
Committee Meeting

of

ASSEMBLY HEALTH AND HUMAN SERVICES COMMITTEE

“Testimony concerning racial and ethnic disparities in health care”

LOCATION: Cicely Tyson School of
Performing and Fine Arts
East Orange, New Jersey

DATE: September 19, 2002
10:00 a.m.

MEMBERS OF COMMITTEE PRESENT:

Assemblywoman Loretta Weinberg, Chairwoman
Assemblyman Herbert C. Conaway, Vice-Chairman
Assemblyman Willis Edwards III
Assemblyman Jerry Green
Assemblywoman Nellie Pou
Assemblywoman Joan M. Quigley
Assemblyman Samuel D. Thompson
Assemblywoman Charlotte Vandervalk



ALSO PRESENT:

David Price
*Office of Legislative Services
Committee Aide*

Wali Abdul-Salaam
*Assembly Majority
Committee Aide*

Tasha M. Kersey
*Assembly Republican
Committee Aide*

Meeting Recorded and Transcribed by
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ASSEMBLYWOMAN LORETTA WEINBERG (Chairwoman):

This has been proven time and time again. And I think Assemblyman Conaway has talked about it. And it's now time for the State of New Jersey to come up with the solutions to this ever vexing problem.

So, with that as a background, Assemblyman Edwards, would you come forth. If things get out of hand, I'm going to reclaim this chair, which I'm sure they won't.

And I just want to remind everybody, please, the only way you can speak is coming forth to the table. You must give us your name. We have to limit this. I don't know if they're all here, but at last list we had 24 speakers. So this must be limited to three or four minutes apiece. And David Price from OLS will help Assemblyman Edwards keep track of the time.

Thank you.

ASSEMBLYMAN EDWARDS: First of all, I'd like to thank all of you for coming today to discuss the issue as it relates to health care disparities throughout the State of New Jersey, and open up testimony.

First, I'd like to call forward Assembly colleague, Dr. Munoz.

ASSEMBLYMAN ERIC MUNOZ: Thank you, Mr. Chairman.

First, I want to thank the members of the Committee for conducting these hearings. I think this is a very important topic. It's not a new topic. This has really been-- For the last 50 years, the United States has realized that we have difficulties in populations getting medical care. I want to salute my colleague in the Assembly -- my physician colleague, Dr. Conaway, because I know both he and I have dealt with this for many years as practicing doctors.

Last week, I attended a series of meetings. I've been appointed by President Bush to sit on a national council, because if you look at the demographics of America and the fact that we have large increases in Afro-American and Hispanic populations -- we have problems with Native Americans and with Pacific Islanders -- and look at the populations and their health, and the fact that they have a tremendous amount of avoidable disease and avoidable mortality. And we do have a lot of figures now.

Both State and Federal government has collected those figures over the last 20 years. So we know, for example, that Afro-Americans -- there are many diseases that go undiagnosed, that they're not treated properly -- same in Latinos.

The real core of the problem becomes, what do we, as State officials, recommend? And I think I complement -- the last session we talked about a loan redemption program. There have been 30 or 40 or 50 things we've tried over the last 20 or 30 years, and those things have only had some limited effect so that -- for example: having adequate numbers of doctors, having adequate reimbursement, having adequate surveillance, having things that we know work in the majority community -- we need to translate that into areas that have tremendous health disparities.

I don't have all the answers. I know that this commission, with its hearings, will make findings and advocate certain recommendations. I do think, if you look at the population of New Jersey, which has large blocks of people with disparities, we have to do something. We cannot, as a State, go on and have a tremendous increase in death rates -- Afro-American men -- their likelihood of dying from violence is way -- many, many fold non-Afro-

Americans. This is something we have to just attack and have to find some solutions to.

So, with that, I think I would compliment all of you. I'll listen carefully and then, of course, I have to rush to Trenton, like all of us. But it's something -- a very, very worthy topic. And I congratulate all of you.

ASSEMBLYMAN EDWARDS: Thank you very much, Assemblyman Munoz.

I'd like to call next Dr. Diane Brown, who is the Executive Director of the Institute for the Elimination of Health Care Disparities. She's also published over 65 publications.

We'd like to hear your approach towards community-based approaches in addressing health care disparities.

D I A N E R. B R O W N, M.D., Ph.D.: Good morning. My name is Diane Brown, and I'm the Executive Director of the newly established Institute for the Elimination of Health Disparities at UMDNJ.

I am honored to be here, not only to present testimony on a very critical topic, but also to have the opportunity to come back to my junior high school alma mater. I have not-- It's been several decades since I have been here in this auditorium. And I'm delighted to see that it's still operating and now focusing its mission on the arts.

The Institute at UMDNJ was established in recognition of the disparate health status and health care experienced by racial and ethnic minorities in New Jersey. Our mission is to be a broad-based partnership dedicated to the elimination of health disparities through research, education, advocacy, and collaboration. Our focus is on the major urban areas where

racial and ethnic populations are concentrated and where health disparities are the greatest.

As we know, New Jersey is among the most diverse states in the nation, with a nonminority population that approaches 28 percent. So we know that health disparities are a critical issue for the welfare of New Jersey as a whole and will continue to be so for the near future. We at UMDNJ monitor these issues vigilantly, because racial and health disparities do not appear to be going away. Rather, in some cases, they're getting worse.

The five leading threats to the health of minorities in New Jersey are:

AIDS: The age-adjusted death rate from HIV/AIDS is 10 times higher in New Jersey's African-Americans than in whites. The incidence of the disease was 23 times greater among New Jersey African-American females ages 15 to 44 than their white counterparts. Among African-American men in the same age bracket, the incidence was nearly 13 times higher.

In terms of asthma, New Jersey's African-Americans are more than three times likely than whites to be hospitalized. The hospital admission rate for asthma is 55 percent higher for Latinos than whites in New Jersey. And Asian/Pacific Islanders are almost twice as likely to die from asthma as are whites.

Cancer: Black men are more than two times likely than white men to die of prostate cancer. Black woman are two times more likely to die from cervical cancer, despite similar rates of pap testing used to diagnose this cancer. Cancer has been the leading cause of death among New Jersey's Asian/Pacific Islander population, followed by heart disease and stroke. This ranking was

true for all major Asian groups except for Asian Indians, for whom heart disease was the leading cause. The cervical cancer incidence rate for Latino females is 86 percent higher than the rate for non-Latino white women. And the mortality rate is also higher.

In terms of diabetes, black New Jerseyans are two-and-a-half times more likely than whites to die of diabetes. And Latinos -- their incidence rates of end-stage renal disease, a complication of diabetes, is almost twice that of whites. Among Asian, especially Asian females -- they have a higher rate of diabetes as a medical risk factor of pregnancy than women of any other race.

Infant mortality: Black infants are more than three times at greater risk than white babies to die in the first year of life, while Latino women have two times as many low birth-weight babies than white women in New Jersey. The largest increase of infant mortality rates was among Asian-Americans -- Pacific Islanders -- at a rate of 6.4 percent. Asian babies were of low birth weight at a rate that was higher than the white rate but lower than that of African-Americans.

And these are just some of the disparities in health outcomes that racial and ethnic minorities in this state endure.

Why do we have health disparities? Why are the rates of morbidity and mortality disproportionately higher in minority populations than in the majority white population? Although the causes are complex and include poverty, poor education, low-paying service jobs lacking benefits, and racism, among other factors, a significant factor is unequal health care. African-Americans, Latinos, and other minorities do not have access to, nor do they receive, the same health care as whites. Most of the health disparities

could be reduced and significantly impacted by having equal access to quality health care. An unacceptably large number of minorities lack access to preventative health care and other services.

More than 158,000 African-Americans in New Jersey lacked health insurance in 1999. This number increased by 70 percent, to over 260,000, in the year 2000, while the number of uninsured whites decreased. Additionally, more than 31 percent of Latino state residents lacked health insurance.

The uninsured represent a cost to the system of health care and a cost the institutions are becoming less willing to absorb. Poor and sick minorities are viewed as contributing to the high cost of health care as hospitals and physicians state that they do not receive adequate reimbursement for charity care. Yet, minorities, especially those of low income -- when they do receive care, it is apt to be fragmented and inadequate.

Even among those minorities with health insurance, findings from recent studies indicate that minorities are less likely to receive the same quality of care as whites. They are less likely to receive innovative and high-technology procedures.

We must keep in mind that the differences in health care occur in the context of broader historic and contemporary, social and economic inequality and persistent racial and ethnic discrimination that are apparent in all aspects of American life. Accordingly, the remedies have to be multifaceted, holistic, and focused.

In moving forward, toward the elimination of health disparities, we encourage you to consider the following: support strategies that ensure that minorities, especially those of low income, have access to quality health care;

specifically, promote incentives that ensure an adequate supply of services to minority patients and that encourage providers to establish practices that address minority health needs in culturally competent holistic ways. Initiate or endorse legislation designed to foster healthy communities in New Jersey, as health disparities are not just a health issue; they involve having quality education, adequate housing, safe neighborhoods, and employment with adequate health care benefits. Thirdly, support the development and implementation of statewide awareness and educational campaigns. And then, fourth, support research needed to plug holes in our data and infrastructure for addressing health care issues and health care needs.

Finally, in this very wealthy State of New Jersey, located within this very wealthy nation, there is no legitimate reason for the existence of disparities of health status and health care in any segment of our population here in New Jersey or in the nation.

Although we at UMDNJ are attempting to address some of these disparities, it is evident that it's going to take all of us, working at various levels, to make a difference.

I'd like to thank you for this opportunity and to congratulate you on having this hearing.

ASSEMBLYMAN EDWARDS: Thank you very much, Dr. Brown, for your compelling testimony.

I'd like to bring to the stage Dr. Duane Dyson, Vice President of Senior Medical Staff Affairs.

DUANE J. DYSON, M.D.: Good afternoon.

First, I'd like to thank you for having this Committee and also inviting me to speak at this Committee.

Let me first say, as did the doctor before me, that I was born and raised in East Orange and that I'm a living example of why we need to support minority health care education -- because a large percentage of us do return to the community and provide medical care for those of us in this community.

Disparities in health care-- I'm not going to-- I understand I have three minutes, and I'm not going to take up the four or five pages that we have prepared, but we will submit a copy to your commission for review.

The New Jersey Department of Health and Senior Services defines health disparities as differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific populations and groups.

The Health Department selected six focus areas in which racial and ethnic minorities experienced serious disparities in the health access and outcomes. These were defined as infant mortality; cancer screening and management; cardiovascular disease; diabetes; HIV infection, AIDS; and, also, immunization.

They concluded that dramatic differences in disease and injury rates between whites and racial and ethnic populations continue to persist in the state, including disparities in areas of pediatric asthma, diabetes, heart disease, and stroke. And you'll hear this over and over again. We can't reinforce what's the obvious and what's been researched time and time again.

The Department of Health, in 1998 -- and things haven't really changed -- the black death rate due to coronary artery disease was 20 percent

higher than whites. And the black death rate due to stroke was nearly 80 percent higher than the white rate. The death from strokes in persons 45 to 67 was 166 percent higher in blacks compared to that of whites.

We also find, and I found this interesting -- is even in mammographies, we found that in East Orange and areas that are traditionally considered areas of health disparity -- where patients were eligible for mammographies, only 45 percent of those patients in East Orange utilized those services. In Orange it was 41 percent, and in Irvington it was 41 percent. When compared to other areas that tended to be more affluent -- in Essex Fells, 78 percent of those patients utilized the services. In Short Hills it was 76 percent.

Most studies suggest that there's an explanation for the disparities, which include four factors: access to health care, lifestyles and habits of the target populations, patient-provider communications, and quality of health care delivery. Access to health care is a factor that stands out as one of the most obvious determinants in explaining disparities in health care outcomes.

There were surveys that also showed that timing physician appointments and getting clinic appointments for patients tended to be a large factor regarding access to health care. And when they also took a look -- that one of the biggest barriers for patients were those that were uninsured.

Some facts about uninsured patients that we've taken a look at-- The poor and near-poor compromise nearly two-thirds of the uninsured population. Eighty-three percent of the uninsured are in working families. Seventy-two percent live in households with full-time workers and 11 percent part-time workers. We found that most of the uninsured happen to be adults,

because of the program that New Jersey implemented a few years ago that provided insurance for a population of children.

But it was interesting to also find that within the United States, the uninsured population vary dramatically. In Rhode Island it was 7 percent, and New Mexico, 27 percent.

I could go on and on. I think a few other issues that need to be brought to the commission are: the overall -- the overview of social and economic factors that affect access to health care suggest that we're looking at rough waters. A few years ago, the economy was doing much better. We're in a state of emergency now. And health care costs are being cut.

We have a number of factors that you're going to need to consider, because this is prominent and forefront right now. Malpractice insurance issues, limiting the ability of providers to provide services -- that needs to be addressed; rising health care costs that may prompt employers to drop health benefits or pass on more costs to the workers; there's a severe nursing shortage that is impacting our quality of care; an undersupply of physicians in certain areas, most notably areas such as East Orange; providers dropping out of the health care plan networks; emergency department overcrowding, which I'm well-aware of, being the Director of Emergency Medicine.

In conclusion -- and this report is pretty extensive -- their report also suggested that expansion of State and Federally funded programs, such as community health centers, could increase the availability of free or low-cost care for uninsured people. Even as the market pressure is reduced, their access to provide health care providers--

I guess the bottom line, regardless of the different reports-- I practice in East Orange, and one of my goals as a child was to become a physician, to return to my community, and to provide health care. I didn't realize that times were going to be so different than when I decided to go into this field. The disparities in health care are obvious, and they affect this country and this community dramatically.

I think that it's up to the legislative branch, and also up to those of us who are concerned about our communities, to push forward for health care, to reduce these disparities. And it's been constantly said, and I hope that this is not true, that those who live in these communities aren't the ones who are, necessarily, voting for our legislators. And they're not the ones who are supporting certain political organizations.

So I hope that when we make decisions about funding to these organizations that we leave politics behind us. And this comes to us on a daily basis. The livelihood of these communities and for our patient populations are at risk. And I hope -- and I've seen some very positive legislation that will reduce this. And I hope that this will continue in the future.

Thank you.

ASSEMBLYMAN EDWARDS: Doctor, if you could just stay for a moment, in case any of my colleagues have a question for you.

One of the things that this Committee's heard over and over again was access to health care. And you spoke about uninsured and the Medicaid population. One of the things that concerns me -- whether or not there's a correlation between the uninsured and the Medicaid population in those districts that are in the Abbott districts, those 30 municipalities, and how that

relates to education and the good quality of health care and talking about the access to health care--

DR. DYSON: That's an excellent question. We can use East Orange as an example for that. The Abbott districts, the Medicaid-- We have a number of issues. Just on that question alone, I guess, I could talk for hours. I'm sure no one here wants to have me get started.

Access to care is one of our biggest problems, even at East Orange General Hospital, which serves a patient population where the average yearly income, I believe at last note, was \$13,000 or less. When you have patients who are more or less worried about feeding their families and putting shelter over their heads, health care becomes a secondary issue, both for their children and definitely for our patients.

We need to provide educational programs. And we need to have outreach programs that will allow patients easy access to the health care system. Right now, it tends not to be as user-friendly as it could be. And these programs, quite frankly, require a certain amount of funding. But it most definitely requires specific funding for specific areas. And without providers to give access -- and in some instances where patients have to wait for weeks and even months to see a physician -- as one patient put it to me, "By the time I get to see the doctor, my mortician will already have my body."

So we need to set up programs and education. And we need to get into the community. And again, this goes back to supporting the health care workers in the health care system.

ASSEMBLYMAN EDWARDS: Thank you very much.

Are there any comments from my colleagues? (no response)

Thank you, Doctor.

DR. DYSON: Thank you.

ASSEMBLYMAN EDWARDS: At this time, I'd like to call up Kamille King, a student. (applause)

K A M I L L E K I N G: Uneven health care services: The problem that many urban and minority residents face today is a loyal health care provider. Because of the money disadvantage in urban communities, residents don't receive the medical attention they need. The want is not free medication, but a healthy community.

Did you know that an estimate of 40 percent of children's office visits are due to infectious diseases that require antibiotics or other prescription drugs? What about the white senior citizens -- intended recipients of home-delivered meals, which would contribute to a healthier lifestyle -- who refuse the meals thinking them to be handouts? Only about 9 to 13 percent accept them. Where does the rejected food go? Many elderly minorities are in need of a good meal but never get to voice their opinion. Should they starve because no one seems to care?

Most say the reasons for racial disparities and imbalances in medical care conditions, between urban and suburban areas, are limited transportation, distance from doctors and hospitals, and no health care insurance. To limit the medical assistance in urban areas is ridiculous, since there is a need for such great services.

In addition, a cancer in one part of the nation's body will eventually drain resources from the whole nation. The solution is to promote local health care companies, including doctors, nurses, medication, and medical

data. By instituting and promoting local companies, employment opportunities along with health care benefits will be increased.

A possible solution might be a local medical profession summit, to gather input from the professionals about implementing procedures to address the medical needs of the disadvantaged portions of the population. We might develop a panel of business-minded entrepreneurs and medical personnel to brainstorm ideas, while keeping the cost factor in mind.

The health care dividers -- I mean, health care providers should be ashamed of rejecting anyone seeking medical assistance, but that's just how it is when you put cost above people. Maybe there can be government incentives for companies who donate major medical equipment or monetary contribution to medical treatment centers located in underprivileged areas to be used to offset the cost of servicing those lacking health care benefits.

Finally, our leaders should be more creative and forceful in assuring proper medical services for their communities.

Thank you. (applause)

ASSEMBLYMAN EDWARDS: Miss King, first let me thank you for your testimony. It was compelling, as well as very informative, and offered a lot of exciting suggestions.

At this time, I'd like to bring forward Ms. Lee Redfern.

LEE REDFERN: Good morning -- good afternoon.

I'd like to thank Assemblyman Willis Edwards for inviting me to testify. And I would like to thank all the members of the Committee for coming to East Orange. It really is a wonderful thing.

My name is Lee Redfern. I am a 20-year resident of East Orange. I have a B.A. from the University of Iowa, a Master's in education from Seton Hall University. I was a volunteer mentor in the girls' unit of the Essex County Juvenile Detention Center for over three years, under Joe Clark. I have been on the East Orange HIV/AIDS sharing network for one year now. I have been involved in civic life, actively, for over five years.

My comments will be based on extensive personal experience with being economically poor. My comments are also based on being actively involved with the people of my neighborhood and my building, as well as 10 years of street mission work on the sidewalks of East Orange, speaking with and working with some of our most vulnerable people.

The first health issue which comes to my mind, which I have experienced repeatedly, is hunger. I'm asking the Committee to do everything that you can, whether in your Committee and supporting other bills, to prevent hunger. Food stamps are just not adequate. I ask you to support share programs and food banks actively. I ask you to raise the minimum wage. Raising the minimum wage -- I ask you to support raising the minimum wage. That will be a step to preventing hunger.

At one point in my life, I was on General Assistance in East Orange. The General Assistance check has been at \$140 per month for many years now. I'm asking you to kindly increase that amount.

Frankly speaking, in my seven months as a General Assistance client, I starved. It became so stressful, because it followed a personal physical assault on me by three 14-year-old boys. And two months after that happened, after experiencing all this repeated hunger being on General Assistance, I

ended up in the crisis center of East Orange General Hospital and checked myself in to the mental health unit.

What I'm trying to point out to you is that hunger, also boys' attitudes to girls, girls' self-esteem, is all tied up with a person's health and mental health.

I'm asking you to restore the family care for General Assistance recipients. In actual practice, I have to say -- and with my -- with other people's experience backing me up -- that charity care is, in practice, a discriminatory practice against our most vulnerable, because it limits and denies adequate and appropriate health care for the indigent.

I understand the State was in a budget crisis this June when they switched to charity care for the General Assistance recipient, but only for the General Assistance recipient. Therefore, would you kindly restore the Family Care so that someone who's at the very bottom will have one physician -- a relationship with one physician who will monitor their care and, hopefully, help them get what they need.

My next comment is about social service agencies. We ask that you fund them so that they can meet the increasing needs of the urban community who may be exhausting unemployment checks, who are at the risk of being homeless. Help them keep their apartment, their home. I believe it was the doctor who was up here a few minutes ago who said, if you don't have a roof over your head, you're not thinking about health care.

We just had a 15-story building in East Orange evacuated. About 500 people were thrown out. So please fund the social service agencies more so that they can help those who may not yet be eligible for public assistance,

but are at the risk of really-- Why should we make people become desperately, desperately poor before we give them help?

My next comment is about dental care. I was very happy to hear the person talking about that. I had a little help -- someone doing research on that.

ASSEMBLYMAN EDWARDS: I just want to point out we have a number of speakers. And you have about another minute left.

MS. REDFERN: Thank you, Assemblyman Edwards.

According to the American Dental Association, Division of Equity and Diversity, there's been a decline in the number of African-American dentists due to lower enrollment into dental schools, which, in turn, seems to come from dismantling affirmative action programs and higher tuition.

Could you please have more satellite programs -- dental programs out in the community, for instance, from UMDNJ? I understand they do their best. However, it is really jam-packed down there. We need dental care out in the community.

I'll wrap up by saying a few other issues, which I think will help our health care -- is to bring complementary medicine and healing nutrition into the hospitals. And let's not look at it as adversary. Let's not be adversaries with complementary medicine or so-called alternative practices. We can't afford to think of them as alternatives. We can prevent -- we can lower the incidences of renal disease, heart disease, diabetes, spine trouble by actively bringing in such things as acupuncture, chiropractic, acupressure, massage, herbs. We cannot afford to think of complementary medicine as something outside the box. It's not.

Again, please help prevent health problems and hunger by increasing minimum wage. And I ask you to support a handgun ban. That will go a long way to preventing a lot of injuries and deaths.

Thank you very much. (applause)

ASSEMBLYMAN EDWARDS: Thank you very much.

Are there any comments from my colleagues? (no response)

At this time, I'm going to call up Dr. Ortiz, from the New Jersey Academy of Family Physicians.

T H O M A S R. O R T I Z, M.D.: Thank you very much, Mr. Chairman. Assemblyman Edwards, congratulations on bringing this issue to the forefront, once again, as we have over many years been fighting the good fight and doing the Lord's work in trying to provide adequate health care to all the people in the State of New Jersey and in this country.

I represent-- I'm a family physician. My name is Thomas Ortiz. I'm board-certified. I've been practicing in the great city of Newark, New Jersey, for the past 20 years. I'm one of the few family physicians who decided to take on the urban center, in terms of providing care to a population in need, when I was told it was impossible to do.

I have recently been elected to the Board of Directors of the New Jersey Academy of Family Physicians. And I speak to you -- my initial comments -- in that vein.

The New Jersey Academy of Family Physicians wants to partner with the State Legislature and the Committees on Health to help to develop whatever legislation comes through in a comprehensive way that will, eventually, meet these disparities in health care, because they have an effect on

all of us, whether you're receiving health care or not, because we're all paying for it.

We're interested in promoting education in the schools and access to education for all students interested, particularly minority students. We're interested in developing manpower to treat people in underserved areas. And we're interested in developing financial mechanisms by which we can accomplish this.

We need to keep doing what's working for us right now or had been. It looks like, for instance, the Family Care Program -- this is the closest we came to a universal health care program where we can provide health care for all the citizens of the state. But unfortunately, recently, we've seen, as the previous speaker just mentioned, a decline in the development of that program. I think this is a mistake. I think that we need to continue to move ahead on that program, along with the Kid Care Program.

We need to invest in the community rather than invest in our corporations. For instance, you were interested, Mr. Chairman, regarding the reasons for high infant mortality and low birth-weight babies. Again, we bring up access. This only means higher cost with neonatology. We know that Hispanics -- asthma, obesity, and diabetes -- the diabetic epidemic far outshadows the problems which you've mentioned.

The low immunization rates-- We have a VFC program in the State of New Jersey, free vaccines for children, yet we cannot get beyond the situation where our kids are not being vaccinated, to a certain degree. Even with no insurance or with Medicaid, vaccines are free. We can't get the levels up. The question is, why?

The high rates of HIV and AIDS, again-- These all come down to access. As a physician, we're always looking for the answers, the reason why. We just don't want to treat the symptoms and continue to put Band-Aids on the hemorrhage, which is what we've been doing for many years in the state.

We need to come up with a much more comprehensive approach to health care. And it all comes down, really, to the economic model that we have our system in. If the system is not working, and these health disparities are very good evidence that the system is not working the way it currently is established, that means we need to make some changes. And I think we all need to get a grip on it -- and the fact that we do need to make some changes.

There's a tremendous lack of infrastructure in primary care, particularly in the urban areas. Being one of three family physicians in the entire city of Newark, a city of 400,000 people, the greatest city in the State of New Jersey, is a disgrace to our civilized population. People cannot have a personal relationship with their physician. They cannot get counseling on all of the preventable diseases that we've talked about. They cannot get early preventive treatments. They cannot receive nutritional guidance. They're not able to get the immunizations they need, because the infrastructure does not exist for them to be there.

We talked for many years about the concept of health enterprise zones, much like economic enterprise zones, where we provide incentive for practitioners and health care professionals to develop health care infrastructure in the inner city areas and areas that are of greatest need. This could be part of a larger program of universal coverage that I think the State Legislature really has to get their arms around and start considering.

Right now, the health care financial model-- The only winner is that of the corporation and the executives and their insurance companies, whose incentives could never be aligned with addressing the disparities that we talked about today and which you're well aware of. Until we have the will to make the decision to tackle the issues of addressing these disparities, the delivery system will not change, and the disparities will not change. They'll only get worse.

Essentially, we need to make health care available to every citizen in the State of New Jersey. We could use technology to streamline and reduce the costs. There's already enough money in the system to cover every man, woman, and child with health care. We spend about \$4500 per person in this country for health care, mostly spent in the first few days of life and in the last month of life. That leaves about 10 percent of the dollars to go for primary care prevention and to meet these disparities.

ASSEMBLYMAN EDWARDS: Dr. Ortiz.

DR. ORTIZ: Yes.

ASSEMBLYMAN EDWARDS: I don't mean to cut you off, but we do have some other Committee meetings. And some other members have expressed some interest to address you with some questions, if you yield to some questions for a moment.

DR. ORTIZ: The Family Physicians Group is willing to work in any way possible to help you come up with the ideas. With this pen, I write millions of dollars worth of health care every day, every year. And I think that we need to be in a good partnership and a good relationship with the Committees.

ASSEMBLYMAN EDWARDS: Thank you very much. Would you yield to some questions?

DR. ORTIZ: Certainly, sir.

ASSEMBLYMAN EDWARDS: Assemblywoman Weinberg.

ASSEMBLYWOMAN WEINBERG: Thank you.

Would you just go over the part-- You talked about something like medical enterprise zones. I kind of missed what you called that. It was something akin to urban enterprise zones.

DR. ORTIZ: Yes, I called it health enterprise zones. This is not a policy of the Family Physicians Group. This is a policy that has been developed through -- early on when we had the LABs, local area planning boards. Our Essex County group, which I was chairman of the primary care commission-- We developed a concept of health enterprise zones. This would be an area that's been identified through these factors that we talked about, all the health care disparities, as an area of great need. Where do we spend the most dedicated dollars? Where do we have the most uninsured? Where is it that we have the lack of infrastructure? That's the reason.

So, now, we identify those areas. Let's provide incentives -- State incentives, either-- Several things could be used. We could use low interest loans to help practitioners develop facilities, buy equipment, and open offices. We could use tax-free Medicaid payments. In other words, instead of -- not only do I get \$16 a visit on Medicaid for the past 20 years that I've been in practice, but I pay taxes on that money. Why not allow that practitioner to get an enhanced dollar payment for that health care and be exempt from paying State tax or Federal tax on that particular dollar for the service that you're

providing. This way, we can also expand the loan redemption program. For instance, I have two PAs that work for me in the office. They both receive the loan redemption program and are doing an excellent job with providing access, because we can be open later. We can be open on weekends. We can expand our facilities because of the fact that we now have some dollars available to us to do that.

These are the types of things that the health enterprise zone could accomplish within the larger plan that I would consider regionally understood -- North, Central, and South Jersey plans that are administered by a board that would look at that. And they would be responsible for administering the dollars that would be made available for that, because health care is local, and we know that we need to provide health care on a local basis. It's different in every city. There's different needs. Let's try and identify them. We're small enough to be individualized on that. And the money is there. It's just how we're spending it. Which way is the money flowing? Is it flowing to a hundred different insurance companies outside the state, or is it flowing to the State of New Jersey and the collection system that we could create?

Does that answer your question?

ASSEMBLYWOMAN WEINBERG: Yes, thank you.

ASSEMBLYMAN EDWARDS: Assemblywoman Vandervalk.

ASSEMBLYWOMAN VANDERVALK: Thank you.

Doctor, I appreciate your testimony. I've been a fan of Federally qualified health centers. Do they meet the need -- obviously not, because you wouldn't be here testifying. Would that concept help if it were expanded?

DR. ORTIZ: The Federally qualified health centers are usually run by business people who hire physicians. Some of them are repaying a service to the government through the National Service Corps, for instance.

You know that the crux of health care is in the doctor-patient relationship. Particularly Hispanic women -- and we talked about cervical cancer rates in Hispanic women. The most intimate exam that a woman has to undergo should be performed by somebody that she has trust and confidence in, that she's just not meeting for the first time.

What happens in those health care centers is there's a lot of turnover. There's a lot of practitioners that are just there to do their duty, and they're really not committed to the health care of that community. I think, and America has proved this, that private enterprise and being in the free enterprise of health care, in which doctors right now are not -- we're in an artificially controlled environment -- do meet a need for a certain group of people. But they're not going to meet the need for all the people. There's just not enough of them.

There's a lot of money being spent there. I'm not sure if there are ways that they could be improved. But I have one Federally qualified health center down the block from me. We do about three times the business that they do. And it's just a matter of the quality of care and the relationships that the patients can develop with their physician on a long-term, (indiscernible) continuity basis, which is what family practice is all about.

Family practitioners tend to want to practice in the areas where there is need, but again, the financial incentives have not been there to, kind of, draw us into the areas where we need it the most.

ASSEMBLYMAN EDWARDS: Thank you very much, Dr. Ortiz.

DR. ORTIZ: Thank you for your very interesting questions. I hope it's helped.

ASSEMBLYMAN EDWARDS: Next, I'll call up Ken Morris, Director of Urban and Community Affairs for Saint Joseph's Regional Medical Center.

KENNETH MORRIS JR.: Good afternoon, ladies and gentlemen. I'd like to thank you for this opportunity to give testimony before you this afternoon. My name is Ken Morris Jr., and I am the Director of Urban and Community Affairs at Saint Joseph's Regional Medical Center, in Paterson, New Jersey.

I am here to discuss some of the particular needs and challenges of hospitals in providing health care to the state's poor -- because when you talk about racial and ethnic disparities, you're really talking about the state's poor -- and some suggestions as to the measures that the New Jersey State Legislature may take to assist urban hospitals.

Saint Joseph's Hospital and Medical Center is located in the middle of Paterson, the state's third largest city. Like many urban hospitals, its physical plant is somewhat dated in appearance, is surrounded by substandard housing and streets, and it does not have additional acreage because it is literally a part of the community around it. Yet, Saint Joseph's is a high-quality, academic-oriented medical center with virtually every medical and pediatric specialty, a trauma center, a children's hospital, and teaching programs for medical students, nursing, and a variety of other students. Most importantly, it serves the needs of its community in a high quality,

comprehensive, caring, and mission-oriented fashion. It is also the largest employer in Passaic County, employing almost 4000 persons, and one of the major economic anchors of Paterson.

Despite all of the wonderful contributions that Saint Joseph's makes each day, we are faced with having to discontinue programs that directly impact the health care of New Jersey's black and Latino population. This is for a number of reasons. A part of it is because the hospital reflects the community it serves. And when the community does not have health insurance and is unable to pay its bills for health care, the hospital likewise does not have the resources that it would like to pay its vendors.

Despite the fact that Paterson has a population of 147,000 people, 1.8 percent of New Jersey's population, Saint Joseph's cares for almost 6 percent of all of the charity care patients in the State of New Jersey and cares for almost 6 percent of all the Medicaid patients in the state.

Medicaid reimbursement covers only a portion of the costs to a hospital of providing services. And New Jersey's charity care system reimburses only a percentage of the costs of providing services to documented charity care patients.

Saint Joseph's estimates that it loses over \$20 million per year providing services to charity care patients. This is a function of both the fact that Saint Joseph's is providing care for one of the State's poorest cities, with a high percentage of charity care patients, and the fact that the charity care system in New Jersey is underfunded.

Another reason for the financial hardship being experienced by so many urban hospitals today is the medical malpractice insurance crisis in New

Jersey. Although this is affecting all hospitals in New Jersey, urban hospitals are often particularly hard hit, because they often have more difficulty obtaining physician coverage of high risk areas, such as obstetrics, than do suburban hospitals where physicians are eager to cover the emergency room because it is a source of insured patients.

Last year, Saint Joseph's paid approximately \$5.6 million for its liability insurance. This year, the hospital is paying \$8.5 million, an increase of \$2.9 million, and a 51 percent increase. These increases in payments for malpractice have to be taken from somewhere, and that, unfortunately, is being from the budget in those areas that serve the community.

Lastly, urban hospitals are hurting because of the change in State policy over the last several years that now allows almost any hospital to open, virtually, any service. This means that suburban hospitals are opening programs in the most profitable areas of medicine and attracting paying patients, leaving urban hospitals caring only for those patients unable to pay, rather than for a broader payer and patient mix. This dynamic has evolved over the past number of years.

Previously, urban hospitals were allowed, through the certificate-of-need laws, to operate large programs in certain specialities that, because there were no other local programs, attracted patients from a broad geographical range to the urban center of excellence. Saint Joseph's open-heart program, a recognized leader in this area, used to attract patients from a broad area and was able to utilize this program to subsidize its clinics and other programs to assist the medically needy in the area. Now, with the change in certificate-of-need policy, nearby suburban hospitals have open-heart

programs, as well, and attract suburban patients who are more comfortable remaining in suburban settings, leaving Saint Joseph's with a lesser payer mix.

There are several things that you can do to assist urban hospitals. One, recognize the impact on urban hospitals of State funding decisions such as removing people who receive General Assistance from the FamilyCare Program. When 27,000 people who used to receive FamilyCare were removed from such, it meant hospitals were no longer reimbursed through the FamilyCare program for any hospital care provided. This decision by the State cost hospitals an estimated \$75 million.

Recognize the need for additional charity care funding for urban hospitals. Hospitals in New Jersey provide approximately \$624 million in documented charity care, yet are reimbursed only \$381 million, a shortfall of \$243 million. As mentioned, Saint Joseph's pays over \$20 million to take care of charity care patients.

Vote for tort reform in New Jersey. Hospitals' insurance premiums are increasing so dramatically that hospitals are looking at programs to cut to make up for the increase in insurance, and urban hospitals are having difficulty finding doctors to provide coverage in certain specialties. California, which implemented tort reform in 1975, is one of the lucky states that has had a long and continued period of stabilization of medical malpractice suits and damages. Although the number of malpractice cases seems to have stabilized, the amount of verdicts are ever-rising, and the fear of doctors and insurance companies in being hit with a large verdict drives settlements in nonmeritorious cases. Please vote for a cap of damages and for measures that

don't allow obstetricians and hospitals to be sued 23 years after they deliver a baby.

Support measures that would strengthen urban hospitals and their communities. It is important for all people, from a broad swatch of society, to continue to come into urban areas, utilizing not only the high quality hospitals that exist there, but patronizing the businesses there and keeping those employees with a paycheck.

Thank you for your attention.

ASSEMBLYMAN EDWARDS: Thank you very much.

Ken Morris, would you yield to some questions?

MR. MORRIS: Sure.

ASSEMBLYMAN EDWARDS: Assemblyman Conaway.

ASSEMBLYMAN CONAWAY: Thank you for your testimony, particularly your comments on medical malpractice liability, and the great cost burdens that it creates on the health care delivery system, and the fact that it can lead, and is leading, to losses of capacity in terms of health care delivery.

You may know that there are some efforts in certain quarters to decrease what is thought to be the excess capacity of hospitals in the State of New Jersey. And, of course, we do have a diverse state. We have urban areas, suburban areas, rural areas.

I don't know if you've given much thought about this overcapacity question. You may not agree with it. But could you comment on that process and what policy makers will need to think about, as it regards critical hospitals, critical areas, and the losses of certain hospitals to some areas, as regards to access to care?

My point is, if we're going to go to this competitive environment -- you talked about the (indiscernible) process being watered down, removed, and that that competitive pressure is putting hospitals, like yourself -- the one you represent, into trouble. Maybe we ought to be thinking about how we reduce this capacity, particularly as it regards to making sure the critical populations are protected with this drawdown if, in fact, it occurs and if there's a policy to make that happen.

I'll take your answer, and I will apologize to others who -- and to the chairpersons, because I do have to leave for an Appropriations Committee meeting starting in about an hour-and-a-half.

MR. MORRIS: Just briefly, one of the protections that you see in process -- offered particularly large hospitals in urban areas -- was for those hospitals to be able to develop centers of excellence to attract patients, paying patients, from surrounding suburban areas.

This did several things: one, it allowed for those programs to begin to supplement some of the mission-driven programs such as clinics, dentistry, and so forth. Two, it brought people into urban areas who may not have other reasons to come into those areas and, therefore, gave them, more or less, sort of an education. So, rather than their only experience being about what they may have read in the paper or heard through hearsay, they had an opportunity to visit these urban areas. And the hope was they then begin to participate in the economic viability of these areas.

By watering down the (indiscernible) process, it then allowed, as I said earlier, hospitals in suburban areas to begin to open up these centers of excellence that compete directly with the urban centers. And quite frankly,

those patients felt more comfortable going into these areas. So, not having the money to supplement some of the mission-driven programs, it forced these hospitals to, basically, make a decision. Either you begin to cut these programs that are mission-driven in order to keep your doors open, or you went further and further into the red.

ASSEMBLYMAN CONAWAY: Thank you.

ASSEMBLYMAN EDWARDS: Thank you.

Assemblywoman Weinberg.

ASSEMBLYWOMAN WEINBERG: Just a quick question, if I may.

The \$20 million figure you used for charity care at Saint Joe's -- is that net after you get paid for charity care, or is that overall?

MR. MORRIS: That's net.

ASSEMBLYWOMAN WEINBERG: I'm sorry I asked. (laughter)

MR. MORRIS: Saint Joseph's is, essentially, functioning as the State's public hospital.

ASSEMBLYMAN EDWARDS: Thank you very much for highlighting some complexities that face urban communities.

ASSEMBLYWOMAN QUIGLEY: I was just going to comment that as a hospital administrator, I agree with you. And you said it very well. So, thank you for bringing all of these issues to our attention. (applause)

ASSEMBLYMAN EDWARDS: Thank you very much.

At this time, I'm going to call Carla Nisbett, Morgan Lewis, Rhondiqua Jackson, and Rashida Rowe. (applause)

R H O N D I Q U A J A C K S O N: Good afternoon.

My fellow classmates and I -- we've come up with a few solutions to get people more involved with avoiding health issues in the urban community.

The first solution that we came up with is a health fair. The health fair would be similar to a block party, but it would give out information about health issues, such as asthma, obesity, etc. There would be food, entertainment, and information provided, such as holistic remedies to asthma and information on how obesity can be caused by a chemical imbalance in the brain and not just by overeating.

Another solution that we came up with is a free concert with guest celebrities. But the only stipulation is that, in order to get into the concert, it would be mandatory to get checked out for AIDS, HIV, cancer, etc. There would be booths with professional doctors and all the proper instruments set up in front of the concert hall.

Another solution was fines for parents that do not take their children for immunization. There would be a warning sent out in the mail. And if the parent doesn't comply, they will have to pay a fine of the amount that it would have cost for the whole check-up, or if they decided to go to a free clinic there would be a government set fee for them to pay.

And then, the last solution that we came up with is patient teaching. A doctor or nurse goes out into the community and gives one-on-one teachings about the procedures that have to be done while getting tested and how important it is to get annual check-ups.

ASSEMBLYMAN EDWARDS: Thank you very much. Could you just state your name for the record.

MS. JACKSON: My name is Rhondiqua Jackson.

ASSEMBLYMAN EDWARDS: I just want to commend you on these outstanding recommendations to the Committee. I know in East Orange you're actually having a health fair this Saturday, September 21.

I think it's an outstanding idea about the free concert. And it's something that definitely requires some more thought to look into, maybe, providing fines for parents who don't go out and utilize those programs and save children's lives.

So I commend you all in your efforts and your attention to the issues that relate to health care disparities.

Thank you very much.

MS. JACKSON: Thank you. (applause)

ASSEMBLYMAN EDWARDS: At this time, I will call up Betty Lawson.

I'm just going to remind the speakers that we have three minutes. And we do have another Committee meeting in Trenton.

BETTY LAWSON, R.N.: Good afternoon.

I would like to say thank you to Assemblyman Willis Edwards for bringing the Committee into the city of East Orange.

I would like to introduce myself. My name is Betty Lawson, and I work with the East Orange Health Department. My position there is Supervisor of Nursing for the Public Health Nursing Division. I have been a Registered Nurse for 27 years, and 10 of those years have been spent in community health nursing. Prior to coming to the East Orange Health

Department, I was with the Newark Health Department for five years. And I have now been with East Orange for five years.

The city of East Orange is a community which suffers from poverty and poor health. The residents are living in a high-risk, low-income community. Access to quality health care is limited because of financial hardship and the absence of insurance coverage.

At a local health department, we see the residents of the city that are uninsured or underinsured. We also see residents that have nowhere else to go.

In the city of East Orange, there is one hospital, and the services provided by the hospital are limited. The services are limited because of finances. The hospital, unfortunately, does not offer any type of obstetrical services. This is a cause for concern. Each year, approximately 1167 babies are born to East Orange women. All of these babies are born outside of the city of East Orange.

Up until two years ago, the city of East Orange had the highest rate of black infant mortality in the state. The East Orange Health Department secured funding from the New Jersey Department of Health to institute the BIMR Program, which is Black Infant Mortality Reduction. In addition, with additional funding from Healthy Mothers, Healthy Babies of Essex, we had been able to bring down the incidence of black infant mortality in our city. But we still have a long way to go. A birthing hospital in East Orange would help make an even more significant impact on reducing these mortality rates.

Sick babies have to be taken to hospitals outside of the city for emergency room visits and inpatient services. We have mothers enrolled in our program whose babies may become sick, and before they can even take the baby to the hospital, they drop by the Healthy Mothers, Healthy Babies program to get car fare from us in order to get their babies to a hospital.

We need to support the community hospital, which is East Orange General. We need to come together as a community to give them the financial services that they need so that they can be of a help to the residents.

In addition to providing Healthy Mothers, Healthy Babies services, the Health Department also is limited and restricted due to resources. We do provide free immunizations for children, STD screening, lead screening, and treatment for tuberculosis. There are many other things that we could do as a community if there was finances.

East Orange has a very large population of, what we call, undocumented. These are the immigrants that are presently residing in East Orange but, because of their documentation status, they are unable to obtain any type of health care services. These are the people that we deal with each and every day.

The city depends very heavily on East Orange General Hospital, because it is the only hospital that we have in the community. We collaborate with the hospital on several different ventures, and we are trying to work together to make this a healthy city.

Health promotion, health education, risk reduction, and disease prevention must be ongoing and it must be practiced by all city health care

providers. We must all collaborate together. But in order for us to make our community a healthy community, we need some assistance. Please help us out.

Thank you. (applause)

ASSEMBLYMAN EDWARDS: Thank you very much.

Keith DaCosta, 100 Black Men of New Jersey.

KEITH DaCOSTA: Good afternoon.

ASSEMBLYMAN EDWARDS: Can you use the mike, please?

MR. DaCOSTA: Good afternoon.

First of all, I'd like to start off by bringing greetings from my president of 100 Black Men of New Jersey, Mr. Carey J. Hines.

I want to commend Assemblyman Willis Edwards III, as well as his colleagues, for hosting such a forum. It is so important that these types of forums continue to happen on our communities to address the health disparity crisis that exists within the minority community.

I'm here today representing the 100 Black Men of New Jersey as Executive Vice President, as well as the Health and Wellness Chairperson. I'm also representing my own company, which -- I'm a health care provider, and I'm representing (indiscernible) Home Care Services today.

So I think it's very fitting that we start off talking about some of the issues that we are concerned about at the 100, and one of the programs that we're currently working in in the 100 is to address cancer and address the enormous death rates of cancer in minority communities.

As you may or may not know, for all cancer combined, African-American men and women have the highest death rates of any racial or ethnic

group. African-Americans -- the survival rate was significantly lower than white counterparts, no matter what stage of the disease.

I'm not going to start off with just giving you a lot of statistical information and talk from there, because a lot of the previous speakers spoke and gave you a lot of statistical information. I've spoken at health disparity forums all over the country on various levels. So, as one who's been involved in this process for a very long time, I would rather get to the core of the problems and also talk about what are we going to do to address these problems.

I attended one of these forums a couple years ago that Assemblyman Bill Payne hosted. And some of the same statistics four years ago were mentioned today. And the Committee talked about some of the things that we wanted to do to change and reduce these rates in terms of the statistics.

What I want to talk about is some of the things that we can do, make recommendations, and also talk about some of the things that this body can do, in terms of supporting some of the initiatives that are already in place -- and also be encouraged to look at new initiatives, new creative ideas in addressing these same old problems.

So, with that, I would like to talk about the involvement of community-based organizations and the important role that community-based organizations play in addressing health disparities, through developing partnerships with health organizations, as well as faith-based initiatives that are going on around the state.

I represent a volunteer organization where we're all volunteers. We are black men concerned about the health of our community. And with that, we have identified partners, those individuals that can come together working with us and working with other organizations to address this enormous health disparity.

One of those partnerships that the State has supported, and I hope that the State continues to support, is the partnership between the Dean and Betty Gallo Prostate Cancer Center. And that partnership has enabled us to come together and address prostate cancer in the African-American community. Through the resources that the Gallo Center has made available to our organization, as well as other organizations, understanding that the only way we're going to effectively address health disparities-- The goal is to eliminate health disparities. But I think -- long-term -- but the short-term goal should be reducing the health disparity that exists.

And one of the ways of going about that is recognizing the value, again, of community-based organizations and the role that they do play and to engage them into the discussion, as well as the faith-based community, to get the faith-based community into this process. And they have already been in the process of addressing HIV/AIDS. And I think some of the presenters have already spoke on that. And some of the ones that are coming behind me will speak on that. The important role that the faith-based community plays in addressing these health disparities--

But one other piece is also making sure that we have adequate funding. One, the Department of Minority Health is an agency within the State that should be adequately funded and given the resources necessary to

effectively address health disparities when you talk about minority communities. So that's one area that I would like the State to continue to support, that particular office and the work that it does.

Also, when you talk about programs that are out there to address cancer, to address HIV/AIDS -- that that funding continues to stay at the levels, and consider increasing those funding levels, to adequately address these disease areas. So, that is one area. And you guys all have the specifics on the particular funding sources and the funding that needs to be allocated for these various programs.

But again, talking about what community-based organizations can do and what the community-based organizations are doing and volunteer organizations are doing-- There are fundings available from the State. One year, we received a grant of \$25,000, which was from the Christmas Tree account. And that was the first time I ever heard that we had a Christmas Tree account. And that money was made available to the 100. And through that \$25,000 that was given to us, we were able to educate and screen men of African decent for prostate cancer. That is the kind of creative funding streams that is important to be continued in this state. Understanding that we're facing a crisis within our budget, we must not lose sight of how important it is that we adequately fund these agencies and fund these programs.

I'm concerned about Medicaid and the lack of access that exists as it relates to the minority populations and getting adequate coverage -- the ChildCare -- the FamilyCare plan -- that has changed. Now you're only accepting children, no adults.

As a corporation who employs, as welfare-to-work partner -- who employs women off of welfare -- looking at our welfare reform act in New Jersey. The former Governor talked so highly about the reduction in welfare -- 50 percent. Also, the former Governor introduced a tax incentive plan for those who are low income from welfare-to-work.

We need to continue that type of funding in those types of programs. But one of the problems that we're finding, hiring from this population, is health insurance. Now that the State has cut the funding for FamilyCare and has limited it to only children, I have an enormous amount of adults who can't get health insurance.

Also, there's the issue about adequate child care. This is all related to health. There's not enough funding for child care. I spoke to parents for programs -- for parents the other day to refer a client, and was informed that there's a six-month waiting list. So how can you talk about health disparities, talk about reduction off of welfare, talk about all of these issues and not adequately fund the programs that's supposed to assist these at-risk families with moving into a positive direction?

I know that my time is limited. I can go on and on, again. But one of the things I just really want to emphasize and really push is that it's important that we work with the community and that you guys recognize the value of all of the community and what they play.

And the last thing that I want to say is, a program that we are involved with with the State, a commission on cancer research -- which is called IMPACT, to improve access to minorities on clinical trials on cancer. Now, it is very important that the minority community understands the long-term and

short-term benefits of participating in clinical trials, and also their involvement as it relates to new drugs and treatments that are being developed through research that -- how it impacts them.

So, with all of this said, I just want you guys to please continue to support, please continue to host these types of forums, and have an open mind when people come to you with creative, new approaches. Because, clearly, if all the stuff that has been put in place in the past worked, it wouldn't be necessary for us to have these forums. It has not worked, and we have to recognize it has not worked. And we have to be creative and open up our creative minds to look at new approaches to addressing the same old problems.

Thank you very much.

ASSEMBLYMAN EDWARDS: Well, thank you very much.
(applause)

I'm certain that the State of New Jersey is indebted to your continuous hard work towards eradicating some of the health care disparities that are prevalent in our communities.

At this time, I'd like to also call forward Dr. Yvonne Wesley, who's with the Black Infant Mortality--

Y V O N N E W E S L E Y, R.N., Ph.D.: Hello.

My name is Dr. Yvonne Wesley.

ASSEMBLYMAN EDWARDS: Dr. Wesley, if you could just use the mike, please.

DR. WESLEY: Good enough.

Hello, my name is Dr. Yvonne Wesley. I'm the Vice President for Research and Development at the Northern New Jersey Maternal/Child Health Consortium.

As many of you may know, the literature has shown, and many studies have shown, that race has an impact on health outcomes. Specifically, black infants are two-and-a-half times more likely to die in the first year of life compared to their white counterparts. The largest portion of this disparity is due to the fact that 12 percent of black women deliver prematurely, regardless of their age, their education, and marital status.

A growing body of literature contributes the high rate of pre-term delivery to psycho-social factors. Most prominent among these factors is stress. Based on the literature, the Reduce Stress for Baby's Best project was designed to decrease stress among pregnant black women to prevent pre-term labor and to prevent low birth weight. Approximately 120 women have been enrolled in this project from the northern part of New Jersey.

Registered nurses and social workers are trained as intervention specialists to provide free, one-on-one stress reduction sessions at approximately 15, 20, and 25 weeks gestation. Initial enrollment procedures include the completion of a demographics questionnaire along with a global measure of perceived stress scale.

The morning prior to the first intervention, the participants are asked to provide a saliva sample for cortisol analysis. This is a biochemical marker of stress. The intervention lasts 45 minutes and is guided by a stress management workbook. Participants are encouraged to maintain a journal about their feelings and stressful events during their pregnancy. They are

instructed to listen to a guided imagery audiotape especially designed for the Reduce Stress project, at least once a week.

The morning after the third intervention, the perceived stress scale is completed again, and a second saliva sample is obtained. Long-term follow-up data including birth weight, gestational age at delivery, and medical complications are obtained.

As of March of this year, 119 women have completed the project. Unfortunately, approximately 30 percent of the women disenrolled because they were unable to keep the three visits. The remaining women were, on average, 26 years of age, they had at least one year of college, and had a mean annual income of \$40,000. On average, this was the third pregnancy, and 63 percent of women were unmarried at the time they participated in this project. However, the data shows that women who had three visits had larger babies and kept them in utero longer than those women who disenrolled. The numbers are before you in the table.

Independent t-test analysis actually saw a significant difference in the reduction of stress from their first test to their last test. And, most important, the cortisol level did not increase significantly, as it should have, from pre- to post-intervention.

What I'm trying to say to you is that it's very, very important that we get a better understanding of why black women deliver prematurely. We need to know more, and we need to have more community-based programs that are systematically analyzed. They collect data. They actually look at their data and then disseminate their findings. We can no longer afford to just

compare races, because, by now, I think enough scientists understand that, from our genetic scientists, race is a social construct.

So I would ask that we begin to compare blacks to one another and not to compare across race. We really want to see an improvement in health outcomes.

ASSEMBLYMAN EDWARDS: Thank you very much, Dr. Wesley. Before you leave, Assemblywoman Weinberg has a question for you.

DR. WESLEY: Sure.

ASSEMBLYWOMAN WEINBERG: How interesting. Every time I think I know so much, I find out I don't. But we were given some written testimony from Ann Marie Hill, who is the Executive Director of New Jersey Commission on Cancer Research, that I just kind of perused. She's not going to be testifying.

But she did say that the New Jersey Commission on Cancer Research, in collaboration with the New Jersey Department of Health, are offering requests for applications for programs designed to foster the development of new research initiatives that will help identify-- Well, this mainly refers to cancer rates. But this is a-- These kinds of research programs are probably something that our Health Department -- and the liaison is sitting there -- should be involved with helping you analyze this kind of data so that we can make the -- so that you can make the appropriate medical decisions on this.

DR. WESLEY: Absolutely. There are certainly similarities in outcomes on all health outcomes when comparing black and white. The notion that the disparity for cancer is blacks dying higher from prostate cancer or

breast cancer-- I do believe, whether we call it research or community-based programs, I think the key thing is that we really do need to design interventions that are incredibly rigorous, that we understand what the impact of our intervention is. We're looking at a very community-based model here where we're using nurses and social workers to actually go in and intervene. We're not using medications, we're not using tablets, but we're using something that can be broadly used. And so when we talk about research, some people perceive that as something that's very scientific, something that's with a test tube as opposed to something that can really be community-based.

Thank you.

ASSEMBLYWOMAN WEINBERG: Thank you, Doctor.

ASSEMBLYMAN EDWARDS: Just one moment.

Assemblywoman Vandervalk.

ASSEMBLYWOMAN VANDERVALK: Thank you.

This is the first time I've ever heard there was something--

I guess this isn't working? (referring to PA microphone)

I was very interested in cortisol being a marker for stress and that you can-- It sounds like a simple test. Maybe it's not. And if it's simple, maybe it's inexpensive. And when you--

I mean, over and over and over, you hear that stress is a major factor on people's health. And since you had been able to turn this into something positive that you can work with pregnant women and see the better outcomes, is this really simple enough that we could use this across the board as-- I mean, all the years I've been to doctors, no one ever said, I want to stress your test -- I mean, test your stress. (laughter)

DR. WESLEY: Thank you.

The State Department of Health and Senior Services has actually funded this project. We don't actually label it as research, but it is a rigorous community-based project. The saliva samples cost us \$44 a sample. And, yes, it is a measure of stress. And that specific hormone, cortisol, actually elevates levels that will trigger that mom into labor.

And so we can all experience stress. But certainly for those pregnant women, and especially black women who are already at risk for pre-term labor and much greater risk than others, we really want to try to identify those black women who have high cortisol levels, because they are at increased risk of delivering prematurely. And so far, the data is suggesting that we have an intervention that's working. And so we'd readily be willing to replicate it. And the State Department of Health has begun to help us do that.

ASSEMBLYWOMAN VANDERVALK: I really thank you for that information.

ASSEMBLYMAN EDWARDS: Thank you.

Thank you very much, Dr. Wesley. It was very informative in providing a lot of insight to this Committee. (applause)

I'd like to call Gloria Caboy, from Horizon Mercy.

G L O R I A C A B O Y: Thank you very much for having me here.

ASSEMBLYMAN EDWARDS: If you could just use your mike.

MS. CABOY: Yes, thank you.

My name is Gloria Caboy. I'm a social worker with Horizon Mercy, the Health Maintenance Organization. We cover the whole State of New Jersey. We have the contract -- well, one of the contracts. And

personally, I work out of the northern region. I am the Senior Social Worker for the North, which means we cover most of the North -- all of the northern counties. A lot of the urban black and Hispanic populations are there. I am here to address the disparities and barriers to receiving health care from a social service perspective, as a social worker.

Prior to coming to Horizon Mercy, I worked for the Coalition on AIDS in Passaic County and, also, for domestic violence at a home -- at a shelter for abused women. And across the board, all of the social services are, basically, the same.

The main issue for health care is the issue of transportation. We depend on livery service to bring our clients to and from doctor's appointments. And they have been found to be very unreliable. They come in late. They don't show up. They have long waits. And most of our members are quite sick, and they have very -- they have a lot of difficulty waiting for service to pick them up and to bring them back home. Most of our members do not drive. They have no other way of getting to the doctor.

That leads me to the next barrier, which is cash flow. Members have no financial means to get to the doctor, whether it's -- except for livery transportation or by public transportation. And they really don't have the means or the moneys. Somebody before me spoke, already, of the little moneys they get from either welfare, SSI, TANIF, all the programs. So they really have no moneys to pay for public transportation or for taxi services.

Communication -- a lot of our members have no phones. It's very, very difficult to get to them. It's very, very difficult for them to get to a phone if they need to call to make an appointment with a doctor, to make an

appointment for follow-up visits, or even to call 9-1-1 if they have to. It is extremely difficult to reach them, and we are dependent on their families and friends to give messages to them.

Here again, another issue is child care, which I also heard somebody talk about. Child care-- Like I said, the members have no moneys to pay for child care. And it's very hard for them, when they do get to the doctor's office, to pay attention, and to know what they're doing, with little children running around the office. Also, they have a lot of difficulty if they have older children in school while they're at the doctor's office waiting, and they have to wait there for long periods of time and they have to rush to get their children picked up from the doctor.

One thing that affects a lot of my clients is the language barriers. Communications are very difficult with Spanish-speaking and other languages, also. Members cannot reach out for services, and they have difficulty communicating with their pharmacists, with their doctors, and with any other social care agency that I would refer them to. We do have bilingual personnel in my office. But for those that don't, it's very hard talking through an interpreter.

Illiteracy is a very big barrier, also, that they have to overcome.

And also, I heard somebody here talk about the housing and the food -- that those are very big issues for our members. Our members are usually at risk. And when you're at risk, health insurance, health care becomes a secondary issue. They cannot concentrate on trying to get -- access their medical help if they don't know whether they're going to be out of a house by next week, or no food for them or for their kids.

Lack of information in the community for our members is a big issue, too. I ask you to support the legislation that will expand and improve all of these services, allowing them to get to the medical help they really need.

And I thank you for the opportunity and the time you have given me.

ASSEMBLYMAN EDWARDS: Thank you very much.

I'd like to call up Lula Linder.

But in this moment, I'd like to recognize Assemblyman Thompson. He has a question for Dr. Wesley.

ASSEMBLYMAN THOMPSON: Dr. Wesley, I apologize for being a little late in bringing this up. But I was still reading over your study as you left. I have just a suggestion for you.

DR. WESLEY: Yes, thank you.

ASSEMBLYMAN THOMPSON: I note that of those that remained in the program through the three interviews or sessions, it indicates that on the average, this was the third pregnancy for these individuals.

If the data is available, I would think it would be interesting to compare the birth weights and the gestation periods for those people with their first and second babies when they did not go through this, to see if they themselves experienced a change.

DR. WESLEY: Although the data there doesn't show that, for those women who participated, we still had that same 12 percent pre-term labor. So, we haven't looked at the data to see whether or not our intervention prevented 12 percent of our numbers. They're too small right now. If you see, that's data on 44 women. And so our data is too small right now. But we will

be looking to see, can we decrease the percentage of women who deliver prematurely? Certainly, we could see the women who had the three interventions -- their babies weighed more than the women who didn't. And their gestations were longer than the women who didn't. But we will begin to see, whether or not, when our sample gets larger.

ASSEMBLYMAN THOMPSON: There was a change for the same people that had it.

DR. WESLEY: That's right. Are we changing the percentage of women who deliver?

ASSEMBLYMAN THOMPSON: There was a change for the same people that had it, because here you have people who had previously had babies but did not have intervention at that time.

DR. WESLEY: We couldn't-- That would kind of be a bit of a retrospective, and we were trying to go prospectively. In the sense of trying to look back at their previous pregnancies, we could, maybe, use those as a control group to say whether or not -- "Well, you never had an intervention. Did you deliver prematurely then?" But, certainly, for women who have delivered prematurely in the past, they're even at increased risk for delivering prematurely.

But I do appreciate your comments. Thank you.

ASSEMBLYMAN THOMPSON: Thank you.

ASSEMBLYMAN EDWARDS: Thank you very much, Dr. Wesley, for those remarks.

I'd like to call up Mrs. Linder, from AD House.

I did tell the members that they would be able to get out of here by 1:00 today to get back to Trenton. However, we have about five more speakers. I'll just ask that you please be mindful of the time. The members have been very patient, and I'm very appreciative of their time and attention to this very important issue.

LULA LINDER: Thank you. Good afternoon. I would like to thank the Committee for coming to East Orange and inviting me to testify.

My name is Lula Linder, and I'm the Founder and Executive Director of AD House. I'm a licensed social worker. The AD House is located in the heart of Newark, in the community.

I'm here to talk about black infant mortality. Dr. Wesley has already given important information, which I will not repeat. But I'd like to talk about some of the issues that relate to Newark, in terms of infant mortality.

In Newark, each week, 12 children are born with low birth weight. Each month, 23 babies are born not having received prenatal care. And each month, over 74 babies are born to girls under 19. The number of births to unwed mothers was 69 percent. The total births to women under the age of 14 was 25, and the birth of women -- birth of babies to women age 15 to 19 was 863.

In 1998, 13.2 percent of the births were low birth weight. Six percent received no prenatal care, from the total births of 4748. And the infant mortality rate per 1000 was 13.5 percent. And according to research, stress has been shown to be a significant risk-factor for pre-term delivery and low birth weight.

AD House is a private, nonprofit organization that received funds from the State Department of Health for infant mortality -- to prevent infant mortality. And what we provide is a real outreach program, to outreach -- for the pregnant women to get them in for early prenatal care. We've been very successful with the project. However, we do still need funding for more nonprofit organizations to provide support for the pregnant women in the cities of Newark, East Orange, Irvington, and Orange.

AD House has been able to provide the barriers for the women accessing our prenatal care, and those barriers were transportation. We provide the bus tickets for the parents to get back and forth to their prenatal care appointments and, also, to other appointments that they might have, such as blood work, ultra sounds, or other appointments that are made by the midwives.

We also have incentives to help them to keep their appointments. And we have follow-up -- a strenuous follow-up program where we actually go to home visits for people that have missed appointments. We also send out letters and make phone calls.

My plea to you is that there should be more money available for nonprofit organizations to help with this problem, which is black infant mortality.

ASSEMBLYMAN EDWARDS: Thank you very much for that testimony.

Mrs. Lula Linder, I'm familiar with the work that you do, and I commend you for your efforts. And thank you, again.

MS. LINDER: Thank you.

ASSEMBLYMAN EDWARDS: At this time, I'm going to call up Linda Ellerbe. And following her will be Mr. Fairley Martin.

REVEREND LINDA G. ELLERBE: Thank you.

To our Chairman Edwards, and to the Committee Chair Weinberg, and the Co-Chair, and to the Committee, thank you for the opportunity to address the current status of HIV/AIDS in the minority community.

I've provided, for each of you, a red folder. That was me. And a lot of the information is encouched in there to cut down on my talking time.

Unfortunately, the report is just not good when it comes to what is happening with HIV and AIDS in our community. And we understand that the minority community is in a health crisis in general and being assailed, in particular, by HIV and AIDS.

I am privileged to direct a statewide HIV faith-based community mobilization agency, which is funded by the New Jersey Department of Health. And we are the New Jersey Human Development Corporation Project Faith. And we do education, prevention, and we collaborate so that testing and care and treatment information can be disseminated to people. We work specifically through houses of worship.

While great efforts have been made in care and treatment, and research efforts have been herculean, the numbers of HIV-infected and dying continue to rise in our community.

The New Jersey Department of Health has identified 10 cities which were most severely impacted. You have the list before you. In the 8.4 million residents in New Jersey, coming from the 2000 year census, we find

that 13.6 are African-American, 13.3 are Latino. When we begin to look at what is happening with regard to HIV in our state, we find that there are 42,000-plus cases that have been reported. About 26,000 of those case reports have expired. They are now deceased.

In the African-American population, 56 percent of all reported cases come from that community, 16 percent from the Latino community. I do just want to put a pin in that 56 percent number, because it reflects 2 percent of the African-American population. And that does have some significance when it comes to epidemiology.

It is my understanding that when a pandemic or epidemic reaches 2 percent of a population, it is time to move from overconcern to panic. Ten years ago, in Africa, we had 2 percent. If you look at what happened, it did not go from 2 percent to 3 percent to 5 percent. It went from 2 percent to 10 percent to 20 percent. It begins to move on an exponential level. And we need to understand that, in New Jersey, we have hit that mark in the African-American community. And it is time for us to be very concerned and take action.

New Jersey still ranks fifth in the nation of reported HIV/AIDS cases, following only New York, California, Florida, and Texas. And we have the dubious distinction of practically leading the nation in percentage of cases caused by intravenous drug use. Across the nation, you will find that HIV is being spread through sexual transmission, whether it be in the gay community or in the heterosexual. But in New Jersey, the leading cause comes from drug use, using needles -- using dirty needles. And I know there's some legislation somewhere that wants to talk about that.

Unfortunately, noncommunication about critical issues is inherent in the African-American and Latino cultures. There are just some things that we're not comfortable talking about. But I've come today to say that we've got to take the lead, as leadership in the state, and begin to talk about the things that are killing our people. Sex, sexuality, drugs, personal choices must be talked about openly. The repercussion of our silence is death.

In my opinion, it is imperative that our leadership take some immediate actions to identify persons who are infected. We have numbers that represent those who have been tested and reported. Our biggest fear is that there is a larger percentage than those that have been reported that are infected and don't know it.

There is precedent-setting legislation already, in terms of immunizing children. You're not supposed to go to school unless you get your shots. There are some places where you can't get a passport unless you've been tested for certain diseases and get certain immunization. We need to find ways to legislate mandatory testing.

Today, if you become pregnant, you're supposed to be tested to see if you're HIV positive so that you can be adequately treated. There are certain things you have to do before you go to college. There are certain things you used to have to do before you got married. We don't have to get tested for syphilis anymore. And as just an aside, syphilis is on the rise in New Jersey. So perhaps we need to go back and say, "There are certain places in our lives, before you are allowed to do certain things, you need to know your status, because you are at risk, and could be a risk to public health."

The asymptomatic period for HIV and AIDS is such that you can be a positive person, have a zero-positive reaction to the test, and feel fine, look fine, not have any symptoms at all, and you can still infect others.

We need to spread an emphatic emergency message in our communities with regard to prevention, care, and treatment. We're dying too fast in the African-American community. There are medications that are available that give quality of life and long life. But either they are not available, or to get them it's so difficult that people who are already dealing with issues that we've heard about, housing and food, cannot navigate the system to access what they need to live.

We need to teach prevention in school. We need to teach it in houses of worship. And that's what Project Faith does. In cultural clubs, in social settings, we have to make the message an in-your-face, everywhere-you-go message.

I'm very proud of New Jersey for the efforts we have made for nonsmoking. I have seen billboards in Spanish. I've seen them in English. I've seen them with black folks. I've seen them with white folks. And the message is, "You don't need to smoke," especially for our young adults. I have not seen any billboard about HIV. I have not seen anything in a newspaper. I have not seen anything on a cable station. I have not seen or heard anything on the radio that carries the message that we're in the midst of an epidemic. And I think that we need to appropriate funds to make sure that everyone, on every level, gets the message.

And then we need to address the pertinent issues surrounding HIV. Intravenous drug use, the availability for persons that don't want to get

high anymore but can't get into a detox, can't get into a rehab-- There's legislation that we can move to appropriate funds to make available more beds. I understand that the drug industry is a leading industry in New Jersey. But if we can decrease the demand for the drug, we can reduce-- And then if there's legislation that makes it a little tougher to sell drugs-- There's a lot that we can do.

We need to, also, look at legislation about how you are released from the penal system. On a State level, you get tested when you're going in. And in some counties and local facilities, you are tested, as well. But a lot of people are not being tested as they come out and get mainstreamed back into society.

So I may have gone to jail and tested negative, but while I was in jail, engaged in activity that put me at risk, and when I'm coming out, I'm positive. But nobody's testing me. So when I go home to my wife, when I go home to my mate, I'm carrying that with me.

And the fact is that there is a new culture, and there is some new terminology that's coming forth, that every man who engages in sex with a man is not going to identify as gay nor bisexual and is called the down-low or the DL. These brothers are coming out of jail-- They will deny until they die that they have engaged in that activity, because it's going to wreck their happy home, or it's going to change their status in the community, or it's going to put their job at jeopardy. But we need to begin to dialogue and put things in place so that innocent people and unknowing people are not affected.

The last thing that we would need to address is teen pregnancy and sexuality. And I believe that we can do that through school and through some of the CBOs and FBOs that are in place.

Project Faith is happy to do what we do. We're funded by the Department of Health. I've given you information about some of the activities, and some of the profiles, and some of the things that we are doing, so we're not going to address that at this time.

But I do thank you for the opportunity to say a word about HIV.
(applause)

ASSEMBLYMAN EDWARDS: Thank you very much.

If you'll just hold on for one question, because Assemblywoman Weinberg has one.

ASSEMBLYWOMAN WEINBERG: Thank you very much, Ms. Ellerbe.

First of all, on your target cities, what constitutes a hot city, as opposed to an impact city?

MS. ELLERBE: Impact cities were designated by the Department of Health as those cities most severely impacted.

For the work of Project Faith, when we looked at that, we found that it was not an adequate list for our work. We identified areas that are-- If they had 20 cities -- impact cities, these would be the other 20. But these are the areas that are next in line, but they have not been designated by the Department of Health or by my agency.

ASSEMBLYWOMAN WEINBERG: Okay. I have one comment, and then another question.

I was at a women's health conclave over this past weekend. And one of the statistics that I was given that I quoted -- and this just affected women, it was not separated out by color, and I'm pretty sure I remember this correctly -- the average in the country of AIDS per women, per 100,000 population, was a little over nine. The average in New Jersey was close to 27 per 100,000 population. I mean, it was just phenomenal how much higher we were.

But I would, also, like to ask you for a comment on needle exchange, which is a program that the Governor has embraced if it's a hospital-based needle exchange program. And it is an issue that this Committee will be taking up in the not-to-distant future.

MS. ELLERBE: They told me you were going to ask--

ASSEMBLYWOMAN WEINBERG: I'm sorry if I caught--

MS. ELLERBE: Because we are State-funded, I do have to be careful about what I say about needle exchange. And I will preface that by saying this is my personal opinion. Amen.

One, with regard to your statistics, before I get there, in the United States, for the African-Americans, the statistics are just outstanding. One out of every 50 men are infected, and one out of every 160 women. So, when she's talking about 27 per 1000, that's not us. Our statistics are much, much worse across the country.

With regard to needle exchange, I think that simply exchanging dirty needles for clean needles is not enough. I think that when you surround needle exchange with education, with rehab, with detox, with some other areas that treat the whole person, you can begin to become effective.

One of my concerns is that, even if needle exchange becomes law and it's available, we have to be careful how we present it to the people that need it the most, because there is, of course, a fear that I'm engaging in an illegal activity, yet the State is saying, "Okay, we're going to help you do that." So I think there would be a reluctance on the part of persons that need it the most.

But if you put needle exchange in the community, in CBOs and FBOs that already have relationships with the people -- they're already getting condoms, they're already getting counseling, they're already being case managed, and you add that as a risk-reduction tool for those that are already engaged in the work, I think that you would see major success. But I think that we have to be careful how we frame the legislation for that and how it's implemented.

ASSEMBLYWOMAN WEINBERG: We will be back in contact with you as that issue gets developed.

MS. ELLERBE: Thank you.

ASSEMBLYMAN EDWARDS: Thank you very much.

At this time, I'm going to call Mr. Fairley Martin.

FAIRLEY H. MARTIN: Good afternoon. I would like to thank the Committee for allowing me to speak today.

This is, basically, a follow-up to -- can you hear me -- a follow-up to Ms. Ellerbe. And within the context of racial and ethnic disparities in health care is a subcategory of disparities that impact our elderly, and, therefore, compound health care problems for the elderly black and Latinos.

Over the past five years, my wife and I have been working as grant writing consultants for various educational and social services agencies, child care to senior care. For the past two years, we've been working with senior services agencies writing direct service grants, most of which have health care components.

What has disturbed us most during this process of securing health care funds for seniors has been the reluctance of funding agencies and foundations to provide funding for senior health care initiatives. When my wife and the director of one of the agencies for which we work met with one health care foundation's board to present an innovative proposal to direct senior clients to health care sources and resources for health care -- AIDS and Hepatitis C -- one board member asked, "What's the point? They're going to die soon anyhow." In other words, why are we wasting money on the health care for seniors whose lives are almost over?

The point is, all persons classified as elderly or seniors are not locked away where the community can be protected from whatever communicable disease that they might have. HIV/AIDS is one that comes to mind. Over 10 percent of all new AIDS cases in the U.S. occur in people over the age of 50. In the last few years, new AIDS cases rose faster in middle age and older people than in people under 40. While many of these AIDS cases are the result of HIV infection at a younger age, many are due to becoming infected after age 50.

It is difficult to determine rates of HIV infection among older adults, as very few persons over the age of 50 at risk for HIV routinely get pregnant -- I mean tested -- very sorry. Most older adults are first diagnosed

with HIV at a late stage of infection, when they seek treatment for an HIV-related illness.

A common stereotype in the U.S. is that older people don't have sex or use drugs. Very few HIV prevention efforts are aimed at people over 50. And most educational ad campaigns never show older adults, making them an invisible at-risk population.

Women comprise a greater percentage of AIDS cases as age increases. While 6.1 percent of all AIDS cases among those aged 50 to 59 are women, the percentage of cases occurring among women rises to 13.2 percent for age 60 to 69, and 28.7 percent for those 65 and older.

Doctors and nurses often do not consider HIV to be a risk for older patients. Many people live -- many older people live in assisted living communities where there is still a great stigma attached to HIV/AIDS. And we have all heard of the stories of the first-of-the-month issues with prostitutes and senior men. It's true.

Unfortunately, few prevention programs exist that target adults over 50. Most programs for older adults offer support for HIV-positive persons or target clinicians and caregivers of older adults.

While HIV/AIDS is the example used to point out health care disparities between seniors and the young, in the paper that I've written the attitude of, "What's the point? They're going to die soon anyhow," when applied to health care in general, can have serious consequences for the general population, and the black and Latino communities, especially.

Thank you.

ASSEMBLYMAN EDWARDS: Thank you very much.

Mr. Martin, as chairman of a local housing authority in an urban community, I oftentimes look at the staggering numbers that come through of the cases of senior citizens who have contracted HIV at an older age, and it's alarming because of all of the other health associated issues that go along with them. And it's definitely an issue that we need to address and delve into with the same sort of veracity that we have in other areas.

Thank you very much for your testimony.

At this time, we will call Kristina Thomson, from the American Cancer Society. And following Ms. Thomson is Dr. Dolores Ensley.

K R I S T I N A T H O M S O N: Good afternoon.

My name is Kristina Thomson, and I am a licensed clinical social worker with over 20 years of experience in health care. Probably a third of my career I actually worked here in this community at one of the local hospitals.

In light of the fact of the time, I am not going to read directly off of my testimony, but will share a copy of it for you. And rather, what I wanted to do was take a moment to talk a little bit about my experience.

As a social worker here in this community, over 10 years ago I remember walking into the radiation oncology department to find a young woman in her 30s who had waited to come and be seen by a physician, despite the fact that she felt a lump in her breast and now the lump is protruding through.

My memory fails me to tell you whether or not it was because she was afraid of what she was going to find, and she knew what it might be; or was it she was concerned that she knew she didn't have health insurance, and it was a question between paying the rent or putting food on the table for her

children. I don't know, though I know that from all the other testimony that you've heard, those are often the reasons that people delay getting treatment.

Also, there are many myths around cancer, its treatment, and what it means, and so people are reluctant, in their concern, on whether or not the health care system will be there for it.

The speakers before me so eloquently, already, told you about the statistics and how certain minority populations are more affected both by diagnosis, diagnosis at later stages, lack of access to care, prevention, or early detection. And that information is also available for you in my testimony.

What I want to take a moment just to share with you is my most recent experience. For the last three years, I've been privileged to be the Director of the Pain Initiative, a project of the American Cancer Society. And in that role, I walk throughout the state with various health care facilities, primarily acute care facilities, working with their teams to address pain management. This has been a great focus by the joint commission. And we actively work to train over 2000 health care professionals in the state on, really, what are the best practices in pain management.

I am sorry to have to report to you, despite the fact that I haven't lived in, or worked in, this community in the last 10 years, that what I was still horrified to hear is, that in certain urban settings, physicians are reluctant to prescribe pain medication for patients and are actually prescribing placebos.

Now, obviously, I cannot identify which hospitals it came from, but I can tell you I've heard it more than once throughout this state in various urban settings, because there are concerns about addiction, because there is not knowledge of physicians about appropriate pain medication. This is just

horrible. And by looking at your faces, I know that you agree with me that this should not occur. There needs to be more done.

As an organization, the American Cancer Society has developed numerous programs to be able to reach out to those populations that are underserved in terms of cancer. And those programs -- some of them are highlighted for you, Tell A Friend, Sister to Sister. We've worked with the 100 Men Black Caucus around prostate cancer, as well.

And as I mentioned, in my work with the Pain Initiative, we've really tried to go out and help to dispel those myths, so people should not be frightened or afraid. We need to continue to do that. We need to collaborate on many, many levels -- the organizations, the people represented here today, as well as all of you.

Thank you very much for your time.

ASSEMBLYMAN EDWARDS: Thank you very much.

Dr. Dolores Ensley.

D O L O R E S E N S L E Y, D.C.: Good afternoon.

I'd like to thank you for being here and allowing me to speak.

I'd like to use my time to speak more -- put my focus on prevention and education, more so than treating.

My name is Dr. Dolores Ensley. I practice chiropractic in Orange, New Jersey. I'm also the President -- Chairperson of the Gap Committee for the Newark Branch, NAACP.

What we do is, we team up with other organizations and associations, and we have volunteer medical doctors in every discipline to come

out. And we engage in community-based health fairs -- health forums. We go out, we teach, we do basic screening, and we raise the awareness.

What I'd like to, also, shed a little light on is that health disparities also exist with insured minorities. So, it's not just-- We talked a lot about the uninsured and the underinsured. But the Institute of Medicine did a recent study showing that minorities receive approximately 40 percent less care than their white counterpart, even if they're equally insured. So I just wanted to state that.

Now, my recommendations are, and you have a list of that, is-- One of the young speakers from the high school -- I concur with some of her ideas about having a healthy fun forum day and making it mandatory. I feel that relentless education, incessant perseverance, and government intervention is probably the only way we really will eliminate health disparities, because what we have found in our history is that people don't always do the right thing.

So I feel that each individual has to take responsibility for their own health. It's up to us, as health care professionals, to teach, and raise the awareness, and empower our patients to go out, and they have to say -- they have to be their own advocate -- "What are my options? What other choices do I have?" I don't think we can just leave the entire responsibility to the health care professionals. I think the persons have to assume some of that responsibility.

So I suggest that a mandatory health forum, where we speak in a language that our people want to hear, appeals to us, because we can't use white majority solutions to solve black minority problems. We do things,

sometimes, a little differently. So embrace our cultural differences. And what we want to do is incorporate what makes us different.

Most importantly, we need community-based minority doctors to go out and teach and provide role models for our youth. The child adolescent one-day health fair forum will provide screening, health classes, and one-on-one health consultation. That way will serve a dual purpose. One, it will have the role model -- we need more minority doctors that understand our cultural differences. And two, they could provide one-on-one classes and raise awareness about what's important and what questions you should ask.

So thank you. And that's all I want to say. Thank you.

ASSEMBLYMAN EDWARDS: Thank you very much, Dr. Ensley, for pointing out the disparities that exist in those individuals who do have insurance equal to their counterparts in different ethnicities.

At this point, I'm going to bring up Priscilla Harris-Webb. (no response)

Moving forward, Louise Bates Jennings. (no response)

Moving forward, Tracey Reed, from the March of Dimes. (no response)

Dr. Audrey Jones.

A U D R E Y J O N E S, D.Min.: I just want to say thank you for providing this forum and an opportunity for community residents to come and to speak to this very important issue, certainly an issue that is very important to me.

Some of my predecessors have spoken to the issues that concern me very much. I am the Founder and the President of the East Orange

Community and Congregational Health Promoters, a nonprofit organization that, really, grew out of my doctoral dissertation. I am not a medical doctor. I'm a doctor of ministry.

Some of the things that I look at, or we've looked at, is what the causes of health disparities are. And frankly, I've been kind of tired of talking about the fact that they exist. It seems like everybody knows that they exist, but not a lot is being done. And maybe there is -- there are some things that are being done, but it's a slow process. These health disparities have existed for many, many years. And I think there are things in place or programs in place that can deal with them.

One of our goals is to, in five years, have every church or faith-based organization in the city of East Orange develop a health ministry -- that the health ministry would become a part of the ministries of the church. And, of course, one way of doing that is through parish nursing. And there are other ways to do it.

What we really need to do in the churches-- We look at things such as public policy. Policy, unfortunately, is being made. And those members of our community are not at the table. The pastors, or the churches, or faith-based organizations may become involved in the political arena.

We know that lack of access-- And Dr. Ensley just mentioned this -- that people with insurance-- My experience has been that the problem is not with people that just don't have insurance. There are many people that have insurance that are just, absolutely, afraid to go to the doctor. They are afraid of what the doctors -- number one, what they might tell them, what they might

find out, but they're also afraid of not getting the proper treatment as African-Americans -- not being looked at in the same light.

For example, one of the things that has happened, that was brought to my attention recently, was that a woman had a lump in her breast, went to a doctor, and was told, "We'll watch it." Well, no we won't watch it. We'll do a biopsy. And so we need to educate our people in knowing -- helping them to know that they have a right to say to the doctor, "No, we don't want to watch this. I want to have a biopsy. Would you please send me for that?"

A heart-wrenching experience was what happened to a friend of mine. Her daughter was 27 years old. She had a lump in her breast, went to the doctor, and he said, "You're too young. We'll just watch this." So she watched it. She never told her mom. She lived in Maryland. Her mom lived here in New Jersey. She had just finished college. And by the time she told her mother, her breast was black, and it was just too late. And shortly after that, she passed away from breast cancer.

What I would like to challenge this Committee to do would be to continue funding. We have received -- our organization has received some funding to do some work with HIV/AIDS from the Department of Minority and Multicultural Health. We certainly appreciate that. And we also have received a grant to do some work now on diabetes.

But what I would like for us-- The problem that I see, as we work through this, is a very difficult task -- is that we create coalitions. We've created coalitions of churches that collaborate with local health agencies to get trained.

Now, the problem is, in the churches, money becomes an issue. In the hospitals, money becomes an issue. We have all kinds of great ideas, but the buck stops when everybody gets to the place where they say, "We don't have the money to do this." And we cannot do it without money.

One of the issues that I see is that when we have the hospital -- we have a relationship with East Orange General Hospital. They are the persons who will provide training for our health promoters that the churches have identified, who will do these activities in the churches through the health ministries.

And these people are volunteers. It is very difficult to get people to come out and volunteer to teach classes on Saturday afternoons and other times. Maybe if funding was available to pay them to do the job-- But the idea is to collaborate with local community-based organizations and faith-based organizations, collaborating with the hospitals or other health agencies to get this message out, of education. And we deal with education and prevention.

So I ask you to continue the work that you're doing. The fact that you're here is encouraging for me. And I look forward to seeing more of you in this community. And I look forward to us having more funding to get this job done.

Thank you very much.

ASSEMBLYMAN EDWARDS: Thank you very much, Dr. Jones.

At this time, is there anyone that I did miss? (no response)

Seeing that there are no more speakers before this Committee, first let me thank Cicely Tyson School; Principal Trimmings for opening up her doors, the board of education; my staff; OLS; the Chairwoman, Loretta

Weinberg; and all of you that have come out today to present, to highlight some of the disparities that exist in urban communities.

I thank you, and I'm certain that the Committee thanks you for your time and your insight into these particular areas, so that we can go back and formulate pieces of legislation that can be most effective to all the residents of the State of New Jersey.

At this time, I'm going to turn back over to our Chair, Loretta Weinberg.

ASSEMBLYWOMAN WEINBERG: Thank you very much.

I would like to, again, give a very big thank you to Assemblyman Edwards for coming forth with this idea, for bringing it into the community of East Orange, because it really gives us a chance to hear from the people who are in the front lines and on the front lines.

I think this was, Assemblyman Edwards, a job well-done.
(applause)

And a special thank you to our Office of Legislative staff, to our partisan staff, because when we take a Committee meeting outside of the State House, they are the ones who are responsible for the microphones and the signs. And it really is doubly hard for them to keep this Committee going. So a special thank you to those staff folks. To our reporter, who is sitting at the end-- We will have a verbatim transcript of this, because it is all recorded. Thanks again, to the staff members.

Again, our thanks to the city of East Orange and the school system. And I hope that it helped the kids at school here, who've had an opportunity to see their government in action.

Thank you, one and all.

ASSEMBLYMAN EDWARDS: And also, a thank you for my staff. Councilwoman Johnson, Jeanette Davis, and Dwayne Harris, who have also provided us with some refreshments -- if you'd like to take part and speak to those remaining members.

Thank you very much.

(MEETING CONCLUDED)