



“The AMA, the ACA and the Fight Against Disparities”

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I’m honored to be here on behalf of the American Medical Association and the 185 state, specialty and sub-specialty societies it embraces.

The AMA is a forum for direct engagement among physicians, offers expertise to help physicians manage their practices—is a source of research, education and practice support—and the premier advocate for physicians in the policy arena.

An important element in this portfolio is our partnership with the National Minority Quality Forum, the National Medical Association, the Commission to End Health Disparities and others.

Together, we seek to eliminate inequality of care rooted in race or ethnicity. And I’m proud of the AMA’s leadership role in this effort.

In 1847, the AMA was founded to create a national medical organization, adopt a uniform standard of medical education and a common code of medical ethics.

But missing was the notion of access to medical care for all people.

In 1957 the AMA adopted in our Code of Medical Ethics the 9th Principle: A physician shall support access to medical care for all people.

That principle drove our support of the Affordable Care Act.

It isn't perfect, but it was a long-overdue start. We don't agree with all of it—but there's much in it to like if you're a physician—and if you seek to erase health care disparities and improve quality.

It creates a regulatory framework for health insurance coverage and mechanisms to make it affordable for those who currently go without.

It ends insurance coverage denials based on pre-existing conditions and adds funding for primary care services, without reductions on specialty care.

It includes provisions to combat disparities in health care and treatment.

It expands initiatives to increase diversity in the health care professions and strengthens cultural competency training.

It improves preventive care and care coordination, and increases funding for community health centers.

And when insurance exchanges are in place next year, everyone will have access to quality, affordable health care insurance.

In all, there are more than 60 provisions that could contribute directly or indirectly toward ending disparities.

For example, the ACA seeks to expand the health care workforce and includes initiatives addressing diverse racial and ethnic communities through:

Grants to recruit and train community health workers, with an emphasis on providing education and outreach in racially/ethnically diverse communities...

And to support area health education centers that target underserved populations.

Loan assistance to primary care medical, dental, and mental health professionals, up to \$60,000, to help pay their student loans if they work for 2 years in a medically underserved area; and

Establishment of the National Healthcare Workforce Commission, which will develop strategies for increasing the workforce -- with mental health treatment among its priorities;

The Affordable Care Act provides 5 years of support to aid the development and dissemination of model cultural competence training and education curricula.

All of this is important—and for it to work, it depends very much on the ACA's provisions to make it easier to obtain health insurance.

That's why the expansion of Medicaid starting in 2014 is also important to extend coverage to lower income people.

As you know, originally states would have been required to increase Medicaid eligibility to 133% of the federal poverty level or lose existing federal funding.

However, last August the Supreme Court ruled that states could opt out of Medicaid expansion and still retain federal funding.

Based on the latest analysis by the research company *Advisory Board*, 24 states have committed to expanding Medicaid, 14 states have chosen not to, and the remaining 12 are undecided.

The AMA believes Medicaid expansion is necessary to ensure the nation's most needy citizens get the care they deserve.

Expanded Medicaid coverage would provide for treating more patients and enable many people for the first time to receive mental-health services in addition to vaccines, cancer screenings and management of chronic conditions such as diabetes and high blood pressure.

But I should note that in order for the program to remain viable, physicians must receive adequate reimbursement.

The provision in the ACA that calls for raising Medicaid pay to Medicare levels for primary specialties from 2013—2014 will help.

That's why, when proposals surfaced to eliminate this increase at the end of last year, the AMA organized 261 state, national and specialty medical societies in a letter of opposition.

Fortunately, Congress listened.

Meanwhile, our Advocacy Resource Center continues to support state medical societies in their Medicaid negotiations with legislators.

We've provided an array of resources, from talking points to model legislation—and recently we helped achieve important victories in D.C., New Mexico and Washington state.

I mention this because, as the nation's largest physician group, the AMA takes its position at the center of the health reform debate as a serious responsibility.

We've learned firsthand that those without health insurance, who can't afford a visit to a personal physician, who access care only through an Emergency Department—live sicker and die younger.

In the wealthiest, most technologically advanced society in the history of the world—that is unacceptable.

And some of those most adversely affected are members of minority groups.

You're familiar with the statistics and the scenarios.

People without health insurance make up about 16% of the population. But the uninsured rate for African-Americans is 20%, and for Hispanics, it's 33%.

Among African-American adults, 48% have a chronic disease compared with 39% of the general population.

Half of Hispanics and more than a quarter of African-Americans do not have a regular doctor, compared with one in five whites.

Simply put, this is unacceptable.

Another troubling issue is that only 9 percent of U.S. physicians are Hispanic, American Indian, African-American, Alaska Native or Native Hawaiian. That's not acceptable, either.

The AMA's House of Delegates has reaffirmed our commitment to minority health care by making the elimination of racial and ethnic health disparities an issue of high priority.

In fact, the AMA has been a member of the Secretariat of the Commission to End Health Care Disparities since its inception in 2004.

Today the Commission includes more than 70 members. And one of its primary goals is to ensure that the many Affordable Care Act provisions supporting minority populations are not repealed.

The commission works in four areas

- Educating and training physicians and health professionals about health care disparities and their impact on the quality and safety of care in diverse populations;
- Increasing diversity in medical and allied health professions;
- Advocating for policies that improve health outcomes for minority and multicultural populations; and
- Improving the quality and availability of research and data resources necessary to support elimination of disparities

in health care at national, regional, local and individual practice levels.

Just recently, the Commission issued a white paper on promoting appropriate use of physicians' non-English language skills in clinical care.

This is important, because miscommunication is a leading cause of health and health care disparities for populations with limited English proficiency.

It makes recommendations for policymakers, health system leaders, care delivery organizations and clinicians on approaches to caring for patients with limited English language skills.

They range from educating medical teams on the use of trained interpreters to language training for physicians, to hiring bilingual staff members.

At the AMA, we're offering other practical solutions, such as creating more educational opportunities—including the option of better access to medical school—for those who have suffered discrimination over the decades.

Our AMA Foundation addresses this through minority scholarships, and efforts to help physicians become aware of and appropriately manage low health literacy among patients.

Our Minority Affairs Consortium and the Commission to End Health Disparities—formed with the National Medical Association and National Hispanic Medical Association—contributes through the Doctors Back to School program.

It offers physician mentors and role models for elementary and high school students in medically underserved areas.

Doctors Back to School aims for a diverse work force to deliver health care for a diverse nation. That will require education, and effort.

The AMA has also created a program on health disparities to coordinate many of the AMA's activities in science, ethics, and medical education addressing the issue.

We also reach out directly to individual physicians.

Our Educating Physicians on Controversies in Health Is a series of Web- streaming seminars directed toward primary care doctors that addresses disparities.

The AMA also participates in the American Hospital Association's Equity in Care Group—formerly known as the Special Advisory Group on Improving Care for Minorities, or SAG.

Through this group we continue to study ways to improve hospital care for minority populations—and we submit legislative recommendations to Congress accordingly.

All this might sound like a lot, but it's just a start. Like the efforts toward health system reform, there's always room to improve.

One approach that merits more attention is to give individuals control over their health care destinies —

And to look beyond the unimaginative solutions of the past—which the numbers say have done little to eliminate disparities—and begin to address social determinants of health and encourage people to be strong advocates for their health needs.

A year ago, the AMA adopted a three-part strategy that includes a commitment to improving health outcomes and with it, an equal commitment to ending disparities in care.

This new strategic direction for the AMA is positioning us to offer leadership as new provisions of the health care law are being implemented. The three-part strategy is focused on

- Accelerating change in medical education,
- Shaping delivery and payment reform,

And most relevant to my talk here this afternoon...

Improving health outcomes—by focusing first on a few conditions that significantly impact our population, by marshaling our expertise in public health, quality, safety, advocacy and communications ...

And through partnerships with leading experts in the field and key physicians on the ground.

All three strategies are essential to the reform of our health care system—and needed to shape how medicine in the 21st century will be delivered, taught and practiced.

And now, the AMA is taking the next step.

After months of thorough research and discussions with scores of experts, the AMA today announces a major step in our strategic plan to improve health outcomes.

I do this on behalf of all the AMA staff who have worked so tirelessly toward this goal—and on behalf of an organization that empowers the nation's physicians—and with a profound sense of responsibility to the health of this country's people.

Today, the AMA is making public our long-term commitment to achieve measurable improvements in preventing cardiovascular disease and type 2 diabetes—and improving outcomes for those with these diseases.

And the AMA will dedicate resources, expertise and reach to reduce the significant patient suffering and cost burdens associated with these diseases.

Currently, more than 100 million people in the U.S. have diabetes or prediabetes. Let me repeat that—100 million people—one third of this country's population—have diabetes or pre-diabetes.

And, as many as 1 in 3 U.S. adults could have diabetes by 2050 if current trends continue

Native American, African-American, and Latino communities often suffer rates of diabetes or diabetic complications that are 50- to 100% greater than the general population.

One in every three deaths in the US is attributed to cardiovascular disease.

Almost 70 million U.S. adults have high blood pressure, and heart disease causes a heart attack every 34 seconds and a death every minute.

Those are mothers and fathers, sisters and brothers, sons and daughters.

And treating patients with these two conditions carries a price tag that exceeds \$500 billion a year—and growing fast.

Clearly, the toll of these two diseases—both in dollars and human suffering—is staggering.

That's why this is so urgent for American's physicians, and that's why the AMA's is so determined in this pursuit of healthier people, better health care and lower health care costs.

In this multi-year, multi-million dollar effort we will work in concert with key partners to seek specific improvements in the number of U.S. adults who have blood pressure, blood glucose—or blood sugar -- and lipid levels at their recommended goals.

We believe targeting these risk factors for cardiovascular disease and type 2 diabetes will have a significant, positive impact on our population and the nation.

Every physician—in every specialty, on every team, in every practice type, in every community—sees patients with these conditions or who are at risk for them.

Improving outcomes for these complex conditions will require a combination of strategies, from clinical care redesign to public health advocacy, to cooperation between clinics and the community.

But when America's physicians work together, along with patients and other members of the health care community, we can help reverse these trends and make a tremendous impact on health outcomes.

The AMA has some able partners in this effort. And we will need them, because this is an ambitious goal.

We've coordinated with several national groups, including the U.S. Department of Health and Human Services' *Million Hearts* initiative and the Centers for Disease Control and Prevention's National Diabetes Prevention Program.

We'll be working directly with influential groups to carry this out on the ground.

The AMA's initial steps to prevent diabetes and its associated health complications will be a partnership with the YMCA of the USA.

The AMA will work to increase physician referrals of patients at risk for diabetes to evidence-based diabetes prevention programs at the YMCA.

Turning to hypertension: We will adopt and will help to meet and surpass the Million Hearts goal for 10 million more Americans to have their high blood pressure controlled by 2017.

Our initial focus will be the population of patients who have hypertension and a source of care—but whose blood pressure is still too high. That is more than 30 million people.

Our initial work to improve care for people with uncontrolled hypertension will be in partnership with the Armstrong Institute for Quality and Safety, a research institute within Johns Hopkins Medicine in Baltimore.

In their own words, the Institute states their “goal is to eliminate preventable harm to patients and to achieve the best patient outcomes at the lowest cost possible, and then to share knowledge of how to achieve this goal with the world.”

And they’ve produced real world results, as well, such as their work to reduce central blood line infections. They have a track record for improving outcomes for patients.

What I’ve outlined are just the first steps toward the AMA’s ambitious, long-term pursuit of achieving measurable improvements in health outcomes for patients in the United States.

But the AMA is no newcomer to this goal of quality care to achieve improved outcomes.

For instance, the AMA-convened Physician Consortium for Performance Improvement measures, which span 46 clinical areas and care coordination, are being used in health plans and voluntary physician reporting programs.

Many are now the basis for “next-step” research on clinical and patient-reported outcomes.

Other elements of the AMA’s strategic plan also aid these efforts.

In concert with the AMA Council on Medical Education and our sections on medical schools, medical students, and residents and fellows, we are working to reshape physician education in the US.

Our aim is to accelerate needed changes in medical education to close the gap between current standards for students and residents and the skills needed to make medical education more relevant to the changing practice environment.

This means more emphasis on responding to the coming changes in how care is delivered, on improving outcomes, and learning the nuts and bolts of team-based health care.

It's clear we've come far since the days of a doctor with a black bag holding the tools of his trade.

Today, a physician may text a patient on a smart phone while viewing their medical history on an iPad -- and coordinate their care among a team of physicians and other health care professionals.

Such physician-led teams are crucial components of medicine's future.

As more patients live longer and accumulate more complex medical conditions, their care will require more coordination, more use of clinical data, and professionals working together.

To be part of a team—and following guidelines and best practices—doesn't mean you've lost your ability to think, to create, to act on behalf of your patients.

It offers more continuous contact with patients, better coordination of care and makes it easier to use evidence-based medicine to guide clinical decisions.

A great example of that is the Nuka system of care at the Southcentral Foundation in Anchorage, run by and for Alaska Natives.

I know many of you are familiar with them, but what they do, and how they do it, bears repeating.

They take a team approach—patients are assigned to a health care team—it might be, for instance, a physician, a nurse, two medical assistants, a behavioral health therapist, and an administrative assistant.

And connected to a nutritionist, pharmacist and specialists. And the team might include traditional healers, as well.

Today, Southcentral employs 1,400 people and serves 60,000 Native Americans in Anchorage, the neighboring Matanuska-Susitna Valley and 60 villages.

It offers 65 programs to tackle domestic violence, suicide, obesity, substance abuse, diabetes, heart disease and other issues. All delivered in a context of cultural sensitivity and understanding.

Through emails and texts, physicians can keep tabs on their patients, reduce unnecessary visits, and through ease of appointment, reduce visits by patients to the emergency room.

In the last decade, Southcentral has seen a decrease of 40 percent in ER visits, 75 percent in hospitalizations and a 30 percent drop in routine doctor visits.

This type of quality care, delivered efficiently, allows Southcentral to handle a seven percent annual increase in patients with only an annual two percent increase in Indian Health Service funding.

This approach will very likely shape the future of medical care in the U.S.—and offers a blueprint that can be effective in fighting disparities nationwide.

As the largest physician group in the US, the AMA is learning important lessons from approaches like this.

On this issue -- and on the issues of the uninsured—access to care—quality medicine—and on the issue of disparities—the AMA has a unique leadership position to inspire our colleagues to do what is right for our patients.

To us, it's a matter of acting on our three professional goals as physicians:

- To bring the best that science can offer to the care of patients;
- To observe the absolutely highest moral and ethical standard;
- And to meld science and ethics in a caring way.

Science—ethics—caring. The foundation of medicine—and a pathway toward seeing that every patient—regardless of origin, race, class or region—gets the best care available.

Every physician in this nation should know they can make a difference. Every physician should do so. Thank you.