The Initiative to Eliminate Racial and Ethnic Health Disparities Is Moving Forward

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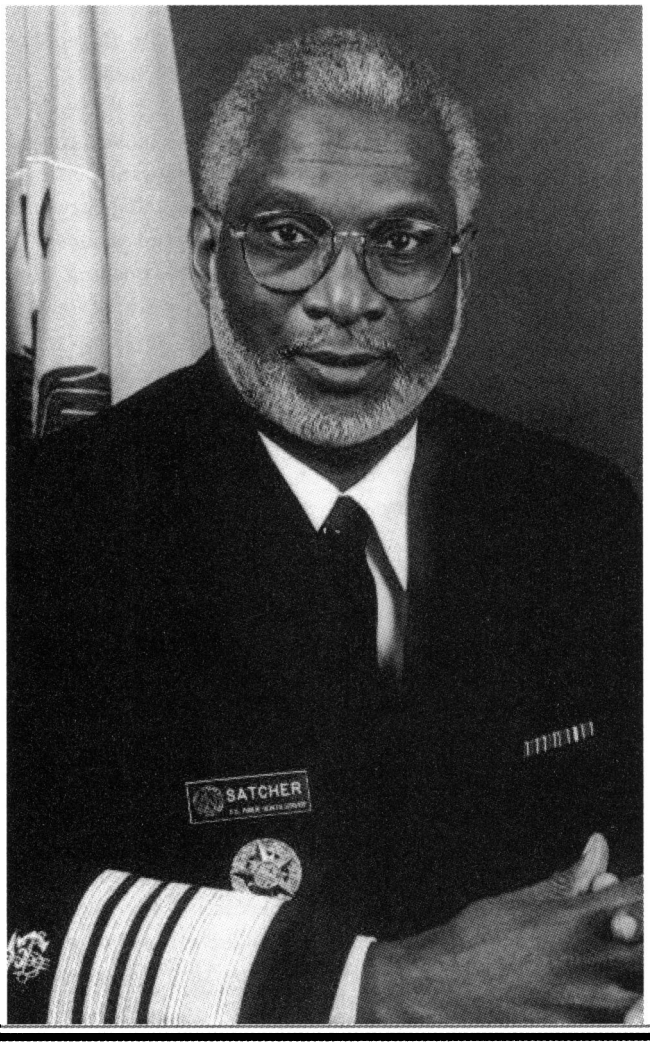
In February 1998, President Clinton announced that the U.S. would commit to a national goal of eliminating racial and ethnic health disparities in six key areas of health by the year 2010. Today, the Initiative to Eliminate Racial and Ethnic Disparities in Health is preparing to move from the drawing board to action on a number of fronts as we gear up to put the first year of funding appropriated by Congress for this effort—$65 million in fiscal year 1999—to work.

The six target areas are: infant mortality, cancer screening and management, cardiovascular disease, diabetes, HIV/AIDS, and adult and child vaccinations.

This year, the Centers for Disease Control and Prevention (CDC) will utilize $10 million to award competitive grants to test promising intervention strategies for reducing health disparities; $10 million to support targeted community-based HIV/AIDS demonstration projects; $5 million for the development of culturally relevant and community-based education and intervention strategies to reduce diabetes morbidity and mortality; $5 million for cardiovascular disease prevention programs for racial and ethnic minorities in specific states; and $5 million for conducting surveys, starting a health communications campaign, conducting research, and developing a control model for prostate cancer.



CDC REACH Projects. The CDC recently outlined its draft plans for the competitive grants program, the Racial and Ethnic Approaches to Community Health (REACH) Demonstration Projects. These are two-phase projects that will test science-based community-level interventions that could be effective in eliminating health disparities, with the goal of replicating their successes in other communities.

Initial plans call for a grant applicant to be the lead organization, or central collaborating organization, for a community coalition of three or more organizations focusing on minority health concerns. The lead organization must have direct fiduciary responsibility for the administration and management of the project and will distribute funds to other partners in the coalition as appropriate.

Phase I is a 12-month planning phase to organize and prepare infrastructure for Phase II. Cooperative agreements in Phase I will support the planning and development of demonstration programs using a collaborative multi-agency and community participation model. Phase I may also include the collection of data necessary to develop baseline measures for assessing the outcomes of the projects. Upon completion of Phase I, grantees will

have utilized appropriate data in developing a Community Action Plan (CAP) designed to reduce disparities for the selected communities in one or more of the six priority areas. The CAP must target a specific racial or ethnic minority community, that is, an African American, American Indian/Alaska Native, Hispanic American, Asian American, or Pacific Islander community. Only applicants selected for Phase I will be eligible to compete for additional funds to implement and evaluate the demonstration program of Phase II. Phase II is the implementation of a demonstration project of specified interventions for a specified priority area(s) for a well-defined minority population. Phase II also involves appropriate evaluations of interventions and outcomes of the project.

For additional information or to request an application kit, call toll-free 888-GRANTS4 (888-472-6874). Specify Program Announcement Number 99064.

HHS prepares for the Initiative. While awaiting Congress' funding decisions, HHS officials were busy last year doing preparatory and planning work on the disparities initiative.

In July 1998, the President's Advisory Board on Race, in conjunction with the Health Resources and Services Administration (HRSA), held a national town hall meeting in Boston on racial and ethnic barriers to health care access. Panelists shared their thoughts on some of the greatest barriers to accessible, high quality, culturally competent health care for racial and ethnic minorities.

The meeting featured two panels—a consumer panel that discussed the difficulties faced in accessing quality health care and a "models that work" panel of local health providers who spoke on programs, many funded by HRSA, that are effective in caring for racial and ethnic minorities. Both panels included African American, American Indian, Asian American, and Hispanic representatives.

Wilson Augustave, who represented migrant farm workers through the National Migrant Health Advisory Council, Rushville, NY, shared information on farm working conditions and recounted personal experiences with the health care system that he believes represents the quality of care that minorities receive. He spoke of the language barriers many migrant and farm workers face. "Sometimes farm workers go into their local communities to be seen at the emergency room...and they don't have someone on staff to translate. Many times [the farm workers] have to have their kids, who may not know the medical terminology, translate."

Meizhu Lui from Health Care for All, an advocacy organization, spoke on workforce diversity and cultural competence, echoing Augustave's concern about translation. "If Asians do have to go to a hospital, interpreter services are missing. It's a common practice to tell patients to bring their own interpreters, and that person is often their child," Lui said. "Not only do children not know how to translate 'medicalese,' a language more complicated than Chinese; not only do they have to hear about their parent's private bodily functions or illnesses that they should not be hearing about; worst of all it upsets the traditional family roles, where adults are dependent on children and not vice versa."

Others on the panel related similar experiences in obtaining health care services.

The models that work panel featured local officials representing five programs from the greater Boston area that have been successful in improving access, ensuring workforce diversity, and providing culturally competent health care to community residents: Great Brook Valley Health Center, Worcester; South Cove Community Health Center, Boston; Southeast Asian Health Program of the Family Health & Social Service Center, Boston; Center for Community, Education, Research and Service, Boston; and North American Indian Center of Boston, Inc.

President Clinton's advisory board on race incorporated information and recommendations obtained during the meeting into its report to the President. Those recommendations included:

- Continue advocating for broad-based expansions in health insurance coverage.
- Continue advocacy of increased health care access for underserved groups.
- Continue pushing Congress for full funding of the racial and ethnic health disparities initiative.
- Increase funding for existing programs targeted to underserved and minority populations.
- Enhance financial and regulatory mechanisms to promote culturally competent care.
- Emphasize the importance of cultural competence to institutions training health care providers.

In September, HHS and Grantmakers In Health (an educational organization that works with foundations and corporate giving programs to improve the nation's health) cosponsored a national leadership conference to discuss strategies for developing and strengthening partnerships that focus on eliminating racial and ethnic disparities in health. Attending the conference were approximately 250 key public policymakers and industry and community leaders, including representatives of foundations, community-based organizations, national organizations with expertise in key health areas and with a history of serving racial and ethnic groups, providers, insurance companies and managed care plans, the media, business, faith-based

organizations, and consumers.

Participants also included representatives of state, local, and tribal governments. Attendees were racially and ethnically diverse, with representation from African American, Hispanic American, American Indian/Alaska Native, Asian American, and Native Hawaiian populations.

By the end of the conference, participants had agreed to the following action recommendations:

Eliminating racial and ethnic disparities must be made a national priority of concern to all Americans.

- Leaders at all levels must understand that all people in this country deserve to be healthy and have access to adequate health care services.
- All Americans must have access to the highest quality health care, either through universal coverage or some other medium.
- Advocacy, including locally and strategically at state, national, and political levels, is essential.
- The development of a shared vision of partnership is key to increasing awareness of the problems and of how we are working to solve them.
- We must work toward creating a national will, awareness, energy, and commitment to eliminate racial and ethnic disparities in health.
- One approach is to infuse spiritual energy into this effort.
- We must help community leaders and advocates to increase awareness and to establish ongoing linkages with these entities that will move the effort forward.

Communicating our vision is essential.

- To help get the message out, we need to tailor talking points to different constituencies.
- Education will play a major role in the elimination of health disparities with efforts targeted at the general public, public officials, community decisionmakers and leaders, and members of ethnic and minority groups themselves.
- The media is an essential partner in the development of successful culturally appropriate educational programs.
- In order to plan and present a serious media campaign, messages must be developed that everybody can rally behind.
- The mass media also is critical to the development and dissemination of prevention messages and positive messages to all elements of the community.
- We should consider additional opportunities for partnering with the media.

Health is affected by many factors, and efforts to address disparities must be comprehensive.

- Activities and partnerships that result from today's efforts must confront disparities in a way that cuts across social and economic levels and all of our minority communities.
- We should broaden the definition of health using a systems approach to encompass factors such as economics, environmental justice, and self-determination.
- We need to consider issues and try to effect change at the systems level. To achieve this, we must first identify the systems that need to change.

Efforts must recognize the diversity of America's racial and ethnic communities and the diversity of their needs.

- Health problems in racial and ethnic groups are found in all income and educational strata.
- We need to stay focused on the big picture while remaining sensitive to the need to develop targeted community-specific approaches.
- Access could be improved by reinstitutionalizing community outreach programs, using the model of the public health nurse.
- We need to take a realistic look at the institutional cultures of the groups we bring to the table.

Improving the flow of information and communication is an important component of success.

- Partners must be willing to take a hard, realistic look at the composition and dynamics of these various relationships and to take the action necessary to sustain them.
- Our efforts should draw on what is already known about partnerships and the skills that are necessary to develop, support, and sustain them.

Changes must be driven by the communities themselves.

- We must think in terms of building infrastructures and collaborations that empower communities to identify and meet their own needs.
- Partnerships should build on the knowledge that the community is the center for development, action, and change.
- Community development will help to promote posi-

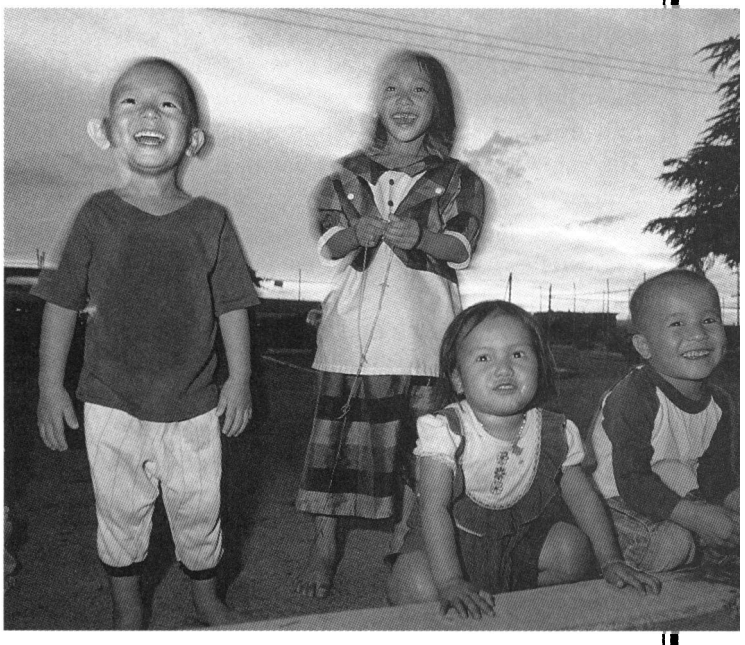
tive change and can be accomplished through effective grantmaking.
- We should work to share resources in creative ways among different community groups.
- Minority representation should be increased on advisory boards, federal program boards, review panels, and boards of directors of foundations and other organizations.
- We need to obtain input from the community level and minority groups in the design of projects and make more inclusive the mix of individuals responsible for allocating the funds, both at the federal level and in foundations.

Better data and uses of data are needed to document problems and measure progress in achieving solutions.

- High quality, uniformly reported data on all racial and ethnic subgroups are urgently needed to accurately reflect the needs of the community and demonstrate the necessity of addressing these disparities.
- Useful and effective outcome measures must be developed to monitor our progress in the elimination of disparities and to assure that we are using accurate data in doing so.
- Process measures are still important.
- In measuring our progress, we need to rethink and clearly define our baseline measures.
- We must develop our ability to conduct applied research and provide training for the individuals who gather and measure the data.
- We must recognize the importance of data to funders, who like others, use this information to evaluate progress and reallocate resources.

Strategies must focus on multiple partners and nurturing those partnerships.

- Cultivating partnerships is an ongoing process, and a follow-up strategy must be developed if the work of this conference is to continue.
- We must develop a new paradigm in which whatever is brought to the table is considered valuable—whether it is information or money.
- We must develop and articulate a plan of action that is specific enough that those affected can believe in it and commit to its implementation.
- Our work should focus on strengths rather than deficits.
- Foundations could pool resources to deal with minority health issues, and government agencies could do the same.



- We need to educate senior executives and corporate boards about the issue of racial disparity in health and help them understand why it is in their best interest to help eliminate these disparities.
- One innovative possibility is that of asking organizations to tithe.
- Attracting more members of ethnic and racial groups to careers in the health care professions will help reduce disparities over the long term.
- We can institutionalize the necessary leadership efforts by actively recruiting and developing strategies to retain minority health professionals.
- Trust is a fundamental component of relationships and partnerships.

Reducing disparities will require sufficient and stable sources of funding.

- Although it is important to convene meetings, it is also important to establish clear funding sources at the same time.
- Seed money is needed to help communities build coalitions to accomplish this based on their own issues and on their own schedules.
- We must recognize that the ways in which we determine strategies and interventions and how we evaluate them are based upon certain assumptions.
- We can help begin to reduce disparities by providing sufficient funding to national, regional, and community organizations.
- Funding should focus more on prevention than it has in the past.

- Cultural appropriateness of programming and cultural competency of staff are essential; however, cultural competency is a two-way street.
- Foundations and government agencies must make cultural competency a criterion for funding programs.
- Appropriate benchmarks must be developed to evaluate and monitor progress.
- Rather than talking about matching funds, we should talk about matching resources that offer community groups the opportunity to buy into programming that addresses disparities
- The ability and talent to achieve our goals exists: we must invest more in developing leadership at the community, state, and national level.

The meeting with Grantmakers in Health helped government agencies and stakeholders to develop a shared vision for moving forward to eliminate disparities. I think it also laid the foundation for government agencies to develop more partnerships and more jointly funded programs.

Minority HIV efforts. Finally, the administration announced in October that HHS will spend an additional $156 million in 1999 to enhance the federal response to HIV/AIDS in racial and ethnic minority communities. This funding is spread across three broad categories: technical assistance and infrastructure support; increasing access to prevention and care; and building stronger linkages to address the needs of specific populations. Federal agencies will use the funding as follows:

Centers for Disease Control and Prevention (CDC). Grants to minority community-based organizations to create new service programs in African American communities heavily impacted by HIV/AIDS; technical assistance for grantees; and funds for a faith-based program to develop HIV and substance abuse prevention training grants at the divinity schools on the campuses of historically black colleges and universities. CDC also plans to strengthen the requirement that state allocation decisions about HIV/AIDS grants reflect the changing face of the epidemic.

Health Resources and Services Administration. Ryan White CARE Act Title I supplemental funding for eligible metropolitan areas that have at least 30% African American HIV/AIDS cases; Title III funding for targeted planning grants to broaden the reach of organizations that serve African American and Hispanic areas highly impacted by HIV/AIDS; Title IV funding to address the prevalence of HIV/AIDS among African American children; and funding for AIDS Education Training Centers at historically black colleges and universities to work with the National Medical Association and the National Black Nurses Association to educate health care providers serving African American communities on the new HIV/AIDS treatment guidelines. HRSA will also broaden its technical assistance programs.

Substance Abuse and Mental Health Services Administration. Funding for comprehensive substance abuse treatment programs for African American and Hispanic women with or at risk for HIV/AIDS and their children as well as for high-risk men; funding targeted to African American youth and women of color prevention programs and activities. SAMHSA plans to earmark funding for HIV and substance abuse treatment for communities of color as part of its Targeted Capacity Expansion Program, which helps address treatment needs for emerging substance abuse problems specific to a city, county, state, or region.

National Institutes of Health. Support for activities to increase the number of African American principal investigators conducting research targeting the links between substance abuse and HIV/AIDS through the Office of Minority Health Research. Special emphasis will be on behavioral and clinical research targeting the links between substance abuse, sexual behavior, and the HIV infection rates in African Americans; outreach education programs; and population-based research.

In addition, in recognition that the HIV epidemic has become highly concentrated in some areas, HHS is prepared to make Crisis Response Teams available to a number of highly affected municipalities. These teams would focus on providing technical help in addressing HIV/AIDS within minority populations. Upon a formal request, and with the participation and coordination of local government and community leaders, HHS will dispatch a team of experts to provide special skills and support over a period of several weeks.

The Office of Minority Health will continue to work closely with HHS agencies and offices as a catalyst, advocate, coordinator, and policy development office on activities related to HIV and AIDS in minority communities.

No one group working alone can achieve the goals that we have set. With increased funding and increased knowledge of what works, we can form productive partnerships and implement programs that will help close the gaps.

If you want to know more about our initiative to eliminate racial and ethnic health disparities, visit our website at **www.raceandhealth.gov** or e-mail us at <healthdisparities@ osaspe.dhhs.gov>. ■