not just 3-6 months from now but also 3-6 years from now." He explained that the impact of Katrina will be felt nationwide, especially by those in leadership positions. "Whether you want it or not," he said, "each of you is going to play a role in this."

Dr. Graham stressed the importance of being cognizant of the challenges faced not only by those who have been uprooted from their homes and communities but also by health care providers treating patients of ethnic and racial backgrounds they may have never encountered before. According to Dr. Graham, a lot of health care providers have no idea how to relate to minority patients.

"This is more than a Black issue, a Hispanic issue, or an Asian American issue. It's an American issue writ large, a time for national unity."

He said that while the government can't effectively communicate with all displaced people, one of its goals is to help the many local organizations that offer aid to individuals. "We're bringing people together in ways that haven't been done before," said Dr. Graham, citing alliances that include national associations of African American and Hispanic physicians and African American psychologists, social workers, and nurses.

In discussing Medicare and Medicaid, Dr. Graham noted that 87% of minorities, especially African Americans and those over age 65, have required a prescription drug within the last three months. He said that Medicare, for the first time in its history, is going through major changes. "Medicare is going to be paying for prescription drugs," Graham said. He emphasized the need to help constituents take advantage of the benefit during the upcoming enrollment period.

For the average individual, Medicare will pay about $1,300 in prescription drug costs; for low-income beneficiaries, mainly African American and Hispanic, it will offer additional assistance of around $4,500. "That kind of money can go a long way in helping people take care of themselves," Dr. Graham said. He stressed the need for legislators to get the word out about enrollment, which is from November 15, 2005 to May 15, 2006. "This benefit is real," he said. "It's actual dollars—money that people in minority communities can use to their advantage."

"We're talking to people in the health care industry and other communities, bringing them together in ways that have never been done before."

Dr. Graham concluded his talk by reiterating the need for a new kind of unity. "In this post-Katrina world, it can't be business as usual, the same old conversations, the same old dynamics, the same old politics." He urged legislators to talk about policies and programs that will bring people together. He encouraged them to understand their calling in terms of the challenges facing the country today. "This is more than a Black issue, a Hispanic issue, or an Asian American issue," he said. "It's an American issue writ large, a time for national unity."

After Dr. Garth's presentation, comments were heard from the floor. Topics included the need for high-level government action to resolve the problem of the uninsured and those without access to any health care; differences between state and federal approaches to securing aid in the wake of Hurricane Katrina; and how best to access minority health resources at the federal and state levels. Several people discussed concerns about the federal response to Hurricane Katrina.

comments and quotes
from the floor

Texas Senator Leticia Van de Putte discussed a lack of common cause between state and federal approaches to care for displaced victims of Hurricane Katrina. "[In San Antonio], we had about 120,000 people in need of immediate access to WIC (Women, Infants and Children federal program) and other federal programs. While our first priority was to help people, they were more concerned with preventing fraud. It was a total disconnect," she said.

"While our first priority was to help people, they were more concerned with preventing fraud. It was a total disconnect."

"If we can't help, we'll figure out who can, and give them the resources to get the job done."

"The mentality within the beltway is not real life. It's very difficult to get over that when we're trying to do good policy."

Dr. Freeman conveyed a story about how unnecessary red tape prevented an emergency physician from getting to Louisiana to help people. "The online license application was 161 pages," he said, noting that FEMA also required a medical license, DEA number, and four letters of recommendation. "This is an organization chartered by the federal government to get physicians to disaster sites right away. Clearly, this was no way to go about achieving that goal."

"We have a lot of work to do on the bureaucracy before we can get things done."

Dr. Graham compared changes in federal-state relationships to a learning curve; a process with bumps in the road. He said that the federal government responded to the needs of Katrina's victims by doing away with a great deal of paperwork and by supporting local agencies and caregivers. "If we can't help, we'll figure out who can and give them the resources to get the job done."

cultural competency and health policy

Valerie Romero-Leggott, MD

Dr. Romero-Leggott currently serves as Associate Dean of Cultural and Ethnic Programs at the University of New Mexico (UNM) Health Sciences Center/School of Medicine. Among other roles, she is also an Assistant Professor in the Department of Family and Community, and Chair of the Caucus of Minority Women in Medicine.

Dr. Romero-Leggott defined cultural competence as a tool to provide quality care, and, in that way, reduce health disparities. She cited studies supporting the integration of cross-cultural education into clinician training and spoke about policy and legislation on cultural competency in medical education.

According to Dr. Romero-Leggott, the attitudes, knowledge, and skills of cultural competence raise awareness, enhance communications, and strengthen the bond between clinicians and patients. "The provider-patient relationship is the fundamental unit of medical care," she said. Dr. Romero-Leggott stressed the need for clinicians to be aware of their own assumptions and biases as well as those of the US medical system: to learn about the surrounding communities that patients come from; and to acquire the skills needed to elicit their cultural and social contexts.

"No one can know everything about every culture, but every one of us can listen with respect and learn how to appreciate the values and beliefs of our patients."

She explained that a significant body of literature supports the importance of cross-cultural education in the training of health care professionals, and that such programs are recognized and required by accreditation bodies. "The Liaison Committee on Medical Educations has mandated cultural competence training for all undergraduates in medical school, and the Accreditation Council for Graduate Medical Education has done the same thing for residents," she said.

Dr. Romero-Leggott described current models and practices. She said that the University of California, San Francisco has a cross-cultural medicine curriculum in place, and that the University of Texas Health Science Center is developing one for preclinical medical school students. She reported that the UNM School of Medicine is creating and implementing a curriculum for medical students, as well as faculty and residents.

According to Dr. Romero-Leggott, New Jersey is the first state in the nation to pass legislation requiring training in cultural competence as a condition for medical licensure. She also cited New Mexico for its efforts to mandate cultural competence training for all health care professionals. "No one can know everything about every culture," she said, "but every one of us can listen with respect and learn how to appreciate the values and beliefs of our patients."

"The attitudes, knowledge, and skills of cultural competence raise awareness, enhance communications, and strengthen the bond between clinicians and patients."

mental health and health policies

Karen M. Johnson, MD

Karen M. Johnson is Associate Professor of Psychiatry at the David Geffen School of Medicine at the University of California Los Angeles (UCLA) and Medical Director and Director of Academic Affairs at the Augustus F. Hawkins Comprehensive Community Mental Health Center.

Among other topics, she spoke about bridging the gap between health care and mental health, the role of cultural competency in providing effective care, and the treatment needs of special populations. She also discussed her role as a patient advocate. "I speak as a patient advocate because very often, my patients cannot speak for themselves," she said.

Dr. Johnson talked about using information to bridge the gap. "When physicians make choices on medications and treatments, they need to go beyond insurance and what's in the formulary. They need to tell patients how their diagnosis will affect their lives, give them sound choices, and communicate costs in meaningful ways."

She discussed the role of cultural competency. "Knowing that someone is Hispanic isn't enough to provide effective care. There are major differences in the life experiences of patients." She also explained the need to educate patients, as well as families. "There's a family dimension with every patient," she said, "even the homeless."

According to Dr. Johnson, special populations (including children, the elderly, and the homeless) are at heightened risk. "These are the people who fall through the cracks,"

"Mental health problems don't discriminate. It's our responsibility to know how to care for the severely mentally ill, and to provide services in the best ways that we can."

she said, "the ones who need more comprehensive and personalized support." In developing treatment plans, she encouraged physicians to consider the cares and concerns of these patients (e.g., transportation, job skills, cognitive deficits).

"It's not enough to know that someone abuses alcohol or drugs," she said. "We need to know what they take and how often. How much they spend every week, and where they get their money." She emphasized the importance of identifying the specific needs of patients and of developing programs that will be most helpful to them.

"I speak as a patient advocate because quite often, my patients cannot speak for themselves."

cardiovascular disease

Maria L. Rios, MD

Dr. Maria L. Rios is a Clinical and Preventive Cardiologist in Private Practice in Puerto Rico. An expert in antihypertension therapies and clinical trial design, she has published extensively on the subject of women and heart disease.
Dr. Rios' presentation focused on cardiovascular health in Hispanics. She reviewed the epidemiology of cardiovascular disease (CVD) in different ethnic groups and described and compared various risk factors in the Hispanic population. She discussed disparities in cardiovascular diagnosis and care and lack of minority involvement in clinical research.

According to Dr. Rios, cardiovascular disease is the leading cause of death for all men and women. Of its components, coronary heart disease is the number one killer, followed by strokes and congestive heart failure. "Congestive heart failure is the most frequent diagnosis for hospitalization among Medicare patients," she said, noting that its prevalence is increasing and will continue to do so as the population ages. Strokes cause 18% of CVD mortality and are the leading cause of disability in the United States.

Ethnicity and gender play roles in the incidence of CVD. African Americans usually have a more malignant form of hypertension. Puerto Ricans have the highest incidence of diabetes. While Hispanics have lower CVD mortality than other groups, Hispanic men have the highest incidence of metabolic syndrome (a clustering of cardiovascular risk factors). Dr. Rios said that regardless of ethnic group, more women die of CVD than men and have been doing so for the past 20 years. "Most people don't know that," she explained, "but we need to make them more aware."

"We're multicultural, multinational, and most likely, multigenetic, with different predispositions to several diseases."

Other factors that come into play

include socioeconomic status and education. Hispanics earn less and have higher poverty rates, she said. The dropout rate is also much higher for Hispanics than it is for other ethnic groups. “Forty percent of Hispanics under age 56 have no health insurance, and those who do are underinsured. We need wider use of statins, beta blockers, and angiotensin-converting enzyme inhibitors [ACE inhibitors],” she said. “We need programs to increase funding for medications, treatment, and follow-up.”

Dr. Rios referred to several major studies including the National Health and Nutrition Examination Surveys, Heart Outcomes Prevention Evaluation, and meetings such as the First Latin American Symposium of Heart Disease in Women. She noted the importance of clinical trials in the development of treatment guidelines, and stressed the need for more minority involvement. “We like to think we practice evidence-based medicine, but to target treatments for patients, we need more Hispanics and African Americans in clinical trials.”

“We like to think we practice evidence-based medicine, but to target treatments for patients, we need more Hispanics and African Americans in clinical trials.”

luncheon on the St. Regis monarch beach grand lawn

Featured speakers at the luncheon session included Marion McCourt, Vice President of Government Policy and Managed Markets for AstraZeneca, and Julia A. Burgos, National Director of Latino Initiatives for the American Diabetes Association.

Marion McCourt

Marion McCourt introduced members of the AstraZeneca policy and government teams and acknowledged the morning's speakers. "This morning, I heard all the speakers," she said. "I learned something from each and every individual who stood at the podium." She assured conference participants that she and her colleagues would take the messages on the importance of health disparities back to AstraZeneca. At the same time, she reiterated the mission of the legislators: to bring the information from the conference back to their constituents.

Prior to introducing Julia Burgos, she emphasized a core value of AstraZeneca: "You can count on AstraZeneca to bring excellent quality medicines to the marketplace. That's what we do," she said, "but it's only half of our job. Our mission is to make sure that those fine medicines, current and future, get to each and every patient who needs them." McCourt said that the afternoon program would focus on the Medicare Modernization Act and Medicaid.

"Latinos are 1.5 times more likely to develop diabetes than non-Latino whites, and the numbers for African Americans are very much the same."

Julia A. Burgos
Julia Burgos is responsible for the extension and oversight of the American Diabetes Association's Latino initiatives. She develops programs and trains Latino staff throughout the country to broaden outreach about diabetes and its complications into Latino communities

According to Burgos, an estimated 324 million people will have diabetes by 2025. Latinos are 1.5 times more likely to develop the disease than non-Latino whites, and the numbers for African Americans are very much the same. Burgos said that 2 million Latinos in America have diabetes, or 2.2% of those over the age of 18. Latinas have double the likelihood of developing diabetes compared with the general population, and those who have gestational diabetes are 60% more likely to develop type 2 diabetes within 20 years of pregnancy.

Burgos spoke of the relation between diabetes, heart disease, and hypertension. "In all our materials, PSAs, and awareness messages," she said, "we show the three as linked." She described problems Latinos and African Americans have in accessing care including lack of insurance, transportation, and childcare. Cultural differences also contribute to miscommunications, noncompliance, and less than optimal care. She talked about the cost of diabetes. "One in 10 health care dollars is spent on the disease," Burgos said.

"Diabetes is manageable– a disease that can be controlled. You can help your constituents understand that."

She called on legislators to highlight the issue and look for ways to introduce legislation that will focus attention on it in their states. "We need laws that require insurers to provide adequate coverage for diabetes supplies and education." According to Burgos, current laws in 46 states and the District of Columbia cover up to 5.7 million Americans, but if proposed legislation passes, millions of people with diabetes will lose available health protection.

"Diabetes is surrounded by unnecessary shame and despair," she said. She called on legislators to communicate the risks and complications, as well as the hope. "Diabetes is manageable," she said, "a disease that can be controlled. You can help your constituents understand that."

medicare overview

Donald M. Muse, PhD

Donald M. Muse, PhD, is Founder and President of Muse & Associates. His special areas of interest and expertise include the Medicare and Medicaid programs.

His presentation included a brief overview of the Medicare Modernization Act of 2003 (MMA), a review of minority health in general, and of the Medicaid program in particular. He discussed how Medicaid is a huge driver of care, and could be an even more important one in the future; what will happen to prescription drug coverage for minorities when the MMA goes into effect; and the role states will play in the implementation and administration of Medicare's new drug benefit.

"Today we have 58 million people on Medicaid. What we're faced with now is another 8 to 10 million who are eligible for the program but don't currently receive benefits."

After January 1, 2006, the federal government will pay for approximately half of all prescription drugs in the United States. "This is a first," said Muse. He explained that the new drug benefit includes a $35 per month premium with a $250 deductible; a 25% co-pay from $250 to $2,250; no coverage from $2,250 to $5,100; and a 5% co-pay above $5,100. Dual eligibles, people in Medicare and Medicaid, will be automatically enrolled in Medicare Part D.

Muse reported that states will no longer receive matching funds for prescription drugs for Medicaid recipients. "If you want to supplement the coverage, it has to come out of state-only funds," he said, emphasizing the importance of good record keeping on dual eligibles.

He noted that states have a lot of work to do. "One state I've been working with has identified 171 tasks," he said. They run the gamut from changing state laws and working with Federal agencies to educating program participants and coordinating with Prescription Drug Plans. "Today we have 58 million people on Medicaid. What we're faced with now is another 8 to 10 million who are eligible for the program but don't currently receive benefits."

According to Muse, there are more uninsured African Americans and Hispanics than whites. About 28% of Hispanics and 37% of African Americans are dependent on government programs for their care. Minorities rely on Medicaid at three times the rate of whites. "To improve quality of care," he said, "try to work with Medicaid. Laws that improve the care of minorities have a spillover effect on the rest of the population."

Muse ended his presentation with a discussion about fraud. He said Blacks are more likely to have multiple comorbidities (conditions that exist at the same time) and therefore require more prescriptions. However, most drug abuse is by non-Hispanic white recipients. "There's a huge misunderstanding," he said. "The people [non-Hispanic whites] who have better access to and are more able to manipulate the system are the ones who abuse drugs."

"To improve quality of care, try and work with Medicaid. Laws that improve the care of minorities have a spillover effect on the rest of the population."

medicare drug benefit:
impact on states

Linda J. Schofield, MPH

Linda Schofield, MPH, is President of Schofield Consulting. She's a former executive director of Aetna's health plan in Connecticut and Kaiser Permanente of Massachusetts and a former director of the Connecticut Medicaid program.

Schofield covered key MMA issues for Medicaid, the State Pharmaceutical Assistance Programs (SPAPs), other agencies, and state retiree benefits. "A lot of state people think that they can sit back because this is a federal program. But state citizens are involved," she said, "and states need to step up to the plate."

"The MMA is groundbreaking legislation. It has broad implications at federal and state levels for many agencies and those they support through Medicare and Medicaid."

According to Schofield, general concerns include: access to and continuity of care; the potential impact on nondrug costs carried by states in the event of inadequate prescription drug access; the need to commit resources to educate and assist beneficiaries and adapt state programs to MMA; and the impact on state budgets. "States are the safety net providers. When things go wrong," she said, "people don't go running to the federal government. They go to someone who's more local."

Regarding Medicaid savings, she discussed clawback issues and options. These included amounts based on 2003 per capita payments, and the effects of the annual inflation factor. "The clawback was designed to result in some savings for the states," she said, "but the choice of base year and the inflation factor may wind up eroding rather than creating savings."

Other issues she covered included: enrollment; public education; protection for dual eligibles; training for related agencies and providers; transition issues, particularly those concerned with mental health clients; the role of SPAPs; and the impact of mail order drugs on Prescription Drug Plans (PDPs).

"States are the safety net providers. When things go wrong, people don't go running to the federal government. They go to someone who's more local."

She also discussed the benefits of becoming a state-sponsored PDP, and the Federal government's role in encouraging employers to retain their retiree benefits. "The MMA is groundbreaking legislation," she said. "It has broad implications at federal and state levels for many agencies and those they support through Medicare and Medicaid."

panel discussion

experts on MMA

The panel included Shirley Bordelon, Analyst, Medicare Operations, Centers for Medicare & Medicaid Services, Linda Schofield, and Donald Muse

"Any beneficiary who needs information on the prescription drug plan will get that information."

Shirley Bordelon

"If you have prescription drug coverage that's as good if not better than Plan D, keep it."

Don Muse

The 75-minute panel discussion covered a wide range of topics. Types of questions and issues discussed included

- Whether individuals in Medicaid Advantage Plans (i.e., HMOs) should enroll in Medicare Part D
- Whether information on the MMA is available in Spanish, Haitian, Creole, and other languages
- The Medicare appeals process
- When information will be distributed to states
- Who should enroll in the new drug benefit
- The length of the enrollment period
- Penalties for not joining within the enrollment period
- Enrollment period exceptions for Katrina victims
- Support for pharmacists and other health care providers.

"The key is creditable coverage. It's critical that beneficiaries who don't enroll have the right information about whether they have creditable coverage."

Shirley Bordelon

"Dual eligibles don't have to worry about late enrollment. They'll be randomly assigned and auto-enrolled into average- or below-cost plans."

Linda Schofield

DEFINITION

Creditable coverage: prescription drug coverage that is offered in the private sector either through employers, private health plans, or through other appropriate channels that are deemed equal to or better than the option offered by Medicare Part D.

The 2005 Health Disparities Leadership Award

In recognition of invaluable leadership and legislative contributions to close the gap in health disparities

"By doing the right thing for Hispanics and other minorities, we're doing the right thing for all Americans."

Felix W. Ortiz –
NHCSL President and
NY State Assemblyman

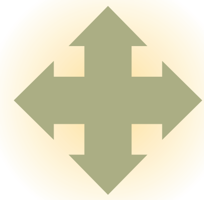
This year's awards dinner launched a new tradition—the presentation of a Health Disparities Leadership Award to two legislators who have shown an exceptional commitment to addressing health disparities in their communities. The 2005 award recipients were Assemblyman Felix W. Ortiz (NY) and Representative Joseph Armstrong (TN).

"Our work's not done until we eliminate the disparities and the statistics that track them. I know that together, we can do the job."

Joe Armstrong –
NBCSL Vice Chair of the
Committee on Health and
Tennessee State
Representative

Breakout

SESSION #1



Sustaining the future of Medicaid after 2006

**Saturday Morning –
Monarch Beach, CA**

Ken Freeman started the Saturday sessions with a recap of the prior day. He then introduced Warren Jones, MD, and Linda Schofield. They spoke on Sustaining the Future of Medicaid after 2006. Dr. Jones is the Distinguished Professor of Health Policy, Senior Health Policy Advisor, University of Mississippi Medical Center. Don Muse moderated the session.

Subjects raised

- State's health care crisis
- Need for and nature of cultural sensitivity
- Power of special interests
- Importance of staying current on all health care legislation
- Status of America's health care system
- The conflict between the need to improve health care and the pressure to cut and contain costs
- The role of providers in perpetuating ongoing budget crises
- The drawbacks of the wraparound approach
- The benefits of a single payer system

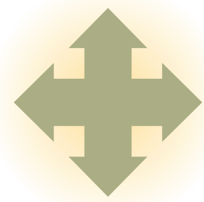
"Cultural sensitivity is not a competency that we measure. It has to be a proficiency that we inculcate into what we do every day."

Warren Jones, MD

"Policymakers need to do a better job in attaching value to the quality of care. Dollars saved is not always an appropriate benchmark."

Linda Schofield

Breakout
SESSION #2



Improving Cardiovascular Care and Working with the Uninsured

Moderator: Lucy Arce-Ferrer, State Senator, PR, Chair of the Puerto Rico Senate Health Committee and NHCSL's Health Care Task Force Chair

Participants: Maria L. Rios, MD, San Pablo Hospital, PR

Anthony M. Fletcher, MD, FACC, FSCAI, Cardiologist, Director of the Cath Lab, St. Vincent Infirmary Medical Center, AR

Rickie C. Keys, MPH, PhD, Founder and Executive Director, National Institute to Combat Health Disparities

Subjects raised

- Timely presentation for symptoms of heart attack or stroke
- A national heart attack and stroke education campaign for people of color
- The importance of education in prevention, access, and timely treatment
- Lack of funds for education programs
- Misrepresentation of risks associated with statins
- Bias in the US medical system
- The impact of fear, misunderstanding, and folklore
- Lack of physical education in public schools
- Cardiovascular disease in children

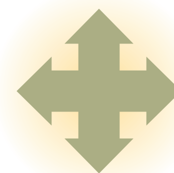
"Stop sanitizing poverty in America. We all know there's no advancement without education. We all know that lack of education is lack of health care."

Senator Billie Breaux (IN)

Factoids

- Only 43% of Hispanics know that they have hypertension
- Diabetes is a major risk factor for CVD; it ranks first in health problems for Hispanics
- In Puerto Rico, 20% of people are uninsured
- Strokes are the leading cause of disability in the United States
- People of color have heart attacks and strokes at a higher rate than the general population
- Morbidity and death from heart attacks and strokes is higher in African Americans and Hispanics compared with the general population
- Fewer African Americans are referred for coronary artery bypass surgery
- Hispanics and African Americans develop hypertension at a younger age than their non-Hispanic white counterparts

Breakout
SESSION #3



Transition of Mentally Ill (re-entry) and the Uninssured Including Best Practices

Moderator: Beverly Earle, NBCSL Health Chair, and State Representative (NC)

Participants: Sergio Aguilar-Gaxiola, MD, PhD, Professor, Department of Psychology, California State University, Fresno, and Principal Investigator, Mexican American Prevalence and Services Survey

Martin Guerrero, Jr., MD, Director of Geriatric Psychiatry, Assistant Director of Research, Department of Psychiatry, Texas Tech University Health Sciences Center, El Paso

Patrice Harris, MD, Medical Director, Georgia Rehabilitation Outreach and Clinical Associate Professor, Department of Psychiatry and Behavioral Sciences, Emory University

Subjects raised

- The economic impact of mental disorders
- Disparities in access to treatment and quality care
- The criminalization of adolescent behavior
- The politics of childhood diagnoses
- The benefits of mental health courts
- The need for more police training
- Increasing rates of geriatric dementia
- Off-label utilization of medications

Factoids

- Most mental disorders start early in life
- Mental disorders account for 5 of the top 10 causes of disability
- About 36% of uninsured individuals are Latinos
- Mental health problems are especially prevalent among second- and third-generation Latinos
- Only about 5 states have mental health courts
- More than 63,000 Americans have been victims of suicide since 2003
- About 50% of the population suffers from one or more mental disorders, with similar rates between African Americans, Hispanics, and non-Hispanic whites
- Ethnicity makes a difference in how drugs are metabolized
- Lack of advocacy limits access to care

"Though brain disorders are equal opportunity diseases, people of color have less access to treatment and get poor quality of care." Patrice Harris, MD

"It is critical for Americans to understand that mental health is essential to overall health." Sergio Aguilar-Gaxiola, MD, PhD

"Access to basic care is compromised in minorities. They've been sicker longer, and start off with more comorbidities." Martin Guerrero, Jr., MD

what Katrina revealed

Texas State Senator Leticia Van de Putte spoke briefly about her experiences as a pharmacist serving as part of a medical team assisting victims of Hurricane Katrina and about the steps Texas has taken to help the victims. She described the conditions of people being treated, as well as the despair, hope, and challenges ahead.

"We never saw the two Americas before. Now the whole world has seen them."

"The people we were helping believed that America left them behind because they're poor and black."

"I went on a medical team because the last thing these folks needed was another politician and another press conference."

gallery of photos

gallery of photos

additional resources

National Black Caucus of State Legislators
www.nbcsl.com

National Hispanic Caucus of State Legislators
www.nhcsl.org

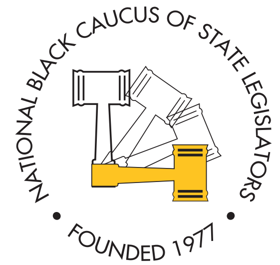
Office of Minority Health
www.omhrc.gov

Office of Minority Health Research
www.ninds.nih.gov/funding/minorities_and_disabilities_pr.htm

Health Resources and Services Administration (HRSA)
www.hrsa.gov

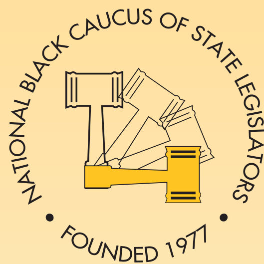
Centers for Disease Control and Prevention (CDC)
Office of Minority Health
www.cdc.gov/omh

About the National Black Caucus of State Legislators



Founded in 1977, the National Black Caucus of State Legislators (www.nbcsl.com) represents more than 600 legislators from 46 states that represent more than 30 million voters. NBCSL provides information to legislators on a number of policy issues. The primary mission of the organization is to develop, conduct and promote educational, research and training programs designed to enhance the effectiveness of its members, as they consider legislation and issues of public policy which impact, either directly or indirectly upon "the general welfare" of African American constituents within their respective jurisdictions.

The National Hispanic Caucus of State Legislators (NHCSL) is the preeminent organization representing the interests of more than 300 Hispanic state legislators from all states, commonwealths, and territories of the United States. Founded in 1989 as a nonpartisan, nonprofit 501(c)(3), NHCSL is a catalyst and advocate for joint action on issues of common concern, such as health, education, immigration, homeownership and economic development to all segments of the Hispanic community. NHCSL also works to design and implement policies and procedures that will impact the quality of life for Hispanic communities; serves as a forum for information exchange and member networking; an institute for leadership training; a liaison with sister U.S. Hispanic organizations; a promoter of public/private partnerships with business and labor; and a partner with Hispanic state and provincial legislators and their associations representing Central and South America. For more information visit www.nhcsl.org.



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