Executive Summary

OVERVIEW

In 1985, the United States Department of Health and Human Services (HHS) released a landmark report documenting the existence of health disparities for minorities in the United States. It called such disparities, "an affront both to our ideals and to the ongoing genius of American medicine." In the decades since the release of that report much has changed in our society—including significant improvements in health and health services throughout the nation. Nevertheless, health and healthcare disparities continue to exist and, in some cases, the gap continues to grow for racial and ethnic minorities, the poor, and other at-risk populations. Beyond the heavy burden that health disparities represent for the individuals affected, there are additional social and financial burdens borne by the country as a whole. These burdens constitute both ethical and practical mandates to reduce health disparities and achieve health equity.

New approaches and new partnerships are clearly needed to help close the health gap in the United States. The *National Partnership for Action to End Health Disparities* (NPA) was established to mobilize a nationwide, comprehensive, community-driven, and sustained approach to combating health disparities and to move the nation toward achieving health equity. The mission of the NPA is to increase the effectiveness of programs that target the elimination of health disparities through the coordination of partners, leaders, and stakeholders committed to action. The NPA is a critical and innovative step forward in combating health disparities by bringing individuals and organizations within the health sector together with other individuals and organizations whose work influences health.

The initial and primary product of the NPA, the *National Stakeholder Strategy for Achieving Health Equity* (National Stakeholder Strategy) provides an overarching roadmap for eliminating health disparities through cooperative and strategic actions. The other two key components of the NPA include: Blueprints for Action that are aligned with the *National Stakeholder Strategy* and guide action at the local, state, and regional levels; and targeted initiatives that will be undertaken by partners across the public and private sectors in support of the NPA.

In addition to the *National Stakeholder Strategy* launch, HHS jointly issued the first ever departmental health disparities strategic action plan. The HHS Action Plan to Reduce Racial and Ethnic Health Disparities is focused on improving the health status of vulnerable populations across the lifespan. It will assess the impact of all HHS policies and programs on health disparities, promote integrated approaches among HHS agencies, and drive the implementation of evidence-based programs and best practices.

Together, the HHS Strategic Action Plan and the *National Stakeholder Strategy* provide visible and accountable federal leadership while also promoting collaborations among communities, states, tribes, the private sector and other stakeholders to more effectively reduce health disparities.

HEALTH DISPARITIES

The existence of health disparities in the United States has been extensively documented beginning with the 1985 *Report of the Secretary's Task Force on Black and Minority Health*, and continuing on with more recent reports such as the 2002 report from the Institute of Medicine (IOM) (*Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*), and the yearly *National Healthcare Quality Report*s and *National Healthcare Disparities Reports* from the U.S. Agency for Healthcare Research and Quality (AHRQ). Earlier reports generally focused on disparities among racial and ethnic minorities and individuals of below average socioeconomic status (SES). However, a body of evidence continues to expand, which documents the existence of other health disparities by, for example, gender, literacy level, sexual orientation or gender identity, disability status, geography, and age. For example, rural and urban areas have significantly different health-related concerns, health risks, and healthcare resources. Individuals at different stages in life may be particularly vulnerable to risk factors for certain adverse health outcomes, which is demonstrated by the fact that adolescents and young adults are particularly at risk for injury deaths, suicide, and illicit drug use. The likelihood of adverse health outcomes for any of these various other populations is often greater when the individuals are from racial or ethnic minority populations.

The list is long for the diseases and related health concerns that are well documented as having significant disparities for certain populations. Examples include, but are not limited to, infant mortality, cardiovascular disease, cancer, HIV/AIDS, diabetes, chronic lower respiratory diseases, viral hepatitis, chronic liver disease and cirrhosis, kidney disease, injury deaths, violence, mental health disorders, and poor oral health.

The causes of health disparities—and the barriers to good health and health care—are multiple and overlapping. Many of the underlying risk factors that contribute to health disparities are the result of a host of interrelated elements that affect individuals across their lifespan, from birth to death. These factors, commonly called "determinants of health," influence the health and well being of individuals and communities for good or ill; together they interact to impact health. The determinants of health can be categorized under four broadly accepted categories:

- **Social determinants of health**—examples include gender, socioeconomic status, employment status, educational attainment, food security status, availability of housing and transportation, racism, and health system access and quality

- **Behavioral determinants of health**—examples include patterns of overweight and obesity; exercise norms; and use of illicit drugs, tobacco, or alcohol

- **Environmental determinants of health**—examples include lead exposure, asthma triggers, workplace safety factors, unsafe or polluted living conditions

- **Biological and genetic determinants of health**—examples include family history of heart disease and inherited conditions such as hemophilia and cystic fibrosis

The significance of the determinants of health has increasingly become a matter of discussion and research, along with the recognition that preventing disease and promoting health—rather than just treating disease once it appears—has tremendous potential for reducing health disparities and improving our nation's health. Placing the emphasis on prevention through, for example, the promotion and support of children and strong families, healthy lifestyles, and healthy working and living conditions has often been undervalued as a means of achieving and maintaining wellness. Efforts to eliminate health disparities must address determinants of health throughout an individual's lifetime. Health status should be of concern to policymakers in all sectors, not just health-related sectors—to develop policies and programs that tackle the fundamental causes of health inequity.

A HEALTH EQUITY STAKEHOLDER STRATEGY

The *National Stakeholder Strategy* development process was initiated and sponsored by OMH and consisted of a series of activities that engaged the wisdom of the multitude of individuals on the ground; in communities; in local, state and tribal organizations; in government agencies; and in places of education, business, and healthcare delivery—in short, the experts in efforts to reduce health disparities throughout the country.

Using a "bottom up" approach—thereby vesting those at the front line of fighting health disparities with the responsibility of identifying and helping to shape core actions for a coordinated national response to ending health disparities—the development process included the following:

Select comments from Regional Conversation participants

- "This Regional Conversation created a wonderful opportunity for each participant to have a voice."
- "I loved being a part of this creative process."
- "I was able to objectively look at our current programs and to be open to new ideas."
- "This experience reminded us all that there is most definitely a need for information sharing between organizations in order to end health care disparities."
- "It's critical to know who our partners are in our efforts to eliminate health disparities. Listening to perspectives from nontraditional partners is essential for applying new ideas."

- A **national summit** of nearly 2,000 leaders who were challenged to consider how best to collectively take action to effectively and efficiently reduce health disparities and advance health equity. OMH responded to the shared concerns of the Summit participants and formulated a draft version of the goals and principles of the NPA.

- A series of **"Regional Conversations"** with stakeholders in the ten HHS health regions in order to define, refine, and collaborate on a plan to eliminate health disparities through cooperative and strategic actions

- A variety of **focused stakeholder meetings** sponsored by OMH to analyze input that had been received—in order to finalize NPA and *National Stakeholder Strategy* goals, principles, and strategies

- An extended opportunity for **public review and incorporation of public input** into the NSS during which the draft version of the *National Stakeholder Strategy* was posted online and approximately 2,200 comments were received. OMH incorporated this input wherever possible.

- A **period of analysis, discussion and planning throughout all of the divisions within HHS**. The results of that dialogue are detailed in the HHS Action Plan to Reduce Racial and Ethnic Health Disparities, which will be reviewed annually to communicate ongoing actions.

Based on the process of community and stakeholder collaboration, the fundamental goals of the NPA and the *National Stakeholder Strategy* were ultimately defined as follows:

Goal 1: Awareness—*Increase awareness of the significance of health disparities, their impact on the nation, and the actions necessary to improve health outcomes for racial, ethnic, and underserved populations.*

Goal 2: Leadership—*Strengthen and broaden leadership for addressing health disparities at all levels.*

Goal 3: Health System and Life Experience—*Improve health and healthcare outcomes for racial, ethnic, and underserved populations.*

Goal 4: Cultural and Linguistic Competency—*Improve cultural and linguistic competency and the diversity of the health-related workforce.*

Goal 5: Data, Research, and Evaluation—*Improve data availability and coordination, utilization, and diffusion of research and evaluation outcomes.*

Four crosscutting, fundamental principles are central to the goals of the *National Stakeholder Strategy*. First, change at the individual or community level is not sustainable without **community engagement** and leadership. Second, the creation of **partnerships** is critical in any action plan to eliminate disparities. The causes of health inequities are multiple and complex. Resources to solve such problems are valuable, finite, and must be strategically deployed. Partnerships allow the pooling of resources, mobilization of talents, and use of diverse approaches. Partnerships can limit duplication of efforts and fragmentation of services. Third, the culture with which an individual identifies informs how he or she understands the meaning of health and disease, and how that individual interacts with health providers or makes personal health or wellness decisions. The level of **cultural and linguistic competency** of healthcare providers and health educators has a powerful impact on the success or failure of any efforts to help individuals achieve optimum health. Finally, the requirement of **non-discrimination** for healthcare access and delivery is not only mandated by federal civil rights laws but also is a moral imperative and a practical necessity for achieving health equity. It must be present in our actions, services, leadership, and partnerships.

STRATEGIES FOR ACTION

The heart of the *National Stakeholder Strategy* resides in the 20 strategies for action to end health disparities that were developed by the collaborative process described above. The strategies reflect the voices and wisdom of a variety of communities, organizations, sectors, geographical locations, and missions (see table on the following page). Each of these strategies is linked to one of the five NPA goals. The *National Stakeholder Strategy* provides twenty summary charts, one for each strategy. Each chart has related lists of objectives, measures, and data sources. These comprise a menu of resources that change-oriented stakeholders can use in a very practical way to devise the specific actions that are compatible with their missions, their needs, their skills and resources, their constituencies, and their spheres of influence. The strategies can be used by any organization in any sector—public, private, and nonprofit—to design and prioritize policy and program changes at the local, state, tribal, regional, and national levels.

The goals and strategies in this plan offer a common reference, language, and starting point for those who wish to join in partnership with like-minded individuals and organizations to achieve health equity in the United States. A shared, nationally based game plan is especially important for the development of strong, strategic, collaborative partnerships of disparate organizations that decide to band together to combat health disparities. With the *National Stakeholder Strategy* in hand, they can begin discussions and planning for action with the same set of goals and potential strategies.

The overarching vision of the *National Stakeholder Strategy* is to promote systematic and systemic change that improves the overall health of the nation and its most vulnerable populations. It is the vision of the many stakeholders across the United States who built the plan and who stand ready to join in partnership to make their vision a reality.

ORGANIZATION OF THE NATIONAL STAKEHOLDER STRATEGY

This *National Stakeholder Strategy* provides background information and four content sections. The initial section describes the opportunities and challenges that influence efforts to achieve health equity; the Strategy's history, goals, and principles; its relationship to the NPA and the Action Plan to Reduce Racial and Ethnic Health Disparities; and the collaborative process that produced the strategies for action. The second section documents the evidence for the wide range of health and healthcare disparities in this country. This evidence provides context for the community and stakeholder-generated strategies that are offered in the third section. The final section provides an initial approach to operationalizing the *National Stakeholder Strategy*. Together these sections present a clarion call to action.

SUMMARY OF NPA GOALS AND STRATEGIES

Goal #	Goal Description	Strategies
1	**AWARENESS—** Increase awareness of the significance of health disparities, their impact on the nation, and the actions necessary to improve health outcomes for racial, ethnic, and underserved populations	1. **Healthcare Agenda** Ensure that ending health disparities is a priority on local, state, tribal, regional, and federal healthcare agendas.
		2. **Partnerships** Develop and support partnerships among public, nonprofit, and private entities to provide a comprehensive infrastructure to increase awareness, drive action, and ensure accountability in efforts to end health disparities and achieve health equity across the lifespan.
		3. **Media** Leverage local, regional, and national media outlets using traditional and new media approaches as well as information technology to reach a multi-tier audience—including racial and ethnic minority communities, youth, young adults, older persons, persons with disabilities, LGBT groups, and geographically-isolated individuals—to encourage action and accountability.
		4. **Communication** Create messages and use communication mechanisms tailored for specific audiences across their lifespan, and present varied views of the consequences of health disparities that will encourage individuals and organizations to act and to reinvest in public health.
2	**LEADERSHIP—** Strengthen and broaden leadership for addressing health disparities at all levels	5. **Capacity Building** Build capacity at all levels of decision-making to promote community solutions for ending health disparities.
		6. **Funding Priorities** Improve coordination, collaboration, and opportunities for soliciting community input on funding priorities and involvement in research and services.
		7. **Youth** Invest in young people to prepare them to be future leaders and practitioners by actively engaging and including them in the planning and execution of health, wellness, and safety initiatives.
3	**HEALTH SYSTEM AND LIFE EXPERIENCE—** Improve health and healthcare outcomes for racial, ethnic, and underserved populations	8. **Access to Care** Ensure access to quality health care for all.
		9. **Children** Ensure the provision of needed services (e.g., mental, oral, vision, hearing, and physical health; nutrition; and those related to the social and physical environments) for at-risk children, including children in out-of-home care.
		10. **Older Adults** Enable the provision of needed services and programs to foster healthy aging.
		11. **Health Communication** Enhance and improve health service experience through improved health literacy, communications, and interactions.
		12. **Education** Substantially increase, with a goal of 100%, high school graduation rates by working with schools, early childhood programs, community organizations, public health agencies, health plan providers, and businesses to promote the connection between educational attainment and long-term health benefits.
		13. **Social and Economic Conditions** Support and implement policies that create the social, environmental, and economic conditions required to realize healthy outcomes.
4	**CULTURAL AND LINGUISTIC COMPETENCY—** Improve cultural and linguistic competency and the diversity of the health-related workforce	14. **Workforce** Develop and support the health workforce and related industry workforces to promote the availability of cultural and linguistic competency training that is sensitive to the cultural and language variations of diverse communities.
		15. **Diversity** Increase diversity and competency of the health workforce and related industry workforces through recruitment, retention, and training of racially, ethnically, and culturally diverse individuals and through leadership action by healthcare organizations and systems.
		16. **Ethics and Standards, and Financing for Interpreting and Translation Services** Encourage interpreters, translators, and bilingual staff providing services in languages other than English to follow codes of ethics and standards of practice for interpreting and translation. Encourage financing and reimbursement for health interpreting services.
5	**DATA, RESEARCH, AND EVALUATION—** Improve data availability, coordination, utilization, and diffusion of research and evaluation outcomes	17. **Data** Ensure the availability of health data on all racial, ethnic, and underserved populations.
		18. **Community-Based Research and Action, and Community-Originated Intervention Strategies** Invest in community-based participatory research and evaluation of community-originated intervention strategies in order to build capacity at the local level for ending health disparities.
		19. **Coordination of Research** Support and improve coordination of research that enhances understanding about, and proposes methodology for, ending health and healthcare disparities.
		20. **Knowledge Transfer** Expand and enhance transfer of knowledge generated by research and evaluation for decision-making about policies, programs, and grant-making related to health disparities and health equity.

Acknowledgements

More than two years ago, the Office of Minority Health (OMH) began meeting with communities and various organizations to begin developing strategies and actions to systematically address health disparities. These meetings led us to this National Stakeholder Strategy for Achieving Health Equity (National Stakeholder Strategy).

We are indebted to the many individuals who contributed their ideas, time, energy, and/or expertise during the community voices meetings; Regional Conversations; National Leadership Summits on Eliminating Racial and Ethnic Disparities in Health; the National Visionary Panel meeting; the National Health Disparities Plan Implementation and Evaluation meetings; the National Health Disparities Plan Consensus meeting; and myriad other meetings that led to the community-inspired strategies found within this National Stakeholder Strategy.

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NATIONAL STAKEHOLDER STRATEGY FOR ACHIEVING HEALTH EQUITY

Development of The *National Stakeholder Strategy*

Changing health outcomes for many of the United States' racial and ethnic minorities, the poor, and other underserved populations is a critical need. Health and healthcare disparities are persistent and pervasive; they are harmful not only to the individuals and communities that experience them, but to the nation as a whole. Everyone benefits when health and healthcare disparities are eliminated and health equity becomes a reality: financial costs are greatly diminished; healthy children can grow into productive adults; healthy adults boost workforce capacity and capability; and values of social compassion are honored.

THE CONTEXT FOR THE *NATIONAL STAKEHOLDER STRATEGY*

In this effort to achieve health equity, the United States aligns itself with similar endeavors throughout the world. There has been significant global attention placed on the risk factors for adverse health outcomes — factors that may long predate the appearance of disease. Such factors are those that relate to social constructs rather than medical constructs and are fundamentally and particularly toxic to health. Well-known factors include low socioeconomic status, low educational status, and inadequate access to (or utilization of) quality health care. There are other adverse determinants of health as well. Examples include residence in geographic areas that have poor environmental conditions (e.g., violence, poor air quality, and inadequate access to healthy foods), racism, inadequate personal support systems, limited literacy, and limited English proficiency (LEP). These determinants are often associated with racial and ethnic minority and underserved communities, and are among the determinants of health.

Margaret Chan, Director-General of the World Health Organization (WHO), drew attention to the urgent worldwide problem of health inequities and its profound consequences when she said, "Health inequity really is a matter of life and death."[1] The significance of social determinants of health has increasingly become a matter of discussion and research, along with the recognition that, although social factors are at the root of many of the inequities in health and health care worldwide, they are not necessarily inevitable and are amenable to intervention.[2] In 2005, WHO formed an independent Commission on Social Determinants of Health (CSDH)[3] to make the case that health status is of concern to policymakers in all sectors (not just health) and to "link knowledge with action" regarding how these factors operate and how they can be changed to improve health and reduce health inequities.

> "Health inequity really is a matter of life and death."
>
> – Margaret Chan, MD, MPH
>
> Director-General, World Health Organization, 2008

The 2008 report of the CSDH,[3] "Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health," notes the powerful link between social factors and health. The report emphasizes that social and economic policies directly impact the health and well-being of those who live and work under them. The report further suggests that interventions and policies to achieve health equity must be based on evidence and result in action, and they must address daily living conditions and issues related to power, money, and resources.

WHO defines the *social determinants of health* as the "conditions in which people are born, grow, live, work, and age, including the health system. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels, which are in and of themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities."[4] Operatively, health inequities often play out as differences in opportunities for healthy lifestyles, differences in quality of care within the healthcare system, and differences in access to the healthcare system (both preventive and curative care).[5]

In the United States, there are examples of health and healthcare disparities by race, ethnicity, gender, literacy level, socioeconomic status, geographic location, disability status, and sexual orientation or gender identity. Examples include disparities in cardiovascular disease, diabetes, HIV/AIDS, infant mortality, oral health, mental health, and health care quality and access.

> "It is time to refocus, reinforce, and repeat the message that health disparities exist and that health equity benefits everyone."
>
> – Kathleen G. Sebelius, Secretary, HHS

Acknowledging that persistent health disparities are the manifestation and interplay of complex factors is critical to solving these problems. It is only as we develop a fuller understanding of the scope and magnitude of factors affecting health outcomes and evidence for what works to reduce disparities that the most effective advancement of appropriate policy and intervention strategies can occur. This will require the combined efforts of governments, academia, institutions, businesses, humanitarian and faith-based organizations, and individuals working across the entire spectrum of public, private, community, and individual enterprise.

Beyond the heavy burden that health and healthcare disparities represent for the individuals affected, there are additional social and financial burdens borne by the country as a whole. These burdens constitute both ethical and practical mandates to reduce health and healthcare disparities and achieve health equity.

DEFINITIONS

The terms — *health inequality*, *health disparity*, *healthcare disparity*, *health equity*, and *health inequity* — are widely used, often without clarification of meaning. Therefore, in an effort to distinguish between these terms, in this *National Stakeholder Strategy:*

- *Health inequality* is the "difference in health status or in the distribution of health determinants between different population groups."[6]
- *Health disparity* a particular type of health difference that is closely linked with social, economic, and/or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater obstacles to health based on their racial and/or ethnic group; religion; socioeconomic status; gender; age; mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion.[7]
- *Healthcare disparity* relates to "differences in the quality of health care that are not due to access-related factors or clinical needs, preferences, and appropriateness of interventions. These differences would include the role of bias, discrimination, and stereotyping at the individual (provider and patient), institutional, and health-system levels."[8]
- *Health equity* is attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities.[9]

HISTORICAL BRIEF: WHAT THE PAST HAS TAUGHT US

The 1985 *Report of the Secretary's Task Force on Black and Minority Health (Heckler Report)* was the initial federal effort to identify and draw national attention to the tragedy of minority health disparities.[10] The report, issued by then-HHS Secretary Margaret Heckler, formally detailed for the American consciousness the existence and extent of racial and ethnic health disparities for Blacks and three other identified minority groups (defined during that time as Hispanics, Asians/Pacific Islanders, and Native Americans). With the exception of information on African Americans, there was limited data available in 1985 about the health and well-being of racial and ethnic minority populations.

Nevertheless, the *Heckler Report* concluded that similar patterns of health disparities existed for all the identified minority groups and called out six areas of particular concern: cancer, cardiovascular disease/stroke, diabetes, infant mortality, chemical dependency, and homicide. Between 1979 and 1981, these six conditions together accounted for more than 80 percent of deaths in excess of that of the White population for African Americans and the other identified minority populations.

In his letter introducing the report, Task Force Chairman Thomas E. Malone (then Director of the National Institutes of Health [NIH]) expressed the hope that the report should serve "not only as a standard resource for department-wide strategy, but as the generating force for an accelerated national assault on the persistent health disparities … " In fact, the report did generate a plethora of public and private programs, entities, and initiatives aimed at reducing the disparity gap, including the immediate formation of the federal Office of Minority Health (OMH). However, while there have been dramatic improvements to both the healthcare delivery system and health outcomes (e.g., mortality and morbidity rates) for all populations in the United States since 1985,[11,12,13] many of the findings and recommendations of the *Heckler Report* are still pertinent. Health disparities still exist and are still serious.[8,13]

The evidence of persistent and pervasive health and healthcare disparities is clearly articulated in the 2002 landmark report of the Institute of Medicine (IOM), *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care (Unequal Treatment Report).*[8] Upon the release of the report, the IOM committee chair noted, "The real challenge lies not in debating whether disparities exist, but in developing and implementing strategies to reduce and eliminate them."[8] The *Unequal Treatment Report* identified multiple contributing factors, including the organization and operation of healthcare systems, the attitudes and behavior of patients, and the biases of healthcare providers. The recommendations in the *Heckler Report* are mirrored and complemented by the *Unequal Treatment Report* and are just as pertinent today.

> "The real challenge lies not in debating whether disparities exist, but in developing and implementing strategies to reduce and eliminate them."
>
> – Alan R. Nelson, Chair,
> IOM Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care

Recommendations in the *Unequal Treatment Report* included avoiding fragmentation of health plans along socioeconomic lines; collecting and reporting data on healthcare access and utilization by patient race, ethnicity, socioeconomic status, and primary language; conducting further research to identify sources of racial and ethnic disparities; assessing promising intervention strategies; and implementing patient education programs to increase patients' knowledge of how to best access care and participate in treatment decisions. The report also provided important insights into the progress of setting and meeting local, state, tribal, regional, and national health disparities goals, and on effectively measuring and enhancing our collective knowledge of health and healthcare disparities.

A quarter of a century ago, the Secretary's Task Force acknowledged that "the factors responsible for health disparities are complex and defy simplistic solutions."[10] This analysis is just as fresh today for those who conduct health disparities research and/or implement it in practice, and who struggle to identify and combat the medical, social, economic, and other factors that lead to adverse health outcomes. New approaches and new partnerships are needed immediately to close the health gap for racial, ethnic, and underserved communities, and the nation.

CURRENT AND FUTURE REALITIES THAT IMPACT HEALTH DISPARITIES

The previous passage provides a historical frame of reference for considering the new approaches and partnerships that are the hallmark of the *National Stakeholder Strategy* for Achieving Health Equity. In this piece, we provide an overview of current realities that will significantly impact efforts to reduce health and healthcare disparities in the United States, and are the context in which the *National Stakeholder Strategy* will be operationalized and evaluated. These realities provide both challenges and opportunities for devising new methods of attacking the persistent problem of health and healthcare disparities in the United States.

Emphasis on Prevention and the Social Determinants of Health

The importance of preventing disease and promoting health — rather than just treating disease once it appears — has tremendous potential for reducing health disparities and improving our nation's health.[14,15] An emphasis on treatment after the fact instead of aggressively, widely, and prominently promoting health and prevention strategies undermines well-being and quality of life, and results in major adverse social and economic impacts.[15] Placing the emphasis on primary prevention through the promotion and support of children and strong families, healthy lifestyles, and healthy working/living conditions has often been undervalued as a means of achieving and maintaining wellness. A strong prevention strategy must ensure that children have stable homes, regular dental and medical checkups, physical activity and healthy foods at school, and safe living environments. It also must address adults' behaviors related to, for example, smoking, eating, and exercise. Removing disadvantages early on may be a powerful preventive measure in decreasing health disparities. The cumulative effect of chronic exposure to harmful factors throughout the life course increases the risk for poor health in adulthood.[16] This social determinant framework expands the concept and practice of health prevention beyond the traditional medical model. Thus, eliminating health disparities will necessitate behavioral, environmental, and social-level approaches to address issues such as inadequate housing, violence, and limited opportunities to earn a livable wage.[17]

Growing Racial and Ethnic Minority Populations

Minority populations now comprise 34 percent of the total U.S. population, are increasing in number faster than the White population, and are expected to represent 40 percent of the population by the year 2030. The District of Columbia and four states (Hawaii, New Mexico, California, and Texas) are now "majority-minority" states, meaning that more than 50 percent of their population is made up of people other than single-race, non-Hispanic Whites.[18] Addressing the health needs of our minority populations has always been an ethical mandate. As the aggregate of our various minority populations moves toward becoming a majority of the country's populace, health equity becomes even more critical. If health inequities are not adequately addressed, everyone suffers — through shared loss of economic capital, loss of human intellectual and leadership capital, and social instability.

> "We need to do all we can to close this gap and empower our communities to meet and master their health challenges in ways that acknowledge and celebrate our diverse American cultures."
>
> – Senator Edward M. Kennedy
> Message to Participants, Third National Leadership Summit on Eliminating Racial and Ethnic Disparities
> February 25, 2009

Broader Minority Health Constituency

Over the last several decades, a large number of minority health-related programs, organizations, advocacies, and initiatives have come into existence at all levels of society — local, state, tribal, regional, national, faith-based, public, private, academic, and business.[19] This sizeable and talented workforce is a significant and sometimes inadequately tapped resource for advancing health equity. Growth of the minority health constituency has also led to parallel growth in the health disparities knowledge base as evidence-based research, practical experience, and best-practice inquiries continue to be important avenues for finding solutions. The diversity of our communities and their languages has also fostered a greater emphasis on recruiting culturally and linguistically competent healthcare providers into the workforce.

Increasing Access for Persons with Disabilities

There are more than 54 million individuals (19 percent of the population) in the United States who experience some level of disability.[20] They became protected against discrimination on the basis of disability through the 1990 Americans with Disabilities Act and its later amendments.[21] A key target for reducing health disparities for disabled Americans is to increase accessibility across a broad spectrum of needs. Healthcare access in this context has the particular meaning of enabling disabled persons to access the functionality, benefits, services, and information provided by healthcare systems to the same extent as those without disabilities. Such access includes the use and development of various assistive technologies. The Surgeon General's Call to Action to Improve the Health and Wellness of Persons with Disabilities[22] encourages healthcare providers to treat the whole person; educators to teach about disability; the public to see an individual's abilities; and communities to ensure accessible health care and wellness services for persons with disabilities.

Growing Awareness of Conditions Impacting Rural Health

In 2009, approximately 17 percent of the U.S. population (50 million individuals) resided in rural (nonmetropolitan) areas.[23] These areas extend throughout 80 percent of the U.S. land area. Since 2001, poverty has been higher in nonmetropolitan areas compared to the rest of the country: 15.4 percent versus 12.5 percent, respectively, in 2007.[24] Poverty is persistent and widespread for rural children.[24] Rural residents face a number of barriers in accessing quality health services, and they experience significant health disparities. Compared to their urban counterparts, rural residents were more likely to report poor-to-fair health; live with a chronic disease such as diabetes; die from heart disease; be admitted for uncontrolled diabetes; and they are less likely to report a dental visit within the past year.[25] Additionally, rural women have lower rates of breast cancer screenings.[26] Minorities living in rural communities are particularly disadvantaged.[25]

Challenges to Urban Health

Urban centers and metropolitan areas have their own set of sociological and environmental factors that can adversely affect health. In the midst of the wealth, commerce, and privilege that exist in most U.S. cities, there is also residential segregation, concentrated poverty, higher levels of poor indoor and outdoor pollution (e.g., noise and air pollution from motor vehicle traffic and industry; indoor exposure to allergens, carcinogens, and lead), and overcrowding (with higher rates of infectious diseases).[27,28,29,30] These factors, and the cumulative effects of social disadvantage, are significant for racial and ethnic minority and underserved populations that are often overrepresented in high-density areas. There is an uneven distribution of socioeconomic status at the neighborhood level in urban areas. An individual's status and place of residence is a social determinant of health across the lifespan.[31,32] The majority of the world's future population will reside in urban areas; seven out of 10 people will be city dwellers by 2050.[33] Urban population growth places a substantial infrastructure and safety burden on governments to provide for public safety and emergency preparedness, safe water and sanitation, solid waste disposal, and adequate education and housing options.

Increasing Knowledge of Health Concerns for LGBT Populations

Persons who identify as lesbian, gay, bisexual, and transgender (LGBT) have specific healthcare needs and face unique barriers in access to quality care.[34,35,36] Examples of barriers include reluctance to disclose sexual or gender identity when receiving medical care to avoid maltreatment and discrimination; lack of provider knowledge of risk factors; insurance policies that limit coverage for domestic partners; and lack of culturally appropriate prevention strategies and services. LGBT persons who also belong to other historically disadvantaged and other vulnerable populations experience compounded obstacles to care and wellness.

Expectations for Improved Data Collection, Reporting, and Diffusion

In the last decade, a greater awareness has developed regarding the importance of collecting reliable data on specific racial and ethnic subpopulations beyond long-standing categories of race and ethnicity.[37] Combining minority subgroups into generalized racial or ethnic categories for data collection can mask dramatic variability in outcomes and thereby inhibit the design of effective, targeted interventions. For example, health outcomes vary dramatically for the populations of the U.S. territories, including the residents of Puerto Rico (who are often placed in the general category of "Hispanics/Latinos"), the residents of the U.S. Virgin Islands (who are often placed in the general category of "African Americans"), and the residents of Guam, American Samoa and the Northern Mariana Islands (who are often placed in the general category of "Pacific Islanders"). Improvements in data collection and reporting hold potential for supporting evidence-based research to identify and solve health inequities.[13,38,39,40,41]

Major Advances in Technology

The increase of computing power and the development of the Internet and other advanced communication and information technologies have led to the enhanced capability to collect, analyze, store, and access massive amounts of data (e.g., products of the U.S. Census Bureau, Agency for Healthcare Research and Quality [AHRQ], Centers for Disease Control and Prevention [CDC], and expanded use of health information technology [HIT]). It has become increasingly necessary for policymakers and healthcare providers to search for efficient and effective means by which to deploy HIT to better manage personal and public health. In 2009, HHS began implementation of the Health Information Technology for Economic and Clinical Health Act (P.L. 111-5), which provides for a national HIT structure that will improve care coordination, enable more effective communication between healthcare providers and patients, and enable an efficient means for healthcare providers and departments of public health to more effectively monitor and analyze public health data. Just as important, the Act is creating programs that include national electronic health record adoption among healthcare providers, workforce training for HIT personnel, and the deployment of health information exchanges.

THE *NATIONAL STAKEHOLDER STRATEGY*: A NEW OPPORTUNITY

An impetus for establishing the *National Partnership for Action (NPA)* as a national movement grew in response to the voices of the nearly 2,000 leaders who attended the National Leadership Summit for Eliminating Racial and Ethnic Disparities in Health sponsored by OMH.[42] The summit broadened the national dialogue about health disparities from the more traditional disease-focused approach to a more systems-oriented approach that addresses crosscutting, multilevel issues. This broader approach can systematically tackle health disparities by bringing individuals and organizations within the health sector together with other individuals and organizations whose work influences health. This approach is in keeping with the mission of OMH to improve and protect the health of racial and ethnic minority populations in the United States through the development of health policies and programs that will eliminate health disparities. It also is aligned with the *Healthy People 2020* objectives to achieve health equity, eliminate disparities, and improve the health of all groups.[43]

In response to the summit, a clear mandate emerged around actions necessary to more effectively and efficiently address health disparities in this country. The views of summit participants were consistent with several recommendations of the *Heckler Report, the Unequal Treatment Report*, key findings in the *National Healthcare Disparities Report (NHDR)* and *National Healthcare Quality Report (NHQR)*, and findings from recent literature on health disparities. The summit honored the 20-year mark since the release of the *Heckler Report* and the remarkable growth since 1985 in health disparities knowledge, activities, and funding. In addition, the summit ushered in a new opportunity to coalesce around a national strategy to end health disparities.

Following the 2006 summit, OMH responded to the common concerns and comments of summit participants in order to begin to formulate NPA goals and principles. The original concept was that partnerships were the unique foundation on which to build the NPA. Refinements and additions to NPA goals and principles and to the *National Stakeholder Strategy* were ongoing via the process described below and were dependent on community and stakeholder input at every stage. The final versions of the NPA goals and principles are presented in detail later in this section.

Relationship Between the *National Partnership for Action* and the *National Stakeholder Strategy*

A prime activity of the NPA was to establish the priorities for a national strategy using a "bottom up" approach. The intent was to change the paradigm of strategy development by vesting individuals — particularly those at the front line of fighting health disparities — with identifying and helping to shape core actions for a coordinated national response.

The "bottom up" approach included focused, localized continuations of the National Leadership Summit on Eliminating Racial and Ethnic Disparities in Health. Details of this process are provided later in this section.

Thus, the natural outcome of the NPA was the development of the *National Stakeholder Strategy* and its two other components: Blueprints for Action (which are being aligned with the *National Stakeholder Strategy* and focus on specific sectors), and targeted initiatives that are being undertaken by partners across the public and private sectors in support of the NPA. These other two components develop subsequent to the launch of the *National Stakeholder Strategy*.

Guiding Principles of the NPA and *National Stakeholder Strategy*

> "We may have all come on different ships, but we're in the same boat now."
>
> – Dr. Martin Luther King Jr.

Four fundamental principles have helped to guide the process by which input from community and other stakeholders was solicited, analyzed, and reviewed. These principles informed the development of the *National Stakeholder Strategy* and include: the importance of community engagement, the value of working via partnerships, the necessity of cultural and linguistic competency to meet the needs of all communities, and the requirement of non-discrimination in actions, services, leadership, and partnerships.

Community Engagement

Communities are made up of diverse individuals, institutions, networks, and organizations in the private and public sectors that may share a physical space (communities of geography) or a history and sense of connection due to a common experience (communities of identity).[44] We experience community where we live, work, learn, play, age, and many other facets of life. Each community has its own unique characteristics that must be considered when engaging their leaders, institutions, and members.

A national effort to end health disparities could not be successful without the input, support, and actions of communities across localities, states, tribes, and regions of the country. Communities experience the consequences of disparities firsthand and understand the solutions needed to improve the conditions that contribute to them. The input of community leaders and members is critical to ensure the solutions to end health disparities are aligned with their community's history, norms, and needs. Leaders and traditional institutions of racial, ethnic, and underserved groups have been a long-overlooked resource for developing solutions for their communities.

When engaged appropriately, communities across the nation have successfully mobilized to fight violence, drug and alcohol abuse, HIV/AIDS, racism, and other problems. Social and medical research over the past 150 years has shown that five factors have the most far-reaching and powerful effect on the ability of communities to mobilize and develop solutions that best fit their values and needs.[45] These factors include:

- A sense of community, which forms when community members believe they have influence, can have their needs met, share similar values, experience feelings of mutual trust and caring, and share an emotional connection
- A community's connections to other communities, networks, and larger and more resourceful institutions that can provide access to opportunities and resources
- Community members' ability to exercise individual and collective control, which can in turn foster a sense of hope for improving the conditions that affect their lives
- Collective action through vehicles such as neighborhood associations, advocacy groups, youth organizing efforts, and other organized entities
- Adequate economic, financial, and other resources that allow individuals, families, and communities to access the opportunities they need to succeed and improve their living conditions and ultimately, their health.

Partnerships

Partnerships are a vehicle through which communities can mobilize and take action to end health disparities. When actual community involvement exists, partnerships can address community health concerns while aiding and developing capacity in those communities. Thus, partnerships are vehicles to increase community participation, leadership skills, resources, social and inter-organizational networks, sense of community, community power, and community problem solving.[46]

> "It's critical to know who our partners are in our efforts to eliminate health disparities. Listening to perspectives from nontraditional partners is essential for applying new ideas."
>
> – NPA Regional Meeting Participant

Thousands of partnerships, anchored by government or community organizations, have formed over the past two decades to support health-related activities. Health partnerships are collaborations in which organizations agree to work together to achieve shared or complementary goals that lead to improvements in health, safety, or well-being.[47] A partnership is action-oriented and focuses on reducing or preventing community problems by analyzing the problem, identifying and implementing solutions, and creating social change. [47]

The best of these partnerships bring people together, expand resources, focus on issues of community concern, and achieve better results than any single group could achieve alone. Partnerships offer many direct and indirect benefits[48] such as:

- Serving as effective and efficient vehicles for exchanging knowledge and ideas
- Demonstrating and developing community support or concern for issues
- Maximizing the power of individuals and groups through collective action
- Improving trust and communication among community agencies and sectors
- Mobilizing diverse talents, resources, and strategies
- Building strength and cohesiveness by connecting individuals and organizations
- Reducing the social acceptability of health-risk behaviors
- Changing community norms and standards

The pooling of resources, mobilization of talents, and use of diverse approaches that typify effective partnerships make them a logical cornerstone in any effort to end health disparities. Inequities in health have multiple causes and consequences that require complex solutions and actions from multiple disciplines and sectors (e.g., social services, health, housing, education, and law enforcement, among others). However, health and human service organizations often are limited in addressing such issues due to duplication of efforts, fragmentation of services, multicultural insensitivity, and unequal access to resources.

Through the sharing of human and material resources, finances, and time, partnerships provide a multifaceted approach to any issue. Such partnerships may even counter the declining trend in civic engagement and re-engage individuals and organizations to address local problems.[49] In fact, partnerships are appealing because they mirror the very principles of democracy that encourage their formation — principles such as civic participation, equality, tolerance, human rights, accountability, and transparency.[50] In short, local, state, tribal, regional, and national organizations must work collaboratively with the individuals, families, and communities that are affected by health disparities if these organizations hope to effect change.

Cultural and Linguistic Competency

Improving cultural and linguistic competency is necessary for achieving better health outcomes for racial and ethnic minorities and underserved populations. *Cultural competency* supports the view that health values, beliefs, practices, and behaviors are culturally bound.[51] Understanding how culture and health intersect fosters improved health outcomes. Many of the challenges encountered when integrating cultural competence into health care come from insufficient understanding of the role of culture in defining health.

Culture can be defined as a "set of shared attitudes, values, goals, and practices."[52] Culture influences a group's ways of thinking, feeling, and acting. Culture informs how a group perceives health, wellness, disease, health care, and prevention. As a concept, a definition, and a set of values, *cultural competency* was originally defined as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations."[53] Since then, service and support agencies and systems have adapted the definition to address their own vision, mission, and values.

Linguistic competency is less debated and more clearly understood by healthcare system administrators and providers. However, in practice, the focus has been more narrow than delineated by its definition, which is "the capacity of an organization and its personnel to communicate effectively and to convey information in a manner easily understood by diverse audiences, including persons of limited English proficiency (LEP), those who have low literacy skills or are not literate, and individuals with disabilities."[54] Most organizations recognize the need to provide translated materials and interpreters to LEP individuals and to individuals with disabilities. Rarely do organizations recognize the relationship of literacy to health literacy. Providing materials for individuals who have low literacy skills is also part of the framework for providing linguistically competent services.

Ensuring that LEP individuals receive services is based on federal law. Title VI of the Civil Rights Act of 1964 and its implementing regulations prohibit conduct that has a disproportionate adverse effect on LEP persons due to their race, color, or national origin. Thus policies and practices that adversely affect people with limited English proficiency may constitute national origin discrimination. The failure of recipients of federal financial assistance (often healthcare system administrators and providers) to take reasonable steps to provide LEP persons with a meaningful opportunity to participate in federally funded programs may constitute a violation of Title VI.[55]

Nondiscrimination

Virtually all hospitals — and most healthcare providers — are subject to federal civil rights laws.[55, 56, 57] These laws prohibit discrimination and ensure that federal funds are not used to support programs or activities that discriminate on the basis of race, color, national origin, disability, or age. For example, HHS implementing regulations for Title VI require that healthcare providers receiving federal funds (including Medicare, Medicaid, Children's Health Insurance Program [CHIP], grants from CDC, NIH, or any other HHS agency) may not engage in any of the following activities based on race, color, or national origin:

- Deny services, financial aid, or other benefits provided as a part of health or human service programs
- Provide a different service, financial aid, or other benefit, or provide them in a different manner from those provided to others under the program
- Segregate or separately treat individuals in any matter related to the receipt of any service, financial aid, or other benefit

In any of a number of their roles — e.g., as members of quality improvement teams, clinician-educators, community and patient advocates, or hospital board members — health and healthcare workers must be sensitive to any potential for civil rights violations. It is critical to be aware of and report concerns about compliance with federal civil rights laws. Everyone should have a commitment to report violations of the law, to protect the vulnerable, and to support access to quality health care for all people. In doing so, we can eliminate discrimination as a cause of health and healthcare disparities.

It is widely accepted that discrimination, racism, and bias directly and indirectly contribute to negative health outcomes and to health disparities.[58-63, 59, 66] The mechanism or magnitude of the connection between racism and health disparities has not yet been fully clarified.[59,60,61,63] Nevertheless, numerous studies associate real or perceived experiences of racism with increased risk for physical and psychological diseases.[59,60,63] For example, there may be associations with increased rates of hypertension, respiratory problems, chronic conditions, and poorer perceived physical health.[59,61,63,64,65] Acute or long-term exposure to racism may manifest as a stress response, which triggers harmful physiological and psychological pathways, as do other stress-causing experiences.[63]

> "Of all the forms of injustice, inequality in health care is the most shocking and inhumane."
>
> – Dr. Martin Luther King, Jr.

Many of the limitations on research that seek to establish and define the link between racism and poor health outcomes relate to the difficulties of measuring racism, ethnicity, and lifespan socioeconomic inequalities.[59, 63] The reality of inadequate data and gaps in knowledge on this subject highlight the need for solid, evidence-based studies on the connection between racism and health disparities — with the objective to determine how long-term exposure to bias affects health.

Racism can be categorized as follows:[60, 62]

- Institutionalized — "differential access to the goods, services, and opportunities of society by race"
- Personally-mediated — "prejudice and discrimination by individuals toward others"
- Internalized — "acceptance by members of the stigmatized races of negative messages about their own abilities and intrinsic worth"

The social movements of the 20th century resulted in significant reductions in discrimination and racism — and in major reductions in early death and the spread of disease. These changes were often interrelated. For example, systemic institutional changes such as the establishment of child labor laws; improved working and housing conditions; the civil rights movement; increased access to care for minorities; and anti-discrimination laws all indirectly or directly led to positive health outcomes, especially for those who had been marginalized in society.[67]

A pertinent illustration is the lack of trust in the medical establishment.[68, 69, 70] It is generally held that this phenomenon reflects an intergenerational awareness of past incidences of medical abuse and mistreatment of minority patients. Examples include segregated medical care; the abuses of the Tuskegee syphilis study of African American men conducted by the Public Health Service; questionable radiation studies among Alaskan Natives in the 1950s; coerced, unwitting, or underage sterilization among American Indian women in the 1960s and 1970s; high rates of sterilization of Hispanic women in New York City, California, and the Southwest; and use of Puerto Rican women during the 1950s as research subjects in early clinical trials of birth control pills.[71-79]

Public policies and personal patterns of behavior that were common in the past may still be reflected in some of our society's old operating patterns, laws, assumptions, and behaviors. For example, existing patterns of housing; location and quality of neighborhoods; bias in medical care access and delivery; the stress of real and perceived racism; and intergenerational internalization of stigma are all social determinants that contribute to health disparities.[63]

Achieving health equity requires cooperative, coordinated, and multifaceted solutions to improving determinants of health that affect various populations.[80] As described below, the mission and goals of the NPA and *National Stakeholder Strategy* aim to identify, support, and replicate such solutions.

Mission and Goals of the NPA and *National Stakeholder Strategy*

The mission of the NPA is to increase the effectiveness of programs that target the elimination of health disparities through the coordination of partners, leaders, and stakeholders committed to action. The *National Stakeholder Strategy*, one of three components of the NPA, was developed through a sequence of activities involving the collaboration of stakeholders from across the country. It was clear by the end of the sequence of activities used to develop the *National Stakeholder Strategy* that the following five goals were imperative:

Goal 1: Awareness — *Increase awareness of the significance of health disparities, their impact on the nation, and the actions necessary to improve health outcomes for racial, ethnic, and underserved populations.*

Goal 2: Leadership — *Strengthen and broaden leadership for addressing health disparities at all levels.*

Goal 3: Health System and Life Experience — *Improve health and healthcare outcomes for racial, ethnic, and underserved populations.*

Goal 4: Cultural and Linguistic Competency — *Improve cultural and linguistic competency and the diversity of the health-related workforce.*

Goal 5: Data, Research, and Evaluation — *Improve data availability and coordination, utilization, and diffusion of research and evaluation outcomes.*

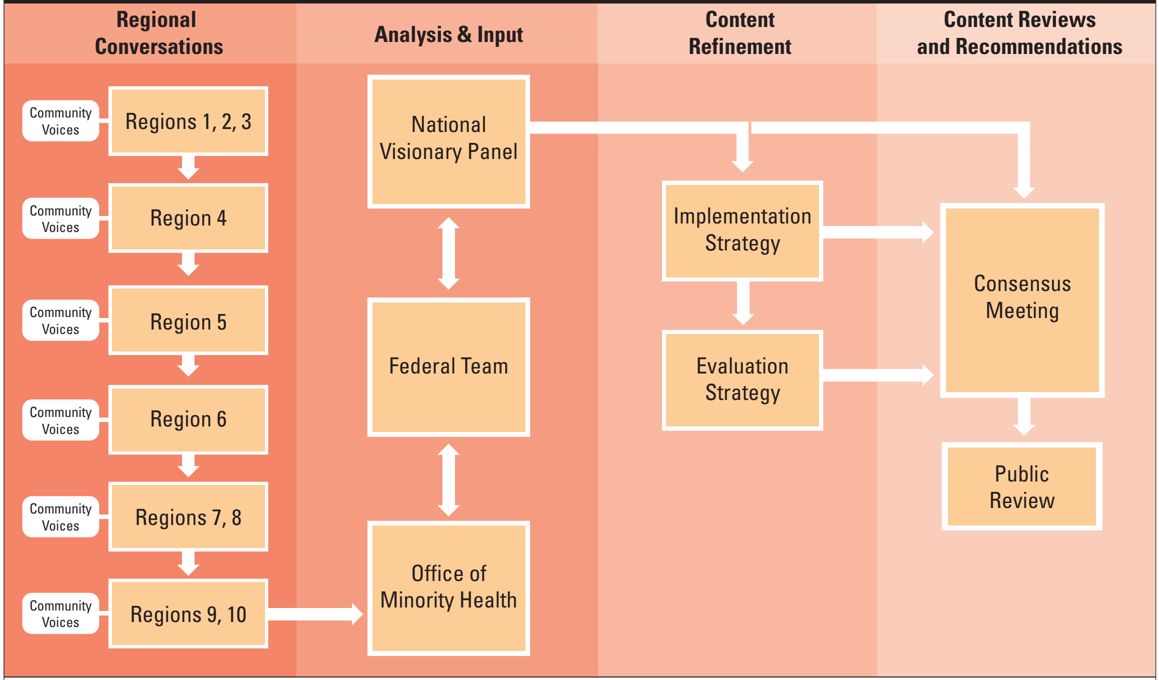
A detailed description of each goal, and the 20 strategies that support the five goals, is provided in Section 3 of this document.

PROCESS FOR DEVELOPING THE *NATIONAL STAKEHOLDER STRATEGY*

Community and Other Stakeholder Input

The process for developing the *National Stakeholder Strategy* was deliberate and began by obtaining the views of community leaders and other stakeholders. As outlined in Exhibit 1-1, the approach began with "Community Voices" meetings and "Regional Conversations" across the United States; continued on with analysis, input, and content refinement from community and additional stakeholders, experts, and representatives of federal agencies; was followed by an extended public review period and incorporation of public input into the *National Stakeholder Strategy*, and concluded with the finalization and dissemination of this document. This approach ensured that wide-ranging communities of stakeholders and diverse voices were heard and considered.

Exhibit 1-1: *National Stakeholder Strategy* for Action Development Process



*Regional Conversations included community-based representatives of African-American, Hispanic, Native American and Alaskan Native, Native Hawaiian and Pacific Islander, and Asian-American attendees at the Regional Conversations. In specific Regional Conversations, representatives from tribal, Caribbean, Pacific Islands, and academia also held meetings and/or provided input to the Regional Conversation outcomes. The Federal Team refers to the FIHET(Federal Interagency Health Equity Team).

Community Voices Meetings

The purpose of the Community Voices meetings was to draw on the expertise of individuals representing different populations to help inform the broader Regional Conversations (see below). It was important to bring together smaller groups that represented different communities to identify priorities and common issues. Participants were individuals representing specific constituencies including local communities, faith-based organizations, tribes, and geographic areas (e.g., U.S. island areas). In addition, participants also included representatives from state offices of minority health that were aligned with community missions to achieve health equity; and from universities and colleges that considered themselves supporters and data/information sources for their local communities.

> "If we as a nation are to learn about creating an effective healthcare system for everybody, it is essential to hear the voices of everybody."
>
> – Community Voices Meeting Participant

During the Community Voices meetings, participants emphasized that community involvement is necessary in creating innovative solutions to improve health outcomes. They also reported awareness of partnerships — among some academic institutions, health providers, and communities — which have played a critical role in promoting programs and solutions to address health disparities (specifically chronic disease disparities).

Regional Conversations

The Regional Conversations were designed to identify community-level priorities and develop community-inspired solutions. Six separate meetings were held in different parts of the country that included the 10 HHS regional areas (see Section 2 for a listing of HHS regional areas).

> “This Regional Conversation created a wonderful opportunity for each participant to have a voice.”
>
> – Regional Meeting Participant

Invitations were extended to participants based upon extensive consultations with various sources including state public health and minority health officials; regional health administrators and minority health consultants; organizations representing different constituencies; and OMH partner organizations and grantees. Individuals were selected from one of six categories — community; tribal government (based on region) and tribal organizations; state government; health and healthcare systems; academic and research sectors; and the private sector (e.g., business community, employers, local and community foundations, etc.). To ensure diversity and generate community-oriented solutions, at least 40 percent of attendees were community leaders drawn from faith-based organizations, neighborhood coalitions, community-based organizations, and local government. Collectively, these conversations elicited input and fostered cooperation among a wide variety of stakeholders.

Insights and information derived from the Community Voices meetings were used as a springboard for discussion during the ensuing Regional Conversation. Each regional meeting included facilitated breakout sessions and also served as a venue for learning and open dialogue, collaborative conversations, and sharing of new ideas and insights. Participants were challenged to become a catalyst for change in their circles of influence.

Prior to each Regional Conversation, participants were asked to review several documents including profiles of health disparity initiatives and specific programs occurring in their region. They also reviewed fact sheets on health disparities and information on the importance of regional planning, building effective partnerships, and developing intrastate and interstate collaborations. Participants also were asked to consider questions such as the following before the meeting:

- What are the most pressing health disparities in your state or region? Which of these can you focus on collaboratively as a region?
- Are there any successful model programs or promising practices in your state that could work on a regional level?
- To eliminate health disparities in your region, what data or research would be useful in helping to develop a strategic action plan?
- How can you be more effective in sharing information on successes and barriers to eliminating health disparities in your region?

- What existing partnerships are successfully addressing health disparities in your state or region?
- Although societal factors (e.g., lack of insurance, economics, discrimination, lack of transportation) have an impact on health status, what local, state, and federal policies would have the greatest impact on eliminating health disparities?
- Are there programs or organizations in your state that have successfully developed a plan for strengthening local leadership?

> “The setting and structure of this meeting allowed for an informal atmosphere in which we were able to objectively look at our current programs and to be open to new ideas.”
>
> – NPA Regional Meeting Participant

The Regional Conversations were foundational for advancing the NPA and developing the *National Stakeholder Strategy*. They also provided meeting participants an opportunity to increase their knowledge about health disparities as well as broaden the diversity of community involvement in identifying priorities, solutions, and barriers to improving the health status of racial and ethnic minority and other underserved populations (Exhibit 1-2 summarizes some of the issues identified by Regional Conversation participants). The conversations provided a venue for exchange of information, formation of new partnerships, and the development of targeted strategies for each region. From

EXHIBIT 1 2: EXAMPLES OF ISSUES IDENTIFIED BY REGIONAL CONVERSATION PARTICIPANTS

Awareness about Health Disparities:
- Medical providers are not familiar with the prevalence of certain diseases among minority populations.
- The definition of “health” is often narrowly defined and lacks awareness that health disparities affect all populations.

Community Engagement and Capacity:
- Communities are not involved in how funding is applied.
- There is a “disconnect” between federal and state agencies when establishing priorities.
- Limited planning and funding are given to capacity building within communities.
- Grant writers are not experienced in writing for minority populations.

Access to Health Care and Quality of Care:
- Lack of preventive care — health care is more disease-management based
- Lack of information and self-guided disease management
- Lack or limited access to care — often non-existent; sometimes based on perceived ability to pay for services
- Mental health is not recognized or acknowledged within many cultures and populations

Cultural and Linguistic Competency:
- Lack of culturally competent care
- Lack of linguistically competent care
- Minorities are not adequately represented in healthcare professions and throughout the healthcare system.
- Lack of culturally competent education for providers
- Lack of respect or acknowledgment for culturally specific healing traditions

Data and Research:
- Small groups and subgroups are not included in data collection and sampling.
- Data are not shared among research institutions.
- Researchers and data collectors use tools of convenience and often will not travel into inner urban neighborhoods, to remote rural areas, or call cell phones (many people do not have landlines).

the outset, Regional Conversation participants identified "strengthening partnerships, enhancing capacity building initiatives, and improving access to care" as critical action steps for addressing health disparities.

Data Analysis, Input, and Content Refinement

A period of iterative analysis of data, input, and content refinement advanced the development of the *National Stakeholder Strategy*. This entire process is illustrated previously in Exhibit 1-1. Input from the Community Voices meetings and Regional Conversations was analyzed and organized, and then shared with community experts and federal representatives for further input and refinement. A federal team — the Federal Interagency Health Equity Team (FIHET) — provided sustained and continuing leadership for this process. The FIHET membership currently includes representatives from the federal departments of Health and Human Services, Agriculture, Commerce, Defense, Education, Housing and Urban Development, Justice, Labor, Transportation, Veterans Affairs, and Homeland Security, as well as from the Environmental Protection Agency.

A National Visionary Panel (NVP) was also convened to provide additional analysis and input. The panel represented a varied constituency of interests for eliminating health and healthcare disparities in the United States and was comprised of experts from community, public health, academic, healthcare, research, private sector, nongovernmental, and other national organizations and associations.

To begin the analysis process, the action step matrices prepared by participants from each Regional Conversation meeting were reviewed to identify the priorities that were common to all the regions. These were strategies for ending health and healthcare disparities that appeared repeatedly across regions. Ten *common* priority strategies emerged. A few regions identified *all* 10 common strategies as priorities for their constituencies; most regions only identified *some* of the common strategies as immediate priorities for their needs.

The 10 strategies common to all the regions were reviewed and refined by the FIHET and the NVP. The aim of the initial analysis of common strategies was to identify crosscutting strategies that could foster a common national reference point for shared action within and across regions. A common reference point for action also fosters efficient evaluation of outcomes.

The FIHET and the NVP identified an *additional 10 related strategies* that support and echo the 10 common strategies identified as priorities by Regional Conversation participants. FIHET and NVP representatives also contributed to linking the strategies to the five NPA goals. Thus, the *final 20 common strategies* provide a cohesive, comprehensive approach to ending health and healthcare disparities with broad applicability.

Meetings About Implementation and Evaluation of the National Stakeholder Strategy

Meetings with community practitioners and experts were also convened to begin exploring implementation and evaluation strategies for the *National Stakeholder Strategy*. These individuals were knowledgeable about a wide range of topics such as community collaboration, community engagement, multi-level support structures and processes, evaluation methods, and data analyses and reporting.

Reviews and Recommendations

The final stages of the development of the *National Stakeholder Strategy* involved input from a consensus meeting representing broad constituencies, an extended period of public review, and incorporation of public comments into the final strategy.

Consensus Meeting

OMH facilitated a meeting that brought together community leaders and other stakeholders to comment and vote on strategies, objectives, and measures. Seven expert panels presented on the strategies, objectives, and measures that had been developed throughout the *National Stakeholder Strategy* development process and provided recommendations for implementation and evaluation. Each panel was followed by a facilitated discussion where meeting participants could respond to the presentations and present additional priority objectives and measures that they believed would best support the NPA and *National Stakeholder Strategy*. At the end of each facilitated discussion, participants were asked to evaluate the information that was presented and discussed, and then vote for the strategies, objectives, and measures that they considered most aligned with the NPA and *National Stakeholder Strategy* goals.

Public Review

The draft *National Stakeholder Strategy* (identified as the *National Plan for Action* at that point in time) was posted online along with information requesting public comment. The process yielded a robust response from the public — approximately 2,200 comments were received, processed, and incorporated into the *National Stakeholder Strategy* wherever possible. Many comments provided information about the organizations submitting comments, health-related topics for inclusion in the *National Stakeholder Strategy*, general views about the *National Stakeholder Strategy*, and recommendations for specific additions and edits.

> "I feel this plan will bring forth true change, as a Community Leader I really feel that this will help us to build trust between our communities and healthcare industry."
>
> – Comment by Public Reviewer

SUMMARY

This section described the past, current, and future context for the *National Stakeholder Strategy* and the process by which it was developed. There is substantial evidence that supports the concerns about health disparities that were raised by community and other stakeholders who participated in the process that produced this strategy. Section 2 provides a detailed review of this evidence that confirms and identifies the wide range of health and healthcare disparities in this country. The evidence for health disparities provided in Section 2 lends context for the stakeholder-generated strategies and tools that are offered in Section 3 and which are the heart of the NPA.

The *National Stakeholder Strategy*

A PRACTICAL CONTEXT FOR CHANGE

The fundamental purpose of *the National Stakeholder Strategy* is to promote systematic and systemic change that improves the overall health of the nation. Achieving this purpose will take time, include many people, and require that steps be taken incrementally while maintaining focus on the ultimate goal of achieving health equity. In this regard, the information in this section addresses the practical matter of what may be required to influence change and improve outcomes for affected communities. It sets out a strategy for change based on the five key goals and 20 strategies that were developed through the extended grass-roots process that is described in Section 1 (see also Exhibit 1.1). The goals and their corresponding strategies provide a starting point and menu of resources for stakeholders to design actions that are achievable through their scopes of influence and areas of expertise.

It is important to reiterate the message from Section 1 that the *National Stakeholder Strategy* responds to the voices of thousands of leaders from across the United States who called for actions to effectively and efficiently address health and healthcare disparities in this country. These leaders represented community-based organizations; faith-based organizations; the business sector; healthcare workforce; health and insurance industries; academia; local, state, tribal, and federal governments; and others. The *National Stakeholder Strategy* is also based on Congressional language, which called for a national strategy that is implemented and monitored in partnership with state and local governments, communities, and the private sector.

Partnerships within and beyond the health sector can address crosscutting, multilevel issues to achieve health equity. Formation of wide-ranging partnerships is the next best step forward towards tackling this ultimate goal. It will be the job of change-oriented organizations and individuals to take the goals and strategies in this document and adapt them to their own missions, interests, and needs—in order to develop the actions that they can implement to effect change.

The resources in this section are not necessarily the final or only methods for ending health disparities and achieving health equity. That is, each strategy is not necessarily applicable to all stakeholders. Rather, this *National Stakeholder Strategy* provides a common reference point, language, and initial set of actions for any group that wishes to seriously engage in ending health disparities. This is especially important for the development of strong, strategic, collaborative partnerships among disparate organizations.

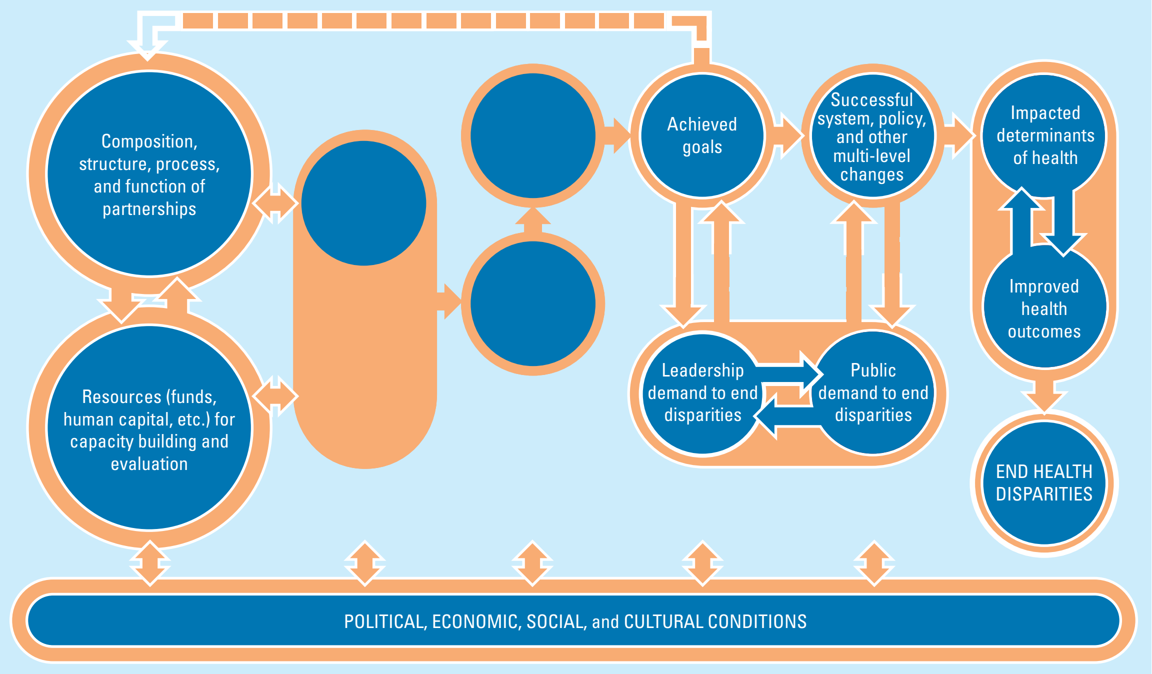
The hope is that stakeholders will be encouraged to use the goals and strategies to ensure focused progress toward achieving health equity. The overarching benchmark that all should aim to realize is the reduction in the incidence and prevalence of health conditions and diseases for which disparities exist, and to seek the gradual elimination of the determinants that are the root causes of poor health.

With this practical background in mind, the following subsection briefly describes a theoretically based context for change. The theory of change model was developed to reflect the process that would begin at this juncture of the *National Stakeholder Strategy's* history. This model is a general road map to ensure that individuals, organizations, and partners stay focused while engaging in incremental steps that lead to the end of health disparities.

A THEORETICAL CONTEXT FOR CHANGE

As shown on the following diagram, the context for change model begins on the far left with input from partnerships (e.g., local, state, tribal, regional, and national) that play the primary role in setting the initial context for change and the impetus for its continuation. The far right of the diagram displays the final output—the overriding goal—of the end of health disparities through changing adverse determinants of health and improving health outcomes. The input, output, and intervening steps all have arrows to indicate the interrelationships of all the steps and the iterative nature of the whole process.

Exhibit 3 1: Context for Change



The composition, structure, process, and function of partnerships will affect their capacity and effectiveness. The partnerships and the entire process depend on resources to build their capacity to function effectively and efficiently and to initiate and evaluate their efforts. Resources include not only funding, but also the necessary resources of knowledge, skills, and other forms of support and human capital that lie within or outside the partnerships. The capacity of partners increases and becomes more effective as they leverage resources and the relationships required to prioritize their objectives and to develop and implement actions that support their strategies. An interactive and iterative effect between the partnerships' initial and increased capacities points to a continuous process of improvement.

Implementation of the strategies could lead to the partial or total achievement of one or more of the five goals and impact two key levers of change: leadership and public demand to end disparities. The combined impact would be successful system, policy, and other multilevel changes. Over time, the continuous interaction among goal attainment, successful changes, leadership, and public demand to end disparities would affect the conditions in which people are born, grow, learn, live, work, play, and age (i.e., determinants of health)—leading finally to an improvement in the health outcomes of people who experience disparities.

The model emphasizes an iterative cycle of adjustments to the partnerships' structure, process, composition, and functions in order to continuously increase their capacity, resources, and relationships for achieving their goals. Partnerships will operate within particular political, economic, social, and cultural contexts. These contexts can dramatically affect the change process. The ability to work across cultures—those based on racial, ethnic, and cultural identities and those based on geographic and organizational settings—affects every goal, strategy, objective, and action.

> "If we as a country want to learn how to create an effective healthcare system for all, it's really important to hear the voices of all."
>
> –NPA Regional Meeting participant

The remainder of this section lays out background information for each of the five NPA goals and links them to the 20 strategies that were developed through the grass-roots process that produced this *National Stakeholder Strategy for Achieving Health Equity*.

Exhibit 3 2: SUMMARY OF NPA GOALS AND STRATEGIES

Goal #	Goal Description	Strategies
1	**AWARENESS—** Increase awareness of the significance of health disparities, their impact on the nation, and the actions necessary to improve health outcomes for racial, ethnic, and underserved populations	1. **Healthcare Agenda** Ensure that ending health disparities is a priority on local, state, tribal, regional, and federal healthcare agendas
		2. **Partnerships** Develop and support partnerships among public, nonprofit, and private entities to provide a comprehensive infrastructure to increase awareness, drive action, and ensure accountability in efforts to end health disparities and achieve health equity across the lifespan
		3. **Media** Leverage local, regional, and national media outlets using traditional and new media approaches as well as information technology to reach a multi-tier audience—including racial and ethnic minority communities, youth, young adults, older persons, persons with disabilities, LGBT groups, and geographically-isolated individuals—to encourage action and accountability
		4. **Communication** Create messages and use communication mechanisms tailored for specific audiences across their lifespan, and present varied views of the consequences of health disparities that will encourage individuals and organizations to act and to reinvest in public health.
2	**LEADERSHIP—** Strengthen and broaden leadership for addressing health disparities at all levels	5. **Capacity Building** Build capacity at all levels of decision-making to promote community solutions for ending health disparities
		6. **Funding Priorities** Improve coordination, collaboration, and opportunities for soliciting community input on funding priorities and involvement in research and services
		7. **Youth** Invest in young people to prepare them to be future leaders and practitioners by actively engaging and including them in the planning and execution of health, wellness, and safety initiatives
3	**HEALTH SYSTEM AND LIFE EXPERIENCE—** Improve health and healthcare outcomes for racial, ethnic, and underserved populations	8. **Access to Care** Ensure access to quality health care for all
		9. **Children** Ensure the provision of needed services (e.g., mental, oral, vision, hearing, and physical health; nutrition; and those related to the social and physical environments) for at-risk children, including children in out-of-home care
		10. **Older Adults** Enable the provision of needed services and programs to foster healthy aging
		11. **Health Communication** Enhance and improve health service experience through improved health literacy, communications, and interactions
		12. **Education** Substantially increase, with a goal of 100%, high school graduation rates by working with schools, early childhood programs, community organizations, public health agencies, health plan providers, and businesses to promote the connection between educational attainment and long-term health benefits
		13. **Social and Economic Conditions** Support and implement policies that create the social, environmental, and economic conditions required to realize healthy outcomes
4	**CULTURAL AND LINGUISTIC COMPETENCY—** Improve cultural and linguistic competency and the diversity of the health-related workforce	14. **Workforce** Develop and support the health workforce and related industry workforces to promote the availability of cultural and linguistic competency training that is sensitive to the cultural and language variations of diverse communities
		15. **Diversity** Increase diversity and competency of the health workforce and related industry workforces through recruitment, retention, and training of racially, ethnically, and culturally diverse individuals and through leadership action by healthcare organizations and systems
		16. **Ethics and Standards, and Financing for Interpreting and Translation Services** Encourage interpreters, translators, and bilingual staff providing services in languages other than English to follow codes of ethics and standards of practice for interpreting and translation. Encourage financing and reimbursement for health interpreting services
5	**DATA, RESEARCH, AND EVALUATION—** Improve data availability, coordination, utilization, and diffusion of research and evaluation outcomes	17. **Data** Ensure the availability of health data on all racial, ethnic, and underserved populations
		18. **Community-Based Research and Action, and Community-Originated Intervention Strategies** Invest in community-based participatory research and evaluation of community-originated intervention strategies in order to build capacity at the local level for ending health disparities
		19. **Coordination of Research** Support and improve coordination of research that enhances understanding about, and proposes methodology for, ending health and healthcare disparities
		20. **Knowledge Transfer** Expand and enhance transfer of knowledge generated by research and evaluation for decision-making about policies, programs, and grant-making related to health disparities and health equity

GOALS AND STRATEGIES

Goal 1. Awareness: Increasing Awareness of the Significance of Health Disparities, Their Impact, and Necessary Actions

The 1985 *Heckler Report* documented the continuing burden of disparities for racial and ethnic minorities, noting that such disparities had "existed ever since accurate federal recordkeeping began more than a generation ago."[10] In assessing access to health information, the *Heckler Report* concluded that minority populations might be less knowledgeable of specific health problems than non-minorities. The *Heckler Report* developed recommendations for improving awareness through outreach and patient education.

Twenty-five years later, the NPA's *National Stakeholder Strategy* points to the necessity of increasing public awareness of health disparities. In spite of the longstanding evidence for health and healthcare disparities in this country, there continues a low level of awareness of health disparities among the American public and among healthcare providers.[8] Various reports over time—such as those described in the paragraphs below—have shown that Americans and health professionals are not sufficiently informed about health and healthcare disparities.

In 1999, the Kaiser Family Foundation conducted a study to assess the public's perceptions and attitudes about racial and ethnic differences in health care. The survey, which included a nationally representative sample of Whites, African Americans, and Latinos, found that most Americans (62 percent) were uninformed about disparities in health care. Another important finding was that there were differing views about the role that race plays in accessing quality care. Most African Americans and Latinos believed that they receive lower quality care and that race and ethnicity influence the ability to get routine care. White respondents did not share this view. The study concluded that "efforts to eliminate health disparities will need to improve public awareness of the problems and address barriers of race and money in health care."[70] A 2006 survey by the Kaiser Family Foundation yielded results similar to those from the 1999 survey.

The Harvard School of Public Health and the Robert Wood Johnson Foundation conducted a poll in 2005 (Whites, African Americans, and Hispanics/Latinos) to evaluate the American public's knowledge about healthcare disparities. Key findings from this survey were similar to those from the Kaiser Family Foundation's study regarding the lack of widespread recognition of the existence of disparities in health care. Overall, only 32 percent of Americans believed that getting quality care was more difficult for minorities. Different populations had diverging views about the influence of race or ethnicity in the quality of care received. Twenty-three percent of African Americans believed that they received poor quality of care because of their race. In contrast, only 1 percent of Whites believed this. Furthermore, 21 percent of Hispanics/Latinos believed that they received poor quality care because of their accent or inability to speak English well.

In 2002, the Kaiser Family Foundation released findings of a national survey showing that, in general, doctors are less likely than the public to say disparities occur "very often" or "somewhat often."[282] However, by 2005, a study by the American Medical Association showed that physicians were becoming more involved in addressing healthcare disparities. Findings from this national survey showed that 55 percent of physicians agreed that minority patients generally receive lower quality care than do White patients.[283]

The challenge before us is to ensure that all stakeholders, not just racial and ethnic minority communities, understand the problem and are working together to enhance the visibility of this critically important public health issue. The challenge also calls for working collaboratively to develop a more coordinated approach to health promotion and disease prevention across the lifespan to encourage healthier lifestyles for all Americans. The awareness goal is not only about doing things differently, but also about working more strategically to obtain a stronger return on our investment.

The four strategy charts below address the goal of awareness through strategies based on healthcare agenda, partnerships, media, and communication. For each strategy, there is a menu of objectives, measures, and potential data sources which are tools for stakeholders to use in implementing any given strategy.

GOAL 1: AWARENESS

Increase awareness of the significance of health disparities, their impact on the nation, and the actions necessary to improve health outcomes for racial, ethnic, and underserved populations

STRATEGY 1: HEALTHCARE AGENDA

Ensure that ending health disparities is a priority on local, stateb, tribal, regional, and federal healthcare agendas

OBJECTIVES[a]	MEASURES[a]	POTENTIAL DATA SOURCES[a]
1. Strengthen city/county, state,b and federal minority health entities (such as an office, commission, council) and tribal health offices and establish a health disparities liaison in non-health departments (such as education, housing, labor) to ensure local, state, and tribal partnerships and decision-making power 2. Identify and develop relationships with non-partisan think tanks and other policy centers to advance and disseminate model policies that address determinants of health, reduce health disparities, and work to achieve health equity across the lifespan 3. Establish and utilize a national minority health information exchange or portal system as the central repository of all minority health data and related information, including government- and private-funded research, publications, podcasts, Web-based resources and trainings, conference proceedings, and best and replicable practices for ending health disparities 4. Develop partnerships among foundations, local businesses, nonprofit organizations, educational institutions, and community leaders to advocate for local policies and actions that create and sustain conditions for good health	1. Number and distribution of state and county/city minority health entities (such as office, commission, council), tribal health offices, health disparities liaisons established, and their degree of collaboration and decision-making power 2. Number, types, scale, and scope of activities conducted by stakeholder groups to address health disparities 3. Number and types of policy actions driven by data about determinants of health and health disparities 4. Number of local, state, tribal, and federal government plans that address health disparities and health equity 5. Percent of public or private funding allocated to support activities, including cross-agency collaborations to eliminate health disparities 6. Utilization trends for a national minority health information exchange	1. Organizational charts, mission statements, and other organizational information for city/county, state, and tribal governments and local health departments, as well as job descriptions for health disparities liaisons 2. City/county, state, tribal, and federal government strategic plans (e.g., departments of health and human services' strategic plans, community strategic plans) 3. State public health budgets—line items related to health disparities 4. National Association of County and City Health Officials' Local Health Department Infrastructure Study—data on local health department expenditures 5. U.S. Census Bureau's Census of Governments—data for government expenditures on health 6. National Conference of State Legislatures' Health Resources and Research—collection of articles, briefs, bills/summaries, databases, and letters and testimonies related to health disparities 7. Surveys of local and state health departments, academic institutions, businesses, philanthropic organizations, and community groups on health disparities 8. Federal Office of Minority Health's awareness surveys

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[a] The objectives, measures, and potential data sources do not directly correlate to each other, but to the strategy to which they are connected.

[b] The use of "state" in this chapter includes Territories and the District of Columbia.

GOAL 1: AWARENESS

Increase awareness of the significance of health disparities, their impact on the nation, and the actions necessary to improve health outcomes for racial, ethnic, and underserved populations

STRATEGY 2: PARTNERSHIPS

Develop and support partnerships among public, nonprofit, and private entities to provide a comprehensive infrastructure to increase awareness, drive action, and ensure accountability in efforts to end health disparities and achieve health equity across the lifespan

OBJECTIVES[a]	MEASURES[a]	POTENTIAL DATA SOURCES[a]
1. Establish or assess and strengthen formal partnerships at different levels (i.e., community, city/county, state, and tribal) and across sectors (i.e., public, nonprofit, and private sectors) that have the potential to impact health disparities, opportunities for new collaboration, and prospects for improved coordination and integration. 2. Identify or create health equity and neighborhood solution groups[b] to help apply and implement Blueprints for Action,[c] support evaluation of activities and results related to the Blueprints, update the Blueprints periodically, and develop annual reports 3. Identify and engage community leaders; local, state, tribal, and regional funders; local coalitions and alliances; nonprofit organizations; and non-traditional partners in neighborhood solution and health equity groups. Provide infrastructure support, and coordinate activities to minimize unnecessary duplication of efforts 4. Connect health equity and neighborhood solution groups, collaboratives working on health disparities-related issues, and alliances representing different racial, ethnic, gender, disabilities, age, and LGBT groups and geographic communities to the *National Stakeholder Strategy* to adopt joint actions for ending health disparities	1. Number, composition, distribution, and goal attainment of partnerships addressing health disparity and health equity issues 2. Distribution and type of health disparity activities, including those that contributed to policy actions or changes, carried out annually by partners at different levels and across sectors 3. Composition and distribution of health equity and neighborhood solution groups 4. Number and type of goals and actions implemented and achieved by health equity and neighborhood solution groups 5. Number of health equity and neighborhood solution groups' recommendations that contributed to policy actions or changes by local, state, tribal, or federal agencies and/or organizations in the nonprofit and private sectors 6. Number of actions by health equity and neighborhood solution groups, and other types of collaboratives and alliances linked to the national efforts to end health disparities	1. Survey of local and state health departments, academic institutions, businesses, and community groups on partnerships to address health disparities 2. National Business Group on Health surveys 3. National Institute on Minority Health and Health Disparities (NIMHHD); National Institute of Mental Health's Outreach Partnership Program; Substance Abuse and Mental Health Services Administration's National Network to Eliminate Health Disparities in Behavioral Health 4. American Public Health Association's Health Disparities Community Solutions Database—review public-private partnership activities 5. Agency for Healthcare Research and Quality's Health Care Innovations Exchange Health Disparities Database—searchable database with information on public-private partnerships 6. Health equity and neighborhood solution groups

[a] The objectives, measures, and potential data sources do not directly correlate to each other, but to the strategy to which they are connected.

[b] Establishment of health equity and neighborhood solution groups are encouraged and anticipated at the neighborhood, city/county, state, tribal, and regional levels.

[c] Blueprints for Action will be developed for each of the 10 HHS regions, people with disabilities, LGBT groups, and the American Indian and Alaskan Native population.

GOAL 1: AWARENESS

Increase awareness of the significance of health disparities, their impact on the nation, and the actions necessary to improve health outcomes for racial, ethnic, and underserved populations

STRATEGY 3: MEDIA

Leverage local, regional, and national media outlets using traditional and new media approaches as well as information technology to reach a multi-tier audience—including racial and ethnic minority communities, youth, young adults, older persons, persons with disabilities, LGBT groups, and geographically isolated individuals—to encourage action and accountability

OBJECTIVES[a]	MEASURES[a]	POTENTIAL DATA SOURCES[a]
1. Encourage public and private partners to develop and support a public relations/social marketing infrastructure for addressing health disparities and health equity that can also serve as a platform for local, state, tribal, regional, national information campaigns in order to "mainstream" the message 2. Maintain media spotlight on health disparities by providing data and information to representatives (e.g., journalists, reporters, bloggers) of mainstream and community-based media outlets, including media specifically used by racial, ethnic, and other underserved populations 3. Create messages about health disparities and potential solutions that are relevant to target audiences (e.g., youth, racial and ethnic minorities, people with disabilities, older adults, LGBT communities) and train leaders, community partners, and health equity advocates to adopt and use them effectively with media representatives 4. Strengthen the ability of media representatives to frame disparities-related stories about the impact of health disparities, the link between health disparities and the social and economic well being of all, and effective solutions (e.g., provide easy access to comprehensive data, link them to appropriate information sources, including experts on the issues, civil rights advocates, and local leaders)	1. Distribution of coordinated public information campaigns for eliminating health disparities 2. Content of health disparity-related news events and stories published 3. Number and types of actions spurred by public information campaigns 4. Number of unique visitors to targeted health disparities Web sites (e.g., Office of Minority Health, Agency for Healthcare Research and Quality, National Institute on Minority Health and Health Disparities) 5. Diversity of media outlets disseminating content on health disparity-related messages 6. Number of first-time town hall or informational meetings and events that address health disparities 7. Placement of health disparities-related articles and stories in print and broadcast mainstream and non-mainstream media, including films and movies	1. Local and national news and media outlets (print, radio, and television)—data on news events stories and publications related to health disparities 2. Survey of minority or special interest media and news outlets for information on stories and news events related to health disparities 3. Federal agencies such as the Office of Minority Health, National Institute on Minority Health and Health Disparities, and the Agency for Healthcare Research and Quality data on Website traffic and unique visitors

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[a] The objectives, measures, and potential data sources do not directly correlate to each other, but to the strategy to which they are connected.

GOAL 1: AWARENESS

Increase awareness of the significance of health disparities, their impact on the nation, and the actions necessary to improve health outcomes for racial, ethnic, and underserved populations

STRATEGY 4: COMMUNICATION

Create messages and use communication mechanisms tailored for specific audiences across their lifespan, and present varied views of the consequences of health disparities that will encourage individuals and organizations to act and to reinvest in public health

OBJECTIVES[a]	MEASURES[a]	POTENTIAL DATA SOURCES[a]
1. Establish common messages grounded in current communications research, about ending health disparities across the lifespan, which can be used by organizations that support the *National Stakeholder Strategy* 2. Create, disseminate, and encourage data briefs about different forms of health disparities based on gender, stages of development (e.g., older adults and young people), race and ethnicity, sexual orientation or gender identity, disability, socioeconomic status, and geographic location to educate opinion leaders and inform solutions 3. Support the use of blogs, podcasts, text messaging, online and mobile video, e-games, social networks, and other interactive technologies to engage diverse racial, ethnic, and other underserved groups in conversations and forums about preventing chronic and infectious diseases 4. Create partnerships to conduct joint information campaigns with health disparity and health equity messages that are appropriately targeted to populations across the lifespan 5. Facilitate conversations with community leaders who can contribute to the development and dissemination of health equity message	1. Distribution of common messages about ending health disparities, including the cost of health disparities to society as a whole 2. Number, distribution, content, and use of health disparity data briefs 3. Distribution and content of viewings or messages on targeted user-generated Web sites 4. Number and distribution of organizations carrying out joint campaign activities with common messages during National Minority Health Month and other relevant awareness celebrations 5. Distribution and content of messages and information on mainstream and culturally specific media outlets that are not health disparities-focused, with messages related to health disparities	1. Local networking Web sites' records on user-created sites related to health disparities and chronic disease prevention and viewings/visits to these sites (e.g., YouTube, Twitter, Facebook) 2. Content analyses of strategy, communications plans, press releases, reports, and campaign materials of *National Stakeholder Strategy* partner agencies for information on messaging 3. National Opinion Survey on Health and Health Disparities 4. Local, state, tribal, and federal agencies that have information campaigns 5. www.gaydata.org

[a] The objectives, measures, and potential data sources do not directly correlate to each other, but to the strategy to which they are connected.

Goal 2. Leadership: Strengthening and Broadening Leadership for Addressing Health Disparities

The underlying causes of health and healthcare disparities are multi-faceted and therefore require comprehensive solutions. The *National Stakeholder Strategy's* goals are intended to address these underlying causes by encouraging cohesive and comprehensive actions. Leaders play a pivotal role in any effort to create change, mobilize stakeholders, and advance solutions to issues of significant concern. Given the breadth, scope, and complexity of health and healthcare disparities, current leaders will need to become more engaged, and new leaders will need to be developed. Building leadership is a key responsibility of any collaborative effort to address complex issues and achieve beneficial outcomes.[284] There is a growing pool of talented leaders among racial and ethnic minorities and underserved communities and an increased willingness to engage them as sources of insight for identifying problems and finding solutions.

Cross-sectoral leadership, from the community to the national level, enables opportunities to harness the full complement of experiences, concerns, and ideas that are critical to developing comprehensive solutions. While leaders are needed at all levels of engagement, community leaders have been a long-overlooked resource for developing local solutions. In many instances, community- and faith-based organizations and other safety-net programs are the most accessible resources for leadership among minority and other underserved communities. These organizations often lack the funding, infrastructure, and technical or personnel support to appropriately tackle disparities. Investing in tools and providing capacity-building assistance is vital for ensuring that community and other leaders can engage as equal partners.

Local businesses and research, academic, health industry, and other organizations play a vital role in providing capacity-building support to develop and engage community leaders. They can serve as conveners of meetings with legislators, public health officials, community representatives, private sector representatives, and others seeking to advance actions to end health disparities. They are also positioned to assist communities in identifying information related to their health concerns and in developing neighborhood strategies to address disparities.

Strengthening and supporting current leadership, however, is not sufficient; we also have to invest in this nation's future leaders. The nation's youth are an important resource for developing current and future leaders. After several years of decline across the nation, the population of young Americans is growing and in coming years will rival the size of the baby- boomer generation. They will ultimately become the adults who make decisions that reshape our social, physical, economic, and cultural environments and produce innovations to combat health and healthcare disparities. Youth-serving organizations are a resource for shaping youth and helping them become the leaders of tomorrow.[285]

The three strategy charts below address the goal of leadership through strategies based on capacity building, funding and research priorities, and youth. For each strategy there is a menu of objectives, measures, and potential data sources, which are tools for stakeholders to use in implementing any given strategy.

GOAL 2: LEADERSHIP

Strengthen and broaden leadership for addressing health disparities at all levels

STRATEGY 5: CAPACITY BUILDING

Build capacity at all levels of decision-making to promote community solutions for ending health disparities

OBJECTIVES[a]	MEASURES[a]	POTENTIAL DATA SOURCES[a]
1. Establish and expand access to leadership trainings and planning and operational tools to equip institutional, local, and community leaders with the capacity to: a) design and deliver effective prevention, wellness, and other services to end health disparities; b) engage community members as equal partners in designing and conducting assessments and taking action; and c) partner effectively with government, academic, private, and nonprofit organizations on activities to end disparities for their communities and constituents	1. Degree to which local health disparity efforts are shaped and led by local and community leaders and, therefore, are tailored to the specific needs, context, and history of the targeted communities	1. U.S. Census Bureau's Census of Governments—review of federal and state budgets and amount of funds allocated to community capacity building to address health disparities
2. Create opportunities for entry- and mid-level professionals to receive leadership training and mentoring in order to create and expand the pipeline of leaders who can address health disparities	2. Proportion of local and state budgets and foundation grants allocated for technical assistance and other supports to help community organizations address health disparities and health equity	2. Interviews with leaders and key informants of programs and initiatives that provide technical assistance and other supports to local groups on ending health disparities
3. Create and implement a system to train and build the skills of leaders and staff in the public and philanthropic sectors and at different levels (i.e., local, state, tribal, or federal) to support and engage in community-oriented prevention and health equity work, particularly in providing equitable opportunities for community organizations to compete for funding	3. Type, frequency, and number of local, state, and regional networks intended to build public, private, and nonprofit organizations' capacities for engaging community representatives in all aspects of planning and implementing solutions for ending health disparities	3. Survey of community-based groups engaged in health disparities programming
4. Provide technical assistance and other resources to improve the capacity of community organizations to collect, analyze, report, and use data for competitive submissions to foundations, government agencies, and other funders	4. Adoption of principles by agencies and organizations in the public, private, and nonprofit sectors for engaging community representatives in decision-making and evidence of such policies, procedures, and practices	4. Agency of Healthcare Research and Quality's Health Care Innovation Exchange Health Disparities Database and American Public Health Association's Health Disparities Community Solutions Database—review of community projects related to *the National Stakeholder Strategy* goals
5. Create principles that for agencies and organizations in the public, private, and nonprofit sectors can use to engage community representatives as equal partners in decisions about how to address the disparities that affect their communities		5. National Association of County and City Health Officials' Local Health Department Infrastructure Study—data on local health department expenditures allocated to community capacity building to address health disparities
		6. Survey of local, statewide, and national foundations to determine amount of funds allocated to community capacity building to address health disparities

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[a] The objectives, measures, and potential data sources do not directly correlate to each other, but to the strategy to which they are connected.

GOAL 2: LEADERSHIP

Strengthen and broaden leadership for addressing health disparities at all levels

STRATEGY 6: FUNDING AND RESEARCH PRIORITIES

Improve coordination, collaboration, and opportunities for soliciting community input on funding priorities and involvement in research and services

OBJECTIVES[a]	MEASURES[a]	POTENTIAL DATA SOURCES[a]
1. Broaden outreach to include representatives of state agencies and nonprofit and community-based organizations, especially those knowledgeable about different racial, ethnic, and underserved populations, as potential grant reviewers and recipients of research projects	1. Number of review panels in public agencies and foundations that include community representatives and health consumers, particularly from different racial, ethnic, and other underserved populations	1. National Institutes of Health, Office of Minority Health, national health foundations and intermediaries, state and local health departments—demographic information of grant review panel members; committees and commissions; and boards of grant recipients, contractors, and partners
2. Work with agencies and organizations in the public, private, and nonprofit sectors to include representatives from different racial, ethnic, age, and gender groups; LGBT and disability communities; and geographically diverse places in decisions about funding, programmatic, and research priorities where they have historically been excluded (e.g., create opportunities for such representation on committees, commissions, and boards)	2. Distribution and diversity of community representatives from different racial, ethnic, and other underserved populations on local, state, and federal committees and commissions and on boards of private and nonprofit organizations	2. National Institutes of Health's Research Portfolio Online Reporting Tools (RePORT)
3. Improve coordination of technical assistance and other resources to help community-based organizations write and submit quality grant proposals	3. Number, distribution, and co-funding of technical assistance and other support programs in grant writing	3. Grant-writing technical assistance activities sponsored by local, state, tribal, and federal agencies; foundations; and other entities
4. Incentivize state agencies, institutions of higher education, academic medical centers, and private and nonprofit research organizations to invest in local health equity efforts and to collaborate with community-based organizations as an equal or lead partner	4. Proportion of funds allocated by local, state, tribal, and federal agencies and private funders and made available to community-based organizations to address at least one *National Stakeholder Strategy* goal	4. Requests for proposals and background, context, or rationale sections of funded proposals
5. Establish regional and national consortia to connect academic and research institutions, evaluators, intermediaries, and community-based organizations to: a) inform the use of funds for research and services, and b) use research and evaluation findings to inform the development and implementation of projects to end health disparities and achieve health equity	5. Degree to which data about determinants of health are required and provided in grant proposals	5. Survey of community-focused centers of excellence
6. Strengthen centers of excellence that focus on concerns, strategies, and solutions informed by community leaders and representatives and people affected by health disparities	6. Number, distribution, and use of community-focused centers of excellence	

[a] The objectives, measures, and potential data sources do not directly correlate to each other, but to the strategy to which they are connected.

GOAL 2: LEADERSHIP

Strengthen and broaden leadership for addressing health disparities at all levels

STRATEGY 7: YOUTH

Invest in young people to prepare them to be future leaders and practitioners by actively engaging and including them in the planning and execution of health, wellness, and safety initiatives

OBJECTIVES[a]	MEASURES[a]	POTENTIAL DATA SOURCES[a]
1. Build the capacity of adults to engage and support youth of different gender, race/ethnicity, geographic location, sexual orientation or gender identity, disabilities, and socioeconomic status, as equal partners in decision-making about programmatic and funding priorities and in the design and implementation of community assessments and initiatives 2. Build the capacity of youth of different gender, race/ethnicity, geographic location, sexual orientation or gender identity, disabilities, and socioeconomic status to lead and participate in publicly and privately supported efforts to end health disparities 3. Educate and train youth, especially youth who have been historically excluded, to become peer leaders and advocates for their health and well-being and to address health disparities and other health-related issues that affect them	1. Distribution and diversity of youth on governing and advisory boards 2. Number and distribution of health education and promotion programs that train and use youth peer leaders and advocates 3. Percent of sessions at conferences that address youth-focused health disparity issues and percent of sessions organized, led, and presented by youth 4. Distribution of local, state, tribal, regional, national youth organizations that include health disparities as a program or policy priority	1. Neighborhood Solution Groups and state, tribal, regional, and national health equity coalitions 2. Agendas of conferences that address health disparities and youth issues 3. Mission statements, policy agendas, program activities, and budgets of local, state, tribal, regional, and national youth and health organizations

[a] The objectives, measures, and potential data sources do not directly correlate to each other, but to the strategy to which they are connected.

Goal 3. Health System and Life Experience: Improving Health and Healthcare Outcomes for Racial, Ethnic and Underserved Populations

Health is influenced by a number of interrelated factors that impact individuals where they live, learn, work, play, and age. These factors include the social, economic, and physical environments as well as individual characteristics and behaviors.[4] Health and healthcare disparities affect individuals across the lifespan and require comprehensive solutions, coordination across sectors, and supportive policies to address them. [32]

The *Unequal Treatment Report* highlights many factors that contribute to disparities in health outcomes. These include health system-related factors, as well as the actions and attitudes of individuals (e.g., healthcare providers, utilization managers, and patients). At a systems level, this can include institutional bias, the lack of cross-cultural education in the training of health professionals, and the lack of policies and infrastructure to address the multiple needs of diverse clients. At the individual level, there may be a lack of knowledge among healthcare providers about multicultural service provision and culturally relevant care, and among patients and other consumers of health services, a lack of understanding about their rights and responsibilities and the role they play in determining their own health futures. When patients have "medical homes" (settings that provide timely, well-organized care and enhanced access to providers), racial and ethnic disparities are reduced.[286]

There is also a need for improvements in the health communication experience for patients and their providers.[287,288] As defined by Healthy People 2010, *health literacy* is "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions."[289] An IOM report further explains *health literacy* as more than individual skills, but as a shared function with health systems and healthcare providers to present information in an appropriate manner.[290] Research from the U.S. Department of Education reveals that only 12 percent of English-speaking adults in the United States have proficient health literacy skills. Furthermore, approximately 45 percent of high school graduates have limited health literacy.[291] Successful communication and interaction between patients and providers promotes respect of patients' wants, needs, and preferences and fosters an environment that promotes understanding of services offered, informed decision-making, and active participation in personal care.[292]

Researchers have found that Hispanics and Asian Americans have less confidence in their physicians than do Whites.[293] African Americans and Hispanics consistently rate as "low" the quality of communication and interaction with their providers.[294] Contributing to these phenomena are the real and perceived experiences of racism among minority populations. This, in turn, fosters mistrust of healthcare institutions and providers and a corresponding diminished willingness to access institutional healthcare resources. Research studies also have identified specific positive provider behaviors (e.g., listening to patients and their families, explaining treatment options, encouraging participatory decision-making, spending time with patients, and patients' perception of respect) as important indicators of patient satisfaction with the health system.[293,295,296]

There is a relationship between education and health.[297] Low educational attainment is a powerful predictor of adverse health outcomes. Although the reasons behind this relationship are complex, a basic component relates to differences in the behaviors of higher- and lower-educated groups. Generally, individuals with higher levels of education have healthier behaviors. For example, they are more likely to exercise, less likely to smoke, and less likely to be exposed to behaviors that may harm health. In the United States, men and women have similar levels of academic achievement. However, African Americans, Native Americans, and Hispanics have lower academic attainment levels. The gap for these three groups widens at higher levels of academic experience. This gap contributes to the health disparities experienced by these populations.

Research also has shown a powerful link between social and economic factors and health.[59,65,67] Eliminating health disparities and achieving health equity will require attention to these issues (e.g., availability and accessibility of nutritious food, adequate transportation, affordable housing, safe living conditions, quality of air and water, accessibility of education and job opportunities, and stress caused by perceived racial discrimination), which require comprehensive solutions, coordinated efforts across sectors, and supportive policies.

Health and healthcare disparities that are linked to the above issues affect individuals across the lifespan. Health disparities based on socioeconomic status can persist, starting from fetal health to elderly health;[32] children and older adults are especially vulnerable. Given existing evidence that links education and health, it is clear that children need the necessary services to help them learn better in order to optimize their potential for high academic achievement. This means that they require the proper oral, mental, physical, and other services to ensure their quality of health throughout their development. Likewise, older adults, especially those with limited mobility and resources, require additional assistance in accessing preventive care, self-management programs, and other types of supportive services.

The six charts below address the goal of health system and life experience through strategies based on access to care, children, older adults, health communication, education, and social and economic conditions. For each strategy there is a menu of objectives, measures, and potential data sources, which are tools for stakeholders to use in implementing any given strategy.

GOAL 3: HEALTH SYSTEM AND LIFE EXPERIENCE

Improve health and healthcare outcomes for racial, ethnic, and underserved populations

STRATEGY 8: ACCESS TO CARE

Ensure access to quality health care for all

OBJECTIVES[a]	MEASURES[a]	POTENTIAL DATA SOURCES[a]
1. Support community-driven needs assessments 2. Communicate the expectations and benefits of a health home (including medical homes and other health settings) to different racial and ethnic groups, underserved populations, and health professional community 3. Improve comprehensive primary health services that include preventive care and screenings and enhance the coordination of care and service delivery, including the use of Community Health Workers, to ensure comprehensive support for culturally, linguistically, and geographically isolated communities 4. Develop and strengthen partnerships to outreach, identify, and improve access for individuals who are eligible for Medicaid or CHIP and for the uninsured and underinsured, rural community residents, racial and ethnic minorities, and others with limited access to health care due to historical exclusion and other barriers 5. Assess the affordability of out-of-pocket health care costs for the under-served and low-income populations and identify strategies for reducing these costs 6. Incentivize culturally and linguistically competent providers to practice in medically underserved areas and to improve their distribution in order to provide first-contact, comprehensive services, and continuous, coordinated care 7. Incentivize health service providers to adopt and adhere to quality improvement standards (safe, patient-centered, effective, timely, efficient, equitable), including the use of health information technology to: a) enable information sharing among providers within the Health Information Portability and Accountability Act's restrictions; b) provide individual patients, including the limited English-proficiency population and individuals with disabilities, access to their individual medical records; and c) generate reports on compliance with quality care standards and support improvements	1. Proportion of providers that use health information technology to monitor and support quality care improvements 2. Increase in proportion of families from different racial, ethnic, and other underserved populations who have access to health homes 3. Decrease in number of inappropriate visits to the emergency room, use of ambulances, and hospitalizations for manageable chronic conditions 4. Increased access to and use of preventive care services (e.g., increase in health screening rates) 5. An infrastructure for monitoring the percent of underserved and low- income populations who do not access health care due to high out-of-pocket cost 6. Increase in health, wellness, and safety programs that target the reduction of health disparities and produce a change in personal health practices (e.g., reduced absenteeism at work, quality of life satisfaction, etc.) 7. Provider-patient ratio in medically underserved areas 8. Increase in healthcare providers who deliver prevention messages to their patients and their families (e.g., exercise safely, wear protective gear, install smoke alarms, etc.) 9. Increase in the use of telemedicine with provider reimbursements equivalent to face-to-face office and clinic visits	1. U.S. Census Bureau 2. Current Population Survey 3. National Health Interview Survey 4. Agency for Healthcare Research and Quality's State Snapshots of Health Quality 5. National Hospital Discharge Survey 6. Healthcare Cost and Utilization Project (The State Emergency Department Database) 7. The Emergency Room Database 8. Indian Health Services Health Promotion/Disease Prevention Wellness Data 9. Medicare, Medicaid, CHIP, community health center, and clinic data

[a] The objectives, measures, and potential data sources do not directly correlate to each other, but to the strategy to which they are connected.

GOAL 3: HEALTH SYSTEM AND LIFE EXPERIENCE

Improve health and healthcare outcomes for racial, ethnic, and underserved populations

STRATEGY 9: CHILDREN

EEnsure the provision of needed services (e.g., mental, oral, vision, hearing, and physical health; nutrition; and those related to the social and physical environments) for at-risk children, including children in out-of-home care

OBJECTIVES[a]	MEASURES[a]	POTENTIAL DATA SOURCES[a]
1. Improve different racial, ethnic, and underserved populations' access to maternal, infant, and early childhood support services, including clinics with expertise in pediatric environmental health and anti-bullying interventions 2. Collaborate with health providers, educators, and caregivers to assure that children are properly immunized and have up-to-date and appropriate well-child visits, including medical, dental, developmental, social, and mental health screenings 3. Establish ongoing health communication to educate children, their parents, and other caregivers about the impact of healthy nutrition, injury prevention, and physical activity on children's life and functioning 4. Support the establishment of school-based health centers to facilitate interaction between providers and school staff, students, and their parents, and provide comprehensive services 5. Use child health outcome data to inform quality of care for children, especially for children and families with specific healthcare needs 6. Promote linkages and strengthen collaboration among pediatricians, early childhood educators, preventive care services, other health and social service providers, and families to ensure school readiness and access to comprehensive services	1. Increase in early periodic screenings, diagnostic, and treatment rates 2. Increase in identification, referral, and treatment for children facing medical, developmental, and other health issues 3. Percent of resources allocated to support state, tribal, and local health agencies in providing no-cost or low-cost immunization 4. Number, distribution, and content analysis of social marketing campaigns on the importance of nutrition and physical activities for children 5. Number and distribution of community health centers or clinics within or adjacent to schools 6. Increase in resources allocated to address stressors that affect children's health 7. Increase in the number of pediatric clinics in at-risk communities with expertise in product safety and environmental conditions/hazards that influence health	1. Children's Health Insurance Research Initiative issue briefs, reports on access to care and services, quality, and disparities among low-income children 2. Health Resources and Services Administration's National Survey of Children with Special Health Care Needs—data on extent to which children with special health care needs have access to health homes, adequate health insurance, and access to needed services, as well as their care coordination and satisfaction with care 3. Local, state, tribal budgets; National Association of County and City Health Officials' Health Department Infrastructure Study—data on local health department expenditures; U.S. Census Bureau's Census of Governments— review for allocation of resources to low- or no-cost immunization services for at-risk children 4. Centers for Medicare & Medicaid Services' Annual Early and Periodic Screening, Diagnostic, and Treatment Report 5. National Children's Health Survey— data on children's health status (physical and oral health) 6. Pediatric Nutrition Surveillance System—data on nutritional status of children five years old and under for federally funded programs 7. American Dietetic Association's Evidence Analysis Library 8. Reports and report cards on children's health

[a] The actions, measures, and potential data sources do not directly correlate to each other, but to the strategy to which they are connected.

GOAL 3: HEALTH SYSTEM AND LIFE EXPERIENCE

Improve health and healthcare outcomes for racial, ethnic, and underserved populations

STRATEGY 10: OLDER ADULTS

Enable the provision of needed services and programs to foster healthy aging

OBJECTIVES[a]	MEASURES[a]	POTENTIAL DATA SOURCES[a]
1. Increase older adults' (especially older adults from racial, ethnic, and other underserved groups) access to and use of preventive healthcare services (e.g., annual influenza and the pneumococcal vaccination, prostate screenings, mammography) through community-based and clinical partnerships and other innovative approaches 2. Establish partnerships between the business sector, medical and health providers, and community-based organizations to ensure that older adults (especially older adults with multiple chronic conditions) have access to appropriate medical, dental, nutritional, and social services, as well as to evidence-based, self-management programs 3. Increase the number of accessible home and community-based provider and caregiver training programs 4. Increase the number of older adults living in frontier, rural, urban, or tribal communities who have access to core services (e.g., nutrition/meal, transportation, and respite care) provided by area agencies on aging 5. Support collaboration among the Aging Network, federally qualified health centers, aging or other organizations committed to aiding older adults, and/or state and local offices of minority health to ensure access for older adults from racial and ethnic minority groups 6. Incentivize the implementation of Naturally Occurring Retirement Communities (NORCs) or similar community aging-in-place models that enable the coordination of community-based services for older adults who live in medically underserved areas (MUAs) and/or health providers shortage areas (HPSAs)	1. Number and distribution of community- and home-based caregiver training programs 2. Number and distribution of evidence-based health, wellness, and safety programs for older adults 3. Decrease in emergency room visits and short-term hospitalizations among older adults 4. Number of older adults from different racial, ethnic, and underserved populations who have access to and receive core services 5. Number of NORCs or similar models implemented within MUAs/HPSAs	1. Medicare, Medicaid, and long-term care data 2. Agency for Healthcare Research and Quality's National Healthcare Disparities Report (NHDR) 3. Administration on Aging's Aging Integrated Database and National Aging Program Information System (NAPIS) 4. Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System data 5. Federal Interagency Forum on Aging-Related Statistics 6. The State of Aging and Health in America Report 7. The National Archive of Computerized Data on Aging 8. National Center for Health Care Statistics 9. Medical Expenditure Panel Survey (MEPS) 10. American Dietetic Association Evidence Analysis Library 11. U.S. Department of Labor, Registered Apprenticeship Office 12. Bureau of Labor Statistics

[a] The objectives, measures, and potential data sources do not directly correlate to each other, but to the strategy to which they are connected.

GOAL 3: HEALTH SYSTEM AND LIFE EXPERIENCE

Improve health and healthcare outcomes for racial, ethnic, and underserved populations

STRATEGY 11: HEALTH COMMUNICATION

Enhance and improve health service experience through improved health literacy, communications, and interactions

OBJECTIVES[a]	MEASURES[a]	POTENTIAL DATA SOURCES[a]
1. Develop health education materials in primary languages spoken by communities to communicate important health messages and improve availability of information on how to access services 2. Use culturally and age-appropriate avenues and direct-to-consumer methods to deliver health and safety messages to individuals with limited English proficiency or low-level or marginal literacy skills 3. Expand the use of eHealth marketing, mobile and interactive media, and social networking to engage and communicate information about disease and injury prevention, health promotion, and health protection 4. Enhance and disseminate guidelines for effective health literacy efforts and support the integration of health literacy training into the activities of social support institutions and networks 5. Establish and disseminate guidelines to medical and healthcare training programs and professional health associations for effective clinical and other health care encounters and patient-provider communication 6. Promote development of clinical tools to improve identification of and communications with at-risk patients (e.g., limited health-literate patients) as part of ongoing improvement initiatives	1. Number, content, and distribution of health communication materials developed in primary languages spoken by the surrounding community 2. Content of health education efforts that use e-marketing and interactive media to engage and communicate information on disease prevention, injury prevention, health promotion, and health protection 3. Application of guidelines on health literacy by medical and healthcare programs, professional associations, and social support institutions and networks 4. Patient satisfaction with their healthcare providers 5. Increase in healthcare providers (e.g., physician offices, hospitals, community clinics) that survey consumers about their satisfaction and interactions with their providers	1. National Center for Education Statistics' National Assessment of Adult Literacy—health literacy component 2. National Center for the Study of Adult Learning and Literacy—resources and briefs on health literacy 3. Ambulatory Care Experience Survey and Primary Care Assessment Survey —data from items/subscales related to patient perceptions of communication with provider 4. Health literacy advocacy organizations and public and private sector organizations reporting adherence to guidelines 5. Accreditation Association for Ambulatory Health Care and The Joint Commission 6. Office of Disease Prevention and Health Promotion's National Action Plan to Improve Health Literacy

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[a] The objectives, measures, and potential data sources do not directly correlate to each other, but to the strategy to which they are connected.

GOAL 3: HEALTH SYSTEM AND LIFE EXPERIENCE

Improve health and healthcare outcomes for racial, ethnic, and underserved populations

STRATEGY 12: EDUCATION

Substantially increase, with the goal of 100%, high school graduation rates by working with schools, early childhood programs, community organizations, public health agencies, health plan providers, and businesses to promote the connection between educational attainment and long-term health benefits

OBJECTIVES[a]	MEASURES[a]	POTENTIAL DATA SOURCES[a]
1. Develop and implement local strategies to reduce health, psychosocial, and environmental conditions that affect school attendance and chronic absenteeism	1. Policies and programs enacted to reduce barriers to school attendance and high school graduation, improve the quality of school environment, and support parent engagement	1. Analysis of local, state, and national polices for information and emphasis on high school graduation
2. Develop effective strategies for supporting parents and other caregivers in addressing the psychosocial and environmental factors that impact their children's lives	2. Number of school programs that incorporate concepts of health disparities, health equity, and determinants of health into their curriculum	2. Centers for Disease Control and Prevention's School Health Programs and Policies Survey, School Health profiles, and Youth Risk Behavior Surveillance System
3. Improve school environment, culture, and other conditions (e.g., healthier food options, physical activity opportunities, anti-bullying programs, adequate staffing and staff training, playground modifications, safe transportation) to support students' readiness and ability to learn	3. Number of scholarships among diverse categories of students (e.g., racial and ethnic minority, disabled and low income)	3. Philanthropic organizations such as the Annie E. Casey Foundation Kids Count Data—state-level data on education
4. Encourage the introduction of concepts about health disparities, health equity, and determinants of health as part of the K-12 curriculum in schools	4. Number of students of different racial, ethnic, gender, LGBT, and disability groups from high school, community colleges, colleges, and universities who pursue a health-related degree	4. National Center for Higher Education Management Systems—public high school graduation rates by year and by site
5. Improve health career pipeline by providing health care-related courses and transition assistance to students from racial, ethnic, and other underserved communities	5. Increased graduation rates, especially among students from racial, ethnic, and underserved groups	5. U.S. and State Departments of Education, Bureau of Indian Affairs, and Bureau of Indian Education— graduation rates
6. Increase investment in strategies to decrease academic achievement gaps (particularly in math and science) among students from racial and ethnic minority groups and low-income families, and increase their opportunity for higher education or career-oriented alternative program	6. Decrease in academic achievement gaps, especially in math and science	6. National Center for Education Statistics
		7. College and university financial aid awards by race, ethnicity, and income of recipients
		8. National Association of Student Financial Aid Administrators

[a] The objectives, measures, and potential data sources do not directly correlate to each other, but to the strategy to which they are connected.

GOAL 3: HEALTH SYSTEM AND LIFE EXPERIENCE

Improve health and healthcare outcomes for racial, ethnic, and underserved populations

STRATEGY 13: SOCIAL AND ECONOMIC CONDITIONS

Support and implement policies that create the social, environmental, and economic conditions required to realize healthy outcomes

OBJECTIVES[a]	MEASURES[a]	POTENTIAL DATA SOURCES[a]
1. Improve the availability, accessibility, affordability (e.g., fresh food financing initiatives, neighborhood store incentives, Electronic Benefits Transfer (EBT) cards at farmers markets), and consumption of healthy, safe, and nutritious food for all families 2. Improve safety of and accessibility to public transportation, walking, and bicycling (e.g., interconnected street strategies, public transit-oriented development), especially in urban communities 3. Improve safety and accessibility of transportation to resources and services in rural and geographically isolated communities 4. Improve housing quality, affordability, stability, and proximity to resources (e.g., housing code enforcement, location of resources, transit system, and mixed-income development) 5. Improve neighborhood conditions (e.g., policies that support crime prevention through environmental design, community problem-oriented policing, etc.) to support healthier living environment 6. Monitor and improve air, water, and soil quality (e.g., enforcement of national water standards, effective lead abatement programs, properly ventilated office and school buildings, etc.) in places where people learn, work, live, play, and age 7. Ensure employment opportunities for people from different racial, ethnic, and underserved populations and enhance their labor market participation through targeted employment initiatives, job training, networking opportunities, and monitoring of employers' compliance with fair pay regulations 8. Support programs and initiatives (e.g., through financial literacy programs, maximum use of earned income tax and child tax credits) to empower families from different racial, ethnic, and underserved populations to save, enhance, and sustain their abilities to live a healthy life and accumulate wealth 9. Expand and strengthen safety net opportunities to ensure services are developed to support individuals and families 10. Strengthen disaster and emergency preparedness plans by accounting for the needs of populations that are vulnerable and underserved (e.g., older adults, people with disabilities, linguistically isolated families, low-income families) 11. Seek stronger partnership between community organizations, businesses, and community colleges to create pathways for youth and adult learners from different racial, ethnic, and underserved groups to acquire the skills that will lead to greater economic opportunities 12. Encourage joint learning and collaboration across sectors to adopt plans to assess (e.g., through racial-impact analysis)	1. Use of health impact assessments and application of assessment findings by public agencies, corporations, and foundations 2. Number and location of supermarkets, convenience stores, and fast food restaurants 3. Expenditures on public and private recreational facilities 4. Fatality rates for pedestrians and cyclists 5. Percent of households reporting unsatisfactory or no public transportation in residential areas 6. Design Value (i.e., air quality status of a given area relative to the level of EPA's National Ambient Air Quality Standards), Air Quality Statistics, Air Quality Index 7. Number of violations, by year and state, for federally regulated drinking water contaminants 8. Labor force participation rates 9. Expenditures on safety net programs 10. Income-to-spending ratios	1. Local, state, and tribal governments and corporations 2. Institute for Disease Control and Prevention's Behavioral Risk Factor Surveillance System 3. U.S. Census Bureau—data on retail trade companies 4. Progress Grocer's—Annual Reports of the Grocery Industry 5. U.S. Census Bureau's Census of Governments 6. Pedestrian and Bicycle Information Center—www.pedbikeinfo.org 7. American Housing Survey and National Household Travel Survey 8. U.S. Environmental Protection Agency's air trends and safe water reports 9. U.S. Bureau of Labor Statistics

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[a] The objectives, measures, and potential data sources do not directly correlate to each other, but to the strategy to which they are connected.

Goal 4. Cultural and Linguistic Competency: Improving Cultural and Linguistic Competency and Diversity of Health-Related Workforce

Cultural and linguistic competency reflects and builds on the premise that understandable communication is a necessity of any successful endeavor. The recipient must understand words and text; otherwise the exercise of providing them is meaningless. Thus, the essential first step in communication is simply to be clear. Understandable messages require, at the most basic level, communication in a language that the recipient understands. Knowledge and accommodation of cultural factors as well as an atmosphere of mutual respect and cooperation are necessary for effective communication.

Cultural humility is an important component of cultural competency. It is the notion that providers can exercise self-awareness in order to foster respectful partnerships with patients. It "incorporates a lifelong commitment to self-evaluation and critique, to redressing the power imbalances in the physician-patient dynamic, and to developing mutually beneficial and non-paternalistic partnerships with communities on behalf of individuals and defined populations."[298]

Awareness of the cultural values, beliefs, and practices of different racial and ethnic groups can help healthcare providers understand and address their unique risk factors. For example, South Asians consume Ayurvedic medicines that may expose them to toxic metals. If such individuals present in a clinical setting with toxicity symptoms, it would be helpful if the consumer volunteered or if the practitioner, through a personalized medical history, understood the toxicity potential and was prepared to obtain critical information to provide the necessary care.

> "Learning from other minority groups was the best. It is important to know how our brothers and sisters from other ethnic groups feel."
>
> –NPA Regional Meeting participant

As language diversity in the United States grows, there is a critical need to ensure that language access services are available in healthcare settings for the expanding number of Limited English Proficient (LEP) patients. The IOM *Unequal Treatment Report* noted that "language barriers can cause poor, abbreviated, or erroneous communication, poor decision making on the part of both providers and patients, or ethical compromises."

The National Standards on Culturally and Linguistically Appropriate Services (CLAS) include four standards related to the provision of language access services based on Title VI of the Civil Rights Act of 1964. The standards emphasize the need for healthcare organizations to provide and assure competent language assistance services (including bilingual staff and interpreting services), inform patients of their rights to those services, and make available linguistically appropriate patient-related materials and signage.

Healthcare interpreters—bilingual professionals who facilitate communication between healthcare providers and patients—play an important part in the healthcare experience for LEP patients. It is important that in order to ensure complete, accurate and confidential communication, patients should not use family and friends as interpreters.

Continuing efforts are underway to provide cultural competency training to current and future healthcare providers and other professionals in the health and related industries. However, it is important to differentiate between receiving training in cultural sensitivity and competency and the actual translation of that training into the acquisition of skills that allow effective interaction and communication with patients. The training is not effective if the skill acquisition does not occur. Providers must possess or learn the cognitive abilities and interpersonal skills that will yield proficiency in customer service. Cultural and linguistic competencies improve collaborative goal setting, planning, and participation of patients in their own care.

Healthcare workers who share the same cultural and linguistic background as those they serve, or who have adequate training in cultural and linguistic competency, can be particularly effective in providing services. Recruitment and retention of racial and ethnic minorities into the workforce continues to be a valuable strategy for promoting cultural and linguistic competency. In addition, increased recruitment of community health workers can aid patient provider communication and mutual understanding. For example, since the 1960s, community health workers, neighborhood workers, indigenous health workers, health aids, “consejeras,” and “promotoras” have fulfilled multiple functions in helping to improve health outcomes for racial and ethnic minority populations.[299] Once trained and deployed strategically, these community members assist LEP and other underserved consumers to successfully negotiate unfamiliar healthcare settings (e.g., interpreting services, explanation of insurance coverage, or availability of social services).

The three strategies below address the goal of cultural and linguistic competency through strategies based on workforce, diversity, and ethics and standards. For each strategy there is a menu of objectives, measures, and potential data sources, which are tools for stakeholders to use in implementing any given strategy.

GOAL 4: CULTURAL AND LINGUISTIC COMPETENCY

Improve cultural and linguistic competency and the diversity of the health-related workforce

STRATEGY 14: WORKFORCE

Develop and support the health workforce and related industry workforces to promote the availability of cultural and linguistic competency training that is sensitive to the cultural and language variations of diverse communities

OBJECTIVES[a]	MEASURES[a]	POTENTIAL DATA SOURCES[a]
1. Monitor health workforce composition; identify competencies needed; improve and develop appropriate education, training, and life-long learning curricula; and enhance recruitment strategies to increase the supply of qualified health professionals	1. Number and distribution of health workers, by health profession	1. National Center for Health Workforce and state departments of health or centers for health workforce data
2. Collaborate with the business sector and work with employers to encourage continuing education in cultural and linguistic competency (that also includes requirements for compliance with Title VI of the Civil Rights Act) for physicians, other health professionals, and administrative staff who participate in their purchased health insurance plans	2. Existence and use of modules that provide standardized training and continuing education on cultural and linguistic competency, including the number of credits that can be earned and percent of staff trained	2. Office of Minority Health's Cultural Competency Curriculum Modules training logs
3. Highlight and disseminate best practices by public health agencies and health organizations to ensure cultural and linguistic competency training and continuing education for healthcare providers and healthcare administrative staff	3. Availability and utilization of cultural humility and competency courses and modules in undergraduate and graduate health professional training degree and certificate programs	3. Assessment of relevant professional competencies in undergraduate and graduate professional training programs through professional organizations and accrediting bodies
4. Develop and integrate model cultural and linguistic competency training courses and modules, particularly on cultural humility, into workforce development programs and undergraduate and graduate professional programs in medicine, dentistry, nursing, allied health, mental health, public health, and environmental health	4. Improved systematic collection and documentation of consumers' primary languages and dialects and use of findings to inform planning and provision of services	4. Survey of health-related accrediting bodies (e.g., The Joint Commission, Accreditation of Ambulatory Health Care, and URAC (formerly the Utilization Review Accreditation Commission)
5. Assist public health clinics, health care organizations, community clinics, and other providers to implement effective language access policies, practices, and procedures that comply with Title VI	5. Allocated resources and incentives, proportionate to other key aspects of professional development, for training and continuing education in cultural and linguistic competency for physicians and other health professionals and administrative staff	5. Federation of State Medical Boards, Liaison Committee on Medical Education, and Accreditation Council for Graduate Medical Education data
6. Use telecommunications, videoconferencing, and other technology to deliver services to people who live in geographically isolated places, have no access to transportation, and/or	6. Inclusion of cultural and linguistic competency training and continuing education as part of information in new staff orientation and criteria for job performance and licensure by accrediting bodies	6. Bureau of Labor Statistics' Employment and Training Administration

[a] The objectives, measures, and potential data sources do not directly correlate to each other, but to the strategy to which they are connected.

GOAL 4: CULTURAL AND LINGUISTIC COMPETENCY

Improve cultural and linguistic competency and the diversity of the health-related workforce

STRATEGY 15: DIVERSITY

Increase diversity and competency of the health workforce and related industry workforces through recruitment, retention, and training of racially, ethnically, and culturally diverse individuals and through leadership action by healthcare organizations and systems

OBJECTIVES[a]	MEASURES[a]	POTENTIAL DATA SOURCES[a]
1. Develop a policy agenda to expand the diversity and cultural and linguistic competency of the health care workforce	1. Number and type of policies developed and implemented by healthcare organizations, accrediting bodies, education programs, and state health agencies to support the diversification of the health care workforce	1. Survey of major health care organizations, accrediting bodies, health and allied health education programs, and state health agencies
2. Work with medical schools, boards of trustees of universities, healthcare systems, professional health associations, and health-related businesses to consider and implement a policy of inclusion in all aspects of their organizational structure and processes	2. Percent of health-related certificates/credentials and professional degrees awarded to members of racial, ethnic, and cultural groups	2. National Center for Health Workforce Analysis Reports
3. Build relationships and collaborate with higher learning institutions, including Historically Black Colleges and Universities, Hispanic-serving Institutions, and Tribal Colleges and Universities to increase recruitment of minorities into public and environmental health-related programs	3. Distribution and percent of schools of medicine and nursing and allied health professional training programs whose basic curricula include core competencies in culturally and linguistically appropriate health promotion and education and disease prevention	3. Survey of major professional health-related education associations (e.g., American Dental Education Association, American Association of Colleges of Nursing, Association for American Medical Colleges, American Academy of Physician Assistants)
4. Educate school counselors and teachers in high schools and colleges about career pathways in the health professions and work with them to support the early recruitment of youth from different racial, ethnic, and cultural backgrounds into these professions	4. Number of internship and fellowship programs in the health field for students from different racial, ethnic, and cultural backgrounds	4. U.S. Census Bureau—Special Equal Opportunity Employment tabulation
5. Increase the number of bridge programs between institutions of higher education and employers in the health sector to provide greater opportunities for students from different racial, ethnic, and cultural backgrounds and low-income families to enter the health care workforce	5. Percent of individuals from different racial, ethnic, and cultural backgrounds, by health profession and position	5. Departments of Labor, Veterans Affairs, and Defense reports

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[a] The objectives, measures, and potential data sources do not directly correlate to each other, but to the strategy to which they are connected.

GOAL 4: CULTURAL AND LINGUISTIC COMPETENCY

Improve cultural and linguistic competency and the diversity of the health-related workforce

STRATEGY 16: ETHICS AND STANDARDS, AND FINANCING FOR INTERPRETING AND TRANSLATION SERVICES

Encourage interpreters, translators, and bilingual staff providing services in languages other than English to follow codes of ethics and standards of practice for interpreting and translation. Encourage financing and reimbursement for health interpreting services.

OBJECTIVES[a]	MEASURES[a]	POTENTIAL DATA SOURCES[a]
1. Promote codes of ethics and standards of practice for interpreting and translation 2. Assist states, healthcare financing entities, and managed care organizations to develop plans to comply with the codes of ethics and standards of practice for interpreting and translation 3. Collaborate with accrediting bodies for healthcare organizations to integrate codes of ethics and standards of practice for interpreting and translation into accreditation requirements 4. Increase the number of interpreters who meet professional standards and certification for health interpretation 5. Encourage financing and reimbursement for medical interpretation services	1. Number of accrediting bodies that include the codes of ethics and standards for interpreting and translation in their requirements 2. Degree to which federal- and state- funded health services, health financing entities, managed care organizations, and healthcare organizations use the codes of ethics and standards of practice for interpreting 3. Percent of interpreters certified by training entities that comply with the codes of ethics and standards for training and practice 4. Percent of agencies and healthcare organizations and services that adopt proper interpreting and translation as a quality improvement indicator 5. Establishment of incentives for hospitals, physicians, and other healthcare settings and health professionals to support interpreting services and compensate for additional time required for interpreting support 6. Inclusion of interpreting assistance in states' and businesses' procurement language for contracts with managed care organizations and healthcare providers 7. Allocated resources, proportionate to other key aspects of service provision used for translation and interpreting services	1. Survey of state and local health departments 2. Survey of accrediting bodies (e.g., The Joint Commission, Accreditation of Ambulatory Health Care, and URAC) 3. The National Board of Certification for Medical Interpreters and state medical interpreter networks or associations 4. American Health Quality Association and State Quality Improvement Organizations 5. Centers for Medicare and Medicaid Services (CMS) 6. State procurement or purchasing offices 7. Survey of the National Association of State Procurement Officials' membership

[a] The objectives, measures, and potential data sources do not directly correlate to each other, but to the strategy to which they are connected.

Goal 5. Data, Research, and Evaluation: Improving Data Availability, and Utilization and Diffusion of Research and Evaluation Outcomes

In 1906, noted historian and philosopher W.E.B. Du Bois published a monograph entitled *The Health and Physique of the Negro American*,[300] which sought to dispel published claims that the known higher levels of mortality and morbidity for African Americans were due to inherent racial traits. Du Bois' monograph is an early example of our nation's long history of using research to document health disparities, define their causes, and confront those conditions.

The need to coordinate and improve research and evaluation of the causes of health disparities is essential to improving the health of Americans and ending health disparities. All minority groups experience health disparities. While research to document these disparities has continued and improved, the research to identify their social and environmental determinants still lags behind—as have the development, dissemination, and translation of scientifically proven models for changing these conditions.

Even among local, state, tribal, and the federal governments and private sector organizations, there may be challenges in data collection, including small numbers of racial and ethnic minorities and underserved populations participating in studies and lack of standardized measurements. Larger data sets allow for more confidence in findings, as well as the ability to break findings down into smaller subsets (e.g., by racial and ethnic subpopulations or by individual behaviors or characteristics). Attention must be given to the integrity of the data collection process and to the scientific approach of collecting that data as a means for documenting the health status and needs of affected communities. Developing collaborative relationships with and among institutions that collect data on minorities and underserved populations is key to ensuring that they provide data in readily accessible forms and that they include all health disparity populations.

> "This experience reminded us all that there is most definitely a need for information sharing between organizations in order to end healthcare disparities."
>
> –NPA Regional Meeting participant

Similarly, there is a need to invest in community-based participatory research and community-originated intervention strategies as a means for developing capacity at the local level. Thousands of programs have been initiated, yet most are not evaluated effectively to determine whether they worked, for whom, and in what way. We cannot build on and improve local and other efforts if we do not understand what works. All programs must have the capacity to conduct basic evaluation that can add to our understanding of how to eliminate disparities. Conducting evaluations in small communities and subpopulations has frequently been a challenge. Smaller communities often do not have the means to collect baseline data and then perform follow-up data collection to measure the results of their interventions and activities.

Research coordination is a critical strategy. There is a particular need for cooperative and coordinated interdisciplinary research that can understand the complex interplay of issues related to health disparities (e.g., the underlying causes of disparities, including racism). Researchers from different disciplines and communities are often unaccustomed to working collaboratively. Furthermore, the inability to agree on the definitions of the problem, its causes, or the appropriate research methodology can inhibit progress. Without coordination and cooperation at all levels (from local communities to academia), identification and implementation of successful solutions are compromised.

Knowledge transfer is challenging but obligatory. Often, findings that may be valuable to communities are published in journals, reports, and other formats that are not widely distributed to them or easily accessible to non-research audiences. Non-traditional media should be used to disseminate data and information to improve accessibility. Improving the health outcomes of minority and underserved communities will take the combined efforts of medical scientists, statisticians, anthropologists, economists, sociologists, epidemiologists, policy analysts, psychologists, social workers, community developers, and others working in collaboration with community organizations.

The four strategies below address the goal of data, research and evaluation through strategies based on data; community-based research and action, and community-originated intervention strategies; coordination of research; and knowledge transfer. For each strategy there is a menu of objectives, measures, and potential data sources, which are tools for stakeholders to use in implementing any given strategy.

GOAL 5: DATA, RESEARCH, AND EVALUATION

Improve data availability, and coordination, utilization, and diffusion of research and evaluation outcomes

STRATEGY 17: DATA

Ensure the availability of health data on all racial, ethnic, and underserved populations

OBJECTIVES[a]	MEASURES[a]	POTENTIAL DATA SOURCES[a]
1. Promote inclusion of data on race, ethnicity, gender, primary language, disability status, and sexual orientation or gender identity on federally and privately conducted or supported healthcare or public health program, activity, or survey 2. Develop and evaluate a framework and standards (e.g., security safeguards) for information management and sharing among systems and policy organizations on the collection, reporting, and use of race-, ethnicity-, health disparities-, and health equity-related data 3. Establish, support, and disseminate information about publicly available surveillance systems to track the causal, contributory, or protective impact of cultural, linguistic, environmental, and socioeconomic factors on health 4. Improve current data collection systems and efforts to increase the accuracy and consistency for how data about race, ethnicity, effects of racism, and categorization of people are gathered, analyzed, reported, and used 5. Increase and improve the inclusion of community stakeholders, particularly from racial and ethnic minority populations, in all aspects of the research and evaluation process 6. Incentivize reporting of quality of care data that can be stratified according to race, ethnicity, primary language, gender, and socioeconomic status	1. Number, accessibility, and use of health information and surveillance systems that adequately represent the conditions experienced by and facing diverse local communities 2. Number of state and federal health disparity-related reports that include cultural, linguistic, environmental, and socioeconomic factors 3. Development and legitimization of improved research designs for assessing health disparities and equity, including the inclusion of community stakeholders, particularly from racial, ethnic, and underserved populations, in all aspects of the research process 4. Distribution and type of organizations in the private, public, and nonprofit sectors, including insurers, that adhere to a common set of standards for data collection and data use, such as the collection of race, ethnicity, and language data 5. Number and distribution of community-level users of publicly available data sources (e.g., track number of unique hits for state data and possibly the number of reports generated from use of the data)	1. Centers for Disease Control and Prevention's Youth Risk Behavior Surveillance System 2. Health-related journals (e.g., American Journal of Public Health, Health Services Research)—content analyses of articles, studies, and information published 3. Center for Health Care Strategies 4. National Center for Health Statistics 5. Health Research and Education Trust and Kaiser Permanente Partnership Group's publications and policies about collection of race and ethnicity data 6. State Departments of Public Health and other state agencies 7. www.gaydata.org

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[a] The objectives, measures, and potential data sources do not directly correlate to each other, but to the strategy to which they are connected.

GOAL 5: DATA, RESEARCH, AND EVALUATION

Improve data availability, and coordination, utilization, and diffusion of research and evaluation outcomes

STRATEGY 18: COMMUNITY-BASED RESEARCH AND ACTION, AND COMMUNITY-ORIGINATED INTERVENTION STRATEGIES

IInvest in community-based participatory research and evaluation of community-originated intervention strategies in order to build capacity at the local level for ending health disparities

OBJECTIVES[a]	MEASURES[a]	POTENTIAL DATA SOURCES[a]
1. Identify and work with community-based organizations and programs to determine and disseminate replicable best and evidence-based practices for ending health disparities 2. Work with researchers and evaluators to develop useful and practical models for evaluating community- originated intervention strategies, including new metrics from interventions that reflect communities' immediate needs 3. Engage community members and enhance their capacity to be equal partners in the conceptualization, planning, design, implementation, interpretation, evaluation, and dissemination of public health interventions, programs, and initiatives 4. Strengthen community ownership of data and research and evaluation products by promoting the principles of community-based participatory research 5. Integrate Title VI-compliant protocols into requests for research proposals and funded projects to ensure non-discriminatory practices	1. Number and type of community- originated interventions and programs identified and evaluated and application of community-generated evaluation metrics 2. Number and funding amount of research and evaluation grants and contracts for community-based, health disparities interventions and programs 3. Number of new community-originated models published in the academic literature 4. Increased funding of community-based participatory research that addresses health disparities and health equity (ensure community members are engaged in the planning, design, evaluation, and dissemination of public health education, programs, disease prevention, and emergency preparedness) 5. Number of sustained academic/research-community partnerships that adhere to community-based participatory research standards 6. Number of agencies and health funders that support community learning processes to help community members interpret, use, and discuss research and evaluation findings in equity plans for their community	1. Survey of community-originated interventions and programs 2. Local, state, tribal, and federal health agencies and health foundations (e.g., National Institutes of Health, Centers for Disease Control and Prevention, Center for the Advancement of Health Disparities Research, Robert Wood Johnson Foundation, The California Endowment, W.K. Kellogg Foundation, Health Resources and Services Administration)—review of budgets to determine proportion of funds allocated for evaluation 3. Major health journals (e.g., American Journal of Public Health, American Journal of Community Psychology, Journal of Health Care for the Poor and Underserved) 4. Community-College/University Partnerships for Health 5. Survey of local, state, tribal, and federal health agencies and health foundations to determine their support of community-based participatory research practices and community learning processes and training

[a] The objectives, measures, and potential data sources do not directly correlate to each other, but to the strategy to which they are connected.

GOAL 5: DATA, RESEARCH, AND EVALUATION

Improve data availability, and coordination, utilization, and diffusion of research and evaluation outcomes

STRATEGY 19: COORDINATION OF RESEARCH

Support and improve coordination of research that enhances understanding about, and proposes methodology for, ending health and healthcare disparities

OBJECTIVES[a]	MEASURES[a]	POTENTIAL DATA SOURCES[a]
1. Improve integrated and cross-disciplinary research to understand the reasons for systemic and continuous disparities in targeted health conditions 2. Evaluate best practices through research or practice-based evidence in order to identify practices or policies that have improved health outcomes and reduced health disparities 3. Encourage community-based participatory research that is inclusive of stakeholders from communities that have been historically excluded 4. Develop teaching modules that educate researchers and communities on how to develop and implement successful collaborative, health promotion and prevention research projects that address health disparities and comply with Title VI requirements	1. Increased funding of research projects, especially integrated and cross-disciplinary research projects, on health disparities and systemic barriers to health equity 2. Number and type of evidence-based best practices evaluated, disseminated, and applied 3. Increase in joint funding and co-sponsorship of health disparities research by private sector and state, tribal, and federal governments on health disparities research 4. Application of cross-training modules that educate researchers and communities about critical factors that need to be addressed in health disparities research	1. National Institutes of Health, Centers for Disease Control and Prevention, State Departments of Health, major health foundations (e.g., Robert Wood Johnson Foundation, The Commonwealth Fund), and professional associations (e.g., American Diabetes Association, American Heart Association) 2. Office of Minority Health Resource Center, Centers for Disease Control and Prevention (e.g., compendium of promising or evidence-based practices), and annual conferences of professional associations (e.g., American Evaluation Association, American Public Health Association) 3. Survey of published research in health and related fields to determine private-public sponsorship and authorship

[a] The objectives, measures, and potential data sources do not directly correlate to each other, but to the strategy to which they are connected.

GOAL 5: DATA, RESEARCH, AND EVALUATION

Improve data availability, and coordination, utilization, and diffusion of research and evaluation outcomes

STRATEGY 20: KNOWLEDGE TRANSFER

Expand and enhance transfer of knowledge generated by research and evaluation for decision-making about policies, programs, and grant-making related to health disparities and health equity

OBJECTIVES[a]	MEASURES[a]	POTENTIAL DATA SOURCES[a]
1. Facilitate the efficient translation and dissemination of culturally and linguistically appropriate interventions, as required by Title VI, that have been shown to improve health 2. Provide training and technical assistance to community stakeholders on the use, interpretation, and transmission of data 3. Provide training and technical assistance to providers, researchers, and evaluators to comply with Title VI requirements and to appropriately engage communities 4. Provide training and technical assistance to professional associations, foundations, advocacy groups, and community organizations on how to interpret and use research and evaluation findings to inform their decisions and programs 5. Promote, as a standard of practice among researchers and evaluators and their sponsors, strategies to make findings accessible, easily understood, and used by policymakers and the public to inform programming and services	1. Distribution and application of standard training and technical assistance materials on data-driven decision-making 2. Degree to which promising community practices are adopted by state, tribal, and local agencies and nonprofit organizations 3. Application of knowledge about use of data, research and evaluation findings, and community engagement in the design or improvement of programs to eliminate health disparities 4. Degree to which research and evaluation findings are used in decision-making about policies, procedures, and practices to eliminate health disparities by policy¬makers, funders, advocates, and community leaders	1. Office of Minority Health Resource Center's Capacity Building Division 2. Agency for Healthcare Research and Quality's Knowledge Transfer/Implementation Program 3. Grant submissions in response to requests for proposals distributed by federal and state agencies to eliminate health disparities

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[a] The objectives, measures, and potential data sources do not directly correlate to each other, but to the strategy to which they are connected.

SUMMARY

This section provides a series of twenty charts to highlight the twenty stakeholder-developed strategies that were developed via the collaborative, grass-roots process that is described in detail in Section 1. These strategies are linked to the five NPA goals and offer a menu of options for individuals, organizations, and partnerships that seek to eliminate health disparities. The following final section outlines an approach for implementing and evaluating these community- and stakeholder-generated strategies.

The *National Stakeholder Strategy*

A PRACTICAL CONTEXT FOR CHANGE

The fundamental purpose of *the National Stakeholder Strategy* is to promote systematic and systemic change that improves the overall health of the nation. Achieving this purpose will take time, include many people, and require that steps be taken incrementally while maintaining focus on the ultimate goal of achieving health equity. In this regard, the information in this section addresses the practical matter of what may be required to influence change and improve outcomes for affected communities. It sets out a strategy for change based on the five key goals and 20 strategies that were developed through the extended grass-roots process that is described in Section 1 (see also Exhibit 1.1). The goals and their corresponding strategies provide a starting point and menu of resources for stakeholders to design actions that are achievable through their scopes of influence and areas of expertise.

It is important to reiterate the message from Section 1 that the *National Stakeholder Strategy* responds to the voices of thousands of leaders from across the United States who called for actions to effectively and efficiently address health and healthcare disparities in this country. These leaders represented community-based organizations; faith-based organizations; the business sector; healthcare workforce; health and insurance industries; academia; local, state, tribal, and federal governments; and others. The *National Stakeholder Strategy* is also based on Congressional language, which called for a national strategy that is implemented and monitored in partnership with state and local governments, communities, and the private sector.

Partnerships within and beyond the health sector can address crosscutting, multilevel issues to achieve health equity. Formation of wide-ranging partnerships is the next best step forward towards tackling this ultimate goal. It will be the job of change-oriented organizations and individuals to take the goals and strategies in this document and adapt them to their own missions, interests, and needs—in order to develop the actions that they can implement to effect change.

The resources in this section are not necessarily the final or only methods for ending health disparities and achieving health equity. That is, each strategy is not necessarily applicable to all stakeholders. Rather, this *National Stakeholder Strategy* provides a common reference point, language, and initial set of actions for any group that wishes to seriously engage in ending health disparities. This is especially important for the development of strong, strategic, collaborative partnerships among disparate organizations.

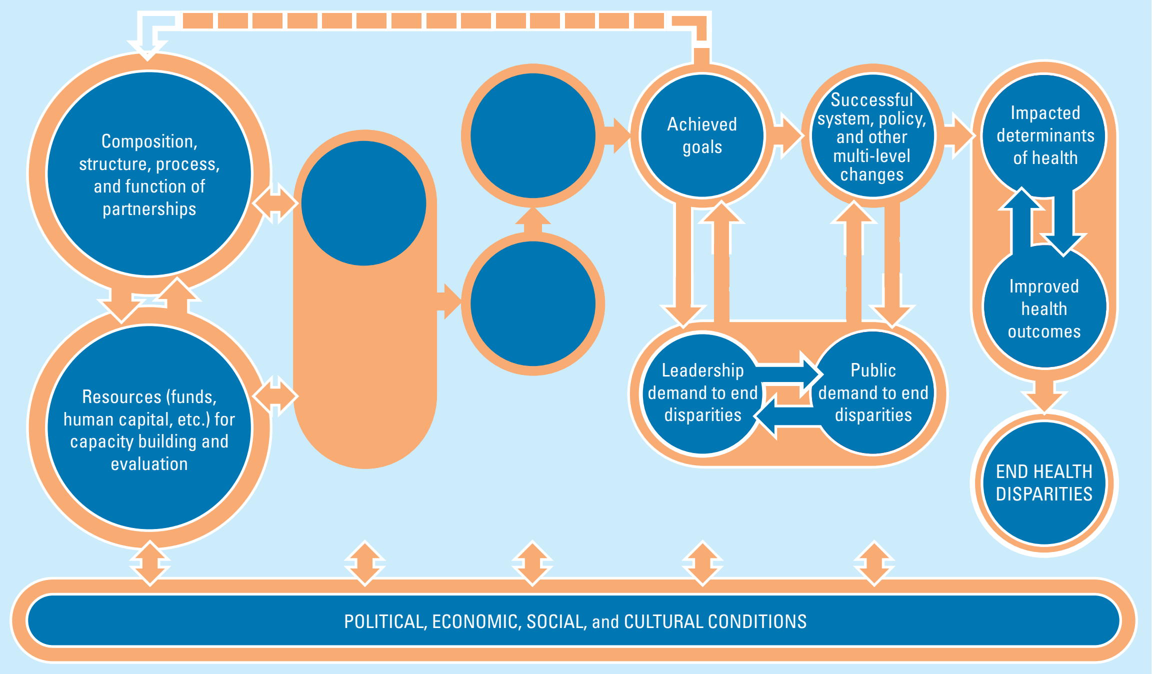
The hope is that stakeholders will be encouraged to use the goals and strategies to ensure focused progress toward achieving health equity. The overarching benchmark that all should aim to realize is the reduction in the incidence and prevalence of health conditions and diseases for which disparities exist, and to seek the gradual elimination of the determinants that are the root causes of poor health.

With this practical background in mind, the following subsection briefly describes a theoretically based context for change. The theory of change model was developed to reflect the process that would begin at this juncture of the *National Stakeholder Strategy's* history. This model is a general road map to ensure that individuals, organizations, and partners stay focused while engaging in incremental steps that lead to the end of health disparities.

A THEORETICAL CONTEXT FOR CHANGE

As shown on the following diagram, the context for change model begins on the far left with input from partnerships (e.g., local, state, tribal, regional, and national) that play the primary role in setting the initial context for change and the impetus for its continuation. The far right of the diagram displays the final output—the overriding goal—of the end of health disparities through changing adverse determinants of health and improving health outcomes. The input, output, and intervening steps all have arrows to indicate the interrelationships of all the steps and the iterative nature of the whole process.

Exhibit 3 1: Context for Change



The composition, structure, process, and function of partnerships will affect their capacity and effectiveness. The partnerships and the entire process depend on resources to build their capacity to function effectively and efficiently and to initiate and evaluate their efforts. Resources include not only funding, but also the necessary resources of knowledge, skills, and other forms of support and human capital that lie within or outside the partnerships. The capacity of partners increases and becomes more effective as they leverage resources and the relationships required to prioritize their objectives and to develop and implement actions that support their strategies. An interactive and iterative effect between the partnerships' initial and increased capacities points to a continuous process of improvement.

Implementation of the strategies could lead to the partial or total achievement of one or more of the five goals and impact two key levers of change: leadership and public demand to end disparities. The combined impact would be successful system, policy, and other multilevel changes. Over time, the continuous interaction among goal attainment, successful changes, leadership, and public demand to end disparities would affect the conditions in which people are born, grow, learn, live, work, play, and age (i.e., determinants of health)—leading finally to an improvement in the health outcomes of people who experience disparities.

The model emphasizes an iterative cycle of adjustments to the partnerships' structure, process, composition, and functions in order to continuously increase their capacity, resources, and relationships for achieving their goals. Partnerships will operate within particular political, economic, social, and cultural contexts. These contexts can dramatically affect the change process. The ability to work across cultures—those based on racial, ethnic, and cultural identities and those based on geographic and organizational settings—affects every goal, strategy, objective, and action.

> "If we as a country want to learn how to create an effective healthcare system for all, it's really important to hear the voices of all."
>
> –NPA Regional Meeting participant

The remainder of this section lays out background information for each of the five NPA goals and links them to the 20 strategies that were developed through the grass-roots process that produced this *National Stakeholder Strategy for Achieving Health Equity*.

Exhibit 3 2: SUMMARY OF NPA GOALS AND STRATEGIES

Goal #	Goal Description	Strategies
1	**AWARENESS**— Increase awareness of the significance of health disparities, their impact on the nation, and the actions necessary to improve health outcomes for racial, ethnic, and underserved populations	1. **Healthcare Agenda** Ensure that ending health disparities is a priority on local, state, tribal, regional, and federal healthcare agendas
		2. **Partnerships** Develop and support partnerships among public, nonprofit, and private entities to provide a comprehensive infrastructure to increase awareness, drive action, and ensure accountability in efforts to end health disparities and achieve health equity across the lifespan
		3. **Media** Leverage local, regional, and national media outlets using traditional and new media approaches as well as information technology to reach a multi-tier audience—including racial and ethnic minority communities, youth, young adults, older persons, persons with disabilities, LGBT groups, and geographically-isolated individuals—to encourage action and accountability
		4. **Communication** Create messages and use communication mechanisms tailored for specific audiences across their lifespan, and present varied views of the consequences of health disparities that will encourage individuals and organizations to act and to reinvest in public health.
2	**LEADERSHIP**— Strengthen and broaden leadership for addressing health disparities at all levels	5. **Capacity Building** Build capacity at all levels of decision-making to promote community solutions for ending health disparities
		6. **Funding Priorities** Improve coordination, collaboration, and opportunities for soliciting community input on funding priorities and involvement in research and services
		7. **Youth** Invest in young people to prepare them to be future leaders and practitioners by actively engaging and including them in the planning and execution of health, wellness, and safety initiatives
3	**HEALTH SYSTEM AND LIFE EXPERIENCE**— Improve health and healthcare outcomes for racial, ethnic, and underserved populations	8. **Access to Care** Ensure access to quality health care for all
		9. **Children** Ensure the provision of needed services (e.g., mental, oral, vision, hearing, and physical health; nutrition; and those related to the social and physical environments) for at-risk children, including children in out-of-home care
		10. **Older Adults** Enable the provision of needed services and programs to foster healthy aging
		11. **Health Communication** Enhance and improve health service experience through improved health literacy, communications, and interactions
		12. **Education** Substantially increase, with a goal of 100%, high school graduation rates by working with schools, early childhood programs, community organizations, public health agencies, health plan providers, and businesses to promote the connection between educational attainment and long-term health benefits
		13. **Social and Economic Conditions** Support and implement policies that create the social, environmental, and economic conditions required to realize healthy outcomes
4	**CULTURAL AND LINGUISTIC COMPETENCY**— Improve cultural and linguistic competency and the diversity of the health-related workforce	14. **Workforce** Develop and support the health workforce and related industry workforces to promote the availability of cultural and linguistic competency training that is sensitive to the cultural and language variations of diverse communities
		15. **Diversity** Increase diversity and competency of the health workforce and related industry workforces through recruitment, retention, and training of racially, ethnically, and culturally diverse individuals and through leadership action by healthcare organizations and systems
		16. **Ethics and Standards, and Financing for Interpreting and Translation Services** Encourage interpreters, translators, and bilingual staff providing services in languages other than English to follow codes of ethics and standards of practice for interpreting and translation. Encourage financing and reimbursement for health interpreting services
5	**DATA, RESEARCH, AND EVALUATION**— Improve data availability, coordination, utilization, and diffusion of research and evaluation outcomes	17. **Data** Ensure the availability of health data on all racial, ethnic, and underserved populations
		18. **Community-Based Research and Action, and Community-Originated Intervention Strategies** Invest in community-based participatory research and evaluation of community-originated intervention strategies in order to build capacity at the local level for ending health disparities
		19. **Coordination of Research** Support and improve coordination of research that enhances understanding about, and proposes methodology for, ending health and healthcare disparities
		20. **Knowledge Transfer** Expand and enhance transfer of knowledge generated by research and evaluation for decision-making about policies, programs, and grant-making related to health disparities and health equity

GOALS AND STRATEGIES

Goal 1. Awareness: Increasing Awareness of the Significance of Health Disparities, Their Impact, and Necessary Actions

The 1985 *Heckler Report* documented the continuing burden of disparities for racial and ethnic minorities, noting that such disparities had "existed ever since accurate federal recordkeeping began more than a generation ago."[10] In assessing access to health information, the *Heckler Report* concluded that minority populations might be less knowledgeable of specific health problems than non-minorities. The *Heckler Report* developed recommendations for improving awareness through outreach and patient education.

Twenty-five years later, the NPA's *National Stakeholder Strategy* points to the necessity of increasing public awareness of health disparities. In spite of the longstanding evidence for health and healthcare disparities in this country, there continues a low level of awareness of health disparities among the American public and among healthcare providers.[8] Various reports over time—such as those described in the paragraphs below—have shown that Americans and health professionals are not sufficiently informed about health and healthcare disparities.

In 1999, the Kaiser Family Foundation conducted a study to assess the public's perceptions and attitudes about racial and ethnic differences in health care. The survey, which included a nationally representative sample of Whites, African Americans, and Latinos, found that most Americans (62 percent) were uninformed about disparities in health care. Another important finding was that there were differing views about the role that race plays in accessing quality care. Most African Americans and Latinos believed that they receive lower quality care and that race and ethnicity influence the ability to get routine care. White respondents did not share this view. The study concluded that "efforts to eliminate health disparities will need to improve public awareness of the problems and address barriers of race and money in health care."[70] A 2006 survey by the Kaiser Family Foundation yielded results similar to those from the 1999 survey.

The Harvard School of Public Health and the Robert Wood Johnson Foundation conducted a poll in 2005 (Whites, African Americans, and Hispanics/Latinos) to evaluate the American public's knowledge about healthcare disparities. Key findings from this survey were similar to those from the Kaiser Family Foundation's study regarding the lack of widespread recognition of the existence of disparities in health care. Overall, only 32 percent of Americans believed that getting quality care was more difficult for minorities. Different populations had diverging views about the influence of race or ethnicity in the quality of care received. Twenty-three percent of African Americans believed that they received poor quality of care because of their race. In contrast, only 1 percent of Whites believed this. Furthermore, 21 percent of Hispanics/Latinos believed that they received poor quality care because of their accent or inability to speak English well.

In 2002, the Kaiser Family Foundation released findings of a national survey showing that, in general, doctors are less likely than the public to say disparities occur “very often” or “somewhat often.”[282] However, by 2005, a study by the American Medical Association showed that physicians were becoming more involved in addressing healthcare disparities. Findings from this national survey showed that 55 percent of physicians agreed that minority patients generally receive lower quality care than do White patients.[283]

The challenge before us is to ensure that all stakeholders, not just racial and ethnic minority communities, understand the problem and are working together to enhance the visibility of this critically important public health issue. The challenge also calls for working collaboratively to develop a more coordinated approach to health promotion and disease prevention across the lifespan to encourage healthier lifestyles for all Americans. The awareness goal is not only about doing things differently, but also about working more strategically to obtain a stronger return on our investment.

The four strategy charts below address the goal of awareness through strategies based on healthcare agenda, partnerships, media, and communication. For each strategy, there is a menu of objectives, measures, and potential data sources which are tools for stakeholders to use in implementing any given strategy.

GOAL 1: AWARENESS

Increase awareness of the significance of health disparities, their impact on the nation, and the actions necessary to improve health outcomes for racial, ethnic, and underserved populations

STRATEGY 1: HEALTHCARE AGENDA

Ensure that ending health disparities is a priority on local, stateb, tribal, regional, and federal healthcare agendas

OBJECTIVES[a]	MEASURES[a]	POTENTIAL DATA SOURCES[a]
1. Strengthen city/county, state,b and federal minority health entities (such as an office, commission, council) and tribal health offices and establish a health disparities liaison in non-health departments (such as education, housing, labor) to ensure local, state, and tribal partnerships and decision-making power 2. Identify and develop relationships with non-partisan think tanks and other policy centers to advance and disseminate model policies that address determinants of health, reduce health disparities, and work to achieve health equity across the lifespan 3. Establish and utilize a national minority health information exchange or portal system as the central repository of all minority health data and related information, including government- and private-funded research, publications, podcasts, Web-based resources and trainings, conference proceedings, and best and replicable practices for ending health disparities 4. Develop partnerships among foundations, local businesses, nonprofit organizations, educational institutions, and community leaders to advocate for local policies and actions that create and sustain conditions for good health	1. Number and distribution of state and county/city minority health entities (such as office, commission, council), tribal health offices, health disparities liaisons established, and their degree of collaboration and decision-making power 2. Number, types, scale, and scope of activities conducted by stakeholder groups to address health disparities 3. Number and types of policy actions driven by data about determinants of health and health disparities 4. Number of local, state, tribal, and federal government plans that address health disparities and health equity 5. Percent of public or private funding allocated to support activities, including cross-agency collaborations to eliminate health disparities 6. Utilization trends for a national minority health information exchange	1. Organizational charts, mission statements, and other organizational information for city/county, state, and tribal governments and local health departments, as well as job descriptions for health disparities liaisons 2. City/county, state, tribal, and federal government strategic plans (e.g., departments of health and human services' strategic plans, community strategic plans) 3. State public health budgets—line items related to health disparities 4. National Association of County and City Health Officials' Local Health Department Infrastructure Study—data on local health department expenditures 5. U.S. Census Bureau's Census of Governments—data for government expenditures on health 6. National Conference of State Legislatures' Health Resources and Research—collection of articles, briefs, bills/summaries, databases, and letters and testimonies related to health disparities 7. Surveys of local and state health departments, academic institutions, businesses, philanthropic organizations, and community groups on health disparities 8. Federal Office of Minority Health's awareness surveys

[a] The objectives, measures, and potential data sources do not directly correlate to each other, but to the strategy to which they are connected.

[b] The use of "state" in this chapter includes Territories and the District of Columbia.

GOAL 1: AWARENESS

Increase awareness of the significance of health disparities, their impact on the nation, and the actions necessary to improve health outcomes for racial, ethnic, and underserved populations

STRATEGY 2: PARTNERSHIPS

Develop and support partnerships among public, nonprofit, and private entities to provide a comprehensive infrastructure to increase awareness, drive action, and ensure accountability in efforts to end health disparities and achieve health equity across the lifespan

OBJECTIVES[a]	MEASURES[a]	POTENTIAL DATA SOURCES[a]
1. Establish or assess and strengthen formal partnerships at different levels (i.e., community, city/county, state, and tribal) and across sectors (i.e., public, nonprofit, and private sectors) that have the potential to impact health disparities, opportunities for new collaboration, and prospects for improved coordination and integration.	1. Number, composition, distribution, and goal attainment of partnerships addressing health disparity and health equity issues	1. Survey of local and state health departments, academic institutions, businesses, and community groups on partnerships to address health disparities
2. Identify or create health equity and neighborhood solution groupsb to help apply and implement Blueprints for Action,c support evaluation of activities and results related to the Blueprints, update the Blueprints periodically, and develop annual reports	2. Distribution and type of health disparity activities, including those that contributed to policy actions or changes, carried out annually by partners at different levels and across sectors	2. National Business Group on Health surveys
3. Identify and engage community leaders; local, state, tribal, and regional funders; local coalitions and alliances; nonprofit organizations; and non-traditional partners in neighborhood solution and health equity groups. Provide infrastructure support, and coordinate activities to minimize unnecessary duplication of efforts	3. Composition and distribution of health equity and neighborhood solution groups	3. National Institute on Minority Health and Health Disparities (NIMHHD); National Institute of Mental Health's Outreach Partnership Program; Substance Abuse and Mental Health Services Administration's National Network to Eliminate Health Disparities in Behavioral Health
4. Connect health equity and neighborhood solution groups, collaboratives working on health disparities-related issues, and alliances representing different racial, ethnic, gender, disabilities, age, and LGBT groups and geographic communities to the *National Stakeholder Strategy* to adopt joint actions for ending health disparities	4. Number and type of goals and actions implemented and achieved by health equity and neighborhood solution groups	4. American Public Health Association's Health Disparities Community Solutions Database—review public-private partnership activities
	5. Number of health equity and neighborhood solution groups' recommendations that contributed to policy actions or changes by local, state, tribal, or federal agencies and/or organizations in the nonprofit and private sectors	5. Agency for Healthcare Research and Quality's Health Care Innovations Exchange Health Disparities Database—searchable database with information on public-private partnerships
	6. Number of actions by health equity and neighborhood solution groups, and other types of collaboratives and alliances linked to the national efforts to end health disparities	6. Health equity and neighborhood solution groups

[a] The objectives, measures, and potential data sources do not directly correlate to each other, but to the strategy to which they are connected.

[b] Establishment of health equity and neighborhood solution groups are encouraged and anticipated at the neighborhood, city/county, state, tribal, and regional levels.

[c] Blueprints for Action will be developed for each of the 10 HHS regions, people with disabilities, LGBT groups, and the American Indian and Alaskan Native population.

GOAL 1: AWARENESS

Increase awareness of the significance of health disparities, their impact on the nation, and the actions necessary to improve health outcomes for racial, ethnic, and underserved populations

STRATEGY 3: MEDIA

Leverage local, regional, and national media outlets using traditional and new media approaches as well as information technology to reach a multi-tier audience—including racial and ethnic minority communities, youth, young adults, older persons, persons with disabilities, LGBT groups, and geographically isolated individuals—to encourage action and accountability

OBJECTIVES[a]	MEASURES[a]	POTENTIAL DATA SOURCES[a]
1. Encourage public and private partners to develop and support a public relations/social marketing infrastructure for addressing health disparities and health equity that can also serve as a platform for local, state, tribal, regional, national information campaigns in order to "mainstream" the message	1. Distribution of coordinated public information campaigns for eliminating health disparities	1. Local and national news and media outlets (print, radio, and television)—data on news events stories and publications related to health disparities
2. Maintain media spotlight on health disparities by providing data and information to representatives (e.g., journalists, reporters, bloggers) of mainstream and community-based media outlets, including media specifically used by racial, ethnic, and other underserved populations	2. Content of health disparity-related news events and stories published	2. Survey of minority or special interest media and news outlets for information on stories and news events related to health disparities
3. Create messages about health disparities and potential solutions that are relevant to target audiences (e.g., youth, racial and ethnic minorities, people with disabilities, older adults, LGBT communities) and train leaders, community partners, and health equity advocates to adopt and use them effectively with media representatives	3. Number and types of actions spurred by public information campaigns	3. Federal agencies such as the Office of Minority Health, National Institute on Minority Health and Health Disparities, and the Agency for Healthcare Research and Quality data on Website traffic and unique visitors
4. Strengthen the ability of media representatives to frame disparities-related stories about the impact of health disparities, the link between health disparities and the social and economic well being of all, and effective solutions (e.g., provide easy access to comprehensive data, link them to appropriate information sources, including experts on the issues, civil rights advocates, and local leaders)	4. Number of unique visitors to targeted health disparities Web sites (e.g., Office of Minority Health, Agency for Healthcare Research and Quality, National Institute on Minority Health and Health Disparities)	
	5. Diversity of media outlets disseminating content on health disparity-related messages	
	6. Number of first-time town hall or informational meetings and events that address health disparities	
	7. Placement of health disparities-related articles and stories in print and broadcast mainstream and non-mainstream media, including films and movies	

[a] The objectives, measures, and potential data sources do not directly correlate to each other, but to the strategy to which they are connected.

GOAL 1: AWARENESS

Increase awareness of the significance of health disparities, their impact on the nation, and the actions necessary to improve health outcomes for racial, ethnic, and underserved populations

STRATEGY 4: COMMUNICATION

Create messages and use communication mechanisms tailored for specific audiences across their lifespan, and present varied views of the consequences of health disparities that will encourage individuals and organizations to act and to reinvest in public health

OBJECTIVES[a]	MEASURES[a]	POTENTIAL DATA SOURCES[a]
1. Establish common messages grounded in current communications research, about ending health disparities across the lifespan, which can be used by organizations that support the *National Stakeholder Strategy*	1. Distribution of common messages about ending health disparities, including the cost of health disparities to society as a whole	1. Local networking Web sites' records on user-created sites related to health disparities and chronic disease prevention and viewings/visits to these sites (e.g., YouTube, Twitter, Facebook)
2. Create, disseminate, and encourage data briefs about different forms of health disparities based on gender, stages of development (e.g., older adults and young people), race and ethnicity, sexual orientation or gender identity, disability, socioeconomic status, and geographic location to educate opinion leaders and inform solutions	2. Number, distribution, content, and use of health disparity data briefs	2. Content analyses of strategy, communications plans, press releases, reports, and campaign materials of *National Stakeholder Strategy* partner agencies for information on messaging
3. Support the use of blogs, podcasts, text messaging, online and mobile video, e-games, social networks, and other interactive technologies to engage diverse racial, ethnic, and other underserved groups in conversations and forums about preventing chronic and infectious diseases	3. Distribution and content of viewings or messages on targeted user-generated Web sites	3. National Opinion Survey on Health and Health Disparities
4. Create partnerships to conduct joint information campaigns with health disparity and health equity messages that are appropriately targeted to populations across the lifespan	4. Number and distribution of organizations carrying out joint campaign activities with common messages during National Minority Health Month and other relevant awareness celebrations	4. Local, state, tribal, and federal agencies that have information campaigns
5. Facilitate conversations with community leaders who can contribute to the development and dissemination of health equity message	5. Distribution and content of messages and information on mainstream and culturally specific media outlets that are not health disparities-focused, with messages related to health disparities	5. www.gaydata.org

[a] The objectives, measures, and potential data sources do not directly correlate to each other, but to the strategy to which they are connected.

Goal 2. Leadership: Strengthening and Broadening Leadership for Addressing Health Disparities

The underlying causes of health and healthcare disparities are multi-faceted and therefore require comprehensive solutions. The *National Stakeholder Strategy's* goals are intended to address these underlying causes by encouraging cohesive and comprehensive actions. Leaders play a pivotal role in any effort to create change, mobilize stakeholders, and advance solutions to issues of significant concern. Given the breadth, scope, and complexity of health and healthcare disparities, current leaders will need to become more engaged, and new leaders will need to be developed. Building leadership is a key responsibility of any collaborative effort to address complex issues and achieve beneficial outcomes.[284] There is a growing pool of talented leaders among racial and ethnic minorities and underserved communities and an increased willingness to engage them as sources of insight for identifying problems and finding solutions.

Cross-sectoral leadership, from the community to the national level, enables opportunities to harness the full complement of experiences, concerns, and ideas that are critical to developing comprehensive solutions. While leaders are needed at all levels of engagement, community leaders have been a long-overlooked resource for developing local solutions. In many instances, community- and faith-based organizations and other safety-net programs are the most accessible resources for leadership among minority and other underserved communities. These organizations often lack the funding, infrastructure, and technical or personnel support to appropriately tackle disparities. Investing in tools and providing capacity-building assistance is vital for ensuring that community and other leaders can engage as equal partners.

Local businesses and research, academic, health industry, and other organizations play a vital role in providing capacity-building support to develop and engage community leaders. They can serve as conveners of meetings with legislators, public health officials, community representatives, private sector representatives, and others seeking to advance actions to end health disparities. They are also positioned to assist communities in identifying information related to their health concerns and in developing neighborhood strategies to address disparities.

Strengthening and supporting current leadership, however, is not sufficient; we also have to invest in this nation's future leaders. The nation's youth are an important resource for developing current and future leaders. After several years of decline across the nation, the population of young Americans is growing and in coming years will rival the size of the baby- boomer generation. They will ultimately become the adults who make decisions that reshape our social, physical, economic, and cultural environments and produce innovations to combat health and healthcare disparities. Youth-serving organizations are a resource for shaping youth and helping them become the leaders of tomorrow.[285]

The three strategy charts below address the goal of leadership through strategies based on capacity building, funding and research priorities, and youth. For each strategy there is a menu of objectives, measures, and potential data sources, which are tools for stakeholders to use in implementing any given strategy.

GOAL 2: LEADERSHIP

Strengthen and broaden leadership for addressing health disparities at all levels

STRATEGY 5: CAPACITY BUILDING

Build capacity at all levels of decision-making to promote community solutions for ending health disparities

OBJECTIVES[a]	MEASURES[a]	POTENTIAL DATA SOURCES[a]
1. Establish and expand access to leadership trainings and planning and operational tools to equip institutional, local, and community leaders with the capacity to: a) design and deliver effective prevention, wellness, and other services to end health disparities; b) engage community members as equal partners in designing and conducting assessments and taking action; and c) partner effectively with government, academic, private, and nonprofit organizations on activities to end disparities for their communities and constituents 2. Create opportunities for entry- and mid-level professionals to receive leadership training and mentoring in order to create and expand the pipeline of leaders who can address health disparities 3. Create and implement a system to train and build the skills of leaders and staff in the public and philanthropic sectors and at different levels (i.e., local, state, tribal, or federal) to support and engage in community-oriented prevention and health equity work, particularly in providing equitable opportunities for community organizations to compete for funding 4. Provide technical assistance and other resources to improve the capacity of community organizations to collect, analyze, report, and use data for competitive submissions to foundations, government agencies, and other funders 5. Create principles that for agencies and organizations in the public, private, and nonprofit sectors can use to engage community representatives as equal partners in decisions about how to address the disparities that affect their communities	1. Degree to which local health disparity efforts are shaped and led by local and community leaders and, therefore, are tailored to the specific needs, context, and history of the targeted communities 2. Proportion of local and state budgets and foundation grants allocated for technical assistance and other supports to help community organizations address health disparities and health equity 3. Type, frequency, and number of local, state, and regional networks intended to build public, private, and nonprofit organizations' capacities for engaging community representatives in all aspects of planning and implementing solutions for ending health disparities 4. Adoption of principles by agencies and organizations in the public, private, and nonprofit sectors for engaging community representatives in decision-making and evidence of such policies, procedures, and practices	1. U.S. Census Bureau's Census of Governments—review of federal and state budgets and amount of funds allocated to community capacity building to address health disparities 2. Interviews with leaders and key informants of programs and initiatives that provide technical assistance and other supports to local groups on ending health disparities 3. Survey of community-based groups engaged in health disparities programming 4. Agency of Healthcare Research and Quality's Health Care Innovation Exchange Health Disparities Database and American Public Health Association's Health Disparities Community Solutions Database—review of community projects related to *the National Stakeholder Strategy* goals 5. National Association of County and City Health Officials' Local Health Department Infrastructure Study—data on local health department expenditures allocated to community capacity building to address health disparities 6. Survey of local, statewide, and national foundations to determine amount of funds allocated to community capacity building to address health disparities

[a] The objectives, measures, and potential data sources do not directly correlate to each other, but to the strategy to which they are connected.

GOAL 2: LEADERSHIP

Strengthen and broaden leadership for addressing health disparities at all levels

STRATEGY 6: FUNDING AND RESEARCH PRIORITIES

Improve coordination, collaboration, and opportunities for soliciting community input on funding priorities and involvement in research and services

OBJECTIVES[a]	MEASURES[a]	POTENTIAL DATA SOURCES[a]
1. Broaden outreach to include representatives of state agencies and nonprofit and community-based organizations, especially those knowledgeable about different racial, ethnic, and underserved populations, as potential grant reviewers and recipients of research projects	1. Number of review panels in public agencies and foundations that include community representatives and health consumers, particularly from different racial, ethnic, and other underserved populations	1. National Institutes of Health, Office of Minority Health, national health foundations and intermediaries, state and local health departments—demographic information of grant review panel members; committees and commissions; and boards of grant recipients, contractors, and partners
2. Work with agencies and organizations in the public, private, and nonprofit sectors to include representatives from different racial, ethnic, age, and gender groups; LGBT and disability communities; and geographically diverse places in decisions about funding, programmatic, and research priorities where they have historically been excluded (e.g., create opportunities for such representation on committees, commissions, and boards)	2. Distribution and diversity of community representatives from different racial, ethnic, and other underserved populations on local, state, and federal committees and commissions and on boards of private and nonprofit organizations	2. National Institutes of Health's Research Portfolio Online Reporting Tools (RePORT)
3. Improve coordination of technical assistance and other resources to help community-based organizations write and submit quality grant proposals	3. Number, distribution, and co-funding of technical assistance and other support programs in grant writing	3. Grant-writing technical assistance activities sponsored by local, state, tribal, and federal agencies; foundations; and other entities
4. Incentivize state agencies, institutions of higher education, academic medical centers, and private and nonprofit research organizations to invest in local health equity efforts and to collaborate with community-based organizations as an equal or lead partner	4. Proportion of funds allocated by local, state, tribal, and federal agencies and private funders and made available to community-based organizations to address at least one *National Stakeholder Strategy* goal	4. Requests for proposals and background, context, or rationale sections of funded proposals
5. Establish regional and national consortia to connect academic and research institutions, evaluators, intermediaries, and community-based organizations to: a) inform the use of funds for research and services, and b) use research and evaluation findings to inform the development and implementation of projects to end health disparities and achieve health equity	5. Degree to which data about determinants of health are required and provided in grant proposals	5. Survey of community-focused centers of excellence
6. Strengthen centers of excellence that focus on concerns, strategies, and solutions informed by community leaders and representatives and people affected by health disparities	6. Number, distribution, and use of community-focused centers of excellence	

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GOAL 2: LEADERSHIP

Strengthen and broaden leadership for addressing health disparities at all levels

STRATEGY 7: YOUTH

Invest in young people to prepare them to be future leaders and practitioners by actively engaging and including them in the planning and execution of health, wellness, and safety initiatives

OBJECTIVES[a]	MEASURES[a]	POTENTIAL DATA SOURCES[a]
1. Build the capacity of adults to engage and support youth of different gender, race/ethnicity, geographic location, sexual orientation or gender identity, disabilities, and socioeconomic status, as equal partners in decision-making about programmatic and funding priorities and in the design and implementation of community assessments and initiatives 2. Build the capacity of youth of different gender, race/ethnicity, geographic location, sexual orientation or gender identity, disabilities, and socioeconomic status to lead and participate in publicly and privately supported efforts to end health disparities 3. Educate and train youth, especially youth who have been historically excluded, to become peer leaders and advocates for their health and well-being and to address health disparities and other health-related issues that affect them	1. Distribution and diversity of youth on governing and advisory boards 2. Number and distribution of health education and promotion programs that train and use youth peer leaders and advocates 3. Percent of sessions at conferences that address youth-focused health disparity issues and percent of sessions organized, led, and presented by youth 4. Distribution of local, state, tribal, regional, national youth organizations that include health disparities as a program or policy priority	1. Neighborhood Solution Groups and state, tribal, regional, and national health equity coalitions 2. Agendas of conferences that address health disparities and youth issues 3. Mission statements, policy agendas, program activities, and budgets of local, state, tribal, regional, and national youth and health organizations

[a] The objectives, measures, and potential data sources do not directly correlate to each other, but to the strategy to which they are connected.

Goal 3. Health System and Life Experience: Improving Health and Healthcare Outcomes for Racial, Ethnic and Underserved Populations

Health is influenced by a number of interrelated factors that impact individuals where they live, learn, work, play, and age. These factors include the social, economic, and physical environments as well as individual characteristics and behaviors.[4] Health and healthcare disparities affect individuals across the lifespan and require comprehensive solutions, coordination across sectors, and supportive policies to address them. [32]

The *Unequal Treatment Report* highlights many factors that contribute to disparities in health outcomes. These include health system-related factors, as well as the actions and attitudes of individuals (e.g., healthcare providers, utilization managers, and patients). At a systems level, this can include institutional bias, the lack of cross-cultural education in the training of health professionals, and the lack of policies and infrastructure to address the multiple needs of diverse clients. At the individual level, there may be a lack of knowledge among healthcare providers about multicultural service provision and culturally relevant care, and among patients and other consumers of health services, a lack of understanding about their rights and responsibilities and the role they play in determining their own health futures. When patients have "medical homes" (settings that provide timely, well-organized care and enhanced access to providers), racial and ethnic disparities are reduced.[286]

There is also a need for improvements in the health communication experience for patients and their providers.[287,288] As defined by Healthy People 2010, *health literacy* is "the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions."[289] An IOM report further explains *health literacy* as more than individual skills, but as a shared function with health systems and healthcare providers to present information in an appropriate manner.[290] Research from the U.S. Department of Education reveals that only 12 percent of English-speaking adults in the United States have proficient health literacy skills. Furthermore, approximately 45 percent of high school graduates have limited health literacy.[291] Successful communication and interaction between patients and providers promotes respect of patients' wants, needs, and preferences and fosters an environment that promotes understanding of services offered, informed decision-making, and active participation in personal care.[292]

Researchers have found that Hispanics and Asian Americans have less confidence in their physicians than do Whites.[293] African Americans and Hispanics consistently rate as "low" the quality of communication and interaction with their providers.[294] Contributing to these phenomena are the real and perceived experiences of racism among minority populations. This, in turn, fosters mistrust of healthcare institutions and providers and a corresponding diminished willingness to access institutional healthcare resources. Research studies also have identified specific positive provider behaviors (e.g., listening to patients and their families, explaining treatment options, encouraging participatory decision-making, spending time with patients, and patients' perception of respect) as important indicators of patient satisfaction with the health system.[293,295,296]

There is a relationship between education and health.[297] Low educational attainment is a powerful predictor of adverse health outcomes. Although the reasons behind this relationship are complex, a basic component relates to differences in the behaviors of higher- and lower-educated groups. Generally, individuals with higher levels of education have healthier behaviors. For example, they are more likely to exercise, less likely to smoke, and less likely to be exposed to behaviors that may harm health. In the United States, men and women have similar levels of academic achievement. However, African Americans, Native Americans, and Hispanics have lower academic attainment levels. The gap for these three groups widens at higher levels of academic experience. This gap contributes to the health disparities experienced by these populations.

Research also has shown a powerful link between social and economic factors and health.[59,65,67] Eliminating health disparities and achieving health equity will require attention to these issues (e.g., availability and accessibility of nutritious food, adequate transportation, affordable housing, safe living conditions, quality of air and water, accessibility of education and job opportunities, and stress caused by perceived racial discrimination), which require comprehensive solutions, coordinated efforts across sectors, and supportive policies.

Health and healthcare disparities that are linked to the above issues affect individuals across the lifespan. Health disparities based on socioeconomic status can persist, starting from fetal health to elderly health;[32] children and older adults are especially vulnerable. Given existing evidence that links education and health, it is clear that children need the necessary services to help them learn better in order to optimize their potential for high academic achievement. This means that they require the proper oral, mental, physical, and other services to ensure their quality of health throughout their development. Likewise, older adults, especially those with limited mobility and resources, require additional assistance in accessing preventive care, self-management programs, and other types of supportive services.

The six charts below address the goal of health system and life experience through strategies based on access to care, children, older adults, health communication, education, and social and economic conditions. For each strategy there is a menu of objectives, measures, and potential data sources, which are tools for stakeholders to use in implementing any given strategy.

GOAL 3: HEALTH SYSTEM AND LIFE EXPERIENCE

Improve health and healthcare outcomes for racial, ethnic, and underserved populations

STRATEGY 8: ACCESS TO CARE

Ensure access to quality health care for all

OBJECTIVES[a]	MEASURES[a]	POTENTIAL DATA SOURCES[a]
1. Support community-driven needs assessments	1. Proportion of providers that use health information technology to monitor and support quality care improvements	1. U.S. Census Bureau
2. Communicate the expectations and benefits of a health home (including medical homes and other health settings) to different racial and ethnic groups, underserved populations, and health professional community	2. Increase in proportion of families from different racial, ethnic, and other underserved populations who have access to health homes	2. Current Population Survey
3. Improve comprehensive primary health services that include preventive care and screenings and enhance the coordination of care and service delivery, including the use of Community Health Workers, to ensure comprehensive support for culturally, linguistically, and geographically isolated communities	3. Decrease in number of inappropriate visits to the emergency room, use of ambulances, and hospitalizations for manageable chronic conditions	3. National Health Interview Survey
4. Develop and strengthen partnerships to outreach, identify, and improve access for individuals who are eligible for Medicaid or CHIP and for the uninsured and underinsured, rural community residents, racial and ethnic minorities, and others with limited access to health care due to historical exclusion and other barriers	4. Increased access to and use of preventive care services (e.g., increase in health screening rates)	4. Agency for Healthcare Research and Quality's State Snapshots of Health Quality
5. Assess the affordability of out-of-pocket health care costs for the under-served and low-income populations and identify strategies for reducing these costs	5. An infrastructure for monitoring the percent of underserved and low- income populations who do not access health care due to high out-of-pocket cost	5. National Hospital Discharge Survey
6. Incentivize culturally and linguistically competent providers to practice in medically underserved areas and to improve their distribution in order to provide first-contact, comprehensive services, and continuous, coordinated care	6. Increase in health, wellness, and safety programs that target the reduction of health disparities and produce a change in personal health practices (e.g., reduced absenteeism at work, quality of life satisfaction, etc.)	6. Healthcare Cost and Utilization Project (The State Emergency Department Database)
7. Incentivize health service providers to adopt and adhere to quality improvement standards (safe, patient-centered, effective, timely, efficient, equitable), including the use of health information technology to: a) enable information sharing among providers within the Health Information Portability and Accountability Act's restrictions; b) provide individual patients, including the limited English-proficiency population and individuals with disabilities, access to their individual medical records; and c) generate reports on compliance with quality care standards and support improvements	7. Provider-patient ratio in medically underserved areas	7. The Emergency Room Database
	8. Increase in healthcare providers who deliver prevention messages to their patients and their families (e.g., exercise safely, wear protective gear, install smoke alarms, etc.)	8. Indian Health Services Health Promotion/Disease Prevention Wellness Data
	9. Increase in the use of telemedicine with provider reimbursements equivalent to face-to-face office and clinic visits	9. Medicare, Medicaid, CHIP, community health center, and clinic data

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[a] The objectives, measures, and potential data sources do not directly correlate to each other, but to the strategy to which they are connected.

GOAL 3: HEALTH SYSTEM AND LIFE EXPERIENCE

Improve health and healthcare outcomes for racial, ethnic, and underserved populations

STRATEGY 9: CHILDREN

EEnsure the provision of needed services (e.g., mental, oral, vision, hearing, and physical health; nutrition; and those related to the social and physical environments) for at-risk children, including children in out-of-home care

OBJECTIVES[a]	MEASURES[a]	POTENTIAL DATA SOURCES[a]
1. Improve different racial, ethnic, and underserved populations' access to maternal, infant, and early childhood support services, including clinics with expertise in pediatric environmental health and anti-bullying interventions	1. Increase in early periodic screenings, diagnostic, and treatment rates	1. Children's Health Insurance Research Initiative issue briefs, reports on access to care and services, quality, and disparities among low-income children
2. Collaborate with health providers, educators, and caregivers to assure that children are properly immunized and have up-to-date and appropriate well-child visits, including medical, dental, developmental, social, and mental health screenings	2. Increase in identification, referral, and treatment for children facing medical, developmental, and other health issues	2. Health Resources and Services Administration's National Survey of Children with Special Health Care Needs—data on extent to which children with special health care needs have access to health homes, adequate health insurance, and access to needed services, as well as their care coordination and satisfaction with care
3. Establish ongoing health communication to educate children, their parents, and other caregivers about the impact of healthy nutrition, injury prevention, and physical activity on children's life and functioning	3. Percent of resources allocated to support state, tribal, and local health agencies in providing no-cost or low-cost immunization	3. Local, state, tribal budgets; National Association of County and City Health Officials' Health Department Infrastructure Study—data on local health department expenditures; U.S. Census Bureau's Census of Governments— review for allocation of resources to low- or no-cost immunization services for at-risk children
4. Support the establishment of school-based health centers to facilitate interaction between providers and school staff, students, and their parents, and provide comprehensive services	4. Number, distribution, and content analysis of social marketing campaigns on the importance of nutrition and physical activities for children	4. Centers for Medicare & Medicaid Services' Annual Early and Periodic Screening, Diagnostic, and Treatment Report
5. Use child health outcome data to inform quality of care for children, especially for children and families with specific healthcare needs	5. Number and distribution of community health centers or clinics within or adjacent to schools	5. National Children's Health Survey— data on children's health status (physical and oral health)
6. Promote linkages and strengthen collaboration among pediatricians, early childhood educators, preventive care services, other health and social service providers, and families to ensure school readiness and access to comprehensive services	6. Increase in resources allocated to address stressors that affect children's health	6. Pediatric Nutrition Surveillance System—data on nutritional status of children five years old and under for federally funded programs
	7. Increase in the number of pediatric clinics in at-risk communities with expertise in product safety and environmental conditions/hazards that influence health	7. American Dietetic Association's Evidence Analysis Library
		8. Reports and report cards on children's health

[a] The actions, measures, and potential data sources do not directly correlate to each other, but to the strategy to which they are connected.

GOAL 3: HEALTH SYSTEM AND LIFE EXPERIENCE

Improve health and healthcare outcomes for racial, ethnic, and underserved populations

STRATEGY 10: OLDER ADULTS

Enable the provision of needed services and programs to foster healthy aging

OBJECTIVES[a]	MEASURES[a]	POTENTIAL DATA SOURCES[a]
1. Increase older adults' (especially older adults from racial, ethnic, and other underserved groups) access to and use of preventive healthcare services (e.g., annual influenza and the pneumococcal vaccination, prostate screenings, mammography) through community-based and clinical partnerships and other innovative approaches 2. Establish partnerships between the business sector, medical and health providers, and community-based organizations to ensure that older adults (especially older adults with multiple chronic conditions) have access to appropriate medical, dental, nutritional, and social services, as well as to evidence-based, self-management programs 3. Increase the number of accessible home and community-based provider and caregiver training programs 4. Increase the number of older adults living in frontier, rural, urban, or tribal communities who have access to core services (e.g., nutrition/meal, transportation, and respite care) provided by area agencies on aging 5. Support collaboration among the Aging Network, federally qualified health centers, aging or other organizations committed to aiding older adults, and/or state and local offices of minority health to ensure access for older adults from racial and ethnic minority groups 6. Incentivize the implementation of Naturally Occurring Retirement Communities (NORCs) or similar community aging-in-place models that enable the coordination of community-based services for older adults who live in medically underserved areas (MUAs) and/or health providers shortage areas (HPSAs)	1. Number and distribution of community- and home-based caregiver training programs 2. Number and distribution of evidence-based health, wellness, and safety programs for older adults 3. Decrease in emergency room visits and short-term hospitalizations among older adults 4. Number of older adults from different racial, ethnic, and underserved populations who have access to and receive core services 5. Number of NORCs or similar models implemented within MUAs/HPSAs	1. Medicare, Medicaid, and long-term care data 2. Agency for Healthcare Research and Quality's National Healthcare Disparities Report (NHDR) 3. Administration on Aging's Aging Integrated Database and National Aging Program Information System (NAPIS) 4. Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System data 5. Federal Interagency Forum on Aging-Related Statistics 6. The State of Aging and Health in America Report 7. The National Archive of Computerized Data on Aging 8. National Center for Health Care Statistics 9. Medical Expenditure Panel Survey (MEPS) 10. American Dietetic Association Evidence Analysis Library 11. U.S. Department of Labor, Registered Apprenticeship Office 12. Bureau of Labor Statistics

[a] The objectives, measures, and potential data sources do not directly correlate to each other, but to the strategy to which they are connected.

GOAL 3: HEALTH SYSTEM AND LIFE EXPERIENCE

Improve health and healthcare outcomes for racial, ethnic, and underserved populations

STRATEGY 11: HEALTH COMMUNICATION

Enhance and improve health service experience through improved health literacy, communications, and interactions

OBJECTIVES[a]	MEASURES[a]	POTENTIAL DATA SOURCES[a]
1. Develop health education materials in primary languages spoken by communities to communicate important health messages and improve availability of information on how to access services 2. Use culturally and age-appropriate avenues and direct-to-consumer methods to deliver health and safety messages to individuals with limited English proficiency or low-level or marginal literacy skills 3. Expand the use of eHealth marketing, mobile and interactive media, and social networking to engage and communicate information about disease and injury prevention, health promotion, and health protection 4. Enhance and disseminate guidelines for effective health literacy efforts and support the integration of health literacy training into the activities of social support institutions and networks 5. Establish and disseminate guidelines to medical and healthcare training programs and professional health associations for effective clinical and other health care encounters and patient-provider communication 6. Promote development of clinical tools to improve identification of and communications with at-risk patients (e.g., limited health-literate patients) as part of ongoing improvement initiatives	1. Number, content, and distribution of health communication materials developed in primary languages spoken by the surrounding community 2. Content of health education efforts that use e-marketing and interactive media to engage and communicate information on disease prevention, injury prevention, health promotion, and health protection 3. Application of guidelines on health literacy by medical and healthcare programs, professional associations, and social support institutions and networks 4. Patient satisfaction with their healthcare providers 5. Increase in healthcare providers (e.g., physician offices, hospitals, community clinics) that survey consumers about their satisfaction and interactions with their providers	1. National Center for Education Statistics' National Assessment of Adult Literacy—health literacy component 2. National Center for the Study of Adult Learning and Literacy—resources and briefs on health literacy 3. Ambulatory Care Experience Survey and Primary Care Assessment Survey —data from items/subscales related to patient perceptions of communication with provider 4. Health literacy advocacy organizations and public and private sector organizations reporting adherence to guidelines 5. Accreditation Association for Ambulatory Health Care and The Joint Commission 6. Office of Disease Prevention and Health Promotion's National Action Plan to Improve Health Literacy

[a] The objectives, measures, and potential data sources do not directly correlate to each other, but to the strategy to which they are connected.

GOAL 3: HEALTH SYSTEM AND LIFE EXPERIENCE

Improve health and healthcare outcomes for racial, ethnic, and underserved populations

STRATEGY 12: EDUCATION

Substantially increase, with the goal of 100%, high school graduation rates by working with schools, early childhood programs, community organizations, public health agencies, health plan providers, and businesses to promote the connection between educational attainment and long-term health benefits

OBJECTIVES[a]	MEASURES[a]	POTENTIAL DATA SOURCES[a]
1. Develop and implement local strategies to reduce health, psychosocial, and environmental conditions that affect school attendance and chronic absenteeism 2. Develop effective strategies for supporting parents and other caregivers in addressing the psychosocial and environmental factors that impact their children's lives 3. Improve school environment, culture, and other conditions (e.g., healthier food options, physical activity opportunities, anti-bullying programs, adequate staffing and staff training, playground modifications, safe transportation) to support students' readiness and ability to learn 4. Encourage the introduction of concepts about health disparities, health equity, and determinants of health as part of the K-12 curriculum in schools 5. Improve health career pipeline by providing health care-related courses and transition assistance to students from racial, ethnic, and other underserved communities 6. Increase investment in strategies to decrease academic achievement gaps (particularly in math and science) among students from racial and ethnic minority groups and low-income families, and increase their opportunity for higher education or career-oriented alternative program	1. Policies and programs enacted to reduce barriers to school attendance and high school graduation, improve the quality of school environment, and support parent engagement 2. Number of school programs that incorporate concepts of health disparities, health equity, and determinants of health into their curriculum 3. Number of scholarships among diverse categories of students (e.g., racial and ethnic minority, disabled and low income) 4. Number of students of different racial, ethnic, gender, LGBT, and disability groups from high school, community colleges, colleges, and universities who pursue a health-related degree 5. Increased graduation rates, especially among students from racial, ethnic, and underserved groups 6. Decrease in academic achievement gaps, especially in math and science	1. Analysis of local, state, and national polices for information and emphasis on high school graduation 2. Centers for Disease Control and Prevention's School Health Programs and Policies Survey, School Health profiles, and Youth Risk Behavior Surveillance System 3. Philanthropic organizations such as the Annie E. Casey Foundation Kids Count Data—state-level data on education 4. National Center for Higher Education Management Systems—public high school graduation rates by year and by site 5. U.S. and State Departments of Education, Bureau of Indian Affairs, and Bureau of Indian Education— graduation rates 6. National Center for Education Statistics 7. College and university financial aid awards by race, ethnicity, and income of recipients 8. National Association of Student Financial Aid Administrators

[a] The objectives, measures, and potential data sources do not directly correlate to each other, but to the strategy to which they are connected.

GOAL 3: HEALTH SYSTEM AND LIFE EXPERIENCE

Improve health and healthcare outcomes for racial, ethnic, and underserved populations

STRATEGY 13: SOCIAL AND ECONOMIC CONDITIONS

Support and implement policies that create the social, environmental, and economic conditions required to realize healthy outcomes

OBJECTIVES[a]	MEASURES[a]	POTENTIAL DATA SOURCES[a]
1. Improve the availability, accessibility, affordability (e.g., fresh food financing initiatives, neighborhood store incentives, Electronic Benefits Transfer (EBT) cards at farmers markets), and consumption of healthy, safe, and nutritious food for all families	1. Use of health impact assessments and application of assessment findings by public agencies, corporations, and foundations	1. Local, state, and tribal governments and corporations
2. Improve safety of and accessibility to public transportation, walking, and bicycling (e.g., interconnected street strategies, public transit-oriented development), especially in urban communities	2. Number and location of supermarkets, convenience stores, and fast food restaurants	2. Institute for Disease Control and Prevention's Behavioral Risk Factor Surveillance System
3. Improve safety and accessibility of transportation to resources and services in rural and geographically isolated communities	3. Expenditures on public and private recreational facilities	3. U.S. Census Bureau—data on retail trade companies
4. Improve housing quality, affordability, stability, and proximity to resources (e.g., housing code enforcement, location of resources, transit system, and mixed-income development)	4. Fatality rates for pedestrians and cyclists	4. Progress Grocer's—Annual Reports of the Grocery Industry
5. Improve neighborhood conditions (e.g., policies that support crime prevention through environmental design, community problem-oriented policing, etc.) to support healthier living environment	5. Percent of households reporting unsatisfactory or no public transportation in residential areas	5. U.S. Census Bureau's Census of Governments
6. Monitor and improve air, water, and soil quality (e.g., enforcement of national water standards, effective lead abatement programs, properly ventilated office and school buildings, etc.) in places where people learn, work, live, play, and age	6. Design Value (i.e., air quality status of a given area relative to the level of EPA's National Ambient Air Quality Standards), Air Quality Statistics, Air Quality Index	6. Pedestrian and Bicycle Information Center—www.pedbikeinfo.org
7. Ensure employment opportunities for people from different racial, ethnic, and underserved populations and enhance their labor market participation through targeted employment initiatives, job training, networking opportunities, and monitoring of employers' compliance with fair pay regulations	7. Number of violations, by year and state, for federally regulated drinking water contaminants	7. American Housing Survey and National Household Travel Survey
8. Support programs and initiatives (e.g., through financial literacy programs, maximum use of earned income tax and child tax credits) to empower families from different racial, ethnic, and underserved populations to save, enhance, and sustain their abilities to live a healthy life and accumulate wealth	8. Labor force participation rates	8. U.S. Environmental Protection Agency's air trends and safe water reports
9. Expand and strengthen safety net opportunities to ensure services are developed to support individuals and families	9. Expenditures on safety net programs	9. U.S. Bureau of Labor Statistics
10. Strengthen disaster and emergency preparedness plans by accounting for the needs of populations that are vulnerable and underserved (e.g., older adults, people with disabilities, linguistically isolated families, low-income families)	10. Income-to-spending ratios	
11. Seek stronger partnership between community organizations, businesses, and community colleges to create pathways for youth and adult learners from different racial, ethnic, and underserved groups to acquire the skills that will lead to greater economic opportunities		
12. Encourage joint learning and collaboration across sectors to adopt plans to assess (e.g., through racial-impact analysis)		

[a] The objectives, measures, and potential data sources do not directly correlate to each other, but to the strategy to which they are connected.

Goal 4. Cultural and Linguistic Competency: Improving Cultural and Linguistic Competency and Diversity of Health-Related Workforce

Cultural and linguistic competency reflects and builds on the premise that understandable communication is a necessity of any successful endeavor. The recipient must understand words and text; otherwise the exercise of providing them is meaningless. Thus, the essential first step in communication is simply to be clear. Understandable messages require, at the most basic level, communication in a language that the recipient understands. Knowledge and accommodation of cultural factors as well as an atmosphere of mutual respect and cooperation are necessary for effective communication.

Cultural humility is an important component of cultural competency. It is the notion that providers can exercise self-awareness in order to foster respectful partnerships with patients. It "incorporates a lifelong commitment to self-evaluation and critique, to redressing the power imbalances in the physician-patient dynamic, and to developing mutually beneficial and non-paternalistic partnerships with communities on behalf of individuals and defined populations."[298]

Awareness of the cultural values, beliefs, and practices of different racial and ethnic groups can help healthcare providers understand and address their unique risk factors. For example, South Asians consume Ayurvedic medicines that may expose them to toxic metals. If such individuals present in a clinical setting with toxicity symptoms, it would be helpful if the consumer volunteered or if the practitioner, through a personalized medical history, understood the toxicity potential and was prepared to obtain critical information to provide the necessary care.

> "Learning from other minority groups was the best. It is important to know how our brothers and sisters from other ethnic groups feel."
>
> –NPA Regional Meeting participant

As language diversity in the United States grows, there is a critical need to ensure that language access services are available in healthcare settings for the expanding number of Limited English Proficient (LEP) patients. The IOM *Unequal Treatment Report* noted that "language barriers can cause poor, abbreviated, or erroneous communication, poor decision making on the part of both providers and patients, or ethical compromises."

The National Standards on Culturally and Linguistically Appropriate Services (CLAS) include four standards related to the provision of language access services based on Title VI of the Civil Rights Act of 1964. The standards emphasize the need for healthcare organizations to provide and assure competent language assistance services (including bilingual staff and interpreting services), inform patients of their rights to those services, and make available linguistically appropriate patient-related materials and signage.

Healthcare interpreters—bilingual professionals who facilitate communication between healthcare providers and patients—play an important part in the healthcare experience for LEP patients. It is important that in order to ensure complete, accurate and confidential communication, patients should not use family and friends as interpreters.

Continuing efforts are underway to provide cultural competency training to current and future healthcare providers and other professionals in the health and related industries. However, it is important to differentiate between receiving training in cultural sensitivity and competency and the actual translation of that training into the acquisition of skills that allow effective interaction and communication with patients. The training is not effective if the skill acquisition does not occur. Providers must possess or learn the cognitive abilities and interpersonal skills that will yield proficiency in customer service. Cultural and linguistic competencies improve collaborative goal setting, planning, and participation of patients in their own care.

Healthcare workers who share the same cultural and linguistic background as those they serve, or who have adequate training in cultural and linguistic competency, can be particularly effective in providing services. Recruitment and retention of racial and ethnic minorities into the workforce continues to be a valuable strategy for promoting cultural and linguistic competency. In addition, increased recruitment of community health workers can aid patient provider communication and mutual understanding. For example, since the 1960s, community health workers, neighborhood workers, indigenous health workers, health aids, "consejeras," and "promotoras" have fulfilled multiple functions in helping to improve health outcomes for racial and ethnic minority populations.[299] Once trained and deployed strategically, these community members assist LEP and other underserved consumers to successfully negotiate unfamiliar healthcare settings (e.g., interpreting services, explanation of insurance coverage, or availability of social services).

The three strategies below address the goal of cultural and linguistic competency through strategies based on workforce, diversity, and ethics and standards. For each strategy there is a menu of objectives, measures, and potential data sources, which are tools for stakeholders to use in implementing any given strategy.

GOAL 4: CULTURAL AND LINGUISTIC COMPETENCY

Improve cultural and linguistic competency and the diversity of the health-related workforce

STRATEGY 14: WORKFORCE

Develop and support the health workforce and related industry workforces to promote the availability of cultural and linguistic competency training that is sensitive to the cultural and language variations of diverse communities

OBJECTIVES[a]	MEASURES[a]	POTENTIAL DATA SOURCES[a]
1. Monitor health workforce composition; identify competencies needed; improve and develop appropriate education, training, and life-long learning curricula; and enhance recruitment strategies to increase the supply of qualified health professionals	1. Number and distribution of health workers, by health profession	1. National Center for Health Workforce and state departments of health or centers for health workforce data
2. Collaborate with the business sector and work with employers to encourage continuing education in cultural and linguistic competency (that also includes requirements for compliance with Title VI of the Civil Rights Act) for physicians, other health professionals, and administrative staff who participate in their purchased health insurance plans	2. Existence and use of modules that provide standardized training and continuing education on cultural and linguistic competency, including the number of credits that can be earned and percent of staff trained	2. Office of Minority Health's Cultural Competency Curriculum Modules training logs
3. Highlight and disseminate best practices by public health agencies and health organizations to ensure cultural and linguistic competency training and continuing education for healthcare providers and healthcare administrative staff	3. Availability and utilization of cultural humility and competency courses and modules in undergraduate and graduate health professional training degree and certificate programs	3. Assessment of relevant professional competencies in undergraduate and graduate professional training programs through professional organizations and accrediting bodies
4. Develop and integrate model cultural and linguistic competency training courses and modules, particularly on cultural humility, into workforce development programs and undergraduate and graduate professional programs in medicine, dentistry, nursing, allied health, mental health, public health, and environmental health	4. Improved systematic collection and documentation of consumers' primary languages and dialects and use of findings to inform planning and provision of services	4. Survey of health-related accrediting bodies (e.g., The Joint Commission, Accreditation of Ambulatory Health Care, and URAC (formerly the Utilization Review Accreditation Commission)
5. Assist public health clinics, health care organizations, community clinics, and other providers to implement effective language access policies, practices, and procedures that comply with Title VI	5. Allocated resources and incentives, proportionate to other key aspects of professional development, for training and continuing education in cultural and linguistic competency for physicians and other health professionals and administrative staff	5. Federation of State Medical Boards, Liaison Committee on Medical Education, and Accreditation Council for Graduate Medical Education data
6. Use telecommunications, videoconferencing, and other technology to deliver services to people who live in geographically isolated places, have no access to transportation, and/or	6. Inclusion of cultural and linguistic competency training and continuing education as part of information in new staff orientation and criteria for job performance and licensure by accrediting bodies	6. Bureau of Labor Statistics' Employment and Training Administration

[a] The objectives, measures, and potential data sources do not directly correlate to each other, but to the strategy to which they are connected.

GOAL 4: CULTURAL AND LINGUISTIC COMPETENCY

Improve cultural and linguistic competency and the diversity of the health-related workforce

STRATEGY 15: DIVERSITY

Increase diversity and competency of the health workforce and related industry workforces through recruitment, retention, and training of racially, ethnically, and culturally diverse individuals and through leadership action by healthcare organizations and systems

OBJECTIVES[a]	MEASURES[a]	POTENTIAL DATA SOURCES[a]
1. Develop a policy agenda to expand the diversity and cultural and linguistic competency of the health care workforce	1. Number and type of policies developed and implemented by healthcare organizations, accrediting bodies, education programs, and state health agencies to support the diversification of the health care workforce	1. Survey of major health care organizations, accrediting bodies, health and allied health education programs, and state health agencies
2. Work with medical schools, boards of trustees of universities, healthcare systems, professional health associations, and health-related businesses to consider and implement a policy of inclusion in all aspects of their organizational structure and processes	2. Percent of health-related certificates/credentials and professional degrees awarded to members of racial, ethnic, and cultural groups	2. National Center for Health Workforce Analysis Reports
3. Build relationships and collaborate with higher learning institutions, including Historically Black Colleges and Universities, Hispanic-serving Institutions, and Tribal Colleges and Universities to increase recruitment of minorities into public and environmental health-related programs	3. Distribution and percent of schools of medicine and nursing and allied health professional training programs whose basic curricula include core competencies in culturally and linguistically appropriate health promotion and education and disease prevention	3. Survey of major professional health-related education associations (e.g., American Dental Education Association, American Association of Colleges of Nursing, Association for American Medical Colleges, American Academy of Physician Assistants)
4. Educate school counselors and teachers in high schools and colleges about career pathways in the health professions and work with them to support the early recruitment of youth from different racial, ethnic, and cultural backgrounds into these professions	4. Number of internship and fellowship programs in the health field for students from different racial, ethnic, and cultural backgrounds	4. U.S. Census Bureau—Special Equal Opportunity Employment tabulation
5. Increase the number of bridge programs between institutions of higher education and employers in the health sector to provide greater opportunities for students from different racial, ethnic, and cultural backgrounds and low-income families to enter the health care workforce	5. Percent of individuals from different racial, ethnic, and cultural backgrounds, by health profession and position	5. Departments of Labor, Veterans Affairs, and Defense reports

[a] The objectives, measures, and potential data sources do not directly correlate to each other, but to the strategy to which they are connected.

GOAL 4: CULTURAL AND LINGUISTIC COMPETENCY

Improve cultural and linguistic competency and the diversity of the health-related workforce

STRATEGY 16: ETHICS AND STANDARDS, AND FINANCING FOR INTERPRETING AND TRANSLATION SERVICES

Encourage interpreters, translators, and bilingual staff providing services in languages other than English to follow codes of ethics and standards of practice for interpreting and translation. Encourage financing and reimbursement for health interpreting services.

OBJECTIVES[a]	MEASURES[a]	POTENTIAL DATA SOURCES[a]
1. Promote codes of ethics and standards of practice for interpreting and translation	1. Number of accrediting bodies that include the codes of ethics and standards for interpreting and translation in their requirements	1. Survey of state and local health departments
2. Assist states, healthcare financing entities, and managed care organizations to develop plans to comply with the codes of ethics and standards of practice for interpreting and translation	2. Degree to which federal- and state- funded health services, health financing entities, managed care organizations, and healthcare organizations use the codes of ethics and standards of practice for interpreting	2. Survey of accrediting bodies (e.g., The Joint Commission, Accreditation of Ambulatory Health Care, and URAC)
3. Collaborate with accrediting bodies for healthcare organizations to integrate codes of ethics and standards of practice for interpreting and translation into accreditation requirements	3. Percent of interpreters certified by training entities that comply with the codes of ethics and standards for training and practice	3. The National Board of Certification for Medical Interpreters and state medical interpreter networks or associations
4. Increase the number of interpreters who meet professional standards and certification for health interpretation	4. Percent of agencies and healthcare organizations and services that adopt proper interpreting and translation as a quality improvement indicator	4. American Health Quality Association and State Quality Improvement Organizations
5. Encourage financing and reimbursement for medical interpretation services	5. Establishment of incentives for hospitals, physicians, and other healthcare settings and health professionals to support interpreting services and compensate for additional time required for interpreting support	5. Centers for Medicare and Medicaid Services (CMS)
	6. Inclusion of interpreting assistance in states' and businesses' procurement language for contracts with managed care organizations and healthcare providers	6. State procurement or purchasing offices
	7. Allocated resources, proportionate to other key aspects of service provision used for translation and interpreting services	7. Survey of the National Association of State Procurement Officials' membership

[a] The objectives, measures, and potential data sources do not directly correlate to each other, but to the strategy to which they are connected.

Goal 5. Data, Research, and Evaluation: Improving Data Availability, and Utilization and Diffusion of Research and Evaluation Outcomes

In 1906, noted historian and philosopher W.E.B. Du Bois published a monograph entitled *The Health and Physique of the Negro American*,[300] which sought to dispel published claims that the known higher levels of mortality and morbidity for African Americans were due to inherent racial traits. Du Bois' monograph is an early example of our nation's long history of using research to document health disparities, define their causes, and confront those conditions.

The need to coordinate and improve research and evaluation of the causes of health disparities is essential to improving the health of Americans and ending health disparities. All minority groups experience health disparities. While research to document these disparities has continued and improved, the research to identify their social and environmental determinants still lags behind—as have the development, dissemination, and translation of scientifically proven models for changing these conditions.

> "This experience reminded us all that there is most definitely a need for information sharing between organizations in order to end healthcare disparities."
>
> –NPA Regional Meeting participant

Even among local, state, tribal, and the federal governments and private sector organizations, there may be challenges in data collection, including small numbers of racial and ethnic minorities and underserved populations participating in studies and lack of standardized measurements. Larger data sets allow for more confidence in findings, as well as the ability to break findings down into smaller subsets (e.g., by racial and ethnic subpopulations or by individual behaviors or characteristics). Attention must be given to the integrity of the data collection process and to the scientific approach of collecting that data as a means for documenting the health status and needs of affected communities. Developing collaborative relationships with and among institutions that collect data on minorities and underserved populations is key to ensuring that they provide data in readily accessible forms and that they include all health disparity populations.

Similarly, there is a need to invest in community-based participatory research and community-originated intervention strategies as a means for developing capacity at the local level. Thousands of programs have been initiated, yet most are not evaluated effectively to determine whether they worked, for whom, and in what way. We cannot build on and improve local and other efforts if we do not understand what works. All programs must have the capacity to conduct basic evaluation that can add to our understanding of how to eliminate disparities. Conducting evaluations in small communities and subpopulations has frequently been a challenge. Smaller communities often do not have the means to collect baseline data and then perform follow-up data collection to measure the results of their interventions and activities.

Research coordination is a critical strategy. There is a particular need for cooperative and coordinated interdisciplinary research that can understand the complex interplay of issues related to health disparities (e.g., the underlying causes of disparities, including racism). Researchers from different disciplines and communities are often unaccustomed to working collaboratively. Furthermore, the inability to agree on the definitions of the problem, its causes, or the appropriate research methodology can inhibit progress. Without coordination and cooperation at all levels (from local communities to academia), identification and implementation of successful solutions are compromised.

Knowledge transfer is challenging but obligatory. Often, findings that may be valuable to communities are published in journals, reports, and other formats that are not widely distributed to them or easily accessible to non-research audiences. Non-traditional media should be used to disseminate data and information to improve accessibility. Improving the health outcomes of minority and underserved communities will take the combined efforts of medical scientists, statisticians, anthropologists, economists, sociologists, epidemiologists, policy analysts, psychologists, social workers, community developers, and others working in collaboration with community organizations.

The four strategies below address the goal of data, research and evaluation through strategies based on data; community-based research and action, and community-originated intervention strategies; coordination of research; and knowledge transfer. For each strategy there is a menu of objectives, measures, and potential data sources, which are tools for stakeholders to use in implementing any given strategy.

GOAL 5: DATA, RESEARCH, AND EVALUATION

Improve data availability, and coordination, utilization, and diffusion of research and evaluation outcomes

STRATEGY 17: DATA

Ensure the availability of health data on all racial, ethnic, and underserved populations

OBJECTIVES[a]	MEASURES[a]	POTENTIAL DATA SOURCES[a]
1. Promote inclusion of data on race, ethnicity, gender, primary language, disability status, and sexual orientation or gender identity on federally and privately conducted or supported healthcare or public health program, activity, or survey 2. Develop and evaluate a framework and standards (e.g., security safeguards) for information management and sharing among systems and policy organizations on the collection, reporting, and use of race-, ethnicity-, health disparities-, and health equity-related data 3. Establish, support, and disseminate information about publicly available surveillance systems to track the causal, contributory, or protective impact of cultural, linguistic, environmental, and socioeconomic factors on health 4. Improve current data collection systems and efforts to increase the accuracy and consistency for how data about race, ethnicity, effects of racism, and categorization of people are gathered, analyzed, reported, and used 5. Increase and improve the inclusion of community stakeholders, particularly from racial and ethnic minority populations, in all aspects of the research and evaluation process 6. Incentivize reporting of quality of care data that can be stratified according to race, ethnicity, primary language, gender, and socioeconomic status	1. Number, accessibility, and use of health information and surveillance systems that adequately represent the conditions experienced by and facing diverse local communities 2. Number of state and federal health disparity-related reports that include cultural, linguistic, environmental, and socioeconomic factors 3. Development and legitimization of improved research designs for assessing health disparities and equity, including the inclusion of community stakeholders, particularly from racial, ethnic, and underserved populations, in all aspects of the research process 4. Distribution and type of organizations in the private, public, and nonprofit sectors, including insurers, that adhere to a common set of standards for data collection and data use, such as the collection of race, ethnicity, and language data 5. Number and distribution of community-level users of publicly available data sources (e.g., track number of unique hits for state data and possibly the number of reports generated from use of the data)	1. Centers for Disease Control and Prevention's Youth Risk Behavior Surveillance System 2. Health-related journals (e.g., American Journal of Public Health, Health Services Research)—content analyses of articles, studies, and information published 3. Center for Health Care Strategies 4. National Center for Health Statistics 5. Health Research and Education Trust and Kaiser Permanente Partnership Group's publications and policies about collection of race and ethnicity data 6. State Departments of Public Health and other state agencies 7. www.gaydata.org

[a] The objectives, measures, and potential data sources do not directly correlate to each other, but to the strategy to which they are connected.

GOAL 5: DATA, RESEARCH, AND EVALUATION

Improve data availability, and coordination, utilization, and diffusion of research and evaluation outcomes

STRATEGY 18: COMMUNITY-BASED RESEARCH AND ACTION, AND COMMUNITY-ORIGINATED INTERVENTION STRATEGIES

IInvest in community-based participatory research and evaluation of community-originated intervention strategies in order to build capacity at the local level for ending health disparities

OBJECTIVES[a]	MEASURES[a]	POTENTIAL DATA SOURCES[a]
1. Identify and work with community-based organizations and programs to determine and disseminate replicable best and evidence-based practices for ending health disparities	1. Number and type of community- originated interventions and programs identified and evaluated and application of community-generated evaluation metrics	1. Survey of community-originated interventions and programs
2. Work with researchers and evaluators to develop useful and practical models for evaluating community- originated intervention strategies, including new metrics from interventions that reflect communities' immediate needs	2. Number and funding amount of research and evaluation grants and contracts for community-based, health disparities interventions and programs	2. Local, state, tribal, and federal health agencies and health foundations (e.g., National Institutes of Health, Centers for Disease Control and Prevention, Center for the Advancement of Health Disparities Research, Robert Wood Johnson Foundation, The California Endowment, W.K. Kellogg Foundation, Health Resources and Services Administration)—review of budgets to determine proportion of funds allocated for evaluation
3. Engage community members and enhance their capacity to be equal partners in the conceptualization, planning, design, implementation, interpretation, evaluation, and dissemination of public health interventions, programs, and initiatives	3. Number of new community-originated models published in the academic literature	3. Major health journals (e.g., American Journal of Public Health, American Journal of Community Psychology, Journal of Health Care for the Poor and Underserved)
4. Strengthen community ownership of data and research and evaluation products by promoting the principles of community-based participatory research	4. Increased funding of community-based participatory research that addresses health disparities and health equity (ensure community members are engaged in the planning, design, evaluation, and dissemination of public health education, programs, disease prevention, and emergency preparedness)	4. Community-College/University Partnerships for Health
5. Integrate Title VI-compliant protocols into requests for research proposals and funded projects to ensure non-discriminatory practices	5. Number of sustained academic/research-community partnerships that adhere to community-based participatory research standards	5. Survey of local, state, tribal, and federal health agencies and health foundations to determine their support of community-based participatory research practices and community learning processes and training
	6. Number of agencies and health funders that support community learning processes to help community members interpret, use, and discuss research and evaluation findings in equity plans for their community	

[a] The objectives, measures, and potential data sources do not directly correlate to each other, but to the strategy to which they are connected.

GOAL 5: DATA, RESEARCH, AND EVALUATION

Improve data availability, and coordination, utilization, and diffusion of research and evaluation outcomes

STRATEGY 19: COORDINATION OF RESEARCH

Support and improve coordination of research that enhances understanding about, and proposes methodology for, ending health and healthcare disparities

OBJECTIVES[a]	MEASURES[a]	POTENTIAL DATA SOURCES[a]
1. Improve integrated and cross-disciplinary research to understand the reasons for systemic and continuous disparities in targeted health conditions 2. Evaluate best practices through research or practice-based evidence in order to identify practices or policies that have improved health outcomes and reduced health disparities 3. Encourage community-based participatory research that is inclusive of stakeholders from communities that have been historically excluded 4. Develop teaching modules that educate researchers and communities on how to develop and implement successful collaborative, health promotion and prevention research projects that address health disparities and comply with Title VI requirements	1. Increased funding of research projects, especially integrated and cross-disciplinary research projects, on health disparities and systemic barriers to health equity 2. Number and type of evidence-based best practices evaluated, disseminated, and applied 3. Increase in joint funding and co-sponsorship of health disparities research by private sector and state, tribal, and federal governments on health disparities research 4. Application of cross-training modules that educate researchers and communities about critical factors that need to be addressed in health disparities research	1. National Institutes of Health, Centers for Disease Control and Prevention, State Departments of Health, major health foundations (e.g., Robert Wood Johnson Foundation, The Commonwealth Fund), and professional associations (e.g., American Diabetes Association, American Heart Association) 2. Office of Minority Health Resource Center, Centers for Disease Control and Prevention (e.g., compendium of promising or evidence-based practices), and annual conferences of professional associations (e.g., American Evaluation Association, American Public Health Association) 3. Survey of published research in health and related fields to determine private-public sponsorship and authorship

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[a] The objectives, measures, and potential data sources do not directly correlate to each other, but to the strategy to which they are connected.

GOAL 5: DATA, RESEARCH, AND EVALUATION

Improve data availability, and coordination, utilization, and diffusion of research and evaluation outcomes

STRATEGY 20: KNOWLEDGE TRANSFER

Expand and enhance transfer of knowledge generated by research and evaluation for decision-making about policies, programs, and grant-making related to health disparities and health equity

OBJECTIVES[a]	MEASURES[a]	POTENTIAL DATA SOURCES[a]
1. Facilitate the efficient translation and dissemination of culturally and linguistically appropriate interventions, as required by Title VI, that have been shown to improve health 2. Provide training and technical assistance to community stakeholders on the use, interpretation, and transmission of data 3. Provide training and technical assistance to providers, researchers, and evaluators to comply with Title VI requirements and to appropriately engage communities 4. Provide training and technical assistance to professional associations, foundations, advocacy groups, and community organizations on how to interpret and use research and evaluation findings to inform their decisions and programs 5. Promote, as a standard of practice among researchers and evaluators and their sponsors, strategies to make findings accessible, easily understood, and used by policymakers and the public to inform programming and services	1. Distribution and application of standard training and technical assistance materials on data-driven decision-making 2. Degree to which promising community practices are adopted by state, tribal, and local agencies and nonprofit organizations 3. Application of knowledge about use of data, research and evaluation findings, and community engagement in the design or improvement of programs to eliminate health disparities 4. Degree to which research and evaluation findings are used in decision-making about policies, procedures, and practices to eliminate health disparities by policy¬makers, funders, advocates, and community leaders	1. Office of Minority Health Resource Center's Capacity Building Division 2. Agency for Healthcare Research and Quality's Knowledge Transfer/Implementation Program 3. Grant submissions in response to requests for proposals distributed by federal and state agencies to eliminate health disparities

[a] The objectives, measures, and potential data sources do not directly correlate to each other, but to the strategy to which they are connected.

SUMMARY

This section provides a series of twenty charts to highlight the twenty stakeholder-developed strategies that were developed via the collaborative, grass-roots process that is described in detail in Section 1. These strategies are linked to the five NPA goals and offer a menu of options for individuals, organizations, and partnerships that seek to eliminate health disparities. The following final section outlines an approach for implementing and evaluating these community- and stakeholder-generated strategies.

Approach to operationalizing and evaluating the *National Stakeholder Strategy*

In general, there is broad agreement that no one sector can address complex issues independently and that cohesive action is a critical component for driving meaningful change. However, the existence of a national strategy that has been collaboratively developed does not in and of itself lead to the achievement of intended outcomes. Success will be dependent upon the ability of stakeholders across sectors and levels to implement and refine the national strategy and to assess progress over time.

> "What can individuals do? Individuals can change the world . . . "
>
> – Sir Michael Marmot

Operationalizing the *National Stakeholder Strategy* will take time, involve many people, and require collaboration and support. Throughout the activities for developing the Strategy, stakeholders made clear that they are ready to work together and asked for support to continue the conversations initiated in their regions and communities about ending health disparities. These requests also correspond with Congressional language which called for a national strategy for eliminating health disparities that is implemented and monitored in partnership with state and local governments, communities, and the private sector.

This section builds on the requests from stakeholders and Congressional language. It provides an implementation framework for bringing leaders together through health equity councils and how the councils can use the information from Section 3. The intent is to facilitate the ability of communities and other stakeholders to operationalize the *National Stakeholder Strategy* based on their needs and within their spheres of influence. While the ultimate goal is to reduce health disparities, the *National Stakeholder Strategy* also provides the unique opportunity to reduce duplication of efforts and improve outcomes through coordinated action, engagement of sectors beyond health, pooling of resources, and creation of new and innovative partnerships.

How Do I Get Involved In Implementing the NPA?

- Request the NPA Toolkit http://www.minorityhealth.hhs.gov/npa/
- Call 1-855-JOIN-NPA (855-564-6672)
- Visit the NPA Web site http://www.minorityhealth.hhs.gov/npa/

As the health equity councils come together, the approach embodied in the implementation framework will be further developed into a plan that outlines reasonable expectations, opportunities for collaborative decision-making, and a "doable" path forward.

Communities of stakeholders do not have to wait for the health equity councils or the implementation plan. There are immediate actions that individuals, communities, and organizations can take to engage with the NPA:

- Access the **NPA Toolkit** on www.minorityhealth.hhs.gov/NPA/ for information about the NPA, specific health disparities, materials on related issues, and creating action in communities; to link with organizations and resources for addressing health disparities; identify promising practices; learn ways to share activities currently underway to address health disparities; and provide feedback.
- Call **1-855-JOIN-NPA** to receive the NPA Toolkit; request data and resources tailored to a specific community; be connected with national or local experts who can speak about the NPA and health disparities; and receive technical assistance with implementing strategies at the community level.

GUIDING CONCEPTS AND THE IMPLEMENTATION FRAMEWORK

A set of key concepts are required for effectively guiding stakeholders throughout the process of acting on the *National Stakeholder Strategy* and monitoring their progress. They include:

- **LEADERSHIP:** Organizing or using existing groups at multiple levels for ensuring continued communications, providing leadership, facilitating coordination and partnership, and driving accountability. These groups must be capable of managing broad participation, coalescing wide-ranging actions, and creating change.
- **OWNERSHIP:** Incorporating actions that support ownership of the *National Stakeholder Strategy* by stakeholders at all levels, are inclusive, and improve alignment across sectors
- **PARTNERSHIP:** Fostering and creating new, more meaningful partnerships by leveraging existing partnerships and resources
- **CAPACITY:** Improving opportunities for individuals and organizations to participate by building capacity for all to contribute
- **COMMUNICATION:** Creating and supporting effective mechanisms for sharing information often, managing communications, and routinely celebrating success

These concepts are embodied in the five goals and 20 primary strategies described in Section 3. Collectively, they support stakeholder participation that is inclusive, operationalizes the *National Stakeholder Strategy*, promotes development of partnerships, facilitates communications across a complex network of individuals and organizations, and creates opportunities for monitoring progress.

The guiding concepts and *National Stakeholder Strategy* will be operationalized through voluntary multi-sector regional councils that can provide leadership, ensure continued information flow, and galvanize action. This coordinated approach will help ensure that all sectors are motivated to: (1) develop and implement measurable actions that address the NPA goals, strategies, and objectives within their areas of need, influence, and expertise, and (2) develop partnerships and coordinated efforts outside their areas of influence and expertise.

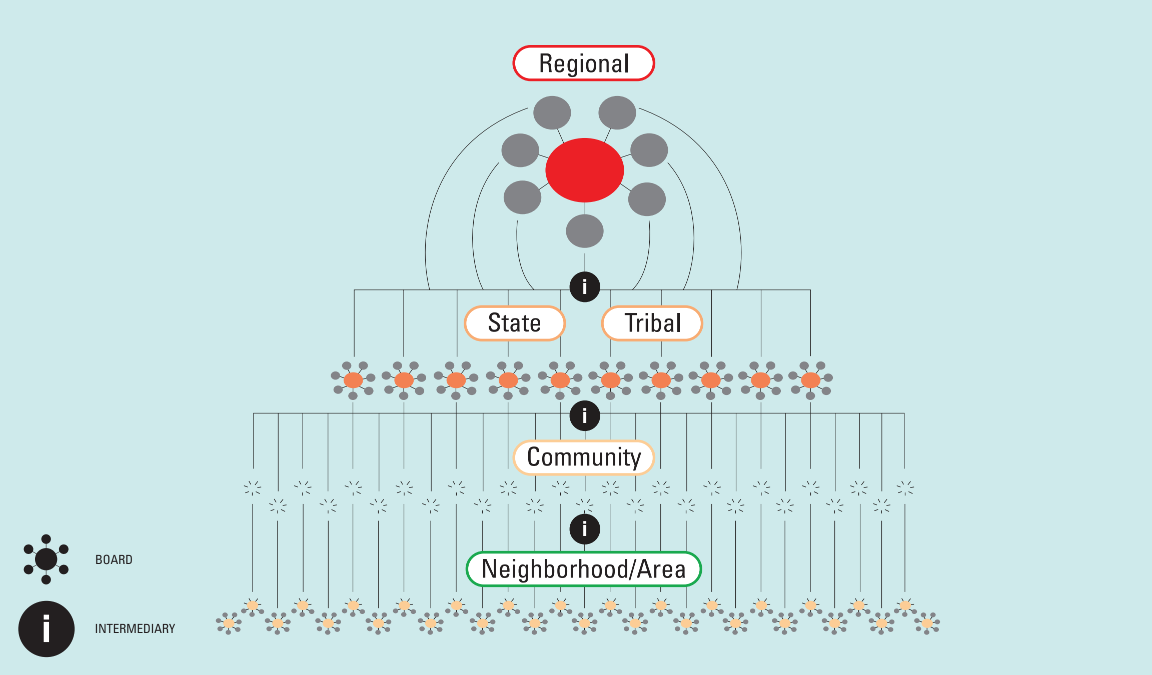
APPLYING THE IMPLEMENTATION FRAMEWORK

As described below, each of the guiding concepts will be aligned to goals and strategies to ensure the *National Stakeholder Strategy* has the most profound and efficient influence on producing far-reaching and sustained changes.

Leadership

Exhibit 4-1 depicts a leadership framework for operationalizing the *National Stakeholder Strategy*. The framework supports a view that all groups can share leadership and act as equal, cooperative partners. It models leadership where ideas and actions flow within and across levels and assume shared responsibility for collective, coordinated action.

Exhibit 4 1: Structural Model of Implementation



General Responsibilities of Regional Councils

- Serve as a body of experts for driving a collaborative health equity agenda
- Use inclusive stakeholder input to refine priority strategies
- Support and collaborate on projects of mutual benefit
- Provide lateral, cross-boundary leadership and partnerships
- Monitor and assess progress
- Assure accountability and drive sustainability

The framework includes the establishment of 10 Regional Health Equity Councils that correspond with the 10 HHS regions. The Councils will address health disparities improvement actions for their geographic areas and work to leverage resources, infuse NPA goals and strategies into policies and practices, and share stories and successes with broad constituencies. The Councils will include individuals from the public and private sectors and represent communities impacted by health disparities, state and local government agencies, tribes, healthcare providers and systems, health plans, businesses, academic and research institutions, foundations, and other organizations.

The Regional Health Equity Councils will function independently of each other to ensure that issues, strategies, and required actions are applicable to the communities in the states that the Councils represent. Some of their most critically important tasks will focus on lateral leadership (i.e., cross-boundary leadership that involves individuals and/or organizations over whom the health equity councils have no control). This type of leadership is collaborative and allows members to share common objectives and strategies, responsibility, mutual investment, and accountability for progress. Creative and informed leveraging of resources and partnerships will drive efficiencies by minimizing duplication and missed opportunities. It is anticipated that this multi-dimensional and multi-level cooperative leadership structure will lead to the natural emergence of "enlightened leadership" which can, in turn, align stakeholders and foster the goals of the NPA.

Ownership

To make the *National Stakeholder Strategy* a living document, stakeholders must decide together the actions necessary to move forward. Such participatory processes allow people to learn from one another, share their successes and challenges, feel ownership over the process and activities, challenge individual ideas and beliefs, and collectively create something better.

Ownership at the community level. Including individuals representing communities in the Regional Health Equity Councils is optimal for ensuring that strategies reach, are appropriate for, and are influenced by people at the grassroots level. It also reflects one of the NPA's guiding principles mentioned in Section 1:

Community Engagement. Establishing opportunities for engaging communities recognizes the value of individuals and brings them "to the table;" allows application of national actions in more pragmatic ways; enhances capabilities and knowledge; improves alignment on issues of importance within communities; and expands the number of people engaged and working on common objectives. It is anticipated that including participation of community representatives will catalyze and organize the discussions that are currently taking place.

National Stakeholder Strategy Approach to Fostering Ownership

- Leverage stakeholder leadership
- Encourage broad participation
- Promote partnership development
- Facilitate bi-directional information flow and communications
- Enhance alignment of efforts across sectors
- Establish accountability for progress

Ownership within health equity councils. While the Regional Health Equity Councils interact with one another, they also define themselves independently. Each group has the flexibility to define its participants' roles and responsibilities, assume ownership for advancing the national strategies and actions, and determine its appropriate functions. Flexibility is of paramount importance to the success of the implementation process. It allows the use of existing infrastructure and leadership that may be most suited for ensuring success, as well as opportunities for leveraging other related efforts.

Ownership and cooperation across health equity councils. Some of the most critically important tasks of the Regional Health Equity Councils will focus on lateral leadership and partnerships (i.e., cross-boundary leadership and partnerships that involve individuals and/or organizations over whom the councils have no control). This type of leadership is collaborative and allows members to share common objectives, strategies, responsibility, investment, and accountability for progress.[10] Creative and informed leveraging of resources and partnerships will save money and drive efficiencies by minimizing duplication and missed opportunities.

Partnership

Another important avenue for organizing and providing leadership in support of the *National Stakeholder Strategy* is through partnerships. It is the power of partnerships that will keep our communities healthy. In a context of increasing demand, and increasingly limited resources, partnerships are not simply making the system more efficient; they are making it better. As described below, partnership principles will be aligned to goals and strategies to maximize individual and organizational expertise and influence, engage change agents, and pool resources to effect national change.

1. **Awareness:** Since community partnerships engage a diverse cross-section of organizations that represent health and human service institutions, nonprofit agencies, government, businesses, educational institutions, community- and faith-based organizations, they have the potential to reach a wide range of populations. By using organizational networks, media outlets, and educational approaches, partnerships have the ability to increase awareness of issues in a profound way.

2. **Leadership:** Leadership is the most often reported internal or organizational factor that helps partnerships create effective systems change.[301] Collaborative leaders broadly share power to set priorities, identify and use resources, and evaluate partnership performance.[302] A partnership must model collaboration and diversity, create the conditions that make principled leadership possible, and foster the emergence of capable, visionary leaders. Leaders must have community interests at heart and must be able to effectively share their vision for a better, healthier nation.

3. **Health and Health System Experience:** When healthcare systems and providers from many disciplines are involved in partnerships, they learn the value and satisfaction of providing their professional expertise and skills within an appropriate context. They can increase their understanding and respect for unique cultural circumstances and can provide useful care, guidance, and instruction as needed. Likewise, by having members of racial and ethnic minority and other underserved communities represented in a partnership, the health system experience, communication patterns, and education activities can be tailored to better meet the health needs of the targeted community.

4. **Cultural and Linguistic Competency:** All partner organizations need to help one another communicate effectively with diverse populations that have varying cultural needs, levels of health literacy, and/or English proficiency.

Steps for Building Effective Health Equity Partnerships

1. Analyze health disparity and health equity issue(s) on which the partnership will focus
2. Create awareness of issue(s)
3. Convene partnership to conduct initial planning (create vision, mission, and goals)
4. Recruit the lead agency and diverse organizational partners
5. Develop resources and funding for partnership
6. Create partnership infrastructure and procedures
7. Elect leadership and identify key staff
8. Create a partnership action plan
9. Sustain activities by actively engaging partners
10. Continuously improve the partnership through evaluation

6. **Research and Evaluation:** The research and evaluation component helps determine whether the partnerships and their activities are sustainable over time. Evaluation improves implementation of strategies or identifies better approaches, increases awareness and support, informs policy decisions, and contributes to the scientific understanding of what works.[303] Participatory and qualitative evaluation methods increase understanding about how and why initiatives work.

It is important that all partnerships be relationship-based, actively nurtured and managed, purposeful and specific, sustainable, and loyal to the core mission and goal of each contributor. In order to thrive, partnerships must be dynamic and responsive to culture, racial and ethnic diversity, customs, and to the ways people usually work together in the community, region, or state. Based on experiences of successful health coalitions, key steps for building effective health equity partnerships can help partners build consensus and actively involve diverse organizations that are positioned to address health disparities.

Capacity

Capacity can be defined as the ability of individuals, organizations, and groups to perform functions, solve problems, and set and achieve objectives in a sustainable manner. As stakeholders seek to implement the *National Stakeholder Strategy*, problems may arise because of gaps in human resources, financial resources, or training; a limited sense of ownership of the processes; dependency on external resources; and inadequate considerations of broader social determinants of health. Capacity building strategies will help address these challenges through the steps below, which are based on a proven process for building capacity at the individual and organizational level. They are intended to be implemented in an ongoing manner to ensure relevancy, responsiveness, efficiency, and effectiveness.

1. **Identify resources to build capacity**, which may include tools, training, and/or direct financial resources to provide assistance in areas such as leadership, program and financial management, assessment and evaluation, grant-writing, and sustainability. In addition to existing efforts to develop, test, and catalog resources, stakeholders can help identify resources they have found to be effective in efforts to reduce health disparities and can often serve as technical assistance providers for each other.

2. **Assess needs and identify required capacity building support** by using assessment tools tailored for use with groups addressing health disparities and health equity. Such tools help groups identify gaps, identify priorities and importance, identify the root causes of performance problems, and identify possible solutions (based on the resource identification activity outlined above).

3. **Leverage capacity development investments** at the local, state, and national levels that may be hindered by requirements, turf issues, and budget limitations. Strategies to improve stakeholder access to existing resources will focus on identifying and sharing information about investments and coordinating efforts within and across stakeholder groups through, for example, joint training events or joint funding announcements.

4. **Build individual capacity** by empowering individuals through access to information, inclusion and participation, and accountability. For example, one key strategy will be to develop youth as future leaders by helping them gain the ability and authority to implement change as key players in health equity council efforts to implement the *National Stakeholder Strategy*.

5. **Build organizational capacity** to carry out day-to-day activities to reduce health disparities but also to develop the capacity to learn and change in response to changing circumstances. Support for implementation of the *National Stakeholder Strategy* will include developing leaders through training, coaching, and facilitation; improving program and process management through an action toolkit and best practice compendiums; and creating and sustaining partnerships and linkages through shared stories and strategic partnership models.

Communication

Effective communication will foster greater efficiency and effectiveness across multiple sectors and levels as they operationalize the *National Stakeholder Strategy*. Key strategies will focus on the following steps:

Communication Goals of the *National Stakeholder Strategy*

- **Increase awareness** among key audiences of the significance of health disparities, their impact on the nation, and the actions necessary to achieve health equity.
- **Help partners promote and address** the goals by making them a priority and sharing information within their individual networks to broaden diffusion of information.
- **Ensure cohesion** in all communications and coordination between and among the leadership groups and their partners.
- **Foster effective communication and sharing of information** by creating dynamic feedback loops between the leadership groups to share relevant activities, policies, emerging issues, priorities, and evaluation/best practices.

1. **Building communications capacity** by equipping leaders to communicate about the *National Stakeholder Strategy* and the importance of ending health disparities through a core set of messages and a toolkit that partners can tailor and use in their own outreach and implementation.

2. **Developing materials** to disseminate messages, keep partners and the public updated, assist with implementation, and keep stakeholders engaged. Materials such as promising practice highlights, data briefs and fact sheets, and lists of resources and organizations addressing these issues can be shared through a dedicated website, E-newsletter, and social media strategies.

3. **Recruiting and engaging partners** to provide the infrastructure needed to increase awareness, drive action, and ensure accountability. Strategies may include messages and materials to support outreach and recruitment, partner engagement through electronic media and sharing of stories, and partner recognition through endorsements or award programs.

4. **Leveraging local, regional, and national media outlets** by using information technology and traditional and new media approaches such as op-eds, feature stories, case studies, and panels discussions to reach a multi-tier audience—including racial and ethnic minority communities, youth, young adults, older persons, persons with disabilities, LGBT groups, and geographically isolated individuals—to encourage action and accountability.

5. **Conducting a public information campaign** that in addition to the launch event for the *National Stakeholder Strategy* may include regular town-halls/informational meetings, coordination with National Minority Health Month and other relevant celebrations, a 12- month anniversary event, and new research with partners to gauge awareness or changes in awareness.

EVALUATING THE *NATIONAL STAKEHOLDER STRATEGY*

As mentioned previously, the NPA consists of three components of which the *National Stakeholder Strategy* is one component. The information provided here about evaluation pertains only to the *National Stakeholder Strategy*; an evaluation design for the NPA that includes the other components will be developed in the near future.

It is not prudent to construct a complete national evaluation plan until critical portions of the *National Stakeholder Strategy* become operational. Nevertheless, a model approach is helpful in illustrating how the *Strategy* could be evaluated. This approach also makes explicit the principles that could guide the design and implementation of the evaluation. The national evaluation approach described here was developed under the guidance of a group of experts in health disparities research and in the evaluation of initiatives aimed at eliminating such disparities.

Evaluating the *National Stakeholder Strategy* is essential for three reasons. First, the "lessons learned" from developing a national evaluation will contribute to the knowledge base about what it takes to eliminate health disparities. Second, it will provide a valuable opportunity for communities to share promising practices and solutions with each other. Third, and most important, the evaluation will monitor and identify the progress and challenges facing the *National Stakeholder Strategy* in order to improve the strategies and strengthen their effectiveness, viability, and sustainability at all levels (e.g., state, tribal, regional, national).[301, 304, 305]

There is no single evaluation methodology that can address the complexities of such a comprehensive, national effort to eliminate health disparities. As evaluation proponents of comprehensive community and systems change initiatives have asserted, different methodologies will have to be combined to assess change within and across levels (e.g., state, tribal, regional, national) and sectors (e.g., education, housing, community environment).[306, 307] The evaluation will require the extensive coordination and cooperation of various data sources. It will also require building the capacity of source organizations so they can collect and report data according to the format, quality, and schedule required by the national evaluator.

Capacity building that only collects and reports data is not sufficient. A supportive strategy is also critically needed for building the capacity of regional, state, tribal, city/county, and neighborhood/area communities—so they have access to data for planning and decision making. This will involve changing the norms of some institutions to practice data-driven decision making and learning from evaluation information.

Evaluation Questions

Based on the theory of change model described in Section 3, an initial set of evaluation questions were identified by the experts who advised the development of this approach:

1. How are leaders in public agencies and in the private, nonprofit, and community sectors engaged in collaborative, efficient, and equitable working partnerships to eliminate health disparities and achieve health equity?

2. Which of the 20 strategies and their accompanying activities are being implemented at the local, state, tribal, regional, and national levels?

3. What are the impacts of the strategies and activities?

4. How well is the nation progressing toward improved outcomes that address the *National Stakeholder Strategy's* goal to eliminate health disparities and achieve health equity?

5. How much is the work to end health disparities integrated into mainstream systems, including public health?

Additional questions may be added during development of the *National Stakeholder Strategy's* evaluation plan. Further, it is likely that city/ county, state, tribal and regional agencies, as well as community and private sector organizations, will develop more questions that specifically fulfill their information needs, as they choose to conduct their own evaluations independent of the national evaluation.

Evaluation Methodologies

There are several possible methodologies for evaluating the *National Stakeholder Strategy*. Some of the methodologies may have to be combined to ensure a comprehensive evaluation that captures the complexity of the *National Stakeholder Strategy*. Some of the possible methodologies include cross-case study design, benchmarking, and longitudinal research; additional methodologies will be explored as the *National Stakeholder Strategy* is operationalized.

Cross-case Methodology

Cross-case study design (sometimes referred to as a multiple-case study methodology) is a widely accepted methodology that uses qualitative and quantitative data for studying change initiatives that are affected by events out of participants' control or implemented differently across different sites—but that may share common characteristics that contribute to the desired outcomes.[308, 309] Experts indicate that this has been a preferred method among federal agencies because of its strengths in exploring "who," "what," why," and "how" questions about a contemporary phenomenon within a real-life context.[308] The cross-case study methodology also can be useful in complementing another methodology to test a theory, and especially to uncover contextual conditions that influence a phenomenon.[308, 309] Cross-case methodology uses case studies to make generalizations by determining if similar results are consistently predicted—or if similar reasons for the results, even if contrasting, are predictable.[308]

Benchmarking Methodology

The benchmarking methodology identifies, shares, and uses best practices to improve any given action.[310] Two components are key in benchmarking: the effort to identify actions and performance that are outstanding; and transferring these best actions and performance to an organization's standards and processes.[311] Benchmarking focuses on the action steps and not strategies. Therefore, it would be part of a larger evaluation than a stand-alone methodology.

Longitudinal Research

Longitudinal research examines the relationship between certain changes (e.g., access to healthy food, improved socioeconomic status) with the anticipated outcomes (e.g., reduction in health disparities) over time. This method could be used to determine the extent to which the *National Stakeholder Strategy* contributed to the changes. Longitudinal research usually involves studying the same group of people over an extended period of time or examining historical information.

Measures of Change

The theory of change model described in Section 3 is also useful for determining the domains for the core set of measures for the national evaluation. The important first step for identifying these measures is to create common health disparities definitions and terminology to ensure uniformity at all levels and across all sectors. Once the definitions and terminology have been agreed upon, then a core set of measures can be established.

Core measures for the national evaluation should be:

- Available by race, ethnicity, education level, gender, disability, sexual orientation or gender identity, age, and other attributes that distinguish the groups affected by health disparities

- Replicable at all levels of analysis (i.e., local, state, tribal, regional, national) and across sectors (e.g., health, education, housing, business)

- Collectable across key differences such as geographic location (e.g., rural and urban areas)

Three types of measures are essential for the national evaluation, including:

1. Measures that predict changes in a person’s health behaviors or conditions (predictor measures). Examples of predictor measures are the social determinants of health such as education, income, access to transportation and other services, social stressors, and the environment. These factors have repeatedly been found to be associated with a wide range of chronic diseases.

2. Measures that examine how programs are implemented or how services are provided (process measures). Examples of process measures are partnership development, quality of collaboration, and implementation of the Blueprints for Action.

3. Measures that determine if the intended results were achieved (short-term, intermediate, and long-term outcome measures). Examples of short-term outcome measures are organizational and community capacity, leadership and public will to eliminate health disparities, resources for eliminating such disparities, and goal attainment. Intermediate outcome measures are the systems and policy changes that support ending health disparities. Long-term outcome measures are the conditions for which disparities exist. These measures can, in turn, be categorized into the following: health conditions, healthcare access and utilization, and healthcare quality and workforce.

DATA ANALYSES

All the data collected can be analyzed and presented in multiple ways to capture the complexity of the *National Stakeholder Strategy*. Some potential analyses strategies and presentations include, but are not limited to, the following:

- A health equity scorecard or index where several measures can be combined and analyzed to determine how well a local community, state, tribe, or region is progressing in their efforts to eliminate health disparities

- Policy analysis where health disparities-related policies are examined and the extent to which these policies benefit a particular group of people

- Cross-sectional analysis, which can be conducted on a particular set of short-term outcomes for a group of people during a particular point in time

- Longitudinal analysis where outcomes, such as prevalence of certain diseases, could be examined over a longer period of time to detect any changes. These outcomes can be monitored at the state, tribal, and regional levels, and comparisons made

COLLABORATION, CAPACITY BUILDING, AND USE OF FINDINGS

The ability to tell the NPA story will depend, in part, on the capacity and collaboration of groups, organizations, and governments at the community, city/county, state, tribal, and regional levels to participate in and support the national evaluation. The evaluation will have to rely, in part, on the capacity of entities at each of the aforementioned levels to collect, access, and report the data needed for the national evaluation. The evaluation should include an inventory of existing state, national and other data systems to avoid duplication of efforts. Investments will need to be made to develop a data infrastructure where there is none or enhancing existing ones, as well as to build capacity to implement these infrastructures.

Building the capacity of groups, organizations, and other stakeholders to collect and report data is not sufficient. Strategies also must be developed to build their capacity to use the findings generated by the national evaluation to inform their actions and decisions on an ongoing basis. The evaluation should include strategies for translating and disseminating findings in formats that are accessible to community groups, organizations and policymakers, and should provide guidance on how to use the findings. Additionally, statewide, regional, and national conferences provide an important venue for trainings on the national evaluation and its findings. In the final analysis, the effectiveness of the *National Stakeholder Strategy* can only be assessed with the engagement of a large and diverse group of people. This is only possible by ensuring everyone has the capacity to participate and that we work collectively to apply what is learned. The health of our nation depends on it.