Health Law and Policy Brief

Volume 4 | Issue 2 Article 3

1-7-2014

State and Federal Perspectives on Health Care Disparities

Carlessia A. Hussein

Recommended Citation

Hussein, Carlessia A. "State and Federal Perspectives on Health Care Disparities." Health Law & Policy Brief 4, no. 2 (2010): 11-19.

STATE AND FEDERAL PERSPECTIVES ON HEALTH CARE DISPARITIES

DR. CARLESSIA A. HUSSEIN:[*] One of the interesting things that we have done in the Maryland Office of Minority Health and Health Disparities, which started in 2004, was to begin to look closely at health data by race and ethnicity. There is plenty of data at the national, federal, state and city levels. But what is interesting is that the data often are not asked questions about race and ethnicity. We have made projections, based on 2008 data on the number of minorities that reside in each of the twenty-three jurisdictions in Maryland and Baltimore City. There are thirty percent minorities in eight of the twenty-four jurisdictions. This is important information because it provides knowledge that differentiates people and enables program interventions to be tailored. For example, when we looked at the vital statistics data in the state of Maryland and the published reports, we saw that there was very little information about minorities. The data were primarily listed by Black and White. That was not sufficient to identify diseases that affected the different population groups in the State. Our office, with the charge to promote programs that reduce health disparities, needed data on the four major minority groups: African-American, Hispanic/Latino, Asian American, and Native American. These groups historically have been medically underserved and experience poor health status in the state of Maryland.

Comparing the racial and ethnic distribution of physicians against the 2007 population data reveals that there is decreasing representation in the health workforce of African-American and Hispanic physicians. We also see that there is an under-representation in the matriculation for African-Americans, Hispanics/Latinos, and Native Americans for the periods 2005 to 2006 and 2008 to 2009. This is critical because we know that the minorities in the health professions are declining due to aging and minorities are entering health professions at lower numbers. The policy implications are clear, reduced diversity in the health workforce diminishes the compatibility of the health worker with the patient. The health care delivery system becomes less efficient and more costly.

To improve minority matriculation in the health professions, we have to improve student capabilities in math and science, create mentoring programs in middle and high schools, and identify achievers among minority populations. These goals are really difficult when we have a tendency to put all students who look similar in the same box and make the same assumptions because the pants hang down on all of them, the caps turn back on all of them, they all speak bizarre languages, and are just talking on the cell phone. But they are different one from the other. We, as teachers and mentors, have a responsibility to learn to identify these differences and make opportunities for those, in spite of how they are dressed. Financial aid is an important issue that must be addressed with the growing costs of university admission. Along with financial aid, the availability of mentors and adequate academic support is necessary for students.

Now I will take a minute to talk about a program that I worked while I was the Associate Dean at the University of California, School of Public Health at Berkeley. I started a Minority Recruitment Program back in the '70s. I located funding on campus that supported travel and recruitment to the Navaho Indian Reservation to explain the program to the elders. Nurses applied and were admitted to the school to obtain a Masters in Public Health. Hispanic/Latino students were also recruited and admitted. The African-American community learned that a minority was in the School and handling admissions, so applications flooded in with anticipation that they would get fair consideration. This debunked the myth that traditional

> “Comparing the racial and ethnic distribution of physicians against the 2007 population data reveals that there is decreasing representation in the health workforce of African-American and Hispanic physicians.”

---

[*] **Dr. Carlessia A. Hussein** has served as the Director of the Maryland Office of Minority Health and Health Disparities since 2004, and the Director of the Cigarette Restitution Fund Program since 2000. Her professional education began as a registered nurse and continued in completion of a Public Health Doctorate at the University of California in Berkeley School of Public Health.

She has served in many professional capacities, including Associate Dean at UC Berkeley School of Public Health, Chair of the Nursing MPH Program at the UC Berkeley School of Public Health, Senior Health Planner for the California State Hypertension Program, and Deputy Health Director of the Los Angeles County Forestry and Fire Department.

Dr. Hussein's accomplishments include establishing a Minority Health Network, managing a Minority OB Program that worked with local health departments and community AIDS groups to reduce the black all-cause cancer mortality disparity by 50.5 percent from 2000 to 2005 in Maryland, and engaging health professional schools and community hospitals to strive for workforce diversity in cultural and neolistic competency in their institutions.

> To improve minority matriculation in the health professions, we have to improve student capabilities in math and science, create mentoring programs in middle and high schools, and identify achievers among minority populations.

White institutions often say that they cannot find 'qualified' minority people. If the presentation of the institution seems welcoming and sincere, minorities will come forth and apply. So with this Program, we were able to raise the admission rates in the School of Public Health up to well over forty-six percent, and the School and I were very pleased.

In addition, with funds from the Chancellor's office, we provided a Summer Preparatory Program, where readiness courses in statistics were offered. As the fall semester got underway and relationships developed with the students, it became apparent that mentoring and on-going support was needed to help the students navigate the university. The support was essential to build and maintain an environment in which the students felt welcomed and that people wanted them to succeed. At that time, I was Associate Dean of Student Admissions and fell into a "Mom" role with all of them. I encouraged the faculty and others to develop stronger mentoring and supportive relationships with the students.

Next, I will briefly discuss workforce diversity and cultural competency. Our Maryland office has a five-year Health Partnership grant with HHS, Office of Minority Health that began in 2005. One objective of our grant was to help increase recruitment and matriculation of minority students in medical, nursing, dental and pharmacy schools in Maryland. One activity with the schools was to lay the ground work for establishing a health alliance in the state of Maryland. The purpose of the alliance would be to encourage the schools to work together, along with our historical black colleges and universities and community colleges to attract and graduate more minorities to enter the health fields. We have been working on the project with Dr. Louis Sullivan, the former HHS Secretary.

Expanding eligibility for the safety net will enable more of the uninsured in Maryland to receive needed health care services. As people have commented, healthcare reform is very important to get through in some reasonable form. So we all pray and wait. We have to resolve issues of chronic high unemployment, which is a big issue now with the down turn of the economy. We need to improve the proportion of employers who offer health insurance to their employees, which health reform would assist if passed.

There is a very important relationship between healthcare and prenatal care. In the state of Maryland, the Black and Hispanic groups experience high rates of late or no prenatal care. This data has policy implications, as well as implications regarding preventing infant mortality, geographic disparities, health insurance disparities, and linguistic and cultural competency sensitivity and respect.

There are two minority health programs I want to discuss. One is the Minority Outreach and Technical Assistance Program (MOTA). It is funded by monies received from the national Tobacco Settlement Program. We use a portion of the monies to fund minority groups and minority-serving groups, such as Holy Cross Hospital, in the jurisdictions with the highest proportion of minorities in the state of Maryland. And we very much appreciate Holy Cross and Montgomery County because they present a community partnership model that works to serve a diverse community. They received funds to address tobacco and cancer control and passed grants to Hispanic, African-American, and Asian groups at the community level. Thus resources got through to the people at the ground level, empowering them to participate in reducing health disparities. So we are very proud of Montgomery County and the Holy Cross Hospital partnership.

The second program on this particular slide is the Minority Infant Mortality Reduction Project. Our office was able to receive monies in the 2009 Budget that we used to fund minority reduction demonstrate grants to reduce minority infant mortality. The African-American infant mortality rate is twice that of Whites. What we did was to fund two jurisdictions. One was Prince George's County, where the minority infant mortality rate is very high. The second is Montgomery County, and everyone's surprised that we selected this county…. "Oh they're wealthy and healthy." But oh no…when you dig down into the data and look at the African-American and Hispanic groups in Montgomery County, they have unacceptable high rates in terms of a number of diseases.

We have a cancer success story. The tobacco settlement monies that came to Maryland funded a program to control cancer in the State. Maryland's share of the Tobacco Settlement was 4.4 billion dollars starting in 2000 for twenty-five years plus. The Cigarette

Restitution Fund Program was launched in 2000. A portion of the funds supported the Minority Outreach and Technical Assistance program (MOTA) that increased awareness and recruited individuals to seek cancer screening and adopt cancer prevention behaviors. MOTA, working with local health departments and community-based organizations was able to significantly increase the number of minorities screened for various cancers. The new and targeted strategy contributed to a 50.5 percent reduction in the all-cause cancer mortality disparity between Blacks and Whites in Maryland from the year 2000 to the year 2005.

Since then things are not going as well. This trend of decreasing disparity has leveled off and is beginning to rise. The Cigarette Restitution Fund monies have not increased with inflation and the cost of cancer screening and treatment services are rising. But the important thing to note is that it is possible to reduce and to eliminate health disparities if we target, focus, and use innovative interventions that are culturally sensitive and culturally competent in trying to work with specific affected groups.

By now you get the point. In Maryland, as in other parts of the country, the White/Black death rates are one to six times higher, depending on which disease you look at.

Improving data collection, doing the proper analysis, asking the data the right questions, and then recording it are all very important. We have published a Maryland Health Disparities Chart Book. And we are publishing the second edition that has data by race and ethnicity and in some cases by small jurisdictions or by counties. In too many cases, we produce data reports by "Black versus White." The reason for this is that, for most racial and ethnic groups, their numbers in the State are too small to complete reliable analyses or the data are not collected for each ethnic and racial group. On the other hand, the African-American population is larger and the data have been collected by race for a number of years. We are very concerned about the Hispanic/Latino population. Although for minority infant mortality, the largest percent of minorities who were Hispanics are in two jurisdictions: Montgomery County and Prince George's County. So we have directed programs and funds there. We strive to improve the collection of data by race and ethnicity within each jurisdiction.

I mentioned that we were working with the various health professional schools, but we are also working with community hospitals, where the community hospital's medical director and president are interested in increasing the cultural competency, sensitivity, and performance of physicians, nurses, and the staff throughout the hospital. So they are undertaking programs to begin to move their facilities in that direction.

Another important program is the Minority Infant Mortality Project. In Maryland, the infant mortality rate compared to Whites was 2.6 times higher for African-Americans and 1.8 times higher for American Indians or Alaskan Natives between 2004 to 2008. For Blacks, the highest number of deaths was in Prince George's County at 116 in 2008. For Hispanics, the highest number of deaths was in Montgomery County at fifteen in 2008. Again, these numbers are the reason we were focusing on those two areas.

I want to try to demonstrate the different aspects of our model to reduce and eliminate minority health disparities. The first part is called "perinatal navigators," which addresses infant mortality. We recruit and train individuals who are living in the communities with the at-risk populations because they have credibility, understanding, and trust. They can serve as effective ambassadors or emissaries to communicate between the healthcare system and the individuals in those communities. We train them to help bring pregnant women in earlier so that they are showing up for prenatal care at an earlier date.

The second part of our logic model is Community Health Coalitions. We funded a coalition and are getting the health departments to pull together elected officials, private care providers, and others in the community, who have been working in isolation and passing each other. Prior to the coalition, there had not been a venue or the stimulus to bring them together collectively. But now, they are talking and sharing, and able to make a greater indent on the problem.

The third part of the model is to enhance clinical services and increase the number of opportunities for prenatal care. We brought in a primary care practitioner to help.

The fourth part of our model is community outreach and education. Our perinatal navigators literally went to the office of every obstetrician in the county, introduced the program, and offered to be of assistance to individuals who might be some of their clients and who may not come to the health department. They tried to make this a seamless program within the community.

And then finally, we promoted inter-jurisdictional partnerships. In our request for application to both counties, Montgomery and Prince George's, we required the applicant to work in partnership with the neighboring county. Because what we knew from looking at the data is that pregnant women cross the boundaries to seek better care and better services. But the providers were not sharing and talking about the fact that individuals were moving back and forth. So now they are sharing, there are economies of scale that they already see by working together.

And finally, I will close by saying that we worked with the H1N1 (Swine) Flu Campaign in Maryland and assisted in setting up a statewide Community Education and Outreach Program whose purpose was to educate and encourage residents to take the H1N1 flu vaccine and practice preventive behaviors. We built this Outreach Program on the existing MOTA program that was focused on tobacco and cancer control.

This Program was supported by the CDC funds sent to state to address H1N1. A network of community health workers were placed in each jurisdiction. The health workers collaborated with the local health department to distribute information on immunization to the entire minority, rural and other, communities in those counties. Their work enabled individuals to better understand immunizations and informed them of the location of H1N1 vaccine clinics.

So that has been a new strategy for our state. We have been asked by CDC to come and present how we developed the Outreach Program because there have not been many examples of this type of true community-based work around the nation. This kind of outreach is different because it takes services to the people instead of saying "Here's my health facility. We're open from 8:00am to 4:00pm. Come on certain days for services and information."

> The Tribal Consultation Policy established minimum standards for the involvement of tribal leaders in the development of policies that affect Native Americans and Alaskan Natives.

HILARY FRIERSON KEELEY:[*] I am a Senior Attorney in the HHS Public Health Division. I am going to discuss the 2006 HHS report on Barriers to Access in Healthcare for Native Americans and Alaskan Natives. It was a barrier study that polled both HHS program officials and tribal leaders on what they perceived to be the barriers to access of HHS grant programs. Since the report has been released, the three major findings that the Department discovered were that: 1) tribal leaders felt that they lacked the ability to find funding opportunities, 2) they lacked the skills or the training to apply for the funding opportunities, and 3) they felt that smaller or rural tribes lacked the ability to compete alongside both larger, more sophisticated tribes, as well as other minorities applicants in the funding process. So, since 2006 the Department has enacted several initiatives to try and combat those three things.

I will also discuss the initiatives that were enacted before 2006; primarily, the role of the IHS within the Department. Finally, I will discuss the changes to the Department's Office of Intergovernmental Affairs and the creation of the Interdepartmental Council on Native American Affairs.

The IHS is the primary federal agency that is responsible for providing healthcare to Native Americans and Alaskan Natives that are members of federally recognized tribes. The IHS provides care to 564 federally recognized tribes in thirty-four states. So naturally when there are issues that involve Native Americans and Alaskan Natives, the senior staff at the Department looks to the IHS in order to formulate policies and for technical assistance.

The IHS has been addressing barriers in Indian country since its inception as a federal agency. In 1975, President Ford signed a piece of legislation called the Indian Self-Determination and Education Assistance Act (ISDEAA), which spoke to two things. First, it recognized the government-to-government relationship between the federal government and tribal leaders. Second, it recognized that tribal leaders are the best suited to make decisions for their members and their communities. It encouraged the use of Indian Self-Determination Act contracting to allow for the transfer of federal management of programs to tribal management. And that is the role that I take on as OGC. I work with a team of regional attorneys throughout the country that provide legal advice to our 12 area office in IHS as we contract for the transfer of federal programs to tribal control.

As of February 2009, the IHS has negotiated seventy-five Title V Self-Governance compacts representing 328 tribes, and there is an additional 249 tribes that operate under Title I Self-Determination Act contracts. To put this into numbers, this means that federally recognized tribes control about 1.15 billion dollars of the IHS's annual appropriation, over thirty-two percent. So when you are dealing with tribal government, controlling thirty-two percent of our IHS appropriation, IHS has really been innovative in the ways that it makes sure that dollars are being used for programs that meet individual needs and also that the tribal governments have a say in the way that federal funds are being utilized.

One of the ways that this is done is through the ISDEAA negotiation process and with the Title V and Title I contracting process. Each year IHS sits government-to-government with tribal leaders and negotiates an annual funding agreement to transfer the funds to operate the programs. Going back to the Barrier Study, one of the things that the Department found out was that tribes felt like they were not competitive or lacked an advantage in competing for federal funds. IHS recognized that a long time ago. And one of the ways that we encourage smaller tribes or less economically established tribes to participate in the self-governance process is through our technical assistance in planning and tribal management grants.

IHS's Office of Tribal Programs and our Office of Tribal Self-Governance offers planning grants to allow tribes to hire financial consultants and to hire legal teams to help them to assess their ability to take on federally managed programs in a way that they are going to succeed. Grants also help create a plan for the transfer of programs, for example if you have a tribe that does not take 100 percent at once, if their financial infrastructure or their management infrastructure would only support perhaps a 5 percent takeover. And so the planning and management grants allow tribes to decide for themselves, but with the assistance of the federal government to make sure that they have the infrastructures in place so that they will ultimately succeed in their self-determination.

Second, the IHS was really innovative in 1997 when the IHS Director implemented the first Tribal Consultation

---

[*] **Hilary Frierson Keeley** a Senior Attorney in the Department of Health and Human Services Public Health Division. She serves as the team leader for national Indian Self-Determination and Education Assistance Act (ISDEAA). She also serves as a Regional Attorney for the Nashville Area Indian Health Service and advises the Nashville area on all the legal issues raised as to contracting and in compacting. She advises ISDEAA headquarters on various issues, including grants management, emergency preparedness, and EIA, Europe Indian Affairs, related education and detention center issues. Miss Keeley is a graduate of the University of Florida and the George Washington University School of Law.

Policy in the federal government. The Tribal Consultation Policy established minimum standards for the involvement of tribal leaders in the development of policies that affect Native Americans and Alaskan Natives. In 2000, President Clinton signed the first executive order requiring federal agencies to establish Tribal Consultation Policies. This has also been reaffirmed recently by President Obama. Since 2000, IHS has already revised its Tribal Consultation Policy twice. It will likely happen again soon because IHS is constantly looking for ways to make the most of both tribal and IHS resources and make sure that the policies that are made in Washington have the best effect that they can have on the ground.

One of the ways that Tribal Consultation has really proved beneficial within IHS is that the Director and senior staff at IHS have used Tribal Consultation, as well as the 638 Negotiation Process, to establish initiatives. When there are limited resources Tribal Consultation has helped the Director to see where limited resources best fit on the ground and in the field. Currently the Director's initiatives are for behavioral health; including suicide, substance abuse, and Methamphetamine abuse prevention. IHS has also have health promotion and disease prevention initiatives and a chronic fair management initiative.

The latter two include IHS's largest grant program, which is the Special Diabetes Program for Indians. Native Americans have the largest rate of Type II Diabetes in the United States. Under the Special Diabetes Program for Indians, Congress has appropriated 150 million dollars per year through fiscal year 2011 to help to remedy the disparities. The funding right now is being used to fund 336 community-based diabetes programs focused entirely on prevention and treatment, and then also sixty-five demonstration projects which will be used to establish best practices, not only for IHS and the Department but that can be used in the private setting as well to address Native American diabetes needs.

There are also a lot of things that have been going on at the Department level, both prior to the 2006 Barrier Report as well as a result of the report. The Office of Governmental Affairs is an office under the Secretary which serves as the primary liaison between state, local, and tribal officials. As a result of Tribal Consultation a permanent position was established under the Office of Tribal Affairs that will be the liaison for tribal issues.

The Office of Governmental Affairs is the office within the Department that is responsible for Tribal Consultation, Departmental level, and this is done in several different ways. The largest effort for Tribal Consultation is the Department's annual budget consultation process and that will be held the first week in March. It is a two-day process where all agencies within the Department that have funding available for Native Americans and Alaskan Natives meet with tribal leaders in Washington and go through their budget proposal and see how much they feel that they are using their budget to meet the needs of the Native Americans. And in turn, tribal leaders are able to propose their own budget initiatives with how they would foresee those same dollars being spent, and hopefully there are concessions made that result in a budget proposal that meets the needs in the field, as well as the needs of Washington.

One of the things that came out of the Barrier Report was that tribes were not aware of funding opportunities. So the Office of Governmental Affairs held a 1-day fair, sort of a tabling fair, a day before the two-day budget consultation process. During the fair, tribal leaders, who are already in town, would have the opportunity to meet with Department agencies and speak to them one-on-one about funding opportunities that will come available in the year, as well as for the preliminary idea of when funding announcements will come out, when they will be due, and if there are specific things that the tribe can be doing to be prepared to be competitive in those types of funding opportunities.

Another thing that came out of the Barrier Study was that Tribal Consultation that always occurs in Washington is not feasible for tribes. Large, wealthy tribes were able to come to Washington, leaving small, less wealthy tribes at home unable to afford the airfare to Washington or unable to leave their tribal affairs behind. One of the ways the Department found to combat those issues was to bring consultation to the tribes in a regional effort. Now, the Department conducts regional consultations throughout the country where multiple agencies combine their efforts together. Substance Abuse and Mental Health Service Administration (SAMHSA), Centers for Disease Control and Prevention (CDC), National Institute of Health (NIH), and Centers for Medicaid and Medicare (CMS) do five regional consultations rather that one consultation in Washington. Those are also coordinated through the Office of Governmental Affairs.

Finally, something that is very innovative and just started happening within the last ten years are things called Tribal Technical Advisory Groups (TTAGs). Currently, SAMHSA, CDC, NIH, and a combination technical advisory group are Federal Advisory Committee Act (FACA) exempt, meaning that they do not require publication under the FACA. Typically when the federal government seeks advice from advisory committees, it requires publication so that all interested parties can participate in the meetings. There is an exemption to the FACA requirements for meetings between federal government and tribal officials. To take advantage of the opportunity to learn from the expertise of tribal leaders, the Department has created these advisory groups that allow the federal government to sit down and actually talk about the way that policy would implicate actions on the reservation if enacted, prior to actually enacting the legislation. And so the TTAG has proved instrumental to CMS in flushing out agency policy before it actually is implemented.

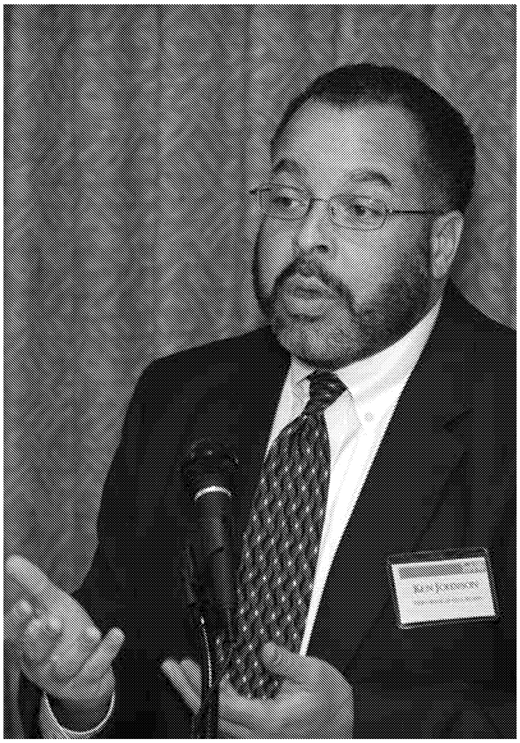
Finally, Congress authorized the creation of the Interdepartmental Council of Native American Affairs. This council meets twice a year. Each agency within the Department has a representative and a technical liaison. They meet to discuss HHS by-polices and how they'll have implications in Indian country and to American Indians and Alaskan Natives. It ensures coordination and also consultation on all of the HHS issues that may have an effect.

KENNETH D. JOHNSON[*]**:** When my son Jay was about one year old, he went off to enroll in a swimming class at our local Fairfax County Recreation Center. When we arrived at that class, I was the only dad. They should have called it “Mommy and Me.” I decided to press on and the reason why I decided to press on was that the Centers for Disease Control and Prevention has reported that Black children are four to five times more likely to suffer an accidental death by drowning than White children. I tell that story because I think it illustrates an important distinction in this discussion.

The different rates of accidental death, the different rates of disease incidents and the different rates of mortality are all examples of health disparities, but what the Office for Civil Rights focuses on is health care disparities. Health disparity is the problem and there are a number of interventions that we can use to address the problem. For example, on the swimming issue, one intervention might be a public education campaign to increase the number of African-American families who enroll their children in swimming lessons. Another intervention might be to increase the number of publicly available swimming facilities that African-American families could use. A third intervention might be, and as law students you’ve probably heard this argument before, to eliminate the vestiges of the dual system.

For some time in America, African-American families were legally barred from using city or county swimming pools. The attitudes that were shaped in that era exist today and we need to overcome those attitudes. Another example might be the health care intervention. Many pediatricians give their patients a book at the end of each year. What would happen if they really talked to the parents about swimming lessons? Would that intervention work?

The important focus that I want you to think about is the health care disparity in terms of a county agency that has a series of health centers all over the county. The way we do the analysis is to think about a hypothetical county agency located in the majority census tract—the all white neighborhood. This county agency has urgent care hours from 5:00 p.m. to midnight. But if you look at the health center in the minority census tract—the black neighborhood—there is no urgent care. That is an example of the health care disparity. That black child with asthma has no urgent care center to go to. That has an impact on the health outcome. Keep that distinction in mind.



I will talk about three things that we do at the Office of Civil Rights (OCR). First, we have traditional civil rights enforcement that is primarily complaint driven. Second, we have an effective communication national initiative with the American Hospital Association. Third, we have a national initiative focused on Title VI education in medical schools.

To file a complaint, someone has to go to their local OCR office, or contact them by e-mail or letter. An example of a complaint is when the individual goes to a hospital and requests language assistance or a translator. The hospital might say no or it might say “It is $100.00 an hour.” The hospital might say, “Can’t your

“Cancer goes back historically to when we had mines in the North, the waterways that come South, and the weather systems that come south from Pittsburgh and other places.”

---

[*] **Kenneth D. Johnson** is the Chief of Section Three in the Civil Rights Division Office for Civil Rights at the U.S. Department of Health and Human Services. He supervises a team of civil right analysts and equal opportunity specialists focusing on health disparities of the Temporary Assistant Screening Families Botanic (ph) Programs, the Children’s Health and Insurance Program (CHIP), HIV/AIDS Treatment and Services, Program and Physical Accessibility for Individuals with Disabilities, and Civil Rights Review of Medicare Providers. Prior to joining the Office of Civil Rights, Mr. Johnson spent nine years litigating housing, fair lending, education, and disability discrimination cases in the Civil Rights Division at the U.S. Department of Justice. As a Senior Trial Attorney in the Housing and Civil Enforcement Section, he worked closely with the Regional Offices of the United States Department of Housing and Urban Development and served as lead counsel on several pattern of practice cases brought under the Fair Housing Act to oppose discrimination on the basis of disability, race, or national origin. Prior to joining the DOJ, Mr. Johnson practiced at Washington, D.C. and Los Angeles-based law firms. He also served as a law clerk to the Honorable Damon J. Keith of the U.S. Court of Appeals for the Sixth Circuit. Mr. Johnson earned his B.A. Degree in Political Science with honors from California State University Fullerton in 1983, and his J.D. Degree from Harvard Law in 1988.

son or daughter interpret for you?" Those are all inappropriate and illegal responses under Title VI, which prohibits national origin discrimination and requires hospitals receiving federal financial assistance to provide meaningful access to individuals with limited English proficiency. Once that complaint is filed, our regional office investigators go out and investigate the complaint. They interview the complainant, the people who were with the complainant, such as family members or friends, as well as the hospital staff who was involved. Oftentimes complaints are filed not only by an individual consumer, but also by an advocacy organization. Sometimes we have complainants who are represented by counsel.

After a complaint is investigated, the regional office decides how the complaint could be resolved. One option might be to find a violation and issue a letter of finding. If OCR finds a violation and issues a letter of finding, then under Title VI the hospital has a certain period of time in which to come into voluntary compliance. Usually, because we have an emphasis on voluntary compliance, we would work with the hospital to get to that point. In an ideal situation we would negotiate a settlement agreement, where the hospital would institute a language assistance services program. That is essentially the best-case scenario. If the hospital is unwilling to negotiate a language assistance program or implement that type of program, then we would have to proceed with enforcement. Our civil rights attorneys in the Office of General Counsel would go to our HHS Departmental Appeals Board and file an action. The goal would be to terminate federal financial assistance to the hospital—basically, Medicare and Medicaid funding. This occurs rarely because usually hospitals or nursing homes would like to settle with us before we get to that point.

Earlier today my colleague talked about the limits of our civil rights enforcement efforts. We need you, as consumers and advocates, to bring complaints to us. The area of limited English proficiency is certainly one where it is very important to have advocates involved. At OCR, the complainant does not have to be the affected party. If you have a client or a colleague or a friend who has a complaint against a hospital, they do not necessarily have to file themselves. You or an advocacy organization can file on their behalf, which would lead to us to investigate that complaint.

Title VI prohibits discrimination on the grounds of race, color, or national origin in settings receiving federal financial assistance. HHS enforces Title VI against those entities that receive federal financial assistance from HHS. Medco is a recent case that we resolved where I do think that we made a splash on the Title VI arena. Medco is the largest national pharmacy benefit company in the nation. It doles out over 100 million prescriptions a year through the mail. In that case, a Spanish speaker filed a complaint with us. She wanted to use the mail-order pharmacy, but none of the documents were in Spanish. Medco did not have support staff on their 800 line to speak with her in Spanish.

Following the investigation, we negotiated with Medco. The company agreed to implement a critical language access plan with a number of different components. One was to use telephonic interpreters, which are now available 150 languages, including Spanish. Medco also agreed to revise its systems by enhancing the ability to route Spanish speakers to those who can actually answer their questions in their native language. A critical outcome of this settlement is that Medco's computer systems will now flag language preference on an ongoing basis. When someone orders prescriptions from Medco for the first time, the system will flag that the person wants to speak with a Spanish-speaking benefits counselor. That request will be in their file for the foreseeable future.

Another example of a Title VI case was a dispute with the state of Hawaii on the limited English proficiency issue. Hawaii's Department of Human Services has a 1.7 billion annual budget. The state covers programs including Temporary Assistance for Needy Families (TANF), Child Care, Child and Adult Protective Services, Vocational Rehab, and the state's Medicaid budget. This is such an important case because it's just critical for people who qualify for Medicaid, which is basically our safety net and the insurer of last resort, to have access to that program in their native language. Hawaii agreed to take reasonable steps to provide meaningful access to its programs for LEP persons who are eligible to receive services and benefits. We entered into a voluntary agreement with Hawaii's governor to maintain her administration's commitment to improving services for people with limited English proficiency. She has required all state and state funded programs to develop plans for providing interpretation services and translated documents.

This illustrates the limits of our litigation. We do not set the benefit standards. CMS does that. CMS is going to determine who qualifies for Medicaid. What OCR can do is enforce Title VI prohibition against national origin discrimination. We can make sure those services are delivered in a way that people with limited English proficiency have meaningful access. For the present moment, the enforcement of Title VI has been primarily in the area of limited English proficiency, but I do want to talk for a moment about a more traditional Title VI enforcement, which we have done in the past.

Traditional Title VI enforcement is much like traditional Title VII enforcement in that there are two legal frameworks, one being disparate treatment, the other being disparate impact. Under Title VI, much like Title VII, you can proceed with disparate treatment, which is intentional discrimination. Disparate impact is a more difficult case because does not require proof of intentional discrimination. It does require that a class of persons be treated differently. Disparate impact claims arise from allegations that a recipient of federal financial assistance is violating Title VI by utilizing a neutral policy or practice that has the affect of disproportionately excluding or adversely affecting members of a protected class.

As a real example, one county health department had both health centers in minority communities and in majority communities. The clinic located in a majority community provided evening appointments, but the clinic located in a predominately black area did not provide evening appointments. The problem with that policy is that it precluded black residents who worked during the day from access to care. The policy, while allegedly not race based, resulted in a disproportionate adverse impact upon African-Americans.

The county had a number of reasons for this policy, and principal among them was safety. They said their county workers did not want to be in this community late at night, and that was their kind of whole defense. However, once we establish an adverse impact we have to look at whether that county can articulate a legitimate non-discriminatory reason. If so, OCR will determine if the alleged non-discriminatory reason is a mere pretext for discrimination, and if there are equally effective alternatives that would result in a lesser discriminatory affect. Here, the safety concern was not necessarily a legitimate non-discriminatory reason in that that safety concern could be addressed by security personnel. It also could be addressed by alternating the evening hours. For example, they county could have had evening hours at the health center in the Black community on Tuesday night, and they could have evening hours at the health center in the White community on Thursday night. That would have addressed the concern of staff costs. The practice of never offering evening appointments at the health clinic in the black area violated Title VI.

The questions we consider in looking at these cases include: Is there a facially neutral policy or practice? Does the policy or practice have a disproportion adverse impact based on race? Is there a legitimate non-discriminatory reason for the policy or practice? If a legitimate non-discriminatory reason is presented, are there equally affective alternatives to the policy?

Recently Martin Luther King Hospital in California closed. One of the reasons for the closure was serious safety issues. Throughout the country, especially in this time period where we are having an economic downturn and where state and local governments are strapped for cash, we are already starting to see hospital closures. We receive resultant complaints that the hospital closure is racially motivated. We did a big case related to this issue in Wilmington, Pennsylvania several years ago. OCR investigated a allegation that racial segregation would be the result of a hospital corporation's plans to modernize one hospital in an urban black area, close two hospitals in urban black areas, and build a new hospital in a suburban white area. The complainants alleged that as a result of these plans, the suburban hospital would be racially segregated.

In that case, we negotiated a voluntary settlement agreement around the primary issue of transportation. The case resolved much like the 1960's cases where we resolved school desegregation with busing. The hospital corporation agreed to provide transportation from the black community to the suburban hospital and from the suburban area to the one remaining black hospital. In this way, everyone would have access to care and to the specialists at both facilities.

QUESTION: I have questions about Maryland. I am from the Eastern Shore originally. Is there any difference in the success of resolving disparities between the city or metropolitan-type counties and the more rural counties, such as on the Eastern Shore or in Western Maryland?

DR. CARLESSIA A. HUSSEIN: There are differences and it depends on a couple of factors. For example, we are very concerned about some of the Eastern Shore counties because their statistics look very poor, not just for African-Americans but for the whites also.

And our concern- and we repeat this all the time- we are not just racial oriented. We are oriented to the entire population. So whichever group has the worst statistics is where we want to focus services. So we are seeing the differences and what we're trying to do is to give that information to the local health department with some recommendations of how they need to focus. Because often times the local health department does not know it, they just have the county total, they do not have the information by the Native American group here and the African-American group and the others.

QUESTION: Are the county health departments more responsive to what you are saying in more urban areas or in more rural areas, or is it the same? I am speaking more about success I guess.

DR. CARLESSIA A. HUSSEIN: It is a mixed bag. Of course, for some people it takes a while to understand that to offer health services in a way that are effective and has results, you have to offer it differently to different people. So, for example, sometimes the African-American rural areas of the Eastern Shore are not receptive. They do not go to the health department, do not feel they are welcome, and cannot visit the department during its open hours because they are times when they are trying to work and make a living. So for other health departments, they are more receptive and understanding and beginning to have late hours.

Some of them offered the H1N1 Swine Flu on a Saturday. Some of them left the health department and went to a church to kind of put things on. So that is why we are trying to get the health officers, their staff, other providers, and hospitals to be more targeted and focused on people. We also have moved heavily in terms of translating materials. We literally dug into the census data by small census tract for the counties to see what languages we needed to translate the H1N1 materials into because people really didn't have that level of detail. They are just generalizing about that population.

I know I do not have a good answer for you, but I am talking about what the effort is. We are beginning to get more people to understand that they need to know the small groups within the county to really organize services to really target people.

QUESTION: Just one other question about Maryland: Is there a role that geographic disparities plays within the broader scheme? I do not know if it is true anymore, but the Eastern Shore had an extraordinarily high cancer rate compared to other areas in Maryland.

DR. CARLESSIA A. HUSSEIN: Cancer is a very interesting concept not just for the Eastern Shore, but also for the Eastern part of the U.S. Cancer goes back historically to when we had mines in the North, the waterways that come South, and the weather systems that come south from Pittsburgh and other places.

There is not accurate data on this to point. The theory is that factories and industries that were developed in the East coast had an effect on the Eastern Shore area. I think that it is because that area is near the waterways. In terms of EPA and other related issues, we are now becoming more knowledgeable about the environment and what is impacting the health of all the people.

QUESTION: I have a question relating to Native American issues. I know that there was an issue with tribes wanting to gain recognition as a tribe. I have heard about that mostly within the context of gambling and casinos, but how does that play within the broader framework of healthcare and whether they are recognized as a tribe by the federal government or not, even though they might be Native Americans?

HILARY FRIERSON KEELEY: There are two agencies in the federal government that deal with Native American issues, one is the Bureau of Indian Affairs, and one is the IHS. We used to all be one part, one agency. Through the Transfer Act, healthcare was segregated and sent to HHS. The Bureau of Indian Affairs determines federal recognition, and it is done through a two-part process. You can either be recognized by the Bureau of Indian Affairs, or you can be recognized through an act of Congress. If you are recognized as a federally recognized tribe then you are part of a political class, which are federally recognized tribes verses Native American as a racial category.

If you are a federally recognized tribe, you are then eligible for IHS benefits. If you are a member of a state recognized tribe, you are not eligible for IHS benefits, generally. There are some programs that state recognized tribes are eligible for. There is the Urban Indian Programs, which are programs for Indians in urban areas, and state recognized tribes can receive benefits there. There are also some grant programs in the Department that extend to state recognized tribes, but those mostly have met the strict scrutiny requirement that they are geared towards health disparities based upon race, not because of political class.

And so often our office is called upon. There are different agencies that would like to extend grants to tribes or to Native Americans, and so they always call us and say, "We would like to extend the grant but what can you tell us?" And we have to advise them that there is different case law, it is the *Morton v. Mancari Standard*[1] or the *Adarand Constructors, Inc. v. Peña.*[2] Standard. If you have met the political classifications, then you do not have to follow their strict scrutiny. But if you are in a racial classification, then you have to fall under strict scrutiny.

A lot of times when you have grantees that are extending their grants to state recognized tribes, and also to Native Hawaiians and Native Samoans, there are underlying reasons that will withstand strict scrutiny. And we work very closely with our OCR in cases like that to make sure that whenever grants go out that the agency understands the difference between what the IHS does, because our appropriation is only for federally recognized tribes, verses some of the granting authorities that would extend beyond this.

QUESTION: One other point I wanted to question is about the islands along Chesapeake Bay, Smith Island, St. Helena Island. From what I know, there are some disparity issues because of the isolation. What is being done in that regard for the populations on those remote islands within the Chesapeake Bay?

DR. CARLESSIA A. HUSSEIN: Not enough…I will just start there. There have been discussions about trying to have better transportation that is easier to get back and forth from the mainland to those islands but the issue of power and politics come into play and so it has not been sufficient. More needs to be done.

And just a comment on the recognition issue; in Maryland there are no state recognized tribes. So this is a big issue. Our office cannot do much other than just express sympathy, but we are certainly trying to talk to them. But it gets complicated because there are issues about ownership of the land, to the state verses to the tribe, and what is on the land and what is in the land. There are really many issues that have not been able to be pulled apart by the state of Maryland, which is unfortunate.

QUESTION: The descriptions about the negotiations with Native Americans appear to be sweeping generalizations that I find a little bit difficult to accept. Because I know there is a big difference between the Iroquois, who live up in New York, and groups down in the Southwest. Certainly the Southwest groups do not have any sense of what a business contract is all about.

HILARY FRIERSON KEELEY: The IHS is organized in the twelve areas that are geographic. Our Area Directors are primarily all appointed by the Director of IHS, but through Tribal Consultation with the affected tribes in those areas. When you are talking about the Albuquerque area, which represents the Pueblo, you have an Area Director who always has expertise and experience dealing with the Pueblo, which are very traditional tribes. For example. the Pueblo are different from the East Coast tribes who for the most part are more assimilated and may have more expertise in business transactions. When choosing Area Directors, the IHS looks for individuals that understand the unique needs of the tribes it represents.

I think that the IHS has really done well in this area. I do a lot of traveling and second chairing with regional attorneys throughout the country. Every negotiation that you go to, whether it's in the Oklahoma area where you are dealing with tribes with no land base with checkerboard reservations or you are dealing with Alaska in the remote villages, you have IHS leadership in place in the areas. The IHS leadership is very in tuned to the specific needs and knows how to negotiate government-to-government. That is something that our office takes great pride in.

I chair a monthly call with a negotiation consistency group with all of the regional attorneys that advise the different areas. Without fail, the Alaska area is probably the most unique because of their geographic location, and the fact that it is difficult to get supplies and to transport patients. Because of the way that IHS is structured and the way that the leadership is appointed, IHS deals with things in a much different way. It is not one size fits all by any means.

[1] 417 U.S. 535 (1974).
[2] 515 U.S. 200 (1995).