E ecuti e Summar

OVERVIEW

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

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

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

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

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

HEALTH DISPARITIES

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

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

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

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

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

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

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

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

A HEALTH EQUITY STAKEHOLDER STRATEGY

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

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

Select comments from Regional Conversation participants

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

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

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

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

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

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

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

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

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

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

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

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

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

STRATEGIES FOR ACTION

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

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

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

ORGANIZATION OF THE NATIONAL STAKEHOLDER STRATEGY

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

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