A STRATEGIC FRAMEWORK FOR IMPROVING RACIAL/ETHNIC MINORITY HEALTH AND ELIMINATING RACIAL/ETHNIC HEALTH DISPARITIES

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Preface

Although the health of all Americans has continued to improve over the more than two decades since the 1985 *Task Force Report on Black and Minority Health* was issued, racial and ethnic health disparities persist and, in some cases, are increasing. The persistence of such disparities suggests that current approaches and strategies are not producing the kinds of results needed to ensure that all Americans are able to achieve the same quality and years of healthy life, regardless of race/ethnicity, gender, and other variables (as reflected in the two overarching goals of *Healthy People 2010*).

The mission of the HHS Office of Minority Health (OMH) is to improve the health of racial and ethnic minority populations through the development of health policies and programs that will help eliminate disparities. OMH has a unique leadership and coordination role to play within the Department and across the Nation relative to this mission. However, such a mission cannot be accomplished by OMH alone. We need the active engagement and sustained efforts over time of all stakeholders working together with us and each other to effect the necessary changes at every level and across all sectors. These stakeholders include racial and ethnic minority communities and those who serve them, other HHS and Federal entities, academic and research institutions, State and Tribal governments, faith- and community-based organizations, private industry, philanthropies, and many others. We also need to examine what we are doing, identify what must be done differently, and determine how best to work together – within and across our respective disciplines, areas of interest, organizational/institutional or geographic boundaries, and spheres of influence – to enhance our individual and collective effectiveness and impacts.

The *Strategic Framework for Improving Racial and Ethnic Minority Health and Eliminating Racial and Ethnic Health Disparities* (*Framework*) presented here is intended to help guide, organize, and coordinate the systematic planning, implementation, and evaluation of efforts within OMH, HHS, and across the Nation to achieve better results relative to minority health improvements and health disparities reductions. The *Framework* is reflective of current knowledge and understanding of the nature and extent of health disparities, their causes or contributing factors, effective solutions, and desired outcomes and impacts. As such, it reinforces the importance of having and using existing science and knowledge as the basis for planning and implementing our program-, research-, or policy-oriented actions and activities. The *Framework* also suggests the need to adequately evaluate our efforts so that new knowledge gained can be used for continuous improvement. In addition, the *Framework* infers the need to fund our efforts accordingly, and to explore ways to enhance efficient use of programmatic and research funds as well as other resources and assets at our disposal.

Several aspects of this framework are worth highlighting:

(1) By using a logic model approach which builds upon current science and expert consensus about racial/ethnic minority health/health disparities and systems problems, contributing or causal factors, and strategies that work, **the *Framework* provides the rationale for efforts funded and conducted as well as for the kinds of outcomes and impacts needed**. This approach can be used as a guide to better move us in the same general direction towards a common set of objectives and goals.

(2) In addition to identifying the usual determinants of health, **the *Framework* emphasizes the role that "systems-level factors" play in promoting or inhibiting the effectiveness of strategies and practices aimed at improving racial and ethnic minority health or reducing racial and ethnic health disparities**. These systems factors include: the nature and extent of available resources and how they are used; coordination and collaboration through partnerships and communication; leadership and commitment through strategic visioning and sustained attention; user-centered design in which the products and services of the system are conceived with the needs of their users in mind; and the use of science and knowledge to inform programs and policies.

(3) Ultimately, **the *Framework* presents a vision–and provides the basis–for a "systems approach" to addressing racial/ethnic minority health problems within and outside of HHS**. A systems approach implies that all parties engaged, in this case, in racial/ethnic minority health improvement and health disparities reduction are, themselves, part of a 'system' or 'nested' systems. As such, each party considers the causal or contributing factors and problems it is most likely to be able to impact with its particular strengths and talents. Resources and assets can then be coordinated and leveraged in more systematic and strategic ways, to achieve a range of outcomes and impacts needed so that, together, all parties can more effectively and efficiently contribute to and achieve long-term objectives and goals. This focus on systems applies as well to how various fields of research work together for greater effectiveness and efficiency to address weaknesses and gaps in scientific knowledge. A systems approach to working across diverse research disciplines may be better able to illuminate our understanding about the nature and extent of minority health and health disparities problems, especially for small population groups; the relative importance of and interrelationships between causal or contributing factors; more effective ways to break the causal chain that produces greater burdens of preventable disease and premature death among racial and ethnic minorities; and the means for measuring desired outcomes and assessing progress.

We believe that the structure and approach outlined in the *Framework* offers a rational and systematic, yet broad and flexible, way of viewing and informing our efforts to achieve the OMH and, in reality, the national mission. We hope that the *Framework* will provide context for the actions needed by OMH and its partners across HHS and the Nation to better leverage resources, establish priorities for ensuring effectiveness of programs and activities funded and conducted, enable identification and promotion of best practices and concrete solutions at all levels, and serve as the foundation for a national results-oriented culture on racial and ethnic minority health improvement and the elimination of racial and ethnic health disparities.

A STRATEGIC FRAMEWORK FOR IMPROVING RACIAL/ETHNIC MINORITY HEALTH AND ELIMINATING RACIAL/ETHNIC HEALTH DISPARITIES

I. INTRODUCTION

The Challenge.–The United States is a diverse Nation. According to 2000 Census data (U.S. Census Bureau, 2000), the population of the United States grew by 13 percent over the last decade, and has increased in diversity at an even greater rate. Racial and ethnic minorities are among the fastest growing of all communities in the country, and today comprise approximately 34 percent of the total U.S. population (U.S. Census Bureau, 2006a, 2). It is projected that, by 2030, 40 percent of the population will be non-White (U.S. Census Bureau, 2004).

Data on health status point to the fact that there is significant evidence of poor health outcomes among racial/ethnic minority populations with respect to premature death and preventable disease. These poor health outcomes for racial/ethnic minorities are reflected in the pervasiveness of health disparities[1] that exist. For example:

- The prevalence of high blood pressure–a major risk factor for coronary heart disease, stroke, kidney disease, and heart failure–is nearly 40 percent greater in African Americans than in Whites (an estimated 6.4 million African Americans have hypertension); and cardiovascular and renal disease damage are more frequent and severe (HHS, 2000a, G-2). In addition, African Americans continue to experience a higher rate of stroke, have more severe strokes, and continue to be twice as likely to die from a stroke as White Americans (HHS, 2000a, G-11).

- Racial and ethnic minority groups, especially the elderly, are disproportionately affected by diabetes. On average, African Americans are 2.1 times as likely as Whites to have diabetes (NCHS, 2006a, Table 55). African Americans with diabetes are also more likely than Whites to experience complications of diabetes, such as amputations of lower extremities (CDC, 2006a) and end-stage renal disease (CDC, 2006b). On average, American Indians/Alaska Natives are 2.3 times as likely as non-Hispanic Whites of similar age to have diabetes (Barnes et al, 2005). Hispanics are 1.7 times as likely to have diabetes as Whites (Lethbridge-Cejku et al, 2006), with Mexican Americans–the largest Hispanic subgroup – more than twice as likely (NCHS, 2006a, Table 55).

- African Americans are 21 percent more likely to die from all types of cancer than Whites, adjusting for age (NCHS, 2006a, Table 29). African American men are more than 50 percent likelier to die from prostate cancer than are Whites (Ries et al, 2006, Tables I-23 and I-24). In addition, while breast cancer is diagnosed 10 percent less

[1]This paper will often use the term "health disparities" to refer to the more precise but longer term "disparities in health care and health status."

frequently in African American women than in White women (Ries et al, 2006, Tables I-20 and I-21), African American women are 36 percent more likely to die from the disease (Ries et al, 2006, Tables I-23 and I-24). In other minority communities, cancer also takes a disproportionate toll. Among Hispanics, women are 2.2 times more likely to be diagnosed with cervical cancer than non-Hispanic White women (NCHS, 2006b, Table 53). Asian/Pacific Islander women are 2.7 times as likely to fall ill from stomach cancer as non-Hispanic White women (NCHS, 2006b, Table 53), and Asian American men suffer from stomach cancer 93 percent more often than do non-Hispanic White men (Ries et al, 2006, Tables I-20 and I-21).

- Mexican American and African American mothers are more than 2.5 times as likely as non-Hispanic White mothers to begin prenatal care in the third trimester, or not receive prenatal care at all (NCHS, 2006b, Table 7).

- Among adults ages 18 to 64, nearly half of Hispanics (49 percent) and more than one of four African Americans (28 percent) were uninsured during 2006, compared with 21 percent of Whites and 18 percent of Asian Americans ((Beal et al, 2007). African Americans and Hispanics also experience differential access to a regular doctor or source of care, with approximately 43 percent of Hispanics and 21 percent of African Americans reporting that they do not have a regular doctor or source of care, compared with 15 percent of Whites and 16 percent of Asian Americans (Beal et al, 2007).

These health issues have been key public health concerns at the Federal level since the *1985 Secretary's Task Force Report on Black and Minority Health* (HHS, 1985) under then Secretary of Health and Human Services Margaret Heckler. However, data demonstrate that these disparities remain formidable challenges today. Reports of progress on the "reducing health disparities" goal of *Healthy People 2000* (HHS, 1990) showed that, in many respects, racial/ethnic minority populations have remained in relatively poor health, and continue to be underserved by the health care system. In many cases, the health gaps identified in the 1985 *Task Force Report* have grown (NCHS, 2001, 8). The need to address racial and ethnic minority health status and health disparities was reinforced in the two overarching goals of *Healthy People 2010*: to increase the quality and years of healthy life for *all* U.S. populations, and to eliminate health disparities, including those that affect racial and ethnic minorities (HHS, 2000a). The challenge for the U.S. is to adequately address poor racial/ethnic minority health status and persistent racial/ethnic health disparities at a time of rapidly increasing racial and ethnic diversity. Successfully meeting this challenge will promote the continued strength and vitality of the Nation.

OMH's Role and Responsibilities.–The Office of Minority Health (OMH) resides within the Office of Public Health and Science (OPHS), in the Office of the Secretary of the U.S. Department of Health and Human Services (HHS). Its creation was one of the most significant outcomes of the 1985 *Task Force Report* (HHS, 1985). OMH is a key player in the Federal effort to improve racial/ethnic minority health and to reduce and, ultimately, eliminate racial/ethnic disparities in health care and health status. The OMH

mission is "to improve the health of racial and ethnic minority populations through the development of health policies and programs that will help eliminate disparities"[2]. This mission statement points to the two key action areas–policies and programs–through which OMH serves as the focal point within HHS for efforts to improve racial/ethnic minority health and eliminate racial/ethnic health disparities.

While OMH is the focal point within HHS for racial/ethnic minority health and health disparities efforts, it is not the only Federal agency involved in efforts to address racial/ethnic minority health and health disparities. Within HHS, a number of agencies and operating divisions engage in extensive activities to improve racial/ethnic minority health and reduce racial/ethnic health disparities. They fund a range of racial/ethnic minority health- and health disparities-related efforts, including health services to underserved (often racial/ethnic minority) communities; community-based health education and health communication campaigns and programs; biomedical, behavioral, and social science research; and health services and community-based prevention research. Such efforts also extend outside of HHS to other public- and private-sector organizations that have a stake in improving the health of racial/ethnic minorities and addressing racial and ethnic health disparities. In spite of these efforts, there is still much room for improvement.

II. BACKGROUND ON THE *FRAMEWORK*

Purpose of the Strategic Framework.–The purpose of this strategic framework is to guide and organize the systematic planning, implementation, and evaluation of OMH and other efforts aimed at improving racial/ethnic minority health–and reducing and, ultimately, eliminating racial/ethnic health disparities. Efforts include those aimed directly at racial/ethnic minority health problems, but also those that support a "systems approach" to addressing such problems across the country. This systems approach has not been previously available in efforts targeted to racial/ethnic minority health and health disparities issues.

OMH, through the application of a strategic framework, can sharpen the focus, coordination, and dissemination of its work, as well as that of its partners inside and outside of HHS. The ultimate goal, for all stakeholders, is that individual and collective efforts on behalf of racial/ethnic minority health will be more evidence-based and will use available resources effectively and efficiently. The strategic framework provides:

- **Rationale for efforts conducted and supported**: The *Framework* can provide a rational basis for identifying and developing effective strategies, practices, and other efforts that are conducted and supported by OMH, its partners, and other stakeholders across the country. The *Framework* does this by drawing on existing science and knowledge about the nature and extent of the long-term problems that OMH must

[2]Racial and ethnic minorities encompassed in OMH's mission include Black or African Americans; Asians; Native Hawaiians or Other Pacific Islanders; American Indians and Alaska Natives; and Hispanics who may be of any race.

address; the factors that contribute to those problems; and the effectiveness of various strategies and practices in addressing those problems.

- **Support for increased quantity and enhanced quality of evaluations of the effectiveness of efforts**: The *Framework* will strengthen OMH's evaluation efforts with its grantees and other partners. Increased quantity and quality of evaluations will help OMH assess whether racial and ethnic minority health improvement and health disparity reduction efforts (funded or supported by OMH and others) are really making a difference and are producing meaningful results.

- **Basis for enhancing effectiveness and efficiency**: The *Framework* can promote the effectiveness and efficiency of efforts by OMH and others to improve racial/ethnic minority health and reduce health disparities through more coordinated and systematic actions.

Approach to Developing the Strategic Framework.–To maximize clarity, a logic model approach is employed for developing the strategic framework. Logic models originate from the evaluation field as a way to plan, implement, and evaluate programmatic efforts, and to provide the theory or rationale undergirding what is being done (HHS, 1999; Taylor-Powell, Jones, and Henert, 2002). Similarly, the *Framework* presents the rational basis for efforts related to racial/ethnic minority health and health disparities by tying together the following components typically found in logic models[3]:

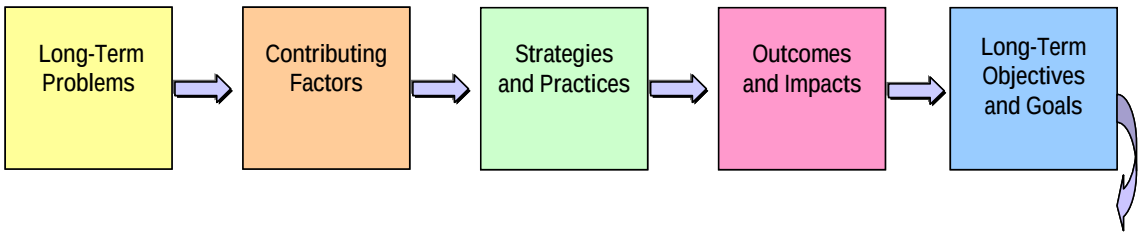
- ***long-term problem(s)*** to be addressed;
- ***factors*** that must be addressed, which contribute to the problem(s);
- ***strategies and practices***, and supporting resources, which can be mobilized to address the factors and the problems;
- ***measurable outcomes and impacts*** that can be expected to result from implementing the strategies and practices; and
- ***long-term objectives and goals*** that can be achieved by effectively producing impacts on the factors and the problems.

Figure 1 is a graphic depiction of the general structure of the strategic framework, which builds upon each of these five components.

Developing a strategic framework using a logic model development process emphasizes five steps which correspond to each of the components in Figure 1: (1) examination of the *long-term problems* that OMH and others are trying to address; (2) review of the *major factors known to contribute to or cause the long-term problems*; (3) identification

[3] Numerous sources exist for information on the use of logic models to enhance program performance. Examples include, but are not limited to, the following sources identified in OMH's evaluation planning guidelines: The Centers for Disease Control and Prevention at http://www.cdc.gov/eval/resources.htm#logic%20model; the University of Wisconsin Cooperative Extention at http://www1.uwex.edu/ces/lmcourse; and the W.K. Kellogg Foundation at http://www.wkkf.org/Pubs/Tools/Evaluation/Pub3669.pdf.

Figure 1. General Structure of the Strategic Framework



of promising, best, and/or evidence-based *strategies and practices* known to impact the causal or contributing factors; (4) presentation of measurable *outcomes and impacts* that might be expected from the strategies and practices; and (5) assessment of the extent to which *long-term objectives and goals* have been achieved.

As the components of the *Framework*–using this five-step logic model approach–were developed, extensive literature reviews and environmental scans were conducted to identify what is known–and not known–about the long-term problems, contributing or causal factors, effective strategies and practices to address the factors, and identification and measurement of expected outcomes and impacts. As necessary, targeted reviews of the literature from fields other than public health and medicine (e.g., systems research) were also carried out to inform OMH's understanding of the content needed in the *Framework*. In this way, the components and subcomponents of the *Framework* build on existing science and knowledge.

Considerations and Limitations in Developing the *Framework*.–The five-step process outlined above results in a strategic framework for addressing racial and ethnic minority health improvements and reducing and, ultimately, eliminating racial and ethnic health disparities. However, several points must be made regarding the task of identifying "best" or evidence-based strategies and practices:

- First, many strategies and practices address multiple contributing factors and may contribute to multiple outcomes and impacts. There is not a one-to-one correspondence or a strictly linear relationship between contributing factors, strategies and practices, and outcomes/impacts.

- Second, there is not adequate scientific evidence to demonstrate the effectiveness of all the strategies and practices that are considered effective. Thus, for some strategies or practices, it will be necessary to rely on expert opinion regarding what might be effective, and to continue to stress the importance of sound and systematic evaluation to determine the effectiveness of particular approaches, interventions, or activities in producing desired results.

Given these limitations and the certainty that any framework will be used within a complex, public policy and decision-making environment, this framework should be viewed as a dynamic, evolving document that provides ***guidelines for action*** rather than as a linear, predictable model for problem-solving and decision-making.

In addition, the utility of this framework does not end with the achievement of some objectives and goals. Rather, results can and should be used to inform OMH and its partners on their level of success in improving racial/ethnic minority health and tackling health disparities. Thus, any knowledge gained can be incorporated into the continuing efforts of all stakeholders. This process will help OMH, its grantees, and other partners consistently monitor and adjust program and policy efforts in ways that will result in greater effectiveness, efficiency, and success. The logic model approach used in the *Framework* and its general structure can, thus, also serve as a guide for action in a number of ways, and for a variety of public and private entities.

III. THE STRATEGIC FRAMEWORK

The *Framework* is presented in five sections, organized sequentially into the components presented in the graphic depiction of its general structure shown in Figure 1. Each component of the *Framework*, and the corresponding step toward its development, is discussed separately. The major elements within each of these sections are drawn from the literature, and briefly outlined and discussed below.

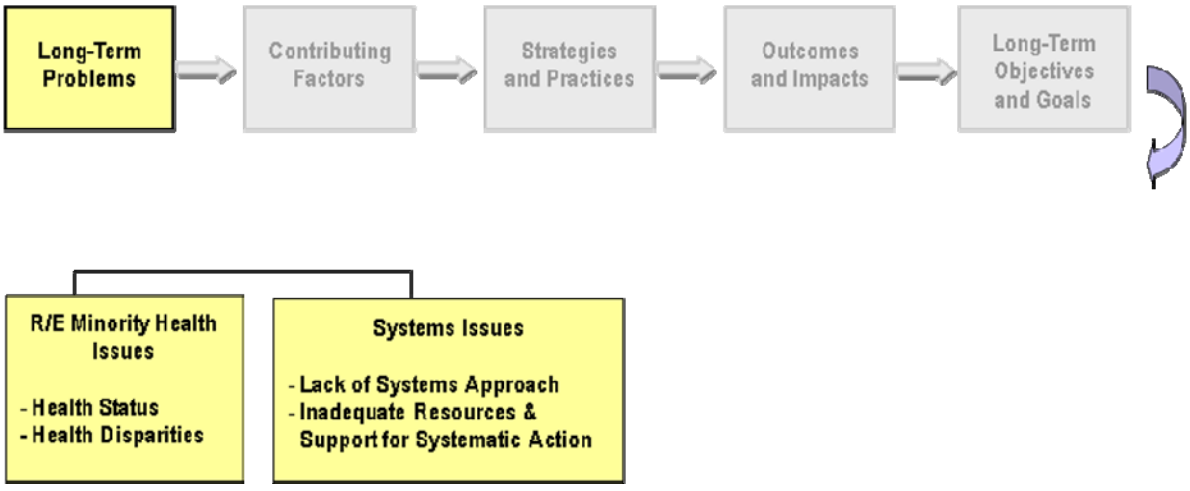
►STEP 1: BEGIN WITH LONG-TERM PROBLEMS

There are two sets of long-term problems that OMH and its partners must continue to address: (1) racial and ethnic minority health problems; and (2) systems issues that inhibit the ability to effectively impact racial/ethnic minority health problems. These long-term problems are depicted graphically in Figure 2.

- ***Racial and ethnic minority health problems*** fall into two categories: racial/ethnic minority health status and, related to that, racial/ethnic health disparities. Racial/ethnic minority health status problems encompass preventable morbidity and premature mortality experienced by racial and ethnic minority individuals and groups without reference to others. Racial and ethnic health disparities entail differences in health status and health care that often reflect a greater burden of morbidity and mortality on racial and ethnic minorities as compared to the majority population.

- ***Systems issues*** encompass a wide variety of conceptual, organizational, structural, and process-related variables that influence the ability to adequately and effectively address complex problems–and that can exacerbate these problems, or constitute problems in their own right. These variables include the availability of adequate resources to support the systems and the strategies and practices aimed at the problems and contributing factors; the extent to which systems support strategies and practices that are evidence-based as well as systematic planning and

Figure 2. Long-Term Problems



evaluation of actions undertaken; the extent to which the systems (and the strategies/practices) are well-coordinated and strategically directed; and the extent to which existing stakeholder groups are willing to work together as parts of an interconnected system. This need for a 'systems approach' and systematic actions applies broadly across all efforts conducted for the purpose of improving minority health and reducing health disparities. It also applies specifically to research and evaluation efforts to address gaps and weaknesses in science and knowledge about the nature and extent of racial and ethnic minority health problems and effective solutions to such problems.

The two racial/ethnic minority health issues–health status and health disparities–parallel and link to the two principal goals of *Healthy People 2010*. (HHS, 2000b) Thus, success in addressing racial/ethnic minority health issues will contribute to the achievement of the two central goals of *Healthy People 2010*.

►STEP 2: ADDRESS CONTRIBUTING FACTORS

Since the factors contributing to poor racial/ethnic minority health–and to racial/ethnic health disparities–are many and complex, they have been organized into three categories or levels: individual-level factors, environmental-/community-level factors, and systems-level factors.

- ***Individual-level factors*** include the knowledge and attitudes that individuals have about health risks, disease prevention, and treatment; the skills that individuals have to put knowledge into practice; the individual behaviors that have an impact on one's own health or the health of others; and the genetic factors that may enhance or reduce individual susceptibility to particular health conditions. In the graphic representation of the contributing factors component of the *Framework* (see Figure 3), individual-

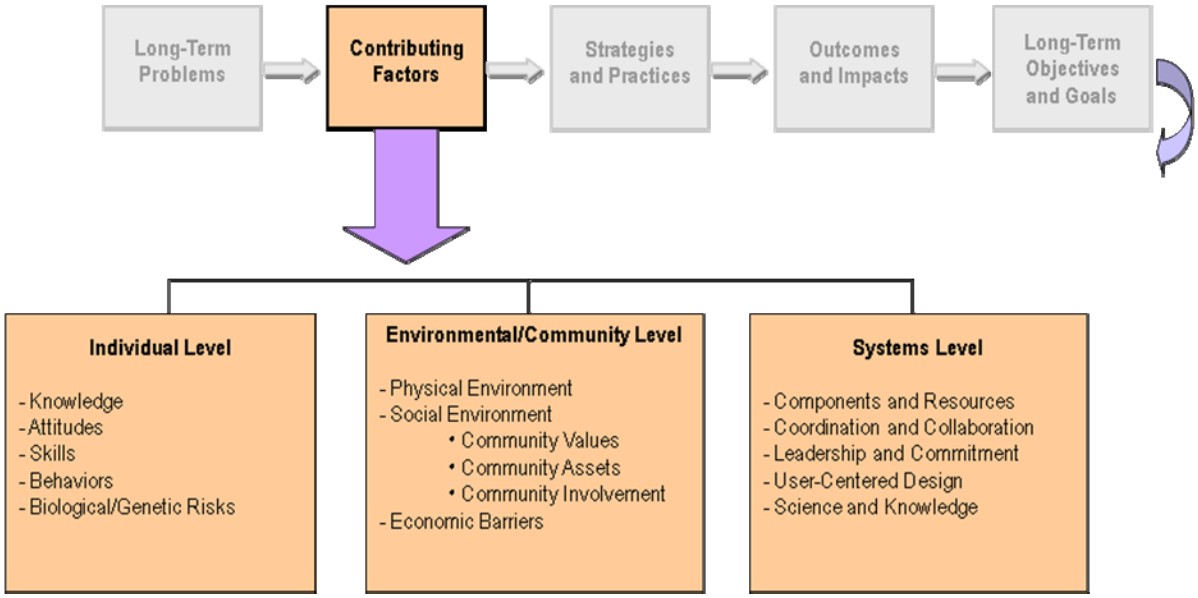
- ***Environmental- and community-level factors*** include the physical environment (both natural and built); social and cultural characteristics of a community; and other economic, political, and organizational/institutional conditions that are not generally within the control of specific individuals but provide the context of their lives. These factors may be either protective of, or pose risks to, health. Such factors include, but are not necessarily limited to: natural and physical hazards or biochemical risks; crime and violence; cultural values and norms that influence individual behavior and can protect or hinder the health and well-being of residents within communities; bias and discrimination; housing conditions and residential segregation; access to and quality of health care as well as schools, parks and recreational sites, nutritious food sources, transportation, and other goods and services; communication networks and infrastructure; family and social networks or other supports for diverse segments of the community; low-income and poverty; unemployment; and the lack of health insurance. For purposes of framework development, environmental- and community-level factors are divided into those related to the physical environment, the social environment, or economic barriers, with the social environment subdivided into community values, community assets, or community involvement (see Figure 3)[4].

- ***Systems-level factors*** include the kinds of systems that a community, State, region, or nation might have (or not have), and approaches used (or not used), for identifying the problems or needs–health-related or otherwise–in their respective jurisdictions and for directing resources to address the problems or needs. Whether such systems and approaches (including public health and health care systems and approaches) *effectively* address such problems or needs depends upon the presence or absence of certain factors that are characteristic, or key components, of systems-oriented, systematic, and strategic thinking and actions. These systems-level factors include, but are not limited to: the adequacy, appropriateness, and mix of components, resources, and assets; the effectiveness of efforts to configure, coordinate, and leverage such components, resources, and assets; the extent to which leadership and commitment are provided to direct and sustain the components and the use of resources and assets, especially as guided by a vision and a strategic plan; the nature and extent of information- and knowledge-sharing and supportive infrastructure; the extent to which systems–and the products or services provided by such systems–are designed, implemented, and evaluated with the needs of their users and beneficiaries in mind; and the continued, coordinated, and effective production of research and evaluation results that are widely shared and adopted for continuous improvement.

[4] Because these factors are so complex and interrelated, many public health and social science researchers investigate and discuss such factors in combination, rather than as the discrete categories that are shown in this particular framework. The literature (see, for example, Kawachi, Kennedy, and Wilkinson, 1999) is replete with examples of the associations between socioeconomic status (SES) and morbidity/mortality–and the significant implications of SES for health. While problems related to low SES also affect White populations, the greatest impact is on racial/ethnic minorities who are overrepresented in the lower socioeconomic categories.

As depicted in Figure 3, in the strategic framework, systems-level factors are organized into five major categories: components and resources; coordination and collaboration; leadership and commitment; user-centered design; and science and knowledge.

Figure 3. Contributing Factors



These three levels, or sets, of factors interact to form the context for considering health outcomes in general (see Evans and Stoddart, 1990; Green and Kreuter, 1999; Green, Potvin, and Richard, 1996), including those specific to racial/ethnic minority health improvement and health disparities reduction. A good example of an interacting factors model that is organized into levels or categories is the Determinants of Health Model in *Healthy People 2010* (HHS, 2000c). In this model, key categories or factors include biology, behavior, social environment, physical environment, policies and interventions, and access to quality health care. The determinants, or factors, approach to health is used herein to synthesize some of what the literature, research, and expert opinion have identified as the key factors that contribute to racial/ethnic minority health problems and disparities in health status and health care.[5]

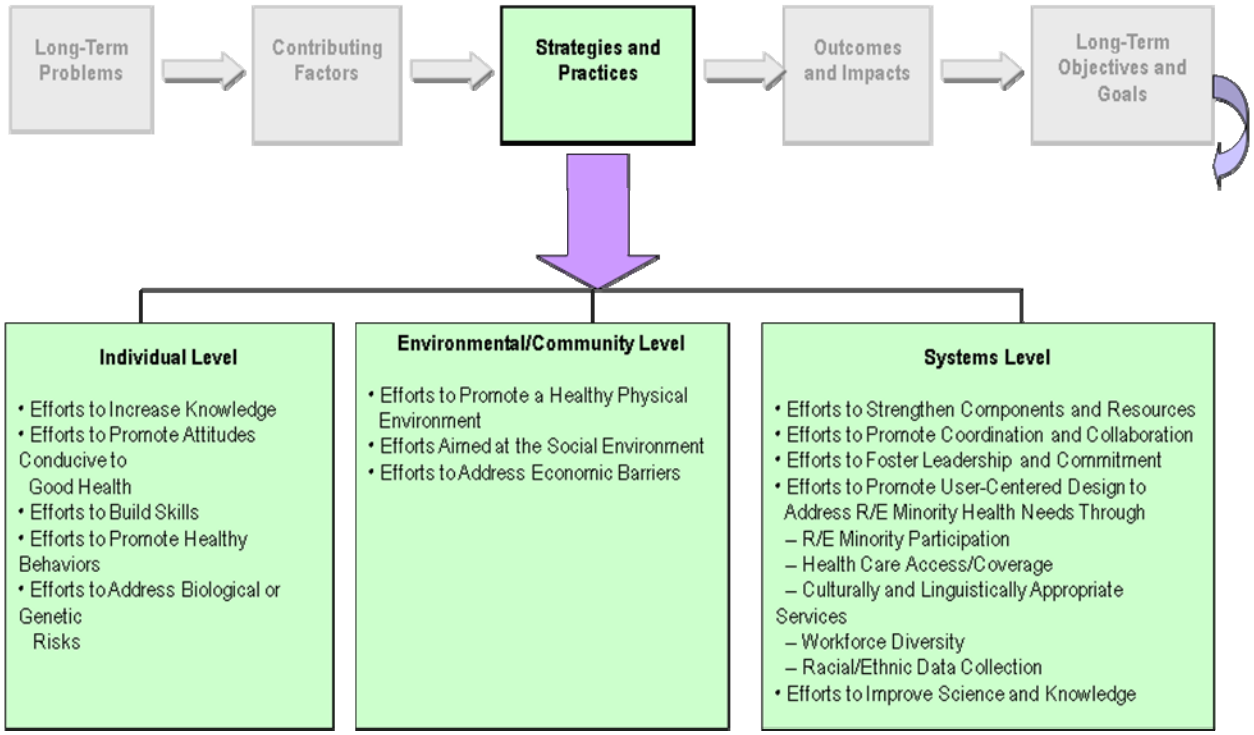
►STEP 3: SUPPORT EFFECTIVE STRATEGIES AND PRACTICES

The contributing factors identified above form the basis for the targets to be addressed by a range of strategies and practices employed by OMH and its partners. The strategies and practices discussed in this document represent what current evidence and expert

[5]Approaches to population health that describe relationships and interactions between multiple determinants of health at the individual and environmental/community levels and how they affect health or illness are sometimes referred to as "ecological models" of health.

consensus suggest to be successful in impacting contributing factors. Those strategies and practices that address the contributing factors and fit into OMH's mission are emphasized. It is important to note that many of the strategies and practices may address several factors at the same time or in sequence, rather than only one factor. A number of strategies and practices are also often effectively combined with others, in more comprehensive approaches. In a number of cases, new strategies or practices need to be developed and tested, as guided by available science and practice. Figure 4 is a graphic depiction of the necessary relationship between the strategies and practices supported and the individual-, environmental-/community-, and/or systems-level factor(s) that cause or contribute to the problem(s) to be solved.

Figure 4. Strategies and Practices



- ***Strategies and Practices to Address Individual-Level Factors***.–Approaches that address individual-level factors include efforts to increase knowledge, promote positive attitudes, and improve skills that affect decisions about health-related behavior. A broad range of informational/educational methods and materials, dissemination channels, and venues may be used (e.g., written materials, including popular and professional publications; radio and television broadcasts; computer- and web-based technologies; mass media campaigns; and one-on-one or group-oriented education, counseling, and training in schools, clinics, worksites, and community settings). With respect to biological and genetic risks, individual-level efforts include informational, screening, and counseling strategies and practices. Strategies and practices may be aimed at a variety of individuals and groups of individuals, including, but not limited to, those who are racial/ethnic minorities themselves, those

meeting some other particular characteristic (e.g, age range, gender, health literacy level) and those who interact with or serve minorities (e.g., health care providers). Effective efforts tend to reflect integrated approaches that address a combination of individual-level factors as well as their interactions with environmental factors that inhibit or support desired behaviors. In addition, health messages are more readily accepted if they do not conflict with existing cultural beliefs and practices, and take into account unique historical and cultural experiences of target audiences, including racial and ethnic minorities.

Strategies and Practices to Address Environmental- and Community-Level Factors.–The strategies and practices included in this category are aimed at those factors that extend beyond individuals, and shape the broader communities and environments within which people live, work, and play. Examples of such efforts are: (1) promotion of a healthy physical environment through the development of policies that promote public health and safety; (2) fostering of a positive social environment by nurturing community values and norms conducive to good health; strengthening community capacity and "assets" for general well-being; and/or increasing community involvement, supports, and networks (i.e., "social capital") via opportunities for civic engagement and positive social interaction that promote self-reliance, buffer stress, and otherwise protect the health and well-being of diverse members in the community; and (3) provision of health care financing and other initiatives that provide support to poor, low-income, and underserved populations (e.g., children's health insurance for low-income families, implementation of prescription drug coverage for Medicare beneficiaries). Many other program efforts have tried to link multiple community-based strategies and practices together to address the interactive nature of all of the environmental- and community-level factors influencing health.

- ***Strategies and Practices to Address Systems-Level Factors***.–A review of systems literature and a research synthesis of "effective" public health and health care systems found that effective systems aimed at complex problems have certain characteristics in common. The systems-level strategies and practices recommended in the *Framework* include efforts to:

  - **Establish, increase, and strengthen system components and resources**, such as infrastructure, staffing, and funding to ensure specific attention to racial/ethnic minority health and health disparities. This often involves obtaining resources from mixed funding streams in order to leverage assets and expand the resource base.

  - **Promote coordination, collaboration, and partnerships** to build relationships and trust; allow for pooling and leveraging of resources, expertise, and talent; and foster synergies that benefit all involved parties. Such coordination and collaboration requires strong information and communications systems and infrastructure.

- **Foster and ensure leadership and commitment**, including the development and implementation of strategic plans that provide vision and direction, set priorities, and coordinate and target resources. Ideally, strategic plans for addressing minority health and health disparities should draw on existing data on minority groups; incorporate input and feedback from community partners; build upon the best of existing and emerging evidence of successful strategies and practices; structure activities around expected outcomes and impacts tied to goal-setting processes (e.g., *Healthy People 2010*) at the State and Federal levels; and employ performance assessment and evaluation results for continuous improvement. Legislative or regulatory initiatives, executive orders, and other administrative mandates comprise another important set of strategies for ensuring sustained attention and commitment to minority health and health disparities issues.

- **Promote user-centered design to address racial/ethnic minority needs**. Racial/ethnic minorities may be disproportionately impacted by such experiences as lack of access to the public goods and services that are important for health and well-being; limited health care coverage or the inability to pay for health services; lack of trustworthiness on the part of health care and research institutions; racial/ethnic bias or discrimination; cultural and linguistic barriers; and lack of respect because of racial, ethnic, cultural or linguistic differences. Recommended strategies and practices to address these concerns include efforts that: increase participation of racial/ethnic minorities in planning, implementation, monitoring, and evaluation of programs and initiatives intended to meet their needs (i.e., community-based participation); increase health care access and coverage; increase availability of culturally and linguistically appropriate services (CLAS); increase workforce diversity; and improve the collection, analysis, and use of racial and ethnic data for performance monitoring and quality improvement purposes.

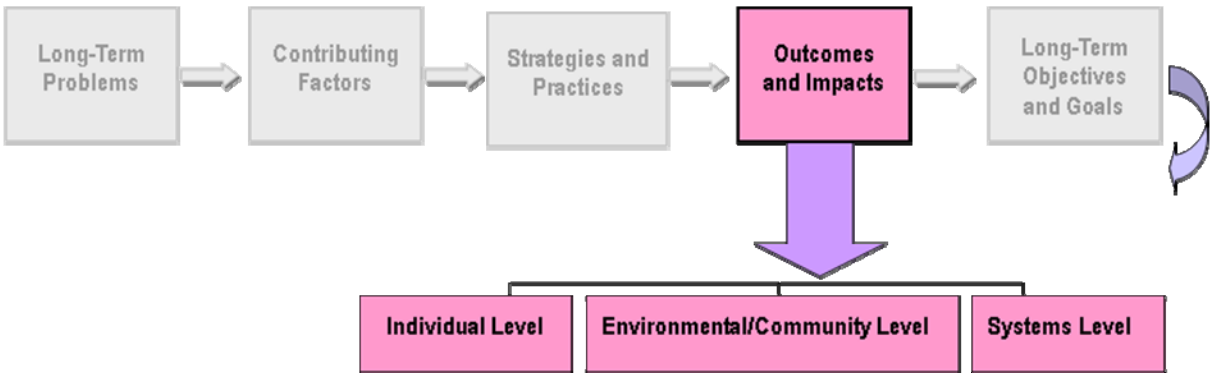
- **Improve science and knowledge about successful strategies and practices** through increased and enhanced research, demonstrations, and evaluation (RD&E). This includes RD&E efforts that strengthen knowledge and understanding about: the nature and extent of minority health/health disparities problems, especially for small or hard-to-reach populations for which data continue to be lacking; the mechanisms by, and extent to, which systems factors inhibit the ability to address minority health and health disparities; the relative importance of the various factors that cause or contribute to the long-term problems and how interactions between these factors promote or inhibit health; effective interventions that not only improve racial/ethnic minority health, but actually reduce racial/ethnic health gaps among populations; effective systems and evidence-based systems approaches to addressing minority health/health disparities problems; and effective methods for disseminating results of research, "translating research into practice and policy," and "putting practice into research" (making research results "practitioner-centered"). Transdisciplinary approaches to research which can inform more multi-faceted solutions to the long-term problems at hand are also emphasized.

► STEP 4: MEASURE INTERMEDIATE OUTCOMES AND LONG-TERM IMPACTS

This step identifies measurable **outcomes and impacts** that might be expected to take place following implementation of the indicated strategies and practices. Such outcomes and impacts relate to the contributing factors. Generally, outcomes refer to short-term results (e.g., increased awareness and knowledge about disease prevention or risk reduction) and impacts refer to long-term results (e.g., reduced morbidity or mortality). The outcomes and impacts include those for which there is actual research evidence as well as those based on expert judgment.

In many current efforts to address racial/ethnic minority health and health disparities problems, the strategies and practices have not been clearly tied to desired or intended outcomes and impacts. Nor have adequate and appropriate evaluations been performed to determine if, indeed, the strategies and practices produce meaningful results. This is a major shortcoming. It is necessary to structure future minority health and health disparity efforts so that they will be more health outcome- and impact-oriented. It is also important to determine the outcomes and impacts of systems-oriented strategies and practices on efforts to effect health outcomes and impacts. Identifying the outcomes and impacts expected from programmatic and policy-oriented minority health/health disparities efforts–as well as systems approaches to addressing minority health/health disparities issues–will inform, and be informed by, future research and evaluations. The *Framework* identifies and organizes a range of outcomes and impacts that might be expected, with reference to the contributing factors and the strategies and practices already discussed. These outcomes and impacts are organized into three categories, or levels, as depicted in Figure 5.

Figure 5. Outcomes and Impacts



A wide range of short-term, intermediate, and longer-term outcomes and impacts are possible and desirable at the individual, environmental/community, and systems levels to

move OMH and other stakeholders towards long-term objectives and goals. The desired or expected results are dependent upon the kinds of strategies and practices being planned and implemented, the factors and problems to be affected, the populations being targeted, and the settings in which interventions are taking place. Some examples of the general kinds of outcomes and impacts that might be produced by the strategies and practices are outlined below.

Individual-Level Outcomes and Impacts

- Increased awareness/knowledge about disease prevention, risk reduction, and treatment and management for racial/ethnic minorities
- Improved attitudes/beliefs conducive to health and health-seeking behaviors among racial/ethnic minorities
- Improved attitudes/beliefs among health care/human service providers and researchers conducive to meeting the needs of racial/ethnic minorities
- Increased skills for racial/ethnic minorities to adopt healthy lifestyle behaviors
- Increased skills for public health/health care providers and other service professionals to provide culturally and linguistically appropriate services (CLAS)
- Increased patient satisfaction with patient-provider communications and interactions.
- Increased patient adherence to prescribed treatment regimens
- Increased engagement in/adoption of healthy lifestyle and appropriate health-seeking behaviors; reduced engagement in/adoption of risky behaviors
- Reduced morbidity and mortality

Environmental- and Community-Level Outcomes and Impacts

- Decreased exposure to risks in the physical environment
- Increased awareness/knowledge about racial/ethnic minority health problems and racial/ethnic health disparities among racial/ethnic minorities, among public health/health care providers and service professionals, and in the general public
- Increased health-conducive changes in community attitudes, values, and norms
- Increased community assets that are protective of the health and well-being of its residents (e.g., health centers in underserved communities, neighborhood restaurants and grocers with healthy food options, faith-based organizations, gathering places)
- Increased number of active organizations and family or social networks that meet the social needs and promote the general health and well-being of racial/ethnic minority populations in the community (e.g., church groups, social clubs, recreational and after-school programs)
- Increased health care access and appropriate utilization

- Increased number of plans and policies that promote and protect health and well-being at the community, State, and national levels, in general, and for racial/ethnic minorities, in particular
- Increased engagement in/adoption of healthy lifestyle and appropriate health-seeking behaviors; reduced engagement in/adoption of risky behaviors
- Reduced morbidity and mortality

Systems-Level Outcomes and Impacts

- Increased inputs, assets, and other resources allocated for racial/ethnic minority health and health disparities–in general and for specific priorities
- Increased dedicated assets and other resources for minority health/health disparities (including, but not limited to, State offices of minority health) and related priorities (as reflected in administrative, legislative, budgetary, and other mandates)
- Increased formal partnerships and collaboration leading to coordination/leveraging of resources for greater efficiency, and enhanced effectiveness of minority health/health disparities initiatives
- Increased strategic planning and implementation of plans, with clearly articulated goals and objectives, for racial/ethnic minority health improvement and health disparities reduction
- Increased integration of evaluation, performance measurement and monitoring, and continuous improvement in planning and implementation of racial/ethnic minority health and health disparities efforts
- Increased collection, dissemination, and use of racial/ethnic data for planning, quality assurance, and performance monitoring/improvement purposes (e.g., to assess whether clinical care guidelines for specific diseases are being employed consistently and appropriately; to address health care disparities)
- Improved system design characteristics that are directed to specific racial/ethnic minority health needs, such as the need to address cultural and linguistic differences, promote trust and trustworthiness, etc. (with measures that focus on, for example, increased involvement/participation of racial/ethnic minorities or representatives in health care quality and research initiatives; increased adoption of CLAS standards by health plans; and/or increased diversity in the public health/health care workforce)
- Increased knowledge development/science base about successful strategies and practices for improving racial/ethnic minority health and reducing health disparities
- Increased dissemination and diffusion of evidence-based strategies and practice to improve racial/ethnic minority health and reduce health disparities
- Increased formal partnerships and collaboration across research disciplines leading to coordination/leveraging of research dollars and more multi-faceted approaches to impacting factors that contribute to poor racial/ethnic minority health outcomes and health disparities

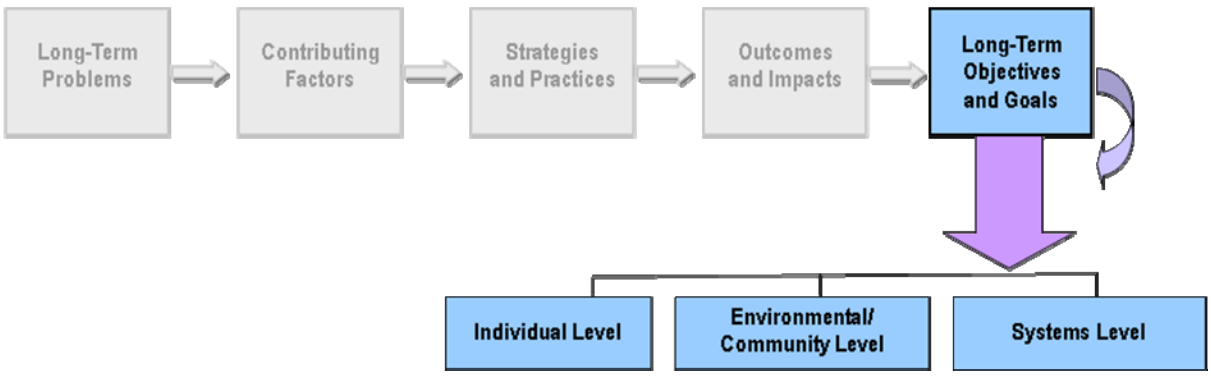
- Increased and improved outcomes and impacts at the individual and environmental/ community levels

The identification of expected outcomes and impacts is an important part of the planning, implementation, and evaluation processes needed in minority health- and health disparities-related efforts conducted or supported by OMH and its partners. Once desired or expected outcomes and impacts are identified, the process of determining performance measures or indicators of progress in achieving such outcomes and impacts can occur. With the identification and selection of performance measures or indicators of the expected outcomes or impacts, the effectiveness of the strategies and practices in producing the desired results can then be evaluated. Hence, the identification of outcomes and impacts within the strategic framework becomes the basis for identifying and developing performance measures as well as the kind of evaluation needed to promote an outcome or results orientation in the efforts being funded or otherwise supported by OMH and other stakeholders.

►STEP 5: ACHIEVE LONG-TERM OBJECTIVES AND GOALS

An important part of the strategic framework is its focus on long-term objectives and goals, including those in *Healthy People 2010*[6]. OMH, States, communities, and other stakeholders can use this framework to guide the selection of problems, factors, and strategies/practices that can be linked to short-term, intermediate-, and long-term objectives and goals, based on identified outcomes and impacts. And, as shown in Figure 6, these objectives and goals can be set, if desired, for the individual, environment/community, and/or systems level(s). With the collection of the appropriate output, outcome, and impact data, stakeholder organizations can evaluate the extent to which the objectives and goals have been attained.

Figure 6. Long-Term Objectives and Goals



[6]OMH encourages and supports efforts that contribute to the long-term objectives and goals specified in *Healthy People 2010*, especially those that are of particular relevance to racial/ethnic minority populations and systems-related priorities.

To the extent that strategies and practices result directly or indirectly in impacts on the determinants of health, and achieve health outcomes, more progress will be made toward the long-term goals of improving racial/ethnic minority health and eliminating racial/ethnic health disparities. Such efforts will necessitate a systems approach–and a concerted effort to build and deploy evidence-based practice–to promote continuous improvement based on coordinated and strategic application of the most current science and knowledge, and to mobilize the resources and talents of all stakeholders.

IV. NEXT STEPS: USING THE *FRAMEWORK* TO SUPPORT EVALUATION AND EVIDENCE-BASED PRACTICES

The *Framework* clearly identifies five steps that must be taken to ensure that strategies and practices aimed at improving racial/ethnic minority health and reducing racial/ethnic health disparities are effective. The five steps include: (1) identify the long-term problems; (2) identify the key factors that contribute to those long-term problems; (3) identify or develop strategies and practices that effectively address the contributing factors and the long-term problems; (4) identify expected outcomes and impacts and determine appropriate measures or indicators of such results; and (5) document progress in achieving agreed-upon objectives and goals. The *Framework* highlights many of the relationships between and among these five steps, and suggests a variety of ways in which the *Framework* can be used at a national, State, Tribal, regional, or local level.

While health status is the ultimate measure of health disparities, the intermediate outcomes–representing key steps along the path toward greater equity in health care and health status–must be based on the kind of rationale and model presented in this document. This is a model that explicitly encompasses the full range of multiple and complex factors that contribute to poor health for many racial/ethnic minorities and high levels of racial/ethnic health disparities. This model is unique in that it includes the need for a "systems approach" to addressing racial/ethnic minority health problems (i.e., working together as an interconnected system) and the lack of systematic planning, implementation, and evaluation of current efforts as a separate set of long-term problems that can have profound and persistent impacts on racial/ethnic minority health status and health disparities. Given their great importance, these systems issues must be addressed as problems in their own right, with attendant strategies and practices that are already proven or that need to be developed and rigorously evaluated. Improvements in systems that have population-wide scope can accelerate progress.

The strategic framework is simply structured, and its structure permits flexibility in its application by various stakeholders to different situations and for different purposes. First and foremost, the *Framework* can be used by OMH, other HHS entities, and HHS partners to focus programmatic and policy-oriented actions that are based on existing science and knowledge about the problems and contributing factors to be addressed and about strategies and practices known to be effective in producing desired outcomes and impacts. Secondly, the *Framework* can also provide the basis for a protocol to systematically evaluate OMH-funded and other activities in a way that produces more

consistent information on what grantees and others are actually doing to improve racial/ethnic minority health status and reduce racial/ethnic health disparities.[7]

In addition, through more systematic and rigorous research and evaluation, the *Framework* can facilitate more targeted and efficient methods for identifying and developing best or evidence-based practices, and can strengthen the justification for directing resources toward such efforts. Any effort to identify best practices, however, requires a set of criteria by which to make that judgment. The work of established, respected, scientific expert bodies within and outside of HHS–such as, the U.S. Preventive Services Task Force, the Task Force on Community Preventive Services, and the British-based Cochrane Collaboration–can inform this process. Both the *Guide to Clinical Preventive Services* (U.S. Preventive Services Task Force) and the *Guide to Community Preventive Services* (Task Force on Community Preventive Services) provide examples of how expert opinion–used as the basis for some strategies and practices where scientific evidence of their effectiveness is not adequate–and empirical evidence can be reconciled.

Thus, the *Framework* can promote use of existing science and knowledge while concurrently fostering the development of new evidence of effective strategies and practices for continuous improvement.

V. CONCLUSIONS

The *Framework* presented in this document is intended to help OMH, its partners, and other stakeholders to use a more systems-oriented and strategic approach, based on existing science and knowledge, to attack the problems related to racial/ethnic minority health and health disparities. In the short run, this framework is being used by OMH to guide the development of a protocol for the evaluation of activities being funded in the States and elsewhere to improve racial/ethnic minority health and reduce racial/ethnic health disparities. In the longer run, this strategic framework can help in multiple ways:

- First, the *Framework* can help enhance the understanding of policymakers, policy analysts, researchers, practitioners, and others about the key strategic components that must be addressed in developing policies or programs that affect racial and ethnic minority populations. These components are identified as the major categories and subcategories in the strategic framework.

- Second, the *Framework* can help deepen understanding about the many ways in which the components relate to one another. These relationships are multiple and complex, but the strategic framework has been designed to make it easier to articulate these multiple and complex relationships, as they play out in concrete situations within communities, States, Tribes, and the Nation.

[7]As part of its Spring 2007 grant cycle, OMH issued its new *Evaluation Planning Guidelines for Grant Applicants* to strengthen evaluation within its grant programs. These guidelines were informed by the strategic framework and serve as the preliminary version of OMH's evaluation protocol for its State-based and other funded efforts.

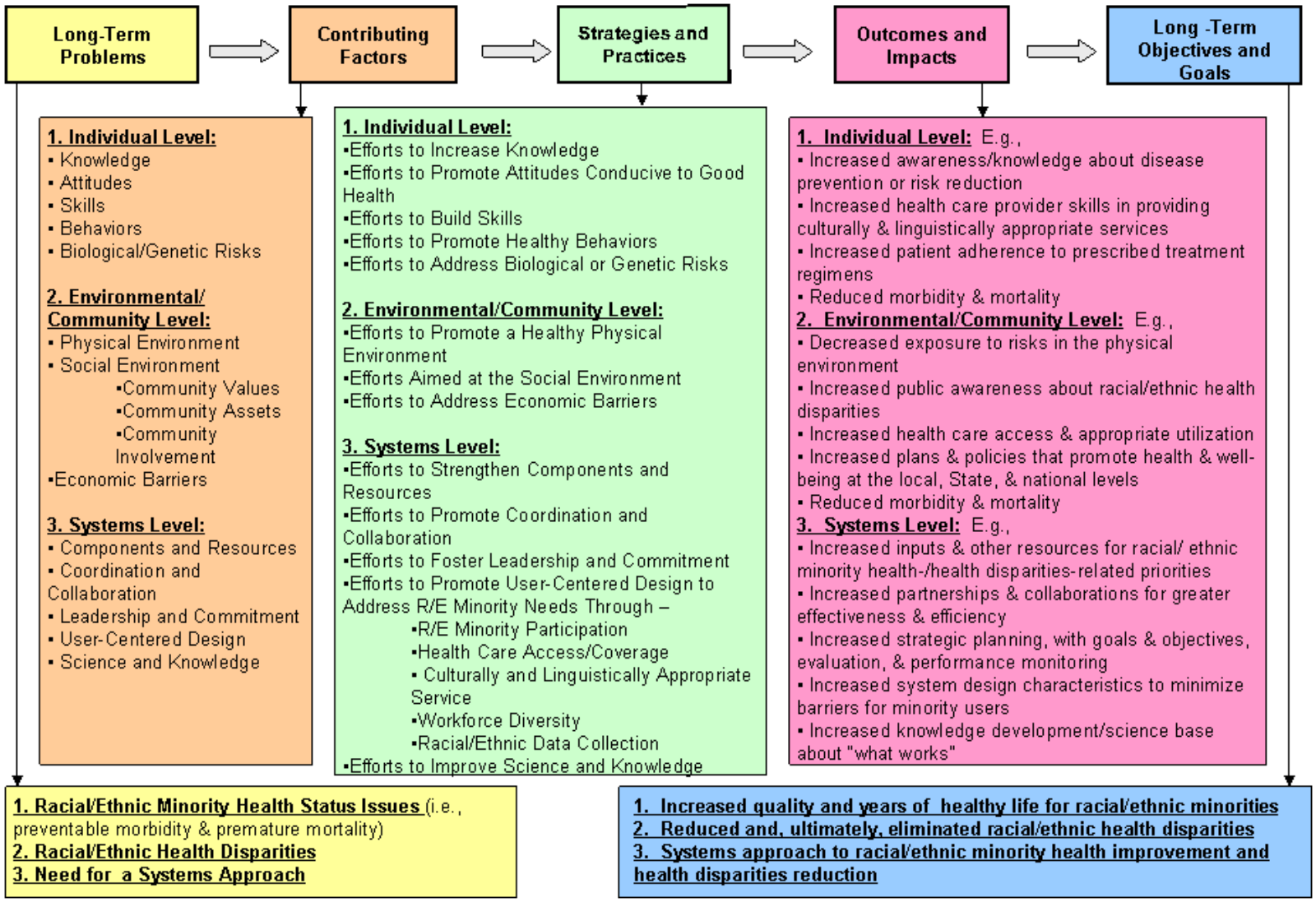
- Third, the *Framework* will make it easier to identify areas and issues that need more input–whether by improved research, data systems, coordination in the use of research results, provision of services, or training of practitioners–if progress is to be made in improving racial/ethnic minority health and reducing or eliminating racial/ ethnic health disparities.

- Fourth, the *Framework* can evolve and improve, both in its structure and in its details, through the full participation of interested parties at the national, State, Tribal, and local levels, and in both the public and the private sectors.

- Finally, the *Framework* can give rise to more systematic planning, testing, documentation, and use of evidence-based strategies and practices that really work. Because of its flexibility, the *Framework* makes it clear that progress in developing and using evidence-based strategies and practices can arise from any number of sources. The *Framework* can provide users with a better understanding of the exact problems and factors to be addressed; the kinds of components of strategies and practices that may best contribute to effectiveness; the measures of outcomes and impacts that are appropriate and feasible; and the kinds of goals and objectives that are realistic and achievable.

Improving the health of racial and ethnic minorities and reducing and, ultimately, eliminating the burden of health disparities will require a multi-faceted process sustained over many years. This process must be guided by systems-oriented, strategic, and systematic approaches.

A STRATEGIC FRAMEWORK FOR IMPROVING RACIAL/ETHNIC (R/E) MINORITY HEALTH & ELIMINATING R/E HEALTH DISPARITIES



(Source: Office of Minority Health, U.S. Department of Health and Human Services, January 2008.)

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