

**Moving Toward Health Equity in New York:
State Strategies to Eliminate Health Disparities**

**A Report for the
Minority Health Council, New York State Department of Health**

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Moving Toward Health Equity in New York: State Strategies to Eliminate Health Disparities

“Despite tremendous efforts on the part of many, the strategies of the past have not effectively closed the gap in health disparities....Let’s change the course of events. Let’s eliminate health disparities....”¹

—*Richard F. Daines, M.D.*
Commissioner, New York State Department of Health

I. Introduction

Health disparities are deep and pervasive in New York State, as they are in almost every state in the nation. Some racial and ethnic minority groups, people with low incomes and/or language barriers, people who live in underserved communities, and many others² have poorer health from birth (e.g., infant mortality) to death (e.g., premature deaths). Across the lifespan, they suffer higher rates of disease and disability. And these problems begin early, adding to the erosion of opportunity for children who often face a constellation of other social and economic challenges. As a result, disparities have a devastating human and economic impact on the state.

New York State has a historic opportunity to correct health disparities and improve the health of all state residents. The state’s leadership, led by Governor David Paterson and Commissioner Richard Daines, has issued a challenge to its agencies and partners to address the problem. Health providers, health systems, and other external partners are increasingly sensitized to the need to eliminate health disparities. Business, labor, and faith groups are calling for action. Given this powerful alignment of forces, stakeholders can ill afford to miss the opportunity for bold steps to move New York State toward achieving health equity.

This paper attempts to identify promising practices to address health disparities and to offer a set of recommendations for New York State action. Based on a review of literature and interviews with state and national leaders, the paper proposes public health approaches, based on the “Ten Essential Public Health Services,” for eliminating health disparities. The “essential services” framework spans clinical and community-level health interventions and emphasizes the need for coordination of health programs across all levels of government and across departments and agencies. As a framework for addressing health disparities, the essential services suggest that action against disparities can and should be integrated into all public health functions.

The paper also examines how state health departments have structured minority health or health disparities entities (e.g., Offices of Minority Health), and identifies characteristics of successful offices. Again, this assessment was based on interviews with state leaders and reviews of state program and policy documents. Finally, the paper examines how one state has worked with American Indian tribes—an often-neglected population in the

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effort to eliminate health disparities—to address their health service and public health needs.

The paper's purpose is to stimulate discussion and build momentum for a state action plan to eliminate health disparities. There are several challenges, however, to this work. In drawing examples from other states, we recognize that one size does not fit all; every state is different in its demographics, health challenges of disparity groups, health care infrastructure, and political climate. New York State must weigh whether and how other states' experiences are applicable. A second challenge relates to evidence. The research literature is thin regarding the effectiveness of specific interventions and policies to address health disparities. As an area of study, health disparities have only recently received significant scholarly attention and funding. Some areas of study are in their infancy. Many published studies suffer from methodological flaws or otherwise have significant limitations. For example, a 2004 review of the literature regarding the effectiveness of cultural competency training conducted by the Agency for Healthcare Research and Quality (AHRQ) found that, of the 64 studies that qualified for their review, only two described randomized controlled trials, eight studies were concurrent controlled trials, and four had an external (non-concurrent) control group. Most studies were designed without a comparison group, and had either a post-intervention evaluation only or a pre- and a post-intervention evaluation. And few studies assessed program costs relative to benefits.³ Other challenges for health disparities research include inadequate measurement tools, short timeframes for evaluation, and limited or poor racial and ethnic data.

Perhaps more importantly, however, any state effort to eliminate health disparities must balance political pressure for quick results against the reality that many of the strategies necessary to intervene must take root over years, and may reap their greatest benefits in future generations. Racial and ethnic health disparities in North America, for example, were shaped by over 350 years of government-sanctioned inequality. A great deal of progress has been made in the last 50 years toward narrowing health gaps, and many of the greatest gains occurred during periods when public policies actively addressed inequality. But today's gaps – which are likely to grow in the face of difficult economic times – will not be eliminated in a few short years. New York State should therefore adopt a long-term perspective and build programs that will create sustainable change, while at the same time recognizing the need for demonstrably positive near-term results.

II. The Scope of the Problem

As is the case in other states, health disparities in New York State often occur along the lines of race, ethnicity, nativity, language ability, socioeconomic status, and geography, among other factors. Some of these disparities are well-documented, while others are not, owing to challenges in data collection and monitoring (to be examined in more detail below).

The New York State Minority Health Surveillance Report reviews 49 state health

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indicators, some of which assess trends over time.⁴ As such, the report is a valuable starting point for any effort to assess the needs of the state's disparity populations, and it offers an important national model of health disparities data collection and reporting. The report examines data for various racial/ethnic, socioeconomic, geographic, and other groups, and finds that health gaps, while narrowing, are generally persistent. Some of these disparities are summarized here:

Racial and Ethnic Health Disparities

Some racial and ethnic minority groups consistently experience poor health relative to majority-group New Yorkers:

- African American and Hispanic New Yorkers die prematurely at rates nearly twice that of white New Yorkers, while Asian American New Yorkers experience rates of premature mortality over 50 percent higher than those of white New Yorkers.
- African American New York State residents experienced rates of infant mortality that were nearly 2.5 times higher than those of whites and Hispanics and over three times higher than those of Asian Americans and Pacific Islanders.
- Statewide, African Americans experience HIV/AIDS mortality rates that are 13 times higher than those of whites, and Hispanics face HIV mortality rates that are seven times higher than those of whites.
- Between 1995 and 2004, Asian and Pacific Islander Americans experienced asthma mortality at a rate 75 percent higher than whites in 2004, while Hispanics and African Americans experienced asthma mortality rates that were over 3.5 and 4 times higher than those of whites.
- Cardiovascular disease, the leading cause of death in New York State, disproportionately claimed lives among African Americans (289 deaths per 100,000).
- Hispanics in New York State die from diabetes at a rate 46 percent higher than white New Yorkers, and New York African Americans experience diabetes mortality rates that are over twice those of whites.⁵

Health Disparities on the Basis of Socioeconomic Status

Epidemiologic studies consistently find a strong positive relationship between socioeconomic status – whether measured by income, education level, or profession – and health.⁶ At each ascending step of the socioeconomic ladder, people tend to enjoy better health, while each descending step is associated with shorter lifespans and higher rates of disease and disability. New York State's 2003-2005 Behavioral Risk Factor Surveillance Survey (BRFSS) data reflect the health-wealth gradient:

- Of persons earning less than \$15,000 per year, 40.1% reported having fair or poor health, while fewer than 5 percent of people earning greater than \$75,000 per year reported fair or poor health.
- Similarly, over 18 percent of people earning less than \$15,000 per year reported experiencing poor mental health for 14 or more days in the past month, while only 6.8% of people earning over \$75,000 reported 14 or more days of poor mental

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- health in the past month.
- Lower-income groups were more likely to report having been diagnosed with diabetes. People earning less than \$15,000 per year in New York State had the highest rate of diagnosed diabetes (14.4%), while those earning more than \$75,000 were least likely to have been diagnosed with diabetes (4.1%).
 - People earning less than \$15,000 also had the highest rate of asthma (11.7%) compared to other income groups; among New Yorkers earning more than \$75,000 per year, 7.2% reported having asthma.
 - Socioeconomic disparities also exist in health risk factors such as obesity and physical activity, as well as in access to and receipt of health services.⁷

BRFSS data also show that socioeconomic differences do not fully account for racial and ethnic disparities. In almost all of the indicators above, African Americans and Hispanics above median income have poorer health and higher health risks than whites (and in some cases, Asian Americans and Pacific Islanders) who are also above median income.⁸

Geographic Disparities – Inequality in the Distribution of Health Care Resources

Place matters for health in profound ways. Where people live, work, study, and play shapes exposure to a range of health risks and resources (e.g., nationally, communities of color are nearly twice as likely as national averages to have an environmental health hazard in their community), just as it influences health behaviors (e.g., people in minority communities are less likely to enjoy a healthful retail food environment, which influences diet, than people in predominantly white communities). Place also shapes the context for access to health care:

- In 2001, an estimated 1.8 million New York State residents lived in medically underserved communities.⁹
- Approximately 3.6 million people in New York State lived in Health Professional Shortage Areas in 2001.¹⁰
- According to a 2006 report by the Center for Enterprise Development, between 2001 and 2005 the number of New York State residents without primary care physicians within economic or geographic reach increased by 13.2 percent.¹¹
- Nearly 60% of New York City's zip codes have an inadequate supply of primary care physicians who are willing to see Medicaid patients.¹²
- More than half a million New York City residents reported needing but not receiving medical care in a 12-month period in 2002-2003.¹³
- Geographic barriers to health care are also profound in rural, non-urban communities. For example, of the physicians working in New York State's federally designated Health Professional Shortage Areas, only 6.5 percent are in non-metropolitan areas.¹⁴

III. State Strategies to Eliminate Health Disparities: Research Evidence and Expert Opinion

A growing body of literature supports a number of promising public health and health system practices to eliminate health disparities. In addition, several states have experimented with strategies to eliminate disparities, the outcomes of which may not be published but nonetheless offer testimony to understanding promising and failed strategies. In this section, we summarize and synthesize this literature along with the viewpoints of selected leaders working in state health departments. In the process, we have identified promising practices that state health departments can adopt to eliminate health disparities. These practices are organized using the framework provided by the National Public Health Performance Standards Program's (NPHPSP) Ten Essential Public Health Services.¹⁵ NPHPSP is a collaborative effort led by the Centers for Disease Control and Prevention to improve the quality of public health practice and the performance of public health systems by:

- Providing performance standards for public health systems,
- Improving quality and accountability of public health practice,
- Conducting systematic collection and analysis of performance data, and
- Developing a science base for public health practice improvement.

Many local health departments are poorly equipped to provide the Ten Essential Public Health Services because of resource limitations. Remedying these deficiencies is therefore the most important and urgent step for state government to address health disparities.

NPHPSP's recommendations for essential state services focus on the state public health system, which includes state public health agencies and other partners that contribute to public health services at the state level.

Linking action on health disparities with the Ten Essential Public Health Services is an important step; however, it is not a panacea. Linking the two has the potential to increase awareness and knowledge among public health practitioners of the ten essential services and of public health action for eliminating health disparities, as many practitioners remain unaware of both. This analysis also provides a framework for developing comprehensive strategies to address health disparities. In addition, cross-walking draws attention to the limitations of the ten essential services, given today's public health problems and inadequate public health infrastructure. Novick, for example, argues that many local health departments are poorly equipped to provide the ten essential services because of resource limitations.¹⁶ But state and local health departments are also the "load-bearing walls" of the nation's public health system.¹⁷ Remedying these deficiencies is therefore the most important and urgent step for state and local government to address health disparities. As Novick writes,

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Simply recommending local responsibility and capability, as defined by the essential public health functions framework, is not enough. The means of attaining this objective, particularly the organization and funding of services, must be identified or we will be left with the myth and scant chance of attainment.¹⁸

This paper seeks to prompt a sober assessment of and response to the state's public health capacity, and to explore and correct the systemic, structural, and institutional forces that produce inaction or indecision on health disparities. This is particularly important given government efforts to improve transparency and accountability in health and other programs. In all likelihood, such an assessment would find, as Blustein (2008) suggests, that several important initial steps must be taken, including:

- “Set[ting] achievable performance targets . . . based on improvement in performance rather than the achievement of a particular level of performance”;
- ““Jump start[ing]’ improvement in underresourced environments by providing targeted infusions of expertise or technology”;
- “Providing funding for investment in needed infrastructure,” such as information technology systems that can improve data collection and monitoring; and
- “Offer[ing] supplemental funding” for safety-net providers and public health departments and systems that care for communities that face greater health burdens.¹⁹

A recurring theme in the strategies identified below is the need to view the essential public health services through the lens of diversity. Culture and language are increasingly important components of today's public health practice. Cultural and linguistic standards, such as those promulgated by the U.S. Department of Health and Human Services in its National Standards on Culturally and Linguistically Appropriate Services (CLAS), should guide the assessment of how public health can intervene – at multiple levels – to address health disparities (see Appendix A for a description of the CLAS standards).²⁰ While the CLAS standards are primarily directed at health care organizations, state and local public health systems can and should strive to achieve cultural competency at all levels of operation.

Method

Literature Review. We reviewed a large body of literature on public health strategies to eliminate health disparities to identify promising or evidence-based practices that states can utilize. This step included a review of the federal Office of Minority Health's (OMH) 2000 study of state efforts to address health disparities, the Centers for Disease Control and Prevention's Community Preventive Services Guide, the Association of State and Territorial Health Officials' Compendium of State and Local Models Addressing Racial and Ethnic Disparities in Health, among others. OMH's review, in particular, sought to “determine whether a statewide system is in place to address health disparities, examine competences and resources, and most importantly look at relationships or linkages between the various sectors (both public and private) providing public health services to respond to the health needs of racial and ethnic minorities.”²¹ The OMH report defined

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capacity as “state and territorial ability to reduce health disparities (and to document that these disparities are decreasing).” This same definition is used for purposes of this paper. We then organized evidence-based interventions using the Ten Essential Public Health Services framework.

Interviews With State and National Leaders. To provide a context for understanding state action to address health disparities, and to add qualitative and experiential data to the mix of evidence reviewed here, we interviewed 20 state and national leaders in health disparities and public health. These leaders included officials and professional staff in departments of public health and/or health in eight states (described below), national experts in health disparities, and a former federal official. These individuals, listed in Appendix B, agreed to be interviewed for this project and provided oral and written information about state health disparities programs, as well as their perspectives on promising state strategies.

State Examples of Promising Practices. We selected eight states (CA, CT, IL, MA, NC, NY, PA, WA) in different geographic regions of the country to identify examples of promising practices that are consistent with the literature review and expert opinion discussed in this paper. These states were selected because their strategies to address health disparities have been reviewed in other publications,²² and because we have relationships with officials and professional staff in many of these jurisdictions. In selecting these states, we do not suggest that they are exemplary or outstanding relative to other states in addressing health disparities. All eight states, however, have developed significant legislative and programmatic initiatives to address health disparities, and therefore offer a rich array of examples, some of which are cited here. We also do not suggest that our review is a comprehensive scan of the activities in these states that can result in the elimination of health disparities. We attempted to identify all relevant examples of promising strategies in these states, but undoubtedly some activities, particularly those conducted outside of minority health offices or state health departments, have been missed. Appendix C provides examples of promising practices employed by these states to address health disparities, organized by the ten essential services framework.

Essential Public Health Services and State Strategies to Eliminate Health Disparities

Essential Service #1

Monitor Health Status to Identify Community Health Problems

As defined by NPHPSP, essential state functions in this domain are:

- Assessment of statewide health status and its threats and the determination of health service needs.
- Attention to the vital statistics and health status of specific groups that are at higher risk of health threats than the general population.
- Identification of community assets and resources, which support the State Public Health Service in promoting health and improving quality of life.
- Utilization of technology and other methods to interpret and communicate health information to diverse audiences in different sectors.

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- Collaboration in integrating and managing public-health-related information systems.

States are often challenged to address this service need for communities of color and other disparity populations because of inadequate data, data systems, and infrastructure. Yet a core function of state health departments is to provide a statewide public health assessment to help prioritize interventions and set baselines for measuring progress. New York State should play a key role in mobilizing partnerships necessary to accomplish this function. Interviews with national and state leaders, as well as the health disparities and public health literature, suggest that the state should:

Assess and improve the state's capacity to identify and track disparities, and develop more robust data collection and monitoring systems with respect to race, ethnicity, and primary language.

Coordinate and integrate state data systems across all health-related agencies and programs. Better coordination of state data is needed because of the often-fragmented nature of state programs.

Improve public accessibility of data. New York State is a pioneer among states in improving public access to health data, through on-line data systems such as the recently launched Prevention Quality Indicator website. But the state can do more to make state data more publicly available as a means of assisting the public in monitoring community health status.

Community-driven health assessments, in particular, can help to strengthen the state's health monitoring. The New York State Department of Health (NYSDOH) has programs planned and in place to engage community health assessment, but should consider growing the infrastructure for community-driven strategies and empower local planning groups to shape policy. Examples include Illinois' community health assessment and planning model – the Illinois Project for Local Assessment of Needs – and North Carolina's work to build the capacity of local communities to identify disparities, collect data, and develop local action plans. These and other examples are discussed in greater detail in Appendix C.

Action Opportunity: New York State should improve and better coordinate the state's data and systems to track disparities, make these data more publicly accessible, and grow infrastructure and support for community-driven health assessment.

Essential Service #2

Diagnose and Investigate Health Problems and Health Hazards in the Community

NPHPSP's essential state functions in this domain include:

- Epidemiologic investigation of disease outbreaks and patterns of infectious and chronic diseases, injuries, and other adverse health conditions.
- Population-based screening, case finding, investigation, and the scientific analysis of health problems.

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- Rapid screening, high-volume testing, and active infectious disease epidemiology investigations.

New York State has devoted significant resources and attention to diagnosing and investigating health problems among the state's marginalized populations, and as a result is well-positioned to take action to eliminate disparities. But as above, state efforts to meet this goal have been hindered by data deficiencies and insufficient resources and capacity. The public health literature and interviews conducted for this project suggest that the state should:

Improve population-based screening and epidemiology in health disparity populations. Public health must improve epidemiologic research with diverse populations. New York State and its local health departments have initiated a number of efforts to address this need, but these can be improved by building stronger community alliances, expanding the use of community health workers, and increasing the diversity and cultural competence of the health workforce (described in more detail below).²³

Promote the use of Health Impact Assessments (HIAs). The purpose of HIAs is to ensure that all government programs and initiatives, whether in or outside the health care delivery sector, are assessed to determine their potential impact on communities' health status.²⁴ Recent HIA studies in the United States have found increased burdens of asthma and lead poisoning among children living in substandard housing, delayed cognitive development in households experiencing food insecurity, and positive health impacts from increased employment at Florida power plants for African Americans living nearby.²⁵ New York State should explore how HIAs can assist efforts to understand how policies in housing, education, employment, and the environment may impact health disparities.

Strengthen the state infrastructure to investigate health hazards, such as environmental and occupational health risks, that disproportionately affect communities of color. Few states have sought to improve environmental and occupational health surveillance and tracking of health conditions that may be related to environmental or occupational hazards. New York State should consider establishing a comprehensive tracking system that would coordinate environmental and health databases, registries, and monitoring systems. CDC's National Environmental Public Health Tracking Program provides grants to states and is building a national integrated environmental and public health information system that integrates federal, state, and local data.²⁶ Other innovative state efforts include California's Environmental Health Tracking Program (CEHTP), an integrated, standards-based system that provides monitoring, reporting, linkage, and communication of data on environmental hazards and environmentally related diseases. CEHTP creates integrated data systems and collaborative programs and partnerships involving environmental and public health professionals and organizations. It tracks environmental hazards to guide exposure-prevention efforts and disease trends (with a focus on disparity populations and specific geographic areas), and it links information on environmental hazards, exposure data, and disease reports. CEHTP is described in greater detail in Appendix C.

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Action Opportunity: New York State should build the capacity of state and local health departments to conduct public health surveillance and epidemiologic research with health disparity populations, develop an integrated environmental public health tracking program, and expand the use of Health Impact Assessments to understand how policies outside of DOH purview influence health disparities.

Essential Service #3

Inform, Educate and Empower People About Health Issues

To address this need, NPHPSP tasks states with developing and maintaining:

- Health information, health education, and health promotion activities designed to reduce health risks and promote better health.
- Health communication plans and activities such as media advocacy and social marketing.
- Accessible health information and educational resources.
- Health education and promotion program partnerships with schools, faith communities, work sites, personal care providers, and others to implement and reinforce health promotion programs and messages.

Health disparity populations often face greater barriers to health literacy and health information. These barriers span the gamut of issues, including low English language proficiency, poverty, and low educational or literacy levels, as well as systemic issues such as residential segregation. NYSDOH supports a broad variety of health promotion and chronic disease programs that are underpinned by health education activities but can improve its ability to educate and empower all state residents with effective health information. A common attribute of these practices is that they depend upon – and must necessarily strengthen – community partnerships. These partnerships are widely viewed as vital to improving the reach and impact of public health messages (and are an essential public health service, as described below). Literature and experts interviewed for this project suggest that the state should:

Build and/or strengthen culturally and linguistically appropriate health literacy programs. These efforts are most successful when designed in partnership with target populations and when language, culture, and other attributes of communities of color are fully addressed.²⁷ Training and fielding residents of health disparity communities as peer health educators is a promising strategy. CLAS offers guidance for the development, implementation, and evaluation of health education and health literacy programs.

Develop, disseminate, and evaluate health promotion messages. Few studies have assessed the effectiveness of communication interventions across diverse groups, but research has identified promising practices.²⁸ The Association of State and Territorial Health Organizations' review of state and local health disparities programs, for example, found that they utilized a wide array of health promotion strategies and vehicles, including media campaigns; partnerships with churches and community-based organizations; multi-lingual radio programs; presentations at health fairs, forums, community dialogues, and town hall meetings; and public service announcements and

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other media outreach to communities of color.²⁹ New York State should develop research-based culturally tailored health promotion messages and aggressively disseminate them through new and traditional media.

Evaluate and tailor emergency preparedness messages for communities of color and linguistic minorities. The National Consensus Panel on Emergency Preparedness and Cultural Diversity recommends that local, state, and federal health agencies coordinate and integrate efforts to address the needs of health disparity populations by:

- Identifying diverse racial/ethnic, immigrant and limited English-proficient populations;
- Establishing sustainable partnerships between community representatives and the public health preparedness system to build and sustain trust; and
- Engaging community representatives in the design, implementation, and evaluation of emergency risk communication strategies.³⁰

Examples of these strategies can be found in California, where the state's *Health Framework for Public Schools, Kindergarten Through Grade Twelve* offers a research-based curriculum tailored to the cultural and linguistic needs of the state's highly diverse student population, and Illinois' *Health Literacy for All* program designed to aid parents in understanding health information. These strategies are described in greater detail in Appendix C.

Action Opportunity: New York State should expand health education and empowerment efforts by building community partnerships to design, implement, and evaluate communications strategies, by training and fielding peer health educators, and by developing and evaluating culturally tailored public health communications messages that are aggressively disseminated through new and traditional media.

Essential Service #4

Mobilize Community Partnerships to Identify and Solve Health Problems

To fulfill this service, state public health systems should:

- Convene, facilitate, and collaborate with statewide partners (including those not typically considered to be health-related) to identify public health priorities and create effective solutions to solve state and local health problems.
- Build statewide partnerships to collaborate in the performance of public health functions and essential services in an effort to utilize the full range of available human and material resources to improve the state's health status.
- Assist communities to organize and undertake actions to improve the health of the state's communities.

NYSDOH, specifically through the work of the Office of Minority Health, has a long history of effectively mobilizing community partnerships to address health disparities. To enhance these partnerships, health disparity communities should be afforded opportunities to help shape policy and guide resources. Interviews conducted for this project, reinforced by the literature regarding effective practices, suggest that New York State should:

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Build and/or strengthen community partnerships for health, leveraging existing resources and models such as the CDC Racial and Ethnic Approaches to Community Health (REACH) program. CDC’s REACH program fosters community partnerships and community-driven strategies to address social, economic, and cultural circumstances that influence health disparities.³¹ Results of the program to date have been impressive: data from the REACH Risk Factor Survey show improvements in health behaviors and reductions in health disparities in the 27 REACH communities that focus on prevention of breast and cervical cancer, cardiovascular health, and diabetes management.³² Examples of successful partnerships in New York State include the Steps program in Broome County, coordinated by NYSDOH, which serves about 700,000 residents in this rural residential county. The program’s goal is to create sustainable policy, environmental, and systems changes and specifically targets African Americans, children and young adults, seniors, veterans, and rural, low-income, and disabled residents.

Develop integrated approaches to community health that coordinate programs across a variety of settings, including schools, worksites, communities, and health care settings. Integrated approaches recognize that individuals’ health-related knowledge, behaviors, and attitudes are shaped by their social networks, and that an integrated response must “saturate all levels of the social structure.”³³ An example of an integrated approach, which coordinates programs implemented in schools, worksites, communities, and health care settings, appears in Table 1. Such approaches also integrate community participation and involvement in disparities-reduction activities by providing communities with the knowledge and skills necessary to identify community health problems, gather data and monitor progress, and leverage existing public and community partnerships to meet public health goals.

Table 1: An Example of an Integrated Approach to Community Partnerships (IOM, 2008)

School-Based:	Worksite:
School Health Index	Worksite Wellness Index
School Health Inventory	Smoking Cessation
Wings 4 Youth	Facilitator Training
Fitness Camps	
Community-Based:	Health Care:
Wings Fitness	Smoking Cessation
Community Physical Activity Events	Facilitator Training
Healthy Restaurants	Quit Line Provider Referral Program
Healthy Women	
BMI Screenings	

Action Opportunity: New York State should expand efforts to mobilize health disparity communities by strengthening community partnerships and developing integrated approaches to community health.

Essential Service #5

Develop Policies and Plans That Support Individual and Community Health Efforts

States can meet this NPHPSP standard through:

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- Systematic health planning that relies on appropriate data, develops and tracks measurable health objectives, and establishes strategies and actions to guide community health improvement at the state and local levels.
- Development of legislation, codes, rules, regulations, ordinances, and other policies to enable performance of the Ten Essential Public Health Services, supporting individual, community, and state health efforts.
- The democratic process of dialogue and debate between groups affected by the proposed health plans and policies is needed prior to adoption of such plans and policies.

Planning is essential to eliminate health disparities, as is the ability to harness policy levers to enable performance of essential public health services. These strategies are enhanced and their likelihood of success is greatly improved to the extent that communities are involved in identifying community health problems, planning strategies to address them, and implementing programs. Importantly, these strategies must also operate “upstream” to address health determinants such as inadequate housing, inequitable educational opportunities, environmental hazards, and the like (see Appendix D for examples of these approaches). NYSDOH already engages in planning activities that address health disparities, particularly through its “Prevention Agenda for the Healthiest State,” which stimulates partnerships between local health departments and community stakeholders such as hospitals, community-based health providers, schools, academia, and others for the purpose of developing local needs assessments and collaborative plans. Literature and expert opinion, as collected for this project, suggests that New York State should also:

Develop, implement, and evaluate a statewide health disparities plan. State leaders interviewed for this project stressed the need for states to develop a strategic plan to address health disparities that describes an integrated set of programs spanning a range of clinical and community services, policies, and initiatives. State agencies responsible for implementing these programs should be clearly identified, as should community partners. Specific action sets, with timetables for reporting and measures for accountability, should be described. Such a plan should be developed in partnership with communities served by the plan, and should reflect these communities’ expressed priorities and needs.

The process of developing a coordinated interdepartmental plan can be facilitated by drawing upon the expertise of NYSDOH’s advisory councils.

Establish a statewide Interagency and Interdepartmental Coordinating Council to establish and coordinate a statewide response to health disparities. A growing number of states are recognizing that efforts to eliminate health disparities must include strategies to improve education, housing, environmental quality, and the like. In Washington State, for example, the Governor’s Interagency Coordinating Council on Health Disparities is charged with developing a statewide action plan, promoting communication and coordination across state agencies (including housing, education, employment, and other

agencies whose policies shape health), gathering information, and issuing

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recommendations to understand how the actions of state government ameliorate or contribute to health disparities. In New York State, the process of developing a coordinated interdepartmental plan can be facilitated by drawing upon the expertise of NYSDOH's 60 advisory councils, which are tasked with developing policy and planning to address individual and community health needs. These advisory groups should include a charge to address disparities in their respective areas.

Promote community health planning. Community health planning has been defined as “the deliberate pursuit of improvements in the health status of a community or the efficiency of the health care system through a public process that allows all members of the community to have significant input.”³⁴ Community health planning has a long history, but its promise has yet to be achieved.³⁵ Health planning, however, has enjoyed greater success in New York State than in other parts of the country. Two Health Systems Agencies (HSAs) continue to operate in the state. One of these HSAs, the Finger Lakes HAS, is often viewed as a national model for a planning process to achieve consensus among diverse stakeholders.³⁶ NYSDOH is already seeking input on promising strategies and models to revitalize community health planning, and the 2008-2009 state budget offers \$7 million in grants to support local health care planning initiatives. These efforts should be expanded and, where appropriate, linked with incentives such as Certificate of Need assessments (described below).

Enhance the potential power of Certificate of Need (CoN) assessments as a tool for reducing geographic disparities and the “fragmentation” of the health insurance market. In most states that employ CoN, the process has required health care institutions seeking to establish or expand services to submit proposals so that state boards may evaluate projects, eliminate unnecessary duplication of services, and ensure that investments are strategic. The process, however, has great potential to encourage a distribution of health care resources that better reflect community and statewide need.³⁷ New York State should evaluate, and if necessary reinvigorate, CoN through new policies that ensure accountability for the use of public funds.

Address upstream determinants of health, such as housing, the retail food environment, and environmental living conditions. States are increasingly addressing “upstream” social and economic conditions that shape health. For example, Pennsylvania's Fresh Food Financing Initiative (FFFI) is a public-private state program that works to increase the number of supermarkets and grocery stores in underserved Pennsylvania communities. The initiative provides financing for supermarkets to operate in communities where infrastructure costs and credit needs cannot be filled solely by conventional financial institutions. These stores are increasing access to healthier foods and improving dietary options, particularly for people living on low wages who have limited ability to purchase higher-quality foods.

Establish a state minority health policy “report card” as a tool in evaluating and promoting state disparities-reduction efforts. New York State should issue a report card to measure state efforts to improve health care access and quality, with the goal of providing transparent public information to enhance government accountability and to

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increase incentives for improved performance.³⁸ Standard variables are needed that can track state performance over time and allow for comparisons between disparity populations.³⁹

Action Opportunity: New York State should develop and support individual and community-level health disparities elimination efforts by:

- *Developing a statewide action plan;*
- *Promoting community health planning as a tool to balance the allocation of health care resources with community needs;*
- *Establishing a state minority health “report card”;*
- *Linking community health planning with incentives, such as Certificates of Need;*
- *Establishing a statewide Interagency and Interdepartmental Coordinating Council to coordinate the work of state agencies to address health disparities; and*
- *Addressing upstream determinants of health, such as the quality of housing, the retail food environment, and recreational options in health disparity communities.*

Essential Service #6

Enforce Laws and Regulations That Protect Health and Ensure Safety

To meet this NPHPSP standard, states must undertake several tasks:

- The review, evaluation, and revision of laws and regulations designed to protect health and safety to assure that they reflect current scientific knowledge and best practices for achieving compliance.
- Education of persons and entities obligated to obey or to enforce laws and regulations designed to protect health and safety in order to encourage compliance.
- Enforcement activities in areas of public health concern, including but not limited to the protection of drinking water; enforcement of clean air standards; regulation of care provided in health care facilities and programs; re-inspection of workplaces following safety violations; review of new drug, biological, and medical device applications; enforcement of laws governing the sale of alcohol and tobacco to minors; seat belt and child safety seat usage; and childhood immunizations.

New York State has developed several state efforts to enforce laws and regulations that protect health and safety, particularly with respect to health disparity populations. For example, New York State’s Department of Environmental Conservation is directed by statute to address environmental justice considerations when reviewing land use policy, particularly for low-income communities and communities of color. But the state should review and evaluate how policies and practices affect health disparity communities, and where necessary strengthen enforcement of state laws and regulations that protect the health and well-being of vulnerable populations. New York State should:

Evaluate the impact of existing laws and regulations, such as those regarding environmental and occupational exposures, violence and injury prevention, and firearms access, on the health of disparity populations. State policy in a broad range of areas –

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such as education, labor, transportation, and criminal justice – has significant implications for health and health disparities. Health Impact Assessments (described above) can offer policymakers important information to weigh the impact of laws, policy, and regulation in these areas. HIA analyses may be based on existing data about current or past conditions and trends; therefore improvements in state health data are important to support HIAs. Recommendations should prospectively assess the potential consequences of policy decisions, and they should be based on multidisciplinary assessment tools.⁴⁰

Assess and, if necessary, improve enforcement of state laws that directly (e.g., environmental health risks) or indirectly (e.g., discrimination in housing and employment) affect the health of people of color. As discussed in Appendix D, research evidence demonstrates that racial and ethnic discrimination persists in sectors such as employment, lending, and housing. To the extent that these unlawful practices limit the socioeconomic opportunities and mobility of people of color or other marginalized groups, they contribute to inequitable health opportunities. New York State should assess whether there is a need for greater enforcement of state anti-discrimination laws, in conjunction with federal law enforcement. Similarly, the State should assess and improve enforcement of environmental and occupational health laws and regulations that disproportionately affect disparity populations.

Several states have developed promising strategies. California, for example, has adopted a comprehensive approach to address environmental justice, including partnership development, leveraging of resources, coordination across state agencies, and involvement of affected communities in program development. Similarly, Illinois has enacted protections from environmental degradation, and it directs the state’s Environmental Protection Agency to assess and address “environmental justice areas” that qualify for state resources. In 2005, the Illinois EPA created an environmental justice advisory group that includes members of community and environmental groups. Massachusetts’ Executive Office of Environmental Affairs assesses community environmental risk and supports participation in environmental policy decision making. The state’s Environmental Justice Policy prioritizes affected communities for funds associated with hazardous waste site removal, environmental inspections, and enforcement actions, and scrutinizes industrial waste facilities and air emissions. The state also creates incentives for open space and other remedies in communities affected by environmental degradation.

Action Opportunity: New York State should review and evaluate how policies and practices affect health disparity communities and, where necessary, strengthen enforcement of state laws and regulations that protect the health and well-being of vulnerable populations.

Essential Service #7

Link People to Needed Personal Health Services and Assure the Provision of Health Care When Otherwise Unavailable

States should provide several services to meet this NPHPSP goal, including:

- Assessment of access to and availability of quality personal health care services

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for the state's population.

- Assurances that access is available to a coordinated system of quality care that includes outreach services to link populations to preventive and curative care, medical services, case management, social and mental health services, culturally and linguistically appropriate services, and health care quality review programs.
- Partnership with public, private, and voluntary sectors to provide populations with a coordinated system of health care.
- Development of a continuous improvement process to assure the equitable distribution of resources for those in greatest need.

New York State has made great strides toward expanding access to needed health care services and has evaluated access to and the availability of quality personal health care services for the state's population. The state can do more, however, to assure access to a coordinated system of quality care and culturally and linguistically appropriate services. To accomplish this, the state should:

Assess health insurance coverage, particularly among underserved populations, and expand public health insurance programs with the ultimate goal of achieving 100% coverage among state residents. New York State should assess take-up rates of public insurance among eligible state residents, develop tailored outreach programs to enroll uninsured eligible people, and expand public insurance programs such as Medicaid and the State Children's Health Insurance Program (SCHIP) to maximize health insurance coverage.

Encourage health systems to adopt "medical home" models, particularly for vulnerable and underserved populations. Medical home models integrate four vital functions including:

- First contact care—or the door on which the patient knocks to initiate help;
- Comprehensive care that addresses a full spectrum of preventative, acute, and chronic health care needs;
- Longitudinal care that offers sustained relationships between patients and health care providers;
- A home base from which other accommodations such as specialists and other care needs can be arranged.⁴¹

Having a medical home is associated with better management of chronic conditions, regular preventive screenings, and improved primary care. Racial and ethnic minorities are less likely to report having a medical home, but when they do their health care access gaps are significantly reduced.⁴² New York State should promote the development of medical homes in community health centers and other state-supported health care institutions.

Support safety net institutions and quality improvement initiatives in these settings. People of color and low-income individuals are more likely than other populations to access health care in safety-net institutions,⁴³ which in many cases face financial vulnerability – the result of low Medicaid reimbursement rates or of the institutions'

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provision of uncompensated care to uninsured individuals.⁴⁴ New York State can do much to expand safety-net institutions and improve health care quality in these settings. For example, through their power to license health care facilities and health professionals, states have helped to ensure that Community Health Centers (CHCs) meet minimum standards and have held centers to additional requirements such as reporting patient safety data. States also can shape and support CHCs through their purchasing authority. Medicaid payments represent a growing share of CHC financial support, and as such state policies regarding coverage and eligibility have a strong influence on CHC operations. In addition, states can appropriate funds or direct federal funds to health centers to achieve state objectives, such as addressing workforce shortages and improving health information technology. In FY2008, states provided nearly \$590 million to support health center capacity for such purposes.⁴⁵

Enhance primary care, particularly in communities with high rates of ambulatory-care sensitive conditions. New York State has recently shifted state funding to invest in more effective and cost-efficient primary care, but the state can do more to stimulate primary care in underserved communities. Through private investment incentives for quality of care improvements, the state can improve its primary care capacity, especially health care services for populations at risk for not receiving adequate primary care.⁴⁶ New York State should also encourage investment of capital in the primary care infrastructure, focusing on facilities, equipment, and health information technology, as well as performance improvement.⁴⁷

Expand language access programs. New York State has developed and implemented a number of language access programs to ensure reasonable accommodation for patients who require language assistance. But the state should consider adopting comprehensive language access provisions that guide not only state agencies but also different types of hospitals, providers, and services, as California has done. For example, California's Department of Managed Health Care has promulgated regulations regarding language requirements for managed health care plans, and the state requires cultural competency training as continuing education for health professionals. Other states have also adopted promising strategies. In 2007, Connecticut authorized Medicaid payments for language services. Washington State requires state certification for medical interpreters. New York State should consider these strategies, as well as providing adequate reimbursement for the services of trained interpreters as part of state Medicaid and Child Health Plus programs.

Include requirements to address health care disparities in all state contracts providing health services through Medicaid, SCHIP, and the state employee health benefit programs (e.g., by encouraging compliance with CLAS standards in all health systems doing business with the state). These can include: requirements that health plans collect data on beneficiaries' race, ethnicity, and language preferences to better understand when and under what circumstances disparities occur, and to develop and evaluate tailored interventions; requirements that health plans include diverse health professionals on provider panels; and the offering of incentives for plans to adopt disparities initiatives and demonstrate success in reducing gaps.

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Action Opportunity: New York State should measure and expand access to quality personal health care services for the state's population, and assure access to a coordinated system of quality care and culturally and linguistically appropriate services by:

- *Assessing public insurance take-up rates among eligible populations;*
- *Expanding health insurance coverage options with the ultimate goal of achieving 100% coverage among state residents;*
- *Encouraging health systems to adopt “medical home” models;*
- *Supporting safety-net institutions;*
- *Expanding access to primary care, particularly in underserved communities;*
- *Expanding language access programs; and*
- *Including requirements to address health disparities in all state health service contracts.*

Essential Service #8

Assure a Competent Public and Personal Health Care Workforce

To meet this NPHPSP standard, states must provide:

- Education, training, development, and assessment of health professionals – including partners, volunteers, and other lay community health workers – to meet statewide needs for public and personal health services.
- Efficient processes for credentialing technical and professional health personnel.
- Adoption of continuous quality improvement and life-long learning programs.
- Partnerships with professional workplace development programs to assure relevant learning experiences for all participants.
- Continuing education in management, cultural competence, and leadership development programs.

New York State has taken a number of steps to improve the education, training, and assessment of health and public health professionals to meet the needs of diverse populations. The state can take additional steps to ensure that health professionals are able to address health disparities, as our interviews and literature review suggest, by:

Continuing education in cultural competence, management, and leadership development. Cultural competence training shows promise as a strategy for improving the knowledge, attitudes, and skills of health professionals to serve increasingly diverse patient populations. AHRQ’s review of published studies found “excellent evidence” that cultural competence training increases the knowledge of health care providers, and “good evidence” that these programs increase providers’ knowledge and skills.⁴⁸ Several states – including California, Washington State, and New Jersey – now require cultural competency training as a condition of licensure.

Promoting diversity in the public health and health professions workforce. Fewer than 8 percent of physicians, nurses, psychologists, and other health professionals are African American, American Indian, or Latino. The United States would need nearly *four times* the present share of underrepresented minority health professionals to match the

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proportion of minorities in the population. Evidence demonstrates, however, that more underrepresented minority professionals are needed to help close the racial/ethnic health care gap. Minority health care professionals are more likely to practice in minority and medically underserved communities and to provide care to poorer, less healthy patients.⁴⁹ Minority professionals are often better able to address cultural and linguistic barriers that patients of color experience in health care systems.⁵⁰ And the likelihood that a minority patient will receive appropriate follow-up and referral increases when the patient is treated by a same-race provider.⁵¹ Not surprisingly, patients of color often express greater satisfaction with the care that they receive from providers of their own background.⁵² States can stimulate diversity efforts by:

- Reducing financial barriers to higher education and health professions education: state governments can offer low-interest loans, scholarships, and tuition payback agreements to health professions students who come from and agree to serve in underserved communities;
- Repaying student loans for health professionals who agree to work in underserved communities;
- In higher education admissions processes, implementing whole file review and considering the needs of the future U.S. health professional workforce in admissions decisions.⁵³

Encouraging the training and employment of community health workers. Also known as lay health navigators or *promotoras*, community health workers function as liaisons between patients and health systems while endeavoring to improve local health outcomes. These individuals, typically members of the medically underserved community they are serving, are trained to teach disease prevention, conduct simple assessments of health problems, and help their neighbors access appropriate health and human resources.⁵⁴ Community health worker models are rapidly spreading, as research and practice indicate that such services can improve patients' ability to receive care and manage illness. States can stimulate these programs by providing grants, seed funding, or other resources.

Action Opportunity: New York State can improve the capacity of its health and public health professionals to respond to the needs of health disparity populations and address health gaps by:

- *Requiring cultural competency training of current and future health care professionals;*
- *Expanding efforts to increase the diversity of the state's health professions workforce; and*
- *Encouraging the training and employment of community health workers.*

Essential Service #9

Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services

To address this NPHPSP service, states should conduct:

- Evaluation and critical review of health programs, based on analyses of health status and service utilization data, to determine program effectiveness and to provide information necessary for allocating resources and reshaping programs

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- for improved efficiency, effectiveness, and quality.
- Assessment of and quality improvement in the state public health system's performance and capacity.

To address disparities, states should evaluate the effectiveness of programs and continuously improve the state public health system's performance and capacity with regard to disparity populations. New York State already conducts evaluations of the effectiveness, accessibility, and quality of personal and population-based health services, but it should include a focus on how these services address the goal of eliminating disparities. For example, New York State can evaluate progress toward eliminating health care quality disparities by collecting and disaggregating Statewide Planning and Research Cooperative System data by patients' race, ethnicity, income or education level, and primary language, and by publicly reporting this information.⁵⁵ Since 1995 California has required that demographic information such as race and ethnicity be collected and reported in inpatient discharge data, and since 1998 that requirement has been included in Emergency Department and Ambulatory Surgery data programs. The state's studies reveal significant disparities along racial and ethnic lines in access to health care, in the delivery of care, and in the outcomes of care. In addition, the California Office of Statewide Health Planning and Development makes this data available to the public.

Action Opportunity: New York State should evaluate the effectiveness of individual and population-based health services in eliminating health disparities, and it should publicly report this information.

Essential Service #10

Research for New Insights and Innovative Solutions to Health Problems

To meet this NPHPSP standard, states are expected to:

- Conduct a full continuum of research ranging from field-based efforts to foster improvements in public health practice to formal scientific research.
- Promote linkage with research institutions and other institutions of higher learning.
- Build internal capacity to mount timely epidemiologic and economic analyses and conduct needed health services research.

NYSDOH has engaged in an array of research projects to address population health, but these efforts have rarely focused on research to better understand and eliminate disparities. The state should increase its capacity to improve the knowledge base and develop new strategies to eliminate health disparities. To this end, the state should:

Support community-based participatory research (CBPR). Community-based participatory research directly engages stakeholders in target communities to help shape the design and conduct of research. These strategies include community members as partners in identifying problems to be studied and research questions, as well as in carrying out the research and interpreting findings. CBPR uses the knowledge of the community to understand health problems and to design interventions, providing immediate benefits from the results of the research to the community. New York State

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can support these efforts by creating special grant funds for partnerships between community-based organizations and research institutions.

Assess and address state and local health department research capacity. New York State should use the National Public Health Performance Standards assessment instruments to assess state and local research capacity. The assessment questions posed in the guide can be tailored to determine how health disparities research issues are addressed. Where gaps are found, the state should determine needs and develop a plan to address them.

Form partnerships with higher education and research institutions focused on health disparities. Given the research resource limitations of many states and local public health departments, state partnerships with academic and research institutions can provide wide-ranging benefits. For state agencies, contractual or partnership arrangements with research institutions can fill gaps and provide complementary analyses. Public academic institutions often find that collaboration with state agencies to address health disparities fulfills aspects of the institutional mission. And, for research institutions, partnership with state health agencies on health disparities research can grow capacity in a rapidly expanding sector of both public and private research support.

Action Opportunity: New York State should support research to understand and eliminate health disparities, drawing upon promising models of community-based participatory research and partnerships with academic and research institutions.

IV. State Health Disparities Entities – How Are Disparities Addressed in State Government?

Offices of Minority Health or other health disparities entities exist in 36 of the 50 states and often serve an important role in coordinating state health department activities related to minority health or health disparities and in elevating the visibility of health disparities in state health departments. Minority health offices serve as leading advocates for minority health issues in state health departments, inform and advise legislators, and provide information to key stakeholders and the general public (programs and functions of minority health offices in the eight states reviewed for this project are discussed in Appendix E). The federal Office of Minority Health's 2000 review of the activities of state offices of minority health in the eight participating states found that several major activities were commonly undertaken by these offices. They include:

- Improving the state capacity to respond to the health needs of communities of color (most often, state offices of minority health sought to address this need by mobilizing community partnerships to identify and address problems);
- Promoting more accurate, detailed, and reliable state data collection;
- Monitoring health status to identify community health problems;
- Developing strategies and programs to improve the cultural competence and diversity of the health professions workforce; and
- Evaluating the effectiveness, accessibility, and quality of personal- and population-based health services.

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Data to assess the effectiveness of state offices of minority health in reducing health disparities is often lacking, the report noted. However, many were successful in core tasks such as elevating the visibility of and coordinating state health disparities programs, building the capacity of the state health infrastructure to respond to the needs of communities of color, and building strong community partnerships. The report found that several factors contribute to the effectiveness of state minority health entities, including:

- Support from state government, including legislative initiatives and endorsement of health disparities programs from political leaders;
- A statewide health disparities plan with specific goals and objectives, as well as task forces or commissions to support and provide oversight of the plan's development and implementation;
- The presence of other state minority health programs and private sector minority health entities and coalitions;
- The presence of health disparities initiatives conducted by the academic and faith communities;
- The presence of strong links between the state minority health entity, communities of color, and the state health department.

Action Opportunity: Provide the support and resources necessary to ensure that the Office of Minority Health is able to successfully carry out its legislative charge and coordinate the department's health disparities efforts.

V. State Health Disparities Strategies and American Indian Tribes

States have played a growing role in addressing the public health and health service needs of American Indians and Alaska Natives (AI/AN), driven in part by the fact that these communities are near the bottom of almost every health, social, and economic indicator in the United States. Forming successful state-tribal alliances for health, however, requires that state agencies attend to the unique circumstances of tribes. First and foremost, states must understand that federally recognized tribes are sovereign nations, and that interactions between states and tribes are government-to-government exchanges that must be predicated on mutual trust and respect.⁵⁶ States must also recognize that some tribes face an array of challenges. The needs of rural American Indians and Alaska Natives can be daunting, and they include geographic isolation, high levels of poverty, a poor or nonexistent public health infrastructure, and in some cases limited access to health care. In addition, states must attend to the broader historical, cultural, and social contexts that shape state-tribal interactions. Historically, states have not collaborated well with tribal governments or interacted with them as equal partners. This has left a legacy of mistrust and misunderstanding.⁵⁷

Some states, however, are meeting and addressing these challenges. Several leading state public health practitioners and policymakers interviewed for this report pointed to Washington State's work with tribal governments as a model of how states and tribes can collaborate to meet tribes' public health needs. Washington State is unique among states in that its state agencies are guided by the Centennial Accord, which acknowledges the

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government-to-government relationship between Washington State and tribes and requires consultation on all matters of mutual concern. The Centennial Accord was cited by several leaders interviewed for this report as an important framework to guide interactions and resolve conflicts between state agencies and tribes. One individual stated that the “state must approach tribes as equals or as a servant, and provide resources and support. States often want to be a parent, but states can’t parent another government. We must be clear about areas of work and let the [Indian] community drive the work.”

In 1994, Washington State established the American Indian Health Commission for Washington State (AIHC), which provides a framework for tribal governments to form partnerships with state and local governments to address health needs. AIHC’s mission is to improve the health status of American Indians by influencing state health policy through the promotion of

increased tribal-state collaboration. The commission meets every other month to facilitate the coordination of services and information dissemination to tribes and state authorities, to build partnerships, and to resolve conflicts. It also conducts a Tribal Leaders’ Health Summit every two years to promote dialogue among the state government, tribal governments, and the federal government and to develop and modify position papers. In addition, AIHC also collaborates with the Washington State Department of Health to produce the state American Indian Health Care Delivery Plan, which describes the health status of American Indians in the state, highlights strategies being used by states and tribes to address health needs, identifies public health priorities, and makes recommendations – driven by tribal leaders – regarding tribal-state health service and public health policies. The most recent plan, released in August 2007, highlighted several promising state-tribal efforts to address specific public health and health service needs, such as emergency preparedness planning, expansions of Medicaid and the state public employee health benefit program to increase health insurance coverage among American Indians, a smoking cessation collaborative, and other efforts.⁵⁸

“States often want to be a parent, but states can’t parent another government.”

Action Opportunity: New York State should develop strong partnerships with tribes and offer government-to-government support to assist tribes in meeting their health goals.

VI. Findings and Recommendations

This review has identified a number of promising strategies that New York State can adopt to reduce and eliminate health disparities. It is clear from the published literature and interviews with state leaders that successful state efforts to address disparities must be comprehensive, employing a range of strategies simultaneously across sectors. Such an approach is important because the programs and policies identified here are unlikely to be successful by themselves in reducing health gaps. Rather, they are complementary and mutually supporting. They should be strategically linked to other policies and programs that can create greater synergy by operating in concert, rather than in isolation.

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New York State government must prioritize, however, and assess whether these policies and programs will yield benefits at the desired scale. Particularly in light of the current economic crisis, few states will have the luxury of developing and implementing a “Marshall Plan” to combat health disparities. In an effort to prioritize and focus on a small number of key strategies that are likely to build momentum toward the elimination of health disparities, the following five strategies are offered.

1. Leverage and Expand Core System and Mission Functions to Assure an Integrative Approach for Addressing Health Disparities

New York State has developed strong core system and mission functions to address the public health needs of state residents, and it is a leader among states in supporting key tools such as community partnerships and community health planning. These core systems and functions, however, are often overlooked or underutilized as mechanisms for addressing health disparities. The state should assess how disparities-elimination strategies can be integrated into core public health functions and develop a comprehensive strategic plan (also described below) that identifies specific action steps to be taken by specific actors and agencies to assure the integration of disparities-elimination strategies in core functions. There are many examples of NYSDOH systems and functions that can effectively address disparities, including:

- Quality initiatives (e.g., the elimination of disparities should be a core goal in the state’s Quality Assurance Reporting Requirements);
- Partnerships with local health departments (e.g., NYSDOH should work with local health departments to plan and support comprehensive disparities-elimination activities);
- Certificate of Need review (e.g., certificates should be contingent on evidence that new services or facilities can contribute to the elimination of disparities);
- Community health planning (e.g., health planning should explicitly address and develop strategies for the elimination of disparities);
- Health services contracting (e.g., state Medicaid and Child Health Plus contracts should explicitly require disparities-elimination activities);
- Data systems (i.e., data collection, aggregation, and reporting should be conducted in a manner that prioritizes the elimination of health disparities); and
- Advisory Councils (i.e., NYSDOH’s Advisory Councils should include a charge to address the elimination of disparities in their respective activities).

2. Improve Data Collection, Data Systems, and Mechanisms for Monitoring and Reporting Disparities

Data are essential for government agencies to identify health disparities, target and plan initiatives, and to measure progress in eliminating disparities. Many states, however, struggle with inadequate data. Particularly lacking are data for Asian Americans, American Indians, and Pacific Islanders, as well as for ethnic subgroups. Also lacking are data on primary language, education level or professional occupation, place of residence, and nativity. To the extent possible, New York State should require that these data

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elements are included in all state health statistics databases. To improve and standardize data collection in challenging areas and systems (e.g., small geographic areas, ambulatory care and small practice settings), New York State should be prepared to offer both resources for improvement of data systems, as well as technical assistance in implementing new data systems. New York State should be particularly attentive to opportunities for integration of these data elements in emerging health information technology and electronic medical records, to the extent that the Department of Health is involved in regulating these tools. Data collection should be conducted in a manner consistent with the federal CLAS standards (e.g., where possible racial and ethnic data should be collected through self-report). Finally, New York State should publicly report these data where feasible. Public reporting provides a mechanism for accountability to state residents and is likely to spur activity toward the elimination of disparities.

New York State has an important opportunity to prioritize disparities in the context of new data systems and tools, such as the recently released Prevention Quality Indicators that will be used to help plan a high-performing, affordable health care system with primary care as the centerpiece. In addition, NYSDOH should continue to build on data systems underway and evaluate their use and effectiveness in monitoring health disparities in the state.

3. Develop, Implement, and Evaluate Disparities Interventions

Despite significant NYSDOH effort to employ promising strategies, this review finds a relative paucity of information on developing, implementing, and evaluating disparity interventions. New York State should consider the needs of disparity populations and develop a strategic plan that (a) is comprehensive (that is, it addresses needs using the Ten Essential Public Health Services or other frameworks that span the gamut of individual health and health education services through upstream social and community-level determinants of health); (b) describes specific action steps to be taken by specific actors or agencies; (c) specifies when these actions should be taken; (d) includes mechanisms of accountability (e.g., reporting structures should be clear and transparent and should specify incentives for action and corrective steps for inaction); and (e) is regularly evaluated and updated. To this end, the state should consider establishing an oversight body and providing funds and/or other resources dedicated specifically for evaluation of the state's progress in eliminating health disparities. In addition, the construction of a health disparities strategic plan should include the input and perspectives of communities that face health disparities. This will improve community support for state efforts and help to shape the NYSDOH's program efforts in meeting the needs of the state's culturally and linguistically diverse populations. New York State should therefore ensure that all communities affected by health disparities have a voice in crafting a state plan.

4. Ensure Leadership and Stakeholder Support for Coordination of Effort and Institutionalize Disparities-Reduction Work

Almost all of the state leaders interviewed for this project noted the lack of coordination,

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integration, and collaboration of disparities efforts across many states' programs and agencies. This is not surprising given the growth of public health programs in most states, particularly efforts focused on addressing specific disease conditions. Unfortunately, however, these programs have evolved in such a way as to establish "silos" of effort. Many states have established free-standing programs to address cardiovascular disease, cancer, diabetes, HIV/AIDS, hypertension, renal disease, and a host of other chronic and infectious diseases. While focused work in each of these disease areas is appropriate, the efforts have resulted, in some cases, in separate data systems, funding structures, and programs that could have a greater impact working in concert. The same dynamic is apparent in New York State. NYSDOH should work to achieve greater integration, collaboration, and coordination across these structures and across all relevant departments and agencies, including non-health agencies, so that the needs of disparity populations are met. As noted earlier in this report, many health disparities have their roots in inequitable housing, public services, education, transportation, and occupational opportunities. The Department of Health should also play a lead role in convening other state agencies that are not charged with addressing residents' health needs but whose actions and policies can play a significant role in either reducing or exacerbating health disparities. An interdepartmental task force can be effective in meeting this need, particularly if convened by the governor, as is the case in Washington State.

Many states have wrestled with the question of whether there should be an office within the health department focused on health disparities, or whether the issues and responsibility to address disparities should be infused throughout state health agencies. Most leaders interviewed for this project argue for both strategies. Health disparities efforts, they note, should be infused throughout all state health programs and coordinated by a state health disparities body. The head of this body should report to the state's highest health authority to give the issue of health disparities the level of prominence and attention necessary to marshal appropriate resources and cooperation across health agencies. The goal, as one state leader interviewed for this report noted, is for state health disparities entities to be able to set policy, not just to fund programs. To this end, New York State should consider elevating the Office of Minority Health to report directly to the State Health Commissioner and coordinate the health disparities activities of NYSDOH agencies.

5. Promote Thoughtful and Ongoing Communication Among and Between State Agencies and Health Disparity Communities, the Public Sector, and the Private Sector to Address Health Disparities

Almost all of the state leaders interviewed for this project emphasized the need for states to establish strong community partnerships and to promote communication between state agencies and health disparity communities. This is particularly important for communities such as American Indian tribes that historically have not had a strong public health partnership with the state. Strong communication and partnership must extend, however, to other key stakeholders – business, labor, and faith leaders; civic and community-based organizations; and the media – in the effort to eliminate health disparities. [CHANGE CORRECT?] NYSDOH should draw upon the coordinating

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power and potential of its Public Affairs Group, a systemic driver in the department's communication efforts, to play a lead role in cross-agency and cross-sector coordination for the elimination of health disparities.

Regardless of the approaches taken, it is clear that states need strong, committed leadership to eliminate disparities and improve the health of all state residents. Leaders must communicate the urgency of addressing disparities and offer a vision for how the state will achieve health equity. They must communicate their support for disparities reduction as a key goal of state health policy. And they must hold people and agencies accountable for action to achieve the vision. New York State's leaders have indicated that the elimination of disparities must be a priority, and that they are committed to directing resources to address the problem.

Appendix A

National Standards on Culturally and Linguistically Appropriate Services (CLAS)

Standard 1

Health care organizations should ensure that patients/consumers receive from all staff member's effective, understandable, and respectful care that is provided in a manner compatible with their cultural health beliefs and practices and preferred language.

Standard 2

Health care organizations should implement strategies to recruit, retain, and promote at all levels of the organization a diverse staff and leadership that are representative of the demographic characteristics of the service area.

Standard 3

Health care organizations should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

Standard 4

Health care organizations must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each patient/consumer with limited English proficiency at all points of contact, in a timely manner during all hours of operation.

Standard 5

Health care organizations must provide to patients/consumers in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.

Standard 6

Health care organizations must assure the competence of language assistance provided to limited English proficient patients/consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except on request by the patient/consumer).

Standard 7

Health care organizations must make available easily understood patient-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

Standard 8

Health care organizations should develop, implement, and promote a written strategic plan that outlines clear goals, policies, operational plans, and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.

Standard 9

Health care organizations should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, patient satisfaction assessments, and outcomes-based evaluations.

Standard 10

Health care organizations should ensure that data on the individual patient's/consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and periodically updated.

Standard 11

Health care organizations should maintain a current demographic, cultural, and epidemiological profile of the community as well as a needs assessment to accurately plan for and implement services that respond to the cultural and linguistic characteristics of the service area.

Standard 12

Health care organizations should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and patient/consumer involvement in designing and implementing CLAS-related activities.

Standard 13

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Health care organizations should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing, and resolving cross-cultural conflicts or complaints by patients/consumers.

Standard 14

Health care organizations are encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

Appendix B State and National Leaders Interviewed for This Report

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Moving Toward Health Equity in New York State

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Appendix C: Promising State Strategies to Address Health Disparities Relative to the “Ten Essential Public Health Services”

Essential Public Health Services

Essential Service #1

Monitor Health Status to Identify Community Health Problems

Essential state functions in this domain are:

- Assessment of statewide health status and its threats and the determination of health service needs.
- Attention to the vital statistics and health status of specific groups that are at higher risk of health threats than the general population.
- Identification of community assets and resources, which support the SPHS in promoting health and improving quality of life.
- Utilization of technology and other methods to interpret and communicate health information to diverse audiences in different sectors.
- Collaboration in integrating and managing public health related information systems.

States are often challenged to address this service need for communities of color because of inadequate data, data systems and infrastructure. Yet a core function of state health departments is to provide a statewide public health assessment to help prioritize interventions and set baselines for measuring progress. State health departments play a key role in mobilizing partnerships necessary to accomplish this function. The health disparities and public health literature suggests that states should:

Assess and improve state capacity to identify and track disparities, and develop more robust data collection and monitoring systems with respect to race, ethnicity, and primary language. States can do better to assess health status and harness vital statistics data for communities of color. Mathematica’s recent (2007) assessment of state capacity to access and utilize data on Healthy People 2010 health indicators revealed that data exist to measure disparities in all states, but that important data gaps exist. Some states, for example, did not report estimates for non-white populations responding to the Behavior Risk Factor Surveillance System or the Youth Behavior Risk Surveillance System because of small sample sizes; several others only reported data as white and non-white. Small sample sizes also limited states’ ability to assess geographic variation, and racial and ethnic subgroup data is particularly difficult to access through these surveys. In addition, the quality of data on race and ethnicity in the National Vital Statistics Systems is inconsistent across states; mortality data for some groups, such as American Indians, continues to be poor because they rely on secondary reports. States also varied considerably in the accessibility of data; only about half of the 50 states allow data to be accessed through interactive databases, and only six had an interactive mapping or Geographic Information Systems component.⁵⁹ Such web-based tools can improve the accessibility of information for state use.

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Coordinate and integrate state data systems across all health-related agencies and programs. Better coordination of state data is needed because of the often-fragmented nature of state programs (e.g., in some states diabetes data reside with the diabetes program, Medicaid data with the Medicaid program, cancer data with the cancer program, etc.). States should undertake efforts to link data sets and systems in a manner that allows for comparison of leading health indicators or other standardized metrics for diverse populations. Several state health leaders interviewed for this project identified inconsistencies and a lack of coordination across state data systems as a major impediment to understanding where and under what circumstances health disparities occur.

Improve public accessibility of data. Mathematica's (2007) report also notes that in some states key data may be available to assess health disparities, but unless these data are accessible they may be underutilized in the effort to identify health disparities and appropriately intervene to address them. The report noted that when data are made available for the public via the internet, they were more likely to be utilized in research and advocacy efforts, and therefore were more likely to be incorporated in state planning. This was particularly true for the 27 states that offer public health data through interactive databases, including six which included interactive mapping or GIS components. Half of the states in their assessment published state Healthy People reports on line since 2003, with some providing a particular focus on health disparities.⁶⁰

Support Community-Based Participatory Research (CBPR) to engage communities in identifying health problems and conducting needs assessments. CBPR emerged from a recognition that public health efforts must involve the intended beneficiaries in all phases of program planning, implementation, and evaluation, and engage communities in a collaborative research enterprise. Having the community function as a partner helps to insure that social and cultural considerations are addressed in public health programming, and fosters community cooperation. Several studies demonstrate that CBPR is effective in enhancing the capacity of community members to identify key health concerns and research questions, participate in the planning and implementation of programs, and in helping to interpret findings.⁶¹ To do this, states should consider measuring the competencies of health department staff to effectively engage in CBPR and assess institutional barriers to greater collaboration. Parker and colleagues, for example, have identified four discrete dimensions of CBPR public health practices by health departments and have developed a measure of CBPR competencies. Such an assessment can guide training programs and improve institutional policies to foster partnerships.⁶² States can support CBPR by providing grants and training opportunities for public health professionals, students, and faculty.

Promising State Strategies to Monitor Health Disparities and Identify Health Problems in Communities of Color

Several states are taking action to improve data collection, measurement, and monitoring of health disparities.

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Connecticut. With funding from the Connecticut Health Foundation, the state's Department of Public Health embarked upon a review of existing data collection practices and capacity with regard to race, ethnicity, and other socio-demographic variables in 37 of the department's health databases, and generated a series of recommendations for improvement. The review found that only 16 percent of the department's databases complied with the 1997 U.S. Office of Management and Budget standards for the collection of race and ethnicity data, and collection of data on socioeconomic status, language, and geographic area of residence was even less frequent. Factors that contributed to the paucity of demographic data included non-compliance with federal standards, reliance on secondary data from larger databases, limited information technology resources, and limited funding to improve data collection. The report offered several specific recommendations for standardizing data collection, increasing the knowledge and skills of data users, and increasing the availability of information technology resources. With regard to data standards, the report recommended that the department:

- Establish minimum data collection standards that meet federal guidelines;
- Establish ideal data collection standards that exceed federal standards, including enhanced data on ethnicity, educational attainment, employment status, occupation, and preferred language;
- Develop a department-wide mechanism for geographic information system management and routine performance of spatial analysis using residential address information;
- Encourage state partners, such as hospitals, clinics, physicians and laboratories to enhance their data collection systems to meet federal standards;
- Provide training for department staff, physicians, and other reporters on minimum standards; and
- Assess the department's technical capacity to meet or exceed federal standards.⁶³

The department is working to improve the coordination of data systems and requires all internal systems to comply with these guidelines by 2012.

Illinois. Illinois has developed an innovative community health assessment and planning model, the Illinois Project for Local Assessment of Needs (IPLAN), which is designed to identify community health problems and solutions. IPLAN communities direct the assessment and planning process, working with local health departments and resulting in a five-year community health plan. The plan addresses a minimum of three health priorities and includes time-referenced outcome objectives with appropriate intervention strategies. It is a community health assessment and planning process that is conducted every five years by local health jurisdictions in Illinois. IPLAN is grounded in the core functions of public health and addresses public health practice standards such as organizational capacity assessment, community health needs assessment, and community health planning.

Massachusetts. Massachusetts is developing an alternative approach to data collection that recognizes the need for consistency with broad federal race and ethnicity categories but collects more detailed ethnicity data. The state's Bureau for Health Information,

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Statistics, Research, and Evaluation finds that the state's diverse population, particularly foreign-born people are more likely to recognize the ethnic categories. Rather than trying to "shoe horn" these categories into the five federal race and two ethnicity categories, the states collect race and ethnicity separately but seeks more detailed ethnicity data to be consistent with federal standards, while providing richer subgroup information. The state's data collection approach is to allow people to identify as many ancestry groups as appropriate, encourage self-report, and to provide training for data collectors (e.g., those administrative staff collecting data at hospital intake). To that end, the Department of Public Health is developing in-person and on-line training. Encouragement and support from the state's leadership has been critical to the success of the data collection effort. Data are used to understand where to target interventions, such as smoking cessation targeted to Portuguese-speaking men. Data are also an advocacy tool, and can be used at the institutional level to focus on internal process.

North Carolina. Since the early 1990s, North Carolina has pursued a relatively unique strategy in that it has focused on building the capacity of local communities to identify disparities, collect data, and develop local action plans. The state's Office of Healthy Carolinians (OHC) has worked closely with county-level public health officials and public health providers to build community coalitions that collect and analyze health data, and to help these groups to develop expertise in data in secondary and primary data analysis. Using both quantitative and qualitative data collection, the state has supported regular community assessments that mine available data and supplement it with new primary data collection to address data inadequacies at the local level. Key to the success of this effort has been the establishment of local partnerships with a wide range of stakeholders, including schools, churches, businesses, civic groups, and others. OHC encourages community partnerships to obtain certification from the Governor's Task Force for Healthy Carolinians, which recognizes local teams that have established community partnerships, conducted a community assessment, and have mobilized resources to address the identified priorities. Typically, local health departments or hospitals play a lead role in establishing community partnerships, consistent with a 1974 legislative mandate that counties conduct regular community assessments.⁶⁴

Essential Service #2

Diagnose and Investigate Health Problems and Health Hazards in the Community

Essential state functions in this domain include:

- Epidemiologic investigation of disease outbreaks and patterns of infectious and chronic diseases, injuries, and other adverse health conditions.
- Population-based screening, case finding, investigation, and the scientific analysis of health problems.
- Rapid screening, high volume testing, and active infectious disease epidemiology investigations.

As above, state efforts to meet this goal have been frustrated by data deficiencies. But the public health literature suggests that states should:

Improve population-based screening and epidemiology in minority communities.

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Conducting epidemiologic research with diverse populations is an historic challenge for public health. Similarly, rates of screening for cancers and other diseases are often lower in communities of color. Disease screenings such as mammography and the Pap smear have significantly reduced deaths related to breast and cervical cancers, but the prevalence and survival rates for both diseases are disproportionately lower among minority women. Public health can improve these statistics through many of the processes described in this report, such as building strong community alliances, expanding the use of community health workers, and increasing the diversity and cultural competence of the health workforce.⁶⁵ But other, more targeted efforts are also needed. For example, community-based outreach efforts such as those undertaken by the University of Pittsburgh's Center for Minority Health have proven effective in increasing prostate cancer screening rates among African-American men by working with barbers and barber shops in the African-American community to disseminate information about the prostate specific antigen blood test and digital rectal examinations. To accomplish this, barbershops were provided with culturally sensitive public health educational and materials, public service announcements encouraged men to learn about prostate cancer screening while visiting barbershops, and Pittsburgh-area health professionals and health professions schools volunteered time to answer questions and conduct screenings. Other efforts have utilized alternative methods to improve screening rates, such as assisting primary care providers to conduct colonoscopies. In South Carolina this approach made screening much more accessible to minority patients, while at the same time reducing wait periods and reducing costs.⁶⁶

Promote the use of Health Impact Assessments (HIA). The purpose of HIA is to ensure that all government programs and initiatives, whether in or outside the health care delivery sector, are assessed to determine their potential impact on communities' health status.⁶⁷ HIA is widely used in Europe as a policy and planning tool, and it is gaining influence in the United States. The San Francisco Department of Public Health, for example, uses the Healthy Development Measurement Tool to identify and assess community health needs and to better understand how land use and development projects can complement public health goals. Moreover, the elimination of health disparities is often a central focus of HIA. Of the 27 major HIA projects conducted in the United States between 1999-2007, HIA studies found "increased burdens of asthma and lead poisoning among children living in substandard housing, delayed cognitive development in households experiencing food insecurity, and that increased employment from Florida power plants could lead to health benefits for African Americans living nearby."⁶⁸

Strengthen the state infrastructure to investigate health hazards that disproportionately affect communities of color, such as environmental and occupational health risks. States can do much to improve environmental and occupational health surveillance and tracking of health conditions that may be related to environmental or occupational hazards, although few states have attempted to develop such a system. The lack of an on-going, comprehensive tracking system contributes to gaps in knowledge about the possible links between environmental hazards and diseases. To do so would require that environmental and health databases, registries, and monitoring systems be coordinated and linked together. Statewide and community level incidence data on chronic diseases are needed

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to identify trends and patterns and improve disease prevention efforts, but in many cases, especially at local levels, it is very difficult to determine what environmental hazards are people exposed to, the degree of exposure, how exposures change over time, whether these exposures compare by populations or communities, and whether there is an unequal burden of environmentally-related diseases in specific populations or communities. To address these deficiencies, CDC's National Environmental Public Health Tracking Program provides grants to states and is building a national integrated environmental and public health information system that integrates federal, state and local data. States can build capacity by participating in the CDC program and similar efforts.⁶⁹

Promising State Strategies to Diagnose and Investigate Health Hazards in Communities that Face Health Disparities

California. California's Environmental Health Tracking Program (CEHTP) is a landmark comprehensive plan for an integrated, standards-based system that provides monitoring, reporting, linkage, and communication of data on environmental hazards and environmentally-related diseases. CEHTP creates integrated data systems and collaborative programs and partnerships involving environmental and public health professionals and organizations. The network will track environmental hazards to guide exposure-prevention efforts, track disease trends (with a focus on disparity populations and specific geographic areas), link information on environmental hazards, exposure data, and disease reports, inform disease prevention and environmental protection programs, and improve public access to information on environmental-health issues.

Essential Service #3

Inform, Educate and Empower People About Health Issues

To address this need, states are tasked with developing and maintaining:

- Health information, health education, and health promotion activities designed to reduce health risk and promote better health.
- Health communication plans and activities such as media advocacy and social marketing.
- Accessible health information and educational resources.
- Health education and promotion program partnerships with schools, faith communities, work sites, personal care providers, and others to implement and reinforce health promotion programs and messages.

Communities of color often face greater barriers to health literacy and health information. These barriers span a gamut of issues including low English language proficiency, poverty, low educational or literacy levels, as well as systemic issues such as residential segregation. States have addressed these needs in a variety of ways, but a common attribute of these practices is that they depend upon—and must necessarily strengthen—community partnerships. These partnerships are widely viewed as vital to improving the reach and impact of public health messages (and are an essential public health service, as described below). Literature indicates to address the health communications needs of disparity populations, states should:

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Build and/or strengthen culturally and linguistically appropriate health literacy programs. Patient education programs teach patients how to effectively navigate health care systems, manage illness, participate fully in treatment plans, and generally ensure that their needs and preferences are being met. For example, culturally-tailored patient-education programs have been found to be effective as a means of reducing racial and ethnic disparities in pain control.⁷⁰ They are most successful when designed in partnership with target populations and when language, culture, and other attributes of communities of color are fully addressed.⁷¹ CLAS offers guidance for the development, implementation, and evaluation of health literacy programs.

Develop, disseminate and evaluate health promotion messages. Few studies have assessed the effectiveness of communication interventions across diverse groups, but research has identified promising practices.⁷² The Association of State and Territorial Health Organizations' review of state and local health disparities programs found that they utilized a wide array of health promotion strategies and vehicles, including media campaigns, partnerships with churches and community-based organizations, multi-lingual radio programs, presentations at health fairs, forums, community dialogues and town hall meetings, as well as Public Service Announcements and other media outreach to communities of color.⁷³

Evaluate and tailor emergency preparedness messages for communities of color and linguistic minorities. The inadequacy of government response to Hurricane Katrina serves to remind us of the need for effective strategies for emergency communications for diverse populations. As the National Consensus Panel on Emergency Preparedness and Cultural Diversity writes,

The integration of racially and ethnically diverse communities into public health emergency preparedness is essential to a comprehensive, coordinated federal, state, tribal, territorial and local strategy to protect the health and safety of all persons in the United States. Such a strategy must recognize and emphasize the importance of distinctive individual and community characteristics such as culture, language, literacy and trust, and promote the active involvement and engagement of diverse communities to influence understanding of, participation in and adherence to public health emergency preparedness actions. Additionally, this strategy must acknowledge the critical commitment to developing effective and sustainable services, programs and policies and building mutual accountability.⁷⁴

The panel recommends that local, state and federal health agencies coordinate and integrate efforts to address the needs of health disparity populations by:

- Identifying diverse racial/ethnic, immigrant and limited English proficient populations;
- Establishing sustainable partnerships between community representatives and the public health preparedness system to build and sustain trust; and
- Engaging community representatives in the design, implementation, and

evaluation of emergency risk communication strategies.⁷⁵

Promising State Strategies to Inform, Educate, and Empower Communities that Face Disparities

The eight states reviewed here offer a wide array of health literacy, health promotion and emergency preparedness programs and services for health disparity populations, of which a few are described below. Most of these are as yet unevaluated.

California. California's *Health Framework for Public Schools, Kindergarten Through Grade Twelve* is a health education curriculum developed at the local level to promote health literacy collaborations between schools, parents and the community. The program is based on research evidence indicating that students should receive sequential, age-appropriate health education every year during the elementary and middle or junior high grades and a minimum of a one-semester health education course at the secondary level. These strategies are tailored to the cultural and linguistic needs of the state's highly diverse student population.

Illinois. Illinois created a Health Literacy Task Force to spearhead "Health Literacy For All," a program designed to aid parents in understanding health information. The Task Force has worked with hospitals, pharmacies, medical providers and medical schools to create low-health literacy pamphlets, posters and electronic information on health issues that are available at hospitals, pharmacies, libraries and literacy programs. To promote the program, the Illinois Department of Public Health annually sponsors dozens of events and activities throughout the state during Minority Health Month, including HIV testing, health fairs, and workshops addressing diabetes, depression, substance abuse, domestic violence, breast and cervical cancer, Hepatitis C and obesity.

Massachusetts. Massachusetts' medical assistance programs provide multilingual assistance, such as health education videos in multiple languages, and train staff to easily convey health care information. The state also has established an Adult Basic Education Health Curriculum Framework for use in adult literacy classes.

New York State. State emergency health preparedness plans are tasked with routinely evaluating and addressing the needs of vulnerable populations. Agencies coordinate community engagement meetings, produce risk communication materials in multiple languages, and develop toolkits and other information resources that are culturally and linguistically appropriate.

Washington. A local initiative developed by the City of Seattle and King County, the Vulnerable Populations Action Team (VPAT), seeks to improve access among all of the county's residents – particularly "hard-to-reach populations," communities of color and linguistic minorities – to public health preparedness, response and recovery information and services. VPAT coordinate preparedness efforts throughout the County with a wide variety of community partners, focusing on influenza pandemic planning

Essential Service #4

Mobilize Community Partnerships to Identify and Solve Health Problems

To fulfill this service, state public health systems should:

- Convene, facilitate, and collaborate with statewide partners (including those not typically considered to be health-related) to identify public health priorities and create effective solutions to solve state and local health problems.
- Build statewide partnerships to collaborate in the performance of public health functions and essential services in an effort to utilize the full range of available human and material resources to improve the state's health status.
- Assist communities to organize and undertake actions to improve the health of the state's communities.

Several states have mobilized community partnerships to address health disparities, but the scholarly literature regarding effective practices, or even how and whether community partnerships affect health determinants or health status, is thin. The federal Office of Minority Health has recently issued a funding announcement to assess the effectiveness of collaborative community-based interventions, implemented at the grassroots level, on reducing health disparities. Yet almost all of the leaders interviewed for this report stressed the need for strong community partnerships to address health disparities. Their view, reinforced by the literature regarding effective practices, is that states should:

Build and/or strengthen community partnerships for health, leveraging existing resources and models such as the CDC Racial and Ethnic Approaches to Community Health (REACH) program. CDC's REACH program fosters community partnerships and community-driven strategies to address social, economic, and cultural circumstances that influence health disparities. Each of the 40 local REACH initiatives is built around a community coalition that includes at least one community-based organization, research institution, and a state or local health department. These coalitions bring together other participants and leverage resources from other government agencies, faith-based groups, and community and civic organizations. CDC provides training, technical assistance, and support to REACH communities to implement and evaluate interventions and disseminate findings. The program's goals are to build and sustain long-term partnerships, to provide participants with tools to seek and demand better health and local resources, to make sustainable improvements to community systems and infrastructures, and to share lessons and best practices that can be used in other communities.⁷⁶ Results of the program to date have been impressive: data from the REACH Risk Factor Survey show improvements in health behaviors and reductions in health disparities in the 27 REACH communities that focus on prevention of breast and cervical cancer, cardiovascular health, and diabetes management. For example:

- Cholesterol screening increased among Hispanics in REACH communities between 2002 and 2006, almost eliminating the gap in screening rates between this population and the overall national population, while screening rates among Hispanics not in REACH communities declined;
- Cholesterol screening rates among African Americans in REACH communities was below the overall national average in 2002, but increased to exceed national

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- screening rates in 2006;
- The proportion of hypertensive American Indians in REACH communities who began taking medication for high blood pressure increased from 67 percent in 2001 to 74 percent in 2004, exceeding national averages for American Indians;
- The proportion of Asian American men in REACH communities who smoked in 2002 exceeded national averages (42 percent), but this rate declined by half by 2006 (20 percent) and is now below the national average for the general population.⁷⁷

Develop integrated approaches to community health that coordinate programs across a variety of settings, including schools, worksites, communities, and health care settings. The Institute of Medicine’s Roundtable on Health Disparities notes that integrated clinical and community approaches offer promise to build community capacity to address health disparities. Integrated approaches recognize that individuals’ health-related knowledge, behaviors and attitudes are shaped by their social networks, and that “lifestyle choices . . . [are] dependent on a complex mix of social and community environments . . . [an] integrated approach [therefore must] saturate all levels of the social structure.”⁷⁸ An example of an integrated approach, which coordinates programs implemented in schools, worksites, communities, and health care settings, appears in Table 1. Such approaches also integrate community participation and involvement in disparities-reduction activities by providing communities with the knowledge and skills necessary to identify community health problems, gather data and monitor progress, and leverage existing public and community partnerships to meet public health goals. In addition, successful programs identify individuals who lack medical care and direct them to services. For example, the Steps to a Healthier US program uses community health workers to match people to health education and disease management resources, while encouraging community coalitions to identify unmet needs and stimulate the development of workplace and school wellness programs, and to advocate for policy changes such as improvements in the built environment and expanding disease registry programs.⁷⁹

Table 1: An Example of an Integrated Approach to Community Partnerships (IOM, 2008)

School-Based: School Health Index School Health Inventory Wings 4 Youth Fitness Camps	Worksite: Worksite Wellness Index Smoking Cessation Facilitator Training
Community-Based: Wings Fitness Community Physical Activity Events Healthy Restaurants Healthy Women BMI Screenings	Health Care: Smoking Cessation Facilitator Training Quit Line Provider Referral Program

Promising State Strategies to Mobilize Community Partnerships to Address Health Disparities

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California. Several REACH grantees in California have successfully mobilized coalitions to promote healthy behaviors, as well as to address community health needs. For example, Community Health Councils (CHC) coordinates the African American Building a Legacy of Health coalition, which conducts community-based participatory research, promotes policies that improve community health, and increases public awareness of health needs of underserved communities in South Los Angeles. In particular, the coalition has focused attention on the relative dearth of healthy food resources in South Los Angeles, and has led the effort to persuade the city council to place a moratorium on the establishment of new fast-food restaurants in the community, as well to create incentives for retailers that sell healthy foods to locate in disadvantaged areas. The coalition has also helped to develop wellness programs in nearly 50 workplaces and preserve a local community fitness center. Another REACH program in Santa Clara California – the Vietnamese REACH for Health Initiative – has tackled the high rate of cervical cancer among Vietnamese-American women by planning and implementing a cervical cancer action plan that uses a multimedia campaign, outreach activities by lay health workers, a Pap test clinic that provides patient navigation assistance, and other strategies. An evaluation revealed that 48 percent of Vietnamese American women who never received a Pap test received one after meeting with a lay health worker, and over half received a repeat test within 18 months. Over 4,000 women were successfully enrolled in a reminder system. The program also successfully increased the rate of mammograms and clinical breast exams among program participants relative to a control group.⁸⁰

New York. The IOM Roundtable report on Challenges and Successes in Reducing Health Disparities highlighted community development programs in New York State that have successfully expanded the capacity of communities to address health disparities. The Steps program in Broome County, coordinated by the NYSDOH, serves about 700,000 residents in this rural residential county. The program’s goal is to create sustainable policy, environmental, and systems changes and specifically targets African Americans, children and young adults, seniors, veterans, and rural, low-income, and disabled residents. Steps programs build upon the existing community infrastructure and attempt to weave programs in to the public health agenda and fabric of the community. Specific strategies are developed that promote partnerships (over 100 traditional and non-traditional partners are involved in the program), enhance coordination between public and private service systems, and encourages systemic identification of common problems and opportunities for addressing them. For example, programs have been developed to foster healthier eating by establishing Farmer’s Markets and a community collaborative effort to provide healthier food options in schools. The initiative’s “Mission Meltaway” works with schools, churches, and workplaces to design and implement weight-loss interventions targeted to the African-American community, and reinforces these effort through individual interventions (e.g., peer training), as well as by encouraging partner organizations to create institutional environments that support healthy eating and exercise programs. Ongoing evaluation is an important feature of the Steps program; data from both the Behavioral Risk Factor Surveillance Survey (BRFSS) and the Youth Risk Behavior Survey (YRBS), as well as local-level data are used to assess progress. To date,

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evaluations of the program suggest that it is attaining its goals. Over 80 percent of Mission Meltaway's participants were classified as overweight or obese at the program's initiation, and all areas of measurement have demonstrated statistically significant health improvements. For example, participants reported an increase in their fruit and vegetable intake by approximately a half-serving a day, consumption of high-calories non-nutritious foods declined significantly, mean weight decreased by nearly 5 pounds per participant, and 62 percent of participants decreased their Body Mass Index by at least 1 point.⁸¹

Washington State. In 2006, Washington State's legislature approved SB 6197, which created the Governor's Interagency Coordinating Council on Health Disparities to plan for the elimination of health disparities and conduct health impact reviews. The Council was charged with:

- Developing a state action plan for eliminating health disparities that will consider health disparities broadly and also explicitly address a number of diseases and conditions;
- Issuing recommendations for improving the availability of culturally appropriate health literature and interpretive services in public and private health-related agencies;
- Promoting communication among and between state agencies and communities of color, the public sector, and the private sector to address health disparities;
- Gathering information, through public hearings and the like, to understand how the actions of state government ameliorate or contribute to health disparities; and,
- Conducting health impact reviews in collaboration with the state Board of Health for reviews requested by the governor or the legislature (discussed in more detail above, under essential service #6).

Essential Service #5

Develop Policies and Plans That Support Individual and Community Health Efforts

States can meet this standard through:

- Systematic health planning that relies on appropriate data, develops and tracks measurable health objectives, and establishes strategies and actions to guide community health improvement at the state and local levels.
- Development of legislation, codes, rules, regulations, ordinances and other policies to enable performance of the Essential Public Health Services, supporting individual, community, and state health efforts.
- The democratic process of dialogue and debate between groups affected by the proposed health plans and policies is needed prior to adoption of such plans and policies.

Planning is essential to eliminate health disparities, as is the ability to harness policy levers to enable performance of essential public health services. These strategies are enhanced and their likelihood of success is greatly improved to the extent that communities are involved in identifying community health problems, planning strategies to address them, and in implementing programs. Community-level public health efforts, moreover, are particularly important and rich areas to state public health work.

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Importantly, these strategies operate “upstream” to attack health determinants such as housing, education, environmental justice, and the like (see Appendix C [THIS IS APPENDIX C...] for examples of these approaches). Literature suggests that states should

Develop, implement, and evaluate a statewide health disparities plan. State leaders interviewed for this project stressed the need for states to develop a strategic plan to address health disparities that describes an integrated set of programs spanning a range of clinical and community services, policies, and initiatives. The responsible agencies should be clearly identified, as should community partners, and specific action sets, with timetables for reporting and measures for accountability, should be described. Such a plan should be developed in partnership with communities served by the plan, and should reflect these communities’ expressed priorities and needs.

Establish a state minority health policy “report card” as a tool in evaluating and promoting state disparities-reduction efforts. Several research and policy organizations have released report cards to measure state efforts to improve health care access and quality. While the results of these report cards have not been assessed, the goal of providing transparent public information to enhance government accountability and to increase incentives for improved performance is compelling. Trivedi and colleagues, for example, measured the minority health policy efforts and performance of all fifty states using four variables (differences in health insurance coverage between minority and non-minority populations in the state, the diversity of the state physician workforce, the presence of a state office of minority health, and the number of racial and ethnic categories in state vital statistics reports).⁸² Because of the trend toward devolution of responsibility for public health programs to states, standard variables are needed that can track state performance over time and allow for comparisons between states. States should consider reporting using a standardized state-level index to compare among and between populations among and between states.⁸³

Promote Community Health Planning. Community health planning has been defined as “the deliberate pursuit of improvements in the health status of a community or the efficiency of the health care system through a public process that allows all members of the community to have significant input.”⁸⁴ It therefore seeks to actively involve residents in their own communities’ planning, evaluation, and implementation of health activities, along with other stakeholders such as health care providers, payers, consumers, and government. Community health planning has a long history, but its promise has yet to be achieved. The National Health Planning and Resource Development Act of 1974 sought to create and support a network of community Health Systems Agencies (HSAs), but a lack of funding, enforcement powers, and effective mechanisms for community input to shape health policy has led to a decline of HSA power and influence.⁸⁵ Health planning, however, has enjoyed greater success in New York State than in other parts of the country. Two Health Systems Agencies (HSAs) continue to operate in the state, and the Finger Lakes HSA is often viewed as a national model for a planning process to achieve consensus among diverse stakeholders (see Text Box 1).⁸⁶

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TEXT BOX 1

NEW YORK STATE: A PIONEER IN COMMUNITY HEALTH PLANNING

Source: Steen J. (2008). Civil Rights, HSAs, CoN, and Public Health, available at <http://hc-cr.blogspot.com/2008/07/powerpoints-and-presentations-from-june.html>, accessed July 2, 2008.

New York State has a rich history of support for community health planning to meet the needs of residents and balance stakeholder interests. In the 1930s, the Hospital Council of Greater New York and the Rochester Hospital Council supported regional efforts to organize health care facilities. At the same time, leaders such as Marion Folsom helped to organize community efforts such as the Patient Care Planning Council in Rochester. This group reviewed hospitals' capital requires, and compared these with the community's need for hospital beds. As a result of the National Health Planning and Resources Development Act of 1974, the federal government established Health Systems Agencies (HSAs) to help states plan health care services, in part modeled after Folsom's work. New York State extended community planning in 1983 when it created a statewide network of HSAs to study and recommend improvements in the delivery of health care services in local communities. These HSAs assessed the need for establishing and constructing new hospitals and long term home health care programs. Federal funding for HSAs was cut in 1987, in New York HSAs continued their work with state grants and other funding. State support ended in 1996, however, and these agencies suspended operation.

New York City's HSA was also effective in providing information and advocacy for the health of the city's neighborhoods. It assessed resource capacity and use trends for the city's neighborhoods and analyzed health status trends, focusing on neighborhoods with high health needs and the fewest health resources. Its reports were disseminated to health plans, providers, consumer groups, and others, and worked with those groups to improve service delivery and health status. It also played a significant role in the state's Certificate of Need (CoN) review; HSA criteria for measuring community access to health care in CoN applications included 27 questions about issues such as whether services were accessible, and whether provider obligations for uncompensated care under Hill-Burton Act (1946) funding were met.

In New York State, of the original eight HSAs, two remain (Rochester and Syracuse) and enjoy significant community support. Rochester's Finger Lakes Health Systems Agency (FLHSA), in particular, is a national model for community planning. It prepares Health Professional Shortage Area applications to the federal Health Resources and Services Administration's Bureau of Primary Care, and also supports intergovernmental and public-private partnerships to address community gaps in health care access and health insurance coverage.

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Enhance the potential power of Certificate of Need assessments as a tool for reducing geographic disparities and the “fragmentation” of the health insurance market. Historically, the purpose of the Certificate of Need (CoN) process has been to control health care costs and ensure that investments in the health care industry reflect community needs. In most states that employ CoN, the process has required health care institutions seeking to establish or expand services to submit proposals; in that way, state boards may evaluate projects, eliminate unnecessary duplication of services, and ensure that investments are strategic. But CoN has met with significant resistance and criticism for its failure as a cost-containment measure. The process, however, has great potential to encourage a distribution of health care resources that better reflect community and statewide need.⁸⁷ States should reevaluate, and in some cases reinvigorate, CoN through new policies that ensure accountability for the use of public funds. CoN, however, is reactive, not proactive, and therefore more powerful and inclusive planning tools are needed to shape a state’s health strategy.

Promising State Strategies to Develop Policies and Plans to Support Community Health Efforts

New York. The New York State Department of Health is seeking input on promising strategies and models to revitalize **community health planning**, and the 2008-2009 state budget offers \$7 million in grants to support local health care planning initiatives. In addition, New York City Mayor Michael Bloomberg has expressed interest in community planning as a model to address many local public health, environmental, and physical infrastructure needs.⁸⁸

Massachusetts. A number of key local activities helped build the momentum to address health disparities. The city of Boston embarked on several disparities-focused activities, including a mayor’s task force on disparities and the implementation of a blueprint. Developed by the Boston Public Health Commission, this blueprint laid out 12 recommendations for eliminating disparities, including over \$1 million in new funding for community-based organizations. At the state level, a Special Legislative Commission on Racial and Ethnic Health Disparities was formed to investigate health disparities, develop recommendations, and lay out a **statewide action plan**.

Washington State. SB 5930 requires the development of a **statewide health resources strategy**, which requires that the state survey the demographics of the state and its regions; inventory existing health facilities, health services, and availability of providers; and assess health care needs in different geographic areas. **Certificates of Need** will be awarded consistent with this strategic planning effort.

Essential Service #6

Enforce Laws and Regulations That Protect Health and Ensure Safety

To meet this standard, states must undertake several tasks:

- The review, evaluation, and revision of laws and regulations designed to protect health and safety to assure that they reflect current scientific knowledge and best practices for achieving compliance.

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- Education of persons and entities obligated to obey or to enforce laws and regulations designed to protect health and safety in order to encourage compliance.
- Enforcement activities in areas of public health concern, including, but not limited to the protection of drinking water; enforcement of clean air standards; regulation of care provided in health care facilities and programs; re-inspection of workplaces following safety violations; review of new drug, biological, and medical device applications; enforcement of laws governing the sale of alcohol and tobacco to minors; seat belt and child safety seat usage; and childhood immunizations.

States should review and evaluate how policies and practices may affect the health of communities of color, and where necessary strengthen enforcement of state laws and regulations that protect the health and well-being of vulnerable populations. States should:

Evaluate the impact of existing laws and regulations on the health of people of color, such as environmental and occupational exposures, violence and injury prevention, and firearms access. State policy in a broad range of areas – such as education, labor, transportation, and criminal justice – have significant implications for health and health disparities. Health Impact Assessments (described above) can offer policymakers important information to weigh the impact of laws, policy and regulation in these areas. HIA analyses may be based on existing data about current or past conditions and trends, and therefore improvements in state health data are important to support HIA. Recommendations should prospectively assess the potential consequences of policy decisions, and should be based on multidisciplinary assessment tools.⁸⁹

Assess and, if necessary, improve enforcement of state laws that directly (e.g., environmental health risks) or indirectly (e.g., discrimination in housing and employment) affect the health of people of color. As discussed in Appendix C, [THIS IS APPENDIX C...] research evidence demonstrates that racial and ethnic discrimination persists in sectors such as employment, lending, and housing. To the extent that these unlawful practices limit the socioeconomic opportunities and mobility of people of color or other protected classes, they contribute to inequitable health opportunities. States should assess whether there is a need for greater enforcement of state anti-discrimination laws, in conjunction with federal law enforcement, to improve socioeconomic opportunities for protected groups.

Promising Practices

California. California has adopted a comprehensive approach to address environmental justice, including partnership development, leveraging of resources and coordination across state agencies, and involvement of affected communities in program development. In 1999 California's legislature mandated inter-agency coordination, an inter-agency working group, and a focus on environmental justice across a broad array of state agency actions. California also is home to a number of innovative **health impact assessments**

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that have influenced policy. For example, a Health Impact Assessment of Proposition 49, which would make state funds available to before- and after-school programs, found that these programs can have a modest effect on improving health, but that gains were unlikely to be realized unless programs were targeted to the neediest students.⁹⁰ The ballot measure was approved, and the state evaluates goals for reaching target populations.

Connecticut. In 1993, the Connecticut Department of Environmental Protection developed an Environmental Equity Policy that states “no segment of the population should, because of its racial or economic makeup, bear a disproportionate share of the risks and consequences of environmental pollution or be denied equal access to environmental benefits.”⁹¹ The state’s Environmental Justice Program assesses and responds to environmental problems in low income and minority communities, develops strategies to increase public participation in the agency’s decision making-processes, and educates the public on DEP environmental justice regulation, policies, and procedures. The agency features complaint investigation services that are unrestricted by jurisdiction.

Illinois. Illinois has similarly enacted protections from environmental degradation, and directs the state’s Environmental Protection Agency to assess and address “environmental justice areas,” which qualify for state resources. In 2005, the Illinois EPA created an environmental justice advisory group that includes members of community and environmental groups.

Massachusetts. Massachusetts’ Executive Office of Environmental Affairs assesses community environmental risk and supports participation in environmental policy decision making. The state’s Environmental Justice Policy prioritizes affected communities for funds for hazardous waste site removal, environmental inspections and enforcement actions, and scrutiny of industrial waste facilities and air emissions. The state also creates incentives for open space and other remedies in communities affected by environmental degradation.

New York State. New York State’s Department of Environmental Conservation is directed by statute to address environmental justice considerations when reviewing land use policy, particularly for low-income communities and communities of color.

Washington State. SB 6197 created the Governor’s Interagency Council on Health Disparities (described below), and authorized this body to conduct **Health Impact Reviews**, when requested by the state legislature, to assess the impact of proposed policies or legislation on health disparities in the state. Health Impact Reviews are different from HIA in that the state has no more than 10 days to conduct a review; HIAs, in contrast, can take months if not years to complete. To do a review, the Interagency Council conducts a literature search, and develops a logic model or framework for how the policy could affect health and health disparities. The Council then makes recommendation. All three of the Council’s HIR reports conducted to date are on its web site. These include an assessment of proposals for a school drop-out prevention program, increased funds for teachers in underserved schools, and requirements for state agencies

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to issue emergency notices in more than one language.

Essential Service #7

Link People to Needed Personal Health Services and Assure the Provision of Health Care When Otherwise Unavailable

States should provide several services to meet this goal, including:

- Assessment of access to and availability of quality personal health care services for the state's population.
- Assurances that access is available to a coordinated system of quality care which includes outreach services to link population to preventive and curative care, medical services, case management, enabling social and mental health services, culturally and linguistically appropriate services, and health care quality review programs.
- Partnership with public, private, and voluntary sectors to provide populations with a coordinated system of health care.
- Development of a continuous improvement process to assure the equitable distribution of resources for those in greatest need.

States should measure access to and the availability of quality personal health care services for the state's population, and assure access to a coordinated system of quality care and culturally and linguistically appropriate services. To accomplish this, states should:

Assess and monitor disparities in access to care, and publicly report disparities in access, quality, and outcomes by race, ethnicity and primary language. There is growing consensus among health organizations and policymakers that states must establish quality assurance measures to ensure that protected groups benefit equally from state programs, including health services.⁹² State agencies are already required to implement a Title VI compliance program, including data collection and record maintenance, to ensure that both Departments of Health and the facilities to which Departments of Health convey federal assistance meet the nondiscrimination requirements of Title VI of the Civil Rights Act of 1964.⁹³ Collection of this information provides the foundation for addressing disparities in access to health care. States can analyze Medicaid claims data, for example, to examine variations in utilization, care quality, and outcomes by beneficiaries' race, ethnicity and primary language.

Encourage health systems to adopt "medical home" models, particularly for vulnerable and underserved populations. Medical home models integrate four vital functions including:

- First contact care – or the door on which the patient knocks to initiate help;
- Comprehensive care that addresses a full spectrum of preventative, acute, and chronic health care needs;
- Longitudinal care that offers sustained relationships between patients and health care providers;
- A home base from which other accommodations such as specialists and other care needs can be arranged.⁹⁴

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Having a medical home is associated with better management of chronic conditions, regular preventive screenings, and improved primary care. Racial and ethnic minorities are less likely to report having a medical home, but when they do, their health care access gaps are significantly reduced.⁹⁵ States should promote the development of medical homes in community health centers and other state-supported health care institutions.

Support safety net institutions and quality improvement initiatives in these settings. People of color and low-income individuals are more likely than other populations to access health care in safety-net institutions,⁹⁶ which in many cases face financial vulnerability—the result of low Medicaid reimbursement rates or of the institutions' provision of uncompensated care to uninsured individuals.⁹⁷ States can do much to expand safety net institutions and improve health care quality in these settings. Several states, for example, are working with the federal Health Resources and Services Administration to establish Health Disparities Collaboratives in Community Health Centers. While Collaboratives vary in specific programs and practices, in general they emphasize strengthening community resources and supports for patients with chronic disease, improving clinical decision support, improving patient self-management, and addressing deficiencies in delivery system design and clinical information systems. These models have proven effective in improving clinical outcomes; for example, diabetic patients in one Midwest collaborative were more likely to receive necessary services (e.g., Hemoglobin A1C measurement, dietary counseling, foot examination) than a control group of similar chronic disease patients.⁹⁸

States can also influence the viability and quality of Community Health Centers (CHCs), which disproportionately serve low-income people and people of color. More than 16 million people receive care at more than 1,100 federally-funded health centers across the nation. CHCs provide comprehensive primary care and a range of other coordinated services, and have often led innovation in the development of culturally and linguistically appropriate services that can reduce disparities in access to care and health outcomes. In the 40 years since the beginning of the community health center movement, states have played a growing role in shaping CHCs. For example, through their power to license health care facilities and health professionals, states have helped to ensure that CHCs meet minimum standards and have held centers to additional requirements such as reporting patient safety data. States also can shape and support CHCs through their purchasing authority. Medicaid payments represent a growing share of CHC financial support, and as such state policies regarding coverage and eligibility have a strong influence on CHC operations. In addition, states can appropriate funds or direct federal funds to health centers to achieve state objectives, such as addressing workforce shortages and improving health information technology. In FY2008, states provided nearly \$590 million to support health center capacity for such purposes.⁹⁹

Enhance primary care, particularly in communities with high rates of ambulatory-care sensitive conditions. Through private investment incentives for quality of care improvements, the State can halt further erosion in primary care capacity – especially health care services for populations at risk for not receiving adequate primary care.¹⁰⁰ The State should also encourage investment of capital in the primary care infrastructure,

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focusing on facilities, equipment, and health information technology, as well as performance improvement.¹⁰¹

Support language access programs. Multiple studies document that people who are not proficient in English receive a lower quality of care when they do not receive appropriate interpretation or translation services. They are more likely to be misdiagnosed, have poor understanding of treatment options, and experience barriers to understanding appropriate follow-up and adherence to treatment recommendations. Inadequate interpreter services can limit access to care for patients with mental disorders. Several studies demonstrate that trained professional interpreters and bilingual health care providers positively influence low-English proficient patients' satisfaction, quality of care, and outcomes. Trained interpreters also reduce risks of interpretation errors.¹⁰² And at least one study has examined cost implications of interpretation services, finding that patients with low English proficiency received significantly more recommended preventive care services than a comparison group of English-speaking patients.¹⁰³ Federal policy requires that managed care plans must make written materials available in languages that are prevalent in a state (states define "prevalence"). These written materials include member handbooks, enrollment packages, and other materials. In addition, plans and states must make translation services available to all enrollees. States should consider providing adequate reimbursement for the services of trained interpreters as part of state Medicaid and SCHIP programs.

Include requirements to address health care disparities in all state contracts providing health services through Medicaid, SCHIP, and the state employee health benefit programs (e.g., by encouraging compliance with CLAS standards in all health systems doing business with the state). Some health plans are beginning to develop initiatives to collect data on beneficiaries' race, ethnicity, and language preferences to better understand when and under what circumstances disparities occur, and to develop and evaluate tailored interventions. Aetna, for example, has instituted a very successful data collection and monitoring program that has enjoyed strong cooperation and support from plan enrollees. A key feature of Aetna's approach was to ask beneficiaries for demographic data after enrollment (rather than as part of the application process) and after the purpose of the initiative was explained. These steps helped to ensure a very strong (85 percent) response rate for collection of racial and ethnic data. States should consider offering incentives for plans to adopt such approaches and "preferential status" in contracting to plans that have disparities initiatives in place and can demonstrate success in reducing gaps. In addition, states should consider collaborating with Quality Improvement Organizations (QIOs), which are funded by the federal government to improve the quality of care provided to Medicare beneficiaries. All QIOs are required to design and implement disparities-reduction projects with managed care organizations serving Medicare beneficiaries, and a number of states are working with QIOs to assist with quality improvement in Medicaid programs.

Support culturally effective disease management programs. The Guide to Community Preventive Services strongly recommends disease management programs that provide organized, proactive, multi-component approaches to health care delivery for people with

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chronic diseases such as diabetes. Such programs integrate a range of preventive and primary care services with case management and health education to manage symptoms and prevent co-morbid conditions. The Community Guide underscores support for diabetes disease management programs in 27 studies that found improvements in measures such as glycemic control and provider monitoring of diabetes-related outcomes such as lipid levels, retinopathy, and peripheral neuropathy.¹⁰⁴

Promising State Practices to Link Health Disparity Populations with Personal Health Services and Assure the Provision of Care

Monitoring Disparities

States typically identify clinical and nonclinical areas in which they require plans to conduct studies and undertake quality-improvement efforts. Because all states must make racial and ethnic data available to managed care plans about their Medicaid enrollees, states could readily require monitoring of racial and ethnic disparities in treatment. States must have a written strategy in place to measure, monitor, and improve the quality of care provided by their Medicaid managed care plans. They must specifically scrutinize the care provided to enrollees with “special health care needs,” as defined by each state. To the extent that it is available, states must provide enrollees with comparative information about plans’ performance on quality indicators.

Promoting Language Access

State legislatures are increasingly recognizing the need for linguistically-appropriate health care and the important role of states in requiring or encouraging health providers to address language barriers. Several states, for example, have enacted laws addressing cultural competency training for health professionals and Medicaid funding for language services. But few states have mandated that language services be available. Several states, for example, specify that access to language services be provided only “to the extent possible.”¹⁰⁵ State laws to stimulate language services include licensure requirements (recently adopted provisions in Colorado, Massachusetts, and New Jersey link facility licensure to the provision of language services), reimbursement of language services in state programs, and certification requirements.

California. California has the most laws of any state addressing linguistic barriers in health and health care, but every state now has at least two language-access laws.¹⁰⁶ California also has some of the most comprehensive provisions; these guide state agencies, general acute hospitals, and services for individuals with developmental disabilities or mental health needs. For example, the Health Care Language Assistance Act of 2003 (SB 853) requires that **insurers assess the language needs of their enrollees and provide them with access to translated materials and language assistance**, when needed. California requires the Department of Managed Health Care and the Insurance Commissioner to **establish language standards and requirements for managed care plans**, as well as for individual and group insurers, to increase access to translated materials and medical interpretation. The law also requires that contracts

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between providers and health plans be in compliance with Department of Managed Health Care standards of language assistance and translation standards. Under California's Medicaid managed care contracts, plans must achieve specific ratios of providers to enrollees, include **provider networks to “meet the ethnic, cultural, and linguistic needs” of plan members**, and contract with a broad representation of traditional and safety-net providers. In addition, plans must assess and report on the linguistic capabilities of interpreters and employed and contracted staff, and they must provide **24-hour access to interpreters** for all members. Groups that meet designated language thresholds must provide corresponding language service at various designated “key points of contact.” Plans must also conduct an assessment of the cultural and linguistic needs of their members and forward any complaints about discrimination to the state for investigation. The state also requires cultural and linguistic competency standards in continuing medical education courses for physicians. In addition, the Departments of Health Services, Mental Health, and Social Services are required to provide language assistance, including interpretation by certified interpreters and written translation. Acute care hospitals in the state must provide language assistance services for linguistic-minority groups that comprise 5 percent or more of the geographical area served by the hospital. State law also requires a biennial survey to collect data on the cultural and linguistic backgrounds of California's licensed physicians.

Connecticut. In 2007, the Connecticut legislature **authorized Medicaid payments for language services** when it passed legislation that requires the state Medicaid plan to include foreign language interpretation services to any low-English proficient beneficiary as a Medicaid covered service. Connecticut also collects data and makes publically available an individual profile on each physician licensed in the state, including a list of languages, other than English, spoken at the physician's primary practice locations.

Illinois. Illinois law established an Advisory Panel on Minority Health, in part to address reduction of language barriers for non-English speaking residents and improve data collection and reporting on minority health care issues. And the state's Community Health Center Expansion Act **mandates that “appropriate personnel fluent in the language spoken”** by a predominant number of people in the service area be available. As a requirement of hospital licensure, hospitals must comply with state language assistance guidelines.

Maryland. Maryland has enacted several laws to expand language access in health settings. **Medicaid managed care plans must document steps to address the needs of low-English proficient enrollees** and provide documents in enrollees' native languages, if these groups exceed five percent of enrollees. In 2002 the Maryland state legislature approved the “Equal Access to Public Services for Individuals with Limited English Proficiency Act,” which requires state agencies to provide equal access to public services for people who have low English proficiency. Primary care providers in the state must provide documents languages that meet the need of a “substantial minority” (3 percent or more) of patients. Additionally, Maryland's Qualified Health Centers must assure access to language interpretation if a substantial portion of the population served is not proficient in English.

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Massachusetts. As with most of the states in this analysis, Massachusetts law mandates a range of language services in specific settings. Massachusetts' acute care hospitals are **required to provide interpretation** for all emergency room services provided to patients not proficient in English, and any non-English speaker denied emergency health care services because interpreter services are unavailable may bring a civil action. To meet licensing standards, acute care hospitals must provide no-cost interpretation for all emergency department services. The state Medicaid program is authorized to cover language services provided by acute and non-acute hospitals, and health plans must provide a statement detailing translator and interpretation services. Medicaid plans must also make multilingual providers and skilled medical interpreters available for the most commonly used languages in any particular geographic area in the plan's service area. The network has to be sufficient so that all enrollees will have a choice between at least two providers who are accepting new patients and able to communicate with the enrollee in a linguistically and culturally appropriate manner, as long as such capacity exists within a service area. In addition, plans' written materials must be translated into prevalent languages as determined by the state—currently, English and Spanish—and plans must offer free oral interpretation in all languages. Written material must be accompanied by a statement in multiple languages instructing the enrollee to contact the plan for assistance with translation.

New York. New York State's legislature has enacted several laws to expand linguistic access. Among these are laws requiring that hospitals provide interpretation and translation of all significant forms for patients needing language assistance, and requiring that hospitals designate a **Language Assistance Coordinator** to connect patients with appropriate services and develop a Language Assistance Program. Interpreters and translators are required to be regularly available for non-English speaking groups that comprise more than one percent of a hospital's service area, and these services must be available within time limits upon request by the patient, the patient's family or representative, or a health care provider. In addition, **health maintenance organization licensure** is conditional upon consideration of the network's ability to provide culturally and linguistically competent services to meet the needs of the enrollee population. Medicaid managed care plans must meet the linguistic needs of enrollees.

Pennsylvania. Pennsylvania law requires that **managed care plans provide a description of how they address the needs of non-English-speaking enrollees**, and providers that contract with the state's Medicaid program must ensure use of qualified interpreters for each non-English speaking patient.

Washington. Washington law requires **all health carriers to file an access plan with the insurance commissioner** that includes a description of the health carrier's efforts to address the needs of covered persons with limited English proficiency. The state's Department of Health and Social Services must also provide language services for applicants or service recipients, including interpreter services in person and/or over the telephone, and translation of printed materials.

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Supporting Safety Net Institutions

Massachusetts. In its 2006 legislation to expand health insurance coverage in the state, the Massachusetts legislature authorized a **Health Safety Net Office** (within the Commonwealth's Medicaid office), part of whose authority is to administer a Health Safety Net Trust Fund and an Essential Community Provider Trust Fund. These funds are established for the purpose of “**improving and enhancing the ability of acute hospitals and community health centers to serve populations in need** more efficiently and effectively.” Among the **criteria for grants** is **addressing “the cultural and linguistic challenges presented by the populations served** by the provider.” The law also increases Medicaid rates for physicians and acute-care hospitals, which should help to reduce financial disincentives for providers and hospitals to serve the state's Medicaid population.

Washington. SB 5930 attempts to **strengthen the health care infrastructure in underserved communities** and to reduce the financial vulnerability of health care institutions that serve poor and minority communities. These institutions include community health centers providing primary health care and dental services, migrant health services, and maternity care services. In addition, this section seeks to better **align state health care resources with community needs**, as it authorizes the state health authority to “work with community and migrant health clinics and other providers of care to underserved populations, to ensure that the number of people of color and underserved people receiving access to managed care is expanding in proportion to need, based upon demographic data.”

Promoting Medical Homes

Washington. SB 5930, passed by the legislature in 2007, authorizes the state Department of Social and Health Services to develop **medical homes** for certain populations (aged, blind, or disabled clients, for example). While this provision does not specify that racial and ethnic minorities or other underserved populations must also benefit from special outreach, the state should consider how this effort could be expanded. SB 5093, also passed in 2007, seeks improvements in care for children and the establishment of **medical homes** for children. The state will measure: provider performance, and eventually tie provider rate increases to immunization rates; well-child care, including developmental, behavioral, and oral health screening; care management for children with chronic conditions; emergency room utilization; and preventive oral health utilization. The state will encourage dentists participating in CHIP to provide dental screening, fluoride varnish, and other preventive dental services for children.

Essential Service #8

Assure a Competent Public and Personal Health Care Workforce

To meet this standard, states must provide:

- Education, training, development, and assessment of health professional - including partners, volunteers and other lay community health workers - to meet statewide needs for public and personal health services.

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- Efficient processes for credentialing technical and professional health personnel.
- Adoption of continuous quality improvement and life-long learning programs.
- Partnerships with professional workplace development programs to assure relevant learning experiences for all participants.
- Continuing education in management, cultural competence, and leadership development programs.

States should provide education, training, development, and assessment of health professionals to meet the needs of diverse populations. To address this need, the literature offers support for:

Continuing education in cultural competence, management, and leadership development. Cultural competence training shows promise as a strategy for improving the knowledge, attitudes, and skills of health professionals to serve increasingly diverse patient populations. AHRQ's review of published studies found "excellent evidence" that cultural competence training increases the knowledge of healthcare providers, and "good evidence" that these programs increase providers' knowledge and skills.¹⁰⁷ Similarly, Beach and colleagues synthesized the findings of studies examining the effectiveness of cultural competence training programs for health professionals, selecting studies that used either a before- and after-intervention evaluation or a control group for comparison. They found "excellent evidence" that cultural competence training improves the knowledge of health professionals, and "good evidence" that cultural competence training improves the attitudes and skills of health professionals. They also found "good evidence" that cultural competence training improves patient satisfaction.¹⁰⁸ However, studies not have been able to establish a link between cultural competency training and patient adherence to therapy, health outcomes, and equity of services across racial and ethnic groups. States can stimulate this work by offering incentives for health plans and institutions to improve evidence-based training programs and curricula, and by linking training to health professionals' state licensure.

Promoting diversity in the public health and health professions workforce. Fewer than 8 percent of physicians, nurses, psychologists, and other health professionals are African American, American Indian, or Latino. The United States would need nearly *four times* the present share of underrepresented minority health professionals to match the proportion of minorities in the population. Evidence demonstrates, however, that more underrepresented minority professionals are needed to help close the racial/ethnic health care gap. Minority health care professionals are more likely to practice in minority and medically underserved communities, and to provide care to poorer, less healthy patients.¹⁰⁹ Minority professionals are often better able to address cultural and linguistic barriers that patients of color experience in health care systems.¹¹⁰ And the likelihood that a minority patient will receive appropriate follow-up and referral increases when the patient is treated by a same-race provider.¹¹¹ Not surprisingly, patients of color often express greater satisfaction with the care that they receive from providers of their own background.¹¹² States can stimulate diversity efforts by:

- Reducing financial barriers to higher education and health professions education. State governments can offer low-interest loans, scholarships, and tuition payback

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agreements to health professions students who come from and agree to serve in underserved communities;

- Repaying student loans for health professionals who agree to work in underserved communities;
- In higher education admissions processes, implementing whole file review and considering the needs of the future U.S. health professional workforce in admissions decisions.¹¹³

These programs incur significant costs to states, and policymakers must weigh costs and benefits. Few studies in the present public health or health services literature have examined the costs of stimulating health professional diversity relative to the range of presumed benefits. But indirect evidence suggests that greater diversity in the health care workforce is associated with:

- Improved access to cost-effective primary care among underserved minorities;
- Greater cultural sensitivity and skill in public health and health care delivery systems;
- The inclusion of a broader array of cultural perspectives, an increased volume of and enhanced body of research on health disparities.¹¹⁴

Encouraging the training and employment of community health workers. Also known as lay health navigators or *promotoras*, community health workers function as liaisons between patients and health systems while endeavoring to improve local health outcomes. These individuals, typically members themselves of the medically underserved community, are trained to teach disease prevention, conduct simple assessments of health problems, and help their neighbors access appropriate health and human resources.¹¹⁵ Community health worker models are rapidly spreading, as research and practice indicate that such services can improve patients' ability to receive care and manage illness. States can stimulate these programs by providing grants, seed funding, or other resources.

Promising State Strategies

Workforce Diversity and Cultural Competence

A small but growing number of states have enacted or are considering legislation to require future and current health care providers receive cultural competency training. New Jersey recently enacted legislation (March 2005) mandating that physicians in the state receive cultural competency training. Cultural competency training will be integrated into the curriculum in all of New Jersey's medical schools, and for physicians already licensed in the state, training will be a mandatory condition for license renewal. Other states have also passed legislation involving cultural competency training. California, as described in more detail below, requires cultural competency curricula in continuing medical education courses. Bills addressing this issue have also been proposed in Arizona, New York, Illinois, and Ohio.

California. In 2006 California's legislature passed a bill that **requires continuing medical education** courses to **address cultural and linguistic competency**. The bill also requires accreditation associations to develop cultural and linguistic competency

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standards. The Community Healthcare Service Expansion Act of 2002 (AB 982) established the California Physician Corps, a **loan-repayment program to increase the number of providers in underserved areas**. Candidates who speak a Medi-Cal threshold language receive priority consideration, as do candidates with economically disadvantaged backgrounds and those with significant training in culturally and linguistically appropriate service delivery. Also, the Cultural and Linguistic Competency of Physicians Act of 2003 (AB 801) created a voluntary program for physicians that stresses foreign-language training and cultural-competency certification. The law also included a patient-satisfaction survey to evaluate physicians' treatments.

Massachusetts. In 2006 Massachusetts captured national attention when its legislature approved a bill to expand health insurance coverage to nearly all state residents. The law establishes a **Health Disparities Council** which is authorized to, among other things, “**address diversity and cultural competency in the health care workforce**, including but not limited to doctors, nurses, and physician assistants.” The council is required to submit an annual report with recommendations for addressing these concerns.

Washington State. Among the legislation enacted in 2006 was a provision **requiring cultural competency training** for certain health care professionals, and establishing an ongoing multicultural health awareness and education program for providers. The legislation's goal is "to raise awareness and educate health care professionals regarding the knowledge, attitudes, and practice skills necessary to care for diverse populations to achieve a greater understanding of the relationship between culture and health." All professions regulated by the Washington State Department of Health (DOH) were required to integrate multicultural education into their basic curriculum by July 1, 2008. DOH has developed a web-based training tool available for health professionals, but training programs can develop their own educational approaches. And recent legislation also mandated biennial surveys of the race and ethnicity makeup of the provider workforce.

Medicaid and SCHIP Programs

A growing number of state governments have addressed cultural competence and quality issues in their contracts with Medicaid managed care organizations or SCHIP plans. Federal law and regulations require that provider networks must be adequate to serve its members, and states must take into account, among other factors, the geographic locations of providers and the characteristics, health care needs, and service utilization of people expected to enroll in the plans. States must identify the race, ethnicity, and primary language spoken by Medicaid beneficiaries and provide this information to managed care contractors.

California. Under California's Medicaid managed care contracts, plans must conduct a **satisfaction survey of members**, including those who are limited in their command of English. And in their quarterly reports to the state, plans must provide data on their provision of cultural and linguistic services and on the ethnic composition of providers in their networks.¹¹⁶

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Illinois. Illinois' All Kids and Medicaid programs require that plans meet provider ratios, make services available within designated periods of time, and translate written materials into a language if more than five percent of households in a Human Services local office area speak it (and speak limited English). In addition, **plans must furnish oral interpreters** over age 18, free of charge, to all enrollees speaking another language who request the service. Moreover, plans cannot discriminate based on race and must comply both with Illinois laws and federal laws regarding nondiscrimination.

Massachusetts. Massachusetts' Medicaid and Commonwealth Care programs both contain **standards for cultural competency and language access** that are more protective than those of other plans marketed by the Connector. For example, plans' provider networks must be responsive to the linguistic, cultural, and other unique needs of minority-population members, and must meet provider-to-enrollee ratios and standards about waiting time for appointments and distance from enrollees' homes. The state provides data to the plan, to the extent available, about race, ethnicity, and language of enrollees.

Pennsylvania. Pennsylvania's "Health Choices" agreement for Medicaid managed care includes provisions that plans must meet provider ratios, make services available within designated periods of time, and use providers located within specified distances of enrollees' homes. In addition, plans must consider enrollees' language needs and cultural compatibility in assigning primary care providers to people who have not chosen their own, and plans and providers must demonstrate sufficient cultural competency that cultural differences cannot present a barrier to access or receipt of care.¹¹⁷

Washington. The state contracts require plans to consider enrollee demographic information in order to maintain an appropriate provider network, and they must ensure that there is equal access for enrollees who face communication barrier. **Plans must arrange for free interpreters.** Though the plan makes the arrangements, the state pays for interpreters used in outpatient medical services while hospitals pay for interpreters involved in inpatient services. Plans must also ensure that there are providers within certain distance limits from enrollees' homes and that services will be available within designated periods of time. In addition, plans must monitor performance using HEDIS (standardized performance measures) and CAHPS (a nationally standardized survey of patient experience).

Essential Service #9

Evaluate Effectiveness, Accessibility, and Quality of Personal and Population-Based Health Services

To address this NPHPSP service, states should conduct:

- Evaluation and critical review of health programs, based on analyses of health status and service utilization data, to determine program effectiveness and to provide information necessary for allocating resources and reshaping programs for improved efficiency, effectiveness, and quality.
- Assessment of and quality improvement in the State Public Health System's

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performance and capacity.

To address disparities, states should evaluate the effectiveness of programs and continuously improve the state public health system's performance and capacity with regard to disparity populations. New York State already conducts evaluations of the effectiveness, accessibility and quality of personal and population-based health services, but should include a focus on how these services address the goal of eliminating disparities. For example, New York State can evaluate progress toward eliminating health care quality disparities by collecting and disaggregating Statewide Planning and Research Cooperative System data by patients' race, ethnicity, income or education level, and primary language, and by publicly reporting this information.¹¹⁸ Since 1995 California has required that demographic information such as race and ethnicity be collected and reported in inpatient discharge data, and since 1998 that requirement has been included in Emergency Department and Ambulatory Surgery data programs. The state's studies reveal significant disparities along racial and ethnic lines in access to healthcare, in the delivery of care, and in the outcomes of care. In addition, the California Office of Statewide Health Planning and Development makes this data available to the public.

Essential Service #10

Research for New Insights and Innovative Solutions to Health Problems

To meet this NPHPSP standard, states are expected to:

- Conduct a full continuum of research ranging from field-based efforts to foster improvements in public health practice to formal scientific research.
- Promote linkage with research institutions and other institutions of higher learning.
- Build internal capacity to mount timely epidemiologic and economic analyses and conduct needed health services research.

New York State's DOH has engaged in an array of research projects to address population health, but these efforts have rarely focused on research to better understand and eliminate disparities. The state should increase its capacity to improve the knowledge base and develop new strategies to eliminate health disparities. To this end, the state should:

Support Community-Based Participatory Research (CBPR). Community-based participatory research directly engages with stakeholder individual and organizations in target communities to help shape the design and conduct of research. These strategies include community members as partners in identifying problems to be studied and research questions, as well as in carrying out the research and interpreting findings. CBPR uses the knowledge of the community to understand health problems and to design interventions, providing immediate benefits from the results of the research to the community. New York State can support these efforts by creating special grant funds for partnerships between community-based organizations and research institutions.

Assess and Address State and Local Health Department Research Capacity. New York State should use the National Public Health Performance Standards assessment

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instruments to assess state and local research capacity. The assessment questions posed in the guide can be tailored to determine how health disparities research issues are addressed. Where gaps are found, the state should determine needs and develop a plan to address them.

Form Partnerships with Higher Education and Research Institutions Focused on Health Disparities. Given the research resource limitations of many state and local public health departments, state partnerships with academic and research institutions can provide wide-ranging benefits. For state agencies, contractual or partnership arrangements with research institutions can fill gaps and provide complementary analyses. Public academic institutions often find that collaboration with state agencies to address health disparities fulfills aspects of the institutional mission. And for research institutions, partnership with state health agencies on health disparities research can grow capacity in a rapidly-growing sector of both public and private research support.

Appendix D

STRATEGIES OUTSIDE OF PUBLIC HEALTH FOR HEALTH EQUITY

Increasingly, states recognize that to achieve more equitable health, states must expand efforts beyond traditional public health to include policy in education, housing, employment, transportation, and other sectors. Though some of these strategies are beyond the purview of the state public health infrastructure, state public health departments should convene stakeholders and leverage opportunities to coordinate health equity efforts in other policy spheres.

Expand access to high-quality preschool and other early intervention programs. When a child receives a high-quality preschool education, the personal, social and economic impact over-time is long-lasting for both them and their families. Early intervention programs such as the Perry Preschool Project and the Abecedarian Project support disadvantaged, at-risk children by providing them with a rich academic curriculum and essential social services. With a societal economic return of seven dollars per dollar invested, children involved in these programs have achieved higher educational attainment and performance. Participants earn significantly higher scores on intellectual and academic measures as young adults, attained significantly more years of total education, and were more likely to attend a 4-year college. Additionally, they have shown a reduction in teenaged pregnancy, higher adult wages, rates of employment and home ownership when compared with preschool controls.^{119 120}

Reduce Residential Segregation. Because one of the fundamental determinants of racial and ethnic health disparities is segregation and unequal living conditions in majority-white and majority-minority neighborhoods, *housing mobility* strategies are a promising approach to reducing health inequities and expanding opportunity. Research suggests that helping poor people of color relocate to lower poverty neighborhoods can improve health outcomes, although more research is needed to understand how and under what conditions programs work best.¹²¹ Portable rent vouchers and tenant-based assistance are the most common housing mobility strategies, but legal efforts that challenge residential and school segregation have also produced results. Rigorous enforcement of antidiscrimination and equal opportunity laws remains critical to prevent redlining and ensure fair lending practices, including protection from sub-prime home loans. One obstacle, however, remains white flight from middle class destination communities.¹²²

Improve Housing Stock. Housing is an important factor contributing to health disparities. People of color disproportionately live in older and less healthful housing

Reduce Geographic Barriers to Opportunity. While increasing housing options for people of color is one important strategy, policies should not ignore the needs of majority-minority communities. Many such communities, as noted above, are *segregated from opportunity* in ways that ultimately harm the health of their residents. To address these problems, policies should be examined that reduce geographic barriers to opportunity. For example, new job creation is increasingly taking place in suburban and exurban communities, far from segregated communities of color in urban cores and inner-ring suburbs; many of the residents in these communities don't have cars or other opportunities to get to these jobs. A range of public policies – including public transportation, economic empowerment zones, housing mobility, and zoning – can reduce the distance between people and employment opportunities. Most of these policies require regional planning and coordination across local jurisdictions, and can be supported by state and federal incentives.

Reducing Inequality in Public Education – As a result of residential segregation, children of color are more likely than their white peers to attend high-poverty schools that lack high quality teachers and educational resources.¹²³ A range of policies have been tried to close the achievement gap, from standardized testing, to student performance based incentives for public school teachers, to transportation programs. For significant progress to be made, state and

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federal governments must consider revamping tax policy, such that resources for public education are properly distributed across the entire citizenry, rather than directed to those in the wealthiest communities.

Reforming the Criminal Justice Complex – As the prison population continues to increase with diminishing returns with regard to violent and street crime, policymakers are increasingly asking whether government resources spent on incarceration might be better allocated elsewhere. Reconsidering current arrest and sentencing policies seems especially prudent considering the destructive impact of incarceration on neighborhoods and families across the socioeconomic and racial spectrum. Programs that emphasize strengthening families and communities, rather than simply penalizing offenders, are best fit to combat neighborhood disorder and recidivism.¹²⁴

Appendix E – A Review of State Minority Health Entities

Offices of Minority Health or other health disparities entities exist in 36 of the 50 states and often serve an important role in coordinating state health department activities related to minority health or health disparities and in elevating the visibility of health disparities in state health departments. Minority health offices serve as leading advocates for minority health issues in state health departments, inform and advice legislators, and provide information to key stakeholders and the general public. The federal Office of Minority Health’s 2000 review of minority health entities’ activities in 8 states found that several major activities were commonly undertaken by these offices, including:

- Improving the state capacity to respond to the health needs of communities of color (most often, state offices of minority health sought to address this need by mobilizing community partnerships to identify and address problems);
- Promoting more accurate, detailed and reliable state data collection;
- Monitoring health status to identify community health problems;
- Developing strategies and programs to improve the cultural competence and diversity of the health professions workforce; and
- Evaluating the effectiveness, accessibility, and quality of personal- and population-based health services.

Several different strategies were used to conduct the work, including:

- Outreach to minority communities to engage minorities in prevention or health promotion activities;
- Creation and dissemination of health promotion materials;
- Efforts to increase access to health care, which typically focused on removing cultural or other barriers to treatment;
- Development of social marketing campaigns;
- Training health professionals in culturally and linguistically competent public health and health care practices; and
- Establishing task forces or consortia to develop action plans and mobilize relevant stakeholders.

Data to assess the effectiveness of state minority health offices in reducing health disparities is often lacking, the report noted. However, many were successful in core tasks such as elevating the visibility of and coordinating state health disparities programs, building the capacity of the state health infrastructure to respond to the needs of communities of color, and building strong community partnerships. The report found that several factors that contribute to the effectiveness of state minority health entities, including:

- Support from state government, including legislative initiatives and endorsement of health disparities programs from political leaders;
- A statewide health disparities plan with specific goals and objectives, as well as task forces or commissions to support and provide oversight of the plan’s development and implementation;
- The presence of other state minority health programs, and private-sector minority health entities and coalitions;

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- The presence of health disparities initiatives conducted by the academic and faith communities;
- The presence of strong links between the state minority health entity, communities of color, and the state health department.

The OMH report also found that states faced a number of challenges in their efforts to eliminate health disparities. These include:

- A lack of timely, accurate, and reliable health data for minority populations;
- A lack of understanding by health care professionals of the health-seeking behaviors of minority populations;
- A need for increased collaboration among health department, community-based organizations, and communities of color; and
- A need for increased intra- and inter-agency collaboration, given the array of social, economic, and community-level determinants of health (e.g., transportation, education, environment).
- A tendency for states to be reactive rather than proactive in addressing minority health issues.

The OMH report also found that most states struggled to develop an adequate infrastructure – including systems, relationships, competencies, and resources – for state minority health efforts to succeed. The report noted that “infrastructure appears strongest when it is supported at the core by a strong statewide minority health organization, statewide task forces, state strategies plans specifically minority health objectives, and legislation.”¹²⁵ The report cited Arkansas’ model as a particularly strong “force for further evolution of the state’s minority health infrastructure,” as the state has both an independent commission which reports directly to the Governor’s Office and an Office of Minority Health located within the health department. Most minority health offices established strong linkages with communities of color, but had less consistent linkages within and between state agencies. The report also noted that state minority health efforts were strongest when community-based organizations and advocacy groups were most active as partners with state agencies, and where state administrations and legislatures expressed support for state efforts to address disparities.

Examples from the States

The following examples of state health disparities agencies are derived from the National Association of State Offices of Minority Health (NASOMH) analysis of state health disparities agencies, the National Conference of State Legislatures’ (NCSL) review of state minority health programs, as well as from discussion with state and national health disparities officials and experts. Examples of promising state strategies that reflect the state equity framework above are highlighted in text boxes below.

California

California’s Office of Multicultural Health (CA-OMH) serves as an advisor to both the California Department of Public Health (CDPH) and the Department of Health Care

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Services (DHCS), and as a liaison between the departments and outside stakeholders. The office was established by statute in 1999. The mission of the CA-OMH is to work with internal and external groups to identify and eliminate health disparities, and to serve as the focal point within DHCS for improved planning and coordination of programs related to racial and ethnic populations in California. OMH is guided by the Council on Multicultural Health (CMH), which advises both CDPH and DHCS on eliminating health disparities. The CMH is composed of members from racial and ethnic minority communities and includes individuals with diverse professional backgrounds.

The CA-OMH does not administer programs, but rather conducts policy analysis, creates and strengthens information networks between CDPH and DHCS programs and ethnic/racial communities, and promotes community participation in decision-making related to health issues. It also builds capacity through training, technical assistance and strategic planning, and supports the development and dissemination of information, strategies and resources to address health disparities. Its work falls into five general categories:

- Health planning and policy development (e.g., through analysis of legislation and strategic planning to address the needs of diverse populations);
- Technical assistance and training (e.g., by serving as a resource to CDPH and DHCS programs on issues related to multicultural health and cultural and linguistic competency);
- Consultation and strategy development regarding health initiatives, programs, and services;
- Assessment of the impact of program activities on diverse communities; and
- Program evaluation.

CA-OMH operates under a strategic plan that outlines priority goals, objectives, and strategies for calendar years 2007-2008. The strategic plan establishes three goals for eliminating health disparities in California:

Goal 1: Eliminate disparities in health and health care. Priority objectives under this goal include increasing workforce diversity, informing statewide obesity prevention initiatives, and strengthening emergency preparedness risk communication.

Goal 2: Improve and create quality information and resources. The major objective under this goal is to promote the availability and dissemination of health disparity data.

Goal 3: Improve health care access. The major objective of this goal is to improve the provision of language access services as an integral part of CDHS.

Several cross-cutting strategies are identified in the strategic plan, including strengthening statewide collaborations and communications, building ethnic media relationships, ensuring quality, and engaging multiethnic communities and consumers in planning.

Several on-going initiatives have been established consistent with the strategic plan:

- With support from the federal Office of Minority Health, CA-OMH has initiated a statewide partnership for the development of cultural competency training which will develop and test a portable cultural competency curriculum and training

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- program for government and institutional use.
- CA-OMH has also established a Medi-Cal Language Access Services Taskforce to make recommendations about the design of a statewide language interpreter services system that would provide in-person health care interpreters in multiple languages throughout the state. The taskforce has convened a program for leadership staff from relevant state agencies, along with key external stakeholder organizations such as the California Hospital Association, the California Medical Association, the California Primary Care Association, the California Dental Association, as well as several community of color advocacy organizations.
- CA-OMH is also developing models to address emergency preparedness needs in communities of color and is working closely with CDPH's Emergency Preparedness efforts to conduct outreach to racial and ethnic communities throughout the state.

Connecticut

In 2008 the Connecticut State Legislature passed legislation to create the Commission on Health Equity, whose mission is the elimination disparities in health status based on race, ethnicity and linguistic ability, and improvement of the quality of health for all of the state's residents. The commission will review and comment on proposed state legislation and regulations that would affect the health of disparity populations, review and comment on the Department of Public Health's health disparities performance measures, advise the Governor and the General Assembly on the state's health disparities policies, and serve as a liaison between disparity populations and state agencies. In addition, the Commission will evaluate strategies to eliminate health status disparities and convene the directors and commissioners of all state agencies relevant to the elimination of health disparities (including Public Health, Social Services, Children and Families, Developmental Services, Education, Mental and Addiction Services, Labor, Transportation, the Housing Finance Authority and the Office of Health Care Access). The Commission will also prepare an annual report, pilot and provide grants for new programs, and collect and analyze government and other data regarding health status of state residents. In addition, the legislation grants the Commission the authority to draft and recommend proposed legislation, regulations and other policies designed to address disparities.

Previously, the state legislature established the Office of Multicultural Health (CT-OMH) during the 1998 session. The mission of Connecticut OMH is to ensure that "all people receive [and] benefit from effective and comprehensive programs and services for health promotion and prevention of disease, injury, and disability." The CT-OMH also seeks to establish an inventory of systems and services throughout state programs that address health disparities.

CT-OMH initiated several key programs and activities, including:

- A program to work with medical translators and form an organization of people and firms providing translation services, to promote training, and establish standards to assure quality services;
- A partnership to address the workforce development needs of the state and

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increase the number of health care and public health professionals who represent the state's demographics; and,

- A cross cultural training committee to assess cultural competence among the state's public health and health care workforce.

Illinois

Illinois' Center for Minority Health Services (CMHS) was created by statute in September 1991, with the mission of serving "as a vehicle for implementing change, and . . . to assess the health concerns of minority populations in Illinois and to assist in the creation and maintenance of culturally and linguistically appropriate programs." CMHS works within the state Department of Public Health and coordinates with other relevant federal, state, and local entities to raise awareness of minority health issues and to increase culturally and linguistically competent services and programs throughout the state. CMHS's director reports to the director of public health. CMHS has several priority areas, including HIV/AIDS, cardiovascular disease, communicable disease, lead poisoning, and health education services. CMHS is guided by a Minority Health Advisory Panel, whose membership includes health professionals, healthcare providers, educators, and community members. The committee is charged with expanding access to health care providers, establishing relationships between units within the department and minority organizations, and developing collaborative approaches to assist the department in addressing minority health issues.

Specific initiatives of CMHS, in collaboration with the state Department of Public Health, include:

- The Illinois HIV/AIDS Communities of Color Minority AIDS Initiative, which has developed projects in conjunction with faith-based and community-based organizations to provide culturally competent HIV/AIDS education and prevention messages, counseling and testing services, linkages to care and treatment options, and capacity building services;
- The Illinois Breast and Cervical Cancer Communities of Color Initiative, which addresses the high incidence of breast and cervical cancer deaths among African American and Hispanic women in Illinois by promoting awareness campaigns and early screenings;
- The Stand Against Cancer Initiative, a collaboration between Illinois churches, faith-based organizations, hospitals, clinics, community organizations and the American Cancer Society to reduce racial and economic disparities in access to breast and cervical cancer screening and treatment;
- The Hispanic Communities of Color Initiative, which was developed to address the need for culturally sensitive outreach strategies to increase awareness about breast and cervical cancer and the importance of early detection;
- The Illinois Prostate Cancer Communities of Color Initiative, which promotes education, awareness and early detection of prostate cancer among African American and Hispanic men in Illinois;
- Programs to increase access to health care services among medically underserved minority populations through the expansion of mobile health care; and

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- The Refugee and Immigrant Health Screening Program, which coordinates health screenings to Illinois refugees and immigrants through the identification, treatment and follow-up of health problems.

Maryland

In 2004, Maryland's state legislature enacted House Bill 86 and Senate Bill 177 to establish the Office of Minority Health and Health Disparities (MHHD) in the Office of the Secretary of the Department of Health and Mental Hygiene (DHMH). In addition, the legislature established the Secretary's Task Force on Eliminating Health Disparities as a DHMH internal advisory group.

MHHD's mission is to "focus the [DHMH]'s resources on eliminating health disparities, partner with statewide organizations in developing policies and implementing programs, and monitor and report the progress to elected officials and the public." The DHMD's vision is "a state in which health care services are organized and delivered in a manner designed to eliminate health disparities among its ethnic and racial populations, thereby leading the way to a Healthy Maryland in the New Millennium."

MHHD has developed a number of initiatives and programs to address its charge. To develop a guiding framework for its activities, MHHD assembled four working committees to serve as a resource and provide advice and guidance in identifying key information sources, to recommend goals for eliminating health disparities, and to ensure that key community and professional perspectives were represented. The result was a strategic plan, the *Maryland Plan to Eliminate Minority Health Disparities*, which focuses on areas such as health profession education, funding, access to healthcare services, and measuring health disparities. MHHD has also created and leads a health disparities data work group that consists of DHMH data management program staff. Additionally, the Secretary of DHMH has established a Minority Health Disparities Collaborative which serves as a senior level steering committee to guide internal assessment.

Consistent with the strategic plan, MHHD is involved in several programs and activities:

Departmental Assessment. This five-year initiative, also funded by the federal Office of Minority Health, seeks to identify and develop DHMH capacity to target program resources to address health disparities. The three components of this initiative require that DHMH conduct a self-assessment and identify action plans, implement a management review, and identify best practices, with the goal of instituting a "systems change" approach to increase the Department's focus on health disparities. To this end, MHHD has published and disseminated a report on best practices in capacity building and disease management and prevention to address health disparities.

Minority Health Disparities Data. MHHD is leading a DHMH data workgroup to develop recommendations for a standardized approach to racial and ethnic data collection, data analysis, and data reporting. These data will be used to develop and

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assess future statewide health disparities strategic plans and to monitor progress toward the elimination of health disparities. To that end, MHHD published the *Maryland Chartbook of Minority Health and Minority Health Disparities Data* in November of 2007, and also produces smaller data reports for various purposes, including public events and briefings to legislators and the executive branch. The data program also provides assistance to Maryland's local health departments in their collection, analysis, and reporting of racial and ethnic health data.

Program Analysis. MHHD reviews existing and proposed laws and regulations to assess how they address the needs of communities of color and recommend changes. During the Maryland 2008 legislative session, MHHD reviewed 22 bills, several of which passed, addressing issues such as cultural diversity programs, cultural competency courses at institutions of higher education, physician shortages in rural areas, newborn screenings for hereditary and congenital disorders, and HIV testing for pregnant women.

Annual Statewide Health Disparities Conference. Beginning in 2004, MHHD has hosted an annual statewide health disparities conference to allow stakeholders to share strategies, best practices, successes, and barriers to reducing health disparities in the state. These conferences also provide important input for assessment and review of the strategic plan and progress toward achieving its goals.

Workforce Diversity Initiative. The Maryland Workforce Diversity Initiative is a five-year program funded by the federal Office of Minority Health to increase minority representation in the state's health workforce. The initiative focuses on developing partnerships with health professional schools, implementing a campaign to increase awareness of the need for greater diversity in the health workforce, and collecting baseline and annual data to monitor progress and identify best practices. MHHD's partners in this effort include four Maryland hospitals working to address cultural competency issues, the state's Higher Education Commission and the Health Occupations Boards, and the national Sullivan Alliance to Transform the Health Workforce.

Information Clearinghouse. MHHD maintains an information clearinghouse website (<http://www.mdhealthdisparities.org/>) which contains national and statewide health disparities data, as well as Maryland health disparities reports, resources, a language translation tool, a calendar of minority health events, best practices, and funding opportunities. The clearinghouse contains over 1,000 health disparities related documents, reports, books, and other materials.

Minority Outreach and Technical Assistance. Through the state's Cigarette Restitution Fund Program, MHHD has established an outreach and technical assistance program that focuses on educating communities of color to impact cancer and tobacco health care decisions in local jurisdictions. Annual grants have been awarded to minority and minority-serving organizations to reduce cancer and tobacco use disparities since 2000, reaching over 200,000 individuals through cultural events, educational workshops, and information distribution.

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Massachusetts

The Massachusetts Office of Minority Health was created by the Department of Public Health (DPH) in 1990 to support department-wide health disparities activities. In 2002 the Office of Multicultural Health (MA-OMH) was created by a merger of the Office of Minority Health and the Office of Refugee and Immigrant Health. MA-OMH is located in the Bureau of Family and Community Health and reports to the BFCH chief, but interacts with all Bureaus across the Department. MA-OMH seeks to promote the optimal well-being of racial, ethnic and linguistic minority communities, and works to ensure that DPH's programs are inclusive of and responsive to the needs of these communities. MA-OMH promotes policies to address health disparities, serves as a department-wide resource and provides technical assistance to department programs, develops and implements uniform standards related to racial, ethnic and linguistic minority populations, and collaborates with public and private entities to address health system infrastructure to meet the needs of communities of color.

MA-OMH activities focus on language access, developing programs and policies to eliminate health disparities, and mobilizing communities. These activities are done in partnership with internal and external agencies, academic institutions, and community initiatives.

Language Access. MA-OMH has initiated a number of language access programs. In collaboration with the state's Determination of Need program (DoN) at the Center for Health Quality Management, MA-OMH assesses the quality of interpretation services in healthcare systems and attaches interpreter services conditions to DoN approval. MA-OMH also coordinates interpreter services for the state Bureau for Substance Abuse Services and other department programs that provide direct linkage services such as care coordination program for children with special health care needs. In addition, MA-OMH coordinates telephonic interpreter services for all direct client services in the BFCH and DPH's legal office. MA-OMH has also issued guidelines on working effectively with interpreters (available online at http://www.mass.gov/dph/bsas/providers/interpreter_bsas_guidelines.pdf), and has issued guidance for translating materials from English to a target language. In addition, MA-OMH has developed guidance, in collaboration with the Center for Emergency Preparedness, for local coordinating agencies on ensuring language access during emergency situations,

Eliminating Health Disparities Statewide Initiatives. MA-OMH has developed several statewide disparities initiatives that are designed to increase the capacity of state health care and public health systems to meet the needs of communities of color. With support from the federal OMH, Massachusetts' OMH has developed an initiative to develop state-specific standards consistent with the 14 U.S. Department of Health and Human Services Cultural and Linguistic Access Standards for procurement, contracting, monitoring and evaluation processes. MA-OMH also collaborated with the Center for Health Information, Statistics, Research and Evaluation to implement a methodology for the collection of race, ethnicity and language data across all DPH programs and

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healthcare settings. Similarly, MA-OMH, other relevant state agencies responsible for regulating data reporting, and the Boston Public Health Commission developed a race and ethnicity data collection methodology, and worked with the Massachusetts Hospital Association to train hospital access and registration personnel for its implementation.

Community Partnerships to Reduce Disparities. MA-OMH works to increase collaboration with racial, ethnic and linguistic minority communities to eliminate health disparities, as well as within DPH to improve the department's capacity to respond to health disparities. For example, MA-OMH partially funds Critical MASS, a program located at the Center for Community Health Research and Services (CCHERS), to develop regional coalitions to address health disparities and to produce a community action toolkit to improve local groups' capacity to address disparities. In addition, MA-OMH supports CCHERS's work to increase the use of community based participatory research principles and practices, and to better understand how to craft public health messages, especially emergency preparedness messages, for minority populations through focus group research.

North Carolina

The mission of the North Carolina Office of Health and Health Disparities (OMHHD) is to “promote and advocate for the elimination of health disparities of all racial and ethnic minorities and other underserved populations” in the state. Its Director reports to the state Assistant Secretary for Health. Its predecessor, the North Carolina Office of Minority Health (NC-OMH) was established by the North Carolina General Assembly in 1992, as was the Minority Health Advisory Council (MHAC). MHAC, a fifteen-member council which consists of state legislators, community leaders, and health and human service professionals, advises the Governor and the Secretary of the Department of Health and Human Services (DHHS) on minority health issues. OMHHD works in partnership with faith-based organizations, local non-profits, American Indian Tribes and other organizations and provides a range of capacity building services, including training, leadership and skills development, resource development, financial assistance, and technical assistance. OMHHD's five focus areas are research and data, cultural and linguistic access, policy and legislation, communications, and partnership development.

Health Planning and Policy Development. North Carolina's minority health entities have played a significant role in shaping health policy in the state—an attribute that is rare among the states assessed here. This approach is also widely praised by the experts interviewed for this project. MHAC pursues a proactive legislative agenda, advocating for health disparities programs and increased funding each year. In 2005, for example, MHAC advocated for \$2,000,000 to establish the Community Focused Eliminating Health Disparities Initiative (described below) and \$250,000 to fund interpreter positions in local health departments. North Carolina has also established a Hispanic Health Task Force, comprised of 28 Hispanic leaders from the public and private sector, and the American Indian Health Task Force, consisting of Tribal appointed representatives and 4 DHHS representatives, both of which work collaboratively to address health and human services needs of these populations in North Carolina.

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Health Initiatives, Programs, and Services. OMHHD's health disparities initiatives focus on building infrastructure and capacity within community and faith based organizations, local health departments, American Indian Tribes, and state agencies. The Community Focused Elimination Health Disparities Initiative (CFEHD) provides grants to these entities to address health disparities in HIV/AIDS, infant mortality, homicide, motor vehicle deaths, diabetes and cancer. The federal OMH has helped to support an expansion of this initiative through its State Partnership Grant Program to support planning and capacity building. The North Carolina DHHS Cancer Care and Prevention Branch provided additional funding for expansions of cancer screening and prevention programs. OMHHD has also partnered with the University of North Carolina at Greensboro's School of Nursing Research Office to expand prevention and risk avoidance research focused on eliminating health disparities for African-Americans, Hispanics, and low-income children and adults. Other health disparities initiatives in recent years have included a regional program to implement a state of the art diabetes care management services for African American Medicaid beneficiaries in three communities in North Carolina; an outreach initiative to implement a statewide Medicare Part D education and enrollment effort to increase the enrollment of eligible African Americans in the program; a grant to assess the extent of alcohol use, abuse and unintended worksite injuries in Hispanic communities in the state; and a program to provide training, technical assistance, and leadership and resource development to address the health concerns of the Hmong community in North Carolina.

Pennsylvania

Pennsylvania's Office of Health Equity (OHE) was established by the executive order of Governor Ed Rendell in 2007. The Order formalized the Office of Health Equity in the Bureau of Health Planning in Pennsylvania's Department of Health. OHE answers directly to the Secretary of Health. BHP was selected as the locus for OHE because of its expertise and history of work with medically underserved populations. OHE was established to address disparities in the delivery and utilization of health services that occur by race and ethnicity gender education and income, disability, geographic location, and sexual orientation. In 2006, the Secretary established the Health Equity Advisory Committee, which brings together representatives from minority-based organizations, providers, insurers, advocacy organizations, state agencies, statewide commissions, and DOH staff to advise the Secretary on eliminating disparities.

OHE focuses its programs on education and information dissemination, collaborative efforts and partnership, and community outreach. Examples of its programs include:

State Health Improvement Plan. In 2006, DOH issued the third State Health Improvement Plan which places emphasis on the elimination of disparities. It includes data and strategies as well as links to Healthy People 2010 objectives.

Technical Assistance and Training. OHE has created a catalogue of DOH programs that address disparities, the Disparity Resource Database. It provides information about state

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programs such as the service area, target population, and budgets. The database provides information at multiple levels, including county activity, disparity groups targeted, and funding sources.

Health Workforce Diversity. Four major OHE initiatives are focused on increasing the diversity of the health workforce. These include programs to:

- Encourage racial and linguistic minority students to explore health careers by training health school guidance counselors to mentor and support interest;
- Support minority faculty mentors in health professions schools.
- Increase the numbers of foreign-language interpreters with the knowledge, skills, and ability to work in primary care.
- Create incentives for health professions schools to establish medical interpreter training in their curriculum.

Eliminating Health Disparities Statewide Initiatives. OHE has launched several programs to eliminate health disparities, including:

- A wellness program for African-American faith based organizations with support from the Centers for Disease Control and Prevention and the National Cancer Institute;
- the *BE-A-BRIDGE Partnership*, a multi-disciplinary collaborative comprised of local, statewide and national organizations to improve the health of communities disparately affected by tobacco-related disease;
- the Pennsylvania Perinatal Partnership, a statewide organization of Pennsylvania's Healthy Start Projects, local health department maternal and child programs, and representatives of the Pennsylvania Departments of Health and Public Welfare, which identifies barriers to access and formulates potential solutions;
- a medical interpreter program, in collaboration with Pennsylvania State University, whose goal is to increase the number of programs in the state which train multi-lingual medical assistants to serve as professional medical interpreters.

Communication Strategy. OHE has developed a communication strategy to engage community partnerships and others in local efforts to reduce health disparities. The first phase of the project focuses on broad audiences by providing and disseminating products to address the question, "What are health disparities?" The campaign also focuses on conditions affecting specific populations. A second phase targets practitioners, providers, and policy makers, and will include print and media campaigns, as well as a speakers' bureau to make presentations to diverse audiences.

Washington State

Washington State does not have a minority health office within the state's Department of Health. Instead, the state legislature established the Governor's Interagency Council on Health Disparities in 2006. The 17-member Council has a chair appointed by the Governor, two public members, and representatives of other relevant state agencies, boards and commissions, such as: the commissions on Asian Pacific American, African

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American, Hispanic, and Indian Affairs; the State Board of Health, Superintendent of Public Instruction, Health Care Authority, Department of Health, Department of Agriculture, Department of Social and Health Services, Department of Ecology, and Department of Early Learning. The goal of the interagency council is to provide recommendations regarding the coordination of efforts across state agencies that influence health disparities. The Council is charged with the following responsibilities:

- Creating a state action plan for eliminating health disparities;
- Establishing advisory committees to address specific issues;
- Issuing recommendations, based on public input, for improving the availability of culturally appropriate health literature and interpretive services within public and private health-related agencies;
- Promoting communication among state agencies and between state agencies and communities of color, the public sector, and the private sector, to address health disparities;
- Gathering information from a wide range of sources to understand how the actions of state government ameliorate or exacerbate health disparities; and,
- Collaborating with the State Board of Health in the development of health impact reviews requested by the Governor or the Legislature.

In 2007, the Council was awarded a State Partnership Grant from the Department of Health and Human Services' Office of Minority Health. The grant was used to hire a Health Disparities Outreach Coordinator to improve the Council's capacity to engage communities of color in its work, particularly in the development of an action plan to eliminate health disparities in Washington State and in increasing awareness of health disparities. Through leadership, collaboration, coordination, planning, and the creation of linkages between public and private entities, the Council aims to simultaneously increase the overall capacity of organizations throughout Washington to communicate with hard-to-reach individuals and groups, particularly communities of color, in ways that help eliminate disparities.

Appendix F – About the Author

Brian D. Smedley, Ph.D. is Vice President and Director of the Health Policy Institute of the Joint Center for Political and Economic Studies in Washington, DC. Formerly, Smedley was Research Director and co-founder of a communications, research and policy organization, The Opportunity Agenda (www.opportunityagenda.org), where he led the organization's effort to center equity in state and national health reform discussions and to build the national will to expand opportunity for all. To that end, Smedley is a co-editor, along with Alan Jenkins, of a book, *All Things Being Equal: Instigating Opportunity in an Inequitable Time*. Other relevant publications include a 2008 monograph published by the Commonwealth Fund, with Beatrice Alvarez, Rea Pañares, Cheryl Fish-Parcham, and Sara Adland, *Identifying and Evaluating Equity Provisions in State Health Care Reform*.

Prior to helping launch The Opportunity Agenda, Smedley was a Senior Program Officer in the Division of Health Sciences Policy of the Institute of Medicine (IOM), where he served as Study Director for the IOM reports, *In the Nation's Compelling Interest: Ensuring Diversity in the Health Care Workforce* and *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, among other reports on diversity in the health professions and minority health research policy. Smedley came to the IOM from the American Psychological Association, where he worked on a wide range of social, health, and education policy topics in his capacity as Director for Public Interest Policy. Prior to working at the APA, Smedley served as a Congressional Science Fellow in the office of Rep. Robert C. Scott (D-VA), sponsored by the American Association for the Advancement of Science. Among his awards and distinctions, in 2004 Smedley was honored by the Rainbow/PUSH coalition as a "Health Trailblazer" award winner; in 2002 he was awarded the Congressional Black Caucus "Healthcare Hero" award; and in August, 2002, was awarded the Early Career Award for Distinguished Contributions to Psychology in the Public Interest by the APA.

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