Good afternoon, again. We started late this morning, but we caught up and we're going to start on time this afternoon, so we'll have the full time to interact and interchange. I don't know about you, but I had a very interesting and exciting morning listening and I hope you got a sense of the lens I was talking about, the public health ethics lens. Just looking at the same issues from a different context and trying to assess what you heard from a different frame. Not the facts, per say, though they are critically important, but what are the facts, who are the stakeholders, what do we do and what are the consequences if we do nothing. That's the framework that I hope you're able to use as we continue. What are the facts? Who are the stakeholders? What do we do? And what are the consequences if we do nothing? This afternoon's session really embraces that framework. What do we do? And from my context, we've got to get it right. We must get it right. And, I know my time in public health, I didn't hear words like right and wrong, I heard words like is it statistically correct? Is it valid? Is it reliable? But is it right? Well, what does right mean? And from whose context? And who's right are we talking about? So the speakers were outstanding, and you were equally as provocative in not asking the same old public health questions. New questions, a new framework. And this afternoon will be equally as exciting. And we, the speakers, the three of us had a conference call the other day to talk about the session, because we want to get it right. And I listened very thoughtfully as they shared the issues that the intend to come forth with. And as I listened, I got excited. And I assured them, I'm going to be here, I was going to show up, because I wanted to hear from their perspective. And then the traditional forums conversation convention, you spend too much time reading the bio sketches, the resumes of the speakers. And I'm not going to do that. Let me assure you, we have the best of the best. We thought about the topics and how we can get a different framework. And we also agreed to give them the time so they wouldn't have to rush through their comments. Dr. Flores, Lynn Flores, and hear me clearly, distinguished chair with health policy research, medical research institute and research affiliate, the Department of Health Sciences Research, Mayo Clinic. When I think of Mayo Clinic, I think of the best place in the world to go and get fixed. Go to Mayo Clinic. But to have a colleague talk about the policy which drives getting it fixed, is exciting. Alphonso Rodriguez Lance, and I was particularly excited because I saw the degree, PhD, and that's okay, but I saw DVM. I'm at Tuskegee and we've got an outstanding school of veterinary medicine. So we've got a physician, we've got a veterinarian and, by the way, I'm a dentist. So we've got a real rich opportunity. So we'll have the speakers come from as they're listed in the program, and we'll have this conversation, because you have as much to give as we do. I look forward to the dialogue. Dr. Flores.

So thank you for that kind introduction. So this is the getting the data right for Latinos session. I'm going to talk about appropriate language in sub group data are critical for public health and social justice. The objectives of my talk will be to talk about the prevalence of limiting English proficiency, which I'll refer to as LEP, among U.S. Latinos. How language barriers impact health and health care. Why LEP is the best measure of assessing language barriers, the collection of language and LEP data in clinical settings, national surveys and research. And, finally, the importance of collecting data on Latino sub groups. So, just as a back drop, the world's population of 7.3 billion people inhabits 191 countries and speaks over 6,000 languages. And between 1990 and 2014 the number of people in the U.S. speaking a language other than English at home rose from 31.8 million to 63.1 million. And the number of LEP Americans grew from 14 million to 25.6 million. And LEP, as had been mentioned before, is defined as the self rated English speaking ability of less than very well, that's using the census questions, which
we'll get to later. Being a pediatrician, I always like to take a look at what's going on with kids, and we
know that 12 million school aged children, so that's 22%, speak a language other than English at home,
and that's a number which has tripled since 1979. And we also know that Latinos absolutely dominate
the speakers of non English language at home, and the LEP. So we just said 61.3 million Americans, so
that's 21% speak a language other than English at home, well, Latinos, who speak Spanish, make up 39.3
million, so that's 62% of that group. And then 25.6 million Americans, or 9% are LEP. Well, Latinos make
up 16.4 million, and that's also about 2/3 of everybody in that group. By comparison, when we look at
Asian Pacific Island languages, about 4 1/2 million or 19%, other Indo European languages is 3.4 million,
or 13%, and then all the other languages are little under a million, and it's about 4%. So a lot of you
know there is a federal mandate for providing language services for LEP Americans. So title 6 of the Civil
Rights Act of 1964 clearly states that denial or delay of medical care for LEP patients due to language
barriers constitutes a form of discrimination. And this actually requires that all Medicaid and Medicare
recipients, which is almost all providers of clinical care, have to provide adequate language assistance to
LEP patients. But in spite of that, we know that language problems impact multiple aspects of health
care. We know that they impact access to care, we know that they impact health status, we know that
they impact the use of health services, patient and physician communication, satisfaction with care, and
quality and patient safety. Unfortunately I only have 20 minutes, because I could spend a few hours
about this. And I encourage you to take a look at example of a review that we did a few years ago that's
cited there. So just a few of the key issues for LEP patients. When you look in psychiatric settings, we
know that LEP patients have a greater likelihood of a diagnosis of more severe psychopathology. They're
more likely to leave the hospital against medical advice. They're less likely to establish a good rapport
with their physician. They're less likely to receive an adequate explanation of their therapeutic regimen.
And they're less likely to give feedback to their physician. And then there's some recent studies that
document especially egregious hazards of using ad hoc interpreters for LEP cancer patients. So an ad hoc
interpreter is an untrained person. They can be untrained staff, like a medical assistant. They can by the
custodian, Jose, who's cleaning the floor, and somebody grabs him and says come interpret. They can be
somebody pulled from the waiting room, and even pulled from the streets. So, and we've done a lot of
work on this. I'll just very briefly touch upon a little of it later, but I want to show you some examples
from the literature, specifically for LEP cancer patients. And these are some examples. So in one case,
the physician said, we think there is a 40% chance that the treatment will prolong your life. And the
interpreter said the treatment will prolong your life. In another case, the physician said, the doxy,
referring a chemotherapeutic agent doxorubicin, could hurt your heart, and the interpreter said the
doxy can give you pain. The physician in the next case said the results of these tests lead me to conclude
that you do have breast cancer, and the interpreter says this test will tell me if you have cancer. And
then finally, one important thing that you have going for you is the fact that the cancer has probably
been caught early, which the interpreter interpreted as one important thing is the fact that the cancer's
working quickly in your body. We also have found a few studies that are, I think, equally striking. There's
one study of a major pediatric residency program, by the way, for you trainees, I encourage you to do
these sorts of studies because there are enough, and this study found that 68% of pediatric residents
spoke little or no Spanish. 53% of the non Spanish proficient residents, however, used their inadequate
language skills in patient care often, or even daily. And many residents reported that LEP families under
take care never or only sometimes understood their child's diagnoses over half the time, medicates
over a quarter of the time, discharge instructions 43%, and the follow up plan 40%. And 80 percent of
these residents reported they avoided all communication with LEP families, so you can think about how
good the care was, then. And then, although all of these residents agreed that hospital interpreters are effective, 75% reported never or only sometimes using hospital interpreters. And then I had a medical student who was very ambitious, and so we did a study together that looked at 128 pharmacies in a major U.S. city. Any pharmacists here? Well, what we found was that about half of the pharmacies can never or only sometimes actually prepare non English language prescription labels. Over half the pharmacies never or only sometimes can provide these non English language information packets, including 15% who can never do it. And about 2/3 of the pharmacies never or sometimes can orally communicate in non English languages, including 1 in 6 who never can do so. We know that health processes outcomes and use of services have a, will end up being better when you have interpreter services. We know that they positively impact these outcomes. So one study a few years back of children presenting to the emergency department found that LEP patients with professional interpreters did not differ from the English proficient patients in test cost, use of IV hydration and also had a lower likelihood of testing. We know that LEP patients with type 2 diabetes who have trained, professional interpreters are actually two times more likely than people who speak English to receive care meeting American Diabetes Association guidelines. They're three times more likely than English proficient patients to have dietary consults and they don't differ from those English speaking patients in 18 other processes and outcomes. I wish my friend, Ellie Saya [assumed spelling], was still here because I'm going to quote one of his great studies. He looked at patients with hypertension and diabetes and found that health status, physical functioning, psychological well being, health perceptions and even pain scores were higher and even better than those who had language concordant versus discordant physicians, so a physician who spoke their language. There were also a number of studies on quality in patient safety, so in one study in a large children's hospital in the Pacific Northwest, they found that there was a twofold increased risk of serious medical events in Spanish speaking patients requesting interpreters versus those who did not. And these serious medical events include tenfold medication errors, missed or delayed diagnosis, failure to monitor patients, diagnostic procedures performed on the wrong patient, the wrong diagnostic procedure performed, and administration of breast milk to the wrong patient. And here's some cases that we've reported on. So a two year old fractured her clavicle after falling off her tricycle. A resident physician misinterpreted two Spanish words, [se pego], diagnosed the child with child abuse and contacted the Department of Social Services who, without an interpreter, actually had the mother sign over custody of her two children. In another case, a 10 month old with iron deficiency anemia was given a 13 fold overdose of iron and hospitalized for iron intoxication after her LEP parents were given medication instructions and a prescription only in English, so her parents gave 15 milliliters, so that's 1 tablespoon, of iron elixir based on the prescription label that read 15 milligrams per .6 milliliters, 1.2 milliliters daily, so that's like a dropper. And then there's a famous case where there was misinterpretation of a single Spanish word that was intoxicado, in Florida, which resulted in 18 year old's quadriplegia after being misdiagnosed with a drug overdose. The patient's hematomas, brain stem compression and paralysis were due, actually, to a ruptured aneurysm, and the hospital paid a 71 million dollar malpractice settlement. And I also want to share with you, this is an actual case that occurred, so Juan was a 6 month old, previously healthy male who presented to a children's hospital with ED, with new onset vomiting and diarrhea. The triage history given by mom was interpreted by Juan's 12 year old sister. Needless to say she as not trained as an interpreter. And the sister stated that the patient had 4 dirty diapers and 3 episodes of vomiting that day. Juan was triaged to a non urgent level of care in which documents stated he had vomited 7 times that day, with no diarrhea. He was discharged shortly thereafter with a diagnosis of vomiting instructions in English only for Pedialyte PO ad lib. That means by
mouth. Three days later, Juan returned to the emergency department. He was in severe distress. He had new onset of bloody stools. They admitted him to the hospital and he died 6 hours later of septic shock.

So I want to talk very briefly about a study we conducted. It was published in The Annals of Emergency Medicine. We looked at areas of medical interpretation and the potential critical consequences. We looked at hospital interpreters versus ad hoc interpreters versus having no interpreter. And that's the case where, in many cases we saw this, where an adolescent had interpreted about himself for his mother and to the doctor. So we found that compared with ad hoc interpreters and having no interpreter, the professional hospital interpreters, as you might expect, resulted in significantly lower proportions of omissions during the encounter, false fluency errors, and errors of potential clinical consequence. And ad hoc interprets and having no interpreter can cause miscommunication, a lower quality of care and interpreters that have the potential to cause medical errors. And I want to share with you one of these interactions, this was published in the New England Journal of Medicine, so this is multiple omissions and false fluency errors. This was a 12 year old that came into the emergency department with dizziness and no interpreter. So the mother says,

La semana pasada a el le dio mucho mareo y no tenia fiebre ni nada y la familia por parte del papa todos padezen de Diabetes

which means, last week he had a lot of dizziness and he did not have a fever or anything. His dad's family all suffer from diabetes. So, of course, the adolescent, not being a trained interpreter, says nothing. And the doctor, not knowing Spanish, says uh huh. And the mother says,

[A mi me da miedo porque el nunca ha estado mareado mareado mareado y no tenia fiebre ni nada]

which means I'm scared, because he's dizzy, dizzy, dizzy, and he didn't have a fever or anything. So the doctor says, okay, so is she saying you look kind of yellow, is that what she's saying? And the patient finally says, and he's asking his mother, [es que si me vi amarillo?], which means, is it that I looked yellow? And his mother says,

[Estaba como amarillado, como palido]

which is, you were like dizzy, like pale. So the patient finally turns to the doctor and says, like I was like paralyzed, something like that. So why am I bringing up all these cases and telling you about stuff that doesn't necessarily have to do with data? Well, I now want to move on to something, which is there is a bewildering array of methods for collecting language data. So, of course, unfortunately what we see all too often is a positive response or a nod of the head to the question, do you speak English?, when somebody's coming into the hospital or clinic? Sometimes it's just a quick take by the registration clerk or a researcher. Some people classify the language of interview. Some people say, what's your preferred language? Some people base it on, did you request and interpreter? More and more we're seeing
primary language spoken at home. And then also the U.S. census questions on language spoken at home and LEP. So what the heck works the best? So evidence actually documents that LEP is the best measure of language barriers. And we conducted a study of 1100 children and care givers, it was published in the Public Health Reports, took a pair of primary language spoken at home versus parental LEP and their associations with health status, access to care and use of health services in children. And the key study finds were, after we did multiple variable analysis and we adjusted for all kinds of co-variants, we found that parental LEP was associated with triple the odds of a child having fair or poor health, double the odds of a child spending at least a day in bed for illness in the past year, and significantly greater odds of children not being brought in for needed medical care for 6 of the 9 access barriers to care that we looked at. So, couldn't afford medical care, uninsured, staff doesn't understand culture, transportation difficulties, appointment difficulties, and the clinic is too far away. On the other hand, primary language spoken at home was not associated with any of these health status or access outcomes, which to us was pretty conclusive evidence that this is what we need to be doing. The collection of language data is unacceptably low in clinic settings. So a national survey of 272 hospitals revealed that only 39% collect any data on the patient's primary language, and no statistics were available or presented on what proportions of hospitals or health plans collect LEP data, if any. And I emphasize if any, because I suspect it's close to zero. In another study, a national survey of internists documented that 65% have active LEP patients, this is nationwide, but few practices have a formal mechanism for obtaining data on the patient's primary language, and only 28% record the patient's primary language in the medical record. And, again, there was no mention of whether any LEP data were collected. Another issue, that I think is really important right now, is no national surveys currently collect LEP data. And here's some examples, and I apologize because I know I might not be being a politic guest, because some of these are from the National Center for Health Statistics, but it's something that's troubled me as a researcher for decades and I've been trying to have people think about having LEP in the question. So in this slide, in the first column, you see the survey, is that showing up? Here we go. And the second column was the language measure and the third column was LEP assist. So in, HIS, for example, the national Health Interview Survey, looks at the interview language and there’s no LEP assessment. And Haynes looks at the language usually spoken at home, no LEP assessment. NSFG, that's the National Survey of Family Growth, primary language, but no LEP. Slates is also primary language, but no LEP. Then the National Vital Statistics System, National Death Index and then the MCS is the ambulatory survey, they're not, as far as I know they don't look at a language measure, and they definitely don't look at LEP. And this was taken actually from a site that showed these. And another thing that is really troublesome, and I think speaks to ethical issues, is the exclusion of LEP subjects from clinical research is actually rampant. So, really, I think, probably the most excellent article on the field, is this is an analysis of 172 studies published in major medical journals, and they found that 74% absolutely excluded LEP subjects. And the most common reason for excluding LEP subjects was not having thought of the issue, 51%. Barriers to enrolling LEP subjects that were cited by the researchers included lack of preexisting instruments in the target language by 58%, the need to translate responses into English, 55%, the expense of instrument translation, 45%, and recruitment of bilingual staff, 45%. And of those who actually included LEP subjects in their research, 95% reported that they spent less than 1/5 of the study budget to include LEP, and 36 actually needed no additional funds to include LEP subjects. So it really is inexpensive. And about 1/3 of the researchers believe that the study results would have been very different if the LEP subjects were excluded. And now, another interesting study came up, which is, and it showed that English fluency requirements have actually increased over time on clinicaltrials.gov, so clinicaltrials.gov is the
federal registry where you go if you’re doing a randomized control trial. And this is a recent study that looked at over 10,000 clinicaltrials.gov’s protocols from before 1995 all the way through 2013. And it showed that 7% of these clinical trials overall required English proficiency of their subjects. The EP requirements in this efficiency in the trials has actually increased steadily from a low of about 1.5% of the studies in 1995 to 1999 to now 9% in 2010 or later. The U.S. federal government at about 13% and NEH at 6% actually have significantly higher English proficiency requirement rates versus the industry, which is interesting at 2%, excuse me. And the English proficiency requirements vary by intervention categories, so interestingly the highest barrier was 28% for behavioral intervention. So they had the highest requirement of English proficiency. Those followed by procedure studies at 8%, devices by 5%, and a low of .4% for biologic’s. And another study that looked at IRB’s came to the conclusion that we have insignificant federal, and actually international guidelines on LEP research subjects. So this is a review of policies and procedures on 30 U.S. IRB websites, including 23 of the top ranked medical schools in research. And in this slide what you see is the first column is the IRB policy, whether it’s addressed or not, and the second column is the proportion that actually did so. So the highest was translating the completed consent document. That was 97% surveyed. Discussed language barriers in research, that drops to 53%. Guidance on using interpreters, 40%. Ethical or legal problems enrolling subjects when there are language barriers, that’s only 20%. Problems with excluding LEP subjects from research, 17%. And then guidance for translating other research materials, those are things like questionnaires, or surveys, or brochures, 7%. So here are the key conclusions that the author reached on this IRB study. So intentionally excluding LEP people would be unfair to potential LEP subjects. The principle of justice discussed in the Belmont Report requires fair procedures and outcomes in subject selection. It is unfair to exclude research subjects from a study without a valid scientific or ethical reason. They also concluded that intentionally excluding LEP persons may violate federal research regulations, which state selection of subjects should be equitable. In making this assessment, the IRB should take into account the purposes of the research and the setting in which the research will be conducted, and should be particularly cognizant of the special problems of research involving vulnerable populations. So to spite all of this, assessing LEP really actually is easy in clinical practice and research, and it’s just a two part U.S. Census question. So does this person speak a language other than English at home? And if they say yes, then you go to the next question, if no you skip it. And then you want to ask, of course, what this language is. And then all you ask is how well does this person speak English? Very well, well, not well, not at all. And any response to this question that’s not very well should be classified as LEP and actually this person needs an interpreter. So now I want to shift gears and talk about the importance of Latino subgroup data. And my predecessors today, Dr. Perez-Stable and Dr. Dominguez did a nice job of talking about some of these issues, but I want to focus on one aspect, which is that substantial health and health care disparities exist by Latino subgroup. These subgroup disparities may actually equal or even exceed those among the big racial and ethnic groups, but Latino subgroup data are not consistently collected in clinical practice or national surveys, or health and health care. So my first paper as a faculty member, one of the first, was in the American Journal of Public Health many years ago, and actually looked at childhood disparities and social health and health care measures. And I know this looks a little complicated, but hopefully by walking you through it, it’ll make sense. So y axis is percent, the x axis is different measures. And what I’ve done is I’ve lined up the five major racial and ethnic groups, white, African American, American Indian, Alaskan Native, Asian, Pacific Islander, and then Latino as a whole. And then at that time I was able to look at Cuban, Mexican, Puerto Rican, and what you’re going to see consistently is that the subgroups equal or exceed the magnitude differences
of the major racial and ethnic groups. If you look at family poverty, as many of you know, very high rates in African American and American Indian populations. If you look at Latinos, so they're short of that high, but definitely higher than whites. Break it down by subgroup, and you can see Cubans, almost like whites, then you have Mexican Americans who are about equal to the poverty rates in white, sorry, in African American and American Indian, and then Puerto Ricans are actually off the charts there. When you look at the educational attainment, which was eluded to earlier, you see the same sort of patterns where you look at the first five groups, here in racial and ethnic groups, and you see major differences. And not surprisingly, Latinos are high, but with that Latino subgroup you obscure those differences because you look at Cubans and they have actually pretty good rates that are not that far away from whites, but off the charts are Mexican Americans. Then we move on to health and health care, look at health status not being excellent or very good, you see, again, the two major ethnic groups, racial and ethnic groups that are higher, African American, American Indian and Alaskan Native, whites are low and Latinos are sort of in the middle. But you look at Cubans, they're actually doing well, and then Mexican Americans, Puerto Ricans are about at the same level as the worst racial and ethnic groups. Bed days for illness in the past year, more or less the same pattern. And then going a year since the last physician visit, same sorts of things where you see these subgroups either meet, or in this case, Mexican Americans exceed the differences in the major racial and ethnic groups. And you see this in study and study, one after the other. And I'm only going to touch upon a few. Dr. Perez-Stable mentioned the STOOL Study, and this is the slide. It actually looks very complicated, but I'm going to draw your attention to a couple of key findings. So when you look at hypertension for example, you see a low in South Americans of about 20%, and this is in males, and then the high over here, is actually in Dominicans of 33%. Same thing with females, you see lows of 16% among South Americans, and then a high among Puerto Rican women of 29%. When you go to smoking in males, you see similar disparities within Latinos. So Dominicans have the lowest rate of smoking at about 11%, and then three times that rate in males who are Puerto Rican at about 35%. When you look at females, you can see really big differences in obesity rates. So about 31% for South Americans and Puerto Rican women are 51%. And then take a look at diabetes, and you see a low of 9.8% among South Americans and Puerto Ricans are at 19.4. And then this is another study where I've broken out the diabetes subgroup disparities in the U.S., so if you just look at white, African American and Latino differences, you see whites are about 7%, African Americans, very high at 10%, Latinos are 7%, so they seem like, that's not so bad, right? But then you break it down by group, and in this case they had a number of groups. You see South and Central Americans actually have a very low rate of 4%, Dominicans are also fairly low at 5%, Cubans, then you jump up to 8.8%, Mexicans are equal to African Americans, 10.2% and Puerto Ricans are actually the highest. So if you did not look at these subgroups, you would think, ah, Latinos are doing pretty well. Here is a study on cancer mortality disparities in Florida, so you're looking at the rates per 100,000 population. And in this case, as has been alluded to earlier, you see whites, of course, have a very high rate whether you look at women in pink, or sorry, women in orange and men in pink, and it's you know, 253 versus 376. Latinos, they look like they're doing well, 170 and 290. But, again, you start with Mexicans and they're actually doing fantastic in comparison, but then as you go to other Latino, unfortunately they clumped a lot of the groups, and then Puerto Rican, you get higher. And then by the time you're at Cuban, you're actually getting pretty close to the white rates. So again, if you just looked at Latino, you would think they're doing all right, but you can see the subgroups have some fairly dramatic differences. And then, I believe this is actually a CDC study, this is on HIV mortality disparities, this is the age adjusted HIV death rate per 100,000. And you look and you see that whites, of course,
have the lowest rate, about 11, African Americans have the highest at 122, and Latinos, again, they look like they’re doing all right, about 28. Break it down by the groups, and you see that Mexicans are low, as well as South and Central Americans, about 17 or 18, Dominicans are also fairly low, 19, then you get the Cubans, you’re up to 36, and Puerto Ricans, you’re almost to the African American rate, you’re at 101. So, again, but just looking at this, you would miss all this richness. So, in conclusion, 16.4 million Americans, so that's 1 in 18, are LEP and speak Spanish. Language problems impact multiple aspects of health care, access to health care, health status, use of health services, patient and clinician communication, satisfaction with care and quality in patient safety. LEP is the most helpful data source in assessing impact of language on health and health care, but most hospitals and medical practices do not collect any kind of language data and LEP data rarely are collected. No nation surveys in the U.S. collect LEP data. And a review of major medical journals documents that 74% of studies exclude LEP subjects, and the most common reason being not having thought of the issue. Substantial health and health care disparities exist by Latino subgroups. So these subgroup disparities may equal or even exceed those among the major and racial ethnic groups. And failure to collect Latino subgroup data can result in adverse consequences, which include over testing of low risk subgroups and under diagnosis and inadequate treatment of high risk subgroups. And finally, implications include to ensure optimal health care quality and outcomes, ethical care and equity, data on languages spoken at home. LEP and Latino subgroup should always be collected for all patients and primary caregivers of children, on national surveys of health and health care, and in health and health and health care studies. Thank you.

>> Well, thank you. And thank you for sticking around after lunch. It's been a long day, so it's great to see a lot of very multi-variant participants. And I want to say that [inaudible] have been very nice, you know, calling us [great] experts. I don't consider myself to be one of the best experts, I consider to be a very, very persistent person in terms of dealing with looking at this issue. So I think the representation by Dr. [Flores] has been excellent in terms of he's really done a great job in presenting some of the issue related to research and clinical care and data collection and language access, issues related to those areas. So now I want you to start thinking about more in terms of what does it mean for public health and particularly public health surveillance. At the CDC public health surveillance is one of the main activities or the base for many of the public health actions that we do. So I'll just be talking about the issue of the importance of migration, when you're thinking about Hispanic health, and actually about the health of the U.S. population in general, the importance of including Latinos in national data systems, in particularly surveillance data systems. What are some of the ethical considerations? And finally sound recommendations. So we've been hearing a lot today about the tremendous diversity of the Hispanic population by national origin, culture, language, place of birth. But I think one of the areas that's frequently forgotten, but sometimes it's mentioned, is the importance of immigration and Latino health. Immigration is one of the main driving forces for the increased race ethnic diversity in the U.S., in particularly for the increased diversity in the Latino population in the U.S. Not only the immigrants, but also the children of immigrants born in the U.S. And even though migration is considered to be one of the main demographic factors affecting health, including fertility, mortality, I believe it's frequently forgotten when we think about public health and in particularly in data collection in public health. Here I want to highlight, besides some of these diversity and Latinos include indigenous populations that mainly speak Spanish that have been mentioned in the past, you know, so often Latino populations. So when talking about migration or migration related factors or variables and you're specifically talking
about place of birth, that usually means the country where you have been born. For Puerto Ricans it will be if you were born on the island of Puerto Rico or born in the continental U.S., very different health issues, very different populations. It also includes how many years have you been living in the U.S., specifically for the foreign born. Immigration status is a very important immigration related issue. Are you a citizen of the U.S? Are you not a citizen? Are you an asylum seeker? A refugee? Undocumented? Very, very important significant impact on health in populations. And finally, language. We hear a lot about language. I know we're talking as much about language data collection, but focusing elsewhere or adding a discussion of importance while providing language access to people who don't speak English from a public health surveillance point of view. So just to get this straight one more time, we can show tons of graphs and numbers and tables, but I think this kind of slide tries to illustrate some of these diversities within the Hispanic population. Here, you see an example of Mexican Americans, you have three individuals may consider themselves very likely Mexican Americans. One of them is born in the U.S., is a U.S. citizen by birth, he speaks English and speaks very basic Spanish. The one in the middle, she's born in Mexico, she has a green card, she's a legal, permanent resident, has been living in the U.S. for 10 years, she's a long term resident and speaks Spanish and very, very basic English. The third one is a woman, also born in Mexico, she came as a child, as a companion minor looking for asylum and she's been only two years in the U.S., she speaks [Histeco] a native language from Mexico, doesn't speak Spanish, doesn't speak English. So a tremendous diversity within this. In this example, in terms of life experiences, exposure to different cultures, health, issues in their countries of birth and also in the U.S. and also in communication needs, even just the language that you will communicate with those individuals. So with the 54 million Hispanics, a few points I want to add, because there is a loud misconception that all Hispanics are Mexicans, that Hispanics are foreign born, or undocumented. In fact, 65% of Hispanics are born in the U.S., 35% are foreign born. Those born in the U.S. include about 8.5 million Puerto Rican from the island, born in the continent. Also, 76% of all Latinos or Hispanics in the U.S. are U.S. citizens, the rest are many other types of different immigration status. Now we hear about a very high proportion, 3/4 of Hispanics speak just Spanish at home and 1/3 of Hispanics are LEP population. Now why migration, I'll make the case for why migration is an important factor to consider, interest of data collection particularly. More and more migration is identified as a specific and individual social determinate of health. It's a marker of social vulnerability. There are many issues that affect a migrant that interact with race, ethnicity, poverty and other indications of vulnerability. And I believe that they have to be considered together with these whole more traditional indicators or social determinants of health to really give a good picture of what are the determinants in health of populations. Immigration also tremendously affects access to care. Just by migrating, frequently the risk of breakage and the continuity of care for a number of conditions your practical access to care might be very different, depending on where you have been born. This is a very important factor, access to care and quality of care. And also, it's a very important factor in disease risk. If you're born in the, in Mexico and Brazil, the environmental infectious diseases in elders [inaudible], etc you might be exposed in other countries might be very different to those in which you're exposed here, and by migrating then you might have a combination of both types of exposures. It's very, very important to account in terms of these risks. Neglected diseases, like Chaga's disease, they have a higher burden for foreign born populations and by the way they are monitored in our national surveillance systems. Other diseases Hepatitis B, or Hepatitis C, sorry and more frequently in the U.S. born Latinos. Migration data is also very important to identify health disparities, I will show you in a moment, not only analyzing the data by Hispanic origin, but you are adding information about country of birth or being foreign born or U.S. born
that will really help you identify some additional disparities that you might not see otherwise. And, finally, this is not just an exercise on making more and more complex maps and talking about all these different populations. Really, I think, that the objective of collecting this data is because we are allowed to identify those disparities for a specific populations and then you can target a specific of the limited resources that we have to a specific population that has the highest burden for those conditions. So it's really collecting the data is a way to have more cost effective, targeted programs to go where the poorest are and where the most underserved populations are. And this is an example Dr. Flores mentioned before, the differences between Hispanic origin groups and health insurance. So this one is going to, one is to an additional step we need to take, if now we break this data by U.S. born versus foreign born, we still see that Latinos have lower health insurance level compared to the white, but then for an, also we see that the Mexicans, among the Latinos, have the worst access to health insurance a percentage that don't have health insurance. But I think it's also very, very obvious from this data that for every single race ethnic group, the foreign born has lower health insurance than the U.S. born population, including the whites. But also that we see that foreign born Mexicans have almost 5 times, or in the case, almost double the disparity in access in health insurance than the Mexican born population. So by adding this additional piece of data about the place of birth, you’re able to further identify population that have even greater disparities that you can’t identify just by looking at race ethnicity or race ethnicity and origin information. When I talk about the need to provide language access, what do we mean by that? And first, I think we’re talking about the need to provide data collection instruments in Spanish, at least, now we’re talking about Hispanic populations, but we should consider obviously other languages there, too. Just by translating the instrument frequently is not enough, but it’s a lot of cultural, different cultural meanings of words. Many societies will have certain words that we use in English, and there’s no direct translation, there’s no specific word to translate that. So beyond the translation it’s really ensuring the equivalence that the questionnaires have the same meaning for different cultures is very, very important to get the quality data that you need. This is particularly important, again, for Latinos, because we hear there is a lot of high proportion of Latinos are low literacy, low education, so it’s more important for those populations. Having the documents, or a Spanish translated document may not be enough. It’s very important also if you have the possibility if you can do it and have an interviewer to actually ask the questions in that language, a bilingual interviewer. And, again, it has to do with low literacy of the populations. And it’s a way to really for the interviewer to ask the questions properly and to really consider all the indigenous languages. Proper culturally appropriate outreach is very important, too. That means, some things that we know that we need to do, working with the communities, engaging the communities, working with the community based organizations and the leaders, we gain their trust so they’re more likely to participate in our data collection systems and to provide honest information. Now this is just a rough example, it’s an illustration, because I want to show you how a person who is limited English proficient, May, who is being interviewed in English by an English speaker using an English language questionnaire, this is not true, this is not how our questionnaires look, how that person might hear. He might hear question one, okay, he's going to ask me a question, did you ever blah, blah, blah, blah, blah, blah, blah, yes, no, don't know? I understand the last part. Okay. So what do you think are the options for the limited English proficient person? One, doesn't want to participate. Say, sorry, I can’t. Second, even worse, the surveillance system of the national data source might say sorry, we don't have a translator, I'm really sorry, good luck. Third, they may answer, but they don't understand the question correctly and they might provide you the wrong answer. Actually, you have a 30% chance of getting the wrong answer.
this is just a way to illustrate, this is not something that we're talking as an abstract idea or even something nice for us to do, I consider it to be a tremendous necessity and also a very, very important ethical issue, as we will talk in a moment. So, by not providing language access to this large population, for Latinos it's about 30%, for all populations even higher, you are going to have a lower participation rate in your data collection, so people are going to participate less, particularly in areas like California, like Texas and others, where you have even higher proportions of LEP populations. Secondly, the population that participate in your data doesn't represent the actual population, because who are more likely to participate, U.S. born, English speakers, foreign born, highly educated, better located, better access to care, and these are the people you're going to be learning about, so how are you going to identify disparities of the most vulnerable if you're not even including those individuals in your data collection? You're really shooting yourself in the foot, or living in a kind of an ideal, non ideal unrealistic world. The data is going to have lower quality because a person's going to respond whatever if they don't understand your questions well. They may refuse to answer certain questions, in order they won't respond, so you have missing data, more than you could, and your studies have been proven that are likely going to be biased. So effectively, by not providing language access, we are making large proportion of the U.S. population invisible and also the data that you're collecting, your evidence that you're going to be using for policy and for funding are going to be likely to be biased. So everyone has to think about that. Why we think about the cost of doing something? There have been a number of assessments done on a national level and Dr. Flores mentioned some examples of the availability of data and race, ethnicity, language and migration general, they have identified there are many gaps in the data and also gaps in the quality of data collected. We also did an assessment, and we are ready to publish. We look at 130 data systems used by the CDC to conduct public health surveillance. Looking at do they collect any of these variables. We found that the majority collect at least the basic Hispanic, non Hispanic information, 82%. But only 20% collect in more detail granular Hispanic origin data. 11% collected any language question, any, you know, language spoken or primary language or language interview, anything. Place of birth was collected by 30%. We were surprised positively. Years of resident, 16, immigration established, 11, and [inaudible] Spanish, only about around 20% of the 130 data systems are used in the CDC to monitor disparities and to assess the health of the population and to respond to outbreaks, emergencies, etcetera, etcetera. So major gaps. So what does that have to do with public health ethics? As we mentioned many times, this data is very important to identify and address all these different needs of these different populations and better use the resources. You also, by collecting the data, you can learn where the language and cultural needs of your population so you can better serve those individuals, and they're more likely to follow your recommendations in terms of taking a specific health actions. Also, you will be better to identify inequalities, meaning unjust health disparities based on lowest quality of care being provided by specific groups. Maybe the Latinos, overall, don't have inequality on certain specific access to care services, but maybe the Puerto Ricans are, or the Mexicans or the Mexican immigrants are. So only by collecting this data you can identify the specifics of populations that might be suffering inequalities. And something, I think, we need to be thinking very seriously, if we have a pattern of systematic exclusion of certain populations based on language, based on national origin, or in other important social factors, does it go to the label of are we conducting discriminatory actions in terms of the way we do public health? Okay? Language access, again, this is discrimination if we don't provide language access. Basically of the three, these three individuals represent all the Latinos in the U.S., you will be saying to this lady on the left, sorry, we cannot include you in our data operations system, because we don't want to use the resources to translate our
materials into Spanish. We heard of the four Dominicans, it's about 40%, Central Americans, the largest populations in the U.S., 50% of the population. For Asian, it's about 50 to 60% of certain Asian groups, like Vietnamese and Chinese are also LEP. So tremendous, big groups of populations. Again, if we're doing it in a systematical way, we're excluding these individuals, does it amount to discrimination in the way that we are collecting data? And this is a very, very important ethical issue to continue this custom. So additionally I want to mention, many minds embraced, many of the population that we are talking about are highly vulnerable populations. Some of them are probably, I would make the case, are some of the most vulnerable populations that we have in the U.S. There is a high proportion of individuals, particularly immigrants, Latinos and Asians, who are victims of human traffic. The U.S. is one of the main destinations of human trafficking. This is what's called modern slavery. So these are people that are being enslaved for sexual work, and more and more we find evidence for forced labor in agriculture and other places. So very, very extremely vulnerable populations. Unauthorized immigrants, asylum seekers, indigenous, very, very vulnerable population, that is been more important to try to minimize the risk, particularly the risk of disclosure of information about these individuals so they won't suffer social stigma or they're not being identified by immigration. We have, you know, many of those legal consequences for participating in our data collection systems. We have very, very strong confidentiality and privacy rules. I think, again, because we're talking about collecting what could be sensitive information. Right now, particularly in political environment, where you have a very, very negative anti immigrant environment, people willing to admit I'm Mexican, good luck. People admitting I am Arab, is not easy, it's a very, very sensitive information right now. So we have to be even more careful that we are [in regular circumstances], but we have ways to tell them the way that we protect the data and protect the information of the individuals. And also to provide autonomy of the individuals who participate in our data collection, given that these are our vulnerable populations. I think ensuring that a community participates, by the community I'm talking about the general U.S. community. We're talking about minorities. Minorities have to participate in the different aspects of data, design, analysis and reporting, in that the data benefits really the communities that need it. I had an experience where data is collected from the poorest and then the resources are going to the people who are working where the resource is actually at. So, really the data we collect had to benefit the population more, the more needed. Cost, we don't think it's an excuse, it's an enough excuse not to do anything. We cannot do everything that we could or should do, but I think that definitely there are many good practices and physical strategies that we can implement with not a lot of additional resources. Again, I really think it's going to go to benefit us. There are many experiences of distrust in minority communities, in African American, Latinos, of unethical research and unethical data collection and experiments. It's even more important that we regain and maintain the trust of the community to again, to get for them to participate in our data collection. And they benefit, also, from what we are trying to do for them. So what needs to be done? Oh, this is an older, I don't think I have them anyways. So, and what we need to do now is based on this presenter and the co-author, we have very, very strong, excellent guidelines in the U.S. about what do we need to do. And actually those guidelines, some have been, I think, recommendations have been in place for decades. There is 2011 HHS's data standards, that actually said that we should be doing what we've been talking about today, gathering our data, language data. Yes? One minute. Unfortunately that only applies to public health surveys. I think that it should apply to all data collection systems. The national cultural and linguistically appropriate services guidelines do not only apply to health care. They also apply to public health programs and apply to epidemiology, and for me that means that it applies to surveillance. So, data in promoting cultural and linguistic data
collection, translation and interpreters also apply to surveillance systems. Let's recognize, even though this allowed recommendations of how to collect this data, migration [related] variables that we've been referring to before. And, to conclude, I think there is a very, very strong consensus of what we need to do. We need to collect the data that we have been talking about today. We, also, it's very important to provide language access. This recommendations could apply, should apply to most data collection systems. Very feasible, that we have very good examples, it can be done. Recently, the national [inaudible] country of birth, a number of surveys collect data in different languages. So we know how to do it and we know that it can be done. And, finally, we know about the consequences our data is going to improve. It's going to improve the quality and the capacity to monitor at risk health disparities, these recommendations are based on ethical and social justice, principle, is it something that we're going to do because we're nice, or just because of research, and also base recommendations also critical to implement and to eliminate certain health disparities in the U.S. and to improve the health of the overall U.S. population. So I want to stop here. Thank you, very much.

>> You know, we've run out of time, but I have two questions, and we'll conclude.

>> First of all, both excellent, really great presentations. This question is for Dr. Flores, and has to do with the role of LEP. And, you know, one of the findings that we had in vital signs was that Hispanics have a higher rate of death from liver, chronic liver disease, and so the question is whether LEP can play a, maybe playing a role in that, this higher rate of liver disease from, you know, lack of understanding the instruction of a label? So, for example, over the counter pain relief. You know, people think, oh, one pill works well, maybe I'll take two or three, not clearly reading the instructions or understanding the instructions that we in English. And I was wondering what your thoughts were about that?

>> Yeah, it's a great point. And, I think, LEP affects every aspect of that person's medical care. By that, I mean, okay, I need to call for an appointment. I pick up the phone, I call a clinic or a hospital. Very few hospitals actually have a phone tree that allows you to go to any other language, even Spanish, sometimes. Then you get to the clinic, do they actually classify you as LEP and say okay, you need an interpreter? A lot of times they don't. Or the family may be embarrassed and say I don't need an interpreter. And then can you get an accurate history on somebody if you don't speak their language and you're not even using an interpreter. And, again, unfortunately it's really dramatically bad how infrequently people will still ask for an interpreter when there's a language barrier. And so can you get a good history? And then can you do the right procedures? Can you send them to radiology and have them do what they need to do? Will they follow up with you, is a great question. Sometimes people have the interpreter come, they'll have a great encounter, they'll give them a prescription, and then they won't have the interpreter accompany the parent or the family to the registration desk and get a follow up appointment or that specialty referral. Public health, I don't need to tell you, how can you communicate to populations if you're not communicating with them in their language? How will they know that they need to get the hepatitis B vaccine? So I think there's so many levels. And we know that a lot of Latinos will present much later in their disease course, probably for all of those reasons, including language barriers, so they're going to have more advanced disease, which is harder to treat,
and they’ll have high mortality rates. So you can really see how this is costing everybody, not just LEP and Latinos, but everybody, because it increases health care costs and it increases mortality.

>> Last question.

>> I also have a question for Dr. Flores. In alignment with what Dr. Rodriguez Lainz said about benefit to the community as an ethical issue, you talked a lot about not excluding LEP. Would you want to say anything about inclusion so that the results would be meaningful for that sub population and a benefit to them?

>> So whether, what the benefit is to the population of including them in the studies?

>> That having enough, large enough sample size in the study to actually draw some conclusions.

>> Yeah, so they're out there. It's just that researchers don't make the effort to sample them. And so, I think, part of the implication of your question is are we getting representative biopsies, if you will, of populations when we don't integrate LEP patients into study protocols and into surveys, and can we really draw the kind of conclusions that we're drawing about the populations because we're leaving out a huge component. And we're talking about, it's about 10% of the U.S. population. Yeah. Did that answer your questions?

>> Yes.

>> Okay.

>> Let's thank this powerful panel, please.

>> On to our next panel.

>> Well, good afternoon. I'm Maureen Lichtveld, on a day to day basis I'm professor and chair of the Department of Global Environmental Health Sciences at Tulane University School of Public Health and Tropical Medicine. I'm proud to be a former CDC'er. But today, I'm here as the President of the Hispanic Serving Health Professions School. And with me are three distinguished speakers. The purpose of this
panel, truly, is to bring it all together for you. This is the SWAT panel, if you want to translate it in a popular fashion. All through today I've been identifying the priorities that our speakers have mentioned. And so we'll ask you after this session, during the break, to use your little colored dots, green for very important, yellow for important, but something else has to happen, and red for we have to hold on that. So work with us through that. The three distinguished speakers today, in this panel, are Mr. Guesnerth Josue Perea, he is the communications coordinator of Afro Latin forum. We had an excellent conference call, our speakers together, and Mr. Perea is also the co-founder of Afro Colombia New York, where he is promoting the Latinos of African descent. He has been praised for doing so much of this so much so that he has been quoted by the newspaper in New York as one of the Colombians making a mark in New York City. And it's not easy to make a mark in New York City, so. He holds degrees in Latin American history and in theology. Our second speaker is Dr. Norma Perez. Dr. Perez is, holds medical degree from the Universidad de Monterey in Monterey, Mexico. She is, she hold a doctorate in public health degree in international health and family health from the University of Texas, Houston Health Sciences branch. She's the executive director of the Hispanic Center of Excellence at the University of Texas Medical Branch in Galveston. She holds faculty positions in internal medicine, geriatrics and preventive medicine. She's the executive director of Frontera de Salud, a student organization that provides free care for residents in the lower Rio Grande Valley. But most, closest to my heart, is she's my partner tied to my hips as the Vice President of HSHBS. Our third speaker is equally phenomenal. He, Dr. Rafael Sanchez Cardenas earned his medical degree from the Universidad Autonoma de Santo Domingo. He has a professorship in social and preventive medicine. He has been a professor in high schools, but he's also been a physician in hospitals. But we welcome here, very distinguished as his excellency, the vice minister of international relations of the ministry of higher education, science and technology in the Dominican Republic. I think he's closest to the Tuskegee because globally, Dr. Cardenas promotes the learning outside, learning globally for his students and has two degree programs at the Tuskegee. And so I will, at the end of the three speakers, bring the whole forum together for you. But before that I will turn over the podium to Guesnerth.

>> Good afternoon, everyone. My name's Guesnerth Josue Perea. I'm the, as Dr. Lichtveld mentioned, the director of communications and programs for the Afro Latino Afrolatin Forum. The Afro Latino Afrolatin Forum is a non profit that focuses on emphasizing the importance of race, when discussing Latinos, specifically to discuss that about U.S. populations and to make sure that we're highlighting the race question and race issues for Latinos here in the U.S. And I want to just quickly give a shout out and thanks to Dr. Liburdl and Julio, who have been a great [contact], and Dr. Warren, who we've made connections and that's why we're here. Also glad to see Dr. Lopez, with whom we're working with on a few questions. So what I'm going to talk about is, so a little disclaimer, I am not a health expert. So, just know that, right? So for us in the Afro-latino Forum, and for one of the concerns that we have is that race and ethnicity, for us, are two separate issues that count very importantly and very independently. So that's what I'm going to talk about first. The designation, one of the issues that we have within the Latino population is that the designation Latino, and we use [arrobas] and you see the at symbol, like why is he using the at sign? We use it to delineate gender equality. In Latin America, many groups do that, so it's not like we're the only ones. We're probably the only ones here, but. The Latino population is, the designation Latino or Hispanic, does not fully capture the social and economic inequalities that contribute to the high incidents of certain health concerns, especially among what we call subgroups,
Latino, Latina subgroups. So we can look at say, well, okay, Latinos, and I think everyone here agreed, because everyone has said that, right? We need to further look at the population, we can't just over generalize the Latino population. That's important. But there's a need to improve physical reporting to properly identify particular health situations among, and for our focus Afro Latinos, but individual Latino subgroups. So one of the main points that we've been talking about today is the importance of subgrouping at a national level, and, I think, that that's good, right? We talked about subgroups, we talked about nationality. But I think another very important point is to look at the racial diversity within those subgroups, right, within those, what we are calling subgroups, right? Data points are needed to track how Latinos are being identified, and for better understanding, the conditions within the Afro Latino community, and particularly in other communities within the Latino Pan ethnicity, right? So Latino, Latina, Hispanic are pan ethnic terms. Pan ethnic meaning they're already grabbing broader ethnicity's and lumping them into one. So our emphasis, and our focus, and our challenge, not only as panel, as people who are attending this forum, but as people who work in the public health field, or in the education sector, or in the social justice sector, is to look at those distinctions within the groups and to further into parse out this pan ethnic term, to look at certain situations more holistically. The experience with those sub communities, or subgroups, as we are calling them, especially when consider Afro Latinos in particular, and other Latino groups, effects access to health education and also effects the outcome. And I think that that's an important point. We have to count the experience of the communities. Not only are we looking at, not only are we looking at certain generalizing factors, but we have to look at access, social economic factors, locality, education, all of these contribute to health and education, health education and also outcome. I'm holding a paper here by Dr. Vora [assumed spelling]. Dr. Vora, she's based out of Lehman College with some other colleagues, and she says that she did a study on hypertension, and her study on hypertension said that the Spanish and the Puerto Ricans and the Dominicans have a greater probability of reporting hypertension than whites, are more significant and are more similar to reporting from blacks. Why would that be? It is worth noting that Dominicans and Puerto Ricans have the stronger, have stronger African ancestry exposing them to racial discrimination. So when we're talking specifically about hypertension in her paper, when she talks specifically about hypertension, she's trying to emphasize that racial discrimination by phenal type, right, by race, is what contributes to a higher self recognition of hypertension, which we would not be able to look at if we just say, well, let's just look at how Puerto Ricans identify. Puerto Ricans identify in x number. Dominicans identify in x number. Sure, but let's look at that population more accurately. Also, black Puerto Ricans identify as 66% suffering from hypertension due to racial discrimination, versus 20% or 10% from white Puerto Ricans or white Dominicans looking at that situation. And she concludes in this, and this is a very important point, in fact several studies have underscored the importance of race or skin color among Puerto Ricans and Hispanics as a whole when it comes to health outcomes. So I think that, those are current problems, and that's why we labeled this part current problems. The current problem is that we either have, and I'm going to come to some solutions later, but I think we have a lack of understanding or a difficulty in understanding the diversity within the Latino population. I was really glad to hear Dr. Rodriguez Lainz used the term Afro Latino, as the first speaker today that used the term Afro Latino, even though we've all spoken about black Latinos in different ways. Using the terminology also matters in how we're looking at groups, using different terminology and using language that communities can understand is a very important part of this situation. So some of the problem is that we don't fully understand the Latino population. I think everyone here understands that the Latino population, the Hispanic population is a broad population. I think everyone understands that it has
multiple ethnic groups. But I think it's insignificant to only look at nationality. I think that we need to look within nationality at race problems. And I think that although we can, you know, I know that in biology we go oh, well, it's about genes, I think that's a part of it. But I think racial experience has a big, a big, it's a big determinant to health access and health factors. So what are some of the implications? And she wrote some implications here that I really like and I wanted to highlight. The findings for Puerto Ricans and Dominicans have a higher probability when reporting hypertension underscore the need of data collection of health information beyond traditional racial ethnic categories. And I want to highlight that point. I think that it's very important when we say racial ethnicity, race ethnicity, that we use the slash, but they're very different, they're to different constructs. Race is a completely different idea. And yes, we can say race is a social construct. Technically so can ethnicity be labeled a social construct that's not really accurately, that doesn't accurately depict the population. So in order for us to get a more accurate result, or get a more accurate understanding, we need to improve the data collection so that we're able to understand these different categories. And we need to expand that. It's no sufficient, like what Dr. Flores said, it's not only efficient to ask certain questions in another language, which are important, that's very important, but it's also sufficient to ask race questions in those languages as well. And why does that come? In all of Latin American nations, where we come from, there's a census and the race question is in every one of the country's census. We were just talking about that over lunch with a few colleagues. That the race question is already part of the mindset of people who are Hispanic. It's the way that we're asking the question that becomes a problem. Just saying oh, we just need to simplify the question and that's one, doesn't really remedy the situation. She says the other report, moreover the findings associated with nativity status for Puerto Ricans and Dominicans contradict the overall Hispanic paradox, underscoring the diversity of the Hispanic population and the danger of ignoring this diversity when presenting accurate data for the population. And I want to say that that's important when we're looking at specific nationalities or subgroups, right? So if we look at Colombians, we said all Colombians suffer whatever on, whatever enter your health problem here, that situation gets, that situation is going to look differently once you look at the racial categories within Colombian populations. And yet, and the risk of using aggregate data on Hispanics is exacerbated when these data are used to extrapolate the geographic areas in which the highest proportion of Hispanics are now represented by the subgroups with the lowest or highest prevalence, and I wanted to put like blank, insert your ailment here. In this case, it's hypertension. I think when we look at the subgroups and we look at the Hispanic population, we have to be able to look at the data specifically, and I think that that helps us get to more accurate health situations and health solutions. So some of the solutions that, like Dr. Lichtveld said, that we're going to talk about at the end of this capsule session, we need to improve the infrastructure for racial diversity within Latino groups. And then a further code that I got from a research, I forgot the name of the doctor, in Harvard, the U.S. infrastructure for measuring disparities remains inequitable to federal industry levels. And I don't, and that's going to tie to the next point. We need to attract more multilingual, more multicultural people in the health sector in order to do these surveys, and these two issues tie together. So the reason why we don't have good ways to measure diversity within Latino groups, is because we don't have many diverse people conducting or in the rooms conducting questions to measure Latino groups. Right? So Dr. Perez-Stable mentioned that at the beginning, he said well it's only 3%. 2% of the people in the science research sector were African Americans, 3% were Latino. If we don't have a diverse, a body that's constructing these questions, and that's asking these questions and that's forming the research studies, we're not going to have an understanding of why a diversity is needed and asking for diversity is needed for the populations.
Because we just don’t have that perspective. For me, I’m Colombian, I’m Colombiano and I’m black, and so I consider myself Afro Colombiano, and so for me, I already understand that it’s already part of my makeup to understand that I can’t just generalize and say we’re all Colombians are like this. For me, it’s already part of my psyche to look further into segmented populations. That’s not been the case if the people are forming questions or the people who are conducting research are not diverse. So I think that those two issues go together. Right? The infrastructure is wrong. Why? Because we don’t have a lot of people in those sectors. And then attached to this one, too. Accurate reports of race and ethnicity across all sectors of society and policy not accurate, but also standardized. And I think that that was an important comment that Dr. Perez-Stable made one Latino and that everyone else has kind of touched upon. If the census bureau is what delineates what we all use, then shouldn’t, then, we fight against the census bureau measure that’s looking to erase racial categories in the census. If we’re just, we have to norm ourselves because the census bureau says, you know what, let’s just count all Hispanics as one race, but we say that that’s not a good thing? So should we then fight? We can’t just say well, the census said it, so we have to do it. Then we have to be the ones to look at that. And so what, as Dr. Lichtveld mentioned, so what? Number one, I think that it further unravels socioeconomic factors and their connections to health disparities. I think that we have to look at that and that looking at race helps us to look at socioeconomic factors. Every Latin American nation does racial counting in health sectors. It’s not like we’re asking, or it’s not like I’m mentioning some novel idea. Latin American countries do this all over the world, as Julio could probably tell you. You guys know Julio, who spends him time going around the world. All the nations talk about, and as all of you know, who do research tied to Latino populations, most of the nations count race in their health surveys. Equal treatment and access to health care and health solutions for all Latinos. I think someone asked a question about that earlier, about a solution for, about shouldn’t we look at the disparity, but shouldn’t we also try to increase access for all Latinos? I think that it’s both. I think that we need to look at the inequality and we can only look a the inequality once we’re talking about not only nationality and inequality, but also subgroup and also class when we look at socioeconomic factors that contribute to inequality. But also, secondly, yes we are trying to improve health and health situations for all humans. But we can’t ignore that and say well, we’re looking for all, so let’s not look at the, what’s going on with each population. We have to look at each population in order to be able to get everyone to a level. After treatment and remedies for different Latino population. And I think it’s just overall provides a more holistic approach to Latino, Latina health problems, right? In order for us to actually look at issues that plague the Latino, Latina community, we can easily say okay, let’s generalize and let’s look at, you know Mexicans and Puerto Ricans, we can diversify like that. But that’s not the only thing that we should look at. I think that in addition to those points, we need to look at how those populations, how is it affecting racial groups within those Mexican populations, Puerto Rican populations, Colombian populations and so on. I think that another point that I didn’t write here, but something that I wrote from today, is I think that further diversification of the U.S. population is going to lead us in that direction anyway. I personally think that the more and more diverse the country becomes with all the statistics and projections that by 2050, we’ll have a more diverse country than any other country in the world, are going to lead us to have to look at people holistically. So I’m challenging us to be ahead of the curve and say okay, we know that’s coming, so let’s not wait until 2050 or until whatever point to accurately look at different populations. Latino populations are just one group. One article that we contributed to earlier in the New York times was looking at Arab populations and how they also are very concerned about their counting. And so we’re talking here about Latino, but the challenge is going to spread out to other subsets. And I think that one
of the important things that I want to finish with is that deemphasizing the importance of counting race, it's turning the clock backwards for us. So if we deemphasize the importance of race, and we continue to just say we just need to look at subgroups, and subgroups are only national or ethnic origin, and we're not emphasizing race, I think we're turning the clock back to a time when that was an excuse for a lot of different injustices. I think that I would like to leave us with that, that deemphasizing race is not very important. It's actually a detriment to our cause. Thank you.

>> So good afternoon. I, it is with great pleasure that I join you here today. I bring you warm greetings from the second most beautiful island in America. We can't claim number one because it's your choice, either Puerto Rico or Hawaii. So, but we're the second, so we're okay with that. So, actually I'm very impressed by what I've seen and heard today. I'm inspired by our discussions and I look forward to seeing where this all leads. I know that it requires more than one day, and a small group of people to accomplish our goals in improving Hispanic health research and raising awareness of the issues and health ethics involved, so I want to call on Hispanic health researchers, educators and stakeholders. We need a framework. We need a framework for our future scientists that provides a more accurate picture of the complexity of our Hispanic communities. So we need to be open to the idea that it won't be just one framework. Actually, I should have changed this here. But the study of Latinos and the Hispanic EPSE [assumed spelling], I think we've heard it mentioned today before several times of SOL and the Hispanic EPSE, led by Dr. Kyriakos Markides, a very dear friend of mine, and the extensive longitudinal and historical studies from Dr. Dave Hayes-Bautista, also a very dear friend of mine. Those are foundational, foundational studies that give us a place to start in identifying the framework or frameworks that ultimately will help us to find a heterogeneity of Hispanics. So two underlying issues that we must also bear in mind, and this is when addressing Hispanics, that the issues are that we have undocumented populations and we have uninsured populations. So the issues may confound or contribute to skewed data. So that's something that I personally wanted to emphasize and bring to point that those are two things that we should always keep in mind when gathering data from Hispanics. So I put them in scenarios, three, I thought about it, and I said well there are probably just three large scenarios that I can talk about, and after looking at the topics or the titles of the earlier discussions, and I said well, the first one is going to be from my point is a desperate relationship. So when we are looking at large data systems, we must be aware for the potential for misrepresentation that can lead to a desperate relationship. STARS, the Statistical Administrative Record System is our big national database that includes census information. But if you do not have a social security number or if you are not in the mainstream system, you will not be in this database. So the database may include some of the uninsured, but it may not include the undocumented. Dr. Hayes-Bautista notes, he has given, I've been to several of his talks and this is his quote, the problems inherent in modern day U.S. census day, the chronic under count of Latinos, difficulties in defining exactly who is a Latino, responses confusion over not just race versus national origin, but also self identification as Hispanic already were evident in the censuses from 1950 to 1910. So, I have been pretty lucky throughout my career as a researcher starting in the year 2000, working with individuals like Greg Wilkerson, Dr. Lisa Francini and lately with Dr. Carl Eshbach and Dr. Kyriakos Markides and I asked him, I consulted with him, and I asked him can you give me an example, because he works with large data sets, he was a former Texas demographer, can you give me an example or can you talk to me a little bit about large data sets and the under representation of Hispanics? And he actually, during his tenure as a Texas state demographer,
was able to work with the CDC and they were observing or making a report on the lower Rio Grande Valley. Yes, I'm a blame, I did helicopter research, like many of us starting as researchers in the valley, so we know the valley pretty well. And we know that it's actually one of the poorest parts of the country. So he was telling me that one time the CDC had come up with, but everything was correct, just so you all won't start, it's not coming out in a negative tone here, started coming out noting that Brownsville, the lower Rio Grande Valley, was very healthy. And he said, wait, wait, how can that be? And so after obviously going back in and dissecting the data, yes, it was apparent that it wasn't. And so this is just a simple example of, and he quotes working with the Texas Office of Rural and Community Affairs, we found that model data, like the census bureau's area income and poverty estimates that are based on administrative records or general population surveys under represent need for communities with large immigrant populations. A group that is missing from both types of data systems. So there's a big gap. And that was my take on one of the big scenarios. My next one is the numerator denominator mismatch. So the inception of the U.S. census in 1790, Hispanics were not identified separately. For the most part, Hispanics were fit into the white category. It wasn't until 1930 that a category of Mexican was added to the census. It was dropped from the list for the following four censuses. And Hispanic origin was introduced on the 1970 census as a sample item. And it wasn't until 1980 that it was an actual, complete census count. This alone speaks of our reality when interpreting and utilizing data. The Hispanic ethnicity is a true and all American construct, based on our reality that the U.S. is a melting pot. As scientists, we find reasons to form groups and that is to identify patterns. And as people, we form groups to self identify or self identity. Standing in front of you today, it's very important to me to be Hispanic. However, the moment I step outside of this country, I'm not Hispanic, I'm just an American. So in the 12 years of practicing medicine in Mexico, I've never once had a black man for a patient. He was a gringo, to all of us. So because of the inherent flaws in data gathering, we can find it difficult to merge large data sets. We can miss populations and we may overlook local or regional data that could be shared. My final point is privacy. When the affordable care act, more have access to health care, but there is a greater distinction of those that are not legal, thus increasing lack of privacy and health disparity for disenfranchised populations. That is my quote. With the affordable care act and the requirement for health insurance, the distinction between insured and the uninsured is much more obvious. So to conclude, what does this all mean? So what does this all mean? In 2012, the New York Times published an article titled For Many Latinos, Racial Identity is More Culture Than Color. The main point of this article was that across the broad spectrum of people as people who identified themselves as Latino or Hispanics, most base their identity on cultural concepts and did not identify with any of the race categories that the census provides. And I think this is the professor from Harvard that you were mentioning, Dr. Mary Sue Waters, is that her, a sociology processor at Harvard expounds whenever you have people who can't find themselves in the question, it's a bad question. So my, I have, I'm very dear friends with, and that's where my lucky part is, I talk every day, I have readily available the father of Hispanic Paradox, and that's Dr. Markides, and I asked him before he took off to Greece again, because he's always at Greece, he's Greek, you know, Kyriakos, I need help. I'm giving this talk and I know you are, your database, it's wave 9, it's one of the large ones just like SqOULS [assumed spelling], and just like, you know, your history, like David Hayes-Bautista is, do you have anything to share with the people up there at CDC regarding large data sets? And this is literally what he said, he wrote it down in an official letterhead, he's so cute, and he signed it off, and he said, this is what I have to say. We have not yet understood the implications of rapidly growing numbers of older, disabled Mexican Americans with respect to their dependence on their families. There is a need to systematically investigate how high
rates of co-morbidity, disability and cognitive impairment, dementia, are influencing the quality of life of older Mexican American and other Hispanics and what the consequences of these trends are for the quality of life of their families. We are facing a health crisis. We are facing health crisis that have significant social impact. In order to respond to these effectively, I believe, we need to be able to identify them. Thank you.

>> Thank you. I am Rafeal Sanchez-Cardenas from Dominican Republic. What we have here today is related with how can we change the discrimination and the bad situation of Hispanics in the United States. What I'm going to try to give you a glance, the practical situation of the Dominican Republic of the last three years of the government of the Dominican Republic. I took this picture from Mr. Cesar Fermin, and I think it's a good figure of what is happening and at the same time what we need to do. Dominican Republic have territorial 48,000 square kilometer, 9.5 million people in the population, and a GNP in 2014 of 70 thousand million dollars. The income per capita are $7,400. And we've been increasing GNP year by year at a median of 5.4% year by year. The poverty rates have been changing from the 2000s. At that time, 32% of our population were poverty, in poverty situation. By then 2004, we had a crisis, a crack in the bank system that increase our poverty to 51%. That’s something the Dominican Republic never have lived before. After that, last year, the renovation by means of the Economic Commission for Latin America [Cepal] established that the poverty rate at this moment is 33%. So we need to reduce 1 point more in poverty in order to return to the situation we had 16 years ago. The [Ginny Index], as you can see, changed from 0.56 in 2005 to 0.48 last year. Before we get the government, we established that in Dominican Republic we have three important problems related with discrimination, the social discrimination that we have there. The first one is related with corruption, and the second one education, and the third the health situation of a population. As you can see, for [inaudible] all the government never take the money of the budget for education. In 2012, the budget for education represent 1.9% and after without the government will increase in a [colon] with the civil society to 4% the budget for education, without the money dedicated for education. And that is the point that is changing a lot our education that as everybody have insist during this meeting why Latinos do not speak Spanish. And that represents a real problem from health, not only for her but for jobs, that is important things to have help and to have education. If we don't know that in a society that only speak English, how can you take advantage of the opportunity that that society offer to a citizen. It's a real problem that we have in the United States. But where you come from, from countries that speak Spanish, most of them, but at the same time, the separation of the education that is the main truth, my president, he used to say, that the new name, the education is the new name of freedom. And I can say after hearing all the people that have speak here that it is true. In my society, the higher class do speak English, sure. This is not a problem for them. The problem is related with the poor population of our country. Because my son go to a bilingual college. So there you have problem with that. But what about most of the people in our countries? They don't have it. so here is the problem. Social justice. The [inaudible] in 2011 were 6years. And in 2014, increased to 8 years, the million. The illiteracy rate 40% in 2012, it reduce to 6% last year. And we are expecting, at this moment, that perhaps finishing this year, that it is going to declare the Dominican Republic free from illiteracy. That's because. That's because of the 4% in the budget for education. The matriculation of primary school that were 95% in 2012 increased to 99 last year. But here, an important problem of our education before we [inaudible], the number of class hours per day that children received were three hours in 2012. That means that we had
to change this equation, because each school, each building was divided into three. One in the morning, 3 hours, one in the afternoon, 3 hour, and one at night, 3 hour, too. So how can those children receive a real education plan? Impossible in 3 hour. So we changed the curriculum and increased the number of schools in order to give our children 8 hours a day, not only for science and language and history and social studies, but sport and art. This is a way to increase the spiritual capacity of people. The number of classrooms were 29,000 and we increased it to 49,000 just in three years because of the budget. [The classroom attendance were 3 hours, as I say, and we increased to 8 hours. But we have a diagnosis established that children abandon the school and in other case do not understand what they were receiving by the teachers. Why? For social reasons. Not for intelligence capacity. They don't have the good food before going to school, they don't have shoes, they don't have book, they don't have uniform to go decent to the school, they don't have backpack. So if you think in people in that the programs that you receive in your desk, you have to change the situation. We need to put our children in the school, in the classroom, so if they need food we are going to give food, shoes, uniform, text book, all they need in order to put them in condition to receive the education where they have the right to receive. That's what we need. That's why we are changing all the rates in education at this moment. Just in three years, because of inaudible. But at the same time, 5,000 teacher receive program grants in three years. The teacher's salary increased from 26,000 pesos to 47,000 pesos in three years. But at the same time, those teachers who have a masters or a PhD receive a more incentive. One of our most important action to inspire the modification of the curriculum and the support to children and expand the time in the school is the international program grant that we are supporting nationally. This permits us, for the first time, to send students to Tuskegee University where I'm coming signing an agreement recently. But we have more than 10 agreements with U.S. universities. We are sending more than 2,500 students to make masters and PhD programs out of the Dominican Republic. So I fly all over the world looking for agreements with universities and institutes in order to modify the quality of our human resources for teaching and to make science actions. Tuskegee is a very important and well related with the act we are having today, it is, let's say, a black university I really, I know when I was studying medicine here about the syphilis program there, but nothing more. Now I can speak a lot about this university and the importance for Dominican Republic. We are diversifying the university where we are sending the students and teachers just to receive from the Dominican Republic not one version of education or one version of science. So we send a student to Korea, to Japan, to Singapore, to Russia, to U.K., to France, to Spain. Spain was the first country where we signed a student, of course, they speak Spanish. But we discovered, in this process, that bilingual, as you have demonstrated today, is a necessity for the war of the future. So we open at the same time, in the Dominican Republic, five immersion programs in language. English, where every year we got rates 10,000 students in English, in an intensive course. German, French, Portuguese, Russian and now we are beginning with Mandarin, because Chinese are very important today. One of the most important programs that we are developing is the so called surprise visit of the president. This is something that I'm sure you never hear about. For me it's an innovation. I've been invited to this visit. And this proper policy in the poor people of the Dominican Republic, essentially in the rural sector, where live the poorest of all. This is the picture of the president talking with the farmer, addressing the farmer, with three person, four person, as you can see, no more. Only a body guard. It's a proper policy in three dimension, credit, technical assistance and cooperative in association promotion. Why this policy? Credit is a right all over the world today. Everybody cannot depend on the action of the government, so it is recognized the importance of the entrepreneurship action, to promote the initiative, the private initiative of each citizen and to obtain all
the benefits that his [inaudible] and action can provide to a family. So we increased the credit from 11% in 1991 and reduced the [during the] financial crisis to 3%. But now, last year, we increase it to 20%. Perhaps you don't understand what this mean about the social disparity that it represents. The financial crisis destroyed almost all the rural sector and the urban sector. We increased from 30% poverty to 51, as I told you. With this program, we get traded, but at the same time, before the president get the farm, the technician go there [economists, farmers] and social workers in order to discuss with the community what they need, and at the same time to establish, well establish what they know to do, what they have there. And then come the president in order to discuss vividly, as you can see, in a minute where the president is sitting down in front of people in a plastic chair just at a matter of the people and begin one of the marvelous discussion that I have ever hear and see in my life. Everybody talking, everybody giving his opinion. And he trying with some support to give the answer they are needing. But with a condition, a farmer in the Dominican Republic represent more than 90% are of from 2 to 10 acres. How can they produce so much product with such a farm? Impossible. They need association. And we, the president said, okay, I have the money for you, but you have to increase the number of these associations to double. And usually two weeks after they are prepared to receive the money in this technical support about that you then state, well, at this moment, as you see, we reduced 11% in 4 years the poverty of the Dominican Republic. And we have harder initiatives on the way to dig in these policies in order to keep on reducing poverty in the Dominican Republic. But at the same time to bring forth the access to education. We have 99% of our children at a school. If we keep the children at a school in better condition, because Dominicans are intelligent, of course, I think in 5, 10 years we are going to have a new generation of educated people that are going to continue what are we doing here. This is the reason why the president said education is the new name of freedom. And I think it is true. We have, what we have learned, that a combination of universal public policies, like a macro economy stabilization, pay attention to this Latin America, if we reduce 11% poverty, but we miss the macro economy establishment, we are going to come back again. And that's something that you usually see a lot in America. But at the same time, we need sustainable social protection. At this moment, 85% of the population of the Dominican Republic have a health care insurance. And we think that in 2 years, 100% of them will receive the ticket, the [carnet] for the social protection. Let me remark that the cooperative relevance of the association in our country, it is the social capital that can change a tradition in the distribution of land, but at the same time reduce one of the genetic competitiveness of today to know how to work as a team. Even in research, we need team today in order to improve our knowledge. That's what you are doing right now. What is missing? I think that based in public policies and research outcomes it is a very important action in order to give light to our problem. It is very important. That's why we are implementing it in a national program for [hospital based courses]. Know that you give support with a critical mass to our process. We have to be more efficient in this, what are you planning. It is common that we see the next step, but we don't think in Latin America about the future. There is the only way to see the future [inaudible] to give a large goal to our identification. Thank you.

>> Okay. Yes. I've, I have one slide. And if everybody make sure you have your green, yellow dots ready. So I want to bring it all together for you. And this must be a very familiar framework for Dr. Liburd. We were quite honored to publish this special issue on health equity. So if we look at this as Hispanic health equity, then where does it leave us? Science is for not if we don't translate it into policy. I'm glad the the 5 minutes that ended with policy, because that's not a lot of what is covered today. But yet it is really
policy that will bring equity. Not all the science we have. The application of policy, in turn, has to inform science. Now science also will not influence practice if the science doesn't lead to risk reduction. We've heard a lot about risk factor analysis, but if that doesn't lead to risk reduction then practice can never be good surface. At the same time, practice must inform science so that we don't do science for science sake, not the nice to do things, but the must to do gaps. And that comes from a practice based, a front line driven, a community participatory driven gap analysis. And so before we even can start implementing practice, implementing policy and monitoring practice, we must deal with the issue of equity. Science can never equal health without any of those three. And so I bring this together for you, and looking at the priorities that we have, asking you to help us identify, prioritize those major issues for us, but keep in mind this framework, the three foundations of public health. Thank you. And so we'll take some questions now while you're going through this exercise. So questions for any of our speakers? The priorities are on the wall, and I'll be adding a few more based on this panel's exercise. Yes, please.

>> Hi, good afternoon. My name is [Cipatili Mendoza] and I have a question for the three panelists. I think that throughout the whole day, we've discussed about race, but we haven't talked about racism, which I think is the big elephant in the room that we never really talk about. And I was wondering from your perspective, because I know from the three communities that they're both representative, that those are high, it's a big issue that impacts the population health in all three communities. And so I wanted to know what is being done and how you're addressing them in the work that you're doing.

>> Any of the panelists? Guesnerth.

>> Thank you. That's a very good question, actually. So racism is obviously a huge problem in our community. As many people know, the Latino community suffers from kind of double or triple racism. Racism from within the American, the general American population, so being not citizens or like I'm a citizen here, I'm a black citizen here, I'm an Afro Latino citizen here, but I suffer from the quote, unquote American, United States side, but I also suffer from internal Colombian community, racism from there. So I think that there is, I think that the reason why we're not discussing racism as much is because we haven't discussed race as much as an important point, which is why I think that, it's one of the points that I think everyone tries to highlight. There are many studies that show that racism is very directly connected to problems such as depression. For example, there's a research recently by McGill University which showed that racism is tied a lot to depression amongst black Latino young males, and then therefore leads to suicide rate and all other things that depression links to, all stemming from racism. The same thing with the research I was quoting from hypertension. The hypertension study shows that there's a link in hypertension and racism. So I think that, that's why I think that emphasizing race is important, because I think looking, and not only looking at it by a nationality, but also trying to emphasize the fact that race plays a large factor into certain health conditions in Afro Latino communities.

>> Any other perspectives on racism? A question, a comment, okay.
From the previous speakers combining, which I think is significant to this, for your point, the issue, of course, of lack of proper communication in the collection of data, how skewed the data is, and I was just talking to Dr. Rodriguez saying okay, so example, the patient comes in, [and says tengo un dolor muy grande] I had a terrible pain. And the doctors says, well, where does it hurt? And he says [en todas las entranas]. Now, enter that into Google translate and see what you get. And the reason why I bring this up is because that is exactly what he was saying about skewing the data. And so if you go to five different countries along the Latin American side, you'll get a different answer on that one. not only that, but [entranas is] everything and then if it's a local version, I say [one entrana], which is one internal organ. So it is critical, and I was talking to my partner here, that we find a way, and I don't know how, it's going to take a long time, to normalize, key question here, normalize the way that question is asked and normalize what is exactly we seeking from this patient? Because the majority of them do not know what they're being asked, and I know that. Say in Guatemala, how much that cost? [Speaking foreign language]. It doesn't mean the same in the Dominican Republic. I mean, look it up if you want.

Thank you. Other questions or comments?

Can I just? I just want to finish a point that I forgot, because you said what are we doing? One of the things that our organization is doing, the Afro Latino Afrolatin forum, is we're conducting a survey on kind of looking at a specific segment of the population in New York and how they identify by race category. And then looking at how that affects other issues. So, I just didn't finish to say what we're doing. Sorry.

Thank you. Yes.

Hi. I'm Christina and I'm a junior research scientists at CDC. I'm clearly new, brand new, still learning. So I really enjoyed the conversations and the presentations that, from the previous panels and this. And this [inaudible] is one of my favorite ones. Like as a new researcher I was thinking about implications for practice and policy, and I wanted to ask you guys, given the conversations that you presented today, what is a tip or a recommendation that you would say a young researcher when thinking about doing studies for populations to make sure that we might not fall into the same pitfalls that previous research have gone before, even though they do try to look at the discriminations or disparities that are existing in various populations. Do you have kind of like a, think of this, when you develop your research questions to ensure that your research, or that the findings of your research might not have some unintended consequences? That instead of addressing the disparities that you were looking for, you're actually highlighting it? Because I felt like there was the absence of theme overall in your conversation that although people do try to address the disparities and look at them, there are unintended consequences of not really doing the correct thing. Thank you.
Thank you, so much, for the question. And actually that fits right into the mission of HSHPS. There is, of course if you're looking at NIH or whatever agency you're looking for to apply for a grant there is a very important section in your 12 pager, and that section is innovation. So it is in the innovation section where we show how different you are than all the work that has already been done. And so, you're right, you could use this template and have 6 innovations right there. So where is the innovation in translation or in application or in gap analysis or risk reduction? Today, actually, we're hoping to make this and publish this nationally, today you have a set of priorities, a set of questions, a set of gaps, that we each have contributed that have kernels of innovation. The work that Dr. Flores shared, for example, to look at LEP very differently. And so you could go through each of those speakers and find those kernels. Dr. [Perez-Stable] talked about the four key questions that he's focusing on. But taking those questions and not doing the same old, same old. I always tell my students, and junior researchers, don't do the meat to research. That might get you on somebody's coat tail, but it won't let you grow into an independent researcher. Or, in fact, currently now an interdependent researcher to become part of a transdisciplinary team. But it's the innovation section, and actually the second most important section to me, and it's often ignored by many scientists is the public health relevance section. There's three sentences to me that should read [inaudible] to fund a grant. But, yeah, it's not being seen as peers by the peer reviewers. But those are the two sections to me that are critical.

Can I add something real quickly to that?

Yeah. Sure.

I think another point, one of the issues that we have, especially in the Afro Latino community, of finding out statistics, because there are no statistics and it's very difficult, there are very minimal statistics to find it out. And so what we always try to challenge people to do is to create a norm for developing that statistic, right? So it's difficult for us to, so I can't pull out like 55 research examples of Afro Latino and how race affects health, because they just aren't those, they just don't exist. So someone has to be. So I think that's where the point of innovation comes [that Dr. Lichvield was making], someone has to be the person who starts that and to create a norm. And I think that there are people who are already doing that research. They're starting to. But I think as we parse it out more and as we look at how race affects, or how different questions affect us, I would say you should look at race, well, obviously I'm going to tell you you should look at race, but you should look at race, [inaudible] people in the past haven't done it, therefore it's not an important category, which is usually what happens. Someone says, well, it wasn't done before, therefore we don't need to do it now. I think that it's sometimes good to create a new norm and say well, we do need to actually look at race when we count, you know, the Latino population and what affect does that have on health access and health education. So I think creating the norm is a very important thing. That's why I'm glad that we're in this panel. Because it's creating that new norm to have more numbers to look at. The fact that there is no data doesn't mean that there isn't any data, it just means we haven't got our data.
We'll take one more question and then we'll break.

Actually, following up for your question. I work with the National Alliance for Hispanic Health and we work with a network of community based organizations work with these agencies, okay, doing community participatory research. They already have the language skills, the cultural skills. But don't just go do the research and then leave. Bring back the results, so that way they can get the best of both worlds.

Excellent. What a good not to end.

Priorities, go forward.