

**National Hispanic Medical Association
Hispanic-Serving Health Professions Schools, Inc.**

Testimony

To the

**Subcommittee on Criminal Justice, Drug Policy
And Human Resources,
Committee on Government Reform,
U.S. House of Representatives**

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Chairman Souder, Congressmen, HHS Officials and guests, it is an honor to be here today. The National Hispanic Medical Association (NHMA) represents licensed Hispanic physicians in the United States. The mission of the NHMA is to improve the health of Hispanics. I also work for the Hispanic-Serving Health Professions Schools, Inc. that represents 22 medical schools and 3 public health schools. The mission of this organization is to develop Hispanic student and faculty and research capacity to improve Hispanic health.

The IOM Report, “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care” discusses disparities not due to access-related factors or clinical needs and provides a tremendous amount of evidence that the U.S. health system does not adequately meet the needs of minority patients.

Hispanics are now 14% of the US population and by 2050, one out of every four Americans will be of Hispanic origin. In the case of Hispanic patients, we are challenged by the language needs, literacy levels, lower levels of poverty and education, citizenship status, cultural beliefs and attitudes, family group decision-making, awareness of public health programs or how to follow complex treatment regimens, drug labels, where to go for further tests, x-rays, or specialty care in a health system. Our health system is the best in the world; but in order to be proud of that system, this report challenges us to develop new strategies to improve the quality of healthcare delivery.

I would like to address proposed strategies for the Department of Health and Human Services to continue to decrease race and ethnic disparities in healthcare.

DIVERSITY IN MEDICINE

The United States Federal government has taken the lead to recruit and retain minority and disadvantaged health professional students since the 1960’s, when it was recognized that it is a Federal government role to develop programs that provide healthcare services for vulnerable population groups –Medicare for the elderly and disabled; Medicaid and Community Clinics for poor patients, and the National Health Service Corps and the Health Careers Opportunity Program for poor, disadvantaged or minority students to become health professionals for these communities. In the 1980’s, HHS further developed the Centers of Excellence and the Faculty Development Program for minority students at medical schools. Through its curricular efforts, COEs impact the cultural competency of all their graduates. In addition, both these programs have increased the number of minority faculty that address research and curricular issues related to minority patients and communities.

The literature demonstrates many examples of studies on the outcomes of minority health professionals serving a major need in the U.S., namely that they provide health and mental healthcare services for minority patients of their own ethnicity and for those on Medicaid or uninsured.

HHS Health Resources and Services Administration’s Health Careers Opportunity Program and Centers of Excellence Program have proven track records of graduating 2-3 times more disadvantaged and minority students than the other health professions institutions. However, for the second year, the Bush Administration has called for drastic down-sizing of these programs. We believe strongly that the IOM is a reminder for us, with the changing demographics and continued immigration of Hispanics, especially, to

recognize the critical need for minority physicians. Currently, Hispanics are only 5% of America's doctors and only 2% of America's nurses. Both the HCOP and COE programs should be expanded with increased funding at the level requested by the Congressional Black, Hispanic and Asian Caucus - \$40 million each.

We propose a new strategy: that these programs be expanded into PUBLIC-PRIVATE PARTNERSHIPS MODELS led by HRSA. The medical schools have institutionalized recruitment and retention programs, but they should be required to provide matching funds and fundraising efforts to increase the support for HCOP. We support the request from the Congressional Black, Hispanic and Asian Caucuses to increase support to \$40 million for HCOP and COE programs. Why shouldn't a recruitment program be linked to academic enrichment in middle schools and colleges through a Scholarship incentive program for minority students linked to their annual academic performance? Scholarships could be linked to the students who would be linked to programs developed at certain schools in regional consortia. And why shouldn't businesses, especially the HMOs, hospitals, pharmaceutical companies, medical suppliers and medical groups that are employers and business partners who directly benefit from their linkages with physicians, be fiscal partners in the education process of future physicians?

We recommend increased data collection and monitoring of the alumni of the program that demonstrates the extent that they provide healthcare services to minority communities and link their location of practice to medically underserved area or health professions shortage area, as does both the community clinic and National Health Service Corps programs. We recommend mentoring program development with practicing community physicians and community-based experiences

Furthermore, Medicare GME funding for teaching hospitals should be linked with a policy focus to incentives to produce minority physicians and to decrease physician practices that result in disparities in treatment and management for minority patients.

The COE program and the faculty development programs should be expanded, including loan repayment to provide incentives for more minority faculty in the health professions.

In addition, minority physicians should be encouraged to sign-up for the National Health Service Corps and President Bush's Medical Reserve Corps, not only to focus on Bioterrorism preparedness, but, to assist in the recruitment of minority students to medicine. Lastly, NHMA, the NMA, HSHPS and AMPS, and the AAIP as well as mainstream medical associations – the AAMC, AMA, AAFP, AAP, SGIM, ACP-ASIM, etc. should advocate for the development of diversity programs in medicine that are well documented and evaluated and show performance outcomes.

CROSS-CULTURAL EDUCATION

Currently, medical schools are mandated by accreditation rules to teach cultural competence to all future physicians.

The HSHPS members focus their curriculum development on cultural competence. NHMA has launched its cultural competence guidelines project, documenting Hispanic physicians' best practices on our website (www.nhmamd.org) to

provide care for Hispanic patients. We recognize the critical need for physicians and medical students to be trained on how to respect and communicate with Hispanic patients, because there will never be enough Hispanic physicians to care for the growing Hispanic population.

HHS should convene medical school leadership to discuss the IOM Report challenges about Hispanic patients for future physicians ---to train about perceptions, self-awareness, knowledge about minority groups, Hispanic culture and lifestyle, family centered, community centered, and skills for communication, dealing with interpreters, interviewing about migration status, generational status, occupational status, health beliefs, alternative medicine, the Hispanic Paradox, etc.

We recommend the funding of the HRSA Cultural Competence Curriculum Demonstration Grants that were part of the Health Care Fairness Act of 2000 as well as fostering cultural competence training development by NIH Center for Minority Health, Agency for Healthcare Research and Quality, and the Centers for Medicare and Medicaid Services – so that the Federal government prompts the system to meet its own Culturally and Linguistically Appropriate Services Standards set forth by the Office of Minority Health in 2001.

LANGUAGE SERVICES

I ask you to consider the following: A Spanish speaking family brings an ill baby to an emergency room and cannot communicate with the ER staff. The baby has a fever and is sent home with Tylenol. Another Spanish speaking family brings an ill baby with similar symptoms to an ER with Spanish-speaking staff and the baby is admitted with a diagnosis of appendicitis, is observed with worsening abdominal guarding and has emergent surgery and her life is saved.

Hispanics are reported to speak more Spanish, especially when in the health system. It is also well known, that the use of Spanish language is passed on generation to generation, especially in the more marginalized families and neighborhoods that are isolated, more stressed, more dysfunctional and less healthy (physically and mentally) patients. So the problem is exacerbated for the health system and urgently needs attention.

The White House OMB concluded in its report on assessment of implementing services to Limited English Proficient (LEP) persons, that the benefits seem to outweigh the costs since language services improve access to and can increase effectiveness and distribution of public health programs. Moreover, language services will substantially improve the health and quality of life of LEP individuals and their families.

We propose that HHS support demonstration programs through HRSA, SAMHSA and Centers for Medicare and Medicaid Services to provide incentives to prepare to improve the medical delivery systems of the future.

Interpreter services should be developed for bilingual staff, bilingual providers as well consultant interpreters that should be developed as new auxiliary health positions with certification and training programs. Spanish language training for providers (including CME programs) and for medical students should be supported significantly in

targeted markets. There is a critical need to develop reimbursement policies for these and new technologies that are affordable, especially Medicare and Medicaid.

A new program for managed care partnerships in targeted states as incentives for Medicare programs to expand services to elderly Spanish speaking could be developed for language services and Spanish training of providers.

All of HHS prevention literature and website materials should be increased with Spanish language information.

Media, both English and Spanish, TV, radio, internet, and print, needs to be partnered by HHS to develop targeted public education about health care services and programs.

SYSTEMATIC STRATEGIES

Hispanic-Serving Health Professions Schools, Inc. Faculty Clearinghouse

This project is funded by the CDC for 5 years to develop a mechanism to educate faculty who work for the medical school and public health school members of the HSHPS on opportunities to decrease race/ethnic disparities in healthcare – for EIS and other public health professional advanced training, new grants for minority research, and invitations for Federal conferences, meetings and peer review committees.

National Hispanic Medical Association Leadership Fellowship

This program, a joint effort with the Robert F. Wagner Graduate School of Public Service, was sponsored by HRSA for 3 years. The NHMA Leadership Fellowship Program has been an outstanding success. The Fellowship has promoted the development of leadership potential among 60 mid-career Hispanic physicians from across the nation in 3 years. The program offers a unique health policy leadership development curriculum that has been enthusiastically received by faculty and Fellows. Through the program, we have expanded awareness of important Federal programs, how Congress and the Executive Branch work, as well as awareness of other sectors that impact on health issues that impact Hispanic community through networking with media, foundations, national advocacy organizations and key leaders from different sectors of the health arena. The Advisory Committee, consisting of public health leaders from across the nation, have served as mentors and speakers in the program.

FUTURE DATA COLLECTION & RESEARCH

The Agency for Healthcare Research and Quality, the Centers for Disease Control and Prevention, the Centers for Medicare and Medicaid Services and the National Center on Minority Health and Health Disparities should collaborate on their data collection and Disparities Research programs to build strategic requirements of grantees and to build major minority health research centers. Congress should expand this area of critical research which is a cross –cutting activity that has limited support compared to biomedical research. Without new knowledge with community-based research, we will

never advance beyond the disparities that now exist in the health care system. In addition, states and health surveys and health facilities should be mandated to collect data by race and ethnicity and language use and conduct interviews and have materials in Spanish in order to develop a quality health care system.

Office of Minority Health at each agency at HHS should be supported to provide a collaboration in oversight with these activities and others to promote the goals of the Department targeted at minority populations.

The NHMA established the National Hispanic Health Foundation, a 501(c) 3 organization, to develop health services research and policy analysis to focus on such issues as disparities in the health system, cultural competence, language services and health professions diversity. We are currently negotiating the location of the Foundation at the Robert F. Wagner Graduate School of Public Service, New York University, the largest graduate health management/public service training program in the U.S. with researchers already engaged in Hispanic research. The Foundation would also be linked to the NYU Medical School, which also has a strong interest in Hispanic health research.

The following are the major activities that the Foundation would address:

- 1) Health services research targeted at Access to Health Care, Quality Health Care, Cultural Competence, and Language Services for Hispanic populations across the United States. This research would be done by researchers at the Wagner School and key Hispanic researchers at sites around the country.
- 2) Research Scholars Program for Senior Hispanic researchers on sabbatical from their universities to learn about policy related research for Health.
- 3) Research Training Institutes for Junior Hispanic researchers. We need Hispanic researchers desperately who understand the nuances of their communities and can develop new knowledge for Hispanic health development, at the national and state levels.
- 4) Journal of Hispanic Health. One does not exist in the United States and a peer-reviewed journal would target the physician readers and CME programs so that they can better understand the issues of Hispanic health.

In summary, we need to raise awareness of Hispanic and minority health issues through research and documentation and publication. I believe that these efforts are unique and will offer outstanding information to move the policy and research arena forward for Hispanic health program development.

CONCLUSION

The IOM Report on Unequal Treatment is a wake-up call to America that its health system needs to be fixed. It is ironic that on the verge of a major demographic change, when the workforce will become more minority, in order to maintain a healthy economy, we must prepare to turn the Disparities in Health Care around by developing and enhancing STRATEGIES now. By decreasing disparities for the minority patients, we increase the quality of health care for all Americans.

REFERENCES

Keith (1985, *New England Journal of Medicine*) found that minority medical graduates practiced in federally designated health-manpower shortage areas almost twice as often as non-minority graduates. He also found that minority physicians tended to serve members of their own racial or ethnic population group more than members of other groups.

Moy and Bartman (1987 *National Medical Expenditure Survey*) that minority patients were more than four times more likely to receive care from non-white physicians than were white patients not of Hispanic origin. Low-income, uninsured, and Medicaid patients were also more likely to receive care from non-white physicians.

Kamaromy et. al. (1993 *New England Journal of Medicine*) reported that Black physicians practiced in areas where the percent of Black residents was nearly five times higher than in communities where non-Black physicians practiced. Similarly, Hispanic physicians practiced in areas where the percent of Hispanic residents was twice as high as in areas where non-Hispanic physicians practiced. Hispanic physicians cared for three times as many Hispanics and for more uninsured patients as did other physicians.

Tocher and Larson (1999 *Journal of General Internal Medicine*) reported that there were no differences in the time physicians in a general medicine clinic in the state of Washington spent providing care to non-English speaking patients and English-speaking patients.

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