“Un Gran Reto – A Great Challenge”

Joshua M. Sharfstein, M.D.
Commissioner, Baltimore City Health Department
Remarks in Honor of Hispanic Heritage Month
Tuesday, September 19, 2006

Centers for Medicare & Medicaid Services
Baltimore, Maryland

Thank you for inviting me to the Centers for Medicare & Medicaid Services to celebrate Hispanic Heritage month.

Fifteen years ago today, I unpacked my suitcase in the western highlands of Guatemala. I lived for four months in Quetzaltenango with the generous and warm family of Willy and Nidia Aguirre …. while assisting the efforts of the international health organization Project HOPE to combat Vitamin A deficiency in rural villages.

I then traveled to Costa Rica … where, over the next five months, a community health worker and I went door-to-door weighing and measuring hundreds of refugee children from Nicaragua. We referred those who were underweight or overweight to the local doctor, a nun who worked in a one-room clinic.

While living in Central America, I learned to speak and understand Spanish. I gained a deep appreciation for the values of respect, family, and faith in Latino culture. And I was inspired to pursue a career in pediatrics and public health.

Then I came back to medical school – where my eyes could now see in a new dimension. On my first day as a student on the wards in pediatrics, the senior resident explained test results and the treatment plan in English to a Latino family, who appeared confused.

Against the rules, I lingered behind and offered a brief translation … before running to catch up with the group. When rounds ended a half-hour later, it was time for the medical team to go downstairs to see x-rays.

But the door to leave the unit was blocked. By five Latino mothers. To everyone’s shock, they all pointed at me, the medical student standing in the back. One said, “Queremos entender de nuestros niños tambien.” We want to know what is happening with our children too.

I missed radiology that day.

My experience as a pediatrician has been enriched immeasurably by my ability to serve Latino families. I spent five years as a primary care pediatric resident and pediatrician in the Latino Clinic at Boston Medical Center. I worked Saturday morning shifts in the Martha Eliot community health center in the Dominican community of

Jamaica Plain. After moving to Baltimore in 2001, I signed up for late night weekend shifts about twice a month in the Emergency Department of Children's National Medical Center … where the families of about half of my patients came from Mexico or Central America. I have answered countless pages from my Latino patients and their families, and gone on home visits. I have spoken to many teachers, school nurses, landlords, and employers.

What made all these experiences so rewarding was earning the trust of parents whose lives and cultures are so different from my own – trust that I would take good care of their children.

I owe so much to my Latino patients and to their families … and to my teachers in pediatrics, including Dr. Martha Sacoto, Dr. Amanda Rodriguez, Dr. Ilan Schwartz, Dr. Maria Hill, and especially my mentor and friend Dr. Glenn Flores.

These doctors taught me to provide quality health care to my Latino patients – and to expect quality health care for them from others.

One consequence of my training is that I have become acutely aware of the ways in which our health care and public health systems fail the Latino community.

The Latino population in the United States has grown from 14 million people in 1980 to 42 million in 2005. The U.S. Census Bureau estimates that by the year 2050, one out of four Americans, or about 100 million people, will be Latino.

Yet our health care system is adapting only slowly.

The federal government's most comprehensive assessment of health care quality by race and ethnicity is called the National Healthcare Disparities Report. Of eight measures of healthcare access in the report, Latinos fared worse than non-Hispanic whites on seven. Over one-third of Latino adults report lacking health insurance, and about one-quarter of Latino children. Latinos are much less likely to have a regular source of health care, such as a primary care doctor.

The 2005 report also assessed 38 measures of health care quality. The report found that on more than half of these measures, Latinos fared worse than non-Hispanic whites.

Latina women are less likely to get mammograms and pap smears… and Latino men less likely to get pain medication in the Emergency Department for long bone fractures. Latinos receive less effective care for pneumonia, less advice to quit smoking, and less mental health care and substance abuse treatment when they need it.

Latino children receive inadequate dental care, too few immunizations and less comprehensive evaluations for stomach complaints in the Emergency Department.

Poor access to health care. Health care of lower quality. And according to the National Healthcare Disparities Report, most of these problems are getting worse. The impact of the health care system's failures – coupled with economic stress and difficulties with acculturation -- can be seen across the life cycle.

Latino boys have the highest rates of obesity, and one in two Latino children born in the last five years is expected to develop diabetes. According to recent research, one in

six Latina girls attempt suicide. Puerto Rican immigrants have the highest rates of asthma, with more than 1 in 10 suffering from the disease. Teen pregnancy, school drop-out, and binge drinking are serious problems. Among adults, Latinos have especially high rates of diabetic complications such as end-stage renal disease. At the end of life, Latinos are more likely to have pressure sores and be restrained in nursing homes.

On some public health indicators, such as infant mortality, Latinos fare better than non-Hispanic whites. But this silver lining has a cloud: The advantages tend to disappear with each successive generation living in the United States.

It all adds up to un gran reto – a great challenge – for the United States.

And here is the challenge: to make high quality health care accessible to the Latino community. Healthcare that extends and enhances life … health care that respects family, community, and faith.

It is a great challenge for all of us.

In Baltimore, we have a rapidly growing Latino community, now estimated at approximately 40,000 people.

In one small survey, 60% of the Latinos surveyed in Baltimore had no health insurance. Patients crowd a mobile van from Johns Hopkins Bayview Hospital and a small clinic run by the Hispanic Apostolate that provide very basic health services. Many clinics and offices are not accessible in Spanish. Community organizations such as Centro de la Comunidad and Adelante Familia report that many of their clients have difficulty accessing care, including mental health and substance abuse treatment.

So where to begin?

First, education. We're placing kiosks in key locations in the Latino community stocked with information on health topics and available services. By key locations, I mean social services agencies, health care clinics, and supermarkets. At Great Value in Highlandtown, you practically run into our kiosk just as you leave the store.

Second, outreach. Through an affiliated nonprofit agency called Baltimore Healthcare Access, we have a team of community health workers that seeks out and connects Latina women and children to Medicaid coverage.

We also have a public health clinic located in East Baltimore near the largest population center in the Latino community. About 20% of our patients speak Spanish, and that's without our even trying to recruit more. Now we're going to try. Our clinic is on Caroline Street, and so we are marketing our services as La Carolina. We have Spanish speaking clinicians and translators and a plan to reach out across the Latino community. Our goal is to expand access to all of our public health services – from dental care to reproductive health care to tuberculosis treatment – to the growing Spanish-speaking population..

Third, partnerships. We're working with the state and with community health centers to enhance the safety net for the uninsured. We're also reaching out to private health insurers … to encourage them to market solid insurance plans in Spanish in concert with community organizations. We are engaging the city's substance abuse and mental health treatment systems to ensure that these critical services become more

accessible to the Latino community. We will be working closely with our city's hospitals as well.

Fourth, advocacy. We are fighting for expanded services and support for all of the uninsured, including those in the Latino community. We are paying special attention to fair treatment for immigrants. I recently provided expert testimony in a lawsuit against the State of Maryland for dropping thousands of legal-immigrant pregnant women and children from the Medicaid program.

I will be the first to admit Baltimore is not doing enough. We are not doing enough education, we are not doing enough outreach, we have not established enough partnerships, and we are not doing enough advocacy.

We will always not be doing enough until we can see progress for dozens, then scores, then hundreds and ultimately thousands of our city residents.

Yet even at our most ambitious, the scale of our efforts is minimal … compared to your work at CMS. Tiny decisions made every day in this building can change the healthcare of tens of thousands of people. Your major policy decisions affect the lives and health of hundreds of thousands or even millions of people.

CMS has the tools to rise to this great challenge.

CMS can rise by enrolling more of the uninsured into Medicare and Medicaid. The most efficient and effective methods to reach the eligible – such as simplified forms, tandem enrollment in other programs, and community-based case management -- are well known and well proven. Encouragement and leadership by CMS can spread these best practices across the country.

CMS can rise by breaking down language and cultural barriers. 23 million Americans have limited English proficiency, two-thirds of whom are native speakers of Spanish. And they are having a hard time being understood in the health care system.

Three in ten Latino patients report problems communicating with health care providers in the past year. Case reports have documented missed appendicitis and inappropriate removal of children to social service custody due to language barriers. Yet despite the clear impact of poor communication on health care quality, and despite legal opinions that failure to provide appropriate translation services is a violation of the Civil Rights Act, only about a dozen state Medicaid programs provide reimbursement for interpreter services.

CMS can rise by encouraging diversity in its own ranks and in the healing professions. Only 3% of medical school faculty, 2.8% of dentists, and 2% of nurses are Latino. The Institute of Medicine has found that the "benefits of diversity in the health professions will accrue broadly, as this diversity helps to expand the disciplines' ability to conceptualize and respond to the health needs of increasingly culturally and linguistically diverse populations."

And CMS can rise by remaining an expert scientific agency … even in the face of mean-spirited immigration politics intended to sway your mission.

I blame these politics for the absurd provisions of the Deficit Reduction Act, which require that millions of people provide proof of identity and citizenship before they

can receive federal support for their health insurance. The Act is generating enormous expense and hassle to address a problem that the Inspector General could not find and Dr. McClellan has said has not been proven to exist. The paperwork burden alone could cause tens of thousands of eligible beneficiaries – or more -- to lose access to health care coverage. .

CMS must not stand by and let this happen. I hope that Dr. McClellan, when he leaves the agency, will speak out to change this misguided law.

And before he leaves … permit me to make one other request of Dr. McClellan.

I ask that he reconsider a recent CMS policy that will adversely affect thousands of Latino newborns—one that is totally up to CMS and is not required by the Congress.

For years, babies born to women on Emergency Medicaid could be considered automatically eligible for full Medicaid coverage. This made sense. After all, as soon as they are born in the U.S., these babies are U.S. citizens. Medicaid had even paid for their births in U.S. hospitals.

Yet CMS recently advised states to suspend automatic eligibility for the babies of many immigrant parents. Parents must now submit proof of the baby's identity and citizenship before qualifying for federal support.

The new requirement is discriminatory… in that it does not apply to non-immigrant children in exactly the same situation.

It is also senseless. The effect will be to impede access to health insurance during one of the most vulnerable periods of human existence … the first few months of life. As a pediatrician, I can list dozens of medical catastrophes in these early months that must be addressed at the first sign of a problem. Adding barriers to care at the start of life is a recipe for disaster. And that disaster will ultimately be the financial responsibility of the Medicaid program, since all of these children are citizens and will be eligible.

Since this is CMS's own decision, I respectfully suggest that it would be good timing during Hispanic Heritage month to drop this policy.

It is also good timing for us to take a positive step together.

Let me extend an offer for collaboration and cooperation across levels of government and party lines. In Baltimore, we would be happy to partner with CMS in any efforts to expand coverage to our city's residents or improve the quality of health services, including efforts geared towards the Latino population.

Fifteen years ago today, as I unpacked my bags in remote Guatemala, I thought I could not be further away from my medical education. How wrong I was. My experiences in Central America are at the core of who I am as a doctor.

Fifteen years from now, I hope we look back at this celebration of Hispanic Heritage as anything but a break from our work in health care and public health. Serving the Latino community is central to our work in health care and public health.

I look forward to joining you in meeting this great challenge.