NATIONAL PARTNERSHIP FOR ACTION

to End Health Disparities

Changing Outcomes: Achieving Health Equity

Summary of the National Plan for Action

U.S. Department of **Health & Human Services**

Office of Minority Health

Changing Outcomes – Achieving Health Equity

The National Plan for Action

INTRODUCTION

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

The significance of the social determinants of health has increasingly become a matter of discussion and research, along with the recognition that, although social factors are at the root of many of the inequities in health and health care worldwide, they are not necessarily inevitable and are amenable to intervention. In 2005, The World Health Organization formed an independent Commission on Social Determinants of Health (CSDH) to make the case that health status is of concern to policymakers at all levels (not just health) and to "link knowledge with action" regarding how these factors operate and how they can be changed to improve health and reduce health inequities. The 2008 report of the CSDH, *Closing the Gap in a Generation: Health Equity Through Action on the Social Determinants of Health*, denoted the powerful link between social factors and health. The report emphasizes that social and economic policies directly impact the health and well-being of those who live and work under them.

HEALTH DISPARITIES, HEALTHCARE DISPARITIES, AND HEALTH EQUITY

A health disparity is a particular type of health difference that is closely linked with social or economic disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater social and/or economic obstacles to health and/or a clean environment based on their racial or ethnic group, religion, socioeconomic status, gender, mental health, cognitive, sensory or physical disability, sexual orientation, geographic location, or other characteristics historically linked to discrimination or exclusion. Healthcare disparities relate to "differences in the quality of healthcare that are not due to access-related factors or clinical needs, preferences, and appropriateness of interventions."

In the United States, there are numerous examples of health and healthcare disparities. Acknowledging that persistent health disparities are the manifestation and interplay of complex factors is critical to solving these problems. It is only as we develop a fuller understanding of the scope and magnitude of factors affecting health

outcomes, and evidence for what works to reduce disparities, that the most effective advancement of appropriate policy and intervention strategies can occur. This requires the combined efforts of governments, academia, institutions, businesses, humanitarian and faith-based organizations, and individuals working across the entire spectrum of public, private, community and individual enterprise. Beyond the heavy burden that health and healthcare disparities represent for the individuals affected, there are additional social and financial burdens borne by the United States as a whole. These burdens constitute both ethical and practical mandates to reduce health disparities and achieve health equity.

Health equity is defined as the attainment of the highest level of health for all people. Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health and healthcare disparities.

ECONOMICS OF HEALTH

The contribution of health and healthcare disparities to the rising cost of health care is often unrecognized, as is the potential for reducing costs through the reduction of disparities. In addition to the impacts of the social determinants of health, barriers to improved health outcomes include inadequate or unavailable health insurance coverage; inadequate or unavailable sources of care and of a primary care provider; and underutilization of health care. A recent study, *The Economic Burden of Health Inequalities in the United States,* issued by the Joint Center for Political and Economic Studies, provides insight to the costs associated with not eliminating health inequalities. The study concluded that the combined costs of health inequalities and premature death in the United States during the three-year period reviewed were $1.24 trillion. Based on this study, the cost of health disparities will only continue to rise exponentially in the near future.

THE NATIONAL PARTNERSHIP FOR ACTION (NPA) TO END HEALTH DISPARITIES

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 serves as a catalyst for collective leadership action around five main objectives: awareness, leadership, health system and life experience, cultural and linguistic competency, and research and evaluation. The chart on page four provides a description of the five objectives, the 10 national benchmarks, and the 20 national strategies for action.

FORMATION OF THE NATIONAL PLAN FOR ACTION

The *National Plan for Action* is one of three components of the NPA. The two other components include: (1) Blueprints which are aligned with the *National Plan for Action*; and (2) targeted initiatives that will be undertaken by public and private sector partners. The *National Plan for Action* is a multi-sector, multi-level strategy that was

developed using a "bottom up" approach. The intent was to change the paradigm of strategy development by vesting individuals with identifying and helping to shape core actions for a coordinated national response. The view is that local leaders rarely participate in policy development, yet they are fundamental to formulating relevant community-driven solutions.

The "bottom up" approach included Regional Conversation meetings that were preceded by smaller community "voices" meetings. The information from these meetings was reviewed for common and priority actions. These actions were subsequently used as the basis for a National Visionary Panel, an implementation strategy workgroup, an evaluation strategy workgroup, and national health disparities plan consensus meeting. Ultimately, this collective process resulted in the establishment of the 20 common strategies for action that form the basis for this *National Plan for Action* (refer to page 4).

APPROACH FOR IMPLEMENTING THE NATIONAL PLAN FOR ACTION

In general, there is broad agreement that no one sector can address complex issues independently and that cohesive action is a critical component for driving change. However, the existence of a plan for change that has been collaboratively developed does not in and of itself lead to the achievement of intended outcomes. Success is dependent on the ability of stakeholders across sectors to implement and refine the strategies and actions contained in the plan over time. Implementing a plan is as important as developing it.

The *National Plan for Action* is intended for use by the public and private sectors at the national, regional, tribal, state, and community levels. To encourage and support multi-sectoral action and progress, a structure for advancing the national strategies at all levels will be developed. This structure will support leadership and provide ownership and accountability; support capacity building, planning, communication, coordination, partnership development, evaluation; and reporting of health and healthcare disparities actions and progress.

The overall structure for implementation includes two primary components: (1) federal leadership; and (2) voluntary multi-sector, multi-level boards. The federal Office of Minority Health will serve as the lead entity for coordinating and supporting implementation, evaluation, reporting, and sustainability of the *National Plan for Action*. These efforts will be carried out in partnership and with the guidance of the Federal Interagency Management Team (Federal Team) which was specifically established to guide the development of the NPA. The Federal Team is comprised of representatives from the U.S. Departments of Health and Human Services, Agriculture, Commerce, Defense, Education, Housing and Urban Development, Labor, Transportation, and Veterans Affairs, and the Environmental Protection Agency. The mission of the Federal Team is to foster communication and partnership. It also guides the activities of the NPA within federal agencies and their partners to increase the efficiency and effectiveness of policies and programs that can contribute toward ending health disparities.

The second component of the implementation structure includes voluntary multi-sector boards who represent organizations and individuals at the national, regional, tribal, state, or community levels. The boards do not advise

National Goals, Benchmarks, and Strategies			
Goal #	**Goal Description**	**Benchmarks**	**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 and ethnic minority populations	1. Increases in the percentage of adults who believe that ending health disparities is a national priority 2. Increase in active state and regional partnerships with representation from key public and private sectors (e.g., government, business, health and human services, faith, youth, and ethnic groups)	1. **Healthcare Agenda** Ensure that ending health disparities is a priority on local, state, regional, tribal and federal healthcare agendas.
			2. **Partnerships** Develop and support partnerships among public and private entities to provide a comprehensive infrastructure for awareness activities, 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 (i.e., social marketing, media advocacy) as well as information technology to reach a multi-tier audience-including racial and ethnic minority communities, rural populations, youth, persons with disabilities, older persons, and geographically isolated individuals-to compel action and accountability.
			4. **Communication** Create messages targeted towards and appropriate for specific audiences across their life spans, and present varied views of the consequences of health disparities that will compel (motivate/promote) individuals and organizations to take action and to reinvest in public health.
2	**LEADERSHIP**—Strengthen and broaden leadership for addressing health disparities at all levels	3. Increases in the percentage of youth on national, regional, tribal, state, and city/county coordinating bodies for the NPA	5. **Capacity Building** Support capacity building at all levels of the decision-making process as a means of promoting community solutions for ending health disparities.
			6. **Funding and Research Priorities** Improve coordination, collaboration, and opportunities for soliciting community input on funding priorities and involvement in research.
			7. **Youth** Invest in young Americans to prepare them to be future health leaders and practitioners by actively engaging and including them in the planning and execution of health initiatives.
3	**HEALTH SYSTEM AND LIFE EXPERIENCE**—Improve health and healthcare outcomes for racial and ethnic minorities and for underserved populations and communities	4. Decrease in prevalence of health conditions for which racial and ethnic disparities exist (e.g., asthma, hypertension) every five years 5. Increased high school graduation rates and local coalitions working to promote holistic school readiness 6. Increased provision and utilization of coordinated, holistic care for and by older adults	8. **Access to Care** Ensure access to quality health care for all.
			9. **Health Communication** Enhance and improve health service experience through improved health literacy, communications, and interactions.
			10. **Education** Substantially increase, with a goal of 100%, high school graduation rates by establishing a coalition of schools, community agencies, and public health organizations to promote the connection between educational attainment and long-term health benefits; and ensure health education and physical education for all children.
			11. **At-risk Children** Ensure the provision of needed services (e.g., mental, oral and physical health, and nutrition) for at-risk children.
			12. **Older Adults** Enable the provision of needed services and programs to foster healthy aging.
4	**CULTURAL AND LINGUISTIC COMPETENCY**—Improve cultural and linguistic competency	7. Increases in diversity of leadership in local and state health care professional associations as well as in the leadership of major health organizations (e.g., health systems, hospitals, etc.) 8. Increased percent of insured population whose public and private health insurers offers full reimbursement for medical interpretation costs	13. **Workforce Training** Develop and support broad availability of cultural and linguistic competency training for physicians, other health professionals, and administrative workforces that are sensitive to the cultural and language variations of racially and ethnically diverse communities.
			14. **Diversity** Increase diversity and competency of the healthcare and administrative workforces through recruitment and retention of racially, ethnically, and culturally diverse individuals and through leadership action by healthcare organizations and systems.
			15. **Standards** Require interpreters and bilingual staff providing services in languages other than English to adhere to the National Council on Interpreting in Health Care Code of Ethics and Standards of Practice.
			16. **Interpretation Services** Improve financing and reimbursement for medical interpretation services.
5	**RESEARCH AND EVALUATION**—Improve coordination and utilization of research and evaluation outcomes	9. Institute standard race and ethnicity categories in all national healthcare-related databases 10. Increased cross-disciplinary and cross-agency supported research at the federal level	17. **Data** Ensure the availability of health data on all racial and ethnic minority populations.
			18. **Authentic Community-Based Research [and Action] and Community-Originated Intervention Strategies** Invest in authentic community-based participatory research and evaluation of community-originated intervention strategies in order to enhance capacity development 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 knowledge transfer regarding successful programs that are addressing social determinants of health (e.g., housing, education, poverty).

federal agencies—they provide a means for multi-sector organizations to plan, collaborate, and drive efforts of mutual benefit. While the boards will interact with one another across levels, they are intended to define themselves independently. Each board will have the flexibility to define its members and determine how it will function. Flexibility of the board structure allows for use of existing infrastructure and leadership that may be most suited for ensuring success, as well as opportunities for leveraging other efforts.

APPROACH FOR EVALUATING THE NATIONAL PLAN FOR ACTION

Although the National Plan, Blueprints, and initiatives of the NPA are connected by the same objectives, the evaluation plan must account for actions undertaken within each of these components as well as the overall contribution of the NPA in closing persistent health gaps. No single evaluation design can address the complexities of a comprehensive, national effort to end health disparities—different methodologies will be combined like pieces of a jigsaw puzzle to assess change within and across levels (e.g., national, regional, tribal, state) and sectors (e.g., early childhood education, community participatory research, quality of public housing conditions).

The evaluation plan will address a range of measures including: (1) predictor measures to determine the degree to which the actions might have helped reduce health disparities (e.g., education, income, access to transportation, social stressors, and the environment); (2) process measures (e.g., partnership development, quality of collaboration, and implementation of the Regional Blueprints); and (3) short-term, intermediate, and long-term outcome measures.

The ability to tell the NPA story will depend, in part, on the capacity and collaboration of organizations and governments at the regional, state, tribal, city and county, and/or community levels to participate in and support the national evaluation. In order to leverage cooperation and collaboration, the NPA evaluation will include methods for engaging communities throughout the process. These methods are especially critical for certain community groups that have historically been marginalized or harmed by research and evaluation (e.g., Native Americans, African Americans, people with disabilities) and, therefore, distrust researchers and evaluators.