UNITED STATES OF AMERICA

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THE PRESIDENT'S INITIATIVE ON RACE

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Health Care Rx: Access For All, U.S. Department of Health and Human Services Town Meeting on Race and Health

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FRIDAY

JULY 10, 1998

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BOSTON, MASSACHUSETTS

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The Advisory Board to the President's Initiative on Race met at the Great Hall, Faneuil Hall, Boston, Massachusetts, at 9:33 a.m., Claude Earl Fox, III, M.D., M.P.H., Moderator, presiding.

BOARD MEMBERS:

DR. JOHN HOPE FRANKLIN, Chairman
GOVERNOR THOMAS H. KEAN
GOVERNOR WILLIAM WINTER
MS. JUDITH WINSTON, Executive Director

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(9:33 a.m.)

DR. FOX: I'm Dr. Earl Fox, the Administrator for the Health Resources and Services Administration.

We're the federal agency in HHS that is charged with ensuring access to essential care, for under-served Americans. We appreciate each of you joining us today for this Health Care Rx: Access For All, U.S. Department of Health and Human Services Town Meeting on Race and Health.

I'd like to take just a minute at the beginning to thank a number of people who have been helpful and without whose involvement this day would not happen, including to begin with, Judith Winston, who is the Executive Director of the President's Initiative on Race; Laura Harris, consultant to the President's Initiative on Race Advisory Board; Dennis Hayashi, who will be introduced a little later; Judith Kurland, on my left, who is HHS Regional Director for New England; Marilyn Gaston, who is the Associate Administrator for the Bureau of Primary Care within HRSA, and the other HRSA and regional office staff.

We also are fortunate to have with us

today, several members from Worcester Community Conversation on Race Relations. Congressman Jim McGovern has convened this group and I understand that several members are in the audience and we are pleased to have them with us. And also, the advocacy group Health Care for All, has a large presence here today, and this is a consumer based organization that is dedicated to the principle that health care is the right of every man, woman and child in Massachusetts. Health Care for All has worked tirelessly for the rights of all consumers, particularly the uninsured and under-insured, since 1985.

We also, I understand, will have some members of staff from the congressional delegation, most of them are in Washington today for some votes that are going to be taken on the floor.

We are here today to discuss barriers, barriers and bridges to health care for racial and ethnic minorities. We do have an ambitious agenda this morning and I know you are as eager as I am to hear the perspectives of those on the panel, and actually, we are anxious to hear comments from you as well.

It’s my pleasure to open this meeting this

morning with a welcome from the President of the United States. As most of you, I hope, know, the President is absolutely committed to improving the quality of race relations in this country.

The President's Initiative on Race, which this meeting and the Health and Human Services initiative to eliminate racial disparities in health, are important parts, this is a vital force, we hope, to promote a national dialogue on race issues, to increase the understanding of the history and the future of race relations, hopefully to promote increased opportunities for all Americans and to address other pressing issues related to race.

Ladies and gentlemen, the President of the United States, Bill Clinton.

Roll the video.

(Whereupon, U.S. President William Clinton addressed the assembly via a videotaped message.)

PRESIDENT CLINTON: I'd like to welcome you and thank you for participating in this important conversation about race in America. America has always stood for the shining ideal that we are all

created equal. We haven't always lived up to that ideal but it has guided our way for more than two centuries.

As we enter the 21st Century, we know that one of the greatest challenges we still face is learning how we can come together as one America. America will soon be the most diverse nation in the world, will those differences divide us or will they be our greatest strength? The answer depends on what we are willing to do together.

We must confront our differences in honest dialogue, yes, but we must also talk about the common dreams and the values we share. We must fight discrimination in our communities and in our hearts and we must close the opportunity gaps that divide too many Americans in real life.

That is why I launched this national initiative on race and I'm very glad you're joining us, your views, your ideas, they are very important, I ask you to share them with Dr. Franklin and the members of my Advisory Board. They are helping me reach out to communities like yours all across our nation. I look forward to hearing from them about the results of your conversation.

Please go back to your neighborhoods, your schools, your work places, your places of worship, and continue this conversation about race. Take a leadership role. Together we can build a stronger America for the 21st Century, as one America. Thank you for helping us to meet this most important challenge.

DR. FOX: I always wanted to say, roll the video.

(Laughter)

DR. FOX: We are now, before we move into our keynote address and our discussion with our two panels, going to have a few remarks by members on the podium here.

I'd first like to introduce Judith Kurland, Judith Kurland is the Regional Director for HHS for the New England Region. Judith not only has been Commissioner of Health for the City of Boston but has worked tirelessly to help the under-served in many communities in this region receive care, and also has been extremely involved and instrumental in this meeting becoming a reality. And I'm going to ask Judith to introduce our next presenter.

MS. KURLAND: Thank you, Earl.

On behalf of the New England Region of HHS, I'd like to welcome Dr. Franklin, Governors Kean and Winter, we are honored that you've chosen Boston, that you've come here to have this conversation about race and health.

And perhaps no other building symbolizes our city's and our state's and our nation's struggle on the interest of race than this building, which at one point was a slave market and was also the place where the Sons of Liberty met, to talk about a new nation, and where abolitionists met later, and yesterday, 500 eager people of every shade were sworn in as our newest American citizens. So I think this shows our ups and downs but our hope for steady progress on the issues of race.

Boston is a city that works and it works in great measure because the man that I have the honor to introduce works, he works really hard. And his goal is actually so simple and so elevated, it is that this city be a place of hope, opportunity and success for everyone who is in it, all of those who work here, all of those who come here. Those whose families have been here hundreds of years and those who came yesterday.

He has struggled to make sure that all children get the benefits of a superb education, that health care is available and appropriate for all. He has made this city, once again, a beacon to the nation. It's my honor to introduce the Mayor, Tom Menino.

(Applause)

MAYOR MENINO: Thank you, Judith, and welcome panelists, to Boston. Judith, thanks for that great introduction.

Judith, at one time, was the Commissioner of Health and Hospitals for the City of Boston, and even though she was appointed by the previous administration, she had some problems there. I was a city councilor at the time, and it was always a twelve to one vote, with Judith, I was the only supporter, and Judith was the commissioner. She had the good ideas but you know how mayors sometimes control the agenda.

(Laughter)

MAYOR MENINO: But Judith was a breath of fresh air when she was Commissioner of Health and Hospitals.

Let me first welcome you all to this

historic town meeting on race and health. You have come to the right place and the right city to discuss this pressing issue. Nearly 200 years ago, Paul Revere founded the nation's first local board of health, right here in Boston. Because of this early public health agency, Boston weathered an outbreak of cholera, in 1832, with almost no deaths, far better than other cities in this country.

I am proud of our tradition of our concern for the health of all people and proud today to uphold this value as a major priority in our city's administration. Two years ago, we took the bold steps of merging, to keep the city's public hospital open to serve all who came to its doors, Judith and I started that five years before I became mayor, we could never get anybody to listen to us about merging a public hospital and a private hospital, when I became mayor there was only one decision maker, it was me, and we did it.

Because it was important to save the mission of Boston City Hospital. That was so important. Let me just say today, we have maintained the mission, health care for all, no matter whether you can pay or you can't pay, no matter where you came

from, that hospital, Boston Medical Center today, is doing the job that I committed to over two years ago.

At the same time as the merger happened I established Boston's first Public Health Commission, led by a diverse board of experts, and John Auerbach is in the front row there, is executive director. It takes an active leadership role to insure the health of all Bostonians, regardless of their race, income, or their language.

Boston boasts some of the world's best medical facilities. As I often say, there is no reason why we can't make sure every one has access to quality health care. Every child, every person, every family, deserves the information and care they need to be safe and healthy. Because we focus on this issue of equality in Boston we have had some successes in improving access to health care for communities of color. We worked hard to achieve the nation's highest child immunization rate for all our children. And 1997 marked the third consecutive year in a row we claimed the honor.

We have substantially decreased infant mortality among black children, narrowing the gap between blacks and whites. But we can't rest on our

laurels, we still have a lot of work to do. Unfortunately, down in Washington, the majority of Congress isn't willing to take action on these issues.

But as a city and as a nation, we cannot and we must not sit by while too many African-American women are dying of breast cancer compared to their white counterparts And while mortality from AIDS is increasing for blacks and Hispanics at the same time it's decreasing for whites. That is why my Public Health Commission will launch a new mammogram van to reach more women with early detection services, which is so important. That's why in the last two years I increased by 20 percent, my budget for expanded HIV/AIDS education and treatment services.

With communities of color expected to compose the majority of Boston's population in the next 10 years, it's crucial that we address inequalities in health care now. We must provide affordable, culturally sensitive services. For example, Boston's innovative partnership among a network of neighborhood health centers provide care for residents in their own languages.

We must reach people where they are, like Healthy Baby, Healthy Child, which offers prenatal

care to pregnant moms at home, when they can't get to the doctor's office. We must target resources, local, state and federal, to programs that try to solve the problem.

In Boston I have made particular commitments to close the gaps in the fight against cancer. According to the American Cancer Society, if all Bostonians had equal access to information, screening and treatment, we could cut cancer deaths in half. To encourage people to get early detection tests, I issued an Executive Order granting all city employees four paid hours a year to go for cancer screening.

And just to tell you how beneficial that has been to one of my closest staff members, she took advantage of that and she was detected with breast cancer, early, we saved her life, by that one thing we did as an Executive Order. Four hours off, it doesn't count against your vacation, sick or any other kind of time. We just give it, we want to make sure we have the healthiest work force in America.

This winter, I also appointed a cancer control task force, to figure out how to get everyone the necessary prevention and treatment. We still have

a lot of work to do, that's why I'm happy to be here this morning at this town meeting. When we combine our resources, knowledge and commitment, we'll be able to create equal health care for all.

I'd like to thank the President for putting this commission together, it's so important, Secretary Shalala, Dr. Satcher, and Judith, of course, for convening this crucial discussion. And to all of you, thank you for coming out in July, in the middle of the summer, you could be doing a lot of other things, but you care.

Let me just say on this issue of diversity, any city that doesn't recognize the issue of diversity is a city that does not have any future. In Boston we recognize the demographics of our city is changing every day. We are trying, we're addressing those issues as best we can. And we need all of you to work together. When people come to me and you know, we have a lot of dignitaries that come to Boston, I do the official greeting and they ask me, where is the key to Boston? I always say, there is no key to our city because a key means there is a lock, we have no lock in Boston, Boston is an open city, open to all people.

Thank you for coming. Thank you.

(Applause)

DR. FOX: Thank you, Mayor.

We also are fortunate to have with us, Beverly Wright, who is the chairperson of the tribal council of the Wampanoag Tribe of Gay Head/Aquinnah, to give us some opening remarks.

Ms. Wright?

MS. WRIGHT: Good morning. President Clinton, Mayor Menino, distinguished panel members and moderators, and to you, the audience here at Faneuil Hall and across Turtle Island, I am pleased to be part of today's town meeting on race and health. I am the tribal chairperson for the Wampanoag Tribe of Gay Head/Aquinnah, the only federally recognized tribe in the State of Massachusetts, but one of 23 federally recognized tribes east of the Mississippi, that make up the united south and eastern tribes.

American indians have staggering health problems. They have the lowest health level and the highest disease rate of all major population group sin the United States. Most disturbing, Indian deaths occurring from curable illnesses, such as tuberculosis, dysentery, and influenza, is over 400

times the national average.

Many physical illnesses suffered by Indians are directly related to malnutrition and substandard housing. While many of their psychological problems, reflected in excessive alcohol abuse, a rising divorce rate, and increasing violent crime are attributed to chronic unemployment, a personal sense of displacement and cultural conflicts.

The federal government has continually attempted to make a concerted effort to meet Indian health needs. What the government has provided to date has been substandard and inadequate, so that many Indians distrust government health services and refuse to use them even when they're available.

Another part of the problem is that Indians live in small isolated communities, like my tribe on Martha's Vineyard Island, far from medical centers and far from physicians and dentists that accept Medicaid reimbursement. In addition, many Indians are reluctant to seek medical care from non-Indians for a variety of cultural reasons.

As you know, President Clinton will make his fourth visit to Martha's Vineyard Island. There is an idea out there that Martha's Vineyard is only

for the rich and famous to come and vacation. The Martha's Vineyard tribe can trace its existence on Martha's Vineyard back 10,000 years, and we are not rich and famous, we are struggling to keep our tribe together on Martha's Vineyard. These problems are shared by other minority populations in this land as well, be it urban centers such as Boston or in rural areas throughout New England.

However, with all due respect to our brothers and sisters of color, the federal government has a unique obligation to provide for the welfare of American Indians, known as its trust responsibility. This was affirmed by Congress in 1976 by the passage of the Indian Health Care Improvement Act. I do not refer to a relationship that exists only in the abstract, but rather in a Congressionally recognized duty to provide services for a specific human need.

The proposed budget for FY99 for Indian Health Service is approximately $2.4 billion. This represents less than a one percent increase over FY98. And please listen clearly to these figures now. Further, in FY97, the per capita expenditure for American Indian person was $1,430, as compared to $3,369 for a Medicaid beneficiary, $3,489 for an

inmate in the bureau of prisons, and $5,458 for a Veterans Administration beneficiary. This is morally wrong, particularly when a national budget surplus is predicted.

We ask the United States Congress to fund, now, the appropriate dollars to meet the legal obligations for health care for our tribes. Already, tribes across the country are suffering from insufficient funding. 21 of the 23 USET tribes are on priority one, which means emergency and life threatening only. My health care program has been on priority one since May of this year. We are experiencing an erosion of the trust obligations that our ancestors secured when they exchanged more than 500 million acres for a promise of health care, education and other goods. It’s ironic, but this was the first health care in the United States.

We, the tribal leaders, have a duty to ensure that the solemn treaty commitments of our ancestors are upheld in all matters related to health, human services, for the next seven generations. In the meantime, my health director and all other Indian health directors across the country, are trying to improve Indian health in the face of a chronically

under funded, crazy health system that has become a way of life.

We applaud the panel of best practices in their attempts to provide the very basic components of health care for their populations. We applaud the President, William Clinton, in his efforts for universal health care for all, his efforts for one America, his efforts for fairness and what is right. Without adequate funding for health care, whether on moral or legal grounds, that no American, regardless of race, can even hope for a balance of life's circle. Or for non-Indians, life, liberty and the pursuit of happiness, to aspire to a better way of life for ourselves and our children is the dream of all Americans.

I thank you for the opportunity to provide my comments on the unmet health needs of American Indians, Alaska Natives, and for all people of color. I stand in peace. Thank you.

(Applause)

DR. FOX: Thank you, Ms. Wright.

We are also pleased to be joined by the Counselor to the Deputy Secretary of HHS, Dennis Hayashi. Mr. Hayashi has been a long advocate, very

vocal, for equal opportunity for all. And prior to joining HHS, Dennis was the National Director for the Japanese American Citizens League, the oldest and largest Asian specific American civil rights organization in the United States.

Mr. Hayashi?

MR. HAYASHI: Thank you, Dr. Fox, for that very generous introduction. Mayor Menino, Ms. Wright, Chairman Franklin and members of the Advisory Board, on behalf of Secretary Donna Shalala, Deputy Secretary Kevin Thurm, and the Department of Health and Human Services, I have the distinct opportunity of welcoming you to this very important town meeting on race and health.

Let me acknowledge at the outset, the tremendous efforts of both Dr. Fox and the Health Resources and Services Administration and Dr. Judith Kurland and her staff here in the region, in putting this event together. It is with great pride that the department is hosting this dialogue on the health care system and problems of access for racial and ethnic minorities.

Thank you, Chairman Franklin, Governor Winter, Governor Kean and staff of the President's

Advisory Board on Race for being here with us today. I also want to extend thanks to the distinguished panelists who have graciously agreed to share with us their insights and recommendations. And of course, special thanks to Dr. David Satcher, for lending his thoughts to this this morning.

The subject of this meeting is one that HHS believes is a key component of the President's Initiative on Race. As a department, we believe that any discussion about the quality of care in America must include an analysis of the equality of care. Discrimination and disparate treatment in the delivery of health care are not phenomena of the distant past, but current issues that we cannot afford to ignore. We know that medical redlining and bedside bias continue to exist and that we must do more to enforce anti-discrimination laws.

We are concerned about the role that language and cultural differences play in the provision of reliable health care. We remain committed to the ideal that the health profession must serve everyone and are mindful that diversity within the profession is a significant factor in whether care is provided to under served communities.

I am proud to state that HHS has been a leader in putting resources into projects promoting measurable improvements in health care delivery and education. For example, the National Institute of Health has supported focused research on minority health, the Food and Drug Administration has translated mammography brochures and nutritional labeling information into various languages. And of course, the president's initiative to end racial and ethnic disparities in health is being ably coordinated by Dr. Satcher and Dr. Hamburg, the Assistant Secretary for Planning and Evaluation.

Indeed, although these examples are significant, it should be noted that every division of HHS is playing an active role in carrying out department wide minority initiatives, designed to strengthen the inclusiveness of programs, personnel and private partners. Addressing the complex issues of race in health care access, however, is the responsibility of all of us. Our personal interest in doing so is based on the fundamental fact that infectious disease and illness does not discriminate on the basis of race or ethnicity.

So today we welcome you but also challenge

you to think deeply about these problems and to give us your straightforward and constructive suggestions on how to address them. As we engage in this educational dialogue, tell us how we should work with you to implement and carry out meaningful reform.

Let me assure you that the Department of Health and Human Services does not view this forum as a culmination of its commitment to advancing the President's dialogue and Initiative on Race, but as one opportunity out of many to substantively address and resolve the intractable problem of eliminating racial and ethnic disparities in health care.

Thank you.

(Applause)

DR. FOX: Thank you, Mr. Hayashi.

We are also very fortunate to have with us today the chairman and two members of the President's Initiative on Race Advisory Board. This distinguished seven member board was convened by the president, last year, to counsel him on ways to improve the quality of American race relations.

In the last 12 months, this board has reached out to the nation and engaged individuals in an open and enlightening dialogue on race. We are

here today to continue that dialogue. The members of the Advisory Board are here primarily to listen, to listen to the panel, to listen to you, so that they can carry the message back to the President and to others, and to make recommendations that we hope will help extend the impact of promising practices, like some we hope to hear of today.

With us today from the board are the former Governor of New Jersey, the current President of Drew University and the Chairman of the President's Campaign to Reduce Teen Pregnancy, Thomas Kean, down on the end.

Also joining us this morning is the former Governor of Mississippi, and long time friend of mine, and Chairman of the National Commission on State and Local Public Services in the National Issue Reform Institute, former Governor William Winter.

And here also we have Dr. John Hope Franklin, who is head of this board. Dr. Franklin is, by training, an historian, so it is fitting that he has earned for himself a prominent place in the history of our nation's quest to continue his endeavor to secure an equal opportunity for all Americans.

And Dr. Franklin, we'd like to have some

comments from you, we are pleased to have you here today.

(Applause)

CHAIRMAN FRANKLIN: Thank you very much, Dr. Fox and all of my dear and esteemed colleagues on the platform and ladies and gentlemen.

It's really wonderful to be here today, and as I stand here at this place, I think of the first time I looked in that door, 62 years ago, when I was a first year graduate student at Harvard University, and I was moved beyond words, as I am today, as I observe this historic place.

I want to thank Mayor Menino and other hosts and hostesses in Boston for their hospitality and their very gracious reception of us in this fine city and state. I would also like to thank the United States Department of Health and Human Services and the Health Resources and Services Administration for convening this meeting for the advisory board on this extremely important topic. We could not possibly think of our work having been completed without having given due consideration to the whole question of access to health care to all persons in the United States, as a part of a move toward one America.

We are all delighted that the distinguished Surgeon General, Dr. David Satcher has found it possible to be with us this morning.

As many of you now, the President's Initiative on Race is about to come to a year long end for its initiative to engage the nation in moving toward a stronger, more just and united America. Throughout the past 12 months we have examined issues surrounding race and our common future. We have looked at existing laws and policies and we have made recommendations looking toward insuring that we will become one America in the 21st Century. We have heard from and we have enlisted individuals, communities, businesses and governments at all levels in our effort to promote understanding and respect and to celebrate our differences.

We are determined to repeat to the President, our view that justice in every respect should be accorded our gracious hosts and hostesses, the Native Americans, who received us here in the 17th century and who have been most gracious and kind and patient with their other, not always gracious guests.

The President appointed a seven member Advisory Board to help meet the goals and objectives

of the initiative and at that time, I was asked by the president to serve as chair of this distinguished board and it has been a great honor and privilege for me to do so.

Several members of the board could not be with us today, in addition to those which Mr. Fox made reference to, I want to remind ourselves that we also have, as members of this board, the Honorable Angela Oh, a distinguished lawyer from Los Angeles, a member of the 1992 riot commission; the Reverend Dr. Susan Johnson Cook, the pastor of the Bronx Christian Fellowship Baptist Church in New York; Mr. Robert Thomas, Executive Vice President of Republic Industries in Florida; and Linda Chavez-Thompson, the Executive Vice President of the AFL-CIO in Washington. They were unable to be with us today but we are delighted that our colleagues, Governor Kean and Governor Winter, were able to be here. The others send their best regards and their good wishes that we shall have a successful meeting today and we shall certainly share our findings with them.

So far, in the course of the initiative, we have held meetings on a host of topics, education, the administration of justice, economic opportunity,

stereotypes, poverty and housing, to name just a few of the more important ones. Perhaps though, no topic we have covered is more important than access to health care. Quality health is fundamental for all Americans, both for individuals and racial groups, as well as for our nation as a whole. Without good health, other areas of life have relatively little meaning or significance. Consequently, we felt it important to address the ways that race impacts health on different groups, and the ways that groups access health care.

Specifically, the purpose of this meeting is to discuss barriers to health care for racial and ethnic minorities in the area of access, workforce diversity and cultural competency. We also hope to identify available solutions to improve the health care infrastructure, to break down these barriers and eliminate health care disparities in this country.

Let us provide some context for this discussion. The fact that we are examining the relationship between race and health, to some people may seem to imply that the board really believes there are significant biological differences among racial groups, this would be incorrect. The Advisory Board

holds no such view. At the same time, we must observe that even in increasing portions of the scientific community is concluding that race is not a valid biological construct. For instance, in a recent report entitled "The Meaning of Race in Science: Considerations for Cancer Research" the President's cancer panel found that the biological concept of race is untenable, rather race is a social construct, a product of the nation's social and political history.

(Applause)

CHAIRMAN FRANKLIN: Studies using such new technologies for understanding, measuring and conceptualizing the sources of human variation, reveal that approximately 85 percent of all variations in gene frequency occurs within populations of races and only 15 percent variation occurs between or among persons of different races. They argue therefore, that there is no genetic basis for racial classifications. By contrast, in the social sciences, studies of race from a social and political perspective may be justified, since these are studies of society as it exists.

But before I go any further and before I am misunderstood, misquoted or misinterpreted, I want

to say that these discussions are for the experts in the field, of which I am not one. Therefore, at this time I will relinquish the floor to the people who have come to be heard and I will relinquish the floor also to those who know.

I would like therefore, to thank all of you for your attendance and your support of this meeting and the initiative. Thank you very much.

(Applause)

DR. FOX: Thank you, Chairman Franklin, we really appreciate your presence here, and the presence of the other two members, to listen to the comments.

Prior to moving into our two panels it is my distinct honor to introduce our keynote speaker, a man who has worked tirelessly to improve access for care for various racial and ethnic minorities across this country, a man who has pledged to use the power of the bully pulpit to eliminate racial disparities in health, a man to whom we look as the standard bearer in HHS, in the HHS initiative to eliminate racial disparities.

I am pleased and delighted to introduce to you today, my friend, my colleague, the Surgeon General of the United States, Dr. David Satcher.

(Applause)

HONORABLE DR. SATCHER: Thank you very much for that very kind introduction and that very warm reception. I am delighted to be here. And to Chairman John Hope Franklin and the distinguished members of the President's Advisory Panel on Race, to Judy Kurland and all the outstanding members of the platform, and to all of you distinguished people, I am very pleased to be able to join you today for this very important deliberation.

Now, some of you know me, and you know how compulsive I am about time, and according to the schedule, I'm already out of time.

(Laughter)

HONORABLE DR. SATCHER: So I've got to move on and try to be brief.

I do want to say one word about John Hope Franklin. I never asked him or anybody else why his parents gave him that name, why his middle name is Hope, but you know, that is what he really has been, for me and I think a lot of other people in this country, a real beacon of hope, the way he has put American history in perspective for us and for all people, and the leadership that he has provided for

this panel in dealing with America's most difficult issue, the issue of race.

So I do want to express my appreciation to John Hope Franklin and just the fact that I had a little time to spend with him last night was really quite rewarding and makes the whole trip worthwhile. I just wanted to say that because he has contributed so much to our understanding, he had cared so much about this country.

Let me say that since he is obviously America's outstanding historian, let me just say a word about history and today. On Friday, I was in Philadelphia to celebrate the 200th anniversary of the public health service. In 1798, President John Adams signed the act of Congress, giving rise to the Marine Hospital Service, that was dedicated to the health of merchant seamen, at a time in our history when we were very dependent upon the sea for trade and security.

It was a great celebration and we even reminisced about the great yellow fever epidemic and the role of people like Epsilon Jones and others, in helping to care for people who were so ill during that time. And the role of race even then, in 1793, when Richard Allen and Epsilon Jones played that great

role.

But I do want to say something else about that and that is that the first marine hospital was here in Boston. So, in April I came here with Senator Kennedy to officially kick off this 200 year anniversary and I had a chance to visit a middle school in Charlestown, near where the first marine hospital was set up and to see African-American and Hispanic students in that middle school providing leadership in getting their peers not to smoke. And I just thought about the place of history in all of this.

I also sat there this morning and this morning as I was jogging along the Charles River, which is one of my favorite places to jog, I thought about when I was a student at Case Western Reserve, in the ‘60s and H. Jack Geiger came to lecture and the whole concept of a community health center was first explained to us as students. Now as you know, the community health center concept was started by Jack Geiger, you know the role of Columbia Point here and Mount Bayou in Mississippi. So almost 35 years ago that lecture took place at Case Western and really inspired me in terms of my approach to health and the

health care system.

So I’m delighted to be here. But more than that, I think as I have said before, as Surgeon General, in the words of Robert Frost: "I have promises to keep and miles to go before I sleep."

I was two years old, my earliest memories, when I had a severe case of whooping cough, which turned into pneumonia. And I lived in rural Alabama, on a small farm, neither of my parents finished elementary school, we had a large family. We didn’t have access to health care because even though there was a hospital in Anison, there was no pl ace in that Hospital for us.

But finally my dad talked the one black physician in that area into coming out to the farm and looking at me. And he ended up spending the whole day there and he taught my mother how to keep my chest clear and to keep my fever down. But when he left, he said, I have to be frank with you, I don’t expect this child to live out the week. And of course my mother took up that challenge, I remember still, the hope in her eyes. But obviously, I survived.

And I take very seriously my responsibility. As I told a group in Geneva last

week, I never take for granted one breath that I take and I certainly don't take for granted the awesome responsibilities which I have as a leader in the Department of Health and Human Services and as Surgeon General.

Well, having said that, let me just say a word about our commitment in eliminating racial disparities in health. Because as a nation, we are not only diverse today but we are growing increasingly diverse and I don't have to tell you that we believe by the year 2030, over 40 percent of the people in this country will belong to what we now call minority groups, and somewhere around 2050, about half of the people in this country will belong to one of those groups. We are quite a diverse nation.

A former Secretary of Health and Human Services, we really called it Health, Education and Welfare then, John Gardner, used to say, 'life is full of golden opportunities carefully disguised as irresolvable problems.' And let me tell you, diversity is just that, it is a golden opportunity for this country, as the countries of the world become more diverse, in Europe and elsewhere, and they look to America for leadership, in an area where we should

be providing the leadership, in dealing with the tremendous opportunities of diversity. And we see those in the health care system and in the public health system.

Well, President Clinton asked all of the cabinet members to develop some strategy for contributing to the race initiative. And in our department, under the leadership of Donna Shalala, we decided to make a commitment to eliminate disparities in health among racial and ethnic groups, as compared to the majority population, by the year 2010. And we selected six areas, as you know, and I won't dwell on them. We selected infant mortality, immunizations, cardiovascular disease, diabetes, especially prevention of diabetes complications, we selected cancer and asbestos screening and management and we selected the area of HIV/AIDS.

Now, those are not the only areas we're interested in but we felt that these were areas where we had the kind of baseline data that we needed, that we could monitor our progress toward reaching a goal. And these were also areas where if you think about the risk factors, if we are able to deal successfully with the risk factors in these six areas, we will make a

difference in the health of people in America, all the people in America, So that's our commitment.

There are some interesting exampleS of disparities, and you know these examples, and I'll mention them briefly. In the area of infant mortality, an African-American baby born today is two and half times more likely to die in the first year of life; an American Indian baby, one and a half times more likely to die in the first year of life. In the area of diabetes, where African-Americans are 70 percent more likely to be diabetic, but Hispanics are twice as likely to be diabetic as the majority population. And some American Indian tribes, the Pima Tribes especially, have the highest rate of diabetes in the world. These are major challenges.

In the area of cancer, Vietnamese women are five times as likely to have cervical cancer as white women in this country and Asian-American, especially Asian-American men, are far more likely to die of liver cancer, sometimes related to hepatitis-B.

But all of these are areas where we have tremendous challenges and opportunities. Recently, the HIV/AIDS epidemic has become increasingly an

epidemic of color. As you know, when we started out with this epidemic in the early 1980s, white gay men were the major victims and in a sense, the epidemic was defined in those terms.

But in recent years it has become more and more an epidemic of color, an epidemic of the young, more and more an epidemic of women. I said in Geneva last week, that if you look at the 13 to 24 year olds who are positive for HIV, today 44 percent of them are female. And in 1995, only seven percent of persons with AIDS were female. This epidemic is changing. Over 60 percent of them are African-American and Hispanic. This epidemic is becoming an epidemic of color and epidemic of women.

And it's interesting how it's developing, as you heard earlier, we've developed very sophisticated therapy for AIDS and we've seen over a 50 percent decrease in death rates in the last two years. Mainly for white males, we have not seen that type of decrease for African-Americans or Hispanics. So we have some major challenges in these areas.

Briefly, what is the role of access in these areas of challenge? Well, I think access is critical, if you start with infant mortality, right

away you ask the question, in this very critical area of prenatal care, what kind of differences do we see? Well, African-American women are less likely to get prenatal care in the first trimester of pregnancy, in fact, whereas, ten percent of white women do not get prenatal care in early pregnancy, about 25 to 30 percent of African-American women do not get prenatal care. And we see similar access for American Indians. So it's directly related to what we see in terms of infant mortality.

In the area of diabetes, where we know with tight control of diabetes we can prevent the complications of blindness, in stage renal disease, the need for amputations, so many Hispanics, where we have 35 percent of the people uninsured, so many Hispanics do not have access to that tight control, or even the early diagnosis of diabetes that would be so critical. So many American Indians with diabetes don't get that early diagnosis, the early intervention, and therefore, suffer unnecessarily for those complications.

So many African-American men don't get the interventions that are so critical, in terms of preventing cancer, and detecting it early, whether

it's lung cancer or prostate cancer. So we see increased risk for death. You can go on and on, but access, in every area, we see the tremendous role of access in these disparities.

Well let me just say a word about access and then close. What is the nature of this access problem that you've come here today to examine and to orient our system towards resolving? Let me just mention five things briefly, in terms of access problems in this country.

Number one, obviously, we have areas of this country that are under-served, where people actually don't have access to physicians and dentists and quality nursing care and other areas. African-Americans and Hispanics, American Indians and Asian Pacific Islanders are more likely to live in under-served areas. In fact, two-thirds of the people living in these areas are minorities, two-thirds in these under-served communities, a very interesting statistic.

Well, in addition, I mentioned the uninsured and the under insured, we made some progress in this country in the '70s, in terms of access, especially with Medicaid and Medicare, but in recent

years, as you know, we've seen an increase in the number of people uninsured. In fact, over 42 million people in this country today are uninsured and almost that many are under insured, on any given day. That's what we're struggling with, even with all the efforts and managed care, et cetera. So being under insured is something that hampers access to quality care.

But also being under represented and we are severely under represented in the health professions. I think the figures are that, whereas, we constitute, as minority groups, over 25 percent of the population, approaching 30 percent, about ten percent of physicians are from these groups.

And I want to make a point here this morning that diversity is important in health care an din prevention, we need more diversity. Our profession needs to reflect the diversity of the population we serve and it does not. And I am convinced that it is a major barrier to access.

But I also want to say something else, since I've spent, like Governor Kean, so much of my career in academia, including the years at UCLA and Drew and Morehouse and then president at Maharey Medical College. Diversity is important in medical

education. I do not believe that we can prepare physicians to take care of diverse communities without having a diverse population of students and a diverse faculty, it cannot be done.

(Applause)

HONORABLE DR. SATCHER: And therefore, I was back in my alma mater, Case Western Reserve, to give the commencement address a few weeks ago and I told the students that regardless of how they tried, they would never be able to leave Case Western Reserve University, it would always be a part of them, a part of how they thought, a part of how they approached the practice of medicine. And it's a great institution. But I also remembered many things, but one thing stands out in my mind, when I was a student. And most of you know, I was there for seven years on the M.D. Ph.D. program and I was very close to graduation, I think it was in my sixth year, I was doing the OB/GYN clerkship and then I was going to take a year and finish my dissertation for the Ph.D.

But the first day of the OB/GYN clerkship in the hospital there, they brought us into the room where we to learn to do pelvic examinations. Now, back in that time, they had what they call staff

patients, these were patients who didn't have the money to pay, 95 percent of them were African-American, this was Cleveland, Ohio, and I had had some experience in that community talking with people about prevention, et cetera.

But on this particular day we entered the room to begin our training and the situation was interesting because what they had was they had women in the beds, their legs in stirrups, and we lined up to practice pelvic examinations on those women. I stood there and I looked and I said, I can't do it and I walked out. Well now, the head of OB/GYN was very upset, he said that not only would he see that I be put out of that program but I would be put out of school and maybe he would see that I wouldn't get into any other medical school. I don't tell this story a lot.

But I remember it very well because I remember that night, I had worked very hard, I had worked just about every job available on that campus, ran the laboratory on weekends and holidays and I was about to lose it all. And I got the word that the dean wanted to see me the next morning and I went to see him, and you now who the dean was, it was Fred

Robbins, the winner of the Nobel Prize for developing and growing the polio virus in vitro, an outstanding pediatrician.

And I'll never will forget going in and sitting down and Fred Robbins saying to me, well, David, you've done a great job as a student here, and he recounted how well I had performed, but now you've gotten yourself into some trouble. Why don't you tell me about it? And I tried to explain to him that when I viewed the situation there it was something that I felt I could not participate in. I felt it was inhumane. What I saw when I looked at those women, who were black, was my mother, my sister, my cousin, my aunt, that's what I saw.

(Applause)

HONORABLE DR. SATCHER: And I don't know what other people saw, I was the only black student in my group, in fact there were only two in my class at that time, so I don't know what other people saw. So Fred Robbins listened to me and he said, David, do you know what happened this morning? I said, no. He said, well, the rest of your classmates walked out on that rotation.

(Applause)

HONORABLE DR. SATCHER: And they said, if it were inhumane for you to do it then they felt it was inhumane for them to do it too. And he said we are going to change that rotation, the students have demanded that we change it.

Well, I think diversity is important. In Washington, people like to say, what you see is determined by where you sit. You know, that's only about half true, what you see is also determined by what you bring to the seat, your life experience, your view of life, your history determines what you see. And therefore, there cannot be quality medical education or quality dental education, without diversity. Diversity of perspective of students, diversity of perspective of faculty.

I've gotten a lot of letters since I've been surgeon general but some of them stand out and letters from people who trained with me at Rochester, in medicine saying, I remember the day when we stopped to talk about a patient and a professor asked you to talk about the racial implications of what this patient was up against, why we were having difficulty getting compliance. And he said, I knew then that one day you were going to be in a leadership role. I

didn’t even remember that but this guy remembered it as we studied together.

Well let me close. There are serious cultural barriers to access, they go beyond all of our sophisticated technology, all of our in-depth biomedical knowledge, it relates to how well we understand the people we try to serve. Some of you have, and I’ve read what you wrote, have had some tremendous experiences, some of you are making great contributions in this area. And I just urge you to continue, I just wish I could be here today to hear you discuss it in person, but I do urge you to continue to break down the cultural barriers to access to quality care in this country.

I want to end on another area, I said there were five components, and the other one is environmental. And I’m in public health, so I want you to know that you can talk about health care but the health of people in this country depends on more than health care, it depends on individual behavior.

(Applause)

HONORABLE DR. SATCHER: It depends on access to prevention, to preventive interventions. And there are environmental barriers. You know, a few

years ago, an article by Fagan McGinnis in JAMA, the *Journal of the American Medical Association*, which I encourage the students to read, pointed out that over half of the deaths in this country each year were related to human behavior. Out of 2.1 million deaths in 1990, 400,000 were related to smoking, 300,000 were due to physical inactivity and nutrition, 100,000 to alcohol and other drugs.

You can go on and on, you can talk about sexual behavior, how we behave with one another; you can talk about violence, how we behave toward other people; suicide, how we behave towards ourselves; environmental problems, how we behave toward the environment. Behavior. So there are environmental barriers to access. Poverty is an environmental barrier to access.

And the reason I mentioned at the beginning of this about hope and Dr. Franklin, I am convinced that the most important thing we can give to young people is hope. And when young people grow up in environments of hopelessness, they will smoke, they will engage in risky sexual behavior, they will experiment with drugs. If their environment is one of hopelessness, they will get caught up in gangs, they

will be victims of violence, they will be perpetrators of violence and they will commit suicide, they will go to school and shoot and not care what happens to them.

And obviously, there are different kinds of hopelessness, some people are hopeless because of depression, clinical depression and other people are hopeless just because of the environment. Whether they are ever going to be able to make a difference, whether things are going to ever change for them. And I think one of the most important things America must do its people is to provide hope. So I think we have to work together to change the environments that give rise to human behaviors that are not consistent with good health. And together we must do that.

Well, I said I was going to close, so let me close with this story.

(Laughter)

HONORABLE DR. SATCHER: I was going to tell you about the Surgeon General's priorities but that wouldn't be -- well, I'll mention them rapidly.

(Laughter)

HONORABLE DR. SATCHER: There are five and I'm just going to --. I'm committed to helping every American to better understand and access better

quality health care. To work and to see that every child has a healthy start. To see that we deal with mental health in a more positive fashion than we've dealt with it in the past, without blame, without stigmatization.

(Applause)

HONORABLE DR. SATCHER: To help Americans take more personal responsibility for their health, physical activity, nutrition, responsible sexual behavior, avoiding toxins like tobacco, cocaine, marijuana, et cetera. I'm committed to eliminating disparities, controlling emerging infectious diseases.

But there is a story I like to tell and some of you may have heard this and you'll hear it again, but it's the story of Elizabeth. Andrew Adamway wrote this story in the *Daily Guidepost* last year and I was in a hotel one day and read it. But he tells the story about his daughter Elizabeth, who was only two and a half years old and she loved to be read to by her father. And her favorite book was a book that her grandmother had given her and her favorite story in this book was the Good Samaritan.

And you know the story, the man was on the road from Jerusalem to Jericho, he was attacked by

thieves, beaten and he was left to die, he was bleeding to death. On that particular day a man came by on the other side of the street and he happened to be a priest, he looked over at the man bleeding to death, he looked at his watch and he said, you know I'm going to be late for church, and he went on.

Then there was another church leader who came by and he looked over and he said, what will happen to me if I stop and help this man? And he went on. Then a man came by who was supposed to be his enemy, he was a samaritan and he looked at the man and he said, what will happen to this man if I don't stop and help him? So he went over, bound up his wounds, stopped the bleeding, put him on his horse, took him to town, left him to be cared for and promised he would pay for all of his care.

Well, Andrew Adamway has read this story to Elizabeth many times and every time, he quizzes her, he says, now, Elizabeth, did the priest stop? And Elizabeth says, yes. So he reads the story again. Then he says, Elizabeth, did the priest stop? And she says, yes. And he is getting really concerned about Elizabeth, you know how we are, when you're a parent you start thinking about the SATs, the LSAT--

(Laughter)

HONORABLE DR. SATCHER: So, what is wrong with you. Elizabeth, I've read you this story almost a hundred times, every time I ask you did the priest stop and you say, yes. And one day Elizabeth said, well, Daddy, I want the priest to stop, the priest is supposed to stop. I want the priest to stop, I want the story to be different.

I want the health care system to stop, I want quality access for all people. But we're adults, we're not children, we know that we can't change the past. But I guarantee you that together we can shape the future, and I look forward to working with you.

Thank you.

(Applause)

DR. FOX: Thank you, Dr. Satcher, we are indeed fortunate to have you as our number one physician.

Well, we have an ambitious agenda and we are going to spend the rest of the meeting with two panels, we're going to hear first from a group of people who are going to tell us about the problems with access. We're going to listen to some of the things that many of you already know well about what

happens when we don't have access to care. Then we're going to hear from a panel about some promising practices that do have a positive effect, and maybe some things that we might be able to use elsewhere in this country, and we're also going to hear from you.

I'm pleased to introduce the moderator who will preside over our first panel discussion, focusing on consumer perspectives for the need for access, cultural competence and workforce diversity, Hortensia Amaro, from Boston University School of Public Health.

Let me also, before I forget, remind the panelists, we are running behind schedule and we have a lot of ground to cover, we want to have time to have comments, questions from you as well as our advisory members who are here. So I'd ask our panelists to please try to stay within their five minute time frame.

Dr. Amaro is a professor in the Department of Social and Behavioral Sciences and Maternal and Child Health at BU School of Public Health. She studied intensively and published extensively on social, emotional, developmental, behavioral and cultural factors that shape Latino health. My agency, HRSA, last year honored her, and I'm especially

pleased to have her chairing this panel, for her efforts on behalf of the moms project, for teenage mothers, it's one of our models at work projects. Her innovative residential treatment for Hispanic mothers and their children is really one of a kind. So we are very fortunate to have her lead this next panel.

Thank you.

(Applause)

WHAT DOES THIS MEAN TO US?

Consumer Perspectives on Need for Access, Cultural Competency and Workforce Diversity

MS. AMARO: Good morning. Buenos dias. Oh, that's wonderful, we have some Spanish speakers out there.

I'm delighted to have the opportunity to be part of this historic moment in our country. Our President Bill Clinton has provided great leadership in inviting the American people to initiate a dialogue on race. Indeed, this is an incredibly historic moment. As an immigrant and as a refugee to this country, and now as an American citizen, I'm proud to be an American today.

Today's first panel discussion will focus on the voices of consumers. It is meant to provide

communities with the first sentence of this dialogue, the beginning of what we hope will be a number of ongoing conversations that will help all of us as community members and health care providers, to come to a better understanding of how to improve our health care system and the health of all Americans.

Today, is only the first sentence in our ongoing dialogue, so clearly we won't be able to get all of the issues or to hear from all of the voices of consumers. However, we will be able to hear from a number of consumers with powerful messages and experiences from which we can learn important lessons. Today, we will take time to listen to what they have to say and to think about how the issues they bring up can be used to improve our health care system.

Prior to beginning the panel, I'd like to invite you to consider keeping in mind three points, the first point is many times when we think of the health care system, the most powerful figure that comes to mind is who, the physician, the nurse, the direct medical care provider.

But as Dr. Satcher pointed out, in reality, the health care system is made up of many people who provide public health programs that help to

prevent disease and health problems so that we don't have to see the direct health provider as often. These public health professionals are the health educators, the outreach workers, the peer educators. They include the programs that provide information about nutrition, child injury prevention, communicable diseases.

These public health programs also work to help prevent addiction of tobacco, alcohol and drugs and to prevent adolescent pregnancy, and to prevent the transmission of diseases and HIV.

Public health programs, as well as medical care, are important to eliminating racial disparities in health. If we are going to eliminate racial disparities in health status, we must have effective programs to prevent disease as well as effective approaches to the treatment of disease.

The second point is that health from a holistic perspective includes physical well-being as well as emotional well-being. And again, I was delighted to hear Dr. Satcher point this out. Our health care system is most advanced at providing for treatment of disease and much less capable of providing for emotional well-being. Let us try to

remember through these discussions that mental health is a critical and integral part of health, coverage and access to effective mental health services and substance abuse treatment are critical to the well-being of our communities.

As other communities under great stress, the multiple stresses and life conditions experienced by many in our community place us at risk for conditions such as depression and the life conditions surrounding many of our communities can lead our youth to addiction. Access to comprehensive and effective treatments and prevention programs for mental health and addiction are a critical part of access to health care.

The third point is brief. It is clear from the health statistics and from what we are going to hear from panelists, that poverty is a major cause of racial disparities in health. It is not the only one, but it is a major cause of the disparities. Thus, true prevention from a public health perspective needs to include a strategy that brings together economic development and health care in our communities.

Now, I'm delighted to introduce to you the

members of the panel. I'm going to introduce them all at once then they are going to speak one at a time and then at the end we'll take some questions from the audience.

The first speaker is Wilson Augustave, who was born in the Bahamas to Haitian parents, he migrated to the United States at the age of ten and moved to central Florida, where he entered the, he and his family entered the eastern migrant stream, picking oranges in Florida, peaches in Georgia and watermelons in Missouri, then moved to New York to pick apples.

In New York, Mr. Augustave was able to leave the migrant stream and obtained a job with the Finger Lakes Migrant Health Care Project, as a community health worker and case manager. He works with farm workers of all racial and ethnic backgrounds. And Mr. Augustave was able to obtain his general education diploma, he has become an HIV/AIDS educator, a pesticides trainer, a cultural diversity facilitator and an alcohol and substance abuse educator in his state, in the migrant labor camps. Mr. Augustave is a member of the National Migrant Health Advisory Council.

The next speaker will be Marianela Garcia,

who works as a case manager for Worcester Housing Authority's Economic Development and Supportive Services office. The mission of this office is to make employment and training opportunities a reality for the residents of the public housing developments. She is also a board member with the Mass. Union of Public Housing Tenants, which is organized to help residents of public housing learn their rights and become active members of the community. Marianela is a board member of the Great Brook Valley Health Center. Her hopes are that by educating herself she can in turn assist the community to empower itself.

Craig Cobb is the third speaker, right here from our hometown, Boston. Craig Cobb is actually originally from Dayton, Ohio, he relocated to Boston in 1991, where he finished a masters in marketing, communication and advertising. His interest is in community based health care and communication, which led him to a career in HIV education and prevention, targeting communities of color. He is currently the coordinator of prevention education for the HIV services cluster at Dimock Community Health Center.

The fourth speaker is Patricia Thomas,

Patricia lives on Pueblo of Laguna Indian Reservation in New Mexico. She is a single parent of two children, a daughter Kori and a son, Travis, both of whom have chronic health conditions. Her son Travis also requires special education services. She is recognized as a national speaker and lecturer on issues affecting children who have special health care needs.

She continues to work locally, regionally and nationally, educating policy makers, the media, health care and educational professionals on cross cultural differences that become barriers to accessing services for children not in the mainstream and who have special health care needs. Trish currently serves on boards, task forces and committees at state and national levels that affect children and youth, with special health care and educational needs.

The last speaker is also somebody that most of us know, from our hometown here, Meizhu Lui, the daughter of Chinese immigrants and a long time Boston community activist. She worked for many years in the kitchen at Boston City Hospital, became the president of the AFSCME union local, she led her fellow workers, mostly people of color, in organizing.

She is currently the lead organizer for Health Care for All, in Boston.

Meizhu has worked with residents from Boston's minority and immigrant communities for many years, educating them about their rights, accessing barriers to their health, identifying resources and mobilizing people to make change.

So please help me in welcoming our panel and we will be starting with Wilson Augustave.

(Applause)

MR. AUGUSTAVE: Bonjour, Monsieurs et Madames, which means good morning ladies and gentlemen.

It's an honor for me to be here to talk about this most import issue of access to care for all. I'm going to be talking to you about, from the perspective of a migrant farm worker, the conditions that they face. Migrant farm workers, the majority of them happen to be people of colors and I believe that some of the laws and policies in most states stem from racism, from after the time of the Emancipation Proclamation, which came about the farm worker labor exemptions.

In most states in this country, they do

not provide protection to farm workers, in regards to the labor law exemptions. For instance, farm workers are full time workers, they travel up and down the east coast, the midwest, also the west coast, harvesting fruits and vegetables that most likely some of us have had the opportunity to eat. Now, even though they are full time employees, most of the states don't provide health insurance to migrant farm workers. They also don't provide disability insurance to farm workers. That in itself, I believe has an effect on the health of migrant farm workers.

Let me give you some facts about migrant farm workers. First of all, they have a shorter life span than most other workers in this country, the work that they do is one of the most dangerous occupations that there is, for instance, working around heavy machinery, falling off of ladders while picking fruits out of the trees.

Also, in terms of housing, many times there is lax and unenforced housing code inspections. Also, field sanitation, in most states they don't provide a port-a-john, for people to use restrooms in the field where they are working. Just to give you a perspective on that, just imagine you are working

somewhere in the middle of the boondocks, there is no McDonald's anywhere that you can go to, and you have to use the restroom. And you could be working in the cabbage fields where you can see as far back as the eye can see and there is nowhere togo. There are men, women and children that are working out there. And as all of you know, women have different needs too, from men. So just in that itself as you can see, it doesn't help to preserve the dignity of farm workers.

Let me go into, for the access, in terms of barriers, one of the problems is that farm workers make very low salaries and even though there are some services available to them, many times they may need some ongoing specialty care and there may not be any funds available for that. And the money that they make is so crucial for them to be able to pay their bills, back in their home states.

Another problem is language barriers. For instance, sometimes farm workers go into their local communities to be seen at the emergency room or somewhere else and they don't have somebody there on staff to translate. Many times they have to have their kids, who may not the medical terminology to translate, which is also a barrier. The welfare

reform, it really hurt immigrants in this country big time, you know.

I have a horrific story but I don't have enough time to say it. But regardless, this, it shouldn't have happened to this gentleman, however, because he's an immigrant, he has been working in this country for many years, he didn't qualify to get medicaid. This guy needs food to eat and has bills that he needs to pay, but he didn't qualify for social services. There is also the issue of transportation. many a times farm workers live in areas, for instance in upstate New York, in very isolated areas, where if you didn't know that farm workers existed, that's how it would remain.

Let me talk a little bit about cultural competence. I'm running out of time, I got the red light already.

In terms of cultural competence, there is a lack of training for dominant culture staff about the cultures of migrant farm workers and when there is diversity training it doesn't address the core issues of power differences between cultures. Also, such training often doesn't assist the providers in examining their hidden biases in order to shift their

attitudes, which is a barrier for farm workers.

In terms of workforce diversity, in most of the country migrant health clinics are administered and run by white people. Many times these clinics are located in predominantly white areas and many times the hiring comes from that pool of the community. And usually outreach workers who happen to be people of color, are confined to those types of positions.

In conclusion, what I'd like to say is that the labor law exemptions, we should work with our legislators to get rid of the labor law exemptions, get them out by the year 2000, so we can all go in the 21st century together, equally. And also, there should be a national health care for migrant farm workers and their children.

Thank you very much.

(Applause)

MS. AMARO: Thank you, Mr. Augustave.

Now we are going to hear from Marianela Garcia, from the Worcester Housing Authority. Please join me in welcoming her.

(Applause)

MS. GARCIA: Good morning. My name is

Marianela Garcia, I live in Worcester, Massachusetts and I am a resident of Great Brook Valley. Great Brook Valley is one of the largest public housing developments in the City of Worcester. Great Brook Valley is predominantly Latino, but African-American, African, white and Vietnamese families reside here as well.

Drug dealing, gang activity, reasonable access to health care, day care and other problems, such as child neglect and domestic violence are daily realities. Job and skills training are needed by residents, many who can’t get jobs because of a lack of transportation. It is a daily struggle for many to provide all the necessities for their families.

In 1995, I began working as a volunteer for Valley Residents for Improvement, the local tenant association, because I wanted to educate myself on my rights as a public housing tenant and I wanted to make a change in my community. In 1996, I was hired as a community health worker for the Great Brook Valley Health Center. I learned that the needs of the community were many and that I could relate to them because I experienced many of the same needs as my neighbors.

In my time as a community health worker, I found that access to health care from a Latino perspective varied from household to household. In one home I would find that their needs were being met because they were fortunate to find providers who understood their needs. This positive relationship provided a feeling of satisfaction with their health care.

In other homes it was a different story. On many home visits I would find that it had been months, even years, since families sought health care. Many adult males over the age of 18 were uninsured and had medical issues that needed immediate attention. Many residents did not feel the need to see a doctor because according to them, they felt fine. After questioning them, I would find a family history of hypertension, diabetes and asthma. Many residents were distrustful of the system because at one time in their lives they were made to feel unimportant.

The Latino community experienced great difficulty obtaining health coverage for themselves and their children. I know that language barriers play a major part in accessing quality health care, this is a barrier in my community. English is a

second language in my community and offering services in a language that residents can understand is essential.

Substance abuse is a major barrier to receiving health care for my community. Detox services are difficult to access for the Laotian community. More programs are needed to address the needs of the Latin population. A couple of weeks ago, a young man overdosed and died across the street from my home. Everybody went about their business like it was an everyday occurrence. People have become desensitized, this in itself is a barrier.

I am now employed with the Worcester Housing Authority's new Economic Development and Supportive Services office. I continue to learn and understand the needs of my community and together with the staff work diligently to make opportunities a reality for each and every resident who walks through our door.

How can we make changes a reality? I asked myself that question over and over again. I know that change scan be made if the Latino community works together to bring a change in the system and in themselves. This is not a one-sided issue. A health

care facility can only do so much without the cooperation of the client.

The Latino community is a strong community, but more must be done, we must empower ourselves to equally access not just health care, but job, education and career opportunities and a sense of real belonging.

I would recommend that more community based education programs continue to help combat against the many barriers facing communities today. Health centers across the nation are now more than ever, understanding the role of peer education and the importance it plays in the health care relationship. All providers can benefit from cultural competence training to better service their clients. When a client is understood and their needs are being met, the likelihood that the client will follow through with doctor’s orders will be greatly improved. Having providers who understand the community in which they service will only make for a better relationship. And I know that this is the goal of all health care providers.

Thank you.

(Applause)

MS. AMARO: We are now going to be hearing from Craig Cobb, from the Dimock Community Health Center. Please join me in welcoming him.

MR. COBB: Good morning. I'm standing before speaking on behalf of African-Americans and that' s difficult to do because we are not a monolithic population of people. So, I'm going to give you a perspective and I hope that in some regard it fits.

Cultural competency, access to health care, race and workforce diversity all exist on the same plane, they can't be separated. They depend on one another to make an ideal environment to live for any American. My experience is probably not reflective of the majority of African-American people in the United States, however, my experience is just as valid as anyone else's who may have sat in that seat.

I have health insurance, a reasonably good job and access to simple luxuries in life that make my life palatable. I did this because my parents taught me that. My parents did it because their parents taught them that. And I'm speaking of generational links, one generation taught the next and we've handed

down the baton ever since. Clearly, generational links like these speak to a lot about the African-American condition in history in this country.

I chose my health care providers based on their ability to listen to me and in turn, ask me relevant and appropriate questions about who I am and what my experience has been. If I confront a provider who doesn't ask me questions about who I am and what I'm about, I'm out the door. Simply.

Issues like affordable housing, jobs that only pay half the rent, bills that are due and jobs that don't allow us to save money and social oppression on a variety of levels continue to be major themes in the African-American story. Because people of color often live in less than moderate conditions than those of whites, we remain at risk for many social and health issues that affect our lives. I once read somewhere that where a man lays his head, where and how he eats his food, and where he washes his body, directly affect his self-perception.

Poverty affects how and what people eat. It also affects if and when they get health care. It further influences their abilities to secure a good job or develop a trade. So again, none of the topics

for today exist by themselves. HIV and AIDS and substance abuse are two of the most devastating forces facing African-Americans today. Greater the 30 percent of all HIV infections are among people of color. 71 percent of all women's HIV infections are directly or indirectly related to a needle. That speaks mounds to the needs for substance abuse intervention.

(Applause)

MR. COBB: Where does holistic and non traditional methods of health care fit into our insurance system? As an African-American man, my belief in God is a great part of who I am. And I don't believe that I am any different from most African-Americans when I say that my belief in God has to be a part of every nook and cranny of who Craig Cobb is.

People's perceptions of themselves affect how they take care of themselves and affect high risk behaviors in which they will engage. A lot of poor people in our country continue to depend on welfare. From what I understand, the recent changes in welfare in the Commonwealth of Massachusetts allow welfare recipients only two years of dependence in a five year

span. Given that scenario, what happens to a pregnant mother? in scenarios like this she lacks the option of staying home with her child, instead, she must beat the two year clock that ticks against her.

Wealthy people tend not to do crack cocaine, poor people usually do. Poor inner city youth tend to generally be involved in drugs, be they dealers or users, wealthy suburban white teens generally don't. The realities are not coincidences, they are systematic conditions. They also do not exist alone, they are all part of other contributing conditions. I think that national figures should speak less about freedom and the luxuries of independence and more about empowerment, we get that.

Create environments and opportunities to build and rebuild lives, no more band aids and scotch tape repairs to social problems. Instead of welfare dollars and government housing, trade and education programs that change everybody's lives.

Thank you and God bless you.

(Applause)

MS. AMARO: Our next speaker, Patricia Thomas, is here from Family Voices, please join me in welcoming her.

(Applause)

MS. THOMAS: Good morning. And I am standing.

(Laughter)

MS. THOMAS: My name is Trish Thomas and I am from the Pueblo of Laguna in New Mexico and I am a member of that tribe and I've lived on the reservation the majority of my life and I participate in our traditional ceremonies throughout the year.

I'm a single mother, I have two children, a daughter, Kori and a son, Travis, both of whom have special health care needs and chronic conditions. My children and I use several systems of health care, that include the Indian Health Service, my private insurance, state programs and federal programs and we also use our traditional healing system.

But unfortunately, most of the time, for my children and myself, our health care system has been disappointing, I'd like to give you some examples. My daughter Kori, when she was younger, had breathing problems and seizures and she was misdiagnosed several times. Because the practitioners tended to move from place to place and because funding and regulations change frequently, there was no

consistency in the care that was provided by her primary health care provider. Nor were there pediatric specialists, let alone Indian pediatric specialists. So every time we took Kori in, a different nurse or doctor examined her and she underwent duplicate blood tests, they stuck her in the arm way, way too many times and they still could not diagnose her problem.

Kori was finally diagnosed with asthma and severe allergies. Her primary health provider did not provide us with the necessary equipment to monitor her asthma, which is a peak flow meter. At one time she almost died, she went into anaphylactic shock because her chart was not properly coded, that she was allergic to penicillin.

My son Travis has multiple difficulties, he has significant bilateral hearing loss and has a vision impairment. And he needs numerous specialists, like an ENT and we don’t have one located at out home service unit. He needs to be seen by an orthopedic person but we have not been referred to one, to the specialist he needs. We are told he can get the special medical attention he needs when funds are available.

Although we do get referrals to specialists, our service unit can still refuse payment, which they recently did for my son, he had to be taken to an emergency room that was different from the one he normally utilizes. Travis had experienced an allergic reaction to a shot given earlier at an Indian health care facility. When the emergency occurred, Travis was taken to a facility that his school normally used for emergency care and treatment. Now currently our service unit has refused to pay for this emergency.

I also have been the caretaker of my aunt, who was 103 years old, and she died recently. In her earlier years she also required special health care services. This winter my aunt was on full code alert, which meant that she was to have immediate medical care and intervention if and when she required it. On March 3rd, she became unresponsive and no intervention was taken until 48 hours later. By that time she lapsed into a coma and died.

Over the past 18 years, my children and I have often had to travel great distances for health care. We struggle with four systems of health care, three educational systems. Although this is all very

nice that these programs and services exist on paper, we've found that none of them have adequately worked for us. They don't provide my children or families with the consistent quality accessible and culturally competent care that they need and deserve.

Rules change, providers move, Indian Health Service, commercial health care services are inconsistent and contradict one another and worst of all, assume that another, not them, have the responsibilities of payment. Imagine the paper shuffles, the phone calls on hold and the clinic waiting time.

The experiences of my family are not unique, families throughout this country whether urban or rural, face the same frustrations of health care and education across the country. This should not happen to families anywhere and especially should not happen to families whose ancestors settled this great country and with whom many, many promises were made.

I would like to recommend that there be culturally competent training of health care and educational professionals at the undergraduate and graduate levels. The Indian Health Service should be adequately funded to provide the quality care and

specialty care at all levels across the country. They should create and fund a family initiative for children's health information centers in every state, where families can find objective, family-friendly, culturally competent information about health care resources for their children with special health care needs, create partnerships and incentives for minority and traditionally under-served students to enroll in the health care profession and create a system of health care services that will ensure pediatric and geriatric health care for our nations two most vulnerable populations.

Thank you.

(Applause)

MS. AMARO: Thank you, Patricia, for bringing us into your experience and into your emotion, because it's very important for us to remember that we're not dealing with an academic exercise.

(Applause)

MS. AMARO: We're trying to be distant but the things that are being described by all of our speakers are things that impact the real lives of people, of families, and often can destroy the lives.

So as health care providers and those of us in position of making decisions, we have to stay connected to the impact that this has. And that I hope pushes us to act more swiftly and affectively, something that government is well known for, but we really need to do that.

The last speaker is Meizhu Lui, from Health Care for All. Please join me in welcoming Meizhu.

(Applause)

MS. LUI: When I was growing up and I had to identify myself by race, I had three boxes to choose from, black, white and other. Today, Asian Pacific Islander Americans have our own box, that’s progress, but we’re still largely invisible when it comes to health, as you can see from the lack of data on Asians in the chart book. To take one example, how many of you have heard of thalassemia, it’s a disorder of red blood cells, carried by about ten percent of Asians, causing severe anemia. Lack of data has led to lack of information, which has led to lack of funding for our health needs.

My parents are Chinese immigrants, they believe that staying healthy is not like keeping your

car running, it's not about your body parts getting fixed by a mechanic or about ingesting the latest high octane pharmaceutical concoction. My dad is not someone who s going to demand a prescription for Viagra.

(Laughter)

MS. LUI: The Asian view is that being healthy is about the wholeness of mind, body and spirit and maintaining harmony between you, your family and society. But it's pretty hard to feel harmonious when society makes you feel unwelcome. Recent racist anti-immigration legislation has added to the pain of being cast adrift from everything familiar. People of color are less healthy because we are more poor, as has been pointed out repeatedly. No matter how good your access to medical treatment, if you don't eat you want be healthy. So thanks, guys on the big hill, for restoring food stamps to legal immigrants.

(Applause)

MS. LUI: Asthma is a major threat to Asian children, but asthma and asthma attacks can be prevented if you live in a house that's free of mold, cockroaches and rats. It's ironic to read the U.S.

press applauding China for abandoning its policy of providing housing for everyone, when we know that here, with an unregulated marketplace, the growing lack of affordable quality housing is killing our kids.

(Applause)

MS. LUI: Asians are not only less likely to be insured, they don't even understand the concept of appointments, pre-approvals, collection agencies or the outrageous cost of care. One Chinese immigrant said, there should be free shots for everybody who needs it, like in Hong Kong. Fear of INS consequences stops many from seeking care they are entitled to, disabled Asians don't know what is available for them. There are not enough community health workers, trusted peers to help them navigate the troubled waters.

Many Asians prefer practitioners of Eastern alternative medicines, like herbalists, acupuncturists or ch'i gung specialists. However, even the best insurance doesn't reimburse for these services. If Asians do have to go to a hospital, interpreter services are missing. It's a common practice to tell patients to bring their own interpreter and that person is often their child. Not

only do children not know how to translate medicalese, a language more complicated than Chinese, not only do they have to hear about their parent's private bodily functions or illnesses that they should not be hearing about, worst of all it upsets the traditional family roles, where children are dependent on adults and not vice-versa.

(Applause)

MS. LUI: Some Asians who have practiced traditional remedies, like coining or cupping on their children, which leaves red marks on the skin, have been reported to DSS for child abuse and threatened with removal of their children. There are next to no American providers who understand our health beliefs and practices, while foreign trained health professionals end up working as housekeepers, unable to get recertification.

Southeast Asians surviving the horrors of war obviously require mental health services but these are sorely lacking. Even reunited families, even for them mental health is an issue. The irony is that the more successfully younger people integrate into U.S. society, the less they follow the tradition of respect and service to their elders, grandparents and parents

feel useless, disrespected and isolated culturally, even from their own children, and often become depressed and sometimes suicidal. We need to pay attention to these issues.

On the other hand, I had to laugh last year at the newspaper story about the research documenting the positive effects of ginkgo on memory retention, that hit the Asian newspapers 2,000 years ago, before some had paper. And only 25 years ago, acupuncture was considered a really crazy idea, how could those Asians believe that being stuck with needles could help in any way? And yet today, it's a therapy that helps even European-Americans deal with problems from drug addiction to arthritis.

Asians have much to learn, but we also have a lot to teach. There are people on both side of every barrier, don't assume we'll be fine just because we can cross the barrier by assimilating. It's better to build bridges that go in two directions and allow a free flow across the cultures. this goes beyond looking for the lowest common denominator, it means all of us enlarging our visions and enriching each other's menu of choices and progressing toward a system of multi-cultural competency. And we can do

it.

(Applause)

MS. LUI: As one Chinese immigrant said, the U.S. is such an advanced country, why don't we have a better health care system? If they put their mind to it, they can do it.

Thank you.

(Applause)

MS. AMARO: Thank you.

Now didn't I promise you a powerful panel? They were terrific.

(Applause)

MS. AMARO: We have heard three recurring themes. First, that services that are linguistically and culturally appropriate, provided by a diverse work force is the one that's going to understand the needs and the life experiences of the consumers and that that is what we need to put into place.

Second, that economic development to address issues of poverty that contribute to lack of access to services, but also to the increased risk for almost every health condition that we know about, needs to be addressed. So that means public health and prevention programs that help the poor, but also

economic development programs that help people out of poverty.

Third, the development and funding of public health prevention and intervention strategies that are appropriate and effective with our communities, we will be hearing about this in the next panel.

Now we are going to be opening up for discussion. I want to, before we get started and as you think about your questions, lay out some ground rules. We have very limited time and we would like as many people as possible to get to ask questions. So, I'm going to ask you to please keep your questions brief and to the point. If you have comments, that is you really don't have a question, try to resist the temptation of putting it into a question and instead, write it on the back of this card. Does everybody have this card? Please register and put it in the back. These are going to be transcribed and given to the commission.

So folks, if there are people who may need an interpreter, I'm not sure if there are people here who speak languages other than English, you can identify yourself by coming to the front and we will

try to accommodate you.

We'll form two lines. There will be microphones, I believe down the middle of the aisle and you can line up and ask your question. When you are going to speak, please state your name so we know who you are and where you live. We are going to first allow the advisory panel to ask questions, so the floor is open for questions.

DR. FOX: We want to give the first opportunity to members of our advisory panel for any questions or comments that they might have, then we'll take audience questions.

Yes, Governor Kean?

GOVERNOR KEAN: One question. The job we've been given is to give recommendations to the President of the United States to consider. If each of you had one most important recommendation, something the President could do, what would it be, what should we recommend to the President?

MS. LUI: One idea is to institutionalize the role of community health care workers into our health care system, as care is moving more and more out of hospitals and into community settings, that will become more important. But it's the community

health workers, and several people here have played that role, they are the bridges between community residents and the health care system.

MS. THOMAS: Mine would be to create and fund a family initiative for children's health information centers--

GOVERNOR KEAN: Pull the microphone up a little closer, I want to make sure everybody can hear you.

MS. THOMAS: It would be to fund the Indian Health Service more adequately across the country and to create and fund the family initiative for children's health care and information centers in every state.

MR. COBB: I'd say, continue advocating for needle exchange, with treatment on demand.

(Applause)

MS. GARCIA: My recommendation would be adequate funding for programs described, but especially for community health workers, so they could have a salary that would help them succeed in life and help their families.

MR. AUGUSTAVE: I would say, more cultural diversity trainings in our communities, for providers

and everybody.

MS. AMARO: I'm going to go ahead and add two to that. I think funding for training of public health and health care professionals, physicians, but also other health care professionals such as nurses, social workers, and people who work in public health and develop public health programs. If we do that, we will impact our universities, as teaching institutions they will be motivated to change the curriculum and all students will benefit.

The second would be to really work toward removing the existing barriers to health care coverage so for example, trying to extend health care coverage to men and adolescents more than we have right now. And to remove or include and improve the coverage for behavioral health care, including mental health services and substance abuse treatment.

Currently, the coverage is totally inadequate, we rely a lot on block grants. The reimbursement rate for block grants, for example, for residential treatment for one day of treatment, for a woman, in this state is $53 a day, for $53, you cannot provide adequate substance abuse treatment. That needs to change, we need to incorporate it into the

package of health care that we provide.

(Applause)

DR. FOX: Any other questions from our advisory members?

(No verbal response)

DR. FOX: All right, shall we move to the audience?

MS. AMARO: Okay. We have our microphones.

Would you please introduce yourself, Nicholas?

MR. CAROLAITA: I'm Nicholas Carolaita (ph) from the Latino Health Institute and I was planning to speak in Spanish now to point out that fact that we do have, and I am very happy, interpreters. But in this time and age we should be moving other language interpreters, other people do exist and they don't come to these things because they know they won't be able to understand.

My question is, to any of the panelists, do you recommend that the U.S. Department of Health and Human Services recommend guidance for the inclusion of medical interpretation as a medical procedure, so we can get it reimbursed and therefore,

finally get it on a professional basis?

MS. AMARO: Who would like to answer that, Meizhu?

MS. LUI: Yes.

(Laughter)

MS. GARCIA: And I would second that motion.

MS. AMARO: Do we have another person?

I think you got total approval on that one.

MR. CLARK: Good morning.

MS. AMARO: Good morning.

MR. CLARK: My name is Darren Clark, I'm from Dimock Community Health Center, I'm the program manager of a peer leadership program, I have one of my peers with me. I also am the youth minister of Mohammed's Mosque number 11 of the Nation of Islam, here in Boston.

My question is that we have identified from the panel here a great deal of diseases that are infecting the community. And the underlying disease from my perspective and from the youth perspective is the underlying racism that has brought about all these diseases.

My question is, is the term access for all inclusive of youth, when you have a government that cuts youth programs that are preventive and educational, cuts them by billions of dollars this past year, to where we are not going to be able to prevent these such diseases that were identified today. I want to know today, is the recommendation to the president to get back these funds to help prevent these diseases in the future?

Thank you.

MS. AMARO: Thank you. I think we understood that was a statement, yes?

Do you want to address it as a question to the panel? I guess the question is, is there, that the American public feels confused by the degree of commitment to adolescent and youth and doesn't understand why some programs are cut.

I think the panel will take this concern back to the President, as an issue that has come up and try to highlight the concern that was expressed here.

We have other folks on this side.

MR. GARRETT: My name is Haskell Garrett, I'm from Burlington, Vermont--

MS. AMARO: Could you hold on a second, we are going to have a response to that question and then we'll take you right after that.

DR. FRANKLIN: We'd be glad to take the question back for the President's consideration, to the extent that it is a federal responsibility. I would like to observe that most of the funding for educational programs, to which the gentleman referred, are state and local programs, which we have no jurisdiction over, you see.

Education is primarily a local responsibility. there are federal funds, but they wouldn't begin to impact the problem to which he has referred. To the extent that we can increase or support from the federal funds, programs for education we'd be glad to do so. But the moment the federal government goes beyond a certain point, the local and state forces individual citizens offices, raise the most profound, vigorous objections to what they call federal intervention in local education. So that's what we have to remember when we're talking about this.

MS. AMARO: Thank you, Professor Franklin.

Yes, can we take the next question.

MR. GARRETT: My name is Haskell Garrett and I'm from Burlington, Vermont. Vermont enjoys a reputation of being one of the whitest states in the country. However, that is simply not true, Vermont is changing significantly.

My question to the advisory committee is given the changing demographics of that state, however, at this point in time, resources are not targeted to communities of color when health initiatives are being discussed. We don't meet the formularies simply because we don't have the numbers right now, but all the data indicates that at some point five years down the line that we will represent a significant portion of the population.

MS. AMARO: Excuse me, I am going to ask you to be brief and to the point, because time is very limited.

MR. GARRETT: Okay. My question then is, is the federal government beginning to think about tying some kind of conditions around cultural competency and targeting funds to organizations directly that work with those populations, opposed to it going to the usual suspects?

MS. AMARO: Okay.

MR. GARRETT: Which is the state.

DR. FOX: Let me comment on that within HHS. We have within HRSA some specific activities right now around cultural competency and we're trying to look at ways we can go beyond where we are today. But I think all of our programs, particularly provided through the community health centers, through our HIV/AIDS programs, which again, many address adolescents and young adults, a question that was addressed previously, we are looking for ways to provide those in a culturally competent fashion.

And I just might mention that we just recently hired four primary leadership positions in the Ryan White Program and all of them were filled with minorities. So we're trying very hard within our agency to address that, we obviously need to continue to push that envelope.

MS. AMARO: We'll take another question from this side and then we're going to have to end, from what I'm told. I would encourage other people who are not going to get to talk, because we do need to go on to the other panel, to please submit your questions and your comments to us on your card.

MS. AMATIEL: My name is Neela Amatiel

(ph) and I'm originally from Haiti, chair of the nursing department at Atlantic Union College, South Lancaster. Unfortunately I'm not going to ask a question regarding the curriculum, but I will ask a question on behalf of sickle cell patients, why is such a less awareness, the public, the community have such less awareness of sickle cell? I have few answers they say because this chronic illness is not visible like cancer, like when you have chemotherapy, you have a bald head.

I would like to see, if it's possible, that the White House attend to this need in educating the community, the health care workers, to know that a sickle cell patient, when they come to the emergency room, disaster could happen.

MS. AMARO: Okay, your concern and comment will be noted and we will convey that.

I want to thank the panelists, please join me in giving them a round of applause, they came from far away to share with us.

Thank you.

(Applause)

DR. FOX: We apologize for not being able to take all the questions. But we have one more panel

and then we'll take some questions subsequent to that. So we want to have time to do that.

MODELS THAT WORK

DR. FOX: We've had the panelists share with us a number of the health care issues around health care access and problems. We want to talk now about some of the programs that appear to be working. We have to moderate our next panel, Joan Reede, from Harvard Medical School, if the panel and Dr. Reede could come up?

As you're doing so, I'll introduce Dr. Reede. She is Associate Dean for the Faculty Development and Diversity and Director of the Minority Faculty Development Program. She also holds appointments with Harvard Medical School, Harvard School of Public Health and Massachusetts General Hospital.

Her dedication to minority students, residents, to scientists, to physicians is all encompassing and has spawned efforts such as the biomedical science careers project that brings together academia, industry and education to the professions to assist minority students, trainees and professionals pursuing biomedical careers.

She has developed mentoring programs for high school, undergraduate, graduate and medical school students and a training program for middle and high school teachers. She recently received the Salzburg Seminary Presidential Fellowship, which she has used to study race and ethnicity models of diversity.

And we have no one that is any better qualified than Dr. Reede to lead our next panel.

(Applause)

DR. REEDE: Thank you very much. Thank you, Dr. Fox and members of the President's Advisory Board and others who are here today. It's a wonderful opportunity to participate in this conversation on race and in particular this discussion on the identification of barriers and the building of bridges that will enable us to close gaps, gaps that relate to health disparities and issues of poverty, housing, education, employment, issues that have been discussed by previous presenters. And borrowing from Dr. Satcher, access gaps, access gaps that are related to being uninsured, under insured, under represented and under served.

This second panel will address models,

successful models concerning issues of access, workforce diversity and cultural competence. In the interests of time, I'm going to introduce each of the presenters or speakers in order now and they will come up subsequent to that.

Our first presenter is Elmer Freeman, who is the former Executive Director at the Whittier Street Neighborhood Health Center, from 1981 to 1997. He is currently Executive Director of the Center for Community Health Education, Research and Service, otherwise known as CCHERS, here in Boston.

The second presenter is Zoila Torres Feldman, a nurse who also has a Master of Science from Harvard School of Public Health and has been the Executive Director of the Great Brook Valley Health Center since 1983. This center is located in Worcester.

The third presenter is Peggy Leong. Dr. Leong is currently the administrative Director for the Department of Neurology at the Beth Israel/Deaconess Medical Center and was formerly, from 1983 to 1997, the Director of Clinical Operations for the South Cove Community Health Center, here in Boston.

The fourth presenter, Barbara Namias, is a member of the St. Regis Mohawk Indian Tribe. She has directed U.S. Title 5 Indian Health Services programs here in the Boston area for over 17 years and is currently with the North American Indian Center of Boston.

Our final presenter is Vanna Lee. Vanna came to the United States in 1980, from Vietnam and since 1992 has served as Director of the Southeast Asian Health Program, which is in the Family Health and Social Service Center, in Worcester, Massachusetts.

Thank you and we'll start with Elmer Freeman.

MR. FREEMAN: Good morning. I want to say it is a distinct honor to be engaged in this dialogue on race and health care. I want to thank the panel and the Advisory Board for coming to Boston to hold this particular dialogue.

As Joan indicated, I am the Executive Director for the Center for Community Health Education, Research and Service, fondly known as CCHERS. CCHERS was started in 1991 as a partnership between Boston University School of Medicine,

Northeastern University's College of Nursing, Boston Medical Center, Boston Public Health Commission and 12 community health centers within the city. It was one of seven projects funded nationally by W.K. Kellogg Foundation in its Community Partnerships in Health Professions Education Initiative.

CCHERS is a model for preparing suitable educated primary care providers and to address the health care needs of under-served populations in Boston. CCHERS has fostered major curriculum changes in medical and nursing schools, has increased access to health promotion and disease prevention services in the neighborhoods an initiated a community derived and directed research into health issues that are unique to urban populations. Health professions programs at high school, college, graduate and professional levels have been transformed to prepare providers to meet the needs of people and communities.

Community health centers have been transformed into academic community health centers that incorporate teaching and research into their historic service missions. Most significantly, the great divide that existed between communities and health profession institutions has been bridged

through this partnership.

For 16 years, however, I was the Executive Director of the Whittier Street Neighborhood Health Center here in Roxbury, serving a population of predominantly low income African-Americans and Latinos. When I decided, as the director of Whittier Street, in 1991, that the center would become a partner in the CCHERS project it was because I recognized the opportunity CCHERS represented for recruitment and retention of community oriented providers.

I understood professional education as a socialization process and knew that if given the opportunity we could effectively grow our own providers. Just think, doctors and nurses who are culturally competent and reflected the community based primary care principles and values of the health centers. Values of equity, access and respect. No matter what your ability to pay, no matter what language you spoke, and no matter what color of your skin. We believe the words of Reverend Dr. Martin Luther King, who said, that of all forms of inequity, injustice in health care is the most shocking and the most inhumane.

The goal of CCHERS is to increase the number of primary care providers being educated in community based centers, practicing in interdisciplinary health care teams and providing quality health care to medically under-served populations. Starting with the education of medical and nursing students, CCHERS has expanded to include primary care residents in internal medicine, pediatrics and family practice, graduate nurse practitioners, social workers and physical therapists, as well as other allied health disciplines.

Additionally, that which I am most proud of, is the Boston Health Careers Academy, the first public high school in the city for students interested in pursuing a career in the health professions, established by CCHERs in 1996. The academy has 220 students, grades nine through twelve, of which 94 percent are African-American and Latino. And come this September, it will be relocated to the campus of Northeastern University.

CCHERS is a model of health professions education and improves access and ensures workforce diversity and promotes cultural competence. The interrelationship between these factors are evident.

CCHERS has achieved some significant accomplishments over the past six and half years, such as increase access to health care, greater workforce diversity and ensuring culturally competent services.

We know that racial minorities are more likely to be uninsured, live in under-served areas with a shortage of physicians and other health care providers, Income level and insurance coverage are major determining factors associated with access to health care.

Every year, about 500 medical, nursing and allied health students provide a range of health promotion and disease prevention services to thousands of Boston residents in health centers, public housing developments, elderly nutrition sites, day care centers, schools and a host of other community based organizations. We know that the representation of African-Americans, Latinos and other minorities have not reached parity with the population and the enrollments of individuals from these groups in medical schools and other health professions schools, in fact is declining.

CCHERS is changing the perceptions, values and motivations of medical and nursing students and

more of them are choosing primary care and careers in community health. We know that cultural competence is a vital part of the efficacy and quality of health care services provided. Culturally competent providers contribute to improved health outcomes, greater patient satisfaction and compliance and ultimately more efficient cost of care.

We have created a model in which the combination of community based education, research and service allows the community health center to parallel a teaching hospital. CCHERS is a model and should be replicated.

And I will close with the following recommendations to the Advisory Board. Government funding for graduate medical education through federal Medicaid and Medicare reimbursement must be extended to community health centers through consortia with hospitals and health profession schools.

(Applause)

MR. FREEMAN: Secondly, graduate medical education and funding should be made available to support other health profession disciplines, such as nursing and social work and also provide incentives for recruitment of racial and ethnic minorities.

And finally, faculty rewards for promotion and tenure, and colleges and universities should place greater value on community service and research instead of the university mantra of publish or perish.

Thank you for this opportunity.

(Applause)

MS. FELDMAN: Good morning. It's an honor to be invited here today, but it really has been a privilege for me to work for 18 years at a community health center.

For 33 years, community health centers have been at the forefront of developing a niche that responds to the special needs of vulnerable populations. the locations of community health centers have been determined in large part by the location of medically under-served communities.

Also, in order to provide culturally competent medical care to minority populations, community health centers have not only used translators and non-English speaking personnel on their staffs, but also hire and nurture multidisciplinary teams of minority professionals.

But is has seen the need to eliminate disparities in the quality of health of the medically

under-served populations that has led CHCs to develop innovative and effective models of care. At the great Brook Valley Health Center, in Worcester, we serve clients with limited access to primary care from the City of Worcester and 51 surrounding towns. While our clients speak many languages and represent many ethnic groups, the majority of our clients are poor, Latino, with little or no fluency in English. Almost half of our clients are uninsured.

The model of care delivered at Great Brook Valley Health Center is a blended primary care and public health model and our target is the improvement of the health status in the community. Our approach, grounded in the principles of population based medicine, requires the cooperative efforts of an interdisciplinary team of outreach workers, clinicians and case mangers. The first critical component of our model requires tracking the changes in health and status indicators through a variety of methods, ranging from home health assessment and street outreach, to comparisons of our patients' diagnoses with local, state and federal epidemiological data. Our analysis of data is used them to develop or modify our programs on an ongoing basis.

Second, because we view every meeting with a patient as an opportunity to improve his or her health and the health of the community, the care provided at Great Brook Valley Health Center is defined by the client's actual needs rather than by the matter in which he or she sought care. Through the use of standard care protocols, our multilingual nurses assess every client's needs at the time of the visit, including a review of the need for such preventive measures as immunizations, tuberculosis or hepatitis screening, or chronic disease assessment or monitoring, regardless of whether the client is there for a continuity of care appointment or an urgent care visit.

This client specific model, while successful in caring for vulnerable populations in an urban environment is amenable to be used in any setting and holds a special relevance in a rural or outpost environment, where a provider may not see the client on a frequent basis.

Last week, for example, one of our patients with AIDS walked in seeking a letter required to access care at an AIDS services organization. The HIV nurse case manager identified the client's overdue

need for a pentamidine treatment, laboratory follow up, medication management and continuity care. He left having received not just am appointment for a pentamidine treatment, but rather the treatment itself, along with the necessary laboratory, medications, medication management, education and tools and a connection with a social worker and primary care worker.

Nationally, community health centers, with support from HRSA, are involved in establishing similar models of care through parallel systems of continuity and urgent care. At Great Brook Valley, this version of primary care with a public health focus is funded by HRSA through its public housing and community health center funding programs. The effectiveness of this model can be measured by as indicated by the following examples:

Approximately eight percent of our clients live in public housing, where asthma is highly prevalent. At Great Brook Valley we have successfully implemented the NIH guidelines through an educational program that uses an analogy which is culturally congruent, linguistically appropriate and easy to understand. In the three and a half year study of

enrolled asthma clients, Great Brook Valley reduced hospital admissions by 42 percent, reduced hospital days for those clients that needed admission by 28 percent and reduced use of emergency room visits by 25 percent. Those same patients reported a significant increase in their air flow measurements and quality of life indicators.

One particular asthmatic client, a Spanish speaking uninsured 51 year old man who had been hospitalized nine times in two years, had visited the emergency room 35 times during the same two years, and had been intubated four times during those two years. through our teaching and case management protocols, following our call in on our Spanish speaking radio, we were able to reduce his visits to the emergency room to two during the first year under our care and none in the second. Additionally, the patient had no admissions to the hospital and no intubations during the two year period.

We estimate conservatively that the annual medical cost of this client before entering our care was $140,000. Our nurse saw him monthly, for which we receive an annual reimbursement of $800.

Because of the high prevalence of Diabetes

Mellitus in Latinos, as documented by the CDC, three years ago we instituted an initiative to screen for diabetes and to educate and give our patients the necessary tools to manage their diabetes. In a relatively short time, we have accomplished significant success. Since the program was implemented we obtained a 63 percent increase in the number of diabetics with HgA1c measurement of equal or less than eight, a way of measuring glucose management. More than half of our clients are controlling their glucose levels, twice as many as before have received care from a podiatrist, and 83 percent of those who smoked have participated in smoking cessation training.

This culturally appropriate targeted initiatives at Great Brook Valley Health Center and at community health centers in general are the preferable means by which we can expand access and address the more recently identified disparities in racial minorities.

Thank you very much.

(Applause)

MS. LEONG: Good morning, ladies and gentlemen. Thank you for the honor of selecting South

Cove Community Health Center as a model for culturally appropriate health care delivery. I'm the new Executive Director of South Cove Community Health Center and I wish to acknowledge my predecessor, Jean Chin, Jean has been with the health center for ten years.

(Applause)

MS. LEONG: So, Jean, I hope I'm going to say what you would have said today.

South Cove is a private nonprofit agency founded in 1972 by Asian community activists in response to the lack of primary health care available in the Boston Chinatown community. 26 years later, with a staff of 150, we provide services to 13,500 patients from diverse ethnic backgrounds, living in more than 30 towns and neighborhoods in greater Boston. Our staff speak Vietnamese, Cambodian, Laotian, Japanese, a little Malay, I speak that, and several Chinese dialects, including Mandarin, Cantonese, Toucenese and Foucanese.

Our services include internal medicine, pediatrics, obstetrics, gynecology, mental health, dentistry, optometry and podiatry. South Cove also provides support services, such as health education

outreach and social services tailored to the specific needs of the Asian community. South Cove's mission is to provide accessible and affordable health care to the Asian community.

We give priority to the low income, first generation chinese, Vietnamese and cambodian immigrants and refugees. South Cove's sites are located in the Boston Chinatown and North Quincy area, where many Asian-Americans live. Our clinics are located near public transportation so that we lower the geographical barrier of access.

We also negotiate for grants, to help reduce the cost of delivering health care to the Asian-American population. South Cove also negotiates with tertiary hospitals in the Boston area to help our patients navigate the in-patient and specialty medical system. An example of this is our special obstetric program that we do in conjunction with the Beth Israel/Deaconess Medical Center.

This program is designed for Asian women to receive 24 hour support from our specialty trained labor coaches and nurse midwives. The labor coaches serve as supportive friend, interpreters and coaches during delivery, especially for women coming from

cultures where their husbands do not usually go into the delivery room with them.

This outstanding program also has prenatal classes, nutritional counseling and newborn education for the program participants. And this is all done in their primary language and using examples relevant to their culture.

On the issue of workforce diversity, South Cove's practice model is to encompass the strength in the Asian and in the American cultures in delivering primary care and mental health care to our population. We actively recruit bilingual, bicultural providers so that our patients can communicate directly and identify with our providers. 90 percent of our staff speak at least one Asian language. The majority of our staff also live in the communities that they serve.

On cultural competence, our staff is a cross section of the Asian communities in greater Boston. We have learned a great deal about valuing differences among the diverse Asian populations from our patients. Our staff work not only with our patients but with their families. Our mental health team brings special cultural sensitivity in helping

our patients deal with mental illness, an often unmentioned problem in several Asian communities.

South Cove's goal is to target those health risks more prevalent among new immigrant Asian-Americans, such as hepatitis-B, tuberculosis, thalassemia, stroke and cancers.

Now, to recommendations. We recommend to the panel to bring back to the President that they should continue to support programs like CCHERS so that it will help train more minority health care providers so that we can recruit them to work with us in community health care centers.

And finally, we believe South Cove's success is due to the grass roots support from our community, a blending of the best of the Asian and american cultures. And South Cove's goal is to be the best health care provider to the Asian-American community and also to be the best health care employer to Asian-Americans in the greater Boston area.

Thank you.

(Applause)

MS. NAMIAS: Good morning and good health.

I've been asked to profile the community health service delivery system operating from the

North American Indian Center of Boston, or NAICOB. The system's purpose is to assist in raising the level of health care for American Indians and Alaskan Natives residing in the greater Boston area.

According to the 1990 census, this population numbers close to 6,000 individuals, yet little health data exists at the state level or within the health profiles of the 103 towns in cities in NAICOB's health service delivery area. Within Massachusetts, most racial and health indicators track only white, black, Hispanic and Asian service users. American Indian, Alaskan Natives are gathered, if at all, in an "other" category.

To complicate matters, Native Americans is the term used in Massachusetts to imply American Indian, Alaska Native tribal identity. However, this term does not provide an accurate count of the targeted North America Indian population.

NAICOB's health system promotes community wellness from a preventative perspective, by reinforcing traditional cultural methods for maintaining health, physically, mentally, psychologically, emotionally and spiritually. We promote maintenance of healthy minds, bodies and

spirit, through proper nutrition, exercise and inner fortification, thereby preparing the individual to contribute to the overall wellness and sustenance of the community.

Traditionally, the tribal community, with its extended family or clan systems, stress the good of the group over the individual. Sharing was the norm, not saving. Cooperation instead of competition led one in harmony with, not master over, the environment. These strengths we revisit with our community members who share their thoughts, experiences with urban life, and their spirits. Together we plan for the next cycle.

A disease specific initiative known as the Circle of Wellness has developed an HIV/AIDS education and peer training curriculum. The series illustrates and supports value systems appropriate for North Eastern American Indian societies. Within NAICOB's service user population, Northeastern native societies have the largest representation, although tribal populations serviced by NAICOB include citizens of over 20 native nations within North America. Value commonalities within the target audience allow for interactive learning settings and culturally competent

program development, rich in tribal diversity.

Between October ‘97 and September ‘98, 197 individuals accessed health services, through NAICOB’s program, for a total of 2,647 annual service encounters. By far, this service population demonstrates that American Indian people living in Greater Boston do have unmet health needs, even with Mass. Health, Comm. Health, the Children’s Medical Security Plan and other state health insurance models. Our service utilization record demonstrates that the community will access available health services provided from the urban Indian center, at a rate higher than if the service were provided by a non Indian provider.

This past Wednesday, July 8th, the Union Square Family Health Center in Somerville, Massachusetts began setting aside one afternoon per week to provide American Indian, Alaska Native adults with primary care. The attending physician and the assisting RN are both American Indian, thereby offering the only American Indian provider consumer clinic in the Commonwealth of Massachusetts. Access to the clinic is through the community health program at the North American Indian Center of Boston.

Beginning in the very near future are three new programs design ed after the extremely popular and successful Circle of Wellness program. They include two disease specific programs targeting cervical cancer and diabetes, as well as a program targeting the 55+ plus community, Senior Wellness.

The services in place at NAICOB are made possible by the funding from the United States Indian Health Service. Only the Circle of Wellness program is funded by a non-federal source, the Commonwealth of Massachusetts' Department of Public Health, but only after assistance from another minority service provider. unable to survive in the cost reimbursement state vendor system, NAICOB entered into an agreement with the Latino health Institute to serve as the fiscal conduit for the grant. This agreement is now entering its fourth successful year.

The Diabetes and the Senior Wellness program will have 100 percent funding from the Indian Health Service. The other, a cervical cancer screening and education series, is jointly funded by the Dana Farber Cancer Institute and the United Way of Massachusetts Bay.

Maintenance of the above community health

system is threatened by federal redesign and budget reduction initiatives. States lack service delivery experience and practical applications systems. HRSA must lead federal efforts to provide states with the necessary tools and information which permit Indian operated health service delivery systems to continue and grow and welcome the 21st Century.

Thank you.

(Applause)

MS. LEE: Good morning. My name is Vanna Lee. I have been working at Family Health & Social Service Center as the Director of the Southeast Asian Health Program. This program is a community based health program, disease prevention program that provides outreach, health education, screening and assisting client access to health care services. Some of these health education screening and counseling include hepatitis-B, tuberculosis, diabetes, breast cancer, cervical cancer and tobacco related diseases.

The clients we serve are faced with many life challenges and problems, like adjustment disorder, stress of acculturation and the need to find and keep a job, post traumatic stress disorder as well as chronic disease risk factors. Although the risk

factors of certain chronic diseases and cancer are high, their awareness of risks associated with undetected cancer and chronic diseases is low.

Through our health risk assessment tool, we have found that 71 percent of Southeast Asian women over the age of 18 have never had a Pap test. 73 percent of the women over the age of 40 have never had a mammogram. And 80 percent of our individuals have never had hepatitis-B.

At the same time, these individuals encounter many barriers to health education and health care services. There are many significant sociocultural and access barriers than just language, traditional health practices, gas and transportation, lack of knowledge of existing services and lack of health insurance. Nearly all the clients we serve over the age of 30 spoke limited English. Over 60 percent of the clients had been in the U.S. for five years or less. And 50 percent were found to have no health insurance coverage.

Experience has shown that many of these barriers can be overcome when services are provided in a culturally and linguistically sensitive manner, when the program model is rational and innovative and when

health care infrastructure is supportive. The Southeast Asia Health program employs highly skilled bilingual and bicultural Southeast Asians who are cross trained in all different areas of health and social services. They are also trained in diversity to ensure that our service is sensitive to the needs of each individual and family that we serve.

Furthermore, all of our health educators are recruited from the community, they know the community well, and are respected by the community, and all demonstrate a commitment to work with the community by providing outreach and education in the evenings and weekends, and also in places that are convenient for clients.

Staff are also involved in development of cultural and linguistic sensitive health literatures, videos, newsletters, as well as providing culturally sensitive trainings to area health care and social service providers. The program involves an extensive amount of collaboration both within and outside the health center. Internally, the program links with every aspect of the operation. Externally, the program collaborates with schools, Vietnamese bilingual teachers, local HMOs, health care and social

service providers, civic and faith organizations.

In conjunction with the health center staff, we conduct special ongoing evening and weekend Pap clinics and mammography screening. The health center phlebotomist also accompanies us to health fairs, community and cultural celebrations, in order to provide health screening. We work with the Worcester Public Schools in order to provide education and provide certain screening to Southeast Asian students. And we collaborate with local HMOs to provide free hepatitis-B screening, open to the public.

The program also incorporates evaluation activities, which focus on assessing the effectiveness of program activities while simultaneously striving to identify previously unrecognized high risk groups or conditions within the Southeast Asian community.

Of the people we encounter, over 50 percent have no primary care provider. Program staff assist in linking them to a health care provider by making appointments, arranging transportation as needed. We help them by helping them apply for essential care and our sliding fee scale at the health center. On the first visit, we will meet up with

clients at the door to provide orientation to the health care system and to direct them with checking in and registration.

The multiple departments within the health center are also staffed with bilingual and bicultural Vietnamese employees who can further assist patients with health care access. Over the years we have made many successful preventions and interventions and I want to give you one example in particular.

Through our outreach, a health educator encountered a 48 year old Vietnamese woman who had just arrived in this country. She did not have a primary care provider nor health insurance. She also appeared very healthy and didn't think that she needed to be seeing a doctor or any of our services.

After much convincing, she agreed to have all the recommended screening. The results came back and she was found positive with hepatitis-B. We contacted all her close contacts for hepatitis-B tests and immunization. She also had an abnormal Pap smear and subsequent biopsy showed she was at risk for cervical cancer. Because she did not have a primary health care provider, did not have health insurance, preferred to be seen by a female doctor, did not have

transportation and did not speak any English, all of our staff at the health center, including nurses, doctors, case managers and interpreters came together to work with her. And I'm happy to say that she is doing very well today.

This program works because of a synergy between carefully selected and devoted staff members, supportive direction from the community and rational and innovative program model with the community health center, and a commitment to collaboration and thorough evaluation programs. Many of these essential services would not be possible if it wasn't for funding from the department. And we need this financial support to continue providing these important services.

Thank you.

(Applause)

DR. REEDE: I want to thank all of the panelists, we've had a lot of discussions about keeping their time in frame and they kept looking over at me, saying, do I have another second, do I have another second? So, thank you very much.

In listening to the five presenters, there are four themes that I've been able to note, one is the use of multidisciplinary and interdisciplinary

teams, where the importance of workforce diversity is recognized, clearly recognized and taken into consideration.

The second is the importance of collaboration and partnering, on multiple levels. They talked about internal and external partnering, public and private partnering with community agencies, partnering with academic institutions.

Third, the need for data. The need for data gathering and analysis as a substantive component of the infrastructure.

And fourth, that ensuring access and cultural competency in their health systems requires the involvement of the community, it’s an essential element.

With this we are going to open and turn over to the question component and I’d like to begin with the questions from the Advisory Board. While we’re starting this, I’d like people to start to queue up on the sides. I’m going to ask you, with your questions, the questions from the audience, that you make them questions not comments and for your comments, if you actually write them on the back of these yellow pieces of paper you will get a response

to them. And also that you limit yourself to one question, not more than one.

With that I'd like to open it up to the Advisory Board.

EXEC. DIR. WINSTON: I was particularly struck by the themes, Dr. Reede that you indicated but I am also particularly interested in the degree to which the ability to partner with other entities within the community, the degree to which it is, those partnering agreements are impeded or supported by state, local or federal regulations? What is the importance of the partnering relationship with schools, businesses, churches, social service agencies, and to what extent are you finding it easy or not, to develop those partnerships through programs supported by state, local and federal entities?

MS. LEE: I'm sorry, the question was was it easy to form the partnerships?

EXEC. DIR. WINSTON: To what extent are you aided in forming those partnerships? How important are they and to what extent are you aided or impede by state, local and federal rules? That sort of thing.

MS. LEE: I couldn't really hear because

of the echoes.

EXEC. DIR. WINSTON: In terms of the partnerships that have been created, to what extent have they been impeded or assisted, looking at federal, state, local initiatives, programs, funding, et cetera? How easy it is for you to do the partnering?

MS. LEE: With the local organizations, for example like churches or temples or the civic organizations, it has been extremely difficult and challenging to form that kind of partnership because the priority of the community has been to help the community with housing and jobs and things like that, so it takes a lot of education and informing the community and the leaders that this is also a very important and that they have to take it into consideration.

MR. FREEMAN: A significant impediment to us in the creation of the CCHERs project has been, In fact, the way graduate medical education is being funded through Medicare and Medicaid and the reimbursement system. For years now, I'd say as many as 10 to 15 years, residency programs have been moving towards communities, but even more so today.

Teaching hospitals historically have gotten money to support residency training through the reimbursement system, clearly that needs to follow the residents into community health centers, which are much more vulnerable, relative to finances and the ability to actually build the capacity to do residency training.

I think society has made a conscious decision under the Medicare act, when it decided that the training of doctors was something that was good and beneficial to society. I suggest that the training of other health professionals particularly nurses, social workers and community health workers is also beneficial to society, relative to eliminating many of the disparities and the barriers of access to people of color.

And I would suggest that a reform of graduate medical education take into account the expansion into other health disciplines and into community based centers.

DR. REEDE: Any other questions from the panel?

(No verbal response)

DR. REEDE: I'd like to ask one question

myself, in the area, we talked about community involvement and the importance of community involvement and how have you been able to achieve that, furthering on the other questions? And to what extent has that been important in terms of bringing up the issues of access and cultural competence?

MS. FELDMAN: I think that community participation is really critical, that has been demonstrated by other examples and other programs. The participation of the community and governance, the community health centers, I think, is a really critical way of keeping us in touch with what the community needs. But in addition to that, you seem -- recruiting individuals to work at the health center, community health workers, individuals who live in the community who are familiar with the neighborhood, who are doing home health assessments.

Beyond that, making sure that we still have focus groups, that we have opportunities for our clients to participate in the evaluation. We have a system where we have a question of the month so that it’s not once a year that we ask whether the people are satisfied or whether they have a particular, so I think there is a particular --.

So I think there is a need and a real strength in our ability to keep really in touch every day with our community.

DR. REEDE: Thank you.

I'm going to open it up to the audience again.

CHAIRMAN FRANKLIN: The kind of reports that these five panelists have presented are the kind that give us great hope for the program generally because they are subsumed under what we call promising practices. Although the initiative was in many instances, long before our own board was thought about, they nevertheless point the way to things and activities which certainly give us hope and give us optimism about the use of these sort of grass roots activities as examples of what might be done in various parts of the country. So they are promising practices, certainly some of them should be on our website so that they can be shared with other part of the country.

DR. REEDE: Wonderful.

Please state your name.

GOVERNOR WINTER: I wanted to add this comment to what Dr. Franklin has said. We are here in

New England, Dr. Fox and I have come from rural Mississippi. Yesterday afternoon I was involved in a forum in Mount Bayou Mississippi, in the heart of the Mississippi delta. Mount Bayou is a community that was established by former slaves after the Civil War, an African-American enclave, it still is all African-American.

And a meeting was held there yesterday involving some of the expatriate citizens of that community who had gone off and been very successful educational leaders in other areas of the country and we met there in a church in Mount Bayou. And I must tell you that it could not be more different, the setting could not be more different than this setting here in Faneuil Hall in Boston.

But I must also tell you that the concerns and the issues and the needs, the problems in Mount Bayou, Mississippi are not unlike those that we've heard about here. It is a problem that across this country, as our Initiative on Race has heard from people like you in all areas of the country, it is a problem that involves all of us, from whatever section we come from. And it is our ability to work together to solve these problems, with respect to the delivery

of health care so that nobody gets left out, is a national problem and we cannot become truly one America until we solve these problems together.

That's why it is so important and so meaningful for us to hear this testimony from those of you who have been working at the grass roots level. And hopefully, out of this experience here, we can create an understanding across this country of how inter-related we are and how we must solve these problems together. That is the message I hope this initiative will be able to carry to the President, but to carry to the American people also.

DR. REEDE: Thank you.

MR. MARA: My name is Bob Mara.

When President Clinton went to Africa, he talked about slavery and he talked about reparations. My question i sin two parts, what do you think, especially Dr. Franklin and Mr. Winter, about reparations for American slavery?

And what do you think American slavery means, does it include Caribbean-Americans who were slaves and does it include Brazilian-Americans who were slaves, many of whom enriched most of the white men in that picture up there, long before there was

slavery in that part of the world.

What do you think, again, about reparations as an issue and do you think that at a minimum, reparations should include access to health care and food stamps for descendants of those slaves, including immigrants from those countries I just mentioned.

CHAIRMAN FRANKLIN: I am of the opinion that if you can get reparations, get them.

(Laughter)

CHAIRMAN FRANKLIN: I am also of the opinion that you're barking up the wrong tree. If you can't have affirmative action, which is a form of reparations, without people yelling that it's un-American, unconstitutional, illegal and all the rest of it, they don't give that, even begrudgingly, how in the world are you going to get someone to even countenance in any serious way, reparations for deeds that were committed 150 to 200 years ago, and to whom they will be paid is another matter.

I will further point out that the period of the most abject suffering, on the part of African-Americans and others, has occurred in this century.

(Applause)

CHAIRMAN FRANKLIN: Not in a slave period, but in this century, with the lynchings and the burnings and the riots and the indignities and the segregation from which blacks and others have suffered in this century, really, in a sense almost obscures that period, except to indicate that there is a linkage.

So as I look at the present and at the future, I would be greatly heartened if we could get some support for programs in 1998 that will level the playing field and would give people the opportunity to live decently, respectable lives. To have these great major industries to stop deliberately discriminating against people, if you want to rent a car, you can't rent one without going through the most extraordinary activities and efforts in some places. If you want to get a meal, even in 1998, it takes some doing.

So let's talk about, I'm a historian and I look back on that period with great disdain and great feeling, but I would pull the curtain on that if I could get some decent treatment today, in 1998.

(Applause)

CHAIRMAN FRANKLIN: I was pushing my own

grocery cart in Grover's, in Durham, yesterday, doing my shopping and a white man came up to me and says, you work here, where are the tomatoes?

(Laughter)

CHAIRMAN FRANKLIN: I simply pointed to my, I wouldn't trust myself, I simply pointed to my own shopping cart and went on.

(Applause)

CHAIRMAN FRANKLIN: It is my view that we ought to address the problems that exist in this country in 1998. I know there are backdrops and period s in the past with which I am intimately acquainted, I spent 80 years working on it, but even with that, I think the present and the future demand our attention. Our wounds are there, we must lick them and we must soothe them and move on.

MR. CHING: Hi, my name is Kevin Ching and I have a question directed to Peggy Leong and to Vanna Lee.

What measures or programs are being implemented here in Boston to address the mental health status of Southeast Asian youth and the rising incidence of gang violence and gang activity in their community?

MS. LEONG: South Cove has a program called MICA, which is Metropolitan Indochinese Adolescent Program, in Dorchester and in Lynn. We have recruited bilingual, bicultural case workers, mental health professionals to work with teenagers.

In the summer we have multiple programs, hoping to engage teens in team building, in peer development, for leadership and trying to engage them early while they are on break from school. And during the school year, to have after school programs, where they can learn from each other and from the leaders we have as employees. We have gone after grants and funding in order to provide this kind of service, it's free to the participants.

MS. LEE: Besides the health education component of chronic disease, we also have a peer leadership program as well. All these peers are recruited from the schools, either middle school or high school, and they are all Southeast Asians. And some of the issues they work on are self-identities and cultural sensitivities and many other health issues and gang violence is also part of that.

We also work with bilingual teachers in the school system and principals, so that any time

there is any of these issues arise, or even to prevent it, there will be sources that we can identify with.

In terms of mental health, Family Health also has a mental health component where we employ Asian staff and our staff is also working very closely with the mental health department. And when we do outreach, we also, mental health education is also part of the education that we provide.

MS. DUNEDAY: Hello, my name is Lisa Duneday, I'm the director of the Community Health Education Center, which is a program of the Boston Public Health Commission, dedicated to the professional development of community health workers.

I would like to add one more item to the 1998 program list for Mr. Franklin. We've talked about the disparities in access and the need to diversify the health care work force.

I would like to point out a major disparity within health professions that in my opinion severely threatens our goal of achieving workforce diversity. Community health workers are that ideal work force we've been talking about, they represent and live in the communities they serve, they are skilled in public health issues and health areas, they

have walked in the shoes of the clients they so effectively serve. Yet they are currently funded by grants and are really an add-on, rather than essential members of the health care team.

My recommendation, and I would love a reply or comments from the panel, is that you look closely at the outstanding track record of these public health professionals and find ways to fund them on a permanent basis, as core members of the public health team.

(Applause)

DR. REEDE: Couldn't hear?

If you could hold the microphone closer and if you could just repeat briefly your final recommendation, briefly.

MS. DUNEDAY: I will do it faster, how's that?

We have talked about the disparities in access to care and the need to diversify the health care workforce. I would like to point out the majority disparity within health care professions that in my opinion severely threatens our goal of achieving work force diversity. Community health workers are that ideal work force we've been talking about, they

represent and live in the communities they serve, they are skilled in public health issues and health areas, they have walked in the shoes of the clients they so effectively serve. Yet they are currently funded by grants and are really an add-on, rather than essential members of the health care team.

My recommendation, and I would love a reply or comments from the panel, is that you look closely at the outstanding track record of these public health professionals and find ways to fund them on a permanent basis, as core members of the public health team.

EXEC. DIR. WINSTON: Let me thank you, on behalf of the Initiative, for that recommendation and ask that you submit that comment to us and we will indeed look closely at that recommendation, as you suggest we should.

DR. FOX: Can I make a comment. I might state that, as you know, HRSA has funded in a variety of communities, community health workers. The dilemma is the inability to obtain funding on a fee-for-service or reimbursement basis from third party carriers, to provide sustainability and growth among those community workers. And that’s the problem and

that's the need in this country, a way to fund those as we fund doctors and nurses and others, so that there is a sustained source of income to support those community workers. We agree with you.

DR. REEDE: In the interests of time, this is going to be the last question.

MR. JONES: My name is Charles Jones, I live in Norwood, Massachusetts.

I would like to ask Dr. Franklin to just ask the President to do one thing before he leaves office and that is to guarantee for all Americans, the type of health care that they guarantee our military.

Thank you.

(Applause)

DR. REEDE: The recommendation from the last person was that the level of care that is guaranteed in the military be guaranteed for all Americans.

With this I want to say thank you to all of you, thank you to the panelists for the work you've done, for the work that your centers have done and for your marvelous presentation.

And the other thing I'd like to say, just on a personal note, that so much of correcting or

addressing issues of race and disparity in what goes on in the health care system is not just an issue for the federal government of for the states, it's really something that is part of the responsibility for all of us.

DR. FOX: Thank you.

Let me remind you, we apologize for not having any more time, but if you will, if you have other comments or questions, please put them on the yellow card and give them to us because we want your comments, and this is a way to do that. And we promise we will look at them and consider them, and they will go in, just as if you had the chance to stand up and make them verbally.

Let me say in closing, we want to thank the panelists, the Advisory Board members and all the people who've worked hard to put this conference together.

But quite frankly, what Dr. Satcher said in his comments is that to continue the racial disparities in this country as we have today is not humane. It is not humane to have a mother and two children have to take two buses and a cab to get to her clinic appointment.

It is not humane to have to have six weeks or eight weeks before you get your first prenatal visit. It is not humane to not have dental care. It is not humane to have a provider that doesn't speak your language. It is not humane to be denied a voice in your own health care. And it is not humane to receive health care only at the end of your disease process.

You know, we have in this country now, the highest rate of immunization that we've ever had and we certainly haven't solved the immunization rate among all our racial groups. But we have the best rates we've ever had and do you now why we have that, because we've done everything, we've done everything that we know to do. And we need to do the same thing with regard to racial disparities.

I guess the message I've gotten today is, for me, reinforced what I think I already knew, this continues to be a problem in America and it's a problem we need to keep on the radar screen and it's a problem we do have some answers for. We do have some things that do work, we know they work, the problem is we don't have enough of them and we don't have them everywhere we need them.

(Applause)

DR. FOX: I don't think any of us up here are Pollyannaish enough to know that we are going to solve this tomorrow, but we do want to solve it. The President wants to solve it, the Administration wants to solve it. We need to work on it together, we look forward to doing that. I think we all need to push the envelope wherever we are, we commit to do that within the administration. I know the Advisory Board commits to do that. But we've got to continue to do that, we've got to do it together. And I think if we do do it together, we will succeed.

Thank you so much for being here today.

(Applause)

(Whereupon, at 12:41 p.m., the meeting was concluded.)