

**PROCEEDINGS**

**ON THE ROAD TO ELIMINATING HEALTH DISPARITIES:  
WARD BY WARD**

**20 May 2008**

Walter E. Washington Convention Center  
801 Mount Vernon Place N.W.  
Conference Room 103  
Washington, DC 20001

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# I. EXECUTIVE SUMMARY

## INTRODUCTION

This report constitutes the proceedings of **ON THE ROAD TO ELIMINATING HEALTH DISPARITIES: WARD by WARD**, a community health issues forum sponsored by the Community Health Partnership, Inc. at Walter E. Washington Convention Center in the District of Columbia (DC) on May 20, 2008.

Health disparities are gaps in the quality of health and healthcare across racial, ethnic and socio-economic groups.<sup>1</sup> The purpose of our health forum was to facilitate a community wide discussion on factors that may contribute to health disparities from different perspectives of patients and residents, health care providers, health insurance and pharmaceutical companies. The target audience for this forum was comprised of DC residents, Advisory Neighborhood Commissioners, local church members, DC Department of Health officials, DC City Council members, private/public health insurers, private/public physicians, and other health-related organizations.

The District of Columbia (DC) is a city with a 2007 population estimate of 588,292.<sup>2</sup> The land mass is 61.4 square miles.<sup>2</sup> The people of the District are medically served by seven hospitals, more than fifty adult primary care centers, and numerous private medical physicians. DC residents experience rates of disability and death from cancer, diabetes, heart disease and HIV/AIDS that are among the highest in the nation.

## MEETING OBJECTIVES

The objectives for this meeting were to:

1. increase awareness of health disparities
2. share state of the science in epidemiology and health trends in DC
3. identify salient issues related to the physician's ability to deliver evidenced based care; and patient's right to expect and to receive medical management of conditions based upon the most up-to-date scientific and clinical evidence, medications and procedures for a particular condition.
4. discuss implications of minimal access to appropriate medications, preventive care education and healthcare disparities education.

The desired outcome for this meeting was to ensure a rich community dialogue aimed at generating recommendations to positively impact:

- legislation being developed
- physician's ability to care for their patients
- quality of healthcare and services provided to patients
- health outcomes of ethnic minorities in the District of Columbia.

*One immediate outcome achieved during the forum was to link a 50-year old DC employee, who was uninsured and suffering from lupus, with two existing programs that covered her primary health care and recent hospitalizations.*

## **BACKGROUND**

**ON THE ROAD TO ELIMINATING HEALTH DISPARITIES: WARD by WARD** was organized by the Community Health Partnership, (CHP) Inc. CHP is a 501 (c) (3) nonprofit coalition of community stakeholders working in DC to develop and to implement community-driven solutions to address health disparities. CHP was founded by members of Church of the Nativity in 2002 because it was believed that it is not in the best interests of ethnic minorities for health interventions to focus too narrowly upon one disease, when the data and life experiences demonstrate that minority populations are at considerable risk for multiple chronic conditions.

CHP members represent churches, civic associations, DC residents, educational, local government and other health-related organizations. CHP's mission is to build healthy neighborhoods and reduce health disparities through education and outreach activities that aim to: (a) improve individual health literacy; (b) promote access to care and treatment; (c) improve ethnic minority health outcomes; and (d) enhance quality of life for all members of the community. The objective of CHP programs is to help people become better self-advocates for their own health.

## **ACKNOWLEDGEMENTS**

Grateful acknowledgement is made to Pfizer, Inc. for providing CHP with a nonbinding educational grant in support of ON THE ROAD TO ELIMINATING HEALTH DISPARITIES: Ward by Ward. CHP wishes to express sincere appreciation to the many outside experts and community members who contributed their time and talents to planning and participation in this event.

## **CHP BOARD OF DIRECTORS**

Elaine H. Ellis, *President*

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Evelyn L. Lewis M.D., M.A., FAAFP

Michael A. Stoto, Ph.D.

## II. HEALTH FORUM

### AGENDA

<b>ON THE ROAD TO ELIMINATING HEALTH DISPARITIES: WARD by WARD</b>	
Tuesday, May 20th, 2008 Walter E. Washington Convention Center, Conference Room 103 801 Mount Vernon Place N.W., Washington, DC 20001	
<b>8:00 – 9:00 A.M.</b>	<b>REGISTRATION</b>
<b>9:00 – 9:10 A.M.</b>	<b>INVOCATION</b> <i>Reverend Renee Woodard-Few</i> Associate Pastor of Health , Emory United Methodist Church
<b>9:10 – 9:20 A. M.</b>	<b>Meeting Overview and Introductions</b> <i>Dr. Evelyn L. Lewis</i> , Medical Policy Director, Pfizer Board of Directors, Community Health Partnership
<b>9:20 – 9:40 A.M.</b>	<b>Keynote Address</b> <i>Dr. Gloria Wilder</i> President and CEO COREHEALTH
<b>9:40 – 10:00 A.M.</b>	<b>Health in District of Columbia: Epidemiology and Trends</b> <i>Dr. John Davies-Cole</i> , State Epidemiologist, DC Department of Health Board of Directors, Community Health Partnership
<b>10:00 – 10:10 A.M.</b>	<b>Questions and Answers</b>
<b>10:10 - 10:20 A.M.</b>	<b>BREAK</b>
<b>10:20 - 10:40 A.M.</b>	<b>Physician Challenges</b> <i>Dr. Denice Cora Bramble</i> , Children’s National Medical Center
<b>10:40 – 11:00 A.M.</b>	<i>Dr. Ricardo Galbis</i> , Andromeda Transcultural Health
<b>11:00 – 11:20 A.M.</b>	<b>Patient Rights &amp; Health Literacy</b> <i>Jann Keenan</i> , Keenan Group, LLC.
<b>11:20 – 11:40 A.M.</b>	<b>Health Insurance Challenges</b> <i>Dr. Malcolm Joseph</i> , Medical Director, CareFirst Blue Cross Blue Shield
<b>11:40 – 12:00 P.M.</b>	<i>Dr. Walter Faggett</i> , Medical Director of DC Department of Health Medical Assistance Administration
<b>12:00 – 12:15 P.M.</b>	<b>Questions and Answers</b>
<b>AFTERNOON Session</b>	
<b>12:00 – 1:00 P.M.</b>	<b>WORKING LUNCHEON</b>
<b>12:00 – 2:30 P.M.</b>	<b>ROUNDTABLE DISCUSSIONS</b>
<b>2:30 – 3:30 P.M.</b>	<b>RECOMMENDATIONS</b>
<b>4:00 PM</b>	<b>MEETING ADJOURNS</b>

## KEYNOTE ADDRESS

Dr. Gloria Wilder provided a poignant keynote address targeting social justice issues that have a significant impact upon quality of health care received, *as well as* quality of life. Her motivating speech set the tone for the health forum. She helped us to understand that we need a health care system that considers *layers of health and wellness*. Dr. Wilder challenged the meeting participants to consider things that may be equally important when designing health care interventions:

- access to quality education
- access to jobs not welfare: *ending generational poverty*
- access to economic opportunities: *working for a living wage*
- access to an unbiased legal system: *2.3 million in persons in U.S. prisons, 1 out of 15 is African American, 1 out of 36 is Hispanic*
- environmental justice: *a safe place to live and work that is free of violence*

“A society that practices justice creates balance”. Dr. Wilder cautioned meeting participants that health insurance coverage alone... will not automatically buy us access to quality health care. She provided several examples from her personal experiences as a medical practitioner in DC:

- A mother given antibiotics for a child’s ear infection. Within a few days, she returns to hospital because her child’s condition had critically worsened. Why? In error, the mother put drops into the child’s ear, not understanding this antibiotic medication should be taken orally by mouth.
- A mother torn between waiting with one child for medical treatment, and rushing home to salvage her family and personal belongings from same day residential eviction for non-payment of rent.
- Parents of an African American infant awaiting their child’s death because physicians had pre-determined the condition was not treatable.

Dr. Wilder stated that changing *disparity into equity* is one of the most daunting issues facing the multitude of non-profits operating in the District. She reminded us that the nonprofit sector must learn to clearly define its programs and to measure program outcomes. “Nonprofits have really great objectives, but without positive action they only become charity. Charity without justice is cruel. We must challenge ourselves. We must fight against generational poverty. We must all realize that health is not only about disease. Competition for services is necessary to improve quality of life. The question to be asked is...*how to create economic markets in our communities?*”

Dr. Gloria Wilder is a nationally recognized public speaker on social justice and economic segregation. She received her Doctor of Medicine degree from Georgetown University, completed her Fellowship in Community Pediatrics and Child Advocacy at Georgetown University, and earned a Master’s in Public Health at George Washington University. She is the founding President of both **CoreHealth**, a consulting firm specializing in providing outcome focused solutions to the nonprofit sector, and **Justice Speaks** a multi-issue social justice nonprofit dedicated to educating and advocating for an end to poverty. Dr. Wilder formerly served as the Chair of Mobile Health Programs for the Children’s Health Project of DC at Georgetown University and Children’s National Medical Center. She is fondly known as Dr. Gloria.

“The District of Columbia is a city with seven (7) major medical centers on the West side of town. On the East side, there is one (1) hospital that has been closed three times.”

## PANEL PRESENTATIONS

### MORNING SESSION

#### **EVELYN L. LEWIS, M.D., M.A., FAAFP, MODERATOR**

Dr. Evelyn L. Lewis serves on CHP board of directors. She is a medical policy director for Pfizer and nationally recognized for her expertise in the areas of cultural competency and healthcare disparities. She is a Fellow of the American Academy of Family Physicians and holds faculty appointments at the Uniformed Services University in the Department of Family Medicine and Medical and Clinical Psychology. Her professional and research interests include adolescent medicine, adolescent sexuality and pregnancy issues, weight management (obesity and overweight), health and healthcare disparities, clinical trials and minority participation, cultural proficiency and women's health care delivery. She is a member of several medical associations: Society of Teachers of Family Medicine, the American Academy of Family Physicians, the National Medical Association (NMA), the American Medical Association (AMA), and AMA NMA Commission to End Healthcare Disparities.

#### **JOHN DAVIES-COLE, PH.D., MPH**

Dr. John Davies-Cole serves on CHP board of directors. Dr. Davies-Cole is State Epidemiologist and Interim Senior Deputy Director, Center for Policy, Planning & Epidemiology at the District of Columbia Department of Health (DOH).

Dr. John Davies-Cole provided health forum attendees with an overview of Health in the District of Columbia: *Epidemiology & Trends*. He reported that the health status of the District is a description of the health of its population. The information used to report health status comes from a variety of sources: birth and death records, hospital discharge data, health information collected from health care records, personal interviews and telephone surveys. The 2006, estimated population in DC is 581,530. By race the population is 56.5% Black, 38.4% White, 8.2 % Hispanic and 3.2% Asian Pacific Islander. Life expectancy in District of Columbia was 72.6 years in 2000 compared to 77.0 years for the U.S. nationally. This was the lowest compared to all states.

Dr. Davies-Cole's presentation provided the community with Ward by Ward comparisons and national comparisons for crude death rates from heart disease, hypertension, cancer, diabetes, homicide, infant mortality, HIV/AIDS, and unintentional injuries. For the first time, many community members were exposed to data and statistics for the prevalence of disease by race, as well as risk behaviors Ward by Ward.

As the State Epidemiologist and Interim Senior Deputy Director at Center for Policy, Planning & Epidemiology for DOH, Dr. Davies-Cole is responsible for a comprehensive epidemiology and risk assessment program that includes collecting and analyzing vital statistics data for District of Columbia. He is author and contributor to over (30) publications in peer-reviewed journals, invited publications, annual reports and newsletters. Dr. Davies-Cole received his Masters degree in Public Health from the George Washington University School of public Health and Health Services, Ph.D. from the University of Sierra Leone, and carried out postdoctoral studies at the University of Oldenburg in the Federal Republic of Germany.

Dr. John Davies-Cole has over twenty years of experience in public health, research and control of infectious diseases, epidemiological methods, surveillance and outbreak investigations. He currently is involved in emergency preparedness, especially identifying unusual activity and identification of events of bioterrorism. He was previously involved in international public health, especially control of vector-borne diseases, and water supply and environmental sanitation issues in developing countries. He conducted training programs and international consultancies in Kenya, Uganda, Tanzania and Sudan.

Following the overview on health in District of Columbia, the program moderator invited guest speakers to give meeting attendees presentations framed around three questions from the different perspectives of their professional work. The three questions:

- What are greatest challenges to the physicians' ability to deliver evidence based health care?
- How do these challenges contribute to health disparities in District of Columbia?
- What are your suggestions for removing these barriers to deliver patients the most up-to-date scientific and clinical evidence or best treatment, medications and procedures for a particular condition?

#### **DENICE CORA-BRAMBLE, M.D., MBA**

Dr. Denice Cora-Bramble is a Professor of Pediatrics at George Washington University School of Medicine, and Executive Director of the Diana L. and Stephen A. Goldberg Center for Community Pediatric Health at Children's National Medical Center (CNMC) in Washington, DC. In her role as Executive Director, Dr. Cora-Bramble leads the clinical, research, education and advocacy activities of the Goldberg Center. She is the first minority and currently the only woman to lead a clinical center of excellence at CNMC.

Dr. Cora-Bramble provided health forum attendees with an excellent overview of challenges faced from childhood health disparities.

**Pediatric disparities:** Among Latino children, there is higher incidence of overweight and obesity, asthma, injuries, hospitalizations and death, tuberculosis, Type-2 diabetes, developmental problems and dental decay.

**Childhood Obesity:** Since 1970, there has been 400 % increase in childhood obesity nationally. In District of Columbia, 33% of preschoolers, 43% of 6-10 years old, and 47% of 11-21 years old are overweight or obese. DC has highest rate nationally of overweight 10-17 year olds (22.8%).

Being overweight as a child is associated with multiple chronic diseases that typically manifest in adulthood, such as type-2 diabetes, cardiovascular disease and certain cancers. Many adult complications, such as type-2 diabetes and hypertension are increasingly being seen in overweight adolescents. Obese children tend to use more medical resources and experience more frequent hospital days, ER visits, outpatient visits and pharmaceuticals.

Obese children are twice as likely to be hospitalized as compared with non-obese children. Psychosocial outcomes include: discrimination and teasing, poor self-esteem, eating disorders, family problems, behavioral and learning problems, lower education and socioeconomic status.

**Asthma:** Both African American and Latino children enrolled in Medicaid managed care had worse asthma status and were less likely to be using preventive asthma medications than White children

**Contributing risk factors to health disparities included** race, income, insurance status, language and culture barriers. There are also unknown factors that have yet to be identified.

**Recommendations:**

- Access to health care services that easily accessible, affordable, and culturally responsive
- Community as empowered consumer
- Partnerships between researchers, clinicians, advocates and communities
- Targeted clinical interventions

The Goldberg Center is one of the six Centers of Excellence at Children’s Hospital and includes the Divisions of General Pediatrics, Adolescent and Young Adult Medicine, Pediatric Dentistry, the Child and Adolescent Protection Center, the Mobile Health Program, seven health centers and multiple related programs. The Goldberg Center is the largest provider of pediatric primary care in the District of Columbia, delivering more than 78,000 visits per year and serving an urban, multicultural population.

**RICARDO GALBIS-BELTRAN, M.D.**

Dr. Ricardo Galbis-Beltran is Executive Director of Andromeda Transcultural Health. Andromeda provides prevention and treatment of HIV/AIDS, HIV testing, primary care, case management, substance abuse counseling, mental health counseling, and referral for housing and hospitalization. Free services are available to DC residents.

**Challenges to delivery of evidence based care to patients in DC**

- Un-insured and under-insured are barriers to access to care
- Ability of community based organizations to effectively operate without funding or donations, e.g. children’s mental health
- Significant need for mental health services. Not all insurance plans cover mental health services or psychiatric medications
- Co-morbid conditions: HIV/AIDS, Mental Illness, Substance Abuse, Diabetes, Hepatitis C
- Adherence to treatment: Medication resistance, Non-compliance
- Risky Behavior: unprotected sex, drug use
- Stigmas towards illness

**How challenges contribute to health disparities:**

- Latino adolescents report more suicidal ideations compared to non-Hispanic white adolescents
- Recombined families, Nonfunctional families, Latchkey children

- Higher incidence of alcoholism
- Higher incidence of anomie- breakdown or absence of social norms caused by uprooting
- Precursors to gang activity e.g. non peer group acceptance and desire to belong

**Suggestions for breaking barriers:**

- Address the educational disparity and language barrier
- Implement more cultural competency training for providers
- Health education to decrease stigma for both HIV/AIDS and mental illness
- Access to Care
- Reach out to patients within their community

Ricardo Galbis-Beltran, M.D. was born in La Habana, Cuba. He studied medicine at Tulane University, Universidad de la Habana (closed during Batista’s Regime), and transferred to Wake Forest University, N.C., to obtain his Doctorate of Medicine in 1960. Dr. Galbis completed an internship at D.C. General Hospital, and a Psychiatric residency at Saint Elizabeths. In 1967, he completed a Fellowship in Child Psychiatry at Georgetown University where he was encouraged to pursue his interest in Community Health. Dr. Galbis co-founded the Washington Free Clinic in 1968, and founded Andromeda in 1970, now known as Andromeda Transcultural Health (ATH). ATH targets the growing Hispanic population, and the need for health services that are more personal, culturally and linguistically appropriate and affordable. Dr. Galbis is a Senior Attending Physician at the Washington Hospital Center. He is a Distinguished Life Fellow of the American Psychiatric Association. Recipient of the Life Time Achievement Award from March of Dimes “Celebrando el Espritu Latino (2007).”

**JANN KEENAN, ED.S.**

Jann Keenan is a health literacy specialist and public health educator. Keenan’s presentation, HEALTH LITERACY & HEALTH DISPARITY, helped meeting attendees to understand the impact of low health literacy on health outcomes.

**Challenges:** The biggest predictor of a person’s health status is literacy skills. The majority of those with low literacy skills in the United States are white, native-born Americans. Yet, ethnic minority groups and seniors are disproportionately affected by low literacy. In District of Columbia literacy skills are substantially lower than those in the US overall. 36% of DC adults have functional illiteracy versus 21% nationally. **Translation:** 1 in 3 in DC has low functional literacy versus 1 in 5 in the nation. There are a growing number of Hispanic and Ethiopian residents in DC who are not proficient in English.

**Low health literacy contributes to health disparities:** A person’s ability to understand and to act upon health information is based upon literacy skills. When patients do not understand what the doctor says, they:

- Have poorer overall health
- Use health services more often
- Are less likely to go to screenings
- Are more likely to be hospitalized

- Seek treatment in later stages of disease
- Have less understanding of their treatment and less adherence to medical regimes

**Recommendation for Providers to Help reduce health disparities:**

- Slow down when talking to patients
- Use analogies to draw comparisons- two similar things
- Use living room language, i.e., benign = not cancer; lateral = side; Anaphylactic reaction = shock, throat closing; Oral= by mouth; Monitor = watch; Hypertension = blood pressure
- Limit information given at one time: REPEAT and REPHRASE
- Show or draw pictures
- Use “teach back” or “show me”
- Be respectful, welcoming, and caring
- Encourage questions: empower patients to participate in their own health care

Jann Keenan uses her expertise to create award-winning health education materials and design nationally and internationally recognized health promotion campaigns. She offers lively workshops on health literacy, health disparities and cultural competency throughout the U.S. She holds a Masters and Educational Specialist degree from Indiana University. Jann received the federal government’s Blue Pencil Award for outstanding plain language writing and five National Institutes of Health Awards. She was also awarded the Maryland State Governor’s citation, The Maryland Black Legislative Caucus, and the Maryland House of Delegates awards for community service, working to reduce health disparity, and promoting health literacy in the State of Maryland. Ms. Keenan serves on the American Diabetes National Board for publications. Her articles on health literacy concerns have appeared in the *American Family Physician*, *Pharmaceutical Executive*, *Vascular Journal*, and *Correct Care* magazines.

**MALCOM JOSEPH, III, M.D., MPH**

Dr. Joseph is a medical director at CareFirst Blue Cross Blue Shield. The CareFirst mission is provide health benefits of value to customers across the regions of District of Columbia, Maryland, Northern Virginia and Delaware. CareFirst offers Point of Service Plans (POS), Preferred Provider Organizations (PPO), Managed Care Organizations (HMO) and Consumer Directed Health Plans. To fulfill this mission, CareFirst commits:

- To offer a broad array of quality, innovative insurance plans and administrative services that are affordable and accessible to our customers
- To fairly address the needs of customers in each of the jurisdictions in which we operate.
- To conduct business responsibly as a non-profit health services plan, to ensure the Plan’s long-term financial viability and growth.
- To support public and private efforts to meet needs of persons lacking health insurance.
- To collaborate with the community to advance health care effectiveness and quality
- To foster health systems integration and health care cost containment to benefit the people in areas we serve
- To promote respect, fairness and opportunity for our associates

**Challenges for health insurance providers:**

- Health care complex, poorly organized
- Inadequate information infrastructure
- “Toxic Payment system – rewards are unrelated to quality
- After-effects of poor quality care
- 44,000-98,000 deaths/year from medical errors - more than breast cancer, AIDS, or motor vehicle accidents (Institute of Medicine, *To Err Is Human*, 1999)
- Only 55% of patients receive recommended care (McGlynn, *New England Journal of Medicine*, 2003)
- Poor quality costs \$17-\$29 Billion per year

**Barriers and Challenges: Contributors to health disparities**

- High rates of poverty
- Unemployment
- Un-insured
- Access to care
- Low primary and specialty care rates
- Critical shortages of physician and medical providers
- Lack of EMR
- Coordination/fragmentation of Care

**Recommendations for Removing Barriers:**

- Adapt IOM recommendations to reduce health disparities “promote the consistency and equity of care through the use of evidence-based guidelines”.
- Develop collaborative partnerships with private and public sector, general public and key stakeholders
- Increase awareness of disparities
- Increase health care provider awareness
- Race and ethnicity data collection

Dr. Joseph joined CareFirst after retiring from military service in the United States Air Force. He retired with an aeronautical rating of Chief Flight Surgeon and the rank of Colonel. Dr. Joseph graduated from the College of the Holy Cross and Boston University School of Medicine, Massachusetts. He completed his internship at Malcolm Grow Medical Center, Andrews Air Force Base and residency in Occupational Medicine at The Johns Hopkins University. He has a Masters Degree in Public Health from The Johns Hopkins University. He serves on the Adventist HealthCare Center’s Health Disparities Advisory Board and the Maryland Statewide Steering Committee on Services for Adults with Sickle Cell Disease.

## **WALTER L. FAGGETT, M.D.**

Dr. Walter L. Faggett currently serves in the District of Columbia Department of Health (DCDOH)--first as Chief Medical Officer where he is second-in-command of the entire health department and its city-wide divisional networks; and concurrently as Medical Director of DCDOH's Medical Assistance Administration.

Dr. Faggett reported that:

- Wards 2 and 3 had lower rates of hypertension, heart disease, cerebrovascular disease, and diabetes compared to the city as a whole.
- Ward 7 had the highest rates of hypertension, diabetes, and poor or fair self-reported health. These rates were statistically higher than the mean rate for all of DC.
- Premature mortality rates from heart disease, hypertension, HIV/AIDS, cerebrovascular disease and accidents were highest in Ward 8.
- Ward 5 had higher rates of hypertension and overweight/obesity compared to the citywide average.

### **Challenges:**

Access barriers to health care include: insurance, literacy, linguistic competence, cultural competence, provider diversity, structural, legal, and personal issues.

Rand report - Rates of health insurance coverage among adults were higher in the District than in comparable cities, probably largely as a result of the Alliance.” “Despite a relatively high rate of insurance coverage, about 20 percent of District residents—children and adults—reported no usual source of care.”

### **Contributing factors to health disparities:**

Lack of medical insurance - leads to postponed medical care and deprivation of prescription medications.

Lack of regular source of care- leads to difficulty in obtaining care, fewer doctor visits, and more difficulty obtaining prescription drugs

### **Recommendations and District's response:**

- Expansion of existing access programs
- Children's Health Access Plan

Dr. Faggett holds a faculty appointment as Assistant Professor of Pediatrics at the Howard University College of Medicine. Dr. Faggett is a graduate of the University of Michigan School of Medicine. He completed internships and a pediatric residency at Walter Reed Army Medical Center and a Psychiatric Liaison Fellowship at DC General Hospital in the District of Columbia. Dr. Faggett is the current President of the Medico-Chirurgical Society of DC. He holds licensure to practice medicine in five states, including the District of Columbia and Maryland. The recipient of the highly acclaimed Skinner Medal from the Academy of Health Sciences, Dr. Faggett's career reflects his stellar leadership abilities, clinical competencies and commitment to community service.

## ROUNDTABLE DISCUSSIONS

### AFTERNOON SESSION

The afternoon session for ON THE ROAD TO ELIMINATING HEALTH DISPARITIES: Ward by Ward consisted of a working luncheon and roundtable discussions. During working luncheon, four of the invited guest speakers went from table to table to answer any questions that they did not have time to address during their 20-minute morning presentations.

Following the working luncheon, the large group of meeting attendees broke up into (7) smaller workgroups of (5 to 8) people for roundtable discussions. No assignments were made. Participants randomly selected their working groups.

Moderator for the afternoon session was health literacy specialist, Jann Keenan, ED.S. Meeting participants were provided with written instructions to provide responses to three questions addressed by the morning panel from the patient and consumer's perspective:

- What are greatest challenges to the patient's right to receive evidence based health care?
- How do these challenges contribute to health disparities in District of Columbia?
- What are your suggestions for removing these barriers to deliver patients the most up-to-date scientific and clinical evidence or best treatment, medications and procedures for a particular condition?

Each workgroup appointed a single speaker to report out responses to the three questions and recommendations from their group.

**QUESTION 1: What are greatest challenges to the patient's right and ability to receive evidence based health care in DC?**

### RESPONSES FROM ALL GROUPS:

- "We need health clinics to extend their hours to offer residents more evening and weekends hours that are more convenient for patients".
- "We need all new health clinics in Ward 7 built with ample parking for patients. Most physician offices and medical buildings in Ward Seven do not have any parking.
- A seven minute office visit is too short to get to the root of the patient's problem(s). This group suggested new legislation to allow longer office visits.
- Lack of hospitals in Ward 8. This access issue creates disparity.

- There is lack of understanding by patients about how to use their medications. Even when there is help available from pharmacists to explain the prescription, there is lack of awareness by patient that they can “ask” for this assistance.
- Illiteracy: Too many kids are dropping out of school. Limited literacy is a barrier to getting the health care and information that patients need.
- Language barrier. There are not enough health materials developed into multiple languages.
- Doctors of Asian descent may not understand the needs of their African American patients. This contributes to a lack of trust and a feeling that the patient is not being heard.
- “We need supportive and professional staff working with public assistance programs. Staff working with intake services at 645 H Street NE are demeaning to people seeking Medicaid and food stamps.”
- “Without jobs we lack health insurance. Unemployment assistance counselors are making people feel embarrassed when they seek help. Some of the counselors at Marshall Heights Community Development Corporation have no compassion or empathy for residents who are seeking jobs.”
- “People think that DC General Hospital is closed.”
- Working mothers can’t get their children to the doctors. Transportation can be a barrier.
- People don’t know about free medication programs so they can’t take advantage of the programs.
- The mistrust between doctors and patients. This group felt that at times African American and other people of color may not fully trust a doctor who is of a different race or ethnicity.
- “We need mental health services for HIV-positive women. These women suffer from depression and other mental health problems.”
- “We need to assist low income HIV positive women with child care and transportation services to help them keep medical appointments.
- “We need access to dental services.”
- People have transportation challenges. Gas is going up and this may contribute to people not being able to afford to go to the doctors.
- People in Wards 7 and 8 seem isolated from the rest of the District. This group felt that doctors and politicians need to strategize ways to better communicate with people from these Wards.

- Patients don't know the resources available to them in their community. There needs to be an educational campaign.
- Time constraints are too great on doctor's time to see patients. Patients are rushed out and may only get to one health problem when more than one problem may exist.
- People are not able to self-manage their healthcare because they don't understand how to take their medicines. There have to be more grassroots programs and efforts in the grocery stores, laundry mats, and salons to help people learn about health and the importance of healthy lifestyles.
- People with mental health challenges can't get their prescriptions filled because they do not have health advocates. Doctors give samples of medicines and these medicines run out and psychiatric medicines are very expensive.
- Sometimes people of color are given too much medicine for sleep and stress. Diet and exercise is not stressed in this community. Doctors need to spend more time on prevention and less time on writing prescriptions when life changes can help. And other times people are given too little medicine when they need more. The doctors need to know about the needs of their patients.
- Waiting time to receive services at some hospitals can exceed twelve hours.
- Insensitivity to patients- which could be shown by rushed appointments or tone of voice. Doctors of Asian descent may not understand the needs of their African American patients. This contributes to a lack of trust and a feeling that the patient is not being heard.

**2. How do these challenges (identified in question #1) contribute to health disparities in District of Columbia?**

- "You have to be almost dead before doctors at these clinics believe there is anything really wrong with you." This group felt that doctors tend to treat people only when they are very sick and ignore the patients until they get that sick.
- Distrust on the part of the patient
- There is not continual care by single provider. A person may see one doctor one week and another the next.
- Insensitivity could result in a misdiagnosis when the provider rushes through assessing the patient- who is of a different racial/ethnic background than the provider.
- Patients of color who can't afford cars may have a hard time picking up medicines. This group felt that a person should be allowed to fill a prescription a few days before the

prescription runs out because it is not always easy to get to the pharmacy the day medicine is needed.

- Ads (posters, billboards, subway posters) are too harsh for the 18-24 year old age group and this may turn this group off about adopting healthy behaviors.
- HIV/AIDS is very high among youth in DC. This is killing the youth of the city and something needs to be done to bring to light to show how prevalent the problem is. More prevention messages are needed to reach youth
- The hospital is in one location and transportation remains an issue.
- Medical clinics and doctors offices are not open when needed, at times that are most convenient for patients.
- Lack of hospital in Ward 8. This access issue creates disparity.
- There is limited health care in Wards 7 and 8. There are also no sit-down restaurants in these Wards and that promotes eating high-fat fast foods.
- There is a stigma among transgender youth and MSM. This groups' members shared a story of how the doctor could not relate to his patient. Doctors need training on sensitivity.
- People don't have access to the Internet and can't keep up with the latest health information.

**QUESTION 3:** What are your suggestions for removing barriers to deliver patients the most up-to-date scientific and clinical evidence or best treatment, medications and procedures for a particular condition?

- Health education should start at earlier age. There should be a health tract in schools so students can learn and adopt healthy behaviors for lifetime.
- Put the clinics back in the DC public schools. Education on nutrition and health so kids don't think that a "Cup o'Noodles" is dinner.
- Get the Word Out that DC General Hospital is open with hours of operation for clinics.
- Recommend policy and procedures to increase length of time for office visits and lobby for changes that include more time with the doctor.
- Cultural sensitivity training for providers. We need to educate providers to treat patients differently. All patients are not alike and physicians need to provide individualized care. Surveying patients' need is vital and not assuming what the patient needs.

- Doctors need to be more attuned to their patients' health status. They need to request electronic health records for all patients and request legislation to make it happen.
- Educate patients to navigate the health care system. There should be access to advocates for patients who need recourse when they complain about their provider's behavior and need to deal with potential for retaliation and cutoff of services.
- Teach patients to advocate for themselves and to look up health information on the Internet.
- Mobile units help to remove transportation barrier and provide variety of services including immunizations and HIV testing. There should be more mobile vans to provide medical care to the marginalized
- Centrally locate information about health care resources in DC. Make it easier for people to find these locations.
- DC Health Care Alliance should include coverage for mental health care services.
- Remove the barriers by promoting education, health promotion, engaging the community, working with community based organizations and sharing resources
- There have to be more grassroots programs and efforts in the grocery stores, laundry mats, and salons to help people learn about preventative care and the importance of healthy lifestyles.
- Follow-up with sick patients must be in place so that if someone has high blood pressure there will be a referral.
- Conduct a town hall meeting in the community to bridge the gap between the patients and health care providers
- Older adult patients need their children to go to visits with them because too often the senior citizen doesn't understand directions, is too respectful to ask questions or to question the doctor.
- Patients need to take action. They need to know their medicines, to know their height and weight to see if they are overweight and to know their blood pressure. Patients need to take questions to ask the doctor in writing and get back something in writing such as a brochure so they can be empowered in the time between office visits
- Adult children need to take a more active role in their aging parent's health care. They need to take notes. (It was mentioned that Kaiser gives a patient a sheet when the patient leaves the office and this group recommended that every healthcare company and doctor's office offer this to patients upon leaving.)

- The message about health disparities and people of color needs to come from the pulpit. This group felt that a message from the minister will go a long way in guiding people to take steps for better health. Churches need to be more involved in health fairs and community outreach. There is a high trust of spiritual leaders and this can help to bridge the gap.
- Communication between the pharmacist and the patient could be improved. This group felt the pharmacist does not take the time to explain the medicine to the patient and that explaining will help barriers to medical compliance.
- DC needs to regulate businesses to pay a fair living wage and not just a minimum wage so people can eat better and healthier
- There needs to be education to inform doctors about their patients' needs and culture
- There need to be many, many more PAID community health care workers instead of relying on the low-paying jobs with Americore workers.
- The community needs to switch from the curative to the preventive. There should be a free fund for people who want to be in Weight Watchers.
- Get rid of any non-compete exclusions for doctors to practice. Competition improves quality.
- There should be classes on label reading. People in our community need to see the impact of obesity on health.
- Sub-sets of various populations need to be addressed. Ward 2 is divided. There is the Shaw Community versus Dupont Circle where the sub-population is poor.
- Financial incentives for nurses, nurse practitioners to help buy houses in the city. When providers live in the communities they serve, trust goes up with patients.

## QUESTION 1: Synopsis

What are greatest challenges to the physician's ability to deliver evidenced based care; and patient's right to expect and receive medical management of conditions based upon the most up-to-date scientific and clinical evidence or *best* treatment, medications and procedures for a particular condition.

### ACCESS TO CARE

- Clinics not open when needed
- Lack of hospitals in Wards 7 and Ward 8
- Lack of medical insurance - deprivation of prescription medications and causes people to postpone medical care

### QUALITY OF CARE

- Length of time for office visit does not allow physician to fully understand patient needs.
- No coverage for mental services
- Lack of wrap-around support services for: public assistance, unemployment, and transportation

### COMMUNICATION

- Physician/provider behavior towards patients
- Lack of trust between patient and physician due to different race/ethnicity of physicians
- Lack of cultural sensitivity because physician is different race/ethnicity and does not understand the culture of patients
- Lack of adherence due to language barriers that impact understanding medical directions from physicians, and/or how to take medication

### PREVENTIVE CARE EDUCATION

- Preventive education for childhood obesity
- Lack of adherence due to low literacy levels to medication and following physician instruction

## QUESTION 2: SYNOPSIS

How do these challenges (identified in question #1) contribute to health disparities in District of Columbia?

### DELAYED TREATMENT

- Lack of medical insurance - leads to postponed medical care and late-stage diagnosis of chronic condition may contribute to higher mortality rates
- Lack of regular source of care- leads to difficulty obtaining care, fewer doctor visits, more difficulty obtaining prescription drugs
- People in some areas of DC can't get good access to care because there is no hospital in that area contributing to health disparities among the poorer areas of the city.

- Poorer patients are marginalized by not having funds or transportation to pick up medicines.

#### **QUALITY OF CARE**

- Insensitivity by physicians could result in a misdiagnosis
- Deprivation of prescription medications.

#### **COMMUNICATION**

- Patients do not know about resources that are available to them and thus cannot access services.

#### **EDUCATION**

- Poor adherence to HIV/AIDS medication leads to more resistant strains of disease
- Stigma regarding HIV/AIDS as well as people who are transgender can delay people seeking treatment.

#### **Recognizing that the poorer areas of the city and some sections of the DC area are marginalized:**

- People in some areas of DC can't get good access to care because there is no hospital in that area contributing to health disparities among the poorer areas of the city.
- Poorer patients are marginalized by not having funds or transportation to pick up medicines.

### III. SUMMARY OF RECOMMENDATIONS

Many of the recommendations from this forum were a call to improve upon existing services and infrastructure. Some people are falling through the cracks simply because they are unaware of available services.

*“People think that DC General Hospital is closed”.*

#### **COMMUNICATION:**

- Centrally locate information about existing health services and programs to increase awareness among residents.
- Implement more cultural competency and sensitivity training for health care providers.
- Address the language barrier
- Reach out to patients within their neighborhoods and community. Education should occur from sources that community member’s trust, i.e. churches. Health Information should be disseminated at supermarkets, laundry mats, etc.
- Professional courtesy needed at DC medical assistance intake center and unemployment counseling centers.

#### **QUALITY OF CARE**

- Continuity of care from dedicated physicians assigned to a patient.
- Provide coverage for mental health services
- Introduce legislation to increase time for office visits

#### **ACCESS TO CARE**

- Build hospitals east of the river to serve Ward Seven and Ward Eight
- Bring jobs to DC that pays a living wage.

#### **EDUCATION for Providers**

- Promote consistency and equity of care through use of evidence-based guidelines.
- Provide physicians with additional training so they can instruct their patients about nutrition, adopting healthy lifestyles, and participating in disease prevention.
- Provide pharmacists with training to help patients understand the proper dosage and use of medicines.
- Address the educational disparity and language barriers
- Implement more cultural competency training for providers

#### **Patient Self-Advocacy EDUCATION**

- Start health education at earlier age to prevent childhood obesity.
- Re-institute health clinics in the schools.
- Health education to decrease stigma for both HIV/AIDS and mental illness
- Patients need more education to become better health advocates for themselves. Patients need more training on finding health resources on the Internet. Patients need more training with label reading.

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