

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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1 P-R-O-C-E-E-D-I-N-G-S

2 (9:33 a.m.)

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

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

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

24 We also are fortunate to have with us

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

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

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

24 It's my pleasure to open this meeting this

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

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

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

16 Roll the video.

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

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

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

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

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

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

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

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

10                   (Laughter)

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

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

24                   MS. KURLAND: Thank you, Earl.



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

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

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

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

7           (Applause)

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

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

20           (Laughter)

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

24           Let me first welcome you all to this

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

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

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

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

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

10 Boston boasts some of the world's best  
11 medical facilities. As I often say, there is no  
12 reason why we can't make sure every one has access to  
13 quality health care. Every child, every person, every  
14 family, deserves the information and care they need to  
15 be safe and healthy. Because we focus on this issue  
16 of equality in Boston we have had some successes in  
17 improving access to health care for communities of  
18 color. We worked hard to achieve the nation's highest  
19 child immunization rate for all our children. And  
20 1997 marked the third consecutive year in a row we  
21 claimed the honor.

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

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

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

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

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

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

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

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

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

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

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

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

1 Thank you for coming. Thank you.

2 (Applause)

3 DR. FOX: Thank you, Mayor.

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

8 Ms. Wright?

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

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



1 times the national average.

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

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

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

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

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

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

18           The proposed budget for FY99 for Indian  
19 Health Service is approximately \$2.4 billion. This  
20 represents less than a one percent increase over FY98.  
21 And please listen clearly to these figures now.  
22 Further, in FY97, the per capita expenditure for  
23 American Indian person was \$1,430, as compared to  
24 \$3,369 for a Medicaid beneficiary, \$3,489 for an

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

5 We ask the United States Congress to fund,  
6 now, the appropriate dollars to meet the legal  
7 obligations for health care for our tribes. Already,  
8 tribes across the country are suffering from  
9 insufficient funding. 21 of the 23 USET tribes are on  
10 priority one, which means emergency and life  
11 threatening only. My health care program has been on  
12 priority one since May of this year. We are  
13 experiencing an erosion of the trust obligations that  
14 our ancestors secured when they exchanged more than  
15 500 million acres for a promise of health care,  
16 education and other goods. It's ironic, but this was  
17 the first health care in the United States.

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

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

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

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

20 (Applause)

21 DR. FOX: Thank you, Ms. Wright.

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

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

6 Mr. Hayashi?

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

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

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

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

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

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

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

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

24 So today we welcome you but also challenge

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

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

13 Thank you.

14 (Applause)

15 DR. FOX: Thank you, Mr. Hayashi.

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

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



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

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

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

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

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

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

3 (Applause)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10 (Applause)

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

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

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

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

9 (Applause)

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

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

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

1 (Applause)

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

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

14 (Laughter)

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

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



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

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

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

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

1       role.

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

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

1 health care system.

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

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

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

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

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

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

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

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

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

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

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

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

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

21  
22           But all of these are areas where we have  
23 tremendous challenges and opportunities. Recently,  
24 the HIV/AIDS epidemic has become increasingly an

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

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

15 And it's interesting how it's developing,  
16 as you heard earlier, we've developed very  
17 sophisticated therapy for AIDS and we've seen over a  
18 50 percent decrease in death rates in the last two  
19 years. Mainly for white males, we have not seen that  
20 type of decrease for African-Americans or Hispanics.  
21 So we have some major challenges in these areas.

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

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

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

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



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

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

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

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

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

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

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

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

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

5 (Applause)

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

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

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

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

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

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

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

15                           (Applause)

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

24                           (Applause)

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

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

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

1 didn't even remember that but this guy remembered it  
2 as we studied together.

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

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

21 (Applause)

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

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

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

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



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

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

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

17 (Laughter)

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

21 (Laughter)

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

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

6 (Applause)

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

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

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

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

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

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

1 (Laughter)

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

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

14 Thank you.

15 (Applause)

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

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

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

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

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

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

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

7 Thank you.

8 (Applause)

9 **WHAT DOES THIS MEAN TO US?**

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

24           Now, I'm delighted to introduce to you the

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

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

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

24           The next speaker will be Marianela Garcia,

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

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

24 The fourth speaker is Patricia Thomas,

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

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

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

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

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

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

10 (Applause)

11 MR. AUGUSTAVE: Bonjour, Messieurs et  
12 Madames, which means good morning ladies and  
13 gentlemen.

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

24 In most states in this country, they do

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

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

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

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

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

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

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

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

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

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



1 attitudes, which is a barrier for farm workers.

2

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

10 In conclusion, what I'd like to say is  
11 that the labor law exemptions, we should work with our  
12 legislators to get rid of the labor law exemptions,  
13 get them out by the year 2000, so we can all go in the  
14 21st century together, equally. And also, there  
15 should be a national health care for migrant farm  
16 workers and their children.

17 Thank you very much.

18 (Applause)

19 MS. AMARO: Thank you, Mr. Augustave.

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

23 (Applause)

24 MS. GARCIA: Good morning. My name is

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

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

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

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

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

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

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

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

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

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

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

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

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

23 Thank you.

24 (Applause)

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

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

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

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

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

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

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

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

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

9 (Applause)

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

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



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

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

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

20           Thank you and God bless you.

21           (Applause)

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

1 (Applause)

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

4 (Laughter)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

13 Thank you.

14 (Applause)

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

20 (Applause)

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

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

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

10 (Applause)

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

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

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

6 (Laughter)

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

20 (Applause)

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



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

6 (Applause)

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

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

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

8                               (Applause)

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

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

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

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

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

1 it.

2 (Applause)

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

7 Thank you.

8 (Applause)

9 MS. AMARO: Thank you.

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

12 (Applause)

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

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

1 economic development programs that help people out of  
2 poverty.

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

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

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

1 try to accommodate you.

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

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

13 Yes, Governor Kean?

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

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

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

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

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

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

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

17 (Applause)

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

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

1 and everybody.

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

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

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



1 package of health care that we provide.

2 (Applause)

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

5 (No verbal response)

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

8 MS. AMARO: Okay. We have our  
9 microphones.

10 Would you please introduce yourself,  
11 Nicholas?

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

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

1 finally get it on a professional basis?

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

4 MS. LUI: Yes.

5 (Laughter)

6 MS. GARCIA: And I would second that  
7 motion.

8 MS. AMARO: Do we have another person?

9 I think you got total approval on that  
10 one.

11 MR. CLARK: Good morning.

12 MS. AMARO: Good morning.

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

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

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

10           Thank you.

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

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

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

22           We have other folks on this side.

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

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

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

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

23 MS. AMARO: Thank you, Professor Franklin.

24 Yes, can we take the next question.

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

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

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

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

24                  MS. AMARO: Okay.

1 MR. GARRETT: Which is the state.

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

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

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

24 MS. AMATIEL: My name is Neela Amatiel

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

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

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

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

21 Thank you.

22 (Applause)

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

1 and then we'll take some questions subsequent to that.

2 So we want to have time to do that.

3 **MODELS THAT WORK**

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

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

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



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

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

10           (Applause)

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

24           This second panel will address models,

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

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

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

18 The third presenter is Peggy Leong.  
19 Dr. Leong is currently the administrative Director for  
20 the Department of Neurology at the Beth  
21 Israel/Deaconess Medical Center and was formerly, from  
22 1983 to 1997, the Director of Clinical Operations for  
23 the South Cove Community Health Center, here in  
24 Boston.

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

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

13           Thank you and we'll start with Elmer  
14 Freeman.

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

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

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

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

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

1 through this partnership.

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

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

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

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

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

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

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

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

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

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

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

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

19 (Applause)

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



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

5           Thank you for this opportunity.

6           (Applause)

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

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

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

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

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

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

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

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

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

1 need for a pentamidine treatment, laboratory follow  
2 up, medication management and continuity care. He  
3 left having received not just an appointment for a  
4 pentamidine treatment, but rather the treatment  
5 itself, along with the necessary laboratory,  
6 medications, medication management, education and  
7 tools and a connection with a social worker and  
8 primary care worker.

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

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

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

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

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

24 Because of the high prevalence of Diabetes

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

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

21 Thank you very much.

22 (Applause)

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

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

7 (Applause)

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

20 Thank you.

21 (Applause)

22 MS. NAMIAS: Good morning and good health.

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

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

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

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

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

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

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

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

1 program development, rich in tribal diversity.

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

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

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

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

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

24           Maintenance of the above community health

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

8 Thank you.

9 (Applause)

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

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

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

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

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

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



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

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

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

1 service providers, civic and faith organizations.

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

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

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

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

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

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

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

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

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

15 Thank you.

16 (Applause)

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

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

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

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

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

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

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

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

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

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

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

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

24 MS. LEE: I couldn't really hear because

1 of the echoes.

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

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

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

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

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

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

21           DR. REEDE: Any other questions from the  
22 panel?

23           (No verbal response)

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



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

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

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

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

4           DR. REEDE: Thank you.

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

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

21           DR. REEDE: Wonderful.

22           Please state your name.

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

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

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

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

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

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

13 DR. REEDE: Thank you.

14 MR. MARA: My name is Bob Mara.

15 When President Clinton went to Africa, he  
16 talked about slavery and he talked about reparations.  
17 My question is in two parts, what do you think,  
18 especially Dr. Franklin and Mr. Winter, about  
19 reparations for American slavery?

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

1 slavery in that part of the world.

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

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

10 (Laughter)

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

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

1 (Applause)

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

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

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

23 (Applause)

24 CHAIRMAN FRANKLIN: I was pushing my own

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

4 (Laughter)

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

8 (Applause)

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

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

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

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

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

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

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



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

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

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

14 I would like to add one more item to the  
15 1998 program list for Mr. Franklin. We've talked  
16 about the disparities in access and the need to  
17 diversify the health care work force.

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

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

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

11 (Applause)

12 DR. REEDE: Couldn't hear?

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

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

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

1 represent and live in the communities they serve, they  
2 are skilled in public health issues and health areas,  
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8 reply or comments from the panel, is that you look  
9 closely at the outstanding track record of these  
10 public health professionals and find ways to fund them  
11 on a permanent basis, as core members of the public  
12 health team.

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

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

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

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

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

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

13 Thank you.

14 (Applause)

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

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

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

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

6 DR. FOX: Thank you.

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

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

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

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

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

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

1 (Applause)

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

13 Thank you so much for being here today.

14 (Applause)

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

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