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# Today's Topics in Health Disparities: HHS' Action Plan to Reduce Health Disparities
# Kaiser Family Foundation
# April 25, 2011

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**CARA JAMES, PHD:** Hello and welcome to the Kaiser Family Foundation's Today's Topics in Health Disparities. I'm Cara James, Director of the Disparities Policy Project at the Foundation. Today's Topics is a series of conversations that address issues relating to health and health care disparities in the U.S. Today's topic, HHS' Action Plan to Reduce Health Disparities, comes two weeks after the Department of Health and Human Services released its first action plan to reduce racial and ethnic health disparities and the national stakeholders' strategy for achieving health equity.

In recent months, the department has also released several other strategies including the national strategy for quality improvement in health care, the national prevention and health promotion strategy, and Health People 2020. It also comes at a time when discussions over federal, state, and local budgets are causing some programs to lose funding and making it extremely difficult to get funding for new initiatives.

Our conversation today will discuss the specifics of HHS' action plan and the national stakeholders' strategy as well as how these and other recent released strategies fit together. We will also address what these plans mean for people on the ground and how the current political environment may affect the implementation of these plans and ultimately our

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ability to reduce health disparities. We welcome your questions. So feel free to email us. The address is ask@kff.org.

Our panel today includes three distinguished guests whose bios are available on our website. In our studio, we have Dr. Carolyn Clancy, Director for the Agency for Healthcare Research and Quality at the U.S. Department of Health and Human Services. Next to her is Dr. Garth Graham, Deputy Assistant Secretary for Minority Health at the U.S. Department of Health and Human Services, and last but not least is Dr. Herbert Smitherman, Jr., who is Assistant Dean of Community and Urban Health, an Associate Professor of Internal Medicine at Wayne State University School of Medicine and President and CEO of Health Centers Detroit Foundation, Inc. I want to thank you all for joining us. Thank you.

So as we get started, Dr. Clancy, I'd like for you to help frame this conversation a little bit. Your agency has responsibility for releasing the national health care disparities report each year. What are some of those findings in our latest report that you have?

**CAROLYN CLANCY, MD:** Thank you and it's really a pleasure to be here today. So this year was the eighth year that we released to the Congress as required by law, our annual reports on quality of health care and disparities in health

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care. The two reports use exactly the same quality measures. The quality report, those are broken our further by states and in the disparities report, they're broken out by different subgroups.

In addition, the disparities report contains information and measures on access to care. In the past eight years, what we've seen is steady statistically significant improvements in quality overall, all populations in all settings but a very modest level in the order of one to two-percent. If you think about how fast health care spending is going up, much, much more rapidly than those improvements.

In the disparities report, I would say we've seen two things. One is that for all subgroups, disparities in quality remain stubbornly persistent even though for each group and the patterns are slightly different, we also see some areas that are improving not completely eliminated in terms of disparities but actually getting better, which says to me that disparities are not immutable because we're tracking the same measures over time. On the access side, on the other hand, the picture is much more bleak. The average change has been -0.6-percent, so actually heading in the wrong direction, not a huge drop off but nothing to be terribly proud of.

**CARA JAMES, PHD:** Dr. Smitherman, as someone who's working in some of the community health centers, what are some

of the big challenges that you see in the populations that you're treating?

**HERBERT SMITHERMAN, JR., MD, MPH, FACP:** Well one of the major issues is really insurance coverage and access to care. I think what we're looking at and seeing on the ground is tremendous increases in poor access and poor quality and we have a lot of these studies. We have the National Quality Study, National Prevention Study, and all the national health care quality reports, National Healthcare Disparities Report, and I think for us, we're really looking at how the reports relate, how they work together, who's on first base, how we as practitioners can use this information to really impact the communities we serve.

Public policy for us, what we're looking for is to see all the dots connected. For example, a woman will come into our practice who is on Medicaid, she then gets a job. The job is low-paying. It doesn't cover health insurance. She continues to get care. There's no health insurance. She loses her Medicaid because she has this job and then she cycles back into poor health because right now, she's lost the job and she has no insurance.

So this issue of cycling patients who have health insurance, they get jobs. They make too much money to retain the health insurance. They lose the health insurance and go

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back without health insurance. These kind of cycles are really hurting our patient populations.

**CARA JAMES, PHD:** So Dr. Graham, we've heard now, making some progress on the quality side, maybe not so much on the disparities side and maybe even less so on the access side and hearing some on the ground perspective. So you guys worked with the Secretary's office to release the HHS action plan as well as the stakeholders' strategy. So I'm going to start with the action plan and can you tell our viewers what is the HHS action plan?

**GARTH GRAHAM, MD, MPH:** So the two plans released are actually separate but similar in terms of synergistically working together. So the HHS action plan is a set of specific actions that the department will undertake over the next couple of years starting right now. In fact, some of those things have just started even over the last couple of weeks in terms of one of the things that our Secretary wanted to make sure was that there would be no delay, it would get started right away. So there are a number of actions that are described within our plan that the department will undertake.

The other report that was released simultaneously with that is the national stakeholders' strategy and that was a document that actually we worked with communities over years with a number of community meetings with a number of different

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venues and locations to try and get a sense of what were some of the key things that communities wanted to see happen, how could we coalesce that into one document that was representative of all those community voices.

We got probably close to four or 5,000 different folks and organizations that really had input into that and then put that together as a community strategy document, so two separate but related. One started articulating what the department will be doing over the next couple of years starting right now and as well as a series of strategies and thought patterns that emanated from the community.

Let me say one thing in terms of, much in terms of what Carolyn just outlined. There are some challenges that our country has certainly been facing in terms of health disparities as it pertains to access to care, certainly health insurance coverage and a number of other things. Though that is not the end all/be all for the existence of health disparities, those are key anchor weights in terms of key indicators for progress.

So our plan starts off specifically targeting access, targeting health insurance, using much of what's in the Affordable Care Act and what we need to do with the Affordable Care Act and making sure that we implement that appropriately

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to meet the needs of minority communities. That was a vision from the top and that's certainly what we started off doing.

**CARA JAMES, PHD:** Okay and what are some of those specifics, so we have increased coverage, what are some of the other goals or specific action items of the plan?

**GARTH GRAHAM, MD, MPH:** Sure. So access and coverage is one of the first priorities. There are a number of activities in there that CMS will undertake, a number of things that OSIIO, our new office that will be implementing a lot in terms of health reform and work with the health insurance exchanges, a lot of stuff that's going to happen there in terms of culture, linguistic, competent care, and some other components but beyond that, we also took a look at what were some of the other things that needed to happen, some other challenges that our country's been facing with workforce diversity, some of the other challenges that our community has been facing in terms of some specific diseases that needed to be targeted, heart disease, smoking, as well as some other specific disease processes that disproportionately impact minority communities overall.

We also wanted to take a very serious look at data collection. What are some of the strategies that we can do to bolster data collection? There's a lot in terms of data collection, the Affordable Care Act. We wanted to make sure

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that where appropriate, we went beyond that in terms of outlining a vision for data collection and there's some very key things we wanted to do in terms of streamlining how the department works together and making this truly a transdepartmental process.

One thing I want to say is that this really was across the department. Our Secretary charged all our senior leaders and everyone stepped up to the plate from ARC to the Centers for Medicare and Medicaid Quality, to HRSA, to CDC and a number of different components.

**CARA JAMES, PHD:** So you said the stakeholder strategy was developed with a lot of community input. So what was the process for developing the action plan?

**GARTH GRAHAM, MD, MPH:** Oh the process for developing the departmental action plan, so we had the stakeholder document in terms of some of the thoughts from stakeholders. Our Secretary said well we got to make sure that HHS steps up to the plate and does some specific things to help reduce if not ultimately eliminate disparities. So that process was really a lot of internal organizations.

So we took the stakeholder document, made sure that we looked through some of the key components of the document. We heard a lot of what you articulated, a lot of things the community wanted to see, more access, more insurance, more

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connectivity, making sure that we weren't just implementing something here in D.C. that didn't mean anything to the average person on the ground. So we went through some key actions in that document and made sure that there was some HHS-specific actions that would help.

One of the other things our Secretary also wanted to make sure is that we had, as I said before, the commitment as well as the input from all the senior leaders across the department in all the various different agencies.

**CARA JAMES, PHD:** Okay. So Dr. Clancy, you've mentioned that you've been doing the national healthcare disparities, the national healthcare reports since 2003. One of the questions that I've been asked a lot and so I wanted to ask both you and Dr. Graham and Dr. Smitherman your perspectives on is why is this a big deal or is it a big deal?

**CAROLYN CLANCY, MD:** Well what's interesting is if you were to look at when we first became attuned to and knowledgeable about disparities in health care, a lot of it coincides with the creation of the Agency for Health Care Research, and Quality. Some of that is literally about cheaper computing power.

Now before you think I've left the planet with this thought, before then there were a few studies, not very many

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but they were very much limited by wherever it was that the researchers decided to study the problem.

So in one very large community in the south, they looked at the university hospital and found no differences in care provided to Blacks and Whites for people with heart disease. This is the 1970s. Now it turns out that actually the vast majority of African Americans in that community actually got care at the public hospital.

So what they were reporting was true but it wasn't the whole picture. Cheaper computing power actually enabled many leading researchers like those from Dartmouth, from Rand, and so forth to actually pull together data from multiple sites of care and it's almost the equivalent of being able to create better maps once you can get in an airplane and see what's below you. It gave us a different view of what was going on in health care.

So when the Institute of Medicine published their landmark study on equal treatment in 2002, the vast majority of studies came from studies funded by AHRQ because people were doing that work. They were looking at variations in care. It was quite logical and natural for team members to focus in on which variations seem to be significantly associated with patient characteristics and so forth but when we were given the charge, up until then, it was a matter of debating studies.

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So I might say I think this is a big problem and Garth, because here's the study, and Dr. Graham might say well we think it's a huge problem and here's another study.

Now we have a common set of metrics that we can track our progress because we're collecting data in a nationally representative way. It's important to note and I think this is also part of HHS' challenge, all of us together, in some areas for some specific subgroups, there is no information in the table because we don't have enough data but even being very clear and transparent about that, we think is a contribution and frankly that's the feedback we've gotten from those communities as well.

So being able to track, over time, how we're doing, what do the patterns look like, are disparities the same for all groups? The answer is no. There are some commonalities but there are some really big differences as well.

Ultimately, to get to Dr. Smitherman's issue, what you need is local data to help you figure out how can we begin to identify who's at the highest risk for poor quality whether it's because of changing employment and losing insurance or other reasons or changing providers, whatever the issue is.

That's when people can use the data to take action because the national report isn't all that helpful locally because the first response is usually wow, things are actually

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worst than I thought. Thank God it's not here. It's when you've got local data that you can actually use it to make change.

**HERBERT SMITHERMAN, JR., MD, MPH, FACP:** The uninsured in this country, over the last decade or so, went up by about 11-percent. Poverty increased by 13-percent. Unemployment, in my community, is around 28-percent and if you X out those people who have ceased looking for work, it's 44-percent.

The people are really hurting and access to care and appropriate health care is at a point where we are seeing, just on the ground, I can tell you in our local communities, large disparities in all of the health care indicators no matter what the disease is. So I think what we see from our government and I think the standardization of the data is critically important because we would get a lot of different reports with a lot of different information and stats and trying to negotiate all that was very difficult.

I think the reporting that the government does and especially the HHS action plan, I think is an excellent report from the standpoint and the actual stakeholder strategy because I think it was group-up and I think that's important to get the information from the community especially if it's community-driven.

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I think that's important but I think in all of these reports, the description of what's going on and why it's happening done very, very well. How to solve it, that's the issue. That's what we're looking for. We've had 30 years of reports and I think that especially the attempt to connect those two latest reports that were just released with the Affordable Care Act, which I think is, from my standpoint, the major resourcing.

I mean it's one thing to have a report but then how do you do it? What are the resources that we have in our country to actually actualize any of these different recommendations because that's what we've been missing.

The issue of expanding access from Medicaid up to 133-percent of poverty, building the exchanges in place, the whole HRSA plan with the expansion of community health centers but of course then we have the community health centers, which is a major part of the strategy to improve access but of course, the CHC budget just got cut by 33-percent.

So we have, where we were trying to expand basic access to people with an insurance card that's going to be coming out by 2014, we also have to have providers and communities to actually be able to see these patients once they have the insurance card. We saw in Massachusetts that they provided broad access to health insurance.

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What they didn't do is build up their infrastructure with respect to primary care and their costs went up by 33-percent. It was because everyone had an insurance card. They ended up in the emergency room. So we have to have that primary care capacity. Here's where I say connect the dots. We have insurance.

We had a plan for the primary care capacity expansion but then we cut that primary care capacity plan by 33-percent. So even with that primary care capacity budget, we would not have been able to meet the additional 33 million people coming into the system now with health insurance. What's going to happen with the 33-percent cut?

So that, I can say on the ground level, what we're seeing is these are wonderful guidelines, wonderful recommendations and I think they tell the story very well. How do we move that to real action? How do we have the resources to really put in place, to align what we're talking about as far as a recommendation and the budget?

**GARTH GRAHAM, MD, MPH:** Yes and Dr. Smitherman raises a number of good points. I want to touch on that. I think one was a description of the challenges that folks are facing on the ground. A lot of folks were facing health challenges, not just health. It's about jobs. It's about clean access to a number of non-polluted areas.

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Let me say that's probably the best way to articulate it. One of the things we tried to articulate in this document is the social determinants of health approach, so certainly understanding that we need to pull in labor.

**HERBERT SMITHERMAN, JR., MD, MPH, FACP:** That was good and that was good. I like that. I did notice that. So I said that was the first time I saw that integration of both social determinants and behavioral determinants and environmental determinants. I mean that was an important step that we have not seen previously. So that was good. Yes I like that.

**GARTH GRAHAM, MD, MPH:** Really that point is just because, as I said before, he articulated well that the average person in terms of what they're facing, I mean it's more than just health. They're facing a number of challenges that impact their health so we got to take a step back and certainly deal with the social determinants of health approach.

I think Dr. Smitherman also raises a number of other good points, which is as we move forward, we have to be able to look at all the different lenses and understand how one Venn diagram impacts another and really at the end of the day, it's all about being able to make progress.

Again the other excellent point is that we are using

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the Affordable Care Act as an engine for change. There are a number of different components of the Affordable Care Act that I think are going to be very beneficial to minority communities. That's one of the driving factors in terms of the HHS portion of the plan as well.

**HERBERT SMITHERMAN, MD, MPH, FACP:** I was going to say 56-percent of those who are uninsured are people of Color. So the Affordable Care Act will have a significant impact on this community.

**CARA JAMES, PHD:** Right. So we are definitely going to talk a lot more about implementation but I want to make sure that all of our viewers are clear on what this action plan is and a couple of questions that we had come in specifically about the plan are for you Dr. Graham. One, does it include oral health?

**GARTH GRAHAM, MD, MPH:** It does. In fact one of the things that's already moving forward and this has a lot to do with leadership at CMS, Cindy Mann, Don Berwick and others in terms of an emphasis in pediatric oral health care. There's some specific activities that Medicaid is going to do.

Dr. Marsha Lillie-Blanton and a lot of folks over there leading that shop in the right direction to try and improve pediatric oral health and working with Medicaid and the state Medicaid directors for a series of activities that will

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hopefully help improve pediatric oral health. So it has that specific focus and a very targeted set of activities primarily through the Medicaid lens to help improve pediatric oral health.

Let me just say this. There are a number of other things that we have to continue to do to improve oral health and make sure oral health continues to be our priority but we specifically, in our plan, have some direct activities around oral health, in particular pediatric oral health.

**CARA JAMES, PHD:** Dr. Clancy, one of the small populations that we are clearly aware of and something that came in as a question are the American Indians and the Alaskan Natives. So what are some of their particular challenges and what are some of the efforts at ARC that you guys have around disparities for that population?

**CAROLYN CLANCY, MD:** We've had the privilege of working very closely with them. So just to tick off a couple of examples, it's now widely recognized that the patients' experience of care is a key part of how we think about quality. So several years ago, we had the privilege of working with the Navajo Nation to take the patient experience survey, which is called CAHPS and actually tailor it for their needs and we're looking to do more things like that.

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We worked very closely with some colleagues in Indian Health Service, which does not cover all Native Americans because many of the tribes have taken over their own health systems but in the HIS, they have taken phenomenal advantage of health IT and have become really leaders for the nation in showing what a positive impact that can have on improving care and outcomes for people with diabetes and so forth. I mean the results have been phenomenal. The challenge now is to be able to scale that and bring it to others.

That said, I would say that urban Native Americans and so forth are a much tougher problem even in terms of having good data. So it remains an issue that we're struggling with and many of the social determinants that Dr. Graham just described remain big, big issues there as well.

**CARA JAMES, PHD:** Dr. Graham, the specific question was how is the Native American population being included in the action plan?

**GARTH GRAHAM, MD, MPH:** So certainly there's a lot of things that are occurring as part of not just health reform but the reauthorization of the Native American Healthcare Improvement Act. So there are a number of things that HHS, overall, will be doing to help move forward Native American healthcare. So we have some things certainly mentioned that are planned but even beyond the scope of just the plan.

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There's a lot that's moving forward certainly under the leadership of Dr. Roubideaux.

**CARA JAMES, PHD:** Okay. So now you've already introduced the implementation. So everybody wants to know how is this going to work. So how is the action plan to be implemented?

**GARTH GRAHAM, MD, MPH:** Sure. So certainly we are implementing two processes synergistically. Certainly there is, if you read through the plan, one of the things you'll see again and again the word accountability. So a number of things to say as we move forward, we want to make sure that people hold HHS accountable to do the things that we said we're going to do in terms of those action steps.

So we're working together, as a department, cohesively to look at individual actions as well as cross-cutting actions and if you see at the start of the plan, there's a lot of talk about cross-cutting secretarial initiatives to do data initiatives, to do improving quality, to deal with all of those things. So we have a little implementation group that's going to be meeting and moving forward.

One key aspect of the Affordable Care Act that helps us with this is the Affordable Care Act creates additional minority health infrastructure in key agencies, Centers for Medicare and Medicaid Services, SAMHSA, FDA, certainly

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authorizing what’s in place at CDC as well as HRSA and continuing to work with AHRQ who’ve done a great job in terms of their health care disparities infrastructure there as well.

So those key components will help to catalyze what we’ll have to do on the HHS side. Moving forward in terms of on the stakeholder side, we’re going to do the same kinds of processes. We engage communities building this and we’re going to engage communities moving forward.

So we’re going to be having a series of similar kinds of community engagement strategies to pull together community folks to work on strategies at a grassroots level so that we connect what’s occurring at HHS with what’s occurring in the communities as well. That’s what we’ve been trying to do with this process.

Granted I think one of the things that Dr. Smitherman pointed out is going to be important, which is even on the HHS process, we got to keep that community lens, that community focus intact. We have to be able to keep that moving forward. I’d be remiss if I didn’t mention the Secretary’s taskforce on Black and minority health.

There was an initial report that came out in 1985 and created another series of infrastructure in ‘86 as well as moving forward. So one of the things, why I mentioned that is that report helped spawn state offices of minority health,

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other minority health infrastructure that allowed the connectivity of communities around health disparities one perspective.

So we're hoping to help mirror that here again by continuing to work with folks across the board and to spawn various local levels of activity because if all we do is create a nice report with glossy pictures, and there are glossy pictures, then that wouldn't be beneficial.

I mean what we're really trying to do is spur an action beyond outside of the federal government. So we're hoping that other people get inspired by what we're going to be doing and also that business sector, we work with the National Business Group of Health, national, NCSL, state legislators as well as other folks who are part of this process. So we want to, hopefully, spawn action at a variety of different tiers.

**CARA JAMES, PHD:** Okay. I know that with each action item of the plan with that accountability, there's a lead agency and there are going to be agencies that are going to be working with that lead agency to get this action item accomplished. So obviously Dr. Clancy, you mentioned the data piece.

I know that AHRQ is gong to be co-leading some of the action items around that data collection piece. Is it too soon to talk about how that's going to happen? I mean it's all of

two weeks out. So I'm sure you've got this all worked out but how do we see these lead agencies working with the other agencies to actually get a particular item accomplished?

**CAROLYN CLANCY, MD:** SO the regally good news though is that in a number of areas of the National Action Plan, which is what made putting it all together in such a terrific way a bit challenging is that there are some fast moving areas of activity. So today at AHRQ, we actually have convened a number of really best and brightest in the research field who just got funding from AHRQ and CMS to support the development of better measures to assess quality of care for kids enrolled in CHIP and Medicaid.

Now the way this was laid out in the Child Health Insurance Plan Reauthorization Act was first, there was a set of voluntary measures, measures for voluntary reporting by states. Those were released but then the bill provided resources to develop better measures. Now making sure that disparities is part of this equation is absolutely required of all of these people, of all of the grantees who are just meeting in-person together for the first time today.

So we're very excited about that because if you look at the diversity of the population of children that represents both an important challenge and an opportunity.

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**CARA JAMES, PHD:** One of the other things we had a question come in and it's most of the action plans that we're talking about are regionally and ethnically-focused in terms of their disparities but obviously the IOM recently released a report on data needs for tracking the LGBT community and obviously we still see racial and ethnic disparities within that. So what are some of the efforts, this viewer wanted to know, that are being done about data collection for this population because that is clearly a huge challenge.

**GARTH GRAHAM, MD, MPH:** Sure. Soon after the IOM report was released, there was a memo that was transmitted from the Secretary to the President describing a set of actions that HHS will do to help improve LGBT health and I got to say that there are specific data needs in terms of things that we got to do and when I say we, I mean generically the whole health care system, to improve data that's collected on LGBT populations. The IOM report was, as you know, funded by our department and it was really meant to help us, guide us, in terms of a number of different ways and opportunities that we have to improve data collection.

So those of you who have seen the memo, I know it was made very public and a lot of folks saw the memo from the Secretary to the President and it detailed some of the specific things that we'll be doing overall through the department's

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LGBT coordinating committee, which is chaired by Dr. Howard Koh as well as by some other senior leaders in our department.

So there's some specific things that we're doing. Certainly we're collecting LGBT data on surveys such as the National Survey for Family Growth as well as another survey. So there are some specific surveys that were already collecting data but certainly we have it in our scope to continue to do better because really we got to move towards better standardization of the way we ask the question, the way we collect and report the question so that we can accurately report on the LGBT challenges affecting the population but great question and also just want to emphasize definitely continues to be our priority for our department.

**CARA JAMES, PHD:** So one of the other questions is you mentioned these new offices of minority health that are going to be established in the various departments and agencies, I should say, within HHS, and then we have other ones that are already there. How are all of these offices going to work together and what is their role with the implementation on the action?

**GARTH GRAHAM, MD, MPH:** Sure. They're all working together already. It's a great set of leaders, a lot of key talent that's really emerged. At CDC, Dr. Leandris Liburd has already hit the ground running. Terris King over at CMS as

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well as folks over at FDA, HRSA, and we already had great leadership in place over at AHRQ. So that group has already met a number of times. In fact, a lot of those folks help pulled together the action plan and those items.

So they're a part of the process and building that are certainly a part of the process moving forward. They're a part of that core group that helped pull together this plan working with folks across the agency. What we did in setting up these offices is we didn't want folks working in silos. We wanted to make sure that it was a lot of interconnectivity and that people got to know each other certainly not just in terms of just on paper but on the sense of the key activities moving forward.

So we worked proactively to break down and not even create those silos in terms of moving forward but I think one of the key components of success of those offices is the fact that there is great talent in place already to lead that infrastructure in the different agencies.

**CAROLYN CLANCY, MD:** So I mean just to say one of the reasons I like the strategy and I'm acutely attuned to your issues about implementation and connecting the dots right here where I live but the strategy was very thoughtful in terms of laying out clear aims and priorities and commitments for what the department is doing, without attempting to say

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Monday afternoon at 2:00 you will do X and then at 3:30 you are going to transition to Y and so forth.

In other words, there's enough flexibility so that AHRQ and CMS, for example, have already had several meetings because Dr. King came to us and said we know you've got the disparities report so I need to focus our efforts and we need to work together and so forth. I think the action plan has really inspired and motivated a lot of that and we're likely to see more.

**HERBERT SMITHERMAN, JR., MD, MPH, FACP:** I think especially with the national stakeholders' strategy, I think they did a good job with engaging the community. It was community-driven. So this step of engaging our community, better connecting that with our federal government so that the community is engaged in this process, that the federal government is starting to reorganize how it does its business.

I understand as Dr. Graham is saying, they are integrating offices of minority health within multiple agencies within HHS. They're determining what their metrics are. They're trying to standardize those metrics across all of your different systems so that we're all measuring the same thing.

We're all monitoring the same thing so that reports

don't look different and confuse us out there, which we've seen that in the past, so I think that connectivity with community and I think also their partnerships between all the federal departments that you're doing. So it's not only internally within DHHS.

It's DHHS working with department of Transportation, Department of Education, all of these other departments to try to bring together how the social determinants of health, all of these different departments within the federal government who impact the social determinants of health can work together to improve it. So I think the framework has been set. I think that they've done a nice job at that.

Now the question is taking that nice framework and translating that into real movement in the numbers because what we're seeing on the ground is a worsening of health disparities in general. A lot of that has to do with the worsening of the economy. I mean I can tell you that the average income for someone who is uninsured in my community, which is not uncommon in other urban settings, is $10,851.

So we were hearing policies about where we're going to give tax credits of $5,000 for health insurance, which is $14,000 to buy a health insurance policy for a family of four. I make $11,000. I'm going to give you a tax credit of $5,000. I still have nine, $10,000 left and I only make

$11,000.

What I'm saying is it's how these different structures and how that framework begins to coordinate all the different policies from CMS to HRSA to the Office of Minority Affairs to AHRQ, how it begins to pull the coordination because to us, what we're saying is it's the coordination of these agencies that's really, really going to help us. I think move the needle forward.

**GARTH GRAHAM, MD, MPH:** Yes, great point. I think that's why it's the centerpiece of it certainly is better coordination, more strategizing and more streamlining, to your point exactly in terms of understanding how policies affect individuals. That's where utilizing the appropriate engine of the Affordable Care Act helps us to be able to do that.

So we don't just implement the Affordable Care Act, which is a huge game changer. We don't implement this just in a siloed aspect. We want to understand what are the needs of the community and continue to do that as we're moving forward. Certainly that is one thing we make sure we try and build health insurance exchanges that incorporate health disparity strategies and understand a lot in terms of what works with disparities.

So I think your point, Dr. Smitherman again, in terms

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of just grounding us is key. Moving forward, we've got to be grounded in not just what we do at a 10,000-foot level but what change all of this makes at the grassroots level as well.

**CARA JAMES, PHD:** So talking a little bit, getting us closer to the ground, moving from federal to state, one of the questions we had is, is there, and I sort of hesitate to move into this part of the conversation before we get there but the money.

**HERBERT SMITHERMAN, JR., MD, MPH, FACP:** It always comes to money.

**CARA JAMES, PHD:** Right. It always comes down to the money and so one of our viewers wanted to know is there money in this for the state plan, State Offices of Minority Health.

**GARTH GRAHAM, MD, MPH:** Yes. So we, last week, convened a call of the state office of Minority Health to talk about this and to talk about how we will work with them moving forward. Let me tell you, the states, we know that there are many states that are going through challenges right now and many states, we've reached out to them to make sure that we can assist as much as possible, understanding there's a lot of state dynamics and so we have to be respectful of that.

State Offices of Minority Health, in many key states, Ohio, North Carolina, Florida, many other states across the

board are doing great work. So we won't be able to move this forward without engaging the states.

They're a key engine for us in terms of moving this forward, the State Office of Minority Health as well as other state infrastructure and Paul Jaris who is the head of ASTHO, was very helpful in putting this together. We have Carlessia Hussein over at Maryland who is also providing some leadership for the National Association for State Office of Minority Health. These are all the right people in the right places and also people who we need to be a part of the engagement moving forward.

**CARA JAMES, PHD:** In the engagement process moving forward, one of the other questions we had is, is there an HHS strategy for education about the plan in the way that you did the regional stakeholder meetings?

**GARTH GRAHAM, MD, MPH:** Yes, yes, yes, yes exactly. Moving forward, we're going to be doing similar kinds of regional activities starting in June of this year to help engage folks. Now what's interesting is when we did the launch here in D.C., we also had similar launch activities in a number of places across the country from West Coast, East Coast, and everything in between.

We had a lot of organized activity by the State Office of Minority Health directors. A lot of those guys

that, last minute, saw this was happening and pulled together resources and want to continue to say thank you to those guys who did a great job on the ground.

In doing that, what we tried to do was to again take this out of just the Beltway activity and make sure that there was similar sparks of energy being created at different points. There were some people who attended those launch meetings who didn't know this was happening. Even that was an engagement process and they were excited as well. So we're going to continue to try and have our tentacles be as much outside of the Capitol as much as possible in terms of moving forward.

**CARA JAMES, PHD:** Okay and so I want to switch now to some of the other plans that have been released in the past couple of months by HHS. I think it's nice to see that we've had a report come out on the HHS activities related to minority health and we have Healthy People putting 2020 as a goal of reducing and eliminating health disparities and we have the disparities plan. Dr. Clancy, your agency has been very involved in the national quality strategy. So could you talk to us a little bit about that and the role that disparities plays in that strategy?

**CAROLYN CLANCY, MD:** Yes. So the first overarching messages linking assessing and improving quality with assessing

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and reducing and ultimately eliminating disparities in health care is completely vital. This isn't just our idea. It is our idea. Of course we're very, as you're hearing from my colleague, very excited about that but because this is a national strategy and in this country, the federal government pays for a substantial proportion of health care delivered but almost all of it is actually provided in the private sector.

We recognize from the get-go that this had to be a collaborative effort. Now we couldn't really invite everyone to RFK Stadium or some other large place to write together. What we did was to post a very broad framework and ask for public input. We got a lot of input. So a lot of feedback from stakeholders really reinforce the disparities has to be a key part of our activities in quality moving forward.

I think the other place where you saw this and I was very encouraged and impressed by this when the HITECH Act was moving through the Congress rapidly, a very broad multi-stakeholder coalition, more than 100 groups came together and understand there's a lot moving now and no one's actually even sure who they should be reaching out to, to basically say that investments in meaningful use of health IT to promote better care needed to be able to assess disparities associated with race, ethnicity, socioeconomic status, and gender, which I think was a really big deal.

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So I do think there’s a lot of forward movement because at the end of the day, if you think about what it’s going to take to change this. Dr. Smitherman’s comments to me have been very reinforcing here. It’s information, we’re really good at this [Laughter], and it’s incentives and infrastructure right because reports without incentives and infrastructure are interesting to read but it doesn’t actually help you solve the problems in your community.

The Affordable Care Act provides resources for the infrastructure. The National Quality Strategy also provides a broad framework for the public and private sectors to work together to be able to make sure that the infrastructure we’re using to assess and improve quality of care also has a dual use in focusing on disparities.

**HERBERT SMITHERMAN, JR., MD, MPH, FACP:** I think why this is critically important, having widening gaps in health disparities increases cost of health care. It is exploding our costs. It’s unsustainable. When someone doesn’t have health insurance, it’s not that they don’t get health care. They end up in our emergency rooms getting the most expensive care in the most expensive settings. So widening gaps in health disparities increases cost and decreases our ability to be competitive in the world markets.

So I also believe that as I heard Dr. Clancy say and she mentioned the high-tech, which I think is critical because the whole idea of adopting electronic health records, having meaningful use of those records, exchanging information electronically allows us to not only improve individual health but population-based health. It allows us to better monitor populations with the set of metrics.

I mean if you are in a practice and you're exchanging information, you have 10 or 15 or 20 different physician practices that are able to sort on all of the diabetics in their practice and understand what the hemoglobin A1C is on average in that practice. You determine that it starts out at a quality level of 10. We want this down to seven. We can monitor that progress because we understand what's happening and we have the ability to track and monitor communities.

So I think the next, as far as I'm concerned, the next big step for us to really improve on health disparities is understanding what's happening in populations and the ability to exchange information and understand large population data is very critical to that.

So that high-tech bill that you guys put through in the Affordable, well actually through ARRA actually, I think it was through ARA, that was as a community member, as a practicing physician, as someone who is involved in workforce training as

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far as medical students, etc., and as far as serving an underserved population, to us, that was a critical step.

**GARTH GRAHAM, MD, MPH:** Yes, yes. Again Dr. Smitherman is on point of a number of key issues. One, the potential benefits of health information technology to reduce health disparities by not just garnering data at the population level but also introducing some reminders as well as other standardization that can make health care quality better for our populations.

If you go right now to the Office of the National Coordinator website, you’ll see a little blog post that was posted recently there talking about how we’re going to all work together as a department to utilize, try and develop some more concrete strategies to utilize health information technology to reduce health disparities.

Here is the bottom line with that. I think it has tremendous potential. There are tools there. I think we are going to have to be proactive in making sure that those tools as well as those mechanisms reach many communities and so that we bring the benefits to all but it’s again, it’s part of our plan.

It’s definitely part of what we got to do moving forward but that leads me to another point that he mentioned, which is the role of other partners in this and partnerships.

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So we did a little call to the vendor community not too long ago and got some interesting responses but I said vendor community in the health information technology field. It was interesting because a lot of vendors have been stepping up to want to do more to reduce health disparities and work together.

I think it's part and parcel understanding that there's a role for the government and government has to have strong leadership. There is a strong role for other components of the health care sector system that need to have this as a priority as well. This is not just government and community-based organizations, businesses as well as other folks who kind of play in this field as well. So that's another key driving force in this is change will only come when we're all together on the same page making change.

**CARA JAMES, PHD:** So it's a good transition. We've got a good summary of the framework. We're talking about connecting the dots. We've talked about the fact that we have a quality strategy. We have a prevention strategy. We have a domestic HIV strategy. We have an action plan for disparities and the stakeholder strategy.

If someone out there is trying to address this, what is the priority? How do you start? Where do you begin? Which of these do you start with and to some extent, where is HHS'

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priority in connecting all of these plans together and moving forward?

**GARTH GRAHAM, MD, MPH:** So I'll say that certainly one of the things the department is doing is moving on all fronts. We have to move on all fronts to be able to make change. So what do I mean? So we have to make sure that we have activities in place that will help or reduce incidence as well as a transmission, incidence and prevalence of HIV. I think there's some very key activities that are moving forward there.

At the same time, we have to also make sure that we're doing activities to increase health insurance, to increase quality of care, that as we move forward with the implementation with electronic health records as you said before.

So I think what we'll try to do is to make sure that there are roles and responsibilities for everyone. Everyone has, in their sphere, what it is that they need to be able to do next and all of that come together appropriately but to be honest, there has to be activity on all different levels to be able to implement change at this point.

**CAROLYN CLANCY, MD:** I would also point out that much of what we're discussing is not a new idea. It has also been tested. The new part is actually scaling it so that it happens everywhere. I will say from the Secretary on down, from the

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President on down, it is very clearly a high priority. Much of how we're structured in working together is to make sure that we are connecting those dots.

**CARA JAMES, PHD:** This is a very good question. Scalability is huge and all politics are local, disparities are local, and the efforts and things underway very significantly in terms of what we have going on in Dr. Smitherman's area and maybe some of the other areas. So I guess the question would be in terms of priorities of resources. We have some communities who are moving forward on this and maybe just need a little bit of a leg up.

We have other communities that are really struggling with even just understanding what the problem is in their area because of lack of resources either for whatever reason. What is the focus? Where do you allocate the limited dollars that you have in your thinking about how we move forward on making this scalable?

**CAROLYN CLANCY, MD:** Well I think that's a very, very big question but I can say throughout this administration, almost every investment we've made and one concrete example might be the Beacon communities.

Now these are multi-stakeholder collaborative activities going on in a variety of communities across the country that are focused on the effective use of health

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information technology or electronic health records and so forth as well as the capacity to exchange relevant information in a confidential secure way across settings so that your information follows you when you discharge from the hospital and so forth.

Almost all of those investments have been designed from the get-go to have a spectrum of communities and a variety of different variables whether that's these specific populations, whether that's how advanced they were to begin with but there's been a very purposeful effort throughout not to just say well let's find the communities that are most advanced and they can show the rest of the nation how it's done.

Instead, what you see routinely is a spectrum. I think from that we will learn a great deal because we know from some of these investments already that some areas will do extraordinarily well and those won't always be the ones that were the most advanced from the get-go.

**CARA JAMES, PHD:** So as we're beginning to wrap up, I want to talk obviously a little bit about the current environment in which all of this is happening. So we just had a pretty interesting budget battle to get some funding for the next six month and have another one coming forward, what do you see as the long-term future for these plans given the current environment and what might happen?

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**GARTH GRAHAM, MD, MPH:** We're going to be moving forward. I think we've already started moving forward. A major part of our plan or part of our plan was an emphasis on community health workers and promoters. Last week, we brought a bunch of leaders from the field of promoters to D.C. and it was just energetic and exciting and I learned so much from them the time that I was there as well as with the HHS folks.

What I mean by saying all of this, a lot of varied activities in this panel, a lot of stuff Carolyn talked about in terms of even just researchers meeting today and moving forward with how they move and implement grant systems and a lot of things in terms of moving forward. So a lot of stuff is already happening. I think our real vision is continuing to make progress certainly with what we know we have. I think that's part and parcel of this.

**CAROLYN CLANCY, MD:** I guess I would also raise Dr. Smitherman's point again and its cost. I mean everyone, every American, every person who lives here is worried about the economy, what's happening, what is the future going to hold for their children, their grandchildren, and so forth.

I mean I think the country is very worried to the extent that we are wasting resources, that we're not using resources in health care, and community services that could be much more effectively deployed to improve health and

health care and to lower costs. I think that's going to be sustainable. I think we've got a huge opportunity to make that case.

I still think, as you said, a lot of this is going to play out different locally but the notion of using data and information locally so that you come up with a solution that's customized for Detroit that might or might not work anywhere else but in Detroit, they know what they're doing. They know what their assets are and what are their toughest challenges and so forth. I think that's what's going to make it sustainable.

**HERBERT SMITHERMAN, JR., MD, MPH, FACP:** I think I like what Dr. Clancy and Dr. Graham are saying. We are going to move forward. I think they're saying, as a government, we're going to move forward because from our standpoint, when we saw the Ryan plan that was passed in the House where they, and remember a lot of the two strategies, the HHS action plan and the national stakeholder strategy, the core foundation of the how is the Affordable Care Act.

That's where the resources are coming from to implement this, which is expansion of Medicaid exchanges, etc. That's where a lot of this is going to happen.

One out of three people in the United States are on Medicare, Medicaid, and SCHIP. So when we see a plan that

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comes out that actually passed the House that cuts Medicare funding by $389 billion or so over 10 years or cuts Medicaid by $700-plus billion over 10 years, and puts it as a block grant so that it could be used as whatever.

These are the structures and the insurance underpinning of the Affordable Care Act. If those are cut in significant ways then it's going to have a tremendous impact on what happens moving forward with these bills and with trying to eliminate health care disparities in the United States. So I think that's going to be critical.

**CARA JAMES, PHD:** Dr. Smitherman, as someone who's on the ground, if you had 10 minutes with the Secretary to give her your wish list of what you need to move forward with addressing whatever action piece you wanted to tackle, what would you say you needed?

**HERBERT SMITHERMAN, JR., MD, MPH, FACP:** I think these are remarkable plans from the standpoint of defining what the problem is and why we are in the condition we're in with respect to health disparities. Everything is about human endeavor.

The big question is how we're going to move from the 2,000 leaders that were helped to inform this because we are 300 million people, how do we get a community, the United States, engaged in real change in health care when 51-percent

of it is our lifestyle choices and all of what that means, obesity, exercise, tobacco, alcohol, sedentary lifestyle.

I mean how do we get these reports and the information filtered down in a real way on the ground with communities so they understand, first of all, what their government is trying to do and they become engaged in that process in a real way not only on a local, federal, and state level but on an individual level.

How do we get the individual engaged in this process because without that, you can have a lot of resources, a lot of money, a lot of reports but if the community is not engaged in that in a real way, you're not going to move that needle forward. So that's what I would suggest.

**CARA JAMES, PHD:** So to Dr. Clancy and Dr. Graham, we've talked about a lot here today moving forward, a couple of plans that are going off, what would be the final thought you would want to leave with our viewers about either your particular plan or the action plan that we have moving forward so that that takeaway image for them?

**GARTH GRAHAM, MD, MPH:** So I'm actually going to take a note from what Dr. Smitherman said. The core of a lot of what we're doing is certainly understanding community. We built this based on community input and we want to bring this back to the community with an emphasis of a strong role for the federal

government's going to do but to your point, the crux of this is going to be getting everybody on board. This is not just an HHS problem that belongs to the Secretary. This is not just a problem that belongs to Dr. Clancy or myself. This is a problem that belongs to you.

It belongs to all of the folks that are watching this. It belongs to folks who are leaders in business, folks who are leaders in academia who are leading large academic health centers, many of which are located in high minority populations. These are all the different folks who need to be involved. So I think the word here is we're starting with something but we need everybody on board to be able to make progress and be able to make change.

**CAROLYN CLANCY, MD:** I agree with what my two colleagues have said. I mean it's such an exciting time but if there's one message that how to come out of the disparities action plan as well as the national quality strategy and others.

It's that what you're hearing from the federal government is a very clear commitment to change and a very clear recognition that making that change is a team sport. That is very much about what's driven by communities, by states so that they can take resources from HHS including glossy

reports and good information and actually use it to make change that best fits the needs of their communities.

So far, I think we're seeing amazing leadership just by one example. Garth just mentioned that many academic centers have a very high proportion of minority populations. Well very recently they actually launched a big serious campaign focused on improving quality of care.

They recently announced a patient safety campaign, Partnership for Patients. I couldn't even tell you how many partners have signed up because of changes almost by the minute. These aren't just waving a great idea. These are people making serious sustained commitments. So I'm very optimistic and hope that people listening to this will be as well.

**CARA JAMES, PHD:** Alright. Well thank you all. We will definitely have to follow up as we keep going, keeping people accountable and keeping track of the progress we make. I think that this has been a very good conversation to get us started and help people understand what you guys are trying to do and how it's going to work for those on the ground.

So before we close, I would like to thank Dr. Carolyn Clancy, Dr. Garth Graham, and Dr. Herbert Smitherman for joining me today. I would like to thank all of you for your

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questions. Again, I'm Cara James of the Kaiser Family Foundation. Thank you.

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