



**Transcript of CHI's Patient Perspectives Podcast Series:
*Highlighting Disparities in Diabetes Care for Minorities***



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DAVID: Good morning. I am David Gallagher. I am the CEO of the California Healthcare Institute and I would like to welcome you to CHI's podcast. Today, we are joined by Dr. Gary Puckrein from National Minority Quality Forum and Dr. Kirk Geter, who is chief of podiatry at Howard University Hospital. Today's podcast is a discussion of the problem of healthcare disparities among minorities in America, especially as this relates to diabetes and what results of inequality and healthcare disparities have been and what could be done at the community level to have a real impact on saving and improving lives.

Just a bit of background about the California Healthcare Institute, CHI is 270 members strong. We encompass biomedical companies from early-stage startups to established companies in drugs, devices and diagnostics, as well as academic research institutions. We are a hybrid organization that brings together academic institutions and the commercial biomedical community in an effort to improve the environment for innovation in California.

Healthcare disparities are an important issue for CHI and our members. One in three residents of the United States self-identifies as either African-American, American Indian, Alaskan native, Asian, Native Pacific Hawaiian, Pacific Islander, Hispanic, Latino or multiracial. By the year 2050, this ratio is expected to increase to two to one. So despite significant advances in civil rights, race remains a significant factor in determining whether an individual receives high-quality care or any care at all and what the outcomes of care will be.

The Institute of Medicine in a landmark report, called Unequal Treatment, provided compelling evidence that racial and ethnic disparities persist in medical care for many health conditions and services. CHI's members are engaged in numerous efforts to reduce or eliminate racial and ethnic healthcare disparities and to address some of the social factors

that affect healthcare outcomes, yet despite these efforts disparities remain. So, Gary, I would like to begin by having you tell us a little bit about National Minority Quality Forum and the D-Atlas and where you see the most glaring healthcare disparities among minorities.

GARY: Thank you so much. The National Minority Quality Forum was organized in 1998 and our focus was on eliminating health disparities, really trying to understand the disproportionate outcome of disease burden and really death in minority populations. To look at that, we quickly began trying to reach out for data to try to understand where disparities were localized. We did not believe that an African-American or a Hispanic living in New York City had the same health pattern as an African-American or a Hispanic living in California or Texas or Colorado and there was not really a good data set out there and so we began collecting data at the zip code level. We have been collecting data for over a decade now. We have accumulated more than 500 million records and we really do know where, not just in terms of the minority population because now we are able to look across the landscape and we can see that there are disparities across racial and ethnic groups and we think it has profound implications for the cost of healthcare, the quality of care and really the future of healthcare in the country. So we have been taking our data and putting it out online.

One of the, we call them Atlases, and you can go online and look at, in this instance, diabetes. It is a map for the whole country. You can look at it by state, by county, by congressional district, by state legislative district. For those who are familiar with Google Earth, it's like Google Earth in the sense that you can drill down really to the local level and see the prevalence of disease and I think what is important, takeaways from us, as we've been looking at the data across all these disease states, is that there really are what we would call stable consumption patterns that chronic diseases are not the same throughout the country, that there are communities with higher prevalence and challenges with diseases like diabetes and chronic heart failure, etc., and trying to understand why those communities are shaped the way they are in terms of the prevalence of disease, trying to understand the quality of care that patients have access to, how patients are responding to the disease and also how the healthcare financing system is responding for the needs of those patients. We like to think of it as sort of the Walmart model. What we are trying to do is understand the patient's need before the patient comes to the store because our fundamental belief is that if we can service patients before they have an acute event, hospitalizations, for example, there are lots and lots of resources that can be saved and through that smarter application of our healthcare resources, we think that we will save money and improve outcomes. So we are broadened our scope a little bit in terms of we are not just looking at minority populations. We are looking at how do we provide appropriate healthcare for a diverse America using information so that we can begin to reduce acute events because it is really acute events that are driving healthcare costs.

DAVID: And so, Gary, you produce a wealth of information, as you said, at the zip code level, congressional district level, and so forth. How do you help connect that information to clinical care for patients?

GARY: You know, we do it two ways. One is we do a lot of our own research and so one of the things that we are finding as we start researching through the data that it is those patients who have chronic diseases who are not getting appropriate care are the real cost driver in the healthcare system. There is a lot of thought out there that it is a small group of

patients who cost a lot consistently, meaning the same individuals, and those are the ones who are driving cost of America. That's not what is happening. We have patients who have diabetes or chronic heart failure who are not getting appropriate care to guidelines and when you actually look at how much we spend on them...so if you take Medicare, for example, two-thirds of the diabetics in Medicare, we are spending about \$1,500 a year in their care. You can't manage diabetes on \$1,500 a year and so what you see is the following year their costs go up 1,000 percent and that 1,000 percent is what is pushing costs up in Medicare. So we are trying to say in the middle of a lot of healthcare debate that wait a minute, we may not have our eye on the right ball here in terms of what is the cost driver in the system and we need to spend some attention doing that. The other thing that we are trying to do is to empower the consumer. By consumer, we actually mean patients. It gets confusing in our healthcare system who the client is sometimes, but we are trying to say to consumers, so here is what disease burden looks like in our country, here are the communities where we see greatest risk, here are the kinds of resources that we are applying against them now, here is why we need to apply greater resources to them, and guess what? If we move resources around a little bit out of acute care into secondary and primary prevention, the cost is actually going to go down because we are going to better manage those patients with chronic diseases and so we are trying to start that conversation.

DAVID: That's terrific. Kirk, you're in the clinic every week and I'm sure that you see the practical implications of what Gary is talking about. Maybe you could describe some of what you are seeing.

KIRK: Sure, absolutely. He is absolutely right. Presently, what we see now is not as much on the preventative side, but we tend to experience on a daily basis the complication part where a patient comes in through the emergency room that is diabetic that may have a black toe or a sore and they have not been or may have been seen by their primary. But they have not really gotten into the system, and so, subsequently, what happens is they may have to have an amputation, a part of their foot removed or come into the system as being hospitalized, like Gary was referring to. And then all of a sudden this individual has so many more burdens on the system. That may include special footwear, transportation issues, loss of work or just even a change in quality of their life. So we see it on a daily basis.

DAVID: So what strategies or tactics would you recommend, based on your experience, for catching these patients earlier before the disease has progressed to such a serious state?

KIRK: Well, what probably could be done is use this Atlas to look at these areas and probably do more work at the grassroots or community level using churches as a focal point, maybe the school systems because so many younger people now are becoming exposed to diabetes and so one would expect them to also be at risk for the complications. Other organizations, like sororities or fraternities, may be beneficial, as well as family reunions. I think that this needs to be more of a grassroots issue as we can get information out to communities on a daily basis.

DAVID: So, Gary, is there a way that your activities and the D-Atlas can connect with organizations and institutions to bring prevention and bring care in at earlier levels to these minority communities?

GARY: Absolutely. So part of our work now is because we now know where chronic diseases are manifesting themselves. So here is a point of information. There are 38,000 zip codes in the United States where people live. 80 percent of all the diabetics live in 8,000 zip codes and so if we are having a conversation about diabetes in America, for whatever reason, we have got 8,000 zip codes, which are really taking the brunt of this disease and we need to step in and take a look at, certainly we want to know the underlying cause of the disease and why it is manifesting itself in those communities, but what is the quality of care that those patients are receiving because what we see is that of the patients in those communities, the vast majority of them are not getting quality care and every year, a significant percentage of them end up with acute events. And it is those acute events that are really costing us a lot of money. So the argument we would make is that it is actually cheaper to prevent these patients from having an acute event, that the difference between the acute event and what we are actually spending on them now, there is so much room there in terms of potential savings that by investing a little in secondary prevention and indeed primary prevention, keep them from having diabetes, for example, there is real value. So we are working on some initiatives to target these communities and make them visible; I do not think they are quite visible to the American public yet, and then have a conversation about what we can do about getting appropriate interventions in place.

DAVID: Thank you. Kirk, I'm sure that the last thing that you want to be doing in the clinic is amputations in people who have serious, progressive disease. What do you think, as a practical matter, can be done in communities where you have a lot of diabetes, a lot of obesity and so forth to turn this around?

KIRK: Well, better or earlier detection of the disease itself would be great. Some other tactics could also be once a person is diagnosed with diabetes that they get into a buddy system where they have a buddy that they work with to stay out of harm's way, so to speak. Maybe using some other vehicle in communities, such as pharmacies, where if an individual has to pick up their medicine for their diabetes, there is a little card that has 10 things on it that you want to make sure that you do to stay out of complications, so to speak, so that they would have a check-off so they could almost check off the list to make sure that they're staying abreast of things. More things like that and also just using maybe other vehicles in urban areas like radio stations, things that other certain groups of people will listen to more so, putting things more at a community level and helping them to understand. It is kind of interesting that you get the person's attention once you have removed a part. They want to listen more, they want to be more informed, and there is some kind of way we can use all these things we are talking about to get them more interested in a prevention as opposed to dealing with it after they have had a problem.

DAVID: It sounds like, in part, what Gary is doing is identifying and localizing some of the communities where these educational and preventive efforts could take place. Is that right, Gary?

GARY: Yes. That is absolutely correct because if we can target our resources, we can be a lot more efficient. So when we are looking at diabetes in America, it is a daunting issue. I mean if you think about it, if you think it is all over the country, it becomes really unmanageable, but if you think, "Well it is just 8,000 zip codes that we are really looking at here," now it is an opportunity to sort of drill down and understand and ensure our resources

are aligned with where the disease is. The performance measure has got to be keeping them out of the hospital. I mean that has to be the bottom line performance measure. If we are failing, we are getting these patients into the hospital and they are going to cost us too much. So I think the challenge that sits in front of us is that we actually know where the problem is now. What can we do to begin to intervene and improve quality while reducing costs?

DAVID: I think that is right and I think what you are doing is terrific with respect to identifying and localizing the problem in the first instance. I would like to thank you, Gary Puckrein and Dr. Kirk Geter, for your contributions to the podcast today. Our biomedical research and development community, which is made up of academic research institutes and private sector biopharmaceutical, medical technology and diagnostics firms is committed to addressing these gaps and improving diabetes treatment and prevention in minority and other underserved populations. I hope today's podcast provided our listeners with information on the seriousness of diabetes in these communities along with the discussion of some of the tools and policies and community level strategies that can help confront and reverse this growing epidemic. CHI will continue to engage our members, as well as legislators on this issue and I welcome you to visit our web site, www.chi.org, for more information. Thank you.