

**Testimony of Risa Lavizzo-Mourey, M.D., M.B.A.**  
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**Before the Subcommittee on Health of the Committee on Energy and Commerce**  
**U.S. House of Representatives**  
**H.R. 3014, Health Equity and Accountability Act of 2007**  
**June 24, 2008**

Chairman Pallone, Ranking Member Deal, Representative Solis, and members of the Subcommittee, thank you for this opportunity to testify about the critical importance of addressing disparities in health and health care, and to express my support for the Health Equity and Accountability Act.

I am Dr. Risa Lavizzo-Mourey, president and CEO of the Robert Wood Johnson Foundation, the nation's largest philanthropy devoted exclusively to improving the health and health care of all Americans.

To improve the health and health care of all Americans means that we must tackle multiple issues on a number of fronts. As a philanthropy committed to producing measurable impact, the challenges we face in health and health care—from the epidemic of childhood obesity to the millions of Americans without health insurance coverage—are formidable, and are often interrelated. Like you, we have to think about these challenges on a number of levels, and understand that some solutions are short-term, whereas others will take longer to succeed. For example, we recognize that Americans' health results from different factors, like personal health behaviors and factors in the surrounding environment, such as housing. We recognize that getting good care is a matter of both access and the quality of care in a person's local community.

In order to make good on our commitment to improve the health and health care of all Americans, we cannot ignore the evidence that certain groups persistently suffer worse health and worse health care. Both race and social class, independently and in combination, contribute to health inequalities in the United States. Lower income generally means worse health, and racial and ethnic differences in health status also persist.

To be clear: Racial or ethnic disparities do not simply reflect differences in income. Such disparities are also seen within each income group. I was vice-chair of the Institute of Medicine committee that produced the 2002 *Unequal Treatment* report. We reviewed hundreds of research studies documenting gaps in care between black and Hispanic and white patients, and it was sobering. We found that racial and ethnic disparities in care persisted, even when other factors such as health insurance and income level were equal.

A combination of health and health care disparities—poor living conditions, personal health behaviors, and poor quality care—can lead to marked racial or ethnic disparities in devastating health outcomes. The Foundation recently commissioned research from the Dartmouth Atlas Project that found considerable variation in care by region and by race. In Mississippi, 57 percent of female patients aged 65-69 got mammograms in 2004-2005, compared to the national average of 64 percent. Maine fared best with 74 percent—a 17-point gap between the high and low states. Overall, the study shows 64 percent of the white women got mammograms, compared to 57 percent of African-American women. Perhaps most strikingly, this research shows that the rate of leg amputation nationally is four times greater for black Medicare patients with diabetes than

for whites. Among states, the overall leg amputation rate was highest in Louisiana and lowest in Utah.<sup>1</sup>

When we released the amputation data, we got a lot of questions about that statistic. We were asked, “Well, whose fault is it? What causes the amputation rates for black patients to be so much higher? Is it personal health behaviors, like smoking? Or is it poor care?”

And our answer was, “There IS no single cause behind this devastating outcome for black patients. This is an unacceptable outcome that usually comes from a number of things that progress over a period of time. And we want to focus on the solutions, rather than focus on who’s to blame.”

To be truly effective, the goal and solutions will need to be tailored to different regions, and doing so requires data.

So how does one begin to think about closing these gaps in health and health care? Well, we all need a starting point. And to illustrate one such starting point, let me ask a question: How does the amputation rate for Hispanic patients compare?

And the answer is, we don’t know. The processing of Medicare claims, which leads to the database that supplies the information for the Dartmouth analysis, does not yield this

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<sup>1</sup> See “Disparities in Health and Health Care Among Medicare Beneficiaries: A Brief Report of the Dartmouth Atlas Project,” at <http://www.rwjf.org/files/research/dartmouthexecutivesummary.pdf><http://www.rwjf.org/files/research/dartmouthexecutivesummary.pdf>

information. The data tells us only about black-white differences in care, not what is happening with the quality of care for Hispanic or Latino Americans, Asian-Americans, or Native Americans.

The Health Equity and Accountability Act would change that, ensuring the collection of data on both race and ethnicity, as well as on primary language.

The Robert Wood Johnson Foundation has long recognized that data collection on race and ethnicity can be a critical first step to reducing disparities and to improving health for all. We have approached the issue in several stages: We first supported efforts to establish that the collection of such data was legal, a matter that organizations such as the National Health Law Program and the George Washington University Health Information Law Project have since clearly resolved. When conducted as part of a program to improve health care quality, identifying patients' race and ethnicity does not violate federal or state law, or increase the risk of race-based malpractice claims.<sup>2</sup>

Next, we demonstrated that educating patients about why their race and ethnicity matters in the health care context is critical, and that patients agree that collecting that data is acceptable when such data are used to improve health care.<sup>3</sup> Finally, we commissioned the National Academy for Social Insurance to create an expert panel that showed that the Medicare program can do much more to help us reduce inequality in care. The panel made 17 recommendations for how Medicare, using its leverage as the largest purchaser and regulator of health care, could play a

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<sup>2</sup> See <http://www.rwjf.org/pr/product.jsp?id=21878>

<sup>3</sup> See "Key Findings Among a National Survey Conducted Among Adults With Health Insurance," <http://www.rwjf.org/pr/product.jsp?id=15783><http://www.rwjf.org/pr/product.jsp?id=15783>

leading role in five different areas, including the standardization of racial and ethnic data collection.<sup>4</sup>

However, data collection is the first step. We also have to show that health care organizations serving high numbers of minority patients can improve care. And we're seeing that they can.

In 2005, the Foundation launched a program called *Expecting Success: Excellence in Cardiac Care*. This program was specifically aimed at improving cardiac care for minority patients in hospitals. Why did we choose cardiac care? Treatment for heart disease represents an area where the evidence of racial and ethnic gaps is strong, both in care and outcomes. Heart disease is a leading killer of African Americans. And cardiac care is an area of medicine where the standards of care are well-established.

There were a range of hospitals participating – ranging from smaller safety-net hospitals to some well-known academic medical centers. Many of the hospitals were surprised to see stark gaps in the level of care they were providing to different patients.

Most physicians think that they're providing great care to all patients, but the data often show a very different picture. For example, one Expecting Success hospital found that 83 percent of non-Hispanic patients were receiving discharge instructions after a cardiac episode, compared to 66 percent of Hispanic patients. To address that disparity, first, they instituted some training

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<sup>4</sup> See [http://www.nasi.org/usr\\_doc/Strengthening\\_Medicare's\\_Role.pdf](http://www.nasi.org/usr_doc/Strengthening_Medicare's_Role.pdf)

procedures among hospital staff to ensure that the discharge instructions were given out.

Second, they made sure that the materials were available in Spanish.

These steps are seemingly so straightforward and simple—measure the quality of care delivered in each group, implement interventions designed to improve the quality of care for each group, and measure again. Through this process, the Expecting Success hospitals made impressive progress: at one hospital, the rate of providing proper discharge instructions soared from 74 percent to 98 percent, and counseling for smoking cessation jumped from 76 percent to 92 percent. But without the data collection that identified the disparity in the first place, this hospital would not have known where to target its efforts to improve.

Much of what we continue to learn about reducing disparities on all fronts will be applied in what is the Foundation's biggest effort to date to improve the quality of health care for all Americans, *Aligning Forces for Quality*. *Aligning Forces*, which aims to lift the overall quality of care in targeted communities and, at the same time, close racial and ethnic gaps. The initiative aligns the key players and market forces within 14 geographic regions across the U.S., representing about 11 percent of the nation's population. I'm pleased that the legislation before you today would provide grants for similar work in communities with high minority populations.

The 14 *Aligning Forces* community teams have already committed to measuring and publicly reporting on health care by the end of the year 2009, and are now also committing to collecting patient data by race and ethnicity.

This regional approach is critical to reducing disparities because, like any quality problem, disparities do not look the same everywhere. In some areas, as the recent research we commissioned from Dartmouth shows, black Medicare patients received equal to or better care than white patients, but the overall quality of health care was poor for everyone. And in many instances, as the leg amputation data suggest, the quality of care for black patients is still far worse, with tragic consequences.

Collection and reporting of race and ethnicity data are essential to reducing disparities. Another essential step is increasing the quality and availability of health care language services for patients with limited English proficiency.

Poor communication can lead to devastating, even deadly consequences for patients. With nearly 20% of the nation's population speaking a language other than English at home, our health care system needs to do a better job of ensuring that all patients, regardless of the language they speak and understand, receive high-quality, culturally competent care.

The Health Equity and Accountability Act will not only support standards for language services, but also provide additional research on the barriers, cost-effectiveness and best practices for delivering language services.

These are serious and ongoing issues, and we believe that fixing the problems of health and health care disparities by focusing on any one cause just won't work, and that there is no single solution to the persistent problems of disparities. The Health Equity and Accountability Act takes

a broad view and targets a number of approaches for reducing racial and ethnic disparities that together will make tremendous strides toward closing the gap. We look forward to working as partners on the same path to improving health and health care for all Americans.

Thank you for your attention to this issue and for the opportunity to testify today.