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Mark Masselli: This is Conversations on Health Care. I am Mark Masselli.

Margaret Flinter: And I am Margaret Flinter.

Mark Masselli: It's the dog days of August and Margaret and I are on vacation but we planned ahead and we are bringing you a brand new episode for your listening ears.

Margaret Flinter: Alright, Mark so let's jump right into today's show and introduce our guest.

Mark Masselli: Today, we will be speaking with Dr. Garth Graham, Deputy Assistant Secretary for Minority Health within the Department of Health and Human Services. He will discuss federal policy in Minority Health and what work remains to ensure that health care needs of racial and ethnic populations are being met. We are happy to welcome Dr. Graham to our show today.

Margaret Flinter: No matter what the story, you can hear all of our shows on our website www.chcradio.com, subscribe to iTunes and get the show downloaded or, if you want to hang on to our every word and read a transcript of the shows, come visit us at www.chcradio.com. And don't forget, you can become a fan of Conservations on Health Care on Facebook and follow us on Twitter.

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Mark Masselli: Welcome Dr. Graham.

Dr. Garth Graham: Thank you for having me Mark.

Mark Masselli: The Office of Minority Health was created in 1986 and came out of then President Reagan's Secretary of Health and Human Services Task Force on Minority Health. Yet, health disparities continue today even though many people know very little bit about such disparities in United States. Can you start out by telling us about the Office of Minority Health?

Dr. Garth Graham: Sure. As you probably know Mark, our office was created as a result of something called the Secretary's Task Force on Black and Minority Health which was issued back in the mid '80s and actually was the first federal document to really document this issue of health disparities and spawned a lot of different activities both here at HHS but in a number of states across the country and started up the health disparities research activities over at NIH as well. So really kind of spawned or really helped to I should say elevate the health disparities movement. Our office has been charged over the years with

coordinating all the policies across HHS, and when I say HHS I mean the Food and Drug Administration, CDC, NIH as well as the Health Resources and Services Administration, and a whole bunch of other agencies so coordinating much of those policies. But we also work with states and over the years have helped to support and create a number of State Offices of Minority Health that also exist at the state and local level. So it's been a journey so far in terms of the role and the responsibilities of this office but certainly an exciting journey so far, and a lot under the Affordable Care Act having to do with our office as well.

Margaret Flinter: So Dr. Graham, I would like to step back in time a little bit even before the Office of Minority Health was established and go back to the Civil Rights Movement of the late '50s and '60s and certainly the Reverend Martin Luther King spoke eloquently to the issue of disparities saying, "Of all the forms of inequality, injustice, health was the most shocking and the most inhumane". Can you give us a perhaps bit of a historical perspective on how federal policy has affected health and health care for minority groups in the US over these past 50 years, specific legislation or programs that were implemented?

Dr. Garth Graham: Sure. Yeah you are right in going back to the 1960s because there were a number of important things that happened in the 1960s. The passage of legislation on Medicare desegregated hospitals and interestingly enough, when you look back to exactly what that meant and going back some of the words of Martin Luther King, it really pointed to the issue of up until that time minorities were quite frankly receiving segregated care I should say and care where people would only be physically located in one section of the hospital and be seen by only one set of clinicians as well as health care services. So you are right in really articulating that. This issue goes way, way, way, way back before the Secretary of Task Force of Black and Minority Health. So Martin Luther King articulated things well in terms of highlighting just how important this issue of health and health care is to not only the health of a community but the future of a community.

So what you saw from the late 1950s and 1960s and onwards, first the desegregation of health care for minority populations which was a big move back in the mid 1960s. In the 1970s, there was a Surgeon General Report that also articulated much in terms of the disproportion and burden of illnesses that minority communities faced so there were a lot of different not only reports but activities. Interestingly now, when you look at the health disparities, health disparities has a lot to do not just with the race and ethnicity of a person but also more importantly I should say where they live. So we still to some degree see health care that is based on the quality of care that a person receives in a particular location depending on the location that the person lives in, there is a lot of history that leads to the actual residential area in which a number of communities end up in.

So it's an interesting intermixing of not only the health care system but really telling the story of social infrastructure and how social infrastructure has interacted with minority communities.

Mark Masselli: Now Dr. Graham, you mentioned a few minutes ago that the Affordable Care Act lays out some opportunities to improve health outcomes and specifically requires that the Secretary of Health make sure that federally supported health surveys collect data on race, ethnicity, sex, primary language and disability status. But the new rules that HHS put forward require federal agencies collect health information at a much higher and more specific standard and I think and hope that you will better understand the significant health issues in specific populations. So tell us about your hope what you learned from the enhanced data and how do you envision it being used to improve health outcomes and reduce health disparities.

Dr. Garth Graham: Sure. So as you just pointed out, we just put out our proposed standards for data collection around race, ethnicity, primary language, sex, and disability status. And on the race ethnicity portion, previously in the 1990s, Office of Management and Budget, OMB had put out a series of standards for race and ethnicity. And over the past couple of years even prior to those standards, the country had become more and more and more diversified. So it means that when we say Asian-American, there are a lot of differences between the Hmong population and the Japanese population, great differences between the Vietnamese population and Korean population. When we say Hispanic and the Latino in terms of ethnicity, there are differences in terms of health outcomes between Puerto Rican population and Cuban American population. So there are differences even within category. So what we are trying to do with these new standards is building on the OMB, the Office of Management and Budget criteria that was put forward in the mid 1990s. It's to further disaggregate data for race, ethnicity so when you look at and when we talk about Asian-American, we go on to talk about Korean-American, Vietnamese-American and other sub-segments of the Asian-American community. Similarly, when you look at the Hispanic community, we are also again looking at different sub-segments of the community. So really what we are trying to do is to further and further disaggregate data on race and ethnicity as well as looking at this issue of getting more definition around the primary language that people speak. So we are hoping that that will be the new baseline but certainly we hope and expect that there are many other surveys and data collection activities that will go into more detail and granularity than even just those surveys.

Margaret Flinter: Today, we are speaking with Dr. Garth Graham, Deputy Assistant Secretary for Minority Health at the Department of Health and Human Services. Dr. Graham, not so long ago the Commonwealth Fund issued a report and made a bold statement based on their research that a high performance health system can markedly reduce or even eliminate disparities in health and

health care. But we still see some disparities in health such as the persistent gap in birth outcomes for African-American women for instance even when the gains have been made in income and education and in access to health care. Tell us little bit about the state of research in this area on health care disparities but also on health outcome disparities even when other factors seem to have improved for the better.

Dr. Garth Graham: Sure. The statistics around infant mortality in minority communities really point to the complexity of the problem in terms of just all the different factors that go into the health outcomes in minority populations. So you are right that when we look on that infant mortality rate from comparing African-American women to the rest of the general population, in many cases the infant mortality rate which is the rate at which babies die within the first year of life, babies of African-American women who have graduate degree, their infant mortality rate is still higher than other women from a majority community who have not graduated high school. So we see those disparities that still persist even when you for lack of better terminology control for socioeconomic status. So what does that mean in terms of moving forward? Well it means one, that there is no simplistic way to deal with issue of health disparities, you can't just categorize it as a socioeconomic status issue and just kind of chalk it up to that. There are other issues that go beyond that and certainly access to cure is an issue, certainly understanding how we interact with all the different for lack of a better terminology social determinants of health, those things outside just the definition of health, talking about jobs and education and all that kinds of things, and how those things interact. Now one of the interesting things around the infant mortality data is there is some data about the role of stress and just how the role of stress in minority communities play a role in terms of those infant mortality numbers. So it's really a multifactorial kind of issue but as we move to the high performing health care system that not only the Commonwealth Fund but all of us involved in health and health care would like to see happen. I think it's going to be important to keep the patient at the center of that and understand all the different dynamics that the patients go through.

Mark Masselli: Dr. Graham, Margaret and I have both been involved in health care movement for quite a time and I think it's axiomatic in our field that having health insurance and having access to health care is fundamental to reducing and eliminating health disparities. Now the Affordable Care Act speaks to that for all Americans but what elements of the Health Reform Bill specifically addresses health disparities either in terms of access or innovation or research or training. And have any of those elements been implemented to date, can you let our listeners, give them a little look at the waterfront?

Dr. Garth Graham: Yeah. So as you have pointed out, the insurance part of it has been the part that has gotten the most attention and certainly we are trying to improve the health system and access to the health system by providing various options for improve the access whether that be through strengthening Medicaid

as well as other things like the Pre-Existing Condition Insurance Plan and other kinds of plans like that to increase access to care. But you are right, the word health disparities is mentioned numerous times across the Affordable Care Act not just in the area of the insurance provision and to give you kind of a preview, it talked about one of those things in terms of improving data on minority populations, and that's certainly one aspect. Also it does a number of things to improve the infrastructure of how Department of Health and Human Services deals with health disparities, it puts in health disparities infrastructure into the Centers for Medicare and Medicaid Services, it puts health disparities infrastructure in a number of different ages from Substance Abuse and Mental Health Services Administration to the Food and Drug Administration to a number of places to have specific _____ 13:57 in those agencies that deal with health disparities. It goes beyond that to also directing the department to put more of an emphasis on cultural competency and things that we do around cultural competency to help improve access to cultural competency curriculum and things like that. So these are all things that have either been implemented or are in the process of being implemented. So it's really a transformative time period but I think it's also important to understand that the Affordable Care Act is not the end all be all for all things health disparities related and there will need to be ongoing and continued efforts outside of that. It's certainly a step forward but it's not the panacea for the reduction of health disparities.

Margaret Flinter: Well you know Dr. Graham certainly one of the hallmarks of everybody at HHS these days seems to be a commitment to innovation and to strategic thinking and certainly inserting those centers for health disparity within all the different agencies is a great step forward. But on the innovation front I know I have heard you speak I think about the interest within your area of looking at community health workers, something people don't generally think of as part of the traditional health care system although in many parts of the country that's a very proven model. Tell us a little bit about why that rises to the level of an innovation that you would like to see put forth and what it promises to offer in the area of reducing or eliminating health disparities.

Dr. Garth Graham: Sure. So community health workers have been quite frankly a part of the community for a long time. I think the health care system is just catching up to figuring out how to utilize those kinds of individuals and people in communities that have been the go-to a person for understanding how you navigate systems and for understanding all kinds of things about local communities. And so that's been in place historically in a number of underserved communities, you kind of have that one person who can help people understand what it is they need to do. What we are finding more and more is that the incorporation of those kinds of individuals into the health care system, into health care teams allows us to be able to reach folks in a number of different ways and allows us to interact with the community like never before. So, as part of our departmental strategic plan, our own health disparities, we have put a big emphasis on community health workers. In the Latino community, they are

referred to Promotores and in fact our secretary, Secretary Sebelius, just announced a Promotores initiative that we are doing; she announced it about two or three weeks ago. And the long and short of it is what we are trying to say is the department is going to be funding as well as working with forming partnership with community health workers/ Promotores at a number of different levels and the goal there really is to come up with new and innovative ways to reach people. I understand that in many ways communities have already defined how they interact with each other and it's about the health care system interacting with communities at the grassroots level.

Mark Masselli: Well I think that's an exciting work and certainly I think it flies in the face of most people's thinking that the Federal Government is here to help but it's not here to help at a local level, and you have really transformed that with your initiatives there. Pull the thread a little if you will on how you are using social media. I think so many of the younger people today are texting, they are on Facebook and Twitter and I am probably dating myself because there are probably newer things I should be saying here already. So talk to us a little bit about how you start to conceptualize this local commitment using those outlets.

Dr. Garth Graham: Sure. So,, the story around social media is interesting. I mean I think the revolution has been happening for some time now and it's just now that health care is catching up to utilize the social media in the right way so there are number of different ways. Now certainly in our practical sense we have made sure that we are present and availed in all the Twitter world as well as all the other forms of social media whether it's Facebook or anything along those lines to make sure that we connect to people in a way that they are accustomed to being connected with and interacting with the world. That's one aspect. More importantly though, what we are finding out is that these are powerful tools in terms of reaching people in a very different kind of way. So right now as a department we have a number of Text for X&Y campaign. So we have been trying to reach young pregnant women with a Text4baby Campaign which basically sends text messages to women who are pregnant with health messages. And we are using that model in a number of other text for X or text for Y campaigns in terms of using text messaging to reach folks. One of the interesting things in 1999, the Department of Commerce released a study looking at how minority communities interact with technology and it was one of those initial reports to highlight the issue of a digital divide. What's interesting if you look over the past 9 or 10 years that digital divide those till present is closing. The Pew Hispanic Research folks published a recent data showing that Hispanic-Americans as well as other minority communities too are utilizing broadband technology and mobile phone technology all kinds of those technologies at a faster rate compared to the general population. So that means that even though the divide exists, the actual rate of the divide is closing because people are starting to utilize these technologies as they become cheaper and cheaper. So with that being said and done it's about us utilizing these methodologies as much as other people are utilizing them appropriately.

Mark Masselli: When you look around the country and the world what do you see in terms of innovation and who should our listeners at Conversations be keeping an eye on?

Dr. Garth Graham: Oh that's an interesting question. Well, across the country I think what you see is you see a lot of pockets of innovation at local level. You see some interesting things in New York City where people are trying to create local healthier zones and things along those lines. You see some interesting things in Colorado where people are trying to link hospital systems to a lot of kind of local health collaboratives, and you see interesting things in a number of different local communities like that. What I would say we should keep an eye on is even beyond that there are a number of I would say kind of younger people coming up. And the other day the USDA had a bunch of us judging young chefs who were in high schools who were cooking healthy meals on an annual healthy foods competition. And it's interesting to me just how many of those young kids who were 17-18 years old understood how to create food in a way that would be appealing to young people and old people alike. So my point in saying that long-winded answer is we have to pay attention to what's going on at the local level and find some of those young and even older unsung heroes who are coming up with local solutions to problems that hopefully at some point we can translate to a national level.

Margaret Flinter: Today, we have been speaking with Dr. Garth Graham, Deputy Assistant Secretary for Minority Health at the Department of Health and Human Services. Dr. Graham, thank you so much for joining us on Conversations Today

Dr. Garth Graham: Thank you for having me.

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Mark Masselli: Each week, Conversations highlights a bright idea about how to make wellness a part of our communities and everyday lives.

This week's bright idea focuses on an initiative that uses a strategic public health approach to violence prevention. CeaseFire has its roots in Chicago where youth violence is often referred to as an epidemic. Last year, nearly 700 children were hit by gunfire, an average of almost 2 a day. So in 2000, when the program was launched by the Chicago Project for Violence Prevention, finally it began to be treated as a public health crisis instead of merely a crime problem. CeaseFire uses public education campaigns, GED Programs, and various counseling opportunities to target violence but its main tool is community mobilization. Trained volunteers from the community called Violence Interrupters establish a rapport with gang leaders and other at risk youth just like outreach workers within a public health campaign. Many interrupters are from the communities they serve and many are former criminals who know violence firsthand. The

interrupters work the streets helping to keep minor arguments from becoming deadly and mediating more aggressive ones between gangs. After a shooting, they intervene with non-violent alternatives to stop the victim's friends and family from retaliating. The program has produced encouraging results. The US Department of Justice conducted a three year evaluation in 8 of 18 Chicago communities where CeaseFire has been adopted. Shooting and killings have been reduced by 41% to 73% and retaliatory killings by a 100% in five of the communities. The model has been replicated more than a dozen times nationally. A public health approach to stopping violence with hard statistics to back it up, now that's a bright idea.

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Margaret Flinter: This is Conversations on Health Care. I am Margaret Flinter.

Mark Masselli: And I am Mark Masselli. Peace and health.

Conversations on Health Care, broadcast from the campus of Wesleyan University at WESU, streaming live at www.wesufm.org and brought to you by the Community Health Center.