



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

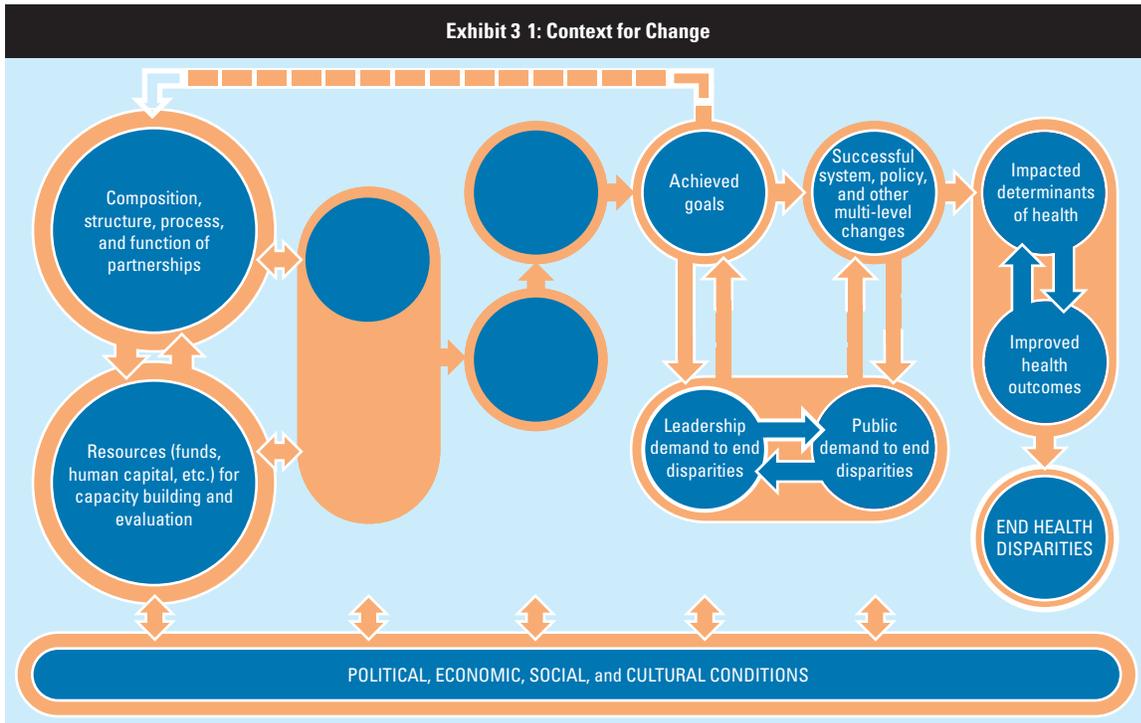
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reduction in the incidence and prevalence of health conditions and diseases for which disparities exist, and to seek the gradual elimination of the determinants that are the root causes of poor health.

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.





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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.

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*.

“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

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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.



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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, state ^b , tribal, regional, and federal healthcare agendas		
OBJECTIVES ^a	MEASURES ^a	POTENTIAL DATA SOURCES ^a
<ol style="list-style-type: none"> 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 	<ol style="list-style-type: none"> 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 	<ol style="list-style-type: none"> 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.

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<p align="center">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</p>		
<p align="center">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</p>		
OBJECTIVES ^a	MEASURES ^a	POTENTIAL DATA SOURCES ^a
<ol style="list-style-type: none"> 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 <i>National Stakeholder Strategy</i> to adopt joint actions for ending health disparities 	<ol style="list-style-type: none"> 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 	<ol style="list-style-type: none"> 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
<ol style="list-style-type: none"> 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) 	<ol style="list-style-type: none"> 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 	<ol style="list-style-type: none"> 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

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

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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
<ol style="list-style-type: none"> 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 <i>National Stakeholder Strategy</i> 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 	<ol style="list-style-type: none"> 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 	<ol style="list-style-type: none"> 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 <i>National Stakeholder Strategy</i> 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.

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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
<ol style="list-style-type: none"> 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 	<ol style="list-style-type: none"> 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 	<ol style="list-style-type: none"> 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 <i>the National Stakeholder Strategy</i> 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
<ol style="list-style-type: none"> 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 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) 3. Improve coordination of technical assistance and other resources to help community-based organizations write and submit quality grant proposals 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 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 6. Strengthen centers of excellence that focus on concerns, strategies, and solutions informed by community leaders and representatives and people affected by health disparities 	<ol style="list-style-type: none"> 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 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 3. Number, distribution, and co-funding of technical assistance and other support programs in grant writing 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 <i>National Stakeholder Strategy</i> goal 5. Degree to which data about determinants of health are required and provided in grant proposals 6. Number, distribution, and use of community-focused centers of excellence 	<ol style="list-style-type: none"> 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. National Institutes of Health’s Research Portfolio Online Reporting Tools (RePORT) 3. Grant-writing technical assistance activities sponsored by local, state, tribal, and federal agencies; foundations; and other entities 4. Requests for proposals and background, context, or rationale sections of funded proposals 5. Survey 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.

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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
<ol style="list-style-type: none"> 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 	<ol style="list-style-type: none"> 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 	<ol style="list-style-type: none"> 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}

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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.



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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
<ol style="list-style-type: none"> 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 	<ol style="list-style-type: none"> 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 	<ol style="list-style-type: none"> 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.

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<p align="center">GOAL 3: HEALTH SYSTEM AND LIFE EXPERIENCE Improve health and healthcare outcomes for racial, ethnic, and underserved populations</p>		
<p align="center">STRATEGY 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</p>		
OBJECTIVES ^a	MEASURES ^a	POTENTIAL DATA SOURCES ^a
<ol style="list-style-type: none"> 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 	<ol style="list-style-type: none"> 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 	<ol style="list-style-type: none"> 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
<ol style="list-style-type: none"> 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) 	<ol style="list-style-type: none"> 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 	<ol style="list-style-type: none"> 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.

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<p>GOAL 3: HEALTH SYSTEM AND LIFE EXPERIENCE Improve health and healthcare outcomes for racial, ethnic, and underserved populations</p>		
<p>STRATEGY 11: HEALTH COMMUNICATION Enhance and improve health service experience through improved health literacy, communications, and interactions</p>		
OBJECTIVES ^a	MEASURES ^a	POTENTIAL DATA SOURCES ^a
<ol style="list-style-type: none"> 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 	<ol style="list-style-type: none"> 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 	<ol style="list-style-type: none"> 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
<ol style="list-style-type: none"> 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 	<ol style="list-style-type: none"> 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 	<ol style="list-style-type: none"> 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.


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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
<ol style="list-style-type: none"> 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) 	<ol style="list-style-type: none"> 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 	<ol style="list-style-type: none"> 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

^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.

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.

“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

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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
<ol style="list-style-type: none"> 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 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 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 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 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 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 	<ol style="list-style-type: none"> 1. Number and distribution of health workers, by health profession 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 3. Availability and utilization of cultural humility and competency courses and modules in undergraduate and graduate health professional training degree and certificate programs 4. Improved systematic collection and documentation of consumers' primary languages and dialects and use of findings to inform planning and provision of services 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 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 	<ol style="list-style-type: none"> 1. National Center for Health Workforce and state departments of health or centers for health workforce data 2. Office of Minority Health's Cultural Competency Curriculum Modules training logs 3. Assessment of relevant professional competencies in undergraduate and graduate professional training programs through professional organizations and accrediting bodies 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. Federation of State Medical Boards, Liaison Committee on Medical Education, and Accreditation Council for Graduate Medical Education data 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.

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<p>GOAL 4: CULTURAL AND LINGUISTIC COMPETENCY Improve cultural and linguistic competency and the diversity of the health-related workforce</p>		
<p>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</p>		
OBJECTIVES ^a	MEASURES ^a	POTENTIAL DATA SOURCES ^a
<ol style="list-style-type: none"> 1. Develop a policy agenda to expand the diversity and cultural and linguistic competency of the health care workforce 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 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 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 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 	<ol style="list-style-type: none"> 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 2. Percent of health-related certificates/credentials and professional degrees awarded to members of racial, ethnic, and cultural groups 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 4. Number of internship and fellowship programs in the health field for students from different racial, ethnic, and cultural backgrounds 5. Percent of individuals from different racial, ethnic, and cultural backgrounds, by health profession and position 	<ol style="list-style-type: none"> 1. Survey of major health care organizations, accrediting bodies, health and allied health education programs, and state health agencies 2. National Center for Health Workforce Analysis Reports 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. U.S. Census Bureau—Special Equal Opportunity Employment tabulation 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
<ol style="list-style-type: none"> 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 	<ol style="list-style-type: none"> 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 	<ol style="list-style-type: none"> 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

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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.

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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
<ol style="list-style-type: none"> 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 	<ol style="list-style-type: none"> 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) 	<ol style="list-style-type: none"> 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 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		
OBJECTIVES ^a	MEASURES ^a	POTENTIAL DATA SOURCES ^a
<ol style="list-style-type: none"> 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 	<ol style="list-style-type: none"> 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 	<ol style="list-style-type: none"> 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.

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<p>GOAL 5: DATA, RESEARCH, AND EVALUATION Improve data availability, and coordination, utilization, and diffusion of research and evaluation outcomes</p>		
<p>STRATEGY 19: COORDINATION OF RESEARCH Support and improve coordination of research that enhances understanding about, and proposes methodology for, ending health and healthcare disparities</p>		
OBJECTIVES ^a	MEASURES ^a	POTENTIAL DATA SOURCES ^a
<ol style="list-style-type: none"> 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 	<ol style="list-style-type: none"> 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 	<ol style="list-style-type: none"> 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.



<p align="center">GOAL 5: DATA, RESEARCH, AND EVALUATION Improve data availability, and coordination, utilization, and diffusion of research and evaluation outcomes</p>		
<p align="center">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</p>		
OBJECTIVES ^a	MEASURES ^a	POTENTIAL DATA SOURCES ^a
<ol style="list-style-type: none"> 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 	<ol style="list-style-type: none"> 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 	<ol style="list-style-type: none"> 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 decorative graphic consisting of several interlocking puzzle pieces in shades of beige and light brown, arranged in a cluster at the top left of the page.

▶ SECTION THREE

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.